

Public Trust Board

Thu 24 July 2025, 10:00 - 13:00

Velindre Trust Headquarters / Microsoft Teams

Agenda

10:00 - 10:20
20 min

1. STANDARD BUSINESS

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 22nd May 2025 and Extraordinary Public Trust Board meeting held on 26th June 2025

Prof. Donna Mead OBE, Chair

-  1.4.0a FINAL Public Trust Board Minutes 22.05.2025 (v3)DM.pdf (14 pages)
-  1.4.0b Minutes PUBLIC Extraordinary Trust Board_26.06.2025(v3)DM.pdf (5 pages)

1.5. Public Action Log

Prof. Donna Mead OBE, Chair

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

1.6. Matters Arising

Prof. Donna Mead OBE, Chair

1.6.1. Radiotherapy Satellite Centre / Paperless Go Live update

Anne Carey, Chief Operating Officer

-  1.6.1 paperless go live cover sheet_FINAL.pdf (7 pages)
-  1.6.1a Paperless Progress V4.pdf (1 pages)

10:20 - 10:30
10 min

2. KEY REPORTS

2.1. Chair's Report

Prof. Donna Mead OBE, Chair

-  2.1.0 Chair's update Trust Board 31.07.2025 (DM).pdf (6 pages)

2.2. Chief Executive's Report

David Donegan, Chief Executive Officer

-  2.2.0 CEO's Update Trust Board 24 July 2025 v2.pdf (6 pages)

10:30 - 11:15
45 min

3. QUALITY, SAFETY & PERFORMANCE

3.1. Performance Management Framework (May 2025)

Lauren Fear, Interim Director of Transformation, Anne Carey, Chief Operating Officer, Sarah Morley, Executive Director of OD & Workforce, Carl Taylor, Chief Digital Officer, Matthew Bunce, Executive Director of Finance

 3.1.0 Trust Board 24.07.25 MAY PMF Data 2025 PowerPoint version v6 Final Draft.pdf (28 pages)

3.2. Financial Report (May 2025)

Matthew Bunce, Executive Director of Finance

 3.2.0 Month 2 Finance Report Cover Paper - Trust Board 24.07.2025 FINAL.pdf (12 pages)

 3.2.0a Appendix 1 - M2 VELINDRE UNHS TRUST FINANCIAL POSITION TO MAY 2025 - TRUST BOARD 24.07.2025.pdf (29 pages)

 3.2.0b Appendix 2 - nVCC Project Finance Paper Trust Board 24.07.2025.pdf (14 pages)

3.3. VUNHST Risk Register

Non Gwilym, Interim Director of Corporate Governance

 3.3.0 TRR -TB - COVER PAPER -24.07.2025 -V01.pdf (8 pages)

 3.3.0a TRR - APPENDIX 1 -TB - 24.07.2025 -V01.pdf (8 pages)

3.4. Trust Assurance Framework

Non Gwilym, Interim Director of Corporate Governance

 3.4.0 TAF Cover Paper - TB 24.07.2025 v0.3.pdf (7 pages)

 3.4.0a TAF INFORMATION FOR TB 24.07.2025 V01.pdf (13 pages)

 3.4.0b TAF SUMMARY - TB - 24.07.2025 - V01.pdf (2 pages)

 3.4.0c TAF 01 - SERVICE CAPACITY.pdf (6 pages)

 3.4.0d TAF 02 - QUALITY AND SAFETY.pdf (7 pages)

 3.4.0e TAF 03 - RD&I.pdf (3 pages)

 3.4.0f TAF 04 - UNIVERSITY STATUS.pdf (3 pages)

 3.4.0g TAF 05 - SUSTAINABILITY.pdf (3 pages)

 3.4.0h TAF 06 -CULTURE.pdf (6 pages)

 3.4.0i TAF 07 - DIGITAL.pdf (5 pages)

 3.4.0j TAF 08 - GOVERNANCE.pdf (4 pages)

 3.4.0k TAF 09 - FINANCE.pdf (12 pages)

 3.4.0l TAF 10 - TRANSFORMATION.pdf (3 pages)

 3.4.0m TAF11 - WORKFORCE.pdf (5 pages)

11:15 - 11:25
10 min

BREAK

11:25 - 12:10
45 min

4. ANNUAL REPORTS 2024-2025

4.1. Social Partnership Duty Annual Report

Sarah Morley, Executive Director of Organisational Development & Workforce

 4.1.0 Social Partnership annual report Trust Board July 2025_.pdf (5 pages)

 4.1.0a Social Partnership Duty report (on template) v1 – Appendix 1.pdf (10 pages)

4.2. Gender Pay Gap Annual Report

Sarah Morley, Executive Director of Organisational Development & Workforce

 4.2.0 Trust Board Gender Pay Gap Report 2025.pdf (5 pages)

 4.2.0a NHS_VELINDRE_REPORTS_GENDER PAY GAP_V08.pdf (7 pages)

4.3. Equality, Diversity & Inclusion Annual Report

Sarah Morley, Executive Director of Organisational Development & Workforce

- 📄 4.3.0 Trust Board Annual Equality Report 2025.pdf (5 pages)
- 📄 4.3.0a NHS_VELINDRE_REPORTS_ANNUAL EQUALITIES_V07.pdf (8 pages)

4.4. Welsh Language Annual Report

Sarah Morley, Executive Director of Organisational Development & Workforce

- 📄 4.4.0 Welsh Language Annual Report Trust Board Cover Paper docx.pdf (5 pages)
- 📄 4.4.0a Welsh Language Report Appendix 1.pdf (18 pages)

4.5. Quality & Safety Annual Report

Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Scientists

- 📄 4.5.0 Quality Safety 2024-25 Annual Report - Trust Board.pdf (75 pages)

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

Lauren Fear, Director of Transformation (Interim)

- 📄 4.6 Cover Paper WBFGA Annual report - Trust Board 24.7.25 - vfinal.pdf (3 pages)
- 📄 4.6a WBFGA report 2024-05 (on template) v2.pdf (13 pages)

4.7. Duty of Quality Annual Report

Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science

- 📄 4.7.0 DOQ Annual Report - Trust Board.pdf (73 pages)

4.8. Professional Registration / Revalidation Annual Report

Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science

- 📄 4.8.0 Professional Registration Revalidation Annual Report 2024-2025(002).pdf (5 pages)
- 📄 4.8.0a NHS_VELINDRE_REPORTS_ANNUAL_PROFESSIONAL REGULATION_V03.pdf (10 pages)

4.9. Annual Report on Compliance with the Nurse Staffing Levels (Wales) Act 2016

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

- 📄 4.9.0 NSL Wales Act Annual Report QSP4.pdf (16 pages)

12:10 - 12:15 5. COMMITTEE ANNUAL REPORTS

5 min

Prof. Donna Mead OBE, Chair

5.1. Audit Committee Annual Report

Gareth Jones, Independent Member and Chair of Audit Committee

- 📄 5.1.0 Audit Committee Annual Report 2024-2025 Final v2.pdf (17 pages)

12:15 - 12:20 6. PLANNING AND STRATEGIC DEVELOPMENT

5 min

Prof. Donna Mead OBE, Chair

6.1. Strategic Planning Update

Lauren Fear, Director of Transformation (Interim)

****Next update to follow at September Board.**

12:20 - 12:30
10 min

7. CONSENT ITEMS FOR APPROVAL

Prof. Donna Mead OBE, Chair

7.1. Amendments to Standing Orders – Schedule 3 Annual Review Committee Terms of Reference

Non Gwilym, Director of Corporate Governance (interim)

- 📄 7.1.0 Trust Board Amendment to Trust Standing Orders - Schedule 3 - JULY 2025.pdf (5 pages)
- 📄 7.1.0a APPENDIX 1 nVCC Project Scrutiny Sub Committee ToR - Track Changes.pdf (11 pages)
- 📄 7.1.0b APPENDIX 2 nVCC Project Scrutiny Sub Committee ToR - CLEAN.pdf (10 pages)
- 📄 7.1.0c APPENDIX 3 LPF - TOR - UPDATED - Track Changes.pdf (7 pages)
- 📄 7.1.0d APPENDIX 4 LPF - TOR - UPDATED - CLEAN.pdf (7 pages)

7.2. Chair's Urgent Actions Report

Non Gwilym, Director of Corporate Governance (Interim)

- 📄 7.2.0 PUBLIC Chairs Urgent Action Report JUL 2025 v1.pdf (4 pages)

7.3. People and OD Policies for Approval

Sarah Morley, Executive Director of Organisational Development & Workforce

- 📄 7.3.0 People and OD Policies Cover Paper Trust Board.pdf (6 pages)
- 📄 7.3.0a Family Friendly Policy v.2.pdf (5 pages)
- 📄 7.3.0b Maternity Leave Procedure v.3.pdf (10 pages)
- 📄 7.3.0c Maternity Leave Application Form v.3.pdf (4 pages)
- 📄 7.3.0d Pregnancy and Maternity Leave Guidance v.2.pdf (3 pages)

12:30 - 12:40
10 min

8. CONSENT FOR NOTING

Prof. Donna Mead OBE, Chair

8.1. Public Strategic Development Committee Highlight Report (01/05/2025)

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

- 📄 8.1.0 TRUST BOARD PUBLIC SDC HIGHLIGHT REPORT 01.05.2025 v1.pdf (5 pages)

8.2. Public nVCC Project Scrutiny Sub-Committee Highlight Reports (20/03/2025, 06/05/2025 & 10/06/2025)

Hilary Jones, Independent Member and Chair of the TCS Scrutiny Sub-Committee

- 📄 8.2.0a TRUST BOARD PUBLIC TCS HIGHLIGHT REPORT 20.03.2025 v1.pdf (5 pages)
- 📄 8.2.0b TRUST BOARD PUBLIC TCS HIGHLIGHT REPORT 06.05.2025 v1.pdf (4 pages)
- 📄 8.2.0c TRUST BOARD PUBLIC TCS HIGHLIGHT REPORT 10.06.2025 v1.pdf (4 pages)

8.3. Public Audit Committee Highlight Reports (13/05/2025 & 25/06/2025)

Gareth Jones, Independent Member and Chair of the Audit Committee

- 📄 8.3.0a Highlight Report Public Audit Committee 13 May 2025 FINAL docx.pdf (4 pages)
- 📄 8.3.0b Highlight Report Public Audit Committee 24 June 2025 V2.pdf (3 pages)

8.4. Public Quality, Safety & Performance Committee Highlight Report (17/07/2025)

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

- 📄 8.4.0 Public QSP Highlight Report 17th July 2025 (VM).pdf (10 pages)

8.5. Public Charitable Funds Committee Highlight Report (03/06/2025)

- 📄 8.5.0 Highlight Report PUBLIC CFC 3 June 2025 (DM).pdf (2 pages)

8.6. Local Partnership Highlight Report (15/07/2025)

Sarah Morley, Executive Director of Organisational Development & Workforce

 8.6.0 LPF Highlight Report V01.pdf (3 pages)

12:40 - 13:00 9. ADDITIONAL

20 min

Prof. Donna Mead OBE, Chair

9.1. Statement by the Chair, Professor Donna Mead OBE

Prof. Donna Mead OBE, Chair

9.2. Any Other Business

Prof. Donna Mead OBE, Chair

*Prior approval required by Chair

9.3. Date of next meeting

Prof. Donna Mead OBE, Chair

Thursday, 25th September 2025.

13:00 - 13:00 10. CLOSE

0 min

The Board is asked to adopt the following resolution:

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

13:00 - 13:00 11. The following items will be discussed / noted at the private / part B session of the Trust Board

0 min

- Previous Private Trust Board minutes and actions
- VCS Restructure
- Whitchurch Land – next steps
- BECS update
- TrAMs update
- IP5 Roof Overcladding Business Case
- 4-5 Charnwood Lease
- National Influenza Immunisation Programme – Operational Arrangements
- Regional Planning Update
- Private Trust Risk Register
- Chair's Urgent Actions
- Business Continuity and Emergency Preparedness Annual Report
- Private Committee Highlight Reports
- Shared Services Committee Report
- Shared Services Audit Committee Highlight Report
- Joint Commissioning Committee Highlight Report
- South East Wales Pre-Registration Training

**MINUTES PUBLIC TRUST BOARD MEETING
VELINDRE UNIVERSITY NHS TRUST
22nd May 2025 10:00-13:00**

PRESENT Prof. Donna Mead OBE Lindsay Foyster Gareth Jones Prof. Andrew Westwell Stephen Harries Vicky Morris Carl James Nicola Williams Lauren Fear Matthew Bunce Dr Jacinta Abraham Sarah Morley ATTENDEES Anne Carey Non Gwilym Kyle Page	Chair Vice Chair Independent Member Independent Member Interim Independent Member Independent Member (<i>remotely</i>) Acting Chief Executive Officer Executive Director of Nursing, Allied Health Professionals & Health Scientists Interim Director of Transformation Executive Director of Finance Executive Medical Director Executive Director of Organisational Development & Workforce Chief Operating Officer Interim Director of Corporate Governance Business Support Manager (Secretariat)

1.0.0	PRELIMINARY MATTERS	LEAD
1.1.0	Welcome and Apologies: The Chair welcomed attendees to the meeting and the following apologies were noted: - David Donegan, Chief Executive Officer - Hilary Jones, Independent Member - Carl Taylor, Chief Digital Officer - Alan Prosser, Director of Welsh Blood Service	
1.2.0	In Attendance: The Chair extended a warm welcome to the following additional attendees: - Katrina Febry, Audit Lead, Audit Wales (<i>remotely</i>) - David Cogan, Patient and Carer Representative (<i>remotely</i>) - Peter Richardson, Head of Quality, Safety and Regulatory Compliance, Deputy Director Welsh Blood Service (for item 4.2.0) - Llinos Madeley, Interim Head of Corporate Governance Board members introduced themselves to newly appointed Llinos Madeley. Stephen Harries was welcomed as newly appointed interim Independent Member for Finance, noting that the recruitment process for a permanent Independent Member for Finance continues. Lindsay Foyster was welcomed to her first Trust Board meeting as Vice Chair.	

1.3.0	Declarations of Interest There were no declarations of interest noted in respect of today's agenda.	
1.4.0	Minutes of the Public Trust Board meeting held on 27th March 2025 Gareth Jones referred to item 4.5.0 (Trust Values Culture Report), indicating that the minutes referred to the requirement for a clear action plan and deliverables and queried whether an action for this had been logged. It was accepted that the minute was accurate and that this would be captured under the action log or matters arising. Following this, the Trust Board confirmed that the minutes of the meeting held on the 27 th March 2025 were an accurate reflection of proceedings.	
1.5.0	Action Log The Board was content to close all actions marked as 'propose to close', with the exception of the following: • Action 43 (5.3.0) 27.03.2025 – Lindsay Foyster requested that this action be reopened until discussion at today's private session and the deep dive exercise mentioned in the action had concluded. • Action 37 (4.1.0) 27.03.2025 – Gareth Jones queried whether work package 9 (the target date of which had been extended to the 31st July) had concluded. Lauren Fear advised that work packages continue to be tracked, with regular updated to completion dates, and it was agreed to reopen the action. The Board reviewed the remaining open actions as follows: • Action 3 (7.1.4) 23.05.2024 – Non Gwilym advised that a review of the relevant Terms of Reference is ongoing and would conclude in July for July Trust Board review. It was agreed to amend the deadline to the July meeting. • Action 19 (4.1.0) 28.11.2024 – Non Gwilym advised that a review of the Risk Policy is currently underway and that a Governance Assurance and Risk (GAR) meeting was scheduled for next week. It is the intention to introduce an additional section to the target of the risk. It was agreed to extend the target date to the July meeting. Lindsay Foyster noted that action 3 had remained open for a significant amount of time and emphasised the importance of ensuring resources are in place to move more quickly on technical governance matters in the future. In response, Non Gwilym indicated that a comprehensive programme of improvement will now be implemented following the appointment of Llinos Madeley, and that significant progress had already been made. It is anticipated that both actions 3 and 19 would conclude by July and Non Gwilym emphasised the importance of the Corporate Governance Manual in managing activities.	
1.6.0	Matters Arising Gareth Jones again referenced page 8 of the minutes of the previous meeting (item 4.5.0 - Trust Values Culture Report), requesting that an action be recorded on the log so as not to lose sight of the requirement for an action plan and deliverables. Gareth also referenced item 4.6.0 (Staff Survey Results) in the previous minutes, suggesting the need to capture an action in relation to actions (including timelines) taken to address the issues highlighted in the survey.	Secretariat /SM SM

2.0.0	KEY REPORTS	
2.1.0	Chair's Report Professor Donna Mead OBE, Chair The Chair highlighted the following key items of the Chair's Report: • Thanks to David Cogan, Patient and Carer Representative, for his inspirational talk at the Trust's May Multiprofessional Conference regarding his journey as a cancer patient, emphasising the importance of keeping patients and families at the centre of the Trust's endeavours. • The launch of the first art exhibition at the Cancer Centre, <i>'It's a Wonderful Still Life'</i>, with a series of paintings by a patient on sale, with proceeds going to the Charity. • VE Day had been celebrated throughout the organisation across both divisions. • WBS Donor Awards – The Chair noted that positive feedback had been received in relation to a new process, which sees Donors receive a message following donation, informing them where their donation was sent. The Trust Board NOTED the content of the Chair's update Report.	
2.2.0	Chief Executive's Report For noting in CEO's absence The CEO report provided information to the Board on several key matters and activity since the last Board meeting, for noting. In the absence of the Chief Executive, Carl James, Deputy Chief Executive, provided the following update in relation to the Velindre @ Nevill Hall Radiotherapy Unit: • The final building fit-out and other unseen tasks are currently underway, with efforts to stay on track despite losing approximately 12 weeks due to early construction issues such as asbestos and flooding. • Staff are working diligently, including weekends, to ensure the completion of the project, demonstrating significant dedication and commitment. • The target date for opening the unit remains set for June, with plans to scan the first patient and begin radiation treatment shortly after. • The Project Board, consisting of members from various regional bodies, has shown strong collaboration and commitment to the project. • The facility is impressive, and there is significant excitement among cancer patients and local representatives regarding the benefits of receiving treatment closer to home. • Local MPs and regulatory bodies are scheduled to visit the facility to familiarise themselves with the development, which is very close to completion. The Chair had become aware of patients welcoming the opportunity to attend treatment in Abergavenny as opposed to having to travel to Velindre. The Deputy Medical Director of Powys Teaching Health Board had indicated that a significant number of their patients currently having to travel out of Wales for treatment may now potentially receive treatment closer to home at Nevill Hall. The Chair added that Consultants had considered Nevill Hall a reason for their interest in working for the Trust. The Trust Board NOTED the content of the CEO's report and additional update.	

3.0.0	QUALITY, SAFETY & PERFORMANCE	
3.1.0	Performance Management Framework (March 2025) Led by Lauren Fear, Director of Transformation (interim), Anne Carey, Chief Operating Officer, Matthew Bunce, Executive Director of Finance and Sarah Morley, Director of Organisational Development & Workforce The Performance Management Framework (PMF) highlighted key issues for the attention of the Trust Board (identified and discussed by Executive Management Board and Quality, Safety & Performance Committee), on an exception basis, for the month of March 2025. Lauren Fear advised the following: • The level of assurance for digital resources had decreased to Level 3. • The high number of Radiotherapy breaches following the transition to a paperless system is related to the Satellite Centre at Nevill Hall project. • The levels of assurance discussed in the Quality, Safety, and Performance Committee have remained the same, except for the decrease in digital resources. • The updated version of the development work packages is being managed by the Performance Management Framework Group, with no highlights on this occasion. Anne Carey advised the following: • Presentation of data has been improved based on feedback to allow for more meaningful representation. • The Go Paperless project, which went live on March 10th 2025, is a key enabler for better understanding patient pathways and managing productivity in Radiotherapy; further development of the system is anticipated and aims to connect systems for Radiotherapy. • Initial difficulties with coding led to more breaches, but these have since been resolved. The situation has now recovered, and improvements are reflected in the April position. Jacinta Abraham provided the following summary of the Radiotherapy pathway: • Changes in the Radiotherapy pathway are significant and have been challenging, with some elements working seamlessly and others not so. • There are capacity issues in getting job plans on time with many steps involved in the process, including patient attendance and digitisation of previously paper-based processes. • The importance of the transition to a digital system being progressed safely, considering many elements and aligning demand with job plans and time. • The ability to see demand points and phases in the system is transformative, but it will take several months to fully settle and match the capability of responding to it. • Managing expectations is crucial, as not all breaches occur due to the transition and time will be required to evidence the full benefits. • Breaches are managed by assessing clinical risk and prioritising patients according to need. Gareth Jones referenced the long-standing risk (logged on the Risk Register) regarding emails received by clinicians, querying whether this would be mitigated by the Go Paperless project. Anne Carey indicated that while the project would help to some extent, the largest volume of emails is driven by the SACT pathway (only a component is Radiotherapy). The Chair requested a review and report at Board	AC

	at an appropriate time, noting measures implemented and improvements evidenced. Anne Carey agreed to provide a pathway diagram of steps and risk. Anne Carey advised that patients continue to be treated on time and that a reduction in breaches had been evidenced. Additionally, a good level of SACT performance continues, involving several key areas of work: • Implementation of a cancer Patient Tracking List (PTL) to manage patient pathways more effectively. • Reviewing and improving outpatient processes to enhance efficiency and patient care. • Prioritising the digital infrastructure required to support these improvements. • Ensuring that all elements are integrated to provide a comprehensive and effective approach to managing SACT performance. Lindsay Foyster requested that an update be brought to a future Board meeting, noting the difference made by visibility of the patient pathway and Go Paperless project. Anne Carey indicated that the patient pathway visibility was developing positively, with disparities in data quality across health boards being addressed. Anne Carey highlighted the following key points relating to the Welsh Blood Service: • An improvement plan is in place following ongoing challenges in relation to Red Cell Serology turnaround times. A new authorisation process has been implemented to check turnaround at day four, ensuring that work is underway, despite bottlenecks with senior skilled personnel. • The process is being monitored on a weekly basis, with improvements expected to be reflected in the next performance report. • The improvement plan relies on personnel and training, which takes time to show results. The Chair noted the benefit of using the buccal swab process for recruitment to the Welsh Bone Marrow Donor Registry, which had resulted in the service exceeding the target set by the Cabinet Secretary in last year's appraisal. Sarah Morley provided the following update in relation to key workforce metrics: • Actions are in place to bring PADR (Performance Appraisal and Development Review) compliance within target this year, with a significant overhaul of the process and positive feedback on the new streamlined approach. • The current sickness absence rate is 5.1%, with a target of 4.7% by the end of the financial year; various actions are being taken to support reductions in absence, including local ownership of actions by senior leadership teams and the development of six SMART actions by the Welsh Blood Service. • Collaboration with Corporate teams to reflect a step change in performance. David Cogan advised that there had been significant discussion regarding staff wellbeing at the Patient Carer and Partnership Board meeting. The Board is aware of workload pressures and potential impact on staff due to the level of change and introduction of new services, which directly affect patient care and service quality. Lindsay Foyster queried whether the six SMART actions developed by the Welsh Blood Service Senior Leadership Team would also be implemented in Velindre Cancer Service and the Corporate Team. Sarah Morley advised that the actions had been developed based on the Welsh Blood Service performance review. However, it was suggested that a similar approach could be adopted by the new	AC

	Triumvirate in the Cancer Service and within Corporate Services, emphasising the importance of local ownership at a divisional level. Carl James provided the following update relating to Digital matters: • IT Business Continuity - ongoing efforts to resolve national issues with DHCW, meeting every Friday to ensure support for NHS organisations. • Progress is being made in cyber training, with improvements noted, but further work is required to ensure all staff are sufficiently trained. • Metrics indicate that the digital services are responsive, and users are relatively satisfied, though there are still issues to address. Stephen Harries queried the cyber security risk posed by third-party suppliers interacting with Trust systems, highlighting the increasing risk associated with legitimate third-party access to systems and its potential impact. Carl James advised that the organisation is broadly compliant with the Cyber Assessment Framework (CAF), also adding that the majority of the cyber security measures are contracted for under the relevant contracts signed with third parties and that legacy contracts are more of a concern. Lauren Fear highlighted the following key points regarding Estates / Health & Safety: • Confirmation that the compliance data for planned preventative maintenance on sites other than the Cancer Centre and Welsh Blood Service had been corrected. These sites are being monitored manually and are all at 100% compliance; the final elements of transferring all buildings onto the new system are being completed. • This is the first report where NWSSP (NHS Wales Shared Services Partnership) data had been included in the dashboard, emphasising the importance of reflecting the Trust's accountabilities effectively for health and safety. NWSSP and Health Technology Wales are in attendance at quarterly health and safety Trust meetings. Matthew Bunce provided the following update in relation to finance: • The Financial Report is included separately due to statutory requirements, ensuring that certain financial information is presented to the Board in compliance with Standing Orders and Standing Financial Instructions (SFIs). • The three Key Performance Indicators (KPIs), Revenue balance, remaining within the Capital Resource Funding limit and meeting public sector payment performance, had all been met, subject to audit. • Ongoing conversation as to whether the finance report should be appended to the Performance Management Framework (unless items require detailed discussion). Should the separate finance report item be superseded, it would be necessary to identify the required information for the Performance Management Framework to ensure compliance with statutory requirements. Gareth Jones requested clarification on the financial position, specifically querying whether the £4.42 million figure mentioned represented an underspend or an overspend. Matthew Bunce confirmed that this figure was an underspend. The Trust Board NOTED the Performance Management Framework for assurance and individual assurance levels as stated in the report were agreed by the Board.	

3.2.0	Financial Report (March 2025) Led by Matthew Bunce, Executive Director of Finance The Finance report outlined the position and performance for the period to end of March 2025, covering Long Term Agreement Financial Values and Contract Rebase, Integrated Medium Term Plan financial plan and forecast and KPIs (Key Performance Indicators). Matthew Bunce highlighted the following: • The three Key Performance Indicators (KPIs), Revenue balance, remaining within the Capital Resource Funding limit and meeting public sector payment performance, had all been met, subject to audit. • Signoff of long-term agreements had been achieved, with some negotiation around certain contracts. • The first month of financial reporting for the new financial year is on track, according to the financial plan. • The need to include the level of assurance in the financial report going forward, as discussed in the Quality, Safety & Performance Committee. • The rebasing issue which affects all NHS organisations requires escalation through the Chief Executive to the All-Wales Chief Executive Forum. This broader debate is necessary to address the challenges related to the financial values and contract rebasing. Following a query from the Chair regarding the 'underachievement' in relation to the Welsh Bone Marrow Donor Registry, Matthew Bunce indicated that this had not been the result of not meeting the income target, which is based on the income received for providing resources to donors across the world. The improvement in the Registry through initiatives such as the use of buccal swabs is expected to increase the chances of matching donors, which will eventually improve income, however this will take time. It was concluded that this is a funding matter as opposed to an underachievement in performance. Stephen Harries queried the key enablers of achieving a balanced financial position, specifically highlighting instances where the report indicated falling short of savings. Matthew Bunce acknowledged the reliance on non-recurrent savings to achieve a balanced financial position, noting that while bank interest rates are out of the Trust's control, there are mechanisms to offset the absence of recurrent savings through provisions on the balance sheet and other non-recurring.non recurring what? Gareth Jones queried the £483,000 figure, specifically in relation to the NICE high-cost drug income. Clarity was requested regarding the details and context of this figure within the financial report, and the potential significant increase in this figure into the year going forward. Matthew Bunce explained that as contracts comprise two elements (patient activity and high-cost drugs), the potential increase to £843,000 includes an additional £360,000 relating to patient activity. Gareth Jones asked about the financial risks related to additional capacity and how the risk remains with the Trust, specifically referencing a £1.3 million investment in capacity and inquired about the implications and management of this risk. Matthew Bunce advised that the last financial year had presented concern around the recovery of marginal income from long-term agreements, however, improved data capture and an increase in activity had resulted in the significant reduction of the initial £800,000 shortfall to £240,000.	

	Carl James noted the importance of benchmarking to provide a strong evidence base to influence commissioning arrangements and government investments. Gareth Jones queried whether a benchmarking exercise had been undertaken and how the Trust compared with others. Lauren Fear advised that key priority areas for benchmarking had been discussed with the Leadership Team, with particular focus on the Performance Management Framework and accreditation with external bodies. Gareth Jones asked whether cost comparisons had been undertaken and the implications for efficiency and productivity. Matthew Bunce indicated that a project had been undertaken to compare costs across other cancer centres in Wales and England, noting that Velindre's clinical and medical Oncology services were efficient and favourable compared to others. However, Radiotherapy services showed less efficiency due to the fixed cost-heavy investment in new capacity. Matthew also advised that engagement with finance Directors in key partners in England would allow more meaningful comparisons, however this information would not be available for a number of months. Peter Richardson added that the Welsh Blood Service actively participates in a twice-yearly benchmarking exercise with other European blood services, comparing operational metrics. It was noted that while the Service excels in some areas, it faces challenges in others, often due to economies of scale. The importance of triangulating such exercises with quality measures to ensure a comprehensive assessment of service performance was recognised. The Trust Board NOTED the content of the March 2025 financial report, in particular: • The year to date and forecast revenue 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.	
3.3.0	VUNHST Risk Register Led by Non Gwilym, Director of Corporate Governance (interim) Non Gwilym provided an overview of the Trust Risk Register, focusing on risks scoring 12 and above for Quality / Safety and 15 and above for all other domains. Non reiterated the importance of narrative in the register to provide context and a comprehensive understanding of the risks, risk scores and mitigating actions taken. The current assurance level of 3 was noted, an increase from the level 2 rating reporting at the March meeting of the Trust Board. Vicky Morris advised that discussions at the Quality, Safety & Performance Committee had resulted in the increase, based on the ability to demonstrate the progress made in taking the Framework forward. The Board concurred with the revised assurance level of 3. Vicky Morris advised that risk 3448 had been mitigated and was no longer at a level requiring Trust Board attention. However, it was noted that the narrative did not include details on how this had been achieved and that this information should be included for completeness. Gareth Jones referred to the risks relating to patient safety, emphasising the importance of addressing taking prompt action, continuous monitoring and	NG NG

	mitigation and updates to the paper to ensure accurate representation of these. Non Gwilym agreed to include this. Lindsay Foyster commented that the narrative relating to risk #8 indicated no movement in the risk score, which is set to remain unchanged until the replacement system is live. Lindsay highlighted the discrepancy between the current risk score of 12 and target risk score of 4, questioning the lack of further controls and mitigations. Peter Richardson advised that the Welsh Blood Service had implemented as many manual checks as possible to manage the risk. It was acknowledged that the replacement system, (delivery of which is anticipated during the second half of this year) will significantly mitigate the risk, therefore reducing the risk to an acceptable level. It was agreed that this is required as soon as possible as the risk is currently being managed outside our tolerance. Stephen Harries commented that the narrative relating to risk #11 indicated a deficiency in firewalls which will not be resolved until April 2027. Carl James indicated that the information presented in the risk register is misleading. It was advised that the issue with Windows clients was all but resolved, with only two client servers remaining, to be addressed the following week. Carl James reiterated the need to ensure accurate representation of the specifics of each risk. It was also acknowledged that a review of what is included in a public report is required versus what may be a legitimate security issue. In this context, the Trust Board NOTED the risks in the Quality & Safety domain with a score of 12 and risks in other domains with a score of 15 and above.	
3.4.0	Trust Assurance Framework Led by Non Gwilym, Director of Corporate Governance (interim) The report provided Board members with the latest updates to the Trust Assurance Framework. Non Gwilym advised the following: • The current assurance rating of level 2. • Following today's meeting, the Trust Assurance Framework would be presented in a new, more comprehensive format, which would better align with the organisation's needs. The Trust Board NOTED the current status of the Trust Assurance Framework.	
3.5.0	People's Experience Framework Led by Tina Jenkins, Head of Quality, Safety & Assurance The revised People's Experience Framework had been launched in April 2025, advocating the adoption of an always-on approach to experience, using both active and passive methodologies, enabling experiences to be left at a time and location convenient for the individual. Tina Jenkins provided the following overview: • The framework aims to integrate various methods of collecting people's experiences, including complaints, compliments, stories, incidents, surveys, and lived experiences, from both service users and staff. • The Trust has already conducted a self-assessment based on the draft framework, identifying areas where improvements are needed. This covers leadership, capacity and capability, using feedback for quality improvement, and reporting and analysis.	

	• The Trust is currently rated as amber in most areas, indicating that there is significant work to be done, particularly in effectively collecting and utilising feedback. • There is a need for a collaborative approach to improve the framework's implementation, involving various stakeholders across the organisation. • The Trust has gone live with the national People's Experience Survey, which includes 10 core questions that cannot be changed. This survey will help benchmark data across different areas. • Next steps will focus will be on increasing survey responses and ensuring that the feedback collected is used to drive meaningful improvements. It was noted that it is important to align the framework with existing surveys to avoid survey fatigue among respondents. Stephen Harries queried the methods for engaging with patients and families within the People's Experience Framework, inquiring specifically about how the framework would incorporate experiences from areas like the Chemotherapy Day Unit and Radiotherapy waiting areas, where patients might be looking for meaningful distractions while waiting. Nicola Williams advised that this had been discussed at the Integrated Quality & Safety Group, including aligning the collection of patient feedback with the existing infrastructure. While the Trust aims to communicate with patients in real time, the current method is primarily through letters for appointments and that the introduction of any new methods such as texting patients, should be consistent with communication regarding appointments. Lindsay Foyster welcomed the People's Experience Framework and its bringing together of the various aspects of patient and donor experiences, highlighting the importance of benchmarking and learning from other organisations. Lindsay also expressed interest in the staff experience component of the framework, emphasising that behind every patient and donor experience, there is a staff experience and inquiring how the framework would draw on staff experiences in relation to the "speak up" initiative. Tina Jenkins acknowledged the importance of Section 2 of the self-assessment document, which focuses on capacity and capability for effectively collecting feedback. A working group has been set up to address this, focusing on gathering feedback from staff, particularly about their experiences with investigations and meetings. Nicola Williams suggested that a dedicated Board Development Session focused on the leadership section of the framework would be beneficial, emphasising the importance of aligning the Board and senior leadership with the framework's goals. Sarah Morley welcomed the inclusion of staff experience in the framework, which allows for a holistic approach, integrating various sources of staff experience data, such as the annual survey to ensure a comprehensive understanding of staff wellbeing. It is also important to minimise employee harm and address issues relating to employee investigations and grievances to improve staff experiences. The Trust Board APPROVED the implementation of the national People's Experience Framework.	
3.6.0	Trust Quality Priorities 2025-2026 Led by Tina Jenkins, Head of Quality, Safety & Assurance Tina Jenkins advised that the Trust Quality Priorities had been produced collaboratively by the three Trust quality hubs, focusing on specific actions derived from findings of investigations, patient and donor feedback and national drivers.	

	The priorities aim to be more tangible and measurable, addressing areas identified during the previous year. Tina Jenkins also emphasised the requirement for collaboration across the organisation to ensure effective implementation of the priorities, including appropriate monitoring to enable reporting to the Integrated Quality & Safety Group. The Trust Board APPROVED the proposed 2025-2026 Trust Quality Priorities, noting the assurance rating of level 4.	
3.7.0	Action taken following Supreme Court Ruling Led by Sarah Morley, Executive Director of Organisational Development & Workforce Following the April 2025 Supreme Court Ruling pertaining to the meaning of sex in the application of the Equality Act 2010, Sarah Morley highlighted the importance of considering the impact of the Ruling on patients, donors and staff. The Equality and Human Rights Commission (EHRC) had published interim guidance while broader consultation is undertaken. The following actions have subsequently been taken by the Trust in response: • Engaging with the staff network to understand concerns. • Conducting a gap analysis of provisions, including patient services and the new Cancer Centre (nVCC). • Ensuring sufficient gender-neutral provisions in the nVCC design. • Continuing to work on service provisions, identifying and addressing any gaps. Sarah Morley indicated that while no issues had been raised by staff to date, support mechanisms would be available as required. Lindsay Foyster queried the implications of the Ruling on the facilities and provisions at the Welsh Blood Service collection centres, both for staff and donors, and whether this may restrict the service provided. Sarah Morley acknowledged the importance of this and confirmed that conversations would be undertaken with the Welsh Blood Service to address this to ensure staff and donors are supported. Tina Jenkins suggested issuing a general communication to reassure the transgender community, reinforcing the Trust's commitment to treating all individuals equally and to reassure that the ruling would not impact care or treatment provided. Lindsay Foyster suggested that while this may be well-intentioned, the Trust would need to exercise caution to avoid exacerbating the situation and be mindful of potential legal implications while maintaining the Trust's values. The Trust Board NOTED the actions taken by the Trust.	
3.8.0	Public Quality, Safety & Performance Committee Highlight Report (08/05/2025) Led by Vicky Morris, Independent Member and Chair of the Quality, Safety & Performance Committee Vicky Morris noted that the key issue to escalate to the Board was related to the financial matters already addressed during the meeting by Matthew Bunce (LTA Contract Rebasing). Vicky also confirmed that the Committee had ENDORSED several items for Board APPROVAL, which had been discussed during the Performance Management Framework item.	

	Nicola Williams referenced the Quarter 4 Quality & Safety report, in particular a reduction in the 30-day complaints response time. It was noted that the response rate had dropped to 50% due to unexpected absences and complex concerns. However, Nicola assured the Board that resilience methods were being explored to address this and that the government target of 75% response time had been met notwithstanding the reduction. The Trust Board NOTED the key deliberations and highlights from the meeting of the Quality, Safety & Performance Committee held on the 8th May 2025.	
4.0.0	PLANNING AND STRATEGIC DEVELOPMENT	
4.1.0	Strategic Planning Update Led by Lauren Fear, Director of Transformation (Interim) Lauren Fear provided updates to the Board in relation to several key areas: Regional Cancer Programme – The agenda from the April meeting was appended to provide a view of the development of programme of work. The Ministerial Advisory Group (MAG) review had resulted in the merging of the Cancer Network and Cancer Recovery Fund team into the NHS Executive's Planned Care Directorate; this will result in an integrated cancer plan to combine existing national cancer plans and MAG recommendations. Strategic Planning Maturity Matrix – The Executive Management Board will assess its current position on the maturity matrix, with the intention to set goals for the coming year; this will provide structure, in addition to assurance to the Strategic Development Committee. Integrated Medium Term Plan (IMTP) – Formal feedback on the IMTP was pending at the time of writing and is expected early June. However, a series of staff engagement sessions had been planned during June and July regarding the plan and its delivery. It was advised that the core content for each service area remains unchanged. Next steps – To undertake a review of both the Trust's 10 year destination strategy and five year cancer plan, with a view to integrate wellbeing goals and the Social Partnership Act. The Trust Board NOTED the update.	
4.2.0	BECS Full Business Case – Executive Summary and Strategic Case Led by Peter Richardson, Head of Quality, Safety and Regulatory Compliance, Deputy Director Welsh Blood Service The final Business Case for the Blood Establishment Computer System (BECS) had been brought to today's Board for approval. Peter Richardson highlighted the following key points: • The Strategic Case had been updated based on engagement with the marketplace and further assessment of requirements. • The Trust Board had recently approved the procurement 'standstill' period out of Committee (commencing 9th May 2025) and a 'standstill' letter had been issued, notifying bidders of the outcome. • An updated Quality Impact Assessment (QIA) had been completed, but not included with the papers (however, included with the private meeting papers)	

	and would be uploaded and made available following the meeting. Vicky Morris requested that for future Business Cases, it would be of benefit if the Executive Summary could include that the QIA had been considered and who had provided sign off. • It was noted that more detailed discussion would take place in today's private session. Lindsay Foyster assured the Board that the case had been afforded sufficient consideration at the May Public Strategic Development Committee, in particular the procurement process. The Trust Board: • NOTED the continuation of procurement activity during May, with the commencement of the 10-day 'standstill' period, from the 9th May 2025. • APPROVED 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.	
4.3.0	Public Strategic Development Committee Highlight Report (20/03/2025) Led by Lindsay Foyster, Vice Chair and Chair of the Strategic Development Committee Lindsay Foyster introduced the Strategic Development Committee Highlight Report, which contained items of escalation to the Board. The following update was provided in relation to the Committee's activities: • March meeting – The report reflected the discussions and escalations from the March meeting, in particular, concerns relating to the TrAMs programme. • May meeting – It was advised that updates from the May meeting would follow within the next highlight report; key issues discussed included the Strategic Digital Capacity and Resilience and the requirement for a deep dive exercise in this area. • Trust Assurance Framework (TAF) – The Committee reviewed the draft (proposed) version of the TAF, noting progress and the need to focus on content rather than format, once approved. • Escalations – It was advised that issues relating to TrAMs and the Radiology Informatics System Procurement (RISP) would be addressed in today's private session. Lindsay Foyster welcomed the refreshed approach to the Strategic Development Committee, emphasising the importance of early engagement and collective shaping of strategic initiatives. The Trust Board NOTED the content of the report and any actions being taken to address any issues highlighted in the meeting.	
5.0.0	CONSENT ITEMS FOR APPROVAL	
	There were no items for APPROVAL .	
6.0.0	CONSENT ITEMS FOR NOTING	
6.1.0	Public Charitable Funds Committee Highlight Report (19/03/2025) Led by Professor Donna Mead OBE, Chair and Chair of the Charitable Funds Committee	

	The Trust Board NOTED the content of the report.	
6.2.0	Public Audit Committee Highlight Report (25/03/2025) Led by Gareth Jones, Independent Member and Chair of the Audit Committee The Trust Board NOTED the content of the report.	
6.3.0	Trust Seal Report Led by Non Gwilym, Director of Corporate Governance (interim) The Trust Board NOTED the content of the Trust Board Seal Register for the period 21st March – 21st May 2025 .	
6.4.0	Trust-wide Policies Approved Update Led by Non Gwilym, Director of Corporate Governance (interim) The Trust Board NOTED the policies that had been approved during the period April 2025 to May 2025 .	
7.0.0	ANY OTHER BUSINESS Professor Donna Mead OBE, Chair Gareth Jones referred back to item 3.3.0 (Trust Risk Register), in particular the Workforce risks paper. Gareth requested that the paper be updated to reflect timelines, the current status of risks and the inclusion of more detailed information regarding the mitigations and management checks implemented to address these. Non Gwilym acknowledged the requirement for an update and agreed to liaise with Sarah Morley to ensure inclusion of the relevant information, advising that an updated paper would be re-shared with Board members prior to the next meeting.	NG/SM
8.0.0	DATE OF NEXT MEETING Professor Donna Mead OBE, Chair Thursday 31 st July 2025. It was noted that an additional, extraordinary public Trust Board meeting would also take place on the 26 th June, for the approval of the Trust's Annual Accounts and Annual Report.	
9.0.0	CLOSE	
10.0.0	It was noted that the following items would be addressed at the Private / Part B Session of the Trust Board: • Minutes of previous private Trust Board meeting • Private 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 OF EXTRAORDINARY PUBLIC TRUST BOARD MEETING
(ANNUAL ACCOUNTS / ANNUAL REPORT)
26th JUNE 2025 (10:00-11:00)
VUNHST TRUST HEADQUARTERS, NANTGARW / TEAMS WEBINAR**

PRESENT Prof. Donna Mead OBE Lindsay Foyster Prof. Andrew Westwell Vicky Morris Gareth Jones David Donegan Carl James Lauren Fear Sarah Morley Matthew Bunce Nicola Williams Jacinta Abraham Anne Carey Carl Taylor Non Gwilym Kyle Page	VUNHST Chair (<i>Chair</i>) VUNHST Vice Chair and Independent Member Independent Member (<i>remotely</i>) Independent Member (<i>remotely</i>) Independent Member (<i>remotely</i>) Chief Executive Officer (<i>remotely</i>) Executive Director of Strategy & Planning / Interim Deputy CEO Interim Director of Transformation, Planning & Digital Executive Director of Organisational Development & Workforce Executive Director of Finance Executive Director of Nursing, Allied Health Professionals and Health Scientists Executive Medical Director Chief Operating Officer Chief Digital Officer Interim Director of Corporate Governance Business Support Manager (<i>Secretariat</i>)

		ACTION LEAD
1.0.0	PART 1 - STANDARD BUSINESS	
1.1.0	Welcome and Apologies Led by Prof Donna Mead OBE, Chair The Chair welcomed attendees to the Extraordinary Public Trust Board meeting, which had been convened in order to approve the Trust's Annual Accounts, Accountability Report and Annual Performance Report. This meeting had been preceded by an Audit Committee held on the 24th June 2024, where papers presented at today's meeting had been robustly reviewed and discussed. The Chair acknowledged and expressed thanks for the significant effort that had contributed to today's papers. No apologies had been received, however it was noted that Prof. Andrew Westwell would join the meeting late due to a prior commitment.	
1.2.0	In Attendance: Led by Prof Donna Mead OBE, Chair The Chair extended a warm welcome to the following additional attendees: • Tracy Hughes, Head of Financial Operations (<i>for item 2.2.0</i>) (<i>remotely</i>) • Stephen Chaney, Head of Internal Audit, NHS Wales Shared Services Partnership (<i>for item 4.1.0</i>) (<i>remotely</i>) • Richard Harries, Director Financial Audit, Audit Wales (<i>for item 5.1.0</i>) • Katrina Febry, Audit Lead, Audit Wales (<i>remotely</i>) • Bethan Davis, Welsh Translation Service (<i>HEIW</i>)	

1.3.0	Declarations of Interest Led by Prof Donna Mead OBE, Chair There were no declarations of interest pertinent to the items on today's agenda.	
2.0.0	ANNUAL REPORT AND ANNUAL ACCOUNTS 2024-2025	
2.1.0	Cover Paper for the Annual Report and Accounts 2024-2025 Led by Lauren Fear, Director of Transformation (interim), Matthew Bunce, Executive Director of Finance and Non Gwilym, Director of Corporate Governance (interim) Non Gwilym introduced the cover paper for the Annual Report and Account 2024-2025, noting that NHS Bodies are required to publish, as a single document, a three-part Annual Report and Accounts, to include a Performance Report, Accountability Report (to include the Corporate Governance Report, Directors' Report and Remuneration Report) and the Annual Accounts, in line with the structure stipulated in the Government Financial Reporting Manual 2024-2025. Non highlighted the significant amount of work involved in producing the report and accounts, expressing gratitude to colleagues across the Trust and those supporting from Audit Wales and Shared Services, given the complexities of the year, in particular the arrangements with hosted services. 1. Performance Report – Lauren Fear provided the following overview: • The report provides an overview of the Trust's performance for 2024-25, including detailed analysis for each area, focusing on delivery against commitments to patients and donors. • The report also covers staff wellbeing, the sustainability strategy, and includes detailed climate-related disclosures as required by legislation. • The report also addresses Welsh Language requirements and includes a forward look. • There is an overlap between the Performance Report and Annual Report and Accounts, with cross-referencing between sections. Lauren Fear thanked internal audit and Audit Wales colleagues for their feedback on the Performance Report, stating that their comments had been worked through and included in the final version. Gareth Jones also advised the Board that the Annual Report and Accounts had been robustly reviewed at this week's Audit Committee, adding his thanks and acknowledging the significant amount of work involved. Lindsay Foyster welcomed sight of the full year's performance in one document, reflecting on the dedication of staff in both Divisions in achieving the reported outcomes and to those who presented the report. 2. Accountability Report – No comments or queries were raised. 3. The Annual Accounts – Matthew Bunce highlighted that the Financial Statements had been reviewed at this week's Audit Committee, identifying the following issues: • A contingent liability relating to a supplier claim. • A classification issue regarding Welsh Risk Pool provisions.	

	It was confirmed that these had been addressed in the accounts. Matthew Bunce thanked the Finance Team for their efforts, noting the increasing complexity of the accounts due to service growth and hosting arrangements. The support received from internal audit and Audit Wales in navigating these complexities was also recognised. Lauren Fear wished to clarify that the overpayment of her salary noted within the document had been raised by her, and that the mechanism to facilitate repayment had not yet been provided by payroll. The Board acknowledged that this is a live issue and that repayment would be made as soon as possible. No issues were raised and the Trust Board APPROVED all three reports, noting that the organisation had met all its statutory financial duties.	
2.2.0	Appendix 1 – Letter of Representation 2024-2025 Led by Matthew Bunce, Executive Director of Finance Matthew Bunce introduced the Letter of Representation as an appendix to the Annual Report and Accounts; this standard document sets out and provides assurances in relation to financial statements, knowledge of fraud and associated risks. Information contained in the letter was subdivided as follows: Section one – Management representations (assurances from the Chief Executive / Accountable Officer relating to the financial statements and information provided). Section two – Financial representations, specifically the preparation of accounts and all supporting information relating to assets, liabilities and transactions. Section three – Board representations, where the Chief Executive and Chair sign on behalf of the Board collectively. Section four – Confirmation of access to relevant information, knowledge of fraud, related party transactions and compliance. It was NOTED that the Letter of Representation was covered by the recommendation above and detailed discussion was not proposed as it would form part of Audit Wales's overall package.	
3.0.0	INTERNAL AUDIT & ASSURANCE SERVICES	
3.1.0	Head of Internal Audit Opinion Led by Stephen Chaney, Head of Internal Audit, NHS Wales Shared Services Partnership The Chair advised that the purpose of the report is to contribute to the assurances available to the Chief Executive (as Accountable Officer) and the Board. The report had been based on 17 audits, reporting an overall assurance rating of 'Reasonable', indicating arrangements for governance, risk management and internal control are suitably designed and applied effectively. Stephen Chaney began by thanking Trust colleagues for their assistance throughout the year, which had facilitated an easier audit process. Stephen explained that the opinion had been based on a plan developed around key organisational risks, including capital and IT audit work, focusing on core Trust activities. It was noted that the opinion is a key element in providing assurance to the Accountable Officer and Board, and that overall risk exposure is currently considered to be low to moderate. Comments and questions were welcomed.	

	David Donegan stated that, for the public record, the documents reflect that the internal control work by Stephen Chaney had been limited historically and in the current year to core elements of the Trust. David advised that as part of the ongoing review with Welsh Government, the internal audit programme for the coming year (25-26) would be amended to address any assurance gaps that may arise from the external review into the governance of hosted functions. This did, however, not change the support for the current Head of Internal Audit Opinion. Lindsay Foyster emphasised the importance of internal audit as a driver for continuous improvement, as opposed to simply for reassurance purposes. Lindsay also advised that the Audit Committee would monitor how Management implements recommendations from internal audit, expressing hope that the internal audit process had provided helpful prompts and pointers to enable continuous organisational improvement. The Chair indicated that the Audit Tracker is now being robustly implemented, allowing improvements highlighted by internal audit to be tracked and acted upon more comprehensively than at the beginning of her tenure. The Trust Board NOTED The content of the Head of Internal Audit Opinion, thanking Stephen Chaney for the approach taken by his team on this work.	
4.0.0	AUDIT WALES AUDIT OF FINANCIAL STATEMENTS 2024-2025	
4.1.0	Audit Wales ISA 260 Report 2024-2025 Led by Richard Harries, Director Financial Audit, Audit Wales The ISA 260 Report had been prepared as part of work performed in accordance with statutory functions. Richard Harries advised the following: • The report provided an unqualified (clean) opinion for the Trust, achieved by open conversations, a positive outcome. • The report had not been sighted at Audit Committee, rather an oral update had been provided. • A final review and sign off of the report remain outstanding. • No recommendations had been included in the report as none had been warranted. • Lessons learned from the process will be discussed with the Finance Team to improve timelines and quality next year. • The report included a substantive section to bring public attention to governance issues related to hosted bodies / Shared Services, reflecting concerns raised by the Trust and the ongoing Welsh Government review. It was advised that the opinion had not been altered by these issues, however the process for closing the accounts had been more challenging this year due to these complexities. Stephen Harries queried whether the audit opinion for the ISA 260 report covers Shared Services as a hosted body, or whether a separate audit opinion exists for this. Richard Harries advised that the opinion covers the organisation in its entirety, including hosted services and associated transactions and audit work. Lindsay Foyster welcomed the clear setting out of the issues relating to governance and hosted bodies in the report, emphasising the importance of effective arrangements for both the Trust and Shared Services (and the significant public funds involved). Lindsay also queried whether the bringing forward of deadlines year on year would continue, expressing concern regarding potential	

	impact on the Trust and quality of reporting. Richard Harries indicated that bringing forward deadlines any earlier may affect the quality of work or become unfeasible; the current deadline would remain until next year at the very least. Lauren Fear added that deadlines be brought forward any earlier would create issues for performance reporting, as it is a requirement to report on the full year up to the end of March and sufficient time is then required to prepare robust reports for the May Trust Board. Additionally, Lauren highlighted a factual inaccuracy in the report regarding salary overpayment, clarifying that this had been identified by her and not Audit Wales. Richard Harries agreed to amend this. Returning to the query raised by Stephen Harries, David Donegan clarified that he was content that the financial auditing covered the organisation as an entity, including hosted bodies, and that both internal and external audit work around finances had been comprehensive. However, other external audit work around structured assessment and audits relating to governance and compliance had been limited to core Trust; therefore it had been flagged that if the Board is to remain accountable for the performance and governance of hosted bodies, strengthening the internal and external audit opinions to cover the whole entity, and not just core services, will be required. Stephen Harries noted that page 29 of the report referenced concerns regarding governance and accountability arrangements, which could be misinterpreted as being discovered by Audit Wales, when in fact, they had been raised by the Trust. Stephen Harries suggested that the wording should be amended to reflect this, to avoid misunderstanding by readers of this public document. Richard Harries agreed to amend this. The Trust Board APPROVED the ISA 260 Report, <u>subject to</u> the amendments discussed.	
5.0.0	Any other Business Led by Prof Donna Mead OBE, Chair No other business was raised.	
6.0.0	Date of next meeting Led by Prof Donna Mead OBE, Chair The next regular public meeting of the Trust Board will take place on Thursday 24th July 2025.	
7.0.0	CLOSE The Chair closed the meeting.	

ACTION LOG	Column1	Column2	Column3	Column4	Column5	Column6	Column7
MEETING DATE	AGENDA ITEM	Action number	ACTION	LEAD	DEADLINE DATE	UPDATE (including date)	STATUS
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 24/07/2025 25/09/2025	July 2025 Compliance with Duty of Quality and Duty of Candour legislation embedded in Quality, Safety & Performance Committee Terms of Reference for SDC consideration in September. 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. 3 March 2025 All Committee Terms of Reference under review. New Terms of Reference to be confirmed by Trust Board May 2025. 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.	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 24/07/2025	July 2025 Dates have been included in the Trust Risk Register when risk leads expect the target date to be reached. May 2025 Actions now include target dates. Target date to complement target score under review for completion by end of June 2025. 3 March 2025 Target ratings in register from May 2025. Target dates are included on Datix, as part of the intial assessment and review process.	PROPOSE TO CLOSE
27.03.2025	4.1.0		PERFORMANCE MANAGEMENT FRAMEWORK - JAN 2025				
		37	Amend stem cell collection data figures to reflect that demand is met. Further clarify presentation of SACT data. Inclusion of Targets (work package 4) - update to reflect that this has concluded (target date of 31st January). Benchmarking (work package 9) - extend target date from 31st March to 31st May 2025. Clarify data for Trust Waste Recycling Performance. Update cover paper to include discussion at Audit Committee on 25th March 2025.	Chief Operating Officer Chief Operating Officer Interim Director of Transformation Interim Director of Transformation Interim Director of Transformation Interim Director of Transformation	24/07/2025	July update: Work package 9 date amended. May update: Action addressed. Slides updated. Updated PMF Development Plan with amended deadlines for Inclusion of Targets workpackage 4 with update. Updated Benchmarking workpackage 9 (target date extended to 31st July as further work has been identified.) 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. 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. **Request at May Trust Board for the action to be reopened until all work packages had concluded (date of work package 9 had been extended to end of July 2025). Action reopened.	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	24/07/2025	July 2025 - TrAMs update provided to Board in May 2025 with item due for further consideration at July Private Board. Request at May Trust Board for the action to remain open until deep dive exercise has concluded. Action reopened. TrAMS to be considered at May 2025 Private Trust Board meeting.	PROPOSE TO CLOSE
22.05.2025	1.6.0		MATTERS ARISING				
		44	Item 4.5.0 from March meeting (Trust Values Culture Report) - Request for a clear action plan, including timelines and deliverables. Item 4.6.0 from March meeting (Staff Survey Results) - Request for an update on actions (including timelines) taken to address issues highlighted in the survey.	Executive Director of Organisational Development & Workforce	24/07/2025 25/09/2025	Update refers to both actions: A combined Culture and Inclusion paper will be brought to September Board, which will report against the actions within the associated work programmes.	OPEN
22.05.2025	3.1.0		PERFORMANCE MANAGEMENT FRAMEWORK				
		45	Report noting measures implemented and improvements evidenced regarding the long-standing risk regarding emails being received by clinicians and related benefits of the Go Paperless project. Provide update at a future Board meeting, noting the difference made by visibility of the patient pathway.	Chief Operating Officer Chief Operating Officer	24/07/2025	Information to be presented to July Board under matters arising item.	PROPOSE TO CLOSE
22.05.2025	3.3.0		TRUST RISK REGISTER				
		46	Risk 3448 has now been mitigated and is no longer at a level requiring Trust Board attention. Detail to be included in the narrative as to how this was achieved. Update Risk Register in relation to patient safety risks, to reflect addressing taking prompt action and continuous monitoring and mitigation.	Interim Director of Corporate Governance Interim Director of Corporate Governance	24/07/2025	July 2025 - item covered in the July risk report. July 2025 - Communication sent to Executive team and Directors of services to address actions promptly in relation to safety risks.	PROPOSE TO CLOSE

TRUST BOARD	
Radiotherapy Treatment Pathway – Paperless Go Live	
DATE OF MEETING	24 July 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	Angharad Boundford, IRS Programme Manager Philip Parsons, IRS Workflow Project Lead
PRESENTED BY	Anne Carey, Chief Operating Officer
APPROVED BY	Anne Carey, Chief Operating Officer
EXECUTIVE SUMMARY	The implementation of a paperless system has transformed the radiotherapy pathway—across all steps. Real-time, automated, handover of tasks and streamlined, digital workflows have replaced manual, paper-based processes. This shift enables faster access to records, enhances interdepartmental collaboration, and significantly reduces administrative burdens. Moreover, the paperless approach contributes to sustainability by eliminating physical waste, minimising the physical record storage and reducing the emissions associated with document transportation. Enhanced visibility into workflow bottlenecks and delays further supports continuous improvement and quality assurance, which will offer the potential to optimise productivity.

	Additionally, financial savings from reduced paper, printing, and storage costs can be reinvested into patient care and technological innovation. Overall, the move to a paperless system not only optimises clinical operations but also aligns with broader goals of environmental stewardship and improved healthcare delivery.	
RECOMMENDATION / ACTIONS	This paper provides the Board with information requested at its meeting in May on the development of paperless workflow for patient treatment for Radiotherapy - within the overarching integrated Radiotherapy (IRS) programme.	
GOVERNANCE ROUTE		
List the Name(s) of Committee / Group who have previously received and considered this report:		Date
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS n/a		
7 LEVELS OF ASSURANCE		
If the purpose of the report is selected as ' ASSURANCE ', this section must be completed.		
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Select Current Level of Assurance	
APPENDICES		

1. SITUATION

Transitioning to a paperless workflow in radiotherapy marks significant digital progress. This initiative aims to fully digitise and optimise the patient treatment pathway, ensuring compliance, efficiency, safety, and sustainability.

2. BACKGROUND

The radiotherapy pathway involves a complex, multi-disciplinary process with oncologists, radiographers, and physicists. Previously reliant on paper documentation, it now uses a paperless system that digitally manages and connects each stage of the patient's journey—from Radiotherapy Request to treatment delivery and review. This

integration allows real-time task handovers, automated workflows, and full access to radiotherapy data and documentation.

3. ASSESSMENT

Before and After: Key Improvements

Before (Paper-Based)	After (Paperless System)
Departments could not work with the same documents simultaneously.	Digital access allows real-time, collaborative working across disciplines.
Documents at risk of being lost, damaged, or breaching confidentiality.	Secure digital storage ensures safety, integrity, and confidentiality of records.
Delays and bottlenecks were difficult to identify or track.	Full visibility of the workflow enables early identification and resolution of issues.
Significant physical waste from paper use.	Zero-paper usage reduces the department's environmental footprint.
High costs from paper, printing, and storage.	Cost savings can be reinvested into patient care and technology upgrades.

Efficiency and Quality Gains

- **Timesaving:** Faster access to digital records means less time spent on administrative tasks and more on direct patient care.
- **Workflow visibility:** Enhanced transparency across the treatment pathway helps detect and address bottlenecks or breaches efficiently, which will enable workforce and resource planning to optimise productivity.
- **Collaboration:** Improved interdepartmental communication supports seamless teamwork, critical in multi-specialist pathways like radiotherapy.
- **Clinical safety:** Automated handovers reduce the risk of manual errors and ensure that each clinician has immediate access to the latest information.
- **Clinical development:** Clinical radiotherapy planning and treatment data is stored in a single system increasing the potential for evidence-based, clinical research and development.

Environmental and Financial Value

- **Reduced physical waste:** Eliminating paper dramatically decreases waste production.
- **Lower carbon emissions:** No need for physical transport of documents reduces emissions tied to logistics.
- **Cost-effectiveness:** Money previously spent on printing, paper, and storage can now be redirected to innovation and service improvement.

4. SUMMARY OF MATTERS FOR CONSIDERATION

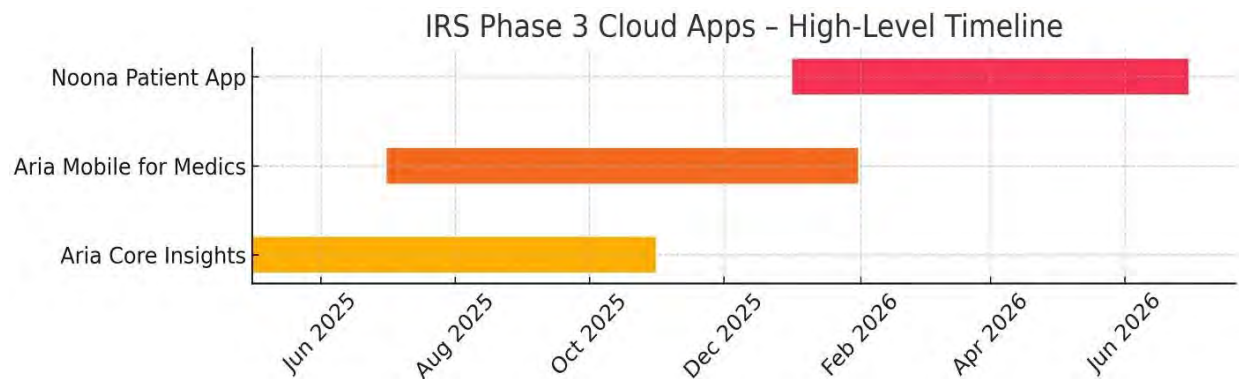
The move to a paperless radiotherapy workflow is not just a technological upgrade; it is a strategic enhancement of clinical operations, environmental responsibility, and patient-centred care. By enabling seamless collaboration, improving safety, and unlocking efficiencies, this digital transformation aligns with the NHS's broader goals for sustainability, modernisation, and high- quality service delivery.

This progress marks a significant milestone and a key enabler in transforming how care is delivered, ensuring that radiotherapy services remain efficient, sustainable, and fit for the future.

This workstream of IRS will next focus on delivering further benefits via deploying a suite of cloud- based tools to enhance radiotherapy services, clinician workflows, and patient engagement. The project will roll out three main applications:

- **Aria Core Insights:** A next-generation analytics platform aimed at improving data-driven decision-making in radiotherapy and smart dashboards.
- **Aria Mobile for Medics:** A mobile solution enabling clinicians to access RT data, use voice dictation, contact patients directly, and approve items on the go.
- **Noona Patient App:** A patient-facing application designed to collect Patient Reported Outcome Measures (PROMS), share data with patients, and support remote engagement. This will empower patients with access to their radiotherapy data and tools to report outcomes

A high-level timeline is below.



5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals:	
Choose an item	
If yes - please select all relevant goals:	
• Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF)	08 - Digital Transformation
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Select all relevant domains below
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒

	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021).
QUALITY IMPACT ASSESSMENT	Choose an item
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Not required
TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT	
The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated. Please indicate whether any of the matters outlined in this report impact the Trust's Wellbeing goals: YES - Select Relevant Goals below	
If yes select the relevant goals:	
• A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities. ☒ • A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience. ☒ • A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health ☒ • A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances ☒ • A Wales of more Cohesive Communities - Attractive, viable, safe and well-connected communities. ☐ • A Wales of Vibrant Culture and Thriving Welsh Language -Promoting and protecting culture, heritage and the Welsh language, encouraging people to participate in the arts, and sports and recreation. ☐ • A Globally Responsible Wales – Consideration of whether an action may make a positive contribution to global well-being ☒	
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream

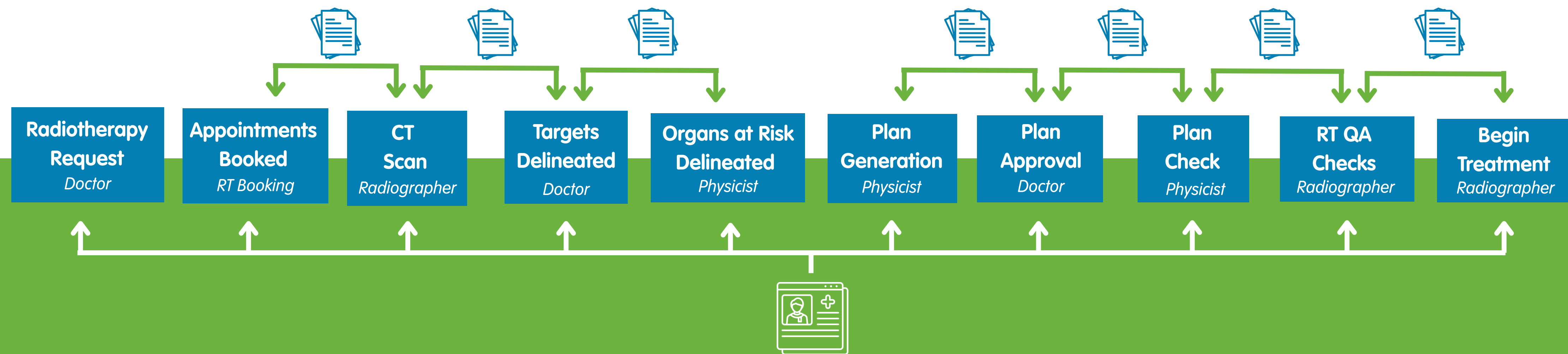
	This project is part of the wider Integrated Radiotherapy (IRS) programme that is Welsh Government funded. The project has not required any extra funding than forecast. This project now live will not require any extra resource but will add efficiencies to the existing patient pathway. Source of Funding: Welsh Government Type of Funding: Capital Funding Type of Change Major Programme
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

6. RISKS

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

Before Paperless

- ✗ Departments unable to work with documents simultaneously
- ✗ Potential for documents to be lost or damaged, or for confidentiality to be breached
- ✗ Physical waste through paper copies, resulting in negative environmental impact
- ✗ Lack of visibility to track delays, bottlenecks or breaches and limited ability to resolve.



After Paperless

- ✓ Automated patient handover in real-time.
- ✓ Eliminating paper use cuts down on physical waste, helping to lower the department's environmental footprint.
- ✓ Money saved on paper, printing, and storage can be redirected toward patient care and technological advancements.
- ✓ Digital systems streamline workflows, reducing the need for printing, storage, and transportation of paper documents, consequently facilitating remote and flexible working
- ✓ Digital systems capture and integrate pathway and clinical data, supporting evidence-based practices and driving continuous improvement in healthcare delivery. This approach minimises risk and ensures a single, reliable source of information.
- ✓ Faster access to digital records improves efficiency, allowing staff to focus more on patient treatment rather than administrative tasks.



TRUST BOARD	
CHAIR'S UPDATE REPORT	
DATE OF MEETING	24 th July 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:

- Private Trust Board meeting (22nd May 2025)
- Extraordinary Public Board meeting (26th June 2025)
- Welsh Blood Service Donor Awards – Cwmbran Area (14th May 2025)
- Spotlight on Service Improvement event (15th May 2025)
- Third Annual Advanced Therapies Wales Symposium 2025 (11th June 2025)
- Chairs' Peer Group (24th June 2025)
- Welsh Blood Service Donor Awards – Cardiff Area (24th & 25th June 2025)
- Visit of the Cabinet Secretary (3rd July 2025)
- Welsh Blood Service Donor Awards – Carmarthenshire Area (9th & 10th July 2025)

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Private Trust Board meetings:

22nd May 2025 (regular) - Discussions at this private meeting of the Trust Board addressed the following items:

- 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
- IMTP

3.2 Extraordinary Trust Board meetings:

26th June 2025 – Discussions at this extraordinary meeting of the Trust Board addressed the following items:

- Accountability Report 2024-2025
- Trust Final Accounts 2024-2025
- Trust Response to Audit Wales regarding Trust Governance & Management arrangements
- Audit Wales ISA 260 Report 2024-2025
- Head of Internal Audit Opinion
- Annual Performance Report

3.3 Welsh Blood Service Donor Awards – Cwmbran Area (14th May 2025)

The May Donor Award ceremony took place at the Parkway Hotel & Spa in Cwmbran. 62 milestone donors from the area received their award. The donors that attended had collectively made 3,802 donations, potentially saving the lives of 11,202 patients in need. A number of stem cell donors were also in attendance and the Chair delivered a speech and presented awards.



3.4 Spotlight on Service Improvement event (15th May 2025)



Once again, May's Spotlight Event shone a light on some of fantastic improvements, with our WBS Director, Alan Prosser opening the event. It was fantastic to have the opportunity to see some of the 5 minute improvement activities being carried out throughout the organisation by staff members from all levels. There were 69 attendees at this hybrid event, including the Chair, CEO, Independent Member and Executive Team Colleagues.

The Blood Health Team was the winner of the 5 Minute Improvement of the Year Award, for their improvement around inputting the hospital blood stocks using the Blood Stocks Management System (BSM).

3.5 Third Annual Advanced Therapies Wales Symposium 2025 (11th June 2025)

The Chair attended the Annual Advanced Therapies Wales Symposium, held at the Swansea University Bay Campus. The aim of the event was to nurture growth of the ecosystem by ensuring that patients are kept at the centre, every step of the way and to hear about the exciting developments in the field. It was also an opportunity to network with colleagues and be part of collaborative conversations.



Several presentations were made by Velindre University NHS Staff. The Chair of proceedings, Suzanne Rankin, congratulated Velindre on being awarded JACIE accreditation for the Welsh Bone Marrow Registry. This achievement was referred to several times during the day.

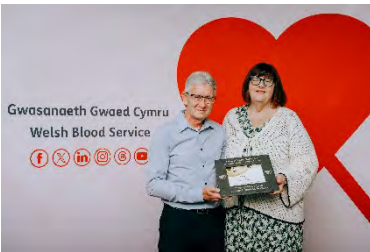
3.6 Chairs Peer Group

On 24 June the Chair attended the chair's peer group meeting. This was followed on 30th June by a meeting at which the Chief Executive of Llais was in attendance to discuss future plans.

3.7 Welsh Blood Service Donor Awards – Cardiff Area (24th & 25th June 2025)



The June Donor Award ceremonies took place at the Village Hotel in Cardiff. On the 24th, 58 donors from the area received their award, collectively having made 3,685 donations, potentially saving the lives of 9,678 patients in need. Lynne Read received special recognition for her support through over 200 platelet and blood donations.



On the 25th, 57 donors were in attendance, having made a collective 3,382 donations, potentially saving 9,932 lives. Malcolm Farmer also received special recognition for his

support through over 200 platelet and blood donations.



3.8 Visit of the Cabinet Secretary – (3rd July 2025)

The Cabinet Secretary for Health and Social Care, Jeremy Miles MS, visited the construction site of our new Velindre Cancer Centre - one of the most significant infrastructure and healthcare investments Wales has seen in decades. The project, on track to welcome our first patients in Spring 2027, will ensure that people affected by cancer in south Wales continue to receive outstanding care for generations to come.



During the visit the Cabinet Secretary met with Velindre University NHS Trust leaders, clinicians and construction partners from the Acorn consortium and Sacyr UK. He was shown the significant construction progress and heard about the lasting clinical, environmental, workforce and community benefits the new centre will deliver.

The Cabinet Secretary welcomed the development of the new Velindre Cancer Centre as a 'transformative step forward in cancer care for Wales'.

3.9 Welsh Blood Service Donor Awards - Carmarthenshire Area (9th July 2025)



The July Donor Award ceremony took place at the Diplomat Hotel in Llanelli. This was the Chair's final Donor Award ceremony. 54 donors attended, in addition to 3 stem cell



donors. They had collectively made 3,003 donations with 8,803 lives potentially saved.

During the reporting period, the Chair met with several individuals interested in applying for one of the vacant IM posts. Unfortunately, it has not been possible for the public appointments unit to progress these appointments.

4 IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: NO	
If yes - please select all relevant goals: - Outstanding for quality, safety and experience ☐ - An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ - A beacon for research, development and innovation in our stated areas of priority ☐ - An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ - A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF)	Choose an item
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	24 July 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 the Chief Executive's activity since the May Board meeting.

Tessa Jowell Centre of Excellence status

I'm delighted to report that, since my last Board update, the south Wales Neuro-oncology Centre, which includes Velindre Cancer Centre, has once again been designated as a Tessa Jowell Centre of Excellence. This prestigious accreditation is awarded to centres across the UK who have met or exceeded standards across the treatment, care and research they provide to patients with a brain tumour and follows a rigorous review process led by a committee of NHS and patient experts.

Welsh Bone Marrow Donor Registry receives JACIE accreditation

At the end of May, the Welsh Bone Marrow Donor Registry (WMBDR) received accreditation from JACIE for the collection of stem cells at Velindre Cancer Centre.

The WMBDR performs stem cell and lymphocyte collections at specialised cell collection rooms located at Velindre Cancer Centre. This is only possible due to the close working environment cultivated between colleagues at Welsh Blood Service and Velindre Cancer Centre.

From the European Society for Blood and Marrow Transplantation, JACIE is Europe's only official certification body in the field of haematopoietic cell transplantation and cellular therapy. Accreditation greatly enhances the reputation of Velindre University NHS Trust as a leading supplier of life saving stem cell and lymphocyte collections in Wales.

Quarterly meeting of the Welsh Government Health Strategy Board

On 3rd June I attended the quarterly meeting of the Health Strategy Board (HSB). The HSB holds me and my team to account for the delivery of the new Velindre Cancer Centre (nVCC) project. I am pleased to report that the HSB concluded that the nVCC project has made good progress in the last six months.

In May 2025 we received an external assurance report reviewing our progress in implementing the recommendations they made in relation to governance arrangements for the nVCC project. Their report confirmed that all the recommendations had been appropriately implemented, including all matters related to strengthening the governance of the nVCC project. The findings were presented to the HSB on 3 June 2025. They were positively received, with HSB

officials informing Trust officers that they were pleased with the progress being made.

Investment in Life Sciences meeting

On 23 June we were part of a discussion with Welsh Government and Cardiff public sector leaders around the opportunity to work more closely with industry and to secure investment in the region. The aim is to foster collaboration which benefits patients, staff and economic growth. We will be developing proposals as part of Cardiff Health Partners over the next 3 months and working on a vision for a Cardiff health sciences campus as a focus for innovation, research and development.

Welsh Blood Service's Project ELSA wins sustainability award

The WBS's Project ELSA—an innovative initiative aimed at improving the sustainability of blood transportation within the Service—was named Product of the Year at the NHS Wales Sustainability Awards on 20 June 2025. Reusable cooling devices (PCMs) are used instead of dry ice to cool the transport boxes. Previously, single use plastic bags containing dry ice (CO₂) were used. This option was costly, detrimental to the environment and carried a health and safety risk to staff. I would like to congratulate everyone involved in Project ELSA on their success. It is deserved recognition of the team's dedication and innovation, and an important step towards the WBS's long-term goal of greater sustainability.

Organisation of European Cancer Institutes (OECI) membership

I am delighted to confirm that Velindre Cancer Service has become only the third UK Cancer Centre to be admitted as a member of [OECI](#), a global organisation promoting excellence in cancer care and research. We're looking forward to the hard work of getting fully accredited as a Comprehensive Cancer Centre over the next two years, as we continue to transform the Cancer Services delivered by the Trust.

Joint Executive Team meeting and continuation of routine oversight and escalation arrangements

On 26 June the Executive Team held a successful meeting with senior Welsh Government officials to discuss the organisation's end of year position for 2024-25. We highlighted our key achievements across the Velindre Cancer Service and Welsh Blood Service and discussed how we will meet ministerial expectations for 2025-26. We also confirmed Board endorsement of the annual report and annual accounts (see next section for details).

Following the JET meeting, a positive summary of our constructive discussions was received from the Director General Health, Social Care & Early Years Group / NHS Wales Chief Executive on 8 July. I was pleased to receive a further letter from her on 15 July confirming that Velindre University NHS Trust's escalation status remains at level 1 (routine arrangements). This demonstrates that we continue to meet the highest level of assurance in respect of governance; leadership, capability and culture; performance and outcomes; finance, strategy and planning; quality of care; fragile services; and other issues as appropriate.

I am grateful to all Trust colleagues whose work enables us to continue to demonstrate this high level of assurance of our performance, quality, and safety across our organisation.

Submission of the Trust's Annual Report and Accounts

The Trust's Annual Report and Accounts were submitted to Audit Wales at the end of June in accordance with the Welsh Government's timetable. The report reflects another year of unwavering commitment to providing outstanding care, advancing research, and supporting the health and wellbeing of our communities across Wales. We continue to make significant progress in transforming our services, guided by our ambition to provide the best care possible for patients, donors, and their families and carers. From embracing new technologies and treatments, strengthening our governance to developing our workforce and infrastructure, we are laying strong foundations for the future.

Cabinet Secretary for Health and Social Care visits new Velindre Cancer Centre

On 4 July we hosted the Cabinet Secretary for Health and Social Care, Jeremy Miles MS, at the construction site of our new Velindre Cancer Centre. It was a pleasure for Trust leaders, clinicians and construction partners from the Acorn consortium and Sacyr UK to discuss this cutting-edge facility with the Cabinet Secretary. He was shown the significant construction progress and heard about the lasting clinical, environmental, workforce and community benefits the new centre will deliver. The Cabinet Secretary described the development of the new Velindre Cancer Centre as a "transformative step forward in cancer care for Wales" and welcomed the "world-class care and support it will provide for patients and their families across south east Wales".

Executive Team away day

On 9th July I led an Executive Team away day. The purpose of this session was to reflect on the achievements we've delivered as a team during my first six months in post, and to plan ahead for the next 24 months.

Tackling Cancer (Making it Happen) meeting with the Cabinet Secretary for Health and Social Care

On 15th July I attended this group, chaired by the Cabinet Secretary. Its purpose is to ensure that, at a national level, Wales is contributing to and embracing new approaches to cancer care. This meeting agreed new approaches to support information sharing and innovation adoption across the NHS system more consistently and faster.

Appointment of new Chair

On 15th July, the Cabinet Secretary for Health and Social Care announced that Sara Moseley will take up the role of Chair of Velindre University NHS Trust from 1 September 2025. An Independent Board Member of Cardiff and Vale University Health Board, Sara was formerly Director of Mind Cymru, Executive Director of Mind and Chief Executive Officer of Moondance Cancer Initiative. We look forward to welcoming Sara to the organisation later this year.

Thank you – Diolch Donna

As a final note in this update to the Board, I would like to put on record my heartfelt thanks to our Chair, Professor Donna Mead OBE, whose tenure comes to an end this month. We are enormously grateful to Donna for her years of dedicated service and commitment to all aspects of the Trust's work. I know I speak for colleagues across the Trust, our Board members past and present, our partners and stakeholders, and most importantly, our donors, and our patients and their families and fundraisers who have always remained at the heart of everything she has delivered as our Chair, in saying an enormous thank you to her.

We will miss you greatly but wish you all our very best – ar ran tîm Felindre, pob hwyl a diolch o galon, Donna.

4 IMPACT ASSESSMENT

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

5 RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

TRUST BOARD

VELINDRE UNIVERSITY NHS TRUST PERFORMANCE MANAGEMENT FRAMEWORK REPORT DETAILED ANALYSIS FOR MAY 2025/26.

DATE OF MEETING	24/07/2025

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE, INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	INFORMATION / NOTING

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Peter Gorin, Head of Strategic Planning and Performance

PRESENTED BY	1. Lauren Fear, Director of Transformation -interim (Introduction) 2. Anne Carey, Chief Operating Officer, (VCS and WBS) 3. Sarah Morley, Executive Director OD & Workforce, 4. Carl Taylor, Chief Digital Officer, 5. Lauren Fear, Director of Transformation -interim (Estates) 6. Matthew Bunce, Executive Director of Finance

APPROVED BY	Lauren Fear, Director of Transformation – interim

EXECUTIVE SUMMARY	PERFORMANCE MANAGEMENT FRAMEWORK (PMF) OVERVIEW The report provides the detailed analysis of all the Performance Management Framework Key Performance Indicators (KPIs) and supports the PMF Executive High-level slides in Section 1 which focus on the key issues to be raised and discussed for the month of May 2025.

RECOMMENDATION / ACTIONS	The Trust Board is asked to NOTE the Performance Management Framework detailed analysis for May 2025.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	Date
WBS SMT / Performance Review	(11/06/2025)
VCS SLT / Performance Review	(18/06/2025)
Executive Management Board	(30/06/25)
Quality Safety and Performance Committee	(17/07/25)
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The report has been considered and endorsed at the VCS and WBS Performance Review, EMB and QSP Committee meetings and is presented to the Trust Board for information and noting. The EMB Run and QSP Committee considered the following matters: Assurance - Performance Management Framework for May was received by the EMB Run and QSP Committee and the levels of assurance were agreed. - During the May cycle Digital Services level of assurance was decreased from 4 to 3. This was reported at QSPC and Trust Board. - For future PMF reports, the trend in Assurance scores will be reported - QSPC discussed the following metrics seeking the relevant assurance: (i) Paperless workflow – noting separate report on this (ii) RT Benchmarking, utilisation and breaches – capacity and demand work ongoing alongside Benchmarking work with Clatterbridge and potentially Swansea Bay. (iii) Time expired platelet performance – improved with demand and capacity trial underway. (iv) Reference Serology Target changed. PMF Development - Two actions remain open within the PMF Development section around automation and benchmarking. The Head of Strategic Planning is meeting individual teams to finalise benchmarking for each portfolio and performance areas. VCS The improved SACT performance was recognised, however, discussions on the performance of the cancer centre radiotherapy were highlighted: Performance: There was discussion about the current performance of the radiotherapy services, particularly in relation to capacity and the impact of staff shortages. The performance was noted to be better than anticipated given the circumstances, but still not at the desired level. Initials in graphs to be removed following QSPC. Capacity and Demand: The discussion emphasised the need for a better understanding of the capacity and demand for radiotherapy services. There was a suggestion to have a deep dive analysis to understand the gaps and actions needed to improve performance.	

- **Communication and Integration:** better communication and integration between different departments was highlighted and teams to ensure that changes and improvements are effectively implemented.
- **SPC Charts for RT and SACT:** need to confirm that the ranges of the upper and lower control limits in the graphs are appropriate.
- **Future Steps:** It was suggested to have a session in the summer, outside of the regular meetings, to focus specifically on radiotherapy, involving the divisional team to understand the current state and plan for improvements.

WBS

- Stock continues to be healthy for May 2025.
- Two incidents reported to the regulator relating to Red Cell Immunology (RCI). Both are included in the Trust Risk Register.
- A new slide is included relating to Quality, Assurance, Incidents and Audits which raises some issues from serious adverse events, quality related GMP Incidents and non-conformance through internal and external audits. Recovery plans are in place.
- A number of new KPIs have also been introduced with challenging target timescales with appropriate mitigation plans developed.
- The specific performance on Time Expired Platelets (impact of Bank Holidays and need for demand management tool), Reference Serology (training plans in place to support new team) and Stem Cell Donors (target reduced to 40 and improved swab training improving take-up) was discussed.

Workforce, Digital and Health and Safety

- Highlighted good work in WBS on sickness management.
- Good progress being made on the Statutory and Mandatory training and PADR implementation.
- Good progress being made on a number Digital initiatives.
- Health and Safety stocktake of tree safety.
- Improve the Fire Safety graph format following feedback from QSPC

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

APPENDICES	
	Not applicable

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

VELINDRE NHST PERFORMANCE REPORT FOR MAY 2025

PMF Work Packages Progress

The Velindre University NHS Trust Executive Management Board have approved eight packages (previously nine 2 and 3 merged due to overlap / duplication) 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.

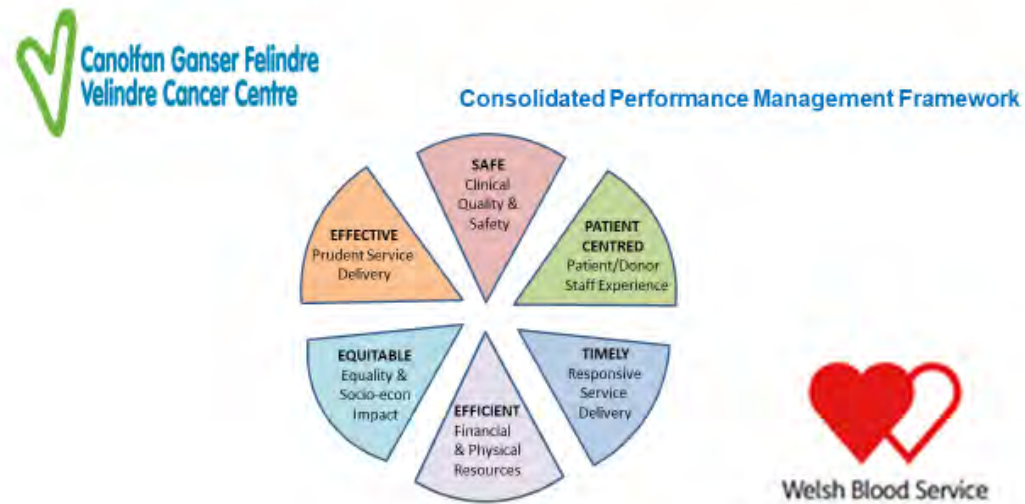
Work Package	Work Package Summary	Target Date for Completion	Progress Update	Lead(s)
1 Current Performance Measures and the Level of Statutory Compliance	To analyse the current range of Trust Performance Metrics and to evaluate the current level of Statutory Compliance	December 2024 (To be repeated 6 -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	The Health and Social Care (Quality and Engagement) Wales Act, which came into force on 1 April 2023, places a number of additional reporting requirements. The mechanisms to report on these areas are being developed. In particular, the Quality Act requirement for 'always on' reporting on key performance areas.	27 th July 2025	Completed – Always On site 'live' on Trust Internet Guidance gives flexibility on content, and engaging with Patient and Donors on measures reported Currently taking stock of current position and drafting plan for next stage of development	Director of Transformation (Interim) Chief Digital Officer Head of Strategic Planning and Performance
3 Inclusion of Targets	To ensure that all KPIs have a set target against which to manage performance.	30 th June 2025	Completed – a new range of WBS KPIs have been introduced to the May PMF report, with new targets being refined, as well as those developed earlier by VCS. This is an ongoing process to ensure the PMF targets remain relevant to manage our performance.	Head of Strategic Planning and 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.	29 th 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.	~~31st July 2025~~ – Further extension to be confirmed by Data and Insight Team prior to 31 st July.	Revised Target – highlighted under recent PMF Audit Recommendation 'Objective 2 Resources' A specific resourcing issue was identified by BI colleagues to support the completion of the 'BI automation' of PMF. Progress has now been made and the development is moving forward.	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.	31 st July 2025 – Detailed update to agree with Exec leads by 31 st July.	Updated target for next phase – The Performance Management Framework Development Group is overseeing a piece of work to ascertain the KPI benchmarks that are currently available against individual KPIs and the potential to develop new benchmark measures. A series of meetings has been arranged with key service leads to take this forward. WBS, Sustainability and Health and Safety benchmarks have been shared.	Head of Strategic Planning and Performance

2. ASSESSMENT OF PERFORMANCE AND MATTERS FOR CONSIDERATION BY EXCEPTION FOR MAY 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.

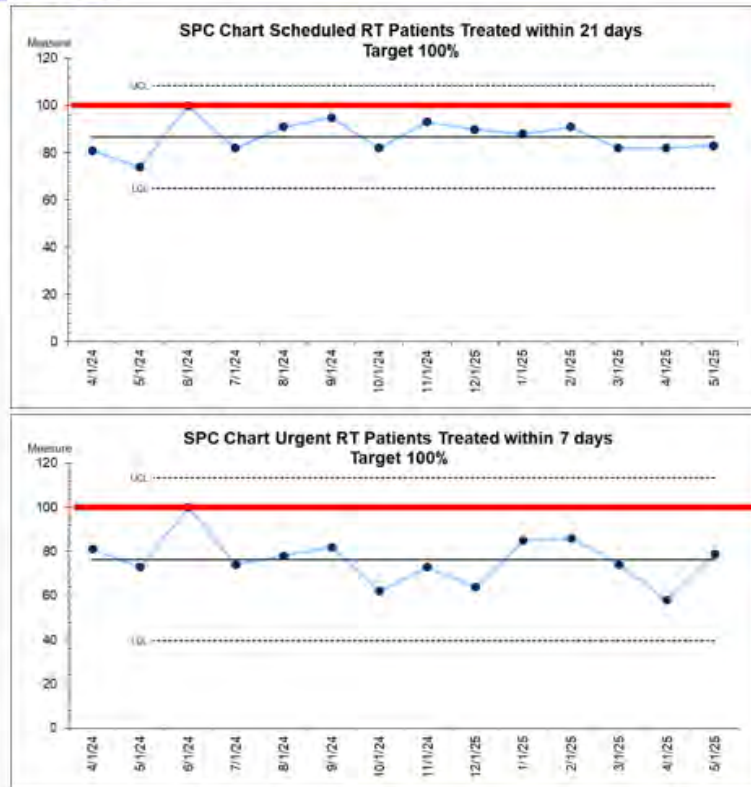


- 2.2 The following PMF PowerPoint slides highlight the key issues for the attention of the Trust Board, (on an exception basis), identified and discussed by the previous Executive Management Board and Quality Safety and Performance Committee meetings.

2.3 Radiotherapy

Radiotherapy Waiting Times

May 2025



Updates on Last Month:

- Pre-treatment CT capacity remained constant at 17 hours per day.
- Schedule performance was 83%, Elective Delay was 99%, Urgent SC was 79% and Emergency was 100% within 2 days.
- Longest wait for scheduled was 37 days one due to late delineation.
- Data warehouse issues from March data have been resolved with more accurate data provided.
- May validation has been done for the second full month of using the paperless ARIA referral form and has provided improvements in the validation process of 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

- There is a risk that the development and implementation of capacity utilisation and reporting service improvements such as Carepath, Paperless and InSightive may be impacted by demands from other major change programmes.
- There is a risk that Planned Capacity for March – July will be impacted because of increased demand on staff resource through implementation of paperless and Fit out and ramp up of services at VCC@NHH

Forecast / Next Month

- Capacity has been extended where possible through the provision of locum radiographers.
- Planned Linac Capacity is 78 hours. No increase in activity due to paperless implementation
- Where demand exceeds capacity, all referrals are submitted through escalation where prioritisation and clinical harm assessment is undertaken and are thus booked according to clinical priority.
- 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.
- Delay in go live at VCC@NH Radiotherapy Unit

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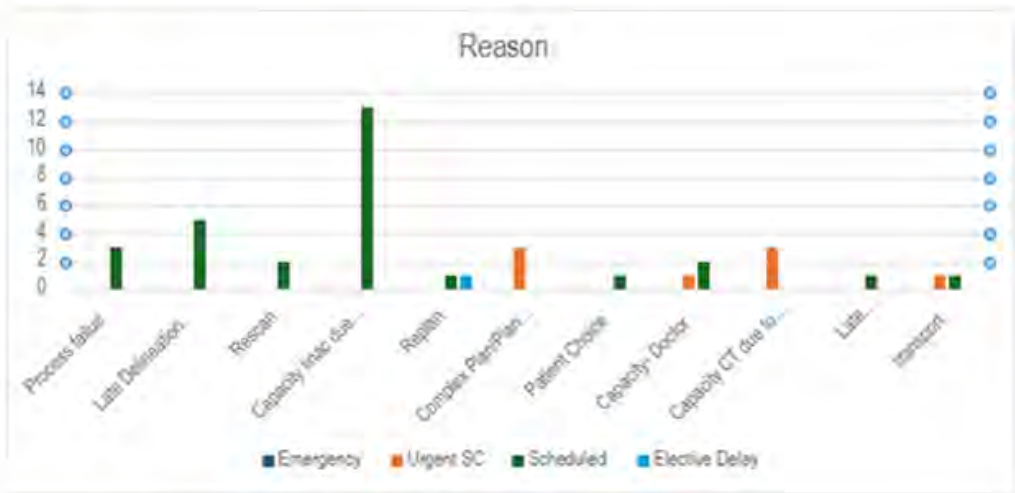
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Radiotherapy - Breach data

May 2025



Process Failure- 3
Late delineation-5
Rescan- 2
Capacity linac due to Bank Holidays- 13
Replan-2
Complex plan/Plan required- 3
Patient Choice- 1

Capacity DR- 3
Capacity CT due to Bank holiday- 3
Transport- 2
Late Authorisation/Approval-1

Action/Mitigation underway

Capacity
Locum staff to ensure Linac capacity is maintained in place until June 2025.

Due to undefined delay in the go-live of the VCC@NH SRU, discussions are in place to ensure capacity is available at VCC Cardiff - June/July 2025 with maintaining the locum Radiographers to support the service until beyond June.

Review of linac uptime to be undertaken with Radiotherapy and Radiotherapy physics ensure downtime is recorded in Aria aligns with Varian Equip reporting- development extended to 1 June 2025, mitigation due to issues experienced with paperless implementation

Pathway
Implementation of Aria Radiotherapy request as part of the IRS paperless solution form March 2025 – reduced risk of process failures in RT request

Implementation of Carepath for Radiotherapy IR(ME)R practitioners – improved visibility of the pathway

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

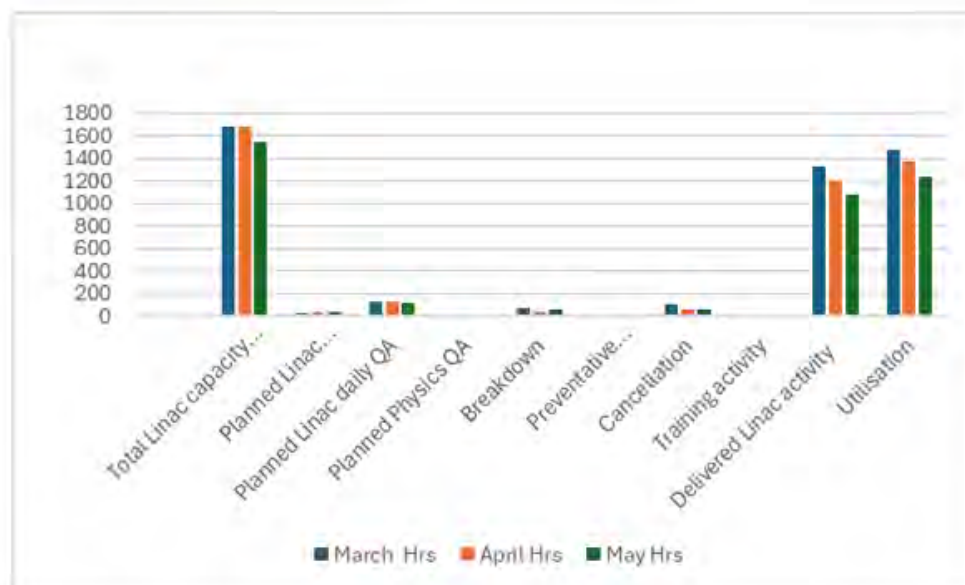
- Income
- Capacity utilisation
- Development in readiness to InSightive (Oncology Specific Analytics) implementation scheduled Q2.
- Development of activity reporting for Brachytherapy – following paperless go live
- Development of activity reporting – following paperless go live

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

May 2025

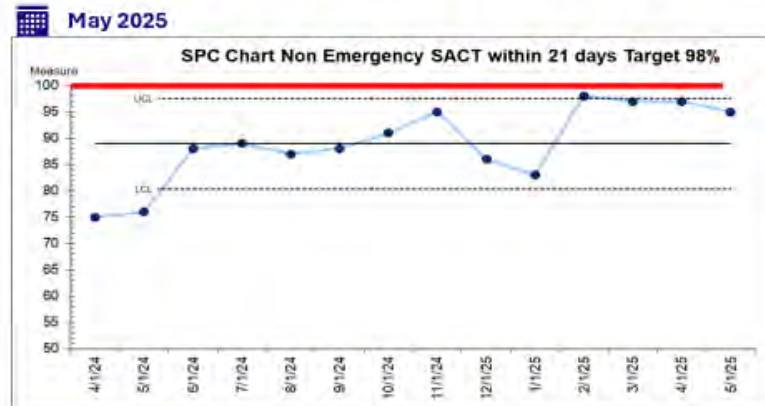


Summary

- May total capacity was lower than April.
- Reduction in cancelled hours 53 hours (3%) due to patient cancellations, breakdown, complex planning, rescans and late delineations.
- Reactive Linac capacity 21 hours delivered out of hours including weekends.
- Overall, May utilisation was 80% against 82% in April, higher breakdown rate, redistributed patients, no patient breached clinical protocol, therefore no patient harm.
- Only marginal productivity gains possible ahead of Insightive becoming operational, scheduled for Q2.

2.4 SACT

SACT Non-Emergency Waiting Times



Action / Mitigation Underway:

- SACT delivery group continues to focus on improvement delivery.
- Data quality issues remain resulting in a continued hold on operational use of SharePoint tool. This has been escalated.
- Planning discussions underway for review of DTT process, to reduce number of breaches and accurately record patient waits, ensuring VCS is comparative to Wales.
- 8 breaches attributed to scheduling delays/issues, review of the workforce capacity within scheduling team, using time and motion to update capacity vs demand and develop a workforce plan if required.
- SACT performance manager started 9th June primary focus to improve the SACT booking process.

Updates on Last Month:

- Phase 1 of the Cancer PTL (single source of the truth) is in place with the SACT view on track for delivery in phase 2.
- This is supporting the work with the Health Boards to streamline patient information transfer to reduce pathway and treatment delays.
- Recruitment of 2 X ACP has concluded, as part of the workforce change for SACT pre-assessment transitioning from Consultant delivered to Consultant led.
- 6/7 Working group continues to introduce additional SACT capacity, expansion of capacity.
- Longest wait for treatment was 32 days - 2 patients - 1x due to Deferral (Awaiting CT) - 1x due to OP date requested by prescriber

Key Issues / Risks:

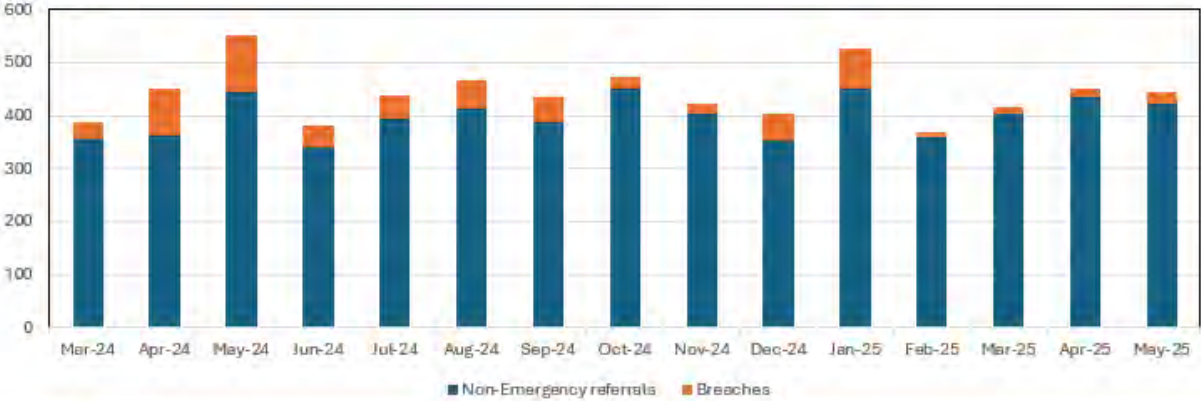
- **Referral Rates vs. Breaches** - analysis ongoing to understand any correlation of these measures and actions to improve the patient pathway.
- **Digital** - ongoing conversations with DHCW to support the delivery of Hospital Initiated Referrals (HIR) into VCS interim solution being developed
- **Patient Pathway Visibility** - mitigations in place for the lack of visibility of patients with Cancer PTL, phase 2 due May 25 (SACT view)
- **Workforce recruitment** - Bespoke and targeted recruitment processes, nursing roles filled, medical roles recruitment underway.
- **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
- Assess Impact of additional PICC capacity on June performance

Breach data

May 2025



Number	Reason	Action
3	Outpatient Capacity	Will form part of the Scheduling review to ensure that appropriate escalations are made where there are capacity constraints
8	Scheduling Delay	Scheduling Workforce Capacity review underway, to examine all breaches of >21 days by AB or SK to determine opportunities to flex the pathway
3	PICC Capacity	Expedite 3 wave training to identify opportunities to increase capacity across the week if required. Interim measure for AB and SB to link with IV access when capacity related constraints.
1	Outpatient date requested by prescriber	No mitigation
1	DTT issue	Presentation to be given in SMSC to educate wider workforce on the importance of updating DTT.
4	Deferral (waiting for diagnostic test/result)	No mitigation – Review/improve the deferral process to minimise breaches

2.5 Welsh Blood Service

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

May 2025



Updates on last month:

- All clinical demand was met for O, A & B+ groups.
- We manufactured 4% more red blood cells than we issued to hospital, helping to maintain excellent stock levels.
- Provided mutual aid to NHSBT (30 O Negs)
- Stock levels are at their highest in five years, despite the challenges of the recent bank holiday period.

Key Issues / Risks:

- The need to balance the differences in hospital demand and blood collection across various blood groups to ensure no operational imbalance between supply and demand.

Action / Mitigation Underway:

- Daily Resilience meetings to ensure immediate operational responses and mitigate any arising issues.
- Monthly Blood Supply Chain Planning Group meetings with focus on medium and long-term planning.
 - Developing an Operational Assurance Framework – Qtr2
 - Collaborating with Health Technology Wales around recruiting and retaining younger donors – Qtr 3

Forecast / Next Month:

- Performance remains strong and closely aligned with red cell demand.



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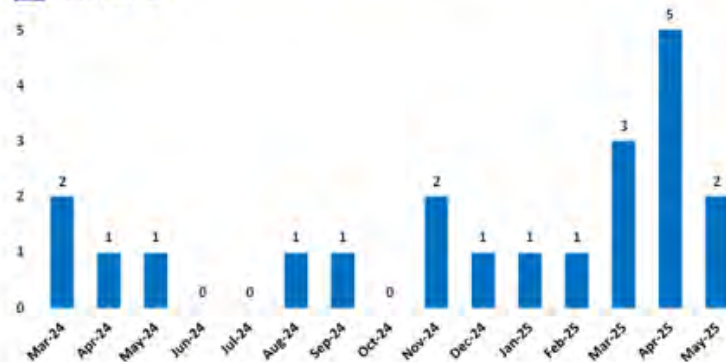
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WBS Incidents Reported to Regulator / Licencing Authority



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May 2025



Two 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 136: The cross-match labels for two red cell units were accidentally swapped. Note both units were intended for the same patient.

SABRE 137: Incorrect blood group transcribed onto patient record.

Both events relate to the Red Cell Immunology (RCI) Laboratory reporting process, which is complex and includes manual input into an outdated I.T. system (SERIF). A Recovery Plan and new service improvement initiative is expected to yield improvements from June 2025 onwards.

No patient harm occurred from either event.

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Quality Assurance – Incidents & Audits

May 2025



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

- 5 exceeding target date for closure (in reporting month)
- 3 that remain overdue at month end
- 10.2% overdue actions from open incident action plans

Mitigations in place:

- 2 of the 3 incidents that remained overdue at the end of May have now been closed, while one remains open pending acknowledgement from the Human Tissue Authority (HTA).

Quality (GMP) Incidents:

- 6 exceeding target date for closure (in reporting month)
- 11 that remain overdue at month end
- Age of oldest open overdue incident – 289 days

Mitigations in place:

- Training scheduled throughout 2025.
- Overdue incidents escalated to the SLT to increase visibility, accountability and early intervention. New Lead Nurse role will play a pivotal supporting role.

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

- 0 from internal audits in the last month
- 0 from external audits in the last month
- 63.4% overdue actions from open audit action plans

Mitigations in place:

- Focussed recovery plan with timelines being developed for next EMB meeting.
- Overdue actions escalated to the SLT & Integrated Quality & Safety Group to increase visibility, accountability and early intervention.

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Time Expired Platelets

May 2025



Updates on Last Month:

- Platelet expiry rose to 16% in May, exceeding the 10% target.
- Despite intentionally reducing planned overproduction during the bank holiday period to minimise post-holiday waste, unexpectedly low demand still led to excess expiry (11% unexpected reduction in demand).

Key Issues / Risks:

- Prioritising platelet supply, e.g. during bank holiday periods, may lead to excess platelet expiry if demand is reduced, given their relatively short shelf life of 5-7 days.

Action / Mitigation Underway:

- Monitoring the age of platelet stock as part of the daily Resilience meetings.
- Developing a platelet strategy to optimise platelet production (December 2025).
- Developing a manufacturing tool to inform decisions around pooled platelet manufacture. Evaluation continuing throughout May 2025.

Forecast / Next Month:

- Performance is expected to return to target in June 2025.
- Lessons learnt from recent bank holidays are being reviewed to support the next holiday period.



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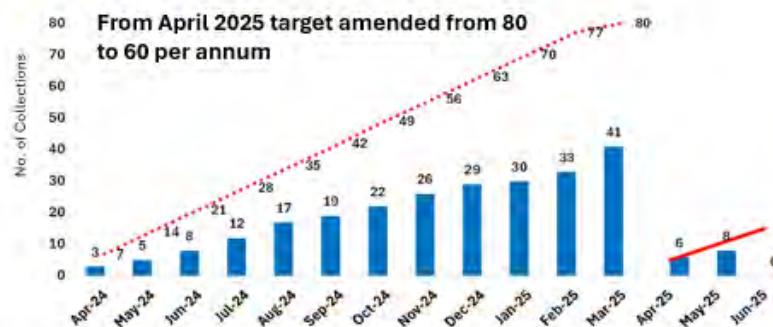
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Stem Cell Collections

May 2025



Updates on Last Month:

- The target of 5 Peripheral Blood Stem Cell (PBSC) collections was missed due to insufficient requests and transplant centre cancellations.
- However, total cell provision was 8, where 3 cell collections took place from Welsh donors (PBSC and Peripheral Blood Lymphocyte (PBL), and 5 cell imports from International donor registries for the University Hospital of Wales (there is currently no KPI target for overall provision).

Key Issues / Risks:

- Currently experiencing cancellation/postponement rates of up to 38% due to patient fitness and donor availability issues.
- Although SWAB recruitment has increased volunteers, 33% of these donors have sub-optimal genetic typing results making them less likely to be selected for collection.

Action / Mitigation Underway:

- Maintain buccal swab recruitment to boost donor panel and stem cell collection requests.
- Training for Donor Engagement Coordinators on proper swab techniques was carried out in May and will continue into June 2025 to support improvements in genetic test results.

Forecast / Next Month:

- Increasing the donor panel size through buccal swab recruitment is expected to improve long-term performance.
- Training underway on proper swab techniques will improve sample quality, supporting genetic typing results.

In May 2025, 24% of recruited donors were from Black, Asian, mixed, or minority ethnic backgrounds, compared to 5.8% in the Welsh population.

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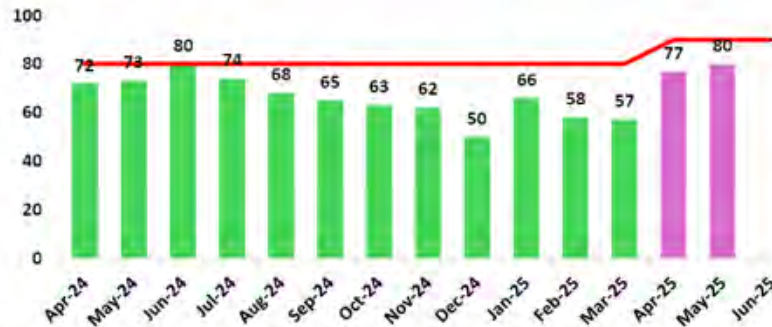
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Reference Serology Turnaround Times

May 2025



Updates on Last Month:

- Performance improved in May, but still fell short of 90% target, achieving 80%.

Note: Since April 2025, performance is measured against the RCI User Guide target, which aims to provide 90% of results within 5 working days.

Key Issues / Risks:

- Capacity and resilience issues.
- Outdated digital system requiring manual data entry.

Action / Mitigation Underway:

- Recovery Plan implemented to support short term capacity and resilience issues (impact 6 – 12 months).
- Prioritising updates to the digital system.
- Launched focussed service improvement initiative using Lean methodology to identify root causes, reduce waste and streamline processes by engaging front line staff in problem solving and prioritising value-added activities.

Forecast / Next Month:

- Implementing the Recovery Plan and new service improvement initiative is expected to yield improvements from June 2025 onwards. Performance is being monitored on a weekly basis, and improvements are evident for June.



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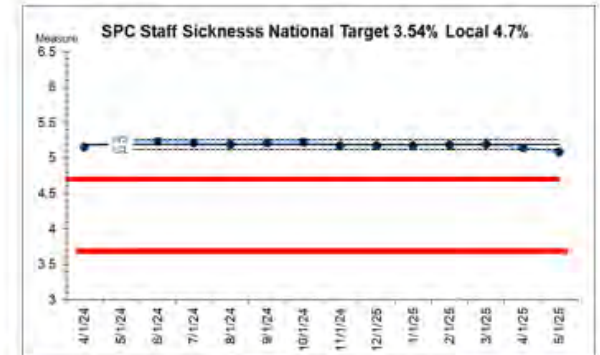
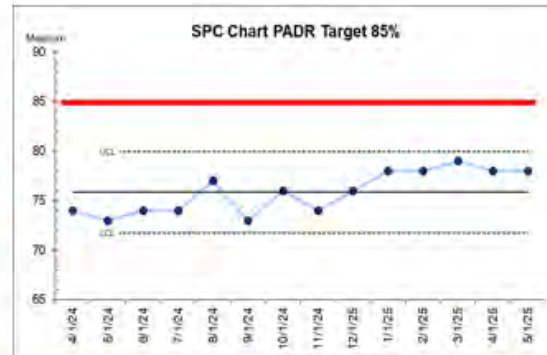
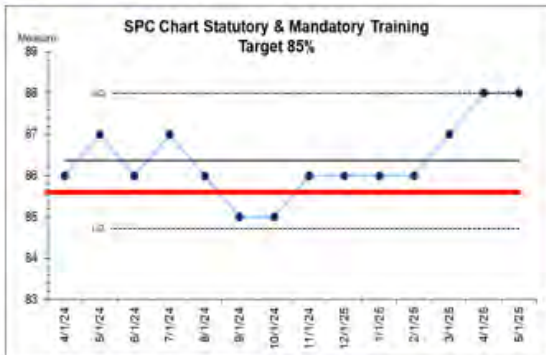


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2.6 Workforce and Wellbeing

Workforce, Wellbeing & Organisational Development

May 2025



Updates on Last Month:

- **PADR** – New templates launched, feedback received notes managers and staff welcome a more streamlined process
- **Sickness** – Trust action plans following absence analysis has resulted in detailed action plans in hotspot areas
- **S&M Training** – continues improvement

Forecast / Next Month:

- **PADR** – as new systems are implemented and embedded, an improvement is anticipated over the forthcoming summer months
- **Sickness** – forecast expected to continue the improve as divisional action plans are implemented, aligned to the detailed data analysis.
- **S & M Training** – to remain above 85% target

Action / Mitigation Underway:

Action plans in place

- Fundamentals of Management Training Package being rolled out across the Trust

Key Issues / Risks:

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

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Gofal ardderchog, dysgu ysbrydoledig, pobl iachach



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2.7 Digital Services

Digital Services

May 2025



Updates on Last Month:

- Service performance – Our performance remains above the agreed percentage for both Incidents and Requests. However, there was a slight decline in request performance due to the impact of non-BAU project activity.
- Compliance with statutory and mandatory training IG and Cyber training improved in May. However, 150 staff members still require completion.
- No significant incidents were raised in May, marking the first reduction in the rolling 12 month total in over a year.
- Successful on time implementation of digital service within the Velindre@Nevil Hall site.

Action / Mitigation Underway:

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

Forecast / Next Month:

- Digital Service improvement work ongoing to increase automation of tasks across the Digital Service Desk, to ensure current performance gains can be sustained over the long-term.
- Installation of capital funded technical refresh digital client devices and network/server infrastructure in progress.
- Capital funding used to upgrade legacy IT infrastructure across Radiotherapy Physics service in March 2025 – for installation in Q1/Q2 2025/26..

Key Issues / Risks:

- Capacity to complete technical refresh and infrastructure projects on time due to demand.

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2.8 Estates Infrastructure and Sustainability

Estates Sustainability



May 2025

Electricity – WBS Total

Electricity WBS - December 2023 - May 2025



Updates on Last Month:

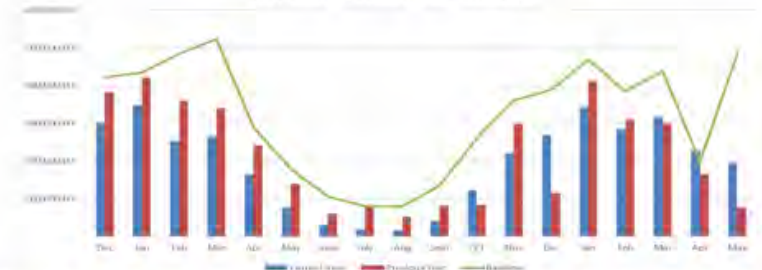
- Decrease of gas consumption across TG – anticipated continued decrease (partly due to weather comparatively to last year)
- Slight increase in electricity consumption across the Trust, still lower than baseline consumption.
- Staff engagement events undertaken highlighting initiatives to reduce consumption, e.g. the Great Big Paper Cut

Action / Mitigation Underway:

- Internal Energy Management Audits of departments ongoing
 - LED lighting survey completed – identified areas for improvement, will include motion sensory & day light sensors
 - Renewable feasibility study to be undertaken in next quarter
- Monitoring of consumption ongoing through Estates Management Group with BMS controls monitored to identify hotspots/recurring increases to reduce consumption
- Attendance at WEOG to monitor potential price increases

Electricity – VCS

VCS Hospital - December 2023 - May 2025



Forecast / Next Month:

- Elevation in gas / electricity cost- all energy purchased through All Wales contract
- Ongoing Building Management system Monitoring to improve levels of usage within VUNHST Buildings.
- Increase in electricity consumption due to A/C usage during hot weather

Key Issues / Risks:

- New waste contract in place across the Trust, ongoing work to ensure recycling meets targets/aligns with the Trust strategy
- Energy prices are still elevated and is monitored through the Welsh Energy Operational Group (WEOG) where VUNHST staff (finance and estates) attend.
- Compactor at VCS requires repair, resulting in reduction in recycling (likely increase in general waste next month).

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Gofal ardderchog, dysgu ysbrydoledig, pobl iachach



GIG
Prifysgol Felindre

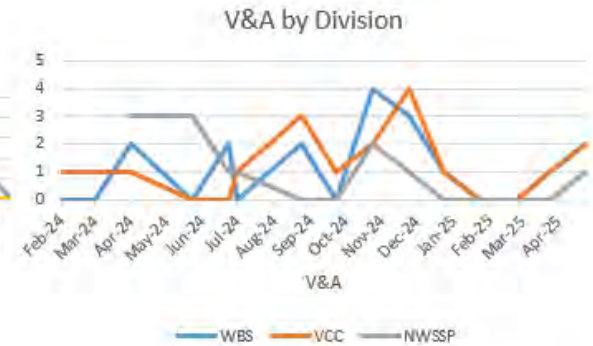
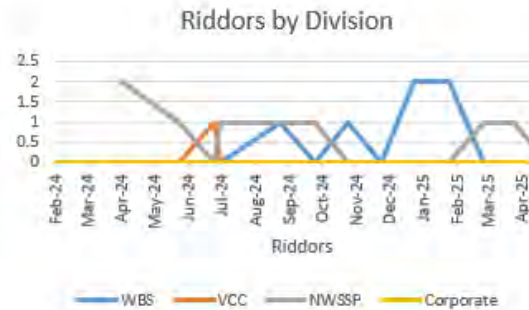
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Prifysgol Felindre
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Health & Safety

May 2025



Updates on Last Month: Total of incidents

NWSSP - 5
VCS - 6
WBS - 4
Riddor - 0

Forecast / Next Month:

NWSSP - Applicant has been appointed and await start date.
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 meetings also ongoing
WBS - Meeting set up to look at the accident reporting mechanism

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 meeting held with the BSM's and tracking the booking systems for compliance
WBS - Improve Datix incident reporting process to avoid late reporting

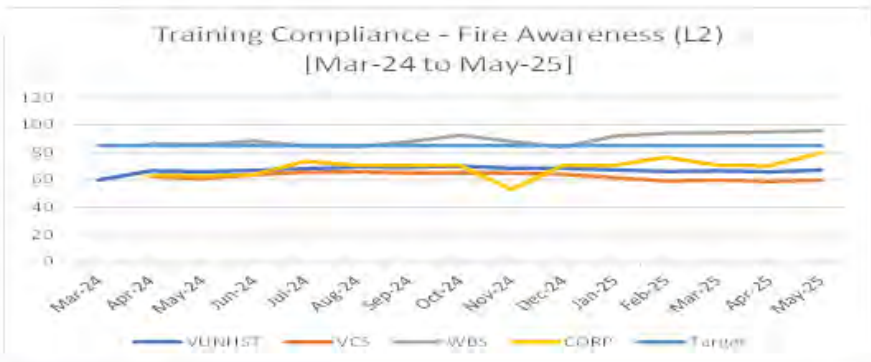
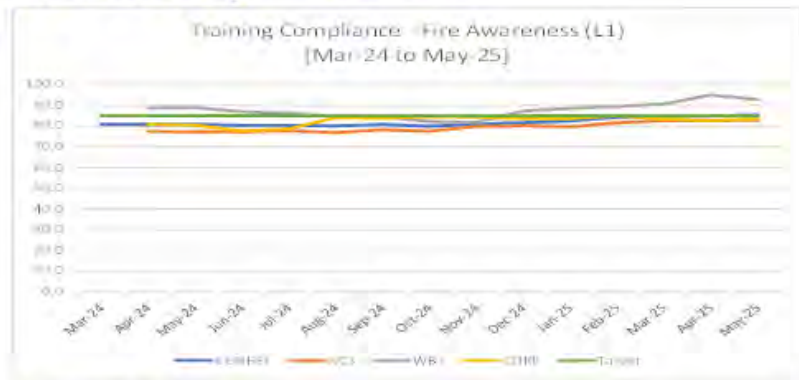
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Fire Safety

May 2025



Updates on Last Month:

STRATEGIC

- Continuation with development of fire safety protocols
- Annual fire safety Audit delayed until mid-June 2025

VCS

- Continued improvement in fire safety training compliance for both L1 and L2 training
- Evacuation drills undertaken

WBS

- Continued improvement in fire safety training compliance for L1 and L2 training
- Emergency Response drills undertaken.

Corporate

- Fire drill still overdue
- Further conversation on n-VCC fire strategy

Action / Mitigation Underway:

VCS

- Review of fire risk assessments ongoing
- Draft of revised emergency evacuation strategy
- Commitment to regular evacuation drills in non-clinical areas

WBS

- Setting up more fire safety training sessions

CORPORATE

- Review of FRA highlighting non-compliances

Forecast / Next Month:

STRATEGIC

- 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

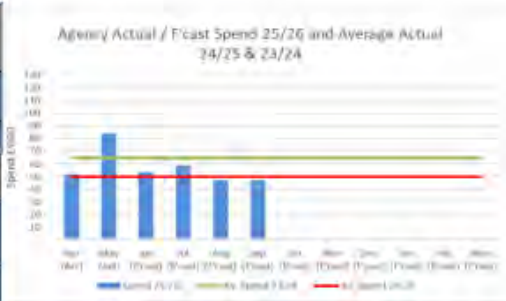
- Run evacuation drill as urgent action.

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.

Financial Performance

	May 2025											
Trust Revenue Position (core)	24/25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26
Variance (Cum) £m	3.7	0	0									
Target	0	0	0	0	0	0	0	0	0	0	0	0
Trust Capital Position	24/25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26
Actual spend (Cum) £m	15,072	0.910	2,380									
Target £24,144m CEL		0.910	2,380									



Updates on Last Month:

- The Trust has reported a small underspend of £0.009m for May and is currently in line with the 2025-26 IMTP planning assumptions.
- The Trust is currently overachieving and expected at this stage to meet the Public Sector Payment Performance (PSP) target of paying 95% of Non-NHS invoices within 30 days for 2024-25.
- At this stage, the Trust is expecting to achieve the Capital Expenditure Limit (CEL).
- Currently several savings schemes are still RAG rated amber which poses a considerable risk to the delivery of the overall savings target.

Forecast / Next Month:

- The Trust is expecting to maintain a forecast breakeven outturn position for 2025-26, albeit with material risk associated.
- At this stage, the Trust is expecting to achieve the Capital Expenditure Limit (CEL) for 2025-26.
- Current expectation is that savings schemes will have agreed delivery plans and turn RAG rated green during quarter two, however there remains challenges in achieving this.

Action / Mitigation Underway:

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

Key Issues / Risks:

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

3. IMPACT ASSESSMENT

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

SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: For more information: https://www.gov.wales/socio-economic-duty-overview	Not required
TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT	
The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated. Please indicate whether any of the matters outlined in this report impact the Trust's Wellbeing goals: YES - Select Relevant Goals below	
If yes select the relevant goals: • A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities. ☐ • A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience. ☐ • A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health ☒ • A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances ☐ • A Wales of more Cohesive Communities - Attractive, viable, safe and well-connected communities. ☐ • A Wales of Vibrant Culture and Thriving Welsh Language -Promoting and protecting culture, heritage and the Welsh language, encouraging people to participate in the arts, and sports and recreation. ☐ • A Globally Responsible Wales – Consideration of whether an action may make a positive contribution to global well-being ☐	
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx	Not required - please outline why this is not required [

ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

4. RISKS

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



TRUST BOARD

FINANCE REPORT FOR THE PERIOD ENDED 31ST MAY 2025 (M2)

DATE OF MEETING	24/07/2025
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 – Deputy Director of Finance
PRESENTED BY	Matthew Bunce, Executive Director of Finance
APPROVED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SUMMARY	The attached report outlines the financial position and performance for the period to the end of May 2025. The three main issues are highlighted below: 1. Long Term Agreement (LTA) Financial values & Contract Rebase <u>LTA Financial Values</u> - The formal agreement of the Trust income planning assumptions has been summarised

	within respective Commissioner Long Term Agreements for 2025-26 with planning principles agreed on the 28th February 2025. The Trust has now in place signed LTAs with all organisations other than Hywel Dda UHB, as referenced below. • The Trust has agreed with Commissioners an uplift to LTA values of 1.77% which amounts to £1.548m in 2025-26 less £0.883m loss in income recurrently from Hywel Dda UHB. This is an increase of £0.400m from the £0.483m loss agreed with Hywel Dda at the IMTP planning stage. The Trust continues to face a further significant recurrent income risk with Hywel Dda UHB beyond 2025-26 based on the historic shares activity baseline funding of c£360k which will be removed recurrently in 2026-27. The Trust is assuming a 1.5% uplift to LTA values for 2026-27 and 2027-28. • 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 has 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. • To ensure Commissioners fund the total cost of Velindre running cancer services from 2026-27 there needs to be agreement from all Commissioners to change the commissioning principles for Velindre from 'historic shares' based on activity and NICE consumption in 2004-5 to a 'current activity' baseline and NICE consumption. How Commissioners decide to

	manage the financial impact (gain / loss) is for them to agree, but that should not prevent the Trust from moving to charging on current activity and consumption from 2026-27. However, it's important to note that without Commissioners collectively agreeing how the financial impact will be managed across Wales, the dispute between the Trust and Hywel Dda UHB will simply transfer to a dispute between the Trust and other Health Boards. 2. Integrated Medium Term Plan (IMTP) – Financial Plan / Forecast • The Trust submitted a balanced three year IMTP, covering the period 2025-26 to 2027-28 to Welsh Government on the 31 March 2025. • In order to achieve a balanced financial position, the savings target set for 2025-26 must be achieved, all anticipated income is received, and all risks along with any new emerging costs pressures must either be mitigated or funded at Divisional level or managed through the Trust reserves. • At the QSP Committee on 17/07/2025, the Executive Director of Finance (DOF) noted that since the month 2 Finance Report was produced, two new cost pressures had emerged that were not anticipated when the IMTP was developed: - A shortfall in funding for the increase in Employer's National Insurance contributions from 1st April 2025 due the availability of funding available to Welsh Government to pass through to NHS Wales. This has led to a £0.345m unfunded cost pressure in 2025-26 for the Trust. The recurrent value will be forecast when further information is provided by Welsh Government, but is expected to be higher. - The Welsh Risk Pool risk share contributions across NHS Wales has increased based on a revised forecast of cases crystalising in 2025-26. This has led to a £0.365m unfunded cost pressure.

	These new in year cost pressures of £0.710m will require funding from the Trust £0.500m emergency reserve, and the balance of c£0.210m funded from other non-recurrent reserves. The recurrent impact of these cost pressures will need to be funded from anticipated 2026-27 LTA funding. 3. Key Financial Targets / KPIs • The Trust has reported an underspend of £0.009m for May and at this stage is expected to maintain a forecast breakeven outturn position for 2025-26 albeit with some risk associated. • The Trust is currently overachieving and expected at this stage to meet the Public Sector Payment Performance (PSPP) target of paying 95% of Non-NHS invoices within 30 days for 2024-25. • At this stage the Trust is expecting to achieve the Capital Expenditure Limit (CEL) for 2025-26. • At month 2, several savings schemes were still RAG rated amber which posed a considerable risk to the delivery of the overall savings target. The expectation at that point was that that these schemes will have agreed delivery plans and turn RAG rated green during quarter two. The QSP Committee on 17th July 2025 was verbally informed by the DOF that Budget Holders in the Divisions and Corporate departments were expected to hold robust plans for delivery of the amber rated schemes, and if that was not the case, they were expected to find alternative savings schemes to implement and deliver. The DOF advised that the Executive management Board reviews performance delivery against savings schemes as part of the monthly financial performance review. • The Trust Board is advised that post completion of the month 2 report, savings schemes have been reviewed and are all now rated green. This update will be included within the month 3 report, and ongoing updates provided as is usual practice.

RECOMMENDATION / ACTIONS	The Trust Board is asked NOTE the contents of the May 2025 financial report and in particular: • The year to date and forecast revenue and Capital out turn position, and PSPP performance. • The latest position on LTA income for 2025-26 from our Commissioners. • The position with commissioners on the contract rebase agreement. • The latest position of the Trust savings schemes.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	Date
Executive Management Board	30/06/2025
Quality, Safety & Performance Committee	17/07/2025
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	

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

APPENDICES	
Appendix 1	Trust Finance Report – May 2025
Appendix 2	nVCC Finance Report – May 2025

1. SITUATION / BACKGROUND

- 1.1 The attached report outlines the financial position and performance for the period to the end of May 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	Year to date £m	Year End Forecast £m
Revenue	Variance	0.009	0.009	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	0.650	1.565	27.864
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	96.9%	97.9%	95.0%

2.2 Revenue Budget

At this stage of the financial year the overall revenue budget remains broadly in line with expectations as planned within the IMTP, with a projected forecast outturn position of breakeven however there are risks associated in achieving this.

The overall position against the profiled revenue budget to the end of May 2025 is an **underspend of £0.009m.**

Savings

Several saving schemes currently remain RAG rated amber which may impact on the ability to deliver a balanced position, and therefore it is extremely important that those schemes that have not yet gone live are reviewed by Divisional Directors and SMT / SLT to ensure that the schemes have identified responsible officers tasked with confirming by 30.6.2025 action plans are in place to deliver the savings to enable RAG rating to turn green or identified proposals for replacement schemes.

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

LTA Income

A new financial risk emerged last 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. This will remain a risk for 2025-26 with the current forecast predicting a c£0.500m shortfall against the full year target.

In addition, a new risk has emerged this year whereby the forecast activity income in relation to Radiotherapy Satellite Unit (RSU) at Nevill Hall Hospital is not expected to match the level of investment in workforce. This is currently under review, but present expectation is a shortfall of between c£0.500m and £0.750m during 2025/26 which is after mitigations are put in place such as holding vacancies.

LTA Contract Position

The formal agreement of the Trust income planning assumptions has been summarised within respective Commissioner Long Term Agreements for 2025-26 with planning principles agreed on the 28th February 2025 that included a 1.77% general uplift. Welsh Government required confirmation that all agreements had been formally signed by 12th June 2025, and on that date the Trust confirmed that signed LTAs are in place between the Trust and other organisations, with the exception of the LTA with Hywel Dda UHB.

The Trust has agreed with Commissioners an uplift to LTA values of 1.77% which amounts to £1.548m in 2025-26 less £0.883m loss in income recurrently from Hywel Dda UHB. This is an increase of £0.400m from the £0.483m loss agreed with Hywel Dda UHB at the IMTP planning stage. The Trust continues to face a further significant recurrent income risk with Hywel Dda UHB beyond 2025-26 based on the historic shares activity baseline funding of c£360k which will be removed recurrently in 2026-27. The Trust is assuming a 1.5% uplift to LTA values for 2026-27 and 2027-28.

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.

LTA Contract Rebase

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

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

2.3 PSPP Performance

During May 2025 the Trust (core) achieved a compliance level of **96.9%** (April 98.3%) of Non-NHS supplier invoices paid within the 30-day target. The Trust year to date compliance (including hosted) is **98.15%** compared to the target of 95%.

2.4 Reserves

The financial strategy for 2025-26 again includes an emergency reserve of £0.500m which is accommodated on the assumption that all expected income is received, planned savings schemes are delivered and new emerging cost pressures managed.

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

2.5 Financial Risks

There are several financial risks that could impact on the successful delivery of a balanced position for 2025-26, the material risks which have been flagged to WG and considered to

be either high or medium risk include the Non Delivery of Savings (amber schemes £0.360m), LTA income risk c(£0.500m), activity risk associated with the Radiotherapy Satellite unit (£0.500m - £0.750m), the Trust Commissioners not supporting service investment / Growth in VCS, the management of operational cost pressures and potential risk of the Trust not receiving full funding towards the increase in National Insurance (NI) which is currently being quantified but expected to be 15%.

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

2.6 Capital

All Wales Programme

The Trust has secured the majority of expected funding from WG in relation to the All Wales Programme for 2025/26. Those items that are outstanding such as Plasma for Fractionation are in process and under discussion with WG for acquiring funding this financial year.

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.

Discretionary Programme

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

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

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

3. IMPACT ASSESSMENT

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

If yes - please select all relevant goals: • Outstanding for quality, safety, and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development, and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐												
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) For more information: STRATEGIC RISK DESCRIPTIONS	08 - Trust Financial Investment Risk											
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Select all relevant domains below											
	<table> <tr> <td>Safe</td> <td>☒</td> </tr> <tr> <td>Timely</td> <td>☒</td> </tr> <tr> <td>Effective</td> <td>☒</td> </tr> <tr> <td>Equitable</td> <td>☒</td> </tr> <tr> <td>Efficient</td> <td>☒</td> </tr> <tr> <td>Patient Centred</td> <td>☒</td> </tr> </table>	Safe	☒	Timely	☒	Effective	☒	Equitable	☒	Efficient	☒	Patient Centred
Safe	☒											
Timely	☒											
Effective	☒											
Equitable	☒											
Efficient	☒											
Patient Centred	☒											
QUALITY IMPACT ASSESSMENT	Not required - not a strategic decision											
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: For more information: https://www.gov.wales/socio-economic-duty-overview	Not required											

TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT	
The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated. Please indicate whether any of the matters outlined in this report impact the Trust's Wellbeing goals: YES - Select Relevant Goals below	
If yes select the relevant goals: • A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities. ☒ • A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic, and ecological resilience. ☐ • A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health ☐ • A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances ☐ • A Wales of Cohesive Communities - Attractive, viable, safe, and well-connected communities. ☐ • A Wales of Vibrant Culture and Thriving Welsh Language -Promoting and protecting culture, heritage, and the Welsh language, encouraging people to participate in the arts, and sports and recreation. ☐ • Globally Responsible Wales – Consideration of whether an action may make a positive contribution to global well-being ☐	
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	The Trust reported a revenue financial position of an underspend of £0.009m for May 2025, which is currently in line with the IMTP plan.
EQUALITY IMPACT ASSESSMENT	Not required - please outline why this is not required
For more information: https://nhs.wales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx	
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

4. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	Individual financial risks are discussed in section 2.7 of the report and the overall financial sustainability and value risk assessment is reflected in the Trust Assurance Framework (TAF).
WHAT IS THE CURRENT RISK SCORE	16
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	Recipients are provided with detail on the risks and any actions required from them to mitigate / remove the risk are highlighted.
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Individual risks to be managed with the financial envelope for 2025-26. Overall financial and sustainability risks reported and managed through the TAF.
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Yes - please detail below
	Availability of resources to implement work / changes needed and successful negotiations with Commissioners.
All risks must be evidenced and consistent with those recorded in Datix	



GIG
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WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust



FINANCIAL PERFORMANCE REPORT

FOR THE PERIOD ENDED 31 MAY 2025

**TRUST BOARD
24/07/2025**

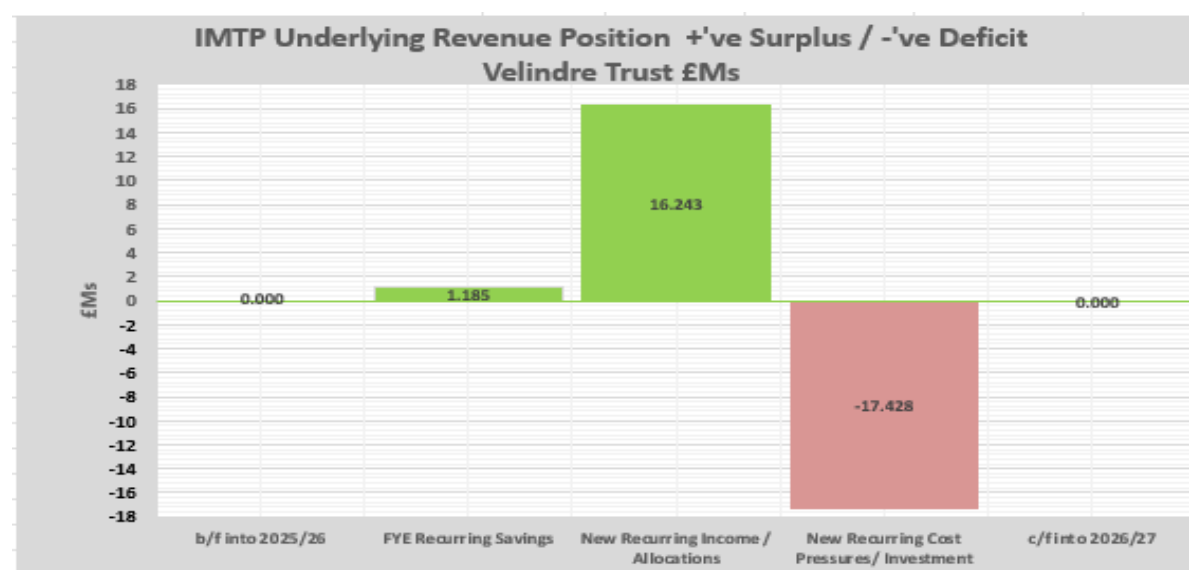
1. Introduction

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

2. Background / Context

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

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



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

3. Executive Summary

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

(Figures in parenthesis signify an adverse variance against plan)

Table 1 - Key Targets

	Unit	Current Month £m	Year to date £m	Year End Forecast £m
Revenue	Variance	0.009	0.009	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	0.650	1.565	27.864
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	96.9%	97.9%	95.0%

Performance against Planned Savings Target

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

Revenue

The core Trust has reported **an underspend of £0.009m** position for May 2025, in line with a yearend forecast outturn of **breakeven**, however there are risks associated in achieving this which are provided later in the report.

The Trust has agreed with Commissioners an uplift to LTA values of 1.77% which amounts to £1.548m in 2025-26 less £0.883m loss in income recurrently from Hywel Dda UHB. This is an increase of £0.400m from the £0.483m loss agreed with Hywel Dda UHB at the IMTP planning stage. The Trust continues to face a further significant recurrent income risk with Hywel Dda UHB beyond 2025-26 based on the historic shares activity baseline funding of c£360k which will be

removed recurrently in 2026-27. The Trust is assuming a 1.5% uplift to LTA values for 2026-27 and 2027-28.

Capital

The approved Capital Expenditure Limit (CEL) for the year ended 31st March 2026 is **£24.344m**. This represents all Wales Capital funding of **£22.344m**, and Discretionary funding of **£2.000m**. The Trust reported total Capital spend to 31st May 2025 is £1.565m, with all funds expected to be fully spent during 2025-26. Some funding for All Wales schemes is still to be confirmed by Welsh Government as can be seen where there are nil values in the “opening CEL” column below.

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

	Opening CEL	Movement	Current CEL
	£m	£m	£m
All Wales Capital:			
nVCC Enabling Works	4.012	-0.161	3.851
nVCC Enabling Works QRA	0.000	0.000	0.000
nVCC Project	11.059	0.000	11.059
nVCC Project QRA - MIM	0.000	0.161	0.161
nVCC Project QRA - Public Sector	0.000	0.000	0.000
Integrated Radiotherapy Solution (IRS)	2.040	0.000	2.040
IRS Radiotherapy Satellite Centre (RSC)	1.200	0.000	1.200
Whitchurch Hospital Site Disposal	0.840	0.000	0.840
Whitchurch Hospital Site Disposal - contingency	0.000	0.000	0.000
WBS HQ Continuity Business Case OBC/FBC fees	2.142	0.000	2.142
WBS Fleet Replacement Programme	0.364	0.000	0.364
DPIF - RISP	0.000	0.000	0.000
DPIF - Blood Establishment Computer System (BECS) replacement	0.416	0.000	0.416
DPIF - Welsh Histocompatibility & Immunogenetics Service (WHAIS)	0.185	0.000	0.185
DPIF - Electronic Prescribing & Medicines Administration (EPMA)	0.086	0.000	0.086
WBS Plasma for Fractionation	0.000	0.000	0.000
Total All Wales Capital Programme	22.344	0.000	22.344
Discretionary Capital	2.000	0.000	2.000
Total CEL	24.344	0.000	24.344

PSPP

During May 2025 the Trust (core) achieved a compliance level of **96.9%** (April 98.3%) of Non-NHS supplier invoices paid within the 30-day target. The Trust year to date compliance (including hosted) is **98.15%** compared to the target of 95%.

Efficiency / Savings

An in-depth review of the Trust’s savings plan was undertaken during the IMTP process. For 2025-26 a savings target has been set, split across the Trust’s core divisions as follows:

Savings Plan by Division	Target £m	Identified (Green) £m	Savings Target Gap £m
Welsh Blood Service	0.705	0.555	(0.150)
Velindre Cancer Centre	1.043	0.593	(0.450)
Corporate Services	0.302	0.302	0.000
RD&I	0.230	0.230	0.000
Total	2.280	1.680	(0.600)

The overall Trust savings performance as of May 2025 shows the in month planned savings of **£0.149m was achieved**.

Currently several savings schemes are still RAG rated amber and poses a significant risk £(0.360)m to the delivery of the overall savings target, current expectation is that these schemes will turn green during quarter two, however there remain challenges in achieving this.

Revenue Position

Cumulative				Forecast		
Breakeven				Breakeven		
Type	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)	Full Year Budget (£m)	Full Year Forecast (£m)	Forecast Variance (£m)
Income	(43.210)	(43.474)	0.264	(262.875)	(262.875)	0.000
Pay	16.998	17.105	(0.107)	102.196	102.196	0.000
Non Pay	26.212	26.359	(0.147)	160.679	160.678	0.000
Total	0.000	(0.009)	0.009	0.000	0.000	0.000

The overall position against the profiled revenue budget to the end of May 2025 is **an underspend of £0.009m**, with a yearend outturn forecast position of **breakeven**.

4.1 Revenue Position Highlights / Key Issues

Underlying Position

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

The formal agreement of the Trust income planning assumptions has been summarised within respective Commissioner Long Term Agreements for 2025-26 with planning principles agreed on the 28th February 2025 that included a 1.77% general uplift. Welsh Government required confirmation that all agreements had been formally signed by 12th June 2025, and on that date the Trust confirmed that signed LTAs are in place between the Trust and other organisations, with the exception of the LTA with Hywel Dda UHB. As previously mentioned, the Trust has had to agree a significant loss in recurrent income which will now be reflected in a revised LTA to be recirculated for signature.

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

Commissioners are expected to pass through, as additional income to the LTA, the 2024-25 Agenda for Change Medical and Senior Manager (VSM) staff costs as per the Welsh Government Pay award matrix. The 2025-26 pay inflation is expected to be funded directly by Welsh Government based on actual staff in post (any shortfall such as staff increments and use of bank staff will need be met by discretionary uplift, additional savings or absorbed by Divisions). Funding from Welsh Government in respect of the additional Employer's National Insurance Contributions from April 2025 is expected, although they have been clear there is a shortfall in the funding they have available and therefore this is recognised as a new risk to the Trust this month.

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

The Trust has been in dialogue with Welsh Government Officials regarding continued funding of £0.867m to cover the cost of the SDEC IO Toxicity Clinics and Ambulatory care services which has always been considered recurrent funding by the Trust in its Financial Plan, given that the costs are recurrent and the service which has been running for a number of years clearly required substantive staffing when first established. WG Officials have confirmed funding for 2025-26 which is positive, however the Trust will need funding post 2025-26 and will remain a risk until the funding is secured. The Trust has therefore asked WG Officials for confirmation as to whether the funding will be provided on a recurrent basis.

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

VCS Long Term Agreement (LTA) Contract Performance

The Trust has agreed with Commissioners an uplift to LTA values of 1.77% which amounts to £1.548m in 2025-26 less £0.883m loss in income recurrently from Hywel Dda UHB. This is an increase of £0.400m from the £0.483m loss agreed with Hywel Dda UHB at the IMTP planning stage. The Trust continues to face a further significant recurrent income risk with Hywel Dda UHB beyond 2025-26 based on the historic shares activity baseline funding of c£360k will be removed recurrently in 2026-27. The Trust is assuming a 1.5% uplift to LTA values for 2026-27 and 2027-28.

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

Wales, the dispute between the Trust and Hywel Dda UHB will simply transfer to a dispute between the Trust and other Health Boards.

A new risk has emerged this year whereby the forecast activity income in relation to Velindre @ Nevill Hall Radiotherapy Unit is not expected to match the leave of investment in workforce. This is currently under review, but present expectation is a shortfall of between c£0.500m and £0.750m during 2025/26 which is after mitigations are put in place such as holding vacancies.

The tables below set out the projected year end LTA income performance based on data to 30th April 2025 (note the data supplied is one month behind the rest of this report due to reporting timelines) by Commissioner and main service delivery areas. The forecast increase in marginal income represents activity performance in excess of 2019/20 baseline contracted activity volumes.

The IMTP planned overperformance against 2019/20 baseline contract levels is £7.061m (this is a planned increase in contract income of £0.709m on 2024-25 out-turn), split across organisations as shown below, against which there is a forecast increase from IMTP of £0.341m as at month 1:

Commissioner	LTA Baseline Growth Assumptions	Forecast Growth as at Month 1	Forecast Variance
Hywel Dda (7A2)	0.015	-0.052	-0.067
Swansea Bay (7A3)	0.014	-0.022	-0.036
Cardiff & Vale (7A4)	2.520	2.593	0.074
Cwm Taf Morgannwg (7A5)	1.937	1.902	-0.035
Aneurin Bevan (7A6)	2.462	2.959	0.497
Powys (7A7)	0.120	0.180	0.060
NHS Wales Joint Commissioning Committee	-0.007	-0.159	-0.152
Forecast LTA Activity Performance Position M1	7.061	7.402	0.341

As highlighted elsewhere in this report, there is a potential risk that LTA marginal income from cancer activity growth will not match the level of investment into services. Although this data relates to the first month of the year only, and shows some overachievement of income, due to the volatility previously seen, the risk of recognising full forecast overperformance is being held at this point in the year to IMTP planned levels. The activity will be closely monitored throughout the year and forecasts / risks updated regularly.

Comparison to Base Contract Value per Commissioner	Base Contract Value £m	Outturn Variance £m	Outturn £m	Variance (%)
Hywel Dda (7A2)	0.916	-0.052	0.82	-6%
Swansea Bay (7A3)	0.448	-0.022	0.437	-5%
Cardiff & Vale (7A4)	15.809	2.593	18.749	16%
Cwm Taf Morgannwg (7A5)	13.975	1.902	16.298	14%
Aneurin Bevan (7A6)	19.589	2.959	22.926	15%
Powys (7A7)	1.107	0.18	1.269	16%
Joint Commissioning Committee	2.259	-0.159	2.1	-7%
Total	54.104	7.401	62.599	14%

Financial Performance Per Contract Currency	Base Contract Value £m	Outturn Variance £m	Outturn £m	Variance (%)
Radiotherapy Planning	5.963	0.101	6.064	2%
Radiotherapy Delivery	13.641	-0.183	13.458	-1%
Nuclear Medicine	1.041	-0.041	1.000	-4%
Radiology Imaging	3.180	0.664	3.844	21%
Preparation for Systemic Anti-Cancer Therapy	2.946	0.701	3.647	24%
Delivery of Systemic Anti-Cancer Therapy	6.952	1.979	8.931	28%
Ambulatory Care Services	1.419	0.377	1.796	27%
Outpatient Services	10.558	3.599	14.157	34%
Inpatient Admitted Care	6.223	0.204	6.427	3%
Contract Adjustments	2.180	0.000	3.274	0%
Total	54.104	7.402	62.599	14%

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 Welsh Blood Service business cases to JCC relating to key service areas for consideration that help either maintain or improve the safety of the supply chain for the transfused patients in Wales. These cases included:

1. £0.196m for additional capacity 24/7 for the Red Cell Immunohaematology laboratory
2. £0.070m for implementation of Haemoglobin S (HbS) testing to comply with national guidance
3. £0.675m for investment in component development research laboratory capacity to ensure validation and development work required to meet regulations e.g. requirement to replace blood packs which currently contain plasticizer Di (2 ethylhexyl) phthalate (DEHP) due to safety concerns
4. £0.194m for introduction of new Buccal swab testing and testing pathway for recruitment of stem cell donors to expand Welsh Bone Marrow Donor Registry panel
5. £0.323 for additional blood collection capacity to ensure the sufficiency of supply of blood products in Wales can be delivered.

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

The Trust intends to write separately 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 necessary to ensure the safety and quality of the Welsh Blood supply chain.

The Trust has assumed that Welsh Government and / or Joint Commissioning Committee (JCC) will fund both the Phase 2 (Option 2 Apheresis collection of Plasma) WBS Plasma for Medicines (Fractionation) business case and the BECS blood management system business case.

Pay Highlights / Key Issues

As referenced above, Commissioners are expected to pass through, as additional income to the LTAs, the 2024-25 Agenda for Change Medical and Senior Manager (VSM) staff costs as per the Welsh Government Pay award matrix. The 2025-26 pay inflation is expected to be funded directly by Welsh Government based on actual staff in post (any shortfall such as staff increments and use of bank staff will need be met by discretionary uplift, additional savings or absorbed by Divisions).

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

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

Non Pay Key Issues

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

The Trust again holds an emergency reserve of £0.500m in case required to support non-recurrent expenditure which cannot be managed or migrated at Divisional level during the period.

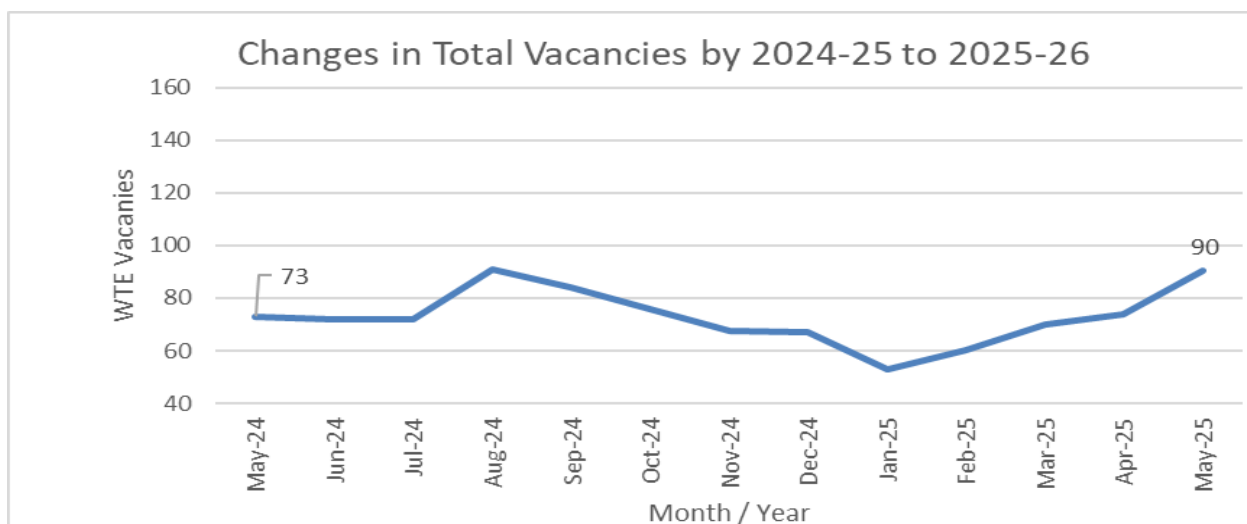
The Trust reserves and previously agreed unallocated investment funding is held in month 12 and will be released into the position to match spend as it occurs throughout the year.

4.2 Pay Spend Trends (Run Rate)

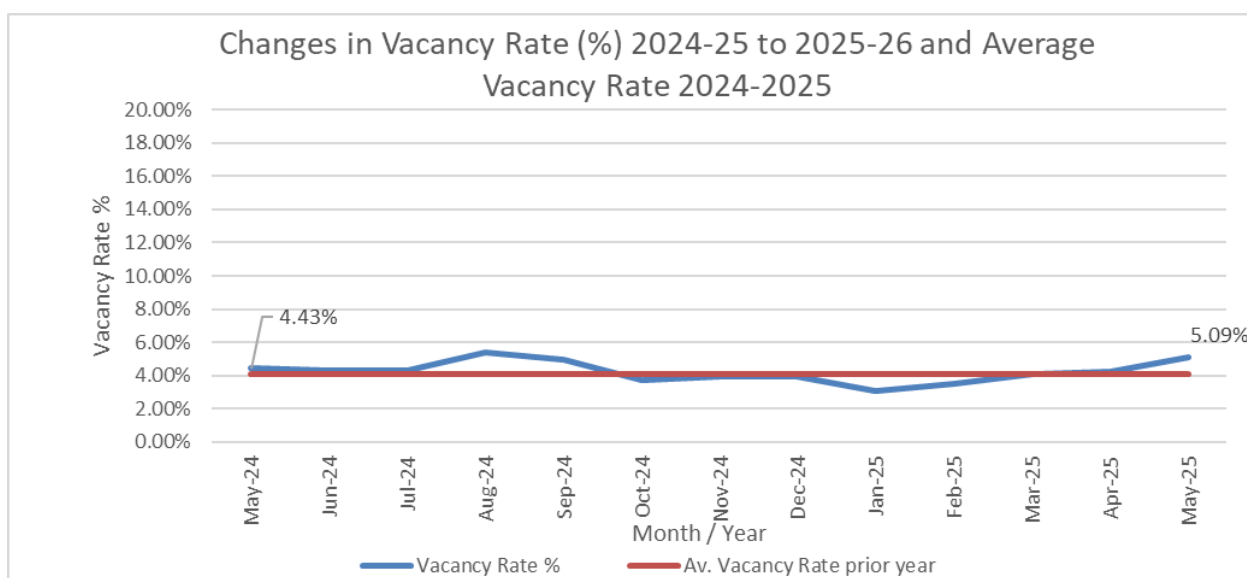
As of May 2025, the current staff in post is 1,685 WTE (March 1,687). The number of vacancies is 90 WTE (April 74), which represents a vacancy rate of 5.09% (4.2% April) against the budget of 1,775 WTE. The vacancy gap is largely being met using agency staff, overtime, or bank staff, and is also supporting each of the division's vacancy factor savings target.

The largest number of vacancies are seen within VCS: 58 WTE. This is an increase from the 47 WTE reported in April, largely due to the addition of posts funded within the Trust's IMTP. Many of the vacancies are expected to be recruited by September, including 9 WTE in the Radiotherapy Satellite Unit.

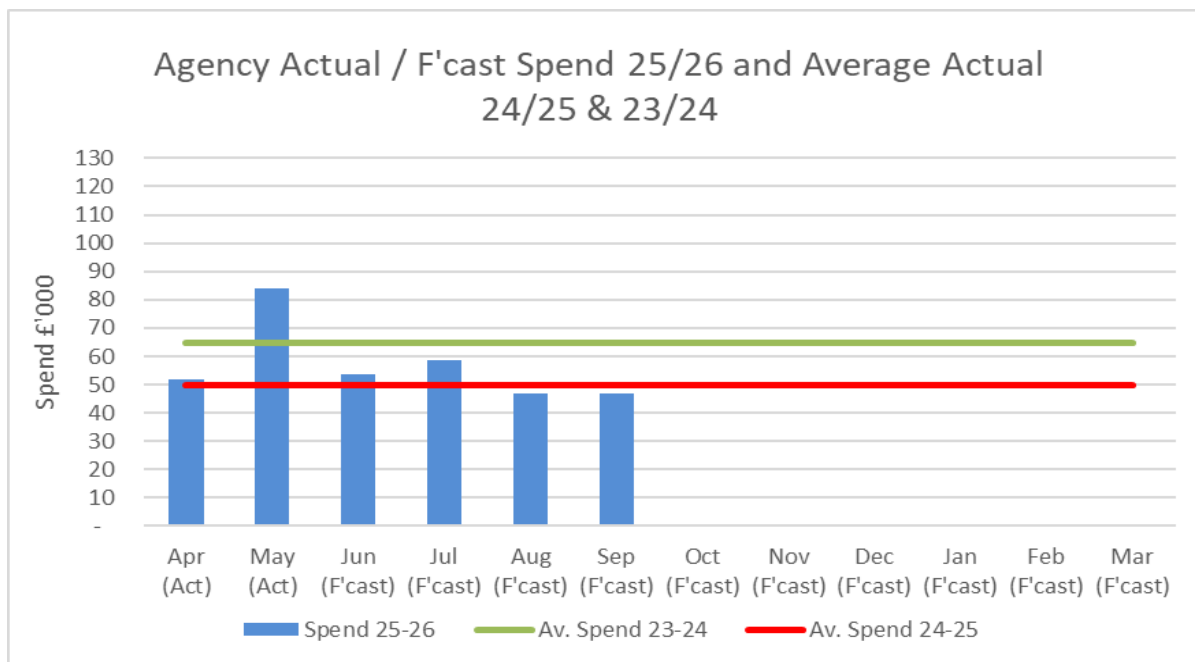
WBS currently are reporting 11 WTE vacancies. 4 WTE of these are currently being recruited to the Donor Contact Centre, with the remainder single vacancies across the service.



The total Trust vacancies as of May 2025 are 90 WTE (April 74 WTE): VCS (58 WTE), WBS (11 WTE), Corporate (6 WTE), R&D (10 WTE), nVCC (1 WTE) and HTW (4 WTE).



The spend on agency for May 2025 was **£0.084m** (April £0.052m) with a year end forecast currently of **£0.342m** (£0.596m 2024/25). In line with WG expectation and the Trust IMTP planning assumptions the ambition is to remove the reliance on use of agency from October 2025, however there will be challenges in achieving this.



The largest area of agency spend relates to Allied Health Professionals, with agency staff utilised to support additional Capacity in Radiotherapy linked to the Radiotherapy Satellite unit (SRU) at Nevill hall hospital, and Therapies to support sickness. There continues to be some reliance on Admin and Clerical to support vacancies, with the ambition that agency support in this area will cease as posts continue to be filled.

The largest area of agency spend relates to Allied Health Professionals, with agency staff utilised to support additional Capacity in Radiotherapy linked to the Radiotherapy Satellite unit (SRU) at Nevill hall hospital, and Therapies to support sickness. There continues to be some reliance on Admin and Clerical to support vacancies, with the ambition that agency support in this area will cease as posts continue to be filled. The forecast is therefore held in line with the planning assumptions in the 2025-26 IMTP. However, this is under review with the likelihood agency costs may remain past September.

Compared to April, May has seen increases in Admin and Clerical and Allied Health Professional agency costs. The Admin and Clerical increase is due to lower estimates than required in April that have been adjusted in May, and the Allied Health Professional increase is due to an additional Radiotherapy post required in May and linked to the above. Future month forecasts are in line with that expected from June onwards.

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.

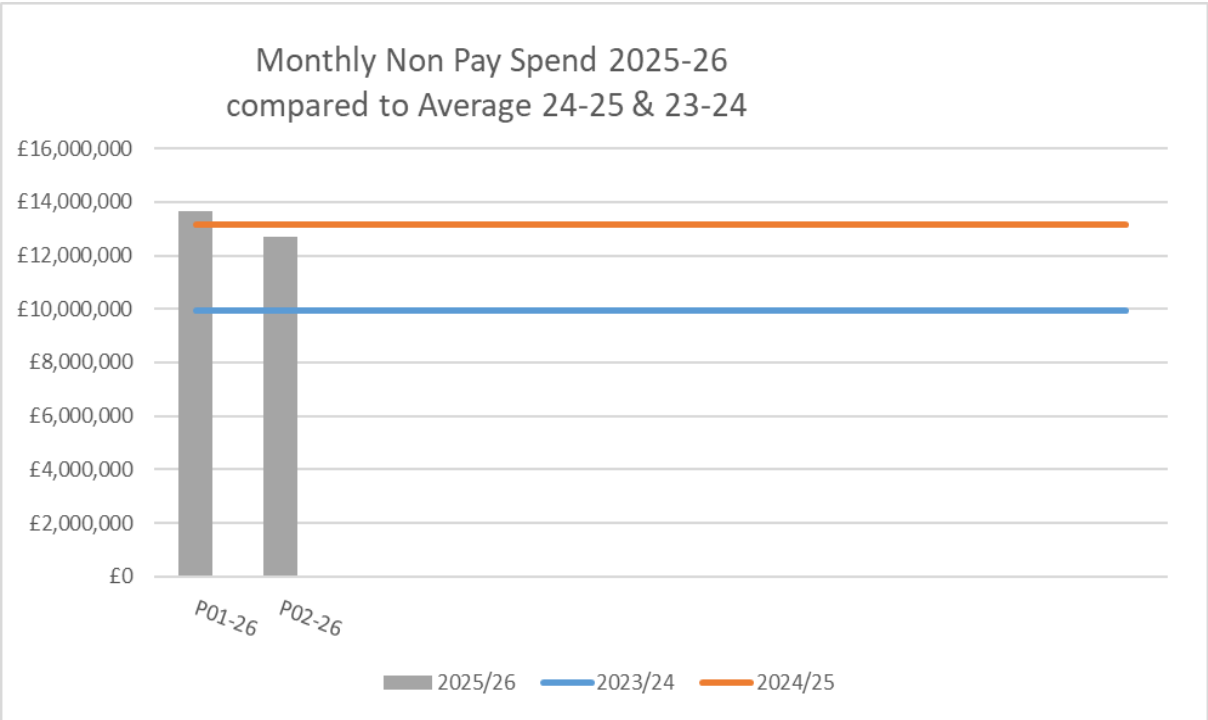
4.3 Non Pay

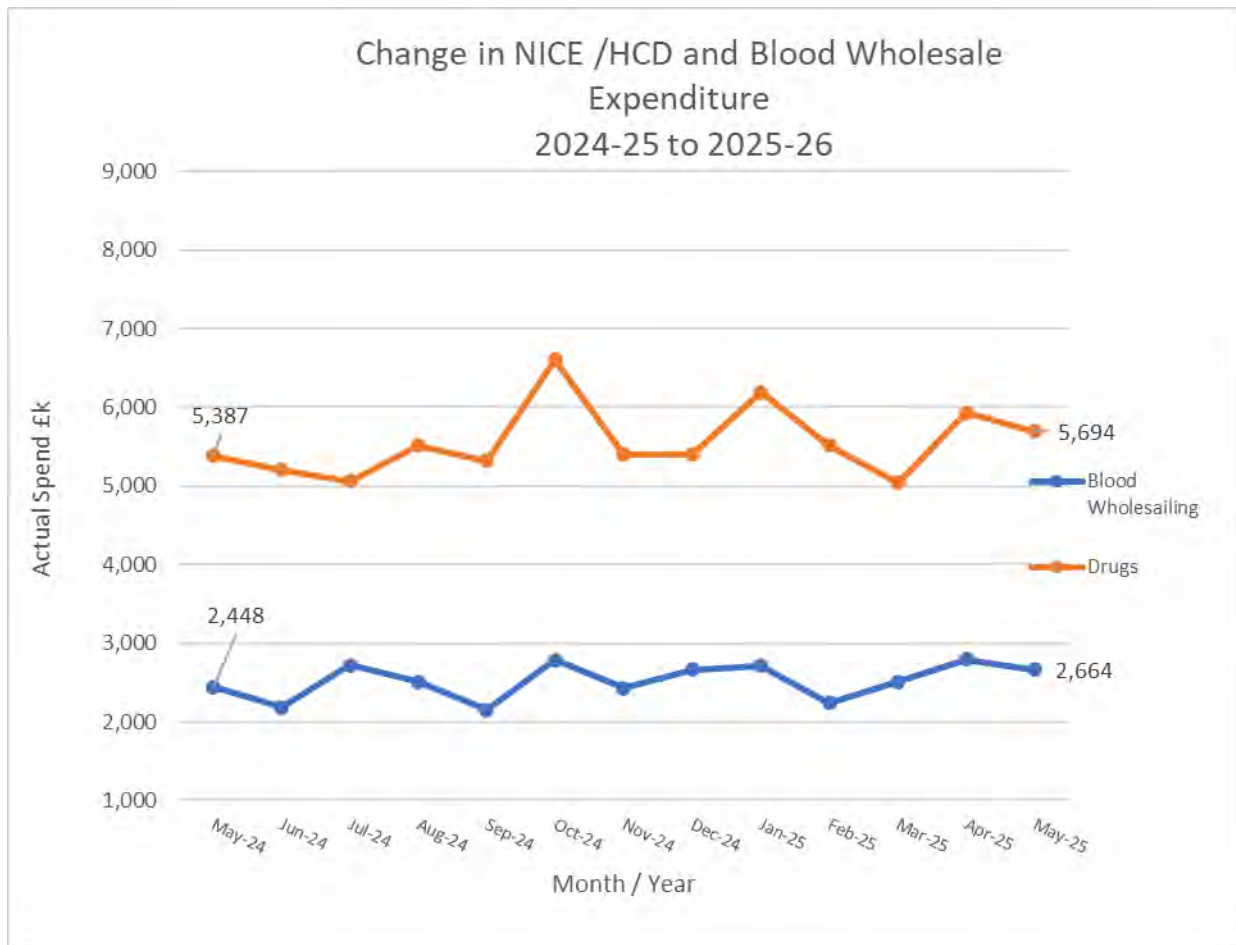
Non-Pay average spend for 2024/25 was £13.1m per month which was a £3.3m increase from the previous whole year. The largest movement was in non-cash as a result of the accelerated depreciation charge on the VCS hospital and the impairment charges associated with the nVCC Asda works (£1.8m average per month). NICE and HCD drugs (£0.7m) and blood wholesale costs (£0.5m) increased which were offset by income recharges to Health Boards. Other small movements included an increase in Clinical Services & Supplies (£0.2m) and General Supplies,

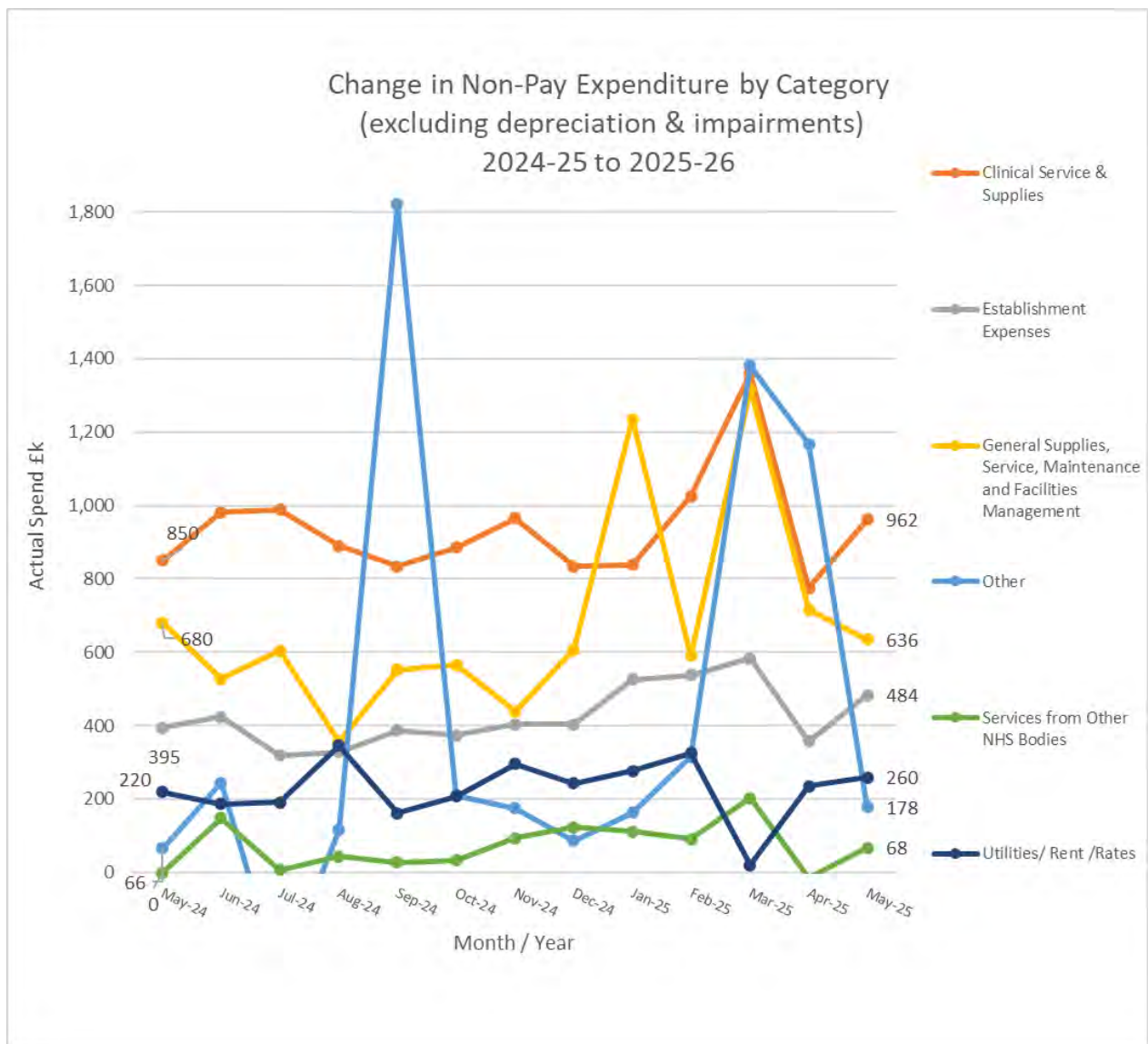
Service, Maintenance & Facilities (£0.1m). All other costs remained fairly static when compared with the year on year average.

The non-pay average monthly spend for 2025/26 to date currently stands at £13.18m. NICE and HCD drugs (£0.026m) and blood wholesale average costs to date (£0.25m) have increased which will be offset by an income increase via recharges to Health Boards. Non-Cash (Impairment charges) are lower by (-£0.76m) due to the charge incurred on the nVCC Asda works during 2024/25. 'Other' charges have increased by £0.35m relating to a provision for legal costs funded via WRP. Clinical Services (-£0.02m) and Establishment Expenses (-£0.07m) are currently lower compared to last year's monthly average which is generally expected during the early part of the financial year following the prior year end spend.

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







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

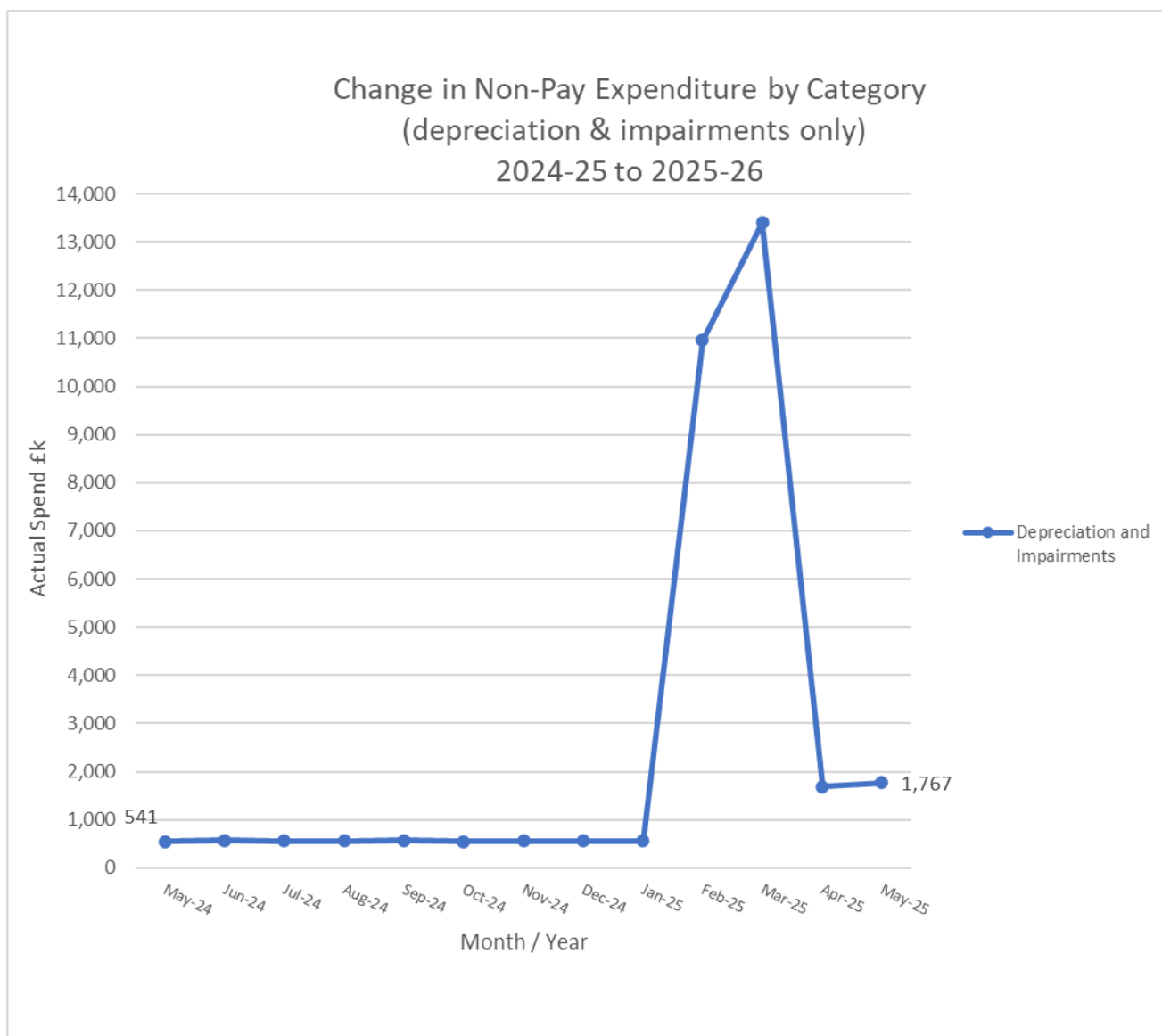
Other spend period 6 2024-25 relates to a provision for legal fees that was incorrectly accounted for as income at the end of 23-24.

The increase in General Supplies, Maintenance and facilities management during December 2024 was 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 was caused by an adjustment that was processed to ensure full year costs were accurately reflected and no charges for 2025-26 billed in advance of 1st April 2025 were included.

The increase in other spend in March 2025 relates to an increase in a provision for future cessium disposal costs. The reduction seen in May 2025 relates to a provision for legal costs of £1.184m which was made in error in April and has been corrected in May.

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



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

4. Savings

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

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

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

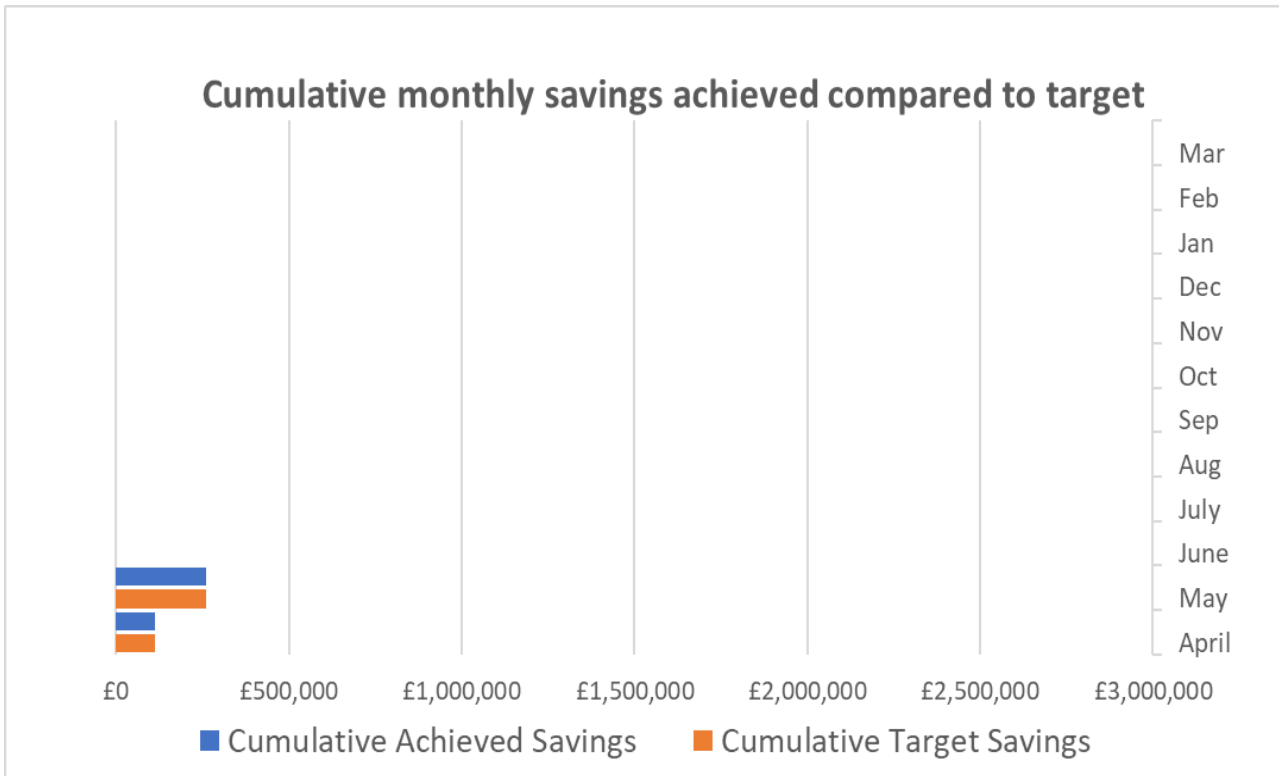
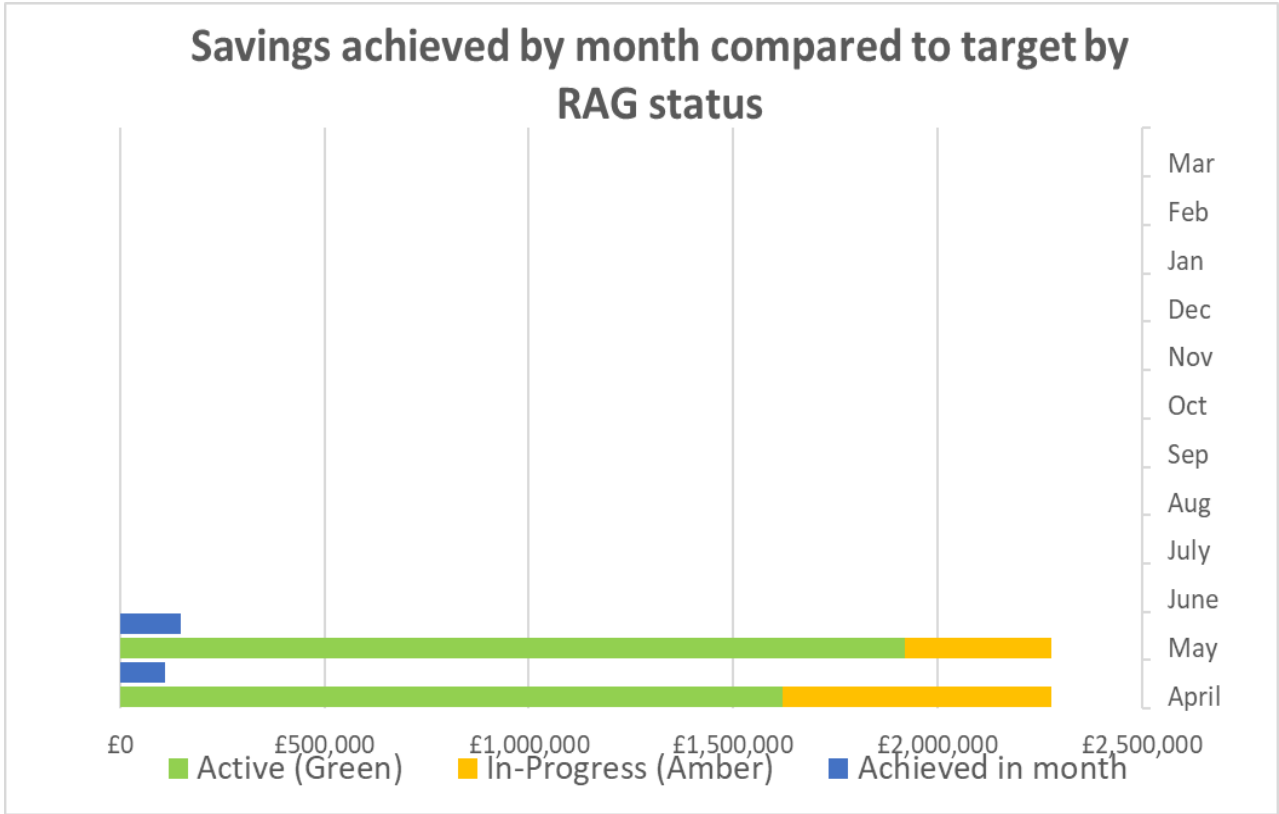
Currently several savings schemes are still RAG rated amber and poses a significant risk £(0.360)m to the delivery of the overall savings target, whilst current expectation is that these schemes will turn green during quarter two, however there remain challenges in achieving this.

Performance

The Trust savings performance as of May is an achievement of £0.260m against a plan of £0.260m. Current expectation is that the annual savings target will be achieved albeit with some risk due to several schemes currently still RAG rated amber.

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

ORIGINAL PLAN					TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	F'cast Full Year £000	F'cast Variance Full Year £000
VCS TOTAL SAVINGS					1,043	84	84	0	1,043	0
						100%			100%	
WBS TOTAL SAVINGS					705	106	106	0	705	0
						100%			100%	
CORPORATE TOTAL SAVINGS					302	50	50	0	302	0
						100%			100%	
RD&I TOTAL SAVINGS					230	20	20	0	230	0
						100%			100%	
TRUST TOTAL SAVINGS					2,280	260	260	0	2,280	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 Premium Red VCS	NR		Green	15	2	2	0	15	0	
Establishment Vacancy Control	VCS	R	Green	150	25	25	0	150	0	
Establishment Vacancy Control	VCS	NR	Green	100	16	16	0	100	0	
Procurement Supply Chain Contracting (VCS	R		Amber	50	0	0	0	50	0	
Review of SLAs to mitigate / reduce serv	VCS	R	Green	30	5	5	0	30	0	
3rd party SACT provision (medicines at IVCS	R		Green	150	13	13	0	150	0	
3rd party SACT provision (medicines at IVCS	NR		Green	70	12	12	0	70	0	
Establishment Vacancy Control	WBS	R	Green	100	16	16	0	100	0	
Procurement Supply Chain Contracting (WBS	R		Amber	100	0	0	0	100	0	
Optimised level of stock retention	WBS	NR	Green	150	50	50	0	150	0	
Demand planning: collections (aspheres	WBS	R	Green	40	6	6	0	40	0	
Demand planning: processing volumes	WBS	NR	Green	60	10	10	0	60	0	
Process efficiencies	WBS	R	Amber	30	0	0	0	30	0	
Process efficiencies	WBS	NR	Amber	20	0	0	0	20	0	
Establishment Vacancy Control	Corporate	R	Green	50	9	9	0	50	0	
Energy cost reduction	Corporate	R	Green	85	14	14	0	85	0	
Establishment Vacancy Control	RD&I	R	Amber	30	0	0	0	30	0	
Establishment Vacancy Control	RD&I	NR	Amber	50	0	0	0	50	0	
Add Establishment Vacancy Control	VCS	NR	Green	128	11	11	0	128	0	
Add Establishment Vacancy Control	WBS	NR	Green	55	10	10	0	55	0	
Add Establishment Vacancy Control	Corporate	NR	Green	67	10	10	0	67	0	
Add Establishment Vacancy Control	RD&I	NR	Amber	30	0	0	0	30	0	
Total Saving Schemes				1,560	209	209	0	1,560	0	
Income Generation										
Private Patients Increased Fees Upon Re VCS	R		Green	150	0	0	0	150	0	
Private Patients Income Overachieveme	VCS	NR	Green	150	0	0	0	150	0	
Maximising income - operational service	VCS	R	Amber	50	0	0	0	50	0	
Sale of Plasma	WBS	R	Green	50	5	5	0	50	0	
Interest on bank income above budget	Corporate	NR	Green	100	17	17	0	100	0	
R&D Commercial Income Generation	RD&I	R	Green	120	20	20	0	120	0	
Sale of Plasma	WBS	NR	Green	100	9	9	0	100	0	
Total Income Generation				720	51	51	0	720	0	
TRUST TOTAL SAVINGS					2,280	260	260	0	2,280	0
						100%			100%	



5. Reserves

The financial strategy for 2025-26 again includes an emergency reserve of £0.500m which is accommodated on the assumption that all expected income is received, planned savings schemes are delivered and new emerging cost pressures managed.

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

6. End of Year Forecast / Risk & Opportunity Assessment

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

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

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

LTA Contract Activity Income – *likelihood: medium, value £1m - £1.250m*

As previously noted, a financial pressure emerged in 2024-25 whereby LTA marginal income from cancer activity growth did not match the level of investment into services. Whilst, in the final few months of 2024-25, performance did improve, an underachievement of £0.240m was reported against the target which was managed within the overall Trust financial position. The position will be tightly managed in 2025-26 and any financial impact identified and mitigated as far and as early as possible. At this stage, c£0.500m underachievement (considered appropriate based on the underachievement seen in 2024-25) is considered as a medium risk to the position, reflective of the 2024-25 legacy risk carried forward of mismatched contract income to investment and further potential mismatch in 2025-26. Whilst month 1 forecast out-turn marginal income is presently in excess of IMTP expectation, the mitigation of 2024-25 legacy risk is the priority allocation of income received above planned levels, and secondly to support the income shortfall projection for the Velindre @ Nevill Hall Radiotherapy Unit.

Velindre @ Nevill Hall Radiotherapy Unit Income Shortfall – *likelihood: medium, value £0.500m-£0.750m*

In addition, a new risk has emerged this year whereby the forecast activity income in relation to Velindre @ Nevill Hall Radiotherapy Unit is not expected to match the level of investment in workforce. This is currently under review, but present expectation is a shortfall of between c£0.500m and £0.750m during 2025-26 (in addition to that outlined in relation to LTA Contract Activity outlined above) which is after mitigations are put in place such as holding of vacancies.

Commissioners not supporting Service Investment / Growth in VCS - *likelihood: medium, value £1.456m*

As described earlier in this report, several service growth investments have been presented to the Trust commissioners, with early indication that only the SACT Treatment Capacity Expansion will be considered for funding support. 2025/26 marginal income growth held to support service investment.

The Trust has received confirmation from JCC that they will not fund any of the WBS Business cases which were submitted to JCC as part of the IMTP process. Funding now sought via Welsh Government following recommendations from the IBI report. A financial risk of c£1.456m is estimated.

Non-Delivery of Savings - likelihood: medium, value £0.360m

The Trust has identified £2.280m of Savings and Income Generation to be achieved during 2025-26 as part of the IMTP. This savings target has been set to ensure that the Trust has the ability to mitigate against the significant cost pressures with the service.

Currently several savings schemes are still RAG rated amber and poses a significant risk £(0.360)m to the delivery of the overall savings target, whilst current expectation is that these schemes will turn green during quarter two, there remains challenges in achieving this.

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

There are several cost pressures that are already within the service which are expected to be managed in line with normal budgetary control procedures or through utilisation of the Trust reserve. However, due to the current demands on the service there is a small risk that these current pressures may be beyond divisional control.

Employer's Increase in National Insurance Contributions - likelihood: medium, value £0.140m

The Trust is recognising a new risk from May in relation to the uncertainty of fully matched funding from Welsh Government for the increased Employer's National Insurance costs for 2025-26. Since the May position was closed, Welsh Government have confirmed they have received funding from UK Treasury of 86% and will increase that by a further 7% from their reserves on a non-recurrent basis in 2025-26. For the Trust, this leaves a shortfall in funding estimated as £0.140m in 2025-26 and £0.280m 2026-27.

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

Opportunities

Vacancy Turnover - likelihood: medium, value £0.400m

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

Emergency Reserve - likelihood: medium, value £0.500m

It is important that the Trust keeps a reserve for emergency cost pressures which may arise over the course of the year, however, if this reserve is not required during 2025-26 then the Trust may be in a position later in the year to release this funding on a non-recurrent basis.

Overachievement of Bank Interest - likelihood: low, value £0.500m

The overachievement this year is likely to be less than in previous years as interest rates have stated to reduce.

Microsoft VAT Benefit - *likelihood: medium, value £0.088m*

The potential release of a provision by DHCW to the Trust may result in an opportunity of £0.088m that would be reported as an Accountancy Gain.

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 2026/27 £m	YTD Spend £m	Budget Remaining @ M2 £000s	F'cast Spend 2025/26 £m	Year End Variance 2025/26 £m
All Wales Capital Programme					
nVCC Enabling Works	4.012	0.538	3.474	4.225	(0.213)
nVCC Enabling Works QRA	0.000	0.000	0.000	0.528	(0.528)
nVCC Project	11.059	0.823	10.236	6.567	4.492
nVCC Project QRA - MIM	0.000	0.000	0.000	6.237	(6.237)
nVCC Project QRA - Public Sector	0.000	0.000	0.000	1.374	(1.374)
Integrated Radiotherapy Solution (IRS)	2.040	0.000	2.040	1.400	0.640
IRS Radiotherapy Satellite Centre (RSC)	1.200	0.169	1.031	1.200	0.000
Whitchurch Hospital Site Disposal	0.840	0.015	0.825	0.840	0.000
Whitchurch Hospital Site Disposal - contingency	0.000	0.000	0.000	0.300	(0.300)
WBS HQ Continuity Business Case OBC/FBC fees	2.142	0.000	2.142	2.142	0.000
WBS Fleet Replacement Programme	0.364	0.000	0.364	0.364	0.000
DPIF - RISP	0.000	0.000	0.000	0.000	0.000
DPIF - Blood Establishment Computer System (BECS) replacement	0.416	0.000	0.416	0.416	0.000
DPIF - Welsh Histocompatibility & Immunogenetics Service (WHAIS)	0.185	0.010	0.175	0.185	0.000
DPIF - Electronic Prescribing & Medicines Administration (EPMA)	0.086	0.000	0.086	0.086	0.000
WBS Plasma for Fractionation	0.000	0.000	0.000	0.000	0.000
Total All Wales Capital Programme	22.344	1.555	20.789	25.864	(3.520)
Discretionary Capital	2.000	0.010	1.990	2.000	0.000
	24.344	1.565	22.779	27.864	(3.520)

The approved 2025-26 Capital Expenditure Limit (CEL) for the year ended March 2026 is currently £24.344m (2024-25 £35.076m). This includes All Wales Capital funding of £22.344m, and discretionary funding of £2.000m. Some further changes are expected as 2025-26 award letters are issued and new bids are considered.

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 2024

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. The Trust is still engaging with WG colleagues and are hopeful we can come to an agreement to progress to FBC shortly.

The Trust has now received a revised funding award letter from DHCW relating to RISP for 2025/26, following a change in accounting treatment due to IFRS 16 which has impacted on the expenditure split between revenue and capital. The Trust's expectation is that this funding will form part of the Trust CEL from next month.

The Trust is also still awaiting a decision from WG on plasma fraction which is following the case being submitted to WG colleagues last financial year.

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

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

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

Performance to date

The actual expenditure to May 2025 on the All-Wales Capital Programme schemes was £1.555m, this is broken down between spend on the nVCC schemes of £1.361m, Whitchurch Hospital Land Disposal £0.015m, RSC £0.169m, and WHAIS £0.010m.

The spend on the Discretionary Capital programme was £0.010m which is not unusual during the first two months of the financial year when plans are being finalised.

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	2026-27	2027/28	Further Years	Total All Wales Schemes

	£m	£m	£m	£m	£m
All Wales Approved Schemes					
TCS nVCC	22.835	39.954	6.056	0.000	68.845
Integrated Radiotherapy Solution (IRS)	1.020	16.820	0.943	0.000	18.783
Velindre@ Nevill Hall Radiotherapy Unit	1.200	0.000	0.000	0.000	1.200
RISP (DPIF)	0.471	0.000	0.000	0.000	0.471
Total Approved Capital Schemes	25.526	56.774	6.999	0.000	89.299
All Wales Unapproved Schemes					
Whitchurch Hospital Site	1.134	0.945	1.741	0.000	3.820
WBS TGI Infrastructure	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.

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

9. CASH FLOW (Includes Hosted Organisations)

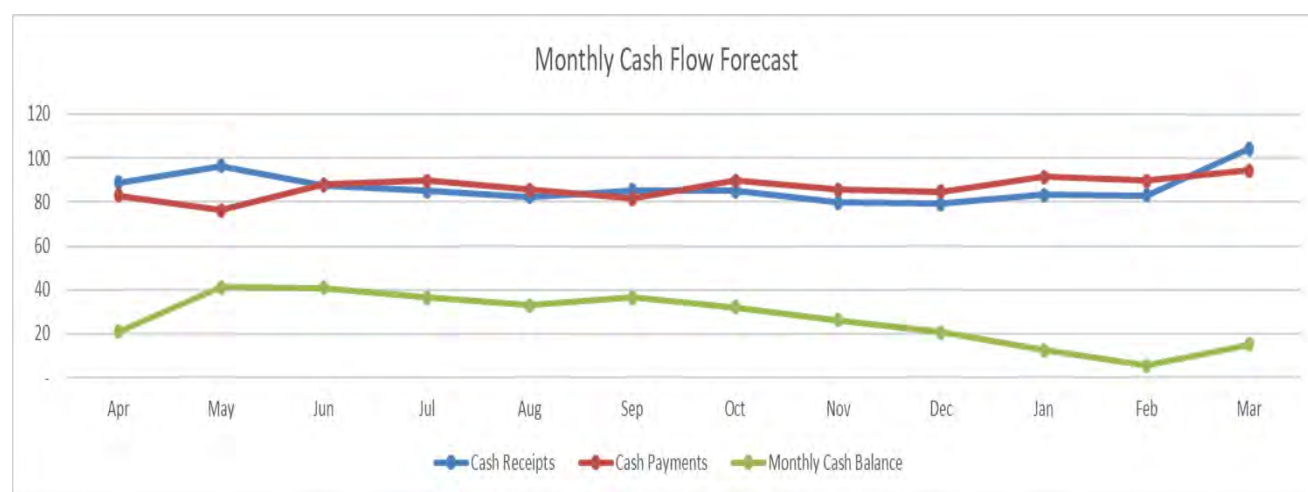
The cash-flow forecast is important to enable the Trust to plan for sufficient cash availability throughout the financial year to pay its debts, such as payroll, services provided by other health

bodies and private companies. The cash-flow forecast ensures that the Trust has an early understanding of any cash-flow difficulties.

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

Year to date cash flows and those forecast to the end of the financial year are shown below.

	Apr £'m	May £'m	Jun £'m	Jul £'m	Aug £'m	Sep £'m	Oct £'m	Nov £'m	Dec £'m	Jan £'m	Feb £'m	Mar £'m	Totals £'m
RECEIPTS													
Income from other Welsh NHS Organisations	49.990	55.994	54.357	54.567	52.467	53.867	51.567	49.467	50.167	51.167	52.467	50.964	627.041
WG Revenue Funding	29.236	33.465	26.145	22.767	22.767	23.767	25.767	23.267	22.767	24.767	24.267	24.767	303.749
Short Term Loans													0.000
PDC								0.000				22.167	22.167
Interest Receivable	0.163	0.119	0.155	0.155	0.155	0.155	0.155	0.155	0.155	0.155	0.155	0.155	1.832
Sale of Assets													0.000
Other	9.452	6.736	6.961	7.605	6.930	7.380	7.605	6.930	6.155	7.155	5.930	6.152	84.991
TOTAL RECEIPTS	88.841	96.314	87.618	85.094	82.319	85.169	85.094	79.819	79.244	83.244	82.819	104.205	1,039.780
PAYMENTS													
Salaries and Wages	30.118	42.171	42.139	42.126	42.126	42.126	42.126	42.126	42.126	42.126	42.126	42.126	493.562
Non pay items	52.934	34.043	43.212	44.950	41.100	36.900	44.950	41.100	40.150	42.850	41.100	45.850	509.139
Short Term Loan Repayment													0.000
PDC Repayment		0.000										0.000	0.000
Capital Payment	0.000	0.000	2.500	2.500	2.500	2.500	2.500	2.500	2.500	6.500	6.500	6.500	37.000
Other items													0.000
TOTAL PAYMENTS	83.052	76.214	87.851	89.576	85.726	81.526	89.576	85.726	84.776	91.476	89.726	94.476	1,039.701
Net cash inflow/outflow	5.789	20.100	(0.233)	(4.482)	(3.407)	3.643	(4.482)	(5.907)	(5.532)	(8.232)	(6.907)	9.729	
Balance b/f	15.183	20.972	41.072	40.839	36.357	32.950	36.593	32.111	26.204	20.672	12.440	5.533	
Balance c/f	20.972	41.072	40.839	36.357	32.950	36.593	32.111	26.204	20.672	12.440	5.533	15.262	



DIVISIONAL ANALYSIS

(Figures in parenthesis signify an adverse variance against plan)

Core Trust

	YTD Budget	YTD Actual	YTD Variance	Full Year Budget	Full Year Forecast	Year End Projected Variance
	£m	£m	£m	£m	£m	£m
VCC	(8.328)	(8.307)	0.021	(49.182)	(49.182)	0.000
RD&I	0.032	0.018	(0.013)	0.440	0.440	0.000
WBS	(3.635)	(3.634)	0.000	(23.679)	(23.679)	0.000
Sub-Total Divisions	(11.931)	(11.923)	0.008	(72.421)	(72.421)	0.000
Corporate Services Directorates	(2.576)	(2.566)	0.010	(15.589)	(15.589)	0.000
Delegated Budget Position	(14.507)	(14.490)	0.017	(88.010)	(88.011)	0.000
nVCC	(0.041)	(0.050)	(0.009)	(0.320)	(0.320)	0.000
Health Technology Wales	(0.022)	(0.022)	0.000	(0.183)	(0.183)	0.000
Trust Income / Reserves	14.570	14.570	0.001	88.513	88.513	0.000
Trust Position	0.000	0.009	0.009	0.0000	0.000	0.000

The in month position for the core Trust is an **underspend of £0.009m**, and the year end forecast is financial **breakeven**, although there are some risks in achieving this.

VCS

	YTD Budget	YTD Actual	YTD Variance	Full Year Budget	Full Year Forecast	Year End Projected Variance
	£m	£m	£m	£m	£m	£m
Income	16.698	16.753	0.056	99.535	99.591	0.056
Expenditure						
Staff	10.079	10.136	(0.057)	60.787	60.843	(0.057)
Non Staff	14.947	14.925	0.022	87.930	87.909	0.022
Sub Total	25.026	25.061	(0.035)	148.717	148.752	(0.035)
Total	(8.328)	(8.307)	0.021	(49.182)	(49.161)	0.021

VCS Key Highlights/ Issues:

The reported financial position for Velindre Cancer Services as at the end of May 2025 was an **underspend of £0.021m** with an expected outturn position at this stage of **breakeven** albeit with some associated risk.

Income at month 2 represents a year to date underspend position of **£0.056m** which is largely a result of an overachievement of Private Patient income.

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 was been made in the service. There is therefore a risk for 2025-26 currently estimated at c£0.500m. In addition, a new risk has emerged this year whereby the forecast activity income in relation to Velindre @ Nevill Hall Radiotherapy Unit is not expected to match the level of investment in workforce. This is currently under review, but present expectation is a shortfall of between c£0.500m and £0.750m during 2025/26 (in addition to that outlined in relation to LTA Contract Activity outlined previously) which is after mitigations are put in place such as holding of vacancies.

VCS have reported a year to date overspend of **£(0.057)m** against staff. Snr Medical costs continue to be the largest pressure for VCS, however, have significantly reduced following funding being provided during 2024-25 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 which may need to be held if marginal income doesn't achieve the target during 2025-26. The vacancies have been helping to support the posts appointed at risk, and the divisional savings target and vacancy factor.

Non-Staff Expenditure at month 2 was **£0.022m** underspent which is largely due to an underspend on a Medical Physics contract, offset by an overspend in Establishment costs (postage).

WBS

	YTD Budget	YTD Actual	YTD Variance	Full Year Budget	Full Year Forecast	Year End Projected Variance
	£m	£m	£m	£m	£m	£m
Income	6.400	6.498	0.098	35.367	35.465	0.098
Expenditure						
Staff	3.227	3.295	(0.068)	19.274	19.342	(0.068)
Non Staff	6.808	6.838	(0.030)	39.772	39.802	(0.030)
Sub Total	10.035	10.133	(0.098)	59.046	59.144	(0.098)
Total	(3.635)	(3.634)	0.000	(23.679)	(23.679)	0.000

Key Highlights/ Issues:

The reported financial position for the Welsh Blood Service at the end of May 2025 was **breakeven** with an expected outturn position at this stage of **breakeven**.

WBS recognised an overachievement of **£0.098m** on income due an overperformance in general activity (plasma sales and additional generic testing).

Per last year there has been a lack of growth in the bone marrow registry, which was largely impacted during the pandemic, which is still yet to show signs of recovery despite the significant swab testing taking place at the beginning of last financial year. Whilst it was originally expected that the payback from the additional swabs would start to be realised before the end of last financial year it is now hopeful that it will crystallise later this 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 partly funded as part of the 2025-26 IMTP process.

Staff overspend of **£(0.068)m** to date 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 have created an unfunded post analysis to determine and monitor the current year and recurrent cost pressure. Some posts were recognised and funded as part of the Trust IMTP for 2025-26. Vacancies across multiple cost centres are helping to support these pay pressures.

WBS report a non-Staff overspend of **£0.030m** as at the end of month 2. Largest cost pressure is the divisional savings target £0.123m to date, offset by activity related performance in month 2: underspends in Apheresis harnesses volume and price savings at the Talbot Green donation clinic, price savings from bulk purchase of test kits, lower activity on bone marrow which is a direct correlation with income under performance and lower testing volumes due to less than demand planning at the manufacturing and distribution laboratory.

Corporate

	YTD Budget	YTD Actual	YTD Variance	Full Year Budget	Full Year Forecast	Year End Projected Variance
	£m	£m	£m	£m	£m	£m
Income	0.802	0.986	0.184	4.733	4.917	0.184
Expenditure						
Staff	2.666	2.654	0.012	15.971	15.959	0.012
Non Staff	0.711	0.898	(0.187)	4.351	4.538	(0.187)
Sub Total	3.378	3.552	(0.175)	20.322	20.497	(0.175)
Total	(2.576)	(2.566)	0.010	(15.589)	(15.580)	0.010

Corporate Key Highlights / Issues:

The reported financial position for the Corporate Services division at the end of May 2025 was an **underspend of £0.010m** with an expected outturn position at this stage of **breakeven**.

The Trust is continuing to benefit from receiving high levels of bank interest as a result of interest rate rises over the last couple of years, however with interest rates decreasing we can expect to see this benefit reduce as the year progresses.

Several vacancies within the division resulted in an 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 has been provided as part of the Trust IMTP to partly support the Estates costs on a non-recurrent basis during 2025-26. The expectation is that these costs will be removed with the move to the nVCC.

RD&I

	YTD Budget	YTD Actual	YTD Variance	Full Year Budget	Full Year Forecast	Year End Projected Variance
	£m	£m	£m	£m	£m	£m
Income	0.883	0.899	0.016	5.220	5.236	0.016
Expenditure						
Staff	0.690	0.712	(0.022)	4.148	4.170	(0.022)
Non Staff	0.161	0.168	(0.007)	0.632	0.640	(0.007)
Sub Total	0.851	0.880	(0.029)	4.780	4.810	(0.029)
Total	0.032	0.018	(0.013)	0.440	0.426	(0.013)

RD&I Key Highlights / Issues

The reported financial position for the RD&I Division at the end of May 2025 was an **underspend of £0.013m** with an expected outturn position at this stage of **breakeven**.

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

nVCC – (Revenue)

	YTD Budget	YTD Actual	YTD Variance	Full Year Budget	Full Year Forecast	Year End Projected Variance
	£m	£m	£m	£m	£m	£m
Income	0.000	0.000	0.000	0.000	0.000	0.000
Expenditure						
Staff	0.026	0.046	(0.020)	0.157	0.157	0.000
Non Staff	0.015	0.004	0.011	0.163	0.163	0.000
Sub Total	0.041	0.050	(0.009)	0.320	0.320	0.000
Total	(0.041)	(0.050)	(0.009)	(0.320)	(0.320)	0.000

nVCC Key Highlights / Issues

The reported financial position for the nVCC Programme at the end of May 2025 is breakeven with a year end forecast of breakeven.

Capital budgets are being reviewed to ensure that the value on the Trust's CEL is reflective of the anticipated spend in 2025-26.

HTW (Hosted Other)

	YTD Budget	YTD Actual	YTD Variance		Full Year Budget	Full Year Forecast	Year End Projected Variance
	£m	£m	£m		£m	£m	£m
Income	0.325	0.234	(0.090)		1.900	1.810	(0.090)
Expenditure							
Staff	0.310	0.263	0.047		1.858	1.812	0.047
Non Staff	0.037	(0.006)	0.044		0.225	0.181	0.044
Sub Total	0.347	0.257	0.090		2.083	1.993	0.090
Total	(0.022)	(0.022)	0.000		(0.183)	(0.183)	0.000

HTW Key Highlights / Issues

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



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

nVCC Project Finance Report For MAY 2025

DATE OF MEETING

PUBLIC OR PRIVATE REPORT

Public

IF PRIVATE PLEASE INDICATE
REASON

Not Applicable - Public Report

PREPARED BY

Mark Ash
Assistant Project Director

PRESENTED BY

Mark Ash
Assistant Project Director

EXECUTIVE SPONSOR APPROVED

Matt Bunce, Executive Director of Finance

REPORT PURPOSE

FOR NOTING

ACRONYMS

1. PURPOSE

- 1.1 The purpose of this report is to provide a financial update to the new Velindre Cancer Centre (nVCC) Project Board outlining spend to date against the Welsh Government (WG) approved/indicative budget as of **MAY 2025**.
- 1.2 The nVCC and Enabling Works Project financial position is continually monitored and updated, and an update will be provided to the nVCC Project Board and Trust Board on a monthly basis.

2. FINANCIAL SUMMARY FOR 2025-26

- 2.1 Key matters are outlined below:

- **Capital funding** has been provided by WG for the nVCC Project resources.
- The **financial position** for the overall Project as of **MAY 2025** is set out below:

New Velindre Cancer Centre Finance									
 Ymddiriedolaeth GIG Prifysgol Felindre Velindre University NHS Trust		Programme nVCC		Project Director David Powell		Report Period May-25			
	Budget	QRA	QRA Called	Approved to Spend (Budget plus QRA Called)	Spend to Date	Committed Costs	Projected	Forecast Spend to Complete	Unallocated Resources (Surplus)
Total Costs 	55.36M	18.70M	752K	56.11M	8.26M	14.31M	33.54M	56.11M	17.94M

- The in-year **financial position** for **MAY 2025** is:
 - o **CAPITAL** in-year spend of **£1.073m**, with a forecast outturn of **c£8.964m** based on run-rates and financial plan

nVCC Project Capital Budget & Spend Summary 2025-26						
	Year to Date			Financial Year		
	Budget May-25 £	Spend May-25 £	Variance May-25 £	Annual Budget £	Annual Forecast £	Annual Variance £
EW FBC Project	538,535	538,522	13	4,225,287	4,225,274	13
nVCC FBC Project	535,686	534,840	846	4,740,068	4,739,136	933
	1,074,221	1,073,362	860	8,965,355	8,964,409	946

- o **REVENUE** in-year spend of **£0.024m**, with a forecast outturn of **c£0.119m** based on run-rates and financial plan

REVENUE						
	Year to Date			Financial Year		
	Budget May-25 £	Spend May-25 £	Variance May-25 £	Annual Budget £	Annual Forecast £	Annual Variance £
Enabling Works						
Project Delivery Support Costs	0	0	0	0	0	0
Enabling Works Revenue Total	0	0	0	0	0	0
New Velindre Cancer Centre						
nVCC Pay	19,875	19,875	0	96,124	96,124	0
Project Delivery Support Costs	0	4,002	-4,002	0	23,000	-23,000
nVCC Revenue Total	19,875	23,876	-4,002	96,124	119,124	-23,000
REVENUE TOTAL	19,875	23,876	-4,002	96,124	119,124	-23,000

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

3. FUNDING

WG funding relates to the period 1 April 2024 to 31 March 2028 and must be claimed in full by 31 March 2028 otherwise any unclaimed part of the funding will cease to be available to you. The funding made available is **£78.662m capital** and **£2.412m revenue** for the nVCC Project.

A summary breakdown of funding is shown below:

Capital Budget: £69.719m consisting of:

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

Revenue Budget: £2.412m consisting of:

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

Enabling Works Budget: £8.943m consisting of:

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

- 3.1 The funding includes IRS implementation costs of £5.071m, which is not managed by the nVCC Project. In respect of the QRA, all QRA budgets are subject to drawdown according to the agreed QRA process. The QRA of c£18.695m will be held by WG until funding has been agreed.
- 3.2 Therefore, the nVCC Project will be responsible for c£54.896m. In addition, the nVCC Project will require c£0.465m from the remainder of the original EW FBC funding. The total funding for the nVCC Project will be **c£55.361m**.
- 3.3 For clarity, it is the Welsh Government's expectation that this capital allocation is the final funding ask prior to the new Velindre Cancer Centre opening.

4. FINANCIAL POSITION – overall Project

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

4.2 The Project overall has an agreed funding of c£56.1m and reflects the budget plus the QRA called. The projected spend is £56.1m leading to a breakeven position. The spend forecast is made up of actual spend of c£8.3m, contractual commitments of c£14.3m and projected spend to completion of c£33.5m. The projected spend element of c£32.5m is primarily equipment and this will begin to turn into commitment with the award of major medical equipment in July 2025.

4.3 The Project retains reserves of c£17.9m. The Project is into the second year of the construction phase and to date has only called down £0.752m of the QRA, which represents 4% of the agreed reserves. Once the major equipment elements are contracted the overall level of retained reserves will be reviewed to determine what remains a prudent provision for the remainder of the contract term

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

New Velindre Cancer Centre Finance									
 Ymddiriedolaeth GIG Prifysgol Felindre Velindre University NHS Trust								Programme nVCC	Project Director David Powell
								Report Period May-25	
	Budget	QRA	QRA Called	Approved to Spend (Budget plus QRA Called)	Spend to Date	Committed Costs	Projected	Forecast Spend to Complete	Unallocated Resources (Surplus)
Enabling Works 	8.04M	1.37M	529K	8.57M	4.40M	3.75M	424K	8.57M	839K
Equipment 	All Selected								
	32.54M	3.58M	0	32.54M	0	0	32.54M	32.54M	3.58M
Transactions (Resource Costs) 	All Selected								
	14.51M	6.10M	0	14.51M	3.72M	10.48M	306K	14.51M	6.10M
MIM (Construction Costs) 	0	7.50M	224K	224K	143K	80K	0	224K	7.28M
Deep Clean 	272K	156K	0	272K	0	0	272K	272K	156K

EW Project – as of May 2025

4.5 The overall financial position is an approval to spend of c£8.57m, which is set out below:

<i>FBC Addendum</i>	£7,575,600
<i>Original FBC</i>	£465,427
<i>QRA Called</i>	£528,800
	£8,569,827

4.6 The overall financial position is set out below:

	FBC Funding	Costs Incurred 2024-25	Costs Incurred to Date May-25	Commitments May-25	Projected Costs May-25
EW Project					
Pay	£300,000	£153,116	£25,949	£120,935	£0
6MVA Supply - National Grid	£480,000	£480,000	£0	£0	£0
Supply Chain Fees	£728,430	£323,268	£49,615	£355,547	£0
Non Works Costs	£113,202	£113,202	£0	£0	£0
Asda Works	£2,143,269	£2,008,269	£4,072	£109,055	£21,873
Walters Design & Build	£116,260	£116,260	£21,873	£0	£21,873
S278 works on Longwood Drive	£3,153,636	£288,858	£261,916	£2,602,862	£0
Offsite Habitat Creation (SW Corner)	£717,333	£434,292	£110,298	£172,743	£0
HV Intake Room	£610,101	£161,286	£64,798	£384,017	£0
Rural Path	£75,000	£0	£0	£0	£75,000
TCAR Habitat	£84,000	£0	£0	£0	£84,000
Revised Emergency Access	£275,000	£0	£0	£0	£275,000
Enabling Works FBC Reserves	£0	£9,921	£0	£0	£9,921
QRA Funding					£0
TOTAL EW PROJECT	£8,569,827	£3,862,068	£538,522	£3,745,159	£424,078
QRA funding	£1,367,400				£1,367,400
HV Intake Room Drawdown	£160,800				£160,800
Asda Final Account Drawdown	£368,000				£368,000
	£838,600	£0	£0	£0	£838,600
TOTAL nVCC EW FUNDING	£9,408,427	£3,862,068	£538,522	£3,745,159	£1,262,678

4.7 The overall financial position of the EW Project is spend to date is c£4.4m, with commitments of c£3.75m and projected costs of c£0.424m.

4.8 The QRA available for the EW Project is c£0.839m and reflects the unallocated resources for the Project. It should be noted that the QRA is reviewed every quarter.

Financial Risks

4.9 The QRA reflects the risks being managed by the EW Project and there are no additional financial risks reported as at May 2025.

nVCC Project – as of May 2025

4.10 The overall financial position is an approval to spend of c£47.544m, which is set out below:

nVCC Project

<i>Equipment</i>	£32,540,286
<i>Transactions(Resource Costs)</i>	£14,507,885
<i>Deep Clean</i>	£272,000
<i>QRA Called</i>	£223,860
	£47,544,031

4.11 The overall financial position is set out below:

	FBC Funding	Costs Incurred	Costs Incurred to Date	Commitments	Projected Costs
		2024-25	May-25	May-25	May-25
nVCC MIM Activities					
Project Management Office	£3,325,884	£1,181,156	£156,041	£1,988,687	£0
Design & Construction Workstream	£2,606,271	£629,664	£99,330	£1,570,994	£306,283
Equipment, Commissioning and Migration Workstream	£3,722,193	£372,839	£109,554	£3,239,800	£0
Digital Workstream	£1,935,417	£113,756	£46,073	£1,775,588	£0
Engagement & Communications Workstream	£380,688	£159,689	£20,643	£200,356	£0
Commercial Activity Group	£2,242,432	£621,540	£76,826	£1,544,066	£0
Strategic Reserves			£0		£0
Project Delivery	£295,000	£117,988	£13,489	£163,523	£0
Major Medical Equipment	£10,676,400	£0		£0	£10,676,400
Other Equipment	£12,385,200	£0		£0	£12,385,200
IM&T infrastructure	£5,359,802	£0		£0	£5,359,802
Digital	£433,415	£0		£0	£433,415
Digitisation of Health Records	£3,685,469	£0		£0	£3,685,469
Non Works Costs	£272,000	£0		£0	£272,000
Asda Traffic Management Drawdown	£223,860	£130,434	£12,883	£80,543	£0
TOTAL nVCC PROJECT	£47,544,031	£3,327,065	£534,840	£10,563,557	£33,118,569
QRA funding	£17,328,000				£17,328,000
Asda Traffic Management Drawdown	-£223,860				-£223,860
	£17,104,140	£0	£0	£0	£17,104,140
TOTAL nVCC MIM FUNDING	£64,648,171	£3,327,065	£534,840	£10,563,557	£50,222,709

4.12 The overall financial position of the nVCC Project is spend to date is c£3.9m, with commitments of c£10.564m and projected costs of c£33.119m.

4.13 The QRA available for the nVCC Project is c£17.104m and reflects the unallocated resources for the Project. It should be noted that the QRA is reviewed every quarter.

Financial Risks

4.14 The QRA reflects the risks being managed by the nVCC Project and there are no additional financial risks reported as of May 2025.



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

5.1 The in year financial position for **MAY 2025** is reporting a **financial break-even** position.

- **CAPITAL** in-year spend of **£1.073m**, with a forecast outturn of **c£8.964m** based on run-rates and financial plan

The detailed capital financial position is set out below:

nVCC Project Budget & Spend 2025-26						
CAPITAL	Year to Date			Financial Year		
	Budget May-25 £	Spend May-25 £	Variance May-25 £	Annual Budget £	Annual Forecast £	Annual Variance £
Enabling Works						
Enabling Works Pay	25,949	25,949	0	145,800	145,800	0
Supply Chain Fees	49,615	49,615	0	385,740	385,740	0
Non Works Costs	0	4,072	-4,072	0	4,072	-4,072
Asda Works	0	0	0	135,000	135,000	0
Walters Design & Build	0	21,873	-21,873	0	21,873	-21,873
6MVA Supply - National Grid	0	0	0	0	0	0
S278 works on Longwood Drive	261,916	261,916	0	2,789,652	2,789,652	0
Offsite Habitat Creation (SW Corner)	112,057	110,298	1,759	295,098	293,339	1,759
HV Intake Room	64,798	64,798	0	449,798	449,798	0
TCAR Extension Planning Application	0	0	0	0	0	0
Rural Path	0	0	0	0	0	0
TCAR Habitat	0	0	0	0	0	0
Revised Emergency Access	0	0	0	0	0	0
Enabling Works FBC Reserves	24,200	0	24,200	24,200	0	24,200
Enabling Works Capital Total	538,535	538,522	13	4,225,287	4,225,274	13
New Velindre Cancer Centre						
Project Management Office	169,697	169,530	167	1,289,716	1,288,785	931
Design & Construction	112,226	112,213	13	557,815	557,815	0
Equipment, Commissioning and Migration	110,220	109,554	666	1,178,490	1,178,489	1
Digital	46,073	46,073	0	628,002	628,002	0
Engagement & Communications Workstream	20,643	20,643	0	130,013	130,013	0
Commercial Activities Group	76,826	76,826	1	662,638	662,637	1
Strategic Reserves	0	0	0	293,394	293,394	0
nVCC Capital Total	535,686	534,840	846	4,740,068	4,739,136	933
CAPITAL TOTAL	1,074,221	1,073,362	860	8,965,355	8,964,409	946

- **REVENUE** in-year spend of **£0.024m**, with a forecast outturn of **c£0.119m** based on run-rates and financial plan

The detailed revenue financial position is set out below:

REVENUE	Year to Date			Financial Year		
	Budget May-25 £	Spend May-25 £	Variance May-25 £	Annual Budget £	Annual Forecast £	Annual Variance £
Enabling Works						
Project Delivery Support Costs	0	0	0	0	0	0
Enabling Works Revenue Total	0	0	0	0	0	0
New Velindre Cancer Centre						
nVCC Pay	19,875	19,875	0	96,124	96,124	0
Project Delivery Support Costs	0	4,002	-4,002	0	23,000	-23,000
nVCC Revenue Total	19,875	23,876	-4,002	96,124	119,124	-23,000
REVENUE TOTAL	19,875	23,876	-4,002	96,124	119,124	-23,000

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

- **Staffing** - WG funded posts **spend of £0.026m**. Reflects the Project posts and a run rate of c£13k per month.

Work Packages are outlined below:

- **Supply Chain Fees** – **spend of £0.050m** - costs associated with advisory support provided by WSP (£0.026m); MDA Consult Ltd (£0.006m); Urbanists (£0.002m) cost consultancy (£0.013m) and Escrow fees (c£0.003m).
- **Non-Works** – **spend of £0.004m** - costs associated with S278 agreement and Cardiff Council for c£0.004m.
- **Asda Works** – **no spend** - costs associated with the Asda car park works costs c£0.000m. The final account is being finalized.
- **Velindre Works** – **spend of £0.022m** - costs associated with the D&B contract by Walters for the site works. Residual costs incurred c£0.022m.
- **S278 Works Longwood Drive** – **spend of £0.0262m** - costs associated with the highway improvement works on Longwood Drive agreed with Cardiff County Council. Works costs c£0.249m and advisory costs c£0.013m.
- **Off-site Habitat** – **spend of £0.111m** - costs associated with the offsite habitat creation required as part of the EPSL. Works costs are c£0.098m and advisors costs c£0.012m.
- **HV Intake Room** – **spend of £0.065m** - costs associated with the design and build of the HV intake room. Works costs are c£0.065m.
- **Reserves** – **no spend** - costs are c£0.000m – no spend to date.

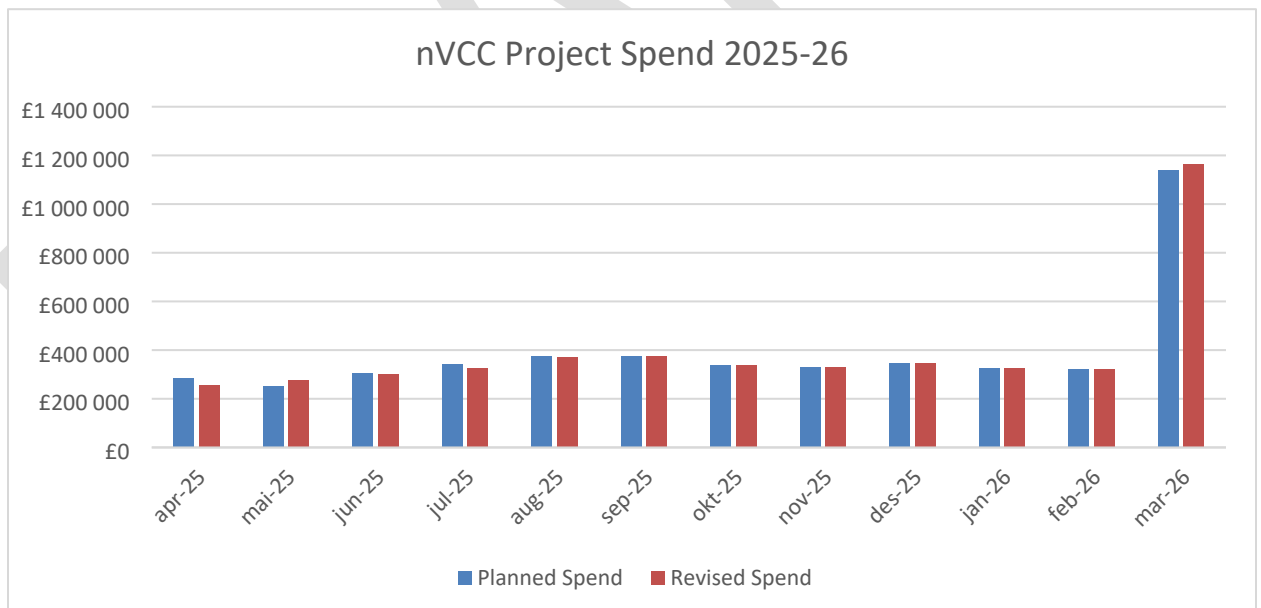
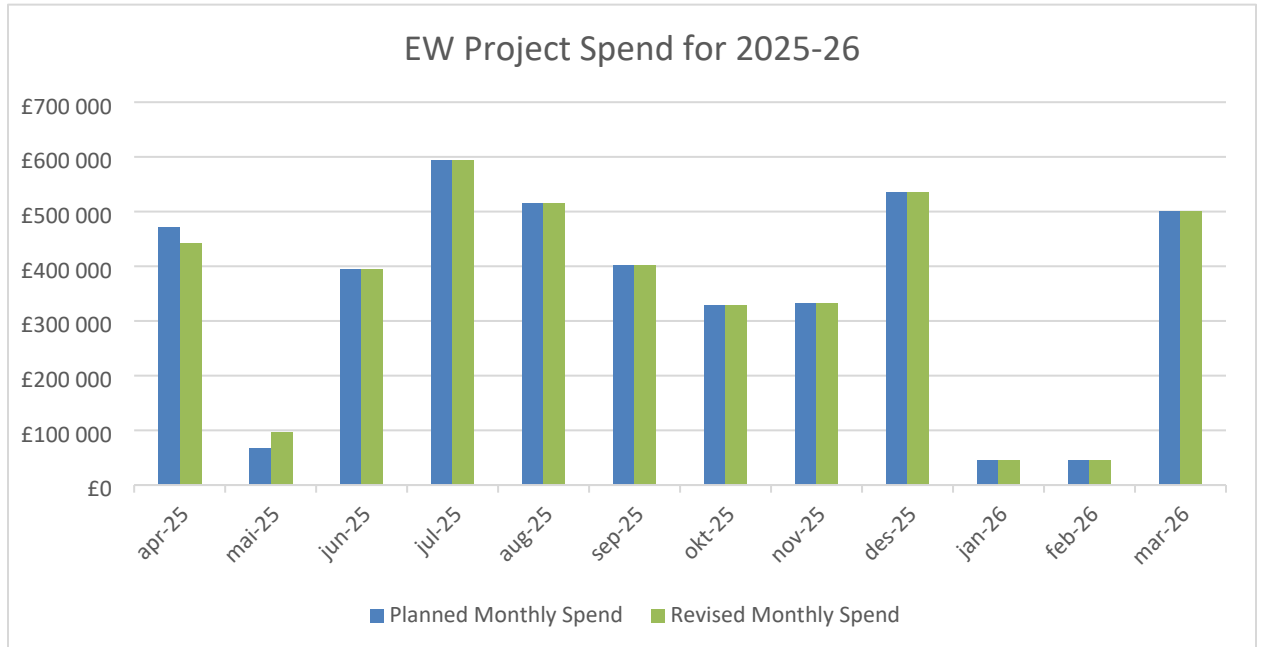
5.3 The key **nVCC CAPITAL** areas of spend to date are explained as follows:

- **Staffing** - WG funded posts **spend of £0.342m**. Reflects the Project posts and a run rate of c£0.170m per month.

Work Packages are outlined below:

- **Project Delivery** – costs associated with the running of the Project Office and spend is **£0.013m**.
- **RDD Process** – **spend of £0.048m** for the reviewable design data process as RIBA stage design is finalized with Project Co.
- **Construction Phase** – **spend of £0.029m** for the services provided by the Authority Construction Surveyor.
- **Equipment Advisers** – **spend of c£0.023m** for equipment advice.
- **Digital equipment** – **spend of c£0.003m**.
- **Project Management Advisers** – **spend of c£0.041m** for the SRO; Project Control and Risk Management support.
- **Professional Advisers** – **spend of £0.035m** for legal advice on the PA and changes, and range of commercial matters; commercial support.
- **Reviews** – **spend of £0.000m** for the governance and capabilities follow-up review of the nVCC Project (PwC £0.000m).
- **Reserves** – **spend of £0.0.00m** – no spend to date.

5.4 **Cashflow** - The graph outlines the actual capital spend to **MAY 2025** is **£1.074m**. The actual run-rate is **slightly higher** than the planned spend.



5.5 **Capital Resource Limit** - the approved CRL for the EW and nVCC Project(s) is **to be agreed with WG**:

- For **MAY 2025** the capital spend forecast outturn is **£8.964m**; and
- For **MAY 2025**, the WG has an **approved** CRL for the Project(s) is **to be confirmed**.

5.6 The CRL position is outlined below:

EW Project

Period 2024-25	Current Approved CRL £m	Actual & Forecast Spend £m	Variance £m
Apr-25		0.442	-0.442
May-25		0.096	-0.096
Jun-25		0.394	-0.394
Jul-25		0.594	-0.594
Aug-25		0.515	-0.515
Sep-25		0.402	-0.402
Oct-25		0.328	-0.328
Nov-25		0.332	-0.332
Dec-25		0.534	-0.534
Jan-26		0.045	-0.045
Feb-26		0.045	-0.045
Mar-26		0.499	-0.499
TOTAL	0.000	4.225	-4.225

nVCC Project

Period 2024-25	Current Approved CRL £m	Actual & Forecast Spend £m	Variance £m
Apr-25		0.258	-0.258
May-25		0.276	-0.276
Jun-25		0.301	-0.301
Jul-25		0.326	-0.326
Aug-25		0.369	-0.369
Sep-25		0.377	-0.377
Oct-25		0.337	-0.337
Nov-25		0.331	-0.331
Dec-25		0.349	-0.349
Jan-26		0.327	-0.327
Feb-26		0.322	-0.322
Mar-26		1.163	-1.163
TOTAL	0.000	4.739	-4.739

6. QUANTIFIED RISK ASSESSMENT (QRA)

6.1 The approved QRA is **c£18.695m** and the detail is set out below:

	2024-25	2025-26	2026-27	2027-28	TOTAL
nVCC QRA MIM	£1,699,200	£5,947,200	£849,600	£0	£8,496,000
nVCC QRA Trust	£324,000	£1,050,000	£3,894,000	£3,564,000	£8,832,000
EW QRA	£568,400	£727,000	£72,000	£0	£1,367,400
TOTAL QRA	£2,591,600	£7,724,200	£4,815,600	£3,564,000	£18,695,400

6.2 The Project has utilised **c£0.753m** of the QRA and the funding has been provided by WG.
The detail is set out below:

QRA UTILISED	2024-25	2025-26	2026-27	2027-28	TOTAL
QRA UTILISED					
Asda Traffic Management	£223,680				£223,680
HV Intake Room		£160,800			£160,800
Asda potential claims	£368,000				£368,000
TOTAL QRA UTILISED	£591,680	£160,800	£0	£0	£752,480

6.3 The remaining QRA is **c£17.943m**.

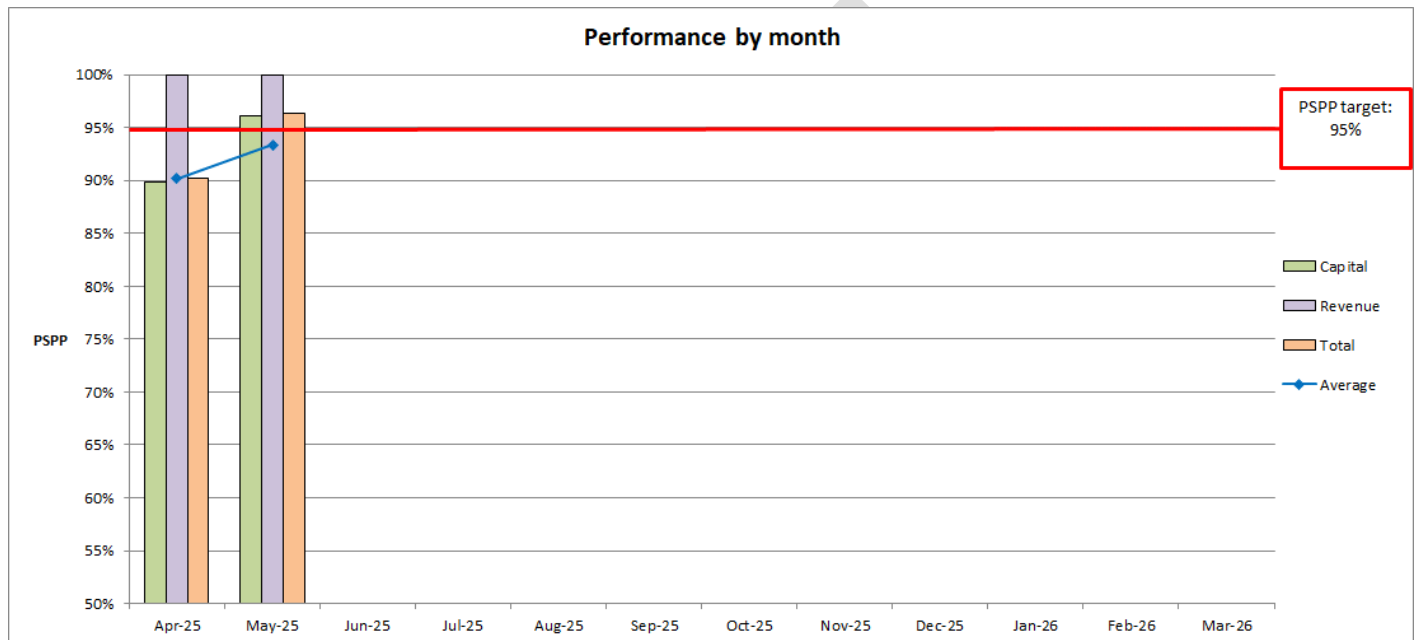
6.4 The Project reviews the QRA on a quarterly basis and the risks quantification re-assessed.
The revised QRA is **c£17.888m**, which means there is potential to reduce the QRA by **c£0.055m**. The revised QRA and profile is set out below:

REVISED QRA	2024-25	2025-26	2026-27	2027-28	TOTAL
nVCC QRA MIM - ORIGINAL	£0	£6,426,000	£849,600	£0	£7,275,600
nVCC QRA Trust - Original	£0	£1,374,000	£5,004,000	£3,396,000	£9,774,000
EW QRA - ORIGINAL	£0	£338,400	£500,200	£0	£838,600
TOTAL QRA	£0	£8,138,400	£6,353,800	£3,396,000	£17,888,200

6.5 As agreed with WG, the remaining QRA is **c£17.943m**.

7. PUBLIC SECTOR PAYMENT POLICY

- 7.1 For **MAY 2025**, the PSPP performance for was **96.36%** and the PSPP target was **achieved**. Of the 55 invoices for payment, 53 invoices were processed within the 30-day deadline.
- 7.2 The average PSPP performance to date for 2025-26 is **93%**.
- 7.3 The Project(s) PSPP monitoring report is outlined below:



8. Considerations for Board

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

9. IMPACT ASSESSMENT

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

6. RECOMMENDATION

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

TRUST BOARD	
TRUST RISK REGISTER UPDATE	
DATE OF MEETING	24 July 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	The report: • 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	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 on the Risk Register.



COMMITTEE / GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING	
COMMITTEE OR GROUP	DATE
VCS SLT	05.06.2025
WBS SLT	11.06.2025
Executive Management Board	30.06.2025
Quality, Safety and Performance Committee (QSP)	17.07.2025
This paper takes into consideration the feedback from VCC and WBS leadership teams on their respective risks. EMB discussed the risks, including the emerging risk themes of general quality of care, workforce and commissioning funding. The EMB considered the benefits of monitoring risk interdependencies e.g. digital and workforce risks affecting service delivery in future. The QSP Committee noted the risks on the current public Trust Risk Register, requesting assurance that all predicted dates to reach targets are achievable. The Executive Directors agreed to review the dates to confirm this.	
ASSURANCE RATING ASSESSED BY EXECUTIVE SPONSOR	Level 3 - Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes
APPENDICES	
1	Trust Risk Register

1. SITUATION

This report informs the Trust Board of the status of reportable risks in line with the 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.

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

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.”

- The likelihood of the risk reduced from 4 to 3 due to the change note for RISP, resetting the start date of the EPMA project.
- The risk score is now 12 in the Performance and Service Sustainability and Quality domains, which is below the reportable threshold to Trust Board.

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.
- This risk now falls below the reporting threshold to Trust Board with a score of 12 in the Workforce domain.

Risk 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.”

- A band 6 post started 30th June 2025.
- Scrutiny update-band 5-6 DT post not approved 20.06.25. Resubmitted to scrutiny for discussion 11th July 2025.
- UGI band 7 post - will be a vacancy from 02.08.25. Scrutiny approval to recruit like for like, job out to advert.
- Scrutiny case needed to extend 0.6wte locum to cover vacancies: 1.0wte band 5 July/August and 1.0wte band 7 UGI post August cover.
- Service model currently delivers to: H&N, UGI (excluding HPB/pancreatic), inpatients. Services suspended include general OP clinic & AU & neuro-oncology.
- Due to more stability within the team & locum cover = 0.04wte below normal establishment, risk reduced to 12.

At its May meeting, the Board requested further assurance regarding the rationale for decreasing the score of Risk 3448:

Risk 3448

“There is a risk to patient safety as a result of the VCC Cancer Associated Thrombosis (CAT) service not continuing due to inability to recruit to key posts following the pending retirement of key individual 2025 leading to patients diagnosed with CAT unable access

specialised services and therefore may lead to sub optimal treatment, delays in their cancer treatments”

- Plans in place to cross cover leave between the IP and Consultant based at VCC.
- The IP is able to access advice via telephone from the Haem Consultant in the VCC Palliative Medicine Consultant absence.
- From August a room has been identified for the Haem Consultant to undertake clinic in person at VCC and be immediately available to the IP during CAT clinic if the Palliative Medicine Consultant is on leave.
- The VCC Palliative Medicine Consultant access the CAT MDT for advice, although where urgent advice is required ,they will also access Haem Cons for advice for complicated patients
- Pre- clinic meeting (MDT) to discuss all patients: attended by VCC Cons, VCC IP and Haem Cons, UHW IP Pharmacist plus ABUHB CAT Cons.
- Close working relationship with ABUHB CAT Consultant.
- VCC IP CAT Pharmacist is pleased to take on the role of Palliative Medicine SST lead Pharmacist from August 2024 as a career development opportunity, whilst noting that this is not a solid tumour SST role. (Significant workload out of planned clinic times (ie resulting in unwanted overtime) that would result in working in both the CAT and a pre-SACT assessment clinic alongside wider departmental pharmacist resource prevents the individual from joining an oncology SST at present).
- The risk reduced from a current rating of 12 to 8. A score of 8 is below the reporting threshold for Trust Board.

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

Risk 3468

“There is a risk to the sarcoma service as a result of the single handed consultant planning on retirement in May 2025 with no robust succession plan in place which will result in patient care being compromised.”

- The risk rating has increased from 12 to 16 due to a Consultant retiring at the end of June 2025 and taking annual leave from the end of May 2025.
- Clinical Oncologist has agreed to support the service until recruitment of permanent oncologists, it is anticipated that this will be in September 2025.
- Permanent Clinical Nurse Specialist posts are being advertised imminently.

Risk 3678

“There is a risk to patient safety as a result of independent result entry and authorisation leading to incorrect results being reported on a patient.”

- This is a new risk during the reporting period.

Risk 3643

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

- This is a new risk during the reporting period.

Risk 3418

“There is a risk to quality, as a result of pre- and post-examination processes, leading to a potential adverse impact on patient care.”

- This is a new risk during the reporting period.

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.
- Six risks with a score of 12 or above reported in the safety/quality domain.
 - o Three on the VCS register
 - o Three on the WBS register.
- 10 with a score over 15 or above reported in other domains.
 - o Three on the VCS register
 - o Three on WBS register
 - o Four on the Corporate risk register.

Risk Themes

Quality and Safety risks affecting patient care

- Clinical information processing and communication: Concerns regarding the duplication of information, excessive email use, and unclear processes for test result reviews are leading to potential delays or errors in clinical decision-making.
- Outdated IT systems and manual workarounds: Legacy systems, increase transcription errors, reporting errors.
- Blood services risks: quality risks from manual processes

Workforce capacity and resilience

- Vacancies and insufficient staffing in critical services (e.g., Radiotherapy Physics, Dietetics, Sarcoma service).
- Heavy reliance on time-limited funded posts creating instability.
- High workload and demand exceeding capacity in digital and clinical teams, leading to risks of burnout and service delays.

Performance and service sustainability

- Dependencies on national programmes and delayed delivery affecting local operational performance.
- Inadequate succession planning impacting service continuity.

Digital and IT system risks

- Delays in integration of digital systems into national architecture slowing transformation.
- Insufficient capacity to deliver digital projects and support critical service changes.

3. Management of Static Risks

A plan has been developed to actively manage static risks. Static risks are defined as risks which have remained at the same level for an extended period without meaningful

reduction. We are starting with risks which have been static on the Trust Risk Register for over 12 months.

The plan includes a systematic review and revalidation of all static risks, to be undertaken as part of the Trust's risk management cycle. Each risk will be reviewed with the risk lead conducting a detailed review of current controls, evaluating the effectiveness of existing mitigation actions, and identifying any gaps or areas requiring additional intervention. Action plans will be refreshed and include clear, measurable milestones with defined timescales for delivery.

Risks that are no longer relevant or adequately mitigated will be formally considered for de-escalation or closure. These reviews will be reported through the Committee to ensure continued oversight and assurance. This approach aims to strengthen accountability, support proactive risk reduction, and maintain a dynamic, current, and responsive risk profile across the organisation. The initial review will be conducted during August 2025 with an update provided to the September Committee.

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

TARGET RISK SCORE DATES

Target dates for reaching target scores are now included in Appendix 1.

DATIX SYSTEM REPLACEMENT

The contract with Datix 14 runs until November 2027.

Plans are being drawn up to establish an internal multidisciplinary working group to consider the next steps for procuring an alternative risk management system to Datix.

The group will be responsible for:

- establishing the internal challenges and limitations of the current system
- establishing the requirements of a new system
- establishing effective engagement with the All Wales Risk Group to deliver joint working if and where appropriate
- recommend a way forward demonstrating being quality led and value for money.

5. 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.

5. IMPACT ASSESSMENT



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

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



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

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.

6. RISKS

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

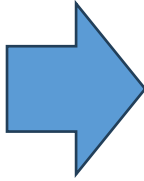
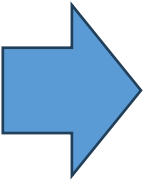
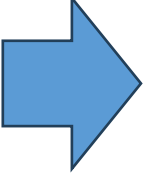
TRUST RISK REGISTER

Trust Board – July reporting cycle

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

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

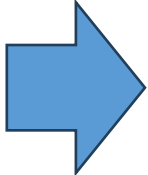
SECTION 1 – Current Trust Risk Register

No	ID & DATE OPENED	DIRECTORATE	RISK DOMAIN	RISK OWNER		INHERENT RATING	CURRENT RATING	TARGET RATING & EXPECTED DATE	RATING CHANGE SINCE LAST REPORTING PERIOD	ACTIONS & DUE DATE	PROGRESS SINCE LAST REPORTING PERIOD
Velindre Cancer Service											
12+ Risks in the Quality and Safety domains											
1	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) Expected date: 01.10.2025		1. Task and Finish group meeting with focus on reviewing the incidents and ensuring the actions proposed address the incidents. Actions are progressing but not yet complete. <i>Due date 01.08.2025</i>	20.06.2025 email task and finish group continuing to progress the recommendations of the email audit. Owners from each service allocated actions. review to be undertaken July. Closure and recommendation report to go to SLT August.
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) Expected date 31.10.24		1. Additional mitigations to reduce the risk are to progress the appointment of the Lead for Novel Techniques and additional MPE vacancies that are currently going through scrutiny	19.06.2025 The extension of SRU implementation and the addition of several other projects to the IRS programme that were originally intended to take place at nVCC have led to increased concern on the availability of resources to complete the required work by Nov 26 and to maintain clinical service. The staff allocation plan is being reviewed and changes to the allocation process will be implemented from 01/07/2025. The risk will be then be reviewed in October 2025 .
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) Expected date:		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.	29.05.2025 Action 1: Extract from T and F group Highlight Report May 2025. Priority: Extend blood sign-off permissions on WCP – SoPs and training, permissions granted. Expected to be commencing at the beginning of July.

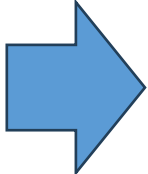
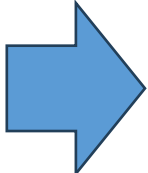
TRUST RISK REGISTER

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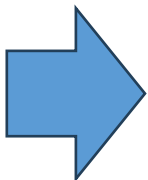
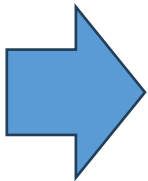
TRUST RISK REGISTER

5	2249 27.02.2020	Velindre Caner 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) Expected date:		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>	19.06.2025 Risk reviewed. No change to risk score. 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
6	3468 12.09.2024 *Returned to TRR	Velindre Cancer Service	Workforce	Consultant	There is a risk to the sarcoma service as a result of the single handed consultant planning on retirement in May 2025 with no robust succession plan in place which will result in patient care being compromised.	20 (4x5)	16 (4x4)	2 (2x1) Expected date: 12.09.25		1. Discussion with existing post holder in relation to delaying resignation date. Agreed to extend retirement date for 12 months <i>Action complete</i>	14.05.2025 Consultant retiring end of June 2025 and taking annual leave from end of May 2025. Clinical Oncologist agreed to support service until recruitment of permanent oncologists anticipated Sept 2025. CNS being advertised as permanent post imminently
	Welsh Blood Service										
	12+ Risks in the Quality and Safety domains										
7	3418 *New to TRR	WBS	Quality/ Safety	Head of Transplantation Services	There is a risk to quality, as a result of pre- and post-examination processes, leading to a potential adverse impact on patient care.	12 (4x3)	12 (4x3)	4 (4x1)	New risk	1. Introduction of LIMS to mitigate the risk of manual transcription errors <i>Due date: 31.12.25</i>	23.06.2025 The treatment plan for this risk involves implementing two new systems: 'WHAISIT LIMS' for Transplantation Services and 'LIMS 2' for Transfusion Services, both aimed at reducing the occurrence of transcription errors in reporting. Implementation of these systems is scheduled between October and December 2025. Additionally, several recent transcription errors—classified as SABRE-reportable—have highlighted that the current outdated IT system (SERIF) contributes to the risk. Replacing this system is therefore considered a key mitigation measure. As the effectiveness of the mitigation is dependent on the successful implementation of the new systems, the overall risk position remains unchanged.

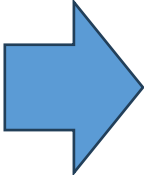
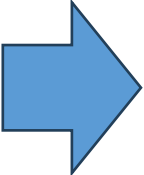
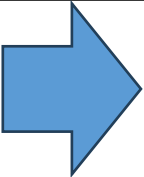
TRUST RISK REGISTER

8	3678 *New to TRR	WBS	Quality/Safety	Head of Transfusion Services	There is a risk to patient safety as a result of independent result entry and authorisation leading to incorrect results being reported on a patient.	12 (4x3)	12 (4x3)	12 (4x3) Expected date 06.05.:.26	New risk	1. Update and add pre-determined comments to standardise reports and minimise transcription. 2. Training of laboratory staff for report writing <i>Due date:01.08.2025</i>	New risk
9	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) Expecte <i>Due date:</i> 31.12.25d date:		3. Implement replacement IT System (Q3) Discovery and planning Transformation workstream - process redesign and system config Data workstream - migration of legacy data Application workstream - build of environments, database and interfaces 19/12/2023 - 26/04/2024 - discovery and implementation planning 26/04/2024 - begin implementation	24.06.2025 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 Go-live Date for the WHAISIT project has been moved to October 2025. No impact on risk scoring.
15+ Risks in other domains											
10	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) Expected date: 18.08.25		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).

TRUST RISK REGISTER

11	3643 11.04.2025 *New to TRR	WBS	Quality/Safety	Head of Transfusion Services	There is a risk to patient safety as a result of an aged Laboratory Information System (SERIF) leading to RCI and Automated Testing being unable to operate a safe service.	16 (4x4)	16 (4x4)	4 (4x1) Expected date: 01.10.25	New risk	1. Validation of upgrade/ Replacement 12.06.2025 Unable upgrade SERIF due to age and lack of digital SME support. The system has been operating safely for over 20 years, current workarounds to remain in place. SBAR drafted to consider all replacement options and timelines (GS). 1. <i>Due date:</i> 01.12.2025	12.06.2025 Expedite implementation of WLIMS2.0 in WBS. Revised order of implementation with DHCW, WBS will go live after the first Health Board instead after all other HBs have taken Blood Transfusion. 2. Re-prioritise WBS Future projects in RCI to create 3. Re-direct staff resources to increase the pace of UAT and Validation testing of WLIMS2.0. 4. Understand inter-dependencies with national BT progress and feasibility of go live by end December 2025.
12	3388 07/05/2024	WBS	Quality	Director of Welsh Blood Service	There is a risk to Quality and Performance as a result of reporting errors and limited accessibility of reports due to no interfaces between the Fetal D IT System (FEDIS) and NHS Wales Digital Applications, leading to suboptimal antenatal care.	16 (4x4)	16 (4x4)	2 (2x1) Expected date: 30.07.25 Expected date: 01.12.27		2. 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>	27.05.2025 Stable/No movement - Application to DHCW approved, awaiting timelines to be confirmed by DHCW to schedule the work and apply for internal resource commitment from Digital Services, Validation and Transplantation Services. Digital to sign off FMEA once DHCW confirm timelines (estimated July 2025).
Corporate											
15+ Risks in other domains											
13	3634 03.04.2025	Corporate	Multiple Risk Domains - Quality Perform	Chief Digital Officer	There is a risk to Quality, Performance and Service Sustainability, and Workforce domains as a result of demand for work on new digital services exceeding the capacity of the Trust digital team and the	16 (4x4)	16 (4x4)	6 (3x2)		1. Agree the final plans with the service areas - expected to be complete by the end of May 2025.	13.06.2025 Risk reviewed. No changes to risk score. Action 1: The service plans have been received.

TRUST RISK REGISTER

					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.			Expected date: 01.04.26		2. External partner will review the roadmap. 3. Capacity demand plan will be developed to support the roadmap. <i>Due date: 29.08.2025</i>	Session in June.2025 to focus on moving this work forward on the capacity plan. Actions 2 &3: The scope of the external roadmap has been written - confirmation of approval awaited
14	3646 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) Expected date:		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>	23.06.2025 Wording sync'd with WBS Futures risk log Risk ID 131
15	3656 24.04.2025	Corporate	Performance and Service Sustainability	Director of Corporate Governance	There is a risk to the quality of clinical and corporate governance due to the current assurance and reporting arrangements of hosted services.	20 (5x4)	20 (5x4)	6 (3x2) Expected date: 31.10.25		1. Review of clinical licensing to be completed by end of May 2025 2. Annual accounts and accountability report to be approved by Trust Board by 26 June 2025. 3. Assurance mapping to be reviewed and completed by end of June 2025 4. WG review of current arrangements to be concluded by end of July 2025 <i>Due date: 31.07.2025</i>	20.06.2026 Action 1: Work underway to map assurances and reporting into QSP Committee. Action 2:work concluded on 26 June. Action 3:Mapping underway for completion by end of August 2025. Action 4:review underway. Awaiting timetable from WG
16	3633 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) Expected date: 31.10.25		1. Share Integration Plan with DHCW to be clear about priorities – Complete 2. Weekly escalation meetings with the DHCW Exec Director responsible to monitor assure on progress. 3. Trust to line up third party suppliers (eg. Thermofisher) to provide their Integration at the right time. <i>Due date: 31.07.2025</i>	13.06.2025 The weekly escalation meetings have been stood down. The interfaces for IRS have been completed successfully. WBS interfaces are underway.

SECTION 2 - Risks Decreased below Board threshold or closed since last Report to Trust Board in May 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
3632 03/04/2025 *dropped below reporting threshold	Corporate	Multiple risk domains -Performance and service sustainability - Quality	Chief Digital Officer	There is a risk to Quality and Performance and Service Stability as a result of National Digital Programmes managed by Digital Health and Care Wales (DHCW) not being delivered to time/cost/quality for use by the Velindre Trust leading to disruption of the clinical model and the plan to transition services to the new Velindre Cancer Centre. The National DHCW programmes of concern for the Trust are RISP/WLIMS/EPMA.	16 (4x4)	12 (4x3)	8 (4x2)		13.06.2025 Risk reviewed. Likelihood reduced from 4 to 3 due to the change note for RISP, resetting the date of EPMA project starting.
3332 02.09.2024 *dropped below reporting threshold	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)		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. This risk now falls below the reporting threshold to Trust Board with a score of 12 in the Workforce domain.

TRUST RISK REGISTER

3392 16.05.2024 *dropped below reporting threshold	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)	12 (3x4)	6 (3x2)		08.07.2025 band 6 post started 30th June 2025. Scrutiny update-band 5-6 DT post not approved 20.06.25. Resubmitted to scrutiny for discussion 11th July 2025. UGI band 7 post - will be a vacancy from 02.08.25. Scrutiny approval to recruit like for like, job out to advert. Scrutiny case needed to extend 0.6wte locum to cover vacancies: 1.0wte band 5 July/August and 1.0wte band 7 UGI post August cover. Service model currently delivers to: H&N, UGI (excluding HPB/pancreatic), inpatients. Services suspended include general OP clinic & AU & neuro-oncology. Due to more stability within the team & locum cover = 0.04wte below normal establishment, risk reduced to 12. 19.06.2025 Band 8a Professional Lead now in post Band 7 UGI specialist - now in post Band 6 specialist appointed, start date 30.06.2025 Band 5 - with scrutiny panel to re-design role. The team currently has 0.6wte locum. Currently 1.4wte down from normal establishment (including Locums) Outpatient service remains suspended with pressure on the other areas of inpatients, H&N and UGI. Risk to remain at 16	



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TRUST BOARD	
TRUST ASSURANCE FRAMEWORK UPDATE	
DATE OF MEETING	24 JULY 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 Trust Board with the latest updates to the Trust Assurance Framework.
RECOMMENDATION / ACTIONS	The Trust Board are asked to: • NOTE the current status of the Trust Assurance Framework. • NOTE the plan to move forward with the Trust Assurance Framework • ENDORSE a proposal to rename the Trust Assurance Framework (TAF) to Board Assurance Framework (BAF), to align VUNHST with all other NHS Wales organisations.
COMMITTEE / GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING	
COMMITTEE OR GROUP	DATE
Executive Management Board	30.06.2025
Quality, Safety and Performance Committee	17.07.2025

The discussions at the Executive Management Board Strategic Risk Discussion meeting on 17.06.2025 and again on 30.06.2025 are incorporated into this report.

The QSP Committee reiterated the importance of the correct use of the lines of defence and noted an expectation that the TAF would be progressed at pace.

The QSP were in agreement that the Trust Assurance Framework should change to the Board Assurance Framework in line with other NHS organisations.

**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	Ten strategic risks
2	Trust Assurance Framework Summary
3	Trust Assurance Framework Detail

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. As part of IMTP process some the strategic risks have been considered in line with strategic goals. The revised strategic risks were considered and approved by Trust Board in March 2025.

2. ASSESSMENT

2.1 As part of the Integrated Medium-Term Plan (IMTP) ten strategic risks were agreed by Trust Board in March 2025. Following Executive Management Team review, it has been agreed that additional work is needed to ensure the strategic risks are appropriately described and reported. A review of the suitability of the strategic risks has been undertaken by the Executive Team, including the consideration of risk titles. The Executive Team agreed an additional workforce risk should be separated from TAF02. This risk is now available as TAF11. Risk TAF02 has now



been refined as a specific risk related to quality outcomes for the cancer service – this risk is currently in development.

2.2 Following constructive discussions at EMB, further work is planned over the coming weeks to:

- finalise the wording of the new risks (risks 03,04,05,10);
- confirm the controls, actions and assurance ratings for these risks;
- refine actions and assurance levels across the TAF.

2.3 Following approval from the Executive team, strategic risk reviews have taken place to ensure that the TAF dashboard is fully reviewed, updated in line with the new template, including rationalised action plans.

2.4 Regular monthly review meetings are in place to support of the management of the strategic risks.

2.6 Appendices 2 and 3 show the current summary for the ten strategic risks and the more detailed information to support.

4 IMPACT ASSESSMENT

RELATED TRUST STRATEGIC GOAL(S)	Please indicate whether or not any of the matters outlined in this report impact the Trust's strategic goals. Please indicate here
Please tick all relevant goals: . Outstanding for quality, safety and experience ☒ . An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ . A beacon for research, development and innovation in our stated areas of priority ☐ . An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ . A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC TRUST ASSURANCE FRAMEWORK RISK	06 - QUALITY & SAFETY



QUALITY AND SAFETY IMPLICATIONS / IMPACT	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Cantered ☒
	The risk register and associated risk framework are imperative to quality and safety in the organisation.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED	Not required.
TRUST WELL-BEING GOAL IMPLICATIONS/IMPACT	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



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

Appendix 1 – Trust Strategic Risks

RISK REF	RISK TITLE	STRATEGIC GOAL/ENABLER	SUGGESTED RISK LEAD(S)
01	There is a strategic risk of failure to deliver timely, safe, effective and efficient services for the local population leading to deterioration in service quality, performance or financial control as a result insufficient capacity and resources.	Outstanding for quality, safety and experience.	Chief Operating Officer
02	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, optimised workforce supply and shape, and lack of consistent quality, outcome and mortality metrics.	An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed, expectations.	Chief Operating Officer Director of Nursing, AHPs and Health Scientists Medical Director
03	There is a strategic risk of: 1. Not effectively delivering against the Velindre Cancer Service 10 year Cancer Research Ambition and the Welsh Blood Service Research Strategy and 2. The ability to fully embed innovation activities in line with the national Innovation Framework.	A beacon for research, development and innovation in our stated areas of priority.	Medical Director
04	There is a strategic risk of failing to optimise the full potential of a University designation.	An established University Trust which provides highly valued knowledge and experience for all.	Director of Corporate Governance
05	There is a strategic risk of not effectively embedding our role as a sustainable organisation, outside of main infrastructure and specific centrally led activity.	future for people across the globe	Director of Planning
06	There is a risk of failure to meet or exceed service expectations without the prevalence of a positive working environment, which is characterised by	Culture	Director of OD and Workforce



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	effective values and behaviours, systems and processes		
07	There is a strategic risk that the Trust fails to sufficiently consider, optimise the opportunities and effectively manage the risks of new and existing technologies, including considerations of Artificial Intelligence and Information Security	Digital	Chief Digital Officer
08	There is a strategic risk that the organisational and clinical governance arrangements do not provide appropriate mechanisms and culture to achieve our medium to long term objectives.	Governance	Director of Corporate Governance
09	There is a strategic risk that the Trust becomes financially unsustainable if it does not secure sufficient funding for the provision of services and does not maximise its use of resources. Unwarranted variation could impact the value and effectiveness of the care our patients and donors receive.	Financial	Director of Finance
10	There is a strategic risk that given this planning window represents such a significant transformation agenda that this change will not be delivered in a way that meets our strategic objectives.	Transformation Delivery	Director of Planning
11	There is a strategic risk to the Trust's ability to effectively deliver quality services and achieve our medium to long term objectives if we are unable to develop and maintain of an optimised workforce supply and shape	Workforce	Director of OD and Workforce

Risk ID	Strategic Objective & Lead	Strategic Risk	Risk Scores (impact x Likelihood)	Key Controls	Action Plan
01	Outstanding for quality, safety and experience. • Chief Operating Officer	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.	Inherent 16 (4x4)	- Blood stock planning and management function between WBS and Health Boards. - Operational Blood stock planning and management function in WBS. - Continuity of core service delivery functions supporting Transfusion, Transplantation and Welsh Bone Marrow Donor Registry (WBMDR). - Delivery of business as usual core services and capacity to support strategic programmes of work. - National Policy decisions/ Directives that are introduced including Regulatory requirements, to ensure the safety of services. - SEW- VUNHST cancer demand modelling programme with HBs and WGDU in place, continues to provide high level assurance on demand projections. - Demand and Capacity Planning to identify gaps within service delivery models	**Action plan has been rationalised with previous TAF and 205-26 IMTP** 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.
			Current 12 (4x3)		01.03 Capacity and demand business cases across a number of operational areas within WBS have been produced and submitted to JCC for consideration. These include: - Red Cell Immuno-haematology workforce due to increases in demand - Collection team resilience to support demand fluctuations and prevent service going into supply shortages - The Introduction of West Nile Virus testing - Increasing recruitment of Welsh Bone Marrow Donor Register Volunteers - Recurrent funding to support our Component Development Laboratory Staffing infrastructure to support mandated changes upstream. July 2025 Plan to re-engage with JCC commissioner business cycle on same cases given financial risk being taken
					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
					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

Executive Lead Summary: WBS – the position is stable and has been sustained for a number of months. VCS – delivery of the SACT service has been sustained close to the treatment standard. Further work is being done across the radiotherapy pathway to continue to build capacity.					
Risk score trend: The risk score has remained static since the last period.					
02	An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed, expectations. - Chief Operating Officer - Director of Nursing, AHPs & Healthcare Scientists - Medical Director	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, optimised workforce supply and shape, and lack of consistent quality, outcome and mortality metrics.	New risk	New risk - The workforce risk has been developed and is now risk TAF11. - Risk leads are currently reviewing the risk and rationalising the action plan.	New risk <i>**Action plan to be further rationalised from previous TAF and IMTP**</i>
			New risk		
			New risk		
Executive Lead Summary: Following a review by the Executive Team, it was agreed to separate TAF02, as drafted in the IMTP, into two risks – a risk to the Quality and Safety related to the cancer service and separate Trust wide Workforce risk (now available as TAF11).					
Risk score trend: this is a new risk. Trend activity unavailable.					
03	A beacon for research, development and innovation in our stated areas of priority. Medical Director	There is a strategic risk of: 1. Not effectively delivering against the Velindre Cancer Service 10 year Cancer Research Ambition and the Welsh Blood Service Research Strategy, and 2. The ability to fully embed innovation activities in line with the National Innovation Framework.	New risk	New risk	New risk <i>**Action plan to be further rationalised from previous TAF and IMTP**</i> - The risk lead has met with the Research, Development and Innovation core team on regarding TAF03. - Key controls and actions are being developed to support TAF03, including rationalising the actions from the IMTP.
			New risk		
			New risk		
Executive Lead Summary: The relevant action plan is being developed by the Research, Development and Innovation team.					
Risk score trend: this is a new risk. Trend activity unavailable.					
04	An established University Trust which provides highly valued knowledge and	There is a strategic risk of failing to retain the Trust's University status.	3 (1x3)	- University Independent Board Member - Robust collaborations with university partners, for example deed of association with the University of Wales, Trinity St Davids, Cardiff University: multi-	New risk <i>**Action plan to be further rationalised from previous TAF and IMTP**</i> Following discussion in the Executive Team, the Director of Nursing, AHPs and Healthcare Scientists carried out an
			3 (1x3)		
			3		

	experience for all. Director of Corporate Governance		(1x3)	professional research SLA; Cardiff Cancer Research Hub Academic partnership arrangements across a range of universities in Wales.	initial risk assessment. The inherent, currant and target risk rating were all assessed as 3. - The suggestion by the Executive Team was that the risk be reviewed every six months to ensure the target rate and risk tolerance are maintained. - The risk is currently being reviewed by the Medical Director and the Director of Corporate Governance.
Executive Lead Summary: Controls have been identified and will be subject to a ratings review over the coming weeks. An initial draft of the actions, controls and assurance levels has been included in the template.					
Risk score trend: this is a new risk. Trend activity unavailable.					
05	A sustainable organisation that plays its part in creating a better future for people across the globe Director of Transformation	There is a strategic risk of not effectively embedding our role as a sustainable organisation, outside of main infrastructure and specific centrally led activity.	New risk	New risk - The risk is currently under review by the Director of Planning. - The action plan will be rationalised as part of this review.	New risk <i>**Action plan to be further rationalised from previous TAF and IMTP**</i>
Executive Lead Summary:					
Risk score trend: this is a new risk. Trend activity unavailable.					
06	Culture Director of OD and Workforce	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.	Inherent 16 (4x4)	- Trust Strategies and enabling strategies (including people, RD&l and Digital) launched November 2023. - Approved Education Strategy and implementation plan to support the educational development of the Organisation to support the Trust direction - Management and Leadership development programmes in place based on compassionate leadership principles - Trust Values and Behaviour Framework - Communication infrastructure in place - Health and Wellbeing infostructure for the Trust to support physical and psychological wellbeing of staff - Governance arrangements in place to monitor and evaluate the implementation of plans - Performance Management Framework in place to monitor the finance, workforce and performance of the Organisation - Clear safe, effective and efficient service models to support role clarity aligned to compassionate leadership principles - Operational workforce plans developed to support agreed service models	<i>**Action plan has been rationalised with previous TAF and 205-26 IMTP**</i>
					06.02 Embed the principles of the Social Partnership Duty into the Trust's strategic development and through the Trust Board cycles of business
					06.05 Implement the actions of the Trust Strategic Equality Plan, including embedding the Anti-Racist Wales Action Plan in the Trust June ‘25 The 2024-25 SEP workplan has been closed and the new plan 2025-26 is in action.
			Current 12 (4x3)		06.06 Implement the actions within the Health and Wellbeing Action plan – supporting wellness and managing action plan for sickness absence June ‘25

			Target 6 (2x3)	Avoidable employee harm principles are embedded into the management of behaviours within the Trust	The 2024-25 Health and Wellbeing workplan has been closed and the new plan 2025-26 is in action.
					06.07 Commence the Values and Behaviour framework project
					06.08 Review performance indicators for a Healthy and Engaged workforce including EQIA measures and hybrid working
					06.09 Deliver an action plan for 2024/25 to support our commitment to the Trust Anti- Racist Action plan
					06.10 Monitor Welsh Language Standards, working with Divisions on improvement plans
					06.11 Implement the WL Culture plan
					06.12 Update all WOD related policies and procedures
					06.13 We will conduct a comprehensive review of all Workforce Policies ensuring documents are up to date with current legislation and best practice. This will involve engaging with key stakeholders, benchmarking and ensuring documents are easily accessible to all staff
					06.14 We will design and implement a structured learning and development framework by that enhances the skills and capabilities of the workforce as well as ensuring there are adequate leadership and management capabilities
					06.15 The People and Organisational Development Team will develop a well-being and engagement framework to support staff and ensure they feel valued and supported within the culture of the organisation June '25 NHS Staff Survey Plans have been developed for the Trust and Divisions – due at Healthy and Engaged Steering Group July 2025. Wellbeing Metrics and Wellbeing Project Evaluation reports due at Healthy and Engaged Steering Group July 2025.

					06.16 The People and Organisational Development Team will support the Trust to develop a workplace culture for our people that is truly inclusive by developing compassionate frameworks aligned to statutory requirements for improving equality and diversity within Wales June '25 This is contained within the SEP Workplan 2025-26. EQIA report for 2024-25 due at Healthy and Engaged Steering Group July 2025 Anti-racist e learning package launched April 2025 and compliance on track for year end target. 06.17 We will support the Trust to develop workforce plans, both strategic and operational based on the changing needs of the labour market and service delivery. Divisional plans will ensure detailed analysis of key workforce data ensuring any actions implemented will bridge gaps and challenges within the workforce. The final plans will be delivered by March 2026 with the next phase being implementation and change management from April 2026 to March 2028 06.18 We will develop and implement a comprehensive talent attraction and retention by. This will include design and roll out of employer branding and attraction campaigns, development of career pathways and supportive access to work initiatives that improve workforce diversity as well as dedicated retention plans where needed within hard to fill roles
Executive 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. Risk score trend: The risk score has remained static since the last period.					
07	Digital Chief Digital Officer	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	Inherent 16 (4x4)	- Trust Digital Strategy - Published Oct '23 - Active work ongoing to leverage existing and deliver on new technologies – e.g. LIMS, IRS, , EPMA - Training & Education packages to develop internal capabilities – including for exec and Board - Training & Education packages for donors, patients	<i>**Action plan has been rationalised with previous TAF and 205-26 IMTP**</i> 07.01 Create the Trust Digital Reference Architecture to support C14 and others June 2025

				• Ring-fencing digital advancement in Trust budget – benchmark 4% • Specifically, development of digital resources capacity and capability • Digital inclusion in wider community • Prioritisation and change framework to manage service requests • Levels of unsupported applications/ legacy systems • Trust digital Governance • Framework of lead and lag indicator reporting into Trust digital governance structure, integrated into wider performance framework • Cyber Assurance Controls in place • Digital transformation is guided by an agreed digital architecture.	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. National Target Architecture programme has now been initiated and the Trust are engaged in the work
			Current 12 (4x3)		07.02 Prioritisation framework needs to be established for the Data and Insight Service June 2025 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 C9 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 C9 Workshop with Exec Director planned for 24/06/2025
			Target 8 (4x2)		07.03 Reviewing control framework with Head of Information Governance for cross-check and alignment June 2025 Initial review undertaken and updates will be collated for August 25 TAF
Executive Lead Summary: Jun '25 Work is ongoing on the key controls - no movement to overall current risk scoring due to overall digital risk position. Assurance ratings moved to 7 levels of assurance. New risks have been added to reflect the operational Digital risk - including challenges with delivering the National Programmes for RISP and LIMS. New go-live date for RISP agreed (Jan '26 from Jun '25) due to National/Regional image viewer capabilities. The 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.					
08	Governance • Director of Corporate 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.	Inherent 16 (4x4)	• Annual Assessment of Board Effectiveness • Board Committee Effectiveness Arrangements • Board Development Programme • Quality of assurance provided to the Board	**Action plan has been rationalised with previous TAF and 205-26 IMTP** 08.01 External benchmarking of Governance, Assurance & Risk best practice as part of the Governance, Assurance & Risk programme of work

				• External benchmarking of Governance, Assurance & Risk best practice as part of the Governance, Assurance & Risk programme of work • Cross-reference of Integrated Medium Term Plan objectives to strategic objectives in the Trust Assurance Framework	08.02 Develop new plan for phase 2 GAR programme
			Current 15 (5x3)		08.03 Review Trust Risk Policy June '25 Wok to be completed for September 2025.
			Target 8 (4x2)		08.04 Develop new TAF template and content - aligned with IMTP. June '25 GAR Group meeting to consider draft of Corporate Governance Manual, including new Board/Committee template and instructions in July 2025.
Executive Lead Summary: Work on developing key documentation supporting the organisation's governance continues – particularly the new TAF, a review of the Risk Strategy and associated documents, all of which inform the development of the Corporate Governance Manual. The Welsh Government's review of the hosting arrangements for Shared Services has commenced and is due to report in July 2025. Dialogue with Audit Wales and Internal Audit on some of the issues considered by the Board on these matters. A draft report reviewing the Board's Board and Governance Arrangements has been received. Work on the GAR programme continues with a keen focus on reviewing the Risk Policy and updating the TAF in line with the Trust approved IMTP. Risk score trend: The risk score has remained static since the last period.					
09	Financial • Director of Finance	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.	Inherent 16 (4x4)	• Divisional Financial Outturn • Quarterly Finance Reviews • Divisional Performance Review • Executive and Trust Board Reporting • Statutory and Mandatory Financial Reporting (inc. Annual Accounts) • Finance and Investment: Enhanced Monitoring • Collective Commissioners Review • Investment Appraisal • Financial Strategy / Medium Term Financial Plan / Budget Setting • Scheme of Delegation and Delegated Financial Authority • Value Based Healthcare programme • Procure to Pay monitoring • Debtors / Cash monitoring • Discretionary Capital Financial Planning and Reporting • Major Capital Programmes monitoring • Counter Fraud • Tax management	**Action plan has been rationalised with previous TAF and 205-26 IMTP** 09.01 Development of VBH programme of work to identify areas of unwarranted variation and actions to improve 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. 2025-26 Progress: • Digital PROMS platform - go live due in July • PROMS Questionnaires - continue to be develop and agree national sets - focus on Breast and Colorectal • SST Data Insights Dashboard ongoing insight and awareness raising to support clinicians in reducing unwarranted variation e.g. referral patterns, admission rates, medicines prescribing, use of VAP service. Also used to calculate opportunities for a virtual thyroid follow up service (to replace telephone) Self administration pathway established for denosumab subcutaneous injections, releasing resource for more complex treatments.

				• Procurement	• Data quality improved for historical open pathways, addressing clinical risk • Training, communication & engagement - communication strategy in place, training & engagement sessions undertaken; further staff members undertaking Swansea University Value in Health course
					09.02 Continuous improvement of Finance and Investment Enhanced Monitoring reporting including identification of Savings Opportunities; Disinvestments and Choices and clear line of sight with Welsh Government Value and Sustainability Board agenda Savings / Efficiencies opportunity Pipeline identified 4 areas being progressed or explored - Pre-operative anaemia pathway expansion (implementation), Medicines Management - NWSSP medicine unit supply (underway) & further areas to be identified through Medicines Strategy Group, Workforce re-design - service divisions to identify all areas of workforce model and pathway review to enable a Trust wide assessment of opportunities for efficiency and productivity improvement, Procurement reviews of non-pay spend to identify opportunities for cost improvement in income recovery. EMB agreed SROs for each of the 4 areas to take accountability at Exec level to oversee the development and delivery. Pharmacy review has been conducted and was presented to Exec Management Board early in 2024. An Internal Audit review of medicines management governance (including financial aspects) was conducted in July / Aug 2024 and reported to Audit Committee in Sep '24 with substantial assurance. Medicines Strategy Group to be established by SRO (Medical Director) for Medicines Group. Newly appointment Deputy Medical Director will establish the Strategy Group during 2025-26. IMTP savings created using SMART actions to strengthen identification, monitor progress and delivery.
			Current 12 (4x3)		09.03 Development and review of Financial Control Procedures Capital financial control procedure approved by Audit Committee. Financial Control Procedure (FCP) update plan and pipeline for review in development. 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: Accruals & Prepayments - Finance teams have created 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. 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. Unidentified income significantly reduced following adoption of suspense account clearing. Petty Cash FCP been updated, priority to review and update all FCPs following accounts submission."
				09.04 Development of Investment Appraisal process and prioritisation framework 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. Several meetings have taken place during May and June with C&V and Cardiff University to find a financially sustainable and risk sharing model. Private Patients 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. Work continues with Liaison Financial external consultants whereby an extensive review of tariffs for all private patient activity has been undertaken and validated by VUNHST and Liaison Financial. Contract negotiations with insurance providers will begin imminently and involve pathology charging as well as payment of old debts.
				09.05 Identification of business development and external funding opportunities

				Cardiff Cancer Research Hub financial plan review has identified that in 2025-26 costs are covered by funding but there is currently a shortfall in 2026-27 between anticipated trial & other income and forecast costs. Further work required to model additional trail activity and impact on cost and income. Several meetings have taken place during May and June with C&V and Cardiff University to find a financially sustainable and risk sharing model. Private Patients 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. Work continues with Liaison Financial external consultants whereby an extensive review of tariffs for all private patient activity has been undertaken and validated by VUNHST and Liaison Financial. Contract negotiations with insurance providers will begin imminently and involve pathology charging as well as payment of old debts.
			Target 8 (4x2)	09.06 Develop Scheme of Delegation and Governance Framework for All Major programmes A Scheme of Delegation and Governance Framework has been developed for nVCC, which has cross referenced findings from PwC and Gateway reviews as well 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. Scheme of delegation previously developed and approved for the Intergrated Radiotherapy Solution. Progress required on setting a revised expenditure approval hierarchy with the Oracle financial system in line with the agreed scheme of delegation.

				Subject to WG approval a Scheme of Delegation and Governance Framework will be developed for the WBS infrastructure programme.
				09.07 Data & Insights team working with Finance team and service leads to investigate where data capture and mapping to contract currencies is not working correctly. Once the issues with the process have been identified corrective action can be taken both in the short term and longer term to ensure all activity is correctly captured and charged for. Risk to be added to Datix to reflect the control weakness in activity data capture and mapping to contract activity to ensure Trust recovers all income for work undertaken. 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 it commissioners. The assessment of 2024-25 VCS LTA income was £240k under the plan. The Trust is proposing that a change in contract currency is adopted to reflect the change in the radiotherapy pathway for hypo fractionated prostate radiotherapy. A business case has been developed and will be presented to the Trust Commissioners on the 25.06.25 seeking support and approval.
				09.08 Exploring opportunity to expand supply for other drugs working with the NWSSP Medicines Unit.

					09.09 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. 09.10 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. 09.11 Divisions reviewing non-value adding clinical practice or processes and changing ways of working through Value-Based Healthcare approach. 09.12 Pre-op anaemia programme: This is a national initiative to address the inconsistencies in the diagnosis and management of anaemia for patients undergoing high risk surgery (specifically 10 procedures identified as being most likely to result in a blood transfusion). It has been developed in conjunction with the Wales Blood Health National Oversight Group (BHNOC).
Executive Lead 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. Operational Summary Risk score trend: The risk score has remained static since the last period.					
10	Transformation Delivery	There is a strategic risk that given this planning window represents such a significant transformation agenda that this change will not be delivered in a way that meets our strategic objectives.	New risk	New risk - The risk is currently under review by the Director of Planning. - The action plan will be rationalised as part of this review.	New risk **Action plan to be rationalised from previous TAF and IMTP**
Executive Lead Summary: TBC. Risk score trend: this is a new risk. Trend activity unavailable.					
11	Workforce	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	16 (4x4)	Trust People Strategy, approved in May 2022, clearly noting the strategic intent of Workforce Planning - 'Planned and Sustained Workforce'	**Action plan has been rationalised with previous TAF and 205-26 IMTP** 11.02

	Director of OD and Workforce	to develop and maintain of an optimised workforce supply and shape		- Approved Workforce Planning Methodology aligned to Trust Values and Behaviours - Educational pathways in place to support the recruitment of new skills and development of new roles - Consistent recruitment and selection process - Trust People Strategy, approved in May 2022. clearly noting the strategic intent of Workforce Planning - 'Planned and Sustained Workforce' - Approved Workforce Planning Methodology aligned to Trust Values and Behaviours - Workforce planning - skills development - Workforce Planning embedded into our Inspire Programme to develop Mangers and leaders in Workforce Planning skills	Embed workforce planning into monthly Divisional Senior Leadership Workforce reporting. June '25 Additional Resource for Workforce Planning through IMTP not supported. Alternative plan to embed workforce planning though the wider team undertaken instead. Monthly meetings underway with ongoing dedicated support for recruitment, development, retention and people analytics.
			12 (4x3)		11.03 Implementation of the Attraction and Resourcing Project June '25 Initial implementation completed. Financial agreement for ongoing resource agreed as part of the IMTP. Project to become part of BAU for POD.
			6 (2x3)		11.04 Implementation of the Nurse Retention Plan through the Professional Nursing Forum June'25 Nurse Retention Plan currently in draft 27.01.2005 EMB endorsed the NRP, implementation underway.
					11.05 Develop a robust Workforce Planning Team and supporting infrastructure (i.e. steering groups, assurance paper etc. for the Trust, that is able to support service leads in the review, design and implementation of comprehensive workforce plans.
Executive Lead Summary: There are many factors that impact on the current supply and shape of our workforce. These are both external, due to the economic landscape impacting the labour market and internal, in the specific MDTs within 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 people development, through effective 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. Risk score trend: The risk score has remained static since the last period.					

TRUST ASSURANCE FRAMEWORK

RISK ID	STRATEGIC RISK	STRATEGIC GOAL/ ENABLER	INITIAL RISK SCORE (I X L)	CURRENT RISK SCORE (I X L)	CURRENT RISK TREND	ASSURANCE RATING	TRUST RISK REGISTER CORRESPONDING RISK
01	There is a strategic risk of failure to deliver timely, safe, effective and efficient services for the local population leading to deterioration in service quality, performance or financial control as a result insufficient capacity and resources.	Outstanding for quality, safety and experience.	16 (4X4)	12 (4X3)	TAF01 20 0 12 12 12 12 12 12 jan... feb... ma... ap... ma... jun...	TBC	- 2465 Inefficient clinical information processing methods - 3562 Uncertain process and ownership for reviewing and accessing blood test results - 2187 Inadequate staffing in Radiotherapy Physics Dept - 3468 Risk to the sarcoma service as a result of the single-handed consultant due to retire with no robust succession plan in place.
02	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, optimised workforce supply and shape, and lack of consistent quality, outcome and mortality metrics.	An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed, expectations.	New risk	New risk	New risk	New risk	- 2187 Inadequate staffing in Radiotherapy Physics Dept - 3332 Wellbeing of medical workforce due to increase in patient clinic numbers - 3392 Dietetic deliver due to staff vacancies - 3468 Single handed consultant service, retirement pending.
03	There is a strategic risk of: 1. Not effectively delivering against the Velindre Cancer Service 10 year Cancer Research Ambition and the Welsh Blood Service Research Strategy and 2. The ability to fully embed innovation activities in line with the national Innovation Framework.	A beacon for research, development and innovation in our stated areas of priority.	New risk	New risk	New risk	New risk	There are no associated risk on the Trust Risk Register
04	There is a strategic risk of failing to optimise the full potential of a university designation.	An established University Trust which provides highly valued knowledge and experience for all.	3 (1x3)	3 (1x3)	New risk	New risk	There are no associated risk on the Trust Risk Register
05	There is a strategic risk of not effectively embedding our role as a sustainable organisation, outside of main infrastructure and specific centrally led activity	A sustainable organisation that plays its part in creating a better future for people across the globe	New risk	New risk	New risk	New risk	There are no associated risk on the Trust Risk Register
06	There is a risk of failure to meet or exceed service expectations without the prevalence of a positive working environment, which is characterised by effective values and behaviours, systems and processes	Culture	12 (4x3)	9 (3x3)	TAF06 20 10 0 12 12 12 12 12 12 jan... feb... ma... apr... mai... jun...	TBC	- There are no associated risk on the Trust Risk Register
07	There is a strategic risk that the Trust fails to sufficiently consider, optimise the opportunities and effectively manage the risks of new and existing technologies, including considerations of Artificial Intelligence and Information Security	Digital	16 (4x4)	12 (4x3)	TAF07 20 10 0 12 12 12 12 12 12 jan-25 feb-25 mar... apr-25 mai... jun-25	4	- 3541 Delay in TrAMS project causing capacity issues for SACT production - 2249 Service disruption due to time limited funding - 3388 Reporting errors and limited access to FEDIS system - 2745 is a risk on the private Trust Risk Register - 3634 Demand exceeding capacity in new digital services team - 3646 Delay in go live date for LIMS Programme
08	There is a strategic risk that the organisational and clinical governance arrangements do not provide appropriate mechanisms and culture to achieve our medium to long term objectives.	Governance	15 (3x5)	15 (5x3)	TAF08 20 0 12 12 12 12 15 15 ja... fe... m... ap... m... ju...	3	- 3656 Quality of current assurance and reporting arrangements in hosted services

TRUST ASSURANCE FRAMEWORK

09	There is a strategic risk that the Trust becomes financially unsustainable if it does not secure sufficient funding for the provision of services and does not maximise its use of resources. Unwarranted variation could impact the value and effectiveness of the care our patients and donors receive.	Financial	16 (4x4)	12 (4x3)	TAF09 20 0 12 12 12 12 12 12 ja... fe... m... ap... m... ju...	4	- 2249 Service disruption due to number of time limited funded posts
10	There is a strategic risk that given this planning window represents such a significant transformation agenda that this change will not be delivered in a way that meets our strategic objectives.	Transformation Delivery	New risk	New risk	New risk	New risk	There are no associated risk on the Trust Risk Register
11	There is a strategic risk to the Trust's ability to effectively deliver quality services and achieve our medium to long term objectives if we are unable to develop and maintain of an optimised workforce supply and shape	Workforce	16 (4x4)	12 (4x3)	TAF11 15 10 5 0 12 12 12 12 12 12 jan-25 feb-25 mar-25 apr-25 mai-25 jun-25	4	- 2187 Inadequate staffing in Radiotherapy Physics Dept - 3468 Sarcoma Service risk due to single consultant led service, with retirement due and not robust succession plan. - 3634 Capacity issues for digital services

SECTION 1 – Summary																					
RISK ID	01	REVIEW DATE	July 2025	Risk Title	There is a strategic risk of failure to deliver timely, safe, effective and efficient services for the local population leading to deterioration in service quality, performance or financial control as a result insufficient capacity and resources.																
				Risk Lead	Chief Operating Officer																
CORE ENABLER	Service Capacity				STRATEGIC GOAL	1 - Outstanding for quality, safety and experience.															
CURRENT SCORE TREND	TAF01 <table><tr><th>Period</th><th>Score</th></tr><tr><td>jan-25</td><td>12</td></tr><tr><td>feb-25</td><td>12</td></tr><tr><td>mar-25</td><td>12</td></tr><tr><td>apr-25</td><td>12</td></tr><tr><td>mai-25</td><td>12</td></tr><tr><td>jun-25</td><td>12</td></tr></table>				Period	Score	jan-25	12	feb-25	12	mar-25	12	apr-25	12	mai-25	12	jun-25	12	CURRENT RISK SUMMARY	WBS - position is stable and has been sustained for a number of months. VCS – delivery of the SACT service has been sustained close to the treatment standard. Further work is being done across the radiotherapy pathway to continue to build capacity. Risk score trend: The risk score has remained static since the last period.	
Period	Score																				
jan-25	12																				
feb-25	12																				
mar-25	12																				
apr-25	12																				
mai-25	12																				
jun-25	12																				

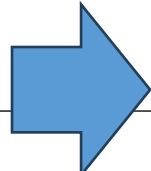
SECTION 2 – Risk Scores									
INHERENT RISK	LIKELIHOOD	IMPACT	TOTAL	CURRENT RISK	LIKELIHOOD	IMPACT	TOTAL	TARGET RISK	LIKELIHOOD
	4	4	16		3	4	12		2
									IMPACT
									4
									TOTAL
									8
								Expected date to reach Target Risk Score	This will be reviewed at the end of Q2.

SECTION 3 – Effectiveness, Controls and Assurance				
Overall Level of Effectiveness Assurance Rating (see definitions tab)	PARTIALLY EFFECTIVE	Overall Assurance Rating	Current Review Period	
			Previous Review Period	
		Rationale for Assurance Rating		
KEY CONTROLS		SOURCES OF ASSURANCE		

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

C4	Delivery of business as usual core services and capacity to support strategic programmes of work.	Directors of WBS and VCS	X			Implementation group for programmes mapping the interdependencies and pressures. Regular touch point meetings with Senior Leadership Team to review capacity to deliver key programmes of work – namely Futures Programmes.	Highlight and performance reports to Senior Leadership Team and EMB to review.	QSP committee and Board and external stakeholders if required. Regulatory Inspections such as Medicines and Healthcare products Regulatory Agency and Human Tissue Authority Internal Audit, Wales Audit Office, regulator audits.
C5	National Policy decisions/ Directives that are introduced including Regulatory requirements, to ensure the safety of services. (Advancements in medicines to improve patient safety).	Directors of WBS and VCS	X			WBS - Horizon scanning and representation at key groups including UK Forum, Joint Professional Advisory Committee (JPAC) for UK blood services, The UK advisory committee on the Safety of Blood, Tissues and Organs (SaBTO). Regular liaison with Blood Policy and Tissue, Cells and Organs Policy team in Welsh Government. VCS - NICE Guidelines re Cancer drugs and treatments	Trust wide clinical and scientific board. Senior Leadership Team and EMB Review. QSP SDC	JCC and Welsh Government
C6	SEW- VUNHST cancer demand modelling programme with HBs and WGDU in place, continues to provide high level assurance on demand projections.	Director of VCS	X	X		SE Wales Group	Performance Report - SLT, EMB, QSP and Board	Welsh Government Quality, Planning and Delivery Review
C7	Demand and Capacity Planning to identify gaps within service delivery models	Director of VCS	X	X		Service area operational planning meeting	Performance Report - SLT, EMB, QSP and Board	Welsh Government Quality, Planning and Delivery Review

GAPS IN CONTROLS			GAPS IN ASSURANCE			ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.		
Lack of real time data on fating of blood to allow business intelligence data set that links Health Board and activity changes to demand and patient outcomes. Addressing this gap would require digital systems to be in place which are out of WBS control. Projects are progressing externally as part of Infected Blood Inquiry recommendations.								
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.								

SECTION 4 – ASSOCIATED OPERATIONAL RISK (in line with Trust Risk appetite)				
DATIX RISK REF		CURRENT RISK RATING	RISK TREND	
2465 VCS	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		

2187 VCS	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	
3562 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	15	
3468 VCS	There is a risk to the sarcoma service as a result of the single handed consultant planning on retirement in May 2025 with no robust succession plan in place which will result in patient care being compromised.	16	

SECTION 5 – ACTION PLAN (IMTP Priority Improvement Actions and TAF Actions)								
ACTION REF	ACTION	OWNER	DUE DATE	ASSURANCE LEVEL	PROGRESS UPDATE	DATE OF UPDATE	IMPACT OF CHANGE ON RISK	DETAIL IMPACT ON ASSURANCE LEVEL/CONTROL WHEN COMPLETE
01.02	Following publication of the Infected Blood Inquiry Report in May 2024 the Blood Health National Oversight Group has produced a paper for consideration by the Welsh government IBI next steps working group to help align the inquiry recommendations against the National Blood Health plan which should in turn improve prudent use of blood across Wales which in turn supports demand and supply for the Welsh Blood Service.	WBS Director	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.	27.01.25	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.	This action is under review and will transfer to TAF XX regarding Trust wide Quality and Safety

01.03	Capacity and demand business cases across a number of operational areas within WBS hav been produced and submitted to JCC for consideration. These include Red Cell Immuno-haematology workforce due to increases in demand Collection team resilience to support demand fluctuations and prevent service going into supply shortages Introduction of West Nile Virus testing Increasing recruitment of Welsh Bone Marrow Donor Register Volunteers Recurrent funding to support our Component Development Laboratory Staffing infrastructure to support mandated changes upstream.	WBS Director	Jan 25		Business case discussions between the Trust and commissioners took place in February 2025. None of the cases were supported.	27.05.2025	WBS has gone at financial risk to support some of these cases as part of its IMTP. July 2025 Plan to re-engage with JCC commissioner business cycle on same cases given financial risk being taken	
01.04	Review of outpatient activity to determine what could be repatriated back to Health Boards releasing capacity within the outpatient facility and providing care closer to home for the patient	VCS Director	Jan 25		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.	18.02.2025		
01.05	Formal demand and capacity operational group to be established to provide oversight of current and future plans, manage D&C plans and identify areas of concern with mitigations for escalation as appropriate	VCS Director	Ongoing		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.	18.02.2025		

SECTION 1 – Summary

RISK ID

02

REVIEW DATE

New Risk

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, optimised workforce supply and shape, and lack of consistent quality, outcome and mortality metrics.

Risk Lead

Chief Operating Officer
Director of Nursing, AHPs & Healthcare Scientists
Medical Director

CORE ENABLER

Patient Outcomes

STRATEGIC GOAL

1 - Outstanding for quality, safety and experience

CURRENT SCORE TREND

NEW RISK

CURRENT RISK SUMMARY

SECTION 2 – Risk Scores

INHERENT RISK

LIKELIHOOD

IMPACT

TOTAL

CURRENT RISK

LIKELIHOOD

IMPACT

TOTAL

TARGET RISK

LIKELIHOOD

IMPACT

TOTAL

Expected date to reach Target Risk Score

SECTION 3 – Effectiveness, Controls and Assurance

Overall Level of Effectiveness Assurance Rating (see definitions tab)

Overall Assurance Rating

Current Review Period

Previous Review Period

Rationale for Assurance Rating

KEY CONTROLS

SOURCES OF ASSURANCE

ID

KEY CONTROLS

OWNER

PREVENTATIVE

MITIGATING

DETECTIVE

FIRST LINE OF DEFENCE

- functions that own and manage risk
- Self-assurance

SECOND LINE OF DEFENCE

- Functions that oversee or specialise in risk management
- Internal oversight/specialist control teams

THIRD LINE OF DEFENCE

- Functions that provide independent assurance
- Internal Audit (provides assurance to the Board and senior management. This assurance covers how effectively the organisation assesses and manages its risks and will include assurance on the effectiveness of the first and second lines of defence); and external oversight

1/7

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C1	Capacity and demand planning and forecasting	COO	X	X		Velindre Cancer Service Senior Leadership Team	Executive Management Board & Quality, Safety & Performance Committee Peer Benchmarking	Internal Audit, HIW, & HEIW
C2	Multiprofessional Workforce Planning which includes a workforce tool and the practice of benchmarking and incorporating Royal College guidance.	COO			X	Velindre Cancer Service Senior Leadership Team	Executive Management Board & Quality, Safety & Performance Committee Peer Benchmarking	Internal Audit, Wales Audit Officer & IQPD
C3	Quality and safety monitoring (Via PMF & AMaT Quality & Regulatory Tracker)	COO Director of Planning Director of Nursing, AHPs & Healthcare Scientists	X			Pathways Programme VCS/ VCS Quality & Safety Group / VCS Senior Leadership Team	Executive Management Board & Quality, Safety & Performance Committee Benchmarking Peer Review	Regional Cancer Board, JET & IQPD
C4	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	COO			X	Velindre Cancer Service Senior Leadership Team/Integrated Quality and Safety Group	Executive Management Board & Quality, Safety & Performance Committee	Internal Audit, IQPD & JET
C5	Effective processes in place to capture patient experience, ensuring effective listening and learning	COO Director of Nursing, AHPs & Healthcare Scientists			X	Velindre Cancer Service Senior Leadership Team/Integrated Quality and Safety Group	Executive Management Board & Quality, Safety & Performance Committee Benchmarking	Internal Audit & WRP Audits
C6	Mortality review process and monitoring	COO Medical Director			X	Velindre Cancer Service Senior Leadership Team/Integrated Quality and Safety Group	Executive Management Board & Quality, Safety & Performance Committee Benchmarking	Internal Audit
C7	Patient reported outcome monitoring (SST level to Board)	COO Medical Director Director of Finance	X	X		VOA Implementation Group	Executive Management Board & Quality, Safety & Performance Committee Benchmarking	HEIW Commissioning Audit, UWTSD Accreditation Audits
C8	Velindre Oncology Academy establishment	Director of Nursing, AHPs & Healthcare Scientists	X	X	X	Velindre Cancer Service Senior Leadership Team/Integrated Quality and Safety Group	Executive Management Board & Quality, Safety & Performance Committee Benchmarking	Internal Audit & Wales Audit Officer Audits
C9	Clinical audit process and systems in place	Director of Nursing, AHPs & Healthcare Scientists Medical Director		X	X	Velindre Cancer Service Senior Leadership Team/Integrated Quality and Safety Group	Executive Management Board & Quality, Safety & Performance Committee Benchmarking	Internal Audit & Wales Audit Officer Audits

C10	Quality & Safety Tracker (improvement monitoring)	Director of Nursing, AHPs & Healthcare Scientists		X		SACT Delivery Group	SACT Steering Group & Quality, Safety & Performance Committee Benchmarking Peer Review	IQPD & JET
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								

ACTION REF	ACTION	OWNER	DUE DATE	ASSURANCE LEVEL	PROGRESS UPDATE	DATE OF UPDATE	IMPACT OF CHANGE ON RISK	DETAIL IMPACT ON ASSURANCE LEVEL/CONTROL WHEN COMPLETE
02.01	Mortality reviews will be completed for deaths within 30 days of SACT and 30/90 days of radiotherapy and will align with best practice.							
02.02	To Integrate Clinical Audit within VCS Quality and Safety function							
02.03	Development of robust Site- Specific Quality Metrics							
02.04	To improve incident and risk management.							
02.05	Continue to review and update the WBS Quality Management Framework, including the development of a new electronic Quality Management System							
02.06	To Successfully Introduce West Nile Virus testing within Welsh Blood Service.							

02.07	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.						
02.08	Review and improvement of donor selection and screening processes						
02.09	Introduction of all Wales foetal D Screening for RhD negative pregnant women.						
02.10	Introduction of electronic result transfer for deceased organ donor HLA typing results to NHSBT-ODT which will reduce risk of manual transcription of results.						
02.11	Achieve JACIE accreditation for the WBMDR						
02.13	Implement an outcome recording system for patients (digital PROMS)						
02.14	Integrated Radiotherapy Solution - Investment in state-of-the-art radiotherapy equipment, with eight of the machines replaced at the centre in Whitchurch, Cardiff and two more housed in the Velindre@ Nevill Hall Radiotherapy Unit. • Deployment of Integrated Radiotherapy • Solution Programme. Phase 2 to conclude Phase 3 to conclude • Deploy Linear Accelerator replacement capacity plan. In progress, concludes Develop and deploy brachytherapy transition plan to support transition to new Velindre Cancer Centre. To start Transition plan development will follow.						

02.15	Acute Oncology Services (AOS) - This includes people who receive an emergency cancer diagnosis at the front door of the hospital, as well as those people living with cancer who suddenly become seriously ill, either because of their illness itself or because of complications with their treatment, including from immunotherapies, as per below. Develop plan for next stage for our Acute Oncology Services with our Health Board partners Re-develop the cancer telephone helpline service – considering options for regional helpline provision						
02.16	Systemic Anti-Cancer Therapies (SACT) Outreach Services - The principle of the clinical model is to move more care being delivered closer to patients' home so that by 2027 care is delivered 10% at home, 45% in the new Velindre Cancer Centre and 45% in outreach settings. Agree the number of hubs, location and staffing to deliver per Site Specific Site and overall facilities, in context of Velindre@ Model Implement						
02.17	Transforming Access to Medicines – Programme to set up a shared pharmacy technical service for Wales, for the sterile preparation of medicines also known as aseptic services. Approach agreed for Transforming Access to Medicines (TrAMS) Model to Velindre Cancer Services						

02.18	Electronic Prescribing and Medicines Administration – To deliver a fully digitised prescribing system across Velindre Cancer Service that will improve safety, efficiency, audit and better access to information. • Implement Electronic Prescribing and Medicines Administration (ePMA) system for use in Velindre Cancer • Virtually Assessed Patient (VAP) Clinics - Virtual Nurse Prescriber led pre-assessment clinic for patients on routine well-tolerated SACT regimens, creating capacity in outpatients for more complex patients. There is opportunity to considerably expand the VAP service to cover all suitable patient groups across all common tumour sites. Expansion of the model of a virtual nurse prescriber led pre-assessment clinic for patients on SACT						

SECTION 1 – Summary

RISK ID

03

REVIEW DATE

New Risk

Risk Title

There is a strategic risk of: 1. Not effectively delivering against the Velindre Cancer Service 10 year Cancer Research Ambition and the Welsh Blood Service Research Strategy and 2. The ability to fully embed innovation activities in line with the national Innovation Framework.

Risk Lead

Jacinta Abraham

CORE ENABLER

Research, Development and Innovation

STRATEGIC GOAL

An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed, expectations.

CURRENT SCORE TREND

New Risk

CURRENT RISK SUMMARY

SECTION 2 – Risk Scores

INHERENT RISK

LIKELIHOOD

IMPACT

TOTAL

CURRENT RISK

LIKELIHOOD

IMPACT

TOTAL

TARGET RISK

LIKELIHOOD

IMPACT

TOTAL

Expected date to reach Target Risk Score

SECTION 3 – Effectiveness, Controls and Assurance

Overall Level of Effectiveness Assurance Rating (see definitions tab)

Overall Assurance Rating

Current Review Period

Previous Review Period

Rationale for Assurance Rating

KEY CONTROLS

SOURCES OF ASSURANCE

ID	KEY CONTROLS	OWNER					FIRST LINE OF DEFENCE - functions that own and manage risk - Self-assurance	SECOND LINE OF DEFENCE - Functions that oversee or specialise in risk management - Internal oversight/specialist control teams	THIRD LINE OF DEFENCE - Functions that provide independent assurance - Internal Audit (provides assurance to the Board and senior management. This assurance covers how effectively the organisation assesses and manages its risks and will include assurance on the effectiveness of the first and second lines of defence); and external oversight
			PREVENTATIVE	MITIGATING	DETECTIVE				
C1									
C2									
C3									

C4									
C5									
C6									
C7									
GAPS IN CONTROLS					GAPS IN ASSURANCE			ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.	

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

SECTION 5 – ACTION PLAN (IMTP Priority Improvement Actions and TAF Actions)								
ACTION REF	ACTION	OWNER	DUE DATE	ASSURANCE LEVEL	PROGRESS UPDATE	DATE OF UPDATE	IMPACT OF CHANGE ON RISK	DETAIL IMPACT ON ASSURANCE LEVEL/CONTROL WHEN COMPLETE

SECTION 1 – Summary									
RISK ID	04	REVIEW DATE	New Risk	Risk Title	There is a strategic risk of failing to retain the Trust’s University status.			Risk Lead	Non Gwilym
CORE ENABLER	University Status				STRATEGIC GOAL	An established University Trust which provides highly valued knowledge and learning for all			
CURRENT SCORE TREND	N/A				CURRENT RISK SUMMARY	Controls have been identified. All controls reporting as preventative and as being managed resulting in a current rating of 3.			

SECTION 2 – Risk Scores											
INHERENT RISK	LIKELIHOOD	IMPACT	TOTAL	CURRENT RISK	LIKELIHOOD	IMPACT	TOTAL	TARGET RISK	LIKELIHOOD	IMPACT	TOTAL
	1	3	3		1	3	3		1	3	3
									Expected date to reach Target Risk Score		
									July 2025		

SECTION 3 – Effectiveness, Controls and Assurance											
Overall Level of Effectiveness Assurance Rating (see definitions tab)		6					Overall Assurance Rating	Current Review Period		6	
								Previous Review Period		n/a	
							Rationale for Assurance Rating	The Assurance Rating is considered on the basis of the risk score, actions and controls in place to mitigate against the risk,			
KEY CONTROLS							SOURCES OF ASSURANCE				
ID	KEY CONTROLS	OWNER	PREVENTATIVE	MITIGATING	DETECTIVE		FIRST LINE OF DEFENCE - functions that own and manage risk - Self-assurance	SECOND LINE OF DEFENCE - Functions that oversee or specialise in risk management - Internal oversight/specialist control teams	THIRD LINE OF DEFENCE - Functions that provide independent assurance - Internal Audit (provides assurance to the Board and senior management. This assurance covers how effectively the organisation assesses and manages its risks and will include assurance on the effectiveness of the first and second lines of defence); and external oversight		
C1	University Independent Board Member	Director of Corporate Governance	X				University Independent Board Member is confirmed and term of office known and understood.	Six monthly review of Board Membership undertaken by Director of Corporate Governance and Trust Board.	Audit Wales Structured Assessment.		

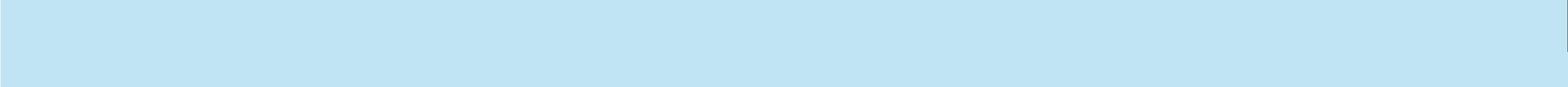
C2	Robust collaborations with university partners, for example deed of association with the University of Wales, Trinity St Davids, Cardiff University: multi-professional research SLA; Cardiff Cancer Research Hub.	Medical Director Executive Director for Nursing, Allied Health Professionals and Health Science.	X				Collaborations instigated at divisional level/EMB. All reporting into EMB for endorsement/approval, as deemed appropriate.	All collaborations reporting into the relevant Trust Committees, specifically Quality, Safety and Performance, Strategic Development and Research, Development and Innovation Committee.	
C3	Academic partnership arrangements across a range of universities in Wales.	Medical Director Executive Director for Nursing, Allied Health Professionals and Health Science.	X				Collaborations instigated at divisional level/EMB. All reporting into EMB for endorsement/approval, as deemed appropriate.	All collaborations reporting into the relevant Trust Committees, specifically Quality, Safety and Performance, Strategic Development and Research, Development and Innovation Committee.	
C4									
C5									
C6									
C7									
GAPS IN CONTROLS						GAPS IN ASSURANCE			ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.

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

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

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

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



SECTION 1 – Summary

RISK ID

05

REVIEW DATE

New Risk

Risk Title

There is a strategic risk of not effectively embedding our role as a sustainable organisation, outside of main infrastructure and specific centrally led activity.

Risk Lead

Director of Planning

CORE ENABLER

Sustainability

STRATEGIC GOAL

A sustainable organisation that plays its part in creating a better future for people across the globe

CURRENT SCORE TREND

New Risk

CURRENT RISK SUMMARY

New Risk

SECTION 2 – Risk Scores

INHERENT RISK

LIKELIHOOD

IMPACT

TOTAL

CURRENT RISK

LIKELIHOOD

IMPACT

TOTAL

TARGET RISK

LIKELIHOOD

IMPACT

TOTAL

Expected date to reach Target Risk Score

SECTION 3 – Effectiveness, Controls and Assurance

Overall Level of Effectiveness Assurance Rating (see definitions tab)

Overall Assurance Rating

Current Review Period

Previous Review Period

Rationale for Assurance Rating

KEY CONTROLS

SOURCES OF ASSURANCE

ID	KEY CONTROLS	OWNER	PREVENTATIVE	MITIGATING	DETECTIVE	FIRST LINE OF DEFENCE - functions that own and manage risk - Self-assurance	SECOND LINE OF DEFENCE - Functions that oversee or specialise in risk management - Internal oversight/specialist control teams	THIRD LINE OF DEFENCE - Functions that provide independent assurance - Internal Audit (provides assurance to the Board and senior management. This assurance covers how effectively the organisation assesses and manages its risks and will include assurance on the effectiveness of the first and second lines of defence); and external oversight
C1								
C2								
C3								

C4										
C5										
C6										
C7										
GAPS IN CONTROLS					GAPS IN ASSURANCE					ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.

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

SECTION 5 – ACTION PLAN (IMTP Priority Improvement Actions and TAF Actions)									
ACTION REF	ACTION	OWNER	DUE DATE	ASSURANCE LEVEL	PROGRESS UPDATE	DATE OF UPDATE	IMPACT OF CHANGE ON RISK	DETAIL IMPACT ON ASSURANCE LEVEL/CONTROL WHEN COMPLETE	

SECTION 1 – Summary																							
RISK ID	06	REVIEW DATE	27.06.2025	Risk Title	There is a risk of failure to meet or exceed service expectations without the prevalence of a positive working environment, which is characterised by effective values and behaviours, systems and processes				Risk Lead	Director of OD and Workforce													
CORE ENABLER	Organisational Culture				STRATEGIC GOAL	2 -An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations																	
CURRENT SCORE TREND	TAF06 <table><tr><th>Period</th><th>Score</th></tr><tr><td>jan-25</td><td>12</td></tr><tr><td>feb-25</td><td>12</td></tr><tr><td>mar-25</td><td>12</td></tr><tr><td>apr-25</td><td>12</td></tr><tr><td>mai-25</td><td>12</td></tr><tr><td>jun-25</td><td>12</td></tr></table>				Period	Score	jan-25	12	feb-25	12	mar-25	12	apr-25	12	mai-25	12	jun-25	12	CURRENT RISK SUMMARY	This Strategic Risk brings together those elements of the culture of the organisation that can impact on the ability of the Trust to deliver its core purpose. There are work programmes underway to address the feedback that the Trust on this subject through a variety of mechanisms. The work considers systems, processes, values and behaviours through development, support, wellbeing and other interventions. There will be a particular focus in 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.			
Period	Score																						
jan-25	12																						
feb-25	12																						
mar-25	12																						
apr-25	12																						
mai-25	12																						
jun-25	12																						

SECTION 2 – Risk Scores											
INHERENT RISK	LIKELIHOOD	IMPACT	TOTAL	CURRENT RISK	LIKELIHOOD	IMPACT	TOTAL	TARGET RISK	LIKELIHOOD	IMPACT	TOTAL
	4	4	16		4	3	12		2	3	6
	Expected date to reach Target Risk Score									31.03.2027	

SECTION 3 – Effectiveness, Controls and Assurance				
Overall Level of Effectiveness Assurance Rating (see definitions tab)	Partially Effective	Overall Assurance Rating	Current Review Period	
			Previous Review Period	
		Rationale for Assurance Rating		
KEY CONTROLS		SOURCES OF ASSURANCE		

ID	KEY CONTROLS	OWNER	PREVENTATIVE	MITIGATING	DETECTIVE		FIRST LINE OF DEFENCE	SECOND LINE OF DEFENCE	THIRD LINE OF DEFENCE	
							- functions that own and manage risk - Self-assurance	- Functions that oversee or specialise in risk management - Internal oversight/specialist control teams	- Functions that provide independent assurance - Internal Audit (provides assurance to the Board and senior management. This assurance covers how effectively the organisation assesses and manages its risks and will include assurance on the effectiveness of the first and second lines of defence); and external oversight	
C1	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				Reports to EMB	Trust Board reporting on strategy and controls via cycles of business	Welsh Government reporting via JET and IMTP	
C2	Approved Education Strategy and implementation plan to support the educational development of the Organisation to support the Trust direction	Sue Thomas	X				People Development and Education Steering Group	Reports to EMB, Committees and Trust Board	Internal Audit Reports	
C3	Management and Leadership development programmes in place based on compassionate leadership principles	Sue Thomas	X				People Development and Education Steering Group	Reports to EMB, Committees and Trust Board	Internal Audit Reports	
C4	Trust Values and Behaviour Framework	Sue Thomas	X				Healthy and Engaged Steering Group	Reports to EMB, Committees and Trust Board	Internal Audit Reports	
C5	Communication infrastructure in place to support the communication of leadership messages and engagement of staff including employee voice	Non Gwilym Sarah Morley	X				Healthy and Engaged Steering Group	Reports to EMB, Committees and Trust Board	Internal Audit Reports	
C6	Health and Wellbeing infrastructure for the Trust to support physical and psychological wellbeing of staff	Sue Thomas	X				Healthy and Engaged Steering Group	Reports to EMB, Committees and Trust Board	Internal Audit Reports	
C7	Governance arrangements in place to monitor and evaluate the implementation of plans	Non Gwilym	X				Reports to EMB	Reports to EMB, Committees and Trust Board	Internal Audit Reports	
C8	Performance Management Framework in place to monitor the finance, workforce and performance of the Organisation	Carl James	X				Regular monitoring at SLTs, where workforce dashboards monitor performance, identify and manage issues.	Reports to EMB, Committees and Trust Board	Internal Audit Reports	

C9	Clear safe, effective and efficient service models to support role clarity aligned to compassionate leadership principles	Anne Carey	X			Regular monitoring at SLTs, where workforce dashboards monitor performance, identify and manage issues.	Reports to EMB, Committees and Trust Board	Internal Audit Reports
C10	Operational workforce plans developed to support agreed service models	Anne Carey	X			Regular monitoring at SLTs, where workforce dashboards monitor performance, identify and manage issues.	Reports to EMB, Committees and Trust Board	Internal Audit Reports
C11	Avoidable employee harm principles are embedded into the management of behaviours within the Trust	Sarah Morley	X			Healthy and Engaged steering group and Local Partnership Forum	Reports to EMB, Committees and Trust Board	Internal Audit Reports
GAPS IN CONTROLS						GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.	

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

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

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

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

06.01	Undertake analysis of current employee voice mechanisms and develop an engagement action plan to improve voice mechanisms and encourage a culture of speaking up across the Trust.	OD Specialist	Mar 25		Feedback from staff showed a desire to have clearer information about how to Speak Up. A video has been created and added to the intranet which is now used for general staff information and in induction situations. Work in Confidence is being commissioned to offer an additional, anonymous, route for reporting concerns. This action has been subsumed into action 6.15 and can be closed.	25.06.2025		
06.02	Embed the principles of the Social Partnership Duty into the Trust's strategic development and through the Trust Board cycles of business	Head of Workforce	Apr 25		06.12.2024 Session planned at Board Development on 17.12.2024. A Social Partnership update will be included. Following session a meeting will be planned with the Chair of Strategic Development Committee to plan governance routes. 27.01.2025 Session delivered to Board on the Duty. Meeting with SDC Chair set up	30.04.2025		
06.05	Implement the actions of the Trust Strategic Equality Plan, including embedding the Anti-Racist Wales Action Plan in the Trust	Head of OD	31.03.202		The 2024-25 SEP workplan has been closed and the new plan 2025-26 is in action.	26.06.202		
06.06	Implement the actions within the Health and Wellbeing Action plan – supporting wellness and managing action plan for sickness absence	OD Specialist	31.03.2026		The 2024-25 Health and Wellbeing workplan has been closed and the new plan 2025-26 is in action.	26.06.2025		
06.07	Commence the Values and Behaviour framework project	OD Sp			The Values and Behaviours have been implemented across the Trust. Any further work on this is covered in action 6.15.			
06.08	Review performance indicators for a Healthy and Engaged workforce including EQIA measures and hybrid working				KPIs and metrics are a standard agenda item on Healthy and Engaged Steering Group. Action Closed			
06.09	Deliver an action plan for 2024/25 to support our commitment to the Trust Anti- Racist Action plan				Contained in action 6.05. This can be closed			

06.10	Monitor Welsh Language Standards, working with Divisions on improvement plans							
06.11	Implement the WL Culture plan							
06.12	Update all WOD related policies and procedures							
6.13	We will conduct a comprehensive review of all Workforce Policies ensuring documents are up to date with current legislation and best practice. This will involve engaging with key stakeholders, benchmarking and ensuring documents are easily accessible to all staff		Year 1 Q4					
6.14	We will design and implement a structured learning and development framework by that enhances the skills and capabilities of the workforce as well as ensuring there are adequate leadership and management capabilities.		Year 2					
6.15	The People and Organisational Development Team will develop a well-being and engagement framework to support staff and ensure they feel valued and supported within the culture of the organisation		Year 1 Q4		NHS Staff Survey Plans have been developed for the Trust and Divisions – due at Healthy and Engaged Steering Group July 2025. Wellbeing Metrics and Wellbeing Project Evaluation reports due at Healthy and Engaged Steering Group July 2025.			
6.16	The People and Organisational Development Team will support the Trust to develop a workplace culture for our people that is truly inclusive by developing compassionate frameworks aligned to statutory requirements for improving equality and diversity within Wales		Year 2		This is contained iwthin the SEP Workplan 2025-26. EQIA report for 2024-25 due at Healthy and Engaged Steering Group July 2025 Anti-racist e learning package launched April 2025 and compliance on track for year end target.			

6.17	We will support the Trust to develop workforce plans, both strategic and operational based on the changing needs of the labour market and service delivery. Divisional plans will ensure detailed analysis of key workforce data ensuring any actions implemented will bridge gaps and challenges within the workforce. The final plans will be delivered by March 2026 with the next phase being implementation and change management from April 2026 to March 2028		Year 3				
6.18	We will develop and implement a comprehensive talent attraction and retention by. This will include design and roll out of employer branding and attraction campaigns, development of career pathways and supportive access to work initiatives that improve workforce diversity as well as dedicated retention plans where needed within hard to fill roles		Year 2				

SECTION 1 – Summary

RISK ID

07

REVIEW DATE

23.06.2025

Risk Title

There is a strategic risk that the Trust fails to sufficiently consider, optimise the opportunities and effectively manage the risks of new and existing technologies, including considerations of Artificial Intelligence and Information Security

Risk Lead

Chief Digital Officer

CORE ENABLER

Digital Transformation

STRATEGIC GOAL

All

CURRENT SCORE TREND

TAF07

Period	Score
jan-25	12
feb-25	12
mar-25	12
apr-25	12
mai-25	12
jun-25	12

CURRENT RISK SUMMARY

Jun '25 Work is ongoing on the key controls - no movement to overall current risk scoring due to overall digital risk position. Assurance ratings moved to 7 levels of assurance. New risks have been added to reflect the operational Digital risk - including challenges with delivering the National Programmes for RISP and LIMS. New go-live date for RISP agreed (Jan '26 from Jun '25) due to National/Regional image viewer capabilities. The 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.

SECTION 2 – Risk Scores											
INHERENT RISK	LIKELIHOOD	IMPACT	TOTAL	CURRENT RISK	LIKELIHOOD	IMPACT	TOTAL	TARGET RISK	LIKELIHOOD	IMPACT	TOTAL
	4	4	16		3	4	12		2	4	8
									Expected date to reach Target Risk Score		

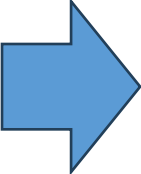
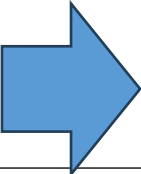
SECTION 3 – Effectiveness, Controls and Assurance					
Overall Level of Effectiveness Assurance Rating (see definitions tab)	PARTIALLY EFFECTIVE		Overall Assurance Rating	Current Review Period	4
				Previous Review Period	4
			Rationale for Assurance Rating		
KEY CONTROLS			SOURCES OF ASSURANCE		

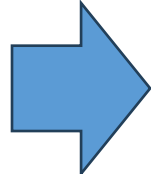
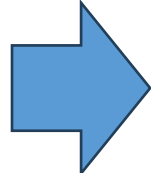
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ID	KEY CONTROLS	OWNER	PREVENTATIVE	MITIGATING	DETECTIVE		FIRST LINE OF DEFENCE	SECOND LINE OF DEFENCE	THIRD LINE OF DEFENCE
							- functions that own and manage risk - Self-assurance	- Functions that oversee or specialise in risk management - Internal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

C9	Prioritisation and change framework to manage service requests	Carl Taylor			X	Trust Digital governance reporting Digital Programme Board	EMB Shape / EMB Run / Cyber Action Plan	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit / Cyber Resilience Unit
C10	Levels of unsupported applications/ legacy systems	Carl Taylor		X		Trust Digital governance reporting - WBS Futures - Velindre Futures - Digital Programme Board IMTP	EMB Shape	Wales Audit OfficeSIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit
C11	Trust digital Governance	Carl Taylor		X		Review via Divisional SMT/SLT	EMB Run	SIRO Reports/ QSP Committee/ Internal Audit / WG IQPD
C12	Framework of lead and lag indicator reporting into Trust digital governance structure, integrated into wider performance framework	Carl James		X		Review via Divisional SMT / SLT/ Cyber Security eLearning (Stat. & Mand)/ Board Development Sessions.	EMB Shape / EMB Run	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit/WG/CRU as competent authority for NIS
C13	Cyber Assurance Controls in place	Carl Taylor	X	X		Review via Divisional SMT / SLT/ Cyber Security eLearning (Stat. & Mand)/ Board Development Sessions.	EMB Shape / EMB Run	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit/WG/CRU as competent authority for NIS
C14	Digital transformation is guided by an agreed digital architecture.	Carl Taylor		X		Digital Programme Board Digital Design Authority being established	EMB Run	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit
GAPS IN CONTROLS			GAPS IN ASSURANCE			ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.		

SECTION 4 – ASSOCIATED OPERATIONAL RISK (in line with Trust Risk appetite)			
DATIX RISK REF		CURRENT RISK RATING	RISK TREND
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	
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	

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	
3646	There is a risk to PERFORMANCE AND SERVICE SUSTAINABILTY 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	

SECTION 5 – ACTION PLAN (IMTP Priority Improvement Actions and TAF Actions)								
ACTION REF	ACTION	OWNER	DUE DATE	ASSURANCE LEVEL	PROGRESS UPDATE	DATE OF UPDATE	IMPACT OF CHANGE ON RISK	DETAIL IMPACT ON ASSURANCE LEVEL/CONTROL WHEN COMPLETE
07.01	Create the Trust Digital Reference Architecture to support C14 and others	Carl Taylor	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. National Target Architecture programme has now been initiated and the Trust are engaged in the work	Jun 25	Digital Design Authority will guide digital transformation	The level of assurance should increase from 3-4 for C13

07.02	C9 - Prioritisation framework needs to be established for the Data and Insight Service	Carl Taylor	Jun 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 C9 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 C9 Workshop with Exec Director planned for 24/06/2025	Jun 25	Will contribute to reduction in likelihood of risk	C9 would move to Effective
07.03	Reviewing control framework with Head of Information Governance for cross-check and alignment	Carl Taylor	Aug 25		Initial review undertaken and updates will be collated for August 25 TAF	Jun 25	Will contribute to reduction likelihood of risk	Additional assurance for C11 and C13

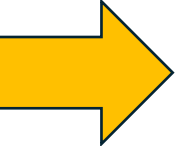
SECTION 1 – Summary																				
RISK ID	08	REVIEW DATE	June 2025	Risk Title	There is a strategic risk that the organisational and clinical governance arrangements do not provide appropriate mechanisms and culture to achieve our medium to long term objectives.															
				Risk Lead	Director of Corporate Governance															
CORE ENABLER	Organisational and Clinical Governance				STRATEGIC GOAL	1 - Outstanding for quality, safety and experience														
CURRENT SCORE TREND	TAF08 <table><caption>TAF08 Score Trend</caption><thead><tr><th>Month</th><th>Score</th></tr></thead><tbody><tr><td>Jan-25</td><td>12</td></tr><tr><td>Feb-25</td><td>12</td></tr><tr><td>Mar-25</td><td>12</td></tr><tr><td>Apr-25</td><td>12</td></tr><tr><td>May-25</td><td>15</td></tr><tr><td>Jun-25</td><td>15</td></tr></tbody></table>				Month	Score	Jan-25	12	Feb-25	12	Mar-25	12	Apr-25	12	May-25	15	Jun-25	15	CURRENT RISK SUMMARY	Work on developing key documentation supporting the organisation’s governance continues – particularly the new TAF, a review of the Risk Strategy and associated documents, all of which inform the development of the Corporate Governance Manual. The Welsh Government’s review of the hosting arrangements for Shared Services has commenced and is due to report in July 2025. Dialogue with Audit Wales and Internal Audit on the relevant issues was undertaken during May and June 2025. A draft report reviewing the Board’s Board and Governance Arrangements has been received. Work on the GAR programme continues with a keen focus on reviewing the Risk Policy and updating the TAF in line with the Trust approved IMTP.
Month	Score																			
Jan-25	12																			
Feb-25	12																			
Mar-25	12																			
Apr-25	12																			
May-25	15																			
Jun-25	15																			

SECTION 2 – Risk Scores											
INHERENT RISK	LIKELIHOOD	IMPACT	TOTAL	CURRENT RISK	LIKELIHOOD	IMPACT	TOTAL	TARGET RISK	LIKELIHOOD	IMPACT	TOTAL
	4	4	16		3	5	15		2	4	8
									Expected date to reach Target Risk Score		

SECTION 3 – Effectiveness, Controls and Assurance				
Overall Level of Effectiveness Assurance Rating (see definitions tab)	Effective	Overall Assurance Rating	Current Review Period	3
			Previous Review Period	3
		Rationale for Assurance Rating		
KEY CONTROLS		SOURCES OF ASSURANCE		

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

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

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

ACTION REF	ACTION	OWNER	DUE DATE	ASSURANCE LEVEL	PROGRESS UPDATE	DATE OF UPDATE	IMPACT OF CHANGE ON RISK	DETAIL IMPACT ON ASSURANCE LEVEL/CONTROL WHEN COMPLETE
08.01	External benchmarking of Governance, Assurance & Risk best practice as part of the Governance, Assurance & Risk programme of work	Non Gwilym	Nov-24	3	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. Output to be considered as accessible to all staff and as an enabler to service improvement.
08.02	Develop new plan for phase 2 GAR programme	Non Gwilym	Dec-24	2	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.	13.02.2025	Activity during January / February 2025 significantly reduces the risk of the lack of clarity of business priorities and focus. A consolidated plan has been developed and progress to implement where there is agreement on actions isn't impeded by the approval of the overarching programme.	The delivery of the GAR programme will provide the Trust with assurance on its governance arrangements. This will impact the risk score significantly.
08.03	Review Trust Risk Policy	Non Gwilym	25 June	2	Wok to be completed for September 2025.	27/06/25	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.

08.04	Ensuring accountability and ownership is in the right place, supported by effective structures, and is empowering for those delivering and those leading the delivery of high quality services today and shaping our services for the future	Non Gwilym	24/25		GAR Group meeting to consider draft of Corporate Governance Manual, including new Board/Committee template and instructions in July 2025.	27/06/2025	- When delivered, the Corporate Governance Manual will provide a means for ongoing reference and information on how Trust governance works and the standards set. - The review of the Trust's current governance structures will take into account changes to the Trust's work programme since the last review in 2020, to ensure we are fit for the future. - Work to review the current hosting arrangements underway and will consider Welsh Government review (July 2025).	A structure fit for the future, clearly articulated in a Corporate Governance Manual that is visible to the organisation and adhered to, as evidenced by KPIs.

SECTION 1 – Summary																							
RISK ID	09	REVIEW DATE	24.06.2025	Risk Title	A strategic risk emerges if the Trust does not secure sufficient funding for the provision of it services or does not maximises its use of finite resources, which could negatively impact on the care that our patients and donors receive.				Risk Lead	Director of Finance													
CORE ENABLER	Financial Sustainability and Long-Term Value				STRATEGIC GOAL	1 -Outstanding for quality, safety and experience 5 - A sustainable organisation that plays it part in creating a better future for people across the globe																	
CURRENT SCORE TREND	TAF09 <table><tr><th>Period</th><th>Score</th></tr><tr><td>jan-25</td><td>12</td></tr><tr><td>feb-25</td><td>12</td></tr><tr><td>mar-25</td><td>12</td></tr><tr><td>apr-25</td><td>12</td></tr><tr><td>mai-25</td><td>12</td></tr><tr><td>jun-25</td><td>12</td></tr></table>				Period	Score	jan-25	12	feb-25	12	mar-25	12	apr-25	12	mai-25	12	jun-25	12	CURRENT RISK SUMMARY	Strategic Summary There are a range of factors that impact on the finance sustainability and long term value risk. We prevent, mitigate or detect impact on this risk through a number of key financial controls. Where these controls are partially effective or not effective actions are being taken to improve the effectiveness of the control and where this achieves the anticipated improvement in control the assurance from that control is increased. Operational Summary Risk score trend: The risk score has remained static since the last period.			
Period	Score																						
jan-25	12																						
feb-25	12																						
mar-25	12																						
apr-25	12																						
mai-25	12																						
jun-25	12																						

SECTION 2 – Risk Scores											
INHERENT RISK	LIKELIHOOD	IMPACT	TOTAL	CURRENT RISK	LIKELIHOOD	IMPACT	TOTAL	TARGET RISK	LIKELIHOOD	IMPACT	TOTAL
	4	4	16		3	4	12		2	4	8
	Expected date to reach Target Risk Score										

SECTION 3 – Effectiveness, Controls and Assurance				
Overall Level of Effectiveness Assurance Rating (see definitions tab)	Effective	Overall Assurance Rating	Current Review Period	
			Previous Review Period	
		Rationale for Assurance Rating		
KEY CONTROLS		SOURCES OF ASSURANCE		

ID	KEY CONTROLS	OWNER	PREVENTATIVE	MITIGATING	DETECTIVE	FIRST LINE OF DEFENCE	SECOND LINE OF DEFENCE	THIRD LINE OF DEFENCE
						- functions that own and manage risk - Self-assurance	- Functions that oversee or specialise in risk management - Internal oversight/specialist control teams	- Functions that provide independent assurance - Internal Audit (provides assurance to the Board and senior management. This assurance covers how effectively the organisation assesses and manages its risks and will include assurance on the effectiveness of the first and second lines of defence); and external oversight
FSLTV1	Divisional Financial Outturn	Head of Financial Planning & Reporting Head of Finance Business Partner Budget Holders			X	Budget holders, reports and training	Divisional Finance Reports and Performance; Finance Business Partners	Internal Audit / External Audit
FSLTV2	Quarterly Finance Reviews	Deputy Director of Finance Head of Finance Business Partnering			X	Directorate Level Budget holders, reports and training	Divisional Finance Reports and Performance; Finance Business Partners	Internal Audit / External Audit
FSLTV3	Divisional Performance Review	Deputy Director of Finance Head of Finance Business Partnering			X	Divisional Senior Leadership Teams, reports	Executive Finance Reports; Senior Finance Team	Internal Audit / External Audit
FSLTV4	Executive and Trust Board Reporting	Executive Director of Finance			X	Executive Budget Holders / Programme SROs	Trust Board Finance Reporting; Senior Finance Team; QSP Committee; Trust Board	Internal Audit / External Audit
FSLTV5	Statutory and Mandatory Financial Reporting (inc. Annual Accounts)	Executive Director of Finance			X	Executive Budget Holders / Programme SROs	Trust Board Finance Reporting; Senior Finance Team; MMRs; Welsh Costing Returns; Audit Committee; Trust Board	Welsh Government / NHS Executive (FP&D) / External Audit
FSLTV6	Finance and Investment: Enhanced Monitoring	Executive Director of Finance		X		Executive Budget Holders / Programme SROs	Trust Board Finance Reporting; Senior Finance Team	Internal Audit / External Audit
FSLTV7	Collective Commissioners Review	Executive Director of Finance	X			Directorate Level Budget holders, reports and training	Collective Commissioning Group LTA reporting Weakness in controls identified in relation to LTA activity data capture and mapping to appropriate currencies to ensure Trust recovers all income due for work undertaken	LHB Commissioners

FSLTV8	Investment Appraisal	Executive Director of Finance Executive Director of Strategic Transformation, Planning & Digital	X			Executive Budget Holders / Programme SROs	Capital Planning and Delivery Group; Executive Management Board; Strategic Development Committee; Trust Board; WG Better Business Cases; HM Treasury Greenbook	LHB Commissioners / Welsh Government / Internal Audit / External Audit
FSLTV9	Financial Strategy / Medium Term Financial Plan / Budget Setting	Executive Director of Finance	X			Executive Budget Holders / Programme SROs	Trust Board and Committees	LHB Commissioners / Welsh Government / Internal Audit / External Audit
FSLTV10	Scheme of Delegation and Delegated Financial Authority	Executive Director of Finance	X			Oracle Financial System Controls; Budget holders; Executive budget holders; Programme SROs	Trust Board and Committees; Delegated Financial Limits	Internal Audit / External Audit
FSLTV11	Value Based Healthcare programme	Executive Director of Finance Executive Medical Director			X	Value Based Healthcare project leads; VBH programme SROs	Value Based Healthcare steering committee / Executive Management Board, Strategic Development Committee	LHB Commissioners / Welsh Government / Internal Audit / External Audit
FSLTV12	Procure to Pay monitoring	Deputy Director of Finance Head of Financial Operations			X	Requisitioners / Budget Holders	PSPP Group; Finance P2P reporting; Expense reporting; Expenses and Purchasing / Credit Card policy; Losses and Special Payments reporting	Internal Audit / External Audit
FSLTV13	Debtors / Cash monitoring	Deputy Director of Finance Head of Financial Operations			X	Budget Holders: Private Patients lead; reports	Debtors Reporting; Senior Finance Team;	LHB Commissioners / Welsh Government (External Financing Limit) / Internal Audit / External Audit
FSLTV14	Discretionary Capital Financial Planning and Reporting	Deputy Director of Finance / Head of Financial Planning and Reporting		X		Budget Holders; Heads of Division; Divisional Directors	Capital Planning and Delivery Group; Executive Management Board; Fixed Assets Register Reporting	Internal Audit / External Audit
FSLTV15	Major Capital Programmes monitoring	Chief Executive			X	Executive Budget Holders / Programme SROs; Scheme of Delegation and Governance Framework	Capital Planning and Delivery Group; Executive Management Board	Internal Audit / External Audit
FSLTV16	Counter Fraud	Deputy Director of Finance / Head of Financial Operations	X			Budget Holders, reports and training	Counter Fraud Reports; Audit Committee	Internal Audit / External Audit

FSLTV1 7	Tax management	Deputy Director of Finance / Head of Financial Operations			X	Budget holders, requisitioners, reports and training	Financial Operations Team; VAT working group	External Advisory (EY) / Internal Audit / External Audit / HMRC
FSLTV1 8	Procurement	Executive Director of Finance / Deputy Director of Finance / Head of Procurement	X			Exec Directors, Divisional Directors, Budget Holders, reporting and training	Procurement Compliance reporting; Audit Committee	Internal Audit / External Audit

GAPS IN CONTROLS

Scheme of Delegation and Governance Framework for All Major Capital Programmes

There is a need to be able to evidence use of medicines are providing the best value for patients

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.

GAPS IN ASSURANCE

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

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.

LTA Activity performance monitoring process currently not providing assurance that all activity is being captured and monitored against Commissioner contracts

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

F6 (Controls); F4 (Assurance)

F2

F7

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

DATIX RISK REF		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	

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

ACTION REF	ACTION	OWNER	DUE DATE	ASSURANCE LEVEL	PROGRESS UPDATE	DATE OF UPDATE	IMPACT OF CHANGE ON RISK	DETAIL IMPACT ON ASSURANCE LEVEL/CONTROL WHEN COMPLETE
09.01	Development of VBH programme of work to identify areas of unwarranted variation and actions to improve	EDoF / DDoF/COO	Delivery over 24/25-26/27	4	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. 2025-26 Progress: • Digital PROMS platform - go live due in July • PROMS Questionnaires - continue to be develop and agree national sets - focus on Breast and Colorectal • SST Data Insights Dashboard ongoing insight and awareness raising to support clinicians in reducing unwarranted variation e.g. referral patterns, admission rates, medicines prescribing, use of VAP service. Also used to calculate opportunities for a virtual thyroid follow up service (to replace telephone) Self administration pathway established for denosumab subcutaneous injections, releasing resource for more complex treatments. • Data quality improved for historical open pathways, addressing clinical risk • Training, communication & engagement - communication strategy in place, training & engagement sessions undertaken; further staff members undertaking Swansea University Value in Health course "	24.06.25	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

09.02	Continuous improvement of Finance and Investment Enhanced Monitoring reporting including identification of Savings Opportunities; Disinvestments and Choices and clear line of sight with Welsh Government Value and Sustainability Board agenda	EDoF / DDoF	Delivery over 2024/25 to 2026/27	4	Savings / Efficiencies opportunity Pipeline identified 4 areas being progressed or explored - Pre-operative anaemia pathway expansion (implementation), Medicines Management - NWSSP medicine unit supply (underway) & further areas to be identified through Medicines Strategy Group, Workforce re-design - service divisions to identify all areas of workforce model and pathway review to enable a Trust wide assessment of opportunities for efficiency and productivity improvement, Procurement reviews of non-pay spend to identify opportunities for cost improvement in income recovery. EMB agreed SROs for each of the 4 areas to take accountability at Exec level to oversee the development and delivery. Pharmacy review has been conducted and was presented to Exec Management Board early in 2024. An Internal Audit review of medicines management governance (including financial aspects) was conducted in July / Aug 2024 and reported to Audit Committee in Sep '24 with substantial assurance. Medicines Strategy Group to be established by SRO (Medical Director) for Medicines Group. Newly appointed Deputy Medical Director will establish the Strategy Group during 2025-26. IMTP savings created using SMART actions to strengthen identification, monitor progress and delivery.	24.06.2025	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

09.03	Development and review of Financial Control Procedures		Year 3	Capital financial control procedure approved by Audit Committee. Financial Control Procedure (FCP) update plan and pipeline for review in development. 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: Accruals & Prepayments - Finance teams have created 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. 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. Unidentified income significantly reduced following adoption of suspense account clearing. Petty Cash FCP been updated, priority to review and update all FCPs following accounts submission."	24.06.2025	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

09.04	Development of Investment Appraisal process and prioritisation framework	EDoF / EDoSTP&D / DDoF / DDoP	Investment appraisal process & prioritisation framework developed by Oct 2025	4	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 trail activity and impact on cost and income. Several meetings have taken place during May and June with C&V and Cardiff University to find a financially sustainable and risk sharing model. Private Patients 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. Work continues with Liaison Financial external consultants whereby an extensive review of tariffs for all private patient activity has been undertaken and validated by VUNHST and Liaison Financial. Contract negotiations with insurance providers will begin imminently and involve pathology charging as well as payment of old debts.	24.06.2025	Alignment of investment with strategic priorities will demonstrate goal congruence and increase the likelihood of securing funding for projects / initiatives	Control 6 - Financial Strategy / Medium Term Financial Plan / Budget Setting will become more effective and financial plans more sustainable further enhancing overall financial assurance

09.05	Identification of business development and external funding opportunities	EDoF / EDoSTP&D / EMD / DDoF	July 2025	4	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 trail activity and impact on cost and income. Several meetings have taken place during May and June with C&V and Cardiff University to find a financially sustainable and risk sharing model. Private Patients 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. Work continues with Liaison Financial external consultants whereby an extensive review of tariffs for all private patient activity has been undertaken and validated by VUNHST and Liaison Financial. Contract negotiations with insurance providers will begin imminently and involve pathology charging as well as payment of old debts.	24.06.2025	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

09.06	Develop Scheme of Delegation and Governance Framework for All Major programmes	EDoF / DDoF	October 2025	4	A Scheme of Delegation and Governance Framework has been developed for nVCC, which has cross referenced findings from PwC and Gateway reviews as well 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. Scheme of delegation previously developed and approved for the Intergrated Radiotherapy Solution. Progress required on setting a revised expenditure approval hierarchy with the Oracle financial system in line with the agreed scheme of delegation. Subject to WG approval a Scheme of Delegation and Governance Framework will be developed for the WBS infrastructure programme.	Mitigate the risks of non-compliant procurement and improve budgetary control procedures by ensuring clear accountability for spend.	Control 15 - Major Capital Programmes monitoring will improve from PE to E and assurance will change from IA to PA

09.07	Data & Insights team working with Finance team and service leads to investigate where data capture and mapping to contract currencies is not working correctly. Once the issues with the process have been identified corrective action can be taken both in the short term and longer term to ensure all activity is correctly captured and charged for. Risk to be added to Datix to reflect the control weakness in activity data capture and mapping to contract activity to ensure Trust recovers all income for work undertaken.	EDoF / EDoSTP&D / COO	Dec '24 to Mar '25	3	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 it commissioners. The assessment of 2024-25 VCS LTA income was £240k under the plan. The Trust is proposing that a change in contract currency is adopted to reflect the change in the radiotherapy pathway for hypo fractionated prostate radiotherapy. A business case has been developed and will be presented to the Trust Commissioners on the 25.06.25 seeking support and approval.	24.06.20258	Initial actions have led to additional activity being captured in the data warehouse and charged to LTAs. A change in contract currency may result in additional income recovery subject to commissioner support and approval.	Control 7 Collective Commissioners Review - Weakness in control systems around data capture and mapping to LTA currencies will be mitigated leading to this control effectiveness being changed from Partially Effective to Effective and Control assurance through second line of defence LTA Performance Monitoring improving from Inconclusive Assurance to Positive Assurance
The Trust will continue to review and integrate the opportunities identified at national level through the Value and Sustainability Board into the Trust's opportunities pipeline. More specifically, this will include:								

09.08	Exploring opportunity to expand supply for other drugs working with the NWSSP Medicines Unit.						
09.09	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.						
09.10	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.						
09.11	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							
09.12	Pre-op anaemia programme: This is a national initiative to address the inconsistencies in the diagnosis and management of anaemia for patients undergoing high risk surgery (specifically 10 procedures identified as being most likely to result in a blood transfusion). It has been developed in conjunction with the Wales Blood Health National Oversight Group (BHNOG).						

SECTION 1 – Summary

RISK ID

10

REVIEW DATE

Risk Title

There is a strategic risk that given this planning window represents such a significant transformation agenda that this change will not be delivered in a way that meets our strategic objectives.

Risk Lead

CORE ENABLER

Transformation Delivery

STRATEGIC GOAL

CURRENT SCORE TREND

New Risk

CURRENT RISK SUMMARY

SECTION 2 – Risk Scores

INHERENT RISK

LIKELIHOOD

IMPACT

TOTAL

CURRENT RISK

LIKELIHOOD

IMPACT

TOTAL

TARGET RISK

LIKELIHOOD

IMPACT

TOTAL

Expected date to reach Target Risk Score

SECTION 3 – Effectiveness, Controls and Assurance

Overall Level of Effectiveness Assurance Rating (see definitions tab)

Overall Assurance Rating

Current Review Period

Previous Review Period

Rationale for Assurance Rating

KEY CONTROLS

SOURCES OF ASSURANCE

ID	KEY CONTROLS	OWNER	PREVENTATIVE	MITIGATING	DETECTIVE	FIRST LINE OF DEFENCE - functions that own and manage risk - Self-assurance	SECOND LINE OF DEFENCE - Functions that oversee or specialise in risk management - Internal oversight/specialist control teams	THIRD LINE OF DEFENCE - Functions that provide independent assurance - Internal Audit (provides assurance to the Board and senior management. This assurance covers how effectively the organisation assesses and manages its risks and will include assurance on the effectiveness of the first and second lines of defence); and external oversight
C1								
C2								
C3								

C4									
C5									
C6									
C7									
GAPS IN CONTROLS					GAPS IN ASSURANCE			ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.	

SECTION 4 – ASSOCIATED OPERATIONAL RISK (in line with Trust Risk appetite)			
DATIX RISK REF		CURRENT RISK RATING	RISK TREND

SECTION 5 – ACTION PLAN (IMTP Priority Improvement Actions and TAF Actions)								
ACTION REF	ACTION	OWNER	DUE DATE	ASSURANCE LEVEL	PROGRESS UPDATE	DATE OF UPDATE	IMPACT OF CHANGE ON RISK	DETAIL IMPACT ON ASSURANCE LEVEL/CONTROL WHEN COMPLETE

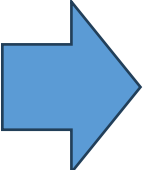
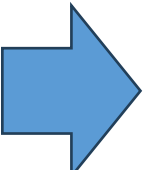
SECTION 1 – Summary																								
RISK ID	11	REVIEW DATE	July 2025	Risk Title	There is a strategic risk to the Trust's ability to effectively deliver quality services and achieve our medium to long term objectives if we are unable to develop and maintain of an optimised workforce supply and shape				Risk Lead	Director of OD and Workforce														
CORE ENABLER						STRATEGIC GOAL	1 - Outstanding for quality, safety and experience																	
CURRENT SCORE TREND	TAF11 <table><tr><th>Period</th><th>Score</th></tr><tr><td>jan-25</td><td>12</td></tr><tr><td>feb-25</td><td>12</td></tr><tr><td>mar-25</td><td>12</td></tr><tr><td>apr-25</td><td>12</td></tr><tr><td>mai-25</td><td>12</td></tr><tr><td>jun-25</td><td>12</td></tr></table>					Period	Score	jan-25	12	feb-25	12	mar-25	12	apr-25	12	mai-25	12	jun-25	12	CURRENT RISK SUMMARY	There are many factors that impact on the current supply and shape of our workforce. These are both external, due to the economic landscape impacting the labour market and internal, in the specific MDTs within 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 people development, through effective 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. Risk score trend: The risk score has remained static since the last period.			
Period	Score																							
jan-25	12																							
feb-25	12																							
mar-25	12																							
apr-25	12																							
mai-25	12																							
jun-25	12																							

SECTION 2 – Risk Scores											
INHERENT RISK	LIKELIHOOD	IMPACT	TOTAL	CURRENT RISK	LIKELIHOOD	IMPACT	TOTAL	TARGET RISK	LIKELIHOOD	IMPACT	TOTAL
	4	4	16		4	3	12		2	3	6
	Expected date to reach Target Risk Score									Current work programme to March 2029	

SECTION 3 – Effectiveness, Controls and Assurance				
Overall Level of Effectiveness Assurance Rating (see definitions tab)	PE	Overall Assurance Rating	Current Review Period	4
			Previous Review Period	4
		Rationale for Assurance Rating	Detail of assurance levels reported though the assurance paper on Workforce Supply and Shape to the Quality, Safety and Performance Committee.	
KEY CONTROLS		SOURCES OF ASSURANCE		

ID	KEY CONTROLS	OWNER	PREVENTATIVE	MITIGATING	DETECTIVE		FIRST LINE OF DEFENCE functions that own and manage risk Self-assurance	SECOND LINE OF DEFENCE Functions that oversee or specialise in risk management Internal oversight/specialist control teams	THIRD LINE OF DEFENCE - Functions that provide independent assurance - Internal Audit (provides assurance to the Board and senior management. This assurance covers how effectively the organisation assesses and manages its risks and will include assurance on the effectiveness of the first and second lines of defence); and external oversight	
C1	Trust People Strategy, approved in May 2022, clearly noting the strategic intent of Workforce Planning - 'Planned and Sustained Workforce'	Sue Thomas	X				People and Development Steering Groups	Performance reporting to Executives and Trust Board	Internal Audit Reports	
C2	Approved Workforce Planning Methodology aligned to Trust Values and Behaviours	Sue Thomas	X				Regular monitoring at SLTs, where workforce dashboards monitor performance, identify and manage issues.	Reports to EMB , Committees and Trust Board	Internal Audit Reports	
C3	Educational pathways in place to support the recruitment of new skills and development of new roles	Sue Thomas	X				Provide operational managers with skills and capabilities to undertake effective workforce planning. Provide formal training and produce a suit of workforce planning tools	Reports to EMB , Committees and Trust Board	Internal Audit Reports	
C4	Consistent recruitment and selection process	Sue Thomas	X				The Trust has a robust programme of evaluation to support the delivery of all trianing programmes, ensuring a continious learning and development system is in place.	Reports to EMB , Committees and Trust Board	Internal Audit Reports	
C5	Trust People Strategy, approved in May 2022, clearly noting the strategic intent of Workforce Planning - 'Planned and Sustained Workforce'	Sue Thomas	X				People and Development Steering Groups	Reports to EMB , Committees and Trust Board	Internal Audit Reports	
C6	Approved Workforce Planning Methodology aligned to Trust Values and Behaviours	Sue Thomas	X				People Development and Education Steering Group	Reports to EMB , Committees and Trust Board	Internal Audit Reports	
C7	Workforce planning - skills development	Sue Thomas	X				Regular monitoring at SLTs, where workforce dashboards monitor performance, identify and manage issues.	Regular performance reports and Supply and Shape paper are submitted to EMB and QSP	Internal Audit Reports - Managing Attendance at Work, Recruitment and Retention and Education Strategy Audit (ongoing)	
C8	Workforce Planning embedded into our Inspire Programme to develop Mangers and leaders in Workforce Planning skills	Sarah Morley	X				Regular monitoring at SLTs, where workforce dashboards monitor performance, identify and manage issues.	Reports to EMB , Committees and Trust Board	Internal Audit	
GAPS IN CONTROLS							GAPS IN ASSURANCE		ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.	

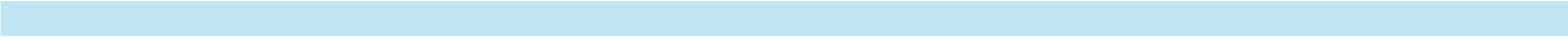
SECTION 4 – ASSOCIATED OPERATIONAL RISK
(in line with Trust Risk appetite)

DATIX RISK REF		CURRENT RISK RATING	RISK TREND
2187 VCS	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	
3468 VCS	There is a risk to the sarcoma service as a result of the single handed consultant planning on retirement in May 2025 with no robust succession plan in place which will result in patient care being compromised.	16	
3634	There is a risk to Quality, Performance and Service Sustainability, and Workforce domains as a result of demand for work on new digital services exceeding the capacity of the Trust digital team and the Trust's capacity to take on the business changes management leading to priority service initiatives enabled by digital not being delivered successfully , stress and burnout for the digital team and regularly changing priorities.	16	

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

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

11.1	Development of a Trust Workforce Plan	Deputy Director of OD and Workforce	September 2025		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 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	April 2025	The impact will be reduced once the short and medium term actions are completed	
11.2	Embed workforce planning into monthly Divisional Senior Leadership Workforce reporting.	Assistant Director of Workforce Planning	Complete	3	Additional Resource for Workforce Planning through IMTP not supported. Alternative plan to embed workforce planning though the wider team undertaken instead. Monthly meetings underway with ongoing dedicated support for recruitment, development, retention and people analytics.	June 2025	Having workforce planning embedded into monthly management meetings with Advisors and BP's ensures alignment between operational performance and effective people management and ensures early intervention to support the development of the workforce at micro and meso levels within the Trust.	
11.3	Implementation of the Attraction and Resourcing Project	Assistant Director of Workforce Planning	Complete	4	Initial implementation completed. Financial agreement for ongoing resource agreed as part of the IMTP. Project to become part of BAU for POD.	June 2025		Assurance Level 4 - Robust plan in place with actions and deliverables reported through Supply and Shape Assurance Paper to Quality, Safety and Performance Committee
11.4	Implementation of the Nurse Retention Plan through the Professional Nursing Forum	Executive Director of Nursing and Divisional Nurse Leads	April 2026	4	Nurse Retention Plan currently in draft 27.01.2005 EMB endorsed the NRP, implementation underway.	April 2025		
11.5	Develop a robust Workforce Planning Team and supporting infrastructure (i.e. steering groups, assurance paper etc. for the Trust, that is able to support service leads in the review, design and implementation of comprehensive workforce plans.	Assistant Director of Workforce Planning	September 2025					



TRUST BOARD

SOCIAL PARTNERSHIP DUTY ANNUAL REPORT

DATE OF MEETING	24 th July 2025
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Susan Thomas, Deputy Director of W&OD Rhiannon Freshney, Sustainability Manager
PRESENTED BY	Sarah Morley, Executive Director of Organisational Development and Workforce Lauren Fear, Director of Transformation (Interim)
APPROVED BY	Sarah Morley, Executive Director of Organisational Development & Workforce
EXECUTIVE SUMMARY	This report outlines the commitment and actions taken by the Trust to comply with the Social Partnership Duty. The duty requires public bodies to engage meaningfully with workforce representatives and other stakeholders to promote fair work, improve well-being, and deliver better public services. The report outlines the key achievements and activities undertaken during 24/25 and notes the challenges and lessons learnt to support future activities.



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

RECOMMENDATION / ACTIONS	The Trust Board is asked to APPROVE the Social Partnership Duty Annual Report prior to providing to Welsh Government.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	Date n/a
Executive Management Board	30.06.2025
Local Partnership Forum	15.07.2025
Quality, Safety and Performance Committee	17.07.2025
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
N/A	

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

APPENDICES	
1	Social Partnership Duty Annual Report 2024-25

1. SITUATION/BACKGROUND

Velindre University NHS Trust is fully committed to fulfilling its Social Partnership Duty under the Social Partnership and Public Procurement (Wales) Act 2023. As a public body, we recognise the importance of co-determining policy and decision-making with our recognised trade unions and wider workforce. This annual report outlines the actions we have taken during 2024–25 to embed social partnership principles into the Trust’s governance, planning, delivery, and procurement activities.

This report outlines the commitment and actions taken by the Trust to comply with the Social Partnership Duty. The duty requires public bodies to engage meaningfully with

workforce representatives and other stakeholders to promote fair work, improve well-being, and deliver better public services. Our Trust remains committed to fostering collaboration with our workforce, trade unions, and external partners to ensure inclusive decision-making and continuous improvement in health services across the region.

2. ASSESSMENT/ SUMMARY OF MATTERS FOR CONSIDERATION

The report outlines the governance and oversight in place to deliver the Trust's social partnership duty, key achievements and activities undertaken during 24-25 and notes the challenges and lessons learnt. The report also notes the future priorities intended by the Trust.

3. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: - Outstanding for quality, safety and experience ☒ - An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ - A beacon for research, development and innovation in our stated areas of priority ☒ - An established 'University' Trust which provides highly valued knowledge for learning for all. ☒ - A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) For more information: STRATEGIC RISK DESCRIPTIONS	04 - Organisational Culture
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Select all relevant domains below
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒



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NHS Trust

	Patient Centred ☒
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: For more information: https://www.gov.wales/socio-economic-duty-overview	Not required

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT For more information: https://nhswales365.sharepoint.com/sites/VEL/Intranet/SitePages/E.aspx	Yes - please outline what, if any, actions were taken as a result
	Individual elements of work described in this paper may be subject to EQIA.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

4. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	<i>This is reflected in the Trust Assurance Framework Risk 04</i>



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WHAT IS THE CURRENT RISK SCORE	12
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	<i>This paper provides an overview of work being undertaken to deliver the Trust's social partnership duty</i>
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Currently being reviewed
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Yes - please detail below
	External factors relating to engagement of stakeholders
All risks must be evidenced and consistent with those recorded in Datix	

Velindre University NHS Trust
Deputy Director of OD and Workforce

Annual Social Partnership Duty Report

1 April 2024 – 31 March 2025



Velindre University NHS Trust is responsible for the delivery of a wide range of specialist NHS Wales services including the Velindre Cancer Service and the Welsh Blood Service and we host Health Technology Wales, and NHS Wales Shared Services Partnership.

Caring

We are always kind, supportive, approachable and show compassion to all.



Respectful

We seek to understand other people's perspectives. We are always open and transparent.



Accountable

We always take personal responsibility for what we do and how we do it.



The Velindre Cancer Service is a specialist treatment, teaching, research and development service for non-surgical tertiary oncology services to patients from across south east Wales and further afield.

The Welsh Blood Service provides essential and highly specialised national services including the collection and production of blood and blood components, specialist diagnostic services and antenatal screening, as well as supporting transplant services for solid organs and stem cells across Wales and internationally.

Health Technology Wales assesses non-medicine health and care technologies and produces national guidance on their use in Wales.

NHS Wales Shared Services Partnership delivers a wide range of professional, technical and administrative services to NHS Wales.

Introduction

Velindre University NHS Trust is fully committed to fulfilling its Social Partnership Duty under the Social Partnership and Public Procurement (Wales) Act 2023. As a public body, we recognise the importance of co-determining policy and decision-making with our recognised trade unions and wider workforce. This annual report outlines the actions we have taken during 2024–25 to embed social partnership principles into the Trust’s governance, planning, delivery, and procurement activities.

This report outlines the commitment and actions taken by the Trust to comply with the Social Partnership Duty. The duty requires public bodies to engage meaningfully with workforce representatives and other stakeholders to promote fair work, improve well-being, and deliver better public services. Our Trust remains committed to fostering collaboration with our workforce, trade unions, and external partners to ensure inclusive decision-making and continuous improvement in health services across the region.

Governance and Oversight

Social Partnership Structures

To embed social partnership principles, we have the Local Partnership Forum (LPF)

The LPF is the formal mechanism within the Trust where the trade unions work together with management, to engage, inform, debate and agree local priorities, in respect of workforce and Trust related issues. The broad term used to describe this is “partnership working”. All members of the LPF are full and equal members and collectively share responsibility for the decisions made by the forum. The LPF provides the formal mechanism for consultation, negotiation and communication between the staff representatives and management. The Trust involves staff representatives in policy formulation, implementation and evaluation at a strategic and operational level and in service decisions, problem solving, service planning, local management meetings and communications. At the earliest opportunity, the organisation engages with staff representatives in all key discussions and decision-making processes. The LPF adheres to the principles and best practice of partnership working, as derived from ‘Partnership Agreement. An agreement between Department of Health, NHS Employers and NHS Trades Unions’. The Local Partnership Forums are supported by Divisional Local Partnership Forums in the Velindre Cancer Service, Welsh Blood Service, Health Technology Wales and NHS Wales Shared Services. The more localised groups ensure matters are discussed and communicated within specific functional areas within the Trust. Representatives from the Divisional

groups sit on the Trust wide Local Partnership Forum, ensuring effective flow of communication and management of partnership working.

In addition, we have the Climate Action Taskforce. This oversees delivery of the Trust's Sustainability Strategy with trade union representation. The Clinical Sustainability Working Group includes clinical and non-clinical staff and trade unions to inform climate action in healthcare settings.



Via these forums we:

- engage staff, through their representatives, in the key discussions and decisions taking place at senior levels and to provide Trade Union representatives with an opportunity to contribute to decisions of the Trust.
- enable management and staff representatives to propose and discuss issues which affect the workforce.
- provide opportunities for unions to contribute to the Trust's service delivery plans at an early stage and to consider implications for staff of service reviews and/or organisational change.
- discuss and to appraise in partnership, the Trust's services and activities against performance targets and to discuss proposals to address resultant issues.
- appraise the trade unions of the financial performance of the Trust.
- inform of any intention by the Trust to begin formal consultation on any issue affecting individual departments or services.
- Ensure regular engagement with local and national workforce advisory groups.

Leadership Commitment

- The Chief Executive and Board members actively champion social partnership principles. The Executive co-chair the Local Partnership Forum in conjunction with the Social Partnership Lead
- The Trust Board gained an additional Independent Member in 2024 with a lead role for Equality Diversity and Inclusion.
- The appointment of a designated Social Partnership Lead will ensure compliance with the duty and oversees partnership engagement.

Key Achievements and Activities

Workforce Engagement and Fair Work

We have ongoing engagement sessions with staff and trade union representatives to address workforce concerns. As a result, we produce in partnership:

- Staff well-being initiatives: including mental health support and flexible working options. The Trust Health and Wellbeing Plan is progressed via LPF.
- Employee Relations: The LPF were given an overview of employee relations activity, providing assurance of the appropriate management of the employment relationship.
- Recruitment: LPF received updates on workforce performance data highlights the Trust performance in relation to sickness, achievement of Personal Development Appraisal Reviews (PADR) and recruitment actively. This provides a forum for open discussion and debate in relation to the supply of staff and areas within the Trust that requires support.



In 2024–25, we refreshed our well-being objectives through a participatory and inclusive process aligned with the Well-being of Future Generations (Wales) Act. This refresh was delivered via a series of engagement workshops and structured consultation sessions involving over 100 staff members, including trade union representatives, clinical leads, non-clinical staff, volunteers, and wider community stakeholders.

Through this engagement, the Trust was able to:

- Re-affirm our long-term vision in alignment with Destination 2033 and NHS Wales strategic aims.
- Integrate sustainability, decarbonisation, equality, and health equity more clearly within the updated objectives.
- Ensure that the refreshed objectives reflected the diverse views and lived experiences of our staff and the populations we serve.
- Strengthen the role of prevention, integration, collaboration, and involvement in how we plan and deliver services.

The result is a new set of well-being objectives that are collectively owned and actively championed across departments. These now underpin major strategies such as our Sustainability Strategy, People Strategy, and Capital Infrastructure Programme.

Promoting Equality, Diversity, and Inclusion (EDI)

We have refreshed our workplan for 2025-26 to support the delivery of our Strategic Equality Plan 2024 – 2028.

Progress with Welsh Language 5 Year Plan, 'More than just words' has resulted in the following outcomes:

- 89% completion of the Welsh Language Awareness training programme.
- The 'Active Offer' is delivered in WBS and VCS through the active Welsh Language Groups
- Training has been delivered to staff in front-facing roles such as Reception.
- Rigorous assessment of Welsh language needs at recruitment

We have used the results of the NHS Staff Survey and Workforce Race Equality Standard (WRES) to better understand the experience of staff across the Trust and a review into Bullying, Harassment and Discrimination highlighted the need for psychological safety; and this has been adopted as a topic for the improvement work for 2025. Divisions and Departments have been enabled to involve staff in reviewing their results and formulating actions to increase engagement and they are now coming forward with concrete actions for change at a local level.

The focus on Attraction and Resourcing has allowed us to improve access to our employment in a variety of ways:

- Changed our recruitment practices to connect with groups who may not have accessed NHS employment in the past.
- Embedded actions from Anti-Racist Wales Action Plan and National Workforce Policy Audit
- Updated recruitment process to ensure reasonable adjustments are in place for candidates at interview
- Achieved Disability Confident Leader status
- Provision of feedback to unsuccessful candidates on request
- Analysed trac data for all reported protected characteristics and fed findings into future recruitment plans.



The Trust's Equality, Diversity and Organisational Development Manager leads regular communications marking religious holidays, creating safe forums for discussion, peer support, and learning. This work directly supports the objective to recognise that inclusive, psychologically safe working environments contribute to both individual and organisational well-being.

We have established six Staff Networks with structured Terms of Reference and links to the Healthy and Engaged Steering Group, as follows.

- Race Network is linked to the national programme on Global Ethnic Majority employment
- LGBTQ+ Network involved in Pride events and raising the profile of equality
- Neuro Diversity network requested training in working with ND, either one's own or a colleague's
- Disability Network contributed to a study on the use of Reasonable Adjustments in the Trust
- Carers' Network is supporting the implementation of the Carer's Passport.
- The Women's Network is in place and will consider the findings of a Trust report on 'Women in STEM'

Sustainable Public Services and Procurement

Velindre's approach to procurement is increasingly shaped by our commitment to social value and ethical sourcing, as required under the Social Partnership and Public Procurement (Wales) Act.

- Embedded fair work and social value criteria into procurement processes.
- Partnered with local suppliers to support community wealth-building.
- Ensured ethical employment practices across contracted services.



Circular economy initiatives, like the Walking Aid Recycling Scheme at Velindre Cancer Centre, reduce emissions and NHS resource use. Returned walking aids are cleaned and reused, reducing procurement need and carbon emissions. Developed in partnership with Men's Sheds and Walters UK using felled trees from the New Cancer Centre (nVCC) site, this project represents an integrated solution to waste, rehabilitation, and community engagement. It also demonstrates collaboration between capital, clinical and voluntary sector teams — and is being scaled through the All-Wales Spread and Scale Academy.

Velindre continues to act as an anchor institution by embedding social value into all that we do. Our Community Benefits schemes attached to major capital programmes ensure that workforce development, inclusive employment, and community health are considered through a social partnership lens. The Community Benefits Governance Board was formed and has successfully funded local community projects. The Board is comprised of partnerships with community groups and voluntary sector organisations have enabled co-creation of site infrastructure using sustainable, locally sourced materials.

We also collaborate with staff and community groups on initiatives such as Ray of Light – a cancer support programme co-developed with patients, staff, and third-sector organisations, enhancing wellbeing and resilience. The Trust's partnership with Ray of Light Cancer Support provides nature-based and therapeutic programmes support holistic care by addressing physical, emotional, and mental well-being. Initiatives like the maintenance of pollinator-friendly habitats, wildflower planting, and the staff-led beehive at Talbot Green promote biodiversity and reconnect staff and patients with nature. Our partnership with Ray of Light Cancer Support has grown to include Social and Therapeutic Horticulture sessions, directly supporting patients through meaningful engagement with the natural world. These initiatives reflect long-term thinking by investing in the environment and well-being, and they embody integration by linking green spaces with clinical and therapeutic services. Through involvement, patients and staff co-produce these spaces and activities, ensuring they meet real needs.

As part of the Hefyd programme, the Trust's Sustainability Team, together with the new Velindre Cancer Centre Project Team, continue to hold Sustainable Jamborees for patients, staff and local community engagement. The Sustainable Jamborees held across summer, autumn and spring—bringing together staff, patients and local communities through events that promote well-being, climate literacy, biodiversity awareness and creativity. A range of different activities were hosted including arts & crafts for the local community, habitat home building and biodiversity themed activities. To engage with as many service users, staff and members of our local community as possible, it was important that we engaged in a variety of different ways in both Welsh & English.

The Trust's Arts in Health programme supports patient wellbeing through creative engagement, aligning with the Well-being of Future Generations (Wales) Act by applying the five ways of working—long-term impact, prevention, integration, collaboration, and involvement. Projects include a partnership with St Fagans National Museum of History, where a pilot social prescribing course for patients with cancer has evolved into Anadlu, a regular mindful walking and creative support group. Ongoing initiatives such as the BBC National Orchestra of Wales' on the Wards, opera performances, weekly Art Cart sessions, and poetry engagement foster connection, emotional expression, and therapeutic benefits. This work contributes to the well-being goals of A Healthier Wales, A More Equal Wales, A Wales of Vibrant Culture and Thriving Welsh Language, and A Wales of Cohesive Communities.



Challenges and Lessons Learned

Challenges

- Balancing operational demands with meaningful engagement.
- Ensuring consistency in partnership working across departments.
- Addressing recruitment and retention challenges within the workforce.

Lessons Learned

- Early and continuous engagement to ensure more effective policy implementation.
- Strong leadership commitment is critical to fostering a culture of partnership.
- Embedding fair work and social value in procurement requires ongoing supplier engagement.

Future Priorities

- Strengthen engagement with frontline staff and trade union representatives.
- Continue to expand partnership working with third-sector organisations and community groups.
- Enhance training on social partnership principles for all staff.
- Develop a monitoring framework to measure the impact of social partnership initiatives.

Conclusion

Velindre University NHS Trust remains committed to upholding the principles of social partnership, ensuring that our workforce and stakeholders play an active role in shaping the future of healthcare in Wales. Through continuous engagement, collaboration, and shared decision-making, we aim to improve working conditions, enhance service quality, and deliver better health outcomes for the people of Wales.

Unit 2, Charnwood Court,
Parc Nantgarw, Cardiff, CF15 7QZ

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Trust Board

Gender Pay Gap Report 2025

DATE OF MEETING

24th July 2025

PUBLIC OR PRIVATE REPORT

Public

**IF PRIVATE PLEASE INDICATE
REASON**

NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE

APPROVAL

**IS THIS REPORT GOING TO THE
MEETING BY EXCEPTION?**

NO

PREPARED BY

Claire Budgen: Organisational Development
Specialist

PRESENTED BY

Sarah Morley, Executive Organisational
Development & Workforce

APPROVED BY

Sarah Morley, Executive Director of
Organisational Development & Workforce

EXECUTIVE SUMMARY

There is a legal requirement to publish a Gender Pay Gap report annually. This report presents the picture of the workforce as at 31 March 2025 and indicates the actions in hand to close the pay gap.



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RECOMMENDATION / ACTIONS	The Trust Board is asked to APPROVE the Gender Pay Gap Report.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	Date
Executive Management Board	30/06/2025
Quality, Safety and Performance Committee	17/07/2025
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
Executive Management Board requested that the actions in Section 5 of the attached Gender Pay Gap Report (Appendix 1) are more clearly linked to the issues raised in the report.	
Quality, Safety and Performance Committee asked for wording in Sections 3.2 and 5. to be reviewed and clarified.	

7 LEVELS OF ASSURANCE	
.	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 2 - Symptomatic issues being addressed

APPENDICES	
1	Velindre University NHS Trust Gender Pay Gap Report 2025

1. SITUATION

- 1.1 The Public Sector Equality Duty (PSED) requires that all public authorities covered under the specific duties in Wales produce a Gender Pay Gap report each year. The report for the Trust for 2024-25 is attached at Appendix 1. The Trust is required to publish this report by 30 March 2026.



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2. 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: <u>STRATEGIC RISK DESCRIPTIONS</u></i>	Choose an item
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Select all relevant domains below
	Safe ☐
	Timely ☐
	Effective ☐
	Equitable ☒
	Efficient ☐
	Patient Centred ☐



	This report highlights the Trust's Gender Pay Gap as at 31 March 2025. By understanding the starting point the Trust will be able to progress the Strategic Equality Plan objectives regarding eliminating pay gaps.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: <i>For more information:</i> https://www.gov.wales/socio-economic-duty-overview	Not required
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances
FINANCIAL IMPLICATIONS / IMPACT	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 <u>X</u>	Not required - please outline why this is not required
	These actions fall within the scope of the Strategic Equality Plan 2024 to 2028 which was developed with an Equality Impact Assessment
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The legal framework for Gender Pay Gap is highlighted in Section 1.1 of the attached report.

3. RISKS

This section should indicate whether any matters addressed in the report carry a significantly increased level of risk for the Trust – and if so, the steps that will be



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taken to mitigate the risk - or if they will help to reduce a risk identified on a previous occasion.

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

Velindre University NHS Trust
Head of Organisational Development

Gender Pay Gap Report

2024/2025



Velindre University NHS Trust is responsible for the delivery of a wide range of specialist NHS Wales services including the Velindre Cancer Service and the Welsh Blood Service and we host Health Technology Wales, and NHS Wales Shared Services Partnership.

Caring

We are always kind, supportive, approachable and show compassion to all.



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We seek to understand other people's perspectives. We are always open and transparent.



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We always take personal responsibility for what we do and how we do it.



The Velindre Cancer Service is a specialist treatment, teaching, research and development service for non-surgical tertiary oncology services to patients from across south east Wales and further afield.

The Welsh Blood Service provides essential and highly specialised national services including the collection and production of blood and blood components, specialist diagnostic services and antenatal screening, as well as supporting transplant services for solid organs and stem cells across Wales and internationally.

Health Technology Wales assesses non-medicine health and care technologies and produces national guidance on their use in Wales.

NHS Wales Shared Services Partnership delivers a wide range of professional, technical and administrative services to NHS Wales.

1. Introduction

1.1 The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 apply to a list of ‘specified public authorities’ in relation to the publication of their gender pay gap data, which came into force on 31 March 2017. These regulations underpin the Public-Sector Equality Duty and require relevant organisations to publish their gender pay gap by 30 March each year. This includes the mean and median gender pay gaps; the mean and median gender bonus gaps; the proportion of men and women who received bonuses; and the proportions of male and female employees in each pay quartile.



- 1.2 It is important for the Trust to analyse its pay data, to gain an understanding of any gaps, what this means for its workforce and as appropriate, use this information and data to develop an action plan that will respond to bridging any identified gender pay gaps.
- 1.3 The analysis of pay data as of 31 March 2025 is presented in this report. The deadline for reporting these figures is 30 March 2026.

2. Background

- 2.1 A Gender Pay Gap report provides data for the mean and median gender pay gaps; the mean and median gender bonus gaps; the proportion of men and women who received bonuses; and the proportions of male and female employees in each pay quartile.
- 2.2 This data can be used to understand any difference in experience between men and women in the workplace and highlight areas for improvement.
- 2.3 The ESR report shows 7,742 staff working in the Trust, including NHS Wales Shared Services. This can be broken down into 5,886 under NHS Wales Shared Services and 1,856 under Velindre Services. The figures in section 3 below reflect the wider Trust inclusive of Velindre services and Shared Services.

3. Our organisational pay gap

3.1 Key findings for 2025

Mean and Median Pay Gap

Gender	Avg. Hourly Rate	Median Hourly Rate
Male	£27.57	£25.29
Female	£25.78	£23.34
Difference	£1.79	£1.95
Pay Gap %	6.49%	7.71%



The Mean Pay Gap, which is the key indicator, is 6.49%. This means that the average hourly rate for men is 6.49% higher than the average for women. In financial terms this is a difference of £1.79 an hour.

The Median Pay Gap shows a gap of 7.71% in favour of men’s salaries. This equates to £1.95 an hour.

Quartile Pay Distribution

Quartile	Female Headcount	Male Headcount	Female %	Male%
1	1080	828	56.60%	43.40%
2	1236	659	65.22%	34.78%
3	1160	820	58.59%	41.41%
4	1044	915	53.29%	46.71%

The hourly pay rates do not align exactly with the Quartiles because there are several increments on each pay band. As a rule of thumb, the following gives a guide to the main areas of employment in each Quartile.

Quartile 1	Bands 1 – 4
Quartile 2	Bands 4 – 6
Quartile 3	Bands 6 – 7, Foundation Doctors (F1 and F2)
Quartile 4	Bands 7+, Speciality Registrars and Consultants

The workforce comprises 58% women and 42% men. Therefore, for parity in pay there would need to be 58% Female in each Quartile and 42% Male in each Quartile. As the table shows, women are over-represented in Quartile 2 and to a small degree in Quartile 3. They are slightly under-represented in Quartile 1 and their lowest representation is in Quartile 4. This shows that the reason for the Gender Pay Gap is that women’s pay is centering on Quartile 2, just below Trust average, and they are not well represented in the highest paid roles as represented in Quartile 4.

Bonuses

Gender	Avg. Pay	Median Pay
Male	£5,397.33	£4,167.50
Female	£3,659.95	£2,794.84
Difference	£1,737.38	£1,372.66
Pay Gap %	32.19%	32.94%

Gender	Employees Paid Bonus	Total Relevant Employees	%
Female	52	4870	1.07%
Male	35	3385	1.03%

There are 52 women and 35 men who received an additional payment which was coded as a bonus. This equates to just over 1% of all women and just over 1% of all men.

When looking at the difference due to gender, there is a Mean Bonus Pay Gap of 32.19%. Men’s average bonus income was £1,737.38 more than women’s average bonus income.

The Median Bonus Pay Gap was 32.94%, or £1,372.66.

3.2 Changes over time

The Mean Pay Gap has gone marginally up and down over the past three years, between 6% and 7%.

Combined	2023	2024	2025
Mean Pay Gap	£6.09	£7.12	£6.49
Median Pay Gap	£13.62	£10.54	£7.71
Mean Bonus Pay Gap	£36.03	£30.89	£32.19
Median Bonus Pay Gap	£2.39	-£1.32	£32.94

However, the picture for Velindre Cancer Service, Welsh Blood Service and Corporate Services, excluding NHS Wales Shared Services, shows a decrease from between 2023 and 2025 from 13.45% to 10.67%.

Velindre Cancer Service, Welsh Blood Service and Corporate Services	2023	2024	2025
Mean Pay Gap	£13.45	£13.85	£10.67
Median Pay Gap	£6.09	£6.14	£7.27
Mean Bonus Pay Gap	£47.45	£41.47	£42.82
Median Bonus Pay Gap	£12.50	0	£16.67

4. Discussion

- 4.1 The headline figure of a Gender Pay Gap of 6.49% shows that work needs to be done to recruit, develop and promote women into the higher quartile roles in the organisation.
- 4.2 An integrated packaged of workforce practices and cultural development is required to reduce this gap. In the short term, fair recruitment and equal access to development will help level the playing field. In the longer term, existing staff in early career stage need to be supported to develop into more senior roles so that representation is consistent for men and for women in each pay quartile. Actions are required across all sections of the Trust with NHS Wales Shared Services Partnership having a key role to play in working within their services and particularly doctors employed under the Single Lead Employer model.
- 4.3 During 2024-25 the following actions were completed to close the Gender Pay Gap:

- The Trust’s Widening Access engagement programme has been extended to create contacts with schools, colleges and the wider community to bring people of all backgrounds into roles within the Trust.
- A deep dive into the experience of women in STEM professions has identified that the main barriers to progression how to balance professional and personal lives and the impact of part-time hours on career advancement. The solution to these issues is to proactively offer flexible hours whilst implementing structured career frameworks which set out the path to



advancement in both clinical and leadership roles. These actions need to sit within a supportive environment for women which includes coaching and mentoring, positive role models and collaboration.

- The Trust Values and Behaviour framework have been embedded into training programmes and management practices to mitigate bias and discrimination.
- The Staff Women's Network has been launched to provide a forum for raising awareness and peer support.



5. Actions to mitigate issues raised

5.1 Strategic Aim

During the second half of 2023-24, the Trust consulted on and renewed its Strategic Equality Plan. The first objective captures our intent as an organisation to address the Gender Pay Gap.

1. **Increase workforce diversity and inclusion and eliminate Pay Gaps.** We would like the workforce to better reflect the diverse nature of the communities that we serve and also to ensure that there is no systemic pay disparity between people of different genders, races or disabilities.

5.2 Listening to women

We will listen to women from across the Trust and in particular take learning from the Women's Staff Network about their experience of bias or discrimination due to gender. This will inform any further actions and shape the approach to communications about gender at work.

5.3 Sexual Safety

We will introduce the All Wales Sexual Safety Policy and training so that all employees, including women, have better protections against illegal harassment or abuse at work. This is under development at an All Wales level and we are ready to implement the training and policy once it is issued.

5.4 Leadership Development

A core component of our Inspire Leadership and Management Development Programme and of Fundamentals of Management is Compassionate Leadership and utilising the Trust values of Caring, Respectful and Accountable. This gives managers skills in creating a workplace free of bias and discrimination and also strategies for responding to it when it occurs. Building a compassionate leadership culture is key to enable people of all genders to thrive and take on roles that fulfil their potential.

5.5 Reasonable Adjustments

We have a broad piece of work in hand to increase the use of reasonable adjustments for individuals at work. Ensuring that reasonable adjustments are easily available for women so they can work to their potential and not be held back by issues relating to disability or menopause, will enable them to thrive at work and in time reduce the Gender Pay Gap.

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Trust Board

Annual Equality Report 2025

DATE OF MEETING

31 July 2025

PUBLIC OR PRIVATE REPORT

Public

IF PRIVATE PLEASE INDICATE REASON

NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE

APPROVAL

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?

NO

PREPARED BY

Claire Budgen, Organisational Development Specialist

PRESENTED BY

Sarah Morley, Executive Organisational Development & Workforce

APPROVED BY

Sarah Morley, Executive Director of Organisational Development & Workforce

EXECUTIVE SUMMARY

There is a legal requirement to publish an equality report annually. This report presents the picture of the workforce as at 31 March 2025 and indicates the actions in hand to increase workforce diversity and inclusion.



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RECOMMENDATION / ACTIONS	The Trust Board is asked to APPROVE the Annual Equality Report.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	Date
Executive Management Board	30/06/2025
Local Partnership Forum	15/07/2025
Quality, Safety and Performance Committee	17/07/2025
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
Executive Management Board requested that the actions in Section 5 of the attached Equality Monitoring Report (Appendix 1) are more clearly linked to the issues raised in the report.	
Quality, Safety and Performance Committee requested that all relevant categories should include reference to Census data from 2021.	

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 2 - Symptomatic issues being addressed

APPENDICES	
1	Velindre University NHS Trust Equality Monitoring Report 2025

1. SITUATION

- 1.1 The Public Sector Equality Duty (PSED) requires that all public authorities covered under the specific duties in Wales produce an equality report by 31st March each year. The report for the Trust for 2025 is attached at Appendix 1. The Trust is required to publish this report by 31 March 2026.



2. 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: <u>STRATEGIC RISK DESCRIPTIONS</u></i>	04 - Organisational Culture											
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Select all relevant domains below											
	<table><tr><td>Safe</td><td>☐</td></tr><tr><td>Timely</td><td>☐</td></tr><tr><td>Effective</td><td>☐</td></tr><tr><td>Equitable</td><td>☒</td></tr><tr><td>Efficient</td><td>☐</td></tr><tr><td>Patient Centred</td><td>☐</td></tr></table>	Safe	☐	Timely	☐	Effective	☐	Equitable	☒	Efficient	☐	Patient Centred
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Patient Centred	☐											



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	This report highlights the Trust's workforce characteristics as at 31 March 2025. By understanding the starting point the Trust will be able to progress the Strategic Equality Plan objectives regarding making the workforce representative of the community.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: <i>For more information: https://www.gov.wales/socio-economic-duty-overview</i>	Not required
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT <i>For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx</i>	Not required - please outline why this is not required
	These actions fall within the scope of the Strategic Equality Plan 2024 to 2028 which was developed with an Equality Impact Assessment
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The legal framework for the Annual Equality Report is set out in Section 1.1 of the attached report.



3. RISKS

This section should indicate whether any matters addressed in the report carry a significantly increased level of risk for the Trust – and if so, the steps that will be taken to mitigate the risk - or if they will help to reduce a risk identified on a previous occasion.

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

Velindre University NHS Trust
Head of Organisational Development

Annual Equalities Report

2024/2025



Velindre University NHS Trust is responsible for the delivery of a wide range of specialist NHS Wales services including the Velindre Cancer Service and the Welsh Blood Service and we host Health Technology Wales, and NHS Wales Shared Services Partnership.

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Health Technology Wales assesses non-medicine health and care technologies and produces national guidance on their use in Wales.

NHS Wales Shared Services Partnership delivers a wide range of professional, technical and administrative services to NHS Wales.

1. Introduction

- 1.1 This report provides the equality monitoring data in line with the Equality Act 2010 and the Public Sector Equality Duty (2011). The equality duty was created under the Equality Act 2010. The equality duty replaced the race, disability and gender equality duties.
- 1.2 The Public Sector Equality Duty (PSED) requires that all public authorities covered under the specific duties in Wales should produce an annual equality report by 31st March each year. The Trust is required to publish this report by 31 March 2026.
- 1.3 The essential purpose of the specific duties under the Equality Act, in relation to monitoring, is to help authorities to have better due regard to the need to achieve the three aims of the general duty, which are to:
- Eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Act;
 - Advance equality of opportunity between people who share a protected characteristic and people who do not share it;
 - Foster good relations between people who share a protected characteristic and people who do not share it.
- 1.4 Therefore, as a specific duty itself, the role of annual reporting is to support the Trust in meeting the general duty. It also has a role in setting out achievements and progress towards meeting the other specific duties. In particular, the annual report supports the Trust to have a better due regard to the duties by providing an opportunity to;
- Monitor and review progress;
 - Monitor and review the effectiveness and appropriateness of arrangements;
 - Review objectives and processes in light of new legislation and other new developments;
 - Engage with stakeholders around these issues, providing partners and the public with transparency.
- 1.5 The report references the Trust's Strategic Equality Plan which run from 2024 to 2028 and highlights the objective that directs our actions in relation to the Equalities Report.
- 1.6 The Census 2021 results were published in 2022 and key statistics from this have been included to offer a measure of the Trust's demographic alignment in relation to that of the population of Wales.



2. Background

2.1 This report focuses on the workforce aspects of equality in the organisation and links to the Trust’s People Strategy, which sets out the vision of a ‘Healthy and Engaged Workforce: within a culture of true inclusivity, fairness and equity across the workforce. A workforce that is reflective of the Welsh population’s diversity, Welsh language and cultural identity’. This analysis will support our progress towards this vision.

3. Our organisational profile

3.1 There are nine protected characteristics under the Equality Act 2010 which all public sector organisations report on annually. Statistics are neutral; it is the picture they paint that can help us understand potential difference in experience of employees from different backgrounds.

To give context, the overall composition of the workforce is shown below. This shows an increase over the last three years in all staff groups.

The Medical and Dental group includes 3,450 resident doctors employed through the Single Lead Employer arrangement and as such working in any health organisation across Wales.

Velindre University NHS Trust, workforce profile by staff group

Staff Group	Headcount 2023	Headcount 2024	Headcount 2025
Add Prof Scientific and Technic	86	92	112
Additional Clinical Services	394	415	427
Administrative and Clerical	2238	2327	2422
Allied Health Professionals	154	174	173
Estates and Ancillary	584	603	742
Healthcare Scientists	178	180	186
Medical and Dental	3259	3468	3608
Nursing and Midwifery Registered	249	258	298
Students	2	3	2
Grand Total	7144	7520	7970



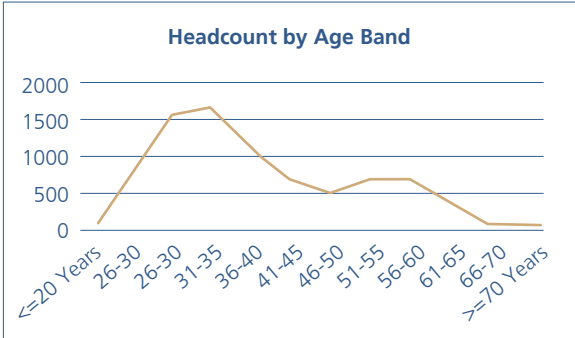
1

Age

63% of the workforce is under 40 with the largest group in the range 31 to 35 years old. This is in part a reflection of being the Single Lead Employer for doctors in training, many of whom are in their 20s or 30s.

Age Band	Headcount	%
<=20 Years	26	0.33
21-25	844	10.59
26-30	1537	19.28
31-35	1599	20.06
36-40	1041	13.06
41-45	676	8.48
46-50	526	6.60
51-55	607	7.62
56-60	623	7.82
61-65	376	4.72
66-70	83	1.04
>=71	32	0.40
Grand Total	7970	100.00

Headcount by Age Band



When compared with figures for the working age population in Wales, we can see that our employees are clustered in the 25 to 49 age group which means we need to focus on attracting and retaining people form younger and older groups.

The comparator statistics are taking from stats.wales.gov.uk for Employment of People in Wales aged over 16 as at 31.3.25.

Age	Wales Headcount	Percentage of Wales Workforce	Trust Headcount	Percentage of Trust Workforce	Difference
16-24	336,500	17.4	870	10.92	-6.48
25-49	954,300	49.5	5,379	67.48	17.98
50-64	636,200	33	1,721	21.6	-11.4

2

Disability

Over the past three years the proportion of staff declaring a disability has increased from 2.94% in 2023 to 3.64% in 2024 and now to 4.09%.

In real terms, 326 people declared a disability in 2025.

However, the Census reports 78% of the population as Not Disabled, 22% Disabled. This shows that the Trust is under-representative of Disabled people by between 6% and 18%.

Disability	Headcount	%
No	6672	83.71
Not Declared	180	2.26
Prefer Not To Answer	31	0.39
Unspecified	761	9.55
Yes	326	4.09
Grand Total	7970	100.00

3

Gender Reassignment

ESR does not record Gender Reassignment and therefore we do not hold statistics on this characteristic.

The Office for Statistics Regulation confirmed on 12.9.24 that the gender identity estimates for the Census 2021 are no longer accredited official statistics.

Whilst we cannot present statistics on Gender Reassignment the Trust has a Supporting Transgender Staff Policy which provides a framework for staff who have transitioned or who are in the process of transitioning their gender.

4

Marriage or Civil Partnership

Just over one-third of the workforce is married and more than a quarter are single. 30% of the workforce have no known Marital Status recorded on ESR.

According to the 2021 Census, 43.8% of adults in Wales are married or in a civil partnership.

Marital Status	Headcount	%
Civil Partnership	115	1.44
Divorced	272	3.41
Legally Separated	27	0.34
Married	2830	35.51
Single	2229	27.97
Unknown	1264	15.86
Widowed	42	0.53
(blank)	1191	14.94
Grand Total	7970	100.00

5	Pregnancy or Maternity	Maternity Leave – 2025				
	2.48% of the workforce were on maternity leave as at 31 March 2025. This is very stable compared with the 2.89% in 2024 and 2.49% in 2023.	On Maternity	Headcount	%		
		Yes	198	2.48		
		No	7772	97.52		
		Grand Total	7970	100.00		
6	Race	Ethnic Origin				
	72.52% of staff are recorded as White, with the second largest group being Asian at 10.3%. These results compare to the Census showing 94% of the population of Wales as White and the second largest group being Asian, at 3%. The percentage of staff records showing Not Stated or Unspecified is 7.87%.	Headcount	%			
		Asian	821	10.30		
		Black	305	3.83		
		Chinese	62	0.78		
		Mixed	134	1.68		
		Not Stated	156	1.96		
		Other	241	3.02		
		Unspecified	471	5.91		
		White	5780	72.52		
	Grand Total	7970	100.00			
7	Religion or Belief	Religious Belief				
	The largest group is Christianity at 30.9%, followed by Atheism at 22.65%. However, 30.64% are listed as Do not wish to disclose or Unspecified, leaving gaps in our understanding. The Census showed 43% of people in Wales as Christian and 46% No Religion, which may not correlate exactly with Atheist.	Headcount	%			
		Atheism	1805	22.65		
		Buddhism	52	0.65		
		Christianity	2463	30.90		
		Hinduism	133	1.67		
		Do not wish to disclose	872	10.94		
		Islam	481	6.04		
		Jainism	2	0.03		
		Judaism	8	0.10		
		Other	569	7.14		
		Sikhism	15	0.19		
		Unspecified	1570	19.70		
			Grand Total	7970	100.00	
8	Sex (Gender)	Employment Category By Gender				
	Despite the population of Wales being 51% female, 49% male (according to the 2021 Census), the Trust has a 59:41 gender split, which shows a slight increase towards a female workforce. However, 64% of women are in full time employment compared with 82% of men.	Female Headcount	Male Headcount	Total		
		Full Time	3022	2673	5695	
		Part Time	1705	570	2275	
		Grand Total	4727	3243	7970	
9	Sexual Orientation	Sexuality				
	71.73% of staff recorded themselves as Heterosexual or Straight. 4.97% of people chose not to state their sexual orientation and 2.21% were Bisexual, 2.2% Gay or Lesbian and less than 1% reported Other Sexual Orientation or Undecided. 18.64% are recorded as Unspecified. This compares with 89.4% of the adult population of Wales reporting as Straight in the 2021 Census.	Headcount	%			
		Bisexual	176	2.21		
		Gay or Lesbian	175	2.20		
		Heterosexual or Straight	5717	71.73		
		Not stated	396	4.97		
		Other sexual orientation not listed	15	0.19		
		Undecided	5	0.00		
		Unspecified	1486	18.64		
			Grand Total	7970	100.00	

5. Actions to mitigate issues raised

5.1 Strategic Aim

During the second half of 2023-24, the Trust consulted on and renewed its Strategic Equality Plan. The first objective captures our intent as an organisation to address the issues seen within the statistics presented in this report:

1. **Increase workforce diversity and inclusion and eliminate Pay Gaps.** We would like the workforce to better reflect the diverse nature of the communities that we serve and also to ensure that there is no systemic pay disparity between people of different genders, races or disabilities.

5.2 Age Profile

We are developing our Widening Access Engagement Programme to direct our engagement with schools, colleges and the wider community. This will broaden the age range of people joining the Trust and thereby smoothing the Age Profile and bring in people from different backgrounds with different ideas and talents.

5.3 Disability

We have been accredited as Disability Confident Level 3, a Leader in disability employment. This shows that we are proactive in every stage of recruitment and employment of people with disabilities. Over the course of 2025-26 we anticipate that more people with disabilities will be offered roles and are subsequently supported in all areas to thrive at work. We will monitor our progress with this over the course of the year.

5.4 Data Quality

This report identified a level of under-reporting of equalities data on ESR, particularly with doctors employed through the Single Lead Employer arrangement. NHS Wales Shared Services Partnership is using a working group to improve reporting, particularly looking at the ways they communicate with SLE trainees. We will track whether we have more comprehensive coverage of staff characteristics during the course of the year.



Unit 2, Charnwood Court,
Parc Nantgarw, Cardiff, CF15 7QZ

029 2019 6161 | velindre.nhs.wales

TRUST BOARD	
WELSH LANGUAGE ANNUAL REPORT 2024-25	
DATE OF MEETING	24 July 2025
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Jo Williams
PRESENTED BY	Sarah Morley, Executive Director of Organisational Development & Workforce
APPROVED BY	Sarah Morley, Executive Director of Organisational Development & Workforce
EXECUTIVE SUMMARY	The Trust is required to report its annual compliance against the Welsh Language Standards. This report will then be placed on the Trust website and available for the Welsh Language Commissioner.
RECOMMENDATION / ACTIONS	The Trust Board is asked to APPROVE the Welsh Language Annual Report.
GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	Date
Executive Management Board	30.06.2025
Quality, Safety and Performance Committee	17.07.2025
Being presented at the Welsh Language Steering Group	(14.08.2025)
Not required legally for presentation on the website before September 2025	
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	

Information within the report is specified by the requirements of the Welsh language standards.	
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 The level of assurance reflects the WL Standards. The majority are implemented but some are yet to fully compliant. There is an ongoing action plan with identified actions, working through compliance requirements.
APPENDICES	
1	Welsh Language Annual Report 2024/25

1. SITUATION

- 1.1 All Local Health Boards and Trusts are required to provide a Welsh Language Annual Report. This report has a set structure and is provided for assurance and compliance against a set of Welsh Language Standards to the Welsh Language Commissioner.
- 1.2 The Trust’s hosted services, NHS Wales Shared Services Partnership (NWSSP) and Health Technology Wales (HTW) have also provided information as they are not required to provide a separate account, however, NWSSP develop their own report, which sits on their website and is also made available to the Welsh Language Commissioner.

2. BACKGROUND

- 2.1 The Trust received its Welsh Language Standards compliance notice in 2018 and has, since then, been working proactively to provide bilingual services for patients and donors. This report gives an overview of the 2024/25 successes along with ambition to continue to strengthen this provision.
- 2.2 We continue to work proactively with our hosted services and with Welsh Government and the Welsh Language Commissioner.

3. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)												
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below												
If yes - please select all relevant goals:												
• Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒												
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) <i>For more information: STRATEGIC RISK DESCRIPTIONS</i>	03 - Workforce Supply and Shape											
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply											
	<table> <tr><td>Safe</td><td>☐</td></tr> <tr><td>Timely</td><td>☐</td></tr> <tr><td>Effective</td><td>☐</td></tr> <tr><td>Equitable</td><td>☒</td></tr> <tr><td>Efficient</td><td>☐</td></tr> <tr><td>Patient Centred</td><td>☒</td></tr> </table>	Safe	☐	Timely	☐	Effective	☐	Equitable	☒	Efficient	☐	Patient Centred
Safe	☐											
Timely	☐											
Effective	☐											
Equitable	☒											
Efficient	☐											
Patient Centred	☒											
QUALITY IMPACT ASSESSMENT	Not required - not a strategic decision											
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Not required											
TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT												
The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated. Please indicate whether any of the matters outlined in this report impact the Trust's Wellbeing goals: YES - Select Relevant Goals below												
If yes select the relevant goals:												

• A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities. ☐ • A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience. ☐ • A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health ☐ • A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances ☐ • A Wales of more Cohesive Communities - Attractive, viable, safe and well-connected communities. ☐ • A Wales of Vibrant Culture and Thriving Welsh Language -Promoting and protecting culture, heritage and the Welsh language, encouraging people to participate in the arts, and sports and recreation. ☒ • A Globally Responsible Wales – Consideration of whether an action may make a positive contribution to global well-being ☐	
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT <i>For more information:</i> https://nhs.wales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx	Not required - please outline why this is not required
	This report outlines key activities and does not require an EQIA on retrospective activity
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Each breach of non-compliance with the WL Standards could result in a £5000 financial penalty.

4. RISKS

This section should indicate whether any matters addressed in the report carry a significantly increased level of risk for the Trust – and if so, the steps that will be taken to mitigate the risk - or if they will help to reduce a risk identified on a previous occasion.

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	
WHAT IS THE CURRENT RISK SCORE	

HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	
All risks must be evidenced and consistent with those recorded in Datix	

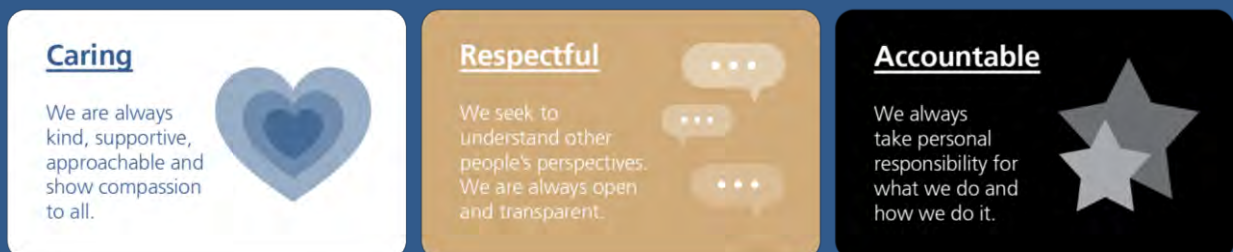
Velindre University NHS Trust
Welsh Language Manager

Welsh Language Annual Report

1 April 2024 – 31 March 2025



Velindre University NHS Trust is responsible for the delivery of a wide range of specialist NHS Wales services including the Velindre Cancer Service and the Welsh Blood Service and we host Health Technology Wales, and NHS Wales Shared Services Partnership.



The Velindre Cancer Service is a specialist treatment, teaching, research and development service for non-surgical tertiary oncology services to patients from across south-east Wales and further afield.

The Welsh Blood Service provides essential and highly specialised national services including the collection and production of blood and blood components, specialist diagnostic services and antenatal screening, as well as supporting transplant services for solid organs and stem cells across Wales and internationally.

Health Technology Wales assesses non-medicine health and care technologies and produces national guidance on their use in Wales.

NHS Wales Shared Services Partnership delivers a wide range of professional, technical and administrative services to NHS Wales.

Welsh Language Annual Report

1 April 2024 – 31 March 2025

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Foreword

Our annual report supports a strong cultural and Governmental aim to provide opportunity for current Welsh speakers but to also increase the number of Welsh speakers through the aims of the 2050 strategy.

As a Trust we have been charged with delivering the Welsh Language Standards since 2018 and we have increased our compliance with these requirements. The report outlines not only our regulatory compliance, but our aims to promote the Welsh Language across the Trust and facilitate a bilingual environment for our staff.

We have developed a new set of organisational values, ensuring that the Welsh Language and Culture are at the heart of these values. We have embedded these values and provided training through a new induction programme 'Croeso', giving staff opportunity to feel a stronger connection with the services we provide. This has been a huge success, opening up discussion forums aimed at engaging staff with Welsh culture. We will continue to strengthen this as we move through 2025/26.

Our Divisional Welsh Language groups go from strength to strength providing guidance to staff and supporting key changes that are needed to move this agenda forward in a positive way. Welsh Blood and the Cancer Service are working with staff to embed a positive culture change. As part of this culture change, the Active Offer concept has been strongly embedded and will continue to be a focus for us.

2024-25 at a glance...

96% of staff have recorded their Welsh language skills

15 WBS Bespoke training sessions for Reception

5 Welsh Language Steering Group meetings

1+million Words translated

2 Chair and Chief Executive Welsh language training meetings

12 Welsh Language Divisional Group

Chief Executive welcome

I fully support the work of the Trust in engaging with and using the Welsh language and have been attempting to learn some Cymraeg myself since I started in my role in December. I have also been impressed with our use of translation during our public board meetings and the contribution our Independent Members make to holding us to account in Welsh. As we know the Welsh language (Wales) measures 2011 provides a legal framework for the language and ensures that as a public organisation we continue to strive for a truly bilingual service.

It is my first Annual Report as Chief Executive and I am encouraged by the importance we place on our bilingual provision.

We recognise our responsibility to promote and facilitate the use of the Welsh language internally in everything we do. Our staff have access to bilingual support, as it should be, and we are always looking at ways to improve their abilities to support our services.

Our commitment goes beyond our statutory duties, it is about the respect we offer to the rights of Welsh speakers, whether it's through our services, our workforce initiatives or our communications, we aim to provide an environment that is visible and accessible.

I am positive that we can achieve our aims and ambitions and as decisions are made, the Welsh language will be considered right alongside all of our other access needs.

Moving forward we will be focusing on our clinical plans and our ability to communicate with patients and each other in the Welsh language and I am positive that we can create a more equitable service for our patients and donors.



David Donegan
Chief Executive
Velindre University NHS Trust



We said and we did....

Since our last annual report our main concerns have been addressed... we have developed a more focussed in-patient plan, a more targeted Clinical consultation plan and we continue to challenge our internal understanding of the needs for bilingual assessments as part of the recruitment process.

In-patients

Our plan provides focus for in-patients, being clear on what they have the right to receive whilst spending time at Velindre Cancer Service. In its simplicity it provides a pathway for patients giving them the support they need should they require bilingual information or communication. Our digital systems enable us to record their needs, and this is then translated into action should a patient require to use the Welsh language.

Clinical Consultations

Working with the Welsh Language Commissioner and attending the open discussion events has enabled us to focus our plan (standard 110).

We have worked closely with the Welsh Language Commissioner and her aims for co-working and we are encouraged by the support and open approach to this aim. It is clear to see how co-regulatory working can improve understanding and performance, translating into greater support for our patients' and donors' bilingual needs. Focussing on what we can achieve and delivering on these aims whilst holding open discussions on areas of difficulty promotes a healthy relationship with the Commissioner's office.

We will now consult with the teams and relevant members of responsible staff to ascertain the practicality of such a plan. This will be our focus for 2025/26.

Compliance

The Welsh Language Standards and the More than Just Words Framework continue to drive our compliance work, giving us a focus and a stronger ability to embed our Welsh Language provision. We have seen an increase in awareness of the 'Active Offer' due to staff communication and training.

As a Trust we have always been adamant that language support for our patients and donors and our staff is of utmost importance and is complimented by the legal frameworks across Wales. Legislation has proved to raise an awareness of these needs, and we will continue to increase our compliance.

Background

Since 2018 we have been developing our workforce and services to deliver the Welsh Language Standards. We are fully aware that some of the Standards are challenging and will continue to prove difficult for us in light of the workforce struggles faced by the NHS, however we are committed to ensure all that we do considers the implications faced by the Welsh Language workforce in order to increase our ability to provide a strong bilingual presence.

We continue to work with Local Health Boards and are an active member of the All-Wales group that has a focus on sharing best practice on a national level. We also participate in the Welsh Government group looking at delivering positive outcomes on the 'More than Just Words' framework. All of this work feeds positively into our initiatives in support of the Welsh Language Standards.

Situation

In this section we have quantified our current position of compliance against the Standards.

Since November 2018 the Trust has received two formal Investigations against our ability to comply with the Welsh Language Standards. One was closed almost immediately and the other has been officially received and we are awaiting a response. The work undertaken against the Investigation is reflected in the colour coding of our achievements.

Service Delivery Standards

Green – High level of assurance

Yellow – Medium to high

Orange – low to medium level of assurance

Standards	Assurance rating	
	23/24	24/25
Correspondence (1,4,5,6,7)	Green	Green
Telephone services main numbers (8,9,10,11,12,13,14,15,16)	Orange	Orange
Telephone services direct numbers (16,17,18, 19)	Orange	Orange
Telephone automated systems (20)	Orange	Orange
Meetings (21,22, 22A, 22CH)	Green	Green
In-Patients (23-25)	Green	Green
Public Meetings (26,27,28,29)	Green	Green
Displaying written material at public meetings (30)	Green	Green
Public Event (31,32,33,34)	Green	Green
Forms to be completed by individuals (36)	Green	Green
Documents available to individuals (37)	Green	Green
Documents and Forms (38)	Green	Green
Websites (39, 40,41,42,43)	Green	Green
Apps (used on electronic devices) (44)	Green	Green
Social media (45,46)	Green	Green
Signage in publicly accessible areas (47,48,49)	Green	Green
Reception services (50, 52, 53)	Orange	Orange
Applications and documents for grants (54,55,56)	Yellow	Orange
Invitations to Tender (57,58,59)	Green	Green
Promote Welsh language services (60-61)	Green	Green
Corporate Identity (62)	Green	Green
Public Address Systems (64)	Yellow	Orange

The Trust is fully committed to continued professional development and this year we have completed a number of bespoke training sessions for front line staff responsible for reception services. This was in direct response to a formal investigation, and it has given us an opportunity to promote and further educate staff in the needs and expectations of Welsh Speaking Patients and Donors.

Website and Social Media

Our Bilingual Social Media platforms grow from strength to strength. It is Trust policy to ensure a bilingual approach to posting videos and content and we actively encourage response from Welsh speakers on our websites.

Activity to the sites over the last twelve months demonstrate a clear connection with the public.

Velindre University NHS Trust - 126,923 views on the English language and 198 views the Welsh language site.

Welsh Blood Services views are 316,771 and of those 2746 in Welsh which is 0.86% of the views.

Operational Standards

Green – High level of assurance

Yellow – Medium to high

Orange – low to medium level of assurance

Standards	Assurance rating	
	23/24	24/25
Welsh Language Policy – Using Welsh internally (79)	Green	Green
Contract of Employment (80)	Green	Green
Documents relating to employment of employees (81)	Green	Green
Policies relating to employment & workplace (82)	Green	Green
Complaints made by staff & disciplinary matters (83 – 88)	Green	Green
Computer software for spelling and grammar & interfaces (89)	Green	Green
Intranet pages (90 – 95)	Green	Green
Assessing Welsh language skills of employees (96)	Green	Green
Training for staff in key areas (97 & 98)	Green	Green
Opportunities to learn Welsh (99 – 103)	Green	Green
Email signatures, wording and Welsh language logo (104)	Yellow	Yellow
Welsh badges and branding for staff (105)	Green	Green
Assessing skills, advertising, recruiting (106 – 109)	Green	Green
Development and Publishing of a Clinical Consultation plan (110)	Orange	Green
Signage & notices (113)	Yellow	Green
Recorded announcements (114)	Green	Green

This year we saw the launch of the Welsh Blood Welsh Language intranet page, giving the division a greater focus on the work that they have been doing to support the Welsh Language, and opportunity for staff to see it from a Welsh Blood perspective. The site is an excellent resource for the division and has its own branding.

The ‘Active Offer’ has been the main focus for the service this year. They have proactively founded a relationship with Menter Rhondda Cynon Taf and now run a Welsh Language discussion group once a week. Staff who are learning or need to raise their confidence in the language can attend and have informal discussions. Lessons are also provided for reception staff with specific topics agreed to suit their areas of work and improve their ability to answer the telephone bilingually.

The divisional working groups continue to promote and provide guidance to staff on the requirements of the Welsh Language Standards.

Velindre Cancer Service's governance structure has been changed to ensure the Welsh Language priorities feed into the main planning group at the centre. Highlighting the needs of the service to senior managers and ensuring a cohesive approach to embedding the Welsh language in all that we do.



Employee excellence awards



This year's awards were held at Coleg y Cymoedd and the Welsh Language award for promotion of and support to the delivery of Welsh Language services went to the Welsh Blood Service Divisional Welsh Language group for their proactive work around the promotion of the Welsh language to services for staff and donors.

Highlights of the current year's work would be the identification of current IT systems needing development to support the Welsh Language, the promotion of Welsh language annual events, training for staff and making connections with external support agencies to open up partnership working.

The group are highly visible across the service and has a clear action plan supporting the Welsh Language Standards and Trust wide commitments.

Translation

Our translation team continue to go from strength to strength, streamlining the translation process and providing translations to meet the service demands. We have made significant use of translation memory software giving us a greater insight into translated documents saving time in the process.

Translation figures will drop as the process is now identifying past translations and therefore what needs to be translated is reducing. It is a system we will continue using in 2025/26.

Translation staff have also been able to tap into national translation training, ensuring they are up to date with modern translation methods. This investment is proving to be very positive to the translation process.



We continue to provide simultaneous translation for our Public Board meetings and all our agendas and minutes are available in Welsh and English.

Responses to the Trust social media platforms are provided in Welsh, should that be required, and all our sent posts have bilingual platforms and are translated in time for publication.

Recruitment

Knowing our workforce skills enables us to plan accordingly for vacant posts. The Trust, along with all other Health organisations in Wales, use the Electronic Staff Record to record Welsh language skills. This year we have embedded the need to record these skills and are currently over 95% compliant. This will assist us with identifying areas for recruitment and language needs across the Trust.

This year we have worked closely with the divisions to embed a deeper understanding of language requirements, and we will continue to strengthen this understanding and process, providing guidance and support for recruitment managers and learning from our partners across the NHS.

Working with the recruitment digital systems available we will now embed the language assessment process into these processes. It will mean that assessing language needs will be non-negotiable. Supporting recruitment managers to make these decisions will be crucial to make this a successful process.

2024/25 recruitment statistics

Welsh Blood Service 2024-2025

Total number of vacancies advertised as:	
Welsh language skills are essential	0
Welsh Language skills are desirable	110
Welsh Language skills need to be learnt when appointed to the post	3
Welsh Language skills are not necessary	2
Total Number of vacancies advertised 01/04/2024 - 31/03/2025	115

Velindre Cancer Centre 2024-2025

Total number of vacancies advertised as:	
Welsh language skills are essential	1
Welsh Language skills are desirable	315
Welsh Language skills need to be learnt when appointed to the post	0
Welsh Language skills are not necessary	3
Total Number of vacancies advertised 01/04/2024 - 31/03/2025	319

Velindre NHS UT 2024-2025

Total number of vacancies advertised as:	
Welsh language skills are essential	2
Welsh Language skills are desirable	172
Welsh Language skills need to be learnt when appointed to the post	0
Welsh Language skills are not necessary	9
Total Number of vacancies advertised 01/04/2024 - 31/03/2025	183

The posts advertised as Welsh Language essential were receptionist and support officer. The posts advertised as Willing to Learn were reception staff.

The Trust has also mandated that all reception posts must be advertised as 'Essential'. Should there be a recruitment issue with this then we will re advertise as 'Willing to Learn', demonstrating a real commitment to front line communication posts in support of our Patient and Donor needs.

Current Welsh Language skills

Trust Welsh Language (Listening/Speaking) (31 March 2025)

Welsh Language (Listening Speaking)	Count	Headcount	%
0 - No Skills / Dim Sgiliau	1320	1913	69.00%
1 - Entry/ Mynediad	250	1913	13.07%
2 - Foundation / Sylfaen	79	1913	4.13%
3 - Intermediate / Canolradd	52	1913	2.72%
4 - Higher / Uwch	60	1913	3.14%
5 - Proficiency / Hyfedredd	68	1913	3.55%
Capability Stated	1829	1913	95.61%
Not Stated	84	1913	4.39%

Concerns and Complaints

Concerns regarding our bilingual services continue to be low, however, this year we have received two official complaints from the Welsh Language Commissioner. Following a mystery shopper exercise delivered by the Commissioner's office it became clear that two elements of our current provision did not fully comply with the Welsh Language Standards and provided a less than equal service to Welsh speakers.

One focussed on our social media presence and one focussed on the Trust's ability to provide bilingual telephony services at the main in Velindre Cancer Centre and the Welsh Blood Service.

A task and finish group was established to address these issues, driven by the Director of Workforce and following a rigorous process of identifying where the risk to services was greatest, the Welsh Language Steering Group set about developing an action plan to address the issues raised by the Welsh Language Commissioner.

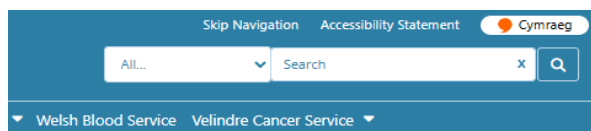


The Communication teams worked diligently to resolve the issues relevant to external information and making the Welsh Language easily visible to users. Visibility and the need to highlight the service is central to many of the Welsh Language Standards.

Processes were changed to support patient and donor need for bilingual information in a clear and accessible format. Going forward, Welsh Language visibility will continue to be a priority for us.

We acknowledged the need to have a clear deep dive into the current telephony systems at the Velindre Cancer Centre and changes were made to messages for patients and inward bound calls. We continue to investigate opportunities to support the language needs of callers, and this will be our focus for the coming financial year as we recognise that there is still some way to go with providing a fully bilingual main line service at the Velindre Cancer Centre.

The Welsh Blood Service have recruited successfully and have trained and continue to train, current staff in providing a Welsh Language telephony service. The investigations have provided a focus for us to concentrate and fully examine our processes for front line telephony services.



We continue to vigorously monitor the concerns and conduct 'mystery shopper' exercises, feeding back results to divisions and ensuring an awareness is raised with staff. Being aware that

staff require continued support to ensure compliance in this area assists us with forward planning our workforce Welsh Language skills.

Policy Making

The Trust has updated its Welsh Language Policy this year to reflect the current political climate. We have also established a new policy group aimed at agreeing new and updated policies. This sits alongside the work of the Impact assessment group and Welsh Language has a proactive role to play in assuring policies reflect the needs of Welsh speakers and Welsh culture and reflects the updated RAG rating to Standards 76 and 77.

Policy Making Standards

Green – High level of assurance

Yellow – Medium to high

Orange – low to medium level of assurance

Standards	Assurance rating	
	23/24	24/25
Formulating a new policy – opportunities and threats to the language (69)		
New or revised policy – positive effects on the language (70)		
New or revised policy – opportunities to use the language (71)		
Publishing a policy or related document (72)		
Publishing a consultation document and seeking views on the formulation of a policy (73)		
Seeking views on a published consultation document (74)		
Undertaking research to assist a policy decision and considering the effects on the Welsh language (75)		
Commissioning of research to assist in a policy decision (76)		
Commissioning of research to ensure no adverse effects or opportunities for the Welsh language (77)		

More than just words

The Health and Social Care Framework compliments the Welsh Language Standards, and its actions are in support of all we do at the Trust.

Most relevant themes are:

Theme 2 - Supporting and developing the Welsh Language skills of the current and future workforce

This year we have, as suggested in the Framework, developed an induction process able to accommodate space and time for staff to discuss the aims and objectives of the Active Offer, to challenge any negativity around a bilingual service and to be aware of all the Trust has to support staff in providing a bilingual service.

We are proactively promoting all forms of on-line training and are in discussion with the Welsh Government funded organisation, 'Iaith Gwaith' to attend 'Croeso i'r Gymraeg' training and supporting courses.

Theme 3 -Sharing best practice and an enabling approach

We continue to be an active member of the national Welsh Language Managers group, facilitated by Welsh Government. We are also participating in a cross organisational group looking at Welsh Language, facilitated by Digital Health and Care Wales. Sharing best practice is the aim of both groups.

The Trust has taken advantage of the training offered by the Government funded organisation and will be working in partnership with Aneurin Bevan University Health Board and Coleg Gwent, this coming year, to provide training for staff at three different levels. This will be our focus in 2025/26 and will feed into our response to Welsh Government on the specific areas within the framework.

The Trust reports annually to Welsh Government on its compliance with the framework.

Our Hosted Organisations

(This is a snapshot of compliance and further information can be found on the hosted organisation's websites)

NHS Wales Shared Services Partnership (NWSSP)

Most of the standards remained the same as the previous year. However, there were some slight variations. Here is a breakdown of the variations for 2024/25 by comparison to 2023/24:

- Telephone services direct numbers (16,17,18, 19)

From secret shopper audits of telephone numbers applicable to these standards, there was an increase in staff awareness of the need to answer telephone calls through the medium of Welsh.

- Websites (39,40,41,42,43)

A comprehensive audit of our website and pages was undertaken in February 2025. We saw a slight fall in compliance on some of our webpages. Whilst pages were available through the medium of Welsh, the following issues were identified on a few pages:

- documents were found on the site that hadn't been assessed to be available in Welsh,
- videos uploaded onto a few pages were only available in English.
- Links to other webpages in NHS Wales or other public organisations were only linking to English language pages, although there were Welsh language pages that could be linked to.

The matter has been communicated to the relevant teams to address and rectify these issues as a piece of work to be undertaken during quarters 1 and 2 of 2025/26.

Social Media

Similar issues were identified on our social media accounts. Mostly where videos were only created in English. The timetable to address this will also be the early part of 2025/26.

protocols are reviewed that are available to all members of staff employed by NWSSP annually to ensure that our protocols and processes are deliverable across all service delivery areas. All protocols are available on the internal Welsh language support page.

NWSSP promotes that they welcome correspondence and telephone calls in Welsh on their websites and in emails and corporate letterheads.

Most meetings are now hosted on virtual platforms, such as Microsoft TEAMS and Zoom. A protocol as to how meetings can be facilitated in both languages and the Welsh Language Unit supports all divisions and service delivery areas to source interpreters as and when required.

Agendas and minutes of the Shared Services Partnership Committee are available in Welsh on the website. Most events are not public facing. However, when an event is organised, there is a protocol and a checklist in place for event organisers to ensure that they consider and accommodate the Welsh language when planning.

All NWSSP Forms and Documents intended for use by individuals are available in Welsh, whether they are hard copies or whether they are digital copies. NWSSP also recognise that it is important to give instruction as to how to use these resources where staff manage the administration and dissemination of documents and forms.

Social media posts are planned ahead, and translation support is available to support our corporate social media accounts, if required in advance of any social media events and activities. NWSSP reply to Welsh language social media posts in Welsh if a reply is required.

One request for Invitations to Tender to be published through the medium of Welsh was received in 2024/25. 5 bids through the medium of Welsh in response to the invitation to tender were also received. Response documents were published in Welsh as required by Standards 57, 58 and 59.

Training for procurement staff was provided, giving advice to Health Boards and Trusts to assess whether an invitation to tender needs to be published through the medium of Welsh.

Investigation to Telephone Services – CS1040 November 2023 to January 2025

The work to remedy the concerns raised in the CS1040 investigation has now concluded. Some work remains to be completed, but NWSSP have started to map out a process to assess new and vacant posts and will pilot this with a small cohort of divisions in NWSSP prior to launch later in 2025/26.

Whenever a post responsible for answering calls on our main telephone number is vacant the role will always be advertised as Welsh Essential at level 4 or 5 in speaking, understanding, reading and writing in Welsh.

Health Technology Wales (HTW)

HTW continues to work diligently following the Welsh Language Standards of the Trust. They have an action log that is revisited regularly to ensure compliance with the relevant Standards within the scope of their organisations.

Outside of the regulatory requirements, this year HTW have five staff members are learning Welsh with LearnWelshCymru at various levels and HTW has welcomed a fluent Welsh speaker to the team, who is joining HTW on Secondment from NWSSP to cover maternity leave.

The Social Wellbeing committee are planning further Welsh language virtual coffee breaks to help to encourage team member to use their Welsh Language skills.

A Welsh Language teams chat has been created to encourage learners to practice their Welsh language skills.

The Future for Velindre University NHS Trust

The Trust's commitment is clear, and we will remain diligent in continuously improving our services and learning from the needs of our patients and donors. It is an exciting time of change for the Trust, and we enter this with positivity and a keen commitment to working with our partners.

Unit 2, Charnwood Court,
Parc Nantgarw, Cardiff, CF15 7QZ

029 2019 6161 | velindre.nhs.wales



TRUST BOARD	
2024/2025 Trust Annual Integrated Quality & Safety Report	
DATE OF MEETING	24 th July 2025
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Tina Jenkins, Head of Quality, Safety and Assurance
PRESENTED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences
EXECUTIVE SUMMARY	The Velindre University NHS Trust's first Integrated Quality & Safety Report Annual Report covers the period 1st April 2024 to 31st March 2025. The following are the highlights: • The triangulation of data in this annual report 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 most incidents are not attributed to harm, they are causing a significant impact on patient's cancer journey and negatively impacting their experience. • Overall satisfaction scores for both Welsh Blood Service and Velindre Cancer Service remain positive, 98% in the Welsh Blood and 96% Velindre Cancer Service. • Compliance with Putting Things Right timescales for complaints response has decreased to 75% from 93% in 2023/2024, this was due to capacity issues in the VCS concerns team and the complexity of concerns (national target is 75%). • Ten incidents triggered the Duty of Candour, two of

	which also met the criteria to be reported nationally due to the level of harm. • The Trust continues to comply with legislative safeguarding responsibilities and reporting. • Hospital Associated Infection rates remain low. • Work has been undertaken during this year to strengthen Trust oversight and governance in relation to licences held across the organisation (including hosted bodies). • 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 an improvement plan with staff across WBS and VCS.
RECOMMENDATION / ACTIONS	The Trust Board are asked to APPROVE the Integrated Quality & Safety 2024-2025 Annual Report prior to publication.
GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	Date
Integrated Quality and Safety Group	25/06/2025
Executive Management Board	30/06/2025
Quality, Safety & Performance Committee	17/07/2025
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Integrated Quality & Safety Group - The draft report was condensed. Information was amended to ensure that cases could not be identified. To apply caution, due to low number reporting from an information governance perspective the annual report was amended to reflect comments and endorsed outside of the meeting. Executive Management Board - endorsed the report. Quality, Safety & Performance Committee – Endorsed the report and commended the format. Requested an enhanced summary slide for future reports.	
7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 4 - Increased extent of impact from actions
	2023/2024: Patient Experience level 4 Putting Things Right level 3
APPENDICES	
Appendix 1	Integrated Quality & Safety Annual Report

1. ASSESSMENT AND SUMMARY OF MATTERS FOR CONSIDERATION

The Trust 2024/25 Integrated Quality & Safety report is attached. The report provides information on how our systems and processes have developed over the reporting period for the effective investigation and engagement with patients/donors and their families, providing comprehensive responses to each concern raised.

The report provides analysis of key outcomes, activity, learning and improvement during the year as well as contextualizing over time, will meet all legislative requirements i.e. Putting things Right Regulations and Quality & Engagement (Wales) Act 2020, Mortality Duty of Candour & Duty of Quality and includes:

- o VCC Divisional Report
- o WBS Divisional Report
- o Infection Prevention & Control
- o Safeguarding and Vulnerable Groups
- o Safety Alerts
- o Datix standards
- o Putting things Right
- o Claims, inquests, compliments
- o Information Governance
- o Health & Safety
- o Quality outcome metric overview
- o Mortality
- o Regulatory compliance
- o Learning from external reports.

The organisation must ensure that the annual report does not identify individuals or any related sensitive information.

2. IMPACT ASSESSMENT

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

A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) <i>For more information: STRATEGIC RISK DESCRIPTIONS</i>	06 -Organisational and Clinical Governance
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021).
QUALITY IMPACT ASSESSMENT	Not required - not a strategic decision
	The <u>QIA tool</u> should be completed to support any proposal for a strategic decision to be made and be presented with the proposal to the appropriate decision-making forum. The QIA tool does not replace the need for the proposal; it accompanies it. As a minimum, decisions made by the Board or by Committees of the Board are considered strategic and should be assessed for their impact on Quality through the lens of the Health and Care Quality Standards. This culture and discipline of quality-driven decision-making should also permeate the organisation to more broadly promote good decision-making practice.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Not required

<i>For more information:</i> https://www.gov.wales/socio-economic-duty-overview	The Putting Things Right Regulations and the Duty of Candour ensure that, in the interests of justice, there is a requirement to be open and honest and to ensure that adequate provision is made to assist those who are socially disadvantaged when dealing with concerns. As part of the concerns governance processes, there is a need to assess if any equality/social economic issues arise that could potentially have a consequence on the service user or those representing the service user's best interests in relation to a concern. Reducing inequalities prevents social injustice.
TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT	
The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated. Please indicate whether any of the matters outlined in this report impact the Trust's Wellbeing goals: YES - Select Relevant Goals below	
If yes select the relevant goals: • A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities. ☐ • A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience. ☐ • A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health ☒ • A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances ☐ • A Wales of more Cohesive Communities - Attractive, viable, safe and well-connected communities. ☐ • A Wales of Vibrant Culture and Thriving Welsh Language -Promoting and protecting culture, heritage and the Welsh language, encouraging people to participate in the arts, and sports and recreation. ☐ • A Globally Responsible Wales – Consideration of whether an action may make a positive contribution to global well-being ☐	
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	Source of Funding: The report contains details of redress matters against the Trust which give rise to financial impact in addition to potential reputational

	damage and lack of confidence in the services provided where harm is identified, all of which has the potential for adverse financial consequences. Type of Funding: Revenue Financial impact of the Trust Redress cases is outlined in the Handling Concerns Policy, Welsh Risk Pool Procedures and Welsh Risk Pool Indemnity arrangements. Scale of Change Please detail the value of revenue and/or capital impact: The Welsh Risk Pool indemnifies the Trust in respect to a damage's settlement, up to the PTR threshold of £25,000.
EQUALITY IMPACT ASSESSMENT For more information: https://nhs.wales365.sharepoint.com/sites/VEL/Intranet/SitePages/E.aspx	Not required - please outline why this is not required
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Not required for annual reports
	Yes (Include further detail below)
	The Trust is responsible for addressing Part 6 of the Putting Things Right Regulations. This places an onus on the Trust to ensure that concerns are properly investigated, and appropriate Redress remedies offered.

3. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	Risk 2465 - Use of email for communicating critical medical information – Current Score 12. Latest update key pieces of work around developing processes within departments for contacting colleagues. Risk 3562 – No defined process for ensuring that all blood tests taken are reviewed in a timely manner – Current risk score 12. Latest update: Task & finish group established, project plan in place & being monitored via SLT

	Risks 3247, 3246 – outpatient clinics overbooked and increased waiting times for patients – scoring 12 and 9 (reduced from 16 to 12 due to actions taken). Anticipated further reduction in risk at handover of two new rooms (3247) and Outreach project established. Review of clinic templates underway. Management of pre-SACT assessments underway (3246) Risk 3216 – Treatment helpline risk due to increased complexity, demand, inappropriate calls and workforce model - Current score 10. Latest update: Full review undertaken. Further work planned – helpline to move to acute oncology management. Risk 3215 – Document Management System risk - Current score 6 (decreased in April from 8). Latest update: Resource in place to support escalation. Weekly reports provided to Heads of Service. Improvement maintained. Risk 3346 – Delay in processing outpatient clinic activity – Current risk score 9. Latest update 9/4/25 – workforce plan developed identifying resource requirements. Meeting scheduled to discuss actions going forward. Bank resource in place.
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Many barriers to risk are resource, capacity and prioritisation.
All risks must be evidenced and consistent with those recorded in Datix	

Velindre University NHS Trust
Head of Quality, Safety and Assurance

Annual Integrated Quality and Safety Report

2024/2025



Velindre University NHS Trust is responsible for the delivery of a wide range of specialist NHS Wales services including the Velindre Cancer Service and the Welsh Blood Service and we host Health Technology Wales, and NHS Wales Shared Services Partnership.

Caring

We are always kind, supportive, approachable and show compassion to all.



Respectful

We seek to understand other people's perspectives. We are always open and transparent.



Accountable

We always take personal responsibility for what we do and how we do it.



The Velindre Cancer Service is a specialist treatment, teaching, research and development service for non-surgical tertiary oncology services to patients from across south east Wales and further afield.

The Welsh Blood Service provides essential and highly specialised national services including the collection and production of blood and blood components, specialist diagnostic services and antenatal screening, as well as supporting transplant services for solid organs and stem cells across Wales and internationally.

Health Technology Wales assesses non-medicine health and care technologies and produces national guidance on their use in Wales.

NHS Wales Shared Services Partnership delivers a wide range of professional, technical and administrative services to NHS Wales.

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 six 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.



I. Introduction

The Trust’s annual integrated quality & safety report provides analysis of key outcomes, activity, learning and improvement during the past year 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.

Quality & Safety Indicators Overview

Putting Things Right Formal Complaints 38 55 2024/25 2023/24	Putting Things Right Compliance 75% 93% 2024/25 2023/24	Early Resolution Complaints 106 147 2024/25 2023/24
Re-Opened Complaints 7 4 2024/25 2023/24	New Inquests 12 11 2024/25 2023/24	Ombudsman Cases 0 4 2024/25 2023/24
Incidents 2085 2059 2024/25 2023/24	Duty of Candour Incidents 10 8 2024/25 2023/24	Nationally Reportable Incidents 2 4 2024/25 2023/24
New Redress 6 5 2024/25 2023/24	Written Compliments on Datix 471 355 2024/25 2023/24	Welsh Blood Service Satisfaction 98% 98% 2024/25 2023/24
Velindre Cancer Service Satisfaction 96% 96% 2024/25 2023/24	Incident Open Over 30 Days 352 682 2024/25 2023/24	Safeguarding Duty Of Report 13 16 2024/25 2023/24

The triangulation of data in this annual report 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 last year to 75%. This is still within the national PTR target of 75%. This has been due to capacity issues within the Velindre Cancer Service Concerns team and the complexity of concerns.

Ten 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.

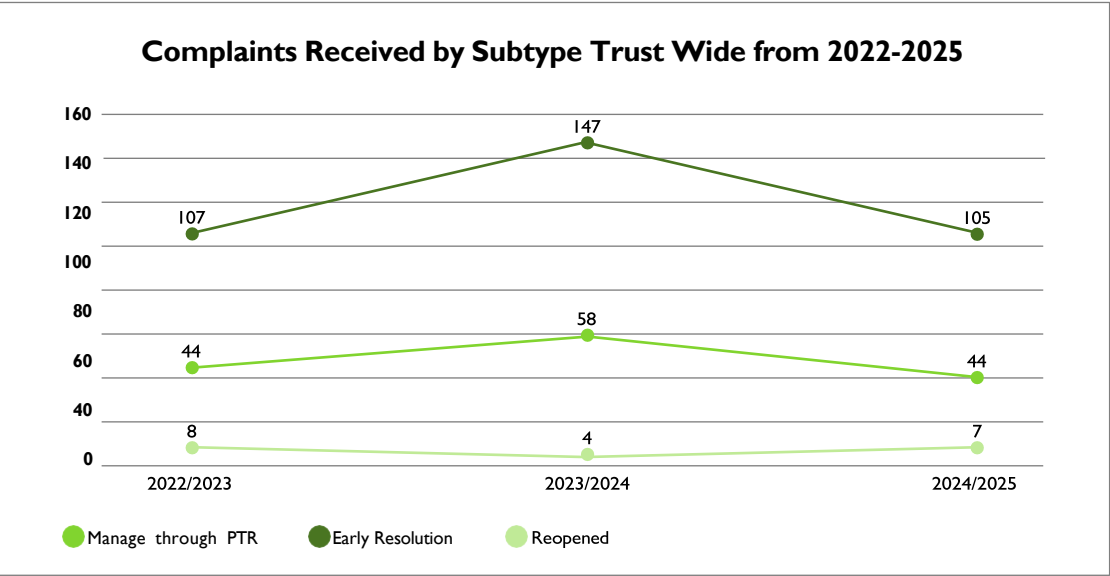


2. Complaints

2.1 Complaints - Trust

overview Analysis

As shown in graph 1, the Trust has seen a decrease in complaints managed through Putting Things Right (formal) from last year and the year prior. The number managed through Early Resolution has also decreased, this can indicate that the Trust has had less complaints overall and has been successful at managing complaints without the complaint becoming formal.



Although compliance has decreased since last year. The Trust is still within the national PTR target, which is 75%. 2 complaints remain open; one is still within the PTR timescales. The complexity of the complaints received has increased.

	Total complaints raised	% Compliance with 30 day resolution targets
2022 / 2023	159	86.4%
2023 / 2024	209	93%
2024 / 2025	153	75%

2.2 Complaints - Ombudsman

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 informs the public of how to contact the Ombudsman if they are unhappy with our complaints handling.

Analysis

There were no open Public Services Ombudsman cases in the year 24/25. This provides a positive assurance regarding our concerns management and comprehensive responses provided to our service users or their families.

	Ombudsman cases opened against the Trust
2022 / 2023	4
2023 / 2024	0
2024 / 2025	0

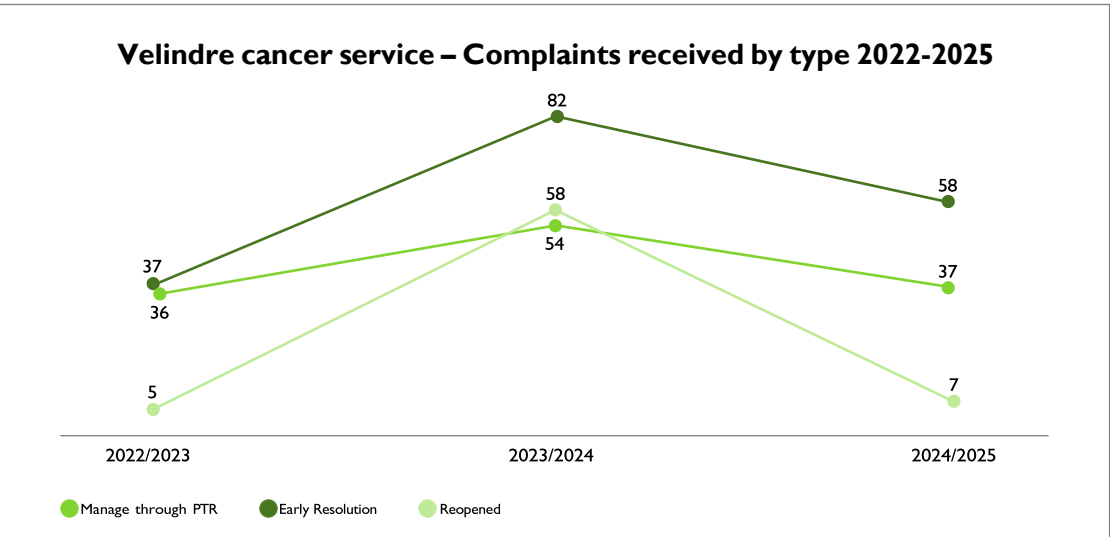
2.3 Complaints - Velindre Cancer Service

There has been an overall decrease in the number of complaints received in the past year compared to 2023/2024. The most common reason for complaints was related to communication of appointments and difficulty contacting departments. The Trust conducted a Pain Point Review into these concerns and work is underway to address the issues.

95 complaints were received in total (0.04% of patient attendances)

7 complaints were reopened complaints where complainants were not satisfied with their final response. In person meetings have been offered and concerns reviewed. All template letters have been reviewed and amended to improve the quality of the content and layout ensuring they meet the requirements of accessibility.

2 concerns identified a breach of duty of care which resulted in potential harm.

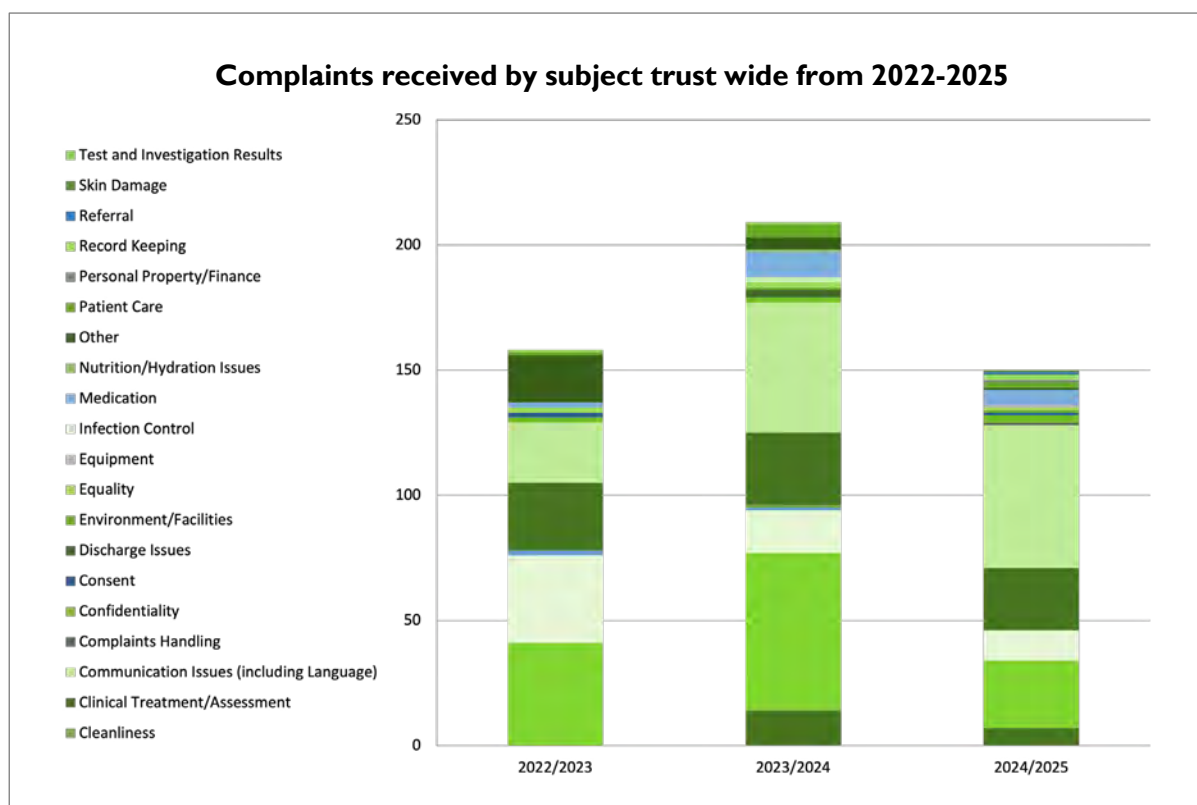


Total Complaints raised	Number managed as Early Resolution	Number managed under Putting Things Right	Number Reopened
95	58	37	7

Analysis

As shown in graph 4, communication issues continue to be the main theme of the Cancer Service complaints in 2024/2025, specifically around outpatient and SACT appointments.

Concerns were raised regarding information being given in consultations around treatment plans and prognosis is also identified as a communication theme, as well as patients concerned that they have not seen their named consultant since their first appointment.



Learning and improvements identified from velindre cancer service complaints

- A review of processes around managing telephony in medical secretaries' team was undertaken, and the importance of always ensuring professionalism when speaking to patient or families was emphasised.
- Two new outpatient clinic rooms have been made available, and the clinic templates have been reviewed to ensure that clinic time and space is being optimised, with the goal of reducing clinic waiting times.
- Feedback was provided to consultants regarding the importance of Advanced Care Planning and Do Not Attempt Cardiopulmonary Resuscitation at the earliest opportunity, and information to support medical colleagues surrounding discussion is available on the intranet.
- The processes around communicating appointment information to ensure the patient is notified in a timely manner have been re-emphasised to staff.
- Reinforcing the opportunity to discuss unexpected scan reports with radiologist before discussing with the patient.

- A number of improvements have been made to PICC line care in the Cancer Service.
- Closer working and earlier referral/discussion with the Trust Safeguarding Lead has been achieved, leading to strengthened collaborative working.
- Theme identified around patients' expectation of seeing consultant each time in clinic. Improved communication to be shared with patients around the role of the multi-disciplinary team especially in outpatient clinics – working with patient engagement team and communications team to utilise the screens and include information about MDT in patients first clinic letters.

2.3 Complaints - Welsh Blood Service

Learning and outcomes

Further learning and improvement areas following concerns have led to:

Collections Team working in collaboration with Planning Department to look at alternative venues across the Service, particularly in North Wales.

Staff reminded of the importance of always wearing a name badges and complying with Trust Values and Behaviours.

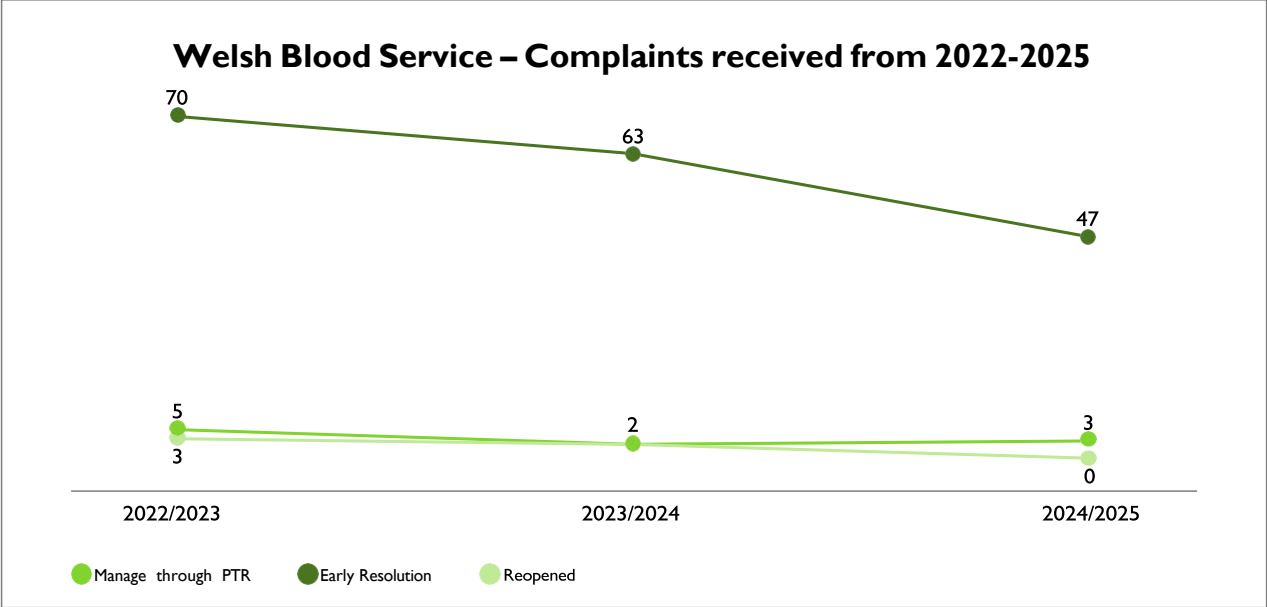
Operational Managers ensuring that where the start of a donation session is delayed, where possible, donors booked later in the day are contacted to reschedule their appointments to reduce donor inconvenience.

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 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.

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.



Analysis

47 concerns raised (0.05% of donors), all managed through early resolution.

3 formal concerns were raised; all were closed within the required timeframe.

No complaints were reopened.

The main themes and opportunities for improvement related to attitude & behaviour, communication, appointments, clinical assessment & treatment/procedure mainly within donor collection teams.

These concerns continue to be spread across a variety of teams and locations.

	Managed through PTR	Early Resolution	Reopened
2022 / 2023	5	70	3
2023 / 2024	2	63	2
2024 / 2025	3	2	0

3. Velindre Cancer Service – Patient Experience

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. **2124** patients provided feedback during **2024/2025** financial year (an increase from 1434 in **2023/2024**)

978 patients completed the ‘Your Velindre Experience’ and 1146 completed the ‘VCC Friends & Family’.

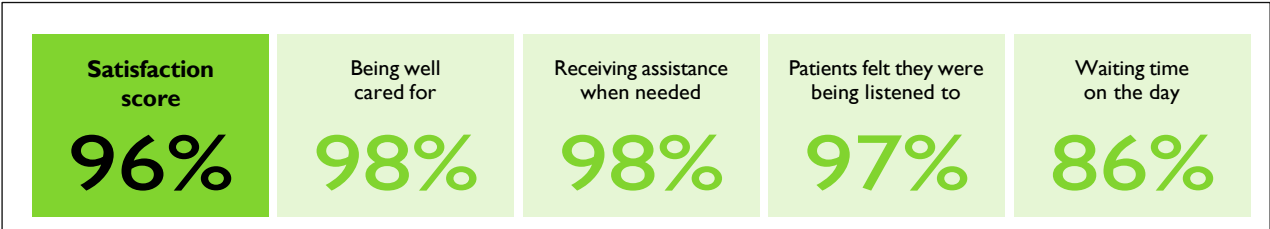
Velindre Cancer Service is undertaking work to increase patient feedback numbers by using SMS messaging.

Analysis and learning

96% of patients stated they were overall satisfied with their care. However, **2%** of respondents did not feel well cared for or felt they did not receive assistance when needed, and **3%** said they did not understand what was happening in their care. **11%** of patients felt their waiting time was either ‘**a bit too long**’ or ‘**much too long**’.

There has been a consistency in patient ratings throughout each quarter – with waiting times remaining an area in need of improvement in outpatients. Much work has been undertaken in outpatients to manage the waiting times, including **2 new clinic rooms** and improved signage and information re. current waiting times. Velindre Cancer Service will continue to monitor feedback to assess the efficacy of these changes.

Feedback about your Experience



		Question 1	Question 3	Question 4	Question 5	Question 6
		Overall, how was your experience of our service?	Did you feel that you were listened to?	Were you able to speak Welsh to staff if you needed to?	How did you find the waiting time in your recent visit?	Did you feel well cared for?
		VCC - Friends and Family	Your Velindre Experience 23/24	Your Velindre Experience 23/24	Your Velindre Experience 23/24	Your Velindre Experience 23/24
Integrated care	444	99	100	92	90	100
Operational services	657	97	92	90	80	92
Pharmacy	53	100	83	83	67	100
Radiation services	433	100	100	94	95	99
SACT	462	100	96	90	89	99
Overall		99	97	91	88	98
Benchmark		85	85	85	85	85

		Question 7	Question 8	Question 9	Question 10	Question 11	Overall
		If you asked for assistance did you get it when you needed it?	Did you feel you understood what was happening in your care?	Were things explained to you in a way that you could understand?	Were you as involved as you wanted to be in decisions about your care?	How would you rate your overall experience? 0 is very bad and 10 is excellent.	
		Your Velindre Experience 23/24	VCC - Friends and Family	Your Velindre Experience 23/24	Your Velindre Experience 23/24	Your Velindre Experience 23/24	
Integrated care	444	99	99	100	99	96	97
Operational services	657	92	92	91	92	89	91
Pharmacy	53	100	100	100	100	93	97
Radiation services	433	99	100	99	100	99	99
SACT	462	98	97	98	98	93	96
Overall		98	97	98	97	94	96
Benchmark		85	85	85	85	85	92

A breakdown of question 5 identified only 3 surveys completed, and only 1 person felt wait in pharmacy was too long.

Question 5: During your most recent visit to Velindre Cancer Centre, how did you find the waiting time?

Available answers	Responses	Score (%)
Shorter than expected	0	0.00%
About right	2	66.67%
A bit too long	0	0.00%
Much too long	1	33.33%
Total	3	100%

We asked	You said	Together we
	You said	We did
	"It would be nice to be able to buy snacks while waiting for Clinic"	New coffee shop has now opened in the outpatient's waiting area.
	"Unclear signage indicating baby-changing facilities"	We have added baby-changing signs to the toilet doors.
	"Waits for blood tests in Outpatients"	Another phlebotomy chair has been added to increase capacity and reduce waiting times.
	"The food could be improved (First Floor Ward). More vegan options on the menu"	New menus have been introduced following consultations with patients and staff.
	"Bookings sometimes get confused wrong appointment times"	A root and branch review of all administrative processes has been undertaken, and an improvement plan is in progress.
	"More patient toilets in new hospital"	New hospital plans have now taken this into account.
	"Need early access to leaflets & more info about the process & how it works"	We have undertaken a full review of all information leaflets and made these available to patients at all stages of their cancer journey.
	"Waiting times are ridiculous long beyond appointment time"	We have undertaken a wholesale review of outpatient clinics and made a number of improvements including introducing more clinic rooms to help ease the pressure.
	"Later appointments for the Therapies Clinics"	Following feedback from patients we have introduced an evening clinic.

3.1 Velindre Cancer Service – Patient Engagement

During 2024 the Trust has continued to embed its patient engagement culture offering a wide range of opportunities through its Velindre Voices structure, Volunteers Service, Patient and Carer Partnership Board (PCPB) and through formal consultation opportunities.

Highlights

The Patient and Carer Partnership Board (PCPB) has strengthened.

A recruitment campaign in the Spring/Summer of 2024, the PCPB held their first formal meeting in November 2024. PCPB has engaged in the following:

- Llais Living with Cancer Report
- Value Based Healthcare Project
- Development of Trust's Integrated Medium-Term Plan (IMTP)
- Velindre Oncology Academy course development
- Serenity trial implemented in research areas such as Cardiff University

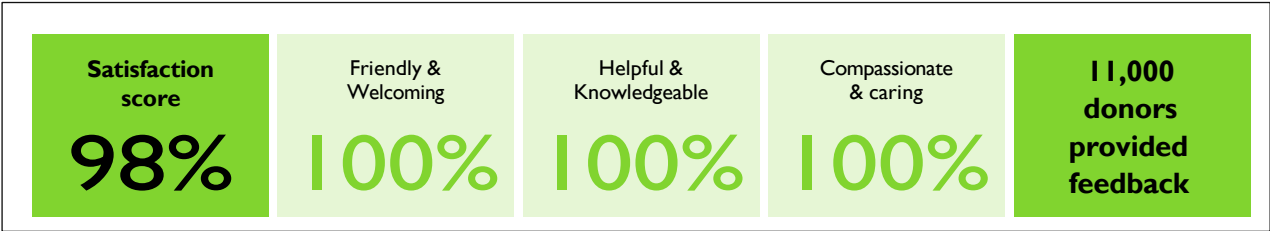


3.2 Welsh Blood Service – Donor Experience

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.

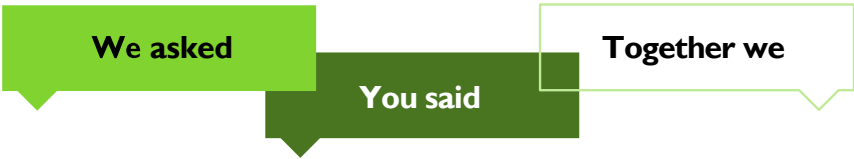
11,000 (12%) donors provided feedback during this period with an overall satisfaction score of 98%.

Feedback about your Experience



	Question 1	Question 2	Question 3	Question 4	Question 5	Question 6
	On a scale of 1-5 how satisfied are you with your overall experience within the collection clinic	Based on today's visit did you find staff welcoming & friendly?	Based on today's visit did you find staff helpful & knowledgeable?	Based on today's visit did you find staff professional, compassionate & caring?	Based on today's visit did you feel you were treated with dignity & respect?	Based on today's visit were you provided with enough info about the donation process?
	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.
WBS	98	100	100	100	100	100
Overall	98	100	100	100	100	100
Benchmark	95	95	95	95	95	95

	Question 7	Question 8	Question 9	Question 10	Question 11	Question 12
	Based on today's visit did you receive adequate emotional & physical support?	Based on today's visit did you find a good standard of hygiene & cleanliness?	Based on today's visit did you feel safe?	Based on today's visit do you feel you were offered quality of care?	Based on today's visit are you satisfied with the venue & facilities?	Based on today's visit were you satisfied with the snacks and beverages available to you?
	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.
WBS	100	100	100	100	99	100
Overall	100	100	100	100	99	100
Benchmark	95	95	95	95	95	95



Based on feedback received, operational managers have:

- Reviewed the 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.

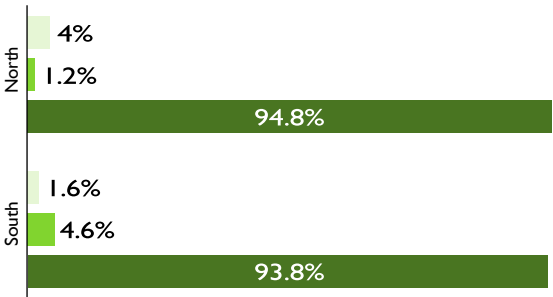
Welsh Blood Service undertakes a monthly email survey to evaluate donor satisfaction from initial contact to post-donation experience. The goal is to improve donor retention. Survey results are reviewed, and the overall satisfaction score is reported to the Welsh Government.

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.

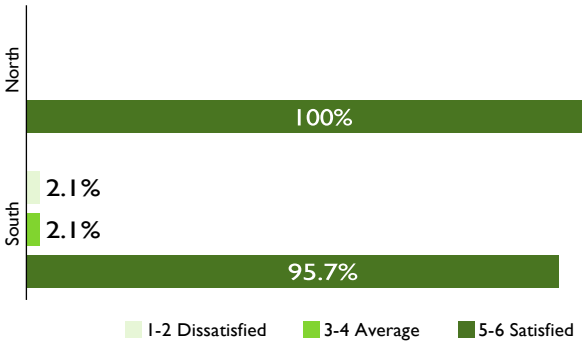
Donor satisfaction for those who had successfully donated was 97.1%

Overall (734)	97.1%
N.Wales (157)	99.4%
S.Wales (577)	96.5%



Donor satisfaction for every respondent, including incomplete donations

Overall (802)	94.0%
N.Wales (173)	94.8%
S.Wales (629)	93.8%



1-2 Dissatisfied 3-4 Average 5-6 Satisfied

Donation day

Donation day experience

96.2%

85.1% scoring 6/6

Process comfort

96.2%

87.4% scoring 6/6

Process duration

97.1%

90.8% scoring 6/6

Donor engagement and sentiment

Contact centre experience

96.1%

76.4% scoring 6/6

Feeling valued

95.7%

83.8% scoring 6/6

Eligibility info. Available

93.3%

80.3% scoring 6/6

Venues

Cleanliness

97.4%

84.8% scoring 6/6

Accessibility

94.2%

81.1% scoring 6/6

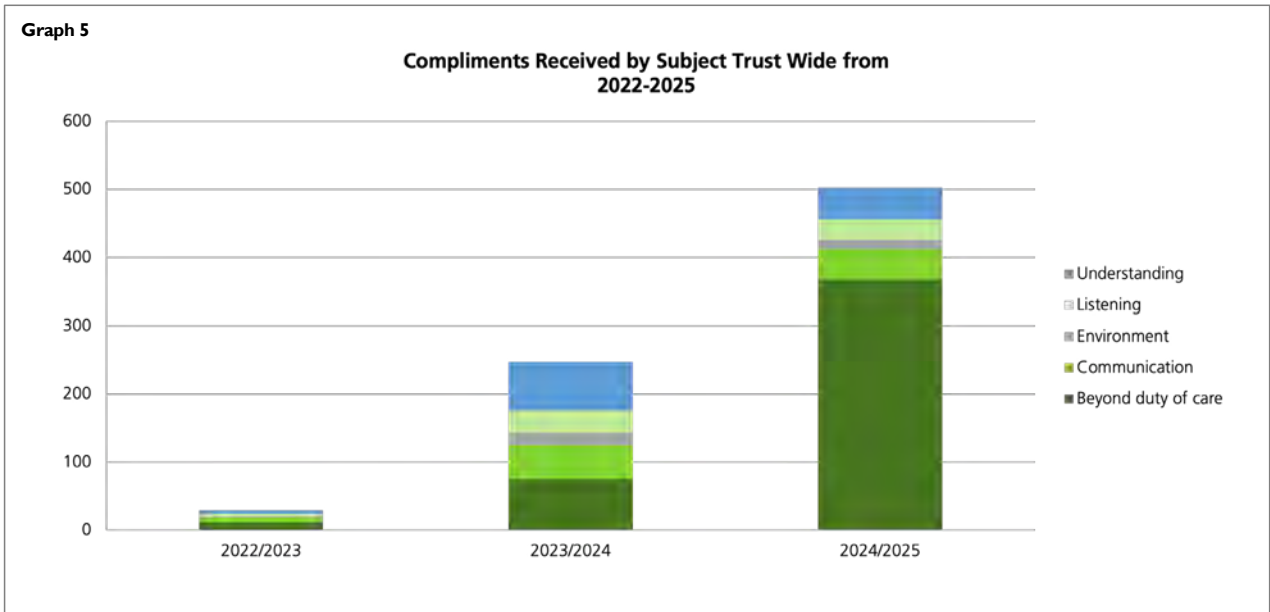


4. Trust Overview – Compliments

For 2024/25 a total of 423 compliments were recorded on Datix. This is an increase from the previous year (365) following work to improve recording of compliments on Datix.

374 compliments were received by Velindre Cancer Service and 49 compliments were added to Datix by Welsh Blood Service.

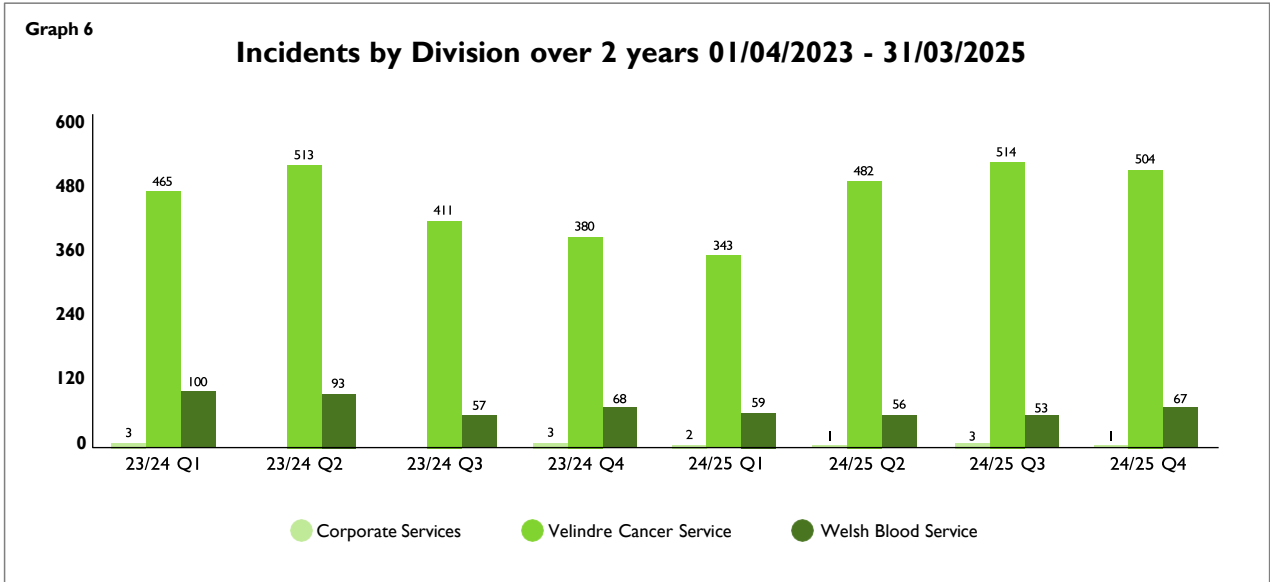
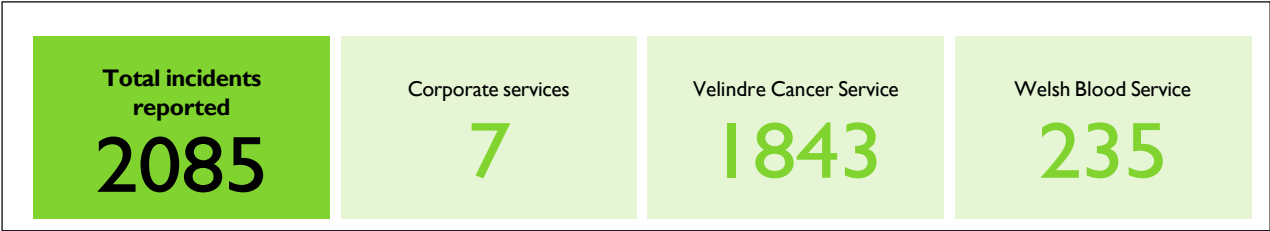
Work is being undertaken in WBS regarding recording compliments on Datix as other systems within the division are used for this gathering this information.



4.1 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/donors receiving healthcare. Incidents are all reported and reviewed at service level, through Quality and Safety leads and the Quality and Safety Hubs.

2024-25 Trust Incident Summary



Analysis of incidents is provided per Division later.

5. National Reportable Incidents (NRI)

Analysis

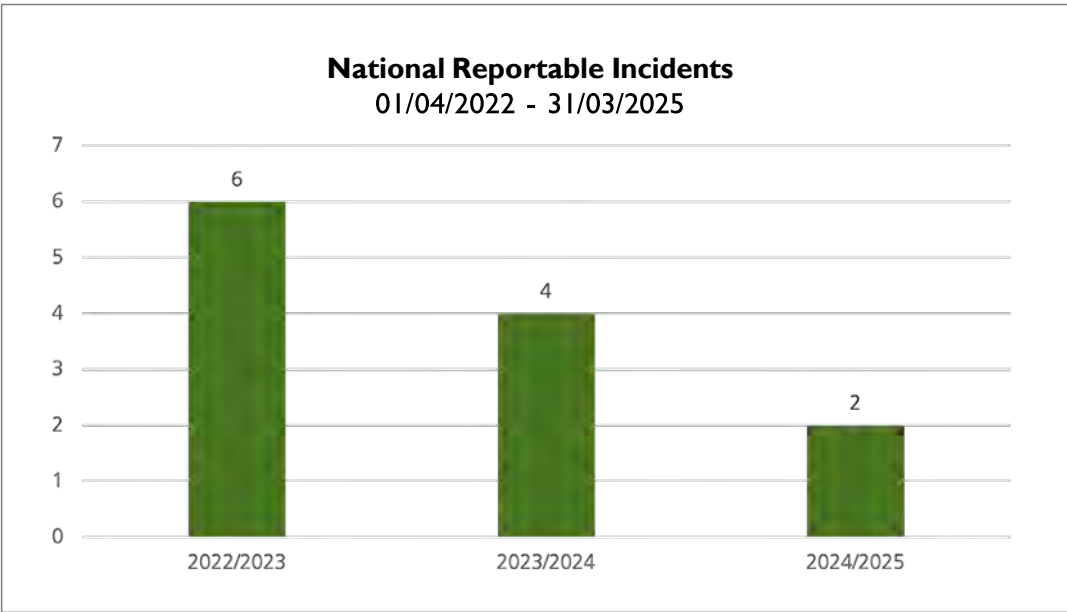
There have been 2 Nationally Reportable Incidents in 2024/25, both occurring in January 2025. This is a reduction in comparison to 2023/24, which had 3 national reportable incidents.

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.

Following the NRI incidents, the Trust undertook in-depth investigations, and developed improvement plans to prevent similar events from occurring.



Severe Harm:

A service user experiences a permanent disability or loss of function and the NHS care did or may have contributed.



Death:

A service user dies and the NHS care did or may have contributed to the death

5.1 Incidents – Duty of Candour

Since the Duty of Candour was enacted in April 2023 there has been an increase in incidents reported as our processes have become embedded into incident management.

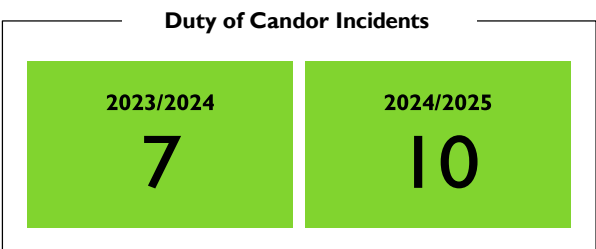
In NHS Wales, the Duty of Candour is a legal requirement for organisations to be open and honest with service users when something goes wrong during their care or treatment, potentially causing harm. This duty stems from the Health and Social Care (Quality and Engagement) (Wales) Act 2020.

In March 2025, an internal audit commenced, field work to provide assurance that the Trust was compliant with the requirements of the Duty of Candour.

The findings of the audit will be reported in quarter 2 of 2025/2026 reports.

Analysis

10 incidents during 2024-25 have been managed under Duty of Candour meaning they potentially caused moderate harm or above, with 2 of the incidents also being reported as a National Reportable Incident meaning they potentially caused severe harm. 6 investigations were closed, and 4 Duty of Candour incidents are currently under investigation, at the end of 2024-25.



Themes noted

- 1 | Use of email for communicating urgent medical information. The risk has been recorded on the risk 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 is 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.
- 6 | Contact with SACT Treatment Helpline and management of patients.
- 7 | High clinic workloads and environmental interruptions increase the risk of errors during the prescribing and verification processes.

Improvement Actions

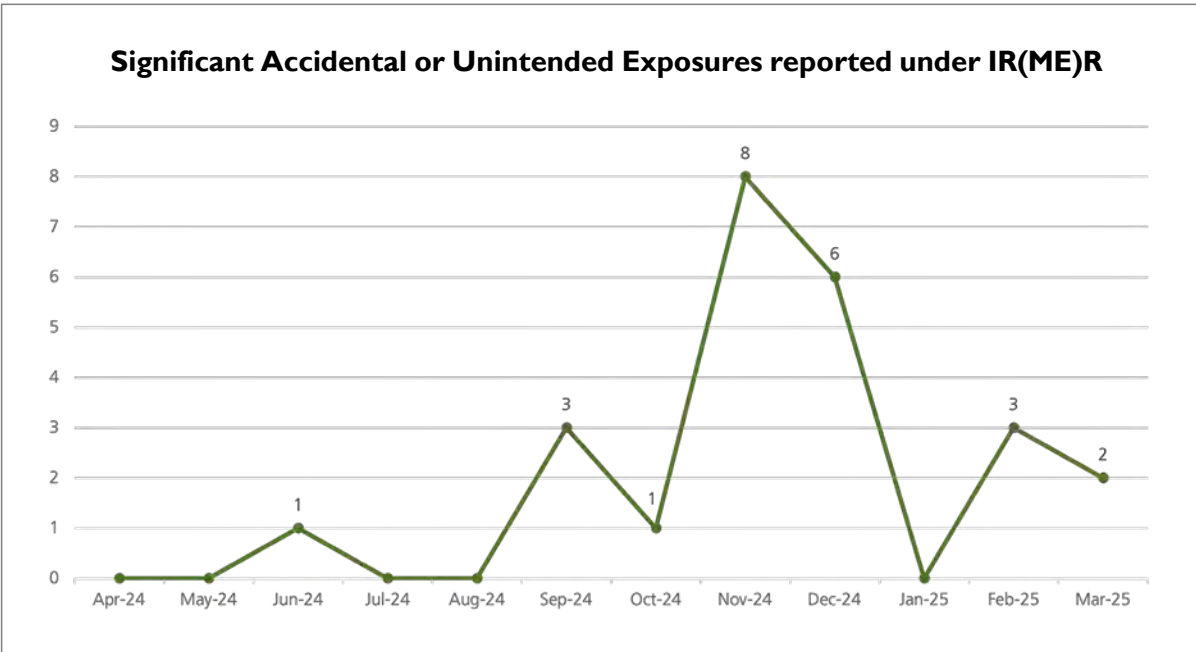
Improvement plans have been developed based on the investigation recommendations. These will be monitored via the Trust Regulatory Tracker and Quality & Safety governance processes. The findings and learning for these investigations will be reported in the future quarterly reports.

5.2 Ionising Radiation (Medical Exposure) Regulations (Ir(Me)R) Reportable Incidents

24 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. The change in guidance (reverting back to reporting 3 failed images in a fraction) has resulted in a significant increase in reportable incidents in Radiotherapy Physics due to CBCT technical faults.

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)

5.3 Sharing Learning From Incidents & Improving Culture

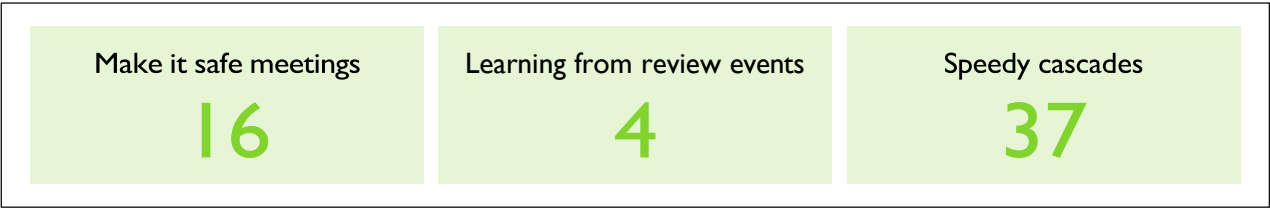
The ethical duty of openness applies to all incidents, and any failure in care that has occurred whilst being treated through the healthcare that we provide.

The Duty of Candour applies to incidents whereby moderate and greater harm has occurred.

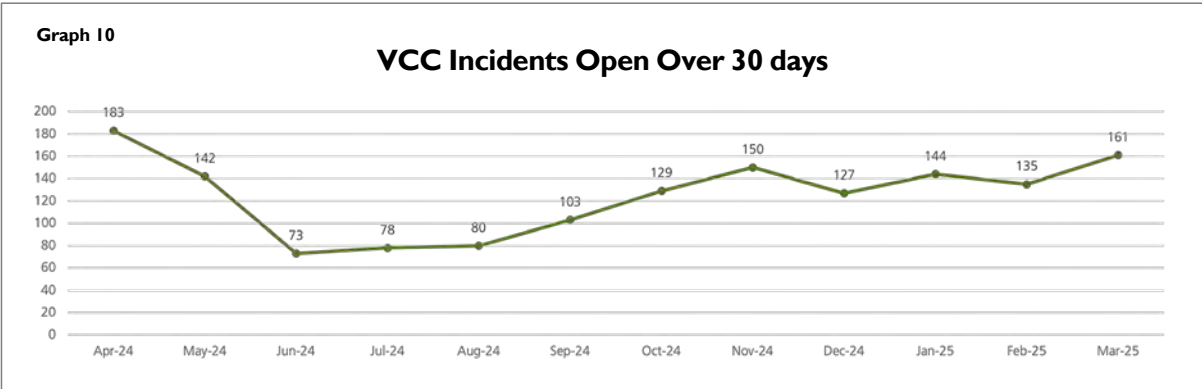
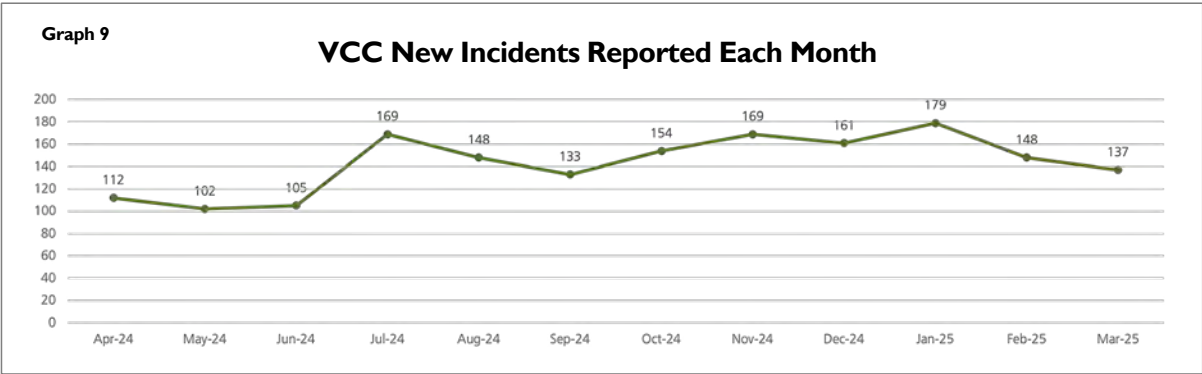
Our clinical colleagues and support teams have enabled the Trust MAKE IT SAFE reviews to effectively identify improvements by raising and reviewing incidents in line with the Trust Incident Framework. All staff involved in the Make it Safe process have commended the supportive Just Culture collaborative 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.

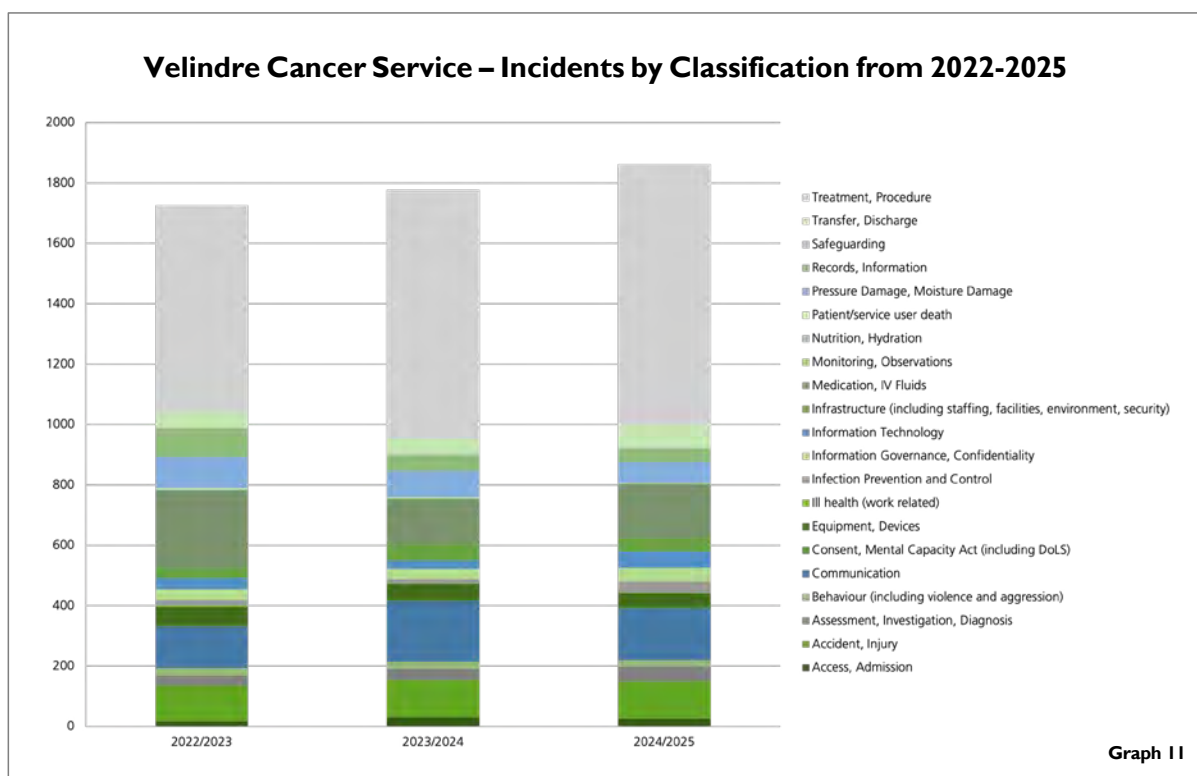


5.4 Velindre Cancer Service – Incidents



Graph 10 following a successful push to reduce the number of incident open over 30 days across the cancer services during the 1st quarter, we are seeing a gradual increase once again. Work is ongoing with departments to manage this, including regular reports and training and education.





The graph identifies that the highest number of incidents related to treatment and procedure which is in keeping with previous reporting periods.

Themes, Learning And Improvements

- Medication Incident deep dive review: Undertaken in January 2025 due to an increase in medication administration errors at VCS SACT Units between September & December 2024 (10 incidents). This identified that these incidents were occurring in the “unplanned activity” work such as where there is an unwell patient, delay in treatment on unit, transport delays etc.
- Themes identified related to inpatient areas through incidents, concerns, and mortality reviews surrounding communication of care, and roles and responsibilities of inpatient staff such as management of fluid balance charts.
- Themes emerging (VCS & Community related) from incidents and concerns related to end connectors not being attached to PICC lines. This necessitates removal and reinsertion of the PICC line. Measures have been taken to address these issues through education and ‘speedy cascades’ both with VCS and community teams & shared with Once for Wales learning and advisory group for national learning. There have been no incidents or concerns related to this in January to March 2025.
- A theme was identified around the telephone helpline management of patient symptoms when they are unwell (with a high temperature). Management of specific symptoms have been clarified and processes updated and shared with the treatment helpline staff. A speedy cascade has been shared with all VCS staff. Referral routes into Health Boards SDEC (Same Day Emergency Care) has been strengthened resulting in patients not always needing to self-present in the Emergency Department.

- Theme continues within incidents around the use of emails, particularly high-volume email traffic, and use of emails for clinical communication. An email working group has been established and met to identify solutions and improved ways of working.
- Learning and improvement has been made in relation to transcribing information and the importance of documenting patient information directly on to their electronic casefile (Welsh Clinical Portal) including SACT toxicities and prescribing intent. Learning has been shared via speedy cascade to all clinical staff regarding updating a patient's weight when prescribing chemotherapy.
- Improvement actions include education and clinical audits.

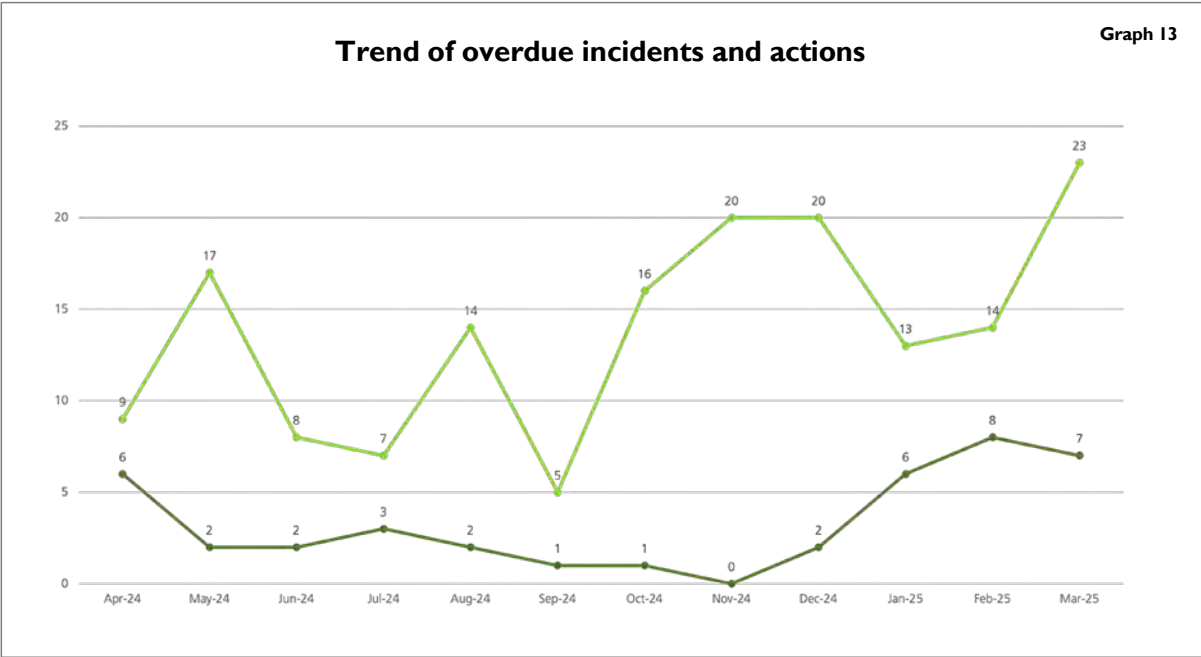
5.5 Welsh Blood Service – Incidents

Incidents which may result in harm to donors, patients, or staff are reported in Datix Cymru for consistency across the Trust.



Analysis

Graph 12: Incident reporting via Datix shows variation across the past 12 months, with a peak in February (27 events). The main category for Datix reports is accident and injury. Overall, the number of reports is low, with no significant trends identified. Monitoring of reports for trends is continuous.



Overdue Activity Performance Trends

Graph 13: The number of incidents exceeding the target date for closure (30 days) has remained low throughout the year.

The rise experienced from December onwards is potentially due to staffing pressures within the Clinical Services team.

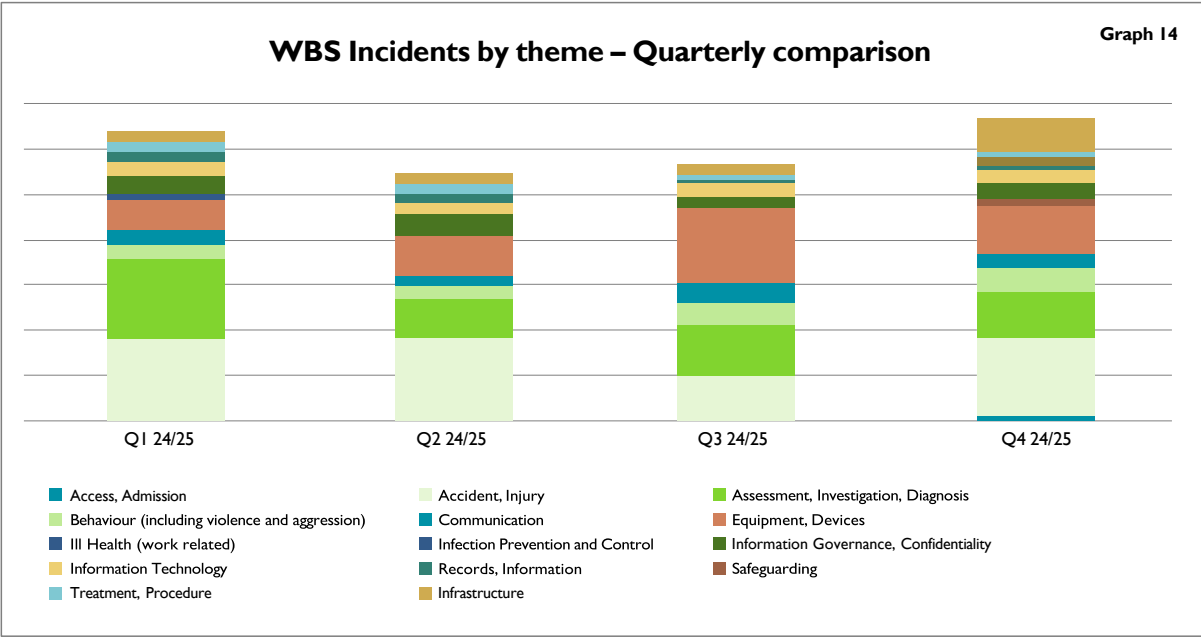
Overdue actions fluctuate from month to month and often reflect a high workload versus staff availability; occasionally a single event may result in one person managing several actions to address root cause.

Learning and Outcomes

Senior Leadership Team are advised of these statistics monthly and are responsible for following up with their teams.

Reasons for delays are explored, and where necessary workloads and actions are reassigned to support timely incident management.

Managers must assess risk and submit a formal extension request where actions have been open longer than expected.



Analysis

Graph 14: The most frequently reported themes across the year are:

Accidental injury (red): Information on accidental injury reports can be found in the Health and Safety section of the report.

Equipment & Devices (orange): These errors are often isolated to a piece of equipment (no trend). Where operator error is involved, these events are trended against individuals to ensure there are no competency/training issues.

Assessment, investigation, diagnosis (green): These usually related to ‘late donor information’, which is subjective to each donor, and occasionally to donor acceptance errors.

Learning and Outcomes

All events have been investigated, with no significant trends identified.

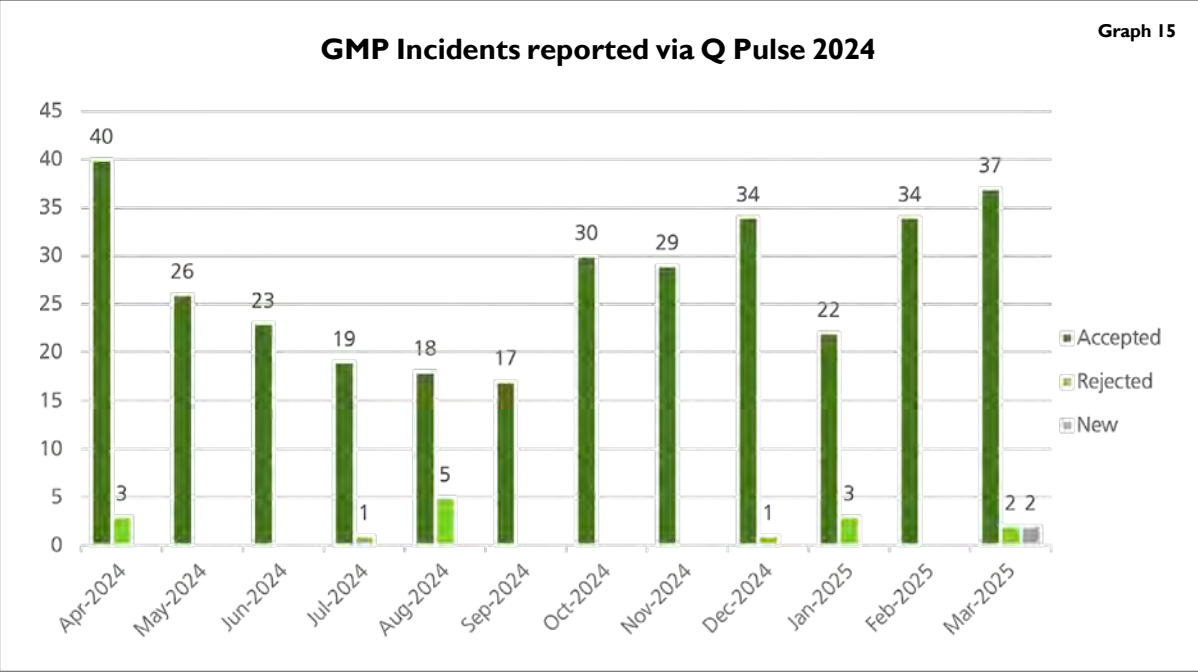
Where ‘late’ (post-donation) donor information has been received the decision to accept the donor was usually correct, based on information available at the time of donation. Where a donor acceptance error has been made these have been fully investigated:

The process for assessment of travel related risk relies on individuals making assessment using the Donor Selection Guidelines (DSG) and Geographical Disease Risk Index (GDRI)

The DSG and GSRI can be complex, therefore assessing donor travel risk and whether a donor is eligible based on any medication they are taking is not always straightforward.

WBS is working with an external company to develop an automated digital tool that reduces complexity by analysing answers to donor eligibility questions then advising on whether to defer to accept or defer the donor.

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.



Analysis

The number of GMP incidents reported across the year is subject to variation.

The decline to September 2024 was attributed to the decision by WBS IQSH to report events such as ‘clip errors’ only when there is an identified trend with an individual. The process for managing clip errors is proceduralised and therefore no process deviation has occurred.

The sharp increase from January relates 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 are not unexpected where manual processes are involved, however the complexity of manual reporting processes, combined with an ageing and underdeveloped IT system, and an inadequate verification process have been identified as the main causes of these errors. Contributory factors include high workload and operational pressures, working environment, senior staff changes and skill gaps (caused by absence of experienced staff).

A designated quiet area for report writing and authorisation has been implemented. Additional actions to reduce recurrences include implementation of a temporary digital solution, adoption of a two-person writing and authorisation process, and reallocation of workload. New staff are also being recruited to support the operational workload within this laboratory

5.6 Welsh Blood Service – Externally Reported Incidents (SABRE/MHRA)

Analysis

18 adverse events were reported externally to MHRA via the SABRE portal this year.

All events were risk assessed and made safe prior to full root cause analysis investigation; where necessary this involved a multi-disciplinary team of subject matter experts and members of the Clinical and/or Quality teams.

Corrective and preventive actions were reviewed by relevant members of the Divisional Integrated Quality and Safety Hub before submission to the Regulatory body.

Theme	Outcome / Improvement
Donor travel risk not assessed correctly	• Exploration of implementing a digital tool that allows donors to verify their travel history; this will reduce reliance on memory and verbal communication. • 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.
Transcription errors on manually generated patient reports issued to customer hospitals	• Implementation of a temporary digital solution that pre-populates reports. • Utilising a dedicated quiet space for report authorisation. • Development and delivery of a learning session. • Recruitment of additional staff to support laboratory workload.
Communication issues	• Updated guidance for staff regarding cross-functional activities. • Implementation of a discussion forum to ensure mutual understanding of systems/processes. • Pre-briefing discussions with auditors from other Divisions to outline, expectations, roles and escalation procedures.

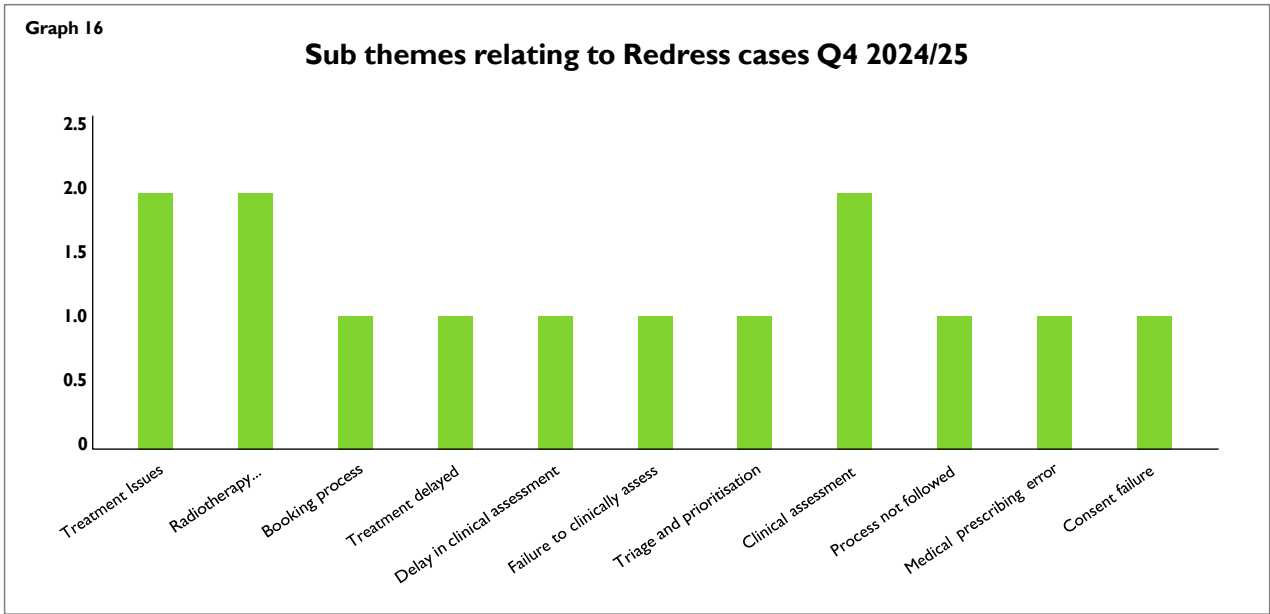
Analysis

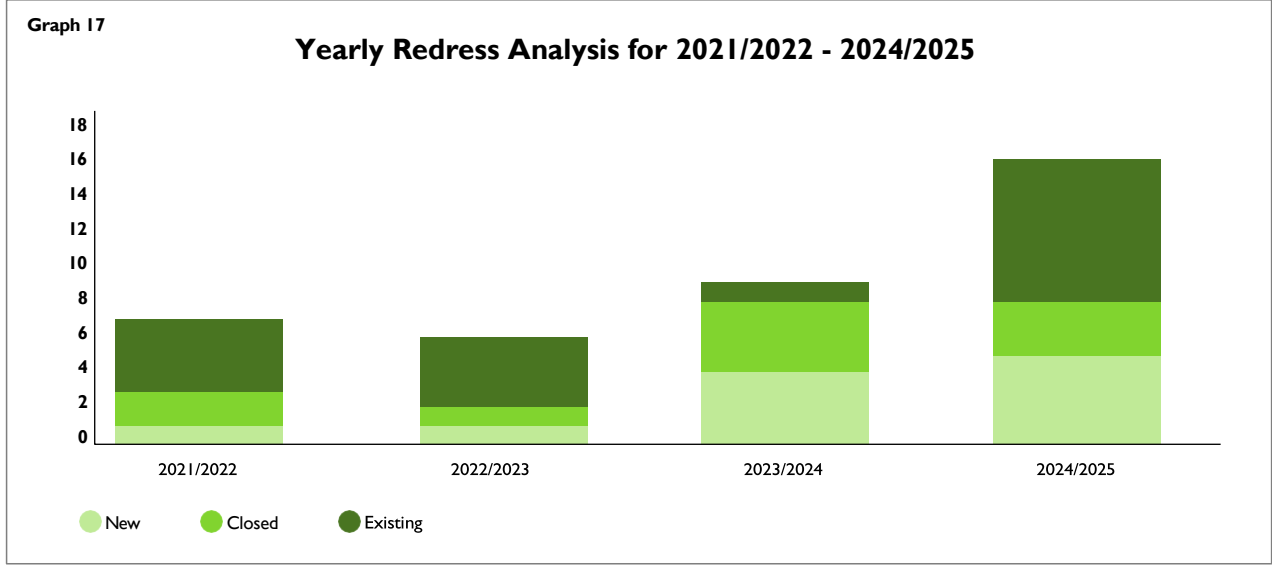
3 adverse events reported to the Human Tissues Authority (HTA) involved collection of stem cells by a 3rd party. These were reviewed and investigated, and root cause analyses and corrective actions have been reviewed by relevant members of the WBS Integrated Quality and Safety Hub.

Theme	Outcome / Improvement
One of three bags harvested was positive for skin bacterium. Risk to patient safety is low; these bacteria very rarely cause post- transplant complications, but this could not be ruled out.	• No patient harm. • 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 centre that undertake stem cell collection on behalf of WBS are HTA and JACIE accredited centre; their contamination rate of 11% is in line with global rates for this procedure. The WBMDR will continue to monitor and report similar events to the relevant bodies.

6 Redress

The Redress analysis for the reporting period illustrates an overall rise in Redress matters compared to previous years, following the introduction of Duty of Candour.



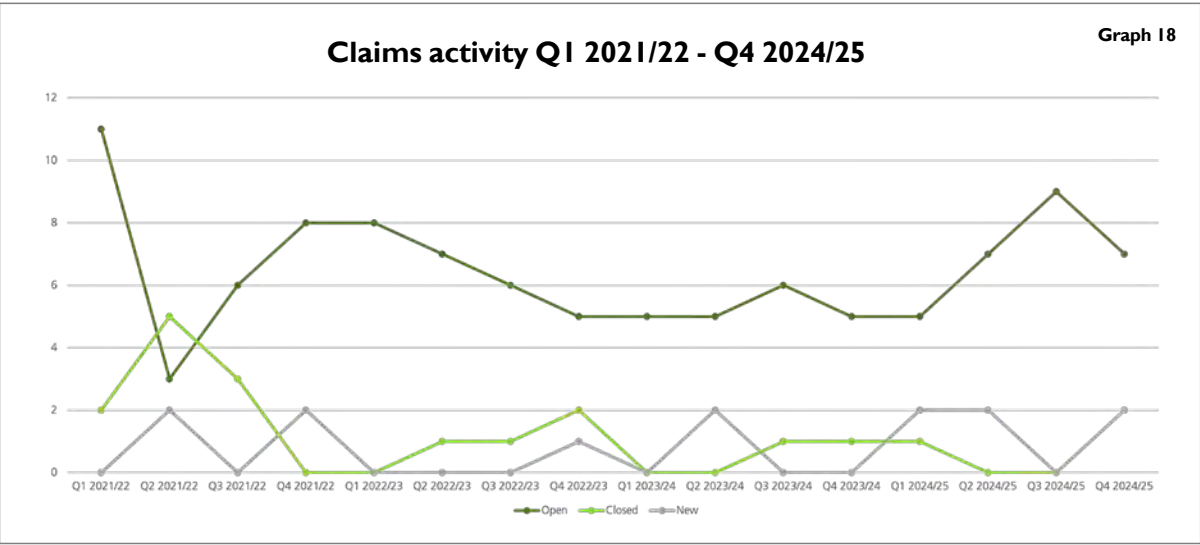


Quality Improvements made following Redress investigations		
Development of an escalation pathway for urgent medical reviews	Enhanced Systemic Anti-Cancer Therapy training including assessing and completing the UK Oncology Nurses Society triage tool	Reduction on the reliance on emails to manage referrals with increased communication to escalate/urgent clinical information
Introducing SpR and Junior Doctor handbooks	Strengthening the induction process for clinicians	Strengthening the referral processes
Implementing the patient discharge checklist	Implementing the Velindre Cancer Service Discharge Policy	Enhanced sepsis training and reflective practice learning
Implementing a SHO practical guide	SACT telephone review and audit	Improving training for secretarial staff

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:

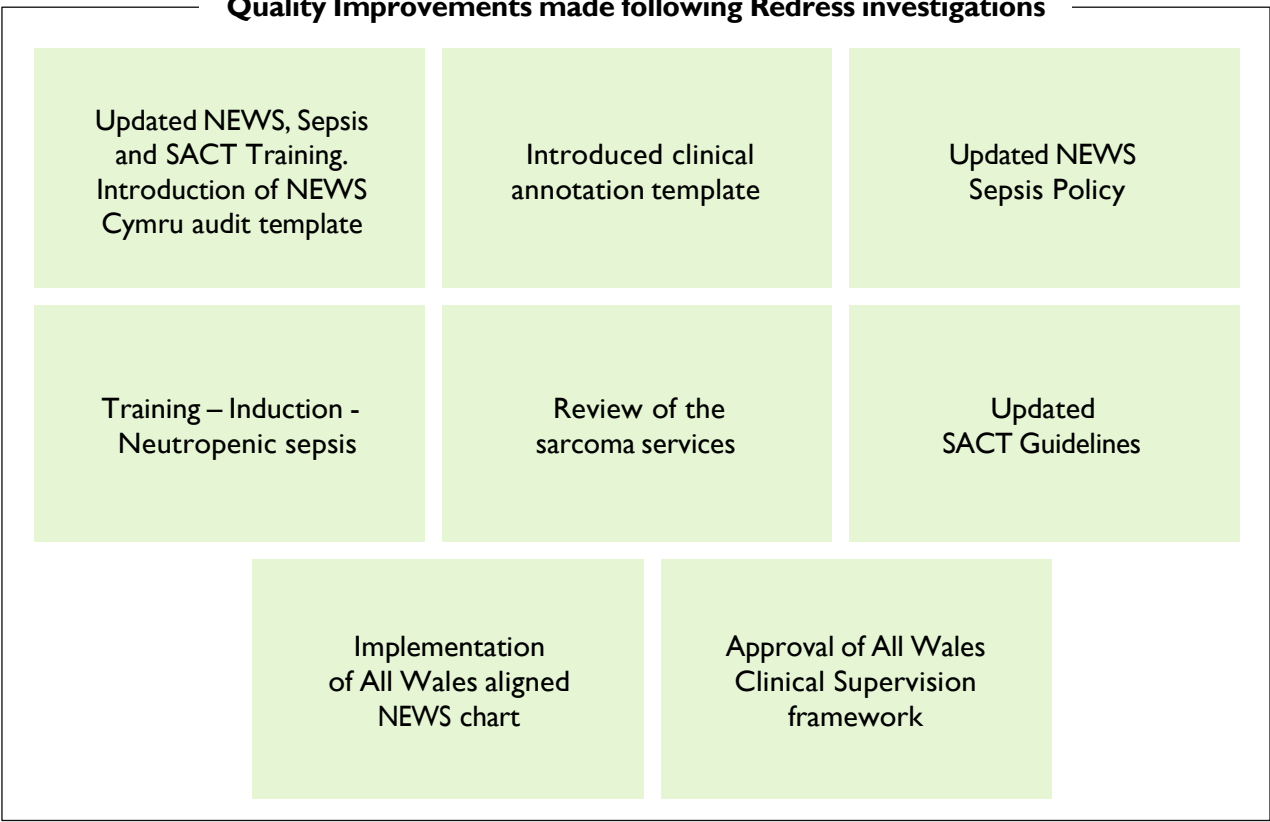
- Delays experienced in receiving Compensation Recovery Unit Certificates issued by the Department of Works and Pension due to misdirection. Without a valid CRU Certificate the case cannot proceed to settlement. Efforts are being made to identify the reasons to prevent undue delay in quantifying cases.
- 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.



Graph 18 shows claims activity during 2024/2025:

- The Trust has 9 claims open at the end of the reporting period, which includes claims for clinical negligence and personal injury.
- During 2024/2025, 6 new claims were received.
- 3 claims were closed.
- There were no themes noted.

7.1 Claims Improvements



Key claims developments

- **Recruitment** of additional part time Claims, Inquests and Redress Manager.
- **Implementation of Lawtel** – an online platform providing access to case law, legislation, articles, and press coverage. It also provides the means to assist in quantify claims by reference to specific cases that act as a guide in reaching suitable offers of financial compensation.
- **Claims Audit** – Introduced during 2024/25, which now forms part of the governance arrangements in place. Carried out bi-monthly.

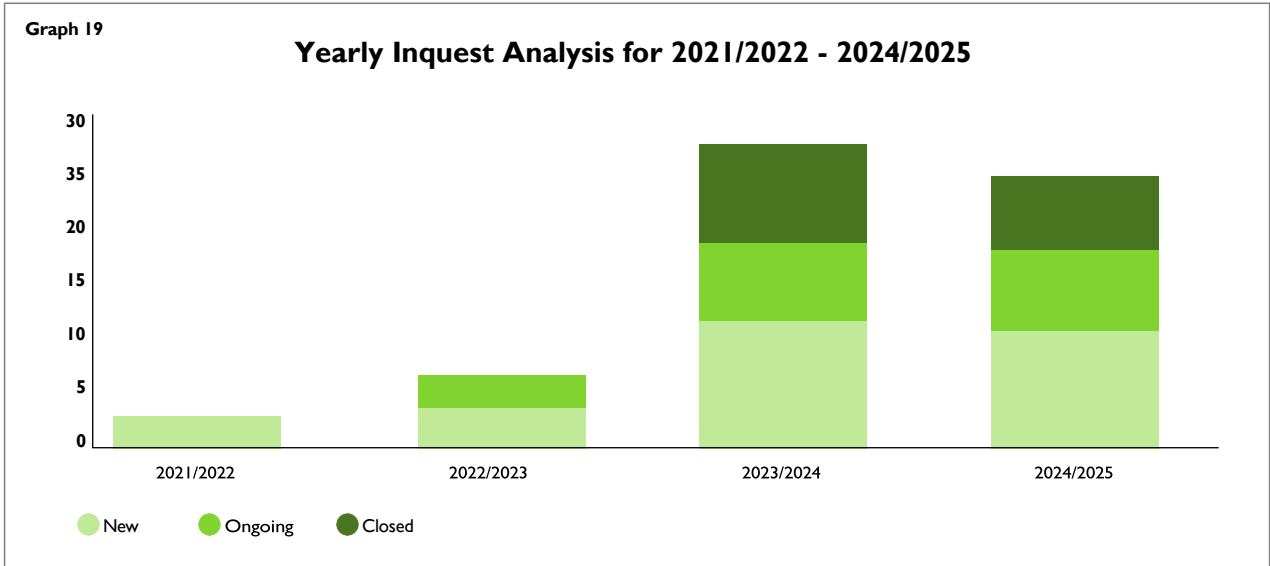
8 Inquests

Analysis

Whilst there has been a rise in inquests being opened during the financial year, no trends, themes, risks or issues have been identified in relation to the Trust. 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.

Activity during 2024/2025

- 12 new inquests were opened
- 8 inquests were closed - no issues were identified affecting the Trust



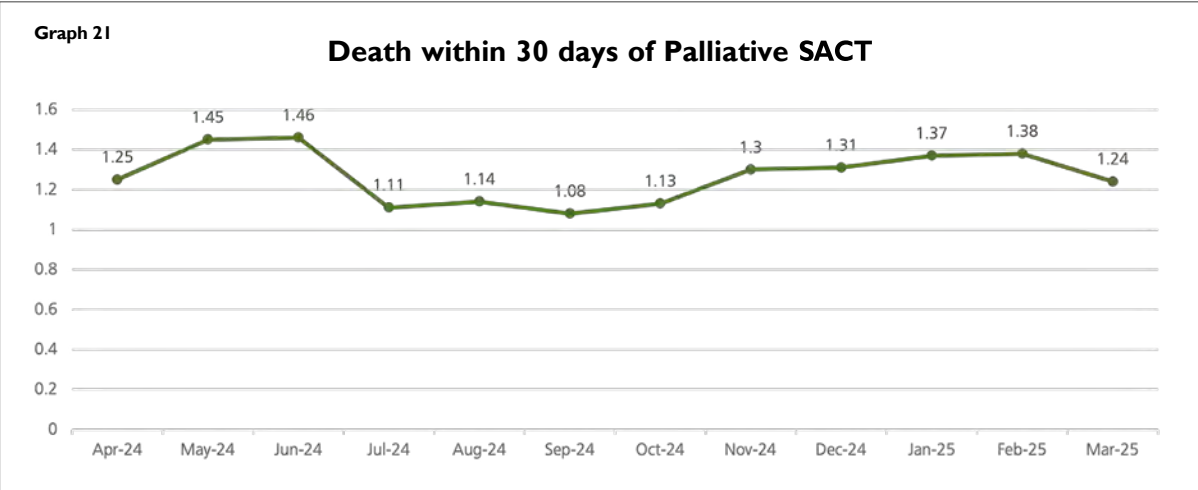
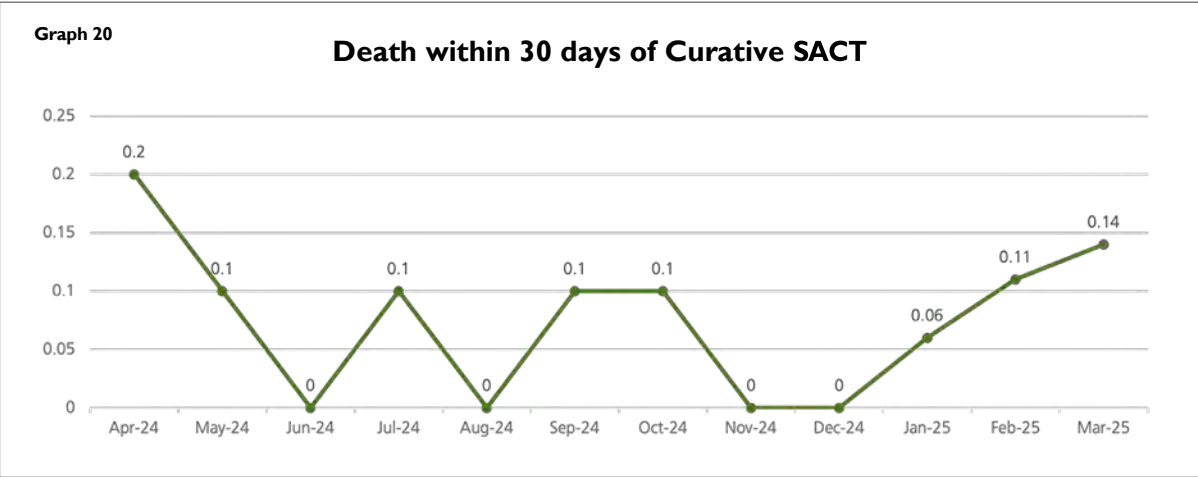
9 Mortality

Analysis

SACT mortality data is collected and reported monthly. Although there is no benchmark for curative or palliative SACT, a 2% 30-day mortality rate from the 2008 NCEPOD report is commonly used for SACT overall, and VCS remains below it.

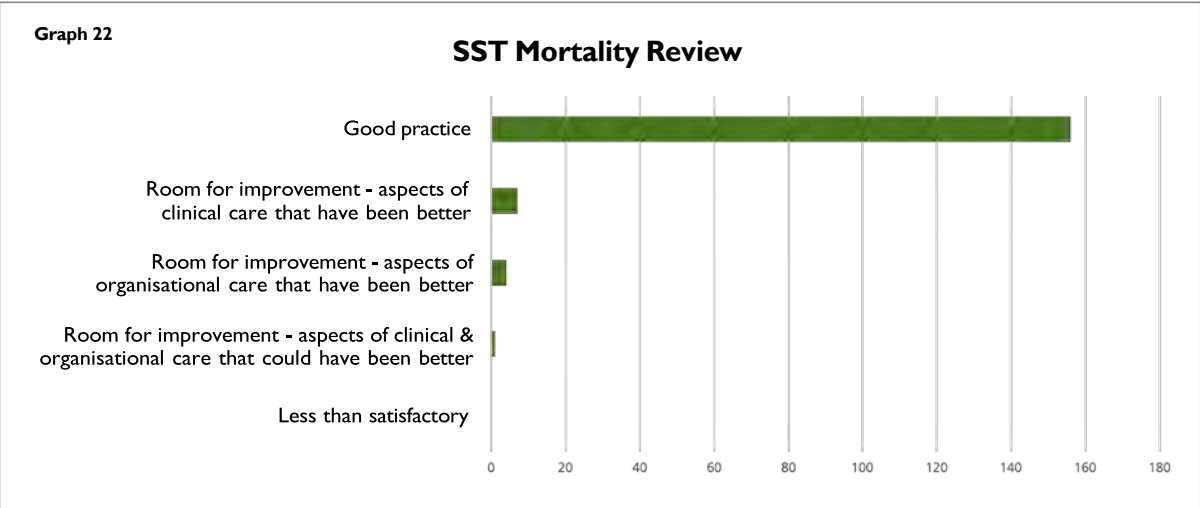
All SSTs now review deaths within 30 days of SACT, 30 days of palliative radiotherapy, and 90 days of radical radiotherapy. Each SST hold these meetings quarterly, are well attended with good engagement. Feedback from the SSTs is positive of the learning and reflection opportunities the meetings provide.

Radiotherapy data validity issues prevent full reporting through to PMF, but the Data and Insight team aims to resolve this by quarter I 2025/26. However, 30- and 90-day radiotherapy mortality data continues to be captured and reviewed by the mortality team and SSTs.



Themes for Learning and Improvement

- Develop SOP for patients within specific SST who can be referred to Virtual Assessment Pathway clinic, this will increase capacity within SST outpatients' clinics.
- Consideration of the performance score and frailty state of patients: this needs to be included in radiotherapy requests from DGH's, and practitioners and prescribers need to be more mindful when considering and prescribing SACT.
- Communication with health care partners: improvements required related to oncology communication with Primary Care and Health Boards and the need to communicate important information in letters as opposed to documenting on Welsh Clinical Portal only.
- Management of raised blood glucose: education and guidelines updated for treatment helpline staff.
- Sarcoma service: Delay in patients being referred to VCS (due to delays in biopsy and delays in MDT process). VCS involved in work with Health Boards to review the pathway.



Analysis

Velindre Cancer Service (VCS) is compliant with all aspects of the Medical Examiner Service (MES) – reviewing cases referred to VCS and feeding back findings and identifying learning.

All inpatient deaths are reviewed independently by the MES and internally at VCS at the monthly Inpatient Mortality Review Meeting.

No clinical concerns were identified from MES or within the VCS mortality reviews.

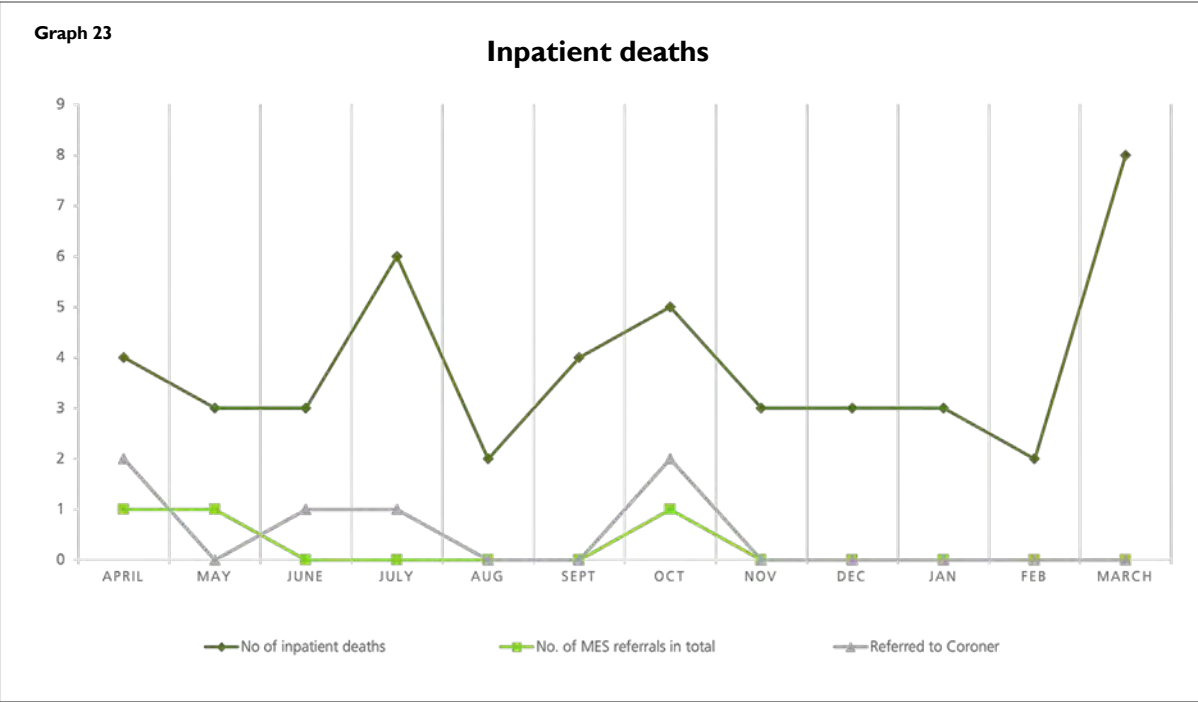
There was an increased number of patients who died in July 2024 and March 2025, but no concerning themes or clinical concerns identified.

Cases referred to the Coroner were not related to care and treatment received in VCS.

Themes for Learning and Improvement

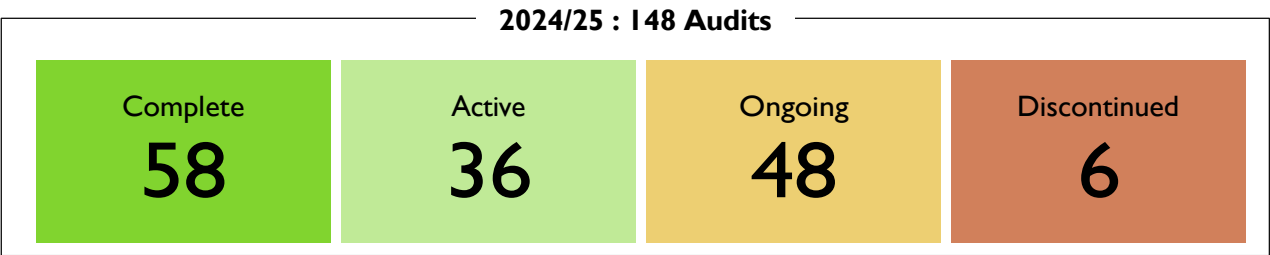
Although no clinical concerns were identified from the MES, opportunities for learning were identified from the inpatient mortality review meeting:

- Ensuring assessment proforma is completed if a patient is admitted to the ward directly (i.e. not via assessment unit).
- Unwell patients should not be transferred between departments if procedure / treatment required can be undertaken at the bedside.
- Improvement needed in the communication between hospitals and VCS when transferring patients for emergency treatment, to ensure decision making regarding the appropriateness for treatment before the patients is moved.
- Development of stoma care education for VCS nursing staff by ANP with extensive surgical experience and Tissue Viability Nurse leading.
- Improvements made in the safety and storage of oxygen procedures on the ward.



10 Clinical Audit – AMaT Clinical Audit Projects

The Clinical Audit department ensures the Cancer Centre can demonstrate, sustain and improve high quality of care throughout all its departments. The Audit team seek to support and facilitate all aspects of audit work within the cancer centre. Key performance indicators are defined through NICE and Royal College guidelines, national audits, safety parameters and patient experience. Throughout the year 2024/2025 a total of 100 projects have been submitted via AMaT, 36 active, 58 completed, and 6 discontinued.



There are an additional 48 ongoing continuous monitoring projects not registered via AMaT and are reported via Tendable or the PMF. The majority of clinical audit projects are captured via the AMaT system with the exception of the frequency of audits and the radiation services regulatory audits. However, the frequency of audits are in the process of being transferred from Tendable to AMaT and will be captured in the Ward and Area module.

Project type	Count
Clinical Audit	63
Patient/Staff Survey	15
Service Evaluation	16



10.1 Clinical Audit – Key Successes

An audit of patient outcomes (with regards to survival and toxicity) after treatment with Sotorasib for KRAS G12C mutated non-small cell lung cancer at Velindre Cancer Centre

- Sotorasib appeared to be generally well-tolerated given that the majority of treatment discontinuation was due to disease progression as opposed to inability to tolerate toxicities. Sotorasib was also shown to have some effect on disease regression or at least stabilising disease for a period of time.



A Service Evaluation Looking at the Non-Surgical Management of Relapsed Prostate Cancer Following PSMA PET-CT Evaluation

- PSMA PET CT scans have revolutionized the way that BCR is investigated and therefore managed. More sites of disease are being picked up and at earlier stages than previously, meanwhile newer methods of treatment have gained prevalence such as SABR, resulting in increased intervention

An evaluation of the Immunotherapy Toxicity Service at Velindre

- 100% of Staff found the IO service a valuable service, with advice from the team seen as a useful resource

An Audit of DPYD Testing in Velindre Cancer Centre

- Velindre Cancer Centre have implemented a quick and efficient DPYD testing process.

A Review of Pre-Treatment FDG PET-CT Imaging for High-Risk, Locally Advanced Head and Neck Malignancies

- The results of this audit highlight that HNC patients across South East Wales are being investigated appropriately according to NWJCC guidelines as 88.6% of patients who required PET-CT for initial staging pre-treatment, did receive one.

A Service Evaluation of the Liquid Biopsy Service for Lung Cancer Diagnostics in Wales

- Overall, liquid biopsy ctDNA tests have a quicker turnaround time than tissue genomic biopsies and with correct usage they can be a helpful tool in meeting the new 49-day lung cancer pathway target.

Is the information in patient treatment escalation plans (TEPs) useful in the ongoing care of patients in the community and in future admissions? To what extent is the information within a patient's TEP communicated to other healthcare professionals in different care settings?

- Despite significant gaps in TEP completion and subsequent documentation on EDALs, results suggest that patients with Advance Care Planning on EDALs informed by TEPs experience fewer hospital readmissions and ambulance calls, and arguably, a better quality of life.

10.2 Clinical Audit – AMaT Key Concerns

A Service Evaluation Of The Referral and Diagnostic pathway of Oesophago-Gastric Cancer

- Health Boards in South Wales are having difficulty meeting the optimal treatment and investigation timelines
- Action: Recommendations are outside Velindre remit, however, we are constantly trying to achieve activity that corresponds to optimal pathways

An evaluation of the Immunotherapy Toxicity Service at Velindre

Lack of awareness of the wider activities of the service beyond purely 'support' managing IO toxicities. Three quarters of respondents were unaware of the adrenal education workshop. Half the respondents were unaware of the endocrine MDT

Actions: Expansion of the service required, therefore a business case for band 7 CNS was submitted. Training plan developed in order to upskilling/training of current staff to keep up with new developments. Pathways developed to provide clarity on who should be referred to the service? The IO service was presented at the consultants meeting in order to increase awareness of what the service is currently offering.

Is the information in patient treatment escalation plans (TEPs) useful in the ongoing care of patients in the community and in future admissions? To what extent is the information within a patient's TEP communicated to other healthcare professionals in different care settings?

EP not being appropriately completed. Appropriate Information regarding the patients cancer status contained within a TEP is not being cascaded appropriately onto the eDAL and therefore shared with primary care and unscheduled care colleagues. There is scope to improve the information pertinent to patients disease status and advanced care planning within the eDAL.

Action: Further data collection to take place to look at current recordings within an eDAL, this will establish if the correct/relevant information is being made available to appropriate working partners and providing the best outcome for patients. The prevalence of incomplete TEPs and EDALs lacking ACP emphasises the need for ongoing QI initiatives to enhance outcomes.

10.3 Clinical Audit – Post Project Impact

Evaluation of the benefits of the Day 8 Callback for patients receiving SACT capecitabine

A decision was made based on the evidence provided from the project that day 8 call backs are no longer required and therefore have been stopped. This frees up staff time/resource. The project findings were discussed at the ICOG and the SST leads meeting. This will also be present for information at the medicines management group.

A service evaluation of symptom control for palliative inpatients at Velindre Cancer Centre

Patients have been offered additional therapies and pharmaceutical drugs to help alleviate symptoms. The team will continue to monitor and look at alternative therapies and medication in the future to enhance the patient experience.

DNACPR FORMS – 2024 Audit Data Collection Results and Analysis Velindre University NHS Trust

Velindre is in the process of switching to electronic note writing in the new Specialist Palliative Care Module in Welsh Clinical Portal. This is already having a demonstrable impact on how other teams are viewing and reviewing information on Future Care Planning preferences, for instance preferred place of care, performance status and also whether DNACPR has been discussed. Further discussions are taking place to extend the current ACP Flag system online into FCP Flag with a document uploader, where forms such as the All Wales DNACPR form, but also patient held Advance Decisions to Refuse Treatment (ADRT) can be stored and shared.

Less patients hold these, but we are seeing more people bring them in. We now have a process in place where any such form can be uploaded to Welsh Clinical Portal, so that the wider team is aware of its existence. We will audit the use of the Future Care Planning Flag on the front page on WCP records (in the Adverse Reaction box).

Implementation of the ‘Antibiotic Review Kit (ARK) Project’ into VCC

Overall it was a success and virtual microbiology ward rounds have now been implemented.

A Retrospective audit of admissions to first floor and assessment unit at Velindre Cancer Centre during May 2023

Aspects of certain audits require longer term actions and will be included in larger pieces of work following the structure changes currently taking place.

Nurse Led Post Radiotherapy Clinic for Gynaecological patients

Post project impact is that due to the success of the clinic and 100% patient satisfaction, the clinic is being continued and the team are looking to expand this service to the vaginal and vulva patients.

Physio-led Prehab Clinic for gynae-oncology patients – Staff Questionnaire

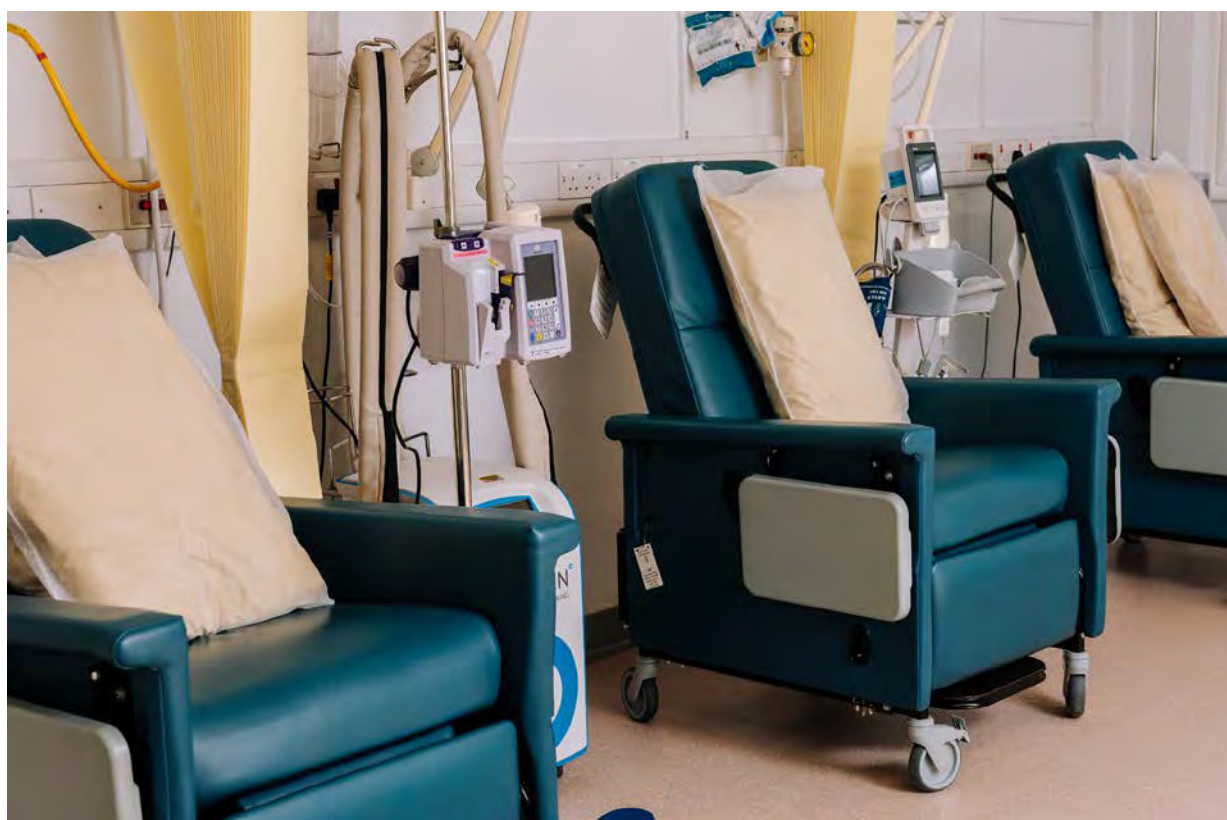
This project highlighted that some staff felt there was a huge benefit with having a dedicated Physio-led Prehab clinic for gynae oncology patients, other staff members felt there was a lack of communication and several improvements could be made. Unfortunately changes are unable to be carried out due to the physio staff member leaving the trust so is no longer being in post.

10.3 Clinical Audit – Improvements achieved

- Developed a robust governance process for the approval and escalation of issues.
- IPCT audits have been moved from MEG to AMaT.
- Enhanced collaboration on the clinical audit plan with the quality and safety team to incorporate audits from incidents, complaints and patient safety issues. This has been supported by clinical audit department becoming part of the quality and safety team.
- Frequency audits are in the process of being moved from Tendable to AMaT, so the majority of audit activity is captured in one system.

Areas of development for VCC

- Identify a clinical lead for audit.
- Strengthen the quality hubs to ensure projects are reviewed to ensure alignment with SST/ IMTP/ QI objectives.
- Strengthen the quality hubs to ensure learning from audit projects are disseminated and any identified improvements undertaken.
- Annual Trust Clinical Audit and Quality Improvement events to share learning and foster a culture of clinical effectiveness and improvement through the VCS Grand Round events.
- Development of Quality & Safety Dashboard to include clinical audit activity and will be available for each SST.



II Safety Alerts

Analysis

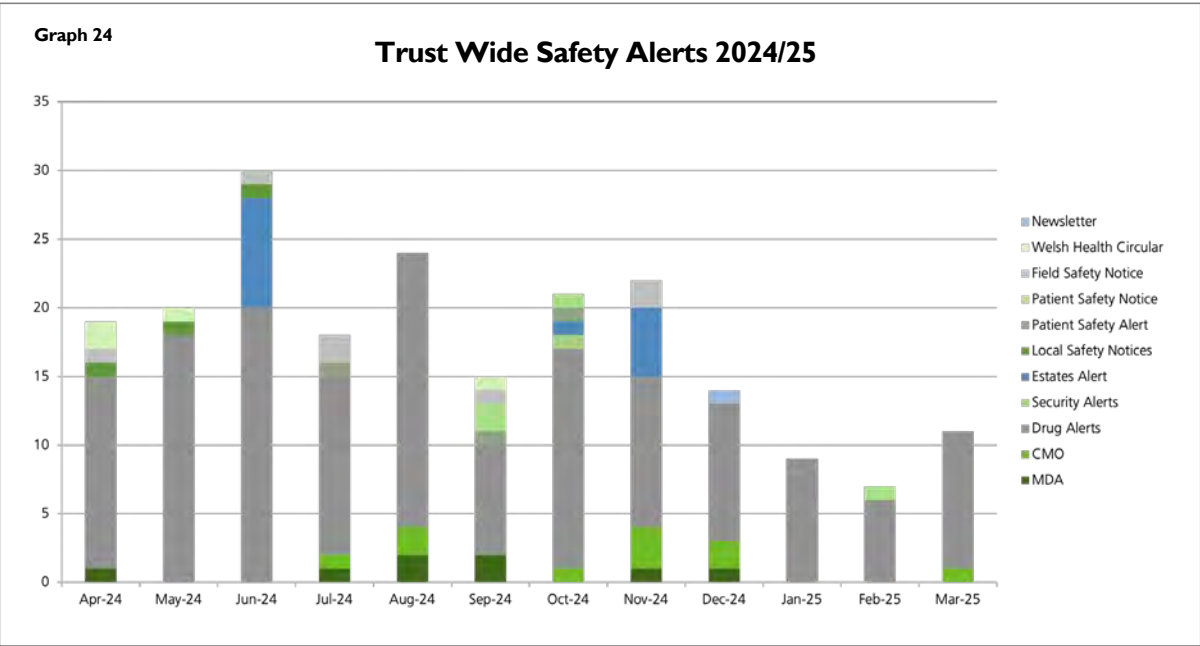
210 safety alerts were received in 24/25; this is a decrease from 23/24 (225). Drug/pharmaceutical alerts continue to be the highest number of alerts received, 155. The drug alerts relate to medicine recalls and stock issue notifications from suppliers. Drug alerts assessed as being applicable to the Trust were further shared, with pharmacists to take appropriate actions.

Themes and Outcomes

The most common theme for Safety Alerts were medication shortages. Any alerts that were applicable to the Trust were addressed, e.g. stock checking and using the recommended alternatives. There are numerous types of Safety Alerts, these are all shared to the appropriate teams across the Trust and dealt with accordingly.

Positive Assurance

Each of the alerts received have been reviewed by subject matter leads and appropriate actions taken. From 1st April 2025, the Safety Alerts will be recorded in a module on Datix Cymru.



12 Information Governance

Annual Report 2024-25 (1st April 2024 - 31st March 2025) – 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 indepth 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 of 1st January annually and may affect CAG status.

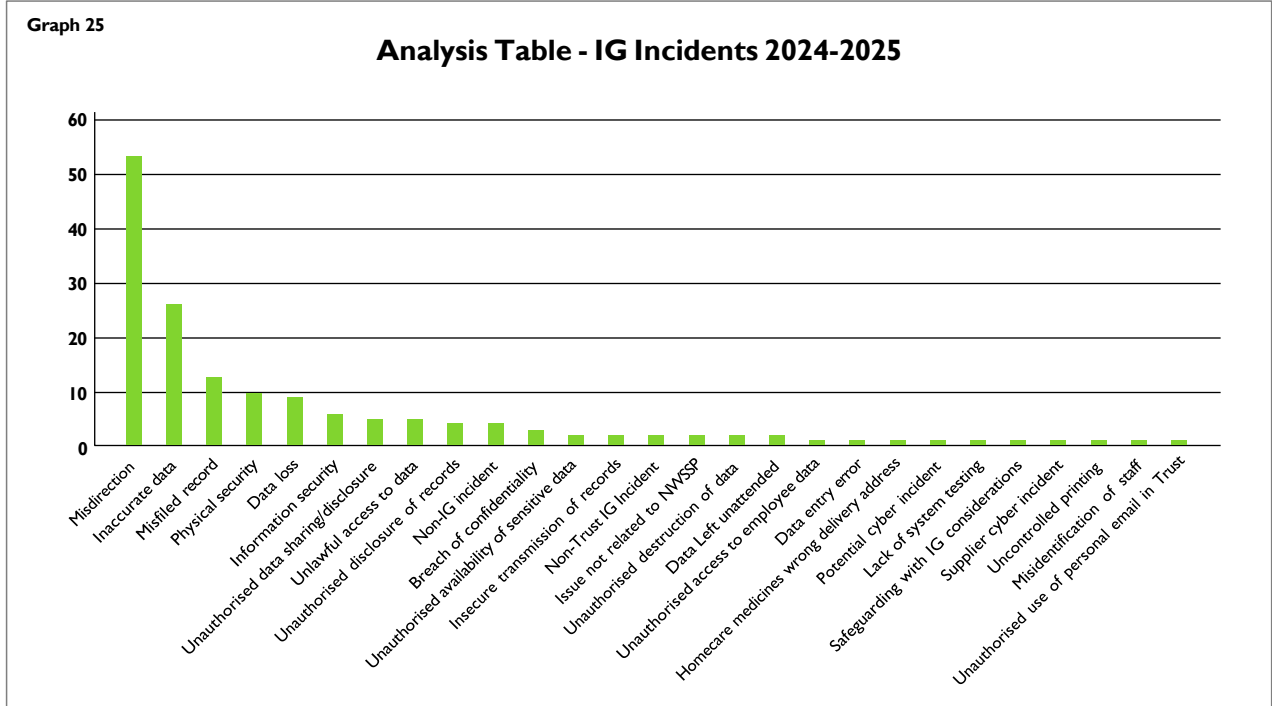


Incidents – 1st April 2024 to 31st March 2025

	DATIX Incident	Incident reported to the ICO	Total	Low Risk / No harm	Root Cause Analysis	Total
Quarter 1 2024-2025						
Corporate Service	0	0	0	0	0	0
Velindre Cancer Service	23	3	23	20	3	23
Digital	0	0	0	0	0	0
Welsh Blood Service	7	1	7	6	1	7
TCS/NVCC	0	0	0	0	0	0
NWSSP	12	0	12	12	0	12
Total for Q1 2024-2025	42	4	42	38	4	42
Quarter 2 2024-2025						
Corporate Service	1	0	1	1	0	1
Velindre Cancer Service	23	0	23	23	0	23
Digital	0	0	0	0	0	0
Welsh Blood Service	6	0	6	6	0	6
TCS/NVCC	0	0	0	0	0	0
NWSSP	17	0	17	17	0	17
Total for Q2 2024-2025	47	0	47	47	0	47
Quarter 3 2024-2025						
Corporate Service	4	0	4	4	0	4
Velindre Cancer Service	14	0	14	14	0	14
Digital	0	0	0	0	0	0
Welsh Blood Service	5	0	5	5	0	5
TCS/NVCC	0	0	0	0	0	0
NWSSP	6	0	6	6	0	6
Total for Q3 2024-2025	29	0	29	29	0	29
Quarter 4 2024-2025						
Corporate Service	0	0	0	0	0	0
Velindre Cancer Service	22	0	22	22	0	22
Digital	0	0	0	0	0	0
Welsh Blood Service	9	0	9	9	0	9
TCS/NVCC	0	0	0	0	0	0
NWSSP	14	0	14	14	0	14
Total for Q4 2024-2025	45	0	45	45	0	45
Total for 2024-2025	163	4	163	159	4	163

Analysis table for Incidents – 1st April 2024 to 31st March 2025

Reason	Number of Incidents	Corporate	VCS	WBS	Digital	TCS/ NVCC	HTW	NWSSP
Misdirection	55	3	14	7	0	0	0	31
Inaccurate data	27	1	21	1	0	0	0	4
Misfiled record	13	0	12	1	0	0	0	0
Physical security	10	0	9	1	0	0	0	0
Data loss	9	0	2	6	0	0	0	1
Information security	6	0	5	1	0	0	0	0
Unauthorised data sharing / disclosure	5	0	1	3	0	0	0	1
Unlawful access to data	5	0	5	0	0	0	0	0
Unauthorised disclosure of records	4	0	1	1	0	0	0	2
Non-IG incident	4	0	1	1	0	0	0	2
Breach of confidentiality	3	1	1	1	0	0	0	0
Unauthorised availability of sensitive data	2	0	1	1	0	0	0	0
Insecure transmission of records	2	0	2	0	0	0	0	0
Non-Trust IG incident	2	0	1	0	0	0	0	1
Issue not related to NWSSP	2	0	0	0	0	0	0	2
Data left unattended	2	0	0	1	0	0	0	1
Unauthorised destruction of data	2	0	0	0	0	0	0	2
Unauthorised access to employee data	1	0	1	0	0	0	0	0
Data entry error	1	0	1	0	0	0	0	0
Homecare medicines delivered to incorrect address	1	0	1	0	0	0	0	0
Potential cyber incident	1	0	1	0	0	0	0	0
Lack of system testing	1	0	0	1	0	0	0	0
Safeguarding with UG considerations	1	0	1	0	0	0	0	0
Supplier cyber incident	1	0	1	0	0	0	0	0
Uncontrolled printing	1	0	0	1	0	0	0	0
Misidentification of staff	1	0	0	0	0	0	0	1
Unauthorised use of personal email in Trust email system	1	0	0	0	0	0	0	1
Total for 2024/2025	163	5	82	27	0	0	0	49



VCS (Medical Records) Subject Access Requests – 1st April 2024 to 31st March 2025

Month	Number of requests	Number of requests completed within statutory timeframe	Request breached	Percentage compliance
April	18	13	5	72.22%
May	20	16	4	80%
June	15	15	0	100%
July	16	14	2	87.5%
August	27	27	0	100%
September	15	15	0	100%
October	22	22	0	100%
November	14	13	1	92.85%
December	21	21	0	100%
January	24	24	0	100%
February	16	16	0	100%
March	19	19	0	100%
Total	227	215	12	94.71%

Corporate (Non-Medical Records) Subject Access Requests – 1st April 2024 to 31st March 2025

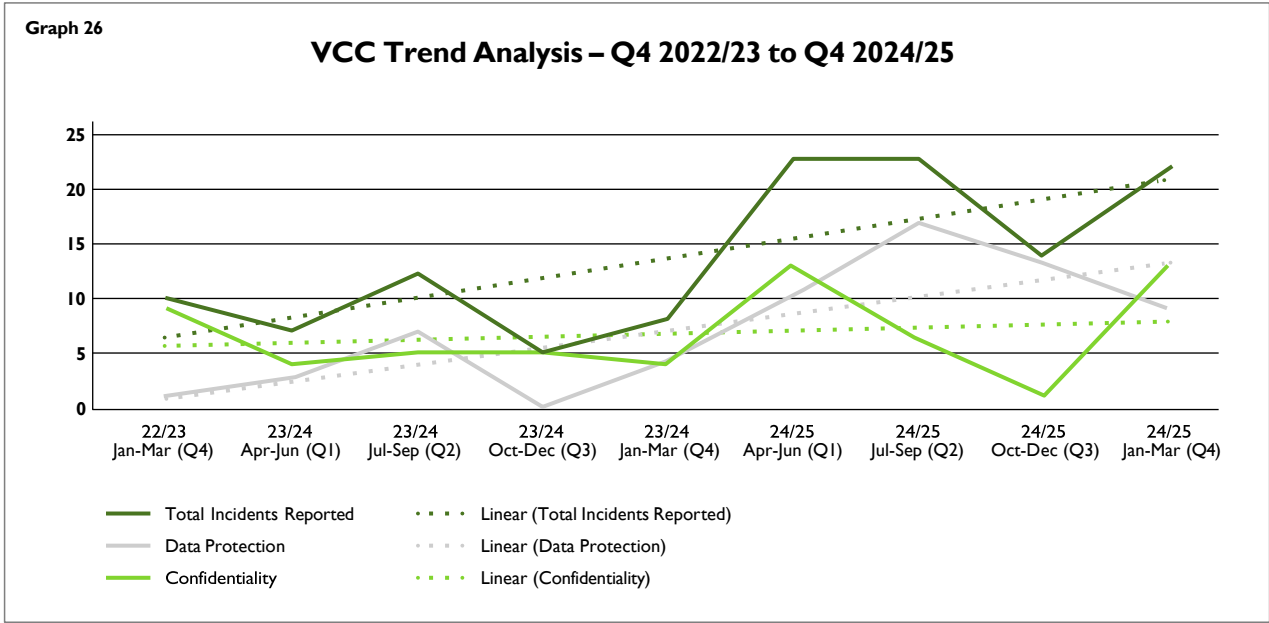
Month	Number of requests	Number of requests completed within statutory timeframe	Request breached	Percentage compliance
April	2	2	0	100%
May	1	1	0	100%
June	1	1	0	100%
July	3	3	0	100%
August	1	1	0	100%
September	0	0	0	100%
October	0	0	0	100%
November	3	3	0	100%
December	0	0	0	100%
January	0	0	0	100%
February	0	0	0	100%
March	1	1	0	100%
Total	12	12	0	100%

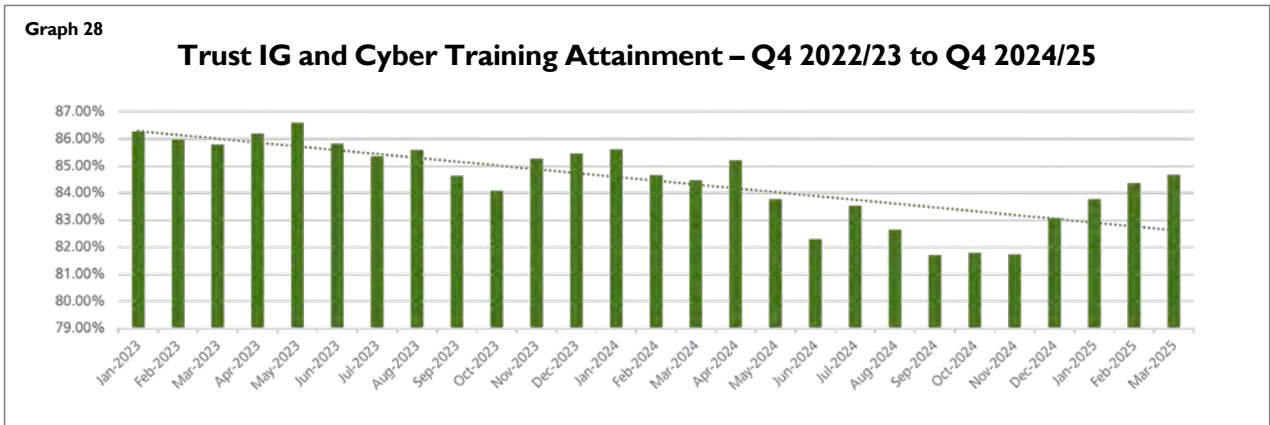
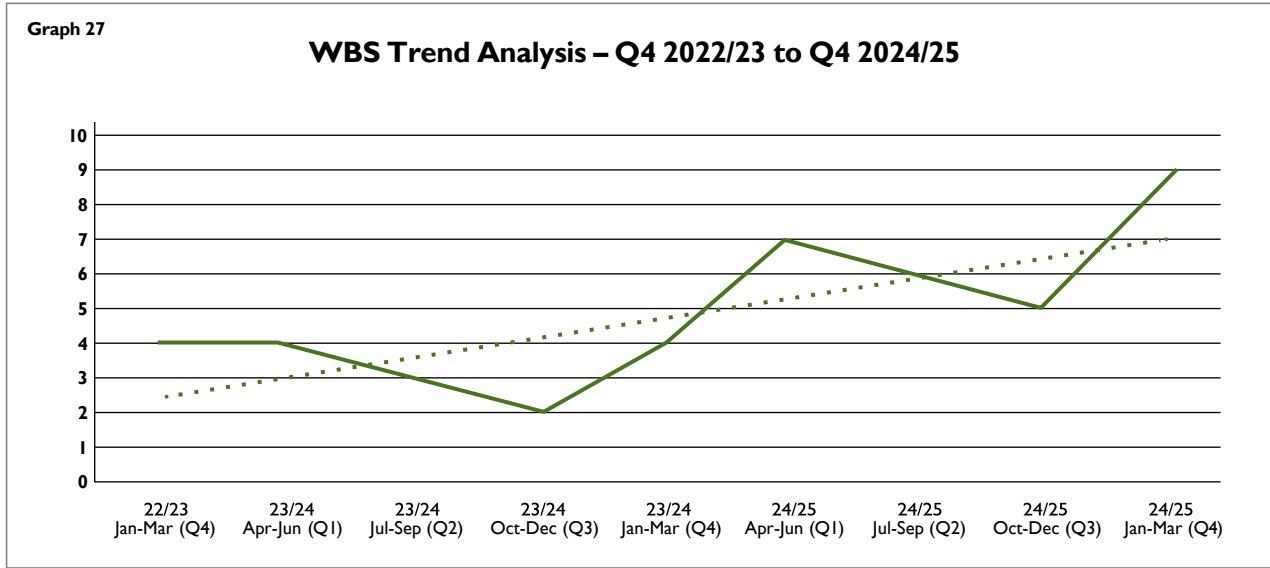
WBS (Donor Records) Subject Access Requests – 1st April 2024 to 31st March 2025

Month	Number of requests	Number of requests completed within statutory timeframe	Request breached	Percentage compliance
April	18	18	0	100%
May	8	8	0	100%
June	11	11	0	100%
July	14	14	0	100%
August	11	11	0	100%
September	6	6	0	100%
October	6	6	0	100%
November	5	5	0	100%
December	7	7	0	100%
January	11	11	0	100%
February	12	12	0	100%
March	16	16	0	100%
Total	125	125	0	100%

NWSSP Subject Access Requests – 1st April 2024 to 31st March 2025

Month	Number of requests	Number of requests completed within statutory timeframe	Request breached	Percentage compliance
April	2	2	0	100%
May	0	0	0	100%
June	0	0	0	100%
July	0	0	0	100%
August	0	0	0	100%
September	0	0	0	100%
October	1	1	0	100%
November	1	1	0	100%
December	0	0	0	100%
January	1*	0	0	100%
February	0	0	0	100%
March	0	0	0	100%
Total	5	4	0	100%





Positive Assurance

1 | Training

- Training throughout 2024/25 was delivered in multiple ways, including via ESR, inductions and specific workshops. It will continue to be delivered in the same format for 2025/26. It is planned to deliver training in Welsh in North Wales to WBS Collections teams in June 2025, a first for NHS Wales.
- IG Training compliance on 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 of 31st March 2025 which equates to 15.33% of the workforce.
- 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 disestablishment of WIGB, DPO/SIRO/CG in discussion in peer groups for an all-Wales route to approval via a DDAT.

- 3 | **SAR Compliance** – Steady across the Trust, 100%
- 4 | **DPIAs** – 45 DPIAs, 6 LIA's and 18 DPA's were approved across the Trust in 2024/25.
- 5 | **IG Toolkit** – IG toolkit submitted on time, 28th March 2025 for 2024/25 timeframe – compliance observations and resultant IG workplan is included in main IG Annual Report

Risks to compliance with legislation, policies, procedures and standards and mitigation activity

- 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 for 2024/25. VCS has increased compliance from 82.23% to 83.22% within Quarter 4 of FY 2024/25. 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 contacted HTW in early April 2025 stating that non-compliance requires addressing as soon as possible.
- 2 | **Incidents** – The Misdirection whilst aligning with UK statistics (17% of all IG incidents are misdirection) is far too high in incidence. This represents high risk to the Trust, the impact often far outweighs the act of misdirection itself.
- 3 | **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. This has had a wider impact and DPO is working with NWSSP L&R in order to produce an aligned approach across NHS Wales.
- 4 | **TAF Risk** – DPO continues to review TAF 05 with CDO. Cyber Resilience exercise was conducted on 24 Mar 25 in VCS, second exercise is planned for 7 Apr 25. UK Blood Forum exercise planned for June 2025.
- 5 | **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 with support of DPO if required.
- 6 | **Training Risk Mitigation** – The provision of workshops and sessions throughout the Trust in 2024/25 whilst offered have not seen as large a take up as was expected, but this is most likely due to Service Pressures. 477 Staff received face to face IG training during 2024/25. Divisional Directors continue to support the approach taken by DPO.

Analysis, themes and learning

- 1 | **Incidents** – Overriding theme in 2024/25 remains constant; misdirection, inaccurate data and misfiling of records remain a constant in each quarter of reporting to QS. It is avoidable, how to avoid it is taught by the DPO in all face to face sessions. IG Team will explore further resources online in 2025/26.
- 2 | **ICO Reported Incidents** – 3 incidents were reported to the ICO in 2024/25, all of which resulted in NO REGULATORY IMPACT on the Trust. Training provision was updated to reflect lessons learned, further analysis is in the IG Annual Report.
- 3 | **Training** – Training compliance in 2024/25 dipped mid-year. 2024/25 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 data protection by design and default 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.

13 Infection Prevention and Control

Key Highlights:

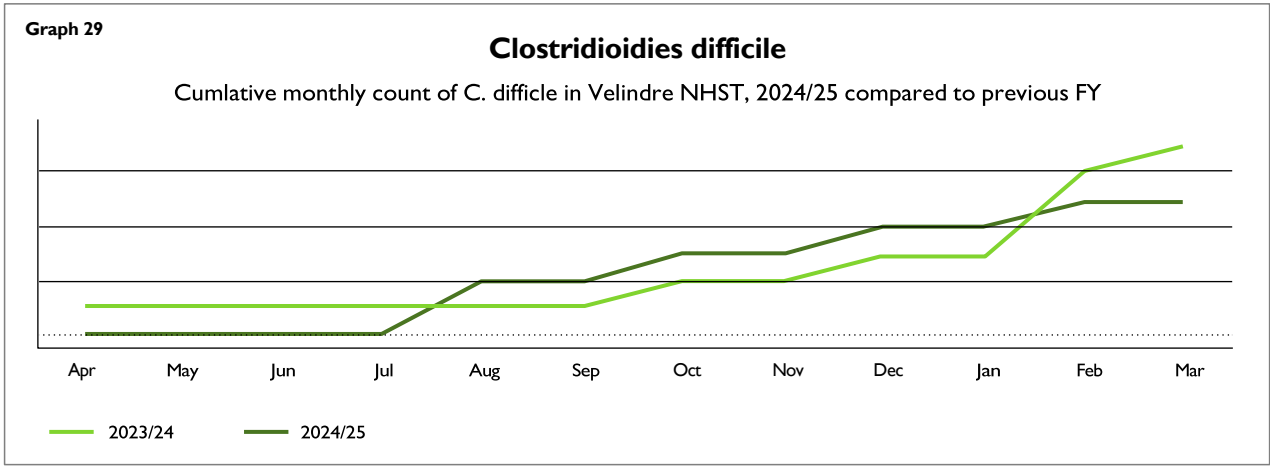
- Sustained zero incidence of *Pseudomonas aeruginosa* bacteraemia for second year
- International Infection Prevention Week 2024 – Escape Room - The team developed a unique, innovative learning experience
- Benchmarking – creating links with peers in transfusion services/cancer units
- Significant increase in uptake of Influenza vaccine
- IPCT members successfully completed Decontamination and Water Safety courses giving greater resilience and knowledge base.

Healthcare Associated Infection

Healthcare acquired infection is a patient harm indicator and we need to do all we can to prevent patients acquiring such infections. During 2024-2025 the following occurred:

Healthcare Associated Infection

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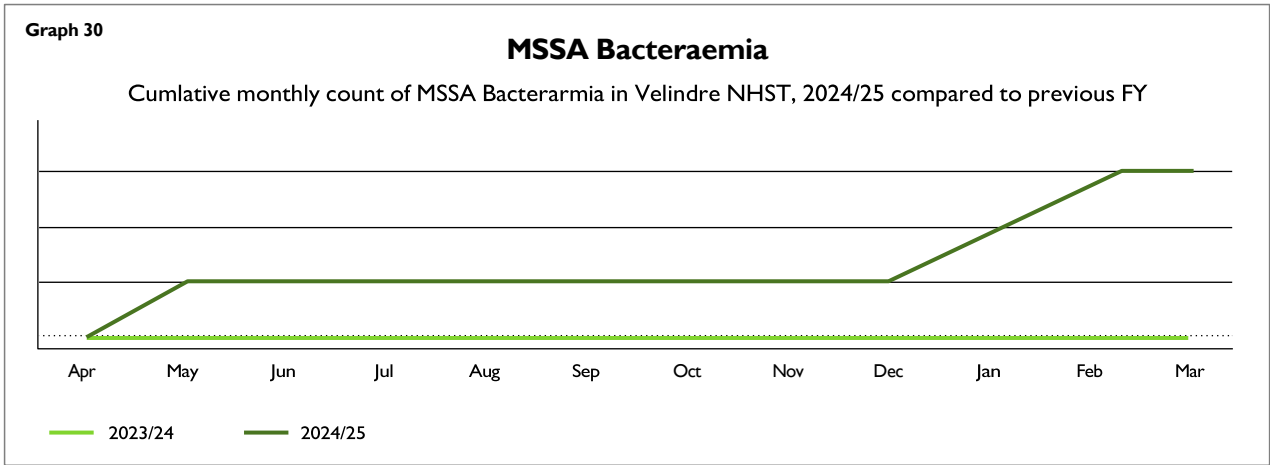


During the **2024/25** reporting period, **5 cases** of healthcare-associated Clostridioides difficile infection (CDI) were reported. This marks a reduction of **2 cases (29%)** compared to the previous year, reflecting a positive trend in infection prevention efforts.

Root cause analysis determined that three of the reported cases were attributable to acquisition within Velindre. Investigations into each case have informed ongoing quality improvement initiatives aimed at further reducing the incidence of healthcare-associated infections. Learning included improved communication between multi-disciplinary teams and correct use of anti-microbial therapy.

MRSA Bacteraemia

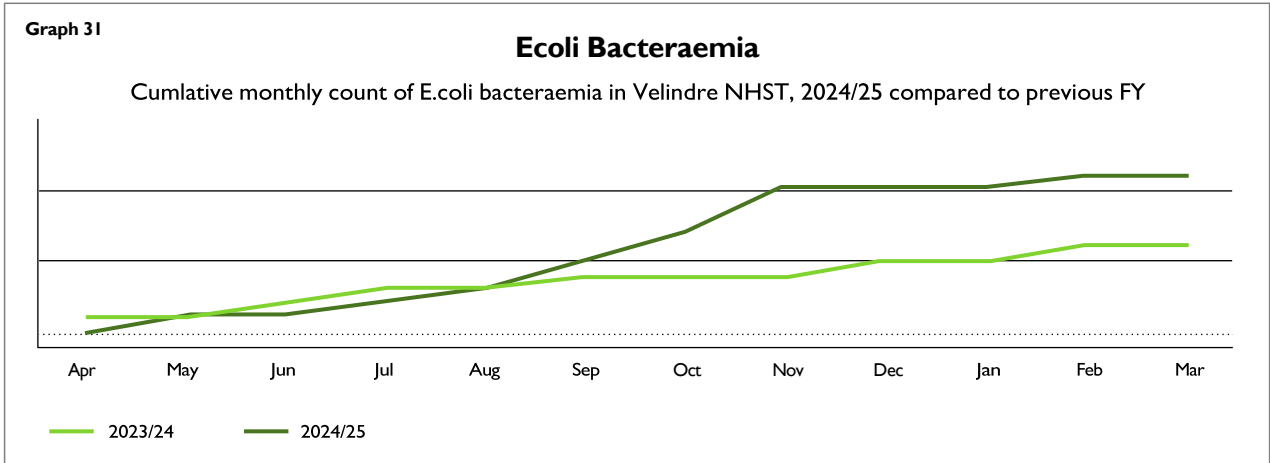
One case of Methicillin-Resistant Staphylococcus aureus (MRSA) bacteraemia was reported in the 2024/25 period, consistent with the number recorded in the previous year. Following investigation, the case was determined not to be acquired at Velindre as the patient was colonised on admission. The review of this infection resulted in education regarding admission screening, compliance with MRSA screening subsequently improved.



In the **2024/25** reporting period, there were **3 cases** of healthcare-associated Meticillin-Sensitive Staphylococcus aureus (MSSA) infection. This represents no change from the previous year’s total. Following an investigation, none of these cases were identified as having been acquired at Velindre.

Ecoli Bacteraemia

In the 2024/25 reporting year, there were 11 recorded cases of healthcare-associated E. coli bacteraemia. This represents an increase of five cases compared to the previous year. Following investigation, only one case was identified as having been acquired within Velindre.

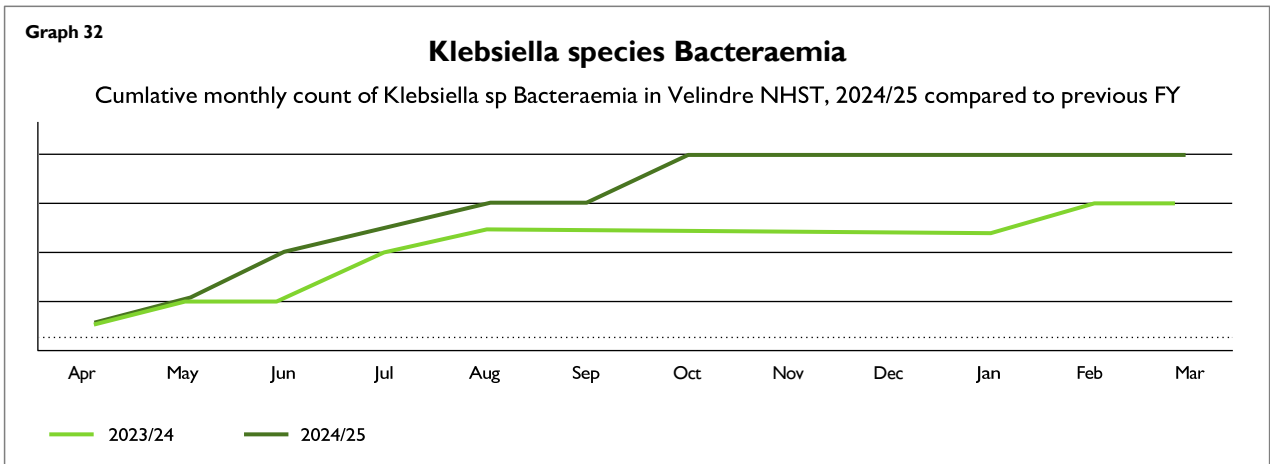


Pseudomonas aeruginosa Bacteraemia

There were no reported cases of Pseudomonas aeruginosa bacteraemia in the 2024/25 period, maintaining the zero-incidence level achieved in the previous year.

Klebsiella species Bacteraemia

During 2024/25, eight cases of healthcare-associated Klebsiella species bacteraemia were reported, representing an increase of three cases from the previous year. Detailed investigation found that only one of the eight cases was likely acquired within Velindre.

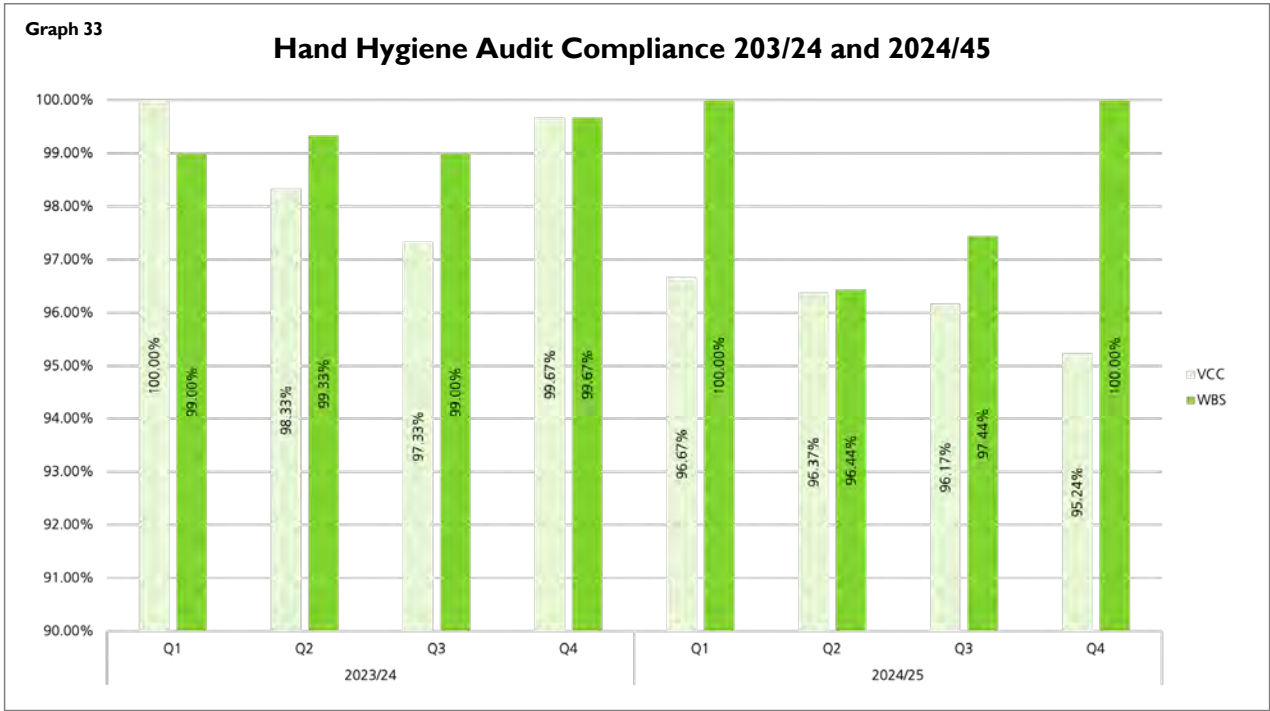


Audits Clinical Practice Audits

Clinical practice audits are necessary elements of healthcare as they ensure delivery of high quality and safe patient care. Throughout the clinical areas of VCC, the audits serve as systematic evaluations of practices, processes, and outcomes, aiming to identify areas of improvement and adherence to standards and guidelines and areas of excellence. Clinical practice audits undertaken include compliance with urinary catheter bundles, ANTT, central venous catheter maintenance, and peripheral cannula care bundles. This high compliance is reflected in the sustained low infection rates.

Hand Hygiene

Observational audits were conducted throughout the year in alignment with the World Health Organisations ‘5 Moments for Hand Hygiene’ framework, which emphasises critical points of patient care where hand hygiene is essential to prevent healthcare-associated infections. Audits were conducted by both departmental hand hygiene champions and the IPCT, providing valuable insights into compliance and serving as a proactive measure to reinforce best practices. Observers identified several missed opportunities — most commonly before patient contact and after patient environment — which are promptly addressed through immediate, constructive feedback and on-the-spot education. This real-time approach not only supports individual accountability but also fosters a culture of continuous improvement and patient safety across clinical teams.



Innovation & Sustainability

Infection prevention and control measures contribute to NHS sustainability by reducing healthcare-associated infections, thereby decreasing the demand for intensive treatments and prolonged hospital stays. This not only improves patient outcomes but also supports environmental goals through more efficient use of resources, including time, more ethically produced gloves and reduced waste.

The IPC team has worked in close collaboration with the Surgical Materials Testing Laboratory (SMTL), Welsh Blood Service, and the Trust Sustainability Lead to advance several key projects aimed at improving both infection control practices and environmental responsibility.

Current initiatives include

FFP3 Mask Streaming	Sustainable Hand Hygiene Solutions	Optimising Use of Blue Couch Roll	Ethically Sourced Gloves
Exploring transitioning to a UK-manufactured FFP3 mask that not only supports local production but is expected to deliver cost savings and significantly reduce staff fit-testing time from approximately one hour to just 20 minutes.	Exploring alternatives to traditional alcohol-based hand sanitisers to reduce environmental impact while maintaining high standards of hand hygiene.	Reviewing usage practices to ensure blue couch paper is used appropriately and sustainably. Minimising unnecessary waste.	Assessing options for gloves that are ethically produced and responsibly manufactured, supporting fair labour practices and reducing environmental impact.



14 Safeguarding and Vulnerable Groups

The Trust’s achievements in Safeguarding is driven by a strong organisational culture, which embeds the Trust’s values, fosters professional curiosity, encourages scrutiny and supports the actions required to protect those at risk of abuse or in need of care and support.

This section of the Quality and Safety Annual Report provides the Trust with assurances that the organisation is meeting the statutory duties under the Children Act 2004, The Social Services & Wellbeing (Wales) Act 2014, the Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015, the Domestic Abuse Act 2021 and Wales Safeguarding Procedures.

Key Achievements 2024/25

- 10% Increase in safeguarding training compliance when comparing end of year figures with 2023-2024.
- Increase in safeguarding Duty to Reports submitted during this reporting period.
- The completion of an Audit reviewing the quality of documentation of Deprivation of Liberty Safeguards (DoLS) applications.
- 5 new Dementia champions who have completed inhouse dementia training at influencer level.
- 2 Kings Fund Environmental assessments completed in Outpatient Department and Radiotherapy.
- 2 Carefit for VIPS self-assessment completed.
- Safeguarding information stands and Welsh Blood Service and Velindre Cancer Centre during National Safeguarding Week.

Key Challenges 2024/25

- Progressing the workplan in relation to people who are living with a Learning Disability.
- The completion of a pathway to facilitate contact between victims of domestic abuse/sexual violence.
- Dissemination of health specific recommendations made following Practice Reviews undertaken in Wales and evidencing how staff learn and improve practice from accessing these resources. **The Head of Safeguarding & Vulnerable Persons lead will participate in the Learning Framework workstream which is part of the Strengthening Safeguarding in Health Delivery Group.**
- Operational demands continue to impact on staff attending training.

Safeguarding and Public Protection Activity

Analysis

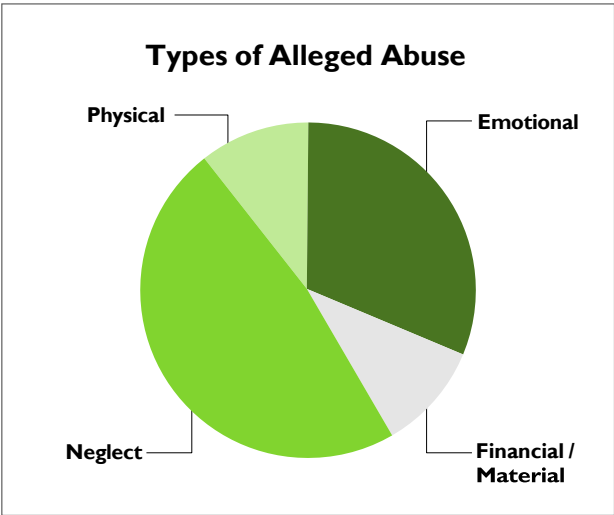
15 Duty to Reports were submitted during 2024-25, this is a slight increase on the previous reporting years.

The number of adult at risk reports submitted this year is lower than previous years. This may be a consequence of signposting/referring adults experiencing domestic abuse to specific support services rather than through the Adult at Risk process. However, there has been an increase in the number of child reports submitted. The 43% increase in Level 3 Safeguarding Children training compliance, could be a contributing factor to an improvement in staff recognising and responding to safeguarding issues related to children.

Report type	2022/23	2023/24	2024/25
Adult at Risk	11	13	9
Child at Risk	3	1	6
Total	14	14	15

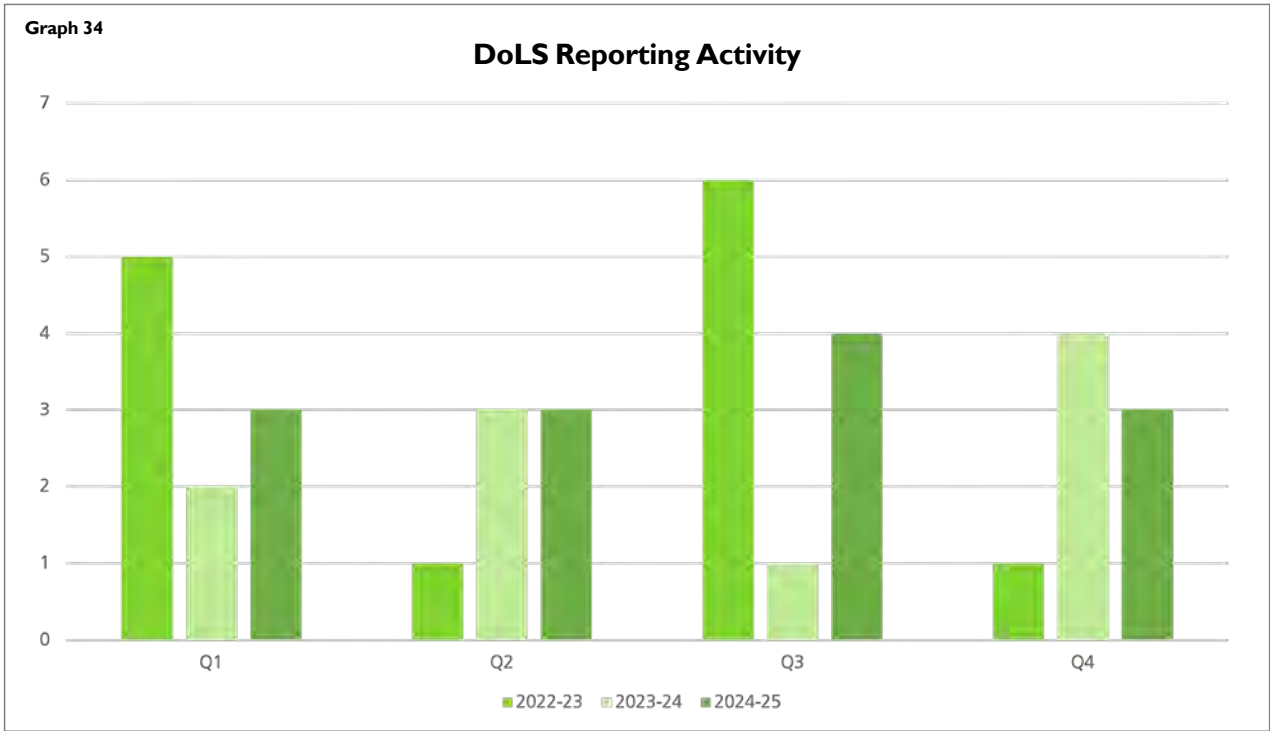
The chart on the right illustrates the type of alleged abuse cited in the safeguarding reports submitted during this reporting year. This reflects the same categories as the previous year, however, during 2024-25 the number of reports highlighting Neglect as a concern has overtaken Emotional/Psychological.

All reports were raised by staff in Velindre Cancer Centre with an even distribution of reports submitted to Local Authority areas across South- East Wales. One exception was a report which was submitted out of area to the Hereford locality.



Deprivation Of Liberty Safeguards (DoLS) activity

At the end of this reporting year, we said a fond farewell to our Practice/Educator for MCA/ DoLS. I would like to take the opportunity to say a big Thank-You to them, for their dedication, professionalism, support and guidance. It is through their hard work that our position in MCA/ DoLS training, staff knowledge and access to resources has been strengthened.



Analysis

13 applications for Deprivation of Liberty Safeguards (DoLS) were made during this reporting period. This is an increase on the number (10) submitted during 2023-24, and equal to the number submitted 2022-23.

Mental Capacity Act (MCA)/DoLS training compliance has increased by 22% when compared with the end of year total for 2023-24. Equipping Staff with confidence and competence in supporting patients, families and caregivers where there are concerns related to mental capacity.

Training materials were updated to include information related Mental Capacity and Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR). This was in response to the recommendations related to training found in the Health Inspectorate Wales (HIW) report Review of DNACPR Decisions for Adults in Wales 2024.

Infographic on the DoLS process developed.

Following patient feedback, staff working within VCC Outpatient Dept have resources enabling them to support patients to access Advocacy Services.

Violence Against Women, Domestic Abuse & Sexual Violence

Domestic abuse causes long-lasting physical and mental health harm. It can impact on cancer care, treatment, recovery and a person's ability to attend and donate in donor sessions. Working in the Cancer Centre and Welsh Blood Service provides a unique window to **'Ask & Act'**.

This year the Trust supported victims/survivors who experience these forms of abuse by:

- Displaying the Live Fear Free Helpline in public areas. Empowering victims/survivors to access this specialist service.
- Providing training to staff at all levels to recognise and respond to issues related to VAWDASV. There has been a 14% increase in training compliance when compared with the end of year total for 2023-24.
- Clinical Nurse Specialists for Gynaecological Cancer have included signposting services on a newly developed patient information leaflet and padlet.
- Promotion of the Cancer and Domestic Abuse: A toolkit for professionals during Ask & Act training, staff can also access this resource through the safeguarding hub.
- Staff have successfully supported victims to access community or health based Independent Domestic Violence Advisers (IDVAS).
- Ensuring Safeguarding processes are triggered where an adult or child at risk is affected by these issues.



Key Priorities for 2025-2026

- 01

Work with senior leadership team within WBS to explore whether a routine enquiry question related to Violence Against Women, Domestic Abuse & Sexual Violence (VAWDASV) could be included on the questionnaire completed by donors when they attend sessions. Work with the senior leadership teams across VCC and WBS to develop a ‘targeted enquiry’ pathway which will support staff to facilitate contact between victims/ survivors of VAWDASV and the Live Fear Free Helpline.
- 02

We will continue to monitor and review the Trust’s position against Dementia Care Pathway of Standards.

Audit the use of the cognitive impairment symbol on First Floor Ward and implement a person-centred assessment (PORT).
- 03

We will implement a reasonable adjustment checklist for patients who are living with a Learning Disability, Cognitive Impairment, Physical or Sensory Disability, ensuring that there is equitable access to services delivered by the Trust.

15 Health and Safety

VUNHST Health & Safety Annual Update

VUNHST H&S 2024/25	RIDDOR Events 5	Incidents 91

Outcome

Overall, the Trust has made clear improvements in key areas such as infrastructure, equipment safety, and behavioural incidents. The reduction in accident/injury numbers in 2024-25 is encouraging, although still the most common category.

The 91 RIDDOR incidents highlights the need for continued vigilance and follow-up action. The data provides a solid platform for ongoing improvement, learning and prioritisation of safety efforts.

Themes

Violence and Aggression (V&A) Incident Overview: The Trust has seen a positive reduction in Violence and Aggression (V&A) incidents over the last financial year:

- WBS reported a 18.75% decrease, with incidents dropping from 16 to 13.
- VCS achieved a 5% reduction, which is particularly encouraging given the ongoing efforts to improve incident reporting as part of the Anti-Violence Collaborative Forum.
- In support of these efforts, VCS held drop-in workshops in partnership with the Cardiff Hospital Liaison Police Officer, promoting personal safety and security. These initiatives reflect the Trust's commitment to reducing violence and aggression while supporting staff wellbeing and a safer working environment.

Focus – Summary of Focus Area Outcomes:

Over the past year, the Trust made meaningful progress across all three health and safety focus areas. A new Health and Safety Technician was successfully recruited, strengthening the team's capacity and enabling greater coverage and responsiveness across key areas. The development of a structured Health and Safety Management System began, with Principle 1 (Leadership and Accountability) in active implementation through monthly audits and executive-led Safety Tours. Although the Welsh Government's 85% compliance target for statutory and mandatory training was not yet fully achieved, the Trust significantly improved performance from 81% to 84%. Efforts to enhance accessibility and accountability have brought the organisation within 1% of the target, reflecting a strong and ongoing commitment to safety, leadership, and staff development across the Trust.

Trends – Combined Incident Theme Summary – WBS & VCS (2021-2025):

An analysis of incident themes across WBS and VCS over the past three financial years highlights three key themes of concern across the Trust:

1 | Slip, Trip or Fall

- This theme has been the most consistent across both divisions, with incidents reported each year in both WBS and VCS.
- These types of incidents point to ongoing environmental and procedural risks, such as flooring hazards, cluttered walkways, and slippery surfaces. Continued focus on workplace safety and preventative measures is essential.

2 | Contact with Object or Animal

- This theme has emerged consistently over the years from both divisions, suggesting that patient care and clinical handling may be contributing factors, particularly in high-risk areas.
- It points to the need for enhanced training and ergonomic risk assessments in environments where staff are regularly interacting with patients or equipment.

3 | Exposure to Hazardous Substances & Sharps/Needles

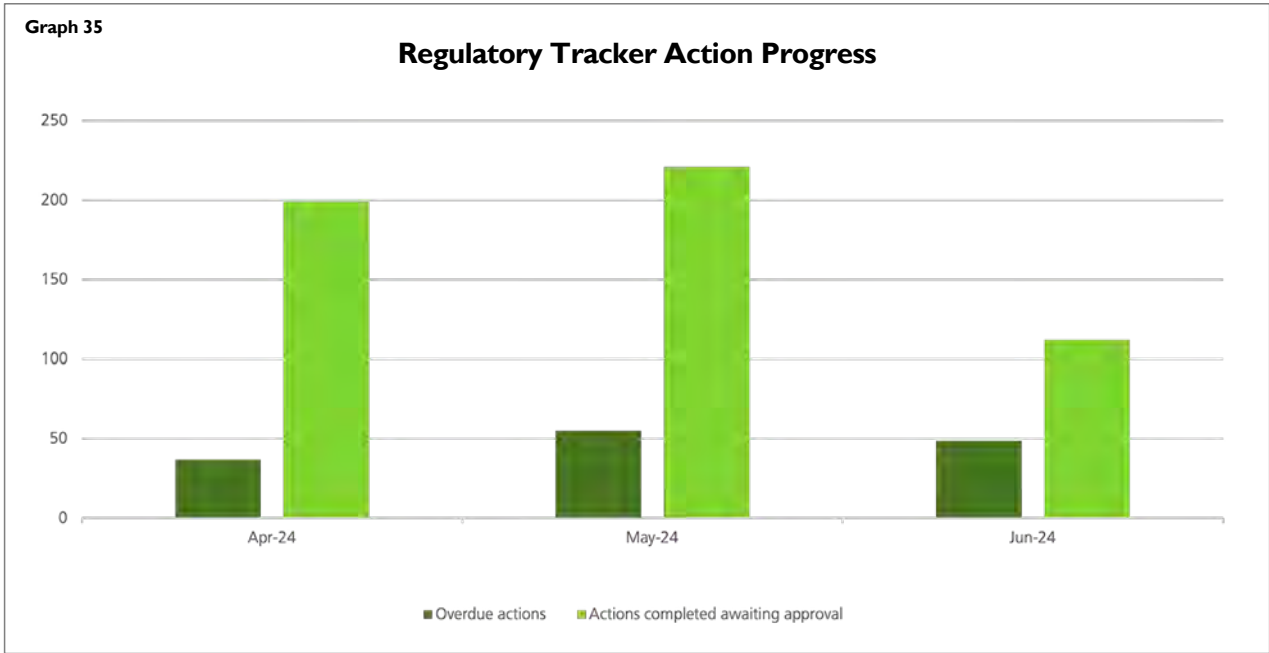
- WBS has reported exposure incidents involving hazardous substances consistently, while VCS has seen sharps/needle-related incidents re-emerge in 2024-2025.
- These incidents highlight the critical need for rigorous protocols, safe handling training, and proper waste disposal practices.

16 Regulatory Quality and Safety Tracker Compliance

During Q1, 2 new improvement plans were added to the Tracker.

- The HIW DNA CPR review improvement plan
- A moderate incident (Duty of Candour) improvement plan (following a missed referral at VCC)

The Tracker contained 13 improvement plans related to the following:



Significant progress was made during both Quarters in:

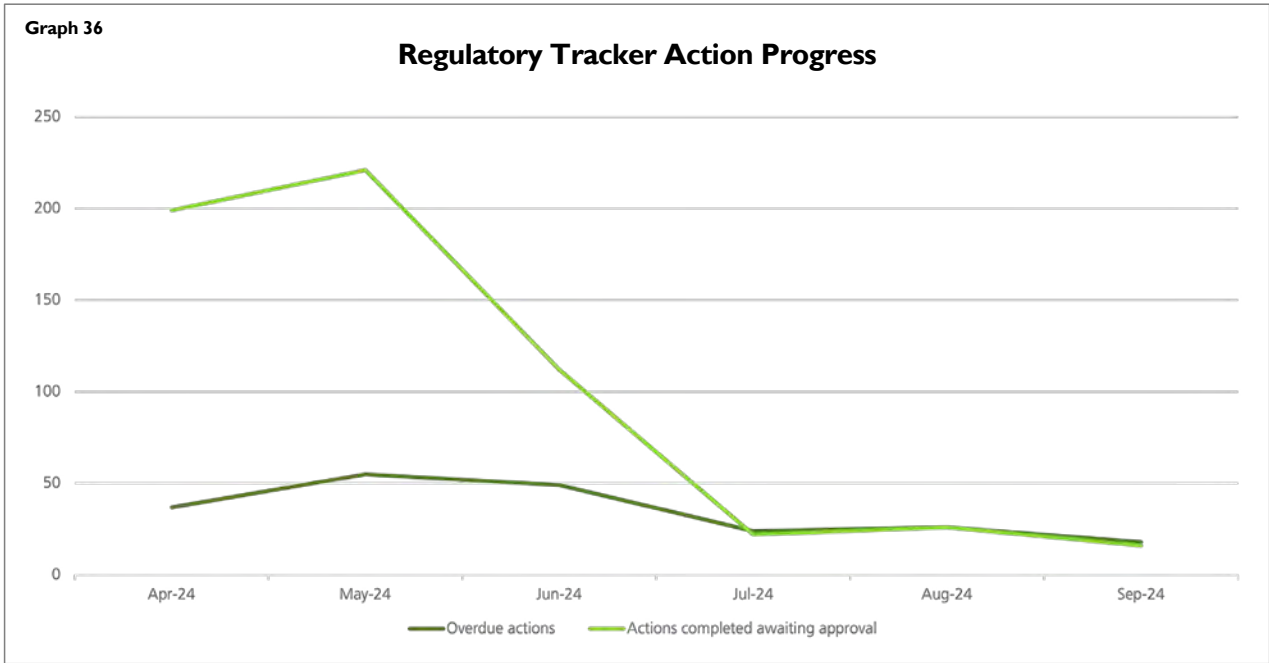
- Completing actions contained in the Regulatory Tracker
- Achieving final sign off for completed actions

This is due to concerted efforts by Divisional teams to address actions and engage with senior leadership to provide evidence of completion.

During Q2, 6 new improvement plans were added to the Tracker.

- 3 Duty of Candour incidents related to Total Parenteral Nutrition (TPN) feeding, delay in treating Metastatic Spinal Cord Compression (MSCC) & missed opportunity for chemotherapy dose reduction
- Medicines Management Internal Audit Report Aug 2024
- United Kingdom Accreditation Service (UKAS) inspection (Welsh Blood Service laboratories)
- Natural Resources Wales (NRW) High Activity Sealed Sources (HASS) inspection (Velindre Cancer Service Radiation Services)

The Tracker contained 17 improvement plans related to the following:



During Q3, 7 new improvement plans were added to the Tracker.

- 15 Step Visit of VCC Pharmacy
- Implementation of Quinolone Prescribing and Counselling Aids
- IR(ME)R (Amendment) 2024 - compliance of Radiotherapy Service
- IRMER CAS-INVES-11653
- MARRS Action Plan (October 2024)
- Pharmacy 15 Step Challenge
- WMDA Inspection 18th - 20th November 2024

The Tracker contained **17 improvement plans** related to the following:



The Quarter showed:

- 50 actions in progress
- 4 actions partially complete
- 1 action partially complete and overdue
- 7 actions overdue
- 19 actions awaiting approval
- 0 rejections
- 6 actions approved unable to complete

Divisions were reminded to approve/sign off the completed actions within their services.

During Q3, 4 new improvement plans were added to the Tracker.

- 15 Step Visit - Radiology Department
- IR(ME)R (Amendment) 2024 – Compliance of Radiotherapy Service
- MARRS Action Plan (October 2024)
- WMDA Inspections 18th-20th November 2024

The Tracker contained 25 improvement plans related to the following:



The Quarter showed:

- 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

17 Priorities for quarter 2025-26

Quality Priorities For 2025-2026

- 1 | Improve patient and donor communications
- 2 | Strengthen Quality & Safety infrastructure
- 3 | Improve patient & donor safety
- 4 | Improve opportunities together and learn from people’s feedback

The Trust quality priorities have been co-produced by the quality hubs, across the Trust. The priorities have been developed based on learning from incidents, concern and reviews.

The 4 main priority themes are:

- Improve Patient & Donor Communications
- Strengthen Quality & Safety infrastructure
- Improve Patient & Donor Safety
- Improve Opportunities to gather and learn from people’s feedback.

Unit 2, Charnwood Court,
Parc Nantgarw, Cardiff, CF15 7QZ

029 2019 6161 | velindre.nhs.wales

TRUST BOARD	
Well-being of Future Generations Act Annual Report 2024-5	
DATE OF MEETING	24 July 2025
PUBLIC OR PRIVATE REPORT	Private
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	DISCUSSION
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Rhiannon Freshney, Sustainability Manager
PRESENTED BY	Lauren Fear, Director of Transformation (Interim)
APPROVED BY	Lauren Fear, Director of Transformation (Interim)
EXECUTIVE SUMMARY	Annual report for Well-being of Future Generations Act 2024-5
RECOMMENDATION / ACTIONS	The Trust Board is asked to APPROVE the annual report.
COMMITTEE / GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING	
COMMITTEE OR GROUP	DATE
Executive Management Board	30 th June 2025
ENDORSED	
QSPC	17 th July 2025
ENDORSED – The QSP Committee acknowledged and welcomed the first annual report for the Well-being of Future Generations Act emanating from an Audit Wales action. Although evidence was collated from across the Trust and allocated to the associated Goals the Committee did question: the breadth and depth of the report, especially as the WFGA had been ongoing for ten years: how has the WFGA embedded the “spirit” of	



legislation across Trust? The Chair of QSPC suggested that this topic could be discussed at a Board Development session and that there are some synergies with the Strategic Development Committee (SDC) and questions relating to resourcing.

QSPC also requested the assurance rating be changed to Level 3 as KPI's were being refined to align with revised goals.

**ASSURANCE RATING ASSESSED
BY EXECUTIVE SPONSOR**

**Level 3 - Actions for symptomatic, contributory
and root causes. Impact from actions and
emerging outcomes**

APPENDICES

1	Well-being of Future Generations Act Annual Report 2024-25

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 TRUST
ASSURANCE FRAMEWORK RISK**

10 - GOVERNANCE

**QUALITY AND SAFETY
IMPLICATIONS / IMPACT**

Safe	☒
Timely	☒
Effective	☒
Equitable	☒
Efficient	☒
Patient Cantered	☒



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED	Not required.
TRUST WELL-BEING GOAL IMPLICATIONS/IMPACT	There are no direct well-being goal implications or impact in the current risks in this paper.
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT	No - Include further detail below
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

Velindre University NHS Trust
Sustainability Manager

Well-being of Future Generations Act Annual Report

2024-2025



Velindre University NHS Trust is responsible for the delivery of a wide range of specialist NHS Wales services including the Velindre Cancer Service and the Welsh Blood Service and we host Health Technology Wales, and NHS Wales Shared Services Partnership.

Caring

We are always kind, supportive, approachable and show compassion to all.



Respectful

We seek to understand other people's perspectives. We are always open and transparent.



Accountable

We always take personal responsibility for what we do and how we do it.



The Velindre Cancer Service is a specialist treatment, teaching, research and development service for non-surgical tertiary oncology services to patients from across south east Wales and further afield.

The Welsh Blood Service provides essential and highly specialised national services including the collection and production of blood and blood components, specialist diagnostic services and antenatal screening, as well as supporting transplant services for solid organs and stem cells across Wales and internationally.

Health Technology Wales assesses non-medicine health and care technologies and produces national guidance on their use in Wales.

NHS Wales Shared Services Partnership delivers a wide range of professional, technical and administrative services to NHS Wales.

Well-being of Future Generations Act Annual Report

2024-2025

Setting and Delivering Our Well-being Objectives

Velindre University NHS Trust remains fully committed to the principles and duties set out under the Well-being of Future Generations (Wales) Act 2015. Our refreshed Trust Strategy — Destination 2033, alongside the Specialist Strategies for Cancer and Blood and Transplantation Services (2023–2033), places sustainability and long-term well-being at the heart of all we do.

In line with Section 3.17 of the Act, the Trust undertook a comprehensive refresh of its Well-being Objectives in 2024, involving internal and external stakeholders working collaboratively with staff, partners, and communities to provide the option for a range of voices were involved in shaping our direction. This inclusive approach reflects the evolving needs of our patients, communities, and workforce. The updated objectives are designed to maximise our contribution to the national well-being goals and ensure the Sustainable Development Principle — with its five ways of working (long-term, prevention, integration, collaboration, and involvement) — is embedded in all strategic and operational decisions.

The Trust is developing Key Performance Indicators (KPIs) for each objective to ensure clearer monitoring, accountability, and impact measurement, as recommended in the Audit Wales thematic review. To strengthen our position and alignment with the Act, in 2025–26 we will integrate our refreshed well-being objectives with our strategic vision and corporate planning processes, in line with the feedback from Audit Wales. This will ensure that the Well-being of Future Generations (Wales) Act continues to be a central organising principle across the Trust. This report demonstrates some of the strong work already underway across the organisation in support of each well-being objective. While not an exhaustive list, the examples included provide a meaningful reflection of the progress being made.



Reduce health inequalities, make it easier to access the best possible healthcare when it is needed and help prevent ill health by collaborating with the people of Wales in novel ways

The Welsh Blood Service's Genetic Haemochromatosis (GH) team is addressing health inequity and improving preventative care by increasing access to blood donation for eligible GH patients. By enabling venesection to take place through blood donation appointments, patients can manage their condition more flexibly and locally, improving their experience and reducing pressure on specialist clinics. Increasing GH patient enrolment in donation is a mutually beneficial initiative - reducing pressure on Clinical Haematology clinic nursing staff while offering GH patients a more flexible and convenient way to manage their venesections at locations and times that better suit their needs.

This initiative exemplifies prevention through early intervention and long-term thinking and has been developed through strong collaboration across hospital teams and the Welsh Blood Service.

The Trust Value Based Healthcare grant funding will support the expansion of this initiative by funding a Senior Nurse position, who will help establish a referral support service across all hospitals in Wales, connecting people with GH with the Welsh Blood Service. The service will seek to create an integrated approach that connects clinical services with donation opportunities, expanding the reach and efficiency of care.



Based at Nevill Hall Hospital, the new radiotherapy unit is set to enhance patient experience and bring additional radiotherapy capacity to south-east Wales cancer treatment services. Delivered in partnership between Velindre Cancer Service and Aneurin Bevan University Health Board, the unit will be staffed by a team of Velindre Cancer Service experts and will operate as an extension of Velindre Cancer Centre in Cardiff. Work has progressed throughout 2024 –25 to ensure the facilities opens in the summer of 2025, the state-of-the-art facility will eventually increase radiotherapy capacity in the

region by up to 20%. The unit will initially treat breast cancer, prostate cancer and palliative radiotherapy patients who meet a set of clinical criteria. Delivering precise and effective radiotherapy treatments from two advanced linear accelerator machines, the unit will also offer tailored radiotherapy planning, regular on-treatment reviews, comprehensive on-treatment education, and advanced imaging with a CT simulator. This work aligns with our ambitions for care closer to home.

To continue to provide care closer to home, the Trust has introduced the Self-Administration of Subcutaneous Treatment led by 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.

Improve the health and well-being of families across Wales by striving to care for the needs of the whole person

The Trust's partnership with Ray of Light Cancer Support provides nature-based and therapeutic programmes support holistic care by addressing physical, emotional, and mental well-being. Initiatives like the maintenance of pollinator-friendly habitats, wildflower planting, and the staff-led beehive at Talbot Green promote biodiversity and reconnect staff and patients with nature. Our partnership with Ray of Light Cancer Support has grown to include Social and Therapeutic Horticulture sessions, directly supporting patients through meaningful engagement with the natural world. These initiatives reflect long-term thinking by investing in the environment and well-being, and they embody integration by linking green spaces with clinical and therapeutic services. Through involvement, patients and staff co-produce these spaces and activities, ensuring they meet real needs.



The Trust's Arts in Health programme supports patient wellbeing through creative engagement, aligning with the Well-being of Future Generations (Wales) Act by applying the five ways of working—long-term impact, prevention, integration, collaboration, and involvement. Projects include a partnership with St Fagan's National Museum of History, where a pilot social prescribing course for patients with cancer has evolved into Anadlu, a regular mindful walking and creative support group. Ongoing initiatives such as the BBC National Orchestra of Wales's on the Wards, opera performances, weekly Art Cart sessions,

and poetry engagement foster connection, emotional expression, and therapeutic benefits. This work contributes to the well-being goals of A Healthier Wales, A More Equal Wales, A Wales of Vibrant Culture and Thriving Welsh Language, and A Wales of Cohesive Communities.

The Equality, Diversity and Organisational Development Manager leads regular marking of religious holidays, creating safe forums for discussion, peer support, and learning. This work directly supports this objective to recognising that inclusive, psychologically safe working environments contribute to both individual and organisational well-being. It aligns with the national well-being goal of A More Equal Wales, while also fulfilling duties under the Social Partnerships and Public Procurement (Wales) Act 2023, where workforce involvement in shaping inclusive policies is a key requirement. Wales, while also fulfilling duties under the Social Partnerships and Public Procurement (Wales) Act 2023, where workforce involvement in shaping inclusive policies is a key requirement.



Create new, highly skilled, jobs in Wales and attract investment by increasing our focus on research, innovation and new models of delivery

In March 2025, the Value Intelligence Centre hosted two Value Labs events, empowering multidisciplinary teams to explore and accelerate value-based healthcare projects. These sessions supported a collaborative and integrated approach to innovation, involving staff across Welsh Blood Service and Velindre Cancer Centre in shaping new care models, examples of the initiatives discussed:

- Establishing a Genetic Haemochromatosis Blood Donor Enrolment Service – Welsh Blood Service
- Reducing variation in the use of Intraoperative Cell Salvage for major surgery procedures – Welsh Blood Service
- Evaluation of New Blood Packs in preparation for legislative changes – Welsh Blood Service
- Liquid Biopsy for Cancer of Unknown Primary to improve outcomes and pathway effectiveness – Velindre Cancer Service
- Self-Administration Pathways to improve patient experience and outcomes – Velindre Cancer Service

These events not only strengthen the long-term transformation of services but also embed prevention by prioritising patient outcomes and sustainable resource use. They foster a learning culture and demonstrate how bringing together expertise from across divisions results in more impactful, joined-up healthcare delivery.

The Innovation team launched 'Bright Ideas', an innovative platform enabling staff to contribute ideas aligned with the Trust's strategic objectives. The initiative empowers staff, builds capacity and capability, and supports the Trust's commitment to implement the ISO 56001 Innovation Management System. A pilot launched in December 2024 has led to successful engagement, with plans for Trust-wide rollout early 2026.

Deliver bold solutions to the environmental challenges posed by our activities

Our ISO 14001:2015 certification reflects long-term environmental governance and robust operational control across all sites. Locally tailored Sustainability Implementation Plans were introduced at every site to empower departments to set their own goals around waste, energy, travel, and staff engagement — embedding prevention and enabling ownership across the organisation.

Circular economy initiatives, like the Walking Aid Recycling Scheme at Velindre Cancer Centre, reduce emissions and NHS resource use. Developed in partnership with Men's Sheds and Walters UK using felled trees from the nVCC site, this project represents an integrated solution to waste, rehabilitation, and community engagement. It also demonstrates collaboration between capital, clinical and voluntary sector teams — and is being scaled through the All-Wales Spread and Scale Academy.

Similarly, the Trust launched a new Cycle to Work Scheme with electric bike options and multiple retailers, responding to staff feedback gathered through travel surveys. This not only supports low-carbon commuting but reflects how involvement and collaboration can drive successful implementation.

Our move to a paperless radiotherapy workflow after two years of collaboration with Varian is a flagship example of how long-term planning, digital innovation, and integrated clinical operations can lead to significant environmental and patient care benefits. This transformation will save substantial resources, eliminate printing and storage demands, and enhance patient safety and record accuracy — exemplifying how sustainable innovation can also drive excellence in service delivery.

Demonstrate respect for the diverse cultural heritage of modern Wales

At The Trust, the 'Active Offer' has been the focus for the service this year. Proactively the Trust has founded a relationship with Menter Rhondda Cynon Taf and now run a Welsh Language discussion group once a week. Staff who are learning or need to raise their confidence in the language can attend and have informal discussions. Lessons are also provided for reception staff with specific topics agreed to suit their areas of work and improve their ability to answer the telephone bilingually.



The divisional Welsh Language working groups continue to promote and provide guidance to staff on the requirements of the Welsh Language Standards. Velindre Cancer Services' governance structure has been changed to ensure the Welsh Language priorities feed into the main planning group at the centre. Highlighting the needs of the service to senior managers and ensuring a cohesive approach to embedding the Welsh language in all that we do.

Arts in Health is a new initiative for Velindre University NHS Trust and it has taken time, vision and a lot of energy from all areas of the organisation to develop the programme from scratch. launched the arts programme with a month-long celebration which invited staff to experience the benefits of Arts in Health for themselves. More than 200 staff engaged. Activities included:

- Online talks, a poetry reading
- workshop by Ray of Light
- Welsh National Opera singing workshop
- creative mindfulness
- screen printing workshop
- a creative writing workshop
- art trail



Bring communities and generations together through involvement in the planning and delivery of our services

The Trust expanded our approach to delivering social and environmental value through procurement, planning, and capital projects. Our Community Benefits initiatives - embedded in both the new Velindre Cancer Centre (nVCC) and Talbot Green Infrastructure Upgrade, ensures employment, skills, community grants and local economic growth are monitored and maximised. The Hefyd initiative enabled staff and patients to co-create habitat homes and contribute to local biodiversity improvement through engagement. Our capital development approach for the new Velindre Cancer Centre and Talbot Green Infrastructure embeds carbon, biodiversity, and well-being metrics from design to construction. The Community Benefits Governance Board was formed and has successfully funded local community projects. The Board is comprised of partnerships with community groups and voluntary sector organisations have enabled co-creation of site infrastructure using sustainable, locally sourced materials.

As part of the Hefyd programme, the Trust's Sustainability Team, together with the new Velindre Cancer Centre Project Team, continue to hold Sustainable Jamborees for patients, staff and local community engagement. The Sustainable Jamborees held across summer, autumn and spring—bringing together staff, patients and local communities through events that promote well-being, climate literacy, biodiversity awareness and creativity. A range of different activities were hosted including arts & crafts for the local community, habitat home building and biodiversity themed activities.



To engage with as many service users, staff and members of our local community as possible, it was important that we engaged in a variety of different ways in both Welsh & English. The Jamborees were extensively promoted online through Twitter posts, staff newsletters & the intranet, news updates and via staff word-of-mouth, yet we recognise that not everyone is digitally connected. To ensure we were accessible and inclusive to as many people as possible, clear & well-placed signage and posters were placed around the Cancer Centre. Posters were also placed in Whitchurch Library to make sure we engaged with as many of our local community as possible.

Strengthen the international reputation of the Trust as a centre of excellence for teaching, research and technical innovation whilst also making a lasting contribution to global well-being

The Trust's innovation portfolio has expanded through the absorption of 2 new programmes in the period and the development of the ISO 56001 programme of work. The portfolio encompassing a range of projects and initiatives that drive forward its strategic objectives. Key areas of focus include advanced radiotherapy, workforce development, and the integration of cutting-edge technologies to improve patient care through innovation pipeline development and innovation adoption.

16 Open Projects					
Innovation overview		Year	Q4	Programme projects	
	Projects	51	(+41)	ARC	5
	Programmes	4	(+4)	→ ARF	33
	Education and training	5	(0)	Bright ideas	2
	Promotion	31	(+8)	CCfLRI	1

Launched in 2023, the Advancing Radiotherapy Cymru (ARC) programme formally became part of the innovation portfolio programmes in 2024. ARC is an all-Wales programme aimed at driving innovation in radiotherapy treatment. With £3 million in funding over five years, ARC supports projects that align with its five themes, including supporting innovation within radiotherapy, training the workforce, and expanding patient access to services. As of Q4 2024, five projects were approved, such as the Velindre Oncology Academy and the PRECISION study.

The Component Development & Research Lab have been progressing in the large-scale laboratory validation of new blood packs. Having identified that their team is spending excessive time on non-value-adding tasks, they have been awarded funding for an Associate Practitioner post. This role will help expand capacity for senior scientists, allowing them to focus on essential blood component research.

Future Generations Report and Audit Wales Report

A decade into its implementation, two significant reports—the Future Generations Report 2025 by the Future Generations Commissioner and “No Time to Lose” by Audit Wales—provide critical insights into the progress and challenges faced in realising the Act's vision.

While the Audit Wales report primarily assesses the Welsh Government’s leadership role, alongside selected reviews of other public services, it provides important lessons and examples of what effective implementation looks like. The Future Generations Commissioner’s report includes 50 specific recommendations (some for Welsh Government, some for public bodies) for improving national delivery of the Act’s aims, with direct relevance to local implementation. This integrated review consolidates recommendations from both reports and the Audit Wales report from 2024, which identifies how Velindre can align its own sustainability and well-being objectives, governance, and assurance systems with national priorities. For the Trust, these reports offer welcome guidance to align its strategies with national objectives and will prove valuable during the integration of the Well-being Objectives and strategic direction in 2025/26.

Key Findings:

- **Mixed Progress:** While there have been improvements in areas like volunteering, significant challenges remain in health inequalities, youth well-being, and climate action.
- **Youth Challenges:** Post-pandemic, children and young people face declining life satisfaction, reduced participation in sports, and lower educational attainment.
- **Climate Concerns:** Greenhouse gas emissions increased by 7% from 2020 to 2021, indicating a need for urgent climate action.
- **Cultural Risks:** Climate change threatens cultural heritage sites, with many at risk due to flooding and erosion.

Recommendations:

- **Accelerate Climate Action:** Implement urgent measures to reduce emissions and protect biodiversity.
- **Support Youth Well-being:** Invest in programs targeting the health and education of young people.
- **Protect Cultural Heritage:** Develop strategies to safeguard cultural sites from climate impacts.
- **Promote Equity:** Address disparities in health, education, and economic opportunities.

Audit Wales Report: "No Time to Lose"

Key Findings:

- **Implementation Gaps:** Despite the Act's intentions, public bodies often fail to fully integrate its principles into decision-making.
- **Preventative Focus Lacking:** There's insufficient emphasis on preventative measures in public services.
- **Need for Systemic Change:** The Act has not yet driven the widespread systemic change envisioned.



Recommendations:

- **Embed Act Principles:** Ensure that long-term thinking, prevention, integration, collaboration, and involvement are central to all public body operations.
- **Enhance Accountability:** Develop mechanisms to hold public bodies accountable for implementing the Act.
- **Invest in Prevention:** Allocate resources towards preventative services to reduce future burdens.

Conclusion and Next Steps

Our progress in 2024–25 and review of the objectives demonstrates our commitment to embedding the Well-being of Future Generations Act as a central organising principle. The Audit Wales review, and the two assessment reports provide guidance for the Trust and how we can strengthen our commitment and action to meet the ambitious goals in the Act. Over the coming year, we will:

- Finalise and publish KPIs for each Well-being Objective.
- Strengthen internal reporting and public transparency.
- Integrate our well-being objectives with our strategic vision and corporate planning to further embed the Act in all levels of decision-making.
- Share learning and collaborate further with other NHS Wales organisations.

We are proud of the progress we have made — and excited to continue working with our communities and partners to create a greener, healthier, and fairer Wales.

Unit 2, Charnwood Court,
Parc Nantgarw, Cardiff, CF15 7QZ

029 2019 6161 | velindre.nhs.wales



TRUST BOARD	
Duty of Quality Annual Report 2024-2025	
DATE OF MEETING	24 th July 2025
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Tina Jenkins, Head of Quality, Safety & Assurance
PRESENTED BY	Tina Jenkins, Head of Quality, Safety & Assurance
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences
EXECUTIVE SUMMARY	This is the Trust's second Duty of Quality report that has been developed in line with the Duty of Quality statutory requirement. The report includes the steps the Trust has taken to comply with the duty and improvements that have been made across our services. The Trust reached out to Llais to gather views of the public on how they would like to see information presented. It is recognised that this report will mature in future years. Key messages are. • The Trust has made good progress on the agreed quality priorities for 2024-2025. However further work is required during 2025/26. • The Trust has adopted and implemented the national Quality Impact Assessment process to support quality led strategic decisions • The Trust has developed its quality hubs and collaborative working. • A selection of improvements made across the Trust are included mapped against the domains of quality and quality enablers. • Further work is required to develop our quality data and always on reporting metrics.

RECOMMENDATION / ACTIONS		To APPROVE the Trust Duty of Quality Annual Report prior to translation and publication on the Trust’s website.
GOVERNANCE ROUTE		
List the Name(s) of Committee / Group who have previously received and considered this report:		Date
Integrated Quality and Safety Group		25/06/2025
Executive Management Board		30/06/2025
Quality, Safety & Performance Committee		17/07/2025
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS		
<i>Integrated Quality & Safety Group</i> - Agreed contents of the report. <i>Executive Management Board</i> – Endorsed for approval and agreed an overall assurance rating of a level 4. <i>Quality, Safety & Performance Committee</i> - Endorsed for approval and agreed an overall assurance rating of a level 4. Request for acronyms to be removed and a plain English review. This has been completed where possible, however due to the short turnaround time the acronyms from images will be amended prior to publication on the Trust’s website.		
7 LEVELS OF ASSURANCE		
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR		(2023-24 Assurance Rating – 3) Level 4 - Increased extent of impact from actions
APPENDICES		
Appendix 1	Duty of Quality Annual Report 2024-2025	
Appendix 2	NWSSP Duty of Quality Annual Report 2024-2025	

1. BACKGROUND

The Welsh Ministers are required to publish an annual quality report on the steps they have taken to comply with the duty to exercise their functions in relation to the health service with a view to securing improvement in the quality of health services. The report must include an assessment of the extent of any improvement in outcomes achieved by virtue of those steps, and the Welsh Ministers must lay a copy of the report before the Senedd.

Each Local Health Board, NHS Trust and Wales-only Special Health Authority is required to publish an annual quality report on the steps it has taken to comply with the duty to exercise its functions with a view to securing improvement in the quality of health services. The report must include an assessment of the extent of any improvement in outcomes achieved by virtue of those steps.

2. ASSESSMENT

2.1 Duty of Quality Annual Report

Quality reporting requirements (Duty of Quality Statutory Guidance 2023)

The annual quality report allows actions taken by NHS bodies and quality improvements to be monitored transparently. The report should describe the progress and challenges on the quality journey to their respective population and stakeholders. Quality reporting needs to be meaningful for NHS bodies, their stakeholders and our population if it is to optimise real time learning, improvement and sharing opportunities. Quality reporting should reflect the breadth of the Health and Care Quality Standards and quality management system within its structure and content.

'NHS bodies may choose to use various qualitative and quantitative data and information to support their quality reporting duty. They should focus on information that will demonstrate the duty of quality in decision-making, action taken following learning, quality improvement and ultimately, improved outcomes for the population. The Health and Care Quality Standards and quality management system components provide a quality report structure. It is recognised that there is already significant work underway across the health system relating to indicators and measures. The intention is that NHS bodies will make use of information and reporting mechanisms already in place wherever possible. They will need to adopt an agile approach to mature their quality report as outcome measures develop, aligned to the Health and Care Quality Standards.'

- *The annual quality report is intended to summarise and reflect an NHS body's progress to improve the quality of their services and population outcomes. It is anticipated that NHS bodies will sign-post readers to the information provided through the 'Always on' reports that outline learning and improvements that have been made at regular intervals through the year.*
- *The annual quality report should include a look back at what has been achieved, including where things may not have gone well, together with a forward look about the organisation's quality priorities and ambitions for the upcoming year, alongside how progress will be monitored. There should be continuity between annual reports across subsequent years.*
- *The annual quality report will describe what key strategic decisions have been taken by the NHS body, and how the duty of quality has informed these decisions.*
- *The annual quality report should be prepared as soon as practicable after the end of each financial year. To streamline reporting requirements and reduce duplication, it is suggested that NHS bodies align the annual quality report to their Annual Report and Accounts process.*
- *Examples of evidence to be used to assess the duty of quality and the extent of any improvement in outcomes includes:*

- *Existing performance, outcome and delivery indicators and measures from the quality management system*
- *Patient Reported Outcome Measures and Patient Reported Experience Measures (PROMS and PREMS)*
- *Mortality data*
- *Information contained within the Once for Wales Concerns Management System such as incidents and concerns.*
- *Patient and staff stories*
- *Strategic decision-making that has been driven by the Health and Care Quality Standards*
- *Reports following external reviews or inspections by inspectorate and licensing bodies.*
- *Consideration of the recommendations and implications of significant national reports, for example, following national inquiries.*

2.2 Planning for our Duty of Quality Annual Report

Key messages from the Duty of Quality Report Meeting:

- A template will not be prescribed or shared from the NHS Executive or Welsh Government.
- The report should be prepared for the reader as a member of the public.
- The Quality Annual Report should have a chair and chief executive summary.
- We should ask our population what they want to know and how they would like information presented.
- Ensure that the report is linked to the organisation's strategic quality priorities.
- Include the Trust priorities for next year.
- Present your report as a story, this is not an assurance report for the organisation.

2.3 What Llais told us in relation to what members of the public want to see in a Duty of Quality Annual Report

- Information should be straight to the point, using everyday language and large print to ensure everyone would be able to read and understand the information. It may be helpful to use colour and images to make the Report more engaging.
- It would be helpful to include information around what the Organisation has done (i.e., events/activities/projects), and how this has had a positive impact and change to the public and/or patients. It comes back to the phrase of 'what does this mean for me'. We know that the public don't always see the strategies or high-level work, they just want to know what it means for them and the care that they receive.
- It would be helpful to include figures such as the number of people engaged with, what communities you have engaged with, as well as any themes coming through – it would be good to include some direct quotes from people you have engaged with.

- As part of the above information, you may also want to include figures around the number of complaints/concerns you have received and again highlight the common themes being picked up.
- Finally, it might be helpful to include a section around what your plans are for the future, so that people can have an idea of what is going on and how this may affect them.

3. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals:	
• Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) For more information: STRATEGIC RISK DESCRIPTIONS	06 -Organisational and Clinical Governance
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	Provides Quality, Safety and Performance Committee with the details of discussions held and decisions made at both the Integrated Quality and Safety Group and Quality, Safety and Performance Committee which impact upon all domains of quality.
QUALITY IMPACT ASSESSMENT	Not required - not a strategic decision

SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: For more information: https://www.gov.wales/socio-economic-duty-overview	Not required This report provides details of discussions and decisions made within Integrated Quality and Safety Group and Quality Safety and performance Committee as opposed to service delivery and approach change with a direct impact upon Socio Economic Duty.
TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT	
The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated. Please indicate whether any of the matters outlined in this report impact the Trust's Wellbeing goals: YES - Select Relevant Goals below	
If yes select the relevant goals: • A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities. ☐ • A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience. ☐ • A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health ☒ • A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances ☐ • A Wales of more Cohesive Communities - Attractive, viable, safe and well-connected communities. ☐ • A Wales of Vibrant Culture and Thriving Welsh Language -Promoting and protecting culture, heritage and the Welsh language, encouraging people to participate in the arts, and sports and recreation. ☐ • A Globally Responsible Wales – Consideration of whether an action may make a positive contribution to global well-being ☐	
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx	Not required - please outline why this is not required This report provides details of discussions and decisions made within Integrated Quality and Safety Group as opposed to service delivery and approaches change that would require an equality assessment.

ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

4. RISKS

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

Velindre University NHS Trust

Duty of Quality Report

1 April 2024 – 31 March 2025



Velindre University NHS Trust is responsible for the delivery of a wide range of specialist NHS Wales services including the Velindre Cancer Service and the Welsh Blood Service and we host Health Technology Wales, Advanced Therapies Wales and NHS Wales Shared Services Partnership.

Caring

We are always kind, supportive, approachable and show compassion to all.



Respectful

We seek to understand other people's perspectives. We are always open and transparent.



Accountable

We always take personal responsibility for what we do and how we do it.



The Velindre Cancer Service is a specialist treatment, teaching, research, and development service for non-surgical tertiary oncology services to patients from across southeast Wales and further afield.

The Welsh Blood Service provides essential and highly specialised national services including the collection and production of blood and blood components and supporting the transplant programmes through the Welsh Transplantation and Immunogenetics Laboratory services.

Health Technology Wales assesses non-medicine health and care technologies and produces national guidance on their use in Wales.

NHS Wales Shared Services Partnership delivers a wide range of professional, technical, and administrative services to NHS Wales.

Velindre University NHS Trust

Duty of Quality Report

1 April 2024 – 31 March 2025

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Foreword

Chair & Chief Executive Officer

We are really pleased to provide you with Velindre University NHS Trust’s 2024 – 2025 Duty of Quality Annual Report. This is our second report since the Duty of Quality legislation was enacted in April 2023. This report provides you with an overview of what we have been doing over the last year to improve both the quality oversight and infrastructure across the Trust and the quality of the services, care and treatment we provide to our population, patients and donors. At the centre of how we operate as a Trust is to always strive to provide the very best care we can for our patients and donors and when we don’t get this right to learn from this and continually improve.

We have worked with LLAIS and the Trust’s engagement team to further enhance our report this year by, requesting feedback on last years’ report and asking what, in addition our patients, donors and public would like to see in future reports.

We have developed our Quality and Safety Management System this year to ensure that quality, patient / donor safety and experience is firmly at the heart of everything we do, within every decision we make, enabling the active involvement of both the people who receive care / services and those who provide it, whilst placing a focus on learning and improvement.’

For this to be successfully realised, we have been working on creating a ‘just’ culture of openness, transparency, psychological safety and collaborative and compassionate leadership approach. This, our Duty of Quality Annual Report will look back at some of the achievements that we have made to improve the quality of our services.



David Donegan,
Cheif Executive Officer



Professor Donna Mead,
Trust Chair

Introduction

This is the second Velindre University NHS Trust (“the Trust”) Annual Duty of Quality Report. This Quality report is intended to summarise and reflect the Trust’s progress to improve the quality of our services and population outcomes during the last year. The report describes the progress and some of the challenges on our quality journey and reflects the breadth of the health and care quality standards. These standards are part of the Duty of Quality which was brought into effect on the 1st April 2023 through the Health & Social Care (Quality Engagement) (Wales) Act 2020. This legislation defines quality as:



“Continuously, reliably and sustainably meeting the needs of the population we serve.”

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.

Looking back – Quality Priorities 2024/2025

The Trust's goals for improving quality in 2024-2025 were planned by looking at what could be improved and what lessons could be learned from past incidents and complaints. Any goal that wasn't fully completed will be included in the 2025-2026 goals to make sure it gets done.

WHAT WE HAVE ACHIEVED	BEING PROGRESSED	
We have introduced foetal D Screening for Rhesus D negative pregnant women across Wales	Revising our administrative and patient communication mechanisms across Velindre Cancer Service e.g. revised regional referral mechanism	Reviewing and improving our donor selection and screening processes
We have successfully introduced West Nile Virus testing within the Welsh Blood Service	Developing robust Cancer Site-Specific Quality Metrics	Undertaking targeted work to create psychologically safe environments
Clinical Audit has been integrated within VCS Quality and Safety function	Improving incident and risk management processes across Velindre Cancer Service	Implementing live digital connectivity across community-based donation clinics to enable real time access to all digital systems
We have achieved JACIE accreditation for the Welsh Bone Marrow Donor Registry (WBMDR)	Introducing 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	Introducing Human Leukocyte Antigen testing electronic result transfer between Welsh Blood Service and NHSBT, to reduce manual transcription risks

Trust Quality Framework

The framework aims to provide a strong foundation and structured approach to ensure every level of our organisation functions as an effective quality management system, ensuring the care and services we provide are high quality, consistent, person focused and aligned with the needs of the population we serve. To achieve this the framework has been developed in line with the six domains of quality (safe, timely, effective, efficient, equitable and person centred) and six quality enablers (leadership, workforce, culture, information, learning and improvement and whole systems approach) in line with the requirements of the Duty of Quality (Wales) (2023). The framework was refreshed in November 2024 to include the Trusts quality management system.



Through the development of our Quality Management System, we aim to:

- Enable a positive, psychologically safe, and Just quality culture through the provision of compassionate leadership.
- Enable a shared responsibility and voice for Quality to ensure the provision of safe, timely, effective, efficient, equitable and person-centred care.
- Embed Quality Driven Decision Making at all levels of the Trust.
- Demonstrate a quality approach based upon learning and continuous improvement.

Trust Quality Management System Progress

Quality Planning	Quality Improvement	Quality Control	Quality Assurance
Revising and embedding Trust Quality Framework	Enhanced multi-professional research & innovation opportunities	Performance Management Framework aligned to the Health & Care Quality Standards (STEEEP)	Quality Matrix and Outcome Framework Development
Quality, Safety & Experience Outcomes used to agree IMTP & Improvement priorities	Quality Priorities determined through quality, safety & experience outcome mapping	Trust Incident Framework developed and launched	Improved governance and assurance through AMaT Quality & Regulatory Tracker
Embedding Quality Impact Assessments (QIA) across org. – practical guidance sessions	Learning Framework developed and implemented – internal & external learning (reflective learning events)	Agreed audit plan for Quality & Safety activity	All quality & safety procedures updated in line with Duties of Quality & Candour.
Embedding Quality Impact Assessment Process & alignment of Quality Priorities in IMTP process	Successful 5 Minute Improvement programme (WBS) – Roll out planned VCC	Quality & Regulatory Tracking via AMaT system	Internal Audit Duty of Candour & Duty of Quality Audits planned (Q3 &4)
Development of Trust Clinical & Scientific Strategic Board / Clinical & Scientific strategy	Revised Trust Values, focussed cultural work focussing on creating culture of psychological safety	Strengthened Quality Hub working to provide analysis of key outcomes, activity, learning and improvement	Further expanding 'Always On' Reporting Measures inc. publication of our first Duty of Quality Annual Report
Improving patient & donor feedback mechanisms to feed into quality planning	Strengthening mortality review processes and monitoring	Adoption of national Duty of Candour and national incident reporting procedures	
Integrated Quality & Safety Group & Quality Hubs co-ordinating quality planning at all levels			

Quality Driven Decision Making

A Quality Impact Assessment is a tool for considering and capturing the impact of proposals / decisions on the Quality of our healthcare system, to inform strategic decision-making. Key to the success of the implementation of the Quality Impact Assessment across healthcare in Wales is that it must be proportionate, have clinical sign-off, and feed into existing corporate processes rather than creating new ones. Organisations must be able to evidence that their strategic decisions have been made through a Quality lens.

The Quality Impact Assessment has been undertaken for several strategic decisions between 1st April 2024 and 31st March 2025. These are summarised below.

Electronic Prescribing and Medicines Administration

It was proposed that the Trust adopts the Electronic Prescribing and Medicines Administration system, aiming to replace traditional paper-based prescribing with a fully digital platform. This initiative is designed to enhance the quality of care by significantly improving medication safety, reducing prescription errors, and supporting evidence-based

Quality-driven decision-making
Quality Impact Assessment

Title of proposal this Quality Impact Assessment (QIA) is supporting: *For example: Use of business case*

Reference of proposal: *For example: J20001234567890*

Details of Board Committee the paper is being presented to and where: *For example: Audit Committee on 20/09/2024*

Part 1: Health and Care Quality Standards assessment

1.9. Briefly outline how this proposal or strategic decision impacts on the delivery of healthcare services (in line with STEEP Quality Standard).

Quality Standard	Positive (Y/N) Meets / Exceeds (Y)	Negative (Y/N) Does not meet (N)	Level of impact High (H) Medium (M) Low (L)	Impact Positive Negative Neutral	Key points and rationale
Click each icon for its definition					
Overall impact	<i>Using the key points and rationale and scores above, summarise in words whether the overall impact appears to be positive or negative, and the overall level of that impact (High, Medium, Low). Please note that numerical sums may cancel each other out.</i>				

decision-making. The Electronic Prescribing and Medicines Administration system integrates real-time tracking, decision support, and improved auditing capabilities, ensuring safer, more efficient workflows for clinical staff. By streamlining processes, it not only reduces delays and enhances patient outcomes but also aligns with sustainability goals by eliminating paper usage. Comprehensive training and change management strategies are proposed to support staff in adapting to the new system. The implementation of Electronic Prescribing and Medicines Administration promises to strengthen the quality, safety, and efficiency of the services NHS Wales provides to patients.

Blood Establishment Computer System Business Case

It was proposed that the Trust procures an upgraded Blood Establishment Computer System to manage the collection, processing, distribution, and tracking of blood and components across Wales. This replacement is critical to ensuring continuity of service after the current system ends in 2027. A new Blood Establishment Computer System will enhance patient safety, regulatory compliance, operational efficiency, and donor management while reducing errors and administrative burdens. The Quality Impact Assessment highlights overwhelmingly positive impacts on safety, timeliness, and effectiveness, with risks like project complexity and resource needs mitigated through phased implementation and strong stakeholder engagement. This investment will strengthen the resilience and quality of the Welsh Blood Service, ensuring it remains fit for the future.

Clinical and Scientific Strategy

It was proposed that the Trust adopts the new Clinical and Scientific Strategy to set the clinical and scientific vision, strategic aims, and objectives for the next five years. The strategy is needed to ensure that the Trust remains clinically and scientifically driven, aligning local priorities with national policies and statutory requirements. The strategy creates a shared vision to guide improvements, strengthening clinical and scientific leadership, driving innovation and transformation, and improving collaboration for sustainable services and enhanced outcomes for patients and donors. The strategy's overall impact is assessed as positive across all quality domains—safety, timeliness, effectiveness, efficiency, equity, person-centredness, leadership, workforce, culture, information, learning, and whole-systems approach—with recommended ongoing monitoring to ensure progress and early identification of any issues.

Implementation of the new Welsh Blood Service Research Development & Innovation Strategy

It was proposed that the Trust adopts the new Welsh Blood Service Research, Development & Innovation Strategy, highlighting its positive impact on safety, effectiveness, efficiency, and person-centred care by fostering innovation, reducing health inequalities, and supporting evidence-based decisions. The strategy emphasizes strong leadership, workforce development, and enhanced digital capabilities, with most initiatives building on existing

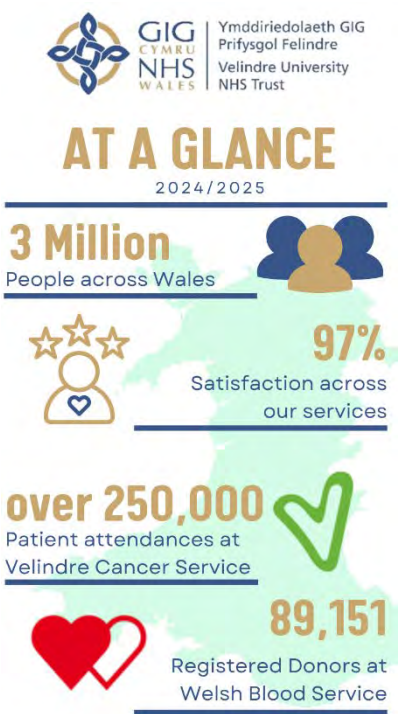
activities. Overall, the strategy is assessed as offering significant benefits to improve quality and outcomes.

Quality Data

The Trust develops and publishes a quarterly and annual public integrated quality and safety report. This report provides analysis of key outcomes, activity, learning and improvement, where possible, and provides themes, trends, and comparative data. The report provides assurance in relation to key legislative requirements including Putting Things Right Regulations (2011) & 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, Efficient, Equitable and Person-Centred Care.

Please see the link below to view the full report:

INSERT LINK

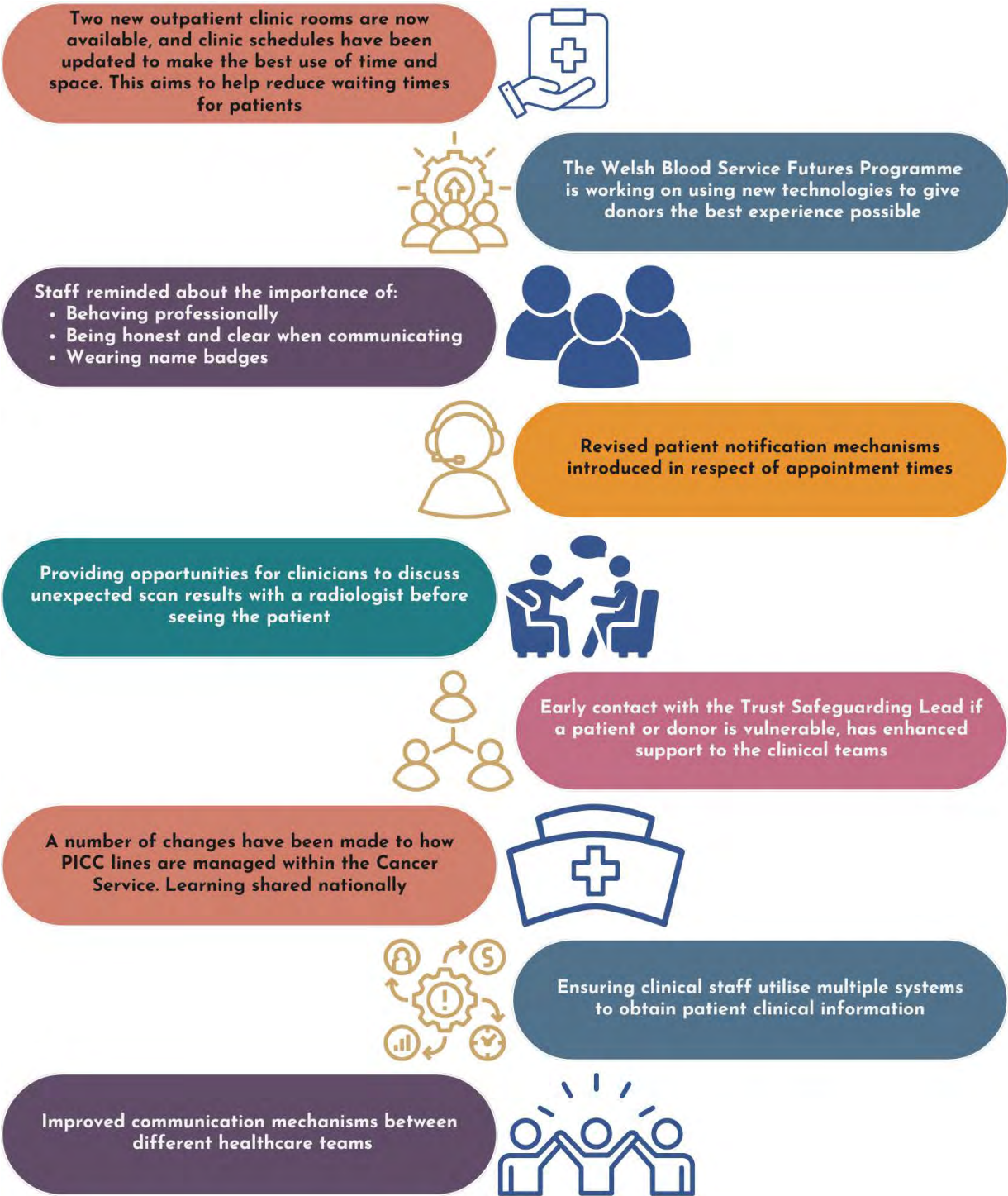


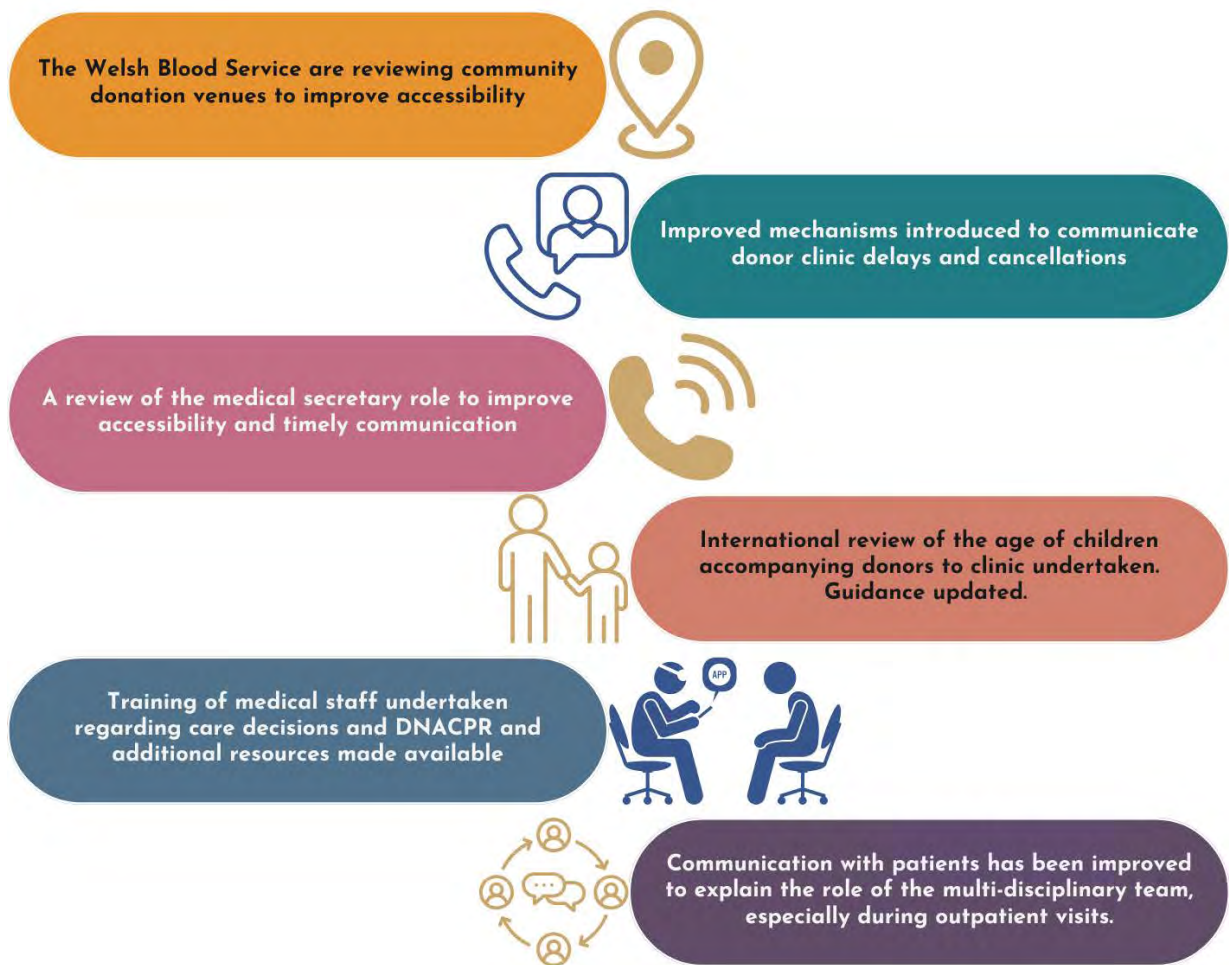
Activity at a Glance



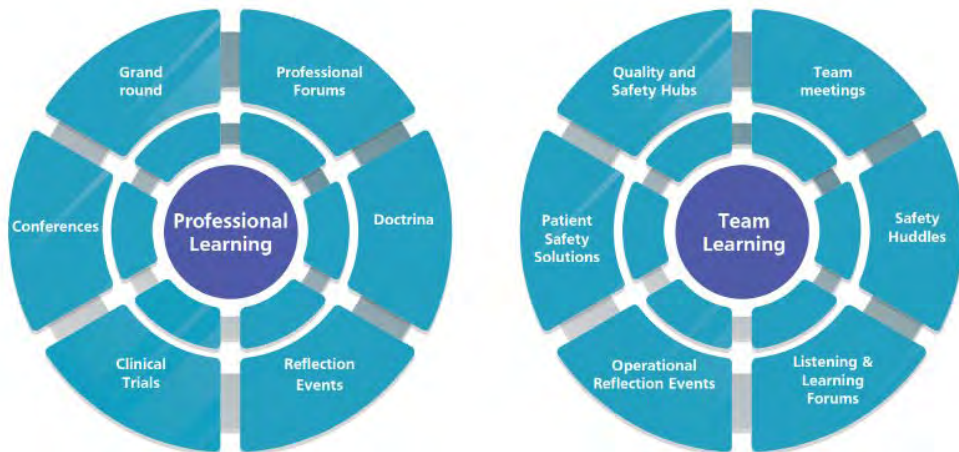
Learning from Concerns and Incidents

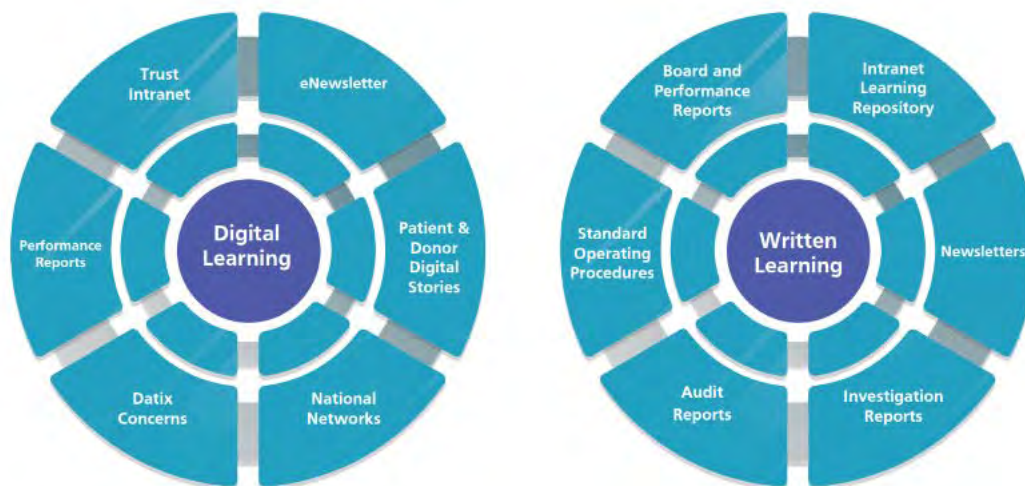
The below shows an overview of learning identified from our concerns and incidents in 2024/2025:





The Trust is committed to promoting a culture which values and facilitates learning, in which the lessons learned are used to improve the quality of patient and donor care, safety and experience. Continuous improvement is based on the idea that there is always room to advance in the healthcare we provide, and as a Trust we should consistently seek ways to enhance the service provided to our donors and the treatment provided to our patients. The Trust has a variety of methods of how learning is shared and embedded across the organisation.





Enhancing Care through Reviews

Patient Care after Death Reviews

Mortality reviews are an important way of identifying problems in healthcare and areas of care which could be improved, such as early recognition and escalation of the deteriorating patient, and appropriate and timely end of life care. Reviews often highlight aspects of excellent care also, and it is important that learning from both areas of excellence as well as those in need of improvement, are shared across the Trust and the wider healthcare system. Within Velindre Cancer Service the care of all patients who die on First Floor Ward are reviewed within the monthly inpatient mortality review meeting. For patients who have died within 30 days of receiving Systemic Anti-Cancer Treatment or Radiotherapy, they are discussed within the appropriate Site-Specific Team mortality meeting which are held every 3 months. Each SST now has a mortality meeting and positive feedback has been received that there is a forum for discussion, reflection, learning, and peer support.

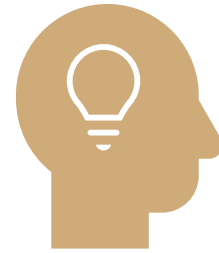


National Medical Examiner Service

The National Medical Examiner Service provides independent scrutiny of all deaths that are not investigated by the coroner. A medical examiner is an experienced doctor with additional training in death certification and the review of documented circumstances of death. The Medical Examiners ensure that an accurate cause of death is recorded, identify any concerns surrounding the death itself which can then be further investigated if required, and take the views of the bereaved into consideration. The Medical Examiner will contact the Trust to raise any concerns from their reviews or to request information to inform their reviews. No clinical concerns identified by the Medical Examiner for patients who have died within Velindre Cancer Centre.

Identified Learning

- Theme identified regarding diagnosis and referral process for patients with sarcoma. This was taken forward to the regional working group.
- To ensure patients performance status and overall health is considered when attending for emergency radiotherapy from other hospitals.
- Need for a clear process in the management of raised blood glucose levels for outpatients.
- Education provided to ward nurses on the management and care of stomas.
- Need for prompt and open discussions regarding resuscitation.
- Education provided and regular audit being undertaken on the ward around the monitoring and management of patient's hydration.



External Reviews

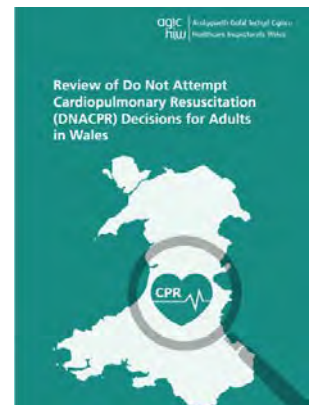
Recommendations from external reviews and inspections

In 2024/2025, the Trust had a number of inspections and reviews. These are required to ensure the Trust's assurance and that we work within the correct standards and procedures.

Healthcare Inspectorate Wales Review of Do Not Attempt Cardiopulmonary Resuscitation Decisions for Adults in Wales

This review was published and formally received by the Trust in May 2024. A working group was established, and The Trust has committed to numerous actions.

This review will be used to help the Trust improve our processes relating to the Do Not Attempt Cardiopulmonary Resuscitation decision making process, and the communication between clinicians and patients and those close to them.

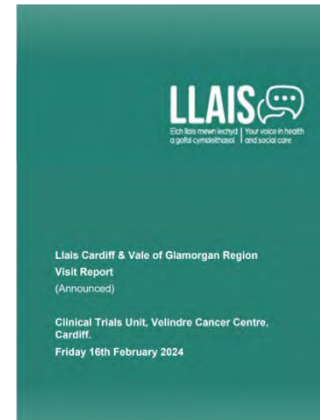


Llais Report on Visit to Clinical Trials Research Unit, Velindre Cancer Centre May 2024

Llais visited the Clinical Research Trials Unit at Velindre Cancer Centre to engage and listen to patients, carers, and others regarding their experiences.

The Trust received the report in May 2024. Llais were complementary of the welcome they received from staff, and the informative discussions that took place. They reported that relationships between staff, patients and family members was an “absolute joy” to witness. Parking and travel were raised as an issue for some. Upon receipt of the report an improvement plan was developed and the Trust committed to a number of actions including:

- Canvassing those attending the unit about their experience of the seating, and acting on any feedback received
- Improved signage at the unit
- Repairing the broken tea and coffee machine



Llais Cardiff & Vale of Glamorgan Region
Living with Cancer April 2024

As part of Llais’ ongoing engagement with the public, they target specific service areas in order to gather feedback around a particular theme or service. On this occasion they decided to look at Cancer Services, and hearing from people who have recently accessed these services, either recently being diagnosed or going through treatment. Velindre Cancer Service developed an improvement plan based on the recommendations within the report.

FEEDBACK FOR GOOD PRACTICE

Suggestions of good practice to Velindre Cancer Centre;

1. VCC to share the positive feedback received with staff within the relevant service areas.

2. It would be helpful for patients to understand how Velindre communicates with other healthcare services, such as GP's or other cancer hospitals.

3. Concerns were raised around lack of communications between patients and staff. Could you please clarify how VCC ensures that communication between staff and patients are reliable and consistent.

4. It would be helpful to understand how VCC share feedback with WAST around concerns raised about the transport services.

5. It would be helpful for patients to know what discussions have been held around having blood tests to be undertaken in their local area, rather than having to travel to VCC.

6. VCC to ensure food and drink facilities are working appropriately to avoid staff having to step away from providing care to patients.

VUNHST Welsh Risk Pool Concerns Assessment
Action Plan October 2024

The Welsh Risk Pool undertook a Concerns Assessment audit on the 12th June 2024. Following the assessment, the Welsh Risk Pool provided an assurance report and proposed recommendations. An improvement plan was developed. All involved were commended on the improved audit position from 2023, and the Trust was given ‘Reasonable Assurance’ status.

Assurance Summary

Management of Concerns (Incidents)	REASONABLE ASSURANCE	
Management of Concerns (Complaints & Enquiries)	REASONABLE ASSURANCE	
Redress Case Management	SUBSTANTIAL ASSURANCE	
Claims Case Management	SUBSTANTIAL ASSURANCE	
Inquest Case Management	SUBSTANTIAL ASSURANCE	
Learning from Events	SUBSTANTIAL ASSURANCE	
WRP Reimbursement Process	SUBSTANTIAL ASSURANCE	

Medicines and Healthcare Regulatory Agency Inspection of Welsh Blood Service
December 2024

The Medicines & Healthcare products Regulatory Agency carried out a routine inspection of the Welsh Blood Service (South Wales) from 9th to 13th December 2024 to assess compliance with the Blood Safety & Quality Regulations 2005. There were no ‘critical’ findings. There was one ‘major’ deficiency, relating to deficiencies in the control of data integrity and 5 ‘other’ findings.



A 'major' deficiency indicates a major deviation from good manufacturing practice and distribution practice or a combination of several 'others'. Welsh Blood Service have developed an action plan which will address specific findings but also resolve potential gaps in the wider quality management system.

National Reviews

The **National Infected Blood Inquiry** published its final report on Monday 20 May 2024 into the circumstances in which men, women and children treated by the NHS between 1970 and 1991 were given infected blood, and blood products. The trust is fully engaged and supporting the Welsh Government in developing an action plan.



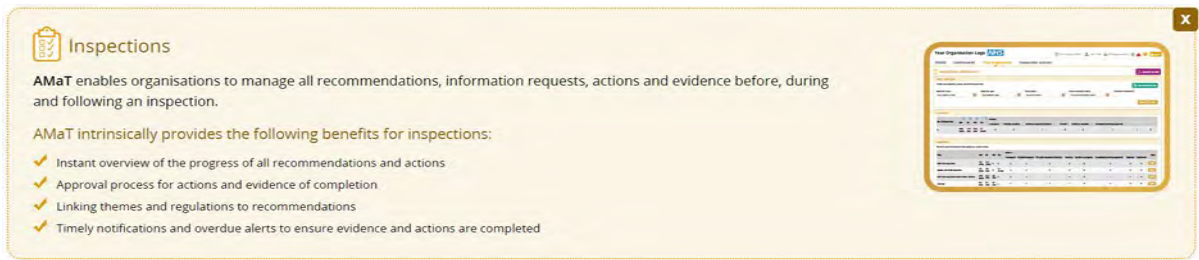
The **Thirlwall Inquiry** Review of Implementation of Recommendations from Previous Inquiries into Healthcare Issues: prepared by the Thirlwall Inquiry Legal Team 15th May 2024. On 2nd August 2024, representatives from the 3 Quality Hubs attended a Trust workshop to consider the Thirlwell recommendations review and identified learning for the Trust.



Out of the over 1500 recommendations, only 23% were identified as being clearly implemented. There are probably a range of reasons, but this is not fully explained within the review. This session reinforced the importance of ensuring recommendations with successfully implemented to improve quality and service user outcome within the NHS.

Regulatory Quality and Safety Tracker Compliance

To support the management of recommendations and improvements from investigations and reviews, the Trust has adopted the use of a Regulatory Quality and Safety Tracker utilising the Audit Management and Tracking system. See image below:



More information can be found in the Integrated Quality and Safety Annual Report.

Please see the link below to view the full report:

[LINK](#)

Internal Audit

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).



To provide assurance that the Trust is implementing the requirements of the Duty of Quality and Duty of Candour.

The field work commenced for both audit and commenced in March 2025, early feedback has been positive the completed audit reports will be presented at the July internal audit committee. The audit findings will provide an opportunity for the Trust to learn and reflect on the progress made since the implementation in April 2023.

Patient and Donor Voices

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. In February 2025, the Trust developed the peoples feedback standard.



Velindre University NHS Trust Peoples Feedback Standard

Both divisions capture feedback via several methods:

- Complaints are part of the experience feedback family and are an expression of dissatisfaction, which is significant enough to prompt the patient/donor to raise the matter.
- Complaints are managed through the robust policy framework and processes of 'Putting Things Right Regulations.'
- 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, donors, staff, or visitors.
- Incident reporting and investigation systems are used to find and address clinical incidents promptly.
- 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.
- Surveys and feedback.



Careful examination of patient/donor feedback will highlight the areas that need improvement to provide a better service for our patients and donors and supply the evidence for change.

During 2024 the Trust has continued to embed its patient engagement culture offering a wide range of opportunities through its Velindre Voices structure, Volunteers Service, Patient and Carer Partnership Board and through formal consultation opportunities.

Highlights include:

The Patient and Carer Partnership Board has strengthened.

A recruitment campaign in the Spring/Summer of 2024, the Patient and Carer Partnership Board held their first formal meeting in November 2024. Patient and Carer Partnership Board has engaged in the following:

- Llais Living with Cancer Report
- Value Based Healthcare Project
- Development of Trust’s Integrated Medium-Term Plan
- Velindre Oncology Academy course development
- Serenity trial implemented in research areas such as Cardiff University

Our new engagement strategy for patients, families and carers at Velindre

What is patient engagement?

Through our new Patient Engagement Strategy, we aim to:

1. Ensure that patient's voices are heard

2. Empower all patients to engage

3. Put patient engagement at the heart of our culture

4. Maximise our reach through preferred tools and techniques

5. Signpost the right information at the right time

6. Raise awareness of the increased opportunities to take part in research

7. Excel in our statutory obligations

How to get involved:

Donor Feedback Opportunities

ON SESSION FEEDBACK

Digital on-session feedback forms
At each donation session, digital feedback forms are made available to all donors across Wales to provide on the spot experience feedback. Feedback is then collated and utilised to inform service improvements.

Donor Adverse Event Reports
At times donors can experience an adverse event as a result of donating blood, i.e. bruising, discomfort or feeling lightheaded. All donors who experience such an adverse event are contacted by a member of clinical staff on the next working day.

Concerns Management
Easily accessible process with multiple contact opportunities. All concerns managed in line with 'putting things right' with a strong focus on collaboration and service improvement.

POST-DONATION FEEDBACK

Donor Contact Centre and social media
Donors can provide feedback through our social media channels which are operated during typical office hours or call 0800 252 266. Feedback is forwarded to the relevant department for review and action.

Donor awards ceremonies
Each year we host around 12 award evenings where senior management sit amongst donors and gather qualitative feedback.

Digital satisfaction survey
Each attendee is invited to complete a digital survey based on their session experience. Staff receive instant emails based on particular donor words used (e.g. bruising). A monthly report is shared, forming part of continuous improvement and/or escalation.

How we have improved quality across the Trust



Systemic Anti-Cancer Treatment Capacity and Demand

Once of the biggest challenges for the Trust this year was our Systemic Anti-Cancer Therapy capacity. This is what we did to improve our provision.

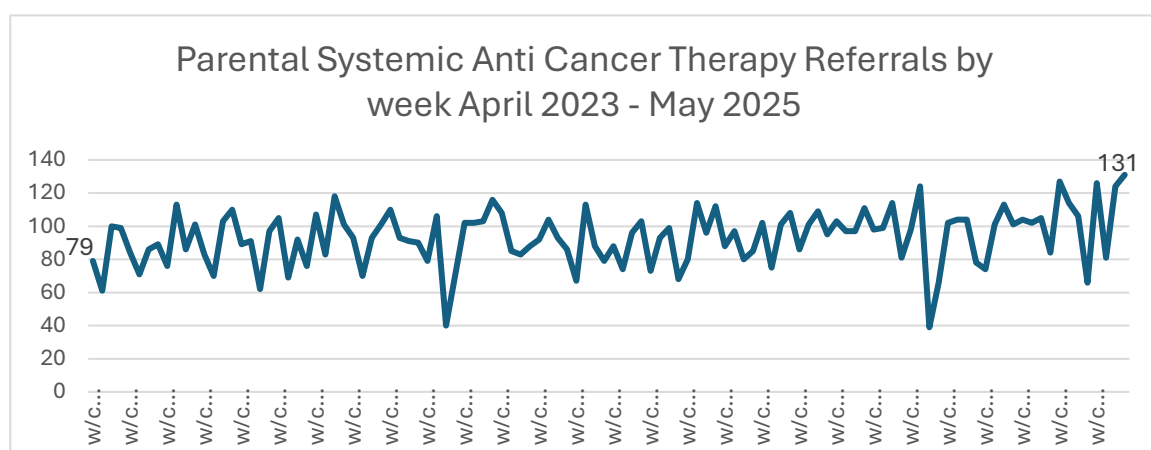
Addressing Increased Demand for Systemic Anti Cancer Therapy

In January 2024, Velindre Cancer Service's ability to provide non-urgent Systemic Anti-Cancer Therapy within the required 21 days had significantly reduced due to increased demand for treatments. It was noted that with the growing prevalence of cancer, the centre needed to optimise and expand its capacity.

The Trust is transitioning from a medically delivered model (provided directly by doctors) to a medically led model (overseen by doctors but delivered by a broader team of health professionals under their guidance). This will allow the service to expand capacity and better utilise doctors' time.

Overview of Parenteral Systemic Anti Cancer Therapy Referrals

The graph below provides an overview of Parenteral (non-oral) Systemic Anti-Cancer Therapy referrals for Cycle 1 Treatment between April 2023 and 19th May 2025. The demand for Parenteral cycle 1 treatment for 2025/26 is 18.8% higher than the 2023/24 average.



Performance Against the 21-Day Standard

The graph below shows the Trust's performance against the 21-day non-emergency waiting times standard. In April 2024, the Trust's performance was at 75% (target 98%). However, over the last three months, performance has improved to the Trust either meeting or being within 1% of meeting the standard.

Key Actions for Improvement

In addition to increasing Systemic Anti-Cancer Therapy delivery capacity, Pre-assessment processes and pathways required urgent change. Key actions undertaken include:

- Completing a full review of capacity and demand modelling and forecasting
- Increasing availability of pharmaceuticals and Systemic Anti-Cancer Therapy treatment
- Introducing nurse-led Immunotherapy Clinics
- Expanding Medicines at Home provision to provide 40 additional patient treatments per week
- Improved booking flexibility and maximising the utilisation of all available capacity.
- Appointing a Senior Systemic Anti-Cancer Therapy Improvement Lead
- Identifying pathway bottlenecks to improve patient flow through the system

Capacity Increases

Creation of new capacity: Mobile Unit capacity doubled from 24 in April 2024 to 48 by the end of August 2024. Velindre Cancer Service Pharmacy capacity plan increased from 515 in April 2024 to 550 per week by September 2024.

Improving utilisation of available Systemic Anti-Cancer Therapy Capacity: Utilisation of the Pharmacy capacity in Prince Charles Hospital was increased from an average of 40 treatments per week in 2023/24 to an average of 45 treatments in 2024/25.

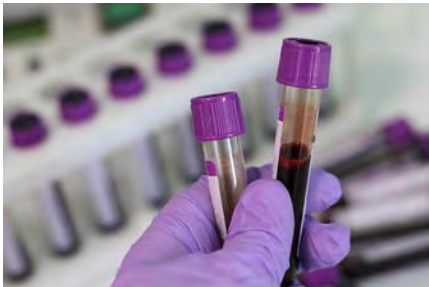
Expansion of Nursing and Pharmacy workforce: Recruitment into the Nursing and Pharmacy workforce in the first phase of expansion created capacity for a further 55 regimens per week.

By embracing innovation, expanding access, and prioritising patient-centred practices, the centre continues to set a benchmark for healthcare delivery. Velindre's 21-day performance against the operational target has either met or been within 1% of compliance for each of the last three months, demonstrating its ability to maintain performance against continuously increasing demand.

West Nile Virus Testing

Hundreds of donors have been able to successfully donate, just two months into the introduction of West Nile Virus testing.

The change was made on 1 May 2024 as part of the Welsh Blood Service Futures' Laboratory Service



Modernisation Programme and the benefits are already being seen on our shelves.

The new test helps those who have recently travelled to 'risk areas' for West Nile Virus during the mosquito season (1 May to 30 November), the most popular time for international travel. Previously, travelling to these areas meant a four-week deferral, now these donors are able to donate, and the new West Nile Virus blood test is performed on their blood samples.

Donors no longer face being unnecessarily deferred after arriving at clinic for West Nile Virus risk, resulting in a smoother and more efficient process.

Avoiding deferrals means that donation appointments are being better utilised, reducing the number of slots that are lost from deferrals.

The work has already resulted in 373 potential donations within the first two months, bolstering blood stock levels during what can be difficult summer months for the Service.



Cancer Patient Tracking List

This year Velindre Cancer Service has been developing the Cancer Patient Tracking List. Using a patient tracker list in a cancer service provides multiple benefits, including better coordination among multidisciplinary teams, improved patient management, and timely follow-up of care. It helps to monitor each patient's progress through various stages of diagnosis and treatment, reducing the risk of missed appointments or delays. The tracker also supports data-driven decisions, efficient resource allocation, and compliance with regulatory standards. Ultimately, it enhances patient safety, streamlines workflows, and contributes to better outcomes and patient experiences within cancer care services.



Blood Stock Collection

The Welsh Blood Service aims to hold around seven days of each blood type. The red cells within a blood donation last for 35 days; receiving too many donations in a short period can mean these vital donations expire before being used by a hospital. Similarly, not receiving enough donations means they would not be available when they are needed for patients. This is why a steady supply of each blood product is so important.



Appointments help manage the supply and also help predict future stock levels, allowing the Welsh Blood Service to tailor invites to the blood groups most in need.

This year Welsh Blood Service has updated the donor booking portal with improved functionality, making it easier for donors to engage with the Service and book appointments to donate.

- Change to our services to improve the **equitable collection of blood donations** across North Wales, ensuring fair access for all donors. Including expanding our capacity for blood collection.
- Introduced overnight stays for collection staff to increase the number of **mobile donation locations** we can visit, enhancing convenience and reaching more communities.



Rhesus Anti-D

Welsh Blood Service transplantation laboratories introduced the groundbreaking non-invasive foetal Rhesus D testing program continues to demonstrate transformative benefits for prenatal care. This program identifies foetal Rhesus D type from cell-free DNA in maternal blood, significantly reducing unnecessary use of anti-D immunoglobulin for Rhesus D-negative mothers. By targeting prophylaxis only when the foetus is Rhesus D-positive, the program has enhanced patient safety, conserved limited blood product supplies, and aligned with ethical best practices this avoids the unnecessary administration of Anti-D immunoglobulin.



New Vaccine for Colorectal Cancer

A Velindre Cancer Service patient has become the first person in Wales to receive an investigational vaccine designed to fight her own specific form of cancer, as part of a groundbreaking new research study.

Lesley Jenkins was diagnosed with Stage 2 colorectal cancer in April 2024 after completing a free NHS bowel screening test. She had



surgery to remove the tumour and chemotherapy and is now taking part in a research study at Velindre Cancer Centre.

"Being diagnosed with colon cancer came as a shock as I hadn't noticed any symptoms. Things moved very quickly - in April I didn't know I was ill, and by December I had finished chemotherapy and was told I didn't need any more treatment, which was brilliant!" said Lesley.

The study is investigating whether personalised vaccines can prevent colorectal cancer from returning. The trial, known as BNT122-01, is part of a new collaboration between BioNTech and Health and Care Research Wales, to boost the clinical research infrastructure across Wales and give Welsh patients greater access to trials.



Paperless workflows for Radiotherapy patients

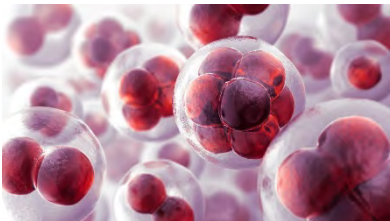
In March 2025, after 2 years of development alongside Varian's Clinical Implementation team, Radiotherapy at Velindre has begun the transition to completely paperless processes.



All new Radiotherapy Requests will be via Varian's Oncology Management System, Aria. These patients will follow a completely paperless workflow. Radiotherapy Requests previously created using the Welsh Clinical Portal will continue to the end of their treatment using paper-based workflows. This will help deliver improved quality, safety, and a more patient-centred experience. This is a key achievement that will act as the glue to realise the full patient benefits of the integrated radiotherapy solution.

Genetic Hemochromatosis

Genetic Haemochromatosis is the most prevalent genetic disorder in Wales and is particularly common amongst Celtic populations. It results in excessive iron absorption from the diet, but without an effective excretion mechanism, it can lead to iron accumulation and subsequent organ damage if not treated. Symptoms include tiredness, cognitive impairment, weight loss, and joint pain. Approximately 20,000 people in Wales are at risk (1 in 150), but with early treatment, life expectancy is normal.



Currently, most people with Genetic Haemochromatosis receive treatment through their Health Board's Clinical Haematology Service, involving regular venesection (blood removal) to manage iron levels. This blood, taken outside the donation system, is discarded via incineration.

Supporting people with Genetic Haemochromatosis to donate blood through the Welsh Blood Service offers a dual benefit: releasing clinical chair time and nursing staff time in the hospital, whilst contributing to national blood stocks.

Benefits include a broader choice of donation times and locations, along with the post-donation refreshments. Note that the same donor eligibility criteria apply therefore not all people with Genetic Haemochromatosis are able to donate. Resource savings have been estimated at £50,000 across Wales.



Bone Marrow Registry

More people than ever before can now join Welsh Blood Service's bone marrow registry to help patients overcome blood cancers and blood disorders.

Whilst previously only allowing 17 to 30-year-olds to join its Registry, the Welsh Blood Service is now enabling 16-year-olds to pre-register their interest to join and raising the upper age limit to 45-years-old for volunteers from a Black, Asian, or Mixed heritage background.

On the 5th of August, the Welsh Bone Marrow Registry reached its 100th donation at the Velindre Cancer Centre collection rooms. This is a major milestone, and the Trust showed its appreciation to all our donors as well as the staff.



Anti-Racism Wales

Wales is on a journey to becoming an anti-racist nation by 2030. The Welsh Government’s refreshed Anti-Racism Wales Action Plan sets out the key changes needed to make this vision a reality.



The Trust has developed an Anti-racist Wales action plan has been embedded with equality objectives for Board members, a staff Race Network and the launch of the Anti-racist Wales electronic-learning package. This course will help us all develop the awareness and skills to challenge racism and create a truly inclusive workplace.

The results of the Workplace Race Equality Standard have contributed to improvements to how we support international recruits in the workplace and how we encourage unsuccessful applicants to access feedback in order to improve at a subsequent selection process.



Trust Values

The Trust's shared values capture what is important to us and how we should all behave.

Our refined values were developed through a process of wide-ranging consultations with staff and members of the public. We felt it was time to review our values for the first time since 2015 because we are always evolving as individuals and as an organisation.

Our values are a mix of continuity and change, reflecting our commitment to delivering and developing our services, and we are proud to have them in place.





New Chief Executive Officer

In December 2024, David Donegan was very proud to be the Trust's new Chief Executive Officer. He has a passion and ambition for Velindre, and he connects strongly with our mission of being world class in our clinical and academic endeavours. David brings with him a wealth of relevant international experience in both blood and cancer services.



New Velindre Cancer Service Leadership Team

On the 21st March 2025, the Trust was pleased to announce the appointment of three key leadership roles within Velindre Cancer Service, forming our Divisional Triumvirate.

These roles will provide leadership capacity and support, recognising the demands of the new hospital and clinical service pressures, while we continue to evolve to meet the needs of our patients and colleagues.

The All-Wales Compassionate Leadership Pledge was adopted by Trust.



Supporting staff

Embedding a Just Culture

Taking a person-centred learning approach, ensuring our investigations are fair and proportionate and the focus is on understanding why incidents occurred to that systemic issues are identified so that learning takes place and staff are not made to feel blamed, so we improve patient and donor safety outcomes.

Psychological Safety

Civility saves lives and human factors training has been undertaken.



Listening to our Staff

The findings of our staff survey have been analysed through a quality lens. Three priority groups have been established.



Speaking up Safely

We are focussing on having a positive culture across all areas of the Trust, where staff feel safe and are supported to speak up, where our values, attitudes and behaviours at all levels contribute to a supportive, respectful, and engaging work environment.



The Trust is committed to promoting a positive and supportive work environment. The challenges facing healthcare workers in Wales are well documented. We are committed to implementing innovative recruitment and retention strategies and workforce remodelling. The Trust values the importance of recognising staff achievements to promote innovation and staff wellbeing.

Inspirational colleagues from across the Trust have been recognised and celebrated at the Employee Excellence Awards.

The 2024 ceremony saw a total of 20 members of staff from across the organisation take home an award.

Their incredible achievements were recognised in various areas of excellence, from digital development and innovation to sustainability and health and wellbeing,

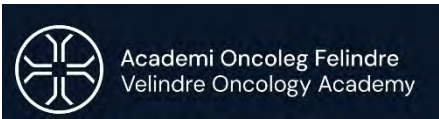


with over 200 nominations submitted across the 16 different categories.



Velindre Oncology Academy

The Velindre Oncology Academy aims to establish a national standard-setting oncology academy at the Velindre Cancer Service, providing accredited non-surgical education, training, and upskilling to the workforce across Wales.



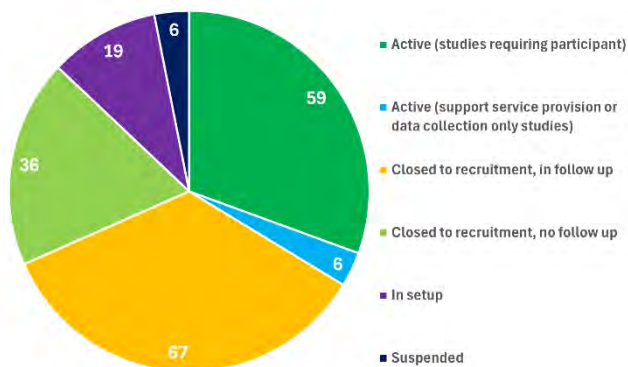
The Velindre Oncology Academy has been dedicated to establishing a strong foundation of essential learning for the oncology workforce. This commitment has led to the successful delivery of oncology-focused courses to professionals across South East Wales and beyond. One of the most exciting upcoming developments is the launch of a Postgraduate Certificate in Cancer Care, in partnership with University Wales Trinity Saint David, scheduled to begin in September 2025. It is anticipated that this programme will significantly enhance patient care and experience by equipping the workforce with advanced knowledge and skills.

More information can be found in the link below:

<https://www.velindreoncologyacademy.org.uk/>

Research

Velindre Trust is committed to research and innovation and has been involved in numerous research studies throughout the year. The pie chart shows the number of research projects undertaken in 2024-2025 and what stage they are in.



First Patient in Europe

Dr Annabel Borley and trial team was the first European site to randomise a patient into the TROPION 03 trial combining Datopotamab Deruxtecan with Investigator’s Therapy Choice in Triple-negative Breast Cancer patients.

Ground-breaking Trial

The Phase II **ARISTOCRAT trial** is investigating whether combining cannabinoids and chemotherapy can extend glioblastoma patient's lives. Recently BBC Wales talked about the trial with consultants Jillian MacLean and James Powell, along with the husband of a patient who passed away with this tumour.

Exciting Progress in Improving Platelet Quality (Welsh Blood Service)

The Welsh Blood Service has made exciting progress in the bid to improve the quality of platelet storage, following research conducted by the Component Development and Research Laboratory in collaboration with Cardiff Metropolitan University.

Currently, the Welsh Blood Service collects 15,000 – 20,000 platelet units every year and have to carefully manage supply due to their shelf life of only seven days. Improvements in modern storage containers have already increased shelf life from 3-5 days to 5-7 days, but there are still significant challenges.

At the end of 2024, Dr Jamie Nash from Component Development and Research Laboratory, together with Dean Pym, a PhD student at Cardiff Metropolitan University, in collaboration with Component Development and Research Laboratory and their colleagues, published pioneering data on enhancing oxygen availability for platelet storage.

Chloe George, Head of Component development at the Welsh Blood Service, said:

"The Component Development & Research laboratory is fast becoming a leader in platelet concentrate research, thanks to the groundbreaking collaborations it is forming with innovative research institutions such as Cardiff Metropolitan University and the invaluable contributions of PhD students who are driving forward new discoveries and advancements. Our ultimate aim is providing blood components that result in improved outcomes in patients as well as improving the efficacy of the blood supply chain."





The Trust remains committed to fostering a culture and building the capability for evidence-based decision-making at all levels. Recently, we participated in a new training course designed to enhance the skills and confidence of team leaders and managers across the Trust.



Two-thirds of participants felt more confident in using data for decision-making and over half felt more assured about modern analytical techniques. This initiative proved particularly beneficial in the redesign of Systemic Anti Cancer Therapy delivery. The team felt empowered to propose, implement, and monitor changes to the Service based on the enhanced data.

Similarly, at the Welsh Blood Service, we have focused on improving the timely delivery of information to support daily planning meetings, working closely with our team leaders to ensure that necessary information is available and presented in a manner that enhances their understanding and decision-making.



Clinical and Scientific Strategy

This year the Trust has been developing its first Clinical and Scientific Strategy, setting out our direction for the next five years across cancer, blood, and transplant services.

This milestone strategy strengthens our role within the national and regional healthcare system, articulating how we will lead, collaborate, and innovate to deliver high-quality, safe, and person-centred care.

The vision for this strategy is to be at the forefront of clinical science delivering excellent, high-quality, person-centred



care. This will be launched in our first multi-professional conference in May 2025.

New Velindre Cancer Centre Progress Update

This week marks one year since construction work began on our new Velindre Cancer Centre.

Over the past 12 months, we have seen major progress - from groundworks and foundations to the beginnings of the building’s structure taking shape. Each milestone brings us one step closer to delivering a world-class cancer centre for people across south Wales for generations to come.



Our world-class cancer centre is scheduled to open in Spring 2027 - just two years away.

New Velindre Cancer Centre project director David Powell said:

“Our new cancer centre is not just about the building; it’s about delivering improved care, improved outcomes and a better experience for both our patients and our dedicated staff.”

Hosted Organisations

Health Technology Wales

Velindre University NHS Trust hosts Health Technology Wales. Health Technology Wales is a national body working to improve the quality of care in Wales. We collaborate with partners across health, social care and the technology sectors to ensure an all-Wales approach. We are funded by Welsh Government and hosted within NHS Wales, but independent of both.



An important remit of Health Technology Wales is to promote and audit the adoption of Health Technology Wales and National Institute for Health and Care Excellence medical technology guidance in Wales.

During this year, Health Technology Wales successfully delivered the objectives outlined in the Strategic Plan published in 2021 and continued to develop its vision to become a world class Health Technology Assessment organisation.

JANUARY 2024	CATHETER LOCKING SOLUTIONS
DECEMBER 2024	DIGITAL TOOLS FOR DIABETES MANAGEMENT

DECEMBER 2024	ROBOT-ASSISTED BENIGN GYNAECOLOGICAL SURGERY
DECEMBER 2024	ENHANCE LIVER FIBROSIS TEST
NOVEMBER 2025	ADVANCED PARAMEDIC PRACTITIONERS
AUGUST 2024	ARTIFICIAL INTELLIGENCE ASSISTED TOOLS FOR PROSTATE CANCER DIAGNOSIS USING WHOLE SLIDE BIOPSY SLIDES
JULY 2024	FLOSEAL IN THE TREATMENT OF EPISTAXIS
JULY 2024	ARTIFICIAL INTELLIGENCE-ASSISTED ENDOSCOPY FOR GASTROINTESTINAL CANCER

Please see the link for the full report:

[HTW Annual Report](#)

Shared Service Partnership

Velindre University NHS Trust also hosts Shared Services Partnership. Shared Services deliver, value, innovation and excellence through partnership.
Please see the link to the full report:
SHARED SERVICES ANNUAL REPORT



Advanced Therapies Wales

Throughout 2024–2025, Advanced Therapies Wales has worked tirelessly to improve access to cutting-edge treatments and ensure high-quality care for patients across Wales.



Key achievements include creating a detailed plan, approved by government ministers, to make advanced therapies more available, train healthcare staff, and prepare our health system for the future. We have set up a national team to tackle barriers preventing patients from getting these treatments and have secured temporary support for critical testing services. Additionally, we have started engaging with patients and clinicians to shape a better service model for blood cell collection (apheresis) in Wales.

On a UK-wide level, we have led efforts to raise public awareness about advanced therapies and are developing a Patient Charter to ensure patients’ rights and voices are at the heart of these treatments.

Advanced Therapies Wales has also supported groundbreaking research by funding new projects and sharing the latest insights on upcoming therapies and clinical trials. Through events like the Advanced Therapies Wales Symposium, we have fostered collaboration and kept patients at the centre of everything we do.

Looking Forward

Quality Priorities 2025/2026



For quality priorities to be achieved and deliverable it is important that they reflect identified issues within the organisation’s quality management system. It is essential to work collaboratively to identify shared priorities. Giving everyone a voice and bringing together staff and patient, donor feedback to design our services and drive improvements is essential. Each division decided on their annual priorities; they have been approved and will monitored through the Trust governance routes. They have also been included in the Trust Integrated Medium Term Plan. This plan sets out the organisation priorities and how they will be achieved.

The 4 main priority themes are:



Working Towards Organisation of European Cancer Institutes Accreditation

The Trust has been accepted as a member of the Organisation of European Cancer Institutes and is committed to working towards achieving globally recognised accreditation:



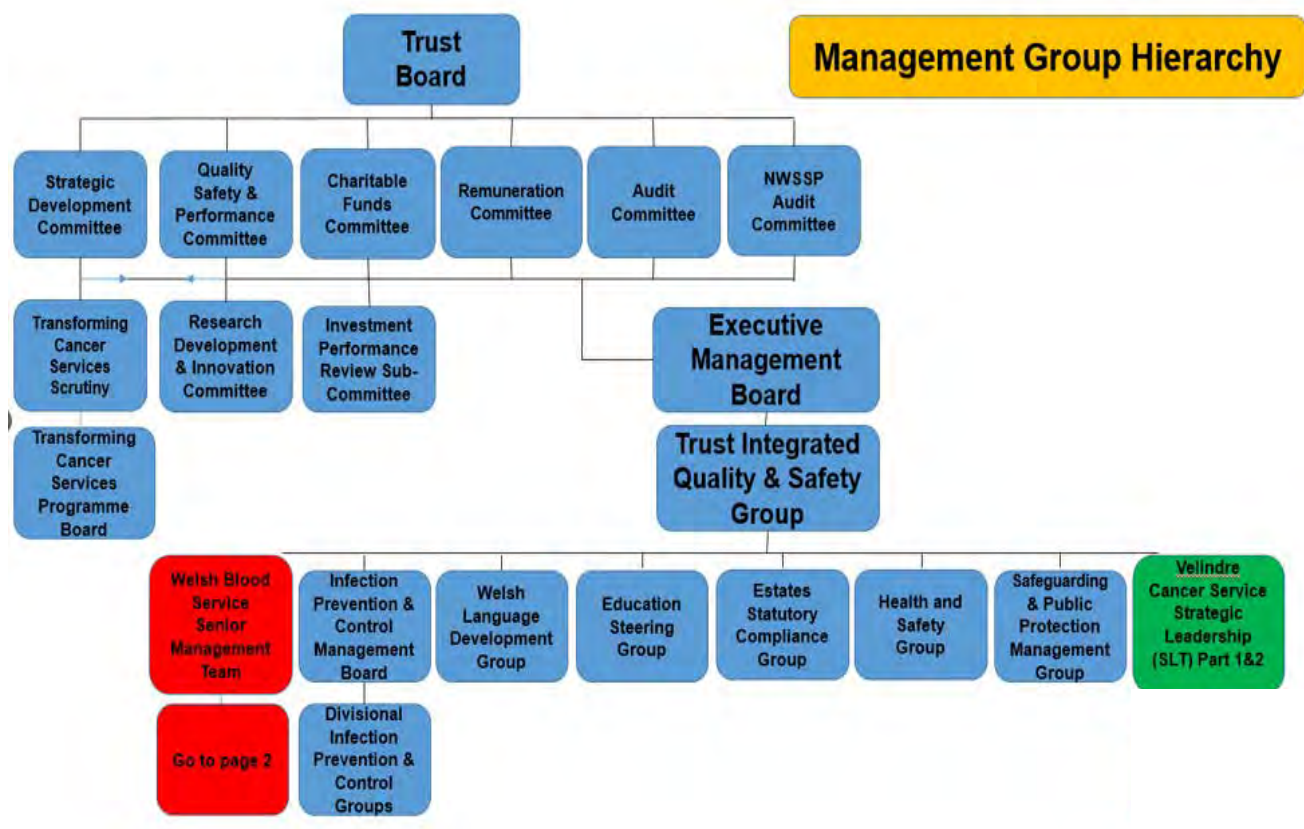
1. Quality Assurance: Will ensure we meet the globally recognised high standards of quality in cancer care, research, and education, which will improve patient outcomes and experience.
2. International Recognition: Organisation of European Cancer Institutes accreditation provides international recognition. This will enhance the Trusts reputation globally, attracting collaborations, top-tier professionals and funding.
3. Continuous Improvement: The process involves regular assessments and feedback, promoting continuous improvement in clinical practices, research methodologies, and administrative processes.
4. Networking Opportunities: Accredited institutes become part of a network of leading international cancer centres, facilitating the exchange of knowledge, best practices, and innovative approaches to cancer treatment and research.
5. Benchmarking: Both membership and accreditation facilitates reciprocal international benchmarking mechanisms.

- 6. Patient and Population Confidence: Internationally recognised will enhance overall confidence in the Trust as it demonstrates adherence to stringent standards of care and commitment to providing the best possible treatment.

Quality Strategic Approach

The Trust’s three Quality Hubs were established in 2023, and meet monthly to provide analysis of key outcomes, activity, learning and improvement in order that the Trust can meet its legislative requirements in line with the *Putting Things Right Regulations (2011) & Health and Social Care (Quality and Engagement) (Wales) Act (2020) (Duty of Quality & Duty Candour)*.

The Quality Hubs report into the Integrated Quality & Safety Group, the Executive Management Board and then into the Quality, Safety and Performance Committee.
The Quality Hubs maintain a strong focus on learning and improvement in order to ensure the continued provision of Safe, Timely, Effective, Efficient, Equitable and Person-Centred Care.



Conclusion/Summary

Velindre University NHS Trust is committed to providing the very highest quality of care to our patients and donors. This can only be achieved through continuously developing and improving our services. Much has been achieved over the past year, and there is a plan in place to ensure that we continue to improve the quality of our services. We will achieve this through the continued determination and dedication of our staff, and through working in partnership with our patients and donors and our Health Board partners. We look forward to providing another report in a years' time documenting our ongoing quality improvement journey and achievements.



Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust



Gwasanaeth Cancer Felindre
Velindre Cancer Service



Gwasanaeth Gwaed Cymru
Welsh Blood Service



Technoleg Iechyd Cymru
Health Technology Wales



Codi Arian
CANOLIAN CANCER
VELINDRE
CANCER CENTRE
Fundraising



Partneriaeth
Cydwasaethau
Shared Services
Partnership

Unit 2, Charnwood Court,
Parc Nantgarw, Cardiff, CF15 7QZ

029 2019 6161 | velindre.nhs.wales

NHS WALES SHARED SERVICES PARTNERSHIP

Duty of Quality Annual Review 2024-2025





Introduction from Chair and Managing Director of NWSSP

We take great pride in presenting the second annual report on the implementation of the Duty of Quality within NWSSP.

Since the Duty of Quality came into force on 1st April 2023 it has been embraced within NWSSP, not only to give us the ability to demonstrate how we implement the high standards of service provision which we aspire to deliver to the population of Wales, but also to enable our staff to show how they deliver within their divisions and departments and to show the pride that they take in the quality of their work. This is demonstrated in the live links within the Quality Wheel **page 12**, where you can listen to our staff discussing how they work, and reflect on the importance of the Duty of Quality.

NWSSP provides an ever-expanding portfolio of services across the NHS in Wales, and includes services ranging from Legal to Laundry, from Procurement to Pharmacy, from Accounts Payable to Audit, from Payroll to Primary Care Services, Specialist Estates and Surgical Materials Testing Laboratories and so many more.

We have taken the opportunity given to us by the implementation of the Duty of Quality to connect this with our core values and strategic objectives, ensuring an overarching principle of quality in everything we do. We hope that this report, which will be available to the public, will showcase the role of NWSSP within the NHS in Wales and the services we provide which enhance and enable patient care.

We hope that it will provide you with the assurance that we have quality at the heart of what we do and that we are consistently focussed on improving the quality of the services we provide.



Tracy Myhill OBE,
Chair



Neil Frow OBE,
Managing Director

Medical Directors Report

Last year I quoted Aristotle, 'Quality is not an action, it is a habit' and I hope you will agree that this 2024/25 report shows that, for NWSSP, the philosophy and practice of quality really is a habit.

As I reflect on the progress we have made since the production of our first annual report, it is evident that the staff in NWSSP have truly embraced using the 12 health and care quality domains and enablers as a way of ensuring progress in the monitoring, assurance, improvement and planning of the services we deliver to NHS Wales.

Our first annual report aimed to showcase as many of our divisions as we could, demonstrating the breadth of services delivered by NWSSP and the impact of our non-clinical services on the NHS in Wales. The aim of the report was to provide 'bite-sized' pieces of information, utilising short videos and associated text to demonstrate how we use the Duty of Quality to inform our planning and decision making. This approach is now being picked up by other NHS organisations as an accessible means of delivering complex information.

In the past year our internal quality steering group has expanded with new members joining as the divisions see the value of demonstrating how we continuously improve the quality of the services we deliver.

We have received positive comments from staff on our approach to implementing Duty of Quality, including:

- Focusses our thoughts.
- Gives us a refresh in our approach.
- Using videos in both the always on reporting and annual report gives a real insight into the meaning of quality in the work of NWSSP.
- The use of short videos makes your approach to quality understandable and accessible.

This year's report demonstrates again how our services aim to be the best that they can be:

- We have retained our customer service excellence award and maintained or achieved higher levels of compliance in all domains.
- We have achieved and retained a number of prestigious external accreditations and awards, including ISO accreditations for environmental management systems in our Surgical Materials and Testing Laboratory Division.
- Procurement Services operate in compliance with Good Distribution Practice (GDP)
- We have again embedded the Duty of Quality principles into our IMTP development and use our quarterly review process to ensure achievement of our quality initiatives and provide assurance to the Partnership Board.
- We have, this year, begun the process of self-assessment for each division against the health and care quality standards, this will continue into 2025 forming our baseline for continual improvement, again linking with each division's IMTP (See Appendix A) and ensuring the sustainability of always on reporting.
- We have continued to upload divisional reports to our SharePoint site so that the divisions can learn from each other.

I hope that you find our second annual report encouraging and that you will be able to understand what quality means to our largely non-clinical services, and how we plan, deliver, assure and continuously improve quality.

Our Values



Listening & Learning

To continually reflect upon and improve the quality and effectiveness of all we do.



Taking Responsibility

For brave and compassionate decisions and making the right things happen.



Working Together

Inclusively with colleagues, customers, and suppliers.



Innovating

To be courageous and creative through continuous improvement.

Our Services



Audit and Assurance Services



Laundry Services



Finance and Corporate Services



Accounts Payable



Lead Employer for medical, dental & pharmacy trainees



Planning, Performance and Informatics



Counter Fraud Wales



Legal and Risk Services



People and Organisational Development



Central E Business Team



Medical Examiner



Surgical Materials Testing Laboratory



Digital Workforce Solutions



Primary Care Services



Salary Sacrifice



Employment Services



Procurement and Supply Chain Services



Student Awards Services



e-Enablement



Pharmacy Services



Welsh Risk Pool



Finance Academy (hosted)



Specialist Estates Services



Wales Infected Blood Support Scheme



Health Courier Service

Key Achievements 2024-2025

We were pleased to submit our first annual Duty of Quality report on time and to note that it was received very well by both other Health Boards and Trusts in Wales and by Welsh Government.

Our innovative use of videos and vlogs in our first year was particularly noted and has continued to influence the production of this year's report with our focus on accessibility for the public. This was recognised by the Welsh Government review on last years reports.

- We have continued to deliver both formal and informal sessions to our staff, extending this from board to divisions and teams.
- We have used workshops to encourage staff to demonstrate their commitment to quality by producing their own blogs and vlogs, sharing these on SharePoint to enable best practice.
- We have maintained our organisational and legal commitment to the Welsh Language by ensuring that the report and all other external communications are available in the medium of Welsh.
- The Duty of Quality implementation team has continued to meet and the champions and leads in each division are cascading their knowledge of the duty of quality throughout their areas of expertise.

Quality Planning and Decision Making

The IMTP and the Duty of Quality report continue to be integrated into our working practices this year. There are ongoing challenges in terms of service improvement and financial constraints, however, we have ensured that, by using the Duty of Quality and the quality wheel to guide decision making, the quality of the services we provide has been maintained and driven forward to ensure service improvement.

2025

2024

2022

2023



Quality Management Systems

Each of our divisions have their own Quality Management System (QMS) tailored to the very different needs of each division, ranging from a clinically based QMS for our Pharmacy Services and Surgical Materials Testing Laboratory to the largely non-clinical Procurement and Workforce Divisions. The diversity of the divisions within NWSSP requires a flexibility of implementation to ensure that service provision is maintained and enhanced across NHS Wales. Sharing of best practice across divisions is a key element of our ongoing quality improvement strategy. This is done through senior leadership meetings, at local divisional meetings and through the Duty of Quality Implementation team meetings. More locally this will be embedded through both face to face and online learning.

Quality Driven Reporting

One of the main principles which we have applied as part of our Duty of Quality reporting is in using always on reporting which we have in many of our divisions already and is well established. This supports the quality management systems which are in place and, with the IMTP, provide assurance and evidence that projects and initiatives are on track to be achieved in a timely fashion. The video submissions for this year are [available here](#) in both English and Welsh, and our Digital and Workforce Productivity Solutions Division video demonstrates very effectively the way in which they approach their Quality Driven Reporting process, with specific reference to the Duty of Quality.

Quality Driven reporting into Health Boards and Trusts

NWSSP has a unique position within the NHS in Wales. We are hosted by Velindre University NHS Trust (VUNHST) and report through their Quality, Safety and Performance Committee to the Welsh Government for the annual Duty of Quality Report. Our divisional structure enables the provision of a variety of services across the whole of NHS Wales. Examples include:

- The Specialist Estates Services team has an all-Wales lead role in buildings, transport, Infrastructure, Estates planning and land use, providing advice and support to improve health care environments. The team work closely with Health Boards and Trusts to develop and support premises assurance for an estate of over 2 million square metres.
- Our laundry services span the entirety of NHS Wales. They provide collection, linen treatment and delivery to clinical centres including major hospitals and community sites. They have undertaken significant work in reducing waste and reusing heat from wastewater and further information on this can be found on our YouTube channel and linked to the Quality Wheel (see below).
- Decarbonisation – As NWSSP is responsible for Specialist Estates Services and procurement within the NHS in Wales, it has a major influence on areas such as transport, travel and buildings. This is outlined in more detail in the [2024-2026 Decarbonisation Action Plan](#).



Quality Control and using data for quality improvement

We continue to undertake divisional quarterly reviews which provide compliance assurance. During this process, divisions are held to account for Key Performance Indicators (KPIs), which are based on the safe, timely, effective, efficient, equitable and person-centred quality domains. This is an ongoing mechanism which NWSSP uses to ensure that quality is central to our service delivery.

The KPIs inform quality improvement projects which feed into improved quality measures and inform the Integrated Medium-Term plan (IMTP). This gives the senior leadership team and the partnership board assurance. The IMTP, submitted to the Welsh Government yearly, supports the principles of delivering value, innovation and excellence through partnership and is also underpinned by the approach taken by NWSSP to the Duty of Quality. This shows the further integration of the principles of the Duty of Quality into the daily business of NWSSP.

The diverse nature of NWSSP means that each division is held accountable for a unique set of measures, which include such elements as sickness absence, analytics for improvement, Wales wide service improvements and compliance with internal and external standards. Each division uses their own data sets to identify performance and assure quality improvement.

Below we outline 3 projects within NWSSP which demonstrate how we collect and use data to inform quality and service improvements, both within NWSSP and across the NHS in Wales.

Digital and Workforce Productivity Solutions

The national services provided by the Digital and Workforce Productivity Solutions team are fundamental to enabling health care services across Wales. The team use a Quality Improvement Action Log (QIAL) which uses Microsoft Lists as a tool to enable automatic notifications to be used to ensure that Quality Improvements are driven forward in a timely manner. They embedded the DoQ into their service delivery model as part of the drive for continuous service improvement. Feedback from service users ensures that the internal audits undertaken are externally verified. 60% of the service improvements identified have been implemented to date. These include developing a Quality management site which allows visibility of progress and sharing of best practice and translating the e-rostering intranet page and systems notifications to ensure that the system is bi-lingual and fully compliant with the Welsh Language Standards (2016). Future developments planned for 2025-2026 will include developing ways to automate transactional tasks, launching an all-Wales portfolio pathway for International Doctors and facilitating the reduction of agency spend across Wales. This forms part of the Digital and Workforce Productivity Solutions teams plan for continuous improvement, using data and keeping quality at the heart of their work.





Medical Examiner Service and Mortality Review Teams (Primary Care Services)

This is an example of collaborative working between the Medical Examiner Service (MES) which reviews all deaths in Wales (with the exception of those investigated by His Majesty's Coroner), and Mortality Review teams across Wales – a true once for Wales solution which will standardise the interface between the MES and Mortality Review teams, using the Duty of Quality as the cohesive framework. This supports the categories and analysis used for learning from deaths across all care providers in Wales. Using the Duty of Quality to support this ensures a uniform and consistent approach to enable thematic analysis. The six domains of quality (safe, timely, effective, efficient, equitable and person centred) are used to categorise feedback provided from the MES to the service provider. Following review of this information the care provider can use the six enablers (leadership, workforce, culture, information, learning, improvement and research and whole systems approach) to support further structured mortality review. This enables categorised and thematic learning, using the data provided to improve patient care and treatment, in primary and secondary care. This ensures a whole system approach to learning from events and a focus on quality throughout.



Procurement Services

The Procurement Services Team use data as an integral part of their Quality Management System to deliver a quality and professional service to customers and ultimately to patients, based on the principle of **Right First Time**.

The Quality Management System uses data and analytics to identify opportunities for improvement and to demonstrate benefits delivered as part of the planning process. Quality Assurance is ensured through a performance management framework and a risk management framework, whilst quality control is supported by the use of dashboards and workflow reports. Quality improvement is measured through a variety of measures including ongoing review, updating staff skills and ensuring PADRs are undertaken, creating a learning environment for staff.

A 3 yearly cycle of Quality planning is in place, supported by a published plan which meets the requirements of ISO 9001 (external award) for management review. This then supports the production of the IMTP. Third party audit and internal audit are used to assure service quality.



External Quality Reviews, accreditations and awards

Customer Service Excellence Accreditation (CSE)

We strive to ensure that our customers and partners are at the heart of everything we do. To ensure that we are able to demonstrate this we sought, in 2023, external validation of this customer centred approach. The entire organisation was able to gain Customer Service Excellence Accreditation. We have maintained the inherent linkage between CSE and the Duty of Quality over this time period and have again been awarded CSE accreditation for the entirety of the organisation.

Our internal SharePoint site links CSE and the Duty of Quality, emphasising the inter-dependence between the two. It also reinforces to internal stakeholders the way in which we can use the work done for CSE as examples for the Duty of Quality and vice versa.

The feedback from CSE assessors will continue to be used as feedback to improve our processes and we will continue to use our always on reporting systems to inform this. The CSE report also demonstrates the linkage and collaboration between the various divisions in NWSSP.

Below are more examples of the Internal and External Quality Reviews, accreditations and awards received by divisions and staff in NWSSP over the last year. These demonstrate the quality of services which we provide in NWSSP.

Achievement	Division	Quality Domains	Quality Enablers
Decision to seek, and achievement of, NWSSP wide customer service excellence accreditation (CSE)	NWSSP wide	- Equitable - Person centred	- Leadership - Culture - Information
Development of a water and energy recovery system for Laundry Services BS14065:2016 for biocontamination control systems	SES	- Effective - Efficient - Safe	- Information - Whole system - Learning, improvement and research
Maintaining Divisional accreditations – these act as a visible assurance of quality	NWSSP wide	- Person Centred - Safe - Effective	- Learning, improvement and research - Leadership - Culture - Whole System
Speaking up safely	People and Organisational Development	- Safe - Equitable	- Leadership - Workforce - Culture

Achievement	Division	Quality Domains	Quality Enablers
SMTL have achieved ISO/IEC 17025:2017 Testing and calibration and environmental management systems. A UKAS audit showed zero noncompliance with one minor recommendation (this level of compliance for an organisation is rare)	Surgical Materials and Testing Laboratory	• Safe • Timely • Efficient • Effective	• Information • Whole system • Learning, Improvement and research
Monitoring and managing quality across business and identifying areas for improvement ISO 9001	Primary Care Services	• Efficient • Effective • Equitable • Safe • Timely	• Information • Leadership • Culture
Procurement Services hold multiple ISO and other standards including ISO 9001 Quality Management ISO 45001 Occupational Health and Safety STS Food Safety Standard	Procurement Services	• Safe • Timely • Efficient • Effective • Equitable • Person Centred	• Information • Leadership • Culture • Learning, Improvement and Research • Workforce • Whole System
ISO2000-1 standard and BACS certification, covering information technology - service management system requirements and gained 100% customer satisfaction in a survey for its BACS bureau performance	Central Team E-Business Services	• Effective • Efficient • Safe • Timely	• Information • Whole system • Leadership • Workforce
Maintained Law Society Lexcel service excellence accreditation (Lexcel)	Legal & Risk Services	• Timely • Effective • Efficient • Equitable • Person centred	• Leadership • Workforce • Culture • Information • Learning, improvement and research • Whole system approach

As an example of the robust nature of these external assessments, our Legal and Risk team, which provides a service across NHS Wales, were assessed over a 3-day period. This is a yearly assessment which supplements the 5-day assessment which is held every 3 years. The assessor interviews staff members from all levels, selects a random group of legal cases for review and also assesses the policies and procedures in place, ensuring a full and objective assessment process.

Whilst these are formal, internal and external, these and other divisions within NWSSP also undertake other forms of internal quality assurance. This includes the work undertaken by the People and Organisational Development team who, quantitatively and qualitatively, measure responses to surveys and evaluations including the People and OD survey, the NHS Wales Staff survey, experiential and impact evaluations of courses, action point response times and the quality of external speakers. These assessments provide feedback for the organisation, course and survey participants and staff, allowing for improved service delivery.

Staff Voices

The 12 health and care standards which comprise the 6 measures of quality and the 6 key enablers laid out in the Duty of Quality are shown in the inner ring and outer ring respectively on the wheel below.

The **6 measures** of quality are:

- **Safe** - This focuses on avoiding preventable harm, getting processes and care right, and learning from incidents and concerns to prevent repetition.
- **Timely** – This is described as providing high quality care in the right timeframe.
- **Effective** – This reflects utilisation of evidence-based practice including prevention as well as treatment.
- **Efficient** – a values-based approach to improve outcomes for people.
- **Equitable** – providing equality of opportunity and human rights.
- **Person Centred** – meeting people's needs.

The **6 enablers** are:

- **Workforce** – Ensuring that the workforce is skilled and available to provide care and support to those providing care.
- **Leadership** – clear vision with governance and accountability embedded in the organisation.
- **Culture** – Quality systems and safety in a supportive way enabling sharing new ideas and learning from mistakes.
- **Information** – Using data and knowledge to inform service quality and development.
- **Learning and Improvement** – Quality improvement to deliver quality services and outcomes.
- **Whole system approach** – Improving quality across the health care system to improve population outcomes.

These can be further explored by clicking on the following link:

 [The Duty of Quality Statutory Guidance 2023](#)



Explore the wheel below (by clicking on each section) to hear staff in NWSSP explaining how quality is key to their work on behalf of NHS Wales and what it means to them, or to see links explaining how quality is demonstrated in NWSSP.



A background image showing a group of people in a meeting room. They are seated around a large table, which is covered with various items including water bottles, glasses, and colorful sticky notes. The room has large windows and a modern interior.

Leadership

This segment demonstrates the impact of the learning and development strategy, which supports compassionate and effective leadership and facilitates the development of staff throughout the organisation to enable our objectives to be met in a meaningful and sustainable way.

Workforce

This demonstrates a clear link between the Duty of Care and service improvement. It defines the links between the internal and external audit cycle and quality and enhancement of services.

Culture

Demonstrating the value to the organisation of compliance with the Welsh Language Measures 2011 and associated Standards and Strategies to promote the use of the Welsh Language within the organisation and for the benefit of service users and patients of the NHS in Wales.

Information

The importance of these aspects are demonstrated in this short video, presented in both English and Welsh, about our Central E Business team. Members of the team present how they work with the Duty of Quality in mind and how the Duty is embedded in the work they do.

Whole systems approach

This shows the work of the Welsh Translation Unit in supporting and enabling the use of the Welsh Language across the NHS in Wales, both through Service Level Agreements with other Health Bodies and internally in developing the skills of our workforce to be able to communicate bilingually.

Learning, improvement and research

This information demonstrates how learning taken from audit has led to improvements in service delivery both for internal and external stakeholders. It also supports compliance with Welsh Language Standards. There is also an explanation of how the current audit cycle has led to forward planning as part of the continuous improvement process and Quality Management System which is in place.

Safe

The Legal and Risk team facilitated training for medical staff to promote a safe and consistent approach to informed consent. As part of this they clarified information on informed consent and material risk and the need for appropriate language to be used to give information to patients. This provided expert training for our medical practitioners to promote safe and best practice.

Please note that this presentation was done using external specialist legal speakers and is not available in Welsh. We have committed to addressing this for the future.

Timely Effective Efficient

This short video, presented by members of our Laundry Services Team, demonstrates very effectively the timely, effective and efficient aspects of the Duty. The video shows the breadth of the impact of laundry services across NHS Wales and the ways in which they are improving the efficiency of the service in order to enhance sustainability and reduce cost to the NHS.

Equitable

Our People and Organisational Development Team work to ensure that we understand the demographic of the workforce in NWSSP, which enables us to ensure that services are delivered equitably to all staff, fairly and in a non-discriminatory way, helping the organisation to be a person-centred employer.

Person Centred

This discusses the evolution of the Performance Appraisal Development Review (PADR) within NWSSP, which is designed to ensure a person-centred approach, effective conversations between managers and staff, and aligning goals to the priorities of NWSSP.



The Future

Following on from last year's Duty of Quality report, we have continued our quality journey and hope that this report will demonstrate the commitment of NWSSP and its staff to providing a quality service to our partners and patients across NHS Wales.

Muhammed Yunus, Nobel Laureate, stated that "Truly affordable but high-quality health care tools and services are the only means by which quality health care can be provided to all." NWSSP, in its ongoing aspirational approach to ensure a sustainable quality approach to NHS services in Wales, models this principle.

We have shown in this report that ensuring quality within NWSSP, covers the four major processes:

- **Quality Planning (QP):** through our IMTP, demonstrating the way we have continued to embed quality into our organisational culture.
- **Quality Assurance (QA):** from our always on reporting model, to our internal and external accreditations.
- **Quality Control (QC):** Ensuring that our KPIs are regularly reviewed with quality measures in mind and that our regular rhythm of review for divisions has quality at its heart.
- **Quality Improvement (QI):** being central to our discussions in quarterly reviews, Senior Leadership Group and Partnership Board.

Looking forward to our next reporting period we will be reviewing how we can ensure that our quality reporting can be made more effective through data (QC), in developing dashboards to reflect our quality journey (QA) and to ensure measurability which will drive further improvement (QI). This approach will align with our quarterly divisional reporting process which aligned with the IMTP and KPIs.

Our previous report was well received, and we look forward to further developing future reports in line with the feedback given. We have discussed approaching Llais with a view to engaging with them to ensure citizen driven reporting and would anticipate that this will strengthen citizen understanding and engagement with NWSSP.

In line with our colleagues across Wales we will be looking to refine our self-assessments against the quality maturity matrix and to continue our cross divisional learning. The refined self-assessments will provide each division a focus for their next year's quality agendas.

In short, this is a snapshot report showing the quality approach of some of our divisions in NWSSP. Our diversity precludes a single approach to quality, with services ranging from direct to indirect patient and community impact, but it is clear that the same high standards and the culture of continual quality improvement holds across the organisation.



Appendix A

IMTP Duty of Quality Appendix 2025-28





This appendix demonstrates further alignment to our commitment to the Duty of Quality within NWSSP. We have been able to map the relevant health and care standards logos throughout the IMTP to identify associated work streams.



Digital Workforce Solutions Develop and digitise learning platforms which will support the continued professional development of the current and future Health and Social Care Workforce. This aims, among other benefits, to enable the transferability of learning records.

Digital Workforce Solutions The Digital Workforce and Productivity Solutions (DWPS) Quality Management System continues to develop. This will support implementation of a framework to monitor, assess and continuously enhance the service, thereby improving healthcare services across NHS Wales and ensuring fulfilment of the Divisional responsibilities under the Duty of Quality.

Specialist Estates Services SES are focussing on providing additional resilience in the Engineering Team Decontamination section. This not only allows for developing our current and future staff but is aimed at producing the capacity of the service which supports patient outcomes across Wales.

Accounts Payable Increasing staff benefit services across NHS Wales and assess the feasibility of creating a portal as part of the digital gateway process

Accounts Payable The team plan to ensure that all staff within the division will receive relevant and robust “purchase to pay” training. This has involved creating training frameworks and reviewing and refreshing induction training.

All Wales Laundry Service Investigate options to support succession planning for the current laundry management team.

Digital Workforce Solutions Support the re-procurement and implementation of a Health Roster Solution on an All-Wales basis – a once for Wales solution



Pharmacy Services Work continues to support management of the supply chain throughout Wales which will quantify volumes and enable resilience for the complex issue of medicine shortages. This will require robust data consolidation and data integrity.

All Wales Laundry Service

Investigation and data collection on strategic linen stock holdings to create resilience across the service

Central team eBusiness Services

Extend robotics support to Health Organisation's Financial Management (FMS) processes, including service desk support and implementation and design of new finance and procurement processes in the Microsoft Power platform.

Procurement and Central Team eBusiness Services

It is planned to increase the number of invoices processed via e-trading by 10%, which will ensure seamless delivery whilst freeing up resource and improving data analysis and decision making.

All Wales Laundry Service IT support for the service will be migrated from Local Health Board support to NWSSP and Digital Health Care Wales (DCHW) support. This will enable customers to contact one single number for Wales and requests can be supported in an efficient and timely manner.

Digital Workforce Solutions Roll out of Health Rostering across NWSSP and Public Health Wales, providing a consistent central support model for all rostering queries.

Digital Workforce Solutions Support the re-procurement and implementation of a Health Roster Solution on an All Wales basis – a once for Wales solution.



Digital Workforce Solutions Working with Welsh Government to extend the All-Wales International Recruitment Programme. This will support workforce sustainability across NHS Wales.

People and Organisational Development

Developing and implementing Speaking up Safely for all medical and dental trainees in Wales, ensuring that staff managed under the Single Lead Employer model are supported and treated fairly.

All Wales Laundry Service Develop the engineering team by investigating the implementation of part time engineering degrees alongside work, creating a learning culture and opportunities.

Accounts Payable Increasing staff benefit services across NHS Wales and assess the feasibility of creating a portal as part of the digital gateway process

Employment Services Employment Services has renewed a Law Contract via procurement exercise is now in place to support complex area of Right to Work for non-UK staff.

Procurement Procurement will support any procure 2 Pay (P2P) initiatives that emerge from the various governance groups.



Central Team eBusiness Support Co-ordinate development and service desk support for Scan for Safety Continuous Service improvement (SCI) and review server requirements.

Surgical Materials Testing Laboratory SMTL are leading a group looking at the procurement of reusable gowns for NHS Wales. This supports the decarbonisation targets and the climate change emergency work.

Digital Workforce Solutions Lead the development of the Workforce Transformation Solution Programme, moving from planning to mobilisation stage.

Employment Services Develop a recruitment continuous service improvement programme that advances our service efficiencies through innovation and digital automation of legacy and new systems to better support a shared service model.

Accounts Payable It is planned to continue to increase the proportion of Electric/Hybrid vehicles that are on the Salary Sacrifice fleet to 90% during 2025-2026.

Procurement and HCS Support the national medical workforce productivity agenda and lead national initiatives, promoting collaborative working and introducing a robust system to identify rota gaps and speciality shortages on a national and local level.

Digital Workforce Solutions Support the re-procurement and implementation of a Health Roster Solution on an All-Wales basis – a once for Wales solution.

NHS Counter Fraud Services Explore the provision of specialist financial investigation services to other public sector services in Wales.



Primary Care Services PCS are introducing and embedding research and development within primary care services for the four contractor groups. The aim of this is to take opportunities to use resources more effectively and to ensure sustainability of service delivery.

Surgical Materials Testing Laboratory SMTL are leading a group looking at the procurement of reusable gowns for NHS Wales. This supports the decarbonisation targets and the climate change emergency work.

Pharmacy Services The Pharmacy Services Medicines Unit continues to develop new products with a current portfolio of 4 drugs and 7 product lines ongoing. This sets a standard for best practice in partnership with the Health Boards and helps to bring forward new products which will benefit patients across Wales.

Procurement and Central Team eBusiness Services A training framework is being developed to enhance the current training provision for all Procurement and Accounts Payable staff relating to purchase-to-pay to improve the customer experience resulting in a reduction in service desk calls.

Digital Workforce Solutions Continue to work in partnership with all Universities, mapping national NHS Wales e-learning requirements, ensuring compliance prior to placement and transferability of compliance.



Digital Workforce Solutions Lead the development of the Workforce Transformation Solution Programme, moving from planning to mobilisation stage.

Accounts Payable It is planned to continue to increase the proportion of Electric/Hybrid vehicles that are on the Salary Sacrifice fleet to 90% during 2025-2026.

Audit and Assurance Training and upskilling of all staff to add value to audit provision through increased efficiency enabling key risk areas to be targeted.

Central Team eBusiness Lead a review of the team structure to reflect changes to service delivery and support to ensure that it continues to meet customer demands.

People and Organisational Development Create a community of practice to support NHS organisations in the implementation of establishment reporting, addressing the skills and knowledge gap to initiate this. This will enable safe assessment of vacancy data at local and national levels and support strategic workforce plans.

Pharmacy Services Set up a national microbiological monitoring service for pharmacy services to analyse and report on samples generated from manufacturing/preparation units. This is essential to support and maintain the new radio pharmacy unit.

Pharmacy Services Lead on the development of a national medicines stockpile to ensure medicines resilience to ensure that stocks are effectively managed in times of crisis.





Pharmacy Services Pharmacy Services will continue to work to maintain the required regulatory and professional licences and registrations (including the Medicine and Healthcare Products Regulatory Agency (MHRA), home Office licencing and General Pharmaceutical Council Pharmacy registration). This will assure service users that our pharmacy services are maintaining a standard of quality evidenced from external review.

Procurement and HCS There are plans in place to develop improved communication methods to ensure that information for customers and staff is managed, clear and accessible. This will improve information flow and ensure that both staff and customers are given consistent messages. This will also reduce frustration and increase well being

People and Organisational Development Create a community of practice to support NHS organisations in the implementation of establishment reporting, addressing the skills and knowledge gap to initiate this. This will enable safe assessment of vacancy data at local and national levels and support strategic workforce plans.

Procurement and HCS Support the national medical workforce productivity agenda and lead national initiatives, promoting collaborative working and introducing a robust system to identify rota gaps and speciality shortages on a national and local level.

Digital Workforces Solutions Develop and digitise learning platforms which will support the continued professional development of the current and future Health and Social Care Workforce. This aims, among other benefits, to enable the transferability of learning records.

Pharmacy Services Set up a national microbiological monitoring service for pharmacy services to analyse and report on samples generated from manufacturing/preparation units. This is essential to support and maintain the new radio pharmacy unit.



Accounts Payable It is planned to continue to increase the proportion of Electric/Hybrid vehicles that are on the Salary Sacrifice fleet to 90% during 2025-2026.

Procurement and Central Team eBusiness Services It is planned to increase the number of invoices processed via e-trading by 10%, which will ensure seamless delivery whilst freeing up resource and improving data analysis and decision making.

All Wales Laundry Service Real time monitoring systems will be developed for tracking energy usage across utilities and major consumers. This will allow sharing of energy usage with customers and demonstrate that the service is playing an active role in reducing its carbon footprint across Wales.

All Wales Laundry Service Establishment of base line strategic linen stock holdings to create service resilience. This will prevent patient care being disrupted if there is breakdown at a laundry site.

Digital Workforce Solutions Support the re-procurement and implementation of a Health Roster Solution on an All Wales basis – a once for Wales solution.

Legal and Risk Provide guidance and support to NHS organisations with the introduction of revised national guidance for Putting Things Right (PTR). This will support the fair, effective and efficient management of cases.

Primary Care Services Identify solutions to drive automation and support embedding the Wales Ophthalmic contract to ensure the timely and effective submission and payment of claims.

Procurement The team plan to increase the value of rebates earned by 10% by March 2026, with a baseline determined at the end of March 2025.

Procurement and Central Team eBusiness Services It is planned to increase the number of invoices processed via e-trading by 10%, which will ensure seamless delivery whilst freeing up resource and improving data analysis and decision making.

Procurement and Central Team eBusiness Services A training framework is being developed to enhance the current training provision for all Procurement and Accounts Payable staff relating to purchase-to-pay to improve the customer experience resulting in a reduction in service desk calls.

All Wales Laundry Service IT support for the service will be migrated from Local Health Board support to NWSSP and Digital Health Care Wales (DCHW) support. This will enable customers to contact one single number for Wales and requests can be supported in an efficient and timely manner.

Digital Workforce Solutions Support the re-procurement and implementation of a Health Roster Solution on an All-Wales basis – a once for Wales solution.

Employment Services Carry out a feasibility study into the ability of the current payroll system to undertake an all-Wales weekly pay for Nurse Bank employees, releasing wages earlier and promoting a reduction in agency spend.



Accounts Payable It is planned to increase the number of suppliers using new statement reconciliation software to improve efficiency within the service

Accounts Payable Plans are in place to re-procure the duplicate payment and statement matching software to provide an improved and more efficient Procure to Pay process

All Wales Laundry Service IT support for the service will be migrated from Local Health Board support to NWSSP and Digital Health Care Wales (DCHW) support. This will enable customers to contact one single number for Wales and requests can be supported in an efficient and timely manner.

All Wales Laundry Service Real time monitoring systems will be developed for tracking energy usage across utilities and major consumers. This will allow sharing of energy usage with customers and demonstrate that the service is playing an active role in reducing its carbon footprint across Wales.

Audit and Assurance Training and upskilling of all staff to add value to audit provision through increased efficiency enabling key risk areas to be targeted.

Procurement and HCS Support the national medical workforce productivity agenda and lead national initiatives, promoting collaborative working and introducing a robust system to identify rota gaps and speciality shortages on a national and local level.

Legal and Risk Provide guidance and support to NHS organisations with the introduction of revised national guidance for Putting Things Right (PTR). This will support the fair, effective and efficient management of cases.





Procurement and HCS There are plans in place to develop improved communication methods to ensure that information for customers and staff is managed, clear and accessible. This will improve information flow and ensure that both staff and customers are given consistent messages. This will also reduce frustration and increase well being

All Wales Laundry Service Linen segregation awareness training will be introduced to all customers, ensuring that they are all equally aware of the need to segregate linen effectively and to prevent linen being inappropriately sent to landfill. This will help to reduce the carbon footprint of the service.

Audit and Assurance The team will develop relationships with other internal audit providers for the identification of best practice, to ensure that the department can continue to add value with the service it provides through comparative benchmarking.

Audit and Assurance Supporting integrated assurance across NHS Wales organisations, and bringing together a suite of assurance sources. This will help to embed robust assurance arrangements and reduce variable processes.

Digital Workforce Solutions Support the re-procurement and implementation of a Health Roster Solution on an All Wales basis – a once for Wales solution

Legal and Risk Provide guidance and support to NHS organisations with the introduction of revised national guidance for Putting Things Right (PTR). This will support the fair, effective and efficient management of cases.

Medical Examiners Service Review and align all output reporting to the Duty of Quality domains and ensure that this meets customer/stakeholder requirements, driving best practice and ensuring broader learning outcomes.





Accounts Payable Increasing staff benefit services across NHS Wales and assess the feasibility of creating a portal as part of the digital gateway process.

Procurement and Central Team eBusiness Services A training framework is being developed to enhance the current training provision for all Procurement and Accounts Payable staff relating to purchase-to-pay to improve the customer experience resulting in a reduction in service desk calls.

All Wales Laundry Service A shift pattern review will be undertaken to ensure operating hours match demand and capacity, with a planned and thoughtful rota which should allow for working hours to be undertaken within normal operating hours. This will allow room for overtime if needed while supporting a healthy work life balance.

Audit and Assurance Training and upskilling of all staff to add value to audit provision through increased efficiency enabling key risk areas to be targeted.

Digital Workforce Solutions Lead the development of the Workforce Transformation Solution Programme, moving from planning to mobilisation stage.

Procurement and HCS Support the national medical workforce productivity agenda and lead national initiatives, promoting collaborative working and introducing a robust system to identify rota gaps and speciality shortages on a national and local level.

Medical Examiners Service Review and align all output reporting to the Duty of Quality domains and ensure that this meets customer/stakeholder requirements, driving best practice and ensuring broader learning outcomes.

Primary Care Services Develop intelligence services to underpin and support delivery of the Primary Care strategic workforce plan, supporting sustainability.



We hope that this report has been informative and has given an insight into our drive to continually demonstrate, assure, and improve quality in the services provided by NWSSP.

For any questions on the content of this review, please contact:

Shelley Jones
Business Manager to the Medical Director



02921 500500



shelley.jones2@wales.nhs.uk



www.nwssp.wales.nhs.uk



NHS Wales Shared Services Partnership



NHS Wales Shared Services Partnership,
4-5 Charnwood Court,
Heol Billingsley,
Parc Nantgarw,
Cardiff,
CF15 7QZ

TRUST BOARD	
2024/2025 PROFESSIONAL REGULATION / REVALIDATION ANNUAL REPORT	
DATE OF MEETING	24 July 2025
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	N/A
REPORT PURPOSE	ASSURANCE
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Anna Harries, Head of Nursing Professional Standards and Digital, Bethan Tranter, Chief Pharmacist and Elizabeth Eddie, Executive Medical Business Manager
PRESENTED BY	Anna Harries, Head of Nursing, Professional Standards and Digital
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs & Health Sciences and Dr Jacinta Abraham, Executive Medical Director
EXECUTIVE SUMMARY	This Professional Registration/Revalidation Report covers the period 1st April 2024 - 31st March 2025 and is to provide assurance in relation to professional regulation governance. During this period: • There were no Health Care Professionals Council, General Pharmaceutical Council or General Pharmaceutical Council registration lapses. • There was one Nursing & Midwifery Council Registration lapse, the staff member was not on duty during this period and did not work whilst not registered. • 80 Medical appraisals were undertaken; 26 positive recommendations were made to the GMC to revalidate and 2 recommendations to defer due to extenuating circumstances. • The Trust Revalidation and Registration Policy has been updated with review date September 2027.

	The Trust is currently reviewing professional registration and revalidation oversight in respect of those professions employed or seconded to work within hosted services.
RECOMMENDATION / ACTIONS	To NOTE the 2024/2025 Professional Regulation / Revalidation Annual Report in respect of professional registration / revalidation compliance across professional groups employed within the core Velindre University NHS Trust whilst governance in respect of hosted services is being worked through.
GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	Date
Professional Nursing Forum	28.05.2025
Allied Health Professionals/Health Sciences Meeting	27.05.2025
Executive Management Board	30.06.2025
Quality, Safety & Performance Committee	17.07.2025
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSION	
Report noted and endorsed for onward Trust Board consideration	
7 LEVELS OF ASSURANCE	
If the purpose of the report is selected as ' ASSURANCE ', this section must be completed.	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 3 - Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes

1. BACKGROUND

All healthcare professionals are required to re-register, and some revalidate. There is variation across the professional groups that is detailed within the report.

2. ASSESSMENT

2.1 *Registration Assurance*

There were no HCPC, GPhC, or GMC registration lapses or revalidation issues.

2.2 *Registration Lapses*

During the year 1st April 2024-31st March 2025 there was one NMC registration / revalidation breach, a nurse whose registration lapsed while on long term sick leave. The nurse did not work without an active registration. The management team took appropriate action.

2.3 *GMC Appraisals*

There were 105 prescribed connections for the Trust, although 25 (23.8%) doctors were exempt from appraisal due to having less than one year's service or extenuating circumstances. Of the remaining 80 doctors, 78 (97.5%) completed appraisals on time. The remaining 2 doctors have since completed their appraisals.

There were 26 out of 28 positive revalidation recommendations made to the GMC in the reporting period, with 2 recommendations for deferral due to reasonable circumstances.

2.4 Hosted Body Registration and revalidation

The Executive Medical Director has oversight and assurance in respect of the registration and revalidation of medical staff employed, where the Trust is the Designated Body within hosted services. Trust professional oversight arrangements for other regulated professions in NWSSP is currently being reviewed. This is in place for other hosted services.

3. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals:	
- Outstanding for quality, safety and experience - An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations - A beacon for research, development and innovation in our stated areas of priority - An established 'University' Trust which provides highly valued knowledge for learning for all. - A sustainable organisation that plays its part in creating a better future for people across the globe	☒ ☒ ☐ ☐ ☐
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) For more information: STRATEGIC RISK DESCRIPTIONS	06 - Quality and Safety
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Select all relevant domains below
	Safe ☒ Timely ☐ Effective ☒

	Equitable ☐ Efficient ☒ Patient Centred ☐
	Professional registration is a legal requirement. Having appropriately registered clinical staff is critical for clinical safety.
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	Yes - please Include further detail below, including funding stream
	Financial impact if staff unable to practice due to failure of this process and potential legal action. No direct financial implication from this paper
EQUALITY IMPACT ASSESSMENT For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.asp X	Yes - please outline what, if any, actions were taken as a result
	<i>All Registered staff to be considered in this process, including those on long term leave. The Trust policy would have included this Equality Impact Assessment.</i>
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	It is a legal requirement for registrants to have a live registration when practicing.

4. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	<i>Staff must be registered to practice by legislation</i>
WHAT IS THE CURRENT RISK SCORE	6
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	<i>Risk now lower as policy updated, for review Sept 2027</i>
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Achieved and continually monitored
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
All risks must be evidenced and consistent with those recorded in Datix	

Velindre University NHS Trust
Head of Nursing, Professional Standards and Digital

Annual Professional Registration/Revalidation Report

2024/2025



Velindre University NHS Trust is responsible for the delivery of a wide range of specialist NHS Wales services including the Velindre Cancer Service and the Welsh Blood Service and we host Health Technology Wales, and NHS Wales Shared Services Partnership.

Caring

We are always kind, supportive, approachable and show compassion to all.



Respectful

We seek to understand other people's perspectives. We are always open and transparent.



Accountable

We always take personal responsibility for what we do and how we do it.



The Velindre Cancer Service is a specialist treatment, teaching, research and development service for non-surgical tertiary oncology services to patients from across south east Wales and further afield.

The Welsh Blood Service provides essential and highly specialised national services including the collection and production of blood and blood components, specialist diagnostic services and antenatal screening, as well as supporting transplant services for solid organs and stem cells across Wales and internationally.

Health Technology Wales assesses non-medicine health and care technologies and produces national guidance on their use in Wales.

NHS Wales Shared Services Partnership delivers a wide range of professional, technical and administrative services to NHS Wales.

1. Introduction

- 1.1 This Professional Registration/Revalidation Report covers the period 1st April 2024-31st March 2025 and is to provide assurance in relation to professional regulation governance. During this period:
- 1.2 There were Zero Health Care Professionals Council, General Pharmaceutical Council or General Pharmaceutical Council registration lapses.
- 1.3 There was one Nursing & Midwifery Council Registration lapse, the staff member was not on duty during this period and did not work whilst not registered.
- 1.4 80 Medical appraisals were undertaken; 26 positive recommendations were made to the GMC to revalidate and 2 recommendations to defer due to extenuating circumstances.
- 1.5 The Trust Revalidation and Registration Policy has been updated with review date September 2027.



2. Background

- 2.1 All healthcare professionals are required to re-register, and some revalidate. There is variation across the professional groups that is detailed below:

Nursing & Midwifery Council (NMC)

Every qualified nurse on the NMC Professional register is required to complete a process of re-registering yearly and revalidation three yearly. If a registrant does not re-register or revalidate when due their registration will lapse. If registration lapses a registrant cannot practice and they will need to apply to the NMC to be re-registered – this can take up to 6 weeks.

There is a legal requirement for any individual using the protected title of registered nurse or registered midwife in the UK to revalidate every three years. Nurses must evidence that they have met the following requirements in order to revalidate:

- 450 practice hours
- 35 hours of continuing professional development (20 of which must be participatory)
- Five pieces of practice-related feedback
- Five written reflective accounts detailing learning, resultant changes or improvements to practice, and relevance to the Code
- A reflective discussion with another NMC-registered nurse
- Declarations of health and character
- Evidence of appropriate indemnity arrangements.
- Confirmation of adherence with the revalidation process, usually by the employer.

2.2 Health & Care Professions Council (HCPC)

The HCPC regulate 15 professions. These professions have designated titles that are protected by law and professionals must be registered with the HCPC to use them. These are:

• Arts Therapists	• Orthoptists
• Biomedical Scientists	• Paramedics
• Chiropodists / Podiatrists	• Physiotherapists
• Clinical Scientists	• Practitioner Psychologists
• Dieticians	• Prosthetists / Orthotists
• Hearing Aid Dispensers	• Radiographers
• Occupational Therapists	• Speech and Language Therapists
• Operating Department Practitioners	

HCPC Registrants need to re-register every two years. Each profession has a set month during the two-yearly cycle when registration is required to be completed by. Registrants will receive notification of renewal deadlines and needs to complete a professional declaration and pay a renewal fee no later than the deadline to avoid being removed from the register. If removed, they cannot practice. A random sample of 2.5 percent of the profession will be selected to submit a continuing professional development (CPD) profile for the renewal period.

There are no revalidation requirements.

2.3 General Medical Council (GMC)

Every doctor on the General Medical Council (GMC) register is required to revalidate, normally every five years. To maintain a license to practice a doctor must demonstrate that they work in line with the principles set out within the GMC's Good Medical Practice Guidance. Medical revalidation, through statutory duties will provide assurance that doctors in the UK are fit to practice.

A Responsible Officer or suitable person is required to make a recommendation to the GMC about whether a doctor connected to them should be revalidated. Following this, the GMC decides whether a doctor can be revalidated based on the recommendation and any other information that they hold. There are three types of revalidation recommendations that can be made:

- Recommendation to revalidate
- Recommendation to defer
- Recommendation of non-engagement.

In order to make a recommendation which is consistent, fair and reliable the Responsible Officer requires evidence that a doctor is regularly appraised on their whole practice, ensuring the completeness and quality of supporting information and their reflections on it. Any areas for development in a doctor's practice should be identified and addressed in a targeted way, and concerns about a doctor's fitness to practice referred to the GMC where appropriate.

Connected doctors are required to have annual appraisals where there is evidence of:

- Scope of work
- Review of PDP
- CPD
- Review of complaints and compliments
- Review of Significant events
- Probity and Health declarations
- In every revalidation cycle the doctor additionally is required to provide evidence of Formal patient and colleague feedback.
- Information supporting a quality improvement.

2.4 General Pharmaceutical Council (GPhC)

To practise in Great Britain, pharmacists and pharmacy technicians must be registered with the GPhC and have satisfied the council that they meet its requirements.

Pharmacist and pharmacy technician are protected titles and therefore there is a legal requirement that only registered and re-validated individuals can use these titles.

Pharmacies must also be registered with the GPhC (or be a pharmacy department based in a hospital or health centre) to operate in Great Britain and to use the title 'pharmacy'. As VCS Pharmacy provides pharmaceuticals to a third-party provider for its private patient practice, the pharmacy is registered premise with the Chief Pharmacist identified as the Superintendent Pharmacist for the purposes of premises registration.

Pharmacists, pharmacy technicians and registered pharmacies must renew their registration annually, which involves completing a declaration stating that they meet all professional, fitness to practise and ethical standards.

Annual re-validation for pharmacists and pharmacy technicians includes submission of:

- 4 x CPD records,
- a peer review discussion to ensure engagement with others on the individual's learning and practice and
- a reflective account to encourage consideration of how the individual meets professional pharmacy standards.



3. Assessment

3.1 Trust Registration / Revalidation Policy

Updated with review date of September 2027.

3.2 Registration Assurance

There were no HCPC, GPhC, or GMC registration lapses or revalidation issues.

3.3 Registration Lapses

During the year 1st April 2024 – 31st March 2025 there was one registration / revalidation breach. This was an NMC breach, an experienced nurse whose registration lapsed while on long term sick leave. The management team followed process to remain in contact with the staff nurse and the lapse was escalated to the Director of Nursing.

3.4 GMC Appraisals

There were 105 prescribed connections for VUNSHT although 25 (23.8%) doctors were exempt from appraisal due to having less than one year's service or extenuating circumstances. Of the remaining 80 doctors, 78 (97.5%) completed appraisals on time. The remaining 2 doctors have since completed their appraisals.

There were 26 out of 28 positive revalidation recommendations made to the GMC in the reporting period, with 2 recommendations for deferral due to reasonable circumstances.



Welsh Revalidation and Appraisal Group reporting as at the 31.03.2023

Important: Only doctors with whom the designated body has a prescribed connection should be included in this section. Each doctor should be included in only one category.

	Number of prescribed connections	No of doctors exempt from appraisal	No of completed appraisals (Summary agreed)
Consultants (including honorary contract holders)	77	9 (5 with less than one year in post, therefore appraisal not due, 4 extenuating circumstances)	66
Staff grade, associate specialist, specialty doctor (including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere)	9	3 (2 with less than one year in post, therefore appraisal not due, 1 extenuating circumstances)	6
Doctors with practising privileges (for independent healthcare providers only); all doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade)	N/A	N/A	N/A
Temporary or short-term contract holders (including trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts)	17	13	4
Other (Including some management / leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc.)	2	0	2
Overall	105	25 (23.8%)	78 (97.5% of non-exempt doctors; 76.2% of all doctors)

The Responsible Officer is supported by the revalidation team which comprises of the Deputy Responsible Officer, the Executive Medical Business Manager, the Consultant Clinical Appraisal Lead, and the Revalidation and Appraisal Manager. Regular compliance meetings are held where forthcoming recommendations are discussed to allow sufficient time to make a recommendation ahead of revalidation dates.

The all Wales recommendation of a 0.5 session remuneration per 10 appraisals has been adopted by the Trust. There are currently 10 Appraisers, with one due to retire at the end of July 2025. Two new appraisers have been recruited, pending training.

An Independent Member will be identified to take on the role of lay representative. Role profile is being developed following a benchmarking exercise across Wales Health Boards undertaken by the Revalidation Manager in July/August 2024 to look at duties, job descriptions/person-specs, and recruitment and remuneration of lay/patient/public representatives.

The full 2024/25 Revalidation Progress Report is available from the Executive Medical Director if required.



Unit 2, Charnwood Court,
Parc Nantgarw, Cardiff, CF15 7QZ

029 2019 6161 | velindre.nhs.wales

TRUST BOARD	
Annual Assurance Report on Compliance with the Nurse Staffing Levels (Wales) Act 2016	
DATE OF MEETING	24 th July 2025
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
REPORT PURPOSE	APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Rhian Wright, Lead Nurse Workforce, Education and Standards
PRESENTED BY	Anna Harries, Head of Professional Standards and Digital
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences
EXECUTIVE SUMMARY	This paper is to provide Trust Board with the assurance that all statutory requirements of the Nurse Staffing Levels (Wales) Act 2016 are being met. Aligning with the requirements of the Nurse Staffing Levels (Wales) Act 2016 the biannual nursing establishment reviews have taken place using a triangulated approach for first floor ward, 25B area. Although not a current mandated requirement the same process of biannual establishment reviews have been enacted for 25A areas. Report highlights are: • All reasonable steps have been taken to maintain the nurse staffing level in line with the requirements of the Act. • 79.73% of shifts on the First Floor Ward were deemed to be appropriately staffed with a data compliance rate of 93.88%. • There have been no instances of reportable harm for pressure damage, falls or medication never events or instances where nurse staffing levels were thought to be a contributory factor to harm or complaints. • There have been two Putting Things Right complaints relating to nursing care on the ward

	- Investigations concluded staff levels were not a contributory factor, there were no breaches of duty. The learning outcomes have been enacted. • <i>Currently, the nursing establishment is sufficiently funded and appropriate to provide the planned roster for First Floor Ward.</i> The establishment includes the required 26.9% headroom.
RECOMMENDATION / ACTIONS	The Trust Board is asked to APPROVE the 2024/2025 Nurse Staffing Levels Wales Annual Assurance report prior to onward submission to Welsh Government.
GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	Date
Professional Nurse Forum (PNF)	15/04/2025
Executive Management Board (EMB)	30/06/2025
Quality, Safety & Performance Committee	17/07/2025
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
PNF & EMB: The report was endorsed by both. Quality, Safety & Performance Committee – The Committee requested that 2024 comparative data is added into the table on page 10 to facilitate comparative analysis – this action has been taken, although robust comparators cannot be drawn due to different collection methodologies between the two years – manual (2024) v's electronic (2025)	
7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 4 - Increased extent of impact from actions

1. BACKGROUND

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

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

The Velindre Cancer Service First Floor Ward was re-classified in April 2021 as meeting the wider definition of a 'medical ward' as it is a specialist oncology medical ward and therefore, the ward and Trust are now required to meet the full reporting requirements of the Nurse Staffing Levels (Wales) Act 2016. Bi-annual nursing establishment reviews of both 25A and 25B areas are carried out utilising a triangulated approach. The full detailed report will follow however part of this is considered in the assessment/summary below.



2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 *Nurse Staffing Levels Act Reporting*

To facilitate the preparation of the statutory three yearly report to Welsh Government, there is an agreed All Wales requirement that an annual assurance report be prepared to provide assurance to the Board that all statutory requirements are being met. The Nurse Staffing Levels (Wales) Act 2016 Annual Assurance Report has been completed, and the report (using the national reporting template) is attached. This report highlights:

- There has been no change to the establishment or planned roster for first floor in the last 12 months
- All reasonable steps have been utilised to maintain the nurse staffing level in line with the requirements of the Nurse Staffing Levels (Wales) Act 2016
- First Floor establishment includes the required 26.9% headroom
- There are no financial concerns in the funding of the establishment for first floor ward
- 79.73% of shifts were deemed to be appropriately staffed with a data compliance rate of 93.88%
- All reasonable steps have been utilised to maintain the nurse staffing level in line with the requirements of the Nurse Staffing Levels (Wales) Act 2016
- There have been no instances of reportable quality indicators/harm to patients during this period and no harm reported due to nurse staffing levels
- Two complaints relating to nursing care were addressed through the "Putting Things Right" process. Both complaints concluded that there was no breach of duty, and the learning outcomes have been communicated to the team
- Registered nursing skill mix has posed some challenges following international nurse recruitment and student streamlining; however, this is an improving picture
- Establishment reviews in 25A areas follow the same format as 25B establishment reviews and are conducted bi-annually
- The previously identified gap in sufficient headroom within the CNS team has been addressed through the recruitment of two new generic CNS's.
- The nursing workforce rosters on the First Floor Ward, the Ambulatory Unit and Assessment Unit have now been separated to facilitate more robust oversight in line with the Act requirements.

3.2 *Establishment Reviews*

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

- Current funded establishments
- Vacancies and staff in post
- Datix Incidents – related to service delivery and staffing
- Complaints relevant to establishment or staffing
- Training compliance
- PADR compliance
- Review of roster
- Patient feedback (CIVICA)
- Audits (Tendable)
- Acuity that may be formally assessed, i.e. First floor or discussion of area for understanding
- KPI review
- Quality indicators (25B)
- Service plans or clinic templates as applicable (not all areas)

In summary, there were no incidents or harm relating to the reportable quality indicators effecting care linked to nurse staffing levels for the reporting period.

3.3 *Electronic Rostering*

Health Roster is fully utilised in nine nursing areas/teams and for the nurse bank. Rostering Key Performance Indicators (KPIs) are produced electronically which are scrutinised locally to assess rostering efficiency and effectiveness. An overview of these KPIs is also undertaken as part of establishment reviews. Health Roster also facilitates rapid and robust assurance that staffing levels are safe across all nursing areas. These rosters are legible, auditable and viewed in one centralised location for visibility of responsible staff.

4. 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:	
• Outstanding for quality, safety and experience	☒
• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations	☒
• A beacon for research, development and innovation in our stated areas of priority	☐
• An established 'University' Trust which provides highly valued knowledge for learning for all.	☐
• A sustainable organisation that plays its part in creating a better future for people across the globe	☐

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) For more information: STRATEGIC RISK DESCRIPTIONS	06 - Quality and Safety
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Select all relevant domains below
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	The Nurse Staffing Levels (Wales) Act 2016 covers all aspects of safe, timely and effective care. Rostering of staff against demand considers equitable and efficient care to deliver patient centered delivery.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: For more information: https://www.gov.wales/socio-economic-duty-overview	Not required
	Socio-economic disadvantage and inequality of outcome is not relevant to this paper
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
	To enable us to achieve a Healthier Wales and our organisational goals we need a sufficient workforce with the right skills and in the right place to be able to provide safe, timely and effective care to our patients and donors.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT For more information: https://nhswales365.sharepoint.com/sites/VEL_I/ntranet/SitePages/E.aspx	Not required
	There is no evidence to suggest that the information in this paper could benefit or disadvantage any particular group of people.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Compliance with the relevant sections of the Nurse Staffing Levels (Wales) Act 2016 is a statutory obligation and will be subject to scrutiny

5. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

Annual Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act: Report for Board/Delegated Committee			
Health board/trust	Velindre University NHS Trust		
Date annual assurance report is presented to Board	Date this report presented to Board Reporting period - 6th April 2024 to the 5th April 2025 <i>This annual report refers only to year 2024/2025 but this report forms part of the 3 yearly assurance report that will be presented to Welsh Government in October 2027 for the reporting period from April 2024- April 2027</i>		
	Adult acute <u>medical</u> inpatient wards	Adult acute <u>surgical</u> inpatient wards	Paediatric inpatient wards
During the last year the lowest and highest number of wards	1		
During the last year the number of occasions (wards where section 25B applies) where the nurse staffing level has been reviewed/ recalculated outside the bi-annual calculation periods	0		
The process and methodology used to calculate the nurse staffing level.	The triangulated approach outlined in the Welsh Levels of Care Toolkit has been applied to inform the calculation of nurse staffing levels on First Floor Ward. This approach includes analyses of key quality indicators such as patient falls, pressure damage, medication errors, and patient complaints, all of which contribute to determining safe nurse staffing levels. Establishment reviews are conducted bi-annually with the senior nursing management team, following the completion of the bi-annual nurse staffing calculation.		

	First Floor establishment includes the required 26.9% headroom to account for factors such as sickness, study leave, and annual leave. The ward manager remains supernumerary to the planned roster, and a nurse coordinator is also surplus to the roster during each day shift. As part of the establishment review process, the designated person asks each ward/unit manager whether they have adequate staffing levels to ensure the delivery of sensitive and appropriate care to patients. The annual presentation of the nurse staffing levels report was submitted to the executive board in January 2025. There have been no changes to the establishment during the last 12-month reporting period. The ward’s primary purpose has remained unchanged throughout this period, and no recalculations have occurred outside the established bi-annual calculation cycle.			
Informing patients	Bilingual All Wales ‘Informing Patients Posters’ are displayed at the entrance of the ward, informing patients and relatives of the nurse staffing numbers calculated for the identified period and the date that the calculation was undertaken and signed off by the designated person. The posters are amended following each bi-annual re-calculation. Bilingual easy read Frequently Asked Questions (FAQ’s) are displayed alongside the informing patients posters. In addition, bilingual copies of the All-Wales FAQ’s for Nurse Staffing Levels are available for patients and visitors to view on the ward. The Nurse Staffing Programme Lead regularly checks and updates the information displayed. Patients can provide anonymous feedback through a digital feedback system called CIVICA. This helps to ensure that patients can provide real time feedback for any concerns relating to patient care.			
Section 25E (2a) Extent to which the nurse staffing level has been maintained As the nurse staffing level is defined under the NSLWA as comprising of both the planned roster <i>and</i> the required establishment, this section should provide assurance of the extent to which the planned roster has been maintained <i>and</i> how the required establishments for Section 25B wards have been achieved/maintained during the period of this annual report				
Extent to which the required establishment has been maintained within <u>adult acute medical and surgical wards.</u>		Period Covered April 24 – Nov 24.....		
		Number of Wards:	RN (WTE)	HCSW (WTE)
	Required establishment (WTE) of adult acute medical and surgical wards <u>calculated</u> during first cycle (May)	1	28.42	14.21

NB: First cycle: spring 2024 following January audit Second cycle: autumn 2024: following June audit	WTE of required establishment of adult acute medical and surgical wards <u>funded</u> following first (May) calculation cycle	1	28.42	14.21
	Required establishment (WTE) of adult acute medical and surgical wards <u>calculated</u> during second calculation cycle (Nov)	1	28.42	14.21
	WTE of required establishment of adult acute medical and surgical wards <u>funded</u> following second (Nov) calculation cycle	1	28.42	14.21
	WTE Supernumerary band 7 sister/charge nurse (funded but excluded from planned roster)	WTE: 1		
	There has been no required change to the funded establishment during the current reporting period. In addition to the Ward Manager, a supernumerary nurse co-ordinator WTE 1.269 is funded but excluded from the planned roster. The nursing establishment is adequately funded and appropriate to provide the planned roster for First Floor. There are no financial concerns in relation to the staffing of First Floor. Following a review of the current funded nursing establishment against the required staffing levels for First Floor Ward, the Integrated Care Directorate is of the opinion that the current establishment is sufficient to manage and deliver sensitive care to patients on First Floor Ward, up to the full capacity of 32 beds. <i>In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within the data for this report.</i>			

Extent to which the planned roster has been maintained within <u>adult acute medical and surgical wards</u>		Total number of shifts	Shifts where planned roster met & appropriate	Shifts where planned roster met but not appropriate	Shifts where planned roster not met but appropriate	Shifts where planned roster not met and not appropriate	Data completeness
	TOTAL 2025	1095 365 nights +365 early shifts and 365 late shifts	353 32.24% (electronic system don't account for empty beds)	31 2.83%	520 47.49% (due to empty beds)	124 11.32% (co-ordinator would then undertake clinical duties to offset)	93.88 %
	TOTAL 2024	682 shifts (incomplete data)	593 86.95 %	26 3.81%	10 1.47%	53 7.77%	93.2%
	Professional judgment is applied by the nurse coordinator or nurse in charge to assess whether a shift is appropriately staffed. This should be quality checked by the Ward Manager – an action from this years analysis is to strengthen this validation using a safety assurance lens – the Senior Nurse is leading on this. Shifts may not always be considered appropriate due to unforeseen factors such as increased patient acuity or short-notice staff sickness. In these instances, reasonable steps are taken to ensure staffing levels are adequately addressed. This includes exploring options such as redeploying supernumerary staff, reassigning staff from other areas such as co-ordination, and requesting bank, overtime, or agency staff to meet staffing requirements. The data prior to 2025 was collected using different methodologies, which accounts for the variation in reported shift figures. Determinations regarding appropriate staffing are based on professional judgement by the ward coordinator or nurse in charge. On occasions where there are unoccupied beds, staffing may be reported as inadequate based on the assumption of full occupancy (e.g., if there should be 5 registered nurses on duty, with 10 empty beds but reported as inadequate as only 4 nurses on shift).						

	This issue has been discussed with ward staff, and recent improvements in reporting practices have been implemented to enhance accuracy and consistency. The above validation enhancements should also help. The percentage of shifts that have not been met and not appropriate have also increased from 7.77% to 11.32%, a recent deep dive has highlighted that this refers to a shortfall in either a registered nurse or healthcare support worker or both. The most cited reasons for shifts being deemed inappropriate include rising patient acuity levels and an imbalanced skill mix. However, it is noted that the rationale behind these decisions is not always documented. To address this, staff have received training to ensure that when they report insufficient nurse staffing levels, they also raise a red flag, which triggers an alert to the senior nursing team for appropriate escalation and oversight.
Process & systems for capturing data on the extent to which the planned roster has been maintained on wards where section 25B applies.	During the reporting period from April 2024 to April 2025, First Floor Ward has recorded acuity twice a day solely utilising the SafeCare system. <i>NHS Wales is committed to utilising a national informatics system that can be used as a central repository for collating data to evidence the extent to which the nurse staffing levels have been maintained and to provide assurance that all reasonable steps have been taken to maintain the nurse staffing levels required. Extensive work has been undertaken across NHS Wales to implement a national informatics system to enable health boards/trust to meet the reporting requirements of the Act and follow the Once for Wales approach to ensure consistency.</i>
Process for maintaining the Nurse staffing level	Risk escalation processes are in place to enable real time monitoring and escalation of nurse staffing concerns. Any issues regarding nurse staffing levels in Velindre Cancer Centre are escalated to the senior nursing team via a bleep system. In addition, staff can submit Red Flags using the SafeCare system to highlight any staffing concerns, the raising of a red flag triggers an email notification to the Ward Manager and Senior Nurse. Operational teams take “all reasonable steps” to maintain the nurse staffing levels required based on acuity and bed occupancy. If nurse staffing levels are deemed insufficient, reasonable steps such as redeployment of staff from other areas as well as the use of bank and agency are fully explored. Operational steps to maintain the nurse staffing level include: • Clearly defined mechanisms in place to ensure deployment of staff to ensure appropriate clinical and/or

leadership skills.

- Deployment of staff deemed as supernumerary or non-rostered for example, ward manager, nurse coordinator and practice educator to provide direct patient care.
- Appropriate utilisation of bank, overtime and agency.

Section 25E(2b) Impact on care due to not maintaining the nurse staffing levels on adult acute medical and surgical inpatient wards

Incidents of patient harm with reference to quality indicators and complaints about nursing care	Avoidable hospital acquired pressure damage (grade 3, 4 and unstageable).	Falls resulting in moderate harm, serious harm or death (i.e. level 3, 4 and 5 incidents).	Medication administration errors resulting in moderate harm, severe harm, death & never events (i.e. level 3, 4, 5 and never events incidents).	Any complaints received about nursing care (Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR))
	TOTAL	TOTAL	TOTAL	TOTAL
Number of incidents/complaints closed during the current reporting period . (Please note these may include incidents/complaints opened prior to this reporting period).	0	0	0	2
Number of incidents/ complaints occurring when the nurse staffing level (planned roster) had not been maintained	0	0	0	0
Number of those incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor	0	0	0	0

<i>Number of incidents/complaints occurring when the nurse staffing level (planned roster) had been maintained</i>	0	0	0	2
<i>Number of those incidents/complaints when the nurse staffing level was deemed to have been a contributing factor, even when planned roster had been maintained.</i>	0	0	0	0

Velindre has not experienced any incidents of patient harm in relation to quality indicators over the past year that meet the reportable criteria. There have been two complaints in relation to nursing care managed through the putting things right process. Both complaints concluded that there was no breach of duty, and the learning outcomes have been communicated with the team. The first complaint was a delay in the referral process to social services and the second an omission in providing a take home medication on discharge. On the day of the second complaint, the nurse staffing level had the potential to fall below the planned roster; however, the supernumerary nurse coordinator assumed responsibility for a cohort of patients during the shift.

Based on a review of the Health Boards/Trusts first 3 yearly reports and feedback from operational leads on their experience completing the reports; an SBAR was presented to the Executive Nurse Directors and CNO in 2021, which included a series of recommendations to improve and refine the reporting process. Following this a sub-group of the All-Wales Nurse Staffing Group was set up to improve and refine the reporting process to standardise reporting and be in line with the Duty of Candour set out in the Quality & Engagement Act (2020), with the aim of broadening the scope of incidences of harm to provide more meaningful data, by including moderate risk falls and medication administration error incidents.

The work of the Reporting Sub-Group included a review of the measures for the adult medical and surgical inpatient wards and these were presented to the Executive Nurse Directors in August 2023. The changes to the adult wards measures were agreed, with the intention that the amended measures come into effect at the beginning of the next reporting period i.e. April 2024.

Since EDoNs agreed the recommendations in August 2023 it became apparent that the way data is being captured on Datix to meet the reporting requirements of the Duty of Candour (DoC), which came into force in April 2023, may impact our data collection under the duties of the NSLWA. Previously, we anticipated that the changes in the reporting criteria to include moderate levels of harm would increase overall reporting, however, following this clarification this anticipated increase may not be seen. It must be noted that previous NSLWA reports have reported on the actual harm sustained without validation, as opposed to the number of incidents found to be resulting from an act or omission when in receipt

of NHS Care. To align with patient safety incident reporting to Welsh Government all future NSLWA reports, as from April 2024, will report on closed patient safety incidents which have been validated with a level of harm moderate or above (as per patient safety incident definition) and whether the nurse staffing levels contributed to the incident.

The quality indicators for the adults in-patient wards will be as follows:

- Avoidable hospital acquired pressure damage (grade 3, 4 and unstageable).
- Falls resulting in moderate harm, serious harm or death (i.e. level 3, 4 and 5 incidents).
- Medication administration errors resulting in moderate harm, severe harm, death & never events (i.e. level 3, 4, 5 and never events incidents).
- Any complaints received about nursing care (Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR))

The data to be reported for each of the above will be:

- Number of incidents/complaints closed during the current reporting period. (Please note these may include incidents/complaints opened prior to this reporting period).
- Number of incidents/ complaints occurring when the nurse staffing level (planned roster) had not been maintained
- Number of those incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor
- Number of incidents/complaints occurring when the nurse staffing level (planned roster) had been maintained
- Number of those incidents/complaints when the nurse staffing level was deemed to have been a contributing factor, even when planned roster had been maintained.

Section 25E (2c) Actions taken if the nurse staffing level is not maintained (or maintained but not appropriate *)

Actions taken if the nurse staffing level was not maintained in wards where section 25B applies

When nurse staffing levels have not been maintained, there is evidence that operational teams are taking 'all reasonable steps' to address the situation. These steps include utilisation of the temporary workforce and employing a risk-based approach to redeploy staff. If staffing is deemed insufficient the ward manager or the ward coordinator intervenes to provide direct patient care. Staff can raise red flags on

	SafeCare to indicate concerns in relation to staffing levels and the senior nurse is readily available via the bleep system. In addition: • All incidents related to inpatient falls and pressure damage are reviewed by monthly learning panels, nurse staffing levels are considered as a possible contributing factor of the investigations conducted. • The medication safety group meets monthly to discuss all incidents relating to medication errors, to share good practice and plan any relevant learning. • Regular Trust wide complaints meetings are conducted to discuss complaints, concerns and compliance with the Putting Things Right process.
	Section 25A: Duty to have regard to provide sufficient nurses
Requirements of Section 25A (NB: Section 25A refers to the Health Boards/Trusts overarching responsibility to ensure appropriate nurse staffing levels in any area where nursing services are provided or commissioned, not only wards where section 25B applies)	Establishment reviews in 25A areas follow the same format as 25B establishment reviews and are conducted biannually. The 2024 establishment review process identified a gap in sufficient headroom within the Clinical Nurse Specialist (CNS) team. To address this, two new generic CNS positions have been successfully recruited, strengthening the team's capacity and ensuring adequate headroom. In February 2024, we successfully recruited 14 internationally educated nurses into Velindre Cancer Service. These nurses are now fully integrated into their roles. Although the skill mix posed some initial challenges, this is an improving picture. Additionally, we have commenced the recruitment of newly qualified nurses through student streamlining, further reinforcing our nursing workforce. We are also supporting several healthcare support workers through the Certificate in Higher Education (CertHE), to facilitate their progression into registered nursing roles. Historically, the staffing and rostering on the First Floor Ward have incorporated staff working across other areas. In order to improve rostering analysis and efficiency, the Velindre Cancer Services (VCS) team has provided assurance that the process of separating the Band 5 and Band 3 nursing workforce on the First Floor Ward roster from the Ambulatory and Assessment Units will be completed by the end of the financial year. This process is currently underway and is expected to be finalised imminently.

	Conclusion & Recommendations
	• <i>There have been no patient safety incidents or harm reported on the ward due to nurse staffing levels.</i> • There has been no change to the establishment or planned roster for first floor in the last 12 months. • All reasonable steps have been utilised to maintain the nurse staffing level in line with the requirements of the Nurse Staffing Levels (Wales) Act 2016. • First Floor establishment includes the required 26.9% headroom • There are no financial concerns in the funding of the establishment for first floor ward • 79.73% of shifts were deemed to be appropriately staffed with a data compliance rate of 93.88% • Two complaints relating to nursing care were addressed through the "Putting Things Right" process. Both complaints concluded that there was no breach of duty, and the learning outcomes have been communicated to the team. • Establishment reviews in 25A areas follow the same format as 25B establishment reviews and are conducted bi-annually.



AUDIT COMMITTEE

ANNUAL REPORT 2024/2025

Audit Committee

Annual Report 2024/2025

1. Foreword

I am pleased to present the Annual Report of the Velindre University NHS Trust Audit Committee. It outlines the coverage and results of the Committee's work for the year.

I have acted as the Chair of the Audit Committee since October 2023 and have been ably supported by Independent Member, Vicky Morris throughout the year. In addition, during parts of the year, support was provided by Independent Member, Lindsay Foyster and Alun Lloyd, Associate Independent Member. I would like to take this opportunity to put on record my sincere thanks to Vicky, Lindsay and Alun for their significant contributions made during the year.

I would like to express my thanks to all the officers of the Committee who have supported and contributed to the work carried out and for their commitment in meeting important targets and deadlines. I also wish to record my appreciation for the support and contribution given by Internal Audit at NHS Wales Shared Services Partnership, Local Counter Fraud Services and by Audit Wales.

Meetings have been well attended and have been a hybrid approach of face to face and online. The meetings have been characterised by constructive dialogue and challenge, and the willingness of all parties to raise issues, acknowledge shortcomings and put forward positive suggestions to help bring about meaningful improvements to services, systems, and day-to-day working practices. This approach is to be welcomed and is very much appreciated by the Committee.

Going forward, the Committee intends to continue to pursue a full programme of work as set out in the cycle of business, covering a wide range of topics and subject areas as part of its long-term aim to help further strengthen the governance arrangements of the Trust, in order to achieve better value for money and high quality, sustainable outcomes for NHS Wales.

Gareth Jones
Chair of the Velindre University NHS Trust Audit Committee
18 March 2025

2. Introduction

This report summarises the key areas of business activity undertaken by the Committee between March 2024 and March 2025 and highlights some of the key issues which the Committee intends to give further consideration to over the next 12 months.

The report reflects the Committee's key role in the development and monitoring of the governance and assurance framework within which the Trust operates.

3. Role and Responsibilities

The primary purpose of the Audit Committee is to advise and assure the Board and the Accountable Officer on whether effective arrangements are in place – through the design and operation of the Trust's system of assurance – to support them in their decision taking and in discharging their accountabilities for securing the achievement of the Trust's objectives, in accordance with the standards of good governance determined for the NHS in Wales.

Where appropriate, the Committee will advise the Board and the Accountable Officer on where and how its system of assurance may be strengthened and developed further.

The Trust operates a separate Audit Committee to provide assurance on the work of the NHS Shared Services Partnership (NWSSP). Whilst the same Independent Members sit on both committees, they are entirely separate, and the NWSSP Audit Committee produces its own Annual Report.

4. Agenda Planning Process

The Chair of the Committee, in conjunction with the Trust's Executive Director of Finance and Director of Corporate Governance, draws up the agenda for Committee meetings, which is based upon an agreed annual programme of work and clearly linked to the Committee's Terms of Reference.

The Trust Governance team aim to disseminate the agenda and papers to Committee members at least five working days before the date of the meeting.

5. Operating Arrangements

The Committee's Terms of Reference are reviewed annually, with the next review being considered at the September 2025 Audit Committee. A copy of the Terms of Reference extant at the point of writing this report is attached at Appendix 2.

The Audit Committee Cycle of Business for August 2024 to July 2025 was noted in July 2024 and will next be updated and presented in May 2025. The agenda of each meeting, however, is sufficiently flexible to allow the committee to consider any emerging issues.

6. Membership, Frequency and Attendance

The Terms of Reference of the Committee state that the Committee should consist of a minimum of three Independent members of the Board. One of these members must also be a member of the Quality & Safety Committee.

The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

During the year the Committee met on six occasions (including an Extraordinary Joint Audit Committee and Quality, Safety & Performance Committee), with attendance as follows:

Name	Audit Committee
<i>Mr Gareth Jones (Independent Member) Chair</i>	6 out of 6
<i>Mrs Vicky Morris (Independent Member)</i>	5 out of 6
<i>Mr Alun Lloyd (Associate Independent Member)</i>	4 out of 6
<i>Mrs Lindsay Foyster (Independent Member)</i>	1 out of 6

During the year, the meetings were supported by the following:

- Steve Ham, Chief Executive Officer
 - Carl James, Interim Chief Executive Officer
 - Matthew Bunce, Executive Director of Finance
 - Tracy Hughes, Interim Head of Financial Operations
 - Lauren Fear, Interim Executive Director of Transformation
 - Rachel Hennessy, Interim Director of Velindre Cancer Services
 - Jonathan Fear, Estates Manager
 - Suzanne David, Head of Finance Business Partnering
 - Non Gwilym, Interim Director of Corporate Governance & Chief of Staff
 - Jacinta Abraham, Executive Medical Director
 - Carl Taylor, Chief Digital Officer
 - Vivienne Cooper, Head of Nursing
 - Mark Ash, Assistant Project Director
-
- Steve Wyndham, Audit Wales
 - Dave Burridge, Audit Wales
 - Kate Febry, Audit Wales
-
- Simon Cookson, Director of Audit & Assurance
 - Stephen Chaney, Head of Internal Audit
 - Emma Rees, Deputy Head of Internal Audit
 - David Butler, Internal Audit Manager
 - Melanie Goodman, Internal Audit Manager
 - Gareth Lavington, Lead Local Counter Fraud Specialist
 - Henry Bales, Lead Local Counter Fraud Specialist

7. Audit Committee Activity 2024/2025

The Audit Committee fulfilled its planned work for 2024/2025 covering a wide range of activity. This work can be summarised under the following headings:

7.1 External Audit

- The Committee approved the Audit Wales Plan for 2023/2024 in July 2024. Updates from representatives from Audit Wales were given at each meeting.
- Audit Wales documentation was provided to the Committee during the year in relation to the:
 - Annual Audit Plan 2023/2024
 - Financial Audit 2023/2024
 - Structured Assessment 2024
 - Review of Cost Savings Arrangements
 - Setting of well-being objectives

7.2 Internal Audit

- The Committee received regular progress reports from the Internal Audit team during the calendar year following agreement of an Internal Audit Plan for 2024/2025 in July 2024.
- During the year the Committee considered 16 reports completed by Internal Audit: their assurance ratings are shown below, with a full list of the reports shown in Appendix 1.

Rating	Number
Substantial	1
Reasonable	13
Limited	2
	16

- Internal Audit's annual assurance opinion for 2023/2024 was reported to the Committee in July 2024. It stated that "the Final Opinion provides the Board with **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact** on residual risk exposure until resolved".

7.3 Finance

- The Committee meeting in July 2024 received the audited 2023/2024 Annual Accounts, Annual Governance Statement, Accountability Report and the Trust's response to Audit Wales regarding governance arrangements. The Committee endorsed and recommended the approval of the Trust's Annual Accounts and other documents to the Trust Board.
- In December 2024, the Committee received a report on the Consolidation of the Charitable Fund Accounts and approved the recommendation not to consolidate going forward.
- The Committee received regular updates in relation to Losses & Special Payments, the Private Patient Service Plan (including Aged Debt), plus Technical Accounting Issues.
- In March 2025, the Committee approved the adoption of the NHS Wales No PO NO Pay Policy.

7.4 Counter Fraud

- The Committee received the Counter Fraud Annual Report for 2023/2024 in July 2024.
- The Committee received the Annual Workplan for 2024/2025 in March 2024, and progress reports from the Lead Local Counter Fraud Specialist at each meeting.

7.5 Internal Assurance & Risk Management Monitoring

- Procurement Compliance was reported regularly to the Committee.
- Declarations of Interests, Gifts, Sponsorship, Hospitality & Honoraria were presented in the March and September 2024 meetings.

- The Trust Risk Register and Trust Assurance Framework were presented at every meeting for review by the Committee, noting that more detailed reviews also took place in the relevant Committee and Divisional meetings.
- The Audit Action plan, which tracks the implementation of the recommendations of audit, was reviewed by the Committee at each meeting.
- The Committee received regular updates on the Governance Assurance & Risk Programme of Work.
- The Committee also received and reviewed the legislative and regulatory compliance register at their December 2024 meeting.
- The Committee received details of amendments to the Trust Model Standing Orders / Standing Financial Instructions, Delegation of Powers for NHS Trusts and Delegation of Financial Limits.

8. Reporting the Committee's Work

The Chair of the Audit Committee reports to the Board on the key issues discussed at each meeting by way of a written Highlight Report. These reports are supported by the more detailed Committee minutes. Committee papers and committee minutes are routinely published on the Trust's website.

9. Conclusions and Way Forward

The work of the Audit Committee in 2024 has been varied and wide-ranging. The Committee's programme of work will continue to be reviewed to ensure that its contribution to governance, risk management, financial management, counter fraud and internal control is maximised.

This report demonstrates that the Audit Committee has fulfilled its terms of reference and significantly contributed to improving internal control within the Trust.

The Committee can provide the Board with assurance that, by addressing its terms of reference, it has scrutinised the levels of control in place and that where necessary has recommended improvements to controls.

Appendix 1

Levels of Assurance Assigned by Internal Audit

Substantial Assurance	The Board can take substantial assurance that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with low impact on residual risk exposure .
Reasonable Assurance	The Board can take reasonable assurance that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved.
Limited Assurance	The Board can take limited assurance that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with moderate impact on residual risk exposure until resolved.

List of Internal Audits Undertaken and Assurance Ratings - Velindre University NHS Trust

Internal Audit Assignment	Assurance Rating 2023/2024
Education Strategy	Reasonable
Private Patients	Reasonable
Recruitment & Retention	Reasonable
Estates Assurance: Estates Condition	Limited
Governance Assurance & Risk Programme	Reasonable
Financial & Service Sustainability	Reasonable
Decarbonisation	Reasonable
Business Continuity	Reasonable
Digital Strategy & Transformation Programme	Reasonable
nVCC Digital	Reasonable
nVCC MIM Commercial Approval Points	Reasonable
nVCC MIM Planning	Reasonable
Enabling Works	Limited
IRS Procurement	Reasonable
Medicine Management	Reasonable
Follow-up of Prior Year Recommendations	Substantial
nVCC Validation of Management Action	Advisory

SUMMARY (excluding advisory reports)	
Substantial	1
Reasonable	13
Limited	2
Total	16



Audit Committee

Terms of Reference & Operating Arrangements

Reviewed:	January 2023
Approved:	July 2024
Next Review Due:	July 2025

1. INTRODUCTION

- 1.1 The Trust's standing orders provide that *"The Board may and, where directed by the Welsh Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees"*.
- 1.2 In line with standing orders and the Trust's scheme of delegation, the Board shall nominate annually a Committee to be known as the **Audit Committee**. The detailed terms of reference and operating arrangements set by the Board in respect of this Committee are set out below.
- 1.3 These Terms of Reference and Operating Arrangements are based on the model Terms of Reference as detailed in the NHS Wales Audit Committee Handbook June 2012.

2. PURPOSE

- 2.1 The purpose of the Audit Committee ("the Committee") is to:
- **Advise** and **assure** the Board and the Accountable Officer on whether effective arrangements are in place - through the design and operation of the Trust's **system of assurance** - to support them in their decision taking and in discharging their accountabilities for securing the achievement of the Trust's objectives, in accordance with the standards of good governance determined for the NHS in Wales.
- 2.2 Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further.
- 2.3 A separate Audit Committee is in operation for the NHS Wales Shared Services Partnership (NWSSP) which has its own Terms of Reference.

3. DELEGATED POWERS AND AUTHORITY

- 3.1 With regard to its role in providing advice to the Board, the Committee will comment specifically upon:
- The adequacy of the Trust's strategic governance and assurance arrangements and processes for the maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical) designed to support the public disclosure statements that flow from the assurance processes, including the Annual Governance Statement, providing reasonable assurance on:
 - the organisation's ability to achieve its objectives,
 - compliance with relevant regulatory requirements, standards, quality and service delivery requirements and other directions and requirements set by the Welsh Government and others,
 - the reliability, integrity, safety and security of the information collected and used by the organisation,

- the efficiency, effectiveness and economic use of resources, and
 - the extent to which the organisation safeguards and protects all its assets, including its people to ensure the provision of high quality, safe healthcare for its citizens;
- The Board's Standing Orders, and Standing Financial Instructions (including associated framework documents, as appropriate);
 - The accounting policies, the accounts, and the annual report of the organisation, including the process for review of the accounts prior to submission for audit, levels of error identified, the ISA 260 Report 'Communication with those charged with Governance' and managements' letter of representation to the external auditors;
 - The Schedule of Losses, Compensation and Special Payments;
 - The planned activity and results of internal audit, external audit, clinical audit and the Local Counter Fraud Specialist (including strategies, annual work plans and annual reports);
 - The adequacy of executive and managements' response to issues identified by audit, inspection and other assurance activity via monitoring of the Trust's audit action plan;
 - Anti-fraud policies, whistle-blowing processes and arrangements for special investigations as appropriate; and
 - Any particular matter or issue upon which the Board or the Accountable Officer may seek advice from the Committee.

3.2 The Committee will support the Board with regard to its responsibilities for governance (including risk and control) by reviewing:

- All risk and control related disclosure statements (in particular the Annual Governance Statement together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances), prior to endorsement by the Board;
- The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct and accountability requirements; and
- The policies and procedures for all work related to fraud and corruption as set out in Welsh Government Directions and as required by the NHS Counter Fraud Authority.

3.3 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from other assurance providers, regulators, directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.

- 3.4 This will be evidenced through the Committee's use of effective governance and assurance arrangements to guide its work and that of the audit and assurance functions that report to it, and enable the Committee to review and form an opinion on:
- The comprehensiveness of assurances in meeting the Board and the Accountable Officer's assurance needs across the whole of the Trust's activities, both clinical and non-clinical; and
 - The reliability and integrity of these assurances.
- 3.5 To achieve this, the Committee's programme of work will be designed to provide assurance that:
- There is an effective internal audit function that meets the standards set for the provision of internal audit in the NHS in Wales and provides appropriate independent assurance to the Board and the Accountable Officer through the Committee;
 - There is an effective counter fraud service that meets the standards set for the provision of counter fraud in the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee;
 - There is an effective clinical audit function that meets the standards set for the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee;
 - There are effective arrangements in place to secure active, ongoing assurance from management with regard to their responsibilities and accountabilities, whether directly to the Board and the Accountable Officer or through the work of the Board's Committees through the effective completion of Audit Recommendations and the Committee's review of the development and drafting of the Trust's Annual Governance;
 - The work carried out by key sources of external assurance, in particular, but not limited to the Trust's external auditors, is appropriately planned and co-ordinated and that the results of external assurance activity complements and informs (but does not replace) internal assurance activity;
 - The work carried out by the whole range of external review bodies is brought to the attention of the Board, and that the organisation is aware of the need to comply with related standards and recommendations of these review bodies, and the risks of failing to comply;
 - The systems for financial reporting to the Board, including those of budgetary control, are effective; and that
 - The results of audit and assurance work specific to the Trust, and the implications of the findings of wider audit and assurance activity relevant to the Trust's operations are appropriately considered and acted upon to secure the ongoing development and improvement of the organisation's governance arrangements.

In carrying out this work, the Committee will follow and implement the Audit Committee's Annual Work plan and will be evidenced through meeting papers, formal minutes, and highlight reports to Board and annually via the Annual Governance Statement and Annual

Report to the Board.

Authority

- 3.6 The Committee is authorised by the Board to investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the Trust relevant to the Committee's remit, and ensuring patient/client and staff confidentiality, as appropriate. It may seek relevant information from any:
- Employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and
 - Any other Committee, sub Committee or group set up by the Board to assist it in the delivery of its functions.
- 3.7 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.
- 3.8 The Committee is authorised by the Board to approve policies relevant to the business of the Committee as delegated by the Board.

Access

- 3.9 The Head of Internal Audit and the Auditor General for Wales and his representatives shall have unrestricted and confidential access to the Chair of the Audit Committee at any time, and the Chair of the Audit Committee will seek to gain reciprocal access as necessary.
- 3.10 The Committee will meet with Internal and External Auditors and the nominated Local Counter Fraud Specialist without the presence of officials on at least one occasion each year.
- 3.11 The Chair of Audit Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

- 3.12 The Committee may, subject to the approval of the Trust Board, establish sub Committees or task and finish groups to carry out on its behalf specific aspects of Committee business. At this stage, no sub Committees/task and finish groups have been established.

4. MEMBERSHIP

Members

- 4.1 A minimum of three (3) members, comprising:

Chair	Independent member of the Board (Non-Executive Director)
	Two independent members of the Board (Non-Executive Directors) <i>[one member should be a member of the Quality, Safety & Performance Committee]</i>

The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

The Chair of the organisation shall not be a member of the Audit Committee.

It is considered best practice that the Vice Chair of the Trust Board does not chair the Audit Committee.

Attendees

4.2 In attendance:

Chief Executive (*who should be present when the Committee considers the Internal Audit Plan, the Annual Governance Statement, Annual Quality Statement and the Annual Accounts.*)

Executive Director of Finance

Director of Corporate Governance and Chief of Staff

Head of Internal Audit

Head/individual responsible for Clinical Audit

Local Counter Fraud Specialist

Representative of the Auditor General for Wales

Other Executive Directors / Directors will attend as required by the Committee Chair and their attendance will be required when they are Lead for an Audit Report

By invitation

The Committee Chair may invite:

- the Chair of the **Trust**
- any other Trust officials; and/or
- any others from within or outside the organisation

to attend all or part of a meeting to assist it with its discussions on any particular matter.

Secretariat

4.3 Secretary

As determined by the Director of Corporate Governance and Chief of Staff

Member Appointments

4.4 The membership of the Committee shall be determined by the Board, based on the recommendation of the Trust Chair - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

4.5 Members shall be appointed for a maximum of 3 consecutive years before formally reviewing their role on the Committee. During this time a member may resign or be removed by the Board.

Support to Committee Members

- 4.6 The Director of Corporate Governance and Chief of Staff, on behalf of the Committee Chair, shall:
- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and
 - Ensure the provision of a programme of organisational development for Committee members as part of the Trust's overall Organisational Development programme developed by the Executive Director of Workforce & Organisational Development.

5 COMMITTEE MEETINGS

Quorum

- 5.1 At least two members must be present to ensure the quorum of the Committee.

Frequency of Meetings

- 5.2 Meetings shall be held no less than 4 times per year, and otherwise as the Chair of the Committee deems necessary – consistent with the Trust's annual plan of Board Business. The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

Withdrawal of individuals in attendance

- 5.3 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

6 RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES / GROUPS

- 6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, the Board retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.
- 6.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.
- 6.3 The Committee, through its Chair and members, shall work closely with the Board's other Committees to provide advice and assurance to the Board by taking into account:
- Joint planning and co-ordination of Board and Committee business; and
 - Sharing of information
- in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

- 6.4 The Committee will consider the assurance provided through the work of the Board's other

Committees and sub Committees to meet its responsibilities for advising the Board on the adequacy of the Trust's overall system of assurance by receipt of their annual work plans.

- 6.5 The Committee shall embed the **duty of quality through the Heath and Care Quality Standards** through the conduct of its business.

7 REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- Report formally, regularly and on a timely basis to the Board and the Accountable Officer on the Committee's activities. This includes verbal updates on activity and the submission of written highlight reports throughout the year;
- Bring to the Board and the Accountable Officer's specific attention any significant matters under consideration by the Committee;
- Ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant Committees of any urgent/critical matters that may affect the operation and/or reputation of the Trust.

7.2 The Committee shall provide a written, annual report to the Board and the Accountable Officer on its work in support of the Annual Governance Statements, specifically commenting on the adequacy of the assurance arrangements, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the Committee's self-assessment and evaluation.

7.3 The Director of Corporate Governance and Chief of Staff, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any sub Committees established. In doing so, account will be taken of the requirements set out in the NHS Wales Audit Committee Handbook.

8 APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum [*as per section on Committee meetings*]

Cross reference with the Trust Standing Orders.

9 REVIEW

9.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee with reference to the Board.

10 CHAIR'S ACTION ON URGENT MATTERS

- 10.1 There may, occasionally, be circumstances where decisions which normally be made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance and Chief of Staff as appropriate, may deal with the matter on behalf of the Committee, after first consulting with two other Independent Members of the Committee. The Director of Corporate Governance and Chief of Staff must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.
- 10.2 Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.



TRUST BOARD

AMENDMENT TO STANDING ORDERS – SCHEDULE 3 ANNUAL REVIEW COMMITTEE TERMS OF REFERENCE

DATE OF MEETING	24 July 2025
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
REPORT PURPOSE	FOR APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	YES
PREPARED BY	Kay Barrow, Corporate Governance Manager
PRESENTED BY	Non Gwilym, Interim Director of Corporate Governance
APPROVED BY	Non Gwilym, Interim Director of Corporate Governance
EXECUTIVE SUMMARY	The purpose of this report is to outline the required changes to Schedule 3 of the Trust Standing Orders, resulting from the Annual Review of the Terms of Reference and Operating Arrangements in respect of the following Committees / Sub Committees / Advisory Groups: - Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee (Appendices 1 and 2). - Local Partnership Forum (LPF) (Appendices 3 and 4)
RECOMMENDATION / ACTIONS	The Trust Board is asked to APPROVE the revisions to the Terms of Reference and Operating Arrangements in respect of the following Committees / Sub Committees / Advisory Groups: - Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee (Appendices 1 and 2). - Local Partnership Forum (LPF) (Appendices 3 and 4)

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	Date
Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee	06/05/2025 & 10/06/2025
Local Partnership Forum	15/07/2025
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS - The Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee ENDORSED the revisions to the Committee Terms of Reference for Approval by the Trust Board (Appendices 1 and 2). - The Local Partnership Forum ENDORSED the revisions to the Committee Terms of Reference for Approval by the Trust Board (Appendices 3 and 4).	
7 LEVELS OF ASSURANCE - N/A	
APPENDICES	
Appendix 1	new Velindre Cancer Centre (nVCC) Project Scrutiny Sub-Committee Terms of Reference – tracked change version
Appendix 2	new Velindre Cancer Centre (nVCC) Project Scrutiny Sub-Committee Terms of Reference – clean version
Appendix 3	Local Partnership Forum (LPF) Terms of Reference – tracked change version
Appendix 4	Local Partnership Forum (LPF) Terms of Reference – clean version

1. SITUATION

- 1.1 Velindre University National Health Service Trust is a statutory body that came into existence on 1st December 1993 under the Velindre National Health Service Trust (Establishment) Order 1993 (S.I. 1993/2838), as amended, “the Establishment Order”.
- 1.2 Velindre University NHS Trust has a duty under Regulation 19(2) of the National Health Service Trusts (Membership and Procedure) Regulations 1990 to make Standing Orders for the regulation of their proceedings and business. It is important to note that the Trust is able to vary or suspend its own Standing Orders, providing that it is able to satisfy that it complies with the relevant regulations.

2. BACKGROUND

- 2.1 The Velindre University NHS Trust Standing Orders form the basis upon which the Trust’s governance and accountability framework is developed and, together with the adoption of the Trust’s Values and Standards of Behaviour framework, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.
- 2.2 All Trust Board members and officers must be made aware of these Standing Orders and, where appropriate, should be familiar with their detailed content.

3. ASSESSMENT

3.1 The purpose of this report is to outline the required changes to Schedule 3 of the Trust Standing Orders, resulting from the Review of the Terms of Reference in respect of the:

- Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee (**Appendices 1 and 2**)
- Local Partnership Forum (LPF) (**Appendices 3 and 4**).

4. SUMMARY OF MATTERS FOR CONSIDERATION

4.1 Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee

- 4.1.1 To align with the recommendations from the PwC review, the Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee Terms of Reference have been reviewed.
- 4.1.2 To align with the purpose of the Sub-Committee to oversee, scrutinise and provide assurance in relation to the new Velindre Cancer Centre (nVCC) Project, it is proposed to make the following changes to the Sub-Committee Terms of Reference:
- Change of Sub-Committee name to the new Velindre Cancer Centre (nVCC) Project Scrutiny Sub-Committee.
 - References to Transforming Cancer Services and / or TCS to be amended to new Velindre Cancer Centre (nVCC).
 - Amend the wording related to interdependencies to align with the purpose of the Sub-Committee.
- 4.1.3 The amendments outlined in 4.1.2 have been formally received and **ENDORSED** for Trust Board **APPROVAL** by the Transforming Cancer Services (TCS) Project Scrutiny Sub-Committee.

4.2 Local Partnership Forum (LPF)

- 4.2.1 In accordance with Local Partnership Forum (LPF) Terms of Reference and Operating Arrangements, an annual review has been undertaken of the Terms of Reference and Operating Arrangements.
- 4.2.2 In order to align with the responsibilities under the Duty of Quality, Compliance with the Duty of Quality Legislation has been added as 2.6 under Section 2 Purpose.
- 4.2.3 Under Section 3 Membership, amendments have been made to 3.3 Membership of the LPF. The Joint Vice Chair Staff Representative will be the role of the Social Partnership Lead and the Chief Executive Officer has been removed as the Joint Vice Chair Management Representative and changed to a Management Representative Member.

4.2.2 The amendments detailed in 4.2.2 and 4.2.3 have been formally received and **ENDORSED** for Board **APPROVAL** by the Local Partnership Forum (LPF).

4.4 The Trust Board is asked to:

- **APPROVE** the new Velindre Cancer Centre (nVCC) Project Scrutiny Sub-Committee Terms of Reference which form part of Schedule 3 of the Trust's Standing Orders (**Appendices 1 and 2**).
- **APPROVE** the Local Partnership Forum (LPF) Terms of Reference which form part of Schedule 3 of the Trust's Standing Orders (**Appendices 3 and 4**).

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals:	
• Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) For more information: STRATEGIC RISK DESCRIPTIONS	10 - Governance
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	Evidence suggests there is correlation between governance behaviours in an organisation and the level of performance achieved at that same organisation. Therefore, ensuring good governance within the Trust can support quality care.

QUALITY IMPACT ASSESSMENT	Not required - not a strategic decision
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: For more information: https://www.gov.wales/socio-economic-duty-overview	Not required
	<i>There are no socio-economic impacts linked directly to the activity outlined in this report.</i>
TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT	
The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated. Please indicate whether any of the matters outlined in this report impact the Trust's Wellbeing goals: NO	
<i>There are no Trust Well-Being goal implications or impact linked directly to the activity outlined in this report.</i>	
FINANCIAL IMPLICATIONS / IMPACT	<i>There is no direct impact on resources as a result of the activity outlined in this report.</i>
EQUALITY IMPACT ASSESSMENT For more information: https://nhs.wales365.sharepoint.com/sites/VEL/_ntranet/SitePages/E.aspx	Not required - please outline why this is not required
	<i>There is no direct equality impact in respect of this report.</i>
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	<i>It is essential that the Trust complies with its standing orders.</i>

6. RISKS

The Trust's governance structure aims to identify issues early to prevent escalations and the Committee integrates into the overall Board arrangements.

ARE THERE RELATED RISK(S) FOR THIS MATTER	No



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

~~Transforming Cancer~~ ~~Services~~ new Velindre Cancer Centre (nVCC) ~~Programme~~ Project Scrutiny Sub-Committee

Reviewed:	~~September 2024~~ <u>January 2025</u>
Approved:	
Next Review Due:	~~April 2025~~ <u>January 2026</u>
Version:	~~V1.1~~ <u>V2</u>

1. INTRODUCTION

- 1.1 Within 3.1.1 of the Trust's standing orders it provides that *"The Board may and, where directed by the Welsh Ministers must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees"*.

In line with standing orders (and the Trust's scheme of delegation), the Board shall nominate annually a Sub-Committee to be known as the ~~Transforming Cancer Services (TCS)-new Velindre Cancer Centre (nVCC) Programme Project~~ Scrutiny Sub-Committee.

As part of their functions, the Quality Safety and Performance Committee and the Strategic Development Committee are supported by the ~~Transforming Cancer Services-new Velindre Cancer Centre (nVCC) Programme Project~~ Scrutiny Sub-Committee to provide assurance to the programme governance arrangements for the ~~Transforming Cancer Services~~new Velindre Cancer Centre (nVCC) Programme Project, which extends to its constituent projects. At a project level the Sub-Committee will examine Project arrangements, the application and project management methodologies, monitor project performance, risk management, progress and provide assurance to the Quality, Safety and Performance Committee.

~~Assurance from the new Velindre Cancer Centre (nVCC) Project Scrutiny Sub-Committee on the Project and its interdependencies will be provided to the development or proposed changes to the programme scope or strategic direction will be provided to the~~ Strategic Development Committee.

Assurance reporting will also be reported to Trust Board.

The detailed terms of reference and operating arrangements set by the Board in respect of this Sub-Committee are set out below.

2. PURPOSE

- 2.1 The purpose of the ~~Transforming Cancer Services~~new Velindre Cancer Centre (nVCC) Programme Project Scrutiny

Sub-Committee is to:

- Provide assurance that the leadership, management and governance arrangements are sufficiently robust to deliver the outcomes and benefits of the ~~programme~~Project.
- Scrutinise the progress of the ~~programme~~Project and provide the Trust Board with assurance that implementation is effective, efficient and within the budget available.

- Undertake any other scrutiny activity relating to the ~~Transforming Cancer Services~~new Velindre Cancer Centre (nVCC) Programme Project as directed by the Trust Board or Senior Responsible Owner (SRO).
- Seek advice and guidance from appropriate Technical Advisors as well as the Mutual Investment Model (MIM) Transactor ~~(if relating to the new Velindre Cancer Centre Project)~~ to assist the Sub-Committee with their scrutiny of the ~~Transforming Cancer Services~~new Velindre Cancer Centre (nVCC) Programme Project.
- Provide assurance to the Trust Board on all aspects of the ~~Transforming Cancer Services~~new Velindre Cancer Centre (nVCC) Programme Project in relation to approvals sought on all decisions reserved for the full Board.
- Receive all audit, gateway and assurance reviews pertaining to the ~~programme Project~~ or its constituent projects and provide assurance (or otherwise) to the Trust that the ~~programme project~~ is being delivered in accordance with all professional, financial and Trust standards.
- Provide assurance to the Trust Board and support to the Senior Responsible Officer in signalling the new Velindre Cancer Centre (nVCC)~~TCS~~ closure activities once it has met its objectives.

2.2 Where appropriate, the Sub-Committee will advise the Trust Board and the Accountable Officer on where, and how, its system of assurance in relation to the new Velindre Cancer Centre (nVCC)~~Transforming Cancer Services Programme Project~~ may be strengthened and developed further.

3. DELEGATED POWERS AND AUTHORITY

With regards to its role in providing advice to the Trust Board, the Sub-Committee will fulfil the following functions:

3.1 Strategy and Policy Development

- Scrutinise ~~programme and~~ project documentation to ensure the direction of the new Velindre Cancer Centre (nVCC) ~~Transforming Cancer Services Programme Project~~ remains within the scope and parameters set by the Trust Board and its alignment with the external commissioner and political environment.
- Scrutinise and provide assurance that the ~~Programme Project~~ and its constituent projects are conducted in line with the Trust's requirements on policy and legislative compliance, best practice and within the Trust's governance framework.

3.2 Governance, Monitoring and Review

The Sub-Committee will, in respect of its assurance role:-

- Provide assurance that the Programme-Project has a clear and consistent strategic direction of travel aligned with the Trust Boards requirements; strong and effective leadership; clear and transparent lines of accountability and responsibility; and effective reporting to key stakeholders and decision-makers.
- Provide assurance that Programme-and Project governance arrangements are appropriately designed, proportionately applied and implemented and are operating appropriately to ensure the provision of a high-quality programme-and project management delivery.
- Undertake scrutiny and assurance of the Programme-Project progress against the master programme-project plan, seeking explanations and remedies for any deviation from Programme-Project timelines. It will report any concerns to the Trust Board as and when appropriate and necessary.
- Undertake scrutiny and assurance of Programme-Project risks, issues and mitigating actions to satisfy itself that they can be placed back under the required levels of control.
- Scrutinise all sources of independent assurance in relation to the delivery of the Programme-Project (e.g. Internal/External Audit, Independent Reviews, Gateway Reviews, and CAP etc.) and scrutinise and monitor the organisation's response to independent reviews.
- Provide assurance that there are robust monitoring and management arrangements in place to identify important enablers and dependencies between the programmes-projectsProject and the relevant corporate and Velindre Cancer Service projects and programmes, as failure to do so could impact on the programmes-Projects critical path.
- Scrutinise and assure that the Programme-and Project expenditure against the budget allocated is appropriate and managed effectively.

3.3 Authority

The Sub-Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference. In doing so, the Sub-Committee shall have the right to inspect any books, records or documents of the Trust relevant to the Sub-Committees remit and ensuring patient/service user, client and staff confidentiality, as appropriate. It may seek any relevant information from any:

- Employee (and all employees and directed to cooperate with any reasonable request made by the Sub-Committee); and
- Other Committee, sub Committee, or group set up by the Board (including the Project Board) to assist it in the delivery of its functions.
- Obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it

considers this necessary, subject to the Board's budgetary and other requirements; and

- By giving reasonable notice, require the attendance of any of the officers or employees and auditors of the Board at any meeting of the Sub-Committee.

Provide assurance that any proposals /actual amendments to delegated limits as necessary in relation to the ~~all Transforming Cancer Services Projects~~ are in accordance with the Trust Boards direction and its Standing Orders and Statutory Financial Instructions.

3.4 Access

The Chair of the ~~new Velindre Cancer Centre (nVCC) Transforming Cancer Services Programme Project~~ Scrutiny Sub-Committee shall have reasonable access to Executive Directors, Directors and other relevant staff.

4. MEMBERSHIP

4.1 Members

A minimum of three (3) members to include:

Chair - Independent member of the Board (Non-Executive Director)

Two (2) other Independent members of the Board (Non-Executive Director)

Other Trust Board members are extended an open invitation to attend all/any meeting

4.2 Attendees

Core Attendance:

- Chief Executive Officer
- Senior Responsible Owner
- ~~TCS Programme Director~~
- ~~TCS- nVCC~~ Project Director
- Executive Director of Strategic Transformation, Planning and Digital
- Executive Medical Director
- Executive Director of Nursing, AHP's & Health Scientists
- Director of Corporate Governance and Chief of Staff
- Executive Director of Organisational Development and Workforce
- Executive Director of Finance
- Director of Commercial and Strategic Partnerships
- Director Velindre Cancer Centre
- Chief Operating Officer
- Chief Digital Officer
- Velindre Futures Programme Director

4.3 Specialist Estates and Governmental Support

Invites to the new Velindre Cancer Centre (nVCC) TGS Project Scrutiny Sub Committee shall be extended to NWSSP- Specialised Estates Services (SES) and Welsh Government representatives in the capacity as observers. These representatives will support the Sub Committee by adopting a “Critical Friend” approach, thus providing assurance as required to the Sub Committee.

4.4 Other Programme / Project Staff as required

The Sub-Committee Chair may extend invitations to others from within or outside the organisation who the Sub-Committee consider should attend, taking account of the matters under consideration of each meeting.

4.5 Secretariat

As determined by the Director of Corporate Governance and Chief of Staff.

4.6 Member Appointments

The membership of the Sub-Committee shall be determined by the Board based on the recommendation of the Trust Chair – taking account of the balance of skills and expertise necessary to deliver the Sub-Committee's remit and subject to any specific requirements or directions made by the Welsh Government

Members shall be appointed -for a maximum of three consecutive years before formally reviewing their role on the Sub-Committee. During this time a member may resign or be removed by the Board.

4.7 Support to Sub-Committee Members

The Director of Corporate Governance and Chief of Staff on behalf of the Sub-Committee Chair shall:

- Arrange the provision of advice and support to Sub-Committee members on any aspect related to the conduct of their role: and
- Ensure the provision of a programme of Organisational development for Sub-Committee members as part of the Trust's overall OD programme developed by the Director of Workforce and Organisational Development.

5. SUB-COMMITTEE MEETINGS

5.1 Quorum

At least two (2) Independent members must be present to ensure the quorum of the Sub-Committee, one of whom should be the Sub-Committee Chair. -If the Chair of the new Velindre Cancer Centre (nVCC)TGS Programme-Project Scrutiny Sub-Committee is not present an agreement as to who will chair the Sub-Committee must be agreed between the Independent Members, in absence of the new Velindre Cancer Centre (nVCC)TGS Programme-Project Scrutiny Sub-Committee Chair

5.2 Frequency of Meetings

Meetings shall be held no less than four times a year and otherwise as the Chair of the Sub-Committee deems necessary – consistent with the Trust’s annual plan of Board Business.

5.3 Withdrawal of individuals in attendance

The Sub-Committee Chair may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

6. RELATIONSHIPS & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 Although the Board has delegated authority to the Sub-Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for the safety, security and use of information to support the quality and safety of healthcare for its citizens through the effective governance of the Organisation.

6.2 The Sub-Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.3 The Sub-Committee, through its Chair and members, shall work closely with the Board’s other Committees and Groups to provide advice and assurance to the Board through the:

- Joint planning and co-ordination of Board and Committee business; and
- Sharing of information

In doing so, contributing to the integration of good governance across the Organisation, ensuring that all sources of assurance are incorporated into the Board’s overall risk and assurance framework.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Sub-Committee Chair shall:

- Report formally, regularly and on a timely basis to the Quality, Safety and Performance Committee, the Strategic Development Committee and the Accountable Officer on the Sub-Committee’s activities. This includes verbal updates on activity and the submission of written highlight reports by exception throughout the year. This reporting is also reported to the Trust Board.
- Bring to the Board’s specific attention any significant matters under consideration by the Sub-Committee;

- Ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive or Chairs of other relevant Committees/Groups of any urgent/critical matters that may affect the operation and/or reputation of the Trust.
- 7.2 The Sub-Committee shall provide a written, annual report to the Board on its work. The report will also record the results of the Sub-Committee's self-assessment and evaluation.
- 7.3 The Director of Corporate Governance and Chief of Staff, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Sub-Committee's performance and operation.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

- 8.1 The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Sub-Committee, except in the following areas:
- Quorum – as per section 5.1 above.
- Cross reference with the Trust Standing Orders

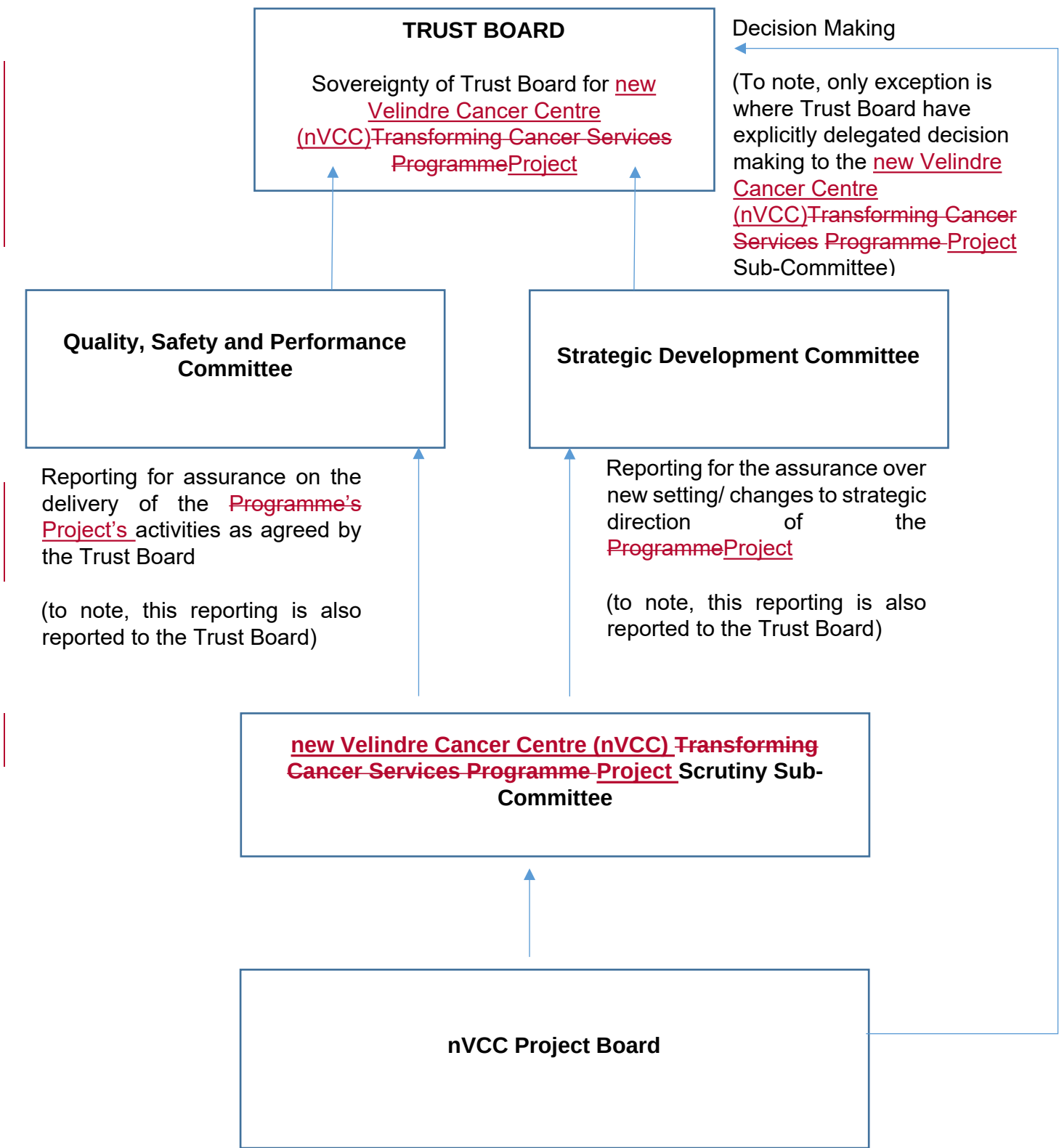
9. REVIEW

- 9.1 These Terms of Reference shall be reviewed annually by the Sub-Committee with reference to the Trust Board.

10. CHAIR'S ACTION ON URGENT MATTERS

- 10.1 There may, occasionally, be circumstances where decisions which normally be made by the Sub-Committee need to be taken between scheduled meetings. In these circumstances, the Sub-Committee Chair, supported by the Director of Corporate Governance and Chief of Staff as appropriate, may deal with the matter on behalf of the Board, after first consulting with one other Independent Members of the Sub-Committee. The Director of Corporate Governance and Chief of Staff must ensure that any such action is formally recorded and reported to the next meeting of the Sub-Committee for consideration and ratification.
- 10.2 Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

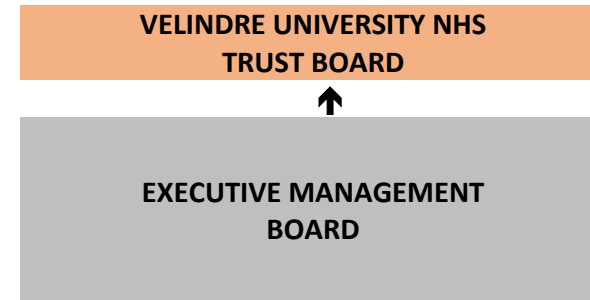
Structure and Governance Arrangements



SCRUTINY AND ASSURANCE



MANAGEMENT ACCOUNTABILITY





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Velindre University
NHS Trust

new Velindre Cancer Centre (nVCC) Project Scrutiny Sub-Committee

Reviewed:	January 2025
Approved:	
Next Review Due:	January 2026
Version:	V2

1. INTRODUCTION

- 1.1 Within 3.1.1 of the Trust's standing orders it provides that *"The Board may and, where directed by the Welsh Ministers must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees"*.

In line with standing orders (and the Trust's scheme of delegation), the Board shall nominate annually a Sub-Committee to be known as the new Velindre Cancer Centre (nVCC) Project Scrutiny Sub-Committee.

As part of their functions, the Quality Safety and Performance Committee and the Strategic Development Committee are supported by the new Velindre Cancer Centre (nVCC) Project Scrutiny Sub-Committee to provide assurance to the programme governance arrangements for the new Velindre Cancer Centre (nVCC) Project, which extends to its constituent projects. At a project level the Sub-Committee will examine Project arrangements, the application and project management methodologies, monitor project performance, risk management, progress and provide assurance to the Quality, Safety and Performance Committee.

Assurance from the new Velindre Cancer Centre (nVCC) Project Scrutiny Sub-Committee on the Project and its interdependencies will be provided to the Strategic Development Committee.

Assurance reporting will also be reported to Trust Board.

The detailed terms of reference and operating arrangements set by the Board in respect of this Sub-Committee are set out below.

2. PURPOSE

- 2.1 The purpose of the new Velindre Cancer Centre (nVCC) Project Scrutiny Sub-Committee is to:
- Provide assurance that the leadership, management and governance arrangements are sufficiently robust to deliver the outcomes and benefits of the Project.
 - Scrutinise the progress of the Project and provide the Trust Board with assurance that implementation is effective, efficient and within the budget available.
 - Undertake any other scrutiny activity relating to the new Velindre Cancer Centre (nVCC) Project as directed by the Trust Board or Senior Responsible Owner (SRO).

- Seek advice and guidance from appropriate Technical Advisors as well as the Mutual Investment Model (MIM) Transactor to assist the Sub-Committee with their scrutiny of the new Velindre Cancer Centre (nVCC) Project.
 - Provide assurance to the Trust Board on all aspects of the new Velindre Cancer Centre (nVCC) Project in relation to approvals sought on all decisions reserved for the full Board.
 - Receive all audit, gateway and assurance reviews pertaining to the Project or its constituent projects and provide assurance (or otherwise) to the Trust that the project is being delivered in accordance with all professional, financial and Trust standards.
 - Provide assurance to the Trust Board and support to the Senior Responsible Officer in signalling the new Velindre Cancer Centre (nVCC) closure activities once it has met its objectives.
- 2.2 Where appropriate, the Sub-Committee will advise the Trust Board and the Accountable Officer on where, and how, its system of assurance in relation to the new Velindre Cancer Centre (nVCC) Project may be strengthened and developed further.

3. DELEGATED POWERS AND AUTHORITY

With regards to its role in providing advice to the Trust Board, the Sub-Committee will fulfil the following functions:

3.1 Strategy and Policy Development

- Scrutinise project documentation to ensure the direction of the new Velindre Cancer Centre (nVCC) Project remains within the scope and parameters set by the Trust Board and its alignment with the external commissioner and political environment.
- Scrutinise and provide assurance that the Project and its constituent projects are conducted in line with the Trust's requirements on policy and legislative compliance, best practice and within the Trust's governance framework.

3.2 Governance, Monitoring and Review

The Sub-Committee will, in respect of its assurance role:-

- Provide assurance that the Project has a clear and consistent strategic direction of travel aligned with the Trust Boards requirements; strong and effective leadership; clear and transparent lines of accountability and responsibility; and effective reporting to key stakeholders and decision-makers.
- Provide assurance that Project governance arrangements are appropriately designed, proportionately applied and implemented and are operating

appropriately to ensure the provision of a high-quality project management delivery.

- Undertake scrutiny and assurance of the Project progress against the master project plan, seeking explanations and remedies for any deviation from Project timelines. It will report any concerns to the Trust Board as and when appropriate and necessary.
- Undertake scrutiny and assurance of Project risks, issues and mitigating actions to satisfy itself that they can be placed back under the required levels of control.
- Scrutinise all sources of independent assurance in relation to the delivery of the Project (e.g. Internal/External Audit, Independent Reviews, Gateway Reviews, and CAP etc.) and scrutinise and monitor the organisation's response to independent reviews.
- Provide assurance that there are robust monitoring and management arrangements in place to identify important enablers and dependencies between the Project and the relevant corporate and Velindre Cancer Service projects and programmes, as failure to do so could impact on the Projects critical path.
- Scrutinise and assure that the Project expenditure against the budget allocated is appropriate and managed effectively.

3.3 Authority

The Sub-Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference. In doing so, the Sub-Committee shall have the right to inspect any books, records or documents of the Trust relevant to the Sub-Committees remit and ensuring patient/service user, client and staff confidentiality, as appropriate. It may seek any relevant information from any:

- Employee (and all employees and directed to cooperate with any reasonable request made by the Sub-Committee); and
- Other Committee, sub Committee, or group set up by the Board (including the Project Board) to assist it in the delivery of its functions.
- Obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject to the Board's budgetary and other requirements; and
- By giving reasonable notice, require the attendance of any of the officers or employees and auditors of the Board at any meeting of the Sub-Committee.

Provide assurance that any proposals /actual amendments to delegated limits as necessary in relation to the Project are in accordance with the Trust Boards direction and its Standing Orders and Statutory Financial Instructions.

3.4 Access

The Chair of the new Velindre Cancer Centre (nVCC) Project Scrutiny Sub-Committee shall have reasonable access to Executive Directors, Directors and other relevant staff.

4. MEMBERSHIP

4.1 Members

A minimum of three (3) members to include:

Chair - Independent member of the Board (Non-Executive Director)

Two (2) other Independent members of the Board (Non-Executive Director)

Other Trust Board members are extended an open invitation to attend all/any meeting

4.2 Attendees

Core Attendance:

- Chief Executive Officer
- Senior Responsible Owner
- nVCC Project Director
- Executive Director of Strategic Transformation, Planning and Digital
- Executive Medical Director
- Executive Director of Nursing, AHP's & Health Scientists
- Director of Corporate Governance and Chief of Staff
- Executive Director of Organisational Development and Workforce
- Executive Director of Finance
- Director of Commercial and Strategic Partnerships
- Director Velindre Cancer Centre
- Chief Operating Officer
- Chief Digital Officer
- Velindre Futures Programme Director

4.3 Specialist Estates and Governmental Support

Invites to the new Velindre Cancer Centre (nVCC) Project Scrutiny Sub Committee shall be extended to NWSSP- Specialised Estates Services (SES) and Welsh Government representatives in the capacity as observers. These representatives will support the Sub Committee by adopting a "Critical Friend" approach, thus providing assurance as required to the Sub Committee.

4.4 Other Programme / Project Staff as required

The Sub-Committee Chair may extend invitations to others from within or outside the organisation who the Sub-Committee consider should attend, taking account of the matters under consideration of each meeting.

4.5 Secretariat

As determined by the Director of Corporate Governance and Chief of Staff.

4.6 Member Appointments

The membership of the Sub-Committee shall be determined by the Board based on the recommendation of the Trust Chair – taking account of the balance of skills and expertise necessary to deliver the Sub-Committee's remit and subject to any specific requirements or directions made by the Welsh Government

Members shall be appointed -for a maximum of three consecutive years before formally reviewing their role on the Sub-Committee. During this time a member may resign or be removed by the Board.

4.7 Support to Sub-Committee Members

The Director of Corporate Governance and Chief of Staff on behalf of the Sub-Committee Chair shall:

- Arrange the provision of advice and support to Sub-Committee members on any aspect related to the conduct of their role: and
- Ensure the provision of a programme of Organisational development for Sub-Committee members as part of the Trust's overall OD programme developed by the Director of Workforce and Organisational Development.

5. SUB-COMMITTEE MEETINGS

5.1 Quorum

At least two (2) Independent members must be present to ensure the quorum of the Sub-Committee, one of whom should be the Sub-Committee Chair. -If the Chair of the new Velindre Cancer Centre (nVCC) Project Scrutiny Sub-Committee is not present an agreement as to who will chair the Sub-Committee must be agreed between the Independent Members, in absence of the new Velindre Cancer Centre (nVCC) Project Scrutiny Sub-Committee Chair

5.2 Frequency of Meetings

Meetings shall be held no less than four times a year and otherwise as the Chair of the Sub-Committee deems necessary – consistent with the Trust's annual plan of Board Business.

5.3 Withdrawal of individuals in attendance

The Sub-Committee Chair may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

6. RELATIONSHIPS & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 Although the Board has delegated authority to the Sub-Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for the safety, security and use of information to support the quality and safety of healthcare for its citizens through the effective governance of the Organisation.

6.2 The Sub-Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.3 The Sub-Committee, through its Chair and members, shall work closely with the Board's other Committees and Groups to provide advice and assurance to the Board through the:

- Joint planning and co-ordination of Board and Committee business: and
- Sharing of information

In doing so, contributing to the integration of good governance across the Organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Sub-Committee Chair shall:

- Report formally, regularly and on a timely basis to the Quality, Safety and Performance Committee, the Strategic Development Committee and the Accountable Officer on the Sub-Committee's activities. This includes verbal updates on activity and the submission of written highlight reports by exception throughout the year. This reporting is also reported to the Trust Board.
- Bring to the Board's specific attention any significant matters under consideration by the Sub-Committee;
- Ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive or Chairs of other relevant Committees/Groups of any urgent/critical matters that may affect the operation and/or reputation of the Trust.

- 7.2 The Sub-Committee shall provide a written, annual report to the Board on its work. The report will also record the results of the Sub-Committee's self-assessment and evaluation.
- 7.3 The Director of Corporate Governance and Chief of Staff, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Sub-Committee's performance and operation.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

- 8.1 The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Sub-Committee, except in the following areas:
- Quorum – as per section 5.1 above.
- Cross reference with the Trust Standing Orders

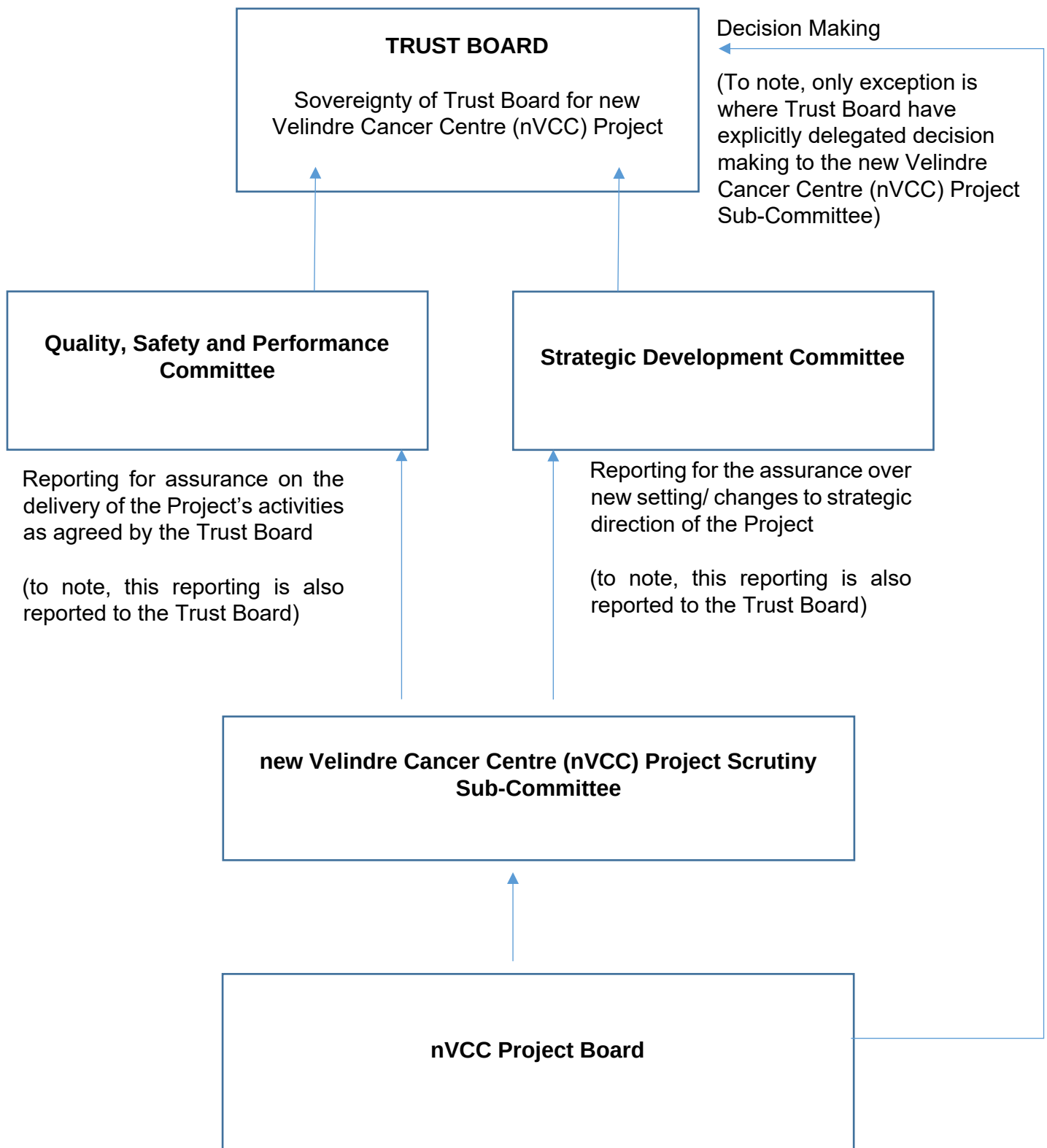
9. REVIEW

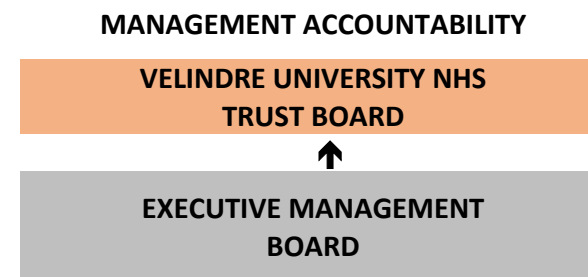
- 9.1 These Terms of Reference shall be reviewed annually by the Sub-Committee with reference to the Trust Board.

10. CHAIR'S ACTION ON URGENT MATTERS

- 10.1 There may, occasionally, be circumstances where decisions which normally be made by the Sub-Committee need to be taken between scheduled meetings. In these circumstances, the Sub-Committee Chair, supported by the Director of Corporate Governance and Chief of Staff as appropriate, may deal with the matter on behalf of the Board, after first consulting with one other Independent Members of the Sub-Committee. The Director of Corporate Governance and Chief of Staff must ensure that any such action is formally recorded and reported to the next meeting of the Sub-Committee for consideration and ratification.
- 10.2 Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

Structure and Governance Arrangements







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Velindre University
NHS Trust

Local Partnership Forum

Terms of Reference & Operating Arrangements

Reviewed:	September 2023 ~~4~~
Next Review Due:	~~June 2025~~ September 2024

1. INTRODUCTION

- 1.1 The Trust's standing orders provide for the establishment of a Local Partnership Forum (LPF) and that the Board must formally approve terms of reference and operating arrangements for the LPF.

The LPF will also operate in accordance with the Trade Union Congress (TUC) six principles of partnership working, namely;

- A shared commitment to the success of the organisation.
- A focus on quality of working life.
- Recognition of the legitimate roles of the employer and trade union.
- A commitment by the employer to employment security.
- Openness on both sides and willingness by the employer to share information and discuss future plans of the organisation.
- Adding value – a shared understanding that the partnership is delivering measurable improvements for the employer, the union and employees.

- 1.2 The detailed terms of reference and operating arrangements set by the Board in respect of this forum are set out below.

2. PURPOSE

- 2.1 The purpose of the Local Partnership Forum (LPF) is;

To provide a formal mechanism where the Trust, as employer and trade unions/professional bodies representing Trust employees (hereafter referred to as staff organisations) work together to improve health services for the citizens served by the Trust – achieved through a regular and timely process of consultation, negotiation and communication. In doing so, the LPF must effectively represent the views and interests of the Trust's workforce.

- 2.2 It is the forum where the Trust and staff organisations will engage with each other to inform, debate and seek to agree local priorities on workforce and health service issues; and inform thinking around national priorities on health matters.

- 2.3 The Trust may specifically request advice and feedback from the LPF on any aspect of its business and the LPF may also offer advice and feedback even if not specifically requested by the Trust. The LPF may provide advice to the Board:

- In written advice or
- In any other form specified by the Board.

- 2.4 The Local Partnership Forum will seek consensus and compromise through effective consultation in Trust's strategic decisions that have significant impact on our people.

- 2.5 The Local Partnership Forum will Seek consensus and compromise though effective consultation on the Trust's delivery of its well-being objectives, including those ~~set~~setset under section 3(2)(a) of the WFGA 2015.

2.6 Compliance with Duty of Quality legislation

3. MEMBERSHIP

Joint Chairs

- 3.1 The LPF shall have two Chairs on a rotational basis, one of whom shall be drawn from the management representative membership, and one from the staff representative membership.

The Chairs shall be jointly responsible for the effective operation of the LPF:

- Chairing meetings, rotated equally between the Staff Representative and Management Representative Chairs;
- Establishing and ensuring adherence to the standards of good governance set for the NHS in Wales, ensuring that all business is conducted in accordance with its agreed operating framework and
- Developing positive and professional relationships amongst the Forum's membership and between the Forum and the Board.

The Chairs shall work in partnership with each other and, as appropriate, with the Chairs of the Trust's other advisory groups. Chairs shall ensure that key and appropriate issues are discussed by the Forum in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions.

The Chairs are accountable to the Board for the conduct of business in accordance with the governance and operating framework set by the Trust.

Joint Vice Chairs

- 3.2 The LPF shall have two Vice Chairs, one of whom shall be drawn from the Management Representative membership, and one from the staff representative membership.

Each Vice Chair shall deputise for their Chair in that Chair's absence for any ~~reason,~~ ~~and reason and~~ will do so until either the existing Chair resumes their duties or a new Chair is appointed.

The Vice Chair is accountable to their Chair for their performance as Vice Chair.

Members

- 3.3 Membership of the LPF comprises;

	Staff Representative	Management Representative
Joint Chair	TBC	Executive Director of Organisational Development & Workforce (WF&OD)
Joint Vice Chair	~~TBC~~ ~~Staff Rep~~ <u>Social Partnership Lead</u>	~~Social Partnership Lead~~ Chief Executive
	<u>All accredited staff reps within the Trust</u>	<u>Chief Executive Officer</u>
	~~All accredited staff reps within the Trust~~	Deputy Director of OD & Workforce
		Executive Director of Finance

		Executive Director of Nursing, Allied Health Professionals and Health Science
		Chief Operating Officer
		Director VCC
		Director WBS

All members of the LPF are full and equal members and collectively share responsibility for its decisions.

All members must:

- Be prepared to engage with and contribute to the LPFs activities and in a manner that upholds the standards of good governance set for the NHS in Wales.
- Comply with their terms and conditions of appointment.
- Equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes and
- Promote the work of the LPF within the professional discipline they represent.

Members of the LPF who are unable to attend a meeting may send a deputy, providing such deputies are eligible for appointment to the LPF and their attendance has been agreed by the Joint Chairs/Vice Chairs prior to the meeting.

Appointment and Terms of Office

3.4 Management representative members shall be determined by the Board.

Staff representatives shall be determined by the staff organisations recognised by the Trust, subject to the following conditions:

- Staff representatives must be employed by the Trust and accredited by their respective trade union and
- A member's tenure of appointment will cease in the event that they are no longer employed by the Trust or cease to be a member of their nominating trade union.

The Management Representative Chair shall be appointed by the Board.

The Staff Representative Chair shall be elected from within the staff representative membership of the LPF, by staff representative members, in a manner determined by the staff representative members. The Staff Representative Chair's term of office shall be for one (1) year.

The Management Representative Vice Chair shall be appointed from within the management representative membership of the LPF by the Management Representative Chair.

The Staff Representative Vice Chair shall be elected from within the staff representative membership of the LPF, by staff representative members, in a manner determined by the staff representative members. The Staff Representative Vice Chair's term of office shall be for one (1) year.

A member's tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements determined for the position. A member must inform their respective LPF Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on the conduct of their role.

Removal, suspension and replacement of members

3.5 If an LPF member fails to attend three (3) consecutive meetings, the next meeting of the LPF shall consider what action should be taken. This may include removal of that person from officer unless they are satisfied that:

- (a) The absence was due to a reasonable cause and
- (b) The person will be able to attend such meetings within such period as the LPF considers reasonable.

If the LPF considers that it is not conducive to its effective operation that a person should continue to hold office as a member, it may remove that person from office by giving immediate notice in writing to the person and the relevant nominating body.

3.6 Before making a decision to remove a person from office, the LPF may suspend the tenure of office of that person for a limited period (as determined by the LPF) to enable it to carry out a proper investigation of the circumstances leading to the consideration of removal. Where the LPF suspends any member, that member shall be advised immediately in writing of the reasons for their suspension. Any such member shall not perform any of the functions of membership during a period of suspension.

3.7 A nominating body may remove and, where appropriate, replace a member appointed to the LPF to represent their interests by giving immediate notice in writing to the LPF.

4. SUB FORA

4.1 The LPF may establish sub-fora to assist it in the conduct of its work, to facilitate:

- Ongoing dialogue, communication and consultation on service and operational management issues specific to Divisions/Directorates/Service areas: and or
- Detailed discussion in relation to a specific issue(s).

Sub fora that have been established;

- The LPF Policy Sub-Group.

5. MEETINGS

Quorum

5.1 At least two members must be present to ensure the quorum of the LPF, one of whom should be the Management Chair or Vice Chair or the staff representative Chair or Vice Chair.

Frequency of Meetings

5.2 Meetings shall be held quarterly or otherwise as the Joint Chairs deem necessary. Where joint Chairs agree, an extraordinary meeting of the LPF may be scheduled with 7 calendar days notice.

6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

- 6.1 The LPF's main link with the Board is through the Executive Members of the LPF.
- 6.2 The Board may determine that designated Trust Members or staff shall be in attendance at LPF meetings. The LPF's Chair may also request the attendance of Trust members or staff, subject to the agreement of the Trust Chair.
- 6.3 The Board shall determine the arrangements for any joint meetings between the Board and the LPF's staff representative members.
- 6.4 The Board's Chair shall put in place arrangements to meet with the LPF's Joint Chairs on a regular basis to discuss the LPF's activities and operation.
- 6.5 The LPF shall ensure effective links and relationships with other groups/fora at a local and, where appropriate, national level.

7. SUPPORT TO THE LPF

- 7.1 The LPF's work shall be supported by two designated Secretary's one of whom shall support the staff representative members and one shall support the management representative members.
- 7.2 The Director of Workforce and OD will act as Management Representative Secretary and will be responsible for the maintenance of the constitution of the membership, the circulation of agenda and minutes and notification of meetings.
- 7.3 The Staff Representative Secretary shall be elected from within the staff representative membership of the LPF, by staff representative members in a manner determined by the staff representatives.
- 7.4 Both Secretaries shall work closely with the Trust's Board Secretary who is responsible for the overall planning and co-ordination of the Trust's programme of Board business, including that of its Committees and Advisory Groups.

8. REPORTING AND ASSURANCE ARRANGEMENTS

- 8.1 The Joint Chairs shall:
- Report formally, regularly and on a timely basis to the Board and the Accountable Officer on the LPF's activities. This includes verbal updates on activity and the submission of written Highlight Reports.
 - The Committee shall provide a written, annual report to the Board on its work. The report will also record the results of the Committee's self-assessment and evaluation
 - bring to the Board and the Accountable Officer's specific attention any significant matters under consideration by the LPF;
 - ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant Committees of any urgent/critical matters that may affect the operation and/or reputation of the Trust.

- 8.2 The Director of Corporate Governance, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any Sub Committees established.

9. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

- 9.1 The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the LPF, except in the following areas:

- Quorum – as per section 5.1 above.

Cross reference with the Trust Standing Orders.

10. REVIEW

- 10.1 These terms of reference and operating arrangements shall be reviewed annually by the LPF with reference to the Board.

11. CHAIR'S ACTION ON URGENT MATTERS

- 11.1 There may, occasionally, be circumstances where decisions which normally be made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Board, after first consulting with two other Members of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.
- 11.2 Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

Date Terms of Reference Approved: xxxxxxxx



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NHS Trust

Local Partnership Forum

Terms of Reference & Operating Arrangements

Reviewed:	September 2023
Next Review Due:	July 2025

1. INTRODUCTION

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- A shared commitment to the success of the organisation.
- A focus on quality of working life.
- Recognition of the legitimate roles of the employer and trade union.
- A commitment by the employer to employment security.
- Openness on both sides and willingness by the employer to share information and discuss future plans of the organisation.
- Adding value – a shared understanding that the partnership is delivering measurable improvements for the employer, the union and employees.

- 1.2 The detailed terms of reference and operating arrangements set by the Board in respect of this forum are set out below.

2. PURPOSE

- 2.1 The purpose of the Local Partnership Forum (LPF) is;

To provide a formal mechanism where the Trust, as employer and trade unions/professional bodies representing Trust employees (hereafter referred to as staff organisations) work together to improve health services for the citizens served by the Trust – achieved through a regular and timely process of consultation, negotiation and communication. In doing so, the LPF must effectively represent the views and interests of the Trust's workforce.

- 2.2 It is the forum where the Trust and staff organisations will engage with each other to inform, debate and seek to agree local priorities on workforce and health service issues; and inform thinking around national priorities on health matters.

- 2.3 The Trust may specifically request advice and feedback from the LPF on any aspect of its business and the LPF may also offer advice and feedback even if not specifically requested by the Trust. The LPF may provide advice to the Board:

- In written advice or
- In any other form specified by the Board.

- 2.4 The Local Partnership Forum will seek consensus and compromise through effective consultation in Trust's strategic decisions that have significant impact on our people.

- 2.5 The Local Partnership Forum will Seek consensus and compromise though effective consultation on the Trust's delivery of its well-being objectives, including those set under section 3(2)(a) of the WFGA 2015.

- 2.6 Compliance with Duty of Quality legislation

3. MEMBERSHIP

Joint Chairs

- 3.1 The LPF shall have two Chairs on a rotational basis, one of whom shall be drawn from the management representative membership, and one from the staff representative membership.

The Chairs shall be jointly responsible for the effective operation of the LPF:

- Chairing meetings, rotated equally between the Staff Representative and Management Representative Chairs;
- Establishing and ensuring adherence to the standards of good governance set for the NHS in Wales, ensuring that all business is conducted in accordance with its agreed operating framework and
- Developing positive and professional relationships amongst the Forum's membership and between the Forum and the Board.

The Chairs shall work in partnership with each other and, as appropriate, with the Chairs of the Trust's other advisory groups. Chairs shall ensure that key and appropriate issues are discussed by the Forum in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions.

The Chairs are accountable to the Board for the conduct of business in accordance with the governance and operating framework set by the Trust.

Joint Vice Chairs

- 3.2 The LPF shall have two Vice Chairs, one of whom shall be drawn from the Management Representative membership, and one from the staff representative membership.

Each Vice Chair shall deputise for their Chair in that Chair's absence for any reason and will do so until either the existing Chair resumes their duties or a new Chair is appointed.

The Vice Chair is accountable to their Chair for their performance as Vice Chair.

Members

- 3.3 Membership of the LPF comprises;

	Staff Representative	Management Representative
Joint Chair	TBC	Executive Director of Organisational Development & Workforce (WF&OD)
Joint Vice Chair	Social Partnership Lead	
	All accredited staff reps within the Trust	Chief Executive Officer
		Deputy Director of OD & Workforce
		Executive Director of Finance
		Executive Director of Nursing, Allied Health Professionals and Health Science

		Chief Operating Officer
		Director VCC
		Director WBS

All members of the LPF are full and equal members and collectively share responsibility for its decisions.

All members must:

- Be prepared to engage with and contribute to the LPFs activities and in a manner that upholds the standards of good governance set for the NHS in Wales.
- Comply with their terms and conditions of appointment.
- Equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes and
- Promote the work of the LPF within the professional discipline they represent.

Members of the LPF who are unable to attend a meeting may send a deputy, providing such deputies are eligible for appointment to the LPF and their attendance has been agreed by the Joint Chairs/Vice Chairs prior to the meeting.

Appointment and Terms of Office

3.4 Management representative members shall be determined by the Board.

Staff representatives shall be determined by the staff organisations recognised by the Trust, subject to the following conditions:

- Staff representatives must be employed by the Trust and accredited by their respective trade union and
- A member's tenure of appointment will cease in the event that they are no longer employed by the Trust or cease to be a member of their nominating trade union.

The Management Representative Chair shall be appointed by the Board.

The Staff Representative Chair shall be elected from within the staff representative membership of the LPF, by staff representative members, in a manner determined by the staff representative members. The Staff Representative Chair's term of office shall be for one (1) year.

The Management Representative Vice Chair shall be appointed from within the management representative membership of the LPF by the Management Representative Chair.

The Staff Representative Vice Chair shall be elected from within the staff representative membership of the LPF, by staff representative members, in a manner determined by the staff representative members. The Staff Representative Vice Chair's term of office shall be for one (1) year.

A member's tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements determined for the position. A member must inform their

respective LPF Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on the conduct of their role.

Removal, suspension and replacement of members

3.5 If an LPF member fails to attend three (3) consecutive meetings, the next meeting of the LPF shall consider what action should be taken. This may include removal of that person from office unless they are satisfied that:

- (a) The absence was due to a reasonable cause and
- (b) The person will be able to attend such meetings within such period as the LPF considers reasonable.

If the LPF considers that it is not conducive to its effective operation that a person should continue to hold office as a member, it may remove that person from office by giving immediate notice in writing to the person and the relevant nominating body.

3.6 Before making a decision to remove a person from office, the LPF may suspend the tenure of office of that person for a limited period (as determined by the LPF) to enable it to carry out a proper investigation of the circumstances leading to the consideration of removal. Where the LPF suspends any member, that member shall be advised immediately in writing of the reasons for their suspension. Any such member shall not perform any of the functions of membership during a period of suspension.

3.7 A nominating body may remove and, where appropriate, replace a member appointed to the LPF to represent their interests by giving immediate notice in writing to the LPF.

4. SUB FORA

4.1 The LPF may establish sub-fora to assist it in the conduct of its work, to facilitate:

- Ongoing dialogue, communication and consultation on service and operational management issues specific to Divisions/Directorates/Service areas: and or
- Detailed discussion in relation to a specific issue(s).

Sub fora that have been established;

- The LPF Policy Sub-Group.

5. MEETINGS

Quorum

5.1 At least two members must be present to ensure the quorum of the LPF, one of whom should be the Management Chair or Vice Chair or the staff representative Chair or Vice Chair.

Frequency of Meetings

5.2 Meetings shall be held quarterly or otherwise as the Joint Chairs deem necessary. Where joint Chairs agree, an extraordinary meeting of the LPF may be scheduled with 7 calendar days notice.

6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS

COMMITTEES/GROUPS

- 6.1 The LPF's main link with the Board is through the Executive Members of the LPF.
- 6.2 The Board may determine that designated Trust Members or staff shall be in attendance at LPF meetings. The LPF's Chair may also request the attendance of Trust members or staff, subject to the agreement of the Trust Chair.
- 6.3 The Board shall determine the arrangements for any joint meetings between the Board and the LPF's staff representative members.
- 6.4 The Board's Chair shall put in place arrangements to meet with the LPF's Joint Chairs on a regular basis to discuss the LPF's activities and operation.
- 6.5 The LPF shall ensure effective links and relationships with other groups/fora at a local and, where appropriate, national level.

7. SUPPORT TO THE LPF

- 7.1 The LPF's work shall be supported by two designated Secretary's one of whom shall support the staff representative members and one shall support the management representative members.
- 7.2 The Director of Workforce and OD will act as Management Representative Secretary and will be responsible for the maintenance of the constitution of the membership, the circulation of agenda and minutes and notification of meetings.
- 7.3 The Staff Representative Secretary shall be elected from within the staff representative membership of the LPF, by staff representative members in a manner determined by the staff representatives.
- 7.4 Both Secretaries shall work closely with the Trust's Board Secretary who is responsible for the overall planning and co-ordination of the Trust's programme of Board business, including that of its Committees and Advisory Groups.

8. REPORTING AND ASSURANCE ARRANGEMENTS

- 8.1 The Joint Chairs shall:
 - Report formally, regularly and on a timely basis to the Board and the Accountable Officer on the LPF's activities. This includes verbal updates on activity and the submission of written Highlight Reports.
 - The Committee shall provide a written, annual report to the Board on its work. The report will also record the results of the Committee's self-assessment and evaluation
 - bring to the Board and the Accountable Officer's specific attention any significant matters under consideration by the LPF;
 - ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant Committees of any urgent/critical matters that may affect the operation and/or reputation of the Trust.

- 8.2 The Director of Corporate Governance, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any Sub Committees established.

9. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

- 9.1 The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the LPF, except in the following areas:

- Quorum – as per section 5.1 above.

Cross reference with the Trust Standing Orders.

10. REVIEW

- 10.1 These terms of reference and operating arrangements shall be reviewed annually by the LPF with reference to the Board.

11. CHAIR'S ACTION ON URGENT MATTERS

- 11.1 There may, occasionally, be circumstances where decisions which normally be made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Board, after first consulting with two other Members of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.
- 11.2 Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

Date Terms of Reference Approved: xxxxxxxx

TRUST BOARD	
CHAIR'S URGENT ACTION MATTER REPORT	
DATE OF MEETING	24 July 2025
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	TO RATIFY
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Kay Barrow, Corporate Governance Manager
PRESENTED BY	Non Gwilym, Interim Director of Corporate Governance
APPROVED BY	Non Gwilym, Interim Director of Corporate Governance
EXECUTIVE SUMMARY	This report details Chair's Urgent Actions taken between the 14/05/2025 – 17/07/2025. There was one (1) urgent item of business for the Trust Board that was considered via Chairs Urgent Action during this period: 1. E-Rostering Contract Renewal No objections to approval were received in respect of the items of business considered.
RECOMMENDATION / ACTIONS	To RATIFY the Chairs Urgent Action taken between the 14/05/2025 – 17/07/2025 .
GOVERNANCE ROUTE	
Trust Board Members – Via Email	12/06/2025: E-Rostering Contract Renewal
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
The Trust Board APPROVED each item of business considered via Chair's Urgent Action.	
7 LEVELS OF ASSURANCE – N/A	
APPENDICES – N/A	

1. SITUATION

This paper provides the Trust Board with an overview of key decisions and outcomes considered via Chair's Urgent Action between the **14/05/2025 – 17/07/2025**.

2. BACKGROUND

- 2.1 In accordance with the Trust Standing Orders, there may occasionally, be circumstances where decisions, which would normally be made by the Board, need to be taken between scheduled meetings and it is not practicable to call a meeting of the Board. In these circumstances, the Chair and Chief Executive, supported by the Interim Director of Corporate Governance, as appropriate, may deal with the matter on behalf of the Board – after first consulting with at least two other Independent Members. The Interim Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Board for consideration and ratification. Where issues are included in the Schedule of 'Expected Urgent Decisions' and prior approval is sought from the Board, these issues will not be reported here.
- 2.2 Chair's Action may not be taken where either the Chair or the Chief Executive has a personal or business interest in an urgent matter requiring decision. In this circumstance, the Vice-Chair or the Executive Director acting on behalf of the Chief Executive will take a decision on the urgent matter, as appropriate.

3.0 ASSESSMENT/SUMMARY OF MATTERS FOR CONSIDERATION

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

3.1 E-Rostering Contract Renewal

The Trust Board was sent an email and Chair's Urgent Action Report on the **12th June 2025** in relation to the E-Rostering Contract Renewal that required urgent approval.

The Trust Board was requested to:

- **NOTE** and **APPROVE** the renewal of the current All Wales E-Rostering Contract to the preferred supplier RL Datix, to take effect from January 2026, thus ensuring there is no interruption to service delivery.
- **AUTHORISE** the Chief Executive to **APPROVE** the award of the contract summarised within the report and supporting appendix.
- **AUTHORISE** the Chief Executive to **APPROVE** requisitions for expenditure under the named agreements.

On Friday, 13th June 2025, Gareth Jones, whilst content to approve as requested, highlighted an important point in procurement terms that this was an award of a new contract to the incumbent supplier and not the renewal of the current contract.

Recommendation Approved by:

- Donna Mead, Chair
- David Donegan, CEO
- Stephen Harries, Independent Member
- Andrew Westwell, Independent Member
- Vicky Morris, Independent Member
- Gareth Jones, Independent Member
- Sarah Morley, Executive Director of Organisational Development and Workforce

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	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒

	This action is by exception and with prior approval from the Chair. The provision to permit this urgent action is to allow for quick decisions to be made where it is not practicable to call a Board meeting and to avoid delays that could affect service delivery and quality.
QUALITY IMPACT ASSESSMENT	Not required - not a strategic decision
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Not required
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience.
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	Financial impact was captured within the documentation considered by the Board.
EQUALITY IMPACT ASSESSMENT	Not required
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Legal impact was captured within the documentation considered by the Board.

4 RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

TRUST BOARD	
People and Organisational Development Policies and Processes	
DATE OF MEETING	24 July 2025
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Amanda Jenkins, Acting Assistant Director of Workforce
PRESENTED BY	Amanda Jenkins, Acting Assistant Director of Workforce
APPROVED BY	Sarah Morley, Executive Director of Organisational Development & Workforce
EXECUTIVE SUMMARY	This paper provides an overview of updates made to Workforce and Organisational Development (OD), bringing them up to date with current employment legislation and best practice.
RECOMMENDATION / ACTIONS	The Trust Board are asked to APPROVE the polices.
GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	Date
People and OD Policy Review Group	23/04/2025
Executive Management Board	29/05/2025
Quality, Safety and Performance Committee	17/07/2025
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
The People and OD Policy Review Group has been set up as a systematic way to review the accuracies of POD polices and ensure they are compliant with recent legislation and changes in employment law. The group also considered the importance of only having written control documents that are relevant, intentional, and impactful for staff. Detailed feedback on each policy is included in the body of the paper.	



APPENDICES	
1	Family Friendly Policy
2	Maternity Leave Procedure
3.	Maternity Leave Application Form
4.	Pregnancy and Maternity Support Guidance

1. SITUATION

This paper provides an overview of updates made to Workforce and Organisational Development (OD) Policies, bringing them up to date with current employment legislation and best practice.

2. BACKGROUND

The new systematic review process is in place within the Trust and the following have been designed in a new format by the People and OD Policy Group on 23rd April 2025, for legislative and best practice compliance.

The key changes proposed are that the Trust will have one over arching Family Friendly Policy that encompasses all statutory and occupational leave options for staff underpinned by procedures and manager guidance documents that our people can easily follow.

3. ASSESSMENT

3.1 The following are the changes or additions to current policies to bring them up to date with current legislation and best practice that Trust Board are asked to approve:

3.1.1 Family Friendly Policy:

- New policy designed to encompass current policies and procedures and bring together the statutory and occupational terms and conditions for staff into one document



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- Removal of jargon and complex terms, making this user friendly and easy to read
- Underpinned by procedures that staff can easily access and that encompass inclusive language and tone.

3.1.2 Maternity Leave Procedure:

- The first procedure to be written in this new style and format
- Aims to be user friendly and speak directly to employees about their entitlements
- Change in tone and removal of complex jargon and language
- New application form

3.1.3 Pregnancy and Maternity Support Guidance

- Easy to use staff and managers guide
- A standard operating procedure with clear directions and links (currently in yellow) to relevant documents

4. SUMMARY OF MATTERS FOR CONSIDERATION

The Trust Board is asked to **APPROVE** the design of this policy and supporting procedures.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals:	
• Outstanding for quality, safety and experience	☒
• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations	☒
• A beacon for research, development and innovation in our stated areas of priority	☒
• An established 'University' Trust which provides highly valued knowledge for learning for all.	☒



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A sustainable organisation that plays its part in creating a better future for people across the globe ☒													
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) For more information: STRATEGIC RISK DESCRIPTIONS	04 - Organisational Culture												
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply												
	<table> <tr> <td>Safe</td> <td>☒</td> </tr> <tr> <td>Timely</td> <td>☒</td> </tr> <tr> <td>Effective</td> <td>☒</td> </tr> <tr> <td>Equitable</td> <td>☒</td> </tr> <tr> <td>Efficient</td> <td>☒</td> </tr> <tr> <td>Patient Centred</td> <td>☒</td> </tr> </table>	Safe	☒	Timely	☒	Effective	☒	Equitable	☒	Efficient	☒	Patient Centred	☒
	Safe	☒											
Timely	☒												
Effective	☒												
Equitable	☒												
Efficient	☒												
Patient Centred	☒												
Having well designed and values driven People Policies will support the Trust to ensure fairness and inclusion by outlining the responsibilities of both employer and employee. Having well-articulated and clear directions for staff will can impact motivation, organisation reputation and the ability to attract and retain talent, creating mutual benefits for employees and organisations as well as providing statutory protections where these are essential for the Trust.													
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: For more information: https://www.gov.wales/socio-economic-duty-overview	Yes												
	NA – assessments completed on each policy												
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	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 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												



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	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
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT For more information: https://nhswales365.sharepoint.com/sites/VEL/_layouts/15/Default.aspx	Yes - please outline what, if any, actions were taken as a result
	Each policy or procedure has undergone an EQIA in line with the statutory requirements of assessing policy impact on Protected Characteristics. None of the policies or procedures outlined in this paper required further action.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Not having well designed people policies could result in further challenge through employment tribunals.

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	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. TAF 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.



	TAF 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. TAF 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.
WHAT IS THE CURRENT RISK SCORE	Various as outlined on the Trust Assurance Framework
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	Having well designed and values driven People Policies will support the Trust to ensure fairness and inclusion by outlining the responsibilities of both employer and employee. Having well-articulated and clear directions for staff will can impact motivation, organisation reputation and the ability to attract and retain talent, creating mutual benefits for employees and organisations as well as providing statutory protections where these are essential for the Trust.
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	NA – Specific risks aligned to the strategic Trust risks and reviews as part of the Trust Assurance Framework
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Yes - please detail below
	Ensuing the right people are able to review and comment on the policy development. This will hopefully be mitigated by a new systematic review process that will commence in September 2024.
All risks must be evidenced and consistent with those recorded in Datix	



Ref: **TBC (New Policy)**

Family Friendly Policy

Executive Sponsor & Function:	Executive Director of Organisational Development and Workforce
Document Author:	People and OD Policy Group
Approved by:	Trust Board
Approval Date:	TCB
Date of Equality Impact Assessment:	TBC
Equality Impact Assessment Outcome:	TBC
Review Date:	TBC
Version:	DRAFT V.1

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INTRODUCTION

At Velindre University NHS Trust, we are dedicated to fostering a supportive and inclusive environment for all our staff. Our Family-Friendly Policy is designed to help employees balance their work and family responsibilities effectively. We offer comprehensive support through our Family-Friendly procedures and guidance.

We understand the importance of family and are committed to providing flexible and compassionate support to our employees. Our Family Friendly Policy encompasses the following procedures and guidance:

- **Supportive Guidance:** Detailed guidance documents outlining steps to be taken on implementing the Family Friendly Policy and relevant Procedures as well as providing clarity on roles and responsibilities.
- **Neonatal Leave:** Neonatal care leave allows parents to have additional time off to be with a baby who is receiving neonatal care.
- **Maternity Leave:** Offering leave entitlements to support employees to ensure a smooth transition before and after childbirth.
- **Adoption Leave:** Ensuring adoptive parents receive the necessary time and support to bond with their new child.
- **Paternity Leave:** Providing leave for partners to support their family during the early stages of a child's life.
- **Shared Parental Leave:** Allowing parents to share leave in a way that best suits their family needs, promoting a balanced approach to childcare responsibilities.

By implementing these family-friendly initiatives, we aim to create a workplace where everyone can achieve a healthy work-life balance and feel valued as part of the Velindre University NHS Trust family.

OBJECTIVES

The objective of this Policy is to ensure staff are aware of their legal entitlements to family leave and pay as well as the additional benefits Velindre University NHS Trust provides to employees to support a flexible balance between their professional responsibilities and family commitments.

SCOPE

The policy applies to all Velindre University NHS Trust employees, including hosted organisations, who meet the eligibility criteria within each of the relevant procedures.

All employees will be treated with dignity and respect regardless of their gender identity or sexual orientation relating to the application of this Policy.

ROLES AND RESPONSIBILITIES

The Trust is responsible for maintaining compliance with relevant employment laws and regulations, ensuring that all family-friendly initiatives are implemented fairly and consistently. By fulfilling these responsibilities. The Trust aims to create a workplace where employees feel valued, supported and able to thrive both professionally and personally.

Detailed responsibilities for employees and Trust Officers, managers and employees are outlined in each of the relevant procedures or guidance documents.

RESOURCES

In addition to the relevant procedures and guidance documents specifically outlined in this Policy, the following additional resources may be important for supporting our employees to maintain a flexible balance between their professional responsibilities and family commitments.

- **NHS Wales Special Leave Policy:** Parental Leave, Emergency Carers and Dependent Leave, Fertility Treatment and other relevant special leave entitlements
- **NHS Wales Flexible Working Policy:** The relevant procedure for all staff to make a formal request for flexible working.
- **NHS Wales Managing Attendance at Work Policy:** Pregnancy Related Illness and other relevant absence management processes.
- **Carers Leaves Policy:** Policy to support all staff to take statutory leave where they care for a dependant with a serious health condition.

RELEVANT LEGISLATION

The Velindre University NHS Trust Family-Friendly Policy has been produced to ensure the relevant provisions offered to employees comply with the following:

- Employment Rights Act 1996
- Equality Act, 2010
- Paternity and Adoption Leave (Amendment) Regulations 2014
- The Parental Bereavement Leave Regulations 2020
- The Maternity Leave, Adoption Leave and Shared Parental Leave (Amendment) Regulations 2024

TRAINING AND DEVELOPMENT

Managers will be expected to maintain their compassionate leadership skills through formal and informal mechanisms available to them within the Trust. These mechanisms ensure managers are able to support team members, handle leave requests, and manage flexible working arrangements.

REVIEW OF POLICY

This Policy and relevant procedures and guidance will be subject to regular review at a frequency determined by the Trust Policy Group or when relevant legalisation changes.

GETTING HELP

For help and advice in relation to this policy you can contact the People Relationship Team via velindre.workforceandod@wales.nhs.uk



Ref:

Maternity Leave Procedure

Executive Sponsor & Function:	Executive Director of Organisational Development and Workforce
Document Author:	People and OD Policy Group
Approved by:	Trust Board
Approval Date:	TCB
Date of Equality Impact Assessment:	TBC
Equality Impact Assessment Outcome:	TBC
Review Date:	TBC
Version:	DRAFT V.1

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1. Introduction

The rules covering maternity leave and pay can be complex; this procedure aims to ensure you, as an employee of Velindre University NHS Trust or a host organisation are informed of your entitlements and responsibilities when taking maternity leave and pay.

The procedure also explains the specific steps you and your manager should take to claim these entitlements.

2. Maternity Leave

2.1 Eligibility for Maternity Leave

You have the right to 52 weeks of maternity leave from work if you are pregnant and legally classed as an employee. This is also applicable if you are a surrogate.

In relation to Velindre University NHS Trust you are an employee if you have a contract of employment to work within the Trust or with one of our host organisations.

You are not an employee if:

- You work only on the bank
- You are an agency worker; you should inform your agency of your pregnancy, as you may be eligible for maternity rights through them
- You are self-employed and contracted to undertake work for the Trust
- You are a third-party worker via a company contracted to do work for the Trust

If you are not an employee you will be eligible to take compulsory maternity leave, which is 2 weeks following the birth.

2.1 Details of Maternity Leave

If you meet the eligibility for maternity leave, you will be entitled to 52 weeks of maternity leave, this is made up of 26 weeks ordinary maternity leave and 26 weeks of additional maternity leave. Ordinary and additional maternity leave run concurrently and cannot be taken at different times.

A week, in the context of maternity leave and pay is defined as: full 7 days from Sunday to Saturday.

You are not required to take the full entitlement of 52 weeks however the law does require you to take compulsory maternity leave which is a minimum of 2 weeks following the birth.

You get the same amount of maternity leave even if you have a multiple birth.

Maternity leave can start from 11 weeks before the baby is due up to the day you give birth, unless the birth is premature. If your baby is born before, prematurely, your maternity leave will start on your first day of absence.

If your child requires neonatal care, either from being born prematurely or some other reasons you may be eligible for additional leave, in addition to your maternity leave. Details of eligibility and the procedure for this can be found in the Trust's Neonatal Leave Procedure.

If you are sick or suspended from duties, due to reasons related to your pregnancy, your maternity leave will automatically start 4 weeks before the baby is expected to be born.

If you give birth before the maternity leave was due to start, you should notify your manager, in writing, of the date of the birth, as soon as reasonably practicable.

You may be able to share 50 weeks of your maternity leave with your partner. Details of eligibility and the procedure for doing this can be found in the Trust's Shared Parental Leave Procedure.

3. Maternity Pay

3.1 Types of Pay

After giving birth, you may be eligible for one of the following types of pay:

- Occupational maternity pay
- Statutory maternity pay
- Maternity allowance

There are different eligibility criteria for each of the types of pay depending on your contractual position within the Trust and your length of service.

3.2 Eligibility for Occupational Maternity Pay

Occupational maternity pay is a contractual benefit, which includes statutory maternity pay and enhanced payments, for some people who meet the eligibility criteria.

You are entitled to occupational maternity pay if you meet all of the following criteria:

- You are an employee and have at least 12 months continuous NHS service, up to the 11th week before your baby is due
- You notify the Trust in writing 15 weeks before the baby is due (or as soon as practical if this is not possible)
- You provide a MATB1 form from your midwife or GP setting out the expected week of childbirth
- You intend to return to work following the period of maternity leave for a minimum of 3 months

3.3 Amount of Occupational Maternity Pay

If you are eligible for occupational maternity pay you will receive the following amount of pay:

- Full pay for the first 8 weeks
- Half pay, plus statutory maternity pay for the next 18 weeks

- statutory maternity pay for the next 13 weeks

During the final 13 weeks of maternity leave you will not be paid.

With prior agreement you can also ask for your maternity pay to be paid differently, for example, a fixed amount spread equally over your maternity leave.

Calculations for full weeks' pay will depend on your Terms and Conditions of Service (i.e. Agenda for Change, Medical and Dental or Executive and Senior Pay). The People and OD Team or Payroll will be able to provide more information on how this is calculated.

3.4 Refunding Occupational Maternity Pay

If you had originally intended to return to work within the Trust, or for an alternative NHS Organisation, following your maternity leave but change your mind you will be liable to pay back any enhancements received above statutory maternity pay.

Taking up an NHS bank position will not constitute a return to work and you will still be liable to pay back benefits that you should not have received.

The Trust retains their rights of discretion relating to the paying back of occupational maternity pay where enforcing this will cause hardship or undue distress.

If you return to work to the Trust or another NHS Organisation for at least 13 full weeks you will not be required to pay back your occupational maternity pay that you received.

3.5 Eligibility for Statutory Maternity Pay

Statutory maternity pay is the minimum payment you will receive if you are an employee, meet the eligibility criteria but are not eligible for occupational maternity pay.

You are entitled to statutory maternity pay if you meet all of the following criteria:

- You have been working for the Trust continuously for 26 weeks up to the qualifying week
- You earned at least £125 a week, on average, for 8 weeks before the qualifying week
- You notify the Trust in writing 15 weeks before the baby is due (or as soon as practical if this is not possible)
- You provide a MATB1 form from your midwife or GP setting out the expected week of childbirth

The qualifying week is 15 weeks prior to the expected date of childbirth.

If you were employed by another organisation at up to the qualifying week they will pay your statutory maternity pay, you will need to contact your previous employer to arrange this.

3.6 Amount of Statutory Maternity Pay

If you are eligible for statutory maternity pay you will receive the following amount of pay:

- 90% of your average weekly earnings for the first 6 weeks
- £187.18 or 90% of your average weekly earnings (whichever is lower) for the next 33 weeks

During the final 13 weeks of maternity leave you will not be paid.

Average weekly earnings are calculated by payroll, based on your gross pay (before deductions), for 8 weeks prior to the start of your maternity leave. It is important to note that a number of factors impact the average weekly earnings, including:

- Pay awards or pay progression increments, even if retrospectively implemented
- Sick pay, annual leave, overtime, bonus and pay in arrears
- Salary sacrifice schemes

If you have a period of back-to-back maternity leave or return to work for only for a short period before taking a further period of maternity leave, you should contact payroll to check the implications this may have for you.

3.7 Maternity Allowance

If you are not eligible for occupational maternity pay or statutory maternity pay you may be eligible for maternity allowance which is paid by the Job Centre Plus. You can find out if you are eligible for maternity allowance on the [Gov.uk](https://www.gov.uk) website or by contacting your local Job Centre Plus.

3.8 Pension Contributions

If you are a member of the NHS Pensions Scheme your contributions will still be paid during your maternity leave. This will avoid a break in service and the possible loss of pension rights, which have already been accrued. Deductions are calculated on the variable amount of pay received each month.

During any unpaid periods of maternity leave contributions cannot be deducted however the arrears will be deducted from your salary when you return to work. Ordinarily these arrears will be taken over the same period of time that they have been accrued but if you return to work on a part-time basis, the repayment period can be extended.

If during the unpaid periods of maternity leave you become eligible for a tax refund, this will automatically be paid in your salary. It should however be noted that payroll will normally offset this with any pension arrears owed. If you have any queries relating to this you can contact payroll for more information.

3.9 Promotion or Change in Pay

If you are appointed to another role within the Trust or another NHS organisation during your maternity leave, that would ordinarily change your salary, this will not impact on your maternity pay. Any changes in pay made as a result of your new role will take effect on your return to work.

4. Antenatal Care

You should inform the Trust as soon as you become pregnant because this will ensure you get time off to attend your antenatal appointments. Antenatal care may include relaxation and parentcraft classes, in addition to medical examinations.

Part-time employees are also able to take reasonable time off where their appointments when these fall during normal working time.

To be entitled to take time off for antenatal care, you need to share evidence with your manager of your pregnancy from your doctor, midwife or health visitor. In the case of your first antenatal appointment this evidence can be the form of an appointment card or note.

We do ask that staff inform their line manager as soon as possible of any antenatal appointments and to arrange them as near to the start or end of a shift as possible. This will support ensuring your manager can maintain our services during your appointment.

You will need to book the time off for antenatal appointments through ESR.

5. Health and Safety

As well as ensuring you get time off for antenatal care, informing the Trust of your pregnancy will ensure we can manage any health and safety risks during the pregnancy.

5.1 Workplace Risk Assessment

Your manager will undertake a workplace risk assessment with you to identify any risks to you or your baby's health and safety while at work. This risk assessment will need to be reviewed every three months of your pregnancy and when you return to work.

If your workplace risk assessment identifies and risks to you or your baby's health and safety in the workplace, your manager will need to put in place adjustments to remove these risks or provide temporary alternative work.

If it is not possible for your manager to remove the risks or there is no suitable alternative work your manager may suspend you from work, on maternity grounds until such time as there are no longer any risks.

5.2 Maternity Suspension

If you are suspended from work during the period of your pregnancy, this does not have any impact on your employment or statutory maternity rights.

You will be entitled to your normal pay, as if you had been in work during the suspension.

Suspension on maternity grounds may last the entire length of your pregnancy or until your manager is able to remove the identified risks.

6. Temporary, Fixed-Term and Training Contracts

6.1 Ending contracts during Maternity Leave

If you are an employee appointed on a temporary, fixed-term or training contract which is due to end 11 weeks before your baby is born and if you are eligible for maternity leave, your contract with the Trust will be extended so that you have the full 52 weeks maternity leave.

During this time, you will be paid as per your eligibility for maternity pay.

If your contract ends following your maternity leave, and was expected to end regardless of your pregnancy, then you will not be subject to pay back of any occupational maternity pay.

6.2 Rotational Training Contracts

If you are employed on a rotational contract with one or more NHS organisation you will have the right to return to the same post or the next planned rotational post even if the contract was to end during your maternity leave.

Your contract of employment will be extended so that you can complete the training programme.

You should contact your training or educational lead to discuss the options for your training programme.

7. Redundancy

If you are pregnant or on maternity leave and your job is being made redundant you will have special protection for a set period of time. The special protection lasts from the day you inform us you are pregnant until 18 months following the birth of your baby.

The special protection from redundancy means that if there is a suitable alternative role available you will have priority over others for this role.

If there are more people with redundancy protections than suitable roles available then the Trust will evaluate each person based on the following criteria:

- Skills
- Job Knowledge
- Experience

If there is no suitable alternative employment available you will be terminated on grounds of redundancy and full redundancy rights and payments will apply.

8. Keeping in Touch Days

During your maternity leave you will have the opportunity to work up to 10 days as keeping in touch (KIT) days. KIT days help you stay in touch with the Trust while you

are on maternity leave and therefore using KIT days will not extend your maternity leave.

You cannot work KIT days during the first 2 weeks of your maternity leave.

How you chose to work KIT days, if any, will need to be agreed between you and your manager, it's important to note however even if you chose to work a few hours, this will be counted as a whole KIT day.

If you work more than 10 KIT days this will automatically end your maternity leave.

You will be paid your normal contractual hourly rate, in respect of the number of hours actually worked.

As well as formal KIT days, prior to going on maternity leave you should agree with your manager how you would like to be informed of what is happening in the workplace.

15. Return to Work

You will be entitled to return to work to the same position that you had in the Trust prior to your maternity leave and your terms and conditions will be the same as if you had not been absent.

If you intend to return to work following the full 52 weeks of maternity leave you will not be required to provide notification of this to your manager.

If you however wish to return from maternity leave early, you will need to provide at least 56 calendar days' notice in writing. If you do not provide adequate notice your manager will have discretion to postpone your return date.

15.1 Failure to Return to Work

If you have notified your manager of your intentions to return to work and you do not do so at the end of your maternity leave this may result in the termination of your contract of employment.

You will be contacted by your manager in writing, and allowed 14 days to respond before the Trust terminates your contract of employment.

You will be liable to repay any occupational maternity pay, if your contract of employment is terminated.

15.2 Breastfeeding in the Workplace

We want to support returning mothers who chose to breastfeed or express to continue this when you return to work. You will need to inform your line manager as soon as practically possible of your intentions to breastfeed or express and they can consider a number of options that would allow you to do this safely and with dignity.

Your manager will need to carry out a formal risk assessment of your working conditions to identify any health and safety risks with breastfeeding or expressing when you return to work.

Potential options for supporting you in your return to work to breastfeed or express could be:

- Flexible working arrangements
- Time off (unpaid) to feed your baby away from the workplace
- Your baby could be brought to the workplace to be fed
- A clean, private and dignified space dedicated to expressing with appropriate secure storage for milk

There is no one size fits all in relation to agreeing how best to support you in breastfeeding or expressing on your return to work so you will need to discuss this with your line manager.

16. Sickness Absence

We understand that occasionally your pregnancy may result in sickness absence and you and your manager should consult the NHS Wales Managing Attendance at Work Policy to support you through this process.

17. Parental Bereavement

If a child is stillborn (after 24 weeks of pregnancy) you will still be entitled to the full 52 weeks of maternity leave, however they Trust will be sensitive in communications in this case and you will be asked if you would like to call this leave something different.

You and your partner will also be entitled to 2 weeks paid parental bereavement leave which is added onto the end of the maternity leave.

If you experience miscarriage (first 24 weeks of pregnancy) there is no entitlement to parental bereavement leave, however the NHS Wales Special Leave Policy sets out additional leave you may get during this time.

MATERNITY LEAVE APPLICATION FORM

This form must be completed on or before the 15th week before the baby is due or if that is not practicable, as soon as reasonably practicable to do so. This form must be completed, regardless of intentions to return to work following maternity leave.

PART A – EMPLOYEE / APPLICANT TO COMPLETE

Applicant Details			
Name	Click or tap here to enter text.		
Home Address			
Job Title	Click or tap here to enter text.		
Employee Number	Click or tap here to enter text.		
Contracted Hours	Full-time ☐ Part-time ☐	If part-time please state the number of contracted hours per week	00.00 Hrs Per Week
Division / Organisation	Click or tap here to enter text.	Department	Click or tap here to enter text.
Start Date in Velindre University NHS Trust	Click or tap to enter a date.		
Start Date in the NHS	Click or tap to enter a date.		
Maternity Leave Request			
Return to Work – Please select one option			
I intend to return to work, for the Trust or another NHS organisation following maternity leave for a minimum of 13 weeks			☐
I will not be returning to work, for the Trust or another NHS organisation following maternity leave			☐
I am undecided about returning to work for the Trust or another NHS organisation following maternity leave			☐
Pregnancy Details			
Expected date of childbirth <i>As sated on the MATB1</i>		Click or tap to enter a date.	
Proposed start date of maternity leave		Click or tap to enter a date.	
Proposed end date of maternity leave		Click or tap to enter a date.	
MATB1 Form Attached		Yes ☐	No ☐
Annual Leave			
Full year annual leave entitlement		Click or tap here to enter text.	
Annual leave already taken		Click or tap here to enter text.	

Annual leave remaining at time of application	Click or tap here to enter text.	
Do you want to apply to take remaining annual leave, prior to commencing maternity leave	Yes ☐	No ☐
If yes, how much annual leave would you like to take, prior to commencing maternity leave	Click or tap here to enter text.	
Current Salary	£ Click or tap here to enter text.	
Type of service to be considered	Reckonable Service ☐ Reckonable Experience ☐	
<i>please see note 2 in the guidance notes below</i>		

PART B – MANAGER TO COMPLETE

I confirm the maternity leave request by the employee has been checked	☐
I confirm I have discussed with the employee their ability to keep in touch days	☐
I confirm I have received, with the application, the MATB1	☐
<i>I confirm the application and attached MATB1 has been fully validated, and I consider them to be applicable in line with the Family Friendly Policy and Maternity Leave Procedure.</i>	
Name	Click or tap here to enter text.
Position Title	Click or tap here to enter text.
Signed	Date Click or tap to enter a date.

Please submit the application form and MATB1 to the People and OD Department at Velindre.WorkforceandOD@wales.nhs.uk

People and OD Department / Payroll Department	
Date application received	Click or tap to enter a date.
MATB1 received	Yes ☐ No ☐
Does the employee qualify for maternity leave	Yes ☐ No ☐
Does the employee qualify for occupational maternity pay	Yes ☐ No ☐
Does the employee qualify for statutory maternity pay	Yes ☐ No ☐
Name	Click or tap here to enter text.
Position Title	Click or tap here to enter text.

Signed		Date	Click or tap to enter a date.

Approved applications will be forwarded to the Payroll Department, along with the relevant documentary evidence

The employee will be informed in writing of the outcome of the application for maternity leave by the People and OD Department.

Managers will be informed of the application decision and a copy of the application will be retained on the employee file.



Ref:

Pregnancy and Maternity Leave Support Guidance

Executive Sponsor & Function:	Executive Director of Organisational Development and Workforce
Document Author:	People and OD Policy Group
Approved by:	Trust Board
Approval Date:	TBC
Date of Equality Impact Assessment:	TBC
Equality Impact Assessment Outcome:	TBC
Review Date:	TBC
Version:	DRAFT V.1

1. Introduction

This guide sets out the roles and responsibilities for staff, managers and other Trust officers in supporting employees who are pregnant in the workplace.

2. Pregnant Employee

If you are a pregnant employee it is your responsibility to:

- Familiarise yourself with the Family Friendly Policy and relevant procedures
- Inform your line manager as soon as you know you are pregnant
- Complete the **application form** for maternity leave
- Provide the Trust with the original MATB1 from your midwife or doctor
- Comply with any recommendations, that are the outcome of **a workplace risk assessment**
- Attend occupational health, as required
- Inform your manager of your intentions to return to work

3. Line Manager

If you are a line manager of a pregnant employee it is your responsibility to:

- Provide a copy of the Family Friendly Policy and relevant procedures to the employee if they do not have access to them
- Support the employee in the workplace during the pregnancy in line with Trust Policy and Procedures
- Seek advice and guidance from the **People and Relationship Team** if you are unsure about anything related to supporting the employee in the workplace during their pregnancy
- Undertake a **workplace risk assessment** with the employee, considering all physical, chemical and biological hazards to the health and safety of the employee and their baby
- Review the risk assessment with the employee at least every 3 months
- Review the **application form** for maternity leave and complete the relevant manager section
- Send the maternity application with the MATB1 to the **People and Relationship Team** as soon as this is completed. *Delays in sending this documentation could result in over / underpayments for the employee.*
- Confirm the start and end dates of maternity leave with **payroll**
- Confirm any hours worked in line with KIT Day rules, with **payroll**

It is also your responsibility to:

- Ensure service provision is adequately covered during the course of the maternity leave (i.e. through recruitment or temporary changes in responsibilities)
- Hold the role open if the employee identifies that they will be returning to the workplace at the end of their maternity leave

- Keep the employee on maternity leave informed of developments within the Trust, Department and Team
- Ensure the employee is consulted on any significant changes that may impact their role (i.e. Organisational Change)

4. People and OD Department

It is the responsibility of the People and OD Department to:

- Advise pregnant employees of their rights in relation to Trust Policies and Procedures
- Support Managers in the application of relevant Policies and Procedures
- Administer maternity leave provisions in conjunction with payroll

5. Payroll

It is the responsibility of the Payroll Department to:

- Ensure that payments are made in line with current Occupational and Statutory Pay rules
- Ensure that Maternity Pay is made in line with the correct calculations set out in Terms and Conditions or Statutory Regulations.
- To ensure that the employee's membership to the NHS Pension Scheme is protected during paid and unpaid maternity leave
- To inform staff if they are not able to claim Statutory Maternity Pay from Velindre University NHS Trust and to issue an exclusion form promptly enabling the employee to claim Maternity Allowance directly from Jobcentre Plus

3.4 Occupational Health

It is the responsibility of the Occupational Health Department:

- To advise managers and employees of the risks involved in undertaking certain activities whilst pregnant or on returning from maternity leave
- To provide independent medical advice regarding maternity issues in employment

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE PUBLIC STRATEGIC DEVELOPMENT COMMITTEE

DATE OF MEETING	24 July 2025
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Kay Barrow, Corporate Governance Manager
PRESENTED BY	Lindsay Foyster, Independent Member and Chair of the Strategic Development Committee
EXECUTIVE SPONSOR APPROVED	Carl James, Executive Director of Strategic Transformation, Planning and Digital
REPORT PURPOSE	FOR NOTING

ACRONYMS

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

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

1. PURPOSE

- 1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the Public Strategic Development Committee held on 1st May 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	Welsh Blood Service Futures Highlight Report The Committee considered the WBS Futures Highlight Report and the main concern for WBS was the significant pressure on digital resources both nationally and locally within the Trust impacting on the ability to support both current and future projects. The importance of addressing the digital challenges in ensuring the successful implementation of key projects within WBS both locally i.e. Blood Establishment Computer System (BECS) and nationally i.e. Laboratory Information Management System (LIMS), as well as preparing for a digitally enabled nVCC by Spring 2027 was emphasised.
	It was highlighted that from a Quality, Safety and Performance Committee perspective, a number of digital risks have started to be raised through the Trust risk register with action plans being tracked through that process.
	The Committee agreed that a future session was required to review the digital issues from a strategic perspective focused on the capacity and resilience of the Trust's digital services, given that it was underpinning a number of the Trust's strategic programmes.
	Velindre Cancer Service (VCS) Futures Highlight Report The Committee considered the VCS Futures Highlight Report, noting that the content and format of the reporting was a work in progress to

	ensure that its purpose and aim was aligned with Committee's role and remit. The following points were noted: • The complexities of managing both local and national projects / programmes was recognised. • Current risks are around Transforming Access to Medicines (TrAMS) Programme and Radiology Informatics System Procurement (RISP) which carry national risks that are being managed and mitigated locally. • Electronic Prescribing and Medicine Administration (EPMA) has been agreed and the Trust is aware of its requirements and there is a plan. It is a future piece of work and not currently a live project. Reporting of this will need to be considered. • Outreach is in the planning phase, and there is ongoing work to triangulate the outreach, digital programmes and outpatient modernisation programmes to determine the critical path and what elements are reported to the Committee. The Committee: • NOTED the contents of the report together with the updates provided. • NOTED the overall Level 3 Assurance however, there was need to provide an assurance level against each element of the reporting going forward.
ADVISE	BECS Full Business Case The Committee considered the Public elements of the BECS Full Business Case, acknowledging the critical importance of the project for Welsh Blood Services and emphasising its role in ensuring the safety and effectiveness of blood products in Wales. The following points were noted: • There has been an extensive procurement process for the new blood establishment computer system, including informal supplier engagements, formal invitations to tender, and assessment of tenders against various criteria. • Engagement with reference customers had highlighted successful implementation of similar systems within a year, which provided confidence in the proposed implementation timeline for the new system. • The potential funding challenges were highlighted, with discussions on the need to secure funding from the Welsh Government's Digital Priorities Investment Fund for the implementation phase and ongoing revenue support from the Trust's Commissioners for the operationalisation. • Concerns were raised on the project's dependency on funding and in the event that external funding is not secured, the need to prioritise internal investment was highlighted as a contingency with the Trust potentially having to accept certain risks to ensure

	the project's continuation. • The resource required detailed in the business case would support the timely implementation of the new system, addressing the complexity and due diligence required. The Committee: • NOTED the continuation of procurement activity, with the process moving into the 10 day 'Standstill' period, in early May 2025. • ENDORSED FOR APPROVAL the Full Business Case (FBC) – Executive Summary and Strategic Case - for the replacement of a Blood Establishment Computer System as a critical part of the WBS digital infrastructure and key to future proofing the service and enabling greater functionality.
ASSURE	Trust Assurance Framework (TAF) The Committee received an update on the progress with the revisions to the TAF and the following points were noted: • Need to simplify the TAF to make it more manageable and effective, with a focus on reducing complexity and ensuring it meets the needs in providing an overview of the Trust's strategic risks. • Benchmarked and reviewed various BAF templates from other NHS organisations to identify best practices and ensure the new TAF meets the Trust's needs. • The new 10 strategic risks approved as part of the IMTP by the Trust Board in March 2025 are being reviewed for clarity and completeness. Some of the risks are new although there is one amalgamated risk. • The Executive Management Board will workshop these risks before presenting a new version of the TAF to the Governance, Assurance and Risk Group with a commitment to complete the work by July 2025. • Emphasised the importance of finalising the TAF to ensure it provides clear and concise assurance. The Committee: • CONSIDERED the amended strategic risk TAF08 as an example of the revised structure. • DISCUSSED the changes to the TAF format, which was work in progress as benchmarking of other formats and best practice is explored. • NOTED the current status of the move towards a simplified TAF. • NOTED the 10 strategic risks were those that had been approved by the Board and that any material changes will be brought back to the Committee. • NOTED the commitment to complete the work by July 2025.

INFORM	There were no items to inform the Trust Board
APPENDICES	NOT APPLICABLE

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE PUBLIC TRANSFORMING CANCER SERVICES (TCS) PROGRAMME SCRUTINY SUB-COMMITTEE

DATE OF MEETING	24 July 2025
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Kay Barrow, Corporate Governance Manager
PRESENTED BY	Hilary Jones, Independent Member and Chair of the TCS Programme Scrutiny Sub-Committee
EXECUTIVE SPONSOR APPROVED	Carl James, Executive Director of Strategic Transformation, Planning and Digital.
REPORT PURPOSE	FOR NOTING

1. PURPOSE

- 1.1 This paper has been prepared to provide Trust Board with details of the key issues considered by the Public TCS Programme Scrutiny Sub-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

TRaMS

Discussion at the Sub-Committee highlighted that the TRaMS 'Go Live' date had slipped to January 2027. It was agreed to escalate TRaMS to the Chief Executive due to the critical impact on service readiness. A deep dive would be required to identify risks, operational impacts, and contingency requirements. This would align with the action captured at the Strategic Development Committee to ensure appropriate organisational and external escalation routes are identified..

ADVISE	There were no items identified to advise the Trust Board.
ASSURE	nVCC Project Highlight Report The Sub-Committee received the nVCC Project Highlight Report setting out progress during the reporting period. The following key highlights were noted: • Reporting now separates Plan Performance between the Authority and the overall project with each component – plan performance, risk and change control – assigned an individual RAG rating. • Whilst the new reporting format was welcomed, the balance of the visual versus the supporting narrative would need to be refined to include additional narrative to support data interpretation, provide clearer assurance and enhance accessibility for public audiences. • There are no site health and safety concerns although there have been a high volume of safety observations recorded however, this is a positive indicator of a proactive safety culture. • The overall project status is Amber with the completion of the Reviewable Design Data (RDD) process identified as the key issue on the critical path. The Sub-Committee: • AGREED that the project team would work collaboratively with Committee members to refine the structure and content of future iterations. • NOTED that the Reviewable Design Data (RDD) process remains on the project's critical path, and that updated milestone reporting and critical path visibility will be included in the next version of the report. nVCC Programme Finance Report The Sub-Committee received the nVCC Programme Finance Report and noted that for the period as at 28th February 2025: • Capital, the 2024–25 budget is £7.3m, with year-to-date spend of £6.3m and a forecast outturn of £7.3m, indicating only a small underspend anticipated at year-end. • Revenue, the budget is £800k, with £640k spent year-to-date and a break-even forecast of £799k Additional Welsh Government funding to cover two Quantified Risk Assessment (QRA) elements for this financial year 2024-25: • Final account settlement with Asda, and

- Traffic management measures required for site access via Asda land.

The Sub-Committee was informed that the focus for 2025-26 would be on the financial reporting for the nVCC and Enabling Works projects. Other aspects, including the Programme Office, service development, and Whitchurch Hospital, currently covered in the report, will be addressed through the Trust's financial reporting regime or in discussions with corporate finance

The Sub-Committee **NOTED:**

- The financial position for the nVCC Project as at 28th February 2025, including a capital year-end forecast of £7.3m (with £6.3m spent to date) and a revenue forecast of £799k (with £640k spent to date).
- The receipt of additional Welsh Government QRA funding for the Asda final account and traffic management measures, as well as clarification regarding the £111k advisory budget for the Whitchurch Hospital site.
- That the disposal strategy will be presented to the Trust Board in May 2025.

Programme Director and Interdependency Management Report

The Sub-Committee received the Programme Director and Interdependency Management Report for the period 1st to 28th February 2025. The key updates included:

- **Satellite Radiotherapy Unit (SRU):** The SRU has been re-baselined with a revised delivery timeline of June 2025. Emerging risks include delivery timeline pressures and the removal of a ventilation fan from the radiotherapy engineer's office, which now requires reinstatement. Mitigations are in place to address these issues.
- **TRaMS:** As noted in the Alert / Escalation section, the revised go-live date for TRaMS is January 2027, which is closely aligned with the operational commissioning of the nVCC. Pharmacy-related commissioning that may begin before this date.
- **Delivery Confidence Assessment (DCA):** While there had been previous discussions around downgrading the overall programme status to Amber, given the emerging risks within the satellite programme and the delay in TRaMS, the Red-Amber status should remain in place. Programme Teams are being

	encouraged to adopt a 'path to green' approach to reduce sustained Amber ratings. • Workforce Reporting: Workforce reporting has been strengthened with monthly updates including job compliance, filled positions, and pending vacancies. A tri-monthly update will be provided, with the next scheduled update for May 2025. • Interdependencies: The interdependencies section has been revised, adding the digitisation of medical records as a formal interdependency due to the lack of physical record storage at the nVCC. GB confirmed that Digital colleagues are currently progressing feasibility work in this area. • Project Risks: Only risks formally accepted by the Board are reported, though the Programme Team continue to monitor emerging risks internally, contributing to the overall Amber-Red status. The Sub-Committee: • NOTED the Interdependencies Report, and the updates provided. • WELCOMED the proposed improvements to future reporting, including clearer timelines, specific actions, and progress descriptions. The need for more detailed updates on the digitisation of medical records and the ongoing feasibility study was acknowledged. • NOTED the transition plan and ongoing support for the COO's team to ensure a smooth handover of the Interdependencies Report.
INFORM	Communication and Engagement Update Report The Sub-Committee was informed of the successful launch of staff site tours, with over 70 attendees to date. Further visits are planned, and interest from external stakeholders continues to grow, including an upcoming delegation from the Health Improvement Alliance Europe and recent participation by Audit Wales. The Sub-Committee was informed of the Trust's involvement in a regional roundtable on master planning for North West Cardiff, chaired by Anna McMorris MP, with representatives from Cardiff and Vale UHB, Cardiff Council, and Transport for Wales. This ensures the organisation remains engaged in wider system-level discussions, particularly regarding the Whitchurch Hospital site.



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	The Sub-Committee welcomed the installation of new video displays in the Outpatients Department and suggested the inclusion of nVCC construction footage to improve patient awareness, which would be followed up with a written proposal. The Sub-Committee NOTED the Communications and Engagement Update.
APPENDICES	None

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE PUBLIC TRANSFORMING CANCER SERVICES (TCS) PROGRAMME SCRUTINY SUB-COMMITTEE

DATE OF MEETING	24 July 2025
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Kay Barrow, Corporate Governance Manager
PRESENTED BY	Hilary Jones, Independent Member and Chair of the TCS Programme Scrutiny Sub-Committee
EXECUTIVE SPONSOR APPROVED	Carl James, Executive Director of Strategic Transformation, Planning and Digital.
REPORT PURPOSE	FOR NOTING

1. PURPOSE

- 1.1 This paper has been prepared to provide Trust Board with details of the key issues considered by the Public TCS Programme Scrutiny Sub-Committee held on 6th May 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

Programme Director and Interdependency Management Report
The Sub-Committee received the Programme Director and Interdependency Management Report for the period 1st to 31st March 2025.

The following areas were highlighted for information:

- **Integrated Radiotherapy Solution (IRS):** ETHOS Backup is a solution to store back up patient treatment information, but it is not yet in place. The SRO has formally escalated and notified Varian within the IRS contract management arrangements requiring Varian to provide a compliant solution by 7th March, with

	full completion of implementation plan and disaster recovery plan, by Friday 25th April. This will maintain the critical path for SRU go live, however if not met, risks SRU implementation plan. • Satellite Radiotherapy Unit (SRU): There is a risk to the plan due to the ETHOS software backup (an interdependency with IRS project) with a possible impact on the clinical commissioning of the Linac machines and the 'go live' date • The NWSSP TrAMS Programme timelines have been re-baselined and have surpassed the original 'go live' date of January 2026. The revised 'Go Live' date is anticipated to be April 2027. There is a risk that will impact on the delivery of services within nVCC, due to 'go live' 2027. The risk and potential mitigations are currently being assessed. • Workforce Reporting: Number of vacancies across Major Programmes team (nVCC Project and Velindre Cancer Service Futures) leading to reduced oversight and delivery capability. • Interdependencies: The interdependencies section has been revised, adding the digitisation of medical records as a formal interdependency due to the lack of physical record storage at the nVCC. GB confirmed that Digital colleagues are currently progressing feasibility work in this area. • Project Risks: Only risks formally accepted by the Board are reported, though the Programme Team continue to monitor emerging risks internally, contributing to the overall Amber-Red status. • Delivery Confidence Assessment (DCA): The Delivery Confidence Assessment (DCA) for the current scope of the TCS Programme has been assessed against the DCA criteria and remains at Amber-Red in this reporting period, as there have not been any significant de-escalations reported via formal project governance. The Sub-Committee NOTED the content of the Programme Director and Interdependency Management Report and the updates provided.
ADVISE	Amendment to Standing Orders – Schedule 3 Annual Review Sub-Committee Terms of Reference The Sub-Committee considered the revisions to its Terms of Reference which were proposed to align with the recommendations from the PwC review however, a number of queries were raised in relation to the interdependencies with the Strategic Development Committee.

	The Sub-Committee REQUESTED that further clarification would be sought to ensure that the role of the Sub-Committee relating to the interdependencies was explicit and reflective of the role of the Sub-Committee.
ASSURE	nVCC Project Highlight Report The Sub-Committee received the nVCC Project Highlight Report setting out progress during the reporting period. The following key highlights were noted: • The overall project status was reported as Amber. This is regarding the main hospital and the enabling works. • The contractor has addressed the issues with the mechanical systems design data, and new designs are being submitted. Efforts are underway to overcome delays in the early works phase and aim for completion by November 2025. Obtaining approval for the mechanical design is crucial for this progress. Once approved, will proceed with procurement and integration into the building. • Four near misses have been reported and lessons learnt have been shared to avoid any reoccurrences and to ensure a safe site. • The overall financial position for 2024/25 is Green. The Sub-Committee NOTED the nVCC Project Highlight Report for the month of March 2025 and the Project status of AMBER. TCS Delivery and Governance Arrangements The Sub-Committee received a report that outlined the revisions to the delivery, governance and reporting arrangements following the separation of the TCS Programme components into the nVCC Project (new hospital building) and the nVCC related projects and interdependencies that sit within the Velindre Futures Programme. The Executive Lead for the nVCC Project will remain as the Executive Director of Strategic Transformation, Planning and Digital however, the Executive Lead for the for nVCC related projects that sit within the Velindre Futures Programme would change to the Chief Operating Officer to align with interdependency reporting. The Sub-Committee NOTED the TCS Delivery and Governance Arrangements.



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INFORM	Communication and Engagement Update Report The Sub-Committee received the report and noted an increase in complaints about noise disturbance on social media and at the recent Residents Meeting. There are ongoing discussions between the Communication Team and Project Director regarding addressing the complaints received. The Sub-Committee NOTED the Communications and Engagement Update and the plans to develop a programme of Summer events across the region.
APPENDICES	None

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE PUBLIC TRANSFORMING CANCER SERVICES (TCS) PROGRAMME SCRUTINY SUB-COMMITTEE

DATE OF MEETING	24 July 2025
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Kay Barrow, Corporate Governance Manager
PRESENTED BY	Hilary Jones, Independent Member and Chair of the TCS Programme Scrutiny Sub-Committee
EXECUTIVE SPONSOR APPROVED	Carl James, Executive Director of Strategic Transformation, Planning and Digital.
REPORT PURPOSE	FOR NOTING

1. PURPOSE

- 1.1 This paper has been prepared to provide Trust Board with details of the key issues considered by the Public TCS Programme Scrutiny Sub-Committee held on 10th June 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	There are no items for Alert / Escalation for Trust Board
ADVISE	Amendment to Standing Orders – Schedule 3 Annual Review Sub-Committee Terms of Reference The Sub-Committee considered the revisions to its Terms of Reference to clarify and strengthen the interdependencies relating to the role of the Sub-Committee.

	The Sub-Committee ENDORSED for Trust Board APPROVAL the amendments to the Sub-Committee Terms of Reference which form part of Schedule 3 of the Trust's Standing Orders.
ASSURE	nVCC Project Highlight Report The Sub-Committee received the nVCC Project Highlight Report setting out progress during the reporting period. The following key highlights were noted: • The project remains at an overall Amber status, mainly due to factors outside the Trust's direct control, while all Trust obligations are on track as Green. • Construction is ahead of plan on one side of the building but behind on the other. Acceleration measures are in place to bring the programme back in line. • High numbers of health and safety observations were noted as positive, with a significant increase in observations compared to the previous year. There was a minor reporting inconsistency regarding near misses, which will be corrected in future reports. • The number of staff engagement responses remains low, making trend analysis difficult. However, a new QR code system is being implemented to improve response rates. There was discussion about interpreting the data, with clarification that some categories have migrated (e.g., more staff now feel "very well informed"). • Financial position remains Green. No additional QRA has been drawn down; £16.65 million in reserves remain. Major equipment procurement decisions are expected by the end of July/early August, with contracts to be finalised and prices fixed for future delivery. • Community benefits are being delivered by the contractor as per the MIM contract. There have been 66 complaints since project start, mainly about extended working hours and noise, but these are being addressed individually and through improved communications. • A new change control methodology has been implemented for milestone management, providing greater transparency and governance over schedule changes. The process is currently fully applied only to the RDD section but will be rolled out more broadly across the Project over the coming weeks. • The timing of reports was discussed, noting that data is often several weeks old by the time of the meeting. Options for improving the timeliness of information and escalation processes were considered.

	• Suggestions were made to improve the clarity and public-facing nature of the report, especially around health and safety and community benefits to incorporate more explanatory narrative in future reports The Sub-Committee NOTED the nVCC Project Highlight Report for the month of April 2025 and the Project status of AMBER. Interdependencies Report The Sub-Committee received the revised report and acknowledged that it was a good starting point and provided more information on the interdependencies than previously reported. However, there were a number of comments made in relation to lack of detail for individual project progress, associated risks and impact on critical path. The Sub-Committee NOTED the Interdependencies Report, recognising that the report was evolving but requested more rounded assurance for any interdependencies. The Chair agreed to meet with the Executive Lead to discuss the comments that have been raised.
INFORM	Tracking of nVCC Business Case Outcomes and Commitments The Sub-Committee received a presentation regarding the scope and mandatory obligations, as required by Welsh Government linked to the investment fund, which the Trust must deliver and report on in relation to the specific benefits listed in the nVCC FBC. These include cash releasing, non-cash releasing and societal benefits, such as a 25% reduction in temporary staffing costs; improved adjacencies; increased innovation opportunities; more flexible facilities; more energy efficient building; creation of new construction jobs, etc. • Current Challenges: Currently poor definition of baselines, owners, and timescales for these benefits, making measurement and tracking difficult. Work is underway to clarify these elements and ensure accurate tracking. • Approach and Next Steps: Appointment of Benefits Lead with immediate focus on developing a tracking tool for the business case benefits. The first priority is to define and agree baselines and owners, and to develop metrics to measure, monitor and report against performance. • Wider Benefits: Emphasised that while the business case benefits are the immediate focus, there is a broader set of benefits and interdependencies across the overall programme (e.g., service improvements, clinical outcomes) that should be captured in the future.

	The Sub-Committee NOTED the presentation for this important piece of work and the development of a Tracking Tool to monitor the nVCC Business Case Outcomes and Commitments. Communication and Engagement Update Report The Sub-Committee received the report and the marking of one year of construction with a series of positive communications internally with staff and externally with key stakeholders. The widespread complaints linked to noise levels have significantly reduced due to the work with Sacyr to improve their communication processes to help with the busier months and increased working hours. The Summer series of events start on 11th June 2025 at Swansea University and there is a full calendar of events through to August 2025. There are a number of events scheduled during September and October 2025. However, there was recognition that communications and engagement opportunities should be explored across the wider SE Wales region. Work is underway to include more metrics around the staff engagement taking place in areas such as the staff teams meetings that have been averaging around 100 attendees since inception to better reflect the feedback being received. It was highlighted that patients did not know that there is a new cancer centre being built. With the new TV system in the Outpatients Department and Radiotherapy Waiting Area this was an opportunity to make patients and relatives more aware of what the Trust is doing for them i.e. flyers, QR codes and signposting to social media, as well as engaging with local communities. The Sub-Committee NOTED the Communication and Engagement update and the work to be taken forward in raising more awareness with patients and seeking opportunities to hold events across the wider SE Wales region.
APPENDICES	None

VELINDRE UNIVERSITY NHS TRUST BOARD	
PUBLIC AUDIT COMMITTEE HIGHLIGHT REPORT	
DATE OF MEETING	13 May 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 has been prepared to provide the Trust Board with details of the key issues and items considered by the Audit Committee at its meeting held on the 13 May 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 13 May 2025:

ALERT / ESCALATE	There were no items identified to ALERT or ESCALATE to Trust Board.
ADVISE	AUDIT WALES UPDATE: Audit Committee were informed of the following by Audit Wales: • Financial Audit: Audit Wales reported that the draft accounts were received on time, and the audit is progressing as planned. However, the accountability report, including the annual governance statement and

	remuneration report, was still pending submission. It was assured that the audit is on track to be completed by the end of June and noted that no significant issues have been identified in the audit work so far, but it is still early in the process. • Performance Audit: Audit Wales provided an update, stating that two pieces of work are currently at the fieldwork stage: the review of digital transformation and the quality governance follow-up work. They also highlighted the publication of a report on the Well-being of Future Generations Act, highlighting positive practices and ongoing challenges for public bodies, with recommendations to Welsh Government. • Audit Plan: It was noted that the audit plan for 2025-2026 is still under discussion, with some comments received from the Trust and will hopefully be submitted to the June Committee for approval. The Audit Plan for 2025-2026 is still under review and there are ongoing discussions with Audit Wales and Welsh Government to finalise it. Audit Committee RECEIVED the report and NOTED the content. 2024/25 INTERNAL AUDIT PROGRESS UPDATE Overall, the internal audit progress for 2024/25 has been positive, with substantial completion of audit work and improved engagement from the organisation, with only a small number of non-capital audit pieces remaining. The draft Internal Audit Plan for 2025/26 has been prepared, ensuring coverage across all areas within cancer services and Welsh Blood Service. It is subject to approval and may change mid-year if the risk profile increases. The Audit Committee NOTED the progress report. DRAFT 2025/26 INTERNAL AUDIT PLAN The Audit Plan is based on discussions with Executives, risk assessments, and analysis of themes from national audit work. It aims to ensure coverage across all areas within cancer services and the Welsh Blood Service, limited by the number of available days. The plan is flexible and can be revised mid-year if the risk profile changes. The Audit Committee NOTED the internal audit plan, with the caveat that the recommended changes are made and circulated for an out of committee approval.
ASSURE	TRUST RISK REGISTER The report: • 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 Audit Committee to have effective oversight and assurance of the way in which risks are being managed across the Trust; and
- provides the Audit Committee with a summary of activity related to the status of the risks and associated movement.

It was recommended that the assurance rating change from Level 2 to Level 3, acknowledging improvements in reporting, training, and the inclusion of likelihood consequences and run rates. The Committee **AGREED** this change. The Committee emphasised the need for a clear action plan and evidence of outcomes to justify a Level 4 rating in the future.

TRUST ASSURANCE FRAMEWORK

The Trust Assurance Framework (TAF) presented to Committee is the current version being used. The new TAF for 2025-2026 is in development, with discussions held at the Executive Management Board to align it with the Integrated Medium-Term Plan (IMTP) for 2025-2026.

The Audit Committee **NOTED** the current status 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.
- That 6 (15%) Internal Audit Report actions and 3 (50%) External Audit Report action have been completed since the March '25 Audit Committee (Green Status).
- That 26 (63%) Internal Audit Report actions and no External Audit Report actions are on target for complete by agreed date (Yellow Status).
- That 4 (9.8%) Internal Audit Report actions and no External Audit Report actions are NOT on target for complete by agreed date (Orange Status).
- That 5 (12.2%) Internal Audit Report actions have passed the agreed implementation date (Red Status) since the March 2025 Audit Committee.

The Audit Committee **NOTED** the Red / Overdue actions and **AGREED** to change the assurance level for the audit action tracker from Level 4 to Level 3. This decision was based on concerns about gaps, lack of extension requests, and updates provided in the narrative.

INFORM

INTERNAL AUDIT REPORTS

	The Audit Committee received one internal audit report, which reported a reasonable level of assurance: • Duty of Quality OTHER BUSINESS: The Committee also received written reports under the following agenda items: • Draft Head of Internal Audit Opinion • Counter Fraud Annual Report 2024 – 2025 • Counter Fraud Progress Report • Committee Effectiveness Survey Report – Verbal update • Audit Committee Annual Report – Verbal update • Losses and Special Payments Report • Receipt of Finance Technical Updates • Cycle of Business • Declaration of Interests, Gifts, Sponsorship, Hospitality & Honoraria
APPENDICES	NONE

3. RECOMMENDATION

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

VELINDRE UNIVERSITY NHS TRUST BOARD	
PUBLIC AUDIT COMMITTEE EXTRAORDINARY MEETING HIGHLIGHT REPORT	
DATE OF MEETING	24 July 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 has been prepared to provide the Trust Board with details of the key issues and items considered by the Audit Committee at its meeting held on 24 June 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 24 June 2025:

ALERT / ESCALATE	There were no items identified to ALERT or ESCALATE to Trust Board.
ADVISE	INTERNAL AUDIT 2024 – 2025 Head of Internal Audit Opinion and Annual Report Assurance rating: Reasonable

	This opinion is based on the outcome of the work undertaken during the audit year, considering other reviews completed across NHS Wales, particularly within shared services, transactional audit work, capital work, and IT work. The purpose of the annual Head of Internal Audit opinion is to contribute towards the assurances available to the Accountable –Officer and the Trust Board, underpinning the Board's own assessment of the effectiveness of the organisation's system of internal control. The Committee agreed to NOTE the content of the report, subject to the clarification provided by David Donegan regarding the scope of the audits. EXTERNAL AUDIT Audit Wales Plan 2024-25 Audit Wales colleagues presented the plan; apologising for its late submission and explaining the complexities involved in finalising the plan due to ongoing discussions with the Executive team and the Welsh Government review. It was emphasised that the plan might need adjustments based on the review's outcomes. The Audit Committee RECEIVED the report and NOTED the content on the understanding that adjustments may be necessary based on the Welsh Government review. Confirmed Final Accounts – VUNHST Annual report and Accounts 2024-2025 The Trust's Annual Report for 2024-2025 was presented in three main parts: • The performance report, • The accountability report (including the Corporate Governance report, Director's report, and Remuneration report), and • The annual accounts. The report was developed in line with the Welsh Government's Manual for Accounts. The Committee NOTED and ENDORSED the Accountability Report and Annual Accounts for 2024-2025 for approval by the Trust Board on 26th June.
ASSURE	Audit Committee Annual Report The Audit Committee Annual Report was APPROVED as part of the consent agenda without any objections or requests for further discussion.

	Chair's Urgent Action: Use of the AMaT system for monitoring Internal and External Audit Management Actions The Chair's urgent action regarding the AMaT system was included for approval. This system is intended to be used for monitoring internal and external audit management actions. The item was APPROVED as part of the consent agenda without any objections or requests for further discussion.
INFORM	INTERNAL AUDIT REPORTS The Audit Committee received six internal audit reports, which reported the following levels of assurance: • WBS Infrastructure Programme Assurance rating: Reasonable Assurance • Follow-up of Previous Audit Recommendations Assurance rating: Substantial Assurance • Finance and Service Sustainability: Value Based Healthcare Assurance rating: Reasonable Assurance • Procurement and Contract Management Advisory review • Duty of Candor Assurance rating: Substantial Assurance • nVCC Digital Project Assurance rating: Reasonable Assurance
APPENDICES	NONE

3. RECOMMENDATION

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

TRUST BOARD

PUBLIC QUALITY, SAFETY & PERFORMANCE COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	24 th July 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	Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science
REPORT PURPOSE	FOR DISCUSSION

1. PURPOSE

This paper is to provide the Trust Board with details of the key issues and risks considered by the Quality, Safety & Performance Committee at its meeting held on the 17th July 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 17TH JULY 2025

The core aim of this meeting was to consider and receive the Quality, Safety & Performance related annual reports. A new Trust Annual Report template had been developed to have greater consistency to approach and clear identification of the annual report purpose i.e. statutory requirement, national requirement or Trust assurance.

3.1 Triangulated themes

The following triangulated themes were identified:

- Overall positive developments across the majority of areas under the Committee remit.
- The need to **enhance digital / informatics infrastructure, capability, capacity and integration** was a core theme emerging from a number of the annual reports.
- **Need for Comparative Data:** There was a recurring theme about the need for comparative data to track year-on-year performance and improvements. This was highlighted in discussions around the Performance Management Framework, Freedom of Information Requests, and other annual reports.
- **Clarity and Detail in Reporting:** The importance of providing clear and detailed information in reports was emphasised. This included ensuring that evidence supports levels of assurance, using post titles instead of initials, and improving the readability of visuals.
- **Realistic Target Dates:** The need to ensure that target dates for reaching risk levels are realistic and achievable was discussed, particularly in the context of the Trust Risk Register.
- **Inclusivity in Imagery:** There was a suggestion to ensure that the imagery used in reports is representative and inclusive, reflecting diversity and the report subject matter.

In addition it was agreed that Future Annual Reporting to the Committee needs to have a dedicated meeting assigned to it to ensure there is sufficient time for discussion across all areas.

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/public-quality-safety-amp-performance-committee-17-07-2025/>

3.3 Summary of Committee Highlights

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

ALERT / ESCALATE	There were no items to alert the Trust Board.
ADVISE	Gender Pay Gap Annual Report The Committee received the Gender Pay Gap Annual Report, noting a 6.5% average hourly rate gap across the organisation, with men more often in the lowest and highest pay bands and women clustered in the middle. The gender pay gap within the Velindre section has shown a positive downward trend, now at 10.6%, down from 13% in previous

years. Key actions to achieving this include listening to women's experiences, focusing on flexible working, implementing an all-Wales policy on sexual safety, and leadership development. Subsequent discussions emphasised the importance of intersectionality and reasonable adjustments.

The Committee **agreed** the **assurance level 2** given the work that is still required in respect of gender pay gap and **ENDORSED** the Gender Pay Gap Annual Report for onward Trust Board approval.

Social Partnership Duty Annual Report

The Committee received the Trust's first Social Partnership Duty Annual Report, which outlined the actions taken to embed social partnership principles into governance, planning, delivery, and procurement activities. Key points included:

- Governance and oversight through the local partnership forum.
- Achievements in areas such as equality action plans, Welsh language plans, and well-being action plans.
- Extensive work in procurement, including community benefit schemes and sustainability initiatives.
- Challenges in balancing operational demands with meaningful engagement.
- Future priorities to strengthen engagement with frontline staff and trade union representatives.

The **level of assurance of 4** was discussed. However, the Committee suggested the removal of the level of assurance, noting the need for further work to clarify the purpose of the report, its alignment with the trust's overarching strategy, and the governance route.

The Committee **APPROVED** the Social Partnership Duty Annual Report.

Fire, Risk, Estates, Health & Safety and Sustainability Annual Report

The Committee discussed the first combined Trust Fire, Risk, Estates, Health & Safety, and Sustainability Annual Report. The following key points were highlighted:

- Progress in fire safety priorities, with training compliance improving to 90%. No fire incidents reported, and six false fire alarm activations noted.
- Good progress in statutory obligations, pre-emptive maintenance, and capital projects. Collaboration with Shared Services specialist estates was highlighted.
- Activities aligned with the sustainability strategy, including climate risk reporting.

- Future focus: finalising protocols, updating KPIs, improving statutory training compliance, and embedding health and safety principles.

The level of assurance of 4 was discussed, however, the Committee suggested that the overall level of assurance might be more appropriate at **Level 3**, with the recommendation of breaking down the levels of assurance for each section.

The Committee **ENDORSED** the Fire, Risk, Estates, Health & Safety and Sustainability Annual Report for onward Trust Board approval.

Wellbeing of Future Generations Act (2015) Annual Report

The Committee received the Wellbeing of Future Generations Act (2015) Annual Report. The following key points were highlighted:

- Reference to the "No Time to Lose" report from the Commissioner and the need to consider its key themes.
- Next Steps: Finalising KPIs, integrating well-being objectives into strategic vision and corporate planning, and sharing learning and collaboration.

The Committee discussed the need for a broader focus on inclusivity and community engagement, beyond just Welsh language, was emphasised, along with the importance of understanding the impact on diverse communities. The Committee agreed it would be appropriate to bring the report back to the Strategic Development Committee for further consideration and to plan a Board Development session on the topic.

The assurance level 4 was discussed, however the Committee agreed that a **level 3** rating would be more appropriate, due to the ongoing development of KPIs and further work needed.

The Committee **ENDORSED** the Wellbeing of Future Generations Act (2015) Annual Report.

Digital Services Annual Report

The Committee received the Digital Services Annual Report. Achievements included the digital inclusion charter accreditation, infrastructure improvements at Nevill Hall, and the introduction of the new IT service management tool, Halo. Key risks identified were the national position on major programs such as radiology and laboratory information systems, and the capacity of the digital team to meet program needs.

The report noted good KPI performance and 11 major incidents, five of which were national issues.

	The Committee discussed the significant work required to map out a comprehensive clinically led digital capacity and demand plan to ensure the Trust has the required capability, clinical digital leadership and infrastructure. The Committee discussed and agreed the Level 3 assurance rating, noting the move from Level 3 due to the national position on digital capability and capacity constraints. The Committee APPROVED the Digital Services Annual Report. Finance Report for the period ended 31st May 2025 (M2) The Committee received the Finance Report, which highlighted that all Long Term Agreements were signed except for one in its final negotiation stages. The report confirmed the approval of the Integrated Medium Term Plan balance plan and indicated KPIs were on course to meet statutory targets. Significant cost pressures, not reflected in the financial plan, were noted: a £350K shortfall in National Insurance funding, along with unexpected additional costs. These pressures will be managed on a non-recurrent basis this year, underscoring the ongoing need for recurring savings initiatives. Trust Assurance Framework The Committee received the Trust Assurance Framework (TAF) which has been revised to align with the IMTP. Discussions among executive colleagues are ongoing to finalise the wording and amalgamation of multiple risks. The TAF presented to the Committee reflected some of these discussions, including the splitting of certain risks into separate entries. Some new risks have been populated, while others have not, leading to the proposed level of assurance being set at Level 2. The Committee agreed the assurance level 2 and noted the ongoing work to improve it. In addition, the Committee endorsed a proposal to rename the Trust Assurance Framework (TAF) to the Board Assurance Framework (BAF) to align VUNHST with all other NHS Wales organisations.
ASSURE	Duty of Quality Annual Report The Committee received the Duty of Quality Annual Report, which outlined the Trust's efforts to comply with the statutory duty of quality. The report highlighted key achievements, including the implementation of a Quality Management System, improvements in patient and donor feedback mechanisms, and the introduction of "Make It Safe" meetings to enhance transparency and learning from incidents. The report also addressed challenges such as the demand on services impacting patient

appointments and communication, and the need for better data collection and analysis. The Committee noted the ongoing work to enhance quality governance and the importance of integrating quality priorities with the Trust's strategic objectives.

The Committee **agreed** the **assurance level 4** and **ENDORSED** the 2024-2025 Duty of Quality Annual Report for onward Trust Board approval.

Trust Annual Integrated Quality & Safety Report

The Committee discussed the Integrated Quality & Safety report, noting the effort to reduce duplication and ensure data privacy. Key points included the improvement in PTR compliance, the increase in duty of candour cases, and the positive infection control outcomes. The report also highlighted the need for obtaining experience feedback from a greater volume of patients. .

The Committee **agreed** the **assurance level 4** and **ENDORSED** the Integrated Quality & Safety 2024-2025 Annual Report for onward Trust Board approval.

Information Governance Annual Report

The Committee received the Information Governance Annual Report, which demonstrated significant support for the COVID inquiry, ongoing tailored advice and guidance, and flexible training approaches. Three data security incidents were noted, which had been reported to the ICO, all closed with no further action, and no cyber incidents, though it remains a high-risk area. Policies are being updated independently of the delayed all-Wales process, and data protection impact assessments are conducted based on risk levels.

The Head of Information Governance was widely praised for his expertise, transparency, and national leadership in information governance. Members emphasised the importance of the role and the need for succession planning to ensure knowledge is shared internally.

The Committee **agreed** the **assurance level 3** and **APPROVED** the 2024-2025 Velindre University NHS Trust Information Governance Annual Report.

Annual Equality Report

The Committee discussed the Equality report, which detailed the Trust's efforts to promote diversity and inclusion. The report highlighted key achievements, including the recruitment of staff from diverse backgrounds and the implementation of initiatives to support underrepresented groups. Discussions emphasised the importance of continuous improvement in equality practices, with a focus on ensuring

that all staff have access to training and development opportunities. The Committee also discussed the need for better data collection to monitor progress and the impact of recent changes to UK immigration rules on international recruitment. The report was well-received, and the Committee acknowledged the positive steps taken while recognising areas for further improvement.

The Committee **agreed** the **assurance level 2** and **ENDORSED** the Annual Equality Report for onward Trust Board approval.

Welsh Language Annual Report

The Committee discussed the Welsh Language Annual Report, which highlighted significant achievements such as >95% compliance with Welsh language standards, improved translation processes, and strong collaborative efforts with the Welsh Language Commissioner. Ongoing risks were noted, particularly around telephony services, however the Committee were advised that action plans are in place to address these. The proactive approach to embedding Welsh language skills in service delivery was highlighted, along with and the exciting opportunities presented by the new Welsh Language and Education Act.

The Committee **agreed** the **assurance level 4** and **APPROVED** the Welsh Language Annual Report.

Trust Risk Register

The discussions on the Risk Register highlighted several key points:

- The inclusion of risk themes and target dates for reaching target scores for the first time.
- A plan to manage static risks and conduct a review over the summer to cleanse the risk register.
- Exploration of plans for a replacement for the current risk management system, Datix.

The Committee **agreed** the **assurance level 3**.

NHS WALES SHARED SERVICES PARTNERSHIP

Duty of Quality Annual Report

The Committee received the Duty of Quality Annual Report for NHS Wales Shared Services Partnership (NWSSP). The report aims to give voice to people on the ground delivering quality in non-clinical services, as the duty of quality applies to non-clinical services for the first time, and includes innovative elements such as live links to videos and a focus on staff contributions to quality.

The Committee discussed the importance of benchmarking and evidence to support the level of assurance. The Committee were advised that benchmarking had been done, and improvements were seen in the Medical Examiner Service. This report will be added as an appendix to the Trust's Duty of Quality Report.

The proposed assurance level of 6 was agreed. The Committee also recognised the need to work together to supports this and future considerations of assurance levels.

Surgical Materials Testing Laboratory (SMTL) Annual Report

The Committee received the Surgical Materials Testing Laboratories (SMTL) Annual Report, noting that the SMTL operates in a highly regulated environment with annual inspections; the latest inspection had no outstanding actions.

The Committee **agreed** the **assurance level 7**. The Committee also recognised the need to work together to supports this and future considerations of assurance levels.

Medical Examiner Service (MES) Annual Report 2024/25

The Medical Examiner's Service (MES) Annual Report was presented to the Committee. The MES was fully implemented in September, despite initial challenges with untrained staff and an early peak in mortality rates. Significant improvements have been made, and the service is now within UK certification timelines.

The Committee discussed the proposed assurance level 5. However, it was suggested that a level 4 may be more appropriate, reflecting the improvements made and the action plans in place, but acknowledging that outcomes have not yet been fully realised.

Pharmacy Technical Services Update

The Committee received the Pharmacy Technical Services update and **agreed** the **assurance level 6**.

Transforming Access to Medicines (TrAMs) Update

The Transforming Access to Medicines (TrAMs) update was presented to the Committee and the following points were highlighted:

- The Outline Business Case was approved by the Shared Services Partnership Committee, with several themes to be finalised before the Full Business Case submission.
- There is a proposal to change the composition of the programme board to include more senior involvement from affected health boards and trusts.

	The update included discussions on the need to address clinical trials provision, with ongoing conversations to ensure this is adequately covered in the Full Business Case. The Committee queried the timescale for the Full Business Case submission. It was confirmed that this would be in December.
INFORM	Staff Story - Velindre Cancer Services The Committee received a video story detailing the experience of an international nurse recruit from India, who shared his journey of transitioning to working in Velindre Cancer Service. The video highlighted his motivations for moving, the support he received, and the challenges he faced, particularly around accommodation and salary. The discussion emphasised the importance of cultural awareness and the need for better support systems for international recruits. The Committee acknowledged the positive aspects of the recruitment program while also recognising areas for improvement, such as consistent access to training and examinations, and the impact of recent changes to UK immigration rules on international recruitment. Performance Management Framework (PMF) Report The PMF report for May 2025 was presented, maintaining its familiar structure and including new KPIs from the recent review. The report highlighted radiotherapy productivity, with an upcoming board paper to provide more details on the paperless project and its productivity benefits. An increase in radiotherapy breaches was noted, primarily due to capacity issues over bank holidays. Potential solutions, such as moving to a six to seven-day working cycle, were discussed. The issue of time expired platelets during bank holidays was discussed, with a focus on learning from past experiences to improve future performance. The report included the new metric for serology turnaround, with discussions on the forecast for sustainable improvements. Overall, the discussions emphasised the need for continuous improvement, better data presentation, and benchmarking to enhance the understanding and management of performance metrics. The proposed levels of assurance for each area were noted, however the Committee discussed the importance of including year-on-year trend data to better track performance improvements and provide clearer evidence to support applied assurance levels. The Committee agreed the assurance level 4.

	New Velindre Cancer Centre (nVCC) Scrutiny Sub-Committee Highlight Reports [20th February 2025, 20th March 2025 & 6th May 2025] The Committee received the highlight reports from February, March, and May meetings, noting a significant issue with the secretariat which had delayed the presentation of the earlier reports to the Committee. The Committee APPROVED the following Annual Reports: Freedom of Information Requests Annual Report Communications and Engagement Annual Report The Committee ENDORSED the following Annual Reports for onward Trust Board approval: Professional Regulation/Revalidation Annual Report Nurse Staffing Levels (Wales) Act 2016 Annual Report 2024/25 The Committee ENDORSED the following People & OD Policies and Processes: • Family Friendly Policy • Maternity Leave Policy including the Maternity Leave Application Form • Pregnancy and Maternity Support Guidance
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 17th July 2025.

TRUST BOARD

PUBLIC CHARITABLE FUNDS COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING

24th July 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 3rd June 2025.

Key highlights from the meeting are reported in Section 2.

The Trust 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 Board from the meeting of the Charitable Funds Committee (CFC) held on the 3rd June 2025:

ALERT / ESCALATE	There were no items for alerting or escalating to the Trust Board.
ADVISE	There were no items to advise the Trust Board.
ASSURE	Charity Risk Register Risks identified include GDPR concerns while transitioning to the new CRM system, the risk of missing donation opportunities while the new CRM system is being implemented., and safety issues in the fundraising finance office due to lack of safety locks in order to protect cash and staff. Mitigating actions that have been taken include installing panic alarms and safety locks in the fundraising finance office, to reduce the risk of safety concerns. The new CRM system will be ready to use in June 2025 All risks are due for review at the end of the month, following the introduction of the new Customer Relationship Management (CRM). The Committee RECEIVED the report and APPROVED.
INFORM	Charity Directors Update Report The report provided an overview of the contents of the report including the key points below: • Events update • UK Giving Report 2025 by the Charity Aid Foundation The Committee NOTED the Charity Directors Update Report. Financial Update Paper The Committee received an update on the the financial performance and Charity's investment portfolio for the period ending 31st March 2025 including: • Income • Expenditure • Investment Portfolio The Committee NOTED the financial update papers.

3. RECOMMENDATION

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

TRUST BOARD	
HIGHLIGHT REPORT FROM THE CHAIR OF THE LOCAL PARTNERSHIP FORUM	
DATE OF MEETING	24 July 2025
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Sarah Haberfield, Business Support Officer
PRESENTED BY	Sarah Morley, Executive Director of OD and Workforce
EXECUTIVE SPONSOR APPROVED	Sarah Morley, Executive Director of OD and Workforce
REPORT PURPOSE	FOR NOTING
ACRONYMS	
LPF	Local Partnership Forum
SLT	Senior Leadership Team
VCS	Velindre Cancer Service
WBS	Welsh Blood Service

1. PURPOSE

- 1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the Local Partnership Forum held on 15th July 2025.
- 1.2 Key highlights from the meeting are reported in section 2.
- 1.3 The Board is requested to **NOTE** the contents of the report and actions being taken.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	Nothing to escalate to Trust Board
ADVISE	Nothing to advise to Trust Board
ASSURE	Nothing to assure
INFORM	The Local Partnership Forum considered the following matters at the meeting: Social Partnership Duty Annual Report • LPF welcomed the layout and format of the report • A discussion took place regarding the appointment of the Social Partnership Lead role and the difficulty in getting the appointed person released from their substantive post. • NOTED the Social Partnership Duty Annual Report prior to onward submission to Quality, Safety and Planning Committee Assurance and Trust Board Approval prior to providing to Welsh Government. Annual Equality Report • It was requested that comparisons with National Census data be added to each protected characteristic section of the report • NOTED the content of the Annual Equality Report prior to submission to Quality, Safety and Planning Committee for Assurance and Trust Board Approval. Gender Pay Gap Annual Report • LPF welcomed the layout and format of the report • NOTED the content of the Gender Pay Gap Annual Report prior to submission to Quality, Safety and Planning Committee for Assurance and Trust Board Approval. Local Partnership Forum Terms of Reference • ENDORSED the Local Partnership Forum Terms of Reference prior to Trust Board Approval. Velindre University NHS Trust Workforce Plan • The Forum received a presentation on the approach being taken to workforce planning within the organisation along with actions and time scales for delivery. • NOTED the Velindre University NHS Trust Workforce Plan Velindre Cancer Service Restructure Update



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

	• NOTED the Velindre Cancer Service Restructure Update reporting the first phase is nearly complete, with most SLT posts confirmed and recruitment for new leadership roles underway. Further structure changes and engagement with Trade Unions will continue as the process moves forward.
APPENDICES	None