

Public Trust Board

Thu 22 May 2025, 10:00 - 13:00

Velindre University NHS Trust Headquarters

Agenda

10:00 - 10:15 **1. STANDARD BUSINESS**

15 min

1.1. Welcome and Apologies

Prof. Donna Mead OBE, Chair

1.2. In Attendance


Prof. Donna Mead OBE, Chair

1.3. Declarations of Interest

Prof. Donna Mead OBE, Chair

1.4. Minutes of the Public Trust Board meeting held on 27th March 2025

Prof. Donna Mead OBE, Chair

 1.4.0 (Unconfirmed) Public Trust Board Minutes 27.03.2025 (v3DM).pdf (13 pages)

1.5. Public Action Log

Prof. Donna Mead OBE, Chair

 1.5.0 PUBLIC TRUST BOARD ACTION LOG - MAY 2025.pdf (2 pages)

1.6. Matters Arising

Prof. Donna Mead OBE, Chair

*There are no matters arising for discussion.

10:15 - 10:25 **2. KEY REPORTS**

10 min

2.1. Chair's Report

Prof. Donna Mead OBE, Chair

 2.1.0 Chair's update Trust Board 22.05.2025 (003) final version from DM.pdf (8 pages)

2.2. Chief Executive's Report

For noting in CEO's absence

 2.2.0 CEO's Update Trust Board 22 May 2025.pdf (5 pages)

10:25 - 12:05 **3. QUALITY, SAFETY & PERFORMANCE**

100 min

3.1. Performance Management Framework (March 2025)


Lauren Fear, Interim Director of Transformation, Anne Carey, Chief Operating Officer, Matthew Bunce, Executive Director of Finance and Sarah Morley, Executive Director of Organisational Development & Workforce

 3.1.0 22.5.25 Trust Board MAR PMF Data 2025 PowerPoint FINAL version2-lf.pdf (24 pages)


3.2. Financial Report (March 2025)

Matthew Bunce, Executive Director of Finance

 3.2.0 Month 12 Finance Report Cover Paper - TRUST BOARD 22.05.2025.pdf (12 pages)

 3.2.0a Appendix 1 - M12 VELINDRE NHS TRUST FINANCIAL POSITION TO MARCH 2025 - TRUST BOARD 22.05.2025 FINAL.pdf (29 pages)


 3.2.0b Appendix 2 (a) P12-25 TCS Programme Finance Paper (March 2025) - Cover Paper.pdf (7 pages)

 3.2.0c Appendix 2 (b) P12-25 TCS Programme Finance Paper (March 2025) - Main Report.pdf (15 pages)

3.3. VUNHST Risk Register

Non Gwilym, Interim Director of Corporate Governance


 3.3.0 TRR -TB - COVER PAPER -27.05.2025 -V03.pdf (8 pages)

 3.3.0a TRR - APPENDIX 1 -TB- 22.05.2025 -V03.pdf (12 pages)

3.4. Trust Assurance Framework

Non Gwilym, Interim Director of Corporate Governance

 3.4.0 TAF Cover Paper - TB- 27.05.2025 V02.pdf (11 pages)

 3.4.0a APPENDIX 1 - TB - V75 TAF DASHBOARD-V01.pdf (37 pages)

3.5. People's Experience Framework

Tina Jenkins, Head of Quality, Safety & Assurance

 3.5.0 Peoples Experience Framework.pdf (46 pages)

3.6. Trust Quality Priorities

Tina Jenkins, Head of Quality, Safety & Assurance

 3.6.0 2025-2026 Trust Quality Priorities Board.pdf (12 pages)

3.7. Action taken following Supreme Court ruling

Sarah Morley, Executive Director of Organisational Development & Workforce

 3.7.0 Action Taken Following Supreme Court Ruling - May Board.pdf (3 pages)

3.8. Public Quality, Safety & Performance Committee Highlight Report (08/05/2025)

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

**Item for escalation.*

 3.8.0 Public QSP Highlight Report 8th May 2025.pdf (75 pages)


12:05 - 12:25
20 min

4. PLANNING AND STRATEGIC DEVELOPMENT

4.1. Strategic Planning Update

Lauren Fear, Interim Director of Transformation

 4.1.0 Strategic Planning Update - May Board vFINAL.pdf (5 pages)

 4.1.0a Appendix 1 - Regional Cancer Programme Board - 10.04.2025 V6 CLEAN.pdf (2 pages)

4.2. BECS Full Business Case - Executive Summary and Strategic Case

Peter Richardson, Head of Quality, Safety and Regulatory Compliance, Deputy Director Welsh Blood Service

- 📄 4.2.0 20250522 Trust Board PUBLIC - Cover Paper - BECS Final Business Case FINAL.pdf (11 pages)
- 📄 4.2.0a 20250522 Trust Board PUBLIC - BECS Full Business Case (Exec Summary & Management Case only)FINAL (i).pdf (20 pages)

4.3. Public Strategic Development Committee Highlight Report (20/03/2025)

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

**Item for escalation.*

- 📄 4.3.0 TRUST BOARD PUBLIC SDC HIGHLIGHT REPORT 20.03.2025 v1.pdf (7 pages)

12:25 - 12:25 5. CONSENT FOR APPROVAL

0 min

Prof. Donna Mead OBE, Chair

**There are no items for approval.*

12:25 - 12:40 6. CONSENT FOR NOTING

15 min

Prof. Donna Mead OBE, Chair

6.1. Public Charitable Funds Committee Highlight Report (19/03/2025)

Prof. Donna Mead OBE, Chair and Chair of the Charitable Funds Committee

- 📄 6.1.0 Highlight Report PUBLIC CFC 19 March 2025 MB Review with DM change.pdf (4 pages)

6.2. Public Audit Committee Highlight Report (25/03/2025)

Gareth Jones, Independent Member and Chair of the Audit Committee

- 📄 6.2.0 Highlight Report Public Audit Committee 25 March 2025 FINAL.pdf (4 pages)

6.3. Trust Seal Report

Non Gwilym, Interim Director of Corporate Governance

- 📄 6.3.0 Trust Seal Report 21.03.2025-21.05.2025.pdf (4 pages)

6.4. Trust-wide Policies Approved Update

Non Gwilym, Interim Director of Corporate Governance

- 📄 6.4.0 TRUST WIDE POLICIES APPROVED UPDATE MAY 2025.pdf (4 pages)
- 📄 6.4.0a APPENDIX 1 QS01 National Policy on patient safety incidents_MAY 2025.pdf (24 pages)

12:40 - 12:40 7. ANY OTHER BUSINESS

0 min

Prof. Donna Mead OBE, Chair

**Prior approval required by Chair.*

12:40 - 12:40 8. DATE OF NEXT MEETING

0 min

Prof. Donna Mead OBE, Chair

Thursday, 31st July 2025. An additional extraordinary public Trust Board meeting will also take place on Thursday 26th June, to approve the Trust's Annual Accounts and Annual Report.

12:40 - 12:40 **9. CLOSE**

0 min

Prof. Donna Mead OBE, Chair

12:40 - 12:40 **10. The following items will be discussed / noted at the Private / Part B session of the Trust Board:**

0 min

- Minutes of previous private Trust Board meeting
- Action log
- Whitchurch Land Update
- Private Trust Risk Register
- TrAMs / Pharmacy update
- BECS Full Business Case – Economic, Commercial, Financial and Management Cases
- Chair's Urgent Actions
- Plasma 4 Medicines update
- Private Committee Highlight Reports
- Shared Services Partnership Committee Assurance Report
- Joint Commissioning Committee Highlight Report

**MINUTES PUBLIC TRUST BOARD MEETING – PART A
VELINDRE UNIVERSITY NHS TRUST LIVE STREAMED
27th MARCH 2025 AT 10:00AM**

<p>PRESENT Professor Donna Mead OBE Stephen Harries (SH) Professor Andrew Westwell (AW) Vicky Morris (VM) Gareth Jones (GJ) Lindsay Foyster (LLF) Hilary Jones (HJ) David Donegan (DD) Carl James (CJ)</p> <p>Dr Jacinta Abraham (JA) Matthew Bunce (MB) Lauren Fear (LF)</p>	<p>Chair Vice Chair Independent Member Independent Member (<i>remotely</i>) Independent Member (<i>remotely</i>) Independent Member Independent Member (<i>remotely</i>) Chief Executive Officer Executive Director of Strategy & Planning / Deputy CEO (interim) Executive Medical Director Executive Director of Finance Director of Transformation (interim)</p>
<p>ATTENDEES Anne Carey (AC) Carl Taylor (CT) Non Gwilym (NG) Kyle Page (Secretariat)</p>	<p>Chief Operating Officer Chief Digital Officer Director of Corporate Governance (interim) Business Support Manager</p>

1.0.0	STANDARD BUSINESS	
1.1.0	<p>Welcome and Apologies</p> <p>The Chair apologised for the late start to the meeting owing to technical difficulties, which were being experienced in other areas of the NHS. Non Gwilym provided a bilingual explanation of the technical difficulties encountered. Attendees and members of the public were thanked for their patience and further apologies were extended for the loss of the Welsh translation facility at today’s meeting.</p> <p>The Chair welcomed attendees to the meeting and the following apologies were noted:</p> <ul style="list-style-type: none"> • Sarah Morley, Executive Director of Organisational Development and Workforce • Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Scientists • David Cogan, Patient Representative 	
1.2.0	<p>In Attendance</p> <p>The Chair extended a warm welcome to the following additional attendees:</p> <ul style="list-style-type: none"> • Susan Thomas, Deputy Director of Organisational Development & Workforce (deputising for Sarah Morley) 	

	<ul style="list-style-type: none"> Annie Evans, Deputy Director of Nursing, Quality & Patient Experience (deputising for Nicola Williams) Katrina Febry, Audit Lead, Audit Wales (<i>remotely</i>) Alan Prosser, Director of Welsh Blood Service (<i>remotely</i>) 	
1.3.0	<p>Declarations of Interest</p> <p>There were no declarations of interest pertinent to today's agenda.</p>	
1.4.0	<p>Minutes of the Public Session held on 30th January 2025</p> <p>The Board confirmed that the minutes of the meeting held on the 30th January 2025 were an accurate reflection of proceedings.</p>	
1.5.0	<p>Action Log</p> <p>The Board was content to close all actions marked as 'propose to close' and updates were provided by the Executive Leads for all open actions as follows:</p> <p>7.1.4 (23/05/2024) (Action 3) – It was agreed that the action remains open, as Committee Terms of Reference are currently under review, to be confirmed at the May 2025 meeting of the Trust Board (target date to be amended).</p> <p>4.1.0 (28/11/2024) (Action 19) – It was proposed to close this action at the May 2025 meeting of the Trust Board, following inclusion of target ratings in the Risk Register from May 2025 onwards (target date to be amended).</p> <p>6.1.2 (28/11/2024) (Action 30) – The Chief Operating Officer advised that this had been addressed at a recent Independent Members' meeting and that an out of Board approval had been actioned. It was agreed to close the action.</p> <p>4.1.0 (30/01/2025) (Action 32) – It was advised that this item had been deferred for consideration at the May 2025 meeting of the Trust Board.</p> <p>4.1.0 (30/01/2025) (Action 33) – Jacinta Abraham advised that in terms of changes to personnel and associated risks, progress has been evidenced with a move to nurse / pharmacy model and the development of a more sustainable leadership and oversight option in relation to the service. This risk had now reduced to 12 and it was recognised that a review of the service and new changes would ensure a seamless handover of care (commencing 1st April 2025). It was accepted that a piece of work in relation to the capture and management of all fragile services would be undertaken and sighted by the Strategic Development Committee, therefore it was agreed that this item could be closed.</p> <p>4.4.0 (30/01/2025) (Action 36) – Matthew Bunce advised that marginal income figures would be addressed at the April Board Development Session and that a conversation prior to this with Independent Members' requirements would help shape the presentation accordingly.</p> <p>The Trust Board accepted the position and updates noted above.</p>	MB
1.6.0	<p>Matters Arising</p>	

	There were no matters arising for discussion.	
2.0.0	KEY REPORTS	
2.1.0	<p>Chair's Report Professor Donna Mead OBE, Chair</p> <p>The report provided an overview of the Chair's activity since the previous meeting of the Trust Board, highlighting the following:</p> <ul style="list-style-type: none"> • Swansea Blood Service Donor Awards: Recognition of two staff members for their significant contributions in blood donations, with awards for 75 and over 100 donations. • Consultant Appointments: Successful recruitment of two new consultants, highlighting the high calibre of applicants and the benefits of the satellite centre development in attracting established professionals. • Welsh Blood Service Electrical Infrastructure: Successful replacement of the electrical infrastructure at the Talbot Green processing centre, ensuring resilience and continuity of service during the replacement. • Appointment of Dr. Seema Arif: Announcement of Dr. Seema AReef's Arif's new role in leading on quality and diversity for NHS Executive in relation to the Women's Health plan, which is aligned to one of the Ministerial priorities. It is the intention for Seema to attend a future Board meeting to advise further on the purpose of the role. <p>The report emphasised the Trust's ongoing efforts in staff recognition, recruitment, infrastructure improvements and maintaining high standards in service delivery.</p> <p>There were no queries and the Trust Board NOTED the content of the Chair's Update Report.</p>	
2.2.0	<p>Chief Executive's Report David Donegan, Chief Executive Officer</p> <p>The report provided information to the Board on a number of key matters and achievements within the organisation, for the period February to March 2025. David Donegan highlighted the following:</p> <ul style="list-style-type: none"> • Staff Achievements: The impressive contributions of staff recognised within the report, emphasising their achievements and the positive impact on the organisation. • High-Calibre Appointments: The high calibre of recent appointments, including the Velindre Cancer Service Triumvirate, Anne Carey's permanent appointment as Chief Operating Officer and the new substantive SRO for the nVCC project, Mark Trumper. • Welsh Government Assurance: The Trust had received the highest level of assurance from Welsh Government, placing it among the best-performing health bodies in Wales across all domains. • Cabinet Secretary Visit: The Cabinet Secretary visited on World Cancer Day to discuss the work of Welsh Blood Service and Velindre Cancer Service, with plans for another visit to discuss the satellite unit opening over the summer. • Victory in Europe Day Celebrations: Plans are underway to celebrate VE Day on May 8th, with the canteen at the Cancer Centre preparing an appropriate menu and decorations. A thanksgiving event will be held at the cancer centre and at WBS HQ 	

	There were no queries and the Trust Board NOTED the content of the Chief Executive's Update Report.	
3.0.0	INTEGRATED GOVERNANCE	
	There were no items for discussion at today's meeting.	
4.0.0	QUALITY, SAFETY AND PERFORMANCE	
4.1.0	<p>Performance Management Framework (January 2025)</p> <p>Lauren Fear, Director of Transformation (interim), Anne Carey, Chief Operating Officer, Matthew Bunce, Executive Director of Finance and Susan Thomas, Deputy Director of Organisational Development & Workforce</p> <p>The Performance Management Framework (PMF) highlighted several key points and updates across the divisions. Lauren Fear advised the following:</p> <ul style="list-style-type: none"> Assurance levels for each section of the report had been endorsed at the March Quality, Safety & Performance Committee. An internal audit had been carried out on the PMF development work, which had been discussed in detail at the Audit Committee on the 25th March 2025. Progress of manual handling training, noting the transition from a previous long-standing Service Level Agreement with Cardiff and Vale University Health Board, to in-house training. A joint weekly update (between Health & Safety and Velindre Cancer Service teams) continues to monitor progress and completion of a data clean-up is expected to conclude by the end of April for reporting on at the May meeting of the Trust Board. Blood Supply Chain Planning: Anne Carey highlighted the establishment of a planning group (led by Alan Prosser) to address medium and long term initiatives, including donor engagement and red cell collection. Radiotherapy Productivity: Anne Carey advised that new systems would be implemented to better understand productivity in Radiotherapy, with initial steps taken during March and further developments anticipated in April. SACT performance continues to improve. <p>Specific concerns were raised about the accuracy of a number of performance metrics, as follows:</p> <ul style="list-style-type: none"> Stem cell collection data – Anne Carey advised that demand is met and therefore the performance figures would be corrected. Serology – Anne Carey confirmed that while guidelines stipulate delivery within 5 days, 2 days had been entered as standard, impacting performance figures. A review of ongoing issues had identified the need for additional training to authorise results. SACT data requires further clarity. Anne Carey agreed to review the presentation of the data, however the Board was assured that the Trust had recently acknowledged its best performance to date with regard to SACT. Inclusion of Targets (work package 4) – It was queried whether the target date of the 31st January required extending. Lauren Fear advised that this has concluded and should have been updated to reflect this. Benchmarking (work package 9) – extension of the target date from 31st March 2025 to 31st May is required. 	<p>AC</p> <p>AC</p> <p>LF</p> <p>LF</p>

	<ul style="list-style-type: none"> • Estates Efficiency – Lauren Fear agreed to clarify data for Trust Waste Recycling performance. • Radiotherapy waiting times – The Chair noted the longest waits for scheduled and urgent Radiotherapy were 34 and 24 days respectively and sought assurance regarding potential patient harm due to delays. Anne Carey advised that all patients treated outside the target timeframe are reviewed by the relevant Consultant and an assessment of the risk to the patient versus the treatment required is made, occasionally resulting in this level of delay due to planning for this. The Board was assured that new systems would enable more effective scrutiny of such delays that is currently possible. • Gareth Jones noted that the cover paper had not included the discussion at Audit Committee on the 25th March. <hr/> <p>Digital Carl Taylor advised the following:</p> <ul style="list-style-type: none"> • Cyber Mandatory Training: The Trust had seen an increased uptake in training, requiring the running of additional sessions, reporting compliance of 83.47% against a target of 85% for February. • Halo: Performance at the Service Desk continues to improve as a result of the implementation of Halo. • Printing: The rollout of new printers during January has resulted in the drastic reduction of invoices received in relation to printing. • Significant Incidents: The Trust is still trending above average, however 60% are nationally reported issues; four local issues regarding the Welsh Clinical Portal have been followed up with Digital Health and Care Wales. <hr/> <p>Workforce Susan Thomas advised the following:</p> <ul style="list-style-type: none"> • PADR process – New templates and supporting documents are in the pilot stage to provide a robust framework for the implementation of the new People Development Policy. An improving trend towards the KPI target of 85% is anticipated. • Sickness – Trust wide actions plans have been developed within both divisions following detailed analysis of absence patterns and trends. Lindsay Foyster suggested year on year trend reporting would be of benefit, to enable identification of potential seasonal trends. • Management Training Package has been launched with the intention to roll out more comprehensively across the Trust. <p>The Trust Board NOTED:</p> <ul style="list-style-type: none"> • The Performance Management Framework detailed analysis for the month of January 2025. • The progress against the nine agreed work packages. • The levels of assurance for each Division/ Directorate, as agreed by Executive Management Board and discussed and noted at Quality, Safety and Performance Committee (also included in the document). 	<p>LF</p> <p>LF</p>
<p>4.2.0</p>	<p>Financial Report (January 2025) Matthew Bunce, Executive Director of Finance</p> <p>The Financial Report outlined the financial position and performance to the end of January 2025. Matthew Bunce highlighted the following:</p>	

	<ul style="list-style-type: none"> • Revenue Balance: The Trust is projected to meet its revenue balance for the year, despite challenges in negotiating long-term agreements (LTAs) with commissioners due to historic baselines. An £800,000 reduction in income was noted. • Savings Targets: The Trust is on track with its savings targets, except for a shortfall of £100,000. This shortfall will not impact the overall position for this year due to non-recurrent savings. • Key Performance Indicators (KPIs): The Trust will meet its revenue balance, stay within its capital resource limit, and comply with public sector payment policy targets. • Business Cases: A range of Business Cases had been submitted across the Trust’s services, however, due to financial constraints, it had not been possible for Commissioners to fund the £1.5m Welsh Blood Service business cases, nor the £1.5m Velindre Cancer Service business cases, in particular around provision of further capacity for SACT. • Next year: Welsh Government has agreed to fund the Trust’s SDEC provision, improving the projected deficit to a balanced position. <p>Gareth Jones referenced the position noted in the cover paper relating to Hywel Dda and the intention to change the Trust funding base from historic shares to actual cost, noting that unless an agreement was reached imminently, the Trust would be unable to sign the LTAs for the coming year which would lead to arbitration. Matthew Bunce advised that the paper had not been updated to reflect February’s position (an agreement has been reached for the forthcoming year only) and that the paper would be updated.</p> <p>Gareth Jones also queried whether an LTA marginal income underachievement of £500k was still expected. Matthew Bunce advised that the income shortfall had shown some improvement due to improved data capture in areas where this was previously not the case.</p> <p>The Trust Board NOTED the content of the January 2025 financial report, in particular:</p> <ul style="list-style-type: none"> • The year to date and forecast revenue out turn position and PSCP performance. • The agreed position on LTA income for 2024-25 from our Commissioners. • The position with Commissioners on the contract rebase agreement. • The latest position on the LTA activity performance for 2024-25. <p>The Chair indicated that a significant number of acronyms had been included within the report, which may impede ease of reading for some audiences, and Non Gwilym advised that a glossary is currently under development.</p>	MB
4.3.0	<p>VUNHST Risk Register</p> <p>Non Gwilym, Director of Corporate Governance (interim)</p> <p>The Risk Register summarised the current extract of Risk Registers for risks scoring 12 and above for quality and safety and 15 and above for all other domains. Non Gwilym highlighted the following:</p> <ul style="list-style-type: none"> • The risk register had been regularly updated during the reporting period and the governance section of the paper summarised discussions held at a number of Committees, highlighting common themes such as the 	

	<p>careful use of domains, queries regarding static risks, and ensuring executive accountability.</p> <ul style="list-style-type: none"> The Audit Committee had received a report from internal audit on risk that received 'reasonable' assurance (green status). <p>Carl James advised that that while better understanding of digital risks across the Trust was under development, there is a requirement for a comprehensive composite score for digital risks, a single digital risk register, and scoring national projects separately to understand their impact on the organisation.</p> <p>Gareth Jones emphasised the need to revisit risks that have remained static since 2020, ensuring they are thoroughly reviewed and appropriately mitigated and Non Gwilym advised that the number of risks recorded in Datix are under active review to mitigate duplication and ensure that risks can be viewed at the appropriate time.</p> <p>Vicky Morris advised that discussion at Audit Committee had highlighted the importance of identifying workforce risks, particularly those affecting fragile services, which will require separate capture and review.</p> <p>Finally, Stephen Harries indicated discrepancies in risk scoring calculations (either the total or the multiplier), which will be corrected.</p> <p>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, noting that a rework of figures would be undertaken to maintain accuracy. The Board also NOTED the current assurance level of 2.</p>	<p style="text-align: center;">NG</p>
<p>4.4.0</p>	<p>Trust Assurance Framework Non Gwilym, Director of Corporate Governance (interim)</p> <p>The Trust Assurance Framework was discussed in detail, highlighting the current assurance level of 2. The following was discussed:</p> <ul style="list-style-type: none"> The inclusion of narratives from executive leads to provide a view of how the risk scores are moving. This pilot approach had received positive feedback from all relevant Committees. Updates contained in red text, reflecting the latest changes. Vicky Morris and Lindsay Foyster supported the Committee discussions, noting the importance of aligning strategic objectives with risks and the need for specific actions to mitigate risks. Gareth Jones noted that historic trends for each risk had been omitted, with the exception of TAF08. Non Gwilym confirmed that this process would be reinstated in future reports. <p>The Trust Board NOTED the satisfactory current status of the Trust Assurance Framework and current assurance level of 2.</p>	<p style="text-align: center;">NG</p>
<p>4.5.0</p>	<p>Trust Values Culture Report Susan Thomas, Deputy Director of Organisational Development & Workforce</p> <p>The report set out a summary of the Trust's actions in relation to the development of organisational culture, including feedback, desired culture, ideas on the way forward, and an action plan. Susan Thomas highlighted</p>	

	<p>the importance of defining parameters for culture, as culture is shaped by attitudes, expectations and practices.</p> <p>The report identified key themes which require focus in shaping the culture, such as valuing differences, embedding compassionate leadership and ensuring psychological safety. The Board agreed to endorse the conclusions in section 4 and confirm the assurance at level 2, however indicating that a clear action plan with timescales and deliverables is still required.</p> <p>Board colleagues noted lack of urgency / timelines in addressing the more serious issues of the Trust's culture, given that the Culture and Values workstream had been established during 2022. It was felt that staff would appreciate a tangible, timebound action plan with SMART objectives. It was suggested that issues and actions could be worked through at a future Board Development session.</p> <p>The Trust Board:</p> <ul style="list-style-type: none"> • AGREED the assurance level of 2. • ENDORSED the three conclusions and the next steps in section 4 as the way forward in designing a programme for the continued development of an effective culture within the Trust (noting that the Board has requested assurance regarding pace and development towards an initial end goal). 	
<p>4.6.0</p>	<p>Staff Survey Results Susan Thomas, Deputy Director of Organisational Development & Workforce</p> <p>The Staff Survey Results evidenced progress in all themes, compared with 2024. Susan Thomas noted that, as below average scores appeared in six of the ten themes, a Staff Survey Group had been established as the approach to developing action plans at both Trust and Divisional levels in response.</p> <p>Further discussion of the results highlighted several key points and concerns regarding the accuracy and presentation of the data:</p> <ul style="list-style-type: none"> • Data Accuracy: The Chair noted that the percentage differences provided in the report were incorrect, with significant discrepancies between the reported and actual figures. For example, the report indicated a -4.5% variance in burnout, whereas the actual figure was -13%. This issue was acknowledged as stemming from the external agency procured to produce the report and that use of the term 'percentage point' was required. It was also noted that listing hosted units as separate organisations further complicated figures. • Themes Identified: The survey results were categorized into three main themes: psychological safety, PADRs (Performance Appraisal Development Reviews), and team time. These themes were chosen based on the clinical team's analysis of the data, aiming to address key areas of concern across the organisation. Gareth Jones expressed concern regarding the lack of detailed assurance on actions being taken to address the issues highlighted in the survey. Specifically, there was a call for more concrete steps and timelines to improve scores in areas such as team time and PADRs. 	

	<ul style="list-style-type: none"> • Presentation: A number of issues were raised in relation to how the data had been presented, including the use of percentages for questions requiring numerical responses i.e. not Likert Scales, leading to confusion and potential misinterpretation. For example, the report indicated that 94.8% of respondents had experienced unwanted behaviour of a sexual nature, which had not been clearly explained in relation to how often, etc. • Action Plan: Susan Thomas emphasised that while the report provided a snapshot of the survey results, there are currently ongoing interventions at a number of levels to address the issues raised, including support mechanisms for teams and managers to tackle specific problems at the most basic level. • Next Steps: It was agreed that a note should be added to the report to clarify the deficiencies in the data and its presentation. Additionally, there was a suggestion to split the report into three sections, to provide more targeted and meaningful insights. Susan Thomas also agreed to confirm how the three themes had been determined. <p>The Trust Board NOTED the report, and that colleagues would respond to the team that produced the report.</p>	<p>ST</p> <p>ST</p>
5.0.0	PLANNING AND STRATEGIC DEVELOPMENT	
5.1.0	<p>Integrated Medium Term Plan (IMTP) 2025-2028</p> <p>IMTP 2025-26 including Corporate Objectives Lauren Fear, Director of Transformation (Interim)</p> <p>The report outlined the context in which the plan had been set, development of services and delivery of the Trust’s Strategy. The IMTP also included a substantial document for assurance purposes, detailing compliance with statutory requirements.</p> <p>Lauren Fear highlighted the following:</p> <ul style="list-style-type: none"> • Efforts undertaken to ensure alignment with strategic objectives and compliance with planning guidance. • The structured approach taken, which included context, key milestones and desired outcomes for each service area. • The plan reflects contributions from a number of teams across the Welsh Blood Service, Velindre Cancer Service and Corporate functions. • The aim of the IMTP to provide a clear roadmap for the next three years, focusing on values such as care, respect and accountability. Specific updates had been made following feedback received from the Strategic Development Committee. • Formatting (including new approved images of our own patients, staff, donors and premises) would be improved for the final version. <p>Andrew Westwell raised the following:</p> <ul style="list-style-type: none"> • Whilst desired outcomes had been appropriately mapped to the Trust’s values, the statement regarding ‘increase in the retention and recruitment of staff’ implied expansion of the service. ‘Sustained’ or ‘managed’ were suggested as alternatives. 	<p>LF</p>

	<ul style="list-style-type: none"> The accuracy the use of JAHS (Joint Academic Health Science Programme) was also queried and it was confirmed that this would be referred to as 'Cardiff Health Partners' going forward. However, as this had not yet been officially adopted, it was agreed to include this in brackets. Referencing the mention of National and International Research Collaborations (within the Research and Development section), it was noted that this referred to Welsh initiatives only and that this section requires expanding in terms of the organisation's intentions. <p>Matthew Bunce requested the inclusion of Welsh Government's agreement to provide the SDEC funding mentioned under the financial item earlier in the meeting, as the plan within the current iteration indicated a £800k deficit.</p> <p>The Trust Board APPROVED the Integrated Medium Term Plan 2025-2028, subject to the minor amendments noted above. Lauren Fear agreed to circulate the final 'designed' version to Board members.</p>	<p>LF</p> <p>LF</p> <p>LF</p>
<p>5.2.0</p>	<p>Strategic Planning Update Lauren Fear, Director of Transformation (interim)</p> <p>Lauren Fear provided an update, focusing on the Regional Cancer Programme and the collective progress made to date, which had been presented to the recent Regional Oversight Board. The report also highlighted the ongoing updates to the strategic planning matters, including the integration of the Strategic Development Committee's refreshed cycle of business.</p> <p>Lauren emphasised the importance of aligning the strategic objectives with the Well-being of Future Generations Act, as discussed in the recent Audit Committee meeting.</p> <p>The Trust Board NOTED the update.</p>	
<p>5.3.0</p>	<p>Strategic Development Committee Highlight Report (20/03/2025) (oral item) Lindsay Foyster, Independent Member and Chair of the Strategic Development Committee</p> <p>Lindsay Foyster advised that the March 20th meeting of the Strategic Development Committee had focused on several key areas, in particular the Velindre Cancer Service Futures Highlight Report.</p> <p>The Committee had expressed significant concerns regarding the Transforming Access to Medicines (TrAMs) programme, noting substantial delays and risks; the expected delivery date for TrAMs had been revised from January 2026 to January 2027, raising apprehension regarding the programme's impact on service delivery and patient care. Issues discussed included the overall communications service model, governance structure, fragility of internal services and clarity on service delivery responsibilities. The Committee had proposed escalating these concerns to the Trust Board and suggested a deep dive into the programme to explore underlying issues. The Committee concluded that the overall Level 3 assurance rating should <u>exclude</u> TrAMs due to these concerns.</p>	

	<p>David Donegan indicated that concerns had been raised within more than one Committee, suggesting the potential attendance of a senior Shared Services colleague at a future Trust Board to allow for further discussion in this regard. It was also agreed that the Board had not received visibility of the programme, given the Trust's responsibility as host for a national programme.</p> <p>David Donegan suggested that the Risk Register entry should be amended to Level 1, to reflect the concerns raised (both as customer and host) and for this to be addressed via an immediate deep dive, to be discussed further at the May 2025 meeting of the Board.</p> <p>Gareth Jones advised (for information) that the next Shared Services Audit Committee would take place on the 15th April 2025 and that a detailed timeline of the TrAMs programme is expected to be provided at this meeting.</p> <p>The Trust Board NOTED the update.</p>	NG
6.0.0	CONSENT ITEMS	
6.1.0	CONSENT FOR APPROVAL	
6.1.1	<p>Chair's Urgent Actions Report Non Gwilym, Director of Corporate Governance (interim)</p> <p>One urgent item of business for the Trust Board was considered via Chair's Urgent Action during this period:</p> <ul style="list-style-type: none"> Renewal of Contract for Human Leukocyte Antigen (HLA) Typing by Next Generation Sequencing (NGS). <p>While no objections to approval had been received to date, a number of concerns had been raised and were detailed in the report.</p> <p>The Trust Board RATIFIED the Chair's Urgent Action taken between 24th January and 20th March 2025.</p>	
6.1.2	<p>Amendments to the Model Standing Orders and Reservation and Delegation of Powers for NHS Trusts Non Gwilym, Director of Corporate Governance (Interim)</p> <p>The report advised the Trust Board of the amendments to the Model Standing Orders and Reservation and Delegation of Powers for Local Health Boards, NHS Trusts and Special Health Authorities, following the making of the Local Health Boards, NHS Trusts and Special Health Authorities (Constitution, Membership and Procedures) (Miscellaneous Amendments) (Wales) Regulations 2024.</p> <p>The Trust Board APPROVED the adoption of the revised Trust Model Standing Orders, Reservation and Delegation of Powers.</p>	
6.2.0	CONSENT FOR NOTING	
6.2.1	<p>Public Strategic Development Committee Highlight Report (05/12/2024) Lindsay Foyster, Independent Member and Chair of the Strategic Development Committee</p> <p>The Trust Board NOTED the content of the report.</p>	

6.2.2	<p>Public Transforming Cancer Services Programme Scrutiny Sub Committee Highlight Reports (17/10/2024; 19/12/2024; 23/01/2025 & 20/02/2025) Hilary Jones, Independent Member and Chair of the TCS Scrutiny Sub-Committee</p> <p>The Trust Board NOTED the content of the reports.</p>	
6.2.3	<p>Public Quality, Safety & Performance Committee Highlight Report (13/03/2025) Vicky Morris, Independent Member and Chair of the Quality, Safety & Performance Committee</p> <p>The Trust Board NOTED the content of the report.</p>	
6.2.4	<p>Public Charitable Funds Committee Highlight Report (23/01/2025) Professor Donna Mead OBE, Chair of the Charitable Funds Committee</p> <p>The Trust Board NOTED the content of the report.</p>	
6.2.5	<p>Trust Seal Report Non Gwilym, Interim Director of Corporate Governance</p> <p>The Trust Board NOTED the content of the Trust Board Seal Register for the period 30th January 2025 – 20th March 2025.</p>	
6.2.6	<p>Trust Wide Policies Approved Update Non Gwilym, Director of Corporate Governance (interim)</p> <p>The Trust Board NOTED the policies that had been approved during the period February 2025 to March 2025.</p>	
7.0.0	<p>Any Other Business Prof. Donna Mead OBE, Chair</p> <p>The Chair advised the Board that this would be the last Trust Board meeting attended by Stephen Harries, who would be stepping down as Vice Chair at the end of April 2025. The Chair expressed a great deal of gratitude on behalf of the Board for Stephen's significant contribution during his tenure, his expertise and insight in relation to digital matters and staff wellbeing, and his enthusiasm as Chair of the Transforming Cancer Services Programme Scrutiny Sub-Committee.</p> <p>Stephen responded with thanks, noting that it had been a privilege to have been part of an organisation which provides such an important service.</p>	
8.0.0	<p>DATE OF NEXT MEETING</p> <p>The next public meeting of the Trust Board will take place on Thursday 22nd May 2025.</p>	
9.0.0	<p>CLOSE</p>	
10.0.0	<p>It was noted that the following items would be addressed at the Private / Part B Session of the Trust Board:</p> <ul style="list-style-type: none"> Minutes of the previous private Trust Board meeting 	

	<ul style="list-style-type: none">• Action log• Velindre Cancer Service Structure Update• MIM Governance Protocol• nVCC Project Scheme of Delegation and Governance Framework• Commitments of Expenditure Exceeding CEO Limit• Hosted Functions and Major Projects• Private Committee Highlight Reports	
--	---	--

Unconfirmed

ACTION LOG	Column1	Column2	Column3	Column4	Column5	Column6	Column7	Column8
MEETING DATE	AGENDA ITEM	Action number	ACTION	LEAD	DEADLINE DATE	UPDATE (including date)	STATUS	IF CLOSED WHAT ACTION WAS TAKEN
23.05.2024			REVISIONS TO SCHEDULE 3 OF TRUST STANDING ORDERS					
	7.1.4	3	Terms of Reference for relevant Committees to be amended to include reference to requirements to demonstrate quality-led decision-making through receipt of Quality Assessments (at Committees where strategic decisions are undertaken).	Interim Director of Corporate Governance	26/09/2024 27/03/2025 22/05/2025	<p>16 May 2025 Compliance with Duty of Quality and Duty of Candour legislation embedded in Quality, Safety and Performance Committee Terms of Reference. Further provision for inclusion in revised SDC ToR in draft for SDC consideration and endorsement for July meeting. Wording also included in draft Corporate Governance Manual.</p> <p>3 March 2025 All Committee Terms of Reference under review. New Terms of Reference to be confirmed by Trust Board May 2025.</p> <p>16 January 2025 Updated Terms of Reference template for all Trust Board Committees to have proposed new wording which ensures that all matters, including Quality Impact Assessments, that need to be undertaken by the Trust Board in decision making, are referenced. (ie the Impact Assessment section of the cover paper). This is included in the Corporate Governance Manual for Audit Committee in December. Action to be reconsidered following Audit Committee meeting and consideration of manual. All ToR to be revised accordingly and considered as part of annual cycle.</p>	OPEN	
28.11.2024			VUNHST RISK REGISTER					
	4.1.0	19	Confirm timescale for when 'target rating' may be achieved. To be discussed with Executive Team.	Interim Director of Corporate Governance	30/01/2025 27/03/2025 22/05/2025	<p>May 2024 Actions now include target dates. Target date to complement target score under review for completion by end of June 2025.</p> <p>3 March 2025 Target ratings in register from May 2025. Target dates are included on Datix, as part of the initial assessment and review process.</p> <p>16 January 2025 Target date for target rating to be reviewed at next EMB discussion of risk on 10 February.</p>	OPEN	
30.01.2025			VUNHST RISK REGISTER					
	4.1.0	32	Risk 2187 and 2249 - Develop report specific to Workforce risks for discussion at Board.	Executive Director of Organisational Development & Workforce	22/05/2025	<p>Update April 2025 May Trust Risk Register paper includes report as requested.</p>	PROPOSE TO CLOSE	
30.01.2025			FINANCIAL REPORT - DECEMBER 2024					
	4.4.0	36	Calculation of Marginal Income figures to be addressed at a Board Development session.	Executive Director of Finance	10/04/2025	<p>Separate sessions were held by the DoF with Independent Members to provide more detail around the basis of the financial & activity baseines for the Log Term Agreements (LTAs), the impact and implications of re-basing the LTAs, what marginal costs are and how marginal income is calculated based on activity performance</p>	PROPOSE TO CLOSE	
27.03.2025			PERFORMANCE MANAGEMENT FRAMEWORK - JAN 2025					
	4.1.0	37	<p>Amend stem cell collection data figures to reflect that demand is met.</p> <p>Further clarify presentation of SACT data.</p> <p>Inclusion of Targets (work package 4) - update to reflect that this has concluded (target date of 31st January).</p> <p>Benchmarking (work package 9) - extend target date from 31st March to 31st May 2025.</p> <p>Clarify data for Trust Waste Recycling Performance.</p> <p>Update cover paper to include discussion at Audit Committee on 25th March 2025.</p>	<p>Chief Operating Officer</p> <p>Chief Operating Officer</p> <p>Interim Director of Transformation</p> <p>Interim Director of Transformation</p> <p>Interim Director of Transformation</p> <p>Interim Director of Transformation</p>	22/05/2025	<p>Action addressed.</p> <p>Slides updated.</p> <p>Updated PMF Development Plan with amended deadlines for Inclusion of Targets workpackage 4 with update.</p> <p>Updated Benchmarking workpackage 9 (target date extended to 31st July as further work has been identified.)</p> <p>The presentation of Trust Waste Recycling performance data has been reviewed and confirmed that the amount of waste recycled by weight kg is monitored against monthly targets and not cumulative for the year.</p> <p>Audit Committee Governance Route not recorded – the result of the PMF Audit 'reasonable assurance' was recorded on page 3 of the report. However, as the Trust Board papers deadline of was a week before the Audit Committee on 25th March, the minute recording the discussion could not be included.</p>	PROPOSE TO CLOSE	

27.03.2025	4.2.0		FINANCIAL REPORT - JAN 2025					
		38	Update cover paper to reflect the agreement reached for one year with Hywel Dda, to avoid arbitration.	Executive Director of Finance	22/05/2025	Cover paper updated to reflect that a non-recurrent agreement reached with Hywel Dda on the financial value for the LTA to avoid arbitration		PROPOSE TO CLOSE
27.03.2025	4.3.0		VUNHST RISK REGISTER					
		39	Address discrepancies in scoring calculations (incorrections in either the total or the multiplier).	Interim Director of Corporate Governance	22/05/2025	Complete.		PROPOSE TO CLOSE
27.03.2025	4.4.0		TRUST ASSURANCE FRAMEWORK					
		40	Reinstate historic trends for each risk (which is currently only included in TAF08).	Interim Director of Corporate Governance	22/05/2025	TAF includes graph to map trend.		PROPOSE TO CLOSE
27.03.2025	4.6.0		STAFF SURVEY RESULTS					
		41	Add note to the report clarifying discrepancies in data and presentation. Draft response to the team that produced the report.	Deputy Director of Organisational Development and Workforce	22/05/2025	Update 29/04/2025 - note added to the report describing discrepancies as discussed. Update 29/04/2025 - a response has been sent to HEIW from the Trust highlighting the issues identified.		PROPOSE TO CLOSE
27.03.2025	5.1.0		IMTP					
		42	Substitute use of 'INCREASE' in the retention and recruitment of staff, with 'sustained' or 'managed' as appropriate. Include 'Cardiff Health Partners' in brackets where JAHS (Joint Academic Health Science Programme) appears. Expand section referencing National and International Research Collaborations to include initiatives beyond Wales. Include Welsh Government agreement to fund SDEC funding, as the plan in the current iteration indicates an £800k deficit.	All Interim Director of Transformation.	22/05/2025	All updates included in final version submitted to Welsh Government.		PROPOSE TO CLOSE
27.03.2025	5.3.0		STRATEGIC DEVELOPMENT COMMITTEE HIGHLIGHT REPORT (20/03/2025)					
		43	Amend Trust Risk Register to reflect an assurance level of 1 for TrAMS risk, to include an immediate deep dive for discussion at the May Trust Board meeting.	Interim Director of Corporate Governance	22/05/2025	TrAMS to be considered at May 2025 Private Trust Board meeting.		PROPOSE TO CLOSE

TRUST BOARD	
CHAIR'S UPDATE REPORT	
DATE OF MEETING	22 nd May 2025
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	Prof. Donna Mead OBE, VUNHST Chair
APPROVED BY	Non Gwilym, Interim Director of Governance and Chief of Staff
EXECUTIVE SUMMARY	This report provides information to the Board regarding the Chair's activity since the previous meeting of the Trust Board.
RECOMMENDATION / ACTIONS	To NOTE the content of the Chair's update report.
GOVERNANCE ROUTE	
N/A	
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
N/A	
7 LEVELS OF ASSURANCE – N/A	
APPENDICES – N/A	

1. SITUATION

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

2. BACKGROUND

2.1 Matters addressed in this report cover the following areas:

- Board Development Sessions (10th April 2025)
- Private Trust Board meeting (27th March 2025)
- Chairs of Public Bodies in Wales forum (19th March 2025)
- Professor Peter Groves (Health Technology Wales) (19th March 2025)
- Grand Slam 20th Anniversary in aid of the Maxwell Family Fund (21st March 2025)
- Chairs of Health Bodies in Wales peer group meeting (25th March 2025)
- Welsh Blood Service Donor Awards - Swansea area (26th / 27th March 2025)
- Government Priorities meeting (7th April 2025)
- Welsh Blood Service Donor Awards - Wrexham area (29th / 30th April 2025)
- Patient Art Exhibition – (6th May 2025)
- VE Celebrations (8th May 2025)
- Advisory Committee of Health and Care Research Wales (8th May 2025)
- Trust Multiprofessional Conference (12th May 2025)

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Board Development Sessions

One Board Development Session took place during the period (10th April 2025 2024), to discuss the following:

- Trust Hosting Arrangements
- New Political Landscape and matters concerning forthcoming Elections
- Information Governance and Cyber Awareness Training

3.2 Private Trust Board meetings:

27th March 2025 (regular) - Discussions at this private meeting of the Trust Board addressed the following items:

- Velindre Cancer Service Structure update
- MIM Protocol
- nVCC Project Scheme of Delegation and Governance Framework
- Private Trust Risk Register
- Hosted Functions and Major Projects
- Commitments of Expenditure exceeding CEO limit
- Private Committee Highlight Reports

3.3 19th March 2025 - The Chair attended a meeting of the **Chairs of Public Bodies in Wales forum**. The main agenda item was diversity on public boards.

3.4 19th March 2025 - The Chair attended an event to recognise the end of term of office for Prof Peter Groves, chair of Health Technology Wales (hosted by Velindre University NHS Trust) and took the opportunity to thank Peter for his leadership in establishing health Technology Wales as an internationally recognised source of technology appraisals.

3.5 Grand Slam 20th Anniversary in aid of the Maxwell Family Fund (21st March 2025)

On Friday 21st March, the Chair attended the 2005 Grand Slam 20th Anniversary event, which took place at the Principality Stadium, Cardiff, in aid of the Maxwell Family Fund. The lunch, hosted by Jonathan 'Jiffy' Davies OBE, Shane Williams MBE among others included a three course meal, captivating Q&A session, live music and entertainment and pitch side refreshments. Funds raised are donated to the Craig Maxwell Family fund at Velindre University NHS Trust



3.6 25th March 2025 – The Chair attended the Chairs of Health Bodies in Wales peer group meeting.

3.7 Welsh Blood Service Donor Awards - Swansea area (26th / 27th March 2025)



The Chair attended the Donor Awards at the Village Hotel in Swansea on the 26th / 27th March.

On the 26th, 44 milestone donors from Swansea and the surrounding areas received their award. The donors that attended had collectively made 2,852 donations, potentially saving the lives of 8,002 patients in need.

At the award ceremony, Jayne Davey, our former Head of Collections, received an award for 100 donations of platelets. Jayne retired on the 28th March so the opportunity was taken to thank her for the tremendous contribution she has made to WBS.



On the 27th, a further 44 milestone donors received their award. They had collectively made 2,675 donations, potentially saving the lives of 8,225 patients. We were delighted to welcome Max Boyce to present the awards.

3.8 7th April 2025 - The Chair attended, along with Stephen Harries, Vice Chair, and other members of the board, a meeting held in Cardiff at which Jeremy Miles, Cabinet Secretary for Health and Social care, set out government priorities going forward. The link to his speech can be found here: <https://www.gov.wales/nhs-confederation-speech>

3.9 Welsh Blood Service Donor Awards - Wrexham area (29th / 30th April 2025)

The Donor Awards event that took place at the Ramada Hotel in Wrexham on the 29th / 30th April was attended by Vicky Morris.

On the 29th, 47 milestone donors from Wrexham and surrounding areas received their awards, having collectively made 3,127 donations, potentially saving the lives of a staggering 9,377 patients in need. The ceremony on the 30th was attended by a further 45 donors, who had collectively made 2,676 donations, with potentially 8,026 lives saved.



The team also presented a special award to Roy Mills, who has donated blood an incredible 140 times over several decades, making him one of Wales' longest serving donors.

Frank Murphy received a special recognition award for not only being a donor himself, but for his help in hosting eight blood donation sessions at HMP Berwyn where his work has helped over 400 others to come forward, with 126 of those coming to donate for the very first time. 21 of those donors also became stem cell volunteers. The Chair is grateful to Vicky Morris for her attendance.

3.10 Patient Art Exhibition launched (6th May 2025)



On 6 May, the Chair attended the launch of Velindre's first art exhibition. The exhibition space (corridor next to Linac 1) is dedicated to showcasing the creative talent of our staff, patients and local artists. The exhibition is called, *It's a Wonderful Still Life*. A series of paintings have been produced by artist Viv Leach and it is the first exhibition we have held. The

exhibitions will change every 4 months to showcase different artists and provide energy and interest in the physical environment of the hospital.



In 2023, Viv Leach was unexpectedly diagnosed with lung cancer. During the early days of her treatment, she found solace in the beauty of flowers, gifts from friends and family, that brightened her days. They were symbols of love and support and it was through painting these flowers that Viv rediscovered her passion for creativity.



In recognition of what Viv describes as the excellent Care she received at Velindre, she decided that she wanted to give something back and the exhibition has resulted from this. Viv has donated all the paintings to Velindre and they are available to purchase with funds raised being given to Velindre.

3.11 VE Day Celebrations (8th May 2025)



A day of celebrations across both sites took place on May 8th in honour of the 80th anniversary of VE Day. This included cake sales, bunting, 1940s music and paper poppy making.

Serving members and Veteran Staff Members and Volunteers were encouraged to wear uniform or regiment items and a 2 minute silence took place at 11am.



Ian Bevan, Head of Information Governance, provided a dignified reading of 'In Flanders Fields. The Chair spoke at the outset, prior to unfurling the flag. The Welsh National opera attended and led us in singing. 'There will be lilacs in the spring again' as well as 'We'll keep the Home fires burning and The White Cliffs of Dover.' As well as providing a festive menu and atmosphere in the canteen for patients, staff and visitors, the canteen staff provided refreshments for those who attended the unfurling ceremony. Refreshments included Jam Tarts, Ginger Beer and also dandelion and Burdock pop and Camp (chicory) coffee which the Chair noted she hadn't drunk since she was a little girl.



Thanks to Lisa Miller and Sally Thelwell, Arts Coordinator, for organising a fitting commemoration to those who served.

3.12 8th May 2025 – The Chair attended the advisory Committee of Health and Care Research Wales. The main agenda item was public participation in the design and conduct of research in health and social care.

3.13 Trust Multiprofessional Conference (12th May 2025)



On Monday 12th May, the Trust's Clinical and Scientific 'Working Together' Conference took place at Sophia Gardens in Cardiff, coinciding with International Nurses' Day.

The conference presented the exciting opportunity to bring our multi-professional clinical and scientific colleagues together to strengthen effective team-working, clinical and scientific leadership, personal development and advanced practice.

The focus was on the importance of working together to achieve better outcomes, and sessions were dedicated to developing leadership skills and personal growth, which are essential for advancing in these fields.

The event featured several notable speakers and a variety of inspirational talks. Speakers shared their personal career journeys, offering inspiration and guidance to attendees. Patient and donor stories were particularly powerful, reinforcing the profound impact of clinical and scientific work on individuals' lives. We were very pleased to welcome the TENOVUS choir to the conference.



4 IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: NO	
If yes - please select all relevant goals:	
<ul style="list-style-type: none"> • Outstanding for quality, safety and experience <input type="checkbox"/> • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations <input type="checkbox"/> • A beacon for research, development and innovation in our stated areas of priority <input type="checkbox"/> • An established 'University' Trust which provides highly valued knowledge for learning for all. <input type="checkbox"/> • A sustainable organisation that plays its part in creating a better future for people across the globe <input type="checkbox"/> 	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF)	Choose an item
QUALITY AND SAFETY IMPLICATIONS / IMPACT	There are no specific quality and safety implications related to the activity outlined in this report.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Not required
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	N/A
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

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

5 RISKS

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



TRUST BOARD	
CHIEF EXECUTIVE’S UPDATE REPORT	
DATE OF MEETING	22 May 2025
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	David Donegan, VUNHST Chief Executive
PRESENTED BY	David Donegan, VUNHST Chief Executive
APPROVED BY	David Donegan, VUNHST Chief Executive
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 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 Chief Executive’s activity since the March Board meeting.

Health and Social Care Winter Summit

On the 31 March, I attended a meeting of the Health and Social Care Winter Summit – an opportunity for the Chief Executives of NHS Wales’s statutory organisations to reflect on the lessons learned and data from 2024-25 winter, consider the strategic context and expectations - including actions and outcomes - for winter 2025-26. The summit was attended by the Cabinet Secretary for Health and Social Care who delivered the opening remarks before the CEOs of NHS Wales shared a collective view.

Maggie’s and City Hospice – working together

On 1 April I visited the fantastic Maggie’s centre and City Hospice and met with their Business Development Director and CEO. The centres are located either on or are adjacent to the Trust’s estate in Whitchurch. I am deeply impressed by the operation of both centres and take great pride in the way in which our organisations are working together today. Our discussions centred on how these relationships can be strengthened in future as our cancer service evolves and we progress work on the new Velindre Cancer Centre.

All-Wales Meeting – NHS Wales

Following the successful winter summit, on 7 April, I, along with our Chair, Vice Chair and Executive Board attended an NHS Wales meeting in Cardiff to consider the role we play in delivering the Cabinet Secretary for Health and Social Care’s priorities. This was an opportunity for us to consider our Trust’s unique contribution to healthcare delivery in the wider regional and national NHS Wales context.

Best Healthcare Project Award win at the Partnership Awards – new Velindre Cancer Centre project

I take great pride in the work we deliver as a Trust. I was delighted to attend the annual Partnership Awards on 1 May where our new Velindre Cancer Centre project won the Best Healthcare Project. The project was described as “a paradigm shift in sustainable healthcare, providing cutting-edge facilities and treatment in a building designed with sustainable material innovation, community inclusion, and a commitment to preserving the environment”. Recognising both the design and ambition of our project, winning in the competitive healthcare category was a significant milestone for the project and a reflection of the dedication, innovation, and teamwork that has brought us to this point.

National Cancer Workshop

I was pleased to lead on the delivery of a National Cancer Workshop in partnership with the Wales Cancer Network on 9 May. As the NHS Wales Lead CEO for cancer, my priority is bringing the relevant constituent parts of NHS Wales to a single

conversation about how we improve collaboration to deliver the Welsh Government's prioritise for cancer. Key to our success will be how we benchmark progress and learn from experiences from elsewhere in the UK and wider afield and it was a privilege to welcome and hear from colleagues from the Royal Marsden to our proceedings.

New Appointments

I am delighted to report that Dr Richard Skone has been appointed Deputy Medical Director at Velindre University NHS Trust. Richard will be with us on secondment from Cardiff and Vale University Health Board (CV UHB) to support our Trust Quality and Safety agenda and will be help strengthen and transform our clinical model for blood and cancer services, in partnership with CV UHB. Richard is currently a Consultant in Paediatric Intensive Care Medicine and Anaesthesia. He has also held several senior leadership positions including Responsible Officer, Interim Medical Director, Deputy Medical Director and Caldicott Guardian.

I am also pleased to welcome Eleri Schiavone to the Welsh Blood Service as our new Head of Blood Donation Services.

NHS Wales Sustainability Awards – three Trust nominations

Three Velindre University NHS Trust teams have been nominated for this year's NHS Wales Sustainability Awards to be held in June.

Project ELSA, run by Stephen Pearce and Justyna Zielska-Mikitia of the WBS Stock Holding Unit, is an innovative initiative aimed at improving the sustainability of blood transportation within the Welsh Blood Service. This is achieved by using reusable cooling devices (PCMs) instead of dry ice to cool the transport boxes.

The project has achieved significant financial, environmental, and service improvements.

The IRS Paperless Radiotherapy Project is a forward-thinking service improvement from the Integrated Radiotherapy Solution project. It removes the need for physical documents throughout the radiotherapy treatment journey, replacing this with a new Oncology Management System, Varian's Aria. By transitioning to fully digital systems, the project not only reduces unnecessary paper waste but also ensures that patient information is streamlined, accurate, and accessible at every step of care.

The final nomination goes to Self Administration of Subcutaneous Treatment Initiative. Led by the Value Based Healthcare Team, this programme empowers patients to take control of their treatment by administering medication in the comfort of their own homes. Aligned with the Welsh Government's *A Healthier Wales* strategy and the

nVCC Full Business Case target for 10% of treatments to be home-based, the initiative is already showing strong impact.

Good luck to you all!

The Trust's first Clinical and Scientific Multiprofessional Conference

Our Trust has a dedicated, committed workforce that live our Trust values of being caring, respectful and accountable. In the midst of busy, challenging diaries, it is crucial that we make time to come together to reflect and celebrate our achievements. May 12 2025 provided an opportunity for our multi-professional clinical and scientific colleagues to come together and consider how to strengthen effective team-working, clinical and scientific leadership, personal development and advanced practice. The event featured several notable speakers. Ruth Crowder, the Chief Allied Health Professionals Advisor for the Welsh Government, shared her insights on the important and evolving role of allied health professionals, and Rhiannon Jones, the Deputy Director of Nursing, Quality, Safety, and Improvement at NHS Wales Executive, discussed the importance of multidisciplinary cohesion within healthcare services.

I was humbled to hear powerful personal stories from patients and donors and from Dr Joseph Framer form the Civility Saves Lives who spoke about the importance of kindness and compassion in the workplace. We also heard inspirational stories from other guest speakers, including our Trust Chair, Professor Donna Mead OBE who shared her career journey.

4 IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: NO
If yes - please select all relevant goals: <ul style="list-style-type: none">• Outstanding for quality, safety and experience <input type="checkbox"/>• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations <input type="checkbox"/>• A beacon for research, development and innovation in our stated areas of priority <input type="checkbox"/>• An established 'University' Trust which provides highly valued knowledge for learning for all. <input type="checkbox"/>• A sustainable organisation that plays its part in creating a better future for people across the globe <input type="checkbox"/>

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

5 RISKS

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



TRUST BOARD	
VELINDRE UNIVERSITY NHS TRUST PERFORMANCE MANAGEMENT FRAMEWORK REPORT ANALYSIS FOR MARCH 2024/25	
DATE OF MEETING	22 May 2025
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	Peter Gorin, Head of Strategic Planning and Performance
PRESENTED BY	Lauren Fear, Director of Transformation – interim Anne Carey, Chief Operating Officer, Sarah Morley, Executive Director OD & Workforce, Matthew Bunce, Executive Director of Finance
APPROVED BY	Lauren Fear, Director of Transformation – interim
EXECUTIVE SUMMARY	<p>PERFORMANCE MANAGEMENT FRAMEWORK (PMF) OVERVIEW</p> <p>The report highlights key issues for the attention of the Trust Board, on an exception basis, for the month of March 2025.</p> <p>The PMF PowerPoint slides present the issues identified and discussed by the previous Executive Management Board and Quality Safety and Performance Committee meetings.</p>
RECOMMENDATION / ACTIONS	The Trust Board is asked to note the paper for assurance.
GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	Date
Welsh Blood Service (WBS) SLT / Performance Review	(09/04/2025)
Velindre Cancer Service (VCS) SLT / Performance Review	(16/04/2025)

Executive Management Board (EMB)	(29/04/2025)
Quality, Safety and Performance (QSP) Committee	(08/05/2025)
<p>SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS</p> <p>The report has been considered and endorsed at the VCS and WBS Performance Review meetings, EMB and QSP Committee and is presented to the Trust Board for assurance.</p> <p>Executive Management Board Meeting 29.04.2025</p> <p>The areas that were highlighted by the EMB to QSP Committee were:</p> <ul style="list-style-type: none"> • Digital discussion on resource pressures impacting on ability to support transition projects. Agreed half day workshop to identify priorities, action mapping and funding and increase Assurance to Level 3. • Investigating high number (62) of RT breaches, following 'go paperless' transition. <p>Quality Safety and Performance Committees held on 8th May 2025</p> <p>Velindre Cancer Service</p> <ul style="list-style-type: none"> • The Infection Prevention and Control (IPC) Scorecard measure has been updated to say Velindre Acquired rather than Healthcare-acquired Infections, emphasising that we only record incidences under our control and not those acquired in the community. • Radiotherapy transition to 'go paperless' has caused some short-term data validation issues that have now been resolved for next month and assurance provided over analysis of breaches. <p>Planned Preventative Maintenance</p> <ul style="list-style-type: none"> • PPM data is currently not available for certain sites due to CAFm system transition. However, an action was taken to confirm and it has been confirmed all PPM completed in these locations and is reflected in this paper. <p>WBS Infection Prevention and Control Audit</p> <ul style="list-style-type: none"> • WBS Serious Adverse Blood reactions and Events (SABRE) 127 & 129 incidents were discussed regarding arm cleansing procedure failures noted during the audit. However, corrective actions were taken, and no harm occurred. • The updated suite of KPIs for WBS was approved and agreed upon for implementation in the next PMF cycle, starting with June data. • Reference Serology turnaround internal targets have been reviewed; currently meeting nationally agreed 5-day target. <p>Workforce and Organisational Development</p> <ul style="list-style-type: none"> • PADR rates continue to not meet requires targets. New PADR documentation will provide a more robust framework for improvement and anticipated that Sickness levels will improve as divisional action plans start to take effect. <p>Other items</p> <ul style="list-style-type: none"> • Amended Financial Services to Financial Performance in Assurance table • Noted that other performance exceptions were being addressed 	

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 4 – Increased extent of impact from actions
Digital Services	Level 3 – Actions for symptomatic, contributory and root causes, impact from actions and emerging outcomes
Estates, Infrastructure and Sustainability	Level 3 – Actions for symptomatic, contributory and root causes, impact from actions and emerging outcomes
Health and Safety	Level 4 – Increased extent of impact from actions
Financial Performance	Level 4 – Increased extent of impact from actions
ACRONYMS AND INITIALISM	
VUNHST	Velindre University NHS Trust
QSP	Quality Safety and Performance Committee
QSF	Quality and Safety Framework
EMB	Executive Management Board
SLT	Senior Leadership Team
PMF	Performance Management Framework
PPM	Planned Preventative Maintenance
QSF	Quality Safety Framework
VAI	Velindre Acquired Infections
KPI	Key Performance Indicators
RIDDOR	Reporting Injuries Diseases Dangerous Occurrences Reporting
RD&I	Research Development and Innovation
SPC	Statistical Process Control Charts
SMART	Relating to goal setting “Specific, Measurable, Achievable, Relevant, Timely”
SACT	Systemic Anti-Cancer Therapy
SLA	Service Level Agreement
RT	Radiotherapy
LINAC	Linear Accelerator
SABRE	Serious Adverse Blood Reactions and Events
MHRA	Medicines Healthcare (products) Regulation Agency
PADR	Performance appraisal and Development Review
WHO	World Health Organisation
WHC	Welsh Health Circular

1. SITUATION AND BACKGROUND

PMF Development Work Packages Progress

The Velindre University NHS Trust Executive Management Board have approved nine packages of work in relation to the Trust Performance Management Framework. The NWSSP Internal Audit has concluded a review of the PMF development plans and new format PMF reporting with 'reasonable assurance' finding whilst also identifying some resourcing constraints.

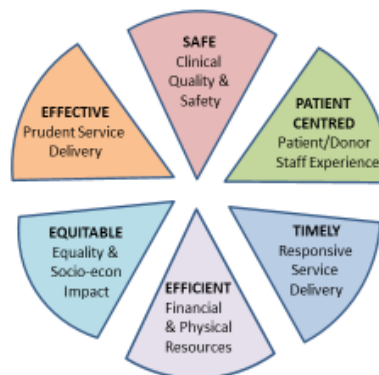
	Work Package	Work Package Summary	Target Completion Date	Progress Update	Lead(s)
1	Current Performance Measures and the Level of Statutory Compliance	To analyse the current range of Trust Performance Metrics and to evaluate the current level of Statutory Compliance	December 2024 (To be repeated 6 - monthly)	Completed – Compliance summary table reported previously. Next Compliance table June 2025	Director of Velindre Cancer Service Director of Welsh Blood Service Trust-wide PMF leads
2	Duty of Quality & Always On reporting targets	Deliver on the Quality Act requirement for 'always on' reporting on key performance areas.	30th June 2025	On Target	Executive Director of Nursing, Allied Health Professionals and Health Science Chief Digital Officer
3	Inclusion of Targets	To ensure that all KPIs have a set target	30 th June 2025	Revised Target – a number of new KPI targets have been developed and reported in	Head of Strategic Planning and

		against which to manage performance.		the current PMF Scorecards e.g. RT and SACT 30-day Mortality at 2%. However, work continues to finalise some remaining areas	Performance (with support from service and Trust-wide PMF leads)
4	Exception/ Threshold Reporting	To agree an approach in relation to exception / threshold reporting.	29 th November 2024	Completed - An approach has been agreed to include exception reporting data only for the Trust Executive Management Board, the Trust Quality, Safety and Performance Committee and the Trust Board.	Director of Transformation – Interim
5	Future PMF Development Plans	VCS, WBS and Trust-wide PMF leads to review the current Trust PMF. This must include any further additional Quality metrics.	April 2025	Completed – current KPI measures have been reviewed and a number of new KPIs added to PMF Scorecards. This is an ongoing process to ensure the PMF scorecard measures remain relevant to manage our performance	Director of Velindre Cancer Service & Director of Welsh Blood Service Trust-wide PMF leads
6	PMF Automation	To ‘automate’ the production of the PMF performance report in order to reduce the current level of manual interactions in the current process.	July 2025	Revised Target –highlighted under recent PMF Audit Recommendation 'Objective 2 Resources' A specific resourcing issue has been identified by BI colleagues to support the completion of the 'BI automation' of PMF to replace the current 'manual Teams' PMF production process – being escalated	Head of Strategic Planning and Performance Trust Business Information PMF lead
7	Pyramid Reporting	To agree with the Executive Management Board a preferred way for reporting within the IMTP.	21 st December 2024.	Completed – It has been agreed that, from January 2025, the PMF will be based upon ‘exception only’ reporting and that the EMB will make this assessment based upon the agreed levels of assurance.	Director of Transformation - Interim

8	Benchmarking	To agree the scope and approach to being able to benchmark our performance data against other comparable organizations.	July 2025	Updated target for next phase – The Performance Management Framework Development Group will oversee a piece of work to ascertain the KPI benchmarks that are currently available against individual KPIs and the potential to develop new benchmark measures	Head of Strategic Planning and Performance

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

2.1 The Performance Management Framework (PMF) operated by the Trust is based on the ‘six domains’ of the Quality Safety Framework (QSF), namely safe, effective, patient/donor centred, timely, efficient and equitable care.

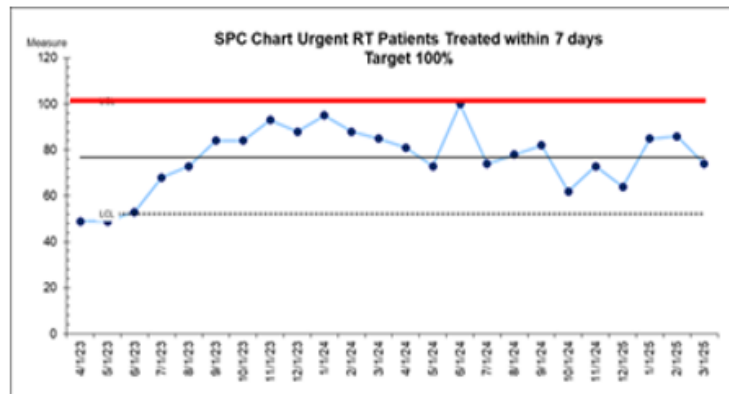
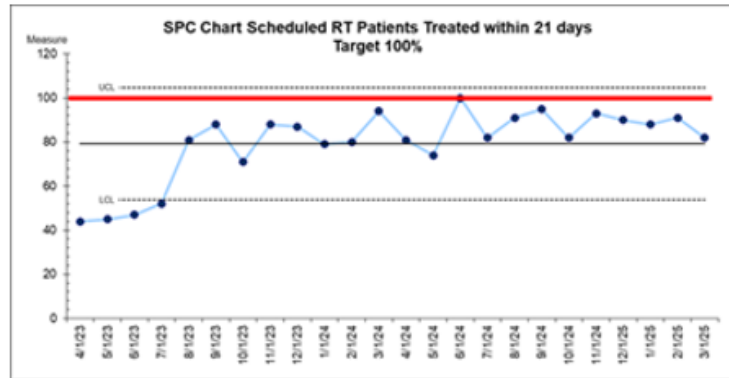


2.2 The following PMF PowerPoint slides highlight the key issues for the attention of the Trust Board, (on an exception basis), identified and discussed by the previous Executive Management Board and Quality Safety and Performance Committee meetings.

2.3 Radiotherapy

Radiotherapy Waiting Times

March 2025



Updates on Last Month:

- Pre-treatment CT capacity remained constant at 17 hours per day
- Increase in machine breakdowns with La4 (Varian Truebeam) being the most affected.
- Linac uptime Varian is 96.4% and Elekta is 98.5%.
- Schedule performance was 82%, Urgent SC was 83% and Emergency was 100% within 2 days
- Longest wait for scheduled was 2 referrals of 39 days one due to a late delineation.
- Data warehouse unable to provide accurate data- with no data on emergency referrals available, a manual check using ARIA was required which utilised significant time to validate and cross check all the data.
- Management of known risks of related to paperless go live – capacity draw for the implementation which coincides with SRU work at Nevill Hall.

Key Issues / Risks

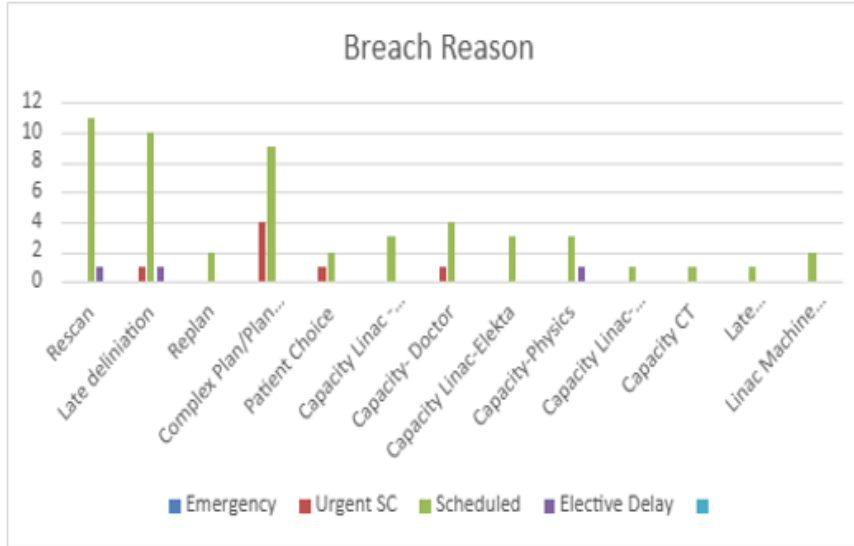
- Alignment of consultant job plans with radiotherapy pathway timings results in non-capacity related breaches.
- Ability to forecast and manage this will increase once Aria InSightive post March 2025. This is a delay is due to the DHCW 'Go paperless' programme

Forecast / Next Month:

- Capacity has been extended where possible through the provision of locum radiographers.
- Due to the public holidays in April, extra capacity is available on these days with staff working planned overtime to treat CAT 1 patients.
- Planned Linac Capacity is between 77.8 hours and 82.5 hours. No increase in activity due to paperless implementation
- Actual performance improvements may be evident in the medium/long term and linked to improvement in pathway management as well linac capacity.
- Implementation of paperless will affect the validation process of the referral data and may cause a slight delay in release

Radiotherapy - Breach data

March 2025



- 12- Rescan
- 12- Late delineation
- 2 - Replan
- 14- Complex plan/plan required
- 3- Patient Choice
- 2- Capacity Linac Truebeam
- 5- Capacity –DR

- 3- Capacity Linac- Elekta
- 4- Capacity –Physics
- 1- Capacity Linac- Halcyon
- 1 -Capacity CT
- 1 -Late Approval/Authorisation
- 2 -Linac Machine Breakdown

Action/Mitigation underway

Capacity

Scrutiny Business case and SBAR for locum staff to ensure Linac Capacity is maintained. SBAR for extension of LA7and LA8 to May 2027 – Approved

Review of linac uptime to be undertaken with Radiotherapy and Radiotherapy physics ensure downtime is recorded in Aria aligns with Varian Equip reporting to be concluded by 1 June 2025 ensure consistent approach with SRU.

Pathway

Implementation of Aria Radiotherapy request as part of the IRS paperless – successful Go Live – March 2025.

Implementation of Carepath for Radiotherapy IR(ME)R practitioners – improved visibility of the individual patient pathway successful completion March 2025

Activity Reporting

Validation of Radiotherapy referrals recorded in data warehouse following implementation of paperless.

Review of data capture on Aria with data and insights, finance and Radiotherapy physics computing, to better reflect RT activity informing:

- Income
- Capacity utilisation
- Development in readiness to InSightive (Oncology Specific Analytics) implementation
- Development of activity reporting for Brachytherapy – following paperless go live
- Development of activity reporting – following paperless go live

Assurance

Where demand exceeds capacity, all referrals are submitted through escalation for clinical prioritisation.

All failures to meet waiting times targets are investigated at pathway level to identify delay reasons and have a clinical review. Themes are logged and mitigations developed to offset as far as possible before fleet replacement

Radiotherapy – Utilisation

March 2025

Utilisation	January		February		March	
	Hrs	%	Hrs	%	Hrs	%
Total Linac capacity (Patient and non-patient activity)	1683	100	1533.5	100	1687.5	100
Planned Linac Maintenance	18	1	37.5	2	19.5	1
Planned Linac daily QA	130.5	8	114.75	7	124.5	7
Planned Physics QA	8.75	1	7.5	0	6.66	0
Breakdown	38.94	2	49.58	3	73.48	4
Preventative maintenance	2.25	0	10.75	1	0	0
Cancellation	65	4	65.08	4	98.08	6
Training activity	2	0	16.75	1	2.25	0
Delivered Linac activity	1236.75	73	1135.5	74	1329.67	79
Utilisation	1396	83	1312	85	1483	88
Reactive Linac clinical capacity - overtime	18.3	1.1	11.08	0.7	31.08	2%
Reactive Linac clinical capacity - Weekend	7	0.4	4.25	0.2	5.5	0.3
Weekend hours treatment forecast	0		0		0	
Out of hours physics services						
Out of hours physics forecast						

Summary

- March total capacity was higher, increased from Feb with additional capacity provided for Paperless implementation.
- Cancelled 98 hours (6%) due to patient cancellations, breakdown, complex planning, rescans and late delineations.
- Reactive Linac capacity 36.6 hours delivered out of hours including weekends.
- Overall, March utilisation was 88% against 85% in February, higher breakdown rate, redistributed patients, no patient breached clinical protocol, therefore no patient harm.
- Only marginal productivity gains possible ahead of Insightive becoming operational

Ymddiriedolaeth GIG Prifysgol Felindre

Gofal ardderchog, dysgu ysbyrdoledig, pobl iachach



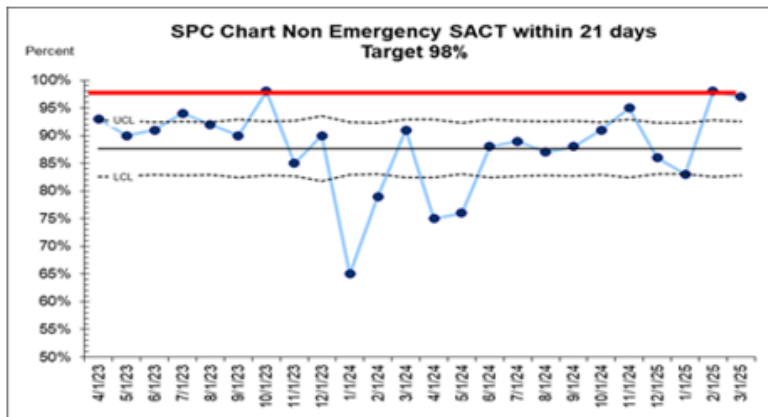
Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

Velindre University NHS Trust

Excellent care, inspirational learning, healthier people

SACT Non-Emergency Waiting Times

March 2025



Action / Mitigation Underway:

- Workplan developed by SACT improvement group has now transitioned to SACT delivery group with increased focus on delivery
- General manager lead in post for the SACT directorate increasing leadership and delivery of management tools and improvements
- Recently appointed pathway coordinator roles are now fully trained and independently validate breaches.
- Data quality issues remain resulting in a continued hold on operational use of SharePoint tool, this has been escalated,
- SACT performance manager role is out to advert as part of the approved business case to improve the SACT booking process.

Updates on Last Month:

- The Cancer PTL (single source of the truth) on track for delivery in April 25.
- Work with the Health Boards has commenced to streamline patient information transfer and reduce pathway delays.
- Pharmacy and nursing capacity increase planned, extra 10 cycles per week has been implemented
- Progress 2 X ACP recruited as part of the workforce change for SACT pre-assessment transitioning from Consultant delivered to Consultant led
- 6/7 Working workshop held aiming to introduce additional SACT capacity
- Longest wait for treatment was 1 patient at 45 days, this was due to CT scan requirement, discussion underway to resolve the reason for this wait.

Key Issues / Risks:

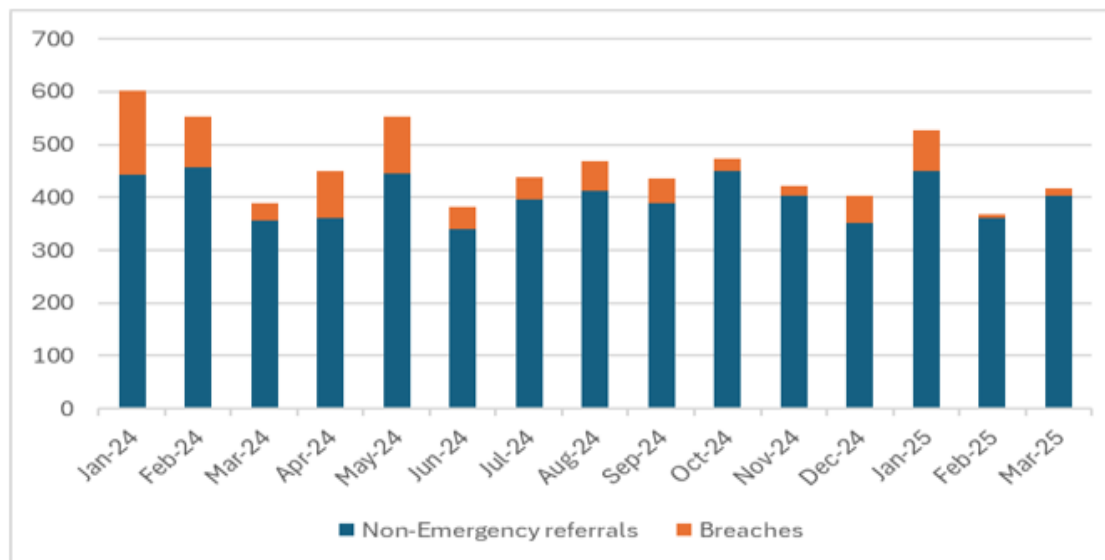
- **Referral Rates** - processes in place to monitor daily & weekly referral rates against predicted capacity and delivery of 21days
- **Digital** – ongoing conversations with DHCW to support the delivery of Hospital Initiated Referrals (HIR) into VCS
- **Patient Pathway Visibility** - mitigations in place for the lack of visibility of patients with Cancer PTL, phase 1 due April 25
- **Workforce recruitment** - Bespoke and targeted recruitment processes.
- **Data quality** - identifying these issues is enabling root cause analysis and interventions to resolve matters

Forecast / Next Month:

- Increased focus due to Systemic Therapies Directorate team introduction
- Update on-going initiatives via the SACT delivery group
- Potential PICC related breaches forecast for April, capacity expansion scheduled for 5th May.

Breach data

March 2025



Number	Reason	Action
6	Capacity constraints	Capacity plan in place via SACT delivery group
1	Clinical request (no rationale)	Further detail requested from clinician
1	Deferral	Further detail requested from clinician
1	Patient safeguarding	Complex social circumstances for patient
2	Interdependent pathway delay (Muga scan)	Restricted isotope, mitigation to avoid future occurrence underway
1	CT scan required	Delay with pre scan appointment, discussions with department underway
1	Administration error	Misinterpretation of notes, investigation and lessons learnt underway

2.5 Welsh Blood Service

WBS Incidents Reported to Regulator / Licencing Authority



Gwasanaeth Gwaed Cymru
Welsh Blood Service

 March 2025

In March, three Serious Adverse Blood Reactions and Events (SABRE) incidents were reported to the Medicines and Healthcare products Regulatory Agency (MHRA). All incidents have been risk reviewed, made safe, and are under investigation. Root causes, corrective & preventative actions and lessons learnt will be shared with internal quality groups for assurance.

- **SABRE 127:** An Infection Protection Control (IPC) Audit found issues with donor arm cleansing that were not managed on the day of the audit.
- **SABRE 128:** An interface failure between two software systems required manual monitoring from 22:40 on 03/03/25 to 06:00 on 04/03/25, which was not performed due to a miscommunication by the Digital Services "on-call" team. Bacteriology monitoring data was available, checked, and showed no positive results.
- **SABRE 129:** There was a failure to follow the donor arm cleansing procedure. This incident is similar to SABRE 127 but involved a different team member.

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



Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

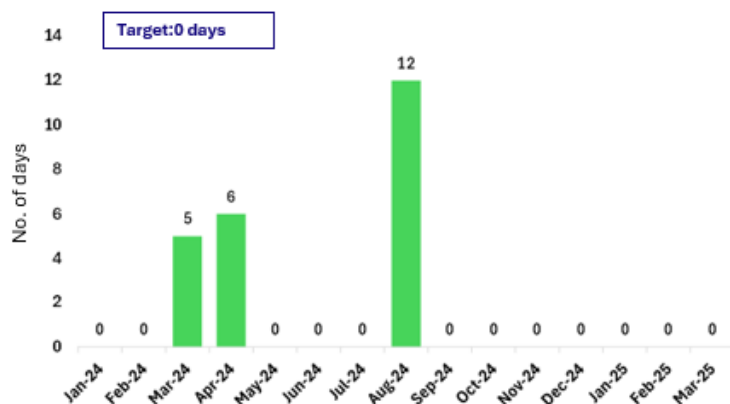
Velindre University NHS Trust
Excellent care, inspirational learning, healthier people

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



Gwasanaeth Gwaed Cymru
Welsh Blood Service

March 2025



Key Issues / Risks:

- Differences in hospital demand and blood collection across various blood groups can lead to an imbalance between supply and demand.

Action / Mitigation Underway:

- Daily Resilience Group meetings are held to ensure immediate operational responses and mitigate any arising issues.
- Monthly Blood Supply Chain Planning Group meetings now place greater emphasis on medium and long-term planning.

Updates on last month:

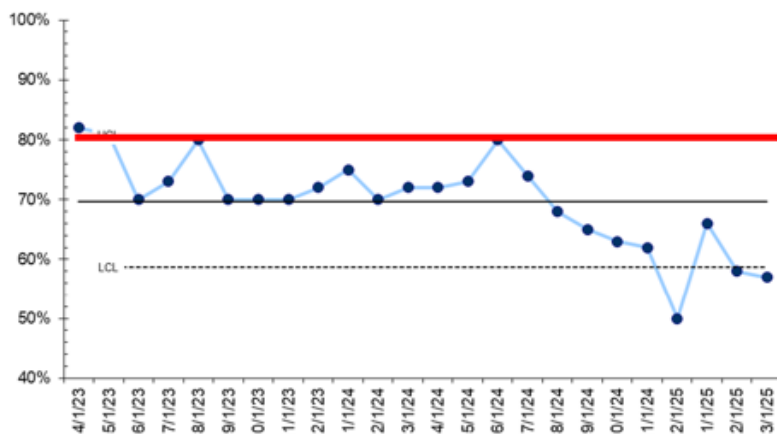
- All clinical demand was met for O, A & B+ groups.
- The number of red cells manufactured as a percentage of the issues to hospitals was 104%, supporting stock build.

Forecast / Next Month:

- Next month's forecast is on target, and planning for stock build for the April/May bank holiday is underway. Scheduled debriefs between Bank Holidays.

Reference Serology Turnaround Times (2 working days)

March 2025



Updates on Last Month:

- 100% of time critical testing was reported within the required timeframe of 2 days.
- Performance for non-urgent referrals did not meet the current target of 80% of results provided within 2 working days.



Key Issues / Risks:

- Non-urgent referral target not aligned with RCI User Guide (90% of non-urgent results provided within 5 working days).
- Even if aligned, performance is at 79% this month due to workforce capacity and resilience issues impacting efficiency.

Action / Mitigation Underway:

- Metric to be aligned with the RCI User Guide from April 2025.
- Recovery Plan developed to support short/medium term capacity and resilience issues (impact from May 2025).
- Recommendations from the external RCI review to support medium to long-term improvements.

Forecast / Next Month:

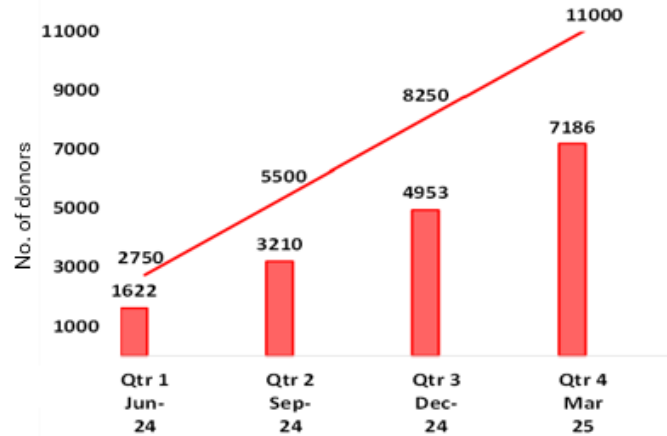
- Implementing the Recovery Plan is expected to yield improvements from May 2025 onwards, with additional medium to long-term benefits anticipated from the RCI Review recommendations (impact from Qtr 4 2025/26).

New Whole Blood Donors (Quarterly Reporting)



Gwasanaeth Gwaed Cymru
Welsh Blood Service

March 2025



Key Issues / Risks:

- Prioritising known blood groups to balance supply and demand reduces appointment availability for new donors.
- Focusing on retention of existing donors limits opportunities for new donors to donate.

Action / Mitigation Underway:

- Increase appointment opportunities at locations ideal for new donors (schools, businesses, educational settings) – approach proven successful in north-west Wales.
- Research study on recruitment & retention and the impact on maintaining a stable and sufficient donor base.
- Engagement Strategy – collaboration with VUNHST Charity to explore opportunities.

Updates on Last Quarter:

- This quarter, 2,233 new whole blood donors were recruited, which did not meet the quarterly target of 2,750.

Forecast / Next Quarter:

- Performance is not expected to increase significantly while prioritising known blood groups. New donor recruitment is expected to continue to be below target next quarter, with projections for April and May significantly falling short of the monthly goal.

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

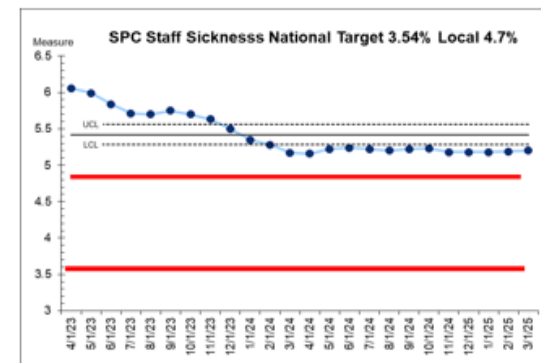
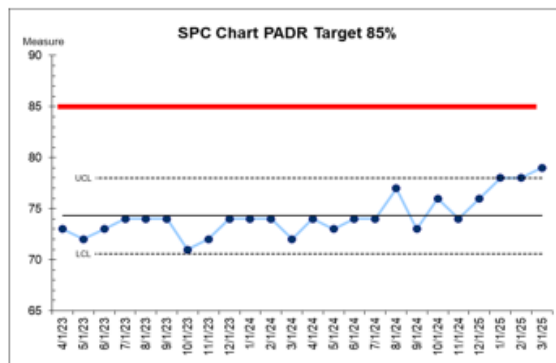
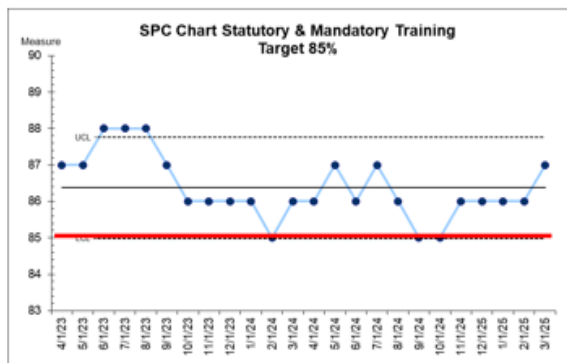


Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

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

Workforce, Wellbeing & Organisational Development

March 2025



Updates on Last Month:

- **PADR** – New templates and supporting documents to be launched 1st April provide a robust framework for implementation of the new People Development Policy
- **Sickness** – Trust action plans following detail absence analysis are ongoing and progress towards target is being seen.

Forecast / Next Month:

- **PADR** – as systems for completion of PADR's improves we forecast an improving trend towards the KPI target of 85%
- **Sickness** – forecast expected to continue the improve as divisional action plans are drawn up aligned to the detailed data analysis.
- **S & M Training** – to remain above 85% target

Action / Mitigation Underway:

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

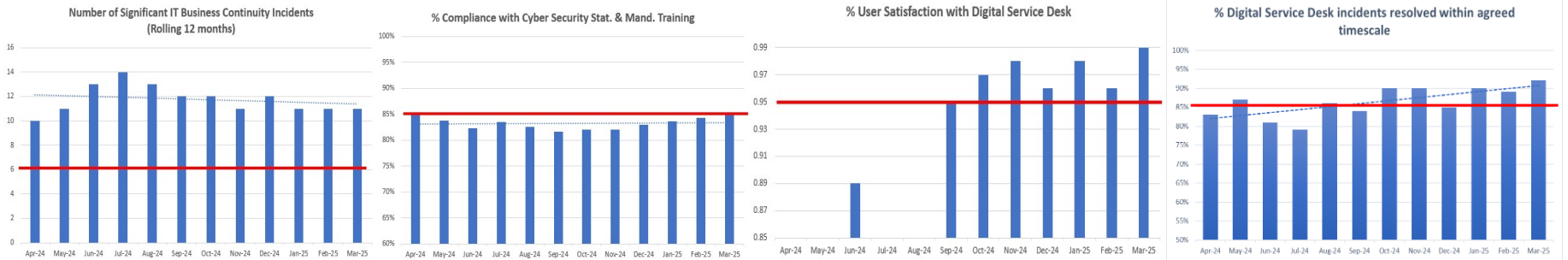
Key Issues / Risks:

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

2.7 Digital Services

Digital Services

📅 March 2025



Updates on Last Month:

- Performance improvements observed across in Digital Service Desk measures sustained in March 2025 – a reflection of process improvements following introduction of new HalolTSM service desk platform in late-2024.
- Target for compliance with cyber security statutory & mandatory training achieved in March 2025 – work ongoing to target service areas under compliance to ensure performance is maintained.
- No change in rolling 12-month number of significant IT incidents in March 2025.

Action / Mitigation Underway:

- **Significant Incidents** – Ongoing work with DHCW to improve service management arrangements of national IT services (e.g. WCP). Approx. half of all SIs relate to national (DHCW -managed) services.

Forecast / Next Month:

- Work ongoing to increase automation of tasks across Digital Service Desk, to ensure current performance gains can be sustained over the long -term.
- Additional capital funding has been approved for the technical refresh of digital client devices and network/server infrastructure. Procurement completed in March 2025, for deployment in 2025/26 .
- Capital funding also being used to upgrade legacy IT infrastructure across Radiotherapy Physics service in March 2025 – for installation in Q1 2025/26..

Key Issues / Risks:

- Compliance with IG and Cyber security statutory and mandatory training needs to be maintained. Corporate, VCS and TCS are all currently below the target of 85% compliance. Targeted comms / engagement (e.g. additional face-to-face training) underway to drive up performance.

Ymddiriedolaeth GIG Prifysgol Felindre

Gofal ardderchog, dysgu ysbrydoledig, pobl iachach



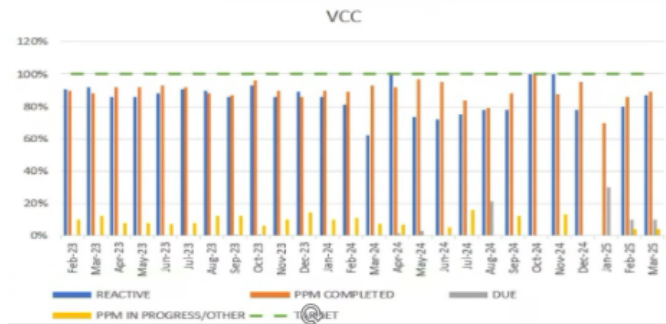
Velindre University NHS Trust

Excellent care, inspirational learning, healthier people

2.8 Estates Infrastructure and Sustainability

Estates and Infrastructure

March 2025



Updates on Last Month:

- VCS PPM 89% Reactive - 87%
- WBS HQ PPM 69% Reactive – 95%
- Dafen - 100%
- Wrexham - 100%
- Bangor - 100%
- 19 Park Road - 100%
- Nantgarw - 100%

Action / Mitigation Underway:

- Manually cross-referencing PPM tasks to ensure system continuity of work PPM tasks to be distributed across all sites that have not been uploaded to new CAFm system.
- No Data collected on WBS remote sites 19 park road and Nantgarw due to transition of CAFm systems to symbiotix – for assurance all PPM & Reactive tasks have been completed during the March period.

Forecast / Next Month:

- 491PPMs planned for VCC
- 95 PPMs planned for WBS sites.
- Prioritise outstanding PPM and finalise other sites with CAFm provider to ensure they are available on system.
- Ongoing manual cross referencing of

Key Issues / Risks:

- Reporting function on Symbiotix currently causing issues. Road map to resolve fix estimated by June 2025
- Unable to meet PPM benchmark compliance at VCS and WBS. No data was distributed due to issues with CAFm system and development requests.
- Cafm System Reporting function experiencing issues, meeting scheduled to discuss other options and resolve current issues with supplier on May 20th 2025.

Ymddiriedolaeth GIG Prifysgol Felindre

Gofal ardderchog, dysgu ysbrydoledig, pobl iachach

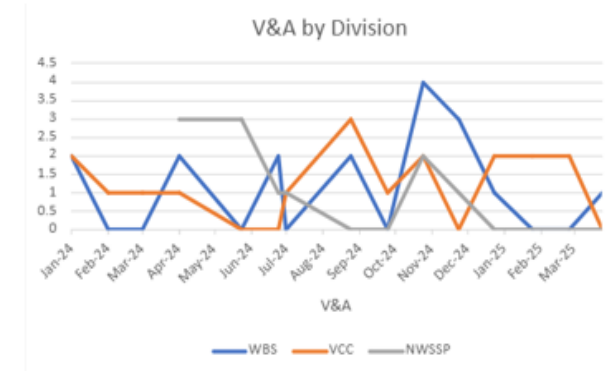
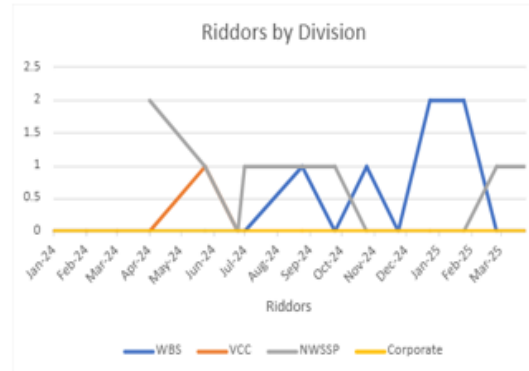
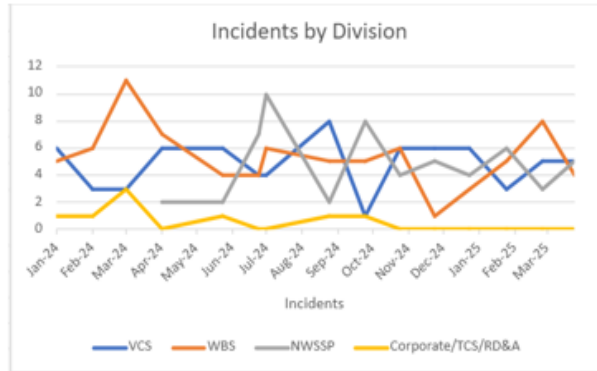


Velindre University NHS Trust

Excellent care, inspirational learning, healthier people

Health & Safety

📅 March 2025



Updates on Last Month: Total of incidents

- NWSSP - 5
- VCS - 5
- WBS - 4
- Riddor – Slip, Trip & Fall – reported within timeframe to HSE (NWSSP)

Forecast / Next Month:

- NWSSP - Applicants have been shortlisted and interviews to commence.
- VCS – Annual report and patient manual handling continues to be the focus
- WBS – Review V&A training for the collection teams and complete the TNA

Action / Mitigation Underway:

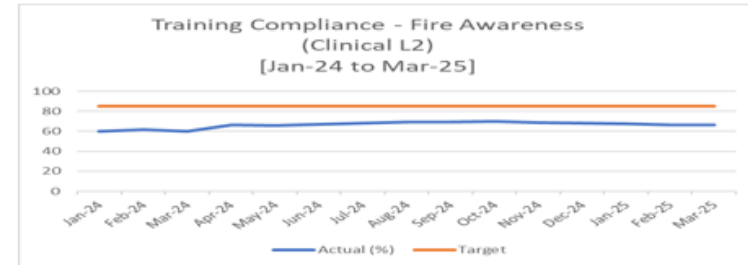
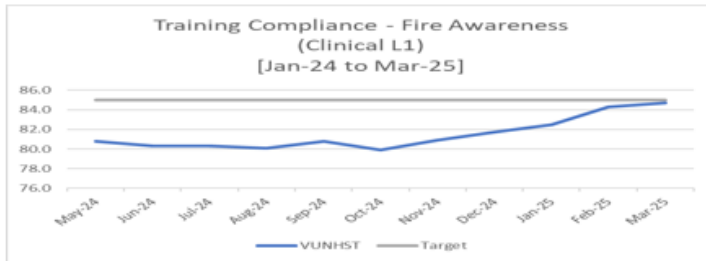
- NWSSP - Removal of archiving from Companies House Repository area due to RAAC. Revised HSG65 question set issued in readiness for new financial year.
- VCS – Ongoing meeting with VCS staff around training plans - Radon Mitigation
- WBS –

Key Issues / Risks:

- NWSSP - Ensuring Church Village and Glangwili hub align to HSG65 process within NWSSP. Appointing to Health and Safety Support Officer Post.
- VCS – Patient Manual Handling requires a plan from VCS, next meeting 25th March
- WBS – Improve Datix incident reporting process to avoid late reporting

Fire Safety

March 2025



Updates on Last Month:

STRATEGIC

- Continuation with development of fire safety protocols
- Continuation with annual fire safety Audit

VCS

- Improvement in fire safety training compliance for both L1 and L2 training
- Evacuation drills undertaken
- SWFRS exemption granted for VCC and Whitchurch site

WBS

- Improvement in fire safety training compliance for L1 and L2 training
- SWFRS Exemption granted for WBS Headquarters

Corporate

- Drop in fire safety training compliance
- Fire drill overdue
- Further conversation on n-VCC fire strategy

Action / Mitigation Underway:

VCS

- Review of fire risk assessments
- More departments setting up local training arrangements
- Commitment to regular evacuation drills in non-clinical areas

WBS

- Setting up more fire safety training sessions

CORPORATE

- Schedule evacuation drill by end of April.

Forecast / Next Month:

STRATEGIC

- Complete fire audit and finalise with Board Level Director (Fire) for submission by end of May 2025
- Continue to develop fire safety protocols
- Continued engagement with WOD around improving delivery of fire safety training

VCS

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

WBS

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

CORPORATE

- Run evacuation drill

Key Issues / Risks:

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

Ymddiriedolaeth GIG Prifysgol Felindre

Gofal ardderchog, dysgu ysbrydoledig, pobl iachach



Velindre University NHS Trust

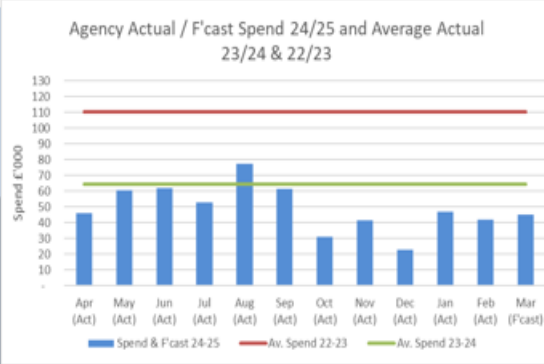
Excellent care, inspirational learning, healthier people

Financial Performan

March 2025

Trust Revenue Position (core)	23/24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Actual (Cum) £k	30	5	7	8	8	15	18	21	23	29	32	32	42
Target		0	0	0	0	0	0	0	0	0	0	0	0

Trust Capital Position	23/24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Actual (Cum) £m	31.002	0.416	2.113	4.925	6.322	7.419	8.153	14.749	23.018	24.451	25.792	27.817	35.072
Target £35.076 m CEL		0.416	2.113	4.925	6.322	7.419	8.153	14.749	23.018	24.451	25.792	27.817	35.076



Updates on Last Month:

- The revenue position for March was broadly in line with the IMTP planning assumptions. The draft, unaudited year end position is £0.042m.
- The Trust has achieved its CEL (Capital Expenditure limit), with a slight underspend remaining of £0.004m.

Forecast / Next Month:

- The revenue position for April 2025 is expected to be in line with the recently submitted IMTP.
- The Trust emergency reserve will be held at the start of the year, pending needs arising during the year.
- The Trust is expected to receive an updated 2025-26 CEL (Capital Expenditure limit) shortly, confirming the agreed WG funding to date.

Action / Mitigation Underway:

- VCS LTA Activity is under urgent review within the Division now that it is recognised that the original forecast income was not achieved by year end, and to ensure that all activity is being captured and costed correctly on an ongoing basis.

Key Issues / Risks:

- VCS LTA income activity will not match the level of investment into services at VCS.
- WBMDR income in WBS underachieves against plan in 2025-26.



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:													
<ul style="list-style-type: none"> • Outstanding for quality, safety and experience <input checked="" type="checkbox"/> • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations <input type="checkbox"/> • A beacon for research, development and innovation in our stated areas of priority <input type="checkbox"/> • An established 'University' Trust which provides highly valued knowledge for learning for all. <input type="checkbox"/> • A sustainable organisation that plays its part in creating a better future for people across the globe <input type="checkbox"/> 													
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) <i>For more information: STRATEGIC RISK DESCRIPTIONS</i>	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												
	<table border="0"> <tr><td>Safe</td><td><input checked="" type="checkbox"/></td></tr> <tr><td>Timely</td><td><input checked="" type="checkbox"/></td></tr> <tr><td>Effective</td><td><input checked="" type="checkbox"/></td></tr> <tr><td>Equitable</td><td><input checked="" type="checkbox"/></td></tr> <tr><td>Efficient</td><td><input checked="" type="checkbox"/></td></tr> <tr><td>Patient Centred</td><td><input checked="" type="checkbox"/></td></tr> </table>	Safe	<input checked="" type="checkbox"/>	Timely	<input checked="" type="checkbox"/>	Effective	<input checked="" type="checkbox"/>	Equitable	<input checked="" type="checkbox"/>	Efficient	<input checked="" type="checkbox"/>	Patient Centred	<input checked="" type="checkbox"/>
	Safe	<input checked="" type="checkbox"/>											
Timely	<input checked="" type="checkbox"/>												
Effective	<input checked="" type="checkbox"/>												
Equitable	<input checked="" type="checkbox"/>												
Efficient	<input checked="" type="checkbox"/>												
Patient Centred	<input checked="" type="checkbox"/>												
<p>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).</p> <p>Quality and Safety considerations form an integral part of PMF to monitor our performance and progress against our strategic objectives</p>													

QUALITY IMPACT ASSESSMENT	Not required - not a strategic decision
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Not required
TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT	
<p>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</p>	
<p>If yes select the relevant goals:</p> <ul style="list-style-type: none"> • A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities. <input type="checkbox"/> • A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience. <input type="checkbox"/> • A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health <input checked="" type="checkbox"/> • A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances <input checked="" type="checkbox"/> • A Wales of more Cohesive Communities - Attractive, viable, safe and well-connected communities. <input type="checkbox"/> • 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. <input checked="" type="checkbox"/> • A Globally Responsible Wales – Consideration of whether an action may make a positive contribution to global well-being <input checked="" type="checkbox"/> 	
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.



TRUST BOARD	
FINANCE REPORT FOR THE PERIOD ENDED 31ST MARCH 2025 (M12)	
DATE OF MEETING	22 May 2025
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	INFORMATION / NOTING
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Claire Bowden – Interim Head of Financial Planning & Reporting Steve Coliandris – Acting Deputy Director of Finance
PRESENTED BY	Matthew Bunce, Executive Director of Finance
APPROVED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SUMMARY	<p>The attached report outlines the financial position and performance for the period to the end of March 2025.</p> <p>The three main issues are highlighted below:</p> <ol style="list-style-type: none">1. Long Term Agreement (LTA) Financial values & Contract Rebase <p><u>LTA Financial Values</u> All 2024-25 LTA financial values have been agreed and signed.</p> <p>The financial settlement resulted in a:</p> <ol style="list-style-type: none">£318k reduction in recurrent NICE drug income (£145k Aneurin Bevan University Health Board (UHB), £115k Cwm Taf Morgannwg UHB & £58k reverting to old baseline) compared to plan.

- ii. £483k reduction in Hywel Dda UHB income non-recurrently compared to plan.

As part of the IMTP process for 2025-26 the Trust Finance Team has been in regular dialogue with our Commissioners regarding the Trust income assumptions and have agreed LTA funding principles with all Commissioners for both VCS and WBS. However, in order to reach agreement with Hywel Dda on LTA principles and financial value for VCS the Trust has had to again agree a compromise position with a non-recurrent reduction in NICE / HCD income of c£0.483m as agreed in 2024-25 to reflect resources consumed rather than historic shares. The Trust continues to face a significant recurrent income risk with Hywel Dda beyond 2025-26 of c£0.843m who have given notice that the NICE/HCD £0.483m and historic shares activity baseline funding of c£360k will be removed recurrently in 2026-27.

To ensure Commissioners fund the total cost of Velindre running cancer services from 2026-27 there needs to be agreement from all Commissioners to change the commissioning principles for Velindre from 'historic shares' based on activity and NICE consumption in 2004-5 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.

Commissioners have also not agreed any additional funding above the 1.77% general uplift, for either WBS or VCS. The Trust is managing the pressure for additional capacity invested in outpatients, ambulatory care, SACT and imaging services during 2023-24 and 2024-25 to meet the rising demand and cancer waiting times. Whilst the Velindre Collective Commissioning Group for Cancer have agreed to undertake a more detailed review of the SACT

Business Case submitted as part of the IMTP process, there has been no commitment to fund made as part of the LTA agreements for 2025-26, so the financial risk of this additional capacity implemented remains with the Trust.

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

- The Trust submitted a balanced three year IMTP, covering the period 202-25 to 2026-27 to Welsh Government on the 30 March 2024.
- Following agreement on the LTA the Trust financial plan was revised and the shortfall in LTA income has been recovered through a combination of increased savings target, pausing previously agreed investment decisions, and mitigating cost pressures thus ensuring that the Trust continues to have a balanced financial plan.
- A new financial risk emerged during this year whereby LTA income activity was not expected to match the level of investment into services at VCS. At the end of March 2025 there was full year underachievement of c£0.240m against the target and investment of £1.300m which has been made in the service. Recent months have seen some recovery however, the annual target was not achieved in 2024-25. Work will continue into 2025-26 to ensure that all activity is being captured and recorded correctly.

3. Key Financial Targets / KPIs

- The Trust is reporting an in month underspend of £0.011m and a draft year end underspend of £0.042m.
- The Trust has met the Public Sector Payment Performance (PSPP) target of paying 95% of non-NHS invoices within 30 days for 2024-25.

The Trust has achieved the Capital Expenditure Limit (CEL) which is following the Trust securing the funding for the nVCC Enabling and project costs for 2024-25.

	<ul style="list-style-type: none"> The uncommitted non-recurrent reserve and emergency reserve had been on hold to ensure the Trust could support the financial risk in relation to the nVCC implementation staff & advisor costs and EW advisor costs until WG funding was secured. However, following subsequent recent FBC approval, the non-recurrent revenue funds became available and were utilised to support the WBS underachievement on WBMDR income.
<p>RECOMMENDATION / ACTIONS</p>	<p>Trust Board is asked NOTE the contents of the March 2025 financial report and in particular:</p> <ul style="list-style-type: none"> The year to date and forecast revenue and Capital out turn position, and PSPP performance. The agreed position on LTA income for 2024-25 from our Commissioners. The position with commissioners on the contract rebase agreement. The latest position on the LTA Activity performance for 2024-25.
<p>GOVERNANCE ROUTE</p>	
<p>List the Name(s) of Committee / Group who have previously received and considered this report:</p>	<p>Date</p>
<p>Executive Management Board</p>	<p>29.04.2025</p>
<p>Quality, Safety & Performance Committee</p>	<p>08.05.2025</p>
<p>SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS</p> <p>The report was received and discussed at EMB on the 29th April, and by the QSP Committee on 8th May 2025.</p>	
<p>7 LEVELS OF ASSURANCE</p>	
<p>ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR</p>	<p>Select Current Level of Assurance</p>
<p>APPENDICES</p>	

Appendix 1	Trust Finance Report – March 2025
Appendix 2	nVCC Finance Report – March 2025

1. SITUATION / BACKGROUND

- 1.1 The attached report outlines the financial position and performance for the period to the end of March 2025.
- 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	Draft Year End Position £000	Year End Forecast £m
Revenue	Variance	0.011	0.042	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	10.621	35.072	35.072
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	98.5%	97.7%	97.0%

2.2 Revenue Budget

The overall position against the profiled revenue budget to the end of March 2025 is a draft, unaudited, underspend of **£0.042m**.

LTA Income

A new financial risk emerged this year whereby LTA income activity was not expected to match the level of investment into services at VCS. At the end of March 2025 there was a full year underachievement of c£0.240m against the target and investment of £1.300m which had been made in the service. Recent months have seen some recovery however, the annual target was not achieved in 2024-25.

Pay Award

The Trust has now received funding from WG via the pay matrix for the full 2023-24 consolidated pay award and full funding of the 2024-25 pay award for AFC, M&D and VSM based on actual staff in post as detailed below:

The AFC and M&D pay award processed in November cost the Trust £4.827m based on actual staff in post. This left a gap in funding against full establishment of c£0.337m, and a shortfall against increments of £0.280m which will not be funded by WG. Divisions will be required to manage this shortfall via an increased vacancy factor / additional savings.

The cost of the AFC band 8 and above incremental spinal points processed in January was £0.306m and the pay award relating to VSM was £0.091m.

The 2023/24 medical pay award which was processed in September totalled £1.121m (£0.755m recurrent).

LTA Contract Position

Following discussions between Chief Executives, and to avoid arbitration, a compromise position was agreed on the LTA financial values in line with 30th June deadline which has led to a financial impact to the Trust for 2024-25 as follows:

- £318k Reduction in recurrent baseline uplift income compared to plan.
- £483k Reduction in non-recurrent income compared to plan.

The £483k reduction in income will become recurrent in 2025/26 together with a further recurrent reduction of c£360k which will need to be considered part of the financial plan included with the IMTP.

The shortfall in LTA income has been recovered through a combination of an increased savings target, pausing previously agreed investment decisions, and mitigating cost pressures.

LTA Contract Rebase

The Chair of the Collective Commissioners Group wrote to all Commissioner DoF on 25th September seeking responses by 18th October to the rebasing proposals:

- Retain the original principles of the 2019/20 rebasing exercise.
- Revise the original rebasing exercise to update the baseline using 2023/24 actual activity, expenditure, and income.
- Retain the original agreement to a resource neutral impact by matching changes in rebased expenditure with a matched change in revenue resource allocation.
- The implementation of the rebased LTA Activity & Expenditure for 2025/26 LTAs.
- The adoption of paying for NICE & High Cost Drugs based upon actual utilisation from 1st April 2025.

As part of the IMTP process for 2025-26 the Trust Finance Team has been in regular dialogue with our Commissioners regarding the Trust income assumptions and have agreed LTA funding principles with all Commissioners for both VCS and WBS. However, in order to reach agreement with Hywel Dda on LTA principles and financial value for VCS the Trust has had to again agree a compromise position with a non-recurrent reduction in NICE / HCD income of c£0.483m as agreed in 2024-25 to reflect resources consumed rather than historic shares. The Trust continues to face a significant recurrent income risk with Hywel Dda beyond 2025-26 of c£0.843m who have given notice that the NICE/HCD £0.483m and historic shares activity baseline funding of c£360k will be removed recurrently in 2026-27.

To ensure Commissioners fund the total cost of Velindre running cancer services from 2026-27 there needs to be agreement from all Commissioners to change the commissioning principles for Velindre from 'historic shares' based on activity and NICE consumption in 2004-5 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.

2.3 Savings

In conjunction with the overall financial plan an in depth review of the Trust's savings plan was undertaken during June and resulted in a revised savings target

of £2.875m being set for 2024-25, which is an increase of £0.269m from the £2.606m which was set at the IMTP planning stage.

Several new schemes were identified, which replaced those schemes that had either failed to be implemented or had not yet progressed. The revised target of £2.875m was required to help compensate for the loss of income from the LTA agreements.

The overall Trust savings performance as of March 2025 is a full achievement of the year's plan.

2.4 PSPP Performance

During March 2025 the Trust (core) achieved a compliance level of **98.49%** (February 98.24%) of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **97.71%** at the end of month 12, and a Trust position (including hosted) of **97.91%** compared to the target of 95%.

2.5 Covid Expenditure

The Trust did not draw down any covid funding support during 2024-25.

2.6 Reserves

The uncommitted non-recurrent reserve and emergency reserve had been on hold to ensure the Trust could support the financial risk in relation to nVCC implementation staff & advisor costs and EW advisor costs until WG funding was secured. However, following recent FBC approval, non-recurrent funds became available and were utilised to support the WBS underachievement on WBMDR income.

The recurrent underlying reserves position was considered in conjunction with the IMTP planning exercise for 2025-26 and took into account several key factors including the VCS marginal income risk, LTA contract rebase risk, achievement of 2024-25 recurrent savings, underlying and new emerging cost pressures, Divisional CIP targets and Trust investment decisions / choices.

2.7 Financial Risks

There were several financial risks that could have impacted on the successful delivery of a balanced position for 2024-25, but, by the end of February, all were

re-assessed and removed or mitigated completely for 2024-25. The Trust is continuing to take actions to ensure that risks impacting on the underlying financial position are appropriately managed and mitigated against. All areas of financial plan delivery are risk assessed and where necessary identified risks are included within the Trust wide Risk Register.

2.8 Capital

All Wales Programme

The Trust has received funding towards the nVCC project and enabling costs, support for the nVCC Enabling works QRA, and Whitchurch Hospital and land matters for 2024-25.

The Trust has been provided a funding award letter towards the OBC/ FBC stage for the WBS TGI infrastructure scheme, however progression is currently paused whilst the Trust works with the contractor to understand the proposed step up in costs for delivery of the scheme. WG are both aware and understanding of the situation.

Other Major Schemes in development that are detailed in the finance report will be considered during 2025-26 in conjunction with WG.

Discretionary Programme

The discretionary programme was fully committed and reported a slight overspend against the funding at year end. This was purposely enacted to offset the underspends on the All Wales Capital Programme schemes which were notified to WG.

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

3. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below
If yes - please select all relevant goals:
<ul style="list-style-type: none"> • Outstanding for quality, safety, and experience <input checked="" type="checkbox"/>

<ul style="list-style-type: none"> • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations <input type="checkbox"/> • A beacon for research, development, and innovation in our stated areas of priority <input type="checkbox"/> • An established 'University' Trust which provides highly valued knowledge for learning for all. <input type="checkbox"/> • A sustainable organisation that plays its part in creating a better future for people across the globe <input type="checkbox"/> 	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) <i>For more information: STRATEGIC RISK DESCRIPTIONS</i>	08 - Trust Financial Investment Risk
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Select all relevant domains below
	Safe <input checked="" type="checkbox"/> Timely <input checked="" type="checkbox"/> Effective <input checked="" type="checkbox"/> Equitable <input checked="" type="checkbox"/> Efficient <input checked="" type="checkbox"/> Patient Centred <input checked="" type="checkbox"/>
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: <ul style="list-style-type: none"> • A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities. <input checked="" type="checkbox"/> • A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic, and ecological resilience. <input type="checkbox"/> • A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health <input type="checkbox"/> • A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances <input type="checkbox"/> 	

<ul style="list-style-type: none"> • A Wales of Cohesive Communities - Attractive, viable, safe, and well-connected communities. <input type="checkbox"/> • 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. <input type="checkbox"/> • Globally Responsible Wales – Consideration of whether an action may make a positive contribution to global well-being <input type="checkbox"/> 	
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	The Trust reported a revenue financial position of £0.032m underspend to February 2025, which is currently 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. Click or tap here to enter text

4. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	Individual financial risks are discussed in section 2.7 of the report and the overall financial sustainability and value risk assessment is reflected in the Trust Assurance Framework (TAF)
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?	Individual risks to be managed with the financial envelope for 2024-25. Overall financial and sustainability risks reported and managed through the TAF.
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No

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 MARCH 2024/25

**TRUST BOARD
22/05/2025**

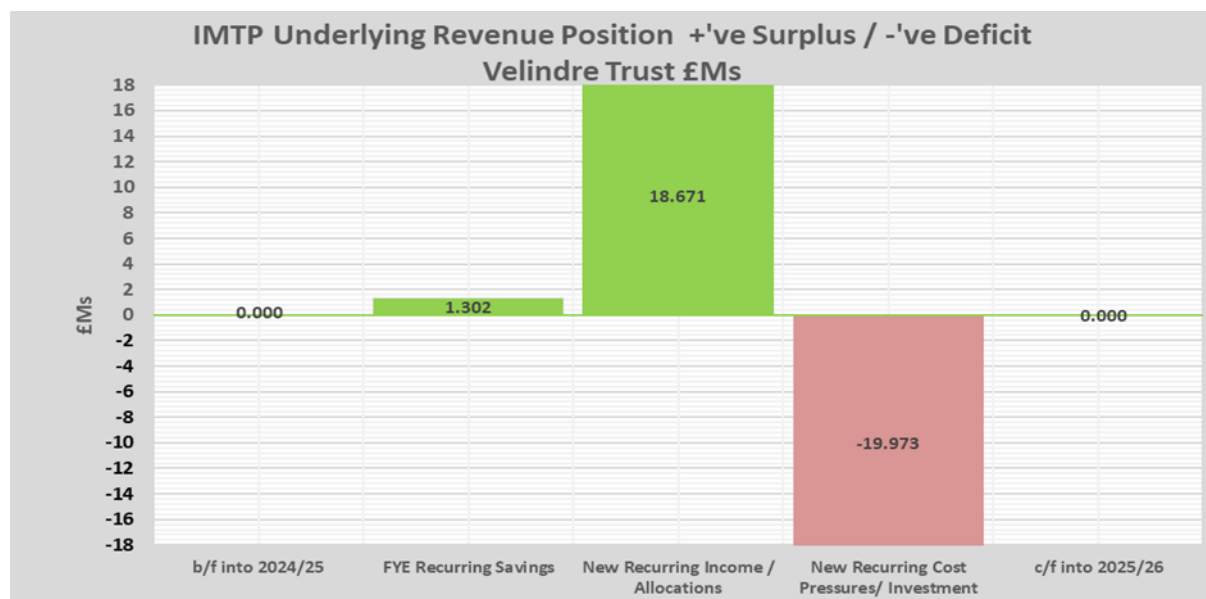
1. Introduction

The purpose of this report is to outline the financial position and performance for the year ended 31st March 2025, performance against financial savings targets, highlight any remaining financial risks, and confirm the actions taken to deliver the IMTP Financial Plan for 2024-25.

2. Background / Context

The draft Trust IMTP Financial Plan for the period 2024-2027 was set within the following context:

- The Trust submitted a balanced three year IMTP, covering the period 2024-25 to 2026-27 to Welsh Government on the 30 March 2024.
- For 2024-25 the Plan included;
 - A balanced position brought forward from 2023-24,
 - **FYE of new cost pressures / Investment of -£19.973m,**
 - offset by **new recurring Income of £18.671m,**
 - and Recurring FYE **savings schemes of £1.302m,**
 - Allowing a **balanced position** to be carried into 2025-26.
- **A significant risk was associated with the income that the Trust was expected to receive from its commissioners in relation to the 3.67% discretionary uplift, which could impact on the plan and the ability to achieve a balanced financial position.**
- **To achieve a balanced financial position, the savings target set for 2024-25 was required to be achieved, all anticipated income need to be received, and any new emerging costs pressures need to be either mitigated at Divisional level or managed through the Trust reserves.**



Underlying Position +Deficit/(-Surplus) £Ms	b/f into 2024/25	Recurring Savings	New Recurring Income / Allocations	FYE New Cost Pressures/ Investment	c/f into 2024/25
Velindre NHS Trust	0.000	1302	18.671	-19.973	0

3. Executive Summary

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

(Figures in parenthesis signify an adverse variance against plan)

Table 1 - Key Targets

Note that figures are draft pending completion of the year end accounts.

	Unit	Current Month £m	Draft Year End Position £000	Year End Forecast £m
Revenue	Variance	0.011	0.042	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	10.621	35.072	35.072
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	98.5%	97.7%	97.0%

Performance against Planned Savings Target

	Unit	Current Month £m	Draft Year End Position £000	Year End Forecast £m
Efficiency / Savings	Variance	(0.007)	0.000	0.000

Revenue

The core Trust has reported a £0.011m underspend position for March 2025, which gives a draft year end position of **£0.042m** underspent.

Following discussions between Chief Executives, and to avoid arbitration, a compromise position was agreed on the LTA which has led to a financial impact to the Trust for 2024/25 as follows:

- £318k Reduction in recurrent discretionary income compared to plan.
- £483k Reduction in non-recurrent income compared to plan. The £483k reduction in income will become recurrent in 2025/26 together with a further recurrent reduction of c£360k which will need to be considered part of the financial plan included with the IMTP.

The shortfall in LTA income has been recovered through a combination of an increased savings target, pausing previously agreed investment decisions, and mitigating cost pressures.

Capital

The approved Capital Expenditure Limit (CEL) for the year ended 31st March 2025 is **£35.076m**. This represents all Wales Capital funding of **£33.165m**, and Discretionary funding of **£1.911m**. The Trust reported total Capital spend to March 2025 is £35.072m and has therefore remained within the CEL for 2024-25.

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

	Opening CEL	Movement	Current CEL
	£m	£m	£m
Discretionary Capital	1.911		1.911
All Wales Capital:			
IRS	5.164	0.315	4.849
IRS RSC	11.265	-1.200	10.065
Digital WHAIS	0.000	0.443	0.443
Digital RISP	0.160	0.000	0.160
BECS	0.750	-0.416	0.334
Backlog Maintenance	0.350	-0.200	0.150
WG Year End Capital Slippage Funding	0.000	0.220	0.220
Whitchurch Land Transfer	0.000	7.800	7.800
nVCC Enabling Costs	0.000	3.500	3.500
nVCC Project Fees	0.000	4.140	4.140
nVCC Enabling Works, Asda QRA	0.000	0.525	0.525
Digital Tech Refresh	0.000	0.874	0.874
Total All Wales Capital	17.689	15.476	33.165
Total CEL	19.600	15.476	35.076

PSPP

During March 2025 the Trust (core) achieved a compliance level of **98.49%** (February 98.24%) of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **97.71%** at the end of month 12, and a Trust position (including hosted) of **97.91%** compared to the target of 95%.

Efficiency / Savings

In conjunction with the overall financial plan an in depth review of the Trust's savings plan was undertaken during June and has resulted in a revised savings target of £2.875m being set for 2024-25, which is an increase of £0.269m from the £2.606m which was set at the IMTP planning stage. Several new schemes were identified, which replaced those schemes that had either failed to be implemented or had not yet progressed. The revised target of £2.875m was required to help compensate for the loss of income from the LTA agreements.

The overall Trust savings performance as of March 2025 shows the target of **£2.875m was achieved**.

Revenue Position

Draft Year End Position			
£0.042m Underspent			
Type	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)
Income	(259.076)	(261.158)	2.082
Pay	104.378	103.459	0.919
Non Pay	154.698	157.658	(2.959)
Total	0.000	(0.042)	0.042

The overall position against the profiled revenue budget to the end of March 2025 is an underspend of **£0.011m** and the draft year end position is an underspend of **£0.042m**.

4.1 Revenue Position Highlights / Key Issues

Underlying Position

The Trust has submitted a balanced IMTP Financial Plan for 2025-26 and is expected to maintain this position over the course of the 3-year planning period albeit there is some risk to this specifically related to the Trust securing funding towards SDEC post 1 April 2026.

To retain a balanced position in 2025-26, 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

The Trust continues to benefit from receiving high levels of bank interest because of interest rate rises, however a significant amount £1.012m (previously £0.662m) has been set against the Trust revised savings target for 2024-25, which is in addition to the baseline budget of £0.165m.

WBS overachievement on Plasma sales had been significantly impacted by supplier payment issues, which following referral to CCI debt management the outstanding debt has now been fully recovered. WBS has since secured a new customer for future Plasma sales.

A new financial risk emerged during this year whereby LTA income activity was not expected to match the level of investment into services at VCS. At the end of March 2025 there was a full year underachievement of c£0.240m against the target and investment of £1.300m which had been made in the service. Recent months have seen some recovery however, as stated, the annual target was not achieved in 2024-25. Work will continue into 2025-26 to ensure that all activity is being captured and recorded correctly, and the finance team will be undertaking an exercise to review the Radiotherapy costing and currency rates.

VCS Long Term Agreement (LTA) Contract Performance

During 2024-25 the Trust undertook discussions with LHB Commissioners in accordance with a few important principles: -

- national guidance from WG regarding the principle of pass through (which for 2024/2025 was 3.67%).
- working in partnership to support all organisations to thrive and deliver safe services of a high quality.

The key differences in LHB Commissioner positions related to the pass through of the Recurrent Discretionary uplift of 3.67%.

A clause was included within all signed 2023/24 LTAs to proceed with the contract rebase exercise and it was expected that this could be implemented from 2024/25 onwards in line with signed agreements. However, LHB Commissioners have not reached consensus on this matter with areas for resolution as follows:

- The baseline year for activity (currently set at 2019/20)
- The allocation adjustment to be applied to maintain cost neutrality at a system level.
- Transfer of Non Specialist services and High Cost Drugs from JCC to LHBs

Consequently, the Trust has had to prepare LTAs on an historic basis, which is not reflective of the population's utilisation of Velindre's services for LHB Commissioners. Further, the lack of agreement regarding the transfer of service has created a contractual risk to the Trust. To manage and mitigate this, the Trust has needed to negotiate a second contract with JCC (value £24m) whilst the matter is resolved.

To avoid arbitration, discussions between Chief Executives led to a compromise on the LTA financial settlement which resulted in a:

- i. £318k reduction in recurrent NICE drug income (£145k Aneurin Bevan University Health Board (UHB), £115k Cwm Taf Morgannwg UHB & £58k reverting to old baseline) compared to plan.
- ii. £483k reduction in Hywel Dda UHB income non-recurrently compared to plan.

As part of the IMTP process for 2025-26 the Trust Finance Team has been in regular dialogue with our Commissioners regarding the Trust income assumptions and have agreed LTA funding principles with all Commissioners for both VCS and WBS. However, in order to reach agreement with Hywel Dda on LTA principles and financial value for VCS the Trust has had to again agree a compromise position with a non-recurrent reduction in NICE / HCD income of c£0.483m as agreed in 2024-25 to reflect resources consumed rather than historic shares. The Trust continues to face a significant recurrent income risk with Hywel Dda beyond 2025-26 of c£0.843m who have given notice that the NICE/HCD £0.483m and historic shares activity baseline funding of c£360k will be removed recurrently in 2026-27.

To ensure Commissioners fund the total cost of Velindre running cancer services from 2026-27 there needs to be agreement from all Commissioners to change the commissioning principles for Velindre from 'historic shares' based on activity and NICE consumption in 2004-5 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.

Commissioners have also not agreed any additional funding above the 1.77% general uplift, for either WBS or VCS. The Trust is managing the pressure for additional capacity invested in outpatients, ambulatory care, SACT and imaging services during 2023-24 and 2024-25 to meet the rising demand and cancer waiting times. Whilst the Velindre Collective Commissioning Group for Cancer have agreed to undertake a more detailed review of the SACT Business Case submitted as part of the IMTP process, there has been no commitment to fund made as part of the LTA agreements for 2025-26, so the financial risk of this additional capacity implemented remains with the Trust.

WBS Position Update

WBS has been managing a number of financial risks within the service that support supply chain sufficiency, demand and patient safety. In addition, since the publication of the Infected Blood Inquiry in May 2024, the service will be required to improve patient safety for transfusion wherever possible.

The Trust submitted five WBS business cases relating to key service areas for consideration that help either maintain or improve the safety of the supply chain for the transfused patients in Wales. These cases include:

1. additional capacity 24/7 for the Red Cell Immunohaematology laboratory
2. implementation of Haemoglobin S (HbS) testing to comply with national guidance
3. 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
4. introduction of new Buccal swab testing and testing pathway for recruitment of stem cell donors to expand Welsh Bone Marrow Donor Registry panel
5. additional blood collection capacity to ensure the sufficiency of supply of blood products in Wales can be delivered

JCC has not approved additional funding for any of the business cases for WBS. This places a significant increased financial risk on the Trust as these cases are necessary to maintain and improve quality and safety, so the Trust will inevitably be forced to make some investment at financial risk.

The Trust has separately written to the DGH&SC regarding the Infected Blood Inquiry (IBI) report recommendations and the estimated resource and financial investment required across WBS and NHS Wales to deliver the actions required to ensure the safety and quality of the Welsh Blood supply chain.

Pay Highlights / Key Issues

The Trust has received funding from WG via the pay matrix for the full 2023-24 consolidated pay award and full funding of the 2024-25 pay award for AFC, M&D and VSM based on actual staff post as detailed below:

The AFC and M&D pay award processed in November cost the Trust £4.827m based on actual staff in post. This left a gap in funding against full establishment of c£0.337m, and a shortfall against increments of £0.280m which was not funded by WG. Divisions will be required to manage this shortfall via an increased vacancy factor / additional savings.

The cost of the AFC band 8 and above incremental spinal points processed in January was £0.306m and the pay award relating to VSM was £0.091m

The 2023/24 medical pay award which was processed in September totalled £1.121m (£0.755m recurrent).

Several posts in VCS and WBS were recruited at risk to create additional capacity required to respond to the Covid activity backlog and service developments without certainty around LTA income pending activity undertaken or FBC funding approval by WG and Commissioners. During August VCS was provided funding that was agreed as part of the IMTP to support several of the unfunded posts. 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.

On top of the savings plans and the shortfall in pay award VCS (£0.450m), WBS (£0.450m) and Corporate (£0.150m) hold a recurrent vacancy factor target, which were largely achieved, leading to a balanced financial position for 2024-25.

Non Pay Key Issues

Per the allocation letter the Trust has received £0.563m of recurrent funding from WG to support the increase in energy prices during 2024-25. The forecast schedule from NWSSP suggested that the full year energy costs would be c£1.745m, which would have left a shortfall of £0.142m against the budget of £1.603m (£1.040m underlying budget plus £0.563m funding provided by WG) which is held by the Trust. The actual costs for 2024-25 were £1.683m which were less than forecast but were still £0.080m higher than budget which required non-recurrent reserve funding during the period.

Energy forecast for next year currently assumes that cost will reduce and will be managed from within the Trust budget and funding envelope.

The Trust reserves were partly released into the position to match spend as it occurred throughout the year, with the balance being held in month 12 to support the WBS underachievement on WBMDR income.

Each Division holds both a general reserve to meet unforeseen costs and a savings target / Cost improvement Plan (CIP). The Trust revised savings target for each division during 2024-25 was VCS £0.939m, WBS £0.569m (previously £0.650), RD&I £0.230m and Corporate £1.138m (previously £0.787m) for 2024-25.

4.2 Pay Spend Trends (Run Rate)

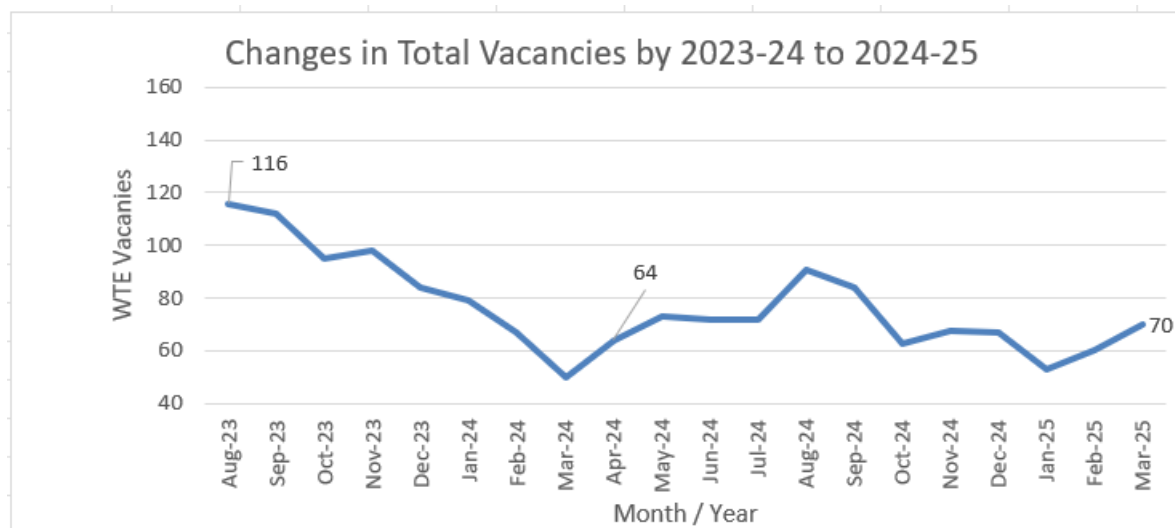
As of March 2025, the current staff in post is 1,655 WTE (February 1,666). The number of vacancies is 70 WTE (February 60), which represents a vacancy rate of 4.06% (3.49% January) against the budget of 1,725 WTE. Vacancies increased in both VCS (5) and WBS (3) during the month. The vacancy gap is largely being met using agency staff, overtime, or the use of bank, and is also supporting each of the division's vacancy factor savings target.

The level of vacancies fell over the course of 2023-24 across several services areas but largely due to the recruitment of 17 WTE Nurses via the international recruitment scheme as demonstrated in the historic trend line on the chart below. As of August'24 vacancies had started to rise again which is principally due to VCS receiving funding and setting budgets during the period for unfunded posts approved via the IMTP, and also for vacancies materialising from approved projects.

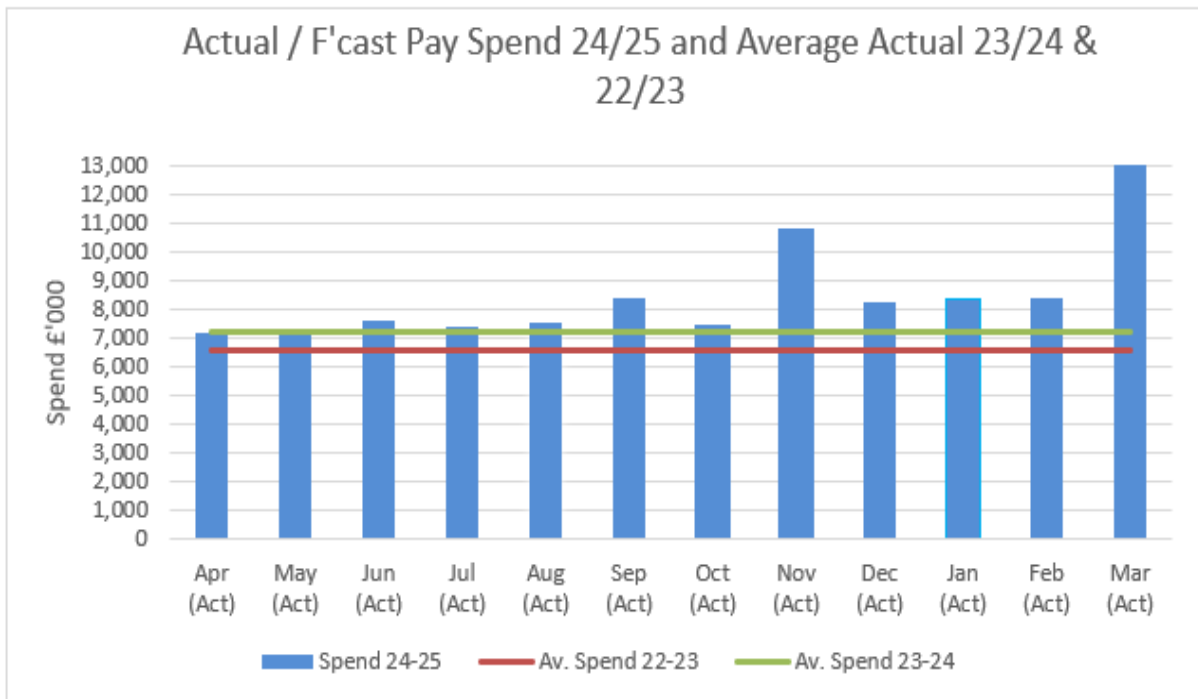
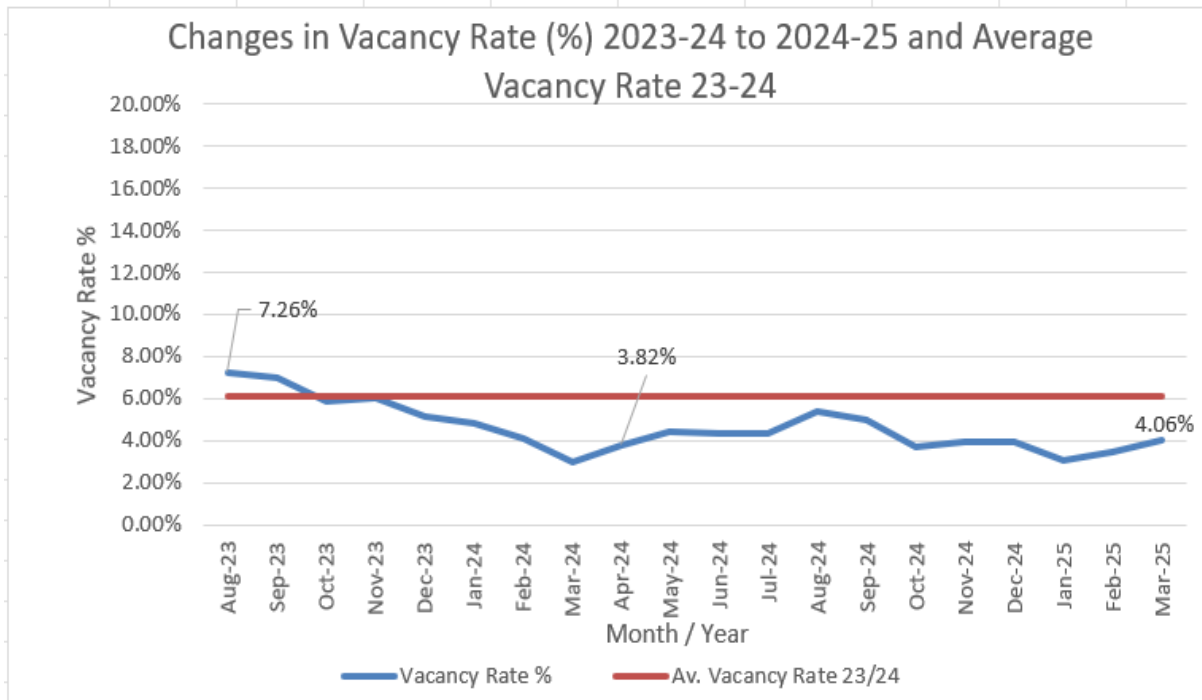
During October VCS recruited into five posts under Additional clinical services (1 in SACT day case, 2 in Pharmacy and 1 in Radiation services). Several posts were also recruited under Professional Scientific & Technical.

Several staff were recruited into VCS during December which included posts within SACT Nursing, Pharmacy, Radiotherapy, Therapies and Medical Records A&C.

WBS recruit collection staff in batches and February saw the start of 8 new Collection Assistants leaving to them now having more staff in post than their budgeted establishment. These were recruited 'at risk' following EMB approval of a business case to JCC requesting funding. This business case has since been declined, however the posts are included within the Trust IMTP as they are essential to maintain and improve quality and safety.



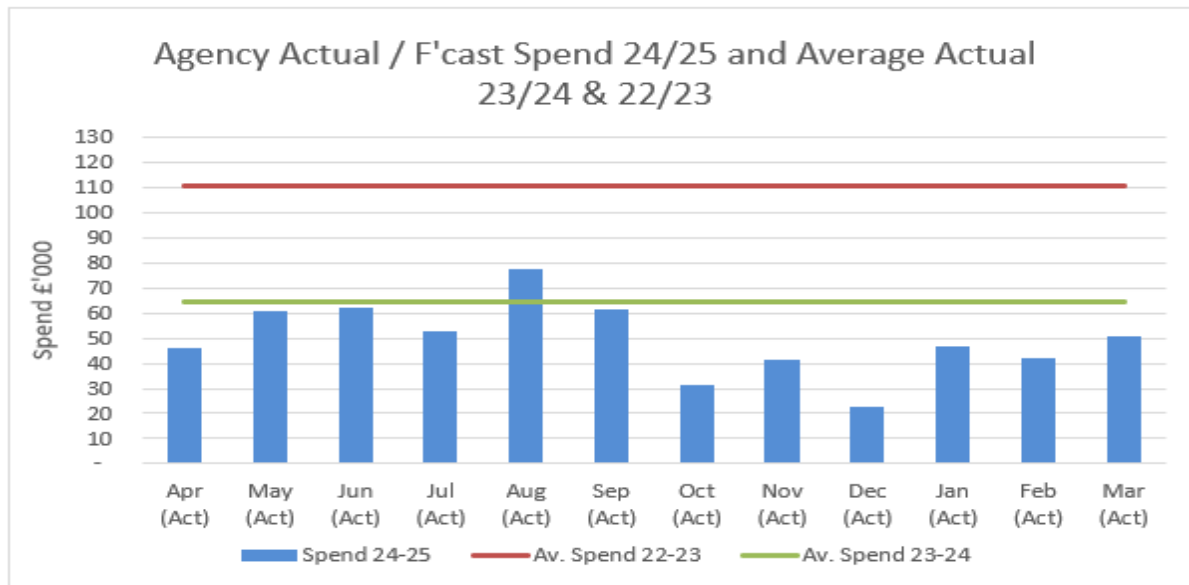
The total Trust vacancies as of March 2025 is 70 WTE (February 60 WTE): VCS (46 WTE), WBS (1 WTE), Corporate (13 WTE), R&D (6 WTE), TCS (1 WTE) and HTW (3 WTE).



The September pay includes the Junior Doctors pay award and back pay relating to 2023-24. The 2024-25 AFC and M&D pay award was processed during in November, and the additional increments for band 8+ staff and VSM pay award was processed in January, which explains the step up in cost during the periods and going forward.

March costs include the additional pension costs which are fully funded by WG.

The spend on agency for March 2025 was **£0.052m** (February £0.042m) which gives a cumulative draft year end position of **£0.596m** (£0.775m 2023/24).



The use of agency within Medical, Physics and Estates has now ceased, and the last member of agency within Radiotherapy is expected to leave shortly. The Trust is currently relying on short term agency support within Therapies to cover sickness and maternity leave and there has been a requirement to get a short term use of agency in Pharmacy to support vacancies. The reliance on Admin and Clerical agency is reducing from last year but continues to support vacancies, with the ambition that agency support in this area will cease shortly as posts continue to be filled.

In line with the Value & Sustainability agenda and Finance & Investment Enhanced monitoring arrangements the Trust is aiming to move away from the dependence on agency, and where possible the Trust will aim to utilise bank staff to reduce reliance on agency and the premium costs associated.

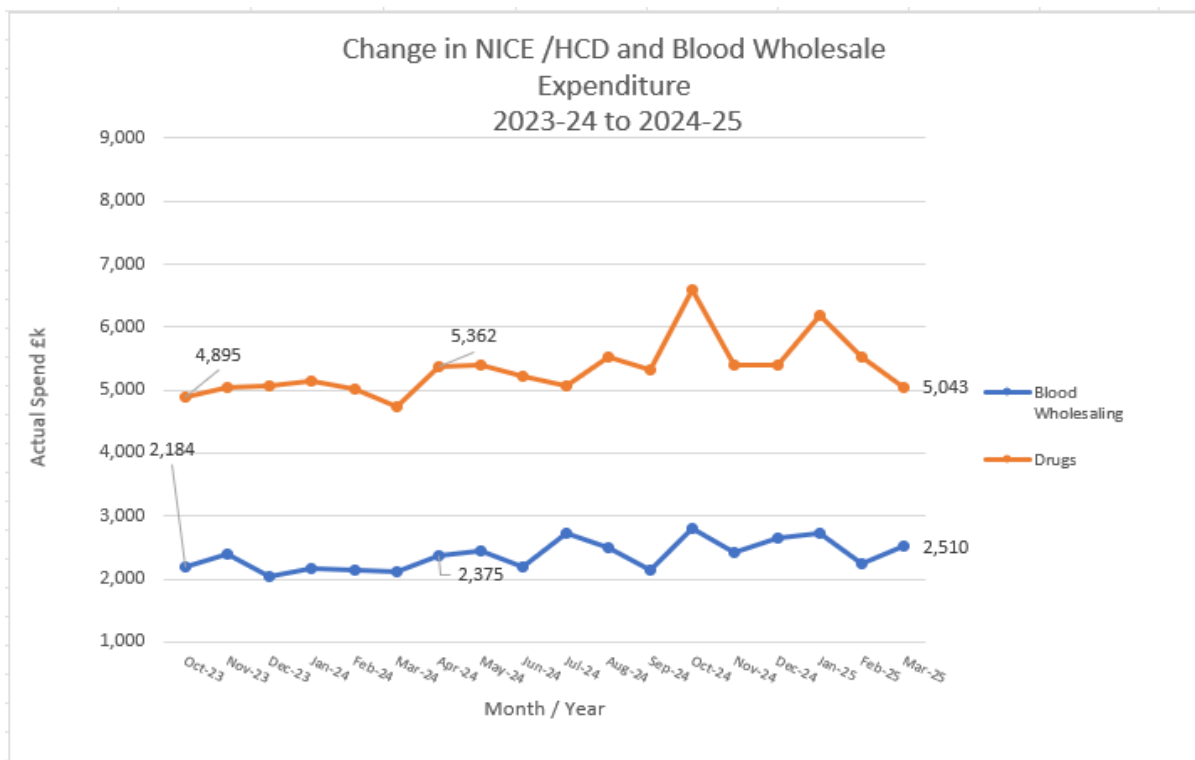
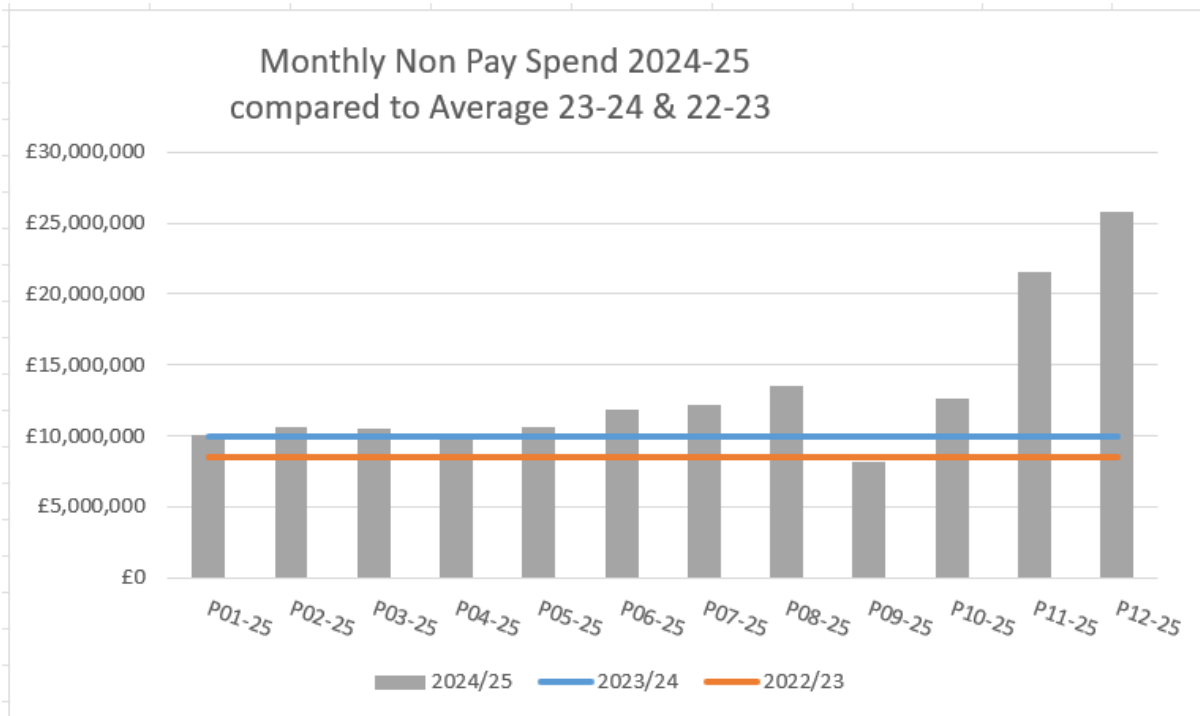
4.3 Non Pay

Average non-pay spend for 2023/24 was £9.8m per month which is a £1.4m increase from the previous whole year average. Largest movement was in drug spend which has increased by £10m in total or £0.9m average per month when compared with the previous year's spend for the same period. Other notable increases year on year include WBS Wholesaling £3.3m or £0.3m average per month and depreciation charges of £1.2m or £0.100m per month.

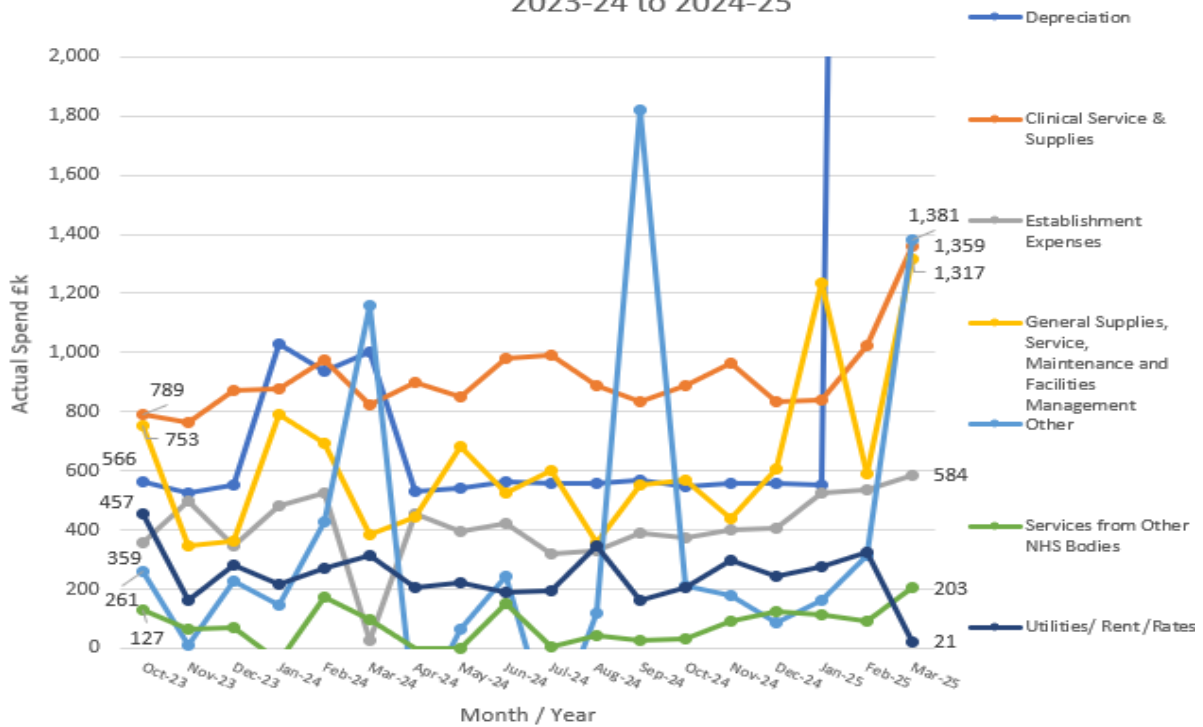
Non-Pay average spend for 2024/25 is £13.1m which is currently £3.3m higher than the average at the same point last year. NICE and HCD drugs (£0.6m), blood wholesale costs (£0.5m), Clinical Services & Supplies (£0.2m) and General Supplies, Service, Maintenance & Facilities (£0.1m), have increased which are offset by income. There has been an increase in depreciation (£1.8m) which includes accelerated depreciation relating to VCS following progression of the nVCC. All other costs have remained fairly static when compared with the year on year average.

The Trust emergency reserve was required this year to support the WBS underachievement on WBMDR.

The graphs provided below show the change in non-pay spend split by expenditure category over the period from April 2023 to March 2025. The significant increase seen in the first graph in both February and March has been caused by additional depreciation and recognition of the Impairment of the nVCC Enabling Works of £10.3m. March spend is also traditionally higher as full year costs are finalised.



Change in Non- Pay Expenditure by Category
2023-24 to 2024-25



*The Depreciation value included in the above graph for is £10.593m for February and £13.405m for March and includes the charge recognised for the impairment of the nVCC Enabling Works of £10.3m.

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

Other spend in period M12 23-24 includes a provision for legal fees which has been partly released in 24-25. Spend in month 6 also relates to the provision for legal fees that was incorrectly accounted for as income at the end of 23-24.

The graph excludes one off spends which incurred in period M12 23-24 which adversely affects the run rate such as the £7.35m AZ income received and transferred as expenditure to the Charity, along with the pass back contribution to WG which supported the overall NHS position.

The increase in General Supplies, Maintenance and facilities management during December is largely due to a catch up on the revenue charges associated with the replacement of Radiotherapy Treatment machines, and several other small variances across the Trust.

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

4.4 Covid-19

The Trust did not require any covid funding support during 2024-25. The Trust was not required to support the LHBs with the vaccination programme and therefore no funding was sought from WG in that respect.

4. Savings

The Trust established as part of the IMTP Financial Plan a savings target requirement of £2.606m for 2024-25 which equates to 3.1% of the Trust's core LTA income and is required to support the level of investment plans and cost pressures within the system.

In conjunction with the overall financial plan an in depth review of the Trust’s savings plan was undertaken during June and has resulted in a revised savings target of £2.875m being set for 2024-25, which is an increase of £0.270m from the £2.606m which was set at the IMTP planning stage. Several new schemes were identified, which replaced those schemes that had either failed to be implemented or had not yet progressed. The revised target of £2.875m was required to help compensate for the loss of income from the LTA agreements.

Of the revised £2.875m total savings target £1.247m (previously at IMTP planning stage £1.302m) is recurrent and £1.629m (IMTP £1.304m) is non-recurrent, with £1.155m (IMTP £1.179m) being categorised as actual saving schemes and the balance of £1.720m (IMTP £1.427m) being via income generation.

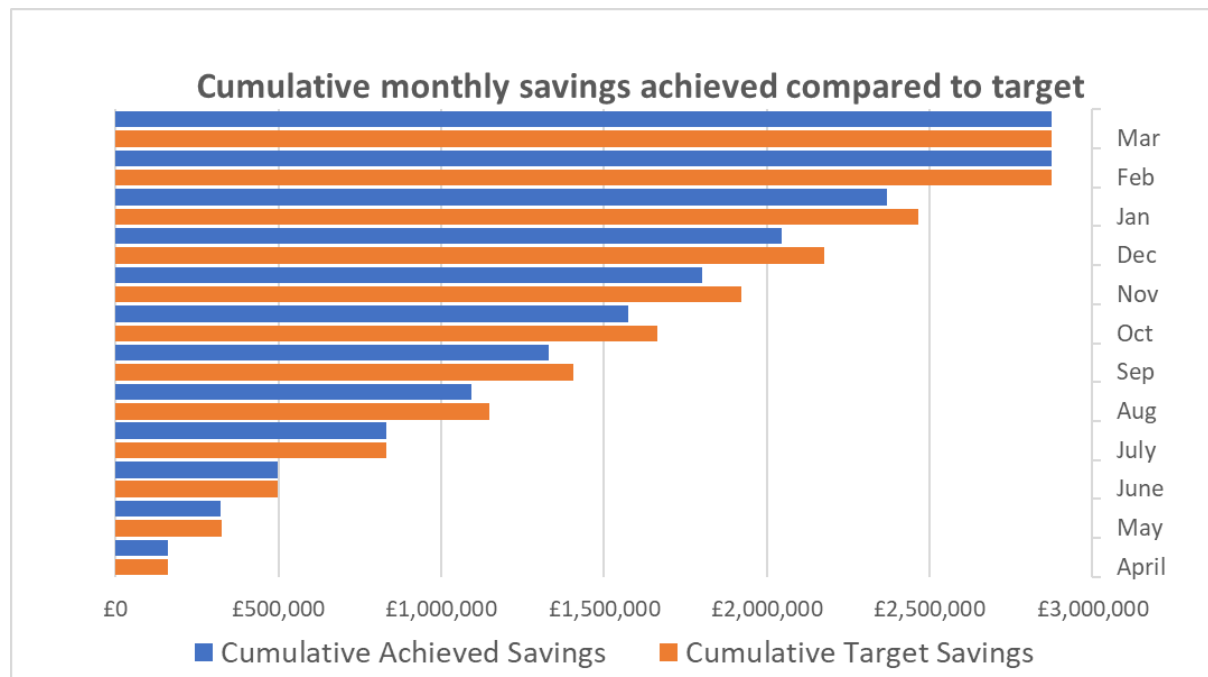
The Divisional share of the revised overall Trust savings target has been allocated to VCS £0.939m (32%) (Previously per IMTP £0.939m (36%)), WBS £0.569m (20%) (IMTP £0.650m (25%)), RD&I £0.230m (8%) (IMTP £0.230m 9%) and Corporate £1.137m (40%) (IMTP £0.787m (30%)).

The WBS savings target was reduced from £650k to £569k in year due to the inability to enact savings schemes against a number of services constraints, not least the Infected Blood Enquiry. In addition, the majority of the replacement schemes that were found are non-recurrent in nature. It is therefore extremely important that work continues in the Division to implement recurrent savings plans to ensure that a balanced position can be carried into 2025-26.

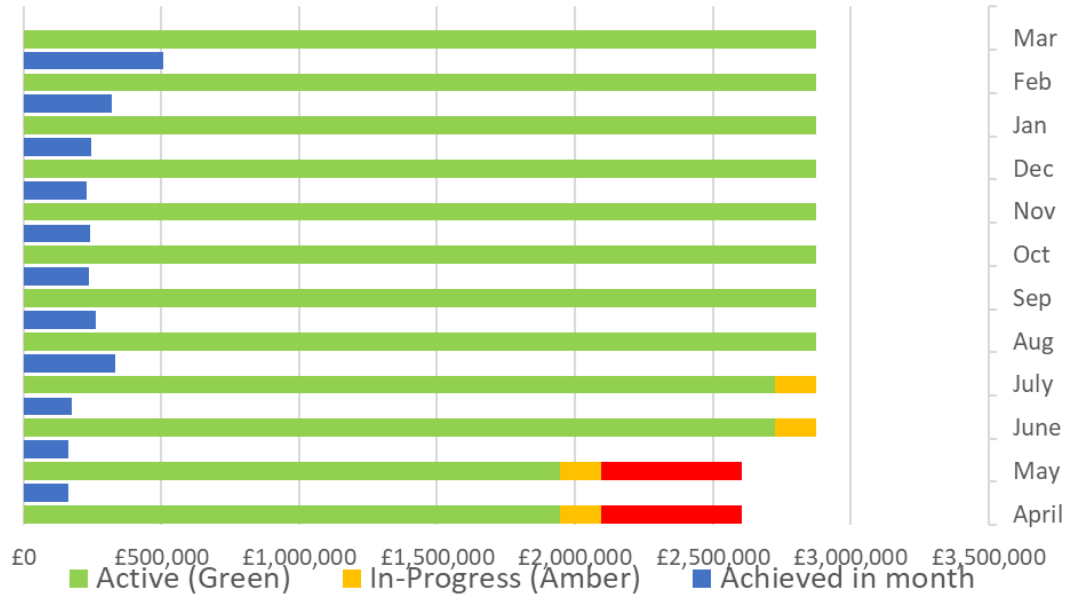
Performance

The overall Trust savings performance as of 31st March 25 is a full achievement of the year’s plan. Whilst some savings schemes overachieved against the target, there are some schemes within WBS and VCS such as procurement efficiencies which underperformed against the original plan. The WBS Stock control did not achieve any savings during 2024-25 with the target met instead via overachievement in other schemes such as bank interest.

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



Savings achieved by month compared to target by RAG status



ORIGINAL PLAN	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	F'cast Full Year £000	F'cast Variance Full Year £000
VCS TOTAL SAVINGS	939	939	939	0	939	0
		100%			100%	
WBS TOTAL SAVINGS	569	569	472	(97)	472	(97)
		83%			83%	
CORPORATE TOTAL SAVINGS	1,137	1,137	1,234	97	1,234	97
		109%			109%	
RD&I TOTAL SAVINGS	230	230	230	0	230	0
		100%			100%	
TRUST TOTAL SAVINGS	2,875	2,875	2,875	0	2,875	0
		100%			100%	

Scheme Type	Division	Recurrent / Non- Recurrent	RAG Rating	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	F'cast Full Year £000	F'cast Variance Full Year £000
Savings Schemes									
Radiation Services - Agency Reduction	VCS	NR	Green	50	50	50	(0)	50	(0)
Establishment Control	VCS	R & N/R	Green	234	234	234	0	234	0
Service Workforce Redesign	VCS	R & N/R	Red	0	0	0	0	0	0
Procurement - Supply Chain	VCS	R	Green	50	50	50	0	50	0
Establishment Control	WBS	R	Green	54	54	67	13	67	13
Stock Control - Scan for Safety Enabled	WBS	NR	Green	150	150	0	(150)	0	(150)
WBS Demand Planning	WBS	R	Red	0	0	0	0	0	0
WBS Demand Planning	WBS	NR	Green	75	75	95	20	95	20
WBS Productivity Efficiencies	WBS	NR	Red	0	0	0	0	0	0
Procurement - Supply Chain	WBS	R	Green	50	50	30	(20)	30	(20)
Service Workforce Redesign	WBS	R	Red	0	0	0	0	0	0
Departmental CIP	Corporate	R	Green	50	50	50	0	50	0
Establishment Control	Corporate	R & N/R	Green	75	75	75	0	75	0
R&D Establishment Control	RD&I	R & N/R	Green	80	80	80	0	80	0
<i>New / Replacement Schemes</i>				0	0	0	0	0	0
Productivity Efficiencies	VCS	R & NR	Green	35	35	35	0	35	0
SACT Provision	VCS	R	Green	150	150	150	0	150	0
Creditor Review	WBS	NR	Green	100	100	100	0	100	0
Budget Efficiencies	WBS	NR	Green	40	40	40	0	40	0
Total Saving Schemes				1,193	1,193	1,055	(138)	1,055	(138)

Income Generation									
Private Patients - Recovery of Debt	VCS	NR	Green	150	150	150	0	150	0
Private Patients - Contract Renewal	VCS	R	Amber	150	150	150	0	150	0
Productivity Efficiencies	VCS	R	Red	0	0	0	0	0	0
Sales of Plasma	WBS	R	Green	100	100	141	41	141	41
WBS Productivity Efficiencies	WBS	R	Red	0	0	0	0	0	0
Bank Interest	Corporate	R & N/R	Green	662	662	759	97	662	0
R&D Commercial Income	RD&I	R	Green	150	150	150	0	150	0
<i>New / Replacement Schemes</i>				0	0	0	0	0	0
Private Patients	VCS	NR	Green	70	70	70	0	70	0
Maximising Income	VCS	R	Green	50	50	50	0	50	0
Bank Interest	Corporate	R	Green	350	350	350	0	447	97
Total Income Generation				1,682	1,682	1,820	138	1,820	138
TRUST TOTAL SAVINGS				2,875	2,875	2,875	0	2,875	0
					100%			100%	

5. Reserves

The financial strategy for 2024-25 enabled the establishment of a recurrent and non-recurrent reserve to support the Trust investment, transformation, and delivery programmes. These reserves were accommodated on the assumption that all expected income was received, planned savings schemes were delivered and new emerging cost pressures managed. In addition, the Trust held an emergency reserve of £0.500m.

The use of investment reserves has been on hold while the Trust reached an agreement with our commissioners around the 3.67% baseline LTA uplift. However, following a review of the overall Trust financial position undertaken in June £0.808m of funding was made available to support investment decisions / choices which were agreed at EMB on the 25th June 2024.

The uncommitted non-recurrent reserve and emergency reserve had been on hold to ensure the Trust could support the financial risk in relation to n VCC implementation staff & advisor costs and EW advisor costs until WG funding was secured. However, following recent FBC approval non-recurrent funds became available, and were utilised to support the WBS underachievement on WBMDR income.

The recurrent underlying reserves position was considered in conjunction with the IMTP planning exercise for 2025-26 and took into account several key factors including the VCS marginal income risk, LTA contract rebase risk, achievement of 2024-25 recurrent savings, underlying and new emerging cost pressures, Divisional CIP targets and Trust investment decisions / choices.

6. End of Year Forecast / Risk & Opportunity Assessment

There were several financial risks that could have impacted on the successful delivery of a balanced position for 2024-25, but by the end of February, all were re-assessed and removed or mitigated. The Trust is continuing to take actions to ensure that risks impacting on the underlying financial position are appropriately managed and mitigated against. All areas of financial plan delivery are risk assessed and where necessary identified risks are included within the Trust wide Risk Register.

The Trust reported to Welsh Government in the February report that all risks and opportunities were being managed to ensure that the Trust would achieve a financially balanced position for 2024-25.

7. CAPITAL EXPENDITURE

Administrative Target

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

	Approved CEL £000s	Full Year Draft Spend £000s	Year End Variance £000s
All Wales Capital Programme			
IRS - Integrated Radiotherapy Solution	4,849	4,816	33
IRS RSC - Radiotherapy Satellite Centre	10,065	10,065	0
nVCC Enabling Costs	3,500	3,494	6
nVCC Enabling Works, Asda QRA	525	368	157
nVCC Project Fees	4,140	4,290	(150)
nVCC Whitchurch Hospital Site	105	105	0
WBS TGI	0	0	0
Digital - WHAIS	443	429	14
Digital - RISP	160	160	0
BECS	334	329	5
WBS Electrical Resilience - Backlog Maintenance	150	150	0
WG Year End Capital Slippage Funding	220	210	10
Whitchurch Land Transfer	7,800	7,800	0
Digital Tech Refresh	874	874	0
Total All Wales Capital Programme	33,165	33,090	75
Discretionary Capital	1,911	1,982	(71)
Total	35,076	35,072	4

The approved 2024-25 Capital Expenditure Limit (CEL) for the year ended 31st March 2025 was £35.076m (February £34.446m). This includes All Wales Capital funding of £33.165m, and discretionary funding of £1.911m.

In line with fixing the CEL on the 30th of October the Trust confirmed the position on the Capital programme which resulted in £1.816m being given back to WG during 2024/25 with a request that £1.616m is re-provided back in 2025/26.

- i. £1.2m in relation to the IRS SRU (to be re-provided during 2025/26) due to a delay in the build completion resulting in the Trust not having access to the building until 15th April (previously 13th February).
- ii. £0.416m in relation to the Blood Establishment Computer System (BECS) programme (to be re-provided during 2025/26), and
- iii. £0.200m given back in relation to backlog building maintenance on a permanent basis.

The Trust CEL has been updated to reflect these changes in 2024/25 and whilst the Trust has assumed that that the £1.616m will be re-provided next year, we have requested formal confirmation from WG Capital colleagues to confirm this position.

The Trust also secured funding from WG to support the nVCC Enabling and Project works, Capital funding for the nVCC Asda QRA works and Traffic Monitoring Resource, and for the Whitchurch site fees.

The Trust has now completed the transfer of the Whitchurch Land with C&V at a purchase cost of £7.800m which was funded by WG.

The discretionary allocation of £1.911m represents an increase of 12% on the £1.683m provided during 2023-24 and was fully spent in 2024-25.

The table below the list of prioritised Capital schemes that was discussed and agreed at the Capital Planning Group on the 16th December.

Capital Schemes by Division	Scheme Cost (£k)
Current Discretionary Balance	583
VCS	
Mobile digital x-ray replacement	-100
Bispectral Index Monitoring Equipment	-5
Replacement Electric Tug	-40
ECG & Ancillary Equipment	-10
Refurbishment of Toilets	-12
Conversion of Room for Medical Storage	-40
Environment Improvements Outpatients	-75
WBS	
WBS Survey Conditions	-34
WBS Critical list	
Total Protein Analyser	-36
Freezer Replacement (1 x -20 / 3 x -40)	-34
Room Temperature Incubator	-6
Liquid Nitrogen Freezers x 2	-22
WBS Priority list	
Fast Filter Wheel for Ix83 Olympus Microscope	-13
Stage Top Incubator	-21
Corporate	
Corporate HQ Refurbishment	-35
Remaining Balance before contingency	100
Contingency	-25
Remaining Balance	75

The Trust is currently still in conversation with WG colleagues around securing funding from All Wales capital during 2025-26 to support the WBS Talbot Green Infrastructure (TGI) OBC Developments. The Trust incurred expenditure of £0.363m from its discretionary funding during 2024-25 which was required to complete the OBC stage of the WBS TGI scheme. WG colleagues have been made aware that to produce a completed OBC/ FBC stage there is a total funding requirement of £2.142m. The Trust received a funding letter from WG on the 18th October acknowledging this requirement, however the Trust is still not in a position to sign the letter due a substantial increase in cost for the works proposed by the contractor. WG colleagues are aware of the situation with the Trust engaging with the contractor to come to an agreed resolution.

WG yearend Slippage

An e-mail was received from WG Capital colleagues on the 13th September asking the Trust to identify a prioritised list of backlog maintenance, infrastructure risks & equipment funding requests for consideration which need to be deliverable in-year. WG intention was to re-allocate the

slippage on schemes already returned to the Welsh Government in early October (subject to Cabinet Secretary for Health and Social Care clearance) and for a further tranche should extra slippage / underspends be reported through the end of October 2024 exercise.

The Trust responded to this request on the 30th September with a prioritised list totalling c£1.300m which was submitted to and approved by EMB. WG informed the Trust on the 24.10.2024 that £0.220m has been awarded to support several schemes within the overall prioritisation list as listed below.

Capital Scheme	Capital Cost 2024/25 (£k)
Centrifuge	44
Centrifuge	44
WBS - Luminex Analyser (2)	58
Platelet Incubator - PC3200I	16
Platelet Incubator - PC3200I	16
PlateletTrac	20
Electronic Delivery Scanning System	12
UNOS Comparison Utility	10
Total	220

On the 10th December the Trust received a further funding award letter from WG totalling £0.874m to support all of the digital schemes that were included in the WG yearend prioritisation list.

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

Performance to date

The actual expenditure to March 2025 on the All-Wales Capital Programme schemes was £35.072m, this is broken down between spend on the nVCC schemes of £8.152m, the IRS £4.816m, RSC £10.065m, RISP £0.160m, BECS £0.329m, WHAIS £0.429m, WBS Electrical Resilience £0.150m, Whitchurch Hospital Site £0.105m, the Whitchurch Land Transfer £7.800m, Digital Technology Refresh £0.874m, and year end WG capital slippage funding £0.210m.

The spend on the Discretionary Capital programme was £1.982m. The slight overspend against the funding was purposely enacted to offset the underspends on the All Wales Capital Programme schemes which were notified to WG.

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 latest position of schemes that were included in the IMTP for 2025-26 and beyond is provided in the table below:

All Wales Approved and Unapproved Capital Schemes	2025-26 £m	2026-27 £m	2027/28 £m	Further Years £m	Total All Wales Schemes £m
All Wales Approved Schemes					
TCS nVCC	22.835	39.954	6.056	0.000	68.845
Integrated Radiotherapy Solution (IRS)	1.020	16.820	0.943	0.000	18.783
Velindre@ Nevill Hall Radiotherapy Unit	1.200	0.000	0.000	0.000	1.200
RISP (DPIF)	0.471	0.000	0.000	0.000	0.471
Total Approved Capital Schemes	25.526	56.774	6.999	0.000	89.299
All Wales Unapproved Schemes					
Whitchurch Hospital Site	1.134	0.945	1.741	0.000	3.820
WBS TGI Infrastructure	2.457	5.762	17.292	41.600	67.111
WBS BECS Blood Management System	TBC	TBC	TBC	TBC	0.000
WBS Plasma for Fractionation	0.910	0.002	0.001	0.000	0.913
WBS Fleet Replacement	0.364	0.738	1851	0.000	2.953
WBS Asset Replacement	0.532	0.215	0.000	TBC	0.747
Digital WHAIS	0.092	0.000	0.000	0.000	0.092
LIMS 2.0	TBC	TBC	TBC	TBC	0.000
EPMA (DPIF)	0.086	0.025	0.000	0.000	0.111
Digital CRM Multi Case Functions (WBMDR, AOS etc)	0.500	0.000	0.000	0.000	0.500
Digital IT Infrastructure	0.500	0.500	0.500	0.500	2.000
Other Digital Service Developments	TBC	TBC	TBC	TBC	0.000
Other Service Developments (New)	TBC	TBC	TBC	TBC	TBC
Total Unapproved Capital Schemes	6.575	8.187	21.385	42.100	78.247
Total All Wales Capital Plans	32.101	64.961	28.384	42.100	167.546

8. BALANCE SHEET (Including Hosted Organisations)

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

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

Due to the financial year end the balance sheet will not be ready for presentation until the accounts are completed at the end of April 25.

9. CASH FLOW (Includes Hosted Organisations)

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

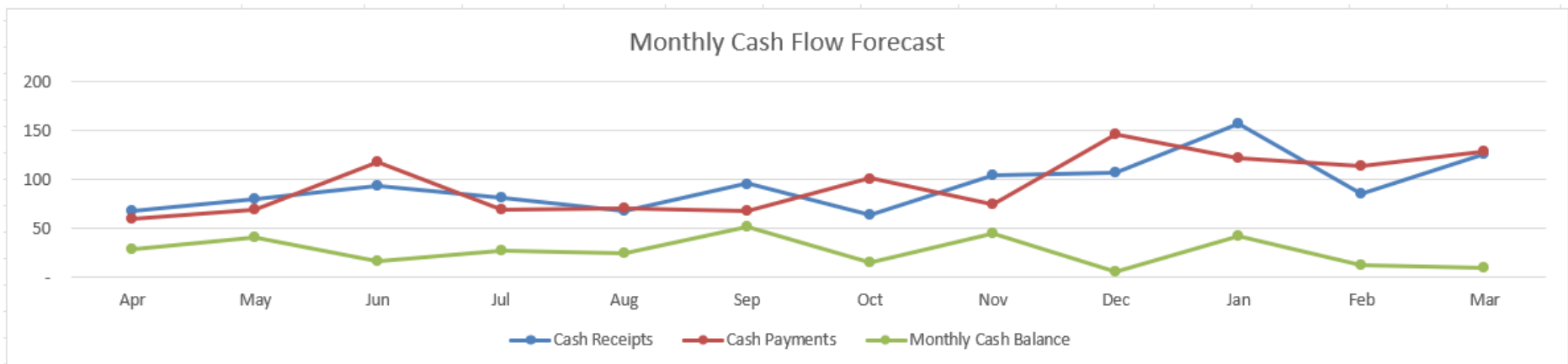
As part of the Brexit emergency planning an additional £4.5m of stock had been purchased by NWSSP and an additional £2.5m of commercial blood products were purchased by WBS, to provide resilience for NHS Wales due to the uncertainty around supply chain reliability because of Brexit.

To aid the Trust's cash flow while the additional stock was being held for Brexit, Welsh Government provided the Trust with additional cash of £7m during 2019-20. WBS did intend to run down the commercial blood stock, however given the ongoing uncertain situation and potential impact on supply chains the Trust continues to hold this stock with assessments ongoing. NWSSP however issued the additional stock and the £4.5m was repaid to WG during February '23.

The Trust has now received the full amount of the agreed funding (based on the HEIW Pay Model) towards the A4C and M&D pay award which was processed during November.

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	50.519	42.117	43.016	40.489	54.755	66.517	49.810	61.858	50.112	66.717	54.456	57.055	637.421
2	WG Revenue Funding	10.504	31.147	45.405	20.761	10.370	24.691	9.261	26.885	52.615	84.112	17.455	60.356	393.562
3	Short Term Loans													0.000
4	PDC								7.800				0.000	7.800
5	Interest Receivable	0.179	0.143	0.186	0.158	0.155	0.167	0.197	0.156	0.161	0.171	0.108	0.085	1.866
6	Sale of Assets													0.000
7	Other	6.657	7.151	4.914	19.701	2.092	4.223	4.503	8.142	4.830	6.253	13.432	8.282	90.181
8	TOTAL RECEIPTS	67.860	80.558	93.521	81.109	67.372	95.598	63.771	104.841	107.718	157.253	85.451	125.778	1,130.830
PAYMENTS														
9	Salaries and Wages	25.845	35.256	35.185	35.848	37.838	48.036	51.634	47.845	51.069	41.726	41.904	53.128	505.314
10	Non pay items	31.288	30.780	81.237	33.050	32.438	19.146	48.747	12.495	94.037	78.729	70.144	69.387	601.478
11	Short Term Loan Repayment													0.000
12	PDC Repayment		0.000										1.053	1.053
14	Capital Payment	2.880	3.178	0.977	0.833	0.470	0.845	0.650	14.205	1.409	1.305	2.006	0.000	28.759
15	Other items													0.000
16	TOTAL PAYMENTS	60.013	69.214	117.399	69.731	70.746	68.027	101.031	74.545	146.515	121.760	114.054	123.568	1,136.603
17	Net cash inflow/outflow	7.846	11.344	(23.878)	11.378	(3.374)	27.571	(37.260)	30.296	(38.797)	35.493	(28.603)	2.210	
18	Balance b/f	20.956	28.802	40.146	16.268	27.646	24.272	51.844	14.584	44.880	6.083	41.576	12.973	
19	Balance c/f	28.802	40.146	16.268	27.646	24.272	51.844	14.584	44.880	6.083	41.576	12.973	15.183	



DIVISIONAL ANALYSIS

(Figures in parenthesis signify an adverse variance against plan)

Core Trust

	Full Year Budget	Full Year Actuals (Draft)	Variance
	£m	£m	£m
VCC	(49.644)	(49.585)	0.059
RD&I	0.260	0.129	(0.131)
WBS	(23.262)	(24.289)	(1.027)
Sub-Total Divisions	(72.647)	(73.745)	(1.099)
Corporate Services Directorates	(16.387)	(15.980)	0.407
Delegated Budget Position	(89.034)	(89.725)	(0.691)
TCS	(0.730)	(0.627)	0.103
Health Technology Wales	(0.183)	(0.183)	0.000
Trust Income / Reserves	89.947	90.578	0.631
Trust Position	0.0000	0.042	0.042

The draft year end revenue position for the core Trust is an underspend of £0.042m.

VCS

	Full Year Budget	Full Year Actuals (Draft)	Variance
	£m	£m	£m
Income	87.330	88.918	1.588
Expenditure			
Staff	57.346	57.515	(0.170)
Non Staff	79.628	80.988	(1.360)
Sub Total	136.974	138.503	(1.529)
Total	(49.644)	(49.585)	0.059

VCS Key Highlights/ Issues:

The reported financial position for Velindre Cancer Services as at the end of March 2025 was **£0.059m overspent**. This included the year to date VCS marginal activity underperformance which did not recover to budgeted levels in the year.

Income at Month 12 represents a surplus of **£1.588m**. This is due to a significant overachievement on private patient drug income which offset the ytd savings target. Other overachievements include the VAT savings from delivering drug home case, catering income, and an increase in the radiation protection SLA with C&V.

For 2024-25, the LTA income activity did not match the level of investment into services. There was an underachievement of c£0.240m against the target and the £1.3m investment which has been made in the service.

VCS have reported a year to date overspend of **£0.170m** against staff. Snr Medical costs continue to be the largest pressure for VCS, however, have significantly reduced following funding being provided during August from the Trust Discretionary uplift in funding, agreed as a part the IMTP. Vacancies remain across several service areas in particular Radiation services due to vacancies related to the satellite centre along with general recruitment challenges. Positively, there have been some recent appointments including posts within SACT Nursing, Pharmacy, Radiotherapy, Therapies and Medical Records A&C. The vacancies have been helping to support the posts appointed at risk, and the divisional savings target and vacancy factor, although the management savings target is underachieving and contributing to the overall overspend seen this month.

Non-Staff Expenditure at Month 12 was **£(1.360)m** overspent which is largely due to an increase in facilities management expenses (Postage, security, rates and ad hoc works on site), catch up of general drugs activity and cost increase expenditure, recruitment fees for Junior doctors, legal fees provision, pathology and haematology SLA, the divisional management savings target and the additional cost improvement programme (CIP) required to support the potential shortfall in pay award funding, with the Trust having confirmed that funding will be received based on actual staff in post rather than full establishment. This position incorporated an increased provision being required for caesium disposal at VCS (and also at WBS) following the Trust obtaining quotes as part of the year end process, which has resulted in costs significantly higher than anticipated and the carried forward provision from 2023/24.

WBS

	Full Year Budget	Full Year Actuals (Draft)	Variance
	£m	£m	£m
Income	35.437	35.238	(0.199)
Expenditure			
Staff	18.752	19.260	(0.508)
Non Staff	39.948	40.268	(0.320)
Sub Total	58.700	59.528	(0.828)
Total	(23.262)	(24.289)	(1.027)

Key Highlights/ Issues:

The reported financial position for the Welsh Blood Service at the end of March 2025 was an overspend of **£(1.027)m**.

An underachievement of **£(0.199)m** on income due to underperformance on bone marrow (currently achieving c50% of target year to date), partly offset by increased activity on Renal marginal activity.

Whilst Plasma Sales activity has been increasing deliveries to Randox (main supplier) were suspended due to the supplier not making payment. A bad debt provision of £0.366m was created at the end of last financial year which has now been settled. The current year debt of £0.289m has also now been fully settled. A new customer has now been identified. There has been a lack of growth in the bone marrow registry, which was largely impacted during the pandemic, which is yet to show signs of recovery despite the significant swab testing taking place at the beginning of the year. Whilst it was originally expected that the payback from the additional swabs would start to be realised later in this financial year it is now hopeful that it will crystallise next financial year, however, remains a significant risk. WBS continue to run campaigns to try and grow the panel in locations such as schools and universities and raise awareness through advertising on platforms such as social media, however there is recognition that the target is too high and was reviewed and considered for funding as part of the IMTP process.

Staff overspend of **£(0.508)m** is due to an increased CIP (savings target), along with advance recruitment and appointments made at risk without identified funding source. Work continues to be underway within WBS SLT to either secure additional funding to support these posts or continue to look into options of migrating staff into vacancies to help mitigate the current risk exposure. The finance team are currently creating an unfunded post analysis to determine the current year and recurrent cost pressure which were partly considered as part of the Trust IMTP for 2025-26.

Non-Staff reported an overspend of **£(0.320)m** as at month 12. There are overspends in areas such as room hire costs which are no longer funded by NHSWJCC, temporary additional security costs at the rear of the building, additional spend within molecular genetics for test kits, the cost of blood imports that took place during August and the Divisional non pay CIP. The cost pressures are being offset by underspends in Apheresis harnesses volume and price savings, price savings

from bulk purchase of test kits, reduced spend on fuel due to the delay in lease vehicles being introduced, and reduced costs from lower activity on bone marrow which is a direct correlation with income under performance. Similarly to that reported above in VCS, the non staff position was impacted in month 12 due to an increased provision being required for cesium disposal at WBS following the Trust obtaining quotes as part of the year end process, which has resulted in costs for WBS of £0.500m that are significantly higher than anticipated and the carried forward provision from 2023/24.

Corporate

	Full Year Budget	Full Year Actuals (Draft)	Variance
	£m	£m	£m
Income	9.316	9.969	0.653
Expenditure			
Staff	22.088	20.881	1.206
Non Staff	3.615	5.067	(1.452)
Sub Total	25.703	25.949	(0.246)
Total	(16.387)	(15.980)	0.407

Corporate Key Highlights / Issues:

The reported financial position for the Corporate Services division at the end of March 2025 was an underspend of **£0.407m**.

The Trust continued to benefit from receiving high levels of bank interest because of interest rate rises, however a significant amount £1.012m (previously £0.662m) had been set against the Trust revised savings target for 2024-25, which was in addition to the baseline budget of £0.165m.

Several vacancies within the division resulted in a large underspend and offset the use of agency and the divisional savings target.

Non-pay overspend is again expected and largely relates to divisional CIP target and the increased running costs associated with the hospital estate. Funding was set aside as part of the Trust IMTP to partly support the Estates costs on a non-recurrent basis during 2024-25 which was transacted during September.

RD&I

	Full Year Budget	Full Year Actuals (Draft)	Variance
	£m	£m	£m
Income	5.045	5.010	(0.035)
Expenditure			
Staff	3.969	3.764	0.205
Non Staff	0.816	1.117	(0.301)
Sub Total	4.785	4.881	(0.096)
Total	0.260	0.129	(0.131)

RD&I Key Highlights / Issues

The reported financial position for the RD&I Division at the end of March 2025 was an overspend of **(£0.131m)**.

Pay overspend was a result of late charges from Cardiff University for staff relating to 2023-24 that could not be recharged to the Charity in 2024-25.

Clinical Trials and Charitable funds income fluctuated in year and was drawn down in line with expenditure.

nVCC – (Revenue)

	Full Year Budget	Full Year Actuals (Draft)	Variance
	£m	£m	£m
Income	0.075	0.085	0.010
Expenditure			
Staff	0.763	0.644	0.120
Non Staff	0.043	0.069	(0.026)
Sub Total	0.806	0.712	0.093
Total	(0.730)	(0.627)	0.103

nVCC Key Highlights / Issues

The reported financial position for the nVCC Programme at the end of March 2025 is a **£0.103m** underspend.

The Division is carrying a small number of vacancies resulting in an underspend against pay.

Escrow bank interest was received, contributing to the surplus position.

HTW (Hosted Other)

	Full Year Budget	Full Year Actuals (Draft)	Variance
	£m	£m	£m
Income	1.654	1.719	0.065
Expenditure			
Staff	1.710	1.684	0.027
Non Staff	0.127	0.219	(0.092)
Sub Total	1.837	1.902	(0.065)
Total	(0.183)	(0.183)	0.000

HTW Key Highlights / Issues

The reported financial position for Health Technology Wales at the end of March 2025 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.

TRANSFORMING CANCER SERVICES PROGRAMME SCRUTINY SUB COMMITTEE

**nVCC Project Finance Report 2024-25
March 2025**

DATE OF MEETING	23 rd April 2025
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	INFORMATION / NOTING
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Mark Ash, Assistant Project Director, nVCC and Enabling Works Projects
PRESENTED BY	Matthew Bunce, Executive Director of Finance
APPROVED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SUMMARY	<p>The purpose of this report is to provide a financial update for the Transforming Cancer Services (TCS) Programme for the financial year 2024-25, outlining spend against budget as at 31st March 2025</p> <p>The spend for the year for the TCS Programme is £7.300m Capital and £0.712m Revenue.</p>



RECOMMENDATION / ACTIONS	The TCS Scrutiny Committee are asked to NOTE the final financial position for the TCS Programme and Associated Projects for 2024-25.
---------------------------------	---

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	Date
	(DD/MM/YYYY)
	(DD/MM/YYYY)
	(DD/MM/YYYY)
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
N/A	

7 LEVELS OF ASSURANCE	
The purpose of the report to provide assurance on the financial position of the EW and nVCC Project.	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Select Current Level of Assurance

APPENDICES	
01	Main nVCC Project Finance Paper March 2025

1. SITUATION

- 1.1 The purpose of this report is to provide a financial update for the nVCC Project for the financial year 2024-25, outlining spend against budget for the full year.
- 1.2 This report currently provides a financial update for the TCS Programme, including the Whitchurch Hospital Site and Service Delivery Projects, and the TCS Programme Management Office. However, these will be removed from future reports and included in the main finance report for the Trust, with the report focusing on the nVCC infrastructure project (including the Enabling Works).
- 1.3 The TCS Programme financial position is continually monitored and updated, with an update provided regularly to both the nVCC Project Board and Trust Board.

2. SUMMARY OF MATTERS FOR CONSIDERATION

- 2.1 The summary financial position for the TCS Programme for the full financial year 2024-25 is provided below. A detailed table of budget, spend and variance for the capital and revenue expenditure is provided in Appendix 1.

Expenditure Type	2024-25 Full Year		
	Budget	Spend	Variance
Capital	£7.311m	£7.300m	£0.011m
Revenue	£0.806m	£0.712m	£0.093m
Total	£8.116m	£8.012m	£0.104m

- 2.2 The final outturn for the Programme is an underspend of £0.104m for the financial year 2024-25 against a budget of £8.116m.
- 2.3 On the 18th November 2024 the Award of Funding was received in respect of nVCC Project Resources Funding 2024-2028. This provided further funding of £69.719m Capital and £2.412m Revenue for the nVCC activities between 2024 and 2028, and £8.943m Capital for the Enabling works relating to works between 2024 and 2027.
- 2.4 The Trust is finalising the profile of spend for each of the Financial Years for WG.
- 2.5 In addition, funding of £0.082m was provided by WG in November 2024 to cover the recurrent pay award for 2024-25.

2.6 There are no remaining financial risks to the TCS Programme for 2024-25.

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:	
<ul style="list-style-type: none"> • Outstanding for quality, safety and experience <input checked="" type="checkbox"/> • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations <input checked="" type="checkbox"/> • A beacon for research, development and innovation in our stated areas of priority <input checked="" type="checkbox"/> • An established 'University' Trust which provides highly valued knowledge for learning for all. <input type="checkbox"/> • A sustainable organisation that plays its part in creating a better future for people across the globe <input checked="" type="checkbox"/> 	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) <i>For more information: STRATEGIC RISK DESCRIPTIONS</i>	Choose an item
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Select all relevant domains below
	<ul style="list-style-type: none"> Safe <input type="checkbox"/> Timely <input type="checkbox"/> Effective <input type="checkbox"/> Equitable <input type="checkbox"/> Efficient <input type="checkbox"/> Patient Centred <input type="checkbox"/>



	<p>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).</p> <p>Click or tap here to enter text</p>
<p>SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: For more information: https://www.gov.wales/socio-economic-duty-overview</p>	<p>Not required</p> <p>Click or tap here to enter text</p>
<p>TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT</p>	<p>A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health</p> <p>If more than one Well-being Goal applies please list below:</p> <p>If more than one wellbeing goal applies please list below: Click or tap here to enter text</p>
<p>FINANCIAL IMPLICATIONS / IMPACT</p>	<p>Yes - please Include further detail below, including funding stream</p> <p><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></p> <p>Narrative in this section should be clear on the following:</p>

	<p>Source of Funding: Other (please explain)</p> <p>Please explain if 'other' source of funding selected: Revenue funding from VUNHST and Commissioners</p> <p>Type of Funding: Revenue and Capital Funding</p> <p>Scale of Change Please detail the value of revenue and/or capital impact: Capital: £7.311m; Revenue £0.806m</p> <p>Type of Change Major Programme Please explain if 'other' source of funding selected: Click or tap here to enter text</p>
<p>EQUALITY IMPACT ASSESSMENT For more information: https://nhs.wales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.asp x</p>	<p>Not required - please outline why this is not required</p> <p>Click or tap here to enter text.</p>
<p>ADDITIONAL LEGAL IMPLICATIONS / IMPACT</p>	<p>There are no specific legal implications related to the activity outlined in this report.</p> <p>Click or tap here to enter text</p>

4. RISKS

<p>ARE THERE RELATED RISK(S) FOR THIS MATTER</p>	<p>Yes - please complete sections below</p>
<p>WHAT IS THE RISK?</p>	<ul style="list-style-type: none"> Additional funding required from the Enabling Works QRA to cover additional works.



GIG
CYMRU
NHS
WALES

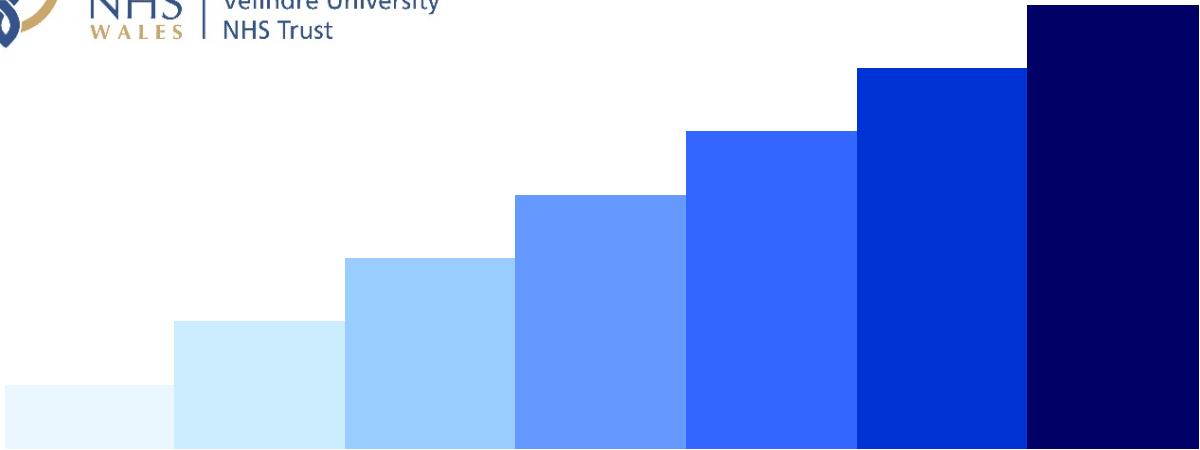
Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

WHAT IS THE CURRENT RISK SCORE	
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	Mitigate the risks by seeking to secure funding from Welsh Government
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	



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust



nVCC PROJECT FINANCE REPORT 2024-25

Period Ending 31st March 2025

Contents	Page
1. INTRODUCTION.....	2
2. EXECUTIVE SUMMARY	2
3. BACKGROUND	2
4. CAPITAL POSITION	3
5. REVENUE POSITION.....	4
6. CASH FLOW.....	4
7. PROJECT FINANCE UPDATES.....	5
Programme Management Office	5
Enabling Works Project.....	5
New Velindre Cancer Centre Project	7
Whitchurch Hospital Site	8
Service Delivery and Transformation Project.....	8
8. KEY RISKS AND MITIGATING ACTIONS.....	9
9. TCS SPEND REPORT SUMMARY	9
APPENDIX 1: TCS Programme Budget and Spend as at 31 st March 2025	11
APPENDIX 2: TCS Programme Funding for 2024-25	12
Appendix 3: Sources of Funding and In Year Changes 2024-25	13
APPENDIX 4: TCS Cumulative Spend Report to 31 st March 2024	14

1. INTRODUCTION

- 1.1 The purpose of this report is to provide a financial update for the nVCC Project for the financial year 2024-25, outlining spend against budget as at 31st March 2025.
- 1.2 This report currently provides a financial update for the TCS Programme, including the Whitchurch Hospital Site and Service Delivery Projects, and the TCS Programme Management Office. However, these will be removed from future reports and included in the main finance report for the Trust, with the report focusing on the nVCC infrastructure project (including the Enabling Works).
- 1.3 The TCS Programme financial position is continually monitored and updated, with an update provided regularly to both the nVCC Project Board and Trust Board.

2. EXECUTIVE SUMMARY

- 2.1 The summary financial position for the TCS Programme for the full financial year 2024-25 is provided below. A detailed table of budget, spend and variance for the capital and revenue expenditure is provided in Appendix 1.

Expenditure Type	2024-25 Full Year		
	Budget	Spend	Variance
Capital	£7.311m	£7.300m	£0.011m
Revenue	£0.806m	£0.712m	£0.093m
Total	£8.116m	£8.012m	£0.104m

- 2.2 The final outturn for the Programme is an underspend of £0.104m for the financial year 2024-25 against a budget of £8.116m.
- 2.3 On the 18th November 2024 the Award of Funding was received in respect of nVCC Project Resources Funding 2024-2028. This provided further funding of £69.719m Capital and £2.412m Revenue for the nVCC activities between 2024 and 2028, and £8.943m Capital for the Enabling works relating to works between 2024 and 2027.
- 2.4 The Trust is finalising the profile of spend for each of the Financial Years for WG.
- 2.5 In addition, funding of £0.082m was provided by WG in November 2024 to cover the recurrent pay award for 2024-25.
- 2.6 There are no remaining financial risks to the TCS Programme for 2024-25.

3. BACKGROUND

- 3.1 In January 2015 the Minister for Health and Social Services approved the initial version of the Strategic Outline Programme 'Transforming Cancer Services in South East

Wales'. Following completion of the Key Stage Review in June/July 2015, approval was received from the Minister to proceed to the next stage of the Programme.

- 3.2 By 31st March 2024, the Welsh Government (WG) had provided a total of £63.295m funding (£60.246m capital, £3.049m revenue) to support the TCS Programme. In addition, the Trust had provided £0.264m from its discretionary capital allocation and £0.512m non-recurrent revenue funding.
- 3.3 NHS Commissioners agreed in December 2018 to provide annual revenue funding to the Trust to support TCS Programme, with £0.400m provided in 2018/19, increased to £0.420m thereafter.
- 3.4 The funding provided to support the TCS Programme in 2024-25 is £7.311m capital and £0.806m revenue. This is outlined in Appendix 2. The sources of funding changes are summarised below, with further detail in Appendix 3.

Funding Source	Capital	Revenue	Total
Welsh Government	£7.311m	£0.092m	£7.403m
LHB Commissioners	£0	£0.420m	£0.420m
Trust Reserves	£0	£0.218m	£0.218m
Escrow Interest	£0	£0.028m	£0.028m
Project Advisory Work	£0	£0.047m	£0.047m
Total Funding	£7.311m	£0.806m	£8.116m

4. CAPITAL POSITION

4.1 The current capital funding for 2024-25 is outlined below:

- Enabling Works Project £3.868m
- nVCC Project £3.332m
- Whitchurch Hospital Site £0.111m
- Total £7.311m**

4.2 The final capital position for the year is outlined below, with an underspend of £0.011m.

Capital Expenditure	2024-25 Full Year		
	Budget	Spend	Variance
Enabling Works Project	£3.868m	£3.862m	£0.006m
nVCC Project	£3.332m	£3.327m	£0.005m
Whitchurch Hospital Site	£0.111m	£0.111m	£0.000m
Total	£7.311m	£7.300m	£0.011m

5. REVENUE POSITION

5.1 The revenue funding for 2024-25 is outlined below:

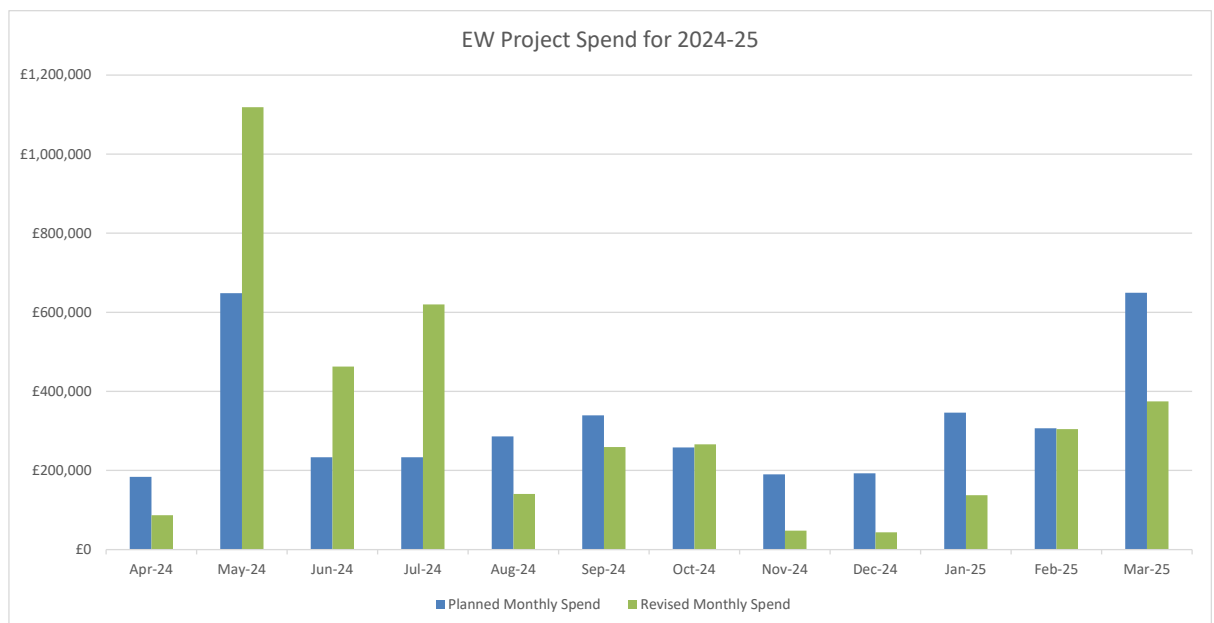
- PMO £0.338m
- Enabling Works Project £0.028m
- nVCC Project £0.116m
- SDT Project £0.323m
- Total £0.806m**

5.2 The final revenue position for the year is outlined below, with an underspend of £0.093m.

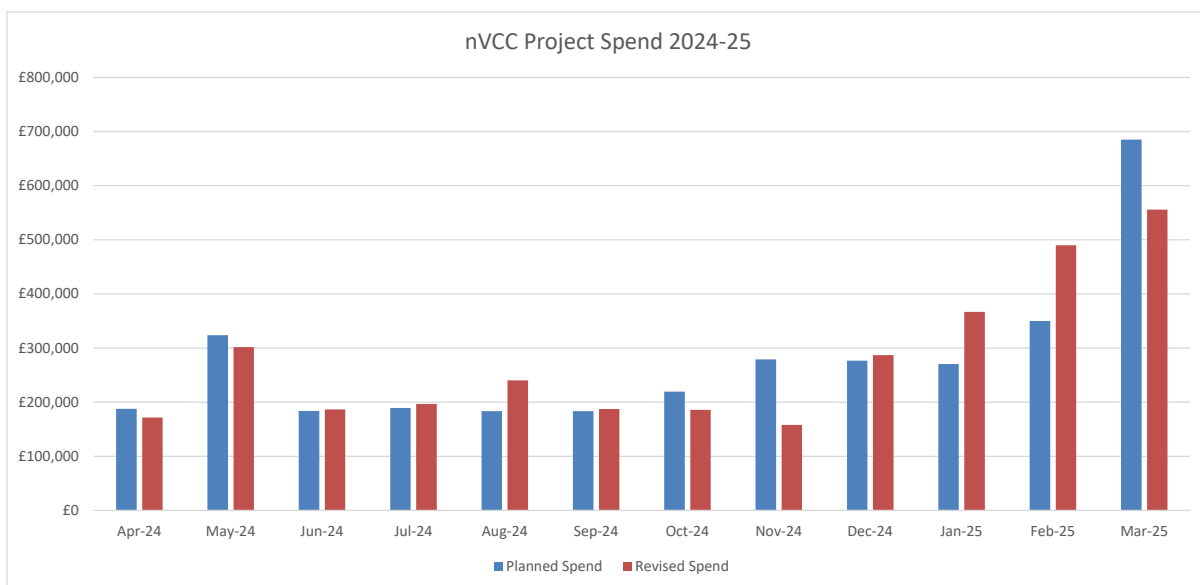
Revenue Expenditure	2024-25 Full Year		
	Budget	Spend	Variance
PMO	£0.338m	£0.330m	£0.008m
Enabling Works Project	£0.028m	£0	£0.028m
nVCC Project	£0.116m	£0.141m	-£0.025m
SDT Project	£0.323m	£0.241m	£0.082m
Total	£0.806m	£0.712m	£0.093m

6. CASH FLOW

6.1 The capital cash flow for the **Enabling Works Project** is outlined below. The actual capital spend for the project for the is £3.862m, with a run rate for the year similar to the planned spend.



6.2 The capital cash flow for the **nVCC Project** is outlined below. The capital spend year for the project for the year is £3.327m, with a run rate for the year in line the planned spend.



6.3 The cash flow for the remainder of the Programme is not reported as it is not of a material nature.

7. PROJECT FINANCE UPDATES

7.1 A detailed table of budget, spend and variance is provided in Appendix 1.

Programme Management Office

7.2 The revenue funding for the PMO for 2024-25 is £0.332m, with £0.240m of this provide from NHS Commissioners' funding, £0.078m from the Trust Reserves, and £0.020m from the WG Pay Award and Band 8 intermediate pay step point funding.

7.3 There is no capital funding requirement for the PMO in 2024-25.

7.4 The final revenue position for the PMO for the year is shown below, with an overall underspend of £0.008m.

PMO Expenditure	2024-25 Full Year		
	Budget	Spend	Variance
Pay	£0.337m	£0.289m	£0.048m
Non Pay	£0.002m	£0.041m	-£0.040m
Total	£0.338m	£0.330m	£0.008m

Enabling Works Project

Capital

7.5 The EW FBC Addendum was submitted to WG on the 3rd September 2024 and on the 18th November 2024, the Award of Funding was received in respect of nVCC Project Resources Funding 2024-2028. This provided further funding of £8.943m Capital for the Enabling works relating to works between 2024 and 2027.

- 7.6 The Project's final financial position for the year is shown below. This reflects an overall underspend of £0.006m for this financial year against a budget of £3.868m.

Enabling Works Capital Expenditure	2024-25 Full Year		
	Budget	Spend	Variance
Pay	£0.153m	£0.153m	£0.000m
Non Pay	£3.715m	£3.709m	£0.006m
Total	£3.868m	£3.862m	£0.006m

- 7.7 The Project spend relates to the following activities:

Enabling Works FBC Project Capital Budget & Spend Summary 2024-25			
Description	Financial Year		
	Annual Budget £	Annual Forecast £	Annual Variance £
PAY			
Enabling Works Pay	153,116	153,116	0
Pay Capital Total	153,116	153,116	0
NON-PAY			
6MVA Supply - National Grid	480,000	480,000	0
Supply Chain Fees	305,291	323,268	-17,977
Non Works Costs	-113,202	-113,202	0
Asda Works	2,008,269	2,008,269	0
Walters Design & Build	481,187	481,188	-1
S278 works on Longwood Drive	288,858	288,858	0
Offsite Habitat Creation (SW Corner)	137,718	137,718	0
HV Intake Room	92,933	92,933	0
TCAR Extension Planning Application	17,978	0	17,978
Rural Path	0	0	0
TCAR Habitat	0	0	0
Revised Emergency Access	0	0	0
Enabling Works FBC Reserves	15,852	9,921	5,931
Enabling Works FBC Project Capital Total	3,714,884	3,708,953	5,931
TOTAL ENABLING WORKS FBC CAPITAL EXPENDITURE	3,868,000	3,862,069	5,931

- 7.8 In addition to the funding award, a QRA has been established of c£1.4m that will be managed by WG. QRA will be reviewed on a quarterly basis with Welsh Government, supported by Technical Advisors so that risks are robustly assessed, quantified and appropriately revised. The Trust will request funding on a quarterly basis from the QRA when matters arise that require additional funding.

- 7.9 Additional funding of £0.368m has been provided from this QRA for ASDA costs. The provision of this funding will mitigate the risk an overspend for this project for 2024-25.

Revenue

- 7.10 There is revenue funding of £0.028m for the Enabling Works Project for 2024-25. This is provided from the interest earned from the Enabling Works Escrow bank account for the ASDA works.

- 7.11 The final revenue financial position for the project for the year is shown below, reflecting an underspend of £0.028m.

Enabling Works Revenue Expenditure	2024-25 Full Year		
	Budget	Spend	Variance
Non-Pay	£0.028m	£0	£0.028m
Total	£0.028m	£0	£0.028m

New Velindre Cancer Centre Project

Capital

- 7.12 The nVCC FBC was submitted to WG on the 3rd September 2024 and on the 18th November 2024, the Award of Funding was received in respect of nVCC Project Resources Funding 2024-2028. This provided further funding of £69.719m Capital and £2.412m Revenue for the nVCC activities between 2024 and 2028.
- 7.13 The Project's final financial position for 2024-25 is shown below, reflecting an underspend of £0.005m against a budget of £3.327m.

Enabling Works Capital Expenditure	2024-25 Full Year		
	Budget	Spend	Variance
Pay	£1.623m	£1.553m	£0.070m
Non Pay	£1.709m	£1.774m	-£0.065m
Total	£3.332m	£3.327m	£0.005m

- 7.14 The Project spend relates to the following activities:

nVCC FBC Project Capital Budget & Spend Summary 2024-25			
Description	Financial Year		
	Annual Budget	Annual Forecast	Annual Variance
	£	£	£
Project Management Office	1,108,150	1,299,144	-190,995
Design & Construction	796,390	760,098	36,292
Equipment, Commissioning and Migration	388,758	372,839	15,919
Digital	154,155	113,756	40,399
Engagement & Communications Workstream	149,168	159,689	-10,521
Commercial Activity Group	735,154	621,540	113,614
TOTAL CAPITAL EXPENDITURE	3,331,774	3,327,065	4,709

- 7.15 In addition to the funding award, a QRA has been established of c£17.3m that will be managed by WG. QRA will be reviewed on a quarterly basis with Welsh Government, supported by Technical Advisors so that risks are robustly assessed, quantified and appropriately revised. The Trust will request funding on a quarterly basis from the QRA when matters arise that require additional funding.
- 7.16 Additional funding is being provided WG/this QRA for site security costs, which will mitigate the risk of an overspend for this project.

Revenue

- 7.17 £0.069m was allocated to the nVCC Project from the revenue pay award funding from WG provided in November 2023, and Band 8 intermediate pay step point funding in February 2025. There is also revenue income for project consultancy work completed by the Project Director for various NHS England organisations, which is currently £0.047m.
- 7.18 The final revenue financial position for the nVCC Project for this year is shown below, reflecting an overspend of £0.025m for the year.

nVCC Revenue Expenditure	2024-25 Full Year		
	Budget	Spend	Variance
Pay	£0.116m	£0.116m	£0
Non-Pay	£0	£0.025m	-£0.025m
Total	£0.116m	£0.141m	-£0.025m

- 7.19 This overspend has been offset by the revenue underspend in other areas of the TCS Programme.

Whitchurch Hospital Site

- 7.20 WG have provided capital funding of £0.111m the Whitchurch Hospital Site Project for 2024-25.
- 7.21 The Project's final financial position for the year is shown below. This spend relates mainly to legal fees associated with the Whitchurch Hospital Site. The forecast position reflects a breakeven position for the year against a budget of £0.111m.

Whitchurch Hospital Site Expenditure	2024-25 Full Year		
	Budget	Spend	Variance
Non-Pay	£0.111m	£0.111m	£0.000m
Total	£0.111m	£0.111m	£0.000m

Service Delivery and Transformation Project

- 7.22 The revenue funding for the Project for 2024-25 is £0.323m from NHS Commissioners' funding, £0.140m from Trust reserves, and £0.003m from the WG Pay Award Funding. The resulting budget is £0.323m for this financial year.
- 7.23 There is no capital funding requirement for the Project in 2024-25.
- 7.24 The SDT Project final position for 2024-25 is shown below, with an underspend £0.082m for this financial year.

SDT Expenditure	2024-25 Full Year		
	Budget	Spend	Variance
Pay	£0.309m	£0.239m	£0.070m
Non-Pay	£0.014m	£0.002m	£0.011m
Total	£0.323m	£0.241m	£0.082m

7.25 The underspend is due to a delay in the procurement of goods relating to the Ways of Working study. These costs will now be borne in the 2025-26 financial year.

8. KEY RISKS AND MITIGATING ACTIONS

8.1 There are no remaining financial risks to the TCS Programme.

9. TCS SPEND REPORT SUMMARY

9.1 At the end of 2019, a financial model was developed by the TCS Finance Team to provide a spend profile for the TCS Programme. The model allocates reported spend by year to defined deliverables and outputs within each project within the Programme. It also allocates spend to the various resources need to deliver the Programme, such as pay, advisors, suppliers, etc. The output for the model itself is an in-year report providing spend details on a quarterly basis. A cumulative report is also produced for the Programme for its inception to the end of the latest quarter.

9.2 Appendix 4 provides cumulative report to 31st March 2024. The report for 2024-25 is currently being developed and will be in line with the approved nVCC FBC.

9.3 The cumulative report shows a total spend for the TCS Programme of £68.635m (£63.443m Capital, £5.192m Revenue) to 31st March 2024. The total pay costs for this period were £15.239m.

9.4 The spend to 31st March 2024 for each Project within the Programme is summarised below.

Programme Management Office	£2.187m
Project 1 Enabling Works	£34.735m
Project 2a nVCC	£26.221m
Project 2c Whitchurch Hospital Site	£0.051m
Project 3a Integrated Radiotherapy Solution	£0.1.049m
Project 3b Digital Strategy	£0.200m
Project 4 Radiotherapy Satellite	£0.393m
Project 5 SACT and Outreach	£0.002m
Project 6 Service Delivery and Transformation	£3.798m
Project 7 Decommissioning	£0m

9.5 The spend to 31st March 2024 for each financial year is summarised below.

2014-15	£0.328m
2015-16	£2.398m
2016-17	£6.168m
2017-18	£3.909m
2018-19	£4.267m
2019-20	£2.928m
2020-21	£3.924m
2021-22	£6.429m
2022-23	£17.365m
2023-24	£20.918m

9.6 The five deliverables with the highest spend during this period are:

Construction Costs	£19.842m
ASDA Works.....	£6.660m
Competitive Dialogue	£6.196m
Advanced Design and Works	£6.016m
Project Control.....	£5.198m

APPENDIX 1: TCS Programme Budget and Spend as at 31st March 2025

TCS Programme Budget & Spend 2024-25						
CAPITAL	Year to Date			Financial Year		
	Budget Mar-25	Spend Mar-25	Variance Mar-25	Annual Budget	Annual Forecast	Annual Variance
	£	£	£	£	£	£
Enabling Works Project						
Enabling Works Pay	153,116	153,116	0	153,116	153,116	0
Supply Chain Fees	305,291	323,268	-17,977	305,291	323,268	-17,977
Non Works Costs	-113,202	-113,202	0	-113,202	-113,202	0
Asda Works	2,008,269	2,008,269	0	2,008,269	2,008,269	0
Walters Design & Build	481,187	481,188	-1	481,187	481,188	-1
6MVA Supply - National Grid	480,000	480,000	0	480,000	480,000	0
S278 works on Longwood Drive	288,858	288,858	0	288,858	288,858	0
Offsite Habitat Creation (SW Corner)	137,718	137,718	0	137,718	137,718	0
HV Intake Room	92,933	92,933	0	92,933	92,933	0
TCAR Extension Planning Application	17,978	0	17,978	17,978	0	17,978
Rural Path	0	0	0	0	0	0
TCAR Habitat	0	0	0	0	0	0
Revised Emergency Access	0	0	0	0	0	0
Enabling Works FBC Reserves	15,852	9,921	5,931	15,852	9,921	5,931
Enabling Works Capital Total	3,868,000	3,862,069	5,931	3,868,000	3,862,069	5,931
nVCC Project						
Project Management Office	1,108,150	1,299,144	-190,995	1,108,150	1,299,144	-190,995
Design & Construction	796,390	760,098	36,292	796,390	760,098	36,292
Equipment, Commissioning and Migration	388,758	372,839	15,919	388,758	372,839	15,919
Digital	154,155	113,756	40,399	154,155	113,756	40,399
Engagement & Communications Workstream	149,168	159,689	-10,521	149,168	159,689	-10,521
Commercial Activities Group	735,154	621,540	113,614	735,154	621,540	113,614
nVCC Capital Total	3,331,774	3,327,065	4,709	3,331,774	3,327,065	4,709
Whitchurch Hospital Site						
Advisory Services	55,000	74,726	-19,726	55,000	74,726	-19,726
Preliminary Works	56,000	36,243	19,757	56,000	36,243	19,757
Whitchurch Hospital Site Reserves	0	-447	447	0	-447	447
WHS Capital Total	111,000	110,522	478	111,000	110,522	478
CAPITAL TOTAL	7,310,774	7,299,656	11,118	7,310,774	7,299,656	11,118

REVENUE						
	Year to Date			Financial Year		
	Budget Mar-25	Spend Mar-25	Variance Mar-25	Annual Budget	Annual Forecast	Annual Variance
	£	£	£	£	£	£
Enabling Works Project						
Project Delivery Support Costs	28,434	0	28,434	28,434	0	28,434
Enabling Works Revenue Total	28,434	0	28,434	28,434	0	28,434
nVCC Project						
nVCC Pay	115,731	115,731	0	115,731	115,731	0
Project Delivery Support Costs	0	25,073	-25,073	0	25,073	-25,073
nVCC Revenue Total	115,731	140,804	-25,073	115,731	140,804	-25,073
TCS Programme Management Office						
TCS PMO Pay	336,939	288,815	48,123	336,939	288,815	48,123
TCS PMO Non Pay	1,500	41,306	-39,806	1,500	41,306	-39,806
PMO Revenue Total	338,439	330,121	8,317	338,439	330,121	8,317
Service Development, Transformation and Transition Project						
SDT Pay	309,327	238,991	70,336	309,327	238,991	70,336
SDT Non Pay	13,754	2,409	11,345	13,754	2,409	11,345
SDT Revenue Total	323,081	241,400	81,681	323,081	241,400	81,681
REVENUE TOTAL	805,684	712,325	93,359	805,684	712,325	93,359

APPENDIX 2: TCS Programme Funding for 2024-25

Description	Date	Funding Type	
		Capital	Revenue
Programme Management Office		£0	£0.338m
Commissioner's Funding	01 April 2024	£0	£0.240m
Trust Revenue Funding	01 April 2024	£0	£0.078m
WG Pay Award	02 December 2024	£0	£0.014m
WG Band 8 Intermediate Pay Step	21 February 2025	£0	£0.006m
Enabling Works FBC		£3.868m	£0.028m
WG Funding	28 November 2024	£3.500m	£0
Escrow Bank Account Interest	04 June 2024	£0	£0.028m
QRA funding for ASDA works	13 February 2025	£0.368m	£0
New Velindre Cancer Centre FBC		£3.332m	£0.116m
WG Funding	28 November 2024	£3.243m	£0
WG Pay Award	02 December 2024	£0	£0.065m
Income for Project Advisory Work	09 January 2025	£0	£0.039m
Virement of funding from 2024-25 to 2025-26	11 February 2025	-£0.067m	£0
WG Band 8 Intermediate Pay Step	21 February 2025	£0	£0.004m
Income for Project Advisory Work	28 February 2025	£0	£0.008m
WG funding for site security	17 March 2025	£0.156m	£0
Whitchurch Hospital Site		£0.111m	£0
WG Funding	28 November 2024	£0.353m	£0
Virement of funding from 2024-25 to 2025-26	28 January 2025	-£0.242m	
Radiotherapy Satellite Centre		£0	£0
No funding requested or provided for this project to date	-	£0	£0
SACT and Outreach		£0	£0
No funding requested or provided for this project to date	-	£0	£0
Service Delivery, Transformation and Transition		£0	£0.323m
Commissioner's Funding	01 April 2024	£0	£0.180m
Trust Revenue Funding	01 April 2024	£0	£0.140m
WG Pay Award	02 December 2024	£0	£0.003m
VCC Decommissioning		£0	£0
No funding requested or provided for this project to date	-	£0	£0
Total		£7.311m	£0.806m

Appendix 3: Sources of Funding and In Year Changes 2024-25

Sources of Capital Funding

Initial Allocation (as at April 2024)

Project	WG Capital	Total Funding
Enabling Works Project	£0	£0
nVCC Project	£0	£0
Whitchurch Hospital Site	£0	£0
Total	£0	£0

Overall Change to Allocation

Project	WG Capital	Total Funding
Enabling Works Project	£3.868m	£3.868m
nVCC Project	£3.332m	£3.332m
Whitchurch Hospital Site	£0.111m	£0.111m
Total	£7.311m	£7.311m

Current Allocation (as at May 2024)

Project	WG Capital	Total Funding
Enabling Works Project	£3.868m	£3.868m
nVCC Project	£3.332m	£3.332m
Whitchurch Hospital Site	£0.111m	£0.111m
Total	£7.311m	£7.311m

Sources of Revenue Funding

Initial Allocation (as at April 2024)

Project	LHB Comm'rs	Trust Reserves	WG Pay Award	Escrow Interest	Project Advisory Work	Total Funding
PMO	£0.240m	£0.078m	£0	£0	£0	£0.318m
EW	£0	£0	£0	£0	£0	£0
nVCC	£0	£0	£0	£0	£0	£0
SDT	£0.180m	£0.140m	£0	£0	£0	£0.320m
Total	£0.420m	£0.218m	£0	£0	£0	£0.638m

Overall Change to Allocation

Project	LHB Comm'rs	Trust Reserves	WG Pay Award	Escrow Interest	Project Advisory Work	Total Funding
PMO	£0	£0	£0.020m	£0	£0	£0.020m
EW	£0	£0	£0	£0.028m	£0	£0.028m
nVCC	£0	£0	£0.069m	£0	£0.047m	£0.116m
SDT	£0	£0.000m	£0.003m	£0	£0	£0.003m
Total	£0	£0.000m	£0.092m	£0.028m	£0.047m	£0.168m

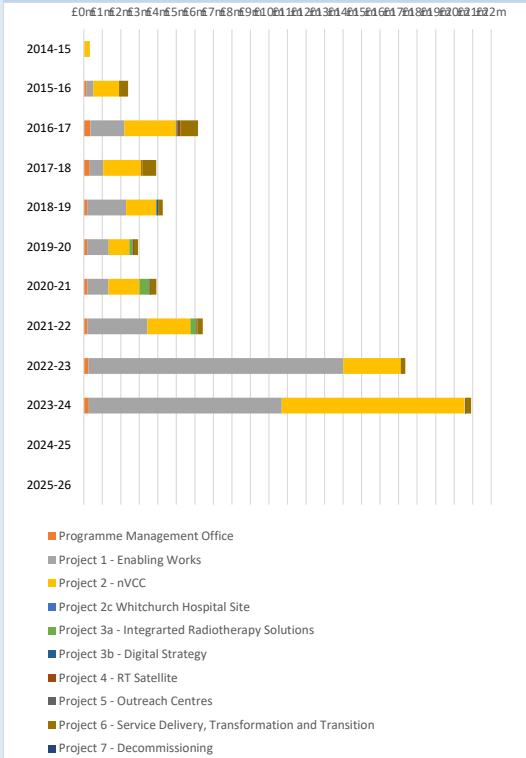
Current Allocation (as at May 2024)

Project	LHB Comm'rs	Trust Reserves	WG Pay Award	Escrow Interest	Project Advisory Work	Total Funding
PMO	£0.240m	£0.078m	£0.020m	£0	£0	£0.338m
EW	£0	£0	£0	£0.028m	£0	£0.028m
nVCC	£0	£0	£0.069m	£0	£0.047m	£0.116m
SDT	£0.180m	£0.140m	£0.003m	£0	£0	£0.323m
Total	£0.420m	£0.218m	£0.092m	£0.028m	£0.047m	£0.806m

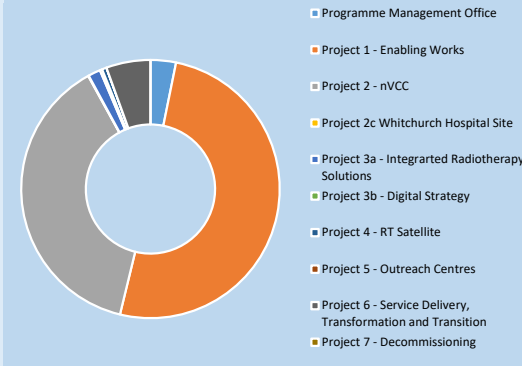
APPENDIX 4: TCS Cumulative Spend Report to 31st March 2024

SUMMARY OF CUMULATIVE TCS SPEND TO 31 MARCH 2024

SPEND PER PROJECT PER YEAR



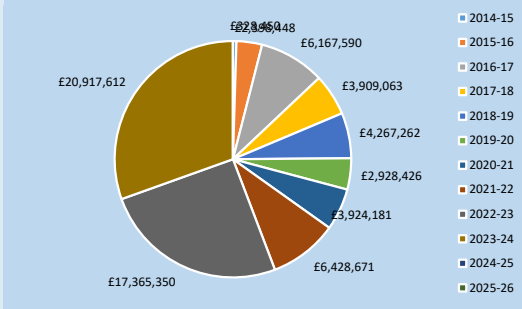
SPEND FOR EACH PROJECT ACROSS ALL YEARS



TOTAL SPEND BY PROJECT TO DATE **£68,635,053**

Project	Total Spend (£)
Programme Management Office	£2,186,915
Project 1 - Enabling Works	£34,734,803
Project 2 - nVCC	£26,220,533
Project 2c Whitchurch Hospital Site	£50,807
Project 3a - Integrated Radiotherapy Solutions	£1,049,425
Project 3b - Digital Strategy	£199,786
Project 4 - RT Satellite	£393,293
Project 5 - Outreach Centres	£1,909
Project 6 - Service Delivery, Transformation and Transition	£3,797,583
Project 7 - Decommissioning	-

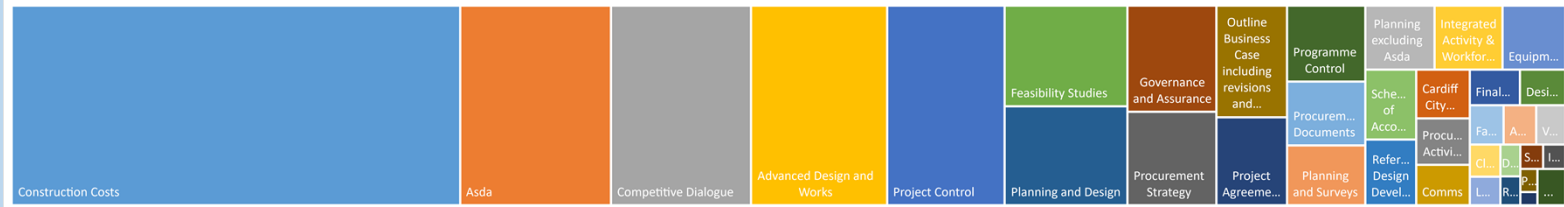
SPEND FOR EACH YEAR ACROSS ALL PROJECTS



DELIVERABLES WITH HIGHEST EXPENDITURE TO DATE

Rank	Deliverable	Total Spend (£)
1	Construction Costs	£19,841,778
2	Asda	£6,659,918
3	Competitive Dialogue	£6,196,147
4	Advanced Design and Works	£6,015,699
5	Project Control	£5,198,999

PROPORATIONAL SPEND FOR EACH DELIVERABLE ACROSS ALL YEARS



TRUST BOARD	
TRUST RISK REGISTER UPDATE	
DATE OF MEETING	22 May 2025
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	<p>The report:</p> <ul style="list-style-type: none"> • highlights the current extract of risk registers for risks scoring 12 and above for Quality/Safety and 15 above for all other domains; • allows the Trust Board to have effective oversight and assurance of the way in which risks are being managed across the Trust; • provides the Trust Board with a summary of activity related to the status of the risks and associated movement.
RECOMMENDATION / ACTIONS	<p>The Trust Board is asked to:</p> <ul style="list-style-type: none"> • NOTE the risks in the quality and safety domain with a score of 12 and risks in other domains with a score of 15 on the Risk Register. • NOTE the Workforce Risk detailed in 2.6 and in Appendix 1.

COMMITTEE / GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING	
COMMITTEE OR GROUP	DATE
VCS SLT	10.04.2025
WBS SLT	09.04.2025
Executive Management Board	29.04.2025
Quality, Safety and Performance Committee (QSP)	08.05.2025
Audit Committee	13.05.2025
<p>This paper takes into consideration the feedback from VCC and WBS leadership teams on their respective risks.</p> <p>The Executive Board discussed the Risk Register on 29 April. Following a detailed discussion about the status of the Radiology Informatics System Procurement Project (RISP), the Board agreed to consider a more detailed risk on the impact of delay on service sustainability.</p> <p>QSP discussed the Trust Risk Register on 08 May and suggested increasing the assurance rating from 2 to 3 in light of developments implemented and training delivered. The assurance rating has been amended in line with the Committee's recommendation.</p> <p>Audit Committee met and discussed the Trust Risk Register on 13 May. There was discussion regarding the need to effectively manage static risks and the need for a comprehensive understanding of the risks reporting under the threshold for the Trust Risk Register.</p>	
ASSURANCE RATING ASSESSED BY EXECUTIVE SPONSOR	3 – Comprehensive actions have been identified and addressed. The cause of the performance issue has been identified and is being actively managed.
APPENDICES	
1	Trust Risk Register
2	Workforce Risk Review

1. SITUATION

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

Service (WBS) monthly risk analysis reports, validated by their Senior Leadership Teams (SLT) and the Executive Management Board.

Risks reported in this paper are:

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

2. ASSESSMENT

2.1 Trust Risk Register

The Trust Risk Register is available as Appendix 1.

2.2 There were 12 Risks on the Public Trust Risk Register at the beginning of the reporting period.

Since the last reporting cycle three risks are no longer reportable on the Public Trust Risk Register:

Risk 3431

'There is a risk to performance and service sustainability as a result of increased demand which has now outstripped capacity in the skin/melanoma SST'.

- The risk rating reduced from 12 to 8 and therefore is now below the threshold for reporting to Trust Board.

Risk 3270

'There is a risk to performance and service sustainability as a result of increased demand for SACT starting to exceed capacity in all clinics leading to the burnout of the medical and supporting workforce due to excessive workloads'.

- This risk is a duplicate of open risk 3332, scoring 16, which is being managed. The risk is closed on the Datix system.

Risk 3448

'There is a risk that the VCC Cancer Associated Thrombosis (CAT) service will not be able to continue as a result of 2 out of the 3 trained practitioners for VCC (medical and non-medical prescribers) having recently indicated that they may no longer be able to continue in the service. This will lead to a loss of the VCC CAT service which will result in a risk to patient safety and organisational reputation as the sustainability of the service is not secured. Patients diagnosed with CAT will not be able to access specialised services and therefore may be sub optimally treated, to include delays in their cancer treatments and longer term sequelae of VTE.'

- The risk rating reduced from 12 to 8, therefore the risk is no long reportable according to the Trust risk threshold.

2.3 There are seven new risks to the Trust Risk Register:

Risk 2745 – There is a risk to quality as a result of a cyber security breach or other equivalent malicious activity leading to a data protection IT security incident and/or disruption to critical operational or clinical services.

Risk 3634 - There is a risk to Quality, Performance and Service Stability, 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.

Risk 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. Specifically on this Risk, EMB discussed the conscious decision to change the implementation timeline on the basis of the risk of loss of visibility of previous patient imaging, impacting patients referred between the partner organisations involved. A risk relating to the impact of the delay on realising project benefits has being formulated and will be governed via the RISP programme Board and into Trust risk governance for the July cycle.

Risk 3646 - There is a risk to Performance and Service Sustainability that the go-live date for the LIMS National Digital Programme will be delayed as a result of: delays in the national programme timeline leading to an impact on realising project outcomes and additional demand for further development of existing legacy systems.

Risk 3388 – There is a risk to Quality and Performance as a result of reporting errors and limited accessibility of reports due to no interfaces between the Fetal D IT System and NHS Wales Digital Applications leading to suboptimal antenatal care.

Risk 3633 - There is a risk to Quality and Performance and Service Stability as a result of the lack of capacity of Digital Health and Care Wales to integrate VUNHST digital systems into the National Architecture on a timely basis leading to delays in the Trusts ability to introduce new digital systems to support its strategic objectives. In particular integration for the IRS, WHAIS, FEDIS projects has had to be escalated to the DHCW Executive for resolution.

Risk 3656 - There is a risk to the quality of clinical and corporate governance caused by the current assurance and reporting arrangements of hosted services.

Five of these risks report in the Digital domain, this is due to a review and strengthening of the digital risk register.

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

- a total of 16 risks reporting onto the public Trust Risk Register in line with the Trust's risk appetite.
- Five risks with a score of 12 or above reported in the safety/quality domain.
 - o Three on the VCS register
 - o One on the WBS register.
 - o One in the Corporate register.
- Eleven with a score over 15 or above reported in other domains.
 - o Four on the VCS register;
 - o Two on WBS register;
 - o Five managed by Trust corporate services.

2.4 One risk has decreased during the reporting period:

Risk 3332 - There is a risk to staff wellbeing as a result of consultants having insufficient time to undertake direct patient administration including prescribing and completion of OONs (Outpatient Oncology note) due to increase in patient clinic numbers, leading to increased email traffic and potential treatment delays.

The risk has reduced from 16 to 12 due to the successful recruitment of GPs to support outpatient clinics, which will support the capacity shortfall across many clinics.

2.5 Risk Themes

During the reporting period, there areas of work reported multiple risks.

Patient Safety Risks:

- 2465 - Duplication of information, excessive use of email, and lack of alternative communication methods for processing clinical information.
- 2187 - Inadequate staffing within the Radiotherapy Physics Department.
- 3562 - Uncertainty around the process and ownership of reviewing and actioning blood test results.

Staff Wellbeing Risks:

- 3332 - Consultants having insufficient time to undertake direct patient administration due to increased patient clinic numbers.
- 3392 - Reduced staffing in the dietetic delivery.

Performance and Service Sustainability Risks:

- 3541 - Delays in the national TrAMS project.
- 2249 - Service disruption caused by posts funded by time-limited funding.

2.6 CORPORATE RISKS

There has been an increase in the number of Corporate risks partly due to considerable work being undertaken by the digital team to strengthen the digital risk register.

2.7 WORKFORCE RISKS

At the request of Trust Board (identified at March 2025 meeting), a detailed report on Workforce risks is included in Appendix 2, for assurance.

The People and Organisational Development Team in collaboration with service leads and the Trust Risk and Assurance Manager ensure operational risks are regularly reviewed. Key messages in the report identify how the identified risks are reviewed and mitigated through the People and OD Workplan, demonstrating the Trust's commitment to robust workforce planning and risk management.

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

DATIX RISK TRAINING

Datix training sessions continue to be offered. Several training sessions are being arranged, including to Health Technology Wales. Bespoke training has been provided where necessary and individual sessions continue to be offered also. Tools are shared following training delivery to assist future use of the Datix system.

During the reporting period, a glitch in the Datix system that would not allow updates/new risks raised to be automatically shared with managers has been rectified.

REVIEWING ASSURANCE LEVELS

At its March meeting, the Quality, Safety and Performance Committee asked for confirmation of the improvements that would lead to a reconsideration of the assurance level for the Trust Risk Register from level 2 to 3. Having reviewed the Governance, Assurance and Risk programme actions related to risk management, it is suggested that an assurance of 3 should be considered when:

- the Risk policy and procedures are updated, and
- an accompanying training programme is embedded across the Trust in support of the reviewed policy.

The Committee discussed the evidence, and on this basis suggested that the current assurance level should be increased to Level 3. The Committee agreed that the delivery of the actions noted above i.e. completion of the review of the risk policy and procedures and the delivery an embedded training programme, would provide evidence for a further review of the Assurance Level Rating.

4. 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 risks in other domains with a score of 15 and above in advance of the Trust Board's consideration of the Risk Register.
- **NOTE** the report shared in Appendix 2, Workforce Risks Review.

5. IMPACT ASSESSMENT

RELATED TRUST STRATEGIC GOAL(S)	
Please tick all relevant goals:	
. Outstanding for quality, safety and experience	<input checked="" type="checkbox"/>
RELATED STRATEGIC TRUST ASSURANCE FRAMEWORK RISK	06 - QUALITY & SAFETY06 - QUALITY & SAFETY



QUALITY AND SAFETY IMPLICATIONS / IMPACT	Safe <input checked="" type="checkbox"/>
	Timely <input checked="" type="checkbox"/>
	Effective <input checked="" type="checkbox"/>
	Equitable <input checked="" type="checkbox"/>
	Efficient <input checked="" type="checkbox"/>
	Patient Centered <input checked="" type="checkbox"/>
	The risk register and associated risk framework are imperative to quality and safety in the organisation.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED	Not required.
TRUST WELL-BEING GOAL IMPLICATIONS/IMPACT	There are no direct well-being goal implications or impact in the current risks in this paper.
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report. There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT	No - Include further detail below No - Include further detail below
	There is no direct equality impact in respect of this paper, however each risk will have an impact assessment where appropriate.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report. There are no specific legal implications related to the activity outlined in this report.

5. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	The specifics of the Trust's risks scoring at or above the threshold are detailed in the paper.
--	---

APPENDIX 1 - TRUST RISK REGISTER
Trust Board – May reporting cycle




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

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

SECTION 1 – Current Trust Risk Register

No	ID & DATE OPENED	DIRECTORATE	RISK DOMAIN	RISK OWNER		INHERENT RATING	CURRENT RATING	TARGET RATING	RATING CHANGE SINCE LAST REPORTING PERIOD	ACTIONS & DUE DATE	PROGRESS SINCE LAST REPORTING PERIOD
Velindre Cancer Service											
12+ Risks in the Quality and Safety domains											
1	2465 05.11.2021	Medical	Quality/ Safety	Director of Cancer Service	There is a risk to patient safety, caused by the duplication of information, excessive use of email and a lack of alternative communication methods for the processing of clinical information.	16 (4x4)	12 (4x3)	4 (2x2)		1. T&F group continue to meet to address key actions <i>Due date 13.05.2025</i> 2. Email guidelines and protocol to be produced for Trust. <i>due date 20.05.2025</i>	16.04.2025 Implementation of PTL is taking place, which will also support the management of emails. Further follow up to take place through the PTL. 09.04.2025 T&F group has made further progress and a closure report with recommendations and summary of improvements made to date. Further update with SLT feedback and next steps to follow, next review date 1st May 2025.
2	2187 14.09.2020	Radiation Service	Quality/ Safety/ Workforce	Director of Cancer Service	There is a risk to patient safety due to inadequate staffing within the Radiotherapy Physics Department and the need to balance core duties with developmental tasks.	25 (5x5)	15 (5x3)	10 (5x2)		1. Re-advertise IRS implementation lead for the development of novel techniques.	16.04.2025 Paperless go live successful in March 2025 RSU on track for June 2025 LA7/8 extension agreed in principle subject to Trust Board approval Head of Radiotherapy physics recruited. recruitment underway for IRS posts, interviews planned for May 2025. further post undergoing job matching following which will be advertised. Likelihood to be reduced subject to Head of Radiotherapy Physics starting post and appointment to IRS posts.
3	3562 30.12.2024	VCS Whole Service	Safety	Clinical Director VCS	There is a risk to patient safety as a result of uncertainty around process and ownership of reviewing and actioning blood tests results which may lead to an omission or delay in undertaking a remedial clinical intervention	20 (4x5)	12 (4x3)	8 (4x2)		1. Widen the scope of appropriate clinical staff who have the necessary permissions on WCP to enable them to sign off blood results; (links to other action regarding communicating to staff to take responsibility for signing off of bloods. <i>Due date: 01.06.25</i>	16.04.2024 project plan with key dates developed. Draft short terms process to be reviewed, developed by end of May 2025. Longer term work required with partner organisations to address outreach requirements and provision To be cross referenced against work inc. SACT protocol development
15+ Risks in other domains											

TRUST RISK REGISTER
TRUST BOARD MAY 2025

4	3332 02.09.2024	Velindre Cancer Service	Workforce	Medical Directorate Business Manager	There is a risk to staff wellbeing as a result of consultants having insufficient time to undertake direct patient administration including prescribing and completion of OONs (Outpatient Oncology note) due to increase in patient clinic numbers, leading to increased email traffic and potential treatment delays.	16 (4x4)	12 (4x3)	4 (2x2)		<p>1. Recruitment of x2 SAS doctors and support structure to provide additional clinics. <i>Complete 14.04.2025</i></p> <p>2. Recruitment of Independent prescribers to support wider outpatient workforce model as identified within the pre-SACT assessment and business case. <i>Due date: 01.07.25</i></p>	<p>14.05.2025 The risk has reduced from 16 to 12 due to the successful recruitment of GPs to support outpatient clinics, which will support the capacity shortfall across many clinics.</p> <p>This risk now falls below the reporting threshold to Trust Board with a score of 12 in the Workforce domain.</p> <p>16.04.2025 Interviews scheduled for May 2025. Outcome will determine if the risk can be reduced.</p>
5	3392 16.05.2024	Velindre Cancer Service	Workforce	Head of Therapies	There is a risk to the Dietetic delivery as a result of reduced staffing due to vacancies, leading to a potential impact on patient care.	20 (5x4)	16 (4x4)	6 (3x2)		<p>1. Agreement to actively recruit to key posts. - Band 8a Professional Lead - interviews 21st January 2025 - Band 7 H&N Specialist – appointed - estimated start date 10th February 2025 - Band 7 UGI Specialist - out to advert - Band 6 Specialist - on hold as annex 21 post and need Professional Lead in post to ensure current governance. Will advertise next week to align with recruitment into band 8a post. <i>Complete 13.05.2025</i></p>	<p>13.05.2025 Band 8a Professional Lead now in post Band 7 UGI specialist - start date 19.05.2025 Band 6 specialist appointed and estimated start date 16.06.2025 Band 5 - with scrutiny panel to re-design role.</p> <p>The team currently has 1.6wte locum. Currently 1.4wte down from normal establishment (including Locums) Risk to remain at 16</p> <p>16.04.2025 Peer review report due beginning of May, which will provide guidance on next steps previous post in place for 2 years following agreement with HEIW. Cost pressure being managed within Directorate and now core service.</p> <p>Proposal to increase banding which would support plans for expansion of SDEC and enhanced care. case to be resubmitted with additional details.</p>
6	3541 02.12.2024	Velindre Cancer Service	Multiple Risk Domains (Quality, Safety, Performance and Service Sustainability)	Chief Pharmacy Officer	There is a risk to performance and service sustainability as a result of national TrAMS project being delayed leading to insufficient capacity within pharmacy technical services to meet SACT production.	20 (5x4)	15 (5x3)	10 (5x2)		<p>1. Option appraisal being developed in response to potential delay in TrAMS project resulting technical pharmaceutical services not being available in advance of nVCC. 8th Jan 2025. Draft options appraisal discussed at Jan VCS TrAMS programme board. Next step to discuss with Exec professional leads in process of being arranged.</p> <p>2. Further discussion with VUNHST triumvirate - paper to be updated for EMB <i>Due date: 01.06.25</i></p>	<p>13.05.2025 PowerPoint presentation shared with COO 13 May 2025, outlining steps to be taken to maintain current VCC activity in nVCC aseptic unit given close timelines between TrAMS and nVCC openings. For discussion by exec colleagues.</p> <p>Paper developed seeking agreement to formalise nVCC aseptic unit product portfolio, clarity on this aspect first will help to formulate options for service contingency and better clarity as to impact that TrAMS delay may have on VCS service provision. Submitted for VCS Trans Programme Board, March 3 2025. Extension on this action, pending VCS Trams PB discussion</p> <p>16.04.2025 Executive team to meet with regional TRAMS team Q1 to review options for delivery</p> <p>March 27 2025: VCS TrAMS Project Board currently paused. paper therefore not discussed</p>

TRUST RISK REGISTER
TRUST BOARD MAY 2025

7	2249 27.02.2020	Velindre Cancer Service	Financial Sustainability	Director of Cancer services	There is a risk to financial sustainability as a result of service disruption due to number of posts funded by time limited funding leading to financial instability, recruitment difficulties.	16 (4x4)	16 (4x4)	6 (3x2)		1. At risks posts to be identified as part of IMTP 2025/26 and business cases developed as requested for discussion with commissioners <i>Due date: 01.07.25</i>	16.04.2025 confirmation business cases submitted to commissioners not approved. Further work to now take place to understand roles identified as cost pressures and opportunities for alternative solutions
Welsh Blood Service											
12+ Risks in the Quality and Safety domains											
8	2774 27/10/2024	WBS	Quality/Safety	Director of WBS	There is a risk to quality and safety as a result of extensive manual workarounds due to outdated legacy IT systems, leading to increased risk of incorrect test results and patient harm.	16 (4x4)	12 (4x3)	4 (4x1)		1. Discovery and planning Transformation Workstream: process redesign and system configuration. 2. Data workstream: migration of legacy data 3. Application workstream: build of environments, database and interfaces. <i>Due date: 31.12.25</i>	17/04/2025 Trend/Direction of Travel = no movement. The risk scoring remains unchanged until the replacement system is live to mitigate. No further controls/mitigations can be identified to reduce the risk prior to replacing the system An SBAR, which recommends a 3 month delay to go live (from July to Oct 2025), has been reviewed and supported by the WHAISIT Project Board, Futures Digital Modernisation Programme Board and the Futures Delivery Board and will be next going to SLT for approval. Once approved, a revised timeline will be agreed and updated with the supplier, and a revised project plan will be released. No impact on risk scoring.
15+ Risks in other domains											
9	3306 15/01/2024	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)		1. Review of risk assessment required by 18/08/2025 <i>Due date: 18.08.25</i>	17/04/2025 Identified works completed for WBS electrical resilience (ACB replacement).
10	3388 *New Risk to TRR	WBS	Quality	Director of Welsh Blood Service	There is a risk to Quality and Performance as a result of reporting errors and limited accessibility of reports due to no interfaces between the Fetal D IT System (FEDIS) and NHS Wales Digital Applications, leading to suboptimal antenatal care.	16 (4x4)	16 (4x4)	2 (2x1)		1. Develop and validate interface between FEDIS and eMPI+WRRS when available 28/03/2025 - update by AD of Digital Delivery. Due to delays, issue was escalated to DHCW executives, escalation managed by VUNHST CDO. The issue remains in an 'escalated' state as the work is yet to be completed. DHCW have advised that they have slots provisioned up to July 2025 to complete this work - awaiting scoping documentation from VUNHST to progress. Deadline update to end of July, to reflect anticipated date for completion of this work. <i>Due date: 31.07.25</i>	14/04/2025 Stable/No movement - Application to DHCW being progressed by Digital Services, awaiting commitment for work to be scheduled. Digital cannot sign off FMEA with a target date until DHCW confirm when they can do the work.
Corporate											
15+ Risks in other domains											



TRUST RISK REGISTER
TRUST BOARD MAY 2025

11	2745 *New to TRR	Corporate	Digital	Head of Digital Delivery	There is a risk to quality as a result of a cyber security breach or other equivalent malicious activity, leading to a data protection / IT security incident and/or disruption to critical operational or clinical services.	25 (5x5)	15 (5x3)	10 (5x2)	New risk	<p>1. The linked Risks increase the likelihood that the Trust will succumb to a cyber security breach. Treating these risks will reduce the Trusts attack surface area potentially lowering both impact and likelihood.</p> <ul style="list-style-type: none"> • 3594 – Windows 7 clients • 2458 – Legacy Windows Servers (2008, 2012) • 2451 – lack of client firewalls in VCC • 2450 – lack of server firewalls in VCC • 3385 – Data Centre Backups affecting resiliency <p>The long due date is related to risk 2450. Whilst the Fortinet firewalls have been installed, they are not protecting the whole of VCC, which may not be achievable until we move into the new cancer centre. <i>Due date: 30.04.27</i></p>	23.04.2025 This is an overarching Cyber Security Risk. Other cyber related risks have been subsumed into this risk.
12	3632 *New to TRR Opened 03.04.2025	Corporate	Multiple Risk Domains	Chief Digital Officer	There is a risk to Quality and Performance and Service Stability as a result of National Digital Programmes managed by Digital Health and Care Wales (DHCW) not being delivered to time/cost/quality for use by the Velindre Trust leading to disruption of the clinical model and the plan to transition services to the new Velindre Cancer Centre. The National DHCW programmes of concern for the Trust are RISP/WLIMS/EPMA.	16 (4x4)	16 (4x4)	8 (4x2)	New Risk	<ol style="list-style-type: none"> 1. Increase the reporting of DHCW led programmes into sub committees with more focus on DHCW progress. 2. Review of Exec alignment to DHCW led programmes. Ensuring the Velindre position is escalated to DHCW leadership. 3. Mitigations plans to be in place for individual service areas. We have worked through LIMS with additional work needed for the existing SERIF system and contract arrangements for Fuji. <p><i>Due date: 01.12.2025</i></p>	New risk. Review due 01.05.2025
13	3634 *New to TRR Opened 03.04.2025	Corporate	Multiple Risk Domains	Chief Digital Officer	There is a risk to Quality, Performance and Service Stability, and Workforce domains as a result of demand for work on new digital services exceeding the capacity of the Trust digital team and the Trust's capacity to take on the business changes management leading to priority service initiatives enabled by digital not being delivered successfully, stress and burnout for the digital team and regularly changing priorities.	16 (4x4)	16 (4x4)	6 (3x2)	New Risk	<ol style="list-style-type: none"> 1. Agree the final plans with the service areas - expected to be complete by the end of May 2025. 2. External partner will review the roadmap. 3. Capacity demand plan will be developed to support the roadmap. <p><i>Due date: 29.08.2025</i></p>	New risk. Review due 01.05.2025

TRUST RISK REGISTER
TRUST BOARD MAY 2025

14	3646 *New to TRR Opened on 15.04.2025	Corporate	Performance and Service Sustainability	Chief Digital Officer	There is a risk to Performance and Service Sustainability that the go-live date for the LIMS National Digital Programme will be delayed as a result of: delays in the national programme timeline leading to an impact on realising project outcomes and additional demand for further development of existing legacy systems.	16 (4x4)	16 (4x4)	6 (2x3)	New Risk	<ol style="list-style-type: none"> 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. <i>Due date: 30.06.2025</i>	New risk. Review due 01.05.2025
15	3656 *New to TRR Opened 24.04.2025	Corporate	Performance and Service Sustainability	Director of Corporate Governance	There is a risk to the quality of clinical and corporate governance caused by the current assurance and reporting arrangements of hosted services.	20 (5x4)	16 (4x4)	6 (3x2)	New Risk	<ol style="list-style-type: none"> 1. WG review of current arrangements to be concluded by end of July 2025. 2. Assurance mapping to be reviewed and completed by end of June 2025. 3. Review of clinical licensing to be completed by end of May 2025. 4. Annual accounts and accountability report to be approved by Trust Board by 25 completed by 26 June 2025. 	New risk.
16	3633 *New to TRR Opened 15.04.2025	Digital	Multiple Risk Domains	Chief Digital Officer	There is a risk to Quality and Performance and Service Stability as a result of the lack of capacity of Digital Health and Care Wales to integrate VUNHST digital systems into the National Architecture on a timely basis leading to delays in the Trusts ability to introduce new digital systems to support its strategic objectives. In particular integration for the IRS, WHAIS, FEDIS projects has had to be escalated to the DHCW Executive for resolution.	15 (3x5)	12 (3x4)	6 (3x2)	New Risk	<ol style="list-style-type: none"> 1. Share Intergration Plan with DHCW to be clear about priorities – Complete 2. Weekly escalation meetings with the DHCW Exec Director responsible to monitor assure on progress. 3. Trust to line up third party suppliers (eg. Thermofisher) to provide their Intergration at the right time. <i>Due date: 31.07.2025</i>	New Risk

SECTION 2 - Risks Decreased below Board threshold or closed since last Report to Trust Board on 27.03.2025. This section is for assurance purposes and is not included in the current risk count reported in the paper.

ID & DATE OPENED	DIRECTORATE	RISK DOMAIN	RISK OWNER		INHERENT RATING	CURRENT RATING	TARGET RATING	RATING CHANGE SINCE LAST REPORTING PERIOD	PROGRESS SINCE LAST REPORTING PERIOD
3431 24.07.2024	Medical	Quality	Clinical Director VCS	There is a risk to performance and service sustainability as a result of increased demand which has now outstripped capacity in the skin/melanoma SST.	20 (5x4)	8 (4x2)	4 (2x2)		02.04.2025 Two additional drugs identified by VAPP Service, reducing pressure in pre-sact clinics. Risk reduced from 12 to 8. Current risk score below Trust Board reporting threshold.
3270 23.11.2023	Velindre Cancer Service	Performance and Sustainability	Medical Directorate Business Manager	There is a risk to performance and service sustainability as a result of increased demand for SACT starting to exceed capacity in all clinics leading to the burnout of the medical and supporting workforce due to excessive workloads.	16 (4x4)	16 (4x4)	4 (2x2)	CLOSED	02.04.2025 Risk closed as it is a duplicate of risk 3332 which is currently open with an risk rating of 16. (scores as risk was when closed).
3448 14.08.2024	Velindre Cancer Service	Performance & Sustainability	Head of Therapies	There is a risk that the VCC Cancer Associated Thrombosis (CAT) service will not be able to continue as a result of 2 out of the 3 trained practitioners for VCC (medical and non-medical prescribers) having recently indicated that they may no longer be able to continue in the service. This will lead to a loss of the VCC CAT service which will result in a risk to patient safety and organisational reputation as the sustainability of the service is not secured. Patients diagnosed with CAT will not be able to access specialised services and therefore may be sub optimally treated, to include delays in their cancer treatments and longer term sequelae of VTE.	16 (4x4)	8 (4x2)	4 (1x4)		27.03.2025 Risk reduced due to plan in process of being delivered with formal transfer of service to Pharmacy overseen by medics w/c 14/04/2025, following which action can be closed. Risk reduced from 16 to 8, which falls below the threshold for reporting to Trust Board.

Appendix 2 - Workforce Risks Review Paper	
PREPARED BY	Amanda Jenkins, Acting Assistant Director of Workforce
APPROVED BY	Sarah Morley, Executive Director of Organisational Development & Workforce
EXECUTIVE SUMMARY	<p>This paper provides assurance on oversight mechanisms and holistic management of operational workforce risks. The report highlights how the People and OD Team in collaboration with service leads and the Trust Risk and Assurance Manager ensure operational risks are regularly reviewed to ensure strategic workforce risks identified in the Trust Assurance Framework and aligned and reflect the operational workforce risks.</p> <p>Key messages in the paper identify how the operational risks identified such as outdated systems, increased workload, staff wellbeing, and critical vacancies are reviewed and mitigated through the People and OD workplan aligned to the strategic workforce risks such as enhanced recruitment strategies, retention programmes and workforce development initiatives that all underpin the Trust's workforce planning and long-term People strategy. Additionally, targeted actions have been taken to address specific service-related risks, ensuring continuity of care and sustainable service delivery.</p> <p>The report endeavours to demonstrate the Trust's commitment to robust workforce planning and risk management, ensuring high-quality care services and addressing emerging workforce challenges effectively.</p>

1. SITUATION

Velindre University NHS Trust like many NHS Organisations faces many key workforce risks that need to be effectively managed to ensure the delivery of high-quality services. Operational risks are entered into the Datix system by

service leads and mitigated locally within the services, with advice and support from the People and OD team. Alongside the operational risks the Trust has two key strategic workforce risks related to Workforce Planning and Organisational Culture that are mitigated through a number of key activities and controls.

2. BACKGROUND

The Trust Board has requested this assurance paper to provide a comprehensive overview of how key operational workforce risks are being managed and fully integrated into the strategic workforce risks and supporting actions and controls.

The People and OD Team with support of the Trust Risk and Assurance Manager meet at least monthly to ensure the workforce risks for the Trust are reviewed, appropriately scored and details of mitigations are outlined in the risks. This also ensures that operational risks are embedded within the strategic risks, or where this is not relevant to ensure the service leads are supported to mitigate the risks as needed.

The Trust has identified several workforce risks via the Datix system, including issues related to outdated IT systems impacting staff morale, increased workload, staff wellbeing, and vacancies in critical roles. These risks have undergone comprehensive review by the People and OD Team in collaboration with the Trust's Risk and Assurance Manager, and amendments have been made where necessary to address emerging issues or close down legacy risks.

As well as monitoring operational risks in collaboration with service leads there are regular reviews of the Trust's two strategic risks related to workforce:

TAF03: There is a strategic risk to the Trust's ability to effectively deliver quality services and achieve our medium to long term objectives if we are unable to develop and maintain an optimised workforce supply and shape, in order to effectively deliver quality services and achieve our medium to long term.

TAF04: There is a risk of failure to meet or exceed service expectations without the prevalence of a positive working environment, which is characterised by effective values and behaviours, systems and processes.

3. ASSESSMENT

The information below represents a summary of current operational workforce risks, scores and controls:

1. WBS – Transplantation: Outdated Legacy Systems (ID: 2777)

- **Risk:** Poor staff morale due to the use of outdated IT systems, leading to excessive manual workarounds, inconsistent remote access, and system errors.
 - **Current Controls:** A working group is managing urgent development work to prevent critical failures.
 - **Current Rating:** 12 (Moderate)
 - **Target Rating:** 3 (Moderate)
2. **VCS – Medical Staff: Increased Workload and Waiting Times (ID: 3247)**
- **Risk:** Overbooked clinics and insufficient consultation rooms leading to increased workload and waiting times for patients.
 - **Current Controls:** Clinic reviews, audits of room utilization, and development of a virtual consultation hub.
 - **Current Rating:** 12 (Major)
 - **Target Rating:** 9 (Moderate)
3. **VCS – Medical Staff: Staff Wellbeing (ID: 3332)**
- **Risk:** Insufficient time for consultants to undertake patient administration, leading to increased email traffic, potential treatment delays, and staff burnout.
 - **Current Controls:** SACT Business Continuity Plan and resulting SACT workforce planning review.
 - **Current Rating:** 16 (Major)
 - **Target Rating:** 4 (Minor)
4. **VCS – Therapies: Dietetic Delivery (ID: 3392)**
- **Risk:** Reduced staffing due to vacancies, impacting patient care.
 - **Current Controls:** Temporary working arrangement, proactive recruitment, and temporary closure of drop-in clinics to manage backlogs.
 - **Current Rating:** 16 (Major)
 - **Target Rating:** 6 (Moderate)
5. **Colorectal Service (ID: 3408)**
- **Risk:** Performance issues related to one team member, potentially destabilizing the service.
 - **Current Controls:** Performance management process and temporary cross-cover arrangements.
 - **Current Rating:** 16 (Major)

- **Target Rating:** 2 (Negligible)

6. **Gynae Service (ID: 3410)**

- **Risk:** Overburdened clinics due to an unfilled medical oncology post, leading to high workloads and inability to cross-cover.
- **Current Controls:** Additional sessions by current consultants and ongoing recruitment efforts.
- **Current Rating:** 12 (Moderate)
- **Target Rating:** 4 (Minor)

7. **Sarcoma Service (ID: 3468)**

- **Risk:** Retirement of a single-handed consultant without a robust succession plan, compromising patient care.
- **Current Controls:** Appointment of locum consultants, peer reviews, and international recruitment.
- **Current Rating:** 12 (Major)
- **Target Rating:** 2 (Minor)

8. **Paediatric Service (ID: 3471)**

- **Risk:** Single-handed consultants not allowing for cross-cover, potentially compromising patient care.
- **Current Controls:** Recruitment of additional consultants and support from a senior clinical fellow.
- **Current Rating:** 12 (Major)
- **Target Rating:** 2 (Minor)

9. **Lymphoma Service (ID: 3490)**

- **Risk:** Retirement of a consultant managing the lymphoma service, leading to a single-handed service.
- **Current Controls:** Discussions with senior trainees and recent appointment of a clinical oncologist.
- **Current Rating:** 9 (Moderate)
- **Target Rating:** 2 (Minor)

4. **SUMMARY OF MATTERS FOR CONSIDERATION**

As well as the specific local controls outlined for the relevant risks the following initiatives are ongoing to support wider workforce risk management as outlined in

the strategic risks in the TAF03 and TAF04. Below is an overview of these initiatives detailed in the controls and actions of the Trust assurance framework.

1. Recruitment:

- Implementing targeted recruitment campaigns to attract qualified candidates for hard-to-fill positions.
- Proactive recruitment into vacant posts and the development of a Trust recruitment campaign.

2. Staff Inclusion and Engagement:

- Development of an engagement action plan to improve employee voice mechanisms and encourage a culture of speaking up.
- Embedding the principles of the Social Partnership Duty into the Trust's strategic development.
- Implementation of the Compassionate Leadership Pledge and action plan.
- Implementation of the Trust Strategic Equality Plan, including embedding the Anti-Racist Wales Action Plan.

3. Retention:

- Developing retention programs that focus on career development, employee well-being, and competitive compensation packages.

4. Learning and Development:

- Investing in training and development programs to upskill existing staff and prepare them for future roles.
- Establishing workstreams to review demand and capacity, and amending clinic start/end times to optimise workforce utilisation.

5. Strategic Workforce Planning:

- Continuously refining workforce planning processes to anticipate future service demands and staffing needs.

6. System Improvements:

- Implementing new staff bank to support temporarily fill critical vacancies and ensure continuity of care, while maintaining lowering of high-cost agency spend.

7. Operational Risk-Specific Actions:

- For risks related to specific services (e.g. dietetics & sarcoma), targeted actions have been identified to support services.

Velindre University NHS Trust has comprehensive measures to address both operational and strategic workforce risks, ensuring the delivery of high-quality care services. The People and OD Team, in collaboration with the Trust's Risk Assurance Manager, regularly reviews these risks to implement effective mitigation strategies.

Operational risks have been managed through targeted actions and more specific initiatives to address immediate challenges where as strategically, the Trust has developed robust controls and actions to address TAF03 and TAF04.

Overall, the Trust's proactive approach to workforce risk management, supported by regular monitoring and stakeholder engagement, provides assurance that key operational and strategic risks are being effectively overseen and mitigated. This ensures sustainable service delivery and the wellbeing of staff, ultimately contributing to the Trust's strategic goals.



TRUST BOARD	
TRUST ASSURANCE FRAMEWORK UPDATE	
DATE OF MEETING	22 May 2025
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	This paper provides the Quality, Safety and Performance Committee with the latest updates to the Trust Assurance Framework.
RECOMMENDATION / ACTIONS	The Trust Board is asked to NOTE the current status of the Trust Assurance Framework.
COMMITTEE / GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING	
COMMITTEE OR GROUP	DATE
Executive Management Board	29.04.2025
Quality, Safety and Performance Committee	08.05.2025
Strategic Development Committee	12.05.2025
Audit Committee	13.05.2025
<p>The discussions at the Executive Management Board are incorporated into this report.</p> <p>Discussion at the Strategic Development Committee included the new template requirements, the need for a simplified TAF whilst ensuring the detail is available for Board review and consideration.</p>	

The Trust's Quality, Safety and Performance and Audit Committees noted that TAF07 is a good example showing mitigations of risks and demonstrating a trend graph of the decreasing risk level.	
ASSURANCE RATING ASSESSED BY EXECUTIVE SPONSOR	2 – Comprehensive actions have been identified and addressed. The cause of the performance issue has been identified and is being actively managed.
APPENDICES	
1	Trust Assurance Framework

1. SITUATION

1.2 Trust Assurance Framework

The Trust Assurance Framework (TAF) was established in 2020 and the refreshed framework, detailing eight strategic risks, was approved by Trust Board in March 2024.

2. ASSESSMENT

2.1 The table below has been developed to record movement within the TAF since the it was presented to Trust Board in March 2025.

2.2 During the current reporting period, strategic lead summaries for each TAF have been updated and are available in the table below

2.3 Work has started to transfer assurance ratings from the historic method used of partial assurance, inconclusive assurance, negative assurance and not assessed to the Seven Levels of Assurance.

Number	Risk Title	Movement since last reporting period
--------	------------	--------------------------------------

TAF 01	There is a strategic risk of failure to deliver timely, safe, effective and efficient services for the local population leading to deterioration in service quality, performance or financial control as a result insufficient capacity and resources.	<p>Actions:</p> <ul style="list-style-type: none"> • 01.01 – The action has been reviewed but there is no progress to update. • 01.02 - The action has been reviewed but there is no progress to update. • 01.03 – The action has been reviewed but there is no progress to update. • 01.04 – The OPD LEAN / SI already underway is now dovetailing with the data from the Cancer PTL, to help refine business processes and address the patient & pathway 'Pain Points' • 01.05 – The completion date for this action has been moved to the summer of 2025, due tin Insightive delays.
<p>Strategic Lead Summary: WBS position is stable. VCS has been under additional pressure due to the increase in SACT referrals and the downtime in radiotherapy, resulting in loss of capacity.</p>		
TAF 02	There is a strategic risk of failure to align our strategic objectives and intent with system partners, including within the health and social care system, third sector and industry partners which could result in an inability to deliver required change to achieve our medium to long term objectives.	<p>Actions:</p> <ul style="list-style-type: none"> • 02.01 - Progress against PMF packages of work are tracked in Quality, Safety and Performance Committee and Trust Board. Action completed and on-going development as part of PMF development. • 02.03 - First Regional Cancer Programme Board held in September 2024. Initial programme of work agreed in November 2024, alongside review of collective cancer strategies and existing programmes of work. This was reported to Trust Board in Strategic Planning update in November 2024. Work progressing to next meeting in February 2025.
<p>Strategic Lead Summary: Key actions to improve strategic partnership and system working continue to be delivered strongly, particularly since December 2024. This is being taken into account</p>		

in the review of strategic risk being considered as part of the 2025-2028 Integrated Medium Term Plan.

TAF 03	<p>There is a strategic risk of an optimised workforce supply and shape in order to effectively deliver quality services and achieve our medium to long term objectives.</p>	<p>Actions:</p> <ul style="list-style-type: none"> • 03.06 - Appointment of AD Workforce Planning 1st May will provide a sharper focus and organisational direction on Workforce Planning to deliver the Supply and Shape workstream of the People Strategy • Workforce plans are in train throughout the Trust and progress noted via the Supply and Shape paper, most recent update to QSP 8th May • A specific paper on Workforce Planning progress will be brought to EMB and committees in the Summer • 03.07 – The assurance level for this action was rated at 3. The impact change of the completion of the action was detailed as, development of the Nurse retention plan supports a move to reduce the Trust's overall workforce planning risk by ensuring a stable and experienced nursing workforce. This leads to improved patient care, reduced recruitment and training costs, and enhanced staff morale. By retaining skilled nurses, the Trust can better manage staffing levels, mitigate the impact of turnover, and maintain continuity of care, ultimately fostering a more resilient and efficient healthcare environment. • 03.08 – the action was updated; Additional resource included in the new investment requests under IMTP. No confirmation received as of yet. This will progress once confirmed by finance. • 03.09 – The action was updated; Completed. HIEW supporting training for People and OD team over the coming 12 months.
---------------	--	--

		<ul style="list-style-type: none"> • 03.11 – The action was updated as follows, completed development plan by March 2025 as agreed. Move implementation phase with completion and final produce to be delivered by September 2025. Additional Resource included in the new investment requests under IMTP to make attraction and retention resource perm. within the People Team. • 03.12 – The action was assessed as assurance level 4.
--	--	---

Strategic Lead Summary:

There are many factors that impact on the current supply and shape of our workforce. These are external and internal to the organisation. We are currently mitigating the risk in this area through our work programme as described below. Our focussed areas of work are in recruitment, retention and operational workforce planning. In addition, we are attempting to maximise the capacity of the workforce through reduction in absence levels - wellbeing interventions and a focus on using workforce policies in a way that minimises harm to staff and teams.

TAF 04	<p>There is a risk of failure to meet or exceed service expectations without the prevalence of a positive working environment, which is characterised by effective values and behaviours, systems and processes.</p>	<p>Actions:</p> <ul style="list-style-type: none"> • 04.05 - Engagement action plan developed and delivered during Q4 2024-25. New resources in place for staff supported by regular communications aimed to encourage a culture of speaking up. • 04.07 – Meeting with LF to plan how this is embedding into the Strategic Development Committee.
---------------	--	---

Strategic Lead Summary:

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

will be a particular focus in 25/26 on the organisational development plan to support the transition to nVCC.

TAF 05	<p>There is a strategic risk that the Trust fails to sufficiently consider, optimise the opportunities and effectively manage the risks of new and existing technologies, including considerations of Artificial Intelligence and Information Security</p>	<p>Risks:</p> <ul style="list-style-type: none"> • Three new risks have been added to TAF 05, 3632, 3634 and 3646. <p>Actions:</p> <ul style="list-style-type: none"> • 05.01 – The assurance level for this action has been assessed as level 2. • 05.02 – The assurance level for this action has been assessed as level 3. • 05.04 – Initial review undertaken and updates will be collated for May 25 TAF
---------------	--	--

Strategic Lead Summary:

Apr '25 Work is ongoing on the key controls - no movement to overall current risk scoring. Assurance ratings moved to 7 levels of assurance. New risks have been added to reflect the operational Digital risk - including challenges with delivering the National Programmes for RISP and LIMS. The delivery of National Programmes through DHCW has been moved into escalation level 3.

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

TAF 06	<p>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.</p>	<p>Actions:</p> <p>Three new actions have been added to TAF06:</p> <ul style="list-style-type: none"> • 06.09 – Develop new TAF template and content aligned with new IMTP. • New risk on hosted unit governance arrangements.
---------------	--	--

Strategic Lead Summary:

A risk on the reporting arrangements for hosted units has been raised during the reporting period. Work is underway to review the current arrangements. Work is also underway to review the Trust's Committee structure and governance arrangements.

Work on the Governance, Assurance and Risk programme continues with a keen focus on reviewing the Risk Policy and updating the TAF in line with the Trust approved IMTP.

Further detailed work on SMART actions will continue in advance of the new TAF reporting into Trust Board for the July cycle.

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

TAF 07	<p>There is a strategic risk that Velindre Cancer Service patient outcomes / experience may be adversely affected due to increasing service demands, the need for significant service delivery transformation to meet the rapidly changing and complex treatment regimes, staffing challenges, and lack of consistent quality, outcome and mortality metrics.</p>	<p>Actions:</p> <ul style="list-style-type: none"> • 07.05 - DHCW have confirmed a review of a single electronic patient referral system into the Cancer Service is on their roadmap - need to confirm which quarter. Health Boards are supportive • 07.06 - Work underway and dovetailing with the Cancer PTL in respect of an overall review of booking systems (including SACT) to be undertaken and revised processes implemented. • 07.16 - Cancer PTL live and first phase work underway with Health Boards to implement a cancer PTL to track and bring together information from all clinical information systems to ensure visibility across the entire patient pathway to ensure efficient management of care pathways.
---------------	---	--

Strategic Lead Summary:

Following closing several key actions and their inclusion as controls, the overall risk score for TAF 7 has been reduced. Further assurances have been embedded into the TAF through external sources.

TAF 08	<p>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.</p>	<p>Actions:</p> <ul style="list-style-type: none"> • 08.01 – PROMs digital platform implementation is progressing. There is a revised date of June 2025 for completion, due to delays in commencing project. • All other actions have been reviewed in this cycle.
---------------	--	---

<p>Strategic Lead Summary:</p> <p>There are a range of factors that impact of 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.</p> <p>Operational Summary</p>		

All changes within the TAF since March have been marked in red in Appendix 1.

2.4 Work is underway to deliver the new Trust Assurance Framework which will be subject to Executive Management Board scrutiny in May prior to reporting into the Trust Board July cycle.

4 IMPACT ASSESSMENT

RELATED TRUST STRATEGIC GOAL(S)	<p>Please indicate whether or not any of the matters outlined in this report impact the Trust's strategic goals.</p> <p>Please indicate here</p>
<p>Please tick all relevant goals:</p> <ul style="list-style-type: none"> . Outstanding for quality, safety and experience <input checked="" type="checkbox"/> . An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations <input type="checkbox"/> . A beacon for research, development and innovation in our stated areas of priority <input type="checkbox"/> . An established 'University' Trust which provides highly valued knowledge for learning for all. <input type="checkbox"/> . A sustainable organisation that plays its part in creating a better future for people across the globe <input type="checkbox"/> 	
RELATED STRATEGIC TRUST ASSURANCE FRAMEWORK RISK	06 - QUALITY & SAFETY

QUALITY AND SAFETY IMPLICATIONS / IMPACT	Safe <input checked="" type="checkbox"/> Timely <input checked="" type="checkbox"/> Effective <input checked="" type="checkbox"/> Equitable <input checked="" type="checkbox"/> Efficient <input checked="" type="checkbox"/> Patient Cantered <input checked="" type="checkbox"/>
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED	Not required.
TRUST WELL-BEING GOAL IMPLICATIONS/IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT	There is no direct equality impact in respect of this paper, however each risk will have an impact assessment where appropriate.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report

3 RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes
WHAT IS THE RISK?	The strategic Risks outlined in the TAF are informed by the Trust's active management and reporting of its operational risks.
WHAT IS THE CURRENT RISK SCORE	n/a
BY WHEN?	Ongoing



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
All risks must be evidenced and consistent with those recorded in Datix	

Appendix 1 – Trust Strategic Risks

01	There is a strategic risk of failure to deliver timely, safe, effective and efficient services for the local population leading to deterioration in service quality, performance or financial control as a result insufficient capacity and resources.
02	There is a strategic risk of failure to align our strategic objectives and intent with system partners, including within the health and social care system, third sector and industry partners which could result in an inability to deliver required change to achieve our medium to long term objectives.
03	There is a strategic risk of an optimised workforce supply and shape in order to effectively deliver quality services and achieve our medium to long term objectives.
04	There is a risk of failure to meet or exceed service expectations without the prevalence of a positive working environment, which is characterised by effective values and behaviours, systems and processes
05	There is a strategic risk that the Trust fails to sufficiently consider, optimise the opportunities and effectively manage the risks of new and existing technologies, including considerations of Artificial Intelligence and Information Security
06	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.
07	There is a strategic risk that Velindre Cancer Service patient outcomes / experience may be adversely affected due increasing service demands, the need for significant service delivery transformation to meet the rapidly changing and complex treatment regimes, staffing challenges, and lack of consistent quality, outcome and mortality metrics.
08	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.

RISK DESCRIPTORS			
RISK NUMBER	RISK THEME/TITLE	DRAFT RISK DESCRIPTION	RISK OWNER
01	Service Capacity	There is a strategic risk of failure to deliver timely, safe, effective and efficient services for the local population leading to deterioration in service quality, performance or financial control as a result insufficient capacity and resources.	Anne Carey Rachel Hennessey Alan Prosser
02	Partnership Alignment	There is a strategic risk of failure to align our strategic objectives and intent with system partners, including within the health and social care system, third sector and industry partners which could result in an inability to deliver required change to achieve our medium to long term objectives.	Lauren Fear Nicola Williams Jacinta Abraham
03	Workforce Supply and Shape	There is a strategic risk of an optimised workforce supply and shape in order to effectively deliver quality services and achieve our medium to long term objectives.	Sarah Morley
04	Organisational Culture	There is a strategic risk of failure to have a positive working environment and high levels of staff engagement through the embedding of appropriate values and behaviours in effective systems and processes.	Sarah Morley

05	Digital Transformation	There is a strategic risk that the Trust fails to sufficiently consider, optimise the opportunities and effectively manage the risks of new and existing technologies, including considerations of Artificial Intelligence and Information Security	Carl James
06	Organisational and Clinical Governance	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.	Non Gwilym
07	Patient Outcomes	There is a strategic risk that Velindre Cancer Service patient outcomes / experience may be adversely affected due increasing service demands, the need for significant service delivery transformation to meet the rapidly changing and complex treatment regimes, staffing challenges, and lack of consistent quality, outcome and mortality metrics.	Nicola Williams Jacinta Abraham Anne Carey
08	Financial Sustainability	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.	Matt Bunce

DEFINITIONS

CONTROL EFFECTIVENESS

Effective		E
Partially Effective	Some aspects of control to be implemented/ embedded; some aspects therefore not yet operating as designed; and may be gaps in associated sources of assurance	PE
Not yet Effective	Significant aspects of control be implemented/ embedded; significant aspects therefore not yet operating as designed; and gaps in associated sources of assurance	NE

ASSURANCE RATING		
Positive assurance	the assuring committee is satisfied that there is reliable evidence of the appropriateness of the current risk treatment strategy in addressing the threat or opportunity	PA
Inconclusive assurance	the assuring committee has not received sufficient evidence to be able to make a judgement as to the appropriateness of the current risk treatment strategy	IA
Negative assurance	the assuring committee has received reliable evidence that the current risk treatment strategy is not appropriate to the nature and / or scale of the threat or opportunity	NA
Not Assessed	Assessment of the assurance arrangements is pending.	Not Assessed

LEVELS OF ASSURANCE DESCRIPTORS

First Line of Defence functions that own and manage risk	Second Line of Defence functions that oversee or specialise in risk management	Third Line of Defence functions that provide independent assurance
--	--	--

Self-Assurance	Internal oversight/specialist control teams, such as:	Internal Audit (provides assurance to the Board and senior management. This assurance covers how effectively the organisation assesses and manages its risks and will include assurance on the effectiveness of the first and second lines of defence); and external oversight , such as:
<p>Risk and control management as part of day-to-day business management</p> <p>Staff training and compliance with policy guidance</p> <p>Teams take responsibility for their own risk identification and mitigation</p>	<p>Quality & Safety</p> <p>IT</p> <p>Governance (corporate/Clinical)</p>	<p>External Audit</p> <p>Regulators & Commissioners</p> <p>Wales Audit Office reviews</p> <p>Stakeholder reviews</p> <p>Scrutiny from public, Parliament, and the media</p>
Examples of assurance	Examples of assurance	Examples of assurance
<p>Management Controls / Internal Control Measures</p> <p>Local management information / departmental management reporting</p> <p>Divisional / Departmental performance reviews, mandates, outcomes frameworks, objectives (Clinical and Nonclinical services)</p> <p>Operational planning / Business Plans - Delivery Plans and Action Plans</p> <p>Governance statements / self-certification</p> <p>Local procedures</p> <p>Exceptions reporting</p> <p>Targets, Standards and KPIs</p> <p>Incident Reporting</p> <p>Staff Training Programmes</p>	<p>Board, Committee and Management Structures which receive evidence from</p> <p>Finance reports</p> <p>KPI's and management information</p> <p>Quality, Safety and Risk reports</p> <p>Training records and statistics</p> <p>Performance reports</p> <p>BAF, VUNHS risk register</p> <p>Policies and Procedures including Risk Management Policy</p> <p>Compliance against Policies</p>	<p>Recent internal audit reviews and levels of assurance</p> <p>External Audit coverage</p> <p>Inspection reports / external assessment e.g. HIW / NHS Wales other regulator and Commissioner compliance reviews</p> <p>Patient Feedback / Patient experience feedback</p> <p>Staff surveys / feedback</p> <p>Comparative data, statistics, benchmarking</p>

STRATEGIC GOALS
1 - Outstanding for quality, safety and experience
2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations

KEY CONTROLS		
CONTROL TYPE	DESCRIPTION	EXAMPLES
Preventative	These controls are designed to limit the possibility of an undesirable outcome being realised. The more important it is to stop an undesirable outcome then the more important it is to implement appropriate	<ul style="list-style-type: none"> • Authorisation limits of and separation of duties • Pre-employment screening of potential staff

3 - A beacon for research, development and innovation in our stated areas of priority
4 - An established 'University' Trust which provides highly valued knowledge and learning for all
5 - A sustainable organisation that plays its part in creating a better future for people across the globe

RISK DESCRIPTORS	
Inherent Risk	Score the exposure before any action has been taken to manage it or if existing controls failed entirely
Residual risk	The threat that remains after all existing controls have been applied
Target risk	Where risks are outside acceptable levels, a target risk score is agreed. This is the level that future mitigation that should be achieved which will vary over time

	implement appropriate preventative controls.	
Mitigating	These controls are designed to limit the scope for loss and reduce any undesirable outcomes that have been realised. They may also provide a route of recourse to achieve some recovery against loss or damage.	<ul style="list-style-type: none"> • Passwords or other access controls • Staff rotation and regular change of supervisors • Exposure reduction by installation on hours worked
Detective	Control is designed to locate problems after they have occurred. Once problems have been detected, management can take steps to mitigate the risk that they will occur again in the future, usually by altering the underlying process.	<ul style="list-style-type: none"> • Periodic performance reporting • Regular review

RISK SCORE

LIKELIHOOD MATRIX					
LIKELIHOOD (*)	1	2	3	4	5
LIKELIHOOD SCORE					
DESCRIPTOR	RARE	UNLIKELY	POSSIBLE	PROBABLE	EXPECTED
Frequency: How often might it/does it happen	Not expected to occur for 10 years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Probability: Will it happen or not?	Less than 0.1% chance	01.-1% chance	1-10% chance	10-50% chance	Greater than 50% chance

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

IMPACT MATRIX

RISK DOMAINS		Impact, consequence score (severity levels) and examples.				
		1	2	3	4	5
		NEGLIGIBLE	MINOR	MODERATE	MAJOR	CATASTROPHIC
01	Compliance <i>Statutory duty/ inspections</i>	No or minimal impact or breach of guidance/statutory duty	Minor breach of guidance/statutory duty Reduced performance rating if unresolved Verbal reports from Regulator	One breach guidance/statutory duty Challenging recommendations Observation reports from regulator	Multiple breaches in statutory duty Enforcement action Improvement notices	Multiple breaches in statutory duty Prosecution Severely critical report
02	Environmental <i>Environmental impact</i>	No or minimal impact on the environment	Minor impact on environment	Moderate impact on environment	Major impact on environment	Catastrophic impact on environment
03	Financial Sustainability <i>Including claims</i>	Insignificant cost increase Small loss risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim(s) less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Loss of 0.5-1.0 percent of budget Claim(s) between £100,000 and £1million	Loss of >1 per cent of budget Claim(s) >£1million
04	Information Governance <i>General Data Protection Regulation (GDPR)</i>	Minimal privacy impact requiring no or minimal intervention	Minor impact on an individual's privacy	Moderate privacy impact requiring professional intervention Possible ICO reportable breach Could result in an event which impacts on a moderate (less than 100) number of patients/donors	Major breach leading to possible larger scale privacy breaches Likely ICO reportable breach if IG standard not adhered to Could result in an event which impacts on a major (between 100 and 1000) number of patients/donors	Serious breaches and non-compliance Definite ICO report required if breach occurs Could result in an event which impacts on a major (more than 1000) number of patients/donors
05	Partnerships <i>Relationships with internal and external stakeholders and in working with system partners</i>	No or minimal issues in establishing and maintaining effective relationships with internal and external stakeholders No or minimal misalignment of operational actions or strategic approach with system partners Minimal issues with collaborative working initiatives within our cancer and blood and transplant systems	Minor issues in establishing and maintaining effective relationships with internal and external stakeholders Minor misalignment of operational actions or strategic approach with system partners Minor issues with collaborative working initiatives within our cancer and blood and transplant systems	Moderate issues in establishing and maintaining effective relationships with internal and external stakeholders Moderate misalignment of operational actions or strategic approach with system partners Moderate issues with collaborative working initiatives within our cancer and blood and transplant systems	Major issues in establishing and maintaining effective relationships with internal and external stakeholders Major misalignment of operational actions or strategic approach with system partners Major issues with collaborative working initiatives within our cancer and blood and transplant systems	Failure to establish and maintain effective relationships with internal and external stakeholders Severe misalignment of operational actions or strategic approach with system partners Severe issues with collaborative working initiatives within our cancer and blood and transplant systems

RISK DOMAINS		Impact, consequence score (severity levels) and examples.				
		1	2	3	4	5
		NEGLIGIBLE	MINOR	MODERATE	MAJOR	CATASTROPHIC
06	Performance and Service Sustainability <i>Business objectives/projects Service/business interruption</i>	Failure to achieve minor objective No or minimal service issue Programme/ projects Insignificant cost increase Less than 5 per cent schedule slippage against timescales	Failure to achieve significant/key objective. Minor impact on service. Programme/ projects 1-10 per cent over project budget. 5-10 per cent schedule slippage against timescales	Failure to achieve multiple significant/ key objectives. Moderate impact on service. Programme/ projects 10-25 per cent over project budget. 10-40 per cent schedule slippage against timescales	Failure to achieve crucial objectives. Major impact on service. Programme/ projects 25-50 per cent over project budget. 40-100 per cent schedule slippage against timescales	Gross failure to achieve multiple crucial objectives Service failure Programme/ projects >50 per cent over project budget More than 100 per cent schedule slippage against timescales
07	Quality <i>Quality/complaints/ audit / GxP</i>	Peripheral element of treatment or service suboptimal Informal complaint/enquiry Temporary insignificant impact upon process or performance with no impact on quality or safety of components produced. Donor/patient/staff discomfort	Overall treatment or service suboptimal Formal complaint (stage 1) Local Resolution Single failure to meet internal standards Temporary minor decline in existing performance or process, no impact on quality or safety of components produced. Donor/patient/staff discomfort, minor interventions required e.g., reassurance.	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Multiple failures to meet internal standards Temporary moderate erosion of existing performance or process, with the potential for impact on quality or safety of components produced.	Non-compliance with national standards with significant risk to patients or donors if unresolved Multiple complaints/ independent review Multiple failures to meet national standards Sustained erosion of existing performance or process, tis has an effect on quality or safety of components produced. Donor/ /staff admission to hospital required, or increased stay in hospital >3days.	Non-compliance with national standards with severe risk to patients or donors if unresolved Inquest/ombudsman inquiry Gross failure to meet national standards Significant uncontrolled erosion of performance or process which has a serious effect on the quality and safety of components produced. Fatal, life threatening, disabling, prolonged hospitalisation, incapacitating the donor or patient if transfused. (SABRE)

08	Reputational Adverse publicity/ reputation	Potential for public concern	Local media coverage Minor reduction in public confidence	Local media coverage Moderate reduction in public confidence	National media Coverage with <3 days service well below reasonable public expectation Major reduction in public confidence	National media Coverage with >3 days service well below reasonable public expectation Gross loss of public confidence
09	Research and Development	Departure from: Established good practice guidelines, and/or Procedural requirements	Departure from: Applicable legislative requirements, and/or Established Good Clinical Practice (GCP) guidelines, and/or	Deficiencies found during regulatory MHRA Good Clinical Practice inspections graded as "major" and/or "other" that leads to recommendations of:	Deficiencies found during regulatory MHRA Good Clinical Practice inspections graded as "critical" and/or "major" that leads to recommendations of:	Deficiencies found during regulatory MHRA Good Clinical Practice inspections graded as "critical" that leads to recommendations of: Communication of the critical findings to external parties, for

RISK DOMAINS		Impact, consequence score (severity levels) and examples.				
		1	2	3	4	5
		NEGLECTIBLE	MINOR	MODERATE	MAJOR	CATASTROPHIC
	has occurred in a Research Study that is not a Clinical Trial of an Investigational Medicinal Product.	Procedural requirements, and/or Good Clinical Practice (GCP) has occurred in a Clinical Trial of an Investigational Medicinal Product (CTIMP) but it is neither "critical" nor "major".	Request for provision of corrective action & preventive action plan (CAPA) updates at periodic intervals	Early re-inspection to determine adequate progress is observed in implementing a corrective action & preventive action (CAPA) plan Request for provision of corrective action & preventive action (CAPA) plan updates at periodic intervals For actions in relation to pending or future clinical trials (for example, suspension or revocation)	example, other competent authorities, other government departments or UK NHS Research Ethics Committees Meetings with senior representatives from the inspected organisations to review the implications of the critical findings, the organisation's proposed actions and the actions Infringement Notice Referral to the MHRA Enforcement Group for investigation with a view to criminal prosecution	
10	Safety Impact on safety of patients, staff or public (physical or psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a number of patients or donors	Major injury leading to long-term incapacity /disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days RIDDOR/agency reportable incident Mismanagement of patient or donor care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects RIDDOR/agency reportable incident An event which has an effect on a large number of patients or donors
11	Workforce and OD Human resources/ organisational development/ staffing/ competence	Short term low staffing level that temporarily reduces service quality (<1day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff. Very low staff morale Very poor staff attendance mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff Very poor staff attending mandatory training /key training on an ongoing basis


DETAILED DEFINITIONS OF 7 LEVELS OF EVALUATION TO DETERMINE RAG RATING / OPERATIONAL

SUMMARY STATEMENTS OF 7 LEVELS

RAG rating	ACTIONS	OUTCOMES	RAG rating	SUMMARY
Level 7	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes over a defined period of time i.e., 3 months.	7	Improvements sustained over time - BAU

Level 6	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement also of desired outcomes.			6	Outcomes realised in full
Level 5	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with little or no evidence of the achievement of desired outcomes.			5	Majority of actions implemented; outcomes not realised as intended
Level 4	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of several agreed actions being delivered, with little or no evidence of the achievement of desired outcomes.			4	Increased extent of impact from actions
Level 3	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Some measurable impact evident from actions initially taken AND an emerging clarity of outcomes sought to determine sustainability, with agreed measures to evidence improvement.			3	Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes
Level 2	Comprehensive actions identified and agreed upon to address specific performance concerns.	Some measurable impact evident from actions initially taken.			2	Symptomatic issues being addressed
Level 1	Initial actions agreed upon, these focused upon directly addressing specific performance concerns.	Outcomes sought being defined. No improvements yet evident.			1	Actions for symptomatic issues, no defined outcomes
Level 0	Emerging actions not yet agreed with all relevant parties.	No improvements evident.			0	Enthusiasm, no robust plan

SECTION 1

RISK ID	01	CURRENT RISK SCORE TREND		CURRENT SUMMARY OF TAF 01	<p>WBS position is stable VCS has been under additional pressure due to the increase in SACT referrals and the downtime in radiotherapy, resulting in loss of capacity.</p> <p>Risk score trend: The risk score has remained static since the last period.</p>
RISK LEADS:	Anne Carey Rachel Hennessey Alan Prosser	RISK TITLE:	There is a strategic risk of failure to deliver timely, safe, effective and efficient services for the local population leading to deterioration in service quality, performance or financial control as a result insufficient capacity and resources.		
RISK THEME:	Service Capacity	STRATEGIC GOAL:	1 - Outstanding for quality, safety and experience		

RISK SCORE (see definitions tab)

INHERENT RISK	LIKELIHOOD	IMPACT	TOTAL	16	CURRENT RISK	LIKELIHOOD	IMPACT	TOTAL	12	TARGET RISK	LIKELIHOOD	IMPACT	TOTAL	8
	4	4				3	4				2	4		

SECTION 3

Overall Level of Effectiveness:			RATING	PE	Overall Trend in Assurance								
KEY CONTROLS							SOURCES OF ASSURANCE						
ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating	
	Trust Risk Register associated risk on Datix. (see section 4)			X									
C1	Blood stock planning and management function between WBS and Health Boards. This includes active engagement with Health Boards in Service Planning including the established annual Service Level agreement,. The overall annual collection plan based on this demand and the active delivery of blood stocks management through the Blood Health Plan for NHS Wales and monthly laboratory manager meetings.	Director WBS	X			E	Annual Service Level Agreement meetings with Health Boards to review supply and demand. Benchmarking against National and International standards. Blood Health Team review of Health Board supply and prudent use of blood annually. Integrated Medium Term Plan (IMTP) review of previous 3 year demand trend to build resilience to inform and predict any surge demand.	Not Assessed	Senior Leadership Team, COO and EMB Review, QSP committee and Board.	Not Assessed	Welsh Government Quality, Planning and Delivery Review.	Not Assessed	
C2	Operational Blood stock planning and management function in WBS. Delivered through annual, monthly and daily resilience planning meetings. Underpinned by the UK Forum Mutual Aid arrangements. Regular meetings with UK Blood Services on position of Blood Supply.	Director WBS	X			E	System pressures can be flagged at an early stage and appropriate action taken through Department Head review with escalation to Senior Leadership Team and Director.	PA	Performance Report to Senior Leadership Team and EMB Review, QSP committee and Board. National Red Cell and Platelet shortage plans	PA	Welsh Government Quality, Planning and Delivery Review Internal Audit, Wales Audit Office, regulator audits.	PA	

C3	Continuity of core service delivery functions supporting Transfusion, Transplantation and Welsh Bone Marrow Donor Registry (WBMDR).	Director WBS	X			E	Business Impact Assessments across service functions identifying Maximum Tolerable Period of Disruption. Contingency equipment, Managed service contracts for critical suppliers, Planned Preventative Maintenance, Additional inventory for contingency of critical supply items. Business Continuity Plans for response. On call provision for Senior Leadership Team and core service functions.	PA	Escalation through VUNHST Business Continuity command structure if system pressures not resolved, invoke Service Level Agreements if appropriate or Technical Agreement with other UK Services.	PA	Invoke UK Blood Services Memorandum of Understanding (MoU) Escalation to Welsh Government Emergency Preparedness, Resilience and Response (EPRR) for Health, Local Resilience Forum - Strategic Coordinating Group. Internal Audit, Wales Audit Office, regulator audits.	PA
C4	Delivery of business as usual core services and capacity to support strategic programmes of work.	Director WBS, VCS	X			E	Implementation group for programmes mapping the interdependencies and pressures. Regular touch point meetings with Senior Leadership Team to review capacity to deliver key programmes of work.	PA	Highlight and performance reports to Senior Leadership Team and EMB to review.	PA	QSP committee and Board and external stakeholders if required. Regulatory Inspections such as Medicines and Healthcare products Regulatory Agency and Human Tissue Authority Internal Audit, Wales Audit Office, regulator audits.	PA
C5	National Policy decisions/ Directives that are introduced including Regulatory requirements, to ensure the safety of services. (Advancements in medicines to improve patient safety).	Director WBS, VCS	X			E	Horizon scanning and representation at key forums including UK Forum, Joint Professional Advisory Committee (JPAC) for UK blood services, The UK advisory committee on the Safety of Blood, Tissues and Organs (SaBTO). Regular liaison with Blood Policy and Tissue, Cells and Organs Policy team in Welsh Government. NICE Guidelines re Cancer drugs	Not Assessed	Trust wide clinical and scientific board. Senior Leadership Team and EMB Review.	Not Assessed	QSP, SDC	Not Assessed
C6	SEW- VUNHST cancer demand modelling programme with HBs and WGDU in place, continues to provide high level assurance on demand projections.	Director VCS	X	X		PE	SE Wales Group	Not Assessed	Performance Report - SLT, EMB, QSP and Board	Not Assessed	Welsh Government Quality, Planning and Delivery Review	Not Assessed
C7	Demand and Capacity Planning to identify gaps within service delivery models	Director VCS	X	X		PE	Service area operational planning meeting	Not Assessed	Performance Report - SLT, EMB, QSP and Board	Not Assessed	Welsh Government Quality, Planning and Delivery Review	Not Assessed

GAPS IN CONTROLS						GAPS IN ASSURANCE				ASSOCIATED ACTION REFERENCE/		
Lack of real time data on fating of blood to allow business intelligence data set that links Health Board and activity changes to demand and patient outcomes. Addressing this gap would require digital systems to be in place which are out of WBS control. Projects are progressing externally as part of Infected Blood Inquiry recommendations.										A1.1		
The demand management for blood still varies across Health Boards and within clinical teams. The Blood Health National Oversight Group work programme continues to address inappropriate use of blood, which impacts demand.										A1.1		

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	CURRENT RISK	RISK TREND
2465	There is a risk to patient safety, caused by the duplication of information, excessive use of email and a lack of alternative communication methods for the processing of clinical information	12	Stable
3562	There is a risk to patient safety as a result of uncertainty around process and ownership of reviewing and actioning blood tests results which may lead to an omission or delay in undertaking a remedial clinical intervention	15	Stable

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Due Date	Assurance Rating 1-7	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
------------	-------------	-------	----------	----------------------	-----------------	----------------	---------------------------	---

01.01	The Infected Blood Inquiry (IBI) report was published in May 2024. Recommendation 7 (in part) outlines the need to improve patient outcomes post transfusion. Mapping work is ongoing with DHCW to understand how best to record the fating of blood products at the patient bedside, and will consider the opportunity of including this with the implementation of the Laboratory Information Management System (LIMS) 2.0. This will be reported into the Welsh Government IBI next steps working group. The fating of blood at the patient bedside in turn will enable Welsh blood Service to understand by hospital and specialty what blood group has been used to help complete the demand and supply picture of blood component usage across Wales.	Alan Prosser	Dec-24	Work is ongoing with WBS and DHCW to understand the digital requirements of fating blood components at the patient bedside. Paper to scope out requirements and solution due for submission to Welsh Government by December 24.	Reviewed April 2025	No current funding route identified within LIMS and may need to be considered when the Infected Blood Inquiry
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.	Alan Prosser	Jan-25	Paper has been endorsed by National Blood Oversight Group on October 8th and was presented to Welsh Government IBI next steps working Group in November. UK Interim report was published in December and work progresses at a UK wide and Welsh level to support delivery of the recommendations. The service has flagged that delivery of these recommendations will require resourcing within the service and to the wider system including digital requirements. As such, a resourcing paper is being prepared for consideration by Welsh Government.	Reviewed April 2025	No current funding route identified within the current LIMS DHCW are scoping and costing the digital requirements identified by the Blood Health National Oversight Group in order to support the resourcing request to Welsh Government.
01.03	Collection capacity within the Welsh Blood Service has struggled for a number of months due to a number of operational variables. A resourcing plan to improve this position is being completed by the service for consideration of commissioners to sustain the sufficiency of supply of blood for the patients of Wales	Alan Prosser	Jan-25	Business case discussions between the Trust and commissioners were due to take place in February 2025.	Reviewed April 2025	The case supports sufficiency of supply for the patients of Wales whilst the Welsh Blood Service moves forward with its transformation programme (WBS Futures) for collections.
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	Rachel Hennessey	Jan-26	Work to be taken forward as part of outreach project. LEAN Practitioner starts in post on 18.02.2025 look at pathways and further appointment made to look at demand. some breast patients repatriated to YYF. Engaging through the new SST model. The OPD LEAN / SI already underway is now dovetailing with the data from the Cancer PTL, to help refine business processes and address the patient & pathway 'Pain Points'	18.02.25 30/04/24	
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	Rachel Hennessey	Ongoing	SACT Delivery Group in place supported by SACT improvement manager with a focus on forecasting demand and capacity requirements. Radiotherapy capacity and Demand meeting schedule for 18.02.2025. Has been delayed to summer '25 due to Insightive delays.	18.02.25 30/04/25	

SECTION 6

IMTP PRIORITY IMPROVEMENT ACTIONS - that Mitigate Trust Assurance Framework Strategic Goal Key Risks

IMTP 2024.25 to 2026.27 Service Area	2024.25	2025.26	2026.27
	VELINDRE CANCER SERVICE	VELINDRE CANCER SERVICE	VELINDRE CANCER SERVICE

<p>Strategic Goal 1 Outstanding for quality, safety and experience</p>	<p>1. Implementation of clinical service at Radiotherapy Satellite Unit in ABUHB (Nevill Hall Hospital) 2. Implementation of Integrated Radiotherapy Solution Programme by 2026/27 3. Implementation of Outreach Programme by 2025-26 4. Implementation of the Transforming Access to Medicines (TrAMs) Model at Velindre Cancer Services 5. Implementation of Regional Acute Oncology Delivery Model and Network Structure 6. Participate in Radiology Informatics System Procurement (RISP) and Implement System for Use by Velindre Cancer Services 7. Implementation of the Approved Full Business case for the Development of the New Velindre Cancer (nVCC) 8. Implement Relevant Standards of the National Pre-habilitation to Rehabilitation / 3 Ps Deliverables 9. Implement Same Day Emergency Care pathways across Velindre Cancer Services by Q4 2024/25</p>		
	<p>11. Implement Recommendations from Peer Review of SACT Treatment Helpline 12. Expand capacity and capability of VAP (Virtually Assessed Patient) Clinics 13. Develop and Implement New Pharmacy Strategy for 2024-2030 via Pharmacy Transformation Programme 14. Design, Commission and Deploy Revised Patient Transport Model 15. Undertake Digitisation of Medical Records 16. Respond to Low / Limited Audit Assurance Findings 17. Implementation of Centre for Collaborative Learning and Innovation</p>		
	<p>WELSH BLOOD SERVICE</p>	<p>WELSH BLOOD SERVICE</p>	<p>WELSH BLOOD SERVICE</p>
<p>Strategic Goal 1 Outstanding for quality, safety and experience</p>	<p>1. Implement improved donor interaction by 2026/27. 2. Develop and implement the Welsh Bone Marrow Donor Registry (WBMDR) strategy re-appraising the collection model and its ambition by 2026/27. 3. Implement new donor strategy by 2025/26. (platelet, blood, bone marrow, plasma) 4. Implementation of the Pre-Operative Anaemia Pathway programme by 2024/25. 5. Develop and implement a platelet strategy by 2025/26. 6. Assess and implement Advisory Committee on the Safety of Blood, Tissues and Organs SaBTO recommendations on blood donor testing to reduce the risk of transmission of Hepatitis B infection as required 2024/25. 7. Establish a quality assurance modernisation programme to develop and implement strategy which supports more efficient and effective management of regulatory compliance and maximises digital technology by 2025/26. 8. Implementation of Foetal DNA typing by 2024/25. 9. Review and Develop strategy for Nucleic Acid Testing (NAT).</p>		
	<p>10. Develop and implement an energy efficient, sustainable, SMART estate at Talbot Green site that will facilitate a future service delivery model. 11. Develop a sustainable workforce model which provides leadership, resilience and succession planning by 2025/26.</p>		

|

SECTION 1

RISK ID	02	CURRENT RISK SCORE TREND	<p>TAF 02 - Current Risk Score</p>	CURRENT SUMMARY OF TAF 02	<p>Key actions to improve strategic partnership and system working continue to be delivered strongly, particularly since December 2024. This is being taken into account in the review of strategic risk being considered as part of the 2025-2028 Integrated Medium Term Plan.</p> <p>Risk score trend: The risk score has remained static since the last period.</p>		
		RISK LEADS	Lauren Fear			RISK TITLE	There is a strategic risk of failure to align our strategic objectives and intent with system partners, including within the health and social care system, third sector and industry partners which could result in an inability to deliver required change to achieve our medium to long term objectives.
		RISK THEME	Partnership Alignment			STRATEGIC GOAL	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations

SECTION 2

RISK SCORE (see definitions tab)														
INHERENT RISK	LIKELIHOOD	IMPACT	TOTAL	12	CURRENT RISK	LIKELIHOOD	IMPACT	TOTAL	8	TARGET RISK	LIKELIHOOD	IMPACT	TOTAL	6
	3	4				2	4				2	3		

SECTION 3

Overall Level of Effectiveness: 7 Levels of Assurance(see definitions tab)				RATING		PE		Overall Trend in Assurance					
KEY CONTROLS								SOURCES OF ASSURANCE					
ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating	
	Trust Risk Register associated risk on Datix. (see section 4)			X									
1.3	Performance data and measures to clearly track progress against objectives				X	PE	Linked through performance framework insight; new performance management framework implemented March 2023	E	Strategic Development Committee/ Quality Safety and Performance Committee	PA	Audit Wales/ Welsh Government	PA	
2.1	Blood - core blood services commissioning arrangements			X		E	Commissioning contracting reporting in place with LB partners; regional/national arrangements in place for blood and cancer services; will be enhanced by creation of Executive Function in Welsh Government in April 2023	E	Strategic Development Committee/ Quality Safety and Performance Committees; introduction of Executive Function in WG will support effective system commissioning; Executive Function in WG from April 2023 will enhance arrangements	PA	Regulatory scope re MHRA tbc; clear standards for services understood and supported by commissioning arrangements across NHS Wales	E	

3.1	Local Partnership Forum		X	X		E	Feedback from LPF; proven to be effective	E	Strategic Development Committee/ Quality Safety and Performance Committee	PA	Audit Wales	E
4.1	Regional Cancer Programme Board			X		PE	Established and initial programme of work agreed and being progressed via assigned leads	PA	Strategic Development Committee/ Quality Safety and Performance Committee	PA	Audit Wales/ Welsh Government	PA
5.1	Partnership Board arrangements with partner Health Boards model;			X		E	Agreed to model for each organisation	PA	Strategic Development Committee/ Quality Safety and Performance Committee	PA	Audit Wales/ Welsh Government	E
5.2	Partnership with other stakeholders e.g. WAST, HEIW and University partnerships.		X			E	Good working relationships with regular communication	E	HIW	E	Regulatory scope	E
5.3	Effective regional /national commissioning of Trust services		x			PE	Regional commissioning groups in place and effective	PA	EMB; Strategic Development Committee; Quality, Safety and Performance Committee		Audit Wales/ Welsh Government	

GAPS IN CONTROLS						GAPS IN ASSURANCE				ASSOCIATED ACTION REFERENCE/ RATIONALE	
Across the models of working in strategic partnerships, there are common themes of control effectiveness – with the models largely in place, further development required on the ways of working/work programmes and even further development required on the reporting mechanisms						First line and second lines of defence assurance are in place to a certain extent				1.9; 1.7; 1.8	
Agreement of need for improved regional cancer Commissioning (core services)										1.6; 1.8	
Need for improved data/quality metrics to track performance						Provision of improved metrics to EMB; QSP and Trust Board				1.3; 1.4	

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	CURRENT RISK RATING	RISK TREND
	There are currently no associated operational risks according to the risk appetite to include		

SECTION 5

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
02.01	Phase 1 complete in 2022. Development of next phase agreed by Executive Management Board in September 2024 and reported through to QSPC and Trust Board in packages of work with associated timeframes for completion of all by March 2025.	Director of Transformation - Interim		01/03/2024 March 2025	Progress against PMF packages of work are tracked in Quality, Safety and Performance Committee and Trust Board. Action completed and on-going development as part of PMF development.	30.04.25	Impact to be assessed as part of risk refresh in line with IMTP – by end May 25.	Impact to be assessed as part of risk refresh in line with IMTP – by end May 25.

02.03	Regional Cancer Programme Board to be established and operating effectively	Director of Transformation - Interim	Mar-25	First Regional Cancer Programme Board held in September 2024. Initial programme of work agreed in November 2024, alongside review of collective cancer strategies and existing programmes of work. This was reported to Trust Board in Strategic Planning update in November 2024. Work progressing to next meeting in February 2025. Action completed	30.4.25	Impact to be assessed as part of risk refresh in line with IMTP – by end May 25.	Impact to be assessed as part of risk refresh in line with IMTP – by end May 25.

SECTION 6

IMTP PRIORITY IMPROVEMENT ACTIONS - that Mitigate Trust Assurance Framework Strategic Goal Key Risks

IMTP 2024.25 to 2026.27 Service Area	2024.25	2025.26	2026.27
Strategic Goal 2 An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations	1. Delivering the Fundamental Cornerstones of Healthcare Provision: <ul style="list-style-type: none"> • Implementing the requirements of the Health and Social Care (Quality and Engagement) (Wales) Act 2021, the National Quality and Safety Framework and the National Clinical Framework to provide services of the highest possible quality • Delivering services that meet the national clinical quality and safety standards and provide an excellent experience • Treating patients as quickly as possible (SACT and RT) • Providing blood and blood products to our partner Health Boards to support the provision of treatment and care to people across Wales • Developing agile and flexible capacity plans which allow us to respond quickly to changes in demand for our services • Supporting the health and well-being of our staff who have been working in extremely challenging circumstances for the past three years • Workforce redesign – optimising multi-professional patient / donor centered care predicated on co-production and top of licence working 		
	2. Improving Population Outcomes and Reducing Inequalities: <ul style="list-style-type: none"> • Improving access to our services to increase uptake and reduce inequalities and ill-health • Strengthening our decision-making to consciously address poor outcomes and inequalities in the communities we serve • Working with our health partners where it is clear and compelling that we can add value and make a difference 		
	3. Regional Working, Partnerships and Collaboration to Improve Outcomes <ul style="list-style-type: none"> • Work with Local Health Board partners to strengthen our support to the delivery lead of improved cancer outcomes for patients in South East Wales • Develop the Velindre@ research hub philosophy across all LHB partners in South East Wales • Further develop the Blood Health Oversight Group work programme to improve the prudent use of blood and blood products across Wales 4. Delivery of Transformation Programmes Non-surgical Tertiary Oncology Services: <ul style="list-style-type: none"> • Implementing the final phase of the Acute Oncology Service regional model • Continue to improve pathways for unscheduled care patients • Delivery of the Cardiff Cancer Research Hub • Implementation of the Integrated Radiotherapy Solution in 2025 • Construction and delivery of the new Velindre Cancer Centre in Whitchurch, Cardiff in 2027 • Construction and opening of the Radiotherapy Satellite Centre, at Nevill Hall Hospital in Abergavenny, in 2025 		
	Blood and Transplant Services <ul style="list-style-type: none"> • Laboratory Modernisation programme: • Refurbishment of the Talbot Green facility by 2027 • Work with the Welsh Government to develop and implement the Plasma for Medicines model for Wales 		

SECTION 1

RISK ID	03	CURRENT RISK SCORE TREND		CURRENT SUMMARY OF TAF 03	<p>There are many factors that impact on the current supply and shape of our workforce. These are external and internal to the organisation. We are currently mitigating the risk in this area through our work programme as described below. Our focussed areas of work are in recruitment, retention and operational workforce planning. In addition we are attempting to maximise the capacity of the workforce through reduction in absence levels - wellbeing interventions and a focus on using workforce policies in a way that minimises harm to staff and teams.</p> <p>Risk score trend: The risk score has remained static since the last period.</p>
RISK LEADS	Sarah Morley	RISK TITLE	There is a strategic risk to the Trust's ability to effectively deliver quality services and achieve our medium to long term objectives if we are unable to develop and maintain an optimised workforce supply and shape, in order to effectively deliver quality services and achieve our medium to long term objectives.		
RISK THEME	Workforce Supply and Shape	STRATEGIC GOAL	1 - Outstanding for quality, safety and experience		

SECTION 2

RISK SCORE (see definitions tab)														
INHERENT RISK	LIKELIHOOD	IMPACT	TOTAL	16	CURRENT RISK	LIKELIHOOD	IMPACT	TOTAL	12	TARGET RISK	LIKELIHOOD	IMPACT	TOTAL	6
	4	4				4	3				2	3		

SECTION 3

Overall Level of Effectiveness: Levels of Assurance(see definitions tab)	7	RATING	PE	Overall Trend in Assurance
--	---	---------------	-----------	-----------------------------------

KEY CONTROLS **SOURCES OF ASSURANCE**

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence			2nd Line of Defence			3rd Line of Defence		
							Assurance Rating			Assurance Rating			Assurance Rating		
	Trust Risk Register associated risk on Datx. (see section 4)			X		PE									
C1	Trust People Strategy, approved in May 2022, clearly noting the strategic intent of Workforce Planning - 'Planned and Sustained Workforce'	Sarah Morley	X			E	People and Development Steering Groups	4		Performance reporting to Executives and Trust Board	4		Internal Audit Reports	4	
C2	Approved Workforce Planning Methodology aligned to Trust Values and Behaviours	Susan Thomas	X			E	Regular monitoring at SLTs, where workforce dashboards monitor performance, identify and manage issues.	5		Reports to EMB, Committees and Trust Board	5		Internal Audit Reports	5	
C3	Workforce planning - skills development	Susan Thomas	X			PE	Provide operational managers with skills and capabilities to undertake effective workforce planning. Provide formal training and produce a suite of workforce planning tools.	4		Reports to EMB, Committees and Trust Board	4		Internal Audit Reports	4	
C4	Workforce Planning embedded into our Inspire Programme to develop Managers and leaders in Workforce Planning skills	Susan Thomas	X			E	The Trust has a robust programme of evaluation to support the delivery of all training programmes, ensuring a continuous learning and development system is in place.	5		Reports to EMB, Committees and Trust Board	5		Internal Audit Reports	5	

C5	Educational pathways in place to support the recruitment of new skills and development of new roles	Susan Thomas	X		PE	People and Development Steering Groups	2	Reports to EMB , Commitees and Trust Board	2	Internal Audit Reports	2
C6	Widening Access Programme to support development of new skills and roles	Susan Thomas	X		PE	People Development and Education Steering Group	2	Reports to EMB , Commitees and Trust Board	2	Internal Audit Reports	2
C7	Monthly dashboard reports are provided to divisional SLTs to monitor performance, identify and manage any issues. Hotspot areas are identified and managed accordingly, such as establishment of Task and Finish Groups.	Susan Thomas	X		E	Regular monitoring at SLTs, where workforce dashboards monitor performance, identify and manage issues.	6	Regular performance reports and Supply and Shape paper are submitted to EMB and QSP	6	Internal Audit Reports - Managing Attendance at Work, Recruitment and Retention and Education Strategy Audit (ongoing)	6
C8	Consistent recruitment and selection process	Sarah Morley	X		PE	Regular monitoring at SLTs, where workforce dashboards monitor performance, identify and manage issues.	4	Reports to EMB , Commitees and Trust Board	4	Internal Audit	4

GAPS IN CONTROLS						GAPS IN ASSURANCE			ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.		
Gaps are evident in understanding agreed service models – both internally and regionally											

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	Current Risk Rating	RISK TREND
2187	There is a risk to patient safety due to inadequate staffing within the Radiotherapy Physics Department and the need to balance core duties with developmental tasks.	12	Stable
3392	There is a risk to the Dietetic delivery as a result of reduced staffing due to vacancies, leading to a potential impact on patient care.	20	Stable

SECTION 5

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Due Date	Assurance Level	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
03.06	Development of a Trust Workforce Plan	Susan Thomas	Sep-25		<p>30.04.2025 Appointment of AD Workforce Planning 1st May will provide a sharper focus and organisational direction on Workforce Planning to deliver the Supply and Shape workstream of the People Strategy</p> <p>Workforce plans are in train throughout the Trust and progress noted via the Supply and Shape paper, most recent update to QSP 8th May</p> <p>A specific paper on Workforce Planning progress will be brought to EMB and committees in the Summer</p> <p>18.09.2024 An initial plan was presented to EMB in September 2024, where short and medium term actions were agreed. These actions were reflected in Workforce Supply and Shape paper in November QSP.</p> <p>02.12.2024 A number of the actions outlined in the Trust's Workforce Plan, were scrutinised at QSP on 14.11.2024 through holistic Workforce and Finance Supply and Shape Paper. Assurance ratings were reviewed against each deliverable area, in detail, and amended as discussed and agreed by the committee. QSP will continue to receive the paper and define the assurance levels related to actions in the plan.</p>	30.04.2025 reviewed	The impact will be reduced once the short and medium term actions are completed	

03.07	Development of a Nurse Retention Plan	Amanda Jenkins	Complete	Assurance Level 3	<p>25.06.2024 The Nurse Retention Plan was agreed to be taken forward by EMB with accountability for developing the plan being lead within the Professional Nursing Forum.</p> <p>24.09.2024 The Nurse Retention Plan (developed in partnership with service leads) was discussed at PNF. The group agreed to take away the plan to review and comment on by the next meeting on 05.12.2024. It is anticipated this will be approved at this meeting.</p> <p>28.01.2025 Approved at EMB</p>	30.04.2025	Development of the Nurse retention plan supports a move to reduce the Trust's overall workforce planning risk by ensuring a stable and experienced nursing workforce. This leads to improved patient care, reduced recruitment and training costs, and enhanced staff morale. By retaining skilled nurses, the Trust can better manage staffing levels, mitigate the impact of turnover, and maintain continuity of care, ultimately fostering a more resilient and efficient healthcare environment.	Assurance Level 4 - Robust Plan in Place being implemented through Action 3.12	
03.08	Embed workforce planning progress into monthly Divisional Senior Leadership	Amanda Jenkins	Oct-25 Apr-25		<p>30.10.2024 A review of the current position was completed however it is clear from this work that further capacity and skilled resource is needed to embed this into the monthly reviews.</p> <p>02.12.2024 Finance meeting to discuss and agree next steps for building additional resource and capacity. Agreed to take forward as part of the IMTP business case aligned to the opportunity pipeline of workforce re-design.</p> <p>27.01.2025 Business Cases for perm workforce planning and attraction resource submitted as part of IMTP. New expected date for completion April 25 aligned to resource.</p> <p>30.04.2025 Additional resource included in the new investment requests under IMTP. No confirmation received as of yet. This will progress once confirmed by finance.</p>	30.04.2025			
03.09	Staff educators to undertake HEIW train the trainer on workforce planning	Amanda Jenkins	Oct-24 Apr-25		<p>29.11.2024 in contact with HEIW to scope train the trainer programme and costs</p> <p>27.01.2025 HEIW limited capacity to support. Exploring other options for the Trust</p> <p>20.02.2025 HEIW and Trust have developed programme of WFP training for the Trust through CIPD with a Train the Trainer course for building capacity within the Trust of workforce planning resource.</p> <p>30.04.2025 - Completed. HIEW supporting training for People and OD team over the coming 12 months.</p>	30.01.2025			
03.11	Implementation of the Attraction and Resourcing Project	Amanda Jenkins	Mar-25 Sep-25		<p>01.10.2024 New Attraction and Resourcing Lead appointed to take actions from the project forward.</p> <p>14.10.2024 Options paper for recruitment campaign agreed to EMB.</p> <p>27.01.2025 Supplier appointed. Initial filming plan underway.</p> <p>30.04.2025 Completed development plan by March 2025 as agreed. Move implementation phase with completion and final produce to be delivered by September 2025. Additional Resource included in the new investment requests under IMTP to make attraction and retention resource perm. within the People Team.</p>	30.01.2025			
03.12	Implementation of the Nurse Retention Plan through the Professional Nursing Forum	Nicola Williams / Divisional Heads of Nursing	Apr-26	Assurance Level 4	<p>Nurse Retention Plan currently in draft</p> <p>27.01.2025 EMB endorsed the NRP, implementation underway.</p>	30.04.2025			
CLOSED ACTIONS									
03.13	Utilise the learning from implementation of the Nurse Retention to develop a Trust	Amanda Jenkins			Completed	30.10.2024	Learning and engagement in Nurse retention plan utilised to develop Trust Retention Plan		
03.01	The Healthy and engaged workplan to be implemented to support workforce capacity within the Trust	Sarah Morley			<p>The Healthy and Engaged workplan 2024-25 was agreed at the Healthy and Engaged Steering Group on 09.03.2024.</p> <p>The Healthy and Engaged Workforce Steering Group reports quarterly to EMB.</p>	14.05.2024		Impact on assurance level was updated in the Supply and Shape paper presented to QSP on 09.05.2024.	

03.02	Establish Hybrid working arrangements as a core way in which the Trust undertakes some of its work.	Sarah Morley	COMPLETE	The Hybrid Working project is presenting the details of a desk top booking approach to EMB in January 2023. This business case will then be further developed following EMB feedback. The Hybrid Working Toolkit has been developed in draft and will be finalised and published in February 2023.	21/12/2023	This programme of work is now completed - a close down report was taken to EMB in August 2023. An review of our infrastructure to support Hybrid Working is now being discussed, led by Estates
03.03	Participate in the NWSSP International nurse recruitment Project	Sarah Morley	COMPLETE	International nurse recruitment has commenced to recruit 17 WTE nurses by December to commence in March 2024. Progress is monitored via EMB. International nurses take up post on 25.03.2024	21/12/2023	13 overseas nurses have been recruited and onboarded and will start in March 2024.
03.04	Develop and Implementation Plan for the People Strategy	Susan Thomas	COMPLETE	A plan to implement the People Strategy will be presented to EMB in December.	21/12/2023	Presented to EMB Shape
03.05	Review Exit Interview Process	Susan Thomas	COMPLETE	The Exit interview process has been rewritten. There is a new dashboard and automated process and engagement sessions have been delivered. A new procedure will be submitted to EMB	20.03.2024	
03.10	Embed Hybrid working principles in training and reporting	Amanda Jenkins	COMPLETE	02.12.2024 People analytics team have developed a process for recording flexible working applications and outcomes via ESR. This is to be rolled out to managers in the month of December and the data will be used from January 2025 in reporting monthly to divisional SLT's. 27.01.2025 Completed	27.01.2025	SLT's have relevant local data in relation to hybrid working to ensure fair and consistent application of hybrid working principles across the Trust. This data will support the development of local optimised workforce models aligned to the clinical model for delivery.

SECTION 6

IMTP PRIORITY IMPROVEMENT ACTIONS - that Mitigate Trust Assurance Framework Strategic Goal Key Risks

IMTP 2024.25 to 2026.27 Service Area	2024.25	2025.26	2026.27
Strategic Goal 1 Outstanding for quality, safety and experience	Planned Ans Sustained Workforce 1. Implement the Education Strategy Implementation Plan 24/25 2. Following the agreement of the Clinical and Scientific Skills Strategy develop Trust wide priorities and implementation plan for multi-disciplinary workforce model 3. Manage the successful implementation of the WL service provision (SLA) to support service bi-lingualism 4. Agree a plan for the Widening Access Programme 5. Ongoing recruitment Marketing Campaigns for hard to fill roles 6. Develop a Nurse retention plan		
	Skilled and Developed Workforce Achieving Excellence through our staff 1. Transforming care pathways Working with the service agree training requirements for care pathways (HSCW, AP and Consultant) through the workforce planning process to shape a Multi-Disciplinary workforce Model 2. Developing our academic profile through the training plan provide education, training, and development opportunities to enable staff to develop their knowledge and skills through life-long learning, through the Valindre Oncology Academy and the Collaborative Centre for Learning and Innovation 3. To create a workforce which has the skills, knowledge and curiosity to maximise the opportunities offered by digital services and technology 4. Working with Digital - Provide training and sources of support to enable the workforce to be confident and competent in the use of new equipment, systems, and technology		

SECTION 1

RISK ID	04	CURRENT RISK SCORE TREND		CURRENT SUMMARY OF TAF 04	This Strategic Risk brings together those elements of the culture of the organisation that can impact on the ability of the Trust to deliver its core purpose. There are work programmes underway to address the feedback that the Trust on this subject through a variety of mechanisms. The work considers systems, processes, values and behaviours through development, support, wellbeing and other interventions. There will be a particular focus in 25/26 on the organisational development plan to support the transition to nVCC. Risk score trend: The risk score has remained static since the last period.
RISK LEADS:	Sarah Morley	RISK TITLE:	There is a risk of failure to meet or exceed service expectations without the prevalence of a positive working environment, which is characterised by effective values and behaviours, systems and processes		
RISK THEME:	Organisational Culture	STRATEGIC GOAL:	2 -An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations		

SECTION 2

RISK SCORE (see definitions tab)

INHERENT RISK	LIKELIHOOD	IMPACT	TOTAL	12	CURRENT RISK	LIKELIHOOD	IMPACT	TOTAL	9	TARGET RISK	LIKELIHOOD	IMPACT	TOTAL	4
	3	4				3	3				2	2		

SECTION 3

Overall Level of Effectiveness: 7 Levels of Assurance(see definitions tab)	RATING	PE	Overall Trend in Assurance	THIS WILL INCLUDE A GRAPH
--	---------------	-----------	-----------------------------------	----------------------------------

KEY CONTROLS								SOURCES OF ASSURANCE					
ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating	
	Trust Risk Register associated risk on Datix. (see section 4)			X									
C1	Trust Strategies and enabling strategies (including people, RD&I and Digital) launched November 2023 to provide clarity and alignment on strategic intent of the Organisation	Carl James	X			E	Reports to EMB	5	Trust Board reporting on strategy and controls via cycles of business	5	Welsh Government reporting via JET and IMTP	5	
C2	Approved Education Strategy and implementation plan to support the educational development of the Organisation to support the Trust direction	Susan Thomas	X			E	People Development and Education Steering Group	4	Reports to EMB , Committees and Trust Board	4	Internal Audit Reports	4	
C3	Management and Leadership development programmes in place based on compassionate leadership principles	Susan Thomas	X			PE	People Development and Education Steering Group	4	Reports to EMB , Committees and Trust Board	4	Internal Audit Reports	4	
C4	Trust Values and Behaviour Framework	Susan Thomas	X			PE	Healthy and Engaged Steering Group	4	Reports to EMB , Committees and Trust Board	4	Internal Audit Reports	4	

C5	Communication infrastructure in place to support the communication of leadership messages and engagement of staff including employee voice	Non Gwilym/ Sarah Morley	X		PE	Healthy and Engaged Steering Group	2	Reports to EMB, Committees and Trust Board	2	Internal Audit Reports	2
C6	Health and Wellbeing infrastructure for the Trust to support physical and psychological wellbeing of staff	Susan Thomas	X		E	Healthy and Engaged Steering Group	5	Reports to EMB, Committees and Trust Board	5	Internal Audit Reports	5
C7	Governance arrangements in place to monitor and evaluate the implementation of plans	Non Gwilym	X		PE	Reports to EMB	3	Reports to Committees and Trust Board	3	Internal Audit Reports	3
C8	Performance Management Framework in place to monitor the finance, workforce and performance of the Organisation	Carl James	X		PE	Regular monitoring at SLTs, where workforce dashboards monitor performance, identify and manage issues.	5	Reports to EMB, Committees and Trust Board	5	Internal Audit Reports	5
C9	Clear safe, effective and efficient service models to support role clarity aligned to compassionate leadership principles	Anne Carey	X		PE	Regular monitoring at SLTs, where workforce dashboards monitor performance, identify and manage issues.	3	Reports to EMB, Committees and Trust Board	3	Internal Audit Reports	3
C10	Operational workforce plans developed to support agreed service models	Anne Carey	X		PE	Regular monitoring at SLTs, where workforce dashboards monitor performance, identify and manage issues.	3	Reports to EMB, Committees and Trust Board	3	Internal Audit Reports	3
C11	Avoidable employee harm principles are embedded into the management of behaviours within the Trust	Sarah Morley	X		PE	Healthy and Engaged steering group and Local Partnership Forum	5	Reports to EMB, Committees and Trust Board	5	Internal Audit Reports	5

GAPS IN CONTROLS						GAPS IN ASSURANCE				ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.	

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	CURRENT RISK RATING	RISK TREND
3332	There is a risk to the health and wellbeing of the medical workforce due to increasing demand resulting in prescribing and the completion of Outpatient Oncology Notes being done outside of job plan hours	16	Stable

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
04.05	Undertake analysis of current employee voice mechanisms and develop an engagement action plan to improve voice mechanisms and encourage a culture of speaking up across the Trust.	Claire Budgen		Mar-25	01.05.2025 Engagement action plan developed and delivered during Q4 2024-25. New resources in place for staff supported by regular communications aimed to encourage a culture of speaking up. 06.12.24 Culture Framework is in development. Engagement sessions took place with senior leaders in November 2024. Culture Framework encompasses the speaking up safely mechanisms.	01.05.2025		
04.07	Embed the principles of the Social Partnership Duty into the Trust's strategic development and through the Trust Board cycles of business	Amanda Jenkins		Apr-25	06.12.2024 Session planned at Board Development on 17.12.2024. A Social Partnership update will be included. Following session a meeting will be planned with the Chair of Strategic Development Committee to plan governance routes. 27.01.2025 Session delivered to Board on the Duty. Meeting with SDC Chair set up 30.04.2025 meeting with LF to plan how this is embedding into SDC	30.04.2025		

04.08	Implement the Compassionate Leadership Pledge and action plan within the Trust	Claire Budgen		Mar-25	06.12.2024 Compassionate Leadership Pledge was signed on 26 September 24 by leaders in the Trust. Action plan is in development and will be governed by the People Development and Education Steering Group	Reviewed 30.04.2025		
04.09	Develop outcome measures for the monitoring and analysis of Health and Wellbeing activities within the Trust	Claire Budgen		Dec-24	06.12.2024 Paper being submitted to Healthy and Engaged Steering Group on 19.12.2024. Complete	Reviewed 30.04.2025		
04.10	Implement the actions of the Trust Strategic Equality Plan, including embedding the Anti-Racist Wales Action Plan in the Trust	Claire Budgen		Mar-25	06.12.2024 Regular updates have been submitted to EMB, committees and Trust Board. An assurance level of 3 was agreed.	Reviewed 30.04.2025		

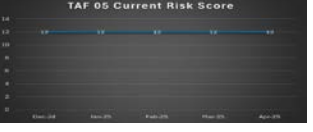
CLOSED ACTIONS

04.06	Embed the Values and Behaviours Framework into Trust communications, policies and processes	Claire Budgen		COMPLETE	06.12.2024 This action is complete. Paper going to EMB in December 2024.	06.12.24		
04.01	Implement a routine of conversations with staff and members of the Executive Team, Divisional Senior Leadership Teams and Extended Leadership Team.	Sarah Morley		COMPLETE	The four leadership teams have established a working group to implement the 'Working Together to Build our Future' ongoing series of discussions across the organisation. These began in September 2023 and will act as a temperature check on how staff are feeling on the ground about the organisation both in routine arrangements and also the changes that are taking place around them. These conversations will also provide the opportunity to talk about the Trust Strategy. Themes from the first eight weeks of conversations have been fed back via a video message. A summary of the themes and proposed actions will be presented to EMB in May 2024. This paper also proposes that the conversations continue as routine in person and virtually.	20/06/2024	The outputs from the WT Sessions are being mapped into the Refresh of the Building Our Future Together Organisational Development Approach. New Sessions are now being scheduled which will cover staff across the bases in Wales	Identification of the needs for an Employee Voice Framework
04.02	Consider feedback from Trust data on the culture of the organisation in a holistic overview in order that the Executive Team and Board can evaluate interventions in place and the forward plan to ensure a positive and effective culture.	Sarah Morley	PA	COMPLETE	Data is being triangulated to understand the current climate within the organisation. A plan is being developed to ensure that appropriate interventions are in place or being introduced to support a positive and supportive culture within the organisation. Many elements of employee voice are being considered as part of this work. Results of the NHS Staff survey have begun to be distilled to further develop our work programme	20/06/2024	We received the Trust level data from the 2023 staff survey with the more detailed dashboards following in May. This data will be used to overlay with other feedback. The areas of data have been mapped onto the current workstreams and management groups to ensure that this will ensure action is taken under the appropriate workstream.	This will encompass the revised BOFT approach in the Trust way of working.
04.03	A staff engagement project to understand levels of staff engagement and also review the Trust Values	Sarah Morley	PA	COMPLETE	A first report against the review of the Trust values was presented to EMB in December 2022. It was decided at that meeting that a broader piece of work was needed to ensure that Trust values were built on the culture the organisation was striving to achieve to deliver its ambitions under the Destination 2033 strategy. A 2nd Phase of engagement activity has been underway with staff, patients and donors. Further opportunities will be provided for Executive management Board and Trust Board to shape this work in November and December 2023.	21/12/2023		
04.04	Promotion of the Speaking Up Safely Framework	Sarah Morley	PA	COMPLETE	The initial task and finish group to establish the Speaking up Safely Framework in Velindre has been completed. Communication and governance processes are in place.	14/05/2024	Initial programme completed - ongoing work to triangulate with wider cultural work	

SECTION 6

IMTP PRIORITY IMPROVEMENT ACTIONS - that Mitigate Trust Assurance Framework Strategic Goal Key Risks

IMTP 2024.25 to 2026.27 Service Area	2024.25	2025.26	2026.27
Strategic Goal 2 An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations	<ul style="list-style-type: none"> 1. Implement the actions within the Health and Wellbeing Action plan – supporting wellness and managing action plan for sickness absence 2. Commence the Values and Behaviour framework project 3. Review performance indicators for a Healthy and Engaged workforce including EQIA measures and hybrid working 4. Deliver an action plan for 2024/25 to support our commitment to the Trust Anti- Racist Action plan 5. Monitor Welsh Language Standards, working with Divisions on improvement plans 6. Implement the WL Culture plan 7. Update all WOD related policies and procedures 		

SECTION 1			
RISK ID	05	CURRENT RISK SCORE TREND	
RISK LEADS:	Carl Taylor	RISK TITLE:	There is a strategic risk that the Trust fails to sufficiently consider, optimise the opportunities and effectively manage the risks of new and existing technologies, including considerations of Artificial Intelligence and Information Security
RISK THEME:	Digital Transformation	STRATEGIC GOAL:	All
		CURRENT SUMMARY OF TAF 05	<p>Apr '25 Work is ongoing on the key controls - no movement to overall current risk scoring. Assurance ratings moved to 7 levels of assurance. New risks have been added to reflect the operational Digital risk - including challenges with delivering the National Programmes for RISP and LIMS. The delivery of National Programmes through DHCW has been moved into escalation level 3.</p> <p>Risk score trend: The risk score has remained static since the last period.</p>

SECTION 2											
RISK SCORE (see definitions tab)											
INHERENT RISK	LIKELIHOOD	IMPACT	TOTAL	CURRENT RISK	LIKELIHOOD	IMPACT	TOTAL	TARGET RISK	LIKELIHOOD	IMPACT	TOTAL
	4	4	16		3	4	12		2	4	8

SECTION 3												
Overall Level of Effectiveness:				RATING		PE		Overall Trend in Assurance				
7 Levels of Assurance(see definitions tab)												
KEY CONTROLS												
ID	Key Control	Owner	Preventative	Mitigating	Detective	Source Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
	Trust Risk Register associated risk on Datax. (see section 4)		X			E	Risk reporting arrangements at divisional, project/programme level	4	QSP/Audit Committees, Trust Board	4	Internal Audit Reports	4
C1	Trust Digital Strategy - Published Oct '23	Carl James	X			E	Tracking key outcomes and benefits map - aligned to Trust Digital Strategy - Digital Programme Board	6	EMB Shape	6	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	6
C2	Active work ongoing to leverage existing and deliver on new technologies - e.g. LIMS, IRS, BECS, EPMA	Chief Digital Officer		X		E	Trust Digital governance reporting - WBS Futures - Valindre Futures - Digital Programme Board	4	EMB Shape / National Programme Boards	3	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit/ National Programme Governance	4
C3	Training & Education packages to develop internal capabilities - including for exec and Board	Chief Digital Officer	X			PE	Staff feedback - KLAS Survey - Mandatory Training stats	4	EMB Shape	4	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	4
C4	Training & Education packages for donors, patients	Chief Digital Officer	X			PE	Patient and Donor feedback - Trust Digital Inclusion Plan	4	EMB Shape / Digital Communities Wales	3	Strategic Development Committee/ QSP Committee/ Internal Audit	3
C5	Ring-fencing digital advancement in Trust budget - benchmark 4%	Chief Digital Officer	X			E	Review of proposals via EMB/Board Digital IMTP - Trust Capital Programme Digital Spend included in PMF (Current 2.6%)	3	EMB Shape / EMB Run	3	Strategic Development Committee/ QSP Committee/ Internal Audit	3
C6	Specifically development of digital resources capacity and capability	Chief Digital Officer	X			PE	Review of proposals via EMB/Board Digital Programme Board	4	EMB Shape	4	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit/ Centre for Digital Public Services	4
C7	Digital inclusion in wider community	Chief Digital Officer	X			E	Tracking key outcomes and benefits map - aligned to Trust Digital Strategy Joint plan with Digital Communities Wales - Digital Inclusion Plan accreditation achieved April 25	6	EMB Shape	6	Strategic Development Committee/ QSP Committee/ Internal Audit / Digital Communities Wales Accreditation	6
C9	Prioritisation and change framework to manage service requests	Chief Digital Officer	X			E	Trust Digital governance reporting - WBS Futures - Valindre Futures - Digital Programme Board IMTP	6	EMB Shape	3	Strategic Development Committee/ QSP Committee/ Internal Audit	3
C10	Levels of unsupported applications/ legacy systems	Chief Digital Officer			X	PE	Trust Digital governance reporting Digital Programme Board	4	EMB Shape / EMB Run / Cyber Action Plan	4	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit / Cyber Resilience Unit	4
C11	Trust digital Governance	Carl James		X		E	Trust Digital governance reporting - WBS Futures - Valindre Futures - Digital Programme Board IMTP	6	EMB Shape	6	Wales Audit Office SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	6
C12	Framework of lead and lag indicator reporting into Trust digital governance structure, integrated into wider performance framework	Chief Digital Officer			X	PE	Review via Divisional SMT/SLT	4	EMB Run	4	SIRO Reports/ QSP Committee/ Internal Audit / WG IQPD	4
C13	Cyber Assurance Controls in place	Chief Digital Officer		X		E	Review via Divisional SMT / SLT/ Cyber Security (Examining Strat. & Manx)/ Board Development Sessions.	3	EMB Shape / EMB Run	4	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit/WG/CRU as competent authority for NIS	4
C14	Digital transformation is guided by an agreed digital architecture.	Chief Digital Officer	X	X		PE	Digital Programme Board Digital Design Authority being established	3	EMB Shape	3	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	3
GAPS IN CONTROLS						GAPS IN ASSURANCE			ASSOCIATED ACTION REFERENCE/ RATIONALE			
Digital architecture needs to be developed to guide digital transformation activities - Digital Design Authority has now met twice and is becoming established						Assurance Arrangements for Digital Architecture will need to be established - intent would be to use Strategic Development Committee						
						Prioritisation and change framework is identifying significant additional demand for Digital capacity for 25/26			IMTP Planning process and prioritisation being undertaken with the divisions			

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite			
DATIX RISK REF	RISK TITLE	CURRENT RISK	RISK TREND
3541	There is a risk to performance and service sustainability as a result of national TrAMS project being delayed leading to insufficient capacity within pharmacy technical services to meet SACT production.	15	Stable
2249	There is a risk to financial sustainability as a result of service disruption due to number of posts funded by time limited funding leading to financial instability, recruitment difficulties.	15	Stable
3523	Inadequate Fibre Divergence There is a risk that the nVCC could lose internet connectivity as a result of the two fibre ducts incoming onto site not being sufficiently diverse and both lines being disabled in a single incident. This could lead to the nVCC not having access to key clinical and non-clinical systems.	15	Stable
2774	There is a risk to quality and safety as a result of extensive manual workarounds due to outdated legacy IT systems, leading to increased risk of incorrect test results and patient harm.	12	Stable
3541	There is a risk to performance and service sustainability as a result of national TRAMS project being delayed leading to insufficient capacity within pharmacy technical services to meet SACT production.	15	Stable
3388	There is a risk to Quality and Performance as a result of reporting errors and limited accessibility of reports due to no interfaces between the Fetal D IT System (FEDIS) and NHS Wales Digital Applications, leading to suboptimal antenatal care.	16	Stable
2745	There is a risk to quality as a result of an cyber security breach or other equivalent malicious activity, leading to a data protection / IT security incident and/or disruption to critical operational or clinical services.	15	Stable
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	New Risk
3634	There is a risk to Quality, Performance and Service Stability, 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. Early analysis of digital support required for the Integrated Medium Term Plan shows 2-3 over demand for digital services.	16	New Risk
3646	There is a risk to PERFORMANCE AND SERVICE SUSTAINABILITY that the go-live date for the LIMS National Digital Programme will be delayed as a result of delays in the national programme timeline leading to an impact on realising project outcomes and additional demand for further development of existing legacy systems	16	New Risk

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Due Date	Assurance Level	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
05.01	Create the Trust Digital Reference Architecture to support C14 and others	Chief Digital Officer	Mar-25	2	Terms of reference drafted for approval at Aug Digital Programme Board Digital Design Authority has now met twice and terms of reference have been agreed.	Apr-25	Digital Design Authority will guide digital transformation	The level of assurance should increase from 3-4 for C14
05.02	C3 - Prioritisation framework needs to be established for the Data and Insight Service	Chief Digital Officer IA	Feb-25	3	Data and Insight formative paper due at SDC in Feb '24 Prioritisation paper presented to EMB in Nov '24 Data and Insight included as part of the Change Advisory Board for C3 Additional band 8a resource recruited Prioritisation paper prepared for EMB Shape/SDC in Feb '25 Both meetings were cancelled to no follow on actions Priorities and team are working to those - long term prioritisation approach still to be agreed for C3	Apr-25	Will contribute to reduction in likelihood of risk	C3 would move to Effective
05.04	Reviewing control framework with Head of Information Governance for cross-check and alignment	Chief Digital Officer IA	Mar-25		Initial review undertaken and updates will be collated for May 25 TAF	Apr-25	Will contribute to reduction likelihood of risk	Additional assurance for C11 and C13


CLOSED ACTIONS

5.05	Introduce a Change Advisory Board (CAB) to manage digital changes to service.	Chief Digital Officer IA	Complete	Scope for CAB has been established CAB is now meeting regularly Action will close from Oct '24 once operating effectively	Oct-24	Will contribute to reduction likelihood of risk	Assurance controls better represent best practice, around C9
05.03	Develop an implementation plan for the Digital Strategy to sit between the strategy and IMTP, including investment	Chief Digital Officer IA	COMPLETE	Digital strategy and plan approved by EMB Nov '24 and on Dec '24 SDC agenda Went to SDC in Dec 24, where the paper was noted.	Jan-25	Will contribute to reduction likelihood of risk	Assurance controls should better represent best practice

SECTION 6

IMTP PRIORITY IMPROVEMENT ACTIONS - that Mitigate Trust Assurance Framework Strategic Goal Key Risks			
IMTP 2024.25 to 2026.27 Service Area	2024.25	2025.26	2026.27
Strategic Goal 5 A sustainable organisation that plays its part in creating a better future for people across the globe	<ol style="list-style-type: none"> "Agile" Delivery Squads introduced to Digital target operating model New Patient Reported Outcome Measures (PROMS) system for Value Based Healthcare Digital inclusion - digitally connect our donors, patients, and carers and staff to our services 24/7 Deploy a range of preventative cyber security tools and services, including staff education programme, to reduce likelihood of cyber breach - Cyber Security Strategic Development Plan (CSSDP) Introduce new Digital Training Platform 	Digital Plan for 2026 is in the process of being agreed with the Divisions - this will be updated once this is agreed.	
	<ol style="list-style-type: none"> Performance Management Framework (Quality Measures) dashboard National Data Resource roadmap Trust wide Data and Insight plan New Velindre Cancer Centre (nVCC) digital enablement Digital enablement of the Integrated Radiotherapy Solution Programme by 2026/27 Implementation of electronic prescribing and medicines administration (ePMA) for Use by Velindre Cancer Services Digital Enablement of clinical service at Radiotherapy Satellite Unit in ABUHB (Nevill Hall Hospital) 		

SECTION 1

RISK ID	06	CURRENT RISK SCORE TREND		CURRENT SUMMARY OF TAF 06	<p>A risk on the reporting arrangements for hosted units has been raised during the reporting period. Work is underway to review the current arrangements. Work is also underway to review the Trust's Committee structure and governance arrangements.</p> <p>Work on the Governance, Assurance and Risk programme continues with a keen focus on reviewing the Risk Policy and updating the TAF in line with the Trust approved IMTP. Further detailed work on SMART actions will continue in advance of the new TAF reporting into Trust Board for the July cycle.</p> <p>Risk score trend: The risk score has increased since the last period.</p>
RISK LEADS:	Non Gwilym	RISK TITLE:	There is a strategic risk that the organisational and clinical governance arrangements do not provide appropriate mechanisms and culture to achieve our medium to long term objectives.		
RISK THEME:	Organisational and Clinical Governance	STRATEGIC GOAL:	1 - Outstanding for quality, safety and experience		

SECTION 2

RISK SCORE (see definitions tab)

INHERENT RISK	LIKELIHOOD	IMPACT	TOTAL	16	CURRENT RISK	LIKELIHOOD	IMPACT	15	TARGET RISK	LIKELIHOOD	IMPACT	TOTAL	8
	4	4				3	5			2	4		

SECTION 3

Overall Level of Effectiveness: <small>Refer to 7 Levels of Assurance (see definitions tab)</small>	RATING	E	Overall Trend in Assurance <small>Refer to 7 Levels of Assurance (see definitions tab)</small>	3
---	---------------	---	--	---

KEY CONTROLS							SOURCES OF ASSURANCE					
ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating

C1	Trust Risk Register associated risk on Datix. (see section 4)	Non Gwilym		X		PE	Risk reporting arrangements at divisional, project/programme level	4	QSP/Audit Committees, Trust Board	6	Internal Audit Reports	4
C2	Annual Assessment of Board Effectiveness	Kay Barrow			X	E	Annual Board Effectiveness Survey	6	Audit Committee	6	Internal Audit Reports	6
							Annual Self- Assessment against the Corporate Governance in Central Governance Departments: Code of Good Practice 2017		Trust Board		Audit Wales Structured Assessment Programme / Reports	
									Joint Escalation & Intervention Arrangements			
C3	Board Committee Effectiveness Arrangements	Non Gwilym	X			E		4	Audit Committee	4	Internal Audit of Board Committee Effectiveness	4
							Internal Audit Review		Trust Board		Audit Wales Structured Assessment	
											Audit Wales Review of Quality Governance Arrangements	
C4	Board Development Programme	Non Gwilym	X			PE	Programme established	4	Trust Board in Board Development	4	Specialist external input as required, for instance on Socio-economic Duty	4
C5	Quality of assurance provided to the Board	Non Gwilym	X			PE	Quality of Board papers and supporting information effectively enabling the Board to fulfil its assurance role.	4	Trust Board assessment via formal annual and additional effectiveness review exercises	4	Internal Audit Reports. Audit Wales Structured Assessment Programme/Reports	4
C6	External benchmarking of Governance, Assurance & Risk best practice as part of the Governance, Assurance & Risk programme of work	Non Gwilym	X			PE	Full cross-reference of Governance, Assurance and Risk work into TAF 06 in this respect	4	Governance, Assurance & Risk Steering Group and Trust Board in Board Development input	4	Benchmarking input	4
C7	Cross-reference of Integrated Medium Term Plan objectives to strategic objectives in the Trust Assurance Framework	Non Gwilym	X			PE	Exercise completed.	4	Trust Board in Board Development	4	Internal Audit Reports. Audit Wales Structured Assessment Programme/Reports	4
GAPS IN CONTROLS							GAPS IN ASSURANCE				ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.	
None							Third line of defence in respect of C4 - Board Development Programme				Refreshed programme to be discussed and agreed in February 2024 Board Development session	

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	CURRENT RISK RATING	RISK TREND
3656	There is a risk to the quality of clinical and corporate governance caused by the current assurance and reporting arrangements of hosted units.	16	New Risk

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
06.06	External benchmarking of Governance, Assurance & Risk best practice as part of the Governance, Assurance & Risk programme of work	Non Gwilym	3	Nov-24	External advice on the Trust's governance arrangements has been commissioned. Benchmarking underway - WAST, CAVUHB, ABUHB and Hywel Dda, Royal Marsden and Christie, NHSBT). Activity to be ongoing to inform further improvements.	20.02.25	Benchmarking will provide further assurance to the Board. GAR Group to receive update at next meeting in May 2025.	Delivery of the action will provide assurance to the Board on the quality of GAR programme output. <input type="checkbox"/> Output to be considered as accessible to all staff and as an enabler to service improvement. <input type="checkbox"/>
06.07	Develop new plan for phase 2 GAR programme	Non Gwilym	2	Dec-24	GAR group meeting on 20 January 2025. Further review with Independent Members of status of Phase 1 Objectives conducted January / February 2025. Refreshed plan to be presented to GAR group meeting for approval in March meeting. This includes reporting mechanisms.	13.02.25	Activity during January / February 2025 significantly reduces the risk of the lack of clarity of business priorities and focus. A consolidated plan has been developed and progress to implement where there is agreement on actions isn't impeded by the approval of the overarching programme.	The delivery of the GAR programme will provide the Trust with assurance on its governance arrangements. This will impact the risk score significantly.
06.08	Review Trust Risk Policy	Non Gwilym	2	Jul-25	Work progressing. First draft of new policy to be considered by working group on 11 April.	17.02.25	Updated policy with updated flowcharts and educational assets available for all Trust staff.	Refreshed process for Risk management, reporting and training. Positive impact on strategic risk related to governance of Trust risks.
06.09	Develop new TAF template and content - aligned with IMTP.	Non Gwilym	2	Jul-25	Work progressing. First draft to be considered in May 2025 by EMB for onward submission to Committees and Trust Board for July cycle.	29.04.25	Socialised, approved TAF will provide clarity on all Trust governance arrangements.	TAF used as effective tool for reporting on IMTP risks, TAF clearly articulates assurances from EMB to Committee's/Board. Board effectiveness scores increase as a result. Positive view from Audit Wales on new TAF as part of structured assessment.

CLOSED ACTIONS

06.01	Refresh of Trust Assurance Framework risks	Lauren Fear	6	Complete	Project TAF 2.0 within the GAR Programme is due to complete in January 2024 Trust Board, risks then to be reviewed on a monthly basis and reported through governance routes accordingly	11.4.24	Requirement for C7 to be put in place	
06.02	Trust Assurance Framework will be mapped through Governance Cycle	Lauren Fear	6	Complete	Work is complete to map Trust Assurance Framework through governance cycles, at present the TAF is received at appropriate committees, EMB Shape, Strategic Development Committee, Audit Committee and Trust Board	11.4.24	Requirement for C7 to be put in place	

06.03	Cross-reference of Integrated Medium Term Plan objectives to strategic objectives in the Trust Assurance Framework to be completed and agreed with Trust Board	Lauren Fear	6	Complete	To be discussed in February 2024 Trust Board development session to then incorporate into reporting from April onwards	11.4.24	Impact to be assessed when delivered	
06.04	Develop and implement formal Governance, Assurance and Risk Programme as part of Trust wide Organisational Development programme of work.	Non Gwilym	4	Complete	Phase 2 GAR programme in development for EMB consideration in October 2024 following endorsement of GAR Steering Group. August 2024 update: Phase 2 GAR refresh underway. Initial thoughts captured at GAR group meeting in August. Refreshed phase two for GAR group consideration in October 2024.	21-Oct-24	Impact to be assessed when delivered	The Governance, Assurance and Risk programme was established as part of the wider Building our Future Together organisational programme in October 2023. The action is effectively complete, and I suggest that we reword with the draft proposed as 06.07.
06.05	Revised reporting mechanism to be developed	Non Gwilym	4	Oct-24	Action being consolidated into the refreshed GAR programme. Propose to close the action on this basis.	18.01.25		

IMTP PRIORITY IMPROVEMENT ACTIONS - that Mitigate Trust Assurance Framework Strategic Goal Key Risks

IMTP 2024.25 to 2026.27 Service Area		2024.25		2025.26		2026.27	
Strategic Goal 1 Outstanding for quality, safety and experience	<p>Our Strategic Delivery Framework provides us with a structured approach to the translation and delivery of our strategic goals and priorities within the organisation</p> <p>Trust Purpose and Vision, aligned to</p> <ul style="list-style-type: none"> • Trust Strategic Goals • VCS Strategy and Priorities and Service Plans • WBS Strategy and Priorities and Service Plans • Support Functions Strategies and Plans 						
	<p>Building our Future Together 'Destination 2033' BOFT is an organisational development approach which is designed to identify and develop the leadership, culture, behaviours, processes and systems that we want to be.</p> <p>Delivery of the BOFT Programme:</p> <ol style="list-style-type: none"> 1. Ensure that we are organised appropriately to support delivery of strategy, which has the safety and quality of care for our patients and donors as its golden thread 2. Provide a way of working and shape to the organisation which enables us to maintain focus 3. 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 4. Draw together our organisational developments with a common sense of purpose 5. Improve our effectiveness, efficiency and value based approach 6. Develop the mechanisms which enable us to prioritise where and when we focus our efforts 7. Provide continued confidence and clarity to our staff that we are set up in a way in which ensures we can collectively deliver on the organisation's ambition 8. Support realistic, authentic and compassionate leadership 						

SECTION 1

RISK ID	07	CURRENT RISK SCORE TREND		CURRENT SUMMARY OF TAF 07	Following closing a number of key actions and their inclusion as controls, the overall risk score for TAF 7 has been reduced. Further assurances have been embedded into the TAF through external sources. Risk score trend: Score has reduced since the last reporting period.
RISK LEADS:	Jacinta Abraham Nicola Williams Anne Carey	RISK TITLE:	There is a strategic risk that Velindre Cancer Service patient outcomes / experience may be adversely affected due increasing service demands, the need for significant service delivery transformation to meet the rapidly changing and complex treatment regimes, staffing challenges, and lack of consistent quality, outcome and mortality metrics.		
RISK THEME:	Patient Outcomes	STRATEGIC GOAL:	1 -Outstanding for quality, safety and experience		

SECTION 2

RISK SCORE (see definitions tab)														
INHERENT RISK	LIKELIHOOD	IMPACT	TOTAL	16	CURRENT RISK	LIKELIHOOD	IMPACT	TOTAL	12	TARGET RISK	LIKELIHOOD	IMPACT	TOTAL	8
	4	4				3	4				2	4		

SECTION 3

Overall Level of Effectiveness: 7 Levels of Assurance(see definitions tab)				RATING	PE	Overall Trend in Assurance					
KEY CONTROLS						SOURCES OF ASSURANCE					
ID	Key Control	Owner	Preventative	Mitigating	Defective Control Effectiveness Rating	1st Line of Defence (Operational Management)	Assurance Rating	2nd Line of Defence (Executive Management)	Assurance Rating	3rd Line of Defence (Board Management)	Assurance Rating
C1	Trust Risk Register associated risk on Datix. (see section 4)			X							
C2	Capacity and demand planning and forecasting	Director VCS / COO				As per TAF 01 C7					
C3	Multiprofessional Workforce Planning which includes a workforce tool and the practice of benchmarking and incorporating Royal College guidance.	Director VCS / Director OD & Workforce	X	X	PE	Velindre Cancer Service Senior Leadership Team	IA	Executive Management Board & Quality, Safety & Performance Committee Peer Benchmarking	IA	Internal Audit, HIW, & HEIW	Not Assessed

C4	Quality and safety monitoring (Via PMF & AMaT Quality & Regulatory Tracker)	Director VCS / Exec Director Strategic Transformation, Planning and Digital / Exec Director Nursing, AHP & HCS			X	PA	VCS Quality & Safety Group / VCC SLT / Intergrated Quality and Safety Group	IA	Executive Management Board & Quality, Safety & Performance Committee Peer benchmarking	IA	Internal Audit, Wales Audit Officer & IQPD	IA
C5	Pathway delivery programme/Service Improvement Programmes: focus on delivery against national optimum pathways, reduction in variation, quality & safety priorities (via the Safe Care Collaborative), realignment of roles and responsibilities ensuring patients remain at centre of service delivery (also see TAF 01). Including Head & Neck Regional Pathway revision & revised risk based admission criteria	Director VCS / COO	X			PE	Pathways Programme VCS/ VCS Quality & Safety Group / VCS Senior Leadership Team	PE	Executive Management Board & Quality, Safety & Performance Committee Benchmarking Peer Review	NA	Regional Cancer Board, JET & IQPD	NA
C6	Effective processes in place to capture patient experience, ensuring effective listening and learning	Director VCS / Exec Director Nursing, AHP & HCS			X	PE	Velindre Cancer Service Senior Leadership Team/Intergrated Quality and Safety Group	PE	Executive Management Board & Quality, Safety & Performance Committee	IA	Internal Audit, IQPD & JET	IA
C7	Mortality review process and monitoring	Director VCS / Exec Medical Director			X	PE	Velindre Cancer Service Senior Leadership Team/Intergrated Quality and Safety Group	PE	Executive Management Board & Quality, Safety & Performance Committee Benchmarking	IA	Internal Audit & WRP Audits	IA
C8	Patient reported outcome monitoring (SST level to Board)	Director VCS / Exec Medical Director / Exec Director Finance			X	PE	Velindre Cancer Service Senior Leadership Team/Intergrated Quality and Safety Group	NA	Executive Management Board & Quality, Safety & Performance Committee Benchmarking	NA	Internal Audit	NA
C9	Velindre Oncology Academy establishment	Exec Director Nursing, AHP & HCS	X	X		PE	VOA Implementation Group	IA	Executive Management Board & Quality, Safety & Performance Committee Benchmarking	IA	HEIW Commissioning Audit, UWTSO Accreditation Audits	IA
C10	Clinical audit process and systems in place	Head of Nursing / CD VCS / Exec Medical Director	X	X	X	PE	Velindre Cancer Service Senior Leadership Team/Intergrated Quality and Safety Group	IA	Executive Management Board & Quality, Safety & Performance Committee Benchmarking	IA	Internal Audit & Wales Audit Officer Audits	IA
C11	Quality & Safety Tracker (improvement monitoring)	Director VCS / Exec Director Nursing, AHP & HCS			X	PA	VCS Quality & Safety Group / VCS SLT & Intergrated Quality & Safety Group &	PA	Executive Management Board & Quality, Safety & Performance Committee	IA	Internal Audit & Wales Audit Officer Audits	IA
C12	SACT Transformational Programme established to deliver the SACT Improvement Plan aligned to TAF1 C7	Exec Director of Nursing, AHP &HCS, Executive Medical Director, Chief Operating Officer and Director of Cancer Service.			X	PA	SACT Delivery Group	PA	SACT Steering Group & Quality, Safety & Performance Committee Benchmarking Peer Review	IA	IQPD & JET	IA
GAPS IN CONTROLS							GAPS IN ASSURANCE				ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.	
Service level to Board monitoring of national standards delivery eg. NICE							Quality & Safety Tracker continues to be refined - not at its optimum				A1	
Service level to Board integrated dashboards							Quality Metrics under development				A2	
Patient reported outcome measures across all SSTs, with service level to Board reporting							PROMa not in place				A3	
Robust and consistent administrative processes for referrals and bookings											A4, A5, A6,A7	
Regional Operational Pathway planning							Operational structure to sit underneath the newly formed regional structure					
SECTION 4												
ASSOCIATED OPERATIONAL RISKS - According to risk appetite												
DATIX RISK REF	RISK TITLE						CURRENT RISK RATING	RISK TREND				

2187	There is a risk to patient safety due to inadequate staffing within the Radiotherapy Physics Department and the need to balance core duties with developmental tasks.	15	Stable
3332	There is a risk to staff wellbeing as a result of consultants having insufficient time to undertake direct patient administration including prescribing and completion of OONs (Outpatient Oncology note) due to increase in patient clinic numbers, leading to increased email traffic and potential treatment delays	16	Stable
3392	There is a risk to the Dietetic delivery as a result of reduced staffing due to vacancies, leading to a potential impact on patient care.	16	down

SECTION 5

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
Actions also aligned with TAF 01 re capacity and demand mapping and service reconfiguration								
7.01	An electronic mechanism to be introduced to monitor compliance with relevant national standards and guidance, including NICE, delivery plans and national frameworks.	Director VCS	1	04/09/2024 Jan-25	Q-pulse being procured. Options appraisal to be undertaken to consider Blue light, Q-Pulse and AmAT systems and agree on which system would be the most effective and efficient Oct 24- Discussions remain underway with VCC paper supported by SLT to utilise AMAT to support monitoring of implementation of NICE approved drugs. paper to be shared with Executive team	20/02/2025	Change will reduce risk through having enhanced mechanisms to implement new clinical changes in a timely manner	Enhanced control and assurance
7.03	Intergrated Quality and Safety dashboards to be developed that align with PMF	Exec Director Transformation, planning, performance and digital	2	04/09/2024 31.03.2025	Initial quality, safety and outcome metrics& implementation plan underway 12 week development programme - due to conclude 31/3/25	02.02.25	Should reduce risk	Enhanced control and assurance
7.04	Value Based Healthcare patient reported outcome plan to be fully delivered (PROM measures across all SSTs agreed and electronic system implemented)	Exec Medical Director / Exec Finance Director	2	Mar-26	Implementation Working Sub-Group established within VCS. Contract signed with Promptly Health in January 2025. User stories and triggers complete for Neuro-Oncology and nearing completion with Prostate and Lung. Work underway with clinical teams to agree SST specific PROM sets where national PROMS have not been set. The programme is collaborating with WCN on this. Breast national set nearing sign-off. Triggers to be defined. When PROMS data is collected digitally it will be available within the data warehouse for analytical and reporting purposes, including at Board level. This is expected in Q1 25/26 for the phase 1 areas.	20/02/2025	Should long term reduce risk by enabling consistent capture of outcomes	Enhanced assurance
7.05	Single electronic patient referral system into the Cancer Service to be developed and implemented	Director VCS / COO	1	Mar-25	Conversations commenced with DHCW re: hospital initiated referrals, including COO and Chief digital officer. DHCW indicated potential date of April 2025. Interim position is to adopt internal supported system. Finalisation of position to be confirmed w/c 9th December 2024 moving forward within implementation working in conjunction with health board partners DHCW have confirmed this is on their roadmap - need to confirm which quarter. HBs are supportive	20/02/2025 30/04/25	Reduce risk	Enhanced control

7.06	Overall review of booking systems (including SACT) to be undertaken and revised processes implemented	Director VCS / Head of Nursing	1	Sep-24	General Outpatient Booking, process reviewed and pre and post clinic checks supported by SOP, data quality report to support management of activity, escalation process in post-clinic checks if outcome has not been provided on WCP, aligned booking clerks to SSTs to increase level of knowledge, compliance and contingency for support arrangements, co-location of SACT schedulers and outpatient bookers Work underway and dovetailing with the Cancer PTL	06/12/2024 30/04/25	Reduce risk	Enhanced control
7.07	Recommendations from SACT treatment helpline peer review to be fully implemented	Director VCS	1	Sep-24	New workforce model in place, relocation of helpline complete, amendments to clinical tool complete, funding secured for 12 months to develop patient education,.	05/11/2024	Change will reduce risk by further enhancing safety of the SACT Telephone helpline Reduce risk	Enhanced control
7.08	Transformational multi professional workforce plans across all areas of the cancer service	Director VCS	1	Mar-26	Team job planning currently taking place across the SSTs Workforce plans to support RSU being implemented with move to medical light model workforce planning taking place as part of IRS/SRU programmes within radiotherapy and as part of SACT service improvement work	20/02/2025	Reduce risk	Enhanced control
7.09	Finalise the delivery of BI solution to ensure robust service level to board mortality data monitoring in line with legislative and best practice standards	Exec Director Transformation, planning, performance and digital	1	Jun-24	Significant work undertaken in respect of mortality review oversight - SACT mortality added to PMF - Work remains underway	02.12.24	Change will reduce risk by having robust mortality monitoring leading to further reviews and identification of further areas for improvement	Enhanced control and assurance
07.10	Implement a robust mortality review and reporting infrastructure that includes reviewing how and for what cases mortality reviews are undertaken and outcomes reporting	Exec Medical Director / Exec Finance Director	1	Aug-24	As above	02.12.24	Change will reduce risk by having robust mortality monitoring leading to further reviews and identification of further areas for improvement	Enhanced assurance
7.11	Fully roll out the Q-Pulse system across all services at VCS and Trust	Interim Director VCS & Director Corporate Governance	1	Mar-25	phase 1 roll out to radiotherapy to commence January 2025. Phase 2 roll out to wider Division April 2025	05/11/2024	This enhanced document management system will reduce risk by having far greater governance in respect of SOP's, policies procedures, guidelines etc	Enhanced control and assurance
7.12	Implementation of the patient engagement framework	Director Corporate Governance e	2	Mar-25		22.3.24	Reduce risk	Enhanced control and assurance
7.13	Fully embed a robust Clinical & Scientific infrastructure including establishment of a robust multi-professional Clinical & Scientific Board	Exec Medical Director / Exec Director Nursing, AHP & HCS	2	Mar-25	Clinical & Scientific Board established. Clinical and Scientific Strategy has been approved by Trust Board (September 2024) Clinical & Scientific Board reinstated and clinical & scientific strategy delivery plan under development	02.02.25	Risk will reduce by having enhanced strategic clinical and scientific direction supporting effective prioritisation and decision making.	Enhanced control
7.14	Develop the Clinical & Scientific Strategy with a clear deliverable implementation plan	Exec Medical Director / Exec Director Nursing, AHP & HCS	1	04/06/2024 31.03.25	As above -Clinical & Scientific Manager in post - implementation plan under development	02.12.2024	Risk will be reduced by having clear clinical and scientific direction informed by research, national standards and patient / donor requirements	Enhanced control
7.15	Establish a regional delivery group to support the work from the Regional Cancer Meeting	Interim Executive Director strategic planning	2		Regional Cancer Board re-established, active participation by VUNHST	05/12/2024		
7.16	Implement a cancer PTL to track and bring together information from all clinical information systems to ensure visibility across the entire patient pathway to ensure efficient management of care pathways	chief Operating Officer/Interim Director VCS	1		paper to EMB outlining proposal, funding identified and in process of going to procurement for identified system system procured, working group taking forward implementation, live demonstration to VCS team Cancer PTL live and first phase work underway with HBS	20/02/2025 30/04/25	risk will be reduced by having single version of patient pathway	

CLOSED ACTIONS

07.02	AmAT Quality & Safety Tracker to be fully embedded as the tracker across VCS	Interim Director VCC	COMPLETE	Mar-24	Oct 24- AmAT Quality & Regulatory Tracker fully rolled out across both divisions	05.11.24	Change will reduce risk by having effective mechanisms to ensure that identified quality and safety improvements have been implemented and had the desired impact	Enhanced control and assurance (Added to controls)
7.15	Undertake a review of the management of inpatients with altered airways - including a regional working group and commissioning of an external peer review	Head of Nursing / CD VCS	COMPLETE	Aug-24	Oct 24 - Work concluded revised pathways and risk stratification processes in place - An assurance external Peer review being arranged	05.11.2024	Risk will be reduced by ensuring robust safety wrap in respect of patients with altered airways	Enhanced control (Added to controls)

SECTION 6

IMTP PRIORITY IMPROVEMENT ACTIONS - that Mitigate Trust Assurance Framework Strategic Goal Key Risks

IMTP 2024.25 to 2026.27 Service Area	2024.25	2025.26	2026.27
Strategic Goal 1 Outstanding for quality, safety and experience	<p>Clinical Quality and safety Priorities:</p> <ol style="list-style-type: none"> 1. To further develop administrative and patient communication systems to prevent patient harm and improve patient experience. 2. Mortality reviews will be completed for deaths within 30 days of SACT and 30/90 days of radiotherapy and will align with best practice. 3. To Integrate Clinical Audit within VCS Quality and Safety function 4. Development of robust Site- Specific Quality Metrics 5. To improve incident and risk management. 6. Continue to review and update the WBS Quality Management Framework, including the development of a new electronic Quality Management System 7. To Successfully Introduce West Nile Virus testing within Welsh Blood Service. 8. Introduce leucodepletion filters, Hepatitis A and Parvovirus B19 testing to support the national Plasma for medicines programme and improve supply chain resilience for plasma-derived medicines. 9. Review and improvement of donor selection and screening processes 10. Introduction of all Wales foetal D Screening for RhD negative pregnant women. 11. Introduction of electronic result transfer for deceased organ donor HLA typing results to NHSBT-ODT which will reduce risk of manual transcription of results. 12. Achieve JACIE accreditation for the WBMDR 13. Commencing rollout of live connectivity of the BECS at community- based donation clinics 14. Implement an outcome recording system for patients (digital PROMS) 		

SECTION 1

RISK ID	08	CURRENT RISK SCORE TREND	<p>TAF 08 - Current Risk Score</p>	CURRENT SUMMARY OF TAF 08	<p>Strategic Summary There are a range of factors that impact of 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.</p> <p>Operational Summary Risk score trend: The risk score has remained static since the last period.</p>
RISK LEADS:	Matthew Bunce	RISK TITLE:	There is a strategic risk that the Trust becomes financially unstable 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.		
RISK THEME:	Financial Sustainability and Long-Term Value	STRATEGIC GOAL:	1-Outstanding for quality, safety and experience 5 - A sustainable organisation that plays it part in creating a better future for people across the globe		

RISK SCORE (see definitions tab)

INHERENT RISK	LIKELIHOOD	IMPACT	TOTAL	16	CURRENT RISK	LIKELIHOOD	IMPACT	TOTAL	12	TARGET RISK	LIKELIHOOD	IMPACT	TOTAL	8
	4	4				3	4				2	4		

SECTION 3

Overall Level of Effectiveness: 7 Levels of Assurance(see definitions tab)	RATING	E	Overall Trend in Assurance
--	---------------	----------	-----------------------------------

KEY CONTROLS								SOURCES OF ASSURANCE					
ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating	
FSLTV1	Divisional Financial Outturn	Head of Financial Planning & Reporting and Head of Finance Business Partner / Budget Holders			X	E	Budget holders, reports and training	6	Divisional Finance Reports and Performance; Finance Business Partners	6	Internal Audit / External Audit	6	
FSLTV2	Quarterly Finance Reviews	Deputy Director of Finance / Head of Finance Business Partnering			X	PE	Directorate Level Budget holders, reports and training	6	Divisional Finance Reports and Performance; Finance Business Partners	6	Internal Audit / External Audit	6	
FSLTV3	Divisional Performance Review	Executive Director of Finance / Deputy Director of Finance			X	PE	Divisional Senior Leadership Teams, reports	6	Executive Finance Reports; Senior Finance Team	6	Internal Audit / External Audit	6	
FSLTV4	Executive and Trust Board Reporting	Executive Director of Finance			X	E	Executive Budget Holders / Programme SROs	6	Trust Board Finance Reporting; Senior Finance Team; QSP Committee; Trust Board	6	Internal Audit / External Audit	6	
FSLTV5	Statutory and Mandatory Financial Reporting (inc. Annual Accounts)	Executive Director of Finance			X	E	Executive Budget Holders / Programme SROs	7	Trust Board Finance Reporting; Senior Finance Team; MMRs; Welsh Costing Returns; Audit Committee; Trust Board	7	Welsh Government / NHS Executive (FP&D) / External Audit	7	
FSLTV6	Finance and Investment: Enhanced Monitoring	Executive Director of Finance			X	PE	Executive Budget Holders / Programme SROs	4	Trust Board Finance Reporting; Senior Finance Team	4	Internal Audit / External Audit	4	

FSLTV7	Collective Commissioners Review	Deputy Director of Finance		X		PE	Directorate Level Budget holders, reports and training	4	Collective Commissioning Group LTA reporting Weakness in controls identified in relation to LTA activity data capture and mapping to appropriate currencies to ensure Trust recovers all income due for work undertaken	4	LHB Commissioners	4
FSLTV8	Investment Appraisal	Executive Director of Finance / Executive Director of Strategic Transformation, Planning & Digital	X			PE	Executive Budget Holders / Programme SROs	4	Capital Planning and Delivery Group; Executive Management Board; Strategic Development Committee; Trust Board; WG Better Business Cases; HM Treasury Greenbook	4	LHB Commissioners / Welsh Government / Internal Audit / External Audit	4
FSLTV9	Financial Strategy / Medium Term Financial Plan / Budget Setting	Executive Director of Finance	X			E	Executive Budget Holders / Programme SROs	6	Trust Board and Committees	6	LHB Commissioners / Welsh Government / Internal Audit / External Audit	6
FSLTV10	Scheme of Delegation and Delegated Financial Authority	Executive Director of Finance	X			PE	Oracle Financial System Controls; Budget holders; Executive budget holders; Programme SROs	4	Trust Board and Committees; Delegated Financial Limits	6	Internal Audit / External Audit	4
FSLTV11	Value Based Healthcare programme	Executive Director of Finance / Executive Medical Director	X			PE	Value Based Healthcare project leads; VBH programme SROs	6	Value Based Healthcare steering committee / Executive Management Board, Strategic Development Committee	6	LHB Commissioners / Welsh Government / Internal Audit / External Audit	6
FSLTV12	Procure to Pay monitoring	Deputy Director of Finance / Head of Financial Operations			X	E	Requisitioners / Budget Holders	6	PSPP Group; Finance P2P reporting; Expense reporting; Expenses and Purchasing / Credit Card policy; Losses and Special Payments reporting	6	Internal Audit / External Audit	6
FSLTV13	Debtors / Cash monitoring	Deputy Director of Finance / Head of Financial Operations			X	E	Budget Holders; Private Patients lead; reports	6	Debtors Reporting; Senior Finance Team;	6	LHB Commissioners / Welsh Government (External Financing Limit) / Internal Audit / External Audit	6
FSLTV14	Discretionary Capital Financial Planning and Reporting	Deputy Director of Finance / Head of Financial Planning and Reporting			X	E	Budget Holders; Heads of Division; Divisional Directors	6	Capital Planning and Delivery Group; Executive Management Board; Fixed Assets Register Reporting	6	Internal Audit / External Audit	6
FSLTV15	Major Capital Programmes monitoring	Chief Executive			X	PE	Executive Budget Holders / Programme SROs; Scheme of Delegation and Governance Framework	4	Capital Planning and Delivery Group; Executive Management Board	4	Internal Audit / External Audit	4
FSLTV16	Counter Fraud	Deputy Director of Finance / Head of Financial Operations		X		E	Budget Holders, reports and training	4	Counter Fraud Reports; Audit Committee	6	Internal Audit / External Audit	6
FSLTV17	Tax management	Deputy Director of Finance / Head of Financial Operations			X	E	Budget holders, requisitioners, reports and training	4	Financial Operations Team; VAT working group	6	External Advisory (EY) / Internal Audit / External Audit / HMRC	6
FSLTV18	Procurement	Executive Director of Finance / Deputy Director of Finance / Head of Procurement	X			PE	Exec Directors, Divisional Directors, Budget Holders, reporting and training	4	Procurement Compliance reporting; Audit Committee	6	Internal Audit / External Audit	4

GAPS IN CONTROLS							GAPS IN ASSURANCE				ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.	
Scheme of Delegation and Governance Framework for the nVCC							Investment Appraisal assurance process improvement to ensure high quality of business case submissions and education of organisation with regards to appropriate funding routes for service developments and initiatives				F6 (Controls); F4 (Assurance)	
There is a need to be able to evidence use of medicines are providing the best value for patients							Medicines management requires more clarity on governance, decision making processes and financial implications including links between NWSSP, National forums and impact on local decision making in VCS. The Trust has a plan to implement the agreed national system Blueetq to assist clinicians in ensuring they are getting the right medications to the right patient for best value.				F2	
There are issues with the processes around LTA activity capture and mapping to currencies with some activity currently not being identified and charged to commissioners.							LTA Activity performance monitoring process currently not providing assurance that all activity is being captured and monitored against Commissioner contracts				F7	

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	CURRENT RISK RATING	RISK TREND
----------------	------------	---------------------	------------

2249	There is a risk to financial sustainability as a result of service disruption due to number of posts funded by time limited funding leading to financial instability, recruitment difficulties.	16	Stable
------	---	----	--------

SECTION 5

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
08.01	Development of VBH programme of work to identify areas of unwarranted variation and actions to improve	EDoF / EMD / COO	4	Delivery over 2024/25 to 2026/27	<p>VBH Programme of work for 2024-25 to 2025-26 agreed by Trust Board overseen by the VBH Steering Group. Assurance provided through review at SDC and QS&P Committees.</p> <p>2025-26 Objectives:</p> <ul style="list-style-type: none"> Digital PROMS platform - complete implementation. PROMS Questionnaires - continue to be develop and agree nationa sets - colorectal focus SST Data Insights Dashboard ongoing insight and awareness raising to support clinicians in reducing unwarranted variation e.g. admission rates, medicines prescribing, use of VAP service Data quality group continued review focussing on improving data quality in areas of clinical and financial risk Training, communication & engagement - communication strategy in place, training & engagement sessions undertaken; further staff members undertaking Swansea University Value in Health course <p>PROMs digital platform implementation progressing, revised date of Jun '25 for completion due to delays in commencing project.</p> <p>PROMs Questionnaires - Breast National set agreed in principle March '25; National Prostate set ammended to align with ICHOM; same Colorectal set being used in SBUHB & HDUHB - plan to adopt as national set</p> <p>SST Dashboard - embedding use and development of case studies and insight session fro breast, skin & melanoma, thyroid and VAP service to shine light on variation</p>	30.4.2025	Identification of opportunities to reduce unwarranted variation and improved allocation and utilisation of resources will support financial sustainability	Control 11 - VBHC effectiveness will improve from PE to E and assurance will be enhanced further
08.02	Continuous improvement of Finance and Investment Enhanced Monitoring reporting including identification of Savings Opportunities; Disinvestments and Choices and clear line of sight with Welsh Government Value and Sustainability Board agenda	EDoF / DDoF	4	Delivery over 2024/25 to 2026/27	<p>Savngs / Efficiencies opportunity Pipeline identified 4 areas being progressed or explored - Pre-operative anaemia pathway expansion (implementation), Medicines Management - NWSSP medicine unit supply (underway) & further areas to be identified through Medicines Strategy Group, Workforce re-design - service divisions to identify all areas of workforce model and pathway review to enable a Trust wide assessment of opportunities for efficiency and productivity improvement, Procurement reviews of non pay spend to identify opprotunities for cost improvement ir income recovery. EMB agreed SROs for each of the 4 areas to take accountability at Exec level to oversee the development and delivery.</p> <p>Pharmacy review has been conducted and was presented to Exec Management Board early in 2024. An Internal Audit review of medicines management governance (including financial aspects) was conducted in July / Aug 2024 and reported to Audit Committee in Sep '24 with substantial assurance.</p> <p>Medicines Strategy Group to be established by SRO (Medical Director) for Medicines Group. Newly appointment Deputy Medical Director will establish the Strategy Group during Q1 2025-26</p>	30.4.2025	Identification of opportunities for new savings initiatives and disinvestments / choices will support financial sustainability and reduce risk	Control 6 - Finance & Investment enhanced monitoring will improve from PE to E and assurance will be enhanced further
08.03	Development and review of Financial Control Procedures	EDoF / DDoF	6	Ongoing Delivery in 2024/25 and annually as part of IA programme	<p>Capital financial control procedure approved by Audit Committee. Financial Control Procedure update plan and pipeline for review in development.</p> <p>The final Audit Report of key financial controls was received at Dec '24 Audit Committee with reasonable assurance. Management agreed to respond to a small number of recommendations:</p> <p>Accruals & Prepayments - Finance teams will create a clear audit trail evidencing segregation of duties for preparing/reviewing prepayments & accruals, e.g. through inclusion of these tasks in the month-end finance checklist.</p> <p>Suspense Account Clearing - Senior Finance Team (SFT) agreed a timeframe of 2 years for the removal of aged items from the Unidentified Income suspense account. This approach has been agreed with Audit Wales & the Welsh Government. The account will be reviewed on a monthly basis by SFT and action taken at the year end to ensure no aged items exceeding 2 years remain.</p>	30.4.2025	Strengthened control procedures will support risk mitigation	Control 10 - Scheme of Delegation and Delegated Financial Authority will improve from PE to E and assurance will be enhanced further

08.04	Development of Investment Appraisal process and prioritisation framework	EDoF / EDoSTP&D / DDoF / DDoP	4	Investment appraisal process & prioritisation framework developed by Oct 2025	EMB Shape agreed high level criteria for assessing investment & disinvestment opportunities: 1) Strategic Fit, 2) Deliverability and 3) Value and Sustainability. Next steps are to develop specific criteria and an evaluation process aligned to the 3 areas identified. Aim to have agreed criteria and process for investment appraisal and prioritisation by Oct 2025 . Investment appraisal process, prioritisation framework and business case templates have been obtained from AB and C&V Health Boards and will be used to help inform development of the Velindre process.	30.4.2025	Alignment of investment with strategic priorities will demonstrate goal congruence and increase the likelihood of securing funding for projects / initiatives	Control 6 - Finance & Investment enhanced monitoring and Control 8 - Investment Appraisal effectiveness will improve from PE to E and assurance will change from IA to PA
08.05	Identification of business development and external funding opportunities	EDoF / EDoSTP&D / EMD / DDoF	4	Jul-25	Cardiff Cancer Research Hub financial plan review has identified that in 2025-26 costs are covered by funding but there is currently a shortfall in 2026-27 between anticipated trial & other income and forecast costs. Further work required to model additional trial activity and impact on cost and income. Private Patents Income: Liaison Financial external consultants re-engaged for Jan-Jun '25 to support the Trust in completion of remaining financial / commercial actions in improvement plan 1) negotiate new contracts with insurance companies & revisions to tariffs 2) additional activity charging separately for pathology 3) negotiation around payment of old debts. Work to also include negotiation with the Trust CAG sharing of the financial risk around PP credit loss (bad debts) and agreeing consistent charges for PP support to consultant private practice .	30.4.2025	Attracting external / alternative sources of income will decrease pressure on reliance on exchequer income thereby supporting financial sustainability and reducing overall financial risk	Control 6 - Financial Strategy / Medium Term Financial Plan / Budget Setting will become more effective and financial plans more sustainable further enhancing overall financial assurance
08.06	Develop Scheme of Delegation and Governance Framework for the nVCC	EDoF / DDoF	4	Jan-25	A Scheme of Delegation and Governance Framework has been developed for nVCC, which has cross referenced findings from PwC and Gateway reviews as well as IA reviews. The Scheme of Delegation has been updated to include links to relevant sections of MIM Governance Protocol and delegation framework for other decisions around quality & time. The Trust Board approved the n VCC Scheme of Delegation in Jan '25 . Scheme of Delegation has been implemented in the n VCC Project with delegated budgets issued to each workstream lead. This financial scheme of delegation will sit alongside the updated MIM Governance protocol to provide the integrated governance framework for the n VCC	30.4.2025	Mitigate the risks of non compliant procurement and improve budgetary control procedures by ensuring clear accountability for spend.	Control 15 - Major Capital Programmes monitoring will improve from PE to E and assurance will change from IA to PA
08.07	Data & Insights team working with Finance team and service leads to investigate where data capture and mapping to contract currencies is not working correctly. Once the issues with the process have been identified corrective action can be taken both in the short term and longer term to ensure all activity is correctly captured and charged for. Risk to be added to Datix to reflect the control weakness in activity data capture and mapping to contract activity to ensure Trust recovers all income for work undertaken.	EDoF / EDoSTP&D / COO	1	Dec '24 to Mar '25	Initial actions focussed on Radiotherapy treatment activity to understand the differences between the treatment activity recorded in the Aria planning system, Data Warehouse and the LTA performance monitoring. Actions being taken to ensure all RT treatment activity is recorded in the Warehouse and charged for through LTA performance monitoring. Work completed to ensure RT treatment activity is all being recorded in the data Warehouse and charged to LTA's. Work ongoing in relation to review of RT Treatment planning activity and mapping of that activity to LTA chargeable currencies. The RT planning work completed by 31.01.25. A wider review of the LTA currencies will be undertaken during 2025-26 to identify where the Trust needs to agree changes with its Commissioners. The assessment of 2024-25 VCS LTA income was £240k under the plan.	30.4.2025	Initial actions have led to additional activity being captured in the data warehouse and charged to LTAs.	Control 7 Collective Commissioners Review - Weakness in control systems around data capture and mapping to LTA currencies will be mitigated leading to this control effectiveness being changed from Partially Effective to Effective and Control assurance through second line of defence LTA Performance Monitoring improving from Inconclusive Assurance to Positive Assurance

SECTION 6

IMTP PRIORITY IMPROVEMENT ACTIONS - that Mitigate Trust Assurance Framework Strategic Goal Key Risks

IMTP 2024.25 to 2026.27 Service Area	2024.25	2025.26	2026.27
Strategic Goal 1 Outstanding for quality, safety and experience	The Trust will continue to review and integrate the opportunities identified at national level through the Value and Sustainability Board into the Trust's opportunities pipeline. More specifically, this will include: <ul style="list-style-type: none"> • Exploring opportunity to expand supply for other drugs working with the NWS&P Medicines Unit. • VBH Pre-operative anaemia pathway work with Health Boards will release bed capacity and plans for further expansion of the pathway to include other patient cohorts will further increase Health Board bed capacity freed-up. • Plasma for Medicine Business case if approved and funded by WG / WHHSC has potential to save c £1.5m in phase 1 on blood derived medicines used by Health Board and if phase 2 approved up to £2m saving to Health Boards. • Divisions reviewing non-value adding clinical practice or processes and changing ways of working through Value-Based Healthcare approach. Value Based Healthcare (VBHC) Initiatives via Value Intelligence Centre <ol style="list-style-type: none"> 1. Pre-op anaemia programme. This is a national initiative to address the inconsistencies in the diagnosis and management of anaemia for patients undergoing high risk surgery (specifically 10 procedures identified as being most likely to result in a blood transfusion). It has been developed in conjunction with the Wales Blood Health National Oversight Group (BHNOC). 		



Trust Board	
National People's Experience Framework & People's Experience Survey	
DATE OF MEETING	22 May 2025
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
REPORT PURPOSE	APPROVE
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	YES
PREPARED BY	Tina Jenkins, Head of Quality, Safety & Assurance
PRESENTED BY	Tina Jenkins, Head of Quality, Safety & Assurance
APPROVED BY	Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science
EXECUTIVE SUMMARY	<p>The revised National People's Experience Framework was launched via Welsh Health Circular (WHC/2024/015) in April 2025.</p> <p>The Framework advocates the adoption of an always-on approach to experience using both active and passive methodologies. This places people at the forefront by enabling experiences to be left at a time and location most convenient to the person.</p> <p>An important enhancement to the framework is the 'local self-assessment tool', which enables Organisations to assess their individual status and maturity, devise ambitious improvement strategies and plans, and ensure continuous learning.</p> <p>The Trust has established a working group to undertake the local self-assessment and develop a plan for improvement.</p>
RECOMMENDATION / ACTIONS	The Trust Board is asked to APPROVE the implementation of the national People's Experience Framework.
GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	Date:

Integrated Quality & Safety Group	23/04/2025
Executive Management Board	29/05/2025
Quality, Safety & Performance Committee	08/05/2025
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
<p><u>Integrated Quality & Safety Group:</u> The group welcomed the launch of the national People’s Experience Framework and noted the progress made on the Trust self-assessment and endorsed its implementation. The group agreed that an improvement plan would be an agenda item for May Integrated Quality & Safety Group.</p> <p><u>Executive Management Board (EMB):</u> EMB discussed the importance of the collaboration with the work and ensuring that the improvement plan is developed in line with clinical risk and service priority. Endorsed for onward approval.</p> <p><u>Quality Safety & Performance Committee (QSP)</u> The group discuss how it is important to integrate this into existing workstreams ensuring patient feedback informs service change and improvement. The committee endorsed the framework for onward approval at Trust Board.</p>	
7 LEVELS OF ASSURANCE	
N/A	
APPENDICES	
Appendix 1: People Experience Framework	
Appendix 2: Quality Impact Assessment	

1. BACKGROUND

The original national Framework for Assuring Service User Experience was initially issued in 2013 and updated in 2015 and 2018. With the aim of making the national framework more inclusive and understandable, it has been renamed and refreshed as ‘The People’s Experience Framework’. This change follows extensive engagement with third-sector organisations, Llais and NHS bodies.

The Framework advocates the adoption of an always-on approach to experience using both active and passive methodologies. This places people at the forefront by enabling experiences to be left at a time and location most convenient to the person. Health Board and Trusts were informed of the revised People's Experience via Welsh Health Circular WHC/2024/015 in April 2025.

2. ASSESSMENT

The national People’s Experience Framework (attached in **Appendix 1**) has been expanded to include a comprehensive set of tools and measures aimed at evaluating and enhancing the quality of health services. An important enhancement to the framework is the 'local self-assessment tool', which enables organisations to assess their individual status and maturity, devise ambitious improvement strategies and plans, and ensure continuous learning. This tool ensures that all aspects of the people's experience umbrella are comprehensively covered. Key components include:

- Complaints
- Compliments
- Stories
- Incidents
- National and local people’s experience (longitudinal) surveys
- People’s Experience Survey (PES)
- Lived experience/People’s groups
- Staff experiences
- Equality

A Quality Impact Assessment has been completed (please see **Appendix 2**).

2.1 Trust Self-Assessment

In readiness for the framework launch, a People’s Experience Trust-wide working group was established. The Patient and Donor Working Group undertook a scoping exercise with both divisions to identify how feedback was obtained and shared across the Trust. The self-assessment is being finalised, and an improvement plan will be developed to ensure that the Trust is fully compliant with all elements of the Framework. This will be brought back to a future Executive Management Board.

The self-assessment approach being undertaken in the Trust has been presented as an exemplar across the national networks.

The baseline self-assessment with the People’s Experience Framework was undertaken collaboratively and high-level findings are detailed below:

	Domain	Self-assessment April 2025
1	Leadership	Trust Board approved the People’s Experiences strategy in place emphasising continuous improvement, and ongoing learning.
2	Capacity & Capability to effectively collect feedback	A variety of feedback and engagement methods are in place and actively promoted and widely disseminated across the Trust.
3	Using peoples feedback to drive quality improvement and learning	The Trust actively and consistently seeks people’s experiences, and works to ensure that learning from this is embedded
4	Reporting and publication	The Trust publishes data and reports in a transparent and accessible way, including the annual Duty of Quality report.



5	Analysis & Triangulation	The Trust has a systematic method for reviewing, analysing, triangulating and learning from people’s feedback and experiences – the results are presented within publicly accessible reports
---	--------------------------	--

Key:

RED - No / insufficient evidence.

AMBER - Evidence available but may need further development.

GREEN - Sufficient relevant evidence

The Self-assessment identified that significant organisation wide collaborative working is required, to achieve full compliance with the Peoples Experience Self-Assessment. A Trust wide improvement plan will be developed and presented in May Integrated Quality & Safety Group.

2.2 People’s Experience Survey (PES)

The national set of bilingual validated core questions and measures, previously known as PREMs, has also been refreshed and renamed as the People’s Experience Survey (PES) This new survey has been rigorously tested and validated across all health settings.

Velindre Cancer Service went live with the National Survey on the 8th April 2025. This replaced the My Velindre Experience Survey.

There is a plan to review the Civica post-donation surveys in line with the PES at the Welsh Blood Service and go live in May 2025.

The Trust is also represented at the relevant national groups including the NHS Executive and the Once for Wales Team National Patient Experience Survey Task and Finish Group to guide and support NHS Wales and professionals to assist with the transition and preparation for the formal ‘Go Live’ of the People’s Experience Framework and People’s Experience Survey in April 2025.

The national survey data will be utilised by the NHS Executive and provide a National People’s Experience benchmarking opportunity. National surveys are overseen by the NHS Executive in line with the national survey road map. The governance process for national surveys is facilitated by the Once for Wales Concerns Management System Central team.

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:	<ul style="list-style-type: none"> Outstanding for quality, safety, and experience <input checked="" type="checkbox"/>



<ul style="list-style-type: none"> • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations <input checked="" type="checkbox"/> • A beacon for research, development, and innovation in our stated areas of priority <input checked="" type="checkbox"/> • An established 'University' Trust which provides highly valued knowledge for learning for all. <input checked="" type="checkbox"/> • A sustainable organisation that plays its part in creating a better future for people across the globe <input checked="" type="checkbox"/> 													
<p>RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) For more information: STRATEGIC RISK DESCRIPTIONS</p>	06 - Quality and Safety												
<p>QUALITY AND SAFETY IMPLICATIONS / IMPACT</p>	<p>Select all relevant domains below</p> <table border="0"> <tr><td>Safe</td><td><input checked="" type="checkbox"/></td></tr> <tr><td>Timely</td><td><input checked="" type="checkbox"/></td></tr> <tr><td>Effective</td><td><input checked="" type="checkbox"/></td></tr> <tr><td>Equitable</td><td><input checked="" type="checkbox"/></td></tr> <tr><td>Efficient</td><td><input checked="" type="checkbox"/></td></tr> <tr><td>Patient Centred</td><td><input checked="" type="checkbox"/></td></tr> </table>	Safe	<input checked="" type="checkbox"/>	Timely	<input checked="" type="checkbox"/>	Effective	<input checked="" type="checkbox"/>	Equitable	<input checked="" type="checkbox"/>	Efficient	<input checked="" type="checkbox"/>	Patient Centred	<input checked="" type="checkbox"/>
Safe	<input checked="" type="checkbox"/>												
Timely	<input checked="" type="checkbox"/>												
Effective	<input checked="" type="checkbox"/>												
Equitable	<input checked="" type="checkbox"/>												
Efficient	<input checked="" type="checkbox"/>												
Patient Centred	<input checked="" type="checkbox"/>												
<p>SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:</p>	Not required												
<p>TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT</p>	A Globally Responsible Wales - Consideration of whether an action may make a positive contribution to global well-being.												
<p>FINANCIAL IMPLICATIONS / IMPACT</p>	<p>Yes - please Include further detail below, including funding stream</p> <p>Potential funding or commissioning impact, needs further consideration.</p>												
<p>EQUALITY IMPACT ASSESSMENT</p>	<p>Not required - please outline why this is not required</p> <p>There has not been a National QIA undertaken.</p> <p>Organisations across NHS Wales will continue to receive support during this transition phase. The aim is to ensure that stakeholders are well-prepared and confident in implementing the new Framework and survey effectively. This includes access to resources including languages other than English and Welsh; Easy Read and British Sign Language and guidance to address any concerns or challenges that may arise.</p>												



ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The People's Experience Framework aligns with various regulations and acts, including the Health and Social Care (Quality and Engagement) (Wales) Act 2020, the National Health Service (Concerns, Complaints, and Redress Arrangements) (Wales) Regulations 2011, the Public Services Ombudsman (Wales) Act 2019, the Well-being of Future Generations (Wales) Act 2015, the Equality Act 2010, the Value Based Health Care Strategy and the Socio-economic Duty.

4. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No



Llywodraeth Cymru
Welsh Government



GIG
CYMRU
NHS
WALES

People's Experience Framework

Review date: August 2028

gov.wales

Contents

4	Aim
4	Scope
4	What is ‘People’s Experience’?
5	Health and Care Quality Standards
6	Duty of Quality – Person Centred quality standard
6	People’s Experience principles should be considered in line with the Duty of Quality
7	The use of and the difference between People’s Experience, Engagement, Patient Reported Experience Measurements (PREMS), Patient Reported Outcome Measurements (PROMs)
7	Use of Patient Reported Experience Measurements (PREMs)
8	Patient Reported Outcome Measurements (PROMs)
9	National People’s Experience Surveys
10	People’s Experience (core questions)
11	Scoring and benchmarking
11	Localised People’s Experience Feedback (Service Specific)
11	Carers/Families
11	Equality Monitoring
12	Values and staff experiences
12	Stories
12	Lived experience/people’s groups
13	Complaints
13	Incidents
13	Compliments

14	Good Practice Local Self-Assessment Tool Recommendation
16	Areas for Local Self-Assessment
21	Capacity and Capability to Effectively Collect Feedback
24	Analysis and Triangulation
26	Using People’s Feedback to Drive Quality Improvement and Learning
28	Reporting and Publication
29	Appendix A: National Surveys Process Document
30	Appendix B: People’s Experience Survey
33	Appendix C: Equality Monitoring
35	Appendix D: The Digital Stories Toolkit – Using Stories to Improve Quality

Aim

This framework is a self-assessment maturity matrix, aimed at empowering organisations to evaluate their current position and to develop

an ambitious improvement plan for people's experience through a Value lens.

Scope

This framework will encompass all services provided by NHS Wales organisations, including commissioned services. Quality and experience indicators must be integrated into all commissioned services arrangements and the data gathered used as part of contractual monitoring and compliance.

The People's Experience Framework aligns with various regulations and acts, including the Health and Social Care (Quality and Engagement) (Wales) Act 2020, the National Health Service (Concerns, Complaints, and Redress Arrangements) (Wales) Regulations 2011, the Public Services Ombudsman (Wales) Act 2019, the Well-being of Future Generations (Wales) Act 2015, the Equality Act 2010, the Value Based Health Care Strategy and the Socio-economic Duty. Listening and learning from people's experiences is an integral element of these regulations.

What is 'People's Experience'?

People's experience is 'the sum of all interactions, shaped by the culture of the organisation, staff and systems'. People's experience can be described as how people feel when using any services and programmes offered by NHS in Wales. Whether it be in a hospital ward, outpatient appointment, participation in national screening programs, engagement with primary care services (such as GP, Optometrist, Pharmacist, Dentist), interaction with health promotion practitioners, or attendance at any event hosted by an NHS Wales Organisation.

In essence, the definition of People's Experience is fundamental to Person and Population-centredness.

The integration of all strands of experience feedback relies on local expertise and resources. However, the triangulation of experience feedback data alongside other metrics, e.g. outcomes, as depicted on the Listening and Learning Tree is indicative of an organisation committed to quality.

Health and Care Quality Standards

To help us understand what excellent quality means and how we can apply it in practice, 12 Health and Care Quality Standards have been developed.

The Standards include the six domains of quality and six quality enablers. The Health and Care Quality Standards are intended to apply broadly to the wide range of services provided by the NHS in Wales.



Duty of Quality – Person Centred quality standard

Our health care system meets people's needs and ensures that their preferences, needs and values guide decision-making that is made in partnership between individuals and workforce. We care about the well-being of individuals, their families, carers and our staff. We ensure that everyone is always treated

with kindness, empathy and compassion and we respect their privacy, dignity and human rights. We are committed to working better together to put people and their families at the centre of decisions, seeing them as experts collaborating with professionals to get the best outcome and experience.

People's Experience principles should be considered in line with the Duty of Quality

- All people who use NHS Wales services, programmes or functions have the right to provide anonymous feedback quickly and easily when they want to.
- 'People's experience' is a continuous feedback stream.
- At times of distress there may be sensitivities in gathering feedback. However, people should still be able to give feedback if they choose to.
- The feedback should be used to celebrate and build on what is working well, and to identify areas where improvements could be made.
- People's experience feedback should be made readily available to the public in an accessible format.
- Information should show that feedback is being listened to and acted upon, e.g. 'You said, we did' and the Duty of Quality report.

The use of and the difference between People's Experience, Engagement, Patient Reported Experience Measurements (PREMS), Patient Reported Outcome Measurements (PROMs)

Engagement with people is different from People's experience and feedback. Although the two activities are related and overlap, engagement is the active participation of members of the public, communities or other stakeholders in service planning, delivery, and evaluation.

To ensure the prioritisation of people's experience, it is recommended that all NHS Wales organisations have in place a People's Experience Strategy.

Use of Patient Reported Experience Measurements (PREMs)

PREMs (Patient Reported Experience Measures) use a series of questions which require an overall rating or another quantifiable value. PREMs can be classified as either relational or functional. Relational PREMs show the patient's experience of their relationships during treatment, and can be disease specific e.g., did they feel listened to? Functional PREMs examine more practical issues, such as the facilities available.

As an example, the CARE measure, a relational questionnaire, is an example of a PREMs tool. PREMs require a large sample of respondents, to generate standardised aggregated and validated measurements and a supporting system which enables clinicians to view and react to individual PREMs feedback. Alongside People's Experience feedback, PREMs also support clinical effectiveness, safety, and quality improvement, and can support a Value-Based approach by combining specific disease specific PREMs with PROMs, but should not be viewed as a replacement for the 'How it felt to use any of the services, functions, and programs of NHS in Wales,' conversation.

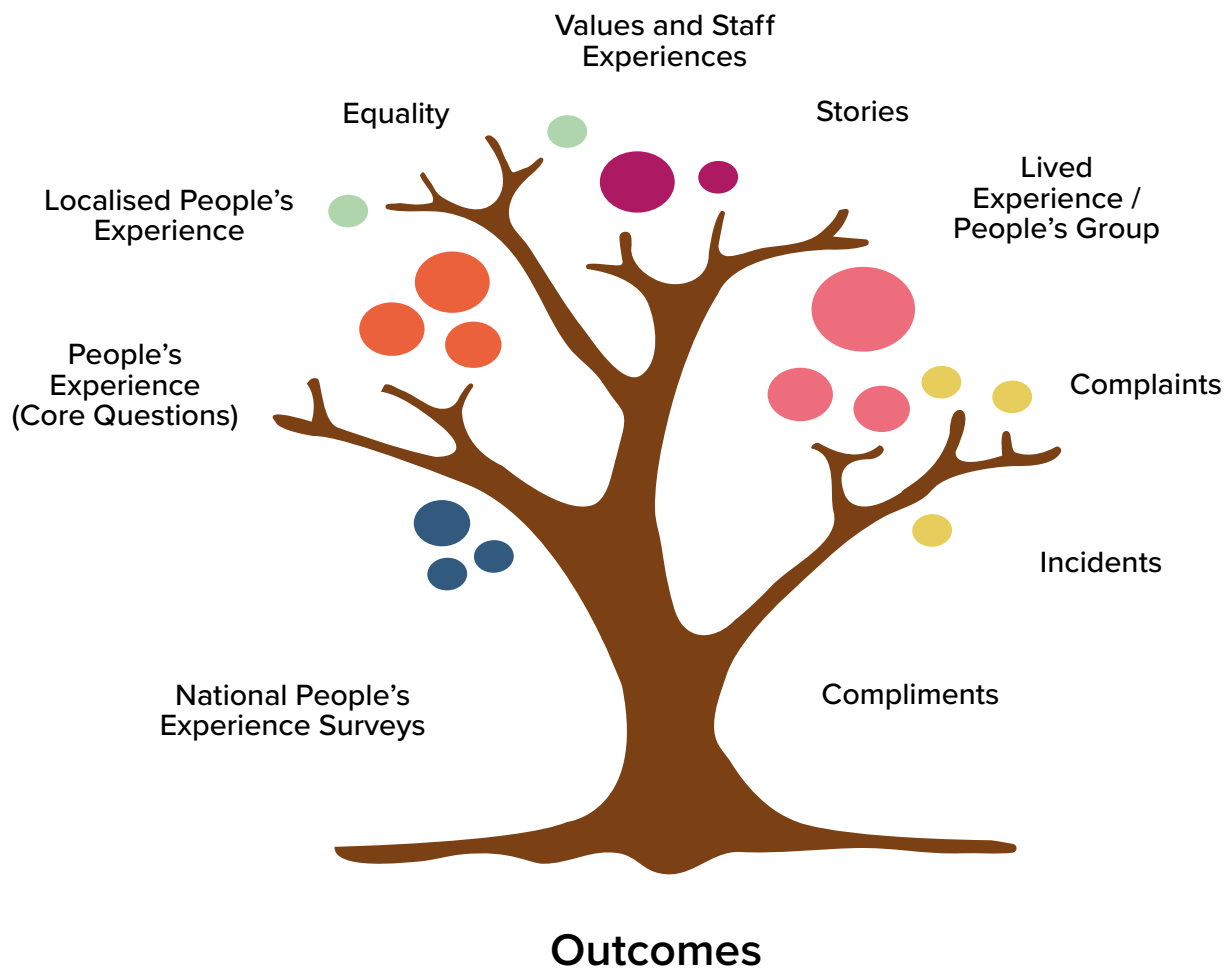
Patient Reported Outcome Measurements (PROMs)

PROMs (Patient reported outcome measures) assessments are essentially a structured communication assessment between a person receiving care and their clinical team, delivering standardised responses about symptom burden and quality of life. PROMs are one of the tools used within a wider toolkit, to evidence Value-Based healthcare, to better understand outcomes which matter most to people and

patients. PROMs are designed and evaluated for symptoms relating to specific conditions or around general health and quality of life.

In addition to PREMs and PROMs there is ongoing development of added measures including CROMs (Clinician Reported Outcome Measures) and SROMs (Staff Reported Outcome Measures).

Listening, Learning and Improving Tree



National People's Experience Surveys

National surveys are developed at the request of clinical areas of work and in conjunction with the NHS Wales Executive Team. There is an approval process set up, (please see Appendix A) to support the development and inclusion of national surveys within the Once for Wales Experience System. Where applicable, all organisations will engage in the national survey approach in line with the Duty of Quality 'always-on' reporting and share with people and communities via local websites, the feedback received and any service improvements that have been undertaken because of the feedback.

Information collected via national surveys will remain the responsibility of clinical areas and organisations supporting the collection. The information will also be used to populate the NHS Wales Executive Quality Dashboard.

People's Experience (core questions)

A Welsh people's experience core set of questions has been developed. Every effort should be made to use the people's experience core set of questions in all experience and feedback surveys, the core set of questions are listed below. In circumstances where people in receipt of services cannot directly provide feedback, consideration should be made for the views of family, friends, and carers (unpaid) to be gathered.

1. How would you rate your overall experience?

- Very poor
 Poor
 Neither good nor poor
 Good
 Very good

2. Was there anything particularly good about your experience you would like to tell us about?

3. Was there anything particularly bad about your experience you would like to tell us about?

4a Which language would you prefer to communicate in?

- Welsh
 Urdu
 Gujarati
 English
 Portuguese
 Italian
 Polish
 Spanish
 British Sign Language
 Romanian
 Arabic
 Other, please specify
 Panjabi
 Bengali

4b Were you able to communicate in your preferred language?

- Always
 Usually
 Sometimes
 Never

Scoring and benchmarking

An All-Wales scoring structure has been agreed upon for the Likert-based question 1, which organisations should use to benchmark, learn from each other, and make publicly available in the spirit of the Duty of Quality.

Response	Weight
Very good	10
Good	7.5
Neither good nor poor	5
Poor	2.5
Very poor	0
I don't know (if included)	N/A

Localised People's Experience Feedback (Service Specific)

Locally requested surveys should reference the National People's Experience question set, included in Appendix B (where appropriate). At a minimum, all local experience and feedback surveys are required to include the people's experience (core questions) question set.

Carers/Families

Carers/Families play a valuable role in the health and well-being of their loved ones and their contribution often goes beyond the cared for and impacts wider society and services. The contribution and role the carers play in the health and well-being of a loved one is sometimes not fully acknowledged. It is often the carer who organises appointments, arranges transportation, plays a role in explaining

information to the patient, assists with medication, as well as helping with a host of other important tasks. This level of involvement places carers in a unique position to share their experiences of services and People's Experiences surveys should be developed to allow carers to offer their feedback.

In addition, the impact of a patient's illness on a carer/family member's own health and well-being has proven to be both widespread and severe and organisations should consider the availability of a FROM (Family Reported Outcomes Measure) type questionnaire. The development and availability of such questionnaires should always be linked to the organisational ability to provide signposting and support.

Equality Monitoring

Health outcomes and experiences are often influenced by the protected characteristics of our people and communities. To support the identification of varying experiences, **all** experience and feedback surveys across NHS Wales should include a nationally agreed set of demographic and diversity (through a quality lens) questions which are included in Appendix C.

These questions should not be compulsory to answer and a clear explanation of how the data will be used and stored should be set out in the survey/questionnaire introduction. Robust processes to support the analysis of information should be developed at a local level and ensure the information provided does not affect individual access to services or care.

Organisations should also develop processes which help the capture of the demographic and diversity information of those people who have raised a complaint (at a time most appropriate).

It is expected that each organisation will have processes in place to support the analytics of information being collected to provide an extra layer to the experience data and be used to support wider quality, improvement, and engagement of communities.

Values and staff experiences

People's experience is 'the sum of all interactions, shaped by the culture of the organisation, staff and systems. The same definition can be applied to staff and put simply, staff and people's experiences are two sides of the same coin. Organisational culture and staff experiences are intrinsically linked to people's experiences. Staff are proud to work for the organisation and speak highly of the culture. Staff throughout the organisation feel able to raise concerns and believe they will be listened to and supported.

We understand that asking people 'What matters to you' instead of 'What's the matter with you' makes a significant difference to their overall experiences of NHS Wales services. How much more difference could we make if we started asking our staff a similar question: 'What matters most to you?' We should remind ourselves that this relationship could be one of the most important moves the NHS Wales makes to drive better productivity and improve experiences of care for the entire population of Wales.

The expectation is that organisations will work with Human Resources, Finance Organisational Development and Planning, Value-Based Healthcare and Data and Analytical teams to establish a work programme, which includes triangulation of data to drive improved outcomes and experiences for people through improving staff experience.

Stories

We cannot ignore the importance of conversations and narrative-based contributions in supporting quality and improvement. The use of people, communities and staff narratives should be embedded across all NHS Wales organisations.

There is an expectation that organisations will have processes in place to allow them to capture and listen to people's stories. These stories should be shared at Committees and Board meetings, in addition to being used as part of staff training and organisational awareness.

To support the collection and thematic analysis of stories from across NHS Wales, it is expected that all organisations contribute to the All-Wales NHS Digital Story Library. To support organisations the NHS Wales Digital Story toolkit is included in Appendix D.

Lived experience/people's groups

Lived experience refers to the unique and personal encounters, perspectives, and insights that individuals gain through direct involvement in particular situations or circumstances. It encompasses the real-life experiences, emotions, challenges, and lessons learned by individuals as they navigate various aspects of their lives. Lived experience is deeply subjective and can be influenced by a person's background, culture, beliefs, and personal circumstances. In various contexts, such as healthcare, social services, or advocacy, lived experience is valued for its authenticity and its potential to offer valuable insights and inform decision-making processes.

It is expected that all organisations consult with their lived experience/people's groups, and this is triangulated as part of their people's experience feedback.

Complaints

Complaints are a part of the experience feedback family and are an expression of dissatisfaction, which is significant enough to prompt the person to raise the matter.

An exemplary organisation will include experience and other sources of feedback so that action can be taken quickly where required. Hotspots can be easily shown and reported to senior leadership, Committees, Board meetings and the public in an accessible format.

Complaints are managed through the robust policy framework and processes of 'Putting Things Right Regulations'. The principles of 'Always on' should be aligned to the sphere of complaints.

Incidents

Clinical incidents refer to unintended or unexpected events that occur during the provision of healthcare services and have the potential to cause harm to patients, staff, or visitors. These incidents can range from errors in medication administration to communication breakdowns, equipment malfunctions, or adverse reactions to treatments. Clinical incidents are typically analysed to understand their causes, prevent recurrence, and improve patient safety and quality of care. Incident reporting and investigation systems are commonly used in healthcare settings to find and address clinical incidents promptly. Incidents should be considered in the triangulation of feedback methods.

Compliments

Compliments are an unsolicited expression of gratitude. People invest their time to leave a compliment in the hope that the behaviours they experience are repeated and routinely available to others. The comparison of compliment and complaint numbers in isolation from the contextual narrative has minimal benefit when looking to support quality and improvements. To support a mutual understanding of what constitutes a compliment and to ensure all NHS Wales Bodies maximise the capturing of compliments, common definition of a compliment is provided below:

'A positive or appreciative statement about any individual NHS Wales staff member, services, programme, or function, which includes the expression of praise, admiration, or congratulations which goes beyond common courtesy. This can be received through a variety of means including verbal and written'.

It is expected that all NHS Wales Bodies develop and implement a robust 'Always on' system for the collection of compliments within easy reach for all people and communities. Organisations should also develop processes which support learning from compliments, processes to recognise areas and staff who are mentioned in the compliment, processes to share good practices highlighted within compliments wider in the organisation.

Good Practice Local Self-Assessment Tool Recommendation

It is recommended that all NHS Wales Bodies complete a local self-assessment Red Amber Green (RAG) rating score for each element of the framework as a basis for local quality and improvements.

National assurance is overseen by NHS Executive Wales.

1. Review each criteria statement and identify the range of evidence available which supports each statement. Ask yourself questions such as:

a. How embedded is the process which supports this criterion?

b. Are we consistent across the organisation/ service as a whole?

2. Then judge the strength of the evidence through a RAG rating –

Red No / insufficient evidence.

Amber Evidence available but may need further development.

Green Sufficient relevant evidence.

Where you have judged the evidence available to support the criteria as **Red**, then this is an area for development/exploration and should be included in your organisation's development plan. The **Amber** criteria will also need to be addressed before assessment, **but if you have ten or more Red criteria focus on these first before adding the Amber criteria to your improvement plan.**

Criteria	Name of person/team completing the self-assessment	Date self-assessment undertaken	What we have in place	Our Rating Red Amber Green	Areas for focus/ improvement in next 12 months	Date of reassessment	Name of group/ committee to receive self- assessment outcome
Leadership							
Capacity and capability to effectively collect feedback							
Analysis and triangulation							
Using people's feedback to drive quality improvement and learning							
Reporting and publication							

Areas for Local Self-Assessment

Leadership

The Board and senior leadership show their dedication to prioritising people's experience in all their initiatives. They work towards enhanced collaboration, ensuring that all individuals play a crucial role in the decision-making processes, to achieve the best possible outcomes and experiences.

Leadership promotes a culture defined by compassion, empathy, and kindness while upholding principles of privacy, dignity, and human rights. These values and behaviours are actively embraced by all members of the workforce.

Characteristics	Suggested requirement needed to meet the characteristic	What will good look like?
The organisation has a strategically endorsed document by the Board aimed at enhancing people's experiences. This document advocates for a system-wide strategy emphasising quality, continuous improvement, and ongoing learning.	<p>The organisation has a People's Experience Document, collaboratively developed with input from individuals and communities, with consultations involving all staff and relevant stakeholders.</p> <p>This document undergoes approval through the organisation's governance process.</p> <p>The People's Experience Framework is designed to be seamlessly aligned with and integral to the Duty of Quality, Health and Care Quality Standards, and Duty of Candour. This approach reflects a commitment to value-based healthcare.</p>	<p>The organisation aims to establish an approved document outlining people's experiences. This document should be easily comprehensible for individuals, communities, and staff.</p> <p>The People's Experience Document is expected to exhibit harmony with other essential policy documents and plans, such as the Quality Strategy, Equality Plan, and others.</p>
The Board can show evidence of actively listening to feedback from individuals and undertaking measures where appropriate to enhance both the experience and the quality of service.	<p>A variety of feedback and engagement methods are in place, actively promoted and widely disseminated.</p> <p>Every staff member is involved, contributing their insights to the development of services and efficiency changes, with a focus on understanding how these changes impact individuals, communities, and staff.</p>	Evidence in public reports of listening, reporting, and acting upon feedback e.g., 'you said, we did,' in line with the Duty of Quality.

Characteristics	Suggested requirement needed to meet the characteristic	What will good look like?
<p>People's experience is integrated into all leadership development initiatives, encompassing efforts by everyone involved. This fosters a culture dedicated to continuous learning and improvement, prioritising quality, safety, and experience.</p>	<p>All leaders and senior managers actively contribute to an efficient quality management system, possessing the requisite skills, knowledge, and values to provide person-centred services. In addition, leaders and senior managers take proactive steps to incorporate learning, quality, and experience into leadership development, staff objectives, appraisals, and other relevant processes.</p>	<p>The organisation can show the use of Peoples Experience feedback in decision-making and planning and delivery of services.</p> <p>The organisation can provide tangible evidence of incorporating people's experience into the decision-making process and the planning, and delivery of services.</p>
<p>The senior leadership team is visible, with a designated Executive Director taking accountability for leading quality, and people's experience to ensure that the organisation fulfils its Duty of Quality and obligation to promote active listening and learning from experiences and feedback.</p>	<p>The Executive Lead or nominated deputy for people's experience consistently helps discussions on experience and regularly presents comprehensive reports to the Board. Proactively taking charge of this domain within the organisation, the nominated lead ensures that people's experiences (including stories) become a routine feature in various meetings, including those held by the Board and its sub-committees.</p>	<p>People's experiences and the corresponding actions are disclosed in the Board and other published reports.</p> <p>People's experience reports cross-reference various experience/ feedback sources, including compliments, general feedback, satisfaction ratings, complaints, and Value-Based healthcare. Information e.g. (PROMS/PREMS), incorporating both goals and shared decision making tools</p> <p>Lived experiences of people along with associated learnings and actions, are shared both internally and externally. This information is balanced with staff experiences and stories.</p>
<p>The organisational development strategy and implementation plans are underpinned by a commitment to improve people's experiences.</p>	<p>People's experience is integrated into the organisational development strategies. This should also include ensuring that our staff are trained and equipped to engage and work collaboratively with our public and communities.</p>	<p>There is recognition that staff experience is critical to people's experience and service quality. This should be referenced in key documents such as IMTPs, and Patient Experience (People's Experience) Strategies.</p>

Characteristics	Suggested requirement needed to meet the characteristic	What will good look like?
<p>The organisation values and celebrates innovation by staff that demonstrates a consistent approach to people's experience and quality improvements.</p>	<p>Staff are supported by senior managers and colleagues to listen and act locally as a response to feedback and the organisation routinely captures, analyses and reports on the outcomes from any quality improvement work.</p> <p>Monitoring takes place against the results of the staff and people experience surveys.</p> <p>Staff behaviour is compassionate, involves people and communities in decision-making and provides good emotional support to people.</p>	<p>Innovations are recognised within a wide range of policies, procedures, and reports to the Board.</p> <p>Also celebrated and recognised at staff awards; appraisal; Research and quality improvement programmes.</p> <p>There are opportunities for shared learning throughout the organisation and wider, including the opportunity to share good practices and learn from mistakes.</p> <p>Staff training includes opportunities to understand and embed:</p> <ul style="list-style-type: none"> • compassionate leadership and culture within the organisation • positive feedback – learning from compliments. <p>People and communities are involved in staff training through a variety of means including lived experience stories to delivering the training. Active involvement of people and communities at NHS Wales meetings can positively impact outcomes and contribute towards raising staff awareness.</p>

Characteristics	Suggested requirement needed to meet the characteristic	What will good look like?
<p>Organisational culture and staff experiences are intrinsically linked to people's experiences. Staff are proud to work for the organisation and speak highly of the culture. Staff throughout the organisation feel able to raise concerns and believe they will be listened to and supported.</p>	<p>The organisation has developed, with people and staff, a set of values, articulated through all corporate documents, which reflect the values of NHS Wales.</p> <p>The organisation has a process for ensuring values are owned by staff.</p> <p>The organisation has in place a values-based recruitment and appraisal system.</p>	<p>Organisations have an agreed and published Values and Behaviour Framework that has been developed with staff, people, communities, and all relevant stakeholders.</p> <p>Person-centred care/provision (population-centredness) is a core element of the organisation's values and promotes a co-productive way of working.</p> <p>Standards for values and behaviours are part of recruitment, interview processes, staff Job descriptions, role profiles and appraisal.</p>
<p>The organisation expresses its commitment to engaging with people and communities through all its communications. This is per the Duty of Quality.</p>	<p>The organisation's website and other externally facing communications are accessible and clear and people would judge them to be user-friendly. They also articulate a commitment to person or population-centred services and programmes.</p> <p>People and communities are actively involved in the development, production, and review of all public-facing health (including promotion) and well-being information.</p> <p>People and communities can access correspondence relating to their health or care in an accessible format suitable for their needs.</p>	<p>Communication is available bilingually in a range of formats (Welsh and English) but should also include user-friendly and jargon-free easy-to-read information, BSL, audio and language of choice. Organisational websites are designed to use language that is clear in meaning and jargon-free.</p> <p>Public-facing information relating to an individual's or community's health and well-being is developed in line with good practice and is subject to stakeholder review before publication. Stakeholder review is inclusive and relevant to the people and communities who would access the information.</p>

Characteristics	Suggested requirement needed to meet the characteristic	What will good look like?
		<p>Organisations compliance in line with the Accessible Information and Health Care and Quality Standards. Every organisation shows how they will implement, comply, and monitor the Accessible Information Standards.</p> <p>Feedback from staff, people and communities is routinely gathered and includes feedback on whether information and communication are accessible.</p>

Capacity and Capability to effectively collect feedback

The organisation has several routes through which People and Communities can provide feedback.

Characteristics	Suggested requirement needed to meet the characteristic	What will good look like?
<p>The organisation ensures that people's experiences and overarching themes are at the core of all surveys, including post-discharge surveys. It collaborates with teams to devise and execute rapid, real, or near-real time feedback processes.</p>	<p>The organisation fully adheres to all mandated mechanisms and has a comprehensive programme dedicated to looking for rapid, real-time experience and feedback from individuals, utilising the most up to date technology available to them.</p>	<p>A unified system for Wales should facilitate benchmarking across organisations and support real-time feedback through various channels, such as SMS, IVR, online platforms, paper, etc.</p> <p>Organisations are encouraged to consider reframing the question from 'What's the matter?' to 'What matters to you?' This shift in focus aims to prioritise and address the individual's concerns and preferences.</p>

Characteristics	Suggested requirement needed to meet the characteristic	What will good look like?
<p>The organisation has established an accessible experience and feedback process that aligns with national guidance and regulations.</p>	<p>The organisation has implemented accessible and user-friendly feedback processes, enabling individuals to easily submit compliments, provide feedback, or raise concerns in their language of choice. Information related to these processes is prominently displayed and accessible across all locations and formats (website and display screens etc).</p> <p>Organisations have in place a systematic process for capturing experiences, feedback, and concerns specifically about how complaints are handled and the overall process. There is unambiguous evidence that feedback is consistently collected, and the organisation has implemented changes in practice.</p> <p>Moreover, these improvements have been sustained over time.</p>	<p>There is robust national guidance and widespread awareness of experience and feedback systems throughout the organisation, both internally and externally, with a particular focus on reaching seldom-heard communities. Clear visibility is ensured through the availability of leaflets and posters in bilingual formats (Welsh and English), and other languages in line with local population needs. In addition accessible formats, including Easy Read, British Sign Language (BSL), audio should also be made available.</p> <p>The organisation can provide evidence of collecting experience and feedback regarding the concerns process. Furthermore, they can demonstrate tangible improvements made because of the gathered experience and feedback.</p> <p>Feedback is systematically collected monthly, and there is documented evidence of improvement (where appropriate). This information is presented within the organisation and externally to the public.</p>
<p>All staff take ownership of and promptly address feedback and concerns at the earliest opportunity. Clear information is provided, and support is extended when individuals express a desire to provide feedback or raise a concern.</p>	<p>All staff are supported by their colleagues in addressing concerns raised by individuals, and there is a structured process for teams and the broader organisation to share and learn from these experiences.</p>	<p>All staff are empowered to reflect on all feedback and receive support to enhance the experiences of individuals. The organisation has clear processes in place to escalate, share, and learn from all feedback.</p>

Characteristics	Suggested requirement needed to meet the characteristic	What will good look like?
<p>Duty of Candour</p>	<p>Staff comprehend and act upon the Duty of Candour as outlined in the Health and Social Care (Quality and Engagement) (Wales) Act 2020.</p> <p>The significance of experience and feedback is integrated into the organisation's approach to staff training.</p>	<p>All staff members, including those who are front facing or involved in service development, have completed Duty of Candour training.</p> <p>The organisation can provide evidence of being open and honest with people and communities when things go wrong.</p> <p>Training on experience feedback is incorporated into all sides of the organisation, including induction processes, leadership development programs, and staff appraisals.</p>
<p>People are provided with information about the various avenues via which they can leave feedback, encompassing paper-based surveys, comment cards, web platforms, text messages, devices, kiosks, and apps.</p> <p>Staff support individuals in utilising these approaches, ensuring consideration for the needs of those who may be less able or less willing to provide feedback.</p>	<p>The organisation disseminates information to individuals in multiple ways to provide feedback. People are informed about various avenues available to them as routes for sharing their experiences and feedback.</p> <p>The organisation utilises a variety of methods to collect feedback from people, tailoring these approaches based on individuals' needs and preferences.</p> <p>Staff members are well-versed in these methods and actively encourage and support people in providing feedback.</p> <p>Organisations are encouraged to establish experience/feedback Quality Indicators (QIs) for all public-facing services, and programmes in alignment with the People's Experience Framework. These should support quality improvements and be reported internally within the organisation while also being made available externally to the public.</p>	<p>The organisation can demonstrate it has in place various accessible methodologies and routes for the capture of people's experiences.</p> <p>Organisations can demonstrate a quality improvement approach to introducing new routes for capturing people's experience and evidence learning which has resulted in improvements.</p> <p>Staff can direct people and communities to a variety of feedback routes.</p> <p>The QIs along with all performance-related information should be made available on websites and in reports in a format which is easily understood. Also, in the case of online, the information should be easy to find.</p>

Analysis and Triangulation

The Organisation has a systematic and consistent approach to analysing and making sense of feedback (qualitative and quantitative) and considers it alongside safety and outcomes data.

Characteristics	Suggested requirement needed to meet the characteristic	What will good look like?
<p>The organisation has implemented a systematic method for analysing feedback and experiences gathered in various forms.</p> <p>Additionally, the organisation has dedicated analytics and intelligence support for its experience data, generating clear and helpful reports.</p>	<p>The organisation routinely and systematically analyses all forms of feedback and experience, consolidating all strands and identifying themes upon which it acts.</p>	<p>The organisation employs real-time sentiment analysis to identify opportunities for early resolutions.</p> <p>All forms of feedback and experience undergo triangulation with various other outcome measures and are included in quality and assurance reports across the organisation, as well as in other public reports. Quantitative data, when available, is graphically plotted over time to provide a visual representation of trends.</p> <p>Demographic and diversity information is analysed aligned to the experiences themes to identify any variation and support improvement or engagement work (as required). The data is translated into business intelligence, informing meaningful quality improvement actions and engagement (where appropriate).</p>
<p>The organisation generates reports displaying the correlation between enhancing outcomes, safety, and the experience of people. This information is routinely triangulated with data from staff surveys, providing a comprehensive perspective on overall performance.</p>	<p>Reports explicitly highlight themes where people's experiences correlate with other quality measures.</p> <p>Organisational reports clearly articulate these relationships and outline the quality improvement actions that result from the analysis.</p>	<p>All forms of feedback and experience undergo triangulation with a variety of other outcome measures and are incorporated into organisational quality and assurance reports. This information is also included in other public reports.</p> <p>A robust relationship is maintained with services and teams to ensure that feedback, wherever feasible, translates into improvements. This collaboration involves staff from a range of disciplines across the organisation.</p>

Characteristics	Suggested requirement needed to meet the characteristic	What will good look like?
<p>The organisation adeptly employs experience data to efficiently identify and pinpoint areas of deteriorating performance, facilitating prompt action to address the underlying causes.</p>	<p>The organisation proficiently utilises experience and feedback data as an early warning system for declining standards. This enables leaders at various levels to detect concerns and implement quality improvement approaches promptly.</p> <p>The organisation utilises data related to experience and engagement to comprehend variations.</p> <p>Experience is fully aligned with and integral to quality improvement efforts.</p>	<p>Trend graphs are employed to identify abnormal activity within the feedback system. Additionally, alerts are set up to trigger actions promptly in response to key concerns. This system helps in staying vigilant to emerging issues and taking timely corrective actions.</p> <p>All quality improvement processes unequivocally demonstrate the utilisation of experience data. The insights derived from the data play a leading role in shaping and enhancing the organisation's quality improvement initiatives.</p>
<p>Experience and feedback information is routinely taken into consideration and acted upon by all teams. When a larger scale service redesign is necessary, such feedback is appropriately escalated and incorporated into the decision-making process.</p>	<p>Services, programmes, and functions receive feedback promptly and in a format that is suitable for their users.</p> <p>Organisations regularly engage in discussions about the data and leverage it for quality improvements.</p> <p>The organisation has an effective approach to celebrating and sharing local learning.</p>	<p>The organisation should have access to a quality management system where data is live and in real-time, providing them with immediate and up-to-date insights. The quality management system should encompass all sources of experience and feedback.</p>

Using People's Feedback to Drive Quality Improvement and Learning

The organisation actively and consistently seeks experiences and feedback from people to foster a learning culture underpinned by quality and service improvement initiatives.

Characteristics	Suggested requirement needed to meet the characteristic	What will good look like?
<p>The organisation actively and consistently seeks people's experiences to foster a learning culture underpinned by quality and service improvement initiatives.</p> <p>There is evidence that the organisation uses these experiences and feedback, and staff are aware that people's experiences are central to influencing quality improvement. Moreover, people are actively engaged as equal partners in the decision-making processes, service plans and evaluation.</p>	<p>Staff demonstrate a good understanding of the theory and practice of shared decision-making with people, and its principles are reinforced through education and training programmes.</p> <p>People are actively involved in all aspects of their health and possess an understanding of the expectations related to their health and well-being.</p> <p>The organisation has a mechanism in place to capture whether people felt involved in decisions about their own or their communities' health and well-being.</p> <p>The organisation has a mechanism in place to capture whether people felt involved in service, programme design or evaluation.</p>	<p>Staff, including those who are front-facing or involved in planning, service development or quality improvement, have undergone education and training for shared decision-making.</p> <p>Public information incorporates health decision information.</p> <p>Clinical and public information are designed to reflect shared decision-making principles, emphasising collaboration between healthcare professionals and the public in the decision-making process.</p> <p>The organisation can evidence and make public, people's involvement right from the outset, highlighting a commitment to hearing and listening.</p>

Characteristics	Suggested requirement needed to meet the characteristic	What will good look like?
<p>The organisation employs quality improvement methodology and tools as part of an ongoing process to enhance services, programmes, and functions continuously.</p>	<p>Staff actively engage in quality improvement skills to identify problems, carry out tests of change, measure their impact, and act on the results.</p> <p>The organisation empowers all staff by providing the opportunity to contribute and act on ideas for quality improvement, with a clear process for measuring their impact through experiences and feedback.</p> <p>The organisation actively benchmarks and can demonstrate the utilisation of people's experience to make informed decisions.</p> <p>This involves comparing its practices and outcomes to identify areas for improvement and implement informed decision-making processes. (e.g., National People's Experience Surveys, Core Questions or Lived Experiences/People's groups).</p>	<p>There is evidence of education and training courses designed to support Quality Indicators (QI's) in service improvement, in line with the Duty of Quality.</p> <p>Organisations should have a process in place to ensure the public is informed about how their experiences and feedback have influenced change. This involves transparent and accessible communication to demonstrate the impact of public input on organisational decisions, evaluations, and improvements.</p> <p>Organisations can evidence how their Lived Experience or People's groups have supported the identification of shared learning and quality improvements. This should be included in the Duty of Quality report, and all other appropriate reports and made available to the public in an easy-to-find and accessible format.</p>

Reporting and Publication

The organisation regularly reports and publishes its people's experience data and co-produces its quality improvement plans with a range of stakeholders including the public, statutory and voluntary organisations, and the organisation's staff group.

Characteristics	Suggested requirement needed to meet the characteristic	What will good look like?
People's experience should be a key component of organisational reports in line with the Duty of Quality.	Relevant reports include information about people's experiences and how the organisation has encouraged feedback, listened to, and is responding to people's experiences, including examples of improvements.	The organisation's Annual Quality report, Improvement, engagement, equality report, Duty of Candour and Putting Things Right reports include examples of how the organisation responds to experiences and feedback. In the case of Incidents/Complaints/Duty of Candour/Inquests, this would include the post-experiences of the handling process.
The organisation routinely publishes transparent and publicly accessible information within easy reach (e.g. 2 clicks) about people's experiences and the organisation's response to feedback (and ensures this information is accessible through multiple routes).	Information is available and accessible via a range of formats and platforms. This should include the accessibility requirements of seldom-heard communities and communities with low socio-economic backgrounds and communities with sensory loss.	The Annual Quality reports, Improvement, Engagement, Equality report, Duty of Candour and Putting Things Right reports should be available via a range of appropriate formats and platforms.
The organisational reports reflect the feedback offered via all external bodies e.g., Llais (Citizens Voice Body), Health Inspectorate Wales, Public Service Ombudsman Wales, and any other regulatory/ statutory body.	Reporting demonstrates that representations made on behalf of the public and feedback to the organisation have been incorporated and considered.	The organisation will review its communication channels to ensure it promotes the role of all regulatory/ statutory bodies in producing reports.

Appendix A: National Surveys Process Document

National Surveys are overseen by the NHS Executive in line with the national survey road map. The governance process for national surveys is facilitated by the Once for Wales Concerns Management System Central (OfWCMS) team.

- The person or group proposing the national survey is responsible for liaison and engagement with the appropriate Executive Director in each organisation to gain support for the national survey to be undertaken.
- The person or group proposing the national survey will attend the Safety & Learning WRP People's Experience Feedback Network meeting to present their survey.
- A national survey request form must be completed and submitted, with the relevant survey questions, to the Once for Wales Concerns Management System Central (OfWCMS) team via email: OnceForWales.CMS@wales.nhs.uk.
- The OfWCMS team will acknowledge receipt of the request form and survey and arrange for the person or representative of the group proposing the national survey to attend a National Editorial Board meeting.
- All proposed national surveys will be presented to the National Surveys Editorial Board.
- Once approved by the National Surveys Editorial Board the national survey request form will be signed by the National System lead for Experience Feedback Wales System and stored by the OfWCMS Central team.
- The person or group proposing the national survey will need to have the survey translated into Welsh and any other language that they wish the survey to be deployed.
- The OfWCMS Central team will liaise with Feedback Experience System Leads and the supplier to progress the various stages required.
- The person or group proposing the national survey will be responsible for identifying and liaising with the teams within the organisations who will roll out the survey locally.
- The teams who will roll out the survey locally will be responsible for liaising with the Feedback Experience system lead within the organisations to ensure weekly feedback reports are set up correctly.
- The OfWCMS Central team, Feedback Experience System Leads, supplier, the person or group proposing the national survey and the teams responsible for the roll out of the survey locally, will agree a launch date.
- The supplier will, at an agreed time, facilitate the transfer of the data received from the survey held in organisations systems, to the national analytical tool.
- Access to the national analytical tool and to the data generated from this system will be managed by the OfWCMS Central team in accordance with the arrangements agreed by the National Surveys Editorial Board and following GDPR Principles.
- The OfWCMS Central team, will work with the Feedback Experience System Leads, supplier, the person or group proposing the national survey and the teams responsible for the roll out of the survey locally, to agree data sets for national reports to be generated both in the national analytical tool and in local systems.

Appendix B: People's Experience Survey

Your NHS Wales Experience

The experience that you have of care is important to us. This might be an appointment with your doctor or health visitor, a hospital stay, an outpatient visit or something else. We would be grateful if you could complete this survey so that we can understand this better.

The questions are based on the things that patients have said matter most. We will ask you questions about **your latest experience of healthcare**. Please help us by giving your honest opinion.

The questions mostly have four options and you are asked to tick the answer that you feel best describes how you feel.

How recent was the experience you are thinking of?

- In the last week Between 1 month and 6 months ago
 Between a week and a month ago More than 6 months ago

Thinking about this experience:

1. Was the time you waited:

- Much shorter than expected A bit shorter than expected About right
 A bit longer than expected Much longer than expected

2. Did you feel well cared for?

- Always Usually Sometimes Never

3. Were you treated with dignity and respect?

- Always Usually Sometimes Never

4a. Which language would you prefer to communicate in?

- | | | |
|-----------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Welsh | <input type="checkbox"/> Urdu | <input type="checkbox"/> Gujarati |
| <input type="checkbox"/> English | <input type="checkbox"/> Portuguese | <input type="checkbox"/> Italian |
| <input type="checkbox"/> Polish | <input type="checkbox"/> Spanish | <input type="checkbox"/> British Sign Language |
| <input type="checkbox"/> Romanian | <input type="checkbox"/> Arabic | <input type="checkbox"/> Other, please specify |
| <input type="checkbox"/> Panjabi | <input type="checkbox"/> Bengali | <input type="text"/> |

4b. Were you able to communicate in your preferred language?

- Always Usually Sometimes Never

5. Did you feel that you were listened to?

- Always Usually Sometimes Never

6. Were you involved as much as you wanted to be in decisions about your care?

- Always Usually Sometimes Never

7. Were things explained to you in a way that you could understand?

- Always Usually Sometimes Never

Thinking of your overall Experience**8. How would you rate your overall experience?**

- Very poor Poor Neither good nor poor Good Very good

9. Was there anything particularly good about your experience you would like to tell us about?

10. Was there anything particularly bad about your experience you would like to tell us about?

Thank you for taking the time to answer these questions

Appendix C

Equality Monitoring

We are committed to ensuring that everyone receives fair and equal respect.

Whatever your age, disability, ethnicity, faith, gender reassignment or sexual identity, you can expect to be treated with dignity. We can only achieve this with your help by providing the information below.

Data will be used for monitoring purposes only and held in strictest confidence. Your identity will not be disclosed to anyone.

1. What is your age?

- | | | | |
|--------------------------------------|--------------------------------------|--------------------------------------|--|
| <input type="checkbox"/> 0-15 years | <input type="checkbox"/> 35-44 years | <input type="checkbox"/> 55-64 years | <input type="checkbox"/> 75+ years |
| <input type="checkbox"/> 16-24 years | <input type="checkbox"/> 45-54 years | <input type="checkbox"/> 65-74 years | <input type="checkbox"/> I prefer not to say |

2. What is your gender?

- | | | | |
|-------------------------------|---------------------------------|--------------------------------|--|
| <input type="checkbox"/> Male | <input type="checkbox"/> Female | <input type="checkbox"/> Other | <input type="checkbox"/> I prefer not to say |
|-------------------------------|---------------------------------|--------------------------------|--|

3. At birth, were you described as:

- | | | | |
|-------------------------------|---------------------------------|--------------------------------|--|
| <input type="checkbox"/> Male | <input type="checkbox"/> Female | <input type="checkbox"/> Other | <input type="checkbox"/> I prefer not to say |
|-------------------------------|---------------------------------|--------------------------------|--|

4. Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months?

- | | | | |
|-------------------------------------|--|-------------------------------------|--|
| <input type="checkbox"/> Yes, a lot | <input type="checkbox"/> Yes, a little | <input type="checkbox"/> Not at all | <input type="checkbox"/> I prefer not to say |
|-------------------------------------|--|-------------------------------------|--|

5. Which of the following options best describes how you think of yourself?

- | | | | |
|---|---|-----------------------------------|--------------------------------|
| <input type="checkbox"/> Heterosexual or straight | <input type="checkbox"/> Gay or lesbian | <input type="checkbox"/> Bisexual | <input type="checkbox"/> Other |
| <input type="checkbox"/> I prefer not to say | | | |

6. What is your religion?

(Please choose one option that best describes your religion)

- | | | | |
|--|---------------------------------|---------------------------------|--|
| <input type="checkbox"/> No religion | <input type="checkbox"/> Hindu | <input type="checkbox"/> Muslim | <input type="checkbox"/> Any other religion |
| <input type="checkbox"/> Christian (all denominations) | <input type="checkbox"/> Jewish | <input type="checkbox"/> Sikh | <input type="checkbox"/> I prefer not to say |
| <input type="checkbox"/> Buddhist | | | |

7. What is your ethnic group?

(Please choose one option that best describes your ethnic group or background)

White:

- | | | |
|---|---|---|
| <input type="checkbox"/> Welsh | <input type="checkbox"/> English | <input type="checkbox"/> Scottish |
| <input type="checkbox"/> British | <input type="checkbox"/> Irish | <input type="checkbox"/> Northern Irish |
| <input type="checkbox"/> Gypsy or Irish Traveller | <input type="checkbox"/> Any other white background | |

Mixed / multiple ethnic groups

- | | |
|--|---|
| <input type="checkbox"/> White and Black Caribbean | <input type="checkbox"/> White and Black African |
| <input type="checkbox"/> White and Asian | <input type="checkbox"/> Any other Mixed / multiple ethnic background |

Asian / Asian British

- | | | |
|----------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Indian | <input type="checkbox"/> Pakistani | <input type="checkbox"/> Bangladeshi |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Any other Asian background | |

Black / African / Caribbean / Black British

- | | | |
|----------------------------------|------------------------------------|---|
| <input type="checkbox"/> African | <input type="checkbox"/> Caribbean | <input type="checkbox"/> Any other Black / African / Caribbean background |
|----------------------------------|------------------------------------|---|

Other ethnic group

- | | | |
|-------------------------------|---|--|
| <input type="checkbox"/> Arab | <input type="checkbox"/> Any other ethnic group | <input type="checkbox"/> I prefer not to say |
|-------------------------------|---|--|

Thank you for taking the time to answer these questions

Appendix D

The Digital Stories Toolkit – Using Stories to Improve Quality

In September 2021 it was agreed by the Welsh Directors of Nursing that digital storytelling would form a keyway of capturing feedback and learning to improve our services. This toolkit covers the methodology and information needed by everyone who is digitally recording stories, related to individual feedback and personal experiences of any of the health services provided via NHS Wales.

This toolkit has been developed in partnership with all NHS Wales organisations. It is for use across all programmes, services, and functions provided under the NHS Wales umbrella where quality and improvement are a priority.

This toolkit can be accessed via the following link: [Digital Story Toolkit \(sharepoint.com\)](#)



Quality-driven decision-making





Quality Impact Assessment

Title of proposal this Quality Impact Assessment (QIA) is supporting:	<i>People's Experience Framework</i>
Reference of proposal:	<i>PEF 01 01/05/2025</i>
Details of Board / Committee the paper is being presented to and when:	<i>Quality, Safety & Performance Committee on 08/05/2025</i>

Part 1: Health and Care Quality Standards assessment

1a: Briefly outline how this proposal or strategic decision impacts on the delivery of healthcare services (in line with STEEEP Quality Standards).






Quality Standard <i>Click each icon for its definition</i>	Overall Impact			Key points and rationale
	Positive (+1) / Neutral / Negative (-1)	Level of impact High (3) Medium (2) or Low (1)	Impact score (product of previous columns)	
	+1	2	3	Capturing people's experience is a key element of improving the safety of organisations. The framework advocate for the always on approach to experience using both active and passive methods.
	+1	2	3	The framework identifies key component of how people's experience is captured. This places people a the forefront by peoples experiences to be left at a time and location most convenient to the person.

	+1	2	3	A key component of the framework includes a good practice self-assessment tool, this also gives examples of what good looks like within organisations.
	+1	2	3	The framework considers the importance of organisations measuring both PREMS and PROMS and how these should be used. This supports clinical effectiveness, safety and quality improvement.
	+1	2	3	A key element of the framework is equity, part of the self-assessment is ensuring that the organisation has capability to gather feedback from harder to reach groups.
	+1	2	3	The aim of making the framework more inclusive and understandable, it has been renamed and refreshed as 'the people's experience framework'. This change follows extensive engagement with third-sector organisations, Llais, and NHS bodies. The updated language now recognises that people interact with NHS Wales services beyond the traditional definitions of "patient" or "service user".
Overall impact	<i>The overall impact of the adoption of the People's Experience framework would be positive. The framework helps us to understand what excellent quality means and how we can apply it in practice.</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
	2	The self-assessment included in the framework has a criteria statement of leadership, the board and senior leaders should ensure that all leaders promote a culture defined by compassion, empathy and kindness.

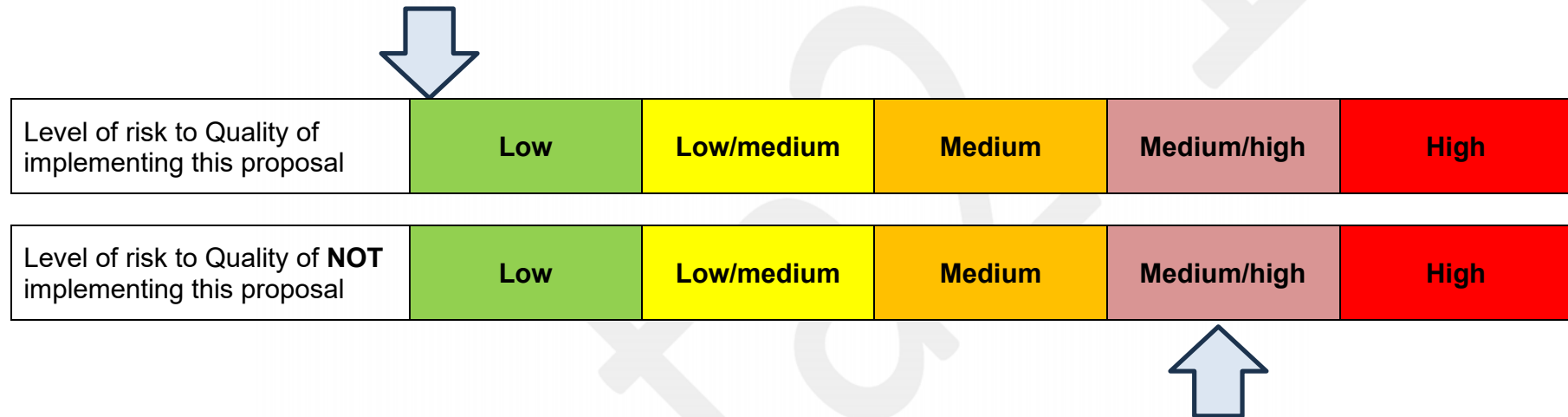
Quality Impact Assessment tool / April 2024

	2	One of the components included in the framework are values and staff experiences. There is an expectation that all organisations work collaboratively with human resources in compliance with the framework.
	2	The framework promotes a culture of compassion, empathy and kindness while upholding privacy, dignity and human rights.
	3	Gathering and reporting data collected from people's feedback is a key component of measuring quality and outcomes.
	3	Using people's feedback to drive quality improvement and learning is a key component of the local self-assessment within the framework.
	2	The framework introduces a national experience survey, this survey has been developed in collaboration with our population. Where applicable, all organisations will engage with a national survey approach and share with people and communities via local websites. The information will also be used to populate the NHS Wales quality dashboard.
Overall amount of activity required		<p><i>The organisation will require a collaborative approach to become fully compliant with the local self-assessment. This will require a number of work streams to be established to produce the evidence that is required to become fully compliant against the five criteria statements:</i></p> <ul style="list-style-type: none"> • <i>Leadership</i> • <i>Capacity and capability to effectively collect feedback</i> • <i>Analysis and triangulation</i> • <i>Using people's feedback to drive quality, improvement and learning</i> • <i>Reporting and publication</i>

Part 2: High-level consideration of risk

Considering responses on all twelve Health and Care Quality Standards in Part 1, what level of risk to **Quality overall** is this proposal or strategic decision?

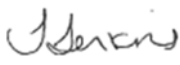
Slide the arrow to indicate the level of risk (recognise this is subjective until full risk assessment undertaken)





Describe the main risks to Quality of implementing this proposal?
Describe the main risks to Quality of NOT implementing this proposal?

- *The risk of NOT implementing the framework would impact on our ability of our healthcare system to meet the needs of our population based on their experiences and feedback.*
- *A missed opportunity to work in true co-production inline with the Duty of Quality the potential to is opportunities to celebrate and build on what I working well and identify areas to improve.*

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
 Tina Jenkins, 01/5/2025	<Name, role and date>	<Name, role and date>

Executive clinical review and sign off (if required)

Clinical Executive 1 sign off / date	Clinical Executive 2 sign off / date	Clinical Executive 3 sign off / date
 Nicola Williams, Director of Nursing, AHP's & Healthcare Scientists, 13/05/2025	 Jacinta Abraham Executive Medical Director 14/05/2025	<Name, role and date>

TRUST BOARD	
Trust 2025-2026 Quality Priorities	
DATE OF MEETING	22 May 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	Trust-wide & Divisional Quality & Safety Teams
PRESENTED BY	Tina Jenkins, Head of Quality, Safety and Assurance
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences
	<p>The 2025-2026 Trust quality priorities have been co-produced by the three Trust quality hubs. They have been developed based on learning from incidents, concern and reviews. The four main priority themes are:</p> <ul style="list-style-type: none"> • Improve Patient & Donor Communications • Strengthen Quality & Safety infrastructure • Improve Patient & Donor Safety • Improve Opportunities to gather and learn from people's feedback. <p>There specific are actions associated with each priority theme. These have been reviewed following feedback from the Duty of Quality Internal Audit to make them more 'SMART' and have a measurable timescale included, these have been shared with both divisions and were endorsed for onward approval pending agreement of divisional timescales.</p>
RECOMMENDATION / ACTIONS	The Trust Board is asked to APPROVE the proposed Trust 2025/26 Quality Priorities.
GOVERNANCE ROUTE	

List the Name(s) of Committee / Group who have previously received and considered this report:	Date
Integrated Quality and Safety Group (IQ&SG)	23/04/2025
Executive Management Board	29/04/2025
Quality, Safety & Performance Committee	08/05/2025
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
<u>Integrated Quality & Safety Group</u> : Confirmed that the priorities were developed in coproduction with the divisions, endorsed for onward approval.	
<u>Executive Management Board (EMB)</u> : Endorsed the proposed Trust 2025/2026 Quality Priorities, for onward approval.	
<u>Quality, Safety & Performance Committee</u> : Endorsed the proposed Trust 2025/2026 Quality Priorities, for onward approval.	
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 4 - Increased extent of impact from actions
APPENDICES	
Appendix 1	Trust proposed 2025/2026 Quality Priorities

1. Quality Priorities 2025/2026

The proposed 2025/26 Trust quality priorities (attached in **Appendix 1**) agreed across the quality hubs into four main themes:

1. Improve Patient & Donor Communications
2. Strengthen Quality & Safety infrastructure
3. Improve Patient & Donor Safety
4. Improve Opportunities to gather and learn from people's feedback.

These have been reviewed following feedback from the Duty of Quality Internal Audit to make them more 'SMART' and have a measurable timescale included, these have been shared with both divisions and were endorsed for onward approval pending agreement of divisional timescales.

The 2024-2025 priorities have been mapped against the 2025-2026 priorities. Where these have not yet been fully achieved, we have demonstrated how they will continue to be pursued or how they link to the new priorities.

The agreed quality priorities are also included in the Trust Integrated Medium Term Plan.

2. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)

<p>Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals:</p> <p style="text-align: center;">YES - Select Relevant Goals below</p>	
<p>If yes - please select all relevant goals:</p> <ul style="list-style-type: none"> • Outstanding for quality, safety, and experience <input checked="" type="checkbox"/> • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations <input checked="" type="checkbox"/> • A beacon for research, development, and innovation in our stated areas of priority <input checked="" type="checkbox"/> • An established 'University' Trust which provides highly valued knowledge for learning for all. <input checked="" type="checkbox"/> • A sustainable organisation that plays its part in creating a better future for people across the globe <input checked="" type="checkbox"/> 	
<p>RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) For more information: STRATEGIC RISK DESCRIPTIONS</p>	<p>06 - Quality and Safety</p>
<p>QUALITY AND SAFETY IMPLICATIONS / IMPACT</p>	<p>Select all relevant domains below</p> <ul style="list-style-type: none"> Safe <input checked="" type="checkbox"/> Timely <input checked="" type="checkbox"/> Effective <input checked="" type="checkbox"/> Equitable <input checked="" type="checkbox"/> Efficient <input checked="" type="checkbox"/> Patient Centred <input checked="" type="checkbox"/>
<p>QUALITY IMPACT ASSESSMENT</p>	<p>Not required - not a strategic decision</p>
<p>SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:</p>	<p>Not required</p>
<p>TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT</p>	
<p>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:</p> <p style="text-align: center;">YES - Select Relevant Goals below</p>	
<p>If yes select the relevant goals:</p> <ul style="list-style-type: none"> • A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities. <input checked="" type="checkbox"/> • A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic, and ecological resilience. <input checked="" type="checkbox"/> • A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health <input checked="" type="checkbox"/> 	

<ul style="list-style-type: none"> • A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances <input checked="" type="checkbox"/> • A Wales of Cohesive Communities - Attractive, viable, safe, and well-connected communities. <input checked="" type="checkbox"/> • 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. <input checked="" type="checkbox"/> • Globally Responsible Wales – Consideration of whether an action may make a positive contribution to global well-being <input checked="" type="checkbox"/> 	
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	There are no specific legal implications related to the activity outlined in this report.

3. RISKS

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



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust



Gwasanaeth Canser Felindre
Velindre Cancer Service



Gwasanaeth Gwaed Cymru
Welsh Blood Service

VELINDRE UNIVERSITY NHS TRUST QUALITY PRIORITIES



QUALITY IMPROVEMENTS
2025/2026

CONTENTS

Quality Priorities	2
The Purpose of Quality Priorities.....	2
Review of 2024/25 Quality Priorities.....	3
Quality Priorities and Target for 2025/2026	4
Priority 1.	4
Improve patient & donor communications	4
Actions to improve our performance.....	4
How improvements will be measured and monitored	4
Priority 2.	4
Strengthen quality and safety infrastructure.....	4
What will we do to achieve this.....	Error! Bookmark not defined.
HOW IMPROVEMENTS WILL BE MEASURED AND MONITORED	5
Priority 3.	6
Improve patient & donor safety.....	6
What will we do to achieve this.....	Error! Bookmark not defined.
How improvements will be measured and monitored	6
Priority 4.	6
Improve opportunities to gather and learn from peoples feedback	6
What will we do to achieve this.....	Error! Bookmark not defined.
How improvements will be measured and monitored	6

QUALITY PRIORITIES

The Duty of Quality applies to all staff in NHS Wales, whether they work in clinical roles (such as doctors or nurses) or non-clinical services (such as porters and administrative roles).

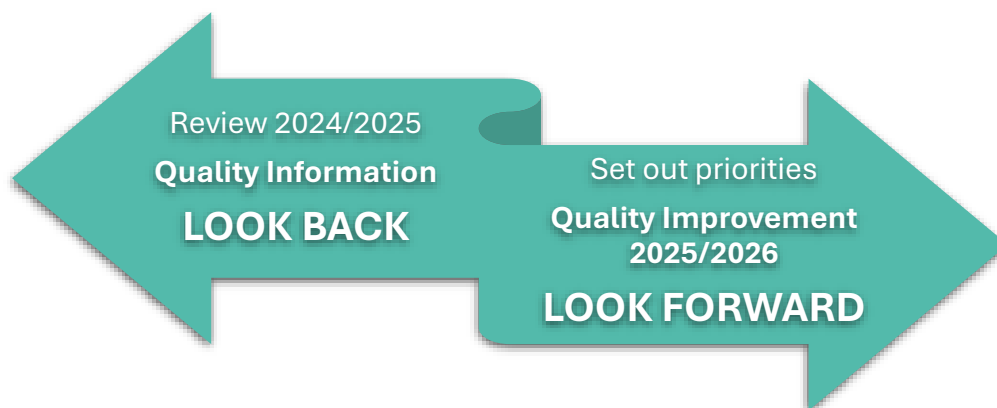
The Duty aims to:

- Improve the quality of health services
- Help people in Wales have more years in good health
- Listen more to people and patients and act on what is shared

All health organisations, including Public Health Wales, need to make sure services are safe and reliable for everyone who uses them by meeting 12 new Health and Care Quality Standards (see below). These standards are part of the Duty of Quality which was brought in on 1 April 2023.

THE PURPOSE OF QUALITY PRIORITIES

1. Set out our quality priorities and objectives for 2025/2026.



The Trust will set a quality priorities and objectives for 2025/2026 under the Quality and Safety domains.



The Trust will explain how these priorities were agreed and how the aims needed to achieve and measure performance.

REVIEW OF 2024/25 QUALITY PRIORITIES

The status of the 2024/5 quality priorities is shown below. Where the 2024/5 priority has not been fully met, the quality priority has been mapped to the 2025/6 priorities to ensure completion.

2024/25 Quality Priority	Status as of February 2025	Mapped to 2025/26 Quality priorities for ongoing attainment
Introduction of all Wales foetal D Screening for RhD negative pregnant women.	Complete: Test platform went live on 31/05/24	N/A
To Successfully Introduce West Nile Virus testing within Welsh Blood Service	Complete: WNV testing is in place	N/A
Mortality reviews will be completed for deaths within 30 days of SACT and 30/90 days of radiotherapy and will align with best practice.	Complete: M&M reviews in place in all Site-Specific Teams and oversight is provided by VCS SLT & IQSG	N/A
To Integrate Clinical Audit within VCS Quality and Safety function	Complete: Oversight of Clinical Audit is now provided by the VCS Quality & Safety function	N/A
Increase in staff psychological safety scores within VUNHST Staff Survey results	Partial completion: Scores in the Staff Survey related to psychological safety have increased from 2023 to 2024.	Mapped to 2025/26 quality priority 2
To further develop administrative and patient communication systems to prevent patient harm and improve patient experience.	Ongoing	Mapped to 2025/6 quality priority 1.
Development of robust Site-Specific Quality Metrics	Ongoing	Mapped to 2025/6 quality priority 2
To improve incident and risk management	Ongoing	Mapped to 2025/6 quality priority 2
Continue to review and update the WBS Quality Management Framework, including the deployment of a new electronic Quality Management System	Ongoing	Delivery by WBS SLT New eQMS being managed via Change Proposal, led by QA Systems Mapped to 2025/6 quality priority 2
Introduce leucodepletion filters, Hepatitis A and Parvovirus B19 testing to support the national Plasma for medicines programme and improve supply chain resilience for plasma-derived medicines	On hold awaiting WG policy and funding decision	Delivery via WBS SLT / WBS Futures programme Mapped to 2025/6 quality priority 2
Review and improvement of donor selection and screening processes	Ongoing	Ongoing delivery via WBS SLT and WBS IQSH. Mapped to 2025/26 quality priority 2
Introduction of electronic result transfer for deceased organ donor HLA typing results to NHSBT-ODT, which will reduce risk of manual transcription of results.	Introduction of electronic result transfer for deceased organ donor HLA typing results to NHSBT-ODT, which will reduce risk of manual transcription of results.	Ongoing delivery via WBS SLT / WBS Futures programme Mapped to 2025/6 quality priority 2

Achieve JACIE accreditation for the WBMDR	Ongoing – On track to be completed by end of Q2	On track to be completed by end of Q2 Mapped to 2025/6 quality priority 2
Commencing rollout of live connectivity of the BECS at community-based donation clinics, and enablement of DATIX, QPULSE connectivity on community-based clinics for incident, risk and concerns recording at point of contact	Partially complete	Mapped to 2025/6 quality priority 2: 5G routers have been ordered to allow roll out of live connectivity across all teams

QUALITY PRIORITIES AND TARGET FOR 2025/2026

The quality priorities and targets for 2025/2026 are outlined in Table 1 below. These have been discussed and agreed upon throughout the year, with input from various Trust and Divisional meetings across the organization.

PRIORITY 1.

IMPROVE PATIENT & DONOR COMMUNICATIONS

HOW WE WILL IMPROVE OUR PERFORMANCE

- Ensure 100% of letters following appointments are sent out to patients (unless the patient has opted out) by the end of March 2026.
- Ensure 100% of letters on the document management system (DMS) are consistently approved and sent within 30 working days by the end of December 2025.
- Improve patient communications regarding disease management and treatment.
- Improve patient and donor appointment communications.

HOW IMPROVEMENTS WILL BE MEASURED AND MONITORED

- Regular audits to ensure that a copy of all clinic letters are sent to patients who have not opted out of receiving a copy.
- Regular audits of the Document Management System to ensure all clinic letters are authorised and sent within 30 working days of the appointment.
- By March 2026, achieve a 25% reduction in the number of concerns where treatment communication regarding patient treatment/outcomes is identified as a theme.
- By March 2026, achieve a 25% reduction in the number of concerns/feedback where appointment communication is identified as a theme.

PRIORITY 2.

STRENGTHEN QUALITY AND SAFETY INFRASTRUCTURE

HOW WE WILL IMPROVE OUR PERFORMANCE

- a) Ensure all levels of patient / donor safety investigations are robust and undertaken by trained investigators at the appropriate levels.
- b) Ensure feedback and support is provided to all staff involved in the incident.
- c) Develop a Trust wide accreditation plan – with clear trajectory to having nationally / internally recognised accreditation across all core services.
- d) Strengthen the quality and safety infrastructure at a service level, including the development of core quality standards and metrics and clinical risk management
- e) Continue to strengthen the quality and safety culture across the organisation, including psychological safety

HOW IMPROVEMENTS WILL BE MEASURED AND MONITORED

- a) By the end of December 2025, undertake sample audits of all patient / donor safety investigations at each level.
- b) By the end of September 2025, introduce staff surveys to identify areas of improvement.
- c) Achieving at least two new accreditations during 2025/26 as well as maintaining existing accreditations.
- d) By end September 2025, undertake a review of quality and safety governance structures through each service area to board.
- e) Staff survey 25/26 results regarding psychological safety

PRIORITY 3.

IMPROVE PATIENT & DONOR SAFETY

HOW WE WILL IMPROVE OUR PERFORMANCE

- a) Reduce the harm from sepsis through early identification and treatment.
- b) Reduce harm related to urgent clinical information being circulated via email.
- c) By September 2025, fully implement 'Call for Concern' in Velindre Cancer Service.
- d) Ensure that 100% of bloods taken within Velindre Cancer Service are reviewed within 48 hours.
- e) We will introduce Haemoglobin S testing to detect the presence of sickle-cell trait in specific whole blood donations.
- f) WBS to review specialist red cell immunohaematology (RCI) services.

HOW IMPROVEMENTS WILL BE MEASURED AND MONITORED

- a) By end of September 2025:
 - Consistently achieve >90% of patients who meet the local criteria of suspected sepsis to be screened within one-hour and given antibiotics within one-hour of diagnosis.
 - Conduct monthly audits to measure compliance against key performance indicators.
 - To reduce the number of incidents related to sepsis recognition and management.
- b) By end of December 2025, there will be processes in place to eliminate the need to send clinical information via email, and the number of incidents resulting in patient harm as a result is reduced to zero.
- c) To develop an implementation plan and monitor via the Trust regulatory tracker.
- d) By end of December 2025, reduce to zero the number of incidents reported where omission or delay in reviewing bloods is identified as a contributory factor.
- e) All blood donations used for the treatment of sickle-cell disorder or for neonates will be tested and confirmed as negative for Haemoglobin S by the end of December 2025.
- f) RCI service response times will meet all nationally agreed targets by the end of March 2026.

PRIORITY 4.

IMPROVE OPPORTUNITIES TO GATHER AND LEARN FROM PEOPLES FEEDBACK

HOW WE WILL IMPROVE OUR PERFORMANCE

- a) Develop and implement feedback methods aimed at increasing feedback from people with additional needs.
- b) Improvements to the mechanisms for staff to support people to speak up safely and with confidence.
- c) Increase opportunities to gather patient and donor feedback through utilising SMS messaging, by end June 2025.

HOW IMPROVEMENTS WILL BE MEASURED AND MONITORED

- a) Regular audits of our accessible feedback channels, adjusting our strategy based on continuous evaluation.
- b) To commence data analysis to identify themes by the end of September 2025.
- c) To compare data each quarter on percentage of service user feedback received.

Action Taken Following Supreme Court Ruling on the Equality Act (2010)

Trust Board
22nd May 2025

Background

- On 16 April 2025, the Supreme Court gave its ruling on the meaning of sex in the application of the Equality Act 2010.
- The Court stated that the meaning of woman within the Equality Act 2010 is based on Parliament's reference to biological sex in the Sex Discrimination Act 1975.
- The court was clear that it was ruling only on the definition of man, woman and sex as they are used in the provisions of the Equality Act 2010.
- Equality and Human Rights Commission published interim Guidance on 25th April 2025.
- Welsh Government issued statement on the 29th April 2025 stating, 'it will take the time to consider the judgment and the interim guidance from the Equality and Human Rights Commission carefully and take the steps required to meet our obligations under the Equality Act 2010 as clarified by the ruling.'

Trust Actions

- Working with LGBTQ+ Staff Network to understand concerns and issues
- Undertaking a gap analysis of provision
- Bring together these two elements of work to understand options across the Trust
- Results will be taken through Integrated Quality & Safety Group and onwards assurance to Board
- Reinforced wellbeing support for Trans staff

TRUST BOARD	
PUBLIC QUALITY, SAFETY & PERFORMANCE COMMITTEE HIGHLIGHT REPORT	
DATE OF MEETING	22 May 2025
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	
REPORT PURPOSE	FOR DISCUSSION
APPENDICES	
Appendix 1	Quarter 3 Quality & Safety Report

1. PURPOSE

This paper is to provide the Trust Board with details of the key issues and risks considered by the Quality, Safety & Performance Committee at its meeting held on the 8th May 2025.

2. BACKGROUND

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

3. HIGHLIGHTS FROM THE MEETING HELD ON 8TH MAY 2025

3.1 *Triangulated themes*

The following triangulated themes were identified:

- **Communication:** Issues related to communication were a recurring theme, particularly in patient stories, incident reporting, and the need for improved communication between departments.

- **Digital Enablement:** The importance of digital services and the challenges faced in digital transformation were highlighted, including the need for prioritisation and resource allocation.
- **Individual Patient Focus:** Emphasis on maintaining the individuality of patient care and ensuring personalised responses and solutions.
- **Data Quality:** The need for accurate data and validation processes to ensure reliable performance metrics and reporting.
- **Strategic Objectives and Risks:** Discussions on aligning the Trust Assurance Framework with strategic objectives and identifying and managing risks effectively.

3.2 Further Information

Board members who are not members of the Committee and would like further detail of the Quality, Safety and Performance (QSP) Committee are able to access the agenda and papers for the May 2025 QSP Committee meeting at: <https://velindre.nhs.wales/about-us/quality-safety-performance/quality-safety-performance-2025/08052025/>

3.3 Summary of Committee Highlights

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

ALERT / ESCALATE	<p>Finance Report for the Period Ended 31st March 2025</p> <p>A query was raised around the status and future expectations regarding the LTA contract rebasing, with concerns expressed about its progress and implications for the Trust. It was noted that progress is hindered by the wider issue of LTA rebasing across NHS Wales, with local commissioners facing their own challenges around LTA income for historical baselines not covering the cost of the services provided. The issue will be raised at the Chief Executives' Management Team meeting, with support from a new Executive experienced in specialist cancer services.</p>
ADVISE	There were no items to advise the Trust Board.
ASSURE	<p>Action plan from the MHRA Inspection of WBS, December 2024</p> <p>The Committee received a brief overview of the report which detailed the actions taken following the MHRA inspection at the Welsh Blood Service in December.</p> <p>There was one major finding regarding data integrity controls due to older computer systems. Actions included risk assessments, reviewing data flows and ensuring data protection.</p> <p>Quality & Safety Group Quarter 4 Report</p>

	<p>The Committee received the Trust quarter 4 Quality & Safety report and VUNHST Quality Priorities for 2025-26. The Quality and Safety report is attached in Appendix 1. The following key points were highlighted:</p> <ul style="list-style-type: none"> • PTR Compliance: Average compliance for timely response to complaints was 50% for the quarter, improving to 100% by March. • Safeguarding Children: Increase in referrals due to improved training uptake, with Level 3 training rising from 14% to 43%. • Duty of Candour: Six incidents triggered the duty of candour, with themes around communication and information sharing between departments. • Communication and Appointments: Ongoing issues with patient communication and appointment scheduling at VCS. Plans for a workshop to address these challenges and improve processes. <p>The Committee noted that an update on the regulatory tracker had not been received for some time and requested that this be included within the consent agenda for future meetings to maintain consistent oversight.</p> <p>The Committee agreed the proposed assurance level of 4.</p>
<p>INFORM</p>	<p>Velindre Cancer Service - Patient Story</p> <p>The Committee received an emotive story which centred around a former Cancer Service patient following a complaint raised by her daughter regarding the Cancer Service's failure to make reasonable adjustments for her mother's needs. The complaint highlighted issues with communication and record-keeping, which led to the quality team addressing these concerns and implementing actions to improve the service. The patient's daughter was supportive of sharing the story publicly to help drive improvements and raise awareness and has agreed to work with the team to develop a patient's story to be shared across the service.</p> <p>Overall, the presentation and discussions emphasised the need for better communication, record-keeping, and proactive adjustments to meet patient needs, along with continuous staff training and involvement of patients and their families in the process.</p> <p>People's Experience Framework</p> <p>The Committee received the People's Experience Framework, a national initiative aimed at enhancing the collection and use of feedback from patients, relatives, and other stakeholders. The following key points were highlighted:</p> <ul style="list-style-type: none"> • Self-Assessment Tool: Velindre NHS Trust completed the self-assessment tool, being ahead of the curve. The assessment highlighted strengths in reporting and publication but identified areas

for improvement in leadership, capability, quality improvement, and triangulation.

- **Improvement Plan:** A working group has been established to develop an improvement plan addressing the identified areas.
- **People's Experience Survey:** The survey has gone live in Velindre Cancer Service, replacing previous surveys. Implementation in Welsh Blood Service is planned for this month, with ongoing work to utilise SMS for feedback collection.

Workforce Supply & Shape and Associated Finance Risks

The Committee received the paper which outlines actions taken to progress the workforce profile against the areas of the people's strategy and details the improvements and planned actions for 2025-2026. The following key points were highlighted:

- **Improvement Trends:** The report shows improvement in several performance metrics, except for flexible working and time to hire, the increase in the latter attributed to high turnover in specific areas like medical records and VCS. Interventions are in place to address these issues.
- **Flexible Working:** The decline in flexible working is due to management resistance in certain areas. New leadership structures are expected to improve this.
- **Actions for 2025-2026:** The paper details ongoing and planned actions to support workforce development, including the design and implementation of a structured learning development framework by April 2028.

With regards to the Finance element of the report, the following key points were highlighted:

- **Financial risk:** The financial risk associated with workforce manifests in paid budgets are being monitored closely. The Trust invested early in staffing to deliver extra capacity given demand, with the expectation that income would flow through activity from Commissioners. Although there had been some concern that income might not meet the target level of investment, the situation improved, and the Trust ended within £240,000 of the target. Some posts where activity in the year did not meet the target will need to be funded.
- **Agency Staff:** The Committee noted the Welsh Government's aim to recruit substantively and reduce reliance on agency staff. Although the Trust improved by reducing agency costs by 23%, there is still a significant amount spent on agency staff, which includes a premium cost.

The **Assurance level 4** was discussed and **supported** by the Committee.

Performance Management Framework (PMF) Report and Supporting Analysis

The Committee discussed the Performance Management Framework, focusing on performance metrics, data quality issues, and specific areas requiring improvement. The following key points were highlighted:

- The need for digital enablement and resource support was highlighted, with ongoing discussions on prioritising and identifying critical paths for digital projects.
- The transition to the Go Paperless project caused data issues, leading to radiotherapy breaches. These issues are being resolved, with validation of data and processes underway.
- Improvements in SACT performance were noted, with ongoing work to support the model of care and workforce changes.
- The reference serology turnaround time was discussed, with plans to improve local adjustments and meet the 5-day standard.
- Monitoring staff training, sickness levels, and PADR compliance were discussed, with focused actions to improve these metrics.
- The overarching Trust cybersecurity risk has increased, with various preventative measures and mitigating actions in place.

Concern was raised about the infection control team not alerting staff at the time of the audit findings regarding cleanliness before taking blood and questioned why immediate corrective actions were not taken during the audit. It was explained that the infection prevention and control (IPC) auditor did not intervene due to a limited understanding of the need for immediate corrective action and a lack of shared understanding between the IPC team and the operational team regarding the criticality of the arm cleansing process. Immediate actions were taken once the deficiency was recognised, including recalling potentially affected blood products and reassessing staff competency. Measures were put in place to improve awareness and establish joint audit protocols to ensure immediate escalation of findings in the future.

With reference to estates and infrastructure, the lack of Planned Preventive Maintenance (PPM) data for several sites, particularly in North Wales was queried, and concern expressed regarding how this issue is being addressed going forward. This is to be investigated further.

The individual assurance levels for each area were discussed and **agreed** as follows:

Velindre Cancer Service	Level 3
Welsh Blood Service	Level 3
Workforce & Wellbeing	Level 4
Digital Services	Level 3
Health and Safety	Level 4
Financial Performance	Level 4

Trust Risk Register

The Committee discussed the risk register which focused on the current status of risks, new risks identified, and improvements in risk management processes.

The following key points were noted:

- The Trust started the reporting period with 12 risks on the register. Three risks have been closed, and seven new risks have been added, particularly related to digital services.
- New digital risks include cybersecurity, team capacity, and support for digital transformation. These risks are being actively managed, with actions being added to the DATIX system.
- A glitch in the system that affected the sharing of risk information has been rectified, improving the overall risk management process.
- The cybersecurity risk was initially identified as a score of 25 but was later reduced to 15 after implementing mitigating actions. This raised questions about the initial risk assessment.

The assurance level 2 was discussed. The Committee **agreed** that, given the action plans in place and outcomes becoming evident, an **Assurance level 3** would be more appropriate.

Trust Assurance Framework

The Committee received the Trust Assurance Framework (TAF) which focused on the current status, improvements and future plans for the framework. Key points were highlighted as follows:

- The TAF presented is a continuation of the previous year's framework. The new strategic risks have been agreed upon as part of the IMTP for the current year.
- The executive team is working on a new template for the TAF to align actions in the IMTP in a manageable way. This includes summarising actions and ensuring the document is concise and effective.
- Benchmarking with external organisations, such as the Royal Marsden, is being done to improve the TAF template and provide a clear summary of the risk position.
- The new TAF will be reported in the July cycle for QSP, Audit, Trust Board, and Strategic Development Committee.

The Committee discussed the assurance level, noting that some improvements have been made, but further work is needed to reach higher levels of assurance. Therefore, the **Assurance level 2** was **agreed**.

National Policy on Patient Safety Incident Reporting & Management

	The Committee APPROVED that use of the National Policy on Patient Safety Incident Reporting & Management remains extant for a further year (May 2026) until the national policy is renewed.
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 8th May 2025.

Velindre University NHS Trust Quality and Safety Report Quarter 4 2024-2025

(1st January 2025- 31st March 2025)



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 12 Quality Standards are used across the trust which help deliver against the 6 quality domains:

- Leadership
- Workforce
- Culture
- Information
- Learning, Improvement & Research
- Whole System Approach



Trust Approach

The Trust has a network for all teams to communicate, which is mainly made up of staff from across the Trust. These included our Divisional Quality Hubs, Integrated Quality & Safety Group, Quality, Safety & Performance and Executive Management Board providing assurance to the Trust Board and the population of Wales on the Trust’s commitment to the Duty of Quality.

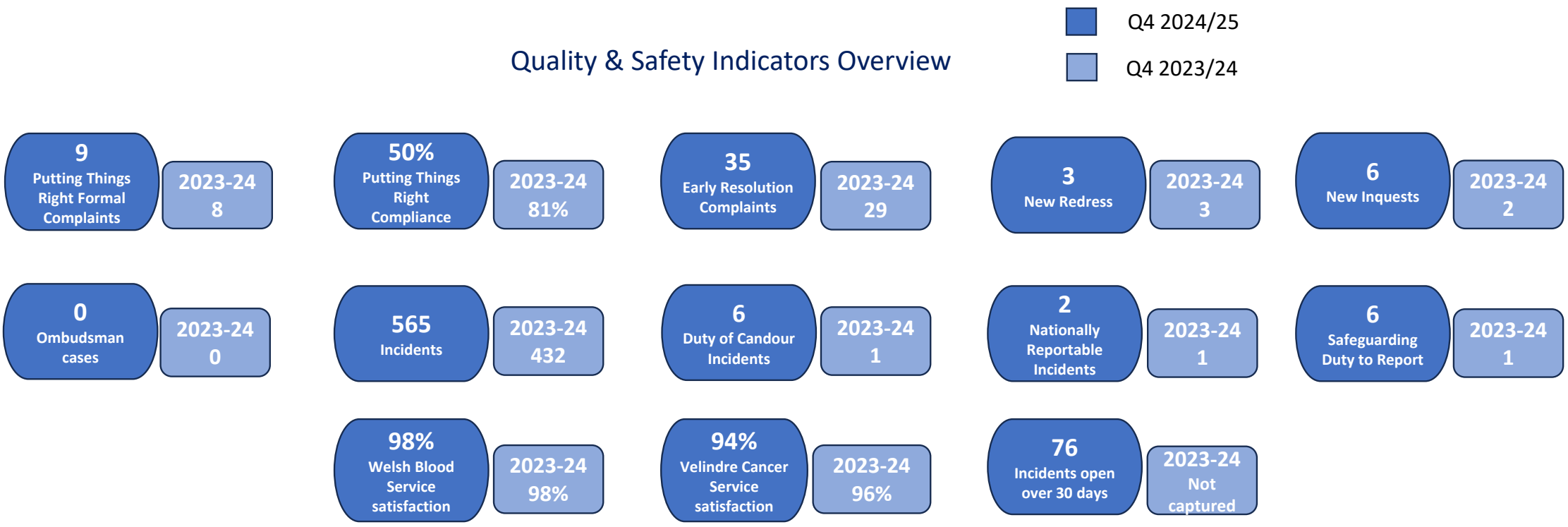


The Trust infrastructure is supported by a range of digital tools and systems to assist with monitoring, collaborating and reporting on the services the Trust supplies across Wales.

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.

1. INTRODUCTION AND EXECUTIVE SUMMARY

The Trust’s quarter 4 integrated quality & safety report provides analysis of key outcomes, activity, learning and improvement during quarter 4 and, where possible, provides themes, trends and comparative data. The report provides assurance in relation to key legislative requirements including Putting Things Right Regulations (2011) & Health and Social Care (Quality and Engagement) (Wales) Act (2020), and maintain a strong focus upon learning and improvement, to ensure the continued provision of Safe, Timely, Effective, Efficient, Equitable and Person-Centred Care.



1. INTRODUCTION AND EXECUTIVE SUMMARY

The triangulation of data this quarter has identified a theme of continued concerns and incidents relating to communication with Velindre Cancer Service. These concerns are continuing to have an impact on Patient satisfaction and confidence in our service. Although the incidents are not attributed to harm, they are causing a significant impact on patient's cancer journey.

Overall satisfaction scores for both Welsh Blood Service and Velindre Cancer Service remain positive.

Compliance with Putting Things Right timescales for complaints response has decreased since quarter 3 to 50%. This falls below the national PTR target of 75%. This has been due to an increase in concerns in quarter 4, capacity issues within the Velindre Cancer Centre Concerns team and the complexity of concerns.

Six incidents in the Trust triggered the Duty of Candour. Two incidents met the criteria for National Reportable incidents across the Trust.

The Trust continues to comply with legislative safeguarding responsibilities and reporting.

Hospital Associated Infection rates remain low.

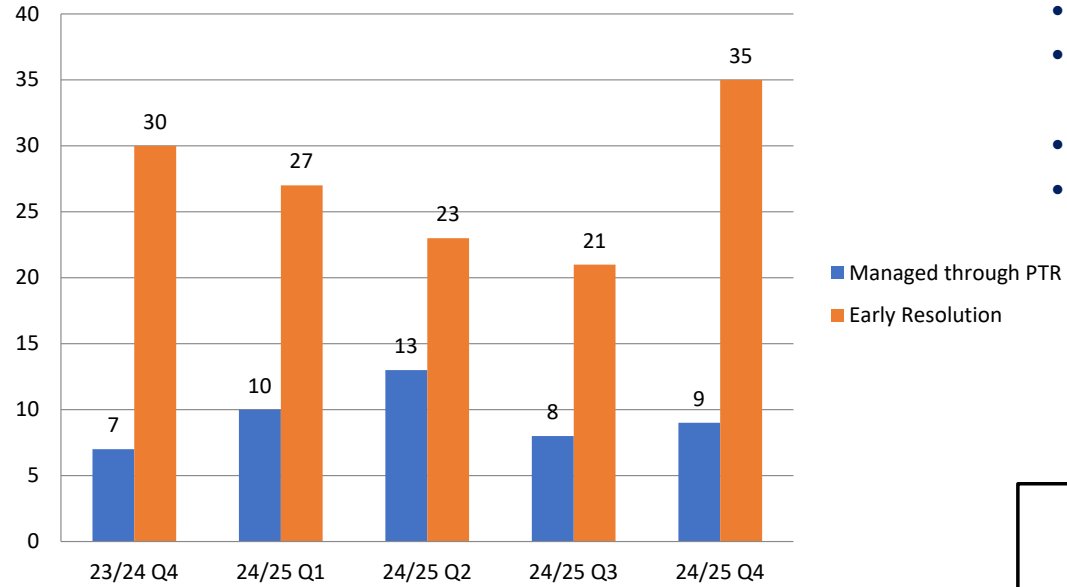
Work has been undertaken to explore further opportunities to gather patient and donor feedback for learning and improvement. A Trust wide Patient and Donor Experience working group has developed and an improvement plan with staff across WBS and VCS.



2. COMPLAINTS – TRUST OVERVIEW

Graph 1

Complaints Received by Quarter - Q4 2024 - Q4 2025



As shown in **graph 1**, the Trust has seen an increase in complaints managed through Putting Things Right (formal) from the last quarter. The number managed through Early Resolution has also increased, this can indicate that the Trust has been successful at managing complaints without the complaint becoming formal.

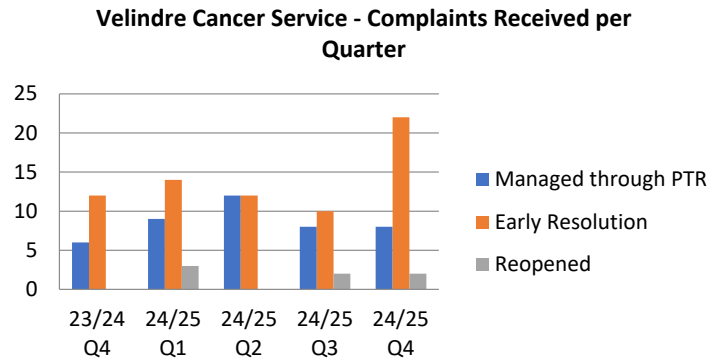
- **44 complaints were raised**, an increase from previous quarters.
- 86% of complaints were acknowledged within the 5 working day target.
- **20 complaints resolved within 30 working days.**
- **4 complaints remain open**; three are still within the PTR timescales.





2.1 COMPLAINTS – VELINDRE CANCER SERVICE

Graph 2



Total New Complaints raised

30

Number managed as Early Resolution

22

Number managed under Putting Things Right

8

Number Reopened

2

Complaints

Complaints

Graph 2:

- There has been an overall increase in the number of complaints received in quarter 4 compared to previous quarters over the last year.
- **30 new complaints** were received in total (0.04% of patient attendances)
- There were **2 REOPENED** complaints where complainants did not feel satisfied with their final response. In person meetings have been offered and concerns reviewed.
- There has been an increase in the number of early resolution concerns in quarter 4 with the majority related to communication of appointments and difficulty contacting departments.

Enquiries

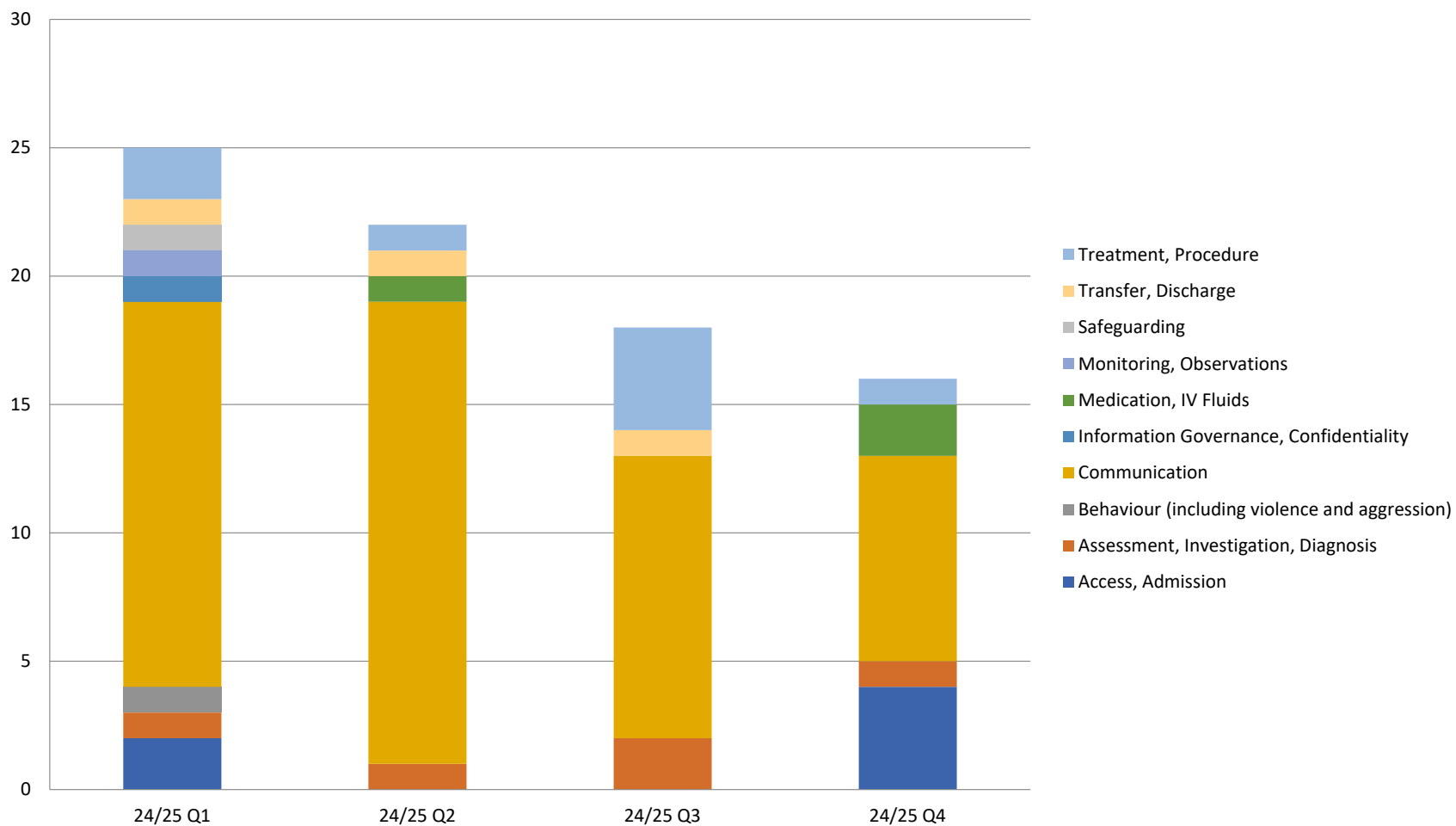
The Trust receives enquires for a number of reasons, including if concerns are being managed by another Health Board and part of their pathway has included care in Velindre. 1 enquiry was received in quarter 4 and information provided promptly to support the Health Board in providing a response to the concerns raised.



2.1 COMPLAINTS – VELINDRE CANCER SERVICE CONT.

Graph 4

Complaints by quarter received and Top 10 classifications



2.1 COMPLAINTS – VELINDRE CANCER SERVICE CONT.

ANALYSIS

- As shown in **Graph 4**, communication issues continue to be the main theme of the Cancer Service complaints in quarter 4, specifically communication around outpatient and SACT appointments.



LEARNING AND IMPROVEMENTS IDENTIFIED FROM VELINDRE CANCER SERVICE COMPLAINTS

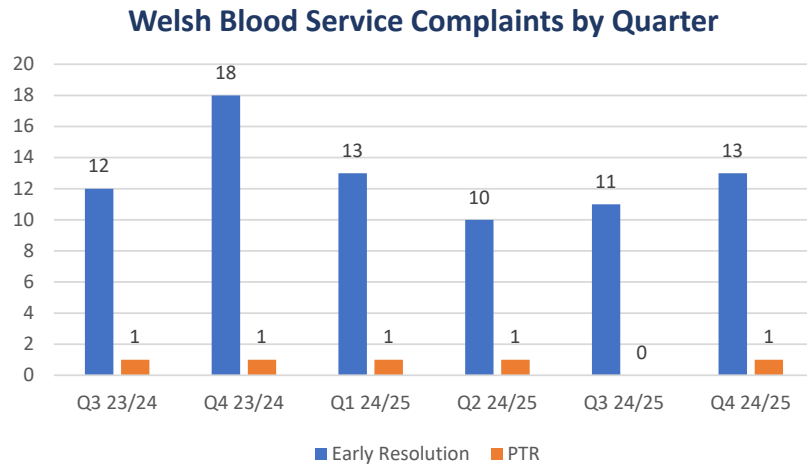
- Review of processes around managing telephony in the medical secretary team.
- Reinforcing the processes around communicating appointment information to ensure the patient is notified in a timely manner.
- Importance of ensuring professionalism at all times when speaking to patient or families has been reemphasised.
- Waits whilst in OPD: Two new clinic rooms have been made available, and the clinic templates have been reviewed to ensure that clinic time and space is being optimised.
- Reinforcing the opportunity to discuss unexpected scan reports with radiologist before discussing with the patient.



2.2 COMPLAINTS – WELSH BLOOD SERVICE



Graph 5



LEARNING AND OUTCOMES

Further learning and improvement areas following concerns have led to:

- Operational Managers reminding staff of the importance of:
 - professional conduct
 - being open and honest with effective communication with our donors at the time that errors occur.
- The Welsh Blood Service Futures Programme is focused on looking at how WBS can implement new technological advancements to help provide our Donors with the best experience possible.
- The Collections Team are continuing to work in collaboration with the Planning Team to look at alternative venues across the Service, particularly in North Wales.
- The Interim Head of Nursing has undertaken an international review of the policies for accepting children at donation clinics. An SBAR outlining the proposal to update the current guidance has been developed. This was an action taken following areas of concern raised by both staff and donors.

ANALYSIS

- 13 concerns raised (0.05% of donors), consistent with previous quarter all managed as early resolution.
- 1 formal/ PTR concern was raised. The final response letter was issued and the concern closed within the required timeframe.
- No complaints were reopened.
- The main themes and opportunities for improvement related to **communication, clinical assessment and treatment/procedure** mainly within donor collection teams.

These concerns continue to be spread across a variety of teams and locations.

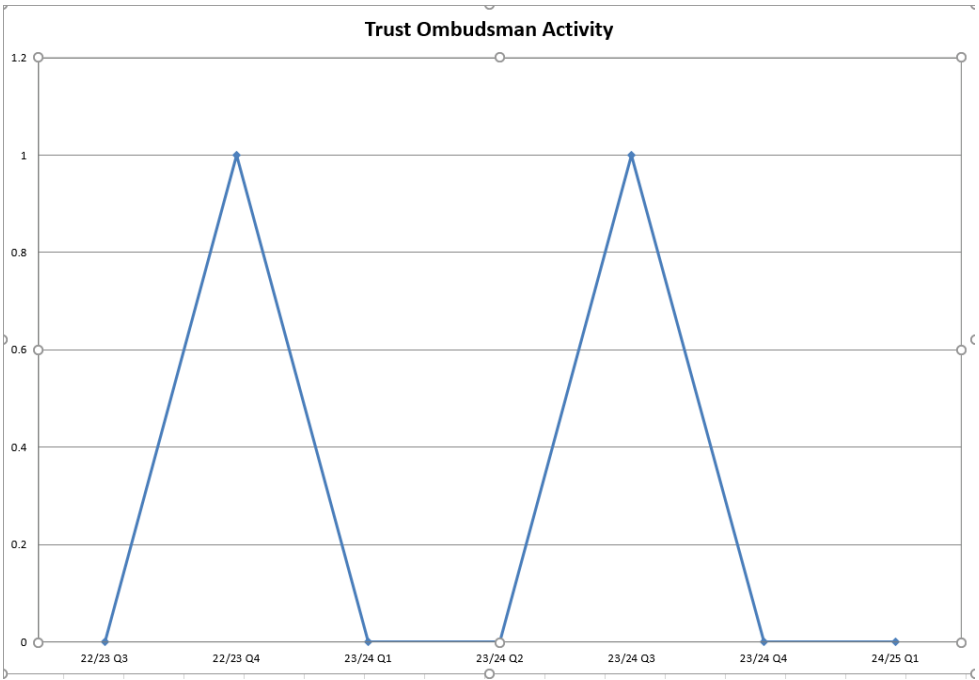


3. PUBLIC SERVICES OMBUDSMAN WALES

The Public Services Ombudsman Wales investigates complaints about unfair treatments by Welsh Public Service 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 of when you became aware. All Trust complaints letters and correspondence inform the public of how to contact the Ombudsman if they are unhappy with our complaints handling.



Graph 6



ANALYSIS

There have been no new cases opened since Q4 2023-24.

4.1 VELINDRE CANCER SERVICE – PATIENT EXPERIENCE



ANALYSIS AND LEARNING

Two national surveys are used, 'Your Velindre Experience', consisting of 24 questions, and 'VCC Friends & Family', consisting of 8 questions. The findings below are from both surveys, including the satisfaction score. 493 patients provided feedback a slight decrease from the previous quarter (494) and a significant increase from Q4 2023/24 (223). 292 patients completed the 'Your Velindre Experience', while 201 completed the 'VCC Friends & Family'.

Velindre Cancer Service is undertaking work to increase patient feedback numbers.

98% of patients stated they were overall satisfied with their care. However, 2% respondents did not feel well cared for or understood their care, with only 1% saying they did not receive assistance when needed. This is the same as the previous quarter. 11% of patients felt their waiting time was either 'a bit too long' or 'much too long'. This is an improvement to the previous 2 quarters (13% and 14%).

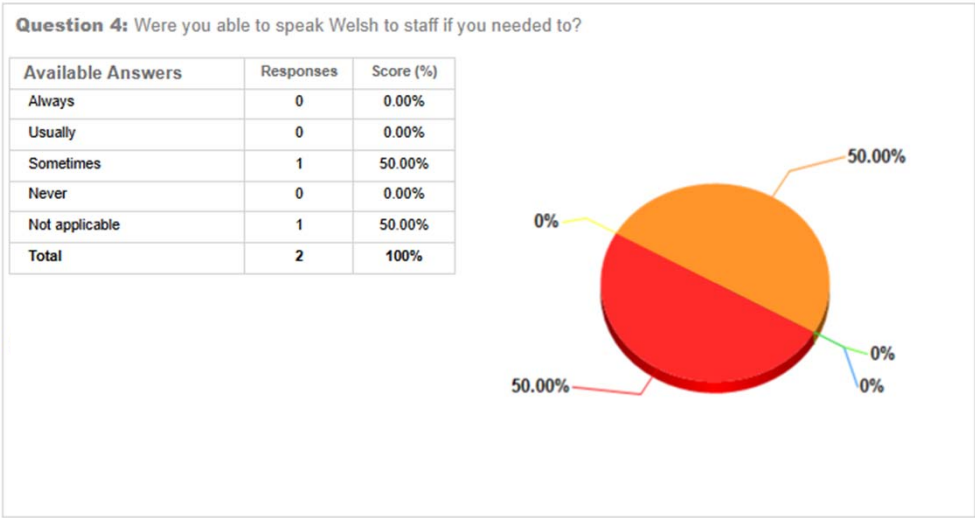
There has been an improvement specifically regarding patients waiting times in outpatients in Q4 with 81% of patients saying the time they waited was 'shorter than expected' or 'about right' compared to 73% – 78% in Q1-3



4.1 VELINDRE CANCER SERVICE – PATIENT EXPERIENCE CONT.

Directorate	Responses	1 - Overall, how was your experience of our service?	3 - Did you feel that you were listened to?	4 - Were you able to speak Welsh to staff if you needed to?	5 - How did you find the waiting time in your recent visit?	6 - Did you feel well cared for?	7 - If you asked for assistance did you get it when you needed it?	8 - Did you feel you understood what was happening in your care?	9 - Were things explained to you in a way that you could understand?	10 - Were you involved as much as you wanted to be in decisions about your care?	11 - How would rate your overall experience? 0 is very bad and 10 is excellent.	Overall
		VCC - Friends and Family	Your Velindre Experience	Your Velindre Experience	Your Velindre Experience	Your Velindre Experience	Your Velindre Experience	Your Velindre Experience	Your Velindre Experience	Your Velindre Experience	Your Velindre Experience	
Integrated care	140	100	100	88	87	100	100	100	100	99	96	97
Operational Services and Delivery	86	100	91	93	85	92	97	94	94	92	89	92
Pharmacy	23	100	100	67	100	100	100	100	100	100	100	98
Radiation services	99	100	100	97	90	97	96	100	100	100	98	98
SACT	137	100	96	90	93	99	99	97	99	98	94	96
	Overall	100	97	91	90	98	99	98	99	97	94	96
	Benchmarks	85	85	85	85	85	85	85	85	85	85	92

Results from: Pharmacy



There were only **two** respondents to the question “Were you able to speak Welsh to staff if you needed to?”. The overall scoring is affected by the answers selected, e.g. selecting ‘Not applicable’ would be classed as a low scoring answer.

4.1 VELINDRE CANCER SERVICE – PATIENT EXPERIENCE CONT.



You Said	We Did
Convenient access to light refreshments for patients & companions	A case has been put forward for funding the reopening of the coffee shop in Radiotherapy
Unclear signage indicating baby-changing facilities	Baby-changing signs have been added to toilet doors
Waited 1 1/2 hours in Outpatients for a blood test	We are working to review our working practices and reduce the waiting time
Could the lights be turned out earlier	We aim to turn the lights off at 10pm but depending on the business this may vary
Bookings sometimes get confused wrong appointment times	This issue has been highlighted to the Bookings Team and work is underway to make improvements to the booking process
More patient toilets in new hospital	New hospital plans have more patient toilets included
Need early access to leaflets & more info about the process & how it works	Started auditing & reviewing all patient information leaflets
Bookings sometimes get confused wrong appointment times	This issue has been highlighted to the appropriate department
A tea or coffee machine for out of hours would be great	While we haven't been able to provide a hot drinks machine out of hours at this time, we encourage patients to ask a staff member for a hot drink, who will be glad to provide one

Wall of Thanks

Thank you to all at Velindre Radiotherapy for the kindness and helpfulness you have shown me throughout my 20 sessions of radiotherapy.

There are no words big enough to thank you. I hope everyone is as good to you all.

Radiotherapy receptionists and staff on LA3, LA5, and LA6 also the doctors and nurses, we would like to thank you all for being so caring and attentive. You have been amazing. Thank you so much.

You all have lives outside of work yet your commitment to making me feel good and reassured has always been there- not just for me but all the other patients under your care



To the radiotherapy reception ladies, your support has been a great help these last five weeks.

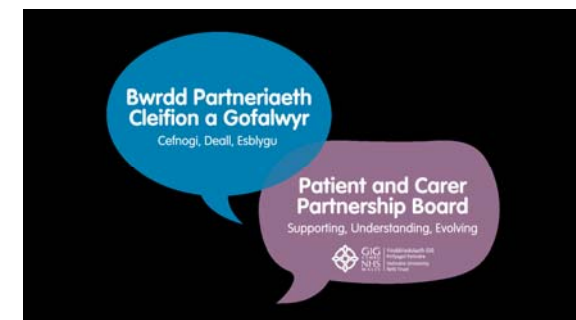
To all the caring and kind staff in Radiotherapy, thank you for the precious time you give to everybody.

Thanks to all [at Radiotherapy] for your help and another chance of life, especially LA6!

4.1 VELINDRE CANCER SERVICE – PATIENT ENGAGEMENT

Patient and Carer Partnership Board continues to meet monthly.

Topics	Output
Improving awareness and engagement with research, innovation and clinical trials (focus group session)	Engagement plan required including review of current web pages.
e-consent for Wales Cancer Biobank donations	Support for e-consent and wider agenda on increasing donations.
Increasing diversity within volunteers and board members	Development of stakeholder list and targeted plan to inform stakeholders of opportunities etc.
Increasing collection of diversity information at patient contact points	Development of script for staff to use.
Copy letters to patients	Anonymised sample letters to be reviewed by PCPB.
Arts in Health Strategy	Representative at MDT.
Radiotherapy Satellite Unit	Representative on Steering Group. Review of communications and information.
Use of QR Coded Wristbands in Palliative Medicine	Representative on Steering Group.
Never Events and Safety Dashboards	Feedback given to Corporate and VCS nursing team.

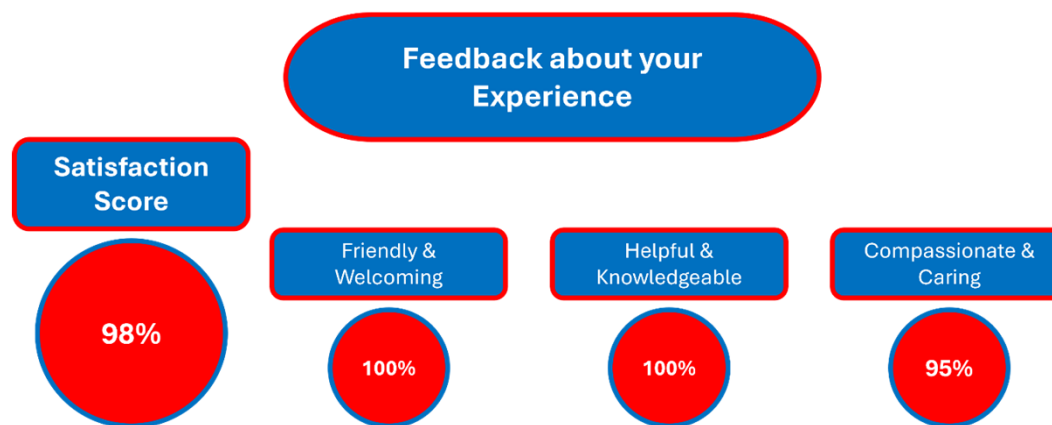


4.2 WELSH BLOOD SERVICE – DONOR EXPERIENCE

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.

**2,517 donors
provided
feedback**

**2,517 (11%) donors provided feedback this quarter - a slight decrease on Quarter 3,
2,791 donors (13%).**



4.2 WELSH BLOOD SERVICE – DONOR EXPERIENCE CONT.

	Responses	1 - On a scale of 1-5 how satisfied are you with your overall experience within the collection clinic to	2 - Based on today's visit did you find staff welcoming & friendly?	3 - Based on today's visit did you find staff helpful & knowledgeable?	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 - Based on today's visit were you provided with enough information about the donation process?	7 - Based on today's visit did you receive adequate emotional & physical support?	8 - Based on today's visit did you find a good standard of hygiene & cleanliness?	9 - Based on today's visit did you feel safe?	10 - Based on today's visit do you feel you were offered quality of care?	11 - Based on today's visit are you satisfied with the venue & facilities?	12 - Based on today's visit were you satisfied with the snacks and beverages available to you?	Overall
Location		Compliments and Concerns. West Team	Compliments and Concerns. West Team	Compliments and Concerns. West Team	Compliments and Concerns. West Team	Compliments and Concerns. West Team	Compliments and Concerns. West Team	Compliments and Concerns. West Team	Compliments and Concerns. West Team	Compliments and Concerns. West Team	Compliments and Concerns. West Team	Compliments and Concerns. West Team	Compliments and Concerns. West Team	
Bangor Team	206	98	100	100	100	100	100	100	100	100	100	99	100	100
Donation Clinic (TG)	11	100	100	100	100	100	100	100	100	100	100	100	100	100
East A	374	98	99	100	100	100	100	100	100	100	100	99	99	100
East B	403	98	100	100	100	100	100	100	100	100	100	99	99	100
East C	531	99	100	100	100	100	100	100	100	100	100	100	100	100
West Team	566	98	100	100	100	100	100	100	100	100	100	99	100	100
Wrexham Team	428	98	100	100	100	100	100	100	100	100	100	100	100	100
	Overall	98	100	100	100	100	100	100	100	100	100	99	99	100
	Benchmarks	95	95	95	95	95	95	95	95	95	95	95	95	

4.2 WELSH BLOOD SERVICE – DONOR ENGAGEMENT

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 ask respondents a number of questions about the service we provide. Respondents are asked to score these services, with six being totally satisfied and one being totally dissatisfied.

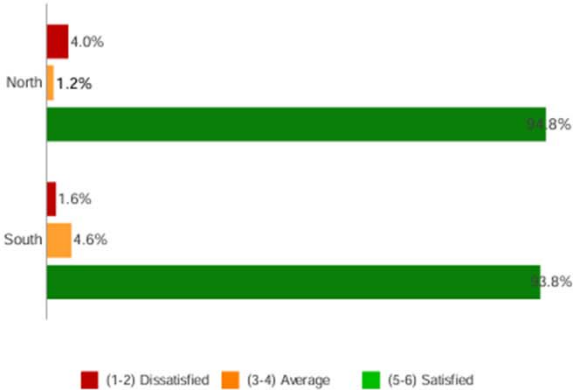
Donor satisfaction for those who had successfully donated was 97.1%.

Donor satisfaction for every respondent, including incomplete donations.

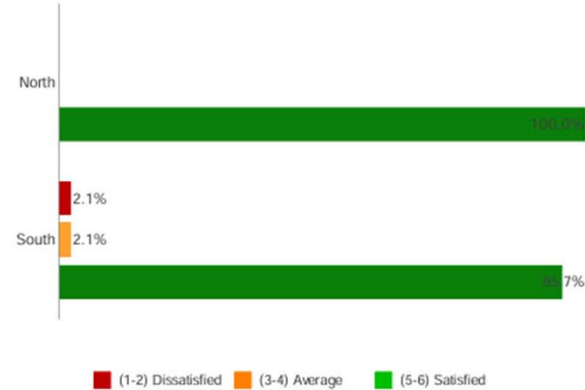
Overall (734) | 97.1%
 N.Wales (157) | 99.4%
 S.Wales (577) | 96.5%

Overall (802) | 94.0%
 N.Wales (173) | 94.8%
 S.Wales (629) | 93.8%

Graph 8



Graph 9



Donation day

Donation day experience	Process comfort	Process duration
96.2% 85.1% scoring 6/6	96.2% 87.4% scoring 6/6	97.1% 90.8% scoring 6/6

Donor engagement and sentiment

Contact centre experience	Feeling valued	Eligibility info. available
96.1% 76.4% scoring 6/6	95.7% 83.8% scoring 6/6	93.3% 80.3% scoring 6/6

Venues

Cleanliness	Accessibility
97.4% 84.8% scoring 6/6	94.2% 81.1% scoring 6/6

4.2 WELSH BLOOD SERVICE – DONOR ENGAGEMENT CONT.



Based on feedback received, operational managers have:

- Reviewed cleanliness of Mobile Donor Units (MDU) to ensure a high standard of cleanliness is always maintained.
 - The MDU's receive a deep clean weekly when the vehicle is available to facilities. The team clean the surfaces and equipment every day and between donors as appropriate.
- Supported staff to undertake Welsh language learning.
 - All staff who have expressed an interest in progressing their language skills have been supported with either study leave or fixed working days to allow them to attend.
- Provided mobile heaters for Collections Teams.
 - New Dysons purchased and sent out to both Trailers.
- Undertaken a full review of venues to identify and address issues that would affect donor experience.

4.2 WELSH BLOOD SERVICE – DONOR EXPERIENCE CONT.

Welsh Blood Service Wall of Thanks

East B - Nothing . I have given blood for 40 yrs and all the staff have always been very welcoming.

Bangor - Everything was carried out with care and professionalism. Nothing needs to change. It was like a well-oiled machine

East A - Nothing. Friendly, welcoming and knowledgeable staff made the process of donating quick, safe and easy.

Platelets - Nothing. Keep up the good work and service that you are already providing

West Team - Staff were very polite Rod, Owen and Emma deserve to be recognised for their extreme patients and kind consideration. Many thanks to all the team

East C - Continue with the good work! You are all doing really well with what you do!

Wrexham - Nothing. The experience was as perfect as always.

4. TRUST OVERVIEW – Patient and Donor Experience cont.



During Q4, The People’s Experience Standard was produced within the Trust. The standard was in preparation for the Peoples Experience Framework that is due to be released by Welsh Government (WG). The Patient and Donor Working Group undertook a scoping exercise with both divisions to identify how feedback was obtained and shared across the Trust. Incorporating this into the Standard. An Implementation Plan was developed, and the Group started to work through the Good Practice Self-Assessment Tool.

The Working Group name changed to match the pending WG Framework, to “People’s Experience Group”. The triangulation of experience feedback data alongside other metrics, e.g. outcomes, as depicted on the Listening and Learning Tree is indicative of an organisation committed to quality.

The Trust is looking at how best we can capture Digital Stories. This was agreed back in 2021 by Welsh Directors of Nursing, that digital storytelling would form a keyway of capturing feedback and learning to improve our services. A Trustwide Digital Story Group has been set up, with meetings taking place monthly. We have an SMS Implementation Plan in place

The Trust is at the infancy stages of implementing SMS for feedback. We have set up a Trust-wide SMS Migration Group.

We are also working towards implementing the People’s Experience National Survey in Quarter 1 across the Trust.



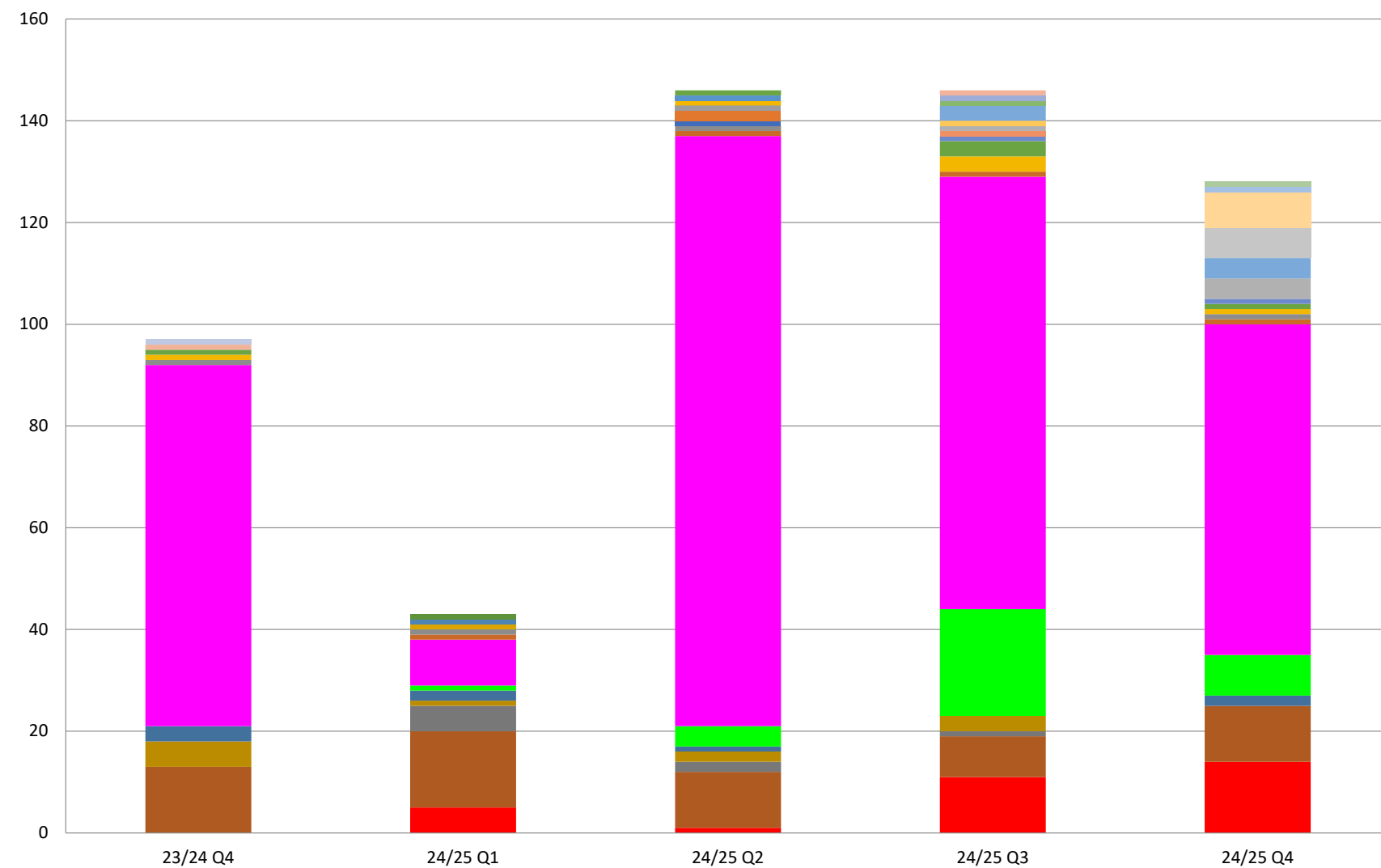
Listening and Learning Tree

4.3 TRUST OVERVIEW – COMPLIMENTS

Graph 10

Compliments Received Trust Wide

- WBS Dafen
- Donation Clinic / Training area
- Rhosyn Day Unit-Ward
- Pharmacy Department
- Chemotherapy Day Unit (CDU)
- Ambulatory Care Unit
- Patient Information Centre
- Palliative Medicine
- Outpatients Department
- Medical Records Department
- First Floor-Ward
- Cancer Services Management Offices
- Velindre Hospital
- Clinical Nurse Specialists
- Trailer 1
- Community Blood Donation Clinics
- VCC Radiotherapy Physics Department
- Clinical Trials Department
- Cancer Research Wales
- Public Place
- Rowan Ward
- Private Patient Department
- WBS Talbot Green
- Speech and Language Therapy Department
- VCC Radiotherapy Department
- Radiology Department (XRAY)
- Physiotherapy Department
- Occupational Therapy Department
- Dietetics Department
- Welsh Blood Service
- Velindre Cancer Service



4.3 TRUST OVERVIEW – COMPLIMENTS



ANALYSIS

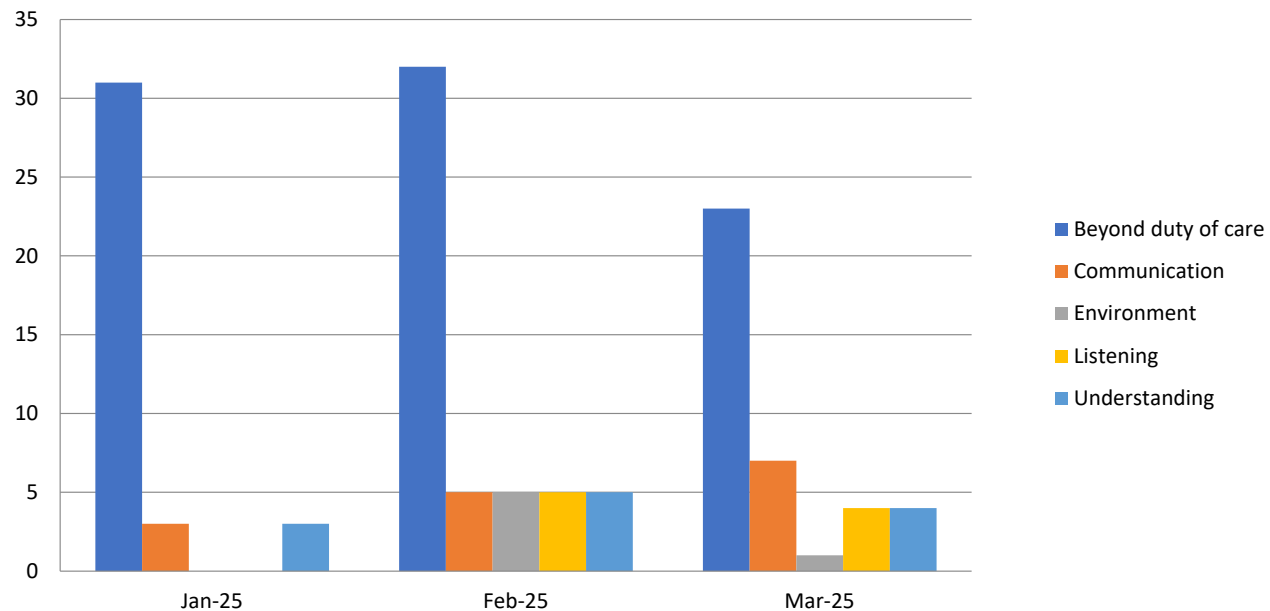
For Q4 a total of **128** compliments were recorded on Datix.

114 compliments were received by Velindre Cancer Service and **14** compliments were received by Welsh Blood Service.

Work is being undertaken in WBS regarding recording compliments on Datix as other systems within the division are used for this gathering this information.

Graph 11

Compliments Received by Subject (Quarter 4)



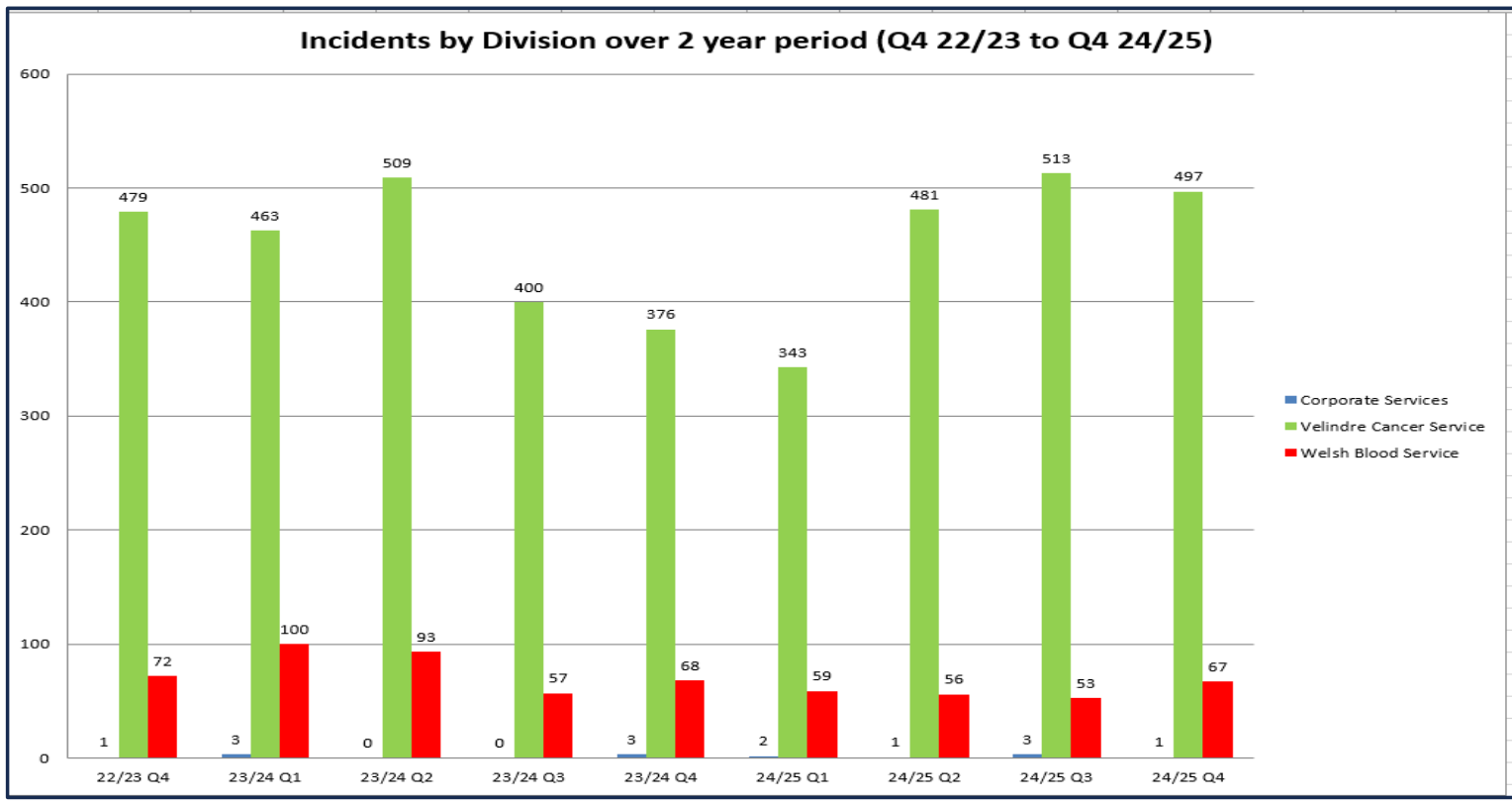
5. INCIDENTS – TRUST-WIDE OVERVIEW

Patient and donor safety incidents are any unintended or unexpected incidents, which could have, or did, lead to harm for one or more patients/donor's receiving healthcare. Incidents are all reported incidents being reviewed at service level, through Quality and Safety leads and the Quality and Safety Hubs.

Quarter 4 Trust Incident Summary

Total Incidents Reported	Corporate Services	Velindre Cancer Service	Welsh Blood Service
565	1	497	67

Graph 12



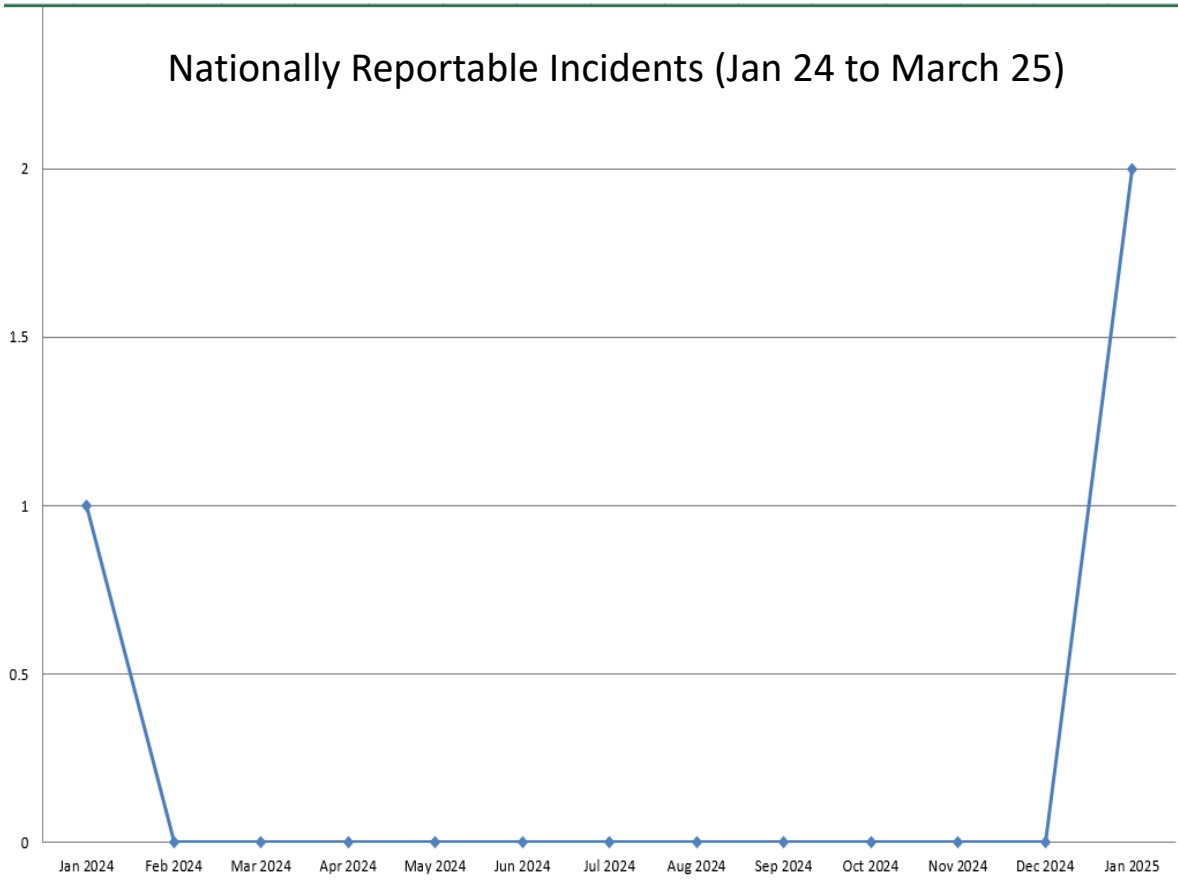
Analysis of incidents is provided per Division in later slides.

5.1 NATIONAL REPORTABLE INCIDENTS (NRI)



Graph 14

Nationally Reportable Incidents (Jan 24 to March 25)



ANALYSIS

As shown in graph 14 there have been 2 nationally reportable incidents in Q4 reported in January 2025 .

Both incidents met the criteria for severe harm and were reported to the NHS Executive in line with National Policy requirements. One investigation remains ongoing and one investigation closed within the 30 day agreed timescale

Learning Identified

- Improved communication between multidisciplinary teams.
- Ensuring Clinical staff utilise multiple systems to obtain patient clinical information.



Severe Harm:

A service user experiences a permanent disability or loss of function and the NHS care did or may have contributed.



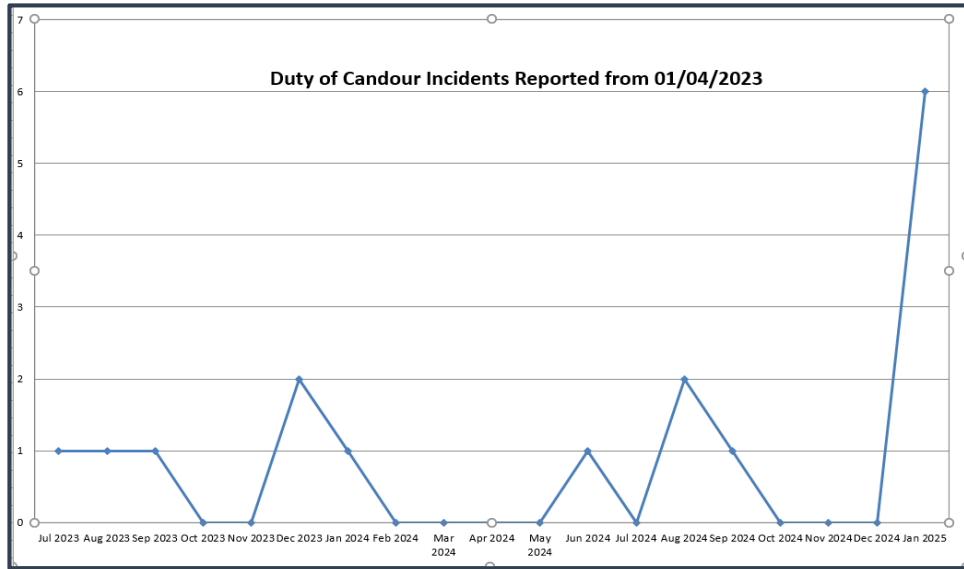
Death:

A service user dies and the NHS care did or may have contributed to the death.

5.2 INCIDENTS – DUTY OF CANDOUR



Graph 13



Harm Assessment

19 incidents were initially reported as moderate and 1 as severe in Quarter 4.

Following the initial management review process the incidents grading was revised as below.

Support is provided by Datix leads to reporters regarding appropriate grading of incidents.

Reporter's initial harm assessment	Manager's interim harm assessment	Number of Incident sRegraded
Moderate	None	3
Moderate	Low	13
Moderate	Moderate	1
Moderate	Severe	1
Severe	Moderate	1

ANALYSIS

During Quarter 4, 19 incidents were initially graded as causing moderate or severe harm. Following review of the harm grading, 16 incidents were downgraded to low or no harm. Following the initial harm assessment 6 incidents triggered the Duty of Candour process in Quarter 4, this includes 2 Incidents reported in Quarter 3 but first identified as Duty of Candour in January 2025. As shown in graph 3, this is a significant increase in moderate or greater harm incidents.



5.2 INCIDENTS – DUTY OF CANDOUR CONT.

ANALYSIS

6 incidents in Q4 are being managed under Duty of Candour meaning they potentially caused moderate harm or above, with 2 of the 6 incidents also being reported as a National Reportable Incident meaning they potentially caused severe harm. One investigation was closed, and 5 Duty of Candour incidents are currently under investigation, at the end of quarter 4.

THEMES NOTED

1	Use of email for communicating urgent medical information. There is a risk in place on the register and a task and finish group established and work ongoing to develop new processes and ways of working
2	Lack of robust process for ensuring all blood test results are reviewed in a timely manner. There is a risk in place on the register and a task and finish group established and work ongoing to develop new processes and ways of working to ensure that all blood results are reviewed in a timely manner
3	Use of electronic clinical systems – numerous issues identified including multiple systems in use that do not interface with each other; multiple clinical systems in use by different professional groups in isolation causing information to be missed; and issue surrounding important clinical information being missed on Welsh Clinical Portal due to the number of non-clinical annotations.
4	Staff knowledge and education around Granulocyte Colony Stimulating Factor medications. Training and education being provided by the Education Team
5	Transferring of acutely unwell patients between departments

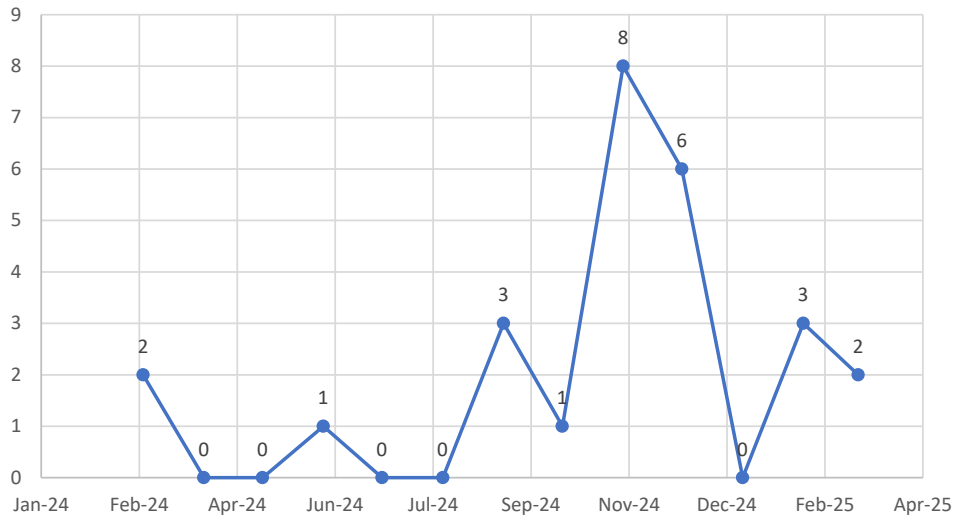
Improvement plans are being developed based on the investigation recommendations. These will be monitored via the Trust Regulatory Tracker and Quality & Safety governance processes. The findings and learning for these investigations will be reported in Quarter 1 25/26

5.3 IONISING RADIATION (MEDICAL EXPOSURE) REGULATIONS (IR(ME)R) REPORTABLE INCIDENTS



Graph 15

Significant Accidental or Unintended Exposures reported under IR(ME)R



- **Five** Significant Accidental or Unintended Exposures (SAUE) under the Ionising Radiation (Medical Exposure) Regulations IR(ME)R were reported to Health Inspectorate Wales (HIW) – On August 21st 2024 there was a change to HIW IRMER notification criteria guidance resulting in an increase in the number of incidents meeting reporting requirements.
- 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.

Radiotherapy Physics lead investigations:

- Two due to issues with the imaging system on the Elekta treatment machine.
- One due to repeat imaging due to an image reconstruction issue on the Varian treatment machines.

Radiotherapy Service lead investigations:

- Planning scan needed to be repeated twice to obtain an appropriate dataset (3 scans in total, including the intended scan)

5.4 SHARING LEARNING FROM INCIDENTS & IMPROVING CULTURE

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 **MAKE IT SAFE** reviews to effectively identify improvements by raising and reviewing incidents in line with the Trust Incident Framework. All staff involved in the Make it Safe process have commended the supportive Just Culture collaborative approach.*

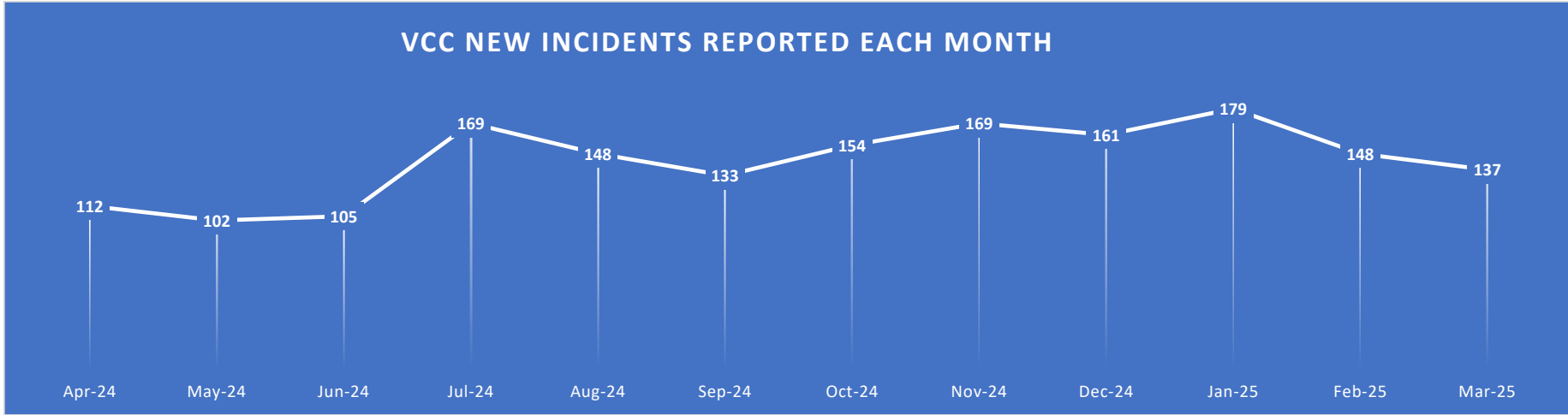
On completion of the full investigation process, a **Learning from Review** event is held, and **feedback is provided to all those involved**, plus the wider teams, to share the **investigation outcome and learning**.

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.

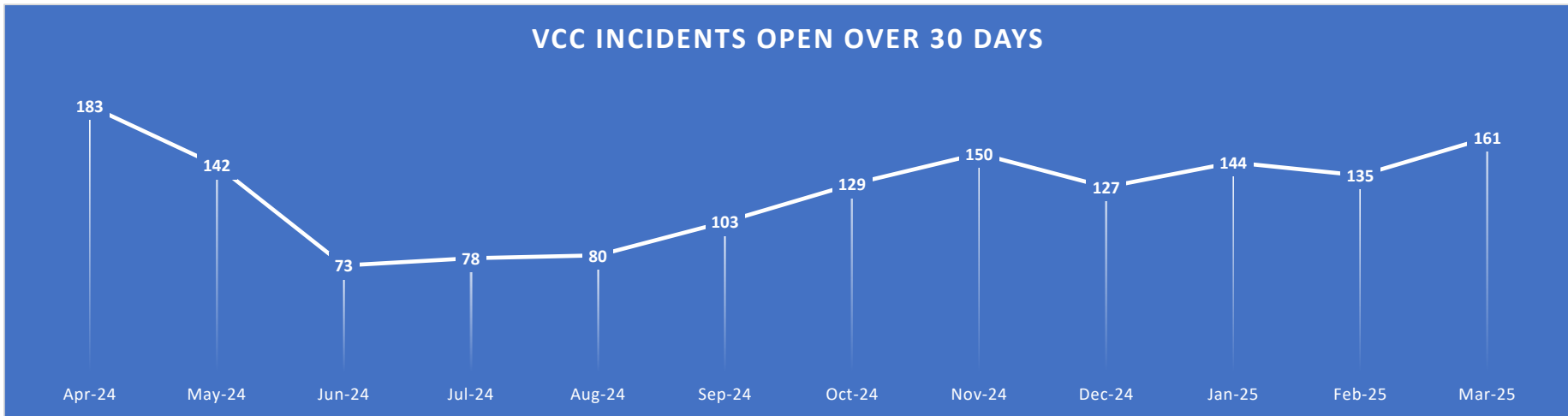


5.5 VELINDRE CANCER SERVICE – INCIDENTS

Graph 16

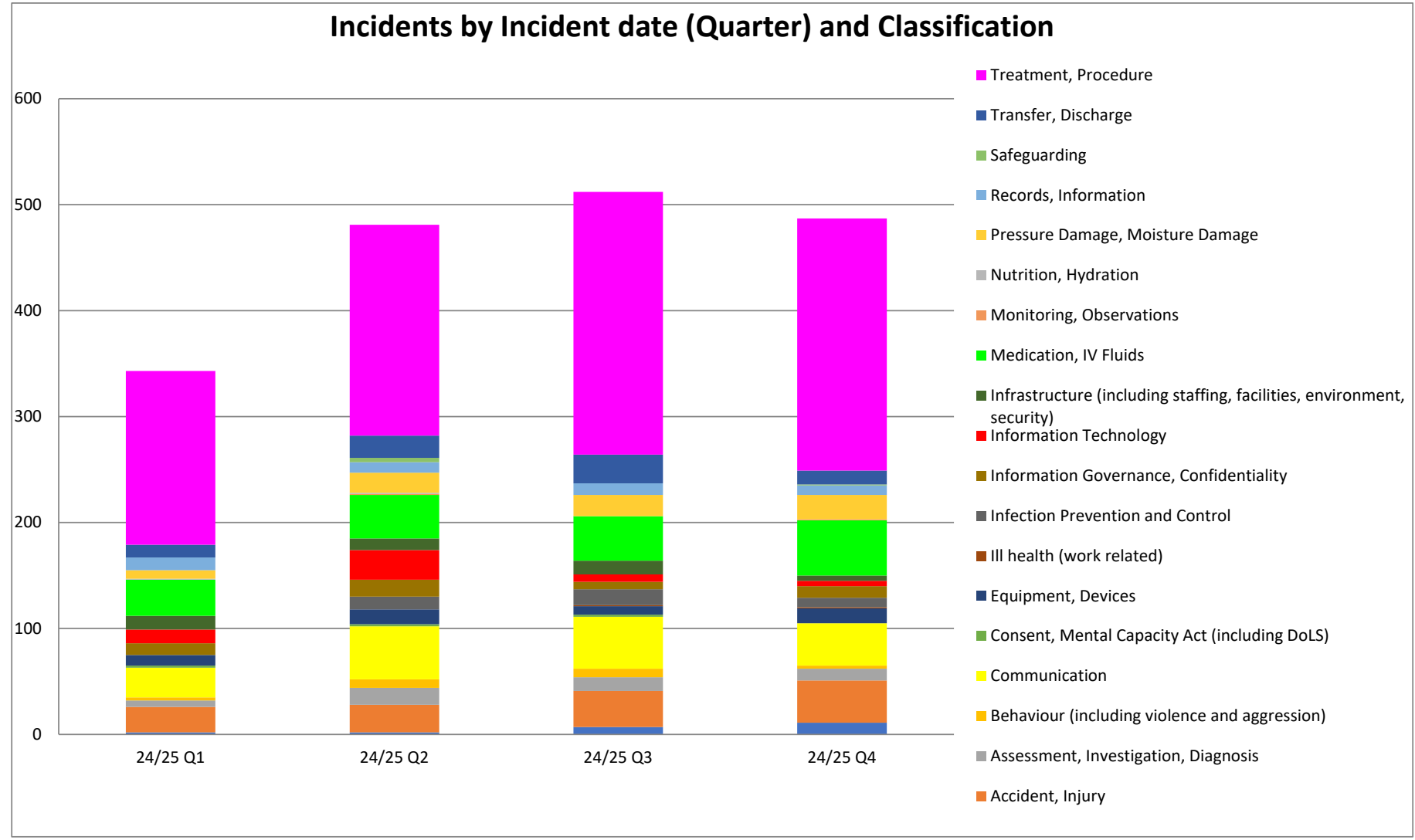


Graph 17



5.5 VELINDRE CANCER SERVICE – INCIDENTS

Graph 18



5.5 VELINDRE CANCER SERVICE – INCIDENTS CONT.

Graph 17 shows an increase in the number of incidents open over 30 days across the Cancer Service. Work is ongoing with departments to improve this, including regular reports and incident management training and education.

Theme noted around hospital provided transport related to delays in Welsh Ambulance Service Trust transport, waiting times for patients, and attitude of taxi drivers (not NHS staff). This is being formally reported through the WAST/VCS meeting.

Theme identified relating to inpatients through incidents (including 2 Duty of Candour incidents), concerns, and mortality reviews mainly around communication of care, and roles and responsibilities of staff. Improvement actions include education and clinical audit.

Graph 18 identifies that the highest number of incidents related to 'Treatment and Procedure' which is in keeping with previous reporting periods. The majority of these relate to no harm incidents associated with a known machine issue in radiotherapy that the Trust is required to record on the Datix system.

5.5 VELINDRE CANCER SERVICE – INCIDENTS CONT.

Following the quarter 3 focus on medication incidents, the quality hubs will undertake focused work using the Yorkshire Contributory Factors to identify trend analysis learning from incidents involving falls and pressure damage. Every month a learning panel held to discuss the data, for both Pressure Ulcers and Falls. At the panel, members determine whether the incident are avoidable or unavoidable. March learning panels have not been discussed due to learning panels not being quorate. Discussions will be held on 24th April 2025.

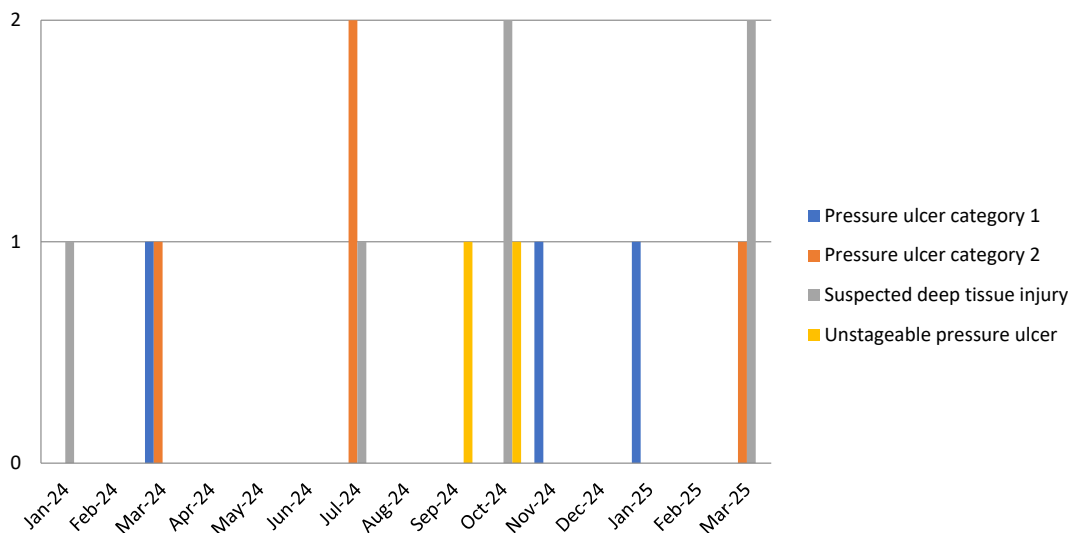
Pressure Ulcers

The graph below shows that 4 incidences of hospital acquired pressure damage were recorded at VCS during quarter 4. All VCS acquired pressure ulcers are investigated in line with the All-Wales Pressure Ulcer Investigation Tool and reviewed in pressure ulcer panel, where it was agreed that the threshold for safeguarding, Duty of Candour and National Reportable Incident was not met.

Learning

A review of the patient handover process between the assessment unit and the ward is underway.

Pressure Ulcers by Category



Falls

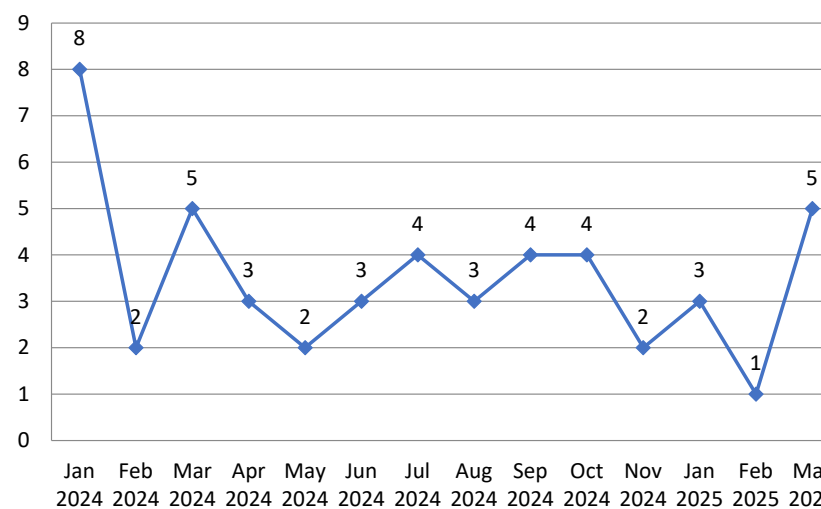
9 inpatients falls were reported in quarter 4, this is a decrease to last year's quarter 4, which was 16 inpatient falls.

In quarter 4, 1 inpatient fall was agreed avoidable. This was due to the handrail in the bathroom detaching from the wall. No injury was sustained to patient.

Learning

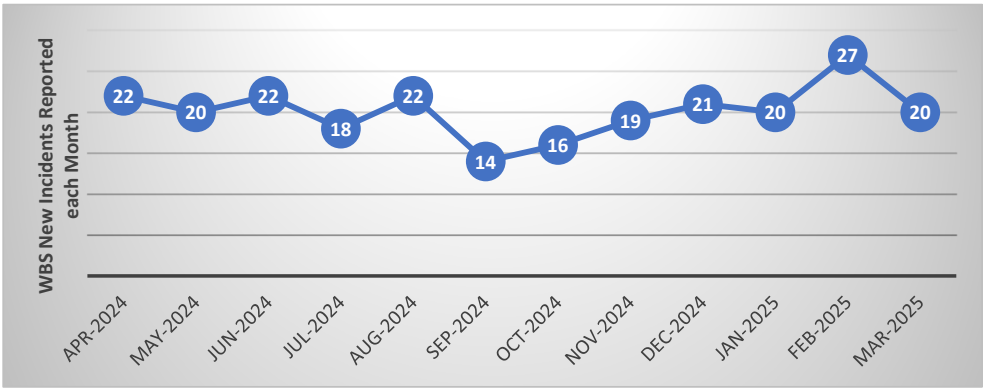
Health and safety were made aware of the incident and have now installed new secure handrails.

Inpatient Falls Reported at VCS by Month

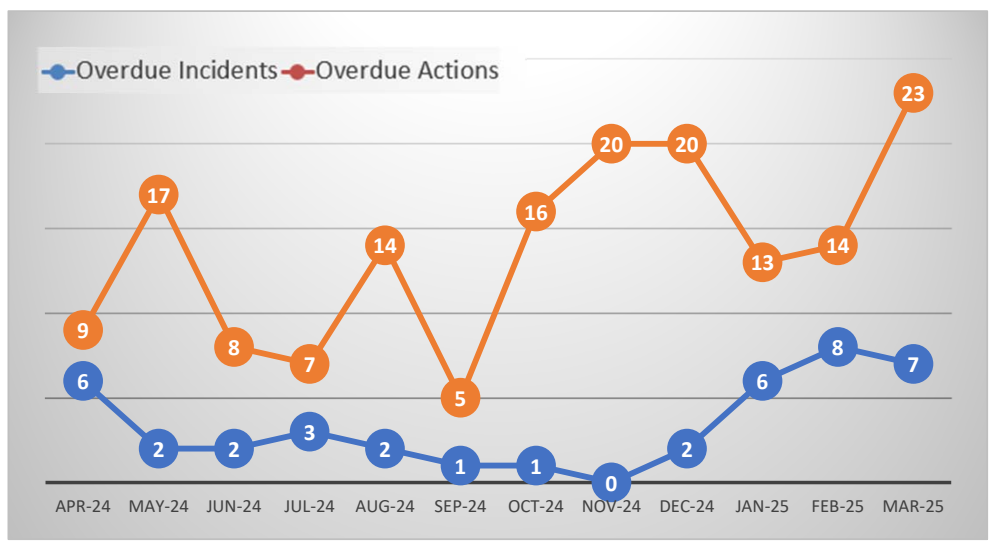


5.6 WELSH BLOOD SERVICE – INCIDENTS

Graph 19 New incidents reported each month



Graph 20 Trend of overdue incidents and actions



Incidents which may result in harm to donors, patients, or staff are reported in Datix Cymru for consistency across the Trust.

ANALYSIS



Graph 19: incident reporting via Datix showed a peak in February (27 events) with the main category being accident and injury. Overall, the number of reports remains low, with no significant trends identified. Monitoring of reports for trends is continuous.

OVERDUE ACTIVITY PERFORMANCE TRENDS

Graph 20: The number of incidents exceeding the target date for closure (30 days) remains very low, however after an initial decline the number of overdue actions has peaked at 23. Reasons for late completion are explored; these usually link to high workload versus staff availability, and occasionally a single event may result in one person managing several actions.

Quality Assurance Triage continue to engage with incident managers and investigators, and information is shared with departmental managers and SLT, to help drive improvement in timely management of reports.

LEARNING AND OUTCOMES

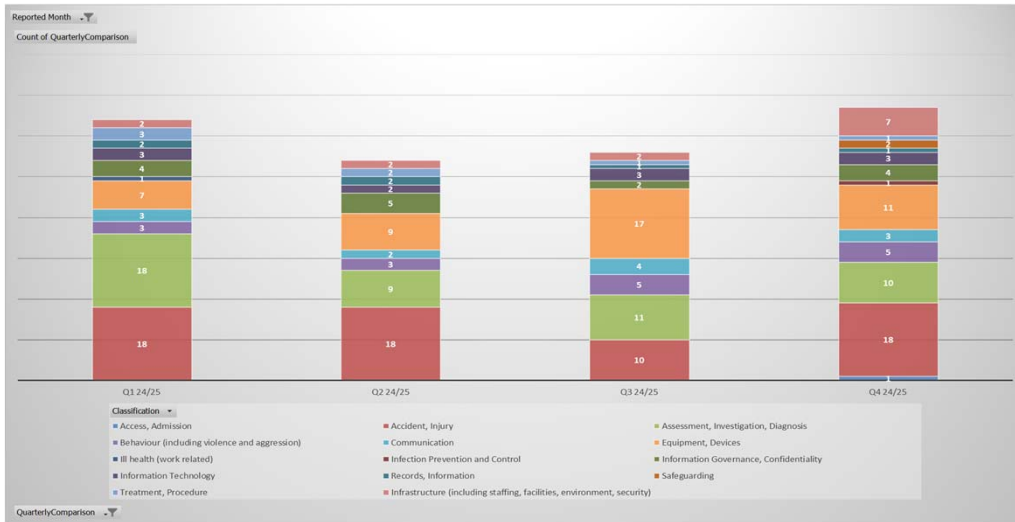


There is a requirement for managers to assess risk and submit a formal extension request where actions have been open longer than expected.

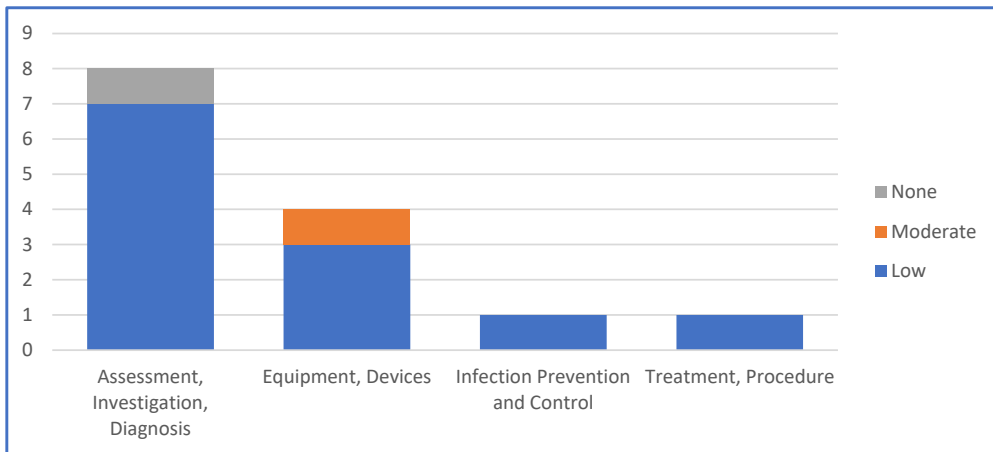
SLT are advised of these statistics monthly and are responsible for following up with their teams. Where an individual has been assigned several actions, they can arrange for these to be reassigned to a suitable colleague.

5.6 WELSH BLOOD SERVICE – INCIDENTS CONT.

Graph 21 WBS Incidents by theme – Quarterly comparison



Graph 22 Datix GMP Incidents reported Oct to Dec 2024



ANALYSIS

Graph 21: The most frequently reported themes in Quarter 4 are consistent with previous quarters:

- Accidental injury (18) - no themes identified
- Equipment and devices (11) - no themes identified.
- Assessment, investigation, diagnosis (10) - usually related to 'late donor information' which is subjective to each donor. No theme identified.



LEARNING AND OUTCOMES

Graph 22: 14 incidents relating to quality and safety of blood components were reported via Datix. The majority relate to late (post-donation) donor information; the decision to accept the donor was correct based on information available at the time of donation.

One of these events was assessed as 'moderate harm' and relates to an HTA reportable event involving a temperature excursion during transport of a stem cell donation – see slide 39 for details.

All events have been investigated, with no significant trends identified.

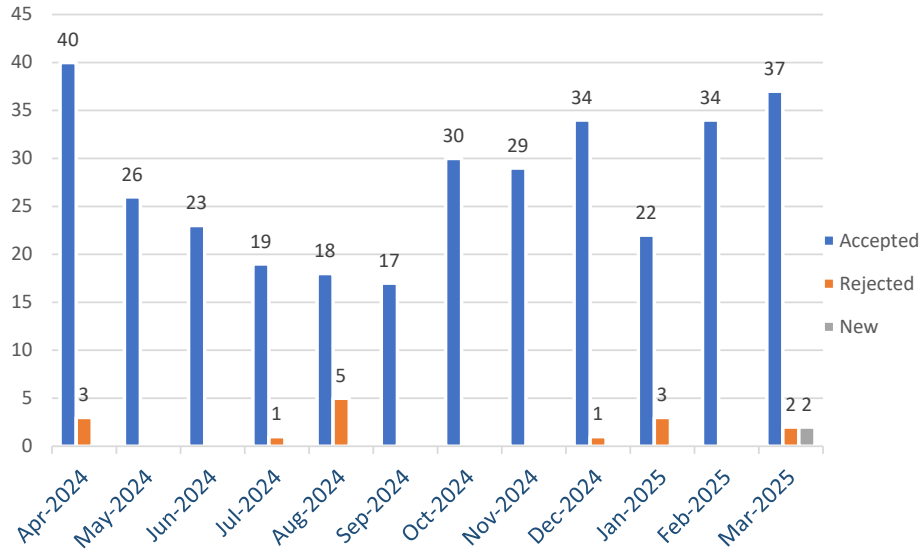
More information on accidental injury reports can be found in the Health and Safety section of the report.

5.6 WELSH BLOOD SERVICE – INCIDENTS CONT.

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 23 - GMP Incidents reported via Q Pulse 2024



ANALYSIS

Graph 23: 100 GMP incidents were reported in Quarter 4, compared to 91 in Quarter 3.

There is one significant trend, relating to manual transcription errors within antibody screening reports; this has been subject to a holistic root cause analysis investigation and barrier analysis.



LEARNING AND OUTCOMES

Transcription errors in manual processes are not unexpected, 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).

A designated quiet area for report writing and authorisation has been implemented. Additional actions to reduce recurrences are: implementation of a temporary digital solution, adoption of a two-person writing and authorisation process, and reallocation of workload .



5.6 WELSH BLOOD SERVICE – EXTERNALLY REPORTED INCIDENTS (SABRE)

ANALYSIS

During Quarter 4, five adverse events were reported externally to MHRA via the SABRE portal.

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.

Incident	Outcome/Improvement
<p>Malaria antibody screening sample not taken from a donor who had travelled to a malaria risk area: The donor's travel to a specific country was overlooked, potentially due to a complex travel history involving visits to multiple countries during one holiday.</p>	<p>Work is being undertaken to explore implementing a digital tool that allows donors to verify their travel history; this will reduce reliance on memory and verbal communication.</p> <p>Travel assessment complexities are being discussed at national level, to try to address the challenges of travel related queries and explore ways to empower staff with the tools and guidance necessary to make accurate assessments.</p>
<p>Donor blood grouping discrepancy not picked up by secondary checks; there was a discrepancy between a historical blood group (1990) and the most recent blood grouping result. The donor had not donated in Wales during the interim period.</p>	<p>An incorrect blood group had been assigned in 1990, due to a failure of the secondary check undertaken during manual testing.</p> <p>MHRA rejected the report as the failure occurred before the introduction of the Blood Safety & quality regulations.</p> <p>The existing quality management system identifies and prevents release of donations where discrepancies have been identified.</p>
<p>IPC Audit findings were not acted on immediately; poor practice was observed at a blood donation session. The auditors did not intervene but reported verbally to a Registered Nurse (RN). The RN did not take immediate action to ensure the donations were managed as non-conforming.</p>	<p>Product recalls were initiated for seven donations identified as non-conforming. Bacterial monitoring status of all donations was checked and found to be negative and there were no reports of suspected transfusion reactions for any of the recipients of these units. A full RCA investigation is being conducted.</p>

5.6 WELSH BLOOD SERVICE – EXTERNALLY REPORTED INCIDENTS (SABRE, page 2)

Incident	Outcome/Improvement
<p>IT communication failure between BacTALERT (bacteriology monitoring system) middleware and eProgesa (the Blood Establishment Computer System). System was not manually monitored for positive results during communication failure.</p> <p>There were no bacteriology positive results during the period when the software was not communicating with eProgesa, but there was a risk that any positive results would not have been managed effectively.</p>	<p>The communication failure was caused by an issue with the firewall. It was assumed, due to recent similar events, that the issue would self- resolve. This assumption led to a failure to advise lab staff that the system should be manually monitored.</p> <p>The firewall is due for replacement, which should remove the risk of a communication failure. Lessons learnt regarding assumptions made will be shared; manual monitoring should be undertaken until Digital Services confirm that issues have self-resolved. This requirement will be included within the process moving forward.</p>
<p>Between 13/03/25 and 20/03/25 there was a risk that a Clinic Collection Assistant (CCA) had not followed the correct process for timing donor arm cleansing prior to venepuncture, leading to a risk of potentially contaminated blood components.</p> <p>A multidisciplinary team reviewed clinical risk and actions required to make safe. All units associated with seven donations were discarded as a precaution and the issue was discussed with the CCA.</p>	<p>The CCA was using a wall clock rather than a digital timer, as the digital timer is difficult to reach due to mobile donation clinic layout.</p> <p>Lesson learnt regarding the need to report difficulties in complying with standard operating procedures shall be shared, to ensure these can be explored and managed effectively.</p> <p>A broader issue regarding failure to escalate concerns about adherence to Aseptic Non-touch technique is being explored by the Clinical Operations Managers; it is suggested that a process should be developed to describe RN responsibilities for handover of concerns that require management within a short timeframe.</p>
<p>IPC Audit findings were not acted on immediately; poor practice was observed at a blood donation session. The auditors did not intervene but reported verbally to a Registered Nurse (RN). The RN did not take immediate action to ensure the donations were managed as non-conforming.</p>	<p>Product recalls were initiated for seven donations identified as non-conforming. Bacterial monitoring status of all donations was checked and found to be negative and there were no reports of suspected transfusion reactions for any of the recipients of these units. A full RCA investigation is being conducted.</p>

5.6 WELSH BLOOD SERVICE – EXTERNALLY REPORTED INCIDENTS (HTA)



ANALYSIS

During Quarter 4, three adverse events were reported externally to the Human Tissues Authority (HTA). All events involve collection of stem cells by a 3rd party. These were reviewed and investigated, and root cause analyses and corrective actions have been reviewed by relevant members of the WBS Integrated Quality and Safety Hub.

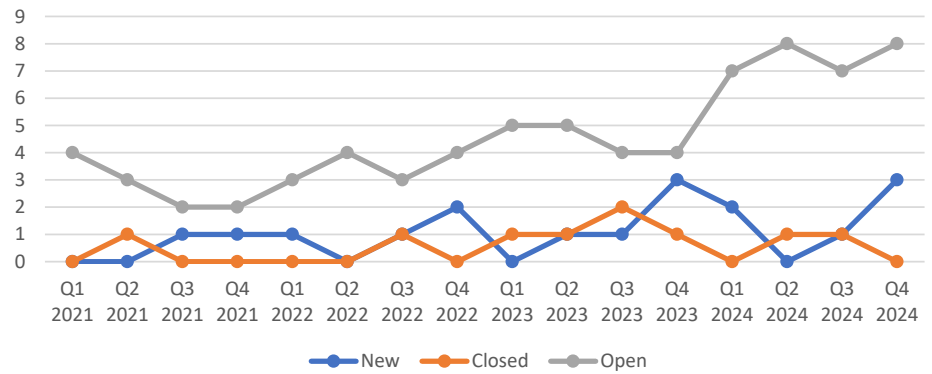
Incident	Outcome/Improvement
<p>CAS-74092-H7X1. (Datix 21579) The London Clinic, which collects stem cells on behalf of WBMDR, reported that one of three bags harvested was positive for Staphylococcus hominis, a skin bacterium. Risk to patient safety is low; these bacteria very rarely cause post transplant complications, but this could not be ruled out</p>	<p>Patient transplant team informed; they indicated that they would administer antibiotics if necessary. The London Clinic were asked to investigate the possibility of sampling error and provided assurance that all protocols were correctly observed. TLC is a HTA and JACIE accredited centre and their contamination rate of 11% is in line with global rates for this procedure. There was no patient harm as a result of this event.</p>
<p>CAS-74412-K5HO (Datix 22092): Transport box issue, stem cells transported below zero degrees (box temperature) which is below the acceptable temperature limits for transportation of stem cells.</p>	<p>Preliminary risk grading (moderate) was revised to 'none' following investigation.</p> <p>Viability of stem cells was 99.9% which indicates the cells had not frozen and could be safely used in the transplant, as planned.</p> <p>The management review found that there are a small number of gaps in the process for transporting stem cells; learning has been shared with UHW and a joint SOP is being developed to cover these gaps. .</p>
<p>CAS-74462-F8Q2 (Datix 22169): Second (separate) report from The London Clinic regarding one of three packs collected being bacterially contaminated.</p>	<p>Bone marrow harvest incurs such incidents as the needle being pushed through the skin may take skin into the needle which then can be transferred to the collection bag. The WBMDR will continue to monitor and report similar events to the relevant bodies. TLC has assured the WBMDR bone marrow harvest is undertaken in line with its regulatory and accreditation responsibilities from the HTA and JACIE.</p>

6. REDRESS



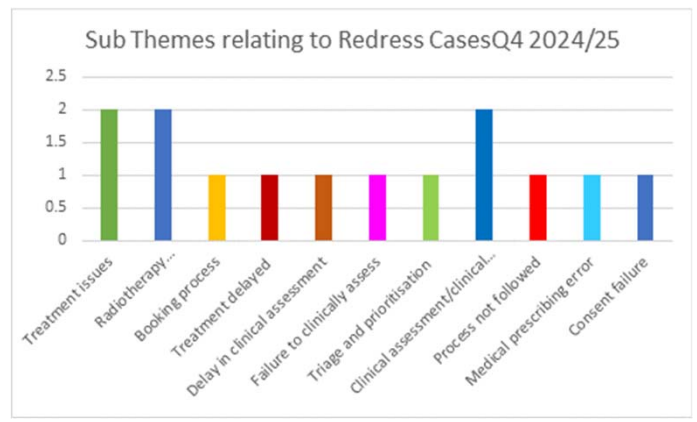
Graph 24

Redress Analysis Comparison from Q1 2021 - Q4 2024/25



Redress themes

No themes were apparent in Redress cases at the end of Q4 2024/25



As demonstrated in Graph 24, Q4 has seen a rise in Redress matters. The increase in Redress cases has arisen following the introduction of the Duty of Candour and aligns with the Duty of Candour principles and the Putting Things Right regulations.

ACTIVITY

3 new Redress cases opened

7 cases remain under investigation. 1 Qualifying liability admitted.

0 cases closed

No Learning from Events Reports were submitted to the Welsh Risk Pool during Q4.

6. REDRESS



Redress Review

8 cases remain under investigation over 12 months from the date when the incident/complaint was reported. This exceeds the Welsh Government target to complete Putting Things Right matters within a 12 month period. There are a number of reasons for breaching the target, including:

- Delays experienced in receiving Compensation Recovery Unit Certificates issued by the Department of Works and Pension due to misdirection. Without a valid CRU Certificate the case cannot proceed to settlement. Efforts are being made to identify the reasons to prevent undue delay in quantifying cases.
- Several PTR investigations have exceeded the target of 30, 60 or 90 days, due to complexity.
- Failure to follow PTR process and identify correct recipient/ personal representative of deceased patient, culminating in delay in proceeding with Redress. A process has since been introduced addressing next of kin issues.
- Delay in receiving medical records from NHS providers.
- Instruction of independent expert - additional time is needed to identify suitability of expert and instruct on joint basis and await findings.
- Increase in workload of cases involving Redress, inquests and claims. The team has recently expanded to 2 part time Claims, Redress & Inquest Managers.

7. CLAIMS

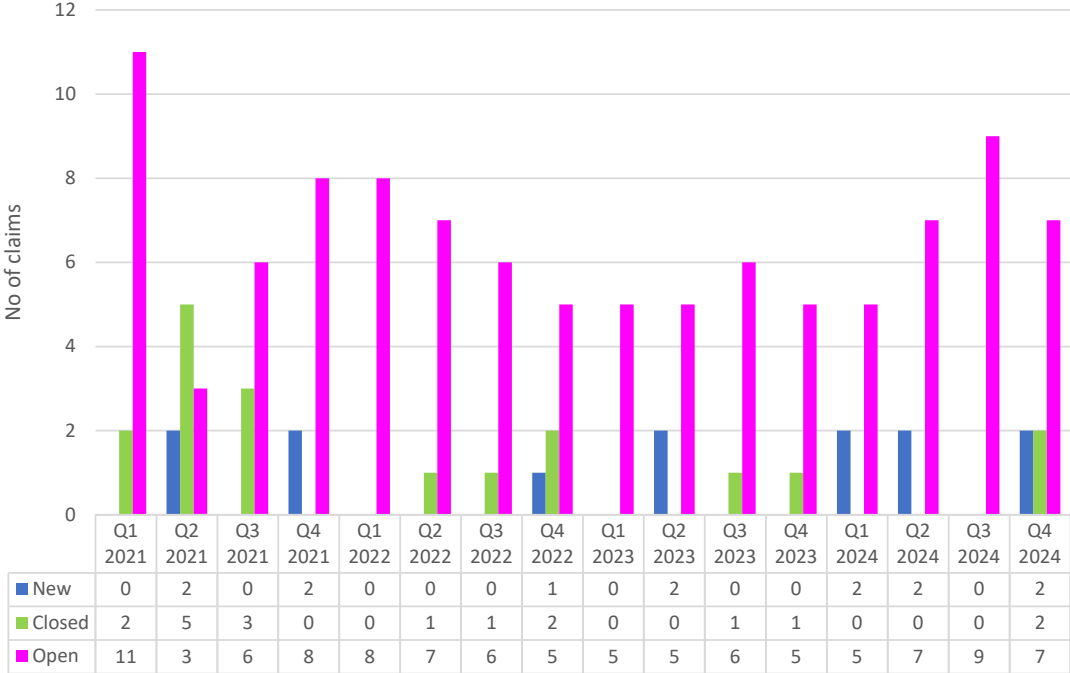


Graph 25 provides an illustration of the claims activity in comparison to previous quarters. During Q4:

- 2 new claims were received.
- 2 claims were closed. 1 was closed following reimbursement by the Welsh Risk Pool in Q3 in the sum of £649,572.50. 1 was closed following denial of liability.
- 7 claims remain under investigation. The claims portfolio for the reporting period continues to remain stable. 1 claim has identified liability and an admission has been made in relation to breach of duty and a Learning from Events Report has been submitted to the Welsh Risk Pool.
- **Financial Liability:** The Trust’s estimated financial liability for claims at the end of Q4 is reduced from £1,534,576.23 in Q3 to £1,498,332.23 in Q4.
- In the event the Trust were to settle its current caseload, the Trust’s liability is £200,000. This is a slight reduction from Q3 by £4,244.

Graph 25

Claims Analysis from Q1 2021 - Q4 2024



7. CLAIMS Improvements



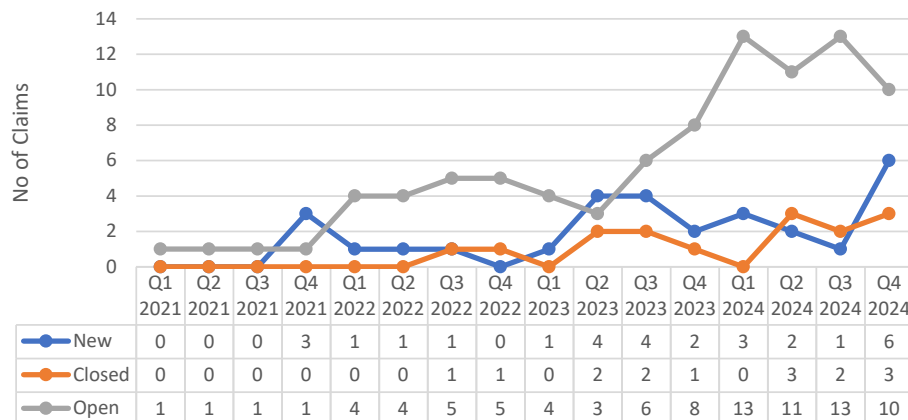
Improvement actions taken following claims investigations				
Updated NEWS, Sepsis and SACT Training	Introduced clinical annotation template	Updated NEWS Sepsis Policy	Implementation of All Wales aligned NEWS chart	Lawtel has been introduced for claims handlers. This will enable claims managers to determine quantum
Introduction of NEWS Cymru audit template	Approval of All Wales Clinical Supervision framework	Training – Induction - Neutropenic sepsis	Updated SACT Guidelines	Review of the sarcoma services

8. INQUESTS



Graph 27

Analysis of Inquests from Q1 2021 - Q4 2024/25



During Quarter 4:-

- 6 new inquests were opened
- 3 inquests were closed - no witnesses from the Trust were summoned to attend the inquests and no issues were identified affecting the Trust.
- 10 inquests remain open - 1 inquest was adjourned pending further evidence sought by the Coroner.

*Please note that the graph above, no longer includes Marie Curie Hospice inquests. Trust personnel provide statements for the Coroner in such inquests.

ANALYSIS

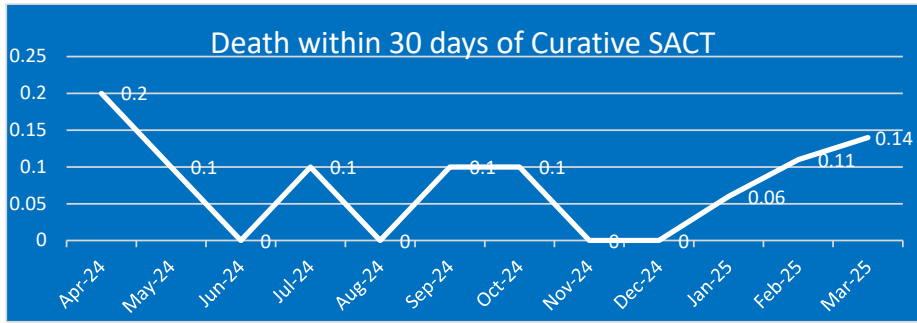
Graph 27: Whilst there has been a rise in inquests being opened during the reporting period, no trends, themes, risks or issues have been identified relating to the new inquests. Following one inquest, the family wished to highlight that they **“couldn’t fault all the care and treatment ... received. All the staff were brilliant”**. This positive feedback demonstrates the level of care and treatment that is provided to our service users.

Update - Outcome of Hearing One inquest has been adjourned pending further evidence sought by the Coroner. During the course of the inquest, it has been identified that there is a risk in relying on the Welsh Clinical Portal, with clinicians reporting difficulties in navigating the system and experiencing difficulties in finding results and investigations. It has also been identified that the Welsh Clinical Portal does not interface with other digital systems. This risk has been highlighted and is currently on the Trust’s Risk Register.

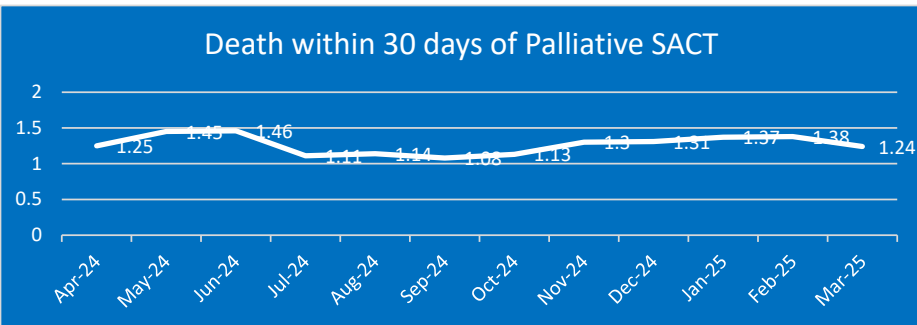
9. MORTALITY



Graph 28



Graph 29



ANALYSIS

SACT mortality data is collected and reported monthly. Although there is no available benchmark for curative or palliative SACT, a 2% 30-day mortality rate from the 2008 NCEPOD report is commonly used, and VCS remains below it.

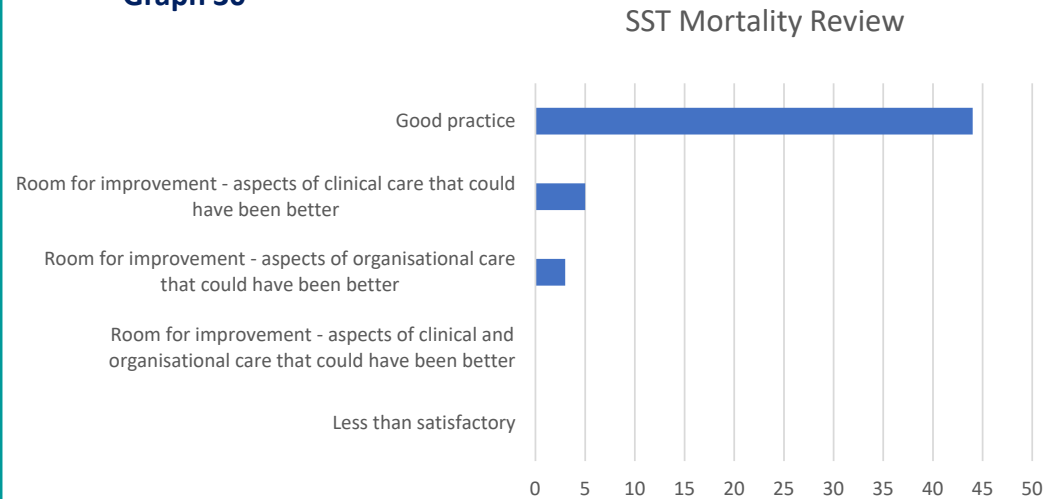
All SSTs now review deaths within 30 days of SACT, 30 days of palliative radiotherapy, and 90 days of radical radiotherapy, holding eight meetings in Q4.

Radiotherapy data validity issues prevent full reporting, but the Data and Insight team aims to resolve this by Q1 2025/26. However, 30- and 90-day radiotherapy mortality data continues to be captured and reviewed by the mortality team and SSTs.

LEARNING AND IMPROVEMENT

- Develop SOP for patients within specific SST that can be referred to Virtual Assessment Pathway clinic, this will increase capacity within SST outpatients' clinics.
- Reminder for all prescribers to be mindful of patient's performance status when commencing SACT
- To explore whether emergency SACT can be given in VCC on weekends

Graph 30



9. MORTALITY CONT.



ANALYSIS

The Cancer Centre is compliant with all aspects of the Medical Examiner Service (MES) – reviewing cases referred to VCS and feeding back findings and identifying learning.

During Q4 no clinical concerns were identified from MES.

There was an increased number of patients who died on First Floor in March. All inpatient deaths were reviewed within the VCS Inpatient Mortality Review Meetings and independently by the MES. No clinical concerns were identified.

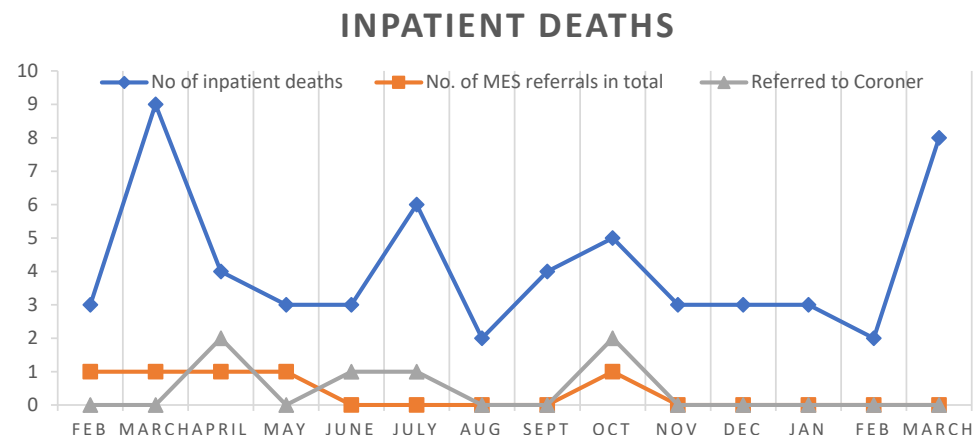
LEARNING AND IMPROVEMENT



Although no clinical concerns were identified from the Medical Examiner Service, an opportunity for learning was identified from the inpatient mortality review meeting:

- Ensuring assessment proforma is completed if a patient attends the ward directly (i.e. is not admitted via assessment unit)
- To ensure that unwell patients are not transferred between departments and to undertake the procedure or treatment required at the bedside

Graph 31



9. 1 DEATH CERTIFICATION

Increased pressure on the Medical Examiner Service (MES) has been seen across all Health Boards and Trusts in Wales since implementation of the new statutory reforms to the death certification process in September 2024. This has resulted in a delay in the death certification process. As a result, communication has been received from Welsh Government in February 2025 with an ask for actions to be undertaken to help reduce the pressure.

The requirement from Welsh Government is to:

- Review and update existing public resources
- Provide clear signposting and education for staff
- Communicate changes to staff
- Ensure bereavement services provide a wrap-around service for bereaved families
- Review and feedback mortuary/ cold room occupancy

A task and finish group has been established in VCS and an action plan devised to ensure each requirement is fully addressed (several actions were undertaken and completed in in VCS in summer 2024 in preparation for the reform). This includes:

- Developing a “bereavement” page on the internet for the public, and a “mortality” page on the intranet for staff with all relevant information and signposting.
- Ensure the information in the bereavement pack regarding the MES is the most up to date
- Ensure training is delivered to each junior doctor cohort.
- Provide easily accessible completed MCCD form with the MCCD book on the ward and on the intranet
- Supportive care team information included within the bereavement pack to provide bereavement support where required.
- Link with Maggie’s charity regarding the bereavement support they provide.
- Collect and provide VCC cold room occupancy rates data and review VCS Cold Room SOP.

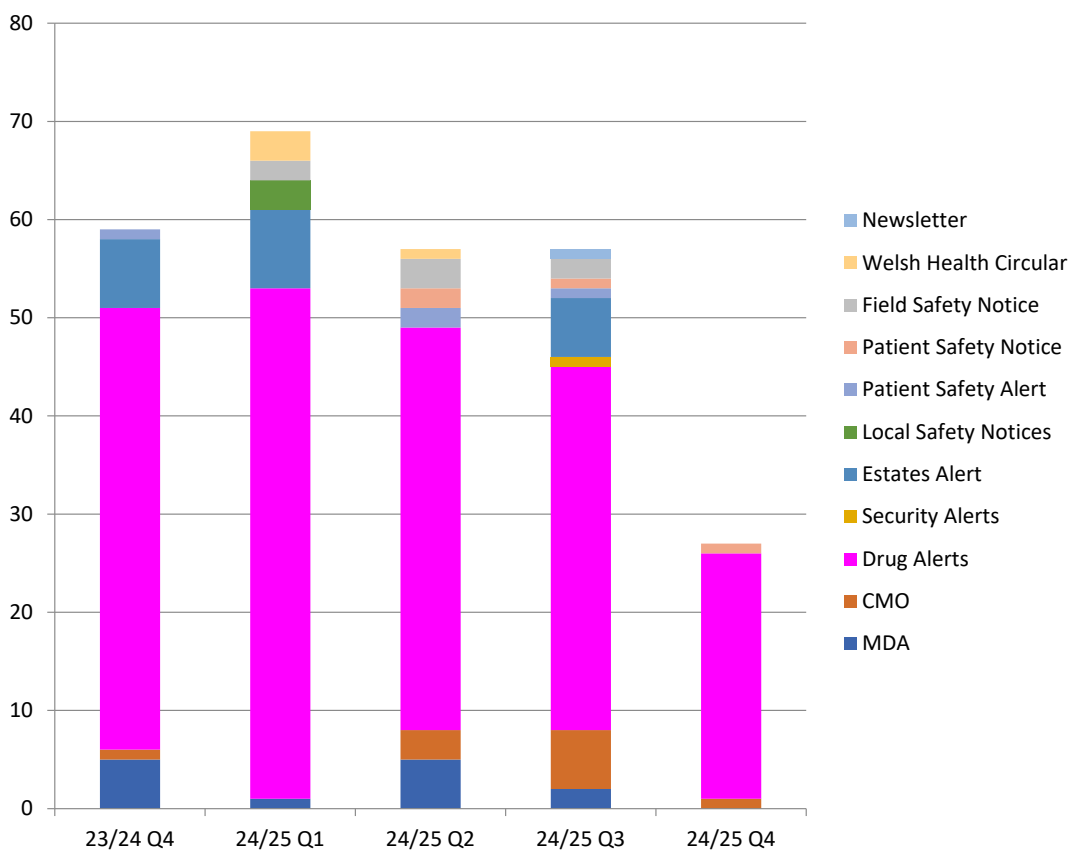
The action plan is on the Trust’s Regulatory Quality & Safety Tracker and all actions on track for completion within timescale.

10. SAFETY ALERTS



Graph 32

Safety Alerts by Quarter and Type



ANALYSIS

27 Safety alerts were received.

Drug/pharmaceutical alerts continue to be the highest number of alerts received in the Trust. 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 consider alternatives or check if the drug is used within the Trust.

THEMES AND OUTCOMES

The most common theme for Safety Alerts were medication shortages. Any of these alerts that were applicable to the Trust were dealt with, e.g. stock checking and using the recommended alternatives. There were two other alerts received in Q4, these were for information only:

- Chief Medical Officer
- Patient Safety notice

POSITIVE ASSURANCE

Each of the alerts received have been emailed to, and reviewed by, subject matter leads who are responsible for reviewing the alert and providing confirmation back to Corporate Services as to whether the alert is applicable to the Trust. From 1st April 2025, the Safety Alerts will be recorded in a new Datix Cymru module. An implementation plan is in place.





11. 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 incident 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 at 1st January annually and may affect CAG status.

Incidents – 1st January - 31st March 2025

Service	DATIX Incidents	Incidents Reported outside DATIX	Total Incidents	Reported to ICO	Investigation			Investigation			
					Low Risk / No Harm	Root Cause Analysis	Total	DATIX Open	DATIX Closed	Total	IG Complete
Corporate Services	0	0	0	0	0	0	0	0	0	0	0
Velindre Cancer Services	22	0	22	0	22	0	22	12	10	22	21
Digital	0	0	0	0	0	0	0	0	0	0	0
WBS	9	0	9	0	9	0	9	2	7	9	9
TCS/NVCC	0	0	0	0	0	0	0	0	0	0	0
NWSSP	15	0	15	0	15	0	15	1	14	15	14
Total Trust	31	0	31	0	31	0	46	15	31	46	44

11. INFORMATION GOVERNANCE CONT.

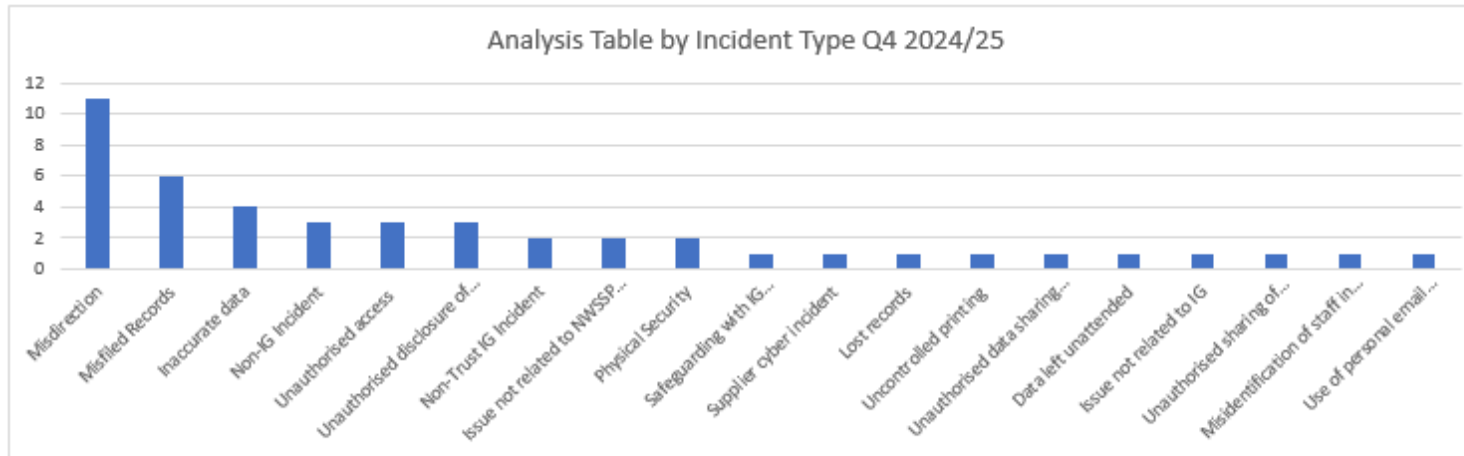
Graph 33

Analysis Table for Incidents – 1st January – 31st March 2025

Reason	Number of incidents	VCC	WBS	NWSSP	Total
Misdirection	11	6	2	3	11
Misfiled Records	6	5	1	0	6
Inaccurate data	4	2	1	1	4
Non-IG Incident	3	1	1	1	3
Unauthorised access	3	3	0	0	3
Unauthorised disclosure of records	3	0	1	2	3
Non-Trust IG Incident	2	1	0	1	2
Issue not related to NWSSP (HB)	2	0	0	2	2
Physical Security	2	2	0	0	2
Safeguarding with IG considerations	1	1	0	0	1
Supplier cyber incident	1	1	0	0	1
Lost records	1	0	0	1	1
Uncontrolled printing	1	0	1	0	1
Unauthorised data sharing (near miss)	1	0	1	0	1
Data left unattended	1	0	1	0	1
Issue not related to IG	1	0	0	1	1
Unauthorised sharing of supplier data	1	0	0	1	1
Misidentification of staff in staff records	1	0	0	1	1
Use of personal email addresses in work email	1	0	0	1	1
Total Trust	46	22	9	15	46

11. INFORMATION GOVERNANCE CONT.

Graph 3¹



VCS (Medical Records) Subject Access Requests – 1st January – 31st March 2025

Month	Number of requests	Requests in Progress	Completed in Statutory timeframe	Requests breached	Total	Percentage compliance
January	24	4 [^]	20	0	24	100%
February	16	1 [*]	15	0	16	100%
March	19	11 ^{**}	8	0	19	100%

[^] 3 x requests paused awaiting evidence of right of access from requester and 1 request extended for 2 months from date of request due to complexity

^{*} 1 x request awaiting evidence of right of access from requester

^{**} 3 x requests paused awaiting evidence of right of access from requester

Corporate (Non-Medical Records) Subject Access Requests – 1st January – 31st March 2025

Month	Number of requests	Number of requests completed within statutory timeframe	Percentage compliance
January	0	0	N/A
February	0	0	N/A
March	1	1	100%

11. INFORMATION GOVERNANCE CONT.

WBS (Donor Records) Subject Access Requests – 1st January – 31st March 2025

Month	Number of requests	Number of requests completed within statutory timeframe	Percentage compliance
January	11	11	100%
February	12	12	100%
March	16	16	100%

NWSSP Subject Access Requests – 1st January – 31st March 2025

Month	Number of requests	Requests in Progress	Completed in Statutory timeframe	Requests breached	Total	Percentage compliance
January	1*	0	0	0	0	N/A
February	0	0	0	0	0	N/A
March	0	0	0	0	0	N/A

*request cancelled by applicant

2024/25 Trust DPIA/Legitimate Interest Assessment (NWSSP only) Activity

Quarter	DPIA'S Commenced	VCC	WBS	Corporate	TCS	RD&I	NWSSP (includes LIA)	Completed in Quarter (for entire Calendar year including DPIA commenced in previous quarters)
Q1 2024/25	13	5	5	3	0	0	No data	2
Q2 2024/25	19	12	2	4	1	0	No data	12
Q3 2024/25	16	8	2	4	1	1	No data	9
Q4 2024/25	10	4	5	0	1	0	9	22 (includes 6 x LIA by NWSSP)
Total FOR 2024/25	58	29	14	11	3	1	9	45 (includes 6 x LIA by NWSSP)

*Full analysis and progress presented to IQSG/SIRO monthly and IM for IG quarterly

2024/25 All-Wales DPIA Activity

Quarter	DPIA'S Commenced	Completed in Quarter	Ongoing
Q3 2024/25	2	1	5
Q4 2024/25	16	0	16

*Full analysis and progress presented to IQSG/SIRO monthly and IM for IG quarterly

11. INFORMATION GOVERNANCE CONT.

Training Statistics by Division for the Trust – 1st January 2025 to 31st March

% Compliance Standards	% attainment
Standard	85%

Division	% attainment		
	January	February	March
NVCC	82.61	78.26	78.26
RD&I	89.23	90.63	92.19
WBS	86.21	87.34	88.54
VCC	82.23	82.43	83.22
Corporate	84.15	85.48	82
Trust Overall	83.77	84.36	84.67

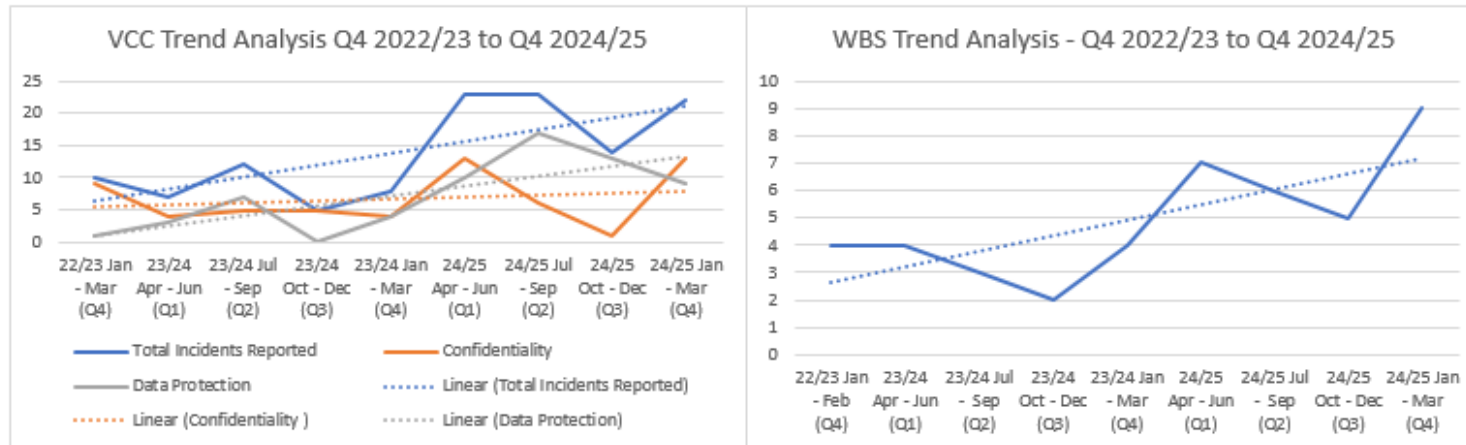
Hosted Body	% attainment		
	January	February	March
NWSSP	90.61	88.58	88.18
HTW	76	79.17	73.91

11. INFORMATION GOVERNANCE CONT.

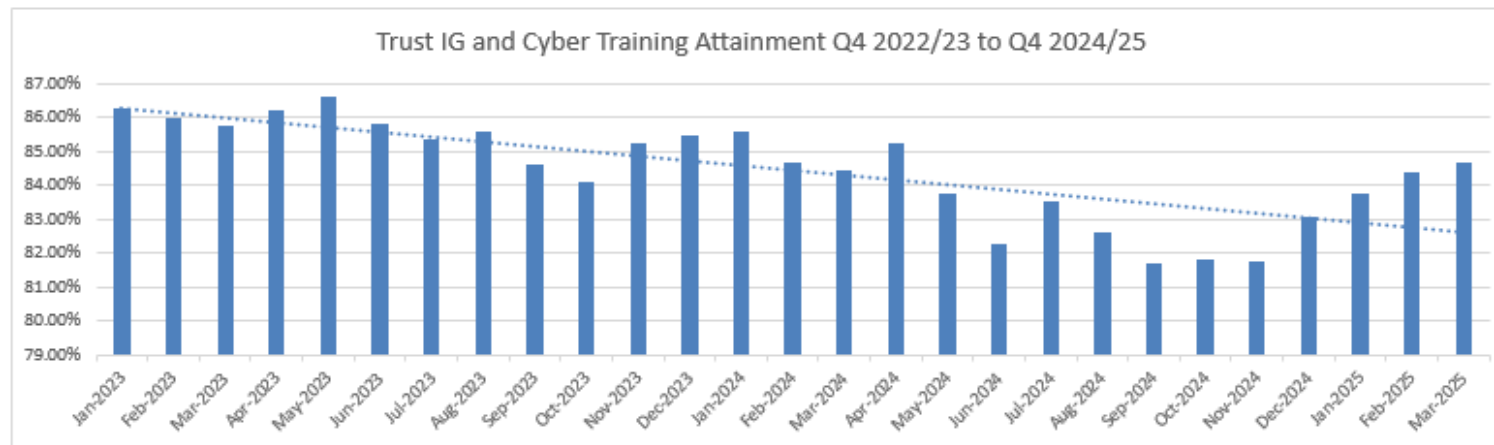
Graph 36

2-year Trend Analysis and Monthly ESR Compliance.

Graph 35



Graph 37



11. INFORMATION GOVERNANCE CONT.

Assurance and Analysis

Positive assurance					
<ol style="list-style-type: none"> 1. Training: <ol style="list-style-type: none"> a. Training continues to be delivered via inductions and specific workshops, and will continue to be so for 2025/26. b. IG Training compliance at 31st March 2025 for the Trust is 84.67% (minimum standard is 85%), 88.18% for NWSSP and 73.91% for HTW. 280 VUNHST Staff are out of date for IG/Cyber as at 31st March 2025 which equates to 15.33% of the workforce. c. From 1st April 2025, HTW will be included in core Trust compliance figures. 2. Email Updated All-Wales IG Policies reviewed by HBs in March 2025. Due to lack of WIGB, DPO in discussion with WG for an all-Wales route to approval 3. SAR compliance - steady across the Trust, 100% 4. DPIA's – 16 DPIA's and 4 DPA's were approved in Q4 2024/26. 5. IG Toolkit – IG toolkit submitted on time, 28th March 2025 for 2024/25 timeframe 					
Risks to compliance with Legislation, Policies, Procedures and Standards and mitigation activity					
<ol style="list-style-type: none"> 1. Compliance Risk – Risk of non-compliance with minimum M&S standards for IG and Cyber Security training on ESR, is an issue, not a risk. VCS has increased compliance from 82.23% to 83.22% within the Quarter. NVCC has dropped compliance from 82.61% to 78.26% and Corporate has dropped compliance from 84.15% to 82%. HTW has highest non-compliance at 73%, DPO has contacted HTW stating that it requires addressing as soon as possible. 2. DPIAs – Trust DPO along with other DPOs in HBs noted last minute projects have resulted in increased IG Risk, one HB has had to approve DPA at risk due to timeframe of procurement 3. TAF Risk – DPO continues to reviewed TAF 05 with CDO. Cyber Resilience exercise was conducted on 24 Mar 25 in VCS, second planned for 7 Apr 25. 4. Overall IG Risk – Cyber risk remains overriding risk in line with the current threat environment, risk level is such that SIRO/CG will meet on All-Wales basis on 11 Apr 25. 5. Training Risk Mitigation – The provision of workshops and sessions throughout the Trust in Q4 whilst offered have not seen as large a take up as was expected, but this is most likely due to Service Pressures. But 135 Staff received face to face training during Q4. Divisional Directors continue to support the approach. 					
Analysis, themes and learning					
<ol style="list-style-type: none"> 1. Incidents –overriding theme in Q4 remains constant; misdirection, misfiling of records, inaccurate data and unauthorised access to information security. All of which are avoidable. 2. ICO Reported incidents – No reported incidents in Q4. 3. Training – Training compliance in Q4 (84.67%) whilst much improved on Q3, still requires further time investment by Corporate, VCS, WBS and HTW in Q1 2025/26 to continue to progress the upward trend and achieve the minimum standard of 85%. 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. 					
Safe	Timely	Effective	Efficient	Equitable	Person Centred
Evidence that Staff recognise their responsibilities in respect of Legislation, Codes of Practice and Trust Policy.	All incidents, reports and SAR's are submitted and/or responded to within required timescales	All IG incident reports have been completed appropriately and where feedback is received it is acted upon.	IG support is accessed at the correct point in any process (data protection by design and default) and where needed for incident management	The principles of Caldicott , Confidentiality and Data Protection are based on the European Convention on Human Rights and Article 8 of the Human Rights Act 1998	Evidence that the Caldicott and data protection principles have been adhered to in all reports made across the Trust. A fair approach has been taken in relation to allegations of any wrongdoing by members of Staff

12. INFECTION PREVENTION AND CONTROL

	<i>C. difficile</i>	MRSA	MSSA	<i>E. coli</i>	<i>P. aeruginosa</i>	Klebsiella sp.
2023-2024	3	0	0	0	1	1
Q1 2024 – 25	0	0	0	0	0	1
Q2 2024 – 25	1	0	0	0	0	0
Q3 2024 – 25	2	0	0	1	0	0
Q4 2024 - 25	0	0	0	0	0	0

Healthcare Associated Infections – There has been an increase in infections during Quarter 3 which were deemed Velindre Acquired..

RCA's are undertaken whenever there is a confirmed HCAI bacteraemia (blood stream infection) and in all Clostridioides *difficile* toxin positive cases. To ensure timely learning and accurate contemporaneous data, RCA's need to be undertaken within a maximum of 2 weeks following a positive result. This has continued to be a challenging process and plans to improve this have been implemented. Some RCA MDT's remain outstanding at time of report, (however there is a planned meeting on 07/01/25 to discuss remaining cases), due to various reasons.

All outstanding RCA's have been completed and discussed at MDT.

Learning identified:

- Increased awareness of the patients primary cancer and reason for admission which may have prevented delay in antibiotic therapy.
- Compliance with the MRSA policy and all wound sites must be swabbed on admission to inpatient ward.
- Ensure patients are aware how to use decolonisation medications correctly.
- Increased vigilance in use of antibiotic therapy for patients at risk of developing *C. difficile* infection

12. INFECTION PREVENTION AND CONTROL

	<i>C. difficile</i>	MRSA	MSSA	<i>E. coli</i>	<i>P. aeruginosa</i>	<i>Klebsiella sp.</i>
2023-2024	3	0	0	0	1	1
Q1 2024 – 25	0	0	0	0	0	1
Q2 2024 – 25	1	0	0	0	0	0
Q3 2024 – 25	2	0	0	1	0	0
Q4 2024 - 25	0	0	0	0	0	0

ASSURANCE

Healthcare Associated Infections – There were no infections during Quarter 4 which were deemed Velindre Acquired.

Flu plan – There is a comprehensive flu plan in place for the staff influenza vaccine campaign 2024/25. The current uptake for the Trust is 52% with 57% frontline staff vaccinated. COVID-19 Booster vaccines are available for frontline staff and links on how staff can access have been shared Trustwide.

Antimicrobial Stewardship report – there has been significant compliance with World Health Organisation antibiotic categories and the Start Smart and Focus measures. A new risk associated with long-term use of quinolones was discussed, with plans to introduce a prescribing checklist and patient counselling list to mitigate potential side effects. This work is being presented at the Medicines Management Committee before the change in process is ratified.

12. INFECTION PREVENTION AND CONTROL



Mpox Update – On 29th January 2025, IPC met with Samantha Matthews (Public Health Wales) and Rebecca Luffman (NHS E) to review VUNHST’s response to potential Mpox cases. They were reassured by the Trust’s established pathways, PPE training, and FFP3 Fit Testing accessibility.

On 20th March 2025, Mpox Clade 1 was officially downgraded and is no longer classified as a High Consequence Infectious Disease. This change reflects the low fatality rate, generally mild to moderate illness, and limited transmission beyond close household contacts—though it remains a public health emergency of international concern per WHO.

Exercise Pegasus – The Trust is scheduled to participate in a high-priority Tier 1 pandemic simulation later this year, with dates to be confirmed. The exercise will test real-time decision-making and aims to enhance policy, preparedness, and assurance of Wales’ pandemic response capabilities. The Infection Prevention and Control Team will coordinate closely with Site Leadership and the Executive Team to ensure comprehensive preparedness across both divisions.

Innovation and Sustainability –

FFP3 Masks - The cancer centre is trialling a new FFP3 mask from Denpro, focusing on staff who haven’t passed fit testing with existing models and currently use PAPR units. In collaboration with the Surgical Material Testing Laboratory (SMTL), the team is reviewing Denpro’s data to ensure compliance with performance and certification standards. A follow-up meeting in May will inform a business case outlining potential cost savings, reduced staff time, and decreased reliance on multiple mask types and PAPR hoods.

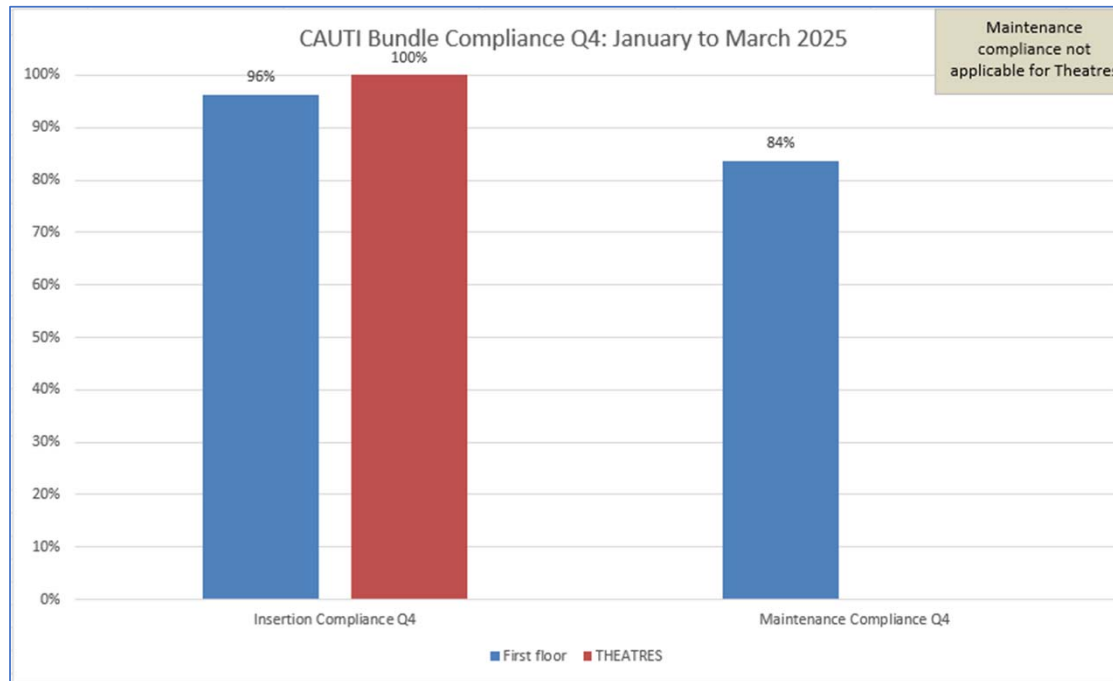
Non-alcohol hand sanitiser - products have been trialled by the Welsh Blood Service for staff unable to use traditional alcohol-based versions. Among the options tested, Spectricept emerged as the preferred choice. A wider trial was conducted across all staff groups in Swansea Bay and Hywel Dda health boards, aiming to replace alcohol-based sanitisers. The results of this broader trial are currently awaited before considering a pilot in the Cancer Centre.

12. INFECTION PREVENTION AND CONTROL CONT.

Compliance to CAUTI Urinary Catheter Bundles

The urinary catheter bundles compliance continues on First Floor Inpatient ward and Theatre department, no issues identified.

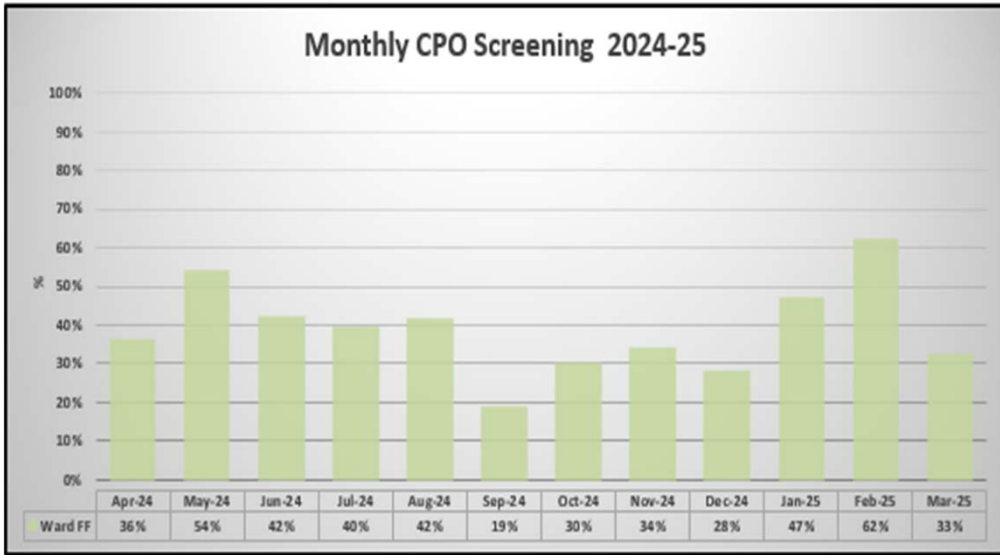
There have been no infections related to urinary catheters January to March 2025.



12. INFECTION PREVENTION AND CONTROL CONT.

Compliance with screening for Carbapenemase Producing Organisms

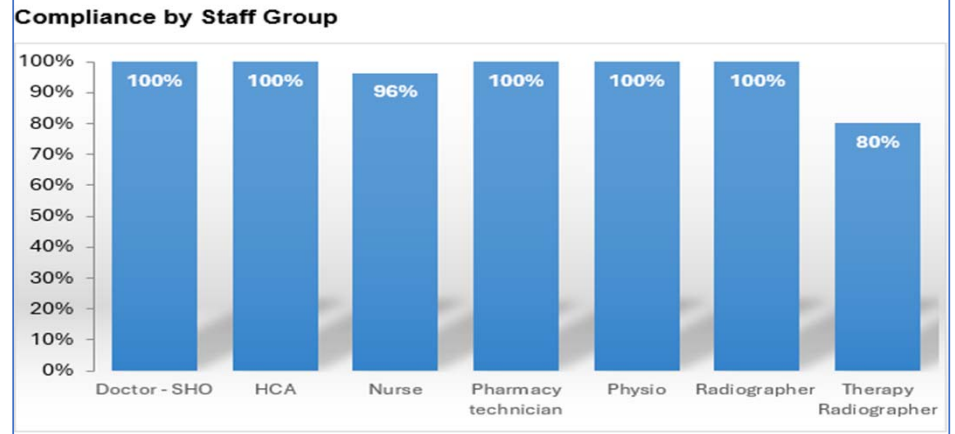
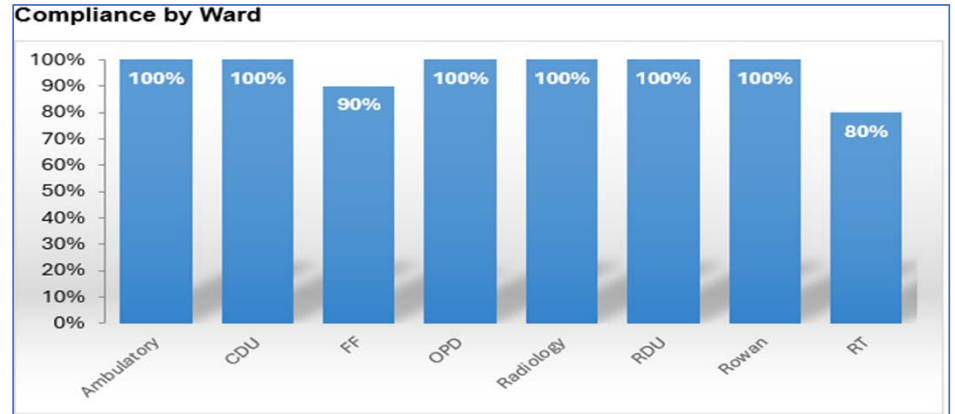
With rising MDRO cases in Wales, routine CPO screening of all admissions is required within a set timeframe, as per national policy. Despite efforts, embedding this practice since compliance reporting began in April 2023 remains challenging. The IPCT is working closely with ward staff to stress its importance. Benchmarking shows other cancer centers outside Wales are successfully implementing CPO screening without issues.



Hand Hygiene compliance

Hand Hygiene audits continue to be undertaken across the Trust. The IPC Team continue to undertake spot checks to validate Hand Hygiene practice.

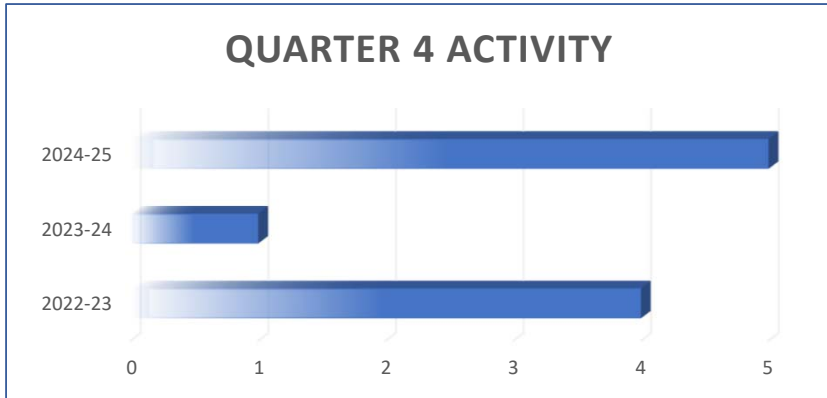
Overall compliance – **97%**



13. SAFEGUARDING AND VULNERABLE GROUPS

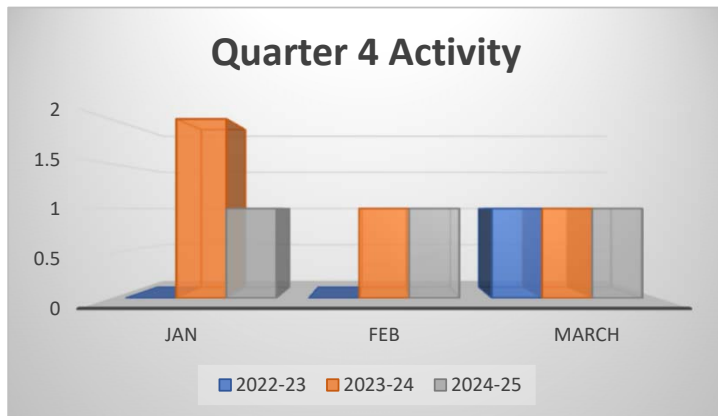
Safeguarding and Public Protection Activity

Graph 42



DoLs

Graph 43



ANALYSIS

5 Duty to Reports were raised during this quarter which is an increase for the same time-period over the past 2 years. **4** reports relate to children, which provides positive assurance that staff are identifying the needs of the family not just the patient. **1** Child at Risk report is being managed under section 47 child protection procedures, which was triggered by the report submitted by staff at VCS. **0** Reports were submitted related to Care provided by the Trust.

3 applications for Deprivation of Liberty Safeguards (DoLs) were made during Quarter 4. Consistent activity noted across the quarter.

A DoLS infograph has been developed which will be displayed on First Floor Ward and Outpatient Dept.

An audit reviewing the documentation standard of DoLS applications was also completed this quarter.



14. HEALTH AND SAFETY

Outcome

As part of our continued contribution to the anti-violence collaborative work, I attended an off-site session focused on complex case management, which is directly aligned with the aims of the collaborative group. The session aimed to explore what content is required within the policy and to determine which training modules are most appropriate to support staff when managing complex or high-risk situations.

In March, we saw a notable increase in compliance with Module C: Violence and Aggression training. This positive shift is a testament to the ongoing efforts of staff promoting the sessions, the support of managers in releasing staff to attend, and the availability of trained facilitators to deliver the courses on site.

This collaborative effort demonstrates the strong commitment across teams to prioritising safety and supporting our workforce in developing the knowledge and confidence needed to respond effectively to incidents of violence or aggression.

Themes

This quarter, my focus has been on ensuring compliance with Patient Manual Handling training across Velindre Cancer Service (VCS). To support this, weekly meetings have been held with the Radiation Services BSM, Learning & Development, and Cardiff & Vale, aimed at resolving ESR-related issues and clarifying the booking process for non-compliant staff. These collaborative efforts have helped improve understanding, streamline course bookings, and ensure staff are allocated to the appropriate training in a timely manner.

Incidents for Q4
2 x Riddor Events
22 incidents



“ VUNHST HEALTH & SAFETY QUARTERLY UPDATE ”



Focus

While the Impact-Ease Matrix continues to provide valuable direction in prioritising our health and safety workstreams, I'm pleased to share that we have now successfully secured an additional team member. This new resource will allow us to shift greater focus towards supporting organisational change within the health and safety landscape. In particular, we can now dedicate time and capacity to progressing key strategic documents, including the completion of the annual plan and beginning work on the Safety Management Plan.

This marks a positive step forward in strengthening our approach and ensuring we remain aligned with both operational needs and strategic objectives.

Trends

- The analysis reveals several recurring themes, including:
1. Needlestick and sharps-related injuries - Indicating a need for ongoing training, safety protocol reviews, and improved use of PPE.
 2. Manual handling and patient safety, highlighting the need for proper handling techniques, better equipment, and safer patient mobility practices.
 3. Environmental hazards involving broken glass, equipment use, and waste handling, which may require a review of workplace safety standards and procedures.

Addressing these trends will require targeted interventions, such as enhanced training, environmental assessments, improved communication, and the review of safety equipment and patient-handling protocols.

15. REGULATORY QUALITY AND SAFETY TRACKER COMPLIANCE

4 new improvement plans were added to the Tracker:

Code	Title
Local (Velindre Quality & Safety)/2024/53	15 Steps Visit - Radiology Department
Local (Velindre Quality & Safety)/2024/48	IR(ME)R (Amendment) 2024 - compliance of Radiotherapy Service
AWMSG/2024/42	MARRS Action Plan (October 2024)
WMDA - World Marrow Donor Association/2024/47	WMDA Inspection 18th - 20th November 2024

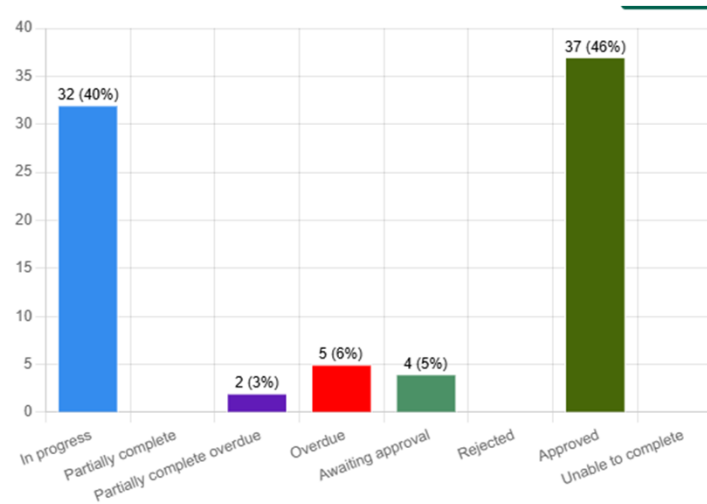
The Tracker currently contains 25 improvement plans related to the following:

- 6 Duty of Candour incidents
- 2 Nationally Reportable Incidents
- 8 external inspections
- 6 internal reviews
- 3 external peer reviews

Graph 44 below shows:

- 32 actions in progress
- 0 actions partially complete
- 2 actions partially complete and overdue
- 5 actions overdue
- 4 actions awaiting approval
- 0 actions rejected
- 37 actions approved
- 0 unable to complete

Graph 44



DUTY OF QUALITY & DUTY OF CANDOUR– TRUST FINAL INTERNAL AUDIT BRIEF

The Duty of Quality (the Duty) came into force on 1 April 2023 and affects all NHS Wales organisations in their health-related functions. The Duty aims to improve the quality of healthcare services and the health outcomes for people in Wales.

The audit review in relation to the Duty of Candour arrangements will be completed in line with the 2024/25 Internal Audit Plan for Velindre University NHS Trust (the Trust).

Scope, Risks & Approach

Scope	<p>To provide assurance that the Trust is implementing the requirements of the Duty of Quality.</p> <p>Objectives of the area under review:</p> <ol style="list-style-type: none"> 1. The Trust has robust governance, reporting and escalation mechanisms for oversight of the Duty. 2. There are clear policies and procedures covering the requirements of the Duty and the related Welsh Government guidance. 3. There is Trust-wide training and ongoing support to help staff meet the requirements of the Duty. 4. The Trust’s Quality Management System and regulatory tracker support compliance with the Duty. 5. The Trust has embedded the Duty into strategic decision-making and across all aspects of the Trust’s activities. <p>We will liaise with Audit Wales to ensure there is no duplication between this audit and the Audit Wales follow-up of the 2022 Quality Governance report.</p>	
Associated risks	<p>Non-compliance with Duty of Quality, leading to:</p> <ul style="list-style-type: none"> • Poor patient / donor experience or patient harm. • Financial or reputational damage. 	
Indicative timings	Fieldwork	March-April 2025
	Debrief meeting	May 2025
	Audit Committee	July 2025

Scope, Risks & Approach

Scope	<p>To provide assurance that the Trust is compliant with the requirements of the Duty of Candour.</p> <p>Objectives of the area under review:</p> <ol style="list-style-type: none"> 1. The Trust has clearly defined policies and procedures for meeting the Duty of Candour requirements. 2. Staff have access to Duty of Candour training and ongoing practical and psychological support. 3. Staff are compliant with the Trust’s Duty of Candour policies and procedures. 4. The Trust identifies and implements actions to reduce the risk of Duty of Candour incidents reoccurring and shares good practice and lessons learnt. 	
Associated risks	<ul style="list-style-type: none"> • Non-compliance with the Health & Social Care (Quality and Engagement) (Wales) Act 2020 and the Duty of Candour Procedure (Wales) Regulations 2023. • Patient / donor harm or poor patient / donor experience. • Reputational damage. 	
Indicative timings	Fieldwork	March-April 2025
	Debrief meeting	May 2025
	Audit Committee	July 2025

The Audits will provide the Trust an opportunity to learn from any feedback and the findings will be presented in quarter 1.



17. QUALITY PRIORITIES 2024-25 UPDATE

Quality Priority:	Division	Update
To further develop administrative and patient communication systems to prevent patient harm and improve patient experience.	VCS	Work continues around all 5 key areas highlighted. New appointment in to Head of Business Planning, Performance, and Operational Services role has this workstream as a priority and will be developing a robust and comprehensive action plan. Meeting planned with Q+S Manager to progress. Update required from Operational Services
Mortality reviews will be completed for deaths within 30 days of SACT and 30/90 days of radiotherapy and will align with best practice.	VCS	Mortality and Morbidity reviews are well established in all Site-Specific Tumours Sites except for one. Work continues to implement the reviews in the outstanding Site-Specific Tumours Site. Terms of reference for the Mortality and Morbidity Review Meetings have been developed and approved by the Site-Specific Tumours Site Leads Group. Mortality data is captured monthly in the Performance management framework. Learning from the mortality reviews are included in monthly reports to Senior Leadership Team and Integrated Quality and Safety Group meeting. Aim in Q1 2025/26 is to report themes and trends quarterly to the Site-Specific Tumours Site Leads Group.
To Integrate Clinical Audit within VCS Quality and Safety function	VCS	Clinical audit is now within the Q+S structure. 2 weekly meetings being held between Quality and Safety and Clinical Audit where themes from concerns and incidents are discussed, as well as learning and recommendations identified in audits. A governance process has been agreed for the approval of clinical audits. This ensures that the directorate are approving all audits being undertaken within their area. This approval includes acknowledging that the audit will likely yield recommendations that the directorate will then own such as the audits planned on the monitoring and management of hyperglycaemia, and on letter communication between Velindre Cancer Service and Primary Care
Development of robust Site-Specific Quality Metrics	VCS	Adaptation of CIVICA and Datix platforms to include Site Specific Teams information means that the Site-Specific Teams are able to see their patients' experiences, concerns, and incidents that affect them across the Cancer Service. For visibility of this information the Quality and Safety team are working with Data and Insights team on developing a Quality Dashboard for the Site-Specific Teams. Key metrics have been identified, and the Data and Insight team are working on building the dashboard. No implementation date as of yet.

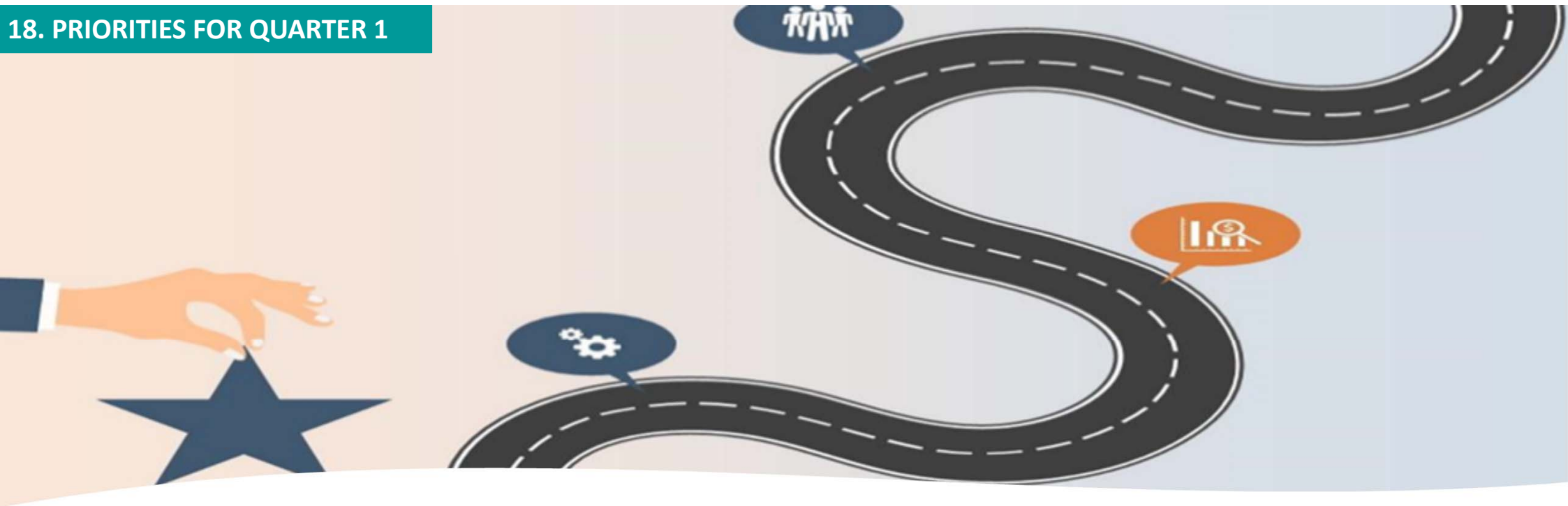
17. QUALITY PRIORITIES 2024-25 UPDATE CONT.

Quality Priority:	Division	Update
To Improve incident and risk management. Continue to review and update the WBS Quality Management Framework, including the deployment of a new electronic Quality Management System	TRUST WBS	Project to introduce new eQMS in progress – estimated go live extended to April 2025 (from October 2024) following a formal agreement for the Documents and Assets modules' data to be migrated by the system provider. This will transfer data for over 4,000 documents and 263 assets. Timelines for data to be copied, migrated and checked are dependent on the availability of system provider technical experts. Data is due to be migrated in early February, with system validation and user training due to be completed in March/April.
To Successfully Introduce West Nile Virus testing within Welsh Blood Service.	WBS	COMPLETE Implemented under Change Control PR000426. Live as of 1 st May 2024.
Introduce leucodepletion filters, Hepatitis A and Parvovirus B19 testing to support the national Plasma for medicines programme and improve supply chain resilience for plasma-derived medicines.	WBS	Validation of new collection packs is complete; use of these packs can be implemented at pace once funding of the Plasma for Medicines programme has been agreed by Welsh Government. Deadline for Parvovirus B19 and Hepatitis A testing has been extended to July 2025.
Review and improvement of donor selection and screening processes	WBS	Gap analysis of WBS process versus other UK services identified that WBS asks additional questions that may be unnecessary or could be amalgamated into a single question. Potential improvements that support correct assessment of donors and eligibility decision making have been identified. The main complexities of process lie with assessment of donor travel; WBS are working with an external company (Black Pear) to develop a prototype algorithm that supports clinical decision making in this area. The list of suggested donor eligibility questions that was previously compiled and approved will be revisited once algorithm is developed.
Introduction of all Wales foetal D Screening for RhD negative pregnant women.	WBS	COMPLETE: Test platform (FEDIS) went live on 31/05/24. Some issues were identified post go-live, involving false positive test results. All issues have been reviewed, and corrective/preventive action is in place (see section 6.5 WBS incidents).
Introduction of electronic result transfer for deceased organ donor HLA typing results to NHSBT-ODT, which will reduce risk of manual transcription of results.	WBS	NHSBT-Organ Donation & Transplant (ODT) have requested this change which is an update to how results are sent to ODT from WBS. Implementation of updated software should improve quality and efficiency of the UK solid organ matching process. Currently awaiting ODT/Vh Bio to release an updated version of the required software (which is being tested). Go live date dependent on software release by ODT.

17. QUALITY PRIORITIES 2024-25 UPDATE CONT.

Quality Priority:	Division	Update
Achieve JACIE accreditation for the WBMDR	WBS	Audit completed August 2024. Formal accreditation is dependent on completion and submission of documented evidence of corrective actions/improvements. This is due for submission by April 2025.
Commencing rollout of live connectivity of the BECS at community-based donation clinics,	WBS	<p>Roll out of live connectivity has not yet commenced.</p> <p>As previously reported, a pilot undertaken by one Collection teams highlighted several issues.</p> <p>Digital Services suggested Collections push forward with the electronic completion of DAERs via 4G mobile dongle, this went live October 2024, successful use of this is dependent on the quality of the 4G signal which isn't always sufficient. In those instances the original paper process is followed.</p> <p>5G routers (and protective equipment) are on order and should allow roll out of live connectivity across all teams, but confirmation of achievable timelines is awaited from Digital Services.</p>
Enablement of DATIX, QPULSE connectivity on community-based clinics for incident, risk and concerns recording at point of contact.	WBS	As above.
*TBC % increase in staff psychological safety scores within VUNHST Staff Survey results.	Trust	<p>Incident and Learning Frameworks have been developed.</p> <p>A review of Trust values was undertaken.</p> <p>Annual staff survey results have been received and an analysis is being undertaken.</p>

18. PRIORITIES FOR QUARTER 1



PRIORITIES FOR QUARTER 1, 2025-2026

- To go live across the Trust with the People's Experience National Survey.
- To undertake the steps required to implement SMS text messaging to obtain people's feedback.
- To continue to explore further opportunities to gather patient and donor feedback to analysis for learning and improvement.
- Improve timeliness of investigation process within agreed timescales.

TRUST BOARD	
STRATEGIC PLANNING UPDATE	
DATE OF MEETING	22 nd May 2025
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	INFORMATION / NOTING
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	LAUREN FEAR – DIRECTOR OF TRANSFORMATON (INTERIM)
PRESENTED BY	LAUREN FEAR – DIRECTOR OF TRANSFORMATON (INTERIM)
APPROVED BY	LAUREN FEAR – DIRECTOR OF TRANSFORMATON (INTERIM)
EXECUTIVE SUMMARY	This paper provides a regular update on key strategic planning matters to the Trust Board.
RECOMMENDATION / ACTIONS	The Trust Board is asked to note the update.
APPENDICES	
1	Regional Cancer Programme – April agenda

1. SITUATION

This paper provides the Trust Board with a strategic planning update and covers the following topics:

- Regional Cancer Programme
- Strategic Planning Maturity Matrix
- Integrated Medium Term Plan
- Strategic Planning Next Steps
- Transformation Team Development

2. UPDATE

Regional Cancer Programme

As previous papers have outlined, there has been positive progress in the development of the southeast Wales regional cancer programme since autumn 2024. The agenda from the April meeting is attached as appendix 1, in order to provide the Board with a view into how the programme of work and regional approach is developing. We are currently revising the Terms of Reference, as it was agreed to hold the first three meetings before doing this so that we could test and shape how this regional approach could add most value.

The way in which the national, regional and local approaches and workplans dovetail together will be further strengthened over the coming period as the national and regional agendas also continue to develop. This will include coordination of the collective delivery against the Ministerial Advisory Group (MAG) review¹, with the Welsh Government response² on improving the performance and productivity of NHS Wales in planned care, diagnostics, cancer and urgent and emergency care services.

The Trust will continue to play a system leadership role, working alongside other NHS Wales organisations and the Welsh Government, to deliver on the recommendations across the cancer pathway and the ways in which cancer governance and planning operates.

Strategic Planning Maturity Matrix

A “Planning Maturity Matrix” was developed last year by the Directors of Planning Peer Group with Welsh Government and NHS Wales Executive planning teams. The framework was initially developed to support organisations who were in an escalated “targeted intervention” status for planning. It considers categories across strategy development, dynamic and engaged planning, best practice approach to improvement and realistic and deliverable plans. The Trust Director of Transformation has taken on a national role on behalf of the Peer Group to develop this into the next version which will also take into account an independent review of NHS Wales planning framework commissioned by Welsh Government. In addition, the Executive Management Board will be considering our current levels

¹ <https://www.gov.wales/sites/default/files/publications/2025-04/nhs-wales-performance-and-productivity-independent-review.pdf>

² <https://www.gov.wales/sites/default/files/publications/2025-04/nhs-wales-performance-and-productivity-government-response.pdf>

on the extant version which will be presented to the July Strategic Development Committee for discussion. This will include discussion on the baseline position, which level we want to reach as an organisation by end of 2025/6, and the action plan to achieve this.

Integrated Medium Term Plan

The Trust Board approved the Integrated Medium Term Plan 2025-8 in the March meeting and noted the additional assurance report produced which cross-referenced the plan against all the planning guidance. This was submitted to Welsh Government and formal feedback is expected in early June. A series of staff engagement sessions will be held during June and July on the Plan and the role of staff in delivering against it. When the plan is formally approved, it will be published alongside a video and refreshed engagement approach for wider stakeholders, including patients, donors and communities.

Strategic Planning next steps

Key strategic development aspects of the Integrated Medium Term Plan that will be progressed over the next period are:

Women's Health

For both blood and cancer services, we are adopting a multi-disciplinary approach to scope the way in which the Trust can add most value to improving outcomes for women and feed this into the development of Women's Hubs in each of the Health Boards. The initial workshop will be in June and is drawing on the expertise across the organisation, including the national clinical leadership for this work, our partner organisations, including Maggie's and making effective use of our engagement approaches for patients, carers and the community.

Review of Trust and Cancer Service Strategies

As outlined in the Integrated Medium Term Plan, both the Trust and Cancer Service strategies require review this year.

For the Trust strategy, this will include delivering on our response to the Audit Wales review in 2024 which recommended that there should be greater integration of the Well-being objectives into the Trust's strategic objectives and in this way, more clearly drive activity across the organisation. In addition, the Social

Partnership and Public Procurement (Wales) Act 2023 now requires NHS bodies to consider the new social partnership requirements in our Well-being objectives.

The current Trust Cancer strategy is for 2020-25 and, as well as therefore being a requirement to review this during the year, it would have been important to do so in any case given the significant developments in the cancer agenda nationally, regionally and in our local strategic planning.

The approach to these various elements of strategic review, including the alignment across all Trust strategies, is being considered. This will be an important matter for the Strategic Development Committee over the course of the year and we will bring the topic to the July meeting to discuss and collectively shape our approach.

Transformation Team Development

To better support the organisation to manage its investment in strategic change, the Transformation Team is developing the arrangements to oversee, report and prioritise the existing programmes, projects, and initiatives. A matrix team structure will be implemented to manage this, facilitated by insights from a Power BI Portfolio Dashboard.

This will also support one consolidated reporting mechanism across the Integrated Medium Term Plan outcomes, deliverables and transformation milestones.

3. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals:
If yes - please select all relevant goals: <ul style="list-style-type: none">• Outstanding for quality, safety and experience <input checked="" type="checkbox"/>• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations <input checked="" type="checkbox"/>• A beacon for research, development and innovation in our stated areas of priority <input checked="" type="checkbox"/>• An established 'University' Trust which provides highly valued knowledge for learning for all. <input checked="" type="checkbox"/>• A sustainable organisation that plays its part in creating a better future for people across the globe <input checked="" type="checkbox"/>

	Safe <input checked="" type="checkbox"/> Timely <input checked="" type="checkbox"/> Effective <input checked="" type="checkbox"/> Equitable <input checked="" type="checkbox"/> Efficient <input checked="" type="checkbox"/> Patient Centred <input checked="" type="checkbox"/>
QUALITY IMPACT ASSESSMENT	Not required - not a strategic decision
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: <ul style="list-style-type: none"> • A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities. <input checked="" type="checkbox"/> • A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience. <input checked="" type="checkbox"/> • A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health <input checked="" type="checkbox"/> • A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances <input checked="" type="checkbox"/> • A Wales of more Cohesive Communities - Attractive, viable, safe and well-connected communities. <input checked="" type="checkbox"/> • 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. <input checked="" type="checkbox"/> • A Globally Responsible Wales – Consideration of whether an action may make a positive contribution to global well-being <input checked="" type="checkbox"/> 	
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	There are no specific legal implications related to the activity outlined in this report.

South East Wales Regional Cancer Programme Board

Agenda

Thursday 10th April 2025 at 09:00 – 10:30

Via Teams

REF	AGENDA ITEM	ACTION	LEAD	
1.0	STANDARD BUSINESS – 25 mins			
1.1	Welcome and Introduction	Note	Nicola Prygodzicz	Verbal
1.2	Minutes of the previous Regional Cancer Programme Board held 4 th February 2025	Approve	Nicola Prygodzicz	Paper
1.3 5 mins	Action Log	Approve	Nicola Prygodzicz	Paper
1.4 20 mins	Patient Story	Note	ABUHB Representative	Verbal Presentation
2.0	MAIN AGENDA – 55 mins			
2.1 10 mins	Regional Data and PTL: <ul style="list-style-type: none"> Project Update 	Note	Anne Carey	Paper
2.2 10 mins	Regional Workforce Modelling <ul style="list-style-type: none"> Project Update incl. draft Work Plan Draft Task & Finish Group Terms of Reference 	Note	Nicola Williams	Paper
2.3 10 mins	Regional MDT Governance & Support Project Update	Note	Lauren Fear and Bethan Williams	Paper
2.4 5 mins	Prehab to Rehab <ul style="list-style-type: none"> Project update and proposed next steps 	Note	Rachael Barlow	Paper <i>(to follow)</i>
2.5 5 mins	National Cancer Workplan	Note	David Donegan	Verbal
2.6 10 mins	Regional Acute Oncology Service (AOS) Update	Note	Chris Dawson-Morris	Paper
2.7 5 mins	Velindre @ Nevill Hall Radiotherapy Unit Update	Note	Hannah Evans & Carl James	Verbal
3.0	FOR BRIEF DISCUSSION / UPDATE – 10 mins			
3.1 5 mins	Breast Axillary Radiotherapy (ART) Update	Note	Jacinta Abraham	Paper

3.2	Provision of 4th PET CT <ul style="list-style-type: none"> Letter to Joint Commissioning Committee 	Note	David Donegan	Paper
3.3 5 mins	Cardiff & Vale UHB & Velindre UNHST provided services <ul style="list-style-type: none"> Brief Update 	Note	Victoria Legrys & Lauren Fear	Verbal
4.0	Any Other Business			
4.1	Regional Cancer Programme Communication Update	Note	Lauren Fear	Paper
5.0	Date and time of next meeting			
	11 th June 2025 at 12:00 – 13:30 Via Microsoft Teams			



TRUST BOARD

**FULL BUSINESS CASE
FOR A REPLACEMENT
BLOOD ESTABLISHMENT COMPUTER SYSTEM (BECS)**

DATE OF MEETING	22/05/2025
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	Elin Griffiths, Assistant Director of Digital Programmes Carl Taylor, Chief Digital Officer Peter Richardson, Deputy Director Welsh Blood Service
PRESENTED BY	Alan Prosser, Director Welsh Blood Service
APPROVED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital/Deputy Chief Executive Officer (Interim)
EXECUTIVE SUMMARY	The Blood Establishment Computer System (BECS) is a business-critical system and without it the Welsh Blood Service (WBS) would not be able to operate causing both direct patient harm and leaving NHS Wales without the capability to

	<p>supply blood and blood products, to the patients and services of Wales.</p> <p>In May 2024, we sought Trust Board approval for the Outline Business Case (OBC) for the new critical Blood Establishment Computer System (BECS), within the Welsh Blood Service.</p> <p>During the last 12 months, the BECS Project Team supported by the Senior Leadership Team within WBS, have successfully completed:</p> <ul style="list-style-type: none"> • A full NWSSP supported procurement exercise, to determine a recommended supplier of a new BECS • The Full Business Case (FBC) – the Executive Summary and Strategic Case are presented here <p>The BECS Project Team was authorised – by a Trust Board – out of committee approval - to proceed to a procurement ‘Standstill’ position in early May 2025, ahead of full and final approval by Trust Board on the 22nd May 2025. This activity will support:</p> <ul style="list-style-type: none"> • External funding partner timescales • Commencement of WBS Audit/Validation due diligence processes, of the recommended supplier, in line with the new BECS
--	---

RECOMMENDATION / ACTIONS	<p>The Trust Board are asked to:</p> <p>NOTE the continuation of procurement activity during May, with the commencement of the 10 day ‘Standstill’ period, from 9th May 2025.</p> <p>APPROVE the Full Business Case (FBC) – Executive Summary and Strategic Case only for the replacement of a BECS, with the key objective of delivering a safe and compliant BECS implementation, by November 2027.</p>
---------------------------------	--

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	Date
WBS Senior Leadership Team	Feb. 2025
BECS Project Group	Mar. 2025
WBS Futures - Digital Modernisation Board	25/04/2025
WBS Senior Leadership Team	25/04/2025
Executive Management Board	29/04/2025
Strategic Development Committee	01/05/2025
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
<p>A formative discussion: WBS SLT Huddle (February 2025) A formative discussion: BECS Project Board (March 2025) Both the WBS SLT and the WBS Futures Digital Modernisation Board reviewed the five cases and ENDORSED FOR APPROVAL the Full Business Case, for the BECS replacement (25/04/2025) The continuation of the Procurement process was NOTED and the FBC was ENDORSED FOR APPROVAL: Executive Management Board (29/04/2025) The continuation of the Procurement process was NOTED and the FBC was ENDORSED FOR APPROVAL: Strategic Development Committee (01/05/2025)</p>	

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	<p>Select Current Level of Assurance</p> <p><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></p>

APPENDICES	
Appendix 1	BECS Full Business Case – Executive Summary and Strategic Case only

1. SITUATION

- 1.1 The Blood Establishment Computer System (BECS) Project was established in Jan '23, to manage the procurement and implementation of a new BECS on behalf of the Welsh Blood Service.
- 1.2 In November 2023, Trust Board approved the extension of the current BECS contract with MAK-SYSTEM until November 2027, to allow for the completion of a full procurement exercise and the potential transition to a new BECS system/supplier.
- 1.3 A Modification Notice was published in February 2024, in accordance with Regulation 72 of the Public Contract Regulations 2015. The publication of the Modification Notice, did not result in any query or legal challenge being received.
- 1.4. Having successfully navigated the publication of the Modification Notice, without legal challenge, the extension provided for the organisation to appropriately manage the procurement and implementation of a new BECS within a longer contracting period.
- 1.5 The Outline Business Case (OBC) for the new BECS, was approved by Trust Board in May 2024. The OBC set out the path for the completion of a procurement process to establish a recommended supplier of a new BECS and for the completion of a Full Business Case (FBC), including costs and implementation timescales.
- 1.6 During the last 12 months, the BECS Project Team supported by the Senior Leadership Team within WBS, have successfully completed:
 - A full NWSSP supported procurement exercise, to determine a recommended supplier of a new BECS
 - The Full Business Case (FBC) – the Executive Summary and the Strategic Case only presented here, for Trust Board approval.

2. BACKGROUND

- 2.1 In 2009, WBS entered into a 5+1+1 contract with MAK-SYSTEM (for the ePROGESA BECS) with operational use commencing in May 2015. Due to the level of complexity and statutory/regulatory nature of a Blood Establishment Computer System, between 2009 and 2015 the new BECS system was categorised as an 'Asset Under Construction' and went live in 2015.
- 2.2 For context, the BECS international supplier market is limited, with a handful of suppliers active in this arena.

- 2.3 Between 2015 and 2019 WBS were using the BECS platform to deliver its operational blood supply chain activities. Over these years, a number of configuration updates were made to the system as part of 'business as usual', to support changes to ways of working and new feature requests. A major system upgrade was delivered in 2018.
- 2.4 Two (1+1) years MAK-SYSTEM contract extensions were invoked:
- 2021 – 2021
 - 2022 – 2024

In February 2024, a final modification to the MAK-SYSTEM contract was issued, taking the final contract period up until the end of October 2027.

- 2.5 The contract extension up until November 2027 provides the space to undertake the procurement and implementation of a new BECS for the WBS.

3. ASSESSMENT OF THE FINAL BUSINESS CASE

- 3.1 The Executive Summary and the Strategic Case only of the Full Business Case (FBC) is set out in Appendix 1. The main points of the case are as follows:
- 3.2 The Blood Establishment Computer System (BECS) is a business-critical system and without it the Welsh Blood Service (WBS) would not be able to operate, causing both direct patient harm and leaving NHS Wales without the capability to supply blood and blood products, to the patients and services of Wales.
- 3.3 The Strategic Case of the FBC outlines the WBS' need to invest in a new BECS in order to deliver the services that are core to its mission.

In addition, the Strategic Case describes the impact of tackling the four main drivers of the case for change in terms of benefits to the WBS and NHS Wales more broadly. The main drivers are:

- That extension of the current contract would cause unacceptable risk of legal challenge to WBS
 - Necessity for a blood management system that meets requirements to assure the continuation of services without disruption
 - Requirement to meet safety compliance and regulatory requirements
 - Desire for a BECS that is has the capacity to be built on iteratively to support future areas of development to align with WBS' strategic objectives.
- 3.4 BECS Project risks
- The Strategic Case also set out that WBS have a clear understanding of the risks, dependencies and constraints that the project faces enhancing confidence

in the ability to achieve a successful news BECS implementation, by November 2027.

3.5 BECS Contract duration

The Economic Case outlines a ten-year contract with two 5-year extensions. The new BECS contract will deliver a new replacement BECS along with additional functionality to allow for the ongoing optimisation of the system.

3.6 BECS Procurement outcome

Following the procurement exercise, a procurement report has been prepared confirming the recommended supplier of the new BECS. The new BECS contract award is contingent on the approval of the BECS FBC.

3.7 BECS costs

The costs set out in the Financial Case of the FBC and are inclusive of purchasing the new BECS and all necessary modules required for the provision of hospital ordering, patient platelets management, appointments management and donor engagement (CRM) functionality and includes an anticipated inflation rate of 3% on top of the suppliers costs which may be subject to contract award and agreeing a fixed contract price.

3.8 BECS Funding route

It is noted that the challenge remains in defining funding routes and associated affordability. For example, matching the Welsh Government strategic Digital priority for Cloud solutions, determines it as a revenue source requirement with a request of funding to the Digital Priorities Investment Fund (DPIF) to support the implementation costs.

Whereas On-Premises solutions will require an initial upfront Capital funding request to the Welsh Government/Digital Priorities Investment Fund to support the implementation costs. Under this option the intention would be to move to a cloud-based revenue model within a year and therefore further funding support would be required for the additional functionality.

Accordingly, the Welsh Blood Service has engaged with commissioners and Welsh Government to ensure their engagement and awareness of developments and that potential funding consequences are aligned within respective organisational IMTPs (Integrated Medium-Term Plan) in accordance with outputs from the procurement process.

4. SUMMARY OF MATTERS FOR CONSIDERATION

As described, NHS Wales cannot operate without the WBS provision of blood and blood products, which in turn means the WBS must have in place a Blood

Establishment Computer System to manage the safety of blood products to the patients of Wales.

The Executive Summary and the Strategic Case of the Full Business Case, set out the preferred way forward for the safe implementation of a new BECS, by November 2027.

The Executive Management Board are asked to:

- **NOTE** the continuation of procurement activity during May, with the commencement of the 10 day 'Standstill' period, from 9th May 2025.
- **APPROVE** the Full Business Case (FBC) – Executive Summary and Strategic Case only for the replacement of a BECS, with the key objective of delivering a safe and compliant BECS implementation, by November 2027.

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:	
<ul style="list-style-type: none"> • Outstanding for quality, safety and experience <input checked="" type="checkbox"/> • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations <input checked="" type="checkbox"/> • A beacon for research, development and innovation in our stated areas of priority <input checked="" type="checkbox"/> • An established 'University' Trust which provides highly valued knowledge for learning for all. <input type="checkbox"/> • A sustainable organisation that plays its part in creating a better future for people across the globe <input checked="" type="checkbox"/> 	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) <i>For more information: STRATEGIC RISK DESCRIPTIONS</i>	07 - Patient Outcomes
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Select all relevant domains below
	<ul style="list-style-type: none"> Safe <input checked="" type="checkbox"/> Timely <input type="checkbox"/> Effective <input checked="" type="checkbox"/> Equitable <input type="checkbox"/> Efficient <input type="checkbox"/>

	<p>Patient Centred <input type="checkbox"/></p> <p>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).</p> <p><i>[Please include narrative to explain the selected domain in no more than 3 succinct points].</i></p> <p>Click or tap here to enter text</p>
<p>QUALITY IMPACT ASSESSMENT</p> <p><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></p>	<p>Choose an item</p> <p>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.</p> <p>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.</p>
<p>SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:</p> <p>For more information: https://www.gov.wales/socio-economic-duty-overview</p>	<p>Choose an item</p> <p><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></p> <p>Click or tap here to enter text</p>
<p>TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT</p>	
<p>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:</p>	

Choose an item

If yes select the relevant goals:

- A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities.
- A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience.
- A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
- A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances
- A Wales of more Cohesive Communities - Attractive, viable, safe and well-connected communities.
- A Wales of Vibrant Culture and Thriving Welsh Language -Promoting and protecting culture, heritage and the Welsh language, encouraging people to participate in the arts, and sports and recreation.
- A Globally Responsible Wales – Consideration of whether an action may make a positive contribution to global well-being

FINANCIAL IMPLICATIONS / IMPACT	Choose an item
	<p>Funding is dependent on the funding route established – please see Section 3.8 above, BECS Funding Route.</p> <p>Source of Funding: Choose an item</p> <p>Please explain if 'other' source of funding selected: Click or tap here to enter text</p> <p>Type of Funding: Choose an item</p> <p>Scale of Change Please detail the value of revenue and/or capital impact: Click or tap here to enter text</p> <p>Type of Change Choose an item</p>

	Please explain if 'other' source of funding selected: Click or tap here to enter text
EQUALITY IMPACT ASSESSMENT <i>For more information:</i> https://nhs.wales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx	Not yet completed - Include further detail below why <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 Once the Trust has announced the cleared the 10-day standstill period and the outcome of the BECS Procurement has been announced, there will be a period of final contract negotiations with the recommended supplier.

6. RISKS

The Risk relating to the established funding route for the BECS project is included below.

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	DATIX: 3512 There is a risk to FINANCIAL STABILITY as a result of a failure to secure external funding for a new BECS, resulting in a significant, long term cost pressure to the Trust.
WHAT IS THE CURRENT RISK SCORE	12
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	VUNHST Financial Leads - continuing dialogue with JCC and Welsh Government funding teams, as the procurement is finalised and the FBC is approved.
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	30/09/2025
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Yes - please detail below If no funding route is established, the project is not able to proceed. A risk regarding the founding route for a new BECS is on DATIX.

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

Welsh Blood Service

BECS Replacement - Full Business Case – Executive Summary and Strategic Case ONLY



Document Control

Owner	Welsh Blood Service
Title	BECS Replacement - Full Business Case - Executive Summary & Strategic Case only

Document History

Version	Date	Author	Reason for Change	Reviewer	Approved by
v0.1	7/02/2025	PA Consulting	First iteration	n/a	n/a
v0.2	28/02/2025	PA Consulting	Second iteration (pre-evaluation conclusion), updates made to Strategic, Economic, and Commercial Cases	n/a	n/a
v0.3	01/04/2025	Amy Smith	SLA Review comments and updates	WBS SLT	
v0.3	22/04/2025	Elin Griffiths / Peter Richardson / PA Consulting / Steven Coliandris	Final iteration	David Mason Hawes	
V0.4	24/04/2025	Elin Griffiths / Peter Richardson / Steven Coliandris	FINAL version	Peter Richardson / Alan Prosser	WBS SLT / Digital Modernisation Programme Board

Table of Contents

Table of Abbreviations.....	3
The Strategic Case	4

Table of Abbreviations

Abbreviation	Full form
BECS	Blood Establishment Computer System
BHNOG	Blood Health National Oversight Group
BMS	Blood Management System
FBC	Full Business Case
HMT	His Majesty's Treasury
HTA	Human Tissue Authority
IBI	Independent Blood Inquiry
IMTP	Integrated Medium-Term Plan
LIMS	Laboratory Information Management System
MHRA	Medicines and Healthcare Products Regulatory Agency
NHSBT	National Health Service Blood and Transplant
NWSSP	NHS Wales Shared Services Partnership
OBC	Outline Business Case
SME	Subject Matter Expert
VUNHST	Velindre University NHS Trust
WBS	Welsh Blood Service
WBMDR	Welsh Bone Marrow Donor Registry
WHAIS	Welsh Histocompatibility and Immunogenetics Service

Executive Summary

The Outline Business Case (OBC) for a new Blood Establishment Computer System (BECS) for the Welsh Blood Service (WBS) was approved by Velindre University NHS Trust Board in May 2024, following which an NHS Wales Shared Services Partnership (NWSSP) supported procurement process was undertaken, to adopt a replacement for the current 'ePROGESA' Blood Establishment Computer System (BECS).

This Full Business Case (FBC) – Executive Summary and Strategic Case only - updates and replaces the OBC, informed by all updated project knowledge including the successful completion of the procurement process and confirmation of a recommended BECS supplier, for an initial contract period of 10 years (with a further optional 5 + 5 years).

Four bids were received, and three of these met the minimum mandatory criteria and were taken forward for detailed assessment by evaluation panels. The assessment process scored bids according to technical criteria (55% weighting), commercial criteria (35% weighting) and social value (10% weighting) Throughout the process clarifications were sought and received from bidders.

The BECS Procurement process has now concluded and an NWSSP Procurement Report for the BECS replacement project, has been prepared, which includes confirmation of a recommended supplier. This BECS Procurement Report will be considered at the Trust Board, at the end of May 2025.

The Strategic Case

Introduction

The purpose of this Full Business Case (FBC) is to provide confirmation of the stages in the Blood Establishment Computer System (BECS) Programme already undertaken, supporting the re-procurement of a BECS, following the expiration of the current BECS contract. It lays out the organisational context including the blood donation and transfusion services that the system enables, and the case for change.

The case for change sets out the background of the current contract, followed by the legal and strategic context for the re-procurement of a BECS. It describes how the new BECS will enable key strategic objectives for the organisation, including the ambitions of digital modernisation within Blood and Transplant Services, delivering a key objective of the Welsh Blood Service 5-year strategy (launched Autumn 2023).

The strategic case also positions the proposed BECS within the strategic objectives of the Trust, as well as the wider mission of NHS Wales. Also included, are the wider benefits to be realised, the risks, the constraints and the dependencies associated with the delivery of a new BECS.

Strategic Context

Importance of Blood Donation and Transfusion

There is usually 'less than a week's supply' of blood in the UK's blood banks, at any one time.

Since the Covid-19 pandemic, there have been issues with shortages across the world, including the UK. In 2023, NHS Blood and Transplant (NHSBT) who supply blood in England declared an amber alert, requiring the cancellation of certain elective procedures in order to conserve blood. Wales managed to avoid an amber alert, but we did have to issue warnings of low stocks and the risk of shortages, to our partner Health Boards.

Blood transfusion therapy is very important in cancer care. In previous studies 33% of patients receiving chemotherapy for cancer require a blood transfusion.¹ Whole blood is manufactured into different blood components: red blood cells, platelets, plasma and a derivative of plasma called cryoprecipitate. Components are further subdivided based on compatibility and special requirements, to best meet the needs of individual patients. 50 - 70% of platelets to treat low platelet counts are transfused to support patients with cancer following chemotherapy, radiotherapy or other treatments. Many blood transfusions are given to cover surgical procedures where there is blood loss

¹ Barret-Lee et al 2000 : <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2363194/>

e.g. surgery for cancer, cardiac bypass surgery for correction of coronary artery disease, vascular surgery for repair of blood vessels and trauma care. The advent of blood transfusion therapy and the ready availability of banked blood have enabled surgical procedures to be adapted and the range of surgical procedures to be extended.

Extensive work in the field of Blood Health / Patient Blood Management has improved the evidence base through research, guidance, education and audit. Overall, this has reduced the demand for blood components with a 18% reduction in red cell demand over a ten-year period 2013 - 2022 in the UK,² though use in some areas has appropriately increased e.g. automated red cell exchange for some patients with sickle cell disease and increased use of plasma in trauma care.

Our ability to 'know' the reasons why blood is being transfused and improve the appropriateness of use is limited to point audits, performed over a typical period of 3 months. These point audits provide the only available figures that can be used to plan and manage provision despite potentially being out of date. Having a BECS that supports greater visibility of demand and supply, will enable the NHS in Wales to better understand where we need to direct our efforts, in terms of ensuring appropriate use and sufficient supply of suitable donations.

National Drivers

Providing sustainable and high-quality healthcare is a priority for the Welsh Government, as articulated in their annual report.³ The digital transformation of health and social care nationally is highlighted as key in their progress towards objectives under the Well-being of Future Generations (Wales) Act 2015. The report highlights the impact of the Covid-19 pandemic on local health and care services, and the importance to the Welsh Government to tackle the biggest healthcare problems faced by the national health services, including large backlogs in care. The Welsh Government has committed more than £1bn in additional funding over the course of this Senedd term to help the NHS recover and cut waiting times.

The Welsh Government's A Healthier Wales: our Plan for Health and Social Care paper underlines the centrality of healthcare improvement to the nation, and the necessity for investment in technology to achieve this.⁴ The express goal is to create an NHS that is 'fit for the future', by encouraging the use of digital technology and platforms that can be built on and enable other key initiatives through the provision of readily available data and insight to support decision-making. The plan highlights that "...Informatics and digital technologies are a foundation for safe high-quality care. Having all the information needed about the individual, or about groups of similar

² Blood Stocks Management Scheme 10-year report 2023 <https://www.bloodstocks.co.uk/resources/annual-reports>

³ Welsh Government Annual Report 2023

⁴ Working Together for a Healthier Wales, 2023-2035

people, will deliver better outcomes by helping clinicians at every level to make better decisions...” In the context of WBS and the BECS, this means investing in a platform that will enable continuous improvement and the highest standard of safety.

Since the approval of the OBC, the Infected Blood Inquiry (IBI) ⁵ final report was published, in May 2024. In addition to informing future policy in terms of safety in blood donation and transfusion, the key findings will have an impact on NHS Wales and WBS’ approach, for which an up-to-date, safe and effective digital approach will be required, for Wales. It emphasizes the critical need for rigorous safety and regulatory protocols in blood collections and transfusions and advocates for comprehensive screening and testing of blood products, ensuring they are free from contaminants before being administered to patients. Additionally, the report stresses the importance of developing a robust safety culture within healthcare settings, which includes implementing systems that prioritize patient safety, encourage reporting of adverse events, and facilitate continuous monitoring of blood product safety throughout the supply chain. This further reinforces the need for a BECS capable of communicating with downstream clinical systems to support ‘vein-to-vein’ blood tracking in the future.

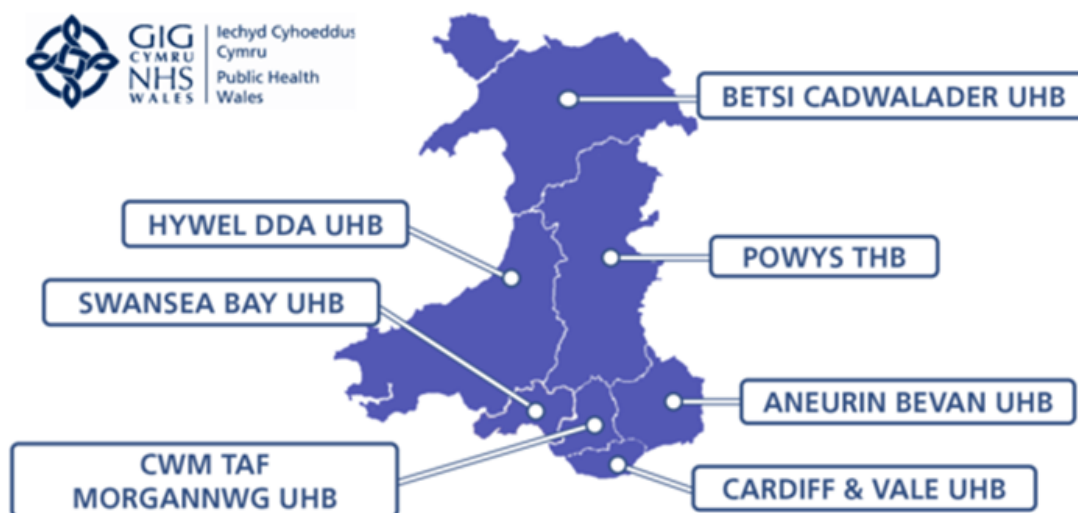
NHS Wales

NHS Wales exists to provide a comprehensive health service for the people of Wales, ensuring that they have timely access to high-quality healthcare services that meet their needs. This includes promoting health and well-being, preventing illness, diagnosing and treating health conditions, and providing care and support to individuals throughout their lives. NHS Wales aims to deliver these services in a way that is equitable, efficient, and sustainable, with a focus on improving health outcomes and reducing health inequalities across the population.

NHS Wales is sub-divided into local health boards, responsible for the planning, funding, and delivery of healthcare services in their respective regions within Wales.

⁵ IBI Executive Summary Report - https://www.infectedbloodinquiry.org.uk/sites/default/files/Volume_1.pdf

Figure 1: Wales Health Boards



A 'digital NHS' is a key component in the overall Digital and Data Strategy for NHS Wales, ⁶ building on existing solutions, making better use of data and insight and maximising the opportunities of emerging technologies. Vein-to-vein blood tracking, a long-held ambition of NHS Wales, is now further supported by the recommendations outlined in the IBI report.

Wales also has an NHS Wales Blood Health Plan, which is implemented by the Blood Health National Oversight Group (BHNOC). ⁷ It has three key strategic aims:

- Supporting individuals to manage their own blood health and wellbeing, avoiding unnecessary intervention
- Using evidence and data to inform planning, improving practice and reducing inappropriate use of blood components
- Placing safety and quality at the core of care, reducing variability and supporting innovation and development

⁶ Digital and data strategy for health and social care in Wales, 2023

⁷ 2024 BHNOC Annual Conference

Velindre University NHS Trust

The Velindre University NHS Trust (VUNHST) strategy - 'Destination 2033'⁸, is also key to understanding how the new BECS will support strategic objectives. These include:

- Delivering world class research, development and innovation to improve tomorrow's care
- Accelerating the implementation of research and new discoveries to improve our patients' and donors' experiences and outcomes
- Prioritising research, development and innovation that is clinically relevant and patient and donor centred

To deliver on the above, deliverables within the Trust's Digital Strategy - 'Digital Excellence 2023 - 2033' are key digital enablers.

Finally, the Trust's ambition to increase their research, development and innovation programmes, confirms its' commitment to providing world class facilities via the Welsh Blood Service Talbot Green Infrastructure Programme, the new Velindre Cancer Centre, Velindre research hubs at University Health Board partners and the Collaborative Centre for Learning and Innovation.

Welsh Blood Service The Welsh Blood Service (WBS) is critical to helping NHS Wales and Velindre University NHS Trust deliver on these commitments. WBS is a division of Velindre University NHS Trust and plays a vital role in giving thousands of people, across Wales and internationally, a lifeline in their time of greatest need in terms of transfusion and transplantation support services. They are the primary supplier of blood products to NHS Wales.

As a Blood Establishment, the Welsh Blood Service is subject to extensive safety regulations and oversight by the Medicines and Healthcare Products Regulatory Agency (MHRA). A key principle underpinning the regulations is the need to maintain a detailed audit trail from donation to administration of donated blood. This includes details of the donor, collection, processing, testing, storage and issue for use of donated blood. The Blood Safety and Quality Regulations require these records to be kept for a minimum of 30 years to support tracing of donors or patients. The extensive and detailed data set required, and the requirement for that data to be accessible for such a long period means that a Blood Establishment Computer System, deployed in a fully validated and supported state, is the best way for a Blood Establishment to comply with its safety and traceability obligations under relevant UK and European regulations.

⁸ Velindre University NHS Trust strategy 'Destination 2033' - <https://velindre.nhs.wales/destination-2033/>

The scope of WBS' activities is reflected in the coverage of the NHS Wales hospitals displayed in the Figure below:

Figure 2: WBS Serviced NHS Hospitals

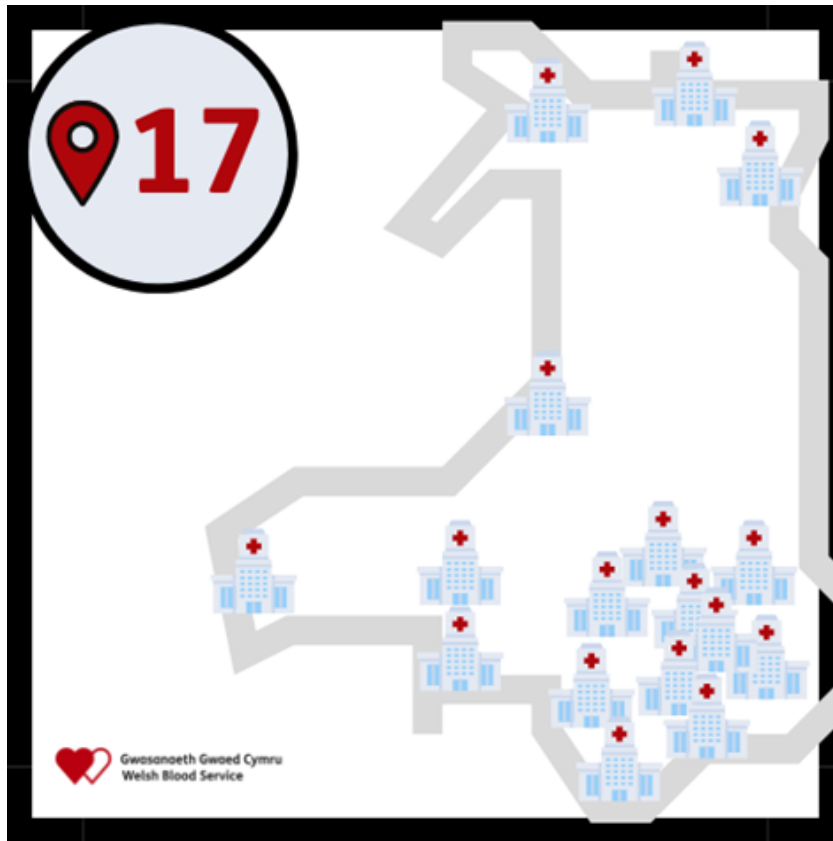


Table 1: WBS Serviced NHS Hospitals

WBS Serviced NHS Wales Hospitals	
1. Bronglais Hospital	10. Singleton Hospital
2. Llandough Hospital	11. The Grange University Hospital
3. Morriston Hospital	12. University Hospital of Wales
4. Nevill Hall Hospital	13. Worthybush Hospital
5. Prince Charles Hospital	14. Ysbyty Glan Clwyd
6. Prince Phillip Hospital	15. Ysbyty Glangwili
7. Princess of Wales Hospital	16. Ysbyty Gwynedd
8. Royal Glamorgan Hospital	17. Ysbyty Maelor Wrecsam
9. Royal Gwent Hospital	

WBS aims to collect in excess of 100,000 donations each year, necessitating around 300 blood donations every day, to meet patient need. Future demand for blood will be influenced by advances in cancer care, the changing population demographic with an

ageing population and a more diverse case mix of patients. The UK ambition to increase self-sufficiency in Plasma-derived medicines will further increase demand for donations.

WBS currently works with 4,000 community influencers to help promote the importance of donating and utilise over 200 locations across Wales by providing a community-facing blood collection service.

The Welsh Bone Marrow Donor Registry (WBMDR) is a panel of donors who have volunteered to become stem cell donors (donating bone marrow or peripheral blood stem cells). Stem cell transplants are used to treat certain types of cancer including blood cancer and other blood, immune system and metabolic disorders. Currently, there are around 72,000 volunteers registered on the WBMDR volunteer panel. Around 4,000 donors are needed to join the panel each year.

WBS also provides platelets, enabling patients to help fight chronic diseases, cancers and recover from traumatic injuries. WBS aims to produce around 11,000 platelet donations each year, of which around 40% come from apheresis donation.

The Health and Social Care (Quality and Engagement) (Wales) Act 2020⁹ places a duty on WBS to consider the 'six domains of quality'. Quality means safe, timely, effective, efficient, equitable and person-centred health care which is embedded within a culture of continuous learning and improvement.

WBS's 5-year strategy¹⁰ (Autumn 2023) commits to building upon existing services and capabilities, to improve current offerings and develop a new range of services and expertise to support the development of healthcare and well-being across Wales. Our areas of focus will include plasma for medicines and support national resilience in the supply of plasma-derived products.

WBS' strategy incorporates seven key themes, outlined in the figure below:

⁹ Health and Social Care Act 2020 (gov.wales)

¹⁰ Welsh Blood Service 5-year Strategy, 2023

Figure 3: WBS Strategic Themes



An up-to-date, safe and effective BECS is pivotal to the achievement of each of these strategic themes, in particular in ensuring the safety of our services and the integrity of the blood supply chain.

The need to maintain detailed blood tracking - from collection to administration of donated blood remains central to the case for change for the BECS,

The publication of the IBI final report endorses the business case for re-procuring a new BECS which will provide exemplar functionality enabling WBS, to continue to comply with both existing and future blood and transfusion legislation.

The recommendations require the implementation of safety management systems, including the digitisation of patient records to improve safety and continuity of care.

These themes feed into the objectives that the strategic case highlights as important to the delivery of the BECS in the Programme Investment Objectives, below. The delivery of a new BECS solution into the WBS is one of a number of key digital objectives under the 'Digital Modernisation' workstream of the WBS Futures Programme – the delivery vehicle for the 5-year strategy.

As digital capabilities evolve and offer increasing functionality and clinical decision support capabilities, the regulatory landscape must be considered. A BECS is currently classified as Class III medical device software under the UK Medical Device Regulations 2002 (and Amendments), this is the highest classification for a medical device. When the new UK Medical Device Regulations enter into force this is not expected to change. Meeting these regulatory requirements is a key requirement for the successful BECS supplier, the detailed requirements of which were included in the BECS procurement specification.

Existing Arrangements

Currently WBS operates a BECS in the form of the on-premise MAK-SYSTEM 'ePROGESA' system which enables it to deliver its services by managing and automating the collection, manufacture, testing, tracing and distribution of all blood components.

Case for Change

The Blood Establishment Computer System (BECS) is a **business-critical system** and without it the Welsh Blood Service (WBS) would not be able to operate, causing both direct patient harm and leaving NHS Wales without the capability to supply blood and blood products, to the patients and services of Wales.

The current WBS operated BECS 'ePROGESA' BMS **cannot be contractually extended beyond the end of October 2027.**

Procuring a new BECS is critical in supporting WBS deliver on its strategic commitments by providing the opportunities for new functionality to be introduced, as well as maintaining and ensuring all future regulatory compliance is met. The new system is critical in enabling WBS to respond to the Welsh Government ambition of a 'digital NHS', to integrate existing systems and create an innovative roadmap towards the implementation of additional elements within the BECS e.g. hospital ordering, improved donor panel and appointments management.

Case for Change: Legal and Regulatory Context

The regulatory requirement for procuring a new BECS remains unchanged. In line with current procurement legislation, Public Contract Regulations 2015 (PCR 2015), Velindre University NHS Trust (VUNHST) has undertaken a fully compliant NWSSP supported procurement process, for a new BECS.

The Council of Europe Good Practice Guidance (GPG), which sets minimum standards for the collection of blood products across Europe, include a requirement for digital systems to be validated before use and to be maintained in a validated state throughout useful life. Validations include the software itself, its deployment to the specific hardware platform and local configurations.

A range of regulatory frameworks and guidance dictate the standards to which Blood Establishments are required to operate in order to maintain their licence to collect and distribute blood products. Compliance with these regulatory standards is enforced through regular inspections by national regulators and competent authorities such as:

- the Human Tissue Authority (HTA) or
- the Medicines and Healthcare Products Regulatory Agency (MHRA).

The WBS Quality Management framework is subject to regular audit by both the HTA and the MHRA. In order to maintain its HTA license and Blood Establishment Authorisation (BEA), any significant changes to operational delivery, including the deployment of a new digital platform, are subject to detailed independent oversight by the regulator and require approval before final deployment depending on the assessed level of risk. Failure to demonstrate compliance with the regulations would result in regulatory sanction and may risk suspension of the HTA license, or Blood Establishment Authorisation. Additionally, the service provided would seek to meet the requirements of the United Kingdom Accreditation Service (UKAS) and the BECS solution would need to support this.

Programme Investment Objectives

The following drivers for the case for change, have been identified:

- Further extension of the current BECS contract would cause unacceptable risk of legal challenge to the Trust
- Necessity for a blood management system that meets minimum requirements to assure the continuation of services
- Ability to meet ALL safety compliance and regulatory requirements
- Re-procurement for a new BECS that can be developed iteratively, to support future capabilities for blood and transfusion services, that align with WBS' strategic objectives

The **four priority objectives**, which align closely to WBS's case for change are:

Table 2: Objectives for the BECS

	Objectives	Rationale (why do we need this)	Outcome (how will we recognise success)
1	Ensuring a sustainable service	Ongoing and sustainable delivery of information management supporting Blood Manufacturing and Tracking	Solution will support donors/users and delivering to a minimum standard of efficiency

	Objectives	Rationale (why do we need this)	Outcome (how will we recognise success)
2	Improving patient outcomes	Ensuring sufficient supply of blood to hospitals	Meeting WBS targets of supporting all required system demands on their services, improving data richness and interconnectivity to support further research
3	Driving use of blood, building donor base	Increased demand for NHS Wales services requires a system to support	Solution will help achieve WBS strategy and KPIs around donor recruitment and retention, and improve donor experience
4	Complying with current and future regulatory requirements	Adherence to a number of regulatory frameworks is required for WBS to provide its services	Maintaining both HTA license and Blood Establishment Authorisation (BEA), and ensuring the ability to implement the recommendations of the Infected Blood Inquiry (as required)

Benefits and Risks

Benefits

The main benefits to be realised following the procurement of a new BECS, are summarised below:

Table 4: Key benefits of the project

Benefit number	Area	Expected benefit
1	Enhanced ability to support safety and to provide auditability and traceability, including efficiency in testing and production areas	Reduction in errors and assured adherence to compliance.

2	Effective donor/patient management and donor-facing services	Ability to select donors based on their eligibility status, key demographics and donation history. Reduced risk of contamination of blood supply chain, improved donor experience and patient safety.
3	Reduction in administrative burden	Releasing time for operational and clinical staff, improved colleague experience while creating efficiency in the blood supply chain.
4	Enhanced stock management and demand management	Improve ability to align capacity with demand thus minimising the risk of component importation, from other Blood Establishments, which carries significant financial burden to the organisation.

This represents the most immediately identifiable benefits and is not an exhaustive list. The benefits are explored more fully in the Economic Case of the FBC (not included here).

Risks

There are a number of risks associated with the delivery of a new BECS, both in its deployment and operations.

A number of key risks are detailed below, including mitigations and controls:

Table 5: Key risks to the BECS project

	Risk	Cause/impact	Mitigations
1	Risks duplicating existing systems and/or not aligning with other areas of delivery	Would increase likelihood of additional investment required and create inefficiency across the system	The BECS will align with the wider digital modernisation ambition within the WBS Futures Strategy and provides the opportunity for iterative development of new functionality/modules.
2	Insufficient resource available with the required knowledge, experience and training to see the project through to completion	Depending on the scope of the solution, WBS would not have sufficient resource to deliver it within certain timeframes or unassisted	The Economic Case details WBS's approach to implementation, including partnering with the recommended supplier
3	Lack of buy-in from WBS stakeholders, both key stakeholders	Any solution would need to reflect the needs of the organisation	The Economic and Management Cases will detail how the options selected will meet the wider

	Risk	Cause/impact	Mitigations
	and wider adopters of the system		needs of the organisation, and how WBS intends to implement it
4	Solution complexity introduces risk to successful delivery and operational use	Not having the resources to deliver due to the complexity of the solution, or the skills required to operate it internally would be a risk to deployment and usage	The Management Case will explore WBS's approach to implementation including the cost of additional resources to allow for successful implementation and achieving stable operations
5	Doesn't deliver expected value to organization/constrains the achievements of WBS strategic goals and objectives	This would risk requiring additional systems to run concurrently or be bolted on to satisfy the needs of the organisation	The Management case details our approach to the iterative development of the BECS, ensuring ALL future capabilities and regulatory requirements can be met
6	Lack of sufficient budget (capital and/or revenue) to implement the solution	This would undermine WBS' ability to deliver core services	The Financial Case covers the affordability of the preferred option
7	Implementation likely to be challenging, run over budget, or not be deliverable within expected timescales	This would run the risk that other services would need to run concurrently to deliver the required functions or that the BECS could not cover all desired areas of implementation	The Economic Case details WBS' approach to factor in additional resources and an iterative development approach
8	The ability of the BECS to meet current and future regulatory standards for healthcare digital systems.	This could limit the functionality available in future to meet only the most basic record-keeping functions and may reduce the useful life of the procured solution.	The procurement specification recognises the need for a BECS and the supplier to hold appropriate regulatory authorisations and accreditations, and for the supplier to demonstrate a clear development roadmap that allows for adaptation to meet emerging standards in the future. Compliance with current standards will be assured through a process of supplier audit and system validation as part of the wider quality Risk Management approach at WBS. The resources to support this are included in the Economic Case.

	Risk	Cause/impact	Mitigations
9	Infrastructure failure or system disruption during/post implementation	Potential major impact on the ability for the solution to operate	Robust contingency plans to be developed for failure and disruption scenarios
10	Delays to awarding of new BECS contract and subsequent initiation of implementation works	Due to possible contract negotiations between the Trust and the recommended BECS Supplier	Plan to incorporate time for negotiations to take place and early discussions with Supplier and Procurement to ensure prompt response and action against any requests for negotiation

Constraints and Dependencies

In addition to the risks above, there are several constraints and dependencies including the need for:

- a continuous, uninterrupted blood service during the implementation phase of the programme and maintaining stable operations and service continuity is critical for donor and patient safety and hospital supply;
- a firm deadline set, for the end of the current BECS contract and;
- additional programme and Service resources will be required to implement the new BECS without affecting existing operations. This will include sufficient skilled resources to ensure that historical data is safely and accurately migrated from the existing BECS to the new system.

The project aligns with Welsh Government and NHS Wales priorities but must adapt to evolving national policies, particularly regarding digital transformation, supplier collaborative partnerships and the IBI recommendations.

A high-level view of constraints and dependencies has been summarised below:

Table 6: Constraints and Dependencies

	Detail	Mitigation
Dependency	Securing sufficient funding for the delivery of a new Blood Establishment Computer System (BECS) contract	Ensuring the BECS project is prioritised as a key operational and strategic priority for WBS, and providing adequate SME and consulting support
Dependency	Ensuring continuity of service will be contingent on a timely delivery of the new solution	Completion, submission and approval of the business case in line with trust timelines

	Detail	Mitigation
Dependency	There is a significant dependency on the supplier to support deployment and implementation	Active testing during the evaluation of their capacity to support the requirements of the solution
Constraint	Concurrent delivery with the commissioning and opening of the new Velindre Cancer Centre	Clear delineation of governance in the Management Case, separation of delivery resource where practically possible, setting of priorities for other programmes of work, and agreed with awareness of the pull-on organisational bandwidth of concurrent projects
Constraint	Complex data migration process	Ensure early discussions with recommended supplier to ensure compatible data migration processes.

The delivery of a new BECS will be concurrent with the opening of the new Velindre Cancer Centre (nVCC), which will require careful management and consideration for the bandwidth of the organisation. This should be flagged as both a constraint and a project risk. While the governance structure presented in the Management Case seeks to mitigate against this by clearly defining the required levels of resource, additional consideration has been given, since the submission of the OBC to reflect both the bandwidth and timescales of running two significant programmes simultaneously.

To ensure both the nVCC and BECS Implementation can be delivered effectively and concurrently, revisions to the BECS implementation resource profile within the FBC have been made to help mitigate the risks associated with the dual running of these two significant scale programmes.

Conclusion

There continues to be a pressing need for a new BECS for the WBS, as stated in the Case for Change which outlines the legislative requirement and the organisational need for the procurement exercise which has now concluded. Since the OBC was approved developments in the regulatory space and the findings of the Infected Blood Inquiry have further reinforced the need for a solution which allows for WBS to fulfil the needs of the Welsh population and remain compliant with relevant regulations.

Appendices

Appendix 1: n/a

DRAFT

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE PUBLIC STRATEGIC DEVELOPMENT COMMITTEE

DATE OF MEETING	22 May 2025
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Christine Sion, Business Support Officer
PRESENTED BY	Lindsay Foyster, Independent Member and Chair of the Strategic Development Committee
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Transformation (Interim)
REPORT PURPOSE	FOR NOTING
ACRONYMS	
AMaT	Audit Management and Tracking (System)
CEO	Chief Executive Officer
DHCW	Digital Health and Care Wales
EDI	Equality, Diversity and Inclusion
EMB	Executive Management Board
EQIA	Equality Impact Assessment
FBC	Full Business Case
IMTP	Integrated Medium Term Plan
IRS	Integrated Radiotherapy Solution
KPIs	Key Performance Indicators
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, plus other identities
NWSSP	NHS Wales Shared Services Partnership
OBC	Outline Business Case
QIA	Quality Impact Assessment
QSP	Quality, Safety & Performance Committee
RAG	Red, Amber, Green (risk rating system)
RISP	Radiology Informatics System Procurement
SBAR	Situation, Background, Assessment, Recommendation

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

1. PURPOSE

- 1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the Public Strategic Development Committee held on 20th March 2025.
- 1.2 Key highlights from the meeting are reported in section 2.
- 1.3 Trust Board is requested to **NOTE** the contents of the report and any actions being taken to address any issues highlighted in the meeting.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	<p>Velindre Cancer Service (VCS) Futures Highlight Report</p> <p>The Committee received the VCS Futures Highlight Report for information and discussion. The report was included on the main agenda due to a number of items being recorded at alert level.</p> <p>It was noted that the reporting period covered activity up to 2 January 2025, and that some projects are developing rapidly. As such, the report may not fully reflect the current status.</p> <p>The Committee noted the overall Level 3 assurance rating for the programme, however agreed that TrAMS does not currently provide sufficient assurance and should be excluded from this rating. TrAMS will therefore be formally escalated to Trust Board via this Highlight Report.</p> <ul style="list-style-type: none"> • Discussions around Transforming Access to Medicines (TrAMS) Programme <p>The Committee noted that the NWSSP TrAMS programme has experienced a further delay, with the anticipated go-live date revised from January 2026 to January 2027.</p> <p>The Trust has been actively engaging with colleagues across Wales to address key areas, which include: the overall clinical and operational service model; the establishment of an appropriate governance structure, beyond the level of Chief Pharmacist to support strategic decision-making process; the ongoing challenges</p>
-----------------------------	--

relating to the fragility of aseptic and technical services in the region; clarity on who is best placed to deliver the service.

Concern was raised on the further delay to the Outline Business Case (OBC) due to a lack of clarity around the financial revenue model. It was queried whether the anticipated cost savings from the centralisation of medicine supply continued to present a sticking point.

As it stands, it was explained that Shared Services is currently gathering baseline information from multiple statutory bodies. Organisations are hesitant to commit resources without understanding the overall clinical model and its associated operating costs. A clear service model is needed before determining which resources each statutory body needs to retain. Understandably, organisations could lose resources centrally, while still being expected to deliver elements of the service.

The Trust Chair proposed that TrAMS be formally escalated to the Trust Board due to the lack of assurance. This was supported by the Committee. A deep dive into the programme was also suggested to explore underlying issues in greater depth.

The following Items are Noted at Alert Level but Within Overall Level 3 Assurance Rating:

- **Integrated Radiotherapy Solution (IRS)**

A risk was identified around the Ethos platform's lack of a permanent patient data backup solution.

An interim mitigation has now been agreed with the supplier (Varian), involving procurement of an on-site server to deliver the required backup functionality. Permanent solution discussions are ongoing as part of IRS Phase 3.

- **Radiology Informatics System Procurement (RISP)**

The Committee was advised of a significant risk relating to access to prior diagnostic imaging from other Health Boards during the transition from Fuji to Philips systems (Feb 2025 – Mar 2026). As a tertiary provider, VUNHST is a net importer of images.

Several mitigations have been taken, including: escalation to Digital Health and Care Wales (DHCW) on 21 February 2025; submission of an SBAR (Situation, Background, Assessment, Recommendation) paper, which also highlighted the significant implications for other tertiary centres, including Swansea Bay and Cardiff and Vale University Health Boards, who are similarly dependent on access to external imaging; Direct engagement with Helen Thomas, Chief

	<p>Executive of DHCW, and a formal letter being prepared for Fuji, outlining the specific technical and clinical requirements from the Trust’s perspective; a workshop in which a potential way forward is currently being explored; confirmation that DHCW is actively seeking clarification from Fuji regarding a comprehensive long-term technical solution.</p> <p>As of the meeting date, there has been no formal change to the planned deployment date of 15 June 2025.</p> <ul style="list-style-type: none"> • Satellite Radiotherapy Unit (SRU): An extraction fan omission in a Radiophysics workshop posed a health and safety concern. <p>The Committee was assured that the issue would be resolved, and it would not affect the planned go-live date for the SRU. While the extraction fan is an essential facility component, it does not affect clinical service areas and therefore will not prevent the SRU from becoming operational. The majority of risks to the programme are now mitigated or resolved.</p> <ul style="list-style-type: none"> • Financial Cost Responsibility: Cost ownership relating to IRS, RISP and SRU fixes were queried. It was confirmed the SRU extractor fan issue falls within the FBC contingency and therefore the cost is accounted for within the approved capital budget. The IRS backup costs remain the supplier’s responsibility as the bid included backup across all system components, though the supplier has contested this. The Trust is seeking resolution collaboratively due to the long-term supplier relationship (i.e. 15 years). <p>The Committee NOTED the contents of the VCS Futures Highlight Report and considered the overall Level 3 assurance rating. It was AGREED that TrAMS did not currently provide sufficient assurance and would be excluded from the Level 3 rating. TrAMS will be escalated to Trust Board via this Committee’s Highlight Report.</p>
<p>ADVISE</p>	<p>Integrated Medium Term Plan 2025–2028</p> <p>The Committee received the draft Integrated Medium-Term Plan (IMTP) 2025–2028 for review and endorsement ahead of its submission to the Trust Board on 27 March 2025.</p> <p>The Committee was informed that the IMTP is being developed with a focus on accessibility, engagement, and alignment with national planning guidance.</p> <p>New strategic risks have been developed aligned with Welsh</p>

	<p>Government guidance. A full review of all existing risks will take place in 2025 as part of the scheduled TAF review cycle.</p> <p>The Committee expressed appreciation for the significant work undertaken to develop the IMTP, noting the value of the revised approach, early engagement, and improved accessibility of the document.</p> <p>The Committee:</p> <ul style="list-style-type: none"> • ENDORSED the draft IMTP 2025–2028, subject to incorporation of the feedback received during the meeting • NOTED that further amendments would be made ahead of submission to the Trust Board on 27 March 2025.
<p>ASSURE</p>	<p>People and Education Strategy: Annual Update</p> <p>The Committee received the People and Education Strategy Annual Update for 2024–2025. The update was provided as part of the Committee’s routine review of progress against key enabling strategies.</p> <p>The Committee acknowledged that the current Education Strategy (2019) predates the overarching People Strategy and wider developments such as the Oncology Academy. While good progress was noted, the Committee recognised the need to review the existing strategy to ensure alignment with current organisational ambitions and workforce priorities.</p> <p>The Committee NOTED the annual update on the People and Education Strategy and confirmed it provided Assurance Level 3, recognising areas of progress as well as the need to review the current Education Strategy to ensure alignment with the overarching People Strategy.</p> <p>Strategic Equality Plan: Progress Update (2024–25) and Future Plans (2025–26)</p> <p>The Committee received a progress update on the Strategic Equality Plan 2024–2028. The Plan is now in its first year of delivery and is being actively implemented across the organisation. Notable developments include the integration of the Anti-Racist Wales Action Plan and the clearer articulation of equality objectives within divisional planning.</p> <p>The Committee NOTED the progress to date and confirmed a rating of Level 3 assurance, recognising strong direction of travel, good implementation momentum, and clear planning for ongoing delivery.</p> <p>Trust Portfolio Tier 1 Reporting – Progress Update</p> <p>The Committee received an update on the development of the Trust’s Portfolio Tier 1 Reporting, which provides an integrated view of progress across the organisation’s major transformation programmes,</p>

including VCS Futures, WBS Futures, and nVCC.

The reporting approach has evolved to consolidate information from highlight reports and RAG assessments, with Tier 1 milestones now baselined from April 2024. The reporting tool is supported by dashboards and Power BI functionality, enabling both real-time tracking and retrospective performance reporting.

The Committee welcomed the positive direction of travel and acknowledged the added value of real-time, integrated reporting for the Trust's transformation agenda. It was noted that continued updates will be important as the tool and governance processes further mature.

The Committee **NOTED** the update and confirmed an **Assurance Level 2**, recognising significant progress and value in the evolving reporting approach, while acknowledging the need for further refinement and embedding of governance structures.

Trust Assurance Framework (TAF) – Update

The Committee received an update on the **Trust Assurance Framework (TAF)**, which had recently been reviewed by the Quality and Safety Committee and was brought forward to provide a strategic overview of current risks and assurance levels.

The Committee was informed that the framework is being regularly updated and that the current version aligns assurance ratings with Trust standards. The TAF also includes a pilot approach to presenting a summary position for all executive leads, intended for adoption in future reporting cycles (from 2025–26 onwards).

The Committee **NOTED** the update and confirmed a current rating of **Level 2 assurance**, recognising that while improvements are being made, further refinement is required in the application of assurance levels and the inclusion of risk trend analysis.

SDC Review of Activities

The Committee received a presentation to support a review of the Strategic Development Committee's (SDC) Terms of Reference and Cycle of Business. The discussion aimed to identify which matters are most appropriate for the Committee to oversee, ensuring relevance, appropriate timing, and the avoidance of duplication across the Trust's governance structure.

Members were invited to provide feedback on the content and structure proposed within the accompanying slide deck. A revised Terms of Reference and Cycle of Business will be brought back to the Committee in May 2025.

	<p>The Committee received initial reflections on the development and positioning of SDC within the governance framework.</p> <p>The Committee NOTED the actions required to undertake the Strategic Development Committee's review of activities. The item will return following the All-Chairs session.</p>
INFORM	<p>The Strategic Development Committee:</p> <ul style="list-style-type: none"> • NOTED the contents of Welsh Blood Service Futures Highlight Report. • NOTED the Digital Programme Highlight Report
APPENDICES	NOT APPLICABLE

CHARITABLE FUNDS COMMITTEE

PUBLIC CHARITABLE FUNDS COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	19 March 2025
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Niké Hooper-Collins, Business Support Officer
PRESENTED BY	Professor Donna Mead OBE, Chair
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance
REPORT PURPOSE	FOR NOTING

ACRONYMS

CRM	Customer Relationship Management
GDPR	General Data Protection Regulation

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 19th March 2025.

Key highlights from the meeting are reported in Section 2.

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

2. HIGHLIGHT REPORT

The following areas were highlighted for reporting to the Board from the meeting of the Charitable Funds Committee (CFC) held on the 19th March 2025:

ALERT / ESCALATE	There were no items for alerting or escalating to the Trust Board.
ADVISE	<p>Matters arising from ‘Implementing the Cancer R&D Ambitions – An Integrated Business Case 2023-2026’</p> <p>The Committee noted that no additional funds were being requested at this time; but the business case requires agreement to an extension to timescales due to delays in recruiting a number of staff.</p> <p>The Committee NOTED the extension.</p> <p>Integrated Bid Annual Evaluation</p> <p>The Committee RECEIVED and APPROVED the report.</p>
ASSURE	<p>Charity Risk Register (Ref: 3502) There is a reputation risk as a result of the current Charity fundraiser data base holding historic personal data with no clear evidence of explicit consent which is not compliant with General Data Protection Regulation (GDPR) guidance and could lead to reputational damage and fines</p> <p>Existing fundraisers have been contacted to seek permission to continue to hold their personal data which provides mitigation that has been applied against this risk reducing it to an acceptable level. An extension was requested to move the review date to 31/07/2025, to align with the post implementation of the new Customer Relationship Management (CRM).</p> <p>The Committee RECEIVED the report and AGREED and extension.</p>
INFORM	<p>Charity Directors Update Report</p> <p>The report provided an overview of the contents of the report including the key points below:</p> <ul style="list-style-type: none"> • CRM system project progress • Fundraising activity January 2025 to June 2026 • Nine Legacies being worked on • Event updates and post-event evaluation of the Morocco Trek and Castle 2 Castle event. Both events proved successful; however, several areas for improvement have arisen from the Morocco Trek • Ratification of Out-of-Committee Approvals for London Marathon, Cardiff Half Marathon and lease of a storage unit <p>The Committee NOTED the Charity Directors Update Report.</p>

Financial Update Paper

The Committee received an update on the the financial performance and Charity's investment portfolio for the period 1st April 2024 to 31st January 2025 including:

- Income
- Expenditure
- Investment Portfolio
- Reserves Policy
- Investment Sub-committee Decisions

The Committee **NOTED** the financial update papers.

Reserves Policy Review

The Committee **APPROVED** the recommendation that the reserves policy should be updated and set at a level which is equivalent to estimated planned commitments covering a period of 10 months. It was also **NOTED** that there will be flexibility to review this if circumstances changed.

Suspension of charges to the charity

The Committee were asked to approve the suspension in 2024-25 of £2m of expenditure recharge to the Charity for cancer service and Research activities (c£0.924m relating to Research and c£1.076m relating to Patient Services) which has approved Charitable Funds support. These costs will be managed within Velindre NHS Trust core budgets from non-recurrent income gained over the period.

The Committee **APPROVED** the recommendation.

Charitable Funds Investment Performance Review Sub Committee Highlight Report 18th March

Key points noted:

- Agreed to transfer £3million from the cash account into the liquidity fund
- Exploring investment in bonds over two years given the high-interest rates
- Year-on-year increase of 7.6% in investment portfolio
- Market instability due to US uncertainty leading to reduction in investment value over last quarter
- Liquidity Fund return £0.350m and Liquidity Bond return of £0.280m
- Task force on Climate related Financial Disclosures (TCFD) Report describes Velindre Charity Investment Portfolio carbon footprint benchmarked against other NHS charities placing Velindre as the highest performing.

Terms of Reference

In line with the requirements of the Trust being the Corporate trustee, it was proposed to change committee membership to include all Trust Board Executive and Independent Members as members of the committee.

3. RECOMMENDATION

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

VELINDRE UNIVERSITY NHS TRUST BOARD	
PUBLIC AUDIT COMMITTEE HIGHLIGHT REPORT	
DATE OF MEETING	25 March 2025
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 provides the Trust Board with details of the key issues and items considered by the Audit Committee at its meeting held on the 25 March 2025. 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 the 25 March 2025:

ALERT / ESCALATE	There were no items identified to ALERT or ESCALATE to Trust Board.
ADVISE	<p>AUDIT WALES UPDATE: Audit Committee were informed of the following by Audit Wales:</p> <ul style="list-style-type: none"> • Financial Audit: All 2023-2024 work is complete, and the team is in a good position for the 2024-2025 draft accounts. Interim audit testing is underway, putting the team ahead of schedule.

- **Performance Audit:** The 2023-24 audit program is complete, with two pieces of work concluding soon. The 2024-25 audit plan includes a follow-up on quality governance recommendations and a deep dive into digital systems investment, set to start in the next few weeks.

Audit Committee **RECEIVED** the report and **NOTED** the content.

2024/25 INTERNAL AUDIT PROGRESS UPDATE

The 2024-2025 audit plan is nearing completion, with 13 general audits and 7 capital audits related to the New Cancer Centre build. Of the 13 general audits, 6 are complete, and 7 are in progress, with 5 expected to be completed in the next few weeks.

There are two remaining audits, including a follow-up piece of work and a contracts audit, which is part of a national comparison across different clients.

The Audit Committee **NOTED** the 2024/25 internal audit progress update and KPI report (appendix 1) and new Internal Audit report style.

Amendments to the Model Standing Orders and Reservation and Delegation of Powers for NHS Trusts

Board members shall be sent an Agenda and a complete set of supporting papers at least 5 clear days before a formal Board meeting. This information may be provided to Board members electronically or in paper form, in an accessible format, to the address provided, and in accordance with their stated preference. Supporting papers may, exceptionally, be provided, after this time provided that the Chair is satisfied that the Board's ability to consider the issues contained within the paper would not be impaired.

The Audit Committee **ENDORSED** the proposed amendment for approval by the Trust Board.

NHS Wales No PO No Pay (No Purchase Order No Payment) Policy

The policy requires that all purchases must have a purchase order (PO) before payment can be made.

The Audit Committee **APPROVED** the report.

TRUST RISK REGISTER

- A comprehensive review and update of the risk register is planned, with a focus on addressing the 11% of risks outside their review dates and ensuring no duplications.
- The level of assurance remains at 2, with ongoing efforts to improve the risk management process and address the identified issues.

ASSURE

The Committee also **NOTED** the detail and **NOTED** the work underway to improve organisational management of risk reporting.

TRUST ASSURANCE FRAMEWORK

Overall, the Trust Assurance Framework is evolving to provide better clarity and consistency in risk management and assurance levels, with ongoing efforts to address static risks and workforce-related issues.

The Audit Committee **NOTED** the current status and on-going development of the Trust Assurance Framework.

REVIEW OF AUDIT ACTION TRACKER – OVERDUE AND COMPLETED RECOMMENDATIONS / ACTIONS FROM INTERNAL & EXTERNAL AUDIT

The Audit Committee were asked to note:

- the contents of the report and the assurance it provides regarding the activities undertaken to address audit actions in response to audit report recommendations and associated risks.
- the 21 (50%) Internal Audit Report actions and 3 (50%) External Audit Report action that have been completed since the December '24 Audit Committee (Green Status).
- the 20 (48%) Internal Audit Report actions and the 3 (50%) External Audit Report actions that are on target for complete by agreed date (Yellow Status).
- 1 (2%) Internal Audit Report action has passed the agreed implementation date (**Red Status**) since the December '24 Audit Committee

The Audit Committee **NOTED** the Red / Overdue recommendation and **AGREED** to extend the due date to May in order to review this at the next Committee meeting.

EXTERNAL AUDIT REPORTS

The Audit Committee received four external audit report:

- Review of Cost Savings Arrangements report
- Setting of Well-Being objectives report
- Annual Audit report 2024

INTERNAL AUDIT REPORTS

The Audit Committee received four internal audit report, which reported a reasonable level of assurance:

- Performance Management Framework
- Board Assurance and Risk Management
- nVCC Validation of Management Action

INFORM

	<p>OTHER BUSINESS:</p> <p>The Committee also received written reports under the following agenda items:</p> <ul style="list-style-type: none"> • Counter Fraud Approval of Annual Plan • Progress Report • Private Patient Service Plan • Private Patient Service Debt Position • Receipt of Finance Technical Updates • Losses and Special Payments Report • Procurement Compliance Report • Legislative and Compliance Register
APPENDICES	NONE

3. RECOMMENDATION

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

TRUST BOARD	
TRUST SEAL REPORT: 21ST MARCH 2025 – 21ST MAY 2025	
DATE OF MEETING	22 May 2025
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 (21st March 2025 – 21st May 2025) .
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	
ACRONYMS	
nVCC	New Velindre Cancer Centre

1. SITUATION/ BACKGROUND

1.1 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 **(21st March 2025 – 21st May 2025)**.

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:												
<ul style="list-style-type: none"> • Outstanding for quality, safety and experience <input type="checkbox"/> • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations <input type="checkbox"/> • A beacon for research, development and innovation in our stated areas of priority <input type="checkbox"/> • An established 'University' Trust which provides highly valued knowledge for learning for all. <input type="checkbox"/> • A sustainable organisation that plays its part in creating a better future for people across the globe <input type="checkbox"/> 												
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) <i>For more information: STRATEGIC RISK DESCRIPTIONS</i>	10 - Governance											
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Select all relevant domains below											
	<table border="0"> <tr><td>Safe</td><td><input checked="" type="checkbox"/></td></tr> <tr><td>Timely</td><td><input checked="" type="checkbox"/></td></tr> <tr><td>Effective</td><td><input checked="" type="checkbox"/></td></tr> <tr><td>Equitable</td><td><input type="checkbox"/></td></tr> <tr><td>Efficient</td><td><input checked="" type="checkbox"/></td></tr> <tr><td>Patient Centred</td><td><input type="checkbox"/></td></tr> </table>	Safe	<input checked="" type="checkbox"/>	Timely	<input checked="" type="checkbox"/>	Effective	<input checked="" type="checkbox"/>	Equitable	<input type="checkbox"/>	Efficient	<input checked="" type="checkbox"/>	Patient Centred
Safe	<input checked="" type="checkbox"/>											
Timely	<input checked="" type="checkbox"/>											
Effective	<input checked="" type="checkbox"/>											
Equitable	<input type="checkbox"/>											
Efficient	<input checked="" type="checkbox"/>											
Patient Centred	<input type="checkbox"/>											
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: <i>For more information: https://www.gov.wales/socio-economic-duty-overview</i>	Not required											
	Click or tap here to enter text											
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://nhs.wales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.asp X	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
10th April 2025	(1) County Council of the City and County of Cardiff, ASDA Stores Ltd, (2) Burwood House Group Ltd and (3) Velindre University NHS Trust. Deed of Variation (in respect of the execution of highway works at Longwood Drive, Coryton, Cardiff, in the City of Cardiff pursuant to Section 278 and Section 38 of the Highways Act 1980.	Professor Donna Mead OBE, Chair, and David Donegan, CEO
10th April 2025	Deed of Easement – Section 278 Works – relating to land associated with ASDA Stores Ltd, Longwood Drive, Cardiff, and to the north and south of Northern Avenue, Whitchurch, Cardiff. (1) The Burwood House Group Limited (2) Velindre University NHS Trust (3) The Welsh Ministers.	Professor Donna Mead OBE, Chair, and David Donegan, CEO
10th April 2025	Agreement for the variation of the supplemental agreements relating to the carrying out of works and the grant of a deed of easement in respect of land at	Professor Donna Mead OBE, Chair, and David Donegan, CEO

Date	Document Details	Signed
	ASDA Cardiff Coryton Supercentre, Longwood Drive, Cardiff, CF14 7EW. (1) The Burwood House Group Ltd (2) ASDA Stores Limited (3) Velindre University NHS Trust.	
8th May 2025	Construction Contract – Construction Services in relation to nVCC Enabling Works (ASDA Longwood Drive S278 Works, Velindre, Cardiff).	Professor Donna Mead OBE, Chair, David Donegan, CEO and Matthew Bunce, Executive Director of Finance



TRUST BOARD	
TRUST WIDE POLICIES APPROVED UPDATE	
DATE OF MEETING	22 May 2025
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 April 2025 to May 2025 .
RECOMMENDATION / ACTIONS	The Trust Board is asked to NOTE the policies that have been approved during the period April 2025 to May 2025 .
GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	Date
APPENDIX 1:	
• Integrated Quality and Safety Group	23/04/2025
• Executive Management Board	29/04/2025
• Quality, Safety and Performance Committee	08/05/2025
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
<ul style="list-style-type: none"> • Appendix 1 – QS01 NHS Wales National Policy on Patient Safety Reporting and Management: The Integrated Quality and Safety Group; Executive Management Board and Quality, Safety and Performance Committee agreed that the Policy was relevant and ENDORSED the continued use of the Policy for the next 12 months pending the national review. 	

7 LEVELS OF ASSURANCE – N/A

APPENDICES

Appendix 1	QS01 NHS Wales National Policy on Patient Safety Reporting and Management
------------	---

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 **April 2025 to May 2025**.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

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

Appendix	Policy Title	Policy Lead / Function	Approving Body	Effective Date
1	QS01 NHS Wales National Policy on Patient Safety Reporting and Management	Executive Director of Nursing, AHP & Health Science	Quality, Safety & Performance Committee	08/05/2025

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>	04 – Organisational Culture												
QUALITY AND SAFETY IMPLICATIONS / IMPACT	<p>Yes -select the relevant domain/domains from the list below. Please select all that apply</p> <table border="0"> <tr><td>Safe</td><td><input checked="" type="checkbox"/></td></tr> <tr><td>Timely</td><td><input checked="" type="checkbox"/></td></tr> <tr><td>Effective</td><td><input checked="" type="checkbox"/></td></tr> <tr><td>Equitable</td><td><input checked="" type="checkbox"/></td></tr> <tr><td>Efficient</td><td><input checked="" type="checkbox"/></td></tr> <tr><td>Patient Centred</td><td><input checked="" type="checkbox"/></td></tr> </table> <p>A robust and clear governance framework for the management of policies is essential to minimise risk to patients, employees and the organisation itself; therefore, the Trust has developed a system to support the development or review, approval, dissemination and management of polices.</p>	Safe	<input checked="" type="checkbox"/>	Timely	<input checked="" type="checkbox"/>	Effective	<input checked="" type="checkbox"/>	Equitable	<input checked="" type="checkbox"/>	Efficient	<input checked="" type="checkbox"/>	Patient Centred	<input checked="" type="checkbox"/>
Safe	<input checked="" type="checkbox"/>												
Timely	<input checked="" type="checkbox"/>												
Effective	<input checked="" type="checkbox"/>												
Equitable	<input checked="" type="checkbox"/>												
Efficient	<input checked="" type="checkbox"/>												
Patient Centred	<input checked="" type="checkbox"/>												
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: <i>For more information: https://www.gov.wales/socio-economic-duty-overview</i>	<p>Yes</p> <p>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.</p>												
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	<p>A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances</p>												
FINANCIAL IMPLICATIONS / IMPACT	<p>Yes - please Include further detail below, including funding stream</p> <p>Non-compliance could result in significant costs due to legal challenges, fines and prosecutions against the Trust.</p>												
EQUALITY IMPACT ASSESSMENT	<p>Yes - please outline what, if any, actions were taken as a result</p> <p>Each policy will be individually assessed to ensure compliance with EIA requirements.</p>												
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	<p>Yes (Include further detail below)</p> <p>Not complying with Trust policy and procedure can result in legal challenges from staff at Employment Tribunal.</p>												

	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
--	-----------

VUNHST Ref: QS01

NHS Wales

National Policy on Patient Safety Incident Reporting & Management

Date to be reviewed:	31 March 2024	No of pages:	23
Document author & owner:	NHS Wales Executive		
Contact email:	PatientSafety.Wales@wales.nhs.uk		
Approved by:	Welsh Government		
Approval date:	4 May 2023		
Effective date (live):	11 May 2023		
Version:	v2.0		
The Trust Quality, Safety & Performance Committee APPROVED a 12 month extension to the review date pending the National Review			

Contents

1. Changes from previous version.....	3
2. Introduction	4
3. Purpose of this policy	4
4. Strategic policy context.....	5
5. Scope of Policy	6
6. References and related documents	6
7. Aims and objectives of this policy	6
8. Responsibilities in relation to this policy.....	7
9. Key Definitions	8
10. Governance & assurance requirements.....	10
11. Local incident reporting, management & investigation requirements	11
12. National incident reporting requirements	15
13. Duty of Candour	17
14. Patient safety incident investigations	18
15. Investigation of incidents occurring to a patient or service user while in receipt of commissioned services	20
16. Investigation outcomes.....	22
17. Future thinking in relation to incident reporting and analysis.....	24
18. Getting Help	24

Supporting sections:

1. NHS Wales Never Events list
2. Nationally Reportable Incident (NRI) reporting processes & flow chart
3. Guidance on nationally reporting specific incident types
4. Joint investigation process
5. Guidance on Safety-II principles
6. Commissioned Services flowchart

1. Changes from previous version

- Merged the content of the policy and the guidance document into a single document
- Removed references to “Phase 1” and “Phase 2” of policy implementation. Phase 2 related to the establishment of systems to thematically analyse incident data, this work has been superseded by the plans to undertake thematic analysis at a national level through the use of the Once for Wales Concerns Management system (Datix Cymru)
- Clarification of the scope of applicability of the policy, particularly with regard to independent service providers
- Improved clarity of roles & responsibilities of all organisations involved in policy delivery, alongside use of more inclusive terminology throughout the document
- Improved clarity on the requirements of the initial assessment process following identification of a patient safety incident
- Strengthened references to the use of Datix Cymru for the reporting and management of patient safety incidents, including the use of the in-built Yorkshire Contributory Factors Framework tool
- Clarified the principles for NHS organisations to consider in determining whether an incident should be nationally reported
- Incorporated the NHS Wales Never Events list
- Endorsement of the just culture guide as a supporting tool
- New/strengthened sections on:
 - Duty of Candour, including alignment of harm definitions
 - Joint safety incident investigations
 - Incidents occurring in relation to commissioned services
- Clarification of accountability for completion (closure) of an incident investigation
- Provision of introductory guidance relating to the use of Safety-II thinking into current incident management processes
- Updated guidance and definitions in relation to specific incident types based on feedback throughout 2021/22 including:
 - patient & service user falls to be retrospectively reported where the investigation has determined the fall was avoidable
 - alignment of reporting requirements associated with maternal & perinatal and infant deaths to National Confidential Enquiry (MMBRACE-UK) definitions
- Clarity on the relationship between Nationally Reportable Incident (NRI) reporting and Welsh Government (WG) Early Warning Notifications

2. Introduction

Patient safety incident reporting is changing across Wales. Historically, incident reporting has been used as a key safety indicator in healthcare to attempt to understand where things go wrong to learn and improve safety, experience and outcomes for future patients and service users. As a nation, our understanding of how to best use intelligence from incident data is continuing to evolve. New conceptual approaches to safety, such as Safety-II, will help us shift the narrative from focussing purely on “what went wrong?” and balance this line of inquiry alongside “what goes right, and how can we learn from that as well?” (see Supporting Section 5 for more information on Safety-II). These new approaches require us to think differently and consider how incident reporting is one component of a whole safe system of care. We must continue to ensure our national processes and approaches to this complex and sensitive area of healthcare are aligned to maximise learning opportunities for the benefit of patients, service users, their families, carers and loved ones, staff and our NHS organisations.

To achieve these ambitions, our national processes must support a just culture for organisations and staff to feel supported to identify, report and learn from patient safety incidents, without the fear of punitive response or action throughout all levels of NHS Wales.

The previous version of this policy (in effect from 14 June 2021) aimed to empower organisations to think differently about what should be reported, taking more ownership and accountability for incident reporting and management. Through this updated version of the Policy, the NHS Wales Executive will take these aims further and continue to work collaboratively with NHS Wales organisations and other key stakeholders in delivering a new system for collecting and analysing incident data which is for the NHS, by the NHS.

3. Purpose of this policy

A patient safety incident occurs when an unintended or unexpected incident could have or did lead to harm for one or more patients or service users receiving NHS-funded healthcare.

While many incidents will not result in significant harm to an individual, the exploration of incident reports can help provide a source of intelligence which can be used by healthcare providers for a variety of purposes, including:

- to **learn** from what has gone wrong and what could have been done differently, by using the incident as a prompt to undertake an investigation and take action in order to make changes to improve the safety of patients;
- to identify and address **emerging risks** by looking for trends, themes and patterns of incident reports; and
- as a mechanism for oversight and **assurance** particularly where significant harm has occurred in the delivery of healthcare, in line with *The National Health Services*

(Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011- also known as ‘Putting Things Right’ (referred to forthwith as ‘the Regulations’).

Incident reports can be a valuable signal to healthcare providers about where to focus resource and attention to improve patient safety. However, they are only one part of the puzzle and should be examined in the wider context of other sources of safety intelligence. This includes triangulation with other data sources (for example, patient experience and complaint data) as well as looking at what goes well the majority of the time, and what we can learn from that (e.g. Safety-II). Throughout 2023 and beyond, the NHS Wales Executive will be working to improve how this triangulation of multiple data sources is undertaken at a national level.

The purpose of this Policy is to set out clear expectations for patient safety incident reporting and management across NHS Wales. It supersedes and replaces the section on “Serious Incidents” within the 2013 ‘Putting Things Right’ (PTR) guidance document.

4. Strategic policy context

The following national programmes and concepts provide context to this Policy:

- [Health and Social Care \(Quality and Engagement\) \(Wales\) Act 2020](#), which underpin the statutory **Duties of Candour and Quality**:
 - The [Duty of Candour](#) is intrinsically linked to incident management. The Duty focusses on the need to be open with patients and service users and anyone acting on their behalf when things go wrong, building on the requirements already set out in the Regulations.
 - The [Duty of Quality](#) has two aims – to improve the quality of services, and to improve outcomes for people in Wales.
- [Quality & Safety Framework: learning and improving](#): the overarching national Framework setting out the national ambitions for Wales in relation to quality and safety in the NHS. In particular, this Policy relates to Action 4 – **the development of a new National Incident Reporting Framework focussing on maximising and sharing learning from incidents**.
- [National Clinical Framework: A Learning Health and Care System](#): the overarching national Framework setting out the national ambitions for Wales in relation to the development of clinical services across NHS Wales.
- [NHS Wales Executive](#): in fulfilment of an objective set down in A Healthier Wales, a number of organisations have brought together under the banner of the NHS Wales Executive from 1 April 2023. National systems for incident reporting will be established, maintained and developed by the NHS Wales Executive.
- **National Quality Management System (NQMS)**: a visionary system for NHS Wales which will ultimately bring together data from a number of sources, including

patient safety incidents, for triangulation and to inform a range of activities in relation to learning and assurance.

- [Once for Wales Concerns Management System](#): the national IT system enabling consistent approaches to a range of processes across NHS Wales. In relation to incident reporting and management, this system is also known as **Datix Cymru**.
- **COVID-19 pandemic & the [National Nosocomial COVID-19 Programme \(NNCP\)](#)**: NHS Wales is still recovering from the effects of the COVID-19 pandemic and this must continue to be taken into consideration in relation to patient safety incident reporting and management. Importantly, learning and changes to process which were brought about by the pandemic must be capitalised on, including in particular learning from the NNCP, which will be incorporated into this and future versions of the policy as applicable.

5. Scope of Policy

This Policy applies to **all** services directly provided or managed by a Health Board, Trust or Special Health Authority in NHS Wales.

NHS Wales organisations that contract, agree or arrange for care to be provided by a nonNHS Wales provider (independent provider) on their behalf, retain responsibility for national incident reporting. This is in keeping with position outlined in the *Health and Social Care (Quality and Engagement) (Wales) Act 2020* for Duty of Candour reporting. The requirement to report extends to Primary Care services providing care as part of NHS Wales.

6. References and related documents

- [Health and Social Care \(Quality and Engagement\) \(Wales\) Act 2020](#)
- [The National Health Services \(Concerns, Complaints and Redress Arrangements\) \(Wales\) Regulations 2011](#) as amended by [National Health Service \(Concerns, Complaints and Redress Arrangements\) \(Wales\) \(Amendment\) Regulations 2023](#)
- [The Duty of Candour Procedure \(Wales\) Regulations 2023](#)
- [The Duty of Candour Statutory Guidance 2023](#)
- [Putting Things Right guidance document \(v3, 2013\)](#)

7. Aims and objectives of this policy

- Provide a clear and consistent national approach to incident reporting, management and investigation across NHS Wales.

- Provide clear guidance on what types of incident should be nationally reported, and how this should occur.

8. Responsibilities in relation to this policy

Welsh Government:

- Setting legislation, statutory guidance and government policy.
- Ensuring that intelligence and learning derived from the outputs of this policy are taken into account in setting legislation, statutory guidance and government policy.
- Publishing official statistics based on reported incidents.

NHS Wales Executive:

- Oversee and deliver national policy and processes in relation to reporting, management and investigation of safety incidents.
- Identification of cross-system learning, ensuring that learning is disseminated.
- Ensuring consistency of application of this policy, including provision of assurance mechanisms in relation to incident reporting, management and investigation.
- Provide national analysis on nationally reported incident data.
- Provide advice, guidance and support to organisations in relation to implementation of this policy, including the reporting, management and investigation of safety incidents.

Health Boards, NHS Trusts and Special Health Authorities

- Accountable for the quality and safety of care and services provided to their respective populations, including care that they contract, agree or arrange for their populations.
- Implementing this policy including endorsement through their Quality & Safety governance framework.
- Ensuring there are appropriate governance and assurance mechanisms in place, facilitating a flow of information across all parts of the organisation.
- Ensuring local systems and processes for incident reporting are in place and embedded.

- Ensuring that there are systems and processes for incident reporting, management and learning for any health care they contract, agree or arrange on behalf of their populations.
- Undertaking analysis of locally reported incidents, including identifying trends and themes from incident data.
- Establishing mechanisms to extract and share learning from incidents, and taking action to reduce the risk of recurrence and improve patient and service user safety, experience and outcomes.
- Ensuring staff are familiar with the requirements of this Policy.

Primary Care (General Medical Services) contractors in NHS Wales

- Accountable for the quality and safety of care and services provided to their respective populations
- Required to locally report incidents that have occurred within their organisations using the Datix Cymru system. The Health Body whose system they report into is responsible for assessing whether incidents have met the NRI threshold and undertaking any subsequent reporting.
- Primary Care Contractors must notify the relevant Health Board of occurrences where the Duty of Candour is triggered in respect of the health care they provide under a contract or other arrangement.
- Establishing mechanisms to extract and share learning from incidents, and taking action to reduce the risk of recurrence and improve patient and service user safety, experience and outcomes.

Once for Wales Concerns Management System programme:

- Responsible for overseeing the development and delivery of relevant Datix Cymru modules to support the implementation of this Policy.

9. Key Definitions

General definitions:

Policy Term	Applicable Definition
Concern	As defined in the <i>NHS Wales (Concerns, Complaints and Redress Arrangements) (Wales) (Amendment) Regulations 2011</i> , a concern is any complaint, claim or reported patient safety incident

Patient Safety Incident	<p>An unintended or unexpected incident that could have or did lead to harm for one or more patients or service users receiving NHS-funded healthcare</p> <p>Note: the term “patient safety incident” refers to an incident occurring in the course of the delivery of healthcare. It is recognised that this may not always be to a patient but can also affect other service users in receipt of NHS-funded healthcare. The language throughout this document has been updated where possible to reflect this but for the avoidance of doubt, the definition of a patient safety incident applies equally to a service user in receipt of NHS funded healthcare even if they are not classified as a patient.</p>
Patient or Service user	<p>A person to whom healthcare is or has been provided</p> <p>Healthcare includes services for the prevention, diagnosis or treatment of illness as well as the promotion and protection of public health. It also includes NHS staff accessing treatment and care through wellbeing/occupational health services</p>
Action	Something done intentionally or unintentionally
Inaction	Something not done intentionally or unintentionally including as a result of indecision, unnecessary delay, failure to act
Nationally Reported Incident (NRI)	A patient safety incident which is nationally reportable in line with this policy
“Must report”	A sub-set of Nationally Reportable Incidents where national reporting is mandated through this Policy

Harm definitions

The following definitions align with the definitions set out in the [Duty of Candour Statutory Guidance](#)

No harm	Any patient safety incident that had the potential to cause harm but impact resulted in no harm having arisen
Low harm	Any patient safety incident that resulted in a minor increase in treatment and which caused minimal harm to one or more persons receiving NHS-funded care
Moderate harm	Any significant but not permanent harm, or harm that requires a 'moderate increase in treatment' relating to the incident. A 'moderate increase in treatment' is further defined as an unplanned return to surgery, an unplanned readmission, a prolonged episode of care, extra time in hospital or as an outpatient or transfer to another treatment area such as intensive care
Severe Harm	The permanent lessening of the bodily, sensory, motor, physiologic or intellectual functions, including the removal of the wrong limb or organ or brain damage, which is related directly to the incident and not related to a natural course of the service user's illness or underlying condition
Death	A death caused or contributed to by a patient safety incident, as opposed to a death which occurs as a direct result of the natural course of the patient or service user's illness or underlying condition

10. Governance & assurance requirements

Organisations must ensure they have robust systems and processes in place in relation to local and national incident reporting, including:

- systems and processes to enact this policy in all areas of the organisation;
- all incidents should be reviewed within an appropriate governance framework to determine required risk management activities as well as any national reporting requirement. Whilst advice and support can be sought from the NHS Wales Executive, it will be expected that organisations are responsible and accountable for their judgements and decisions in line with the policy;
- integration with other relevant clinical and corporate governance processes e.g. management of complaints and claims, mortality review processes etc.;
- internal oversight, scrutiny and quality assurance of all incident reporting and investigation processes, including Executive level sign off on national incident notification and investigation outcome forms;

-
- clear and demonstrable lines of reporting across all parts of the organisation, including through relevant Committees of the Board;
mechanisms for ensuring joint investigations with other responsible bodies and external agencies where applicable and appropriate;
- mechanisms for recording the outcomes of decisions around national reporting and investigation, including decisions on appropriate investigation methodology. In particular, organisations must ensure they keep robust records around the decisions not to report/investigate incidents as this will be needed for quality assurance purposes;
- mechanisms for capturing and demonstrating shared learning;
- mechanisms for ensuring engagement with any affected patient or service user or anyone acting on their behalf, in line with the legal Duty of Candour.

11. Local incident reporting, management & investigation requirements

11.1. Context

Patient safety incidents can be single isolated events, or multiple recurring events which can signal more systemic failures in care or demonstrate system weaknesses. They can also include events which indirectly impact patient safety or an organisation's ability to deliver a service, such as a failure of an IT system. Consequently, there is no definitive list of what constitutes a patient safety incident and accordingly NHS organisations will need to apply judgment when considering what should be reported, both at a local and a national level.

11.2. Systems and processes

All organisations are required to ensure that they have systems and processes for local incident reporting, management and investigation in line with this Policy. This must include systems and processes to analyse incident data, extract learning and disseminate it throughout the organisation, with relevant actions taken to improve patient and service user safety, outcomes and experience.

Organisations should also have systems in place for monitoring and nationally reporting incidents that occur within services that are provided on their behalf by non-NHS Wales providers.

These processes must include the use of Datix Cymru where available to ensure a consistent national approach to data collection and analysis. These processes should be sufficient to capture and analyse data from across all parts of the patient or service user pathway, including (but not limited to):

-
- secondary and acute care settings
- primary and community care, including community pharmacy, optometry, dentistry services
 - urgent and emergency services including emergency departments & ambulance services
- out of hours' services
- public health services
- relevant IT services
- prisons
- commissioned services, and
- incidents identified through the course of other clinical and corporate governance processes, for example Medical Examiner and Mortality Reviews.

The systems and processes must fully align with the organisation's governance and assurance mechanisms, ensuring clear reporting across the entire organisation for relevant information.

Organisations must ensure local processes are reviewed, amended and/or adapted to incorporate the requirements of this Policy.

11.3. Initial assessment to determine risk management activities and next steps

All patient safety incidents will require an initial assessment in order to assess the circumstances, identify the relevant make safe actions required, and determine the next steps to manage the incident. This initial assessment should take place as soon as practicable after the incident has occurred or otherwise been identified.

This initial assessment must include:

- review of known information about the incident and consideration of further information to be obtained to inform the next steps;
- assessment of risk and determination of make safe actions in relation to:
 - all patient(s) or service user(s) affected by the incident, and
 - the organisation, or other safety systems, to prevent recurrence in similar circumstances;
- determination of the depth and parameters of an appropriate investigation;

- - consideration of engagement with the patient or service user and anyone acting on their behalf as appropriate. This assessment will need to balance the desire to engage transparently and compassionately with all affected by the incident whilst having due regard for legal matters of consent and capacity.
- consideration and, where required, escalation e.g.:
- as a Nationally Reported Incident (NRI);
 - through to relevant national frameworks (e.g. multiagency safeguarding processes); and/or
 - through to relevant external bodies; • any relevant communications handling required;
- next steps in terms of incident management.

The depth of the initial assessment will vary depending on the circumstances of the incident. The initial assessment must be undertaken by someone of sufficient seniority and experience in incident management proportionate to the circumstances of the incident, and in many cases will require a multi-disciplinary approach. In some cases, including where the incident requires reporting as an NRI, this may require Executive level oversight.

Depending on the circumstances of the incident, this may be the point at which the organisation considers whether the Duty of Candour has been triggered and if so, who should make the initial “in person” notification – see Section 4 of the Statutory Guidance.

11.4. Use of Datix Cymru

All patient safety incidents should be reported through Datix Cymru (part of the Once for Wales Concerns Management System) in line with the applicable User Guide operational at the date of reporting.

Employees of Health Boards, Trusts and Special Health Authorities should have access to report directly into their employer’s Datix Cymru system.

Primary Care Contractors in NHS Wales are required to report incidents that have occurred within their organisations. More information can be obtained from the [Primary Care Wales Incident Reporting - NHS Wales Shared Services Partnership](#) website.

11.5. Welsh Government Early Warning Notifications (EWN)

Early Warning Notifications (EWN) (previously No Surprise Reporting) is a communication function established by Welsh Government. Its purpose is to provide rapid information to

-

Welsh Government on a range of issues, which may or may not relate to patient safety incidents.

The EWN process is independent of the incident reporting systems described in this Policy, which are overseen and managed by the NHS Wales Executive.

For clarity, where a patient safety incident meets both the requirements of a EWN and a NRI, then both processes must be followed.

12. National incident reporting requirements

12.1. Context

A subset of patient safety incidents will require national reporting to the NHS Wales Executive. The reporting of patient safety incidents at a national level:

- provides oversight and assurance relating to incidents that cause the most harm to patients and service users during healthcare;
- provides oversight and assurance relating to incidents that cause high levels of service impact, disruption or risk;
- enables the identification of organisational and/or system risks; and
- informs learning and action, including e.g. development of patient safety alerts and notices, policies and improvement programmes, national priorities, outcome measures and potential service reforms.

Building on the foundation of the previous version of the Policy, there is a need to move away from prescriptive “trigger list” approaches to determining what incidents require national reporting. This is because of the complexity of healthcare and the incidents that can occur, it would never be possible to determine and list all the types of incidents which should be reported.

Accordingly, NHS organisations must have systems and processes in place to review all incidents on an individual basis and apply judgement to determine what should be reported nationally.

12.2. Nationally Reportable Incidents (NRIs)

As part of the initial assessment process described above, NHS organisations will need to consider whether an incident requires reporting nationally, taking the following principles into account:

Principle 1 - ‘Must reports’

Incidents related to the following are always nationally reportable (please see Supporting Section 3 for more guidance on definitions):

- Never Events, as specified within this Policy, even where no harm has occurred. The current NHS Wales Never Event list can be found in Supporting Section 1 of this Policy;
- suspected mental health homicides;
- suspected suicide or self-inflicted death

- in any clinical setting; or
- during authorised/agreed leave, following recent planned discharge, or following unplanned leave/discharge; and
- maternal, perinatal and infant deaths.

Principle 2 - outcome/harm

A safety incident should be nationally reported if it is **assessed or suspected** an **action or inaction** in the course of a patient or service user's treatment or care, in any healthcare setting, **has, or could have caused or contributed** to their **severe harm or death**.

It will not always be possible to rapidly determine the extent to which a safety incident caused or contributed to the harm or death of a patient or service user within seven working days. In this case, organisations should nationally report the incident, specifying that the position is unclear and/or investigations are ongoing. Incidents can be downgraded at a later date.

Acts and inactions can relate equally to human interactions, technical failures and/or delays in systems and processes.

Principle 3 - number of patients or service users involved

Special consideration must be given to incidents where the numbers of patients or service users affected is significant, even where direct harm has not been, or is difficult to, identify. This includes but is not limited to incidents involving significant:

- screening services;
- IT failures;
- data breaches;
- national system failures; and/or
- service disruptions.

Principle 4 - learning opportunities

Incidents should be nationally reported where they present new learning opportunities, particularly where a similar risk may be present in other NHS organisations. This may include:

- near misses and/or no or low harm incidents where the learning would be beneficial to be shared nationally with other organisations to help raise awareness and mitigate risks for other patients or service users; and/or

- incidents may present which are unusual, unexpected or surprising, where seriousness of the incident requires it to be nationally reported and the learning would be beneficial for others.

Principle 5 - joint decision making around reporting and investigation

Some patient safety incidents will require joint investigation with another organisation. Early consideration must be given to involving relevant stakeholders in any discussions around incidents potentially requiring joint investigation, to ensure relevant information is obtained from all sources in order to inform the discussion. Guidance on the joint investigation process can be found in Supporting Section 4.

12.3. Reporting process

A patient safety incident will be nationally reported to the NHS Wales Executive within seven working days from the date of knowledge of the incident.

The reporting process is set out in Supporting Section 2.

13. Duty of Candour

The provisions of the statutory Duty of Candour, as set out in the [Health and Social Care \(Quality and Engagement\) \(Wales\) Act 2020](#) came into effect on 1 April 2023. This is an organisational duty on all NHS bodies and primary care providers. More information on the Duty of Candour, including the [statutory guidance](#), can be found on the [Welsh Government website](#).

Incident reporting, management and investigation is intertwined with the principles of [Being open: communicating patient safety incidents with patients and their carers](#) and must adhere to the Duty of Candour, so in practice these activities should be fully integrated. In preparation for the Duty of Candour, NHS organisations have been reviewing their systems and processes in relation to concerns and incident reporting, investigation, and management to ensure that they are aligned as far as possible, in order to provide a seamless patient or service user experience.

The Duty of Candour is triggered when:

- an adverse patient safety event (usually an incident) occurs, and the service user sustains or could sustain harm which is
 - unintended or unexpected, and
 - more than minimal e.g., moderate, severe or death, and
- the provision of healthcare was or could have been a factor in that harm occurring.

At the point the incident is reviewed, and it is recognised that the above triggers for the Duty of Candour have been met, the organisation becomes 'aware'. It is at this point that the Duty of Candour procedure should be initiated.

The Duty of Candour is not intended to operate retrospectively and therefore will only apply where the conditions triggering the Duty of Candour as set out in Section 3 of the [Health and Social Care \(Quality and Engagement\) \(Wales\) Act 2020](#) occur after the date on which Section 3 was brought into force (i.e. 1 April 2023). In practical terms, this means that the provision of health care and the harm which ensued, must have taken place after 1 April 2023.

For the avoidance of doubt, the Duty of Candour may be triggered following a retrospective case review but that the conditions which gave rise to the notifiable adverse outcome must have occurred after Section 3 was brought into force.

14. Patient safety incident investigations

14.1. Legislation

All concerns reported in NHS Wales, including patient safety incidents, must be subject to an appropriate and proportionate investigation in line with the *NHS Wales (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011*. In particular, [Regulation 23](#) outlines the requirements of the investigation to be undertaken and requires the organisation to undertake the investigation in the manner that appears, to that organisation, to be most appropriate to reach a conclusion in respect of those matters thoroughly, speedily and efficiently.

14.2. Methodologies

NHS organisations must have systems and processes for determining the appropriate and proportionate investigation to be undertaken in response to each reported safety incident, taking into account considerations such as scale, complexity and type of incident.

Organisations should therefore ensure they have access to a range of suitable investigation approaches/tools to support a proportionate approach across a range of outcomes. It will not be appropriate to conduct in-depth investigations for all incidents, and so it is important to determine as accurately as possible from the outset what will be proportionate in the circumstances.

Methodologies in use by an organisation should ensure the involvement throughout the investigation of appropriate staff and patient, service user or a person acting on their behalf.

For certain incident types, to support a consistent national approach there are a number of focussed review tools built into Datix Cymru, which should be used where they are available. This includes safety incidents relating to:

- Falls
- Pressure damage
- Extravasation

This section will be expanded during 2023 in line with the NHS Wales Executive's work.

14.3. Use of Yorkshire Contributory Factors Framework

The Yorkshire Contributory Factors Framework (YCFF) has been built into Datix Cymru to support a consistent approach to the analysis of incidents, including the identification of cross-cutting themes to enable targeting of improvement activities.

Accordingly, the use of the YCFF is required for NRIs and encouraged for other patient safety incidents.

14.4. Just culture guide

Staff who have been involved in a patient safety incident should be treated in a consistent, constructive and fair way.

NHS Wales endorses the use of the NHS England just culture guide as a tool to support the fair treatment of staff who have been involved in an incident. It supports a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely.

The just culture guide should **not** be used as a routine or integral part of a patient safety investigation – it should only be used when consideration needs to be given to whether an individual member of staff requires support or management to work safely.

The just culture guide, along with supporting reference materials, can be found on the NHS England website - <https://www.england.nhs.uk/patient-safety/a-just-culture-guide/>

14.5. Joint investigations

Some safety incidents will require joint investigations, including between:

- different departments within the same organisation;
- where patients have been moved between organisations, including patient handovers at emergency departments; and
- where services have been commissioned, including relating to social care.

NHS organisations should have systems and processes in place to manage these types of investigations.

For joint investigations involving multiple organisations, please refer to the joint investigation process in Supporting Section 4.

15. Investigation of incidents occurring to a patient or service user while in receipt of commissioned services

Whilst the reporting of patient safety incidents at a national level remains the responsibility of the NHS Wales organisations that provided, managed or commissioned the care at the time of the incident, guidance on the investigation of such incidents is provided within the *The National Health Services (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011* (“the Regulations”). The Regulations require all ‘responsible bodies’ to investigate incidents which occur to services users in receipt of NHS funded care.

A responsible body is defined under the Regulations as:

- a Welsh NHS body:
 - a Health Board;
 - an NHS Trust managing a hospital or other establishment or facility wholly or mainly in Wales;
 - a Special Health Authority • a primary care provider; or
- an independent provider:
 - a person or body who provides healthcare in Wales under arrangements made with a Welsh NHS body; and is not an NHS body or a primary care provider.

When a patient safety incident occurs, [Regulation 23](#) states that “the responsible body must investigate the matters raised in the notification of a concern in the manner which appears to that body to be most appropriate to reach a conclusion in respect of those matters thoroughly, speedily and efficiently, having particular regard to additional criteria set out in the Regulations”. The Regulations also detail what actions responsible bodies must take in terms of *redress*¹, when harm is deemed to have been ‘caused’ to a patient or service user through a ‘breach in duty of care’ to that patient or service user.

When healthcare is funded by another Welsh NHS body (Health Board or Trust), the Regulations require a full investigation up to and including consideration of qualifying

liability (QL). Organisations are required to undertake a joint investigation with a lead organisation agreed.

There are however distinct differences in how the Regulations are applied when healthcare provision has not been provided by a ‘Welsh NHS body’ (Health Board or Trust) through NHS

¹ Redress is a range of actions which include an apology, learning lessons, and/or in certain circumstances, financial compensation.

funding arrangements. The degree in variation is predicated on which other type of 'responsible body' provided the healthcare, and particularly when the healthcare has been provided outside of Wales.

The way in which the Regulations vary can be divided into two categories;

1. NHS Wales funded healthcare provided by another UK NHS provider, i.e.:
 - NHS England; or
 - NHS Scotland; or
 - NHS Northern Ireland; and
2. NHS Wales funded healthcare provided by an 'independent provider', either:
 - provided in Wales under arrangements made with a Welsh NHS body and is not an NHS body or a primary care provider; or
 - provided outside of Wales.

NHS Wales funded healthcare provided by another UK NHS provider

When the Regulatory duty is applied to other UK NHS organisations through cross-border and other commissioning arrangements, it is anticipated that local procedures for managing concerns and investigations will be of a sufficient standard to support investigations in keeping with the Regulations. The Regulations require other UK nations to consider a qualifying liability (QL) and refer the matter back to the NHS Wales commissioning organisation where they consider a QL **does**, or **may** exist. However, there is no requirement on other UK NHS organisations to inform an NHS Wales commissioning organisation where they **do not** consider a QL exists.

NHS Wales funded healthcare provided by an 'independent provider'

The Regulations state any responsible body, who provides healthcare **in Wales** under arrangements made with a Welsh NHS organisation, and who is not an NHS Wales Health Board or Trust, must have arrangements in place to manage and undertake investigations when a concern, including a patient safety incident, is raised.

The first element to highlight is that the Regulations do not apply to private provision of healthcare *outside* of Wales.

The second element relates to private provision *within* Wales. In this regard, this will include healthcare provision in care and residential home settings through continuing healthcare (CHC) and funded nursing care (FNC) arrangements, including local authority managed, third sector/charitable/not for profit sector, and private business. This also extends to any other privately provided healthcare which is NHS funded.

Responsibility to Investigate

Whilst the Regulations require an investigation to be undertaken when a patient or service user is subject of a concern during funded provision of healthcare, there are two key differences when a concern is raised in this regard:

1. the investigation is to be **undertaken by the provider** and not the NHS commissioning organisation, in keeping with the requirement on them to have arrangements in place to do so; and
2. there is no requirement on the provider to consider a QL as part of the investigation process.

Joint investigations in relation to commissioned services

Although the Regulations require the provider to undertake investigations when a concern is raised (including a patient safety incident), it is envisaged that when a concern is raised both in respect of the commissioned healthcare provider, and the commissioning organisation, it will be for the NHS Wales organisation to lead a joint investigation. The Regulations still however limit the independent provider element of the investigation to a factual response and not as far as considering QL, but the NHS element of the investigation is required to consider QL.

Post discharge

Concerns which occur during healthcare provision by an NHS Wales body prior to, or during a transfer of care to an independent provider through NHS funding arrangements, will remain the responsibility of NHS commissioning organisation to manage and investigate, fully in keeping with the Regulations up to and including consideration or QL.

16. Investigation outcomes

16.1. Learning from incident investigations

A fundamental part of undertaking incident investigations is to learn from previous experience in order to identify areas for improvement to reduce the risk of similar incidents occurring in the future.

NHS organisations should ensure they have robust systems and processes in place to support the extraction and dissemination of learning from incident investigations throughout the organisation, and include key learning as part of sharing investigation outcomes with the NHS Wales Executive.

This section will be expanded during 2023 in line with the NHS Wales Executive's work.

16.2. Completing (closing) an incident investigation

The accountability for completing (closing) an incident investigation sits with the NHS organisation who undertook the investigation.

NHS organisations must ensure there are robust processes in place to ensure the timely completion of incident investigations in line with this policy, which incorporate processes for patient or service user involvement, quality assurance, and Executive sign off.

To allow Boards to be assured that incidents within their organisation have been dealt with appropriately, all NHS organisations must ensure robust processes are in place to inform and assure their Boards that:

- the quality of their investigation processes is of a high standard;
- investigations are being undertaken and completed in a timely manner;
- patients or service users or anyone acting on their behalf are being engaged and supported during the investigation process and the findings and outcomes of the investigation are shared with them; and
- appropriate actions are being taken and learning is being shared across the organisation.

16.3. Process for reporting outcomes of an investigation into an NRI

Detailed guidance on the process for reporting NRI investigation outcomes to the NHS Wales Executive is in Supporting Section 2.

16.4. NHS Wales Executive's role in relation to investigation outcomes

The NHS Wales Executive does not “close” incident investigations related to NRIs. As stated above, the completion of an incident investigation is the responsibility and accountability of the NHS organisation who undertook the investigation.

The NHS Wales Executive has an assurance function to ensure that the information shared in relation to the investigation outcomes is of good quality, using a suitable approach, and undertaken in a timely manner. This is to support a patient or service user focused approach, as patients or service users affected by safety incidents and people acting on their behalf require good quality information to be provided to them in a timely manner. Where gaps in assurance are identified, the NHS Wales Executive will liaise with the relevant NHS organisation to seek further assurance.

In addition to the extraction and utilisation of learning from incidents, data and intelligence from NRIs will be used to inform local and national assurance activities.

17. Future thinking in relation to incident reporting and analysis

As described in the introduction section, new conceptual approaches to safety including resilience in healthcare and Safety-II, will be increasingly considered by the NHS Wales Executive to determine how these new ways of thinking can help support continual improvement and evolution of our safety management systems in healthcare.

Some preliminary guidance on how to incorporate elements of Safety-II thinking into current incident management practices is included in Supporting Section 5.

This section will be expanded during 2023 in line with the NHS Wales Executive's work.

18. Getting Help

Please contact PatientSafety.Wales@wales.nhs.uk if help and support in application of this policy is required.