

Public Trust Board

Thursday 30 July 2026, 10:00 - 13:00

Trust Headquarters, Nantgarw / Microsoft Teams

Agenda

10:00 - 10:30 **1. STANDARD BUSINESS**
30 min

Sara Moseley, Chair

1.1. Welcome and Apologies

Sara Moseley, Chair

1.2. In Attendance

Sarah Moseley, Chair

1.3. Declarations of Interest

Sara Moseley, Chair

1.4. Minutes of Previous Meetings

Sara Moseley, Chair

1.4.1. Minutes of the Public Trust Board Meeting Held on 21 May 2026

Sara Moseley, Chair

 1.4.1 Public Trust Board minutes 21.05.2026 (v3SM).pdf (9 pages)

1.4.2. Minutes of the Extraordinary Public Trust Meeting Held on 25 June 2026

Sara Moseley, Chair

 1.4.2 Minutes PUBLIC Extraordinary Trust Board_25.06.2026(v3SM).pdf (5 pages)

1.5. Public Action Log

Sara Moseley, Chair

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

1.6. Matters Arising

Sara Moseley, Chair

None

1.7. Patient Story: Andy's story

Led by Fiona Davies, Head of Safeguarding & Vulnerable Persons

 1.7.0 Andy's story for Trust Board_.pdf (1 pages)

10:30 - 10:40 **2. KEY REPORTS**
10 min

2.1. Chair's Report

Sara Moseley, Chair

 2.1.0 Chair's Report Trust Board 30.07.2026.pdf (10 pages)

2.2. Chief Executive Officer's Report

Carl James, Chief Executive Officer

 2.2.0 CEO's Update Trust Board 30.07.2026 FINAL.pdf (5 pages)

10:40 - 11:30
50 min

3. QUALITY, SAFETY AND PERFORMANCE

3.1. Performance Management Framework (May 2026)

Led by:

- Victoria Oxley, Interim Director of Strategy, Planning and Performance
- Anne Carey, Chief Operating Officer
- Sarah Jenkins, Interim Director of People and Organisational Development
- Carl Taylor, Chief Digital Officer
- Lauren Fear, Director of Place, Portfolio and Partnerships
- Matthew Bunce, Executive Director of Finance

 3.1.0 Trust Board PMF 30.07.26 MAY PMF 2026 Version 001.pdf (42 pages)

 3.1.0a Month 2 2026-27 Finance Report Cover Paper - TB 30.07.2026.pdf (10 pages)

 3.1.0b Appendix 1 - M2 VELINDRE NHS TRUST FINANCIAL POSITION TO MAY 2026 - TB 30.07.2026.pdf (34 pages)

 3.1.0c Appendix 2 - nVCC Project Finance Paper (May 26) FINAL.pdf (17 pages)

3.2. Trust Risk Register

Non Gwilym, Interim Director of Corporate Governance

 3.2.0 TRR Cover Paper - TB - July 2026 - V04.pdf (7 pages)

 3.2.0a Public TRR Appendix -TB- July 2026 - V04.pdf (8 pages)

3.3. Board Assurance Framework

Non Gwilym, Interim Director of Corporate Governance

 3.3.0 Public BAF Cover Paper -TB -JULY-2026 V01.pdf (7 pages)

 01 - CAPACITY JUNE 2026 v02.pdf (6 pages)

 02 - QUALITY - JUNE 2026 v02.pdf (7 pages)

 03 - RDI - JULY - TB 2026.pdf (5 pages)

 04 - FINANCE - JULY TB 2026.pdf (9 pages)

 05 - SUSTAINABILITY - JULY TB 2026.pdf (3 pages)

 06 - POD - MAY 2026 v02.pdf (4 pages)

 07 - DIGITAL - MAY 2026 V02.pdf (4 pages)

 08 - GOVERNANCE JUNE 2026 (002).pdf (5 pages)

11:30 - 11:40
10 min

COMFORT BREAK

11:40 - 12:15
35 min

4. FOR BOARD DISCUSSION AND DECISION

4.1. Terms of Reference – New Committee Structure

Non Gwilym, Director of Corporate Governance (interim)

 4.1.0 Cover Paper Board Committee Restructure.pdf (7 pages)

 4.1.0a Appendix 1 VUNHST Committee Terms of Reference.pdf (53 pages)

 4.1.0b Appendix 2 New Committee Structure Membership and Executive Leads.pdf (2 pages)

 4.1.0c QIA_Committee_Restructure_Completed & Signed.pdf (6 pages)

 4.1.0d EQIA-SIGNED Committee Restructure_Completed_v1.pdf (10 pages)

4.2. Shared Services Commitments of Expenditure

Alison Ramsey, Director of Finance and Corporate Services

- Student Bursary Award System
- NWSSP Material Handling Equipment Lease, Hire and Maintenance

- 📄 4.2.0a Student Bursary Award System VTB CP July 2026.pdf (7 pages)
- 📄 4.2.0b Appendix 1 - Student Bursary Award System Commitment of Expenditure Form VTB July 2026.pdf (8 pages)
- 📄 4.2.0c Appendix 2 - Quality Impact Assessment Student Bursary Award System July 2026.pdf (7 pages)
- 📄 4.2.0d Material Handling Equipment Lease Hire and Maintenance VTB CP July 2026.pdf (10 pages)
- 📄 4.2.0e Appendix 1 - SSP-FTS-60006 - Procurement Outcome Report (Signed).pdf (12 pages)
- 📄 4.2.0f Appendix 2 - Material Handling Equipment Lease & Hire Commitment of Expenditure Form VTB July 2026.pdf (10 pages)
- 📄 4.2.0g Appendix 3 - Quality Impact Assessment Material Handling Equipment Lease Hire and Maintenance July 2026.pdf (6 pages)

4.3. Trust Policies/Procedures for Approval

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

- Childcare Vouchers Policy
- Family Friendly Procedures and Guidance
 - WF59c & WF59d Adoption Leave Procedure and Guidance
 - WF59e & WF59f Parental Leave Procedure and Guidance
 - WF59g & WF59h Shared Parental Leave Procedure and Guidance
 - WF59i & WF59j Paternity or New Parent Support Leave Procedure and Support Guidance note
- Policy and Procedure for Medical Consultant Job Planning

- 📄 4.3.0a Trust Board Childcare Vouchers Policy.pdf (6 pages)
- 📄 4.3.0b Appendix 1 Updated Childcare Voucher Scheme Guidance 2.7.26.pdf (7 pages)
- 📄 4.3.0c Family Friendly Procedures and Supporting Guidance cover paper_July 2026.pdf (7 pages)
- 📄 4.3.0d WF 59c Adoption Leave Procedure v.1_Jan 2026.pdf (12 pages)
- 📄 4.3.0e WF59d Adoption Leave Guidance v.1_Jan 2026.pdf (3 pages)
- 📄 4.3.0f WF 59e Parental Leave Procedure Draft v.1_Jan 2026.pdf (9 pages)
- 📄 4.3.0g WF59f Parental Leave Guidance v.1_Jan 2026.pdf (3 pages)
- 📄 4.3.0h WF59g Shared Parental Leave Procedure v1_Jan 2026.pdf (10 pages)
- 📄 4.3.0i WF59h Shared Parental Leave Guidance v.1_Jan 2026.pdf (3 pages)
- 📄 4.3.0j WF 59i Paternity or New Parent Support Leave Procedure v.1_Jan 2026.pdf (9 pages)
- 📄 4.3.0k WF59j Paternity or New Parent Support Leave Guidance v.1_Jan 2026.pdf (3 pages)
- 📄 4.3.0l 260716 Trust Board Cover paper.pdf (7 pages)
- 📄 4.3.0m App 1 PolicyProcedureMedConJobPlanning.pdf (56 pages)

12:15 - 12:30
15 min

5. COMMITTEE HIGHLIGHTS FOR DISCUSSION

5.1. Public Quality, Safety & Performance Committee Highlight Report (16/07/2026)

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

- 📄 5.1.0 Public QSP Highlight Report 16th July 2026 AE.pdf (8 pages)

5.2. Public Audit Committee Highlight Report (12/05/2026)

Led by Gareth Jones, Independent Member and Chair of the Audit Committee

- 📄 5.2.0 Highlight Report Public Audit Committee 12 May 2026(GJ).pdf (3 pages)

5.3. Public nVCC Project Scrutiny Sub-Committee Highlight Report (18/06/2026)

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

- 📄 5.3.0 v2 Public nVCC Scrutiny Project Sub-Committee Highlight Report 18 June 2026.pdf (2 pages)

12:30 - 12:40
10 min

6. ANNUAL REPORTS FOR APPROVAL

Sara Moseley, Chair

6.1. Duty of Quality Annual Report

Gillian Knight, Interim Executive Director of Nursing, Allied Health Professionals & Health Science

-  6.1.0 TB DoQ Cover Paper July 2026 AE (002).pdf (7 pages)
-  6.1.0a TB 2025-2026 Annual Duty of Quality Report_.pdf (40 pages)

6.2. Trust Annual Integrated Quality & Safety Report

Gillian Knight, Interim Executive Director of Nursing, Allied Health Professionals & Health Science

-  6.2.0 Trust Board cover paper Q and S Annual Report AE.pdf (7 pages)
-  6.2.0a Integrated Quality and Safety Annual Report 2025 to 2026 AE.pdf (78 pages)

6.3. Equality Annual Report

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

-  6.3.0 Trust Board Annual Equality Report 2026.pdf (17 pages)

6.4. Gender Pay Gap Annual Report

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

-  6.4.0 Trust Board Gender Pay Gap Report 2026.pdf (11 pages)

6.5. Welsh Language Annual Report

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

-  6.5.0 Welsh Language Annual Report Cover Paper Trust Board.pdf (4 pages)
-  6.5.0a Welsh Language Annual report 2025 26 v4.pdf (17 pages)

6.6. Social Partnership Duty Annual Report

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

-  6.6.0 Social Partnership Duty Annual Report 2025-2026 Trust Board.pdf (15 pages)

6.7. Fire Safety, Estates, Health & Safety, Sustainability Annual Report

Lauren Fear, Director of Place, Portfolio and Partnerships

-  6.7.0 FRESH Annual report Trust Board Cover Paper.pdf (7 pages)
-  6.7.0a FRESH Annual Report v2 (1) (002).pdf (33 pages)

6.8. Wellbeing of Future Generations Act (2015) Annual Report

Lauren Fear, Director of Place, Portfolio and Partnerships

-  6.8.0 Trust Board Cover Paper - VUNHST WBFGA Annual Report.pdf (6 pages)
-  6.8.0a WBFGA Annual Report 2025-2026 V2.pdf (24 pages)

6.9. Professional Registration, Appraisal and Revalidation Annual Assurance Report 2025-26

Gillian Knight, Executive Director of Nursing, Allied Health Professionals & Health Science

-  6.9.0 TB cover paper for professional registration report.pdf (4 pages)
-  6.9.0a Professional Registration Annual Report FINAL 03.07.26.pdf (16 pages)

12:40 - 12:50
10 min

7. CONSENT FOR NOTING

Sara Moseley, Chair

7.1. Trust Seal Report

Executive Sponsor: Non Gwilym, Interim Director of Corporate Governance

 7.1.0 Trust Seal Report 15.05.2026 - 23.07.2026.pdf (4 pages)

7.2. Chair's Urgent Actions for Ratification

Executive Sponsor: Non Gwilym, Interim Director of Corporate Governance

 7.2.0 PUBLIC Chairs Urgent Action Report JUL 2026 v1.pdf (4 pages)

7.3. Trust-wide policy approvals update

Executive Sponsor: Non Gwilym, Interim Director of Corporate Governance

 7.3.0 TRUST WIDE POLICIES APPROVED UPDATE JULY 2026.pdf (4 pages)

 7.3.0a APPENDIX 1 GC03 Standards of Good Governance and Probity v4_MAY 2026.pdf (49 pages)

 7.3.0b APPENDIX 2 CFC04 Charitable Funds Investment Policy_v6_May 26.pdf (8 pages)

7.4. Extraordinary Public Quality, Safety & Performance Committee Highlight Report (09/07/2026)

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

 7.4.0 Extraordinary Public QSP Highlight Report 9th July 2026.pdf (8 pages)

7.5. Public Strategic Development Committee Highlight Report (07/07/2026)

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

 7.5.0 v3 SDC PUBLIC Highlight Report July 2026 for Trust Board.pdf (2 pages)

7.6. Public Charitable Funds Committee Highlight Report (04/06/2026)

Sponsor: Sara Moseley, Chair and Chair of the Charitable Funds Committee

 7.6.0 Final Highlight Report PUBLIC CFC 4 June.pdf (2 pages)

7.7. Local Partnership Forum Highlight Report (02/06/2026)

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

 7.7.0 LPF Highlight Report for Trust Board - 2 June 2026_(Approved SJ).pdf (4 pages)

7.8. Shared Services Partnership Committee Assurance Report (14/05/2026 & 25th June 2026)

Provided by James Quance, Assistant Director of Corporate Services

 7.8.0 Shared Services Partnership Committee (SSPC) Assurance Report of 14 May and 25 June 2026 VTB CP July 2026.pdf (10 pages)

7.9. Shared Services Partnership Audit Committee Highlight Report (28/04/2026)

Provided by James Quance, Assistant Director of Corporate Services

 7.9.0 NWSSP Audit Committee Highlight Report 28 April 2026 VTB CP July 2026.pdf (9 pages)

7.10. Joint Commissioning Committee Highlight Report (26/05/2026)

Provided by JCC Secretariat

 7.10.0 JC Highlight Report - 26 May 2026 Final.pdf (6 pages)

10 min

Sara Moseley, Chair

13:00 - 13:00 9. ANY OTHER BUSINESS

0 min

*Prior approval required by Chair.

13:00 - 13:00 10. DATE OF NEXT MEETING

0 min

The next meeting will be held on **24 September 2026** at 10:00h.

13:00 - 13:00 11. CLOSE

0 min

The Board is asked to adopt the following resolution:

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

13:00 - 13:00 12. ITEMS FOR DISCUSSION IN PART B

0 min

- Integrated Plan for Board Development
- nVCC update
- Private Risk Register
- Integrated Radiotherapy Solution (IRS)
- Talbot Green Infrastructure
- oVCC Decommissioning Programme
- Transforming Access to Medicines (TrAMs) Business Case
- NWSSP Commitments of Expenditure
- Trust Policies for Approval
- Claims and Redress Annual Report (2025-2026)
- NWSSP Review Implementation Group Update
- Private Committee Highlight Reports

13:00 - 13:00 LUNCH

0 min

MINUTES PUBLIC TRUST BOARD MEETING

VELINDRE UNIVERSITY NHS TRUST

21st May 2026 – 10:00am-1:00pm

PRESENT Sara Moseley Lindsay Foyster Gareth Jones Prof. Andrew Westwell Vicky Morris Hilary Jones John Union Matthew Bunce Dr Jacinta Abraham Gillian Knight Sarah Jenkins ATTENDEES Anne Carey Victoria Oxley Lauren Fear Non Gwilym Kyle Page Emma Williams	Chair Vice Chair Independent Member Independent Member Independent Member Independent Member - <i>remotely</i> Independent Member Executive Director of Finance Executive Medical Director / Deputy Chief Executive Executive Director of People and Organisational Development (interim) Executive Director of Nursing, AHPs and Health Sciences (interim) Chief Operating Officer Director of Strategy, Planning and Performance Director of Place, Portfolio and Partnerships Director of Corporate Governance (interim) Business Support Manager (Secretariat) – <i>remotely</i> Business Support Officer (technical support)

1.0.0	PRELIMINARY MATTERS	LEAD
1.1.0	Welcome and Apologies: The Chair welcomed attendees to the meeting, noting the following apologies: • Carl James, Chief Executive Officer (interim) • Carl Taylor, Chief Digital Officer • Ceri Doyle, Independent Member • Katrina Febry, Audit Lead, Audit Wales, was not present. • David Cogan, Patient Representative, was not present. The Chair also welcomed the following newly appointed Board members to their first Board meeting: • Gillian Knight, Executive Director of Nursing, Allied Health Professionals and Health Sciences (interim) • Victoria Oxley, Director of Strategy, Planning & Performance (interim)	
1.2.0	In Attendance: The Chair extended a warm welcome to the following additional attendees: • Ben Leijokari-Olosunde, Aspiring Board Members Programme Member (<i>in part</i>)	

	• Bethan Davis, HEIW (simultaneous translation) • Arshad Siddiqui, Junior Clinical Fellow (observing) • Elisabeth Davies, Principal Clinical Scientist (Transfusion Medicine) Welsh Blood Service – for staff story • Joanne Gregory, Genetic Haemochromatosis Clinic Co-ordinator, Welsh Blood Service – for staff story • Lindsey Peddle, Patient and Carer Forum • Vaxsika Kumarakulasingham, Cardiff University Medical Student (observing)	
1.3.0	Declarations of Interest There were no declarations of interest noted in respect of today's agenda.	
1.4.0	Minutes of the Public Trust Board meeting held on 26th March 2026 Board members were content that the minutes of the meeting held on 26 th March 2026 were an accurate reflection of proceedings.	
1.4.1	Minutes of the extraordinary Public Trust Board meeting held on 30th April 2026 Board members were content that the minutes of the meeting held on 26 th March 2026 were an accurate reflection of proceedings, subject to clarification on wording (endorsement vs approval for item 2.1).	
1.5.0	Action Log The Board was content to close all actions marked as 'propose to close' and it was noted that an update in relation to the two outstanding actions would be provided at the July meeting in line with the deadlines.	
1.6.0	Matters Arising There were no matters arising for discussion at today's meeting.	
1.7.0	Patient, Donor or Staff Story: Genetic Haemochromatosis – turning treatment into donation Led by Elisabeth Davies, Principal Clinical Scientist (Transfusion Medicine) and Joanne Gregory, Genetic Haemochromatosis Clinic Co-ordinator, WBS Elisabeth Davies and Joanne Gregory presented a story on patients with Genetic Haemochromatosis (GH), highlighting the following: • The initiative focuses on patients with Genetic Haemochromatosis (GH), enabling their routine venesection treatment to be used as blood donation rather than discarded as clinical waste. • The donation pathway is quicker, more convenient, and easier to access (e.g. online booking, closer locations), significantly reducing time burden compared to hospital treatment pathways. • Donated blood is used for patients in need rather than destroyed and a single donor's contributions can support multiple patients (including babies) through blood component use, therefore also providing a societal benefit.	

	• The work has been developed through close collaboration with patients, donors, and health board colleagues, and tools such as videos, SharePoint resources and QR codes support education and confidence in the pathway. • The introduction of an e-referral system has significantly reduced delays in accessing the pathway, while ongoing work is addressing IT and process issues based on donor feedback. • There is potentially a large cohort of patients who could benefit. Board members raised the following points / queries: • The scale of opportunity, given the number of people in Wales with GH and the potential to expand the initiative. It was advised that while this is the most common genetic condition in Wales (affecting around 1 in 150 people), not all will develop symptoms and there are therefore potentially thousands of patients across Wales who may not yet be diagnosed. • Whether it is possible to use a cannula instead of the standard needle for donation. It was advised that using a cannula is unlikely to be suitable as the donation process requires blood to be collected within a specific time frame to maintain product quality. However, the team noted that this option could be explored further by colleagues. • Equity and geographic access; while the service appears to work well in more populated areas, patients in less densely regions may experience a potentially poorer service. The team advised that service location is population driven and that clinics are generally targeted in more densely populated areas to ensure they are visible and can be fully utilised. The team acknowledged the potential to adapt where required, and that if specific pockets of patients are identified in rural areas, there would be scope to consider additional clinic provision. • The great example of an initiative that has been driven by a patient and where they have collaborated fully on a solution. • The initiative has already reduced carbon emissions (250kg over 6 months), as each unit of blood incinerated carries a carbon cost of approximately 0.5kg per bag. The Board thanked the team for sharing the story.	
2.0.0	KEY REPORTS	
2.1.0	Chair's Report The Chair took her report as read and added the following updates which had not been included: • This week marked the second anniversary of the Infected Blood Inquiry publication. The Chair acknowledged its significance and suggested the Board should receive an update on management of consequences and the compensation scheme. • The recent national election and appointment of a new Cabinet Minister for Health and Social Care, confirming that Chairs had written collectively and the Board would also engage and seek opportunities for engagement. The Trust Board NOTED the content of the Chair's update.	
2.2.0	Chief Executive's Report In the absence of Carl James, Jacinta Abraham introduced the report, highlighting the following key points:	

	- Recent engagement (including visits to the new Velindre Cancer Centre) to set ambition for delivering specialist cancer services and strengthening partnerships. - Attendance at the Federation of Specialist Hospitals meeting by the Chief Executive, with a focus on the potential of Artificial Intelligence for specialist services. - A visit to UCLH, highlighting strong organisational values, leadership, and the integration of research and clinical care as aspirations for the Trust. - An away day with clinical medical leaders, to identify themes of organisational readiness for the new Velindre Cancer Centre, including clinical model development, leadership engagement and the work of the Readiness Project Board. The Trust Board NOTED the content of the CEO's update.	
3.0.0	QUALITY, SAFETY & PERFORMANCE	
3.1.0	Performance Management Framework (PMF) (March 2026) Colleagues presented the report, which highlighted key issues for the attention of the Board for the month of March 2026. It was noted that detailed scrutiny takes place via the Quality, Safety & Performance Committee and a recent Board workshop had been valuable in improving understanding of performance issues and demonstrated the benefit of the new divisional structure and diagnostic work on cancer pathways. Members highlighted the significant complexity across cancer pathways and the scale of work underway to understand pathway issues, develop improvement plans and deliver better patient outcomes. Divisional and directorate ownership of pathways, improved accountability and monthly performance reviews were noted as enabling challenge and oversight. It was advised that focus would now be on delivering targeted improvement plans (e.g. Radiotherapy, SACT) and ensuring alignment between current improvement work and readiness for transition to the new Velindre Cancer Centre. It was noted that there is also significant complexity in clinical coding and financial alignment (e.g. a large number of clinic codes), with work underway to simplify these and ensure income reflects activity. Board members queried the organisation's position in terms of digital capacity. Anne Carey explained that an internal Patient Tracking List (PTL) had been developed, pulling data from multiple systems, and that it is the intention to move toward a shared PTL with Health Boards to enable sooner treatment for patients; however, this is currently constrained by wider system limitations. While Board members also recognised and welcomed progress in improving diversity and inclusion within the blood donor base, greater visibility of the actions and initiatives underway was requested, to provide further assurance regarding how the organisation would achieve its diversity targets going forward. Anne Carey advised that the Director of the Welsh Blood Service had visited NHS Blood and Transplant (NHSBT) to observe their initiatives and that the visit had provided learning and insight into good practices. WBS Actions and plans would be refreshed and shared with the Board at a future meeting.	AC

	Victoria Oxley advised that work would be ongoing over the summer to improve the PMF, to ensure a 'single version of the truth' and align performance, finance, workforce and assurance reporting in line with the new Welsh Government Accountability Framework. <u>Finance</u> Matthew Bunce provided an overview of finance, based on discussion at Quality, Safety and Performance Committee: • The Committee had reviewed the March position and noted delivery of statutory financial duties, providing a high level of assurance on the year-end position. • Discussions had also focused on the forward financial position, highlighting risks including delivery of current savings plans, workforce growth pressures and wider NHS Wales financial constraints and funding uncertainty. • The importance of not relying on one-off solutions, noting underlying cost pressures in both Cancer Services and the Welsh Blood Service. • Pressures around commissioning flows and the wider financial landscape. • While financial governance and control were described as robust, there is a need for increased control going forward. • The Trust remains at Level 1 within the accountability framework and will need to maintain this position through continued focus. The Trust Board: • NOTED the Performance Management Framework for assurance purposes. • Reviewed and CONCURRED with the levels of assurance noted in the report.	
3.2.0	VUNHST Risk Register Non Gwilym introduced the report, which provided the Board with a summary of activity related to the status of the risks and associated movement. The following was highlighted as key: • The importance of having clear line of sight across risks, ensuring visibility from operational level through to Board. • Ensuring that risks are clearly articulated and owned, and strengthened in terms of tracking and management within systems. • Ensuring robust and meaningful risk management, to support effective scrutiny. Board members noted the following: • Concern regarding the accuracy of information in the risk register, indicating that while a number of target dates were imminent or due, the narrative suggested that the targets were unlikely to be met. • The need for clear, SMART (Specific, Measurable, Achievable, Relevant, Time Bound) actions and due dates, noting that actions and timelines should be specific, realistic and actively updated. • That it would be useful to consider the wider risk register, acknowledging that there is significant work required to keep all risks up to date and properly reviewed.	

	The Chair emphasised the need for all Executive leads to take active responsibility for reviewing and updating their risks accordingly. The Trust Board NOTED: - the risks in the quality and safety domain with a score of 12 and risks in other domains with a score of 15 and above. - the update on the Datix risk system replacement.	
3.3.0	Board Assurance Framework (BAF) Non Gwilym, Interim Director of Corporate Governance Non Gwilym advised that the Board Assurance Framework (BAF) is being developed as a structured way to align risks with strategic objectives and to provide clearer visibility of assurance and gaps. It was noted that this is still a work in progress, improving how risks, controls and assurances are presented and understood across the organisation. Board members commented as follows: - While the improved alignment of the BAF to strategic objectives was welcomed, further clarity is required regarding whether this reflects current-year deliverables, or the full three-year IMTP period. - That BAF06 (People and OD) requires further clarification. It was confirmed that work would be taken forward for further discussion and development, with the intention of bringing clearer articulation back to the Board. - That some high scoring risks had remained so for a significant amount of time, suggesting that actions are not effective or have not been achieved. The Trust Board NOTED the current status of the Board Assurance Framework, which has a current assurance rating of 2.	Executives SJ
4.0.0	ORGANISATIONAL DEVELOPMENT	
4.1.0	New Operating and Accountability Arrangements 2026 Victoria Oxley introduced the paper, which provided an overview of the new Operating and Accountability Framework, which had been approved by the NHS Wales Leadership Board on the 17th February 2026. The following was highlighted: - The arrangements are a result of the Ministerial Advisory Group (MAG) recommendations, which aim to modernise systems and processes, strengthen accountability and simplify priorities and improve transparency. - The framework is now live and represents a significant shift for both Welsh Government and organisations; - The need to adapt the Framework to reflect the Trust as a specialist organisation, as opposed to mirroring Health Board measures. - Alignment is required between the arrangements and the Trust's Performance Management Framework, Committee structures and consistency between internal and external reporting must be ensured. - There is an expectation to contribute to a national data dashboard, with a focus on ensuring metrics are relevant to the Trust and reflective of specialist services.	

	- The arrangements are linked to a national escalation system, with the Trust currently at the lowest level, but with potential for increased oversight if performance changes. - This presents an opportunity to shape the framework early on, while still in development. Next steps are to include further work to embed and align the framework internally before bringing it back to Board, including through Board Development and Committee alignment. The Trust Board NOTED the new Operating and Accountability Framework for 2026/27 and DISCUSSED the implications for our internal performance and accountability processes.	VO
4.2.0	Board Committee Structure Update Non Gwilym introduced the paper, which provided a further update on work undertaken since the March meeting of the Trust Board, to review and restructure Board Committee arrangements. The following was highlighted: - Engagement had been undertaken with Executive leads to review how the Committee structure operates and where improvements are required; discussions had identified a number of themes and issues across committees, which require working through collectively. - Duplication / gaps across committees should be avoided. - Clear oversight must be maintained, with detailed scrutiny in Committees and assurance remaining visible at Board level. - The intention to test and review the new structure once implemented to ensure it is working effectively. The Trust Board NOTED the proposal and AGREED the revised date for implementation.	
4.3.0	Streamlined Approach for the Culture Milestone Plan Sarah Jenkins introduced the paper, which sought Board approval for a refinement to the implementation approach of the Trust's three-year Culture Milestone Plan, originally approved by the Board in March 2026. Sarah outlined a refined approach to delivering the culture milestone plan, emphasising integration into operational delivery, prioritising high impact areas and reducing duplication. Board members raised the following: - A minor numbering error (six key areas intended as opposed to five). - The need to explicitly embed a learning organisation approach into the plan, highlighting integration of research, innovation and continuous improvement. - Concern around the potential impact of leadership development activity on delivery, highlighting the need to maintain both. It was advised that it is the intention to use a streamlined approach to focus on key leadership behaviours to reduce overload rather than slowing pace; this would be to bring multiple action plans together as opposed to adding new layers of activity, focusing on the correct goals with greater impact. The Trust Board: APPROVED the proposed refinement to the implementation approach for the Culture Milestone Plan; and	

	• APPROVED the streamlining to focus on the key priorities set out: - o Our Governance and Leadership work with Line of Sight - o Executive team recruitment - o Supporting Velindre Cancer Service to move - o Building on actions already taken, such as Speaking Up Safely, embedding these and assessing their impact. - o Staff Survey engagement and action planning (include learning from other sources, for example WRES/WES, with psychological safety at the core); and - o Wider leadership development.	
5.0.0	COMMITTEE HIGHLIGHTS FOR DISCUSSION	
5.1.0	Public Quality, Safety & Performance Committee Highlight Report (07/05/2026) – including Quarter 4 Integrated Quality and Safety Report Vicky Morris introduced the report, the purpose of which was specifically to support discussion in relation to the Trust Risk Register and risk management approach. Vicky highlighted that there are risks associated with the current risk management system (Datix), such as delays in implementation, training and using the system effectively. The Board was informed that work is underway to explore procurement of an enhanced risk management system and that further detailed plans would be brought to the September meeting of the Audit Committee. It was noted that there would not be a 'once for Wales' solution, as organisations are at varying stages of maturity. Further discussion reinforced the need to ensure clear Board visibility of risks, align risk management with governance structures and systems and ensuring that interoperability must be a core requirement in the procurement design, ensuring systems have interface capability. It was emphasised that national digital partners (such as Digital Health and Care Wales) should be involved to ensure interoperability and Board Members expressed disappointment that an all-Wales risk system solution was not being pursued. Risks associated with TrAMs delays were also highlighted, noting the absence of South-East hub support when moving into the new Velindre Cancer Centre and the need for renewed Board assessment and mitigation plan. It was proposed that a clear assessment of the current position and implications should be brought back to the Board, to address this risk. Vicky also emphasised the need for stronger oversight and ownership of Shared Services issues, including improved escalation of concerns from Shared Services forums into Board and Committee governance structures. The Trust Board: • DISCUSSED and NOTED the key deliberations and highlights from the meeting of the Quality, Safety & Performance Committee held on the 7th May 2026. • NOTED the Quarter 4 Integrated Quality & Safety Report.	AC
6.0.0	CONSENT ITEMS FOR APPROVAL	
	There were no items for approval at today's meeting.	

7.0.0	CONSENT FOR NOTING	
7.1.0	Trust Seal Report Led by Non Gwilym, Director of Corporate Governance (Interim) The Trust Board NOTED the contents of the Trust Board Seal Register.	
7.2.0	Trust-wide policy approvals update Led by Non Gwilym, Interim Director of Corporate Governance The Trust Board NOTED the policies that have been approved during the period March 2026 to May 2026 .	
7.3.0	Strategic Partnerships Update Led by Lauren Fear, Director of Place, Portfolio and Partnerships The Trust Board NOTED The content of the report.	
7.4.0	Public Strategic Development Committee Highlight Report (20/01/2026 & 17/03/2026) Led by Lindsay Foyster, Vice Chair and Chair of the Strategic Development Committee The Trust Board NOTED the content of the reports and any actions being taken to address any issues highlighted in the meeting.	
7.5.0	Shared Services Partnership Committee Assurance Report (19/03/2026) Led by Non Gwilym, Interim Director of Corporate Governance The Trust Board NOTED the content of the report.	
7.6.0	Joint Commissioning Committee Highlight Reports (17/03/2026 & 23/03/2026) Led by Non Gwilym, Interim Director of Corporate Governance The Trust Board NOTED the content of the report.	
8.0.0	ANY OTHER BUSINESS The Chair had not been made aware of any items prior to the meeting and no other business was raised.	
9.0.0	DATE OF NEXT MEETING The next public meeting will take place on Thursday, 30 th July 2026 at 10:00h.	
10.0.0	CLOSE	
11.0.0	ITEMS FOR DISCUSSION AT PART B	
	• Whitchurch Land – City Hospice Land Sale • Private Risk Register • Board Assurance Framework – new Strategic Risk • Lineofsight update • NWSSP – Implementation Group update • Committee Highlight Reports • Chair's Urgent Actions	

**MINUTES OF EXTRAORDINARY PUBLIC TRUST BOARD MEETING
(ANNUAL ACCOUNTS / ANNUAL REPORT)
25th JUNE 2026 (10:00-11:00)
VUNHST TRUST HEADQUARTERS, NANTGARW / TEAMS WEBINAR**

PRESENT Sara Moseley Lindsay Foyster Vicky Morris Gareth Jones Hilary Jones John Union Ceri Doyle Carl James Lauren Fear Sarah Jenkins Matthew Bunce Gillian Knight Jacinta Abraham Anne Carey Carl Taylor Kyle Page	VUNHST Chair (<i>Chair</i>) VUNHST Vice Chair and Independent Member (<i>remotely</i>) Independent Member (<i>remotely</i>) Independent Member (<i>remotely</i>) Independent Member (<i>remotely</i>) Independent Member (<i>remotely</i>) Independent Member (<i>remotely</i>) Chief Executive Officer (interim) (<i>remotely</i>) Director of Place, Planning and Portfolio Executive Director of People & Organisational Development (interim) Executive Director of Finance Executive Director of Nursing, Allied Health Professionals and Health Sciences (interim) Executive Medical Director Chief Operating Officer Chief Digital Officer (<i>remotely</i>) Business Support Manager (Secretariat)

		ACTION LEAD
1.0.0	PART 1 - STANDARD BUSINESS	
1.1.0	Welcome and Apologies Led by Sara Moseley, Chair The Chair welcomed attendees to the Extraordinary Public Trust Board meeting, which had been convened in order to approve the Trust's Annual Accounts, Accountability Report and Annual Performance Report. This meeting had been preceded by an Audit Committee held on the 24th June 2026, where papers presented at today's meeting had been robustly reviewed and discussed. The Chair acknowledged and expressed thanks for the significant effort that had contributed to today's papers. It was noted that today's meeting would be hybrid due to the extreme weather conditions. The following apologies had been received: • Victoria Oxley, Deputy Director of Strategy and Partnerships • Andrew Westwell, Independent Member • Non Gwilym, Director of Corporate Governance (interim)	
1.2.0	In Attendance: Led by Sara Moseley, Chair The Chair extended a warm welcome to the following additional attendees: • Jolene Dalton, Head of Corporate Governance (interim) • Tracy Hughes, Head of Financial Operations (<i>remotely</i>)	

	• Stephen Chaney, Head of Internal Audit, NHS Wales Shared Services Partnership (<i>remotely</i>) • Richard Harries, Director Financial Audit, Audit Wales (<i>remotely</i>) • Bethan Davis, Welsh Translation Service (HEIW) • Ben Leijokari-Olosunde, Aspiring Board Members Programme (<i>remotely</i>)	
1.3.0	Declarations of Interest Led by Sara Moseley, Chair There were no declarations of interest pertinent to the items on today's agenda.	
2.0.0	ANNUAL REPORT AND ANNUAL ACCOUNTS 2025-2026	
2.1.0	Cover Paper for the Annual Report and Accounts 2025-2026 Led by Jolene Dalton, Head of Corporate Governance (interim) Jolene Dalton introduced the 2025–26 annual report and accounts for Board consideration and approval, comprising the annual performance report, accountability report, and audited annual accounts. The documents had been prepared in line with the NHS Wales Manual for Accounts and Treasury requirements and the draft had followed the full governance route, including review by the Executive Management Board, Welsh Government, Finance, Audit Group, and Audit Wales, with feedback incorporated. Jolene noted that the accounts had been audited, with outcomes reported separately, and that the annual governance statement and disclosures provided assurance on the Trust's arrangements for risk, control, and governance. She also highlighted that the Audit Committee had considered the documents, including the NWSSP governance statement, strengthening assurance. Tracy Hughes presented a summary of the annual accounts, which had been submitted to Welsh Government by the required deadline, after which Audit Wales completed their audit and identified some adjustments; these adjustments mainly related to the Welsh Risk Pool and some disclosure/presentation changes, but she emphasised that none of these affected the overall financial position. Tracy confirmed that the Trust had achieved all four financial duties: • Break-even, reporting a small surplus (£42k) and achieving it over the three-year period; • Statutory planning duty, with the IMTP approved; • Creditor payments target, exceeding the 95% requirement; • Capital resource limit, remaining within the approved allocation. Carl James provided an overview of performance and accountability, noting that the reporting demonstrated that the Trust had largely met the required standards of quality, safety and patient experience, aligning with national expectations across the core services (blood services and tertiary oncology). Carl advised that he was satisfied that effective and robust systems of internal control and governance were in place, and that the Trust had managed public money appropriately. Board members raised the following:	

	• The report could have captured more information on areas such as therapies, palliative care and volunteering. There was an opportunity to do this in next years reports. • Equality, Diversity and Inclusion reporting appeared overly compliance-focused, describing obligations rather than aspirations and intentions. It was felt that this did the organisation a disservice given that much work was being undertaken in this area. It was requested that if possible, this year's report could include an improved narrative (one additional sentence) in this respect, with wider changes to the accountability report to be made prior to next year's submission. • Whether the presentation of NEWS (National Early Warning Score) scoring was accurate and whether the current presentation is the most appropriate. • Lack of narrative to explain the change in both target and performance donor experience data in June 2025. Carl James suggested that a way forward to address the points noted above would be to 1) look at how other organisations present their reports and identify good practice, 2) engage with stakeholders to understand what information is considered most useful and how best to tell the Trust's story and 3) to better reflect the full range of services. This would then enable wider changes to be made in an informed way prior to next year's submission. Gillian Knight indicated the need for a more consistent approach to how quality and safety measures are identified and reported, noting variations across current inputs into the report. She highlighted that ongoing changes to committee structures and terms of reference should help improve consistent language and clarity of reporting going forward. Additionally, she noted that work was underway to improve how quality and safety data is captured digitally, aiming for a more streamlined approach over the next 6-12 months. Several Board members queried the short timeline between Audit Committee and Trust Board meeting. Historically, there had been a longer gap between Audit Committee and Board, which allowed sufficient time for review and incorporation of lessons learned. As the current process does not allow the opportunity to reflect on Audit Committee discussions, it was suggested that a longer gap would allow the potential use of a workshop approach to improve the process in the future. Board members acknowledged the complexity and scale of the accounts and audit work, particularly referencing the involvement of Audit Wales, Shared Services and the Welsh Risk Pool, while emphasising the importance of continued scrutiny and assurance focus, particularly in relation to high-value and complex elements such as the Welsh Risk Pool. The Chair concurred with this and expressed gratitude for the significant amount of work involved in the preparation of this documentation and challenges involved in managing a large, hosted service and associated risks. She noted suggestions for learning and improvement and concluded with congratulations to the team for achieving a balanced budget and clearly articulated report. The Trust Board APPROVED the Annual Report and Accounts for 2025-2026.	SJ
2.2.0	Appendix 1 – Letter of Representation2025-2026 Led by Matthew Bunce, Executive Director of Finance	

	Matthew Bunce introduced the Letter of Representation as the formal assurance from management and the Board to Audit Wales that the 2025–26 accounts were complete, appropriately prepared, and that all relevant information had been disclosed. He noted that this assurance process had already been considered by the Audit Committee on behalf of the Board, and that the Board was therefore being asked to confirm it was not aware of any additional matters, representations, or disclosures to be raised with Audit Wales before signing. No other matters were raised and the Chair and the Chief Executive confirmed that they were content to sign the letter for submission to Audit Wales.	
3.0.0	INTERNAL AUDIT & ASSURANCE SERVICES	
3.1.0	Head of Internal Audit Opinion Led by Stephen Chaney, Head of Internal Audit, NHS Wales Shared Services Partnership The purpose of the report was to contribute to the assurances available to the Chief Executive (as Accountable Officer) and the Board. The opinion had been based on completion of the full annual internal audit plan (19 audits, of which two were provided substantial assurance, 11 reasonable assurance, one limited assurance and five were advisory / non-opinion reviews.) The opinion provided an assurance rating of "reasonable assurance overall". While some issues were identified, these were generally low to moderate in impact and actions were being progressed, evidenced by improvement in the limited assurance area following a rapid follow-up review. Overall, it was confirmed that systems of governance, risk management and control were suitably designed and applied effectively. The Trust Board NOTED the content of the 2025-2026 Head of Internal Audit Opinion.	
4.0.0	AUDIT WALES AUDIT OF FINANCIAL STATEMENTS 2025-2026	
4.1.0	Audit Wales ISA 260 Report 2024-2025-2026 Led by Richard Harries, Director Financial Audit, Audit Wales The ISA 260 Report had been prepared as part of work performed in accordance with statutory functions. Richard Harries advised the following: • The report reflected a very positive final audit position, with an unqualified audit opinion for the Trust. • No uncorrected misstatements were remaining, and all adjustments made were classification or presentation changes only, with no impact on the bottom line. • No significant matters were identified by the audit process, which reinforced the strength of the accounts and governance arrangements. • Previous governance concerns had progressed sufficiently and were no longer featured in the report, although ongoing monitoring would continue. • Work would continue to refine the accounts process and improve efficiency, tight timescales, etc. Board members raised the following questions:	

	- Due to the close timing between Audit Committee and Board, members would not yet have received a full report. It was queried whether the nature of the misstatements had been sufficiently explored at Audit Committee and whether any lessons learned had been identified and drawn out from this discussion. Richard confirmed that audit misstatements, particularly relating to the Welsh Risk Pool, had been explored at Audit Committee and that lessons learned would be formally reviewed to improve the accounts process going forward. - The need to look more closely (deep dive) at the Welsh Risk Pool figures and arrangements, recognising their scale, complexity and material impact within the accounts. It was recognised that improved understanding of the workings and assurances around this area was required, given its significance across NHS Wales organisations. In response, Matthew Bunce advised that work had already been commissioned at a national level and that Directors of Finance had asked Shared Services to undertake more detailed work on the Welsh Risk Pool and how it operates, to support the Trust's internal understanding and discussions at Board and Committee level. The Trust Board NOTED the ISA 260 Report.	
5.0.0	Any other Business Led by Sara Moseley, Chair No other business was raised.	
6.0.0	Date of next meeting Led by Sara Moseley, Chair The next regular public meeting of the Trust Board will take place on Thursday, 30th July 2026.	
7.0.0	CLOSE The Chair closed the meeting, thanking the team for the effective management of the Trust's finances and governance, despite an extremely busy and complex year.	

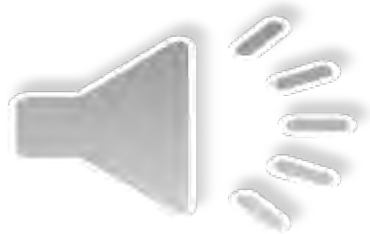
ACTION LOG	Column1	Column2	Column3	Column4	Column5	Column6	Column7
MEETING DATE	AGENDA ITEM	Action number	ACTION	LEAD	DEADLINE DATE	UPDATE (including date)	STATUS
26/03/2026	5.1.0		Embedding the Donor & Patient Voice across VUNHST				
		71	Rework the paper that had been brought to the March Trust Board outside the meeting, retaining requirements for QSP Committee assurance, and to return to Board once the engagement and co-production approach has been more clearly defined.	Executive Director of Nursing (new EDoN not present at meeting)	21/05/2026 TBC	The Trust will be refreshing its Patient Engagement Strategy with the Patient Experience and Engagement Team to strengthen arrangements for engagement, involvement and co-production. Formal partnerships are also being established with organisations such as Llais and Maggies, alongside work with the Cancer alliance and other stakeholders, to ensure patient, donor, carer and community views are systematically captured and used to inform service improvement and strategic decision-making. A revised paper will be presented to QSP for assurance and will return to Board once the refreshed engagement and co-production framework has been agreed.	OPEN
26/03/2026	9.4.0		Public Strategic Development Highlight Report				
		74	Update to be brought back to Board regarding Digital (resource) requirements for both divisions over the next 6-12 months, including an update on the bid submitted to secure additional capital monies.	Chief Executive Officer	21/05/2026 24/09/2026		OPEN
21/05/2026	3.1.0		Performance Management Framework				
		76	Following the Director of WBS's visit to NHSBT to discuss initiatives for engaging diverse communities to recruit to blood donor databases, actions and plans to be refreshed based on learning and further detail to be brought back to a future Board meeting.	Chief Operating Officer	TBC		OPEN
21/05/2026	3.3.0		Board Assurance Framework				
		77	Clarify whether the alignment of the BAF to strategic objectives reflects current year deliverables or the full three year IMTP period.	Executives	30/07/2026		OPEN
21/05/2026	3.3.0		Board Assurance Framework				
		78	Further clarification regarding BAF06 (People and OD). Clearer articulation to be brought back to Board.	Interim Executive Director of People & OD	30/07/2026	23/07/2026 - SJ checking with team. Deadline extension to be requested and subsequently, further discussion around BAF took place in QSP and agreed that a review of all BAF would take place for the next cycle of committees.	OPEN
21/05/2026	4.1.0		New Operating and Accountability Arrangements 2026				
		79	Include further work to embed and align the Operating and Accountability Framework internally, prior to bringing back to Board, including through Board Development and Committee alignment.	Interim Director of Strategy, Planning & Performance	30/07/2026	The new accountability arrangements will be embedded as part of the new governance structure and planned revisions to the Trust's performance management approach. The Executive team now have the accountability framework as a standing item on their Monday meeting and future meetings with NHS P&I are in the diary for September and October 2026.	PROPOSE TO CLOSE
21/05/2026	5.1.0		Committee highlights for discussion - QSP highlight report (07/05/2026)				
		80	A clear assessment of the current position relating to risks associated with TrAMs delays (specifically the absence of south east hub support when moving into the nVCC) and implications to be brought back to Board.	Chief Operating Officer	30/07/2026	The position for aseptic service provision during the commissioning of nVCC, in the absence of the SE Hub, is being worked through to develop robust business continuity options. A summary of the risks has been set out in the TrAMs Board paper, included in part B.	OPEN
(Extraordinary) (25/06/2026)	2.1.0		Cover Paper for the Annual Report and Accounts 2025-2026 (Accountability Report)				
		81	Additional sentence to be added to the narrative around Equality, Diversity and Inclusion, to describe future intentions and what the Trust wishes to achieve, rather than the current narrative which is too compliance-focused.	Interim Executive Director of People & OD	26/06/2026	30/06/2026 – Additional content included in this years Annual Report to provide fuller explanation of our work in ED&I.	PROPOSE TO CLOSE

Andy's Story - Dementia and Cancer Treatment

Andy has dementia, and recently received treatment at the Velindre Cancer Centre.

His story will be presented at Trust Board by Fiona Davies, Head of Safeguarding & Vulnerable Persons.

In advance of this, please click on the 'sound' icon below, then click on 'play' to hear Andy talk about his Velindre Cancer Centre experience





TRUST BOARD

CHAIR'S UPDATE REPORT

DATE OF MEETING	30 July 2026
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	NOTING
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Sara Moseley, Chair
PRESENTED BY	Sara Moseley, Chair
APPROVED BY	Sara Moseley, Chair
EXECUTIVE SUMMARY	This report provides information to the Board regarding the Chair's activity since the previous meeting of the Trust Board.
RECOMMENDATION / ACTIONS	To NOTE the content of the Chair's update report.
GOVERNANCE ROUTE	
N/A	
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
N/A	
7 LEVELS OF ASSURANCE – N/A	
APPENDICES – N/A	

1. SITUATION

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

2. BACKGROUND

2.1 Matters addressed in this report cover the following areas:

- Chief Executive and Board recruitment
- NHS Peer Group Development Day
- Line of Sight Governance Workshop
- NWSSP Chair Interviews
- Senedd Drop-in Event with new MS's
- Sierra Nevada Trek for the Velindre Charity
- NHS Confederation Chairs Development Session
- Extraordinary Trust Board to approve Annual Accounts and Annual Report
- Board Development Session May 2026
- Audit Wales induction
- Meeting between Welsh Government Health and Care Ministers and NHS leaders
- IM and CEO Objective Setting
- Spotlight on Palliative Care

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Chief Executive and Board Recruitment

I am delighted that Carl James has been announced as Velindre University NHS Trust's substantive CEO. We invited everyone in the Trust to say what they wanted from our new CEO, Carl showed us he'll be an accountable and visible leader of Velindre and be driven by his values and commitment to patients, donors and colleagues. This was an intensive and robust recruitment process and Carl and I will now work closely together to lead Velindre. He has mine and the Board's full support in developing the role and leading the team.

We are keeping up the pace on Executive recruitment to ensure that the whole team is in place this year. This is one of the key objectives the Cabinet Minister has set me, so we continue to strengthen and build this organisation. To that end, we interviewed for the Director of People and OD on 16 July and have made an offer which has been accepted.

We are now recruiting a substantive Director of Governance, with interviews being held in September. The role of Executive Director of Nursing, Allied Health Professionals and Clinical Scientists is also currently being advertised. All the roles advertised so far have attracted a good level of interest and I am confident we will have a really strong substantive team.

At the same time, I want to thank everyone who has contributed to the team's work in interim positions. I am very proud of the way that we came together and would like to thank Sarah Jenkins in particular, our Interim Director of People and OD, who has been appointed as an Executive Director in West Wales Fire and Rescue. Sarah has brought energy, passion and extensive knowledge to us over the past ten months.

3.2 NHS Executive Team Peer Group Development Day

Chairs and Chief Executives came together in June to consider and discuss priorities and focus following the Senedd elections in May, and the creation of a Plaid Cymru Government. We reviewed their 100-day plan and manifesto commitments and discussed how we could work together across the system given the scale and depth of what we must do to sustain and improve care.

From the Chairs' perspective, it's been important to find common areas to prioritise focus and action. Later in the month we held a Chair's Development Session with our new lead Chair Neil Wooding of Hywel Dda UHB. As a group, the Chairs have identified the following as matters of fundamental importance to all: digital transformation; leadership – clinical and systems; workforce – productivity and performance as well as safety; capital investment – finding new ways; prevention and early intervention; and collaboration and regional working.

3.3 Governance Review

In March 2026, the Board agreed to review and strengthen our governance to enables us to focus on what really matters, increase transparency, efficiency and model our values. It's been a very intensive time with two major outputs: the restructure of our committees and the emergence of a Board development programme. Both these go firmly hand in hand. How we take accountability, behave, work together, prepare and respond to assurance and strategic development is absolutely crucial if the new committee structure and focus is to make a positive difference.

On 11 June, we spent the day reviewing what we are going to do and have been refining and developing since. Some of the resulting proposals are here for us to

approve today. My thanks go especially to the Chairs and lead Executives of the Committees, the Governance team and, especially, Lindsay Foyster who has played such a fundamental role in leading this review.

3.4 NWSSP Chair and Review Implementation

We continue to work with Welsh Government and NWSSP on implementing the recommendation of the Simon Dean Review and are making good progress. One recommendation was for the Trust Chair to be a member of the selection panel for the appointment of the Chair of the Share Services Partnership Committee, with the committee Chair accountable to the Trust Chair for hosted matters. We interviewed successfully in June and appointed Dr Susan Barnes. Susan has a strong background in procurement in England as well as being the CEO of the Wales Air Ambulance Charity. She started in post this month and I and I am looking forward to working with her.

3.5 Sierra Nevada Trek for our Velindre Charity

Over four gruelling, exhilarating and emotional days I completed a challenge with over 50 others, to raise money for our brilliant charity. Having seen how crucial the money raised is to our patients and researchers, I committed to go at the start of the year. Fundraising was hard but also brought amazing moments – like asking Just MOT, my local garage, for sponsorship and finding that the owner's wife had been a patient and receiving £300.

The trek itself took us to the summit of Spain's highest mountain. We started our ascent in the Sierra Nevada in 40-degree heat and were at 6 degrees with snow at the top. Having been mildly terrified, I really enjoyed the physical challenge. But the best part was talking and walking – meeting people to whom Velindre means so much and sharing their memories, kindness and optimism.

At a time when many charities are struggling to secure engagement, Velindre is hugely successful in running fundraising events. What I saw was that a sense of community, the commitment of our celebrity ambassadors – Rhod Gilbert and Derek Brockway were on this, and every, walking trip – and our amazing staff make all the difference. Thanks for an incredible experience.

3.6 Meeting with Welsh Government Ministers

Earlier this month, NHS Wales Chairs and Chief Executives met the new Ministerial team, facilitated by the Wales NHS Confederation. Mabon ap Gwynfor, Minister for Health and Care; Nerys Evans, Deputy Minister for Public and Preventative Health;

and Delyth Jewell, Deputy Minister for Social Care, Mental Health and Women's Health were all present. All were very engaged, open and friendly. The priorities they set out were very much those in their 100-day plan and manifesto. Timely care and prevention were prominent with Nerys Evans MS emphasising that hers was a cross-government role.

Chairs and CEO's also set out their positions. Paul Mears, the lead CEO, emphasised how strong mutual support and collaboration now is, pointing to some tangible improvements as a result.

3.7 Thank you to Andy

Today's meeting is Professor Andy Westwell's final Board meeting, having spent five years with us as an Independent Member representing Cardiff University. Andy has been appointed Head of the School of Pharmacy and Pharmaceutical Science at the University – a very intensive and time-consuming role. I know Andy as an incredibly committed Board Member, passionate about developing our research, with his background in anticancer drug design. He has been instrumental, in getting ARC (Advancing Radiotherapy Cymru) off the ground nationally, and has been an excellent Chair of the Research, Development and Innovation sub-Committee. He's also given wise counsel on corporate matters and has been a kind and calm colleague. I'll miss him hugely.

3.8 Spotlight on Palliative Care Team at Velindre Cancer Service

In each of my reports, I highlight the work of one of our amazing teams. I've had the privilege of spending time with our Palliative Care team and will never forget the patient conversations I heard and the care, skill and compassion I witnessed. Based at our Cancer Centre, the team also give medical care at local hospices and work closely with community teams supporting patients at home.

The palliative care teams at Velindre, C&V, City Hospice and Marie Curie continue to deliver education and teaching. At Velindre this includes the Tuesday ward rounds (one of which I joined), with medical students, paramedic students and foundation doctors joining to learn more about the specialty. We also have a weekly MDT on Thursdays. The number of visitors can make for a crowded ward round, but feedback remains exceptional, with several Cardiff Uni Surgam awards, most recently 2025. We also often have visitors from abroad, including recent placements from India and Denmark enjoying spending some time with our team. Dr Kirstine Bøndergaard, MD, PhD Student from Denmark, spent some time with the Velindre Palliative care team and mentioned us in her reflections in a [British](#)

[Medical Journal article](#). Her reflections help us to see ourselves through the eyes of others, so it felt fitting to finish with her observations:

"During my stay in Wales I had a clinical observership at Velindre Cancer Centre with Professor Mark Taubert and his colleagues. Mark kindly showed me around the centre and allowed me to observe how he and his team worked clinically during two full days. I attended several ward rounds and saw a number of palliative care patients under the care of Mark's team. It's always fascinating to see how palliative care is practiced across inpatient units, patients' homes, and hospices.

During clinical assessments I was particularly struck by a feeling I've often had during similar encounters in Denmark. The staff are extraordinary. They approach each patient with such empathy and engagement, tuning into that individual's unique needs and wishes. Amidst all the practical tasks, they also make space for the patient's thoughts and concerns, creating a setting where everything, big or small, can be talked about."

Led by Dr Mark Taubert, their work is continually recognised national and internationally:

- The team, led by Mark been awarded a UK National Audit for Care at the End of Life (NACEL) Quality improvement certificate of excellence and been listed as a UK exemplar. Health Inspectorate Wales inspection feedback (19th- 20th May 2026) praised the 'strong palliative care input' in the hospital.
- The team received ESMO certification as a designated Cancer Centre with integrated palliative care, with an award ceremony in Berlin in early 2026 <https://www.esmo.org/designated-centres/velindre-cancer-centre>
- QR-code wristbands (previously known as Pre-Agreed Supportive Care Escalation Plan (PASCEP)) Study's leads include our palliative care team's Drs Alice Crabtree and Elin Harding (integrated bid-funded post). This project looks to use QR code technology to improve communication between healthcare teams for patients with palliative conditions in an emergency situation. The team are collaborating on this project with the Welsh Ambulance Service Trust and Cardiff and Vale University NHS Trust. It has won multiple awards.



QR-Code Cymru Team – Left-Right Mr Ed O'Brian (WAST EOL lead, Professor Nikki Pease, Dr Elin Harding, Dr Alice Crabtree

- Professor Mark Taubert has worked with PaCERS team at Marie Curie Research Centre (MCRC), Dr Elin Harding and Stephanie Sivell on a rapid review of current Future Care Planning literature to underpin a new definition and scope on behalf of Welsh Government. This has been published in the BMJ Supportive and Palliative Care Journal and further publications are being developed
- Marie Curie National Research Conference Poster Award for our Virtual Reality Research Work: The [Joanna Mugridge Award for best research poster at Marie Curie Research Conference 2026](#)
- Our clinical, QI and research palliative and end of work has included UK government on end of life care issues and future care planning (incl [House of Commons](#) & [House of Lords](#))
- Provided Welsh Government with policy advice on [Future Care Planning](#) and end of life care, including the [legislative consent memorandum regarding terminally ill adults bill](#)
- Expert Advisors on national AI impact assessment for Learned Society of Wales [national report](#) based on Velindre experiences. Guardian article featuring this work: <https://www.theguardian.com/technology/2026/feb/26/workers-training-ai-to-do-their-jobs>
- BBC Inside Health Programme (3 episodes including Mark Taubert) discussing palliative and end of life care in the context of access, safeguards and the Terminally Ill Adults Bill - BBC [Inside Health](#) (3 episodes)

Mark also appeared in the Senedd with regard to the issue of equitable access to palliative care and how end of life care must not be allowed to become a postcode lottery.

The palliative care team have changed structure in line with the rest of the organisation, now sitting with the Acute, Palliative and Inpatient (APIC Directorate), with Mark Taubert continuing his role as Clinical Director for Palliative Medicine, and Helen Way leading the nursing team. The team have been short-staffed due to illness recently, but none-the-less have continued to deliver highest quality care. The palliative care [Terms of Reference document](#) has been updated & is available on the intranet, linking with key targets and deliverables from the nation NHS Wales P&I Palliative and End of Life Care Programme.



From our national Palliative Care Framework, recently published by Welsh Government

At the Marie Curie Hospice, Velindre Consultant in Palliative Care Dr Siwan Seaman, together with Dr Hattam and Dr D'Silva (pictured) won a Greener Palliative Care NHS Award. How did they achieve this? Read more about it [here](#).



Dr D'Silva, Dr Seaman and Dr Hattam at the Marie Curie Hospice Cardiff & Vale

4 IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: NO	
RELATED STRATEGIC RISK – BOARD ASSURANCE FRAMEWORK	04 - Organisational Culture
QUALITY AND SAFETY IMPLICATIONS / IMPACT	There are no specific quality and safety implications related to the activity outlined in this report.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Not required
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	N/A
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT	Not required
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

4 RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

TRUST BOARD	
CHIEF EXECUTIVE'S UPDATE REPORT	
DATE OF MEETING	30 July 2026
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	NOTING
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Kyle Page, Business Support Manager
PRESENTED BY	Carl James, Chief Executive Officer
APPROVED BY	Carl James, Chief Executive Officer
EXECUTIVE SUMMARY	This report provides information to the Board regarding the Chief Executive's activity since the previous meeting of the Trust Board.
RECOMMENDATION / ACTIONS	The Trust Board is asked to NOTE the content of the Chief Executive's report.
GOVERNANCE ROUTE	
N/A	
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
N/A	
7 LEVELS OF ASSURANCE – N/A	
APPENDICES – N/A	

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

Executive Recruitment

2. I am pleased to confirm that following interviews for the Executive Director of Workforce and Organisational Development on the 16th of July, we offered the role to a candidate and it has been accepted. We are currently going through final administrative processes, and I will provide a further update at the next meeting.
3. The Executive recruitment programme remains ongoing, with the Director of Corporate Governance appointment panel planned for 9th September and the Executive Director of Nursing, AHP and Clinical Scientists for the 16th September. The remaining post, Executive Director of Strategy, Planning and Digital will be follow. I aim to have the permanent Executive team in place by January 2027.

Meetings of Note

National

Chief Executive Management Team (CEMT) meeting – 2nd June

4. I attended the June meeting of the Chief Executive Management Team, where discussions focused on a Mental Health Strategy briefing session, Artificial Intelligence in Health and Care in Wales, and the emerging position regarding graduate employment.

Health Strategic Board (HSB) quarterly meeting – 12th June

5. The June quarterly HSB meeting was held to review the current position of the new Velindre Cancer Centre (nVCC) project, including communications with Project Co, contingency planning, service readiness, legal matters, and the delivery plan. The Project Team also provided Welsh Government colleagues with an overview of the programme, covering key areas such as workstreams, finance, communications and engagement, and risk management.

National Ministerial Graduate Summit – 18th June

6. The Graduate Summit, held at the Welsh Government Offices and hosted by the Cabinet Minister for Health and Social Care, comprised a series of workshops focused on key themes including understanding the current landscape, maximising opportunities, supporting graduates without substantive posts, and identifying actions to improve outcomes for the 2027 cohorts and future years.

NHS Wales Leadership Board meetings – 19th May and 30th June

7. I attended the May and June meetings of the NHS Wales Leadership Board with fellow CEOs and Welsh Government colleagues, which focused on the following areas:
- Performance, Improvement and Finance
 - Strategic Programme for Mental Health
 - Regional Clinical Support
 - Cancer Programme Update
 - Vaccination and screening update - / winter preparedness
 - Lung Cancer Screening
 - COVID Inquiry Recommendations (Modules 3&4)

Blood Health National Oversight Group (BHNOG) Conference – 23rd June

8. I was delighted to attend the BHNOG Conference at the Vale Resort Hotel. The event focused on the Infected Blood Inquiry and the NHS Wales Blood Health Plan, exploring their impact on patients, staff, and services. Attendees learned about the progress made in implementing the Infected Blood Inquiry recommendations and the shared learning opportunities available. Colleagues from the Welsh Blood Service provided a number of important presentations to the conference.

South East Wales Regional Cancer Programme Board – 1st July

9. I attended the July meeting of the SE Wales Regional Cancer Programme Board along with Executive colleagues, which focused on the following key areas:
- National Cancer Strategy Development, including Government commitments for cancer (100-day plan).
 - New Velindre Cancer Centre (nVCC) readiness update on construction and service readiness for opening.
 - Regional Acute Oncology Service update.
 - Workstream updates.
 - Next phase of Regional Cancer Programme Board.

Trust Business

WBS Senior Leadership Team Away Day – 15th May (Welsh Blood Service)

10. I attended the Welsh Blood Service Senior Leadership Team Away Day where we discussed a wide range of matters including the strategic, national direction of travel and within the blood and transplant service; organisational culture, leadership and governance, Executive recruitment, and the intention to refresh ways of working with Senior Leadership Teams.

Executive Time Out – 18th May

11. The Executive Team attended a time out session, which focused on how we work as a high performing team. Key themes included:
- cultivating a team culture of self-awareness and personal accountability
 - strengthening collaborative skills essential for exceptional team performance
 - enhancing the team’s ability to collectively reflect on progress and foster a shared sense of ownership
 - consolidating workshop insights into actionable next steps.

Welsh Blood Service Divisional Strategic Review – 28th May

12. I chaired the May WBS Divisional Strategic Review at the Welsh Blood Service. The Review focused on delivery of the Welsh Blood Service (WBS) IMTP 2026–2029, balancing ambitious transformation programmes against significant operational pressures and capacity constraints. The review highlighted the breadth of the WBS Futures portfolio across transfusion, donation, transplantation, digital services, plasma for medicines, infrastructure development, and blood health initiatives. The review also considered opportunities to expand plasma collection capability, progress in modernising blood donation services, implementation of Infected Blood Inquiry recommendations, and updates on key transformation programmes.

New Velindre Cancer Centre (nVCC) Readiness Alignment of Scope and Plans

14. I attended a full day workshop with the Executive Team and Velindre Cancer Service colleagues to review our service delivery plans, scope, and accountabilities. The integrated plan is well developed, and the delivery phase is progressing at pace.

Meeting with Varian (23 July 2026)

15. I attended a meeting with the Executive Director of Finance and Velindre Cancer Service colleagues to discuss the plan for Phase 3 implementation into the nVCC. Progress is positive with a number of areas requiring final resolution.

4 IMPACT ASSESSMENT

5

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)	N/A
QUALITY AND SAFETY IMPLICATIONS / IMPACT	There are no specific quality and safety implications related to the activity outlined in this report.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Not required
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	N/A
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT	Not required
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

6 RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No



Trust Board	
VELINDRE UNIVERSITY NHS TRUST PERFORMANCE MANAGEMENT FRAMEWORK REPORT DETAILED ANALYSIS FOR May 2026	
DATE OF MEETING	30/07/2026
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	Philip Hodson, Assistant Director of Planning and Performance. Caitlin Davies, General Management Graduate Trainee.
PRESENTED BY	1. Victoria Oxley, Director of Strategy, Planning and Performance (Interim) 2. Anne Carey, Chief Operating Officer 3. Sarah Jenkins, Executive Director of People and Organisational Development (Interim), 4. Carl Taylor, Chief Digital Officer, 5. Lauren Fear, Director of Place, Portfolio & Partnerships 6. Matthew Bunce, Executive Director of Finance
APPROVED BY	ANNE CAREY, CHIEF OPERATING OFFICER
EXECUTIVE SUMMARY	PERFORMANCE MANAGEMENT FRAMEWORK (PMF) OVERVIEW The report provides the detailed analysis of all the Performance Management Framework Key Performance Indicators (KPIs) and supports the PMF Executive High-level slides in Section 1 which focus on the key issues to be raised and discussed for May 2026.
RECOMMENDATION / ACTIONS	The Trust Board is asked to take ASSURANCE from the Performance Management Framework for the month of May 2026.



GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	Date
WBS SLT / Performance Review	(10/06/2026)
VCS Divisional Board	(23/06/2026)
Executive Management Board	(02/07/2026)
Quality, Safety and Performance Committee	(16/07/2026)
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The report has been considered and endorsed at the VCS and WBS Performance Review meetings, Executive Management Board and the QSP Committee and is presented to the Trust Board for assurance on the Trust's performance for the month of May 2026.	
7 LEVELS OF ASSURANCE	
Velindre Cancer Service	Level 3 - Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes
Welsh Blood Service	Level 3 - Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes
Workforce & Wellbeing	Level 3 - Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes
Digital Services	Level 3 - Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes
Estates, Infrastructure and Sustainability	Level 4 - Increased extent of impact from actions
Health and Safety	Level 3 - Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes
Financial Performance	Level 4 - Increased extent of impact from actions
APPENDICES	
N/A	



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



1. SITUATION AND BACKGROUND

VELINDRE UNHST PERFORMANCE REPORT FOR May 2026

1.1 Overall High-Level Quality Performance Summary

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

Quality Domain	Trust-wide Safety Scorecard			Performance as at May 2026			Compliance against Target or Standard		Slide Ref
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Safe	Total Number of Velindre Acquired Infections (VAIs) across all bacteraemia types (WHC 2024 (38) target) Cumulative 25/26 versus 24/25	National	Monthly	23/24 Base 13	<13 24/25	1 26/27	✓	➔	
	SACT 30 Day Mortality Benchmark	Curative	Monthly	2.00%	2.00%	0.172% Nov	✓	➔	
	Inpatient Mortality Target under development/to be agreed	Inpatient	Monthly	N/A	N/A	5	N/A	N/A	
	Number of National Reportable Incidents	National	Monthly	0	0	1	✗	⬆	
	WBS Serious Adverse Blood Reactions & Events (SABRE) incidents reported to regulator / licensing authority	Local	Monthly	0	-	3	N/A	N/A	
	Overdue Actions from open Serious Adverse Blood Reactions & Events (SABRE) / Serious Adverse Event or Reaction (SAEARs) actions	Local	Monthly	New	<5%	25	✗	⬆	Pages 25-26
	Number of incidents triggering Duty of Candour	National	Monthly	0	0	1	✗	⬆	
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving ⬆ stable ➔ fluctuating □ deteriorating ⬇									



Quality Domain	Trust-wide Timeliness Scorecard			Performance as at May 2026			Compliance against Target or Standard		Slide Ref
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Timely	Scheduled Radiotherapy Patients Treated 80% within 14 Days and 100% within 21 Days	National	Monthly	29% 47%	80% 100%	14% 79%	X	↕	Pages 15-23
	Urgent Symptom Control Radiotherapy Patients Treated 80% within 2 Days and 100% within 7 days	National	Monthly	6% 50%	80% 100%	18% 78%	X	↑	Pages 15-23
	Emergency Radiotherapy Patients Treated 80% within 1 day and 100% within 2 days	National	Monthly	94% 100%	80% 100%	97% 97%	X	↑	Pages 15-23
	% Patients Beginning Non-Emergency (Routine) SACT within 21 days	National	Monthly						
	% Patients Beginning Emergency SACT within 2 days	National	Monthly						
	WBS Turnaround times – antenatal	Best Practice	Monthly	96%	90%	91.9%	✓	↓	
	WBS Turnaround times – Red Cell Reference Serology	National	Monthly	70%	90%	90%	✓	↓	Page 24
	WBS Turnaround times – Foetal RHD Screening	Best Practice	Quarterly	New	90%				
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving ↑ stable → fluctuating □ deteriorating ↓									



Quality Domain	Trust-wide Effectiveness Scorecard			Performance as at May 2026			Compliance against Target or Standard		Slide Ref
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Effective	Number of Cancer Pathway of Care Delays	National	Monthly	1	0		N/A	N/A	
	Clinical demand for red cells met (% manufactured to issued) *met clinical demand – within tolerance	Best practice	Monthly	104%	100%	97%*	X	↑	Page 24
	Clinical demand for platelets met (% manufactured to issued)	Best practice	Monthly	133%	100%	151%	✓	↑	Page 27
	New stem cell volunteers	National	Monthly	3341	333	165	X	↓	
	New Apheresis Donors	Local	Quarterly	21	14				
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving ↑ stable → fluctuating □ deteriorating ↓									

Quality Domain	Trust-wide Efficient Scorecard			Performance as at May 2026			Compliance against Target or Standard		Slide Ref
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 26	Target	Actual	In Month Position	Cumulative data trend	
Efficient	% uptime of critical digital systems (% availability by service, excl. planned maintenance windows)	Local	Monthly	N/A	99%	N/A	N/A	N/A	
	Financial Balance – achievement of Trust forecast (£k) in line with revenue expenditure profile	National	Monthly	£33k	£0	£3k	✓	→	
	Trust expenditure (£k) on Bank and Agency staff against target budget profile	National	Monthly	£346k	£46k	£18k	✓	→	Page 37
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↑↓ deteriorating ↓									



Quality Domain	Trust-wide Equitable Scorecard – Trust-wide position			Performance as at May 2026			Compliance against Target or Standard		Slide Ref
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Equitable	Diversity of Workforce – % Black, Asian and Minority Ethnic people	Local	Quarterly	5.18%	6%	7.81% Mar 26	✓	↑	
	Diversity of Workforce – % People with a Disability within workforce	Local	Quarterly	4.63%	22%	7.56% Mar 26	X	↑	
	% of Workforce who have declared Welsh Language Listening/Speaking capability	National	Quarterly	89.37%	100%	96.72% Mar 26	X	↑	
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↕ deteriorating ↓									

Quality Domain	Trust-wide Experience Scorecard			Performance as at May 2026			Compliance against Target or Standard		Slide Ref
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Person Centred	% of Patients Who Rate Experience at VCS as good or very good	Prof. Std.	Monthly	95	85%	97%	✓	→	
	% of 'formal' VCS concerns responded to within 30 working days	Local	Monthly	100	85%	100%	✓	↑	
	Whole blood donors that rate their experience as excellent	UK Blood Services	Monthly	95%	85%	89.6%	✓	↓	
	Resolution of WBS formal concerns within 'Putting Things Right' regulations timescale. 1 April 2026, the concerns process has transitioned to the new <i>Listening to People</i>	National	Monthly	100%	100%	N/A	N/A	→	
	% Personal Appraisal Development Reviews (PADR) compliance staff appraisal carried out by managers	Prof. Std.	Monthly	73%	85%	80%	X	↕	Page 28-29
	% Rolling average Staff sickness levels	National	Monthly	6.22%	3.54% 4.70%	5.67%	X	↑	Page 28-29
	Number of Incidents of violence and aggression to staff Trust-wide for 2025/26	Local	Monthly	N/A	27 25/26	1 May 6 cum	✓	→	
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↕ deteriorating ↓									



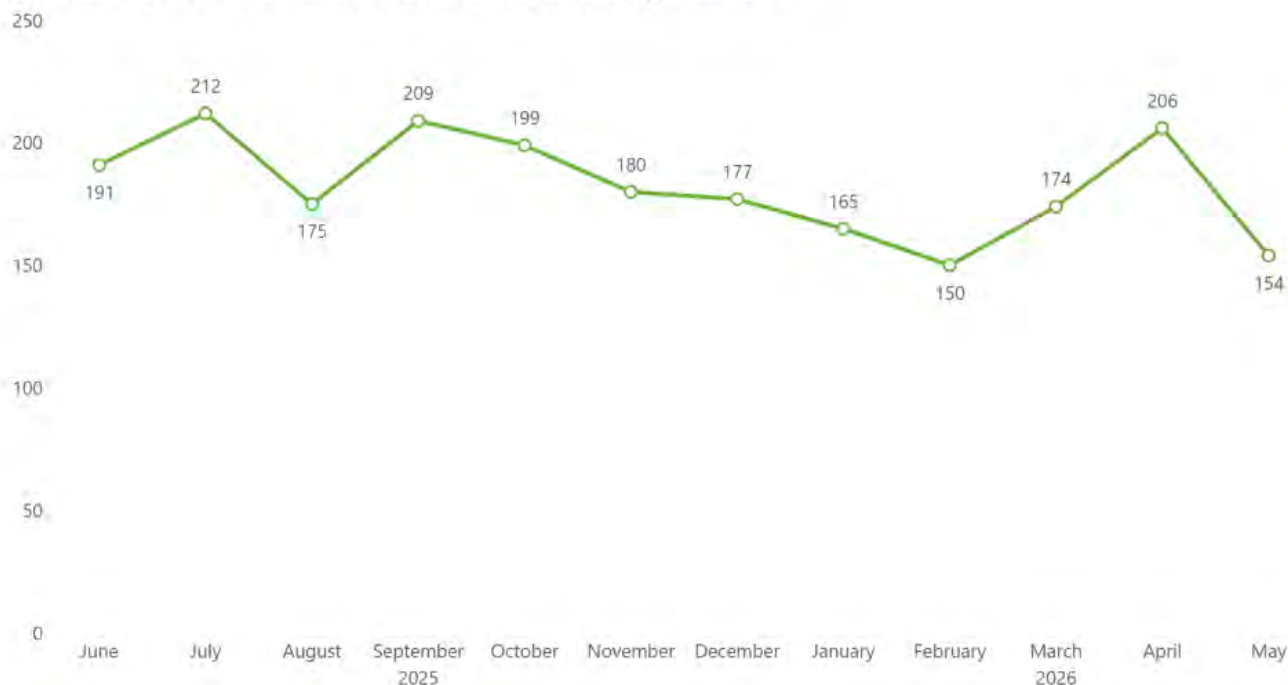
2. KEY ISSUES HIGHLIGHTED BY EXCEPTION

2.1 Velindre Cancer Service

SCP Referrals by Health Board

May 2026

Number of SCP-related referrals received by Velindre



Referrals – a mean of **183** referrals per month which are linked to SCP are received by Velindre.

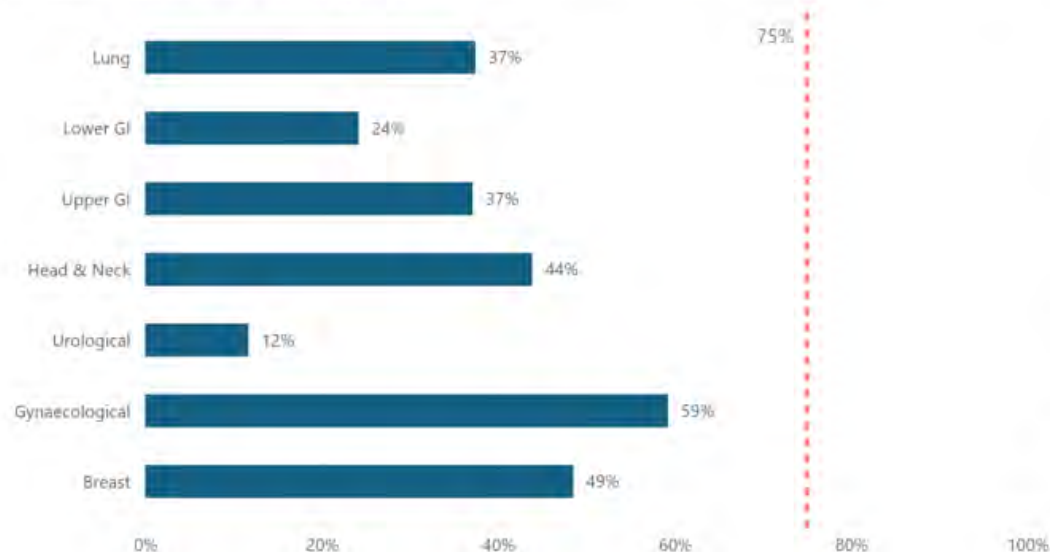
The largest referrer is AB

SCP Performance per SST

May 2026

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

Treatment between June 2025 - May 2026



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

Treatment between June 2025 - May 2026



- 28% of patient FDT (first definitive treatment) within the 62-day SCP vs the 75% target (rolling average 36%).
- 45% of patients treated within 24 days (local target) from receipt of referral to VCS (rolling average 50%).

SCP Pathway Analysis (38 Day)

May 2026

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

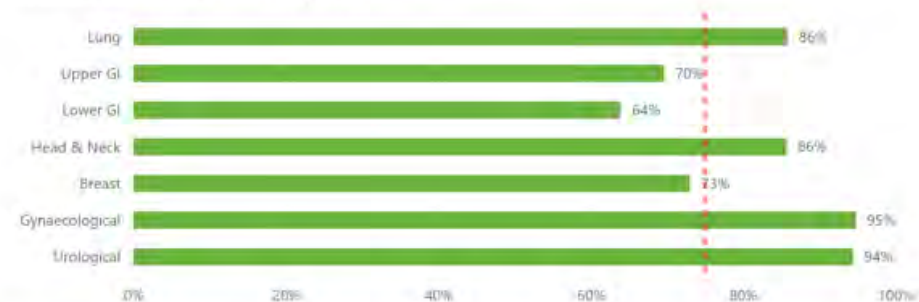


38- days (SCP patients received to VCS)

- 71% patients treated vs 75% target.
- 79% patients, 12month position

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

Treatment between June 2025 – May 2026



Tumour sites achieving the standard

- Lung
- Head & Neck
- Gynaecology
- Urology – new this month

SACT Performance (all treatment intents)

Total

	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
Referrals	268	313	273	293	332	287	310	341	272	328	281	307
Total Breaches	129	163	141	132	163	109	128	173	134	160	139	147
% Compliance	51.9%	47.9%	48.4%	54.9%	50.9%	62.0%	58.7%	49.3%	50.7%	51.2%	50.5%	52.1%

IV First Treatment

	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
Referrals	208	252	219	220	257	211	224	229	201	240	211	236
Total Breaches	115	145	128	113	149	96	112	147	115	145	125	140
% Compliance	44.7%	42.5%	41.6%	48.6%	42.0%	54.5%	50.0%	35.8%	42.8%	39.6%	40.8%	40.7%

Oral First Treatment

	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
Referrals	60	61	54	73	75	76	86	112	71	88	70	71
Total Breaches	14	18	13	19	14	13	16	26	19	15	14	7
% Compliance	76.7%	70.5%	75.9%	74.0%	81.3%	82.9%	81.4%	76.8%	73.2%	83.0%	80.0%	90.1%

An Improvement action plan is in place to drive remedial actions and target hospital related breaches. Deep Dive of SACT Performance supported by Data and Insight Team commencing 8th June 2026.

- 18% of breach patients (P2 category) started treatment between day 15 and Day 18 this increases to 23.6% up to day 21.
- Daycase capacity and scheduling delays equate to 27% of the hospital related reasons. Scheduling and Capacity requirements underpinned by capacity and demand modelling will be included in the SACT Business Case. More detailed operational demand & capacity modelling at tumour site level commenced end of May 2026.
- Work progressing to develop process to accurately identify the first definitive treatment in chemo/radiotherapy pathways. This will change our reporting/figures moving forward once work completed.
- Productivity and efficiency actions are in place to increase utilisation of existing resources, based on the existing limited activity data.
- Live tracking of patient pathways through the SACT PTL will be embedded during June 2026.



SACT Performance (by treatment intent)

May 2026

P1 - Emergency

Oct-25 Nov-25 Dec-25 Jan-26 Feb-26 Mar-26 Apr-26 May-26

Referrals	6	4	6	1	3	1	9	3
Total Breaches	3		4	1	2	1	5	2
% Compliance	50.0%	100.0%	33.3%	0.0%	33.3%	0.0%	44.4%	33.3%

P2 - First definitive

Oct-25 Nov-25 Dec-25 Jan-26 Feb-26 Mar-26 Apr-26 May-26

Referrals	29	21	26	17	23	25	19	13
Total Breaches	23	16	18	12	14	17	15	8
% Compliance	20.7%	23.8%	30.8%	29.4%	39.1%	32.0%	21.1%	38.5%

P2 - Neo adjuvant

Oct-25 Nov-25 Dec-25 Jan-26 Feb-26 Mar-26 Apr-26 May-26

Referrals	64	43	52	40	32	31	38	60
Total Breaches	38	13	27	29	22	19	23	37
% Compliance	40.6%	69.8%	48.1%	27.5%	31.3%	38.7%	39.5%	38.3%

P2 - Palliative

Oct-25 Nov-25 Dec-25 Jan-26 Feb-26 Mar-26 Apr-26 May-26

Referrals	114	96	89	109	104	127	103	107
Total Breaches	76	58	51	73	62	81	60	70
% Compliance	33.3%	39.6%	42.7%	33.0%	40.4%	36.2%	41.7%	34.6%

P3 - Adjuvant

Oct-25 Nov-25 Dec-25 Jan-26 Feb-26 Mar-26 Apr-26 May-26

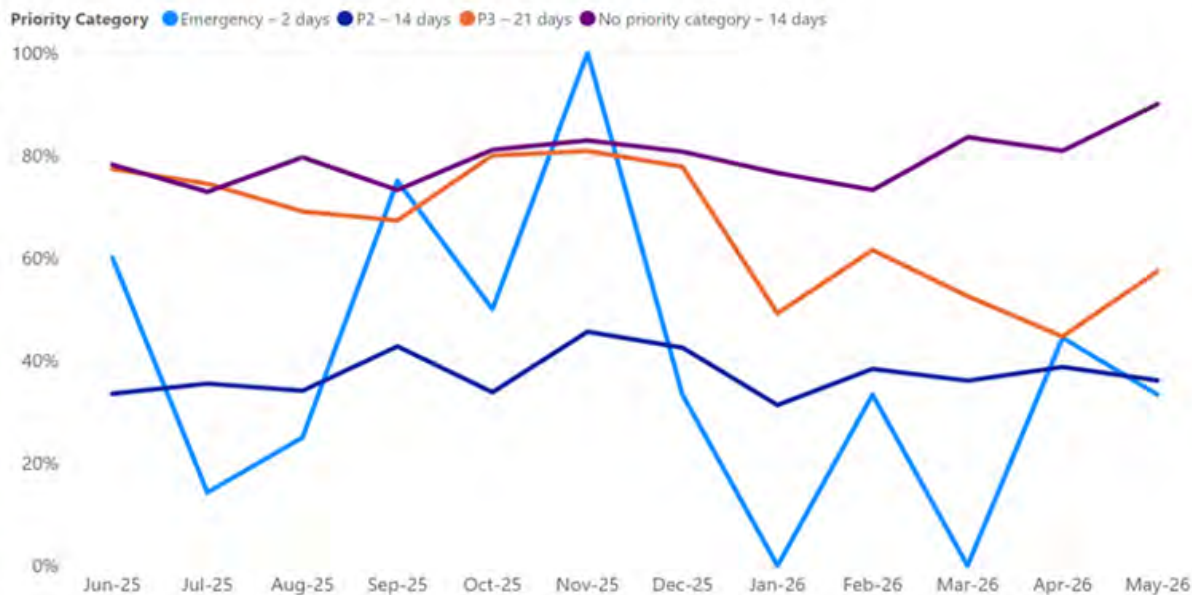
Referrals	45	47	54	63	39	59	47	54
Total Breaches	9	9	12	32	15	28	26	23
% Compliance	80.0%	80.9%	77.8%	49.2%	61.5%	52.5%	44.7%	57.4%

No Priority Assigned

Oct-25 Nov-25 Dec-25 Jan-26 Feb-26 Mar-26 Apr-26 May-26

Referrals	74	76	83	111	71	85	68	70
Total Breaches	14	13	16	26	19	14	13	7
% Compliance	81.1%	82.9%	80.7%	76.6%	73.2%	83.5%	80.9%	90.0%

SACT Performance by Priority Category



SACT Performance (all treatment intents) – Breach Analysis

May 2026

Waiting Reason (Clean)	P1 Emergency	P2: Neo-adjuvant	P2: Palliative	P2: Primary/Definitive	P3: Adjuvant	No Priority	Total Referrals	% Total Referrals
Scheduling delay		9	16		2	10	37	11.86%
Daycase Capacity		15	28			1	44	14.10%
Pre SACT Clinic capacity		2				1	3	0.96%
concurrent RT	1				6		7	2.24%
Booked in line with clinic		2	2			1	5	1.60%
Delay in allocation of SACT		2	2			1	5	1.60%
Awaiting CT/MRI			1				1	0.32%
Muga						1	1	0.32%
Medical	1	2	9			1	15	4.81%
Medical Requested start date			4			3	9	2.88%
Patient requested start date		4	4			3	11	3.53%
Change of SACT			1				1	0.32%
Chemocare Regimen/Programme constraint			1				1	0.32%
Maintenance						1	1	0.32%

Key Breach Highlight

Daycase Capacity breach – Deep dive in place to understand key issues relating to daycase capacity breaches - initial review identified demand and capacity imbalance throughout the week with a particular pinch point on a Friday – for example, 59% (n=26) of the daycase capacity breaches in May related to patients requiring Friday treatment. Of the Friday breaches, 23 were treated at day 15 to 18 reflecting the impact of 5 day working and clinic days. The longest wait for a capacity reason was 23 days .

Scheduling breaches - 35% of the scheduling delays were for Friday treatments. Delays have been due to capacity in the bookings team; resource has improved however a reduction in scheduling times is likely to see some of these patients breaching for capacity reasons (day case and pharmacy capacity). Deep Dive of SACT Performance supported by Data and Insight Team being undertaken to better understand the issues contributing to this to support targeted improvement plan. This work will be completed by the end of quarter 4.

SACT Updates/Actions

May 2026

Update from last month

- SACT PTL changes now Live and in line with SACT Performance Report.
- ACP workforce requirement to support reducing restrictions on chair usage completed and taken through directorate board and OMB.
- Capacity and Demand requirements for IV SACT quantified.
- Pembo treatment roll out - 4.35% in May 2026 sub cut injections with full roll out in development for the ongoing months.
- Short procedure diaries introduced for NHH and PCH to improve utilisation at the start of the working day.
- SACT Performance Dashboard in place to allow review of performance and automatic end of month SACT Performance Report introduced.

Actions for next period

- Live tracking of SACT patients to be embedded using SACT PTL.
- Ongoing work for switch to pembro sub-cut –implementation timeline extended due to access to scheduling capacity. Projecting 18% sub cut in June, and 25% in July.
- Further iteration of SACT Capacity and Demand to be completed to exclude Clinical Trials activity and postcode analysis of SACT treatment requirements to support nVCC plans.
- Formalising Chemocare diary clean-up to support the scheduling process and improve capacity utilisation.
- Progress with implementation of SACT Sharepoint Booking List.
- Finalise the SACT Business Case.
- Deep dive supported by Data and Insight into SACT Performance at SST level.

Key risks/issues

- **Workforce:** Scheduling capacity
- **Capacity Constraints:** capacity and demand imbalance across the SACT delivery service resulting in breaches against clinical indicators.
- **Data & Digital Gaps:** issues with data quality and digital systems hinder effective scheduling and tracking and management information to inform deep dives.

Mitigation

- **Workforce** - New scheduling staff member to start in June 2026 and overtime working in place – team will be fully resourced by end June 2026.
- **Capacity constraints** – flexible use of trials chair capacity and opening of Rowan to address capacity/demand imbalance. Focus on escalation meetings to ensure correct information for decision making and prioritising demand.

Radiotherapy Waiting Times Activity

 May 2026

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



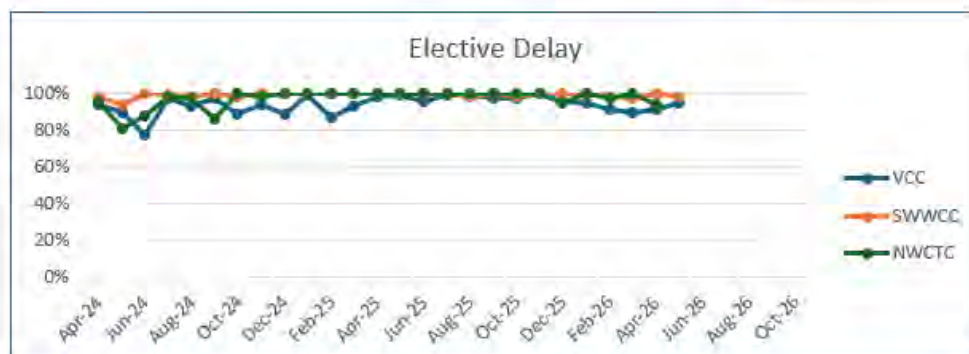
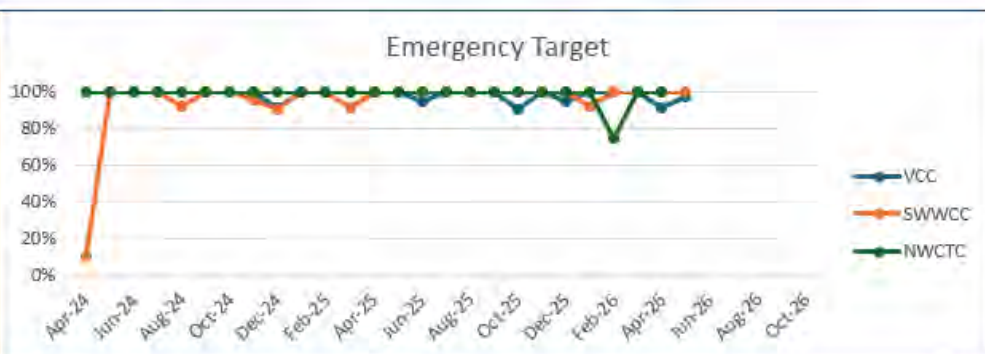
Radiation Services – COSC Mandatory and Optimal Targets May 2026

Mandated Quality Indicator	Target	April	May	Movement
Scheduled radiotherapy patients to begin treatment within 21-days of decision to treat	100%	77%	79%	↑
Urgent symptom control radiotherapy patients to begin treatment within 7-days of decision to treat	100%	71%	78%	↑
Emergency radiotherapy patients to begin treatment within 2-days of decision to treat	100%	91%	97%	↑
Elective delay radiotherapy patients to begin treatment within 14-days of decision to treat	100%	91%	95%	↑
Optimal Quality Indicators				
Scheduled radiotherapy patients to begin treatment within 14-days of decision to treat*	80%	16%	14%	↓
Urgent symptom control radiotherapy patients to begin treatment within 2-days of decision to treat*	80%	10%	18%	↑
Emergency radiotherapy patients to begin treatment within 1-day of decision to treat*	80%	91%	97%	↑
Elective delay radiotherapy patients to begin treatment within 7-days of decision to treat*	80%	89%	90%	↑

Radiotherapy – Emergency and Elective Performance May 2026

May 2026

Complexity of case mix differs across cancer centres with more complex case mix in NWCTC treated at centres in north-west of England. Therefore, direct radiotherapy performance for NWCTC,SWWCC and VCC are not fully consistent



Performance Target: Emergency

- 100% patients to begin treatment within 2 days of DTT (mandatory)
- 80% radiotherapy patients to begin treatment within 1 days of DTT (optimal)

Overview

97% (33 out of 34) of referred patients prescribed emergency radiotherapy in May commenced treatment within both the mandatory and optimal targets.

This constituted an improvement relative to performance in April (91% compliance).

Performance Target: Elective delay

- 100% patients to begin treatment within 14 days of DTT (mandatory)
- 80% patients to begin treatment within 7 days of DTT (optimal)

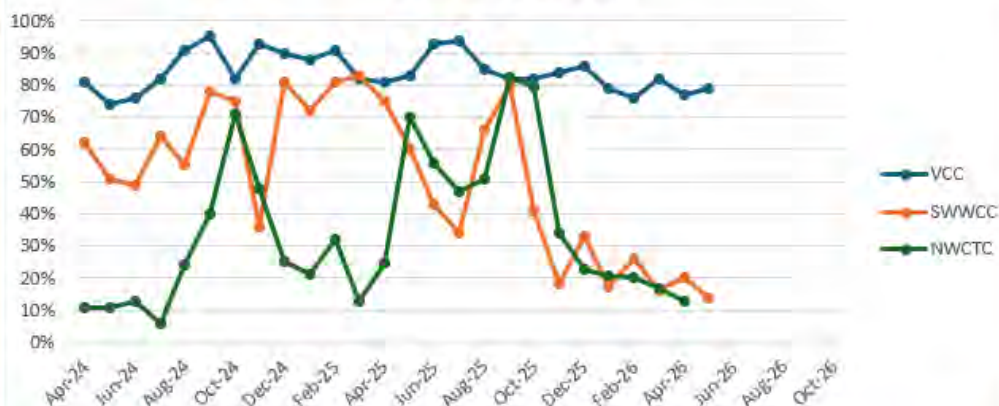
Overview

95% (69 of 73 patients) were treated within both the mandatory and optimal targets in May
This constituted an improvement relative to performance in April (91% compliance)

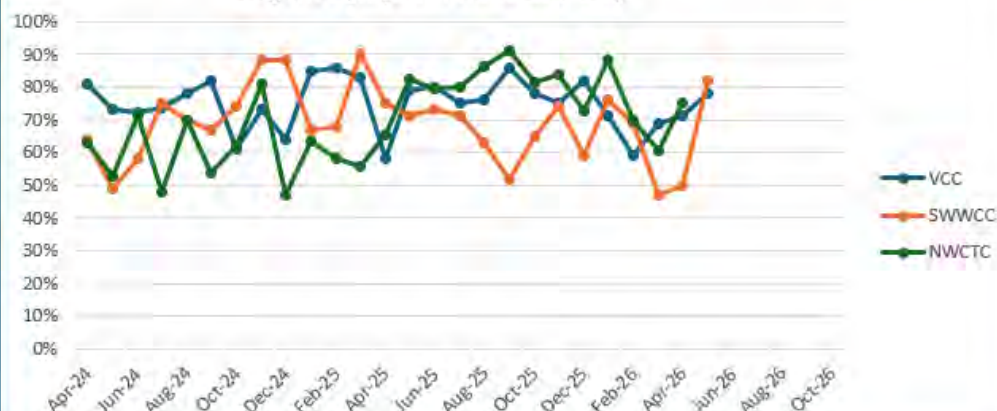
Radiotherapy – Scheduled and USC Performance May 2026

May 2026

Scheduled 21 Day



Urgent Symptom Control 7 Day



Performance Target: Scheduled radiotherapy

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

Overview

Compliance improved with the 21-day mandatory target in May with 79% (168 patients out of a total of 214 referrals) treated within the target, compared to 77% in April). The longest wait to commence treatment was reported as 43-days. - the wait was attributed to patient choice.

Performance Target: Urgent Symptom Control

- 80% patients to begin treatment within 7 days of decision to treat (mandatory)
- 100% radiotherapy patients to begin treatment within 1 day of DTT (stretch)

Overview

There was an improvement in compliance with the urgent symptom control target with 78% (40 patients out of a total of 51 referrals) treated within the 7-day target compared to 71% in April.

Radiotherapy – Performance Breach Analysis

May 2026

The main reasons for the 62 breaches in May were:

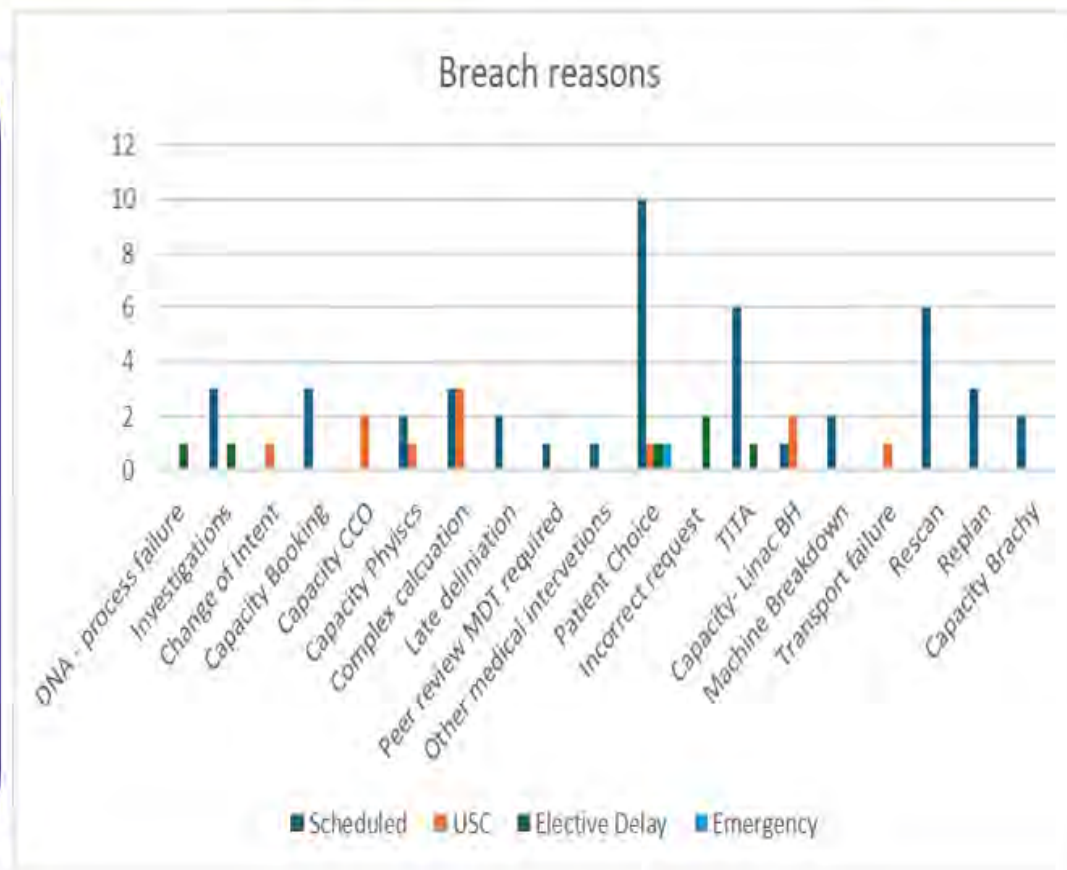
Scheduled (46 breaches) (21% of scheduled referrals) – the main breach reasons was patient choice for the category, patients being too ill to attend treatment and the requirement to re-scan patients.

USC (11 breaches) (22% of USC referrals) – the main breach reason was clinical oncologist capacity and the requirement for complex calculations.

Elective (4 breaches) (5% of Elective delay referrals) – two of the breaches were due to incorrect initial scheduling (against the scheduled pathway rather than the elective one which has a shorter timeframe target and therefore breached when reassigned).

Emergency (1 breach) (3% of emergency referrals)– patient choice. “Other treatment” breaches reflect delays caused by medical interventions needed before radiotherapy, such as PEG insertions or dental extractions. These delay the start of treatment.

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



Radiotherapy Breaches: definitions

May 2026

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

Assurance

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

Radiotherapy Updates/Actions

May 2026

Update from last month

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

Actions for next period

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

Key risks/issues

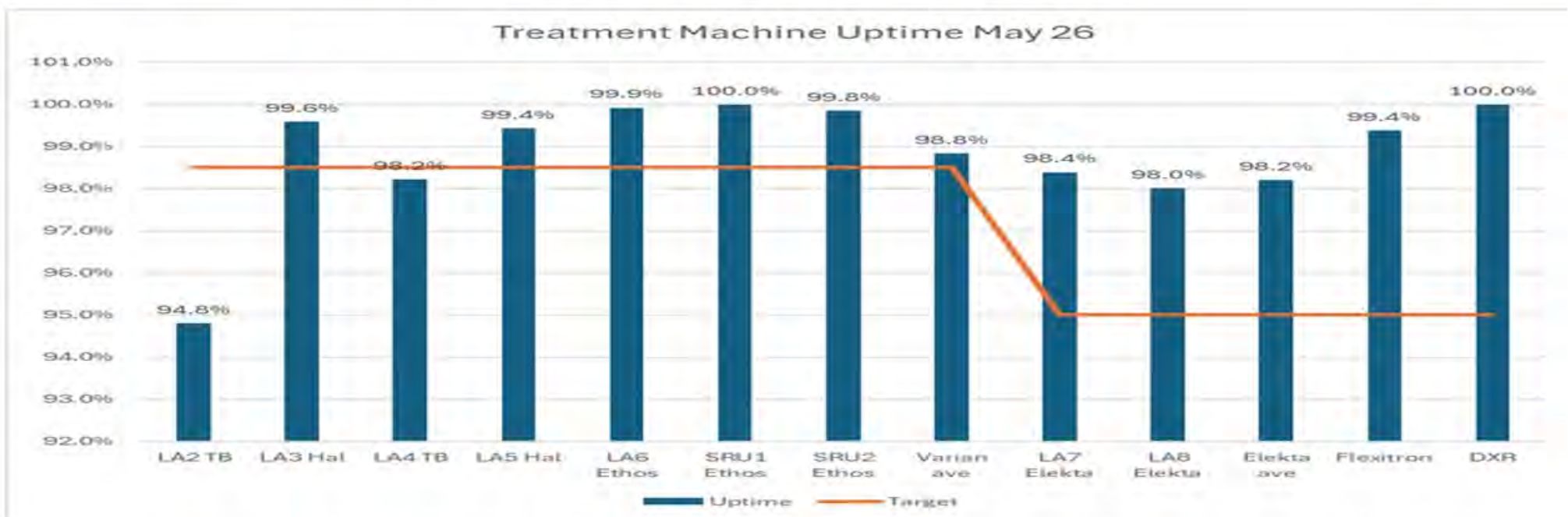
- - **Demand/capacity imbalance and data issues** limiting full performance assurance – especially on USC pathway
- - **Activity reporting and assurance** – gaps in activity and income reporting reduce assurance and benchmarking capability

Mitigation

- **Demand/capacity** – escalation and clinical prioritisation in place
- **Activity reporting and assurance** – joint work with data and insights, finance and physics to strengthen Aria data and reporting

Radiotherapy – treatment machine (Linac) uptime

May 2026



- 'Uptime' relates to the time a Linac machine is available for radiotherapy treatment over standard operating hours.
- The Varian average uptime across both sites was 98.8% which is above the target of 98.5% for the IRS contract.
- The Elekta average uptime was 98.2%. This exceeded the in-house target of 95%.
- The combined Linac, Flexitron and DXR uptime was 98.9% which is above the in-house target of 95%.

2.2 Welsh Blood Service

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



Key Issues / Risks:

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

Action / Mitigation Underway:

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

Forecast / Next Month:

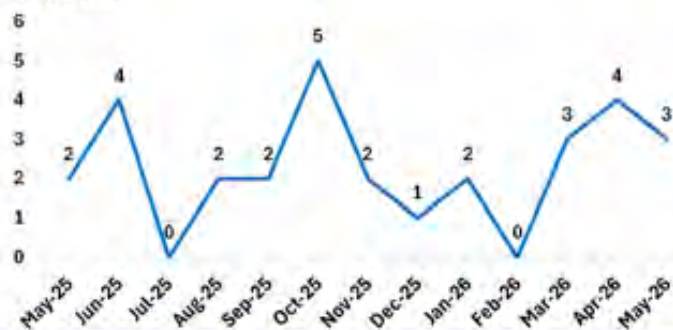
- The pre-amber status continued into June, with recovery to normal stock levels expected before month-end.

Updates on last month:

- All clinical demand was met for O, A & B+ groups.
- A- stock fell below 3 days on 29th May due to short-term collection constraints; effectively managed through operational mitigation (pre-amber alert issued) without further escalation.
- Red Blood Cells manufactured reached 97% of demand (% manufactured to issued); within tolerance and helped rebalance the age of stock.

WBS Incidents Reported to Regulator / Licencing Authority

May 2026



Three Serious Adverse Blood Reactions and Events (SABRE) incidents were reported to the Medicines and Healthcare products Regulatory Agency (MHRA) in May 2026.

Action / Mitigation Underway:

Most recent SABRE reports relate to donor eligibility errors or transcription errors. Mitigation for transcription errors (all three incidents this month) is mainly dependent on national digital infrastructure. While WBS is working collaboratively with the national team, resolution of some system-related issues remains outside direct organisational control.

SABRE 160: Manual transcription error (crossmatch report)

This was a single digit typographical error within a donation number recorded on the report. There was no adverse impact on patient safety; the units issued were compatible and correctly labelled.

SABRE 161: Manual transcription error (compatibility report)

This was a single letter typographical error within the patient's forename recorded on the report. There was no adverse impact on patient safety, and all other identifiers were correct.

SABRE 162: Manual transcription error (compatibility report)

Historic antibody incorrectly transcribed onto the report, with potential risk of inappropriate red cell unit selection; risk of transfusion reaction considered low as the correct antibody history is held in hospital Laboratory Information Management System (LIMS), preventing issue of anti-gen positive units to the patient. Investigation ongoing.



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Welsh Blood Service

Quality Assurance – Incidents & Audits

May 2026



Gwasanaeth Gwaed Cymru
Welsh Blood Service

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

↑ 2 exceeding target date for closure (in reporting month)	Target: 0
↑ 1 that remains overdue at month end	Target: 0
↓ 25% overdue actions from open incident action plans	Target: <5%

Quality (GMP) Incidents:

↓ 5 exceeding target date for closure (in reporting month)	Target: 0
↓ 8 that remain overdue at month end	Target: 0
Age of oldest open overdue incident – 81 days	No target set

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

0 from internal audits in the last month	No target set
0 from external audits in the last month	No target set
↑ 7.7% overdue actions from open audit action plans	Target: <5%

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

Action / Mitigation underway:

- Action plan implemented in January 2026 to address a deteriorating trend in incident management.
- Initial improvement observed, followed by a dip in performance in overdue actions in May 2026.
- This has prompted a targeted review and strengthened focus on delivery of the action plan.
- Additional interventions are now in place to support consistent compliance and sustained improvement.
- The oldest overdue incident has been closed; delay due to unclear ownership and escalation routes, compounded by reliance on Estates to complete repairs.

Time Expired Platelets

May 2026



Updates on Last Month:

- Performance improved significantly but remained above target in May 2026, with continued volatility driven by fluctuations in demand and production balancing.
- Underlying challenge remains balancing production with variable clinical demand, given the short shelf life of platelets.

Key Issues / Risks:

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

Action / Mitigation Underway:

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

Forecast / Next Month:

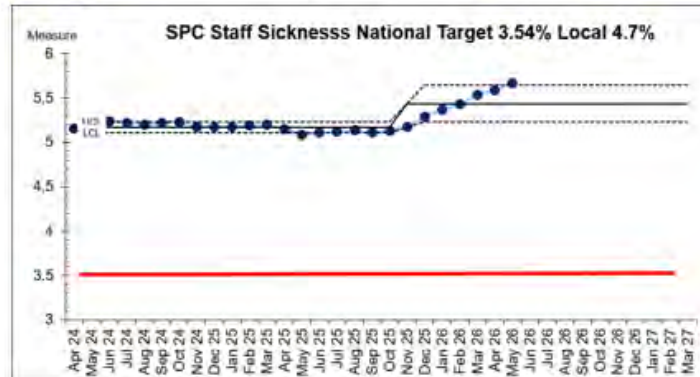
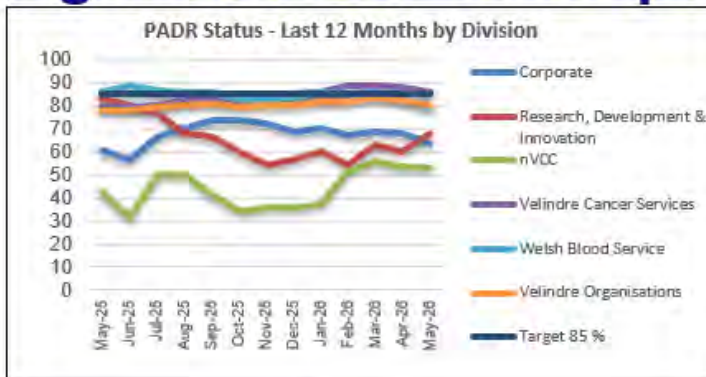
- Performance expected to return to towards target levels, with improved planning and operational controls.
- Some variability is likely to persist, due to reliance on real-time clinical demand and limited production flexibility.



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Welsh Blood Service

People, Wellbeing & Organisational Development

May 2026



Action / Mitigation Underway:

- Policies and processes have been reviewed combined with data analysis to draft comprehensive and holistic action plans for improving KPIs.
- Fundamentals of Management Training (FOMs) package has been offered to all managers and supervisors across the Trust
- In VCS a Deep dive analysis has been undertaken into sickness absence rates and underlying causes within VCS to inform the development of a targeted action plan aimed at supporting managers, reducing absence levels and improving workforce wellbeing and support
- Working in partnership with managers to identify key areas of focus, bringing together initiatives and business areas to ensure a coordinated and effective approach to delivery.
- June will see the finalisation of a targeted action plan to support absence management is underway, with an update to be provided to the Leadership Team. The plan is focused on supporting managers and colleagues through enhanced coaching and guidance, with the aim of improving overall absence trends across the Division.
- Partnering with managers to identify priority people initiatives in preparation for the transition to nVCC
- Within WBS the SLT have developed SMART objectives for the hotspot areas and are being managed by managers supported by WOD
- The workforce dashboards are provided to divisional SLT on a monthly basis highlighting hotspot areas

Forecast / Next Month:

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

Key Issues / Risks:

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

Updates on Last Month:

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



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

People KPIs Heatmap

May 2026

	PADR	Sickness Absence FTE Rolling	Stat & Mand	Welsh Language Awareness	Anti Racism	Turnover FTE Rolling	Job Plan
Corporate	64.04	4.83	85.41	79.48	89.55	11.67	N/A
Research, Development & Innovation	68.42	4.34	90.45	79.10	91.04	16.13	N/A
Velindre Cancer Services	86.27	5.94	89.78	81.38	89.67	8.78	82.61
Welsh Blood Service	79.80	6.15	93.31	83.87	95.91	9.21	100.00
nVCC	53.13	1.07	88.29	70.73	87.80	3.09	N/A
Velindre Organisations	79.95	5.67	90.02	81.41	91.22	9.47	83.33
Target	85%	3.54%	85%	90%	85%	7%	90%



People - NHS Staff Survey Culture Metrics – 2024 and 2025

May 2026

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

This data is from the NHS Wales Staff Survey 2025.

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

*benchmarking average for Health Boards

Digital Services

May 2026



Updates on Last Month:

- Service performance remains above the agreed percentage; Incidents performance remained stable in May. Factors to consider is Windows 11 migration project and seasonal variations on Requests.
- No Major Incidents recorded.
- Percentage of Cyber Security mandatory training above target again this month.

Forecast / Next Month:

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

Action / Mitigation Underway:

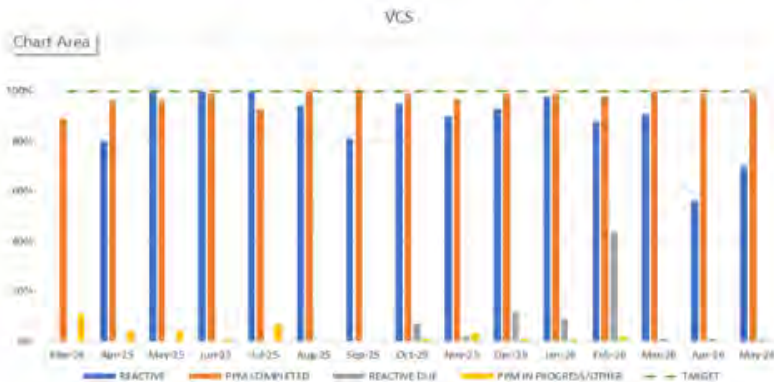
- IMTP review progressing. Investigating the demand between business as usual and project work required, to mitigate future capacity issues.

Key Issues / Risks:

- Capacity v Demand of requests on the IMTP.

Estates and Infrastructure

May 2026



Updates on Last Month:

VCS – PPM = 99% - Reactive = 86%
Trust HQ – PPM = 100% - Reactive = 100%
WBS HQ – PPM = 100% - Reactive = 95%
Dafen – PPM = 100% - Reactive = 100%
Wrexham – PPM = 100% - Reactive = 67%
Bangor – PPM = 100% - Reactive = 100%

Action / Mitigation Underway:

- VCS – May - 86% Reactive jobs- There was a high number of reactive requests during May. Estates team also encountered staff sickness, AL and AP training during this period.
- Wrexham – May, reactive 67%, Low number of work request in month with one low risk task outstanding which requires a contractor visit to complete.

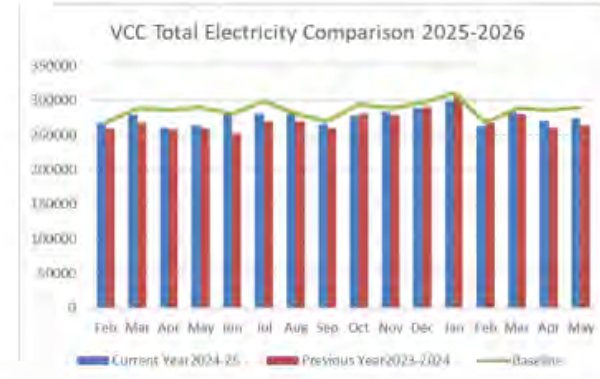
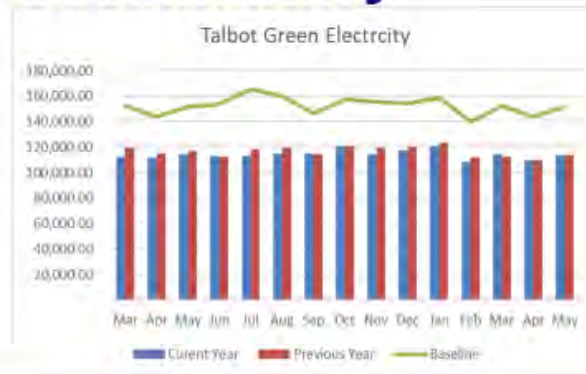
Forecast / Next Month: June 2026

- PPMs May planned for VCS - 564
- PPMs May planned for Trust HQ - 17
- PPMs May planned for WBS sites - 131

Key Issues / Risks:

- Due to the ongoing issues with the current CAFM system, two quotations have been obtained from alternative providers. Confirmation is currently awaited regarding the implementation of the CAFM system at NVCC. Once this has been confirmed, a full evaluation of all three systems will be undertaken to determine the most suitable solution to meet the Trust's operational and strategic requirements.

Estates Sustainability



Updates on Last Month:

- **Gas consumption:** VCC account reconciled after AMR fault, reflected in anomalies in graph above, however, total consumption over year not out of line with previous year. All other accounts business as usual.
- **Electricity use:** Largely stable across the Trust. Reductions are noted in WBS Talbot Green site due to progress in LED lighting upgrade.
- **Great Big Green Week:** Successful week of engagement events for staff on nature, energy and active travel.

Forecast / Next Month:

- **Waste:** Bin replacements across WBS are expected to increase recycling rates.
- **Energy Costs:** Energy costs continue to be monitored via WEOG, with potential price increases linked to Middle East geopolitical factors. April marks the start of NHS Wales contract move to Variable 30 contract.
- Continued progress on LED upgrades, renewable energy planning, and circular procurement.
- Focus on EV chargers to promote and increase staff use.

Action / Mitigation Underway:

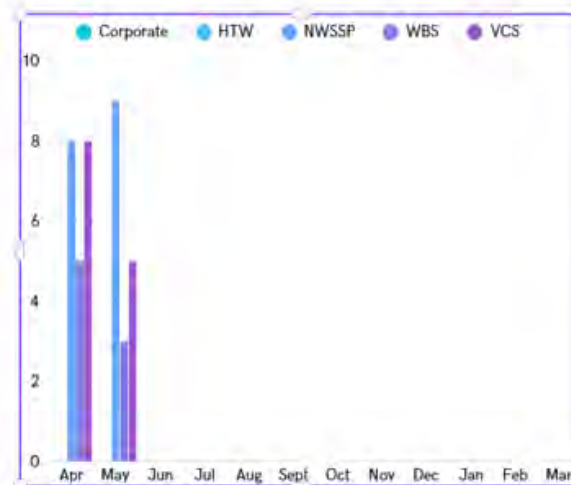
- **Energy Management:** Deliver internal audits, BMS monitoring, and monthly Estates reviews to identify inefficiencies, and track ongoing energy reductions. To be completed monthly.
- **LED Lighting:** Install LED lighting with motion/daylight sensors across all planned areas using procured materials,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

Key Issues / Risks:

- None to note.

Health & Safety

May 2026



Updates on Last Month: Total of incidents

- NWSSP – 9
- VCS - 5
- WBS – 3
- MIM (Trust Managed) - 0
- RIDDOR – 2

Action / Mitigation Underway:

Immediate incident actions completed - sharps injuries, RIDDOR reporting, and violence & aggression incidents managed per protocol with appropriate follow-up.

- Environmental and equipment controls strengthened - issues escalated to Estates with local corrective actions implemented.
- Staff support measures in place - post-incident welfare and management follow-up provided.
- Health & Safety management system development continuing - strengthening governance, reporting, and organisational learning.

Forecast / Next Month:

- Sharps injury reduction through safe practice reinforcement and compliance checks.
- Review of violence & aggression trends in outpatient and donor-facing areas.
- Patient Manual Handling role proposal progressing through Board discussion.
- Continued support to new hospital operations, embedding safe systems of work.
- Increased hazard reporting visibility, aligned to the developing management system.

Key Issues / Risks:

- Workplace violence & aggression (V&A) continues across both divisions (VCS & WBS), including one moderate severity event in WBS Collections.
- Exposure risks in WBS Manufacturing (blood product splashes/leaks) highlight ongoing biohazard handling risks.
- Manual handling and environmental hazards (e.g. cabling, equipment design issues) remain contributory factors.

Health & Safety

Incident Severity - Heinrich's Triangle

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

0

Negligible /
No harm

1

Minor /
First aid

2

Moderate /
Medical
treatment

3

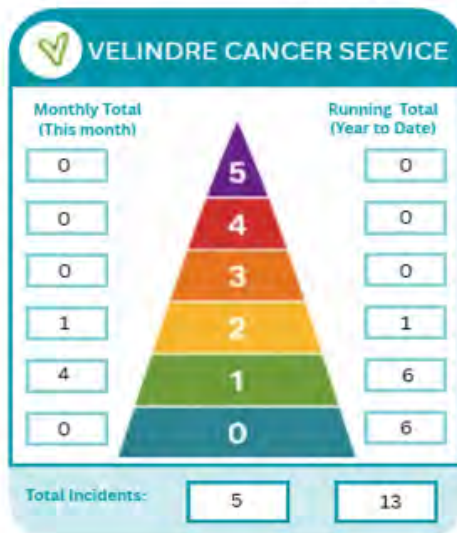
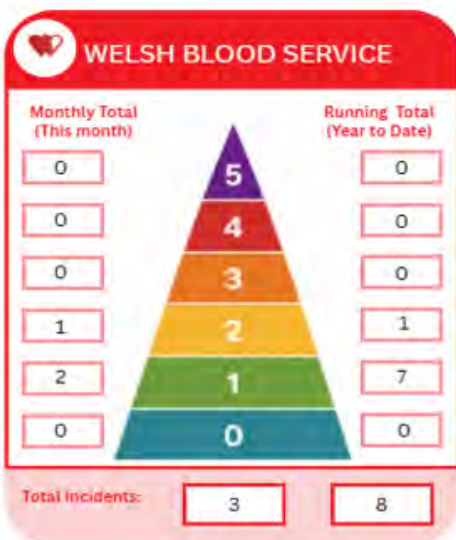
Severe /
Lost time injury /
Serious but
recoverable

4

Major /
Single
fatality

5

Catastrophic /
Multiple
fatalities



Notes:

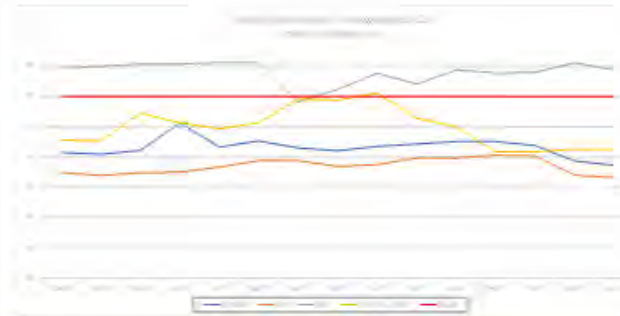
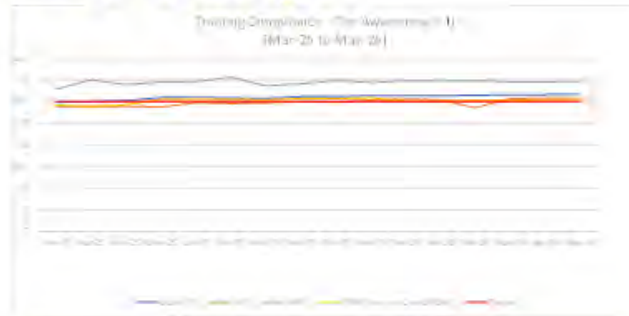
Riddor Reportable incident for VCS
Riddor Reportable incident for NWSSP

21

[PMF LINK](#)

Fire Safety

May 2026



FIVE YEAR BUDGET SUMMARY (2025-26)												2025-26											
		2025-26			2026-27			2027-28			2028-29			2029-30			2030-31						
		2025-26	2026-27	2027-28	2025-26	2026-27	2027-28	2025-26	2026-27	2027-28	2025-26	2026-27	2027-28	2025-26	2026-27	2027-28	2025-26	2026-27	2027-28				
BUDGET SUMMARY (2025-26)		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18				
BUDGET SUMMARY (2026-27)		19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36				
BUDGET SUMMARY (2027-28)		37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54				
BUDGET SUMMARY (2028-29)		55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72				
BUDGET SUMMARY (2029-30)		73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90				
BUDGET SUMMARY (2030-31)		91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108				
BUDGET SUMMARY (2031-32)		109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126				
BUDGET SUMMARY (2032-33)		127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144				
BUDGET SUMMARY (2033-34)		145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162				
BUDGET SUMMARY (2034-35)		163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180				
BUDGET SUMMARY (2035-36)		181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198				
BUDGET SUMMARY (2036-37)		199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216				
BUDGET SUMMARY (2037-38)		217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234				
BUDGET SUMMARY (2038-39)		235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252				
BUDGET SUMMARY (2039-40)		253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270				
BUDGET SUMMARY (2040-41)		271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288				
BUDGET SUMMARY (2041-42)		289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306				
BUDGET SUMMARY (2042-43)		307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324				
BUDGET SUMMARY (2043-44)		325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342				
BUDGET SUMMARY (2044-45)		343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360				
BUDGET SUMMARY (2045-46)		361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378				
BUDGET SUMMARY (2046-47)		379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396				
BUDGET SUMMARY (2047-48)		397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414				
BUDGET SUMMARY (2048-49)		415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432				
BUDGET SUMMARY (2049-50)		433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450				
BUDGET SUMMARY (2050-51)		451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468				
BUDGET SUMMARY (2051-52)		469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486				
BUDGET SUMMARY (2052-53)		487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504				
BUDGET SUMMARY (2053-54)		505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522				
BUDGET SUMMARY (2054-55)		523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540				
BUDGET SUMMARY (2055-56)		541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558				
BUDGET SUMMARY (2056-57)		559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576				
BUDGET SUMMARY (2057-58)		577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594				
BUDGET SUMMARY (2058-59)		595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612				
BUDGET SUMMARY (2059-60)		613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630				
BUDGET SUMMARY (2060-61)		631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648				
BUDGET SUMMARY (2061-62)		649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666				
BUDGET SUMMARY (2062-63)		667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684				
BUDGET SUMMARY (2063-64)		685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702				
BUDGET SUMMARY (2064-65)		703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720				
BUDGET SUMMARY (2065-66)		721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738				
BUDGET SUMMARY (2066-67)		739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756				
BUDGET SUMMARY (2067-68)		757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774				
BUDGET SUMMARY (2068-69)		775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792				
BUDGET SUMMARY (2069-70)		793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810				
BUDGET SUMMARY (2070-71)		811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828				
BUDGET SUMMARY (2071-72)		829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846				
BUDGET SUMMARY (2072-73)		847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864				
BUDGET SUMMARY (2073-74)		865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882				
BUDGET SUMMARY (2074-75)		883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900				
BUDGET SUMMARY (2075-76)		901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918				
BUDGET SUMMARY (2076-77)		919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936				
BUDGET SUMMARY (2077-78)		937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954				
BUDGET SUMMARY (2078-79)		955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972				
BUDGET SUMMARY (2079-80)		973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990				
BUDGET SUMMARY (2080-81)		991	992	993	994	995	996	997	998	999	1000	1001	1002	1003	1004	1005	1006	1007	1008				
BUDGET SUMMARY (2081-82)		1009	1010	1011	1012	1013	1014	1015	1016	1017	1018	1019	1020	1021	1022	1023	1024	1025	1026				
BUDGET SUMMARY (2082-83)		1027	1028	1029	1030	1031	1032	1033	1034	1035	1036	1037	1038	1039	1040	1041	1042	1043	1044				
BUDGET SUMMARY (2083-84)		1045	1046	1047	1048	1049	1050	1051	1052	1053	1054	1055	1056	1057	1058	1059	1060	1061	1062				
BUDGET SUMMARY (2084-85)		1063	1064	1065	1066	1067	1068	1069	1070	1071	1072	1073	1074	1075	1076	1077	1078	1079	1080				
BUDGET SUMMARY (2085-86)		1081	1082	1083	1084	1085	1086	1087	1088	1089	1090	1091	1092	1093	1094	1095	1096	1097	1098				
BUDGET SUMMARY (2086-87)		1099	1100	1101	1102	1103	1104	1105	1106	1107	1108	1109	1110	1111	1112	1113	1114	1115	1116				
BUDGET SUMMARY (2087-88)		1117	1118	1119	1120	1121	1122	1123	1124	1125	1126	1127	1128	1129	1130	1131	1132	1133	1134				
BUDGET SUMMARY (2088-89)		1135	1136	1137	1138	1139	1140	1141	1142	1143	1144	1145	1146	1147	1148	1149	1150	1151	1152				
BUDGET SUMMARY (2089-90)		1153	1154	1155	1156	1157	1158	1159	1160	1161	1162	1163	1164	1165	1166	1167	1168	1169	1170				
BUDGET SUMMARY (2090-91)		1171	1172	1173	1174	1175	1176	1177	1178	1179	1180	1181	1182	1183	1184	1185	1186	1187	1188				
BUDGET SUMMARY (2091-92)		1189	1190	1191	1192	1193	1194	1195	1196	1197	1198	1199	1200	1201	1202	1203	1204	1205	1206				
BUDGET SUMMARY (2092-93)		1207	1208	1209	1210	1211	1212	1213	1214	1215	1216	1217	1218	1219	1220	1221	1222	1223	1224				
BUDGET SUMMARY (2093-94)		1225	1226	1227	1228	1229	1230	1231	1232	1233	1234	1235	1236	1237	1238	1239	1240	1241	1242				
BUDGET SUMMARY (2094-95)		1243	1244	1245	1246	1247	1248	1249	1250	1251	1252	1253	1254	1255	1256	1257	1258	1259	1260				
BUDGET SUMMARY (2095-96)		1261	1262	1263	1264	1265	1266	1267	1268	1													



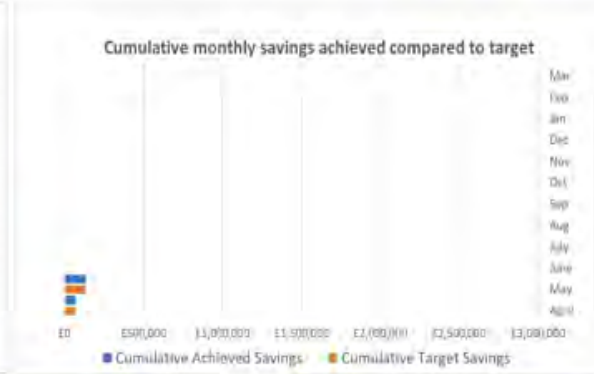
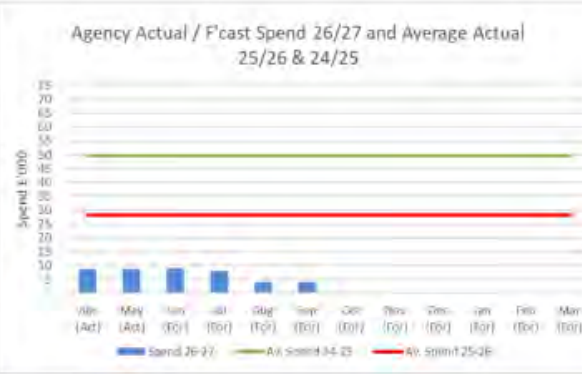
GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

Financial Performance

May 2026

Trust Revenue Position (core)	25/26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26	Nov 26	Dec 26	Jan 27	Feb 27	Mar 27
Actual Cum \$k	33	2	3										
Target		0	0										
Trust Capital Position	25/26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26	Nov 26	Dec 26	Jan 27	Feb 27	Mar 27
Actual Cum £m	20.593	0.395	1.938										
Target \$67.493m CEL		0.395	1.938										



Updates on Last Month:

- The Trust has reported a small underspend up to 31st May 2026 of £0.003m which is in line with the 2026-27 IMTP planning assumptions.
- The Trust has met the Public Sector Payment Performance (PSPP) target of paying 95% of Non-NHS invoices within 30 days for April 2026.
- The Trust is on track to achieve the Capital Expenditure Limit (CEL) for 2026-27.
- All saving schemes for 2026-27 have been identified. Those still RAG rated amber need to meet the criteria for green schemes by 30th June 2026.

Forecast Year End Position:

- The Trust is currently on track to achieve its forecast breakeven position, albeit it is early in the year and there are a number of challenges to manage.
- The Trust is in discussions with WG regarding capital allocations but currently expects to meet its CEL target.
- Savings plans in place need to all meet the green rated criteria by the end of the first quarter.

Action / Mitigation Underway:

- Urgent action required from Divisional / Executive Directors and SLT / SMT to ensure that saving schemes for 2026-27 turn green by the end of June and start / continue to deliver as expected.

Key Issues / Risks:

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

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



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

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

3. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals:	
Choose an item	
If yes - please select all relevant goals:	
• Outstanding for quality, safety and experience	☒
• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations	☐
• A beacon for research, development and innovation in our stated areas of priority	☐
• An established 'University' Trust which provides highly valued knowledge for learning for all.	☐
• A sustainable organisation that plays its part in creating a better future for people across the globe	☐
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF)	06 -Organisational and Clinical Governance
	Quality and Safety considerations form an integral part of PMF to monitor our performance and progress against our strategic objectives
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Select all relevant domains below
	Safe ☒
	Timely ☒
	Effective ☒
	Equitable ☒
	Efficient ☒
	Patient Centred ☒
	Quality and Safety considerations form an integral part of PMF to monitor our performance and progress against our strategic objectives
QUALITY IMPACT ASSESSMENT	Not required - not a strategic decision

	The 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.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Not required
For more information: https://www.gov.wales/socio-economic-duty-overview	[In this section, explain in no more than 3 succinct points why an assessment is not considered applicable or has not been completed].
	Click or tap here to enter text
TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT	
The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated. Please indicate whether any of the matters outlined in this report impact the Trust's Wellbeing goals:	
YES - Select Relevant Goals below	
If yes select the relevant goals:	
• A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities.	☐
• A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience.	☐
• A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health	☒
• A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances	☐
• A Wales of more Cohesive Communities - Attractive, viable, safe and well-connected communities.	☐
• A Wales of Vibrant Culture and Thriving Welsh Language -Promoting and protecting culture, heritage and the Welsh language, encouraging people to participate in the arts, and sports and recreation.	☒
• A Globally Responsible Wales – Consideration of whether an action may make a positive contribution to global well-being	☐

FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	<i>This section should outline the financial resource requirements in terms of revenue and/or capital implications that will result from the Matters for Consideration and any associated Business Case.</i>
	Narrative in this section should be clear on the following:
	Source of Funding:
	Choose an item
	Please explain if 'other' source of funding selected:
	Click or tap here to enter text
	Type of Funding:
	Choose an item
	Scale of Change
	Please detail the value of revenue and/or capital impact:
	Click or tap here to enter text
	Type of Change
	Choose an item
	Please explain if 'other' source of funding selected:
	Click or tap here to enter text
EQUALITY IMPACT ASSESSMENT	
For more information: https://nhs.wales365.sharepoint.com/sites/VEL/Intranet/SitePages/E.aspx	Not required - please outline why this is not required
	[In this section, explain in no more than 3 succinct points what the equality impact of this matter is or not (as applicable)].
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text
	[In this section, explain in no more than 3 succinct points what the legal implications/ impact is or not (as applicable)].

4. RISKS

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

TRUST BOARD	
FINANCE REPORT FOR THE PERIOD ENDED 31ST MAY 2026 (M2 2026-27)	
DATE OF MEETING	30/07/2026
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	INFORMATION / NOTING
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Claire Bowden – Head of Financial Planning & Reporting Steve Coliandris – Deputy Director of Finance
PRESENTED BY	Matthew Bunce, Executive Director of Finance
APPROVED BY	Matthew Bunce, Executive Director of Finance

EXECUTIVE SUMMARY	The attached report outlines the financial position and performance for the period to the end of May 2026. The three main issues are highlighted below: 1. Long Term Agreement (LTA) Financial values, Contract Rebase & VCS LTA Financial Performance <u>LTA Financial Values</u> - The Trust has agreed LTAs with all Commissioners including the 1.11% uplift. - Commissioners have not agreed additional funding above the 1.11% general uplift, for either WBS or VCS. The Trust continues to manage capacity pressures across outpatients,

	ambulatory care, SACT and imaging to meet rising demand and cancer waiting times. <u>Contract Rebase</u> • All Wales DoFs have agreed to establish an LTA / commissioning group to review the historical LTAs across NHS Wales and make recommendations for how these are updated to current activity and cost. This will include recommendations on the principles around how commissioners manage the financial impact (gain / loss) of LTA re-basing. This group is unlikely to report back until the end of 2026/27 to inform 2027/28 financial planning. <u>VCS LTA Financial Performance</u> • The IMTP planned overperformance against 2019/20 baseline contract levels in 2026-27 is £10.673m, this is an increase in contract income of £0.083m against the 2025-26 out-turn and plan set at IMTP. The marginal income forecast overachievement is being held to support the underachievement on Radiotherapy activity and underlying cost pressures within VCS. 2. Integrated Medium Term Plan (IMTP) – Financial Plan / Forecast • A balanced three-year IMTP financial plan, covering the period 2025-28 was approved by Welsh Government. The 2026-29 plan submitted to Welsh Government on 31st March 2026 is awaiting sign off. • The Trust has achieved a minor underspend of £0.003m for the two month period ended 31st May 2026, and is forecasting a breakeven position at 31st March 2027 at this time. • The ability to maintain a balanced underlying position is challenging due to the significant cost pressures and risks the Trust is facing.

	Despite this, the IMTP for 2026-29 reflected a balanced brought forward position which is expected to be maintained over the course of the IMTP. 3. Key Financial Targets / KPIs • Revenue Balance: The Trust has reported a year to date underspend of £0.003m at 31st March 2026. • Public Sector Payment Performance (PSPP): The Trust has achieved the PSPP target of paying 95% of Non-NHS invoices within 30 days. • Capital Expenditure Limit (CEL): The Trust is forecasting achievement of its CEL in 2026-27. Savings Target: Currently several savings schemes are still RAG rated amber and pose a significant risk of £1.190m to the delivery of the overall savings target. Current expectation is that these schemes will turn green by the end of quarter one, however there are challenges in achieving this.

RECOMMENDATION / ACTIONS	The Trust Board is asked NOTE the contents of the May 2026 financial report and in particular: • The year to date and forecast revenue and Capital out turn position, and PSPP performance. • The latest position on Velindre Cancer Service LTA income for 2026-27 from our commissioners. • The position with commissioners on the contract rebase agreement, noting that the LTA issue with Hywel Dda has now been resolved. • The current position of the Trust savings plans.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	Date
Executive Management Board	02/07/2026
Quality, Safety & Performance Committee	16/07/2026
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR – Financial Performance	Level 4 - Increased extent of impact from actions
APPENDICES	
Appendix 1	Trust Finance Report – May 2026
Appendix 2	nVCC Finance Report – May 2026

1. SITUATION / BACKGROUND

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

2. ASSESSMENT / SUMMARY MATTERS FOR CONSIDERATION

2.1 Performance against Key Financial Targets:

	Unit	Current Month £m	Year to date £m	Year End Forecast £m
Revenue	Variance	0.001	0.003	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	1.938	1.938	67.743
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	97.6%	97.6%	95.0%

2.2 Revenue Budget

The core Trust has reported a **minor underspend of £0.003m** position for the period ended 31st May 2026, in line with a yearend forecast outturn of **breakeven**. However, this will be challenging, given the cost and service pressures outlined in the plan, and the additional support required by Commissioners that has not yet been secured.

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

Savings

Currently several savings schemes are still RAG rated amber and pose a significant risk of £1.190m to the delivery of the overall savings target. Whilst current expectation is that these schemes will turn green by the end of quarter one, there are challenges in achieving this.

LTA Income

The Trust has agreed 2026-27 LTAs with Commissioners for VCS and WBS. Signed agreements have been received all organisations except C&V UHB who advised on 8th June 2026 that their Board have agreed the LTA and the documents would be signed within the following 7 days by the Chief Executive.

The LTA activity dispute with Hywel Dda has now been resolved for 2026-27 with the HD agreeing to Pay the Trust the full baseline allocations.

LTA Contract Position

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

LTA Contract Rebase

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

2.3 PSPP Performance

During May 2026 the Trust (core) achieved a compliance level of **97.6%** (April 95.2%) of non-NHS supplier invoices paid within the 30-day target. The Trust year to date compliance (including hosted) is **97.4%** compared to the target of 95%.

2.4 Reserves

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

Use of the recurrent and non-recurrent reserve position will continue to be closely monitored during 2026-27 and will be considered alongside several key factors such as the VCS marginal income risk, LTA contract rebase risk, achievement of the 2026-27

savings target and a review of currently committed support towards Trust investment, transformation and delivery programmes.

2.5 Financial Risks

Risks outlined in section 7 of the attached report in further detail, are listed below:

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

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

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

2.6 Capital

All Wales Programme

The approved 2026-27 Capital Expenditure Limit (CEL) for the year ended May 2026 is currently £67.493m (2025-26 £20.603m). This includes All Wales Capital funding of £65.247m, and discretionary funding of £2.246m. A further £8.688m has been allocated to the unapproved element of the CEL for drawdown from Welsh Government as and when it becomes required by the Trust in relation to nVCC and the sale of the Whitchurch Hospital site. Some further changes are expected as 2026-27 award letters are issued and new funding requests are considered.

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

3. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)

Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety, and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development, and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK – BOARD ASSURANCE FRAMEWORK (BAF)	BAF 04 - There is a strategic risk that the Trust becomes financially unsustainable if it does not secure sufficient funding for the provision of services and does not maximize its use of resources. Unwarranted variation could impact the value and effectiveness of the care our patients and donors receive.
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
QUALITY IMPACT ASSESSMENT	Not required - not a strategic decision
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Not required
TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT	
The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated. Please indicate whether any of the matters outlined in this report impact the Trust's Wellbeing goals: YES - Select Relevant Goals below	
If yes select the relevant goals: • A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities. ☒	

• A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic, and ecological resilience. ☐ • A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health ☐ • A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances ☐ • A Wales of Cohesive Communities - Attractive, viable, safe, and well-connected communities. ☐ • A Wales of Vibrant Culture and Thriving Welsh Language -Promoting and protecting culture, heritage, and the Welsh language, encouraging people to participate in the arts, and sports and recreation. ☐ • Globally Responsible Wales – Consideration of whether an action may make a positive contribution to global well-being ☐	
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	The Trust reported a revenue financial position of an underspend of £0.003m for May 2026, which is in line with the IMTP plan.
EQUALITY IMPACT ASSESSMENT	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.

4. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	Individual financial risks are discussed in section 2.7 of the report and the overall financial sustainability and value risk assessment is reflected in the Board Assurance Framework (BAF).
WHAT IS THE CURRENT RISK SCORE	12
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	Recipients are provided with detail on the risks and any actions required from them to mitigate / remove the risk are highlighted.

BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Individual risks to be managed with the financial envelope for 2026-27. Overall financial and sustainability risks reported and managed through the BAF.
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Yes - please detail below
	Availability of resources to implement work / changes needed and successful negotiations with Commissioners.
All risks must be evidenced and consistent with those recorded in Datix	



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust



FINANCIAL PERFORMANCE REPORT

FOR THE PERIOD ENDED 31 MAY 2026

**TRUST BOARD
30 JULY 2026**

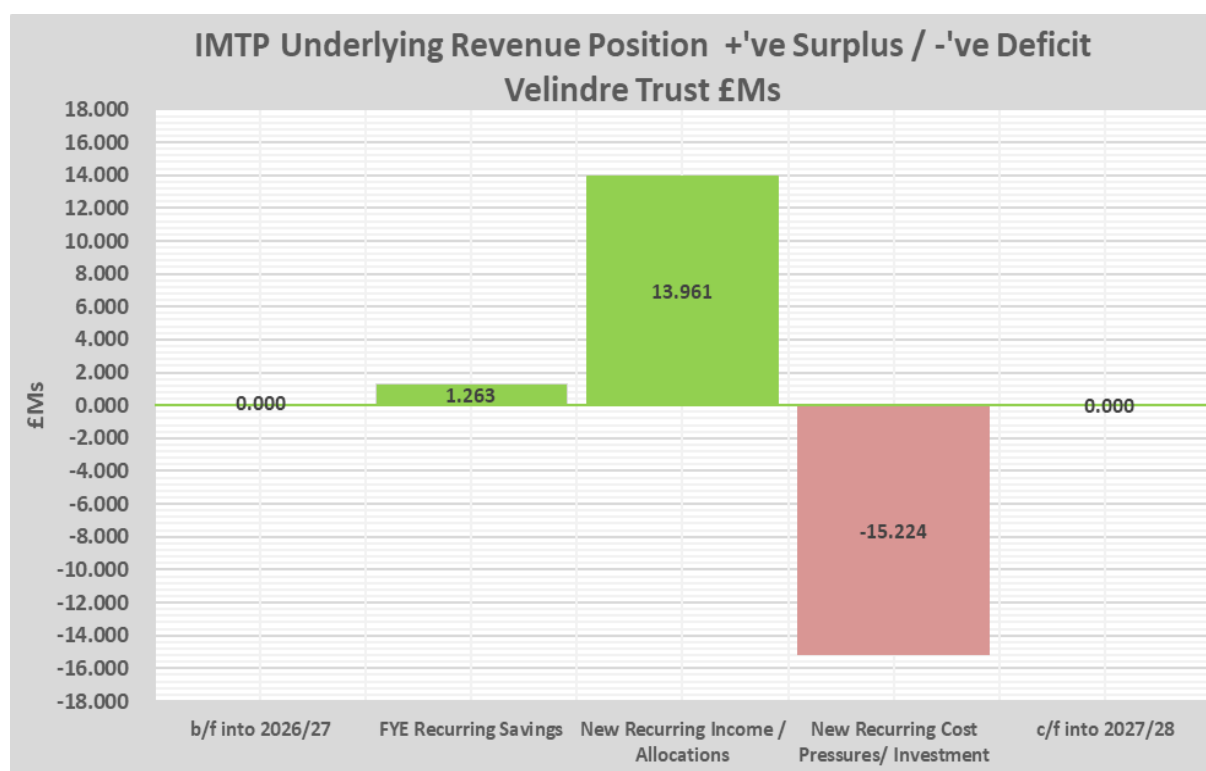
1. Introduction

The purpose of this report is to outline the financial position and performance for the year ended 31st March 2027, performance against financial savings targets, highlight any remaining financial risks, and confirm the actions being taken to deliver the IMTP Financial Plan for 2026-27.

2. Background / Context

The draft Trust IMTP Financial Plan for the period 2026-2029 was set within the following context:

- The Trust submitted a balanced three year IMTP, covering the period 2026-27 to 2028-29 to Welsh Government on 31st March 2026.
- For 2026-27 the Plan included:
 - A balanced position brought forward from 2025-26;
 - **FYE of new cost pressures / Investment of -£15.224m;**
 - offset by **new recurring Income of £13.961m;**
 - and recurring FYE **savings schemes of £1.263m;**
 - Allowing **a balanced position** to be forecast to c/f into 2027-28.
- The 1.11% core discretionary uplift will be required to fund the significant underlying cost pressures, investment in capacity beyond marginal cost, and the revenue investment decisions in relation to the Trust's major infrastructure and equipment projects.
- **To achieve a balanced financial position, the savings target set for 2026-27 is required to be achieved, all anticipated income will need to be received, and any new emerging costs pressures will need to be either mitigated at Divisional level or managed through the Trust reserves.**



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

3. Executive Summary

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

(Figures in parenthesis signify an adverse variance against plan)

Table 1 - Key Targets

	Unit	Current Month £m	Year to date £m	Year End Forecast £m
Revenue	Variance	0.001	0.003	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	1.938	1.938	67.743
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	97.6%	97.6%	95.0%

Performance against Planned Savings Target

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

Revenue

The core Trust has reported a **minor underspend of £0.001m** position for May 2026, leading to a **year to date underspend of £0.003m**. This is in line with a yearend forecast outturn of **breakeven**. However, this will be challenging, given the cost and service pressures outlined in the plan, and the additional support required by Commissioners that has not yet been secured.

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

Capital

The approved Capital Expenditure Limit (CEL) for the year ended 31st March 2027 is **£67.493m**. This represents all Wales Capital funding of **£65.247m**, and Discretionary funding of **£2.246m**. The Trust reported total capital spend to 31st May 2026 is £1.938m, with all funds expected to be fully utilised during 2026-27. Some funding for All Wales schemes is still to be confirmed by Welsh Government, and the nVCC project team are in the process of requesting a drawdown of £0.250m from the QRA contingency held by WG.

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

	Opening CEL £m	Movement £m	Current CEL £m
All Wales Capital:			
Integrated Radiotherapy Solution	17.115	0.000	17.115
WBS HQ Continuity Business Case OBC/FBC Fees	1.142	0.000	1.142
nVCC - Project*	37.825	0.000	37.825
nVCC – Project - Quantified Risk - Public Sector - Drawn down	0.059	0.000	0.059
nVCC - Enabling Works	0.393	0.000	0.393
Welsh Blood Service Fleet Replacement Programme 2026-27	0.882	0.000	0.882
Fees to develop the OBC/FBC for the PET at nVCC	0.256	0.000	0.256
Digital Resource for the nVCC Project	0.550	0.000	0.550
IRS – Next Generation Delivery System (NGDS)	7.000	0.000	7.000
DPIF - ePMA	0.025	0.000	0.025
Total All Wales Capital Programme	65.247	0.000	65.247
Discretionary Capital	2.246	0.000	2.246
Total CEL	67.493	0.000	67.493

PSPP

During May 2026 the Trust (core) achieved a compliance level of **97.6%** (April 95.2%) of non-NHS supplier invoices paid within the 30-day target. The Trust year to date compliance (including hosted) is **97.4%** compared to the target of 95%.

Efficiency / Savings

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

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

The overall Trust savings performance as of May 2026 shows the in month planned savings of **£0.067m were achieved**.

Currently several savings schemes are still RAG rated amber and pose a significant risk £(1.190)m to the delivery of the overall savings target. Current expectation is that these schemes will turn green by the end of quarter one, however there remain challenges in achieving this.

Revenue Position

Cumulative				Forecast		
Breakeven				Breakeven		
Type	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)	Full Year Budget (£m)	Full Year Forecast (£m)	Forecast Variance (£m)
Income	(46.327)	(45.371)	(0.956)	(282.864)	(282.864)	0.000
Pay	18.950	18.712	0.237	113.673	113.673	0.000
Non Pay	27.377	26.656	0.721	169.192	169.192	0.000
Total	(0.000)	(0.003)	0.003	0.000	0.000	0.000

The overall position against the profiled revenue budget to the end of May 2026 is a minor underspend of £0.003m, with a yearend outturn forecast position of **breakeven**.

4.1 Revenue Position Highlights / Key Issues

Underlying Position

The Trust submitted a balanced IMTP Financial Plan for 2026-29 and is expected to maintain this position over the course of the 3-year planning period. Outlined in that plan were some significant financial risk and challenges, particularly in the first year, due to the uncertainties around the income it will receive to cover the committed capacity investment in Velindre Cancer Services.

The formal agreement of the Trust income planning assumptions has been summarised within respective Commissioner Long Term Agreements for 2026-27 with planning principles agreed that included a 1.11% general uplift.

To retain a balanced position in 2026-27, the Trust will be required to manage all current and new financial risks, deliver the agreed savings target, and mitigate or remove any cost pressures that may emerge.

Income

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

Cumulative			
(£0.956m underachieved)			
Type	Year to Date Budget (£m)	Year to Date Actual (£m)	Year to Date Variance (£m)
Core Income - HB / WHSSC	19.629	19.641	- 0.012
Nice/ High Cost Drugs	13.171	13.171	-
WBS Wholesale Blood Products	5.536	5.536	-
WBS Transplantation Services	0.009	0.009	-
WBS Blood Components	0.008	0.110	- 0.102
Home Care Drugs	0.221	- 0.255	0.476
Private Patient	0.224	0.210	0.013
VCC Over Activity	1.765	1.765	-
Radiotherapy Activity Income	0.544	0.431	0.113
IRS Programme	0.194	0.194	-
Radiation Protection	0.017	0.020	- 0.003
Staff Recharges	0.134	0.135	- 0.000
One Wales Palliative and EOL Care	0.245	0.254	- 0.009
Velindre Charity	0.628	0.578	0.050
Other Charity	0.006	0.006	-
RD&I*	0.553	0.431	0.122
HTW	0.303	0.236	0.067
Other Operating Income	3.142	2.900	0.242
Total	46.327	45.371	0.955

*RD&I full year budget includes £2.423m of income from the Velindre Charitable Fund

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

Income from the Velindre Charity is drawn down by divisions in line with agreed business cases and is unlikely to present a risk to the annual income forecast.

An adjustment in respect of recovery of income for legal costs (included within the "other operating income" line above) which is currently being reported via non pay will be actioned in month 3 at c£0.300m. Similarly, there is an offsetting adjustment of £0.476m for home care drugs within non pay that will also be processed in June.

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

The table reflects the pass through by the Trust's Commissioners of the 2025-26 Agenda for Change Medical and Senior Manager (VSM) staff costs as per the Welsh Government Pay award matrix. The 2026-27 pay inflation is expected to be funded by WG and passed through to the Trust via the Health Board commissioning model once Welsh Government confirm the allocation which

will be based on actual staff in post (any shortfall such as staff increments and use of bank staff will need be met by discretionary uplift, additional savings or absorbed by Divisions).

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

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

VCS Long Term Agreement (LTA) Contract Performance

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

The Trust has also agreed LTAs with all other Commissioners for VCS and WBS. Signed agreements have been received from all organisations except C&V UHB who advised on 8th June 2026 that their Board have agreed the LTA and the documents would be signed within the following 7 days by the Chief Executive.

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

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

The IMTP planned performance against 2019/20 baseline contract levels for 2026-27 is £10.590m split across organisations as shown below:

Comparison to Base Contract Value per Commissioner	Base Contract Value £m	Projected Outturn Performance £m	Projected Outturn Total Contract £m	Projected Variance (%)	IMTP Planned Performance £m	Movement From IMTP £m
Hywel Dda (7A2)	0.865	-0.011	0.854	-1%	-0.019	0.008
Swansea Bay (7A3)	0.455	0.006	0.498	1%	0.007	-0.001
Cardiff & Vale (7A4)	16.048	3.518	20.600	22%	3.516	0.002
Cwm Taf Morgannwg (7A5)	14.285	2.748	18.121	20%	2.688	0.060
Aneurin Bevan (7A6)	19.812	3.797	25.099	20%	3.779	0.018
Powys (7A7)	1.080	0.313	1.474	28%	0.312	0.001
NHS Wales Joint Commissioning Committee	2.259	0.301	2.711	13%	0.306	-0.005
Total	54.803	10.673	69.356	20%	10.590	0.083

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

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

Financial Performance Per Contract Currency	Base Contract Value £m	Projected Outturn Performance £m	Projected Outturn Total Contract £m	Projected Variance (%)	IMTP Planned Performance £m	Movement From IMTP £m
Radiotherapy Planning	5.905	0.384	6.289	6%	0.319	0.064
Radiotherapy Delivery	13.508	0.044	13.552	0%	0.007	0.037
Nuclear Medicine	1.031	-0.067	0.964	-6%	-0.046	-0.021
Radiology Imaging	3.149	0.684	3.832	22%	0.745	-0.061
Preparation for Systemic Anti-Cancer Therapy	2.918	1.155	4.073	40%	1.147	0.008
Delivery of Systemic Anti-Cancer Therapy	6.884	2.318	9.202	34%	2.333	-0.015
Ambulatory Care Services	1.405	0.531	1.936	38%	0.521	0.010
Outpatient Services	10.455	5.079	15.534	49%	5.043	0.036
Inpatient Admitted Care	6.162	0.544	6.706	9%	0.520	0.024
Contract Adjustments	3.388	0.000	7.269	0%	0.000	0.000
Total	54.803	10.673	69.356	20%	10.590	0.083

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

Activity Performance Per Contract Currency	Baseline 2019/20 Contract Model Activity Performance	Projected New Contract Model Activity Performance	Projected Outturn Activity Variance	Projected Activity Variance (%)	IMTP Planned Performance	Movement From IMTP
Radiotherapy Planning	3,916	3,988	72	2%	3,957	31
Radiotherapy Delivery	53,586	50,394	- 3,192	-6%	49,781	614
Nuclear Medicine	1,738	1,488	- 250	-14%	1,563	75
Radiology Imaging	9,103	14,400	5,297	58%	14,991	590
Preparation for Systemic Anti-Cancer Therapy	25,262	41,044	15,782	62%	41,049	4
Delivery of Systemic Anti-Cancer Therapy	31,867	50,908	19,041	60%	51,087	179
Ambulatory Care Services	7,874	11,377	3,503	44%	11,291	86
Outpatient Services	59,960	99,909	39,949	67%	100,180	272
Inpatient Admitted Care	9,072	10,582	1,510	17%	10,530	51
Contract Adjustments	-	-	-	0%	-	-
Total	202,378	284,090	81,712	40%	284,429	339

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

This activity is shown below on a Commissioner basis:

Activity Performance Per Commissioner	Baseline 2019/20 Contract Model Activity Performance	Projected New Contract Model Activity Performance	Projected Outturn Activity Variance	Projected Activity Variance (%)	IMTP Planned Performance	Movement From IMTP
Hywel Dda (7A2)	1,202	1,183	-19	-2%	1,127	56
Swansea Bay (7A3)	1,200	1,355	155	13%	1,379	-23
Cardiff & Vale (7A4)	60,809	88,660	27,851	46%	88,916	-256
Cwm Taf Morgannwg (7A5)	59,964	79,502	19,538	33%	79,199	303
Aneurin Bevan (7A6)	74,098	105,219	31,121	42%	105,584	-365
Powys (7A7)	3,619	5,884	2,265	63%	5,915	-31
NHS Wales Joint Commissioning Committee	1,486	2,287	801	54%	2,310	-22
Total	202,378	284,090	81,712	40%	284,429	- 339

Whilst now resolved with the LTA for 2026-27 having been agreed and signed, Hywel Dda UHB requested a recurrent reduction in the LTA financial value from 2026/27 citing a reduction in activity where patients have been re-directed to Swansea Bay UHB. The Trust challenged this as whilst it did see a drop in patients from Hywel Dda between the period 2019-20 and 2024-25, activity levels have now returned back to 2019-20 levels and represent only a 13% reduction against the baseline. On this basis by moving to an actual charge basis there should be minimal to no loss in income received from HD.

The following are cost pressures / service developments within VCS which have been communicated with the Trust Commissioners as part of the IMTP process. Currently no funding support has been provided:

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

WBS Position Update

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

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

JCC has not approved additional funding for any of the cases. This creates significant financial risk, as the investments are needed to maintain and improve quality and safety; the Trust has therefore made some investments at financial risk. The cases were resubmitted to JCC on 8th October 2025 for consideration within the 2026-29 IMTP process, however no funding was provided. Funding will therefore need to be requested from Welsh Government following recommendations from the IBI report. Following recent discussions with JCC there has been agreement to work closer with the Trust during 2026-27 with a view to improve engagement and commission arrangements.

Pay Highlights / Key Issues

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

Several posts in VCS were recruited at risk to create additional capacity required to respond to the Covid activity backlog and service developments without certainty around LTA income pending activity undertaken or FBC funding approval by WG and Commissioners. The majority of these

posts however were funded recurrently as part of the 2024-25 and 2025-26 IMTP process. The remaining unfunded posts are currently under review alongside the LTA activity to try and align the cancer activity demand forecasts and associated income to help mitigate the financial risk exposure. Some funding was ringfenced in the 2026-27 IMTP to support the unfunded posts however it is subject to the above review being undertaken alongside aligning any posts to vacancies.

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

Non Pay Key Issues

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

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

4.2 Pay Spend Trends (Run Rate)

As of 31st May 2026, the current staff in post is 1,727 WTE (March 1,714). The number of vacancies is 105 WTE (March 106), which represents a vacancy rate of 5.74% (5.85% March) against the budget of 1,832 WTE. The vacancy gap is largely being met using overtime or bank staff and is also supporting each of the division's vacancy factor savings target.

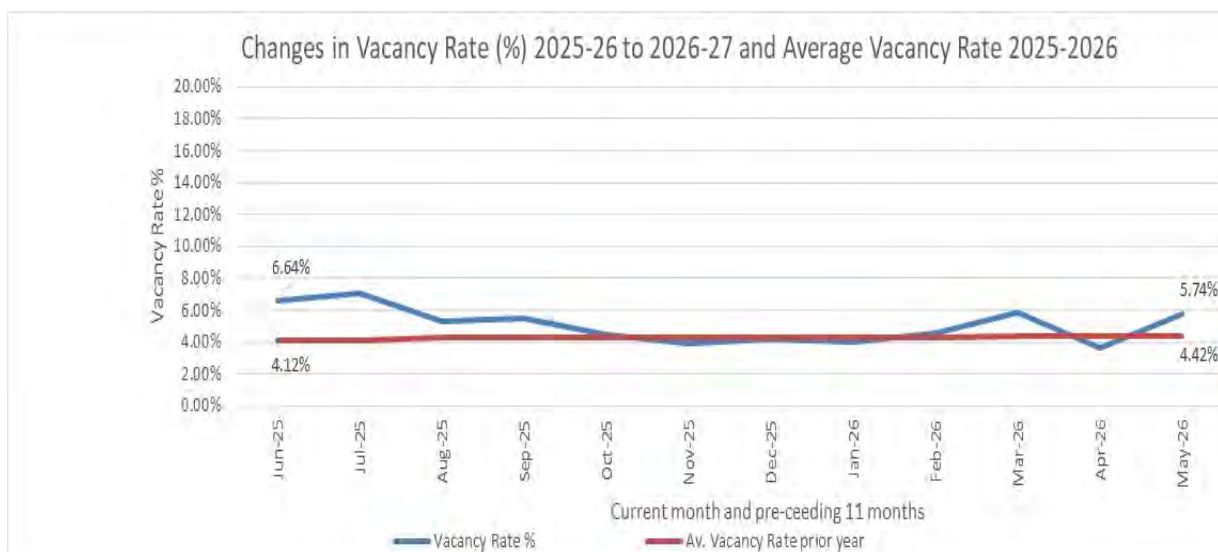
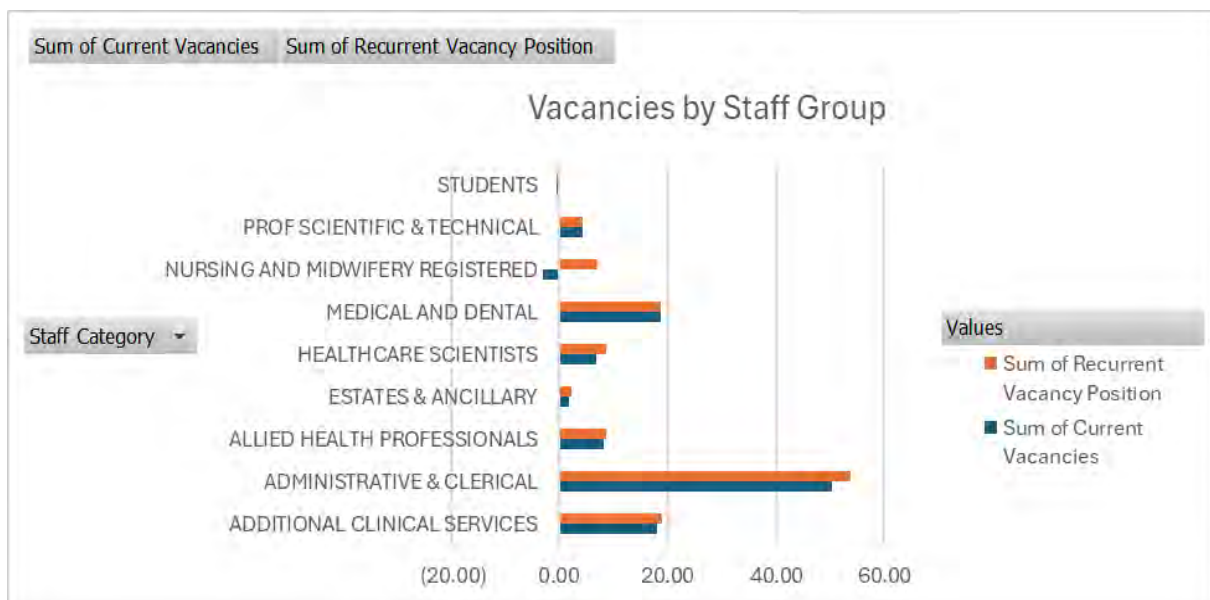
The largest number of vacancies are seen within VCS: 59 WTE. Medical Physics have 12 WTE vacancies, radiotherapy has 5 WTE vacancies, and 5 WTE AHP vacancies are on hold in the Radiotherapy Satellite Unit. 3 WTE band 5 vacancies are being held to accommodate over establishment in nursing. HSS have 6 WTE vacancies in Medical Physics Health Scientists (3 WTE starting in July) and RPS have 6 WTE vacancies. The vacancies reported exclude 30 WTE unfunded posts, 20 WTE of which are recurrent.

WBS currently are reporting 4 WTE vacancies. This is a net position as there are 7 WTE admin and clerical vacancies and 3 WTE additional clinical service vacancies which are being offset by over establishments in nursing (2 WTE), healthcare scientists (2 WTE) and estates staff (2 WTE) linked to business cases submitted to JCC that have not yet been approved. The vacancies reported exclude 18 WTE unfunded posts, 10 WTE of which are recurrent.

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



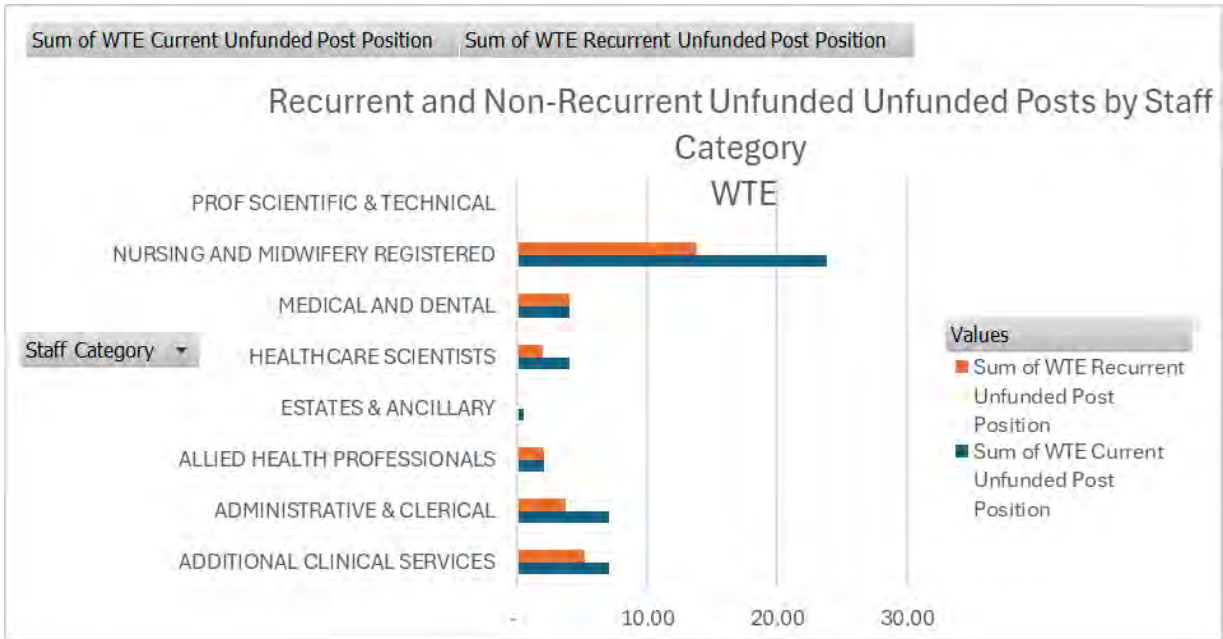
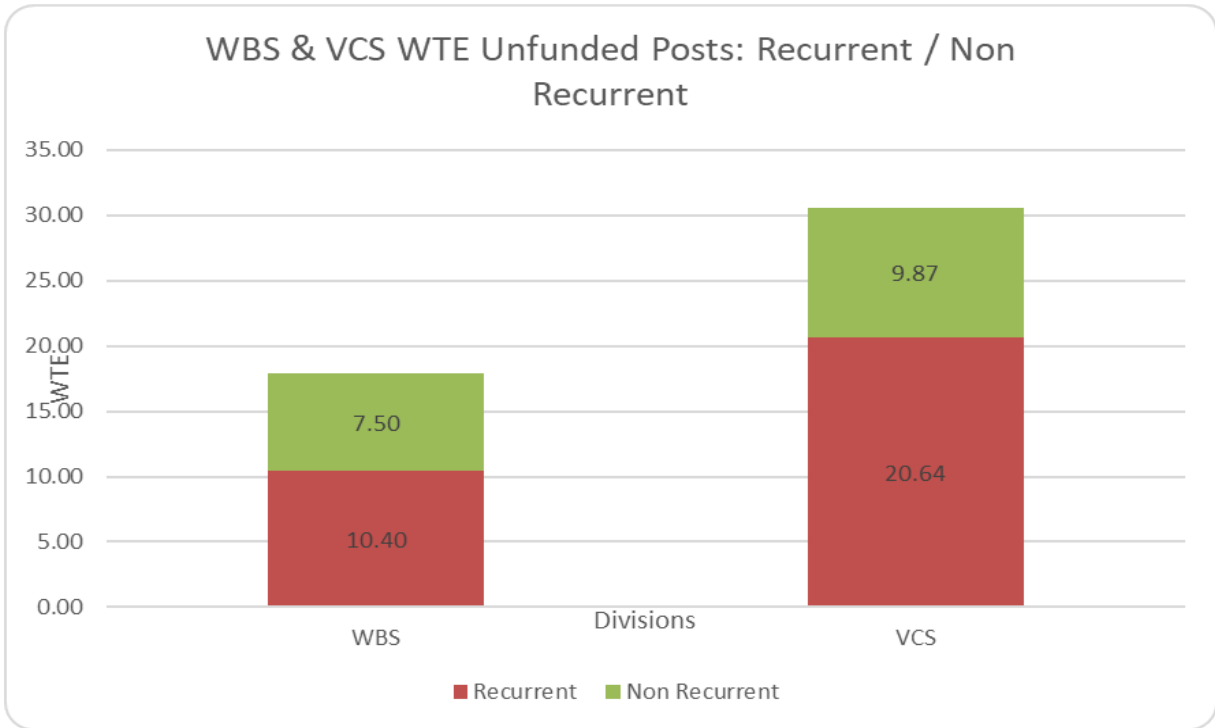
The total Trust vacancies as of May 2026 are 105 WTE (March 106 WTE): VCS (59 WTE), WBS (4 WTE), Corporate (24 WTE), R&D (14 WTE), nVCC (0 WTE) and HTW (4 WTE).

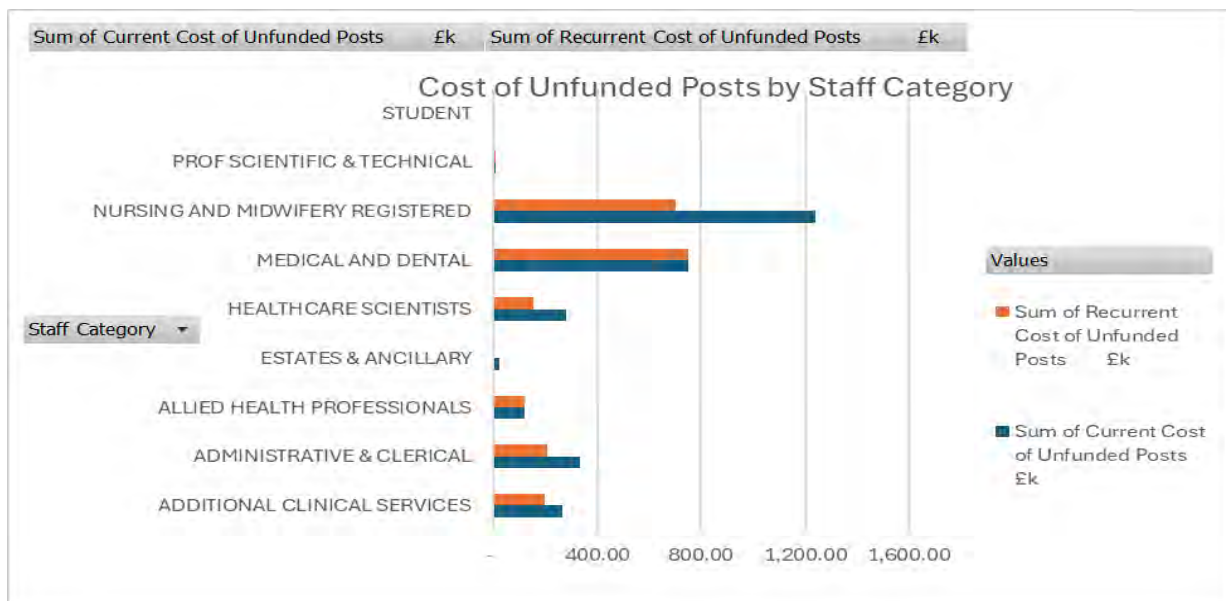


Unfunded posts are shown in more detail below for WBS and VCS. The total unfunded posts as at May 2026 is 49 WTE at a cost of £3m, with 31 WTE (£2.1m) being recurrent. For WBS the staff category with the highest number of recurrent unfunded posts is additional clinical services (5.0 WTE) and in VCS it is nursing and midwifery registered (9.5 WTE).

Staff Category	WBS					VCS				
	Vacancies	Unfunded Posts	Vacancy Position Excl Unfunded Posts	Recurrent Unfunded Posts	Vacancy Position Excl recurrent Unfunded Posts	Vacancies	Unfunded Posts	Vacancy Position Excl Unfunded Posts	Recurrent Unfunded Posts	Vacancy Position Excl recurrent Unfunded Posts
ADMINISTRATIVE & CLERICAL	7.5	3.0	10.5	-	10.5	9.3	4.1	13.4	3.7	9.7
MEDICAL AND DENTAL	1.1	-	1.1	-	1.1	10.7	4.1	14.8	4.1	10.7
NURSING AND MIDWIFERY REGISTERED	- 2.2	5.4	3.2	4.4	- 1.2	- 3.6	18.5	14.9	9.5	5.4
PROF SCIENTIFIC & TECHNICAL	-	-	-	-	-	4.5	0.1	4.6	0.1	4.5
ADDITIONAL CLINICAL SERVICES	2.8	6.0	8.8	5.0	3.8	14.3	-	14.3	-	14.3
ALLIED HEALTH PROFESSIONALS	-	-	-	-	-	9.1	2.8	11.8	2.3	9.5
HEALTHCARE SCIENTISTS	- 2.7	3.0	0.3	1.0	- 0.7	9.8	1.0	10.8	1.0	9.8
ESTATES & ANCILLARY	- 2.2	0.5	1.7	-	- 1.7	5.6	-	5.6	-	5.6
STUDENTS	-	-	-	-	-	- 0.4	-	0.4	-	0.4
PAY BUDGET ADJUSTMENTS	-	-	-	-	-	-	-	-	-	-
Total	4.4	17.9	22.3	10.4	11.9	59.5	30.5	90.0	20.6	69.3

Staff Category	Trust Total			
	WTE Current Unfunded Post Position	Current Cost of Unfunded Posts £k	WTE Recurrent Unfunded Post Position	Recurrent Cost of Unfunded Posts £k
ADMINISTRATIVE & CLERICAL	7.11	336	3.71	209
MEDICAL AND DENTAL	4.07	752	4.07	752
NURSING AND MIDWIFERY REGISTERED	23.85	1,241	13.85	705
PROF SCIENTIFIC & TECHNICAL	0.10	8	0.10	8
ADDITIONAL CLINICAL SERVICES	7.02	266	5.20	198
ALLIED HEALTH PROFESSIONALS	2.11	123	2.11	123
HEALTHCARE SCIENTISTS	4.00	282	2.00	153
ESTATES & ANCILLARY	0.50	22	-	0
STUDENT	-	0	-	0
TOTAL	48.76	3,029	31.04	2,146

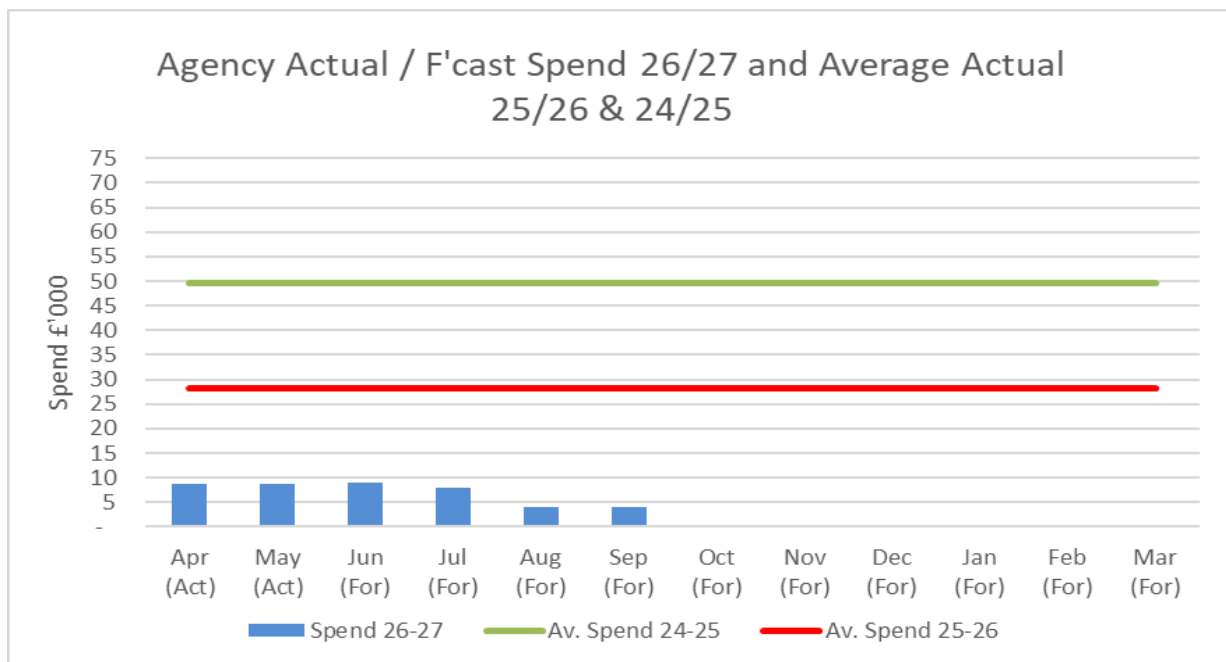




The spend on agency staff for May 2026 was **£0.009m** (April £0.009m) with a yearend forecast currently of **£0.042m** (£0.337m 2025/26).

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

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

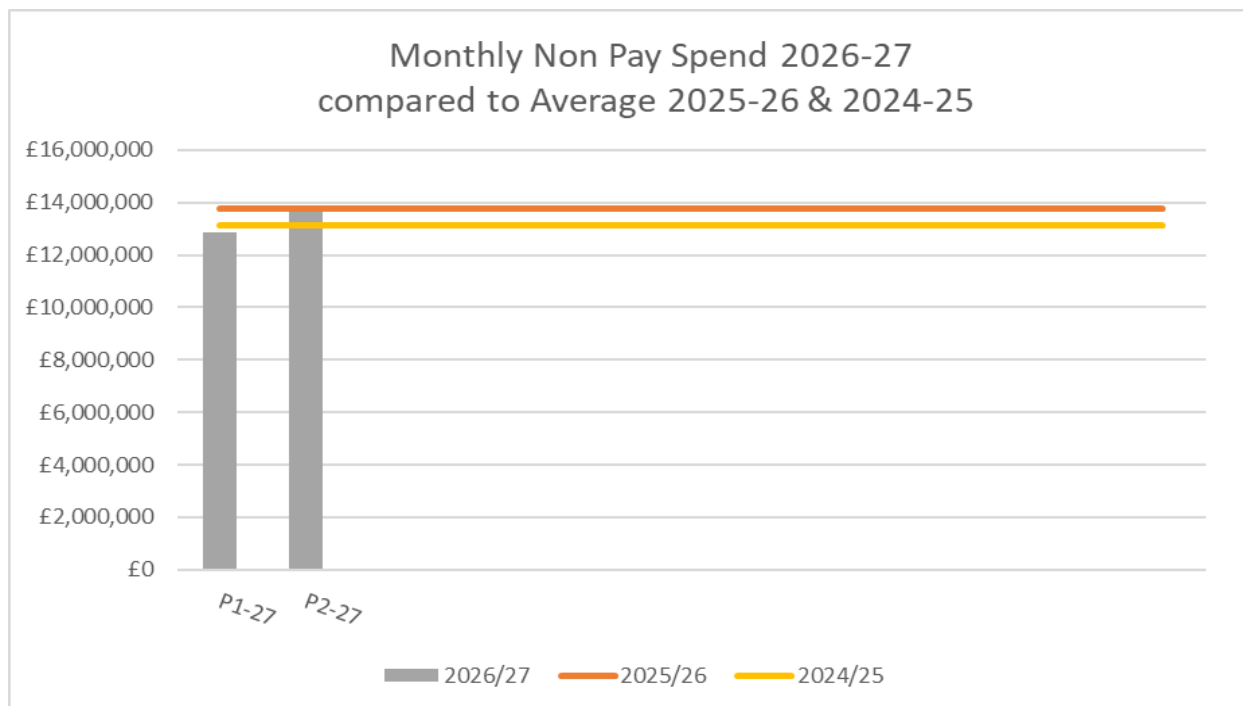


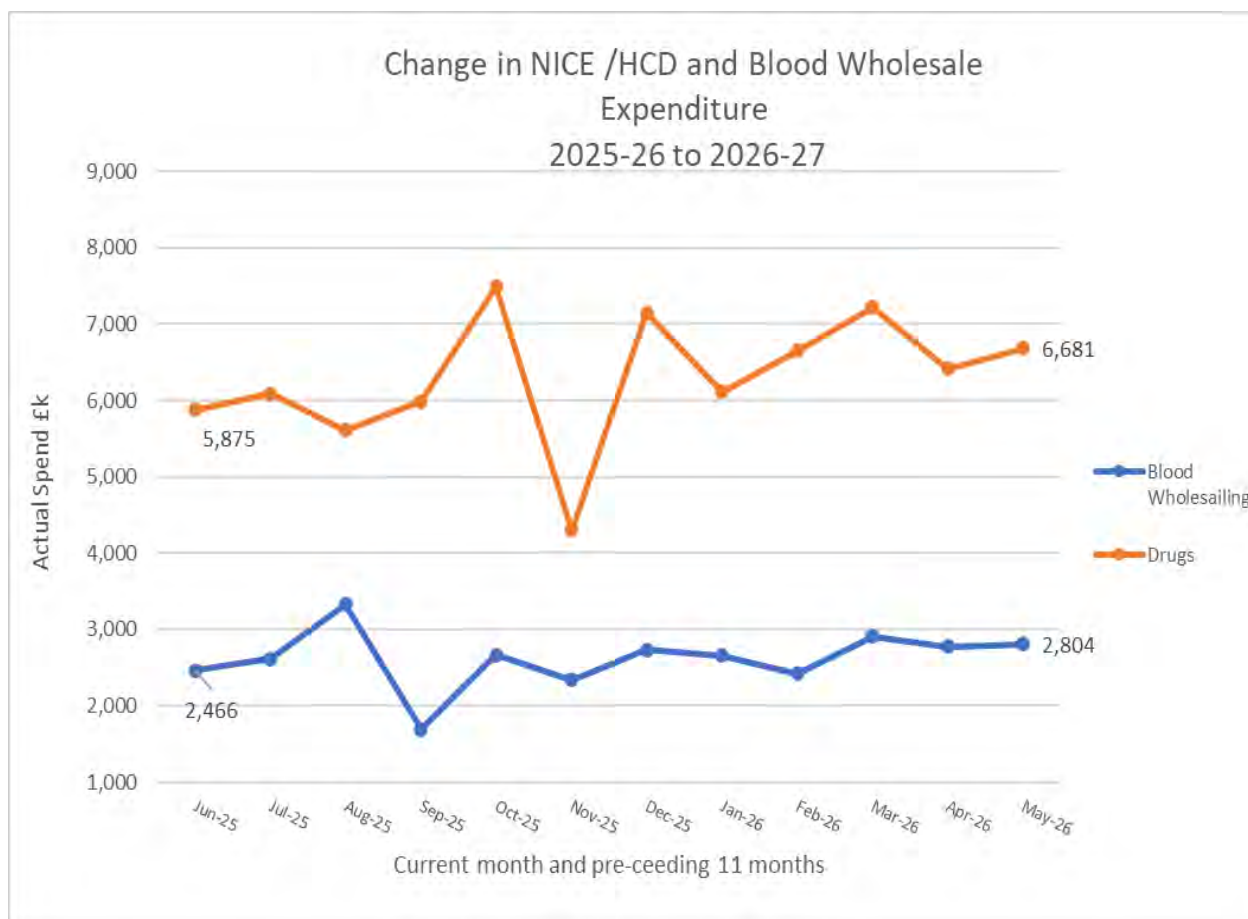
4.3 Non Pay

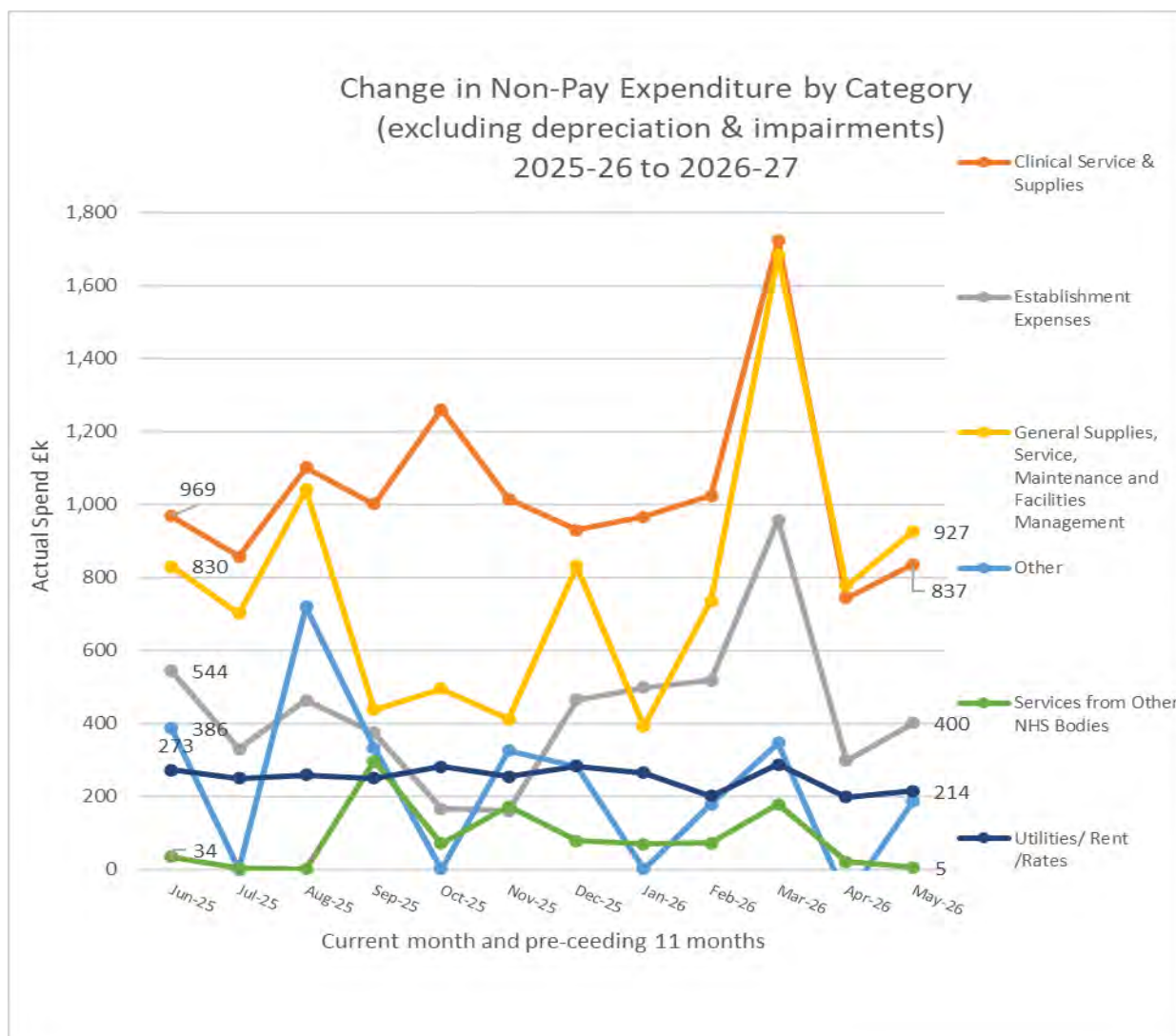
Non-Pay average spend for 2025/26 was £13.741m per month which was a £0.603m increase from the previous financial year. The largest movement was in relation to NICE and HC drugs that saw an increase in average monthly spend of £0.620m, and which were offset by income recharges to Health Boards. Non-cash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

The non-pay average monthly spend for 2026-27 currently stands at £13.328m. NICE and HCD drugs have increased since April by £0.269m and blood wholesale costs have increased by £0.032m, which again will be offset by an income increase for recharges to Health Boards. 'Other' charges have increased by £0.265m but May's spend is still lower than the average 2025-26 spend.

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





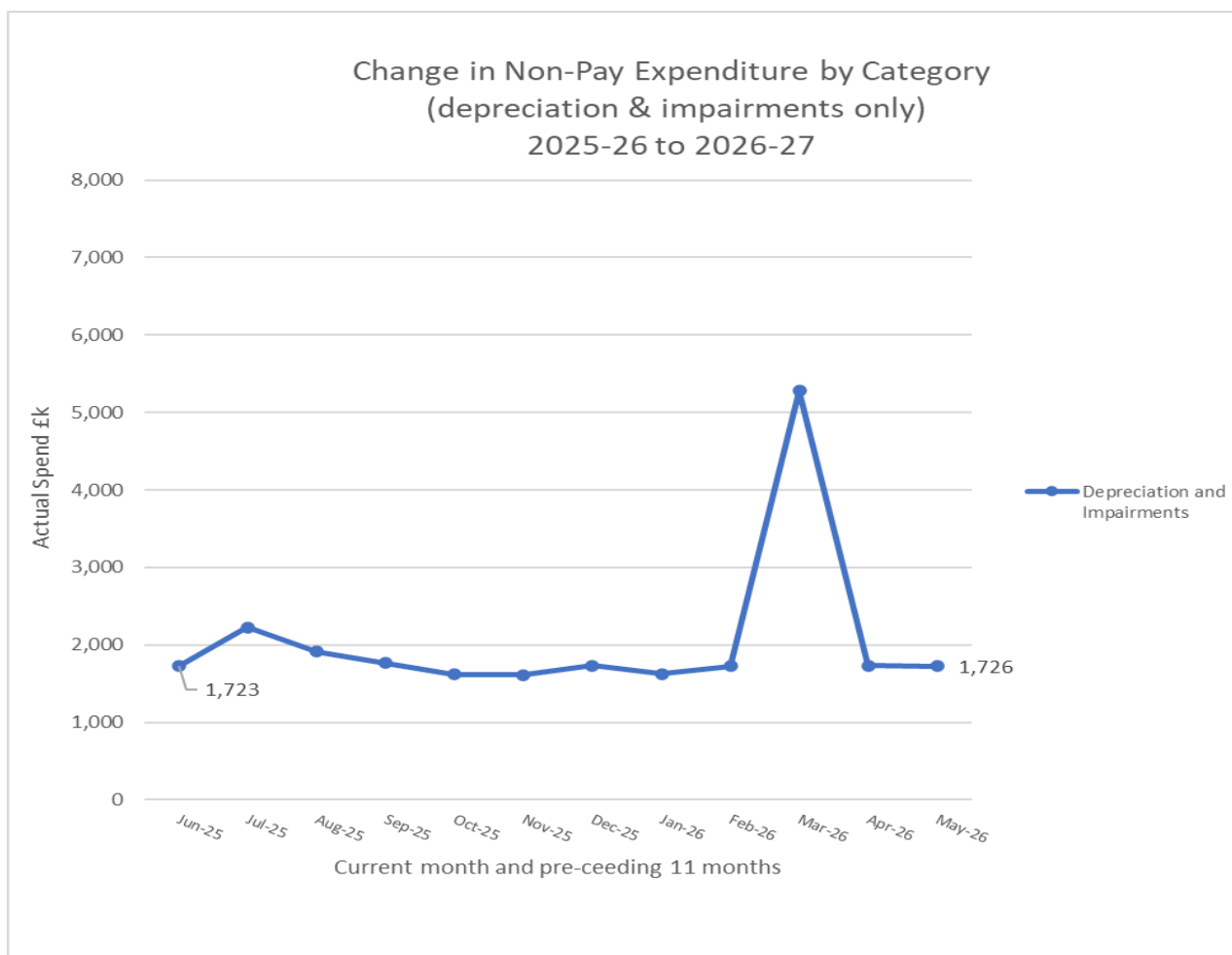


Clinical Services & Supplies saw a sharp decrease in spend from March 2026 to April 2026. Spend was significantly higher in the following divisions & areas in March: Excess Treatment Costs in RD&I of £192k (full 2025-26 year spend reported in one month that will be phased in future); HPC collection costs in WBS of £166k, Blood bags, harnesses & labels in WBS of £156k, laboratory reagents in WBS of £100k, and M&SE maintenance contracts in VCS of £262k.

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

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

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



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

4. Savings

The Trust established as part of the IMTP Financial Plan a savings target requirement of £2.647m for 2026-27 which equates to 2.5% of the Trust's core LTA income and is required to support the level of investment plans and cost pressures within the system.

Of the revised £2.647m total savings target £1.262m is recurrent and £1.385m is non-recurrent, with £1.405m being categorised as actual saving schemes and the balance of £1.242m being via income generation.

The Divisional share of the revised overall Trust savings target has been allocated to VCS £1.303m (49%), WBS £0.879m (33%) RD&I £0.287m (11%) and Corporate £0.178m (7%).

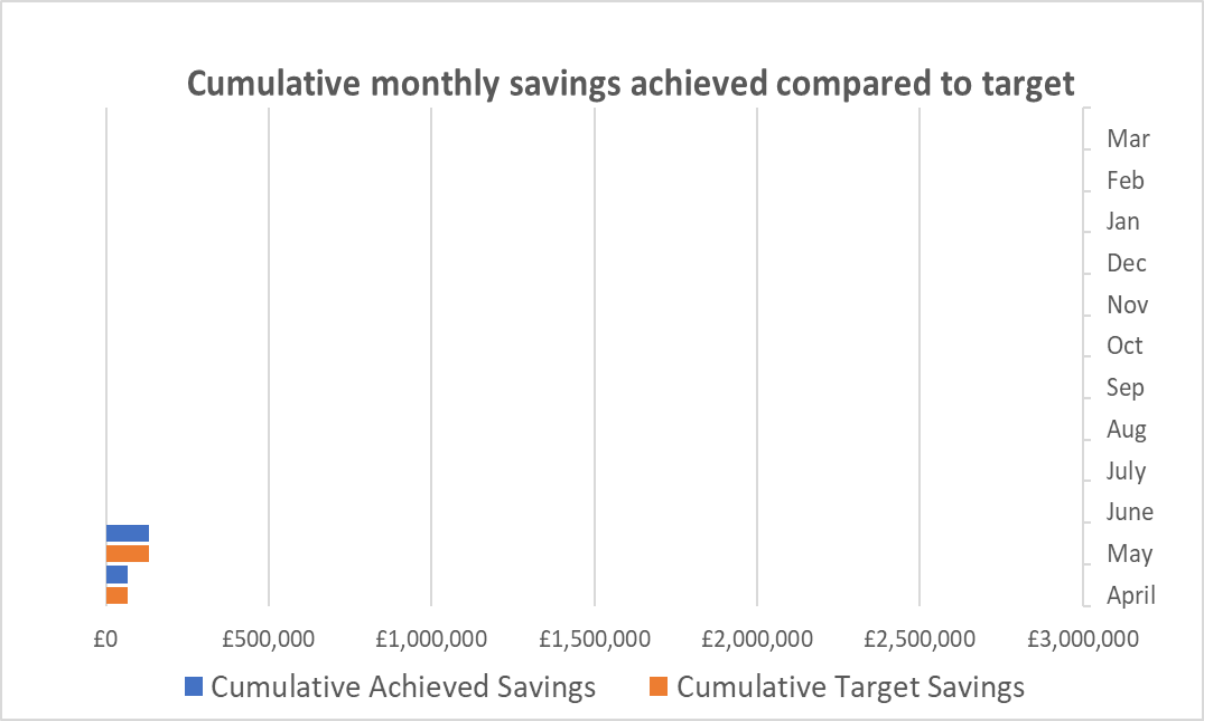
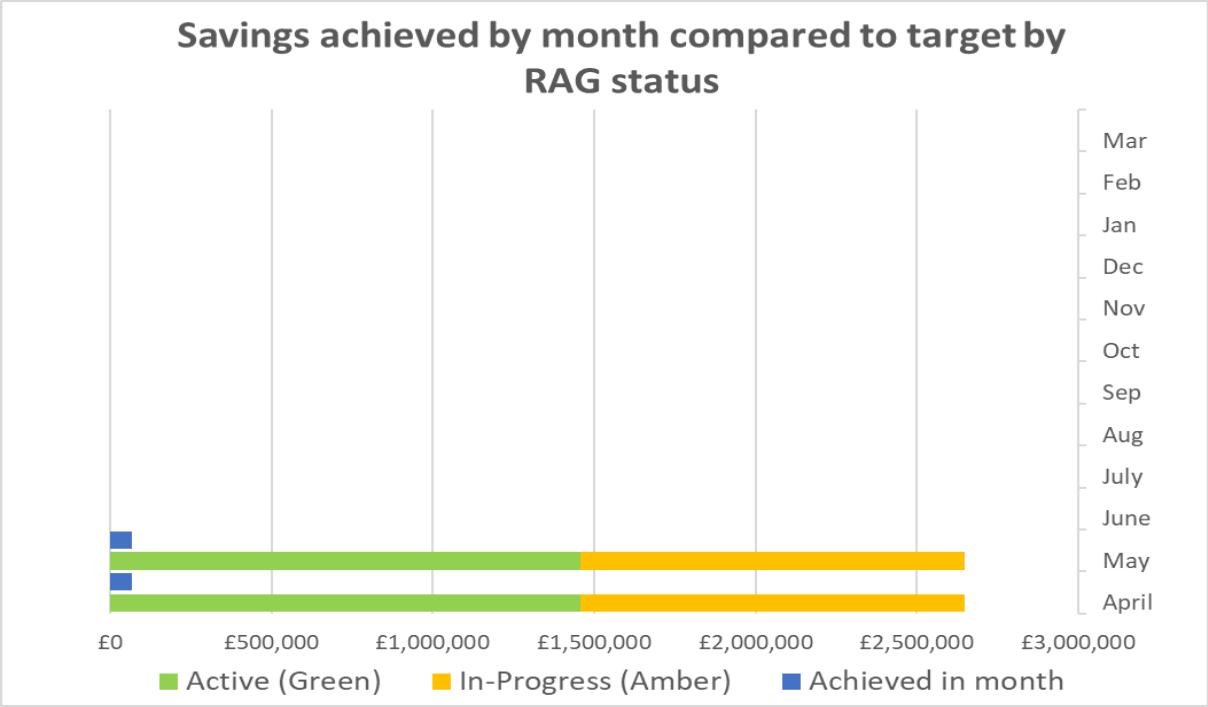
Currently several savings schemes are still RAG rated amber and pose a significant risk of £1.190m to the delivery of the overall savings target, whilst current expectation is that these schemes will turn green by the end of quarter one, however there are challenges in achieving this.

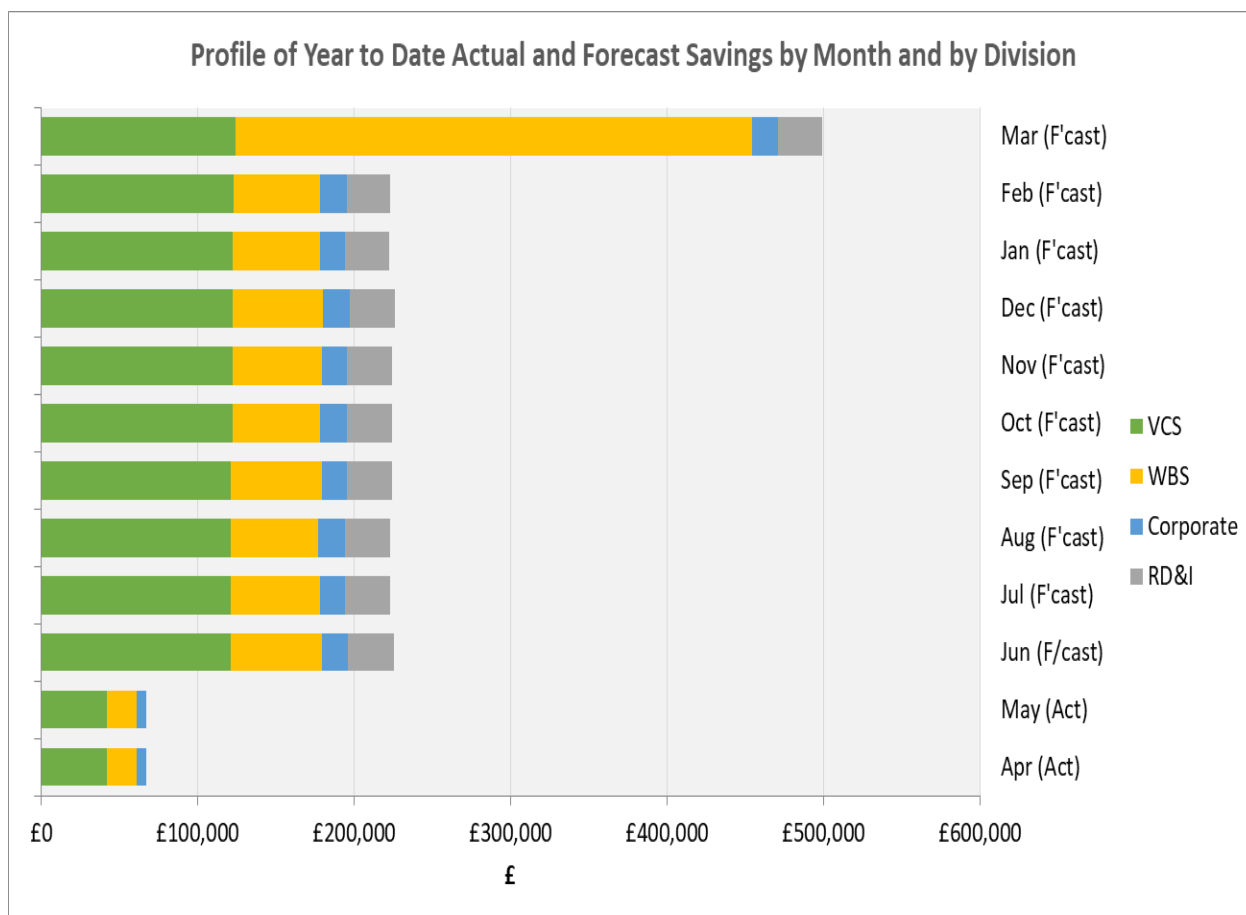
Performance

The Trust savings performance as of 31st May 2026 is an achievement of £0.134m against a plan of £0.134m. Current expectation is that the annual savings target will be achieved albeit with some risk due to several schemes currently still RAG rated amber.

It is extremely important that divisions continually review their current savings schemes, and where delivery may not be achieved, alternative schemes are implemented to ensure that the savings target for 2026-27 is met.

Scheme Type	Division	Recurrent / Non-Recurrent	RAG Rating	TOTAL £000	YTD Planned £000	YTD Actual £000	Variance £000	F'cast Full Year £000	F'cast Variance Full Year £000
Savings Schemes									
Capacity management - improve efficiency prior to recruitment	VCS	R	Amber	56	0	0	0	56	0
Capacity management - improve efficiency prior to recruitment	VCS	NR	Amber	516	0	0	0	516	0
Reduce spend on postage	VCS	R	Amber	10	0	0	0	10	0
Procurement supply chain	VCS	R	Amber	50	0	0	0	50	0
WBS Establishment Control	WBS	R	Green	40	6	6	0	40	0
Stock Control - Optimised level of stock retention	WBS	R	Green	100	0	0	0	100	0
Stock Control - Optimised level of stock retention	WBS	NR	Green	150	0	0	0	150	0
Nucleic Acid Testing new managed service contract	WBS	R	Green	127	22	22	0	127	0
Omnichannel contact centre solution	WBS	R	Green	3	0	0	0	3	0
Omnichannel contact centre solution	WBS	NR	Green	28	4	4	0	28	0
WBS Demand Planning - Processing volumes - Transfusion	WBS	R	Green	30	0	0	0	30	0
WBS Demand Planning - Processing volumes - Transfusion	WBS	NR	Green	50	0	0	0	50	0
WBS Demand Planning - Apheresis - Donation Services	WBS	NR	Green	40	0	0	0	40	0
Establishment vacancy control	Corporate	R	Amber	80	0	0	0	80	0
Establishment vacancy control	Corporate	NR	Amber	20	0	0	0	20	0
Corporate HQ savings	Corporate	R	Green	5	0	0	0	5	0
Capacity management - improve efficiency prior to recruitment	RD&I	R	Amber	50	0	0	0	50	0
Capacity management - improve efficiency prior to recruitment	RD&I	NR	Amber	50	0	0	0	50	0
Total Saving Schemes				1,405	32	32	0	1,405	0
Income Generation									
Maximise profit share	VCS	R	Green	100	16	16	0	100	0
Maximise profit share	VCS	NR	Green	50	8	8	0	50	0
Private patient income optimisation	VCS	R	Green	200	34	34	0	200	0
Private patient income optimisation	VCS	NR	Green	150	26	26	0	150	0
Contract Income Overperformance	VCS	R	Amber	171	0	0	0	171	0
Sales of Plasma	WBS	NR	Green	171	0	0	0	171	0
Ethylenediaminetetraacetic acid (EDTA) Testing Income	WBS	R	Green	40	6	6	0	40	0
Plasma For Medicines (Recovered Plasma)	WBS	R	Green	100	0	0	0	100	0
Bank Interest	Corporate	NR	Green	73	12	12	0	73	0
Commercial Income Generation	RD&I	R	Amber	100	0	0	0	100	0
Commercial Income Generation	RD&I	NR	Amber	87	0	0	0	87	0
Total Income Generation				1,242	102	102	0	1,242	0
TRUST TOTAL SAVINGS					134	134	0	2,647	0
					100%			100%	





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

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

It is vital that these schemes are monitored to ensure that if there is a risk to delivery, they are replaced with alternative schemes well in advance of March 2027.

5. Reserves

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

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

6. Cost Pressures / Investment Decisions

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

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

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

The £707k for unfunded posts support is also being held with a review of the position currently under way.

This table will be included in future reports with relevant commentary from month 3 onwards to enable the impacts to be tracked, and any additional cost pressures to be explicitly discussed in this section of the report.

7. End of Year Forecast / Risk & Opportunity Assessment

Whilst the Trust submitted a three year balanced financial plan, there are significant financial risks and challenges to deliver this plan, particularly during 2026-27 due to the uncertainties around the income it will receive to cover the committed capacity investment in Velindre Cancer Services.

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

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

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

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

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

A risk emerged, and crystallised in part in 2025-26, whereby the forecast activity income in Radiotherapy (in respect of the planned Business Case income for Radiotherapy @ Neville Hall) did not match the level of investment in the Workforce. The impact for the full year was £1.000m after mitigations were put in place, such as vacancies, non-recurrent funding support, contract performance income for wider services, and non-pay reductions. £0.500m was allocated by holding marginal income growth recurrently, which impacts on the Trust's ability to invest further in cancer services during 2026-27. It is currently anticipated that any shortfall in 2026-27 will be managed via overachievement of wider activity which will be subject to close monitoring.

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

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

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

The Trust has identified £2.247m of Savings and Income Generation to be achieved during 2026-27 as part of the IMTP. This savings target has been set to ensure that the Trust has the ability to mitigate against the significant cost pressures with the service.

Currently several savings schemes are still RAG rated amber and pose a significant risk of £1.190m to the delivery of the overall savings target. Whilst current expectation is that these schemes will turn green by the end of quarter one, there remain challenges in achieving this.

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

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

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

The recurrent SDEC funding was clearly identified in the Allocation Letter issued by WG on 19th December 2026, which the Trust assumed was as a result of its representations to WG colleagues in the aforementioned meeting on 28th November 2026.

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

Via a Health Board on 22nd May 2026, the Trust has received a message suggesting that the funding allocated to the Trust was a mistake. If this is the case it will have implications for the Trust financial plan for this financial year and recurrently.

The Trust has raised this risk directly with WG to understand whether the funding will continue on a recurrent basis as expected.

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

Opportunities

Vacancy Turnover - likelihood: low, value £0.200m

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

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

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

8. CAPITAL EXPENDITURE

Administrative Target

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

	Approved CEL 2026/27 £m	YTD Spend £m	Budget Remaining @ M2 £000s	Forecast Spend 2025/26 £m	Forecast Year End Variance 2026/27 £m
All Wales Capital Programme					
Integrated Radiotherapy Solution	17.115	0.004	17.111	17.115	0.000
WBS HQ Continuity Business Case OBC/FBC Fees	1.142	0.010	1.132	1.142	0.000
nVCC - Project*	37.825	1.837	35.988	38.075	(0.250)
nVCC – Project - Quantified Risk - Public Sector - Drawn down	0.059	0.000	0.059	0.059	0.000
nVCC - Enabling Works	0.393	0.000	0.393	0.393	0.000
Welsh Blood Service Fleet Replacement Programme 2026-27	0.882	0.000	0.882	0.882	0.000
Fees to develop the OBC/FBC for the PET at nVCC	0.256	0.027	0.229	0.256	0.000
Digital Resource for the nVCC Project	0.550	0.000	0.550	0.550	0.000
IRS – Next Generation Delivery System (NGDS)	7.000	0.000	7.000	7.000	0.000
DPIF - ePMA	0.025	0.000	0.025	0.025	0.000
Total All Wales Capital Programme	65.247	1.878	63.369	65.497	(0.250)
Discretionary Capital	2.246	0.060	2.186	2.246	0.000
Total	67.493	1.938	65.555	67.743	(0.250)

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

The approved 2026-27 Capital Expenditure Limit (CEL) for the year ended 31st March 2027 is currently £67.493m (2025-26 £20.603m). This includes All Wales Capital funding of £65.247m, and discretionary funding of £2.246m.

A further £8.688m has been allocated to the unapproved element of the CEL for drawdown from Welsh Government as and when it becomes required by the Trust in relation to nVCC and the sale of the Whitchurch Hospital site. The nVCC project team are in the process of requesting a drawdown of £0.250m against this contingency fund. Whilst approval is awaited, the forecast variance at the end of the financial year is reporting an overspend as shown in the table above.

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

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

The Trust is currently still in conversation with WG colleagues around securing funding from All Wales capital to support the WBS Talbot Green Infrastructure (TGI) OBC Developments. The Trust incurred expenditure of £0.363m from its discretionary funding during 2024-25 which was required to complete the OBC stage of the WBS TGI scheme. WG colleagues have been made aware that to produce a completed OBC/ FBC stage there is a total funding requirement of £2.142m: £1.000m of which was awarded and spent in 2025-26, with a further allocation on the 2026-27 CEL. It is currently anticipated that the OBC/FBC will be submitted to WG in May 2027.

A request for c. £1.000m is to be sent to Welsh Government in the form of an SBAR to request funding for the development of an OBC/FBC for the decommissioning of the existing Velindre Cancer Centre site.

In relation to the Blood Establishment Computer System (BECS), a separate case has been provided to Welsh Government for the Implementation and Delivery Capital requirements for 2026/27 & 2027/28. There is a potential further requirement for additional functionality and upgrades, but this will likely form a request into DPIF (c. £2.215m revenue 2028-2033). The costs for BECS are currently being absorbed within the discretionary capital allocation until such a time that funding is confirmed (YTD c. £0.092m).

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

Performance to date

The actual expenditure to 31st May 2026 on the All-Wales Capital Programme schemes was £0.346m, this is broken down between spend on the nVCC schemes of £1.864m, the IRS £0.004m, WBS HQ business case fees £0.010m.

The spend on the Discretionary Capital programme was £0.060m which is not unusual during the early part of the financial year when plans are being finalised. However, as schemes have now been approved it is important that they are progressed as soon as possible in the financial year to prevent pressures later in the year.

Major Schemes in Development

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

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

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

The schemes that were included in the IMTP for 2026-27 and beyond is provided in the table below:

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

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

9. BALANCE SHEET (Including Hosted Organisations)

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

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

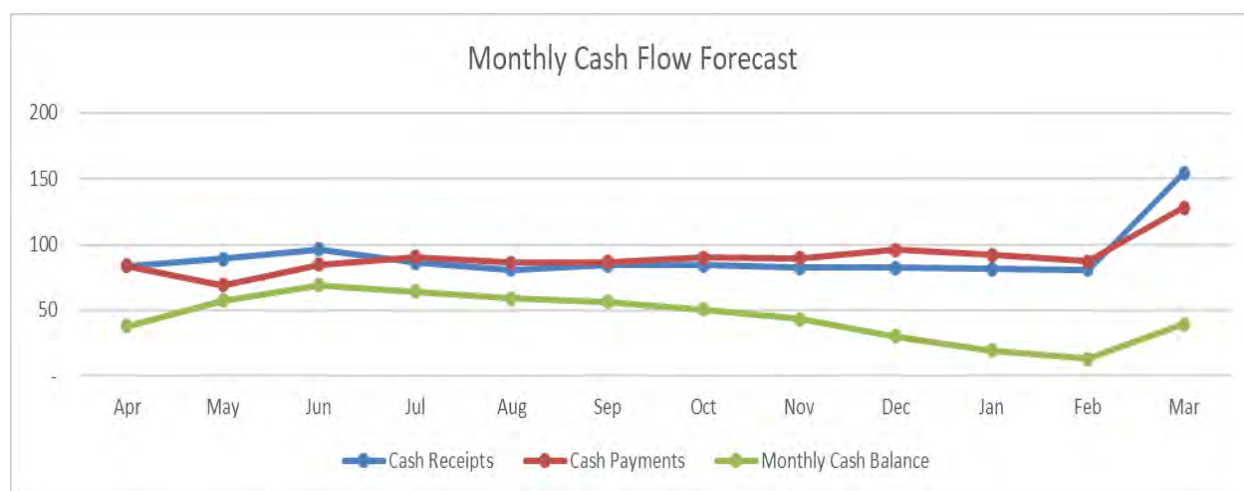
The Statement of Financial Position will be included in this document from reporting period 3 onwards.

10. CASH FLOW (Includes Hosted Organisations)

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

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

		Apr £'m	May £'m	Jun £'m	Jul £'m	Aug £'m	Sep £'m	Oct £'m	Nov £'m	Dec £'m	Jan £'m	Feb £'m	Mar £'m	Totals £'m
RECEIPTS														
1	Income from other Welsh NHS Organisations	71.087	55.921	58.547	57.042	55.542	56.542	56.542	56.042	56.042	55.542	55.542	55.542	689.935
2	WG Revenue Funding	3.983	26.209	30.750	19.550	17.000	18.700	18.700	17.850	17.850	17.000	17.000	17.000	221.592
3	Short Term Loans													0.000
4	PDC												73.669	73.669
5	Interest Receivable	0.186	0.182	0.140	0.140	0.140	0.140	0.140	0.140	0.140	0.140	0.140	0.140	1.767
6	Sale of Assets													0.000
7	Other	8.246	6.592	6.756	9.200	8.000	8.800	8.800	8.400	8.400	8.400	8.000	8.000	97.594
8	TOTAL RECEIPTS	83.502	88.903	96.193	85.932	80.682	84.182	84.182	82.432	82.432	81.082	80.682	154.351	1,084.558
PAYMENTS														
9	Salaries and Wages	31.491	45.082	44.920	44.893	44.893	44.892	44.892	44.892	44.892	44.892	44.892	44.892	525.521
10	Non pay items	49.829	22.744	37.963	44.140	39.200	39.360	44.060	43.980	39.280	39.200	39.200	42.150	481.106
11	Short Term Loan Repayment													0.000
12	PDC Repayment	0.214											0.000	0.214
14	Capital Payment	2.208	1.214	1.948	1.401	2.264	2.224	1.003	0.812	11.598	7.945	2.916	40.904	76.437
15	Other items													0.000
16	TOTAL PAYMENTS	83.743	69.039	84.831	90.434	86.357	86.476	89.955	89.684	95.770	92.037	87.008	127.946	1,083.279
17	Net cash inflow/outflow	(0.241)	19.863	11.362	(4.502)	(5.675)	(2.293)	(5.772)	(7.251)	(13.337)	(10.954)	(6.325)	26.406	
18	Balance b/f	37.929	37.689	57.552	68.914	64.412	58.737	56.444	50.672	43.420	30.083	19.128	12.803	
19	Balance c/f	37.689	57.552	68.914	64.412	58.737	56.444	50.672	43.420	30.083	19.128	12.803	39.209	



DIVISIONAL ANALYSIS

(Figures in parenthesis signify an adverse variance against plan)

Core Trust

	YTD Budget	YTD Actual	YTD Variance	Full Year Budget	Full Year Forecast	Year End Projected Variance
	£m	£m	£m	£m	£m	£m
VCC	(8.976)	(8.976)	0.000	(52.548)	(52.548)	0.000
RD&I	0.054	0.054	(0.000)	0.350	0.350	0.000
WBS	(4.030)	(4.030)	0.000	(24.497)	(24.497)	0.000
Sub-Total Divisions	(12.952)	(12.952)	0.000	(76.695)	(76.695)	0.000
Corporate Services Directorates	(3.024)	(3.017)	0.006	(18.244)	(18.244)	0.000
Delegated Budget Position	(15.976)	(15.969)	0.007	(94.938)	(94.939)	0.000
nVCC	(0.029)	(0.032)	(0.003)	(0.173)	(0.173)	0.000
Health Technology Wales	(0.045)	(0.045)	0.000	(0.272)	(0.272)	0.000
Trust Income / Reserves	16.050	16.050	0.000	95.384	95.384	0.000
Trust Position	0.000	0.003	0.003	0.000	0.000	0.000

The position at close of month 2 is an **underspend of £0.003m**.

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

VCS

	YTD Budget	YTD Actual	YTD Variance	Full Year Budget	Full Year Forecast	Year End Projected Variance
	£m	£m	£m	£m	£m	£m
Income	18.509	17.512	(0.997)	111.827	110.831	(0.997)
Expenditure						
Staff	11.362	11.126	0.236	67.706	67.470	0.236
Non Staff	16.122	15.362	0.760	96.669	95.909	0.760
Sub Total	27.485	26.488	0.997	164.375	163.379	0.997
Total	(8.976)	(8.976)	0.000	(52.548)	(52.548)	0.000

VCS Key Highlights/ Issues:

The reported financial position for Velindre Cancer Services as at the end of May 2026 was **breakeven** with an expected outturn position at this stage of **breakeven** albeit with some associated risk.

Income at month 2 represents a deficit of **£0.997m** which is largely due to underachievement on homecare drugs income (£0.467m) and RSU income (£0.113m) which will be reprofiled and recovered from Health Boards. An adjustment in respect of recovery of income for legal costs which is currently being reported via non pay will be actioned in month 3 at c£0.300m.

VCS report a small year to date underspend of **£0.236m** against staff caused by temporary vacancies across the division, many of which are in the process of being filled.

Non-Staff Expenditure at month 2 was **£0.760m** underspent which is largely due to an underspend on NICE/HCD drugs expenditure of £0.564m and an error in posting recovery of legal costs of c£0.300m to non pay rather than income. This is then offset by other smaller overspends across the service.

WBS

	YTD Budget	YTD Actual	YTD Variance	Full Year Budget	Full Year Forecast	Year End Projected Variance
	£m	£m	£m	£m	£m	£m
Income	6.313	6.387	0.074	38.117	38.191	0.074
Expenditure						
Staff	3.399	3.600	(0.201)	20.744	20.945	(0.201)
Non Staff	6.944	6.817	0.127	41.869	41.742	0.127
Sub Total	10.343	10.417	(0.074)	62.613	62.687	(0.074)
Total	(4.030)	(4.030)	0.000	(24.497)	(24.497)	0.000

Key Highlights/ Issues:

The reported financial position for the Welsh Blood Service at the end of May 2026 was **breakeven** with an expected outturn position at this stage of **breakeven**.

WBS report a small **£0.074m underachievement** of income to date. Overachievement of income for plasma has been offset by underachievement on WBMDR. A cost model is under review to determine a new baseline target.

Staff overspend of **£0.201m** is due to an increased CIP (savings target), largely offset by pay vacancies across the service.

The WBS non-staff position was **underspent by £0.127m** in month 2. Non-recurring activity / volume related benefits from performance below demand planning targets are continuing to offset some of the cost pressures within the supply chain.

Corporate

	YTD Budget	YTD Actual	YTD Variance	Full Year Budget	Full Year Forecast	Year End Projected Variance
	£m	£m	£m	£m	£m	£m
Income	0.702	0.722	0.020	3.855	3.875	0.020
Expenditure						
Staff	3.033	2.869	0.164	17.913	17.749	0.164
Non Staff	0.693	0.870	(0.178)	4.186	4.350	(0.178)
Sub Total	3.726	3.740	(0.014)	22.099	22.119	(0.020)
Total	(3.024)	(3.018)	0.006	(18.244)	(18.244)	0.000

Corporate Key Highlights / Issues:

The reported financial position for the Corporate Services division at the end of May 2026 was an **underspend of £0.006m** with an expected outturn position at this stage of **breakeven**.

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

Several vacancies within the division resulted in the in month underspend, partially within the BI and Quality & Safety teams. These underspends offset the use of agency staff and the divisional savings target. Agency costs are not expected to continue post September 2026 and have been reported as such in the relevant table in the monthly report to WG.

Non-pay overspend largely relates to divisional CIP target, the increased running costs associated with the hospital estate and corporate management costs.

RD&I

	YTD Budget	YTD Actual	YTD Variance	Full Year Budget	Full Year Forecast	Year End Projected Variance
	£m	£m	£m	£m	£m	£m
Income	0.958	0.960	0.002	6.192	6.194	0.002
Expenditure						
Staff	0.799	0.785	0.014	5.173	5.160	0.014
Non Staff	0.105	0.120	(0.015)	0.669	0.684	(0.015)
Sub Total	0.904	0.906	(0.002)	5.842	5.844	(0.002)
Total	0.054	0.054	0.000	0.350	0.350	0.000

RD&I Key Highlights / Issues

The reported financial position for the RD&I Division at the end of May 2026 was **breakeven** with an expected outturn position at this stage of **breakeven**.

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

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

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

nVCC – (Revenue)

	YTD Budget	YTD Actual	YTD Variance	Full Year Budget	Full Year Forecast	Year End Projected Variance
	£m	£m	£m	£m	£m	£m
Income	0.008	0.021	0.013	0.048	0.048	0.000
Expenditure						
Staff	0.037	0.050	(0.013)	0.221	0.221	0.000
Non Staff	0.000	0.003	(0.003)	0.000	0.000	0.000
Sub Total	0.037	0.054	(0.017)	0.221	0.221	0.000
Total	(0.029)	(0.032)	(0.003)	(0.173)	(0.173)	0.000

nVCC Key Highlights / Issues

The reported financial position for the nVCC Programme at the end of May 2026 is a small overspend of **£0.003m**.

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

HTW (Hosted Other)

	YTD Budget	YTD Actual	YTD Variance	Full Year Budget	Full Year Forecast	Year End Projected Variance
	£m	£m	£m	£m	£m	£m
Income	0.303	0.236	(0.067)	1.817	1.750	(0.067)
Expenditure						
Staff	0.319	0.282	0.037	1.916	1.879	0.037
Non Staff	0.029	(0.001)	0.030	0.173	0.143	0.030
Sub Total	0.348	0.281	0.067	2.089	2.022	0.067
Total	(0.045)	(0.045)	0.000	(0.272)	(0.272)	0.000

HTW Key Highlights / Issues

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

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



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

nVCC Project Finance Report For May 2026

DATE OF MEETING

TBC

PUBLIC OR PRIVATE REPORT

Public

**IF PRIVATE PLEASE INDICATE
REASON**

Not Applicable - Public Report

PREPARED BY

Kate Evans
Senior Finance Business Partner

PRESENTED BY

Mark Ash
Assistant Project Director

EXECUTIVE SPONSOR APPROVED

Matt Bunce, Executive Director of Finance

REPORT PURPOSE

FOR NOTING

ACRONYMS

1. PURPOSE

- 1.1** The purpose of this report is to provide a financial update to the new Velindre Cancer Centre (nVCC) Project Board outlining spend to date against the Welsh Government (WG) approved/indicative budget as of **May 2026**.
- 1.2** The nVCC, PET CT and Enabling Works Project financial positions are continually monitored and updated, and an update will be provided to the nVCC Project Board and Trust Board on a monthly basis.

2. PART A – ENABLING WORKS & NVCC

2.1 FINANCIAL SUMMARY FOR 2026-27

2.1.1 Key matters are outlined below:

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

New Velindre Cancer Centre Finance									
		Ymddiriedolaeth GIG Prifysgol Felindre Velindre University NHS Trust		Programme nVCC		Project Director David Powell		Report Period May-26	
	Budget	QRA	QRA Called	Approved to Spend (Budget plus QRA Called)	Spend to Date	Committed Costs	Projected	Forecast Spend to Complete	Unallocated Resources (Surplus)
Total Costs 	54.90M	12.81M	1.57M	56.46M	17.60M	17.46M	21.34M	56.40M	11.31M

- The in-year **financial position** for **May 2026** is:
 - CAPITAL** in-year spend to date of **£1.496m**, against a total budget of **c£36.575m**. The outturn is displaying an overspend position of £0.250m.

nVCC Project Capital Budget & Spend Summary 2026-27

	Year to Date			Financial Year		
	Budget	Spend	Variance	Annual	Annual	Annual
	May-26	May-26	May-26	Budget	Forecast	Variance
	£	£	£	£	£	£
EW FBC Project	0	0	0	393,000	393,000	0
nVCC Project Delivery	559,515	559,515	0	5,193,524	5,193,524	0
nVCC MIM (Construction Costs)	20,613	20,613	0	55,200	55,200	0
nVCC Equipment Procurement	916,037	916,037	0	30,933,163	31,183,113	-249,950
	1,496,164	1,496,164	0	36,574,887	36,824,837	-249,950

- REVENUE** in-year spend to date of **£0.032m**, against a total budget of **c£0.173m**. The outturn is displaying an overspend position of £0.020m.

REVENUE

	Year to Date			Financial Year		
	Budget	Spend	Variance	Annual	Annual	Annual
	May-26	May-26	May-26	Budget	Forecast	Variance
	£	£	£	£	£	£
Enabling Works						
Project Delivery Support Costs	0	0	0	0	0	0
Enabling Works Revenue Total	0	0	0	0	0	0
New Velindre Cancer Centre						
nVCC Pay	28,833	28,833	0	173,000	173,000	0
Project Delivery Support Costs	0	3,425	-3,425	0	20,000	-20,000
nVCC Revenue Total	28,833	32,258	-3,425	173,000	193,000	-20,000
REVENUE TOTAL	28,833	32,258	-3,425	173,000	193,000	-20,000

2.2 FUNDING – EW & nVCC

WG funding relates to the period 1 April 2024 to 31 March 2028 and must be claimed in full by 31 March 2028 otherwise any unclaimed part of the funding will cease to be available to you.

The funding made available in the approved FBC is **£78.662m capital** and **£2.412m revenue** for the nVCC Project.

A summary breakdown of funding is shown below:

Capital Budget: £69.719m consisting of:

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

Revenue Budget: £2.412m consisting of:

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

Enabling Works Budget: £8.943m consisting of:

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

- 2.2.1 The funding includes IRS implementation costs of £5.071m, which is not managed by the nVCC Project. In respect of the QRA, all QRA budgets are subject to drawdown according to the agreed QRA process. The QRA of c£18.695m will be held by WG until funding has been agreed.
- 2.2.2 In respect of the original FBC funding and QRA drawdown, the nVCC project will now be responsible for **c£56.215m**.

- 2.2.3 For clarity, it is the Welsh Government's expectation that this capital allocation is the final funding ask prior to the new Velindre Cancer Centre opening.
- 2.2.4 As a result of the Trust and Welsh Government reassessment of the QRA allocation, the capital funding has been **reduced to £72.779m**. It should be noted that the QRA is reviewed on a quarterly basis.
- 2.2.5 A summary breakdown of the estimated revised funding is shown below:

EW Project

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

nVCC Project

<i>Equipment</i>	£32,540,286
<i>Transactions(Resource Costs)</i>	£14,507,885
<i>MIM Construction Costs</i>	
<i>PROW Diversions</i>	
<i>Deep Clean</i>	£272,000
<i>QRA Called</i>	£650,982
	£47,971,154

£56,464,633

2.3 FINANCIAL POSITION – EW & nVCC

- 2.3.1 Overall the status of the financial position of the Project is a RAG rating of GREEN.
- 2.3.2 The Project overall has an agreed funding of c£56.464m. The projected spend is £56.401m leading to an overall underspend position of £0.063m. The spend forecast is made up of actual spend of c£17.601m, contractual commitments of c£17.460m and projected spend to completion of c£21.340m. The projected spend element of c£21.340m is primarily equipment (c£18.748m).
- 2.3.3 It should be noted that as at May 2026 the Trust has commitments of c£8.9m for major medical equipment, with £8.9m purchase orders raised in September 2025. In addition, there is Network infrastructure c£3.4m. The residual relates to committed pay costs.
- 2.3.4 The Project had reserves as per the FBC of c£18.7m and into the second year of the construction phase and to date has only called down £1.569m of the QRA, which

represents 8.39% of the agreed reserves. In addition, the Trust reviewed the QRA in September 2025 and reduced the risk exposure by c£5.8m. Therefore, the Project retains reserves of c£11.244m.

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

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

New Velindre Cancer Centre Finance									
		Ymddiriedolaeth GIG Prifysgol Felindre Velindre University NHS Trust		Programme nVCC		Project Director David Powell		Report Period May-26	
	Budget	QRA	QRA Called	Approved to Spend (Budget plus QRA Called)	Spend to Date	Committed Costs	Projected	Forecast Spend to Complete	Unallocated Resources (Surplus)
Enabling Works	7.58M	1.37M	918K	8.49M	8.07M	81K	312K	8.46M	481K
Equipment	32.54M	2.58M	250K	32.79M	1.33M	12.71M	18.75M	32.79M	2.33M
Transactions (Resource Costs)	14.51M	5.18M	0	14.51M	7.86M	4.63M	2.01M	14.51M	5.18M
MIM (Construction Costs)	0	3.53M	401K	401K	338K	35K	-4K	369K	3.16M
Deep Clean	272K	156K	0	272K	0	0	272K	272K	156K



EW Project – as of May 2026

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

	FBC Funding	Costs Incurred 2024-25	Costs Incurred 2025-26	Costs Incurred 2026-27	Commitments 2026-27	Projected Costs 2026-27
EW Project						
Pay	£153,116	£153,116	£0	£0	£0	
6MVA Supply - National Grid	£576,000	£480,000	£98,089	£0	£0	
Supply Chain Fees	£645,800	£323,268	£219,614	£0	£81,000	
Non Works Costs	£0	-£113,202	£0	£0	£0	
Asda Works	£1,776,000	£2,008,269	£0	£0	£0	
Walters Design & Build	£0	£116,260	£9,873	£0	£0	
S278 works on Longwood Drive	£3,610,628	£288,858	£3,144,580	£0	£0	
Offsite Habitat Creation (SW Corner)	£717,335	£434,292	£364,125	£0	£0	
HV Intake Room	£627,600	£161,286	£370,756	£0	£0	
Rural Path	£75,000	£0	£0	£0		£40,000
TCAR Habitat	£72,000	£0	£0	£0		£72,000
Revised Emergency Access	£240,000	£0	£0	£0		£200,000
Enabling Works FBC Reserves	£0	£9,921	£0	£0	£0	
TOTAL EW PROJECT	£8,493,479	£3,862,068	£4,207,037	£0	£81,000	£312,000
QRA funding	£1,367,400					£1,367,400
HV Intake Room Drawdown	-£160,800					-£160,800
Asda Final Account Drawdown	-£368,000					-£368,000
Sacrificial Cable	-£96,000					-£96,000
S278 Works	-£293,079					-£293,079
Addn funding						£0
	£449,521	£0	£0	£0	£0	£449,521
TOTAL nVCC EW FUNDING	£8,943,000	£3,862,068	£4,207,037	£0	£81,000	£761,521

2.3.8 The overall financial position of the EW Project is spend to date is c£8.069m, with commitments of £0.081m and projected costs of c£0.762m.

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

Financial Risks

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

nVCC Project – as of May 2026

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

	FBC Funding	Costs Incurred 2024-25	Costs Incurred 2025-26	Costs Incurred 2026-27	Commitments 2026-27	Projected Costs 2026-27
nVCC MIM Activities						
Project Management Office	£3,325,884	£1,181,156	£1,091,450	£155,225	£849,920	£48,133
Design & Construction Workstream	£2,606,271	£629,664	£881,905	£92,511	£743,497	£258,695
Equipment, Commissioning and Migration Workstream	£3,722,193	£372,839	£748,474	£121,009	£1,057,702	£1,422,169
Digital Workstream	£1,935,417	£113,756	£328,524	£65,050	£837,044	£591,043
Engagement & Communications Workstream	£380,688	£159,689	£143,399	£26,555	£154,629	£103,584
Commercial Activity Group	£2,242,432	£621,540	£717,962	£92,994	£647,171	£162,765
Strategic Reserves				£0	£219,942	£219,942
Project Delivery	£295,000	£117,988	£194,460	£6,171	£124,102	£147,721
Major Medical Equipment	£10,676,400	£0	£0	£0	£8,907,612	£1,768,788
Other Equipment	£12,385,200	£0	£167,737	£101,595		£12,115,868
Strategic Reserves(2)						£2,391,853
IM&T infrastructure	£5,609,752	£0	£247,811	£0	£3,383,903	£1,978,038
Digital	£433,415	£0	£0	£0	£419,015	£14,400
Digitisation of Health Records	£3,685,469	£0	£0	£814,442	£2,496,444	£374,583
Non Works Costs	£272,000	£0	£0	£0	£0	£272,000
MIM Construction Costs	£342,032	£130,434	£187,004	£20,613	£34,587	£30,606
PROW Diversions	£59,000			£0	£0	£27,000
TOTAL nVCC PROJECT	£47,971,153	£3,327,065	£4,708,726	£1,496,165	£19,875,569	£20,923,481
QRA funding	£11,471,000					£11,471,000
Asda Traffic Management Drawdown	£225,000					£225,000
PROW Diversions	£59,000					£59,000
PA Changes	£63,218					£63,218
Fibre Divergence	£53,814					£53,814
Network Install & Supply	£249,950					£249,950
Adjustment	£26,000					£26,000
	£10,794,018	£0	£0	£0	£0	£10,794,018
TOTAL nVCC MIM FUNDING	£58,765,171	£3,327,065	£4,708,726	£1,496,165	£19,875,569	£31,717,498

2.3.12 The overall financial position of the nVCC Project is spend to date is c£9.532m, with commitments of c£19.876m and projected costs of c£20.923m.

2.3.13 The QRA available for the nVCC Project is c£10.794m and reflects the unallocated resources for the Project. It should be noted that the QRA has recently been reviewed and adjusted to reflect the current risks within the project.

Financial Risks

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

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

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

- **CAPITAL** in-year spend to date of **£1.496m**, against a budget of **c£36.575m**.

The detailed capital financial position is set out below:

nVCC Project Budget & Spend 2026-27						
CAPITAL	Year to Date			Financial Year		
	Budget	Spend	Variance	Annual	Annual	Annual
	May-26	May-26	May-26	Budget	Forecast	Variance
	£	£	£	£	£	£
Enabling Works						
Supply Chain Fees	0	0	0	81,000	81,000	0
Rural Path	0	0	0	40,000	40,000	0
TCAR Habitat	0	0	0	72,000	72,000	0
Revised Emergency Access	0	0	0	200,000	200,000	0
Enabling Works FBC Reserves	0	0	0	0	0	0
Enabling Works Capital Total	0	0	0	393,000	393,000	0
nVCC Project Delivery						
Project Management Office	161,396	161,396	0	1,135,418	1,135,418	0
Design & Construction	92,511	92,511	0	836,008	836,008	0
Equipment, Commissioning and Migration	121,009	121,009	0	1,178,711	1,178,711	0
Digital	65,050	65,050	0	902,094	902,094	0
Engagement & Communications	26,555	26,555	0	181,184	181,184	0
Commercial Activities Group	92,994	92,994	0	740,166	740,166	0
Strategic Reserves	0	0	0	219,942	219,942	0
Project Delivery Capital Total	559,515	559,515	0	5,193,524	5,193,524	0
MIM (Construction Costs)						
MIM (Construction Costs)	20,613	20,613	0	55,200	55,200	0
MIM Reserves	0	0	0	0	0	0
MIM (Construction Costs) Total	20,613	20,613	0	55,200	55,200	0
Equipment Procurement						
Medical and Other Equipment Procurement	101,595	101,595	0	19,451,606	19,451,606	0
IM&T & Digital Procurement	814,442	814,442	0	9,089,704	9,339,654	-249,950
Strategic Reserves 2	0	0	0	2,391,853	2,391,853	0
nVCC Capital Total	916,037	916,037	0	30,933,163	31,183,113	-249,950
CAPITAL TOTAL	1,496,164	1,496,164	0	36,574,887	36,824,837	-249,950

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

Work Packages are outlined below:

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

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

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

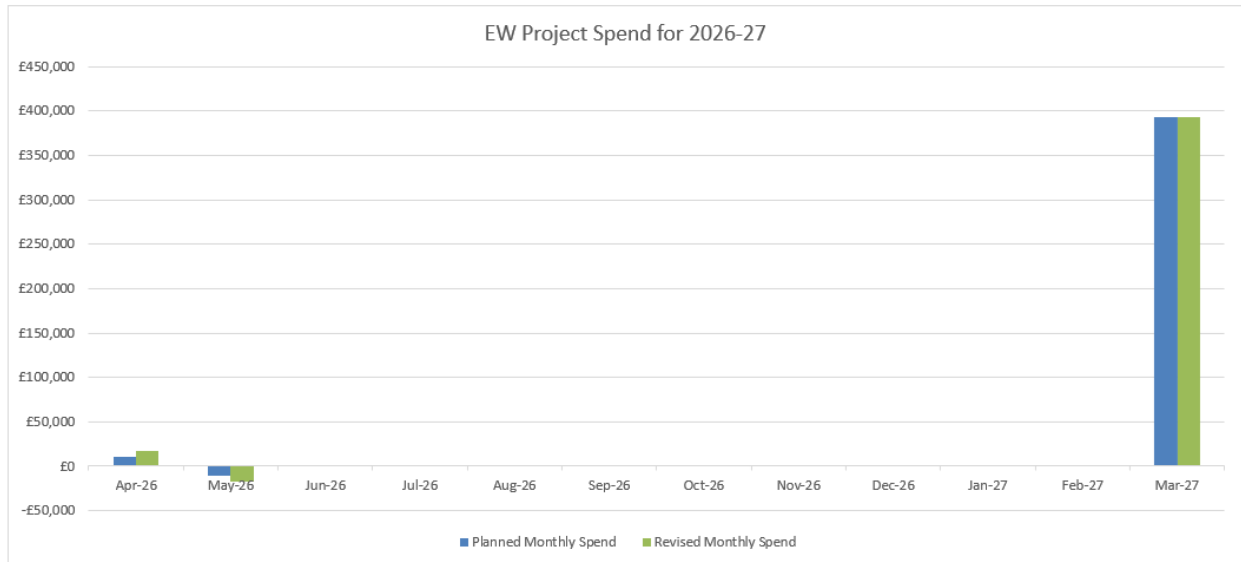
- **Staffing** - WG funded posts **spend of £0.452m**. Reflects the Project posts and a run rate of c£0.226m per month.

Work Packages are outlined below:

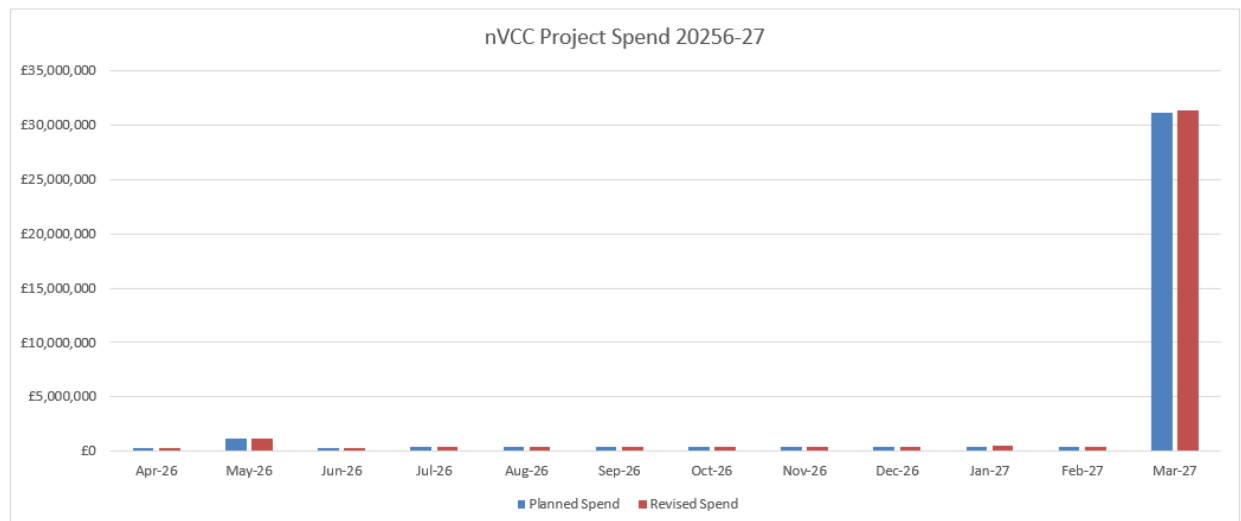
- **Project Delivery** – costs associated with the running of the Project Office and spend is **£0.006m**.
- **Capability Review – no spend.**
- **RDD Process – spend of £0.006m** for the reviewable design data process as RIBA stage design is finalized with Project Co.
- **Construction Phase – spend of £0.027m** for the services provided by the Authority Construction Surveyor.
- **Equipment Advisers & purchases – spend of c£0.005m** for Specialist Equipment advice.
- **Digital and IM&T Equipment procurement – no spend** – costs associated with Network engineers, Digitalisation of Health records programme and Hardware procurement and Patient Engagement.
- **Engagement and Communications – no spend.** Costs are for engagement events.
- **Project Management Advisors – spend of c£0.044m** for the SRO; Project Planning & Control and Technical advisory support.
- **Professional Advisors – spend of £0.019m** for legal advice on the PA and changes, and range of commercial matters; commercial support.
- **Reserves – spend of £0.000m** – no spend to date.

2.4.4 Cashflow

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



The graph below outlines the nVCC actual capital spend to **May 2026** is **£1.496m**. The actual run-rate is **in-line** with planned spend. The majority of the spend is in period 12 due to the scheduled Major Medical equipment delivery timing.



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

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

2.4.6 The CRL position is outlined below:

EW Project

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

nVCC Project

Period 2026-27	CRL awaiting approval £m	Actual & Forecast Spend £m	Variance £m
Apr-26	0.301	0.314	-0.013
May-26	1.195	1.182	0.013
Jun-26	0.348	0.346	0.002
Jul-26	0.377	0.377	-0.001
Aug-26	0.393	0.368	0.025
Sep-26	0.396	0.371	0.025
Oct-26	0.406	0.381	0.025
Nov-26	0.400	0.416	-0.016
Dec-26	0.407	0.422	-0.016
Jan-27	0.461	0.475	-0.013
Feb-27	0.413	0.426	-0.013
Mar-27	31.085	31.353	-0.267
TOTAL	36.182	36.432	-0.250

3. QUANTIFIED RISK ASSESSMENT (QRA)

3.1.1 The **Original QRA position was £18.7m** as per the FBC and approved by Welsh Government. The revised position is now **c£12.812m** following the bi-monthly review conducted with Welsh Government. This reduction of £5.8m reflects the negating of the risks to the project, particularly in the procurement of the Category 2c equipment allocation.

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

3.1.3 The remaining QRA is **c£11.244m with the profiling set out in the below:**

REVISED QRA (JUN 26)	2024-25	2025-26	2026-27	2027-28	Total
REVISED NVCC QRA - MIM (JUN 26)			£3,242,782		£3,242,782
REVISED NVCC QRA - TRUST (JUN 26)			£4,466,035	£3,085,200	£7,551,235
REVISED NVCC EW - TRUST (JUN 26)			£449,521		£449,521
TOTAL QRA	£0	£0	£8,158,338	£3,085,200	£11,243,538

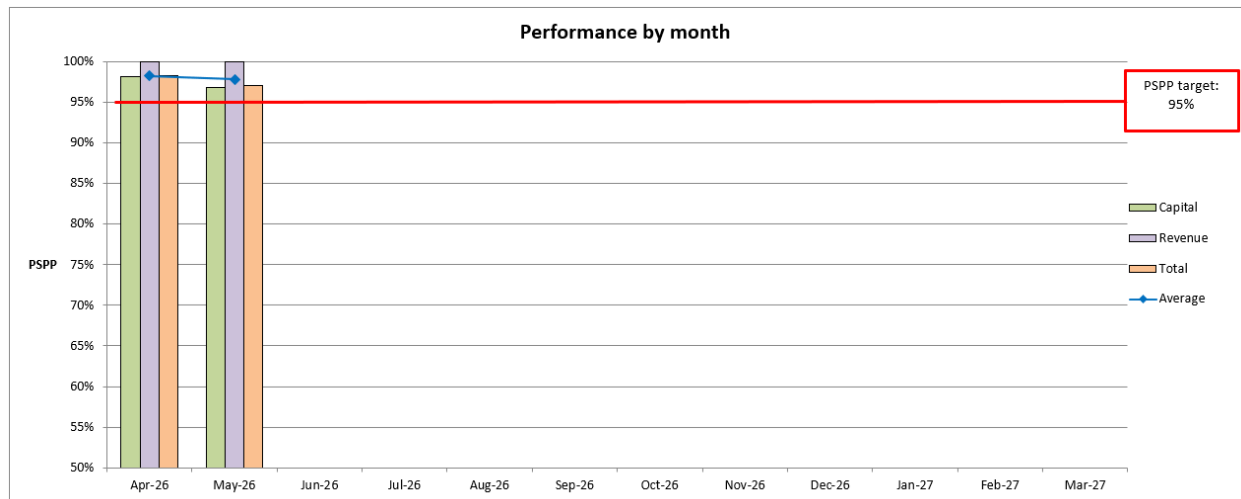
3.1.4 The Project reviews the QRA on a quarterly basis and the risks quantification re-assessed. The next review will take place in Sep 2026.

4. PUBLIC SECTOR PAYMENT POLICY

4.1.1 For **May 2026**, the PSPP performance was **97%** and the PSPP target was **achieved**. Of the 34 invoices for payment, 33 invoices were processed within the 30-day deadline.

4.1.2 The average PSPP performance to date for 2025-26 is **98%**.

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



5. PART B – PET CT

5.1 FUNDING – PET CT

WG funding relates to the period 1 April 2024 to 31 March 2028 and must be claimed in full by 31 March 2028 otherwise any unclaimed part of the funding will cease to be available to you.

The funding made available in the approved FBC is **£0.298m capital**.

A summary breakdown of funding is shown below:

Capital Budget: £0.298m consisting of:

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

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

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

- **CAPITAL** in-year spend to date of **£0.027m**, against a budget of **c£0.256m**. The outturn displays a breakeven position.

The detailed capital financial position is set out below:

nVCC Project Budget & Spend 2026-27						
CAPITAL	Year to Date			Financial Year		
	Budget	Spend	Variance	Annual	Annual	Annual
	May-26	May-26	May-26	Budget	Forecast	Variance
	£	£	£	£	£	£
PET-CT						
PET-CT Pay	0	0	0	54,277	54,277	0
Business Case	18,080	18,080	0	61,066	61,066	0
Design Development	8,980	8,980	0	72,868	72,868	0
Legal & Commercial	0	0	0	67,500	67,500	0
PET-CT Capital Total	27,060	27,060	0	255,711	255,711	0
CAPITAL TOTAL	27,060	27,060	0	255,711	255,711	0

6. Considerations for Board

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

7. IMPACT ASSESSMENT

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

6. RECOMMENDATION

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

Trust Board	
TRUST RISK REGISTER UPDATE	
DATE OF MEETING	30 July 2026
PUBLIC OR PRIVATE REPORT	PUBLIC
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	ASSURANCE
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Mel Findlay, Risk and Assurance Manager
PRESENTED BY	Non Gwilym, Interim Director of Corporate Governance
APPROVED BY	Non Gwilym, Interim Director of Corporate Governance
EXECUTIVE SUMMARY	The report provides the Trust Board with an update on the July 2026 Trust Risk Register. It: • highlights the current extract of risk registers for risks scoring 12 and above for Quality/Safety and 15 and above for all other domains, based on the July 2026 Trust Risk Register. • enables the Board to receive assurance from the Committees' scrutiny of the way in which reportable risks are being managed across the Trust. • provides the committee with a summary of activity related to the status of the risks, associated movement, new risks added to the register and risks which have reduced below threshold levels. • summarises the key themes arising from Executive Management Board and Quality,



	Safety and Performance Committee consideration of the Trust Risk Register, including the need to strengthen risk actions, update target dates, ensure current mitigation work is reflected, and maintain executive-level scrutiny of the highest risks.
RECOMMENDATION / ACTIONS	The Trust Board is asked to: • NOTE the risks in the quality and safety domain with a score of 12 and above and risks in other domains with a score of 15 and above on the Trust Risk Register. • NOTE the new risks added to the register and the risk which has reduced below Board reporting threshold since the previous reporting cycle. • NOTE the update on the Datix risk system replacement.
COMMITTEE / GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING	
COMMITTEE OR GROUP	DATE
Executive Management Board	02 July 2026
Quality, Safety and Performance Committee	16 July 2026
Welsh Blood Service Senior Leadership Team (WBS SLT)	Data Shared
Velindre Cancer Service Leadership Team	Data Shared
The paper was considered by Executive Management Board on 2 July 2026, where directors were asked to review and strengthen risk actions, target dates and mitigation updates ahead of the next committee cycle. The Quality, Safety and Performance Committee subsequently considered the paper on 16 July 2026 and noted the July 2026 Trust Risk Register position, including the three new VCS risks, the risks reduced below Board reporting threshold, and the need for continued focus on target risk dates, the quality of mitigating actions, and the inclusion of clear risk descriptions and current controls to strengthen the overall narrative.	
ASSURANCE RATING ASSESSED BY EXECUTIVE SPONSOR	Level 3 - Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes
APPENDICES	



1	Trust Risk Register

1. SITUATION

This report informs the Trust Board of the status of reportable risks in line with the Trust Board approved risk appetite levels and policy. The baseline information is drawn from Datix, with additional information provided by the Velindre Cancer Service (VCS) and the Welsh Blood Service (WBS) monthly risk analysis reports.

The reporting in Appendix 1 is based on changes to the register since the previous reporting cycle and reflects the July 2026 Trust Risk Register position.

To strengthen the narrative for Board assurance, the report now places greater emphasis on the inclusion of risk descriptions and current controls. This is intended to help members understand the underlying cause and potential impact of each reportable risk, the controls already operating to manage exposure, and the extent to which further action is required to move risks towards their target ratings.

Risks reported in this paper are:

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

1. ASSESSMENT

2.1 Trust Risk Register

The Trust Risk Register is available as Appendix 1.

There are three new risks on the Trust Risk Register. These relate to Velindre Cancer Service risks associated with escalation to senior decision makers, timely access to clinical advice through the treatment helpline, and treatment helpline capacity, demand and call handling arrangements.

Four risks have reduced below the Board reporting threshold during the reporting cycle and is included in Appendix 1, Section 2 for assurance purposes.

The Trust Risk Register was reviewed at Executive Management Board on 2 July 2026. The discussion identified a number of cross-cutting themes relevant to the Committee's oversight role. In particular, members highlighted that risk actions and target dates require

strengthening. Directors were asked to review their risks and ensure actions, progress updates and target dates are current, achievable and aligned to the mitigation work underway.

EMB also noted that risk entries should more clearly link the risk description, controls, current mitigation activity and expected impact on the risk rating. The booking team capacity risk was cited as an example where wider system and process improvements were underway but not fully visible in the recorded risk actions. This reinforces the need for risk owners to ensure that risk narratives and actions accurately reflect the current management response.

In response, risk descriptions and current controls have been included and reviewed as part of the reporting narrative. This provides a clearer line of sight between the risk event, the factors driving the current score, the controls already in place, and the actions required to reduce the risk. This will support more meaningful scrutiny by the Board and its Committees and help distinguish between existing control arrangements and planned mitigating actions.

Work is being considered through the governance improvement programme and the Risk Management Framework review to determine whether a more formal executive risk process should be established.

At its meeting on 16 July 2026, the Quality, Safety and Performance Committee received the July Trust Risk Register and took assurance from the update provided. The Committee noted the overall risk profile and the continued concentration of risks relating to patient safety, service capacity, treatment access, digital dependency and organisational resilience. The Committee also noted the importance of ensuring that risk target dates remain realistic, that recorded actions clearly demonstrate the mitigation activity currently underway, and that risk descriptions and current controls are sufficiently clear to support understanding of the current risk exposure.

- As a result, the current Public Trust Risk Register is showing:
 - A total of 15 risks reporting onto the public Trust Risk Register.
 - o Ten risks with a score of 12 or above reported in the safety/quality domain.
 - Six on the VCS register
 - Four on the WBS register
 - o Six risks with a score of 15 or above reported in other domains.
 - Two on the WBS register
 - Three on the Corporate risk register.

2.2 Risk Themes

The most significant themes relate to patient safety, service capacity, treatment access, digital dependency, and organisational resilience. The July register includes three new VCS risks linked to escalation pathways, timely clinical advice and treatment helpline capacity, alongside continuing risks associated with SACT capacity, booking pressures, manual and ageing systems, delays to national digital programmes, and reliance on external partners for key integrations.

A number of risks remain at high or very high levels, particularly where delays or system limitations could affect patient care, service continuity, or delivery of strategic priorities such as the new Velindre Cancer Centre. One corporate digital risk has reduced below the Board reporting threshold, reflecting improved RISP and EPMA positions; however, WLIMS remains a key dependency and continues to require oversight.

Overall, the register indicates that the Trust's risk profile continues to be shaped by operational pressure, digital transformation dependency, leadership and governance challenges, and demand pressures across clinical pathways. Continued executive oversight and targeted mitigation will be required to reduce exposure in the coming reporting periods.

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

3.1 Datix System Replacement

The contract with Datix 14 runs until November 2027.

Meetings on the relevant issues have taken place with risk peers across NHS Wales during the reporting period. While there is currently no appetite for a once-for-Wales solution, there is support for a collaborative approach to developing requirements and sharing market intelligence. This reflects the fact that some Health Boards are already operating different systems and that there is limited enthusiasm within NWSSP to revisit a national procurement approach following the previous attempt to procure an All-Wales Risk Module. Health Boards and Trusts have therefore agreed to continue working together to identify shared requirements, exchange learning and coordinate supplier engagement where this adds value.

In advance of finalising requirements and a specification, two supplier days have taken place, with suppliers sharing information about their systems and the functionality and support available. These sessions have been useful to aid our understanding of the market offer.

A project manager has been identified from the Digital Project Team and will begin working with the project from 1 July.

A detailed timetable to support the project will be presented to the Audit and Risk Assurance Committee in September.

3. SUMMARY OF MATTERS FOR CONSIDERATION

The Trust Board is asked to **NOTE** the risks in the quality and safety domain with a score of 12 and above, risks in other domains with a score of 15 and above, the three new risks added to the Trust Risk Register, and the risks that have reduced below the Board reporting threshold during the reporting period.

The Board is also asked to **TAKE ASSURANCE** from the scrutiny undertaken by the Quality, Safety and Performance Committee on 16 July 2026 and to note the further work requested to strengthen actions, target dates, mitigation narratives, risk descriptions and current controls to improve the clarity of Board-level assurance.

5. IMPACT ASSESSMENT

RELATED TRUST STRATEGIC GOAL(S)	
Please tick all relevant goals:	
Outstanding for quality, safety and experience	☒
RELATED STRATEGIC TRUST ASSURANCE FRAMEWORK RISK	06 - QUALITY & SAFETY
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Safe ☒
	Timely ☒
	Effective ☒
	Equitable ☒
	Efficient ☒
	Patient Centred ☒
	The risk register and associated risk framework are imperative to quality and safety in the organisation.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED	Not required.



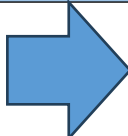
TRUST WELL-BEING GOAL IMPLICATIONS/IMPACT	There are no direct well-being goal implications or impact in the current risks in this paper.
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT	No - Include further detail below.
	There is no direct equality impact in respect of this paper, however each risk will have an impact assessment where appropriate.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

4. RISKS

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

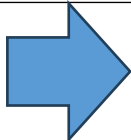
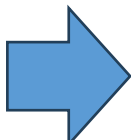
RISK RATING MATRIX - IMPACT X LIKELIHOOD					
RISK MATRIX	LIKELIHOOD(*)				
CONSEQUENCE(**)	1- Rare	2- Unlikely	3 - Possible	4 - Probable	5 - Expected
1 -Negligible	1	2	3	4	5
2 - Minor	2	4	6	8	10
3 -Moderate	3	6	9	12	15
4 - Major	4	8	12	16	20
5 - Catastrophic	5	10	15	20	25

SECTION 1 – Current Trust Risk Register

No	ID & DATE OPENED	DIRECTORATE	RISK DOMAIN	RISK OWNER	RRISK TITLE & DESCRIPTION	INHERENT RATING	CURRENT RATING	TARGET RATING & EXPECTED DATE	RATING CHANGE SINCE LAST REPORTING PERIOD	ACTIONS	CONTROLS IN PLACE & PROGRESS SINCE LAST REPORTING PERIOD
Velindre Cancer Service											
12+ Risks in the Quality and Safety domains											
1	3747 01.08.25	VCS	Safety	Director of Velindre Cancer Centre	There is a risk to patient safety as a result of insufficient capacity within the SACT day case service leading to delay in patients receiving SACT treatment.	20 4x5	12 3x4	6 3x2 Target date: 01.10.2026		1. Business case to be updated to include growth and resource requirements for next 3 year period. 2. Business case held by SACT improvement group, reporting into the SACT Steering Group 3. A Surge Capacity Action Plan will be developed to explore opportunities and implement actions at pace to support mitigation of the current and future capacity gap. This will include exploration of additional capacity across Pharmacy, nursing and pre SACT assessment in the short term.	PROGRESS NOTES: Business case being developed, exploring additional SACT space. Surge capacity being provided through clinical trials and use of Rowan ward on NHH days. Business case to reflect the current growth of 14%. This will ensure sustainable additional capacity is planned for and the VCS has the appropriate workforce across all areas to deliver this capacity safely and efficiently. In addition, there will be a focus to expedite high benefit protocols which will support even balance of activity across the week to ensure optimisation of all available capacity. This will include implementation of new ways of working and transformation of the current SACT Pathway.

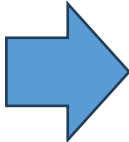
TRUST RISK REGISTER – July 2026

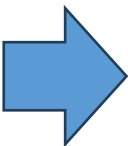
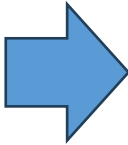
To note, risk scores are calculated by multiplying the impact (first number in brackets) of the risk by the likelihood of the risk (second number in brackets).

2	3714 24.06. 25	VCS	Safety	Director of Velindre Cancer Centre	There is a risk to patient safety as a result of increased demand on the booking team leading to a delay in scheduling SACT treatments and potential breaches	16 4x4	15 3x5	6 2x3 Target date: 31.08.26		1. RAG rated escalation document to be written with associated actions based on Chair Capacity / Pharmacy Capacity / Numbers on pending list and so on - 31.07.2026 2. Need to identify clinical support for administrative SACT booking team to support with clinical prioritisation and escalation. Need to formalise process based on risk by 31.07.2026	PROGRESS NOTES: Risk reviewed - pending list remains >100. New staff recruited, in induction period. Reviewed by Divisional Triumvirate - review of risk target date extended to end of August to allow induction of staff and for impact to be understood.
3	3969 *new Risk	VCS	Safety	Ead of Nursing	There is a risk that patients may not be escalated appropriately to senior decision maker due to unclear escalation pathways, staff uncertainty, scope of practice or availability of on call team due to other workload pressures, resulting in delayed decision making, inappropriate management and increased risk of harm.	20 5x4	15 5x3	8 4x2 Target date: 31.07.26	New risk	1. Clarify and map escalation pathways and produce quick reference guides for staff within resource folder 2. Define role and responsibilities 3. Clarify when escalation to senior decision maker is mandatory 4. Review of on call workload patterns and use of AOS consultant/ consultant on call 5. Review of helpline data to determine wider workforce planning is required 6. Undertake monthly audit of calls on AMaT to assess compliance with escalation . 7. Benchmark with other providers to assess their protocols for escalation 8. Workforce – consider additional member of staff covering helpline – ACP or Medical (Clinical fellow level)	PROGRESS NOTES: • Consultant connect has commenced on 13.07.2026. • Reporting to monthly highlight report to APIC board • Monthly reporting to relevant forum.
4	3832 02.12. 25	VCS	Safety	Director of Velindre Cancer Centre	There is a risk to staff safety administering SACT without the use of closed drug transfer system devices, leading to potential impact on health from repeated cytotoxic exposure.	15 3x5	15 3x5	6 3x2 Target date 30.10.26		1. Escalation to procurement for tender of products, following Board approval - 31.07.2026 2. Education and training for CSTDs for rapid roll out	PROGRESS NOTES: Trial completed of CSTDs. Procurement plan and business case in development.

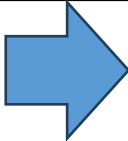
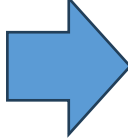
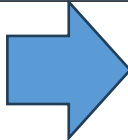
To note, risk scores are calculated by multiplying the impact (first number in brackets) of the risk by the likelihood of the risk (second number in brackets).

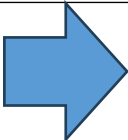
5	3967 *new risk	VCS	Safety	Head of Nursing	There is a risk that patients may be unable to access timely clinical advice during peak demand or out of hours due to their call being unanswered at switchboard, insufficient staffing in the helpline, rising call volumes and complexity, or inappropriate calls being redirected to the helpline, resulting in delayed escalation, unmanaged managed symptoms, and increased emergency admissions, reduced patient confidence in the service and increased levels of reported patient concerns.	15 5x3	12 4x3	10 5x2 Target date: 31.07.26	New risk	1. Review and compare current VCS triage tool with UKONS triage tool to ensure clarity, usability, and clinical relevance and update tool as required with clear escalation triggers, further prompts to support staff in telephone triage assessment and identifying possible red flag symptoms 2. Audit of call recordings and documentation of triage outcomes identify any patterns of incorrect of incomplete triage assessment 3. Implement <i>Attend Anywhere</i> virtual assessment platform into helpline service 4. Completion of relevant sections of AOS passport Level 2 5. Explore access to a dedicated triage module for Helpline practitioners 6. Increase to annual competency update and refresh 7. Improved access to senior clinical decision maker 8. Monthly random audit of at least 10 calls to the THL service with varying RAG categories 9. Encourage reflective practice with staff members ensuring staff member gets support during any investigation processes. 10. Implement virtual assessment platform in helpline to assist in triage practices.	PROGRESS NOTES: Requirements are: - UKONS tool - VCS triage tool - national standards
6	3968 *new risk	VCS	Safety	Head of Nursing	There is a risk that patients may be unable to access timely clinical advice during peak demand or out of hours due to their call being unanswered at switchboard, insufficient staffing in the helpline, rising call volumes and complexity, or inappropriate calls being redirected to the helpline, resulting in delayed escalation, unmanaged managed symptoms, and increased	15 5x3	12 4x3	5 5x1 Target date: 30.09.26	New risk	1. Access to timely advice via Treatment Helpline service 2. Define clear scope of service including scope of follow up calls 3. Prioritise all urgent calls 4. Work with switchboard team to reduce inappropriate redirection of out of scope calls 5. Work with other clinical departments/teams to reduce	PROGRESS NOTES: New risk.

					emergency admissions, reduced patient confidence in the service and increased levels of reported patient concerns.					redirection of calls to helpline (where appropriate) to minimise delays and provide clear signposting for non urgent queries 6. Undertake monthly audits (AMaT) to assess compliance with 30 minute call back target for unwell patients 7. Determine peak call demand surge in call volumes to support with workforce planning 8. Review of OOH workforce model is required 9. Review of helpline scope and update Standard operating policies 10. Longer term review of telephony and call management systems	
Welsh Blood Service											
12+ Risks in the Quality and Safety domains											
7	3418 03.07. 25	WBS	Quality/ Safety	Director of Welsh Blood Service	There is a risk to quality, as a result of pre- and post-examination processes for all tests yielding patient results, leading to a potential adverse impact on patient care.	12 4x3	12 4x3	4 4x1		1. Introduction of LIMS to mitigate the risk of manual transcription errors	PROGRESS NOTES: The risk has been reassessed in light of the HistoTrac LIMS implementation in Transplantation. Although manual transcription has been partially reduced, repeated incidents of incorrect reporting continue within Transfusion, with associated SABRE reporting to the MHRA. As a result, the likelihood cannot be reduced at this time. Mitigating actions should include the planned implementation of LIMS 2 in Transfusion, scheduled for September 2026. A revised risk assessment has been undertaken.
8	3716 24.06. 25	WBS	Quality	Director of Welsh Blood Service	There is a risk to patient safety as a result of reusing sample numbers leading to incorrect patient results reported.	12 4x3	12 4x3	8 4x2		1. Ensure that Immulink information sent manually only contain current sample results. Update to LAB-066 Printing and reporting of results from NEO Iris. SOP is in draft awaiting review 2. Update the middle ware so that it no longer supports the reuse of sample numbers, this will be done via change management process.	PROGRESS NOTES: No change to risk- managing manually and no further incidents. Action outstanding to implement new LIMS system. TCLE National Project has a estimated completion of September 2027.

TRUST RISK REGISTER – July 2026											
To note, risk scores are calculated by multiplying the impact (first number in brackets) of the risk by the likelihood of the risk (second number in brackets).											
								Expected date: 01.12.2026			
9	3388 07/05/ 24	WBS	Quality	Director of Welsh Blood Service	There is a risk to Quality and Performance as a result of reporting errors and limited accessibility of reports due to no interfaces between the Fetal D IT System (FEDIS) and NHS Wales Digital Applications, leading to suboptimal antenatal care.	16 4x4	16 4x4	2 2x1		1. Complete the development, testing, and validation of the FEDIS, eMPI and WRRS interfaces under project reference PR000553. 2. Progression to development and testing is dependent on DHCW resolution of the outstanding connectivity issues and confirmation that the integration is ready to proceed. 3. Once resolved, the WBS Project team will complete User Acceptance Testing (UAT), and end-to-end laboratory validation, including demographic mapping verification and report delivery via WRRS.	Action will be measurable by the implementation of TCLE system. National resources have been allocated to the LIMS TCLE project to ensure delivery. Implementation of TCLE LIMS system will directly address this risk PROGRESS NOTES: Progress is dependent on DHCW – no material progress made since the last review despite ongoing weekly engagement. Connectivity issues affecting message transmission between VUNHST and DHCW systems remain unresolved. The project is being managed under PR000553 and remains under active escalation via WBS Futures. A further extension to the timelines is likely given the lack of progress and unknown timelines for resolution. Risk level remains unchanged. Delays continue to have a direct impact on clinical services due to lack of system integration and limited accessibility of fetal RHD results across Health Boards. Completion will be evidenced by successful validation sign-off of the demographic (MPI) and reporting (WRRS) integrations, with no critical defects.
10	3643 11/04/2 025	WBS	Quality/Safety	Director of Welsh Blood Service	There is a risk to patient safety as a result of an aged Laboratory Information System (SERIF) leading to RCI and Automated Testing being unable to operate a safe service.	16 4x4	16 4x4	4 4x1		1. Implementation of LIMS system	PROGRESS NOTES: Target risk rating expected date amended to align with implementation of LIMS TCLE project timeline. Overall risk has not changed. Action outstanding to implement new LIMS system. TCLE National Project has a estimated completion of September 2027. Action will be measurable by the implementation of TCLE system. National resources have been allocated to the LIMS TCLE project to ensure delivery. Implementation of TCLE LIMS system will directly address this risk.
15+ Risks in other domains											

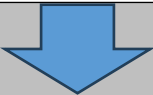
To note, risk scores are calculated by multiplying the impact (first number in brackets) of the risk by the likelihood of the risk (second number in brackets).

11	3801 14.10. 25	WBS	Performance and Service Sustainability	Director of Welsh Blood Service	There is a risk to Performance and Service Sustainability of cell free fetal DNA screening as a result of FEDIS phase 2 schedule slippage against timescales due to unexpected issues identified during the testing phase, leading to uncertainty over confirmation from DHCW on definitive validation and go-live dates. Timelines could shift at short notice if issues arise	16 4x4	16 4x4	8 4x2		1. Continue to escalate FEDIS Phase 2 delivery delays and risks to the WBS Futures Delivery Board to obtain indicative timelines from DHCW. 2. Maintain active monitoring of project progress through weekly touchpoint meetings with DHCW and updated project plan. 3. Identify and implementing feasible efficiencies to reduce the duration of UAT and validation where possible. 4. Progress to be monitored through weekly touchpoint meetings and formally reported to WBS Futures Delivery Board. Agreed timelines to be captured in project plan. Any further changes to project timelines resulting from DHCW delays will be formally managed through the WBS change control process, with submission of a Verto exception report for review and approval.	PROGRESS NOTES: FEDIS Phase 2 project remains delayed because an intermittent message transmission issue within the DHCW system test environment has not yet been resolved, despite ongoing weekly engagement, technical investigations and escalation. DHCW continues to work with Microsoft and Digital Services to identify the cause. Options are being considered to allow the project to progress if the system test issue remains unresolved. The issue has been escalated through WBS Futures and senior Digital and DHCW leadership, with the clinical impact of delayed reporting integration discussed at senior medical director level in July 2026.
12	3306 15/01/ 25	WBS	Performance and Sustainability	Director of Welsh Blood Service	There is a risk of loss of performance and sustainability, as a result of a loss of electrical supply leading to a loss of service and production at Welsh Blood services Llantrisant.	20 5x4	15 5x3	5 5x1 Target date: 01.12..26		1. Review of risk assessment required	PROGRESS NOTES: Incoming electrical supply to be upgraded to dual supplies, this will be actioned with TGI planned works. No change to risk, continue to manage programme across the site.
Corporate											
15+ Risks in other domains											
13	3646 15.04. 2025	Corporate	Performance and Service Sustainability	Chief Digital Officer	There is a risk to that the WLIMS 2.0 go-live date will be delayed due to delays in the national programme timeline causing an impact on realising project outcomes and additional demand for further development of existing legacy systems.	20 4x5	20 4x5	6 2x3 Target date: 31.08.26		1. Participating in national planning for LIMS across NHS Wales. Local plans are ready to test on LIMS 2.0. 2. Agree the new launch date with WBS Futures Programme. 3. Mitigation plan in place with existing SERIF system.	PROGRESS NOTES: The WLIMS 2.0 programme remains high-risk for delivery. The latest proposed national dates for the Blood Transfusion services is Sept '26. Local work on testing is progressing well and WBS resources are directly supporting the National programme.
14	3656 24.04. 25	Corporate	Performance and Service Sustainability	Director of Corporate Governance	There is a risk to the quality of clinical and corporate governance due to the current assurance and reporting arrangements of hosted services.	20 5x4	15 4x4	6 3x2 Target date: 30.09.2026		1. Assurance mapping to be reviewed and completed by September 2026 2. Implementation of NWSSP Review Recommendations to be completed by end of September 2026.	PROGRESS NOTES: WG implementation group considering all relevant issues.

15	3633 15.04. 25		Multiple Risk Domains	Chief Digital Officer	There is a risk to Quality and Performance and Service Stability as a result of the lack of capacity of Digital Health and Care Wales to integrate VUNHST digital systems into the National Architecture on a timely basis leading to delays in the Trust's ability to introduce new digital systems to support its strategic objectives. In particular integration for the IRS, WHAIS, FEDIS projects has had to be escalated to the DHCW Executive for resolution.	15 3x5	12 3x4	6 3x2 Target date: 30.08.26		1. Trust to line up third-party suppliers to provide their Integration at the right time ongoing phase 2 of WHAIS.	PROGRESS NOTES: FEDIS Integration is still underway and under escalation with DHCW. WHAIS integration is planned in phase 2. Risk level remains the same.

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

ID & DATE OPENED	DIR ECT ORA TE	RISK DOMAIN	RISK OWNER		INHERENT RATING	CURRENT RATING	TARGET RATING	RATING CHANGE SINCE LAST REPORTING PERIOD	PROGRESS SINCE LAST REPORTING PERIOD
3632 03/04/25 Risk level reduced	Corporate	Multiple risk domains -Performance and service	Chief Digital Officer	There is a risk to Quality and Performance and Service Stability as a result of National Digital Programmes managed by Digital Health and Care Wales (DHCW) not being delivered to time/cost/quality for use by the Velindre Trust leading to disruption of the clinical model and the plan to transition services to the new Velindre Cancer Centre. The National DHCW programmes of concern for the Trust are RISP/WLIMS/EPMA.	16 (4x4)	12 (3x4)	8 (4x2)		RISP is heading towards stable operations for the end of June. EPMA remains on track. WLIMS the Welsh Blood Service preparation is on track, Go Live is dependent on national programme, which remains high risk. Risk impact has reduced due to improvement in RISP and EPMA, now relates to WLIMS.

3634 03.04.25	Corporate	Multiple Risk Domains Quality, Performance	Chief Digital Officer	There is a risk to Quality, Performance and Service Sustainability, and Workforce domains as a result of demand for work on new digital services exceeding the capacity of the Trust digital team and the Trust's capacity to take on the business changes management leading to priority service initiatives enabled by digital not being delivered successfully, stress and burnout for the digital team and regularly changing priorities.	16 (4x4)	9 (3x3)	6 (3x2)		Additional resources have been funded by nVCC programme, Welsh Government and Trust reserves, ensuring that Digital Services are able to resource sufficiently the 2026 to 2028 Digital IMTP. Active recruitment is in progress. Reducing risk. nVCC Readiness Capacity and Demand plan has been approved. Digital plan has also been agreed, which has reduced some of the demand.
3865 19.01.26	Corporate	Service Sustainability Reputational	Interim CEO/ Interim Executive Director of Workforce and	There is a risk to leadership stability and capacity due to a number of interim positions on the Executive Management Board and a key vacancy.	20 (4x5)	12 (3x5)	4 (2x2)		CONTROLS: 1. Confirm timescales for recruiting into permanent roles 2. Confirm interim positions in accordance with Welsh Health Circulars 3. Confirm decision making processes and accountabilities PROGRESS NOTES: New appointments have been secured. A clear timetable is being progressed for all Executive interim positions following the appointment of the CEO. Risk reduced to 12 on that basis. Expect risk score to decrease further when all appointees are in post.
3887	WBS	Quality	Director of Welsh Blood Service	There is a risk to quality as a result of HNA antibody results either not imported or partially imported into HistoTrac leading to delays in testing or incorrect treatment paths for patients.	12 3x4	6 3x2	6 3x2		Fix to issue has been provided by supplier - updated code to remove reliance on bead numbers - informal testing of fix was successful - updated code will be added to Master Trigger and formally tested as part of UAT and Validation process. Implementation of fix is awaiting further updates to the Master Trigger, but Phase 2 of the WHAISIT project is still on track to be implemented by Nov 2026. Risk score has reduced and reached the target score, now below threshold reportable to Trust Board

TRUST BOARD	
BOARD ASSURANCE FRAMEWORK UPDATE	
DATE OF MEETING	30 July 2026
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	ASSURANCE
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Mel Findlay, Risk and Assurance Manager
PRESENTED BY	• Non Gwilym, Interim Director of Corporate Governance • Lauren Fear, Director of Place, Portfolio and Partnerships • Gill Knight, Director of Nursing and • Anne Carey, Chief Operating Officer • Sarah Jenkins, Director of OD and Workforce • Jacinta Abraham, Medical Director • Matthew Bunce, Director of Finance • Carl Taylor, Chief Digital Officer
APPROVED BY	Non Gwilym, Interim Director of Corporate Governance
EXECUTIVE SUMMARY	This paper provides the Trust Board with an update on the Board Assurance Framework (BAF), including the key issues raised through recent Executive Management Board, Strategic Development Committee and Quality, Safety and Performance Committee. Committees have commented that the BAF is becoming easier to read and more accessible; however, further work is required to strengthen risk narratives, improve visibility of action date changes, enhance links between strategic and operational



	risks, and ensure the BAF operates consistently as a corporate assurance tool.
RECOMMENDATION / ACTIONS	The Trust Board is asked to: • NOTE the status of the Board Assurance Framework and the assurance rating of Level 2; • ENDORSE the proposed improvements to future BAF reporting, including clearer narrative on static risk ratings, revised target dates, links to operational risks, and gaps in controls and assurance.
COMMITTEE / GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING	
COMMITTEE OR GROUP	DATE
Executive Management Board	2 July.2026
Strategic Development Committee	7 July 2026
Quality, Safety and Performance Committee	16 July 2026
This BAF update has been considered by the Executive Management Board, Strategic Development Committee and Quality, Safety and Performance Committee. Members noted that the document is becoming easier to read and more accessible, while identifying further improvements required in relation to action target dates, risk narratives, static risk scores, links between mitigating actions and risk reduction, and executive-level risk scrutiny.	
ASSURANCE RATING ASSESSED BY EXECUTIVE SPONSOR	2 – Comprehensive actions have been identified and are being actively managed. Further work is required to improve the quality, consistency, and effectiveness of the BAF as a corporate assurance tool.
APPENDICES	
1	Board Assurance Framework Dashboards

1. SITUATION

- 1.1 The Trust Assurance Framework (TAF) was established in 2020. Revised strategic risks were considered and approved by Trust Board in March 2025. In July 2025 the Trust Board approved renaming the Trust Assurance Framework as the Board Assurance Framework (BAF), bringing Velindre University NHS Trust in line with other NHS organisations.

2. ASSESSMENT

- 2.1 As part of the IMTP, the Trust Board agreed a refreshed set of strategic risks in March 2026, aligned to the Trust's strategic objectives.
- 2.2 BAF 09 is a strategic risk regarding the nVCC project, proposed for consideration in private, as it contains commercially sensitive information.
- 2.3 Recent committee scrutiny identified that several BAF risk ratings have remained static for a prolonged period. The discussion recognised that risks are at different stages of maturity and that some strategic risks, particularly those relating to culture, organisational change and longer-term transformation, may take considerable time to reduce. Future iterations of the BAF narratives will explain why a risk remains static and when any anticipated step change or reduction in score is realistically expected.
- 2.4 The review also highlighted the need to improve the visibility and accountability of mitigating action dates, and the need to strengthen the alignment between BAF risks and underlying operational risk registers.
- 2.5 In relation to the workforce and culture BAF risk, it was noted that culture is difficult to measure through simple actions and milestones and that improvement is expected to be long term. Future measurement is likely to align with the NHS Wales national culture dashboard as this develops, with staff survey results continuing to provide an important indicator.
- 2.6 The arrangements for risk management reporting will be formalised through the new Board Committee structure, with each BAF strategic risk allocated to a lead committee for scrutiny and onward assurance to the Trust Board. This will strengthen the line of sight between Executive Management Board review, committee scrutiny and Board-level assurance.

BAF Ref	Title	Committee
01	There is a strategic risk that increasing complexity and demand across our specialist services - cancer and blood - will impair the Trust's ability to deliver timely, safe and sustainable national services, impacting patient outcomes, donor services, clinical quality, and organisational reputation.	Quality, Safety and Experience Committee



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

02	There is a strategic risk that the quality of patient/donor/population outcomes and/or experience across the services managed by the Trust may be adversely impacted if the Trust cannot deliver its ambitious change programmes.	Quality, Safety and Experience Committee
03	There is a strategic risk that the Trust is unable to deliver the Velindre Cancer Service and Welsh Blood Service Research Strategies and not fully embedding innovation activities in line with the national Innovation Framework. This would reduce clinical effectiveness and outcomes of care; reduce national and international reputation; and dilute the ability to attract research funding partnership and highly skilled staff, ultimately undermining the delivery of the Trust's strategic objectives.	Research, Development and Innovation Committee
04	There is a strategic risk that the Trust becomes financially unsustainable if it does not secure sufficient funding for the provision of services and does not maximise its use of resources. Unwarranted variation could impact the value and effectiveness of the care our patients and donors receive.	Finance and Performance Committee
05	There is a strategic risk that the Trust fails to effectively embed its role as a sustainable organisation - outside of main infrastructure and specific centrally led activity - resulting in a failure to improve the health of the population we serve and non-compliance with the Well-being of Future Generations Act's requirements	Finance and Performance Committee
06	There is a strategic risk that our people will not feel a sense of belonging, not feel valued in their roles, not understand how they contribute to organisational success, and will be unable to speak up in confidence, resulting in a negative impact on staff experience if we do not foster a cohesive culture in line with our organisational values	People, Culture and Engagement Committee
07	There is a strategic risk that insufficient investment, capacity and capability to maintain, replace and effectively utilise	Quality, Safety and Experience Committee

	digital systems and infrastructure will result in system failures, cyber security vulnerabilities and limited digital transformation, leading to disruption to clinical services, reduced quality and efficiency of care constrained decision-making, systems the Trust fails to sufficiently consider, optimise the opportunities and effectively manage the risks of new and existing technologies, including considerations of Artificial Intelligence and Information Security.	
08	There is a strategic risk that the organisational and clinical governance arrangements do not provide appropriate mechanisms and culture to achieve our medium to long term objectives.	Audit and Risk Assurance Committee

- 2.7 The assurance rating remains at Level 2, reflecting that comprehensive actions have been identified and are being actively managed, while recognising that further work is required to improve the quality and effectiveness of the BAF as an assurance tool.

3 IMPACT ASSESSMENT

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



RELATED STRATEGIC BOARD ASSURANCE FRAMEWORK RISK	06 - QUALITY & SAFETY
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Safe Timely Effective Equitable Efficient Patient Centered ☒ ☒ ☒ ☒ ☒ ☒ The risk register and associated risk framework are imperative to quality and safety in the organisation.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED	Not required.
TRUST WELL-BEING GOAL IMPLICATIONS/IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT	There is no direct equality impact in respect of this paper, however each risk will have an impact assessment where appropriate.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report

4 RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes
WHAT IS THE RISK?	The strategic Risks outlined in the BAF are informed by the Trust's active management and reporting of its operational risks. There is a risk that, without clearer narratives, stronger links between controls, mitigating actions and expected score movement, and improved visibility of overdue or revised actions, the BAF may not provide sufficient strategic assurance to committees and the Board.



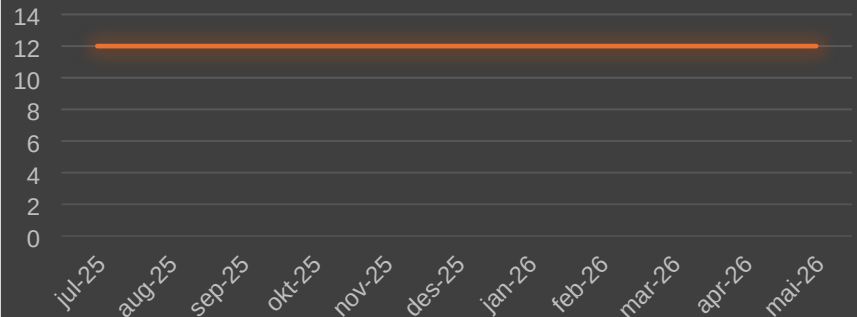
GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

WHAT IS THE CURRENT RISK SCORE	n/a
BY WHEN?	Ongoing
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
All risks must be evidenced and consistent with those recorded in Datix	

Risk 01	There is a strategic risk that increasing complexity and demand across our specialist services - cancer and blood - will impair the Trust's ability to deliver timely, safe and sustainable national services, impacting patient outcomes, donor services, clinical quality, and organisational reputation.												Date Risk Raised			Current Risk Score		
													1 April 2026			12		
													Last Review Date					
													June 2026					
Executive Summary	WBS - position is stable and has been sustained for several months. The position continues to be monitored via the Blood supply Chain Group.																	
	VCS – delivery of the patient care across Radiotherapy Services is planned and supported via the IRS rollout. The SACT service continues to receive sustained focus. However, progress is being limited by the level of performance and activity data available to the teams to information the capacity planning to deliver the consistency required but for the ‘as is’ and future service, at the Hub and spokes. The operationalisation of the Cancer PTL which is increasing ability to track pathways and understand bottlenecks in pathways, for focused work.																	
	Risk score trend: The risk score has remained static since the last period.																	
Associated Strategic Objectives	Outstanding for quality, safety and experience. Provide harm free care, the best outcomes and a great patient and donor experience. Listen to and learn from the experiences patients and donors have of our care to drive continuous improvement. Be an organisation which consistently demonstrates Compassionate Leadership in everything we do.												Exec Lead			Chief Operating Officer		
													Assurance Level			2		
													Risk Appetite			Cautious		
Scoring	Inherent Risk			Q2 – 25/26			Q3 – 25/26			Q4 – 25/26			Q1 – 26/27			Target Risk		
	I	L	Score	I	L	Score	I	L	Score	I	L	Score	I	L	Score	I	L	Score
	4	4	16	4	3	12	4	3	12	4	3	12	4	3	12	2	4	8

01 Capacity



Associated Risks	Risk ID	Risk Title	Current Risk Score
	3747 - VCS	There is a risk to patient safety as a result of insufficient capacity within the SACT day case service leading to delay in patients receiving SACT treatment	12
	3216 - VCS	There is a risk to timely, safe, and reliable management of unwell patients contacting the treatment helpline as a result of increased volume of calls, increased complexity of patients, inappropriate use of the helpline, and current workforce model including difficulty in accessing timely appropriate clinical decision making	15
	3714 - VCS	There is a risk to patient safety as a result of increased demand on the booking team leading to a delay in scheduling SACT treatments and potential breaches	15
	3306 - WBS	There is a risk of loss of performance and sustainability as a result of a loss of electrical supply leading to a loss of service and production at Welsh Blood Service	15
	3643 - WBS	There is a risk to patient safety as a result of an aged Laboratory Information System (SERIF) leading to RCI and Automated Testing being unable to operate a safe service.	16
	3633 - Corp	There is a risk to Quality and Performance and Service Stability as a result of the lack of capacity of Digital Health and Care Wales to integrate VUNHST digital systems into the National Architecture on a timely basis leading to delays in the Trusts ability to introduce new digital systems to support its strategic objectives. In particular integration for the IRS, WHAIS, FEDIS projects has had to be escalated to the DHCW Executive for resolution.	12
	3388 - WBS	There is a risk to Quality and Performance as a result of reporting errors and limited accessibility of reports due to no interfaces between the Fetal D IT System (FEDIS) and NHS Wales Digital Applications, leading to suboptimal antenatal care.	16
	3585 - WBS	Private risk.	15
	3646 - WBS	There is a risk to performance and service sustainability that the WLIMS 2.0 go-live date will be delayed due to national programme delays, impacting delivery of outcomes and increasing demand on legacy systems.	20
	3801 - WBS	There is a risk to performance and service sustainability of cell-free foetal DNA screening as a result of FEDIS phase 2 schedule slippage and uncertainty over DHCW validation and go-live dates.	16

Action to Address Gaps	Action ID	Action Detail	Progress Notes	Action Lead	Target Date
	01.02	Following publication of the Infected Blood Inquiry Report in May 2024 the Blood Health National Oversight Group has produced a paper for consideration by the Welsh government IBI next steps working group to help align the inquiry recommendations against the National Blood Health plan which should in turn improve prudent use of blood across Wales which in turn supports demand and supply for the Welsh Blood Service.	Work is progressing at a UK and Welsh level to support delivery of the Infected Blood Inquiry recommendations, with strengthened leadership, governance and delivery arrangements in place. Key areas of focus include digital connectivity and transfusion laboratory workforce, both identified as priorities to support implementation across NHS Wales. WBS is progressing work to map workforce requirements for transfusion laboratory services, in partnership with Health Education and Improvement Wales, and is developing an Outline Business Case to define the digital requirements needed to support delivery of recommendations, including the ability to better understand and report patient outcomes. Delivery remains dependent on securing appropriate resource and system support across NHS Wales.	WBS Director	December 2026
	01.03	Develop and progress capacity and demand business cases across key operational areas within WBS, and engage with commissioners (JCC) to secure agreement and funding to support sustainable service delivery. These include: • Red Cell Immuno-haematology workforce due to increases in demand • Collection team resilience to support demand fluctuations and prevent service going into supply shortages • Introduction of West Nile Virus testing • Increasing recruitment of Welsh Bone Marrow Donor Register Volunteers • Recurrent funding to support our Component Development Laboratory Staffing	Initial capacity and demand business cases across WBS operational areas were not approved; however, work is ongoing to engage with JCC. Blood Supply Chain Planning Group: Meets monthly to oversee supply chain resilience. Focus areas include demand forecasting, capacity planning, risk mitigation, and research linked to donor recruitment and retention. Operational Assurance Framework: in development to provide assurance on	WBS Director	March 2027

		infrastructure to support mandated changes upstream. The Blood Supply Chain Planning Group has been established to strengthen oversight and coordination across the end-to-end supply chain. The group is leading the development of an Operational Assurance Framework designed to provide assurance that demand forecasting, collection activity, and component production are aligned with service delivery requirements. This framework will support capacity planning, risk mitigation, and performance monitoring, ensuring resilience and sustainability within the blood supply chain.	supply chain alignment. First draft due Q1/2 2026/27; development of supporting dashboard starts in Q3 2026/27.		
	01.04	Review of outpatient activity to determine what could be repatriated back to Health Boards releasing capacity within the outpatient facility and providing care closer to home for the patient	Revised Modelling being undertaken by the Data & Insights Team using the GE model used for the FBC. It is recognised that this model is not granular enough for the level of detail required and a specification has been drafted next stage model. likely to be August 2026. In the meantime, the teams are using the data provided for initial planning discussions. Velindre@ Operational Boards are being established to support a collaborative approach to the work required.	VCS Director	August 2026
	01.05	Formal demand and capacity operational group to be established to provide oversight of current and future plans, manage D&C plans and identify areas of concern with mitigations for escalation as appropriate	Demand & Capacity undertaken at Service level currently i.e. SACT and Radiotherapy. To date this work has been limited due to the level of data available, meaning discrete work required. However, with the advent of the Cancer PTL & the 'go paperless' initiative more reliable information is becoming available to help drive this agenda and maximise productivity. The GE model has been re-run and more detail is required, a more comprehensive / granular model will be commissioned.	VCS Director	February 2026
	01.06	Strengthen WBS service resilience and infrastructure assurance.	Existing business continuity and supply resilience arrangements are in place,		December 2026

			with ongoing monitoring through operational and escalation routes. The Business Justification Case and Outline Business Case for the Talbot Green Infrastructure Programme have been submitted to Welsh Government to support infrastructure upgrades, service sustainability and future capacity requirements. Work is ongoing to develop to Full Business case stage.		
	01.07	Strengthen oversight of digital dependencies affecting WBS capacity and sustainability.	Programme governance arrangements are in place, with risks escalated through relevant WBS, Trust and national routes. Further work is required to provide a consolidated view of digital dependency risks, delivery confidence and impact on WBS capacity and sustainability.	Chief Digital Officer / WBS Director	

Key Controls Established	Key Gaps in Controls	Assurance	Key Gaps in Assurance
Joint blood stock planning with Health Boards (SLAs, Blood Health Plan, regular reviews) Routine stock resilience planning and UK mutual aid coordination Business continuity arrangements for core services (BIAs, contingencies, BCPs, shortage plans) Governance to balance BAU delivery with strategic programmes (WBS Futures/CPG) Blood Supply Chain Planning Group and developing Operational Assurance Framework to strengthen oversight of demand forecasting, collection activity, component production, supply chain resilience and capacity planning.	No real-time “vein-to-vein” data / business intelligence to link Health Board activity changes, blood issuing patterns, demand, and patient outcomes (dependent on external digital systems outside WBS control; being progressed via Infected Blood Inquiry-related programmes). Variation in demand management / blood utilisation across Health Boards and within clinical teams (inconsistent practice drives inappropriate use and affects demand). Limited organisational control over national and supplier-led digital programme timelines, including WLIMS2.0, FEDIS and BECS dependencies, which creates uncertainty for WBS capacity and sustainability planning.	SLA reviews with Health Boards; BHNOG KPI monitoring; operational escalation routes and local operational planning groups (e.g., SE Wales demand modelling; service area operational planning). Reporting through WBS SLT / VCS Divisional Team to EMB; oversight via COO/EMB, QSP Committee and Board; Trust-wide Clinical & Scientific Board. Welsh Government Quality, Planning & Delivery Reviews; regulatory inspections (e.g., MHRA, HTA); escalation via EPRR/Local Resilience Forum where needed; UK Blood Services MoU/mutual aid; Internal Audit, Wales Audit Office and regulator audits. Blood Supply Chain Planning Group reporting and development of the	Limited assurance on demand-related decision-making: WBS cannot validate alignment between issuing patterns, Health Board activity changes and patient outcomes due to lack of real-time “vein-to-vein” data Limited independent assurance on standardisation of utilisation: insufficient independent assurance that variation in blood utilisation across Health Boards/clinical teams is being effectively addressed and sustained Limited assurance on delivery confidence for national and supplier-led digital programmes that affect WBS capacity and sustainability, including WLIMS2.0 and FEDIS. Limited assurance that capacity and demand business cases will secure the investment required to mitigate known demand and sustainability pressures.

Digital dependency management for WBS critical systems and programmes, including escalation of national and supplier-related risks through appropriate WBS, Trust and national governance routes. Commissioning and investment planning controls, including development and resubmission of capacity and demand business cases to support sustainable service delivery. Infrastructure resilience and capacity planning are managed through the Talbot Green Infrastructure (TGI) Programme, including development and submission of the Business Justification Case (BJC) and Outline Business Case (OBC) to support infrastructure upgrades, service sustainability and future capacity requirements.	Delivery of infrastructure improvements remains dependent on approval and funding of the TGI Business Case, limiting current organisational control over timing and implementation of required upgrades. Capacity and demand business cases have been developed and submitted to JCC , but delivery of some mitigations remains dependent on commissioner support and investment decisions.	Operational Assurance Framework, including oversight of demand forecasting, collection activity, component production and supply chain resilience. Programme reporting through WBS Futures and relevant digital governance routes, including monitoring of delivery risks, national dependencies and supplier-related risks affecting WBS sustainability. Commissioner engagement and JCC review of WBS capacity and demand business cases to support scrutiny of service sustainability requirements.	

Risk 02	There is a strategic risk that the quality of patient/donor/population outcomes and/or experience across the services managed by the Trust may be adversely impacted if the Trust cannot deliver its ambitious change programmes.															Date of Risk			Current Risk Score																									
																1 April 2026			16																									
																Last Review Date																												
																June 2026																												
Executive Summary	Considerable enhancements made to health and safety processes. However, there is an increase of Duty of Candor incidents within VCS and repeated themes and trends within both divisions identifying the need for robust learning and improvement mechanisms.																																											
Associate d Strategic Objectives	Outstanding for quality, safety and experience - Provide harm free care, the best outcomes and a great patient and donor experience - Listen to and learn from the experiences patients and donors have of our care to drive continuous improvement - Be an organisation which consistently demonstrates Compassionate Leadership in everything we do - Be recognised as 'Outstanding' by Health Inspectorate Wales, the Medicines and Healthcare Products Regulatory Authority and UK and international peers for the services we provide												Exec Lead						Director of Nursing, AHPs & Healthcare Science, Executive Medical Director & Chief Operating Officer																									
													Assurance Level						3																									
													Risk Appetite						Cautious																									
Scoring	Inherent Risk			Q2 – 25/26			Q3 – 25/26			Q4 – 25/26			Q1 – 26/27			Target Risk																												
	I	L	Score	I	L	Score	I	L	Score	I	L	Score	I	L	Score	I	L	Score																										
	4	5	20	4	4	16	4	4	16	4	4	16	4	4	16	3	3	9																										
02 - Quality <table><thead><tr><th>Month</th><th>Score</th></tr></thead><tbody><tr><td>Jul 25</td><td>16</td></tr><tr><td>Aug 25</td><td>16</td></tr><tr><td>Sep 25</td><td>16</td></tr><tr><td>Oct 25</td><td>16</td></tr><tr><td>Nov 25</td><td>16</td></tr><tr><td>Dec 25</td><td>16</td></tr><tr><td>Jan 26</td><td>16</td></tr><tr><td>Feb 26</td><td>16</td></tr><tr><td>Mar 26</td><td>16</td></tr><tr><td>Apr 26</td><td>16</td></tr><tr><td>May 26</td><td>16</td></tr><tr><td>Jun 26</td><td>16</td></tr></tbody></table>																			Month	Score	Jul 25	16	Aug 25	16	Sep 25	16	Oct 25	16	Nov 25	16	Dec 25	16	Jan 26	16	Feb 26	16	Mar 26	16	Apr 26	16	May 26	16	Jun 26	16
Month	Score																																											
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May 26	16																																											
Jun 26	16																																											

Associated Risks	Risk ID	Risk Title			Current Risk Score	
	3306 WBS	-	There is a risk of loss of performance and sustainability, as a result of a loss of electrical supply leading to a loss of service and production at Welsh Blood Service HQ, Talbot Green.			12
	3418 WBS	-	There is a risk to quality, as a result of pre- and post-examination processes for all tests yielding patient results, leading to a potential adverse impact on patient care.			12
	3716 WBS	-	There is a risk to patient safety and GDPR as a result of reusing sample numbers leading to incorrect patient results reported.			12
	3388 WBS	-	There is a risk to Quality and Performance as a result of reporting errors and limited accessibility of reports due to no interfaces between the Foetal D IT System (FEDIS) and NHS Wales Digital Applications, leading to suboptimal antenatal care.			16
	3801 WBS	-	There is a risk to Performance and Service Sustainability of cell free foetal DNA screening as a result of FEDIS phase 2 schedule slippage against timescales due to unexpected issues identified during the testing phase, leading to uncertainty over confirmation from DHCW on definitive validation and go-live dates. Timelines could shift at short notice if issues arise			16
	3643 WBS	–	There is a risk to quality as a result of an aged Laboratory Information System (SERIF) leading to RCI and Automated Testing being unable to operate a safe service.			16
	3586 WBS	–	Private risk			15
	3585 WBS	–	Private risk			15
	3646 WBS	–	There is a risk to PERFORMANCE AND SERVICE SUSTAINABILITY that the WLIMS2.0 go-live date will be delayed due to delays in the national programme timeline causing an impact on realising project outcomes and additional demand for further development of existing legacy systems.			20
	3633 VCS	–	There is a risk to Quality and Performance and Service Stability as a result of the lack of capacity of Digital Health and Care Wales to integrate VUNHST digital systems into the National Architecture on a timely basis leading to delays in the Trusts ability to introduce new digital systems to support its strategic objectives. In particular integration for the IRS, WHAIS, FEDIS projects has had to be escalated to the DHCW Executive for resolution.			12
	3714 VCS	-	There is a risk to patient safety as a result of increased demand on the booking team leading to a delay in scheduling SACT treatments and potential breaches			16
	3832 VCS	-	There is a risk to staff safety administering SACT without the use of closed drug transfer system devices, leading to potential impact on health from repeated cytotoxic exposure. This is currently under procurement, and the risk will be mitigated once this is complete.			15
Action to Address Gaps	Action ID	Action Detail	Progress Notes	Action Lead	Target Date	
	02.01	Implement the digitisation of a robust set of service level to Board quality, safety outcome and experience metrics including mortality, aligned with the Performance Management Framework.	Some enhancements made to PMF further work required in respect of mortality metrics, PROMs and increasing patient experience feedback at VCS.	Director of Strategy, Planning & Performance	March 2026	

			WBS has established routine reporting of quality, safety and donor experience metrics through the PMF, with improved visibility of laboratory indicators and donor feedback. Further work is required to strengthen Board-level alignment, enhance outcome measures and support integration with developing digital systems.		
	02.02	Deliver a programme of quality and safety investigation training for all potential investigation leads.	Investigation training commenced in November 2025- training dates in place through to end March 2026. WBS continues to roll out investigation training with improving uptake. Review of recent incidents has identified recurring themes, highlighting the need to further embed training and strengthen the quality and consistency of investigations to support learning and improvement.	Director of Nursing, AHP and Health Science	March 2026
	02.03	Implement the digital PROMS system for patients and establish a mechanism for regular analysis and identification of areas for learning and improvement.	Trust digital PROMS system is in place for 4 pathways. Will be going live in VAP to improve clinical efficiency in Q3. Plan in place to roll out across VCS over the next 2-3 years. Work ongoing to import the data to facilitate	Executive Director Finance	March 2028

			meaningful analysis and ease of access for clinicians for direct patient care. Data flow approved for integration with NDR (for WCP) and NHS App. Integration with WCP due December 2026.		
	02.04	Fully implement Electronic Prescribing and Medicines Administration across Velindre cancer Service.	Implementation well under way – on track to have in place by Oct 2026	Chief Digital Officer	July 2026
	02.05	Fully implement all Trust required IBI recommendations.	WBS is contributing to the Trust response to IBI recommendations through established governance and national engagement, with ongoing work in transfusion laboratory education and national digital programmes to strengthen training, data connectivity and reporting.	Chief Operating Officer	October 2026
	02.06	Implement the revised Putting things Right regulations: Listening to People.	Implementation plan being enacted. Only draft statutory guidance document provided by WG as of 16.3.26- final document WG correspondence regarding the phased implementation plan awaited.	Director of Nursing, AHP and Health Science	March 2026
	02.07	Strengthen patient and donor experience feedback mechanisms, specifically to increase the volume of experience feedback provided to the Trust across its services and ensure that patient / donor voice features through floor to Board reporting	Average of 16% feedback for WBS. An increase to 12% VCS patients provided feedback in Quarter 3. New national People Experience framework being implemented on	Executive Director of Nursing, AHP and Health Science Director of Corporate Governance	March 2026

			target for completion by April 2026 as noted.		
	02.08	Strengthen the quality and safety assurance and oversight mechanisms for hosted services.	Some strengthening undertaken within last 6 months. Draft clinical services priority document provided to QSP (March 26). Further work required as part of governance review	Chief Operating Officer and Executive Director of Nursing, AHP and Health Science	March 2026
	02.09	Embed and enhanced learning framework across the Trust, including learning from external organisations.	Learning framework in place. However, quality and safety analysis has identified repeated themes which means further strengthening and embedding required with improved ownership and accountability from service level to accountable Director. Benchmarking and Peer Review being incorporated into service redesign and performance, where possible.	Chief Operating Officer and Executive Director of Nursing, AHP and Health Science	March 2026
	02.10	To refresh and relaunch Trust patient safety framework.	Current framework requires review in light of structural changes and strengthening of accountabilities and responsibilities for quality and safety outcomes and experience and revised LTP regulations	Director of Nursing, AHP and Health Science	March 2026
	02.11	Implement the BCUHB Quality Dashboard and balanced score card	Site visit held – project / implementation plan required - timescales for delivery unclear	Chief Digital Officer	March 2026
	02.12	Strengthen WBS portfolio prioritisation and sequencing	WBS has strengthened portfolio prioritisation through the WBS Futures governance framework, with	Chief Operating Officer / WBS Director	October 2026

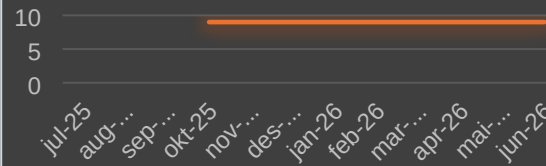
			improved alignment to strategic priorities and clearer management of programme interdependencies. Further work is underway to enhance oversight and align prioritisation to capacity and demand.		
	02.13	Implement capacity and demand planning for transformation delivery at WBS	WBS is reviewing change control processes and developing a workforce planning approach to support capacity and demand planning for transformation delivery.	Chief Operating Officer / WBS Director	December 2026
	02.14	Strengthen governance and assurance of WBS transformation delivery	WBS has strengthened governance of transformation delivery through WBS Futures, improving visibility and escalation of programme risks and dependencies. Further work is underway to align programme reporting with portfolio oversight and Board assurance.	Chief Operating Officer / WBS Director	October 2026

Key Controls Established	Key Gaps in Controls	Assurance	Key Gaps in Assurance
Capacity & demand management: routinely assessed as part of IMTP. Quality & safety oversight: routine monitoring through performance/quality frameworks (e.g., PMF and AMaT tracker). Patient/donor experience feedback: mechanisms to capture experience and feed learning into improvement.	Capacity & demand control: GE model being re-run and additional Business Intelligence Tools being scoped. Quality & safety oversight: routine monitoring through corporate/divisional performance and	Executive Management Board (EMB) and the Quality, Safety & Performance Committee (QSPC), plus benchmarking/peer review and external-facing oversight forums such as the Regional Cancer Board and JET & IQPD. Internal Audit, plus external scrutiny from	PROMs assurance gap: <i>No current PROMs reporting into the Performance Management Framework (PMF).</i> <i>Balanced Scorecards for each service not in place.</i> Board-level quality assurance gap: <i>Quality dashboard not in place</i> (limiting routine assurance to Board/committees). Mortality assurance gap: <i>Mortality metrics not all in place</i> (so assurance on mortality/outcomes is incomplete).

Clinical outcomes review: structured mortality review and the Medical Examiner Service to identify issues and learning. Workforce capability & learning: Velindre Oncology Academy to support training and development. Clinical audit: audit systems and processes to check compliance and drive improvement. Formal portfolio prioritisation and sequencing process across WBS Futures, including management of interdependencies across digital and laboratory programmes. Programme governance arrangements (e.g. WBS Futures Delivery Board) providing oversight, escalation and risk management of transformation delivery. Active management of national and supplier dependencies, including escalation through national forums and structured engagement with DHCW and suppliers. Workforce and SME capacity planning to support delivery of laboratory and digital transformation programmes.	regulatory tracking (PMF and AMaT). Experience feedback control: processes to capture patient/donor experience and use it for learning and improvement. Outcomes surveillance: mortality review and Medical Examiner Service arrangements to identify issues and drive learning. Workforce capability: Velindre Oncology Academy to strengthen skills, training and development. Clinical audit & compliance: audit systems to test adherence to standards and support continuous improvement.	HIW, HEIW, and Wales Audit Office audit activity. Regional Cancer Meeting and WRP audits (noted alongside patient experience controls). Programme reporting through WBS Futures Delivery Board and Trust programme governance structures, including RAG status, milestone tracking and escalation. Portfolio-level reporting aligned to IMTP demonstrating prioritisation decisions, capacity alignment and delivery confidence. Mitigation plans for continued operation of legacy systems pending delivery of replacement platforms. Assurance through national programme boards and digital governance structures regarding delivery of dependencies.	Patient/donor voice assurance gap: <i>Patient/donor voice is not being systematically/formally fed into meeting structures at all Trust levels</i> (weakening assurance that learning from experience is embedded).

Risk 03	There is a strategic risk that the Trust is unable to deliver the Velindre Cancer Service and Welsh Blood Service Research Strategies and not fully embedding innovation activities in line with the national Innovation Framework. This would reduce clinical effectiveness and outcomes of care; reduce national and international reputation; and dilute the ability to attract research funding partnership and highly skilled staff, ultimately undermining the delivery of the Trust's strategic objectives.									Date of Risk			Current Risk Score						
										1 April 2026			9						
										Last Review Date									
										July 2026									
Executive Summary		An inability to deliver research and innovation limits the continuous improvement of high-quality care and outcomes. There is a strategic risk that the Trust is unable to deliver the Velindre Cancer Service and Welsh Blood Service Research Strategies and not fully embedding innovation activities in line with the national Innovation Framework. This would reduce clinical effectiveness and outcomes of care; reduce national and international reputation; and dilute the ability to attract research funding partnership and highly skilled staff, ultimately undermining the delivery of the Trust's strategic objectives.																	
Associated Strategic Objectives		Research, Development and Innovation - Deliver world class research, development and innovation to improve tomorrow's care. - Accelerate the implementation of research and new discoveries to improve patients' and donors' experiences and outcomes. - Prioritise research, development and innovation that is clinically relevant and patient- and donor-centred. - Build a sustainable culture of multiprofessional RD&I involving the whole organisation. - Publish and promote research of the highest quality which achieves UK and international recognition.									Exec Lead			Medical Director					
											Assurance Level			5					
											Risk Appetite			Open					
Scoring		Inherent Risk			Q2 – 25/26			Q3 – 25/26			Q4 – 25/26			Q1 – 26/27			Target Risk		
		I	L	Score	I	L	Score	I	L	Score	I	L	Score	I	L	Score	I	L	Score
		4	3	12	-	-	-	-	-	-	-	-	-	3	3	9	3	2	6

03 - Research, Development & innovation



Associated Risks		Risk ID	Risk Title	Current Risk Score
		Nil return		

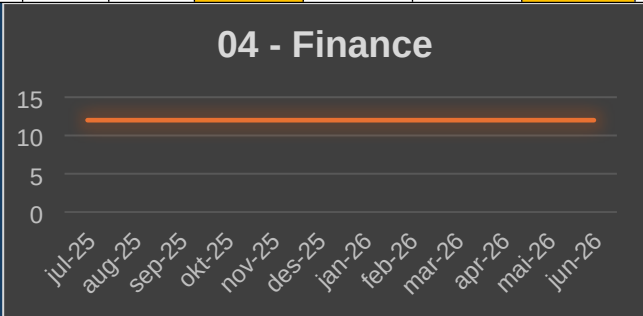
Action to Address Gaps	Action ID	Action Detail	Progress Notes	Action Lead	Target Date
	03.01	Develop and implement a structured benchmarking programme with UK peer cancer centres to review optimal Research Service infrastructure, workforce, and delivery models. Align benchmarking outputs with OECI Designation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

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

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

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

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

Risk 04	There is a strategic risk that the Trust becomes financially unsustainable if it does not secure sufficient funding for the provision of services and does not maximise its use of resources. Unwarranted variation could impact the value and effectiveness of the care our patients and donors receive.												Date of Risk			Current Risk Score																																					
													1 April 2026			12																																					
													Last Review Date																																								
													July 2026																																								
Executive Summary		There are a range of factors that impact on the finance sustainability and long term value risk. We prevent, mitigate or detect impact on this risk through a number of key financial controls. Where these controls are partially effective or not effective actions are being taken to improve the effectiveness of the control and where this achieves the anticipated improvement in control the assurance from that control is increased.																																																			
		Risk score trend: The risk score has remained static since the last period, and has been considered in line with the development of the IMTP.																																																			
Associate d Strategic Objectives		- Outstanding for quality, safety and experience - A leading provider of clinical services that always meet, and routinely exceed, expectations - A sustainable organisation which contributes to a better world for future generations across the globe												Exec Lead			Director of Finance																																				
														Assurance Level			4																																				
														Risk Appetite			Cautious																																				
Scoring		Inherent Risk			Q2 – 25/26			Q3 – 25/26			Q4 – 25/26			Q1 – 26/27			Target Risk																																				
		I	L	Score	I	L	Score	I	L	Score	I	L	Score	I	L	Score	I	L	Score																																		
		4	4	16	4	3	12	4	3	12	4	3	12	4	3	12	4	2	8																																		
												04 - Finance  <table><caption>04 - Finance Risk Score Trend</caption><tr><th>Month</th><th>Score</th></tr><tr><td>Jul-25</td><td>12</td></tr><tr><td>Aug-25</td><td>12</td></tr><tr><td>Sep-25</td><td>12</td></tr><tr><td>Oct-25</td><td>12</td></tr><tr><td>Nov-25</td><td>12</td></tr><tr><td>Dec-25</td><td>12</td></tr><tr><td>Jan-26</td><td>12</td></tr><tr><td>Feb-26</td><td>12</td></tr><tr><td>Mar-26</td><td>12</td></tr><tr><td>Apr-26</td><td>12</td></tr><tr><td>Mai-26</td><td>12</td></tr><tr><td>Jun-26</td><td>12</td></tr></table>										Month	Score	Jul-25	12	Aug-25	12	Sep-25	12	Oct-25	12	Nov-25	12	Dec-25	12	Jan-26	12	Feb-26	12	Mar-26	12	Apr-26	12	Mai-26	12	Jun-26	12						
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Associated Risks		Risk ID		Risk Title														Current Risk Score																																			
		Nil return																																																			
		Action ID		Action Detail						Progress Notes						Action Lead		Target Date																																			

Action to Address Gaps	09.02	Continuous improvement of Finance and Investment Enhanced Monitoring reporting including identification of Savings Opportunities; Disinvestments and Choices and clear line of sight with Welsh Government Value and Sustainability Board agenda	IMTP savings created using SMART actions to strengthen identification, monitor progress and delivery. Finance workshop with Executive team took place in 2025/26 to present the current financial position and discuss disinvestment options and financial recovery. A Finance and Planning Committee to be established during 2026/27 which will focus on the financial position and performance.	EDoF / EDoSTP&D / DDoF / DDoP	Ongoing
	09.04	Development of Investment Appraisal process and prioritisation framework	The investment appraisal will be developed in conjunction with shaping the soon to be created Finance & Planning Committee which have overall control and oversight over Trust investment decisions	EDoF / EDoSTP&D / DDoF / DDoP	October 2026
	09.05	Identification of business development and external funding opportunities	Cardiff Cancer Research Hub financial plan review has identified that in 2025-26 costs are covered by funding but there is a risk of shortfall in 2026-27 between anticipated trial & other income and forecast costs. Further work taking place with Cardiff & Vale to model additional trial activity and impact on cost and income. A tri-party risk share proposal for the Programme Hub element of the service has been agreed in principle with C&V and Cardiff University to contribute to a financially sustainable and risk sharing model. Private Patients Income: Liaison Financial external consultants re-engaged for the first half of the financial year to support the Trust in completion of remaining financial /	EDoF / EDirector of Planning / COO / VCS Director	2026/27

		commercial actions in improvement plan 1) negotiate new contracts with insurance companies & revisions to tariffs 2) additional activity charging separately for pathology 3) negotiation around payment of old debts. Work to also include EDoF / EDoSTP&D / COO negotiation with the Trust CAG sharing of the financial risk around PP credit loss (bad debts) and agreeing consistent charges for PP support to consultant private practice. Draft agreement discussed at CAG and awaits final approval. Work continues with Liaison Financial external consultants whereby an extensive review of tariffs for all private patient activity has been undertaken and validated by VUNHST and Liaison Financial. Contract negotiations with insurance providers is actively underway and involves pathology charging as well as payment of old debts. A revised charging tariff had been agreed with an implementation date of 1st July 2025 with further rates from 1st November 2025. Contract negotiations are actively underway with those insurers that have specific queries and those involving payment of old debts. LTA Activity performance monitoring review has concluded providing assurance and ensuring that controls are in place, however the review process will continue as part of routine practice. An exercise is currently underway to review the contract model to ensure we are recovering the income for cost of service.		

	09.06	Data & Insights team working with Finance team and service leads to investigate where data capture and mapping to contract currencies is not working correctly. Once the issues with the process have been identified corrective action can be taken both in the short term and longer term to ensure all activity is correctly captured and charged for.	Review of contract currency is currently underway in VCS to understand the true cost of service. However, given the status of agreeing the contract base a change in contract currency is not expected to be initiated until at least 2026-27 (see next item). VCS is currently reported a LTA activity over performance for 2025-26 which was used to mitigate the risk on the RSU activity underperformance.	EDof / EDirector of Planning / COO / VCS Director	2026/27
	09.07	LTA contract with Commissioners and re-basing exercise	To ensure Commissioners fund the total cost of Velindre running cancer services from 2026-27 there needs to be agreement from all Commissioners to change the commissioning principles for Velindre from 'historic shares' based on activity and NICE consumption in 2004-05 to a 'current activity' baseline and NICE consumption Hywel Dda UHB unilaterally forced the Trust to move to an LTA based on actual activity in 2025/26. This resulted in a £0.825m loss in income recurrently from Hywel Dda UHB on NICE & HCD. A Deputy Director of finance task and finish group for Commissioning has been established with the first meeting having taken place on the 27.02.2026 to review contract re-basing exercises and agree a standardised approach. Given the status of agreeing the contract base a change in contract currency is not expected to be initiated until at least 2027-28.		2027/28

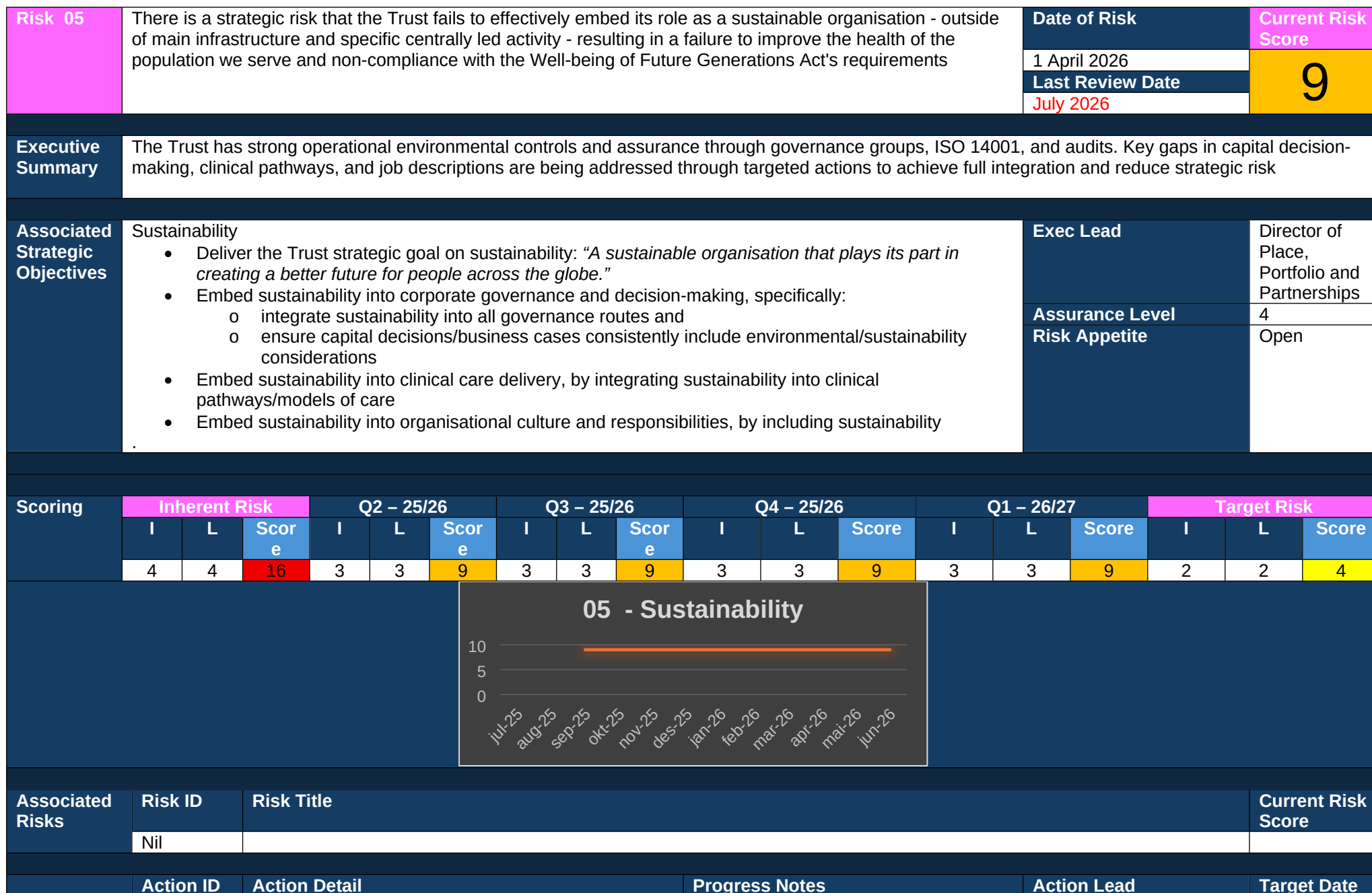
	09.08	Divisions reviewing non-value adding clinical practice or processes and changing ways of working through Value-Based Healthcare approach.	Ongoing work with initial review captured as part of the 2026 IMTP process, with a particular focus on reviewing non-pay expenditure during qtr 1 following year end. This has been shifted to qtr 2 due to capacity gaps in the team.	DDof/ Head of VBHC / Divisional Directors	October 2026 (revised from July 26)
	09.10	Strengthen the effectiveness and assurance of core financial controls covering statutory reporting, P2P, financial systems, debtors and treasury management and tax compliance.	Preparation of the draft 2025/26 Annual Accounts, Financial Returns & Remuneration Report is underway, with The draft 2025/26 Annual Accounts, Financial Returns & Remuneration Report were submitted to Welsh Government & Audit Wales by the required deadlines (1 May & 8 May 2026 respectively). Accounts were endorsed by the Audit Committee on the 24th of June and approved by Trust Board on 25th June, with final submission to WG due by 30 June 2026. The Trust's response to Audit Wales letter seeking information & assurances on fraud & governance matters was submitted on 8 May 2026. lessons learnt from last year's audit will be embedded into the timetable and working paper approach. Early & ongoing engagement with Audit Wales and Welsh Government is supporting consideration of key accounting judgements & disclosures.	Head of Financial Accounting	Ongoing

	29.06.2026	Procurement contract register	The need to create a robust contract management process, with a live maintained contract register held locally and aligned to all Wales registers.	Deputy Director of Finance / Head of Contracts	October 2026
Key Controls Established		Assurance	Key Gaps in Controls	Key Gaps in Assurance	
FSLTV1 – Divisional Financial Outturn (Detective)		Budget holders (reports and training), Touch Point Meetings	LTA activity capture and currency mapping is weak — some activity is not being identified and charged to commissioners. While additional system/process controls have been introduced (partly mitigating issues), a residual weakness remains, particularly relating to Radiotherapy IRS implementation, which is being addressed with Service and Business Intelligence.	LTA activity performance monitoring: a review has provided assurance that controls are in place, but assurance is not yet fully “closed” because the review process needs to continue as routine practice, and a contract model review is underway to ensure the Trust is recovering income that reflects the cost of service.	
FSLTV2 – Quarterly Finance Reviews (Detective)		Directorate Level Budget holders, reports and training, Touch point meetings			
FSLTV3 – Divisional Performance Review (Detective)		Directorate Level Budget holders, reports and training, Touch point meetings			
FSLTV4 – Executive and Trust Board Reporting (Detective)		Executive budget holders / Programme SROs			
FSLTV5 – Statutory and Mandatory Financial Reporting (incl. Annual Accounts) (Detective)		Executive budget holders / Programme SROs			
		Executive budget holders / Programme SROs			

FSLTV6 – Monthly Finance and Performance Meetings (Mitigating)	Directorate Level Budget holders, reports and training, Collective Commissioners Group, LTA Reporting		
FSLTV7 – Collective Commissioners Review (Preventative)	Executive budget holders / Programme SROs, Capital Planning Group		
FSLTV8 – Investment Appraisal (Preventative)	Executive budget holders / Programme SROs		
FSLTV9 – Financial Strategy / Medium Term Financial Plan / Budget Setting (Preventative)	Oracle financial system controls, budget holders, Delegated Financial Limits		
FSLTV10 – Scheme of Delegation and Delegated Financial Authority (Preventative)	Value Based Healthcare project leads; VBH programme SROs, VBHC Steering Group		
FSLTV11 – Value Based Healthcare programme (Detective)	Requisitioners / budget holders, PSPP Group.		

FSLTV12 – Procure to Pay monitoring (Detective)	(P2P), Private Patients lead (debtors), etc. Debtors Reporting		
FSLTV13 – Debtors / Cash monitoring (Detective)	Budget Holders / Capital leads, Capital Planning and Delivery Group, Fixed Asset Register		
FSLTV14 – Discretionary Capital Financial Planning and Reporting (Mitigating)	Programme SROs, Scheme of delegation, governance framework CP&D Group		
FSLTV15 – Major Capital Programmes monitoring (Detective)	Budget Holders, training Counter Fraud Reports		
FSLTV16 – Counter Fraud (Preventative)	Budget Holders, requisitioners, buyers, FA team, VAT Working Group, EY, HMRC		
FSLTV17 – Tax management (Detective)			
FSLTV18 – Procurement (Preventative)	Budget Holders, reporting, training, Procurement compliance reporting		

FDLTV18 – Procurement - Contract Management	<u>Additional assurance is provided by</u> Divisional Finance Reports, Trust Board finance reporting (incl. MMRs, Welsh costing returns) Committees and groups: QSP Committee, Audit Committee, PSPP Group, Capital Planning & Delivery Group, Executive Management Board, Strategic Development Committee, VBHC steering committee, VAT working group, etc. Internal Audit External Audit External oversight/advisory bodies incl NHS Exec (P&I) / WG / LHB Commissioners / HMRC		



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

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

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

Risk 06	There is a strategic risk that our people will not feel a sense of belonging, not feel valued in their roles, not understand how they contribute to organisational success, and will be unable to speak up in confidence, resulting in a negative impact on staff experience if we do not foster a cohesive culture in line with our organisational values												Date of Risk			Current Risk Score		
													April 2026			12		
													Last Review Date					
													July 2026					
Executive Summary	This strategic risk brings together the cultural factors that enable the Trust to deliver its core purpose (including values and behaviours, systems and processes) and the external and internal factors that affect the supply, shape and capacity of the workforce at organisational and multi-disciplinary team level. A People Strategy is in place with work programmes focused on enabling us to become an employer of choice, with the Healthy and Engaged and People Development and Education steering groups, as set out below.																	
	Work programmes are underway to address feedback and mitigate the risk through development, support, wellbeing and other interventions, including effective strategic and operational workforce planning focused on recruitment, retention and people development. In addition, the Trust is seeking to maximise workforce capacity through a reduction in absence levels, supported by wellbeing interventions and the application of workforce policies in a way that minimises harm to staff and teams.																	
	In April 2026 EMB reviewed the Trust Staff Survey result alongside the feedback from Line of Sight and agreed to adjust the Cultural Milestone Plan, agreed on 26 th March 2026, to focus on the following areas:																	
	- Executive recruitment - Leadership - Psychological safety - Supporting VCS to move to the new hospital																	
Associated Strategic Objectives	- Workforce sustainability (how we recruit, retain & develop our workforce capacity and capability) - Culture, values and behaviours / organisational development (belonging, inclusion, speaking up, leadership) - Staff wellbeing and engagement (reduce absence, improve staff experience) - Safe, high-quality care enabled by the workforce (because workforce culture/capacity directly affects patient and donor care)												Exec Lead			Director of People and OD		
													Assurance Level			3		
													Risk Appetite			Open		
Scoring	Inherent Risk			Q2 – 25/26			Q3 – 25/26			Q4 – 25/26			Q1 – 26/27			Target Risk		
	I	L	Score	I	L	Score	I	L	Score	I	L	Score	I	L	Score	I	L	Score
	4	4	16	3	4	12	3	4	12	3	4	12	3	4	12	3	2	6

06 - People and OD



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

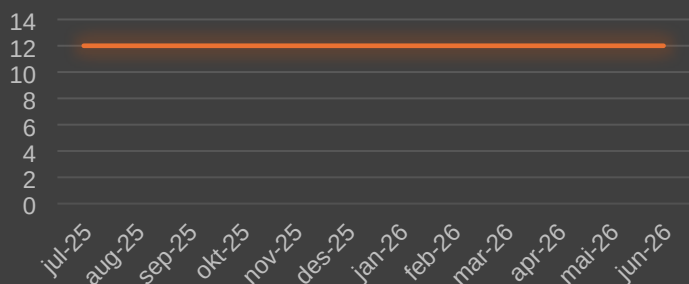
Action to Address Gaps	Action ID	Action Detail	Progress Notes	Action Lead	Target Date
	6.1	Implement the actions of the Trust Strategic Equality Plan, including embedding the Anti-Racist Wales Action Plan in the Trust	New reporting process to Welsh Government in place, with three categories scored out of 5. VUNHST reported 2 (Early Progress) for Workforce and Access and Experience and 3 (Results) for Overall. This report provides foundation for the 2026-27 SEP Action Plan. The received the WES report and Welsh Government feedback on the SEP maturity matrix giving scores of 1 for Workforce and Access and Experience and 2 for Overall. The feedback from both reports will be taken forward in the SEP actions for the remainder of 2026-27	OD Specialist	March 2027
	6.2	Implement the actions within the Health and Wellbeing Action plan – supporting wellness and managing action plan for sickness absence	The Staff Wellbeing service met increased demand in Q4 and provided support and sessions across all levels of the stepped care model. The business case for the Staff Psychology and Wellbeing Service is	OD Specialist	December.2026

			due to be taken through committees in August 2026 with a request for 12 months further funding.		
	6.3	Embed positive values and behaviours across the Trust to create positive culture. Cultural Baseline Review	This work is being progressed through the existing priorities of 1. Our Governance and Leadership work with Line of Sight 2. Executive team recruitment 3. Supporting Velindre Cancer Service to move 4. Staff Survey engagement and action planning (include learning from other sources, for example WRES/WES) 5. Wider leadership development. Capability and capacity required to complete the work. A programme of work for supporting nVCC and for embedding positive behaviours has been outlined with an external provider. The resources to enable this work to take place are being sought.	Interim Director of People and OD	December 25
Key Controls Established		Key Gaps in Controls	Assurance	Key Gaps in Assurance	
Strategy and organisational alignment: Trust strategies and enabling strategies (including the People Strategy) to set direction and align priorities. Leadership, behaviours and culture: values/behaviours framework and leadership development grounded in compassionate leadership. Workforce planning capability and governance: workforce planning methodology, training, dedicated		Control development required: further work is required to fully develop Communication and employee voice: communication infrastructure needs to be in place to support leadership messages and staff engagement, including employee voice	Executive Management Board (EMB) reporting People Development & Education Steering Group / People and Development Steering Groups Healthy and Engaged Steering Group (incl. wellbeing oversight) Routine monitoring through Senior Leadership Teams (SLTs) using workforce dashboards Recruitment metrics reporting (incl. NWSSP recruitment metrics) and divisional/strategic monitoring groups (e.g., Strategic Workforce Planning	Dedicated governance related to People and Culture. Internal governance progress in review.	

infrastructure, and embedded reporting/oversight arrangements. Recruitment, attraction and employer brand: consistent recruitment and selection processes and employer brand activity supported by recruitment metrics. Education and skills pipelines: education implementation planning and pathways to support new skills, new roles and development. Wellbeing and harm reduction: health and wellbeing infrastructure and embedding avoidable employee harm principles. Performance management and assurance: performance management frameworks and routine monitoring through governance forums. Service models and role clarity: clear service models and operational workforce plans aligned to service delivery. Inclusion and language standards: monitoring and improvement plans for Welsh Language Standards.		oversight) Reporting to EMB, Committees and the Trust Board (including cycles of business and committee reporting such as Supply & Shape/QSP reporting) Internal Audit reports Internal and External Audit Welsh Government reporting via JET and IMTP	

Risk 07	There is a strategic risk that insufficient investment, capacity and capability to maintain, replace and effectively utilise digital systems and infrastructure will result in system failures, cyber security vulnerabilities and limited digital transformation, leading to disruption to clinical services, reduced quality and efficiency of care constrained decision-making, systems the Trust fails to sufficiently consider, optimise the opportunities and effectively manage the risks of new and existing technologies, including considerations of Artificial Intelligence and Information Security.												Date Risk Raised			Current Risk Score		
													1 April 2026			12		
													Last Review Date					
													June 2026					
Executive Summary	Work is ongoing on the key controls - no movement to overall current risk scoring due to overall digital risk position and that system wide Cyber threat level remains high.																	
	The aggregate risk for National Programmes for RISP/EPMA/LIMS has been reduced as RISP is now live (April 26), EPMA is on track. There continues to be no go-live date agreed for Tranche 5 (Blood Transfusion) LIMS nationally, although the Trust is well placed with its internal preparations for LIMS and is providing additional support to the National Programme.																	
	Work on agreeing overall digital plans has made progress, with the Digital plan for nVCC Readiness now approved by the Executive. Additional capacity is required for this and additional funding has been made available.																	
	VUNHST Medical Director meeting with DHCW Medical Director in July to review clinical risks associated with DHCW.																	
	AI Policy has now been approved by Trust Board which gives the framework for AI work in the Trust underpinning the AI Strategy.																	
	The delivery of National Programmes through DHCW has now been moved into escalation Level 4: Targeted Intervention (was previously 3) in April 26.																	
	Key controls have been reviewed, gaps identified and action plan updated.																	
Risk score trend: The risk score has remained static since the last period.																		
Associated Strategic Objectives	- Quality, safety and experience - the risk explicitly impacts patient/donor care quality and service disruption - Service delivery / clinical effectiveness - system failures and limited digital transformation affect continuity and efficiency of clinical services - Innovation / digital transformation - the risk is fundamentally about inability to implement and optimise digital systems, including safe adoption of AI/technology - Organisational sustainability / resilience - cyber incidents and fragile infrastructure create operational and reputational exposure												Exec Lead			Chief Digital Officer		
													Responsible Committee			Quality, Safety and Experience		
													Assurance Level			3		
													Risk Appetite			Minimal		
Scoring	Inherent Risk			Q2 – 25/26			Q3 – 25/26			Q4 – 25/26			Q1 – 26/27			Target Risk		
	I	L	Score	I	L	Score	I	L	Score	I	L	Score	I	L	Score	I	L	Score
	4	4	16	4	3	12	4	3	12	4	3	12	4	3	12	4	2	8

07 - Digital



Associated Risks	Risk ID	Risk Title	Current Risk Score
	3643	There is a risk to patient safety as a result of an aged Laboratory Information System (SERIF) leading to RCI and Automated Testing being unable to operate a safe service.	16
	3922	There is risk to Multiple Domains as a result of the failure of the Blood Establishment Computer System, leading to compromised ability to supply blood to Wales.	15
	3646	There is a risk to that the WLIMS 2.0 go-live date will be delayed due to delays in the national programme timeline causing an impact on realising project outcomes and additional demand for further development of existing legacy systems.	20
	3632	There is a risk to Quality and Performance and Service Stability as a result of National Digital Programmes managed by Digital Health and Care Wales (DHCW) not being delivered to time/cost/quality for use by the Velindre Trust leading to disruption of the clinical model and the plan to transition services to the new Velindre Cancer Centre. The National DHCW programmes of concern for the Trust are RISP/WLIMS/EPMA.	16

Action to Address Gaps	Action ID	Action Detail	Progress Notes	Action Lead	Target Date
	07.01	Create the Trust Digital Reference Architecture to support C14 and others	National Target Architecture has been completed and is being formed into a set of business cases for presentation to the new Welsh Government. Digital Design Authority has now meets regularly. National Digital Blueprint is being developed by the CEO peer group which will address digital system leadership.	Chief Digital Officer	August 2026

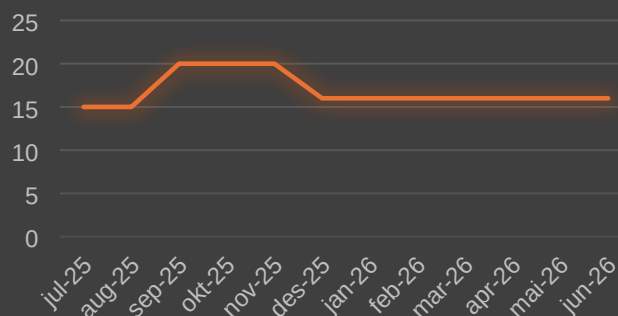
	07.02	Prioritisation framework needs to be established for the Data and Insight Service. Prioritisation framework to be introduced by Portfolio Team.	Ongoing. No consistent prioritisation framework is yet in use across the Trust. Data and Insight work continues to be prioritised locally by the team.	Director of Place, Portfolio and Partnership	March 2026
	07.03	Active participation in new Digital Data and Technology Leadership Group and Delivery Board. Agreed Trust's participation in the two groups and influence the scope.	DDAT Group have met three times and delivery board have met twice. The Trust has been represented in those meetings. A further Digital Advisory Group (consisting of the NHS Wales Digital Directors and Welsh Government) is now also in operation. This action is now complete.	Chief Digital Officer	April 2026 COMPLETE
	07.04	Complete digital diagnostic and the investment case for future investment in the digital service	Initial diagnostic has been completed and presented to Digital Programme Board and EMB. Focus has been on establishing nVCC Readiness digital workstream. Diagnostic work has been delayed by this priority.	Chief Digital Officer and Director of Finance	Sept 2026

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

Ring-fenced digital investment in Trust budget (benchmark 4%). Build digital resource capacity and capability. Digital inclusion in the wider community. Prioritisation and change framework for managing service requests. Reduce/monitor unsupported applications and legacy systems. Trust digital governance. Lead/lag indicator reporting integrated into the wider performance framework. Cyber assurance controls in place. Digital transformation guided by an agreed digital architecture (Design Authority being established). AI strategy, policies and guidance for implementation and maintenance. Trust Information Governance arrangements.		bodies (e.g., IQSG; Caldicott Guardian/SIRO/DPO; Clinical & Scientific Strategy Board). Internal Audit (recurring across controls), plus external/independent oversight where applicable (e.g., Cyber Resilience Unit/WG IQPD as competent authority for NIS, Digital Communities Wales accreditation, External Audit of accounts, ICO/Welsh Government, national programme governance/DDaT leadership boards).	

Risk 08	There is a strategic risk that the organisational and clinical governance arrangements do not provide appropriate mechanisms and culture to achieve our medium to long term objectives.												Date Risk Raised			Current Risk Score		
													February 2025			12		
													Last Review Date					
													June 2026					
Executive Summary	The Trust continues to work with Welsh Government and NWSSP to implement the recommendations of the review of NWSSP Accountability and Governance Arrangements.																	
	The Trust is working with an external expert advice provider on a review of the Board's structure and development programme has been completed due to commence in the new year. The new Board Committee structure is due for Board approval in July 2026 and implementation from September 2026.																	
	Risk score trend: The risk score has remained static since the last period.																	
Associate d Strategic Objectives	Outstanding for quality, safety and experience Be recognised as 'outstanding' by external regulators - Be an organisation that consistently demonstrated compassionate leadership in everything it does - Listen to and learn from patients' and donors' experiences of care to drive continuous improvement												Exec Lead			Director of Corporate Governance		
													Assurance Level			3		
													Risk Appetite			Minimal		
													Risk Appetite			Minimal		
Scoring	Inherent Risk			Q2 – 25/26			Q3 – 25/26			Q4 – 25/26			Q1 – 26/27			Target Risk		
	I	L	Score	I	L	Score	I	L	Score	I	L	Score	I	L	Score	I	L	Score
	4	4	16	3	5	15	4	5	20	4	3	12	4	3	12	4	2	8

08 - Governance



Associated Risks	Risk ID	Risk Title			Current Risk Score
	3656	There is a risk to the quality of clinical and corporate governance due to the current assurance and reporting arrangements of hosted services.			15
		Action Detail	Progress Notes	Action Lead	Target Date
	08.03	Review Trust Risk Policy	New policy, appetite statement and supporting procedures drafted. Being considered as part of wider governance improvement programme. Audit Committee consideration due in September 2026 as part of Governance Improvement Plan.	Director of Corporate Governance	September - 2026
	08.04	Ensuring accountability and ownership is in the right place, supported by effective structures, and is empowering for those delivering and those leading the delivery of high-quality services today and shaping our services for the future	Governance Improvement Plan includes the following activities to deliver action: - New Corporate Governance Manual as a means for ongoing reference and information on how Trust governance works and the standards set. - New Board Committee structure including new Terms of Reference, Cycles of Business, ways of working	Director of Corporate Governance	March 2027

			- New map outlining the Trust's governance framework from The review of the Trust's current governance structures will take into account changes to the Trust's work programme since the last review in 2020, to ensure we are fit for the future. - Work to review the current hosting arrangements underway and will consider Welsh Government review (July 2025).		
	08.07	Participate in WG implementation group re: NWSSP review of accountability and governance and implement recommendations in line with December 2025 statement.	Implementation group meeting on monthly basis. Recommendations re: NWSSP chair progressed. Recommendations re: clinical governance being considered by all parties.	Director of Corporate Governance	Nov.26
	08.09	New Board Development Programme delivered	12 month Board development programme to be considered by Trust Board in July 2026 for completion by March 2027.	Director of Corporate Governance	March 2027
	08.10	New Governance Improvement Plan delivered	Governance Improvement plan to be considered by Trust Board in July 2026 for completion by March 2027.	Director of Corporate Governance	March 2027
Closed Actions					
	08.01	External benchmarking of Governance, Assurance & Risk best practice as part of the Governance, Assurance & Risk programme of work.	Benchmarking integral to the development of the Board Development and Governance Improvement Plan. New Risk Management Framework and System Development informed by NHS Wales benchmarking. Supplier demonstration days held over May-June period to inform system replacement.	Director of Corporate Governance	April 2026
	08.02	Develop new plan for phase 2 GAR programme.	GAR programme stood down and amalgamated into governance	Director of Corporate Governance	December 2025

			improvement programme since March 2026.		
	08.05	Training programme to support Duty of Quality reporting, Quality Impact Assessment completion and Assurance Level awareness.	Ongoing programme of training in place and to be considered as part of Governance Improvement Plan. Key briefing documents shared with Trust Board members and available for staff.	Director of Corporate Governance/Executive Director Nursing, Allied Health Professionals and Health Scientists	Nov-25
	08.06	Coordinate policy review process and update Policy on Policies as standard operating procedure to support organisational development, compliance and awareness of policies.	Policy on Policies developed and approved by QSP Committee in November 2025. Policy review report considered by WSP Committee twice a year.	Director of Corporate Governance	Nov-25
Key Controls Established		Key Gaps in Controls	Assurance	Key Gaps in Assurance	

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

TRUST BOARD	
Board Committees Restructure	
DATE OF MEETING	30 July 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	Jolene Dalton, Interim Head of Corporate Governance
PRESENTED BY	Non Gwilym, Interim Director of Corporate Governance
APPROVED BY	Non Gwilym, Director of Corporate Governance (Interim)
EXECUTIVE SUMMARY	New Terms of Reference have been developed aligned to the Trust's new Board committee structure. A review of committee membership and Executive leads has been undertaken to ensure an appropriate balance of skills, experience and Executive leadership and support across each committee. This paper presents the Terms of Reference, membership and Executive level support for the revised committee structure which (following Board approval) will take effect from 31 July 2026.
RECOMMENDATION / ACTIONS	The Board is asked to APPROVE this paper, including: 1. the Committee structure and accompanying Terms of Reference presented as Appendix 1

	2. Proposed committee membership and Executive leads as presented in Appendix 2. The Board is also asked to NOTE the completion and sign-off of the Quality Impact assessment and Equality Impact Assessment available as Appendices 3 and 4.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	Date
Board Development	October 2025
Board Development	February 2026
Trust Board	March 2026
Trust Board	May 2026
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
7 LEVELS OF ASSURANCE	
N/A	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Select Current Level of Assurance
APPENDICES	
1	Trust Board Committee Structure and Terms of Reference
2	Board Committee membership and Executive support
3	Quality Impact Assessment (completed, signed)

1. SITUATION

Purpose

The purpose of this report is to seek Board approval for the new Terms of Reference developed to support the Trust's new Board committee structure. A review of committee membership and executive leads has also been undertaken to ensure an appropriate balance of skills, experience and executive leadership and support across each committee.

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

2. BACKGROUND

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

The new Committee structure was formally agreed by the Board on 26 March 2026.

The revised Committee structure requires updated Terms of Reference so that each Committee's remit, responsibilities, delegated authority and reporting arrangements are clearly defined and aligned to the new governance framework. The proposed Terms of Reference for each Committee are provided at Appendix 1 for Board consideration and approval.

Further, in line with the amended responsibilities of each Committee, a review of Committee membership and Executive support has proposed changes as attached at Appendix 2.

3. ASSESSMENT

Approval of the proposed changes will:

- Provide greater clarity regarding the role, responsibilities and delegated authority of each committee.
- Reduce duplication and strengthen accountability across the Board's governance framework.
- Ensure committee membership and executive leads reflect the skills, experience and capacity required to discharge committee responsibilities effectively.
- Improve alignment between committee work programmes and the Board's strategic objectives and assurance requirements.
- Demonstrate the Board's commitment to continuous improvement in governance and effective oversight.
- A suite of operational documents is in development to assist transition to the new structure and scheduled meetings in September. These include a new report template, new cycles of business for each committee, guidance on minute taking and a governance handbook on new ways of working which establishes standards, roles and responsibilities for all involved in the conduct of Board and Board Committee business.
- We are already undertaking engagement and communication with Trust services to support the change with more planned over the summer period and into September.
- Due to competing priorities, the Terms of Reference for the Charitable Funds Committee (CFC) have not progressed. They will be considered for endorsement by the CFC in September prior to Board approval at the end of the month.
- Following the Trust Board's consideration of the Terms of Reference, any further amendments required to Model Standing Orders will be presented to the Trust Board in September 2026.
- Each Committee will formally adopt its Terms of Reference and Cycle of Business during the September committee cycle.

- Further work is underway to improve key aspects of the Trust's governance arrangements including, Risk Management, Accountability and Performance Frameworks. Together, these activities will provide the Trust with a much-strengthened governance framework.

4. SUMMARY OF MATTERS FOR CONSIDERATION

The Board is asked to consider and **APPROVE** the following:

- The revised Terms of Reference for each Board Committee.
- The proposed committee memberships, including the appointment of Chairs, Vice-Chairs and Members.
- The implementation of the revised governance arrangements from the date of decision.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals:	
Choose an item	
If yes - please select all relevant goals:	
• Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development and innovation in our stated areas of priority ☒ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☒ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) For more information: STRATEGIC RISK DESCRIPTIONS	BAF 08 Organisational and Clinical Governance
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 ☒
QUALITY IMPACT ASSESSMENT	Yes - Fully completed and signed QIA Enclosed
TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT	
The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated. Please indicate whether any of the matters outlined in this report impact the Trust's Wellbeing goals: Choose an item	
If yes select the relevant goals: • A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities. ☒ • A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience. ☐ • A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health ☒ • A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances ☒ • A Wales of more Cohesive Communities - Attractive, viable, safe and well-connected communities. ☐ • A Wales of Vibrant Culture and Thriving Welsh Language -Promoting and protecting culture, heritage and the Welsh language, encouraging people to participate in the arts, and sports and recreation. ☐ • A Globally Responsible Wales – Consideration of whether an action may make a positive contribution to global well-being ☐	
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT	Not yet completed - Include further detail below why

	The EQIA is currently under review by the Equality Manager.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report. These Terms of Reference have been

6. RISKS

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

Velindre University NHS Trust
Consolidated Committee Terms of Reference

July 2026

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People, Culture and Engagement Committee

Terms of Reference

1. INTRODUCTION

In line with the Standing Orders and Scheme of Delegation, the Board shall annually establish a Committee to be known as the People, Culture and Engagement Committee (the Committee or PCEC).

The Committee will undertake its responsibilities in a manner aligned to the Trust's vision of Excellent Care, Inspirational Learning and Healthier People, together with the Trust's values and associated behaviours of being Caring, Respectful and Accountable. In doing so, the Committee will promote a culture of excellence, openness, inclusion, continuous improvement, and collective leadership.

The purpose and responsibilities of the Committee are set out in Sections 2 and 3. Common operating arrangements applicable across all board committees are set out in Appendix 1.

2. PURPOSE

The purpose of the People, Culture and Engagement Committee (PCEC) is to support the Board by providing strategic oversight and assurance in relation to the Trust's people agenda, organisational culture, engagement, leadership, and organisational development.

The Committee will provide assurance that effective strategies, systems and organisational arrangements are in place to enable a compassionate, inclusive and high performing organisation that reflects the Trust's values and behaviours, engages effectively with staff and stakeholders, and supports the delivery of safe, high quality and person-centred services. The Committee will also ensure that strategic and operational workforce, culture and engagement priorities support delivery of the Trust's objectives, the quality and safety of healthcare, and a positive working environment.

In doing so, the Committee will oversee delivery of relevant strategic priorities, enabling strategies and associated elements of the Integrated Medium-Term Plan (IMTP), providing assurance that these are implemented effectively and deliver the intended organisational outcomes. The Committee will maintain oversight of workforce, culture and engagement performance, risks, portfolio activity and planning arrangements within its remit, ensuring that significant issues, risks, opportunities and interdependencies are identified, monitored and escalated appropriately.

The Committee will not manage operational delivery or assume executive responsibility for services.

In forming its judgement, the Committee will consider whether assurance is reliable, complete, timely and demonstrates impact on outcomes, risk reduction or improvement.

3. SPECIFIC DUTIES / RESPONSIBILITIES

3.1. Workforce strategy, planning, and sustainability

The Committee will:

- Oversee the development and implementation of workforce strategy and provide assurance that workforce priorities and plans support delivery of organisational priorities, the IMTP and service requirements.
- Oversee workforce sustainability, capability, and capacity across the organisation, ensuring the Trust is appropriately positioned to meet current and future service requirements.
- Oversee workforce intelligence, horizon scanning and strategic workforce insight to identify emerging workforce risks, opportunities and external developments that may impact delivery of the Trust's strategic objectives, IMTP priorities and long-term ambitions, informing future workforce priorities and strategic workforce planning.
- Oversee the development of an integrated workforce performance dashboard to inform Board oversight, planning and decision-making.
- Receive assurance on workforce related delivery risks and the implementation and outcomes of relevant Portfolio initiatives.
- Consider workforce implications arising from service transformation, strategic programmes, and organisational change.
- Maintain oversight of workforce supply, recruitment, retention, vacancy management, succession, and workforce productivity and workforce performance.
- Oversee arrangements to ensure the Trust's values and associated behaviours are embedded and consistently demonstrated in practice across leadership, culture, workforce experience, and organisational delivery.

3.2. Culture and organisational experience

The Committee will:

- Provide oversight of organisational culture and seek assurance that the Trust promotes behaviours, leadership practices and ways of working that are consistent with its values and support a compassionate, inclusive, and high performing organisational culture.
- Oversee arrangements to support a compassionate, inclusive, and psychologically safe environment for staff.
- Receive assurance regarding staff wellbeing, experience, and engagement.

- Review organisational insight and thematic intelligence including staff stories, staff survey findings, engagement feedback, speaking up intelligence, workforce equality indicators, wellbeing measures, and workforce experience information.
- Seek assurance that learning arising from feedback and engagement activity is acted upon and embedded.
- Maintain oversight of Speaking Up Safely arrangements and psychological safety.
- Seek assurance that bullying, harassment, discrimination, and unacceptable behaviours are identified and addressed appropriately.

3.3. Engagement, Communications and Community Involvement

The Committee will:

- Provide strategic oversight of the Trust's approach to engagement and communications with external stakeholders and staff, ensuring that arrangements support openness, transparency, and effective dialogue with all stakeholders.
- Seek assurance that staff and external stakeholder communications and engagement activity is aligned to the Trust's strategic vision, objectives, values, organisational priorities, and organisational narrative.
- Seek assurance that communications activity supports a coherent organisational narrative and promotes understanding of the Trust's purpose, priorities and contribution across services and stakeholders.
- Seek assurance that all engagement and communications activity support delivery of the Trust's stakeholder strategy and contributes to organisational learning, improvement, and achievement of the Trust's organisational objectives.
- Monitor the effectiveness of staff and external stakeholder engagement and communications strategies, plans and delivery mechanisms, including how insight and feedback are captured, analysed, acted upon, and communicated back to stakeholders.
- Seek assurance that the Trust maintains constructive relationships with key external stakeholders, partners, and staff and that engagement activity supports trust, confidence, and collaboration.
- Receive assurance that engagement and communications activity reflect relevant statutory duties and organisational commitments, including equality, Welsh language, involvement, and social partnership requirements where applicable.

3.4. Leadership, learning, and organisational development

The Committee will:

- Oversee arrangements to strengthen leadership capability and organisational effectiveness.
- Seek assurance regarding leadership development, talent management, and succession planning.
- Maintain oversight of organisational development priorities and programmes.
- Monitor arrangements relating to education, learning, professional development, and continuous improvement.
- Seek assurance regarding statutory and mandatory training arrangements.
- Maintain oversight of appraisal, professional registration, and revalidation arrangements.
- Seek assurance that the Trust supports a culture of continuous learning and improvement.

3.5. Equity, equality, diversity, and inclusion

The Committee will:

- Provide strategic oversight of equity, equality, diversity, inclusion, and human rights, helping shape the Trust's ambitions and priorities in these areas and ensuring these principles are embedded within its culture, leadership, engagement and organisational priorities.
- Review and monitor progress against relevant equality objectives, standards, and associated improvement plans, seeking assurance that actions are delivering meaningful and measurable outcomes and improvements.
- Seek assurance that inclusive leadership and equitable workforce practices are embedded across the organisation, supporting a culture in which people feel valued, respected, and able to contribute.
- Review workforce equality information, lived experience, staff feedback and other relevant intelligence to identify disparities, barriers, and opportunities for improvement.

3.6. Workforce governance, partnerships, and employee relations.

The Committee will:

- Provide oversight of workforce governance arrangements and professional standards.
- Seek assurance regarding compliance with workforce policies, professional obligations, and safeguarding responsibilities.
- Maintain oversight of arrangements relating to professional conduct, registration, and associated workforce governance requirements.

- Oversee strategic workforce partnerships with education providers, external organisations, and system partners in support of workforce sustainability, workforce development, and organisational capability.
- Seek assurance that workforce governance arrangements support safe, effective and high-quality services.
- Oversee employee relations arrangements, including partnership working with Trade Unions, collective engagement mechanisms, and approaches to promoting constructive employment relations and effective resolution of workforce matters.

4. MEMBERSHIP

The Committee shall comprise:

- A minimum of three Independent Members of the Board, including:
 - One Independent Member appointed as Chair
 - One Independent Member appointed as Vice Chair
- The three Independent Members must include a member of the Quality, Safety and Experience Committee, and the Performance and Finance Committee to ensure consideration of interdependencies.

5. ATTENDANCE

- Attendance by the Executive Director of Organisational Development and Workforce is mandatory, and their Deputy should attend in exceptional circumstances such as annual leave, sickness, or other leave.
- In addition, as a minimum there must be two other Executive Directors in attendance from the following:
 - Executive Director of Nursing, Allied Health Professionals and Health Science
 - Executive Medical Director
 - Executive Director of Finance
 - Chief Operating Officer
 - Director of Corporate Governance
 - Assistant Director of Communications and Engagement
- It is expected that the Director of Strategy, Planning and Performance; and Director of Place, Portfolio and Partnerships will attend additional parts of the meeting to support any analysis relating to IMTPs or Portfolios, respectively.
- Additional attendees may attend meetings, in full or in part, as required to support the effective conduct of business and consideration of agenda items. Additional attendees may include other Executive Directors, subject matter leads, representatives from Cancer and Blood Services, Employee Relations representatives, and other Trust staff or external advisers as required by the Chair.

- Trade Union representatives will be invited to attend a minimum of two Committee meetings each year to support partnership working and provide workforce insight and engagement.

6. FREQUENCY

- Meetings will be held bi-monthly.
- Additional meetings may be convened by the Chair where urgent workforce, culture or organisational concerns require consideration.

Quality, Safety and Experience Committee

Terms of Reference

1. INTRODUCTION

In line with the Standing Orders and Scheme of Delegation, the Board shall annually establish a Committee to be known as the Quality, Safety and Experience Committee (the Committee or QSEC).

The Committee will undertake its responsibilities in a manner aligned to the Trust's vision of Excellent Care, Inspirational Learning and Healthier People, together with the Trust's values and associated behaviours of being Caring, Respectful and Accountable. In doing so, the Committee will promote a culture of quality, safety, continuous improvement, learning and person-centred care.

The purpose and responsibilities of the Committee are set out in Sections 2 and 3. Common operating arrangements applicable across all board committees are set out in Appendix 1.

2. PURPOSE

The purpose of the Quality, Safety and Experience Committee (QSEC) is to support the Board by providing strategic oversight and assurance in relation to quality, safety, clinical effectiveness, patient, donor and service user experience, quality governance and continuous improvement across the Trust.

The Committee will provide evidence-based assurance that effective leadership, systems, processes, controls and governance arrangements are in place and operating effectively to support the delivery of safe, person-centred services, compliance with quality standards, continuous improvement, organisational learning and reduction of unwarranted variation.

In doing so, the Committee will oversee delivery of relevant quality priorities and associated elements of the Integrated Medium-Term Plan (IMTP), providing assurance that risks, concerns, learning and opportunities relating to quality, safety, experience and clinical outcomes are appropriately identified, monitored and addressed.

3. SPECIFIC DUTIES / RESPONSIBILITIES

3.1 Quality Strategy, Governance and Improvement

The Committee will apply a structured assurance framework, and will:

- Seek assurance that quality governance arrangements support effective oversight, escalation and organisational learning.
- Undertake triangulation of quantitative, qualitative and intelligence-based information across domains such as patient, donor and service user safety,

workforce, culture and professional standards to support high quality care, and compliance with statutory requirements.

- Seek assurance that quality priorities, quality plans and delivery arrangements support organisational objectives, the IMTP and service requirements.
- Consider the quality implications of major service changes, pathway redesign, transformation programmes and organisational change.
- Seek assurance that robust quality impact assessment arrangements are in place for service redesign, transformation programmes, operational change and IMTP delivery.
- Maintain oversight of the Trust's Quality Management System and quality improvement arrangements.
- Review progress against quality priorities, improvement programmes and the Annual Quality Statement.
- Seek assurance that the Trust promotes a culture of continuous learning, improvement, openness and safety.
- Seek assurance that the Trust complies with the Duty of Quality and organisational quality governance requirements.

3.2 Patient, Donor and Service User Safety

The Committee will:

- Oversee arrangements to support patient, donor and service user safety and safeguarding.
- Seek assurance regarding compliance with patient, donor and service user safety requirements, Putting Things Right arrangements and relevant national guidance.
- Seek assurance that the Trust complies with the Duty of Candour, including openness, timely disclosure and learning.
- Review themes and trends arising from incidents, patient, donor and service user safety investigations, complaints, claims, inquests and serious events and seek assurance that reviews result in sustainable improvement.
- Ensure that safety systems support early identification and escalation of deteriorating risk trends.
- Maintain oversight of infection prevention and control arrangements.
- Receive assurance regarding medicines safety, medicines optimisation and high-risk therapies.
- Seek assurance that arrangements support the reduction of avoidable harm and continuous improvement in patient, donor and service user safety outcomes.

- Seek assurance that workforce capacity, capability, wellbeing and staffing arrangements support the safe, effective and sustainable delivery of high-quality care, recognising the relationship between workforce experience, organisational culture, patient safety and clinical outcomes, and drawing assurance from the People, Culture and Engagement Committee (PCEC) where appropriate.

3.3 Clinical Effectiveness and Outcomes

The Committee will:

- Oversee arrangements supporting clinical effectiveness and positive patient, donor and service user outcomes, ensuring improvement actions demonstrate measurable impact.
- Seek assurance regarding compliance with evidence-based standards, clinical guidelines and national requirements.
- Maintain oversight of clinical audit, quality improvement and clinical outcomes reporting.
- Review mortality, avoidable harm and learning from deaths arrangements where applicable.
- Maintain oversight of specialist standards, accreditations and peer review arrangements relevant to the Trust's services.
- Review benchmarking information and comparative data to identify opportunities for improvement.
- Review variation in clinical outcomes, performance and practice and seek assurance that unwarranted variation is identified, understood and addressed.

3.4 Patient, Donor and Service User Experience

The Committee will:

- Oversee implementation of strategy and arrangements supporting patient, donor, service user and community involvement and experience.
- Review themes and trends arising from feedback, complaints, concerns, surveys, engagement activity and patient, donor or service user stories.
- Receive assurance that the voice and lived experience of patients, donors, service users and communities informs continuous quality improvement and service development.
- Ensure that patient, donor, service user and community voice is systematically incorporated into assurance, decision-making and prioritisation.
- Seek assurance that experience data is used alongside safety and outcome data to inform triangulated assurance.

- Work with system partners to maintain oversight of patient, donor and service user experience across complex and long-term pathways.
- Seek assurance regarding end-of-life care experience.

3.5 Quality Intelligence, Assurance and Organisational Learning

The Committee will:

- Receive integrated quality intelligence and assurance drawn from national quality measures, the National Quality Management System, patient, donor and service user feedback, benchmarking information and external assurance activity.
- Ensure integration of quality, safety, experience, workforce and operational intelligence to form a whole-system view.
- Review quality indicators and quality metrics within the Integrated Performance Report.
- Undertake triangulation across quality, safety, experience, outcomes and assurance information to identify themes, trends, risks, opportunities and areas of unwarranted variation requiring action.
- Review findings arising from Internal Audit, External Audit and other assurance activity relevant to its remit.
- Seek assurance that recommendations arising from reviews, inspections and investigations are implemented effectively and learning embedded.
- Maintain oversight of high-risk and new innovative clinical pathways where quality, safety, experience or outcomes may be affected.
- Review quality trajectories and seek assurance where performance falls outside agreed standards, expectations or trajectories.

3.6 External Assurance, Regulation and Accreditation

The Committee will:

- Receive relevant national reports and Executive assurance regarding the Trust's response, implementation arrangements and progress against any associated recommendations.
- Receive all reports relating to WBS and VCC with regards to external assurance, regulation and accreditation and seek assurance that action plans are implemented, monitored and evaluated.
- Seek assurance that regulatory findings are translated into sustained continuous improvement and embedded learning across the organisation.
- Maintain oversight of compliance with relevant quality, safety and specialist service standards.

- Receive assurance on matters relating to Healthcare Inspectorate Wales, Llais, the Human Tissue Authority and other relevant bodies where applicable.
- Review significant concerns, findings or recommendations arising from Healthcare Inspectorate Wales, Audit Wales, regulators, inspectors, peer reviews, accreditation bodies and external reviews.

3.7 Digital Services, Transformation and Information Governance

The Committee will:

- Ensure digital risks are considered in the context of patient, donor and service user safety, clinical risk and service reliability.
- Oversee digital services, transformation programmes and digital governance arrangements within the remit of patient, donor and service user safety, clinical risk and service reliability.
- Seek assurance that digital systems and technologies support safe, effective and person-centred care.
- Maintain oversight of digital clinical safety arrangements and risks associated with clinical systems and digital pathways.
- Seek assurance that data supporting quality, safety, experience and clinical outcomes reporting is accurate, complete and timely.
- Receive assurance regarding information governance matters where these directly affect patient, donor and service user safety, clinical quality, confidentiality or patient, donor and service user experience.
- Sign off the annual Information Governance self-assessment and seek assurance on areas requiring improvement.
- Seek assurance regarding digital maturity, digital capability and the effectiveness of digital systems supporting Trust services.
- Review quality, safety and experience implications arising from digital transformation initiatives.
- Work collaboratively with the Performance and Finance Committee (PFC) to ensure digital investment, business cases and transformation priorities are considered alongside quality, safety, clinical risk and service delivery implications.

3.8 Research, Development and Innovation

The Committee will:

- Seek assurance regarding the quality, safety and governance implications of research, development and innovation activities to support safe effective and continuously improving services.

- Consider significant risks, concerns or learning arising from research and innovation activities that fall within the Committee's remit.
- Seek assurance that research and innovation activities support safe, effective and continuously improving services and are aligned with clinical governance and quality assurance frameworks.
- Work collaboratively with the Research, Development and Innovation Committee (RD&IC) to ensure appropriate oversight of the quality, safety and governance implications of research and innovation activities, referring significant quality, safety or clinical governance matters between Committees where appropriate.

4. MEMBERSHIP

Membership should collectively provide skills and expertise to support effective assurance, challenge and scrutiny and shall comprise:

A minimum of three Independent Members of the Board, including:

- o One Independent Member appointed as Chair
 - o One Independent Member appointed as Vice Chair
- The three Independent Members must include a member of the People, Culture and Engagement Committee, and the Performance and Finance Committee to ensure consideration of interdependencies.

5. ATTENDANCE

- Attendance by the Executive Medical Director and the Executive Director of Nursing, AHPs and Health Science is mandatory. Where one of these Executive Directors is unable to attend due to annual leave, sickness or other absence, their nominated Deputy should attend in their place. Attendance by Deputies in place of both Executive Directors should be exceptional and agreed with the Committee Chair.
- In addition, as a minimum there must be two other Executive Directors in attendance from the following:
 - o Executive Director of Organisational Development and Workforce
 - o Executive Director of Finance
 - o Chief Operating Officer
 - o Chief Digital Officer
- It is expected that the Director of Strategy, Planning and Performance; and Director of Place, Portfolio and Partnerships will attend additional parts of the meeting to support any analysis relating to IMTPs or Portfolios, respectively.
- Additional attendees may attend meetings, in full or in part, as required to support the effective conduct of business and consideration of agenda items. Additional attendees may include other Executive Directors, subject matter leads, representatives from Cancer and Blood Services, and other Trust staff or external advisers as required by the Chair.

- Patient, donor and service user representation in full or in part as required to support the effective conduct of business and consideration of agenda items.

6. FREQUENCY

- Meetings will be held bi-monthly.
- Additional meetings may be convened by the Chair where significant quality, safety, experience, clinical governance or regulatory matters require consideration.

Performance and Finance Committee

Terms of Reference

1. INTRODUCTION

In line with Standing Orders and the Trust's Scheme of Delegation, the Board shall nominate annually a Committee to be known as the Performance and Finance Committee (referred to as the Committee or PFC).

The Committee will undertake its responsibilities in a manner aligned to the Trust's vision of Excellent Care, Inspirational Learning and Healthier People, together with the Trust's values and associated behaviours of being Caring, Respectful and Accountable. In doing so, the Committee will support the effective stewardship of resources, delivery of organisational priorities and achievement of sustainable outcomes for patients, donors, service users and communities.

The purpose and responsibilities of the Committee are set out in Sections 2 and 3 while common operating arrangements applicable across all board committees are set out in Appendix 1.

2. PURPOSE

The purpose of the Performance and Finance Committee (PFC) is to support the Board by providing strategic oversight and assurance in relation to operational performance, financial sustainability, strategic planning, and the effective use of resources.

The Committee will provide evidence-based assurance that effective systems, processes and controls are in place to support delivery of the Trust's strategic objectives, Integrated Medium-Term Plan (IMTP), operational priorities and transformation programmes. In doing so, it will oversee delivery against agreed operational, financial and planning objectives, ensuring alignment between organisational priorities, service delivery, financial sustainability and long-term organisational goals.

The Committee will oversee arrangements supporting operational delivery, financial stewardship, strategic planning, and organisational resilience. It will seek assurance that risks, concerns and opportunities relating to operational performance, finance, planning and delivery are appropriately identified, monitored and addressed, and that recovery and improvement actions are implemented where performance or financial sustainability fall outside agreed expectations or trajectories.

The Committee will also provide assurance that planning arrangements support coordinated delivery of organisational objectives, maintain alignment between operational, financial, workforce and quality priorities, and enable effective management of interdependencies, risks and benefits across the Trust.

3. SPECIFIC DUTIES / RESPONSIBILITIES

3.1 Operational Performance and Delivery

The Committee will:

- Maintain oversight of operational performance and organisational delivery arrangements across the Trust with particular focus on areas presenting the greatest risk to the achievement of the Trust's strategic objectives.
- Review performance against key national, regional, local and internal operational targets, trajectories and priorities within the Committee's remit.
- Review operational performance through the Integrated Performance Report and associated delivery frameworks.
- Seek assurance where operational performance is deteriorating, outside agreed tolerance or where significant delivery risks are identified, including assurance regarding recovery, improvement and escalation arrangements.
- Review themes, trends, variation and emerging risks relating to operational delivery, productivity, capacity, flow and service performance.
- Maintain oversight of operational delivery across Velindre Cancer and Blood services, including high-risk, high-demand or high-impact pathways where delivery or sustainability may be affected.
- Seek assurance that operational delivery arrangements support sustainable delivery of safe, effective and person-centred services.
- Commission deep dives or focused reviews into operational services, pathways, programmes or areas of concern where appropriate.

3.2 Financial Planning, Performance and Sustainability

The Committee will:

- Maintain oversight of the Trust's financial planning, financial management and financial sustainability arrangements.
- Review of the Trust's Long-Term Agreements (LTA) arrangements.
- Review and recommend the Trust's Financial Plan and associated financial strategies to the Board.
- Review and recommend the Trust's Budget Setting Policy to the Board.
- Monitor financial performance against agreed plans, statutory financial duties and organisational objectives.
- Seek assurance regarding the Trust's cash management, liquidity, working capital and wider financial resilience.
- Seek assurance regarding financial recovery, mitigation and improvement arrangements where financial risks, pressures or variances are identified.

- Maintain oversight of productivity, efficiency and cost improvement programmes, seeking assurance regarding delivery, sustainability, value for money, quality impact and associated risks.
- Seek assurance that financial planning and resource allocation support delivery of the Trust's strategic objectives, operational priorities and IMTP commitments.
- Review long-term financial planning assumptions, affordability considerations and emerging financial pressures.
- Maintain oversight of financial risks associated with specialist, high-cost, high-demand or strategically significant services and pathways within the Committee's remit.
- Review relevant benchmarking information to support oversight of financial performance, productivity, value and organisational sustainability.

3.3 Strategic Planning and IMTP Delivery

The Committee will:

- Oversee the development, delivery and monitoring of relevant strategic plans, organisational delivery plans and Integrated Medium-Term Plan (IMTP) priorities within its remit.
- Review progress against strategic objectives, IMTP priorities, delivery trajectories and organisational milestones.
- Review barriers, dependencies, risks and emerging issues that may impact delivery of strategic objectives or IMTP commitments.
- Seek assurance that strategic planning arrangements align organisational priorities, operational delivery, financial sustainability, workforce requirements and quality objectives.
- Review strategic implications arising from national policy, regulatory developments, external reviews, audits or system-wide changes relevant to the Committee's remit.
- Seek assurance that enabling services, infrastructure and organisational arrangements support sustainable delivery of strategic objectives and organisational change.
- Seek assurance that relevant portfolio arrangements provide clear visibility of programme status, risks, dependencies, benefits and delivery confidence.

3.4 Capital Planning, Investment and Business Cases

The Committee will:

- Oversee the development and management of the Trust's capital planning arrangements and capital programme.

- Review and recommend the Capital Plan and associated investment priorities to the Board.
- Seek assurance regarding capital prioritisation, affordability, forecasting, delivery risks and mitigating actions.
- Review business cases, investment proposals and significant strategic developments in accordance with the Scheme of Delegation and Standing Financial Instructions.
- Recommend business cases above delegated approval thresholds to the Board where appropriate.
- Seek assurance that investment decisions support strategic objectives, operational delivery, organisational sustainability and long-term organisational priorities.
- Seek assurance that benefits realisation arrangements for major investments and programmes are clearly defined, measurable and effectively monitored.
- Review post-implementation evaluations, delivery outcomes and organisational learning arising from significant investments, programmes or capital developments.
- Work collaboratively with the Quality, Safety and Experience Committee (QSEC) to ensure digital investment, business cases and prioritisation appropriately reflect quality, safety, clinical and operational considerations.

3.5 Procurement and Commercial Governance

The Committee will:

- Maintain oversight of procurement, commercial and contractual governance within its remit.
- Review and approve Procurement Strategies and associated plans where delegated by the Board.
- Seek assurance that procurement and commercial activity comply with relevant legislation, governance requirements and Standing Financial Instructions.
- Maintain oversight of significant contracts, commercial arrangements and procurement-related risks within its remit.
- Seek assurance regarding effective contractual management arrangements.
- Approve contract awards and procurement decisions within delegated authority.
- Seek assurance that procurement and commercial arrangements support strategic objectives, operational delivery, organisational sustainability and value for money.

3.6 Emergency Preparedness, Operational Resilience and Health and Safety

The Committee will:

- Seek assurance that effective arrangements are in place to support Emergency Preparedness, Resilience and Response (EPRR), business continuity and organisational resilience.
- Maintain oversight of organisational resilience arrangements, including preparedness for operational disruption, major incidents, critical infrastructure failure and service continuity risks.
- Review relevant emergency preparedness plans, statutory submissions, assurance reports and improvement actions within the Committee's remit.
- Seek assurance that effective health and safety governance arrangements are in place, including compliance with relevant statutory, regulatory and NHS Wales requirements.
- Maintain oversight of organisational health and safety risks, including fire safety, water safety, workplace safety and operational infrastructure risks within its remit.
- Seek assurance that resilience, infrastructure and health and safety arrangements support safe, sustainable and effective operational delivery.

3.7 Partnerships, Hosted Services and Collaborative Arrangements

The Committee will:

- Maintain oversight of partnerships, hosted services, collaborative working and joint arrangements within its remit.
- Seek assurance that governance, financial, operational and performance frameworks relating to hosted services and collaborative arrangements are effective and aligned with Trust requirements.
- Seek assurance that risks arising from partnerships, hosted services and collaborative arrangements are appropriately identified, monitored, mitigated and escalated.
- Receive assurance regarding operational delivery, performance, governance and compliance within partnership and collaborative arrangements relevant to the Committee's remit.
- Seek assurance that partnership and collaborative working arrangements support strategic objectives, operational delivery, organisational resilience and long-term sustainability.

3.8 Performance Intelligence, Assurance and Organisational Insight

The Committee will:

- Review operational, financial and planning information through the Integrated Performance Report and associated assurance frameworks.
- Seek assurance that operational, financial, planning and delivery risks recorded on the Board Assurance Framework and Trust Risk Register are appropriately identified, monitored, mitigated and escalated.
- Review relevant Internal Audit, External Audit, regulatory and external review findings within the Committee's remit and seek assurance that agreed actions are implemented effectively.
- Review significant findings, recommendations or concerns arising from regulators, inspections, external reviews, audits or assessments relevant to the Committee's responsibilities.
- Seek assurance that action plans arising from performance concerns, external reviews or regulatory findings are implemented effectively and monitored appropriately.
- Undertake horizon scanning to identify emerging operational, financial, strategic or delivery risks relevant to the Committee's remit.
- Seek assurance that governance, risk management and organisational resilience arrangements support sustainable delivery of strategic priorities and IMTP commitments.
- Maintain oversight of compliance with relevant NHS Wales planning, performance, financial and organisational governance requirements within the Committee's remit.

3.9 Estates, Facilities and Sustainability

The Committee will:

- Oversee the Trust's strategic estates, facilities and sustainability arrangements, ensuring they support delivery of organisational priorities, strategic objectives and IMTP commitments.
- Seek assurance that estates, facilities and infrastructure planning is aligned with service development, operational requirements and long-term organisational sustainability.
- Maintain oversight of operational, financial, infrastructure and environmental risks arising from estates, facilities and sustainability matters.
- Review significant estates, facilities and sustainability programmes, developments and investment proposals within its remit.
- Seek assurance that equality and inclusion, sustainability and environmental objectives are appropriately reflected within strategic planning, estates development and operational delivery.

- Review significant incidents, risks or service impacts arising from estates, facilities or environmental matters and seek assurance regarding recovery and improvement actions.
- Seek assurance that relevant statutory, regulatory and NHS Wales requirements relating to estates, facilities, sustainability and the care environment are met.

4. MEMBERSHIP

The Committee shall comprise:

- A minimum of three Independent Members of the Board, including:
 - One Independent Member appointed as Chair
 - One Independent Member appointed as Vice Chair
- The three Independent Members must include a member of the People, Culture and Engagement Committee, and the Quality, Safety and Experience Committee to ensure consideration of interdependencies.

5. ATTENDANCE

- Attendance by the Executive Director of Finance, Chief Operating Officer and Director of Strategy, Planning and Performance is mandatory. Attendance by Deputies in place of both Executive Directors should be exceptional and agreed with the Committee Chair.
- The Executive Director of Finance and the Chief Operating Officer will work collaboratively to coordinate agenda planning, report commissioning, assurance and escalation arrangements. The Executive Director of Finance will have executive responsibility for coordinating and leading the committee.
- In addition, as a minimum there must be one other Executive Director in attendance from the following:
 - Executive Director of Organisational Development and Workforce
 - Executive Director of Nursing, AHPs and Health Science
 - Executive Medical Director
- It is expected that the Director of Place, Portfolio and Partnerships will attend parts of the meeting to support any analysis relating to IMTPs or Estates, Facilities and Sustainability, respectively.
- Additional attendees may attend meetings, in full or in part, as required to support the effective conduct of business and consideration of agenda items. Additional attendees may include other Executive Directors, subject matter leads, representatives from Cancer and Blood Services, and other Trust staff or external advisers as required by the Chair.

6. FREQUENCY

- Meetings will be held bi-monthly.
- The Chair may convene additional meetings where urgent or high-risk operational performance, finance, planning or organisational matters require consideration.

Audit and Risk Assurance Committee

Terms of Reference

1. INTRODUCTION

In line with the Standing Orders and Scheme of Delegation, the Board shall annually establish a Committee to be known as the Audit and Risk Assurance Committee (the Committee or ARAC).

The Committee will undertake its responsibilities in a manner aligned to the Trust's vision of Excellent Care, Inspirational Learning and Healthier People, together with the Trust's values and associated behaviours of being Caring, Respectful and Accountable. In doing so, the Committee will promote a culture of stewardship, accountability, openness, continuous improvement and effective assurance.

The Committee will operate using the Trust's System of Assurance Framework, which links strategic objectives, the principal risks to their achievement, the controls and mitigating actions in place, sources of assurance over the effectiveness of those controls, and reporting and escalation arrangements to the Board and Accountable Officer.

The Committee will use this Framework to plan and prioritise its work, assess whether assurance is comprehensive, reliable and evidence-based across all strategic objectives, evaluate the effectiveness of controls, and identify and monitor gaps in assurance or weaknesses in control, ensuring these are appropriately escalated.

In doing so, the Committee provides independent assurance to the Board and Accountable Officer on the effectiveness of the Trust's governance, risk management and internal control arrangements.

The purpose and responsibilities of the Committee are set out in Sections 2 and 3. Common operating arrangements applicable across all board committees are set out in Appendix 1.

2. PURPOSE

The purpose of ARAC is to support the Board and the Accountable Officer by providing strategic oversight and independent assurance in relation to governance, risk management, internal control and the effectiveness and adequacy of the Trust's overall assurance framework.

The Committee will advise the Board and Accountable Officer on whether the system of assurance is comprehensive, reliable and fit for purpose.

The Committee will assess the completeness of assurance coverage across all strategic objectives, the quality, reliability and integrity of assurance evidence received and the robustness of underpinning data and evidence.

The Committee will provide assurance that effective governance systems, control arrangements and assurance mechanisms are in place to support accountability,

stewardship, organisational resilience and informed decision making across the Trust.

In doing so, the Committee will oversee delivery of relevant governance priorities and assurance activities, providing assurance that governance, risk and control arrangements operate effectively and support delivery of the Trust's objectives. The Committee will also provide oversight of emerging governance and assurance matters and ensure that significant issues, risks and opportunities are identified, monitored and escalated appropriately.

The Committee does not manage operational risks, operate the Trust's system of internal control, or take executive decisions on governance matters. Instead, it provides independent oversight and challenge regarding the adequacy and effectiveness of the assurances provided by management, Internal Audit, External Audit and other independent assurance providers.

3. SPECIFIC DUTIES / RESPONSIBILITIES

3.1 Governance, risk and assurance

The Committee will:

- Oversee governance, risk management and assurance arrangements across the Trust.
- Seek assurance regarding the effectiveness and maturity of governance, assurance processes and internal control arrangements including those applied in the Trusts committees.
- Provide assurance that governance arrangements support the Annual Governance Statement and Annual Quality Statement.
- Maintain oversight of the Board Assurance Framework (BAF) and Corporate Risk Register (CRR), seeking assurance that principal risks, assurance gaps and control weaknesses are appropriately identified, managed and escalated.
- Maintain oversight of the effectiveness and integration of the Trust's governance and organisational frameworks, including arrangements supporting risk management, performance management, strategic planning and portfolio management, seeking assurance that these collectively support effective decision making and delivery of strategic priorities, the IMTP and associated enabling strategies.
- Maintain oversight of assurance mapping and seek assurance that assurance arrangements are proportionate, integrated and support effective board oversight.
- Seek assurance that governance arrangements support effective integration across the Committee structure and avoid unnecessary duplication or gaps in assurance.

- Undertake horizon scanning to identify emerging governance, assurance, control and strategic risks which may impact organisational objectives, resilience or sustainability.
- Maintain oversight of governance arrangements supporting organisational resilience and sustainability where these fall within the Committee's remit.
- Formally consider reports of non-compliance with Standing Orders and Standing Financial Instructions and make proposals to the Board on any action to be taken.
- Review annually the adequacy of arrangements for declaring, registering and handling board members' interests and report to the Board accordingly.
- Review at least annually the adequacy of arrangements for dealing with gifts, hospitality and sponsorship, informed by the relevant Trust registers and reports.
- Review annually the Standing Orders and all documents having effect as if incorporated within them, including Standing Financial Instructions and associated impact assessments, and report proposed amendments to the Board.
- Provide assurance to the Board on the effectiveness of arrangements for the reservation and delegation of powers.
- Assess the adequacy and effectiveness of the system of assurance, including whether controls are sound and complete, assurances are reliable and evidence-based and assurance gaps are clearly identified and addressed.
- Seek assurance that data underpinning assurances is valid, accurate, complete and timely.
- Provide assurance over clinical audit plans, effectiveness and delivery.
- Provide assurance to the Board of the effectiveness of its arrangements for handling reservations and delegations.
- The Committee will produce an annual report to the Board and Accountable Officer, including opinion on completeness and reliability of assurance, and view on effectiveness of risk management and internal control as well as commentary on the governance statement, quality statement and audit effectiveness.

3.2 Internal and external assurance

The Committee will:

- Oversee the effectiveness, independence and performance of Internal Audit arrangements.
- Review and approve the Internal Audit Strategy, Internal Audit Charter and annual Internal Audit Plan.
- Review Internal Audit and External Audit findings, recommendations and management responses.
- Seek assurance that agreed audit recommendations are implemented effectively and within agreed timescales.
- Receive and consider the Head of Internal Audit Opinion and relevant External Audit opinions and assess their implications for governance and assurance arrangements.
- Seek assurance that effective coordination exists across audit and assurance providers.
- Review the External Audit Annual Plan and associated fees, consider material changes to the Plan and seek assurance that an effective and cost-efficient external audit service is delivered.
- Ensure the external auditor is invited to attend each meeting of the Committee and that the Committee maintains an effective working relationship which respects auditor independence.
- Meet privately (without management present) at least annually with Internal Audit, External Audit, Counter Fraud and other assurance providers where appropriate to support independence of assurance arrangements.
- Undertake an annual review of the effectiveness of the Internal Audit function.

3.3 Counter fraud and governance concerns

The Committee will:

- Oversee arrangements to prevent, detect, investigate and respond to fraud, bribery, corruption and financial irregularity.
- Review and seek assurance on whistleblowing / speaking-up arrangements, enabling staff to raise concerns in confidence.
- Seek assurance regarding the effectiveness of counter fraud, anti-bribery and anti-corruption arrangements.
- Review significant investigations, governance concerns, emerging risks and control weaknesses relevant to the Committee's remit.

- Seek assurance that learning and recommendations arising from investigations and reviews are implemented effectively and embedded.
- Seek assurance that arrangements support a culture of openness, accountability and appropriate escalation of concerns.

3.4 Financial governance and stewardship

The Committee will:

- Seek assurance regarding the adequacy and effectiveness of financial governance, stewardship and internal financial control arrangements.
- Review the governance and assurance aspects of the annual accounts process, Annual Governance Statement and associated disclosures prior to Board approval.
- Review the annual accounts in detail, including significant accounting policies and judgments, unadjusted misstatements, management representations and external audit findings and ISA 260 reports.
- Review significant governance and control issues arising from financial reporting or audit findings.
- Seek assurance regarding compliance with relevant governance, accountability and public sector financial requirements.
- Seek assurance that arrangements support value for money, propriety and effective stewardship of public resources.
- Approve arrangements relating to the discharge of the Trust's responsibility as a bailee for patients' donors and service users' property and review assurance on their operation.
- Approve the write-off of losses and the making of special payments within delegated limits and receive regular reports on losses, special payments and related trends.
- Receive reports at each meeting on losses and special payments, including frauds, thefts, arson, suspected irregularities and action taken.
- Receive reports on Single Quotation Applications, Single Tender Applications and exceptional procurement departures, and consider whether further action, review, training or escalation is required.
- Receive regular reports on free-of-charge services provided to the Trust and seek assurance that these do not create unmanaged governance, procurement or value for money risks.

- Receive the outcome of periodic reviews of banking arrangements and seek assurance that banking controls remain efficient, effective and represent value for money.

3.5 Information governance, cyber security and digital assurance

The Committee will:

- Oversee information governance, cyber security and digital assurance arrangements.
- Seek assurance regarding governance, risk management and internal control arrangements relating to cyber resilience, confidentiality, data protection, information assets and digital assurance.
- Seek assurance that significant information governance, cyber security and digital assurance risks are appropriately identified, monitored and escalated.
- Review organisational learning arising from cyber incidents, digital assurance reviews and information governance events.
- Maintain effective interfaces with other Board Committees where information governance, cyber security or digital assurance matters impact broader organisational priorities.

3.6 Hosted services and partnership governance

The Committee will:

- Seek assurance that hosted services, partnerships and collaborative arrangements operate within effective governance, accountability and assurance frameworks.
- Maintain oversight of governance arrangements supporting hosted services and partnership delivery models.
- Seek assurance that accountability, escalation and reporting arrangements are clearly defined and operate effectively.
- Seek assurance that governance and assurance arrangements support organisational resilience and effective stewardship across collaborative arrangements.

3.7 Governance reporting and statutory assurance

The Committee will:

- Review evidence supporting the Annual Governance Statement and Annual Quality Statement and advise the Board on completeness and accuracy. Provide formal advice to the Board on consistency of disclosures with assurance received and completeness of the assurance framework.

- Seek assurance that governance, assurance and accountability requirements are effectively implemented.
- Review findings arising from governance reviews, inspections and external assessments relevant to the Committee's remit.
- Seek assurance that actions arising from governance reviews and assessments are implemented effectively and within agreed timescales.
- Consider assurance and insight from other Board Committees and refer matters where detailed review is more appropriately undertaken elsewhere.

4. MEMBERSHIP

The Committee shall comprise:

- A minimum of three Independent Members of the Board including:
 - One Independent Member appointed as Chair
 - One Independent Member appointed as Vice Chair
- The three Independent Members must include a member of the People, Culture and Engagement Committee, the Quality, Safety and Experience Committee, and the Performance and Finance Committee to ensure consideration of interdependencies.
- At least one Independent Member must have significant financial, audit, governance or risk management expertise.

Members must receive induction and ongoing training in governance, risk and assurance.

The Chair of the Board should not be a member of ARAC.

5. ATTENDANCE

Attendance by the Director of Finance and Director of Corporate Governance is mandatory.

Regular attendees will include:

- Internal Audit representatives
- External Audit representatives
- Counter Fraud representatives

Additional attendees may attend meetings, in full or in part, as required to support the effective conduct of business and consideration of agenda items. Additional attendees may include Executive Directors and senior leaders with responsibility for governance, risk management, performance management, strategic planning, and portfolio management arrangements, together with information governance and

cyber specialists, representatives from hosted services, external advisers and other Trust staff as required by the Chair.

The Committee may request private meetings with audit and assurance providers where appropriate to support independence of assurance arrangements.

6. FREQUENCY

- Meetings will be held quarterly.
- A minimum of five meetings per year, with the fifth meeting dedicated to the review of the Annual Accounts, Annual Report and Accountability Agreement.
- Additional meetings may be convened by the Chair where urgent governance, assurance, audit, cyber security, or risk matters require consideration.

Research, Development and Innovation Committee Terms of Reference

1. INTRODUCTION

In line with the Standing Orders and Scheme of Delegation, the Board shall annually establish a Committee to be known as the Research, Development, and Innovation Committee (the Committee or RD&IC).

The Committee will undertake its responsibilities in a manner aligned to the Trust's vision of Excellent Care, Inspirational Learning and Healthier People, together with the Trust's values and associated behaviours of being Caring, Respectful and Accountable.

In doing so, the Committee will promote a culture of curiosity, learning, collaboration, innovation, and continuous improvement, recognising the important role that research, development and innovation play in improving outcomes for patients, donors and service users advancing knowledge and supporting organisational sustainability.

The purpose and responsibilities of the Committee are set out in Sections 2 and 3. Common operating arrangements applicable across all board committees are set out in Appendix 1. An overview of the RD&I governance structure and reporting arrangements is provided in Appendix 2.

2. PURPOSE

The purpose of the RD&I is to provide strategic oversight and assurance in relation to the Trust's research, development and innovation activities, ensuring they support delivery of the Trust's strategic objectives, improve outcomes for patients, donors and service users, and contribute to organisational learning, service transformation and long-term sustainability.

The Committee will oversee the development and delivery of the Trust's RD&I strategy, plans and priorities, ensuring alignment with the Trust's strategic objectives, Integrated Medium-Term Plan (IMTP), and long-term ambitions. It will seek assurance that appropriate arrangements are in place to support high-quality research, innovation, governance, workforce capability, and regulatory compliance.

The Committee will promote a culture in which research, development and innovation are recognised as core enablers of improved outcomes, continuous improvement, and future organisational success, while supporting the Trust's ambition to strengthen its research profile, partnerships, influence, and impact.

3. SPECIFIC DUTIES / RESPONSIBILITIES

3.1. Research, Development and Innovation Strategy

The Committee will:

- Oversee the development, implementation and periodic review of the Trust's Research, Development, and Innovation Strategy.
- Provide strategic oversight of RD&I priorities, ensuring alignment with the Trust's strategic objectives, organisational priorities, IMTP and long-term ambitions.
- Undertake horizon scanning to identify emerging research, innovation, scientific, technological and policy developments that may create opportunities or risks for the Trust.
- Seek assurance that RD&I activity contributes to improved outcomes, organisational development, and delivery of strategic priorities.
- Receive assurance regarding the delivery of RD&I-related programmes, initiatives, and portfolio activities, ensuring they support delivery of the Trust's strategic objectives and RD&I priorities.
- Seek assurance that research, development and innovation activity delivers measurable benefits, impact and value for patients, donors, service users, staff and the wider organisation.

3.2. Research Governance, Assurance and Compliance

The Committee will:

- Oversee research governance arrangements and seek assurance that they are effective, proportionate and support delivery of high-quality research and innovation activity.
- Seek assurance that the safety, rights, dignity and wellbeing of participants remain paramount in all research activity.
- Seek assurance that RD&I activities comply with relevant legislation, regulatory requirements, ethical standards and national policy frameworks.

- Review significant governance concerns, incidents, risks, investigations and compliance matters relating to RD&I activities.
- Seek assurance that learning arising from reviews, audits, inspections and investigations is implemented effectively and embedded.
- Work collaboratively with the Quality, Safety and Experience Committee (QSEC) to ensure appropriate oversight of the quality, safety and governance implications of research, development and innovation activities, referring matters where they fall within the remit of the respective Committee.

3.3. Partnerships, Collaboration and External Influence

The Committee will:

- Maintain oversight of strategic partnerships that support research, development and innovation activity.
- Promote collaboration with NHS Wales organisations, universities, Cardiff Health Partners and other research and innovation networks.
- Seek assurance that partnership arrangements support the Trust's strategic objectives and maximise opportunities for collaboration, influence and impact.
- Monitor developments within the wider research and innovation landscape and consider opportunities for strategic engagement and leadership.
- Oversee arrangements to benchmark the performance of the Velindre Cancer Service and Welsh Blood Service against comparable leading UK and international research centres.
- Maintain oversight of the strategic approach to achieving and retaining Organisation of European Cancer Institutes (OECI) accreditation.

3.4. Innovation, Culture and Future Opportunities

The Committee will:

- Promote innovation and support the identification, evaluation and development of opportunities that may improve outcomes, services or organisational performance.
- Promote a culture in which research, development and innovation are embedded within clinical practice, service improvement, organisational learning and strategic decision-making.
- Seek assurance that staff are supported and encouraged to participate in research, development and innovation activity where appropriate.

3.5. Workforce, Capability and Organisational Learning

The Committee will:

- Oversee arrangements to develop and sustain the workforce capability required to deliver the Trust's RD&I ambitions.
- Seek assurance that workforce development, leadership development and succession arrangements support delivery of RD&I priorities.
- Promote continuous learning and knowledge sharing arising from research and innovation activity.

3.6. Funding, Investment and Business Cases

The Committee will:

- Oversee arrangements to secure, manage and maximise research, innovation and grant funding opportunities.
- Monitor the financial sustainability and effectiveness of the Trust's RD&I activities.
- Review significant RD&I investment proposals and business cases,
- Scrutinise proposals seeking charitable funding and provide recommendations to the Charitable Funds Committee where appropriate.
- Review and scrutinise proposals seeking funding from the Advancing Radiotherapy Cymru (ARC) programme.
- Seek assurance that RD&I investment and expenditure is appropriately governed, managed and reported.

4. MEMBERSHIP

The Committee shall comprise:

- A minimum of three Independent Members of the Board, including:
 - One Independent Member appointed as Chair
 - One Independent Member appointed as Vice Chair
- The Committee may co-opt additional independent members from outside the organisation where specialist knowledge or expertise would support the discharge of its responsibilities.

5. ATTENDANCE

- Attendance by the Executive Medical Director is mandatory, and their Deputy should attend in exceptional circumstances such as annual leave, sickness, or other leave.
- In addition, as a minimum there must be two other Executive Directors in attendance from the following:
 - Executive Director of Organisational Development and Workforce
 - Executive Director of Nursing, Allied Health Professionals and Health Science

- o Executive Director of Finance
 - o Chief Operating Officer
- Additional attendees may attend meetings, in full or in part, as required to support the effective conduct of business and consideration of agenda items. Additional attendees may include Executive Directors, clinical leaders, research and innovation leads, finance representatives, patient, donor, and service user representatives, university and NHS Wales partners, charitable funding representatives and other individuals as required by the Chair.

6. FREQUENCY

- Meetings will be held quarterly.
- Additional meetings may be convened by the Chair where significant RD&I, governance, funding, partnership or strategic matters require consideration.

New Velindre Cancer Centre Committee

Terms of Reference

1. INTRODUCTION

In line with the Standing Orders and Scheme of Delegation, the Board shall establish a Committee to be known as the new Velindre Cancer Centre Committee (the Committee or nVCC).

The Committee will undertake its responsibilities in a manner aligned to the Trust's vision of Excellent Care, Inspirational Learning and Healthier People, together with the Trust's values and associated behaviours of being Caring, Respectful and Accountable.

The Committee has been established as a time-limited Board Committee to provide strategic oversight of the new Velindre Cancer Centre (nVCC) Programme and its constituent projects, including construction, commissioning, operational readiness and transition into the new facility. In doing so, the Committee will provide enhanced scrutiny, challenge and assurance regarding programme delivery, governance, financial performance, risk management, dependencies and benefits realisation.

The Committee will remain in place until the Board is satisfied that the Programme has achieved its objectives, services have successfully transitioned into the new facility, and appropriate arrangements have been established to support transition into operational and business-as-usual governance arrangements.

The purpose and responsibilities of the Committee are set out in Sections 2 and 3. Common operating arrangements applicable across all board committees are set out in Appendix 1. An overview of the nVCC governance structure and reporting arrangements is provided in Appendix 2.

2. PURPOSE

The purpose of the nVCC Committee is to provide strategic oversight, independent scrutiny and assurance to the Board regarding the successful delivery of the nVCC Programme and its constituent projects.

The Committee will seek assurance that the Programme is delivered in accordance with approved objectives, scope, timescales, budget and anticipated benefits, and that effective arrangements are in place to support commissioning, operational readiness, service transition and the safe commencement of services within the new facility.

In doing so, the Committee will provide constructive challenge and independent scrutiny of programme governance, performance, financial management, risks, dependencies and assurance arrangements, ensuring that significant issues, opportunities and decisions are identified, managed and escalated appropriately to support successful delivery of the Programme.

3. SPECIFIC DUTIES / RESPONSIBILITIES

3.1. Programme Strategy, Scope and Benefits Realisation

The Committee will:

- Oversee the strategic direction of the Programme, ensuring continued alignment with Board approved objectives, scope and intended outcomes.
- Seek assurance that the Programme remains aligned with organisational priorities, external requirements and the wider strategic context within which the Trust operates.
- Maintain oversight of Programme benefits, ensuring appropriate arrangements are in place to monitor, evaluate and realise anticipated benefits and outcomes.
- Consider significant proposed changes to Programme scope, objectives, benefits or strategic direction and provide assurance to the Board as appropriate.

3.2. Programme Delivery, Performance and Dependencies

The Committee will:

- Scrutinise Programme delivery and performance, seeking assurance that progress remains consistent with approved plans, milestones and timescales.
- Receive assurance regarding delivery of constituent projects and workstreams, including progress against the master programme plan and critical path.
- Maintain oversight of key dependencies, interfaces and enabling activities, seeking assurance that these are appropriately managed and coordinated.
- Seek assurance that programme delivery confidence, readiness assessments and exception reporting provide an accurate and timely assessment of the Programme's ability to achieve key milestones and operational objectives.

3.3. Governance, Risk and Assurance

The Committee will:

- Oversee Programme governance arrangements and seek assurance that they remain effective, proportionate and aligned with recognised project and programme management standards.
- Scrutinise Programme risks, issues and mitigating actions, seeking assurance that risks are appropriately identified, managed, escalated and monitored.

- Receive and review relevant internal audit reports, gateway reviews, independent assurance reviews and other sources of assurance relating to the Programme.
- Seek assurance that recommendations arising from audits, reviews and assurance activity are implemented effectively and on a timely basis.
- Provide assurance to the Board regarding the effectiveness of Programme governance, risk management and assurance arrangements.

3.4. Financial Stewardship and Commercial Oversight

The Committee will:

- Maintain oversight of Programme expenditure, affordability and financial performance.
- Seek assurance that Programme resources are managed effectively and that expenditure remains within approved budgets and delegated authorities.
- Review significant financial, commercial and contractual matters relating to the Programme, including the Mutual Investment Model, and provide assurance to the Board where appropriate.
- Seek assurance that robust arrangements are in place to support value for money, financial control and effective stewardship of public resources.
- Seek assurance that contractual obligations, key commercial milestones and associated commitments are being delivered in accordance with approved agreements and that significant contractual risks are identified and managed appropriately.

3.5. Operational Readiness, Transition and Mobilisation

The Committee will:

- Oversee arrangements supporting operational readiness, transition, mobilisation and safe occupation of the new Velindre Cancer Centre.
- Seek assurance that transition and mobilisation plans are aligned to Programme milestones and support safe, effective and uninterrupted service delivery.
- Maintain oversight of organisational readiness across workforce, clinical, operational, digital, estates and support services, including testing, commissioning and contingency arrangements.
- Receive assurance that statutory, regulatory, licensing, compliance and governance requirements necessary for occupation and operation of the facility have been achieved.

- Monitor readiness for opening and receive assurance that criteria for safe occupation, service transfer, stakeholder engagement and commencement of operations have been met.
- Seek assurance that arrangements support the safe continuity of patient care and minimise disruption to patients, staff and services throughout transition and mobilisation.
- Receive assurance that operational readiness, commissioning, rehearsals, testing and contingency arrangements have been completed and demonstrate readiness for safe occupation and commencement of services.

3.6. Programme Closure, Handover and Benefits Realisation

The Committee will:

- Maintain oversight of arrangements supporting Programme closure, handover and transition to business-as-usual arrangements.
- Seek assurance that Programme deliverables have been completed, accepted and transferred to operational ownership, together with any associated assets, services, risks and ongoing obligations.
- Receive assurance that the Programme has delivered its intended objectives and benefits, and that arrangements are in place to monitor ongoing benefits realisation.
- Provide assurance to the Board on Programme closure, residual risks and organisational learning, supporting the Senior Responsible Owner in determining readiness for formal closure.

4. MEMBERSHIP

The Committee shall comprise:

- A minimum of three Independent Members of the Board, including:
 - One Independent Member appointed as Chair
 - One Independent Member appointed as Vice Chair
- The Committee may co-opt additional independent members from outside the organisation where specialist knowledge or expertise would support the discharge of its responsibilities.

5. ATTENDANCE

- Attendance by the Chief Executive Officer, as Senior Responsible Officer (SRO) for the Programme, is mandatory and a nominated Deputy should attend only in exceptional circumstances such as annual leave, sickness or other leave.
- In addition, as a minimum there must be two other Executive Directors or designated senior officers in attendance from the following:

- o Director of Place, Portfolio & Partnerships
- o Chief Operating Officer
- o Executive Director of Finance
- o Executive Medical Director
- o Executive Director of Nursing, Allied Health Professionals and Health Science
- o Executive Director of Organisational Development and Workforce
- o Director of Corporate Governance
- Additional attendees may attend meetings, in full or in part, as required to support the effective conduct of business and consideration of agenda items. Additional attendees may include the nVCC Project Director, Director of Estates, programme and project leads, technical advisers, external assurance providers, commercial advisers, Welsh Government representatives, NWSSP representatives and other individuals as required by the Chair.

6. FREQUENCY

- Meetings will normally be held monthly.
- Additional meetings may be convened by the Chair where significant programme, governance, financial, risk, assurance or strategic matters require consideration.

REMUNERATION AND TERMS OF SERVICE COMMITTEE

TERMS OF REFERENCE AND OPERATING ARRANGEMENTS

1. INTRODUCTION

- 1.1 The Trust's Standing Orders provide that *'the Board may and, where directed by Welsh Government must, appoint committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees.*
- 1.2 In line with Standing Orders and the Trust's Scheme of Delegation, the Board shall nominate annually a Committee to be known as the **Remuneration & Terms of Service Committee**. The detailed Terms of Reference and operating arrangements set by the Board in respect of this Committee are set out below.
- 1.3 The committee will play an important role in supporting the Board in the fulfilment of its responsibilities by:
 - Providing advice on strategic development and performance within its Terms of Reference;
 - Undertaking scrutiny and gaining assurance on key aspects of organisational performance and supporting the achievement of the Trust's specific goals;
 - Carrying out responsibilities as detailed below on the Board's behalf.

2. PURPOSE

- 2.1 The purpose of the Remuneration & Terms of Service Committee (the Committee) is to:
 - **Approve** on behalf of the Board, matters relating to the appointment, termination, remuneration, terms of service and appraisal for the Chief Executive, Executive Directors, and other senior staff (including Interim Director roles) within the framework set by Welsh Government and in accordance with Standing Orders; and
 - **Provide Assurance** to the Board in relation to the Board's arrangement for the remuneration and terms of service, including contractual arrangements, for all staff, in accordance with the requirements and standards determined for the NHS in Wales
- 2.2 Perform certain, specific tasks as set out in delegated powers on behalf of the Board.
- 2.3 The Committee shall have no powers to develop or modify existing pay schemes.

- 2.4 In alignment with the Wellbeing of Future Generations (Wales) Act 2015, this committee will adopt a long-term perspective in its deliberations and decisions and consider the broader implications of its actions,

3. DELEGATED POWERS

- 3.1 With regard to its role in acting on behalf of the Board, and in providing advice and assurance to the Board, the Remuneration Committee will comment specifically upon:

3.1.1 Remuneration, terms of service for the Chief Executive, Executive Directors, other Very Senior Managers (VSMs) (including Interim arrangements) not covered by Agenda for Change; ensuring that the policies on remuneration and terms of service as determined from time to time by Welsh Government are applied consistently.

3.1.2 Approve on behalf of the Board the appointment, appraisal, discipline and dismissal of any Board level Executive appointments and other senior employees, including interim arrangements.

3.1.3 Note the objectives set for the CEO by the Chair as required by the Cabinet Minister for Health and Social Care and review performance of the Chief Executive, Executive Directors and other VSMs.

3.1.4 Ensure that Performance Management systems are in place for those in the positions mentioned above and review and ratify performance assessments

3.1.5 Proposals regarding termination arrangements, ensuring the proper calculation and scrutiny of termination payments in accordance with the provision of the regulations and in accordance with Ministerial Instruction and Welsh Government.

3.1.6 Consideration of anonymous correspondence relating to complaints relevant to the committee as set out within the Anonymous Communications Policy.

3.1.7 Consideration and approval of Voluntary Early Release Scheme (VERS) applications and redundancy/ severance payments in respect of Executive Director/ Director posts, in line with Standing Orders and extant Welsh Government Guidance.

3.2 The Committee is to be advised of **all** VERS applications and severance payments and will seek assurance that these posts are not re-introduced.

3.3 Approve any Strategic Advisor arrangements, including scope and pay.

3.4 In developing remuneration packages the Committee will ensure that there is:

3.4.1 A clear statement of responsibilities of the individual posts and their accountabilities of meeting objectives of the organisation.

3.4.2 A means of assessing the comparative job weight.

3.4.3 Comparative salary information from the NHS, other public sector organisations and industry service organisation

3.5 The committee may, subject to the approval of the Board, establish sub committees or task and finish groups to carry out on its behalf aspects of committee business.

4. RISK AND AUDIT

The committee will monitor the principal risks relevant to its remit and consider the control and mitigation of high-level related risks and provide assurance to the Board that such risks are being effectively controlled and managed. It will also review and audit findings relevant to its remit.

5. AUTHORITY

- 5.1 The committee is authorised to approve those matters listed above.
- 5.2 The committee is authorised by the Trust Board to investigate, or have investigated, any activity within its Terms of Reference. In doing so, it will have the right to seek any information it requires from any employee or inspect any books, records or documents relevant to its remit, ensuring patient/client and staff confidentiality as appropriate. All employees are directed to cooperate with any reasonable requests made by the committee.
- 5.3 The committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements
- 5.4 The Chair of the Committee, may, when it is not practicable to convene a meeting have the authority to approve VERS applications between meetings with advice from the Director of Organisational Development and Workforce and the Board Secretary as appropriate. In such instances the Board Secretary will ensure that the action is formally recorded and reported to the next meeting of the committee for consideration and ratification.

6. MEMBERSHIP

- 6.1 A minimum of four members comprising:
 - Chair or Vice-Chair of the Board, in the event of the Chair being absent for any reason then the Vice-Chair would automatically substitute with full voting rights
 - Chair of the Audit and Risk Assurance Committee
 - Chair of the People, Culture and Engagement Committee
 - One other nominated Independent Member
 - The Trust Chair may, from time to time determine that the business of the Remuneration and Terms of Service Committee requires the attendance of all Independent Members, and as such may extend an invitation to Independent Members to attend for a single item of business or a meeting as appropriate.
 - In the event of long-term absence of a member of the committee, the Chair will be authorised to appoint an alternative independent member of the Board as a long term substitute without the need for a Board decision, whilst a more permanent arrangement is sought.
- 6.2 In attendance by invitation of the Committee Chair:
 - The Chief Executive (except when issues relating to the personal remuneration are being discussed)

- The Executive Director of Organisational Development and Workforce.
- Any other Trust officials, including a Trade Union Representative and/or any others from within or outside the organisation to attend for a single item of business or a meeting as appropriate (except when issues relating to their personal remuneration are being discussed)
- Executives may send deputies in their absence who will act with their full authority. To instigate a substitute arrangement, the Executive Director must notify the Board Secretary before the day of the meeting that they are unable to attend and provide the name of the appointed substitute.

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7. COMMITTEE MEETINGS

7.1 Quorum

At least two members must be present to ensure the quorum of the meeting, including either the Chair or Vice Chair of the Committee.

7.2 Secretariat

As determined by the Director of Corporate Governance

7.3 Membership Appointments

Members shall be appointed to hold office for a period of one year at a time by the Board, up to a maximum of their term in office taking into account the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by Welsh Government. During their period of appointment, a member may resign or be removed by the Board.

7.4 Support to Committee Members

The Director of Corporate Governance, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and
- Ensure the provision of programme of organisational development for committee members as part of the health board's overall organisational development programme developed by the Executive Director of Organisational Development and Workforce

7.5 Frequency of meetings

The Committee will meet quarterly and an annual schedule of meetings will be determined by the corporate calendar.

Any additional meetings will be arranged under exceptional circumstances and shall be determined by the Chair of the Committee in discussion with the Executive Lead

7.6 Withdrawal of individuals in attendance

The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussions of any particular matter.

7.7 Agendas

The agenda and papers will be distributed five working days in advance of the meeting.

The agenda will be based on the Committee workplan, identified risks, matters arising from previous meetings, action lists, issues emerging throughout the year and requests from other committees.

8. REPORTING AND ASSURANCE ARRANGEMENTS

- 8.1 The Committee, through its Chair and members, shall work closely with the other Committees to provide advice and assurance to the Board through joint planning and co-ordination of Board and Committee business, including information sharing. In doing so, it will contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.
- 8.2 The Committee Chair, supported by the Committee Secretary shall:
- 8.2.1 Report formally, regularly and on a timely basis to the Board on the Committee's activities.
 - 8.2.2 Bring to the Board's specific attention any significant matters under consideration by the Committee; and
 - 8.2.3 Ensure appropriate escalation arrangements are in place to alert the Chief Executive and/or other Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Health Board

9. RELATIONSHIP WITH THE BOARD AND ITS COMMITTEES/GROUPS

- 9.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these Terms of Reference, it retains overall responsibility and accountability for these matters:
- 9.1.1 The Committee is directly accountable to the Board for its performance in exercising the functions set out in the delegated powers listed above.
 - 9.1.2 The Committee will consider the assurance provided through the work of the Board's other committees and subgroups to meet its responsibilities for advising the Board on the adequacy of the Health Board's overall system of assurance.
 - 9.1.3 The Committee shall embed the Health Trust's corporate standards, priorities and requirements, eg, equality and human rights through the conduct of its business.
 - 9.1.4

10. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

11. REVIEW

These terms of reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board.

APPENDIX 1

Operational arrangements common to all committees

1. AUTHORITY

Velindre University NHS Trust's Standing Orders provide that:

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

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

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

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

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

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

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

2. STATUTORY AND MANDATORY COMPLIANCE

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

standards, together with associated national and international best practice guidance.

3. GOVERNANCE FRAMEWORK

These Terms of Reference should be read alongside the Trust's Standing Orders, Standing Financial Instructions, Scheme of Delegation and other Board-approved governance frameworks. Together, these documents define the authority, roles, responsibilities, accountabilities, decision-making arrangements and expected behaviours that support effective governance across the Trust.

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

4. COMMON PRINCIPLES

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

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

- o **Quality of Assurance** – Ensure that assurance is reliable, complete, timely and evidence-based, enabling the Committee to determine whether risks are being effectively managed and intended outcomes are being achieved.
- o **Impact Assessment** – Ensure that significant strategies, policies, service changes, business cases and decisions are informed by appropriate Quality Impact Assessments, Equality Impact Assessments and other relevant impact assessments, seeking assurance that potential impacts have been appropriately identified, considered and addressed before decisions are taken.

5. COMMITTEE INTERFACES

Committees will:

- o Collaborate with other Committees and refer matters to the appropriate Committee where issues fall outside its remit or require broader organisational oversight or assurance. This includes the People, Culture and Engagement Committee (PCEC), Quality, Safety and Experience Committee (QSEC), Performance and Finance Committee (PFC), Audit and Risk Assurance Committee (ARAC), Research, Development and Innovation Committee (RD&I), and the new Velindre Cancer Centre Committee (nVCC).
- o Refer matters to ARAC where concerns relate to the overall risk management framework, internal control environment, assurance gaps, or audit findings.
- o Receive matters referred by the Board or other Committees where they fall within the Committee's remit.

6. GOVERNANCE AND RISK

Committees will:

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

7. COMMITTEE EFFECTIVENESS AND PROGRAMME OF WORK

Committees will:

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

8. CROSS COMMITTEE MEMBERSHIP AND ATTENDANCE

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

9. REPORTING TO THE BOARD

- Committees are directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference.
- While each Committee will oversee matters within its delegated remit, integrated oversight of organisational performance, governance and assurance across all domains will remain the responsibility of the Board. The Board may remit more detailed review of specific matters to Committees and Committees may advise the Board on any issues requiring ongoing oversight, escalation, or cross-committee consideration.
- Minutes will be circulated to the Board.
- A formal exception report will be submitted to the Board following each meeting, highlighting matters requiring Board attention, escalation or decision, including material risks, significant concerns, issues requiring cross-committee consideration, or where assurance is insufficient or outside agreed tolerance.
- Where urgent decisions are required between scheduled meetings, the Committee Chair, supported by the Director of Corporate Governance, may act on behalf of the Committee following consultation with the other Committee member. Any action taken will be formally recorded and reported to the next meeting for ratification.
- The Committee will undertake any other responsibilities delegated by the Board.

10. QUORUM

- A minimum of two Independent Members

- A minimum of two Executive Directors from the list above in Section 5, Attendance.
- Members with a conflict of interest will not count towards the quorum for that item or meeting.

11. SECRETARIAT AND COMMITTEE BUSINESS SUPPORT

- Secretariat support will be provided by the Corporate Governance function which will:
 - Ensure that there are appropriate arrangements in place to support Committee proceedings including alignment with relevant equality and Welsh language legislation.
 - Ensure that agendas, papers, minutes, and actions are available to the Committee in line with the standards outlined in Standing Orders and supporting documentation.
 - Arrange an agenda-setting meeting with the Committee Chair and Lead Director at least four weeks prior to each meeting.
 - Ensure that agendas are informed by the Committee work plan, matters arising, identified risks, emerging issues and requests from Committee members.
 - Circulate the agenda and timetable for paper submission to members following approval by the Chair and Lead Director,
 - Obtain approval for all papers from the relevant Lead Director prior to submission.
 - Circulate agendas and papers at least seven days in advance of the meeting.
 - Prepare a draft table of actions within two working days of the meeting.
 - Draft minutes and the action log for circulation to the Lead Director for accuracy review within seven days of the meeting, before circulation to Chair and then Committee members for comment.
 - Submit final minutes and actions to the Committee Chair for approval.
- Members should submit amendments to the Committee Secretariat within seven calendar days of receipt.

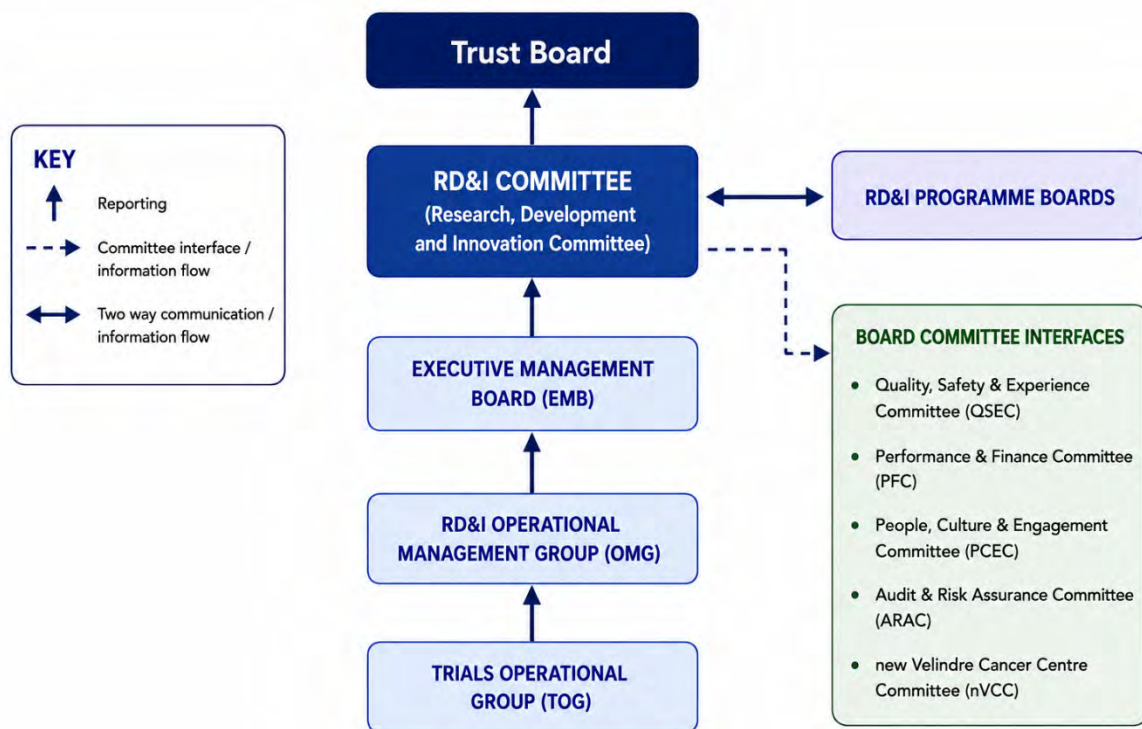
12. EFFECTIVENESS REVIEW

- At the conclusion of each meeting, the Chair will facilitate a brief reflection on the Committee's effectiveness, considering the quality of discussion, challenge and assurance; use of meeting time; strategic focus; alignment with the Committee's Terms of Reference; the quality of papers and information; member participation and behaviours; and the extent to which the meeting added value to the Board's assurance and decision-making. Opportunities for improvement will be identified, recorded and used to support the Committee's ongoing development.
- Terms of Reference for each committee will be reviewed annually and approved by the Board.

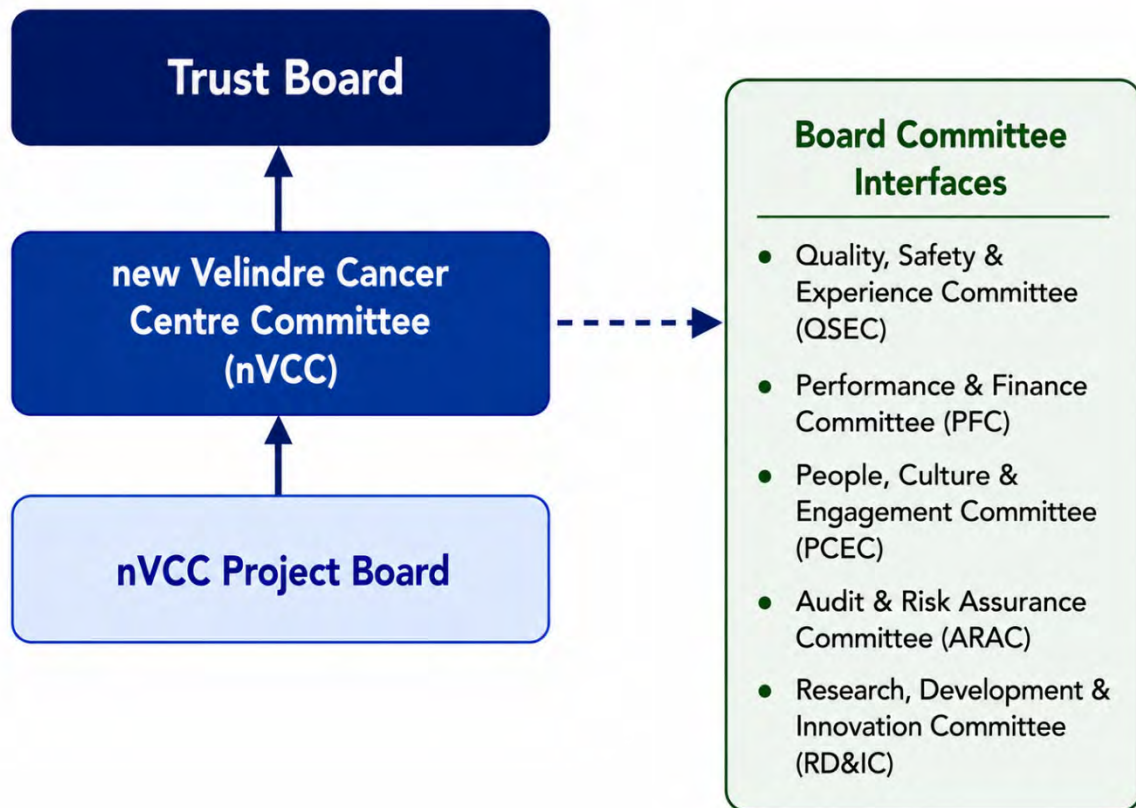
- Committees will undertake an annual self-assessment of its effectiveness and provide an annual report to the Board on its assurance activities, effectiveness, and delivery of its work programme.

APPENDIX 2

RD&I Committee governance structure and reporting arrangements



nVCC governance structure and reporting arrangements



New Trust Board Committee Structure
July 2026
Members and Executive Leads v0.1

Committee Title	Frequency	Chair	Vice Chair	Member	Exec Lead	Supporting Executive Team lead
Trust Board	6 meetings per annum	Sara Moseley	Lindsay Foyster	All other IM's	Chief Executive	All
Quality, Safety and Experience Committee	6 meetings per annum	Vicky Morris	Hilary Jones	Ceri Doyle	Executive Director of Nursing, AHPs & Health Science	Executive Medical Director/ Chief Operating Officer
Performance and Finance Committee	6 meetings per annum	John Union	Lindsay Foyster	Hilary Jones	Executive Director of Finance	Chief Operating Officer
People, Culture and Engagement Committee	6 meetings per annum	Lindsay Foyster	Ceri Doyle	University IM	Executive Director of People & OD	Director of Corporate Governance
Audit and Risk Assurance Committee	Quarterly	Gareth Jones	Vicky Morris	Lindsay Foyster	Director of Corporate Governance	Executive Director of Finance
Research, Development and Innovation Sub-Committee	Quarterly	University IM	Vicky Morris	Ceri Doyle	Executive Medical Director	Executive Director of Nursing, AHPs & Health Science
Remuneration and Terms of Service Committee	as required (minimum quarterly)	Sara Moseley	Lindsay Foyster	Gareth Jones University IM	Executive Director of People & OD	Director of Corporate Governance
nVCC Project Scrutiny Sub-Committee	Monthly	Hilary Jones	John Union	Gareth Jones	Chief Executive supported by Director of Place, Portfolio & Partnerships	Supported by NVCC SRO/ Chief Operating Officer
Charitable Funds Committee	Quarterly	Ceri Doyle	Hilary Jones	John Union	Chief Operating Officer	Executive Director of Finance

Quality-driven decision-making

Quality Impact Assessment

Title of proposal this Quality Impact Assessment (QIA) is supporting:	Board Committees Restructure: revised committee terms of reference, membership, and executive support
Reference of proposal:	Trust Board paper: Board Committees Restructure (30 July 2026)
Details of Board / Committee the paper is being presented to and when:	Trust Board, 30 July 2026

Part 1: Health and Care Quality Standards assessment

1a: Briefly outline how this proposal or strategic decision impacts on the delivery of healthcare services (in line with STEEP Quality Standards).

Quality Standard <i>Click each icon for its definition</i>	Overall Impact			Key points and rationale
	Positive (+1) / Neutral / Negative (-1)	Level of impact High (3) Medium (2) or Low (1)	Impact score (product of previous columns)	
Safe	+1	Medium (2)	+2	Strengthens the Board assurance route for quality, safety, and experience, supporting clearer scrutiny of risks and controls. Reduces ambiguity in committee responsibilities and supports escalation through defined Terms of Reference and cycles of business.

Timely	+1	Low (1)	+1	Clearer committee remit and forward work programmes should support more timely decisions, escalation, and follow-up. Implementation is being phased, with transitional work on Terms of Reference, membership, and executive support.
Effective	+1	Medium (2)	+2	Aligns committee oversight to current Trust priorities, regulatory expectations, and good governance practice. Improves clarity on delegated authority, accountability, assurance flows and the links between committees and the Board.
Efficient	+1	Medium (2)	+2	Aims to reduce duplication across committees and ensure each committee has a distinct remit. May require some short-term governance capacity during transition but should improve the efficiency of committee business once embedded.
Equitable	+1	Low (1)	+1	Provides a more consistent governance framework across Trust services, hosted services, and strategic priorities. Gives clearer routes for assurance where matters affect patients, donors, staff, and wider stakeholders.
Person centred	+1	Medium (2)	+2	Supports stronger visibility of patient and donor voices within the committee structure, particularly through the Quality, Safety and Experience route. Enables Board-level oversight to focus on experience, outcomes and quality alongside performance and assurance.
Overall impact	Overall impact is assessed as positive and medium: the proposal is primarily a governance and assurance improvement, with indirect but important benefits for quality, safety, and experience. Potential negative impact is limited if the transition is actively managed through clear communication, agreed Terms of Reference, executive ownership, and post-implementation review.			

1b: Briefly outline the amount of activity required to ensure successful implementation of the proposal or strategic decision (in line with enabling Quality Standards)

Quality Standard <i>Click each icon for its definition</i>	Amount of activity required High (3), Medium (2) or Low (1)	Key points and actions to achieve the changes required
Leadership	Medium (2)	Board, Committee Chairs and Executive Leads will need to adopt and champion revised remits, ways of working and assurance routes. Clear ownership is required for final Terms of Reference, cycles of business and implementation oversight.
Workforce	Medium (2)	Committee membership and executive support have been reviewed to ensure an appropriate balance of skills, experience, and capacity. Corporate Governance support arrangements need to be aligned to the revised structure and meeting cycle.
Culture	Medium (2)	The change supports a culture of clearer accountability, effective oversight, and continuous improvement in governance. Communication with Chairs, Executive Leads and supporting teams will be needed to embed the new arrangements.
Information	Medium (2)	Forward work programmes, assurance reports, and escalation routes will need to reflect the revised committee responsibilities. Report quality and visibility of key risks, decisions and assurances should be strengthened through the new framework.

Learning, improvement, and research	Low (1)	The proposal supports learning from Board development discussions, governance review work and feedback from Chairs and Executive Leads. Effectiveness will be reviewed after implementation to identify further improvements.
Whole systems approach	Medium (2)	The structure is intended to better align oversight of quality, finance, performance, planning, people, culture, charity, audit, risk, and assurance. The approach should clarify interfaces between committees and improve the flow of assurance to the Board.
Overall amount of activity required	Implementation requires co-ordinated but manageable work across governance documentation, committee membership, executive support, meeting cycles, reporting routes, and communication. The proposal should be supported by clear implementation tracking and a post-implementation effectiveness review.	

Part 2: High-level consideration of risk

Considering responses on all twelve Health and Care Quality Standards in Part 1, what level of risk to **Quality overall** is this proposal or strategic decision?

Slide the arrow to indicate the level of risk (recognise this is subjective until full risk assessment undertaken)



Level of risk to Quality of implementing this proposal	☐ Low	☒ Low/medium	☐ Medium	☐ Medium/high	☐ High

Level of risk to Quality of NOT implementing this proposal	☐ Low	☐ Low/medium	☐ Medium	☒ Medium/high	☐ High



Describe the main risks to Quality of implementing this proposal?

Describe the main risks to Quality of NOT implementing this proposal?

- Implementing the proposal carries a low/medium quality risk during transition, mainly around temporary uncertainty on committee routes, reporting expectations and ownership of cross-cutting issues. This can be mitigated through agreed Terms of Reference, clear cycles of business, communication to report authors and Executive Leads, and implementation oversight through Corporate Governance.
- Not implementing the proposal carries a medium/high risk because existing arrangements may continue to duplicate effort, dilute accountability, weaken assurance flow and reduce Board visibility of quality, safety, experience, performance, and strategic risks.
- The proposal is expected to support mitigation of BAF 04 – Organisational and Clinical Governance by clarifying committee responsibilities, improving assurance routes, and aligning committee work programmes to strategic objectives; any residual risks should be monitored through existing corporate risk processes.

Part 3: Developing and signing off this Quality Impact Assessment

QIA completed by / on date	QIA operationally agreed by / on date	QIA clinically agreed by / on date
Kay Barrow Corporate Governance Manager 15 July 2026	Non Gwilym Interim Director of Corporate Governance 17/07/2026	

Executive clinical review and sign off (if required)

Clinical Executive 1 sign off / date	Clinical Executive 2 sign off / date	Clinical Executive 3 sign off / date
Dr Jacinta Abraham Executive Medical Director Date: 21/07/2026	To be confirmed, if required Date: TBC	To be confirmed, if required Date: TBC



EQIA Template & Action Plan

All policies and decisions that affect people are assessed to identify ways to reduce discrimination and to make Wales fairer. I confirm that an assessment has been undertaken and the relevant actions are highlighted below.

Name of Policy	Board Committees Restructure: revised committee terms of reference, membership, and executive support.		
Manager	Non Gwilym, Interim Director of Corporate Governance		
Date of meeting with OD Manager – ED&I	To be confirmed / not yet held		
Date of submission	20 July 2026		
Date of next review	Initial six-month review by end of March 2027; full post-implementation effectiveness review at 12 months		
These changes will affect:	Staff: ☐	Patients: ☐	Both: ☒

1.1	What is the policy or decision that you are conducting an EQIA for?	This EQIA relates to the proposed restructure of Velindre University NHS Trust's Board Committee arrangements, including revised committee terms of reference, membership, and executive support arrangements. The decision supports a Trust Board paper seeking approval of the revised committee structure and associated implementation arrangements.
1.2	Who owns it?	The proposal is owned by the Trust Board, with executive leadership through the Interim Director of Corporate Governance. Corporate Governance will co-ordinate implementation, working with Committee Chairs, Executive Leads and relevant support teams.
1.3	What is the aim of the change(s)?	The aim is to strengthen Board assurance, clarify committee oversight, reduce duplication, improve report quality, strengthen visibility of quality, safety, experience, performance, finance, people, culture, risk, and assurance matters, and align committee arrangements to the Trust's strategic priorities and future operating context.
1.4	Who is affected most by the change?	The change will most directly affect Independent Members, Committee Chairs, Executive Leads, report authors, Corporate Governance staff and teams supporting committees. It will indirectly affect staff, patients, donors, hosted services and wider stakeholders through clearer assurance routes and improved Board oversight.



1.5	How does this topic fit into the wider context of the organisation?	The restructure forms part of the Trust's wider Board development and governance improvement work. It responds to strategic drivers including major capital development, service transformation, research and innovation, digital interdependencies, external accountability, hosted services governance, and the need to strengthen assurance from Board to frontline services.
1.6	Who is undertaking the EQIA	Corporate Governance Manager, on behalf of the Corporate Governance function, using the EQIA Toolkit and the Board Committee Structure reference papers.
1.7	When will you start and end the EQIA?	The EQIA has been undertaken during development of the final proposal in July 2026 to inform Trust Board decision-making on 30 July 2026. It will remain live through implementation, with monitoring built into the six-month initial review and 12-month post-implementation effectiveness review.
2.1	What data is available to help inform the EQIA?	Available information includes the EQIA Toolkit, the completed Quality Impact Assessment, March and May 2026 Trust Board papers, Board development discussions, committee mapping, feedback from Committee Chairs and Executive Leads, draft terms of reference, proposed cycles of business, and current governance arrangements.
2.2	What information is still needed?	Further information may be required following discussion with the OD Manager – ED&I, finalisation of terms of reference and membership, confirmation of executive support arrangements, and any feedback from staff, committee support teams, or stakeholders during implementation.
2.3	How will missing data be collected?	Missing information will be gathered through targeted engagement with Committee Chairs, Executive Leads, Corporate Governance colleagues, report authors, and relevant support teams, with advice from the OD Manager – ED&I where required. Learning will also be captured through the initial and full post-implementation effectiveness reviews.
2.4	What is considered relevant information and data?	Relevant information includes evidence on how the revised structure affects access to decision-making, participation in governance processes, clarity of reporting routes, Welsh language and accessibility requirements, socio-economic considerations, staff capacity, and the potential for any group to experience differential impact through the new arrangements.

3 - Equality Impact Assessment Template

Questions for you to think about for each of the protected characteristic groups:

- What are the possible impact outcomes?
- What type of impact does the change create?

Protected Characteristic	Potential Impact [Please tick column(s)]			Details	Recommendations
	Positive	Negative	None		
Age Younger people Middle-aged people Older people	☒	☐	☐	The proposal is not expected to affect people differently because of age. Clearer governance routes may support more consistent consideration of quality, safety, experience, and workforce matters affecting different age groups.	Ensure committee reporting continues to consider age-related impacts where relevant, including through quality, experience, workforce, and service reports.
Disability Physical, learning needs, neurodiversity, sensory loss, mental health	☒	☐	☐	No direct adverse impact is anticipated. A clearer committee structure should improve oversight of accessibility, reasonable adjustments, patient/donor experience, and workforce inclusion. There is a potential implementation risk if meeting materials or governance processes are not accessible.	Maintain accessible meeting papers and reporting formats; ensure terms of reference and cycles of business support scrutiny of accessibility, reasonable adjustments, and inclusion issues.
Gender re-assignment	☒	☐	☐	No direct differential impact is identified. Improved people, culture, engagement, and quality oversight should support inclusive practice and the escalation of relevant equality matters.	Ensure equality and inclusion reporting routes are clear within the revised structure and that inclusive language is used in committee documentation.
Marriage or civil partnership	☐	☐	☒	No specific impact has been identified for people because they are married or in a civil partnership.	No specific mitigation required beyond routine equality monitoring and inclusive governance processes.
Pregnancy or Maternity	☒	☐	☐	No direct adverse impact is anticipated. The revised People, Culture and Engagement route should strengthen visibility of workforce matters, including flexible working, maternity, return-to-work, and staff experience themes where reported.	Ensure workforce reporting under the revised structure continues to identify and escalate pregnancy, maternity, flexible working, and return-to-work issues where relevant.

Race	☒	☐	☐	No direct adverse impact is anticipated. Clearer assurance routes may support better visibility of workforce diversity, patient/donor experience, cultural competency, and anti-racism work where relevant.	Ensure relevant committee reports continue to include race and ethnicity analysis where data is available and proportionate.
Religion or belief	☐	☐	☒	No specific impact has been identified in relation to religion, belief, or non-belief. Meeting arrangements should remain mindful of religious observance where practical.	Continue to schedule and support committee activity in a way that is inclusive and proportionate, including consideration of religious observance where relevant.
Sex/Gender	☒	☐	☐	No direct adverse impact is anticipated. The revised structure may improve oversight of workforce, culture, engagement, and quality matters that can include sex or gender-related issues.	Maintain clear routes for reporting workforce and experience data by sex/gender where available and appropriate.
Sexual Orientation	☒	☐	☐	No direct adverse impact is anticipated. The revised structure should support clearer escalation of equality, inclusion, staff experience, and patient/donor experience matters.	Ensure inclusive language is used in committee documentation and relevant experience or workforce themes are escalated through the correct committee route.

Socio Economic Duty	☒	☐	☐	The proposal is a governance change and is not expected to create direct socio-economic disadvantage. It may positively support oversight of inequalities, access, workforce pressures, and service outcomes where these are reported through committee business.	Ensure committee report templates and forward work programmes prompt consideration of socio-economic impacts where relevant.
Welsh Language	☒	☐	☐	The proposal should not treat the Welsh language less favourably than English. A clearer governance structure should support continued oversight of Welsh language duties and bilingual communication requirements where relevant.	Ensure committee documentation and communication comply with Welsh language requirements and that Welsh language implications remain visible in relevant reports.

4.1	You will need to evidence and recommend one of four policy implementation options: 1. No major change 2. Adjust the policy 3. Continue the policy 4. Stop and remove the policy	Recommended option: No major change to the proposal. The assessment identifies primarily positive or neutral equality impacts, with no specific adverse impact identified at this stage. Implementation should proceed with the mitigations and monitoring actions set out in this assessment.
4.2	If the change will be implemented regardless of the presence of a negative impact, you must be able to evidence: the implementation was necessary to carry out specific functions, there is no way of achieving the aims of the policy that has less negative impact and the means employed are necessary and appropriate	No specific negative impact has been identified that would prevent implementation. The proposal is considered necessary and proportionate to strengthen Board assurance, clarify accountability, reduce duplication, and improve oversight of quality, safety, experience, finance, performance, people, culture, risk, and assurance.
4.3	Could the policy be implemented in a different way to avoid negative impact?	No alternative approach has been identified that would better achieve the intended governance improvements with less impact. Potential implementation risks relate mainly to communication, clarity of routes and accessibility of documentation, which can be mitigated through clear guidance, engagement, and review.
4.4	How will this change promote equality of access and equality of opportunity?	The revised structure should promote equality of opportunity by strengthening visibility of equality, inclusion, patient/donor experience, workforce, culture, and quality matters at Board Committee level. Clearer reporting routes should help ensure relevant issues are escalated, scrutinised, and acted upon consistently.
4.5	Is it possible to implement a different policy which achieves practice aims but avoids adverse impact?	No adverse impact requiring a different policy has been identified. The current proposal should be implemented with proportionate actions to support accessible documentation, inclusive language, clear report-writing guidance, and post-implementation review.
5.1	What do you have so far?	A draft EQIA informed by the EQIA Toolkit, the completed QIA, Board Committee Structure papers, governance mapping, discussions with Committee Chairs and Executive Leads, and the proposed implementation timetable.
5.2	Have any themes emerged?	The main themes are clearer accountability, reduced duplication, improved assurance flows, better visibility of quality and experience, stronger people and culture oversight, accessibility of governance processes, and the need for clear communication during transition.

5.3	What do people have to say about our work?	Feedback from Board development work and discussions with Chairs and Executive Leads has informed the scope of committees, proposed ways of working, terms of reference and implementation timetable. Further feedback will be captured during implementation and post-implementation review.
5.4	How will you consult widely on your topic?	As this is an internal governance restructure, engagement will be targeted rather than a full public consultation. Engagement will include Committee Chairs, Executive Leads, Corporate Governance colleagues, report authors and relevant teams affected by the revised reporting routes. Advice will be sought from OD Manager – ED&I where required.
5.5	Who will you consult with?	Committee Chairs, Independent Members, Executive Leads, Corporate Governance Team, report authors, relevant corporate/service leads, and OD Manager – ED&I where required.
5.6	How long will the consultation stage last?	Targeted engagement is taking place during development and implementation of the revised structure. Feedback will continue to be collected through the transition period, with formal review at six months and again at 12 months.
6.1	The action plan must appropriately evidence the decision for one of the following policy options: 1. No major change 2. Adjust the policy 3. Continue the policy 4. Stop and remove the policy	Decision: No major change. The proposal should proceed with the actions identified in the EQIA action plan to support accessible, inclusive, and effective implementation.
6.2	What will you do with the comments or information you have gathered from your consultations?	Feedback will be used to refine terms of reference, cycles of business, reporting routes, meeting support arrangements, and guidance for report authors. Any equality, accessibility or Welsh language issues identified will be logged and addressed through the action plan or governance implementation tracking.
6.3	How did the consultation help guide new policy?	Engagement has helped shape committee scope, implementation timing, leadership responsibilities, and support requirements. It has also highlighted the importance of clear communication and post-implementation review to ensure the new structure is working as intended.
6.4	Will you make any changes to the draft report you produced?	The EQIA will be updated if further feedback identifies additional equality, accessibility, Welsh language, or socio-economic considerations before or after implementation.
7.1	Confirm actions	Actions are set out in the EQIA Action Plan and focus on communication, accessibility, and review.

8.1	Establish timetable for reviewing actions and refreshing the assessment	The assessment will be reviewed as part of the six-month initial review by end of March 2027 and the full post-implementation effectiveness review at 12 months. It may be refreshed earlier if significant equality or accessibility issues are identified.



Equality Impact Assessment – Action Plan

Double-click to add your signature below: C K Barrow Corporate Governance Manager	Double-click to add signature below: X Equality & Diversity Manager

Action Plan

These actions will reduce discrimination and make Wales fairer:

Action	Criterion	By When	Resource implications
1 Communicate the revised committee structure, reporting routes, terms of reference and cycles of business to Committee Chairs, Executive Leads, report authors and governance support teams.	Clear implementation	By go-live from 31 July 2026	Corporate Governance time within existing resources
2 Ensure committee documentation, report templates and meeting processes remain accessible, inclusive, and compliant with Welsh language requirements.	Accessibility and inclusion	During implementation and ongoing	Existing governance, communications, and Welsh language support as required
3 Review the equality, accessibility, and governance impacts of the revised structure through the six-month initial review and 12-month post-implementation effectiveness review.	Monitoring and review	End of March 2027 and 12 months post-implementation	Corporate Governance time: input from Chairs, Executive Leads and OD Manager – ED&I if required

Strategic Alignment

Future Generations Act Wellbeing Objectives	Links to Objective
1 A prosperous Wales	✓
2 A resilient Wales	✓
3 A healthier Wales	✓
4 A more equal Wales	✓
5 A Wales of more cohesive communities	✓
6 A Wales of vibrant culture and thriving Welsh language	✓
7 A globally responsible Wales	✓

Attachments

1. The policy concerned
2. Data used in completing the assessment
3. Details of consultation undertaken
4. Final version of the assessment template

Return to OD Manager – Equality, Diversity, and Inclusion:

VUNHST.Equality&Diversity@wales.nhs.uk

Last updated: 8th January 2024

TRUST BOARD	
Student Bursary Award System	
DATE OF MEETING	30 July 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	Stephen Withers, Deputy Director of Employment Services
PRESENTED BY	Alison Ramsey, Director of Finance and Corporate Services, NWSSP
APPROVED BY	Gareth Hardacre, Director of People, Organisational Development and Employment Services
EXECUTIVE SUMMARY	This paper seeks approval to extend the Student Bursary Award System software contract for 3 years from 1 April 2027 to 31 March 2030 at a cost of £382,515 (excluding VAT). GPUK were awarded the contract to provide a Student Award system in 2022, via a competitive tendering program. There was no “off the shelf” system to provide this type of Customer Relationship Management (CRM) system. The previous bursary system was end of life. It took two years to procure and build the new system due to the limited software houses willing to undertake this project also due to the complexity of the bursary algorithms. We have a Service Level Agreement (SLA) with Health Education and Improvement Wales (HEIW) to provide this service to the NHS Wales Bursary

	Students, approximately 5000 students access and apply for a bursary each year through this system. The system has been designed to reduce administration with the Student Awards Team and maximise the customer journey for the students, the system has been built and developed by GPUK and there have been no issues with the service.	
RECOMMENDATION / ACTIONS	The Trust Board is requested to APPROVE the Student Bursary Award System contract extension for three (3) years with effect from 1 April 2027 to 31 March 2030 with a total cost of £382,515 and to AUTHORISE the Chief Executive to approve the Purchase Order.	
GOVERNANCE ROUTE		
List the Name(s) of Committee / Group who have previously received and considered this report:		Date
Shared Services Partnership Committee (SSPC)		16/07/2026
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS		
AS ABOVE		
7 LEVELS OF ASSURANCE		
Not required		
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Select Current Level of Assurance	
APPENDICES		
1.	Commitment of Expenditure Form	
2.	Completed Quality Impact Assessment	

1. SITUATION

This paper seeks approval to extend the Student Bursary Award System software contract for three (3) years with effect from 1 April 2027 to 31 March 2030 with a total cost of £382,515.

The Student Awards System is a critical service delivered under the Service Level Agreement (SLA) between NHS Wales Shared Services Partnership (NWSSP) and Health Education and Improvement Wales (HEIW). The system provides a digital portal through which Higher Education Institution (HEI) students apply for NHS bursary funding to support the future NHS Wales workforce. The current contract was approved for a four (4) year period to 31 March 2027, with three extension options of 12 months each. At the time of the initial contract award, the future of the bursary payments in NHS Wales were uncertain. Welsh Government has recently commenced consultation on the future of NHS bursary arrangements in Wales.

Whilst the outcome of this consultation remains uncertain, the existing Student Awards System will continue to be required to support bursary administration until at least 2029 to support current students in training. Extending the current contract provides the flexibility required to continue delivering services whilst allowing sufficient time for Welsh Government to determine future policy direction. This approach avoids unnecessary investment in replacement technology that may subsequently require significant redesign or replacement to accommodate future national changes.

2. BACKGROUND

The current system was procured through a competitive tender process, with two suppliers submitting bids. The Outline Business Case was approved through Chair's Urgent Action on 21 July 2021 and subsequently ratified by the Shared Services Partnership Committee on 22 July 2021. GPUK was awarded the contract following a robust evaluation process and has successfully delivered the solution currently in operation.

The system was specifically designed to manage the complex eligibility rules and assessment algorithms associated with NHS bursary funding. By automating these processes, it significantly reduces administrative burden, improves accuracy, and provides a simplified, user focused customer journey through technological innovation.

The implementation of the new Student Awards System formed a key part of the transformation of the NHS Wales Bursary Service, addressing the risks associated with legacy software that had reached end of life while supporting the policy direction established by the Minister for Health and Social Services at the time, Eluned Morgan.

The system continues to represent an improvement from the previous system that relied heavily on manual assessment processes, resulting in lengthy processing times and a

poor customer experience, with students often waiting up to one month to receive confirmation of their bursary entitlement.

The current system provides real time assessment and confirmation of funding, enabling students to make informed decisions regarding their education and financial support without unnecessary delay. Assessment times have reduced significantly, delivering a substantial improvement in both operational efficiency and customer satisfaction.

In addition, the system incorporates streamlined processes that support students' progression from higher education directly into NHS employment across Wales. This contributes to protecting the NHS bursary investment while supporting workforce planning and recruitment across Welsh health organisations.

3. ASSESSMENT

Since implementation, the Student Awards System has developed into a mature, stable and reliable platform supporting the delivery of bursary funding across Wales.

The volume of student applications remains consistently high, and the system continues to effectively manage the complexity of the bursary schemes while maintaining robust integration with HEIs and HEIW.

The Student Awards System is now a critical operational service supporting NWSSP's contractual obligations and the delivery of an essential national service.

Its functionality extends beyond application processing by supporting the wider objective of developing the future NHS Wales workforce through efficient and timely funding decisions.

Due to the limited software providers and the time required to procure, design and implement, along with the additional financial costs, the most viable option is to extend the current GPUK Bursary System. It will not be possible to continue with our SLA with HEIW to provide a NHS Bursary funding scheme for the NHS without this software.

4. SUMMARY OF MATTERS FOR CONSIDERATION

The options considered are set out in the appended Commitment of Expenditure Form.

5. 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	Choose an item Not applicable
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Select all relevant domains below
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	See completed Quality Impact Assessment at Appendix 2.
QUALITY IMPACT ASSESSMENT <i>The duty of quality requires quality-driven decision-making for all strategic decisions. The duty of quality is operationalised through the Health and Care Quality Standards. Therefore, when making decisions about healthcare services, NHS organisations are required to consider the impact of that decision on the Health and Care Quality Standards.</i>	Yes - Fully completed and signed QIA Enclosed
	See completed Quality Impact Assessment at Appendix 2.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: For more information: https://www.gov.wales/socio-economic-duty-overview	Not required
	A socio-economic duty assessment is not required as the paper seeks approval to commit expenditure to extend an existing contract. The proposal does not introduce a new service, policy change or strategic decision that would require assessment under the Socio-economic Duty.

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	
If yes select the relevant goals: • A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities. ☒ • A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience. ☐ • A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health ☒ • A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances ☒ • A Wales of more Cohesive Communities - Attractive, viable, safe and well-connected communities. ☐ • A Wales of Vibrant Culture and Thriving Welsh Language -Promoting and protecting culture, heritage and the Welsh language, encouraging people to participate in the arts, and sports and recreation. ☐ • A Globally Responsible Wales – Consideration of whether an action may make a positive contribution to global well-being ☐	
FINANCIAL IMPLICATIONS / IMPACT	Choose an item
	Source of Funding: Divisional Budget Allocation Please explain if 'other' source of funding selected: Click or tap here to enter text Type of Funding: Revenue Scale of Change Please detail the value of revenue and/or capital impact: Click or tap here to enter text Type of Change

	Choose an item Please explain if 'other' source of funding selected: Click or tap here to enter text
EQUALITY IMPACT ASSESSMENT For more information: https://nhs.wales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx	Not required - please outline why this is not required The proposal relates to the continuation of an existing system, with no change to the current service model or access arrangements.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)

6. RISKS

If the contract is not renewed, we will be unable to fulfil our obligations under our SLA with HEIW to provide an NHS Bursary to NHS Students in Wales.

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	- Contractual - Unable to provide a Bursary Service to NHS Wales Students
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
All risks must be evidenced and consistent with those recorded in Datix	

COMMITMENT OF EXPENDITURE EXCEEDING CHIEF EXECUTIVE'S LIMIT / BUSINESS JUSTIFICATION

SCHEME TITLE	Student Bursary Award System
DIVISION / HOST ORGANISATION	NHS Wales Shared Services Partnership (NWSSP)
DATE PREPARED	01/07/2026
PREPARED BY	Darren Rees, Deputy Director of Employment Services
SCHEME SPONSOR	Gareth Hardacre, Director of People & Organisational Development and Employment Services

**All Divisional proposals must be consistent with the strategic and operational plans of
Velindre University NHS Trust.**

1. DESCRIPTION OF GOODS / SERVICES / WORKS

The purpose of the Student Awards Service is to manage the processing of student bursary applications for healthcare graduates. The service processes on average 9,600 student applications, manages approximately 6,382 phone calls and awards a bursary value of £38.00m each year.

The current software solution is provided by GPUK and the contract has been in place since 2022 on a four (4) year term with optional annual extensions for up to three (3) years. The initial four-year contract is due to expire on 31 March 2027, with options to extend for up to three (3) years from 1 April 2027 to 31 March 2030. The Outline Business Case was approved through Chair's Urgent Action on 21 July 2021 and ratified by the Shared Services Partnership Committee on 22 July 2021.

The existing solution has operated effectively throughout the contract to date:

1. The system has significantly decreased the processing time required to assess Student Applications and there have not been any breaches or non-compliance with the Service Level Agreement (SLA) processing target of 20 days to process an application.
2. The system has been enhanced to maximise efficiencies to enhance customer journeys for our students.



Since the introduction of the GPUK system the process has been transformative to offer a totally customer centric service, due to the efficiency. Calls to the team have significantly reduced by 50%, as the system is transparent and user friendly in its design.

As part of our SLA with HEIW, we have to provide the essential tools to efficiently manage the bursary applications in Wales and importantly to meet all regulatory compliance requirements, such as GDPR and Welsh Language Regulations.

At the time of the initial contract award, the future of the bursary payments in NHS Wales were uncertain. Welsh Government has recently commenced consultation on the future of NHS bursary arrangements in Wales.

Whilst the outcome of this consultation remains uncertain, the existing Student Awards System will continue to be required to support bursary administration until at least August 2029 to support current students in training. Extending the current contract provides the flexibility required to continue delivering services whilst allowing sufficient time for Welsh Government to determine future policy direction. This approach avoids unnecessary investment in replacement technology that may subsequently require significant redesign or replacement to accommodate future national changes.

1.1 Nature of contract:

Please indicate with a (x) in the relevant box

First time

☐

Contract Extension

☒

Contract Renewal

☐

1.2 Period of contract including extension options:

Expected Start Date of Contract

01/09/2022

Expected End Date of Contract

31/03/2027

Contract Extension Options

(E.g. maximum term in months)

36 months available to 31/03/2030

2. STRATEGIC FIT *(Host organisations are not required to complete Section 2)*

2.1 OUR STRATEGIC PILLARS	
This scheme should relate to at least one of the Trust's five strategic pillars. Please mark with a (x) in the box the relevant pillars for this scheme.	
Goal 1: Be recognised as a pioneer in blood and transplantations services across Europe.	☐
Goal 2: Be a recognised leader in specialist cancer services in Europe.	☐
Goal 3: Be recognised as a leader in stated priority areas of research, development and innovation.	☐
Goal 4: An established 'University' Trust which provides highly valued knowledge and learning for all.	☐
Goal 5: An exemplar of sustainability that supports global well-being and social value.	☒

2.2 INTEGRATED MEDIUM TERM PLAN		
Is this scheme included in the Trust Integrated Medium Term Plan?	Yes	No
	☒	☐
If not, please explain the reason for this in the space provided.		
2.3 SHAPING OUR FUTURE WELLBEING OBJECTIVES		
This scheme should relate to at least one of the Trust's wellbeing objectives. Please mark with a (x) in the box the relevant objectives for this scheme.		
Reduce health inequalities, make it easier to access the best possible healthcare when it is needed and help prevent ill health by collaborating with the people of Wales in novel ways.	☒	
Improve the health and well-being of families across Wales by striving to care for the needs of the whole person.	☐	
Create new, highly skilled jobs and attract investment by increasing our focus on research, innovation and new models of delivery.	☐	
Deliver bold solutions to the environmental challenges posed by our activities.	☐	
Bring communities and generations together through involvement in the planning and delivery of our services.	☐	
Demonstrate respect for the diverse cultural heritage of modern Wales.	☐	



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Strengthen the international reputation of the Trust as a centre of excellence for teaching, research and technical innovations whilst also making a lasting contribution to global well-being.

☐

FIVE WAYS OF WORKING (SUSTAINABLE DEVELOPMENT PRINCIPLES) CONSIDERED

Please mark with a (x) in the box the relevant principles for this scheme.

Click [here](#) for more information

Prevention

☐

Long Term

☒

Integration

☒

Collaboration

☒

Involvement

☐

3. OPTIONS CONSIDERED

Include 'business as usual' i.e. 'do nothing'

3.1 Please state alternative options considered and reasons for declining

Option 1 – Do nothing

Not extending the current GP UK system will result in NHS Wales not having a Bursary system to allow Students to apply for bursary funding, resulting in non-compliance with our obligations in accordance with our SLA with HEIW. – **Not an option**

Option 2 – Full competition

Due to the complexities of the Bursary scheme, a robust algorithm CRM system is required to analyse and calculate the payment due to students. It is complex and time consuming to undertake this process manually.

It will take at least two years to procure and build a new system, as this is a bespoke system that cannot be bought "off the shelf" and will incur significant capital expenditure. Given the future of the bursary beyond 2029 is not yet certain, a competitive tender exercise to build a new bursary system is not considered to represent a value for money option for NHS Wales when we have an operational system that meets requirements and extension terms are included within the contract.

Option 3 – Extend the current contract

Due to the optional extensions included within the current contract, the satisfactory operational performance of the current system and the future uncertainty of the bursary across NHS Wales which is under review by Welsh Government, this option is considered to represent the best value for money option to continue to provide Student Bursary Award services for the next 3 years.

4.BENEFITS (Quantifiable / Non-Quantifiable)

The benefits of the software have already been recognised and will continue as part of the contract extension option which include:

- A reduction in headcount of the processing team of 1.0 WTE.
- No failure in KPI's under the SLA since moving to the new system.
- Better customer journey.
- Reduction in calls to the Student Awards Team by 50% due to the visibility and customer centric design of the new system.

5. RISKS & MITIGATION

5.1 Please state risks of not proceeding with the scheme	5.2 Please state any mitigation to reduce the risk if the scheme is not approved
• Due to the above it will not be an option to procure a new system in the time to continue meeting our obligations under our SLA nor providing a robust Student Award System. • Students would be unable to make applications to HEI's for the academic NHS careers.	None.

6. PROCUREMENT ROUTE

6.1 How is the contract being procured? Please mark with a (x) as relevant.	
Competition 3 Quotes ☐ Formal Tender Exercise ☐ Mini competition ☐ Find a Tender ☒ (replaces OJEU Public Contract regulations 2015 still apply)	Single source Single Quotation Action ☐ Single Tender Action ☐ Direct call off Framework ☐ All Wales contract ☐



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Please [click here](#) for link to Procurement Manual for additional guidance

6.2 Please outline the procurement strategy

The original contract was let via a compliant OJEU process in 2022. The contract was awarded to GPUK for an initial 4-year term with options to extend for three further 12-month periods. Costs were confirmed for the lifetime of the contract, including these extensions.

The contract award was completed under the Procurement Contract Regulations (2015) and approved within NWSSP and by Welsh Government.

The Outline Business Case was approved through Chair's Urgent Action on 21 July 2021 and ratified by the Shared Services Partnership Committee on 22 July 2021.

This paper now seeks approval to utilise the extension periods moving forward.

Whilst this paper acknowledges the entire 4+1+1+1 potential term of the contract, the three separate extensions will be conducted annually if required, following completion of the processes outlined within the Procurement Services Document Management System and following all appropriate governance procedures within NWSSP for each of these periods.

6.3 What is the approximate time line for procurement?

The procurement has already been completed.

6.4 PROCUREMENT ROUTE APPROVAL

The Head of Procurement / Delegated Authority has approved the preferred procurement route

Head of Procurement Name:

Andrew Smallwood
Assistant Director of Procurement

Signature:

Date:

14/07/2026



Maximum expected whole life cost relating to the award of contract	Excluding VAT (£) £1,336,499 (£382,515 for extension)	Including VAT (£) £1,603,799 (£459,018 for extension)
The nature of spend	Capital ☐	Revenue ☒
How is the scheme to be funded? Please mark with a (x) as relevant. Existing budgets ☒ Additional Welsh Government funding ☒ Other ☐		
If you have selected 'Other' – please provide further details below:		

7. FINANCIAL ANALYSIS

PROFILE OF EXPENDITURE

EXPENDITURE CATEGORY	Extension Year 1 (exc. VAT) £k	Extension Year 2 (exc. VAT) £k	Extension Year 3 (exc. VAT) £k	Total Future Years (exc. VAT) £k	Total (exc.VAT) £k	Total (inc. VAT) £k
Implementation	0	0	0	0	0	0
Support & Maintenance	124,988	127,488	130,038	0	382,515	459,018
Overall Total	124,988	127,488	130,038	0	382,515	459,018

8. PROJECT MANAGEMENT (if applicable)

What are the management arrangements associated with this scheme? E.g. PRINCE 2	Not required as the system is operational.



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9. DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE

The Lead Director, by providing email confirmation, to seek Board approval is making a declaration that all procurement rules, standing orders and standing financial instructions have been complied with. Procurement Services retain this confirmation electronically in the tender file.	
Lead Director Name:	Gareth Hardacre, Director of People, Organisational Development and Employment Services
ESignature:	
Service Area:	Employment Services
Date:	07/07/2026

10. APPROVALS RECEIVED

List and include date of approvals received in support of this scheme.

Divisions	Date of Approval:
Business Planning Group or local equivalent	
Divisional Senior Management Team	
Executive Management Board	
Quality, Safety & Performance Committee	

Host Organisations	Date of Approval:
NWSSP / NHS Wales Shared Services Partnership Committee	- Outline Business Case approved and ratified at SSPC on 22 July 2021. - Shared Services Partnership Committee approval sought for extension on 16 July 2026.
HTW – Senior Management Team	

Quality-driven decision-making

Quality Impact Assessment

Title of proposal this Quality Impact Assessment (QIA) is supporting:	GPUK Student Award
Reference of proposal:	Not applicable
Details of Board / Committee the paper is being presented to and when:	Shared Services Partnership Committee – 16 July 2026 Velindre Trust Board – 30 July 2026

Part 1: Health and Care Quality Standards assessment

1a: Briefly outline how this proposal or strategic decision impacts on the delivery of healthcare services (in line with STEEEP Quality Standards).

Quality Standard <i>Click each icon for its definition</i>	Overall Impact			Key points and rationale
	Positive (+1) / Neutral / Negative (-1)	Level of impact High (3) Medium (2) or Low (1)	Impact score (product of previous columns)	
	1	3	4	GPUK provides a digital solution for Student Awards, NWSSP, has an SLA with HEIW to provide a Bursary Assessment to Healthcare students in Wales, ensuring that employees claiming a bursary is compliant with the scheme, prescribed by Welsh Government.
	1	3	4	The system allows for employees to make an application for a funded NHS funded Bursary.

Quality Impact Assessment tool / April 2024

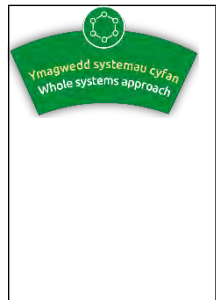
Page 1 of 7

	1	3	4	It handles high volumes of claims daily up to 5,000 per annum with 23,000 students have accessed the system, it has been in place for a number of years, with no issues, it was procured through the Tender process with suppliers, there was limited provides as there is no other system providing this service.
	1	2	3	Due to the volume of application, the system was designed to automate the majority of the claims, thus removing administration and errors in the process.
	1	3	4	It reduces the amount of time for both Students and Student Awards team, as the system has been designed to automate and calculate the bursary payment, all paperwork has been removed. Access to the system for Students, Student Awards and HEI's accessing via the portal.
	1	3	3	The system is quick and efficient, provides a student centric approach, with its transparency and tracking the student it able to see the journey in real time, it has significantly reduced the time to process an application to 1.71 days per claim.
Overall impact	<i>The system is required to deal with high volume of Student Bursary applications with approximately 5,000 highly complex claims per year. It would not be possible to administer these manually, this system deals with minimising administration for Students, Student Award Team and HEI's.</i>			

1b: Briefly outline the amount of activity required to ensure successful implementation of the proposal or strategic decision (in line with enabling Quality Standards)

Quality Standard <i>Click each icon for its definition</i>	Amount of activity required. High (3), Medium (2) or Low (1)	Key points and actions to achieve the changes required
	1	Not applicable.
	3	It handles high volumes of Bursary applications on a monthly basis up to 5,000 claims, with 23,000 users having access to the system, it has been in place for a number of years, with no issues.
	2	The design and service improvement of the functionality has been considered under a person centric approach.

	3	GPUK provides a unique digital solution for Bursary applications to ensure compliance with our SLA and to ensure Students receive the correct bursary. When the Bursary System was originally procured, only two suppliers submitted tenders. Following evaluation, only one supplier met the required criteria and was suitable for progression. The system is highly bespoke and cannot be replaced with an off-the-shelf solution. Within the sector, there are only two other providers of comparable bursary services, SFW and SFE, both of which also operate bespoke systems. The system incorporates complex assessment algorithms required by the Welsh Government to determine bursary eligibility and payment calculations. The procurement, development, and implementation process took approximately two and a half years to complete. GPUK successfully delivered a solution that has significantly improved customer turnaround times and reduced the level of administrative intervention required. In addition, the Welsh Government is currently undertaking a review of the Bursary Scheme. As a result, the existing system will be required for at least a further two academic years beyond the current year. Given the ongoing scheme review by Welsh Government and the time required to procure and implement a replacement solution, it is neither practical nor feasible to undertake a re-procurement exercise at this stage. Extending the current arrangement on an annual basis until a decision is reached on the future of the scheme will ensure continuity of service and enable us to continue meeting our contractual service level obligations on behalf of the Welsh Government.
	2	Following customer feedback that has been translated into changes in the current system, to enhance the customer journey and ensuring it is compliance with WG legislation.

	3	This is system is robust and audited regularly both internally and externally to ensure probity and compliant, any national decision are considered and implemented in the system. During the procurement of the development of the platform accreditation against ISO 270001 and the NHS Wales cloud assessment were undertaken on the provider and the associated platform. At key stages during development the platform was penetration tested by a 3rd party Crest approved company and all vulnerabilities were mitigated. As this is an extension to the current tender the platform will have to undergo this assurance again as part of the extension.
Overall amount of activity required	Limited current system extension, limiting risk in not re procuring with an existing established system.	

Part 2: High-level consideration of risk

Considering responses on all twelve Health and Care Quality Standards in Part 1, what level of risk to **Quality overall** is this proposal or strategic decision?

Slide the arrow to indicate the level of risk (recognise this is subjective until full risk assessment undertaken)



Level of risk to Quality of implementing this proposal	Low	Low/medium	Medium	Medium/high	High

Level of risk to Quality of NOT implementing this proposal	Low	Low/medium	Medium	Medium/high	High



Describe the main risks to Quality of implementing this proposal? Describe the main risks to Quality of NOT implementing this proposal?
<i>Limited risks to quality in implementing this, extension to the current contract no current issues.</i> <i>Risk to quality on not implementing this: No system to assess Bursary applications and limited scope of providers.</i>

Part 3: Developing and signing off this Quality Impact Assessment

QIA completed by / on date	QIA operationally agreed by / on date	QIA clinically agreed by / on date
Stephen Withers Deputy Director of Employment Services 04/03/2026	Stephen Withers Deputy Director of Employment Services 04/03/2026	Martin Edwards Medical Director 12/06/2026

Executive clinical review and sign off (if required)

Clinical Executive 1 sign off / date	Clinical Executive 2 sign off / date	Clinical Executive 3 sign off / date
Martin Edwards Medical Director 12/06/2026	Not applicable	Not applicable

TRUST BOARD	
Material Handling Equipment Lease, Hire and Maintenance (SSP-FTS-60006)	
DATE OF MEETING	30 July 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	Mike Burns, Deputy Head of Supply Chain, Logistics and Transport and Phil Jones, Procurement Business Manger
PRESENTED BY	Alison Ramsey, Director of Finance and Corporate Services, NWSSP
APPROVED BY	Alison Ramsey, Director of Finance and Corporate Services, NWSSP
EXECUTIVE SUMMARY	This report seeks approval to award Contract SSP-FTS-60006 for the provision of Material Handling Equipment lease, short-term hire and maintenance services to Toyota Material Handling UK Limited. The contract will support NWSSP Supply Chain, Logistics and Transport warehouse operations across Denbigh, Bridgend, Picketston and Newport National Distribution Centre. Material Handling Equipment is required to support safe and efficient warehouse activity, including goods receipt, storage, picking, loading, dispatch and movement of stock. The contract will provide a comprehensive, fully managed solution covering lease, short-term hire and maintenance of Material Handling Equipment. The scope also includes optional service and maintenance support for Authority-owned

	equipment and optional training services, where these are operationally or commercially advantageous. The procurement was undertaken through an open competitive procedure in accordance with the Procurement Act 2023. Sixteen potential suppliers accessed the tender documentation and one tender response was received, from Toyota Material Handling UK Limited. Toyota Material Handling UK Limited passed the qualification and mandatory technical requirements and achieved a total evaluation score of 85%. The evaluation concluded that Toyota submitted the highest ranked compliant tender and is therefore recommended for award. The contract will operate for an initial three-year term from 1st September 2026 to 31st August 2029, with the option to extend by two further periods of twelve months. The maximum estimated value over the full five-year term is £1,040,000 excluding VAT. This is an estimated value only and does not create a guaranteed spend commitment. Spend will be demand-led and controlled through approved purchase orders from existing NWSSP Supply Chain, Logistics and Transport (SCLT) operational budgets.
RECOMMENDATION / ACTIONS	The Trust Board is asked to: • Approve the award of Contract SSP-FTS-60006 – Material Handling Equipment Lease, Hire and Maintenance to Toyota Material Handling UK Limited. • Approve the maximum estimated contract value of £1,040,000 excluding VAT over the full five-year term, including both optional extension periods. • Note that expenditure will be funded from existing NWSSP Supply Chain, Logistics and Transport operational budgets and controlled through approved purchase orders. • Note that an initial supplier financial standing concern was identified during the qualification stage, but that a further Dun & Bradstreet report

	was subsequently run and confirmed an improved failure score of 56, representing a low to moderate risk of severe financial stress. The updated score is above the NWSSP recommended exclusion threshold and supplier financial standing will continue to be monitored during the contract term. • Approve progression to Intention to Award, standstill and publication of the Contract Details Notice, subject to completion of all required approvals.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	Date
Shared Services Partnership Committee	16/07/2026
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS AS ABOVE	
7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 6 - Outcomes realised in full
APPENDICES Summary and outcome of previous governance discussions	
1.	Commitment of Expenditure Form
2.	Quality Impact Assessment

1. SITUATION

Approval is sought to award Contract SSP-FTS-60006 for the provision of Material Handling Equipment lease, short-term hire and maintenance services to Toyota Material Handling UK Limited.

The contract is required to support NWSSP Supply Chain, Logistics and Transport (SCLT) warehouse operations across the four regional warehouse sites at Denbigh, Bridgend, Picketston and Newport National Distribution Centre.

Material Handling Equipment is essential to the safe and efficient movement of goods through the warehouse network. The equipment supports goods receipt, storage, picking, loading, dispatch and general movement of stock. If suitable equipment is unavailable, there is a risk of operational disruption, reduced throughput, increased manual handling, health and safety exposure and unplanned cost.

The proposed contract will provide a structured and compliant route for lease, short-term hire and maintenance requirements. It will also allow NWSSP to access service and maintenance support for Authority-owned equipment and training services where required.

2. BACKGROUND

NWSSP Supply Chain, Logistics and Transport rely on Material Handling Equipment to support daily warehouse operations across its regional network.

Previous arrangements did not provide a single structured route covering lease, hire and full maintenance requirements across all sites. This created a risk of inconsistent equipment, reactive servicing costs, reduced asset visibility and limited commercial control.

The requirement was therefore developed to provide a fully managed solution covering lease, short-term hire and maintenance, with flexibility for additional services where required. The contract was structured on a demand-led basis, with no guaranteed minimum spend or equipment volumes. This allows NWSSP to place orders only when there is a confirmed operational need and approved budget.

A single-supplier model was selected to support standardisation of equipment, consistent service levels, simplified ordering, improved asset management and stronger contract management.

3. ASSESSMENT

The requirement was procured through an open competitive procedure under the Procurement Act 2023.

The opportunity was published to the market and sixteen potential suppliers accessed the tender documentation. One tender response was received from Toyota Material Handling UK Limited.

The evaluation was undertaken in accordance with the published Most Advantageous Tender award criteria:

- Qualification – Pass / Fail
- Technical Stage 1 – Pass / Fail
- Technical Stage 2 – 40%
- Commercial – 60%

Toyota Material Handling UK Limited passed the qualification and mandatory technical requirements. Toyota achieved a weighted technical score of 25% out of the available 40% and the full commercial score of 60%, resulting in a combined evaluation score of 85%.

Toyota is therefore recommended for award as the highest ranked compliant tender.

During the qualification stage, an initial Dun & Bradstreet report identified a supplier financial standing concern. This was reviewed by NWSSP Supply Chain, Logistics and Transport and Procurement.

A further Dun & Bradstreet report was subsequently run on 3rd July 2026. This confirmed that Toyota Material Handling UK Limited's failure score had improved to 56, representing a low to moderate risk of severe financial stress.

The difference between the initial and updated reports is understood to be due to a timing issue with Dun & Bradstreet's records, as Toyota Material Handling UK Limited's latest filed accounts had not been reflected in the Dun & Bradstreet assessment at the time of the previous check.

The updated score is above the NWSSP recommended exclusion threshold and the supplier financial standing position is therefore not considered to prevent award. Supplier performance and financial standing will continue to be monitored throughout the contract term.

The contract will provide operational resilience, improved service consistency, better equipment visibility, improved health and safety controls, and stronger commercial governance.

4. SUMMARY OF MATTERS FOR CONSIDERATION

In considering approval to award Contract SSP-FTS-60006, the following matters require consideration:

1. Continuity of Warehouse Operations

Material Handling Equipment is essential to the effective operation of NWSSP SCLT warehouses. Failure to award a contract could create operational disruption and reduce warehouse throughput.

2. Health and Safety

Suitable, maintained and compliant equipment is required to reduce manual handling risk and support safe warehouse operations.

3. Procurement Compliance

The requirement has been procured through an open competitive procedure under the Procurement Act 2023. The recommendation to award is based on the published evaluation methodology.

4. Single Tender Response

Only one tender response was received. However, the opportunity was advertised openly to the market and sixteen potential suppliers accessed the tender documentation.

5. Supplier Financial Standing

An initial Dun & Bradstreet report identified a supplier financial standing concern. A further Dun & Bradstreet report was run on 3rd July 2026, which confirmed an improved failure score of 56, representing a low to moderate risk of severe financial stress. The updated score is above the NWSSP recommended exclusion threshold. The difference between the two reports is understood to be due to a timing issue with Dun & Bradstreet's records, as the supplier's latest filed accounts had not been reflected in the earlier assessment. Supplier financial standing will continue to be monitored throughout the contract term.

6. Financial Control

The maximum estimated contract value is £1,040,000 excluding VAT over the full five-year term. This is an estimated value only and actual spend will depend on operational demand and approved purchase orders.

7. Sustainability

The contract supports sustainable procurement through modern, efficient equipment, improved asset management, planned maintenance, utilisation reporting and lower-emission equipment options.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)								
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below								
If yes - please select all relevant goals:								
• Outstanding for quality, safety, and experience ☐ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development, and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒								
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) For more information: STRATEGIC RISK DESCRIPTIONS	08 - Financial Sustainability and Long Term Value							
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Select all relevant domains below							
	<table><tbody><tr><td>Safe</td><td>☒</td></tr><tr><td>Timely</td><td>☒</td></tr><tr><td>Effective</td><td>☒</td></tr><tr><td>Equitable</td><td>☐</td></tr></tbody></table>	Safe	☒	Timely	☒	Effective	☒	Equitable
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). The proposal has a positive indirect impact on quality and safety. Material Handling Equipment supports safe and efficient warehouse operations, reduces reliance on manual handling, supports timely movement of stock and helps maintain continuity of logistics services across NWSSP SCLT sites. The contract will provide structured maintenance, supplier accountability, service response arrangements and contract monitoring. This will reduce the risk of equipment failure, downtime and operational disruption.
QUALITY IMPACT ASSESSMENT	Yes - Fully completed and signed QIA Enclosed
<i>The duty of quality requires quality-driven decision-making for all strategic decisions. The duty of quality is operationalised through the Heath and Care Quality Standards. Therefore, when making decisions about healthcare services, NHS organisations are required to consider the impact of that decision on the Health and Care Quality Standards.</i>	The QIA tool should be completed to support any proposal for a strategic decision to be made and be presented with the proposal to the appropriate decision-making forum. The QIA tool does not replace the need for the proposal; it accompanies it. As a minimum, decisions made by the Board or by Committees of the Board are considered strategic and should be assessed for their impact on Quality through the lens of the Health and Care Quality Standards. This culture and discipline of quality-driven decision-making should also permeate the organisation to more broadly promote good decision-making practice.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Not required

For more information: https://www.gov.wales/socio-economic-duty-overview	The proposal relates to the lease, hire and maintenance of operational warehouse equipment and does not directly change access to healthcare services or service delivery models for patients. The procurement was conducted through an open competitive procedure and included consideration of social value and sustainability.
TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT	
The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated. Please indicate whether any of the matters outlined in this report impact the Trust's Wellbeing goals: YES - Select Relevant Goals below	
If yes, select the relevant goals: • A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities. ☒ • A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic, and ecological resilience. ☒ • A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health ☒ • A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances ☐ • A Wales of more Cohesive Communities - Attractive, viable, safe, and well-connected communities. ☒ • A Wales of Vibrant Culture and Thriving Welsh Language -Promoting and protecting culture, heritage, and the Welsh language, encouraging people to participate in the arts, and sports and recreation. ☐ • A Globally Responsible Wales – Consideration of whether an action may make a positive contribution to global well-being ☒	
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	The maximum estimated contract value is £1,040,000 excluding VAT over the full five-year term, including both optional extension periods. The estimated annual value is £208,000 excluding VAT. The contract will be funded from existing NWSSP SCLT operational budgets. The

	contract is demand-led and does not create a guaranteed spend commitment. All expenditure will be controlled through approved purchase orders in accordance with NWSSP Standing Financial Instructions and local budget approval processes. Source of Funding: Divisional Budget Allocation Please explain if 'other' source of funding selected: Click or tap here to enter text Type of Funding: Revenue Scale of Change Please detail the value of revenue and/or capital impact: The contract is demand-led and does not create a guaranteed spend commitment. Type of Change Choose an item Please explain if 'other' source of funding selected: Click or tap here to enter text
EQUALITY IMPACT ASSESSMENT <i>For more information:</i> https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx	Not required - please outline why this is not required Not required as this is a commitment of expenditure/procurement approval paper and does not propose a change to services, workforce arrangements or policy that would require an Equality Impact Assessment. No specific adverse equality impacts have been identified. The contract supports safe and effective working arrangements across NWSSP SCLT warehouse sites.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report. Click or tap here to enter text

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	If no contract is in place and additional or replacement Material Handling Equipment is required, costs may be significantly inflated due to the need for short-notice hire, lease or procurement arrangements. There is a risk of non-compliant or fragmented purchasing if Material Handling Equipment requirements are managed through ad hoc arrangements outside of a formal contract. This could reduce cost control, create inconsistent service levels and weaken supplier accountability. There may be no readily available equipment or maintenance support to meet urgent operational requirements across the Denbigh, Bridgend, Picketston and Newport warehouse sites. This could lead to increased hire costs, premium call-out charges and delays in resolving equipment issues. There is a risk that warehouse operations cannot be supported safely and effectively if suitable Material Handling Equipment is unavailable. This could impact goods receipt, stock movement, picking, loading and dispatch activity, and may increase manual handling and health and safety risks.
WHAT IS THE CURRENT RISK SCORE	Not applicable
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	With approval to proceed, the risk will be mitigated.
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Not applicable
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
All risks must be evidenced and consistent with those recorded in Datix.	



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PROCUREMENT OUTCOME REPORT

MATERIAL HANDLING EQUIPMENT LEASE, HIRE
AND MAINTENANCE
SSP-FTS-60006

Agreement Type <i>Framework/Contract</i>	Contract
Brief Agreement Description	Provision of a comprehensive, fully managed solution for the lease, short-term hire and maintenance of Material Handling Equipment (MHE) for NWSSP Supply Chain, Logistics and Transport, including optional service and maintenance support for Authority-owned MHE and optional training services.
Agreement Duration Initial Term and Extension Option	Three (3) year initial term with the option to extend by two (2) further periods of twelve (12) months.
Contract Dates <i>Initial Term & Extension Option</i>	Initial Term: 01/09/2026 – 31/08/2029 Extension One: 01/09/2029 – 31/08/2030 Extension Two: 01/09/2030 – 31/08/2031
Planned / Unplanned	Planned
No. of Tenders Issued	Open Procedure
No. of Tenders Received	One (1)
Annual Value of Current Agreement	N/A - No current single agreement
Annual Value of New Agreement	£208,000 (ex VAT)
Total Value of New Agreement <i>Including Extensions</i>	Initial Term: £624,000 (ex VAT) Extension One: £208,000 (ex VAT) Extension Two: £208,000 (ex VAT) Total: £1,040,000 (ex VAT)
Savings / Increase <i>Cash Releasing Cost Avoidance Cost Pressure</i>	N/A – Demand-led requirement
Lead Body LHB or Trust	NHS Wales Shared Services Partnership
Impact of Change	Risk Identified - Medium

1. Product / Market Overview

This procurement is for the lease, short-term hire and maintenance of Material Handling Equipment (MHE) to support NWSSP Supply Chain, Logistics and Transport operations across Wales. The requirement covers the four regional warehouse sites at Denbigh, Bridgend, Picketston and Newport (NDC).

MHE is essential to the safe and efficient operation of warehouse and distribution activity, including goods receipt, storage, picking, loading and movement of stock. Failure or unavailability of equipment would create operational disruption, reduced throughput and health and safety risk.

The scope includes equipment such as powered pallet trucks, reach trucks, counterbalance forklifts, order picking equipment, scrubber dryers and related equipment. The Agreement also allows NWSSP to access short-term hire, service and maintenance support for Authority-owned equipment and training where this is operationally or commercially advantageous.

The market for MHE is established, with national manufacturers, dealers and rental providers able to supply lease, hire and maintenance solutions. The procurement was structured around clear equipment specifications, service responsiveness, statutory compliance, asset reporting, sustainability and commercial flexibility. No minimum volumes are guaranteed under the Agreement, allowing NWSSP to place orders only where there is a confirmed operational need and budget approval.

2. Procurement Process

The requirement was procured through an open competitive procedure in accordance with the Procurement Act 2023.

The opportunity was published on eTenderWales on 4th February 2026, with a tender submission deadline of 5th March 2026, this was later extended to 1st April 2026 to allow bidders more time to submit a response. The opportunity was also advertised through the relevant public procurement notice routes to support transparency, equal treatment and open market access.

The contract is for a single supplier award. This approach supports consistency of service, standardisation of equipment, simplified ordering, improved asset visibility and robust business continuity across the NWSSP Supply Chain.

Bidders were assessed on the following Most Advantageous Tender (MAT) award criteria:

Award Criteria	Percentage Weighting
Qualification	Pass / Fail
Technical (Stage 1)	Pass / Fail
Technical (Stage 2)	40%
Commercial	60%

Sixteen (16) potential suppliers viewed and accessed the tender document, with one (1) supplier submitting a bid:

- Toyota Material Handling UK Limited

After the publication of the tender notice, all potential suppliers were able to raise clarification questions until 4th March 2026, later extended to 31st March 2026, following the tender extension. Clarification questions, together with the responses provided, were documented and issued to all bidders via eTenderWales. Ten (10) tender clarifications were received and answered.

3. Evaluation	
Qualification	The qualification evaluation was undertaken by Phil Jones – Procurement Business Manager. During the evaluation, it was noted that Toyota Material Handling UK Limited had a Dun & Bradstreet failure score of 6, which represents a high risk of severe financial stress. NWSSP Procurement recommends excluding suppliers with a score below 30. This position was therefore brought to the attention of NWSSP SCLT for consideration. Following review, NWSSP determined that the risk was sufficiently mitigated by the structure of the Agreement. This is due to the demand-led nature of the Agreement, with no guaranteed minimum spend, orders being placed by approved purchase order only, no advance payment commitment and ongoing supplier performance and financial monitoring throughout the life of the Agreement. Toyota Material Handling UK Limited satisfied all other qualification requirements and was therefore progressed to the technical and commercial evaluations in accordance with the published evaluation methodology.
Evaluation Panel(s)	The evaluation panel included four (4) representatives with relevant operational, warehouse and logistics knowledge from NWSSP SCLT: • Mike Burns – Deputy Head of Supply Chain, Logistics and Transport (North Wales) • Christopher Johns – Regional Supply Chain Manager • Nick Hailes – Supply Chain Area Manager • Rob Watts – Regional Supply Chain Manager – South / South West

Technical &
Commercial Scores

Technical Evaluation:

Prior to the scored evaluation, the bidder was assessed against the mandatory pass / fail technical requirements of the specification. The bidder was deemed to have submitted compliant responses and was therefore progressed to the scored technical evaluation.

The scored technical evaluation was undertaken in accordance with the published evaluation methodology and award criteria. The technical element of the tender accounted for 40% of the overall score, made up of 30% technical quality and 10% social value.



SSP-FTS-60006 -
Technical Evaluations.

Toyota achieved a weighted technical / quality score of 25% out of the available 40%. The evaluation identified that their response met the requirement.

Commercial Evaluation:

The commercial element accounted for 60% of the overall score. Bidders were required to complete a commercial pricing schedule which requested pricing against a basket of goods and services representative of the anticipated requirements under the Agreement. This included pricing for a range of material handling equipment lease, hire and maintenance requirements, enabling the commercial evaluation to be undertaken on a consistent and comparable basis.

The basket of goods approach was used for evaluation purposes only and does not represent a guaranteed level of spend or a commitment to purchase all listed items. Actual requirements will be demand-led and ordered as and when required by NWSSP through approved purchase orders.



SSP-FTS-60006 -
Commercial Evaluatio

Toyota Material Handling UK Limited submitted the only commercial response and achieved the full commercial score of 60%. The evaluated commercial basket total was £34,057.48 excluding VAT, based on the submitted pricing schedule.

Combined Evaluation:

Following completion of the qualification, technical, social value and commercial evaluations, the scores were combined in accordance with the published evaluation methodology.



SSP-FTS-60006 -
Combined Evaluation.

Toyota Material Handling UK Limited achieved a score of 85% and were the highest ranked compliant tender and are therefore recommended for award.

4. Price Benchmarking Information

Direct price benchmarking is limited because only one tender submission was received and the requirement is demand-led, with no guaranteed equipment volumes. The procurement was nevertheless advertised openly and evaluated against a structured commercial pricing schedule, allowing each equipment and service element to be assessed consistently.

Toyota submitted lease pricing for each required equipment type for one (1) to five (5) year lease periods and hire pricing for short-term hire periods. The evaluated commercial basket total was £34,057.48 excluding VAT. This comprised lease pricing of £6,814.08, hire pricing of £18,730.66, service and maintenance pricing for Authority-owned equipment of £4,903.74, and training pricing of £3,609.00. The service, maintenance and training elements are captured for visibility and future use where required, but do not commit NWSSP to purchase those services.

The Agreement will operate against the awarded rate schedule. All spend will be controlled through approved purchase orders, with orders raised only where there is an identified operational requirement and budget approval.

5. Financial Implications

The estimated total value of the Agreement is £1,040,000 (ex VAT) over the maximum five (5) year term, including both extension options.

This value is an estimate and does not represent a commitment to spend. The Agreement is demand-led and there are no guaranteed minimum volumes. Actual expenditure will depend on the number and type of lease, hire, service and training orders placed by NWSSP SCLT during the term.

Orders will be placed through official purchase orders in accordance with NWSSP Standing Financial Instructions and local budget approval processes. No order should be placed unless there is a confirmed operational requirement, approved

budget and confirmation that the order is within the scope and pricing of the Agreement.

The commercial structure provides NWSSP with a consistent pricing mechanism for planned lease requirements and short-term hire needs, while retaining flexibility to use service / maintenance and training options only where they provide operational or commercial value.

6. Sustainable Procurement

Sustainability formed part of the technical evaluation, including assessment of asset management, reporting, sustainability outcomes, the Well-being of Future Generations (Wales) Act 2015, the Foundational Economy and carbon reduction.

Toyota’s proposal included electric material handling equipment across the submitted range, service support, I_Site fleet / truck management functionality, pre-operational checks and reporting tools to support asset visibility, utilisation monitoring, safety and preventative maintenance.

The supplier also provided information on its sustainability approach, including a commitment to reducing environmental impact, use of lower-carbon equipment options such as lithium-ion and fuel cell technology and reference to its sustainability reporting and EcoVadis Platinum level assessment.

The Agreement supports sustainable procurement by enabling NWSSP to standardise equipment, improve utilisation visibility, reduce avoidable downtime, manage equipment lifecycle more effectively and only place orders where there is a confirmed operational requirement.

7. Risks and Mitigations

Risk	Rating	Mitigation
Single tender response	Medium	The requirement was advertised through an open procedure using the published notice route, allowing the wider market the opportunity to bid.
Supplier financial standing	Medium	The Agreement structure limits NWSSP’s financial exposure as there is no guaranteed spend, no advance payment commitment and orders will be placed by approved purchase order only. Supplier performance and financial standing will be monitored

		throughout the Agreement, with further financial assurance sought if required.
Equipment availability and operational downtime	Medium	This will be managed through agreed service and maintenance arrangements, response times, replacement equipment where required, contract review meetings and KPI monitoring.
Mobilisation across multiple sites	Low	This will be managed through phased implementation, site-level engagement, agreed delivery plans, asset registers and clear communication between Toyota, NWSSP SCLT and warehouse management.
Health, safety and statutory compliance	Medium	The Supplier will be required to comply with all relevant health, safety and statutory requirements. Compliance will be monitored through inspection records, service reporting and contract review meetings.

8. Recommendations

It is recommended that approval is granted to award contract SSP-FTS-60006 - Material Handling Equipment Lease, Hire and Maintenance to Toyota Material Handling UK Limited.

The recommended award is for an initial term of three (3) years from 1st September 2026 to 31st August 2029, with the option to extend by two (2) further periods of twelve (12) months, taking the maximum term to 31st August 2031.

The estimated total value of the Agreement is £1,040,000 (ex VAT) over the maximum term. This is an estimated value only and does not create a guaranteed spend commitment. Actual expenditure will be controlled by approved purchase orders and will depend on operational demand.

No award, contract execution or purchase order should be progressed until all required internal approvals, notice requirements and any applicable standstill obligations have been completed.

9. Contract Management

Velindre Trust Board meeting: 30th July 2026

It should be noted that the Contract Briefing Paper was submitted to Welsh Government for Ministerial Approval on 27th November 2025, but confirmation of approval remains outstanding at the time of writing. Award of the Agreement will remain subject to receipt of the required Welsh Government approval / confirmation to proceed.

Following receipt of the required internal, Velindre and Welsh Government approvals, NWSSP will issue the required assessment summary to the assessed supplier and publish the UK6 Contract Award Notice. Publication of the UK6 Contract Award Notice will commence the applicable standstill period.

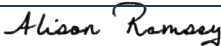
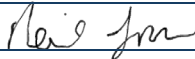
Subject to there being no successful challenge during the standstill period, NWSSP will proceed to enter into the Agreement with the successful supplier. Following contract signature, the required UK7 Contract Details Notice will be published within 30 days of entering into the contract in accordance with the Procurement Act 2023.

12. Working Group Members		
Name	Title	Organisation
Phil Jones	Procurement Business Manager	NWSSP
Mike Burns	Deputy Head of Supply Chain, Logistics and Transport (North Wales)	NWSSP
Christopher Johns	Regional Supply Chain Manager	NWSSP
Nick Hailes	Supply Chain Area Manager	NWSSP
Rob Watts	Regional Supply Chain Manager – South / Southwest	NWSSP

13. Attachments
Appendix 1 - Toyota Material Handling UK Limited Dun & Bradstreet Report
 TOYOTA MATERIAL HANDLING UK LIMITE

14. Contact Information	
If you have any issues you wish to discuss, please do not hesitate to contact:	
Prepared by	
Name:	Phil Jones
Contact Details:	Philip.Jones12@wales.nhs.uk
Date:	29/06/2026
Reviewed by	
Signed:	
Name:	Ian Emptage
Role:	Deputy Head of National Sourcing
Date:	30/06/2026
Procurement Approval	
Signed:	
Name:	Andrew Smallwood
Role:	Assistant Director of Procurement
Date:	30/06/2026
Procurement Approval	
Signed:	 FW_SSP-FTS-60006 - Material Handling E
Name:	Jonathan Irvine
Role:	Director of Procurement
Date:	01/07/2026

15. Acceptance	
Please confirm your acceptance to participate in this procurement and your agreement to the proposal either by signing and returning this Procurement Outcome Report. NB. Your prompt response to this document is critical to maintain agreed timelines.	
Agreement to participate:	
I confirm acceptance of the outcome detailed in this report, and that the expenditure has an identified budget and will not cause any financial pressure which could result in the Organisation not delivering its financial breakeven duty.	
NHS Wales Shared Services Partnership	 RE_SSP-FTS-60006 - Material Handling Equ Signed:

	Name:	Mike Burns
	Role:	Deputy Head of Supply Chain, Logistics and Transport (North Wales)
	Date:	30/06/2026
NHS Wales Shared Services Partnership	Signed:	 RE_SSP-FTS-60006 - Material Handling Equ
	Name:	Christopher Johns
	Role:	Regional Supply Chain Manager
	Date:	30/06/2026
NHS Wales Shared Services Partnership	Signed:	 RE_SSP-FTS-60006 - Material Handling Equ
	Name:	Nick Hailes
	Role:	Supply Chain Area Manager
	Date:	30/06/2026
NHS Wales Shared Services Partnership	Signed:	 RE_SSP-FTS-60006 - Material Handling Equ
	Name:	Rob Watts
	Role:	Regional Supply Chain Manager – South / Southwest
	Date:	30/06/2026
NHS Wales Shared Services Partnership	Signed:	
	Name:	Alison Ramsey
	Role:	Director of Finance & Corporate Services
	Date:	01-Jul-26
NHS Wales Shared Services Partnership	Signed:	
	Name:	Neil Frow
	Role:	Managing Director Shared Services
	Date:	01-Jul-26

COMMITMENT OF EXPENDITURE EXCEEDING CHIEF EXECUTIVE'S LIMIT / BUSINESS JUSTIFICATION

SCHEME TITLE	Material Handling Equipment Lease, Hire and Maintenance
DIVISION / HOST ORGANISATION	NHS Wales Shared Services Partnership (NWSSP) Supply Chain, Logistics and Transport (SCLT)
DATE PREPARED	30/06/2026
PREPARED BY	Mike Burns, Deputy Head of Supply Chain, Logistics and Transport and Phil Jones, Procurement Business Manger
SCHEME SPONSOR	Jonathan Irvine, Director of Procurement and Health Courier Service

**All Divisional proposals must be consistent with the strategic and operational plans of
Velindre University NHS Trust.**

1. DESCRIPTION OF GOODS / SERVICES / WORKS

Approval is sought to award Contract SSP-FTS-60006 for the provision of Material Handling Equipment lease, short-term hire and maintenance services to Toyota Material Handling UK Limited.

The contract will provide a comprehensive, fully managed solution for Material Handling Equipment across NWSSP Supply Chain, Logistics and Transport warehouse operations in Denbigh, Bridgend, Picketston and Newport National Distribution Centre.

Material Handling Equipment is essential to the safe and efficient operation of warehouse and distribution activity, including goods receipt, stock movement, storage, picking, loading and dispatch. Failure or unavailability of this equipment would create operational disruption, reduced warehouse throughput and potential health and safety risk.

The scope includes, but is not limited to:

- Powered pallet trucks;
- Reach trucks;
- Counterbalance forklifts;
- Order picking equipment;
- Scrubber dryers;
- Short-term hire equipment;
- Service and maintenance support for Authority-owned equipment, where required; and



- Training services, where operationally or commercially advantageous.

The contract will be demand-led, with no guaranteed minimum spend or minimum equipment volumes. Orders will only be placed where there is a confirmed operational requirement, approved budget and an approved purchase order.

The contract will support standardisation of equipment across NWSSP SCLT sites, improve service and maintenance arrangements, provide greater cost control, and reduce reliance on ad hoc or reactive arrangements.

1.1 Nature of contract:

Please indicate with a (x) in the relevant box

First time



Contract Extension



Contract Renewal



1.2 Period of contract including extension options:

Expected Start Date of Contract

01/09/2026

Expected End Date of Contract

31/08/2029

Contract Extension Options

Two Optional 12-Month Extensions

(E.g. maximum term in months)

60 Months

2. STRATEGIC FIT (*Host organisations are not required to complete Section 2*)

2.1 OUR STRATEGIC PILLARS

This scheme should relate to at least one of the Trust's five strategic pillars. Please mark with a (x) in the box the relevant pillars for this scheme.

Goal 1: Be recognised as a pioneer in blood and transplantations services across Europe.



Goal 2: Be a recognised leader in specialist cancer services in Europe.



Goal 3: Be recognised as a leader in stated priority areas of research, development and innovation.



Goal 4: An established 'University' Trust which provides highly valued knowledge and learning for all.





Goal 5: An exemplar of sustainability that supports global well-being and social value.		☒
2.2 INTEGRATED MEDIUM TERM PLAN		
Is this scheme included in the Trust Integrated Medium Term Plan?	Yes	No
	☒	☐
If not, please explain the reason for this in the space provided.		
2.3 SHAPING OUR FUTURE WELLBEING OBJECTIVES		
This scheme should relate to at least one of the Trust's wellbeing objectives. Please mark with a (x) in the box the relevant objectives for this scheme.		
Reduce health inequalities, make it easier to access the best possible healthcare when it is needed and help prevent ill health by collaborating with the people of Wales in novel ways.	☐	
Improve the health and well-being of families across Wales by striving to care for the needs of the whole person.	☐	
Create new, highly skilled jobs and attract investment by increasing our focus on research, innovation and new models of delivery.	☐	
Deliver bold solutions to the environmental challenges posed by our activities.	☒	
Bring communities and generations together through involvement in the planning and delivery of our services.	☐	
Demonstrate respect for the diverse cultural heritage of modern Wales.	☐	
Strengthen the international reputation of the Trust as a centre of excellence for teaching, research and technical innovations whilst also making a lasting contribution to global well-being.	☐	
FIVE WAYS OF WORKING (SUSTAINABLE DEVELOPMENT PRINCIPLES) CONSIDERED		
Please mark with a (x) in the box the relevant principles for this scheme. Click here for more information		
Prevention	☐	Long Term
	☒	
Integration	☐	Collaboration
	☒	
Involvement	☐	

3. OPTIONS CONSIDERED

Include 'business as usual' i.e. 'do nothing'

3.1 Please state alternative options considered and reasons for declining
<u>Option 1 – Do Nothing</u>



This is not a viable option. Material Handling Equipment is essential to warehouse operations across Denbigh, Bridgend, Picketston and Newport. If no contract is awarded, NWSSP SCLT would be required to rely on ad hoc arrangements, existing equipment beyond its appropriate lifecycle or short-term reactive hire. This would increase the risk of equipment downtime, service disruption, health and safety issues and unplanned costs.

Option 2 – Continue with separate or site-specific arrangements

This option was considered but rejected. Separate arrangements across sites would reduce standardisation, make contract management more difficult and limit NWSSP's ability to achieve consistent service levels, maintenance standards and asset visibility. It would also make it more difficult to manage expenditure and supplier performance across the regional warehouse network.

Option 3 – Purchase equipment outright

Purchasing equipment outright was not considered the preferred option due to the capital outlay required, the need for ongoing maintenance arrangements, lifecycle management responsibility and the risk of holding equipment that may no longer meet future operational requirements. A lease and hire model provides greater flexibility and supports equipment replacement during the contract term.

Option 4 – Award a single-supplier contract following open competition

This is the preferred option. A single-supplier contract provides consistency of equipment, standardised maintenance arrangements, improved asset reporting, simplified ordering, and clearer supplier accountability. The contract also provides flexibility to place orders only when there is a confirmed operational requirement and approved budget.

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option

Option 4

The preferred option provides the following benefits:

- Continuity of warehouse operations across Denbigh, Bridgend, Picketston and Newport
- Improved health and safety through suitable, maintained and compliant equipment
- Standardisation of equipment across the NWSSP SCLT warehouse network
- Reduced risk of equipment downtime through planned maintenance and agreed service support



- Improved cost control through a structured rate schedule and approved purchase order process
- Flexibility to use lease, short-term hire, maintenance and training services only where required
- Improved asset visibility through supplier reporting and fleet management tools
- Support for sustainability through modern, efficient and lower-emission equipment
- Clearer contract management through a single supplier and agreed performance monitoring arrangements.

The preferred option provides the most appropriate balance between operational resilience, commercial control, safety and flexibility.

5. RISKS & MITIGATION

5.1 Please state risks of not proceeding with the scheme	5.2 Please state any mitigation to reduce the risk if the scheme is not approved
If the contract is not awarded, there is a risk that NWSSP SCLT will not have suitable Material Handling Equipment available to support warehouse and distribution operations. Equipment failure or unavailability could lead to delays in goods receipt, storage, picking, loading and dispatch activity. There is a risk of increased health and safety exposure if ageing or unsuitable equipment continues to be used. There is a risk of increased cost through ad hoc hire, reactive servicing and unplanned maintenance. There is a risk that inconsistent equipment and maintenance arrangements across sites will reduce operational efficiency and make performance management more difficult. There is a risk that NWSSP will be unable to demonstrate best value and appropriate procurement compliance if demand continues to be managed through fragmented arrangements.	Limited mitigation would be available through short-term hire or reactive servicing arrangements. This would not provide the same level of cost control, standardisation, maintenance assurance or supplier accountability. Awarding the contract to Toyota Material Handling UK Limited will mitigate the risk by providing a structured, compliant and demand-led contract route. Spend will be controlled through approved purchase orders and only placed where there is an operational requirement and budget approval. Supplier performance, equipment availability, response times, statutory compliance and financial standing will be monitored through contract management arrangements.



6. PROCUREMENT ROUTE

6.1 How is the contract being procured? Please mark with a (x) as relevant.	
Competition	Single source
3 Quotes ☐	Single Quotation Action ☐
Formal Tender Exercise ☒	Single Tender Action ☐
Mini competition ☐	Direct call off Framework ☐
Find a Tender ☒ (replaces OJEU Public Contract regulations 2015 still apply)	All Wales contract ☐
Click here for link to Procurement Manual for additional guidance	
6.2 Please outline the procurement strategy	
The requirement was procured through an open competitive procedure in accordance with the Procurement Act 2023, the Trust's Standing Financial Instructions and internal governance procedures. The opportunity was advertised openly to the market to support transparency, equal treatment and open market access. Sixteen potential suppliers accessed the tender documentation and one tender response was received from Toyota Material Handling UK Limited. The contract was structured as a single-supplier award to support operational consistency, standardisation of equipment, simplified ordering, improved asset visibility and clear supplier accountability across the NWSSP SCLT warehouse network. The tender evaluation was based on the Most Advantageous Tender. The published award criteria were: - Qualification – Pass / Fail - Technical Stage 1 – Pass / Fail - Technical Stage 2 – 40% - Commercial – 60% Toyota Material Handling UK Limited passed the qualification and mandatory technical requirements and progressed to the scored evaluation. Toyota achieved a weighted technical	



score of 25% out of the available 40% and achieved the full commercial score of 60%, resulting in a total score of 85%.

Toyota Material Handling UK Limited is therefore recommended for award as the highest ranked compliant tender.

During the qualification evaluation, an initial Dun & Bradstreet report identified a supplier financial standing concern. A further Dun & Bradstreet report was subsequently run on 3rd July 2026, which confirmed an improved failure score of 56, representing a low to moderate risk of severe financial stress.

The difference between the initial and updated reports is understood to be due to a timing issue with Dun & Bradstreet's records, as Toyota Material Handling UK Limited's latest filed accounts had not been reflected in the Dun & Bradstreet assessment at the time of the previous check. The updated score is above the NWSSP recommended exclusion threshold and the supplier financial standing position is not considered to prevent award. Supplier performance and financial standing will continue to be monitored throughout the contract term.

6.3 What is the approximate timeline for procurement?

4 February 2026 – Tender Published

The tender was published via eTenderWales and the relevant public procurement notice routes.

1 April 2026 – Tender Closed

The original tender deadline was extended to allow bidders additional time to submit a response.

April to June 2026 – Evaluation and Approval Preparation

Qualification, technical, social value and commercial evaluations were undertaken in accordance with the published methodology. The Procurement Outcome Report and supporting approval papers were prepared following completion of the evaluation.

2 July 2026 – Paper Deadline

Board approval papers to be submitted in accordance with the required governance timetable.

16 July 2026 – SSPC Meeting

The outcome and recommendation to award will be submitted for SSPC review and approval.

30 July 2026 – Velindre Trust Board Meeting

Velindre Trust Board approval will be sought to award the contract.



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

Following Approvals – Intention to Award and Standstill

Once all approvals have been received, the Intention to Award will be issued and the procurement will enter the mandatory standstill period.

Following Standstill – Contract Details Notice and Award

Subject to successful completion of the standstill period, the Contract Details Notice will be published and the contract may be awarded.

1 September 2026 – Contract Commencement

The contract will commence.

6.4 PROCUREMENT ROUTE APPROVAL

The Head of Procurement / Delegated Authority has approved the preferred procurement route

Head of Procurement Name:	Ian Emptage Deputy Head of National Sourcing
Signature:	I.Emptage
Date:	30 June 2026

Maximum expected whole life cost relating to the award of contract	Excluding VAT (£k) £1,040,000	Including VAT (£k) £1,248,000
The nature of spend	Capital ☐	Revenue ☒

How is the scheme to be funded? Please mark with a (x) as relevant.

Existing budgets ☒
Additional Welsh Government funding ☐
Other ☐

If you have selected 'Other' – please provide further details below:

The contract will be funded from existing NWSSP Supply Chain, Logistics and Transport operational budgets.

The estimated annual value is £208,000 excluding VAT. The estimated value over the initial three-year term is £624,000 excluding VAT. If both optional one-year extensions are utilised, the maximum estimated value will be £1,040,000 excluding VAT.



This value is an estimate only and does not create a guaranteed spend commitment. The contract is demand-led and there are no guaranteed minimum volumes. Actual expenditure will depend on operational need and will be controlled through approved purchase orders in accordance with NWSSP Standing Financial Instructions and local budget approval processes.

No order should be placed unless there is a confirmed operational requirement, approved budget and confirmation that the order is within the scope and pricing of the awarded contract.

7. FINANCIAL ANALYSIS

PROFILE OF EXPENDITURE

EXPENDITURE CATEGORY	Year 1 (exc. VAT) £k	Year 2 (exc. VAT) £k	Year 3 (exc. VAT) £k	Total Future Years (exc. VAT) £k	Total (exc.VAT) £k	Total (inc. VAT) £k
Material Handling Equipment Lease, Hire and Maintenance	£208,000	£208,000	£208,000	£416,000	£1,040,000	£1,248,000
Overall Total	£208,000	£208,000	£208,000	£416,000	£1,040,000	£1,248,000

8. PROJECT MANAGEMENT (if applicable)

What are the management arrangements associated with this scheme? E.g. PRINCE 2	Contract management will be led by NWSSP Supply Chain, Logistics and Transport, supported by NWSSP Procurement Services where required. A named contract manager will act as the primary point of contact and will oversee supplier performance, ordering, pricing, service levels and issue resolution. Contract monitoring will include equipment availability, planned preventative maintenance, breakdown response times, statutory inspection compliance, replacement equipment, reporting,



	sustainability and training activity where used. Performance will be reviewed through contract review meetings and supplier management information. Any performance issues, pricing queries, scope changes or requests outside the awarded Agreement should be referred to Procurement before any commitment is made.

9. DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE

The Lead Director, by providing email confirmation, to seek Board approval is making a declaration that all procurement procedures, standing orders and standing financial instructions requirements have been appropriately discharged and observed and that where relevant, appropriate advice and confirmation has been obtained to that effect. Procurement Services retain this confirmation electronically in the tender file.	
Lead Director Name:	Jonathan Irvine, Director of Procurement and Health Courier Services
Signature:	
Service Area:	Procurement Services
Date:	08/07/2026

10. APPROVALS RECEIVED

List and include date of approvals received in support of this scheme.

Divisions	Date of Approval:
Business Planning Group or local equivalent	
Divisional Senior Management Team	
Executive Management Board	

Host Organisations	Date of Approval:
NWSSP / NHS Wales Shared Services Partnership Committee	Shared Services Partnership Committee on 16 July 2026
HTW – Senior Management Team	

Quality-driven decision-making

Quality Impact Assessment

Title of proposal this Quality Impact Assessment (QIA) is supporting:	Material Handling Equipment Lease, Hire and Maintenance
Reference of proposal:	SSP-FTS-60006
Details of Board / Committee the paper is being presented to and when:	Shared Services Partnership Committee – 16 July 2026 Velindre Trust Board – 30 July 2026

Part 1: Health and Care Quality Standards assessment

1a: Briefly outline how this proposal or strategic decision impacts on the delivery of healthcare services (in line with STEEEP Quality Standards).

Quality Standard <i>Click each icon for its definition</i>	Overall Impact			Key points and rationale
	Positive (+1) / Neutral / Negative (-1)	Level of impact High (3) Medium (2) or Low (1)	Impact score (product of previous columns)	
	+1	2	2	The proposal supports the safe delivery of healthcare services by ensuring that NWSSP Supply Chain, Logistics and Transport has access to suitable, maintained and compliant Material Handling Equipment. This supports the safe movement of goods through NHS Wales warehouse operations and reduces the risk of delays, equipment failure, manual handling issues or health and safety incidents that could affect the onward supply of goods to NHS services. Maintaining access to reliable and compliant Material Handling Equipment is important for business continuity and helps reduce the risk of disruption to the NHS Wales supply chain.

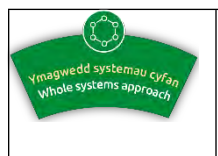
Quality Impact Assessment tool / April 2024

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	+1	2	2	The proposal supports timely healthcare service delivery by helping to maintain the flow of stock through the NHS Wales supply chain. Reliable Material Handling Equipment supports goods receipt, storage, picking, loading and dispatch, which helps ensure that healthcare services receive required supplies within expected timescales.
	+1	1	1	The proposal supports effective healthcare services by strengthening the operational infrastructure that underpins NHS Wales logistics. A managed lease, hire and maintenance contract will help ensure that appropriate equipment is available to support warehouse operations, reducing the risk of service disruption caused by equipment downtime or inconsistent maintenance arrangements.
	+1	3	3	The proposal supports efficient healthcare service delivery by improving the reliability and management of equipment used within the NHS Wales supply chain. Standardised equipment, planned maintenance, supplier reporting and purchase order controls will help reduce avoidable downtime, improve throughput and support better use of resources across the warehouse network.
	-	1	1	No direct impact or link.
	-	1	1	No direct impact or link.
Overall impact	The proposal has a positive indirect impact on healthcare service delivery. While the contract is not patient-facing, Material Handling Equipment is essential to the warehouse and logistics operations that support NHS Wales services. The proposal will help maintain the safe, timely, effective and efficient movement of goods through the supply chain, reducing the risk of operational disruption that could affect healthcare services.			

1b: Briefly outline the amount of activity required to ensure successful implementation of the proposal or strategic decision (in line with enabling Quality Standards)

Quality Standard <i>Click each icon for its definition</i>	Amount of activity required. High (3), Medium (2) or Low (1)	Key points and actions to achieve the changes required
	2	Implementation will require clear leadership from NWSSP Supply Chain, Logistics and Transport, supported by Procurement, to ensure the contract is mobilised correctly, site requirements are confirmed, and the supplier is managed in line with the agreed contract terms and service levels.
	2	Warehouse teams will need to be engaged during mobilisation to confirm equipment requirements, delivery arrangements, maintenance access and any training or familiarisation required. This will support safe use of the equipment and help maintain continuity of warehouse operations that support NHS Wales services. Access to suitable, well-maintained Material Handling Equipment will also help reduce manual handling risks for warehouse staff, supporting a safer working environment and reducing the potential for workplace injuries.
	1	The proposal does not require a significant cultural change.
	1	Accurate asset, service, maintenance and utilisation information will need to be maintained and reviewed. This will support contract management, equipment availability, performance monitoring and timely decision-making across the warehouse network.
	1	Learning will be captured through supplier review meetings, operational feedback and monitoring of equipment performance. Any improvements identified during the contract term can be managed through normal contract management processes.

	2	Implementation will need to be coordinated across Denbigh, Bridgend, Picketston and Newport to ensure that equipment availability, maintenance arrangements and supplier support are consistent across the regional warehouse network. This will support the wider NHS Wales supply chain and help maintain continuity of supplies to healthcare services.
Overall amount of activity required		The overall amount of activity required is assessed as Medium. The contract is not a direct clinical service change, but successful implementation will require coordinated mobilisation, site engagement, staff familiarisation, asset reporting and ongoing contract management. This will ensure that Material Handling Equipment is available, maintained and used safely to support warehouse and logistics operations that underpin healthcare service delivery across NHS Wales.

Part 2: High-level consideration of risk

Considering responses on all twelve Health and Care Quality Standards in Part 1, what level of risk to **Quality overall** is this proposal or strategic decision?

Slide the arrow to indicate the level of risk (recognise this is subjective until full risk assessment undertaken)



Level of risk to Quality of implementing this proposal	Low	Low/medium	Medium	Medium/high	High
Level of risk to Quality of NOT implementing this proposal	Low	Low/medium	Medium	Medium/high	High



Describe the main risks to Quality of implementing this proposal?

If Implemented

Describe the main risks to Quality of NOT implementing this proposal?

If Not Implemented

If implemented, the main risks are:

- Mobilisation delays across multiple warehouse sites
- Supplier performance issues
- Equipment availability or lead time delays
- Financial standing risk linked to the supplier's D&B score
- Possible requirement for additional staff familiarisation or training
- Need to ensure service and maintenance arrangements are properly embedded

These risks will be managed through agreed mobilisation plans, contract review meetings, supplier performance monitoring, purchase order controls, service reporting, asset registers and escalation through Procurement where required.

Describe the main risks to Quality of NOT implementing this proposal

If not implemented, NWSSP SCLT may not have a compliant and structured route to access suitable Material Handling Equipment. This could result in operational disruption, increased manual handling, health and safety exposure, increased reactive hire or maintenance costs, and reduced warehouse efficiency.

Failure to proceed could also reduce NWSSP's ability to manage equipment lifecycle, asset visibility, statutory compliance and supplier performance consistently across the warehouse network.



Part 3: Developing and signing off this Quality Impact Assessment

QIA completed by / on date	QIA operationally agreed by / on date	QIA clinically agreed by / on date
Phil Jones, Procurement Business Manager 30/06/2026	Mike Burns, Deputy Head of Supply Chain, Logistics and Transport 30/06/2026	Martin Edwards, Medical Director 03/07/2026

Executive clinical review and sign off (if required)

Executive 1 sign off / date	Clinical Executive 2 sign off / date	Clinical Executive 3 sign off / date
Jonathan Irvine, Director of Procurement and Health Courier Services 01/07/2026	Martin Edwards, Medical Director 03/07/2026	Not applicable



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

TRUST BOARD	
Childcare Vouchers Scheme Guidance Review	
DATE OF MEETING	30 July 2026
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Claire Budgen, Organisational Development Specialist
PRESENTED BY	Sarah Jenkins, Executive Director of People and Organisational Development (Interim)
APPROVED BY	Sarah Jenkins, Executive Director of People and Organisational Development (Interim)
EXECUTIVE SUMMARY	The Childcare Voucher Guidance has been updated in line with the Trust's policy schedule.
RECOMMENDATION / ACTIONS	To approve the Guidance.

GOVERNANCE ROUTE			
List the Name(s) of Committee / Group who have previously received and considered this report:	Date		
Executive Management Board	2.7.26		
Quality, Safety and Performance Committee	16.7.26		
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The Executive Management Board endorsed the report for onward submission to the Quality, Safety and Performance Committee. The Quality, Safety and Performance Committee endorsed the report for onward submission to the Trust Board.			
7 LEVELS OF ASSURANCE			
<table border="1"> <tr> <td>ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR</td> <td></td> </tr> </table>		ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR			
APPENDICES			
1	Childcare Vouchers Scheme Guidance 30.7.26		

1. SITUATION

The Childcare Vouchers Scheme Guidance was approved in 2020. It has now been reviewed in line with the Trust's policy review schedule.

2. BACKGROUND

HMRC offer a salary sacrifice scheme whereby employees may receive part of their salary tax-free in the form of vouchers to pay for childcare. This provides economic benefits to those who pay for childcare through the scheme. HMRC closed the scheme to new entrants in 2018 and the Trust now has just 13 employees registered and in receipt of vouchers.

3. ASSESSMENT

The Guidance document from 2020 was reviewed in May and June 2026 to ensure factual accuracy. The following changes have been made.

Contributor	Comment	Action
NWSSP	The Velindre ID is still correct and the URL for the payroll page is below: https://nhswales365.sharepoint.com/sites/SSP_Intranet_ES/SitePages/Velindre-NHS-Trust-(Inc-Hosted-Organisations).aspx	Document updated with new link.
OD Specialist	Front sheet out of date	Front sheet updated
OD Specialist	Contact for provider out of date	Contact updated to Eden Red Reward Gateway
OD Specialist	Link to independent financial advice did not work	Replaced with guidance to go to the website of the NHS Business Services Authority and Independent Financial Advisor
OD Specialist	Repetition of Eden Red's contact information at end of document	Repetition of Eden Red's contact information deleted at end of document
OD Specialist	Needed to check if weekly limit in FAQs had changed	HMRC website confirms that the limit is still £55 a week
OD Specialist	Variable line spacing and font	Arial 12 and 1.15 spacing applied

4. SUMMARY OF MATTERS FOR CONSIDERATION

The Trust Board is asked to approve this Guidance.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☐ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK – BOARD ASSURANCE FRAMEWORK (BAF)	Choose an item BAF06 - There is a strategic risk that our people will not feel a sense of belonging, not feel valued in their roles, not understand how they contribute to organisational success, and will be unable to speak up in confidence, resulting in a negative impact on staff experience if we do not foster a cohesive culture in line with our organisational values
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Select all relevant domains below
	Safe ☐ Timely ☐ Effective ☐ Equitable ☐ Efficient ☒ Patient Centred ☐
QUALITY IMPACT ASSESSMENT	Not required - not a strategic decision
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Yes The EQIA highlighted a minor positive impact in relation to socio economic status by enabling relevant employees to make tax savings.
TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT	
The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated. Please indicate whether any of the matters outlined in this report impact the Trust's Wellbeing goals:	

If yes select the relevant goals: • A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities. ☒ • A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience. ☐ • A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health ☐ • A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances ☐ • A Wales of more Cohesive Communities - Attractive, viable, safe and well-connected communities. ☐ • A Wales of Vibrant Culture and Thriving Welsh Language -Promoting and protecting culture, heritage and the Welsh language, encouraging people to participate in the arts, and sports and recreation. ☐ • A Globally Responsible Wales – Consideration of whether an action may make a positive contribution to global well-being ☐	
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT	Yes - please outline what, if any, actions were taken as a result
	No impact was detected in relation to protected characteristics. A minor positive impact was noted und our socio-economic duty. The action that emerged from the assessment was to approve the updates to the Guidance.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

6. RISKS

This section should indicate whether any matters addressed in the report carry a significantly increased level of risk for the Trust – and if so, the steps that will be taken to mitigate the risk - or if they will help to reduce a risk identified on a previous occasion.

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



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Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

Ref: ()

CHILDCARE VOUCHER SCHEME GUIDANCE

APPLIES TO ONLY THOSE EMPLOYEES WHO REMAIN ELIGIBLE IN ACCORDANCE WITH THE HMRC GUIDELINES

Executive Sponsor & Function	Executive Director of People and Organisational Development
Document Author:	Organisational Development Specialist
Approved by:	Trust Board
Approval Date:	30 July 2026
Date of Equality Impact Assessment:	15 June 2026
Equality Impact Assessment Outcome:	No negative impact on any protected characteristics. Minor positive impact from socio economic perspective.
Review Date:	2029
Version:	2 (replaces 2020 guidance)

1. Introduction

This guidance applies to all Velindre University NHS Trust employees who are eligible to remain in the Childcare Voucher Scheme, which closed to new entrants on 4th October 2018. It should be noted that this guidance replaces the former Trust Childcare Voucher Scheme Policy.

2. Background

Velindre University NHS Trust has in place a web based Childcare Voucher Scheme, which continues to run under the HMRC Scheme for current registrants. This Scheme will continue to be available to current registrants until such a time as there are no eligible registrants within the Trust.

The Scheme will continue to be available only to current registrants via the on-line web-based system provided by Eden Red Reward Gateway.

3. Scheme Details

The guidance applies to all current registrant Trust (including hosted organisations) employees who use registered childcare services and have a legal responsibility for a child or children aged up to 15 or 16 if the child is disabled. This includes married couples, civil partners, co-habiting couples, single parents, step-parents, adoptive parent and same sex relationships. A parent is defined as the legal guardian.

- 3.1 The scheme supports the payment for childcare before Tax and National Insurance (NI) contributions are taken from the employee's salary.

The general principles behind the scheme are:

- The employer orders vouchers for the employee from the childcare voucher provider, on a monthly basis;
- The vouchers are paid to the employee, forming part of their gross salary, saving tax and NI on the value of the vouchers;
- Employees select their childcare provider and use their electronic vouchers to pay for part of or all of their childcare costs; and
- Childcare providers can redeem the vouchers electronically (either via email or phone) from the Trust's service provider.

Registrants to the scheme can access information via the childcare voucher website by searching Eden Red Reward Gateway.

The employee will be asked to insert the Trust's Scheme ID to enrol. The Trust's Scheme ID is **VELI7731**.

- 3.2 Employees who remain eligible, will receive childcare vouchers on a monthly basis into their online childcare account. Employees are responsible for making their own arrangements to use the vouchers to pay for their registered childcare.
- 3.3 Trust employees who are current registrants may remain in the scheme provided that:
- They have a contract of employment with the Trust;
 - They have full parental responsibility for the child/ren to apply for and utilise childcare vouchers;
 - They use their vouchers for children up to the age of 15 / 16 * years of age. Vouchers can be requested up until the 1st September after the child's 15th birthday or up until the 1st September after the child's 16th birthday, if the child has a disability;
 - Their childcare provider is registered and has agreed to receive payment in vouchers. The Trust's childcare voucher provider can help clarify this when contacted by the employee. Childcare provision will include nurseries, crèches, out of school schemes, playgroups, after school groups, holiday play scheme, registered child minders and nannies, all of which must be registered;
 - Taking childcare vouchers out of the employee's salary does not bring their wage below the National Minimum Living Wage; and
 - The child was born when the employee applied to join the scheme.

4. Important Financial Implications - Pension Scheme

Employees that pay into the NHS Pension Scheme have their pension contributions calculated from their reduced salary, after the voucher amount has been deducted. Therefore, while employees are paying into the pension scheme and receiving childcare vouchers, their pension contributions will be reduced accordingly.

N.B The Trust advises that you seek independent advice regarding your NHS pension available via the website of the NHS Business Services Authority under Independent Financial Advisors (IFAs).

5. Leaving the Scheme

Current Trust employee registrants on the scheme may leave at any time. However, once they have left the scheme they will not be able to re-join it at a later date.

5.1 Refunds to Employees

Employees considering leaving the scheme should allow sufficient time to ensure that they are able to use their paid up vouchers and to provide the Trust with notice of their intentions. If the reason for an employee leaving the scheme and requesting the refund is not as a result as a life changing situation as classified in the FAQ section (Appendix 1), the Trust is under no obligation to make a refund.

The Trust will examine each case on its merits. If the Trust agrees to request a refund from the voucher provider there is a £25.00 plus VAT charge and the Payroll Department will have to deduct the Tax and NI from the refund at the rate the employee was paid on when they made the salary sacrifice.

Refunds can only be for that tax year, anything outside this cannot be refunded. Employees therefore need to plan their childcare carefully.

6. Contact Details for Queries

Should an employee have a specific question regarding the Childcare Voucher Scheme they should contact:

HMRC for personal queries on eligibility visit:

<https://www.gov.uk/help-with-childcare-costs/childcare-vouchers>

Payroll Team for personal queries on salary visit:

[https://nhswales365.sharepoint.com/sites/SSP_Intranet_ES/SitePages/Velindre-NHS-Trust-\(Inc-Hosted-Organisations\).aspx](https://nhswales365.sharepoint.com/sites/SSP_Intranet_ES/SitePages/Velindre-NHS-Trust-(Inc-Hosted-Organisations).aspx)

FREQUENTLY ASKED QUESTIONS

My childcare costs are greater than £243 per month. Why can't I get childcare vouchers for more than this amount?

The government has capped the limit on which you get childcare vouchers free of tax and NICs to £55/28 a week (*£243 per month. This has been calculated on the basis of 53 weeks x £55/28 divided by 12 and rounded up to the nearest whole pound*) regardless of the number of children you have.

This means that if you take vouchers over this limit there are no financial benefits to yourself. The Trust has to pay the childcare voucher provider company a commission charge for all vouchers provided, so there would be an additional cost to the Trust in providing you with vouchers worth more than £243 per month for which you do not receive any financial benefits. Because of this the Trust has decided to limit the scheme to £243 per month per employee.

What happens if my childcare costs vary from month to month e.g. I only pay for childcare during the school holidays?

You should calculate the total annual amount you spend on childcare and divide by 12 to get the average monthly amount you pay on childcare. This will then be the amount of childcare vouchers you get each month, subject to the maximum of £243 per month.

Can I use more than one childcare provider/carer?

Yes, parents often need to combine different types of care. All carers' details can be included in your application form, and you will then receive registration forms for each carer.

What happens if I go on Maternity Leave to have another baby?

This is regarded as being a 'life change' event so you can choose to opt out of the scheme, noting that you would not be eligible to re-join the scheme at a later date.

As actual maternity leave benefits will be based on your earnings in the 8 weeks prior to the start of the 25th week of your pregnancy, you may choose to give notice and come out of the scheme prior to this, noting that you would not be eligible to re-join the scheme at a later date.

Alternatively you could opt to reduce your voucher payments to the minimum of £5.00 to maintain your membership of the scheme. If you opt to continue in the scheme, your salary will continue to be reduced by the same amount while you are on paid maternity leave.

Can I leave the scheme at any time?

Yes, but only if you experience a major change, such as leaving the Trust, long term sick leave, pregnancy, significant change of employment hours or a child starting school. These are called 'life change' events. Otherwise you can leave the scheme at the end of your 12 month contract. Therefore similar to maternity leave it is recommended that you consider reducing the amount you receive in childcare vouchers to the £5.00 minimum, should you wish to remain in the scheme.

What happens if I forget to tell the Trust that my child has left childcare and I no longer need the vouchers?

If this is not a life change event (see above), the Trust is under no obligation to make a refund. The Trust will examine each case on its merits. If the Trust agrees to request a refund from the voucher provider there is a £25.00 plus VAT charge, payable by the employee. The Payroll Department will be required to deduct the Tax and NI from the refund, at the rate you were on when you made the sacrifice.

What happens if I go on long term sick leave, or take unpaid leave?

Whilst on full sick pay leave your salary will continue to be reduced by the value of your childcare vouchers. If you are off on long-term sickness this would be regarded as a 'life change' event and the scheme arrangement can be reviewed. Actual sick pay will be based on your new basic salary at the appropriate rate(s). If you are unfortunate enough to go into half pay, please be advised that the childcare voucher deduction will continue unless you opt to leave the scheme.

If your salary falls below the National Minimum Wage, your sick pay runs out or you take any other period of extended unpaid leave then the Trust reserves the right to review the provision of this benefit and agree new employment contract terms and conditions with you.

How will purchasing childcare vouchers affect my pension?

Your pension contributions will reduce, as they will be based on your new basic salary.

If you are in the NHS pension scheme:

- Old scheme 1995 - benefits are based on the best final salary you have received in the past three years.

- New scheme 2008 – benefits are based on the last 10 years, looking at the best final salary you have received over 3 consecutive years.

However, once you no longer receive childcare vouchers your full salary will be restored. Pension contributions and future benefits would be based on the restored salary, provided you had received this salary for at least a year. You should discuss the possible effects with an independent financial adviser.

Employees should be aware that their salary, after the salary sacrifice, will be used to calculate pension benefits. Pension benefits, as a result, will be calculated on the lower (revised) gross salary.

This may be of particular importance if an employee were to retire on ill health grounds while participating in this scheme. Whilst this may be an unlikely occurrence, the employee could, nevertheless, give notice to withdraw from the scheme in advance of applying for pension benefits, to allow their full salary to be taken into account.

What happens if I am made redundant whilst in receipt of childcare vouchers?

Any redundancy pay would be based on your total remuneration package i.e. your new basic salary plus the value of the childcare vouchers.

If I don't use my vouchers immediately, what happens?

Vouchers will just sit in your account until you wish to use them.

TRUST BOARD	
POLICIES AND GUIDANCE DOCUMENTS TO SUPPORT FAMILY FRIENDLY POLICY	
DATE OF MEETING	July 2026
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Choose an item
REPORT PURPOSE	APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	SUE PRICE, SENIOR PEOPLE & OD BUSINESS PARTNER
PRESENTED BY	SARAH JENKINS, INTERIM DIRECTOR OF PEOPLE AND OD
APPROVED BY	Sarah Jenkins, Executive Director of People and Organisational Development (Interim)
EXECUTIVE SUMMARY	The Family Friendly Policy was reviewed and revised in July 2025. It was approved by internal governance committees and is now live on our intranet/SharePoint. At the time, there was a procedure and guidance document produced on one element of the policy only, this was the Maternity Leave element. To complete the suite of documents, this report asks for consideration and approval of the 4 additional types of leave associated with the Family Friendly policy.
RECOMMENDATION / ACTIONS	Board are asked to approve the 8 documents (4 procedures and 4 associated supporting guidance documents).

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	Date
People Policy Review and Development Group	(15/04/2026)
EMB	(27/04/2026)
QSPC	(16/07/2026)
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The procedures and support guidance documents discussed in this paper, were considered by the People Policy Review and Development Group on 15 th April 2026. There were no further suggestions for amendments to the documents, and it was agreed that these documents could be proceed through the Trust Committee structures with the aim of making the documents available on the intranet/SharePoint, once approved.	
7 LEVELS OF ASSURANCE	
If the purpose of the report is selected as ' ASSURANCE ', this section must be completed.	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Select Current Level of Assurance N/A
APPENDICES	
WF 59C to WF 59J	Adoption, Parental, Shared Parental and Paternity or New Parent Support Leave Procedures and Support Guidance notes.

1. SITUATION

The supporting documents to the Family Friendly policy have been written, reviewed by the Policy group and now need to be approved and published to sit alongside the Family Friendly policy, to complement the policy and for staff to use to understand how they apply the policy.

2. BACKGROUND

The Family Friendly Policy (WF 59a) was revised in July 2025. It was approved via the usual governance routes and is now live on our intranet/SharePoint. At the same time, a Maternity procedure (WF 59b) was written and approved and is now live. There was a requirement to produce the associated procedures and guidance notes for the other types of leave covered in the Family Friendly policy. This paper and the accompanying appendices are provided to complete this action.

To align with the policy, the procedures provide additional information on how to apply for the leave, and includes statutory changes such as:

Paternity Leave: Employees can take paternity leave from day one of employment, with statutory paternity pay still requiring 26 weeks of service.

Unpaid Parental Leave: The previous 12month qualifying period has been removed, so it is now a day-one right.

3. ASSESSMENT

The procedures and supporting guidance notes have been produced to provide staff with more detail on 'how' they apply the detail of the policy. It is important that we provide this information to colleagues, so managers and staff are aware of their individual responsibilities and staff are aware of entitlements under the policy, in line with statutory rights under the Employment Act 2026.

4. SUMMARY OF MATTERS FOR CONSIDERATION

Providing good quality, easy to read and understand procedures and guidance notes supports employee wellbeing as staff are confident and assured on their employment rights, it reduces queries and confusion and it ensures a consistent Trust-wide approach.

5. 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	Select all relevant domains below												
	<table> <tr><td>Safe</td><td>☒</td></tr> <tr><td>Timely</td><td>☒</td></tr> <tr><td>Effective</td><td>☒</td></tr> <tr><td>Equitable</td><td>☒</td></tr> <tr><td>Efficient</td><td>☐</td></tr> <tr><td>Patient Centred</td><td>☐</td></tr> </table>	Safe	☒	Timely	☒	Effective	☒	Equitable	☒	Efficient	☐	Patient Centred	☐
	Safe	☒											
Timely	☒												
Effective	☒												
Equitable	☒												
Efficient	☐												
Patient Centred	☐												
The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). Click or tap here to enter text													
QUALITY IMPACT ASSESSMENT <i>The duty of quality requires quality-driven decision-making for all strategic decisions. The duty of quality is operationalised through the Heath and Care Quality Standards. Therefore, when making decisions about healthcare services, NHS organisations are required to consider the impact of that decision</i>	Not required - not a strategic decision The QIA tool should be completed to support any proposal for a strategic decision to be made and be presented with the proposal to the appropriate decision-making forum. The QIA tool does not replace the need for the proposal; it accompanies it. As a minimum, decisions made by the Board or by Committees of the Board are considered												

on the Health and Care Quality Standards.	strategic and should be assessed for their impact on Quality through the lens of the Health and Care Quality Standards. This culture and discipline of quality-driven decision-making should also permeate the organisation to more broadly promote good decision-making practice. n.b The EQIA was provided when the Family Friendly Policy was produced in July 2025.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: For more information: https://www.gov.wales/socio-economic-duty-overview	Yes
	Considered as part of the EQIA that was previously provided 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.

	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 Previously provided to support the Family Friendly policy in July 2025
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below) Click or tap here to enter text The procedures have been produced in line with statutory obligations under the Employment Rights 2026

6. RISKS

If not supported, there is a risk that we are not providing staff with information regarding their responsibilities and entitlements. This could lead to low morale, different ways of working, inconsistent practices which could lead to Respect and Resolution complaints and ultimately could result in employment tribunal claims.

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?	No
All risks must be evidenced and consistent with those recorded in Datix	



Ref: WF59c

Adoption Leave Procedure

Executive Sponsor & Function:	Executive Director of Organisational Development and Workforce
Document Author:	People and OD Policy Group
Related to:	Family Friendly Policy
Approved by:	XXX
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1. Introduction

The rules covering adoption leave and pay can be complex; this procedure aims to ensure you, as an employee of Velindre University NHS Trust or a host organisation are informed of your entitlements and responsibilities when taking adoption leave and pay.

The procedure also explains the specific steps you and your manager should take to claim these entitlements.

2. Adoption Leave

2.1 Eligibility for Adoption Leave

You have the right to 52 weeks of adoption leave from work if you are adopting a child, under the age of 18 if you are legally classed as an employee. This includes both domestic and international adoption.

In relation to Velindre University NHS Trust you are an employee if you have a contract of employment to work within the Trust or with one of our host organisations.

You are not an employee if:

- You work only on the bank
- You are an agency worker; you should inform your agency of your adoption as you may be eligible for adoption rights through them
- You are self-employed and contracted to undertake work for the Trust
- You are a third-party worker via a company contracted to do work for the Trust

2.2 Details of Adoption Leave

If you meet the eligibility for adoption leave, you will be entitled to 52 weeks of adoption leave, this is made up of 26 weeks ordinary adoption leave, and 26 weeks of additional adoption leave. Ordinary and additional adoption leave run concurrently and cannot be taken at different times. You are not required to take the full entitlement of 52 weeks.

A week, in the context of adoption leave and pay is defined as: full 7 days from Sunday to Saturday.

Adoption leave can begin **up to 14 days before the child is placed with you** but must be completed within **56 days of placement** (for domestic adoptions) or **the date the child arrives** (for international adoptions).

Adoption leave may start on;

- any day of the week
- the date the child is placed with the adoptive parent, whether this is earlier or later than anticipated; or
- from a fixed date, which can up to 14 days before the expected date of the placement.

2.3 Adoption Leave Start Date

If you are adopting a child from overseas, the leave will start when the child enters the UK, or when you are required to travel for the adoption process. If you are adopting domestically, leave should begin when the child is placed with you.

3. Adoption Pay

3.1 Types of Pay

After adopting a child, you may be eligible for one of the following types of pay:

- Occupational adoption pay
- Statutory adoption pay

There are different eligibility criteria for each of the types of pay depending on your contractual position within the Trust and your length of service.

3.2 Eligibility for Occupational Adoption Pay

Occupational adoption pay is a contractual benefit, which includes statutory adoption pay and enhanced payments, for some people who meet the eligibility criteria.

You are entitled to occupational adoption pay if you meet all of the following criteria:

- You are an employee and have at least 12 months continuous NHS service, ending the week in which you are notified of being matched with a child for adoption
- You notify the Trust in writing at least 15 weeks before the child's expected placement (or as soon as possible if this is not practicable)
- You provide the relevant adoption papers or proof of adoption
- You intend to return to work following the period of adoption leave for a minimum of 3 months

3.3 Amount of Occupational Adoption Pay

If you are eligible for occupational adoption pay you will receive the following amount of pay:

- Full pay for the first 8 weeks
- Half pay, plus statutory adoption pay for the next 18 weeks
- statutory adoption pay for the next 13 weeks

During the final 13 weeks of adoption leave you will not be paid.

With prior agreement you can also ask for your adoption pay to be paid differently, for example, a fixed amount spread equally over your adoption leave.

Calculations for full weeks' pay will depend on your Terms and Conditions of Service (i.e. Agenda for Change, Medical and Dental or Executive and Senior Pay). The People and OD Team or Payroll will be able to provide more information on how this is calculated.

3.4 Refunding Occupational Adoption Pay

If you had originally intended to return to work within the Trust, or for an alternative NHS Organisation, following your adoption leave but change your mind you will be liable to pay back any enhancements received above statutory adoption pay.

Taking up an NHS bank position will not constitute a return to work, and you will still be liable to pay back benefits that you should not have received.

The Trust retains their rights of discretion relating to the paying back of occupational adoption pay where enforcing this will cause hardship or undue distress.

If you return to work to the Trust or another NHS Organisation for at least 13 full weeks you will not be required to pay back your occupational adoption pay that you received.

3.5 Eligibility for Statutory Adoption Pay

Statutory adoption pay is the minimum payment you will receive if you are an employee, meet the eligibility criteria but are not eligible for occupational adoption pay.

You are entitled to statutory adoption pay if you meet all of the following criteria:

- You have been working for the Trust continuously for 26 weeks up to the qualifying week (the week the child is placed)
- You earned at least £125 a week, on average, for 8 weeks before the qualifying week
- You notify the Trust in writing 15 weeks before the child is placed (or as soon as practical if this is not possible)
- You provide the relevant adoption paperwork

If you were employed by another organisation at up to the qualifying week, they will pay your statutory adoption pay, you will need to contact your previous employer to arrange this.

3.6 Amount of Statutory Adoption Pay

If you are eligible for statutory adoption pay you will receive the following amount of pay:

- 90% of your average weekly earnings for the first 6 weeks
- £187.18* or 90% of your average weekly earnings (whichever is lower) for the next 33 weeks (*April 2025 – April 2026 rates)

During the final 13 weeks of adoption leave you will not be paid.

Average weekly earnings are calculated by payroll, based on your gross pay (before deductions), for 8 weeks prior to the start of your adoption leave. It is important to note that a number of factors impact the average weekly earnings, including:

- Pay awards or pay progression increments, even if retrospectively implemented
- Sick pay, annual leave, overtime, bonus and pay in arrears
- Salary sacrifice schemes

If you have a period of back-to-back adoption leave or return to work for only for a short period before taking a further period of adoption leave, you should contact payroll to check the implications this may have for you.

3.7 Pension Contributions

If you are a member of the NHS Pensions Scheme your contributions will still be paid during your adoption leave. This will avoid a break in service and the possible loss of pension rights, which have already been accrued. Deductions are calculated on the variable amount of pay received each month.

During any unpaid periods of adoption leave contributions cannot be deducted however the arrears will be deducted from your salary when you return to work. Ordinarily these arrears will be taken over the same period of time that they have been accrued but if you return to work on a part-time basis, the repayment period can be extended.

If during the unpaid periods of adoption leave you become eligible for a tax refund, this will automatically be paid in your salary. It should however be noted that payroll will normally offset this with any pension arrears owed. If you have any queries relating to this you can contact payroll for more information.

3.8 Promotion or Change in Pay

If you are appointed to another role within the Trust or another NHS organisation during your adoption leave, that would ordinarily change your salary, this will not impact on your adoption pay. Any changes in pay made as a result of your new role will take effect on your return to work.

4. Adoption Placement Meetings

You should inform the Trust as soon as you start your adoption process because this will ensure you get paid time off to attend your adoption placement meetings.

Part-time employees are also able to take reasonable time off where their appointments when these fall during normal working time.

To be entitled to take paid time off to attend up to five adoption placement meetings. Time off is capped at 6.5 hours per meeting.

We do ask that staff inform their line manager as soon as possible of any adoption placement meetings. This will support ensuring your manager can maintain our services during your appointment.

You will need to book the time off for adoption placement meetings through ESR.

5. Health and Safety

As with maternity leave, adoption leave includes workplace risk assessments to ensure there are no risks to the adoptive parent.

6. Temporary, Fixed-Term and Training Contracts

6.1 Ending contracts during Adoption Leave

If you are an employee appointed on a temporary, fixed-term or training contract which is due to end 11 weeks before your child is placed with you, and if you are eligible for adoption leave, your contract with the Trust will be extended so that you have the full 52 weeks adoption leave.

During this time, you will be paid as per your eligibility for adoption pay.

If your contract ends following your adoption leave, and was expected to end regardless of your adoption, then you will not be subject to pay back of any occupational adoption pay.

6.2 Rotational Training Contracts

If you are employed on a rotational contract with one or more NHS organisation you will have the right to return to the same post or the next planned rotational post even if the contract was to end during your adoption leave.

Your contract of employment will be extended so that you can complete the training programme.

You should contact your training or educational lead to discuss the options for your training programme.

7. Redundancy

If you are identified as at risk of redundancy during adoption leave, you will be treated fairly and in the same way as other employees (who are not on leave) at risk of redundancy. You will be consulted regarding any redundancy situation that affects your role, just as other employees would be.

If a suitable alternative role is available, you would be offered the role in the same way as other employees (who are not on leave). You will have the same priority for that role as someone on maternity leave.

If there is no suitable alternative employment available, you will be terminated on grounds of redundancy and full redundancy rights and payments will apply.

8. Keeping in Touch Days

During your adoption leave you will have the opportunity to work up to 10 days as keeping in touch (KIT) days. KIT days help you stay in touch with the Trust while you are on adoption leave and therefore using KIT days will not extend your adoption leave.

How you chose to work KIT days, if any, will need to be agreed between you and your manager, it's important to note however even if you chose to work a few hours, this will be counted as a whole KIT day.

If you work more than 10 KIT days this will automatically end your adoption leave.

You will be paid your normal contractual hourly rate, in respect of the number of hours actually worked.

As well as formal KIT days, prior to going on adoption leave you should agree with your manager how you would like to be informed of what is happening in the workplace.

9. Return to Work

You will be entitled to return to work to the same position that you had in the Trust prior to your adoption leave and your terms and conditions will be the same as if you had not been absent.

If you intend to return to work following the full 52 weeks of adoption leave you will not be required to provide notification of this to your manager.

If you however wish to return from adoption leave early, you will need to provide at least 56 calendars days' notice in writing. If you do not provide adequate notice your manager will have discretion to postpone your return date.

9.1 Failure to Return to Work

If you have notified your manager of your intentions to return to work and you do not do so at the end of your adoption leave this may result in the termination of your contract of employment.

You will be contacted by your manager in writing, and allowed 14 days to respond before the Trust terminates your contract of employment.

You will be liable to repay any occupational adoption pay, if your contract of employment is terminated.

10. Sickness Absence

We understand that the adoption process can be a stressful or emotional process and may result in sickness absence. You and your manager should consult the NHS Wales Managing Attendance at Work Policy to support you through this process.

APPENDIX 1

ADOPTION LEAVE APPLICATION FORM

This form must be completed on or before the 15th week before the placement of the child, or if that is not practicable, as soon as reasonably practicable to do so. This form must be completed, regardless of intentions to return to work following adoption leave.

PART A – EMPLOYEE / APPLICANT TO COMPLETE

Applicant Details			
Name	Click or tap here to enter text.		
Home Address			
Job Title	Click or tap here to enter text.		
Employee Number	Click or tap here to enter text.		
Contracted Hours	Full-time ☐ Part-time ☐	If part-time please state the number of contracted hours per week	00.00 Hrs Per Week
Division / Organisation	Click or tap here to enter text.	Department	Click or tap here to enter text.
Start Date in Velindre University NHS Trust	Click or tap to enter a date.		
Start Date in the NHS	Click or tap to enter a date.		
Adoption Leave Request			
Return to Work – Please select one option			
I intend to return to work, for the Trust or another NHS organisation following adoption leave for a minimum of 13 weeks			☐
I will not be returning to work, for the Trust or another NHS organisation following adoption leave			☐
I am undecided about returning to work for the Trust or another NHS organisation following adoption leave			☐
Adoption Details			
Expected date of placement		Click or tap to enter a date.	
Proposed start date of adoption leave		Click or tap to enter a date.	
Proposed end date of adoption leave		Click or tap to enter a date.	
Adoption paperwork attached? (If no, please provide ASAP)		Yes ☐	No ☐

Annual Leave		
Full year annual leave entitlement	Click or tap here to enter text.	
Annual leave already taken	Click or tap here to enter text.	
Annual leave remaining at time of application	Click or tap here to enter text.	
Do you want to apply to take remaining annual leave, prior to commencing adoption leave	Yes ☐	No ☐
If yes, how much annual leave would you like to take, prior to commencing adoption leave	Click or tap here to enter text.	
Current Salary	£ Click or tap here to enter text.	
Type of service to be considered <i>please see note 2 in the guidance notes below</i>	Reckonable Service ☐ Reckonable Experience ☐	

PART B – MANAGER TO COMPLETE

I confirm the adoption leave request by the employee has been checked	☐
I confirm I have discussed with the employee their ability to keep in touch days	☐
I confirm I have received, with the application, the Adoption Paperwork, or I have an agreed date on which I will receive the paperwork and I ensure this is placed on file	☐
<i>I confirm this application has been made in line with the Family Friendly Policy and Adoption Leave Procedure requirements</i>	
Name	Click or tap here to enter text.
Position Title	Click or tap here to enter text.
Signed	Date Click or tap to enter a date.

Please submit the application form and Adoption paperwork (*when available*) to the People and OD Department at Velindre.WorkforceandOD@wales.nhs.uk

People and OD Department / Payroll Department	
Date application received	Click or tap to enter a date.
Adoption paperwork received	Yes ☐ No ☐
Does the employee qualify for adoption leave	Yes ☐ No ☐
Does the employee qualify for occupational adoption pay	Yes ☐ No ☐

Does the employee qualify for statutory adoption pay		Yes ☐ No ☐	
Name	Click or tap here to enter text.		
Position Title	Click or tap here to enter text.		
Signed		Date	Click or tap to enter a date.

Approved applications will be forwarded to the Payroll Department, along with the relevant documentary evidence

The employee will be informed in writing of the outcome of the application for adoption leave by the People and OD Department.

Managers will be informed of the application decision and a copy of the application will be retained on the employee file.

Ref: 59d

Adoption Leave Support Guidance

Executive Sponsor & Function:	Executive Director of Organisational Development and Workforce
Document Author:	People and OD Policy Group
Related to:	Family Friendly Policy
Approved by:	XXX
Approval Date:	XXX 2026
Review Date:	XXX 2029
Version:	V.1

1. Introduction

This guide sets out the roles and responsibilities for staff, managers and other Trust officers in supporting employees who are planning to commence adoption leave.

2. Employee planning to adopt a child

If you are an employee that is planning to adopt a child, it is your responsibility to:

- Familiarise yourself with the Family Friendly Policy and relevant procedures
- Inform your line manager as soon as you have started making plans
- Complete the application form for adoption leave (15 weeks before or asap)
- Provide the Trust with a copy of the adoption paperwork
- Comply with any recommendations, that are the outcome of a workplace risk assessment
- Inform your manager of your intentions to return to work

3. Line Manager

If you are a line manager of an employee that is planning to adopt a child, it is your responsibility to:

- Provide a copy of the Family Friendly Policy and relevant procedures to the employee if they do not have access to them
- Support the employee in the workplace during their adoption process in line with Trust Policy and Procedures
- Seek advice and guidance from the People and Relationship Team if you are unsure about anything related to supporting the employee in the workplace during their adoption process
- Undertake a workplace risk assessment with the employee
- Review the application form for adoption leave and complete the relevant manager section
- Send the adoption application with the adoption paperwork to the People and Relationship Team as soon as this is completed. *Delays in sending this documentation could result in over / underpayments for the employee.*
- Confirm the start and end dates of adoption leave with payroll (via the adoption application form and ESR)
- Confirm any hours worked in line with KIT Day rules, with payroll

It is also your responsibility to:

- Ensure service provision is adequately covered during the course of the adoption leave (i.e. through recruitment or temporary changes in responsibilities)
- Hold the role open if the employee identifies that they will be returning to the workplace at the end of their adoption leave
- Keep the employee informed of developments within the Trust, Department and Team whilst they are on adoption leave
- Ensure the employee is consulted on any significant changes that may impact their role (i.e. Organisational Change)

4. People and OD Department

It is the responsibility of the People and OD Department to:

- Advise employees planning adoption leave, of their rights in relation to Trust Policies and Procedures
- Support Managers in the application of relevant Policies and Procedures
- Administer adoption leave provisions in conjunction with payroll

5. Payroll

It is the responsibility of the Payroll Department to:

- Ensure that payments are made in line with current Occupational and Statutory Pay rules
- Ensure that Adoption Pay is made in line with the correct calculations set out in Terms and Conditions or Statutory Regulations.
- To ensure that the employee's membership to the NHS Pension Scheme is protected during paid and unpaid adoption leave
- To inform staff if they are not able to claim Statutory Adoption Pay from Velindre University NHS Trust



Ref: WF59e

Parental Leave Procedure

Executive Sponsor & Function:	Executive Director of Organisational Development and Workforce
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1. Introduction

The rules covering Parental leave and pay can be complex; this procedure aims to ensure you, as an employee of Velindre University NHS Trust or a host organisation are informed of your entitlements and responsibilities when taking Parental leave and pay. **Please note Parental Leave is different and distinct to Shared Parental Leave. There is a separate procedure on Shared Parental Leave.**

The procedure also explains the specific steps you and your manager should take to claim these entitlements.

2. Parental Leave

2.1 Eligibility for Parental Leave

You have the right to 18 weeks of unpaid Parental leave if you

- are an employee,
- have commenced your employment with the NHS and
- have parental responsibility for the child.

In relation to Velindre University NHS Trust you are an employee if you have a contract of employment to work within the Trust or with one of our host organisations.

You are not an employee if:

- You work only on the bank
- You are an agency worker; you should inform your agency of your pregnancy, as you may be eligible for Parental rights through them
- You are self-employed and contracted to undertake work for the Trust
- You are a third-party worker via a company contracted to do work for the Trust

To have parental responsibility you must be named on one of the following documents:

- the child's birth certificate
- the child's adoption certificate
- a parental order, for surrogacy
- a legal guardianship

Step-parents can also have parental responsibility where it is agreed between all parents.

If someone is separated from the other parent or does not live with their child, they still have the right to parental leave if they have parental responsibility for their child.

2.2 Details of Parental Leave

If you meet the above eligibility for Parental leave, you will be entitled to 18 weeks of unpaid Parental leave, from work for each child or adopted child that you are responsible for, up to the child's 18th birthday,

A week, in the context of Parental leave and pay is defined as: full 7 days from Sunday to Saturday. Parental leave may start on any day of the week.

2.3 Parental Leave Duration

You can take up to 18 weeks of parental leave for each child until each child is 18 years old. Parental leave must be:

- taken in blocks of weeks
- a maximum of 4 weeks a year for each child

You can take parental leave in blocks of days or hours if you are entitled to one of the following for your child:

- Disability Living Allowance
- Personal Independence Payment

If your child does not have a disability and you need to book a few hours or days to look after your child unexpectedly, you should discuss with your manager the most appropriate type of leave to cover your absence. This may include using annual leave, special leave or authorised unpaid leave (time off for dependants).

2.4 Notice for Parental Leave

You must provide:

- 21 days' notice before the date you want to start a block of parental leave
- the exact dates you plan to start and finish the block of parental leave

If you have a child with a disability and you intend to book parental leave in blocks of days or hours, you should give as much notice as possible to enable your manager to manage resource requirements in the service.

2.5 Reason for taking Parental Leave

Parental leave may be taken to:

- provide care when usual childcare arrangements are disrupted and the time off can be planned in advance
- spend more time with your child
- look after your child during school holidays
- care for your child when they're off school sick
- go to school open days or events with your child
- settle your child into new childcare arrangements
- visit grandparents or other relatives with your child

2.6 Changing Parental Leave Dates

The Trust may need to adjust or postpone your parental leave dates if there are significant business reasons that your original dates can't be supported. However, every effort will be made to accommodate your preferred dates, wherever possible. You must be able to take the leave before your child's 18th birthday.

If we need to postpone your parental leave, we will write to you within 7 days of your request to:

- Explain why the leave needs to be postponed.

- Offer other suitable dates after consulting with you.

If you request to start your parental leave on the day of birth or adoption, before paternity leave, we cannot postpone your parental leave in this situation.

3.1 Pension

3.1 Pension Contributions

If you are a member of the NHS Pensions Scheme your **employer** contributions will still be paid during your Parental leave. This will avoid a break in service and the possible loss of pension rights, which have already been accrued. Deductions are calculated on the variable amount of pay received each month.

During any unpaid periods of Parental leave contributions cannot be deducted however the arrears will be deducted from your salary when you return to work. Ordinarily these arrears will be taken over the same period of time that they have been accrued but if you return to work on a part-time basis, the repayment period can be extended.

If during the unpaid periods of Parental leave you become eligible for a tax refund, this will automatically be paid in your salary. It should however be noted that payroll will normally offset this with any pension arrears owed. If you have any queries relating to this you can contact payroll for more information.

4. Rights during and after Parental Leave

4.1 Right to fair treatment

Whilst you are taking parental leave, all of your usual entitlements and employment rights remain unchanged, except that your parental leave will be unpaid. You will also continue to benefit from all existing employment rights and continue to be covered by the Trust's policies and procedures.

4.2 Right to return to work

If you take less than 4 weeks parental leave in a standalone period, you have the right to return to the same job. This applies when you have taken parental leave only (not combined with any other statutory family leave).

If you have taken more than 4 weeks parental leave in a standalone period, and where there have been significant changes to your service or role in that time, you would be subject to consultation under the Organisational Change Policy (OCP).

4.3 Promotion or Change in Pay

If you are appointed to another role within the Trust or another NHS organisation during your Parental leave, that would ordinarily change your salary, this will not impact on your Parental pay. Any changes in pay made as a result of your new role will take effect on your return to work.

5. Temporary, Fixed-Term and Training Contracts

5.1 Ending contracts during Parental Leave

If you are an employee appointed on a temporary, fixed-term or training contract which is due to end during your parental leave, and if you are eligible for Parental leave, your contract with the Trust will be extended to cover the Parental leave unpaid period.

If your contract ends following your Parental leave and was expected to end regardless of your parental leave, then the usual end of contract process will apply.

5.2 Rotational Training Contracts

If you are employed on a rotational contract with one or more NHS organisation you will have the right to return to the same post or the next planned rotational post even if the contract was to end during your Parental leave.

Your contract of employment will be extended so that you can complete the training programme.

You should contact your training or educational lead to discuss the options for your training programme.

6. Redundancy

If you are identified as at risk of redundancy during Parental leave, you will be treated fairly and in the same way as other employees (who are not on leave) at risk of redundancy. You will be consulted regarding any redundancy situation that affects your role, just as other employees would be.

If a suitable alternative role is available, you would be offered the role in the same way as other employees (who are not on leave). You have the same priority for that role as someone on maternity leave.

If there is no suitable alternative employment available, you will be terminated on grounds of redundancy and full redundancy rights and payments will apply.

APPENDIX 1

PARENTAL LEAVE APPLICATION FORM

This form must be completed at least 21 days before the Parental leave is due to start, unless you are taking blocks of hours or days to care for a child with a disability, in which case you should complete this form ASAP, prior to the leave commencing.

PART A – EMPLOYEE / APPLICANT TO COMPLETE

Applicant Details			
Name	Click or tap here to enter text.		
Home Address			
Job Title	Click or tap here to enter text.		
Employee Number	Click or tap here to enter text.		
Contracted Hours	Full-time ☐ Part-time ☐	If part-time please state the number of contracted hours per week	00.00 Hrs Per Week
Division / Organisation	Click or tap here to enter text.	Department	Click or tap here to enter text.
Start Date in Velindre University NHS Trust	Click or tap to enter a date.		
Start Date in the NHS	Click or tap to enter a date.		
Parental Leave Request			
Eligibility for Parental Leave – Please tick to confirm			
I have commenced employment with the Trust			☐
I am applying for unpaid Parental leave for a child, under the age of 18, that I have parental responsibility for			☐
Parental Leave Details			
Proposed start date of Parental leave		Click or tap to enter a date.	
Proposed end date of Parental leave		Click or tap to enter a date.	
Number of weeks requested (or days /hours if requesting the leave to look after a child with disabilities)		____ weeks/days/hours	
Is this your first Parental Leave request this year relating to the same child? (Apr-Mar)		Yes ☐	No ☐
If you have taken Parental Leave previously this year, relating to the same child, please provide dates and number of weeks/days/hours			

Annual Leave		
Full year annual leave entitlement	Click or tap here to enter text.	
Annual leave already taken	Click or tap here to enter text.	
Annual leave remaining at time of application	Click or tap here to enter text.	
Do you want to apply to take remaining annual leave, prior to commencing Parental leave	Yes ☐	No ☐

PART B – MANAGER TO COMPLETE

I confirm the Parental leave request by the employee has been checked	☐
I confirm the employee meets the eligibility criteria	☐
I confirm I will record this request on ESR so payroll is unaware of the period that needs to be unpaid	☐
I confirm I have considered the resource impact on the service by supporting this request and I will ensure this application is placed on file	☐
<i>I confirm this application has been made in line with the Family Friendly Policy and Parental Leave Procedure requirements</i>	
Name	Click or tap here to enter text.
Position Title	Click or tap here to enter text.
Signed	Date Click or tap to enter a date.

Please submit the application form the People and OD Department at
Velindre.WorkforceandOD@wales.nhs.uk

People and OD Department / Payroll Department			
Date application received	Click or tap to enter a date.		
Parental paperwork received	Yes ☐	No ☐	
Does the employee qualify for Parental leave	Yes ☐	No ☐	
Name	Click or tap here to enter text.		
Position Title	Click or tap here to enter text.		
Signed	Date Click or tap to enter a date.		

Approved applications will be forwarded to the Payroll Department

The employee will be informed in writing of the outcome of the application for Parental leave by the People and OD Department.

Managers will be informed of the application decision and a copy of the application will be retained on the employee file.

Ref: 59f

Parental Leave Support Guidance

Executive Sponsor & Function:	Executive Director of Organisational Development and Workforce
Document Author:	People and OD Policy Group
Related to:	Family Friendly Policy
Approved by:	XXX
Approval Date:	XXX 2026
Review Date:	XXX 2029
Version:	V.1

1. Introduction

This guide sets out the roles and responsibilities for staff, managers and other Trust officers in supporting employees who are planning to take Parental leave.

2. Employee planning to take Parental Leave

If you are an employee that is planning to take parental leave it is your responsibility to:

- Familiarise yourself with the Family Friendly Policy and relevant procedures
- Inform your line manager as soon as you are aware you want to take leave
- Complete the application form for parental leave (21 days before or asap)
- Inform your manager of your intended date of return to work

3. Line Manager

If you are a line manager of an employee that is planning to take parental leave it is your responsibility to:

- Provide a copy of the Family Friendly Policy and relevant procedures to the employee if they do not have access to them
- Support the employee in the workplace during their parental leave in line with Trust Policy and Procedures
- Seek advice and guidance from the People and Relationship Team if you are unsure about anything related to supporting the employee in the workplace during their Parental leave
- Review the application form for parental leave and complete the relevant manager section
- Send the parental leave application form to the People and Relationship Team as soon as this is completed. *Delays in sending this documentation could result in over / underpayments for the employee.*
- Confirm the start and end dates of parental leave with payroll (via the parental leave application form and ESR)

It is also your responsibility to:

- Ensure service provision is adequately covered during the course of the parental leave (i.e. through recruitment or temporary changes in responsibilities)
- Hold the role open for the employee to return to the workplace at the end of their parental leave
- Keep the employee informed of significant developments within the Trust, Department and Team whilst they are on parental leave
- Ensure the employee is consulted on any significant changes that may impact their role (i.e. Organisational Change)

4. People and OD Department

It is the responsibility of the People and OD Department to:

- Advise employees planning parental leave, of their rights in relation to Trust Policies and Procedures

- Support Managers in the application of relevant Policies and Procedures
- Administer parental leave provisions in conjunction with payroll

5. Payroll

It is the responsibility of the Payroll Department to:

- Ensure that payments or deductions are made in line with parental leave rules
- Ensure that the employee's membership to the NHS Pension Scheme is protected during unpaid parental leave



Ref: WF59g

Shared Parental Leave Procedure

Executive Sponsor & Function:	Executive Director of Organisational Development and Workforce
Document Author:	People and OD Policy Group
Related to:	Family Friendly Policy
Approved by:	XXX
Approval Date:	XXX 2026
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1. Introduction

The rules covering Shared Parental leave and pay can be complex; this procedure aims to ensure you, as an employee of Velindre University NHS Trust or a host organisation are informed of your entitlements and responsibilities when taking Parental leave and pay. **Please note Shared Parental Leave is different and distinct to Parental Leave. There is a separate procedure on Parental Leave.**

The procedure also explains the specific steps you and your manager should take to claim these entitlements.

2. Shared Parental Leave

2.1 Eligibility for Shared Parental Leave

You have the right to Shared Parental leave if you

- are an employee,
- have worked for the NHS continuously for at least 26 weeks by the end of the 15th week before your baby is due or the week you are matched with an adopted child,
- have earned at least £120 per week for the 8 weeks leading up to the end of the 15th week before your baby is due or the week you are matched with an adopted child,
- have parental responsibility for the child and the other parent that you will share parental leave with, also meets the above conditions with their employment, and

The parent who gives birth or adopts must have curtailed their maternity or adoption leave for the other parent to then share the remaining leave.

In relation to Velindre University NHS Trust you are an employee if you have a contract of employment to work within the Trust or with one of our host organisations.

You are not an employee if:

- You work only on the bank
- You are an agency worker; you should inform your agency of your pregnancy, as you may be eligible for Parental rights through them
- You are self-employed and contracted to undertake work for the Trust
- You are a third-party worker via a company contracted to do work for the Trust

To have parental responsibility you must be named on one of the following documents:

- the child's birth certificate
- the child's adoption certificate
- a parental order, for surrogacy
- a legal guardianship

Step-parents can also have parental responsibility where it's agreed between all parents.

If someone is separated from the other parent or does not live with their child, they still have the right to shared parental leave if they have parental responsibility for their child.

2.2 Details of Shared Parental Leave

If you meet the above eligibility for Shared Parental leave, there is an entitlement to share up to 50 weeks of leave and 37 weeks of pay for each child or adopted child that you are responsible for

A week, in the context of Parental leave and pay is defined as: full 7 days from Sunday to Saturday. Parental leave may start on any day of the week.

2.3 Shared Parental Leave Duration

Eligible employees can take up to 50 weeks of Shared Parental leave. This leave can be taken in a continuous block or split into separate periods. The total Shared Parental leave available will depend on how much maternity or adoption leave the mother or adopter has already taken.

- If the mother or adopter returns to work early or does not take their full leave entitlement, the remaining leave may be available for the other person with parental responsibility,
- The leave can be taken in one continuous period, or in separate blocks, as agreed.

2.4 Shared Parental Leave Pay

Shared Parental Pay is available for up to 37 weeks, paid at the statutory rate. The pay is split between both parents sharing the leave, so each can claim the statutory pay for the leave they take.

- The first 6 weeks are paid at 90% of average weekly earnings (if this is higher than the statutory rate).
- The remaining 31 weeks are paid at the statutory rate, or 90% of earnings if this is lower than the statutory rate.

2.5 Notice for Shared Parental Leave

To enable Shared Parental Leave, the mother or adopter must first curtail their maternity or adoption leave. If this applies to you, you can curtail your maternity or adoption leave and apply for Shared Parental Leave by completing and submitting the form Appendix 1 at the end of this procedure.

You must provide at least 8 weeks notice of your intention to curtail your maternity or adoption leave.

You can choose when to end your leave, and the remaining leave will then be available to be shared between both parties with shared parental responsibility. The maximum possible Shared Parental leave will be the remainder of the leave after you have returned to work or curtailed your leave.

- visit grandparents or other relatives with your child

2.6 Booking Shared Parental Leave Dates

Shared Parental leave can be taken in one continuous block or in separate blocks of time.

- **Continuous leave** means taking all of your Shared Parental leave in one unbroken period.
- **Discontinuous leave** means taking Shared Parental leave in multiple smaller blocks.
- Both you and the person that you are sharing parental leave with, may take separate blocks at the same time or you may stagger your leave to cover different periods.

Requests for discontinuous leave will need to take account of business needs, and your manager will work with you to accommodate reasonable requests wherever possible.

2.7 Varying or Cancelling Shared Parental Leave Dates

If you wish to change or cancel your planned and approved Shared Parental Leave, you must inform your manager as soon as possible and at least 8 weeks before the start of your planned Shared Parental Leave. If you are not able to provide 8 weeks notice, your manager will work with you to accommodate the changes wherever possible.

2.8 Keeping in Touch

Whilst there is no statutory right to Keeping in Touch days during Shared Parental leave, like there is with Maternity and Adoption leave, it is reasonable for you to be available for occasional contact from your manager to arrange your return to work or to be made aware of important work updates. You are not expected to undertake any work whilst on Shared Parental leave.

3. Pension

3.1 Pension Contributions

If you are a member of the NHS Pensions Scheme your **employer** contributions will still be paid during your Parental leave. This will avoid a break in service and the possible loss of pension rights, which have already been accrued. Deductions are calculated on the variable amount of pay received each month.

During any unpaid periods of Parental leave contributions cannot be deducted however the arrears will be deducted from your salary when you return to work. Ordinarily these arrears will be taken over the same period of time that they have

been accrued but if you return to work on a part-time basis, the repayment period can be extended.

If during the unpaid periods of Parental leave you become eligible for a tax refund, this will automatically be paid in your salary. It should however be noted that payroll will normally offset this with any pension arrears owed. If you have any queries relating to this you can contact payroll for more information.

4. Rights during and after Parental Leave

4.1 Right to fair treatment

Whilst you are taking parental leave, all of your usual entitlements and employment rights remain unchanged, except for the unpaid element of Shared Parental leave (see section 2.4 above). You will also continue to benefit from all existing employment rights and continue to be covered by the Trust's policies and procedures.

4.2 Right to return to work

You have the right to return to the same job. If there have been significant changes to your service or role whilst you are on Shared Parental leave, you would be subject to consultation under the Organisational Change Policy (OCP).

4.3 Promotion or Change in Pay

If you are appointed to another role within the Trust or another NHS organisation during your Shared Parental leave, that would ordinarily change your salary, this will not impact on your Shared Parental pay. Any changes in pay made as a result of your new role will take effect on your return to work.

5. Temporary, Fixed-Term and Training Contracts

5.1 Ending contracts during Shared Parental Leave

If you are an employee appointed on a temporary, fixed-term or training contract which is due to end during your shared parental leave, your contract with the Trust will be extended to cover the Shared Parental leave period.

If your contract ends following your Shared Parental leave, and was expected to end regardless of your shared parental leave, then the usual end of contract process will apply.

5.2 Rotational Training Contracts

If you are employed on a rotational contract with one or more NHS organisation you will have the right to return to the same post or the next planned rotational post even if the contract was to end during your Shared Parental leave.

Your contract of employment will be extended so that you can complete the training programme.

You should contact your training or educational lead to discuss the options for your training programme.

6. Redundancy

If you are identified as at risk of redundancy during Shared Parental leave, you will be treated fairly and in the same way as other employees (who are not on leave) at risk of redundancy. You will be consulted regarding any redundancy situation that affects your role, just as other employees would be.

If a suitable alternative role is available, you would be offered the role in the same way as other employees (who are not on leave). You do not have the same priority for that role as someone on maternity leave.

If there is no suitable alternative employment available you will be terminated on grounds of redundancy and full redundancy rights and payments will apply.

APPENDIX 1

SHARED PARENTAL LEAVE APPLICATION FORM

This form must be completed at least 8 weeks before the Shared Parental leave is due to start.

PART A – EMPLOYEE / APPLICANT TO COMPLETE

Applicant Details			
Name	Click or tap here to enter text.		
Home Address			
Job Title	Click or tap here to enter text.		
Employee Number	Click or tap here to enter text.		
Contracted Hours	Full-time ☐ Part-time ☐	If part-time please state the number of contracted hours per week	00.00 Hrs Per Week
Division / Organisation	Click or tap here to enter text.	Department	Click or tap here to enter text.
Start Date in Velindre University NHS Trust	Click or tap to enter a date.		
Start Date in the NHS	Click or tap to enter a date.		
Shared Parental Leave Request			
Eligibility for Shared Parental Leave – Please tick to confirm			
I am an employee and have worked for the Trust or another NHS organisation continuously for a minimum of 26 weeks by the end of the 15 th week before my baby is due or the week I am due to be matched with an adopted child			☐
I am applying for unpaid Parental leave for a child that I have parental responsibility for			☐
I have earned at least £120 per week for the 8 weeks leading up to the 15 th week before my baby is due or the week I am due to be matched with an adopted child			☐
Shared Parental Leave Details			
Proposed start date of Shared Parental leave		Click or tap to enter a date.	
Proposed end date of Shared Parental leave		Click or tap to enter a date.	
Number of weeks requested		_____ weeks	
Is this your first Shared Parental Leave request this year, relating to the same child? (Apr-Mar)		Yes ☐	No ☐
If you have taken Shared Parental Leave previously this year, relating to the same child, please provide dates and number of weeks			

Annual Leave		
Full year annual leave entitlement	Click or tap here to enter text.	
Annual leave already taken	Click or tap here to enter text.	
Annual leave remaining at time of application	Click or tap here to enter text.	
Do you want to apply to take remaining annual leave, prior to commencing Shared Parental leave	Yes ☐	No ☐

PART B – MANAGER TO COMPLETE

I confirm the Shared Parental leave request by the employee has been checked	☐
I confirm the employee meets the eligibility criteria	☐
I confirm I will record this request on ESR so payroll is unaware of the period that needs to be paid and unpaid	☐
I confirm I have considered the resource impact on the service by supporting this request and I will ensure this application is placed on file	☐
<i>I confirm this application has been made in line with the Family Friendly Policy and Shared Parental Leave Procedure requirements</i>	
Name	Click or tap here to enter text.
Position Title	Click or tap here to enter text.
Signed	Date Click or tap to enter a date.

Please submit the application form the People and OD Department at
Velindre.WorkforceandOD@wales.nhs.uk

People and OD Department / Payroll Department			
Date application received	Click or tap to enter a date.		
Shared Parental paperwork received	Yes ☐	No ☐	
Does the employee qualify for Shared Parental leave	Yes ☐	No ☐	
Name	Click or tap here to enter text.		
Position Title	Click or tap here to enter text.		
Signed	Date Click or tap to enter a date.		

Approved applications will be forwarded to the Payroll Department

The employee will be informed in writing of the outcome of the application for Parental leave by the People and OD Department.

Managers will be informed of the application decision and a copy of the application will be retained on the employee file.

Ref: 59h

Shared Parental Leave Support Guidance

Executive Sponsor & Function:	Executive Director of Organisational Development and Workforce
Document Author:	People and OD Policy Group
Related to:	Family Friendly Policy
Approved by:	XXX
Approval Date:	XXX 2026
Review Date:	XXX 2029
Version:	V.1

1. Introduction

This guide sets out the roles and responsibilities for staff, managers and other Trust officers in supporting employees who are planning to take Shared Parental leave.

2. Employee planning to take Shared Parental Leave

If you are an employee that is planning to take shared parental leave it is your responsibility to:

- Familiarise yourself with the Family Friendly Policy and relevant procedures
- Inform your line manager as soon as you are aware you want to take leave
- Complete the application form for shared parental leave (8 weeks unless exceptional circumstances mean you need to reduce the notice)
- Inform your manager of your intended date of return to work

3. Line Manager

If you are a line manager of an employee that is planning to take shared parental leave it is your responsibility to:

- Provide a copy of the Family Friendly Policy and relevant procedures to the employee if they do not have access to them
- Support the employee in the workplace during their shared parental leave in line with Trust Policy and Procedures
- Seek advice and guidance from the People and Relationship Team if you are unsure about anything related to supporting the employee in the workplace during their Shared Parental leave
- Review the application form for shared parental leave and complete the relevant manager section
- Send the shared parental leave application form to the People and Relationship Team as soon as this is completed. *Delays in sending this documentation could result in over / underpayments for the employee.*
- Confirm the start and end dates of shared parental leave with payroll (via the parental leave application form and ESR)

It is also your responsibility to:

- Ensure service provision is adequately covered during the course of the shared parental leave (i.e. through recruitment or temporary changes in responsibilities)
- Hold the role open for the employee to return to the workplace at the end of their shared parental leave
- Keep the employee informed of significant developments within the Trust, Department and Team whilst they are on shared parental leave of longer than 2 weeks
- Ensure the employee is consulted on any significant changes that may impact their role (i.e. Organisational Change)

4. People and OD Department

It is the responsibility of the People and OD Department to:

- Advise employees planning shared parental leave, of their rights in relation to Trust Policies and Procedures
- Support Managers in the application of relevant Policies and Procedures
- Administer shared parental leave provisions in conjunction with payroll

5. Payroll

It is the responsibility of the Payroll Department to:

- Ensure that payments or deductions are made in line with shared parental leave rules
- Ensure that the employee's membership to the NHS Pension Scheme is protected during the unpaid element of shared parental leave



Ref: WF59i

Paternity / New Parent Support Leave Procedure

Executive Sponsor & Function:	Executive Director of Organisational Development and Workforce
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1. Introduction

The rules covering Paternity leave and pay can be complex; this procedure aims to ensure you, as an employee of Velindre University NHS Trust or a host organisation are informed of your entitlements and responsibilities when taking Paternity leave and pay. **In this procedure, the word Paternity is used to refer to Paternity or New Parent Support Leave.**

The procedure also explains the specific steps you and your manager should take to claim these entitlements.

2. Paternity Leave

2.1 Eligibility for Paternity Leave

You have the right to Paternity leave if you

- are an employee,
- have commenced your employment with the NHS and
- have Paternity responsibility for the child

In relation to Velindre University NHS Trust you are an employee if you have a contract of employment to work within the Trust or with one of our host organisations.

You are not an employee if:

- You work only on the bank
- You are an agency worker; you should inform your agency of your pregnancy, as you may be eligible for Paternity rights through them
- You are self-employed and contracted to undertake work for the Trust
- You are a third-party worker via a company contracted to do work for the Trust

To have Paternity responsibility you must be named on one of the following documents:

- the child's birth certificate
- the child's adoption certificate
- a Paternity order, for surrogacy
- a legal guardianship

Step-parents can also have Paternity responsibility where it's agreed between all parents.

If someone is separated from the other parent or does not live with their child, they still have the right to Paternity leave if they have Paternity responsibility for their child.

2.2 Details of Paternity Leave

If you meet the above eligibility for Paternity leave, you have an entitlement to 2 weeks paternity leave. You can choose to take 1 or 2 weeks Paternity leave.

A week, in the context of Paternity leave and pay is defined as: full 7 days from Sunday to Saturday. Paternity leave may start on any day of the week.

2.3 Paternity Leave Duration

Eligible employees can take up to 2 weeks of Paternity leave. This leave can be taken as either:

- 2 continuous weeks, or
- 2 separate blocks of 1 week (2 x 1 week)

You can choose to take your paternity leave at any time in the first 52 weeks after the birth or matching of an adopted baby.

2.4 Paternity Leave Pay and Statutory Paternity Pay

If you meet the eligibility and qualifying criteria for Paternity leave you will be entitled to 2 weeks of full pay (enhanced paternity pay) if you have at least 12 months continuous service with the NHS.

If you have less than 12 months continuous service with the NHS you are not eligible for enhanced paternity pay, but you will be entitled to statutory paternity pay if you:

- Have been continuously employed by the NHS for at least 26 weeks, at the qualifying week (15th week before the expected date of childbirth) or the date of matching for adoption
- Earn on average at least £125 a week over the 8-week period ending with any day in the qualifying week

Statutory Paternity Pay is either of the following, whichever is lowest:

- £187.18 per week, or
- 90% of your average weekly earnings

2.5 Notice for Paternity Leave

You are required to give 28 days notice of when you want to start the paternity leave.

2.6 Booking Paternity Leave Dates

Paternity leave can be taken as

- One two block, or
- Two separate one-week blocks

2.7 Varying or Cancelling Paternity Leave Dates

If you wish to change or cancel your planned and approved Paternity Leave, you must inform your manager as soon as possible and at least 28 days before the start

of your planned Paternity Leave. If you are not able to provide 28 days notice, your manager will work with you to accommodate the changes wherever possible.

2.8 Keeping in Touch

Whilst there is no statutory right to Keeping in Touch days during Paternity leave, like there is with Maternity and Adoption leave, it is reasonable for you to be available for occasional contact from your manager to arrange your return to work or to be made aware of important work updates. You are not expected to undertake any work whilst on Paternity leave.

3. Pension

3.1 Pension Contributions

If you are a member of the NHS Pensions Scheme with at least 12 months service at the time of your paternity leave, you will be paid in full for your paternity leave and therefore your employer and employee pension contributions will continue as if you were in a normal period of work.

If you have under 12 months service, your **employer** contributions will still be paid during your Paternity leave. This will avoid a break in service and the possible loss of pension rights, which have already been accrued. Deductions are calculated on the variable amount of pay received each month.

4. Rights during and after Paternity Leave

4.1 Right to fair treatment

Whilst you are taking Paternity leave, all of your usual entitlements and employment rights remain unchanged, except for the unpaid element of Paternity leave (see section 2.4 above). You will also continue to benefit from all existing employment rights and continue to be covered by the Trust's policies and procedures.

4.2 Right to return to work

You have the right to return to the same job. If there have been significant changes to your service or role whilst you are on Paternity leave, you would be subject to consultation under the Organisational Change Policy (OCP).

4.3 Promotion or Change in Pay

If you are appointed to another role within the Trust or another NHS organisation during your Paternity leave, that would ordinarily change your salary, this will not

impact on your Paternity pay. Any changes in pay made as a result of your new role will take effect on your return to work.

5. Temporary, Fixed-Term and Training Contracts

5.1 Ending contracts during Paternity Leave

If you are an employee appointed on a temporary, fixed-term or training contract which is due to end during your Paternity leave, your contract with the Trust will be extended to cover the Paternity leave period.

If your contract ends following your Shared Paternity leave, and was expected to end regardless of your Paternity leave, then the usual end of contract process will apply.

5.2 Rotational Training Contracts

If you are employed on a rotational contract with one or more NHS organisation you will have the right to return to the same post or the next planned rotational post even if the contract was to end during your Paternity leave.

Your contract of employment will be extended so that you can complete the training programme.

You should contact your training or educational lead to discuss the options for your training programme.

6. Redundancy

If you are identified as at risk of redundancy during Paternity leave, you will be treated fairly and in the same way as other employees (who are not on leave) at risk of redundancy. You will be consulted regarding any redundancy situation that affects your role, just as other employees would be.

If a suitable alternative role is available, you would be offered the role in the same way as other employees (who are not on leave). You do not have the same priority for that role as someone on maternity leave.

If there is no suitable alternative employment available you will be terminated on grounds of redundancy and full redundancy rights and payments will apply.

APPENDIX 1

PATERNITY LEAVE APPLICATION FORM

This form must be completed at least 28 days before the Paternity leave is due to start.

PART A – EMPLOYEE / APPLICANT TO COMPLETE

Applicant Details			
Name	Click or tap here to enter text.		
Home Address			
Job Title	Click or tap here to enter text.		
Employee Number	Click or tap here to enter text.		
Contracted Hours	Full-time ☐ Part-time ☐	If part-time please state the number of contracted hours per week	00.00 Hrs Per Week
Division / Organisation	Click or tap here to enter text.	Department	Click or tap here to enter text.
Start Date in Velindre University NHS Trust	Click or tap to enter a date.		
Start Date in the NHS	Click or tap to enter a date.		
Paternity Leave Request			
Eligibility for Paternity Leave – Please tick to confirm			
I am an employee and have worked for the Trust or another NHS organisation continuously for a minimum of 26 weeks by the end of the 15 th week before my baby is due or the week I am due to be matched with an adopted child			☐
I am applying for 2 weeks fully paid Paternity leave for a child that I have Paternity responsibility for, as I have or will have 12 months service when I take paternity leave			☐
I have earned at least £187.18 per week for the 8 weeks leading up to the 15 th week before my baby is due or the week I am due to be matched with an adopted child			☐
Paternity Leave Details			
Proposed start date of Paternity leave		Click or tap to enter a date.	
Proposed end date of Paternity leave		Click or tap to enter a date.	
Number of weeks requested		_____ weeks	

Annual Leave		
Full year annual leave entitlement	Click or tap here to enter text.	
Annual leave already taken	Click or tap here to enter text.	
Annual leave remaining at time of application	Click or tap here to enter text.	
Do you want to apply to take remaining annual leave, prior to commencing Paternity leave	Yes ☐	No ☐

PART B – MANAGER TO COMPLETE

I confirm the Paternity leave request by the employee has been checked	☐
I confirm the employee meets the eligibility criteria	☐
I confirm I will record this request on ESR so payroll is unaware of the period that needs to be paid and unpaid	☐
I confirm I have considered the resource impact on the service by supporting this request and I will ensure this application is placed on file	☐
<i>I confirm this application has been made in line with the Family Friendly Policy and Paternity Leave Procedure requirements</i>	
Name	Click or tap here to enter text.
Position Title	Click or tap here to enter text.
Signed	Date Click or tap to enter a date.

Please submit the application form the People and OD Department at
Velindre.WorkforceandOD@wales.nhs.uk

People and OD Department / Payroll Department			
Date application received	Click or tap to enter a date.		
Paternity paperwork received	Yes ☐	No ☐	
Does the employee qualify for Paternity leave	Yes ☐	No ☐	
Name	Click or tap here to enter text.		
Position Title	Click or tap here to enter text.		
Signed	Date Click or tap to enter a date.		

Approved applications will be forwarded to the Payroll Department

The employee will be informed in writing of the outcome of the application for Paternity leave by the People and OD Department.

Managers will be informed of the application decision and a copy of the application will be retained on the employee file.

Ref: 59j

Paternity or New Parent Support Leave Support Guidance

Executive Sponsor & Function:	Executive Director of Organisational Development and Workforce
Document Author:	People and OD Policy Group
Related to:	Family Friendly Policy
Approved by:	XXX
Approval Date:	XXX 2026
Review Date:	XXX 2029
Version:	V.1

1. Introduction

This guide sets out the roles and responsibilities for staff, managers and other Trust officers in supporting employees who are planning to take Paternity leave.

2. Employee planning to take Paternity Leave

If you are an employee that is planning to take Paternity leave it is your responsibility to:

- Familiarise yourself with the Family Friendly Policy and relevant procedures
- Inform your line manager as soon as you are aware you want to take leave
- Complete the application form for Paternity leave (28 days before or asap)
- Inform your manager of your intended date of return to work

3. Line Manager

If you are a line manager of an employee that is planning to take Paternity leave it is your responsibility to:

- Provide a copy of the Family Friendly Policy and relevant procedures to the employee if they do not have access to them
- Support the employee in the workplace during their Paternity leave in line with Trust Policy and Procedures
- Seek advice and guidance from the People and Relationship Team if you are unsure about anything related to supporting the employee in the workplace during their Paternity leave
- Review the application form for Paternity leave and complete the relevant manager section
- Send the Paternity leave application form to the People and Relationship Team as soon as this is completed. *Delays in sending this documentation could result in over / underpayments for the employee.*
- Confirm the start and end dates of Paternity leave with payroll (via the Paternity leave application form and ESR)

It is also your responsibility to:

- Ensure service provision is adequately covered during the course of the Paternity leave (i.e. through recruitment or temporary changes in responsibilities)
- Hold the role open for the employee to return to the workplace at the end of their Paternity leave
- Ensure the employee is consulted on any significant changes that may impact their role (i.e. Organisational Change)

4. People and OD Department

It is the responsibility of the People and OD Department to:

- Advise employees planning Paternity leave, of their rights in relation to Trust Policies and Procedures
- Support Managers in the application of relevant Policies and Procedures
- Administer Paternity leave provisions in conjunction with payroll

5. Payroll

It is the responsibility of the Payroll Department to:

- Ensure that payments or deductions are made in line with Paternity leave rules
- Ensure that the employee's membership to the NHS Pension Scheme is protected during unpaid Paternity leave



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Prifysgol Felindre
Velindre University
NHS Trust

TRUST BOARD	
Policy and Procedure for Medical Consultant Job Planning	
DATE OF MEETING	30 July 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	DR MICK BUTTON / ELIZABETH EDDIE
PRESENTED BY	Elizabeth Eddie, Executive Medical Business Manager
APPROVED BY	Jacinta Abraham, Executive Medical Director
EXECUTIVE SUMMARY	This paper seeks endorsement for approval of the updated <i>Policy & Procedure for Medical Consultant Job Planning</i>. The updated procedure, which has undergone extensive consultation and refinement with leadership teams and the Trust Local Negotiating Committee, provides a robust framework to ensure that job planning for consultants within Velindre University NHS Trust (VUNHST) is consistent, transparent, and aligned with contractual, organisational, and service delivery expectations. It is a key enabler for safe and effective patient/donor care, workforce stability, service resilience, and the effective deployment of our medical workforce across the Trust. It aligns with our strategic ambitions related to people, education, and research.
RECOMMENDATION / ACTIONS	The Trust Board is asked to APPROVE the updated policy as the standard operating framework for consultant job planning across Velindre University NHS Trust.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	Date
Senior Medical Leadership Team and VCS & WBS Directors	16/07/2025
WBS – Senior Leadership Team	13/08/2025
VCC – Senior Leadership Team	20/08/2025
Executive Management Board	26/08/2026
Trust Joint Local Negotiating Committee	11/12/2025
WBS – Senior Leadership Team	13/05/2026
VCS Divisional Board	26/05/2026
People Policy Review and Development Group	11/06/2026
Trust Joint Local Negotiating Committee	11/06/2026
Executive Management Board	02/07/2026
Quality, Safety & Performance Committee	16/07/2026
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Unanimous support for the need and implementation of this new policy. Extensive contributions, comments and points raised for clarification have been incorporated into this latest version, which has been endorsed for approval by all of the above groups/committees/boards. • The procedure has been developed following a full review of existing policies and controls. • It will enable consistent and fair job planning in line with national guidance and contractual obligations. • The procedure will be reviewed 12 months post-implementation or sooner if required due to changes in national policy or contract terms.	
7 LEVELS OF ASSURANCE	
If the purpose of the report is selected as 'ASSURANCE', this section must be completed.	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Select Current Level of Assurance N/A
APPENDICES	
1	Policy and Procedure for Medical Consultant Job Planning

1. SITUATION

Historically, consultant job planning across the Trust has lacked standardisation and structured governance across each of the specialities. Following a comprehensive review of current practices, policies, and governance mechanisms, it was identified that many existing documents were outdated, fragmented, or no longer valid. Considering this, the Trust has developed a refreshed and fully aligned Policy and Procedure for Medical Consultant Job Planning.

The new procedure has undergone extensive consultation and responds to the need for clearer expectations and consistency in job planning, especially since the new Velindre

Cancer Services divisional structure has introduced a broader group of Clinical Directors and General Managers responsible for, and involved in, consultant job planning.

2. BACKGROUND

Job planning is a contractual requirement and essential mechanism for ensuring delivery of safe, high-quality clinical care and organisational priorities. In Wales, job planning guidance has been set nationally through the Consultant Contract (2004 Amendment) and NHS Wales frameworks.

However, variation in interpretation and application has contributed to inconsistency and governance gaps within VUNHST. The lack of a formal committee structure to review and align job planning decisions has further exacerbated these issues and the new divisional structure within Velindre Cancer Services will see a wider group of Clinical Directors and General Managers responsible for job planning, and so clarity on procedure is vital.

To address this, the Medical Consultant Job Planning Procedure:

- Aligns with the Consultant Contract and Welsh guidance.
- Introduces a consistent and standardised approach across all Divisions and Directorates.
- Establishes a Job Planning Oversight Group to ensure equity, consistency and oversight.
- Supports the implementation of the L2P electronic job planning system.
- Clarifies roles, responsibilities, and expectations for all stakeholders.

The procedure is a key enabler for workforce stability, service resilience, the effective deployment of our medical workforce across the Trust and aligns with the quality of patient/donor care and our strategic ambitions related to people, education, and research.

Additionally, it helps mitigate issues identified in previous NHS staff survey & GMC National Training Surveys, such as falling morale in medical teams, additional hours (both paid and unpaid) worked by medical staff, limited time for research, innovation, and formal educational roles, and ongoing and established concerns about time pressures.

3. ASSESSMENT

The new procedure has been co-produced and subject to extensive internal consultation with divisional leadership, workforce representatives, and medical management. It outlines:

- A clear and comprehensive structure for annual and in-year job planning reviews.
- Standard definitions for Direct Clinical Care (DCC), Supporting Professional Activities (SPA), Additional NHS Responsibilities, and External Duties.

- An evidence-based approach to SPA allocation, supported by guidance and tariffs.
- Governance processes to address disputes, appeals, and non-engagement.
- A mechanism for consistent oversight through the Job Planning Oversight Group.

By providing clarity and operational consistency, the procedure will support:

- Alignment of medical time with service priorities.
- Improved consultant engagement and wellbeing.
- Better workforce utilisation.
- Assurance of fairness and transparency in consultant remuneration.

4. SUMMARY OF MATTERS FOR CONSIDERATION

1. Approval of the Policy and Procedure for Medical Consultant Job Planning and its associated appendices as the standard for consultant job planning across VUNHST.
2. Endorse the establishment of a Medical Job Planning Oversight Group to oversee the application and governance of the procedure.
3. Support the rollout and implementation of the procedure across all divisions, including training and engagement activities.
4. Note that the procedure will be reviewed after 12 months, or sooner if there are contractual or national policy changes.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals:	
• Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development and innovation in our stated areas of priority ☒ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☒ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK – BOARD ASSURANCE FRAMEWORK	BAF 08 - There is a strategic risk that the organisational and clinical governance arrangements do not provide appropriate mechanisms and culture to achieve our medium to long term objectives.
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). Please see Appendix 2 for full quality impact assessment.
QUALITY IMPACT ASSESSMENT	Not required - not a strategic decision
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Not required
TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT	
The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated. Please indicate whether any of the matters outlined in this report impact the Trust's Wellbeing goals: YES - Select Relevant Goals below	
If yes select the relevant goals: • A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities. ☐ • A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience. ☐ • A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health ☐ • A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances ☒ • A Wales of more Cohesive Communities - Attractive, viable, safe and well-connected communities. ☐ • A Wales of Vibrant Culture and Thriving Welsh Language -Promoting and protecting culture, heritage and the Welsh language, encouraging people to participate in the arts, and sports and recreation. ☐ • A Globally Responsible Wales – Consideration of whether an action may make a positive contribution to global well-being ☐	
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	Implementation of the procedure will give improved clarity and granularity of resources required to meet service delivery demand, maintain safe and effective

	patient care and deliver our ambitions in research, innovation and education. Source of Funding: Divisional Budget Allocation Type of Funding: Revenue Type of Change Business as Usual Improvement
EQUALITY IMPACT ASSESSMENT	Yes - please outline what, if any, actions were taken as a result An EQIA has been completed and all impacts have been considered in the final draft of the policy and procedure.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

6. RISKS

The following risks have been identified in relation to the implementation of the Consultant Job Planning Procedure:

Risk	Description	Mitigation
Resistance to change	Some consultants or managers may be resistant to the standardisation and oversight introduced through the procedure.	Early and transparent engagement, training, and communication plans will be implemented. Medical leadership (e.g. Divisional Medical Directors and AMD Workforce) will champion the approach.
Non-compliance or delayed engagement	There is a risk that some consultants may not engage with the job planning process or delay agreement.	Clear escalation processes are built into the procedure, including formal timelines and the use of template letters and committee oversight.
Variation in interpretation	Despite a standard procedure, local variations in interpretation could still emerge.	The Medical Job Planning Oversight Group will ensure oversight, alignment, and resolution of any discrepancies or inconsistencies.
Workforce pressures	Divisions may face challenges in completing annual job planning due to competing clinical demands.	Implementation support phased rollout (where necessary), and clear expectations for annual compliance will be provided.
Data accuracy and usage of the L2P system	Inconsistent or incomplete use of the electronic job	Mandatory use of the L2P system, supported by training and audit

Risk	Description	Mitigation
Equity concerns if the process is inconsistently applied	planning tool could undermine transparency.	mechanisms, will reinforce consistent data capture and accountability.
	If SPA allocations, DCC expectations, or additional sessions are not monitored, there may still be perceived unfairness.	Oversight by the Medical Job Planning Oversight Group, audit processes, and escalation routes are in place to monitor equity and address anomalies.

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

Velindre University NHS Trust

**Policy and Procedure for
Medical Consultant Job
Planning**

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This is an active document, which will be subject to continuous review and update as necessary.

- Changes discussed/agreed via Job Planning Oversight Group with input from operational leadership teams as needed
- Changes will then be negotiated via the JLNC

Changes to the policy may need to be made to fit in with any nationally agreed job planning policy. Where guidance overlaps, generally the nationally agreed policy will override this policy.

1. Introduction/Overview

Effective job planning is a key component of the [Amendment to the Consultant Contract in Wales \(2003\)](#) (referred to as the “Consultant Contract” throughout the remainder of this document) and was designed to ensure that individual Consultants and their employer agreed on the content, scheduling and outcome of activities that comprised their contractual commitment.

Job planning is therefore a key mechanism to help ensure high quality clinical care, the wellbeing of Consultants and a means of supporting delivery of the Trust’s objectives and expectations in a fair and transparent way in agreement with the individual.

Effective job planning can be a vehicle to deliver efficiencies, however the main benefits to the organisation are in optimising the contribution of the Consultant workforce to the delivery of patient care.

Job planning is a contractual obligation and should be undertaken annually by Divisional or Clinical Directors, in conjunction with the relevant Directorate Manager. Best practice is for newly appointed Consultants to have an initial review after 6 months.

2. Policy Statement

Differing interpretations of elements in the Consultant Contract can lead to inconsistency in its application. This poses clinical, financial and employment risks to the organisation.

The aim of this procedure is to ensure the annual job planning process (consisting of evidence-based discussion agreement and signing) is Consultant led, managerially supported, and carried out in a timely manner. It is designed to ensure job planning is applied equitably and consistently in a fair, reasonable, and transparent way, and that it is aligned with Value-Based Healthcare and prudent healthcare principles, the strategic objectives of the organisation and supports the individual’s personal objectives and reflects different, evolving phases in a Consultant’s career.

This procedure is designed to ensure consistency in job planning across the whole organisation, in line with the Consultant Contract, and that job planning is delivered in a way that ensures a valued and engaged workforce. It seeks to improve job planning quality and maintain compliance through improved processes and utilisation of an electronic job planning system.

It does not vary any contractual terms which apply but provides clarity and consistency in the way these terms are applied in Velindre University NHS Trust.

3. Aims/Purpose

This procedure aims to:

- Standardise Consultant job planning across the organisation in alignment with the Consultant Contract and the Trust's strategic objectives.
- Ensure the Trust delivers its aims, objectives, responsibilities, and legal requirements transparently and consistently.
- Ensure effective implementation and a resilient clinical service to optimise patient and donor care and safety.
- Support staff wellbeing.

4. Objectives/Outcomes/Benefits

This procedure delivers the following outcomes:

- Medical Consultant job plans aligned to the organisation's service priorities and delivery goals.
- Development of individual job plans that are agreed collaboratively between the Consultant, General Manager and Clinical Director which is consistent in the expectation of activity and recognition of workload across the team.
- Consistent and transparent application of job planning principles ensuring equity and clarity across individuals and teams.
- Allocated sessions that are linked to patient/donor/service need and individual/Trust /service objectives.
- Effective utilisation of contracted hours to maximise productivity and service delivery.
- Levels of service delivery for the year ahead are quantified, documented, and transparently measured on an ongoing basis.
- Support General Medical Council (GMC) revalidation through accurate and detailed job planning documentation.
- Ensure fair and consistent remuneration for all agreed job plan activities, including fixed clinical commitments, short-term or temporary additional sessions, and other non-clinical responsibilities.
- Ensure that service development/improvement, education, training, innovation, research, leadership, and trade union activities are recognised and supported where appropriate with outputs defined in a transparent, equitable and accountable way.
- Support wellbeing, work/life balance and European Working Time Regulation (EWTR) compliance (or equivalent) by ensuring appropriate allocation and regular review of temporary additional sessions, out of hours and on-call arrangements.
- Contract compliance, ensuring job plans meet the terms of conditions of service.
- Clearly measurable SMART organisational and individual objectives covering direct clinical care (DCC) and supporting professional activity (SPA) roles, linking with objectives agreed at the annual appraisal and set out in the personal development plan (PDP).
- Directorate level oversight of delivery of service by distribution and allocation of Consultant time across areas of priority.
- Delivery of improvement and quality in patient and donor care.
- Improved wellbeing of the medical workforce and a more sustainable clinical service.

5. Scope

This procedure applies to:

- Medical Consultants employed by VUNHST on substantive or fixed-term contracts.
- Medical Consultants or Clinical Academics employed by other organisations who undertake activity via a service-level agreement (SLA) or honorary contract on behalf of VUNHST and are jointly job planned for this activity.
- Medical Consultants or Clinical Academics who hold employment contracts with other organisations (in addition to their contract at VUNHST) will be expected to share the number and timing of sessions agreed with their other employer, as part of their VUNHST job plan discussion.

6. Roles and Responsibilities

Executive Medical Director

The Executive Medical Director has overall responsibility for:

- Agreeing the job planning process and procedure within VUNHST.
- Ensuring each doctor has opportunity to engage with job planning and to have an agreed job plan.
- Undertaking the job plan review and agreeing the corporate component of the Deputy Medical Director's job plan, in consultation with the Divisional Medical Directors, who remain responsible for any clinical component.
- Agreeing the corporate component of job plans for the Associate Medical Directors (AMDs).
- Ensuring relevant systems and processes are in place to deliver on the procedure.
- Identifying a deputy to actively support divisional management teams to resolve any job planning issues and disagreements via informal processes.
- Instigating the formal job planning appeals process as determined by the Consultant Contract when required.

Associate Medical Director – Workforce

The Associate Medical Director – Workforce has responsibility for:

- Supporting and advising on the job planning process and associated procedures within VUNHST.
- Supporting divisional/directorate management teams to resolve any job planning issues and disagreements via informal process.
- Advising the Executive Medical Director when the formal job planning appeals process should be instigated as determined by the Consultant Contract.
- Chairing the Job Planning Oversight Group - responsible for reviewing/updating the job planning process and acting as a forum for cross-divisional/directorate collaboration on any job planning process developments.

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Divisional Medical Directors & Directors

The Divisional Medical Directors & Directors have responsibility for:

- Ensuring that each doctor within their division has opportunity to engage in job planning, with the aim of mutually agreeing the current job plan.
- Assisting the Clinical Directors and General Managers in setting the service objectives and developing a team service planning approach.
- Ensuring all job plans can deliver the agreed individual Consultant and wider organisational objectives and service requirements.
- Quality of job planning meetings and process, including job plans that span more than one directorate.
- Supporting any informal discussions within the division where agreement cannot be reached.
- Undertaking the Clinical Directors' job plan reviews.

Clinical Directors and Directorate Managers

Clinical Directors and Directorate Managers have responsibility for:

- Ensuring that each doctor in their portfolio has opportunity to engage in job planning, with the aim of mutually agreeing the current job plan.
- Ensuring the principles of team service planning are applied, and job planning principles are applied equitably within the directorate.
- Ensuring service/activity data (including horizon scanning to anticipate new indications/treatments) is available for both team service planning and individual job planning, and to share the data with Consultants in advance of meetings.
- Ensuring the annual job planning cycle is based on and in line with the NHS Wales [*Effective Job Planning for Consultant Medical and Dental Staff*](#) and appropriate Royal College/other agreed national job planning guidance documents.

Executive Director of Workforce & Organisational Development

The Executive Director of Workforce & Organisational Development is responsible for:

- Providing medical workforce support to the delivery of the strategic framework for job planning.
- Ensuring the relevant corporate systems and processes are in place to support delivery of the procedure, including compliance reporting, training and electronic systems.

Individual Consultants

The individual Consultant has a responsibility to:

- Engage with the annual job planning process and support the delivery of mutually agreed job plans in line with this procedure and the NHS Wales [*Effective Job Planning for Consultant Medical and Dental Staff*](#).
- Participate in job planning more frequently either when requested to by the Clinical Director (e.g. because of a change in service delivery or as part of business case development) or at their own individual request.
- Fulfil the contractual requirement of the Consultant Contract.
- Collate evidence, when necessary, to support resolution of job plans where there is disagreement (e.g. diary exercises).

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- Include completed current job plans in the supporting information for annual appraisals.

Job Planning Oversight Group

- Ensure consistency and fairness in the development and review of individual Consultant job plans across all specialties and directorates.
- Apply agreed principles, policies and standards uniformly to promote equity in the allocation of sessions, including DCC and SPA time.
- Review proposed job plans for:
 - o Alignment with organisational priorities;
 - o Appropriate recognition and allocation of clinical and non-clinical activity (i.e. DCC and SPA) in line with the Consultant Contract;
 - o Compliance with contractual requirements and service objectives/expectations.
- Oversee allocation of additional SPAs, ensuring these are:
 - o Justified and aligned to organisational or service needs;
 - o Distributed fairly across Consultants based on roles, responsibilities, and outputs.
- Aid with resolving discrepancies or disputes in job planning through transparent, objective discussions involving cross divisional/directorate input.
- Ensure remuneration is fair and proportionate to agreed activity within job plans.
- Monitor job plans that consistently exceed 48 hours per week (12.8 sessions), to ensure there are agreed safeguards to protect both the doctor's wellbeing and the quality of the service.
- Inform the Executive Medical Director of all job plans above 12 sessions, as per Welsh Government requirements.
- Collate and report appropriate data related to job planning.
- Update agreed procedural/process documentation as needed.
- Provide assurance to the organisation that job planning is being undertaken regularly, rigorously, consistently, and in line with best practice.

7. Annual Job Planning

Job planning is an annual requirement for all Consultants as outlined in the Consultant Contract. Job plans that meet requirements in the current year may not in the following year. Changes to how services are delivered may necessitate variable or annualised working patterns from week to week.

In addition to the annual review, job plans may be reviewed in-year in response to activity, organisational change, or at the request of the Consultant. A job plan review may also be triggered if a Consultant is regularly working, on average, at least one session more (or less) than stated in their contracted job plan without prior agreement via the job planning process.

[The Royal College of Physicians job planning guidance](#) recommends that 'job plans should reflect the stage of career, with appropriate flexibility applied to team planning and with individual Consultants. Flexibility is required particularly in the first 3 years of an individual Consultant's career, to adapt to development needs and developing wider roles.'

7.1 Annualised job plans

Although some Consultants may continue to work the same pattern every week, it may be more appropriate for others to have job plans which vary week on week over an agreed period, or indeed to have a fully annualised job plan.

An annualised job plan is a form of Consultant job planning where clinical and non-clinical activities are calculated over the course of a year rather than allocated strictly on a fixed weekly timetable.

Instead of stating that a Consultant will deliver, for example, 10 sessions every week, an annualised plan recognises that activity needs may fluctuate (e.g., rota intensity, academic blocks, seasonal service pressures). The total number of sessions required over the year is agreed, and the Consultant works flexibly to meet that annual total.

The Clinical Director and Consultant along with the General Manager will determine whether an annualised plan is possible depending on service requirements and workforce availability. The basis for flexible working is referenced in Section 10 of the Consultant Contract and the decision to support this should be made in reference to this and the [WF23 NHS Wales Flexible Working Policy](#), ensuring all necessary paperwork is completed to support the agreement.

8. Context of Job Planning

Consultant job planning is an annual process of review and is linked to several other activities in the calendar year, as well as being the basis upon which relevant employment conditions are assessed.

8.1 Service delivery

Job planning is not merely a timetabling exercise. It should be a systematic, holistic activity, based on a partnership approach, which is rooted in the needs of the service and designed to produce clarity of expectation for employer and employee in respect of the time and resources required to meet individual and service objectives. This applies to both DCC and SPA, as both elements must reflect the needs of the directorate and the Trust as well as the individual Consultant.

The divisional and directorate triumvirate management teams need to understand the demands of the service, likely future demands and their current capacity to meet this demand. This will determine where potential changes to job plans may be required.

Any job plan may be reviewed within the year to take account of changes in activity or staffing, with the full agreement of the Consultant.

8.2 National Clinical Impact Awards

In March 2022, National Clinical Impact Awards (NCIAs) replaced the National Clinical Excellence Award Scheme (NCEAs). The criteria and eligibility for awards are set nationally in line with current England and Wales arrangements and continue to include participation in annual appraisal and job planning. The job planning process itself may be an opportunity to discuss prospective candidacy for NCIAs.

8.3 Working Time Regulations

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The Trust will ensure that job plans will be working time regulation compliant in accordance with the Trust's [WF44 - VUNHST Working Time Regulations](#) and will provide for:

- An average working week of no more than 48 hours or 12 sessions
- Compensatory rest
- In-shift breaks of 20 minutes after 6 hours

The Trust acknowledges and encourages the importance of staff being able to take reasonable breaks from their work to support their wellbeing and that of their colleagues and patients/donors.

8.3.1 Job Planning of Rest Breaks

A typical working day (not on call) will be made up of 8 hours, composed of 2 x 3.75-hour sessions with a 30-minute break. It is recognised that flexibility will need to be applied in this – a 30-minute break is encouraged but not mandated. The agreed job plan should reflect actual working practices.

Not including rest periods in sessional calculations:

The nature of the work and working patterns for some doctors may not permit them to take an in-shift uninterrupted break as there will be a need to maintain continuity of responsibility for patients. Where colleagues cannot take an uninterrupted break in the working day, the break must not be factored into the sessional value for the day as it will constitute working time and therefore is paid.

Including rest periods in sessional calculations:

If a doctor is able to take a clearly identifiable break, where there is no expectation of them being interrupted or required to do anything work related, then this does need to be considered as part of job planning such that the break is unpaid, the exact timing of the break is flexible and would not necessarily be stipulated in the job plan.

Travel time and rest periods should not be combined and must be recorded as separate activities in the job plan.

8.3.2 Opt-out

Where opt out and derogation of aspects of the Working Time Regulations is permissible within the Trust's [Working Time Regulations Policy](#), Consultants and managers must ensure that all necessary paperwork in line with policy is completed and held on the Consultant's record.

8.4 Temporary Additional Sessions

Temporary Additional Sessions (i.e. above 10 sessions for full-time employees or above the agreed contracted sessions for less than full-time (LTFT) employees) are allocated by mutual agreement between the Consultant and the relevant Clinical Director or Divisional Medical Director, where the service requires this.

Temporary additional sessions will be subject to annual review and clearly identified in the 'Extra Sessions' tab within the electronic job planning system. Dependent on the requirements of the Trust and the agreement of the Consultant, these additional sessions may or may not be extended at the job planning review meeting (para 8.1, Consultant Contract). Where temporary additional sessions are no longer required (either at the request of the Trust or the Consultant), 3 months' notice of the end date must be provided.

There will be a pro-rata allocation of annual leave related to the number of worked sessions (contracted and temporary additional sessions) up to a maximum of 10 sessions. Temporary additional sessions will not alter on call frequency/allocation.

8.5 Unrecognised Additional Work

Where it is identified, through the job planning process, that an individual Consultant is undertaking a session or more a week of additional work on a regular basis, in excess of contracted hours, and not arising at the request of the employer, then the employer can request that such work be continued as additional sessions for the relevant period of time in excess of the contracted sessions or discontinued as required, as defined in paragraph 2.27 of the Amendment. These additional sessions will be voluntary and can be ended at the request of either the Consultant or the employer, with reasonable notice.

8.6 Job Plans Above 12.8 Sessions

Where a job plan consistently exceeds 48 hours per week (12.8 sessions), there should be agreed safeguards to protect both the doctor's wellbeing and the quality of the service. These job plans should be monitored and reviewed regularly to ensure they remain appropriate and do not compromise safety or performance.

The Job Planning Oversight Group must inform the Executive Medical Director of all job plans above 12 sessions, as per Welsh Government requirements.

8.7 Annual Leave and Study/Professional Leave (including prospective cross cover)

Entitlement to leave is governed by the Consultant Contract and equates to an annual entitlement of 6 weeks and 4 days, plus 8 days public holidays for a full-time Consultant; this entitlement is pro-rata for LTFT Consultants. Annual leave entitlements remain the same for those working more than 10 sessions.

The contract provides for 30 days of study/professional leave over three years for a full-time Consultant and remains the same for those working more than 10 sessions; this is generally regarded as 10 days per year for planning and cover purposes, but this is flexible.

For LTFT Consultants, study/professional leave entitlement is initially set as pro-rata to the number of sessions worked on the electronic leave system. It is recognised that Consultants who work LTFT have development needs that may be greater than the pro-rata allocation. Such requests for additional time may be dealt with on an individual basis depending on development needs, length of the course/conference and expenses incurred. If the leave is justified, requests for additional leave above the pro-rata allocation will not be refused solely on the basis that the pro-rata allocation has been exhausted. Consultants who work LTFT and attend courses on non-working weekdays may also make requests to receive time-off-in-lieu (TOIL) in line with this policy.

Additional professional leave allowance for specific roles that require this can be agreed in advance through discussion between the Consultant and the line manager.

The study leave budget is a fixed allowance for all Consultants, independent of specialty or sessions worked (i.e. non-pro rata), including clinical academics. All staff need to demonstrate that requests for study/professional leave are justified and are aligned with their VUNHST roles.

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All time taken out of the agreed working week must be agreed in advance with at least six weeks' notice and needs to be co-ordinated within the clinical team to minimise impact on patient care, staff wellbeing and to ensure equity of access to leave.

Line managers (Clinical Directors and Directorate Managers) are responsible for ensuring there are sufficient members of staff available to provide the service. They must put in place processes for agreeing annual and study/professional leave such that there is minimal impact on core areas of service delivery. Engagement with senior clinicians (e.g. via team service planning) within the speciality should be undertaken to inform the process and assist the manager in determining the minimum number of medical staff required to deliver core services reliably and safely. Leave should not be agreed where the number of doctors available for work will fall below the number that is agreed necessary to deliver safe care.

Based on the leave entitlements outlined, both DCC and SPA should be delivered in line with contractual requirements, regardless of flexible working arrangements (including annualised job plans).

Annual leave should be taken proportionally from both DCC and SPA sessions, and SPA time must be booked as leave—it should not be displaced, rescheduled, or worked through. If a Consultant works for more than one organisation, input from both/all organisations will be needed in terms of allocation/timing.

If an individual Consultant is expected to provide prospective cross cover for periods of leave within the team, the time commitments for all activity should be calculated and recorded explicitly in the electronic job planning system.

8.8 Working on Public Holidays

In the interest of maintaining patient safety, Consultants may be asked to agree to undertake work on public holidays beyond any scheduled on-call rota commitments, e.g. in order to ensure timely review of inpatients. In such cases, they will be entitled to equivalent TOIL of the bank holiday. Such additional work on weekends and Public Holidays is voluntary; where a Consultant agrees to undertake such work, they will be entitled to equivalent TOIL of the bank holiday and any enhancement on the session.

Public Holiday impact on routine outpatient (OP) clinics

Given that the date of Public Holidays is known, any impact on routine OP clinics should be planned well in advance. A team-based approach, with planning well ahead, should minimise the impact of Public Holidays on patient care/clinician workload. Clinical work affected by a Public Holiday should be accommodated through such team-based planning, avoiding displaced clinical activity.

There should be prior agreement and close working between clinical/managerial teams to minimise such displaced work. In circumstances where despite advanced planning there is a need for an additional clinic, such work will be recognised through displaced SPA time if required and remunerated via a claim for the Additional Duties Hours worked.

8.9 Remote Working

Subject to prior agreement with the line manager (and compliance with appropriate regulations e.g. GDPR, Information Governance), working from home or remotely for both SPA and DCC can be considered and agreed in appropriate circumstances, supported by agile working agreements. As this is contracted time, Consultants must be contactable and remain available to return to site if needed. Travel to home to undertake SPA/DCC time will not be included in the job plan.

9. Components of Job Planning

The Consultant Contract states, “the working week for a full-time Consultant will comprise 10 sessions with a timetabled value of 3-4 hours each” and goes on to say that the “total number of hours in the working week will be 37.5 hours”. A full-time Consultant is not obliged to agree to a contract containing more than 10 sessions.

In VUNHST, these sessions can be programmed in appropriate blocks of time to average a 37.5 hour week where this meets the needs of the service.

Job plans are usually based on sessions averaged over 41.6 working weeks a year (to account for annual leave, study/professional leave, and Public Holiday entitlements). It is recognised that there will be scope for variation up and down, in the length of individual sessions from week to week around the average assessment set out in the job plan.

Job plans will be made up of the following core components as outlined in the Consultant Contract.

- DCC
- SPA
- Additional NHS Responsibilities (ANR)
- External Duties
- Fee Paying Work, as defined in paragraph 4.21 of the Amendment

Each component should be assessed individually with average weekly sessions defined and agreed. Where this is not possible, the time commitment necessary for each activity should be defined over a longer period to allow translation into sessions. These should then be brought together as a defined weekly/monthly/annual work programme or job plan.

For all Consultants, the finalised job plan provides the basis of the contractual duties agreed between the individual Consultant and the Trust.

In line with existing local agreements, where a job plan is agreed with a contracted number of sessions expressed to a decimal point, pay will be calculated and paid on the basis of the contracted sessions as agreed. There will be no automatic rounding up or down to the nearest whole or quarter session (e.g. a contract for 9.15 sessions will be paid as 9.15 sessions).

9.1 Direct Clinical Care (DCC)

DCC is work that directly relates to the prevention, diagnosis or treatment of illness that forms part of the services provided by the employing organisation as detailed in para 2.20 of the Consultant Contract. This includes:

- Outpatient activities
- Ward rounds
- Community Visits
- Hospital support reviews
- Radiology reporting sessions
- Ad-hoc and urgent reviews or requests
- Multidisciplinary meetings
- Administration directly relating to patient care
- Administration directly relating to patient Radiotherapy planning time (clinical oncologists)
- Radiotherapy peer review time (clinical oncologists)
- Emergency duties (arising in normal working hours)

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- On-call activity
- Travel

Further detail can be found in [Appendix 3](#).

DCC will be considered to be delivered if:

- A session is cancelled on the day due to operational issues and the Consultant cannot be redeployed to another activity within their speciality
- Work activity in line with contractual commitments is not achieved for reasons beyond the Consultant's control for example a doctor has made themselves available to work a session but the activity has not gone ahead (e.g. last minute clinic appointment cancellations or deferrals)
- The Consultant has authorised absence over and above annual or professional leave e.g., sick or parental leave.

9.2 On-call

DCC includes all emergency work – predictable and unpredictable. This should be programmed into the working week, where possible. On-call and out-of-hours commitments must be recognised and reflected in the job plan. Regular and predictable planned commitments are included as sessions. The actual work undertaken when on-call should be identified in the job plan as either predictable or unpredictable emergency work.

Predictable emergency work is that which take place at regular and predictable times, often because of, or during, a period of on-call work (e.g. post-take ward rounds, attendance in an emergency clinical setting). This should be programmed into the working week as scheduled DCC.

Unpredictable emergency work relates to work which may be required during a period of on-call when not on site e.g. called into site from home, providing remote advice, and responding to phone calls. This unscheduled on-call activity is remunerated by a sessional value in the job plan, which is based on the historic work undertaken – usually over a 6-month period, and the appropriate intensity banding. On-call work remunerated separately e.g. ad hoc locum work – is excluded from diary monitoring and remunerated through a separate process to job planning. Where on-call work needs to take place during a period of scheduled programmed activity, this will replace the scheduled sessional activity in the job planning calculation such that there is no double counting.

Travel to and from work for unscheduled NHS emergencies will count as working time.

On-call diary exercises need to be completed when there is/are:

- An intentional change in the on-call frequency
- Concerns that there is variance of individual practice
- Disagreement

When a diary exercise is considered necessary all members of the rota will be requested to undertake the exercise for a minimum of one rota cycle or 8 weeks, whichever is the greater. The Consultant Contract makes no reference to the validity of a diary exercise or the collective nature of it; it does however reference the helpful nature of a diary exercise in respect of on-call. The Trust encourages Consultants to take part in a diary exercise to ensure consistency. In the event that a Consultant chooses not to participate in the diary exercise, the Clinical Director will use professional judgement in order to determine the work that would have been undertaken and reflected in the exercise if participated in and plan the rota and sessional allocation in the job plan accordingly. On-call diaries should include frequency, period of

diarising, paperwork, detail, scrutiny/verification, and clearly define what activity is countable. The Clinical Director along with the general manager will be responsible for analysing the diary exercise. Suggested tools and process for undertaking a diary exercise are provided in [Appendix 2](#).

Intensity supplement will be calculated using the scoring formula applied to the questionnaire in the Consultant Contract, as submitted by the Consultant and verified by the Clinical Director. This intensity supplement is separate from the actual work undertaken. Intensity banding is assessed at the annual job plan review and banding and associated payment adjusted prospectively where appropriate.

9.2.1 Provision of on-call

There is no specified contractual requirement for Consultants to live within a certain distance of their principal hospital(s) (Base). However, Consultants must exercise professional judgement as to the maximum travel time from where they choose to reside, to the location where they are required to attend, to be able to fulfil their professional obligations safely. Where travel time in excess of this raises clinical concerns for the Divisional Medical Director or Clinical Director, the AMD Workforce will be required to provide a view. It is the Consultant's responsibility to ensure they can meet the requirements of both their contract of employment in relation to on-call work and GMC [Good Medical Practice](#). This means that if there are concerns that the nature of the on-call service is such that the Consultant's travel time poses risk to patients, the Consultant may need to make temporary arrangements for their on-call periods to ensure they can be available on site within 30 minutes.

Each specialty will have its own agreed on-call procedure, which outlines the expectations, responsibilities, and arrangements specific to that service. These procedures and rates will be documented and made available within each specialty for Consultants to review and reference as needed.

Where on-call rotas include pro-rata arrangements for LTFT Consultants, this should be reflected in the job plan.

It is generally the case that all Consultant staff in a department should contribute to the provision of continuing clinical care, including on-call. It is recognised that, in particular circumstances, some colleagues, after agreement with the clinical management team, might not participate in the regular on-call rota.

Specialties should have arrangements in place to accommodate uncommon situations where a Consultant has undertaken significant unpredictable out of hours emergency work during an on-call shift and, therefore, are unable to carry out their timetabled contracted session the following day due to reasons such as fatigue. If this is a regular occurrence, such work may require a change in working pattern or a review of on-call arrangements.

Consultants not on an on-call rota may be asked to return to site occasionally for emergencies but are not required to be available for such eventualities. Emergency work arising in this way should be compensated through a reduction in other sessional activities on an ad hoc basis or through previously agreed additional payments.

9.2.2 Cover for sick/annual/professional leave

In accordance with the Consultant Contract, short-term absence of a Consultant will be covered by colleagues where practicable. If an eventuality (such as a colleague's protracted sick leave) results in sustained additional workload for a Consultant colleague, and where the Consultant agrees to cover this workload, they must be compensated in the short term by additional remuneration or TOIL. Such remuneration would be agreed outside of the contracted job plan.

In the longer term, it may be necessary to undertake an interim job plan review and consider awarding temporary additional sessions in accordance with the Consultant Contract. Where practicable, sickness cover for senior colleagues will be provided by colleagues within the department/specialty/SST.

9.3 Supporting Professional Activity (SPA)

Consultants are a crucial part of the NHS workforce in Wales. They have a central leadership role in many important areas, including:

- The quality of patient and donor care
- The quality of patient, donor, and carer experience
- The management and efficiency of patient and donor care
- The education of doctors and other healthcare professionals
- Research, improvement and innovation activities

For these reasons, Consultants have dedicated contracted time within their working week for SPA. SPA is paid-for-time dedicated to activities that underpin the broader aspects of the delivery of high-quality care.

The aims of SPA within VUNHST are as follows:

- To support Consultants to achieve the necessary requirements for appraisal and revalidation
- To support Consultants' ability to deliver safe and effective DCC activities
- To support Consultants to undertake additional roles within the Trust that are aligned with Trust objectives and strategic aims
- To support Consultants' professional development and wellbeing.

Agreed SPA time must be exclusively dedicated to NHS work. Some of the precise content and detail of SPAs will be developed through appraisal; some of the elements will be primarily agreed through job planning.

The Trust accepts the typical split for full-time Consultants (10 sessions) will be 7 DCC sessions and 3 SPA sessions, as per the amended Consultant Contract. Variations to this ratio will need to be agreed by the employer and the Consultant at the job planning review. 2 SPA sessions will be defined as 'core' (see 9.3.1) for full-time Consultants (see 9.3.3 for LTFT); any SPA sessions above this will need to be evidenced and agreed in advance.

The allocation of SPA time will contain two main components – core SPA and additional SPA. For a clinician to be eligible to undertake additional SPA activity, they will need to demonstrate that they have undertaken the required outputs of core SPA. This will be monitored at the annual job plan review.

9.3.1 Core SPA

Core SPA ensures the delivery of all the normal aspects of the professional service, and personal Continuing Professional Development (CPD), in conjunction with professional/study leave allocation, necessary for the Consultant to revalidate.

Core SPA needs to be evidenced via already established routes e.g. evidence of activities delivered through core SPA such as audit, QiP, research, concern responses, Coroners reports, appropriate compliance with mandatory and statutory training, etc. and reflective practice presented via appraisal, in order to meet the requirements for revalidation. Core SPA outcomes should therefore be recorded and appropriately reflected on, for example, in appraisal and revalidation meetings. The Trust will support all Consultants to have the opportunity to contribute appropriately to research activity – this could be via DCC work, core SPA and, for those with formal research roles including Principal Investigator (PI) roles, additional SPA.

The list of activity within core SPA is detailed in [Appendix 4](#).

The list is not exhaustive. It is also accepted that there may be some variation in proportion of the core SPA dedicated to some activities and according to the Consultant's stage of career.

Newly appointed Consultants will have up to 1 extra core SPA session agreed for the first 12 months to allow attendance at induction activities (pro-rata for LTFT Consultants). After 12 months, the extra core SPA session will then become an 'additional' SPA session where evidence of role delivery will need to be provided.

Variations to the general time allocation for core SPA will be discussed at the Job Planning Oversight Group although the Oversight Group will not make recommendations on individual job plans.

Where an individual works for more than one employer, it is expected that core SPA costs and time will be shared proportionally.

9.3.2 Additional SPA

In addition to core SPA, Consultants will be allocated time within the job plan to undertake additional SPA, typically up to one additional SPA.

Additional SPA is any additional role or activity, beyond core SPA, that a Consultant agrees to undertake. Additional SPAs are highly valued by the Trust and provide a mechanism to secure senior clinical time to lead or support work that is fundamental to the Trust being a safe, high quality and clinically led provider of NHS care.

Additional SPA activities are for the service, division, or the wider organisation to commission. There are a number of essential roles which need to be fulfilled in services/teams, or at Trust level. A Consultant may choose not to take on additional roles and will therefore not be given an Additional SPA allocation or may take a reduced allocation. Other options include conversion to DCC, or 'Additional NHS Responsibilities', subject to mutual agreement.

[Appendix 4](#) provides a list of activities considered as additional SPA, but this list is not exhaustive. There may be other activity which will form part of additional SPA. Any SPA time for activities not currently included in the SPA tariff schedule should be discussed with the Divisional Medical Director who will submit a request to the Job Planning Oversight Group to review and, if needed, commission a diary card exercise.

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When an individual Consultant can evidence that the allocated time for agreed additional SPA role(s) is insufficient, they should request a job plan review meeting to discuss this initially with the Clinical Director. The Clinical Director should then seek advice on an increase in time allowance from the AMD Workforce who will take any request to increase general time allocation for an activity to the Job Planning Oversight Group.

An allocation of SPA over 3 sessions (2 Core, 1 Additional) will not routinely be permitted. In exceptional circumstances, where the Consultant is expected to undertake activity on behalf of the Trust which may require additional time, this must be agreed with the AMD Workforce. Such allocation will be for specific purposes and be temporary. This allocation will be subject to annual review, or more frequently if required.

9.3.3 SPA for less than full-time (LTFT) Consultants

The division of programmed activities between DCC and SPA for LTFT Consultants will be seen broadly as pro-rata for full-time Consultants. However, it is recognised that LTFT Consultants need to devote proportionately more of their time to SPA due to the need to participate to the same extent as full-time Consultants in CPD requirements, therefore the balance between DCC and SPA may be different for LTFT Consultants compared to full-time Consultants.

For Consultants working fewer than 10 sessions, total SPA allocation (to include core and additional SPA) will generally be allocated based on para 10.8 of the Consultant Contract (see table below). The Royal College of Radiologists and The Royal College of Physicians both recommend an absolute minimum of 1.5 core SPA for LTFT Consultants working 4 or more sessions.

Total Sessions	Direct Patient Care	Support Activities
9	6	3
8	5	3
7	5	2
6	4	2
5	3	2
4	2	2
3	2	1

For LTFT Consultants working less than a total of 3 sessions, allocation of SPAs will be discussed with the AMD Workforce who will be mindful of the wider Trust, department and individual requirements when advising on the appropriate number of SPA sessions, however a minimum of 0.5 SPA will be provided.

9.3.4 Timetabling, recording and managing SPA

It will be the responsibility of the individual Consultant and the clinical management team to account for the time spent on SPA in the same way they will need to account for the time spent on DCC activities. This will be supported by the electronic job planning system. When reviewing the time spent on SPAs, Consultants should consider the evidence required to support the outputs of the declared activity and ensure this is clearly recorded in the job plan.

The details of SPA and associated objectives will be recorded in job plans and will provide a description of the activity, location where it is to be conducted, and the expected outcomes. All outcome measures for additional SPA will need to have a clear role/job description with objectives and expectations; outcome measures for additional SPA must be evidenced at the annual job plan review meeting.

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Teaching, day-day supervision activities and research activities which occur as part of DCC, (e.g. in clinics or ward rounds) must not also form part of the additional SPA allocation as this will result in double counting of these items.

Allocations for SPA will be reviewed by the Job Planning Oversight Group to ensure consistency across the Trust for comparable activities as outlined in [Appendix 4](#).

As described in para 2.12 of the Consultant Contract, SPA sessions may, by mutual agreement, be scheduled across the week such that up to one session of contractual commitment may take place outside working hours leaving a similar period free in which there is no contractual commitment during normal working hours. In such instances, any agreed enhancement for work outside normal working hours would not apply.

Consultants should not be routinely asked to undertake DCC activity e.g., supervising clinical work (supervision which is not part of educational or clinical supervision described in the SPA allocation document [Appendix 4](#)) when undertaking SPA on site. This will avoid any conflict between DCC and SPA time.

Ad hoc extra-contractual work may be accommodated through a temporary displacement of a maximum of 1 SPA to a time outside the approved job plan schedule. The nature of the displaced SPA activity and when this will be rescheduled must be agreed in advance and recorded on the extra-contractual payment claim form. Extra-contractual work must not be undertaken in DCC time that is already contracted and paid for by the Trust.

9.4 Teaching and Education

It is expected that all Consultants will take part in departmental teaching activities unless an opt-out has been agreed with the clinical management team, where the teaching commitment may be amalgamated and undertaken by other named individual(s) within a department/specialty/SST.

This teaching may be delivered during DCC activities already accounted for in the job plan such as clinics or ward rounds. If so, it should not be double counted.

Teams are advised to consider the overall teaching requirement for their department/specialty/SST in terms of teaching preparation, tutorials, lectures, and examinations - related to undergraduate, postgraduate, or other healthcare teaching, excluding that which is delivered through clinical sessions. Job plan recognition for individuals may vary depending on their commitment to the team's teaching activity and number of students.

[Appendix 4](#) describes the recommended SPA allowances for specific teaching and training SPA activity.

9.5 Clinical Governance and Audit

Clinical governance and/or audit activities are an integral part of all clinical activity and therefore included in core SPA. However, it is also recognised that certain roles, e.g. leading a national audit, benefits the whole department and may be classed as an additional SPA.

There may be times when Consultants are required to undertake such roles at a time when clinical activity is not undertaken, e.g. scheduled clinical governance, audit or mortality meetings. Information on the detail and expected attendance at such meetings for each specialty must be provided in the specialty guidance notes and individual job plan objectives.

If attendance at such meetings replaces DCC activity already counted in the job plan, there must be a corresponding reduction in the time allocated in the job plan for that activity, or the DCC will need to be delivered at another mutually agreed time to avoid double counting.

The time taken to fulfil governance and audit lead roles and responsibilities will be assessed and agreed by the Divisional Medical Director and translated to additional SPA in the job plan.

9.6 Timetabled management meetings

It is recognised that most departments/specialties/SSTs will need to hold management meetings on a weekly, fortnightly or monthly basis. The requirement to attend and time required for such meetings should be recorded as part of core SPA in the job plan or will be part of the allocated management session for those Consultants with formal management roles (e.g. Associate Medical Directors, Divisional Medical Directors, Clinical Directors, etc.).

If attendance at such meetings replaces DCC activity already counted in the job plan, there must be a corresponding reduction in the time allocated in the job plan for that activity, or the DCC will need to be delivered at another mutually agreed time to avoid double counting.

Information on the detail and expected attendance at such meetings must be provided in the department/specialty/SST job planning guidance notes, and in individual job plan objectives.

9.7 NHS Research

The Trust (and clinical management teams) will support all Consultants to have the opportunity to appropriately contribute to research activity. To ensure all Consultants have the opportunity to engage with clinical research, i.e. to be 'research active', time will be recognised in the job plan for all Consultants, in line with para 2.21 of the Consultant Contract. Research activity may be via DCC (e.g. clinical activity related to trials, delivered within a DCC session), core SPA (GCP training, keeping up to date with relevant clinical trials, some trial activity e.g. sub-investigator work) and some via additional SPA/additional NHS responsibilities (e.g. PI role, Chief Investigator (CI) role, research leadership roles).

For these purposes, 'research active' has been defined based on criteria developed by the Research, Development & Innovation (RD&I) directorate and is agreed as follows: individuals must demonstrate active involvement in research activities that contribute to the organisation's research strategy. This may include acting as a CI or PI on approved studies, significant participation in research grant applications, leading or contributing to peer-reviewed publications, supervising research staff or students, or playing a key role in developing and delivering the research portfolio within the organisation. Recognition as 'research active' will be reviewed annually as part of the job planning process.

[Appendix 4](#) describes the recommended SPA allowances for research activity.

9.8 Quality Improvement (QI) and Innovation

Continuous QI and innovation, embedded into routine clinical practice, is fundamental to enabling clinical teams to learn about and develop/improve the services they provide. As such, all Consultants will be expected to deliver QI/innovation work via their core SPA allocation.

As the organisation moves towards embedding a QI and innovation culture, there may be leadership roles that require the use of additional SPA time within the job plan which will need to be reviewed annually. Appointment to these leadership roles would need to be approved at a Divisional Medical Director level and may include:

- Acting as a trained QI Lead within the directorate/division, including –
 - o Building an infrastructure locally to support QI activity
 - o Supporting/coaching other Consultant staff in their core QI activity
 - o Formal teaching of QI principles
 - o Leading system level/MDT QI work
 - o Leading QI work at a national level

9.9 Additional NHS Responsibilities (ANR)

Where it is not possible to accommodate additional responsibilities in the time allocated for Supporting Professional Activities (SPA), paragraph 2.40 of the Consultant Contract provides for these duties to be either substituted for existing activities or remunerated separately, with prior agreement by the employer. These arrangements must be discussed with the line manager and agreed with the Executive Medical Director (EMD) before any applications or commitments are made. Such responsibilities include:

- Caldicott Guardian
- National Clinical Audit Leads
- External Clinical Tutors
- Regular teaching and research commitments over and above the norm and not otherwise remunerated
- Professional representation roles
- Trade union representative roles

The Trust also recognises the following:

- Responsibilities defined or requested on behalf of the Trust that are not undertaken by the generality of Consultants but are undertaken within VUNHST.
- Activities agreed between the Consultant and the organisation, which cannot be absorbed within time that would normally be set aside for SPA. These include Medical Leadership roles e.g. Deputy Medical Director, Associate Medical Director, Divisional Medical Director, Clinical Director etc., or other duties agreed by the Trust and recorded in the job plan.

9.10 Time-limited Trust projects

There may be occasions when some individuals may be invited to participate as Trust lead clinicians for specific, time-limited Trust projects. These may or may not be substituted for existing DCC/SPA sessions or attract temporary additional sessions, depending on the impact on the service.

The time taken to fulfil these responsibilities/roles should be as detailed in the role/job description, agreed in advance and identified in the job plan to avoid double counting of sessional time.

9.11 External Duties

External Duties (as defined in para 2.42 of the Consultant Contract) are not included in any of the aforementioned definitions or with the definition of Fee-Paying Services or Private Professional Services but are undertaken usually in the interests of the wider NHS or other Government department, and not the Trust e.g. Regional Education Adviser, Undergraduate Dean, Postgraduate Dean. These may be included as part of the job plan by prior agreement between the Consultant, Clinical Director and Divisional Medical/Clinical Director, with reference to the Deputy Medical Director if necessary. These may or may not be substituted for existing sessions, depending on the impact on the service. Where service priorities are

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unable to support time in the job plan, such work may be undertaken in the Consultant's own, or uncontracted, time.

External Duties may have two components:

- Administration time required to be undertaken during the normal working week to support the duty.
- Time required away from the workplace to fulfil the duty.

9.11.1 Agreeing and Managing External Duties

The Trust wishes to support those External Duties which are of benefit to the NHS at regional or national level and will attempt to support these wherever possible, however any decision to do so must be made in the context of providing and ensuring safe and sustainable services and business continuity within VUNHST.

In accordance with para 2.42 of the Consultant Contract, it is expected that any individual seeking to include time in their job plan for an external duty will first ask for the agreement of their Clinical Director who will balance the request against service need. The Consultant must then seek the written agreement of the Divisional Medical Director and AMD Workforce prior to formal application for the external role.

Consultants must be able to fully account for these activities in terms of interest to the Trust, Professional Society, College, or wider NHS.

If an individual receives either payment or an honorarium in respect of the External Duty, then no sessional value should be applied within the individual's job plan. It is important that no double payment occurs. This means that a Consultant may not undertake a paid external role at the same time as a contracted session at another time. It may be possible to provide the contracted session at another time, but this must be agreed in advance with the Divisional Medical Director and may not be possible in every case.

Some External Duties are fully funded externally, and the fee is received by the Trust and not the individual Consultant. In these circumstances, where the service delivery permits, and by agreement with the Clinical Director and Directorate Manager, the Consultant may either reduce their existing SPA and/or DCC activity or take on Temporary Additional Sessions in order to accommodate these duties. The needs of the service will determine whether reduction in DCC is feasible, and this should be judged by the Clinical Director.

External Duties which do not attract additional remuneration may be carried out within the working week with prior agreement. The Trust will commit to working with the Consultant to support such activity within the professional and study leave allowance i.e. up to a total of 30 days over 3 years (maximum) dependent on service requirements.

If a Consultant uses professional leave to undertake External Duties, it is their responsibility to ensure they have sufficient professional/study leave in hand to meet requirements for CPD to allow them to revalidate.

This means that the full impact of External Duties upon an individual Consultant's time may not be able to be met by the Trust and Consultants need to be aware of this. The Trust will, where possible in terms of service delivery, agree to a variation in DCC within the job plan to enable some time for delivery of the role even if it cannot fully accommodate it. Decisions on the allocation of these sessions will be at the discretion of the Deputy Medical Director.

In accordance with para 252 and 253 of the Consultant Contract, the Trust has the discretion to grant additional study and professional leave with or without pay and expenses. Therefore,

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in exceptional circumstances, arrangements may be made to accommodate certain External Duties. National Society roles such as 'Secretary' and 'Treasurer' do not fall under this definition of exceptional. In such circumstances, Consultants should approach the Divisional Medical Director and seek confirmation from the Deputy Medical Director for a sessional allocation/variation to their job plan or paid/unpaid additional leave.

Absence linked to professional leave must be applied for with at least 6 weeks' notice, approved and recorded by the line manager. Any requirement for absences not agreed prospectively will need to be taken from alternative leave allocations (annual and study/professional) unless negotiated separately with the Deputy Medical Director.

Consultants should be sensitive to any increased workload undertaken by their colleagues as a consequence of their absence. Therefore, where possible, External Duties should be scheduled to minimise loss of commitments such as clinics, ward rounds, on-call commitments etc.

Additional sessions for External Duties will not effect on call commitment/frequency (which is based around core, contracted NHS sessions). They may affect annual /study leave allowance for LTFT Consultants as time will still need to be booked. This should be discussed and agreed prior to taking up such roles.

For any other professional activities which are not covered in the job plan, unpaid leave may be available depending on the nature and duration of the duties.

9.12 Trade Union Activities/Duties

The Trust has committed to partnership working and supporting British Medical Associate (BMA) accredited representatives of the Local Negotiating Committee (LNC) with reasonable time for undertaking Trade Union (TU) activities. Further detail can be found in the NHS Wales and BMA Cymru Wales Recognition Agreement.

9.13 Work for Charitable Organisations

The time required to support roles/duties for charitable organisations is not recognised as part of the NHS working week and therefore does not attract sessional allocation assessment or additional leave entitlement. The exception to this is Palliative care where cross-cover arrangements with charities like Marie Curie, City Hospice, or Macmillan mean that scheduled NHS doctor time is spent on premises such as the Marie Curie Hospice in Penarth, for both SPA, and DCC activities, as part of the VUNHST job plan.

9.14 Private Practice Activity

The Consultant Contract and the [Code of Conduct for Private Practice](#) outline the basis for the relationship between NHS and private practice activity.

Work outside NHS commitments must not adversely affect NHS work, nor hinder or conflict with the needs of NHS employers and employees. Consequently, all time required for private practice work must be discussed at a job plan review meeting. If at the job plan review meeting there is an agreed need to change the scheduling of NHS work, reasonable notice (12 weeks where possible) will be given to the Consultant in order to rearrange existing private sessions.

If NHS sessions are disrupted the Consultant should rearrange the private sessions. Agreed NHS commitments take precedence over private work.

It is imperative that no individual is paid twice for the same period of time, regardless of by whom or how they are paid. However, the Trust recognises that there may be ad hoc emergencies, or occasions where it is more efficient (in terms of the wider workforce and facilities resource availability) for Consultants to see private patients at some point during an already established NHS session. Where regular flexible accommodation of private patients is agreed, the estimated average Private Practice Activity time should be calculated and recorded in the job plan such that there is a corresponding reduction in paid time for such activities. This should be monitored regularly via standard job planning processes.

10. Job Planning process

In accordance with Paragraph 1.23 of the Consultant Contract, it is the employer's responsibility to arrange the job plan review within the relevant timescale, and for the Consultant to cooperate and engage with the annual job planning process.

The electronic job planning system was implemented in October 2024. All job plan reviews will now be undertaken within the system, which has been configured to reflect the Consultant and SAS Doctor Contracts.

The finalisation of individual annual job plans will be the responsibility of the Directorate Clinical Directors and overseen by the Divisional Medical Director.

In order to align individual job plans and team working with the requirements of the service, the job planning process should essentially include two stages: team service planning and individual job planning reviews.

10.1 Stage one – Team Service Planning

Team service planning is centred on activities that involve the whole team and provides an opportunity for the team to effectively share responsibilities. It promotes a team approach to service delivery, enabling increased efficiency and visibility.

Team service planning and objective setting is best achieved by looking at the team's objectives together with the aim of:

- Enhancing the quality and efficiency of patient care
- Removing unnecessary duplication of effort amongst colleagues and the wider medical team
- Achieving comprehensive coverage of SPA and other non-clinical work needing to be done. This could include the delivery of education for resident doctors, medical students, other team members and appropriate data about research, innovation and quality improvement processes/activities
- Ensuring that the work is shared fairly and equitably
- Regularly monitoring progress
- Identifying any shortfalls in the ability to deliver commissioned work, which can then be addressed through business planning.

The process begins with defining and quantifying the requirements of the service as a whole including the estimated demand for the various components of that service (e.g. clinics, theatre lists, procedure lists, ward rounds, on-call rotas, MDTs, hospice reviews, etc).

The Clinical Directors, with assistance from the Directorate Managers, will:

- Obtain best available demand and activity data for various components of the service.

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- Review current service components and consider changes – type, time, place, capacity, horizon scanning.
- Consider resource constraints, e.g., outpatient facilities, theatre slot availability, peripheral activity, shared services with other providers.
- Consider subspecialty constraints (e.g., limited individuals available to perform certain functions).
- Consider Royal College Guidance.
- Information on activity (including anticipated changes through new treatment indications)
- Service costs.
- Performance against local and national targets.
- Quality and safety issues.
- Workforce measures; and plans and initiatives for service modernisation and reconfiguration.
- Establish an adequate on-call cover system.
- Appropriate horizon scanning of anticipated changes that may affect service delivery in the next 12 months
- Establish a default 'whole service template' – what happens, when and where, and who does it, during each week.

In preparing for job planning the Clinical Director and Directorate Manager will meet with the specialty/service group to review and agree a proposal for how the job planning process will be applied in their specialty/service.

The service plans for the directorate/speciality should be made available to all team members prior to the team service planning meeting to allow adequate time for review and comment.

It is important that all members of the team make every effort to attend the service planning meetings, which should be chaired and led by the Clinical Director/SST Lead, or equivalent. A template team service planning meeting agenda can be found in [Appendix 5](#).

The team service meeting provides an opportunity to collectively review and discuss the data and information, establishing the team objectives, demand and capacity, and resource required to achieve the service objectives for the year ahead, seeking equity for team members.

While each job plan is individual, individual objectives should be determined within the context of the team and Trust objectives. Equally, while team service planning supports and informs individual job planning discussions, it does not replace the need for them.

During the discussion and agreement of team service plans, care must be taken to respect individual employee confidentiality, ensuring that individually identifiable information is not shared without permission. It will also need to be recognised that some individuals will have requirements or agreed adjustments that will need to factor into team service planning.

The group should review the proposed assessments for DCC activity and agree any required amendments to these e.g., a change in the out-of-hours activity levels, extended working day or week or anticipated changes due to new treatment indications.

For SPA, the group should review overall and individual contributions to the Trust, departmental education and teaching programmes, governance programme and agree how these activities should be reflected in each Consultant's job plan. Similarly, agreement can be reached about the departmental meetings and activity that should be recognised as part of core SPA in the job plan.

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The Clinical Director and Directorate Manager should work towards the development of a Specialty/Service Based Job Planning Guide, which will:

- Define the activities that are applicable to the service, including national plans and Welsh Government service specifications.
- Propose the service standards for time allocated to each of the DCC activities e.g., DCC and related administration time.
- Specify the time allocated to each of the activities (session length), define the expected level of clinical activity delivered (number of patients which corresponds for example to the session template on the hospital Patient Management System) and define whether they are to be timetabled as fixed or flexibly worked activities.
- Define the rules for taking leave, on-call arrangements, intensity supplement and specify the time allocated to scheduled and unplanned emergency work.
- Ensure there is provision for prospective cross-cover where required and that this is recognised in sessional allocation.
- Specify any other agreements – e.g., those that apply to team based annualised job planning.

10.2 Stage two –The individual job plan review meeting

The individual job plan meeting should be undertaken in a spirit of partnership and conducted using a consistent approach across the Consultant workforce that encompasses the Trust's values and behaviours, whilst striving to balance the patient and service specific needs with those of the Trust, the wider NHS and the individual Consultant.

There is no perceived reason or right to be accompanied at an individual job plan review meeting. Any such request should be escalated to the Divisional Director.

Job planning meetings must be scheduled well in advance to ensure Consultants have adequate time to prepare. Further information on job planning is available via the [BMA website](#). Data relating to job plan activity (e.g., clinic and patient numbers, number of scans reported etc.) should be shared with the Consultant ahead of the meeting (ideally two weeks before) to allow all parties to consider the issues and information.

Job planning meeting can be either in person or virtual. It will be delivered by the relevant clinical lead(s) with support from the relevant managerial lead(s); if a Consultant's job plan includes sessions funded/managed by other teams, they will need to appropriately input into/support the job planning process.

If an individual Consultant works in multiple teams, there should be an agreed primary manager(s) who will be responsible for the job planning process, liaising with the other department managers and updating relevant parties on the outcome of the job planning process.

Adequate preparation for the individual job plan review meeting is important, and the best outcomes arise when the following are considered:

- Effective preparation by both parties.
- Sharing of information in advance.
- Starting with objectives and not the timetable.
- Focus on the principles and detail relevant to job planning.
- Offering strong organisational support.
- Partnership approach to facilitate and negotiate a mutually agreed job plan.

The job planning process should include a review of the past year (e.g., what worked well and where there is room for improvement), the current workload and any anticipated changes to duties and responsibilities.

The meeting will establish and document the Consultant's capacity and expected availability (in time) to deliver the various components of the service and support the Consultants' own interest and CPD.

In addition to the stage one service plans and team discussion, the following should be discussed/reviewed in the individual job plan review meeting:

Relevant personal objectives from appraisal/PDP, supporting resources, measures and timescales to ensure the job plan can support these.

- An expectation of provision of agreed DCC activity sessions, to include alignment with Royal College guidance on clinic templates and recommended consultation duration.
- Leave and other absence cover arrangements.
- Actions and resources (to include adequate administration support) required to improve quality and delivery.
- Additional professional / External Duties.
- Frequency of on call and intensity banding.
- Trust/Health Board/service developments to which the Consultant could contribute.
- Identification of all external commitments (including private practice).
- Any amendments to the previous job plan.
- Diary evidence of individual DCC/SPA activities (see [Appendix 2](#)).
- Any additional resources required to fulfil NHS commitments and PDP objectives.
- Any requirement for Wellbeing support with provision of information on the Trust's Wellbeing initiatives, guidance, toolkits and resources.

As a result of the documented discussion the Clinical Director/Directorate Managers will be able to:

- Quantify total sessional commitment (includes additional sessions).
- Define/quantify of SPA and additional/External Duties.
- Define/quantify on-call commitment and any applicable intensity supplement.
- Establish and quantify fixed, timetabled flexibly worked and flexible sessions.
- Calculate expected average DCC/SPA week.
- Calculate expected measurable service delivery over next year.
- Clarify mechanisms of ongoing service delivery recording.
- Calculate expected average prospective cross cover arrangements.

Considering the needs of the service and available workforce, the Clinical Director will agree as part of the job planning process which sessions each individual needs to be available for and allocate fixed and timetabled flexibly worked sessions accordingly. Should it not be possible to reach an agreement through a series of internal informal discussions within a reasonable time frame, ideally within a three-month period, the Consultant may appeal through the job planning appeals process.

Where reasonably possible, the delivery of objectively measurable components of a service should be recorded over time and compared to the expectations as proposed in the job plan. This process is important where timetabled flexible working (including working from home) or annualised working is undertaken (see para 1.17 to 1.21 of the Consultant Contract).

The annual job planning round is also an appropriate time to review strategic workforce decisions, e.g., to optimise the service for changes to demand, workforce shortages or changes e.g., retirements.

Job planning meetings may occur more frequently than on an annual basis if there are particular issues or problems that need raising and addressing (e.g., duties/responsibilities/outcomes are changed or need to change significantly within the year,

or where the time commitment involved breaches the contracted sessions). Consultants or their line managers may call for such interim meetings.

Where Consultants are regularly working more than their contracted sessions (as supported by a job planning diary, see [Appendix 2](#)), a review should take place (either at the planned annual review or at an interim job planning meeting) to identify whether a reduction in workload and/or increase in sessions is needed.

10.2.1 Outcomes/Objectives

The outcomes/objectives for each individual Consultant in relation to their job plan must be set and reviewed at the individual job plan review meeting. Objectives should be appropriate, identified and agreed and be:

- **Specific**
- **Measurable**
- **Achievable and agreed**
- **Relevant**
- **Timed and tracked.**

Outcomes should reflect a balance between service and organisational objectives and personal development objectives and may be a combination of:

- Objectives (service and individual)
- Personal development objectives as identified via appraisal.
- Individual contribution to team performance.
- Performance standards.

10.2.2 Job Planning Meeting Documentation and Sign-Off Process

The job plan itself must include the following elements:

- Routine work as agreed in the job plan, detailing time and location considering that one core SPA session may be worked flexibly in line with para 2.12 of the Consultant Contract.
- Details of on-call arrangements and intensity supplement.
- Other specialty and individual agreements as appropriate including (but not limited to):
 - o Changes to remuneration or working arrangements with appropriate notice.
 - o Time allocated for each of the core components of the sessions allocated.

The discussion and information used to inform the resulting job plan should be documented in the document by the line manager leading the job planning discussion.

For job plans that are above 12 sessions the Executive Medical Director must give approval before sign-off.

All job plans should be recorded on the electronic job planning system and mutually signed off once agreed as soon as possible following the job plan review.

If the job plan remains unsigned, but no concerns have been raised, the Consultant will be advised in writing that, unless they indicate within an agreed timeframe that they dispute the job plan, the job plan will be assumed to be agreed ([Appendix 7](#) shows the 'presumed sign-off process', which takes a maximum of 4 weeks).

Once signed-off, the Directorate Manager will ensure that payroll are notified of any increase or decrease in sessions via the usual process (NWSSP Staff Management App).

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If it is not possible to agree a job plan, the matter will be referred to the Medical Director or nominated deputy, and the appropriate appeal process will be followed as contained in the Amendment to the Consultant Contract – see [Appendix 6](#).

Non-engagement with the Job Planning Process

In accordance with Paragraph 1.28 of the Consultant Contract, it is the employer's responsibility to arrange the job plan review within the relevant timescale, and for the Consultant to co-operate with this.

In the event that a job plan is not reviewed within the 12-month period and the Clinical Director has endeavoured to undertake this review, the Consultant will receive a formal request from the Divisional Medical Director (DMD) to engage in the job planning process.

Failure to engage within a four-week period will result in a formal request from the DMD, which will be followed with meeting with the DMD if required. The escalation process and letters to support this are detailed in Appendices 6 & 7.

Failure to consistently engage with a job plan review and/or agree a job plan will result in attempt at local resolution. If the Consultant fails to consistently engage with this, they will be notified of the unsatisfactory nature of the job plan before the formal appeals process is instigated.

Job Planning Disputes and Appeals

In the majority of cases the job plan review meeting results in a mutually agreed job plan.

However, sometimes difficulties arise. In such cases impartial and informal support to reach resolution can be sought from identified members of the Senior Medical Leadership team. BMA members can also seek advice and support from their trade union and representatives.

Where a Consultant is still unable to agree with a job planning decision, there will be an initial referral to the Medical Director who will continue to attempt informal local resolution within a reasonable time frame, ideally within three-month period before instigating the national formal appeals process.

The formal process is independent of the Trust and there is no right of appeal. An overview of the internal informal resolution process and interface with the national appeals process is detailed in [Appendix 9](#).

11. Resources

Time to familiarise with the new procedure and undertake associated training will be accommodated within core SPA.

12. Training

This procedure forms the basis of all job planning training developed and conducting within the Trust. A distance-learning pack will be created to align with this procedure.

13. Implementation

Communication of the agreed procedure will be via the following routes:

- Divisional and Directorate management structures
- Workforce business partners

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- Joint Local Negotiating Committee
- Medical and Dental Workforce intranet page

14. Equality

The Consultant Job Planning Procedure will be conducted in accordance with the Welsh Language Standards. This includes offering job planning meetings and documentation in Welsh, if requested, and ensuring that Consultants who prefer to communicate in Welsh are able to do so. This provision aims to support the use of the Welsh language within the organisation and ensure that all Consultants can participate fully in the job planning process in their preferred language.

The Equality Impact Assessment (EIA) is available on request from the Executive Medical Business Manager.

15. Environmental Impact

No specific implications.

16. Audit

Audit of compliance with this procedure will be via the internal audit programme.

17. Review

This procedure will be reviewed in 12 months initially, unless there is contract change or new legislation/guidance which necessitates a review.

18. Supporting policies and guidance

- [All-Wales Medical Trainer Agreement \(Secondary Care and Undergraduate Education\) \(2018\)](#)
- [Amendment to the National Consultant Contract in Wales \(2003\)](#)
- [NHS Wales Effective Job Planning for Consultant Medical and Dental Staff \(2014\)](#)
- [NHS Wales Flexible Working Policy \(2023\)](#)
- [NHS Wales Medical and Dental Staff Terms and Conditions of Service \(2003\)](#)
- [RCP Empowering physicians – effective job planning for better patient care \(2025\)](#)
- [RCR Clinical oncology job planning guidance for Consultant and SAS doctors \(2022\)](#)
- [RCR Clinical radiology job planning guidance for Consultant and SAS doctors \(2022\)](#)
- [VUNHST Working Time Regulations Policy and Opt-out Agreement \(2022\)](#)

19. Appendices

- [Appendix 1](#) – Travel and parking times
- [Appendix 2](#) – Diary Exercise guide and tools
- [Appendix 3](#) – Direct Clinical Care (DCC) examples
- [Appendix 4](#) – Supporting Professional Activities (SPA) and Additional NHS Responsibilities (ANR) guidance
- [Appendix 5](#) – Team service planning guidance
- [Appendix 6](#) – Escalation process – flow diagram
- [Appendix 7](#) – Job Plan sign-off process
- [Appendix 8](#) – Escalation letters 1, 2 & 3
- [Appendix 9](#) – Summary of information resolution and appeals process – flow diagram
- [Appendix 10](#) – Medical Job Planning Oversight Group – Terms of Reference
- [Appendix 11](#) – Guidance on allocation of administrative time

- [Appendix 12](#) – Guidance on radiotherapy planning time

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Appendix 1 – Travel and parking times

	City Hospice (Whitchurch)	Llandough Hospital	Marie Curie Hospice (Penarth)	Neville Hall Hospital	Prince Charles Hospital	Princess of Wales Hospital	Royal Glamorgan Hospital	Royal Gwent Hospital	The Grange Hospital	University Hospital Wales	Velindre Cancer Centre	VUNHST Corporate HQ (Nantgarw)	Welsh Blood Service (Talbot Green)	Ysbyty Ystrad Fawr
City Hospice (Whitchurch)		30 mins	30 mins	50 mins	35 mins	30 mins	25 mins	30 mins	35 mins	25 mins	5 mins	15 mins	25 mins	25 mins
Llandough Hospital	30 mins		10 mins	65 mins	55 mins	35 mins	30 mins	40 mins	45 mins	30 mins	30 mins	30 mins	30 mins	40 mins
Marie Curie Hospice (Penarth)	30 mins	10 mins		65 mins	55 mins	35 mins	30 mins	40 mins	45 mins	30 mins	30 mins	30 mins	30 mins	40 mins
Neville Hall Hospital	50 mins	65 mins	65 mins		30 mins	70 mins	60 mins	40 mins	30 mins	55 mins	55 mins	50 mins	60 mins	45 mins
Prince Charles Hospital	35 mins	55 mins	55 mins	30 mins		55 mins	45 mins	50 mins	50 mins	50 mins	40 mins	35 mins	45 mins	30 mins
Princess of Wales Hospital	30 mins	35 mins	35 mins	70 mins	55 mins		30 mins	45 mins	50 mins	40 mins	35 mins	30 mins	30 mins	40 mins
Royal Glamorgan Hospital	25 mins	30 mins	30 mins	60 mins	45 mins	30 mins		35 mins	45 mins	35 mins	25 mins	25 mins	5 mins	35 mins
Royal Gwent Hospital	30 mins	40 mins	40 mins	40 mins	50 mins	45 mins	35 mins		20 mins	25 mins	30 mins	30 mins	35 mins	35 mins
The Grange Hospital	35 mins	45 mins	45 mins	30 mins	50 mins	50 mins	45 mins	20 mins		35 mins	35 mins	35 mins	45 mins	35 mins
University Hospital Wales	25 mins	30 mins	30 mins	55 mins	50 mins	40 mins	35 mins	25 mins	35 mins		25 mins	25 mins	35 mins	35 mins
Velindre Cancer Centre	5 mins	30 mins	30 mins	55 mins	40 mins	35 mins	25 mins	30 mins	35 mins	25 mins		20 mins	25 mins	25 mins
VUNHST Corporate HQ (Nantgarw)	15 mins	30 mins	30 mins	50 mins	35 mins	30 mins	25 mins	30 mins	35 mins	25 mins	20 mins		25 mins	20 mins
Welsh Blood Service (Talbot Green)	25 mins	30 mins	30 mins	60 mins	45 mins	30 mins	5 mins	35 mins	45 mins	35 mins	25 mins	25 mins		35 mins
Ysbyty Ystrad Fawr	25 mins	40 mins	40 mins	45 mins	30 mins	40 mins	35 mins	35 mins	35 mins	35 mins	25 mins	20 mins	35 mins	

Appendix 2 – Diary Exercise guide and tools

VUNHST recognises the BMA Dr Diary app (Welsh contract version), or the Diary Exercise Tool included in this appendix as a suitable system to be used when undertaking a diary exercise.

When should a diary exercise be undertaken?

- For established Consultants, negotiation of job plans is best done based on evidenced activity from a diary exercise over an appropriate number of weeks to reflect activities completed; new Consultants will need to negotiate a preliminary estimated sessional work plan that is then reviewed annually.
 - o It is advisable to complete a work diary in advance of a scheduled or interim job planning meeting to ensure all completed work is recognised with an appropriate allocation of sessions.
- On-call diary exercises should be completed when there is/are:
 - o Concerns that there is variance of individual practice or disagreement/dispute.
 - o An intentional change in an on-call rota.
 - o Disagreement or dispute.

Requests to undertake a diary exercise can be initiated by a Divisional or Directorate Management Team, a group working on a shared rota, or by an individual doctor.

Where there is transparency on fixed sessions and consensus on hours worked between the employer and the employee the Divisional Director may decide a diary exercise is not required, however this must be with the agreement of the doctor(s).

How long should the diary exercise be recorded for?

The exercise should be conducted over a representative amount of time. It is considered best practice for this period to be agreed between the practitioner and their Clinical Director prior to initiating the diary exercise. Advice should be sought from the Corporate Medical Business team if clarity is required on the representative amount of time that diary exercise should be conducted for. This may then be discussed at the Job Planning Oversight Group. A set of principles are outlined below:

- For those working a consistent fixed work pattern this may only require a few weeks.
- For those on fully annualised contracts, it may take a number of months of data capture to be assured that the time is representative of activity in this case the record should be kept for a minimum of 8 weeks.

Completing the diary exercise

- The diary exercise must be completed on the approved tool below or the [BMA Dr Diary tool](#) (Welsh Contract version).



Diary Exercise
Tool.xlsx

- Any exceptional factors (e.g. sick leave, locum cover) should be clearly identified.
- Whilst the Consultant Contract makes no reference to the validity of a diary exercise or the collective nature of it, it does reference the helpful nature of a diary exercise in respect of on-call. Consequently, the Trust encourages Consultants to take part in a diary exercise in order to ensure consistency.
- On-call diary exercises should ideally be undertaken by every member on the on-call rota. In the event that a Consultant chooses not to participate in the diary exercise

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the Divisional Director/Clinical Director will use professional judgment in order to determine the work that would have been undertaken and reflected in the exercise if it had been participated. They will then plan the rota and sessional allocation in the job plan accordingly.

- The diary should include frequency, period of diarising, paperwork, detail, scrutiny/verification, and clearly define what activity is countable.
- On-call work remunerated separately (e.g., acting down or ad hoc locum work) is excluded from inclusion in the diary exercise as they are remunerated through a separate process.

Diary Exercise and Job Planning

- The Clinical Director and Directorate Manager will be responsible for analysing the diary exercise.
- The diary exercise must be shared prior to any job planning meeting.
- Where a group diary exercise has been undertaken the results should be shared prior to team service planning.
- Any sessional changes or changes to on-call supplements as a consequence of the exercise must be discussed at a job plan review and the necessary change form sent to pay roll to amend payment accordingly.
- Should the agreed period of data collection for the diary exercise delay the annual job planning review then it is reasonable for any changes to on-call supplement or sessional allocation to be back dated to the date the job plan review would have been undertaken.

Appendix 3 – Direct Clinical Care (DCC) examples

DCC is work that directly relates to the prevention, diagnosis or treatment of illness that forms part of the services provided by the employing organisation as detailed in para 2.20 of the Consultant Contract. This includes:

- **Outpatient activities** - Regularly scheduled sessions where Consultants assess, diagnose, and manage patients in an outpatient setting. This includes initial consultations and follow-up reviews, delivered either in person or through virtual platforms. Consideration is required for Consultants who act as senior clinical decision makers supervising multiple members of the team in a session (e.g. resident doctors, independent prescribers, Clinical Nurse Specialists). The Royal College of Physicians recommends one Consultant should not supervise more than four staff in a clinic unless their own clinical activity in that time is considerably reduced; if more than four members require supervision, decision-making is most efficient if the Consultant does not have any patients allocated to them.
- **Ward rounds** - Scheduled reviews of inpatients under the Consultant's care, including examination, decision-making, documentation, and coordination of ongoing treatment.
- **Community Visits - Reviews** of patients in the community by Consultants working for the community teams, such as palliative care.
- **Hospital support reviews** - Review of patients in another hospital/hospice in the region, for instance relating to acute oncology or palliative care issues.
- **Radiology reporting sessions** - Regularly scheduled sessions where Consultants review and report radiological investigations or support clinical service delivery such as brachytherapy.
- **Ad-hoc and urgent reviews or requests** - Unscheduled reviews of known patients and/or imaging in day-case setting or other parts of the hospital, such as the assessment unit, day units, brachytherapy suite or during a course of radiotherapy (planning and delivery).
- **Multidisciplinary meetings** about direct patient care – Preparation for and participation in MDT meetings where patient cases are discussed, such as diagnostic MDTs and team-based treatment decision-making meetings, to include work arising following meetings. The inclusion of team meetings in the job plan will require the agreement of the line manager.
- **Administration directly relating to patient care (for detail see [appendix 11](#))** - Administrative activity directly related to patient care is an essential component of DCC. Where administrative work is integral to a DCC session—such as during radiology reporting—it is expected to be delivered within the core session time and does not normally attract additional DCC time.
For other activities where clinical administration occurs outside of the direct patient-facing session —there will be a requirement for separately allocated DCC time. Essential non-face-to-face clinical tasks covered under this allocation include reviewing investigation results, documenting clinical activity (e.g., clinic or discharge letters), communicating with colleagues, patients or families outside of consultations (e.g., by phone or email), responding to clinical queries from colleagues, maintaining accurate clinical records, and referral management (to include triaging of referrals and waiting list management and managing patient pathways) .
The Royal College of Physicians highlights that when Consultants act as senior clinical decision makers supervising multiple members of the team in a session, additional administrative time may be required (e.g., requesting radiological imaging or referrals which allied health professionals are not permitted to complete within their role).
While some variation may exist based on the specific nature of clinical work across specialties, efforts should be made to apply this principle consistently. Any requests for additional DCC time beyond this standard—for example, to accommodate

specialty-specific needs or to support reasonable adjustments—should be evidence-based, supported by workforce advice where appropriate, and agreed through discussion with the line manager. All such arrangements must be clearly documented in the job plan.

- **Radiotherapy planning time (clinical oncologists)**- This includes reviewing diagnostic imaging, staging information and pathology; determining treatment intent and target volumes, prescribing, and collaborating with physics and radiotherapy teams to develop and approve individualised and reactive treatment plans – see [Appendix 12](#).
- **Radiotherapy peer review time (clinical oncologists)** - Peer review time should be included in job plans to facilitate quality assurance and reduce variation in contouring. This is in addition to planning time and should be recorded as such in the electronic job planning system.
- **Emergency duties** (arising in normal working hours)
- **On-call activity** is defined as activity outside the timetabled working week as described in the Consultant Contract. The Consultant Contract identifies that for time worked when on-call, the first session will be regarded as 3 hours for job planning purposes.
- **Travel** to peripheral clinical commitments (included within DCC) – the time counted for travelling should be the difference between the time taken to travel daily from home to base and the time taken to travel from home to the peripheral commitment if the journey commences at home. Such excess travel is defined within the contract as “time spent travelling between home and working site other than the Consultant's main place of work, after deducting the time normally spent travelling between home and main place of work.” If the Consultant is required to travel between sites in the middle of the working day, then the entire journey time will be counted. The agreed times between Trust/Health Board sites are shown in the table in [Appendix 1](#). Rest periods/meal breaks should not be included in travel time.

DCC will be considered to have been delivered if:

- A session is cancelled on the day due to operational issues, and the Consultant cannot be redeployed to another activity within their speciality
- Work activity in line with contractual commitments is not achieved for reasons beyond the Consultant's control for example a doctor has made themselves available to work a session, but the activity has not gone ahead (e.g. last-minute clinic appointment cancellations or deferrals)
- The Consultant has authorised absence over and above annual or professional leave e.g., sick or parental leave.

Appendix 4 – Supporting Professional Activities (SPA) and Additional NHS Responsibilities (ANR) guidance

This guidance should be read in conjunction with the [Amendment to the National Consultant Contract in Wales \(the 2003 Amendment\)](#), referred to as the “Consultant Contract” in the remainder of this document.

Documents used to develop this guidance:

- [RCP Empowering physicians – effective job planning for better patient care \(2025\)](#)
- [RCR Clinical oncology job planning guidance for Consultant and SAS doctors \(2022\)](#)
- [RCR Clinical radiology job planning guidance for Consultant and SAS doctors \(2022\)](#)
- <https://heiw.nhs.wales/files/support-for-trainers-the-all-wales-medical-trainer-agreement/all-wales-medical-trainer-agreement/>

Review date: once agreed, this guidance should be reviewed after an initial period of 12 months then every 2 years (or earlier if significant change occurs) via the Medical Workforce Group/Job Planning Oversight Group and the BMA Local Negotiating Committee (LNC).

1. Core SPA

Examples of **Core SPA** activities and outcomes in the below table are not exhaustive. Example outcomes are provided to ensure that Consultants are aware of the expectations and to assist in agreeing outcomes in the job planning process.

Activity	Rationale	Example outcomes as appropriate for appraisal/job planning meetings
Core SPA allocation – 2 sessions of core SPA time for full-time Consultants (see 9.3.3 for LTFT Consultants). (This is separate to the 30 days study/professional leave allowance over a period of 3 years)		
1. Continuing Professional Development (CPD)	To ensure doctors have local opportunities and time to keep up to date, maintain skills and develop. This type of CPD includes: • Personal study • Preparation and participation in own appraisal and job planning • Activities required for CPD and revalidation • Attending departmental teaching (e.g. grand round, journal clubs, academic meetings, other local teaching) • Departmental/Specialty updates	• Attendance certificates, summaries, etc. • Certificates of training attendance/completion • Mandatory and statutory training records • Personal Development Plan (PDP) • Appraisal summary • Agreed job plan (signed off and dated) • Annual clinical activity information • Annual clinical trial activity e.g. via sub-investigator activity

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	• Maintaining mandatory and statutory training compliance, including Good Clinical Practice (GCP) • Keeping up to date with relevant research/trials protocols • NHS e-learning modules • Induction programme for newly appointed Consultants (additional 1 core session for the first 12 months in post)	
2. Clinical Governance and participation in specialty/local QI activity	To ensure that doctors have opportunities to prepare for and participate in the Trust's core clinical governance activities. Improving the quality of services is relevant to all Consultants' clinical practice and is core to the Consultant role. Core SPA allocation for Quality Improvement (QI) permits Consultants time to link with others to understand problems, set aims and ongoing evaluation/learning regarding any changes. Participation in QI activities is required for the delivery of safe care and to meet the obligations for successful completion of annual appraisal/revalidation. Governance and QI activities include: • Clinical audit (local or national) • Attendance and participation at audit, directorate, SST and Senior Medical Staff Committee (SMSC) meetings, including and medical engagement/departamental away days • Developing/updating relevant clinical protocols • Leading a piece of local specialty-based QI work	• Meeting minutes (where appropriate to share) • Review reports • Case review report • Evaluation reports • Protocol/policy document • QI charter/plan/documentation • Local QI team meeting schedule/membership/notes • Reflections on learning from complaints, incidents, etc. • Audit department certificates • Audit presentation / hand outs • Evidence of Quality Improvement Initiatives • Any outcomes achieved/impact

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	• Supporting/teaching/coaching resident doctors with their QI work • Mortality & Morbidity reviews and meeting attendance • Radiology Events and Learning Meetings (REALM; radiologists) • Review of clinical outcomes • Participation in the management of concerns, complaints, serious incident investigations, critical incident reporting, as required. • Preparation of Coroner reports (in specialties where there are high volume requests, additional time within the job plan may be allocated for this following discussion with the DMD) • Case reviews and discussions • Evaluation of the impact and effectiveness of a piece of health policy and/or management practice • Infection Prevention and Control, including outbreak meetings • Make it Safe meetings • Appropriate input to the development of the nVCC and the transformation of clinical services	
3. Delivering day-to-day research, leadership, management, teaching, supervision and education of junior medical staff and members of the MDT	To ensure all Consultants have opportunities to deliver the day-day leadership, management, research, innovation and teaching requirements of the role (separate to formal, recognised roles within additional SPA): • Delivering teaching, in addition to that implicit in DCC sessional allocation • Day-day team leadership/management, innovation within the clinical service including specialty doctors	• Feedback/structured observations and work-based assessments where relevant • Audit of and monitoring of teaching programmes • Impact of leadership roles • Research activity e.g. trial recruitment

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	Research roles e.g. sub-investigator, co-investigator	

2. Additional SPA

Examples of Additional SPA activities, associated tariffs and outcomes in the below table are not exhaustive. Example outcomes are provided to ensure that Consultants are aware of the expectations and to assist in agreeing outcomes in the job planning process.

Activity	Rationale	Outcome measures – evidence to be provided at each job plan meeting	Sessional allocation, per week
Additional SPA Activity – typically up to 1 session			
Appraiser	A team of trained medical appraisers is essential to facilitate the medical appraisal process within the Trust. Annual appraisal is a contractual obligation and is a GMC requirement for Revalidation.	- Number of appraisals delivered within the appraisal year - Feedback from appraisers - Evidence of attendance at local and national appraiser training and refresher training events – see appraiser role profile for more detail	0.5 sessions to deliver 10 appraisals per year
Medical Appraisal Lead	To ensure the effective delivery of a high-quality medical appraisal system. This role provides leadership, oversight, and consistency in the appraisal process, ensuring that all doctors receive robust, supportive, and fair appraisals that comply with national standards and GMC requirements. By coordinating appraisers, providing training and monitoring compliance, this role fosters a culture of continuous improvement, professional accountability, and	- Monthly compliance report - Annual Revalidation Progress Report - Annual Quality Review report	1 session to deliver leadership role + 10 appraisals per year

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	wellbeing across the medical workforce.		
Educational Supervisor	To supervise residents whilst they are on placement at VUNHST. This support should include meeting regularly with the resident to reflect upon and discuss educational progress, acting as mentor and ensuring that the resident receives the appropriate career guidance and planning. This role will incorporate putting remedial measures in place where any issues are highlighted and will involve working closely with the AMD Medical Education and the relevant Training Programme Director.	• Evidence of CPD pertaining to the role of Education Supervisor and the relevant curriculum Domains • Details of the number of residents • GMC resident feedback • Completion of regular meetings with residents • Evidence of formal and informal teaching (presentations, teaching summary)	0.25 sessions per resident (up to a maximum of 4 residents, 1 SPA)
Named Clinical Supervisor	To supervise residents (including locally employed residents) at VUNHST, to include teaching and training the resident in the workplace, arranging departmental induction, supervising clinical activity, undertaking review meetings and ensuring that the resident is working to his/her level of competence. The named Clinical Supervisor should provide regular formal and informal feedback.	• Evidence of Continuing Professional Development pertaining to the role of Named Clinical Supervisor and the relevant curriculum Domains. • Details of the number of residents • GMC resident feedback • Evidence of formal and informal teaching (presentations, teaching summary)	0.25 sessions per resident
Clinical Supervisor for e.g. the training of independent prescriber/AHPs	Training of the wider multi-professional team to develop new skills and role development is essential e.g. AHPs	• Evidence of training required for the role • Details of number of HCPs trained	0.25 sessions per HCP

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		• Outcome	
Oncology Project Tutor/ SSC project Tutor	To provide tuition, recruit appropriate patients, and give feedback and support to 6 medical students undertaking their oncology projects, and to mark the projects once completed. To supervise and assist in delivering high quality year 3/year 4 student selected projects.	• Details of the number in student cohort (usually 6 per cohort) • Student feedback • Completed projects • Certificate of participation	0.125 sessions (estimated 20 hours per annum)
Oncology Project Lead	To oversee the delivery of c.290 student projects facilitated by c.50 Consultant tutors. This role ensures consistency, quality, and alignment with educational objectives by coordinating tutor efforts, providing guidance, and monitoring project progress.	• Annual feedback report from the Liaison Unit • Student feedback • Completed projects	1 session
Other Teaching	There may be opportunities for teaching and training of undergraduates and other clinical professions, beyond that delivered as part of core SPA. For example: supervising other professions undertaking prescribing/MScs, visiting fellowships.	• Evidence of Continuing Professional Development pertaining to the role • Details of the number of residents/time commitment • Resident feedback • Evidence of formal and informal teaching (presentations, teaching summary)	For negotiation but must not double count with core SPA teaching expectations
Formal research roles within/beyond the organisation	Principal Investigator (PI) Chief Investigator (CI) Other leadership roles recognised: commercial study lead; Early phase	• Study progress, e.g. number of active studies being lead, milestones achieved. • Recruitment metrics vs. UK/global benchmark	Dependent on complexity,, size, active/in follow-up, observational/interventional, commercial vs non-commercial trial.

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	studies lead/delivery; radiotherapy research lead.	- Regulatory compliance - Impact, publications, presentations and outputs - Funding and financial management, including income generation	To be informed by RD+I leadership team.
College Tutor	The College tutor is responsible for the postgraduate training and development within their specialty (e.g. medical oncology). They support trainers and specialty residents and ensure that programmes are delivered to relevant local and national standards.	- Evidence of CPD relevant to college tutor role - No. trainers and specialty residents within specialty - GMC resident feedback - Evidence of relevant teaching timetable	Up to 1 session per week (0.25 sessions per resident), depending on the number of residents.
Other organisational roles not otherwise identified	These will be brought to the Job Planning Oversight Group by the Clinical Director.		
Other external roles	Consultants may have the opportunity to take up formal roles at regional/national level e.g. Training Programme Director, Regional Specialty Adviser, CSG lead etc. These can benefit healthcare services, the individual Consultant and the Trust. Such roles should be included within job plans and discussed and agreed prior to application/appointment, including clarity over funding arrangements, term of office, feasibility alongside other roles etc. Such roles need to be included in whole practice appraisal.		

3. Additional NHS Responsibilities (ANR)

ANR generally are roles that do not require SPA but instead provide management sessions. These can benefit healthcare services, the individual Consultant and the Trust. Such roles should be included within job plans and discussed and agreed prior to application/appointment, including clarity over funding arrangements, term of office, feasibility alongside other roles etc. Such roles need to be included in whole practice appraisal.

Examples in the list below are not exhaustive:

- Divisional Medical Director
- Directorate Clinical Director
- Clinical Director (palliative medicine and radiology)
- WBS Medical Director

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- Marie Curie Cymru Medical Director
- Associate Medical Director (workforce; education; IT+CCIO; RD+I)
- Site-Specific Team (SST) lead
- Clinical Leads (various – pending the detail from the new proposed structures)
 - o Ambulatory lead; AOS internal lead; PROMS lead; SACT lead, RT lead; IPC lead; RT research lead; mortality lead; satellite centre lead; advanced therapies lead; audit lead; VBHC lead, SCIF lead; IRS lead; Private patient lead; IO lead; GP lead, nVCC leadership roles; regional AOS lead
- HEIW Faculty Lead for Medical Education
- SAS Advocate
- LNC Representative/chair (chair allocated 1 session)
- Case Investigator and/or Case Manager for Upholding Professional Standards in Wales (UPSW)
- Roles leading large, complex projects – these should be agreed in advance, funded and included in job planning when the project/role is designed

Appendix 5 – Team service planning guidance

The purpose of team service planning is to establish a framework which outlines the required clinical and non-clinical activity, necessary roles and responsibilities so that individual job plans can then be discussed and agreed.

NB Care must be taken to respect individual employee confidentiality, ensuring that individually identifiable is not shared without permission.

Please note this is a **suggested** meeting agenda. You may wish to change the discussion points depending on the specialty, and you may wish to change the order, or split the agenda over separate meetings.

Part 1: Review and discuss

- 1.1 Provide team members with information about the organisation and team's IMTP objectives, including their clinical, educational, research, and improvement activity for the upcoming year
- 1.2 Review previous year's job plans, activity data, KPIs and activity
- 1.3 Summarise the combined team workforce capacity for the upcoming year e.g. available sessions, taking note of any workforce planning assumptions e.g. retirements, additional posts etc or new treatment indications.
- 1.4 Share horizon scanning information for expected new treatments/indication that may affect workload/clinical service provision.
- 1.5 Set team service development objectives for the following year; these should align with the IMTP objectives
- 1.6 Outline the team's expected clinical output for the upcoming year, based on the team's capacity and demand analysis
- 1.7 Agree a plan for delivering these outputs, including how any on-call/out-of-hours commitments will be managed
- 1.8 Outline the milestone and deadline dates set for this round of job planning

Part 2: Direct Clinical Care (DCC) Activities

- 2.1 Discuss the following for each DCC activity, enabling consistency across the team:
 - Is the activity fixed in the timetable, flexible or annualised?
 - Length of the activity (sessional allocation)
 - Average output per session, e.g. number of patients
 - Any related activities, e.g. ancillary activities, ward rounds, admin tasks, and how much time should be allocated to these tasks within the activity
 - Associated travel time
 - Allocation of activity, i.e. how many sessions will be allocated to each person

You may wish to break DCC activities down into sections and discuss each section separately, e.g.

- Clinics and OPD activity
- Day-case and ambulatory patient review activity
- MDT activities
- Admin directly related to clinical care, including referral management
- Ward rounds and inpatient activity
- Radiotherapy planning and peer review
- Radiology reporting
- Advice and guidance

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- 2.2 Review prospective cross-cover arrangements and ensure that there is provision where required.
- 2.3 Review the current on-call rotas in place and discuss any changes to the on-call rota

Part 3: Supporting Professional Activities (SPA) and other roles

- 3.1 Review leadership and teaching roles that are currently in place and/or required. These will include (list not exhaustive):
 - Clinical and educational supervision of trainees, locally employed doctors, PAs, prescribers etc.
 - Medical appraiser contribution
 - Research activity/roles
 - Formal postgraduate teaching
 - Undergraduate teaching
 - Clinical governance requirements
 - Other activities required of the department
- 3.2 Discuss the roles and any changes, plus additional or redundant roles.
- 3.3 Allocate the roles for the upcoming year.
- 3.4 Confirm the sessional allocation for each role, if applicable.

Part 4: Support, negotiation, and other business

- 4.1 Discuss any other items and issues.
- 4.2 Ensure all team members understand the agreements made.
- 4.3 Identify any potential risk areas.
- 4.4 Identify support required and allocate as needed.

It is advised that notes are made in each meeting to provide a foundation for the following meeting; in addition to this in the event of a job plan dispute mediation or appeals process, the notes will be able to provide evidence of discussions. For this reason, it is also important that any missing individuals are informed of the content of the meetings and the agreements made.

Please note that during the discussion and agreement of team service plans, care must be taken to respect individual employee confidentiality.

[illegible]

Appendix 7 – Job Planning Sign Off Process

Week 2 – Email Notification

Thank you for recently attending your job plan review. Would you please confirm your agreement by logging into the eJob Planning system and signing off your job plan; or immediately advise your Directorate Manager if you are not agreeing and wish to invoke the appeals process contained in the Amendment to the Consultant Contract in Wales.

Week 4 – Email Notification

As per our previous notification, you have not signed-off nor appealed your job plan. We, therefore, conclude that you agree with this job plan.

As a result, the job plan will be locked down and treated as signed-off with any consequent actions affecting your pay.

Week 4 - Actions

The eJob Plan systems administrator locks down the job plan on the system and confirms with the Directorate Manager who will process any necessary pay adjustments.

For compliance purposes, the completed job plan is reported in the same way as a job plan that has been signed on the system by the Consultant.

Appendix 8 – Escalation letters 1, 2 & 3

Letter 1

****INSERT LETTER DATE****

Dear ****INSERT CONSULTANT NAME****,

Contractual Commitment to Job Planning

According to the electronic job planning system, your job plan is due to expire on ****INSERT EXPIRATION DATE****. This letter is to inform you that I have arranged a Job Plan review meeting for ***INSERT MEETING DATE*** in your core SPA time.

As an organisation, we recognise the vital role you play as part of our medical workforce and we wish to support and enable you to deliver the best patient care.

I would be grateful if you could review your job plan on the electronic system and make any adjustments or comments that you would like to discuss at our meeting. Please do not sign off the job plan at this stage in case we need to make further edits following our conversation (edits cannot be made if any party has signed unless it is referred back to you for everyone to re-sign).

If you have any difficulty attending this meeting, please let me know so that it can be re-scheduled.

Yours sincerely,
****INSERT CD NAME/SIGNATURE****
Clinical Director

Letter 2

****INSERT LETTER DATE****

Dear ****INSERT CONSULTANT NAME****,

Contractual Commitment to Job Planning

Despite previous correspondence, your annual job plan review meeting did not take place.

I draw your attention to Clauses 5.8 and 5.9 of the Amendment to the Consultant Contract in Wales (2003), which outlines the process to be followed where an unsatisfactory job review has occurred. Failure to consistently engage with a job plan review and/or agree to a job plan will result in an attempt at local resolution prior to the formal appeals process being instigated.

I have rescheduled your review meeting for ****INSERT REVIEW DATE****. Should you fail to attend this meeting the matter will be escalated to the Deputy Medical Director in the absence of any mitigating circumstances.

I trust you will take the necessary actions required to comply with this contractual request without further delay.

Yours sincerely,
****INSERT DMD NAME/SIGNATURE****
Divisional Medical Director

Letter 3

****INSERT LETTER DATE****

Dear ****INSERT CONSULTANT NAME****,

Contractual Commitment to Job Planning

I am concerned that despite previous correspondence, you have not engaged in the job planning process.

The Amendment to the Consultant Contract in Wales (2003) states “the job planning process is the vehicle for the Consultant and the employer to agree the composition and scheduling of activities into the sessions that comprise the working week, mutual expectations of what is to be achieved through these, and for discussing and agreeing changes on a regular basis.” It also confirms that this process is mandatory. Both you and the Trust are under an obligation to ensure that the terms of the contract are adhered to and applied within your role. This includes an annual job plan review.

If there are reasons why you are unable to agree a date for the job plan review with your Clinical Director, please ensure that these are urgently brought to my attention. Alternatively, I expect to receive confirmation that you have attended a job plan review three weeks from the date of this letter.

I draw your attention to Clauses 5.8 and 5.9 of the Amendment to the Consultant Contract in Wales (2003). Failure to consistently engage with a job plan review and/or agree to a job plan will result in an attempt at local resolution prior to the formal appeals process being instigated.

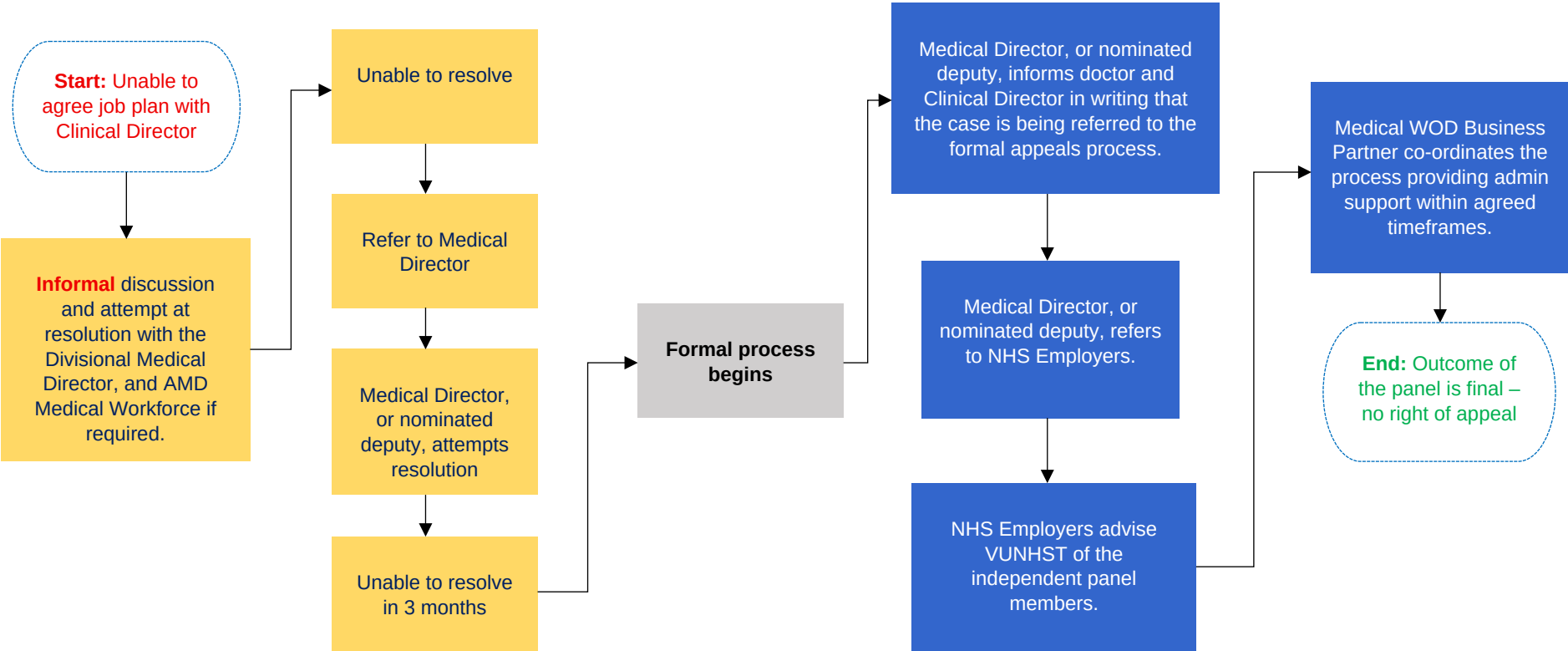
I trust you will take the necessary actions required to comply with this contractual request without further delay.

Yours sincerely,

****INSERT NAME/SIGNATURE****

Associate Medical Director – Medical Workforce

Appendix 9 – Summary of informal resolution and appeals process – flow diagram



Appendix 10 – Medical Job Planning Oversight Group - Terms of Reference

Medical Job Planning Oversight Group
Terms of Reference

1. Purpose

The Medical Job Planning Oversight Group (the Group) is established to ensure that medical job planning across the Trust is:

- Consistent, fair, and transparent.
- Aligned with this policy and the *Amendment to the National Consultant Contract in Wales (the 2003 Amendment)*, national guidance, Trust policies, and service delivery objectives.
- Supportive of effective workforce planning and service sustainability.
- Reflective of the Trust’s commitment to staff well-being, equity, and continuous improvement.

2. Objectives

The Group will:

- Monitor job planning compliance rates against the Welsh Government target of 90%.
- Review medical job plans that have been signed off by the doctor and Clinical Director on the e-job planning system.
- Alert and seek Executive Medical Director approval for all job plans above 12 sessions.
- Interpret and apply national and Trust guidelines on job planning.
- Ensure equitable allocation of Direct Clinical Care (DCC) and Supporting Professional Activity (SPA) sessions).
- Agree and review (at least annually) sessional tariffs for Additional Supporting Professional Activities (SPA) and Additional NHS Responsibilities (ANR) to ensure fair and transparent allocation across the Trust.
- Annually review the Medical Job Planning Guidance document and progress updates as needed.
- Provide advice and support to managers and clinicians regarding the job planning process, and feedback on proposed job plans where adjustments may be appropriate.
- Monitor job planning trends to identify and address inequities or inefficiencies.
- Report appropriate data regarding job planning to give reassurance and highlight any significant issues.
- Support the organisation’s workforce planning by ensuring that all job plans comply with contractual obligations and contribute to achieving the Trust’s strategic and operational priorities.

3. Scope

The Group’s remit includes the following permanent, fixed-term and honorary medical staff across the Trust:

- Consultants
- Specialty Doctors
- Specialist Doctors

4. Membership

The Group will comprise:

- **Chair:** Associate Medical Director – Workforce
- **Members:**
 - o Medical Director – VCS
 - o Medical Director – WBS
 - o Director – VCS
 - o Director - WBS
 - o Clinical Directors
 - o Directorate General Managers
 - o Senior HR Business Partner
 - o Executive Medical Business Manager

Additional members may be co-opted for specific expertise or service representation.

5. Frequency of meetings

- The Group will initially meet **monthly** to review the job plans taken place for the month prior.
- Additional meetings may be convened as required, particularly during periods of major service change or job plan reconfiguration.

6. Quorum

A quorum will be achieved when the following members are present:

- The Chair or nominated deputy.
- At least one divisional Medical Director or Director
- At least one Clinical Director
- At least one Directorate General Manager
- Senior HR Business Partner or Executive Medical Business Manager

7. Governance and Reporting

- The Group reports to the Executive Medical Director and is accountable to the Executive Medical Leadership team.
- Key themes, decisions and outcomes will be recorded and summarised in reports shared with divisional leadership teams and the Medical Workforce Group.

8. Guiding principles

The Group will adhere to the following principles:

- Transparency in all decisions and communications.
- Decisions will be evidence-based, using job planning data, benchmarking reports and relevant activity metrics.
- Equality and equity across all specialties.
- Collaboration with clinical, operational, and workforce teams.
- Alignment with the Welsh Government's medical workforce guidelines and Trust policies.

8. Review of Terms of Reference

- The Group will review these Terms of reference annually to ensure they remain fit for purpose and reflect any changes in guidance, policy, or operational requirements.

Appendix 11 – Guidance on allocation of clinical administrative time (within DCC)

The move to team-based service planning and the introduction of electronic Consultant job planning using L2P demonstrates that the allocation and use of administrative time is variable between Consultants and Site-Specific Teams (SSTs). There is a need for a consistent approach within and across teams. Such administration time needs to reflect changing ways of working (for example, increasing amount of email based clinical administration, separate from regular DCC sessions such as clinics); details may vary depending on the make-up of multi-professional teams e.g. supplementary prescribers in clinic who may not have radiology requesting rights.

Standardising administrative time allocation, defining consistently how time should be allocated for patient related administration, and ensuring that appropriate time is incorporated into clinic templates/job plans is essential to ensure robust service provision, as well as fairness and transparency in team and individual Consultant job planning.

1. RCR Synopsis

The 2022 Royal College of Radiologists (RCR) job planning guidance recommends that sufficient 'direct clinical care' (DCC) should be allocated for patient-related administration, divided into two categories: predictable and unpredictable administrative tasks. The exact allocation of administrative time is best determined through a job diary exercise. This allocation will vary according to clinical workload, multi-professional working arrangements, and geographical site coverage.

2. RCR Points of Consideration

- A 10 (clinical)PA job plan should allocate approximately 1 to 1.5 PA of predictable patient-related administrative time (for example admin related to outpatient or inpatient care such as requesting investigations, booking SACT/radiotherapy or validating letters)
- A 10 (clinical) PA job plan should allocate approximately 0.5 to 1 PA of unpredictable patient-related administrative time (for example responding to calls, emails and letters from patients, colleagues and other services that require a timely response and appropriate documentation)
- The time required for patient appointments will vary; new patient consultations are recommended to last between 45-60 minutes, with SACT and follow-up appointments taking 15-30 minutes. This includes the relevant administrative time following the appointment.
- If Consultants are spending too much time on administrative duties, the Trust should investigate and attempt to reduce this burden by providing support services.

3. Clinical Care/Administration Outside of Consultations

The following table outlines the different combinations of unpredictable and predictable administrative time suggested by the RCR for a 10 (Clinical) PA job plan. Four combinations are described:

Table 1: Admin Session Combinations

Allocation	Unpredictable Admin	Predictable Admin	Total Admin
Minimum Allocations	0.5	1	1.5
Maximum Allocations	1	1.5	2.5
Minimum + Maximum Allocation	0.5	1.5	2
Maximum + Minimum Allocation	1	1	2

The clinic team support available and time allocation for new patient, follow up or SACT clinics will affect the amount of subsequent predictable administration time required in a job

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plan. The total administrative time required may vary based on relevant individual and service factors, but should, in principle, be relatively consistent across an SST.

Appendix 12 – Guidance on radiotherapy planning time

Workforce pressures in Clinical Oncology continue to grow making the job planning process more important than ever to ensure we create and support a robust and sustainable workforce, that can deliver the excellent clinical care to which we aspire.

In support of the job planning process and consistent application of RCR guidance, Medical Services have undertaken a review of the recommendations issued by the Royal College of Radiologists (RCR) relating to radiotherapy planning time, peer review and administrative time (Medical Services: Administrative Time Review document available for review).

1. RCR Synopsis

“The success and safety of modern radiotherapy rely on accurate contouring. Understanding the time taken to complete radiotherapy contours is critical to informing workforce planning and, in the context of a workforce shortfall, advocating for investment in technology and multi-professional skills mix. We aimed to quantify the time taken to delineate target volumes for radical radiotherapy.”

2. RCR Points of Consideration

- Guidance and data supplied by the RCR is based on radical treatment intent.
- Planning time should be protected from any other activity, including patient reviews.
- The time required for planning depends on the tumour site and workload.
- Time is required to review and sign-off plans and manage on-treatment imaging when required.
- Radiotherapy peer review should be included in job plans, avoiding delays to patient treatment, in addition to planning time. The amount of time will vary depending on tumour site and case complexity. Peer review time should be protected and adequate in quantity to not delay treatment pathways.
- On-treatment patient reviews can be carried out by specialist radiographers and nurses but may need medical input.

3. Weekly Sessional Requirement Per Tumour Site

Table 1 outlines sessional planning time per tumour site for target volume delineation and approval, based on RCR collected data published in March 2024. This includes the median planning time for each tumour site. It is advised the median planning time is used as a base to work out planning time/session requirements.

Radiotherapy peer review is additional to time allocated for target volume delineation; the required time should be discussed and agreed by each SST/team.

Table 1: Planning and Approval Time		Number of Patients Planned Annually and Sessional Allowance		
Site	Median Planning Time (minutes)	Session per 50 patients	Session per 100 patients	Session per 200 patients
Breast	48	0.29	0.59	1.17
Genitourinary	55	0.34	0.67	1.34
Skin	54.3	0.33	0.66	1.33
Lung	72	0.44	0.88	1.76
CNS / Neuro	75	0.46	0.92	1.83
Upper GI	94	0.57	1.15	2.30
Colorectal	85	0.52	1.04	2.08
HPB	98	0.60	1.20	2.39

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Sarcoma	115	0.70	1.40	2.81
Head and Neck	130	0.79	1.59	3.17
Gynaecological	135	0.82	1.65	3.30
Overall	95	0.58	1.16	2.32

4. Palliative Radiotherapy Planning Time
There is no formal RCR guidance relating to palliative planning time. Whilst patient numbers are substantially lower, an acknowledgement of the average time and resource will need to be discussed and agreed within each SST.

TRUST BOARD	
PUBLIC QUALITY, SAFETY & PERFORMANCE COMMITTEE HIGHLIGHT REPORT	
DATE OF MEETING	30 th July 2026
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Liane Webber, Business Support Officer
PRESENTED BY	Vicky Morris, Quality, Safety & Performance Committee Chair and Independent Member
EXECUTIVE SPONSOR APPROVED	Annie Evans, Deputy Director of Nursing, Quality & Experience on behalf of Gillian Knight, Executive Director of Nursing, AHPs & Health Scientists
REPORT PURPOSE	FOR DISCUSSION

1. PURPOSE

This paper is to provide the Trust Board with details of the key issues and risks considered by the Quality, Safety & Performance Committee at its meeting held on 16th July 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. The Committee agrees items to highlight to the Trust Board.

3. HIGHLIGHTS FROM THE MEETING HELD ON 16TH JULY 2026

3.1 *Triangulated themes*

The following triangulated themes were identified:

- Workforce planning and sustainability - Discussion across a number of agenda items highlighted the importance of strengthening workforce planning capability, understanding future workforce requirements and ensuring that the organisation is in a good state of preparedness to support the transition to nVCC and wider service transformation.
- Data, intelligence and meaningful performance reporting - Members emphasised the need for improved data, performance intelligence and outcome measures to support strategic decision-making, workforce planning, quality improvement and future engagement with commissioners and regulators.

- Governance, assurance and risk management - Recurring discussion focused on the quality of assurance, the effectiveness of risk management processes, and the need for clear, robust governance arrangements to support meaningful Board assurance and oversight.
- Service transformation and future readiness - Several agenda items highlighted the importance of ensuring services, workforce models, operational arrangements and supporting infrastructure are equipped to meet future demand and organisational priorities.
- Leadership, organisational development and culture - The Committee recognised the role of leadership development, workforce wellbeing and organisational culture in supporting long-term organisational effectiveness and service sustainability.

3.2 Further Information

Should Trust Board members who are not members of the Committee wish to review further detail relating to the Quality, Safety and Performance (QSP) Committee, the agenda and papers for the 16th July 2026 meeting are available via the link below:

<https://velindre.nhs.wales/about-us/quality-safety-performance/quality-safety-performance-papers/quality-safety-amp-performance-committee-16-07-2026/>

3.3 Summary of Committee Highlights

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

ALERT / ESCALATE	Board Assurance Framework The Committee received the Board Assurance Framework (BAF) and welcomed the improvements made to its structure and presentation. Discussion focused on the effectiveness of the BAF as a tool for Board assurance. Members highlighted the importance of ensuring that controls, assurances, gaps in control and gaps in assurance are clearly articulated and accurately reflected within the framework in order to support meaningful scrutiny and decision-making. The Committee emphasised the need for strong executive ownership and oversight to ensure that the BAF provides a clear and reliable assessment of progress against strategic risks and objectives. The Committee welcomed plans to undertake a further review and refinement of the BAF, recognising this as an important component of strengthening the Trust's overall assurance framework and risk management arrangements. Members were content with the proposed Level 2 assurance rating, noting the further work required to improve the maturity, consistency and effectiveness of the framework.

ADVISE	There were no items to advise the Trust Board.
ASSURE	Workforce Supply and Shape The Committee received the Workforce Supply and Shape report and welcomed evidence of progress across a number of workforce indicators, including improvements in recruitment performance, retention and PADR compliance. Members acknowledged the significant work undertaken to strengthen workforce planning arrangements and workforce governance across the organisation. Discussion focused on workforce planning capability, specialist workforce fragility, service transformation and preparedness for the transition to nVCC. Members highlighted the importance of ensuring workforce plans are informed by robust workforce intelligence, productivity data and future service requirements, recognising the challenges associated with planning for highly specialised services. Whilst recognising the progress achieved, the Committee challenged the proposed increase in assurance for the Attraction and Retention workstream from Level 4 to Level 6, noting that further work is required to demonstrate sustainable workforce preparedness and confidence in future workforce requirements. The Committee therefore agreed to maintain the overall level of assurance at Level 4, reflecting both the progress made and the ongoing strategic workforce challenges facing the organisation. Finance Report for the period ended 31st May 2026 (M2) The Committee received the Finance Report and noted the Trust's reported financial position, including progress against savings plans, capital expenditure, and identified financial risks. Members welcomed the detailed reporting on unfunded posts, and discussed the importance of strengthening the triangulation of workforce, financial and quality information to support effective decision-making. Discussion focused on a number of strategic financial risks, including commissioning arrangements, workforce affordability, reserve utilisation, and funding associated with service delivery models. Members highlighted the need to better understand the quality, performance and workforce implications of financial pressures, particularly where service redesign or workforce changes may be required. The Committee supported retention of the overall Level 4 assurance rating, recognising that whilst financial controls and governance arrangements remain in place, a number of significant financial risks and dependencies require ongoing management and oversight.

Members also emphasised the importance of ensuring that financial decisions remain aligned with workforce planning, service sustainability and quality outcomes.

Performance Management Framework

▪ ***Velindre Cancer Services (VCS)***

The Committee received the Velindre Cancer Services performance update and noted the ongoing work to improve the timeliness of the Velindre cancer pathway. Members welcomed improvements in radiotherapy performance, with an excellent compliance with the national targets for 2 of the Radiotherapy performance metrics.

Discussion focused on the interpretation of the current cancer performance measures, particularly the distinction between nationally mandated standards and local quality metrics. Members articulated that further information to support their understanding of the cancer performance data would be welcomed in order to enable greater interrogation of the data.

The Committee also explored the relationship between workforce capacity, service models and performance outcomes, noting the challenges associated with delivering timely treatment within the existing workforce and operational constraints.

The Committee agreed the overall **Level 4 assurance rating**, recognising ongoing improvements, and the strengthening of performance intelligence. However, it was acknowledged that further work is required to achieve sustained performance improvements, and a more comprehensive understanding of outcomes and service effectiveness.

▪ ***Welsh Blood Service (WBS)***

The Committee received the Welsh Blood Service performance update, and noted that, whilst key performance indicators remained broadly stable, the service was currently experiencing significant operational pressures. The impact of sustained hot weather on blood collection activity, including reduced collection capacity, workforce pressures and challenges associated with maintaining blood stock levels was discussed. The Committee welcomed the proactive actions being taken to maintain operational resilience, including service-wide support arrangements and ongoing monitoring of stock levels.

Members also highlighted the importance of learning from recent incidents, seeking assurance that lessons arising from manual transcription errors were being appropriately captured and shared.

Overdue incident actions, and the need for continued oversight of action completion and incident management processes were also discussed.

▪ ***Workforce and Wellbeing***

The Committee received the Workforce and Wellbeing performance update and noted that sickness absence remained an area requiring continued focus. Members welcomed the targeted work being undertaken to understand and address hotspot areas across the organisation, and acknowledged the range of actions being implemented to support workforce wellbeing.

Discussion highlighted the wider context of increasing sickness absence and workforce pressures across the healthcare sector, recognising that many of the contributing factors extend beyond those directly within the organisation's control. Members noted the importance of continuing to focus on areas where targeted interventions can have the greatest impact, whilst maintaining oversight of workforce wellbeing trends and associated risks.

▪ ***Digital Services***

The Committee received the Digital Services performance update, and noted a temporary deterioration in performance. This was attributed to staff sickness and demand outstripping capacity. Members were advised that performance had returned to target in June, and noted the current overall stable position within the service.

▪ ***Estates, Infrastructure and Sustainability***

The Committee reviewed the Estates, Infrastructure and Sustainability performance update – this was undertaken in the absence of a member of the team who could present / respond to any of the Committee's queries. Members noted ongoing concerns regarding planned and responsive maintenance performance at the Wrexham site, and emphasised the importance of understanding whether service standards were being applied consistently across all locations.

▪ ***Health and Safety***

The Committee noted a 'violence and aggression' incident which had been rated as being 'moderately severe'. Further clarity regarding the circumstances of the incident and the actions taken in response were requested.

The levels of assurance for the Performance Management Framework were agreed as follows:

Velindre Cancer Service	3
Welsh Blood Service	3
Workforce & Wellbeing	3
Digital Services	3
Estates, Infrastructure & Sustainability	4
Health & Safety	3
Financial Performance	4

Trust Risk Register

The Committee received the Trust Risk Register and noted progress in several areas, including ongoing work to procure a replacement incident management system.

Discussion focused on the effectiveness and maturity of the Trust's risk management arrangements, including the alignment of divisional and corporate risks, the quality of risk reporting, and the visibility of mitigating actions and assurance. Members recognised the need to strengthen oversight arrangements, and supported ongoing work to refresh the Trust's Risk Management Policy and improve the management and escalation of risk across the organisation.

The Committee considered a number of high-scoring risks, and discussed the current challenges associated with presenting and monitoring risks through the existing risk management system. It was noted that improved reporting functionality would support more effective scrutiny and assurance regarding risk.

The proposed **Level 3 assurance rating** was **agreed**, with members recognising that although progress was being made, further work was required to strengthen risk management processes and reporting arrangements.

Integrated Medium-Term Plan (IMTP): An Update on Outstanding Actions from 2025-26 and a Forward Look to IMTP 2026-29 Tracking

The Committee received an update on delivery of the Integrated Medium Term Plan (IMTP), noting continued progress against actions carried forward from the previous planning cycle, and the significant proportion of year one deliverables that had now been completed.

Discussion focused on the monitoring and reporting arrangements for the 2026–29 IMTP deliverables, particularly in light of recent internal audit recommendations and Structured Assessment findings. The Committee welcomed the work underway to refine the reporting approach, and recognised the need to strike an appropriate balance

	between comprehensive oversight and the practicalities of monitoring a large number of deliverables. Members also emphasised the importance of ensuring that the new committee structure supports effective scrutiny of IMTP delivery, whilst maintaining a clear line of sight to the Trust's strategic objectives.
INFORM	Velindre University NHS Trust - Staff Story The Committee received a staff story presentation highlighting the positive impact of the Inspire leadership development programme. Members welcomed the feedback provided and discussed the importance of measuring the longer-term impact of leadership development activity, including how learning is translated into practice, and how it influences team and organisational performance. Discussion also focused on strengthening oversight of leadership development opportunities across the organisation, improving visibility of programme participation and progression pathways, and exploring wider collaboration with external partners and NHS organisations to support leadership development. Members noted the importance of ensuring clear links between leadership programmes, organisational priorities and future workforce development plans. Policies and Procedures The Committee APPROVED the following policies and procedures: • Family Friendly Procedures and Guidance - o WF59c & WF59d Adoption Leave Procedure and Guidance - o WF59e & WF59f Parental Leave Procedure and Guidance - o WF59g & WF59h Shared Parental Leave Procedure and Guidance - o WF59i & WF59j Paternity or New Parent Support Leave Procedure and Support Guidance note • Childcare Vouchers Policy The Committee ENDORSED the Policy and Procedure for Medical Consultant Job Planning
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 16th July 2026.

VELINDRE UNIVERSITY NHS TRUST BOARD

PUBLIC AUDIT COMMITTEE

HIGHLIGHT REPORT

DATE OF MEETING	12 May 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	Gareth Jones, Chair
EXECUTIVE SPONSOR APPROVED	Non Gwilym, Interim Director of Corporate Governance
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 Audit Committee at its meeting held on 12 May 2026. Key highlights from the meeting are reported in paragraph 2.

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

2. HIGHLIGHT REPORT

The following areas were highlighted for reporting to the Trust Board from the meeting of the Audit Committee held on 12 May 2026:

ALERT / ESCALATE	Audit Action Tracker – AMaT February Update A general observation was made that stronger executive ownership is needed, along with more realistic deadlines and timely requests for extensions where actions cannot be completed as originally planned.
ADVISE	Standards of Good Governance and Probity Policy (GC03) The policy is an updated version of the previous "Standards of Behaviour Policy," now renamed for clarity. Amendments are highlighted in the paper for Committee review.

	The policy was endorsed by the Executive Management Board (EMB) in February and is presented to the Audit Committee for formal approval. The update aligns with ongoing work to improve cycles of business and meeting dates. The Committee APPROVED the revisions to GC03 The Standards of Behaviour Policy and its change of name to the Standards of Good Governance and Probity (in Public Services Roles) Policy.
ASSURE	Trust Risk Register The Audit Committee received assurance that the risk register is actively used, when necessary, with information being inputted into the Datix system. The Committee NOTED the risks in the quality and safety domain with a score of 12 and risks in other domains with a score of 15 and above and NOTED the static risks and sub-threshold risk audits. Digital Transformation Report Six recommendations were made: • improve oversight and tracking of digital infrastructure risks • increase frequency and integrity of cyber reporting • strengthen AI risk management • enhance workforce digital skills development • clarify short/medium/long-term digital investment planning, and • improve evaluation of digital solutions The management response focuses on prioritising digital projects, resourcing the digital and data teams, and developing a comprehensive financial plan for digital investment. The report highlights the need to identify a new IM champion for digital, rejoin the All-Wales IM Digital Network, and clarify which Committee will oversee digital activities and inclusion plans.
INFORM	INTERNAL AUDIT REPORTS The Audit Committee received five internal audit reports, which reported the following levels of assurance: • Follow-up of Previous Audit Recommendations Assurance rating: Advisory • Quality and Safety Governance Service Capacity Assurance rating: Advisory • Trust Assurance Framework (TAF) and Trust Risk Register (TRR) Alignment (Assurance)

	Assurance rating: Reasonable • nVCC Change Control Assurance rating: Substantial • nVCC Validation of Management Actions Assurance rating: Advisory Board Assurance Framework Work is also underway to align BAF risks with the new Committee structure so that each committee reviews the right risks and duplication is reduced. The Audit Committee will focus on overseeing the process rather than reviewing individual risks in detail. The current assurance rating remains at 2 and will be reviewed once the BAF, risk policy and Committee structure are fully aligned. The Committee NOTED the current status of the Board Assurance Framework and maintained the current assurance rating of 2. Counter Fraud Progress Report Quarter 1 2026/27 The update confirmed that: • Mandated awareness completion rate reached 78.32%, showing continued improvement • In-person awareness sessions continue, but attendance is low; efforts are being made to coordinate with Information Governance for better turnout • National Fraud Initiative (NFI) cycle is complete; discussions are underway to explore more live data checks using app check technology • Two investigations are ongoing: one by the Counter Fraud Authority and one locally, with no major updates or significant salary overpayments reported in this period
APPENDICES	NONE

3. RECOMMENDATION

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

TRUST BOARD	
Highlight report from the Chair of the new Velindre Cancer Centre (nVCC) Project Scrutiny Sub-Committee	
DATE OF MEETING	30 July 2026
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not applicable
Prepared by	Tessa Harper-Hughes, Business Support Officer
PRESENTED BY	Hilary Jones, Chair and Independent Member
EXECUTIVE SPONSOR APPROVED	Carl James, Chief Executive Officer
REPORT PURPOSE	FOR NOTING

PURPOSE

- 1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the Public nVCC Project Scrutiny Sub-Committee held on 18 June 2026.
- 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 the assurance provided.

HIGHLIGHT REPORT

ALERT/ ESCALATE	nVCC Programme Delivery and Ongoing Scrutiny The Sub-Committee noted that the project remained at an AMBER status with the programme continuing to be a key area of focus due to the scale and complexity of the nVCC build. A refreshed programme had recently been received and that further detail would be provided through forthcoming reporting cycles. The Sub-Committee recognised that the programme was entering a particularly active and critical phase of construction, requiring continued scrutiny of delivery milestones, sequencing, and coordination of works. Further detailed discussion on programme risks and mitigations was scheduled for the private session.
	Health and Safety The Sub-Committee was advised that health and safety remained a core priority, with increased workforce levels on site as construction activity intensifies.

	It was noted that no RIDDOR events had been recorded and that strong observation levels continued to support a proactive safety culture. Communications and Engagement The Sub-Committee received an update on communications and engagement activity, noting strong staff engagement supported by regular briefings, accessible communication channels, and high attendance at engagement sessions. The Sub-Committee noted that staff feedback continued to inform ongoing improvements to communication and engagement activity, including work to refine methods and learn from comparable projects. The Sub-Committee was advised that a refreshed Communications and Engagement Strategy was being developed and would align with emerging programme milestones and readiness activity. CGI Walkthrough and Stakeholder Engagement The Sub-Committee noted progress in developing a draft CGI walkthrough of the future facility, which was being refined following completion of relevant design information. The finalised walkthrough would be shared at a future meeting.
ASSURE/ INFORM	Project Delivery, Social Value and Financial Position The Sub-Committee: • Noted continued strong progress across the Authority's deliverables, which remained on track. • Was assured that financial and operational management continued to be well controlled. • Noted positive progress in delivering social value commitments, with most performance indicators progressing well. • Welcomed the scheduled independent internal audit work to review reporting and evidence, which would provide further assurance on delivery against commitments. • The project remained on track financially, and risk management activity had enabled a reduction in contingency provision, with funds expected to be returned to Welsh Government. Sub-Committee Scrutiny Clarification was sought clarification on risk reporting, programme support measures, reporting metrics, staff survey insights, and development of the CGI walkthrough. The discussions reflected the Sub-Committee's continued focus on assurance, transparency, and continuous improvement.
APPENDICES	None

TRUST BOARD		
Duty of Quality Annual Report 2025/2026		
DATE OF MEETING	30 th July 2026	
STATUS	Public	
PREPARED BY	Tina Jenkins, Head of Quality, Safety & Assurance Annie Evans, Deputy Director of Nursing, Quality & Experience	
PRESENTED BY	Gillian Knight, Executive Director of Nursing, Allied Health Professionals & Health Science	
APPROVED BY	Annie Evans, Deputy Director of Nursing, Quality & Experience, on behalf of, Gillian Knight, Executive Director of Nursing, Allied Health Professionals & Health Science	
SCRUTINY ROUTE TO DATE	Date	Report considered by committee/group
	09/06/2026	Extraordinary Integrated Quality and Safety Group
	02/07/2026	Executive Management Board
	09/07/2026	Quality, Safety & Performance Committee
	IQSG - Suggestions and comments at IQSG led directly to a number of agreed actions to improve the report's clarity with a focus on patient-centred storytelling, and the undertaking of further data validation. It was also agreed that the report would be shared via the divisional quality meetings to enable wider engagement and contribution.	
	EMB – The Board endorsed the report for onward scrutiny.	
Quality, Safety and Performance Committee – The Committee endorsed the Duty of Quality Annual Report with a Level 4 Assurance rating. The Committee acknowledged the strong progress made, while highlighting the need for future reports to better demonstrate measurable outcomes, organisational learning, and the impact of improvement activities. The Committee also recommended that the report include the Trust's ambition to achieve OECl accreditation –		

	this has since been included in the 'next steps' section of the report.	
ONWARD SCRUTINY ROUTE	N/A	
PURPOSE OF THE REPORT	FOR APPROVAL	
	The Trust is required to produce and publish an annual report for the public, patients and donors which provides an overview of how the Trust has met its responsibilities under the Duty of Quality, as required by the Health and Social Care (Quality and Engagement) (Wales) Act 2020. The 2025/26 Duty of Quality Annual Report provides robust assurance that Velindre University NHS Trust has discharged its requirements under the 'Duty of Quality' during 2025/2026. The report highlights the progress made in strengthening the Trust's quality and safety governance framework, the ongoing positive compliance with the statutory requirements relating to quality and safety, and the continued excellent patient and donor experience feedback. Areas for continued focus during 2026/27 are also highlighted within the report.	
ACTION / DECISION	The Trust Board is asked to consider the contents of the Duty of Quality Annual Report, and to APPROVE it prior to publication.	
APPENDICES	Appendix no.	Appendix title
	Appendix 1	Key considerations
	Appendix 2	2025-2026 Annual Duty of Quality Report
RELEVANT TRUST STRATEGIC GOALS		
This report addresses the following goal(s) within the Trust's strategic plan :		
Outstanding for quality, safety and experience		X
An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations		X
RELEVANT WELL-BEING OF FUTURE GENERATIONS (WALES) ACT 2015 GOALS		
This report addresses the following wellbeing goal(s):		

- **A Healthier Wales** – through improvements in quality, safety, and patient and donor outcomes.
- **A More Equal Wales** – by ensuring equitable access, experience, and outcomes.
- **A Prosperous Wales** – through effective, high-quality services and a skilled workforce.
- **A Wales of Cohesive Communities** – by strengthening engagement, feedback, and partnership with patients, donors, and stakeholders.

QUALITY AND SAFETY IMPLICATIONS

This report impacts one or more of the following [Six Domains of Quality](#):

Safe	Timely
Equitable	Effective
Efficient	Patient centred

QUALITY IMPACT ASSESSMENT (QIA)

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

Status: QIA not completed - strategic decision not being made so not required

APPENDIX 1 – Key considerations

1. PURPOSE

The Duty of Quality Annual Report 2025/26 provides assurance regarding how Velindre University NHS Trust has discharged its responsibilities under the Duty of Quality. The report demonstrates the progress made during 2025/26 in strengthening quality governance across the Trust, improving patient and donor experience, and supporting quality-driven decision making across the organisation.

The report also identifies areas for continued development during 2026/27, including implementing a digital quality metric dashboard, strengthening co-production with patients and donors, and ensuring that organisational learning from incidents / feedback is firmly embedded.

Following Trust Board approval, the report will be translated and published on the Trust's website.

2. SITUATION

The Duty of Quality Annual Report demonstrates that the Trust continues to meet its statutory obligations, and remains committed to continuously, reliably and sustainably improving the quality of services provided to patients and donors.

Key achievements during 2025/26 include:

- Continued development of the Trust Quality Management System and wider quality governance arrangements.
- Progress against the Trust's 2025/26 quality priorities, focused on communication, quality infrastructure, patient and donor safety, and the development of quality metrics.
- High levels of patient and donor satisfaction, and strengthened approaches to capturing and learning from patient and donor feedback.
- Implementation of organisational learning from concerns, incidents, Duty of Candour reviews, audits and external reviews.
- Evidence of quality-driven decision making through the use of Quality Impact Assessments on strategic decisions.
- Implementation of improvements across services, including: outpatient transformation, enhanced donor haemoglobin testing, expansion of radiotherapy services, strengthened safeguarding arrangements and workforce development initiatives.

The report also recognises several areas for ongoing focus during 2026/27:

- Further development of quality intelligence and dashboard reporting.
- Ensuring that organisational learning is consistently embedded
- Strengthening co-production and engagement with patients and donors.

- Implementing and embedding of the NHS Wales Listening to People framework
- Progression towards Organisation of European Cancer Institutes (OECI) accreditation for the Velindre Cancer Service

3. MATTERS FOR CONSIDERATION

The report provides assurance that:

- The Trust has met its statutory Duty of Quality responsibilities during 2025/26.
- Appropriate governance systems are in place to oversee quality, safety and experience.
- There is evidence of learning and improvement arising from patient and donor feedback, incidents, complaints, audits and external reviews
- Quality considerations continue to be embedded within strategic decision making across the organisation.
- The Trust has clear priorities for further improvement during 2026/27.

Board members are asked to note the progress made during 2025/26, and the continued focus on strengthening quality intelligence, organisational learning, patient and donor experience, and maturing the Trust's quality management system.

4. IMPLICATIONS

4.1 Financial Implications

There are no direct financial implications arising from the approval and publication of the Duty of Quality Annual Report. Service improvement initiatives identified within the report will progress through the Trust's established financial scrutiny and governance processes.

4.2 Legal Implications

Publication of the Duty of Quality report fulfils the Trust's statutory responsibilities under the Health and Social Care (Quality and Engagement) (Wales) Act 2020, and provides assurance regarding the Trust's ongoing compliance with the Duty of Quality.

4.3 People Implications

The report highlights the significant contribution of staff across the whole organisation in delivering high-quality services for patients and donors. The Trust recognises that workforce capacity, organisational culture, staff well-being and leadership, remain important enablers of quality improvement, and there will be a continued focus on strengthening these key elements during 2026/27.

4.4 Equality Implications

The report highlights the Trust's commitment to ensuring equitable access to safe, high-quality services, and reflects efforts to reduce variation in care and promote inclusion. The Trust will be working to obtain enhanced data intelligence during 2026/27 (such as survival outcomes data), and this will further aid the identification of any variation in care, which can then be addressed.

4.5 Socio-economic Implications

The report highlights a range of initiatives aimed at improving access, reducing barriers to care, and ensuring that services remain responsive to the needs of the population served.

4.6 Welsh Language Implications

The report will be made available bilingually, ensuring accessibility for Welsh-speaking service users and compliance with Welsh language standards.

4.7 Reputational Implications

There is not considered to be any adverse reputational impact relating to the publication of the Duty of Quality Annual Report.

5. RISKS

The following risks are relevant to the themes identified within the Annual Report:

Risk Title	Risk Number	Risk Lead	Current Score
Outpatient clinics overbooked and increased waiting times for patients	3247	VCS	12
Treatment Helpline risk due to increased complexity, demand, inappropriate calls and workforce model	3216	VCS	15
Risk to patient safety arising from the absence of a Patient Advice and Liaison Service (PALS)	3903	VCS	12
Quality and safety risk associated with the absence of a robust digital quality management metric	3282	Trust-wide	12

6. RECOMMENDATIONS FOR ACTION / DECISION

The Trust Board is asked to:

- **NOTE** the assurance provided within the Duty of Quality Annual Report 2025/26.
- **NOTE** the quality priorities and areas for continued development during 2026/27
- **APPROVE** the Duty of Quality Annual Report 2025/26 for translation and publication.

Velindre University NHS Trust
Head of Quality, Safety and Assurance

Duty of Quality Report

1 April 2025 – 31 March 2026



Velindre University NHS Trust is responsible for the delivery of a wide range of specialist NHS Wales services including the Velindre Cancer Service and the Welsh Blood Service and we host Health Technology Wales, Advanced Therapies Wales and NHS Wales Shared Services Partnership.

Caring

We are always kind, supportive, approachable and show compassion to all.



Respectful

We seek to understand other people's perspectives. We are always open and transparent.



Accountable

We always take personal responsibility for what we do and how we do it.



The Velindre Cancer Service is a specialist treatment, teaching, research, and development service for non-surgical tertiary oncology services to patients from across southeast Wales and further afield.

The Welsh Blood Service provides essential and highly specialised national services including the collection and production of blood and blood components, specialist diagnostic services, and antenatal screening, as well as supporting transplant services for solid organs and stem cells across Wales and internationally.

Health Technology Wales assesses non-medicine health and care technologies and produces national guidance on their use in Wales.

NHS Wales Shared Services Partnership delivers a wide range of professional, technical, and administrative services to NHS Wales.

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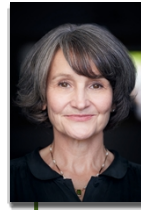
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Foreword

Chair and Chief Executive Officer



Carl James
Interim Chief Executive Officer



Sara Moseley
Trust Chair

At Velindre University NHS Trust quality is at the heart of everything we do. Through Velindre Cancer Service, Welsh Blood and Transplant Services and our hosting arrangements for Health Technology Wales and NHS Wales Shared Services Partnership we provide services that touch the lives of people across Wales every day. We remain committed to ensuring that those who use our services receive care and support that is safe, effective, compassionate, and responsive to their needs.

This Duty of Quality Annual Report describes how the Trust has met its statutory responsibilities during 2025/26 and provides an overview of the progress made to improve quality, safety, and experience across our services. This report highlights areas where we have strengthened our approach, demonstrates how we are learning from feedback, concerns, and incidents, and identifies opportunities for further improvement.

Over the past year, we have continued to develop our quality management systems, governance arrangements, and organisational learning processes. We have strengthened our focus on patient and donor experience, enhanced how we use quality intelligence to inform decision-making, and supported a culture that encourages openness, learning and continuous improvement. These developments provide a stronger foundation for delivering high-quality services and improving outcomes for those we serve.

Central to this work is our commitment to listening. The experiences, feedback and insights of patients, donors, service users, carers, and staff help us understand what matters most and where we need to focus our efforts. By working together and fostering a culture of continuous learning, we can ensure that improvement is meaningful, sustainable, and centred on people.

Whilst we have made substantial progress, we recognise that challenges remain. Increasing demand, workforce pressures, rising expectations and an evolving healthcare landscape mean that we must continue to strengthen our systems, build capability and ensure we consistently deliver safe, high-quality services. We remain committed to learning from our experiences, responding openly to concerns and using evidence to drive improvement.

We would like to thank our staff, volunteers, patients, donors and partners for their continued commitment, professionalism, and support. Their contribution is fundamental to the quality of our services and to our shared ambition of delivering the best possible outcomes and experiences for the people of Wales.

Executive Summary

This report outlines how Velindre University NHS Trust has discharged its Duty of Quality during 2025/26 and provides an assessment of progress in improving quality, safety, patient and donor experience, and organisational learning.

During the year, the Trust has continued to strengthen its quality and safety infrastructure, governance arrangements, and Quality Management System, providing a more systematic approach to quality improvement, assurance, and decision-making. Considerable progress has been made in enhancing patient safety, improving communication and engagement, and embedding learning from incidents, concerns, and Duty of Candour reviews.

Patient and donor experience remains a key strength, with consistently positive feedback regarding the quality of care received. The Trust has further expanded its approach to capturing and using feedback through the People's Experience Framework and co-production initiatives, providing richer insight to inform service improvement.

The Trust has demonstrated a positive culture of transparency and learning, reflected in increased reporting of concerns and incidents. Whilst the volume of concerns has increased, this is considered to represent greater openness and reporting confidence rather than deterioration in care quality. Themes identified continue to highlight opportunities to improve communication, coordination of care and administrative processes.

The Trust has maintained compliance with its statutory responsibilities, including the effective management of incidents meeting the threshold for Duty of Candour, supported by robust governance, investigation, and learning arrangements. Challenges remain, including increasing demand within concerns and redress processes, pressures on investigation timeliness, workforce capacity constraints, and the need to further strengthen quality intelligence through the development of integrated quality dashboards and performance reporting. The introduction of the Listening to People process will also increase expectations regarding responsiveness, transparency, and organisational learning.

Overall, the Trust continues to make progress in improving the quality, safety, and experience of care, while strengthening its approach to quality management, governance, and organisational learning. Continued focus will be required to ensure that systems, processes, and organisational capacity continue to mature and remain responsive to future demands and opportunities for improvement.

Introduction

This is the Velindre University NHS Trust (“the Trust”) Annual Duty of Quality Report. This Quality report is intended to summarise and reflect the Trust’s progress to improve the quality of our services and population outcomes during the last year. The report describes the progress and challenges on our quality journey and reflects the breadth of the health and care quality standards. These standards are part of the Duty of Quality which was brought into effect on the 1st April 2023 through the Health & Social Care (Quality Engagement) (Wales) Act 2020. This legislation defines quality as:

“Continuously, reliably and sustainably meeting the needs of the population we serve.”

The six quality domains and six quality enablers are shown in the image below.



Looking back – Quality Priorities 2025/2026

For quality priorities to be achieved and deliverable it is important that they reflect identified issues within the organisation's quality management system. It is essential to work collaboratively to identify shared priorities. Giving everyone a voice and bringing together staff, patient, and donor feedback to design our services and drive improvements is essential. Each division identified and agreed its annual quality priorities through the Trust's planning and governance processes. These priorities have been incorporated into the Trust's Integrated Medium-Term Plan (IMTP) and will be monitored through established governance arrangements. The IMTP sets out the organisation's strategic priorities and the actions required to deliver them.



The four main priority themes are:

- 01 Improve Patient & Donor Communications
- 02 Strengthen Quality & Safety infrastructure
- 03 Improve Patient & Donor Safety
- 04 Implement a Trust Quality Dashboard

Priority 1 – Improve Patient & Donor Communications

We have made improvements to ensure patients and donors receive information that is timely, clear, and consistent.

Examples from Trust Integrated Medium Term Plan

Outpatient transformation to improve communication

We have improved how we manage appointments and information so that patients receive updates on time and are kept informed at every stage of their care.

Timeliness of communication (letters within 30 days)

We are improving how quickly letters are reviewed and sent, so patients receive essential information without unnecessary delays.

What does this mean for Patients & Donors?

Patients and donors should receive clear, dependable, and timely communication, helping them feel better informed and supported.

Priority 2 – Strengthening the Quality & Safety Infrastructure

We have made improvements to ensure care is safe and that we learn quickly when things go wrong.

Examples from Trust Integrated Medium Term Plan

Development of a strengthened Quality Hub and data analysis capability

Improving how we review information and learn from it, so we can better understand what is working well and where services can improve.

Implementation of regulatory trackers and governance systems

We use systems, such as Audit and Inspection trackers, to check that we are meeting our quality and safety standards.

What does this mean for Patients & Donors?

Patients and donors can feel confident that we have stronger systems in place to keep people safe, learn from problems, and continue improving care.

Priority 3 – Improve Patient & Donor Safety

We have taken important steps to make care safer and reduce the risk of harm to patients and donors.

Examples from Trust Integrated Medium Term Plan

Infection prevention and control improvements

Using insights from investigations, we are strengthening infection prevention and control to reduce infections and improve safety for patients and donors.

National alignment with Duty of Candour and reporting systems

Following national standards for reporting incidents and being open and honest when things go wrong, to improve safety for everyone.

What does this mean for Patients & Donors?

Patients and donors can feel confident that safer systems are in place to manage risks, act quickly on important information, and prevent harm.

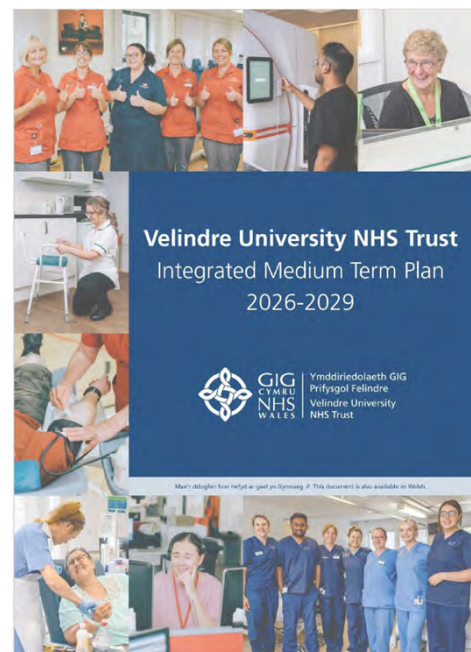
Priority 4 – Implement a Trust Quality Dashboard

Progress against this priority has been slower than anticipated due to competing digital demands and priorities. An agreed Trust roadmap is in place, and this will be taken forward as a quality priority for 2026/27.

Further work to do

While good progress has been made, further work is required to fully achieve these priorities and ensure improvements are consistent, sustainable, and part of everyday practice. These will continue to be Trust Priorities in 2026/2027, and they are all included and will be monitored through our Trust Integrated Medium Term Plan (IMTP).

The Trust Integrated Medium Term Plan (IMTP) is a clear plan that sets out what the organisation aims to improve over the next three years and how this will be achieved. It brings together key priorities, including feedback from patients, donors, and staff, to ensure the Trust focuses on what matters most. The plan also helps track progress and ensures that improvements in quality, safety and patient experience are carefully planned, delivered, and monitored.



Trust Quality Framework

The framework aims to provide a solid foundation and structured approach to ensure every level of our organisation functions as an effective quality management system, ensuring the care and services we provide are high quality, consistent, person focused and aligned with the needs of the population we serve. To achieve this the framework has been developed in line with the six domains of quality (safe, timely, effective, efficient, equitable and person centred) and six quality enablers (leadership, workforce, culture, information, learning and improvement and whole systems approach) in line with the requirements of the Duty of Quality (Wales) (2023). The framework was refreshed in November 2024 to include the Trust's Quality Management System.



The Trust Quality Management System

The Trust continues to develop and mature its Quality Management System (QMS), providing a structured approach to ensuring services are safe, effective, and continually improving. The QMS brings together quality planning, quality control, quality improvement, and quality assurance to support the delivery of care that is safe, timely, effective, efficient, equitable and person-centred, in line with the Duty of Quality.

The QMS supports the Trust to embed quality as a core organisational strategy by:

- Promoting a positive, psychologically safe and learning culture.
- Embedding quality-driven decision-making at all levels.
- Supporting continuous improvement through learning from feedback, incidents, and experience.
- Enabling shared responsibility and accountability for quality across the organisation.
- In practice, this involves triangulating information from performance data, audits, and feedback from patients, donors, and staff, alongside learning from concerns and incidents, to identify themes and drive targeted improvement.

The effectiveness of the QMS is underpinned by strong leadership, a culture of continuous learning, skilled staff, effective systems and infrastructure, robust governance arrangements, and increasing digital capability. Investment in digital solutions and quality intelligence is essential to reduce reliance on manual data collection, improve real-time insight, and support a more efficient and sustainable approach to quality management across the Trust.

Assurance of Safety – strengthening oversight, learning loops, and performance evaluation to ensure accountability and continuous improvement.

Improvement for Safety – driving measurable improvement through co-designed initiatives, staff training, and evidence-based interventions.



Planning for Safety – setting the conditions for safe care through strong leadership, safer system design, education, and forward planning.

Control of Safety – real-time monitoring and use of data insights to manage risks, reduce variation, and embed safe practice consistently.

Quality Driven Decision Making

The Duty of Quality means that whenever the NHS makes important decisions, it must think carefully about how those decisions could affect the quality and safety of care for patients. To do this, teams conduct a “quality impact assessment,” which helps us understand any benefits or risks, make improvements, and ensure patient and donor care remains safe, effective, and centred on people’s needs.

The Quality Impact Assessment, as shown below, has been undertaken for fourteen strategic decisions between 1st April 2025 and 31st March 2026.

 **Quality-driven decision-making**
Quality Impact Assessment

Title of proposal this Quality Impact Assessment (QIA) is supporting:	<For example, fito of business case>
Reference of proposal:	<For example, AC/002/03/min/yxxx>
Details of Board / Committee the paper is being presented to and when:	<For example, Audit Committee on d3/min/yxxx>

Part 1: Health and Care Quality Standards assessment

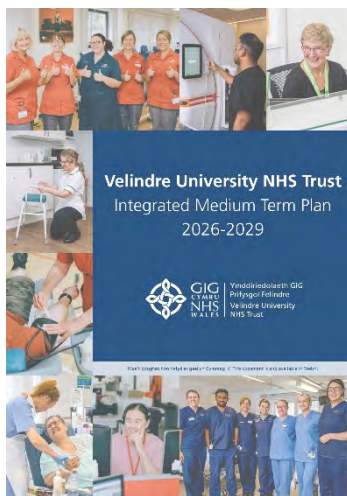
1.1 Briefly outline how this proposal or strategic decision impacts on the delivery of healthcare services (in line with STEEP Quality Standards).

Quality Standard Click each icon for its definition	Overall Impact			Key points and rationale
	Positive (+1) / Neutral / Negative (-1)	Level of impact: High (3) / Medium (2) or Low (1)	Impact score (product of previous columns)	
				
				
				
				
				
Overall impact	<Using the key points and rationale and scores above, summarise in words whether the overall impact appears to be positive or negative, and the overall level of that impact (High, Medium, Low). Please note that numerical sums may cancel each other out>			

We have included examples below:

Staff and Teams Psychology and Wellbeing Service

This proposal supports continuation of the Staff and Teams Psychology and Wellbeing Service, which helps staff access timely psychological and wellbeing support during a period of significant organisational change and increasing service pressures. Continued provision is expected to contribute positively across all quality domains by supporting staff wellbeing, reducing stress-related absence, strengthening team resilience, and helping maintain safe, effective, and compassionate care for patients and donors.



Integrated Medium-Term Plan

The Trust is working to make sure its services are safe, effective, and centred around the needs of patients, donors, and the public. It shows how quality is considered in important decisions, how the Trust is learning from feedback and concerns, and how it is improving the way it checks performance and responds to issues. It also highlights ongoing work to strengthen staff support, improve oversight, and use information more effectively so that services continue to improve and people receive the best possible care and experience.

Transforming Access to Medicines (TRAMS) Programme

The Transforming Access to Medicines (TRAMS) Programme is expected to have a small overall positive effect on quality by improving how medicines are provided, making better use of resources, supporting staff skills, and improving people's experience of care, while continuing to provide fair access for all patients. Putting the programme in place will require significant planning, coordination, monitoring, and information-sharing to ensure safe and effective delivery. Overall, the risk to quality from implementing the proposal is considered low, provided the concerns already raised by the Trust are addressed, while not going ahead with the proposal could create greater risks because there are important gaps in the current programme that still need to be resolved.



Clinical and Scientific Strategy

The Duty of Quality assessment confirms that the Clinical and Scientific Strategy, published in 2025, sets a clear five-year direction for improving care, grounded in evidence, science, and extensive stakeholder input, including over 850 contributors. It is expected to deliver significant benefits by improving quality, safety, outcomes, and patient experience, while strengthening leadership, collaboration, and innovation. The strategy is assessed as having a positive impact across all areas of care, including safety, effectiveness, timeliness, fairness, efficiency, and person-centred care, as well as wider benefits for workforce development, culture, research, and partnership working. The main risk identified is that without the strategy there would be a lack of clear direction and inefficient use of resources, while successful implementation depends on strong delivery planning, workforce capacity, and ongoing monitoring. Progress will be monitored through a structured delivery plan, with a dedicated lead responsible for tracking performance and ensuring continuous improvement, making it essential that the strategy is formally approved, clearly communicated, and effectively implemented to support high-quality, safe and sustainable care.



How the Trust Complies with Putting Things Right and the Duty of Candour

Putting Things Right is the NHS Wales process for dealing with concerns, complaints, and incidents when care or treatment may not have met the expected standard.

The regulations cover how health organisations in Wales must respond when something goes wrong or when someone is unhappy with the care they received. This includes:

- Concerns and complaints about NHS care or treatment
- Investigating what happened and whether the care provided was appropriate
- Providing a clear response and explanation
- Apologising where something has gone wrong
- Learning from mistakes and making improvements to help prevent the same thing happening again
- In some cases, considering whether redress or compensation may apply if harm has been caused



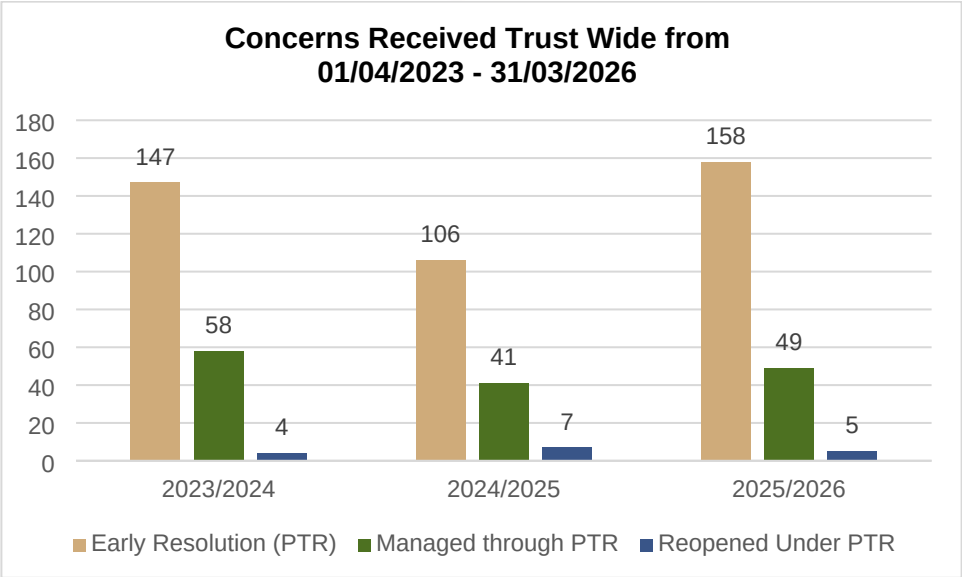
The aim of Putting Things Right is not only to answer people's concerns, but also to make sure services learn and improve. It is designed to help patients, families, and carers raise issues in a fair, open, and supportive way.

Duty of Candour means health organisations should be open and honest when something has gone wrong with a person's care. This includes telling the person what happened, offering an apology, explaining what is known at the time, and keeping them informed about what will happen next. Within Putting Things Right, this principle of openness and honesty is reflected in the way concerns, incidents, and complaints should be managed.

The Trust develops and publishes a quarterly and annual public integrated quality and safety report. This report provides analysis of key outcomes, activity, learning, and improvement, where possible, and provides themes, trends, and comparative data. The report provides assurance in relation to key legislative requirements including Putting Things Right Regulations (2011). Below is a snapshot of activity from 2025/2026. More information regarding the Trust activity and assurance can be found in the published quality & safety committee papers on the Trust internet site:



<https://velindre.nhs.wales/about-us/quality-safety-performance/>



Year	Early Resolution	Managed (PTR)	Reopened	Total concerns
2023/24	147	58	4	209
2024/25	106	41	7	154
2025/26	158	49	5	212

The Trust saw a marked increase in concerns during 2025/26, with an in-depth review undertaken to understand the underlying causes and provide assurance on learning and improvement. This review identified that the rise was not attributable to increased activity, changes in access to the concerns process, or wider national trends, and therefore required closer examination. Concerns activity has increased in 2025/26; however, the majority continue to be resolved through early resolution, indicating effective and timely management of concerns.

The review found that most concerns related to communication, coordination of care, and administrative processes rather than clinical decision-making. common themes

included the clarity and timeliness of information, continuity across teams, and delays or inconsistencies in administrative processes, all of which impacts peoples' experience.

In response, the Trust has strengthened communication standards enhanced continuity of care arrangements introduced measures to improve administrative performance. Progress will continue to be monitored through governance processes to ensure sustainable improvement and a reduction in concerns over time.

While the number of concerns received did increase, the Trust did not see an increase in referrals to the Public Service Ombudsman for Wales, or in the number of reopened complaints, indicating a strong concerns management process.

During 2025/2026, the Trust managed fourteen incidents under the Duty of Candour, including 5 which met the threshold for Nationally Reportable Incidents (NRIs). These incidents are those where patients may have experienced moderate or significant harm, and the Trust has a statutory duty to be open and transparent with those affected. Analysis of these cases identified themes relating to communication, including the use of informal systems such as email for urgent clinical communication, as well as challenges in booking, scheduling, and coordination of care.

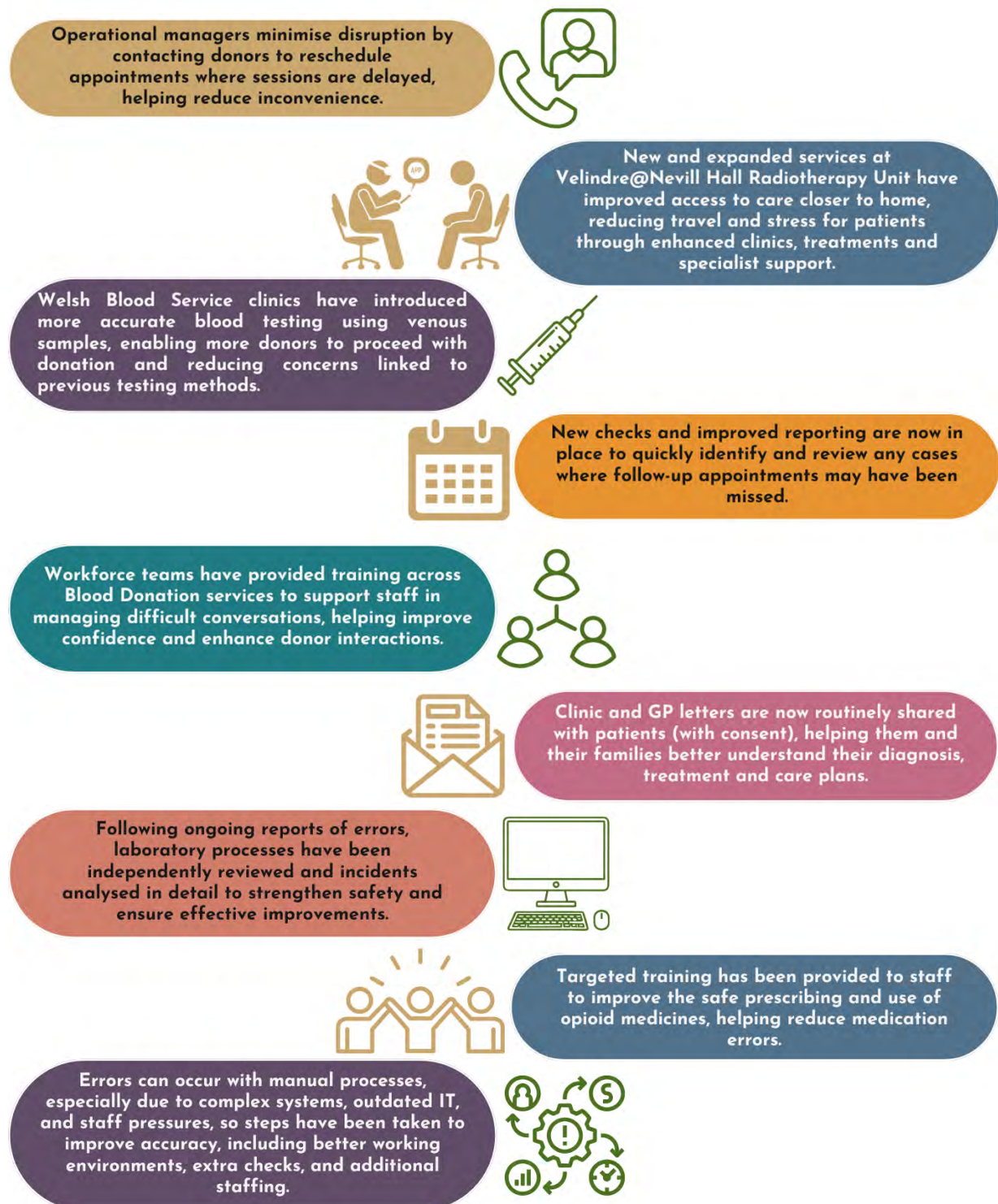
In response, comprehensive investigations have been undertaken, with improvement plans developed for each incident. Actions include strengthening the use of robust clinical systems for communication, improving handover processes between services and Health Boards, and reviewing booking and referral pathways to ensure greater reliability and oversight. Learning from these incidents is shared across the organisation and is monitored via the Trust's Quality and Safety Regulatory Tracker to ensure that changes are embedded and lead to sustained improvements in patient safety and experience.

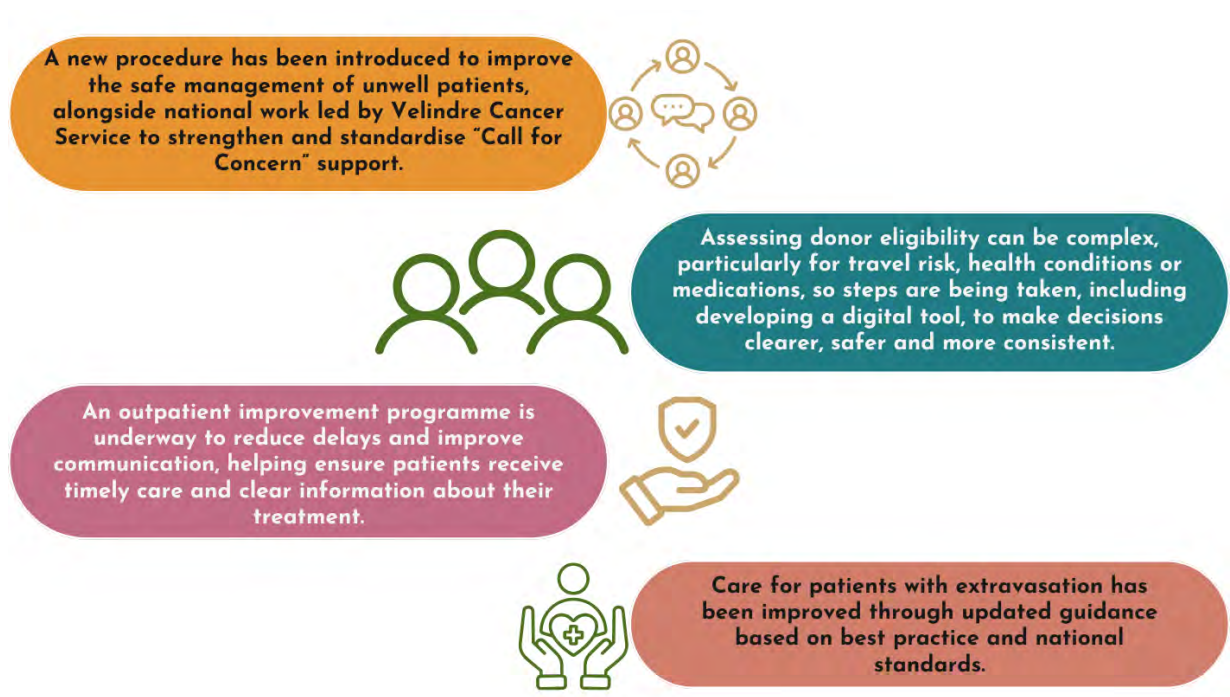
The Trust is committed to promoting a culture which values and facilitates learning, in which the lessons learned are used to improve the quality of patient and donor care, safety and experience. Continuous improvement is based on the idea that there is always room to advance in the healthcare we provide, and as a Trust we should consistently seek ways to enhance the service provided to our donors and the treatment provided to our patients. The Trust has a variety of methods of how learning is shared and embedded across the organisation.



Learning from Concerns and Incidents

The below shows an overview of learning identified from our concerns and incidents in 2025/2026:





The Trust has been preparing for changes across Wales, with the revision of the *Putting Things Right* approach into a more person-centred system, *Listening to People*. From 1 April 2026, updated regulations place greater emphasis on listening, early resolution, clear communication and learning, while retaining the existing legal framework for concerns, complaints, investigations and redress.

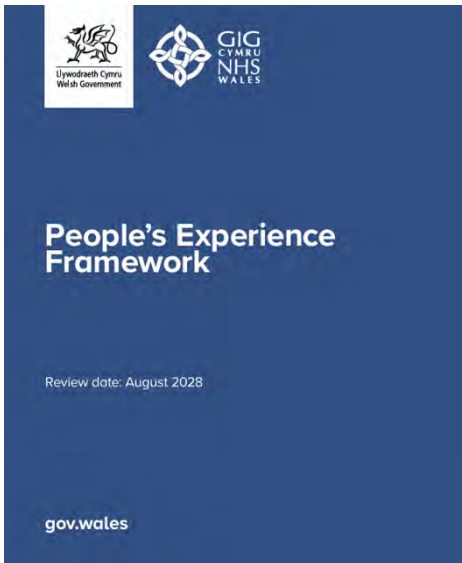
Patient and Donor Voices

Revised People's Experience Framework and People's Experience Survey

In April 2025, NHS Wales introduced a refreshed People's Experience Framework and People's Experience Survey (PES) to better understand, strengthen, and improve people's experiences of care. The framework adopts an "always-on" approach, bringing together feedback, surveys, stories, and staff insights to ensure people's experiences inform service improvement and quality of care.

People's Experience Local Self-Assessment Tool

The framework includes a self-assessment tool that has supported the Trust in reviewing how well it is performing, identifying areas for improvement, and planning future actions. This helps to drive continuous learning and ensures that all



aspects of people's experience are fully considered. The Trust is committed to achieving full compliance with the self-assessment, and this is reflected within the Trust's Integrated Medium-Term Plan.

The National People's Experience Survey

The People's Experience Survey is replaced the previous experience surveys used across the Trust and has been updated and evaluated across all health settings. The new survey ensures experiences are captured more consistently across the entire system.

These improvements support the Duty of Quality by strengthening how feedback is gathered, understood, and used, helping to ensure services are safe, effective, and continually improving in response to the needs of the population. The surveys can be accessed via the QR code below.

Velindre Cancer Service People's Experience Survey

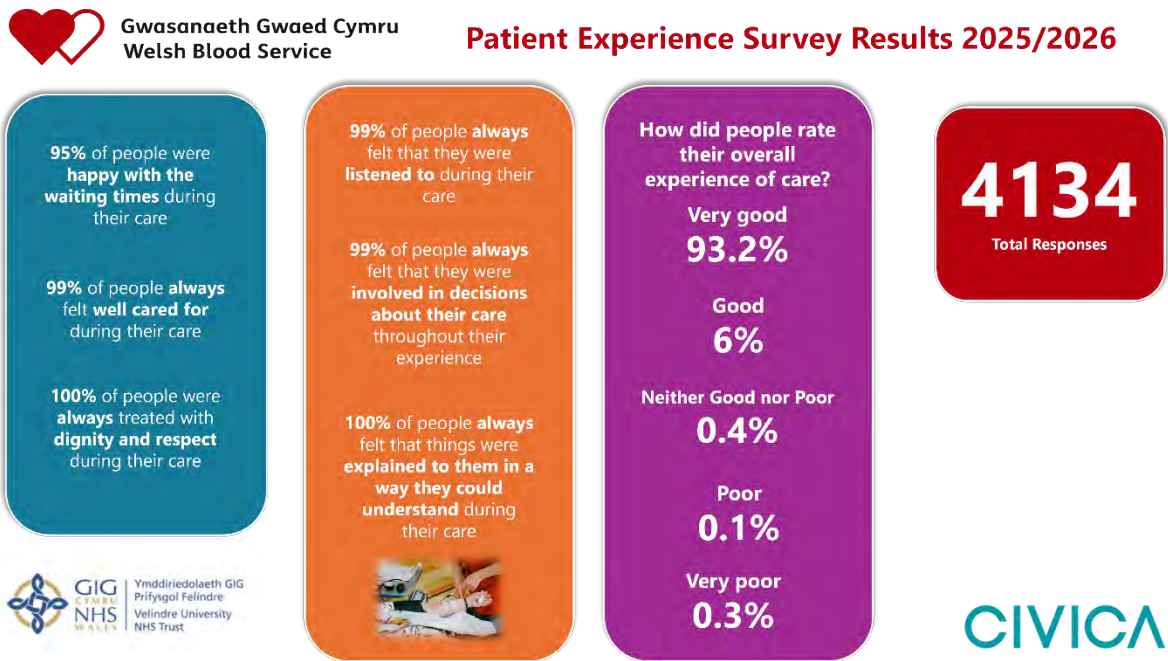


Welsh Blood Service People's Experience Survey



Patient Experience Survey Results 2025/2026

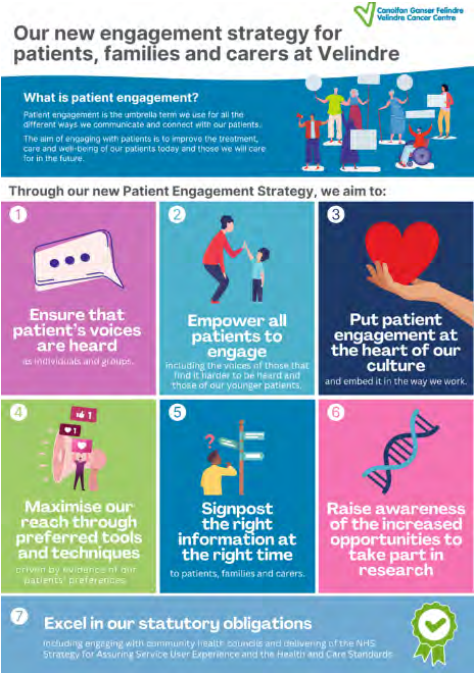




Donor & Patient Engagement

During 2025/2026, Velindre Cancer Service has continued to strengthen its commitment to patient engagement, offering a wide range of opportunities for patients, families, and carers to share their experiences and help shape services. This includes initiatives such as Velindre Voices, the Patient and Carer Partnership Board (PCPB), volunteer services, and formal consultations, all designed to ensure people’s voices are and reflected in how care is delivered. Plans to further strengthen the board and opportunities for engagement are in place for the coming year.

Volunteers have also made an important contribution by supporting patients and their families, helping to enhance the care experience. Alongside this, collaboration with research and innovation teams has strengthened, creating more opportunities for patient involvement. The organisation has also built stronger relationships with a wide range of community and stakeholder groups, including those whose voices are less often heard, helping to ensure services are inclusive and responsive. Together, these efforts demonstrate a continued focus on listening, learning, and improving care, with patients placed firmly at the centre of service design and delivery.

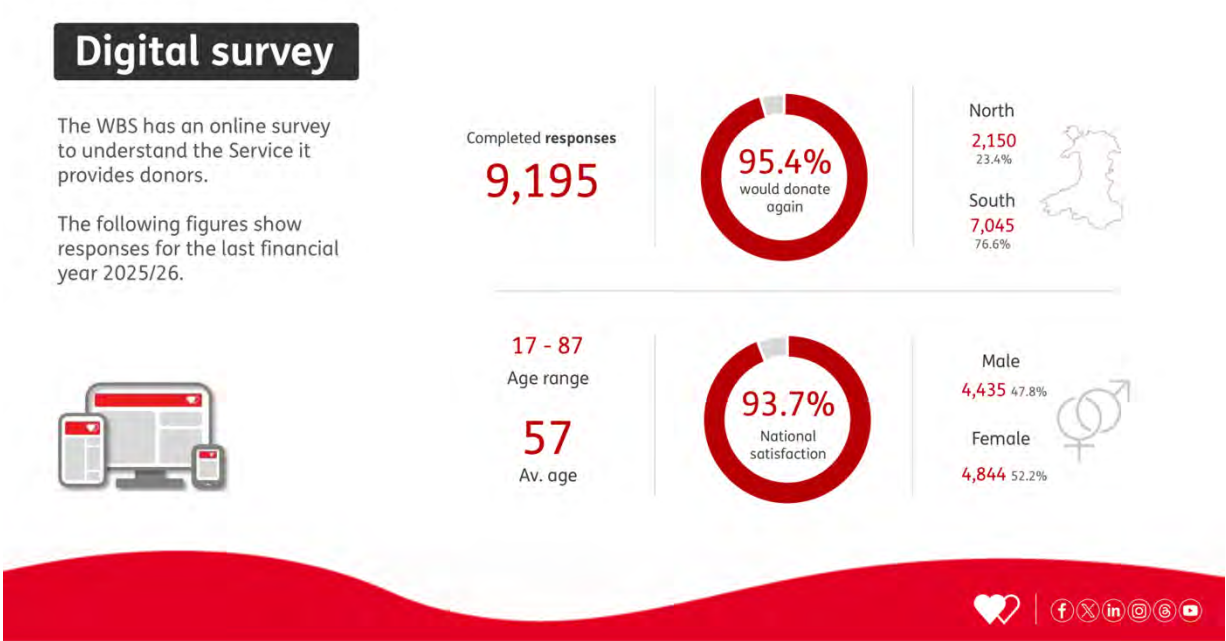


Throughout 2025/2026, the Welsh Blood Service has continued to gather feedback from donors through a monthly survey receiving 9,195 responses in total.

Feedback helps to understand experiences from initial contact through to after donation. This feedback is used to improve services and support donor retention, with overall satisfaction results reported at a national level. Survey scoring has been updated to align with wider standards, allowing comparisons across services and strengthening how performance is measured.



Overall, donor feedback remains very positive, with 95.4% of donors willing to donate again and a satisfaction score of 93.7%, as shown below.



Donors rated their experience highly on donation day, including comfort, process duration, cleanliness, and accessibility of venues. Feedback also shows that donors feel valued, supported by contact centre teams, and well-informed about eligibility. This ongoing focus on listening to donors and acting on their feedback helps ensure a safe, positive, and accessible donation experience for everyone.

The Welsh Blood Service has recently created 'WBS Voices', a dynamic panel of volunteers willing to engage in additional activity to help improve service delivery. The panel has already accrued around 3,000 willing participants of current and former blood donors. Plans to engage with the group will take place in 2026/27 to help co-produce future changes within the Service.

Enhancing Care through Reviews

Patient Care after Death Reviews

Mortality reviews are an important way of identifying problems in healthcare and areas of care which could be improved, such as early recognition and escalation of the deteriorating patient, and appropriate and timely end of life care. Reviews often also highlight aspects of excellent care, and it is important that learning from both areas of excellence as well as those in need of improvement, are shared across the Trust and the wider healthcare system. Within Velindre Cancer Service the care of all patients who die on First Floor Ward are reviewed within the monthly inpatient mortality review meeting. For patients who have died within 30 days of receiving Systemic Anti-Cancer Therapy or Radiotherapy, they are discussed within the appropriate Site-Specific Team (SST) mortality meeting which are held every 3 months. Each SST now has a mortality meeting, and positive feedback has been received that there is a forum for discussion, reflection, learning, and peer support.

National Medical Examiner Service

The National Medical Examiner Service provides independent review of deaths not investigated by the coroner, ensuring causes of death are accurately recorded and any concerns identified and escalated as appropriate. During 2025/26, no clinical concerns relating to deaths at Velindre Cancer Centre were raised by the Medical Examiner Service.



Identified Learning

Learning from patient care reviews

A review of patient deaths did not identify any concerns about the care provided. However, it highlighted areas where we can improve how we record and manage information.



Improving documentation

We are making sure key assessment forms and care plans are completed clearly and updated when a patient's condition changes.

Clearer care records at end of life

When a patient is nearing the end of life, we are ensuring all care decisions are recorded consistently in the correct documentation.

More consistent reviews

A new review form has been introduced to make sure all cases are reviewed in a thorough and consistent way.

Sharing and learning

Any themes or learning identified are shared regularly at quality meetings so that teams can continue to improve care.

External Reviews

Recommendations from external reviews and inspections during 2025/2026:

Review of Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R) (April 2023-March 2024) - Significant Accidental or Unintended Exposures

Healthcare Inspectorate Wales asked the UK Health Security Agency to review radiation-related incident reports submitted between April 2023 and March 2024, resulting in four key recommendations to improve patient safety and learning: organisations should continue to promote an open and positive reporting culture, ensure staff understand when incidents must be reported, make reporting systems easy to use and ensure timely reporting, and check that actions taken after incidents are effective and lead to real improvements. In response, the Trust has addressed all recommendations and will oversee delivery and ongoing improvement through its Radiation Protection and Medical Exposures Operational Group.



Review of the Death Certification Processes in Wales – Report

This report reviewed how deaths are formally certified in Wales and set out practical steps to improve the process, especially to maintain timely certification during busy periods such as winter while ensuring consistency and maintaining independent medical scrutiny. In response, the Trust contributed to the national review, has assessed its own processes, and has plans in place to meet the recommendations; importantly, there are currently no delays or issues, meaning patients' families can expect a timely and reliable death certification process supported by safe, consistent practices.



Llais – Enhancing Cancer Care Experience

Feedback gathered by Llais has helped the Trust identify ways to improve the experience of people living with cancer, with a strong focus on clearer communication, easier access to services, and more personalised, joined-up care. Actions include improving how staff communicate with patients, making it simpler to navigate services, providing a named key contact for support, and ensuring information is accessible to all, including diverse communities. The work also strengthens collaboration across healthcare teams and enhances emotional and mental health support, with the overall aim of continuously learning from patient feedback to improve care quality, safety, and experience for patients.



Pharmacy Technical Services Quality Assurance Audit

In June 2025, a national quality assurance audit of pharmacy technical services at Velindre Cancer Centre found that most safety and quality standards were met, although areas required improvement, particularly relating to systems and staffing. In response, the Trust has developed and is delivering a comprehensive action plan, with most actions already completed or on track, and regular monitoring in place to ensure progress.



Staffing shortage has slowed down progress of late. Importantly, no current risks to patient safety have been identified, and there is clear evidence of improvement, including a significant reduction in quality-related incidents. Overall, this work demonstrates a strong commitment to maintaining ambitious standards, addressing issues promptly, and continually improving the safety and quality of care for patients.

What does this mean for Patients and Donors?

External reviews help NHS Wales improve quality by providing independent checks against national standards, identifying risks and gaps, and giving clear recommendations for improvement. They promote learning from incidents, support a culture of openness, and ensure patient feedback is used to make positive changes. They also enable organisations to compare performance across Wales and ensure services remain safe, effective, and person-centred.

How we have improved quality across the Trust

The Trust uses the Health and Care Quality Standards as a clear framework to guide how services are planned, delivered, and improved, ensuring that care is safe, timely, effective, and centred around the needs of patients and donors. These standards set out what people can expect from NHS services and support consistent, high-quality care by helping teams identify what is working well and where improvements are needed.

This approach supports the Duty of Quality by embedding continuous improvement into everyday practice, ensuring services remain safe, effective, and responsive to the needs of the population now and in the future. Here are examples using the domains of quality to demonstrate some of the Trust's improvements.



Quality Standards Review – First Floor Ward

The First Floor Ward is a specialist inpatient ward for people with cancer who need hospital care, including planned treatment such as chemotherapy or radiotherapy, as well as urgent care for sudden illness or treatment side effects. Patients often need close monitoring, stabilisation, investigations, or end-of-life care. Over the past year, the ward has experienced increased demand and is often at full capacity and is caring for more patients with complex needs who require detailed assessment and support.



The ward review found that patients consistently experienced kind, compassionate care, delivered by committed staff working effectively together. Whilst the overall findings were positive, opportunities for improvement were identified in areas including staffing, handovers, documentation, medicines safety, infection prevention and control, and pressure ulcer prevention. A clear improvement plan is in place to address these areas, with particular focus on strengthening the recognition, escalation, and management of deteriorating patients to ensure opportunities for early intervention are consistently identified and acted upon.

Welsh Blood Service Infection Prevention & Control (IPC)

The IPC team works collaboratively with the Welsh Blood Service to ensure a coordinated, evidence-based approach to the prevention and management of bacterial contamination risks in platelet donations. Infection prevention and control audits are integral to this approach with established baselines and repeat audits undertaken as required to monitor effectiveness, reduce transmission risk, and evidence compliance with best-practice standards. Progress against audit findings is reported through IPC meetings, supporting robust governance, continuous surveillance, and quality assurance to safeguard both donors and recipients.





Velindre @ Nevill Hall Radiotherapy Unit

In June 2025, Velindre opened a new radiotherapy unit at Nevill Hall, helping to make cancer treatment more accessible for people across Southeast Wales. The facility enables more patients to receive care closer to home, depending on their treatment criteria, reducing travel times, and improving convenience, while increasing treatment capacity. Early patient feedback has been positive, highlighting reduced travel, easier parking, and an improved overall experience.



Blood Stock Collection

The Welsh Blood Service aims to hold around seven days of each blood type. The red cells within a blood donation last for 35 days; receiving too many donations in a short period can mean these vital donations expire before being used by a hospital. Similarly, not receiving enough donations means they would not be available when they are needed for patients. This is why a steady supply of each blood product is so important.



Appointments help manage the supply and help predict future stock levels, allowing the Welsh Blood Service to tailor invites to the blood groups most in need.

This year Welsh Blood Service has updated the donor booking portal with improved functionality, making it easier for donors to engage with the service and book appointments to donate.

- Change to our services to improve the **equitable collection of blood donations** across North Wales, ensuring fair access for all donors. Including expanding our capacity for blood collection.
- Introduced overnight stays for collection staff to increase the number of **mobile donation locations** we can visit, enhancing convenience and reaching more communities.



Tebentafusp Reaches First Patient at Velindre

In August 2025, Velindre Cancer Service has successfully treated its first patient with Tebentafusp, a new type of immunotherapy that helps the body’s immune system target cancer cells. This treatment has recently been approved for patients with a rare cancer called uveal melanoma and is available to around half of patients who meet specific criteria following testing. This milestone represents a key step forward in bringing innovative, life-changing treatments to patients in Wales, made possible through the hard work and collaboration of teams across the service.



National Safeguarding Awards

A Welsh Blood Service collection team received a commendation for their work in highlighting safeguarding concerns. It was recognised that the nomination demonstrated the meaningful impact of the team's work- supporting the prevention of harm, protecting those most at risk, and upholding the principles of dignity, safety, and care. The commitment, professionalism, and compassion evident in your contribution reflect the very best of Safeguarding.



Radiotherapy



Velindre Cancer Service has taken a major step forward in improving care by successfully treating palliative patients using advanced radiotherapy technology on the Ethos Treatment Machine. This development allows more patients, including those with complex needs, to benefit from precise and personalised treatment planning, improving the quality and accuracy of care. It also increases the number of patients who can be treated, helping to improve access to radiotherapy services. This achievement has been made possible through close collaboration between clinical, radiography and medical physics teams, and supports the future development of services as they move towards the new Velindre

Cancer Centre.

Outpatients

Velindre Cancer Service has a transforming outpatients plan for new Velindre Cancer Centre. This year we have worked in co-production with our service users and set up a focus group and developed a bespoke survey to find out how we can further improve experience.

We have also made improvements to our outpatient department in Velindre Cancer Centre.

To improve the environment and flow in the clinics, we have opened a brand new reception area. To help patients navigate the change:

- Clear signage is in place
- Our wonderful volunteers have been on hand to guide and support anyone who needs assistance

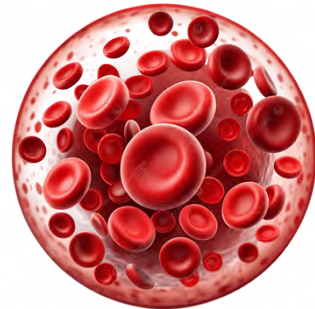


Feedback from patient and their families has been positive.

Point of Care Haemoglobin Testing

The Welsh Blood Service has improved the way we check a donor's haemoglobin (Hb) level prior to donation. If a donor's initial finger-prick test suggests their Hb might be too low or too high to donate blood, we now carry out a second, more accurate test using a small venous blood sample. This helps us make the right decision about whether someone is able to donate on the day.

This enhancement is the result of dedicated work by our Clinical Services and Blood Donation Services Teams, who continue to strengthen our safety processes.



Since introducing this improved testing method, fewer donors have been deferred for low haemoglobin. The rate of "Failed Screening Tests" has fallen from 6.9% in December to 4% in January, showing that the new approach is helping us make more accurate decisions and reducing unnecessary disappointment for donors



We have taken steps to make sure our services meet the diverse needs of people of all stages of life. This means recognising people's individual circumstances and designing services that are fair, accessible, and inclusive for everyone.

Velindre Cancer Service - Grandparents' books introduced to children's book series

To mark Grandparents' Day, Velindre introduced two new children's books (part of a series) to help families talk about cancer. Developed in response to patient and family feedback, the books focus on grandparents undergoing cancer treatment and support children to better understand and cope with a loved one's illness. Funded by Velindre Cancer Charity, the books are now available for patients and families.

New WBS campaign launched inspiring students to save lives

The Welsh Blood Service is launching a new campaign called “Young Blood” to encourage young people across Wales to get involved in saving lives. Aimed at students aged sixteen and over, the campaign collaborates with schools and colleges to inspire them to become blood donors or support the service as advocates. It focuses on increasing the number of first-time donors and people joining the stem cell register, with flexible ways for schools to take part. The campaign will officially launch in the autumn term, with early engagement helping schools and students get involved ahead of time.



Introducing 'Listening to People' – the new patient concerns approach for NHS Wales

The Trust is implementing (From April 2026) the NHS Wales *Listening to People* approach, which will strengthen how concerns and feedback are managed through a more compassionate, person-centred process. The new approach focuses on early engagement, open communication, timely resolution, and organisational learning, ensuring people feel listened to, respected, and supported while driving improvements in care and experience.



Trust Chair

Sara Moseley is the Chair of Velindre University NHS Trust, having taken up the role on 1 September 2025.

A fluent Welsh speaker, Sara has a background in communications, public engagement and governance, having previously served as Director of Communications for the Welsh Government and a large London health trust, as well as Director of Board and Corporate Support for a regional development agency.

She is passionate about ensuring people's voices and experiences are heard and used to shape services, and is committed to improving access to compassionate, effective care and support.

Executive Team & Staff Engagement

There have been significant leadership changes, this year the Trust will introduce clearer and more regular leadership updates to help staff stay informed. Short "Executive Snapshot" updates and open all-staff conversations make it easier to hear directly from senior leaders, ask questions, and understand what is happening across the organisation. These are supported by intranet and newsletter updates, ensuring important information is shared widely, helping to improve communication, transparency, and staff involvement.

The Trust is committed to Building a substantive executive team to guide the organisation with clarity and stability and long-term direction, which is set out in the Trust destination 2030 Strategy.

New Velindre Cancer Service Triumvirate

In December 2025, the Cancer Service were delighted to share that all their triumvirate roles had been recruited to. This strengthens the leadership at Velindre Cancer Service.



Introducing our new Heads of Nursing



Introducing our new General Managers



Divisional Triumvirate appointed



Clinical directors appointed



Director of Medical Physics and
Clinical Engineering - Medical Physics

The newly appointed leadership team is committed to strengthening the quality, safety and experience of care for patients and their families. Please see the intranet news links below:

[Clinical directors appointed – 04/04/2025](#)

[Introducing our new Heads of Nursing – 10/11/2025](#)

[Introducing our new General Managers – 12/12/2025](#)

[Divisional Triumvirate Appointed – 12/12/2025](#)

[Appointment of Director of Medical Physics and Clinical Engineering](#)



Supporting staff

Embedding a Just Culture

We focus on learning from what has happened rather than placing blame. When an incident occurs, we take the time to understand it fully by listening to everyone involved and looking at the wider systems and processes that may have contributed. Our aim is to make sure any investigations are fair and proportionate, so we can identify improvements and prevent similar issues in the future—helping to keep patients and donors safe.



Schwartz Rounds

In June 2025, Velindre University NHS Trust introduced Schwartz Rounds to provide a safe and supportive space for staff from all roles to come together and reflect on the emotional impact of their work. These sessions are not focused on solving problems, but on sharing experiences, supporting one another, and building understanding and compassion across teams, helping to strengthen staff wellbeing and the culture of care within the organisation.



Staff Survey

The Trust-level staff survey results show that the organisation is performing well compared to other NHS organisations, with strong staff engagement and above-average scores across all key areas. Results have remained stable over the past three years, providing a solid foundation to build on and make meaningful, long-term improvements. The Trust is now focusing on further enhancing staff experience by prioritising areas such as creating a safe and supportive working environment, giving teams dedicated time to reflect and improve, expanding flexible working opportunities, and supporting learning and development. Together, these actions aim to strengthen a positive culture and improve the experience of working within the Trust.

See the NHS Wales Staff Survey results



A well-supported workforce provides better care to patients and donors.



Velindre Oncology Academy

The Velindre Oncology Academy continues to develop as a national, standard-setting centre for non-surgical oncology education, providing accredited training and workforce development across Wales.

Building on a strong foundation of essential learning, the Academy has expanded its delivery of oncology-focused education to professionals across Southeast Wales and beyond. The Postgraduate Certificate (PGCert) in Cancer Care, developed in partnership with the University of Wales Trinity Saint David, successfully commenced in September 2025, and continues to support the development of advanced clinical knowledge and skills across the workforce.



**Velindre
Oncology
Academy**
Velindre Cancer
Service

During 2025/26, the Academy has further strengthened its educational offer through the development and delivery of Level 7 modules, including Advanced Communication and Psychological Skills, Leadership and Quality Improvement, Immunotherapy, and the Assessment and Management of Malignant Wounds. These programmes are supporting workforce capability, enhancing clinical practice, and contributing to improved patient experience and outcomes.

More information can be found in the link below:

<https://www.velindreoncologyacademy.org.uk/>

Research

The Trust is committed to research and innovation and has been involved in numerous research studies throughout the year.

Welsh Blood Service - New Research, Development, and Innovation Strategy launched

The Welsh Blood Service has launched a new Research, Development, and Innovation (RD&I) strategy to strengthen its work in improving healthcare and advancing blood and transplant services across Wales. The strategy sets out how the organisation will support and invest in research and innovation, helping Wales remain at the forefront of medical developments. A key focus is to improve the experience and outcomes for patients and donors, ensuring that their needs remain central to how services continue to develop and improve.



Research Partnership Launches to Develop New Cancer Treatments

The Cardiff Cancer Research Partnership (CCRP) is a new collaboration between Velindre University NHS Trust, Cardiff and Vale University Health Board and Cardiff University, bringing together experts in healthcare and research to improve cancer care in Wales. By working together, the partnership aims to increase the number of clinical trials available, giving more patients access to the latest treatments closer to home. It creates a more joined-up approach to cancer research, from early discoveries in the laboratory through to testing new treatments in patients. By combining expertise, facilities and knowledge, the partnership will help develop new and improved treatments, while ensuring patients benefit sooner from the latest advances in cancer care.

Cold Stored Platelets: Progress toward the UK clinical trial

The Cold Stored Platelets project team has taken important steps to prepare for a new clinical trial aimed at improving emergency care for trauma patients. By visiting the air ambulance base in Llanelli, the team gained a clear understanding of how care is delivered in real-life emergency situations, including the challenges of space, equipment, and working conditions. This has helped ensure that the planned trial is practical and can be safely used by frontline crews. The team has



also worked closely with clinical and research experts to refine the study design and ensure all necessary standards are met. A funding application is now being developed, with the aim of launching a wider trial across air ambulance services in the future. This research could lead to faster, more effective treatment and potentially save lives.



Public Accountability Meeting

In January 2026, members of the Velindre University NHS Trust Board took part in a Welsh Government Public Accountability Meeting, providing an open and transparent update on the organisation's performance. This meeting, part of a national series across NHS Wales, offered an opportunity to share progress, highlight what is working well, and outline the steps being taken to address areas for improvement. Discussions covered key areas including cancer services, the Welsh Blood Service, development of the new cancer centre, and the Trust's leadership and governance. The meeting also focused on how the Trust is responding to current challenges and planning for the future.



Llywodraeth Cymru
Welsh Government

These meetings were broadcast online and covered discussions about how the Trust is being run. This allows the public transparent access to important information regarding our service quality.

The meeting can be accessed by following the link below:

<https://www.gov.wales/velindre-university-nhs-trust-public-accountability-meeting-15-january-2026>



Welsh Government approves initial funding for Plasma for Medicines

The Welsh Blood Service secured funding to progress its Plasma for Medicines programme, enabling unused plasma from blood donations to be used in the production of plasma-derived medicines such as Albumin. This will improve the use of donations made in Wales, reduce reliance on imported products, and contribute to a more sustainable and secure supply of essential medicines for patients.

New Velindre Cancer Centre Progress Update

As part of plans to open the new Velindre Cancer Centre in Spring 2027, significant investment is being made to create a modern, expanded facility designed around the needs of patients, families, and staff. The new centre will be twice the size of the current site, providing more space to deliver high-quality care, improve access to advanced treatments and diagnostics, and support innovation, research, and training. It has been carefully designed to enhance patient experience, with easier navigation, better parking, comfortable spaces for families, and a more welcoming environment that promotes dignity and wellbeing. More than just a new building, the centre will help more patients receive the right care at the right time, closer to home where possible, supporting better outcomes for people across Wales.



Looking Forward

Quality Priorities 2026/2027

The Trust will maintain its focus on the four established quality priorities in 2026/2027, recognising that further work is required to fully embed and sustain improvements.



These priorities have been identified through analysis of our quality management systems, alongside feedback from staff, patients, and donors, ensuring continued focus on the areas that matter most.

Each division has agreed its own priorities, which have been formally approved and will continue to be monitored through the Trust’s governance arrangements. These priorities are also embedded within the Integrated Medium-Term Plan, which sets out the approach to delivering sustained improvement.

The six priority areas are:

- 01 Improving patient and donor communication
- 02 Strengthening quality and safety systems
- 03 Improving patient and donor safety
- 04 Implementing a Trust Quality Dashboard
- 05 Fully Embed the People’s Experience Framework
- 06 Implement the Listening to People Regulations

What does this mean for Patients & Donors?

Patients and donors can be reassured that the Trust is continuing to focus on improving communication, safety, and quality of care, with clear plans in place to build on progress already made.

National Patient Safety Plan for NHS Wales 2026-2031

The National Patient Safety Plan sets out how all NHS organisations in Wales, including our Trust, will work together to make care safer. For us, this means putting patient safety at the centre of everything we do—strengthening how we plan, deliver and monitor care so that risks are identified early, learning is shared, and improvements are made before harm occurs. It also means focusing on the areas where patients are most at risk and using better information, data and feedback to guide our actions.



We are committed to creating a culture where staff feel safe to speak up and where patients and families are listened to and involved in improving services. By working closely with partners across the NHS, learning continuously from experience, and demonstrating strong leadership and accountability, we will deliver safer, more reliable care and improve outcomes for the people we serve.

Working Towards Organisation of European Cancer Institutes Accreditation



The Trust has been accepted as a member of the Organisation of European Cancer Institutes and is committed to working towards achieving globally recognised accreditation:

1. **Quality Assurance:** Will ensure we meet the globally recognised high standards of quality in cancer care, research, and education, which will improve patient outcomes and experience.
2. **International Recognition:** Organisation of European Cancer Institute's accreditation provides international recognition. This will enhance the Trust's reputation globally, attracting collaborations, top-tier professionals and funding.

3. Continuous Improvement: The process involves regular assessments and feedback, promoting continuous improvement in clinical practices, research methodologies, and administrative processes.
4. Networking Opportunities: Accredited institutes become part of a network of leading international cancer centres, facilitating the exchange of knowledge, best practices, and innovative approaches to cancer treatment and research.
5. Benchmarking: Both membership and accreditation facilitates reciprocal international benchmarking mechanisms.
6. Patient and Population Confidence: Internationally recognised will enhance overall confidence in the Trust as it demonstrates adherence to stringent standards of care and commitment to providing the best possible treatment

Conclusion/Summary

This report demonstrates the progress made by Velindre University NHS Trust during 2025/2026 in strengthening the quality, safety, and experience of care across the organisation. Through a clear focus on quality priorities, the continued development of the Quality Management System, and a commitment to learning from concerns, incidents and feedback, the Trust has taken important steps to improve outcomes for patients and donors.

The Trust has evidenced a positive culture of openness, learning and continuous improvement, supported by effective governance arrangements and active engagement with patients, donors, staff, and partners. Improvements delivered during the year have enhanced communication, safety, service delivery, and patient experience, while also strengthening the organisation's approach to quality-driven decision-making and assurance.

At the same time, the report recognises the challenges associated with increasing demand, system complexity and evolving regulatory requirements. These pressures require sustained focus to ensure that improvements are fully embedded, performance remains consistent, and risks to quality are effectively managed.

The work set out in this report provides a strong foundation for the year ahead, with clear priorities in place to further strengthen quality, safety, and experience, ensuring that services remain responsive, person-centred, and focused on the needs of the population we serve.

Unit 2, Charnwood Court,
Parc Nantgarw, Cardiff, CF15 7QZ

029 2019 6161 | velindre.nhs.wales

TRUST BOARD		
Integrated Quality and Safety Annual Report 2025-2026		
DATE OF MEETING	30/07/2026	
STATUS	Public	
PREPARED BY	This is a collaborative report which has been prepared by: ▪ Velindre Cancer Service Quality & Safety 'Hub' ▪ Welsh Blood Service Quality & Safety 'Hub' ▪ Corporate Service Leads ▪ Corporate Quality, Safety and Assurance Team	
PRESENTED BY	Gillian Knight, Executive Director of Nursing, Allied Health Professionals & Health Science	
APPROVED BY	Annie Evans, Deputy Director of Nursing, Quality & Experience, on behalf of, Gillian Knight, Executive Director of Nursing, Allied Health Professionals & Health Science	
SCRUTINY ROUTE TO DATE	Date	Report considered by committee/group
	09/06/2026	Extraordinary Integrated Quality and Safety Group
	02/07/2026	Executive Management Board
	09/07/2026	Quality Safety & Performance Committee
	IQSG - A number of actions were proposed and agreed in order to strengthen the report, including: the provision of greater detail in certain areas, the undertaking of enhanced data validation, and obtaining wider Divisional engagement and consultation.	
	EMB - The Board endorsed the paper for onward scrutiny.	
	Quality, Safety and Performance Committee - The Committee endorsed the Integrated Quality and Safety Annual Report with a Level 4 Assurance rating.	
	The Committee acknowledged the strengthened approach to quality governance across the organisation, and noted the Trust's plans to: mature how learning from incidents / feedback is embedded; ensure that data is triangulated and benchmarked; and to develop a quality metric-based	

	dashboard. The addition of trend data relating to health care acquired infections was recommended - this has since been included within the report.	
ONWARD SCRUTINY ROUTE	Trust Board	
PURPOSE OF THE REPORT	The Trust's Integrated Quality and Safety Annual Report 2025/26 provides an overview of quality, safety and experience across Velindre University NHS Trust and demonstrates strong compliance with statutory and regulatory requirements, including the Duty of Quality, Duty of Candour, Putting Things Right Regulations, Listening to People and the Health and Social Care (Quality and Engagement) (Wales) Act 2020. The report provides robust assurance regarding the quality and safety of services delivered by the Welsh Blood Service, Velindre Cancer Service and Corporate Services, highlighting areas of good performance, learning and continuous improvement, alongside priorities for further development. Following approval by the Trust Board, the report will be translated and published on the Trust website. The Trust Board is asked to consider and APPROVE the Trust's 2025-2026 Integrated Quality & Safety Annual Report prior to translation and publication.	
ACTION / DECISION	Appendix no.	Appendix title
	Appendix 1	Key considerations
	Appendix 2	Annual 2025-2026 Integrated Quality and Safety Report
RELEVANT TRUST STRATEGIC GOALS		
This report addresses the following goal(s) within the Trust's strategic plan :		
Outstanding for quality, safety and experience		X
An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations		X
RELEVANT WELL-BEING OF FUTURE GENERATIONS (WALES) ACT 2015 GOALS		
This report addresses the following wellbeing goal(s):		
A Healthier Wales		

QUALITY AND SAFETY IMPLICATIONS	
This report impacts one or more of the following Six Domains of Quality :	
Safe	Timely
Equitable	Effective
Efficient	Patient centred
QUALITY IMPACT ASSESSMENT (QIA)	
A completed and signed QIA must be attached for all reports requiring a decision.	

APPENDIX 1 – Key considerations

1. PURPOSE

The Trust's Integrated Quality and Safety Annual Report 2025/26 provides an overview of quality, safety and experience across Velindre University NHS Trust, and demonstrates strong compliance with statutory and regulatory requirements, including the Duty of Quality, Duty of Candour, Putting Things Right Regulations, Listening to People requirements and the Health and Social Care (Quality and Engagement) (Wales) Act 2020.

The report provides assurance regarding the quality and safety of services delivered by the Welsh Blood Service, Velindre Cancer Service and Corporate Services, highlighting key areas of performance, learning, improvement and future development.

Following approval by the Trust Board, the report will be translated and published on the Trust's website.

2. SITUATION

The Annual Report provides assurance that the Trust continues to operate within a robust quality and safety governance framework, and that it remains compliant with its statutory quality and safety responsibilities. The report demonstrates a maturing culture of learning, continuous improvement, openness and transparency across the organisation.

Key highlights from 2025/26 include:

- Complaint handling compliance of 80.9%, exceeding the national target of 75%. No concerns accepted for investigation by the Public Services Ombudsman for Wales.
- High levels of satisfaction maintained, with 95% patient satisfaction within Velindre Cancer Service and 98% donor satisfaction within Welsh Blood Service.
- Five Nationally Reportable Incidents managed in accordance with national requirements, with learning embedded through governance arrangements.
- Fourteen Duty of Candour incidents managed during the year, reflecting continued compliance with statutory requirements and a culture of openness.
- Sixteen safeguarding Duty to Report referrals appropriately managed.
- Strong infection prevention and control performance, with low levels of healthcare-associated infection and no Velindre-acquired MRSA bacteraemia reported.
- Seventeen new Redress cases and two new claims received, reflecting increased transparency and reporting following implementation of the Duty of Candour.

The Annual Report also identifies a number of recurring themes that will inform improvement priorities during 2026/27:

- Communication and information sharing with patients and donors.
- Access, pathway coordination and appointment management.
- Timeliness of incident investigations and action completion.
- Digital system limitations and reliance on manual processes.
- Further development of quality intelligence, triangulation and dashboard reporting.

3. MATTERS FOR CONSIDERATION

The Annual Report provides robust assurance that effective arrangements are in place to monitor, manage and improve quality, safety and experience across the Trust.

- The Board is asked to note:
- Robust compliance with statutory quality and safety requirements.
- Strong evidence of learning and improvement arising from complaints, incidents, audits, patient and donor feedback, safeguarding activity and service reviews.
- Continued high levels of patient and donor satisfaction.
- Progress made in embedding the Duty of Candour and strengthening quality governance arrangements.

- The Trust's quality and safety priorities for 2026/27, include: improving communication, strengthening quality and safety systems, improving patient and donor safety, implementing a Trust Quality Dashboard, embedding the People's Experience Framework and ensuring ongoing compliance with the Listening to People Regulations.

4. IMPLICATIONS

4.1 Financial Implications

There are no direct financial implications arising from approval of the Annual Report.

Increasing Redress activity and associated legal processes may create future financial and resource pressures – this will continue to be monitored through existing governance arrangements. Improvement initiatives identified within the report will be subject to appropriate financial scrutiny through established governance processes.

4.2 Legal Implications

The Annual Report provides robust assurance regarding compliance with:

- NHS Concerns, Complaints and Redress Arrangements (Wales) Regulations.
- Health and Social Care (Quality and Engagement) (Wales) Act 2020.
- Duty of Quality.
- Duty of Candour.
- Relevant safeguarding legislation and statutory requirements.

4.3 People Implications

The Annual Report highlights that workforce capacity pressures during 2025/26 contributed to challenges in some areas, such as timely incident investigation, pathway coordination and the development of digital quality reporting systems.

Targeted actions have been undertaken to address these challenges, including recruitment to key roles, workforce development and strengthening investigation capability across the organisation. Workforce capacity and staff wellbeing will continue to be monitored during 2026/27.

4.4 Equality Implications

The Annual Report demonstrates ongoing work to improve access, communication, patient and donor experience, dementia care, learning disability support and safeguarding arrangements. No adverse equality implications have been identified.

4.5 Socio-economic Implications

No specific socio-economic implications have been identified.

4.6 Welsh Language Implications

No specific Welsh language implications have been identified. The Annual Report will be translated prior to publication.

4.7 Reputational Implications

There is not considered to be any adverse reputational impact relating to the Report. Publication of the Annual Report demonstrates the Trust's commitment to openness, transparency and accountability.

5. RISKS

The following risks are particularly relevant to the themes identified within the Annual Report:

Risk Title	Risk Number	Risk Lead	Current Score
Outpatient clinics overbooked and increased waiting times for patients	3247	VCS	12
Treatment Helpline risk due to increased complexity, demand, inappropriate calls and workforce model	3216	VCS	15
Risk to patient safety arising from the absence of a Patient Advice and Liaison Service (PALS)	3903	VCS	12
Quality and safety risk associated with the absence of a robust digital quality management metric	3282	Trust-wide	12

6. RECOMMENDATIONS FOR ACTION / DECISION

The Trust Board is asked to:

- **NOTE** the assurance provided within the Integrated Quality and Safety Annual Report 2025/26.
- **NOTE** the quality and safety priorities for 2026/27, and the continued focus on improving quality intelligence, communication, patient safety and organisational learning
- **APPROVE** the Integrated Quality and Safety Annual Report 2025/26 for translation and publication.

Velindre University NHS Trust Annual Quality and Safety Report 2025-2026

(1st April 2025- 31st March 2026)



WHAT IS QUALITY?

The Health & Social Care (Quality Engagement) (Wales) Act 2020 was implemented from 1st April 2023. This law includes the Duty of Quality and defines quality as the following:

‘Continuously, reliably and sustainably meeting the needs of the population we serve’.

This is not limited to the effectiveness of health services; the safety of health services; and positive experience of service users.

The twelve Quality Standards are used across the trust which help deliver against the six quality domains:

- Leadership
- Workforce
- Culture
- Information
- Learning, Improvement & Research
- Whole System Approach



Trust Approach

All teams communicate through a Trust network, formed of colleagues from across the organisation. This includes Divisional Quality Hubs, Integrated Quality & Safety Group, Executive Management Board, and Quality, Safety & Performance Committee, providing assurance to the Trust Board and the people of Wales on the Trust's Duty of Quality commitment.

The Trust infrastructure is supported by a range of digital tools and systems to assist with monitoring, collaborating and reporting on the services the Trust supplies across Wales.

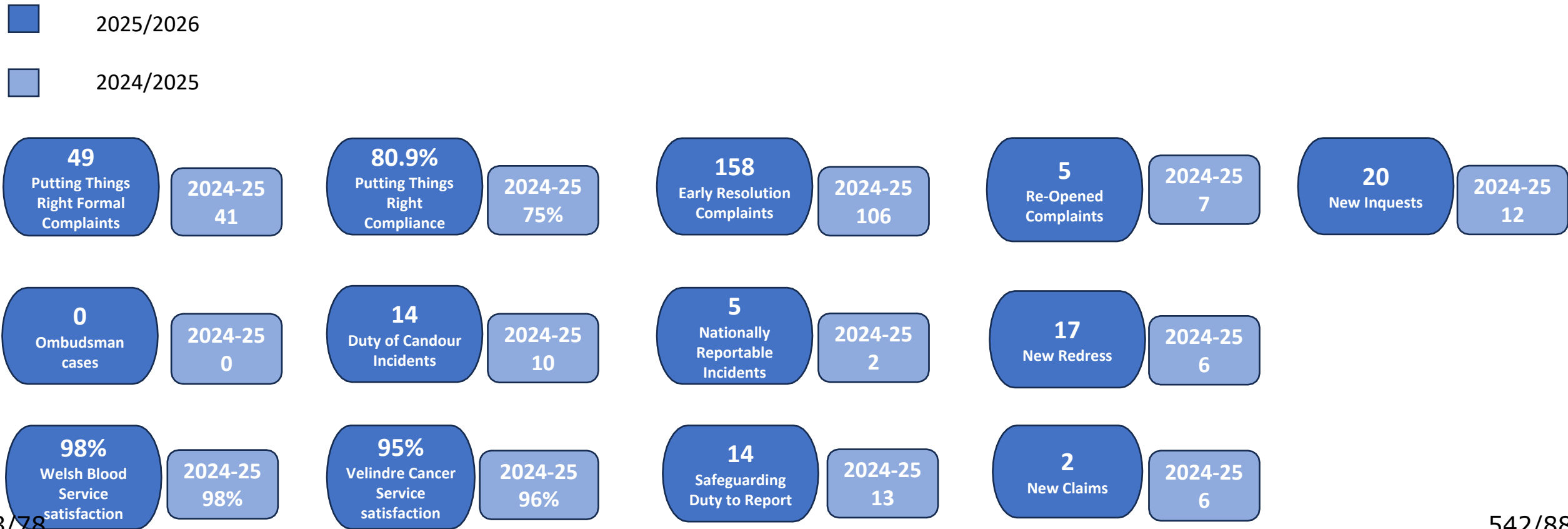
With this infrastructure, quality information can be shared effectively and timely. This can also help identify best practices, risks, areas of improvement or just for reporting purposes.



INTRODUCTION AND EXECUTIVE SUMMARY

The Trust’s annual Integrated Quality and Safety Report is structured into three divisional chapters. It provides analysis of key outcomes, activity, learning and improvement over the past year, as well as themes, trends and comparative data where available. The report also provides assurance against key legislative requirements, including the Putting Things Right Regulations (2011) and the Health and Social Care (Quality and Engagement) (Wales) Act 2020. It maintains a strong focus on learning and improvement to support the continued delivery of safe, timely, effective, efficient, equitable and person-centred care.

Quality & Safety Indicators Overview



Chapter 1:

Welsh Blood Service

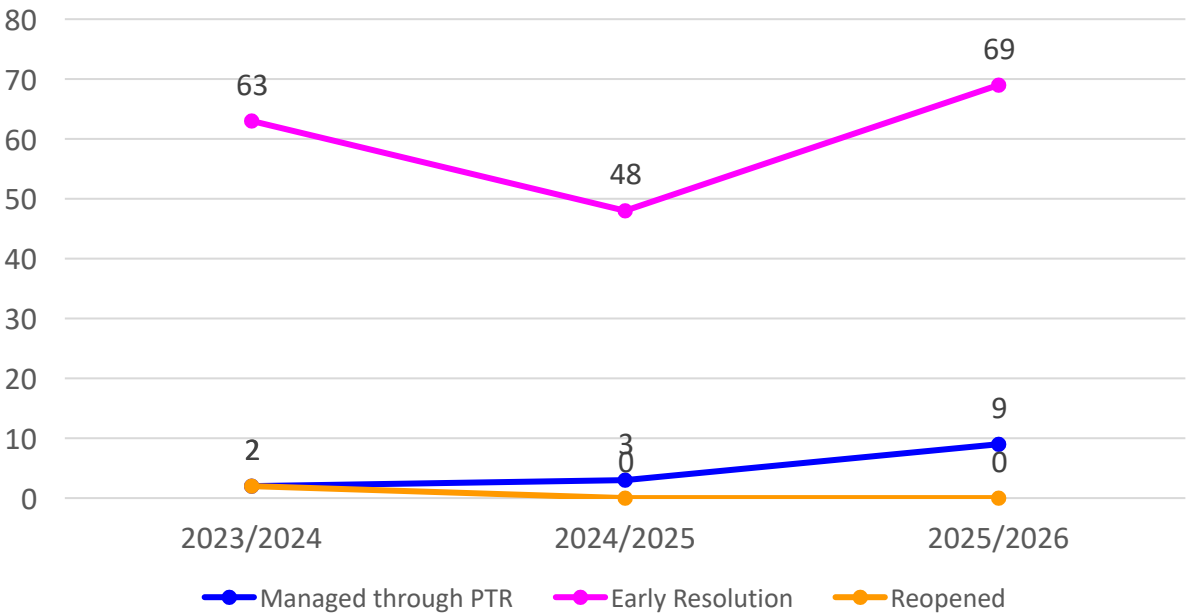
2025-2026



Gwasanaeth Gwaed Cymru
Welsh Blood Service

Graph 1

Welsh Blood Services – Complaints Received by type
2023 - 2026



LEARNING AND OUTCOMES

Further learning and improvement areas following concerns have led to:

- A rise in formal PTR concerns was noted during the reporting period. Review showed that staff were unclear about feedback suitable for early resolution and those to be managed under the PTR process, leading to misclassification. Service wide guidance and targeted training was undertaken to provide clarity around the process.
- The WBS noted an increase in concerns relating to the introduction of capillary HaemoCue testing which erroneously flagged a number of donors as potentially anaemic. The majority of these were managed as early resolution concerns. On 08/12/2025, clinics introduced secondary point-of-care testing using a venous sample to provide a more accurate haemoglobin measurement. This change has enabled more donors to continue with donation and has reduced the concerns associated with capillary HaemoCue testing
- Operational Managers ensure that when the start of a donation session is delayed, donors with later appointments are contacted, where possible, to reschedule, helping to minimise inconvenience.
- The Donor Contact Centre Team Leaders have introduced an extra measure in their process to identify duplicate donor records.
- Workforce teams have delivered training across Blood Donation Services focused on managing difficult conversations. This initiative aims to strengthen staff confidence and improve the quality of donor interactions.

ANALYSIS

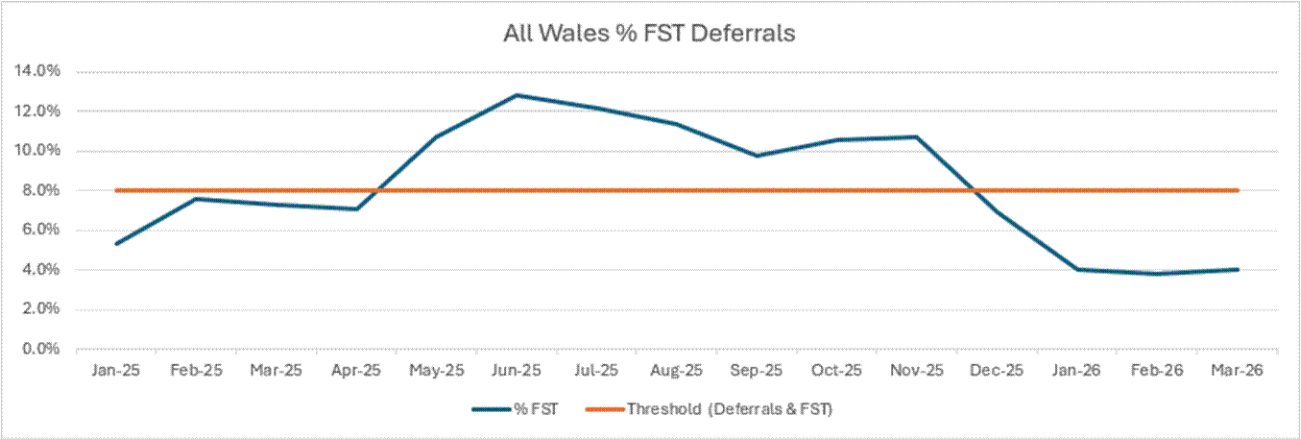
These concerns continue to be spread across a variety of teams and locations.

- During this reporting period 88,692 donors were registered at donation clinics meaning 0.09% of donors raised complaints.
- 69 early resolution concerns were raised; all acknowledged within 2 working day timeline
- 9 formal concerns were raised; all were closed within the required timeframe. This is a significant increase based on the 3 formal concerns recorded in 24/25
- No complaints were reopened.
- The main themes and opportunities for improvement related to **attitude & behaviour, communication, appointments, clinical assessment & treatment/procedure.**

	Managed through PTR	Early Resolution	Reopened
2023/2024	2	63	2
2024/2025	3	48	0
2025/2026	9	69	0

LEARNING AND OUTCOMES

Graph 2



Since, clinics introduced secondary point of care testing using a venous sample to provide a more accurate Haemoglobin (Hb) measurement in December the WBS has not received further concerns relating to this theme. This is a testament to the hard work and dedication by the Clinical Services Team.

Failed Screening Test (FST) Deferral Rates and Point of Care Testing:

As shown in graph 2, the All-Wales FST deferral rate continued its downward trajectory, reducing to 4% in January, compared with 6.9% in December, demonstrating ongoing improvement and the sustained effectiveness of venous sampling in supporting safe and appropriate donor selection.



The Welsh Blood Service values all donor feedback received in helping understanding both successes and further opportunities to improve. We capture, analyse and trend our donor experience feedback, and share it, along with actions taken in response, with our donors, their families and staff in line with the requirements of the Duty of Quality. These are the results of the Civica Surveys and digital on-session feedback forms.

October 2025 saw the implementation of the Peoples Experience Survey (PES). This reporting period encompasses a mixture of the compliments and concerns survey up until the introduction of PES. **11,866 (13%) donors provided feedback during this period with an overall satisfaction score of 98%.**

**11,866 donors
provided
feedback**

For noting The introduction of the PES survey set up a benchmark of 85%, while the Compliments and Concerns survey was set at a higher benchmark of 95% as evidenced in the attached chart.

Responses	1 - On a scale of 1-5 how satisfied are you with your overall experience within the collection clinic to	2 - Was the time you waited:	2 - Based on today's visit did you find staff welcoming & friendly?	3 - Did you feel well cared for?	3 - Based on today's visit did you find staff helpful & knowledgeable?	4 - Were you treated with dignity and respect?	4 - Based on today's visit did you find staff professional, compassionate & caring?	5 - Based on today's visit do you feel you were treated with dignity & respect?	6 - Were you able to communicate in your preferred language?	6 - Based on today's visit were you provided with enough information about the donation process?	7 - Did you feel that you were listened to?	7 - Based on today's visit did you receive adequate emotional & physical support?	8 - Were you involved as much as you wanted to be in decisions about your care?
	Compliments and Concerns Wrexham Team	Welsh Blood Service People's Experience Survey (PES)	Compliments and Concerns Wrexham Team	Welsh Blood Service People's Experience Survey (PES)	Compliments and Concerns Wrexham Team	Welsh Blood Service People's Experience Survey (PES)	Compliments and Concerns Wrexham Team	Compliments and Concerns Wrexham Team	Welsh Blood Service People's Experience Survey (PES)	Compliments and Concerns Wrexham Team	Welsh Blood Service People's Experience Survey (PES)	Compliments and Concerns Wrexham Team	Welsh Blood Service People's Experience Survey (PES)
11866	98	95	100	99	100	100	100	100	98	100	99	100	99
Overall	98	95	100	99	100	100	100	100	98	100	99	100	99
Benchmarks	95	85	95	85	95	85	95	95	85	95	85	95	85



Based on feedback received:

Iron testing accuracy and donation deferrals

Concerns raised by donors about iron testing accuracy and unnecessary deferrals were evident in survey feedback during autumn 2025. Secondary point of care testing using venous samples was introduced in December 2025. Subsequent monitoring confirmed that no further donor concerns were raised following implementation, demonstrating a rapid and effective response within one reporting cycle.

Attending donation sessions with children

Feedback about inconsistencies when attending donation sessions with children was reviewed through Operational Services Group discussions during late 2025. A clear, standardised national approach was agreed and implemented from 5 January 2026, providing clarity for donors and consistency across all venues within the same financial year.

Online donor eligibility quiz

Donor feedback relating to confusion with the online eligibility quiz was identified through recurring themes in surveys during summer and autumn 2025. Improvements to the wording, structure, and navigation of the quiz were implemented during the year. Monitoring through survey results and complaints data indicated a reduction in concerns following these changes.

Travel and medical eligibility assessment

Complexity around travel and medical eligibility assessments was identified through donor feedback and learning from incidents during the year. Development of a digital travel risk assessment tool progressed during the reporting period, with phase one delivered in line with governance approval and further development planned.

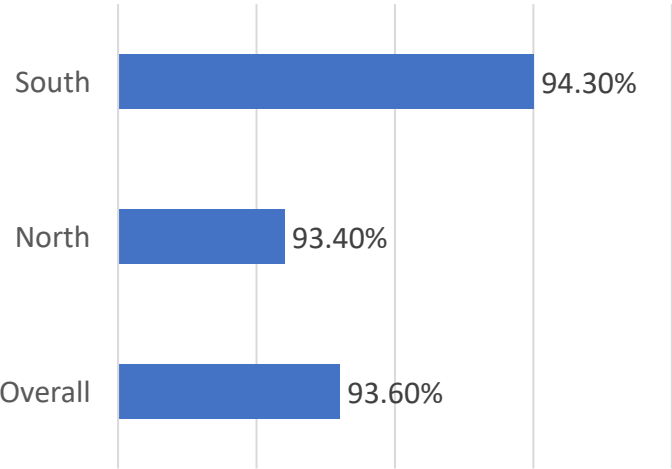
Welsh Blood Service undertakes a monthly email survey to evaluate donor satisfaction from initial contact to post-donation experience. The goal is to improve donor retention. Survey results are reviewed, and the overall satisfaction score is reported to the Welsh Government.

1 | Satisfaction statistics

As part of our questionnaire, we asked respondents a number of questions about the service we provide. Respondents are asked to score these services, from June 2025, the scoring changed from 1 to 6, to 1 to 10, allowing the WBS to measure itself against other services.

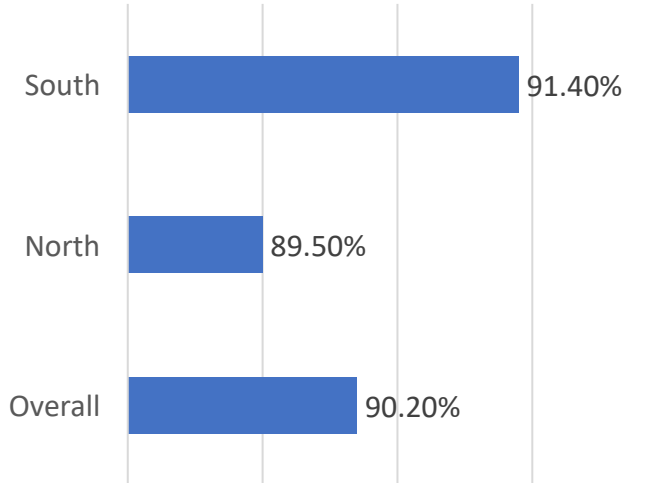
Donor satisfaction for those who had successfully donated was 93.6%.

Graph 3



Donor satisfaction for every respondent, including incomplete donations.

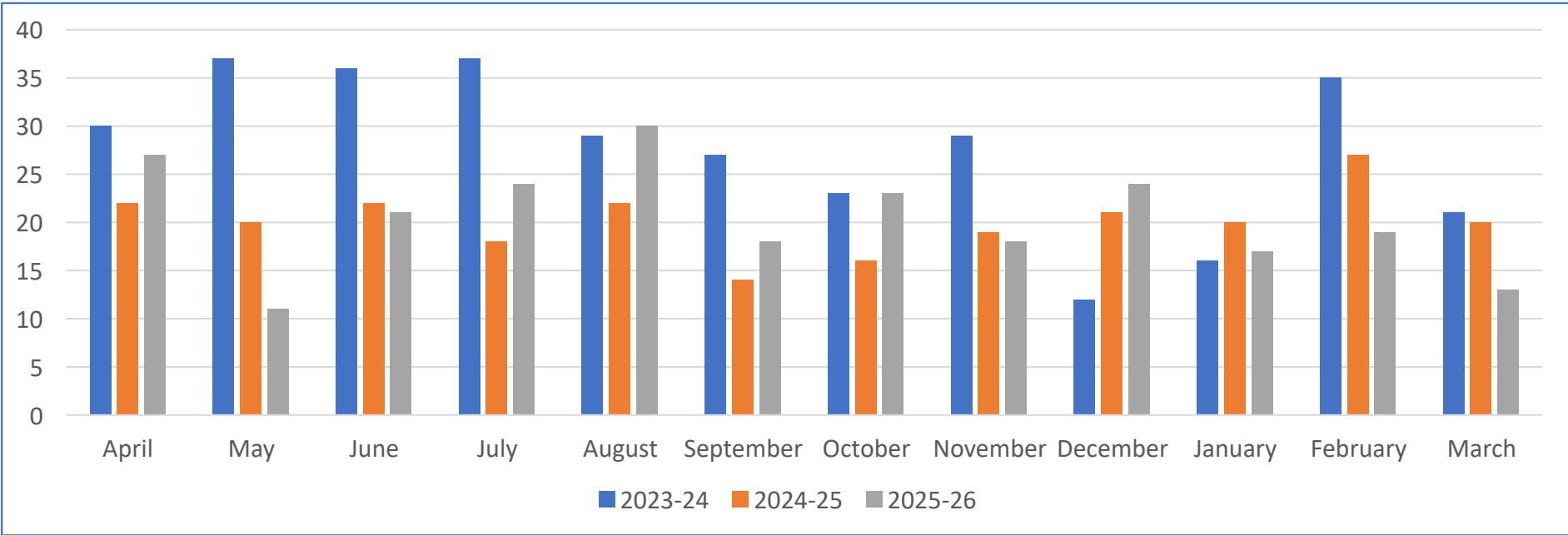
Graph 4



Donation day		
Donation day experience	Process comfort	Process duration
96.2%	96.6%	97.8%
Donor engagement and sentiment		
Contact centre experience	Feeling valued	Eligibility info. available
96.3%	96.3%	95.0%
Venues		
Cleanliness	Accessibility	
97.2%	95.7%	

Incidents which may result in harm to donors, patients, or staff are reported in Datix Cymru for consistency across the Trust.

Graph 5: New incidents reported via Datix each month



ANALYSIS

Graph 5

Incident reporting via Datix shows variation month on month, with no identifiable trends. For 2025-26 the peak was in August (n=30) In 2024-25 the peak was in February (n=27) and in 2023-24 the peaks were in May and July (n=37).

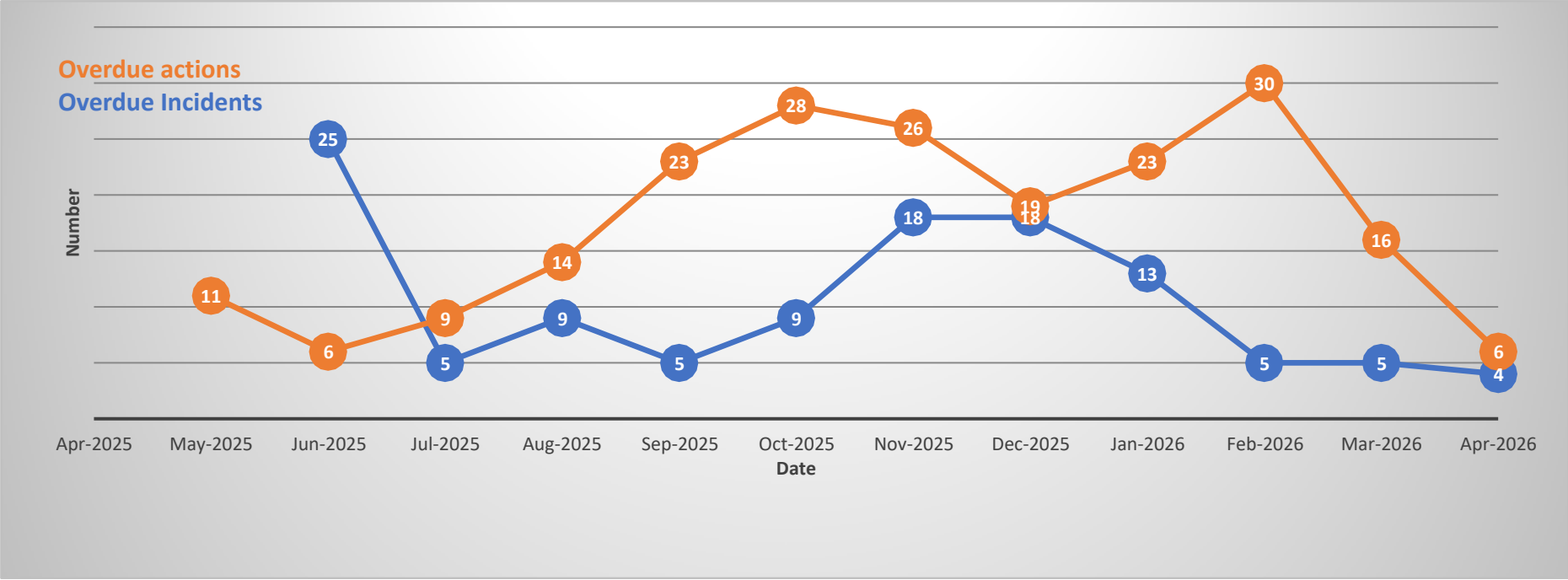
Overall, the number of reports for the financial year 2025-26 is low (n=254), this is comparable with 2024-25 (n=241) but also significantly fewer than 2023-24 (n=332). This is mainly attributable to fewer accidents/injuries and donor assessment errors (see slide 13, graph 7)

The main category reported in 2025-26 is accident and injury (n=55) (see graph 7).

The only significant trend relates to donor eligibility assessment (see slide 17).

Monitoring of reports for trends is continuous.

Graph 6 Trend of overdue incidents and actions



ANALYSIS: OVERDUE ACTIVITY PERFORMANCE TRENDS

The number of incidents exceeding target date for closure (30 days) has been reported since July 2025 (KPI. 35). These events are reported to Senior Leadership Team for follow up with the relevant incident manager. Where necessary, actions are reassigned to staff with capacity to address delays. Incident Managers reported confusion with managing reports through Datix stages and were occasionally unable to close a report within the system. These challenges have been addressed and there has been a steady improvement since the beginning of 2026, with an action plan in place to support sustained improvement.

Overdue actions fluctuate from month to month and often reflect a high workload versus staff availability; occasionally a single event may result in one person managing several actions to address root cause.

LEARNING AND OUTCOMES



A concern was raised with SLT about the upward trend in incidents overdue for closure.

This resulted in an action plan being devised to address the backlog of overdue reports and ensure regular engagement with incident owners to understand and manage challenges.

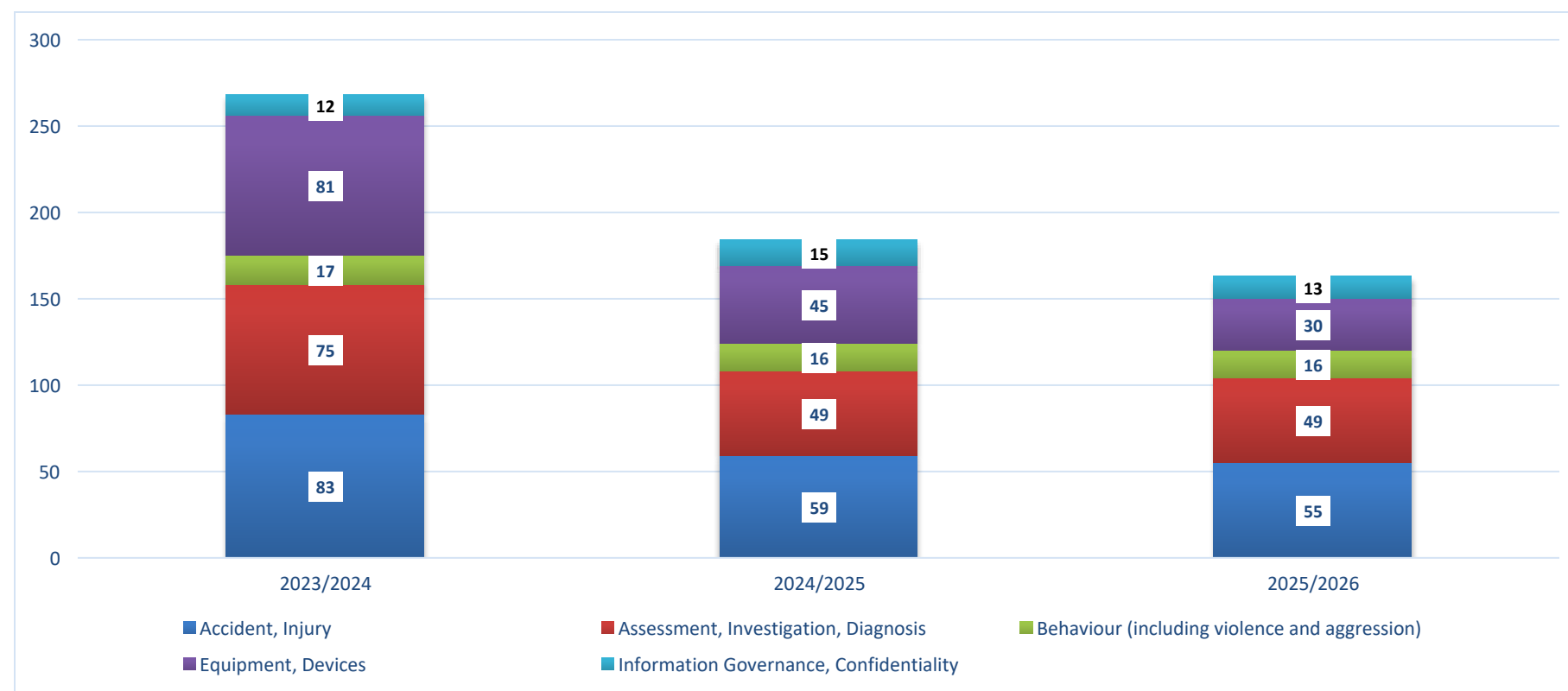


A 'Bite Sized' learning session was held for staff, to ensure responsibilities for managing reports through Datix is understood. The feedback from this event was positive.



Managers must assess risk and submit a formal extension request where actions have been open longer than expected.

Graph 7 WBS Incidents by theme – year on year comparison



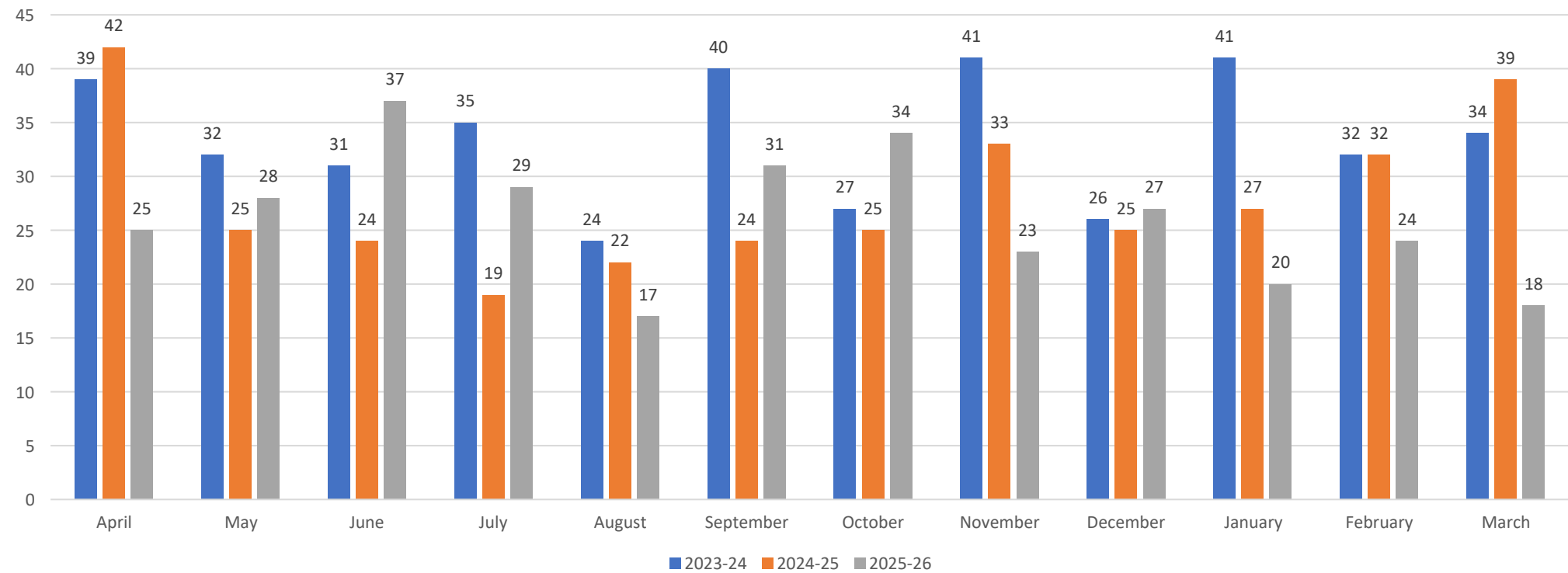
ANALYSIS

The top 3 event categories for 2025 and 2026 are in keeping with previous years, although there are fewer reports within these categories year on year:

- **Equipment & Devices (purple):** These errors are often isolated to a piece of equipment (no trend). Where operator error is involved, these events are trended against individuals to ensure there are no competency/training issues. No common themes were identified.
- **Assessment, investigation, diagnosis (red):** These events usually relate to ‘late donor information’, which is subjective to each donor, and occasionally to donor acceptance errors where staff have made an incorrect decision regarding donor eligibility. Where there is a risk to patient safety these events are fully investigated and reported to MHRA as a serious adverse event (see slide 17).
- **Accidental injury (blue):** Information on accidental injury reports can be found in the Health and Safety section of the report.

Good Manufacturing Practice (GMP) Incidents are reported into the Q-pulse electronic Quality Management System and monitored as a critical part of the overall Quality Management System (QMS), in line with regulatory standards.

Graph 8 GMP Incidents reported via QPulse



ANALYSIS

The number of GMP incidents reported across any year is subject to variation. A positive reporting culture is reflected in reports being submitted across a broad number of departments/laboratories and there is no identifiable reason for the fluctuation in numbers.

From January 2025 there has been a trend in manual transcription errors, reported by the RCI Laboratory. These events have been subject to a holistic root cause analysis investigation, barrier analysis and 7 Levels of Assurance review (see slide 17). Further analysis of mitigating actions was undertaken in Q4; this highlighted that some have been effective whilst others are yet to embed fully. Root cause is linked to system level limitations.



LEARNING AND OUTCOMES

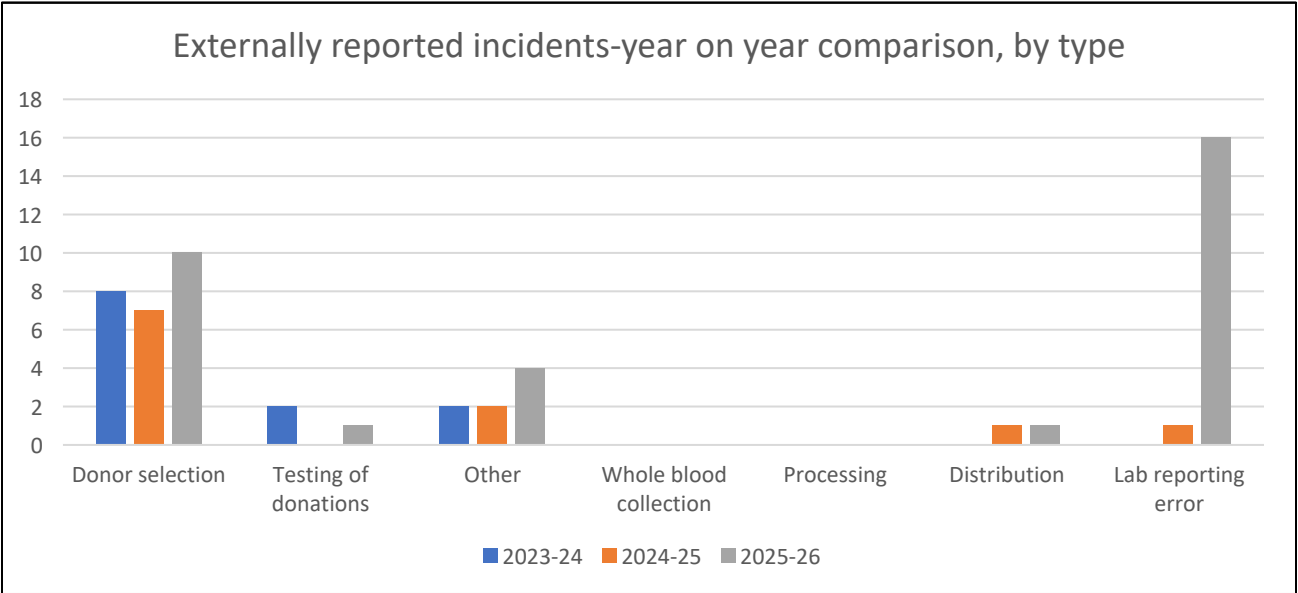
Transcription errors are not unexpected where manual processes are involved, however the complexity of manual reporting processes, combined with an ageing and underdeveloped IT system, and an inadequate verification process have been identified as the main causes of these errors. Contributory factors include high workload and operational pressures, working environment, senior staff changes and skill gaps (caused by absence of experienced staff). To address these issues the following actions were undertaken:

- A designated quiet area for report writing and authorisation has been implemented
- A temporary digital solution has been implemented
- A two-person writing and authorisation process has been adopted
- Workloads have been reallocated where necessary
- New staff have been recruited to support the operational workload within this laboratory.

As manual transcription errors continued to be reported after the above actions were implemented, additional action was taken:

- The Red Cell Immunohaematology (RCI) Laboratory processes for linking and reporting have been independently reviewed
- There was a detailed analysis of RCI Laboratory incidents occurring between July 2025 and January 2026, along with a second 7 Levels of Assurance effectivity review of mitigating actions that were already in place.

Conclusion: Further improvement will require system-level redesign, enhanced digital integration, and controls that reduce dependence on manual transcription and prolonged concentration. The introduction of an all-Wales Laboratory Information Management System (LIMS) is expected to significantly reduce this type of error.



ANALYSIS

55 adverse events have been reported to Medicines & Healthcare products Regulatory Authority (MHRA) via the Serious Adverse Blood Reactions & Events (SABRE) portal since January 2023. The numbers reported for 2023-24 (n=12) and 2024-25 (n=11) are comparable, with the largest number being attributable to donor selection errors. The total number of reports submitted for 2025-26 is significantly higher (n=32) with the majority of these being attributable to manual transcription errors reported by RCI laboratory. Details of a thematic analysis are included in slide 18.

Also to note: In April 2026, there was a failure of the WBS Blood Establishment Computer System (BECS) which affected operational activity for several days. This was successfully managed via the Emergency Planning process which enabled operational activity to continue whilst an investigation and recovery programme were undertaken. MHRA were informed and have received updates about the investigation and recovery process.

ANALYSIS

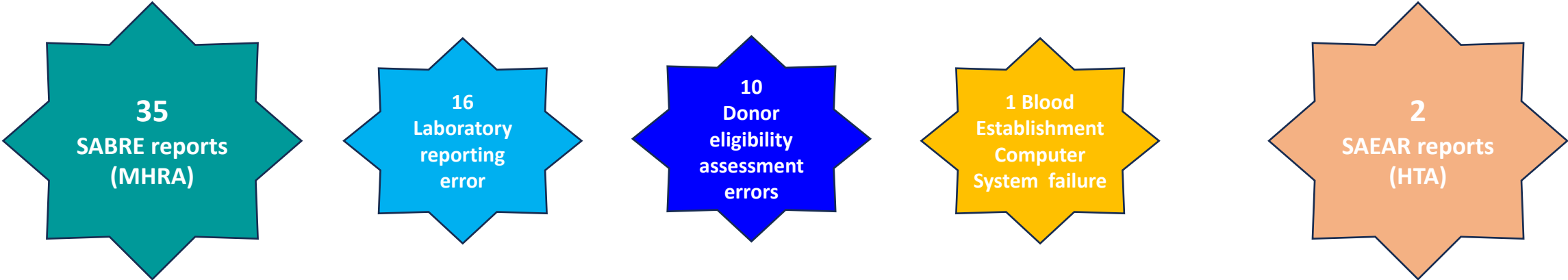
35 adverse events were reported to MHRA via the Serious Adverse Blood Reactions & Events (SABRE) portal in the past year compared with 18 the previous year. Key themes are illustrated below.

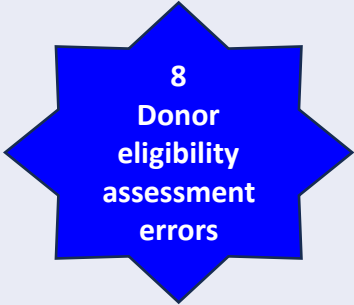
2 serious adverse events (SAEAR) were reported to the Human Tissues Authority (HTA), but no trend was identified. One of these events originated outside of WBS but reported by the WBMDR when they were informed by the external registry.

All events were reviewed and investigated, and root cause analyses and corrective actions have been reviewed by relevant members of the divisional Integrated Quality and Safety Hub before submission to the Regulatory body.

Also to note: There was a failure of the WBS Blood Establishment Computer System (BECS) which affected operational activity for several days. This was successfully managed via the Emergency Planning process which enabled operational activity to continue whilst an investigation and recovery programme were undertaken. MHRA were informed and have received updates about the investigation and recovery process.

Key themes for 2025-26



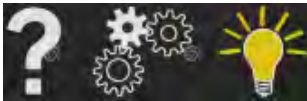
Theme	Outcome/Improvement
Transcription errors on manually generated patient reports issued to customer hospitals 	Root causes are linked to system-level design limitations rather than staff performance or isolated workflow issues, and therefore long-term risk reduction is unlikely to come from training or small workflow changes alone. However, a series of practical improvements have been proposed by staff, to aid risk reduction. The risk aligns with risk nos. 2774 and 3643 on the Trust Risk Register. Further improvement will require system-level redesign, enhanced digital integration, and controls that reduce dependence on manual transcription and prolonged concentration. The introduction of an all-Wales Laboratory Information Management System (LIMS) is expected to significantly reduce this type of error
Donor eligibility assessment errors (travel history, medication, animal bites) 	The number of errors made in relation to the number of donors bled remains small; nevertheless, each event poses a potential risk to patient safety if not managed effectively. The WBS lookback and product recall process ensures any risks are mitigated quickly and effectively. Donor assessment complexities continue to be discussed at national level, to try to address the challenges of eligibility queries and explore ways to empower staff with the tools and guidance necessary to make accurate assessments. Trial of a digital tool that allows donors to verify their travel history and, in time, their medication; this will reduce reliance on memory and verbal communication.

Chapter 2:

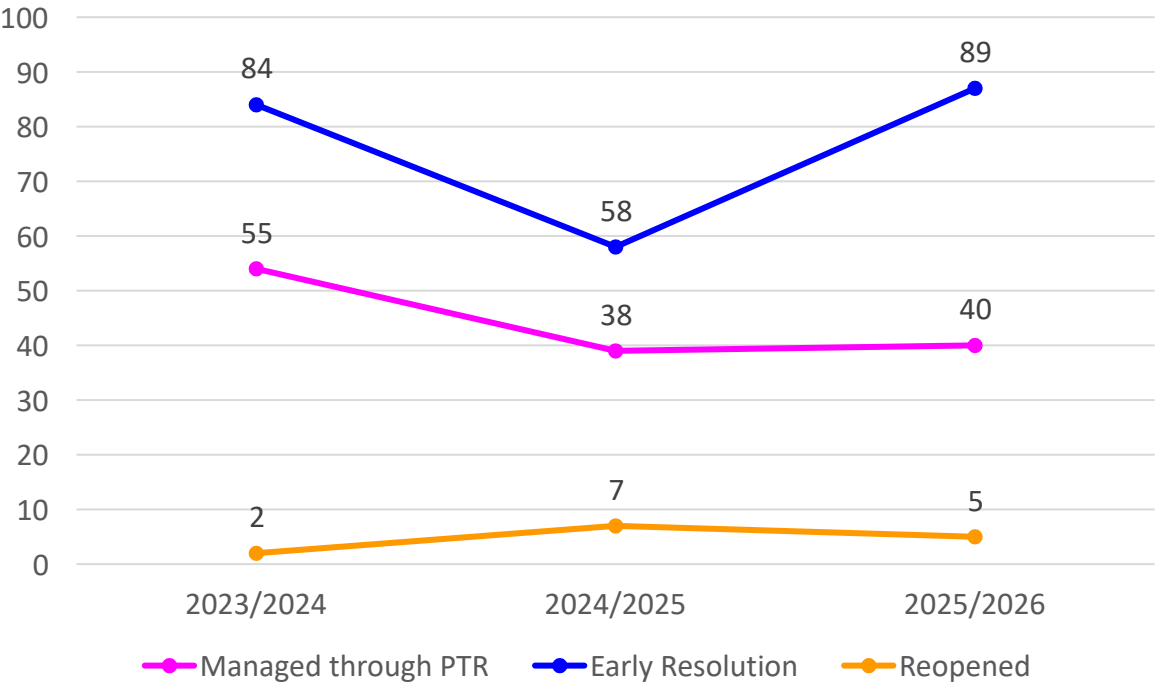
Velindre Cancer Service

2025-2026





Graph 1 Velindre Cancer Service – Complaints Received by Type
2023 - 2026



Complaints

Graph 1:

- There has been an overall increase in the number of complaints received in the past year compared to 2024/2025. The most common reason for complaints remains related to communication of appointments and difficulty contacting departments. The Trust conducted a Pain Point Review into these concerns and work is underway to address the issues.
- **126** complaints were received in total (0.64% of patient attendances)
- **5** complaints were reopened where complainants were not satisfied with their final response. In person meetings have been offered and concerns reviewed. All template letters have been reviewed and amended to improve the quality of the content and layout ensuring they meet the requirements of accessibility.
- **8** concerns identified a breach of duty of care, 2 of which resulted in potential harm.

	Managed through PTR	Early Resolution	Reopened
2023/2024	55	84	2
2024/2025	38	58	7
2025/2026	40	89	5

Complaints received at Velindre Cancer Services
by subject from 2023 - 2026

Graph 2



ANALYSIS

- As shown in **graph 2**, communication issues continue to be the main theme of the Cancer Service complaints in 2025/2026, specifically around outpatient and Systemic Anti Cancer Therapy (SACT) appointments .
- Concerns relating to information regarding treatment plans and prognosis, and how this is communicated in consultations has also been identified as a theme.

LEARNING AND IMPROVEMENTS IDENTIFIED FROM VELINDRE CANCER SERVICE COMPLAINTS

- New and expanded services at Velindre@Nevill Hall Radiotherapy Unit has improved access to care closer to home, reducing travel burden and stress for patients. Developments included Systemic Anti Cancer Treatment (SACT) capacity, new patient clinics for colorectal, breast and palliative radiotherapy, and increased consultant and specialist medical presence on site.
- Introduction and expansion of nurse-led and independent prescriber-led clinics.
- Clinic and GP letters are now routinely sent to patients (with consent), enabling patients and families to revisit and better understand their care and treatment plans. This change supports improved understanding of diagnosis, planned treatment, and monitoring and demonstrates organisational learning from concerns.
- A reduction in appointment-related concerns was achieved following improvements within the SACT Bookings Team. While improvement was evident, emerging capacity challenges were identified again in Quarter 4 and are being actively managed.
- Virtual Assessed Pathway (VAP) clinics have expanded capacity by 20% compared to last year through expansion to new cancer sites such as Hepatobiliary, Upper Gastrointestinal, and Lung and taken on new regimens within existing Site-Specific Team's
- A Standard Operating Procedure for the management of acutely unwell patients in outpatient and day-case areas was developed to strengthen patient safety and senior oversight. Velindre Cancer Service (VCS) team have been leading on 'Call for Concern' implementation nationally. The Acute Physical Deterioration Implementation (APDI) Network have proposed using VCS materials to help standardise Call 4 Concern branding nationally.
- VCS identified a theme regarding patients experiencing delays within outpatients and communication issues, and as such have embarked on a full outpatient transformation programme. It supports improved patient satisfaction, delivering a modern outpatient service and preparing for new ways of working as we get ready to move to the new VCC. Supporting patients, minimising any delays and providing effective communication on their plan is the utmost priority.

Patient experience was captured primarily through the All Wales Patient Experience Survey (PES), with a transition from local Friends and Family surveys early in the year. This shift has strengthened consistency, comparability and future equity analysis across services.

Patient feedback increased significantly across the year, with responses rising from under 400 per quarter at the start of the year to over 1,000 per quarter by year end. Targeted actions included collaboration with Communications, hospital volunteers, patient engagement leads and the Patient and Carer Partnership Board. Approximately 9.4% of patients attending scheduled appointments provided feedback, reflecting sustained improvement in engagement.

Service-level learning and improvement

Bespoke surveys were introduced to support evaluation of specific services, pathways and improvement initiatives.

Key patient experience themes

Recurrent themes included communication around appointments, access to services via telephone, and the clarity of written information. In triangulation with learning from concerns received, these insights have informed quality improvement priorities across clinical teams.

Closing the feedback loop

Patient feedback directly influenced service changes, with clear “You said, we did” actions implemented and communicated.

Patient stories are now routinely shared through Quality and Safety meetings to support learning and assurance.

Looking ahead

Continued focus will be placed on increasing engagement, strengthening analysis, and embedding patient experience intelligence within quality improvement and decision-making frameworks.

	Responses	3 - Was the time you waited:	4 - Did you feel well cared for?	5 - Were you treated with dignity and respect?	7 - Were you able to communicate in your preferred language?	8 - Did you feel that you were listened to?	9 - Were you involved as much as you wanted to be in decisions about your care?	10 - Were things explained to you in a way you could understand?	11 - How would you rate your overall experience?	Overall
Directorate		People's Experience Survey (PES)	People's Experience Survey (PES)	People's Experience Survey (PES)	People's Experience Survey (PES)	People's Experience Survey (PES)	People's Experience Survey (PES)	People's Experience Survey (PES)	People's Experience Survey (PES)	
Acute, inpatient & palliative medicine	641	89	97	98	99	96	95	96	96	96
Radiation services	420	93	97	99	100	98	96	97	97	97
SST Services	582	79	92	95	98	93	92	93	92	92
Systemic Therapies	1302	92	96	98	99	96	94	94	95	95
	Overall	89	95	98	99	95	94	95	95	95
	Benchmarks	85	85	85	85	85	85	85	85	

Question 3: Was the time you waited:

Available Answers	Responses	Score (%)
Much shorter than expected	109	19.19%
A bit shorter than expected	58	10.21%
About right	258	45.42%
A bit longer than expected	96	16.90%
Much longer than expected	47	8.27%
Total	568	100%

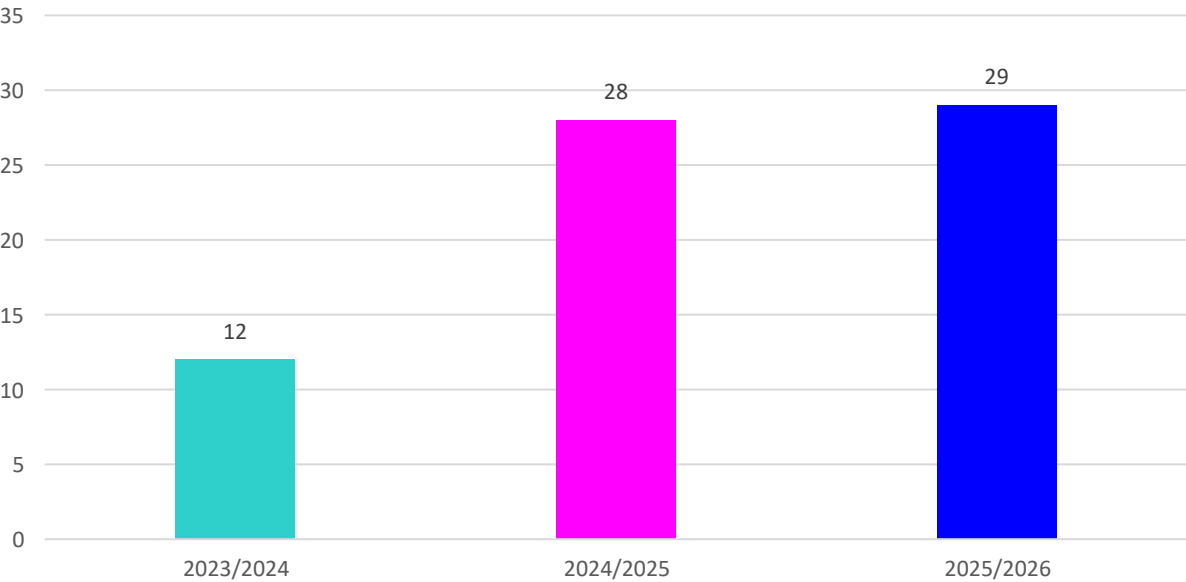
Waiting times continue to result in the lowest satisfaction score. Improving patient waiting times is a key element of the outpatient transformation plan. The Outpatient Department is utilising volunteers to support patients and keep them informed if clinics are delayed.



You said	We did
'Results from the lab are slow'	We will ensure patients are notified may take longer during busier periods
'The coffee shop closes a 2:30pm which is too early when people are still waiting for their appointment'	We have listened to your feedback and have extended the opening times until 3.45pm
'Does everyone need to be in one waiting room? Doesn't feel like the most patient centred solution'	New reception desk is in place which opens up the waiting room, provides more space and lighting
'Convenient access to light refreshments for patients and companions'	The coffee shop in Radiotherapy waiting area has now re-opened
'The bins are too noisy when open and closed on the ward'	We have requested soft closing bins from estates
'Talking about my personal information on the ward (handover), I did not want to listen'	Thank you for highlighting this, we have since revised the way we handover

Graph 3

Significant Accidental or Unintended Exposures reported under IR(ME)R from 01/04/2023 - 31/03/2026



Radiotherapy Physics led investigations

- 12 incidents due to repeat on-treatment verification equipment failures on Elekta
- 2 incidents due to repeat on-treatment verification equipment failures on Halcyon accelerator
- 3 incidents due to separate Elekta linac faults resulting in repeated imaging for multiple patients (theme identified)
- 2 incidents due to two separate equipment faults on ETHOS which resulted in repeated imaging for multiple patients (theme identified)
- 1 incident due to IDENTIFY equipment fault resulting in repeat imaging.

Analysis

As shown in graph 3, the number of radiotherapy events has increased since 2023. This is mainly because the reporting criteria changed in August 2024, meaning some equipment failures that affect more than one person now have to be reported to HIW, even if each individual risk is very low. Some of these incidents have also been linked to known imaging faults in new equipment. Although the risk of harm to each patient is low, they still meet the reporting threshold. A number of these issues are expected to be resolved through the equipment upgrade programme planned for summer 2026, and they have also been reported to the MHRA.

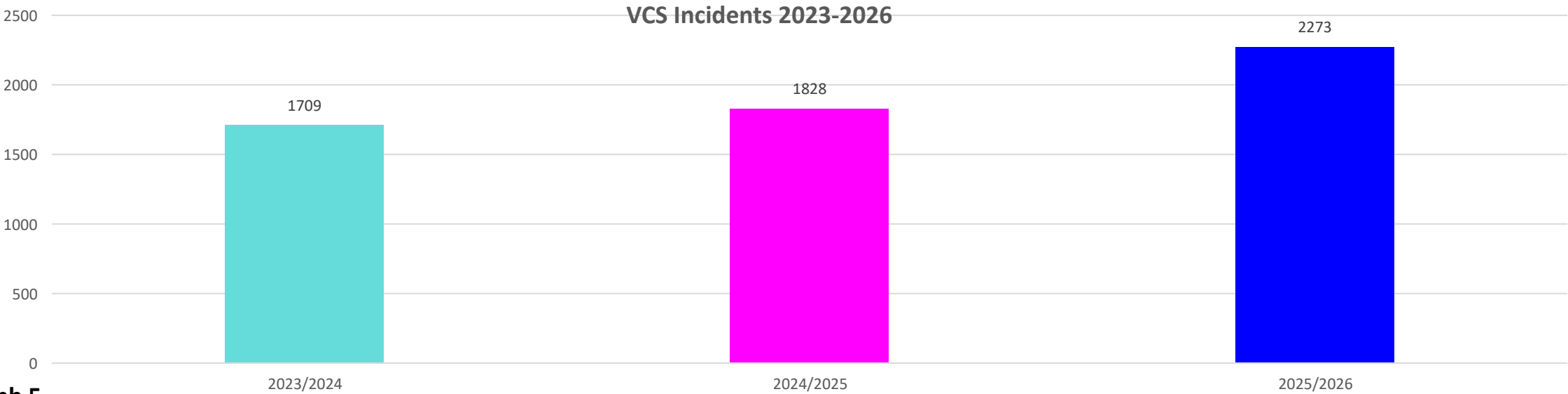
Learning Identified

- 29 Significant Accidental or Unintended Exposures (SAUE) under the Ionising Radiation (Medical Exposure) Regulations IR(ME)R were reported to Health Inspectorate Wales (HIW)
- RT Physics have long standing mitigations to deal with the Elekta imaging fault, which have been discussed in depth with the UK Health Security Agency (UKHSA). This will improve when the Linacs are replaced.
- RT Physics incidents are due to known equipment faults that result in repeat imaging and although meet reporting criteria would not be considered clinically significant. Relevant risk assessments have been completed and are available on datix.

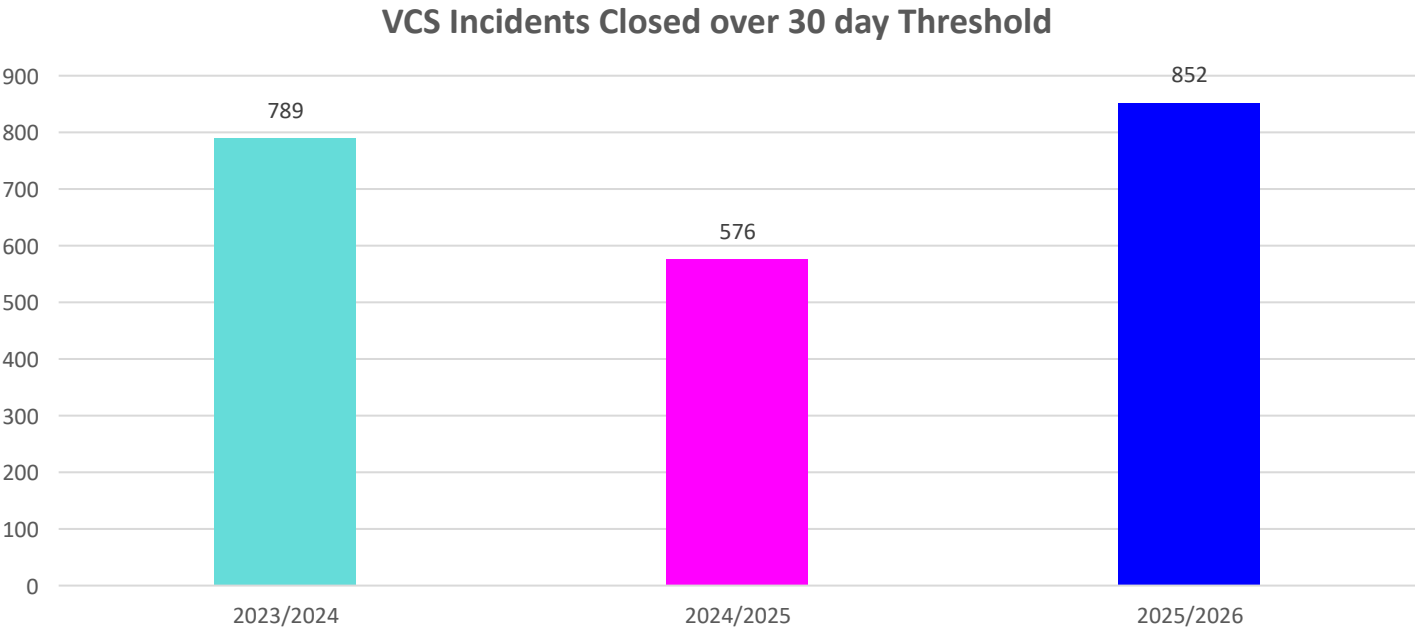
Radiotherapy Service led investigations:

- 4 incidents were unintended On-treatment verification exposures.
 - 2 incidents were accidental planning CT exposures.
 - 1 incident was for multiple patients where a theme had been identified over a number of incidents in respect to online treatment verification image evaluation.
- Sarcoma SST – clinically significant unintended or accidental exposure**
- 1 incident due to incorrect target volume delineation

Graph 4



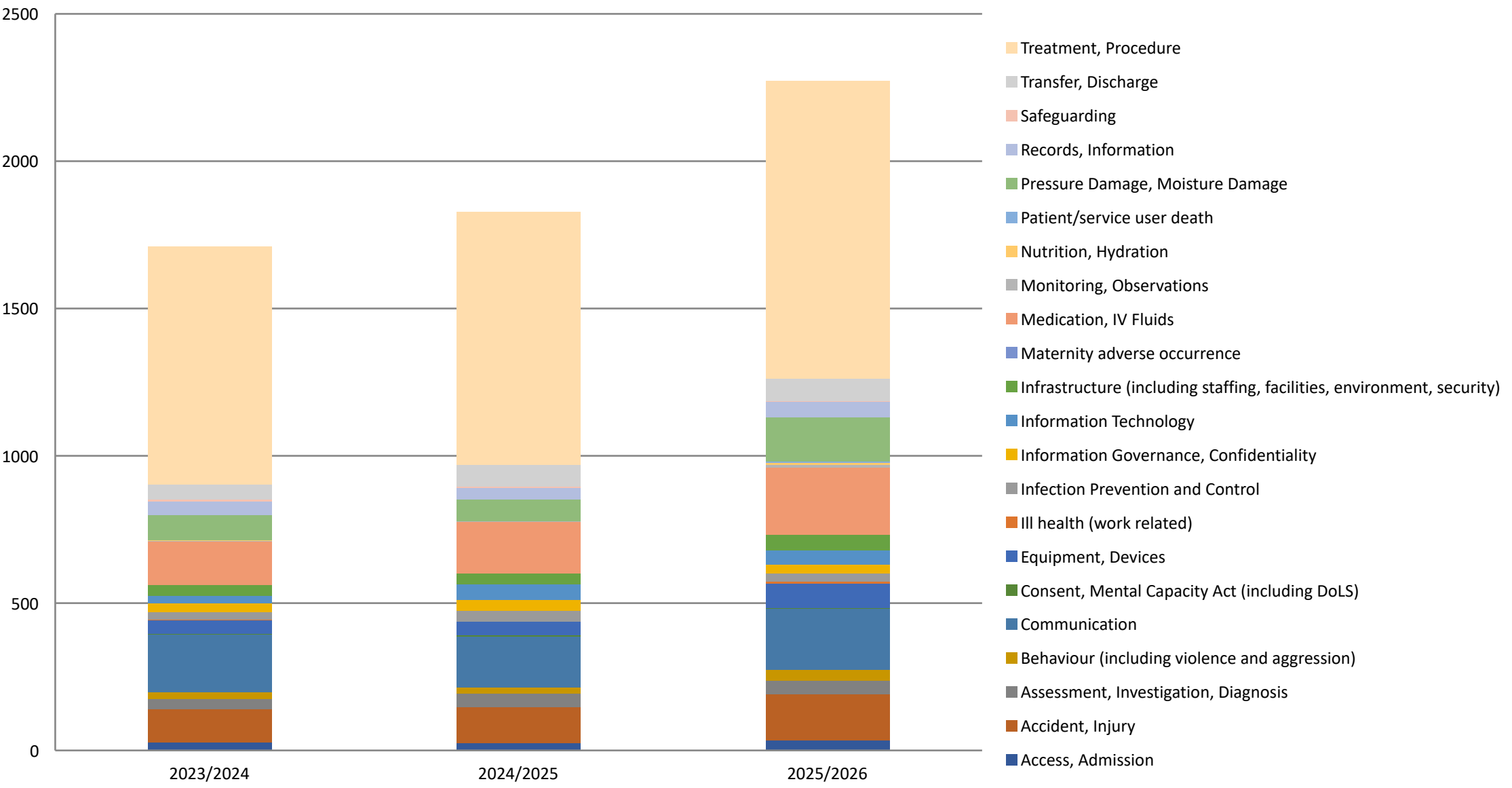
Graph 5



Graph 5 Work is ongoing within Directorates and individual services to improve the timely closure of incidents. The latter months of this financial year has seen a significant improvement across all areas, with weekly assurance to the VCS Triumphant on status, and working with Radiation services to easily identify which incidents are 30, 60 or 90 days for investigation (dependant on external reporting factors), which will give a more transparent picture.

54 incidents remain open over 30 days.

Graph 6 Velindre Cancer Service – Incidents by Classification 2023-2026



- A series of incidents have been raised concerning patients that have not been booked for follow up. Only one incident has resulted in harm, and the majority of patients have appropriately not required a follow up appointment, however due to current reporting this is not evident until a manual review of each case is undertaken. A regular process is now in place for the identification and resolution of any patients identified as potentially follow up not booked – VCS is working with Data and Insights team on developing a robust reporting tool to enable focused and targeted management and review of this cohort of patient
- Targeted education delivered by nursing, palliative care, pharmacy, and medical colleagues, on the prescribing, reconciliation, and administration of opioid medication, including an education video shared with all clinical staff and available online, was undertaken following an emerging theme of opioid related medication errors on the In-patient ward at VCS
- In response to themes emerging from incidents and concerns relating to the co-ordination of Supportive Treatment (Blood Transfusions, Magnesium infusions, iron infusions) at VCS, bookings will now be undertaken by the Ambulatory Care Co-ordinator instead of the SACT bookings team. In addition, work is being undertaken to review the Ambulatory bookings process, and a move to a more digital solution to move away from e-mails.
- A theme was identified surrounding incidents relating to Radiotherapy requests, co-ordination, and communication. Radiotherapy department are updating training and competency packages, revising the radiotherapy quality assurance checks, and reviewing ARIA paperless process.
- During 2025/2026, Velindre Cancer Service experienced a high level of pressure damage developing or worsening during inpatient admissions, with many cases deemed avoidable due to gaps in documentation and equipment use. Encouragingly, incidents reduced in Quarter 4 and no pressure damage exceeded Grade 2. Improving pressure damage prevention and management is a key priority for 2026/2027, supported by new mattresses, improved guidance, increased staff training, designated champions, and strengthened care planning, with plans to explore a Service Level Agreement with Cardiff and Vale Tissue Viability Services.
- As part of our Dietetic Service improvement plan, new procedure and guidance has been written for outpatient consultations – both face to face and via telephone, with the intention of improving patient experience by reducing hospital visits, and increasing capacity
- Learning and improvement has been made in relation to the management of Extravasations, with an update of current extravasation policy through benchmarking of national and local extravasation policies and practice.

NATIONAL REPORTABLE INCIDENTS (NRI)

As shown in graph 8, there have been 5 Nationally Reportable Incidents in 2025/26. This is an increase in comparison to 2024/25, which had 2 national reportable incidents. In line with national guidance, 2 incidents out of 5 were reported based on the number of persons affected and opportunity for shared national learning. There was no harm related to these incidents.

Learning Identified

- A full review of the Treatment Helpline, including scope, staffing model, audits, assurance mechanisms, competencies, medical support, process, and any gaps has been initiated. A Consultant Nurse will lead the work and act as Clinical Lead for the Treatment Helpline. Immediate changes implemented have included the triage tool to be re-completed for all call-backs, and amending the triage tool to not pre-populate the symptoms to "green".
- Adherence to Immuno-Oncology (IO) Toxicity Guidelines – ensure all clinical teams can access IO Toxicity guidelines and follow the pathway according to the severity. Also understand British Thoracic Society guidelines on use of Oxygen via a non rebreathe mask.
- Embed and document peer review for complex radiotherapy cases (target delineation and prescription) within ARIA/workflow, supported by job planning and governance oversight.

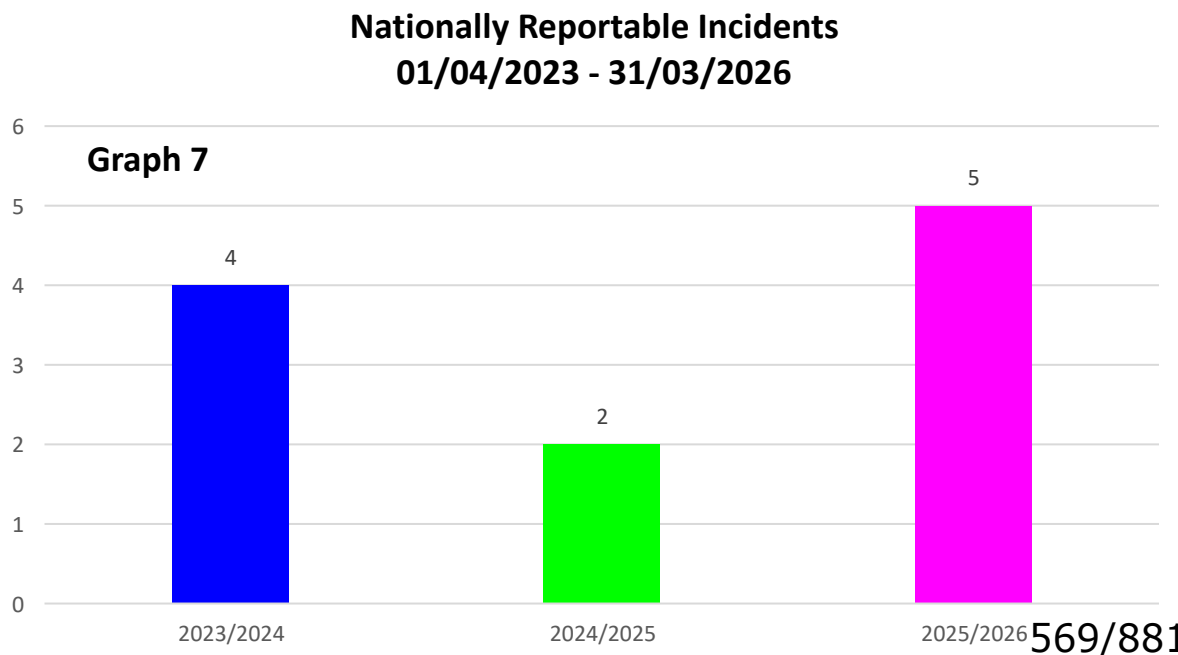
Following the NRI incidents, the Trust undertook in-depth investigations, and developed improvement plans to prevent similar events from occurring.



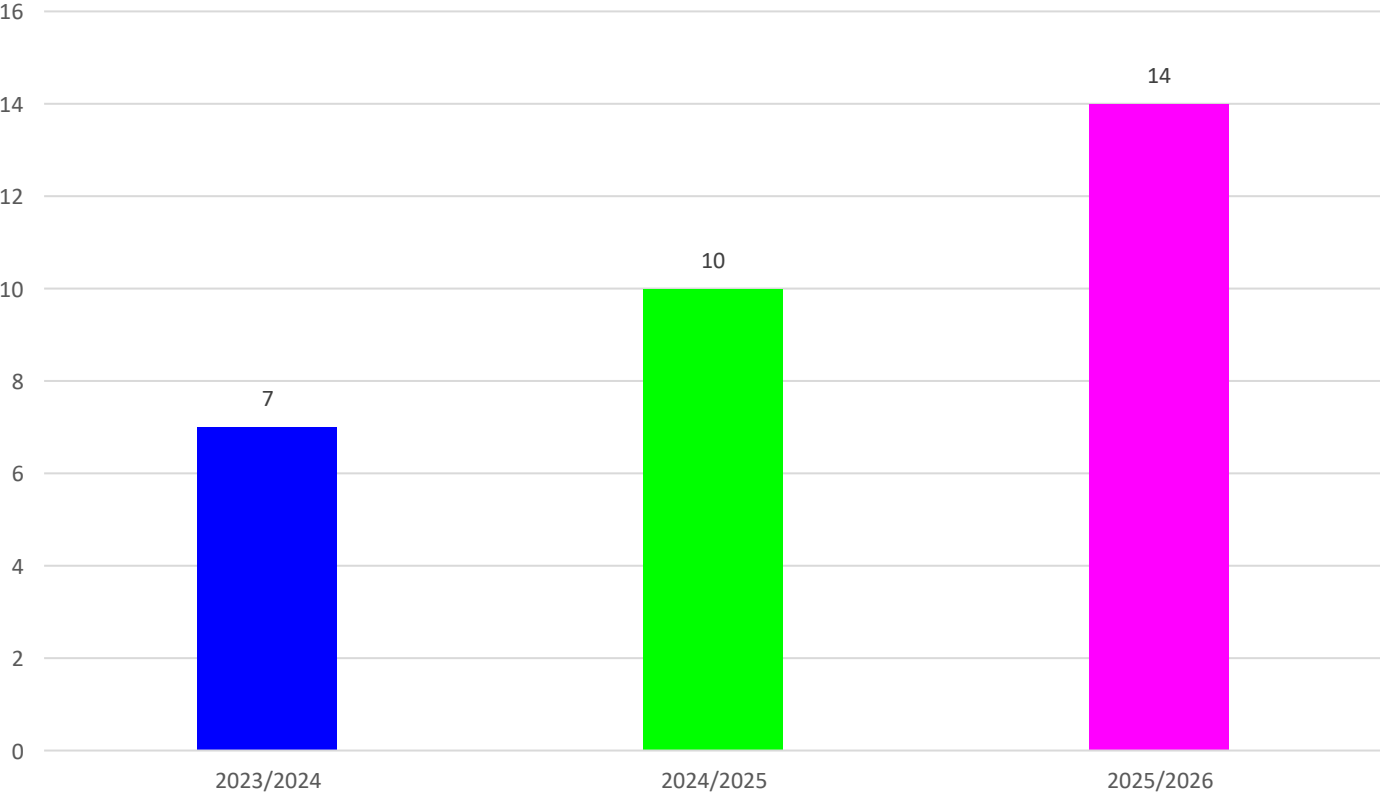
Severe Harm:
A service user experiences a permanent disability or loss of function and the NHS care did or may have contributed.



Death:
A service user dies and the NHS care did or may have contributed to the death.



Graph 8
Duty of Candour Trigger Trust Wide from
2023 - 2026



Since the Duty of Candour was enacted in April 2023 there has been an increase in incidents reported as our processes have become embedded into incident management.

In NHS Wales, the Duty of Candour is a legal requirement for organisations to be open and honest with service users when something goes wrong during their care or treatment, potentially causing harm. This duty stems from the Health and Social Care (Quality and Engagement) (Wales) Act 2020.

Graph 8 shows a gradual increase in incidents triggering Duty of Candour from 2023 to 2026.

An internal audit was undertaken to provide independent assurance that the Trust has appropriate arrangements in place and is effectively implementing the statutory requirements of the Duty of Candour.

The audit findings were shared during Quarter 2. It was concluded that the Trust had **Substantial Assurance** overall.

Due to a programme of continual review some incidents would have been downgraded and therefore data may differ from the figures included in the Quality and Safety Quarter 4 2025-26 Report

ANALYSIS

14 incidents during 2025-26 have been managed under Duty of Candour meaning they potentially caused moderate harm or above, with 3 of the incidents also being reported as a National Reportable Incident meaning they potentially caused severe harm. 7 Duty of Candour investigations were closed, and 5 Duty of Candour incidents are currently under investigation, at the end of 2025-26.

THEMES NOTED

	Theme
1	Communication and Information Flow Failures. Use of email for clinically urgent information instead of robust clinical systems. Poor handover and transfer of care between various services and Health Boards.
2	Booking, Scheduling, and Pathway Coordination. Unreliable booking and pathway coordination in particular: Follow-up appointments, Ambulatory and supportive treatment bookings and referral pathways.
3	Management and Escalation of the Acutely Unwell Patient: Unclear escalation pathways for acutely unwell patients, patients being managed in areas not equipped for acute care, and inconsistent senior clinical oversight.
4	Medication and Transfusion Safety: Medication prescribing, reconciliation, and administration errors, SACT-related risks, blood transfusion safety.
5	Lack of Robust, Standardised Processes: Absence of standard operating procedures, inconsistent practice across teams, over-reliance on manual or work-around processes, poorly defined post-treatment follow-up arrangements.
6	Capacity, Workforce, and System Pressure: Clinician and outpatient clinic capacity, ward medical cover, nursing documentation pressure, inappropriate allocation of appointment types or duration.

IMPROVEMENT ACTIONS

Improvement plans have been developed based on the investigation recommendations. These will be monitored via the Trust Regulatory Tracker and Quality & Safety governance processes. The findings and learning for these investigations will be reported in the future quarterly reports.

The ethical duty of openness applies to all incidents, and any failure in care that has occurred whilst being treated through the healthcare that we provide.

The Duty of Candour applies to incidents whereby moderate and greater harm has occurred.



*Our clinical colleagues and support teams have enabled the Trust **RAPID REVIEW MEETING** to effectively identify improvements by raising and reviewing incidents in line with the Trust Incident Framework. All staff involved in the Rapid Review process have commended the supportive Just Culture collaborative approach.*

On completion of the full investigation process, a **Learning from Review** event is held, and **feedback is provided to all those involved**, plus the wider teams, to share the **investigation outcome and learning**.

A **speedy cascade** is one mechanism used to **share key learning** and messages identified through **patient safety incidents and follows rapid action implementation** after an incident has occurred.

34
MAKE IT SAFE MEETINGS

7
LEARNING FROM REVIEW EVENTS

12
SPEEDY CASCADES

ANALYSIS

Systemic Anti-Cancer Therapy (SACT) mortality data is collected and reported on a monthly basis. In the absence of a national benchmark distinguishing curative and palliative intent, the Cancer Centre continues to align with the widely referenced 2% 30-day mortality rate from the 2008 NCEPOD report as an overall indicator of performance. Velindre Cancer Services (VCS) has consistently remained below this threshold since data collection commenced, suggesting safe delivery of systemic treatment.

It is important to note that direct year-on-year comparison remains limited at present. This reflects both the phased establishment of Site Specific Team (SST) mortality review processes—many of which were not fully embedded until late 2024/2025—and changes in methodology for data extraction and reporting. In particular, the transition to a 4-month rolling reporting framework.

Since August 2025, mortality data has been reported at SST level, enabling more detailed review and enhancing clinical ownership of outcomes. All SSTs now undertake quarterly mortality meetings, reviewing:

- Deaths within 30 days of SACT
- Deaths within 30 days of palliative radiotherapy
- Deaths within 90 days of radical radiotherapy

This structured approach has strengthened multidisciplinary engagement and improved consistency in mortality review processes across tumour groups.

Whilst radiotherapy mortality data continues to be captured and reviewed internally by both the mortality team and SSTs, data validation challenges currently limit full external reporting through formal mechanisms such as the Trust's Performance Management Framework. Work is ongoing to improve data quality and reporting reliability in this area.

THEMES FOR LEARNING AND IMPROVEMENT

The introduction of SST-level reporting has begun to support more meaningful analysis of mortality data, allowing emerging trends, themes, and areas for improvement to be identified at a tumour-specific level, for example:

- Ensure that clinical teams are aware that Kadcyra carries a risk of significant bleeding, including life-threatening haemorrhage. This risk is heightened when used alongside anticoagulants or antiplatelet agents. Ensure patients are monitored closely, and any signs of bleeding are promptly escalated.
- For patients with poor performance status, continuation of treatment may be appropriate following careful clinical assessment. Ensure this is supported by clear documentation and a thorough discussion with the patient, in line with best practice.

It is recognised that further development is required to maximise the value of SST mortality meetings, and key areas of focus over the coming year include:

Benchmarking and External Comparison: Establishing meaningful benchmarking against other cancer centres across Wales and the wider UK. This will require standardisation of data definitions and collection methodologies to ensure comparability and validity of insights.

Improving Data Quality and Reporting: Addressing current limitations in radiotherapy data validation to enable comprehensive and transparent reporting across all treatment modalities.

Strengthening the Impact of Mortality Meetings: ensure these forums move beyond case review to consistently identify actionable learning, system-level improvements, and opportunities to optimise patient pathways—particularly in relation to treatment decision-making, patient selection, and management of treatment-related toxicity.

Focus on Patient-Centred Outcomes: Embedding a stronger focus on outcomes that matter to patients, including treatment appropriateness, experience of care, and quality at the end of life, alongside traditional mortality metrics.

ANALYSIS

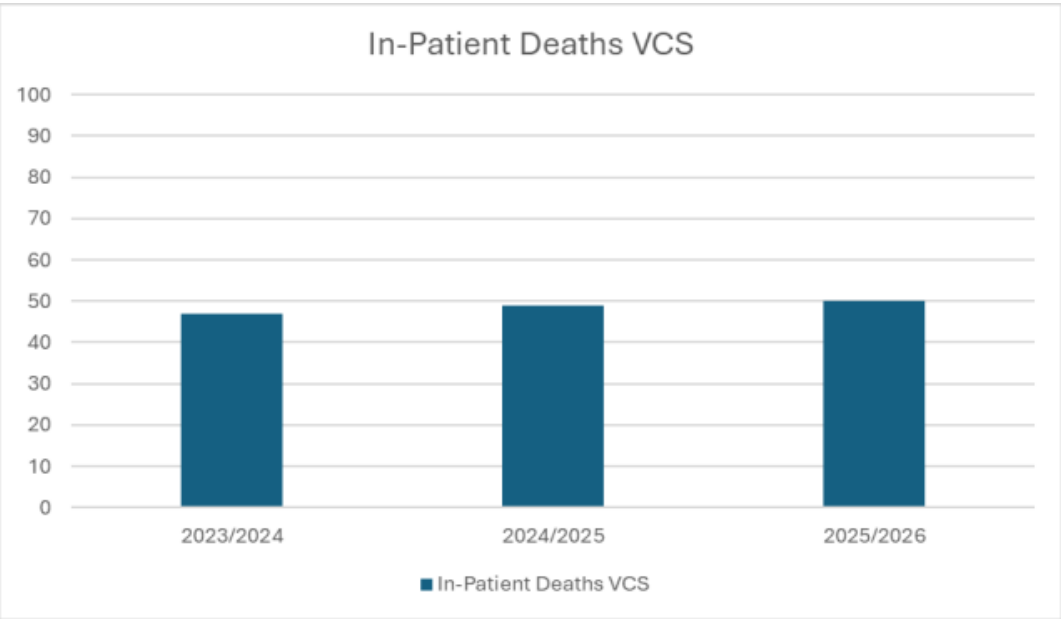
Velindre Cancer Service (VCS) is compliant with all aspects of the Medical Examiner Service (MES) – reviewing cases referred to VCS and feeding back findings and identifying learning.

All inpatient deaths are reviewed independently by the MES and internally at VCS at the monthly Inpatient Mortality Review Meeting.

No clinical concerns were identified from MES or within the VCS mortality reviews.

Further engagement with the VCS Acute services to ensure these meetings also provide a forum to discuss morbidity and the inclusion of acutely unwell patients if relevant

Graph 9



THEMES FOR LEARNING AND IMPROVEMENT

- Opportunities for learning were identified from the inpatient mortality review meeting:
- Ensuring assessment proforma is completed if a patient is admitted to the ward directly (i.e. not via assessment unit) such as Treatment Escalation Plan & DNACPR
 - TEP not being updated when ceilings of care change. Audit currently being undertaken by member of the Palliative Care team
 - Strengthen documentation related to Care Decisions Guidance for last days of life
 - New Inpatient Mortality Review Proforma introduced to ensure robust and consistent quality of review.

We are introducing a bi-annual VCS Audit, Morbidity & Mortality learning event to bring together insights from across site-specific teams and services and turn them into meaningful system-wide improvements.

This will be a protected, VCS -wide session focused on connecting learning from existing site-specific and in-patient M&M meetings, significant events, patient safety themes and informative audits.

The event will provide an opportunity to share M&M metrics across site-specific teams and benchmark where possible, identify cross-cutting themes and system-level issues, reduce recurrence of avoidable harm across services, share M&M audit outcomes and practical

The Clinical Audit department ensures the Cancer Service can demonstrate, sustain and improve high quality of care throughout all its departments. The Audit team seek to support and facilitate all aspects of audit work. Key performance indicators are defined through NICE and Royal College guidelines, national audits, safety parameters and patient experience. Throughout the year 2025/2026 a total of 122 projects have been submitted via AMaT's Clinical audit project module, 57 active, 65 completed, and 10 discontinued.

There are an additional 48 ongoing continuous monitoring projects registered either via AMaT' Ward and Team assurance module, Cumulative module or within certain service areas. All Audits have now been transferred to AMaT and Tendable is no longer in use



63 Quality and Safety related audits undertaken

Clinical Audit Plan 2025/26: complete or in progress/ongoing



Project Type	Count
Clinical Audit	77
Patient/Staff Survey	16
Service Evaluation	29

A Retrospective audit of admissions to first floor and assessment unit at Velindre Cancer Centre during May 2023

The results were compared with previous audit undertaken for May 2021 and saw an increase of 16% in overall attendances, less OOH attendances and the adherence to not meeting the admissions criteria was the same at 3.8%. Therefore, it was felt that admission criteria were still appropriate and mostly adhered to.

A Review of Pre-Treatment FDG PET-CT Imaging for High-Risk, Locally Advanced Head and Neck Malignancies

The results of this audit highlight that HNC patients across South East Wales are being investigated appropriately according to NWJCC guidelines as 88.6% of patients who required PET-CT for initial staging pre-treatment, did receive one.

Investigating the Oncotype Gene Recurrence Score in Node Negative, ER positive, HER 2 negative breast cancer: Impact on adjuvant chemotherapy decision making and patient outcome

The study found that Oncotype DX test is a good predictor for early breast cancer outcomes. Patients with scores of 26 or above had a higher risk of recurrence and a shorter overall survival. The high-scoring individuals also had poorer outcomes following a recurrence, meaning more aggressive illness. The findings stress the importance of using genetic testing to support treatment plans, particularly when choosing who to give chemotherapy to. The clinical benefits of this test also support the economic and cost benefits as this tool, which includes sparing patients who may not need chemotherapy, resulting in considerable cost-savings when used on a large scale.

An Audit of DPYD Testing in Velindre Cancer Service

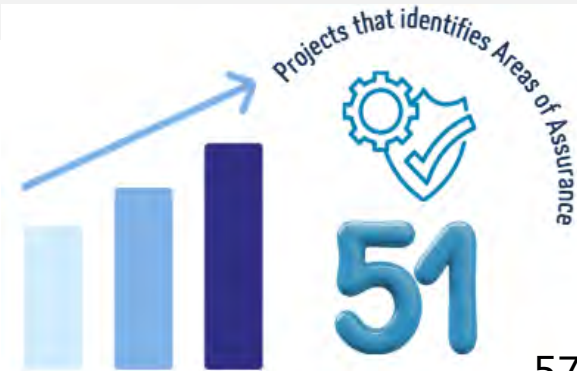
Velindre Cancer Service have implemented a quick and efficient DPYD testing process.

Benchmarking and quality assurance of a new prostate cancer brachytherapy service: prospective data collection and 2 year patient reported outcome measures

Patient selection was appropriate, dosimetrically good quality implants were achieved. The PROMS data at 24 months are in line with expected outcomes. Brachytherapy compares favourably with published surgical series (eg PACE A trial) (better sexual toxicity scoring, lower use of urinary pads, better urinary incontinence scores) and also with radiotherapy (better bowel summary scores) at the cost of a slightly worsened urinary obstructive score.

An evaluation of the Immunotherapy Toxicity Service at Velindre

The survey was answered by 49 staff from Velindre Cancer Service, representing groups including consultants (27%), junior doctors (16%), Advanced Nurse Practitioners (10%) and other allied health professionals. Staff from a wide range of site specific teams completed the survey. Feedback was very positive, with 90% (n=25) strongly agreeing that they viewed the service as valuable. Written comments included phrases such as an ‘excellent’ ‘invaluable service’.



Secondary Breast Cancer: Patient Survey

Patients do not recognise that they have been offered an HNA and a considerable number would benefit from written care plans

Actions: Letters to be written to patients following the nurse led clinic consultation to inform them they have completed their HNA assessment and what its actions were



Implementation of the ‘Antibiotic Review Kit (ARK) Project’ into VCC

Comments were received suggesting that sometimes the SHO’s say to “continue” antibiotics at 72 hours without completing a proper review. Another area of concern is potential missed doses of antimicrobials.50% of respondents stated that they experience problems with prescriptions ending before an antimicrobial is reviewed with 67% stating that these problems occur ‘occasionally’.

Action: Include Antimicrobial stewardship section in SHO induction. ARK chart concept to be introduced and designated time given to complete training. Pilot Virtual antimicrobial ward rounds on a Thursday afternoon. This helps to give greater assurance that antibiotics are reviewed on a regular basis and ensures there is a plan for over the weekend. Ward pharmacists, on a Friday, will flag any patient who is prescribed an antimicrobial whose prescription is due to end over the weekend and ask the SHO to document a plan. Ward pharmacists to further investigate this perception of potential missed doses resulting from the prescription ending before the antimicrobial is reviewed. A DATIX form is to be completed by the ward pharmacist to quantify this potential number, and actions plans developed if needed.

A Retrospective Audit of Adherence to DPYD Testing Protocols for Patients Receiving Fluoropyrimidine-Based Chemotherapy at Velindre Cancer Service

Adherence to protocol was not 100% accurate, therefore recommendations have been made to improve compliance, protocol and patient safety. This audit has provided evidence that increased genomic education at VCS is needed in the hope to increase adherence to DPYD PGx protocol to 100%, optimising patient care and safety. A follow up audit should be completed to confirm that adherence to DPYD testing protocol has increased, and advances have been made to the DPYD protocol to aid this improvement.

Action: Clarify pharmacists' role in DPYD testing to be added to clinical verification training. Further training & education on DPYD testing to be given on an ongoing basis to clarify knowledge. Review protocols to include an emergency dose adjustment for time-critical cases

A Retrospective audit of admissions to first floor and assessment unit at Velindre Cancer Centre during May 2023

Aspects of this audit will require longer term actions and will be included in larger pieces of work following the structure changes currently taking place.

Implementation of the ‘Antibiotic Review Kit (ARK) Project’ into VCC

Overall, it was a success and virtual microbiology ward rounds have now been implemented.



Re-Audit of an Intravenous Access Decision tool for breast cancer patients receiving Systemic Anti-Cancer Therapy

Following presentation at UKONS in 2024, there have been multiple discussions with nursing colleagues in various oncology centres throughout UK who have asked to amend our pathway within their services. There have also been several Teams sessions to discuss how it has impacted on our service, and patient outcomes.

Audit to review antimicrobial prescribing for inpatients admitted to First Floor Ward and compliance with Start Smart Then Focus (SSTF) Principles

Education session have been undertaken with the ward pharmacists on use of antimicrobial guidelines and when to query an antimicrobial prescription. Also with the ward doctors and nursing staff to discuss use of guidelines, significance of prescribing 'incorrect' antimicrobials, and audit results

A bladder cancer patient satisfaction survey to evaluate the role of the Urology Keyworker/CNS service at Velindre Cancer Service

New CNS bladder telephone clinic has been set up and CNS’s are meeting the majority of new patients face to face. A new admin support staff member has been appointed and will be responsible for the information packs and supporting HNA’s.

A Retrospective Audit of Adherence to DPYD Testing Protocols for Patients Receiving Fluoropyrimidine-Based Chemotherapy at Velindre Cancer Service

All pharmacists undertake a BOPA SACT passport which is the official training, Pharmacy has updated the training pack they give to the doctors at induction and the DPYP will now feature in it. Protocols with 5FU drugs have DPYD as a critical test so we need to actively enter the status and then on the description they have a line saying "For information on how to interpret the DPD critical test result, refer to the VCC DPD Test Guideline." Protocols updated.

Improvements achieved

- Frequency audits have been transferred from Tendable to AMaT, enabling the majority of audit activity to be captured within a single system.
- Dr Carys Morgan was appointed as the Velindre Cancer Service Clinical Audit Lead in November 2025, as part of the Divisional Medical Director role.
- In collaboration with the directorates, a robust governance and reporting structure for ward and area audits has been established to provide visibility and assurance.
- A revised organisational structure, including strengthened quality governance arrangements, has been implemented within VCS. These arrangements are being embedded across the new directorates with the triumvirate leads. Audit reporting and shared learning will be further strengthened through these structures.



Areas of development for VCS

- Embedding audit and the associated learning into the improved governance structure.
- Embed bi-annual Divisional Clinical Audit and Morbidity and Mortality (M&M) events to share learning and foster a culture of clinical effectiveness and continuous improvement.
- Develop a Quality and Safety dashboard that includes clinical audit activity, to support oversight and assurance.
- Review current ward and team assurance audits with the Heads of Nursing to align, where appropriate, with audits undertaken across other health boards.
- Strengthen arrangements for embedding learning from the National Audits.
- Improve the streamlining and integration of clinical audit under the Radiation Services directorate into the clinical audit plan.
- Improve links with patient engagement and incorporate into clinical audit.



The Clinical Audit department ensures the Cancer Centre can demonstrate, sustain and improve high quality of care throughout all its departments. The Audit team seek to support and facilitate all aspects of audit work within the cancer centre. Key performance indicators are defined through NICE and Royal College guidelines, national audits, safety parameters and patient experience. Throughout the year 2024/2025 a total of 100 projects have been submitted via AMaT, 36 active, 58 completed, and 6 discontinued.

There are an additional 48 ongoing continuous monitoring projects not registered via AMaT and are reported via Tendable or the PMF. The majority of clinical audit projects are captured via the AMaT system with the exception of the frequency of audits and the radiation services regulatory audits. However, the frequency of audits are in the process of being transferred from Tendable to AMaT and will be captured in the Ward and Area module.

2024/25: 148 Audits



Complete

58



Active

36



Ongoing

48



Discontinued

6



124 Forward Plan



24 Additional Activity



63 Quality and Safety related audits undertaken



Project Type	Count
Clinical Audit	63
Patient/Staff Survey	15
Service Evaluation	16

CLINICAL AUDIT– KEY SUCCESSES

An audit of patient outcomes (with regards to survival and toxicity) after treatment with Sotorasib for KRAS G12C mutated non-small cell lung cancer at Velindre Cancer Centre

Sotorasib appeared to be generally well-tolerated given that the majority of treatment discontinuation was due to disease progression as opposed to inability to tolerate toxicities. Sotorasib was also shown to have some effect on disease regression or at least stabilising disease for a period of time.

A Service Evaluation Looking at the Non-Surgical Management of Relapsed Prostate Cancer Following PSMA PET-CT Evaluation

PSMA PET CT scans have revolutionized the way that BCR is investigated and therefore managed. More sites of disease are being picked up and at earlier stages than previously, meanwhile newer methods of treatment have gained prevalence such as SABR, resulting in increased intervention

An evaluation of the Immunotherapy Toxicity Service at Velindre
100% of Staff found the IO service a valuable service, with advice from the team seen as a useful resource

An Audit of DPYD Testing in Velindre Cancer Centre

Velindre Cancer Centre have implemented a quick and efficient DPYD testing process.

A Review of Pre-Treatment FDG PET-CT Imaging for High-Risk, Locally Advanced Head and Neck Malignancies

The results of this audit highlight that HNC patients across South East Wales are being investigated appropriately according to NWJCC guidelines as 88.6% of patients who required PET-CT for initial staging pre-treatment, did receive one.

A Service Evaluation of the Liquid Biopsy Service for Lung Cancer Diagnostics in Wales

Overall, liquid biopsy ctDNA tests have a quicker turnaround time than tissue genomic biopsies and with correct usage they can be a helpful tool in meeting the new 49-day lung cancer pathway target.

Is the information in patient treatment escalation plans (TEPs) useful in the ongoing care of patients in the community and in future admissions? To what extent is the information within a patient’s TEP communicated to other healthcare professionals in different care settings?

Despite significant gaps in TEP completion and subsequent documentation on EDALs, results suggest that patients with Advance Care Planning on EDALs informed by TEPs experience fewer hospital readmissions and ambulance calls, and arguably, a better quality of life.



A Service Evaluation Of The Referral and Diagnostic pathway of Oesophago-Gastric Cancer

Health Boards in South Wales are having difficulty meeting the optimal treatment and investigation timelines

Action: Recommendations are outside Velindre remit, however, we are constantly trying to achieve activity that corresponds to optimal pathways



An evaluation of the Immunotherapy Toxicity Service at Velindre

Lack of awareness of the wider activities of the service beyond purely 'support' managing IO toxicities. Three quarters of respondents were unaware of the adrenal education workshop. Half the respondents were unaware of the endocrine MDT

Actions: Expansion of the service required, therefore a business case for band 7 CNS was submitted. Training plan developed in order to upskilling/training of current staff to keep up with new developments. Pathways developed to provide clarity on who should be referred to the service? The IO service was presented at the consultants meeting in order to Increase awareness of what the service is currently offering.

Is the information in patient treatment escalation plans (TEPs) useful in the ongoing care of patients in the community and in future admissions? To what extent is the information within a patient's TEP communicated to other healthcare professionals in different care settings?

EP not being appropriately completed. Appropriate Information regarding the patients cancer status contained within a TEP is not being cascaded appropriately onto the eDAL and therefore shared with primary care and unscheduled care colleagues. There is scope to improve the information pertinent to patients disease status and advanced care planning within the eDAL.

Action: Further data collection to take place to look at current recordings within an eDAL, this will establish if the correct/relevant information is being made available to appropriate working partners and providing the best outcome for patients. The prevalence of incomplete TEPs and EDALs lacking ACP emphasises the need for ongoing QI initiatives to enhance outcomes.

Evaluation of the benefits of the Day 8 Callback for patients receiving SACT capecitabine

A decision was made based on the evidence provided from the project that day 8 call backs are no longer required and therefore have been stopped. This frees up staff time/resource. The project finding were discussed at the ICOG and the SST leads meeting. This will also be present for information at the medicines management group.

DNACPR FORMS – 2024 Audit Data Collection Results and Analysis Velindre University NHS Trust

Velindre is in the process of switching to electronic note writing in the new Specialist Palliative Care Module in Welsh Clinical Portal. This is already having a demonstrable impact on how other teams are viewing and reviewing information on Future Care Planning preferences, for instance preferred place of care, performance status and also whether DNACPR has been discussed. Further discussions are taking place to extend the current ACP Flag system online into FCP Flag with a document uploader, where forms such as the All Wales DNACPR form, but also patient held Advance Decisions to Refuse Treatment (ADRT) can be stored and shared.

Less patients hold these, but we are seeing more people bring them in. We now have a process in place where any such form can be uploaded to Welsh Clinical Portal, so that the wider team is aware of its existence. We will audit the use of the Future Care Planning Flag on the front page on WCP records (in the Adverse Reaction box)

A service evaluation of symptom control for palliative inpatients at Velindre Cancer Centre

Patients have been offered additional therapies and pharmaceutical drugs to help alleviate symptoms. The team will continue to monitor and look at alternative therapies and medication in the future to enhance the patient experience.

Implementation of the ‘Antibiotic Review Kit (ARK) Project’ into VCS

Overall it was a success and virtual microbiology ward rounds have now been implemented.



A Retrospective audit of admissions to first floor and assessment unit at Velindre Cancer Centre during May 2023

Aspects of certain audits require longer term actions and will be included in larger pieces of work following the structure changes currently taking place.

Nurse Led Post Radiotherapy Clinic for Gynaecological patients

Post project impact is that due to the success of the clinic and 100% patient satisfaction, the clinic is being continued and the team are looking to expand this service to the vaginal and vulva patients.

Physio-led Prehab Clinic for gynae-oncology patients – Staff Questionnaire

This project highlighted that some staff felt there was a huge benefit with having a dedicated Physio-led Prehab clinic for gynae oncology patients, other staff members felt there was a lack of communication and several improvements could be made. Unfortunately changes are unable to be carried out due to the physio staff member leaving the trust so is no longer being in post.

Improvements achieved

- Developed a robust governance process for the approval and escalation of issues
- IPCT audits have been moved from MEG to AMaT
- Enhanced collaboration on the clinical audit plan with the quality and safety team to incorporate audits from incidents, complaints and patient safety issues. This has been supported by clinical audit department becoming part of the quality and safety team.
- Frequency audits are in the process of being moved from Tendable to AMaT, so the majority of audit activity is captured in one system



Areas of development for VCS

- Identify a clinical lead for audit.
- Strengthen the quality hubs to ensure projects are reviewed to ensure alignment with SST/ IMTP/ QI objectives.
- Strengthen the quality hubs to ensure learning from audit projects are disseminated and any identified improvements undertaken.
- Annual Trust Clinical Audit and Quality Improvement events to share learning and foster a culture of clinical effectiveness and improvement through the VCS Grand Round events.
- Development of Quality & Safety Dashboard to include clinical audit activity and will be available for each SST



Chapter 3:

Corporate Services

2025-2026



OMBUDSMAN

The Public Services Ombudsman Wales investigates complaints relating to unfair treatments by Welsh Public Services and works to improve standards. The Ombudsman can consider complaints made to her within one year of the matters complained about or within one year when an individual became aware that they have a right to raise a complaint with the Ombudsman. All Trust complaints letters and correspondence provides information on how to contact the Ombudsman if they are unhappy with any aspect of the Trust's complaints handling.

There were no open Public Services Ombudsman for Wales cases in 2025/26, reflecting the Trust’s continued commitment to providing clear, thorough responses to individuals, families, and representatives who raise concerns. This consistent approach offers strong assurance that concerns are being managed effectively and transparently across the organisation.

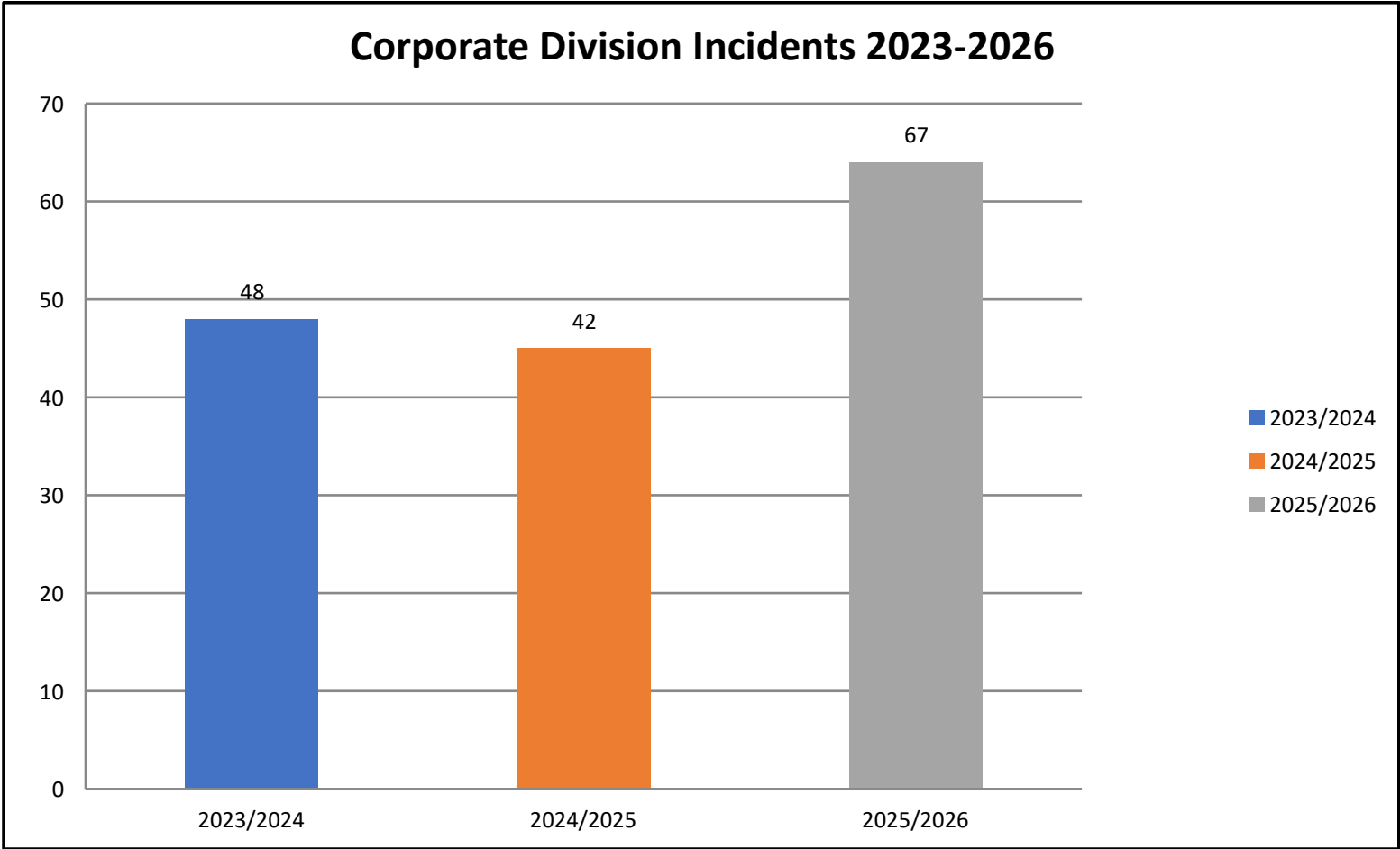
Year	Matters subject to Ombudsman investigation involving the Trust
2022/23	4
2023/24	0
2024/25	0
2025/26	0



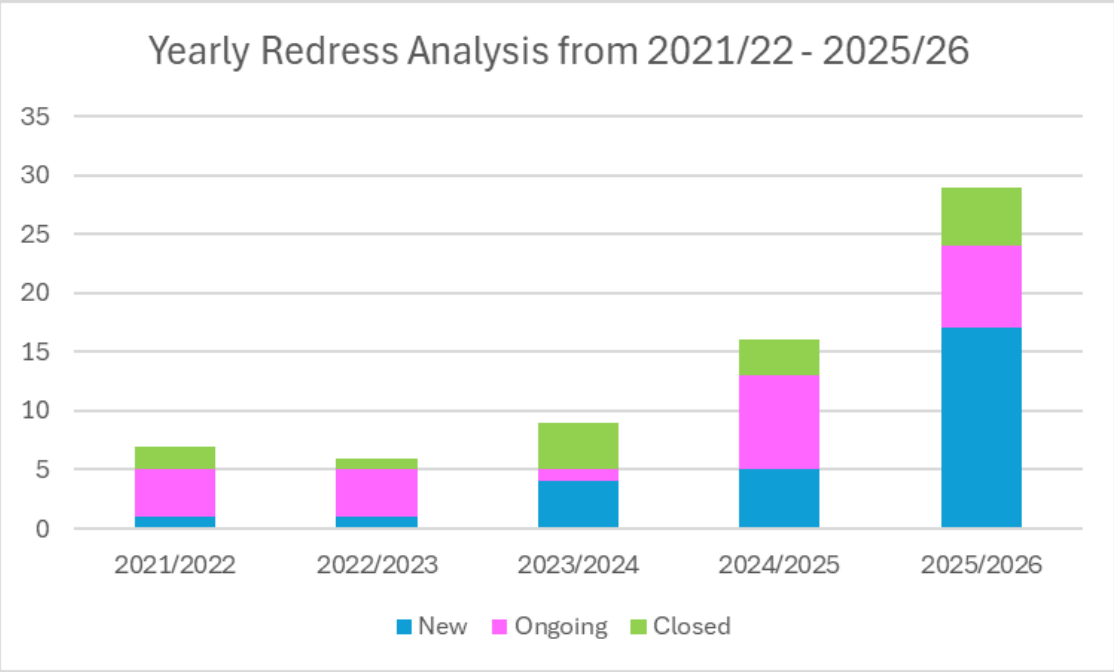
Patient and donor safety incidents are any unintended or unexpected incidents, which could have, or did, lead to harm for one or more patients/donors receiving healthcare. Incidents are all reported and reviewed at service level, through Quality and Safety leads and the Quality and Safety Hubs.

2025-26 Trust Incident Summary

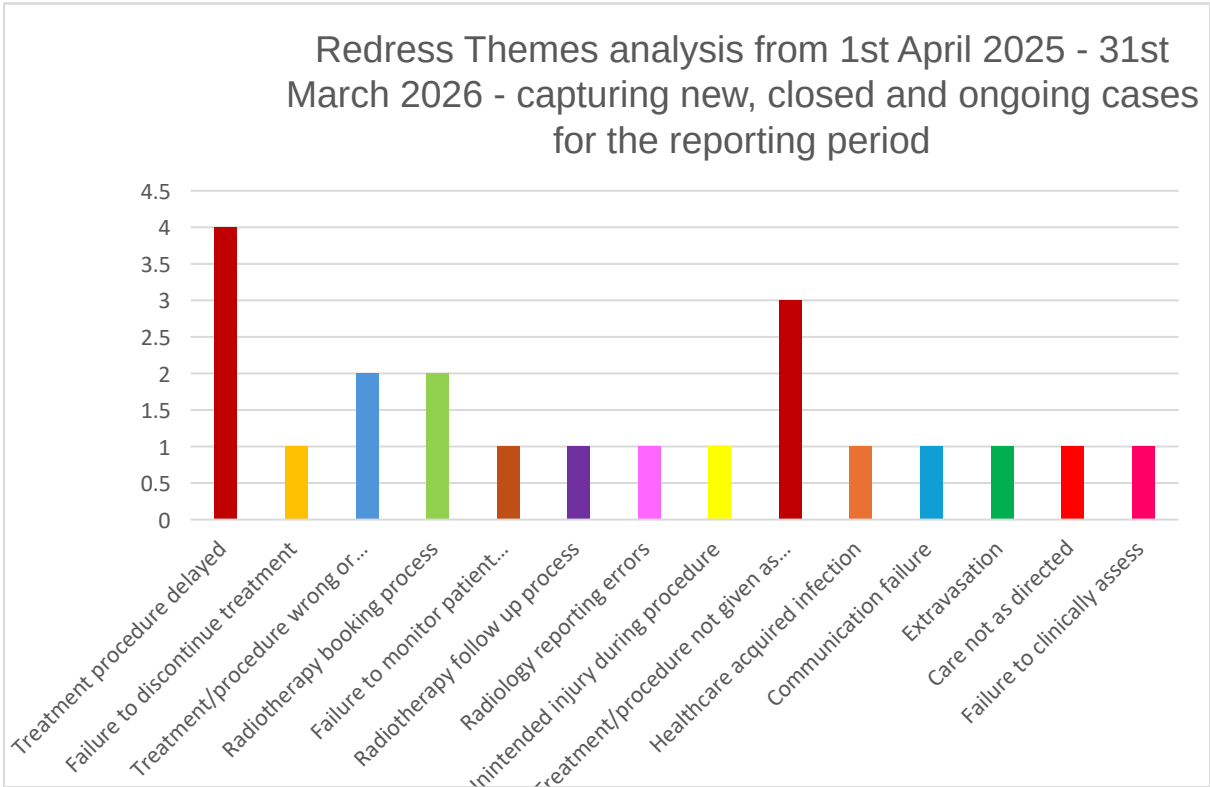
Graph 1



Graph 2



Graph 3



As shown in graph 2, there has been a marked increase in Redress cases compared with previous years, a trend that aligns with the introduction of the Duty of Candour. This rise reflects the strengthened expectation for openness and transparency when harm may have occurred, leading to more matters having been appropriately identified, reported, and reviewed under the Redress process. Graph 3 explains the thematic analysis for the year 2025/26.

Redress Review

At year end 2025/2026, six cases remain under investigation, exceeding the 12-month completion target set out in the NHS Concerns, Complaints and Redress Arrangements (Wales) Regulations. From 1st April 2026, the introduction of the Listening to People Process will strengthen timeliness requirements, including a requirement to issue a final response within 120 working days from the date when the incident occurred or when a complaint was first raised. All Redress matters must now be concluded within the prescribed timescale. It is anticipated that this new timescale is likely to see a rise in the number of matters capable of being completed within the required timeframe due to challenges with the new ruling. Redress has also seen an increase in its financial threshold to settle matters. From 1st April 2026, this will increase from £25,000 to £50,000. In readiness for the changes that will be introduced by the amended regulations, a deep dive was undertaken to identify any actions that could be taken to reduce avoidable delays, including improved administrative processes and expanding the team. However, some delays remain outside of the Trust's direct control, including the complexity of certain investigations, delays in obtaining medical records from other NHS organisations, challenges in securing suitable independent medico-legal experts and increased workload arising from Redress, inquests and potential clinical negligence claims.

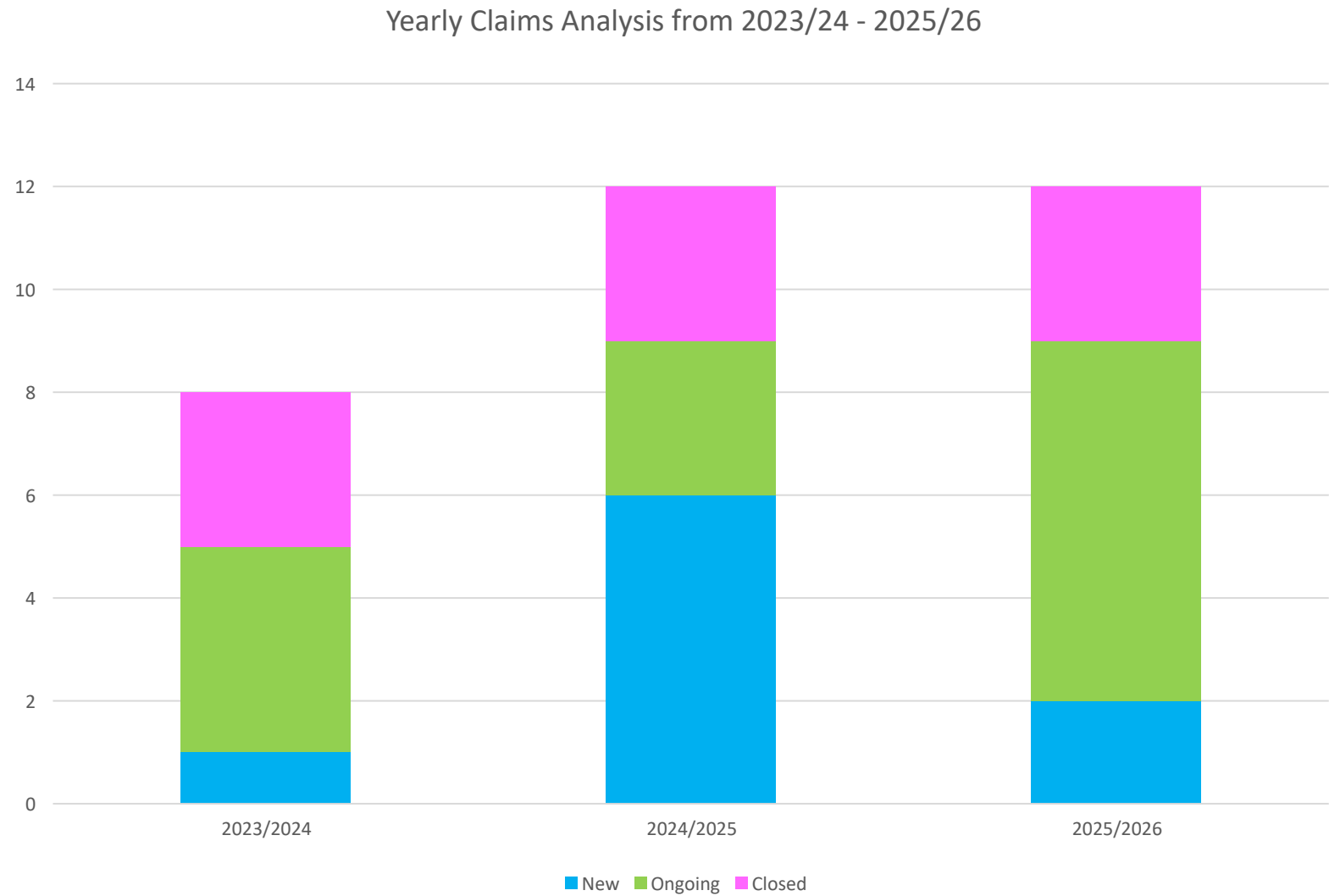


Graph 4 shows claims activity during 2025/2026:

The Trust has **9** claims open at the end of the reporting period, which includes claims for clinical negligence and personal injury.

No themes or trends were identified during the reporting period

Graph 4



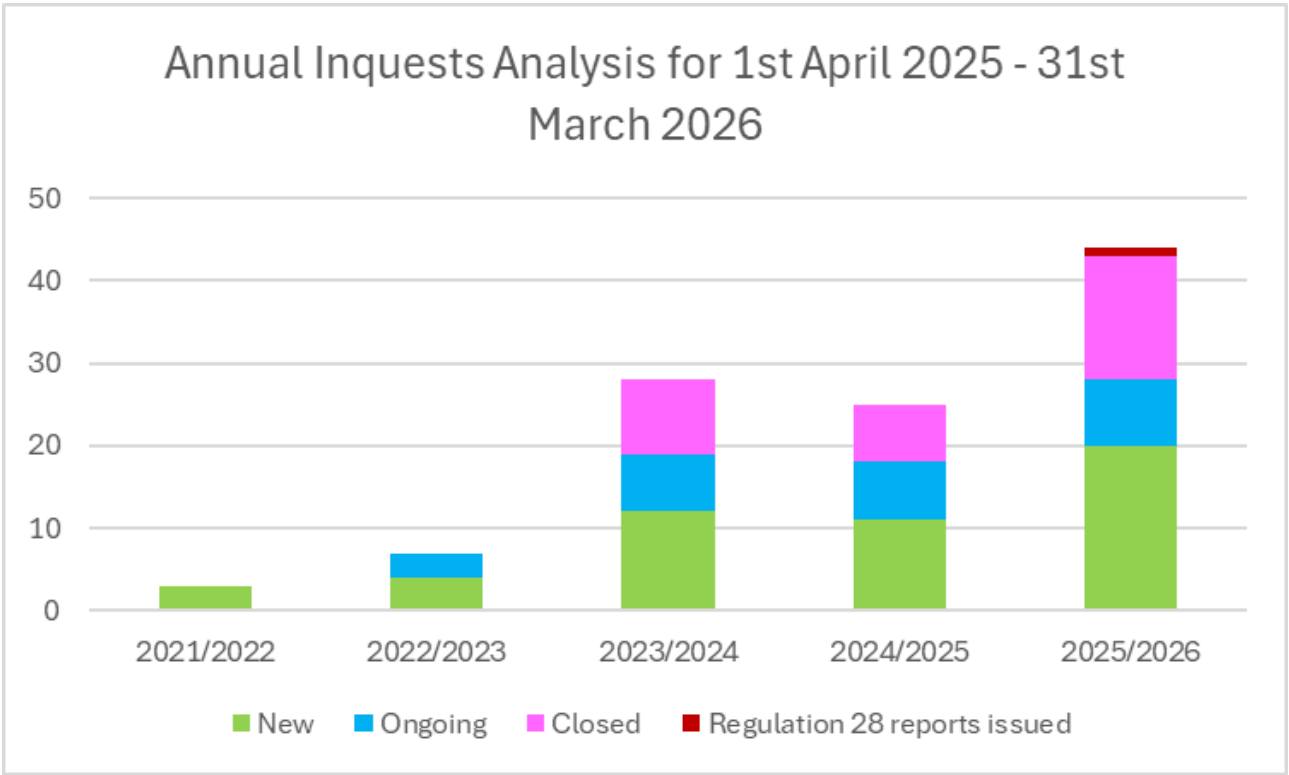
ANALYSIS

Graph 5 shows inquest activity related to the Trust. For this graph we have shown 5 data points to demonstrate the significant increase in inquest activity.

Whilst inquests continue to see an increase year on year, no trends or themes have been identified that give rise to concern. Most inquests have involved witnesses giving evidence in relation to care provided to service users where no harm has been indicated or where an opinion has been sought by a Coroner to determine the cause of death.

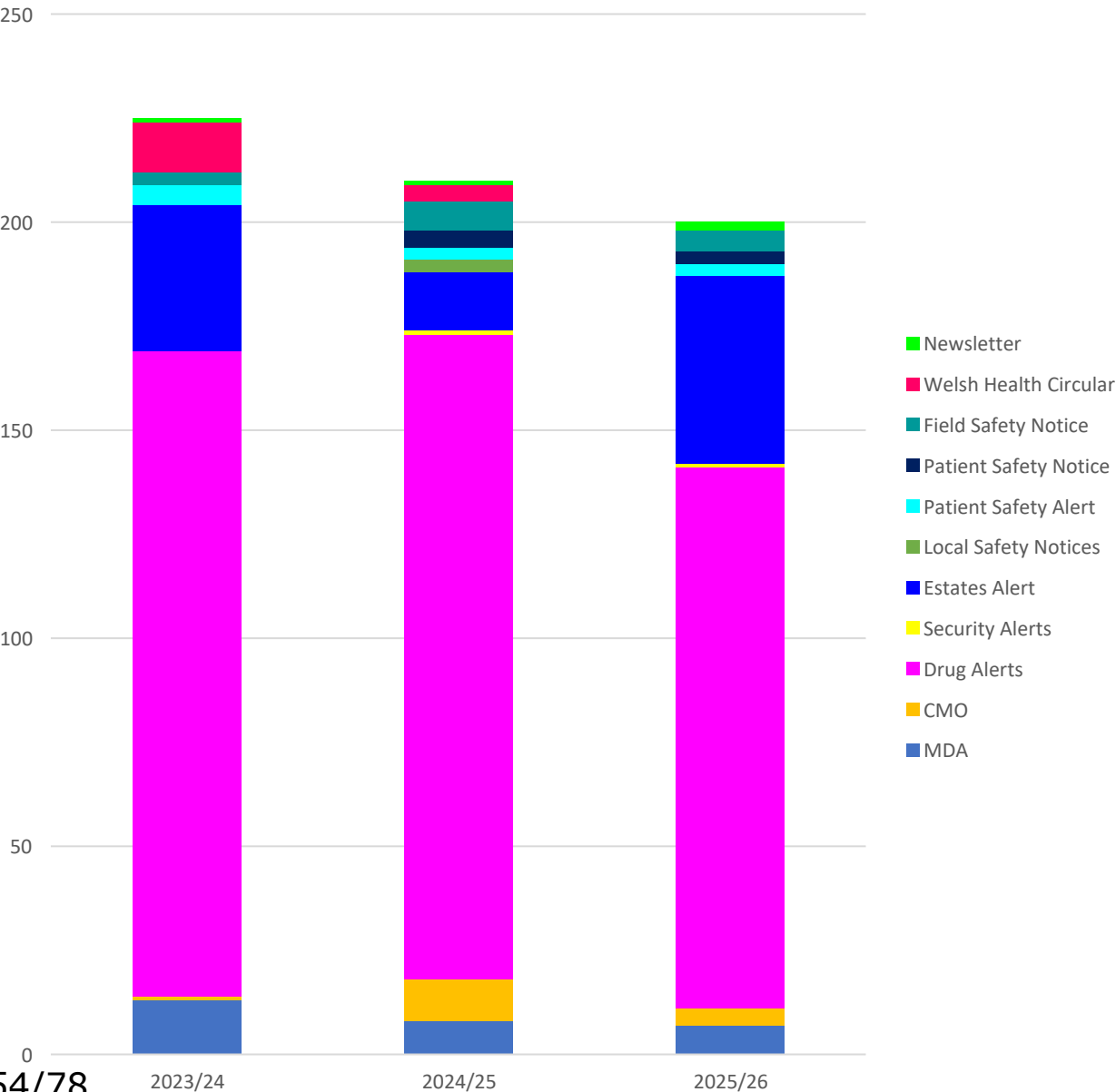
During the reporting period, the Coroner issued a Regulation 28 report highlighting the need for improvements to be made between a health board and the Trust to ensure that provision for monitoring and follow up is made in relation to dietetic services. A number of service improvements have since been made to address the issues identified and a Regulation 29 response has since been submitted to the Coroner addressing the findings.

Graph 5



12. SAFETY ALERTS

Graph 6 Safety Alerts Received by Year and by Type from 01/04/2023 - 31/03/2026



ANALYSIS

Graph 6 shows safety alert activity and analysis within the Trust.

Drug/pharmaceutical alerts continue to be the highest number of alerts received, **130**. The drug alerts relate to medicine recalls and stock issue notifications from suppliers. Drug alerts assessed as being applicable to the Trust were further shared, with pharmacists to take appropriate actions.



THEMES AND OUTCOMES

The most common theme for Safety Alerts were medication shortages. Any alerts that were applicable to the Trust were addressed, e.g. stock checking and using the recommended alternatives. There are numerous types of Safety Alerts, these are all shared to the appropriate teams across the Trust and dealt with accordingly.

POSITIVE ASSURANCE

Each of the alerts received have been reviewed by subject matter leads and appropriate actions taken. From 1st April 2025, the Safety Alerts were be recorded in the Implementation module on Datix Cymru, which has given the divisions the opportunity to provide direct feedback and compliance comments.

Abridged Quality and Safety Report – Annual Report 2025-26 (1st April 2025 – 31st March 2026) – Information Governance

Introduction – Information Governance can be considered as the way in which an organisation manages the information processes and procedures and forms a key component of integrated governance and assurance arrangements along with Clinical Governance, Risk Management, Research Governance, Financial Governance and Corporate Governance. It formally links data quality management, records management, information management, information sharing, information security (including ICT security), risk management, ethics, openness and transparency into an integrated approach and covers a wide spectrum of requirements including procedures and processes to ensure data integrity, availability, security and confidentiality and the collection, storage and dissemination of information.

Incidents and Investigations – Total number of incidents for the quarter **plus** a 2-year run graph displaying the themes and trends.

Root Cause Analysis – Where the cause of the incident is not immediately clear, the Head of IG will conduct a more in-depth investigation.

Reported to the ICO – It is a legal requirement to report certain types of incidents to the ICO (where a personal data breach is likely to result in a high risk to the rights and freedoms of individuals). RCA will also be conducted as a matter of course.

Subject Access Requests – The legal right for a data subject to request their own data, the Trust must respond within 1 month of the date of request, unless the request is complex or technical in its nature, in which case a further 2 months may be granted.

Data Protection Impact Assessments – It is a requirement to report activity to Senior Trust Management via established governance routes so that Assurance is gained that the Trust is complying with its statutory legal obligations. The IG Toolkit assesses annual compliance with this requirement.

Training Attainment – The minimum standard for compliance in NHS Wales is 85%, the compliance (%) is reported as of 1st January annually and may affect CAG status.

Incidents – 1st April 2025 to 31st March 2026

Service		DATIX Incidents	Incidents reported to the ICO	Total			
					Low Risk/No Harm	Root Cause Analysis	Total
Quarter 1 2025-2026							
Corporate Services		3	0	3	3	0	3
Velindre Cancer Service		22	1	22	19	3	22
Welsh Blood Service		1	0	1	1	0	1
TCS/NVCC		0	0	0	0	0	0
NWSSP		9	0	9	7	2	9
Total for Q1 2025/26		35	1	35	30	5	35
Quarter 2 2025-2026							
Corporate Services		2	0	2	2	0	2
Velindre Cancer Service		9	0	9	8	1	9
Health Technology Wales		0	0	0	0	0	0
Welsh Blood Service		3	0	3	3	0	3
TCS/NVCC		0	0	0	0	0	0
NWSSP		11	1	11	9	2	11
Total for Q2 2025/26		25	1	25	22	3	25
Quarter 3 2025-2026							
Corporate Services		1	0	1	0	1	1
Velindre Cancer Service		17	1	17	16	1	17
Health Technology Wales		0	0	0	0	0	0
Welsh Blood Service		6	0	6	6	0	6
TCS/NVCC		0	0	0	0	0	0
NWSSP		14	0	14	12	2	14
Total for Q3 2025/26		38	1	38	34	4	38
Quarter 4 2025-2026							
Corporate Services		4	0	4	3	1	4
Velindre Cancer Service		13	1	13	11	2	13
Health Technology Wales		0	0	0	0	0	0
Welsh Blood Service		6	0	6	5	1	6
TCS/NVCC		0	0	0	0	0	0
NWSSP		16	1	16	15	1	16
Total for Q4 2025/26		39	2	39	34	5	39
Total for 2025-2026							
		137	5	137	120	17	137

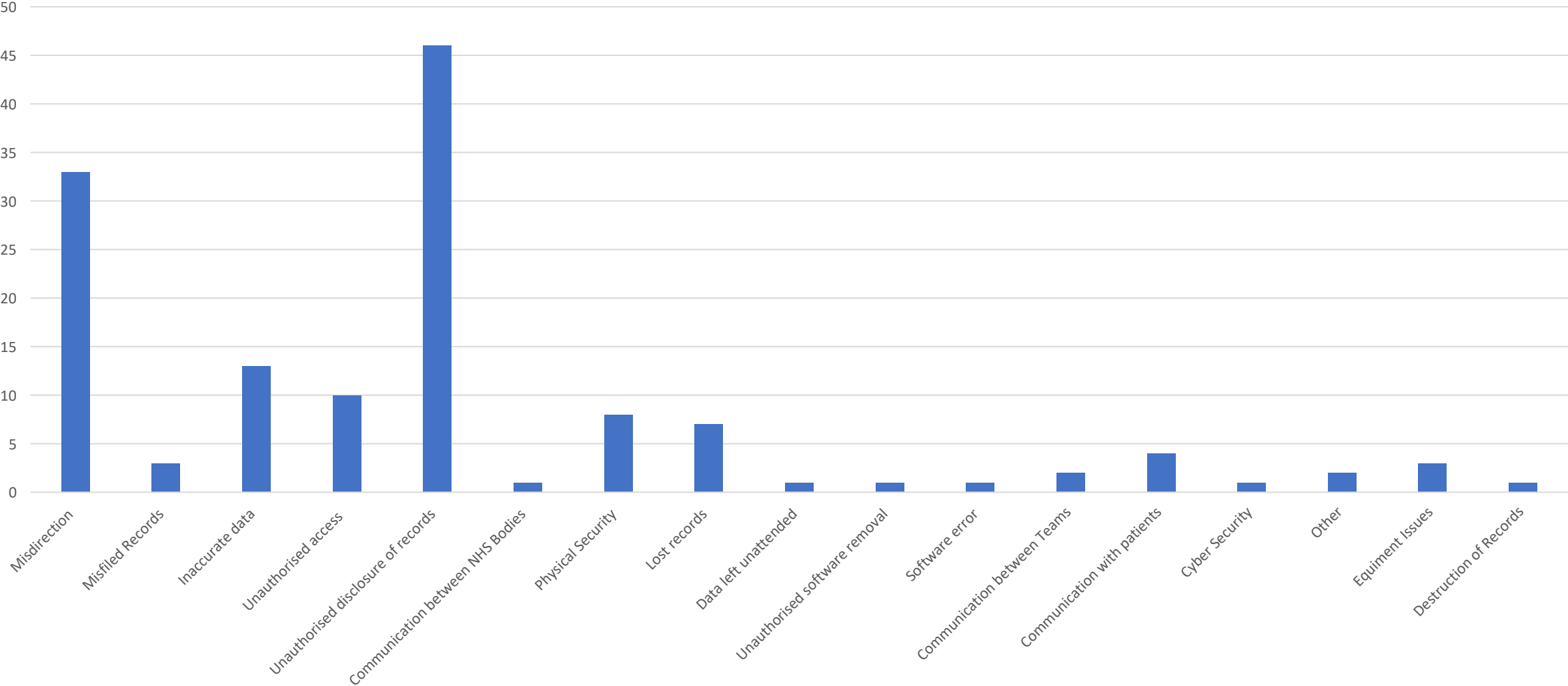
Analysis Table for Incidents – 1st April 2025 to 31st March 2026

Reason	Number of Incidents	% of all reported incidents*	Corporate	VCS	WBS	TCS	HTW	NWSSP
Misdirection	33	24%	9	2	5	0	0	17
Misfiled Records	3	2%	0	2	0	0	0	1
Inaccurate data	13	9%	0	11	0	0	0	2
Unauthorised access	10	7%	0	3	0	0	0	7
Unauthorised disclosure of records	46	34%	5	17	7	0	0	17
Communication between NHS Bodies	1	0.73%	1	0	0	0	0	0
Physical Security	8	6%	1	6	1	0	0	0
Lost records	7	5%	0	3	2	0	0	2
Data left unattended	1	0.73%	0	1	0	0	0	0
Unauthorised software removal	1	0.73%	0	1	0	0	0	0
Software error	1	0.73%	0	1	0	0	0	0
Communication between Teams	2	1%	0	2	0	0	0	0
Communication with patients	4	3%	0	4	0	0	0	0
Cyber Security	1	0.73%	0	0	0	0	0	1
Other	2	1%	0	0	0	0	0	2
Equipment Issues	3	2%	1	1	1	0	0	0
Destruction of Records	1	0.73%	0	0	0	0	0	1
Total of Incidents	137	N/A	16	51	16	0	0	50

*Percentages are rounded down if calculated .5 and below, and up if .6 or above

Graph 7

Analysis Table - IG Incidents 2025/2026



VCS (Medical Records) Subject Access Requests – 1st April 2025 to 31st March 2026

Month	Number of requests	Number of requests completed within statutory timeframe	Requests in Progress or Cancelled	Requests breached	Percentage compliance
April	17	16	0	0	100%
May	22	21	1	0	100%
June	23	22	1	0	100%
July	25	24	1	0	100%
August	22	21	1	0	100%
September	24	19	4	0	100%
October	40	39	1	0	100%
November	28	25	3	0	100%
December	34	25	8	1*	97%
January	30	26	8	0	100%
February	32	25	5	0	100%
March	34	17	17	0	100%
Total	331	280	50	1	99.69%

*Reconstruction of a medical record took 1 month and 1 week, an extension could have been applied but was not on this occasion

Corporate (Non-Medical Records) Subject Access Requests – 1st April 2025 to 31st March 2026

Month	Number of requests	Number of requests completed within statutory timeframe	Requests breached	Percentage compliance
April	3	3	0	100%
May	2	2	0	100%
June	0	0	0	N/A
July	1	1	0	100%
August	1	1	0	100%
September	3	2	1*	75%
October	1	1	0	100%
November	2	2	0	100%
December	0	0	0	N/A
January	0	0	0	N/A
February	3	2 (1 still ongoing)	0	N/A
March	0	0	0	100%
Total	16	14	1	100%

*Complexity of a request which took longer than anticipated due to need to seek external advice

WBS (Donor Records) Subject Access Requests – 1st April 2025 to 31st March 2026

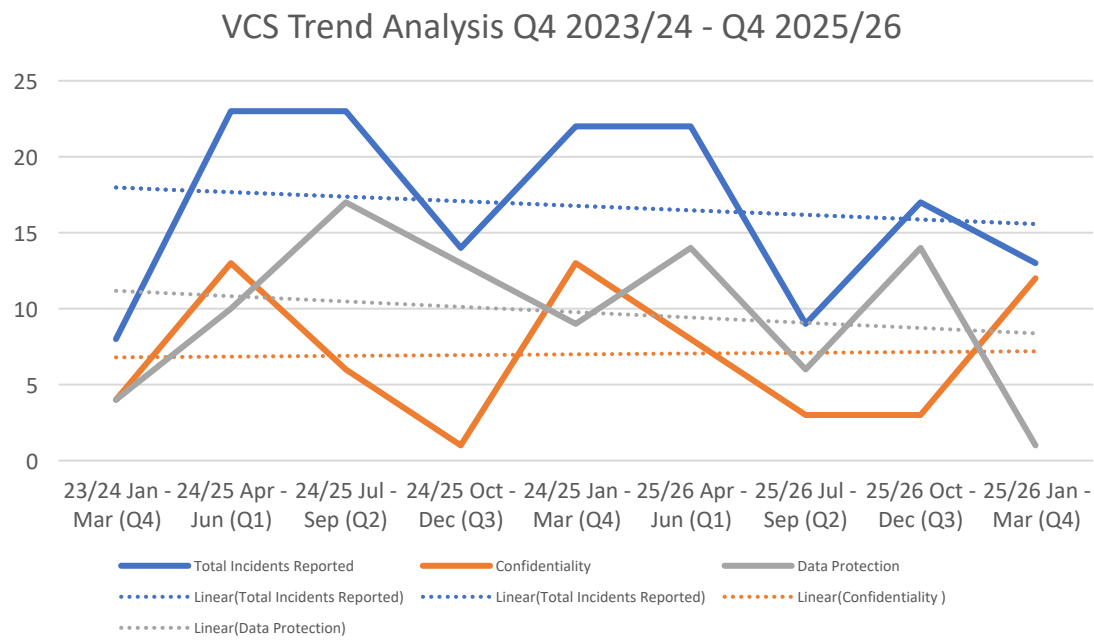
Month	Number of requests	Number of requests completed within statutory timeframe	Requests breached	Percentage compliance
April	16	16	0	100%
May	15	15	0	100%
June	13	13	0	100%
July	21	21	0	100%
August	7	7	0	100%
September	14	14	0	100%
October	11	11	0	100%
November	12	12	0	100%
December	4	4	0	100%
January	2	2	0	100%
February	12	12	0	100%
March	14	14	0	100%
Total	141	141	0	100%

NWSSP Subject Access Requests – 1st April 2025 to 31st March 2026

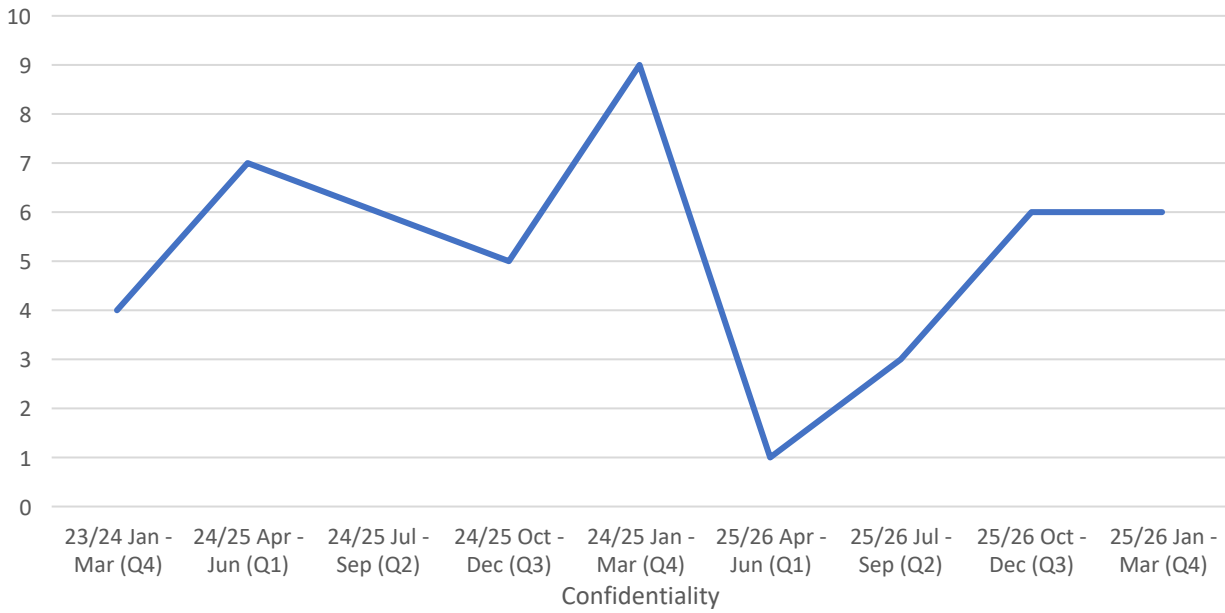
Month	Number of requests	Number of requests completed within statutory timeframe	Requests breached	Percentage compliance
April	1	1	0	100%
May	0	0	0	N/A
June	0	0	0	N/A
July	1	1	0	100%
August	0	0	0	N/A
September	2	1	1*	50%
October	4	4	0	100%
November	1	1	0	100%
December	0	0	0	N/A
January	0	0	0	N/A
February	1	1	0	100%
March	0	0	0	N/A
Total	10	9	1	90%

*Not initially acknowledged, which resulted in delay of response

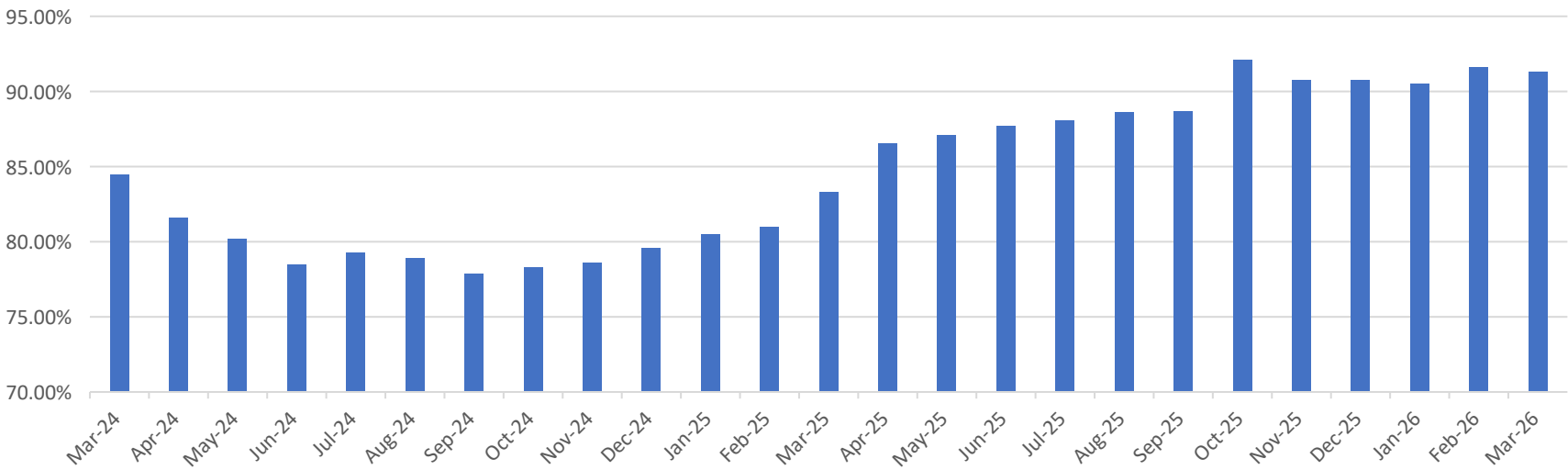
Graph 8 2-year Trend Analysis and Monthly ESR Compliance



Graph 9 WBS Trend Analysis Q4 2023/24 - Q4 2025/26



Graph 10 Q4 2023/24 - Q4 2025/26 Trust IG Training Attainment on ESR



Assurance and Analysis

Positive assurance 1. Training: a. Training throughout 2025/26 was delivered in multiple ways, including via ESR, inductions and specific workshops. It will continue to be delivered in the same format for 2026/27. During June 2025, IG training was delivered with materials in Welsh, it remains a first for NHS Wales. b. IG Training compliance on 31st March 2025 for the Trust is 91.30% and 100% for HTW and 89.53% for NWSSP respectively (minimum standard is 85%), it is an increase of compliance in comparison to 2024/25. 174 VUNHST were out of date for training on 31st March 2026, which compared with 2024/25 (280) is an increase in compliance of 106 staff, a significant overall improvement on the previous year. This has been achieved by increased engagement with POD and Medical Business Staff. 2. Policies – a new Trust wide AI Policy was issued in February 2026. The following Policies were due for approval in April 2026: Acceptable Internet Use, Email and Instant Messaging Policy and IG and Information Security Policy. Once approved this will entail a 100% complete policy suite. Policies have been used as appropriate in internal IG investigations throughout 2025/26. 3. SAR Compliance – remains steady across the Trust, 100% 4. DPIAs – 59 DPIAs, 26 LIA's and 1 all Wales (which is recorded but out of scope) were approved across the Trust in 2025/26. A register of Data Processing Agreements and Data Sharing Agreements will be published in the 2026/27 Annual Report 5. IG Toolkit – IG toolkit submitted on time, for 2025/26 timeframe – compliance observations and resultant IG workplan are included in main IG Annual Report
Risks to compliance with legislation, policies, procedures and standards and mitigation activity 1. Compliance Risk the main risks in terms of compliance are not with training statistics, but incidents, some of which have been classed as reportable to the ICO. Most incidents are due to errors without intent, however, where intent is suspected, they are dealt with in accordance with legislation and Trust policy. 2. Incidents – the top two types of incidents (unauthorised disclosure of records (34%) and misdirection (24%) are those that raise the most concern. Targeted training has been devised and will be delivered to attempt to deal with misdirection, and where unauthorised disclosure has taken place, the cases are used for training purposes (anonymised) and where specific incident take place, action in line with Trust Policy has been recommended where appropriate. 3. DPIAs – the main risk is Service areas instigating but not progressing DPIA's, during 2026/27, the IG function will implement KPI's for DPIA's based on the nature and purpose of processing (DPIA type) 4. TAF Risk – DPO continues to review TAF 05 with CDO. 5. Overall IG Risk – Cyber risk remains overriding risk in line with the current threat environment; regular touch points are maintained with the Cyber team in a formal monthly cyber risk meeting. The Trust also receives weekly cyber intelligence reports which are escalated as appropriate to other Trust Officers, such as SIRO.
Analysis, themes, and learning 1. Incidents – Overriding theme in 2025/26 is; unauthorised disclosure of information and misdirection, it is avoidable, how to avoid it is taught by the IG Team in all face-to-face sessions. Specialist training has been devised by the IG team, focusing on misdirection and targeted to population of the Service most involved in incidents reported (roll-out to commence from July 26 onwards). 2. ICO Reported Incidents – 5 incidents were reported to the ICO in 2025/26, all of which resulted in NO REGULATORY IMPACT on the Trust. Training provision was updated to reflect lessons learned, further analysis is in the IG Annual Report. 3. Training – Training compliance in 2025/26 has increased across all areas. This was because of the recruitment of additional IG resources and the resultant collaborative and effective working with Trust departments. The minimum standard of 85% was achieved. The IG Team have delivered specific training to NWSSP Procurement Teams for Corporate and VCS and it is intended to deliver the same training to NVCC Programme Managers and WBS procurement teams in 2026/27. 4. DPIA – Remains the main methodology to assess compliance with <i>data protection by design and default</i> and address risk and information rights. It should be noted that Service Areas are responsible for the completion of the DPIAs (and related Cyber Risk Assessments where appropriate) to ensure timely delivery of projects. 5. Triangulation – Training compliance correlates with incidents. Points 1&3 above demonstrates that increased training and awareness can reduce incidents.

Key Highlights

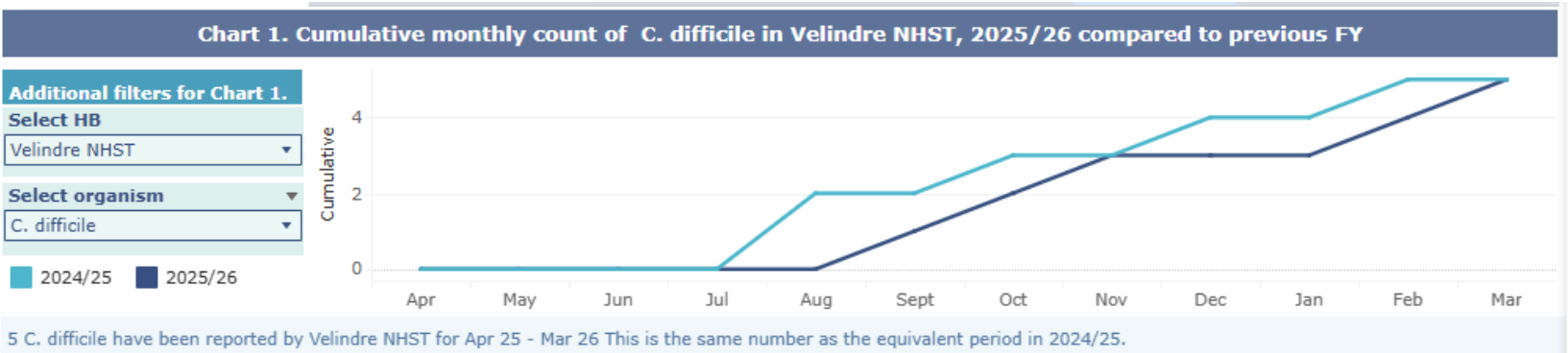
- Sustained zero incidence of Pseudomonas aeruginosa and MSSA/MRSA bacteraemia
- World Health Organisation Hand Hygiene Day – Handopoly - The team developed a unique, innovative learning experience
- Introduced a new FFP3 mask to streamline training, save resources and most importantly improve staff safety
- Increase in uptake of Influenza vaccine
- IPCT member successfully completed Ventilation in the healthcare environment to give added resilience and knowledge base to the team

Healthcare Associated Infection

Healthcare acquired infection is a patient harm indicator and we need to do all we can to prevent patients acquiring such infections. The graphs that follow are from the Healthcare Associated Infection Surveillance tableau and show infections that occurred during 2025-2026 compared to the previous financial year:

Clostridioides difficile

Graph 11



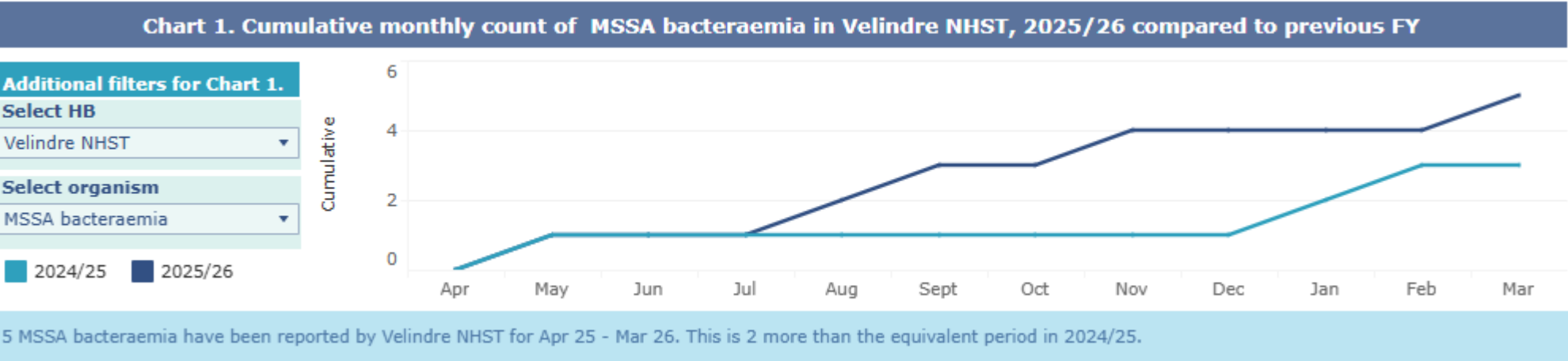
During the **2025/26** reporting period, **5** cases of healthcare-associated Clostridioides *difficile* infection (CDI) were reported. This is consistent with number reported the previous year. Only one case was deemed to be attributed to Velindre following a Root Cause Analysis which marks a reduction of **2** cases (**66%**) compared to the previous year, reflecting a positive trend in infection prevention efforts.

MRSA Bacteraemia

There were no cases of Meticillin-Resistant Staphylococcus aureus (MRSA) bacteraemia were reported in the **2025/26** period, consistent with the number recorded in the previous year. **There have been no Velindre acquired MRSA bacteraemia since 2013.**

MSSA Bacteraemia

Graph 12

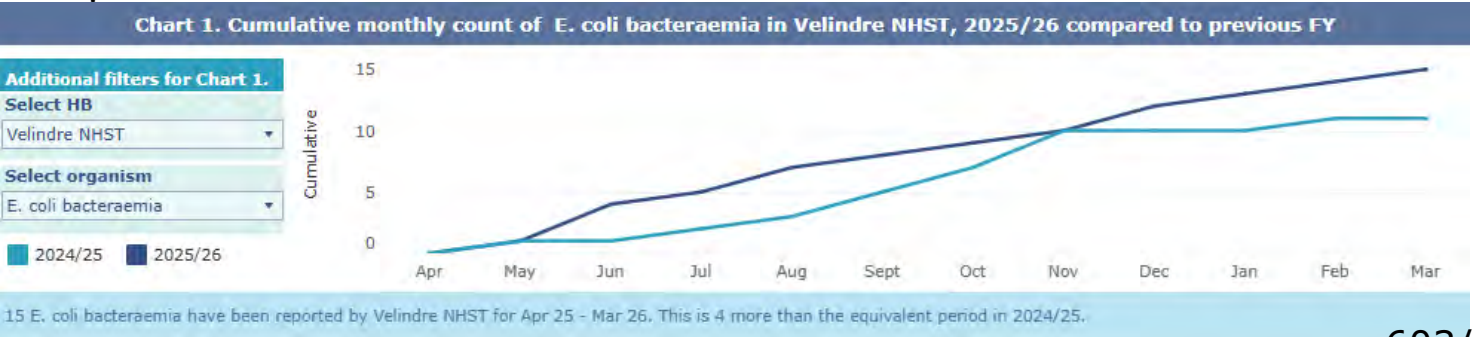


In the **2025/26** reporting period, there were **4** cases of healthcare-associated Meticillin-Sensitive Staphylococcus aureus (MSSA) infection. This represents an increase of one case from the previous year’s total. Following an investigation, none of the cases were identified as having been acquired at Velindre.

E. coli Bacteraemia

In the 2025/26 reporting year, there were 15 recorded cases of healthcare-associated *E. coli* bacteraemia. This represents an increase of four cases compared to the previous year. Following investigation, **five** cases were identified as having been acquired within Velindre.

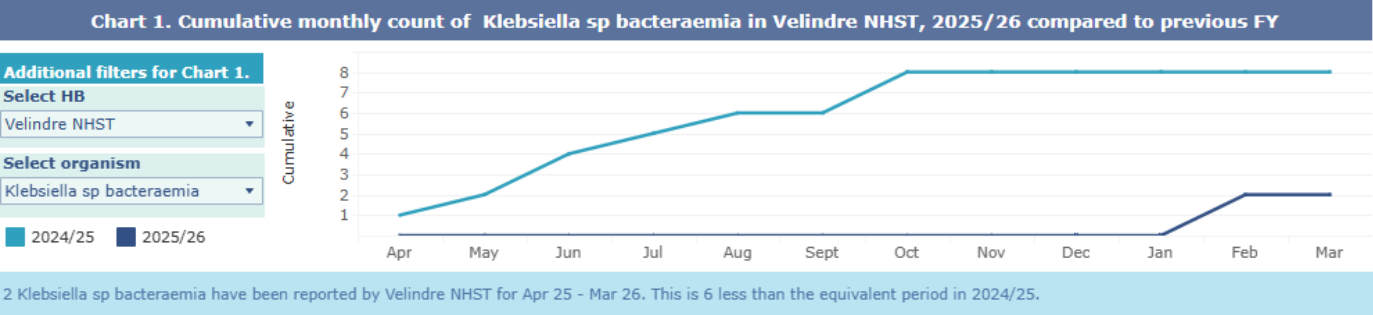
Graph 13



Pseudomonas aeruginosa Bacteraemia

There were two reported cases of *Pseudomonas aeruginosa* bacteraemia in the 2025/26 period, neither were attributable to Velindre. This maintained the zero-incidence level achieved in the previous year.

Klebsiella species Bacteraemia



During 2025/26, two cases of healthcare-associated *Klebsiella* species bacteraemia were reported, representing a reduction of six cases from the previous year. Detailed investigation found that none of the eight cases were acquired within Velindre.

Velindre acquired HCAI (case numbers)	21/22	22/23	23/24	24/2025	25/26
MSSA	2	3	0	0	0
MRSA	3	0	0	0	0
C. difficile	5	3	7	3	1
Klebsiella species	1	1	6	1	0
E. Coli	5	6	6	1	5
Pseudomonas	5	0	0	0	0

Velindre acquired healthcare infections – 5 year trend

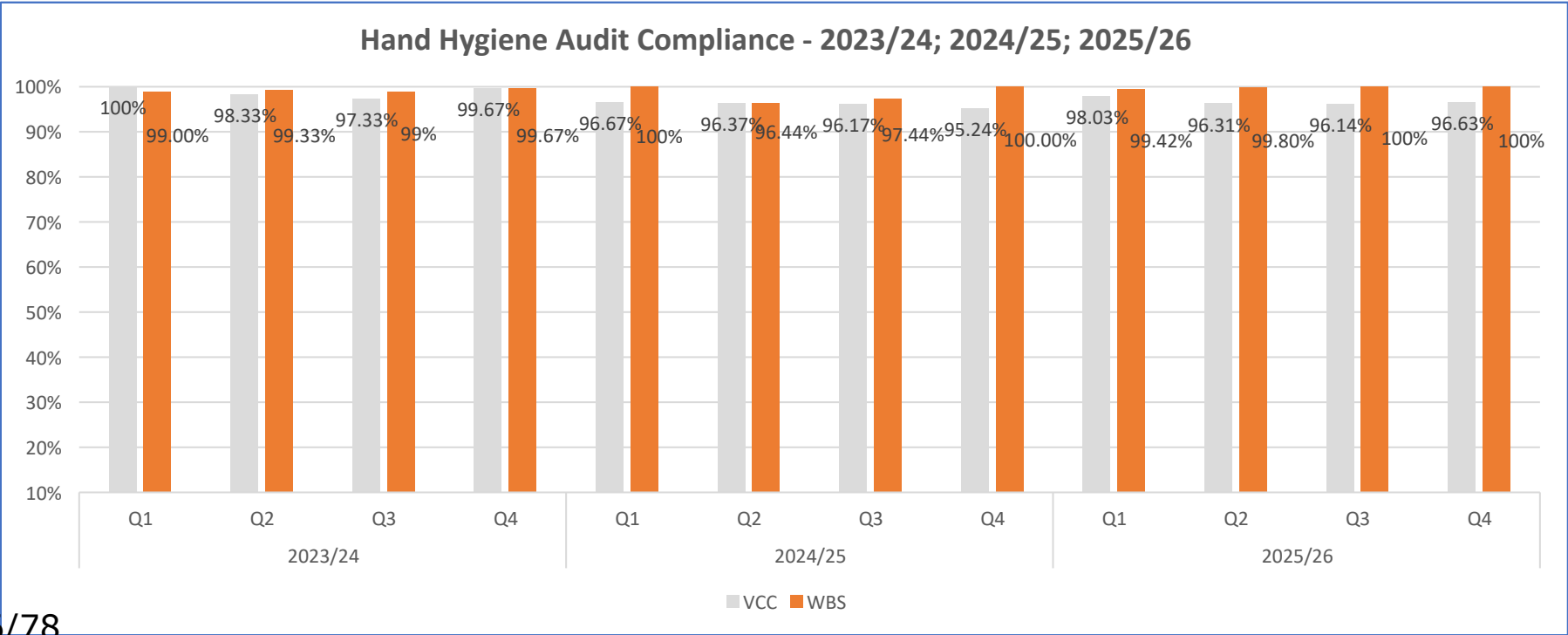
The 5 year trend of Velindre acquired health care infections shows that there is an overall improved picture, However, the situation regarding E-Coli infections will be monitored closely.

Trend data continues to be reviewed at the Infection, prevention and Control Management Group on a quarterly basis.

AUDITS Clinical Practice audits

Clinical practice audits are necessary elements of healthcare as they ensure delivery of high quality and safe patient care. Throughout the clinical areas of VCS, the audits serve as systematic evaluations of practices, processes, and outcomes, aiming to identify areas of improvement and adherence to standards and guidelines and areas of excellence. Clinical practice audits undertaken include compliance with urinary catheter bundles, ANTT, central venous catheter maintenance, and peripheral cannula care bundles. This high compliance is reflected in the sustained low infection rates.

Graph 15



Hand Hygiene

Observational audits were conducted throughout the year in alignment with the World Health Organisations ‘5 Moments for Hand Hygiene’ framework, which emphasises critical points of patient care where hand hygiene is essential to prevent healthcare-associated infections. Audits were conducted by both departmental hand hygiene champions and the IPCT, providing valuable insights into compliance and serving as a proactive measure to reinforce best practices. Observers identified several missed opportunities — most commonly before patient contact and after patient environment — which are promptly addressed through immediate, constructive feedback and on-the-spot education. This real-time approach not only supports individual accountability but also fosters a culture of continuous improvement and patient safety across clinical teams.



Innovation & Sustainability

Infection prevention and control measures play a key role in supporting NHS sustainability by reducing healthcare-associated infections, thereby lowering the need for intensive treatments and extended hospital stays. This improves patient outcomes while also contributing to environmental objectives through more efficient use of resources, including time, more sustainable products and reduced waste.



FFP3 Mask Streamlining:

The organisation has transitioned from the use of multiple FFP3 mask types, with a fit test pass rate between 9% and 29% to a single UK-manufactured FFP 3 masks. This change has supported UK production, delivered financial savings, and significantly reduced the time staff spend away from clinical areas. The new mask, which has a substantially lower unit cost has achieved a 100% fit-test pass rate among VCS staff to date and has enabled more streamlined stock management. Powered Aire-Purifying Respirators (PAPR) units remain available to ensure inclusivity and full compliance.

Through strong collaboration with the Surgical Materials Testing Laboratory (SMTL), Welsh Blood Service, and the Trust Sustainability Lead, the IPC team has progressed two priority projects that improve infection control and promote environmental responsibility.



Sustainable Hand Hygiene Solutions:

The organisation is transitioning to the use of a non-alcohol hand sanitiser as part of its commitment to reducing environmental impact while maintaining high standards of hand hygiene. This change supports sustainability objectives by lowering reliance on alcohol-based products, which have a higher environmental footprint in manufacture, transport, and disposal. The selected product has been carefully assessed to ensure it continues to meet infection prevention and control requirements, providing effective hand hygiene when soap and water are not available. In addition, the move will deliver benefits in staff hand health, with improved skin tolerability, supporting compliance with hand hygiene practices and reducing incidence of occupational skin damage.

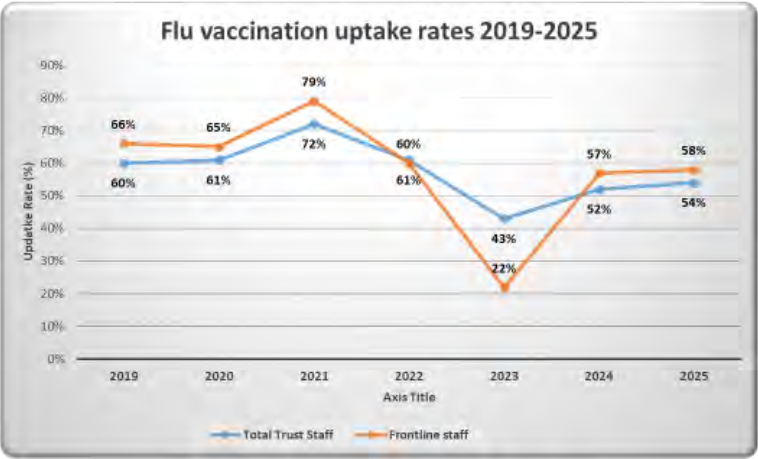


Staff Influenza Campaign

The local vaccine uptake targets for the 2025/26 season for healthcare workers with direct patient contact is unchanged from the previous season remained at 65% alongside 100% of the staff are offered the vaccine.

An overall Trust compliance rate of 54% with frontline staff achieving 58%. This was an improvement from the 2024/2025 campaign with update of flu vaccine amongst Trust staff at 52% and 57% frontline staff.

Graph 16



Decontamination

In line with Welsh Government guidance (WHC/2015/050), all healthcare organisations in Wales are required to ensure that reusable medical devices are safe for patient use and staff handling, and do not pose an infection risk. Effective management of these devices is fundamental to delivering high-quality care across diagnosis, treatment and monitoring while supporting patient safety, clinical effectiveness and financial stewardship.

In the year 2025/26 the Trust Decontamination group has been re-established to provide strengthened oversight, assurance and multidisciplinary governance. Procurement is progressing for an automated theatre pack tracking system, aligned with gold-standard practice to improve traceability, compliance and auditability of reusable medical devices. In parallel, enhance education and training opportunities have been introduced for theatre and decontamination-related staff, supporting competence, consistency and regulatory compliance.

For assurance, there remains no evidence to indicate transmission of infection associated with current decontamination practices and infection prevention and control risks continue to be effectively managed while improvement actions are embedded.

Collaborative Working

The IPC team works collaboratively with the Welsh Blood Service to ensure a coordinated, evidence-based approach to the prevention and management of bacterial contamination risks in platelet donations. Infection prevention and control audits are integral to this approach with established baselines and repeat audits undertaken as required to monitor effectiveness, reduce transmission risk and evidence compliance with best-practice standards. Progress against audit findings is reported through IPC meetings, supporting robust governance, continuous surveillance, and quality assurance to safeguard both donors and recipients.



The Trust's Safeguarding achievements are driven by a strong organisational culture, which embeds the Trust's values, fosters professional curiosity, encourages scrutiny and supports the actions required to protect those at risk of abuse or in need of care and support.

This section of the Annual Report provides the Trust with assurances that the organisation is meeting the statutory duties under the Children Act 2004, The Social Services & Wellbeing (Wales) Act 2014, the Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015, the Domestic Abuse Act 2021 and Mental Capacity Act & Deprivation of Liberty Safeguards (MCA/DoLS).

Key Achievements 2025-2026:

- **4%** increase in safeguarding training compliance when comparing end of year figures with 2024-2025, bringing the overall total for the Trust to **82%**.
- Use of digital systems to support a hybrid approach to delivering safeguarding training. This has increased the number of staff who are able to attend training.
- Introduction of 4 new Learning Disability champions who will join our established safeguarding and dementia champion network.
- Safeguarding information stands at WBS and VCC during National Safeguarding Week .
- Overall increase in safeguarding activity across this reporting year.
- Success for VCC and WBS at the National Safeguarding Service celebration event.

Key Challenges 2025-2026:

- Progressing the safeguarding and vulnerable person workplan.
- The completion of a pathway to facilitate contact between victims of domestic abuse/sexual violence. However, an infographic has been developed for Velindre Cancer Service staff to support victims/survivors experiencing these forms of abuse/violence.
- The post of practice/educator for MCA/DoLS remains vacant.
- Unable to update the Managing Allegations/ Concerns Against a Practitioner or a Person in a Position of Trust due to the delay in the publication of national guidance.
- Ensuring that there is consistent representation at national, regional, and local groups whilst providing operational support to the divisions.

Safeguarding Activity

Report Type	2023/24	2024/25	2025/26
Adult at Risk	13	9	11
Child at Risk	1	6	5
Total	14	15	16

ANALYSIS

During the reporting period, Velindre University NHS Trust submitted a total of **16** Duty to Reports, as reflected in the table opposite. This slight increase reflects heightened awareness, vigilance and the growing confidence among staff in recognising and reporting safeguarding concerns. The range of safeguarding themes identified highlights the complexity and often multifaceted nature of the situations encountered.

Section 5: Concerns/Allegations against a Practitioner or Person in a Position of Trust

Section 5 of the Wales Safeguarding Procedures sets out arrangements for responding to safeguarding concerns about those whose work, paid or voluntary brings them into contact with children and adults at risk.

In previous reporting years, Velindre University NHS Trust has recorded a consistently low number of cases which have either been considered or managed through this process. However, this reporting year has seen an increase in incidents discussed or progressed under Section 5. This reflects the wider national picture being observed across other Health Boards and NHS trusts in Wales.

Cases have been identified through both external referrals, primarily from local authority partners, and internal mechanisms, including staff reporting and safeguarding review processes, demonstrating an increased awareness and appropriate use of Section 5 as part of the safeguarding framework.

Report Type	2023/24	2024/25	2025/26
Practitioner or Person in a Position of Trust	3	0	6
Total	3	0	6

Types of alleged abuse

The charts on the right illustrates the type of alleged abuse cited in the safeguarding reports submitted in 2025-26. Reports were made to 7 Local Authority areas, as we are a commissioned service.

During this reporting period, safeguarding reports have captured a broader range of abuse categories than in previous years, reflecting an increasingly complex safeguarding landscape. This wider representation highlights improvements in staff confidence and competence in identifying, recognising and accurately recording abuse and neglect.

Graph 17



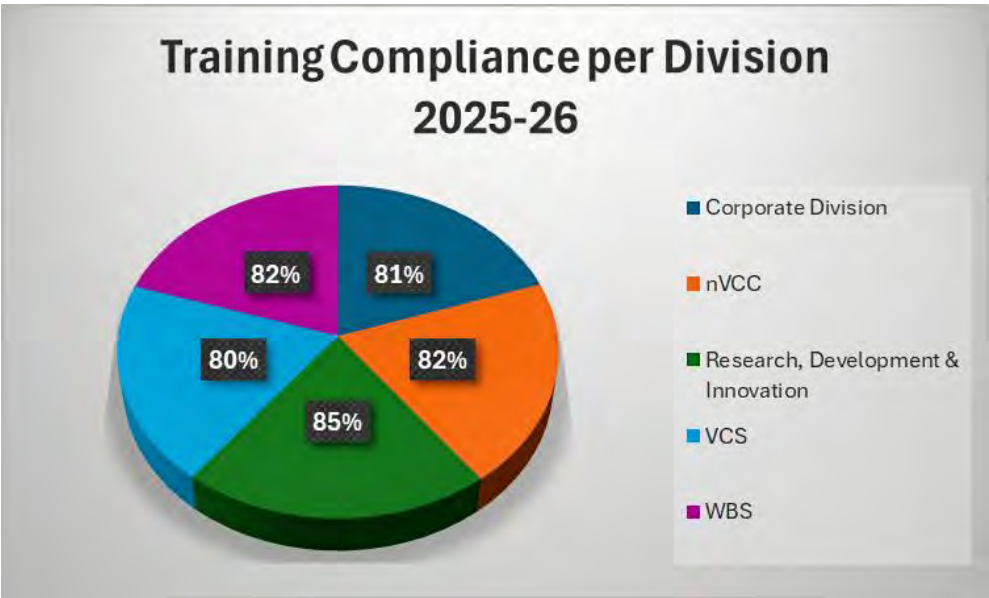
Training

- Safeguarding training compliance across the Trust has increased by 4% during the reporting year, with an end-of-year completion rate of 82%.
- Training is delivered through a range of flexible formats, including live sessions via Microsoft Teams, classroom-based learning, and the LMS365 platform, enabling staff to access learning in a way that supports both individual needs and service delivery.
- A Safeguarding module also forms part of the Trust's Fundamental of Management programme. During this year there have been 12 sessions reaching 238 staff.
- Training packages are regularly updated to reflect learning from safeguarding reviews and current national guidance. Evaluation feedback remains positive, with staff reporting improved confidence in identifying and managing safeguarding concerns.
- There is an opportunity to further explore the use of digital platforms to expand access to safeguarding education to teams where compliance is difficult to achieve, support continuing professional development and enhancing knowledge across the workforce.

Graph 18

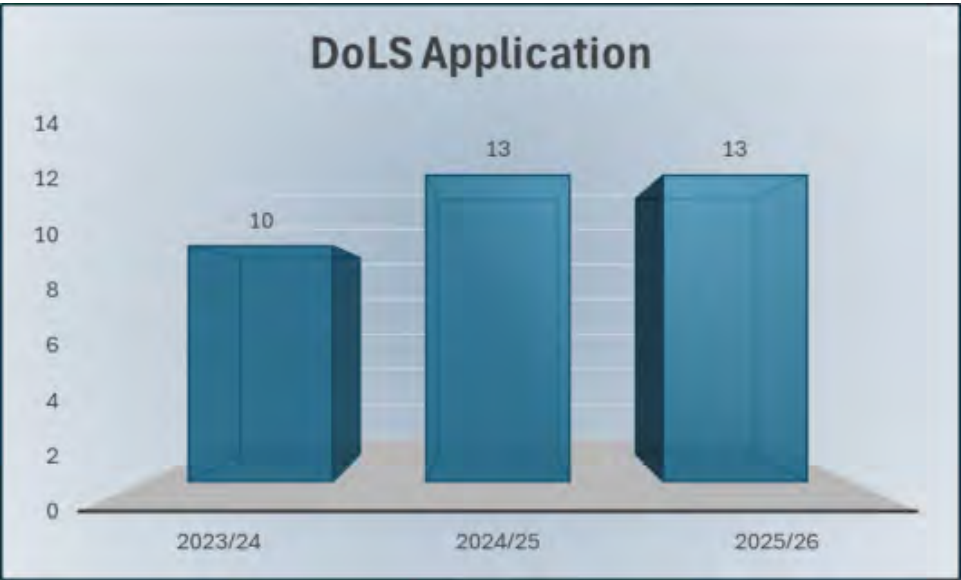


Graph 19



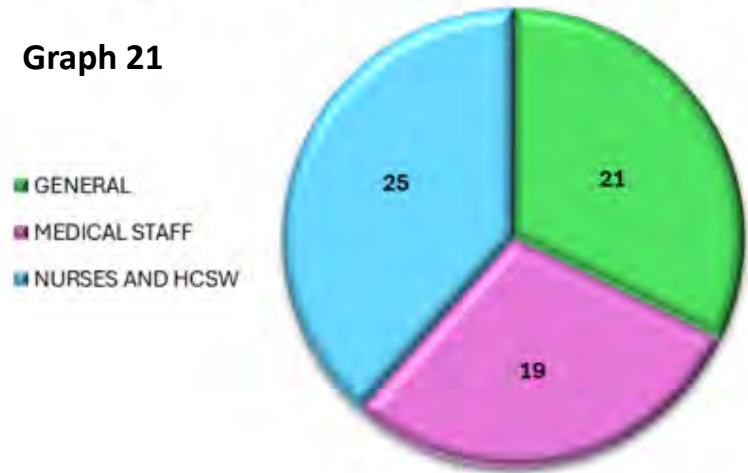
Deprivation Of Liberty Safeguards (DoLS) activity

Graph 21



MCA / DoLS total completed via LMS365

Graph 21



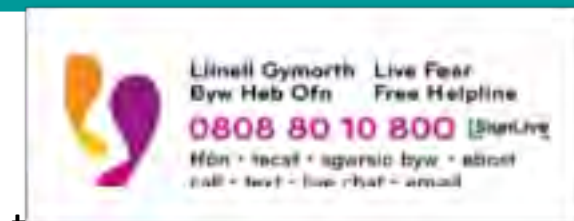
Analysis

13 applications for Deprivation of Liberty Safeguards (DoLS) were made during this reporting period. This is equal to the number submitted 2025-26. However, it was noted that there was not a consistent level of submissions over the quarters as seen in previous years. For example, there was 1 submission in Q1 and no submissions during Q3. There was an increase in applications during Q2 which reflected learning that had been identified following an incident.

MCA/DoLS training is available via LMS 365 learning platform which enables staff to continue to access training despite the MCA/DoLS Practice Educator post remaining vacant. 3 different packages are available, 1 for medical staff, 1 for Nurses and HCSWs and 1 for AHP staff. Access to the course is provided to staff, who will then view a recording and complete a knowledge checker. The course is evaluated well.

MCA resources for staff on first floor ward have been reviewed and updated, and a member of the First Floor Ward team has been identified as a DoLS champion.

Violence Against Women, Domestic Abuse & Sexual Violence



Domestic abuse causes long-lasting physical and mental health harm. It can impact on cancer care, treatment, recovery and a person's ability to attend and donate in donor sessions. Working in the Cancer Centre and Welsh Blood Service provides a unique window to **'Ask & Act'**.

This year the Trust supported victims/survivors who experience these forms of abuse by:

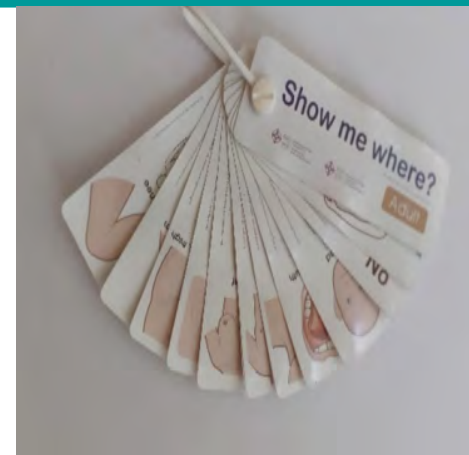
- **Providing training to staff at all levels to recognise and respond to issues related to VAWDASV. There has been a 17.5% increase in training compliance when compared with the end of year total for 2024-25.**
- **2 members of staff have completed the Welsh Women's Aid Train the Trainer course which enables them to deliver 'Ask & Act' training. Ensuring more sessions are delivered across the workforce.**
- **Safeguarding champion for VCC has developed an awareness and signposting resource for staff to support victims/survivors of VAWDASV.**
- **WBS are currently developing a similar resource for donors and staff.**
- **Staff have successfully supported victims to access community or health based Independent Domestic Violence Advisers (IDVAS).**
- **Staff have been supported to complete Domestic Abuse risk assessments for patients and refer into the Multi-Agency Risk Assessment Conference (MARAC) process to ensure ongoing safety planning for a victim/survivor and their family.**
- **Ensuring Safeguarding processes are triggered where an adult or child at risk is affected by these issues.**

Whilst we continue to support more female victims/survivors of VAWDASV, we did see an increase of men who disclosed that they were experiencing domestic abuse during quarter 4 of this reporting period.

Vulnerable persons

Dementia Workplan Key Achievements 2025-2026:

- 5 new Dementia Champions completed Dementia training at Tier 3 influencer level.
- Dementia training Tier 2 is continuing to improve there has been a **15% increase** in compliance from end of year total 2024-25.
- The Carers Pathway has been reviewed and updated, with a view to launch during Carers week in June.
- CareFit for VIPS assessments have been completed on First Floor Ward and OPD, with a further 2 assessments commenced in Therapies and Radiotherapy.



Learning Disability Workplan Key Achievements 2025-2026:

- 4 new LD Champions completed bespoke training delivered by Cardiff LD Community team.
- A reasonable adjustment checklist was developed with the aim for OPD to commence its use in Q1 of 2026-27.
- OPD will pilot the use of DISDAT cards which are visual aids to support patients who are non-verbal to communicate during appointments.
- Benchmarking exercise looking at LD pathways in other cancer centres has been completed. The aim is to look at adopting similar pathways for VCC



Health, Safety & Fire Incidents

Annual Report 2025 - 2026

OUTCOME

✓

Overall incident levels remain stable with continued improvements in several area.

✓

Accident & Injury incident remain the highest category but lower than 2021-2022 levels.

✓

Infrastructure & Equipment incidents remain low.

✓

Most incidents resulted in low or negligible harm.

✓

RIDDOR incidents increased to 8, with all reviewed and investigated.

✓

A positive reporting culture continues to support learning and improvement

FOCUS

➤

Reduce workplace accidents and injuries

➤

Support staff affected by violence, aggression and inappropriate behaviour.

➤

Review manual handling risks and musculoskeletal injuries.

➤

Strengthen learning from RIDDOR reportable incidents

➤

Improve environmental and venue safety.

➤

Promote staff wellbeing and occupational health support

THEMES

Slips, Trips & Falls
Most common cause of injury across staff, patients, donors and visitors.

Manual Handling & MSK
Prominent across clinical and mobile collection services.

Sharps & Exposure
Recurring risk with multiple needlestick incidents.

Violence, Aggression & Antisocial Behaviour
Increase in verbal abuse, threatening behaviour and inappropriate conduct.

Environmental & Equipment Hazards
Doors, trolleys, seating, trailers and venue infrastructure.

TRENDS

↓

Accident, Injury
Reduction since 2021-2022 (116 to 95) with slight increase from 2024-2025.

↑

Behaviour
Increase to 42 (highest since 2021-2022)

↓

Equipment devices
Remains low and stable.

↑

Ill Health (work related)
Increased to 5 and zero in 2024-2025.

↓

Infrastructure
Significant reduction from 30 to 2.

↑

RIDDOR
Increase to 8 (highest in the last 5 years)

INCIDENTS BY CATEGORY OVER 5 YEARS					
	2021-2022	2022-2023	2023-2024	2024-2025	2025-2026
Accident, Injury	116	111	114	91	95
Behaviour	40	31	35	27	42
Equipment, Devices	21	2	8	2	2
Ill Health, Work related	10	2	2	0	5
Infrastructure	30	7	14	0	2
RIDDOR	2	4	3	5	8



Graph 22

The Trust is working to make sure its services are safe, effective, and centred around the needs of patients, donors, and the public. It shows how quality is being considered in important decisions, how the Trust is learning from feedback and concerns, and how it is improving the way it checks performance and responds to issues. It also highlights ongoing work to strengthen staff support, improve oversight, and use information more effectively so that services continue to improve and people receive the best possible care and experience.

- The Trust will maintain its focus on the four established quality priorities in 2026/2027, recognising that further work is required to fully embed and sustain improvements.
- These priorities have been identified through analysis of our quality management systems, alongside feedback from staff, patients, and donors, ensuring continued focus on the areas that matter most.
- Each division has agreed its own priorities, which have been formally approved and will continue to be monitored through the Trust’s governance arrangements.
- These priorities are also embedded within the Integrated Medium-Term Plan, which sets out the approach to delivering sustained improvement.

Priorities for 2026/2027:

Priority 1

Improving patient and donor communication

Priority 2

Strengthening quality and safety systems

Priority 3

Improving patient and donor safety

Priority 4

Implementing a Trust Quality Dashboard

Priority 5

Fully embed the People’s Experience Framework

Priority 6

Implement the Listening to People Regulations

A year of learning translated into safer, more person-centred services

The 2025/26 report demonstrates that the Trust is using feedback, incidents, audit and assurance processes to drive learning and improvement, with quality and safety embedded across governance arrangements.

However, several areas require sustained focus, where performance is **not yet where it needs to be**. The key cross-cutting risks are:

- Communication (appointments, access, treatment information)
- Timely follow-up and closure of incidents and actions
- Pathway coordination and booking processes
- Capacity and workforce pressures
- Reliance on manual and non-standardised processes
- Digital system limitations impacting safety and reliability

These issues matter because they directly affect patient and donor experience, safety and confidence.

Communication remains a consistent theme in complaints and patient feedback, alongside ongoing challenges with waiting times and access to services. Incident management and Duty of Candour reviews highlight recurring risks in communication, escalation, medication safety and pathway management.

In Welsh Blood Service, system-level risks remain in relation to manual transcription and laboratory reporting processes, requiring longer-term digital solutions.

Overall, the Trust has strong evidence of learning and improvement, but the priority for 2026/27 is to ensure this is **consistent, embedded and measurable**, with a clearer focus on the risks that matter most and their impact on patients, donors and services.





GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

TRUST BOARD	
Annual Equalities Report 2026	
DATE OF MEETING	30 July 2026
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	ASSURANCE
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Claire Budgen, Organisational Development Specialist
PRESENTED BY	Sarah Jenkins, Executive Director of People and Organisational Development (Interim)
APPROVED BY	Sarah Jenkins, Executive Director of People and Organisational Development (Interim)
EXECUTIVE SUMMARY	This report describes the workforce profile for the core Trust and supplies statistics and commentary for the core Trust and the combined Trust. The analysis has been supplemented by data from the Gender Pay Gap report, WRES report 2025 and the NHS Staff Survey 2025.
RECOMMENDATION / ACTIONS	• Enhance Board Members' cultural competence through providing a series of development sessions. Aligned to the Line of Sight Board Development Plan to ensure 1 plan. • Actively address race and gender disparity so that we understand what the barriers to high paid roles are and how to address them. Further develop our coaching support, develop interview skills development sessions for minority

	ethnic staff and for women. • Support the Staff Networks to grow in order to advocate, educate and influence, in particular the networks for Women, Race and LGBTQ+. • Implement the programme of Sexual Safety training so that people feel able to address aggression where it occurs and create conditions of respect where it will not thrive. • Run a Pulse Survey against the five themes from the NHS Staff Survey to understand whether there are any disparities in staff experience relating to protected characteristics. • Explore reasons for staff choosing 'Do not wish to disclose' for any monitoring question, particularly regarding their Religion. • Work with Patient and Donor groups to embed the organisational values of Caring, Respectful and Accountable and affirm that discrimination on the grounds of race, sex or gender, or any other protected characteristic, is not welcomed.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	Date
Executive Management Board	2.7.26
Quality, Safety and Performance Committee	9.7.26
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Executive Management Board endorsed the report for onward submission to the Quality, Safety and Performance Committee. The Quality, Safety and Performance Committee welcomed the three-year trend analysis contained in this year's report. They also highlighted as positive the increase in declarations for most of the protected characteristics which enables the Trust to make better-informed decisions. An area for future interest was to understand intersectionality and whether there are any combinations of characteristics that lead to specific areas of disadvantage or challenge. It was reported in response to this point that the forthcoming Workplace Equality Standard report would surface key points of intersectionality for our attention.	
7 LEVELS OF ASSURANCE	
If the purpose of the report is selected as ' ASSURANCE ', this section must be completed.	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 3 - Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes <i>Please refer to the Detailed Definitions of 7 Levels of Evaluation to Determine RAG Rating / Operational Assurance and Summary Statements of the 7 Levels in Appendix 3 in the "How to Guide for Reporting to Trust Board and Committees"</i>
APPENDICES	
1	Velindre Core Trust – three-year statistics for protected characteristics
2	Combined Trust legal entity – three-year statistics for protected characteristics

1. SITUATION

The Public Sector Equality Duty (PSED) within the Equality Act 2010 requires all public authorities covered under the specific duties in Wales to report their equality data each year. The Trust is required to publish this report by 31 March 2027.

2. BACKGROUND

The Trust formally reports equality data for the legal entity of the Trust including all hosted organisations. In addition, the Trust examines the data for its core services, which excludes NWSSP. Therefore, there are two sets of figures used in this report, found at Appendix 1 and Appendix 2.

Actions responding to issues raised by these figures for the core Trust are developed through our Strategic Equality Plan actions.

This year's report includes change over the past three years for the core Trust and the combined Trust. The discussion includes relevant findings from the NHS Staff Survey 2025, the Workforce Race Equality Standard (WRES) and our Gender Pay Gap report. This ensures we have a well-rounded understanding of our workforce profile and what steps to take to fulfil the requirements of the Public Sector Equality Duty.

During the summer of 2026 the WRES will be replaced in NHS Wales by the Workforce Equality Standard (WES). This will give insights across a range of protected characteristics and direct attention to workforce risks and opportunities for improvement for the 2027 Annual Equalities report.

3. ASSESSMENT

3.1 This assessment provides graphs and tables relating the core Trust workforce profile. The narrative also includes commentary on the combined Trust profile in order to address both sets of data.

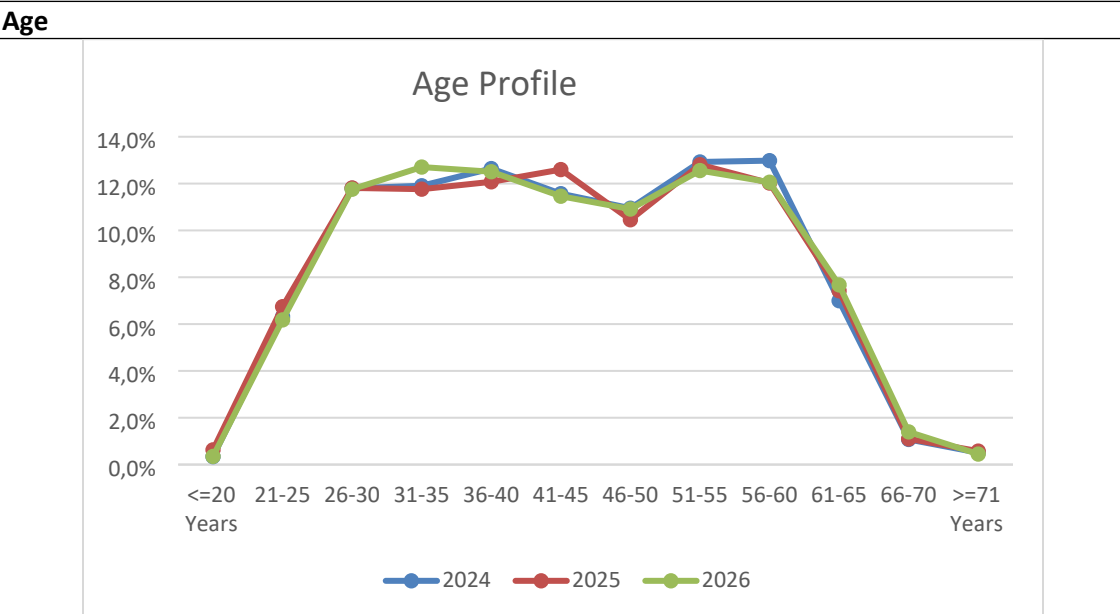
Gender							
Characteristic	Category	2024 Headcount	2024 %	2025 Headcount	2025 %	2026 Headcount	2026 %
Gender							
Gender	Female	1312	74.0%	1427	74.6%	1506	75.0%
	Male	460	26.0%	486	25.4%	501	25.0%
	Grand Total	1772	100.0%	1913	100.0%	2007	100.0%

The Trust employs three times as many women as men. These proportions have remained relatively stable over the past three years, with a marginal increase in the female share of the workforce. With 1,506 women in the workforce, spread over all age ranges, it will be important to support women's health, in particular mitigating any impact of menopause on work. There is a risk that our workforce is impacted where middle aged adults, in particular women, are caring for children and older parents at the same time.

The gender profile for the combined Trust is much more even, with 60% female and 40% male. This reflects the different range of jobs in play in the two groups: NWSSP acts as the Single Lead Employer for Resident Doctors and has a more even spread of men and women within their corporate functions whereas the core Trust employs Nurses and other Healthcare professionals who are more likely to be women.

The mean Gender Pay Gap for the core Trust for 2026 stands at 10.1%. Whilst this is lower than many other NHS organisations, it does reflect a systemic barrier to high paid jobs for women. The root of the pay gap lies in the top end of Quartile 4 of salaries where men are over-represented and also there the highest hourly rates of pay.

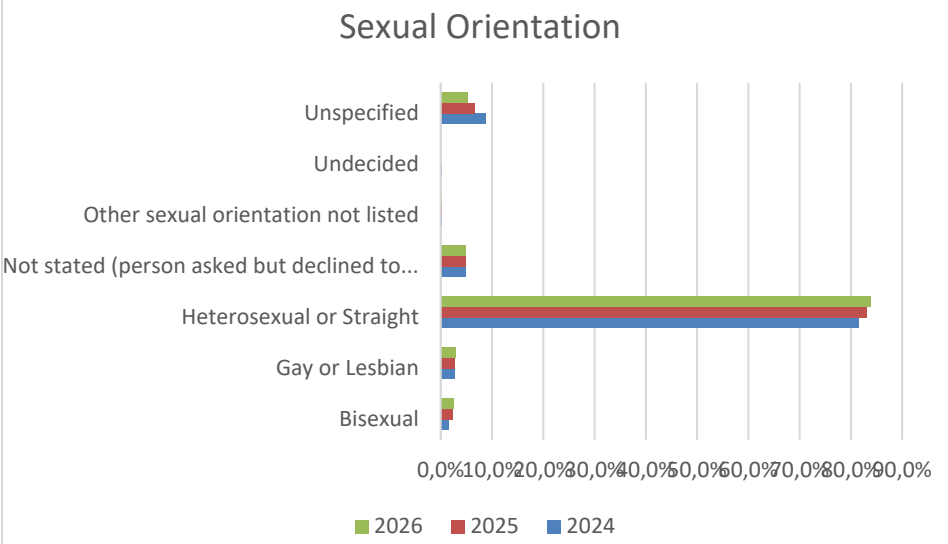
One of the key issues emerging from the 2025 NHS Staff Survey was dissatisfaction with access to flexible working or support for work life balance. This is likely to affect women more often than men, due to the persistence of social norms pertaining to women being chief care givers. This was reflected in the statistics and the free text comments where people have described unequal access to flexible, hybrid or part-time working opportunities.



The age profile shows an even distribution of employees across the age ranges. The 2024 peak at age 60 has reduced and the trend is towards having an even spread across the ages. This is a healthy balance between retaining expertise and developing the next generation of healthcare professionals.

In contrast, the combined Trust shows a weighting towards the age range 26 to 35: the key age groups for Resident Doctors.

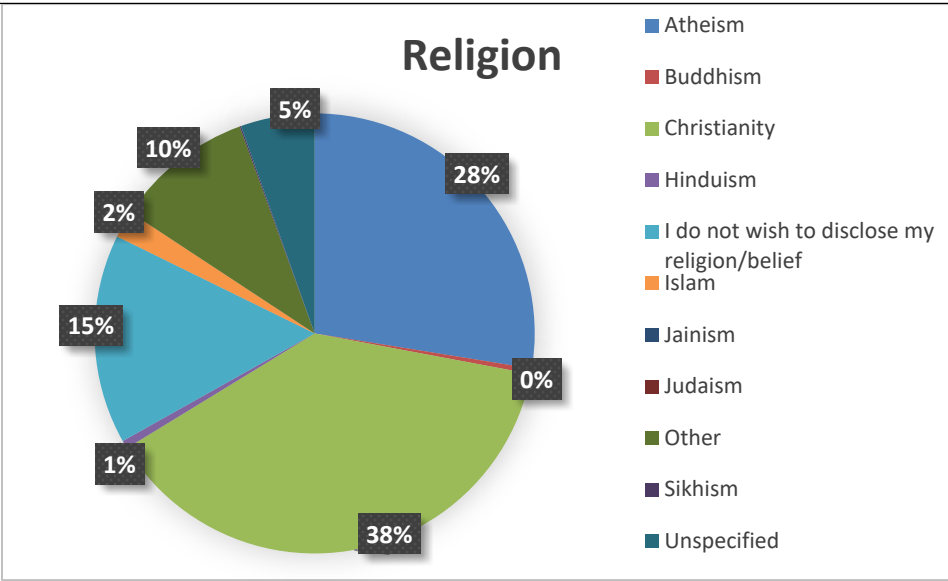
Sexual Orientation



84% of the workforce record themselves as heterosexual/straight. The figures show an increase in all specified categories over the past three years with a corresponding drop in Unspecified/Undecided/Not Stated. Whilst the actual numbers are small, there has been an increase in employees recording themselves as bisexual.

The combined Trust reports a lower proportion for heterosexual/straight people, at 75%. However, this is compensated by 15.7% being unspecified. There are no clear patterns of difference between the other groups when comparing the core Trust and the combined Trust.

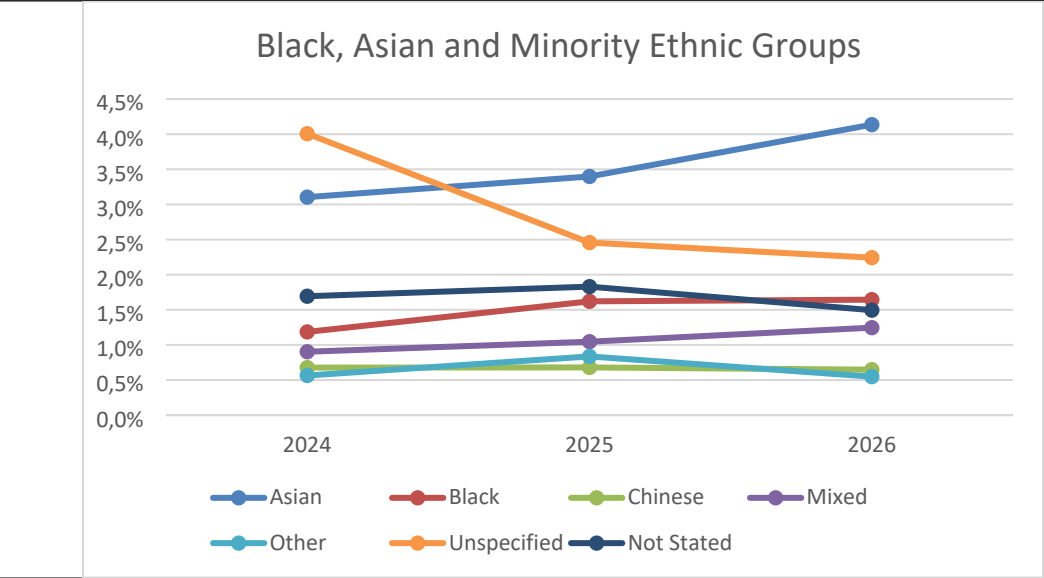
Religion



The largest group is Christianity, followed by Atheism then I do not wish to disclose. The figures at Appendix 1 show that Christianity is decreasing over time whilst Atheism is increasing. All other religions report 2% or lower of the workforce. This reflects a trend towards secularism in wider society.

When looking at the combined Trust, all specified religions report falling percentages over the last three years. The biggest change is the increase in 'I do not wish to disclose my religion' which has gone from 10% in 2024 to 21% in 2026. This compares with a steady 15% for the core Trust. These figures may reflect a nervousness about declaring one's religion and the reasons for choosing this option should be explored sensitively.

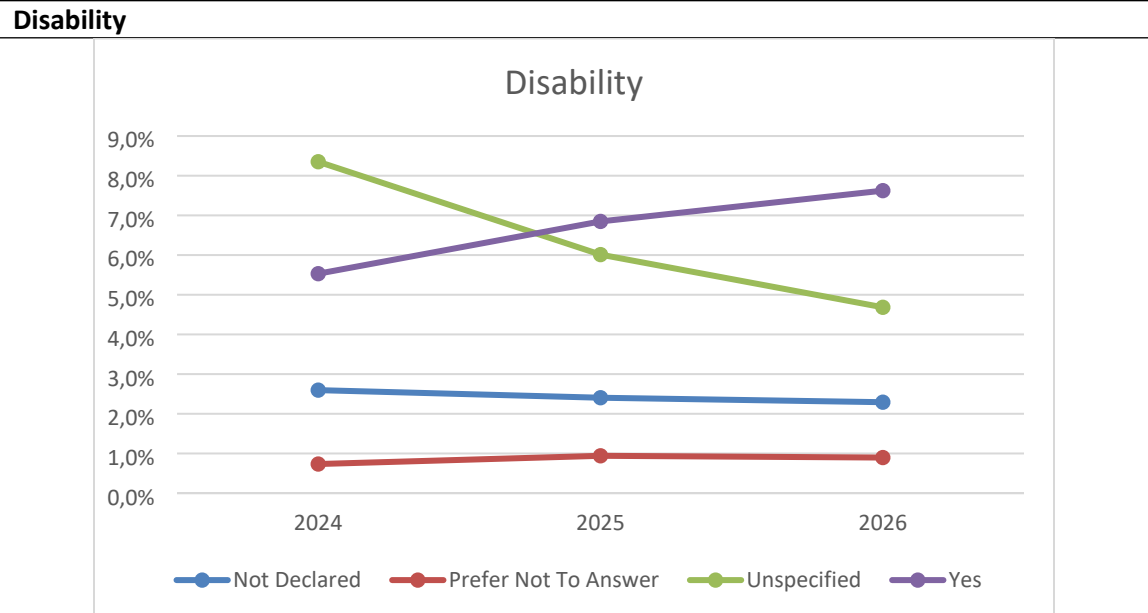
Race



The data at Appendix 1 shows that the proportion of the workforce who are White has remained at 88% for the past three years. The graph above shows the relative change amongst the minority ethnic groups contained within the remaining 12% of the workforce. There has been an increase in staff from an Asian background, moving from 3.1% to 4.1%, and a decrease in employees listed as Unspecified from 4% to 2.2%.

The data for the combined Trust show a broader range, with 71.6% reporting themselves as White and 10.3% selecting Asian as their ethnic group. There is a higher level of non-reporting with a total of 8.7% of the combined Trust not selecting any group.

The WRES report 2025 showed improvements since 2024 in terms of declaring ethnicity on ESR and parity of Board representation and staff composition. However, three main areas of concern emerged where ethnic minority staff were having a poorer experience at work than white colleagues: bullying, harassment and discrimination, perceiving a lack of opportunity to progress and being less likely to be appointed to a role following shortlisting. These findings were taken into account in the equalities programmes in hand during the year.



The data at Appendix 1 shows that 84.5% of the workforce say they do not have a disability, up slightly since 2024. The graph above shows the data for the other reporting categories and demonstrates a clear increase in the percentage of people reporting having a disability, growing from 5.5% in 2024 to 7.6% in 2026. The biggest drop is in the unspecified category which means more people are choosing to actively record their status.

The figure for people saying they do not have a disability was very similar for the combined Trust, at 85.1%. However, the percentage reporting that they did have a disability was lower, at 4.1%. This is blanced by a greater proportion not stating their situation which is 8%.

The results of the 2025 NHS Staff Survey showed dissastisfaction with access to flexible working and support for work life balance which may relate to staff with disabilities. People are able to request changes to working patterns in order to accommodate disabilities. Recognising the change in the law around flexible working that puts the onus on the employer, it is still appropriate for service needs to be considered in addressing any request. The Trust will benefit from extending the understanding of managers about what might be possible under the heading of Reasonable Adjustments for Disability.

Disablity came up as the strongest equalities theme within the free text comments in the 2025 Staff Survey. Comments highlighted concerns about how staff with long-term conditions, mental health needs, and health-related attendance are managed, with a strong emphasis on flexibility, compassion and practical support.

Marital Status							
Characteristic	Category	2024 Headcount	2024 %	2025 Headcount	2025 %	2026 Headcount	2026 %
Marital Status							
Marital Status	Civil Partnership	32	1.8%	38	2.0%	43	2.1%

	Divorced	114	6.4%	124	6.5%	128	6.4%
	Legally Separated	11	0.6%	14	0.7%	10	0.5%
	Married	908	51.2%	981	51.3%	1021	50.9%
	Single	543	30.6%	594	31.1%	641	31.9%
	Unknown	98	5.5%	108	5.6%	109	5.4%
	Widowed	16	0.9%	19	1.0%	22	1.1%
	(blank)	50	2.8%	35	1.8%	33	1.6%
	Grand Total	1772	100.0 %	1913	100.0 %	2007	100.0 %

The proportion of married people has remained stable, varying marginally around 51%. Other categories have increased, compensated by a drop in those having no category reported.

For the combined Trust, married and single are almost equal at 35.1% and 31.1% respectively. This reflects the younger workforce shaped by being the Single Lead Employer. The Office for National Statistics reports the median age for marriage in 2023 as 34.8 years for men and 33 years for women, which is later than the majority of doctors complete their Resident Doctor training.

Maternity

Characteristic	Category	2024 Headcount	2024 %	2025 Headcount	2025 %	2026 Headcount	2026 %
On Maternity							
On Maternity	Yes	39	2.2%	48	2.5%	38	1.9%
	No	1733	97.8%	1865	97.5%	1969	98.1%
	Grand Total	1772	100.0%	1913	100.0%	2007	100.0%

The rate of maternity leave varied between 1.9% and 2.5% during the period, with 38 people on maternity leave on 31 March 2026. This will be a predictable feature within a female dominated workforce with an even age profile, as described above.

There is a slightly higher Maternity rate for the combined Trust, at 3%.

Gender Reassignment

ESR does not record Gender Reassignment and therefore we do not hold statistics on this characteristic.

The Office for Statistics Regulation confirmed on 12.9.24 that the gender identity estimates for the Census 2021 are no longer accredited official statistics.

Whilst we cannot present statistics on Gender Reassignment the Trust has a Supporting Transgender Staff Policy which provides a framework for staff who have transitioned or who are in the process of transitioning their gender.

4. SUMMARY OF MATTERS FOR CONSIDERATION

Priorities for 2026-27 have been selected to respond to the findings from this analysis to also support the achievement of the five goals set out with the NHS Staff Survey Action Plan, measured by the Staff Survey scores set out below.

	NHS Staff Survey 2025 All Staff
Team Time We are stronger together	73.3%
Psychological Safety We are able to speak up	70.7%
Psychological Safety Compassionate Leadership	72.5%
Psychological Safety Negative experiences	92.2%
We nurture healthy working environments	64.7%
We champion flexible working	65.6%
We are continuously learning and improving	67.9%

These actions will be captured in the over-arching Culture and Wellbeing plan. We are in the process of redesigning our Culture & Inclusion Report to become our Culture & Wellbeing Report and Plan. This will align with the new Welsh Government Performance Framework. All intelligence and data we obtain provides a piece of the cultural jigsaw for our organisation.

4.2 Actions for 2026-27

- Enhance Board Members' cultural competence through providing a series of development sessions. This will be connected to the Line of Sight Work on shaping a Board Development Plan, so there is one plan.
- Actively address race and gender disparity during widening access activities so that we understand what the barriers to high paid roles are and how to address them. Further develop our coaching support, develop interview skills development sessions for minority ethnic staff and for women. These activities can be offered to all staff and still have a positive impact on the gender pay gap, WRES and WES.
- Support the Staff Networks to grow in order to advocate, educate and influence, in particular the networks for Women, Race and LGBTQ+.

These groups will have an impact on women and minority ethnic staff's ambition and their preparedness for senior leadership positions. Peer support and sharing of experiences will assist members to learn and improve and seek further opportunities in the Trust.

- Implement the programme of Sexual Safety training, following on from the adoption of the policy so that people feel able to address aggression where it occurs and create conditions of respect where it will not thrive.
- Run a Pulse Survey against the five themes from the NHS Staff Survey to understand whether there are any disparities in staff experience relating to protected characteristics. Take these findings forward with the 2026 NHS Staff results and the new Workforce Equality Standard findings (due July 2026).
- Explore reasons for staff choosing 'Do not wish to disclose' for any monitoring question, particularly regarding their Religion. Address the findings as part of building Psychological Safety within the NHS Staff Survey work.
- Work with Patient and Donor groups to embed the organisational values of Caring, Respectful and Accountable and affirm that discrimination on the grounds of race, sex or gender, or any other protected characteristic, is not welcomed.

5. IMPACT ASSESSMENT

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

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) <i>For more information: <u>STRATEGIC RISK DESCRIPTIONS</u></i>	BAF 06 - There is a strategic risk that our people will not feel a sense of belonging, not feel valued in their roles, not understand how they contribute to organisational success, and will be unable to speak up in confidence, resulting in a negative impact on staff experience if we do not foster a cohesive culture in line with our organisational values											
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Select all relevant domains below											
	<table border="0"> <tr> <td>Safe</td> <td>☐</td> </tr> <tr> <td>Timely</td> <td>☐</td> </tr> <tr> <td>Effective</td> <td>☒</td> </tr> <tr> <td>Equitable</td> <td>☒</td> </tr> <tr> <td>Efficient</td> <td>☐</td> </tr> <tr> <td>Patient Centred</td> <td>☐</td> </tr> </table> The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). <i>[Please include narrative to explain the selected domain in no more than 3 succinct points].</i> Click or tap here to enter text	Safe	☐	Timely	☐	Effective	☒	Equitable	☒	Efficient	☐	Patient Centred
Safe	☐											
Timely	☐											
Effective	☒											
Equitable	☒											
Efficient	☐											
Patient Centred	☐											
QUALITY IMPACT ASSESSMENT	Not required - not a strategic decision											
	The <u>QIA tool</u> 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: <i>For more information: https://www.gov.wales/socio-economic-duty-overview</i>	Not required <i>[In this section, explain in no more than 3 succinct points why an assessment is not considered applicable or has not been completed].</i> 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.
	<i>This section should outline the financial resource requirements in terms of revenue and/or capital implications that will result from</i>

	<i>the Matters for Consideration and any associated Business Case.</i> Narrative in this section should be clear on the following: Source of Funding: Choose an item Please explain if 'other' source of funding selected: 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 <i>For more information:</i> https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx	Not required - please outline why this is not required <i>[In this section, explain in no more than 3 succinct points what the equality impact of this matter is or not (as applicable)].</i>
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below) Click or tap here to enter text The Public Sector Equality Duty (PSED) within the Equality Act 2010 requires that all public authorities covered under the specific duties in Wales report their equality data each year. The Trust is required to publish this report by 31 March 2027.

6. RISKS

This section should indicate whether any matters addressed in the report carry a significantly increased level of risk for the Trust – and if so, the steps that will be taken to mitigate the risk - or if they will help to reduce a risk identified on a previous occasion.

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	BAF06 There is a strategic risk that our people will not feel a sense of belonging, not feel valued in their roles, not understand how they contribute to organisational success, and will be unable to speak up in confidence, resulting in a negative impact on staff experience if we do not foster a cohesive culture in line with our organisational values.
WHAT IS THE CURRENT RISK SCORE	12
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	By contributing to a cohesive culture where all staff are respected in line with our organisational values.
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Insert Date
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
All risks must be evidenced and consistent with those recorded in Datix	

Appendix 1

Velindre – three-year protected characteristics comparison							
Characteristic	Category	2024 Headcount	2024 %	2025 Headcount	2025 %	2026 Headcount	2026 %
Gender							
Gender	Female	1312	74.0%	1427	74.6%	1506	75.0%
	Male	460	26.0%	486	25.4%	501	25.0%
	Grand Total	1772	100.0%	1913	100.0%	2007	100.0%
Age Band							
Age Band	<=20 Years	6	0.3%	12	0.6%	7	0.3%
	21-25	112	6.3%	129	6.7%	124	6.2%
	26-30	209	11.8%	226	11.8%	236	11.8%
	31-35	211	11.9%	225	11.8%	255	12.7%
	36-40	224	12.6%	231	12.1%	251	12.5%
	41-45	205	11.6%	241	12.6%	230	11.5%
	46-50	194	10.9%	200	10.5%	219	10.9%
	51-55	229	12.9%	245	12.8%	252	12.6%
	56-60	230	13.0%	230	12.0%	242	12.1%
	61-65	124	7.0%	142	7.4%	154	7.7%
	66-70	19	1.1%	21	1.1%	28	1.4%
	>=71 Years	9	0.5%	11	0.6%	9	0.4%
	Grand Total	1772	100.0%	1913	100.0%	2007	100.0%
Sexuality							
Sexuality	Bisexual	29	1.6%	44	2.3%	50	2.5%
	Gay or Lesbian	50	2.8%	53	2.8%	58	2.9%
	Heterosexual or Straight	1445	81.5%	1591	83.2%	1685	84.0%
	Not stated (person asked but declined to answer)	86	4.9%	93	4.9%	97	4.8%
	Other sexual orientation not listed	4	0.2%	4	0.2%	5	0.2%
	Undecided	4	0.2%	3	0.0%	5	0.0%
	Unspecified	154	8.7%	125	6.5%	107	5.3%
	Grand Total	1772	100.0%	1913	100.0%	2007	100.0%
Religious Belief							
Religious Belief	Atheism	430	24.3%	515	26.9%	553	27.6%
	Buddhism	4	0.2%	4	0.2%	8	0.4%
	Christianity	698	39.4%	738	38.6%	769	38.3%
	Hinduism	10	0.6%	11	0.6%	12	0.6%
	I do not wish to disclose my religion	263	14.8%	291	15.2%	309	15.4%
	Islam	32	1.8%	34	1.8%	40	2.0%
	Jainism	0	0.0%	0	0.0%	0	0.0%
	Judaism	1	0.1%	2	0.1%	0	0.0%
	Other	178	10.0%	190	9.9%	205	10.2%
	Sikhism	0	0.0%	0	0.0%	2	0.1%
	Unspecified	156	8.8%	128	6.7%	109	5.4%
	Grand Total	1772	100.0%	1913	100.0%	2007	100.0%
Ethnic Origin							
Ethnic Origin	Asian	55	3.1%	65	3.4%	83	4.1%
	Black	21	1.2%	31	1.6%	33	1.6%
	Chinese	12	0.7%	13	0.7%	13	0.6%
	Mixed	16	0.9%	20	1.0%	25	1.2%
	Other	10	0.6%	16	0.8%	11	0.5%
	White	1557	87.9%	1686	88.1%	1767	88.0%
	Unspecified	71	4.0%	47	2.5%	45	2.2%
	Not Stated	30	1.7%	35	1.8%	30	1.5%
	Grand Total	1772	100.0%	1913	100.0%	2007	100.0%
Disability							
Disability	No	1467	82.8%	1603	83.8%	1696	84.5%
	Not Declared	46	2.6%	46	2.4%	46	2.3%
	Prefer Not To Answer	13	0.7%	18	0.9%	18	0.9%
	Unspecified	148	8.4%	115	6.0%	94	4.7%
	Yes	98	5.5%	131	6.8%	153	7.6%
	Grand Total	1772	100.0%	1913	100.0%	2007	100.0%
Marital Status							
Marital Status	Civil Partnership	32	1.8%	38	2.0%	43	2.1%
	Divorced	114	6.4%	124	6.5%	128	6.4%
	Legally Separated	11	0.6%	14	0.7%	10	0.5%
	Married	908	51.2%	981	51.3%	1021	50.9%
	Single	543	30.6%	594	31.1%	641	31.9%
	Unknown	98	5.5%	108	5.6%	109	5.4%
	Widowed	16	0.9%	19	1.0%	22	1.1%
	(blank)	50	2.8%	35	1.8%	33	1.6%
	Grand Total	1772	100.0%	1913	100.0%	2007	100.0%
On Maternity							
On Maternity	Yes	39	2.2%	48	2.5%	38	1.9%
	No	1733	97.8%	1865	97.5%	1969	98.1%
	Grand Total	1772	100.0%	1913	100.0%	2007	100.0%

Appendix 2

Combined – three-year protected characteristics comparison							
Characteristic	Category	2024 Headcount	2024 %	2025 Headcount	2025 %	2026 Headcount	2026 %
Gender							
Gender	Female	4445	59.1%	4727	59.3%	4982	60.4%
	Male	3075	40.9%	3243	40.7%	3260	39.6%
	Grand Total	7520	100.0%	7970	100.0%	8242	100.0%
Age Band							
Age Band	<=20 Years	21	0.3%	26	0.3%	30	0.4%
	21-25	759	10.1%	844	10.6%	865	10.5%
	26-30	1506	20.0%	1537	19.3%	1569	19.0%
	31-35	1555	20.7%	1599	20.1%	1684	20.4%
	36-40	960	12.8%	1041	13.1%	1077	13.1%
	41-45	618	8.2%	676	8.5%	688	8.3%
	46-50	505	6.7%	526	6.6%	553	6.7%
	51-55	592	7.9%	607	7.6%	607	7.4%
	56-60	590	7.8%	623	7.8%	631	7.7%
	61-65	314	4.2%	376	4.7%	421	5.1%
	66-70	71	0.9%	83	1.0%	87	1.1%
	>=71 Years	29	0.4%	32	0.4%	30	0.4%
	Grand Total	7520	100.0%	7970	100.0%	8242	100.0%
Sexuality							
Sexuality	Bisexual	133	1.8%	176	2.2%	199	2.4%
	Gay or Lesbian	139	1.8%	175	2.2%	188	2.3%
	Heterosexual or Straight	4450	59.2%	5717	71.7%	6182	75.0%
	Not stated (person asked but dec	340	4.5%	396	5.0%	354	4.3%
	Other sexual orientation not liste	8	0.1%	15	0.2%	15	0.2%
	Undecided	6	0.1%	5	0.0%	8	0.0%
	Unspecified	2444	32.5%	1486	18.6%	1296	15.7%
	Grand Total	7520	100.0%	7970	100.0%	8242	100.0%
Religious Belief							
Religious Belief	Atheism	1595	21.2%	1805	22.6%	1644	19.9%
	Buddhism	69	0.9%	52	0.7%	48	0.6%
	Christianity	2356	31.3%	2463	30.9%	2306	28.0%
	Hinduism	128	1.7%	133	1.7%	108	1.3%
	I do not wish to disclose my religi	749	10.0%	872	10.9%	1729	21.0%
	Islam	472	6.3%	481	6.0%	369	4.5%
	Jainism	1	0.0%	2	0.0%	2	0.0%
	Judaism	7	0.1%	8	0.1%	4	0.0%
	Other	473	6.3%	569	7.1%	560	6.8%
	Sikhism	14	0.2%	15	0.2%	13	0.2%
	Unspecified	1656	22.0%	1570	19.7%	1459	17.7%
	Grand Total	7520	100.0%	7970	100.0%	8242	100.0%
Ethnic Origin							
Ethnic Origin	Asian	797	10.6%	821	10.3%	852	10.3%
	Black	276	3.7%	305	3.8%	314	3.8%
	Chinese	60	0.8%	62	0.8%	74	0.9%
	Mixed	109	1.4%	134	1.7%	157	1.9%
	Other	201	2.7%	241	3.0%	230	2.8%
	White	5017	66.7%	5780	72.5%	5900	71.6%
	Unspecified	915	12.2%	471	5.9%	545	6.6%
	Not Stated	145	1.9%	156	2.0%	170	2.1%
	Grand Total	7520	100.0%	7970	100.0%	8242	100.0%
Disability							
Disability	No	5474	72.8%	6672	83.7%	7015	85.1%
	Not Declared	198	2.6%	180	2.3%	160	1.9%
	Prefer Not To Answer	27	0.4%	31	0.4%	43	0.5%
	Unspecified	1547	20.6%	761	9.5%	663	8.0%
	Yes	274	3.6%	326	4.1%	361	4.4%
	Grand Total	7520	100.0%	7970	100.0%	8242	100.0%
Marital Status							
Marital Status	Civil Partnership	101	1.3%	115	1.4%	119	1.4%
	Divorced	249	3.3%	272	3.4%	289	3.5%
	Legally Separated	22	0.3%	27	0.3%	26	0.3%
	Married	2680	35.6%	2830	35.5%	2897	35.1%
	Single	2238	29.8%	2229	28.0%	2567	31.1%
	Unknown	1074	14.3%	1264	15.9%	1216	14.8%
	Widowed	39	0.5%	42	0.5%	46	0.6%
	(blank)	1117	14.9%	1191	14.9%	1082	13.1%
	Grand Total	7520	100.0%	7970	100.0%	8242	100.0%
On Maternity							
On Maternity	Yes	217	2.9%	198	2.5%	246	3.0%
	No	7303	97.1%	7772	97.5%	7996	97.0%
	Grand Total	7520	100.0%	7970	100.0%	8242	100.0%

TRUST BOARD	
Gender Pay Gap 2026	
DATE OF MEETING	30 July 2026
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Claire Budgen, Organisational Development Specialist
PRESENTED BY	Sarah Jenkins, Executive Director of People and Organisational Development (Interim)
APPROVED BY	Sarah Jenkins, Executive Director of People and Organisational Development (Interim)
EXECUTIVE SUMMARY	The Gender Pay Gap for the Trust's legal entity is 5.68% and for the core Trust 10.1%. Analysis shows this has been reducing over the past three years and is lower than our near NHS neighbours. Actions for 2025-26 build on those from last year.
RECOMMENDATION / ACTIONS	Address gender disparity during widening access activities to understand barriers to high paid roles. Further develop our coaching support, develop interview skills development sessions. Support the Women's Network to grow in order to advocate, educate and influence. Implement the programme of Sexual Safety training, following on from the adoption of the Anti-Sexual Harassment policy.

	Run a Pulse Survey against the five themes from the NHS Staff Survey to understand whether there are any disparities in staff experience relating to gender. Work with Patient and Donor groups to embed the organisational values and affirm that discrimination is not welcomed.
GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	Date
Executive Management Board	2.7.26
Quality, Safety and Performance Committee	9.7.26
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Executive Management Board endorsed the report for onward submission to the Quality, Safety and Performance Committee. The Quality, Safety and Performance Committee noted that the mean Gender Pay Gap has been on a downward trend over the past three years. They suggested analysing the reasons behind the median Gender Pay Gap to offer accurate insights. They noted the progress made by the Women's Network in leading change and they recognised that addressing disadvantage related to gender requires a Trust-wide approach, including working with Patient and Donor groups.	
7 LEVELS OF ASSURANCE	
If the purpose of the report is selected as ' ASSURANCE ', this section must be completed.	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 3 - Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes
APPENDICES	

1. SITUATION

The Equality Act 2010 (Gender Pay Gap Information) Regulations 2017 require the Trust to produce a Gender Pay Gap report each year. The Trust is required to publish this report by 30 March 2027.

2. BACKGROUND

The Trust formally reports the Gender Pay Gap for the legal entity of the Trust including all hosted organisations. In addition, the Trust measures the Gender Pay Gap for its core services, which excludes NWSSP. Therefore, there are two sets of figures in this report, one of which is submitted to the government portal.

Actions to close the pay gap within the core Trust are developed through our Strategic Equality Plan actions. The findings for the Gender Pay Gap report 2026 will lead to actions in the 2026-27 Strategic Equality Plan action plan.

This year's report includes change over the past three years and findings from the NHS Staff Survey 2025. This ensures we have a well-rounded understanding of the gender pay gap and the actions needed to address it.

3. ASSESSMENT

3.1 Gender Pay Gap 2026 – legal entity including NWSSP

Gender	Avg. Hourly Rate	Median Hourly Rate	Quartile	Female	Male	Female %	Male %
Male	28.6900	26.1000	1	1104.00	851.00	56.47%	43.53%
Female	27.0600	24.8200	2	1318.00	712.00	64.93%	35.07%
Difference	1.6300	1.2800	3	1215.00	791.00	60.57%	39.43%
Pay Gap %	5.6814	4.9042	4	1095.00	911.00	54.59%	45.41%

The key metric for the Gender Pay Gap is the mean/average hourly rate. This is **5.68%**.

The Quartile analysis ranks employees according to their hourly rate and then apports them to four even quartiles. To achieve a nil Gender Pay Gap by this measure the proportion of women or men in each quartile would need to match that for the workforce as a whole.

In the combined Trust, there are 7,997 employees, 59% female and 41% male. To eradicate the Gender Pay Gap within the existing workforce profile, each Quartile listed above would need to reflect a 59% to 41% gender split. In fact, the figures show that **women are under-represented in Quartiles 1 and 4, and over-represented in Quartiles 2 and 3.**

3.2 Bonus Pay Gap 2026 – legal entity including NWSSP

Gender	Avg. Pay	Median Pay	Gender	Employees Paid Bonus	Total Relevant Employees	%
Male	6,706.94	3,280.00	Female	32.00	5099.00	0.63
Female	4,298.54	3,531.60	Male	22.00	3369.00	0.65

Difference	2,408.40	-251.60
Pay Gap %	35.91	-7.67

32 women and 22 men received a bonus in 2025-26. The Gender Pay Gap on bonuses was 35.91%.

3.3 Gender Pay Gap 2026 – core Trust, excluding NWSSP

Gender	Avg. Hourly Rate	Median Hourly Rate	Quartile	Female	Male	Female %	Male %
Male	25.3935	21.1910	1	381.00	110.00	77.60	22.40
Female	22.8279	19.6203	2	377.00	103.00	78.54	21.46
Difference	2.5656	1.5707	3	363.00	141.00	72.02	27.98
Pay Gap %	10.1035	7.4123	4	341.00	152.00	69.17	30.83

The key metric for the Gender Pay Gap is the mean/average hourly rate. This is **10.1%**.

The Quartile analysis ranks employees according to their hourly rate and then apportions them to four even quartiles. To achieve a nil Gender Pay Gap by this measure the proportion of women or men in each quartile would need to match that for the workforce as a whole.

In the core Trust, there are 1,968 employees, 74% female and 26% male. To eradicate the Gender Pay Gap within the existing workforce profile, each Quartile list above would need to reflect a 74% to 26% gender split. In fact, the figures show that **women are under-represented in Quartiles 3 and 4, and over-represented in Quartiles 1 and 2**. This shows that women are clustered in lower-pay jobs and that processes need to help women to be promoted and to enter the workforce in the higher paid positions.

3.4 Bonus Pay Gap 2026 – core Trust, excluding NWSSP

Gender	Avg. Pay	Median Pay	Gender	Employees Paid Bonus	Total Relevant Employees	%
Male	27,555.55	31,000.00	Female	3.00	1564.00	0.19
Female	10,333.32	10,333.32	Male	3.00	531.00	0.56
Difference	17,222.23	20,666.68				
Pay Gap %	62.50	66.67				

3 women and 3 men received a bonus in 2025-26. The Gender Pay Gap on bonuses was 62.5%.

3.5 Changes over time

Legal entity, including NWSSP

Year	Mean hourly gap %	Median hourly gap %	Mean bonus gap %	Median bonus gap %
2024	7.13	10.55	30.89	-1.32
2025	6.49	7.71	32.19	32.94
2026	5.68	4.90	35.91	-7.67

This shows a steady decline in the Gender Pay Gap from 7.13% in 2024 to 6.49% and now to 5.68% in 2026. A similar decline is seen in the Median pay gap. The mean bonus gap has got bigger and the median bonus gap has moved considerably in both directions. Bonuses are much more changeable than substantive pay and also apply to a much smaller group of staff.

Core Trust, excluding NWSSP

	Mean hourly gap %	Median hourly gap %	Mean bonus gap %	Median bonus gap %
2024	13.85	6.15	41.47	0.00
2025	10.67	7.27	42.82	16.67
2026	10.10	7.41	62.50	66.67

This shows a steady decline in the Gender Pay Gap from 13.85% in 2024 to 10.67% and now to 10.1% in 2026. The Median Pay Gap is getting wider which suggests that men are taking up proportionally more of the higher pay roles than women. The mean and median bonus gaps have got bigger. Bonuses are much more changeable than substantive pay and also apply to a much smaller group of staff.

3.6 Experience of discrimination– NHS Staff Survey 2025

The three questions relating to discrimination showed that people were discriminated against on grounds of their sex or gender. The figures show this happened most often from a manager, in 13 cases. However, as a percentage of the incidences for that category, it was the most dominant reason for discrimination when looking at treatment by the public. This shows that actions

are needed both from a People and OD perspective but also from a patient and donor perspective.

Q62 Discrimination from patients or the public	8/31 cases, 25.8% of 31
Q64 Discrimination from manager	13/66 cases, 19.69% of 66
Q66 Discrimination from colleagues	2/15 cases, 13.3% of 15

3.7 NHS Wales comparisons 2025

Pay Gap information can be viewed on the government portal for all relevant organisations. Three comparators have been selected, as below. This shows that the Gender Pay Gap for the core Trust is lower than that of our largest Health Board neighbour and lower than that of our education and improvement body. The Welsh Ambulance Service Trust has the lowest Gender Pay Gap of those considered. This is due to them having an equal split of men and women in the workforce and the concentration of roles being operational and equally distributed between men and women. Where their pay gap emerges is in underrepresentation of women at the higher levels of seniority.

Employer	Action	Status	Employee headcount	Gender pay gap (hourly pay)	
				Mean	Median
Cardiff and Vale University Health Board	Remove	Reported	5000 to 19,999	17.81%	-2.34%
Health Education and Improvement Wales	Remove	Reported	500 to 999	16%	14%
Welsh Ambulance Services NHS Trust	Remove	Reported	1000 to 4999	5.3%	3.9%

4. SUMMARY OF MATTERS FOR CONSIDERATION

4.1 Progress within the core Trust has been made against the five key areas highlighted in 2025.

1. Widening access to jobs within the Trust

A full programme of engagement with schools, colleges and the community has led to more people knowing about careers within the NHS and with the Trust. During 2026, more focus will be given to how we engage with people of different protected characteristics, including gender.

2. Coaching and mentoring

The Trust's coaching and mentoring offer has been significantly developed during 2025-26. More individuals have received training giving them the introductory skills in coaching and mentoring and robust links have been made with experienced coaches and mentors in other NHS organisations. In total, ten women accessed coaching during the year, three of whom have completed their package and seven still underway.

3. **Launch Women's Network**

This network was successfully launched with a key-note event, over two sites, for International Women's Day in March 2026. Further events are in the diary and are being developed by network members. All our staff networks adopt the remit of Advocate, Educate and Influence: this means that our Women's Network provides an important route for women to raise relevant issues and to be heard.

4. **Sexual Safety**

The Trust has adopted the All Wales Sexual Safety Policy and is currently developing training packages to support the roll out and embedding of the policy. This will continue throughout 2026.

5. **Reasonable Adjustments**

An action was agreed last year to promote reasonable adjustments for disability and menopause. This has been achieved through the work of the Wellbeing Coordinators and Menopause Café.

- 4.2 Priorities for 2026-27 have been selected to respond to the findings from the Gender Pay Gap and to also support the achievement of the five goals set out with the NHS Staff Survey Action Plan, measured by the Staff Survey scores set out below. These actions will be captured in the over-arching Culture and Wellbeing plan.

	NHS Staff Survey 2025 All Staff
Team Time We are stronger together	73.3%
Psychological Safety We are able to speak up	70.7%
Psychological Safety Compassionate Leadership	72.5%
Psychological Safety Negative experiences	92.2%
We nurture healthy working environments	64.7%
We champion flexible working	65.6%
We are continuously learning and improving	67.9%

4.3 Actions 2025-26

These actions form part of the wider equalities actions which are highlighted in the Annual Equality Report.

- Actively address gender disparity during widening access activities so that we understand what the barriers to high paid roles are and how to address them. Further develop our coaching support, develop interview skills development sessions. These activities can be offered to all staff and still have a positive impact on the gender pay gap.
- Support the Women's Network to grow in order to advocate, educate and influence. These three roles will have an impact on women's ambition and their preparedness for senior leadership positions. Peer support and sharing of experiences will assist members to learn and improve and seek further opportunities in the Trust.
- Implement the programme of Sexual Safety training, following on from the adoption of the Anti-Sexual Harassment policy so that people feel able to address aggression where it occurs and create conditions of respect where it will not thrive.
- Run a Pulse Survey against the five themes from the NHS Staff Survey to understand whether there are any disparities in staff experience relating to gender. Take these findings forward with the 2026 NHS Staff results and the new Workforce Equality Standard findings (due July 2026).
- Work with Patient and Donor groups to embed the organisational values of Caring, Respectful and Accountable and affirm that discrimination on the grounds of sex or gender, or any other protected characteristic, is not welcomed.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: Choose an item
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐

• A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK – BOARD ASSURANCE FRAMEWORK	BAF06 - There is a strategic risk that our people will not feel a sense of belonging, not feel valued in their roles, not understand how they contribute to organisational success, and will be unable to speak up in confidence, resulting in a negative impact on staff experience if we do not foster a cohesive culture in line with our organisational values
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Select all relevant domains below - Safe ☐ - Timely ☐ - Effective ☒ - Equitable ☒ - Efficient ☐ - Patient Centred ☐
QUALITY IMPACT ASSESSMENT	Not required - not a strategic decision
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Not required
TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT	
The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated. Please indicate whether any of the matters outlined in this report impact the Trust's Wellbeing goals: Choose an item	
If yes select the relevant goals: • A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities. ☐ • A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience. ☐ • A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health ☐ • A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances ☒	

• A Wales of more Cohesive Communities - Attractive, viable, safe and well-connected communities. ☐ • A Wales of Vibrant Culture and Thriving Welsh Language -Promoting and protecting culture, heritage and the Welsh language, encouraging people to participate in the arts, and sports and recreation. ☐ • A Globally Responsible Wales – Consideration of whether an action may make a positive contribution to global well-being ☐	
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT	Not required - please outline why this is not required
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The Gender Pay Gap report is required under the Equality Act 2010 (Gender Pay Gap Information) Regulations 2017.

6. RISKS

This section should indicate whether any matters addressed in the report carry a significantly increased level of risk for the Trust – and if so, the steps that will be taken to mitigate the risk - or if they will help to reduce a risk identified on a previous occasion.

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	BAF06 There is a strategic risk that our people will not feel a sense of belonging, not feel valued in their roles, not understand how they contribute to organisational success, and will be unable to speak up in confidence, resulting in a negative impact on staff experience if we do not foster a cohesive culture in line with our organisational values
WHAT IS THE CURRENT RISK SCORE	12
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	By contributing to a cohesive culture where men and women are respected in line with our organisational values.

ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
All risks must be evidenced and consistent with those recorded in Datix	

TRUST BOARD	
WELSH LANGUAGE ANNUAL REPORT	
DATE OF MEETING	30 July 2025
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	Jo Williams, Welsh Language Manager
PRESENTED BY	Sarah Jenkins, Interim Executive Director of People and OD
APPROVED BY	Sarah Jenkins, Interim Executive Director of People and OD
EXECUTIVE SUMMARY	The Trust is required to report its annual compliance against the Welsh Language Standards. This report will then be placed on the Trust website and available for the Welsh Language Commissioner.
RECOMMENDATION / ACTIONS	Trust Board is asked to APPROVE the Welsh Language Annual Report for 2025-2026.
GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	Date
Executive Management Board	02/07/2026
Quality, Safety & Performance Committee	09/07/2026

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
The Executive Management Board ENDORSED the Welsh Language Annual Report.	
The Quality, Safety & Performance Committee ENDORSED the Welsh Language Annual Report.	
7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 4 - Increased extent of impact from actions <i>The level of assurance reflects the WL Standards. The majority are implemented but some are yet to fully compliant. There is an ongoing action plan with identified actions, working through compliance requirements.</i>
APPENDICES	
1	Welsh Language Annual report 2025/26

1. SITUATION

- 1.1 All Local Health Boards and Trusts are required to provide a Welsh Language Annual Report. This report has a set structure and is provided for assurance and compliance against a set of Welsh Language Standards to the Welsh Language Commissioner.
- 1.2 The hosted organisations have also provided information as they are not required to provide a separate account, however, NWSSP always develop their own report, and this sits on their Website and is also available to the Welsh Language Commissioner

2. BACKGROUND

- 2.1 The Trust received its Welsh Language Standards compliance notice in 2018 and has since then been working proactively to provide bilingual services for patients and donors. This report provides an overview of the 2025/26 successes along with ambition to continue to strengthen this provision.
- 2.2 We continue to work proactively with our hosted organisations and with Welsh Government and the Welsh Language Commissioner.

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) <i>For more information: STRATEGIC RISK DESCRIPTIONS</i>	03 - Workforce Supply and Shape
QUALITY AND SAFETY IMPLICATIONS / IMPACT	There are no specific quality and safety implications related to the activity outlined in this report.
	Safe ☐ Timely ☐ Effective ☐ Equitable ☒ Efficient ☐ Patient Centred ☒
QUALITY IMPACT ASSESSMENT	Not required - not a strategic decision
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Not required
TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT	
The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated. Please indicate whether any of the matters outlined in this report impact the Trust's Wellbeing goals: YES - Select Relevant Goals below	
If yes select the relevant goals:	
A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities. ☐	

• A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience. ☐ • A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health ☐ • A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances ☐ • A Wales of more Cohesive Communities - Attractive, viable, safe and well-connected communities. ☐ • A Wales of Vibrant Culture and Thriving Welsh Language -Promoting and protecting culture, heritage and the Welsh language, encouraging people to participate in the arts, and sports and recreation. ☒ • A Globally Responsible Wales – Consideration of whether an action may make a positive contribution to global well-being ☐	
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT	Not required - please outline why this is not required
	This report outlines key activities and does not require an EQIA on retrospective activity
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Each breach of non-compliance with the WL Standards could result in a £5000 financial penalty.

4. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

Welcome to our Welsh Language Annual Report for 2025/26. We welcome feedback on its detail. Its primary focus is to demonstrate the Trust's commitment and compliance against the Welsh Language Standards, but ultimately it demonstrates our support for safe, effective and person-centred care.

The report has been written in line with the requirements of the Welsh Language Standards. You can find a copy of our Compliance Notice [here](#). You can also find information about our relevant policies and plans [here](#).

The report was approved by Trust Board on 30th July 2026.

This report is also available in Welsh.

Chief Executive's message

Our commitment to the Welsh language continues to play a central role in all that we do for patients, donors and the communities that we serve. Over the past year, we have taken meaningful steps to ensure that the Welsh language is not only respected as a language of choice but is embedded as a core element of our person-centred care.

Our Integrated Medium-Term Plan identifies a continued focus on Welsh language pathways for patients and donors, and we have a clear picture of how Standard 110, the Clinical Consultation Plan, will support both. By framing this plan, we have gained a picture of how our workforce planning and recruitment will need to be strengthened to support its aims, and we are developing our structures to ensure that we can increase the services we provide in Welsh and English.

Our alignment of internal policy against clear national guidelines drives us and we recognise the importance of providing the 'Active Offer'. This is a core consideration and, as we move into our new Velindre Cancer Centre, we will ensure that communication for Welsh speakers is supported by continuing to improve our data collection around language skills, supporting our staff with digital initiatives and making the 'Active Offer' a visual concept that is easily recognised.

Our Welsh Blood Service strives to improve its approach to collecting language needs as part of its donation process. Donor registration has been significantly improved this year through the translation transformation of a clinical system that now supports staff and donors equally in both Welsh and English.

As you will see from the detail in this report, we are not only committed to compliance, but also to meaningful progress in increasing opportunities to use Welsh every day. We look forward to the challenges this brings as we move into 2026/27.

A message from the Chair of Velindre University NHS Trust

This report highlights the steps we have taken to expand our bilingual workforce, improve the visibility and accessibility of Welsh in our services, and ensure that individuals can receive care in their language of choice without having to ask.

We have also focused on supporting our staff to develop their Welsh language skills, recognising that a confident and capable workforce is central to delivering truly person-centred care. I am proud of the enthusiasm and dedication shown across the organisation, from frontline teams to corporate services, in championing the Welsh language and embracing it as a core part of our culture.

While we have made meaningful progress, we know there is more to do. Our ambition is to create an environment where the Welsh language thrives naturally in our services, where patients and donors feel heard and understood, and where staff feel empowered to use and develop their Welsh every day. This report sets out the foundations we have built and the priorities that will guide us in the year ahead.

I would like to thank all colleagues and partners who have contributed to this work. Your commitment ensures that we continue to move forward with purpose and integrity, delivering care that respects and reflects the linguistic heritage of the people we serve.

Legal and reporting context

The Trust has been subject to Welsh Language Standards since 2018. As part of our commitment to these standards and other relevant legislation, such as the 'More than Just Words' framework, we structure our governance around ensuring that our compliance is monitored and reported.

Our divisional groups report into our Trust-wide steering group, and updates are given regularly to senior teams. Our Quality, Safety and Performance Committee receives highlight reports on the Welsh language, and Annual Reports are agreed at Executive and Trust Board level.

Welsh Language Standards (Regulation number 7)

Service Delivery – Standards (Standards 1-64)

Intranet, telephony and social media presence

Welsh Blood Service social media contact this year has been extremely successful. The translation team at the Trust has agreed an updated procedure to ensure full bilingual compliance of posts.

Statistics demonstrate a positive response with over 1,200 followers of the Welsh Language pages and 61 new followers in 25/26.

The Trust website clearly displays a Welsh language speech bubble, which provides Welsh speakers with a visual indication of bilingual availability. Visits to the Trust website were 161,071 and the Welsh language pages in this reporting year were 2,380 or 1.48% of the overall views.

Following receipt of the Welsh Language Commissioner's social media and telephony monitoring survey in February 2026, the Trust is pleased to report that all calls and posts over this reporting year were compliant with the Welsh Language Standards.

Bangor - "Croeso cynnes, gwybod fy mod mewn dwylo da, ac yn gallu siarad cymraeg drwy gydol y profiad – translated - A warm welcome, knowing that I am in good hands, and being able to speak Welsh throughout the experience."

The Trust will continue to monitor this via internal 'mystery shopper' exercises giving us the opportunity to challenge compliance at all levels.

Blood Donor pre-screening system

Historically, the Welsh Blood Service has used an IT system that identifies donor eligibility via a pathway of questions. These questions are pre-

screening requirements through the use of an algorithm.

Until this year, the algorithm was available in only English, and staff were required to adapt the system for Welsh donors. In 2025, over 18,000 donors were taken through this process.

The system is extremely complex and uses clinical terminology. This year, with assistance from the digital and translation team, we have successfully adapted the system, providing staff with the ability to use it in Welsh to assist with the screening of Welsh speakers.

This internal system gives us total equality of process in both languages and brings us closer to our ambition of a truly bilingual donor experience. The work on this process was a winner at this year's internal staff awards, further highlighting our commitment to supporting staff internally to use their Welsh language skills.

Operational Standards

Standard 110 – Clinical Consultation Plan

The development and refinement of a Welsh Language Clinical Consultation Plan under Standard 110 represents a significant milestone in the Trust's approach to equitable services. During this reporting period, we have moved from the initial concept of the framework to a strengthened approach that reflects the national ambition.

We have further work to do to achieve an equitable approach across the services we provide at Velindre Cancer Service and Welsh Blood Service; however, the work already achieved has given us a clear picture of where we need to be.

The plan has been subject to review and is a live document, demonstrating the fluidity of service provision. Early versions highlighted ambition, but the work in partnership with the Welsh Language Commissioner demonstrated the need to look at the plan in a more realistic way and target specific areas of provision to ensure that a real difference was being made and that this difference could be monitored and adjusted as required.

In 2026 we will focus on fully embedding the plan in the areas highlighted for the Welsh Blood Service and Velindre Cancer Services. Workforce planning will run alongside the plan, ensuring a clear shift from reactive to proactive planning. We are confident

that, although there is work to be done, our plan demonstrates a commitment to delivering the standard.

Patient and donor feedback already demonstrates our ability to successfully provide clinical consultations in Welsh, but data and monitoring will provide the platform for further work.

Concerns and Complaints

Following a more robust focus by the Welsh Language Commissioner on how to make complaints relating to the Welsh language, the Trust conducted an audit of its current process.

Complaints officers attended the online awareness sessions run by the Welsh Language Commissioner. Together with the Welsh Language Team, we provided input into the new national process and updated our internet and intranet information.

To mitigate risks, we hold internal 'mystery shopper' exercises in areas such as telephony. This year, three exercises were undertaken, and results are shared with the Trust's divisional working groups and fed back to the relevant staff for training purposes.

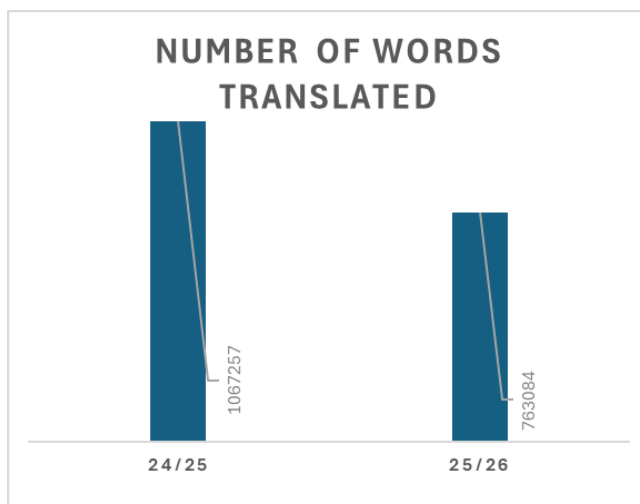
Compliance with telephony responses has increased, however the Trust is fully aware of areas needing further training and recruitment investment.

In 2025/26, the Trust received one complaint regarding a Welsh language service for donor collection. The complaint was dealt with under the Putting Things Right process and resolved.

Translation

The translation team continues to diligently assess the translation process and look at ways to improve the service. This reporting year, we are even more proactive, working with specific teams to ensure that translation times are kept within KPI timescales and improving those timescales by targeting regular translations such as external communications and social media posts.

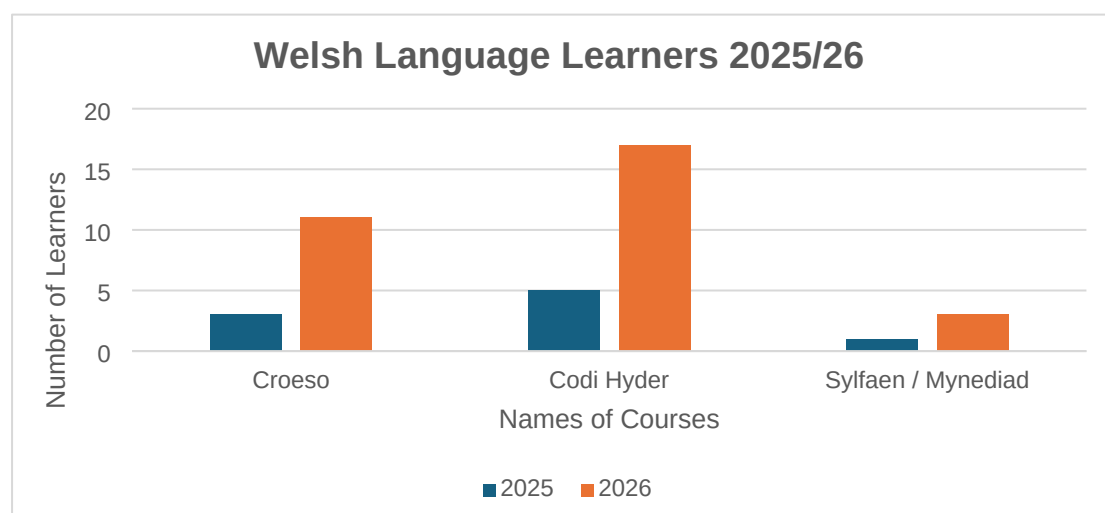
Our SLA with Shared Services Partnership has enabled us to significantly reduce our translation figures. Year on year, this will mean a decrease in cost for the Trust and a more planned approach to the translation process. Sharing memory software means sharing the translations already in the system, which decreases the amount of translation needed in-house.



Welsh Language Training Opportunities

Our partnership with Aneurin Bevan Local Health Board and the national organisation, Dysgu Cymraeg, continues to grow. The partnership has enabled us to access a Welsh language tutor and offer staff free language training at different levels. We will continue to strengthen this over the coming years.

This year, our training figures, although small, are encouraging. Our tutor-led partnership began in August 2025.



Staff understanding of available support has increased, and discussions around raising confidence and staff needs are regular. The partnership with Coleg Gwent, Aneurin Bevan and Dysgu Cymraeg has made a positive difference. The Trust will continue its efforts to increase these learning opportunities in support of the aims of the 'More than Just Words' framework.

"I really enjoyed the course, and I found it really beneficial. ...what it made me do was realise how I would have to seek out more opportunities to practice and improve my Welsh. It also gave me confidence to ask people to practice Welsh with me and I've now signed up to do a 'Codi Hyder' course with Dysgu Cymraeg which I'm looking forward to."

- Kate Cleary

"Although I'm a fluent Welsh speaker and attended Welsh-medium schools, I don't use the language daily anymore, so my confidence had dipped over time. The Welsh Language Confidence Course was incredibly valuable, giving me a safe and supportive space to reconnect with the language. The relaxed atmosphere, just chatting about everyday activities, made it easy to ease back into speaking Welsh, and the gentle guidance helped rebuild my confidence step by step. I feel more comfortable using Welsh in everyday situations, and it has reignited my enthusiasm for the language"

- Donna Dibble

Procurement

Improved compliance with Standards 57, 58 and 59.

In 2025/26, NWSSP developed and piloted an assessment tool to help Velindre University NHS Trust determine when invitations to tender specifications should include Welsh Language requirements. This tool will enable the Trust to assess Welsh language compliance across procured services and systems.

This piece of work also clarifies expectations for third-party contractors delivering patient-facing services and staff-facing systems, strengthening accountability for linguistic accessibility. By embedding Welsh language considerations in procurements, Velindre is better equipped to uphold the duty of quality, improve equity, and ensure person-centred, accessible services in line with Welsh Language Standards and the 'More than Just Words' framework.

Internal Staff Engagement

This year, through our 'Croeso' induction course, we have engaged with 326 newly appointed members of staff. This is crucial in giving staff an introduction to the Trust and its values, including the importance of bilingual care.

The Trust's promotional activities continue to support staff with cultural awareness. It



has been a successful year with attendance at several internal and external events.

Our attendance at the National Eisteddfod with NHS Wales partners provided an exceptional platform for sharing best practice and highlighting the work of the Trust.

Over the week, the Health Minister attended the activities, and we held events to launch aspects of the 'More than Just Words' framework

and Learning Welsh at Work. It also gave us an opportunity to promote the work of our divisions.



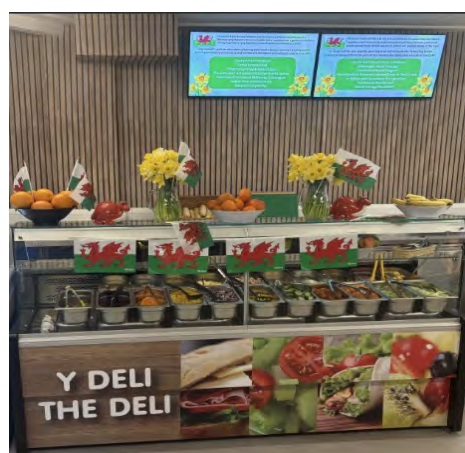
Widening access, providing opportunities to promote and meet possible NHS staff of the future, provides us with another platform for sharing the Trust's opportunities. This year, we attended several careers fairs and spoke to young people about the Trust and what a career in the NHS looks like. To date, we have communicated with over 4,000 young people in schools and over 3,000 in universities and colleges.

St David's Day was celebrated this year with an online staff quiz and a celebratory menu at Velindre Cancer Centre.

This year, we have successfully

developed a series of internal videos for staff. The aim of the videos is to inform staff of the work in support of the Trust's bilingual provision for patients and donors.

Driven by the Welsh Blood Service, the fourth promotional video was 'Meet the Translation Team'. This was promoted on the Trust intranet and offered staff the opportunity to meet the team and learn from their translation process. The Welsh Blood Service will continue to look at other ways of promoting the services as part of its drive to support staff.



Policy Making (Standards 69-77)

Assessing the impact on our Welsh language communities and our staff within all our policies and procedures continues to be a high priority for us. It provides us with an opportunity to discuss the impact of our actions before they become accepted behaviour.

We now have a monthly meeting to discuss all the relevant impact assessments and take action to escalate any questions or actions to the initiator of the policy or practice.

This strengthens the quality of the policy or procedure and gives assurance that all aspects of the Welsh language are considered.

This year, we have assessed 38 policies and procedures, each with a dedicated section on Welsh language impact.

Workforce skills

We continue to promote the need to record language skills across the Trust. Having the correct information on staff skills supports our workforce plans. As of March 2026, we are 96% compliant with the recording of the three Welsh language competency levels within ESR.

Our Welsh language awareness training compliance is also high at 93% Trust-wide.

Welsh-speaking staff identified as having skills at levels 3-5, the skills required to communicate confidently with patients and donors, are:

25-Mar-26							
Row Labels	3 - Intermediate / Canolradd	%	4 - Higher / Uwch	%	5 - Proficiency / Hyfedredd	%	Grand Total
NHS LANG Listening/Speaking Welsh	57	29%	58	30%	80	41%	195
NHS LANG Reading Welsh	50	26%	60	32%	80	42%	190
NHS LANG Writing Welsh	47	29%	42	26%	73	45%	162
Grand Total	154	28%	160	29%	233	43%	547
25-Mar-25							
Row Labels	3 - Intermediate / Canolradd	%	4 - Higher / Uwch	%	5 - Proficiency / Hyfedredd	%	Grand Total
NHS LANG Listening/Speaking Welsh	52	29%	58	32%	71	39%	181
NHS LANG Reading Welsh	48	27%	56	32%	73	41%	177
NHS LANG Writing Welsh	42	28%	41	27%	67	45%	150
Grand Total	142	28%	155	31%	211	42%	508

NB: This information does not include hosted organisations.

Recruitment

Velindre University NHS Trust 2025-2026

Total number of vacancies advertised as:	
Welsh language skills are essential	2
Welsh language skills are desirable	113
Welsh language skills need to be learnt when appointed to the post	2
Welsh language skills are not necessary	7
Total Number of vacancies advertised 01/04/2025 - 31/03/2026	124

Our recruitment process has been updated this year, giving significant assistance to recruiting managers as they work through the recruitment structure and assess the language needs of a vacant post.

Ymddiriedolaeth GIG
Prifysgol Fawddfa
Vale University
NHS Trust

Step 1

Think about whether the post should be categorised as one of the following:

- Welsh language skills are essential
- Welsh language skills are desirable
- Welsh language skills need to be learnt when appointed to the post
- Welsh language skills are not necessary

To do this, think about the factors below:

1

Do the duties of the role mean conversing or corresponding with the public?

2

Do you currently have enough Welsh speakers in your team to provide your service bilingually?

The Welsh Language Team can provide data on this if you don't know

3

Could you support offering Welsh language training to current staff, instead of recruiting a Welsh speaker?

The Welsh Language Team can support this

You must record your justification for these factors under the 'Authorisation' in Trac:

Under 'Working Details' you need to select in the dropdown what role is being filled. If any are needed, explain here. Your justification for that decision. Guidance is available about in this blue section.

This relatively new process will take some time to embed and, as yet, we are not yet seeing this process result in greater numbers in Welsh 'essential' roles. However, we are confident that the monitoring of this will inform future changes to the process, and throughout 2026/27 we will focus on data collection to inform further development.

Moving Forward into 2026/27

This year we will be looking at opportunities to refine our embedded structures. The new Cancer Centre gives us an opportunity to do this with workstreams looking at signage and direct communication with patients and the public.

The Welsh Language Team is central to these discussions and will continue to provide expert advice and guidance. It is an exciting time for the Trust.

Through our IMTP we will lay the foundations for discussions around the possibility of having an in-house trainer, recognising the budget constraints on the NHS throughout this process. An in-house trainer would enable us to focus on face-to-face training needs, central to providing support for staff, patients and donors.

The Trust's Clinical Consultation Plan will continue its focus on donor collection teams and gathering data on donor language need. At the Cancer Centre, we will move forward with identifying areas able to support this plan while being mindful of the imminent changes to the centre's services.

We are committed to these changes and will work with staff to ensure that their needs are met to provide equality of language services to our patients and donors.

RAG rating document

This format follows the Annual questionnaire format provided by the Welsh Language Commissioner
It is sent to all Local Health Boards and Trusts annually.

The Trust adopted the format as its assurance rating on 3 March 2026 at the Welsh Language Steering group meeting.

High assurance of compliance - Green

The organisation complies with all requirements at all times, under all circumstances, except for rare exceptions.

Medium assurance of compliance - Yellow

The organisation generally complies fully, but there are occasional instances or specific requirements where compliance is lacking.

Low assurance of compliance - Red

The organisation complies in some cases or with some requirements, but not fully or consistently.

No assurance of compliance - Red

The organisation does not comply with the requirements at all or only complies occasionally or with very few aspects.

No duty to comply

The requirements have not been imposed on the organisation, or the organisation does not carry out the relevant activity.

Direct contact with the public

	High	Medium	Low	No assurance
Corresponding with the public in Welsh (standard 1-6)	x			
Include a statement welcoming Welsh correspondence and that corresponding in Welsh will not lead to delay (standard 7)	x			
Telephone services available in Welsh (standard 8 - 20)		x		
Conducting meetings in Welsh (standard 21-22Ch and 26-30)	x			
Conducting public events in Welsh (standard 31-32)		x		
Welsh language reception services (standard 50-53)		x		
Establish and record language choice of in-patients (standard 23-24)		x		
Conduct case conferences in Welsh (standard 25)		x		

Published materials and digital services

	High	Medium	Low	No assurance
Publicity and advertising materials are produced in Welsh (standard 33-35)	x			
Documents and forms are published in Welsh (standard 36-38)	x			
English version of a document or form include a clear statement that it is also available in Welsh		x		
Websites and public digital services (including apps) are in Welsh (standard 39-44)	x			
Welsh language is not treated less favourably than English on social media (standard 45-46)	x			

Other Public Services

	High	Medium	Low	No assurance
Signs are displayed in Welsh (standard 47-49)	x			
Processes for awarding grants and contracts ensure that the Welsh language is not treated less favourably than the English language (standards 54-59)			x	
Welsh medium services are promoted to encourage their use (standard 60-61)	x			
Corporate identity is in Welsh (standard 62)	x			

Providing educational courses in Welsh (standard 63)			x	
Announcements over a public address system are made in Welsh and the announcement is made in Welsh first (Standard 64).		x		

Considering the Welsh language when reviewing or formulating policies

	High	Medium	Low	No assurance	No duty
Consider the effects on the Welsh language when developing policies (standard 69)	x				
Consider how a policy could be formulated so that it would have positive effects on the Welsh language (standard 70)	x				
Consider how policies could be formulated so that it would not have adverse effects on the Welsh language (standard 71)	x				
Consider and seek views on the effects on the Welsh language when consulting on policy decisions (standards 72-74).	x				
Ensure that research commissioned or conducted considers the effects on the Welsh language (standard 75-77)		x			
Publish a policy on providing a primary care service that ensures consideration of the impact on					x

the Welsh language when making decisions in relation to providing a primary care service (standard 78-78A).					

Encourage the use of Welsh internally

	High	Medium	Low	No assurance
Policy on using Welsh internally (standard 79)	x			
Provide employment documents to staff in Welsh (standard 80-82)	x			
Provide software for checking Welsh spelling and grammar for staff (standard 89)	x			
Intranet is available in Welsh, and provides services and support materials to assist staff in using Welsh (standards 90-95)	x			
Internal policies are available in Welsh (standard 82)	x			
Staff complaints and disciplinary procedures are available in Welsh (standard 83-88)	x			
Provide internal training to staff in Welsh (standard 97)		x		
Provide wording for staff for e-mail signatures and out-of-office messages in Welsh (standard 104)	x			
Signs and notices displayed in the workplace are in Welsh (standards 111-113)		x		
Announcements are made via audio equipment in the workplace, are made in Welsh, and the Welsh-language announcement is made first (standard 114)		x		

Developing the Welsh language skills of the workforce

	High	Medium	Low	No assurance
Assess employees' Welsh language skills annually (standard 96)	x			
Provide training (in Welsh) on using the Welsh language effectively in meetings, interviews, and complaints and disciplinary procedures (standard 98)		x		
Provide opportunities for staff to receive Welsh lessons (standard 99-101)		x		
Provide training courses to help staff develop awareness of the Welsh language (standard 102-103)	x			

Clinical consultations

	High	Medium	Low	No assurance
Publish a plan for each 5 year period setting out the extent to which you are able to offer to carry out a clinical consultation in Welsh (standard 110)	x			
Three years after publishing the plan - assess the extent to which you have complied with the plan and publish that assessment within 6 months (standard 110A)		x		

Advertising new and vacant posts

	High	Medium	Low	No assurance
Assess the need for Welsh language skills for new and vacant posts and categorising according to the standards when advertising the post (standard 106 and 106A)	x			
State that applications may be submitted in Welsh when advertising the post (standard 107)	x			
Publish recruitment documents and materials in Welsh (standard 107A)	x			
Job application forms include a section for individuals to indicate that they wish to have an interview conducted in Welsh (standard 108)	x			
Inform an individual of our decision regarding a job application in Welsh if the application was made in Welsh (standard 109)	x			

Keep an annual record of –

	High	Medium	Low	No assurance
number of complaints received relating to compliance with the standards (standard 115)	x			
number of employees who have Welsh language skills at the end of every financial year (standard 116)	x			
number of new posts and vacancies that were categorised where Welsh language skills were identified (standard 117)	x			

Publish the following documents on the organisation's website:

	High	Medium	Low	No assurance
document that records the standards you are under a duty to comply with (standard 118)	x			
Complaints procedure which sets out how you deal with complaints about compliance with the standards (standard 119).	x			
Annual report on compliance with the Welsh language standards (standard 120)	x			

TRUST BOARD	
SOCIAL PARTNERHSIP DUTY ANNUAL REPORT 2025-26	
DATE OF MEETING	30 July 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	Susan Thomas, Deputy Director of W&OD Rhiannon Freshney, Sustainability Manager
PRESENTED BY	Sarah Jenkins, Executive Director of People and Organisational Development (Interim) Lauren Fear, Director of Place, Portfolio and Partnerships
APPROVED BY	Sarah Jenkins, Executive Director of People and Organisational Development (Interim)
EXECUTIVE SUMMARY	This report outlines the commitment and actions taken by the Trust to comply with the Social Partnership Duty. The duty requires public bodies to engage meaningfully with workforce representatives and other stakeholders to promote fair work, improve well-being, and deliver better public services. The report outlines the key achievements and activities undertaken 25/26 and notes the challenges and lessons learnt to support future activities.
RECOMMENDATION / ACTIONS	Trust Board is asked to APPROVE the Social Partnership Duty Annual Report 2025-2026.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	Date
Executive Management Board	02/07/2026
Quality, Safety and Performance Committee	09/07/2026
To go to Trust Board	30/07/2026
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The Executive Management Board ENDORSED the Social Partnership Duty Annual Report for submission to the Quality, Safety and Performance Committee. The Quality, Safety and Performance Committee ENDORSED the Social Partnership Duty Annual Report for submission to Trust Board.	
7 LEVELS OF ASSURANCE	
If the purpose of the report is selected as ' ASSURANCE ', this section must be completed.	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Select Current Level of Assurance
APPENDICES	
APPENDIX 1	Social Partnership Duty Annual Report 2025-26

1. SITUATION

Velindre University NHS Trust is fully committed to fulfilling its Social Partnership Duty under the Social Partnership and Public Procurement (Wales) Act 2023. As a public body, we recognise the importance of co-determining policy and decision-making with our recognised trade unions and wider workforce. This annual report (Appendix 1) outlines the actions we have taken during 2025–26 to embed social partnership principles into the Trust's governance, planning, delivery, and procurement activities.

This report outlines the commitment and actions taken by the Trust to comply with the Social Partnership Duty. The duty requires public bodies to engage meaningfully with workforce representatives and other stakeholders to promote fair work, improve well-being, and deliver better public services. Our Trust remains committed to fostering collaboration with our workforce, trade unions, and external partners to ensure inclusive decision-making and continuous improvement in health services across the region.

2. SUMMARY OF MATTERS FOR CONSIDERATION

The report (Appendix 1) outlines the governance and oversight in place to deliver the Trust's social partnership duty, key achievements and activities undertaken 25/26 and notes the challenges and lessons learnt. The report also notes the future properties intended by the Trust.

3. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: Choose an item	
If yes - please select all relevant goals:	
• Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK – BOARD ASSURANCE FRAMEWORK	BAF 06 - There is a strategic risk that our people will not feel a sense of belonging, not feel valued in their roles, not understand how they contribute to organisational success, and will be unable to speak up in confidence, resulting in a negative impact on staff experience if we do not foster a cohesive culture in line with our organisational values

QUALITY AND SAFETY IMPLICATIONS / IMPACT	Select all relevant domains below
	Safe ☐ Timely ☐ Effective ☒ Equitable ☒ Efficient ☐ Patient Centred ☐
QUALITY IMPACT ASSESSMENT	Not required - not a strategic decision
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Not required
TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT	
The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated. Please indicate whether any of the matters outlined in this report impact the Trust's Wellbeing goals:	
If yes select the relevant goals: • A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities. ☐ • A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience. ☐ • A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health ☐ • A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances ☒ • A Wales of more Cohesive Communities - Attractive, viable, safe and well-connected communities. ☐ • A Wales of Vibrant Culture and Thriving Welsh Language -Promoting and protecting culture, heritage and the Welsh language, encouraging people to participate in the arts, and sports and recreation. ☐ • A Globally Responsible Wales – Consideration of whether an action may make a positive contribution to global well-being ☐	

FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT <i>For more information:</i> https://nhs.wales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx	There is no direct equality impact as a result of the activity outlined in this report
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Social Partnership and Public Procurement (Wales) Act 2023, public bodies must align and demonstrate their commitment to comply with the social partnership duty

4. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	BAF06 There is a strategic risk that our people will not feel a sense of belonging, not feel valued in their roles, not understand how they contribute to organisational success, and will be unable to speak up in confidence, resulting in a negative impact on staff experience if we do not foster a cohesive culture in line with our organisational values.
WHAT IS THE CURRENT RISK SCORE	12
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	By contributing to a cohesive culture where all staff are respected in line with our organisational values.
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Insert Date
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
All risks must be evidenced and consistent with those recorded in Datix	

Appendix 1

SOCIAL PARTNERHSIP DUTY ANNUAL REPORT

Velindre University NHS Trust - Reporting Period: April 2025 – March 2026

1. Introduction

Velindre University NHS Trust is fully committed to fulfilling its Social Partnership Duty under the Social Partnership and Public Procurement (Wales) Act 2023. As a public body, we recognise the importance of co-determining policy and decision-making with our recognised trade unions and wider workforce. This annual report outlines the actions we have taken during 2025–26 to embed social partnership principles into the Trust's governance, planning, delivery, and procurement activities.

During 2025–26, social partnership working has continued to mature, moving beyond consultation towards deeper collaboration and shared problem-solving. This report outlines how the Trust has embedded partnership principles into governance, service planning, sustainability, procurement, workforce wellbeing, and community engagement, building on the foundations established in previous years.

This report outlines the commitment and actions taken by the Trust to comply with the Social Partnership Duty. The duty requires public bodies to engage meaningfully with workforce representatives and other stakeholders to promote fair work, improve well-being, and deliver better public services. Our Trust remains committed to fostering collaboration with our workforce, trade unions, and external partners to ensure inclusive decision-making and continuous improvement in health services across the region.

2. Governance and Oversight

2.1 Social Partnership Structures

To embed social partnership principles, we have the Local Partnership Forum (LPF)

The LPF is the formal mechanism within the Trust where the trade unions work together with management, to engage, inform, debate and agree local priorities, in respect of workforce and Trust related issues. The broad term used to describe this is “partnership working”. All members of the LPF are full and equal members and collectively share responsibility for the decisions made by the forum. The LPF provides the formal mechanism for consultation, negotiation and communication between the staff representatives and management. The Trust involves staff representatives in policy formulation, implementation and evaluation at a strategic and operational level and in service decisions, problem solving, service planning, local management meetings and communications. At the earliest opportunity, the organisation engages with staff representatives in all key discussions and decision-making processes. The LPF adheres to the principles and best practice of partnership working, as derived from ‘Partnership

Agreement. An agreement between Department of Health, NHS Employers and NHS Trades Unions'. The Local Partnership Forums are supported by Divisional Local Partnership Forums in the Velindre Cancer Service, Welsh Blood Service, Health Technology Wales and NHS Wales Shared Services. The more localised groups ensure matters are discussed and communicated within specific functional areas within the Trust. Representatives from the Divisional groups sit on the Trust wide Local Partnership Forum, ensuring effective flow of communication and management of partnership working

In 2025–26, LPF engagement has continued to include early involvement in strategic developments, workforce planning discussions, sustainability initiatives, and service transformation activity, ensuring staff voice is embedded at the earliest opportunity. The Climate Action Board provides strategic oversight of climate action and decarbonisation across the Trust, ensuring alignment with the Sustainability Strategy, national NHS Wales priorities and the Well-being of Future Generations (Wales) Act. Operating within the Trust's wider governance framework, the Board provides assurance to senior leadership on progress, risks and opportunities associated with climate change and environmental sustainability.

The Climate Action Board which includes trade union representation on the Terms of Reference and plays a key role in ensuring that climate action is progressed through a social partnership approach. This structure ensures that workforce voice is embedded in decisions relating to sustainability, decarbonisation and environmental change, and that the workforce implications of climate action are considered at an early stage.

Delivery is further supported by a range of operational and thematic groups responsible for progressing activity at a practical level. These include:

- The **ISO 14001:2015 Environmental Management Group**, which supports implementation and continual improvement of the Trust's Environmental Management System
- **Clinical Sustainability Multi-Disciplinary Teams (MDTs)**, bringing together clinical and operational expertise to embed sustainability and carbon reduction into healthcare pathways
- The **Arts in Health multidisciplinary team (MDT)**, contributing to preventative, wellbeing-focused and sustainable approaches within the clinical and care environment

This integrated governance approach ensures that climate action, sustainability and decarbonisation are delivered through co-determination, supporting fair work, staff wellbeing and long-term resilience while strengthening compliance with the Social Partnership Duty

2.2 Leadership Commitment

- The Chief Executive and Board members actively champion social partnership principles. The Executive co-chair the Local Partnership Forum in conjunction with the Social Partnership Lead
- The Trust Board has an additional Independent Member with a lead role for Equality Diversity and Inclusion.

3. Key Achievements and Activities

3.1 Workforce Engagement and Fair Work

We have ongoing engagement sessions with staff and trade union representatives to address workforce concerns. As a result, we produce in partnership:

- Staff well-being initiatives: including mental health support and flexible working options. The Trust Health and Wellbeing Plan is progressed via LPF.
- Employee Relations: The LPF were given an overview of employee relations activity, providing assurance of the appropriate management of the employment relationship.
- Recruitment: LPF received updates on workforce performance data highlights the Trust performance in relation to sickness, achievement of Personal Development Appraisal Reviews (PADR) and recruitment actively. This provides a forum for open discussion and debate in relation to the supply of staff and areas within the Trust that requires support.

3.2 Promoting Equality, Diversity, and Inclusion (EDI)

We have refreshed our workplan for 2025-26 to support the delivery of our Strategic Equality Plan 2024 – 2028.

Progress with Welsh Language 5 Year Plan, 'More than just words' has resulted in the following outcomes:

- 89% completion of the Welsh Language Awareness training programme.
- The 'Active Offer' is delivered in WBS and VCS through the active Welsh Language Groups
- Training has been delivered to staff in front-facing roles such as Reception.
- Rigorous assessment of Welsh language needs at recruitment

We have used the results of the NHS Staff Survey and Workforce Race Equality Standard (WRES) to better understand the experience of staff across the Trust and a review into Bullying, Harassment and Discrimination highlighted the need for

psychological safety; and this has been adopted as a topic for the improvement work for 2025/6. Divisions and Departments have been enabled to involve staff in reviewing their results and formulating actions to increase engagement and they are now coming forward with concrete actions for change at a local level.

The focus on Attraction and Resourcing has allowed us to improve access to our employment in a variety of ways:

- Changed our recruitment practices to connect with groups who may not have accessed NHS employment in the past.
- Embedded actions from Anti-Racist Wales Action Plan and National Workforce Policy Audit
- Updated recruitment process to ensure reasonable adjustments are in place for candidates at interview
- Achieved Disability Confident Leader status
- Provision of feedback to unsuccessful candidates on request
- Analysed trac data for all reported protected characteristics and fed findings into future recruitment plans.

The Trust's Equality, Diversity and Organisational Development Manager leads regular communications marking religious holidays, creating safe forums for discussion, peer support, and learning. This work directly supports the objective to recognise that inclusive, psychologically safe working environments contribute to both individual and organisational well-being.

We have established six Staff Networks with structured Terms of Reference and links to the Healthy and Engaged Steering Group, as follows.

- Race Network is linked to the national programme on Global Ethnic Majority employment
- LGBTQ+ Network involved in Pride events and raising the profile of equality
- Neuro Diversity network requested training in working with ND, either one's own or a colleague's
- Disability Network contributed to a study on the use of Reasonable Adjustments in the Trust
- Carers' Network is supporting the implementation of the Carer's Passport.
- The Women's Network is in place and will consider the findings of a Trust report on 'Women in STEM'

3.3 Sustainable Public Services and Procurement

Velindre's approach to procurement is increasingly shaped by our commitment to social value and ethical sourcing, as required under the Social Partnership and Public Procurement (Wales) Act.

- Embedded fair work and social value criteria into procurement processes.
- Partnered with local suppliers to support community wealth-building.
- Ensured ethical employment practices across contracted services.

Circular economy initiatives, such as the Walking Aid Recycling Scheme at Velindre Cancer Centre, reduce emissions and NHS resource use while delivering wider social value. Returned walking aids are cleaned, repaired and reused, reducing the need for new procurement and lowering associated carbon emissions. The scheme is delivered in partnership with Cardiff and Vale University Health Board and utilises the Probation Service to support the cleaning and repair of walking aids, providing meaningful opportunities for skills development, rehabilitation and community contribution.

Originally developed in partnership with Men's Sheds and Walters UK, using felled trees from the New Velindre Cancer Centre (nVCC) site to create refurbished walking aids, the project represents an integrated solution addressing waste reduction, patient rehabilitation and community engagement. The Trust is now working towards an all-Wales approach, linking with other Health Boards to support adoption of the same solution, enabling consistency, shared learning and greater collective impact across NHS Wales. This work demonstrates effective collaboration across capital, clinical, voluntary sector and justice partners and continues to be progressed through the All-Wales Spread and Scale Academy.

Our work and our connection with our communities have always been central to what we do. The development of the New Velindre Cancer Centre (nVCC) has created a unique opportunity to strengthen this commitment, embrace new opportunities, and redefine Velindre's role across our wider communities for the long term.

Hefyd - meaning "*also*" - is the Trust's community benefits and social value programme, developed to ensure that the benefits of investment, partnership working and service delivery extend beyond our core clinical services and into the communities we serve.

Through Hefyd, the Trust is investing in and developing a series of integrated programmes that bring together arts, green social prescribing, sustainability, meaningful engagement with children and young people, and community benefits delivery. The programme reflects our commitment to social partnership, fair work, prevention, integration and long-term impact.

Under the Hefyd programme, we work across the Trust and with our partners to add value while empowering meaningful collaboration, ensuring that community benefit is co-produced with staff, patients, trade unions, third-sector organisations and local communities.

The Hefyd programme currently encompasses four interlinked strands:

Hefyd: Arts in Health

The Trust continues to deliver a vibrant and well-established Arts in Health programme as a core strand of the Hefyd initiative. This work recognises the important role that creativity, culture and expressive activities play in supporting emotional wellbeing, recovery, connection and dignity for patients, as well as contributing positively to staff wellbeing and organisational culture.

During 2025–26, Arts in Health activity has continued across Velindre sites, supported by partnership working with artists, cultural organisations, volunteers and staff. Key examples include:

- **Art Cart sessions on wards and in clinical areas**, offering patients the opportunity to engage directly in creative activities such as drawing, painting and craft during treatment. These sessions provide meaningful distraction, promote relaxation and give patients a sense of agency and personal expression at a time when choice may feel limited.
- **Music Mondays on the wards**, bringing live music into clinical environments. These sessions create calm, welcoming spaces, supporting emotional wellbeing for patients, visitors and staff, and contributing to a more therapeutic care environment.
- **Poetry and literature engagement**, including poetry writing, creative writing opportunities and facilitated reflection. These activities support emotional expression, connection and meaning-making, particularly during challenging points in the cancer pathway.
- **Choir and group singing initiatives**, which promote social connection, confidence and wellbeing for participants, and foster a sense of shared experience and community.
- **Artist-in-Residence programmes within the Welsh Blood Service (WBS) and Velindre Cancer Service (VCS)**. These roles embed artists within services over a sustained period, enabling deeper relationships with staff and patients and supporting co-created creative outputs that reflect lived experience, organisational values and the realities of care delivery.

This activity aligns with national and local priorities, including the Well-being of Future Generations (Wales) Act, by supporting prevention, integration, involvement and long-term wellbeing. Arts in Health initiatives are developed and delivered in partnership, ensuring that they respond to real needs and complement clinical care rather than sit alongside it.

As part of the Hefyd programme, Arts in Health continues to be viewed not as an add-on, but as a meaningful contributor to patient experience, staff wellbeing and the Trust's role as an anchor institution within its communities.

Hefyd: Green Social Prescribing and Nature-Based Well-being

Green social prescribing continues to form a core element of the Hefyd programme, integrating environmental sustainability with health and wellbeing.

Key initiatives include:

- The Trust's partnership with Ray of Light Cancer Support, providing nature-based and therapeutic activities for patients, carers and staff
- Expansion of social and therapeutic horticulture, including pollinator-friendly planting, wildflower meadows and a staff-led beehive at Talbot Green
- Use of outdoor spaces to support rehabilitation, mental wellbeing and connection to nature

These initiatives demonstrate how sustainability, health and wellbeing can be delivered together through partnership approaches that address physical, emotional and environmental outcomes simultaneously.

Hefyd: Community Benefits and Engagement

Hefyd also provides the framework through which Community Benefits associated with major capital and procurement programmes are delivered.

The New Velindre Cancer Centre (nVCC) has been a key driver of this work, with ambitious Community Benefits targets agreed that reflect a broad and inclusive definition of social value. These include:

- Apprenticeship and skills development opportunities
- Pathways into employment for people who are long-term unemployed or economically inactive
- Support for local community grants and investment
- Improved engagement with local suppliers, community groups and third-sector organisations

The Community Benefits Governance Board has continued to support community investment, workforce development and inclusive employment, reinforcing the Trust's The New Velindre Cancer Centre (nVCC) programme has demonstrated a particularly strong commitment to social partnership through the development of ambitious Community Benefits targets. These targets have been designed to deliver a broad range of social, economic and workforce outcomes, reflecting local need and Welsh Government priorities. They include measures to increase apprenticeship opportunities, support pathways into employment for people who are long-term unemployed or economically inactive, and deliver targeted community grants and investment.

The Community Benefits Governance Board has continued to provide oversight and assurance on delivery, ensuring that commitments made through the nVCC and other major programmes translate into meaningful outcomes for local communities. This approach reinforces the Trust's commitment to community wealth-building, inclusive employment and long-term social value, delivered through partnership working with contractors, local organisations and third-sector partners.

Hefyd: Children and Young People

Engagement with children and young people is a growing and strategically important element of the Hefyd programme.

During 2025–26, this has included:

- Delivery of Sustainability Jamborees as part of the Hefyd programme, engaging children and young people, families and schools in climate literacy, biodiversity, creativity and wellbeing
- Interactive activities such as arts and crafts, habitat home building and biodiversity-themed engagement sessions
- Bilingual engagement approaches to ensure inclusion and accessibility
- Partnership working with Young Ambassadors, including a dedicated planting day that enabled young people to actively improve the site environment while giving back to the community. This activity supported skills development, environmental stewardship and a sense of shared ownership of place.

These activities support early awareness of health, sustainability and wellbeing, while strengthening the Trust's role as a community anchor institution that invests in future generations and creates meaningful opportunities for young people to contribute positively to their communities.

From 2026–27, the Hefyd programme will be incorporated into formal reporting through the Climate Action Board, providing clearer governance, accountability and alignment with the Trust's Sustainability Strategy. This will ensure that Hefyd contributes directly to the Trust's strategic aims relating to environmental sustainability, social value, prevention and long-term community wellbeing.

4. CHALLENGES AND LESSONS LEARNED

4.1 Challenges

- Balancing operational demands with meaningful engagement.
- Ensuring consistency in partnership working across departments.
- Addressing recruitment and retention challenges within the workforce.

4.2 Lessons Learned

- Early and continuous engagement to ensure more effective policy implementation.
- Strong leadership commitment is critical to fostering a culture of partnership.
- Embedding fair work and social value in procurement requires ongoing supplier engagement.

5. FUTURE PRIORITIES

- Strengthen engagement with frontline staff and trade union representatives.
- Continue to expand partnership working with third-sector organisations and community groups.
- Enhance training on social partnership principles for all staff.
- Develop a monitoring framework to measure the impact of social partnership initiatives.

6. CONCLUSION

Velindre University NHS Trust remains committed to upholding the principles of social partnership, ensuring that our workforce and stakeholders play an active role in shaping the future of healthcare in Wales. Through continuous engagement, collaboration, and shared decision-making, we aim to improve working conditions, enhance service quality, and deliver better health outcomes for the people of Wales.



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TRUST BOARD

FRESH Annual Report

DATE OF MEETING	30 July 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	Jon Fear interim director Estates & Capital Planning
PRESENTED BY	Lauren Fear, Director of Place, Portfolio and Partnerships
APPROVED BY	Lauren Fear, Director of Place, Portfolio and Partnerships
EXECUTIVE SUMMARY	The FRESH Highlight Report provides the Trust Board oversight of performance across Fire, Risk, Estates, Sustainability and Health & Safety (FRESH) functions across the Trust's buildings and operational estate. Overall statutory compliance remains stable, with planned preventative maintenance performance meeting the 95% benchmark across almost all locations, with minor variances actively managed. Reactive maintenance performance also remains strong. The key focus for this reporting period is the submission of the FRESH Annual Report 2025–26. The Annual Report provides a comprehensive overview of performance, compliance and strategic progress across Fire, Risk, Estates,



	Sustainability and Health & Safety for the period 1 April 2025 to 31 March 2026. During the reporting period, the Trust strengthened governance, assurance and accountability arrangements across the FRESH portfolio, supported by the establishment of the Place, Portfolio & Partnerships Directorate. This has enabled a more integrated and coordinated approach to managing compliance, risk and service delivery. The report highlights: • Fire Safety: Strong compliance with fire risk assessment requirements, no fire incidents recorded, and improved governance arrangements. • Risk Management: Enhanced oversight and visibility of organisational risks through strengthened governance and risk register processes. • Estates: High compliance performance, targeted capital investment, and the strongest Estates audit outcomes achieved by the Trust to date. • Sustainability: Continued progress in decarbonisation, sustainable healthcare initiatives and environmental objectives aligned with NHS Wales priorities. • Health & Safety: Improved training compliance, strengthened governance arrangements, and continued implementation of the Health & Safety Management System. The report provides assurance that the Trust continues to maintain a safe, compliant and sustainable estate and operating environment, while identifying priority areas for further improvement, including training compliance, backlog maintenance risks, climate resilience and sustaining performance gains.



RECOMMENDATION / ACTIONS	The Trust Board is asked to: 1. Receive and note the FRESH Annual Report 2025–26. 2. Note the significant progress made in strengthening governance, compliance, and assurance across all FRESH functions. 3. Acknowledge the key areas of risk and focus identified within the report, including: a. Training compliance sustainability b. Ageing estate and backlog maintenance c. Climate change and sustainability risks 4. Support the forward priorities for 2026–27, including: a. Transition to the new Velindre Cancer Centre b. Progression of the Talbot Green Infrastructure Programme c. Strengthening compliance, data quality, and reporting d. Continued embedding of FRESH governance arrangements 5. Provide continued strategic oversight and support to ensure sustained improvement and delivery against organisational objectives.								
	GOVERNANCE ROUTE								
<table border="1"> <thead> <tr> <th>List the Name(s) of Committee / Group who have previously received and considered this report:</th> <th>Date</th> </tr> </thead> <tbody> <tr> <td>FRESH Monthly Meeting</td> <td>12/06/2026</td> </tr> <tr> <td>Executive Management Board</td> <td>02/07/2026</td> </tr> <tr> <td>Quality Safety and performance Committee</td> <td>16/07/2026</td> </tr> </tbody> </table>		List the Name(s) of Committee / Group who have previously received and considered this report:	Date	FRESH Monthly Meeting	12/06/2026	Executive Management Board	02/07/2026	Quality Safety and performance Committee	16/07/2026
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FRESH Monthly Meeting	12/06/2026								
Executive Management Board	02/07/2026								
Quality Safety and performance Committee	16/07/2026								
Summary and outcome of previous governance discussions									
7 LEVELS OF ASSURANCE									
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Select Current Level of Assurance FIRE – 3 ESTATES - 4								



	SUSTAINABILITY - 4 Health and Safety - 3
APPENDICES	
1	1 – Annual Report 2 – The FRESH Pack

1. SITUATION

- The Trust has strengthened governance, compliance, and assurance across all FRESH disciplines
- No fire incidents recorded and strong fire safety compliance maintained
- High levels of Estates compliance achieved across multiple sites
- Training compliance has improved but requires continued focus to sustain performance
- Backlog maintenance and ageing infrastructure remain key estate risk

2. BACKGROUND

The FRESH Annual Report brings together performance across Fire, Risk, Estates, Sustainability and Health & Safety into a single, integrated assurance report aligned to organisational governance structures.

During 2025–26:

- Governance has been strengthened and embedded across FRESH functions
- Audit engagement and responsiveness has improved assurance outcomes
- Sustainability and climate adaptation activity has expanded
- Estates capital and backlog programmes have been delivered to mitigate infrastructure risk

3. ASSESSMENT

There is clear evidence of improved governance maturity, strengthened assurance, and greater integration across FRESH disciplines.

Key Strengths

- High levels of planned maintenance compliance across the estate
- Strong audit outcomes across multiple compliance disciplines
- Effective fire safety controls with no reported incidents
- Increasing maturity in sustainability and environmental performance

Key Risks / Challenges

- Ageing estate and backlog maintenance pressures



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- Sustaining training compliance across all areas
- Climate change and environmental risks
- Operational pressures associated with major programmes, including the new Velindre Cancer Centre

4. SUMMARY OF MATTERS FOR CONSIDERATION

- The report demonstrates strong overall assurance across FRESH functions
- Governance and reporting arrangements are significantly improved and embedded
- Key risks are clearly identified and actively managed
- Forward priorities are aligned to strategic programmes and compliance requirements

5. 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)	BAF 02 - There is a strategic risk that the quality of patient/donor/population outcomes and/or experience across the services managed by the Trust may be adversely impacted if the Trust cannot deliver its ambitious change programmes.



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QUALITY AND SAFETY IMPLICATIONS / IMPACT	Select all relevant domains below Safe ☒ Timely ☐ Effective ☒ Equitable ☐ Efficient ☒ Patient Centred ☐
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Not required Click or tap here to enter text
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health.
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	Targeted capital investment continues to address backlog and infrastructure risks. Ongoing funding supports compliance, strategic programmes, and operational resilience, while improved governance and systems support efficiency.
EQUALITY IMPACT ASSESSMENT For more information: https://nhs.wales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx	Yes - please outline what, if any, actions were taken as a result
	Positive impact through provision of safe, compliant, and accessible environments for patients, staff, and communities.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Health and Safety at Work etc. Act 1974 The Management of Health and Safety Regulations 1999. Manual handling Operations Regulations 1992



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6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	Failure to sustain improvements across FRESH functions could result in reduced compliance, increased safety risk, and potential impact on service delivery.
WHAT IS THE CURRENT RISK SCORE	Variable risk scores (inc impact of 5)
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	Strengthens governance, assurance, and delivery against organisational objectives.
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Ongoing reduction in risk through continued investment, governance, and delivery of strategic programmes.
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
All risks must be evidenced and consistent with those recorded in Datix	

Velindre University NHS Trust

Fire, Risk, Estates, Sustainability and Health & Safety Annual Report (FRESH)

1 April 2025 – 31 March 2026



Velindre University NHS Trust is responsible for the delivery of a broad range of specialist services across NHS Wales, including the Velindre Cancer Service and the Welsh Blood Service. In addition, the Trust hosts key national functions, including Health Technology Wales, Advanced Therapies Wales, and NHS Wales Shared Services Partnership.

Caring

We are always kind, supportive, approachable and show compassion to all.



Respectful

We seek to understand other people's perspectives. We are always open and transparent.



Accountable

We always take personal responsibility for what we do and how we do it.



The Velindre Cancer Service is a specialist treatment, teaching, research, and development service for non-surgical tertiary oncology services to patients from across southeast Wales and further afield.

The Welsh Blood Service provides essential and highly specialised national services including the collection and production of blood and blood components, specialist diagnostic services and antenatal screening, as well as supporting transplant services for solid organs and stem cells across Wales and internationally.

Health Technology Wales assesses non-medicine health and care technologies and produces national guidance on their use in Wales.

NHS Wales Shared Services Partnership delivers a wide range of professional, technical, and administrative services to NHS Wales.

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- Introduction
- Fire
- Risk
- Estates
- Sustainability
- Health and Safety

Foreword

Director of Place, Portfolio & Partnerships

The year ahead represents a significant milestone for Velindre University NHS Trust, with a primary focus on the safe and successful transition to the new Velindre Cancer Centre (nVCC). This programme of work will be the Trust's central priority, requiring coordinated effort across Fire, Risk, Estates, Sustainability and Health & Safety (FRESH) to ensure that risks associated with service transfer, estate readiness and operational continuity are effectively managed. Delivering an incident-free transition remains a core objective.

Alongside this, the Trust will progress key strategic estate developments, including the planned disposal of the Whitchurch site and the continued development of infrastructure at Talbot Green. These programmes will require robust oversight to ensure that safety, compliance, environmental sustainability and operational resilience are maintained throughout periods of change.

Across the FRESH portfolio, continued implementation and embedding of the Trust's Health and Safety Management System will remain a priority, with a focus on strengthening governance, improving assurance mechanisms and supporting organisational maturity.

In support of these overarching aims, priority activities for 2026/27 include:

- **Fire Safety:** Supporting the nVCC transition programme, delivering a full suite of updated fire safety protocols by March 2027, and establishing clear fire safety performance indicators as part of the Trust's wider performance framework. Divisional priorities will focus on strengthening emergency preparedness, including updated evacuation strategies, refreshed fire risk assessments and expanded training, drills and exercises across all areas.
- **Estates and Compliance:** Further strengthening statutory compliance, risk management and assurance arrangements across the estate, alongside progressing decarbonisation initiatives and embedding FRESH governance structures to support improved oversight and decision-making.
- **Sustainability:** Prioritising readiness for nVCC through sustainable travel initiatives and active travel engagement, supported by the development of a refreshed Staff Travel Plan (2027–2033). Work will also continue to embed climate change adaptation within planning processes and organisational risk management, alongside expansion of the Arts and Health programme to support wellbeing.
- **Health and Safety:** Supporting the safe transition to nVCC, while advancing the next phase of the Trust's Health and Safety improvement programme. This will focus on embedding consistency, strengthening assurance, and further developing systems and processes aligned to best practice.

Collectively, these priorities will ensure that the Trust not only delivers a safe and effective transition to its new facilities, but also continues to strengthen its approach to risk management, sustainability and organisational resilience for the future.

Introduction

This Annual Report provides an overview of the progress, performance, and impact of the FRESH functions - Fire, Risk, Estates, Sustainability, and Health & Safety - for the period 1st April 2025 to 31st March 2026.

Over the past year, the Trust has continued to strengthen its approach to safety, compliance, and environmental responsibility through improved governance, enhanced systems, and closer integration across these core disciplines. The establishment of the Place, Portfolio & Partnerships Directorate has further supported a more coordinated and strategic approach, enabling clearer accountability and improved oversight of key risks and priorities.

Across all areas, there is clear evidence of sustained improvement, underpinned by proactive management, investment in infrastructure and capability, and strong collaborative working.

While significant progress has been made, the report also identifies areas requiring continued focus to ensure high standards are consistently maintained and further embedded.

This report provides assurance on compliance with statutory requirements, highlights key achievements, and sets out priorities for the year ahead, supporting the Trust's ongoing commitment to providing a safe, resilient, and sustainable environment for patients, staff, and the wider community.

Fire Safety

Introduction

This section summarises the Trust's progress in strengthening fire safety between 1 April 2025 and 31 March 2026.

Significant progress has been made through proactive management, improved governance, and enhanced operational practices. However, continued effort is required across all levels of the organisation to further embed fire safety and sustain improvement into 2026/27.

Key Board Assurance

- Strong compliance with fire risk assessment requirements
- No fire incidents, demonstrating effective controls
- Improvements in systems, governance, and estates compliance
- Training compliance remains the primary risk area, requiring targeted action

Progress against 2024/25 Priorities

Focus Area 1: Supporting Guidance Documentation (Board Summary)

Significant progress has been made in strengthening the Trust's fire safety framework through the development of supporting protocols to underpin the Fire Safety Policy (PP01).

Four priority protocols have been drafted, addressing:

- Core fire safety principles and leadership accountability
- Fire risk assessment, audit, and inspection processes
- Staff training, drills, and exercises
- Emergency planning and evacuation procedures

These protocols provide a structured and consistent approach to fire safety management across the Trust, improving clarity of roles, standardising practice, and supporting compliance with statutory requirements.

This represents a key step forward in enhancing governance, embedding fire safety within organisational processes, and strengthening overall preparedness.

Focus Area 2: Role of the Executive Director (with fire safety responsibility)

The Executive Director provides strategic oversight of fire safety across the Trust, including policy, legislative compliance, estates design and maintenance standards, workforce training, and cross-organisational coordination. Day-to-day operational responsibility is delegated to the Fire Safety Manager.

Following the establishment of the Places, Portfolio & Partnerships (PPP) Directorate, Executive Director accountability for fire safety has been assigned to Lauren Fear.

Fire safety is now embedded as a standing agenda item within:

- PPP Directorate meetings
- FFRESH (Facilities, Fire, Risk, Estates, Health & Safety) forum
- Divisional Cynefin groups

This strengthened governance structure enhances visibility, reinforces accountability, and supports sustained improvement in fire safety performance across the Trust.

Focus Area 3: Fire Safety KPIs (Board Summary)

Under the leadership of the Places, Portfolio & Partnerships (PPP) Directorate, the Trust is strengthening its ability to provide clear internal and external assurance regarding compliance with statutory and mandatory fire safety requirements.

This work focuses on defining what information is required, alongside improving how data is collected, collated, and reported.

Through the Trust's Performance Management Framework (PMF), fire safety performance is structured across four key domains:

- Policy, Protocols & Procedures
- Assessment, Audit & Inspection
- Training, Drills & Exercises
- Fire Incidents & Unwanted Fire Alarm Activations

The development of these KPIs represents an important step toward improved performance oversight, enabling more consistent reporting, enhanced scrutiny, and stronger assurance to the Board on fire safety compliance and risk management.

Policy, Protocols and Procedures

Strategic Progress

The Fire Safety Policy (PP01) remains current (approved May 2024) and aligned with legislation and national guidance.

Development of four supporting protocols has strengthened implementation, integrating fire safety with:

- Health & Safety
- Emergency Preparedness (EPRR)
- Sustainability

This has improved governance, clarified responsibilities, and promoted a stronger safety culture.

Divisional Highlights

VCS: Evacuation strategy under review in response to the Terrorism (Protection of Premises) Act 2025; local procedures being updated collaboratively.

WBS: Emergency procedures reviewed following HSE Improvement Notices; wider site reviews ongoing.

Corporate: Nantgarw site maintains a simple, low-risk evacuation plan, with future enhancements planned to reflect emerging threats

Assessment, Audit and Inspection

Strategic Progress

- Fire Risk Assessment (FRA) and audit protocol in final review phase.
- Adoption of NWSSP SES module enables improved risk tracking, accountability, and Board reporting.

- Annual Fire Audit (2024/25) submitted to NWSSP-SES
- Outstanding DSEAR remedial actions completed.

Key Metrics

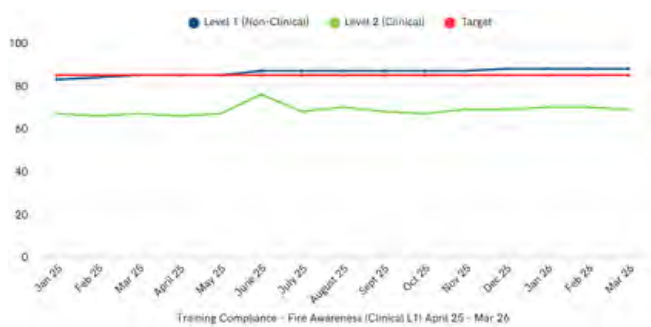
- VCS: 34 FRAs completed (100% compliance).
- WBS: HQ FRA completed; remaining three sites due for review by March 2027.
- Corporate: FRA compliant and updated following EV installation in the car park.
- External audits: None undertaken across the Trust this year.

Training, Drills and Exercises

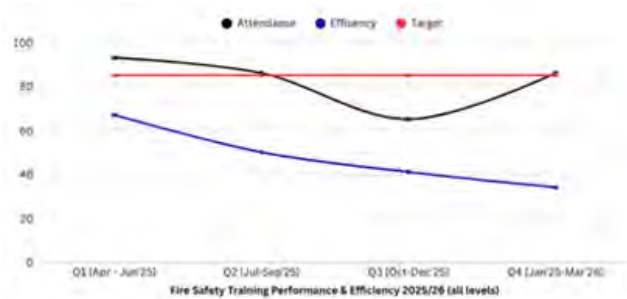
Strategic Progress

- Introduction of ESR “Open House” training programme to improve accessibility and uptake.
- Strengthened collaboration with Education and divisions to improve compliance and engagement.
- Reinforcement of drills and exercises as part of EPRR preparedness.
- Delivery of a board development training session, which was well received and supported, increased awareness of roles, responsibilities, and assurance requirements at a senior level.
- Protocol PP01D provides structured and consistent guidance.

The compliance graph illustrates the Trust's performance based on ESR data. The green line indicates our mandatory compliance level. Both graphs show progress in each training topic.



The graph shows the trend of attendance (Black line) compared to the number of ‘seats’ available for fire safety training [all levels] - ‘Efficiency’ (Blue line); a total of 1,410 ‘spaces’ were offered for face-to-face training but only 674 [47.8%] were filled.



This data will inform planning for fire safety training in the 2026/27 year.

Divisional Highlights

- VCS: Strong local initiatives and drill programmes; further support required.
- WBS: Training delivered; exercises implemented across sites.
- Corporate: Mixed attendance; compliance actions in place including mandatory drill.

Management of Fire Alarm Activations and Service Response

During 2025/26, the Trust has undertaken a detailed review of fire alarm activations at Velindre Cancer Centre in response to changes in South Wales Fire and Rescue Service (SWFRS) attendance arrangements. This work has been undertaken in partnership with SWFRS and provides enhanced assurance over the management of automatic fire alarm (AFA) incidents.

The review confirmed that the site remains within acceptable performance thresholds, with a low number of unwanted fire alarm activations and no fire incidents recorded. However, it also highlighted the complexity of the risk environment, including vulnerable patients, high occupancy levels, and the presence of critical clinical infrastructure such as radiotherapy services and the aseptic chemotherapy unit.

A number of targeted actions have been identified to further improve response arrangements and reduce unnecessary fire service callouts. These include strengthening controls on electrical appliances, enhancing emergency investigation procedures, and exploring system and operational improvements.

This work demonstrates a proactive and risk-based approach to fire safety, ensuring that both life safety and the continuity of critical cancer services are effectively protected.

Fire Incidents and Unwanted Fire Alarm Activations

- No fire incidents recorded across the Trust.

Unwanted Fire Alarm Activations

- VCS: 9 Unwanted Fire Alarm Activations (5 Fire Service attendances). Improvement actions agreed.
- WBS & Corporate: Nil Unwanted Fire Alarm Activations

Estates and Capital Planning

Strategic Progress

- Robust inspection and maintenance of fire systems continues.
- Improved contractor controls, including Permit to Drill system.
- Fire Safety Manager engaged in major developments (incl. new Cancer Centre).

Key Highlights

- VCS: Compartmentation works completed; fire system issues resolved; damper works in progress.
- WBS: Fire safety works completed; digital infrastructure risks under review.
- Corporate: No significant issues identified.

Miscellaneous

- Further integration of fire safety with Business Continuity and EPRR planning.
- Fire safety input into radiation protection and security planning.
- Development of new Cancer Centre fire strategy (aligned to sustainability goals).
- Ongoing DSEAR compliance work and lockdown procedure development.

Forward Look (2026/27 Priorities)

Trust-wide

- Support nVCC transition programme
- Deliver full suite of fire safety protocols (by March 2027)
- As part of Trust performance management, establish and agree Fire Safety KPIs (by July 2026)

Division Priorities

- VCS:
 - o Update emergency plans and evacuation strategies (including alignment with nVCC);
 - o improve training ownership;
 - o expand drills and exercises.

- WBS:
 - o Update FRAs (incl. EV considerations);
 - o strengthen emergency procedures;
 - o continue drills and exercises

- Corporate:
 - o Complete drills;
 - o refresh site emergency plan and evacuation procedure.

Risk

Effective risk management remains central to how Velindre University NHS Trust ensures the delivery of safe, sustainable, and high-quality services. The Trust continues to adopt a structured and proactive approach to identifying, assessing, and mitigating risk, aligned to national standards and embedded within established governance frameworks.

During 2025/26, meaningful progress has been made in strengthening risk management arrangements, with a particular focus on improving the visibility, consistency, and oversight of risks across all divisions.

A key development has been the enhancement of the FRESH (Facilities, Risk, Environment, Sustainability and Health & Safety) meeting, where a more structured and focused review of divisional risk profiles has been embedded. This ensures risks are not only subject to regular scrutiny but are also considered in context, enabling improved understanding of pressures, emerging trends, and interdependencies across services. This approach is now formally reported through the FRESH governance structure to the Executive Management Board (EMB), strengthening organisational oversight and assurance.

In addition, the introduction of a dedicated Risk Register meeting has established a separate forum to focus on the quality, development, and consistency of risk management processes. While this arrangement continues to evolve, it represents a significant step towards a more mature and standardised approach, supporting improved decision-making and clearer alignment between operational and strategic risks.

Risk reviews continue to be undertaken on a regular basis, with risks assessed and scored in line with the Trust's framework. Higher-scoring risks are escalated through established governance routes, including Senior Leadership Teams, while maintaining the principle that all risks—regardless of score—are subject to proactive management and appropriate scrutiny.

Alongside these developments, the Trust has further strengthened its approach to emerging and long-term risks, particularly in relation to sustainability and climate resilience. Building on work undertaken in previous years, the Sustainability Team has advanced the identification and assessment of environmental and climate-related risks using the Climate Change Adaptation Toolkit for Healthcare. This includes risks associated with extreme weather events, supply chain disruption, and the impact of temperature variation on service delivery.

Departments continue to be supported to identify and manage localised and service-specific risks, ensuring that infrastructure vulnerabilities, equipment dependencies, and operational pressures are appropriately captured and addressed. This combined approach provides both

corporate oversight and local ownership, enabling a coordinated and responsive Trust-wide risk framework.

Overall, the developments during 2025/26 demonstrate a clear shift towards a more integrated and mature risk management approach, where risk is increasingly embedded within governance structures, decision-making processes, and operational practice. Continued enhancement of review mechanisms and processes strengthens the Trust's ability to identify emerging risks early, prioritise effectively, and respond with agility.

This work will continue to develop over the coming year, with a focus on improving the quality of risk information, refining processes, and ensuring that risk management remains a key enabler of organisational resilience and continuous improvement.

Building condition and backlog maintenance remain key strategic priorities for the Trust.

The primary estates-related risk continues to be driven by ageing infrastructure within Velindre Cancer Services, which is being actively managed through targeted backlog investment and transition planning to the new Velindre Cancer Centre (nVCC). The Trust's total backlog maintenance liability is currently estimated at just under £22 million. While Welsh Government has released funding to support ageing estate across NHS Wales, Velindre will not be in receipt of this funding due to the significant capital investment already committed to the nVCC and the Welsh Blood Service Tregaron (TGI) project.

Key actions delivered during the year include the prioritisation of high-risk backlog items, targeted infrastructure replacement programmes, procurement of critical spare parts, and alignment of investment with IMTP priorities and transition planning. Collectively, this approach ensures that risks are actively managed while maintaining operational continuity.

Two of the Trust's most significant estate risks relate to the ongoing management of the former Whitchurch site and the challenges associated with maintaining ageing assets in a safe and operational condition. These risks are subject to regular review and oversight through established governance arrangements, demonstrating both the effectiveness of current processes and the increased maturity of the Trust's approach to estate risk management over the reporting period.

Estates

Estates, Land and Capital Annual Report 2025–26

Executive Summary

During 2025–26, the Estates function has delivered a high level of performance, maintaining robust statutory compliance, progressing key capital investments, and strengthening governance and assurance across the estate.

The Trust has achieved its strongest Estates audit position to date, with multiple disciplines attaining Substantial Assurance. This reflects continued improvement in compliance maturity, control effectiveness, and operational delivery. A targeted capital programme has supported infrastructure resilience, reduced backlog risk, and maintained service continuity, alongside ongoing progress in delivering the new Velindre Cancer Centre (nVCC) and wider strategic developments.

Overall, the Estates team has remained focused on providing a safe, compliant, and sustainable estate, aligned to the Trust’s strategic objectives and future service requirements.

Key Highlights 2025–26

- Achieved strongest Estates audit outcomes on record
- Maintained high levels of PPM compliance across all sites
- Delivered targeted capital programme addressing high-risk backlog
- Progressed major strategic developments including nVCC and Talbot Green
- Strengthened governance through FRESH framework and audit engagement

Estates Overview

The Estates function has continued to deliver a comprehensive programme of operational, compliance and capital activity throughout 2025–26, ensuring the Trust’s estate remains safe, resilient, and aligned to future service needs.

All activity has been aligned to the Trust’s Integrated Medium-Term Plan (IMTP) and long-term estates strategy.

This reporting period has seen a strengthened focus on statutory compliance and assurance, backlog risk management and prioritisation, capital delivery and infrastructure resilience, transition planning for the new Velindre Cancer Centre, and sustainability and decarbonisation initiatives.

A continued emphasis has also been placed on governance through the FRESH framework, providing improved visibility and assurance across estate-related risks and operational delivery.

Statutory Compliance and Maintenance

Performance

During 2025–26, the Estates department has continued to embed improvements to its CAFM system, strengthening asset data integrity, maintenance planning and performance reporting. The system remains aligned to SFG20 maintenance standards, Welsh Health Technical Memorandum guidance, and local compliance policies and audit requirements.

For the period April 2025 to March 2026, compliance performance across the estate remained strong overall. Planned Preventative Maintenance (PPM) compliance was consistently high across core, remote and satellite locations, demonstrating sustained control of planned maintenance activity and continued focus on statutory compliance.

Velindre Cancer Service achieved 98% PPM compliance and 88% reactive maintenance compliance. While planned maintenance performance remains strong, the reactive position reflects the pressures associated with an ageing estate and increased operational demand. Targeted improvement actions are in place to support continued improvement.

Site	PPM Compliance	Reactive Maintenance Compliance	Summary
Velindre Cancer Service	98%	88%	Strong PPM performance, with reactive compliance impacted by ageing estate pressures and operational demand.
Welsh Blood Service Headquarters	98%	95%	Consistently strong performance across both planned and reactive maintenance.
HQ Nantgarw	97%	97%	High and balanced compliance performance.
Wrexham WBS	98%	91%	Strong planned maintenance performance, with reactive compliance remaining above 90%.
Bangor WBS	98%	100%	Excellent compliance across planned and reactive maintenance.
19 Park Road	100%	96%	Very strong compliance performance.

Dafen WBS	100%	100%	Full compliance achieved for both PPM and reactive maintenance.

The results demonstrate strong compliance performance across both core and geographically dispersed estate locations. The consistently high PPM position provides assurance that planned maintenance activity is being effectively managed, while reactive maintenance performance remains subject to ongoing monitoring and targeted improvement where required.

Capital Works – Estates Discretionary and Backlog Programme

During 2025–26, the Trust delivered a targeted Estates Discretionary Capital Programme focused on addressing backlog risk, improving resilience and enhancing environments.

Key schemes delivered include upgrades to critical cold water booster pumps, replacement of air handling unit fans in radiotherapy, fire door replacement programmes, and Trust-wide fire damper improvements. Environmental upgrades were undertaken to improve patient experience and meet Infection Prevention and Control standards. Essential generator and electrical infrastructure upgrades were completed across VCS and WBS to improve resilience.

Additional works included theatre ventilation improvements, LED lighting upgrades within Welsh Blood Service laboratory areas, and improvements to the Therapies facility, including staff welfare areas, storage and medical facilities. Electric vehicle charging infrastructure was installed at WBS Headquarters, and staff shower facilities were delivered at VCS Zone 10.

These schemes have reduced high-risk backlog, strengthened statutory compliance, improved infrastructure resilience, enhanced patient and staff environments, and supported decarbonisation objectives.

Strategic Capital and Major Programme Support

The Estates function has continued to support major capital developments across the Trust. This has included ongoing design assurance, technical input and governance support for the new Velindre Cancer Centre, including facilitation of Estates Safety Groups and support to commissioning and transition planning.

The team has also supported the Satellite Radiotherapy Unit at Nevill Hall through collaboration with Aneurin Bevan University Health Board and engagement with specialist suppliers and clinical teams.

Progress has continued on the Talbot Green Infrastructure Programme, with focus on developing a modern, resilient and sustainable facility for Welsh Blood Service operations.

Land, Property and Leases

During 2025–26, the Trust has continued to actively manage its land and property portfolio, including operational accommodation, Welsh Blood Service facilities, NWSSP-occupied premises and community leases.

A lease expiry review has strengthened oversight of lease obligations, break clauses, rent commitments and statutory protection status, supporting improved governance and forward planning.

Key lease renewals during the reporting period included Companies House Cardiff, Pembroke House Wrexham, 4 and 5 Charnwood Court Nantgarw, and Unit 30 Llandegai Industrial Estate Bangor. These renewals ensure continued support for key operational services.

A further lease renewal for 19 Park Road, Whitchurch was completed in April 2026 following the reporting period.

The Trust continues to manage community lease arrangements at Whitchurch Hospital, including agreements with local sports clubs, ensuring community use is maintained alongside strategic estate planning.

Governance, Assurance and Audit

During 2025–26, governance and assurance arrangements have been significantly strengthened through continued engagement with NWSSP audits and Specialist Estates Services, implementation of audit recommendations, strengthened FRESH governance structures, and improved compliance reporting and visibility.

The Trust has achieved its strongest Estates audit outcomes to date.

- Water Safety achieved Substantial Assurance for the third consecutive year.
- Medical Gas also achieved Substantial Assurance.

- Low Voltage systems achieved Substantial Assurance, demonstrating significant improvement.
- High Voltage and Ventilation systems achieved Reasonable Assurance.

These outcomes represent the highest levels of assurance achieved by the Trust and reflect strong engagement with NWSSP Specialist Estates Services, alongside improvements in internal governance and compliance processes. This has been further supported by the continued contribution and collaboration of clinical teams, donor services and wider departments through regular Estates and Safety Group meetings.

Forward Focus 2026–27

Key priorities for the coming year include improving compliance performance toward the 95% target, delivering a risk-based backlog reduction programme, and continuing to strengthen CAFM utilisation and data quality across the estate.

A critical focus will be the transition to the new Velindre Cancer Centre (nVCC), ensuring that Estates, clinical and operational teams are fully prepared and optimally positioned to support a safe and effective commissioning process. This will include structured transition planning, workforce readiness, and continued engagement through governance and Safety Group arrangements.

In parallel, the Estates function will play a key role in the ongoing monitoring and assurance of the nVCC contract model, ensuring performance, compliance and service delivery are maintained in line with contractual and operational expectations.

Progression of the Talbot Green Infrastructure Programme (TGI) will remain a priority, with continued development and submission of the Outline Business Case (OBC) and Full Business Case (FBC) to support delivery of a modern, resilient and sustainable facility for Welsh Blood Service operations.

Further priorities include expanding decarbonisation initiatives, embedding FRESH governance and assurance arrangements, and continuing to strengthen compliance and risk management across all Trust sites.

Sustainability

Introduction

This year has marked continued progress in embedding sustainability across Velindre. Through strong governance, staff engagement, and innovative projects, sustainability has become increasingly integrated into how we deliver care, manage our resources, and support our communities. Our work aligns with NHS Wales priorities and the Well-being of Future Generations (Wales) Act, ensuring that environmental, social, and economic value is created for both current and future generations.

Theme 1: Creating Wider Value – Our Organisational Approach

The Climate Action Board was launched this year, providing strategic oversight of decarbonisation and climate action, and ensuring alignment with national priorities while offering assurance to senior leadership.

Supporting this, the ISO 14001:2015 Environmental Management Group has maintained certification and continues to drive improvement, alongside Clinical Sustainability MDTs and Arts in Health MDTs, embedding sustainability into care and wellbeing. These structures ensure sustainability is integrated across both strategy and day-to-day operations.

Theme 2: Sustainable Care Models

The introduction of the Clinical Sustainability MDT has created an open forum for staff to share ideas and drive change.

Key projects demonstrate impact. The switch from intravenous to subcutaneous Nivolumab significantly reduced waste, cutting plastic use from over 1 kg per treatment to just 47 grams while improving efficiency. The Genetic Haemochromatosis project enables blood reuse and brings care closer to patients' homes, improving access and reducing waste.



Theme 3: Carbon Zero

Progress towards decarbonisation continues, with the Trust on track to achieve 100% LED lighting by 2026/27 for WBS sites, supported by smart controls to reduce consumption.

Welsh Blood Service's Project ELSA received national recognition, winning "Product of the Year" at the NHS Wales Sustainability Awards 2025 for introducing reusable cooling devices, replacing dry ice with a lower-carbon solution.

Theme 4: Sustainable Infrastructure

The Sustainability Team has continued to work closely with the new Velindre Cancer Centre (nVCC) and Talbot Green Infrastructure Upgrade (TGI) projects, ensuring sustainability remains embedded throughout delivery.

Both developments continue to meet high standards, incorporating low-carbon design, energy efficiency, and climate resilience, supported by ongoing stakeholder engagement.

Theme 5: Transition to a Future of Renewables

Progress continues in delivering the all-electric, renewable-focused design of the new Velindre Cancer Centre.

In parallel, work has begun to explore the feasibility of renewable energy across Welsh Blood Service satellite sites in North Wales, identifying opportunities to support wider decarbonisation.

Theme 6: Sustainable Use of Resources

Resource efficiency remains a key focus. The "Great Big Paper Cut" initiative has reduced printing across the Trust, including supporting Pharmacy's introduction of e-signatures.

The rollout of recyclable "Good Cups" and the Walking Aid Recycling Scheme demonstrate practical circular economy approaches, supported by strong community involvement. Additional reuse initiatives have strengthened this work. A partnership with the Welsh Monkey and Ape Sanctuary enables cardboard tubes from blue roll to be reused as animal enrichment materials, delivered through existing Welsh Blood Service transport routes to avoid additional emissions.

We have also worked with Recreate Cardiff to repurpose redundant radiotherapy immobilisation equipment into creative and educational resources, diverting specialist materials from waste while delivering wider community benefit.

Energy performance continues to improve overall, with reductions in electricity use across Welsh Blood Service sites and ongoing work to optimise heating efficiency.



Theme 7: Connecting with Nature

Activities during Great Big Green Week, including wildlife safaris, habitat creation, and wellbeing sessions, have supported biodiversity and staff wellbeing.

The WBeeS initiative expanded with a second hive at Talbot Green, strengthening ecological engagement.

Theme 8: Greening Travel and Transport

The Trust has made progress in promoting sustainable travel. Initiatives such as free bike MOTs, Cycle to Work schemes, and installation of EV chargers across multiple sites are supporting staff to reduce their carbon footprint.

The staff travel survey indicates positive behavioural change, with increases in train use and cycling, alongside a reduction in single-occupancy car use. While challenges around parking and site safety remain, these insights are shaping future improvements.



Theme 9: Adapting to Climate Change

Climate adaptation is increasingly embedded within service delivery. The new radiotherapy satellite site at Nevill Hall demonstrates this approach, using patient postcode mapping to reduce travel distances and associated emissions.

Adaptation is also being incorporated into Sustainability Implementation Plans, ensuring infrastructure and services are resilient to future climate impacts. This approach has been recognised by Welsh Government as an example of good practice.

Theme 10: Our People as Agents for Change



Our people and communities remain central to delivering sustainable change. The relaunch of the Hefyd programme has strengthened community engagement through arts, green social prescribing, and youth-focused initiatives.

Hefyd has delivered extensive outreach through events, community drop-ins, and partnerships, supported by new grant funding opportunities and apprenticeship programmes.



Arts in Health: Arts in Health continues to play a vital role in improving wellbeing for patients, staff, and communities. The Art Cart, delivered at the bedside, offers one-to-one creative sessions that help reduce anxiety, improve mood, and provide a sense of control during treatment. Our partnership with BBC National Orchestra of Wales has continued, bringing regular live music to wards, and following successful pilots, Welsh National Opera has started a regular programme of performances alongside them.



"Sessions help me to feel in the moment and give a space to not think about my situation – always feel good or better than I did before"

Patient feedback from Creative Voices sessions

Additional initiatives such as Creative Voices writing courses, The Poetry Machine, and the Anadlu outdoor support group provide creative and reflective opportunities for patients and those affected by cancer. Staff wellbeing has also been supported through initiatives such as the WBS Choir with Tenovus. This year has also seen the introduction of Artists in Residence within both Radiotherapy and Welsh Blood Service laboratories, further embedding

creativity into clinical and operational environments.

Forward Focus 2026–27

For 2026/27, our forward focus will prioritise readiness for the opening of the new Velindre Cancer Centre, including targeted active travel engagement to support staff in adopting more sustainable commuting behaviours. A refreshed Staff Travel Plan for 2027–2033 will underpin this work. We will also strengthen our approach to climate change adaptation by embedding it within BCEP planning and the organisational risk register, alongside formally recording environmental and sustainability risks on Datix. In addition, we will continue to develop and expand the Arts and Health programme to support wellbeing across the Trust.

Health & Safety

Overview

During 2025/26, Velindre University NHS Trust has continued to strengthen its approach to health, safety, and wellbeing, moving from establishing core foundations to embedding consistent standards, behaviours, and accountability across the organisation.

Further improvements in governance, reporting, and leadership oversight have supported a more coordinated and consistent approach across Velindre Cancer Services (VCS), the Welsh Blood Service (WBS), and Corporate functions. This is contributing to a more mature and proactive safety culture, with increasing evidence of improved risk awareness and ownership.

Overall incident levels remain broadly stable, with some variation across categories. Encouragingly, there have been reductions in several key risk areas, particularly slips, trips and falls within VCS and contact-related incidents within WBS. The continued absence of significant infrastructure-related incidents and low levels of work-related ill health reflect stronger preventative controls and improved operational management.

However, areas of ongoing risk remain. Slips, trips and falls, sharps-related incidents, and contact incidents continue to feature within reported data and require sustained and targeted intervention. In addition, while violence and aggression incidents fluctuate year-on-year, improvements in reporting culture and awareness are influencing trends.

The introduction and early implementation of the Trust's 11 Health and Safety Principles represents a significant step forward in embedding a consistent and proactive framework for managing risk, and these principles are increasingly informing decision-making and behaviours across the organisation.

Overall, 2025/26 represents a year of consolidation and progression, with the Trust strengthening its ability to provide a safe, well-governed, and resilient environment for staff, patients, donors, and visitors.

Progress against 2024/25 priorities

Focus 1 – Health and Safety management System Update: (ongoing 3 year plan)

Progress has continued as part of the Trust's three-year improvement plan, with 2025/26 representing Year 2 of delivery and a continued focus on embedding the 11 Health and Safety Principles in a structured and sustainable way.

During 2024/25, gap analysis was completed against Principles 1, 2 and 9, with Intermediate assurance gained in these areas. Any outstanding actions identified through this process have been incorporated into the Year 2 delivery plan to ensure continuity and completion.

In 2025/26, priority activity has focused on progressing further principles, including:

- Principle 3 (Compliance Assurance)
- Principle 4 (Risk and Opportunities)
- Principle 6 (Occupational health)

- Principle 7 (Asset Management)

This phased and planned approach is ensuring that the principles are being implemented in a logical, measurable, and sustainable way, supporting the continued development of a mature, proactive, and resilient safety culture across the Trust.

Focus 2 – Training Compliance update: Complete (requires maintaining)

Training compliance has improved to **86.7%**, exceeding the Welsh Government target of 85%.

While this reflects strong organisational engagement, maintaining compliance remains a challenge. Performance continues to vary across subject areas, with a “leaky bucket” effect where improvements in some areas are offset by declines in others.

This indicates the need for a more targeted and sustainable approach, focusing on:

- Addressing local barriers
- Strengthening accountability
- Using more flexible and effective training delivery models

Focus 3 – Health & Safety Structure update: (Complete)

The Organisational Change Proposal (OCP) has been successfully delivered, with the new centralised Health and Safety structure implemented from 1 January 2026.

This has resulted in:

- Clearer governance and accountability
- Increased consistency across the organisation
- Improved visibility and management of risk

The new structure provides a strong foundation for a more strategic and coordinated approach to Health and Safety.

Performance Summary

Accident and injury incidents remain the largest reporting category. While overall numbers have remained relatively stable, improvements are evident in key risk areas, particularly in relation to slips, trips and falls within VCS.

The increase in RIDDOR-reportable incidents reflects cases meeting the regulatory threshold for over-seven-day injury, including where staff have been placed on light or restricted duties, rather than a rise in high-severity incidents. This distinction is important, as it indicates that the increase is primarily driven by reporting criteria rather than a deterioration in underlying safety performance. The position reinforces the importance of maintaining appropriate controls for higher-risk activities, while continuing to support effective injury management and early return-to-work arrangements.

Review of Performance data 2025/26

- Number of RIDDOR reportable incidents - 8
- Violence and aggression reported incidents - 42
- Number of Improvement notices from the HSE - 0

Performance data

Health & Safety Incidents

Trust

Incident Category	2021 –2022	2022-2023	2023-2024	2024-2025	2025-2026
Accident, Injury	116	111	114	91	94
Behaviour	46	31	35	27	43
Equipment Devices	21	2	8	2	2
Ill Health	10	2	2	0	5
Infrastructure	36	7	14	0	1
RIDDOR	2	4	3	5	8

Corporate

Incident Category	2021-2022	2022-2023	2023-2024	2024-2025	2025-2026
Accident, Injury	0	6	4	3	3
Behaviour	0	0	0	0	0
Equipment Devices	0	0	0	0	0
Ill Health	0	0	0	0	0
Infrastructure	0	0	0	7	0
RIDDOR	0	0	0	0	0

WBS

Incident Category	2021-2022	2022-2023	2023-2024	2024-2025	2025-2026
Accident, Injury	83	75	81	44	46
Behaviour	22	12	16	13	17

Equipment Devices	0	0	3	0	0
Ill Health	7	1	1	0	1
Infrastructure	0	1	0	7	0
RIDDOR	0	2	2	4	3

VCS

Incident Category	2021-2022	2022-2023	2023-2024	2024-2025	2025-2026
Accident, Injury	33	30	33	44	48
Behaviour	24	19	19	14	26
Equipment Devices	21	2	5	2	2
Ill Health	3	1	1	0	4
Infrastructure	36	6	7	0	1
RIDDOR	2	2	1	1	5

Violence and Aggression

WBS	VCS
27%	32%

Violence and aggression incidents have increased across the Trust during the reporting period, accounting for 27% of incidents within WBS and 32% within VCS. Within VCS, this represents the highest reported incident category for the first time, indicating a notable shift in incident trends. This position is considered to be influenced, in part, by continued efforts to strengthen the reporting culture and encourage consistent incident reporting across services. Similarly, the increase within WBS highlights the need for targeted interventions. In response, Violence and Aggression (V&A) training has been identified as a priority for WBS collection teams, with delivery planned for Quarter 3 to support staff confidence, safety, and effective incident management.

Top 3 Incident Trend Analysis

WBS

2022 - 2023	2023 - 2024	2024 - 2025	2025 - 2026

Contact with object or animal 42%	Contact with object or animal 38%	Contact with object or animal 34%	Contact with object or animal 30%
Slip, Trip or Fall 21%	Contact or exposure to hazardous substances 18%	Contact or exposure to hazardous substances 16%	Slip, Trip or fall 17%
Contact or exposure to hazardous substances 12%	Manual Handling 13%	Slip, Trip or fall 13%	Manual Handling 9%

VCS

2022 - 2023	2023 - 2024	2024 - 2025	2025 - 2026
Slip, Trip or fall 33%	Slip, Trip or fall 42%	Slip, Trip or fall 34%	Slip, Trip or fall 19%
Contact with object or animal 33%	Contact with object or animal 15%	Sharps / needles 20%	Sharps / needles 16%
Sharps / needles 15%	Manual Handling 13%	Contact with object or animal 14%	Manual Handling 13%

Overall Analysis

Across the reporting period, incident trends within both WBS and VCS show a gradual and sustained improvement in key risk areas, reflecting the positive impact of targeted interventions, improved reporting practices, and increased staff awareness.

In WBS, “contact with object or animal” remains the most prevalent category; however, it has steadily reduced from 42% to 30%, indicating improved controls and risk management. Incidents involving hazardous substances and manual handling have also declined, suggesting

strengthening compliance and safer working practices. While slips, trips and falls have fluctuated, the overall trend shows gradual improvement.

Within VCS, slips, trips and falls continue to represent the most significant risk but have reduced markedly from a peak of 42% to 19% in 2025/26, demonstrating the effectiveness of environmental and behavioural interventions. Contact-related incidents have also reduced significantly and are no longer a leading category. Sharps incidents remain relatively consistent and continue to require targeted focus to ensure safe handling practices and compliance.

Overall, the data indicates that preventative measures and safety initiatives are having a measurable impact, though continued focus is required in higher-risk areas to sustain and build on this progress.

Health and Safety Assurance Framework

During 2025/26, the Trust has made significant progress in developing and embedding a structured Health and Safety Management System (HSMS) based on eleven core principles, representing a clear shift towards a more consistent, proactive and mature approach to managing risk. Work undertaken across leadership, competence, communication, and governance has established strong foundations, including defined accountability at Board and Executive level, improved visibility of risks through enhanced governance structures, the introduction of a centralised Health and Safety function, and the rollout of a dedicated intranet hub to support accessible and consistent communication. Collectively, these developments have strengthened organisational oversight, improved staff access to information and support, and enabled more efficient and informed decision-making across services. While overall assurance remains at an intermediate level, reflecting the need to further embed consistency, strengthen compliance assurance, and enhance evaluation of effectiveness, the Trust is now well positioned to progress the next phase of implementation and continue building a resilient, well-governed, and continuously improving safety framework.

HSE Enforcement Action

No breaches of health and safety legislation were identified during the reporting period, and no formal enforcement action was taken.

A small number of concerns were raised through established processes, including a whistleblowing case within WBS. This was fully investigated and appropriately managed, with the matter subsequently closed by the Health and Safety Executive with no further action.

This reflects strong governance arrangements, effective internal processes, and a positive approach to transparency and continuous improvement.

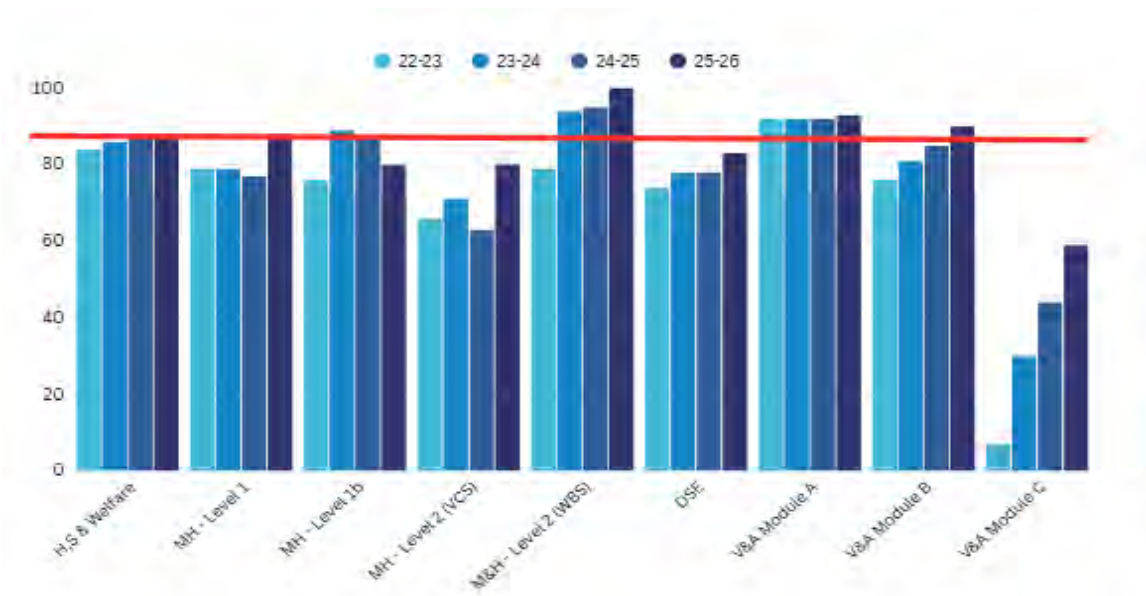
Education and Development

Overall training compliance has reached 86.7%, demonstrating continued progress and strong organisational engagement.

The key challenge moving forward is sustaining this level of performance. Variability across training subjects indicates that the current approach requires refinement, with a need for:

- Targeted interventions in lower-performing areas
- Improved local ownership
- More flexible and accessible training delivery methods

Addressing these challenges will be critical to achieving consistent compliance across the organisation.



Forward focus 26/27

A key focus for 2026/27 will be supporting the transition to the new Velindre Cancer Centre (nVCC), ensuring that risks associated with service transfer, estate readiness, and operational continuity are effectively managed throughout this period of change.

In parallel, continued emphasis will be placed on progressing the next phase of the Trust’s Health and Safety principles, as referenced earlier in this report. This will build on the foundations established in 2025/26, with a focus on embedding consistency, strengthening assurance, and further advancing the maturity of the Trust’s overall safety framework.

Conclusion/Summary

During 2025–26, the Trust has made significant progress across the FRESH functions of Fire, Risk, Estates, Sustainability and Health & Safety. Together, these areas have strengthened the Trust's ability to provide safe, compliant and resilient environments while supporting a more sustainable estate for patients, donors, staff, visitors and the wider communities we serve across Wales.

The reporting period has demonstrated clear evidence of improved governance, stronger assurance arrangements and more integrated working across the organisation. The establishment of the Place, Portfolio & Partnerships Directorate has supported clearer accountability, improved oversight and a more coordinated approach to managing key risks, compliance responsibilities and strategic priorities.

Fire safety arrangements have continued to mature, with strong compliance in fire risk assessment activity, no reported fire incidents, improved systems and governance, and continued progress in developing supporting protocols and performance measures. While training compliance remains an area requiring ongoing focus, strengthened reporting and local ownership will support further improvement in 2026–27.

Risk management has also developed positively, with improved visibility of divisional risk profiles through the FRESH governance structure and the introduction of a dedicated Risk Register meeting. This has supported a more consistent and structured approach to identifying, reviewing and escalating risk, while also enabling better consideration of emerging risks such as climate adaptation, infrastructure resilience and service continuity.

The Estates function has delivered a strong year of performance, maintaining high levels of planned maintenance compliance, delivering targeted capital and backlog investment, and achieving the Trust's strongest Estates audit outcomes to date. This reflects sustained engagement with NWSSP Specialist Estates Services, alongside close collaboration with clinical teams, donor services and wider departments through regular Safety Group arrangements. The focus will now continue on maintaining compliance, supporting transition to the new Velindre Cancer Centre, monitoring the nVCC contract model, and progressing the Talbot Green Infrastructure Programme through OBC and FBC development.

Sustainability has continued to become embedded across the Trust, with progress made in decarbonisation, sustainable care models, resource efficiency, biodiversity, sustainable travel, climate adaptation and staff engagement. The development of the Climate Action Board, continued ISO 14001 certification, and a growing range of practical improvement projects demonstrate that sustainability is increasingly influencing both strategic decisions and day-to-day operations.

Health and Safety has progressed from establishing core foundations to embedding consistent standards, behaviours and accountability across the organisation. The implementation of the centralised Health and Safety structure, increased training compliance, and continued delivery of the Trust's Health and Safety Principles provide a stronger foundation for future improvement. Incident data demonstrates positive movement in several key risk areas, particularly reductions in slips, trips and falls, and contact-related incidents, although

continued targeted work will be required in areas such as sharps, manual handling and violence and aggression.

Overall, 2025–26 has been a year of consolidation, improvement and increasing maturity across the FRESH agenda. The Trust has strengthened its assurance framework, improved collaboration across disciplines, and demonstrated a clear commitment to safety, compliance, sustainability and continuous improvement.

Looking ahead to 2026–27, the priority will be to sustain progress, further embed governance arrangements, improve data quality and performance reporting, and ensure teams are well positioned to support major strategic developments, including the transition to the new Velindre Cancer Centre and progression of the Talbot Green Infrastructure Programme.

The FRESH functions will continue to work collaboratively across the Trust to support safe, effective and sustainable services, enabling the delivery of high-quality care for patients, donors, staff and communities across Wales.

TRUST BOARD	
Wellbeing of Future Generations Annual Report	
DATE OF MEETING	30 July 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	Ella Williamson, Energy and Environment Officer
PRESENTED BY	Lauren Fear, Director of Place, Portfolio and Partnerships
APPROVED BY	Lauren Fear, Director of Place, Portfolio and Partnerships
EXECUTIVE SUMMARY	This report presents the trust's well-being of future generations annual report for 2025/26, summarising progress against well-being objectives and demonstrating how the sustainable development principle has been embedded across the organisation. Key achievements include improved access to care through innovative service models, expansion of arts and health programmes to support wellbeing, strengthened community engagement, and measurable environmental improvements. The trust has also responded to audit Wales recommendations by mapping well-being objectives to departmental KPIs, strengthening accountability and performance monitoring. The report sets out a clear forward focus on embedding the act further into planning and preparing for the new Velindre Cancer Centre.

RECOMMENDATION / ACTIONS		The Trust Board is requested to note the progress made in delivering against the Trust's Well-being Objectives and support the continued embedding of the Well-being of Future Generations Act through departmental KPIs and corporate planning processes.
GOVERNANCE ROUTE		
List the Name(s) of Committee / Group who have previously received and considered this report:		Date
FRESH meeting		12/06/2026
EMB		30/06/2026
Quality safety and Performance Committee		09/07/2026
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS		
N/A		
7 LEVELS OF ASSURANCE		
N/A		
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR		Select Current Level of Assurance
APPENDICES		
1	VUNHST Wellbeing of Future Generations Annual Report	

1. SITUATION

The Trust is required to demonstrate how it is meeting its duties under the Well-being of Future Generations (Wales) Act 2015. This report provides an overview of progress during 2025/26 and evidences how well-being objectives are being delivered across the organisation.

2. BACKGROUND

The Well-being of Future Generations (Wales) Act requires public bodies to carry out sustainable development and contribute to the seven national well-being goals. During 2025/26, the Trust refreshed its Well-being Objectives through engagement with staff, partners and communities, ensuring alignment with the Trust Strategy, Destination 2033.

The Trust has also responded to Audit Wales recommendations by strengthening its performance framework through the development and mapping of Key Performance Indicators across departments, embedding the Act into day-to-day operations and decision making.

3. ASSESSMENT

The report demonstrates strong organisational progress in embedding the principles of the Act. Key areas of impact include:

- Improved access and reduced inequalities through innovative care models
- Enhanced wellbeing through holistic and preventative approaches such as Arts and Health
- Measurable environmental improvements through waste, carbon and resource reduction initiatives
- Strengthened community engagement and co-production through the Hefyd programme
- Increased innovation activity supporting workforce development and economic contribution

The integration of KPIs across departments provides a more robust and transparent framework for monitoring progress and ensuring accountability across the organisation.

4. SUMMARY OF MATTERS FOR CONSIDERATION

The Board is asked to consider:

- The level of progress achieved against Well-being Objectives during 2025/26
- The effectiveness of the new KPI mapping approach in strengthening accountability and performance monitoring
- The extent to which the Trust is embedding the five ways of working across services
- The proposed forward focus for 2026/27, including readiness for the new Velindre Cancer Centre and continued emphasis on prevention, sustainability and community engagement

5. 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) <i>For more information: STRATEGIC RISK DESCRIPTIONS</i>	06 -Organisational and Clinical Governance												
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Select all relevant domains below												
	<table border="0"> <tr> <td>Safe</td> <td>☒</td> </tr> <tr> <td>Timely</td> <td>☒</td> </tr> <tr> <td>Effective</td> <td>☒</td> </tr> <tr> <td>Equitable</td> <td>☒</td> </tr> <tr> <td>Efficient</td> <td>☒</td> </tr> <tr> <td>Patient Centred</td> <td>☒</td> </tr> </table>	Safe	☒	Timely	☒	Effective	☒	Equitable	☒	Efficient	☒	Patient Centred	☒
	Safe	☒											
Timely	☒												
Effective	☒												
Equitable	☒												
Efficient	☒												
Patient Centred	☒												
The activity outlined in this report contributes positively across all quality domains. Improvements in access to care, including virtual clinics and self-administration pathways, support timely and efficient services. Prevention-focused initiatives and holistic care approaches enhance patient outcomes and experience. Environmental sustainability measures improve the safety and quality of the care environment, while community engagement and inclusive approaches ensure equitable and patient-centred service delivery.													
QUALITY IMPACT ASSESSMENT	Not required - not a strategic decision												
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	The report is retrospective and provides assurance on work already undertaken rather than proposing a new policy or service change Click or tap here to enter text												
TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT													
The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated. Please indicate whether any of the matters outlined in this report impact the Trust's Wellbeing goals: YES - Select Relevant Goals below													
If yes select the relevant goals:													

• A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities. ☒ • A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience. ☒ • A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health ☒ • A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances ☒ • A Wales of more Cohesive Communities - Attractive, viable, safe and well-connected communities. ☒ • A Wales of Vibrant Culture and Thriving Welsh Language -Promoting and protecting culture, heritage and the Welsh language, encouraging people to participate in the arts, and sports and recreation. ☒ • A Globally Responsible Wales – Consideration of whether an action may make a positive contribution to global well-being ☒	
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT	Not required - please outline why this is not required
	The report is for assurance and does not propose changes to services or policy
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

6. RISKS

This section should indicate whether any matters addressed in the report carry a significantly increased level of risk for the Trust – and if so, the steps that will be taken to mitigate the risk - or if they will help to reduce a risk identified on a previous occasion.

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No

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

Velindre University NHS Trust
Sustainability Manager

Well-being of Future Generations Act Annual Report

1 April 2025 – 31 March 2026



Velindre University NHS Trust is responsible for the delivery of a wide range of specialist NHS Wales services including the Velindre Cancer Service and the Welsh Blood Service and we host Health Technology Wales, Advanced Therapies Wales and NHS Wales Shared Services Partnership.

Caring

We are always kind, supportive, approachable and show compassion to all.



Respectful

We seek to understand other people's perspectives. We are always open and transparent.



Accountable

We always take personal responsibility for what we do and how we do it.



The Velindre Cancer Service is a specialist treatment, teaching, research, and development service for non-surgical tertiary oncology services to patients from across southeast Wales and further afield.

The Welsh Blood Service provides essential and highly specialised national services including the collection and production of blood and blood components, specialist diagnostic services and antenatal screening, as well as supporting transplant services for solid organs and stem cells across Wales and internationally.

Health Technology Wales assesses non-medicine health and care technologies and produces national guidance on their use in Wales.

NHS Wales Shared Services Partnership delivers a wide range of professional, technical, and administrative services to NHS Wales.

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Foreword

Chair and Chief Executive Officer

It is my pleasure to introduce Velindre University NHS Trust's Well-being of Future Generations (Wales) Act Annual Report for 2025/26, which sets out the meaningful progress we have made in improving outcomes for the people and communities we serve, now and for the future.

This year has been one of continued transformation and ambition. Guided by our Trust Strategy, Destination 2033, and aligned with the Well-being of Future Generations Act, we have embedded long-term thinking, prevention, collaboration and involvement into all aspects of our work. Our refreshed Well-being Objectives reflect the evolving needs of our patients, staff and communities, ensuring our focus remains both relevant and impactful.

Across the organisation, we have seen clear evidence of progress. We have improved access to care through innovative service models, including virtual clinics and self-administration pilots, making services more convenient and reducing pressure on clinical environments. We have strengthened our commitment to caring for the whole person through expanded Arts and Health programmes, which are enhancing wellbeing for patients, families and staff alike.

Our work to drive innovation and research continues to create highly skilled opportunities and attract investment into Wales, while our environmental initiatives demonstrate how practical changes can deliver significant reductions in waste, carbon emissions and resource use. At the same time, we have placed a strong emphasis on community engagement through the Hefyd programme, ensuring that our services are shaped with, and not just for, the communities we serve.

Importantly, this year we have strengthened how we measure and evidence our impact by integrating Key Performance Indicators from across departments to ensure the Well-being of Future Generations Act is embedded within day to day work across the organisation. This approach strengthens accountability, aligns delivery with our wider strategic objectives, and provides a clear framework for demonstrating progress and continuous improvement.

These achievements would not be possible without the dedication and commitment of our staff, partners and volunteers. Their passion, creativity and collaboration are the driving force behind our progress, enabling us to deliver high-quality, compassionate care while building a more sustainable and resilient organisation.

Looking ahead, we remain focused on deepening this work. We will continue to expand preventative approaches, strengthen partnerships, and maximise the opportunities presented by the new Velindre Cancer Centre. Above all, we will maintain our commitment to improving wellbeing, reducing inequalities and delivering lasting value for future generations.

I am proud of what we have achieved together this year and confident in our collective ability to continue driving forward positive change for the people of Wales.

Setting and Delivering Our Well-being Objectives

Velindre University NHS Trust remains fully committed to the principles and duties set out under the Well-being of Future Generations (Wales) Act 2015. Our refreshed Trust Strategy, Destination 2033, alongside the Specialist Strategies for Cancer and Blood and Transplantation Services (2023–2033), places sustainability and long-term well-being at the heart of all we do.

In accordance with the Well-being of Future Generations (Wales) Act, the Trust has continued to strengthen its commitment to improving outcomes for current and future generations. During 2024, and in line with Section 3.17 of the Act, we undertook a comprehensive review and refresh of our Well-being Objectives. This process was shaped through meaningful engagement with staff, partners, stakeholders, and the communities we serve, ensuring a broad and inclusive range of perspectives informed our direction.

Our refreshed objectives reflect the evolving needs of our patients, communities, and workforce. They have been designed to maximise our contribution to the national well-being goals, while embedding the Sustainable Development Principle at the heart of everything we do. This includes a strong focus on the five ways of working: long-term thinking, prevention, integration, collaboration, and involvement.

Our Well-being Objectives are to:

- Reduce health inequalities, make it easier to access the best possible healthcare when it is needed, and help prevent ill health by collaborating with the people of Wales in novel ways.
- Improve the health and wellbeing of families across Wales by striving to care for the needs of the whole person.
- Create new, highly skilled jobs and attract investment by increasing our focus on research, innovation and new models of delivery.
- Deliver bold solutions to the environmental challenges posed by our activities.
- Demonstrate respect for the diverse cultural heritage of modern Wales.
- Bring communities and generations together through involvement in the planning and delivery of our services.
- Strengthen the international reputation of the Trust as a centre for excellence in teaching, research and technical innovation, while making a lasting contribution to global wellbeing.

To support delivery and strengthen accountability, we have mapped the Wellbeing Goals with KPIs across departments to ensure the Act is fully integrated into everything we do. This enables clearer monitoring of progress and impact, in line with recommendations from Audit Wales. Over 2026–27, we will continue to embed our well-being objectives within our strategic vision and corporate planning processes, ensuring the Act remains a central organising principle across the Trust.

This report highlights a selection of the positive progress already underway across the organisation in support of our well-being objectives. While not exhaustive, the examples included demonstrate our ongoing commitment to delivering sustainable, long-term value for the people and communities we serve.

Establishing Key Performance Indicators for Welbeing Goals

Following a recommendation from Audit Wales, the Trust has strengthened its approach to measuring progress against its Well-being Objectives by developing a defined set of Key Performance Indicators (KPIs) and explicitly mapping these against departmental performance measures.

During 2025/26, a comprehensive mapping exercise was undertaken to align each Well-being Objective not only with the Trust's overarching strategic frameworks, such as the; Trust Strategy, Sustainability Strategy, and key operational plans but also with the KPIs already owned and managed by individual departments. This has ensured that responsibility for delivery sits clearly across the organisation, with each department able to demonstrate how its core activities contribute to the wider well-being agenda.

As part of this process, existing indicators and performance metrics, such as; including patient access standards, workforce and organisational development measures, environmental targets, and community engagement data, were reviewed and systematically mapped to both the Well-being Objectives and relevant departmental KPIs. This approach avoids duplication, maximises the use of established data sources, and ensures that the Well-being Objectives are embedded within day-to-day performance management rather than operating as a standalone framework.

For example, patient treatment and waiting time metrics align with clinical service KPIs to support the objective of reducing health inequalities and improving access to care. Workforce metrics such as staff wellbeing, apprenticeships, and organisational development indicators contribute to objectives around job creation, innovation, and social value. Environmental KPIs, including carbon reduction, energy use, and waste targets, are directly linked to estates and sustainability functions. Similarly, community engagement, Welsh language delivery, and digital service performance indicators are mapped to the relevant departmental responsibilities that underpin cultural, community, and international objectives.

This integrated mapping ensures that progress against Well-being Objectives can be consistently monitored through clear lines of accountability at departmental level, using robust, evidence-based data. It also enables more effective performance oversight, supports informed decision-making, and strengthens the Trust's ability to demonstrate its contribution to the Well-being of Future Generations (Wales) Act.

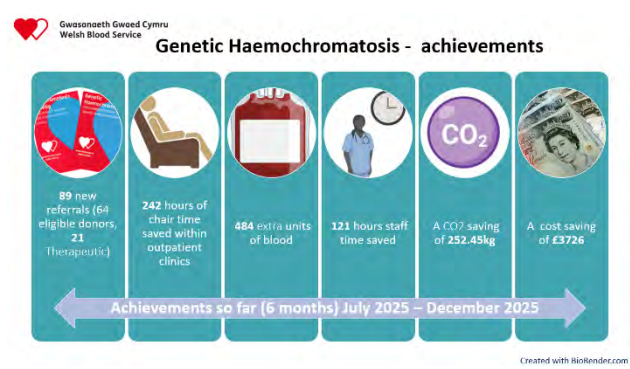
By embedding these measures into existing departmental KPIs, the Trust is better positioned to drive continuous improvement, enhance transparency in reporting, and clearly evidence its impact on patients, communities, and the environment, both now and in the future.

WELLBEING GOAL	MAPPED KIPS
Reduce health inequalities, make it easier to access the best possible healthcare when it is needed, and help prevent ill health by collaborating with the people of Wales in novel ways.	Radiotherapy waiting times (%) Scheduled radiotherapy patients treated within 14 & 21 days (%) % of 'formal' concerns responded to within 30 working days % patients/donors rating care as excellent % patients/donors rating the environment as excellent % of patients receiving care at home or in the local community % of consultations carried out digitally
Improve the health and wellbeing of families across Wales by striving to care for the needs of the whole person.	All patient treatment and waiting metrics (linked to service innovation) % rolling average staff sickness levels % staff who rate the Trust as a good employer Legal & Payment Mechanism measures Development of a social value assessment tool % apprenticeships/student placements offered to local communities % of building assets available for use by local community stakeholders Social value: community benefit audits % of goods and services procured locally
Create new, highly skilled jobs and attract investment by increasing our focus on research, innovation and new models of delivery.	% carbon footprint/emissions reduction against 2018/19 baseline Carbon (parts per million by volume) monitoring 3% gas consumption reduction (year-on-year) 3% electricity consumption reduction (year-on-year) Waste targets: • 26% reduction in total waste • Zero waste to landfill • 50% reduction in avoidable food waste • 70% recycling rate Annual Net Zero reporting to Welsh Government Quarterly Decarbonisation Report % of energy from renewable sources
Deliver bold solutions to the environmental challenges posed by our activities.	Number of individuals signed up to Velindre Voices Number of engagement events, focus groups, and activities Number of work experience placements Number of careers fairs and events attended Number of school visits
Bring communities and generations together through	Implementation of a Trust-wide clinical plan aligned to Standard 110 Increase in Welsh language clinical consultations

involvement in the planning and delivery of our services.	(Baseline: 0; Targets: +5% in 2026/27, +10% in 2027/28) Welsh language training programme based on needs analysis: • Baseline vs increased participation • Training levels: Raising Confidence, Entry Level 1, Entry Level 2
Strengthen the international reputation of the trust as a centre for excellence in teaching, research and technical innovation, while making a lasting contribution to global wellbeing.	Digital service performance: • % requests responded to within agreed timeframes • Digital service desk user satisfaction (%) % patients/donors rating care as excellent % patients/donors rating the environment as excellent % of patients receiving care at home or in the local community % of consultations carried out digitally Audit of the implementation of the Education Strategy Operational Development & Workforce metrics

Reduce health inequalities, make it easier to access the best possible healthcare when it is needed and help prevent ill health by collaborating with the people of Wales in novel ways

The Welsh Blood Service’s Genetic Haemochromatosis (GH) project continues to address health inequalities and improve preventative care by widening access to blood donation pathways for eligible patients across Wales. By enabling venesection through routine donation appointments, individuals with GH are able to manage their condition closer to home, at times that suit them which reduces reliance on outpatient services and therefore improves overall patient experience.

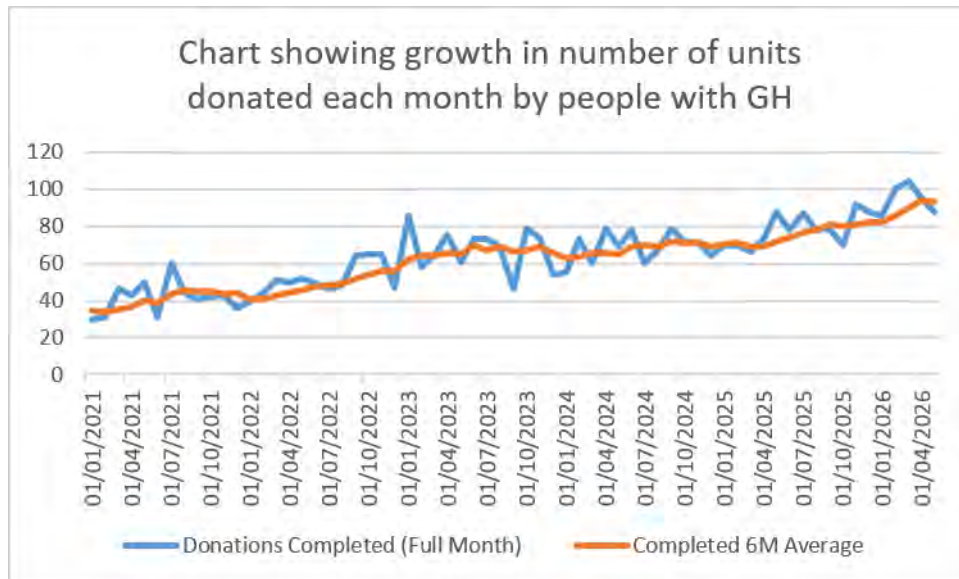


Progress over the last reporting period demonstrates the tangible impact of this collaborative, value-based approach. A total of 89 new referrals were received, with 64 eligible donors successfully onboarded into the donation pathway. This has supported a shift in care delivery, with 242 hours of outpatient clinic time freed up, alongside the collection of 484 additional units of blood, contributing to

wider system benefits. The initiative has also delivered workforce efficiencies, saving 121 hours of staff time, while generating environmental and financial value, including a reduction of 252.45kg of CO₂ and cost savings of £3,726. The scale of improvement continues to grow as the project spreads and scales. The GH donor pathway is consistently achieving over 80 units per month since December 2025. Q1 collections are 30% greater than the same quarter in the previous year.

These outcomes highlight how early intervention and service integration can prevent ill health and reduce pressure on specialist services. The continued development of the referral support model, supported by Value Based Healthcare funding for a Senior Nurse post, is strengthening links between hospital teams and the Welsh Blood Service. This is enabling a more consistent, all-Wales approach that connects clinical pathways with donation opportunities, ensuring more equitable access to the best possible care while delivering benefits for patients, the NHS, and future generations.

The chart below shows the growth in the number of units donated by people with GH each month since 2021.



The Velindre Cancer Service’s self administration of denosumab project is working on establishing a scalable, safe option for patients to treat themselves at home instead of travelling to Velindre or an outreach location for a monthly injection. By collecting the pre-filled syringes from their Community Pharmacy, patients can avoid the burden and disruption of travel. It is currently in pilot phase as refinements are made prior to offering self administration to approximately 200 patients. This approach reduces the carbon footprint of travelling for care, is more convenient for patients and releases valuable treatment room capacity.

Established during covid, the VAP (virtually assessed patient) clinic is a telephone pre-SACT assessment that replaced a face to face appointment. The clinic has shown a year on year increase in activity, growing by 37% in 2025 up to over 8500 telephone appointments. All of these improve convenience in accessing care. The next step in improving the value of the service is to introduce Digital Health Assessments tailored specifically to the patient’s treatment. This is intended to make it easier to patients to let us know about side effects since their previous cycle of SACT and is expected to improve the efficiency of the team in assessing and prescribing the next cycle.

Improve the health and well-being of families across Wales by striving to care for the needs of the whole person

Over the past year, we have continued to strengthen our commitment to improving the health and wellbeing of families across Wales by embedding a holistic, person-centred approach within our services. This recognises that wellbeing extends beyond physical health, ensuring support addresses individuals' emotional, social, and environmental needs.

Our approach has focused on promoting early intervention, improving access to wellbeing resources, and creating supportive environments that enable individuals and families to thrive. By working collaboratively across teams and with partner organisations, we have delivered more integrated support that addresses the wider determinants of health, including mental resilience, workplace wellbeing, and access to appropriate services.

A key area of progress has been the continued development of our Arts and Health programme, which has provided a diverse range of creative opportunities for patients, staff, and the wider community. This has included a community photography exhibition, showcasing personal stories and experiences, helping to strengthen connection between the organisation and the communities it serves.

We have also delivered a regular programme of ward-based activities, ensuring arts are accessible even within clinical settings. This has included:

- A poet-in-residence visiting wards, offering reflective and therapeutic engagement
- The Art Cart, bringing creative materials directly to patients to support relaxation and self-expression
- Live performances from organisations such as the BBC National Orchestra of Wales and Welsh National Opera, including sessions on SACT wards, providing uplifting shared experiences for patients and staff

In addition, we have embedded artists within clinical and non-clinical environments, including:

- An artist working within Velindre Cancer Services (VCS)
- An artist embedded in Welsh Blood Service (WBS) laboratory settings



These initiatives have enabled creative engagement in spaces not traditionally associated with the arts, supporting emotional wellbeing, reducing stress, and providing moments of connection and reflection in otherwise clinical environments.

Feedback from participants and staff highlights improvements in mood, reduced anxiety, and increased feelings of connection and wellbeing. Many individuals reported that engaging with the arts provided a positive distraction during treatment and helped create a more compassionate, human-centred environment.

Through growing participation and consistently positive feedback, the Arts and Health programme provides strong evidence of the value of integrating creative approaches into healthcare delivery. This aligns with our commitment to prevention and early intervention, offering accessible, non-clinical support that complements traditional care pathways.

Through ongoing engagement and increasing utilisation of health and wellbeing, we have seen a positive shift towards a more proactive and preventative culture. This progress demonstrates our continued ambition to care for the whole person and deliver sustainable improvements in wellbeing for families across Wales.

Create new, highly skilled, jobs in Wales and attract investment by increasing our focus on research, innovation and new models of delivery

During 2025/26, the Trust has continued to strengthen its contribution to economic growth and workforce development in Wales by leveraging research, innovation and new models of service delivery. This has supported the creation of highly skilled roles, enhanced workforce capability and positioned the organisation as an attractive partner for investment and collaboration.

A key area of progress has been the continued development of a structured innovation ecosystem, which has enabled the translation of research and ideas into real-world application. This approach not only improves service delivery but also supports the development of specialist roles in areas such as advanced therapies, digital innovation, data, and technical services. Through programmes including Advancing Radiotherapy Cymru (ARC) and innovation funding schemes, the Trust has created opportunities for staff to develop new skills, contribute to cutting-edge work, and participate in innovation-led service transformation.

The Trust has also played an important role in supporting skills development and workforce sustainability, providing training, mentoring and development opportunities that equip staff with the capabilities required for the future health system. Innovation programmes and structured initiatives have enabled multidisciplinary teams to engage in research and improvement work, helping to build a highly skilled and adaptable workforce aligned to emerging technologies and new models of care.

In addition, the Trust's innovation activity has strengthened its ability to attract external investment and partnership opportunities. Collaboration with industry, academia and national programmes has supported access to funding, resources and expertise, contributing to economic value both locally and across Wales. These partnerships enable the adoption and scaling of innovative solutions while supporting job creation through project delivery, research activity and service expansion.

The development of new models of delivery, including the integration of digital technologies and advanced clinical approaches, has further contributed to efficiency, productivity and long-term sustainability, while creating opportunities for new roles and career pathways. This includes the growth of innovation-focused posts and specialist technical positions that support the delivery of modern, high-quality healthcare.

Together, these activities demonstrate how the Trust is contributing to a more innovative and economically sustainable health system, supporting highly skilled employment, attracting investment and fostering a culture of continuous improvement. This work not only benefits

the organisation and its workforce but also contributes to wider prosperity and resilience across Wales.

Deliver bold solutions to the environmental challenges posed by our activities

During 2025/26, the Trust has continued to deliver innovative and practical solutions to reduce the environmental impact of its services, embedding sustainability within routine care and operational practice.



A key development has been the introduction of subcutaneous (S/C) Nivolumab within Velindre Cancer Service. This simple change has transformed both patient experience and environmental performance. Treatment time has reduced from around 1.5 hours to just 45 minutes, improving patient flow and freeing up capacity to treat more individuals. At the same

time, the environmental benefits are significant. Plastic waste per treatment has fallen from approximately 1,194g to just 47g, with a comparable reduction in associated carbon emissions. The move away from pre-prepared intravenous treatments to a “draw on demand” model at the patient bedside, has also removed the risk of wasted medicines and materials. Patient feedback reflects these improvements, with the majority reporting greater convenience and a better overall experience.

Sustainability has also been advanced through innovative operational changes, such as Project ELSA within the Welsh Blood Service. This award-winning initiative replaced the use of dry ice for transporting frozen blood products with reusable phase-changing materials. As a result, the project has reduced carbon emissions, improved safety, and delivered significant financial savings, around £40,000 annually, while making effective use of existing infrastructure. This demonstrates how environmentally responsible approaches can also strengthen efficiency and resilience in essential services.

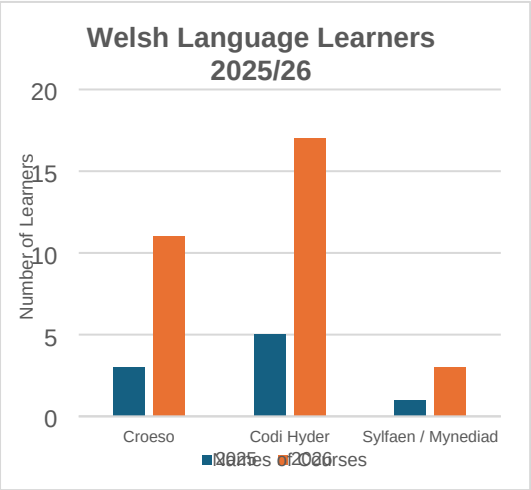


In addition, the Trust has worked with community partners to reduce waste and promote reuse. Collaboration with Re-CREATE Cardiff has enabled radiotherapy immobilisation equipment, no longer suitable for clinical use, to be repurposed for schools and community projects rather than sent to landfill. Similarly, materials such as blue roll cardboard tubes have been diverted for reuse

through partnership with the Welsh Ape and Monkey Sanctuary. These initiatives extend the life of resources, reduce disposal impacts, and create wider social value within local communities.

Collectively, these actions show how the Trust is taking a proactive and integrated approach to environmental sustainability, reducing waste and emissions at source, improving efficiency across services, and working with partners and communities to deliver lasting environmental benefit.

Demonstrate respect for the diverse cultural heritage of modern Wales



During 2025/26, the Trust has continued to strengthen its contribution to respecting and promoting the cultural heritage of Wales through its commitment to the Welsh language. This has included embedding the “active offer” across services, ensuring patients and donors can receive care in their language of choice without the need to ask. Key developments include the introduction of a fully bilingual donor pre-screening system, improved visibility of Welsh language services across digital platforms, and high levels of compliance with Welsh Language Standards. The Trust has also invested in workforce development,

with increased uptake of Welsh language training and over 96% of staff recording their language skills, supporting more proactive service planning.

Cultural awareness has been further promoted through engagement activities such as St David’s Day celebrations, participation in the National Eisteddfod, and outreach to over 7,000 young people. Together, these actions demonstrate a sustained commitment to embedding the Welsh language and culture within everyday practice, contributing to a more inclusive and culturally respectful service.



Bring communities and generations together through involvement in the planning and delivery of our services

This year has seen significant progress in strengthening community involvement and intergenerational engagement through the successful relaunch of the Hefyd programme, alongside the introduction of a new governance structure within the Place, Portfolio and Partnerships Directorate. Hefyd, Velindre's community benefits initiative, provides a coordinated and integrated approach to delivering impactful programmes across arts, green social prescribing, sustainability, and engagement with children and young people.



Our connection with our communities remains central to Velindre's work. The development of the new Velindre Cancer Centre presents a unique long-term opportunity to deepen these relationships, enabling us to embed sustainable approaches and redefine our role as a community-focused organisation for future generations.

Through Hefyd, we have strengthened collaboration across the Trust and with external partners to deliver meaningful engagement and added social value. The programme has expanded Velindre's presence across communities through a wide-ranging programme of outreach and involvement. Regular monthly community drop-in sessions and the "Hefyd on the Road" initiative have created accessible opportunities for involvement, ensuring communities can actively shape and inform our services.

Engagement has been further extended through participation in a range of national and local events, including Cardiff Mela, Pride Cymru, Big Welsh Bite, Whitchurch and Tongwynlais Festival, gofod3, and the Cardiff Half Marathon, alongside regional events such as the Caerphilly Big Cheese and Castle 2 Castle. These activities have strengthened relationships with diverse communities, supporting inclusion and ensuring we are reaching people across different generations and backgrounds.





This work has been complemented by targeted engagement activity, including focus groups, school engagement, creative sessions such as “Crafternoons,” apprenticeship opportunities, and the introduction of grant funding to support community-led initiatives. These initiatives reflect a strong commitment to involvement and prevention, ensuring that a wide range of voices, including children and

young people, are heard early and meaningfully in the planning and delivery of our services.

Partnership working continues to be a key enabler in delivering this goal. Our ongoing collaboration with Ray of Light Cancer Support has supported preventative approaches to wellbeing through green social prescribing, connecting patients, families, and staff with nature to improve physical, emotional, and social wellbeing. These activities contribute to more resilient individuals and communities, while supporting sustainability aims.

Engagement with staff has also been strengthened, for example through initiatives such as the flower printing tote bag workshop during Great Big Green Week, which brought together wellbeing, sustainability and creativity. This demonstrates an integrated approach, linking environmental responsibility with staff wellbeing and wider community outcomes.



Overall, the continued development of Hefyd demonstrates strong alignment with the five ways of working, placing emphasis on long-term impact, prevention, integration, collaboration, and involvement. This approach ensures that our services are not only designed for our communities, but increasingly co-produced with them, supporting stronger, healthier and more connected communities now and into the future.

Strengthen the international reputation of the Trust as a centre of excellence for teaching, research and technical innovation whilst also making a lasting contribution to global well-being

During 2025/26, the Trust has continued to strengthen its international reputation as a centre of excellence for innovation, research and collaboration, while making a meaningful contribution to improving outcomes both nationally and globally. Central to this has been the development of a mature and systematic innovation infrastructure, underpinned by the successful achievement of ISO 56001 Innovation Management System certification and the BSI Innovation Management Kitemark—making Velindre the first healthcare organisation globally to achieve both standards. This externally validated approach demonstrates a robust, transparent and scalable model for innovation, positioning the organisation as a leader in healthcare innovation practice internationally.

The Trust's innovation ecosystem provides a clear and structured pathway from idea generation to implementation and adoption, supported by strong governance, workforce capability building and partnerships across NHS Wales, academia, industry and the third sector. Through programmes such as Advancing Radiotherapy Cymru (ARC), the Advanced Radiotherapy Fund and the Regional Innovation Coordination Hub, the Trust has continued to translate cutting-edge research into clinical practice. This includes the delivery of advanced radiotherapy techniques, digital innovation and precision treatments, improving patient outcomes while contributing to wider system learning and best practice.

International impact is further strengthened through collaboration and knowledge sharing. The Trust's partnerships, including work with academic institutions, industry partners and national programmes, support the exchange of expertise and the development of innovative solutions that can be scaled beyond Wales. Recognition through national awards, participation in conferences such as MediWales Connects, and dissemination through publications and case studies continues to raise the Trust's profile and influence across the wider healthcare and innovation community.

Investment in people and capability has also been a key focus, with innovation training, staff engagement initiatives and structured programmes such as Bright Ideas and the Innovation Small Award Scheme enabling staff to actively contribute to service improvement. This approach is helping to build a sustainable culture of innovation, ensuring the organisation continues to generate and adopt new ideas that enhance care delivery and support long-term system transformation.

Collectively, these achievements demonstrate how the Trust is not only advancing its own services but is also contributing to wider health system innovation, sharing learning, and supporting the development of more effective, efficient and sustainable healthcare. This

strengthens Velindre's position as a recognised leader in innovation, with a growing international reputation and a clear commitment to improving wellbeing and healthcare outcomes beyond its immediate boundaries.

Conclusion and Next Steps

During 2025/26, Velindre has made meaningful progress in delivering against its Well-being Objectives, demonstrating a strong commitment to improving outcomes for current and future generations. Across the year, the Trust has embedded the principles of the Well-being of Future Generations (Wales) Act into its work, with clear evidence of progress in adopting more preventative, collaborative and integrated approaches.

Key areas of achievement include strengthening community involvement through the Hefyd programme, expanding holistic approaches to health and wellbeing through arts and health initiatives, and driving innovation to support a highly skilled workforce and attract investment into Wales. Collectively, these efforts are contributing to improved health outcomes, stronger community connections, and a more sustainable and resilient organisation.

The Trust's approach this year has also demonstrated a clear commitment to the five ways of working, ensuring that services are shaped through involvement, delivered in partnership, focused on prevention, and designed with long-term impact in mind. This has enabled Velindre to not only respond to current needs but also lay the foundations for future transformation, particularly through the development of the new Velindre Cancer Centre. Looking ahead, the Trust will build on this strong foundation by further embedding the Well-being of Future Generations framework into planning, decision-making and service delivery.

Key next steps will include:

- Deepening community involvement and co-production, ensuring that diverse voices continue to shape the design and delivery of services
- Expanding preventative approaches, particularly through wellbeing, arts, social prescribing and sustainability initiatives
- Strengthening partnerships and collaboration, both locally and nationally, to maximise impact and deliver shared outcomes
- Developing workforce skills and innovation capacity, supporting new roles, career pathways and opportunities for growth
- Maximising the opportunity of the new Velindre Cancer Centre, embedding innovation, community integration and sustainable design from the outset

As Velindre moves forward, it remains committed to continuous improvement and learning, recognising that delivering long-term, sustainable change is an ongoing process. By maintaining focus on the needs of people and communities, and by working collaboratively across systems, the Trust will continue to play a key role in contributing to a healthier, more equal and more prosperous Wales for current and future generations.

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TRUST BOARD		
Professional Registration, Appraisal and Revalidation Annual Assurance Report 2025/26		
DATE OF MEETING	30/07/2026	
STATUS	Public	
PREPARED BY	Rhian Wright, Lead Nurse for Professional Standards, Workforce and Education Annie Evans, Deputy Director of Nursing, Quality and Patient Experience	
PRESENTED BY	Gillian Knight, Executive Director of Nursing, AHPs & Health Science	
APPROVED BY	Gillian Knight, Executive Director of Nursing, AHPs & Health Science Dr Jacinta Abraham, Executive Medical Director and Deputy Chief Executive Officer	
SCRUTINY ROUTE TO DATE	Date	Report considered by committee/group
	02/07/2026	Executive Management Board
	09/07/2026	Quality, Safety & Performance Committee
	The Professional Registration, Appraisal and Revalidation Annual Assurance Report 2025/26 was endorsed for onward approval.	
ONWARD SCRUTINY ROUTE	N/A	
PURPOSE OF THE REPORT	FOR APPROVAL	
	To provide the Trust Board with assurance of the Trust's compliance with the regulatory requirements for the registration, appraisal and revalidation of all the registered healthcare professionals at the Trust for the period 1 April 2025 to 31 March 2026.	
ACTION / DECISION	To approve the Professional Registration, Appraisal and Revalidation Annual Assurance Report 2025/26	

APPENDICES	Appendix no.	Appendix title
	Appendix 1	Professional Registration, Appraisal and Revalidation Annual Assurance Report 2025/26
RELEVANT TRUST STRATEGIC GOALS		
This report addresses the following goal(s) within the Trust's strategic plan :		
Outstanding for quality, safety and experience		
An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations		
RELEVANT WELL-BEING OF FUTURE GENERATIONS (WALES) ACT 2015 GOALS		
This report addresses the following wellbeing goal(s):		
A Healthier Wales		
QUALITY AND SAFETY IMPLICATIONS		
This report impacts one or more of the following Six Domains of Quality :		
Safe	Timely	
Equitable	Effective	
Efficient	Patient centred	
QUALITY IMPACT ASSESSMENT (QIA)		
A completed and signed QIA must be attached for all reports requiring a decision.		
Status: QIA not completed - strategic decision not being made so not required		

1. SITUATION

The Trust produces an annual assurance report regarding compliance with the registration, appraisal and revalidation requirements for all registered healthcare professionals employed by and working at Velindre University NHS Trust. The report covers the period 1 April 2025 to 31 March 2026.

2. MATTERS FOR CONSIDERATION

The Professional Registration, Appraisal and Revalidation Annual Assurance Report 2025/26 provides assurance regarding the compliance with professional registration, appraisal and revalidation requirements across the General Medical Council (GMC), Nursing and Midwifery Council (NMC), Health and Care Professions Council (HCPC) and General Pharmaceutical Council (GPhC) regulated workforce.

The Committee is asked to note the following:

- Three isolated registration lapses occurred during 2025/26 (two NMC and one HCPC). No member of staff undertook regulated professional practice whilst unregistered, and there were no patient safety incidents or fitness to practise concerns arising from the registration lapses. A review of the registration lapse cases identified no evidence of systemic control failures, and appropriate action was taken in accordance with Trust policy
- GMC appraisal and revalidation compliance remained high throughout the reporting period, and all GPhC registrants remained compliant.
- Substantial assurance can be provided that the Trust has effective governance arrangements, systems and controls in place to monitor and support compliance with professional registration, appraisal and revalidation requirements. However, further work is being planned during 2026/27 to strengthen the proactive monitoring and oversight of the professional registration processes for the NMC and HCPC regulated workforce across the Trust.

3. ASSESSMENT

3.1 Financial Implications

There are no significant financial implications arising from this report. Compliance with professional registration requirements supports safe and effective service delivery and mitigates potential costs associated with regulatory non-compliance.

3.2 Legal Implications

The Trust has a statutory responsibility to ensure that regulated healthcare professionals maintain appropriate registration with their professional regulatory body. The report provides assurance that processes are in place to support compliance with these requirements

3.3 People Implications

The report relates to all professionally registered healthcare staff employed by the Trust, and provides assurance that staff are appropriately registered, and that they have fulfilled the requirements / standards of their regulatory bodies.

Learning from the three registration lapse cases will be used to strengthen awareness of individual professional responsibilities and organisational monitoring arrangements

3.4 Equality Implications

No specific equality impacts identified

3.5 Socio-Economic Implications

No specific socio-economic impacts identified.

3.6 Welsh Language Implications

No specific Welsh language impacts identified.

3.7 Reputational Implications

Failure to maintain professional registration requirements could result in regulatory, workforce and reputational consequences for the Trust. The report provides assurance that identified registration lapses were managed appropriately, no staff practised whilst unregistered, and no patient safety concerns arose.

3.8 Risks

There are no risks currently recorded on the Trust Risk Register relating to professional registration, appraisal and revalidation compliance.

The principal risk identified is the potential for future registration lapses; however, robust monitoring arrangements are in place, and further improvements are planned during 2026/27 to strengthen the proactive management and oversight of the compliance with registration, appraisal and revalidation requirements, and this will mitigate the risk.

Velindre University NHS Trust

Professional Registration, Appraisal and Revalidation Annual Assurance Report 2025/26

1 April 2025 – 31 March 2026



Velindre University NHS Trust is responsible for the delivery of a wide range of specialist NHS Wales services including the Velindre Cancer Service and the Welsh Blood Service and we host Health Technology Wales, and NHS Wales Shared Services Partnership.

Caring

We are always kind, supportive, approachable and show compassion to all.



Respectful

We seek to understand other people's perspectives. We are always open and transparent.



Accountable

We always take personal responsibility for what we do and how we do



The Velindre Cancer Service is a specialist treatment, teaching, research and development service for non-surgical tertiary oncology services to patients from across South East Wales and further afield.

The Welsh Blood Service provides essential and highly specialised national service, including the collection and production of blood and blood components, specialist diagnostic services and antenatal screening, as well as supporting transplant services for solid organs and stem cells across Wales and internationally.

Health Technology Wales assesses non-medicine health and care technologies and produces national guidance on their use in Wales.

NHS Wales Shared Services Partnership delivers a wide range of professional, technical and administrative services to NHS Wales.

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Carl James
Interim Chief Executive Officer



Sara Moseley
Trust Chair

Foreword

Chair and Chief Executive Officer

As Chair and Chief Executive Officer of Velindre University NHS Trust, we are pleased to present the Trust's Professional Registration, Appraisal and Revalidation Annual Assurance Report for 2025/26. A highly skilled, professionally regulated workforce is critical to the delivery of safe, effective and compassionate services across the Trust.

Maintaining professional registration and meeting the standards required by professional regulators are fundamental responsibilities for all regulated healthcare professionals, and form an important component of the Trust's quality, safety and governance framework.

Velindre University NHS Trust remains committed to fostering a culture that promotes professional accountability, lifelong learning and continuous improvement. Through robust governance arrangements, effective professional leadership and comprehensive workforce monitoring systems, the Trust supports staff to meet the standards required by their respective regulatory bodies.

The Trust acknowledges the commitment of all registrants who continue to uphold the standards of their professions, and recognises and appreciates the support provided by professional leaders, managers and workforce teams across the organisation.

This report demonstrates that, between 1st April 2025 and 31st March 2026, the Trust maintained strong compliance with professional registration, appraisal and revalidation requirements across the Nursing and Midwifery Council (NMC), Health and Care Professions Council (HCPC), General Medical Council (GMC) and General Pharmaceutical Council (GPhC) regulated workforce. Whilst a small number of registration lapses occurred, these were promptly identified and appropriately managed, and none of the staff members worked as registrants during the period of their registration lapse.

Overall, this report provides substantial assurance regarding the effectiveness of the Trust's systems and controls for professional regulation, registration, appraisal and revalidation.

1.0 Executive Summary

Velindre University NHS Trust employs a diverse regulated workforce including nurses, doctors, pharmacists, pharmacy technicians, radiographers, physiotherapists, scientists and other allied health professionals.

Each healthcare profession is regulated by its respective professional body, and is required to comply with ongoing professional and regulatory standards in order to maintain registration, and the ability to work as a registrant in the UK.

The Trust has established governance arrangements, monitoring systems and supporting policies in place to ensure that regulated healthcare professionals maintain their professional registration and comply with the relevant appraisal and revalidation requirements.

During the period 1st April 2025 - 31st March 2026, there were no GMC nor GPhC registration lapses. There were two NMC registration lapses, and one HCPC registration lapse. However, no registrant undertook professional practice whilst unregistered. The lapses all were managed in accordance with Trust policy, and all staff affected have since been re-registered. Compliance with GMC appraisals remained consistently high throughout the reporting period, and all GMC revalidation requirements were met.

Overall, substantial assurance can be provided that during 2025/26, the Trust's governance arrangements for the management of professional registration, appraisal and revalidation remained effective, and that all registered healthcare professionals working at the Trust met the regulatory standards



2. An overview of the registration, appraisal and revalidation requirements for healthcare professionals

Healthcare professionals practising within the United Kingdom must maintain registration with their professional regulatory body. Professional regulation serves several key purposes, including:

- Protection of patients and the public.
- Assurance of professional competence
- Promotion of continuous professional development.
- Maintenance of professional standards and ethics.
- Management of concerns relating to fitness to practise.

Velindre University NHS Trust employs healthcare professionals regulated by the following:

- Nursing and Midwifery Council (NMC)
- Health and Care Professions Council (HCPC)
- General Medical Council (GMC)
- General Pharmaceutical Council (GPhC)

Each of the professional regulatory bodies have different processes and requirements for ensuring that their registrants continue to meet the required standards. The requirements for each of the regulatory bodies is set out below

2.1 Nursing & Midwifery Council (NMC) – registration and revalidation requirements

Nurses and Midwives are required to renew their NMC registration annually through completion of the annual registration process and payment of the registration fee. Revalidation to demonstrate and evidence that they meet the required professional standards is required every 3 years.

Revalidation requires registrants to provide evidence of:

- 450 practice hours undertaken
- 35 hours of continuing professional development (20 of which must include participatory learning)
- Five pieces of practice-related feedback
- Five written reflective accounts detailing learning, changes or improvements to practice, and relevance to the Code
- A reflective discussion with another NMC-registered nurse
- Declaration of health and character
- Declaration of appropriate indemnity arrangements
- Confirmation of adherence with the revalidation process, usually by the employer.

If a registrant does not re-register or revalidate when they are due to, their NMC registration will lapse. Once the registration has lapsed, a registrant cannot practice as a nurse, and they need to apply to the NMC to be re-registered. Any lapses in NMC registration are taken extremely seriously, and the Trust has a policy in place to manage this.

2.2 Health & Care Professions Council (HCPC) – registration requirements

The Health and Care Professions Council (HCPC) regulates 15 professions. These professions have designated titles that are protected by law, and professionals must be registered with the HCPC to use them. These are:

- Arts Therapists
- Biomedical Scientists
- Chiropodists / Podiatrists
- Clinical Scientists
- Dieticians
- Hearing Aid Dispensers
- Occupational Therapists
- Operating Department Practitioners
- Orthoptists
- Paramedics
- Physiotherapists
- Practitioner Psychologists
- Prosthetists / Orthotists
- Radiographers
- Speech and Language Therapists

Registrants must renew their HCPC registration every two years, and must:

- Maintain continuing professional development
- Evidence that they meet the HCPC standards of proficiency
- Complete professional declarations
- Participate in the HCPC's audit (2.5% random sample) of the registrant's portfolio of evidence regarding the above

If registrants do not re-register with the HCPC, they cannot practice. As with all registration lapses, this is taken extremely seriously at the Trust.

2.3 General Medical Council (GMC) – registration, appraisal and revalidation requirements

Doctors practicing in the United Kingdom must maintain GMC registration. An annual appraisal, and a full revalidation every 5 years are also required in order to assess and provide assurance that the professional standards and requirements of the GMC have continued to be met.

Revalidation is informed by annual appraisal activity, and supporting information relating to the below is required:

- Scope of work.
- Continuing professional development.
- Quality improvement activity.
- Significant events.
- Complaints and compliments (including formal feedback from patients and colleagues)
- Health and probity declarations.

Physician Associates (PAs) are required to be registered with the GMC. Unlike doctors, they are not currently subject to a formal revalidation process; however, GMC guidance advises PAs to undertake annual appraisals and maintain evidence that will support future revalidation arrangements.

To date, PAs have been participating in the annual Performance and Development Review (PADR) process. This will continue going forwards with the addition of an annual whole practice appraisal recorded on the Medical Appraisal and Revalidation System (MARS).

2.4 General Pharmaceutical Council (GPhC) – registration and revalidation requirements

In order to practice in the UK, Pharmacists, Pharmacy Technicians and Pharmacy 'Owners' must be registered with the General Pharmaceutical Council (GPhC) regulatory body, and must demonstrate and evidence that they meet the requirements of the GPhC. Registrants must renew their registration with the GPhC on an annual basis.

The annual re-validation process for Pharmacists and Pharmacy Technicians includes the submission of:

- Continuing Professional Development (CPD) records
- Evidence of a peer review discussion having taken place regarding the individual's learning and practice
- A reflective account in which the individual considers and reflects on how they meet the professional pharmacy standards.

Pharmacies must also be registered with the GPhC (unless based within a Health Centre / Hospital). Due to its 3rd party responsibilities, the Velindre Cancer Service's Pharmacy is classified as a 'registered premise', with the Chief Pharmacist identified as the Superintendent Pharmacist. Appropriate GPhC 'premises' registration has continued during 2025/26.



3.0 Accountability and governance arrangements regarding healthcare professional registration at the Trust

Responsibility for maintaining professional registration lies with the individual registrant. However, the Trust has named Executive Leads who have overall responsibility for ensuring that the Trust has systems and processes in place to support compliance with the professional regulatory requirements for healthcare professionals.

The Trust's Professional Registration and Revalidation Policy (2024) provides a framework for the monitoring, management and escalation of healthcare professional registration, appraisal and revalidation, and the All Wales Medical Appraisal policy provides the framework for the management of the medical appraisal process. The policies can be viewed in **Appendix 1** and **Appendix 2**

3.1 Accountability and governance arrangements for GMC Medical Registration, Appraisal and Revalidation

The Trust's Executive Medical Director is the Responsible Officer for the Trust. The Responsible Officer is a statutory appointment with responsibility for overseeing the appraisal and revalidation of doctors and Physician Associates, monitoring their compliance with the GMC standards, and making recommendations to the GMC in accordance with the Medical Profession (Responsible Officers) Regulations.

The Responsible Officer is supported by the Trust's Revalidation team which comprises of the Deputy Responsible Officer, the Executive Medical Business Manager, the Medical Appraisal Lead, and the Revalidation and Appraisal Manager. Regular compliance meetings are held where forthcoming Revalidation recommendations are discussed in order to allow sufficient time to make a recommendation ahead of the revalidation dates.

The All-Wales recommendation of a 0.5 session remuneration per 10 appraisals has been adopted by the Trust. There are currently 10 Appraisers, with 3 newly recruited and trained in 2025/26.

Following a good practice recommendation from the HEIW Revalidation Support Unit, an Independent Member will be appointed as Lay Representative in 2026/27. The inclusion of a Lay Representative within the medical appraisal and revalidation governance framework will provide additional assurance that processes are fair, transparent and focused on maintaining public confidence in the medical profession. By bringing an objective perspective from outside the profession, the Lay Representative will offer constructive challenge to help ensure that decisions and processes are robust, evidence-based and consistent with GMC requirements.

3.2 Accountability and governance arrangements for NMC Nursing registration and revalidation

The Trust's Executive Director of Nursing, Allied Health Professionals and Health Scientists has executive responsibility for ensuring that systems and processes are in place to verify that nursing staff employed by the Trust maintain registration with the NMC and comply with the Council's revalidation requirements. This provides assurance that nurses continue to meet the professional

and regulatory standards required for registration and practice.

The monitoring and assurance processes which are in place to deliver on the above are led by the Trust's Workforce team, and are supported by the senior nursing teams across the organisation. An additional 'monitoring' mechanism in place at the Velindre Cancer Service.

3.3 Accountability and governance arrangements for General Pharmaceutical Council (GPhC) registration

The Trust's Executive Medical Director has executive responsibility for ensuring that appropriate governance arrangements are in place to support compliance with GPhC registration requirements, and to provide assurance that pharmacists and pharmacy technicians employed by the Trust maintain their professional registration and fulfil the relevant regulatory requirements associated with professional practice.

The monitoring and assurance processes which are in place to deliver on the above are led by the Trust's Workforce team, and are supported by the Chief Pharmacist who undertakes additional annual audits to ensure compliance with GPhC registration.

3.4 Accountability and governance arrangements for Health & Care Professions Council (HCPC) registration

The Executive Director of Nursing, Allied Health Professionals and Healthcare Scientists has executive responsibility for ensuring that appropriate governance arrangements are in place to support compliance with HCPC requirements. This includes providing assurance that HCPC-registered staff employed by the Trust maintain their professional registration and fulfil the ongoing regulatory requirements associated with registration and professional practice.

The monitoring and assurance processes which are in place to deliver on the above are led by the Trust's Workforce team, and are supported by the Service Leads, and individual line managers across the organisation.



4.0 Trust compliance with registration, appraisal and revalidation processes during 2025/26

The detail overleaf reflects the period 1st April 2025 – 31st March 2026

4.1 Compliance with GMC registration, appraisal and revalidation at the Trust

Performance with GMC registration, appraisal and revalidation at the Trust during 2025/26 demonstrates a strong level of compliance. In particular:

- No GMC registration lapses were reported.
- 10 out of 12 positive revalidation recommendations were submitted to the GMC, with 2 recommendations for deferral made due to extenuating circumstances
- Appraisal compliance was consistently maintained above 87% throughout the year, and exceeded 95% in the majority of the monthly reporting periods. The summary table is shown below.
- The Trust submitted its 2025/26 annual GMC Revalidation and Appraisal report to Health Education and Improvement Wales in June 2026, and declared full compliance / assurance with the requirements. The report is available from the Trust's Medical Revalidation and Appraisal Manager if required.
- The Physician Associates employed by the Trust have also undergone the required annual performance, appraisal and development review, and have fulfilled all the GMC registration requirements.

Summary Table of 2025/26 GMC appraisal compliance

Medical staff group	Number of prescribed connections	No of doctors exempt from appraisal due to extenuating circumstances or exempt due to <1 year in post	No of completed appraisals (Summary agreed)

General Practitioners	0	N/A	N/A
Consultants (including honorary contract holders)	84	7 (4 with <1 year in post)	77
Staff grade, associate specialist, specialty doctor	9	1 (1 with <1 year in post)	7
Doctors with practising privileges	N/A	N/A	N/A
Temporary or short-term contract holders	20	6 (6 with <1 year in post)	14
Other	2	1	1
Trainee doctor on national postgraduate training scheme (for Deaneries only)	N/A	N/A	N/A

To summarise, during 2025/26, GMC appraisal compliance was high across all eligible medical staff groups. Of the 115 doctors with a prescribed connection to the Trust, 15 were exempt from appraisal due to approved circumstances, primarily because they had been in post for less than one year. Of the remaining 100 doctors eligible for appraisal, 99 completed a satisfactory annual appraisal, representing an overall completion rate of 99%.

4.2 Compliance with GPhC registration requirements

The Trust maintained full compliance with GPhC registration requirements during 2025/26. In particular, there were:

- No GPhC registration lapses
- No concerns raised associated with registration compliance
- Appropriate monitoring arrangements remained in place

4.3 Compliance with NMC registration and revalidation requirements

During the reporting period, there were no breaches in NMC revalidation requirements. However, two Trust staff members had a lapse in their Nursing & Midwifery Council (NMC) registration as detailed below.

Case 1

A staff member working at the Welsh Blood Service had a lapse in NMC registration due to having insufficient funds in their Bank account to cover the direct debit for the annual NMC registration fee. Revalidation had successfully been undertaken by the staff member, but the registration fee payment had not been made. This occurred over the Christmas / New Year period, and there was a 5 day lapse

in registration. This was compounded by the fact that the staff member did not receive emails from the NMC as they had gone into the 'junk' mail box, so were unread – this has been reported to be a recent issue with some of the communication from the NMC.

During the 5 day registration lapse period, the staff member worked in a non-registrant capacity for 1 day, the other days were already arranged as annual leave. Once the NMC payment was made, the staff member was re-registered, and re-commenced their clinical duties.

Case 2

A staff member working at the Velindre Cancer Service had a lapse in NMC registration due to an inadvertent failure to update the NMC regarding a change in their bank account details. This prevented payment being made via direct debit to the NMC for the annual registration fee. The staff member did not work during the period of lapsed registration, and was reinstated within 24 hours.

Both of the above cases were managed appropriately in accordance with Trust policy (including any adjustments in salary), and established governance processes. In each instance, the importance of maintaining NMC registration, together with the individual professional accountability and responsibility for ensuring registration compliance was reiterated in both cases. This was reinforced to all staff via the Trust's Professional Forums.

4.4 Compliance with HCPC Registration and Revalidation requirements

During the reporting period, there was 1 HCPC registration lapse as detailed below. There were no other issues / concerns regarding HCPC registered staff at the Trust.

Case 1

An HCPC registered staff member at the Velindre Cancer Service had a lapse in registration while critically unwell and on long term sick leave from work. The HCPC lapse was four months in duration. No work was undertaken by the staff member during this period. The staff member has since re-registered with the HCPC, and has returned to work.

The case was managed appropriately via the Trust's policy.

4.5 Summary of registration, appraisal and revalidation compliance at the Trust

Overall, during 2025/26, substantial assurance can be provided that the Trust's registered healthcare professional workforce was compliant with the registration, appraisal and revalidation requirements of their regulatory bodies.

The review of the three registration lapse cases identified no evidence of systemic control failures. In each case, appropriate action was taken to prevent registrant practice whilst unregistered, and the cases were managed in accordance with Trust policy.



5.0 Recommendations

The Board is asked to note the contents of the Professional Registration, Appraisal and Revalidation Annual Assurance Report for 2025/26, and to be assured that effective systems and controls are in place to support compliance with the professional registration, appraisal and revalidation requirements across all regulated healthcare professional groups.

The Board is asked to note that three isolated registration lapses occurred during the reporting period; however, no registrant practised whilst unregistered and no patient safety concerns arose as a result.

During 2026/27, the Trust will:

- Review the opportunities for greater proactive monitoring of registration renewal and revalidation dates for NMC and HCPC registrants.
- Explore opportunities for greater automation of the monitoring and oversight systems to reduce reliance on individual local line managers, and to develop strengthened corporate oversight mechanisms.
- Implement the learning identified through the review of the registration lapse incidents in 2025/26
- Provide a further annual assurance report on professional registration, appraisal and revalidation compliance in 2026/27.

6.0 Conclusion

The Trust has maintained strong compliance with professional registration, appraisal and revalidation requirements throughout 2025/26.

Governance arrangements remain effective, and provide assurance that regulated professionals are appropriately registered and supported to maintain the professional standards stipulated by their regulatory bodies. GMC appraisal and revalidation processes continue to operate effectively, and GPhC compliance was maintained throughout the reporting period. The small number of NMC and HCPC registration lapses were isolated, appropriately managed and resulted in no patient safety concerns.

The Trust remains committed to continuous improvement, and will continue to strengthen workforce monitoring arrangements to minimise the risk of future registration lapses, and to support staff in meeting their professional responsibilities.

Appendices

Appendix 1 – Velindre University NHS Trust Professional Registration and Revalidation Policy

https://nhs.wales365.sharepoint.com/sites/VEL_Intranet/Policies%20and%20procedures/Forms/AllItems.aspx?id=%2Fsites%2FVEL%5Fintranet%2FPolicies%20and%20procedures%2FWorkforce%20%28HR%29%2FWF22%20%2D%20Professional%20Registration%20Policy%2FWF22%20Professional%20Registration%20Policy%5FV3%202024%2Epdf&parent=%2Fsites%2FVEL%5Fintranet%2FPolicies%20and%20procedures%2FWorkforce%20%28HR%29%2FWF22%20%2D%20Professional%20Registration%20Policy

Appendix 2 – All Wales Medical Appraisal Policy

https://nhs.wales365.sharepoint.com/sites/VEL_Intranet/Policies%20and%20procedures/Forms/AllItems.aspx?id=%2Fsites%2FVEL%5Fintranet%2FPolicies%20and%20procedures%2FWorkforce%20%28HR%29%2FWF60%20All%20Wales%20Medical%20Appraisal%20Policy%2FWF60%20All%20Wales%20Medical%20Appraisal%20Policy%2DV15%202025%2Epdf&parent=%2Fsites%2FVEL%5Fintranet%2FPolicies%20and%20procedures%2FWorkforce%20%28HR%29%2FWF60%20All%20Wales%20Medical%20Appraisal%20Policy

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TRUST BOARD	
TRUST SEAL REPORT: 15 MAY 2026 – 23 JULY 2026	
DATE OF MEETING	30 July 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 (15th May 2026 – 23rd July 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 **(15th May 2026 – 23rd July 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 <i>For more information:</i> https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx <u>X</u>	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
01/07/2026	Deed of Collateral Warranty of the electrical package (zone 3), in respect of the nVCC in Whitchurch, Cardiff, Wales, between (1) VUNHST and (2) Highadmit Projects Limited.	Sara Moseley (Chair) Carl James (CEO (interim))
01/07/2026	Deed of Collateral Warranty of the electrical package (area 1), in respect of the nVCC in Whitchurch, Cardiff, Wales, between (1) VUNHST and (2) F.P. Hurley & Sons Limited.	Sara Moseley (Chair) Carl James (CEO (interim))
01/07/2026	Deed of Collateral Warranty of the Aseptic Suite Designer, in respect of the nVCC in Whitchurch, Cardiff, Wales, between (1) VUNHST and (2) Enbloc Limited.	Sara Moseley (Chair) Carl James (CEO (interim))
01/07/2026	Deed of Collateral Warranty of the design and build of the lifts package, in respect of the nVCC in Whitchurch, Cardiff, Wales, between (1) VUNHST and (2) Stannah Lifts Limited.	Sara Moseley (Chair) Carl James (CEO (interim))
01/07/2026	Deed of Collateral Warranty of the steel structure frame package, in respect of the nVCC in Whitchurch, Cardiff,	Sara Moseley (Chair)

Date	Document Details	Signed
	Wales, between (1) VUNHST and (2) B&K Hybrid Solutions Limited.	Carl James (CEO (interim))
01/07/2026	Deed of Collateral Warranty of the design of secondary support structure to Gabion cladding, in respect of the nVCC in Whitchurch, Cardiff, Wales, between (1) VUNHST and (2) John Wilkinson Trading as the Wilkinson Partnership.	Sara Moseley (Chair) Carl James (CEO (interim))
01/07/2026	Deed of Collateral Warranty of the design, supply and install of the RF Cages and magnetic shielding, in respect of the nVCC in Whitchurch, Cardiff, Wales, between (1) VUNHST and (2) Raybloc X-Ray Protection Limited.	Sara Moseley (Chair) Carl James (CEO (interim))
01/07/2026	Deed of Collateral Warranty of the Design and Construction of the Aseptic Suite, in respect of the nVCC in Whitchurch, Cardiff, Wales, between (1) VUNHST and (2) Enbloc – <i>*to note this is a separate collateral warranty from the above (one is as designer under an earlier design services appointment and one as Subcontractor under a later design-and-build contract.</i>	Sara Moseley (Chair) Carl James (CEO (interim))
01/07/2026	Deed of Collateral Warranty of the security systems works, in respect of the nVCC in Cardiff, Wales, between (1) VUNHST and (2) ADT Fire and Security Limited.	Sara Moseley (Chair) Carl James (CEO (interim))
09/07/2026	Deed of Novation between (1) Gleeds Management Services Limited, (2)(Gleeds Cost Management Limited and (3) VUNHST (Project Manager – Lot 1).	Sara Moseley (Chair) Dr Jacinta Abraham (Acting CEO)
09/07/2026	Deed of Novation between (1) Gleeds Management Services Limited, (2)(Gleeds Cost Management Limited and (3) VUNHST (Project Manager – Lot 2).	Sara Moseley (Chair) Dr Jacinta Abraham (Acting CEO)

TRUST BOARD	
CHAIR'S URGENT ACTION MATTER REPORT	
DATE OF MEETING	30 July 2026
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 22/05/2026 – 23/07/2026. There was one (1) urgent item of business for the Trust Board that was considered via Chairs Urgent Action during this period: 1. All Wales Disciplinary Policy and Process and Improving Performance at Work Policy No objections to approval were received in respect of the items of business considered.
RECOMMENDATION / ACTIONS	The Trust Board is asked to RATIFY the Chairs Urgent Action taken between the 22/05/2026 – 23/07/2026 .
GOVERNANCE ROUTE	
Trust Board Members – Via Email	09/06/2026: All Wales Disciplinary Policy and Process and Improving Performance at Work Policy
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
The Trust Board APPROVED each item of business considered via Chair's Urgent Action.	
7 LEVELS OF ASSURANCE – 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 **22/05/2026 – 23/07/2026**.

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 May 2026:

3.1 All Wales Disciplinary Policy and Process and Improving Performance at Work Policy

The Trust Board was sent an email and Chair's Urgent Action Report on the **9th June 2026** in relation to the All-Wales Disciplinary Policy and Process and Improving Performance at Work Policy that required urgent approval.

The Trust Board was asked to **APPROVE** the All-Wales Disciplinary Policy and Process and Improving Performance at Work Policy for adoption within the Trust.

There were no objections or comments made during the approval process.

Recommendation Approved by:

- Sara Moseley, Chair
- Lindsay Foyster, Vice Chair
- Ceri Doyle, Independent Member

- Vicky Morris, Independent Member
- Carl James, Interim Chief Executive
- Sarah Jenkins, Executive Director of People and Organisational Development (Interim)

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 - BOARD ASSURANCE FRAMEWORK (BAF)	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 ☒ 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.
QUALITY IMPACT ASSESSMENT	Not required - not a strategic decision
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Not required
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience.

FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	Financial impact was captured within the documentation considered by the Board.
EQUALITY IMPACT ASSESSMENT	Not required
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Legal impact was captured within the documentation considered by the Board.

5. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

TRUST BOARD

TRUST WIDE POLICIES APPROVED UPDATE

DATE OF MEETING	30 July 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 May 2026 to July 2026 .
RECOMMENDATION / ACTIONS	The Trust Board is asked to NOTE the policies that have been approved during the period May 2026 to July 2026 .

GOVERNANCE ROUTE

List the Name(s) of Committee / Group who have previously received and considered this report:	Date
• Executive Management Board	23/02/2026
• Audit Committee	12/05/2026
• Charitable Funds Committee	04/06/2026

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

The following policies, procedures and guidance were **ENDORSED** by the Executive Management Board and **APPROVED** by the respective Committees as follows:

- The Audit Committee **APPROVED** The Standards of Good Governance and Probity Policy (GC02).
- The Charitable Funds Committee **APPROVED** the Charitable Funds Investment Policy (CFC04).

7 LEVELS OF ASSURANCE – N/A

APPENDICES	
Appendix 1	GC02 Good Standards of Governance and Probity Policy
Appendix 2	CFC04 Charitable Funds Investment 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 **May 2026 to July 2026**.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

- 2.1 Since the last report, the following policies have been **APPROVED**, which has been uploaded to the Trust Intranet and Internet site and circulated via the policy distribution list for immediate implementation.

Appendix	Policy Title	Policy Lead / Function	Approving Body	Effective Date
1	GC02 Good Standards of Governance and Probity Policy	Interim Director of Corporate Governance	Audit Committee	12/05/2026
2	CFC04 Charitable Funds Investment Policy	Executive Director of Finance	Charitable Funds Committee	04/06/2026

3. IMPACT ASSESSMENT

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

RELATED STRATEGIC RISK - BOARD ASSURANCE FRAMEWORK (TAF)	04 – Organisational Culture												
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply <table> <tr> <td>Safe</td><td>☒</td></tr> <tr> <td>Timely</td><td>☒</td></tr> <tr> <td>Effective</td><td>☒</td></tr> <tr> <td>Equitable</td><td>☒</td></tr> <tr> <td>Efficient</td><td>☒</td></tr> <tr> <td>Patient Centred</td><td>☒</td></tr> </table> 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 policies.	Safe	☒	Timely	☒	Effective	☒	Equitable	☒	Efficient	☒	Patient Centred	☒
Safe	☒												
Timely	☒												
Effective	☒												
Equitable	☒												
Efficient	☒												
Patient Centred	☒												
QUALITY IMPACT ASSESSMENT	Not required - not a strategic decision												
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Yes Through better decision making, the duty will improve the outcomes for those who suffer socio-economic disadvantage. The Duty will contribute towards a fairer and more prosperous Wales.												
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances												
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream Non-compliance could result in significant costs due to legal challenges, fines and prosecutions against the Trust.												
EQUALITY IMPACT ASSESSMENT	Yes - please outline what, if any, actions were taken as a result Each policy will be individually assessed to ensure compliance with EIA requirements.												

ADDITIONAL LEGAL IMPLICATIONS/ IMPACT	Yes (Include further detail below)
	Not complying with Trust policy and procedure can result in legal challenges from staff at Employment Tribunal. Not complying with legislative requirements could result in fines and prosecutions against the Trust from respective government agencies.

4. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

Ref: GC 03

STANDARDS OF GOOD GOVERNANCE AND PROBITY (IN PUBLIC SERVICE ROLES) POLICY

Executive Sponsor & Function	Director of Corporate Governance Governance
Document Author:	Head of Corporate Governance
Approved by:	Audit Committee
Approval Date:	12 th May 2026
Date of Equality Impact Assessment:	October 2025
Equality Impact Assessment Outcome:	Approved
Review Date:	May 2029
Version:	4

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1. POLICY STATEMENT

The Trust is committed to ensuring that its employees and Independent Members practice the highest standards of conduct and behaviour. This policy sets out those expectations and provides supporting guidance so that all employees and Independent Members are supported in delivering that requirement/aim.

2. INTRODUCTION

2.1 Public Service Values

The Welsh Government's Citizen-Centred Governance Principles apply to all public bodies in Wales. These principles integrate all aspects of governance and embody the values and standards of behaviour expected at all levels of public services in Wales.

“Public service values and associated behaviours are and must be at the heart of the NHS in Wales”

The Board is strongly committed to the Trust being value-driven, rooted in “Nolan” principles and high standards of public life and behaviour, including openness, customer service standards, diversity and engaged leadership.

The Trust is committed to ensuring that all employees and Independent Members practice the highest standards of corporate and personal conduct and behaviour, based on the recognition that the needs of service users must come first. This policy sets out those expectations and provides supporting guidance so that all employees and Independent Members are supported in delivering that requirement.

The “Seven Principles of Public Life” (the “Nolan Principles”), form the basis of the Trust’s Standards of Behaviour requirements for its employees and Independent Members. These are:

- **Selflessness** – Individuals should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or friends;
- **Integrity** – Individuals should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties;
- **Objectivity** – In carrying out public business, including making public appointments, awarding contracts, recommending individuals for rewards and benefits, choices should be made on merit;

- **Accountability** – Individuals are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate for their position;
- **Openness** – Individuals should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands it;
- **Honesty** – Individuals have a duty to declare any private interests relating to their duties and to take steps to resolve any conflicts arising in a way that protects the public interest, and;
- **Leadership** – Individuals should promote and support these principles by leadership and example.

The Codes of Conduct and Accountability for NHS Boards and the Code of Conduct for NHS Managers Directions 2006 reinforce the seven principles of public life and focus on the crucial public service values which must underpin the work of the health service; these are available via the following link: <https://www.gov.wales/codes-conduct-and-accountability-nhs-boards-and-code-conduct-nhs-managers-directions-2006-2006-no>

In support of these principles, employees and Independent Members must be impartial and honest in the way that they go about their day to day functions. They must remain beyond suspicion at all times. They can achieve the seven principles of public life by:

- Ensuring that the interests of service users remain paramount;
- Being impartial and honest in the conduct of their official business;
- Using public funds to the best advantage of the service and the service users, always seeking to ensure value for money;
- Not abusing their official position for personal gain or to benefit family or friends;
- Not seeking advantage or to further private business or other interests in the course of their official duties; and
- Not seeking or knowingly accepting preferential rates or benefits in kind for private transactions carried out with companies, with which they have had, or may have, official dealings on behalf of the Trust.

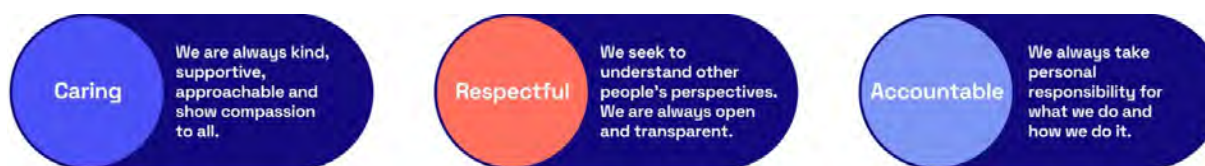
This policy re-states and builds on the provisions of Section 8 Values and Standards of Behaviour of the Trust Standing Orders. It re-emphasises the commitment of the Trust to ensure that it operates to the highest standards, the roles and responsibilities of those employed by the Trust, and the arrangements for ensuring that declarations of interests, gifts, hospitality, honoraria and sponsorship can be made. The policy is supported by a short guide on the Standards of Good Governance and Probity Framework (see Appendix 1) that provides a summary of expected conduct.

There are also a number of Professional Codes of Conduct which complement this policy. These are as follows:

- Nursing and Midwifery Council: <https://www.nmc.org.uk/standards/code/>
- Health and Care Professions Council: <http://www.hcpc-uk.co.uk/>
- NHS Consultants and General Practitioners: <https://www.gmc-uk.org/about/how-we-work/governance/council/code-of-conduct>

Trust Organisational Values

The Trust has also developed its own values and behaviour framework:



These values were updated and approved in March 2024 and were developed through a process of wide-ranging consultations with staff and members of the public. Our values are a mix of continuity and change, reflecting our commitment to delivering and developing our services.

3. SCOPE

This policy is applicable across the whole of the Trust in all locations. It applies to all employees and Independent Board Members. The term “employees” includes all those who have a contract of employment or honorary contract with the Trust.

Any reference in this Policy to the Trust should also be applied to any organisations or programmes that the Trust hosts such as the NHS Wales Shared Services Partnership (NWSSP), Health Technology Wales (HTW) and Advanced Therapies Wales (ATW).

The policy also applies to Trustees of Velindre University NHS Trust Charity and any activities arising from fundraising activity.

4. AIM

The Trust is committed to ensuring that all employees and Independent Members practice the highest standards of corporate and personal conduct and behaviour, based on the recognition that the needs of service users must come first.

The aim of this policy is to ensure that arrangements are in place to support employees and Independent Members to act in a manner that upholds the Good Governance and Probity Framework, as well as setting out the arrangements in place to manage declarations of interests, gifts, hospitality, honoraria and sponsorship, through the

standard forms in place; these are accessible via the Governance and Communications policy intranet page via the following link:

https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/Governance-&-Communications.aspx

The policy also aims to capture public acceptability of behaviours of those working in the public sector in order that the Trust can be seen to have exemplary practice in this regard.

5. OBJECTIVES

The objective of this policy is to clarify the relative responsibilities of employees and Independent Members in the discharging of this policy and adhering to the Standards of Good Governance and Probity Framework.

The policy is designed to assist the Trust and its employees and Independent Members in maintaining ethical standards in the conduct of NHS business. It sets out the principles the Trust expects all employees to uphold, and the steps which the Trust as an employer will take to safeguard the organisation where conflicts of interest arise.

A conflict of interest can be defined as 'A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold.'

A conflict of interest may be:

- **actual** - a material conflict between one or more interests
- **potential/perceived** – the possibility of a material conflict between one or more interests in the future

All employees are expected to be familiar with the content of this policy, and line managers have a responsibility for bringing the policy to the attention of their staff.

6. RESPONSIBILITIES

6.1 Chair

The Chair has the responsibility for performance managing the Independent Members of the Trust through the annual individual performance review process on behalf of the Cabinet Secretary for Health and Social Services, and also has the responsibility for holding the Chief Executive to account.

The Chair should;

- Ensure that Independent Members are aware of the requirements contained within this policy.

- Lead by example and ensure they personally declare any relevant interest or the offer of gifts, hospitality, honoraria or sponsorship.
- Approve (or not) the acceptance of gifts, hospitality, honoraria or sponsorship that have been offered to Independent Members **PRIOR** to the event.

6.2 Chief Executive

The Chief Executive is the 'Accountable Officer' with overall responsibility for ensuring that the Trust operates efficiently, economically and with probity. The Chief Executive will ensure a policy framework is set and that arrangements are in place to support the delivery of that framework.

6.3 Director of Corporate Governance

The Director of Corporate Governance has delegated responsibility for ensuring that the Trust is provided with competent advice and support regarding the contents and application of this policy and the Standards of Good Governance and Probity Framework.

The Director of Corporate Governance will ensure that:

- A Register of Interests is established and maintained as a formal record of interests declared by employees and Independent Members. The Register will include details of directorships, pecuniary (financial) and non-pecuniary interests in organisations that may have dealings with the NHS, and membership of professional committees and third sector bodies. Where relevant, it will also include details of interests of close family members (spouse, partner, civil partner, children, etc.).
- Arrangements are in place to prompt specific groups of employees and Independent Members to complete a Declaration of Interest Form on initial employment with the Trust, and at periodic intervals thereafter as follows:
 - o **Board Members and Board Level Directors** – Annually on 31st March.
 - o **Directors, Deputy Directors, Associate Directors and Assistant Directors** – Annually in the first quarter of the financial year for the forthcoming financial period.
 - o **Hosted Organisations Directors and Programme Managers** – Annually on 31st March.
 - o **Budget Holders** – Annually in the first quarter of the financial year for the forthcoming financial period.

Note: It is the individual employee's or Independent Member's responsibility to make a declaration should their circumstances change within these timescales.

- Scrutiny is applied to the declaration forms received to ensure appropriate declarations and acceptances have been made in compliance with the Standards of Good Governance and Probity Policy.
- A Register of Gifts, Hospitality, Honoraria and Sponsorship, whether accepted or declined, is maintained.
- The Registers of Interests and Gifts, Hospitality, Honoraria and Sponsorship are published on the Trust's internet site in accordance with the requirements of the organisation's Freedom of Information Act Publication Scheme.
- Reports detailing the content of the Registers of Interests and Gifts, Hospitality, Honoraria and Sponsorship, and the effectiveness and adequacy of the arrangements in place, are provided as a regular agenda item to the Audit Committee.
- The forms that employees and Independent Members should complete when making a declaration of interest or when advising of gifts, hospitality, honoraria or sponsorship accepted or declined, are available on the Trust's intranet site and attached at Appendices 2 and 3.

6.4 Executive / Divisional Directors

Executive / Divisional Directors have overall responsibility for their areas and must ensure that:

- Employees are aware of the requirements contained within this policy and the Standards of Good Governance and Probity Framework.
- They lead by example and ensure that they personally declare any relevant interest or the offer of gifts, hospitality, honoraria or sponsorship.
- Approve, or decline the acceptance of gifts, hospitality, honoraria and sponsorship that have been offered within their functions / Divisions **prior** to the event (and during periods of annual leave and prolonged absence, ensure that their responsibilities are delegated to their nominated deputy).
- They review the contents of the Registers of Interests and Gifts, Hospitality, Honoraria and Sponsorship to assist with the verification of the accuracy of the information contained within it when alerted to do so by the Director of Corporate Governance.
- They ensure any acceptances of gifts, hospitality, honoraria or sponsorship complies with the standards outlined within this policy.

6.5 Departmental / Line Managers

Departmental / Line Managers will:

- Ensure that this policy and the Standards of Good Governance and Probity Framework is brought to the attention of employees for whom they are responsible, and that they are aware of its implications for their work.
- Ensure that employees are aware of the requirement to follow and comply with the policy and Standards of Good Governance and Probity Framework, through discussions at Performance Appraisal Development Reviews, Consultant Appraisals and as part of the Consultant Job Plan Reviews, as appropriate.
- Support their employees in the application of the policy and the Standards of Good Governance and Probity Framework, seeking advice from the Director of Corporate Governance, where necessary.

6.6 Employees, Independent Members and Volunteers

All employees, including those on Honorary Contracts, and Independent Members must ensure that they:

- Understand this policy and the Standards of Good Governance and Probity Framework, consulting their line manager if they require clarification.
- Are not in a position where their private interests and NHS duties may conflict. Employees and Independent Members must declare all private interests which could potentially result in personal gain as a consequence of their position within the Trust.
- Declare to the Trust for recording in the Register of Interests any relevant interests
 - o At the commencement and conclusion of employment;
 - o Whenever a new interest arises;
 - o If asked to do so at periodic intervals by the Trust.
- Relevant interests (including those of close family members or associates) may include:
 - o Directorships, including Non-Executive Directorships held in private companies or Public Limited Companies (PLCs), with the exception of dormant companies;
 - o Ownership or part-ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with the Trust. This includes shareholdings, debentures or rights where the total nominal value is £5,000 or one hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less;

- o A personal or departmental interest in any part of the pharmaceutical/ healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team;
 - o Sponsorship or funding from a known NHS supplier or associated company/ subsidiary;
 - o A position of authority in a charity or voluntary body in the field of health and social care;
 - o Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests;
 - o Self-employment or employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of agency working and private practice.
 - o Research funding/grants that may be received by an individual or their department.
- Inform service users and their relatives as appropriate, when referring them for treatment, investigation, or any aspect of their care if they have a material interest in an organisation to which they plan to refer a service user. The fact that the service user has been informed must be recorded appropriately.
 - Verbally declare any relevant interest when a potential for conflict arises e.g. at Board and Committee meetings, during procurement processes, and at other Divisional / Departmental meetings, as appropriate.
 - Obtain permission from their Line Manager and Executive / Divisional Director **prior to** accepting a gift, hospitality, honoraria or sponsorship which requires declaring and recording in the Register of Gifts, Hospitality, Honoraria and Sponsorship.
 - Observe the Standing Orders, Standing Financial Instructions and procurement policies and procedures of the Trust.
 - Where employees or Independent Members wish to engage in any outside employment which may affect their contractual obligation to the Trust, they must first discuss it with their Departmental / Line Manager. This will ensure that their position in the Trust is not compromised. Agreement to such outside employment will not be unreasonably refused.
 - **NOTE:** Employees should also refer to appropriate Professional Codes of Conduct and relevant documents issued by the Welsh Government which will complement this Policy and the Standards of Good Governance and Probity Framework.

It is the responsibility of all employees and Independent Members to ensure they are not placed in a position that risks, or appears to risk conflict between their private interest and

the NHS. This responsibility applies to all Trust staff, including those who commit resources directly by ordering goods or services, and those who do so indirectly.

The onus regarding declaration will reside with the individual employee or Independent Member. It is recognised that a judgement may be required in individual circumstances regarding the appropriateness for a declaration to be made when, for example, there is a specific contractual situation, a set of circumstances, or series of specific circumstances or a close connection. Advice should be sought from the Director of Corporate Governance in this regard as such an interest may be deemed to be a potential conflict to the business of the Trust.

Where there is doubt, a declaration of interest should be made.

Appointing officers, for example, must declare any known relationship with potential applicants, and where a relationship is declared, the appointing officer must not be involved in any decisions relating to financial aspects of the individual's offer of employment. On an ongoing basis, there should not be any involvement in any other financial decisions relating to the individual to whom the manager has declared any relationship. This shall include salaries, re-grading, authorisation of travelling expenses, overtime payments, etc.

It is also important that all volunteers adhere to Trust policies and procedures, and this Standards of Good Governance and Probity Policy is consistent with the Wales Council for Voluntary Action Code of Practice for organisations involving volunteers.

6.7 Procurement Department

Where an employee is requested to participate in the Trust's procurement process and has not previously completed a Declaration of Interest Form, they will be asked to do so prior to participating, or asked to reaffirm their interests and to confirm that there are no other relevant interests that should be declared.

The Procurement Lead will scrutinise such individual Declarations of Interest to ensure that there is no opportunity for any conflicts of interest.

The NHS Wales Shared Services Partnership (NWSSP) will ensure that all procurement staff complete declaration of interest forms in line with their procedures. NWSSP will advise the Trust, through the Director of Corporate Governance, of any such interests impacting on Trust services.

Whilst individual staff must not seek or accept preferential rates or benefits in kind for private transactions carried out with which they have, or may have, official dealings with on behalf of the Trust, this does not apply to concessionary agreements negotiated with companies by NHS management, or by recognised staff interests on behalf of all staff, for example, NHS staff benefits schemes.

All staff in contact with suppliers and contractors, particularly if authorised to sign purchase orders or place contracts for goods, materials or services, shall adhere to accepted professional standards i.e. the NHS Wales Shared Services Partnership Procurement Policy and the Standing Orders and Standing Financial Instructions of the Trust.

Senior managers should ensure that no special favour is shown to current or former staff or their close relatives or associates in awarding contracts to private or other businesses operated by them or employing them in a senior or relevant managerial capacity.

Contracts may be awarded to such businesses where they are won in fair competition against other tenderers, but care must be taken to ensure that the selection process is conducted impartially, and that staff who are known to have a relevant interest play no part in the selection.

For further information in respect of procurement related declarations of interest and the relevant forms to complete please contact NHS Wales Shared Services Partnership – Procurement Services by emailing: ProcurementServicesenquiries@wales.nhs.uk

7. REGISTER OF INTERESTS

The Head of Corporate Governance, on behalf of the Director of Corporate Governance, will maintain the Registers of Board Members and Staffs Interests. Appropriate information from these Registers will be made available on the Trust's website.

A copy of the registers, together with the forms which are used to inform their content, will be retained by the Corporate Governance Department.

Any enquiries should be made to VUNHST.CorporateGovernance@wales.nhs.uk

8. DECLARATIONS OF INTEREST AT MEETINGS

It is a requirement that at the beginning of every Trust Board, Committee or decision making meeting, members and those in attendance are invited to declare their interests in relation to any items on the agenda.

Where a potential conflict is material or the individual has a financial/pecuniary interest in the matter under discussion, the individual shall withdraw from discussions pertaining to that agenda item and shall not vote upon it. The potential conflict and the action taken to avoid it will be recorded in the minutes of the meeting and the Register of Interests will be updated if required.

Where it becomes evident part way through a meeting that there may be a potential conflict, the individual must declare their interest immediately.

Under certain circumstances, the Chair may choose to waive the need for the individual to leave the meeting. The advice of the Director of Corporate Governance should always be sought prior to such a decision being made.

From time to time, employees and Independent Members may need to declare interests at other NHS organisations or partnership meetings. Such declarations will be recorded as if it were a Trust Board or Committee meeting and the individual will be asked to withdraw from discussions pertaining to that agenda item.

The Register of Interests for Independent Members and Executive Directors will be made available at every Board Meeting.

9. GIFTS, HOSPITALITY, HONORARIA AND SPONSORSHIP

Employees and Independent Members have a personal responsibility to volunteer information regarding offers of gifts, hospitality, honoraria and sponsorship, including those offers that have been declined.

Employees should seek approval from their Line Manager and relevant Executive/ Divisional Director, prior to accepting any gifts, hospitality, honoraria or sponsorship. These details must be recorded on a Gifts, Hospitality, Honoraria and Sponsorship Form (see Appendix 2) and submitted to the Director of Corporate Governance for inclusion on the register.

In determining whether to accept gifts, hospitality, honoraria and sponsorship, it is not always possible to make explicit a situation in which these may be considered acceptable as each offer should be considered independently. In determining whether any offer of a gift, hospitality, honoraria or sponsorship should be accepted, the following principles should be considered:

- **Openness:** It has been openly offered and the offer will not be construed as any form of inducement and will not put the individual under any obligation to those offering it;
- **Legitimate interest:** Regard should be paid to the reason for the contact on both sides and whether it is a contact that is likely to benefit the Trust i.e. further the aims of the organisation;
- **Relationship:** Consideration should be given as to whether the Trust is likely to enter into a contractual relationship with the organisation/individual making the offer;
- **Value:** Gifts and benefits of a trivial or inexpensive seasonal nature, e.g. diaries/ calendars, are more likely to be acceptable and can be distinguished from more substantial offers. Similarly, hospitality in the form of a working lunch would not be

treated in the same way as more expensive social functions, travel or accommodation;

- **Frequency:** Acceptance of frequent or regular invitations particularly from the same source would breach the required standards of conduct;
- **Reputation:** If the body concerned is known to be under investigation by, or has been publicly criticised by, a public body, regulators or inspectors, acceptance of a gift or hospitality might be seen as supporting the body or affecting in some way the investigation or negotiations. As such it should always be declined.

Bribery Act 2010

Employees must be impartial and honest in the conduct of business and remain beyond suspicion. It is an offence under the Bribery Act 2010 for an employee to accept a bribe in his or her official capacity, or to corruptly show favour or disfavour in the handling of contracts or other business. Employees need to be aware that a breach of the provisions of this Bribery Act may render them liable to prosecution and disciplinary action.

The Bribery Act introduced a new criminal offence in 2011 where an individual or organisation offers or receives a bribe to bring about or reward the improper performance of a function or activity. Broadly, the Act defines bribery as 'Giving or receiving a financial or other advantage in connection with the "improper performance" of a position of trust, or a function that is expected to be performed impartially or in good faith.'

Bribery has the potential to impact upon an employees' or Independent Members' standard of behaviour, particularly in regard to the acceptance of gifts, hospitality, honoraria or sponsorship, although guidance on the Act indicates that only 'lavish' hospitality, or hospitality that is otherwise 'inappropriate' would normally fall under the bribery definition.

The Bribery Act also introduced a 'corporate offence' of failing to prevent bribery by the organisation not having adequate preventative procedures in place. This is not a standalone offence, but always follows from a bribery and/or corruption offence committed by an individual associated with the company or organisation in question.

However, an organisation can avoid conviction if it can show that it had procedures and protocols in place to prevent bribery. The provisions within this Standards of Good Governance and Probity Policy in terms of prohibiting the giving or acceptance of inappropriate gifts, hospitality, honoraria and sponsorship complies with the requirements of the Bribery Act and subsequent guidance.

Employees and Independent Members are therefore expected to:

- Report any issues relating to fraud, bribery or corruption to the Local Counter Fraud Specialist within the Trust;

- Declare any external interest which may result in the employee or persons known to the employee gaining direct or indirect financial advantage as a consequence of their work, which could influence any decisions made by the employee, or which could interfere with contractual obligations to the organisation;
- Ensure the interests of patients are paramount and that use, or management of any public funds ensures value for money;
- Check each payslip as soon as possible following receipt to ensure that the amount paid is correct, with any queries raised with the line manager. If the employee believes that they have been overpaid, they must declare it without delay. Where employees do not understand their payslip, they should contact the Payroll Department.

The risks of breaching the Bribery Act include the following:

- Criminal justice sanctions against Board Members, Directors and other senior staff;
- Damage to the organisation's reputation;
- Conviction of bribery or corruption may lead to the organisation being precluded from future public procurement contracts;
- Potential diversion and/or loss of resources;
- Unforeseen and unbudgeted costs of investigations and/or defence of any legal action; and
- Negative impact on patient/stakeholder perceptions.

Guidance regarding the types of gifts, hospitality, honoraria and sponsorship which may or may not be acceptable is provided below:

9.1 Gifts

A gift is an item of personal value, given by a third party e.g. a patient, donor or a supplier. The definition includes prizes in draws and raffles at sponsored events/conferences.

It is an offence to accept any money, gift or consideration as an inducement or reward from a person or organisation holding or seeking to hold a contract with the Trust. Such gifts should be refused and if they have already been received they should be returned clearly advising why they cannot be accepted.

The appropriate Executive / Divisional Director and the Director of Corporate Governance should be advised immediately.

Any acceptance of a gift needs to be justified. Think about the context in which the offer has been made, and the effect on your position. For example, is the gift likely, or could it be seen as likely, to influence you? The onus is on you to make sure that the acceptance of a gift will not be misconstrued.

This Standards of Good Governance and Probity Policy excludes gifts between members of staff, for example birthday presents or leaving gifts.

9.2 Gifts from Service Users or their relatives

Gifts up to the value of £25 may be accepted from service users and relatives as a mark of their appreciation e.g. for the care that has been provided. This can include gift vouchers/ cards, chocolate, flowers, cards. A common sense approach should be applied to the valuing of gifts using an actual amount if known, or an estimate that any reasonable person would make as to its value.

There is no requirement to declare such gifts up to this value, other than where several small gifts are received to the value of £25 from the same or closely related source in a 12 month period. Where gifts are provided to a group of staff, it is the responsibility of the Line Manager to declare the gift if over the value of £25.

Where a gift is offered that is likely to be over £25 in value it should be politely declined. In some cases the gift may have already been made and it may be difficult to return it, or it may be felt that the bearer may be offended by the refusal. Under such circumstances the gift can be accepted, and the bearer advised that it will be utilised for the benefit of Charitable Funds e.g. used as a prize in a raffle. A Gifts, Hospitality, Honoraria and Sponsorship Form (see Appendix 2) declaring that the gift has been received must be completed.

Personal gifts of cash from service users or their relatives is **not** acceptable. These may only be accepted as a donation to an appropriate Charitable Fund and recorded as such.

The Trust's Charity Director / Head of Fundraising can provide advice regarding the mechanism for appropriately receipting such items in accordance with the Institute of Fundraising Code.

9.3 Gifts from Suppliers, Contractors and Commercial Organisations

Low cost branded or promotional gifts may be accepted where they are under the value of the common industry standard of **£6 in total** (selected with reference to existing industry guidance issued by the ABPI) and need not be declared. Any gifts outside this definition from suppliers, contractors and other commercial organisations doing business or likely to do business with the Trust above this value, should be politely but firmly declined.

Whilst it is not necessary to declare gifts of low intrinsic value, where other items are offered and declined, a Gifts, Hospitality, Honoraria and Sponsorship Form (Appendix 2) should be completed to allow the Trust to monitor when such organisations are inappropriately offering gifts or potential inducements.

Under some circumstances, suppliers may send gifts to all of its clients as custom and practice e.g. hampers at Christmas or chocolates at Easter. Whilst such practices should

be discouraged and whilst it is not acceptable for staff to personally accept these gifts, following discussion with the supplier/contractor/commercial organisation and the appropriate Executive / Divisional Director, it may be considered appropriate to accept the gift and utilise it for the benefit of Charitable Funds. The Trust's Charity Director and/or Head of Fundraising can provide advice regarding the mechanism for appropriately receipting such items.

Employees in contact with contractors should be on their guard against offers of gifts which might later be misconstrued as hampering their strict independence and impartiality. Where pressed to accept an offer, the employee to whom the offer has been made should seek further advice from their manager who may contact the Director of Corporate Governance, where appropriate.

9.4 Gifts from Dignitaries/Overseas Organisations

There may be occasions when visits are made by dignitaries or overseas organisations who consider it 'culturally custom and practice' to exchange gifts. In such cases, employees should seek guidance from the Director of Corporate Governance and declare these gifts on a Gifts, Hospitality, Honoraria and Sponsorship Form (see Appendix 2). A decision will then jointly be made as to the most appropriate way to manage the gift. This will depend on the nature of the 'gift culture' and may include decisions to 'keep and display in public', 'donate to an internal user group', 'auction for charity', etc.

9.5 Bequests / Legacies / Wills

Employees are not permitted to accept bequests left to them by a deceased patient who became known to them through providing care or treatment as part of their Trust employment. Accepting a gift of this nature, particularly where a patient is considered vulnerable, could leave the staff member open to accusations of financial abuse, fraud (by abuse of position) or misconduct. If an employee is made aware that they may be a beneficiary in a patient's will, they must declare this, with any complex cases escalated to the Director of Corporate Governance.

9.6 Gifts by way of Inducement or Reward

The Prevention of Corruption Acts, 1906 and 1916, prohibit staff from soliciting or receiving any gift or consideration of any kind from contractors or their agents, or from any organisations, firms or individuals with whom they are brought into contact by reason of their official duties, as an inducement or reward for:

- Doing or refraining from doing anything in their official capacity; or
- Showing favour or disfavour to any person in their official capacity.

A breach of the provisions of these Acts renders staff liable not only to dismissal but to prosecution under the Acts, and it is expected that the Trust would deal severely with any such breaches.

Staff should be aware that the Trust is required in accordance with its Standing Orders to insert in every formal contract a clause entitling them to cancel the contract and recover any losses if any inducement or gifts are offered by the contractor or by his employees, whether with or without his knowledge. Any such offer of an inducement or gift should accordingly be reported by the person to whom it is made to the Director of Corporate Governance.

10. HOSPITALITY

Hospitality is where there is an offer of food, drink, accommodation, entertainment or entry into an event or function by a third party, regardless of whether provided during or outside normal working hours e.g. attendance at an awards ceremony, cheque presentations in respect of fundraising events.

Employees and Independent Members should refuse hospitality which may compromise or may be seen to compromise their professional judgement or integrity, or which seeks to exert influence to obtain a preferential consideration.

Employees in contact with contractors should be particularly mindful of accepting any offer of hospitality that might later be misconstrued as impacting on strict independence and impartiality. Where pressed to accept an offer, the employee to whom the offer has been made should seek further advice from their manager who may contact the Director of Corporate Governance, where appropriate.

Any acceptance of hospitality needs to be justified. Think about the context in which the offer has been made, and the effect on your position. For example, is the hospitality likely, or could it be seen as likely, to influence you? The onus is on you to make sure that the acceptance of hospitality will not be misconstrued.

Hospitality must be authorised by their Line Manager and Executive / Divisional Director **prior to** their acceptance and a Gifts, Hospitality, Sponsorship and Honoraria form (Appendix 2) must be completed. The hospitality should be proportionate i.e. it should not be of significant value and only the minimum number of members of staff to achieve the purpose of representing the organisation should attend.

Offers which go beyond modest, or are of a type that the organisation itself might not usually offer, need authorisation from their Line Manager and Executive / Divisional Director, and should only be accepted in exceptional circumstances, and must be declared.

For example, employees may receive an offer of payment for their travel and accommodation, when invited to speak at an event or attend a meeting. Modest offers to

pay some or all of the travel and accommodation costs related to attendance at events may be accepted and must be declared on a Gifts, Hospitality, Sponsorship and Honoraria form (see Appendix 4). However, where business class or first class travel and accommodation (including domestic travel) or offers of foreign travel and accommodation are offered, a clear reason should be recorded on the declaration form as to why it is deemed permissible to accept travel and accommodation of this type.

10.1 Acceptable Hospitality

Employees and Independent Members may accept the occasional offer of hospitality, provided that it is 'modest and proportionate' and similar in scale to that offered by the NHS. For example, acceptance of food and non-alcoholic refreshments during the working day will generally be deemed acceptable and need not be declared.

Hospitality must be secondary to the purpose of a meeting. The level of hospitality offered must be appropriate and not out of proportion to the occasion; and the costs involved must not exceed the level which the recipients would normally adopt when paying for themselves, or that which could be reciprocated by the NHS. It should not extend beyond those whose role makes it appropriate for them to attend the meeting.

Other hospitality may be accepted where it furthers the aims of the Trust, provided it is normal and reasonable in the circumstances, for example lunches in the course of working visits. Where the value is estimated to be over £25, a declaration should be made.

Other hospitality that may be accepted but will need to be declared includes instances where:

- There is a genuine need to impart information, or represent the organisation at stakeholder community events e.g. Local Authority or charitable organisations which have an association with the Trust;
- An employee has been invited to receive an award or prize in connection with the work of the organisation, or their role within it;
- An employee is invited to a Society or Institute dinner or function which is to be funded by a commercial organisation and where there is a genuine benefit to the professional standing of the individual or the Trust.
- An event is clearly part of the life of the stakeholder community or where the organisation should be seen to be represented;
- A function or event is hosted for both staff and non-staff, which adds benefit and value to the Trust or the wider NHS;

- A function or event is hosted externally for staff only for the purposes of training or organisational development.

These types of hospitality **must be authorised** by their Line Manager and Executive / Divisional Director **prior to** their acceptance and a Gifts, Hospitality, Honoraria and Sponsorship Form (see Appendix 2) must be completed. The hospitality should be proportionate i.e. it should not be of significant value and only the minimum number of employees to achieve the purpose of representing the Trust should attend.

10.2 Unacceptable Hospitality

Unacceptable hospitality includes the following examples as general guidance:

- A holiday or weekend/overnight break;
- Offers of hotel accommodation when this is not associated with a sponsored course or conference (see below);
- Use of a company flat or hotel suite;
- Attendance at a function or event restricted to employees which is not for the purposes of training or organisational development;
- Lunch or dinner provided by a private company or their representative which does not form part of a training or development event;
- Entertainment and/or tickets/hospitality at sporting and other corporate entertainment events.

If employees are not clear whether an offer falls into one of these categories, advice should be sought from their line manager or the Director of Corporate Governance.

Employees should report any case where they have felt pressurised into accepting an offer of hospitality which might be open to objection. They should also declare on the appropriate form any offers of hospitality which are declined.

11. SPONSORSHIP

Sponsorship is an offer of funding to an individual, team or to the Trust from an external source, whether in cash, goods, services or benefits.

Sponsorship is sometimes provided by organisations to allow employees to attend conferences. It may also include sponsorship of posts and research and development.

Employees may be offered sponsorship in the form of sponsored research, including publishing, an operational post, training, and costs associated with meetings, conferences or a working visit. The sponsorship may cover some or all of the costs.

No sponsorship should be accepted **without the prior agreement** of the Line Manager and Executive / Divisional Director. A Gifts, Hospitality, Honoraria and Sponsorship Form (see Appendix 2) should be completed **prior to** the acceptance of any sponsorship. If

sponsorship is inappropriately offered and/or declined, this should also be declared. In cases of doubt, advice from the Director of Corporate Governance or the Director of Corporate Governance should be sought.

Any acceptance of sponsorship needs to be justified. Think about the context in which the offer has been made, and the effect on your position. For example, is the sponsorship likely, or could it be seen as likely, to influence you? The onus is on you to make sure that the acceptance of any sponsorship will not be misconstrued.

Some health related companies provide commercial sponsorship to the NHS, including sponsoring equipment, employees and training events. In accordance with the All Wales Code of Conduct (Business) for NHS staff, all employees must consider fully the implications of a proposed sponsorship deal before entering into any arrangement. Only very senior managers with the necessary authority can sign up to, or enter into, any advertising contract or agreement with a company or its representatives. Employees must not allow unauthorised advertising on Trust premises or documentation.

More detail is provided below regarding the many forms that sponsorship may take. This list is not exhaustive and offers of other sponsorship will need to be considered on a case by case basis.

11.1 Commercial Sponsorship for Attendance at Courses/Conferences

Employees may accept sponsorship for attendance at relevant conferences and courses, but only where attendance would further the aims of the Trust and where the employee has obtained permission in advance from their Line Manager and Executive / Divisional Director and in line with the Trust's Study Leave Policy. The sponsorship should only be extended to the number of employees who would have normally attended if funded by the Trust. The employee, Line Manager and the Executive / Divisional Director must be satisfied that acceptance will not compromise purchasing or any future decision-making in any way.

11.2 Commercial Sponsorship to attend Demonstrations/Technical Evaluations

Employees may be invited to view products or equipment at another location. There may be occasions when it is appropriate as part of a procurement exercise to visit a suppliers' reference site to observe equipment in operation in a medical or laboratory setting. Such sponsorship is not usually considered appropriate and the Trust will normally meet the costs of such a visit so as to protect the integrity of subsequent purchasing decisions.

Arrangements whereby the company meets all or part of the cost of such a visit must be approved by their Line Manager and Executive / Divisional Director following consideration of the implications for the integrity of subsequent purchasing decisions.

11.3 Commercial Sponsorship – ‘Linked Deals’

Pharmaceutical companies and other suppliers may offer to sponsor, wholly or partially, a post or equipment for the Trust. The Trust will not enter into such arrangements, unless it has been made clear to the company concerned that the sponsorship will have no effect on purchasing decisions within the Trust.

Linked deals must be approved and managed within an agreed process in order that appropriate monitoring arrangements are established to ensure that purchasing decisions are not being influenced by the sponsorship agreement. Under no circumstances may ‘linked deals’ be agreed, whereby sponsorship is linked to the purchase of particular products, or to supplies from particular sources.

11.4 Sponsored Posts

Sponsored posts are posts that are funded, in whole or in part, by organisations external to the NHS. Sponsored posts can offer benefits to the delivery of care, providing expertise, extra capacity and capability that might not otherwise exist if funding was required to be used from the NHS budget. However, safeguards are required to ensure that the deployment of sponsored posts does not cause a conflict of interest between the aims of the sponsor and the aims of the organisation, particularly in relation to procurement and competition.

The following should be considered when sponsored posts are offered:

- External sponsorship of a post requires prior approval from the relevant Executive/ Divisional Director.
- Rolling sponsorship of posts should be avoided unless appropriate checks are put in place to review and withdraw if appropriate.
- Sponsorship of a post should only happen where there is written confirmation that the arrangements will have no effect on purchasing decisions or prescribing and dispensing habits. This should be audited for the duration of the sponsorship. Written agreements should detail the circumstances under which organisations have the ability to exit sponsorship arrangements should conflicts of interest which cannot be managed arise.
- Sponsored post holders must not promote or favour the sponsor’s products, and information about alternative products and suppliers should be provided.
- Sponsors should not have any undue influence over the duties of the post or have any preferential access to services, materials or intellectual property relating to or developed in connection with the sponsored posts.

The relevant Executive / Divisional Director should declare any posts sponsored by external organisations on a Gifts, Hospitality, Sponsorship and Honoraria form (see Appendix 2) and submit it to the Director of Corporate Governance for recording on the register.

11.5 Sponsorship of Events in the Context of Partnership Arrangements with the Pharmaceutical Industry or other Commercial Organisations

The pharmaceutical industry and allied commercial sector representatives may organise meetings, conferences or an activity in support of specific functions or specialties within the healthcare sector. Under such arrangements they are permitted to fund the hiring of accommodation, meet any reasonable actual costs which may have been incurred and to provide appropriate hospitality. If no hospitality is required, there is no obligation or right to provide it, or indeed any benefit of equivalent value.

The Pharmaceutical Industry is expected to adhere to the ABPI Code of Practice for the Pharmaceutical Industry which clearly specifies what is and what is not acceptable; this is available via the following link: <https://www.abpi.org.uk/reputation/abpi-2024-code-of-practice/>

An example of hospitality which would not be acceptable under these circumstances is where a company takes the attendees, on the conclusion of a course, for a meal in a restaurant.

Where the Trust receives or invites offers of sponsorship for events which are hosted wholly or partly by the Trust, the relevant Executive / Divisional Director must consider whether it is appropriate to accept the offer. For all offers, whether accepted or declined, a Gifts, Hospitality, Sponsorship and Honoraria form (see Appendix 2) must be completed and sent to the Director of Corporate Governance.

The following guiding principles should apply:

- Sponsorship of events by appropriate external bodies will only be approved if a reasonable person would conclude that the event will result in clear benefit for the Trust and the NHS.
- During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation.
- No information should be supplied to the sponsor from whom they could gain a commercial advantage, and information which is not in the public domain should not normally be supplied.

- At the organisation's discretion, sponsors or their representatives may attend or take part in the event, but they should not have a dominant influence over the content or the main purpose of the event.
- The involvement of a sponsor in an event should always be clearly identified.
- Members of staff within the organisation involved in securing sponsorship of events should make it clear that sponsorship does not equate to endorsement of a company or its products and this should be made visibly clear on any promotional or other materials relating to the event.
- Members of staff arranging sponsored events must declare this to the organisation.

Whilst it is recognised that sponsorship can provide a useful source of funding for particular events or activities, it can also present risks and in considering whether to accept sponsorship, the following principles should be adhered to:

- Sponsorship should be sought in an open and consistent manner with opportunities being offered as widely as possible;
- Benefits should be for the Trust (not an individual) and should be proportionate;
- Arrangements must not compromise the reputation of the Trust;
- Sponsorship should be for a specific activity or event and not a general endorsement of the Trust;
- The sponsorship must not imply the Trust endorses particular products, services or companies and organisations;
- Sponsorship should not be accepted from inappropriate sources, such as companies with dubious or doubtful backgrounds or who have poor financial or business practices;
- Any arrangements which could bring adverse publicity to the event or the Trust.

Particular care should be taken when considering sponsorship from companies or organisation for which the Trust has, or could have, contractual business arrangements.

The above principles should be adhered to and a renewal or an award of a contract should not be influenced by any sponsorship arrangements.

A sponsor would normally expect to receive a reciprocal benefit which may be beyond a modest acknowledgement, and companies may seek sponsorship for a number of legitimate business reasons. These include:

- To raise the company's image and profile;
- To improve public/community relations;
- To generate public exposure and media coverage;
- To differentiate the company from its competitors;
- To increase profit/market share.

Careful consideration should always be given to understanding what a sponsor might gain from the arrangement and these should be in-keeping with the principles listed above.

Employees and Independent Members may, on occasion, be asked to provide an endorsement of an event, conference or training course that they have attended which was organised by a third party. Caution should be exercised in these circumstances as it may not be appropriate to cite such an endorsement. It is also important to consider any potential future conflict for example, where the third party may be in the process of re-tendering for the work or be seeking commercial gain from the endorsement.

The Trust may also receive unsolicited proposals for sponsorship which is not in response to any action that the Trust has taken. The Trust should carefully consider such offers and ensure that the proposal meets the Trust's requirements, standards and principals. The Trust will need to ensure there are no conflicts of interest or that better value for money cannot be obtained by testing wider market interest.

All sponsorship arrangements should be approved by the appropriate Executive / Divisional Director as appropriate.

12. HONORARIA

An honorarium is an ex gratia payment i.e. one which would not usually be expected to be provided.

Employees may be invited to give presentations at conferences, provide responses to surveys or attend professional meetings where a one off payment or honoraria is offered.

If this activity is to be undertaken during hours when the employee is contracted to work for the Trust, the payment should be made to the Trust. Individuals may accept payment for activities that they undertake in their own time, subject to the provisions regarding outside employment contained within the various employee Contracts and Terms of Service. The activity should be reported using a Gifts, Hospitality, Honoraria and Sponsorship Form (see Appendix 2) and it should be authorised by the appropriate Executive / Divisional Director.

NOTE: There are tax and national insurance contribution implications relating to honoraria that should be borne in mind as set out below:

- **Honoraria received for work undertaken during Trust hours** - when appropriate authorisation has been granted to permit an employee to be involved in activity outside their normal contract during Trust hours, any honoraria paid must be received back to the Trust's revenue budget to reimburse the Trust for the employee's time.

To ensure good governance, the honoraria must be paid into a revenue budget that is **not** managed by the employee who has provided their services during Health Board time.

To avoid personal tax implications, the employee is strongly advised to request the honoraria is paid directly to the Trust. This is then seen as reimbursement to the Trust to cover the loss of employee time, and not honoraria. This money will then be transferred into the Trust's revenue budget. The employee who has undertaken the work must **not** be the budget holder for the budget receiving the funds in lieu of the honorarium to avoid any conflict of interest.

Where the employee receives the honoraria directly and then reimburses the Trust, the employee remains liable for the payment of both tax and National Insurance Contributions (NIC), regardless of the final destination of the honoraria.

- **Honoraria received for work undertaken in an individual's own time (out of normal working hours or on authorised annual leave)** - individuals are personally liable for the payment of both tax and NICs on any honoraria payments received for work undertaken in their own time. Following their first receipt of honoraria in this instance employees will be asked to sign the declaration statement that will be held on file by the Director of Corporate Governance which confirms they understand their responsibilities regarding Tax and NICs. (See Appendix 4).

Where an employee wishes, a donation may be made to the Trust's Charitable Funds in lieu of an honoraria. This must be received into the Charity's general fund and it is then for the Charity's Trustees to determine how the donated funds should be used, with the principle being that the employee giving their own time should have no influence over how the donation is then used in order to lessen the risk of this being interpreted as being of any benefit to them as 'income' in any sense.

In cases of doubt, employees should seek advice from the Director of Governance and should report any case where an offer of sponsorship or honoraria is pressed which might be open to objection.

Instances where honoraria has been offered and declined should be declared on the Gifts, Hospitality, Honoraria and Sponsorship Declaration Form (see Appendix 2).

13. USE OF THE TRUST BRANDING

Permission needs to be obtained from the Assistant Director of Communications & Engagement on all occasions where approaches are made by an outside organisation seeking to use the Trust's branding in connection with an event or function. Permission should also be sought by any member of staff wishing to use the logo in connection with any non-Trust related matter/event.

14. RESEARCH, DEVELOPMENT AND INNOVATION

All research, development and innovation activity sponsored by commercial companies, including those sponsored by the pharmaceutical industry, must be approved by the appropriate mechanism, and governed by the specific policies and procedures.

The Research, Development and Innovation leads, along with Corporate Governance should be contacted in these circumstances to offer advice and support in this area.

15. CHARITABLE FUNDS

There may be occasions when commercial organisations offer to pay monies into Charitable Funds as a way of funding attendances at courses or conferences. Monies paid into charitable funds from commercial companies must only be accepted as donations or for sponsorship. Where sponsorship is received, it should only be used to fund expenditure which is in line with the terms of the charitable fund's use. Such sponsorship should be declared on the Gifts, Hospitality, Honoraria and Sponsorship Form (see Appendix 4).

Expenditure from Charitable Funds and charitable fundraising within the workplace does not fall within the remit of this policy, however there may be a close association. Further guidance is available from the Trust's Charity Director.

16. SECONDARY EMPLOYMENT & PRIVATE PRACTICE

16.1 Secondary Employment (Paid, Unpaid or Self-Employed)

Employees should inform their line manager of any secondary employment and ensure that this does not affect their Trust employment. Declarations should be made using the Staff Declaration of Interests Form (see Appendix 3). There should be no conflict with their normal contractual employment obligations to the Trust, and such work should not involve the use of any confidential or commercial information obtained in the course of their employment with the Trust.

Where employees have or are contemplating other employment, they must ensure this does not compromise their availability or physical or mental fitness to carry out their duties as an employee of the Trust. Employees must also ensure this does not place them in a

position where their judgement or actions might be influenced by considerations arising from their other employment.

Employees have a responsibility to ensure that their line manager is made aware of any hours worked in order that the Trust fulfils its statutory requirement of the Working Time Directive; this is available via the following link.

<http://www.hse.gov.uk/contact/fags/workingtimedirective.htm>

An employee, absent because of sickness, is regarded as unfit to work and should not undertake any paid or unpaid work in any capacity during a period of sickness absence from the organisation, unless it is deemed jointly by their manager and the Occupational Health Department to be therapeutically beneficial to their recovery. Express written permission must be granted by the manager in advance in all such cases.

An employee found to be undertaking other work during sickness absence without the prior written consent of the manager, may be considered in breach of contract and will be subject to disciplinary action which may result in the involvement of the Counter Fraud Department, the possibility of criminal investigation and/or dismissal. Such action will only be taken following advice from the Workforce & Organisational Development Department.

16.2 Private Practice

There are codes for good private patient practice which clearly include the fact that private practice should not adversely affect NHS duties.

The time spent in private practice does not count towards the 48 hours of the Working Time Directive Regulations, however, health and safety law indicates that no employee of the Trust should work in a way detrimental to their health and performance.

Failure to notify their line manager of secondary employment and/or private practice may invoke the Trust's Disciplinary Policy.

For medical staff, the amendment to the consultant contract in Wales clarifies the relationship between NHS work, private work and fee-paying work, in that it sets out that an NHS consultant's first responsibility is to the NHS. Participation in private medical services or fee-paying services should not result in detriment to NHS patients or services or diminish the public resources available for the NHS.

Employees should:

- Seek prior approval before taking up private practice.
- Declare what they practice (name of private facility); what they practice (specialty, major procedures); when they practice (identified sessions/time commitment).

- Ensure that, where there would otherwise be a conflict or potential conflict of interest, NHS commitments take precedence over private work.

17. REWARDS FOR INITIATIVE

Potential intellectual property rights (IPR) should be identified, as and when they arise, in order to protect and ensure that the Trust receives any rewards or benefits (such as royalties) in respect of work commissioned from third parties, or work carried out by its employees in the course of their duties.

Most intellectual property is protected by statute e.g. patents are protected under the Patents Act 1977, and copyright (which includes software programmes) under the Copyright Designs and Patents Act 1988. Appropriate specifications and provisions should be built into contractual arrangements before they are entered into or before work is commissioned or begins. Legal advice or advice provided via the Research & Development Department should be sought if in doubt in any specific cases.

With regard to patents and inventions, in certain defined circumstances the Patents Act gives employees a right to obtain reward for their efforts, and the Trust should agree a suitable reward for individual circumstances as appropriate. Other rewards may be given voluntarily to employees who within the course of their employment have produced innovative work of outstanding benefit to the NHS. Similar rewards should be voluntarily applied to other activities such as giving lectures and publishing books and articles.

In the case of collaborative research and evaluative exercises with manufacturers, the Trust should obtain a fair reward for the input its employees provide. If such an exercise involves additional work for an employee outside that paid for by the Trust under their contract of employment, arrangements should be made for a share of any rewards or benefits to be passed on to the employee(s) concerned from the collaborating parties.

Care should be taken that involvement in this type of arrangement with a manufacturer does not influence the purchase of other supplies from them.

Employees are reminded that all information generated during the course of their employment with Trust is the property of the Trust and remains so, irrespective of origin or authorship.

Conflicts of interest can arise when a member of staff who hold patents and other intellectual property rights, is involved in decision making and procurement. In addition, where product development involves use of time, equipment or resources from the organisation, this can also create risks of conflicts of interest, and it is important that the Trust is aware of this in order to manage it appropriately.

Employees are responsible for:

- Declaring patents and other intellectual property rights they hold (either individually, or by virtue of their association with a commercial or other organisation), including where applications to protect have started or are ongoing, which are, or might reasonably be expected to be, related to items to be procured or used by the organisation.
- Seeking prior permission from Trust before entering into any agreement with bodies regarding product development, research, work on pathways, etc., where this impacts on the organisations own time, or uses its equipment, resources or intellectual property.
- Where holding of patents and other intellectual property rights give rise to a conflict of interest, then the management actions outlined in this policy should be considered and applied to mitigate risks.

Members of staff are also reminded of their responsibilities to ensure the correct use of copyrighted information.

Advice on Intellectual Property and copyright is available from the Trust Research & Development Manager and Trust Intellectual Property Policy.

18. SOCIAL NETWORKING SITES

All employees must uphold the reputation of the Trust, and their professional body where appropriate, at all times. This means that conduct online and conduct outside of work should be judged in the same way, and should be of a similar high standard.

The All Wales Social Media Policy (GC19), accessible via the Governance and Communications policy intranet page via the following link: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/Governance-&-Communications.aspx sets out employee's responsibilities when using social media, and the implications involved. The term social media is used in reference to all Internet social networking and media sharing sites, such as Facebook, Twitter, YouTube, Snapchat, Instagram, Flickr etc., and to all 'blogs', 'chat', on-line commentaries, diaries, discussion forums, 'wikis' and sites allowing the posting of user generated content for mass consumption.

The policy is not intended to stop the use of social media, indeed the Trust itself uses social networks to engage with patients, service users, staff and other stakeholders to deliver key messages, but rather to outline areas of best practice and illustrate where problems can arise for individuals and NHS Wales. It applies to the use of social media for business and personal purposes, both at work and outside of the work environment.

The Trust acknowledges that everyone has a right to express themselves using social media but also recognises its role in offering advice on the safe use of social media and highlighting the responsibility of employees to be aware of the potential consequences of posting content on to publicly accessible platforms. The blurring of boundaries between an individual's private and professional life on social media is recognised and it is important that employees understand and are mindful that inappropriate use could damage both their and NHS Wales' reputation.

In terms of the business use of social media, local restrictions are in place to ensure that only those employees having a genuine business need are given access to organisational social media pages and can issue corporate or organisational statements and update content. Anyone wishing to develop a social media site or application on behalf of the organisation should speak to the Assistant Director of Communications & Engagement in order for them to provide advice and guidance on the local approval process.

In terms of the personal use of social media, it is important for employees to understand their role as ambassadors for the Trust and to be conscious of the impact of their actions and words online which may negatively impact on the reputation and trust of the public.

The relationship with social media changes as soon as employees identify themselves or are identified as employees of NHS Wales or Trust. In these circumstances, they must make it clear that any views and opinions are personal and not necessarily those of the Trust. As an NHS Wales employee, it is important to remember that expressing views or commenting on content on the internet in relation to the NHS cannot be divorced from one's working life, and any unguarded comments could bring the organisation into disrepute, and may also invite legal action against both the employee and the Trust.

Where the Trust uses public Wi-Fi (wireless fidelity network), employees are encouraged to use their own personal devices to utilise any social media channels they wish to access.

However, personal use of social media should not be allowed to interfere with the performance of an employee's duties and any such access should occur during breaks or outside of normal working hours.

The Trust reserves the right to monitor and log comments and references on social media sites, including those made by its employees, relating to itself, its employees, its services and the patients in its care.

Failure to adhere to the All Wales Social Media Policy may lead to disciplinary action up to and including dismissal, depending on the individual circumstances of the case.

19. TIME KEEPING

The time of employees is a Trust resource in the same way as the buildings and equipment. The Trust spends a significant amount of its funding on salaries and wages therefore it is essential that it receives the full value for this expenditure. Where an

employee is occasionally late for work or may have to leave early, this does not necessarily present an issue provided it is discussed with the line manager concerned.

What is not acceptable is where the employee falsifies time records to disguise absence or to claim attendance. This may be fraud or may amount to obtaining a monetary advantage by deception

Employees must ensure that all time keeping records are accurately completed and if an inadvertent error is noticed, their line manager notified immediately. The types of records where care should be taken are:

- on-call registers
- additional duty hours claims
- annual leave records
- shift registers
- sickness records, including "self-certification"
- expense claims
- bank claim forms
- domiciliary visit claims
- clock cards
- flexi/time-in-lieu sheets

20. ELECTION CAMPAIGNS

Welsh Government has produced guidance to NHS employees on their role and conduct during election campaigns.

The general principles that should be observed during the period of elections are that, as at other times, NHS staff should not engage in activities which could give rise to the criticism that individuals paid from public funds are being used for party political purposes, or which distract attention unduly to election campaigns.

The principles set out in this guidance apply to the NHS at all times, but particular note should be taken in the period between the start of formal campaigns and polling day.

All employees and Independent Members are requested to follow these guidelines:

- The NHS and its constituent bodies have no party-political affiliation. Nothing should be said or done by any employee or Independent Member in their official capacity that suggests otherwise.
- NHS employees or Independent Members should not engage in activities which could give rise to the criticism that people paid from public funds are being used for party political purposes.

- No visits to Trust premises will be permitted by party political candidates and/or spokespeople for the purposes of personal canvassing. Party political meetings should not be held on NHS premises during the pre-election period.
- Political posters should not be displayed in public areas on NHS premises. Other posters and advertising material purporting to be apolitical and published by other groups should be carefully scrutinised to ensure that they cannot be regarded as favouring or opposing a particular candidate or party.
- Existing health promotion campaigns can continue, but new campaigns and all high profile publicity (large scale mail drops, posters and advertising) should be deferred until after the elections.
- Social and electronic media has become more important to political parties and organisations during the pre-election period and staff should comply with existing guidance around its use both professionally and personally.
- All enquiries from political parties and candidates should be directed to the Chief Executive's Office and treated consistently.
- All media enquiries should be directed through the Assistant Director of Communications & Engagement via Velindre.Communications@wales.nhs.uk
- Routine Trust Board meetings which would normally be held in public may be held in the pre-election periods. Any public lectures given for educational purposes by the Trust employees on health matters need not be cancelled or postponed, but should avoid debate or speculation on the outcome of the election and any impact that might have on government health policy.
- NHS employees are free, in their private capacity, to engage in public debate or comment during the election period. However, they should not use NHS premises or equipment and should not make comments based on information not generally available to the public. It must be clearly stated that the views expressed are those of the individual and not of the Trust.

21. FAILURE TO ADHERE TO STANDARDS OF GOOD GOVERNANCE AND PROBITY POLICY

If any employee or Independent Member fails to declare an interest or gift, hospitality, honoraria or sponsorship as defined within this policy, and then:

- participates in a decision making process where special favour is shown to unfairly award a contract; or

- abuses their official position or knowledge for the purpose of benefit to themselves, their family or friends

disciplinary action may follow. The action taken will depend on the individual circumstances and will be in accordance with the Trust's Disciplinary Policy. Under some circumstances, failure to follow this policy could be considered gross misconduct.

In addition to any potential disciplinary action being taken, if there is any suspicion that fraud, corruption and/or bribery has been or is being committed, then all such cases must be reported at the earliest possible opportunity to the Local Counter Fraud Specialist (LCFS). This is also extended to include the inappropriate acceptance of any gifts, hospitality, honoraria or sponsorship.

Furthermore, if an employee breaches this policy or the Standards of Good Governance and Probity Framework, this could in certain circumstances result in notification/reporting to the appropriate professional codes of conducts/registration/memberships i.e. Health Professions Council (HPC), General Medical Council (GMC), Nursing and Midwifery Council (NMC), etc. This could incur registrations being revoked and employees no longer continuing to be employed in their current position within the Trust.

Failure to declare a relevant interest by an Independent Member of the Trust will be reported by the Chair to the Cabinet Secretary for Health, Well-being and Sport, Welsh Government.

22. EQUALITY

The Trust is committed to ensuring that, as far as is reasonably practicable, the way it provides services to the public and the way it treats its employees reflects their individual needs and does not discriminate against individuals or groups.

The Trust has undertaken an Equality Impact Assessment to establish whether there are any possible or actual impacts that this policy may have on any groups in respect of gender (including maternity and pregnancy as well as marriage or civil partnership issues), race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or other protected characteristics.

The assessment found that there was **no impact** to the equality groups mentioned above. Where appropriate, the Trust will make plans for the necessary actions required to minimise any stated impact to ensure that it meets its responsibilities under the equalities and human rights legislation.

23. RESOURCES

The implementation and management of the arrangements associated with this policy and the Standards of Good Governance and Probity Framework do not present any significant resource implications to the Trust.

24. TRAINING

All staff are required to comply with this policy. Whilst there are no particular training requirements or formal training programmes in place to ensure implementation of the policy, each Executive / Divisional Director and Departmental / Line Manager must ensure that all employees are made aware of the policy provisions and that they are adhered to at all times.

Awareness of the importance of compliance with the policy will require reference to it in induction programmes, during Performance Appraisal Development Reviews, Consultant Appraisals, and Consultant Job Plan Reviews and at times when employees and Independent Members are invited to make declarations.

25. IMPLEMENTATION

The Registers of Interests, and Gifts, Hospitality, Honoraria and Sponsorship will be maintained by the Corporate Governance Department. The Department will also be responsible for issuing periodic invitations to employees and Independent Members to declare interests, gifts, hospitality, honoraria and sponsorship.

In order to ensure that all employees and Independent Members are aware of their responsibilities in regard to declaring interests, and gifts, hospitality, honoraria and sponsorship, a number of communication methods will be utilised to raise awareness, including the use of the staff intranet, and e-mails to remind employees and Independent Members of this policy, and their responsibility to comply with it.

Targeting of specific groups and forums will also be undertaken to raise awareness of the policy such as corporate and local induction, the Local Partnership Forum, Medical Leadership Forum, Senior Management Team Meetings, and other key meetings, 1:1's, etc.

Executive / Divisional Directors and Departmental / Line Managers will need to be aware of their responsibilities for advising employees accountable to them of their responsibilities in connection with the policy.

26. PUBLICATION OF REGISTERS

The Registers of Interests and the Registers of Gifts, Hospitality, Honoraria and Sponsorship will be published on the Trust's internet site. An updated version will be

added to the website quarterly. When making a declaration, employees and Independent Members are able to make representations that information on their interests or offers of gifts, hospitality, honoraria and sponsorship received, should not be published. This will allow for, in exceptional circumstances, an individual's name and/or other information to be redacted from any publicly available registers where the public disclosure of information could give rise to a real risk of harm or is prohibited by law.

An interest will remain on the public register for a minimum of 6 months and no more than 12 months after the Director of Corporate Governance has been informed that the interest has expired. A record of historic interests will be retained by the Trust for a minimum of 6 years after the date on which it expired.

27. AUDIT AND MONITORING

The Director of Corporate Governance is responsible for the monitoring of this policy and its formal review every three years.

The Director of Corporate Governance will arrange for the Declarations of Interest Register and an overview of the gifts, hospitality, honoraria and sponsorship activities within Trust to be presented to the Audit Committee and Executive Management Board meetings.

The Audit Committee will review and report to the Board upon the adequacy of the arrangements for declaring, registering and handling interests, gifts, hospitality, honoraria and sponsorship at least annually.

Audit Wales and the Trust's Internal Audit Service may also review the arrangements in place from time to time and their findings are also reported to the Audit Committee.

Staff should note that following the implementation of the Freedom of Information Act 2000, the information contained within the Trust's Register will be subject to disclosure to any member of the public on request.

28. DISTRIBUTION

The policy will be made available via the Trust internet and intranet sites. Where employees do not have access to these sites, their line manager must ensure that they have access to a copy of this policy.

Managers also have a responsibility to bring this policy to the attention of their staff. New members of staff will be made aware of this policy as part of the corporate induction process

29. CONFIDENTIALITY

As set out in employee's job descriptions, all employees may have access to confidential information about patients, staff or health service business. On no account must such information be divulged to anyone who is not authorised to receive it. Confidentiality of information must be preserved at all times whether at or away from work. Any breach of such confidentiality is considered a serious disciplinary offence, which may be liable to dismissal and/or prosecution under current statutory legislation (The Data Protection Act/ General Data Protection Regulations (2016) or any subsequent legislation to the same effect) and the Trust's Disciplinary Policy. Any breach of confidentiality may lead to disciplinary action and may be regarded as gross misconduct justifying summary dismissal.

Where employees are unsure about the use or sharing of patient identifiable information, advice should be sought from the Trusts Information Governance Manager.

30. LEGISLATIVE AND NHS REQUIREMENTS

This Policy aims to ensure the Trust complies with the requirements set out in:

- DGM (93)84: Standards of Business Conduct for NHS Staff;
- Director General. Health and Social Services, Chief Executive NHS Wales, Shared Values and Reinforcing Behaviour in NHS Wales (January 2011)
- Commercial Sponsorship-Ethical Standards for the NHS, Department of Health (November 2000);
- Code of Practice for NHS Wales Employers, Welsh Assembly Government (January 2011);
- WHC (2005) 016 The NHS & Sponsorship by the Pharmaceutical Industry;
- The Codes of Conduct and Accountability for NHS Boards and the Code of Conduct for NHS Managers Directions 2006 (2006 No.95);
- Trust Standing Orders & Standing Financial Instructions (GC02);
- Trust Intellectual Property Policy (RD01);
- Bribery Act 2010
- General Medical Council Good Medical Practice guidance – financial and commercial arrangements and conflicts of interest, 2013
- Nursing & Midwifery Council gifts and gratuities guidance , September 2013 and The Code: Standards of conduct, performance & ethics for nurses & midwives
- Association of British Pharmaceutical Industry (ABPI) Code of Practice for the Pharmaceutical Industry 2016
- All Wales Procedure for the Recovery of Overpayments – Salary & Expenses (WF11)
- Counter Fraud, Bribery and Corruption Policy and Response Plan (FP02)

- Code of Conduct for Healthcare Support Workers in Wales, Welsh Assembly Government (January 2011);
- The Institute of Chartered Secretaries and Administrators (ICSA), Model Conflicts of Interest Policy for NHS Trust Board Members (June 2010).

31. ACKNOWLEDGEMENTS

This Policy has been reviewed and developed against the following NHS Wales policies:

- Aneurin Bevan University Health Board – Standards of Business Conduct (September 2024);
- Cardiff and vale university health board – Standards of Behaviour Policy (November 2022);
- Cwm Taf Morgannwg University Health Board – Standards of Good Governance and Probity Policy (May 2025).

32. FURTHER INFORMATION

Further information and support on the policy or completion of the forms can be obtained from the Corporate Governance Team VUNHST.CorporateGovernance@wales.nhs.uk

APPENDIX 1

STANDARDS OF GOOD GOVERNANCE AND PROBITY FRAMEWORK - SUMMARY

The Board has described those values that underpin the way that services are provided within the Trust. To support this, all employees and Independent Members must ensure that they carry out their roles with dedication and commitment to the Trust and its core values.

All employees and Independent Members must have the highest standards of corporate and personal conduct and behave in an exemplary manner based on the following seven principles:

1. **Selflessness** – Individuals should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or friends;
2. **Integrity** – Individuals should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties;
3. **Objectivity** – In carrying out public business, including making public appointments, awarding contracts, recommending individuals for rewards and benefits, choices should be made on merit;
4. **Accountability** – Individuals are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate for their position;
5. **Openness** – Individuals should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands it;
6. **Honesty** – Individuals have a duty to declare any private interests relating to their duties and to take steps to resolve any conflicts arising in a way that protects the public interest, and;
7. **Leadership** – Individuals should promote and support these principles by leadership and example.

To uphold these principles you must:-

- Ensure that the interests of patients and the public remain paramount;
- Be impartial and honest in the conduct of your official business;
- Use NHS resources to the best advantage of the service and the patients, always seeking to ensure value for money;
- Not abuse your official position for personal gain or to benefit your family or friends;
- Not seek advantage or to further private business or other interests in the course of your official duties, and;
- Not seek or knowingly accept preferential rates or benefits in kind for private transactions carried out with companies, with which they have had, or may have, official dealings on behalf of the Trust.

The Standards of Good Governance and Probity Policy outlines the arrangements within the Trust to ensure that staff comply with these requirements, including recording and declaring potential conflicts of interest and handling of gifts, hospitality, honoraria and sponsorship (even if these are declined).

It is your responsibility to ensure that you are familiar with the requirements of the policy and supporting guidance. The relevance of this information will vary depending on your role within the Trust and your interests outside of your employment.

In summary:

Do:

- Make sure that you are not in a position where your private interests and NHS duties may conflict.
- Declare any relevant interests. These include:
 - a) Directorships, including Non-Executive Directorships held in private companies or PLCs.;
 - b) Ownership or part-ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with the Trust.
 - c) A position of authority in a charity or voluntary body in the field of health and social care;
 - d) A personal or departmental interest in any part of the pharmaceutical or healthcare associated industries that could be perceived as an influence on decision making or on the provision of advice to members of the team;
 - e) Sponsorship or funding from a known NHS supplier or associated company/ subsidiary;
 - f) Employment where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice;
 - g) Anything else that could cause a potential for conflict.

If in doubt declare it!

- Remember that the need to declare an interest also includes those of your close family and possibly friends.
- Seek your manager's permission before taking any outside work, in accordance with employment terms and conditions.
- Obtain your Line Manager and relevant Executive / Divisional Directors permission before accepting any commercial sponsorship or hospitality;
- Declare offers of gifts, hospitality or sponsorship using the appropriate form where required.

Do not:

- Accept any gifts from suppliers or commercial organisations unless they are of low value e.g. pens, diaries;

- Accept any gifts over the value of £25 from patients or their relatives, these should be politely declined;
- Accept any inappropriate hospitality or sponsorship from suppliers or commercial organisations;
- Abuse your position to obtain preferential rates for private deals;
- Unfairly advantage one competitor over another or show favoritism in your dealings with commercial organisations;
- Use NHS resources for your own private use.

For any queries or to return the fully completed approved declaration, please email:
VUNHST.Corporate.Governance@wales.nhs.uk

Appendix 2 – Gifts, Hospitality, Honoraria and Sponsorship Form

GIFTS, HOSPITALITY, HONORARIA AND SPONSORSHIP DECLARATION FORM

It is a requirement that staff advise the Trust if they accept or are offered any gifts, hospitality, honoraria or sponsorship in accordance with Trust Standards of Good Governance and Probity Framework Incorporating Declarations of Interest Gifts, Hospitality & Sponsorship Policy.

Once agreement has been provided by your line manager and approval received by the Divisional Director or Executive Director, the completed and signed form should be forwarded by email to VUNHST.CorporateGovernance@wales.nhs.uk for inclusion in the Register of Gifts, Hospitality, Honoraria and Sponsorship.

Please Note: This form should be used to seek the approval to accept any gifts, hospitality, honoraria or sponsorship **PRIOR** to acceptance.

Please Note: Tax Implications of Honoraria:

i) Honoraria received for work undertaken during Trust hours

When appropriate authorisation has been granted to permit an employee to be involved in activity outside their normal contract during Trust hours, any honoraria paid must be received back to the Trust revenue budget to reimburse the Trust for the employee's time.

To ensure good governance, the honoraria must be paid into a revenue budget that is not managed by the employee who has provided their services during Trust time.

To avoid personal tax implications, the Trust employee is urged to request the Honoraria is paid directly to the Trust. This is then seen as reimbursement to the Trust to cover the loss of employee time, and not honoraria. This money will then be transferred into the Trust revenue budget. The Trust employee who has undertaken the work must not be the budget holder for the budget receiving the funds in lieu of the honorarium due to a conflict of interest.

*If the employee receives the honoraria directly and then reimburses the Trust, the employee **remains liable for the payment of both tax and NIC**, regardless of the final destination of the honoraria.*

ii) Honoraria received for work undertaken in an individual's own time (out of normal working hours or on authorised annual leave)

*Individuals are **personally liable for the payment of both tax and NICs** on any honoraria payments received.*

If such an employee wishes to suggest a donation may be made to the Trust Charity in lieu of an honoraria, this must be received into the Charity's general fund and it is then for the Charity Trustees to determine how the donated funds should be used. The basic principle being that the employee giving their own time should have no influence over how the donation is then used and therefore lessens the risk of this being interpreted as being of any benefit to them as 'income' in any sense.

Full Name:		Position:	Department:
Gift: ☐ Hospitality: ☐ Sponsorship: ☐ Honorarium ☐		Accepted: ☐ Declined: ☐	
		IF ACCEPTED, Please specify the reason why this gift/hospitality/sponsorship/honorarium has been accepted in the box below:	
Event Details including location (if applicable):			
Start Date of Event: (If Applicable)		End Date of Event: (If Applicable)	
Description: (Including course title, fees, travel, accommodation etc)			
Sponsor/Donor: (Name & address of organisation/company/individual)			
Are you aware of any current or future commercial relationship with the provider of the gift/ hospitality/ sponsorship/ honorarium?			
Exact/Approximate Value: Travel Accommodation Meals/Refreshments Conference/Registration Fees Other (please specify)		£ £ £ £ £	
Study Leave Required? Yes ☐ No ☐ Annual Leave Required? Yes ☐ No ☐		Has a Study Form Been Completed? Yes ☐ No ☐	

Signature of Applicant:	Date:
Approved by (Line Manager): Print Name : Signature:	Date:
Approved by (Divisional Director/Executive Director): Print Name : Signature:	Date:
Recorded on Register of Gifts, Hospitality & Sponsorship: (Executive Offices) Print Name : Signature:	Date:

For any queries or to return the fully completed approved declaration, please email:
VUNHST.Corporate.Governance@wales.nhs.uk

Appendix 3 – Declaration of Interest Form

 Ymddiriedolaeth GIG Prifysgol Felindre Velindre University NHS Trust	Declarations of Interest Form – Trust (& Charity If Applicable)		
Full Name: (Please Print)			
Contact Address:			
Tel No:			
Position Held in Trust			
In accordance with the Code of Conduct and Accountability, Standing Orders and Standing Financial Instructions. I list below my relevant interests and those of my family for inclusion in the Register of Members' Interests. If in doubt, declare! Proceed to Section h) after noting section f) if you have nothing to declare.			
Declaration	Nature of Relationship	Period of Involvement	Financial Transactions or Benefits in Kind
a) DIRECTORSHIPS Public or private appointments, employment or consultancies. Company directorship's in private or limited companies	Personal:		
	Spouse/Partner or other Relationship Specific to a Contract or Series of Contracts		
b) INTEREST IN COMPANIES AND SECURITIES Substantial interest is ownership or part ownership, more than 1/100 th (i.e. share) of private companies, businesses or consultancies	Personal:		
	Spouse/Partner or other Relationship Specific to a Contract or Series of Contracts		

c) OTHER POSITIONS OF AUTHORITY (Not included in a.) A position of authority (i.e. Director, Chairman. Trustee etc.) in a charity or voluntary body in the field of health and social care	Personal:		
	Spouse/Partner or other Relationship Specific to a Contract or Series of Contracts		
d) PERSONAL OR DEPARTMENTAL SPONSORSHIP a personal or departmental interest in any part of the pharmaceutical industry or Sponsorship or funding from a known NHS supplier or associated company/subsidiary, e.g. Baxter funding research, staff or equipment	Personal:		
	Spouse/Partner or other Relationship Specific to a Contract or Series of Contracts		
e) ANY OTHER INTEREST Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests	Personal:		
	Spouse/Partner or other Relationship Specific to a Contract or Series of Contracts		
f) I undertake to notify the Trust of any changes which may occur within four weeks from the date of the change via email to: VUNHST.CorporateGovernance@wales.nhs.uk			

g) I confirm that the list accurately reflects my interests and those of my close family and understand that these declarations will be included in the register available <i>public inspection</i>				
Signed:		Date:		
h) I confirm a <i>nil declaration</i>				
Signed:		Date:		
i) Authorisation Section				
Having considered the activity declared on this form is there any action required to manage any potential conflicts of Interest? Please indicate with a (X) in the relevant box.	Yes <i>If yes, please outline in the 'Management Action' box below the steps and action that will be taken to manage any potential conflict</i>		No	
If a conflict has been identified have you sought advice from the Director of Corporate Governance for advice on how to manage and report the conflict? Please indicate with a (X) in the relevant box. <i>Director of Corporate Governance Contact Details:</i> VUNHST.CorporateGovernance@wales.nhs.uk	Yes		N/A	

Management Action Agreed: <i>(if not applicable please indicate this by writing N/A in the box below)</i>	
By signing below you are confirming that you have: • Considered the activity Declared on this form. • Identified if there are any potential conflict of interest • If a declaration of interest is perceived, considered the management action required to manage the conflict, sought advice from the Director of Corporate Governance and; • Communicated the action required to the individual declaring the interest	
Print Name:	
Designation:	
Signature:	
Date:	

For any queries or to return the fully completed approved declaration, please email:
VUNHST.Corporate.Governance@wales.nhs.uk

Appendix 4

Declaration Statement

Tax and National Insurance Contributions in respect of Honoraria

I confirm that I shall fulfil the Tax and National Insurance contributions responsibilities associated with receiving honoraria payments, as outlined in the Trust Standards of Good Governance and Probity Policy.

I understand that where honoraria is received for events undertaken in my own time (out of normal working hours or on authorised annual leave) I am **personally liable** for the payment of both Tax and National Insurance Contributions on any honoraria payments received and it is my responsibility to personally declare this income to the Inland Revenue.

Where an honorarium is received for events undertaken in work time and/or whilst on study leave I will advise the sponsor that the payments should be paid **direct** to the Trust. These funds will then be reimbursed to the appropriate Trust revenue budget.

Print Name:	
Position:	
Signature:	
Date:	

For any queries or to return the fully completed approved declaration, please email:
VUNHST.Corporate.Governance@wales.nhs.uk

Ref: CFC 004

Charitable Funds Investment Policy

Date to be reviewed:	December 2028	No of pages:	8
Author job title(s):	Deputy Director of Finance		
Responsible dept / director:	Executive Director of Finance		
Approved by:	Charitable Funds Committee		
Date approved:	04/06/2026		
Effective Date (live):	June 2026		
Version:	6		

Date EQIA completed:	Not required
Documents to be read alongside this policy:	This policy should be read in conjunction with the following information: • Terms of Reference of the Investment Performance Review Sub Committee • The Trustees Act 2000 • CC14 Charities and Investment Matters: A Guide for Trustees.
Current review changes: e.g. review/ current changes Significant changes following advice from the Charity investment managers and bench marking against other Charity investment policies. Reviewed in accordance with agreed policy review:	

Executive Summary: The purpose of this policy is to formalise the responsibilities of Velindre University NHS Trust Charitable Funds Corporate Trustee (Being the Velindre University NHS Trust Board Members) in respect of the management of charitable fund assets held by the Trust.					
First operational:	Date: July 2012				
Previously reviewed:	December 2025				
Changes made <u>yes/no</u>:	December 2025				

PROPRIETARY INFORMATION

This document contains proprietary information belonging to Velindre University NHS Trust/ Ymddiriedolaeth GIG Prifysgol Felindre. Do not produce all or any part of this document without written permission from Velindre University NHS/Ymddiriedolaeth GIG Prifysgol Felindre

Charitable Funds Investment Policy

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Charitable Funds Investment Policy

1) Policy Statement

This policy has been prepared following the request by Velindre UNHS Trust Charitable Funds Committee to ensure that our organisation is managing appropriately and transparently the charitable funds assets and complying with all the legal regulations, guidance and best practices established by governmental and regulatory bodies.

2) Purpose

This Investment Policy sets out the principles and guidelines for the management of investments held by Velindre University NHS Trust Charity ensuring that funds are managed prudently, ethically, and in alignment with the organisation's objectives and statutory responsibilities.

3) Scope

This policy applies to all Velindre UNHS Trust Employees and Independent Members, particularly to Charitable Funds Committee Members, Investment Subcommittee members and Investment advisors

This policy applies to all investments made by or on behalf of Velindre University NHS Trust Charity, including but not limited to:

- Cash reserves
- Short- and medium-term deposits
- Long-term investment portfolios

4) Objectives

The primary objectives of the investment policy are:

- Capital Preservation: To safeguard the principal value of invested funds.
- Liquidity: To ensure sufficient liquidity to meet operational and strategic needs.
- Return on Investment: To achieve a reasonable return within acceptable risk parameters.
- Ethical Standards: To ensure investments align with the organisation's values and relevant ESG (Environmental, Social, and Governance) criteria.

5) Governance and Responsibilities

The Velindre University NHS Trust Board as the Corporate Trustee of the Charity approves the investment policy and has overall responsibility for investment decisions.

The Charitable funds Committee sub delegates to the Investment Sub Committee to oversee implementation and compliance.

Investment Managers: Manage funds in accordance with this policy and any specific mandates.

6) Investment Powers

The Velindre University NHS Trust instrument of the charity places no restrictions on investment therefore the charity's assets must be invested in accordance with the Trustee Act 2000. The Act confers on the Corporate Trustee the general power of investment which allows a trustee to place funds in any kind of investment, excluding land, as though they were the absolute owner of those funds. Investment decisions are to be made by the Charitable Funds Investment Committee on the advice of the Charity's investment advisers.

The Corporate Trustee must attempt to maximise the investment return on the charitable funds whilst minimising the risk to the funds themselves. Furthermore, the Corporate Trustee have a legal duty to avoid speculative forms of investment.

- **General objectives**

The investments must be managed in such a way as to provide sufficient income to supplement income normally received from donations and bequests to enable the charity to continue to carry out its purposes effectively both in the short term and over the longer term. Income generated from investments should year on year be at least comparable to that generated for similar portfolios in the charity sector.

A performance analysis for the period covered by the report (quarterly) providing the statistics necessary to comply with the performance requirements detailed in the Investment Policy Statement.

- **Balance between intended capital growth and immediate income requirements**

The Corporate Trustee wish to maintain a balance between capital growth and the generation of income, so that where possible, the value of the assets should at least keep pace with inflation over the longer term while continuing to generate a rate of income comparable with similar portfolios in the charitable sector. To achieve this investments are expected to achieve, over a 5 year rolling period, an income return of at least 3% pa and capital growth of at least the increase in CPI to maintain real growth in assets.

7) Time Horizon

The time horizon for the Velindre University NHS Trust Charity Funds general investment account is between 5 to 7 years.

8) Risk Appetite

A "medium risk" (cautious) approach is to be adopted in the management of the charity's investments. This means:

Investment in markets where financial services are closely regulated, and compensation schemes are in place.

Diversification of the portfolio.

Avoidance of speculative forms of investment such as hedge funds and private equity.

9) Ethical Criteria and Restrictions

The Velindre University NHS Trust Board as Corporate Trustee has a responsibility for formulating a responsible investment policy. The investment managers will assess this by reviewing all proposed screens against the Morgan Stanley Capital International (MSCI) all country world index. Collective investments are more difficult to screen but the Velindre University NHS Trust Charity Funds will expect as a minimum that such collective funds are managed, where possible, in line with the requirements of the UK Stewardship Code published by the Financial Reporting Council.

To ensure responsible investing the Charity requires the investment advisor to consider environmental social, and governance factors into consideration when recommending or monitoring any investment within the portfolio.

At the discretion of the Corporate Trustee investment in companies that are deemed to have an approach to risk mitigation around the issues of ethical employment considered 'Weak' are an organisation that provides a risk rating in relation to the Environmental, Social & Governance (ESG) factors of a company that can be brought into the financial decision making of investors. Responsible investment ensures the Charity protects its reputation and possibly avoids conflict with the Charity's purposes.

In addition, the Charity also has a number of investment restrictions in place within the Investment Strategy, including:

- the Board as Corporate Trustee has determined that the Velindre University NHS Trust Charity Funds should not be invested in companies whose trade is inconsistent with the aims of the Velindre UNHS Trust, so those companies may be expressly excluded. The Corporate Trustee may not, however, exclude investments in companies for any other reason e.g. political.
- SUCH EXCLUSIONS AS EXPRESSLY IDENTIFIED BY THE BOARD AS CORPORATE TRUSTEE ARE COMPANIES WHO DERIVE A SIGNIFICANT PROPORTION OF THEIR INCOME FROM FOSIL FUELS, GAMBLING, TOBACCO, ALCOHOL AND ARMOURMENT ACTIVITIES.

There are further restrictions on investment in Russin/ Belarussian companies in line with UK Government sanctions. Further restrictions may apply on countries where there is conflict or where sanctions have been placed upon them, which will be at the discretion of the Velindre University NHS Trust Board as Corporate Trustee.

- Investments shall comply with the rules and regulations of the Trustees Act 2000.

The Board as Corporate Trustee reserves the right to exclude any investments which they judge might prove damaging, directly or indirectly, to the purposes, reputation or public support of the charity.

10) Liquidity

At all times it must be ensured that sufficient liquid resources are available to meet routine payment requirements. The investment advisers will provide recommendations to the Charitable Funds Investment Committee on any excess cash in the Velindre University NHS Trust Charity Funds that it wishes to invest. Any additions to the investment portfolio, must be approved by the Corporate Trustee.

- At least 80% of the Velindre University NHS Trust Charity Fund portfolio should be invested in assets that are readily realisable within one week.
- There is recognition that some property funds may only have a quarterly trading date and note these are unlikely to form a large part of the portfolio.

11) Appointment of the Charity's Investment Adviser

The Charitable Funds Committee's recommendations to the Velindre University NHS Trust Board as Corporate Trustee regarding the selection of investment manager(s) must be based on the Procurement Act 2023 which provides the guidance and legislation for public procurement. A qualifying investment manager must be a registered investment advisor under the Investment Advisor Act of 1961, or a bank or insurance company which is authorised and regulated by the Financial Services Authority.

Investment Managers are to be reviewed at a minimum of five years.

Board members of VUNHST as part of the Corporate Trustee of the Velindre UNHS Trust Charity Funds are specifically excluded from providing investment advice, even though they may be so authorised.

12) Functions delegated to the Trustees' Investment Advisor

The Advisor will:

- Provide advice on and recommendations for investments on the Charitable Funds Investment Committee to enable it to make investment decisions in accordance with the Investment Policy.
- Manage the portfolio of investments, to include purchase and sale of investments authorised by the VUNHST Board Members as part of the Corporate Trustee and provision/facilitation of high interest cash on deposit account(s).

- Monitor portfolio performance and provide regular, formal reviews of portfolio performance and investment recommendations to the Charitable Funds Investment Committee.
- The VUNHST Board Members as part of the Corporate Trustee are liable for acts or defaults of the investment advisors, since responsibility may not be delegated under the Trustees Investment Act 1961.

Investment managers shall be reviewed twice annually as part of the Investment Committee meeting regarding performance, personnel, strategy, research capabilities, organisation and business matters, and other qualitative factors that may impact their ability to achieve the desired investment results.

In addition to complying with the specific requirements detailed in the investment policy statement the appointed investment manager must pay heed to the general power of investment embodied in Section 3 of The Trustee Act 2000. All investments should be suitable and, overall, constitute a degree of diversification as required by Section 4 of The Trustee Act 2000.

13) Reporting

A report will be expected from the Investment Advisors demonstrating how the Velindre University NHS Trust Charity fund's portfolio performance compares with movements in various published indices and other appropriate investment performance “benchmarks” on a six month basis. These investment performance indicators will be agreed between the Corporate Trustee and the Investment Advisors and should provide an assessment of both capital growth as well as income performance.

The Investment Fund Manager is also required at the end of each quarter to provide a valuation and accompanying report encompassing the following:

- list of all investments held together with their respective book costs, current market value and estimated income and yield.
- A performance analysis for the period covered by the report (quarterly) providing the statistics necessary to comply with the performance requirements detailed in the Investment Policy Statement.
- A transaction schedule detailing purchases, sales and dividends (Income).

A separate report will be prepared at the end of the charity's financial year, 31st March providing such information as is required by the Corporate Trustee to meet their reporting obligations. This will also include a comprehensive list of transactions for the financial year.

These investment reports shall be reported to the Charitable Funds Investment Committee every six months.

14) Authorised Persons

Transfers of cash to and from the Investment portfolio will be authorised by the Executive Director of Finance, acting on behalf of the Corporate Trustee,

or an authorised signatory in their absence, such action to be subsequently notified to the Charitable Funds Committee.

15) Review Process

The Deputy Director of Finance will review the operation of the policy as necessary and at least every 3 years.

16) Legislation and Guidance

- The Trustees Act 2000
- Trustees Investment Act 1961
- CC14 Charities and Investment Matters: A Guide for Trustees
- Velindre UNHS Trust Charitable Funds Governing Document from January 1995.

17) Contact Information

Further information and support is available from the Deputy Director of Finance on Tel: 02920 615888
Steven.coliandris@wales.nhs.uk

TRUST BOARD	
EXTRAORDINARY PUBLIC QUALITY, SAFETY & PERFORMANCE COMMITTEE HIGHLIGHT REPORT	
DATE OF MEETING	30 th July 2026
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Liane Webber, Business Support Officer
PRESENTED BY	Vicky Morris, Quality, Safety & Performance Committee Chair and Independent Member
EXECUTIVE SPONSOR APPROVED	Annie Evans, Deputy Director of Nursing, Quality & Patient Experience <i>on behalf of</i> Gillian Knight, Executive Director of Nursing, AHPs & Health Science
REPORT PURPOSE	FOR DISCUSSION

1. PURPOSE

This paper provides the Trust Board with an overview of the key discussions of the Quality, Safety & Performance Committee at its meeting held on 9th July 2026. This extraordinary meeting was held in addition to the scheduled meeting on 16th July 2026 in order to receive the suite of Trust annual reports relating to quality, safety and performance.

2. BACKGROUND

The Quality, Safety and Performance Committee meets on a bi-monthly basis, and provides an opportunity to interrogate and triangulate information and data in respect of quality, safety, finance, workforce, performance and digital. Due to the volume of annual reports to consider, an extra-ordinary meeting was held on 9th July 2026 specifically to review, consider and endorse the reports to enable onward consideration at the Trust Board meeting on 30th July 2026.

3. HIGHLIGHTS FROM THE MEETING HELD ON 9TH JULY 2026

3.1 *Triangulated themes*

The following triangulated themes were identified:

- **Strengthening data quality:** A recurring theme identified across a number of annual reports was the need to further improve data quality, with enhanced dashboard reporting. It was discussed that this would also provide a greater ability to interrogate, analyse and learn from the data.

- **Demonstrating and evidencing learning:** The Committee emphasised the importance of moving beyond describing activity to demonstrating outcomes, organisational learning and measurable improvement. The Committee encouraged that in the future, the reports provide clearer evidence of the learning, and the actions being taken to implement and embed this.
- **Workforce capacity, capability and organisational sustainability:** A key theme within the discussions at the Committee meeting related to demand versus capacity in a number of areas, and the resultant pressure, particularly on the smaller teams / key individuals. The importance of ensuring sufficient workforce capacity and capability to meet future service demands and organisational priorities was noted.

3.2 Further Information

Board members who are not members of the Committee, and who wish to review the agenda and papers from the Quality, Safety and Performance (QSP) Committee's meeting on 9th July 2026 can access them via the link below:

<https://velindre.nhs.wales/about-us/quality-safety-performance/quality-safety-performance-papers/public-quality-safety-amp-performance-committee-09-07-2026/>

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 or escalate to the Trust Board.
ADVISE	There were no items to advise the Trust Board.
ASSURE	Duty of Quality Annual Report The Committee received the Duty of Quality Annual Report, which demonstrated the progress made during 2025/26 in strengthening quality governance, organisational learning and the patient and donor experience. Members welcomed the continued focus on developing quality intelligence and data triangulation arrangements to support improvement and assurance across the organisation, whilst also discussing opportunities to further strengthen future reporting, including the demonstration of outcomes and progress towards OECl (Organisation of European Cancer Institutes) accreditation. The Committee agreed the Level 4 Assurance rating and ENDORSED the Duty of Quality Annual Report for onward Trust Board approval.

Trust Integrated Quality & Safety Annual Report

The Committee received the Trust Integrated Quality & Safety Annual Report, which provided an overview of quality, safety and experience across the Trust during 2025/26. Discussion focused on opportunities to strengthen the presentation of organisational learning, benchmarking, quality intelligence and data reporting, together with the ongoing development of quality dashboards and improved triangulation of information to support assurance and decision-making. It was noted that data collection still required strengthening in order to reduce the reliance on manual processes.

The Committee **agreed the Level 4 Assurance rating**, recognising the progress made whilst noting the continued reliance on manual data processes and the need to further develop integrated quality intelligence and reporting arrangements.

The Committee ENDORSED the Trust Integrated Quality & Safety Annual Report for onward Trust Board approval.

Annual Equalities Report

The Committee received the Annual Equalities Report and noted improvements in workforce data quality, increased declaration rates across protected characteristics and the availability of three-year trend data. Discussion focused on persistent inequalities identified through workforce, staff survey and equality data, including experiences of bullying, harassment and discrimination. The importance of continuing to work to address these areas of concern was reinforced.

The Committee **agreed the Level 3 Assurance rating**, recognising positive progress whilst noting that a number of inequalities remain, and further work is required to achieve the pace of improvement expected.

The Committee **ENDORSED** the Annual Equalities Report for onward Trust Board approval.

Gender Pay Gap Annual Report

The Committee received the Gender Pay Gap Annual Report and noted continued improvement in the Trust's gender pay gap position. Discussion focused on the representation of women in more senior roles, the importance of understanding the underlying causes of the pay gap, and the use of workforce data to inform targeted action.

Members also discussed the value of considering both mean and median pay gap data, together with wider equality and workforce

intelligence, to support a more comprehensive understanding of inequality.

Members welcomed the ongoing work of the Women's Network and the continued focus on leadership development and workforce progression initiatives.

The Committee **agreed the Level 3 Assurance rating**, recognising positive progress, whilst noting that further work is required to address structural inequalities and improve representation in higher-paid roles, and **ENDORSED** the Gender Pay Gap Annual Report for onward Trust Board approval.

Welsh Language Annual Report

The Welsh Language Annual Report was received, with members noting strong compliance across the majority of Welsh Language Standards, together with progress in bilingual service delivery, workforce capability and Welsh language learning opportunities. Discussion focused on areas requiring further improvement, including clinical consultations, workforce planning and telephony services.

It was noted that the Independent Member lead for the Welsh Language had not had the opportunity to review and input into the report prior to its review by the Committee. It was therefore agreed that the report would be subject to Independent Member review, in addition to a further quality assurance review. It was proposed that following this, 'out of Committee' endorsement would be sought prior to submission to Trust Board.

Social Partnership Duty Annual Report

The Committee received the Social Partnership Duty Annual Report and noted progress in embedding social partnership principles within governance, workforce engagement and sustainability programmes across the Trust. Discussions highlighted the importance of meaningful engagement with Trade Union representatives, strengthening partnership working across services, and ensuring staff-side voices are involved early in organisational change and decision-making processes.

Members noted opportunities to further strengthen monitoring arrangements and demonstrate the impact of social partnership working. The Committee **agreed the Level 3 Assurance rating**, recognising good progress had been made, but acknowledging the need for greater consistency of approach and further development of

outcome measures. The Committee **ENDORSED** the Social Partnership Duty Annual Report for onward Trust Board approval.

Fire Safety, Estates, Health & Safety and Sustainability Annual Report

The Committee received the Fire Safety, Estates, Health & Safety and Sustainability (FRESH) Annual Report and noted continued progress across the portfolio, including strong compliance performance, positive audit outcomes, improvements in governance and oversight arrangements, and ongoing sustainability initiatives.

Discussion focused on the key risks associated with the ageing infrastructure, training compliance, climate change and the transition to the new Velindre Cancer Centre and future developments at Talbot Green. The Committee also discussed the differing levels of assurance across the portfolio, and the actions required to improve assurance in areas of fire safety and health and safety. Members also considered how future reporting could provide greater clarity regarding risk management and future assurance ambitions.

The Committee **APPROVED** the FRESH Annual Report and noted the following assurance ratings: **Fire Safety - Level 3; Estates - Level 4; Health & Safety - Level 3; Sustainability - Level 4.**

Wellbeing of Future Generations Annual Report

The Committee received the Wellbeing of Future Generations Annual Report, noting that the report provides an overarching summary of the Trust's contribution to the seven wellbeing goals and five ways of working.

Members discussed progress made in embedding the Act across the organisation, including developments in sustainability, prevention, community engagement and the use of newly established performance indicators to strengthen oversight and accountability. The Committee also highlighted the importance of ensuring that imagery used in public-facing reports accurately reflect the diversity of the communities served by the Trust.

The Committee **ENDORSED** the Wellbeing of Future Generations Annual Report for onward Trust Board approval.

Digital Services Annual Report

The Digital Services Annual Report was received. Members noted continued progress in delivering the Trust's digital strategy, including significant developments in digital infrastructure, cyber security, business systems and digital transformation programmes.

Discussion focused on the increasing demand placed upon digital services, national dependencies, workforce capacity and capability, and the importance of ensuring sufficient digital leadership and infrastructure to support organisational priorities and the transition to the new Velindre Cancer Centre.

The Committee recognised the work underway to strengthen prioritisation arrangements and address capacity challenges, whilst noting the ongoing risks associated with national digital programmes and supplier dependencies. The Committee **agreed the Level 3 Assurance rating** and **APPROVED** the Digital Services Annual Report.

Freedom of Information Requests Annual Report

The Committee received the Freedom of Information Requests Annual Report, and noted that compliance had been maintained above the Trust target despite a significant increase in the volume and complexity of requests received during the year. Members recognised the contribution of departmental leads in supporting performance and discussed opportunities to further improve efficiency through enhanced digital systems and data accessibility.

The strong level of compliance achieved and the effectiveness of arrangements in place to manage Freedom of Information requests across the organisation were noted. Following discussion, the Committee **agreed that a Level 5 Assurance rating was more appropriate than the proposed Level 4**, reflecting the positive outcomes being achieved whilst recognising further opportunities to enhance supporting systems and processes. The Committee **APPROVED** the Freedom of Information Requests Annual Report.

Medical Devices Annual Report

The Committee received the Medical Devices Annual Report and noted continued progress in strengthening medical devices governance, regulatory compliance and readiness for the new Velindre Cancer Centre. Members welcomed the implementation of the new asset management system, the appointment of a Medical Device Safety

	Officer and the progress being made in supporting equipment replacement planning, maintenance and regulatory oversight. Members discussed opportunities to further strengthen assurance arrangements through the development of a Medical Devices Assurance Dashboard, enhanced performance reporting and continued development of equipment replacement and obsolescence planning. The Committee recognised the significant progress made during the year and agreed the Level 3 Assurance rating, reflecting the maturity of arrangements currently in place and the further enhancements planned for 2026/27. The Medical Devices Annual Report was subsequently APPROVED. NHS Wales Shared Services Partnership Duty of Quality Annual Report The Committee received the NHS Wales Shared Services Partnership Duty of Quality Annual Report and welcomed the continued maturity of quality governance arrangements across Shared Services. Members noted progress in embedding quality within routine business management processes and the development of an overarching Quality Management System to support a range of non-clinical services delivered across NHS Wales. The Committee noted the Level 6 Assurance rating, reflecting the strong progress made in embedding the Duty of Quality. Members also discussed the importance of maintaining a consistent approach to assurance ratings across organisations whilst recognising the differing nature and maturity of services. The Committee NOTED the NHS Wales Shared Services Partnership Duty of Quality Annual Report.
INFORM	NHS Wales Shared Services Partnership Surgical Materials Testing Laboratory (SMTL) 2025/26 Briefing The Committee received the SMTL 2025/26 Briefing and noted the Laboratory's strong operational and financial performance during the year. Members were advised that SMTL had exceeded its key performance indicators, maintained high levels of customer satisfaction and successfully retained external accreditation following inspection, with no major findings identified. The Committee also noted SMTL's continued role in providing assurance through medical device and PPE testing, adverse incident investigations and technical research activity across NHS Wales. The Committee NOTED the SMTL 2025/26 Briefing.

	NHS Wales Shared Services Partnership Medical Examiner Service Annual Report The Committee received the Medical Examiner Service Annual Report and noted the continued maturity of the service following statutory implementation. Members were advised that over 28,000 deaths had been reviewed during the year, with improvements in timeliness and strong engagement with bereaved families. The Committee also noted the growing contribution of the service to patient safety, organisational learning, mortality surveillance and the identification of themes and trends across NHS Wales. Discussion highlighted the importance of ensuring learning arising from Medical Examiner reviews is effectively shared and translated into service improvements across the wider NHS. The Committee also noted workforce capacity and sustainability as areas which would require ongoing monitoring. The Committee NOTED the Medical Examiner Service Annual Report.
APPENDICES	N/A

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 9th July 2026.

TRUST BOARD	
Highlight report from the Chair of the Strategic Development Committee Public Session	
Date of meeting	30 July 2026
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not applicable
Prepared by	Tessa Harper-Hughes, Business Support Officer
PRESENTED BY	Lindsay Foyster, Committee Chair and Trust Vice Chair
EXECUTIVE SPONSOR APPROVED	Non Gwilym, Director of Corporate Governance (Interim), deputising for Carl James, Chief Executive Officer
REPORT PURPOSE	FOR NOTING

PURPOSE

- 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 7 July 2026.
- Key highlights from the meeting are reported below.
- Trust Board is requested to **NOTE** the contents of the report and the actions being taken.

HIGHLIGHT REPORT

ALERT / ESCALATE	No items were escalated for Trust Board action at this meeting.
ADVISE	Board Assurance Framework The Committee noted that further development of the Board Assurance Framework was required to strengthen its effectiveness as an assurance tool. Members highlighted the need for improved visibility of revised action dates, clearer rationale for risk scores and stronger linkage between strategic and operational risks. An updated staff-related BAF document, which had been presented to Executive Management Board but omitted from the Committee paper, will be circulated to members. Governance Transition and Committee Closure The Committee considered arrangements for the redistribution of SDC responsibilities under the Trust's revised committee structure. Members sought assurance that highlight reports, action logs and ongoing programme oversight would transfer appropriately and that no matters would be lost during transition.

	The Committee noted that the paper would be amended to make clear that future committee allocation would be determined through approved governance structures and Terms of Reference, with Executive Management Board providing recommendations where appropriate. Portfolio Reporting The Committee received the latest portfolio performance report and supported continued development of the portfolio reporting framework. Members requested further clarity on dashboard functionality, RAG rating methodology, data validation and the use of overridden ratings. A familiarisation session for Independent Members has been arranged.
ASSURE / INFORM	Welsh Blood Service Futures and Digital Programme Updates The Committee received updates on the Welsh Blood Service Futures Programme and the Digital Programme. Members noted progress with the Welsh Bone Marrow Donor Registry digital system, plasma fractionation work, service development discussions and the successful implementation of the RISP replacement programme. The Committee also noted that a number of digital initiatives had secured Welsh Government funding, while recognising continuing external dependencies linked to national digital programmes and DHCW delivery timescales. Service Preparedness and nVCC Scrutiny The Committee received the Public nVCC Project Scrutiny Sub-Committee Highlight Report and noted the continued focus on Service Preparedness, readiness planning, programme interdependencies and alignment with wider nVCC delivery milestones. Assurance was provided that operational and construction milestones were being brought together into a single programme view and that key risks would continue to be monitored through the appropriate governance routes. Action Log and Standard Business The Committee approved the minutes of the previous meeting and received updates to the Action Log, including actions to close, transfer into the new governance structure or continue through future reporting cycles.
APPENDICES	None

TRUST BOARD	
PUBLIC CHARITABLE FUNDS COMMITTEE HIGHLIGHT REPORT	
DATE OF MEETING	30 th July 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	Lindsay Foyster, Vice Chair
EXECUTIVE SPONSOR APPROVED	Non Gwilym, Interim Director of Corporate Governance
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 4th June 2026.

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 4th June 2026:

ALERT / ESCALATE	NONE
ADVISE	CFC004 Charitable Funds Investment Policy The Committee discussed and confirmed that all requested amendments were included, and no further concerns were raised by members.

	The policy was APPROVED by the Committee.
ASSURE	nVCC Readiness Financial Plan – Resource Requirements The Committee was asked to approve up to £2 million from the Charity to support nVCC readiness resource requirements over the next 18+ months, covering both employment and procurement of professional services needed for the new hospital transition. Funding sources include ring-fenced Charity funds (from reduced charges over previous years), capital underspend from nVCC procurement, and non-recurrent reserves. Welsh Government has verbally approved the capital funding switch, with high assurance of formal approval. The plan is a one-off investment, not ongoing support for core NHS services, with a clear exit strategy and alignment to charitable objectives. Legal advice has been sought to ensure compliance, and the Committee confirmed the distinction between Charity-funded enhancements and NHS core services. Risks include workforce recruitment challenges and potential reliance on agency/procurement, which may increase costs but allow faster onboarding. The maximum spend is £2 million, but actual expenditure may be less depending on recruitment outcomes. The Committee APPROVED the funding, noting the importance of pace, resource management, and strategic alignment.
INFORM	NONE

3. RECOMMENDATION

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

TRUST BOARD	
HIGHLIGHT REPORT FROM THE CHAIR OF THE LOCAL PARTNERSHIP FORUM	
DATE OF MEETING	30 July 2026
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Kay Barrow, Corporate Governance Manager
PRESENTED BY	Sarah Jenkins, Executive Director of People and Organisational Development (Interim)
EXECUTIVE SPONSOR APPROVED	Sarah Jenkins, Executive Director of People and Organisational Development (Interim)
REPORT PURPOSE	FOR NOTING
ACRONYMS	
LPF	Local Partnership Forum
SLT	Senior Leadership Team
VCS	Velindre Cancer Service
WBS	Welsh Blood Service

1. PURPOSE

- 1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the Local Partnership Forum held on 2 June 2026.
- 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 are no items to Alert / Escalate to Trust Board.
ADVISE	There are no items to Advise to Trust Board.
ASSURE	Workforce Performance The Forum received assurance that overall workforce metrics remain broadly positive, with sickness absence reducing overall, long-term absence declining, and mandatory training and PADR compliance remaining high. Concern was raised by trade union representatives about potential inconsistency in management approach for flexible working and the need for further training/cultural shift. Limited data is currently available, particularly on rejected or verbally declined requests. The importance of capturing more robust data e.g. requests versus approvals, processing times, informal refusals was emphasised. Further work will be undertaken to explore the data capture of flexible working requests. Assurance was provided that the Health Care Support Worker (HCSW) Band 2/3 transition has been implemented in line with the All-Wales framework, with collaborative working across Workforce, Finance and staff-side colleagues; payment has been deferred to July 2026 to ensure accuracy and avoid overpayments. Although there were some outstanding concerns regarding whether some Welsh Blood Service roles fall within scope of the All-Wales framework. Further review and staff communication will be undertaken to provide further assurance. Neutral Assessment An overview was provided of the independent neutral assessment, commissioned in response to anonymous concerns regarding culture and organisational change. It was emphasised that the review was a listening exercise not an investigation, capturing staff perceptions rather than establishing factual findings. The process was independent, anonymised, and voluntary, with feedback shared directly with staff and an opportunity for open dialogue with executive leadership. The assessment identified both positive aspects i.e. committed staff, strong relationships, patient focus, and areas of concern i.e. culture,



	leadership behaviours, communication and working practices. Delivery of the recommendations will be taken forward through ongoing cultural and workforce programmes connected to our staff survey plans. LPF will be updated as the key forum for ongoing partnership working and oversight of the cultural improvement activity. Cultural Baseline An overview was provided of the cultural baseline work, drawing on multiple data sources including staff survey results, exit interviews and wider workforce insight to understand current organisational culture. The cultural baseline work indicated that, while staff survey results remain above benchmark and demonstrate a generally healthy culture, improvement work is continuing with strong partnership working and emphasis on psychological safety, speaking up and leadership behaviours. Workforce Risks A high-level overview of the strategic and operational risks was provided, noting that risks are managed across both corporate and service levels. Queries were raised about whether the current risk scoring accurately reflected priority workforce pressures, with concerns that some areas may not represent the most significant risks. There was agreement to review and refresh the workforce risks to ensure alignment with current pressures and service intelligence. The Blood Donation Services OCP was reported as concluded with a positive overall outcome, with a lessons learned report being finalised to support future organisational change processes and will be presented to the Forum at its next meeting.
INFORM	The Forum received a high-level overview of the NHS Wales Financial Position noting a worsening context across NHS Wales which is increasingly constrained, reinforcing the importance of organisational awareness and planning within this environment. Terms of Reference Review and Revised Meeting Approach and Format A review of the Terms of Reference will be undertaken which will align with a proposed refreshed approach to LPF meetings to strengthen effectiveness, with greater use of standardised reporting, discussion by exception, and a more purposeful, discussion-led agenda. This will



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	include a section to bring forward staff-side priorities, alongside stronger partnership working to ensure the Forum operates as a genuinely collaborative mechanism rather than solely a reporting forum. A joint piece of work between management and staff-side representatives will now be taken forward to develop the revised format and agenda.
APPENDICES	None



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TRUST BOARD	
ASSURANCE REPORT NHS WALES SHARED SERVICES PARTNERSHIP COMMITTEE (SSPC)	
DATE OF MEETING	30 July 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	Roxann Davies, NWSSP Corporate Services Manager and James Quance, NWSSP Assistant Director of Corporate Services
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 May and the extraordinary meeting convened on 25 June 2026.
RECOMMENDATION / ACTIONS	The Trust Board is asked to NOTE the contents of the Assurance Report.
GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	Date
SSPC Committee Members (by email)	10/07/2026
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS As above	
7 LEVELS OF ASSURANCE	
Not applicable	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Select Current Level of Assurance Not applicable

APPENDICES	
0.	Not applicable

SHARED SERVICES PARTNERSHIP COMMITTEE ASSURANCE REPORT MEETING OF 14 MAY 2026 AND EXTRAORDINARY MEETING OF 25 JUNE 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 May 2026 and the extraordinary meeting convened on 25 June 2026, for **NOTING**.

2. BACKGROUND

A summary of the business matters discussed at the last Shared Services Partnership Committee meeting, is outlined below.

3. SUMMARY OF MATTERS FOR CONSIDERATION

Reporting Committee	Shared Services Partnership Committee
Chaired by	Huw Thomas, Executive Director of Finance at Hywel Dda University Health Board and Vice Chair of SSPC (14 May 2026) and Professor Tracy Myhill OBE, NWSSP Chair (25 June 2025)
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 May 2026
Summary of key matters including achievements and progress considered by the Committee and any related decisions made	
Managing Director's Update Report - The Managing Director presented a comprehensive update on key developments across NWSSP since the previous meeting, highlighting continued organisational maturity and impact as the organisation marked its 15-year anniversary, with sustained delivery of value, innovation and partnership across NHS Wales. Governance and accountability arrangements remain under development through the Implementation Group, supported by ongoing engagement, alongside positive external visibility following the Chief Executive's visit to IP5. A balanced financial position was confirmed (subject to audit), including delivery of the £6m savings requirement to NHS Wales and Welsh Government, alongside full utilisation of capital funding to support strategic infrastructure, digital, estates, decarbonisation and resilience priorities. Ongoing focus on the Welsh Risk Pool was noted, supported by Welsh Government investment, with further work required to address emerging reimbursement pressures.	

An update was provided in relation to development of key national programmes including Transforming Access to Medicines (TrAMS) and the Future Workforce Solution. While positive progress was noted in TrAMS, including advancements across regional hub developments and digital solutions, risks remain in relation to organisational approvals and Welsh Government sign-off, with potential delays linked to the formation of the new government. The Future Workforce Solution programme continues at pace but is impacted by external dependencies, including delays in documentation and outstanding clarity on system functionality.

Reasonable assurance was reported for the Single Lead Employer model following internal audit, with improvement required in specific operational areas, particularly sickness management processes, which the Committee noted as a shared responsibility. Significant risks associated with Resident Doctors' contract reform were highlighted, including operational, financial and compliance implications, with further detailed scrutiny provided to the Committee in the deep dive presentation.

The overarching report provided the Committee with updates across a broad portfolio, including Transforming Access to Medicines (TrAMS), Radiopharmacy and the Hub Programme; the NHS Wales Influenza Vaccination Programme; Primary Care Services; Laundry Services; decarbonisation and adaptation activity; engagement and leadership activity; and awards and recognition.

In addition, the Committee was advised of the most recent developments in relation to senior appointments, including the appointment of Dr Martin Edwards as Medical Director, following the retirement of Dr Ruth Alcolado in March 2026; ongoing recruitment to the Deputy Medical Director role; and progress in the Chair's recruitment process, with interviews scheduled for 15 June 2026. Confirmation is awaited regarding Tracy Myhill OBE remaining in post until 30 June 2026.

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

Deep Dive Presentations

Implementation of the Resident Doctor Contract Reform - The Committee received a detailed presentation on the implementation of the Resident Doctor contract reform, noting progress across a range of workstreams in line with a challenging timetable for the August 2026 go-live date. This included advancements in system development, contractual negotiations, policy development and organisational engagement. It was noted that the majority of contractual terms have been agreed with the British Medical Association (BMA), with final documentation nearing publication, and that associated policies are progressing through governance arrangements. The e-rostering system remains a key dependency, with revised timelines and interim arrangements in place to mitigate risks and support ongoing delivery. Variability in organisational readiness was recognised, alongside continued work to ensure compliance with rota requirements and to evidence workforce needs.

Key risks were highlighted in relation to workforce capacity, financial implications and the requirement for additional staffing to accommodate reduced working hours under the new contract. Mitigating actions, including enhanced workforce planning, bank usage and continued scrutiny of additionality requirements, were noted. The Committee was advised that programme governance arrangements are robust, supported by an active risk register and clear escalation processes.

Further assurance was provided through evidence of improved engagement across organisations, positive recruitment fill rates and progress in system solutions to support transition. Committee

Members raised a number of queries relating to governance coverage, readiness assurance, benefits realisation, rota impact assessment and workforce additionality. It was confirmed that readiness is being monitored through structured processes and regular reporting, with post-implementation evaluation planned to assess outcomes and inform future phases.

Radiopharmacy at IP5 - The Committee received a presentation on the development of the new Radiopharmacy facility at IP5, noting significant progress and the successful completion and handover of the purpose-built facility in April. Commissioning is currently underway, with the programme progressing through a structured internal qualification phase to ensure that the facility, equipment, processes and workforce meet all required regulatory and operational standards. The specialised nature of Radiopharmacy services was acknowledged, including the complexity of manufacturing short shelf-life medicines and the requirement for robust quality assurance, safety and distribution processes. The comprehensive design of the facility, incorporating clean room environments, specialist equipment and controlled workflows aligned to stringent regulatory requirements was recognised.

The complex regulatory landscape was highlighted, with oversight from multiple bodies, and the need to ensure full compliance across environmental, staff safety and medicines regulation standards including updates to various licenses. The qualification process includes detailed testing and validation prior to progression to operational use. Plans for service implementation remain on-track for summer 2026, with a phased approach to go-live. Initial service delivery will be limited to Aneurin Bevan University Health Board to support workforce training and operational readiness, before scaling to a broader all-Wales service. Arrangements to maintain continuity of supply during transition, including collaboration with Swansea Bay University Health Board, were also noted.

Additionally, the Committee observed the virtual tour of the facility, providing assurance regarding the infrastructure, layout and technical capabilities supporting delivery.

The Committee **NOTED** the updates provided in relation to the implementation of the Resident Doctor Contract Reform and Radiopharmacy at IP5.

Items for Approval

NWSSP Performance Management Framework – The Committee **DISCUSSED** and **APPROVED** the application of the Performance Management Framework as set out in the paper and **NOTED** that elements may be subject to change pending revisions to Welsh Government accountability arrangements. The Committee was assured that arrangements are established and operating as intended, supported by regular and comprehensive performance reporting. The Framework provides clear oversight, aligned reporting and ongoing engagement with NHS Wales organisations, underpinned by defined governance principles and accountability through the Managing Director, as Accountable Officer.

NWSSP Duty of Quality Annual Report 2025–26 - The Committee **APPROVED** the NWSSP Duty of Quality Annual Report 2025–26, noting continued maturity in the organisation's approach to quality, with strengthened governance, enhanced visibility and a clear focus on delivering measurable outcomes across NHS Wales. The proportionate, system-wide approach to quality management was recognised, alongside ongoing development of an overarching quality management system to support continuous improvement.

Items for Noting
Chair's Appointment - The Committee NOTED the update regarding the Chair's appointment process, including progress and confirmation of interviews scheduled for 15 June 2026, with final shortlisting feedback awaited and interim arrangements in place, with the current Chair agreeing to remain in post to ensure continuity.
Finance, Performance, People, Programme and Governance Updates
Finance Report – The Committee noted the draft financial position for 2025/26, subject to audit, confirming the revenue position closed broadly in line with forecast, achieving a small surplus of £9k. Savings of £6.7m were delivered, including £0.7m applied to the National Insurance funding shortfall, with the remaining £6m returned to partners. Capital expenditure of £11.7m was achieved and delivery of key capital investments was noted, including Radiopharmacy developments and estates decarbonisation schemes, such as solar panels, electric vehicle infrastructure and hot water reclamation. The Welsh Risk Pool outturn of £192m was reported in line with forecast, supported by Welsh Government funding and Risk Share Agreement contributions, with continued growth in liabilities highlighted, including a £246m increase in provisions to £1.957bn and contingent liabilities rising to £1.2bn. Committee Members acknowledged the achievement of a balanced position while noting the scale of Welsh Risk Pool liabilities as a significant system pressure. People and Organisational Development (POD) Report – The Committee noted the updated reporting format and the latest workforce position, with sickness absence remaining broadly stable, albeit above target in some areas, and turnover slightly above the NHS Wales average but trending downward and aligned with comparable organisations. Strong performance was noted in key areas, including PADR compliance at 85.62%, and time to hire remaining well within target, at approximately 55 days. Continued progress was reported across learning uptake, corporate induction improvements and workforce planning, supported by enhanced data and improved leavers' feedback, through increased response rates. It was confirmed that areas requiring improvement have been escalated to divisional Senior Management Teams, for action. Performance Information Report – The Committee noted overall performance against key performance indicators for the period December 2025 to March 2026, with strong performance reported and ongoing engagement with organisations through quarterly reporting arrangements. It was highlighted that this represents the final year of reporting in the current format ahead of revised strategic objectives for 2026/27. Three indicators were reported as amber, including Audit and Assurance turnaround performance, impacted by delays in management responses, and customer satisfaction measures within Digital Workforce Solutions and Central Team e-Business Services, with contributory factors including system migration issues, staffing pressures and challenging scoring thresholds. Mitigations were noted as in place, with continued focus on partnership working and benchmarking to support improvement. Outcome Measures Report – The Committee noted performance against outcome measures aligned to NWSSP's strategic objectives, with enhancements to reporting including increased use of statistical process control and expanded operational and customer metrics. Strong performance was reported across most service areas, with customer satisfaction targets achieved, as noted above. Increased operational activity was highlighted, including call volumes of approximately 17,000, meeting performance targets. Workforce indicators remained stable, with turnover aligned to sector

benchmarks, and value measures demonstrated continued contribution to the foundational economy, with 44% of spend with Welsh suppliers. The inclusion of 'Voice of the Customer' appendix provided assurance through a summary of individual customer conversations, demonstrating that urgent matters are addressed promptly while highlighting key themes emerging from customer feedback.

Transformation Management Office (TMO) Update Report – The Committee noted the update on the TMO portfolio, including a refined approach to benefits realisation to strengthen reporting of value and impact. The portfolio currently comprises 17 projects, 2 programmes and 6 service improvement initiatives, with the majority of activity aligned to All Wales priorities. Generally positive delivery was reported, with key updates including completion of the TrAMS Radiopharmacy project and transition to post-project evaluation, improved progress within the Welsh General Ophthalmic Services (WGOS) contract reform programme, and ongoing delays to the Legal and Risk case management system, due to technical stabilisation issues. Assurance was provided that risks and mitigations are actively managed and that overall delivery remains within expected parameters.

Draft NWSSP Annual Governance Statement (AGS) 2025–26 – The Committee noted the draft publication, recognising its importance within the organisation's assurance framework and its role in providing transparency to the Committee, Velindre University NHS Trust (as host) and wider stakeholders. The AGS reflects governance, risk management and internal control arrangements, including consideration of the Welsh Government-commissioned Independent Review of Accountability & Governance and a balanced assessment of strengths and areas for development. Committee Members were invited to provide further comments ahead of finalisation and approval, at NWSSP Audit Committee on 15 June 2026.

NWSSP Corporate Risk Register – The Committee noted the current position within a dynamic operating environment, with 17 risks for action identified including six rated red and 11 amber. Key red-rated risks relate to cyber security, pharmaceutical supply, delivery of Radiopharmacy and TrAMS developments, financial and workforce pressures, the Future Workforce Solution and Welsh Risk Pool forecasting. It was noted that certain risks are being maintained within risk appetite where full mitigation is not achievable, with ongoing monitoring and management actions in place. Assurance was provided that Committee business is aligned to the NWSSP Corporate Risk Register, supporting focused scrutiny and forward planning, with further detailed consideration of cyber security risks scheduled for a future meeting.

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

Items for Information

The Committee received the following items for information:

- Finance Monitoring Returns (Month 12 of 2025-26)
- Personal Protective Equipment (PPE) Report
- Audit Wales Audit Assurance Arrangements for NWSSP 2025-26
- NWSSP Internal Audit Plan, Mandate and Charter 2026-27
- NWSSP Counter Fraud Plan 2026-27
- SSPC Forward Plan 2026-27

Part B - Private	
The Committee NOTED and ENDORSED the proposed approach as set out in the Welsh Risk Pool Update.	
Extraordinary (Private) Meeting of the SSPC Held on 25 June 2026	
At its extraordinary meeting on 25 June 2026, the Committee (SSPC) NOTED that the appointment process for the new Chair had been undertaken in accordance with the SSPC Standing Orders and APPROVED the recommendation of the appointment panel chaired by an Independent Assessor appointed by Welsh Government.	
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 Meeting	Thursday 16 July 2026 at 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	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). Not applicable as this is an Assurance Report from the SSPC meeting.
QUALITY IMPACT ASSESSMENT <i>The duty of quality requires quality-driven decision-making for all strategic decisions. The duty of quality is operationalised through the Health and Care Quality Standards. Therefore, when making decisions about healthcare services, NHS organisations are required to consider the impact of that decision on the Health and Care Quality Standards.</i>	Not required - not a strategic decision 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. Not applicable as this is an Assurance Report from the SSPC meeting.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: For more information: https://www.gov.wales/socio-economic-duty-overview	Not required Not applicable as this is an Assurance Report from the SSPC meeting. 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.
	This section is not applicable as this paper relates to the SSPC Assurance 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://nhs.wales365.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 Not applicable

5. RISKS

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
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	30 July 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 28 April 2026.
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 28 April 2026.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	Date
Formal Senior Leadership Group (FSLG)	23/07/2026
Shared Services Partnership Committee (SSPC)	16/07/2026
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
As per above	
7 LEVELS OF ASSURANCE	
Not applicable	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Select Current Level of Assurance
	Not Applicable
APPENDICES	
0.	Not applicable

NWSSP AUDIT COMMITTEE HIGHLIGHT REPORT – 28 APRIL 2026

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 28 April 2026, 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 matters delegated through the Trust and NWSSP Standing Orders. A summary of the business considered at the meeting held on 28 April 2026 is outlined below.

3. SUMMARY OF MATTERS FOR CONSIDERATION

ALERT / ESCALATE	There were no matters for alert/escalation to the Board.
ADVISE	The Committee noted continued progress with the Transforming Access to Medicines Services (TrAMS) programme, including Radiopharmacy readiness and hub development. Delivery remains subject to MHRA approval and Welsh Government business case approvals, with implementation likely to be early 2028 at the earliest.

ASSURE	Update from NWSSP Managing Director The Managing Director provided members with a comprehensive update on significant developments within NWSSP, as summarised below: • Further to the WG Review of NWSSP Accountability and Governance, a Working Group has been established to implement the recommendations, with a programme of meetings currently being developed. • Following the resignation of Tracy Myhill as NWSSP Chair, the process to appoint a successor has commenced. • Following a robust recruitment process, Dr Martin Edwards has been appointed as NWSSP Medical Director, succeeding Dr Ruth Alcolado. Laura-Jayne Keating has also been appointed as Director of Pharmacy Technical Services, following the retirement of Colin Powell. • NWSSP achieved a break-even position for the 2025–26 financial year, with a £9k surplus and £6m savings returned to NHS Wales organisations and WG. • The NWSSP Integrated Medium Term Plan has been submitted to WG, with the outcome awaited. • The Welsh Risk Pool (WRP) remains the most significant financial pressure. Work remains ongoing with WG and partners to strengthen forecasting and assurance, with WG agreeing to provide additional funding to organisations presenting a balanced financial plan. • Preparatory work for the 2026–27 influenza vaccination programme is underway. • Winter planning arrangements within the Medical Examiner Service were effective, with lessons learned being embedded. It was noted that the relatively new service has demonstrated significant improvement.
ASSURE	Audit Wales Update Audit Wales provided an update on progress, noting that the audit of Velindre University NHS Trust (VUNHST) accounts was underway. It was also noted that the NWSSP Remuneration Report would be incorporated into the VUNHST Annual Report for the first time.
ASSURE	2025-26 NWSSP Audit Assurance Arrangements Audit Wales presented the report outlining the assurance work undertaken in support of the core functions delivered by NWSSP on behalf of NHS Wales organisations. This work offers assurance to the relevant audit teams and underpins the audit of the 2025-26 financial statements. Planned work remained consistent with the previous year, with the addition of the Case Management System (CMS) for the Welsh Risk Pool, which replaced the Quantum system in April 2025. The transition was completed successfully, with no issues identified. Any matters arising from the audit work will be reported in the Management Letter later in the year.

ASSURE	Internal Audit Progress Report The Head of Internal Audit provided an update on progress against the 2025–26 Internal Audit Plan, confirming that three reports had been finalised during the period and were included on the agenda. It was noted that several further reports were in progress and expected to be completed by 31 May 2026. These will be presented at the NWSSP Extraordinary Audit Committee meeting scheduled for 15 June 2026.
ASSURE	Internal Audit Reports The Committee received Internal Audit reports and was provided with assurance that key systems and controls operate effectively, with Substantial and Reasonable assurance ratings across all reviews. Progress against the actions identified will be monitored via the NWSSP Agreed Management Action Tracker. • Payroll Services: The audit evaluated the design and operation of systems and controls within Payroll Services and received Substantial Assurance, with one medium-priority finding identified. • Single Lead Employer (SLE): The audit assessed compliance with a range of policies and procedures and received Reasonable Assurance, with one high-priority finding identified for action. • Digital Strategy: The audit reviewed the implementation of the Digital Strategy and received Reasonable Assurance, with four medium-priority findings identified for action.
ASSURE	Internal Audit Plan and Charter 2026–27 The Head of Internal Audit presented the draft Internal Audit Plan, Charter and Mandate for 2026–27 developed in line with the relevant Internal Auditing Standards and taking account of the implications of the NWSSP Governance and Assurance Review. The draft Audit Plan was reviewed and endorsed by the Senior Leadership Group in April 2026. Progress against the Plan, together with any proposed amendments, will be monitored and reported throughout the year. The NWSSP Audit Committee APPROVED the 2026–27 Internal Audit Plan, Charter and Mandate.
ASSURE	Counter Fraud Progress Report The Committee received the Q4 Counter Fraud progress update from NWSSP's Local Counter Fraud Manager, providing an overview of activity to date, which included: • A total of 42 days were recorded during the quarter, contributing to 115.5 days for the year. Reactive work totalled 16.75 days during the quarter, bringing the year-to-date total to 95.5 days. Overall activity amounted to 211 days, exceeding the 210 days outlined in the workplan, primarily due

	to collaborative work with Swansea Bay University Health Board in respect of risk assessments. • Eight fraud awareness sessions were delivered, reaching 266 staff. In addition, a further 58 staff completed the Fraud Awareness e-learning module, resulting in a total of 579 staff reached during the period. • Several alerts were received from the Counter Fraud Authority regarding corporate impersonation, with the potential for NHS email addresses to be compromised.
ASSURE	Counter Fraud Annual Plan 2026-27 The 2026–27 Annual Counter Fraud Plan was presented to the Committee for approval. The Plan has been developed in alignment with the Cabinet Office Standards for Counter Fraud Arrangements. It was noted that the 2026–27 work plan would be subject to ongoing review throughout the year, with its effectiveness evaluated and reported in the year-end Annual Report to the Audit Committee. The NWSSP Audit Committee APPROVED the Draft Counter Fraud Annual Plan 2026–27.
ASSURE	Governance Matters The Governance Matters report detailed contracting activity for the last quarter. There was one occasion where a contract award was not progressed in accordance with the Standing Orders and Scheme of Delegation. There were 50 contracts let by NWSSP and 24 further contracts let on an All-Wales basis for NHS Wales. Two declarations had been made in relation to gifts, hospitality or sponsorship since the last meeting, and no internal audit reports were concluded as Limited or No Assurance. Of 123 audit recommendations, 115 had been implemented, 6 were not yet due and 2 were overdue. The overdue recommendations are dependent on a third-party organisation for full implementation. Requests to extend the target dates were approved by the NWSSP Audit Committee. The NWSSP Corporate Risk Register contains 6 red risks and 11 amber risks for action. Overall, the Committee was assured of robust governance, control, and risk management arrangements across NWSSP.
ASSURE	Losses and Special Payments Paper The Manual Accounts stipulate that: <i>'NHS Wales health bodies do not have unlimited powers to make special payments or to write-off losses. They must obtain the written approval of the</i>

	<i>Welsh Government H&SSG Finance Director before writing-off a loss or making, or undertaking to make, any special payment that exceeds their delegated limit.'</i> <i>Annex 4 to Chapter 6 sets out the delegated limits above which Health bodies need to obtain WG approval for the write off of the loss. The delegated limit is £50,000.</i> The Deputy Director of Finance and Corporate Services presented the Losses and Special Payments report for 2025–26, noting a 35% reduction in losses compared with the previous year. The report included Single Lead Employer losses, which are recharged to Health Boards. The reported loss was £906k gross, or £615k net. The value of stock at 31 March 2026 was £25.713m and the value of stock issues from 1 April 2025 to 31 March 2026 was £54.427m. Losses related to slow moving, obsolescent stock and special payments. Assurance was received regarding compliance with Welsh Government approval requirements.
ASSURE	NWSSP Annual Reporting Timeline The Assistant Director of Corporate Services presented the annual reporting timeline for approval of the NWSSP Annual Governance Statement (AGS), Head of Internal Audit Opinion and Annual Report 2025–26. A proposal was put forward to convene an Extraordinary Audit Committee meeting on 15 June 2026 to facilitate approval of these items in line with Velindre University NHS Trust reporting timelines; this was agreed.
INFORM	The following item was received for information: NWSSP Audit Committee Forward Plan 2026-27.

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	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 Not applicable as this is a Highlight Report from the NWSSP Committee meeting.
QUALITY IMPACT ASSESSMENT <i>The duty of quality requires quality-driven decision-making for all strategic decisions. The duty of quality is operationalised through the Heath and Care Quality Standards. Therefore, when making decisions about healthcare services, NHS organisations are required to consider the impact of that decision on the Health and Care Quality Standards.</i>	Choose an item 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	Choose an item Not applicable as this is a Highlight Report from the NWSSP Committee meeting.
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.
	This section is not applicable as this paper relates to the NWSSP Audit Committee Highlight 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://nhs.wales365.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

5. RISKS

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	

Joint Commissioning Committee

Highlight Report from the Joint Commissioning Committee

Dyddiad y Cyfarfod / Date of Meeting	26/05/2026
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Gareth Mitchell, Corporate Governance Manager, NWJCC
Cyflwynydd yr Adroddiad / Report Presenter	Juliet Brown, Chief Commissioner, NWJCC
Noddwr yr Adroddiad / Report Sponsor	Juliet Brown, Chief Commissioner, NWJCC

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
		Choose an item.

1. SITUATION / BACKGROUND

This report had been prepared to provide Health Board (HB) Chief Executive Officer Members of the Joint Commissioning Committee (JC) with a summary of the key issues considered at its public meeting on 26 May 2026.

Key highlights from the meeting are reported in Section 2.

2. HIGHLIGHT REPORT

(Links to reports highlighted [May 2026 - NHS Wales Joint Commissioning Committee](#)).

Status	Update
Alert / Escalate	- The Chair's Report noted the need to undertake a Chair's Action on 30 March 2026 following discussions at the Extraordinary Meeting of the JC held on 23 March 2026. Following the meeting, a majority of JC Members approved the following wording to approve the NWJCC Annual Plan (2026-27): The NHS Wales Joint Commissioning Committee resolved to: <i>APPROVE the 2026/27 plan subject to the requirement for the JCC to work collaboratively with Local Health Boards to urgently develop the 2026/27 priorities to maximise cost improvement efficiencies and savings to improve the additional financial requirement of £16.2m in year</i> This was reported at May's JC for consideration and ratification. - It was reported that there was currently only one Health Board (HB) CEO member of the Quality, Safety and Outcomes Sub-Committee with the need for another to ensure continuity of attendance at each meeting.
Advise	The Chief Commissioner's Report incorporated Director of Commissioning Reports to highlight performance and quality issues that had arisen since updates shared at Sub-Committee meetings in April 2026. These updates included: - o Women and Children's Services Neonatal assurance meetings continue across providers, with the next cycle of engagement underway. These provide ongoing oversight of staffing, quality and safety, alongside supporting continued improvement following recent independent reviews. Workforce constraints within paediatric radiology at Cardiff and Vale University Health Board present a risk to sustaining a 24/7 service, with mitigation arrangements in place including locum cover and remote specialist support where required. Paediatric neurology services continue to experience capacity challenges, including reduced provision at Alder Hey Hospital and workforce changes within Wales, impacting access and equity of specialised services for patients. Mitigation actions were being progressed in partnership with health boards. - o Ambulance Patient Handover Ambulance handover performance remains a significant area of system pressure. While improvement was demonstrated following renewed national focus on the 45-minute standard, performance remains variable across Wales with a total of 16,468 lost hours in March 2026. Whilst there has been some improvement, handover delays remain significantly above levels of commissioned activity. The root cause is predominantly system driven, linked to emergency department/hospital capacity, patient flow and discharge delays across HBs. Phase 2 of the Ambulance Performance Framework

Status	Update
	has further evidenced the direct correlation between hospital handover delays and lower ambulance response times in the community, indicating that this issue cannot be resolved by the provider or commissioner alone. o Review of Adult Gender Incongruence Services The NWJCC is undertaking a comprehensive review of adult gender services in NHS Wales to ensure commissioned provision is efficient, effective and delivers high-quality care aligned to current evidence and system requirements. NWJCC commissions the gender care pathway for Welsh patients, including assessment, referral and ongoing care via the Welsh Gender Service, and access to surgery through NHSE via cross-border arrangements, but does not directly commission or provide surgery itself. NHSE commissions all gender surgery services, including the surgical pathway and provider contracts. The review of the Welsh Gender Service commenced in Q1, with scoping, methodology and stakeholder engagement progressing through Q2, followed by detailed assessment of demand, capacity, quality, cost and pathway effectiveness. This work is being undertaken in the context of increasing demand and emerging findings from the parallel NHSE national review. There is a clear opportunity to align the Welsh Gender Service review with NHSE methodologies, data frameworks and emerging service specifications to ensure consistency, comparability and futureproofing across systems. The review will focus on adult non-surgical services, with consideration of pathway interfaces, and will engage key stakeholders across HBs and partner organisations. Initial findings are expected in Q3/4, with a report and recommendations to the JC thereafter. The NWJCC Annual Plan Delivery - Strategic Priority and Deep Dive Specifications Report was received along with nine scoping documents that provided a consistent and proportionate overview of each strategic priority area, each of which was approved by the JC. It was noted that the information captured through the scoping documents would support the development of more aligned and consistent reporting, monitoring and oversight arrangements across the strategic priority portfolio during 2026/27. A report on Clinical Support Hubs and NHS 111 Digital Front End was received. Members approved Option 2: allocation of funding and commissioning responsibility of the Clinical Support Hubs to the NWJCC. This was an interim measure and aligned to discussions at the NHS Wales Leadership Board. Further work would be undertaken regarding longer term arrangements.

Status	Update
	The provision of the recurrent ring-fenced allocation for the development of the NHS 111 digital platform had also been granted to the NWJCC. This will allow the NWJCC to support, more strategically, the digital front end of the NHS 111 service.
Assure	The Committee received the following Sub-Committee assurance reports: - Quality, Safety and Outcomes Sub-Committee - Planning, Performance and Finance Sub-Committee - CTMUHB Audit and Risk Committee The NWJCC Organisational Risk Register as of 31 March 2026 was received and approved. There were 14 risks with a score of 15 or above as of 31st March 2026. The Corporate Governance Report included updates on Welsh Health Circulars, the NWJCC Internal Audit Programme and the ongoing review of hosting arrangements between the NWJCC and CTMUHB. The JC approved the Annual Governance Statement and endorsed the updated NWJCC Standing Orders, Standing Financial Instructions and the Guidance on the Handling of Interests, which are scheduled to be approved by all Health Boards.
Inform	The Chair's Report summarised the JC Strategy Session held on 14 April 2026, including key planning principles for the delivery of the NWJCC plan, assurance regarding key milestones and shared definitions of each priority area and roles and responsibilities. The Chief Commissioner's Report included updates on: - o WAST Performance Indicators - Welsh Government (WG) feedback on the Annual Plan was positive and included a request for further information on WAST Performance indicators. - o CAR-T Service - Ongoing conversations in relation to surge capacity for CAR-T with alternative centres secured including Bristol, Birmingham and London. - o NEPTS Eligibility - Llais asked for consultation on any potential changes to NEPTS eligibility. - o St Andrews - NHS England was currently looking at alternative providers for patients with plans being developed for St Andrews to retain some capacity. This will not affect Welsh patients. A June deadline had been given for removing Welsh patients from the site. - o Hereditary Anaemia Service - A business case for the Hereditary Anaemia service was being developed by Cardiff and Vale University Health Board to improve workforce resilience, there was no timeline currently scheduled for completion. - o Collaborative Commissioning Leadership Group – the meeting held on 21 April 2026 considered close-out of the NWJCC Foundation Plan 2025-26, delivery arrangements for the NWJCC

Status	Update
	Annual Plan for 2026-27 and also endorsed the findings and next steps for the NWJCC referral management review across the seven HBs. The Committee received the Month 12 Finance Report 25/26, Month 01 Finance Report 26/27 and the Operational Performance Report o It was agreed that granularity of the Month 2 Finance report be enhanced for scrutiny at the next Planning, Performance and Finance (PPF) Sub-Committee and July's JC meeting.
Appendices	None.

3. ASSESSMENT

Objectives / Strategy	
Dolen i Amcan (au) Strategol CBC Link to JCC Strategic Objectives(s)	Maximise Value
	Ensure Quality; Reduce Duplication; Improve Equity & Population Health; Facilitate Integration
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	A Resilient Wales
	A Healthier Wales
Dolen i Hwyluswyr Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality (Duty of Quality Statutory Guidance (gov.wales))	Leadership
	Culture and Valuing People; Learning, Improvement and Research; Whole-systems Perspective
Dolen i Feysydd Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality (Duty of Quality Statutory Guidance (gov.wales))	Effective
	Efficient; Equitable; Person-centred; Timely; Safe
Effaith Amgylcheddol / Cynaliadwyedd (5R) / Environmental / Sustainability Impact (5Rs)	No - Not Applicable

Impact Assessment

Ansawdd Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / Quality Have you undertaken a Quality Impact Assessment Screening?	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: This is a summary of the latest meeting of the JCC
Cydraddoldeb Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? / Equality Have you undertaken an Equality Impact Assessment Screening?	Yes: ☒	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please include rationale below: This is a summary of the latest meeting of the JCC
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Joint Committee as a result of the activity outlined in this report.	
Effaith Adnoddau (Pobl /Ariannol) / Resource Impact (People / Financial)	Yes (Include further detail below)	
	The performance of the services will be used to develop the IMTP and identify the areas where resources may be required.	

4. RECOMMENDATIONS

The Health Board is asked to:

- Note the highlights outlined in Section 2 of this report.