Public Trust Board

Thu 25 September 2025, 11:00 - 13:30

Velindre Trust Headquarters / Microsoft Teams

Agenda

11:00 - 11:15
15 min

1. STANDARD BUSINESS

1.1. Welcome and Apologies

Sara Moseley, Chair

1.2. In Attendance

Sara Moseley, Chair

1.3. Declarations of Interest

Sara Moseley, Chair

1.4. Minutes of the Public Trust Board meeting held on 24th July 2025

Sara Moseley, Chair

- 1.4.0 DRAFT Public Trust Board Minutes 24.07.2025 (v3LLF) amended.pdf (11 pages)
- 1.4.0a DM Legacy Final Draft Report 24 july 2025.pdf (14 pages)

1.5. Public Action Log

Sara Moseley, Chair

- 1.5.0 PUBLIC TRUST BOARD ACTION LOG - SEPT 2025.pdf (1 pages)

1.6. Matters Arising

Sara Moseley, Chair

*There are no matters arising.

11:15 - 11:25
10 min

2. KEY REPORTS

2.1. Chair's Report

Sara Moseley, Chair

- 2.1.0 Chair's update Trust Board 25.09.25_FINAL.pdf (5 pages)

2.2. Chief Executive's Report

David Donegan, Chief Executive Officer

- 2.2.0 CEO's Update Trust Board 25092025 v1 (003DD).pdf (7 pages)

11:25 - 12:15
50 min

3. QUALITY, SAFETY & PERFORMANCE

3.1. Performance Management Framework (July 2025)

Led by:

- Lauren Fear, Director of Place, Portfolio and Partnerships
- Anne Carey, Chief Operating Officer
- Jacinta Abraham, Executive Medical Director
- Nicola Williams, Executive Director of Nursing, AHPs and Health Scientists
- Sarah Morley, Executive Director of Organisational Development & Workforce
- Carl Taylor, Chief Digital Officer
- Matthew Bunce, Executive Director of Finance

3.1.0 JULY PMF Data 2025 PowerPoint version vTrust Board final.pdf (25 pages)
3.1.0a Month 4 Finance Report Cover Paper - Trust Board 25.09.2025.pdf (13 pages)
3.1.0b. Appendix 1 - M4 VELINDRE UNHS TRUST FINANCIAL POSITION TO JULY 2025 - TB 25.09.2025.pdf (33 pages)
3.1.0c Appendix 2 - nVCC Project Finance Paper (July 25) FINAL.pdf (16 pages)

3.2. VUNHST Risk Register

Non Gwilym, Interim Director of Corporate Governance

3.2.0 TRR -Trust Board - COVER PAPER -25.09.2025.pdf (11 pages)
3.2.0a TRR - APPENDIX 1 -TRUST BOARD -25.092025 -V01.pdf (8 pages)

3.3. Board Assurance Framework

Non Gwilym, Interim Director of Corporate Governance

3.3.0 BAF Cover Paper - Trust Board 25.09.2025 V01.pdf (7 pages)
3.3.0a BAF AT A GLANCE - TRUST BOARD - SEPT 2025.pdf (4 pages)
3.3.0b BAF INFORMATION FOR TRUST BOARD - SEPT 2025 V01.pdf (16 pages)
3.3.0c TB - BAF 01 - SERVICE CAPACITY- V02.pdf (6 pages)
3.3.0d TB - BAF 02 - QUALITY -V03.pdf (5 pages)
3.3.0e TB - BAF 03 - RDI -V02.pdf (5 pages)
3.3.0f TB - BAF 04 - UNIVERSITY STATUS (1).pdf (3 pages)
3.3.0g TB - BAF 05 - SUSTAINABILITY V03.pdf (5 pages)
3.3.0h TB - BAF 06 -CULTURE (2).pdf (6 pages)
3.3.0i TB - BAF 07 - DIGITAL (2).pdf (5 pages)
3.3.0j TB -BAF 08 - GOVERNANCE (1).pdf (4 pages)
3.3.0k TB - BAF 09 - FINANCE (1).pdf (13 pages)
3.3.0l TB - BAF 10 - TRANSFORMATION V03.pdf (4 pages)
3.3.0m TB - BAF 11 - WORKFORCE.pdf (4 pages)

12:15 - 12:25
10 min

4. COMMITTEE ESCALATIONS

Sara Moseley, Chair ir

4.1. Public Audit Committee Highlight Report (02/09/2025)

Gareth Jones, Independent Member and Chair of Audit Committee

4.1.0 Highlight Report Public Audit Committee 2 September 2025 Final.pdf (4 pages)

4.2. Public Quality, Safety & Performance Committee Highlight Report (11/09/2025)

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

4.2.0 Public QSP Highlight Report 11th September 2025 v3.pdf (8 pages)

12:25 - 12:35
10 min

BREAK 12:25-12:35

12:35 - 12:45
10 min

5. CONSENT ITEMS FOR APPROVAL

Sara Moseley, Chair

5.1. Amendments to Standing Orders, Scheme of Delegation and Standing Financial Instructions

Non Gwilym, Director of Corporate Governance (interim) and Matthew Bunce, Executive Director of Finance

- 5.1.0 Revisions to Schedule 1 & 3 SOs and Model SFIs_SEPT 2025_v1.pdf (7 pages)
- 5.1.0a APPENDIX 1 - RDI Sub-Committee ToR 2025-26 - Track Changes.pdf (11 pages)
- 5.1.0b APPENDIX 2 - RDI Sub-Committee ToR 2025-26 - Clean.pdf (9 pages)
- 5.1.0c APPENDIX 3 - NHS SFI Procurement NHS TRUST PROCUREMENT AND CONTRACTING FINAL.pdf (19 pages)

5.2. Talbot Green Infrastructure - Revised Approach

Lauren Fear, Director of Place, Portfolio and Partnerships

- 5.2.0 TGI Business Case Approach Paper - Trust Board - Sept 2025.pdf (8 pages)

12:45 - 13:05
20 min

6. CONSENT FOR NOTING

Sara Moseley, Chair

6.1. Trust Seal Report

Non Gwilym, Interim Director of Corporate Governance

- 6.1.0 Trust Seal Report 22.05.2025.2025-18.09.2025.pdf (4 pages)

6.2. Public nVCC Project Scrutiny Sub-Committee Highlight Report (16/07/2025)

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

- 6.2.0 TRUST BOARD PUBLIC nVCC PROJECT SCRUTINY SUB-COMMITTEE HIGHLIGHT REPORT 16.07.2025.pdf (5 pages)

6.3. Culture and Inclusion Report

Sarah Morley, Executive Director of Organisational Development & Workforce

- 6.3.0 Culture and Inclusion Trust Board 25.9.25.pdf (17 pages)
- 6.3.0a C&I Report - App. 1 NHS Staff Survey Action Plan - Trust.pdf (5 pages)

6.4. Wales Infected Blood Support Scheme (WIBBS) Annual Report 2024-25

Lauren Fear, Director of Place, Portfolio and Partnerships

- 6.4 WIBBS cover paper - Trust Board.pdf (2 pages)
- 6.4a WIBSS Annual Report vfinal.pdf (26 pages)

6.5. Strategic Partnership Update

Lauren Fear, Director of Place, Portfolio and Partnerships

- 6.5.0 CHP and CCRP Update -September Trust Board.pdf (9 pages)

13:05 - 13:15
10 min

7. COMMITTEE ANNUAL REPORTS 2024-2025

Sara Moseley, Chair

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

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

- 7.1.0 Annual Report Cover Paper - SDC 2024-2025_comments v2 - TRUST BOARD.pdf (3 pages)
- 7.1.0a - Appendix 1 - SDC Annual Report 2024-2025 v0.2_comments v2.pdf (6 pages)

7.2. New Velindre Cancer Centre (nVCC) Project Scrutiny Sub-Committee Annual Report

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

7.2.0 nVCC Project Scrutiny Sub-Committee Annual Report Cover Paper - v1 - comments - for TRUST BOARD.pdf (3 pages)

7.2.0a Appendix 1 - nVCC Project Scrutiny Annual Report 2024-2025 v2_comments.pdf (8 pages)

13:15 - 13:15
0 min

8. ANY OTHER BUSINES

Sara Moseley, Chair

**Prior approval required by Chair*

13:15 - 13:15
0 min

9. DATE OF NEXT MEETING

Sara Moseley, Chair

The next meeting will be held on **27th November 2025** at 10:00 in the Trust Headquarters, 2 Charnwood Court, Parc Nantgarw, Cardiff.

CF15 7QZ

13:15 - 13:15
0 min

10. CLOSE

Sara Moseley, Chair

The Board is asked to adopt the following resolution:

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

13:15 - 13:15
0 min

11. ITEMS FOR DISCUSSION AT PART B

- Minutes and actions from last meeting
- Whitchurch Land update
- nVCC and Enabling Works Quantified Risk Assessment Update
- Private Trust Risk Register
- Anonymous Letters update
- Governance Review of NWSSP
- Chair's Urgent Actions
- Charnwood Close Lease (NWSSP)
- Private Committee Highlight Reports
- South-East Wales Regional Planning – Regional Joint Committee

MINUTES PUBLIC TRUST BOARD MEETING
VELINDRE UNIVERSITY NHS TRUST
24th July 2025 10:00-13:00

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

1.0.0	PRELIMINARY MATTERS	LEAD
1.1.0	**Welcome and Apologies:** The Chair welcomed attendees to the meeting, advising that this would be her final Trust Board. The following apologies were noted: • Carl James, Executive Director of Strategy & Planning / Interim Deputy CEO	
1.2.0	**In Attendance:** The Chair extended a warm welcome to the following additional attendees: • Katrina Febry, Audit Lead, Audit Wales *(remotely)* • David Cogan, Patient and Carer Representative • 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 • Bethan Davis (HEIW) – Simultaneous Welsh Translation	
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 22nd May 2025 and Extraordinary Trust Board meeting held on 26th June 2025** The following amendments were noted: (22nd May minutes page 7) – Unfinished sentence referring to reliance on non-recurrent savings. (26th June minutes attendance) – Hilary Jones' attendance had not been included. Subject to the amendments noted above, the Trust Board was content that the minutes were otherwise accurate reflections of proceedings. It was, however, agreed that Trust Board minutes in general contain too much information. Further discussion regarding a consistent format across all Committees / Board is required.	**NG / Board**
1.5.0	**Action Log** The Board reviewed the action log and current status of actions as follows: • **Action 3 (23.05.2024)** – Non Gwilym advised that draft Terms of Reference require further discussion and will be addressed at the September meeting of the Strategic Development Committee. • **Action 19 (28.11.2024)** – It was agreed that the request at the May meeting of the Trust Board had been actioned and subsequently sighted at the Quality, Safety and Performance Committee. The action was CLOSED. • **Action 37 (27.03.2025)** – This action was CLOSED. • **Action 43 (27.03.2025) –** This action was CLOSED. • **Action 44 (22.05.2025) –** Sarah Morley advised that a combined culture and inclusion paper would be brought to the September Board meeting. • **Action 45 (22.05.2025) –** While it was noted that a paper would be addressed under matters arising at today's meeting, that the risk requires reopening and rewording appropriately. • **Action 46 (22.05.2025) –** The action was CLOSED.	**NG** **SM** **AC**
1.6.0	**Matters Arising** Professor Donna Mead OBE, Chair	
1.6.1	**Paperless Go Live Update** Anne Carey, Chief Operating Officer The Paperless Go Live project would not be fully completed until the end of June 2026 and a collaborative effort across Wales would enable other Welsh organisations to use the same interfaces for Radiotherapy systems. Lindsay Foyster noted that a number of lessons learnt would have emerged and wanted to clarify how staff are supported through the transition and how learning would inform future projects. Anne Carey advised that lessons learned would be captured throughout the process and included in the final feedback. While the team was congratulated on this achievement, the Chair emphasised that while digital systems bring many benefits, new risks may also be introduced such as data breaches / loss, which must be managed alongside the elimination of paper-based risks. The Trust Board **NOTED** the update.	

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: • Frequent attendance at a number of blood donor awards, recognising their value and the opportunity to thank donors on behalf of the Trust. • Velindre's strong presence at the Advanced Therapies Wales Symposium, also noting that the Trust had received JACIE accreditation for the stem collection unit. • Ongoing efforts to engage with the Llais organisation, noting a lack of attendance at Board meetings. • Concern regarding the shortage of Independent Members on the Board. • The new Chair, Sara Moseley, will commence on the 1st September and that interviews for Independent Members are expected to take place during August. The Trust Board **NOTED** the content of the Chair's update Report.	
2.2.0	**Chief Executive's Report** David Donegan, Chief Executive Officer David Donegan highlighted the following key points of the Chief Executive Report: • The annual report had received an unqualified opinion from Audit Wales for the first time in a number of years, marking a positive development. • Positive feedback following the JET meeting with Welsh Government, with the Trust maintaining its escalation level at the lowest (level 1), a status few organisations in Wales have sustained. • Confirmation that the Trust's Integrated Medium Term Plan (IMTP) had been approved for the next three years. • Velindre @ Nevill Hall had received its first patients and will be officially launched later in the year. • The Trust had met all its statutory duties. 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 (PMF) (May 2025)** Lauren Fear, Director of Transformation (interim), Anne Carey, Chief Operating Officer, Sarah Morley, Director of Organisational Development & Workforce, Carl Taylor, Chief Digital Officer and Matthew Bunce, Executive Director of Finance The Performance Management Framework (PMF) highlighted key issues for the attention of the Trust Board for the month of May 2025. Vicky Morris noted that the Quality, Safety and Performance Committee was unable to scrutinise the PMF as desired due to time constraints. Vicky also queried the planned Linac capacity (78 hours), seeking clarification on whether the comment regarding no increase in activity due to paperless implementation was retrospective or forward-looking. Anne Carey confirmed that the total Linac capacity figure included quality assurance time, advising that more	

	appropriate presentation in an infographic would follow. Benchmarking data from other providers had been requested and comparative reports on Radiotherapy performance across Wales would be shared with the Board. Anne Carey agreed to amend the Linac capacity narrative in the paper post-meeting. Workforce Key Performance Indicators (KPIs) • Targets on sickness, PADRs (appraisals) and statutory / mandatory training had flatlined, with only the training target being met. • Sickness stood at 5.06% as at 23rd July with local work underway to address known issues. • Wellbeing remains a main focus with a wellbeing review being presented at August's Executive Management Board. • The PADR target is national, therefore allowing for benchmarking with other organisations. The Trust has yet to see improvements in PADR levels, the 85% target may not be reached. The Board emphasised the importance of monitoring progress, understanding differences between high and low performing teams and drilling down into team-level data. The potential for a digital library of consistent, accessible reference material was suggested, or the inclusion of links to such data in Board papers. Digital Key Performance Indicators (KPIs) • A reduction in significant incidents related to Digital Services was reported, with approximately a 50/50 split between national and local incidents. • Statutory / mandatory training for Digital remains above target, as does service desk performance. • The Digital infrastructure for the new Velindre @ Nevill Hall has reduced the risk for the nVCC, as the same technologies and partners are being used. • Focus is now on the migration from Windows 10 to Windows 11 across the Trust. Estates • As of July, all statutory Health & Safety training standards had been met Trust-wide, which had not been the case for a number of years. The Board discussed its response to potential terrorist threats and the work underway to strengthen the Trust's position. Gareth Jones requested an update on the two SABRE (Serious Adverse Blood Reactions and Events) incidents, actions taken to address the two issues and the status of any investigations. Peter Richardson advised that the Red Cell Immunohematology (RCI) is an area working under pressure, however, investigations into both incidents had been completed, immediate corrective actions had been implemented and the regulator had closed down the cases. A joint programme with the provider is underway to improve processes and provide longer term resilience. The Trust Board **NOTED** the Performance Management Framework for assurance and individual assurance levels as stated in the report were agreed by the Board.	**AC**
3.2.0	**Financial Report (May 2025)** Matthew Bunce, Executive Director of Finance The Finance report outlined the position and performance for the period to end of May 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:	

	• Two national cost pressures had arisen - (1) Reduced funding for employers' National Insurance contributions (resulting in a £345k shortfall) and (2) increased costs from the Welsh Risk Pool (WRP) due to a rise in claims (adding a further £365k pressure); whilst these will be managed in-year through emergency and non-recurrent reserves, this will impact next year's budget. It was important to note that these cost pressures are in no way related to Trust performance. • All savings schemes are now green (fully implemented). • Challenges of outdated Long-Term Agreements continue, and resolution requires Welsh Government leadership and collective agreement across Wales, as organisations cannot solve this individually. It was accepted that the ongoing impact of these pressures is largely recurrent. Nicola Williams added a further financial risk that is emerging following the introduction of the Duty of Candour had resulted in greater recognition of harm incidents, which has increased the cases being managed under NHS redress and could potentially increase to a claim. In addition, the proposed changes to the NHS Wales Putting Things Right Regulations that are due to take effect from the 1st April 2025 will further increase redress cases being managed by the Trust; although, long term, this should reduce the number of claims. A full regulatory change impact assessment is being undertaken. The Trust Board **NOTED** the content of the May 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 2025-26 from our Commissioners. • The position with Commissioners on the contract rebase agreement. • The latest position on the Trust savings schemes.	
3.3.0	**VUNHST Risk Register** Led by Non Gwilym, Director of Corporate Governance (interim) Non Gwilym provided an overview of the current Trust Risk Register, focusing on risks scoring 12 and above for Quality / Safety and 15 and above for all other domains, noting regular review of the Register at the Quality, Safety and Performance Committee and the inclusion of relevant dates by which risks will be reduced. It was recognised that work is ongoing to review static risks; it was agreed to consider prioritising the highest scoring risks and those with the largest discrepancy between current and target scores. Non Gwilym also advised that discussions are ongoing with colleagues at other Health Boards regarding Risk Register systems. A further update would be provided to the September Board. While it was noted that the TrAMs risk continues to reduce following agreement to maintain an aseptic Pharmacy unit at the nVCC, Andrew Westwell expressed concern around closing this completely. Anne Carey advised that the new TrAMs plan would result in new risks for the Register.	

	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, also **NOTING** the assurance level of 3.	
3.4.0	**Trust Assurance Framework (TAF)** 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 Trust Assurance Framework continues to be updated to better reflect strategic objectives and risks, acknowledging feedback that more explicit links to strategic objectives are required. Vicky Morris added that it is essential for the Board to be sighted on the strategic objectives beneath the goals. • A proposed change of nomenclature from TAF (Trust Assurance Framework) to BAF (Board Assurance Framework), adopting this terminology to align with other NHS organisations. • Further development is anticipated prior to the September meetings of the Quality, Safety and Performance Committee and Trust Board. Lindsay Foyster sought clarity on the purpose of the document, noting that it is important to focus on highlighting gaps in controls and assurance related to strategic objectives. The Trust Board: • **NOTED** the current status of the Trust Assurance Framework. • **NOTED** the plan to move forward with the Trust Assurance Framework. • **APPROVED** the proposal to rename the Trust Assurance Framework (TAF) to Board Assurance Framework (BAF), to align the Trust with all other NHS Wales organisations. • **NOTED** the Assurance level rating of 2.	
4.0.0	**ANNUAL REPORTS 2024 - 2025**	
4.1.0	**Social Partnership Duty Annual Report** Sarah Morley, Executive Director of Organisational Development & Workforce Sarah Morley noted that it had been agreed to remove the level of assurance (included in error) from the report as this is the first instance of the report and there is therefore currently no comparator. The Trust Board **APPROVED** the report prior to providing to Welsh Government.	
4.2.0	**Gender Pay Gap Annual Report** Sarah Morley, Executive Director of Organisational Development & Workforce No comments were received and the Trust Board **APPROVED** the report.	
4.3.0	**Equality, Diversity & Inclusion Annual Report** Sarah Morley, Executive Director of Organisational Development & Workforce No comments were received and the Trust Board **APPROVED** the report.	

4.4.0	**Welsh Language Annual Report** Sarah Morley, Executive Director of Organisational Development & Workforce Hilary Jones raised concerns that the Trust was not meeting the terms of the Welsh Language Act, in relation to the publishing of Board papers in Welsh prior to the meeting. Hilary stated that this is a fundamental issue and that therefore, the level of assurance for the report should be reduced from 4 to 3 due to this non-compliance. It was recognised that achieving full compliance would require significant investment in resources and that the Trust is currently not in a position to do so. It was agreed that translating the agenda into Welsh as a minimum would be a first step toward compliance. David Donegan noted an action to explore realistic options regarding what could be achieved. The Trust Board **APPROVED** the report, subject to the modification of the level of assurance.	**SM**
4.5.0	**Quality & Safety Annual Report** Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Scientists Nicola Williams highlighted that the Quality and Safety Annual Report showed a reduction in the 30-day response target for complaints, due to a small number of complex concerns involving multiple organisations and some team absenteeism. The Trust had met the national target, had very few concerns overall, and had not had a Public Services Ombudsman referral since December 2023. The Trust Board **APPROVED** the report, prior to publication.	
4.6.0	**Wellbeing of Future Generations Act (2015) Annual Report** Lauren Fear, Director of Transformation (Interim) No comments were received and the Trust Board **APPROVED** the report.	
4.7.0	**Duty of Quality Annual Report** Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Scientists Nicola Williams re-iterated that the report is a legal requirement and was intended for the public. It was noted that the report contained content from all but one of the Trust's hosted bodies (the exception being Shared Services which had produced a separate report, and which had been included as an appendix). The Trust Board **APPROVED** the report, prior to publication on the Trust's website.	
4.8.0	**Professional Registration / Revalidation Annual Report** Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Scientists Nicola Williams advised that the assurance level of 3 noted in the report had been due to a lapse in a Nursing and Midwifery Council (NMC) registration for one Nurse during the period; it was also noted that while the individual did not work whilst unregistered, this had been a repeat incident.	

	Jacinta Abraham highlighted that medical appraisal compliance is exemplary in Wales at 97.5%, with completion of all required appraisals, and quality of appraisals recognised as very good. Jacinta indicated that she would be attending a quality assurance session with HEIW on revalidation. The Trust Board **NOTED** 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.	
4.9.0	**Annual Report on Compliance with the Nurse Staffing Levels (Wales) Act 2016** Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Scientists Nicola Williams confirmed full compliance with the Act, noting no reportable incidents due to staffing levels in the relevant ward area. Lindsay Foyster requested for photographs contained in all future annual reports to be more representative of staff and population groups. Gareth Jones questioned the staff cost of producing annual reports, highlighting the time required to produce them and importance of making the process as automated as possible to mitigate this. Nicola Williams advised that a move towards more data-driven, automated reporting would be explored over the year, containing less narrative and more succinct information, enabling more efficient production. The Trust Board **APPROVED** the report, prior to onward submission to Welsh Government.	
5.0.0	**COMMITTEE ANNUAL REPORTS**	
5.1.0	**Audit Committee Annual Report** Gareth Jones, Independent Member and Chair of Audit Committee No comments were received and the Trust Board **APPROVED** the report.	
6.0.0	**STRATEGY AND PLANNING**	
6.1.0	**Strategic Planning Update** Led by Lauren Fear, Director of Transformation (Interim) The Trust Board **NOTED** that the next update would follow at the September meeting of the Trust Board and that the key points had been addressed under item 2.2.0 (CEO report).	
7.0.0	**CONSENT ITEMS FOR APPROVAL** Professor Donna Mead OBE, Chair	
7.1.0	**Amendments to Standing Orders – Schedule 3 Annual Review Committee Terms of Reference** Non Gwilym, Director of Corporate Governance (interim) The Trust Board **APPROVED** 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)***	
7.2.0	**Chair's Urgent Actions Report** Led by Non Gwilym, Director of Corporate Governance (Interim) There was one (1) urgent item of business for the Trust Board that was considered via Chair's Urgent Action during this period: • E-Rostering Contract Renewal No objections to approval were received in respect of the items of business considered and the Trust Board **RATIFIED** the Chair's Urgent Action taken between the **14/05/2025 – 17/07/2025.**	
7.3.0	**People and OD Policies for Approval** Sarah Morley, Executive Director of Organisational Development & Workforce The Trust Board **APPROVED** the following policies: • Family Friendly Policy • Maternity Leave Procedure • Maternity Leave Application Form • Pregnancy and Maternity Support Guidance	
8.0.0	**CONSENT FOR NOTING**	
8.1.0	**Public Strategic Development Committee Highlight Report (01/05/2025)** Led by Lindsay Foyster, Vice Chair and Chair of the Strategic Development Committee The Trust Board **NOTED** the content of the report.	
8.2.0	**Public nVCC Project Scrutiny Sub-Committee Highlight Reports (20/03/3035, 06/05/2025 & 10/06/2025)** Led by Hilary Jones, Independent Member and Chair of the TCS Scrutiny Sub-Committee The Trust Board **NOTED** the content of the reports.	
8.3.0	**Public Audit Committee Highlight Reports (13/05/2025 & 24/06/2025)** Led by Gareth Jones, Independent Member and Chair of the Audit Committee The Trust Board **NOTED** the content of the report.	
8.4.0	**Public Quality, Safety & Performance Committee Highlight Report (17/07/2025)** Led by Vicky Morris, Independent Member and Chair of the Quality, Safety & Performance Committee The Trust Board **NOTED** the content of the report.	
8.5.0	**Public Charitable Funds Committee Highlight Report (03/06/2025)** Led by Donna Mead, Chair and Chair of the Charitable Funds Committee	

	The Trust Board **NOTED** the content of the report.	
8.6.0	**Local Partnership Highlight Report (15/07/2025)** Led by Sarah Morley, Executive Director of Organisational Development & Workforce The Trust Board **NOTED** the content of the report.	
9.0.0	**ADDITIONAL**	
9.1.0	**Statement by the Chair, Professor Donna Mead OBE (oral item)** The Chair read a previously prepared legacy statement to members of the Board as a final farewell, as this was her last meeting as Trust Chair, summarising key achievements during her tenure at the Trust. Board members were advised that the statement would be appended to the meeting minutes. Thanks and congratulations to the Chair followed from colleagues as noted below: David Donegan – on behalf of staff past and present, for the Chair's compassion and empathy as a nurse, passion and ambition as an academic and as a wife, mother, colleague and friend, continuing to play a role in connecting staff with what the Trust's services mean to patients and carers. Jacinta Abraham – on behalf of medical colleagues, for the personal support received in her role as Medical Director, and for promoting leaders, Consultant appointments and engagement events. For her insight and intuition during the COVID Pandemic, elevating the clinical voice and supporting Research & Development within the organisation. Nicola Williams – on behalf of nursing, AHP and Scientific colleagues, for putting patients and donors at the heart of the services provided by the Trust. For raising the profile of nurses, Allied Health Professionals and Scientists, implementing support mechanisms for Research and for the Chair's support with navigating the relationship with University of Wales Trinity St David to facilitate the provision of accredited courses at the new Velindre Oncology Academy. Matthew Bunce – on behalf of the Trust's Charity, for the Chair's leadership and commitment to ensuring that money earned by Fundraisers is scrutinised and invested to provide the best outcomes and for encouraging continued engagement with the Charity. Lindsay Foyster – on behalf of Independent Members, past and present, for the Chair's dedicated leadership and commitment to patients, donors and fundraisers. For shared experiences, focused and honest discussions, passion and humanity. Stephen Harries – on behalf of colleagues past and present, for the Chair's years of dedicated service and leadership during the challenges faced during her tenure. It was recognised that the Chair's legacy will bring real and lasting improvement to the services provided by the Trust.	
9.2.0	**ANY OTHER BUSINESS** Professor Donna Mead OBE, Chair No prior notice of any other business had been received.	
9.3.0	**DATE OF NEXT MEETING**	

	The next public meeting will take place on Thursday, 25th September 2025.	
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:** • Previous Private Trust Board minutes and actions • VCS Restructure • Whitchurch Land – next steps • BECS update • TrAMs update • IP5 Roof Overcladding Business Case • Lease on 4-5 Charnwood Court, Nantgarw • 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 Partnership Audit Committee Highlight Report • Joint Commissioning Committee Highlight Report • South East Wales Pre-Registration Training	

A Legacy of Compassion, Courage and Collaboration

A personal reflection by Professor Donna Mead OBE, Chair of Velindre University NHS Trust, 2018 – 2025

Foreword

I first walked through Velindre's doors on May 1st 2018 with a notebook in one hand, butterflies in my stomach and big shoes to fill. I already knew the stories. How our nurses treat strangers like family, how half of Wales pulls on a red Velindre T-shirt to run marathons—yet I also knew our filing cabinets were bulging, our estate was creaking, and our digital systems refused to shake hands with the rest of the NHS.

Seven years later my notebook is full of names and small miracles: porters who pause to straighten a family photograph, physicists who calibrate beams at dawn so clinics can start on time, volunteers who appear with a cup of tea the moment uncertainty crosses a face. The pages that follow are not an annual report (our auditors handle that) and not an authorised history (future scholars can quarrel over footnotes). They are simply my testimony—what happens when compassion, evidence and sheer Welsh stubbornness line up behind a single purpose.

I offer these reflections first to the Velindre family who made every line possible; secondly to our partners across Wales who trusted us with their citizens; and finally to anyone who believes a small specialist trust can punch far above its weight when love of service is genuine

"When you work with Donna, you get Donna—the whole person. She never treats leadership as a transaction; she starts by building trust and sharing who she is."

Steve Ham, former Chief Executive, Velindre University NHS Trust

"Donna's leadership was marked by compassion, integrity and insight. But, if I had to choose just one of those words, it would be compassion. Compassion for patients, for staff and for volunteers." Stephen Harries, former Deputy Chairperson, Velindre University NHS Trust

"Donna doesn't just leave an important legacy; she leaves a lot of friends too. She always gave clear leadership – a caring, honest and humble approach to leadership that leaves the organisation in a better place." Carl James, Executive Director of Strategic Transformation, Planning and Digital, and Deputy Chief Executive Officer

1. **Start Where the Patient Is: Velindre Then and Now**

People in South-East Wales speak of Velindre with an almost protective affection. Ask around and you'll hear: "They nursed my dad," "They took my blood," or "They cheered

me over the finish line." What the public could not see back in 2018 was the backstage fragility. Paper notes overflowed; home-made databases spoke dialects nobody else understood; and cancer incidence was edging up each year. The Welsh Blood Service faced its own headwinds: ageing donors, platelet packs that expired in days, buildings which needed updating and renovation and the possibility that there would be no in-country stem-cell collection.

Fast-forward to today and the progress is there to see.

One digital spine - now connects clinic, lab and ward; nobody hunts dusty folders at 3 a.m.

Research has found its scaffolding. Grants arrive with clear objectives and even clearer governance.

There is a Stem Cell Collection Unit based in the cancer centre. Blood and stem-cells travel smarter. A donor in Pwllheli can sign up by phone and, within forty-eight hours, know their donation is on its way to an operating theatre in Swansea.

University Trust status. Twice externally reviewed—confirms Velindre meets the full tripartite test of education, research and clinical innovation.

The pages ahead tell some of the story about how those shifts took root.

2. Building Tomorrow's Workforce: The Velindre Oncology Academy

A gap that gaped

In my first month I started to hear a familiar story from staff recently returned from postgraduate studies

"I spent two years and a small fortune on my MSc—and still had to learn adaptive planning during lunch breaks on my return."

Two days a week in university could leave rosters threadbare, yet the courses were mostly too generic for our hyper-specialist world.

My worlds collided – in a good way

This seemed like a problem that my varied career in health and education seemed – completely accidentally – designed to solve. So I made some enquiries with the University of Wales Trinity Saint David.

That would it take, I asked, for you to enable Velindre to provide courses which would be accredited and lead to a degree.

The answer that came back – was “quite a lot” – but it wasn’t an impossible ask, by any measure.

After 18 months of library inspections and governance paperwork, a deed of association was signed—the first time a Welsh university delegated such powers to a non-educational body.

What makes the Academy different?

- Work-based projects.—real problems, solved in real clinics with the learning which ensued contributing to the degree being awarded. .
- Annual skills census. We ask staff what they need next; the September timetable is built around those answers, not around a distant campus diary.
- A hybrid classroom. Lecturers stream from a boardroom in Cardiff to lecture theatres across Wales—and increasingly, right around the world.
- Cost & carbon savings. Fewer motorway miles, fewer twelve-hour shifts patched together to cover study leave, and tuition that fits oncology’s rhythm rather than the other way round.
- Being taught and mentored by the experts in the field who posses cutting edge clinical knowledge
- Staff who teach and mentor on our courses having the opportunity to study for teaching qualification

Impact so far

Staff have stepped into advanced-practice and clinical-academic posts that simply didn’t exist five years ago. More telling than any metric is the new default question : *Which module are we designing next?* The Academy is now a talent magnet we never could have afforded to build in bricks and mortar.

3. The Pandemic: Crisis as Catalyst

Quick transformation

When lockdown hit, immune-suppressed patients faced an awful choice: risk crowded district hospitals for pre-treatment bloods or delay therapy. Our estates team ripped up carpet tiles, built corridors, repurposed units and opened new hubs in forty-eight hours flat to provide an environment which would enable immune suppressed patients to come to Velindre for pre- treatment bloods. —proof that necessity really is the mother of re-wiring.

Learning the art of virtual care

Before Covid, video appointments were an exotic experiment – not really trusted by clinicians; by midsummer they were lifelines. We learned to check broadband speeds, camera angles—and whether a patient’s cat was likely to stroll across the keyboard at

a critical moment. Those lessons now sit in a standard operating procedure that outlasts the pandemic.

Hypo-fractionation—less travel, same cure

There was mounting evidence suggesting some cancer patients needed only five high-precision radiotherapy sessions instead of the more usual twenty, led by our medical director, we moved quickly to implement the evidence. It spared hundreds of people extra journeys, and debilitating side effects - and it also freed machine time for new referrals—proof that innovation can be compassionate as well as clever.

A chair in scrubs

Re-qualifying as a vaccinator at my age was mildly terrifying—there's nothing like a twenty-something pharmacist who is really proficient watching you practice to sharpen the wits—but by February 2021 I was drawing up Pfizer vials in a snow-dusted clinic. Once reconstituted, the vials lasted only 2 hours. Motivated by our executive Director of Nursing, Allied Health professionals and clinical scientists, who counted every vial, we adopted all kinds of strategies to ensure there was no waste of this precious vaccine. Those winter clinics remain some of the most hopeful hours of my career.

4. Transforming Cancer Services: From Vision to Construction

There are things we are sometimes asked to do that really stretch us beyond what we thought possible, where we find out just how resilient we are – as individuals – and as teams. I don't think any experience taught me more about myself, than the project to build a new dedicated cancer centre in Cardiff. Transforming Cancer services was always more than building a new regional cancer centre. The initiative included an integrated Radiotherapy solution, a radiotherapy satellite centre at Neville Hall Hospital, implementing a digital solution and care closer to home. Progress has been made with each one.

The Mutual Investment Model (MIM)

First of all, we were the first health project in Wales to use this new investment model. And that meant a lot of learning on the go – for us, for Welsh Government, and for everyone involved in the project. I am convinced of the merit of this model, and its superiority to simple PFI schemes, but we certainly had to do a lot of heavy lifting to make this good idea have a good outcome.

Community benefits

Alongside the construction of a world class cancer facility for Wales, I'm very proud the building of the new centre has given opportunities to hundreds of local people. The contractual targets included the hiring of new, local apprentices; a large Welsh supply-chain spend – and a sustainable and biodiversity friendly building. With so

many apprentices involved in this project, the legacy of the new centre will live on in the skills and opportunities provided in the local area.

Europe's most advanced LINAC fleet

When we finish, Wales will have the best fleet of LINACs in Europe. Somebody will overtake us one day, but right now that's just an absolutely incredible achievement. What you quickly realise, and I never thought I would need to know this – is that installing a linear accelerator is no small feat. You need to build concrete bunkers so thick the arc of the beam can dive underground and come up safely on the other side. Then come endless calibration graphs, software checks and midnight cable pulls so daytime clinics never stop.

By completion, Velindre will run ten brand-new LINACs. Two are already humming at the existing cancer centre —swapped in early because our ageing machines simply couldn't wait. Two have already been installed at the new radiotherapy centre at Neville Hall Hospital and six more will slot into the new Cancer Centre along with the two already purchased and installed. There will also be a dedicated research bunker so clinical trials no longer fight for machine time.

This new kit's intelligence is mind-blowing. From the use of AI and a new level of accuracy that lets clinicians change the prescription while the session is still running— something that used to take weeks.

With this fleet Velindre can treat more patients, spare more healthy tissue and push Welsh-led radiotherapy research onto the European stage.

Navigating opposition

Of course, it wasn't always easy getting to where we are today, with the new centre within touching distance as I write. Some of the opposition to the site was difficult to navigate, and sadly became quite personal at times. But, I always challenged myself – and the Trust – to make sure we were doing the right thing, the right way and in the right place. I am confident that once built and fully operational, the new centre will wow even the most strident of opponents.

5. Research & Innovation: Accelerating Discovery

From its earliest days Velindre has punched well above its weight in clinical trials and research, yet by 2018 our research offer relied too much on goodwill, squeezing research in between busy clinics and other duties and excel spreadsheets for data capture. There is now an increasing body of evidence that there is a positive association between the engagement of individuals in health care organisations in research and improvements in health care performance. I wanted a platform that matched our clinical ambition, so we set three priorities: stable funding accessible by

all professions to increase both capacity and capability for research, -wide collaboration across South Wales and beyond and a sharper grasp of intellectual property.

The Advancing Radiotherapy Fund (ARF)

Three philanthropic families— Probert, Lucas and Moondance provided significant funding . An advancing radiotherapy board was established to administer the fund. Its first chair was Jan pickles, independent member and when Jan's term of office came to an end, I occupied that seat.

Some of the achievements of which I am most proud include

Advancing Radiotherapy Fund (ARF): Examples of Funded Impact at Velindre University NHS Trust – 2020 to 2025

The following examples demonstrate the Advancing Radiotherapy Fund's strategic impact:

1. Accelerating New Radiotherapy Developments and Innovations into the Clinic

The ARF has enabled the rapid translation of clinical and technological advances into patient care. Examples include:

- **SABR Acceleration for Oligometastatic Disease**
  Accelerated the introduction of Stereotactic Ablative Body Radiotherapy (SABR) into routine clinical use in South Wales for patients with low burden metastatic (oligometastatic) disease, improving access to highly conformal, targeted treatment.
- **SRS Repatriation**
  Supported the repatriation of Welsh patients requiring Stereotactic Radiosurgery (SRS) for skull base tumours from English centres, ensuring patients could be treated closer to home.
- **Pandemic-Era Treatment Adaptation**
  Enabled rapid adoption of hypofractionated radiotherapy schedules for breast and prostate cancer during the COVID-19 pandemic, reducing patient visits and safeguarding treatment continuity.
- **PRECISION Study – Advanced Prostate Radiotherapy**
  Funded implementation of the **Raypilot® Hypocath®** system to support Velindre's participation in the international **PRECISION** Phase II study of 3-fraction prostate SBRT. This facilitates ultra-hypofractionated treatment for men with low/intermediate-risk prostate cancer, supporting innovation in prostate cancer care while reducing treatment burden and increasing capacity.

2. Supporting Cutting-Edge Research and Innovation to Improve Radiotherapy Treatments

The ARF has invested in transformative research platforms and studies that advance the scientific understanding of radiotherapy effects:

- **Neurocognitive Function Study**
  Applied advanced MRI techniques to investigate biological changes in the brain following SRS, linking them to neurocognitive outcomes and enhancing understanding of treatment-related brain toxicity.
- **PEARL Study**
  Investigated PET-based Adaptive Radiotherapy in head and neck cancer, tailoring treatment according to early biological response, with the aim of reducing unnecessary toxicity in responding patients.
- **SARRP Research Technician Funding**
  Provided £120,000 to support a Grade 6 Research Technician role to run the **Small Animal Radiation Research Platform (SARRP)** at Cardiff University's PETIC facility. This platform enables translational radiotherapy research with in vivo models, supporting preclinical development of novel radiotherapy combinations, and improving Wales's competitiveness in national infrastructure bids.

3. Enabling Our Multi-Disciplinary Workforce to Lead Improvements in Patient Care

ARF support has helped build and empower a skilled, agile radiotherapy workforce:

- **Patient Support Unit (PSU)**
  Established a walk-in ambulatory **Patient Support Unit** providing immediate, expert care for radiotherapy patients experiencing side effects. Initially ARF-funded for 3 years, the PSU has since secured permanent Welsh Government funding, demonstrating its value and sustainability.
- **Workforce Upskilling in Advanced Clinical Practice**
  Supported radiotherapy and medical physics staff to undertake formal training, including Postgraduate Certificates in Advanced Clinical Practice, enhancing their outlining, planning skills, and expanding their scope of practice.

PRECISION Study Training

Enabled training of the clinical and physics workforce in innovative motion management technologies (Raypilot® and Hypocath® systems), fostering skill development in ultra-precise prostate radiotherapy and positioning Velindre as a centre for SBRT expertise.

In September there is going to be a workshop to showcase the amazing achievements made possible because of ARF funding.

As the funds from our benefactors were used up, we did not wish to lose the momentum for innovation and research in radiotherapy which had built up. We had to keep the momentum going to achieve all our goals. The ARF Board set about acquiring funds to establish new research and innovation. We took the maxim that one way to keep momentum going is to have constantly greater goals.

One of our goals was to scale up what we had learned to cancer centres across Wales so this time we collaborated with cancer centres in West Wales and North Wales. Applications for funding were made to the Moondance Foundation and to the Velindre charitable funds committee and a further £3million was obtained. There is now a single governance board with representatives from across Wales, clinically led by Dr James Powell, supported as always by our medical director Jaz Abraham.
A key decision was nomenclature and ARC (Advancing Radiotherapy Collaboration) was born.

ARC now issues competitive calls and is funding everything from MR-guided adaptive planning to virtual-reality simulation suites for trainee physicists. A number of peer-reviewed papers are already in print. MSc fellows from Swansea University are being funded to complete Masters degree dissertations on ARC-supported topics.

Turning data into dividends
One of our biggest coups came when a large pharmaceutical company approached us for Velindre-led real-world data obtained from trials into metastatic-breast-cancer. Working with our legal and charity teams we licensed the anonymised dataset—retaining ownership—and secured a £1 million unrestricted research grant for the Velindre Charity. For a Trust of our size it was transformative proof that specialist centres can be both generous with knowledge and commercially astute. Most importantly of all, the trial of the new treatment concerned has demonstrated that life expectancy is extended by an average of 10 months and in many cases, longer.

Digital Excellence
As anyone who has worked with me can tell you, one of my favourite phrases is “the plural of anecdote is not data.” Research thrives on data, so in 2023 we launched a ten-year roadmap to knit together cancer, blood and hosted-body datasets.

6. Welsh Blood Service – Lifelines in Motion
“You are life-givers. When you donate, you declare the kind of society you want to live in.” one which involves donating to someone who you don’t know and will never meet.

My conviction here is personal. My daughter-in-law’s final months were sustained by transfusions, and during my own recent surgery I felt an overwhelming assurance knowing cross-matched units sat ready. This kind of lived experience coloured every board decision on the Welsh Blood Service (WBS), and every day I worked at Velindre.

Innovation with heart - Platelets that travel further

WBS scientists are trialling cold-stored platelets with Royal Navy medics so field teams can carry life-saving packs for a product with a current shelf-life of 7 days only. The same packs now fly with the Welsh Air Ambulance—proof that research can translate to front-line care.

Plasma back in Welsh hands.
After UK regulators lifted vCJD restrictions, WBS began gearing up for plasma fractionation—separating plasma into immunoglobulins that could power cancer immunotherapy and treat autoimmune disease. Local clinics will keep the supply chain on Welsh soil and cut import costs.

Stem-cell registry – rain, song and swabs
Switching from blood samples to simple buccal swabs has revolutionised recruitment to the Wales stem-cell Registry. At the 2024 National Eisteddfod in rain-soaked Pontypridd, staff signed up more than a hundred new registrants *in a single day.* I was there. Despite being drenched like a drowned rat, it was one of my proudest afternoons. The weather was biblical, but the enthusiasm was heaven-sent.

Inclusion milestone – FAIR project (Fair Assessment of Individual Risk)
In June 2021 Wales became the first UK nation to accept donations from men in same-sex relationships under a new individual-risk policy. I was on the clinic floor when two married men offered the inaugural units. Their hands held, I will never forget one of them turning to me in tears and saying, *"Today my humanity is recognised."* The moment confirmed to me something I have always strongly believed - safety and equality can walk hand-in-hand.

We will never take our whole blood, platelet and stem cell donors for granted. The Welsh Blood service needs to collect between 80,000 – 100,000 thousand donors each year to keep the 20 NHS hospitals in Wales supplied with Blood. We feel its important to say thank you to our selfless blood donors. When a donor reaches a particular milestone, eg donating either 50, 75 or 100 units of blood we invite them to an award evening in which their invaluable contribution to society is recognised. These award evenings are an inspiration. To reach a particular milestone a donor will have been attending blood donor clinics for at least 11 years. The evenings are held all over Wales and I rarely miss one so that I can say "Thank you " on behalf of the Trust and the people in Wales. I always seem to meet someone from my past who I have either nursed or taught – a source of great delight for me. One very memorable evening involved me presenting my own husband with his reward for donating 52 units of blood. I gave him a quick kiss as well as a handshake and certificate!

Quiet heroes behind the cool boxes

From logistics crews who doubled their mileage during lockdown to lab techs who meet red-eye flights with stem-cell couriers, WBS staff, led by Alan Prosser, embody the Trust's approach of service first, ego last. We don't just move blood; we move futures.

7. Culture of Compass – Little Things With Big Hearts

Some legacies are written in steel and concrete; others live in everyday gestures. Velindre's culture is woven from the latter. It's the little things which people remember. Nothing is too much trouble even the smallest of things. Gwnewch y pethau bychain I wneud gwahaniaeth mawr. Paraphrasing St David. Do the little things to have big effects.

Volunteers – humanity in hi-vis

Everyone who has been through Velindre says the same thing – people go above and beyond here – and that's what makes a difference. Nowhere is this more true than in the case of our army of volunteers. One patrols outpatients asking every single person how long they have waited, chasing delays before anxiety can take root. Another can spot the "lost-visitor look" at fifty paces; stand gazing at a ceiling tile and you will be rescued in under two minutes. I must confess to once having been rescued myself after setting off in the wrong direction to examine a new art installation!

A Charity which doesn't just improve the odds it changes the odds.

It has been my great privilege to chair the Trusts Charitable funds committee. The Charity's success is dependent on our amazing volunteer fundraisers, who ride bikes, walk, climb mountains, knit and natter and grow and sell vegetables. The Commercial sector plays its part by hosting events. I have come to know many of our army of volunteer fundraisers, now considering many as friends. I have enjoyed participating in many events to play my part in fundraising. Walking has tested the limits of my physical endurance. I remain highly embarrassed that on two occasions while walking for the charity, once in Angharad Park and then in Aberdare Country Park, that I was lapped several times by the more physically able. On both occasions, I stumbled rather than walked across the finishing line. I have enjoyed attending craft fayres where products made by our fundraisers are sold. I always leave such events poorer than I entered them, staggering under the weight of the items purchased!

As Chair, I am deeply proud of the journey our charity has taken. One shaped by unwavering dedication, resilience, and a clear vision for the future. Our staff, too have been the beating heart of the charity, often working long hours, being away from home and driven by an unshakable commitment to our mission. When the world was brought to a halt by the COVID-19 pandemic, fund raising staff did not falter. Instead, they adapted swiftly, stepping into new roles to help deliver frontline services with compassion and professionalism. Their ability to morph in the face of crisis not only

sustained our impact during unprecedented times but redefined what we are capable of achieving together.

Emerging from those challenges, our charity found a renewed energy. We've seen exemplary growth in our fundraising efforts, built dynamic relationships with celebrity ambassadors, and grown a loyal and engaged public following. Our transformation into a modern, responsive charity has been both deliberate and inspiring. Today, we are proud to operate within a strong and sustainable structure, one that serves as a model for the future and positions us to deliver even greater benefit to those we support.

We have embraced technology to improve how we work and how we connect. The introduction of our new CRM system has already had tangible impact streamlining donor engagement, enhancing supporter relationships, and enabling smarter, data-driven decisions. On the cusp of launching our new and highly improved website, we're excited to offer a more accessible, user-friendly experience that makes regular giving not just easy, but appealing and meaningful for donors.

This charity stands today on solid foundations, stronger than ever before, and ready for the future. I leave my role as Chair with immense pride and gratitude, for the people, the progress, and the potential that lies ahead.

Operational Services & Catering – taste as therapy

During the Queen's Platinum Jubilee our world class catering crew assembled individual trifles—sponge, custard, crown-embossed chocolate—for every in-patient. This is just one example of how these heroes go the extra mile. When a terminally ill patient wishes to marry, ops staff find a dress, bake a cake and transform a family room into a chapel. No policy mandates this; compassion does. That is what Velindre does to our staff and volunteers, it elevates them.

Honouring service – the Armed-Forces Covenant

I am so proud of how we make veterans and reservists and families feel at home. We signed the Armed Forces covenant in 2019. By 2024 we held the MoD Gold Employer Recognition Award. A granite cenotaph stands in the hospital garden so that patients on Remembrance Day can honour comrades without leaving the site – it is good to know this will transfer to the new site. I will always remember our armistice day services.

8. Leadership Through Adversity – Lessons From the Meadow Storm

The new cancer-centre project unleashed some unexpected forms of protest—placards, petitions, even ceramic nails hidden in trees. Twice we faced High-Court challenge; twice the project prevailed, at a cost.

That juxtaposition clarified everything. Overcoming adversity clarified everything.

- Resilience is purpose plus people. When a patients garden had to be uprooted in order to provide space to build a new corridor during Covid, estates colleagues preserved every shrub uprooted for COVID corridors so that they could be replanted. Facilities staff cared for my family with such kindness alongside nursing and medical staff during my daughter in law, Clare's illness. The same estates staff led the initiative to ensure apprenticeships in a building some refused to believe would ever rise.
- Data disarms dogma. Emergency-transfer audits, biodiversity counts and costed community-benefit clauses cut through myths better than any press release.
- Communication matters—but do not feed the flames. We answered every direct email but refused social-media mud-wrestling, focusing instead on open-door drop-ins held over several months —where evidence lay on the table and tempers cooled over tea.

These experiences forged the leadership maxims I hope to leave behind. Lead with compassion, argue with evidence, and if you have any time left over—communicate, communicate and communicate some more.

9. Lessons for the future – What Seven Years Taught Me

Leadership manuals come and go; oncology wards and donor clinics keep their own score. If I could sit down with my successor for one unhurried coffee, here are the five lessons I would press into their notebook:

1. Anchor every debate in patient benefit. During any procurement conversation, detours into brand loyalty and bunker aesthetics will vanish the moment you ask, “Which option delivers safest beam-on time for Rhian from Rhondda?” Return to patients and you will disarm ego.

2. Data trumps opinion—but only if shared early. Emergency-transfer audits, carbon baselines and apprenticeship trackers defused myths more effectively than any polished slide deck. Publish your working, invite scrutiny and watch trust build.

3. Celebrate success or someone else will write the narrative. We are modest in Wales; trumpet-shouting feels gauche. Yet silence leaves a vacuum that sceptics will happily fill. A regular “bright-spots” note can keep morale aloft and give the media something other than protest noise to quote.

4. Volunteers and donors are a strategic asset, not a side show. Operational crises—from snow-blocked vaccine days to platelet shortages—were solved because volunteers and donors stepped up. Invest in their experience as diligently as you would a new scanner.

5. Win the long game; you need not win every meeting. I lost the first round debate on relocating a secondary-access road for the new cancer centre, then won it some

months later with better costings and calmer minds. Patience, facts and courtesy outlast volume every time.
These maxims are not etched in marble—context evolves—but they served me faithfully through seven years of service.

10. Looking to 2030 – A Vision Within Reach
By Spring 2027 the new Velindre Cancer Centre will open its doors—an all-electric, BREEAM-Excellent building where birdsong pipes through rooftop gardens and apprentices from the Meadows project supervise the next cohort of trainees.

The Talbot Green infrastructure project will be completed providing a building fit for purpose for a 21 Century Blood and Transfusion Service. The infrastructure for collecting plasma for fractionation will be in place providing a service which will benefit patients and provide cost savings for the NHS.

Advances in personalised Medicine, many being developed by Advanced Technologies Wales will preserve and prolong life.
Blood Products being delivered by drone is a technology which is being actively worked up.

These targets are ambitious but not fanciful. I commend them to the Board with confidence and affection.

11. Acknowledgements – Hands That Shaped the Journey
Board & Executive: Nicola Williams, whose nursing-science fusion birthed the Oncology Academy; Jacinta Abraham, champion of hyper-fractionation and medical leadership; Carl James who has lived our transforming cancer vision from the beginning and never once lost faith in it. Jonathan Fear, whose estates magic built corridors overnight; James Powell, radiotherapy scholar and ARC anchor.
Clinical & Scientific Colleagues: Every consultant who taught after hours, every physicist who calibrated beam data at dawn, every radiographer who piloted VR-simulation trials.
Welsh Blood Service Family: Sue Jones and the whole collections team, the donor engagement team who work so hard to keep our donors motivated, field-hospital heroes; the FAIR (For the Assessment of Individual Risk) Project task-force who proved equity and safety can co-exist.
Operational Services & Volunteers: Catering queen Sue Shepherd-Jones for trifle diplomacy; Michelle Pengelly and the Patient Support Unit for lion cubs and quiet magics; the donation-hall stewards who greet every arm like returning royalty.
Partners & Donors: UWTSD for trusting us with degree-awarding powers; the Probert, Lucas and Moondance families for betting on Welsh radiotherapy; apprentices who laid bricks in rain and will soon lay foundations in their own communities.

My team of independent members who personified the principles of good governance. To the PAs who wrestle with diaries every day and still mange to get me to the right place at the right time (mostly) and especial thanks to Kyle Page for her infinite cheerfulness
Family & Friends: To my husband, who chauffeured through snow so Pfizer doses would not thaw; to Craig and three lion-hearted grandsons who teach me daily why compassion matters.

If any name is missing, the fault lies with space, not gratitude.

Passing the Torch
Seven years ago I walked into Velindre with lots of experience, but no idea what awaited me. Throughout it all, I was determined to blend compassion with curiosity. I leave certain of two truths: first, that kindness is a form of precision—it lands exactly where pain lives; second, that evidence is love made reproducible.

To the patients and donors who trusted us with veins, hopes and final breaths; to the colleagues who chased impossible deadlines and laughed in break rooms at 03:00; to the protesters who—unknowingly—sharpened our diligence; and to Clare, whose last days taught me that excellence is measured one family at a time: ***diolch o galon.***

I step aside with a full heart and a shorter to-do list. The files are backed up, the flowerbeds replanted, and the best chapters are already drafting themselves in clinics and workshops. May you write them boldly.

Professor Donna Mead OBE, DSc, PhD, RN
July 2025

ACTION LOG	Column1	Column2	Column3	Column4	Column5	Column6	Column7	Column8
MEETING DATE	**AGENDA ITEM**	**Action number**	**ACTION**	**LEAD**	**DEADLINE DATE**	**UPDATE (including date)**	**STATUS**	**IF CLOSED WHAT ACTION WAS TAKEN**
23.05.2024			**REVISIONS TO SCHEDULE 3 OF TRUST STANDING ORDERS**					
	7.1.4	**3**	Terms of Reference for relevant Committees to be amended to include reference to requirements to demonstrate quality-led decision-making through receipt of Quality Assessments (at Committees where strategic decisions are undertaken).	Interim Director of Corporate Governance	~~**26/09/2024**~~ ~~**27/03/2025**~~ ~~**22/05/2025**~~ ~~**24/07/2025**~~ **25/09/2025**	**September 2025** Amends included for Strategic Development Committee and New Velindre Cancer Cetnre Scrutiny Sub-Committee consideration for November cycle. Revised Terms of Reference (including compliance with Duty of Quality legislation) approved by Research, Development and Innovation Committee at September meeting. **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**	
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: Culture and Inclusion Report discussed at Quality, Safety and Performance Committee on 11/09/25 and on September Board Agenda for Noting.	**PROPOSE TO CLOSE**	
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**~~ **25/09/2025**	**September update:** For RT the Go paperless project (due to be completed by Oct '26) and the the Cancer PTL which has been developed to include the functionality to enable changes to patient pathways to be communicated via teams and flagged, creating worklists and notifications for teams. This will remove the need for email communications and ensure that all patient related communications is visible to the full MDT around the patient. The Cancer PTL will also benefit the SACT and other treatment pathways.	**PROPOSE TO CLOSE**	
25.07.2025	**1.4.0**		**MINUTES**					
		47	Following the consensus that Board minutes contain too much information in general, further discussion regarding a consistent format across all Committees and Board is required.	Interim Director of Corporate Governance / Board Members	**25/09/2025**	Principles developed and considered by the Governance, Assurance and Risk Group on 31 July. GAR group to receive revised guidance at its next meeting on 7 October.	**PROPOSE TO CLOSE**	
25.07.2025	**3.1.0**		**PERFORMANCE MANAGEMENT FRAMEWORK**					
		48	Amend Linac capacity narrative and include appropriate presentation in an infographic.	Chief Operating Officer	**25/09/2025**	**September update:** Work in progress which will start to feed through to the PMF in November. However with the changes to pathway tracking and the introduction of 'internal standards' this will continue to evolve over time.	**PROPOSE TO CLOSE**	
25.07.2025	**3.1.0**		**PERFORMANCE MANAGEMENT FRAMEWORK**					
		49	Facilitate monitoring progress of PADR levels, understanding differences between high and lowe performing teams, drilling down to team level data. Potentially establish a digital library of consistent, accessible reference material, or the inclusion of links to such data in Board papers.	Executive Director of Organisational Development & Workforce	**27/11/2025**	**September update** - Currently working on ways to best include further data in the PMF. Divisional breakdown added to report at present following July meeting, however further information to be made available at November Board.	**OPEN**	
25.07.2025	**3.3.0**		**VUNHST Risk Register**					
		50	Whilst work is ongoing to review static risks, prioritise the highest scoring risks and those with largest discrepancies between current and target scores.	Interim Director of Corporate Governance	**25/09/2025**	September update - Risk Register for September Board will include the outcome of a static risk audit which presented to the Audit and QSP Committees.	**PROPOSE TO CLOSE**	
25.07.2025	**4.4.0**		**Welsh Language Annual Report**					
		51	Realistic options to be explored regarding what can be achieved in terms of meeting the Welsh Language Act (publishing of Board papers in Welsh prior to each meeting).	Executive Director of Organisational Development & Workforce / Interim Director of Corporate Governance	~~**25/09/2025**~~ **27/11/2025**	Guidance sought from Welsh Language Manager - matter to be considered through Governance Assurance and Risk Group.	**OPEN**	

TRUST BOARD	
CHAIR'S UPDATE REPORT	
DATE OF MEETING	25 September 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	Sara Moseley, Chair
PRESENTED BY	Sara Moseley, Chair
APPROVED BY	Sara Moseley, Chair
EXECUTIVE SUMMARY	This report provides information to the Board regarding the Chair's activity since the previous meeting of the Trust Board.
RECOMMENDATION / ACTIONS	To **NOTE** the content of the Chair's update report.
GOVERNANCE ROUTE	
N/A	
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS N/A	
7 LEVELS OF ASSURANCE – N/A	

APPENDICES – N/A

1. SITUATION

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

2. BACKGROUND

2.1 Matters addressed in this report cover the following areas:

- Taking up post as Chair of the Trust (1 September 2025)
- Interviews for Independent Members (5 and 8 September 2025)
- Visit to Welsh Blood Service (10 September 2025)
- Radiotherapy Research and Innovation Showcase Event (17 September 2025)
- Cardiff Cancer Research Partnership Launch (17 September 2025)
- Observing committee meetings (throughout September)
- Introductory meetings with Independent Members of the Trust and with Executive Directors and their teams (throughout September)

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Taking up post as Chair of the Velindre University NHS Trust (1 September 2025)

I would like to open my update report by thanking colleagues for the welcome I have received since taking up my post as Chair on 1 September. I have been greeted with warmth, energy and an openness to sharing and learning. Diolch o galon am y croeso.

Velindre holds a unique and precious place in Wales. So many people have been keen to share their experiences and support with me since I was appointed. We have the potential to play an increasingly important role in developing specialist services and care that are better and fairer. I am spending my first few weeks and months deepening my understanding of how we contribute now and in the future in our communities and with our NHS partners.

I can already see that what is special is the people who work here, with their depth of expertise and passion, and the relationships we have with patients, donors and families, and with our NHS, charities and local partners. As well as listening and learning, enabling our people to thrive—so care is exemplary and the culture strong—is very important to me. As is making the most of opportunities for all of us through successfully delivering some of the biggest and most important capital developments in NHS Wales.

I am looking forward to getting to know the Trust and its people, to better understanding the important and innovative work that is done here, and to hearing what is important to colleagues, patients, donors and their families and carers.

3.2 Interviews for Independent Members (5 and 8 September 2025)

It was a pleasure to spend my first days as Chair, along with the Trust's Vice Chair, Lindsay Foyster, interviewing candidates for our two vacant Independent Member posts.

The pool of candidates was strong, with many speaking about their direct experience of the services and care our Trust provides to patients and donors.

Our recommendations for appointments to the roles have been shared with the Cabinet Secretary for Health and Social Care and I hope to be able to provide an update on progress very soon.

3.3 Visit to Welsh Blood Service (10 September 2025)

I was delighted to visit WBS at Talbot Green during my first fortnight and was struck by the passion and expertise demonstrated by staff across the Service. From the moment I arrived, I was struck by the clarity of purpose shared by everyone I met—from the receptionist to the teams working in laboratories, blood processing, manufacturing, and hospital services.

The complexity of what is done to keep donors and patients safe is truly remarkable, and I left with a deep appreciation of WBS's international impact and the critical role this work plays in supporting hospitals throughout Wales. I am already looking forward to returning—hopefully very soon—to spend time with other teams and learn even more about the incredible work happening there every day.

3.4 Radiotherapy Research and Innovation Showcase Event (17 September 2025)

I joined colleagues at the Noddfa Skills Lab to celebrate the radiotherapy research and innovation project work that has been made possible through the contributions to the Advancing Radiotherapy Fund, supported by Velindre Charitable Funds and Moondance, alongside the Lucas and Probert Funds. These charitable contributions have played a vital role in advancing radiotherapy research, and have enabled pioneering treatments, research infrastructure and cutting-edge technology, all of which have improved patient care and helped shape the future of cancer services in south Wales. This was a brilliant example of what highly skilled and ambitious people can achieve with support and space to innovate.

It was an honour to celebrate the outcomes of these projects, to better understand the positive impact each has had on our patients, and to thank the donors and project teams who are at the heart of this work.

3.5 Cardiff Cancer Research Partnership Launch (17 September 2025)

The Cardiff Cancer Research Partnership (CCRP) is a tripartite partnership between Velindre University NHS Trust, Cardiff & Vale University Health Board and Cardiff University, focused on improving cancer outcomes. Formerly known as the Cardiff Cancer Research Hub, it combines world class academic and clinical capabilities from across the partner organisations to provide a holistic bench-to-bed cancer research pathway in Wales.

I was inspired by the information shared at this launch event, and I look forward to learning more about how clinical outcomes will be improved by increasing patient access to research. Delivering groundbreaking cancer research in Wales and developing our capabilities for the future is at the heart of our strategic goal of being a beacon for research, development and innovation, and it is great to see this important initiative getting off the ground.

3.6 Observing committee meetings (throughout September)

The work undertaken by our committees is key to ensuring the transparency, accountability and effectiveness required of us as a Trust in executing our functions and supporting our organisation to develop.

One of my priorities since taking up post has been to become familiar with the work of our committees. I am grateful for the welcome I received at the Audit Committee, the Strategic Development Committee, the Quality, Safety and Performance Committee, the nVCC Project Scrutiny Sub-Committee and the Local Partnership Forum during the course of September, and I look forward to attending meetings of the remaining committees over the weeks and months ahead. My thanks to all the Independent Members who clearly put so much into these committees and have covered some long-standing gaps which will soon be filled.

During the private Board meeting I will speak in a little more detail about my observations to date, and I look forward to working with the Board and its committees on how we develop and evolve.

3.7 Introductory meetings with Independent Members of the Trust and with Executive Directors and their teams (throughout September)

It has been a pleasure to meet with Independent Members of the Trust and members of the Executive team and their teams over the last three weeks. On joining the Trust I was clear that meeting colleagues from all areas of the Trust's functions was a key priority for me. Learning more about the breadth of the wonderful and varied work that each team does, and each area our Independent Members champion, has been a highlight of my induction so far, and I look forward to continuing with this programme into October.

4 IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: NO	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF)	**Choose an item**
QUALITY AND SAFETY IMPLICATIONS / IMPACT	There are no specific quality and safety implications related to the activity outined 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	25 September 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. Introduction

I'm sure many of our staff will have taken some time off over the last two months to take some well-deserved leave and enjoy time with their friends and family. It has been a very busy couple of months for our organisation, as we said our goodbyes and thanks to our last Trust Chair Prof Donna Mead OBE, were supported in August by our Vice Chair Lindsay Foyster, and welcomed and undertook the induction of our new Trust Chair Sara Mosley whom we are delighted started with us on the 1st of September.

Sara's professional background lies in communications, engagement, policy and leadership. Her previous roles have ranged from Communications Director for Welsh Government, and similar directorships for a large London NHS Trust and a Regional Development Agency. Other roles include Director of Mind Cymru and CEO of the Moondance Cancer Initiative. We are delighted to have her join the Trust and as CEO I am looking forward enormously to working with her. I hope you will join me in making Sara welcome and arrangements are currently underway for Sara to meet you all individually.

Senior management appointments

I am pleased to confirm that Carl James has agreed to take on the Deputy Chief Executive Officer responsibilities for a further period of two years from the 1st September and will therefore no longer be defined as Interim.

Additionally, I am delighted to inform you that Lauren Fear has been appointed to the new post of Director of Place, Portfolio and Partnerships for a period of two years from 1st September.

The Trust has also successfully appointed a new Executive Director of People and Organisational Development. Sarah Jenkins will commence in post from the 1st October. Sarah joins us from Swansea Bay and Hywel Dda University Health Boards, on an interim basis pending the review of our Corporate HR function and the implications for governance arising from the Shared Services review commissioned by Welsh Government. As we say hello to Sarah Jenkins, we must take a moment to say goodbye and sincere thanks to our outgoing Executive Director, Sarah Morley, who is retiring in October. This will be her last Trust Board meeting, and on behalf of myself, the organisation and her executive team, I know we wish her every happiness in the next chapter of her life.

2 Highlighting some key activity over the last two months

National Cancer Group

On the 12th of August, as lead CEO, I chaired the National Cancer Group, part of the Wales Cancer Network. We reviewed the progress being made by the National Cancer Programme, approved a number of new pathways for cancer patients, and discussed priorities for action over the next 6 months. We received a presentation on the overall improvement in performance in most areas and most tumour sites over the first 6 months of the year at a national level.

Welsh Blood Service North Wales visit – Wrexham and Denbigh

On the 20th August, I visited WBS North Wales, to better understand how WBS provides an all-Wales service, from recruitment of donors, to ensuring donations are collected from and distributed to hospitals in North Wales. I spoke with staff across a number of departments, including the Stock Holding Unit, Transport and Donor Engagement.

I also visited a collection clinic in Denbigh and heard from donors about why they donate and their experience as donors. The visit was the perfect opportunity to see how the teams ensure that the exemplary standards of the Welsh Blood Service are felt across Wales. I also welcomed the opportunity to donate at the clinic.

NHS Confederation & ABPI

On the 1st of September I was invited to a roundtable between NHS leaders and senior representatives form the pharmaceutical industry, to explore recent successes such as the cancer vaccine trials, new drug licensing and QuickDNA projects that Velindre have been leading. We also discussed how we can work even closer together over the coming year.

Deputy Chief Medical Officer visit to nVCC

On the 3rd September, the Deputy Chief Medical Officer, Dr James Calvert, visited the nVCC site. Following a welcome and introduction, the Executive Medical Director and senior colleagues provided an overview of the Trust's divisions, responsibilities and services, in addition to ongoing work across the system, such as Transforming Cancer Services (including progress of the new Velindre Cancer

Centre) and the Trust's Research & Development ambitions. We also discussed the Trust's role in supporting the whole of Wales to improve Cancer Outcomes nationally.

Welsh Cancer Alliance

Also on the 3rd of September, I met with the leads of all of the charities who work to support patients and families affected by Cancer in Wales and had a very good conversation about their priorities for the future. I thanked them for their ongoing work, and we discussed how they can engage more directly with our plans at a national level through the Welsh Cancer Network.

Meeting with CEO of Varian

On the 6th of September I had a very helpful introductory meeting with the global head of Varian, one of the world's leading producers of Radiotherapy equipment and the supplier of our latest LINAC fleet @ Nevill Hall and nVCC. We discussed how Velindre Cancer Service was one of the largest cancer services in the world, and how we might explore greater partnerships between our two organisations as we develop our research bunker and programme in Radiotherapy and Diagnostic Imaging.

Sue Tranka site visit to VCS @ Nevill Hall

On the 12th September, we welcomed Sue Tranka, Chief Nursing Officer for Wales, to the new Velindre Cancer Service @ Nevill Hall – Satellite Radiotherapy Unit. In partnership with Aneurin Bevan University Health Board, the unit is fully equipped with the latest Varian Ethos Linacs and Siemens Healthineers Diagnostic Imaging Machines. The visit was also joined by Velindre Radiotherapy colleagues and Director of Nursing.

Maggie's Cancer Charity

On the 16th September, I attended an event hosted on behalf of Maggie's Charity, at Sir John Soane's Museum, London. I had the opportunity to meet the Chief Executive of Maggie's, the Director of Sir John Soane's Museum and the son of Richard Rogers, Architect, who designed the Royal Marsden Maggie's Centre for

patients. This was followed by a Q&A session and private viewing of the '*Richard Rogers: Talking Buildings*' exhibition.

Velindre prides itself on long-standing, good working relationships with charity partners across NHS Wales and beyond, including third sector organisations. We are also keen to ensure the work we do with Maggie's is fully supported as we plan our move to our new centre.

Research and Innovation Showcase Event

On September 17th, I attended the Research and Innovation Showcase Event at the Noddfa Building, to celebrate the work that was supported through the establishment of the Advancing Radiotherapy Fund (funded by VCC Charitable Funds and Moondance), and the Lucas and Probert Funds. The Advancing Radiotherapy Fund has allowed the Cancer Centre to develop a programme of activity which will enable the development of further Radiotherapy technology for the benefit of patients across Wales. The Lucas fund supported the development of an infrastructure to deliver Radiotherapy research and developments, and the Probert Fund has enabled Head and Neck Cancer Research and developments.

Cardiff Cancer Research Partnership Launch

Also on the 17th September, I attended and presented at the Cardiff Cancer Research Partnership Launch at Cardiff University. The Partnership is a groundbreaking collaboration between the Trust, Cardiff and Vale University Health Board and Cardiff University, aiming to discover pioneering cancer research studies and explore opportunities for involvement. The afternoon also included a session by Denise Calder, Director of Strategic Partnerships at Cancer Research UK Scotland Centre, who delivered a keynote talk titled 'A Successful NHS-Academic Partnership in Action'.

NHS Confederation – CEO Peer Forum

On the 23rd of September I will join other NHS CEOs at an event in London to explore how, as peers, we can support and learn from one another in addressing the challenges facing healthcare across the UK.

Bilaterals with NHS CEOs

Over the month of September I held direct discussions with the CEOs of C&VUHB and ABUHB on progress in our joint working. I also attended a number of Southeast Region and National CEO fora, discussing system priorities and agendas, plans to establish a South East Joint Committee and plans to conduct public accountability meetings with Ministers later this year.

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 outined 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 JULY 2025/26	
DATE OF MEETING	25/09/2025
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE, INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	ASSURANCE
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Peter Gorin, Head of Strategic Planning & Performance
PRESENTED BY	1. Lauren Fear, Director of Place, Portfolio and Partnerships obo Carl James, Executive Director of Strategic Transformation, Planning and Digital 2. Anne Carey, Chief Operating Officer 3. Sarah Morley, Executive Director OD & Workforce 4. Carl Taylor, Chief Digital Officer 5. Lauren Fear, Director of Place, Portfolio and Partnerships 6. Matthew Bunce, Executive Director of Finance
APPROVED BY	Lauren Fear, Director of Place, Portfolio and Partnerships

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 July 2025.

RECOMMENDATION / ACTIONS	**The Trust Board is asked to note the Performance Management Framework detailed analysis for July 2025 for ASSURANCE.**

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
WBS SLT / Performance Review	13/08/2025
VCS SLT / Performance Review	20/08/2025
Executive Management Board	26/08/2025
Quality, Safety and Performance Committee	11/09/2025
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The report has been considered at the VCS and WBS Performance Review meetings, Executive Management Board and Quality Safety and Performance Committee.	

The following matters of note were discussed at Executive Management Board and were highlighted to the Quality, Safety & Performance Committee.

- There has been an increase in the number of regulatory incident reports at the Welsh Blood Service. Management action has been to carry out a number of in-depth reviews to understand this. The Divisional Director at WBS has added some supporting information in this regard.

- The requirement remains to develop more Quality metrics as part of the PMF. This remains the responsibility of the Data and Insights team, informed by the professional lead of Director of Nursing, AHP's & Healthcare Scientists. The automation work has been paused to ensure the data and insight resource is focused on ensuring the correct metrics are in place and then automating from this agreed baseline.

- The Director of Nursing, AHP's & Healthcare Scientist informed EMB that it had been identified that there may have been some inconsistency in reporting pressure ulcers – a detailed piece of work is underway to correct this and it may lead to an increase in numbers in the PMF.

The following matters of note were discussed at the Quality, Safety & Performance Committee:

- The Chief Operating Officer highlighted that additional KPIs from the newly developed Patient Tracker List, to provide insight across the patient pathway, had been discussed at the Regional Cancer Programme Board. The plan to include this data in the Trust PMF is being developed and there will be a further update in the November governance cycle.

- Radiotherapy performance was challenged by Committee Members and assurance provided on the clinical review and prioritisation processes for those patients outside of the expected time for treatment. The further work on resilient radiotherapy performance will continue to be highlighted to the Committee.

- It was highlighted by Committee Members that the report does not include the clear actions and expected timescales to reach the next level of assurance. It was agreed that this would be worked through by each of the areas and included in the next report.

- The level of assurance for Workforce and Well-being was challenged by Committee Members, on the basis that sickness levels had been stagnant for some time, despite the various actions taken. It was agreed by the Committee to decrease the assurance rating from a 4 to a 3 on this basis. In addition it was agreed that there would be further detail on the targeted interventions for PADR compliance and the impact to date of these actions, would be shared with the Committee in the next report.

- The increase in Violence and Aggression incidents was highlighted to the Committee and the Committee was informed that further insight would be provided following a deep dive.

- It was confirmed that the Finance report would be included as part of the PMF going forwards, with the statutory reporting elements appended.

7 LEVELS OF ASSURANCE	
Velindre Cancer Service [Trend – stable at 3]	**Level 3 - Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes**
Welsh Blood Service [Trend – stable at 3]	**Level 3 - Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes**
Workforce & Wellbeing [Trend – decreased from 4 in September 2025]	**Level 3 – Actions for symptomatic, contributory and root causes, impact from actions and emerging outcomes**
Digital Services [Trend – decreased from 4 in May 2025]	**Level 3 - Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes**
Estates, Infrastructure and Sustainability [Trend – stable at 3]	**Level 3 – Actions for symptomatic, contributory and root causes, impact from actions and emerging outcomes**
Health and Safety [Trend – stable at 4]	**Level 4 – Increased extent of impact from actions**
Financial Performance [Trend – stable at 4]	**Level 4 – Increased extent of impact from actions**

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

1. SITUATION AND BACKGROUND
VELINDRE NHST PERFORMANCE REPORT FOR JULY 2025

PMF Work Packages Progress

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

Work Package	Work Package Summary	Target for Completion	Progress Update	Lead(s)
1 Current Performance Measures and 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.	27th 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.	30th 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)

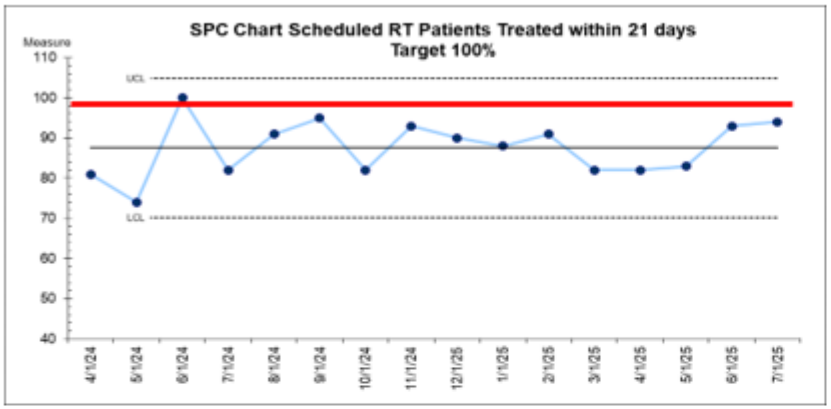
4 Exception / Threshold Reporting	To agree an approach in relation to exception / threshold reporting.	29th November 2024	**Completed** - An approach has been agreed to include exception reporting data only for the Trust Executive Management Board, the Trust Quality, Safety and Performance Committee 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.	29th 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~~ *New date to be agreed following Data and Insights team prioritisation*	**Revised Target** – The Head of Planning and Performance has continued to work closely with the Data & Insight and Performance Team with regards to the PMF automation recommendation. Progress has been made with circa 85 of 125 measures being automated. However, resource availability and high demand in the Data, Insights and Performance team to finalise the remaining work and prepare the transition to an automated environment is part of a prioritisation exercise by the Executive.	Head of Strategic Planning and Performance Trust Business Information PMF lead

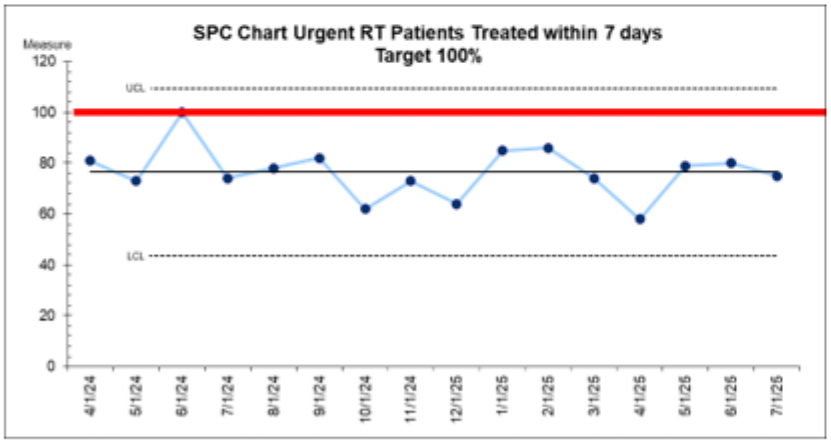
7 Pyramid Reporting	To agree with the Executive Management Board a preferred way for reporting within the IMTP.	21st December 2024	**Completed** – It has been agreed that, from January 2025, the PMF will be based upon 'exception only' reporting and that the EMB will make this assessment based upon the 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.	31st July 2025	**Completed** – 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 held with key service leads to take this forward. WBS, Sustainability and Health and Safety benchmarks will be shared in a first version of the Benchmarking table in Section 3 on the report shared with QSPC, using current WBS benchmarks for illustration. This appendix will continue to develop and will include insight from cancer accreditations programmes for instance in the future. The development package is closed to start the process of embedding benchmarking as part of the BAU process.	Head of Strategic Planning and Performance

1.1 Radiotherapy

Radiotherapy Waiting Times

July 2025





Updates on Last Month:

- Schedule performance was 94 %, Elective Delay was 99%, Urgent SC was 75 % and Emergency was 100% within 2 days.
- Longest wait for scheduled was 39 days one due to rescan required (complex patient)
- Pre-treatment CT capacity remained constant at 8.5 hours per day totally 17 hours at VCC Cardiff and ramp up of hours at V@NHRU as per plan.
- Data warehouse issues have been resolved with more accurate data provided.
- July validation has been done for the fourth full month of using the paperless ARIA referral form and has provided improvements in the validation process of the data.

Key Issues / Risks

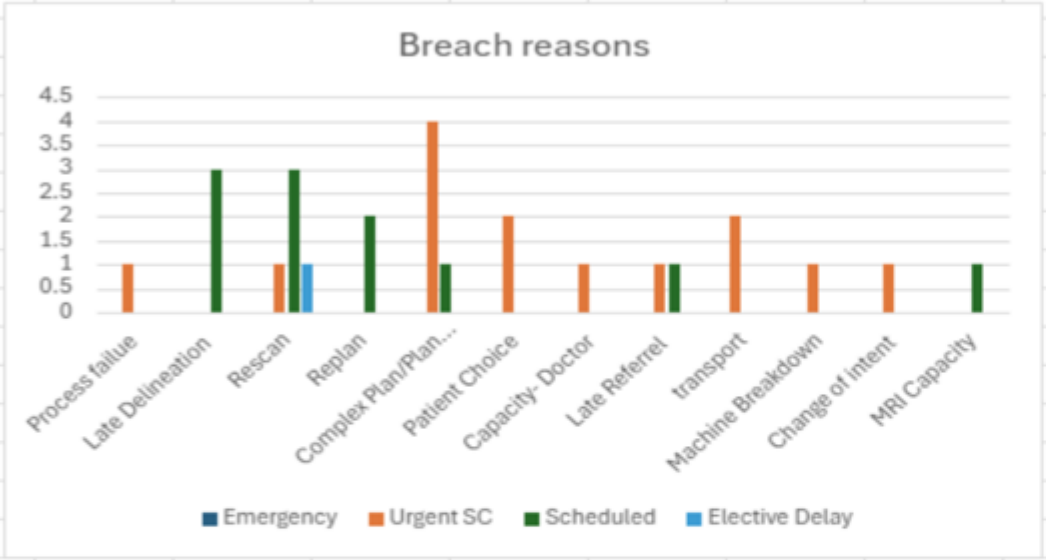
- There is a risk that the development and implementation of capacity utilisation and reporting service improvements such as Carepath, Paperless and Aria InSights may be impacted by demands from other major change programmes.
- There is a risk that Planned Capacity for the period to September will be impacted due to increased demand on staff resource through implementation of paperless.

Forecast / Next Month

- Capacity has been extended where possible through the provision of one locum radiographer.
- Planned Linac Capacity is 82.5 hours over VCS. No increase in activity due to paperless implementation and ramp of V@NHRU
- 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.

Radiotherapy - Breach data

July 2025



RT Pathway Reasons
Process Failure- 1
Late delineation- 3
Rescan- 5
Replan- 2
Complex plan/Plan required- 5
Patient Choice- 2
Capacity DR- 1
*Late Referral- 2
Transport- 2

**Change of intent – 1
Capacity MRI – 1
Machine Breakdown- 1

*Late referral – this is when Referrers submit a radiotherapy request late.

** New category highlighted as Change of Intent – this is when Referrers submit a Referral as Scheduled then changed to USC.

Action/Mitigation underway

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

Due to undefined delay in the go-live of the VCC@NH RU, discussions are in place to ensure capacity is available at VCC Cardiff

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 September 2025, mitigation due to issues experienced with paperless implementation

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

The implementation of Aria Core Insights through IRS will result in more sophisticated pathway analysis and targeted improvement proposals

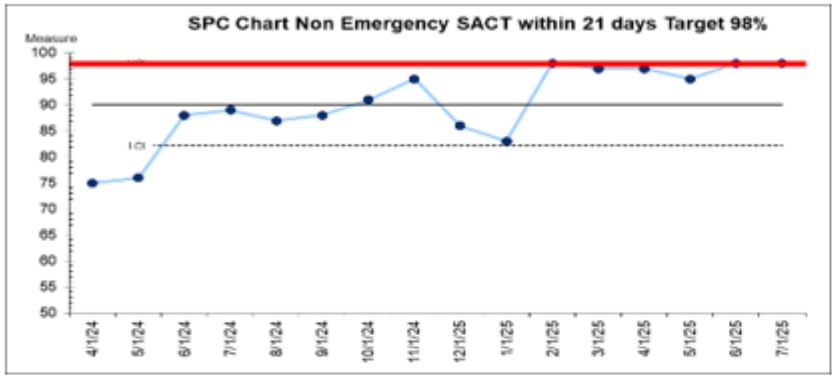
Activity Reporting
·Income – Review of EHFRT – Prostate under discussed with commissioners on 25/6/25- awaiting formal decision
·Capacity utilisation, inline with Velindre@NH RU ramp up
·Development in readiness to Aria Core InSights (Oncology Specific Analytics) implementation
·Development of activity reporting for Brachytherapy – following paperless go live
·Development of activity reporting – following paperless go live

Assurance
Where demand exceeds capacity, all referrals are submitted through escalation for clinical prioritisation.
All failures to meet waiting times targets are investigated at pathway level to identify delay reasons and have a clinical review. Themes are logged and mitigations developed to offset as far as possible before fleet replacement

1.2 SACT

SACT Non-Emergency Waiting Times

July 2025



Action / Mitigation Underway:

- Work has resumed on the SharePoint tool a proposed soft launch has been set for Oct 2025.
- Planning discussions underway for review of DTT process, to reduce number of breaches & accurately record patient waits, ensuring VCS is comparative to Wales. National meeting to agree standards being arranged.
- Introduction of a new escalation SOP for booking of OPA's is working well with only 1 patient breach being attributed to booking issues. The performance manager is investigating the root cause of this breach and will feed back to the staff member..
- 8 non-emergency SACT breaches recorded in July with compliance to the SACT non-emergency standard of 98% holding its position from June.

Updates on Last Month:

- General PTL now being prepared for 'Go Live' and work has commenced in the SACT PTL.
- During the next phase work will commence with the Health Boards to streamline patient information transfer to reduce pathway and treatment delays.
- 2 ACPs recruited, 1 has started in Breast and will be extending scope of practice into Gynae from September. The 2nd ACP will be starting in September and will be supporting Lung and Melanoma.
- Working group remains committed to maximising capacity across the outreach estate through continuous evaluation and innovation.
- Longest wait for treatment (from Outpatient appointment) was 1 patient who waited 29 days – breach due to patient requiring MUGA scan before treatment.

Key Issues / Risks:

- **Referral Rates vs. Breaches** - breach analysis are themed with ongoing to actions incorporated into patient pathway improvements.
- **Digital** – DHCW to e deliver Hospital Initiated Referrals (**HIR**) into VCS to remove risk of 'unknown unknowns'
- **Patient Pathway Visibility** - mitigations in place for the lack of visibility of patients with Cancer PTL (SACT view)
- **Workforce recruitment** - Bespoke and targeted recruitment processes, nursing roles filled, medical roles recruitment underway. Gap analysis in progress for SACT Scheduling Team
- **Data quality** - identifying these issues is enabling root cause analysis and interventions to resolve matters

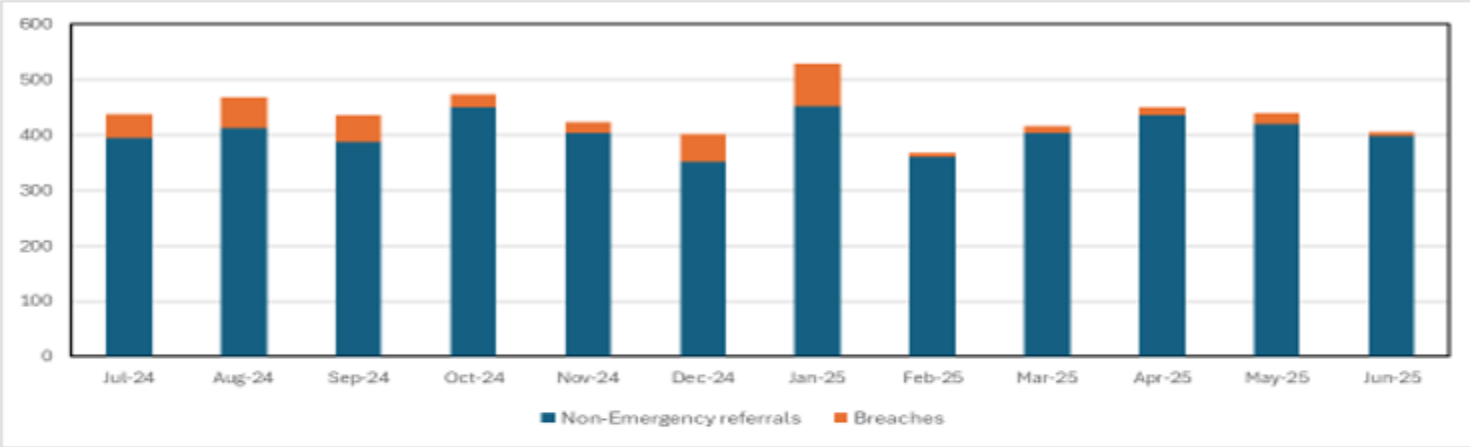
Forecast / Next Month:

- To review referral rates by HB and SST Vs Breaches.
- Review clinic models and templates, with learning for Pain Point Audit.
- To review September forecasted performance

1.3 Welsh Blood Service

Breach data

July 2025



Number	Reason	Action
1	Treatment date to start after MUGA	No mitigation – To review MUGA timing issues with CD.
1	Patient choice awaiting second opinion from the Marsden.	No mitigation
1	Booking Error	Fed back to performance manager for investigation
5	Requested start dates, no clear documentation in WCP	No mitigation – (Missing data relates to rationale for 'Start date' being requested outside treatment intent target timeframes)

WBS PMF – Key Improvements for July 2025

Gwasanaeth Gwaed Cymru
Welsh Blood Service

Red Cell Serology Turnaround Times

- **Target met again in July 2025** – only the 2nd time since June 2024 – marking a major milestone in service performance.
- Lean-led transformation project identified root causes, reduced waste and streamlined processes.
- Staff actively engaged and empowered, driving sustainable change.

Time Expired Platelets

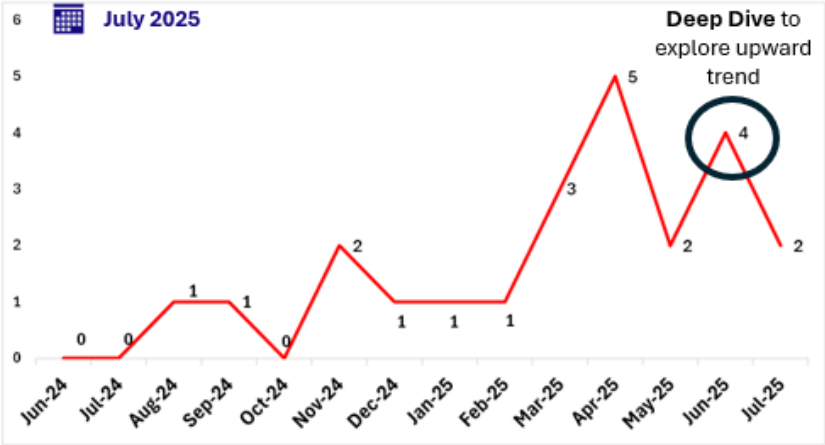
- **Wastage reduced from 19% in June to 8% in July**, surpassing the maximum target of 10% for the first time in 4 months.
- Evidencing early impact from the new platelet planning tool supporting pooled platelet manufacturing decisions.

Incidents reported to Regulator / Licencing Authority

- **No incidents reported in July 2025**, breaking the upward trend seen since February 2025.
- Deep dive in June 2025 revealed most issues stem from **donor eligibility assessments** and **Laboratory transcription errors**. Donor eligibility screening has been recognised nationally by all UK blood services as an area for improvement.
- A digital Donor Travel Screening tool trial has shown a marked reduction in travel-related screening errors since May, and scoping work is underway to introduce medicines screening functionality. Additional experienced resource has been allocated to support RCI laboratories whilst a full review of processes to reduce complexity is completed.

WBS Incidents Reported to Regulator / Licencing Authority

Gwasanaeth Gwaed Cymru
Welsh Blood Service



No further incidents were reported in July 2025, following an upward trend evidenced since February 2025; a deep dive was undertaken in June 2025 to investigate underlying causes and inform mitigation.

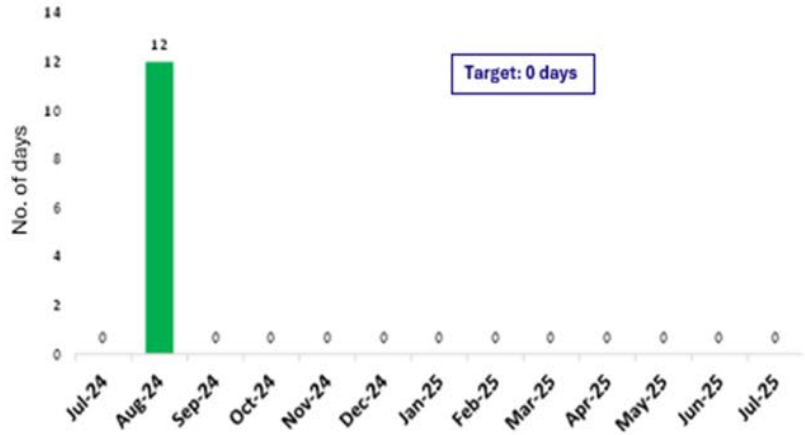
Key findings from Deep Dive in June 2025:

- Donor screening errors (travel, medication & medical history) have been a significant cause of incidents reported; a digital tool is being piloted to support eligibility decisions following travel and reported errors have already reduced with only 2 reports in 2025. Scoping work is now underway to include medication and medical history screening into the tool.
- Laboratory Transcription errors stem from outdated digital systems ,complex processes and manual data transcription; Process reviews and Lean initiatives aim to reduce transcription errors in the immediate term until the All-Wales LIMS project is in place to remove manual data entry steps. Additional scientific resource has been allocated to support.

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

Gwasanaeth Gwaed Cymru
Welsh Blood Service

July 2025



Key Issues / Risks:

- There is a risk that fluctuations in hospital demand across different blood groups may not be matched by corresponding collection.

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 – Qtr. 2.
  - Collaborating with Health Technology Wales around recruiting and retaining younger donors – Qtr. 3.

Updates on last month:

- All clinical demand was met for O, A & B+ groups.
- Excellent stock levels across blood groups in July 2025.

Forecast / Next Month:

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

Quality Assurance – Incidents & Audits

July 2025

Gwasanaeth Gwaed Cymru
Welsh Blood Service

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

- ⬇ **2** exceeding target date for closure (in reporting month)
- ➡ **0** that remain overdue at month end
- ⬆ **11.9%** overdue actions from open incident action plans (target: <5%)

Quality (GMP) Incidents:

- ⬇ **9** exceeding target date for closure (in reporting month)
- ⬆ **5** that remain overdue at month end
- ⬆ Age of oldest open overdue incident – **34 days (against ??)**

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

- ⬇ **2** from internal audits in the last month
- ➡ **0** from external audits in the last month
- ⬆ **12%** overdue actions from open audit action plans (target: <5%)

Mitigations in place:

- Overdue actions escalated to the SLT & Integrated Quality & Safety Group to increase visibility, accountability and early intervention.
- Recovery plan being developed to address overdue actions.
- New Lead Nurse position will play a pivotal supporting role (recruitment in September 2025).

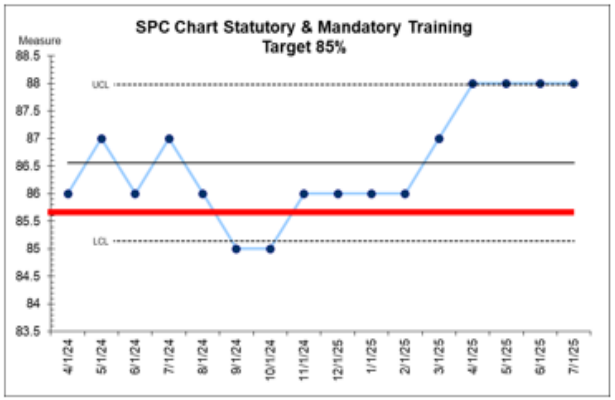
Key:

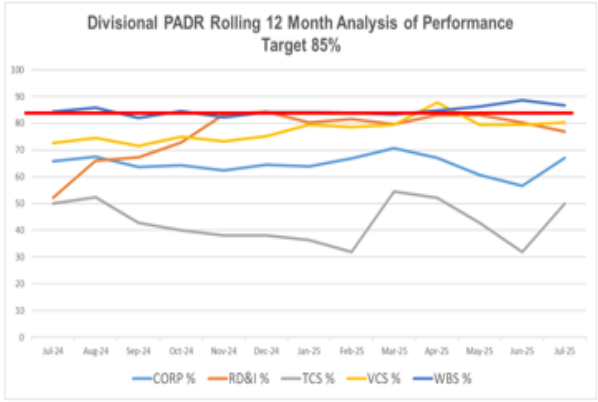
- ⬆ Increase in performance
- ➡ Performance remained the same
- ⬇ Decrease in performance

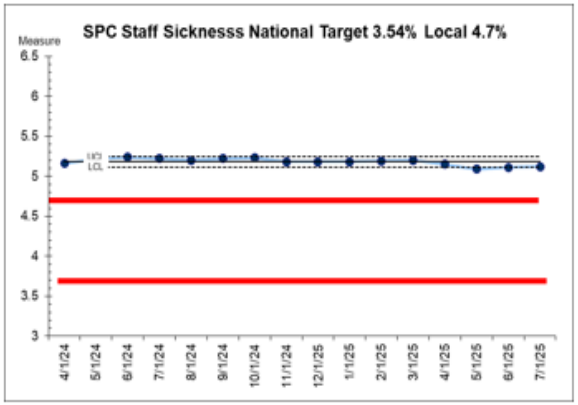
1.4 Workforce and Wellbeing

Workforce, Wellbeing & Organisational Development

July 2025







Updates on Last Month:

- **PADR** – breakdown of PADR by divisional area notes areas of lower compliance. Targeted interventions in place to support improvement
- **Sickness** – Absence analysis in hotspot areas undertaken to identify causes of sickness with targeted intervention plans in place
- **S&M Training** – hotspot areas targeted with improvement plan in place

Forecast / Next Month

- **PADR** –With engagement in targeted interventions then improvement is anticipated
- **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
- Targeted action plans in hotspot areas in place to address specific issues

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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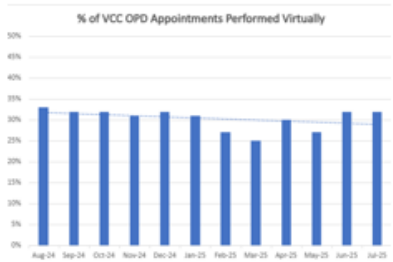
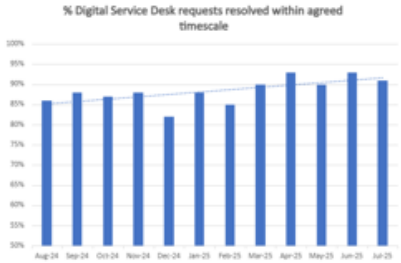
1.5 Digital Services

Digital Services

July 2025





Updates on Last Month:

- Service performance – Our performance remains above the agreed percentage for both Incidents and Requests. However, there was a slight increase in incident closure performance and a decline in request closure performance.
- % of Virtual OPD consultant appointments performed continues at 32%, no % target yet agreed for virtual appointments. (Phone, Attend Anywhere)
- x1 National significant incident raised in July, issue relating to Welsh Clinical Portal outage. There is however a reduction to 8 incidents in a rolling 12-month.

Forecast / Next Month:

- Digital Service improvement work ongoing to increase automation of tasks across the Digital Service Desk, to ensure current performance gains can be sustained over the long-term.
- Installation of capital funded technical refresh digital client devices and network/server infrastructure in progress. Including migration from Windows 10 to Windows 11.
- **Cyber Security** - Publish the new CAF audit and review Incident response plan

Action / Mitigation Underway:

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

Key Issues / Risks:

- Capacity to complete technical refresh and infrastructure projects on time due to demand. Extra resources now agreed to assist with the Windows 10 to 11 upgrade.

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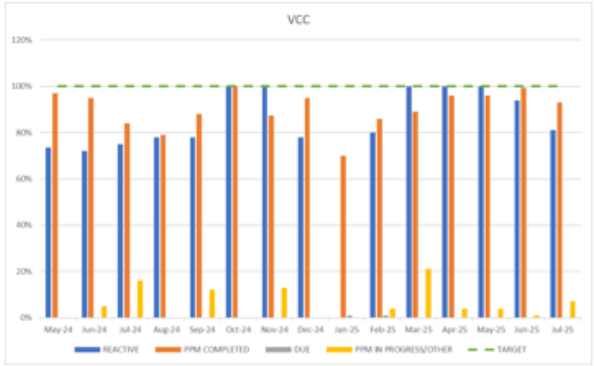
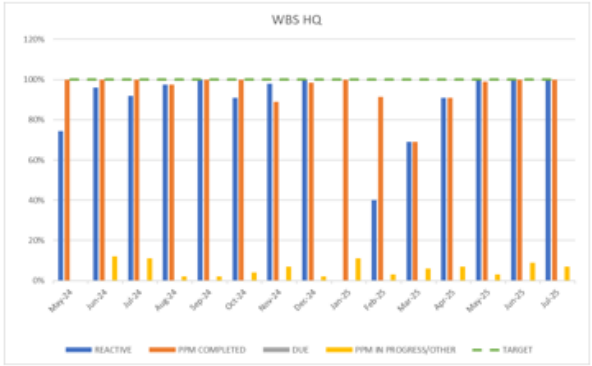
1.6 Estates Infrastructure and Sustainability

Estates and Infrastructure

July 2025





Forecast / Next Month:
VCS – 93% PPM – Reactive – 81%
WBS HQ – 100% PPM Reactive 100%
Trust HQ – 100% PPM Reactive – 100%
Dafen – 100% PPM Reactive – 100%
Wrexham – 98% PPM Reactive – 90%
Bangor – 100% PPM Reactive – 100%

Action / Mitigation Underway:
•Manually cross-referencing PPM tasks to ensure system continuity of work PPM tasks to be distributed across all sites that have not been uploaded to new CAFm system.
•Monthly Meeting Scheduled 13th August with Synbiotix to update road map with issues that have been identified on CAFm system.

Forecast / Next Month:
• 128PPMs planned for VCC
• 53 PPMs planned for WBS sites.

Key Issues / Risks:
• Reporting function on Symbiotix currently causing issues. Road map is due to be issued by software provide by end of August.

•Unable to meet PPM benchmark compliance at VCS due to Sickness and AL.

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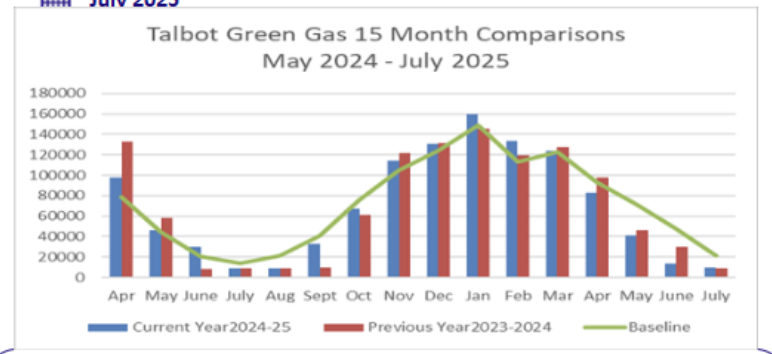
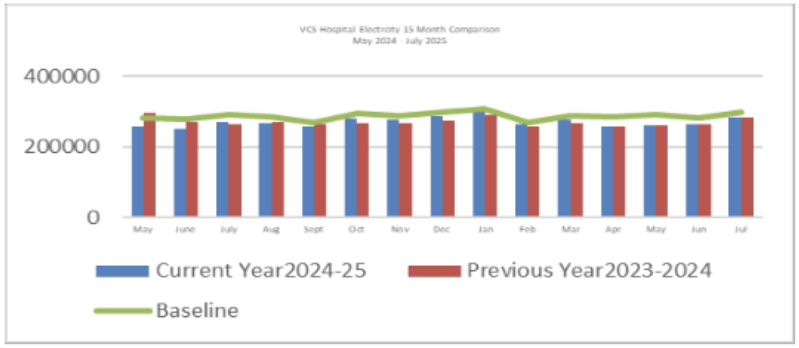
Estates Sustainability

Gas– WBS Total

July 2025



Electricity – VCS



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 (e.g. increase in electricity consumption in Trust HQ)
- Staff engagement events undertaken highlighting initiatives to reduce consumption

Forecast / Next Month:

- 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
- Installation and beginning of usage of electric vehicle charging units across 5 sites – anticipated increase of electricity

Action / Mitigation Underway:

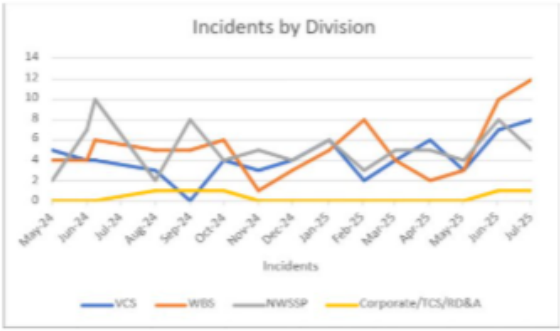
- Internal Energy Management Audits of departments ongoing
  - LED lighting survey completed – identified areas for improvement, will include motion sensory & day light sensors
  - Renewable feasibility study to be undertaken in next quarter
- Monitoring of consumption ongoing through Estates Management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

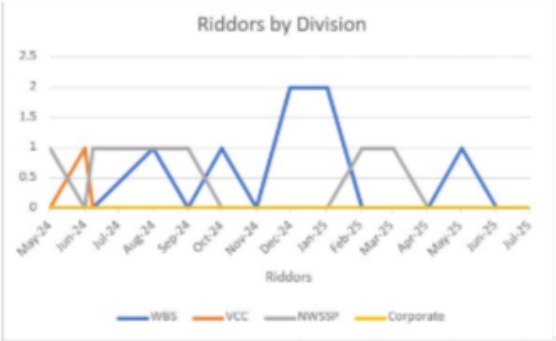
Key Issues / Risks:

- 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.

Health & Safety

July2025





Updates on Last Month: Total of incidents
NWSSP - 5
VCS - 8
WBS – 12
Corp - 1
Riddor – 0

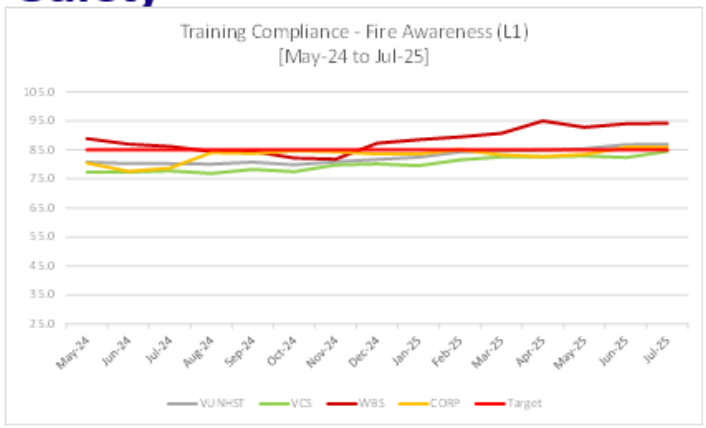
Forecast / Next Month:
NWSSP - Issue MSDS and DSE Survey in September 2025
VCS – Contractor training to commence for Patient manual Handling / Go Live HS&F Intranet page
WBS – Go live with the Health, Safety & Fire Intranet Page

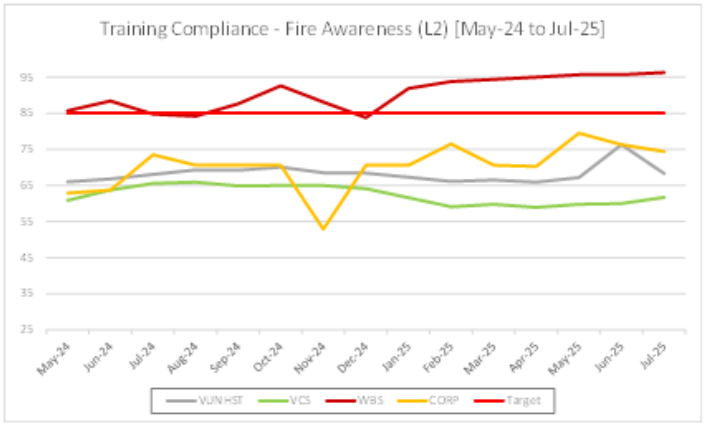
Action / Mitigation Underway:
NWSSP - Removal of archiving from Companies House Repository area due to RAAC.
Revised HSG65 question set issued in readiness for new financial year.
VCS – Await feedback from the Radon Monitors and consider engineering solution
WBS – Meeting set up to look at the accident 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 – Attendance to the Patient manual handling training delivered by contractors
WBS – Improve Datix incident reporting process to avoid late reporting

Fire Safety

July 2025





Updates on Last Month:

STRATEGIC
- Continuation with development of fire safety protocols
- Submission annual fire safety audit further delayed until early August 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
- Work with BDT on electrical safety at venues.

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

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.

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

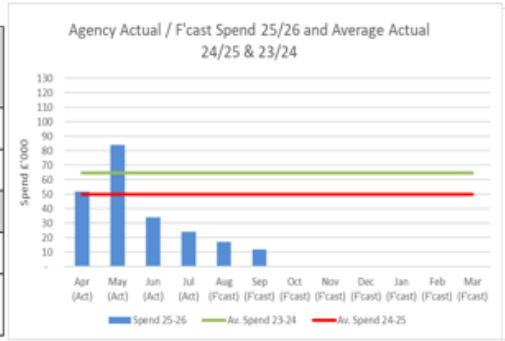
Key Issues / Risks:
- Continued low compliance for fire safety training [VUNHST]
- Need for evacuation drills and exercises in all Services
- Closure of risks identified in fire risk assessments / further education on new FARS fire risk assessment module
- Alignment of emergency evacuation procedures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

1.7 Finance

Financial Performance

July 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	Mar 26
Actual Cum £k	42	0	9	2	7								
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**	**Mar 26**
Actual Cum £m	35.072	0.915	1.565	2.594	3.880								
Target £28.824m CEL		0.915	1.565	2.594	3.880								



Updates on Last Month:

- The Trust has reported a small year to date underspend of £0.007m at the end of July 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 (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).
- All savings schemes are now RAG rated green, although there remain challenges to delivery.

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.
- Savings plans are expected to continue to deliver, and cost pressures that are emerging will need to be mitigated.

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
- VCS Service Transformation Investment
- Ability for Divisions to manage new / emerging Cost pressures

2. IMPACT ASSESSMENT

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

The duty of quality requires quality-driven decision-making for all strategic decisions. The duty of quality is operationalised through the Heath and Care Quality Standards. Therefore, when making decisions about healthcare services, NHS organisations are required to consider the impact of that decision on the Health and Care Quality Standards.	The QIA tool should be completed to support any proposal for a strategic decision to be made and be presented with the proposal to the appropriate decision-making forum. The QIA tool does not replace the need for the proposal; it accompanies it. As a minimum, decisions made by the Board or by Committees of the Board are considered strategic and should be assessed for their impact on Quality through the lens of the Health and Care Quality Standards. This culture and discipline of quality-driven decision-making should also permeate the organisation to more broadly promote good decision-making practice.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required *[In this section, explain in no more than 3 succinct points why an assessment is not considered applicable or has not been completed].* **Click or tap here to enter text**

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

• A Wales of Vibrant Culture and Thriving Welsh Language -Promoting and protecting culture, heritage and the Welsh language, encouraging people to participate in the arts, and sports and recreation. ☐ • A Globally Responsible Wales – Consideration of whether an action may make a positive contribution to global well-being ☐	
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	This section should outline the financial resource requirements in terms of revenue and/or capital implications that will result from the Matters for Consideration and any associated Business Case. Narrative in this section should be clear on the following: **Source of Funding**: Choose an item Please explain if 'other' source of funding selected: Click or tap here to enter text **Type of Funding:** Choose an item **Scale of Change** Please detail the value of revenue and/or capital impact: Click or tap here to enter text **Type of Change** Choose an item Please explain if 'other' source of funding selected: Click or tap here to enter text
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	[In this section, explain in no more than 3 succinct points what the equality impact of this matter is or not (as applicable)].

ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text
	[In this section, explain in no more than 3 succinct points what the legal implications/ impact is or not (as applicable)].

3. RISKS

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

TRUST BOARD

FINANCE REPORT FOR THE PERIOD ENDED 31ST JULY 2025 (M4)

DATE OF MEETING	25/09/2025
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 July 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, including Hywel Dda UHB which was signed on 12th August 2025. • The Trust has agreed with Commissioners an uplift to LTA values of 1.77% which amounts to £1.548m in 2025-26 less £0.824m (previously £0.483m) loss in income recurrently from Hywel Dda UHB. This is an increase of the £0.342m from the £0.483m 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£200k 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 had agreed to undertake a more detailed review of the SACT Business Case submitted as part of the IMTP process, there has been a strong indication that no commitment will be made this year and therefore the case will be included in the 2026/27 IMTP process for consideration. • 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.

- This month a new cost pressure is highlighted within the finance report relating to BMA contract negotiations of c£0.400m.

  The ability to maintain a balanced underlying position is continuing to prove to be a challenge due to the significant cost pressures and risks which have materialised since the submission of the IMTP as described in the main body of the report.

3. Key Financial Targets / KPIs

- The Trust has reported an underspend of £0.007m as at 31st July 2025 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. • All savings schemes are now RAG rated green and need to be carefully managed to ensure delivery is as forecast. Budget Holders and service leads in the Divisions and Corporate departments are expected to find alternative savings schemes to implement and deliver if forecasts reduce.

RECOMMENDATION / ACTIONS	**The Trust Board** is asked **NOTE** the contents of the July 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	**26/08/2025**
Quality, Safety & Performance Committee	**11/09/2025**
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Noted	

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 – July 2025
Appendix 2	nVCC Finance Report – July 2025

1. SITUATION / BACKGROUND

1.1 The attached report outlines the financial position and performance for the period to the end of July 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	0.005	0.007	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	1.287	3.880	28.640
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	97.1%	96.5%	95.0%

2.2 Revenue Budget

The core Trust has reported an in month underspend of £0.005m leading to a **year to date underspend of £0.007m** position as at 31st July 2025.

The position remains in line with a year end forecast outturn of **breakeven**, however there are risks associated in achieving this which are detailed in the report.

The ability to maintain a balanced underlying position is however now proving to be a challenge due to the significant cost pressures and risks which have materialised since the submission of the IMTP as described in the main body of the report.

Savings

All savings schemes are now RAG rated green, although there remain challenges in meeting the full value currently planned. The value of risk will be reassessed and quantified in quarter 2.

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£0.200m shortfall against the full year target. This has reduced from the previous estimate of c£0.400m shortfall in last month's report.

In addition, a new risk has emerged this year whereby the forecast activity income in relation to Velindre @ Nevill Hall Radiotherapy Unit (RSU) 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.

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. All LTAs for 2025-26 have now been signed, including the Hywel Dda UHB LTA.

The Trust has agreed with Commissioners an uplift to LTA values of 1.77% which amounts to £1.548m in 2025-26 less £0.824m loss in income recurrently from Hywel Dda UHB. This is an increase of £0.342m 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£0.200m 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 had agreed to undertake a more detailed review of the SACT Business Case submitted as part of the IMTP process, there has been a strong indication that no commitment will be made this year and therefore the case will be included in the 2026/27 IMTP process for consideration.

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 July 2025 the Trust (core) achieved a compliance level of 97.1**%** (June 95.1%) of Non-NHS supplier invoices paid within the 30-day target. The Trust year to date compliance (including hosted) is 97.6% compared to the target of 95%.

2.4 Reserves

The financial strategy for 2025-26 again included an emergency reserve of £0.500m which was accommodated on the assumption that all expected income is received, planned savings schemes are delivered and new emerging cost pressures managed. This month, £0.345m of the reserve has been allocated to mitigate the unfunded element of the increase in Employer's National Insurance contributions.

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, emerging cost pressures, 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 LTA income risk, activity risk associated with the Radiotherapy Satellite unit (£0.500m - £0.750m), the Trust Commissioners not supporting service investment / Growth in VCS, and the management of operational cost pressures including those the additional WRP risk share contribution.

There are several opportunities highlighted in the finance report including utilisation of the uncommitted investment reserves and the remaining 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. In July 2025, WG noted their position in correspondence to the Trust, including that the current proposed costs of c£60m is not considered supportable. WG also stated that as the scope of works is now expanding beyond infrastructure to include a wider lab modernisation together with the acquisition of the Wound Centre, and OBC setting out all the options would be required. How the additional revenue requirement of that option would be afforded would also need to be explained.

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** Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed, and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). *[Please include narrative to explain the selected domain in no more than 3 succinct points].* **Click or tap here to enter text**

QUALITY IMPACT ASSESSMENT *The duty of quality requires quality-driven decision-making for all strategic decisions. The duty of quality is operationalised through the Heath and Care Quality Standards. Therefore, when making decisions about healthcare services, NHS organisations are required to consider the impact of that decision on the Health and Care Quality Standards.*	Not required - not a strategic decision The QIA tool should be completed to support any proposal for a strategic decision to be made and be presented with the proposal to the appropriate decision-making forum. The QIA tool does not replace the need for the proposal; it accompanies it. As a minimum, decisions made by the Board or by Committees of the Board are considered strategic and should be assessed for their impact on Quality through the lens of the Health and Care Quality Standards. This culture and discipline of quality-driven decision-making should also permeate the organisation to more broadly promote good decision-making practice.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required *[In this section, explain in no more than 3 succinct points why an assessment is not considered applicable or has not been completed].* **Click or tap here to enter text**

TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT

The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated. Please indicate whether any of the matters outlined in this report impact the Trust's Wellbeing goals:

YES - Select Relevant Goals below

If yes select the relevant goals:

- A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities. ☒
- A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic, and ecological resilience. ☐
- A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health ☐
- A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances ☐
- A Wales of 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 £0.007m** for July 2025, which is currently in line with the IMTP plan. **Source of Funding**: **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Choose an item** **Scale of Change** Please detail the value of revenue and/or capital impact: **Click or tap here to enter text** **Type of Change** Choose an item Please explain if 'other' source of funding selected: **Click or tap here to enter text**
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	[In this section, explain in no more than 3 succinct points what the equality impact of this matter is or not (as applicable)].
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text
	[In this section, explain in no more than 3 succinct points what the legal implications/ impact is or not (as applicable)].

4. RISKS

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

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	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	

Gwasanaeth Canser Felindre
Velindre Cancer Service

GIG CYMRU NHS WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

Welsh Blood Service
Gwasanaeth Gwaed Cymru

FINANCIAL PERFORMANCE REPORT

FOR THE PERIOD ENDED 31 JULY 2025

TRUST BOARD
25/09/2025

1. Introduction

The purpose of this report is to outline the financial position and performance for the month ended 31st June 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

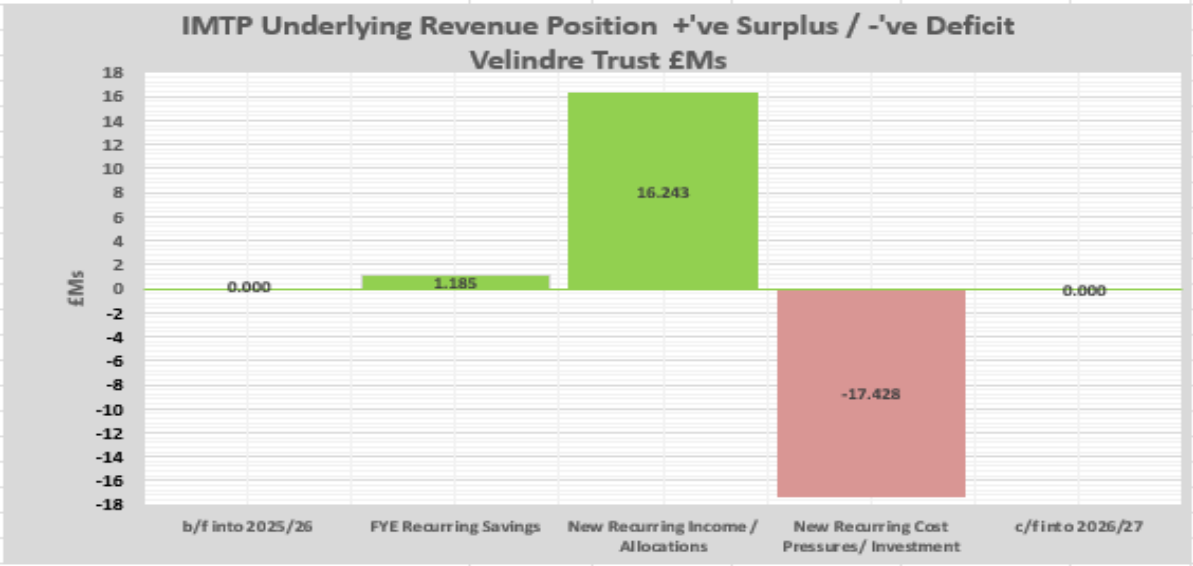
The draft Trust IMTP Financial Plan for the period 2025-2028 was set within the following context:

- 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	0.005	0.007	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	1.287	3.880	28.640
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	97.1%	96.5%	95.0%

Performance against Planned Savings Target

	Unit	Current Month £m	Year to date £m	Year End Forecast £m
Efficiency / Savings	Variance	(0.057)	0.024	0.000

Revenue

The Trust has agreed with Commissioners an uplift to LTA values of 1.77% which amounts to £1.548m in 2025-26 less £0.824m (previously £0.483m) loss in income recurrently from Hywel Dda UHB. 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£200k which will be removed recurrently in 2026-27. The Trust is currently 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 **£28.824m**. This represents all Wales Capital funding of **£26.824m**, and Discretionary funding of **£2.000m.** The

Trust reported total Capital spend to 31st July 2025 is £3.880m, 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:

	Approved CEL 2025/26 £m	YTD Spend £m	Budget Remaining @M4 £m	Full Year Forecast Spend £m	Year End Variance 2025/26 £m
All Wales Capital Programme					
nVCC Enabling Works	4.062	1.376	2.686	4.226	(0.164)
nVCC Enabling Works QRA	0.337	0.000	0.337	0.528	(0.191)
nVCC Project	7.297	1.727	5.570	7.342	(0.045)
nVCC Project QRA - MIM	6.559	0.000	6.559	6.237	0.322
nVCC Project QRA - Public Sector	1.374	0.000	1.374	1.374	0.000
Integrated Radiotherapy Solution (IRS)	1.400	0.025	1.375	1.400	0.000
Velindre @ Nevill Hall Radiotherapy Centre (RSC)	1.200	0.308	0.892	1.200	0.000
Whitchurch Hospital Site Disposal	0.840	0.106	0.734	0.840	0.000
Whitchurch Hospital Site Disposal - contingency	0.300	0.000	0.300	0.300	0.000
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	0.214	0.000	0.214	0.214	0.000
DPIF - Blood Establishment Computer System (BECS) replacement	0.416	0.155	0.261	0.416	0.000
DPIF - Welsh Histocompatibility & Immunogenetics Service (WHAIS)	0.185	0.084	0.101	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
Non-Radiology Ultrasound Replacement	0.048	0.000	0.048	0.048	0.000
Total All Wales Capital Programme	26.824	3.781	23.043	26.902	(0.078)
Discretionary Capital	2.000	0.099	1.901	2.000	0.000
	28.824	3.880	24.944	28.902	(0.078)

PSPP

During July 2025 the Trust (core) achieved a compliance level of 97.1**%** (June 95.1%) of Non-NHS supplier invoices paid within the 30-day target which gives a cumulative year to date position of 96.5%. The Trust year to date compliance (including hosted) is 97.6**%** 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 July 2025 shows the year to date planned savings of £0.620m were **overachieved by £0.024m**. **Actual delivery to date is therefore £0.644m**.

All savings schemes are now RAG rated green, although there remains some challenges in achieving the full values currently planned.

Revenue Position

Cumulative Breakeven			
Type	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)
Income	(85.997)	(86.606)	0.609
Pay	34.247	34.070	0.177
Non Pay	51.750	52.528	(0.777)
Total	**0.000**	**(0.007)**	**0.007**

Forecast Breakeven		
Full Year Budget (£m)	Full Year Forecast (£m)	Forecast Variance (£m)
(262.325)	(262.325)	0.000
101.806	101.806	0.000
160.518	160.518	0.000
0.000	**0.000**	**0.000**

The overall position against the profiled revenue budget to the end of July 2025 is **an underspend of £0.007m**, with a yearend outturn forecast position of **breakeven**.

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 is now reflected in a revised, signed LTA with Hywel Dda UHB on the 12th August.

The ability to maintain a balanced underlying position is however now proving to be a challenge due to the significant cost pressures and risks which have materialised since the submission of the IMTP. These include the increased WRP charges £0.310m, ENIC cost pressure £0.345m, BMA contract negotiations c£0.400m, along with the significant challenge that the Trust has faced from

Hywel Dda UHB on the LTAs resulting in a loss of Trust income on NICE/ HCD of £0.824m, and the risk on the activity income shortfall associated with the Velindre @ Nevill Hall Radiotherapy Unit as described below under the risk section.

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 and new investment decisions that may emerge. This is becoming increasingly challenging.

Income

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

Cumulative (£0.609m overachieved)			
Type	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)
Core Income - HB / WHSSC	38.329	38.342	-0.013
Nice/ High Cost Drugs	22.515	22.515	0.000
WBS Wholesale Blood Products	10.512	10.514	-0.002
WBS Transplantation Services	0.004	0.004	0.000
WBS Blood Components	0.177	0.481	-0.304
Home Care Drugs	0.384	0.429	-0.047
Private Patient	1.253	1.327	-0.074
VCC Over Activity	2.354	2.531	-0.177
Velindre @ Neville Hall RU	1.155	1.025	0.130
IRS Programme	0.404	0.404	0.000
Radiation Protection	0.322	0.329	-0.006
Staff Recharges	0.197	0.251	-0.054
One Wales Palliative and EOL Care	0.426	0.452	-0.026
Velindre Charity	0.146	0.440	-0.294
Other Charity	0.263	0.065	0.198
RD&I*	1.679	1.737	-0.058
HTW	0.650	0.443	0.207
Other Operating Income	5.227	5.316	-0.089
Total	**85.997**	**86.604**	**-0.609**

*RD&I full year budget includes £2.259m of Velindre Charity 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, and any shortfall such as staff increments will need to be met by, additional savings or absorbed by Service Divisions and Corporate Departments. Funding from Welsh Government in respect of the additional Employer's National Insurance Contributions from April 2025 has now been confirmed. The allocation for the Trust is 82.93% of that required in 2025-26, leaving a shortfall of £0.345m to be met by an element of the planned unallocated Trust reserve this year. The recurrent shortfall in funding has not yet been confirmed by Welsh Government, although an early understanding of the calculation method has been requested to enable early quantification of the recurrent pressure.

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 had agreed to undertake a more detailed review of the SACT Business Case submitted as part of the IMTP process, there has been a strong indication that no commitment will be made this year and therefore the case will be included in the 2026/27 IMTP process for consideration.

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. If the funding is not provided on a recurrent basis it will lead to a financial cost pressure for the Trust. If the Trust is unable to fund in full or in part, disinvestment would significantly reduce the benefits to Health Boards in terms of admissions avoided, and shorter length of stays for the Oncology Patients Velindre Cancer Service supports. The Trust is therefore in dialogue with WG Officials to understand 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 £0.824m loss in income recurrently from Hywel Dda UHB. This is an increase of the £0.342m 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£0.200m 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.

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.

Discussion around NHS Wales contract rebasing at the July 2025 DoF meeting identified that C&V UHB were currently undertaking an exercise to rebase the activity & cost of their LTAs, in particular to better reflect the resources consumed in delivering specialist services. The DoFs’ view was WG should take a leadership role around NHS contract re-basing and agreed to seek a view from WG.

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 June 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 £0.552m as at month 3:

Comparison to Base Contract Value per Commissioner	Base Contract Value £m	Outturn Variance £m	Outturn £m	Variance (%)	IMTP Planned Performance £m	Movement From IMTP £m
Hywel Dda (7A2)	0.865	-0.054	0.811	-6%	-0.050	-0.004
Swansea Bay (7A3)	0.455	-0.021	0.434	-5%	-0.034	0.013
Cardiff & Vale (7A4)	16.048	2.750	18.798	18%	2.470	0.280
Cwm Taf Morgannwg (7A5)	14.285	1.874	16.159	14%	1.767	0.107
Aneurin Bevan (7A6)	19.812	2.916	22.728	15%	2.873	0.043
Powys (7A7)	1.080	0.171	1.251	16%	0.177	-0.006
NHS Wales Joint Commissioning Committee	2.259	-0.023	2.236	-1%	-0.142	0.119
Total	**54.803**	**7.613**	**62.416**	**14%**	**7.061**	**0.552**

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 two months 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.

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

Financial Performance Per Contract Currency	Base Contract Value £m	Projected Outturn Performance £m	Projected Outturn Total Contract £m	Projected Variance (%)	IMTP Planned Performance £m	Movement From IMTP £m
Radiotherapy Planning	5.905	0.138	6.043	2%	0.022	0.116
Radiotherapy Delivery	13.508	-0.204	13.303	-2%	-0.174	-0.031
Nuclear Medicine	1.031	-0.038	0.993	-4%	-0.032	-0.006
Radiology Imaging	3.149	0.692	3.840	22%	0.646	0.046
Preparation for Systemic Anti-Cancer Therapy	2.918	0.751	3.669	26%	0.659	0.092
Delivery of Systemic Anti-Cancer Therapy	6.884	1.960	8.844	28%	1.926	0.034
Ambulatory Care Services	1.405	0.386	1.791	27%	0.367	0.019
Outpatient Services	10.455	3.680	14.134	35%	3.443	0.237
Inpatient Admitted Care	6.162	0.248	6.410	4%	0.203	0.044
Contract Adjustments	3.388	0.000	3.388	0%	0.000	0.000
Total	**54.803**	**7.613**	**62.416**	**14%**	**7.061**	**0.552**

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

Activity Performance Per Contract Currency	Baseline 2019/20 Contract Model Activity Performance	Projected New Contract Model Activity Performance	Projected Outturn Activity Variance	Projected Activity Variance (%)	IMTP Planned Performance	Movement From IMTP
Radiotherapy Planning	3,916	3,842	- 74	-2%	3,794	48
Radiotherapy Delivery	53,586	49,128	- 4,458	-8%	50,060	-932
Nuclear Medicine	1,738	1,540	- 198	-11%	1,528	12
Radiology Imaging	9,103	14,425	5,322	58%	14,002	423
Preparation for Systemic Anti-Cancer Therapy	25,262	37,304	12,042	48%	37,202	102
Delivery of Systemic Anti-Cancer Therapy	31,867	47,795	15,928	50%	47,751	44
Ambulatory Care Services	7,874	9,914	2,040	26%	9,701	213
Outpatient Services	59,960	91,315	31,355	52%	91,043	272
Inpatient Admitted Care	9,072	9,767	695	8%	9,652	115
Contract Adjustments	-	-	-	0%	0	0
Total	**202,378**	**265,031**	**62,653**	**31%**	**264,733**	**298**

As can be seen, Radiotherapy Delivery remains a key factor which is under review aligned with the Velindre @ Nevill Hall planned performance financial risk.

This activity is shown below on a Commissioner basis:

Activity Performance Per Commissioner	Baseline 2019/20 Contract Model Activity Performance	Projected New Contract Model Activity Performance	Projected Outturn Activity Variance	Projected Activity Variance (%)	IMTP Planned Performance	Movement From IMTP
Hywel Dda (7A2)	1,202	942	-260	-0	963	-21
Swansea Bay (7A3)	1,200	1,211	11	0	1,162	49
Cardiff & Vale (7A4)	60,809	83,636	22,827	0	82,794	842
Cwm Taf Morgannwg (7A5)	59,964	73,943	13,979	0	74,013	-70
Aneurin Bevan (7A6)	74,098	99,211	25,113	0	99,839	-628
Powys (7A7)	3,619	4,962	1,343	0	5,003	-41
NHS Wales Joint Commissioning Committee	1,486	1,126	-360	-0	959	167
Total	**202,378**	**265,031**	**62,653**	**31%**	**264,733**	**298**

As mentioned elsewhere in this report, Hywel Dda UHB have requested a recurrent reduction in the LTA financial value from 2026/27 given a reduction in activity where patients have been re-directed to Swansea Bay HB as is demonstrated by the above forecast data.

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 cases will be re-submitted to JCC by the end of August 2025 for consideration of funding as part of the 2026-27 IMTP process.

The Trust is writing separately to the DGH&SC regarding the Infected Blood Inquiry (IBI) report recommendations. It is likely that this correspondence will advise that resources will be required and they, including the costs, will be the subject of separate business cases.

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

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, and any shortfall such as staff increments, will need be met by additional savings or absorbed by Service Divisions and Corporate Departments.

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.

In 2025-26 the Trust again set an emergency reserve of £0.500m in case of a requirement to support non-recurrent expenditure which cannot be managed or migrated at Divisional level during the period. £0.345m of this reserve has now been allocated the manage the cost pressure arising from the shortfall in funding of the increase in Employer's National Insurance Contributions from April 2025.

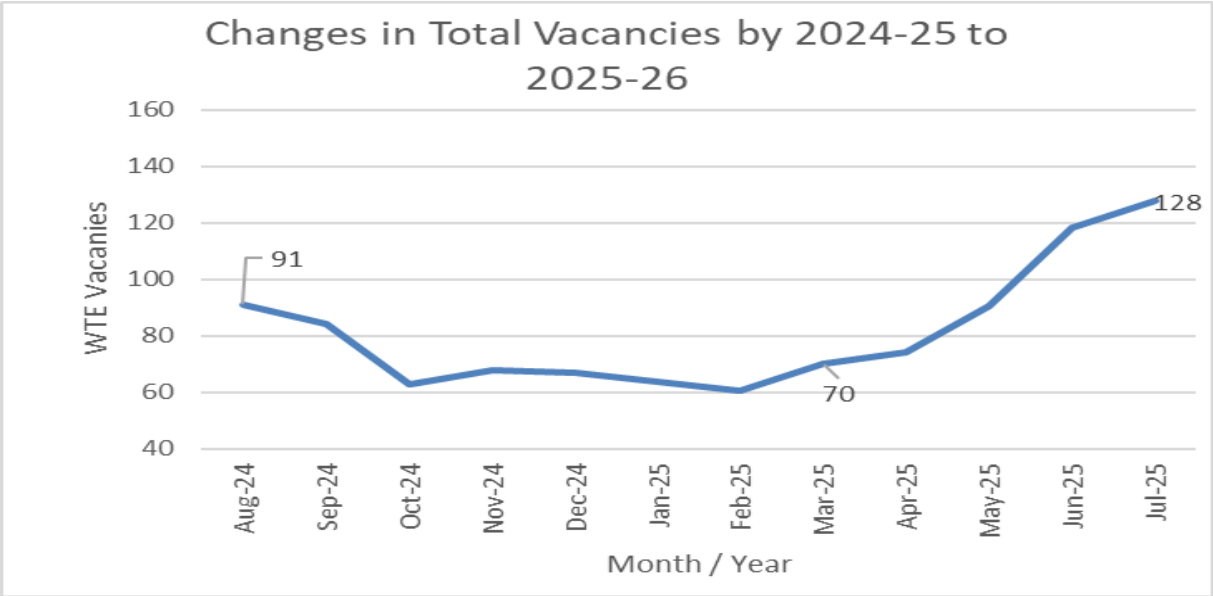
The remainder of the Trust reserves and previously agreed unallocated investment funding is held in month 12 and will be released into the position to match spend as it occurs throughout the year.

3.1 Pay Spend Trends (Run Rate)

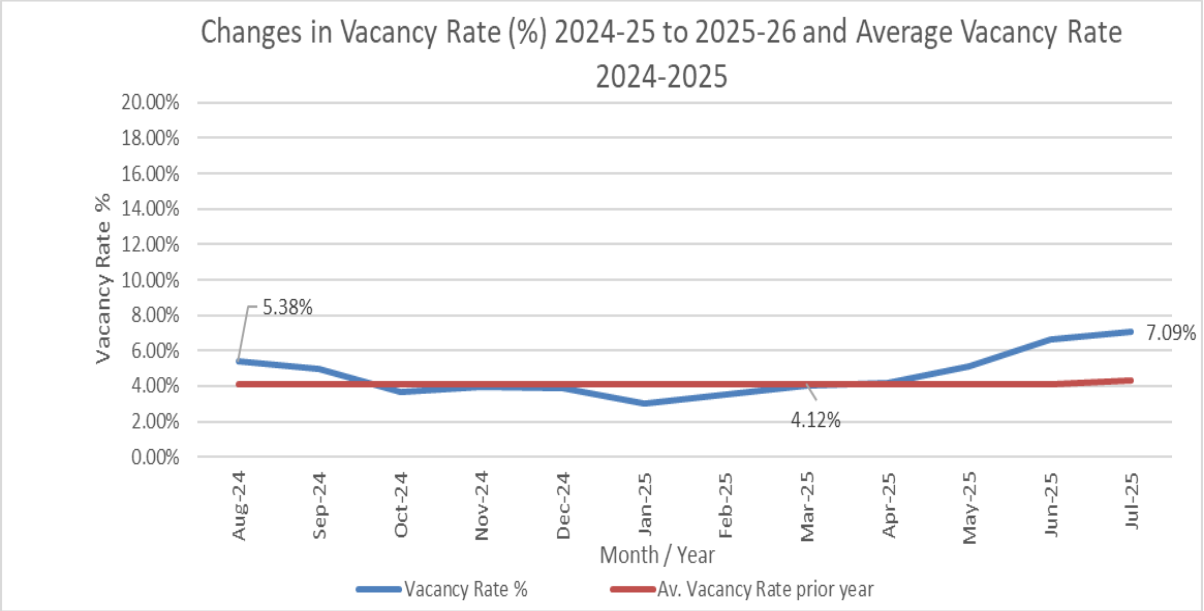
As of July 2025, the current staff in post is 1,671 WTE (June 1,661). The number of vacancies is 128 WTE (June 118), which represents a vacancy rate of 7.09% (6.64% June) against the budget of 1,798 WTE. The vacancy gap is largely being met using overtime or bank staff and is also supporting each of the division's vacancy factor savings target. In line with the WG requirement to cease the use of agency posts, currently only a few remain, and both Service Divisions anticipate no agency staff will be in post from September 2025.

The largest number of vacancies are seen within VCS: 85 WTE. This is a slight increase from the 83 WTE reported in June which followed an earlier review of the use of the increased activity income growth that will be used to fund additional posts. 12 WTE vacancies relate to the Velindre @ Nevill Hall Radiotherapy Centre, and include 8 AHP vacancies that are expected to start in September. Vacancies are spread across many other services, particularly Medical Physics (3.5 WTE), and Radiotherapy (5.0 WTE).

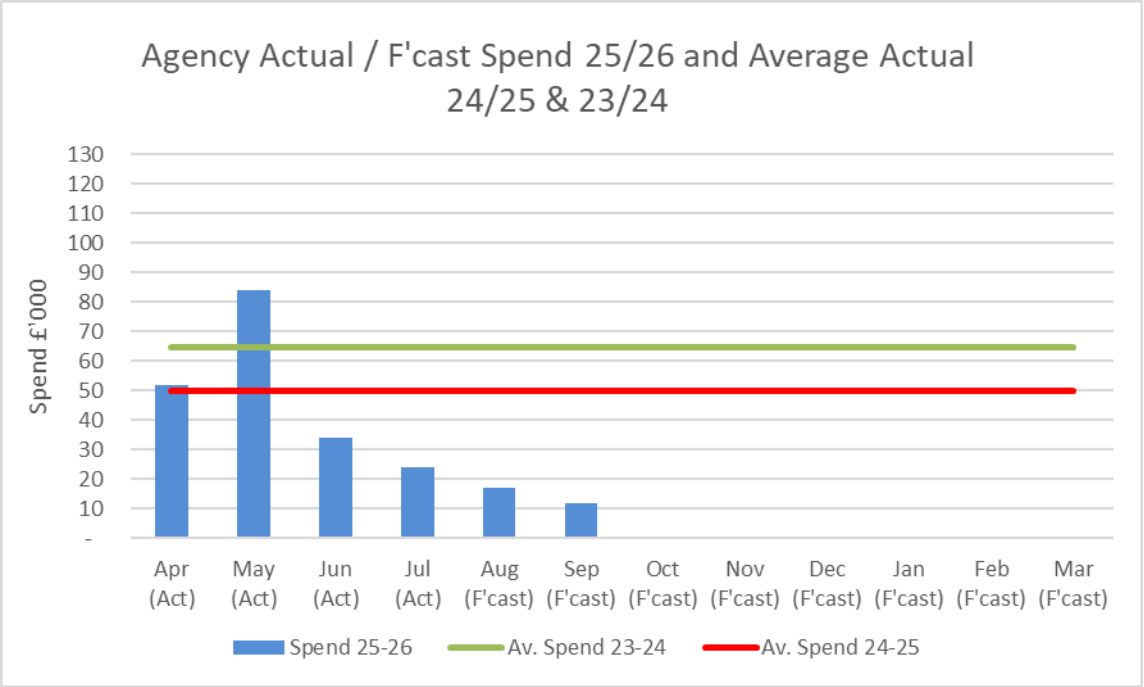
WBS currently are reporting 14.98 WTE vacancies. 5.5 WTE of these are pending start dates within the Donor Contact Centre, with the remainder single vacancies across the service.



The total Trust vacancies as of July 2025 are 128 WTE (June 118 WTE): VCS (85 WTE), WBS (15 WTE), Corporate (12 WTE), R&D (12 WTE), nVCC (0 WTE) and HTW (4 WTE).



The spend on agency for July 2025 was **£0.024m** (June £0.034m) with a year end outturn forecast currently of **£0.223m** (£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. Service Divisions currently anticipate no agency spend post 30th September 2025, with the Corporate Division likely to incur spend until the end of October. It is important that processes are in place to ensure future short term or emergency staff requirements can be met without further agency involvement.



The largest area of agency spend relates to Allied Health Professionals, with agency staff utilised to support additional Capacity in Radiotherapy linked to the Velindre@ Nevill Hall Radiotherapy unit, and Therapies to support sickness. There continues to be some reliance on Admin and Clerical agency staff 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 and appears to be on track.

July has seen a further decrease in Admin and Clerical costs of £0.026m. This relates to removing incorrectly reported professional fees in VCS as secondment / pay costs. Future month forecasts are in line with that expected from June onwards.

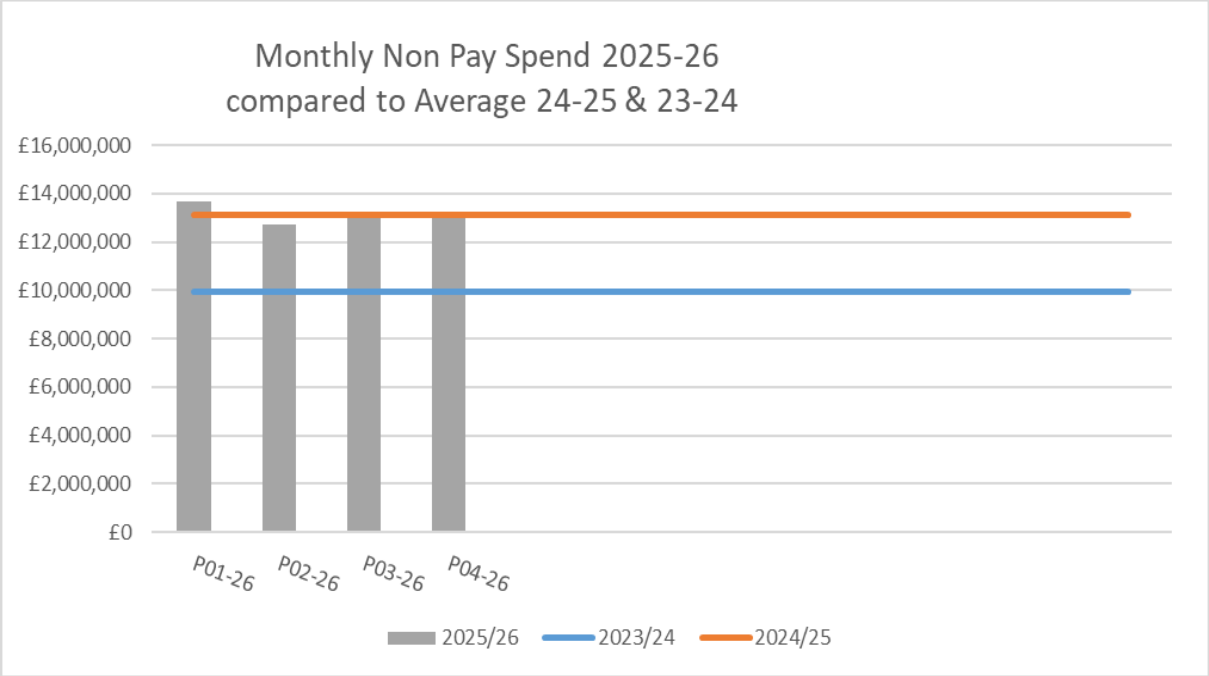
In line with the Value & Sustainability agenda and Finance & Investment Enhanced monitoring arrangements the Trust is continuing to move away from the dependence on agency staff.

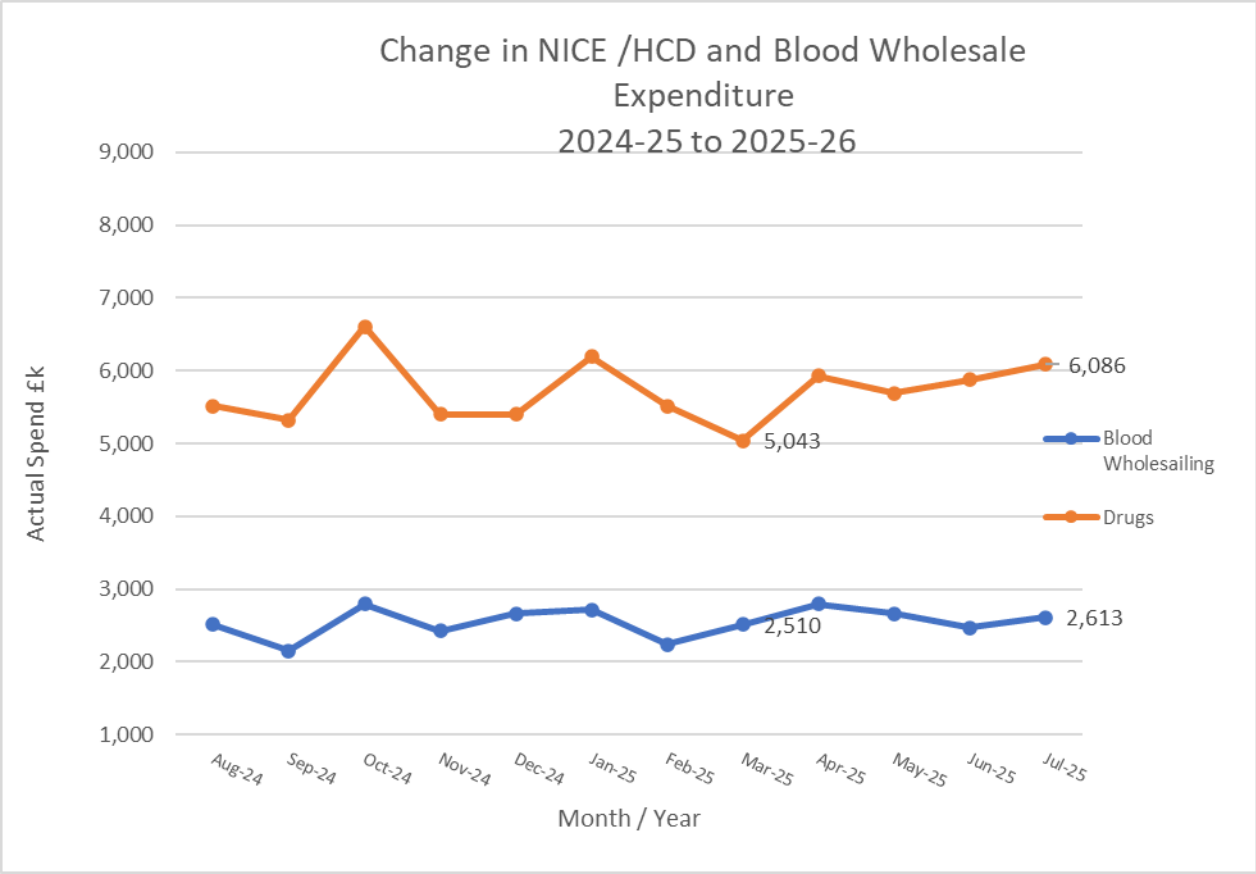
3.2 Non Pay

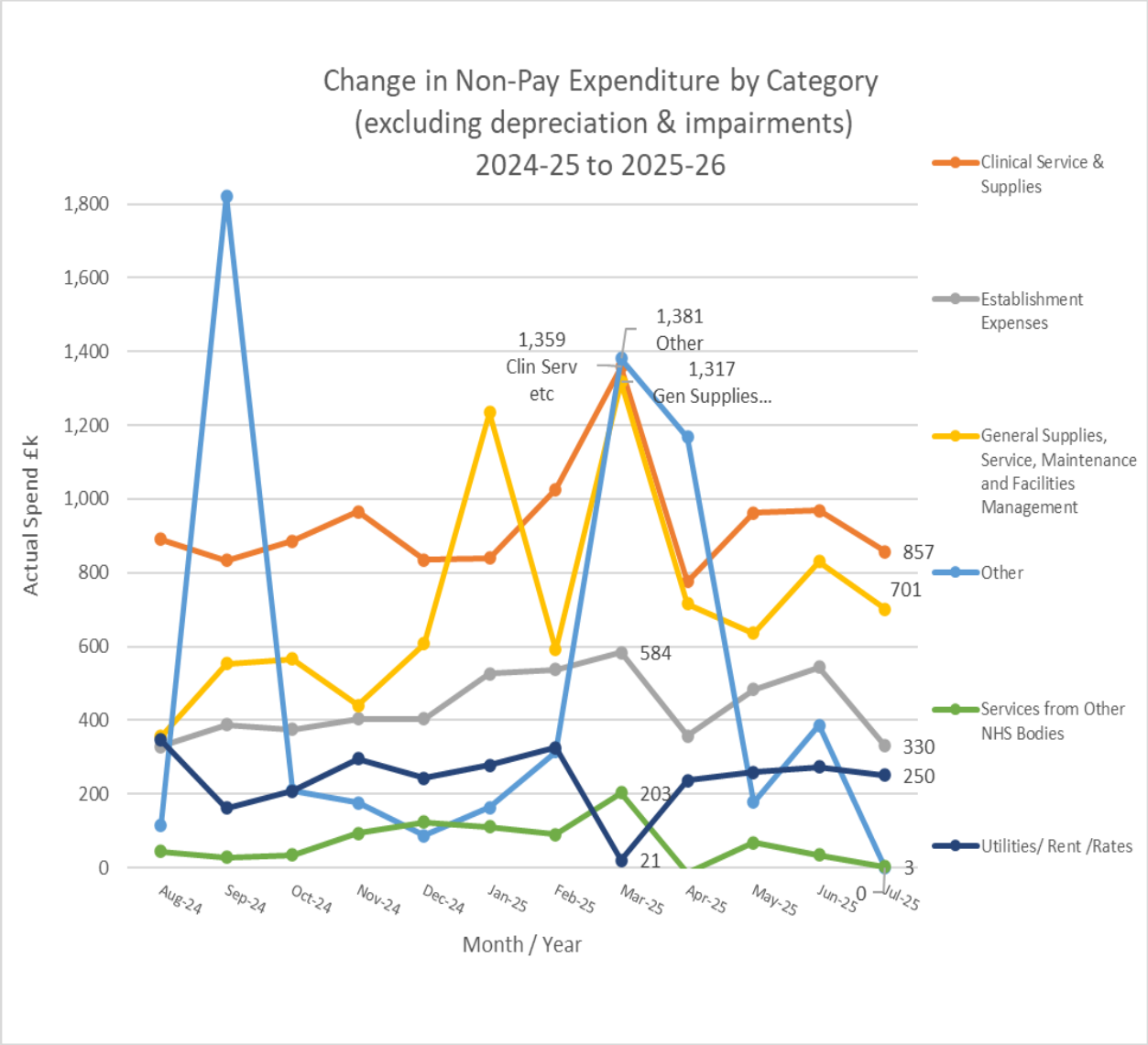
Non-Pay average spend for 2024/25 was £13.1m per month which was a £3.3m increase from the previous whole year. The largest movement was in non-cash as a result of the accelerated depreciation charge on the VCS hospital and the impairment charges associated with the nVCC Asda works (£1.8m average per 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 £13.1m. NICE and HCD drugs (£0.340m) and blood wholesale average costs to date (£0.157m) have increased which will be offset by an income increase via recharges to Health Boards. Non-Cash (Impairment charges) are lower by (-£0.640m) due to the charge incurred on the nVCC Asda works during 2024/25. 'Other' charges have increased by £0.095m which includes £0.024m relating to a provision for legal costs funded via WRP. Clinical Services (-£0.001m) 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. Establishment expenses have now started to increase slowly (£0.0585m) which is not irregular once quarter one invoices start to be received and compared with estimates.

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.


Monthly Non Pay Spend 2025-26
compared to Average 24-25 & 23-24
£16,000,000
£14,000,000
£12,000,000
£10,000,000
£8,000,000
£6,000,000
£4,000,000
£2,000,000
£0
P01-26
P02-26
P03-26
P04-26
2025/26
2023/24
2024/25


Change in NICE /HCD and Blood Wholesale Expenditure
2024-25 to 2025-26
Actual Spend £k
9,000
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
6,086
5,043
2,510
2,613
Blood Wholesailing
Drugs
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Mar-25
Apr-25
May-25
Jun-25
Jul-25
Month / Year



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

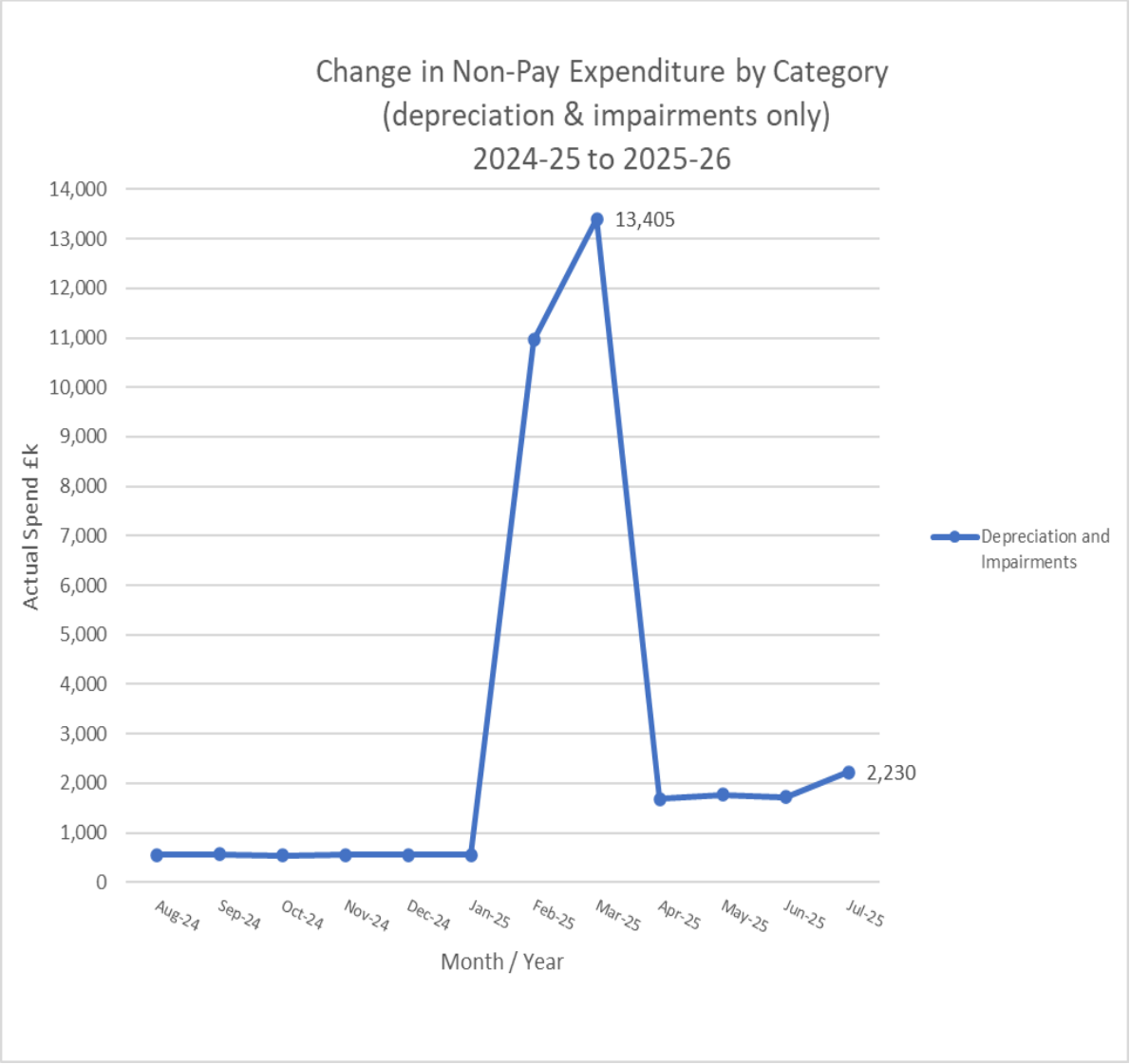
Other spend period 6 2024-25 relates to a provision for legal fees that was incorrectly accounted for as income at the end of 23-24. The graph above relates only to non staff costs, and therefore the associated variance in the income movement is not shown.

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. A further reduction is seen in July which is due to the reimbursement of legal costs by WRP of £1.369m.

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%).

All schemes are now RAG rated green, however there remain some challenges in achieving the full values forecast across all schemes.

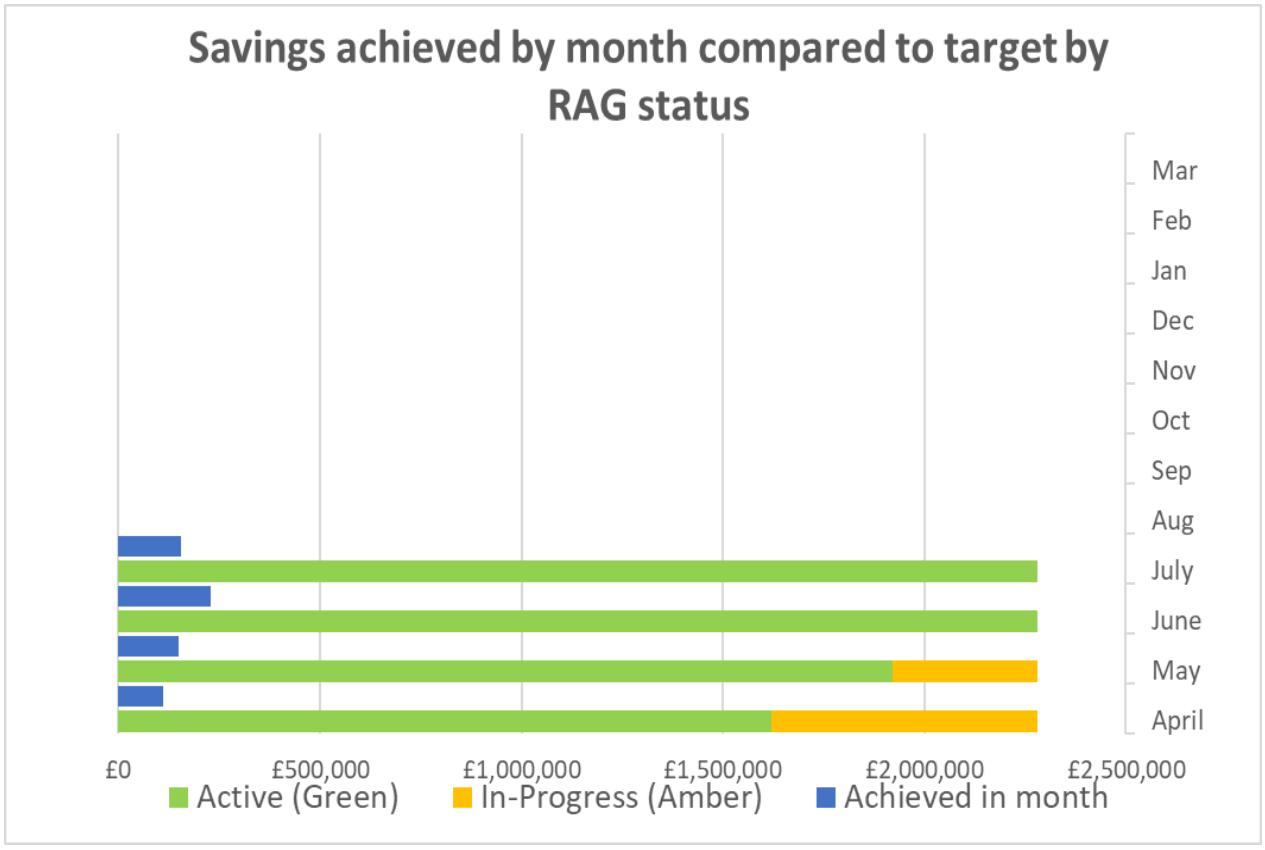
Performance

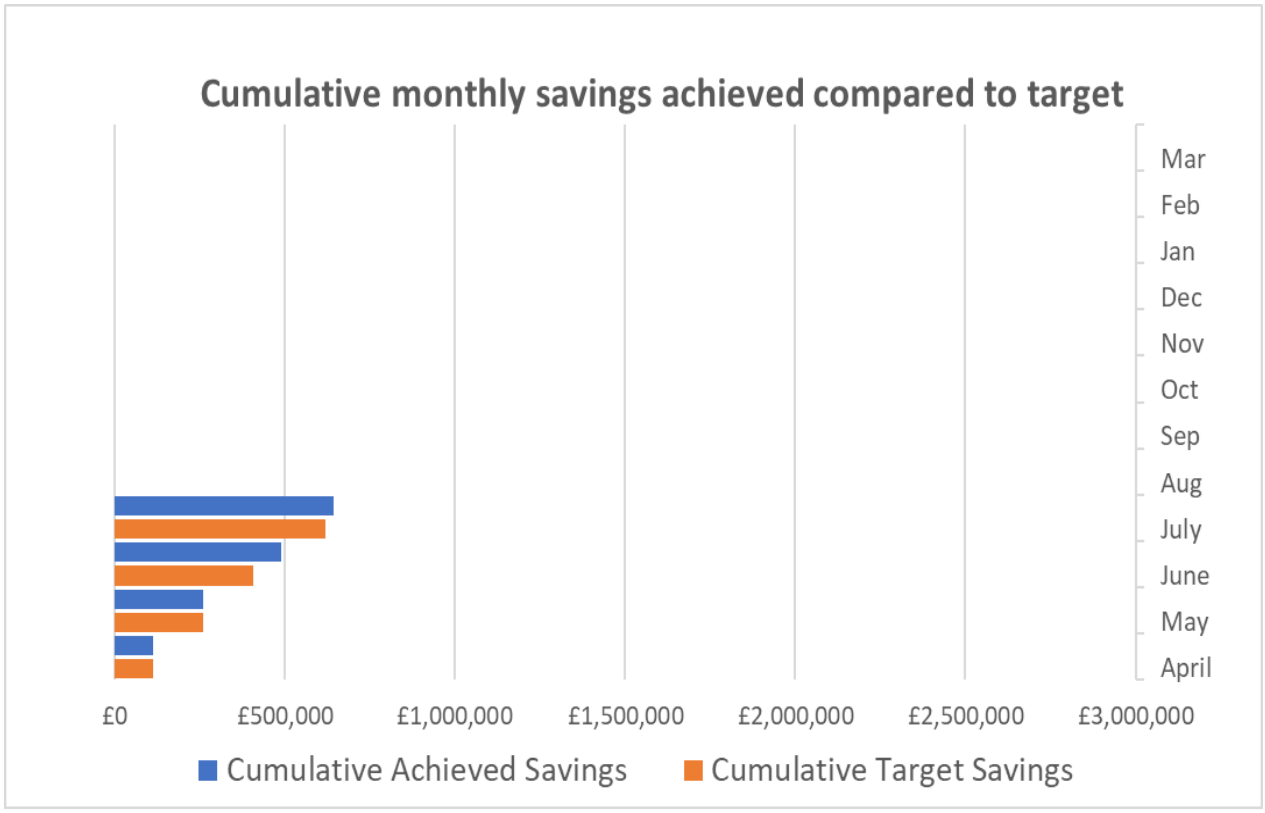
The Trust savings performance as at 31st July 2025 is an achievement of £0.644m against a year to date plan of £0.620m. Current expectation is that the annual savings target will be achieved although this is not without risk.

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**	**239**	**250**	**11**	**1,043**	**0**
			105%		**100%**	
WBS TOTAL SAVINGS	**705**	**231**	**239**	**8**	**705**	**0**
			104%		**100%**	
CORPORATE TOTAL SAVINGS	**302**	**98**	**115**	**17**	**302**	**0**
			117%		**100%**	
RD&I TOTAL SAVINGS	**230**	**52**	**40**	**(12)**	**230**	**0**
			77%		**100%**	
TRUST TOTAL SAVINGS	**2,280**	**620**	**644**	**24**	**2,280**	**0**
			104%		**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 Reduction	VCS	NR	Green	15	4	4	0	15	0
Establishment Vacancy Control	VCS	R	Green	150	50	37	(13)	150	0
Establishment Vacancy Control	VCS	NR	Green	100	34	25	(9)	100	0
Procurement Supply Chain Contracting Cost Reductions	VCS	R	Green	50	6	0	(6)	50	0
Review of SLAs to mitigate / reduce service support	VCS	R	Green	30	10	10	0	30	0
3rd party SACT provision (medicines at home)	VCS	R	Green	150	38	38	0	150	0
3rd party SACT provision (medicines at home)	VCS	NR	Green	70	24	24	0	70	0
Establishment Vacancy Control	WBS	R	Green	100	32	32	0	98	(2)
Procurement Supply Chain Contracting Cost Reductions	WBS	R	Green	100	0	0	0	100	0
Optimised level of stock retention	WBS	NR	Green	150	100	75	(25)	75	(75)
Demand planning: collections (aspheresis price saving)	WBS	R	Green	40	12	12	0	38	(2)
Demand planning: processing volumes	WBS	NR	Green	60	20	20	0	60	0
Process efficiencies	WBS	R	Green	30	3	24	21	24	(6)
Process efficiencies	WBS	NR	Green	20	2	20	18	20	0
Establishment Vacancy Control	Corporate	R	Green	50	17	17	0	50	0
Energy cost reduction	Corporate	R	Green	85	28	28	0	85	0
Establishment Vacancy Control	RD&I	R	Green	30	3	0	(3)	30	0
Establishment Vacancy Control	RD&I	NR	Green	50	6	0	(6)	50	0
Add Establishment Vacancy Control	VCS	NR	Green	128	33	22	(11)	128	0
Add Establishment Vacancy Control	WBS	NR	Green	55	20	20	(0)	57	2
Add Establishment Vacancy Control	Corporate	NR	Green	67	20	20	0	67	0
Add Establishment Vacancy Control	RD&I	NR	Green	30	3	0	(3)	30	0
Total Saving Schemes				**1,560**	465	428	(37)	1,478	(82)
Income Generation									
Private Patients Increased Fees Upon Renewed Contract	VCS	R	Green	150	17	45	28	150	0
Private Patients Income Overachievement	VCS	NR	Green	150	17	45	28	150	0
Maximising income - operational services	VCS	R	Green	50	6	0	(6)	50	0
Sale of Plasma	WBS	R	Green	50	15	9	(6)	9	(41)
Interest on bank income above budget	Corporate	NR	Green	100	33	50	17	223	123
R&D Commercial Income Generation	RD&I	R	Green	120	40	40	0	120	0
Sale of Plasma	WBS	NR	Green	100	27	27	0	100	(0)
Total Income Generation				**720**	155	216	61	802	82
TRUST TOTAL SAVINGS				**2,280**	**620**	**644**	**24**	**2,280**	**0**
						104%		**100%**	


Savings achieved by month compared to target by RAG status
Mar
Feb
Jan
Dec
Nov
Oct
Sep
Aug
July
June
May
April
£0
£500,000
£1,000,000
£1,500,000
£2,000,000
£2,500,000
Active (Green)
In-Progress (Amber)
Achieved in month


Cumulative monthly savings achieved compared to target
Mar
Feb
Jan
Dec
Nov
Oct
Sep
Aug
July
June
May
April
£0
£500,000
£1,000,000
£1,500,000
£2,000,000
£2,500,000
£3,000,000
Cumulative Achieved Savings
Cumulative Target Savings

5. Reserves

The financial strategy for 2025-26 again included an emergency reserve of £0.500m which was accommodated on the assumption that all expected income is received, planned savings schemes are delivered and new emerging cost pressures managed. This month, £0.345m of the reserve has been allocated to mitigate the unfunded element of the increase in Employer's National Insurance contributions.

A review of the recurrent and non-recurrent reserve position remains 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.

As highlighted earlier significant cost pressures and risks have materialised since the IMTP planning stage which will need to be managed or mitigated to ensure that the Trust achieves the outturn forecast position of breakeven and maintains a balanced underlying position going forward.

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

LTA Contract Activity Income – *likelihood: low, value £0.200m (reduced from medium likelihood in month 3)*

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£0.200m underachievement (considered appropriate based on the underachievement seen in 2024-25) is considered as a low 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. As at month 4, the forecast contract marginal income has addressed the legacy brought forward financial risk, the next key priority for any growth needs to be allocated to the Velindre @ Nevill Hall Radiotherapy Unit income shortfall.

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 the

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 and WBS - *likelihood: medium, value £TBC*

As described earlier in this report, several service growth investments had been presented to the Trust Commissioners, with early indication that only the SACT Treatment Capacity Expansion may have been considered for funding support. However there has since been a strong indication that no commitment will be made this year and therefore the case will be included in the 2026/27 IMTP process for consideration. 2025/26 marginal income growth is being 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 2025/26 IMTP process. The business cases will be re-submitted to JCC by the end of August 2025 for consideration as part of the 2026/27 IMTP process. If these cases are again not supported, funding will need to be sought via Welsh Government following recommendations from the IBI report.

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.

Non Delivery of Mitigations to Recover the Increase in the Welsh Risk Pool Risk Share Cost *– likelihood: medium, value £0.310m*

NWSSP have provided an additional forecast of the risk share costs to organisations which has resulted in an increase for the core Trust of £0.310m. Plans to mitigate this pressure are being considered but should be recognised as a risk at this stage, and may require funding from the Trust's emergency reserve.

Cost Pressure Arising from VCS Restructure *– likelihood: medium, value c£117k in 2025-26 and £369k recurrently*

Following agreement of the VCS restructure by the Executive Management Board, further work is required to confirm the financial position regarding mitigation funding to offset costs. Clarity on the net additional cost, post completion of the Phase 2 (Tier 3) recruitment, will inform a decision as to whether the costs can be met recurrently or non recurrently in 2025-26, with a commitment for priority funding from 2026-27 uplift funding.

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.

<u>Opportunities</u>

Vacancy Turnover - *likelihood: low, value £0.400m*

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

Emergency Reserve - *likelihood: low, value £0.155m (reduced from £0.500m in month 3)*

It is important that the Trust keeps a reserve for emergency cost pressures which may arise over the course of the year. £0.345m of the £0.500m planned emergency reserve has been allocated to mitigate the cost pressure arising in year relating to the shortfall in funding for the increase in Employer's National Insurance Contributions with effect from 1st April 2025. The remainder is likely to be utilised to mitigate other cost pressures arising it is currently deemed unlikely this opportunity will materialise; however, this will be kept under constant review.

Overachievement of Bank Interest - *likelihood: low, value £0.250m (reduced from £0.500m in month 4 and previously rated medium risk)*

The overachievement this year is likely to be less than in previous years as interest rates have stated to reduce. The first call on any overachievement will be to support savings schemes that are not delivering as forecast, and therefore but the value and likelihood of this opportunity have now decreased.

Microsoft VAT Benefit – *to be removed from future reports*

The potential release of a provision of £0.088m by DHCW to the Trust previously reported is now being removed from future reports.

DHCW are managing communication with HMRC on behalf of NHS Wales and have now received a protective assessment from HMRC which requires the provision to be held while HMRC continue to consider the case.

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 2025/26 £m	YTD Spend £m	Budget Remaining @M4 £m	Full Year Forecast Spend £m	Year End Variance 2025/26 £m
All Wales Capital Programme					
nVCC Enabling Works	4.062	1.376	2.686	4.226	(0.164)
nVCC Enabling Works QRA	0.337	0.000	0.337	0.528	(0.191)
nVCC Project	7.297	1.727	5.570	7.342	(0.045)
nVCC Project QRA - MIM	6.559	0.000	6.559	6.237	0.322
nVCC Project QRA - Public Sector	1.374	0.000	1.374	1.374	0.000
Integrated Radiotherapy Solution (IRS)	1.400	0.025	1.375	1.400	0.000
Velindre @ Nevill Hall Radiotherapy Centre (RSC)	1.200	0.308	0.892	1.200	0.000
Whitchurch Hospital Site Disposal	0.840	0.106	0.734	0.840	0.000
Whitchurch Hospital Site Disposal - contingency	0.300	0.000	0.300	0.300	0.000
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	0.214	0.000	0.214	0.214	0.000
DPIF - Blood Establishment Computer System (BECS) replacement	0.416	0.155	0.261	0.416	0.000
DPIF - Welsh Histocompatibility & Immunogenetics Service (WHAIS)	0.185	0.084	0.101	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
Non-Radiology Ultrasound Replacement	0.048	0.000	0.048	0.048	0.000
Total All Wales Capital Programme	26.824	3.781	23.043	26.902	(0.078)
Discretionary Capital	2.000	0.099	1.901	2.000	0.000
	28.824	3.880	24.944	28.902	(0.078)

The approved 2025-26 Capital Expenditure Limit (CEL) for the year ended March 2026 is currently £28.824m (2024-25 £35.076m). This includes All Wales Capital funding of £26.824m, 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.

In July 2025, WG noted their position in correspondence to the Trust, including that the current proposed costs of c£60m is not considered supportable. WG also stated that as the scope of works is now expanding beyond infrastructure to include a wider lab modernisation together with the acquisition of the Wound Centre, and OBC setting out all the options would be required. How the additional revenue requirement of that option would be afforded would also need to be explained.

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. This has been added to the Trust CEL.

The Trust is also still awaiting a decision from WG on plasma fractionation 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 July 2025 on the All-Wales Capital Programme schemes was £3.781m, this is broken down between spend on the nVCC schemes of £3.128m, Whitchurch Hospital Site Disposal £0.106m, Velindre@ Nevill Hall Radiotherapy Unit £0.308m, BECS £0.155m and WHAIS £0.084m.

The spend on the Discretionary Capital programme was £0.099m which is not unusual at this point in the financial year.

Major Schemes in Development

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

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

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

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

All Wales Approved and Unapproved Capital Schemes	2025-26 £m	2026-27 £m	2027/28 £m	Further Years £m	Total All Wales Schemes £m
All Wales Approved Schemes					
TCS nVCC	22.835	39.954	6.056	0.000	68.845
Integrated Radiotherapy Solution (IRS)	1.020	16.820	0.943	0.000	18.783
Velindre@ Nevill Hall Radiotherapy Unit	1.200	0.000	0.000	0.000	1.200
RISP (DPIF)	0.471	0.000	0.000	0.000	0.471
Total Approved Capital Schemes	**25.526**	**56.774**	**6.999**	**0.000**	**89.299**

All Wales Unapproved Schemes					
Whitchurch Hospital Site	1.134	0.945	1.741	0.000	3.820
WBS TGI Infrastructure	2.457	5.762	17.292	41.600	67.111
WBS BECS Blood Management System	TBC	TBC	TBC	TBC	0.000
WBS Plasma for Fractionation	0.910	0.002	0.001	0.000	0.913
WBS Fleet Replacement	0.364	0.738	1851	0.000	2.953
WBS Asset Replacement	0.532	0.215	0.000	TBC	0.747
Digital WHAIS	0.092	0.000	0.000	0.000	0.092
LIMS 2.0	TBC	TBC	TBC	TBC	0.000
EPMA (DPIF)	0.086	0.025	0.000	0.000	0.111
Digital CRM Multi Case Functions (WBMDR, AOS etc	0.500	0.000	0.000	0.000	0.500
Digital IT Infrastructure	0.500	0.500	0.500	0.500	2.000
Other Digital Service Developments	TBC	TBC	TBC	TBC	0.000
Other Service Developments (New)	TBC	TBC	TBC	TBC	TBC
Total Unapproved Capital Schemes	**6.575**	**8.187**	**21.385**	**42.100**	**78.247**
Total All Wales Capital Plans	**32.101**	**64.961**	**28.384**	**42.100**	**167.546**

8. BALANCE SHEET (Including Hosted Organisations)

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

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

	Opening Balance Beginning of Apr 25	Closing Balance End of 31 July 2025	Movement from 1st April to 31 July 2025	Forecast Closing Balance at 31 March 2026
Non-Current Assets	**£'m**	**£'m**	**£'m**	**£'m**
Property, plant and equipment	311.793	315.596	3.803	315.596
Intangible assets	11.160	11.160	0.000	11.160
Trade and other receivables	1,350.042	1,350.181	0.139	1,350.181
Other financial assets	0.000	0.000	0.000	0.000
Non-Current Assets sub total	1,672.995	1,676.937	3.942	1,676.937
Current Assets				
Inventories	31.666	32.950	1.284	32.950
Trade and other receivables	592.821	571.959	(20.862)	594.311
Other financial assets	0.000	0.000	0.000	0.000
Cash and cash equivalents	15.206	37.702	22.496	15.350
Non-current assets classified as held for sale	0.000	0.000	0.000	0.000
Current Assets sub total	639.693	642.611	2.918	642.611
TOTAL ASSETS	2,312.688	2,319.548	6.860	2,319.548
Current Liabilities				
Trade and other payables	(253.207)	(260.527)	(7.320)	(260.527)
Borrowings	(1.530)	(1.456)	0.074	(1.456)
Other financial liabilities	0.00	0.00	0.000	0.00
Provisions	(364.179)	(727.915)	(363.736)	(727.915)
Current Liabilities sub total	(618.916)	(989.898)	(370.982)	(989.898)
NET ASSETS LESS CURRENT LIABILITIES	1,693.772	1,329.650	(364.122)	1,329.650
Non-Current Liabilities				
Trade and other payables	(3.555)	(3.555)	0.000	(3.555)
Borrowings	(108.810)	(108.385)	0.425	(108.385)
Other financial liabilities	0.00	0.00	0.000	0.00
Provisions	(1,362.437)	(998.731)	363.706	(998.731)
Non-Current Liabilities sub total	(1,474.802)	(1,110.671)	364.13	(1,110.671)
TOTAL ASSETS EMPLOYED	218.970	218.979	0.009	218.979
FINANCED BY:				
Taxpayers' Equity				
General Fund	0.000	0.000	0.000	0.000
Revaluation reserve	36.469	36.469	0.00	36.469
PDC	162.684	162.685	0.001	162.685
Retained earnings	19.817	19.825	0.008	19.825
Other reserve	0.000	0.000	0.000	0.000
Total Taxpayers' Equity	218.970	218.979	0.009	218.979

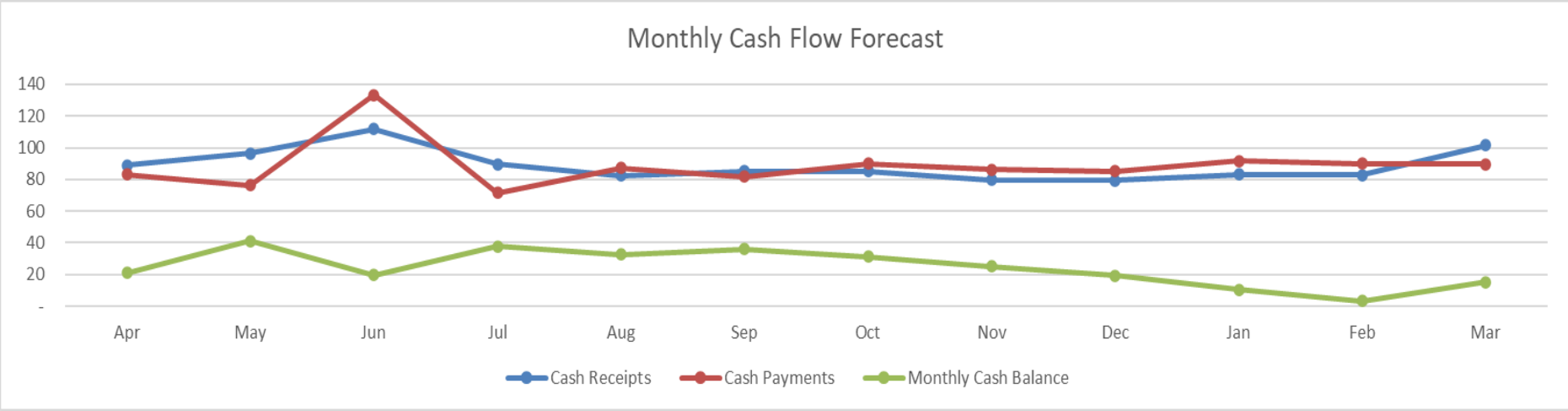
9. CASH FLOW (Includes Hosted Organisations)

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 in table and graph format 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													
1	Income from other Welsh NHS Organisations	49.990	55.994	45.475	48.706	52.467	53.867	51.567	49.467	50.167	51.167	52.467	50.964	612.298
2	WG Revenue Funding	29.236	33.465	64.624	27.572	22.767	23.767	25.767	23.267	22.767	24.767	24.267	24.767	347.033
3	Short Term Loans													0.000
4	PDC								0.000				17.613	17.613
5	Interest Receivable	0.163	0.119	0.142	0.136	0.155	0.155	0.155	0.155	0.155	0.155	0.155	0.155	1.800
6	Sale of Assets													0.000
7	Other	9.452	6.736	1.583	13.156	6.930	7.380	7.605	6.930	6.155	7.155	5.930	7.976	86.988
8	TOTAL RECEIPTS	**88.841**	**96.314**	**111.824**	**89.570**	**82.319**	**85.169**	**85.094**	**79.819**	**79.244**	**83.244**	**82.819**	**101.475**	**1,065.732**
	PAYMENTS													
9	Salaries and Wages	30.118	42.171	41.742	41.568	43.696	42.440	42.440	42.440	42.440	42.440	42.440	42.440	496.375
10	Non pay items	52.934	34.043	86.348	29.681	41.100	36.900	44.950	41.100	40.150	42.850	41.100	40.609	531.765
11	Short Term Loan Repayment													0.000
12	PDC Repayment		0.000										0.000	0.000
14	Capital Payment	0.000	0.000	5.038	0.387	2.500	2.500	2.500	2.500	2.500	6.500	6.500	6.500	37.425
15	Other items													0.000
16	TOTAL PAYMENTS	**83.052**	**76.214**	**133.128**	**71.636**	**87.296**	**81.840**	**89.890**	**86.040**	**85.090**	**91.790**	**90.040**	**89.549**	**1,065.565**
17	Net cash inflow/outflow	5.789	20.100	(21.304)	17.934	(4.977)	3.329	(4.796)	(6.221)	(5.846)	(8.546)	(7.221)	11.926	
18	Balance b/f	15.183	20.972	41.072	19.768	37.702	32.725	36.054	31.258	25.037	19.191	10.645	3.424	
19	Balance c/f	20.972	41.072	19.768	37.702	32.725	36.054	31.258	25.037	19.191	10.645	3.424	15.350	



DIVISIONAL ANALYSIS

(Figures in parenthesis signify an adverse variance against plan)

Core Trust

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
VCC	(16.725)	(16.922)	(0.197)	(49.242)	(49.242)	0.000
RD&I	0.050	0.035	(0.015)	0.440	0.440	0.000
WBS	(7.335)	(7.335)	0.000	(23.679)	(23.679)	0.000
Sub-Total Divisions	**(24.009)**	**(24.221)**	**(0.212)**	**(72.481)**	**(72.481)**	**0.000**
Corporate Services Directorates	(5.261)	(5.042)	0.219	(15.772)	(15.772)	0.000
Delegated Budget Position	**(29.270)**	**(29.263)**	**0.007**	**(88.253)**	**(88.253)**	**0.000**
nVCC	(0.046)	(0.046)	0.000	(0.096)	(0.096)	0.000
Health Technology Wales	(0.057)	(0.057)	0.000	(0.183)	(0.183)	0.000
Trust Income / Reserves	29.373	29.373	0.000	88.532	88.532	0.000
Trust Position	**0.000**	**0.007**	**0.007**	**0.0000**	**0.000**	**0.000**

The in month position for the core Trust is an underspend of £0.005m, leading to a year to date **underspend of £0.007m.** The year end forecast is financial **breakeven**, although there are some risks in achieving this.

VCS

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**31.330**	**31.797**	**0.468**	**97.907**	**98.375**	**0.468**
Expenditure						
Staff	20.264	20.491	(0.227)	60.031	60.258	(0.227)
Non Staff	27.791	28.228	(0.437)	87.118	87.359	(0.240)
Sub Total	**48.055**	**48.719**	**(0.664)**	**147.149**	**147.617**	**(0.468)**
Total	**(16.725)**	**(16.922)**	**(0.197)**	**(49.242)**	**(49.242)**	**0.000**

VCS Key Highlights/ Issues:

The reported financial position for Velindre Cancer Services as at the end of July 2025 was an **overspend of £0.197m** with an expected outturn position at this stage of **breakeven.** There are however challenges in meeting this given the reported overspend position at this point in the year. This will need to be closely monitored as the year progresses.

Income at month 4 represents a year to date overachievement of **£0.468m** which is largely a result of an overachievement of Private Patient income, together with additional income for Support Services Palliative Care.

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£0.200m which has reduced from that previously reported given the improvement seen so far this financial year. 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 **£(0.227)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 4 was **£0.437m** overspent which includes overspends of £0.082m for postage costs, £0.054m for consultancy fees, £0.044m for general supplies, and £0.285m on clinical costs. The Division will need to ensure it understands the causes of these cost increases and put steps in place to mitigate them.

WBS

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**12.497**	**12.562**	**0.065**	**35.524**	**35.588**	**0.065**
Expenditure						
Staff	6.509	6.474	0.035	19.272	19.237	0.035
Non Staff	13.323	13.423	(0.100)	39.930	40.030	(0.100)
Sub Total	**19.832**	**19.897**	**(0.065)**	**59.203**	**59.267**	**(0.065)**
Total	**(7.335)**	**(7.335)**	**0.000**	**(23.679)**	**(23.679)**	**0.000**

Key Highlights/ Issues:

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

WBS recognised an overachievement of **£0.065m** on income due an increase in activity for the bone marrow registry, and additional plasma sales.

This is promising given that last year there had been a lack of growth in the bone marrow registry, which was largely impacted during the pandemic, and is still yet to show significant 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 crystalise 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 **£(0.035)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 **£0.100m** as at the end of month 4. Largest cost pressure is the divisional savings target, offset by activity related performance in month 4: 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 £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**1.701**	**1.928**	**0.226**	**5.114**	**5.340**	**0.226**
Expenditure						
Staff	5.444	5.124	0.320	16.326	16.006	0.320
Non Staff	1.518	1.846	(0.328)	4.559	5.105	(0.546)
Sub Total	**6.962**	**6.970**	**(0.008)**	**20.886**	**21.112**	**(0.226)**
Total	**(5.261)**	**(5.042)**	**0.218**	**(15.772)**	**(15.772)**	**0.000**

Corporate Key Highlights / Issues:

The reported financial position for the Corporate Services division at the end of July 2025 was an **underspend of £0.218m** 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 £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**1.679**	**1.737**	**0.058**	**5.322**	**5.379**	**0.058**
Expenditure						
Staff	1.371	1.428	(0.057)	4.222	4.280	(0.057)
Non Staff	0.258	0.274	(0.016)	0.660	0.660	(0.000)
Sub Total	**1.629**	**1.702**	**(0.073)**	**4.882**	**4.940**	**(0.058)**
Total	**0.050**	**0.035**	**(0.015)**	**0.440**	**0.440**	**0.000**

RD&I Key Highlights / Issues

The reported financial position for the RD&I Division at the end of July 2025 was an **overspend of £0.015m** with an expected outturn position at this stage of **breakeven.** However, this is not without risk given the reported overspend position at this point in the year. This will need close monitoring as the year progresses.

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

nVCC – (Revenue)

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**0.000**	**0.000**	**0.000**	**0.023**	**0.023**	**0.000**
Expenditure						
Staff	0.040	0.030	0.010	0.096	0.096	0.000
Non Staff	0.007	0.016	(0.010)	0.023	0.023	0.000
Sub Total	**0.046**	**0.046**	**0.000**	**0.119**	**0.119**	**0.000**
Total	**(0.046)**	**(0.046)**	**0.000**	**(0.096)**	**(0.096)**	**0.000**

nVCC Key Highlights / Issues

The reported financial position for the nVCC Programme at the end of July 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, and the nVCC team are currently in dialogue with WG in this respect.

HTW (Hosted Other)

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**0.650**	**0.443**	**(0.207)**	**1.900**	**1.693**	**(0.207)**
Expenditure						
Staff	0.619	0.524	0.095	1.858	1.763	0.095
Non Staff	0.087	(0.024)	0.111	0.225	0.113	0.111
Sub Total	**0.706**	**0.500**	**0.207**	**2.083**	**1.876**	**0.207**
Total	**(0.057)**	**(0.057)**	**0.000**	**(0.183)**	**(0.183)**	**0.000**

HTW Key Highlights / Issues

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

nVCC Project Finance Report
For JULY 2025

DATE OF MEETING	TBC

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Kate Evans Senior Finance Business Partner
PRESENTED BY	Mark Ash Assistant Project Director
EXECUTIVE SPONSOR APPROVED	Matt Bunce, Executive Director of Finance

REPORT PURPOSE	FOR NOTING

ACRONYMS	

1. PURPOSE

1.1 The purpose of this report is to provide a financial update to the new Velindre Cancer Centre (nVCC) Project Board outlining spend to date against the Welsh Government (WG) approved/indicative budget as of **JULY 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 **JULY 2025** is set out below:

New Velindre Cancer Centre
Finance

Programme	Project Director	Report Period
nVCC	David Powell	Jul-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	0.75M	56.11M	9.48M	13.41M	33.23M	56.11M	17.94M

- The in-year **financial position** for **JULY 2025** is:
    - **CAPITAL** in-year spend of **£2.290m**, with a forecast outturn of **c£9.618m** based on run-rates and financial plan.

nVCC Project Capital Budget & Spend Summary 2025-26

	Year to Date			Financial Year		
	Budget Jul-25	Spend Jul-25	Variance Jul-25	Annual Budget	Annual Forecast	Annual Variance
	£	£	£	£	£	£
EW FBC Project	1,117,394	1,117,394	0	3,987,606	3,987,606	0
nVCC FBC Project	1,172,109	1,172,109	0	5,630,000	5,630,000	0
	2,289,503	**2,289,503**	**0**	**9,617,606**	**9,617,606**	**0**

- **REVENUE** in-year spend of **£0.046m**, with a forecast outturn of **c£0.119m** based on run-rates and financial plan.

REVENUE

	Year to Date			Financial Year		
	Budget Jul-25	Spend Jul-25	Variance Jul-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	39,749	39,749	0	96,124	96,124	0
Project Delivery Support Costs	6,744	6,076	668	23,000	23,000	0
nVCC Revenue Total	**46,493**	**45,825**	**668**	**119,124**	**119,124**	**0**
REVENUE TOTAL	**46,493**	**45,825**	**668**	**119,124**	**119,124**	**0**

- **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£9.48m, contractual commitments of c£13.41m and projected spend to completion of c£33.2m. 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 currently in progress.

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 £0.753m 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

Programme: nVCC | Project Director: David Powell | Report Period: Jul-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	4.98M	3.16M	434K	8.57M	839K
Equipment (All Selected)	32.54M	3.58M	0	32.54M	16K	0	32.52M	32.54M	3.58M
Transactions (Resource Costs) (All Selected)	14.51M	6.10M	0	14.51M	4.31M	10.20M	0	14.51M	6.10M
MIM (Construction Costs)	0	7.50M	224K	224K	178K	46K	0	224K	7.28M
Deep Clean	272K	156K	0	272K	0	0	272K	272K	156K

EW Project – **as of July 2025**

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

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

4.6 The overall financial position is set out below:

	FBC Funding	Costs Incurred	Costs Incurred to Date	Commitments	Projected Costs
		2024-25	Jul-25	Jul-25	Jul-25
EW Project					
Pay	£300,000	£153,116	£22,047	£124,837	£0
6MVA Supply - National Grid	£480,000	£480,000	£0	£0	£0
Supply Chain Fees	£728,430	£323,268	£129,760	£275,402	£0
Non Works Costs	£21,798	-£113,202	£4,072	£109,055	£21,873
Asda Works	£2,008,269	£2,008,269	£0	£0	£0
Walters Design & Build	£116,260	£116,260	£21,873	£0	-£21,873
S278 works on Longwood Drive	£3,153,636	£288,858	£706,050	£2,158,728	£0
Offsite Habitat Creation (SW Corner)	£717,333	£434,292	£104,676	£178,365	£0
HV Intake Room	£610,101	£161,286	£128,916	£319,899	£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	-£9,921	£0
QRA Funding					£0
TOTAL EW PROJECT	**£8,569,827**	**£3,862,068**	**£1,117,395**	**£3,156,365**	**£433,999**
QRA funding	£1,367,400				£1,367,400
HV Intake Room Drawdown	-£160,800				-£160,800
Asda Final AccountDrawdown	-£368,000				-£368,000
	£838,600	**£0**	**£0**	**£0**	**£838,600**
TOTAL nVCC EW FUNDING	**£9,408,427**	**£3,862,068**	**£1,117,395**	**£3,156,365**	**£1,272,599**

4.7 The overall financial position of the EW Project is spend to date is c£4.9m, with commitments of c£3.1m and projected costs of c£0.434m.

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 as at July 2025. An additional emerging risk has been identified as outlined below:

Project agreement obligation to install a **Sacrificial cable** by the 28th October 2025 that will provide power from the TCAR boundary to the HV intake room at a cost of **c£0.100m** (incl VAT). NGED have a planned start date of 1st September which should take up to 3 weeks. **This work is currently unfunded and will require a QRA call-down**.

***nVCC Project* – as of July 2025**

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

nVCC Project	
Equipment	£32,540,286
Transactions(Resource Costs)	£14,507,885
Deep Clean	£272,000
QRA Called	£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	Jul-25	Jul-25	Jul-25
nVCC MIM Activties					
Project Management Office	£3,325,884	£1,181,156	£349,891	£1,794,836	£0
Design & Construction Workstream	£2,606,271	£629,664	£236,715	£1,739,892	£0
Equipment, Commissioning and Migration Workstream	£3,722,193	£372,839	£174,084	£3,175,270	£0
Digital Workstream	£1,935,417	£113,756	£89,168	£1,732,493	£0
Engagement & Communications Workstream	£380,688	£159,689	£41,550	£179,449	£0
Commercial Activity Group	£2,242,432	£621,540	£154,336	£1,466,557	£0
Strategic Reserves			£0		£0
Project Delivery	£295,000	£117,988	£62,788	£114,224	£0
Major Medical Equipment	£10,676,400	£0	£2,171	£0	£10,674,229
Other Equipment	£12,385,200	£0	£0	£0	£12,385,200
IM&T infrastructure	£5,359,802	£0	£14,262	£0	£5,345,540
Digital	£433,415	£0	£0	£0	£433,415
Digitisation of Health Records	£3,685,469	£0	£0	£0	£3,685,469
Non Works Costs	£272,000	£0	£0	£0	£272,000
Asda Traffic Management Drawdown	£223,860	£130,434	£47,144	£46,282	£0
TOTAL nVCC PROJECT	**£47,544,031**	**£3,327,065**	**£1,172,109**	**£10,249,003**	**£32,795,854**
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**	**£1,172,109**	**£10,249,003**	**£49,899,994**
IRS Implementation	£5,071,000	£963,000	£603,000	£3,505,000	£0
TOTAL nVCC MIM FUNDING	**£69,719,171**	**£4,290,065**	**£1,775,109**	**£13,754,003**	**£49,899,994**

4.12 The overall financial position of the nVCC Project is spend to date is c£4.5m, with commitments of c£10.249m and projected costs of c£32.796m.

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 July 2025.

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

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

- **CAPITAL** in-year spend of **£2.290m**, with a forecast outturn of **c£9.618m** 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 Budget Jul-25	Year to Date Spend Jul-25	Year to Date Variance Jul-25	Financial Year Annual Budget	Financial Year Annual Forecast	Financial Year Annual Variance
	£	£	£	£	£	£
Enabling Works						
Enabling Works Pay	22,047	22,047	0	66,140	66,140	0
Supply Chain Fees	129,760	129,760	0	372,584	372,584	0
Non Works Costs	4,072	4,072	0	4,072	4,072	0
Asda Works	0	0	0	0	0	0
Walters Design & Build	21,873	21,873	0	21,873	21,873	0
6MVA Supply - National Grid	0	0	0	0	0	0
S278 works on Longwood Drive	706,050	706,050	0	2,785,374	2,785,374	0
Offsite Habitat Creation (SW Corner)	104,676	104,676	0	284,508	284,508	0
HV Intake Room	128,916	128,916	0	453,055	453,055	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	0	0	0	0	0	0
Enabling Works Capital Total	**1,117,394**	**1,117,394**	**0**	**3,987,606**	**3,987,606**	**0**
New Velindre Cancer Centre						
Project Management Office	412,679	412,679	0	1,218,225	1,218,225	0
Design & Construction	283,859	283,859	0	735,130	735,130	0
Equipment, Commissioning and Migration	174,084	174,084	0	1,164,362	1,164,362	0
Medical Equipment	2,171	2,171	0	644,400	644,400	0
Digital	89,168	89,168	0	582,559	582,559	0
IM&T & Digital Procurement Costs	14,262	14,262	0	191,750	191,750	0
Engagement & Communications Workstream	41,550	41,550	0	130,059	130,059	0
Commercial Activities Group	154,336	154,336	0	735,603	735,603	0
Strategic Reserves	0	0	0	227,911	227,911	0
nVCC Capital Total	**1,172,109**	**1,172,109**	**0**	**5,630,000**	**5,630,000**	**0**
CAPITAL TOTAL	**2,289,503**	**2,289,503**	**0**	**9,617,606**	**9,617,606**	**0**

- **REVENUE** in-year spend of **£0.046m**, 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 Budget Jul-25	Year to Date Spend Jul-25	Year to Date Variance Jul-25	Financial Year Annual Budget	Financial Year Annual Forecast	Financial Year 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	39,749	39,749	0	96,124	96,124	0
Project Delivery Support Costs	6,744	6,076	668	23,000	23,000	0
nVCC Revenue Total	**46,493**	**45,825**	**668**	**119,124**	**119,124**	**0**
REVENUE TOTAL	**46,493**	**45,825**	**668**	**119,124**	**119,124**	**0**

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

- **Staffing** - WG funded posts **spend of £0.022m.** Reflects the Project posts and a run rate of c£6k per month.

Work Packages are outlined below:

- **Supply Chain Fees** – **spend of £0.130m -** costs associated with advisory support provided by WSP (£0.080m); MDA Consult Ltd (£0.008m); Urbanists (£0.006m) cost consultancy (£0.032m) and Escrow fees (c£0.004m).
- **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 £0.706m -** costs associated with the highway improvement works on Longwood Drive agreed with Cardiff County Council. Works costs c£0.697m and advisory costs c£0.009m.
- **Off-site Habitat** – **spend of £0.105m -** costs associated with the offsite habitat creation required as part of the EPSL.
- **HV Intake Room – spend of £0.129m** - costs associated with the design and build of the HV intake room. Works costs are c£0.125m.
- **Reserves** – **no spend -** costs are c£0.000m – no spend to date.

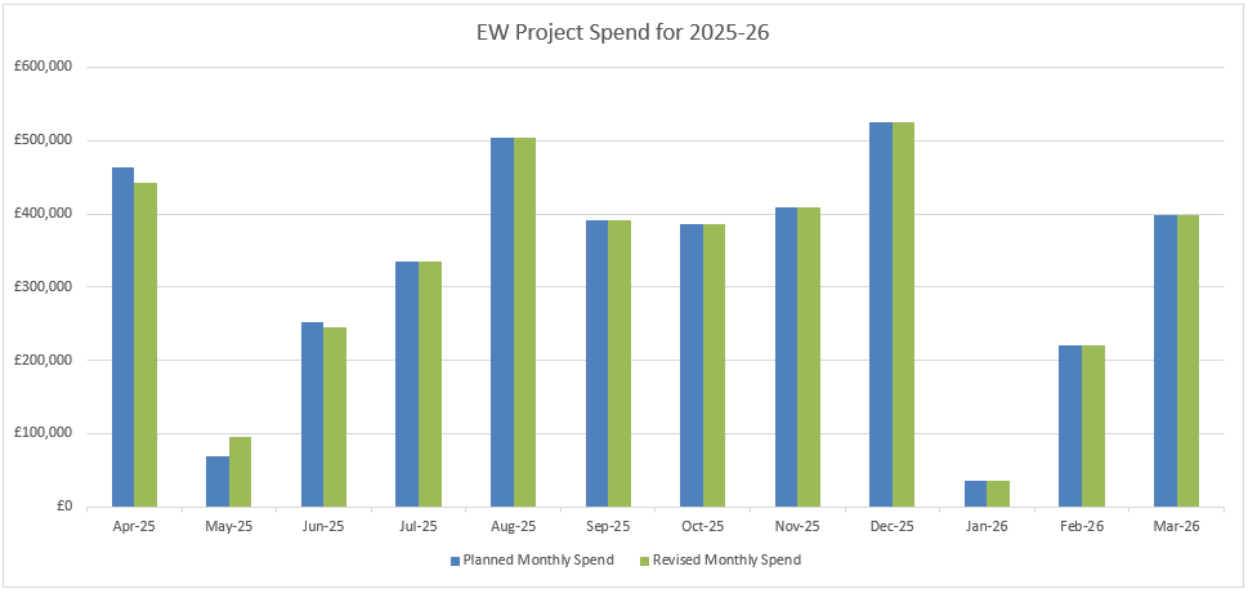
5.3 The key **nVCC CAPITAL** areas of spend to date are explained as follows:

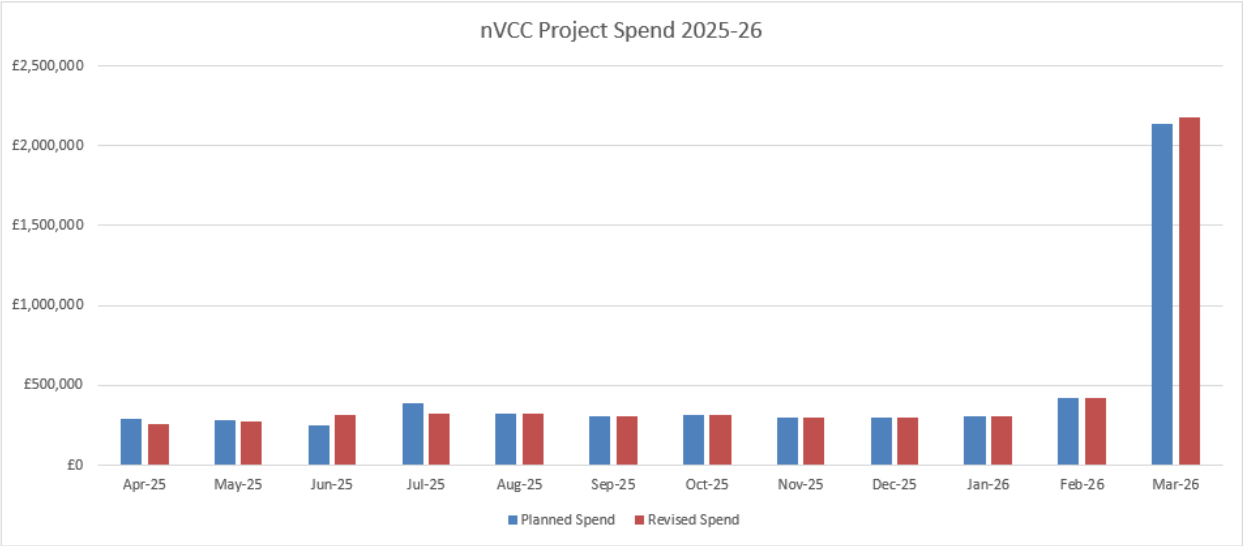
- **Staffing** - WG funded posts **spend of £0.723m.** Reflects the Project posts and a run rate of c£0.180m per month.

Work Packages are outlined below:

- **Project Delivery –** costs associated with the running of the Project Office and spend is **£0.063m.**
- **RDD Process** – **spend of £0.091m** for the reviewable design data process as RIBA stage design is finalized with Project Co.
- **Construction Phase – spend of £0.091m** for the services provided by the Authority Construction Surveyor.
- **Equipment Advisers – spend of c£0.021m** for equipment advice.
- **Digital equipment procurement – spend of c£0.014m.**
- **Project Management Advisers – spend of c£0.054m** for the SRO; Project Control and Risk Management support.
- **Professional Advisers – spend of £0.111m** 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 **JULY 2025 is £1.117m**. The actual run-rate is **aligned** with the planned spend.





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

- For **JULY 2025** the capital spend forecast outturn is **£9.618m;** and
- WG has an **approved** CRL for the Project(s) **confirmed**.
- We will be conducting a full financial review of the project forecast which will be reviewed also with WG.

5.6 The CRL position is outlined below:

EW Project

Period 2025-26	Current Approved CRL £m	Actual & Forecast Spend £m	Variance £m
Apr-25	0.442	0.442	0.000
May-25	0.096	0.096	0.000
Jun-25	0.245	0.245	0.000
Jul-25	0.593	0.334	0.259
Aug-25	0.514	0.504	0.009
Sep-25	0.401	0.391	0.009
Oct-25	0.396	0.387	0.009
Nov-25	0.331	0.409	-0.078
Dec-25	0.534	0.525	0.009
Jan-26	0.045	0.036	0.009
Feb-26	0.045	0.221	-0.176
Mar-26	0.584	0.398	0.186
TOTAL	4.225	3.988	0.237

nVCC Project

Period 2025-26	Current Approved CRL £m	Actual & Forecast Spend £m	Variance £m
Apr-25	0.258	0.258	0.000
May-25	0.276	0.276	0.000
Jun-25	0.268	0.314	-0.046
Jul-25	0.271	0.323	-0.052
Aug-25	0.332	0.326	0.006
Sep-25	0.335	0.310	0.025
Oct-25	0.406	0.314	0.093
Nov-25	0.307	0.300	0.006
Dec-25	0.324	0.300	0.024
Jan-26	0.313	0.304	0.009
Feb-26	0.308	0.421	-0.113
Mar-26	2.071	2.181	-0.111
TOTAL	5.470	5.630	-0.160

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**

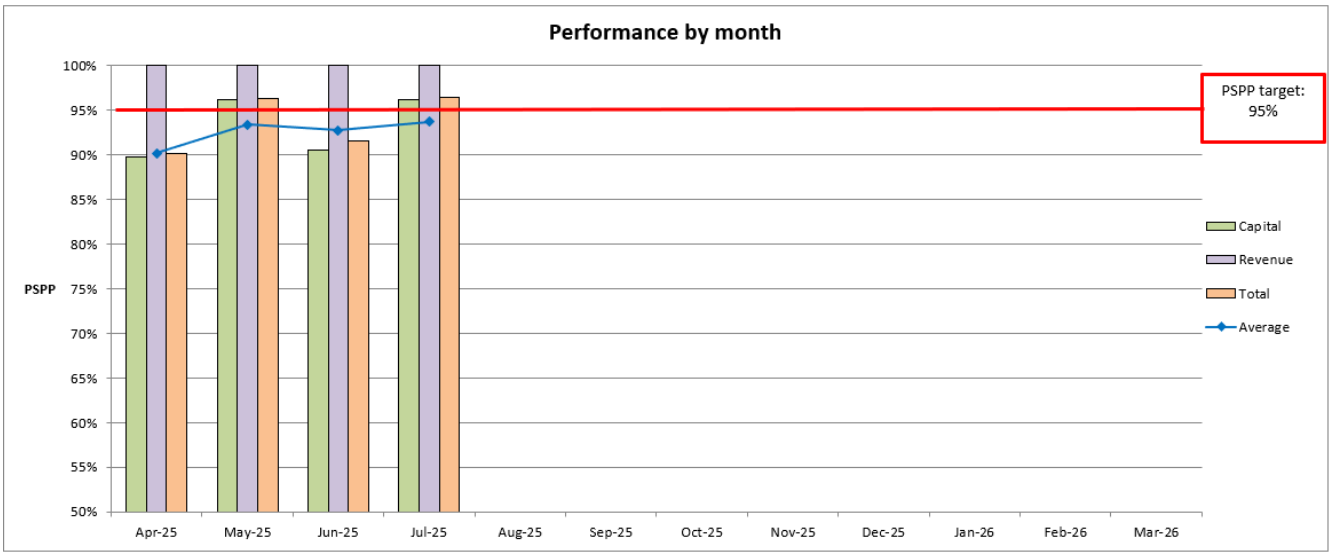
6.5 As agreed with WG, the remaining QRA is **c£17.943m.**

7. PUBLIC SECTOR PAYMENT POLICY

7.1 For **JULY 2025,** the PSPP performance was **96.49%** and the PSPP target was **achieved**. Of the 57 invoices for payment, 55 invoices were processed within the 30-day deadline.

7.2 The average PSPP performance to date for 2025-26 is **94%**.

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 outined 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	25 September 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 and 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. • Provides the Trust Board with detail and outcomes from audits carried out in respect of static risks and sub-threshold risks.
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. • **NOTE** the static risks and sub-threshold risk audits.

COMMITTEE / GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING	
COMMITTEE OR GROUP	**DATE**
Velindre Cancer Service Senior Leadership Team (VCS SLT)	08.08.2025
Welsh Blood Service Senior Leadership Team (WBS SLT)	13.08.2025
Executive Management Board	26.08.2025
Audit Committee	02.09.2025
Quality, Safety and Performance Committee	11.09.2025

This paper takes into consideration the feedback from VCS and WBS leadership teams on their respective risks.

The Executive Management Board considered the risk register and agreed to review the risks ahead of Audit Committee. Following the meeting, the VCS Director carried out a review of risks, the amendments of which are detailed in this paper.

The Audit Committee noted the current position and updates on the Trust Risk Register (TRR) and welcomed the inclusion of information regarding static risks and sub-threshold risks. A review of sub-threshold risks will be presented to Audit Committee twice a year (September and March) with a target of zero risks remaining outside the agreed review period. Further information has been added to closed risks 2187, 2249 and 2465 at the Committee's request.

The Quality, Safety and Performance Committee discussed the digital risks, noting the merits of working collaboratively with other NHS Wales organisations to share knowledge. The Committee recommended that the work to consider risk management systems also included consideration of Datix and considered as part of the digital programme.

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) and the Welsh Blood Service (WBS) monthly risk analysis reports.

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 five risks are no longer reportable on the Public Trust Risk Register:

Risk 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.'

The risk rating reduced to g(5x1), and the risk has been closed with the following rationale: Decision to maintain aseptic capacity/ model at VCS to support production of SACT obtained by COO with EMB colleagues. Therefore, delays to national TrAMS will not affect nVCS SACT aseptic production capacity.

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 current risk rating reduced below the threshold reportable to Trust Board for a risk in the workforce domain. A clinical Oncologist from Urology has been released to spend additional time in the SARCOMA service, until October 2025. Successful recruitment of a clinical oncologist with a start date of 06.10.2025. Successful recruitment of a Clinical Nurse Specialist (CNS), who is currently working their notice period will be joining the organisation in the next two months. Support is being provided from a lead CNS one day a week in the SARCOMA service.

Risk 2465

'There is a risk to patient safety, caused by the duplication of information, excessive use of email and a lack of alternative communication methods for the processing of clinical information.'

The PTL (Patient Tracker Live) is due to be implemented within the SACT department. This will provide an alternative method of communication for messages containing clinical information. In addition to the implementation of the PTL a targeted piece of work is being carried out throughout VCC by a nominated task and finish group, to implement recommendations from an audit that reviewed email use. Whilst this does not remove the risk, it is being effectively managed and there is ongoing work to improve email etiquette and behaviour. Considering this it is felt that the risk can be reduced to 10. Further work is ongoing to encourage good behaviours with regards to email use and recommendations generated from the email audit are currently being implemented. Advice on good email etiquette is also being periodically shared and the message reinforced within all workforce groups.

Risk 2187
'There is a risk to patient safety due to inadequate staffing within the Radiotherapy Physics Department and the need to balance core duties with developmental tasks'

The frequency at which the multiple demands may occur could be as frequently as daily. Hence currently likelihood score probable will reduce with anticipated recruitment and therefore it would then drop to a 2/3.

The allocation of staff to each of the projects concerning the implementation of the IRS, including commissioning of the equipment at nVCC has been reviewed. Additionally, the Head of Radiotherapy Physics and additional Medical Physics Engineers (MPEs) have been recruited. However, the former were internal appointments and will require backfilling in due course.

Although the risk rating has been reduced the service remains fragile due to the extremely tight commissioning schedule at nVCC and the volume of work required to be completed prior to November 2026 when exclusive access to nVCC will be granted.

Risk 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.'

Initial risk relates to ongoing risk of externally funded posts. Removed on the basis that this is an ongoing issue that continues to be reviewed. New risk to be created to capture financial sustainability of Velindre Cancer Services.

Work will now be consumed as part of the Divisional Triumvirate review of all unfunded posts. The purpose of this review is to assess the need and funding requirements for all posts in scope to ensure that sustainable financing is identified and exit strategies in place for any future funding cessation.

2.2 There is one new risk on to the Trust Risk Register:

Risk 3735
'There is a risk to Performance & Service Sustainability as a result of Health Boards delaying 'go live' dates resulting due to delays in other organisations ahead of Velindre University NHS Trust in national deployment plan'

There is a workshop arranged for 3rd September 2025 where the order of go live dates for Health Boards is part of the agenda. Decision will be made by following the confirmed HB order.

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

- A total of 13 risks reporting onto the public Trust Risk Register in line with the Trust's risk appetite.
- Four risks with a score of 12 or above reported in the safety/quality domain.
    - One on the VCS register
    - Three on the WBS register.
- Nine with a score over 15 or above reported in other domains.
    - One on the VCS register
    - Three on WBS register
    - Five on the Corporate risk register.

Risk Themes

1. **Patient Safety & Quality of Care**

- Delays or errors in blood test result management (risks 3562, 3418, 3678).
- Outdated or manual processes increasing the chance of incorrect results (2774).
- Aged or limited Laboratory Information Systems creating patient safety risks (3643, 3388).

2. **Digital & IT System Risks**

- Dependence on legacy IT systems and manual workarounds.
- Risks linked to delays or failures in national digital programmes (RISP, WLIMS, FEDIS, EPMA).
- Limited capacity for integration with national architecture (3633).
- Workforce burnout from high digital service demand and competing priorities (3634).

3. **Performance, Service Sustainability & Business Continuity**

- Risks from delayed national or local programme deployments impacting the Trust's operations (3735, 3646, 3632).
- Electrical supply loss at Welsh Blood Service site (3306).
- Assurance and reporting gaps for hosted services (3656)

3. Management of Static Risks

The purpose of conducting a Static Risk Review is to ensure that all risks recorded on the Trust Risk Register remain current, accurate, and reflective of the organisation's operational and strategic environment. Static risks—defined as those with an unchanged risk score for 12 months or more—require particular scrutiny to confirm that they are still relevant, appropriately assessed, and managed effectively.

Reviewing static risks promotes good governance by ensuring that the Board and senior management have assurance that risk information is reliable, that resources are directed appropriately, and that no risks are retained without ongoing justification.

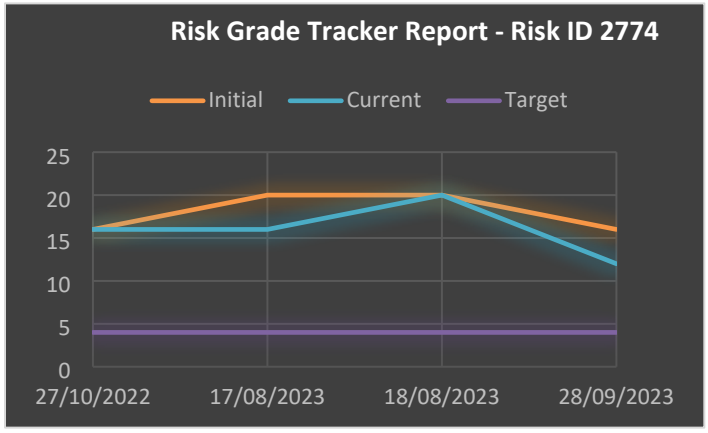
The Trust Risk Register submitted to Trust Board in July 2025 was reviewed by the Risk and Assurance Manager, working with risk leads to examine the context, controls, assurances, and scoring of each static risk.

Since October 2024, there has been a notable improvement in the management of what were static risks at that point. This is in part due to a more collaborative approach between risk owners, operational managers, and the Risk and Assurance Manager. Regular reviews have been embedded into routine governance processes, enabling earlier identification of changes to risk context and the consistent application of mitigating controls. This joint effort has improved the accuracy of risk scoring, enabled improved challenge by Divisional and Executive leadership resulting in strengthened assurance on the appropriateness of current controls, management of action plans and target dates and reduced the number of risks remaining static without clear rationale.

A static risk audit was undertaken to review risks recorded on the Trust Risk Register that meet the agreed threshold tolerance and have remained on the register for 12 months or longer without any change to their current risk score. The audit focused on identifying risks that have not moved in score over time, to assess whether they remain valid, appropriately managed, or require further action.

One risk on the Trust Risk Register fitted the criteria of a static risk:

Risk 2774
"There is a risk to Quality and Safety as a result of extensive manual workarounds due to outdated legacy IT systems, leading to increased risk of incorrect test results and patient harm."



A review of the data on Datix alongside liaison with the risk lead and the Quality and Risk Development Manager at the Welsh Blood has evidenced sound and regular management of this risk. Monthly reviews have taken place including a review of the risk score and rating, the controls in place and the review and management of the SMART action plan.

The current risk is due to manual workarounds implemented within Transplantation Services due to the ongoing use of an IT legacy system. The project has seen no movement in the trend or direction of travel. The risk scoring remains unchanged until the replacement system is live to mitigate. No further controls or mitigations can be identified to reduce the risk prior to replacing the system.

Progress up to now:

- Implementation began on 26/05/2024.
- Twice-weekly meetings were set up with the supplier to support system configuration, development, and super-user training.
- Three workstreams were established to support concurrent work:
    - Transformation workstream: process redesign and system configuration.
    - Data workstream: migration of legacy data.
    - Application workstream: build of environments, database, and interfaces.
- On-site training from the supplier took place from 17/06/2024 to 20/05/2024.

Milestones and future milestones include:

- User Acceptance Testing (UAT), started in January 2025.
- Validation commenced in April 2025.
- Go-live planned for October 2025.

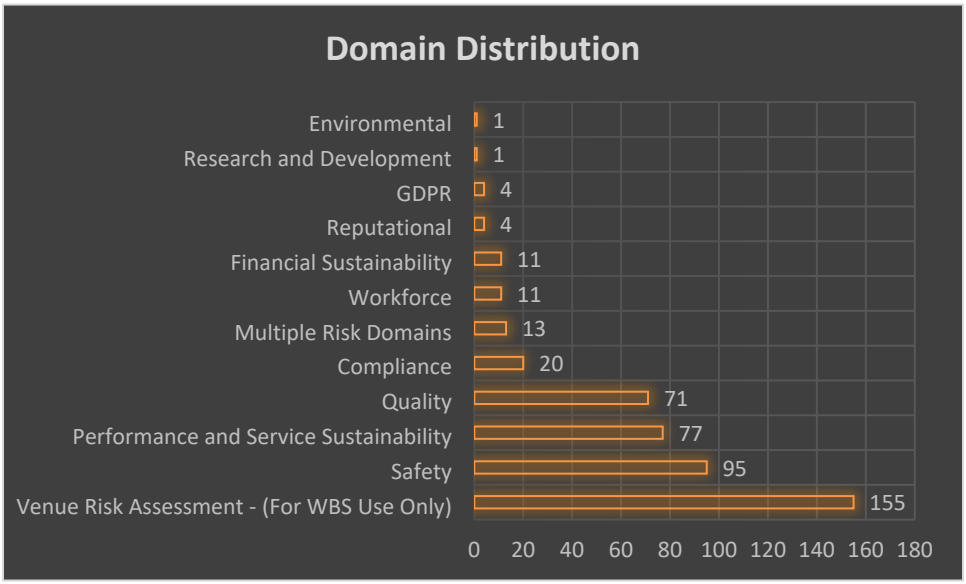
Delays occurred, and the project team has assessed options for potential re-scoping of key project milestones. An SBAR recommending a three-month delay to go live (from July to October 2025) was supported by various boards followed by approval and will be presented to the Senior Leadership Team (SLT). The go-live date for the WHAISIT project has been moved to October 2025

Sub-Threshold Risk Audit

The review was undertaken to assess the management of sub-threshold risks within the Trust's risk management framework. For the purposes of this review, sub-threshold risks are defined as those recorded on Datix in August 2025 that sit below the reporting threshold for escalation to the Trust Board.

In line with established governance arrangements, all Quality (71 risks) and Safety (95 risks) related risks presenting on Datix are monitored and managed through the Quality and Safety Hubs, with escalation through the Integrated Quality and Safety Group as appropriate. Each Hub considers and challenges the risks presented.

In addition, 155 risks associated with Welsh Blood Service (WBS) venues are recognised as tolerated risks for the duration of each venue's operational lifespan. To date, the main focus of this review is to ensure that remaining sub-threshold risks are being appropriately monitored, reviewed, and mitigated in line with the Trust's risk management policy.



49 risks have a current risk rating the same as the target risk, in which case the risk is tolerated and remains on the system for review. 44 risks have an out-of-date review, 18 of which are corporate risks, VCS risks, WBS risks, and 2 nVCC risks.

The review, which included the consideration of review dates, identified that a total of 45 risks had overdue reviews. Of these, 11 were recorded as corporate risks, 1 related to nVCC, 5 to WBS, and the remaining 28 to VCS.

To address overdue risk reviews, the Risk and Assurance Manager has started to work with risk leads to implement clear review schedules, which are supported by automated reminders. Each risk has a risk lead who will be needed to carry out timely updates, with compliance monitored through routine reporting. Training and guidance will reinforce the importance of reviews, while integration into governance meetings will ensure regular oversight.

To strengthen management of sub-threshold risks, the following actions will be taken:

- **Clear Review Schedules** – Each risk has an agreed review frequency, with automated reminders and escalation where deadlines are missed.
- **Ownership and Accountability** – Risk leads will be responsible for timely updates, with compliance monitored through routine reporting.
- **Training and Support** – Risk leads will receive training and guidance to reinforce the importance of timely reviews and effective risk management.
- **Governance Integration** – Sub-threshold risk oversight will be embedded into existing governance meetings via an Operational Risk Management Meeting to provide regular assurance and ensure overdue reviews are addressed.
- **Monitoring and Reporting** – Progress will be tracked, with overdue risks prioritised for immediate action supported by the Risk and Assurance Manager for oversight.

This plan will ensure sub-threshold risks are effectively managed, the accuracy of the risk register is maintained, and the Trust Board receives appropriate assurance. A bi-annual review of sub-threshold risks will be presented to Audit Committee twice a year (September and March) with a target of zero risks remaining outside the agreed review period.

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

DATIX SYSTEM REPLACEMENT

The contract with Datix 14 runs until November 2027.

The inaugural meeting of the internal multidisciplinary working group to consider the next steps for procuring an alternative risk management system to Datix, will take place on 26th September 2025.

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.

A meeting on the relevant issues took place on 20th August 2025 of risk peers across NHS Wales. There was an appetite to agree a specification for the new system collaboratively. It was agreed that intelligence around systems will be shared, as will sessions booked for demonstrations from providers. The collegiate approach was favoured by Health Boards and Trusts represented at the meeting.

The agreements from the meeting were:

- To explore whether DHCW could be commissioned to develop a bespoke system.
- Liaise with NWSSP Procurement to explore a national procurement option
- Establish a Risk System Teams Channel and Group to meet bi-monthly.
- Nominate representatives from each organisation.
- WAST representative to consider if they could hold the reign on this new group.
- Arrange a collective demo of AMAT following a collaborative specification being created.

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

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.
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 – September 2025 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

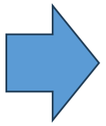
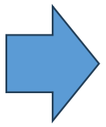
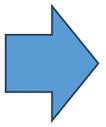
To note, risk scores are calculated by multiplying the impact (first number in brackets) of the risk by the likelihood of the risk (second number in brackets).

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	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:28.03.2025		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.	18.08.2025 Action for risk lead to review the risk and update progress notes. 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 date: 31.10.25		2. Clarity to all applicable staff as to their responsibility for the review and sign off of blood tests according to their roles. 3. SDEC services – resource required for cover off ad-hoc results –Options appraisal to be created and reviewed by Lead SST Clinician and Clinical Director. This will be presented to appropriate forum (TBC). *Due date: 01.09.25*	Expected to be commencing at the beginning of July. The due date for this action has thus been extended to 01 Sept 2025. Action 2: Extract from T and F Group Highlight Report May 2025: • Discussed with all non-medical clinical teams regarding extending the sign-off of bloods and test results on WCP, to spread the load of this task across the service. At present this sits with the SRC. Positive response to date. • SST leads addressed in monthly meeting explaining the scenarios, and the decision made by the Group that all outstanding blood results not yet reported by the time clinics end, is the responsibility of the SST to follow-up. This was agreed. • SACT Assessment Lead Nurse informed the group that new SACT protocols are being rolled out across the SSTs. This will standardise the way planned bloods are managed bringing clarity regarding their review and subsequent actions. The roll-out is expected to take 6 to 9 months to complete. • Discussions regarding Pharmacy signing off the D8 and D15 bloods concluded this would not be safe, as the parameters reviewed in the Pharmacy critical tests, do not cover all the parameters reported in the full 'clinical' test. Given the multiple potential staffing groups - the due date for this action has been extended to 01/09/25.
	15+ Risks in other domains										
2	3735 16.07.2025 **New to TRR	Radiation Services	Performance and Service Sustainability	Head of Radiation Services	There is a risk to Performance & Service Sustainability as a result of Health Boards delaying to go live with their instance of the new Philips RISP solution delaying go live resulting in Velindre implementation may be impacted by delays in other organisations ahead of trust in national deployment plan	**15** (5x3)	**20** (5x4)	**4** (2x2) Expected date: 12.09.25	New risk	Smart Action Plan to be created. *Review date: 29.08.2025*	27.08,2025 This is a project risk to be reviewed at September VCSF board before acceptance to Trust Risk Register. 19.08.2025 There is a workshop arranged for 3rd September 2025 where the order of go live dates for Health Boards is part of the agenda. Decision will be made by following the confirmed HB order

TRUST RISK REGISTER

	Welsh Blood Service										
	12+ Risks in the Quality and Safety domains										
3	3418 03.07.2025	WBS	Quality/ Safety	Head of Transplantation Services	There is a risk to quality, as a result of pre and post-examination processes for all tests yielding patient results, leading to a potential adverse impact on patient care.	**12** (4x3)	**12** (4x3)	**4** (4x1) Expected date 01.08.2025		1. Introduction of LIMS to mitigate the risk of manual transcription errors *Due date: 23.12.25*	14.08.2025 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 December 2025 and January 2026. 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.
4	3678 30.05.2025	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)	**4** (4x1) Expected date: 01.12.25		1. Update and add pre-determined comments to standardise reports and minimise transcription. 2. Training of laboratory staff for report writing *Due date:01.11.2025*	06.08.2025 Extensions added to the actions. Change control to be raised to capture update to reporting process. Reporting writing training will be covered by the change control
5	2774 27/10/2024	WBS	Quality/ Safety	Director of WBS	There is a risk to quality and safety as a result of extensive manual workarounds due to outdated legacy IT systems, leading to increased risk of incorrect test results and patient harm.	**16** (4x4)	**12** (4x3)	**4** (4x1)		1. Implement replacement IT System (Q3) 2. Discovery and planning 3. Transformation workstream - process redesign and system config 4. Data workstream - migration of legacy data	26.08.2025 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

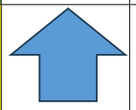
TRUST RISK REGISTER

								Expected Due date: 31.12.25		5. Application workstream - build of environments, database and interfaces	Go-live Date for the WHAISIT project is currently undergoing a review and an SBAR is being produced to evaluate a go-live date. No impact on risk scoring.
	15+ Risks in other domains										
6	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 *Due date: 06.02.2026*	26.08.2025 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 is currently undergoing a review and an SBAR is being produced to evaluate a go-live date. No impact on risk scoring.
7	3643 11.04.2025	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: 01.12.25		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). *Due date*:01.12.2025	18.08.2025 Communication between Digital Services and RCI made to understand current SERIF system & its capabilities. No progression on work currently. Risk remains the same.
8	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)		1. Develop and validate interface between FEDIS and eMPI+WRRS when available	14.08.2025 Stable/No movement - work ongoing with DHCW to complete the demographic and reporting integrations (being managed under a Change Proposal). DHCW have now signed off the demographic (MPI) production after receiving queries to test the connection. Still on target for close out 28/11/2025.

TRUST RISK REGISTER

								Expected date: 28.11.25			
Corporate											
15+ Risks in other domains											
9	3634 03.04.2025	Corporate	Multiple Risk Domains - Quality - Performance and Service sustainability - Workforce	Chief Digital Officer	There is a risk to Quality, Performance and Service Sustainability, and Workforce domains as a result of demand for work on new digital services exceeding the capacity of the Trust digital team and the Trust's capacity to take on the business changes management leading to priority service initiatives enabled by digital not being delivered successfully , stress and burnout for the digital team and regularly changing priorities.	**16** (4x4)	**16** (4x4)	**6** (3x2) Expected date: 01.04.26		1. Agree the final plans with the service areas - expected to be complete by the end of May 2025. 2. External partner will review the roadmap. 3. Capacity demand plan will be developed to support the roadmap. *Due date: 15.09.2025*	15.08.2025 Risk reviewed. No changes to risk score. Action 1: The service plans with service areas to be finalised. Actions 2 &3: The scope of the external roadmap has been written and confirmed following external partner review. A capacity demand plan will be developed to support the roadmap.
10	3646 15.04.2025	Corporate	Performance and Service Sustainability	Chief Digital Officer	There is a risk to PERFORMANCE AND SERVICE SUSTAINABILITY that the WLIMS 2.0 go-live date will be delayed due to delays in the national programme timeline causing an impact on realising project outcomes and additional demand for further development of existing legacy systems.	**16** (4x4)	**20** (4x5)	**6** (2x3) Expected date: January-March 2026		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.	15.08.2025 Wording sync'd with WBS Futures risk log Risk ID 131 Participating in national planning for LIMS across NHS Wales. Local plans are ready to test on LIMS 2.0. Launch date has been agreed as January-March 2026, this was agreed at WBS Futures Delivery Board. There is still risk to delivery by the national programme.
11	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 *Due date: 31.07.2025*	26.08.2025 Annual Report approved by Trust Board in July 2025. Review of reporting mechanisms into QSP underway. Review of licences completed. Still awaiting outcome of Welsh Government review. 20.06.2025 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

TRUST RISK REGISTER

12	3633 15.04.2025	Corporate	Multiple Risk Domains	Chief Digital Officer	There is a risk to Quality and Performance and Service Stability as a result of the lack of capacity of Digital Health and Care Wales to integrate VUNHST digital systems into the National Architecture on a timely basis leading to delays in the 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. *Due date: 15.09.2025*	15.08.2025 Share Intergration Plan with DHCW to be clear about priorities - Complete The weekly escalation meetings have been stood down. The interfaces for IRS have been completed successfully. Trust to line up third party suppliers (eg. Thermofisher) to provide their Intergration at the right time.
13	3632 03/04/2025	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)	**16** (4x4)	**8** (4x2) Expected date: 15.9.25		Risk reviewed. Likelihood reduced from 4 to 3 due to the change note for RISP, resetting the date of EPMA project starting. *Review date: 15.09.2025*	15.08.2025 Risk reviewed. RISP project has movement in the health board deployment schedule, which will have a potential impact on the go live date of January 2026 for VUNHST. Formal escalation to the national programme has taken place. Likelihood has increased from 3 to 4 with a current score of 16.

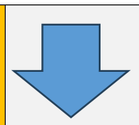
Commented [NG1]: Can you confirm this please Carl?

TRUST RISK REGISTER

SECTION 2 - Risks Decreased below Board threshold or closed since last Report to Trust Board in July 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
3541 02.12.2024	Velindre Cancer Service	Multiple Risk Domains (Quality, Safety, Performance and Service Sustainability)	Chief Pharmacy Officer	There is a risk to performance and service sustainability as a result of national TrAMS project being delayed leading to insufficient capacity within pharmacy technical services to meet SACT production.	**20** (5x4)	**5** (5x1)	**10** (5x2)	↓	23.07.2025 The risk has been closed with the following rationale: Decision to maintain aseptic capacity/ model at nVCS to support production of SACT obtained by COO with EMB colleagues. Therefore delays to national TrAMS will not affect nVCS SACT aseptic production capacity. A new risk relating to TRAMS will be assessed.
3468 12.09.2024	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)	**12** (4x4)	**2** (2x1)	↓	24.07.2025 Current risk rating reduced below the threshold reportable to Trust Board for a risk in the workforce domain. Clinical Oncologist from Urology released to spend additional time in the SARCOMA service, until October 2025. Successful recruitment of clinical oncologist, with a start date of 06.10.2025. Successful recruitment of CNS currently working notice period. will be joining the organisation within the next 2 months. Support from lead CNS one day a week in SARCOMA service.
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)	**10** (2x5)	**4** (2x2)	↓	05.09.2025 The PTL (Patient Tracker Live) is due to be implemented within the SACT department. This will provide an alternative method of communication for messages containing clinical information. In addition to the implementation of the PTL a targeted piece of work is being carried out throughout VCC by a nominated task and finish group, to implement recommendations from an audit that reviewed email use. Whilst this does not remove the risk, it is being effectively managed and there is ongoing work to improve email etiquette and behaviour. Considering this it is felt that the risk can be reduced to 10. Further work is ongoing to encourage good behaviours with regards to email use and recommendations generated from the email audit are currently being implemented. Advice on good email etiquette is also being periodically shared and the message reinforced within all workforce groups.

TRUST RISK REGISTER

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)	**8** (2x4)	**10** (5x2)		27.08.2025 The frequency at which the multiple demands may occur could be as frequently as daily. Hence currently likelihood score probable will reduce with anticipated recruitment and therefore it would then drop to a 2/3. The frequency at which the multiple demands may occur could be as frequently as daily. Hence currently likelihood score probable will reduce with anticipated recruitment and therefore it would then drop to a 2/3. The allocation of staff to each of the projects concerning the implementation of the IRS, including commissioning of the equipment at nVCC has been reviewed. Additionally, the Head of Radiotherapy Physics and additional Medical Physics Engineers (MPEs) have been recruited. However, the former were internal appointments and will require backfilling in due course. Although the risk rating has been reduced the service remains fragile due to the extremely tight commissioning schedule at nVCC and the volume of work required to be completed prior to November 2026 when exclusive access to nVCC will be granted.
2249 27.02.2020	Velindre Cancer Service	Financial Sustainability	Director of Cancer services	There is a risk to financial sustainability as a result of service disruption due to number of posts funded by time limited funding leading to financial instability, recruitment difficulties.	**16** (4x4)	**16** (4x4)	**6** (3x2)		27.08.2025 Initial risk relates to ongoing risk of externally funded posts. Removed on the basis that this is an ongoing issue that continues to be reviewed. New risk to be created to capture financial sustainability of Velindre Cancer Services. Work will now be consumed as part of the Divisional Triumvirate review of all unfunded posts. The purpose of this review is to assess the need and funding requirements for all posts in scope to ensure that sustainable financing is identified and exit strategies in place for any future funding cessation.

TRUST BOARD	
BOARD ASSURANCE FRAMEWORK	
DATE OF MEETING	25 September 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 • Lauren Fear, Director of Performance, Place & Portfolio • Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science • Anne Carey, Chief Operating Officer • Sarah Morley, Executive Director of OD and Workforce • Jacinta Abraham, Executive Medical Director • Matthew Bunce, Executive Director of Finance • Carl Taylor, Chief Digital Officer
APPROVED BY	Non Gwilym, Interim Director of Corporate Governance
EXECUTIVE SUMMARY	This paper provides the Trust Board with the latest updates to the Board Assurance Framework.
RECOMMENDATION / ACTIONS	The Trust Board are asked to: • **NOTE** the status of the Board Assurance Framework. • **DISCUSS** the plan to move forward with the Board Assurance Framework.

COMMITTEE / GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING	
COMMITTEE OR GROUP	**DATE**
Executive Management Board	26.08.2025
Audit Committee	02.09.2025
Strategic Development Committee	09.09.2025
Quality, Safety and Performance Committee	11.09.2025

The Executive Management Board discussed and noted the status of the Board Assurance Framework.

The Audit Committee noted the updates on the Board Assurance Framework (BAF) and discussed strengthening the link to strategic objectives and the IMTP going forward.

The Quality, Safety and Performance Committee noted the Strategic risks, noting the need to strengthen the strategic objectives with the strategic risks in the BAF. The Committee wanted to ensure that all Risks on the Trust Risk Register were included in the BAF.

The Strategic Development Committee noted the static nature of the vast majority of the risks and challenged the management teams to review the risk scores during the next reporting period.

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	Board Assurance Framework at a Glance
3	Board Assurance Framework Detail
4	Board Assurance Framework Dashboards

1. SITUATION

1.1 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 the Integrated Medium-Term Plan (IMTP) process, 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.

In July 2025 the Trust Board approved renaming the Trust Assurance Framework as the Board Assurance Framework (BAF), bringing Velindre University NHS Trust in line with other NHS organisations.

2. ASSESSMENT

2.1 As part of the IMTP, 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. An initial review has been undertaken by the Executive Team which has considered risk titles and the suitability of the strategic risks. The Executive Team agreed an additional workforce risk should be separated from BAF02. This risk is now available as BAF11. Risk BAF02 has now been refined as a specific risk related to quality outcomes and experience for both cancer and blood services.

2.2 Following submission to Trust Board in July 2025 the following work has been undertaken or is planned:

- Strategic risks have been reviewed, including scrutiny of actions and assurance levels across the BAF.
- The risk in BAF02 has been reviewed and updated. The risk is a quality risk which has been developed, fully populated with action plans in place, controls, assurance ratings and gaps in controls identified.
- Following collaboration with the Sustainability Manager and the Transformation Team, BAF05 (Sustainability) and BAF10 (Transformation) have been developed, and are fully populated, with action plans in place, controls, assurance ratings and gaps in controls identified.
- Following collaboration with the Research, Development and Innovation team to develop BAF03 (Research, Development and Innovation) the strategic risk has been developed, fully populated, including action plans, controls and assurance ratings.

2.3 The remaining strategic risks have been reviewed and updated. Regular monthly review meetings are in place to support the management of the strategic risks.

2.4 Appendices 2, 3 and 4 show the current summary for the eleven strategic risks and the more detailed information to support, including full dashboards.

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 BOARD 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

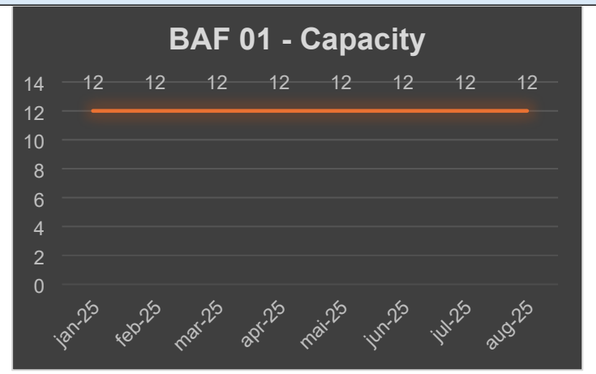
3 RISKS

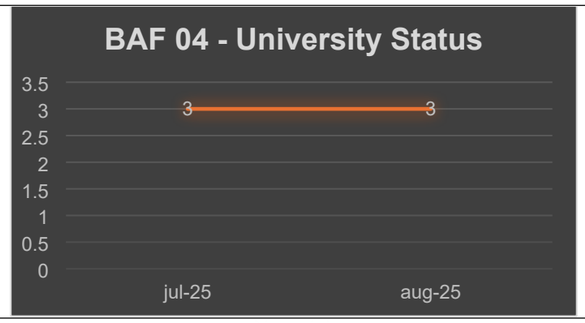
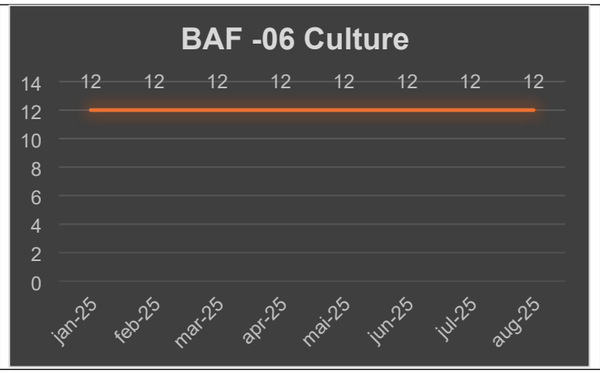
ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes
WHAT IS THE RISK?	The strategic Risks outlined in the BAF are informed by the Trust's active management and reporting of its operational risks.
WHAT IS THE CURRENT RISK SCORE	n/a
BY WHEN?	Ongoing
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
All risks must be evidenced and consistent with those recorded in Datix	

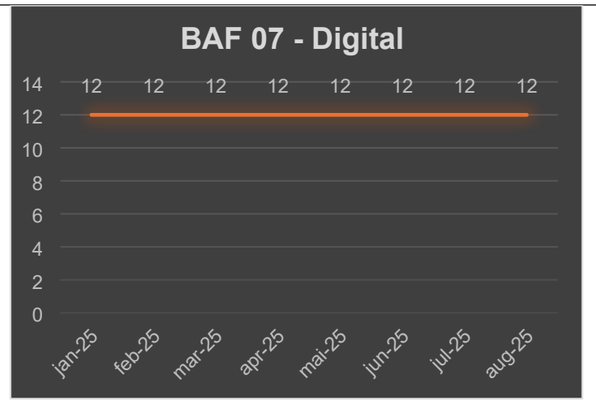
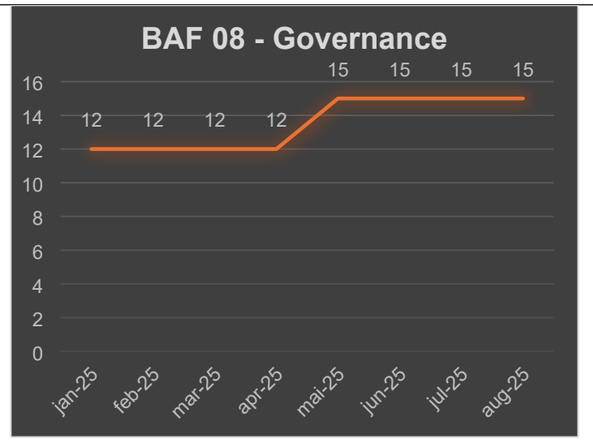
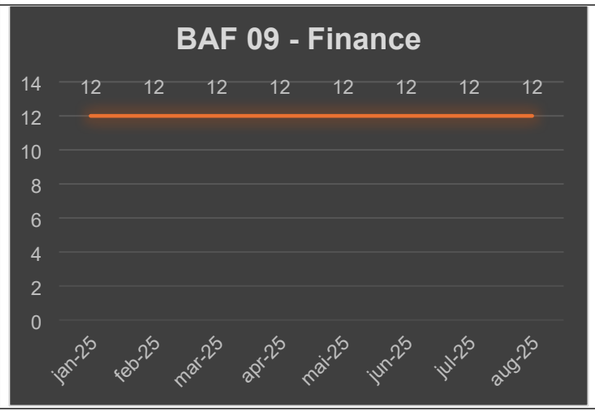
Appendix 1 – Trust Strategic Risks

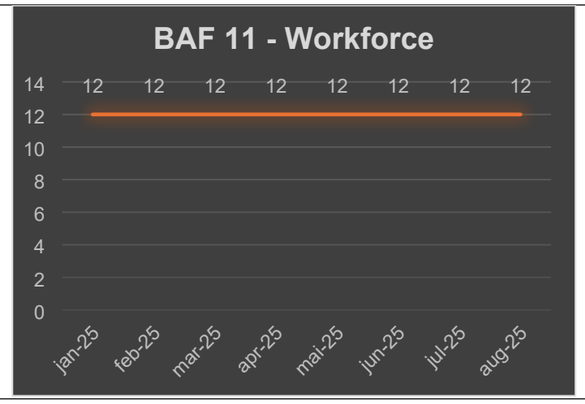
RISK REF	RISK TITLE	STRATEGIC GOAL/ENABLER	SUGGESTED RISK LEAD(S)
01	There is a strategic risk of failure to deliver timely, safe, effective and efficient services for the local population leading to deterioration in service quality, performance or financial control as a result insufficient capacity and resources.	Outstanding for quality, safety and experience.	Chief Operating Officer
02	There is a strategic risk that the quality of patient/donor/population outcomes and/or experience across the services managed by the Trust may be adversely impacted due to increasing demands, complexities and the need for significant service transformation.	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 Strategies, 2. Not fully embedding 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 retain the Trust's University status.	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 effective values and behaviours, systems and processes.	Culture	Director of OD and Workforce

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 risk that the scale and complexity of the transformation across the organisation may exceed the organisation's capacity to manage and execute effectively resulting in a failure to deliver on core strategic goals and an associated loss of benefits realisation which will impact on stakeholder confidence	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 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)		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 – **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. – **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. – **2774** There is a risk to quality and safety as a result of extensive manual workarounds due to outdated legacy IT systems, leading to increased risk of incorrect test results and patient harm. – **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. – **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. – **3586** There is a risk to QUALITY as a result of the potential change of supplier, leading to an insufficient timeline to complete extensive testing and validation on the new BECS and potentially compromising WBS ability to perform as a Blood Establishment within Wales e.g. collect, process, test and supply blood to Wales – **3585** There is a risk to PERFORMANCE & SERVICE SUSTAINABILITY as a result of the potential change of supplier, leading to a lengthy transition to a new system and insufficient time to absorb slippage due to immovable date. Project ID: W2-01 – **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.
02	There is a strategic risk that the quality of patient/donor/population outcomes and/or experience across the services managed by the Trust may be adversely impacted due to increasing demands, complexities and the need for significant service transformation.	An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed, expectations.	20 (4x5)	16 (4x4)	New risk	New risk	– **3562** –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

							– **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. – **2774** – There is a risk to quality and safety as a result of extensive manual workarounds due to outdated legacy IT systems, leading to increased risk of incorrect test results and patient harm. – **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.
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 Strategies, 2. Not fully embedding innovation activities in line with the national Innovation Framework.	A beacon for research, development and innovation in our stated areas of priority.	12 (4x3)	9 (3x3)	New risk	New risk	There are no associated risks on the Trust Risk Register
04	There is a strategic risk of failing to retain the Trust's University status.	An established University Trust which provides highly valued knowledge and experience for all.	3 (1x3)	3 (1x3)		6	There are no associated risks 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	16 (4x4)	9 (3x3)	New risk	4	There are no associated risks 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)		TBC	There are no associated risks 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)		3	– **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)		3	– **3656** Quality of current assurance and reporting arrangements in hosted services
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)	16 (4x4)		4	– **2249** Service disruption due to number of time limited funded posts
10	There is a risk that the scale and complexity of the transformation across the organisation may exceed the organisation's capacity to manage and execute effectively resulting in a failure to deliver on core strategic goals and an associated loss of benefits realisation which will impact on stakeholder confidence	Transformation Delivery	16 (4X4)	16 (4X4)		3	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)		4	- **3634** Capacity issues for digital services

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) Current **12** (4x3)	• 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	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. 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 August 2025 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. July/ August '25 the nVCC modelling to be revisited and assumptions rescoped in advance of discussions with the HBs

			Target **8** (4x2)		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 August 2025 SACT Delivery Group / SACT improvement manager undertook demand and capacity, which identified the need to move the MoC to consultant led. Once model is embedded reviewed Capacity & Demand work is required. Radiotherapy Capacity and Demand will be enabled by the 'go paperless' initiative and maximise productivity.
Executive Lead Summary: WBS - position is stable and has been sustained for several months. The position continues to be monitored via the Blood supply Chain Group. VCS – delivery of the patient care across SACT and Radiotherapy services requires sustained focus. Further work is needed to deliver the consistency required and to continue to build capacity. This work is being supported by increasing ability to track pathways and understand bottlenecks in pathways, for focused work. Risk score trend: The risk score has remained static since the last period.					
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 the quality of patient/donor/population outcomes and/or experience across the services managed by the Trust may be adversely impacted due to increasing demands, complexities and the need for significant service transformation.	Inherent 20 (4x5)	• Capacity and demand planning and forecasting • Quality and safety monitoring (Via PMF & AMaT Quality & Regulatory Tracker) • Processes in place to capture patient experience, ensuring effective listening and learning • Mortality review process and monitoring and Medical Examination Service (MES) in place. • Velindre Oncology Academy establishment • Clinical audit process and systems in place	02.01 Implement the digitisation of a robust set of service level to Board quality, safety outcome and experience metrics including mortality, aligned with the Performance Management Framework. Content to be confirmed.
					02.02 Deliver a programme of quality and safety investigation training for all potential investigation leads. August 2025 Currently insufficient people trained. Quality issues with current investigations and new staff are being employed requiring training.
					02.03 Implement the digital PROMS system for patients and establish a mechanism for regular analysis and identification of areas for learning and improvement.
			Current 16 (4x4)		02.04 Fully implement Electronic Prescribing and Medicines Administration across Velindre cancer Service.

					02.05 Fully implement all Trust required IBI recommendations. August 2025 Trust is aware of the need to progress infrastructure work and develop business cases for consideration by Joint Commissioning Committee.
			Target 6 (2x3)		02.06 Fully implement the revised Putting things Right regulations. August 2025 Awaiting Senedd Committee approval of revised regulations (planned for October 2025). Statutory guidance in development, Planned implementation date, 1 April 2026.
					02.07 Strengthen patient and donor experience feedback mechanisms, specifically to increase the volume of experience feedback provided to the Trust across its services. August 2025 Average of 16% feedback for WBS. Less than 0.1% of VCS patients. New national People Experience framework being implemented on target for completion by April 2026 as noted.
					02.08 Strengthen the quality and safety assurance and oversight mechanisms for hosted services. August 2025 Some strengthening undertaken within last 3 months. Awaiting WG hosting arrangements review.
					02.09 Embed and enhanced learning framework across the Trust, including learning from external organisations. August 2025 Learning framework in place. However, quality and safety analysis has identified repeated themes which means further strengthening and embedding required with improved ownership and accountability from service level to accountable Director.
					02.10 To refresh and relaunch Trust patient safety framework. August 2025

					Current framework requires review in light of structural changes and strengthening of accountabilities and responsibilities for quality and safety outcomes and experience.
Executive Lead Summary: Considerable enhancements made to health and safety processes. However, there is an increase of Duty of Candor incidents within VCS and repeated themes and trends within both divisions identifying the need for robust learning and improvement mechanisms.					
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 Strategies, 2. Not fully embedding innovation activities in line with the national Innovation Framework.	Inherent 12 (4x3) Current 9 (3x3) Target 6 (2x3)	• Research strategies defining Trust ambitions for research & innovation in line with national priorities (Trust Cancer Research Ambition, WBS Strategy, WG Innovation Framework) • Deliver plans for research governance/delivery are monitored to assure progress on delivery • Benchmarking research activity (through OECI accreditation membership, UK peer cancer centre comparisons) • Engagement with UK / National bodies • Cardiff Cancer Research Partnership (CCRP) • Welsh Blood Service research governance	03.01 Develop and implement a structured benchmarking programme with UK peer cancer centres to review optimal Research Service infrastructure, workforce, and delivery models. Align benchmarking outputs with OECI Designation criteria and partnership theme. August 2025 Initial discussions with Clatterbridge on delivery / finance models. Meeting being arranged to visit Clatterbridge 03.02 Commission a programme of internal and independent audits of Research Service processes, including study set-up, delivery, and governance. Scope to cover compliance with UK Clinical Trials Regulation and ICH GCP E6(R3), coming into force in April 2026, linked to workforce development/training theme. August 2025 Mapping of SOP refresh and training requirements underway; draft framework developed for SOP suite and training. 03.03 Develop and implement a sustainable funding model for RD&I, reducing dependency on charitable and short-term funding streams. Link to financial sustainability theme and VPAG/charitable investment planning. August 2025 VPAG investment plan in place. Charitable Fund Integrated Bid 2026–29 submitted through Trust governance infrastructure.

Executive Lead Summary: The risk is currently assessed as moderate but managed, with robust strategies in place to deliver against both the Velindre Cancer Service 10-year Cancer Research Ambitions and the Welsh Blood Service Research Strategy. The risk is being actively managed through robust governance structures reporting to the Trust's RD&I Sub-Committee and onward to the Quality, Safety & Performance and Strategic Development Committees and then to Trust Board, as appropriate. This ensures the Trust maintains alignment with the UK Policy Framework for Health and Social Care Research, The Medicines for Human Use (Clinical Trials) Regulations 2004, as amended; and the ICH Good Clinical Practice Guidelines E6. The oversight of the research risks by the Research Service is supported by delivery plans to manage digital transformation, regulatory preparedness, and strengthen assurance. Key residual risks remain around sustainable funding, workforce capacity, and evidencing OECI / benchmarking outcomes – these are being addressed through targeted actions.					
04	An established University Trust which provides highly valued knowledge and experience for all. • Director of Corporate Governance	There is a strategic risk of failing to retain the Trust's University status.	Inherent 3 (1x3) Current 3 (1x3) Target 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-professional research SLA; Cardiff Cancer Research Hub • Academic partnership arrangements across a range of universities in Wales.	04.01 Review Board membership August 2025 Review will take place during September alongside new Chair and Independent Members Group. 04.02 Review of Academic Partnership Board August 2025 Review will take place during September alongside new Chair and Independent Members Group.
Executive Lead Summary: Controls have been identified. All controls reporting as preventative and as being managed resulting in a current rating of 3.					
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.	Inherent 16 (4x4) Current 9 (3x3) Target 4 (2x2)	• Creating Wider Value: Our Organisational Approach • Sustainable Care Models • Carbon Zero • Sustainable Infrastructure • Transition to a Renewable Future • Connecting with Nature • Greening Our Travel and Transport • Adaption to Climate Change • Our People as Agents for Change	05.01 Embed sustainability considerations into capital project decision-making processes, including mandatory environmental impact assessments in business cases 05.03 Include sustainability and Well-being of Future Generations duties in all job descriptions and recruitment materials September 2025 Actions included following Audit, QSP and Strategic Development Committees' consideration of the BAF

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

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) Current **12** (4x3)	• Trust Strategies and enabling strategies (including people, RD&I 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 • Avoidable employee harm principles are embedded into the management of behaviours within the Trust	06.02 Embed the principles of the Social Partnership Duty into the Trust's strategic development and through the Trust Board cycles of business Session delivered to Board on the Duty. Meeting with SDC Chair set up. 11/09/2025 - closed. 06.05 Implement the actions of the Trust Strategic Equality Plan, including embedding the Anti-Racist Wales Action Plan in the Trust Aug 25 The 2024-25 SEP workplan has been closed and the new plan 2025-26 is in action. This is monitored through the Healthy and Engaged Steering Group and QSP. Q1 2025-26 reports were submitted to these groups. September 25 This is monitored through the Healthy and Engaged Steering Group and QSP. Q1 2025-26 reports were submitted to these groups 06.06 Implement the actions within the Health and Wellbeing Action plan – supporting wellness and managing action plan for sickness absence Aug 25 The 2024-25 Health and Wellbeing workplan has been closed and the new plan 2025-26 is in action. This is monitored through the Healthy and Engaged Steering Group and QSP. Q1 2025-26 reports were submitted to these groups September 25 This is monitored through the Healthy and Engaged Steering Group and QSP. Q1 2025-26 reports were submitted to these groups. 06.07 Commence the Values and Behaviour framework project Aug 25

					The Values and Behaviours have been implemented across the Trust. This action should be closed and replaced with an action on embedding positive values and behaviours across the Trust.
			Target **6** (2x3)		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 Aug 25 Contained in action 6.05. This **can be closed**
					06.10 Monitor Welsh Language Standards, working with Divisions on improvement plans Sept 25 Welsh Language standards are being monitored through Trust wide governance and summaries with an annual report that is approved by Trust Board.
					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 Polices 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 Aug 25

					NHS Staff Survey Plans have been developed for the Trust and Divisions – shared at Healthy and Engaged Steering Group July 2025. Wellbeing Metrics and Wellbeing Project Evaluation reports shared 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 Aug 25 This is contained within the SEP Workplan 2025-26. EQIA report for 2024-25 which was shared 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 2025/26 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) Current **12** (4x3) Target **8** (4x2)	• Trust Digital Strategy - Published Oct '23 • Active work ongoing to leverage existing and deliver on new technologies – e.g. LIMS, IRS, BECS, EPMA • Training & Education packages to develop internal capabilities – including for exec and Board • Training & Education packages for donors, patients • 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.	07.01 Create the Trust Digital Reference Architecture to support C14 and others 15.08.2025 Working with National Target Architecture programme to align targets. 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 07.02 Prioritisation framework needs to be established for the Data and Insight Service 15.08.2025 Papers on Data and Insight in September 2025 and Priority going to EMB in August a 2025. 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: 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 • 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	***Action plan has been rationalised with previous TAF and 2025-26 IMTP*** 08.01 External benchmarking of Governance, Assurance & Risk best practice as part of the Governance, Assurance & Risk programme of work 08.02 Develop new plan for phase 2 GAR programme

				Framework	August 2025 GAR focused on improvements on decision/action reporting for minutes, refreshed risk policy and finalising BAF.
			Current **15** (5x3)		08.03 Review Trust Risk Policy August 2025 First phase due for completion by end of 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.
					08.05 Review Terms of Reference for all Board Committees capturing all requirements in relation to Duty of Quality. August 2025 To be completed by end of September.
					08.06 Training programme to support Duty of Quality reporting, Quality Impact Assessment completion and Assurance Level awareness. August 2025 Initial discussions resulting in changes of requirement re: Duty of Quality reporting in Board/Committee paper template. Discussion with assurance level trainer underway.
					08.07 Coordinate policy review process and update Policy on Policies as standard operating procedure to support organisational development, compliance and awareness of policies August 2025 First phase – report for consideration of September 2025 QSP meeting. Second phase – depending on outcome of QSP meeting to raise awareness of new Policy on Policies and implications for staff.

Executive Lead Summary:
GAR programme met in July 2025 to consider next steps. Further focused work in development on standard operating procedure for minute taking (including decisions and actions), strengthening the BAF and reviewing policy and procedures in support of the Trust's management of risk.

The Trust awaits the distribution of the Welsh Government's review of the hosting arrangements for Shared Services.

Committees' effectiveness surveys to be launched in August and support the review of Committee Terms of Reference and Cycles of Business in advance of September cycle.

Policy on Policies to be considered by QSP on XX September.

Review of induction of new Chair key to support good governance. Plans underway to support for 1 September.

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 • Procurement	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. • 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 August 2025 Finance workshop with Executive team in diary for 18.08.2025 to present the current financial position and discuss disinvestment options and financial recovery.

			Current **12** (4x3)		09.03 Development and review of Financial Control Procedures August 2025 A plan is in place to review and update all FCPs, with a completion date of December 2025.
					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 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.
					09.05 Identification of business development and external funding opportunities August 2025 CCRH project group continues to meet with a financial model developed on 04.08.2025 which is currently under review A revised charging tariff has been agreed with an implementation date of 1st July 2025. Contract negotiations have been arranged with those insurers that have specific queries and those involving 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. August 2025 Commissioners rejected the prostate radiotherapy business case on the basis that current charges are based on the historic share basis. Discussion around NHS Wales contract rebasing at the July 2025 DoF meeting identified that C&V UHB were currently undertaking an exercise to rebase the activity & cost of their LTAs, in particular to better reflect the resources consumed in delivering specialist services. The DoFs' view was WG should take a leadership role around NHS contract re-basing and agreed to seek a view from WG.
					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. August 2025 Finance workshop with Executive team in diary for 18.08.2025 to present the current financial position and discuss disinvestment options and financial recovery.
					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).
Executive Lead 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, however, given the significant emerging cost pressures the risk score may need review in future months.					
10	Transformation Delivery • Director of Estates and Portfolio	There is a risk that the scale and complexity of the transformation across the organisation may exceed the organisation's capacity to manage and execute effectively resulting in a failure to deliver on core strategic goals and an associated	Inherent 16 (4x4) Current 16	• Executive Leadership • Develop a Portfolio Governance Framework / Handbook • Portfolio Prioritisation and Phasing • Capacity & Resource Planning • Benefits Management and Realisation plan • Effective Portfolio Reporting	10.1 Develop a Portfolio Governance Framework / Handbook August 2025 Portfolio Handbook 80% complete
					10.2 Carry out Portfolio Prioritisation and Phasing

		loss of benefits realisation which will impact on stakeholder confidence	(4x4) Target 6 (2x3)		August 2025 Draft Prioritisation Framework complete requires approval before prioritisation exercise can be completed 10.3 Carry out Capacity & Resource Planning August 2025 Dependent on action 10.2 10.4 Carry out Benefits Management and Realisation plan August 2025 Not started yet 10.5 Establish Effective Portfolio Reporting August 2025 Effective Power BI dashboard in place 90% of data correct work ongoing to improve compliance with incremental design improvements to dashboard. September 2025 Actions included following Audit, QSP and Strategic Development Committees' consideration of the BAF
Executive Lead Summary: VUNHST has a substantial programme of transformation over the next five years, totalling in excess of £500million capital funding and associated service change. Although most of the main programmes and projects have their own governance arrangements there has been no overall portfolio management. Portfolio management is currently being implemented and this should lead to improved prioritisation, resourcing, benefit delivery and the reduction of transformation related risks at an organisational level.					
11	Workforce • Director of OD and 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 to develop and maintain of an optimised workforce supply and shape	Inherent 16 (4x4)	• 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 • 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	11.01 Development of a Trust Workforce Plan 11.09.2025 Paper on Workforce Planning progress has been integrated into the new iteration of 'Supply and Shape' assurance paper. This is due to EMB in October and QSP in November. 11.02 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

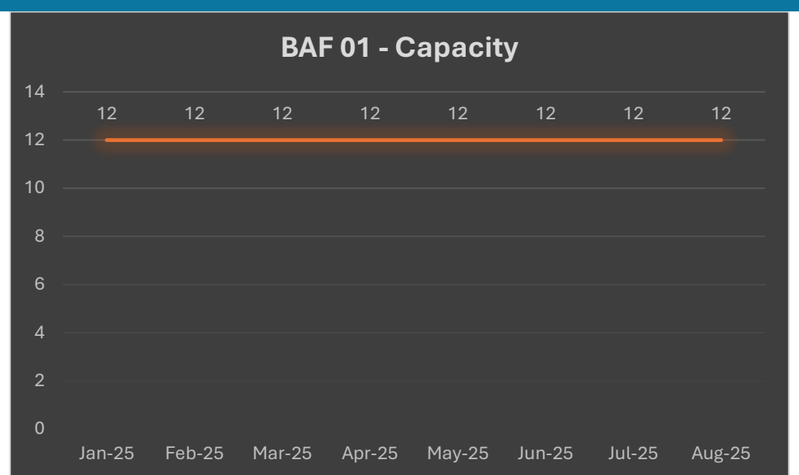
				• Workforce planning - skills development • Workforce Planning embedded into our Inspire Programme to develop Mangers and leaders in Workforce Planning skills	with ongoing dedicated support for recruitment, development, retention and people analytics.
			Current 12 (4x3)		11.03 Implementation of the 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.
			Target 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. August 2025 Appointment of Access to Work Coordinator confirmed August 2025 Appointment of Attraction and Resourcing Lead confirmed August 2025 11/09/2025 Completed
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, within the organisation, or granular at Multi-disciplinary team level. We are currently mitigating the risk in this area through effective strategic and operational workforce planning, with a focus on recruitment, retention and people development. 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.					

SECTION 1 – Summary

RISK ID	**01**	**REVIEW DATE**	August 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



CURRENT RISK SUMMARY

WBS - position is stable and has been sustained for several months. The position continues to be monitored via the Blood supply Chain Group.

VCS – delivery of the patient care across SACT and Radiotherapy services requires sustained focus. Further work is needed to deliver the consistency required and to continue to build capacity. This work is being supported by increasing ability to track pathways and understand bottlenecks in pathways, for focused work.

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

SECTION 2 – Risk Scores

	LIKELIHOOD	IMPACT	TOTAL		LIKELIHOOD	IMPACT	TOTAL		LIKELIHOOD	IMPACT	TOTAL
INHERENT RISK	4	4	**16**	**CURRENT RISK**	3	4	**12**	**TARGET RISK**	2	4	**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**	3
	Previous Review Period	NA
Rationale for Assurance Rating		

KEY CONTROLS	**SOURCES OF ASSURANCE**

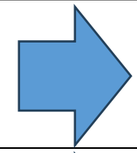
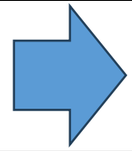
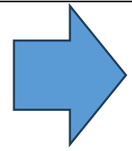
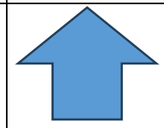
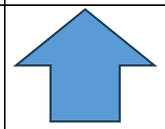
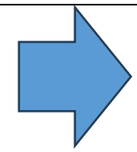
ID	KEY CONTROLS	OWNER	PREVENTATIVE	MITIGATING	DETECTIVE	FIRST LINE OF DEFENCE • *functions that own and manage risk* • *Self-assurance*	SECOND LINE OF DEFENCE • *Functions that oversee or specialise in risk management* • *Internal oversight/specialist control teams*	THIRD LINE OF DEFENCE • *Functions 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	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
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	12	

3418 WBS	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	
3678 WBS	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	
2774 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.	12	
3643 WBS	There is a risk to patient safety as a result of an aged Laboratory Information System (SERIF) leading to RCI and Automated Testing being unable to operate a safe service.	16	
3388 WBS	There is a risk to Quality and Performance as a result of reporting errors and limited accessibility of reports due to no interfaces between the Fetal D IT System (FEDIS) and NHS Wales Digital Applications, leading to suboptimal antenatal care.	16	
3586 WBS	There is a risk to QUALITY as a result of the potential change of supplier, leading to an insufficient timeline to complete extensive testing and validation on the new BECS and potentially compromising WBS ability to perform as a Blood Establishment within Wales e.g. collect, process, test and supply blood to Wales	20	
3585 WBS	There is a risk to PERFORMANCE & SERVICE SUSTAINABILITY as a result of the potential change of supplier, leading to a lengthy transition to a new system and insufficient time to absorb slippage due to immovable date. Project ID: W2-01	20	
3634 WBS	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 BAF 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 BAF XX regarding Trust widebaf Quality and Safety
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 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. July/ August ‘25 the nVCC modelling to be revisited and assumptions rescoped in advance of discussions with the HBs	18.08.2025		
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 / SACT improvement manager undertook demand and capacity, which identified the need to move the MoC to consultant led. Once model is embedded reviewed Capacity & Demand work is required. Radiotherapy Capacity and Demand will be enabled by the ‘go paperless’ initiative and maximise productivity.	18.08.2025		

SECTION 1 – Summary

RISK ID	**02**	**REVIEW DATE**	August 2025	**Risk Title**	There is a strategic risk that the quality of patient/donor/population outcomes and/or experience across the services managed by the Trust may be adversely impacted due to increasing demands, complexities and the need for significant service transformation.	**Risk Lead**	Director of Nursing, AHPs & Healthcare Science, Executive Medical Director & Chief Operating Officer

CORE ENABLER	Patient and Donor Outcomes and Experience	**STRATEGIC GOAL**	1 - Outstanding for quality, safety and experience
CURRENT SCORE TREND	NEW RISK	**CURRENT RISK SUMMARY**	Considerable enhancements made to health and safety processes. However, there is an increase of Duty of Candor incidents within VCS and repeated themes and trends within both divisions identifying the need for robust learning and improvement mechanisms.

SECTION 2 – Risk Scores

	LIKELIHOOD	IMPACT	TOTAL
INHERENT RISK	4	5	**20**
CURRENT RISK	4	4	**16**
TARGET RISK	2	3	**6**

Expected date to reach Target Risk Score

SECTION 3 – Effectiveness, Controls and Assurance

Overall Level of Effectiveness Assurance Rating (see definitions tab)	3

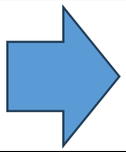
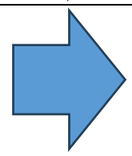
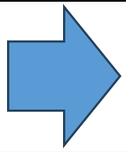
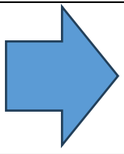
Overall Assurance Rating	**Current Review Period**	3
	Previous Review Period	n/a
Rationale for Assurance Rating	Some measurable impact evident from actions initially taken and an emerging clarity of outcomes sought to determine sustainability, with agreed measures to evidence improvement.	

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	Capacity and demand planning and forecasting	Chief Operating Officer	X	X		Velindre Cancer Service Senior Leadership Team	Executive Management Board & Quality, Safety & Performance Committee Peer Benchmarking	Internal Audit, HIW, & HEIW
C2	Quality and safety monitoring (Via PMF & AMaT Quality & Regulatory Tracker)	Director of Nursing, AHPs & Healthcare Science COO Director of Planning	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
C3	Processes in place to capture patient experience, ensuring effective listening and learning	Director of Nursing, AHPs & Healthcare Science Chief Operating Officer			X	Velindre Cancer Service Senior Leadership Team/Intergrated Quality and Safety Group	Executive Management Board & Quality, Safety & Performance Committee Benchmarking	Internal Audit & WRP Audits
C4	Mortality review process and monitoring and Medical Examination Service (MES) in place.	COO Medical Director			X	Velindre Cancer Service Senior Leadership Team/Intergrated Quality and Safety Group	Executive Management Board & Quality, Safety & Performance Committee Benchmarking	Internal Audit
C5	Velindre Oncology Academy establishment	Director of Nursing, AHPs & Healthcare Science	X	X	X	Velindre Cancer Service Senior Leadership Team/Intergrated Quality and Safety Group	Executive Management Board & Quality, Safety & Performance Committee Benchmarking	Internal Audit & Wales Audit Officer Audits
C6	Clinical audit process and systems in place	Director of Nursing, AHPs & Healthcare Science Medical Director		X	X	Velindre Cancer Service Senior Leadership Team/Intergrated Quality and Safety Group	Executive Management Board & Quality, Safety & Performance Committee Benchmarking	Internal Audit & Wales Audit Officer Audits

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.
No PROMS information available to report to the organisation. Quality metrics (including mortality) aren't currently included in Performance Management Report.		

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

DATIX RISK REF		CURRENT RISK RATING	RISK TREND
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	12	
3418 WBS	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	
2774 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.	12	
3388 WBS	There is a risk to Quality and Performance as a result of reporting errors and limited accessibility of reports due to no interfaces between the Fetal D IT System (FEDIS) and NHS Wales Digital Applications, leading to suboptimal antenatal care.	16	

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
02.01	Implement the digitisation of a robust set of service level to Board quality, safety outcome and experience metrics including mortality, aligned with the Performance Management Framework.	Executive Director of Strategic Transformation Planning and Digital	Dec. 2025	2	Content to be confirmed.	August 2025	A reduction in the likelihood of the risk due to enhanced assurance mechanisms.	
02.02	Deliver a programme of quality and safety investigation training for all potential investigation leads.	Director of Nursing, AHP and Health Science	March 2026	3	Currently insufficient people trained. Quality issues with current investigations and new staff are being employed requiring training.	August 2025	Action should reduce impact and likelihood of the risk through determining the root cause of incidents to prevent future incidents.	
02.03	Implement the digital PROMS system for patients and establish a mechanism for regular analysis and identification of areas for learning and improvement.	Executive Director Finance	March 2027	2	tbc	August 2025	Action should reduce impact and likelihood of the risk if there is robust analysis and appropriate action taken following reviewing PROMS outcomes.	
02.04	Fully implement Electronic Prescribing and Medicines Administration across Velindre cancer Service.	Chief Digital Officer	October 2026	1	tbc	August 2025	Should reduce risk (likelihood and impact) as there is clear evidence that electronic prescribing systems reduce medication, prescription and administration errors.	
02.05	Fully implement all Trust required IBI recommendations.	Chief Operating Officer	tbc	4	Trust is aware of the need to progress infrastructure work and develop business cases for consideration by Joint Commissioning Committee.	August 2025	Should reduce risk (likelihood and impact) by virtue of evidence of learning lessons as outlined by the IBI.	

02.06	Fully implement the revised Putting things Right regulations.	Director of Nursing, AHP and Health Science	April 2026	3	Awaiting Senedd Committee approval of revised regulations (planned for October 2025). Statutory guidance in development, Planned implementation date, 1 April 2026.	August 2025	Action should reduce the likelihood of the risk by enhanced listening mechanisms	
02.07	Strengthen patient and donor experience feedback mechanisms, specifically to increase the volume of experience feedback provided to the Trust across its services.	Chief Operating Officer and Executive Director of Nursing, AHP and Health Science	April 2026	3	Average of 16% feedback for WBS. Less than 0.1% of VCS patients. New national People Experience framework being implemented on target for completion by April 2026 as noted.	August 2025	Action should reduce both likelihood and impact due to enhanced listening mechanisms and opportunities for learning and improvement.	
02.08	Strengthen the quality and safety assurance and oversight mechanisms for hosted services.	Executive Director of Nursing, AHP and Health Science Director of Corporate Governance	April 2026	2	Some strengthening undertaken within last 3 months. Awaiting WG hosting arrangements review.	August 2025	Action should reduce both the Trust's overall health and safety risk by being assured that the appropriate quality and safety reporting mechanisms are in place.	
02.09	Embed and enhanced learning framework across the Trust, including learning from external organisations.	Chief Operating Officer and Executive Director of Nursing, AHP and Health Science	End of March 2026	3	Learning framework in place. However, quality and safety analysis has identified repeated themes which means further strengthening and embedding required with improved ownership and accountability from service level to accountable Director.	August 2025	Action should reduce likelihood and impact of risk by ensuring appropriate action will be taken to avoid, in as far as possible, future incidents occurring.	
02.10	To refresh and relaunch Trust patient safety framework.	Director of Nursing, AHP and Health Science	End of Dec. 2025	4	Current framework requires review in light of structural changes and strengthening of accountabilities and responsibilities for quality and safety outcomes and experience.	August 2025	Action should reduce likelihood and impact of risk by having improved awareness, ownership and accountability at all levels.	

SECTION 1 – Summary

RISK ID	**03**	**REVIEW DATE**	August 2025	**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 Strategies, 2. Not fully embedding innovation activities in line with the national Innovation Framework.	**Risk Lead**	Executive Medical Director

CORE ENABLER	Research, Development and Innovation	**STRATEGIC GOAL**	Strategic Goal 3: A beacon for research, development and innovation in our stated areas of priority
CURRENT SCORE TREND	New Risk	**CURRENT RISK SUMMARY**	The risk is currently assessed as moderate but managed, with robust strategies in place to deliver against both the Velindre Cancer Service 10-year Cancer Research Ambitions and the Welsh Blood Service Research Strategy. The risk is being actively managed through robust governance structures reporting to the Trust's RD&I Sub-Committee and onward to the Quality, Safety & Performance and Strategic Development Committees and then to Trust Board, as appropriate. This ensures the Trust maintains alignment with the UK Policy Framework for Health and Social Care Research, The Medicines for Human Use (Clinical Trials) Regulations 2004, as amended; and the ICH Good Clinical Practice Guidelines E6. The oversight of the research risks by the Research Service is supported by delivery plans to manage digital transformation, regulatory preparedness, and strengthen assurance. Key residual risks remain around sustainable funding, workforce capacity, and evidencing OECI / benchmarking outcomes – these are being addressed through targeted actions.

SECTION 2 – Risk Scores

	LIKELIHOOD	IMPACT	TOTAL
INHERENT RISK	4	3	**12**
CURRENT RISK	3	3	**9**
TARGET RISK	2	3	**6**

Expected date to reach Target Risk Score	August 2030

SECTION 3 – Effectiveness, Controls and Assurance

Overall Level of Effectiveness Assurance Rating (see definitions tab)	PE

Overall Assurance Rating	**Current Review Period**	5
	Previous Review Period	-
Rationale for Assurance Rating	Strategies aligned to national frameworks are in place. Governance structures and oversight are operational. New digital tools roll-out to begin planning for implementation commencing in FY2025/26, Q3. Evidence against OECI accreditation metrics, and confirmed sustainable funding not yet embedded.	

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	Research strategies defining Trust ambitions for research & innovation in line with national priorities (Trust Cancer Research Ambition, WBS Strategy, WG Innovation Framework)	Executive Medical Director					- Strategies set direction and ensures alignment to national priorities. - Progress and Performance reported through RD&I Integrated Performance Report - Internal self-assurance. - RD&I Senior Core Team oversight. - RD&I Operational Management Group oversight.	Oversight through the Trust RD&I governance structures: - Executive Management Board - RD&I Sub-Committee - Quality, Safety & Performance Committee.	Oversight from: - National reporting of key indicators to Health and Care Research Wales. - Monthly meetings with HCRW Research Delivery Management - Joint Executive Team Management meetings with Welsh Government. Additionally external peer feedback.
C2	Deliver plans for research governance/delivery are monitored to assure progress on delivery	Head of R&D					- Delivery plans allow oversight and tracking and include IMTP, VPAG delivery reporting, and Charitable Fund Investment plans - Defines Key Indicators and timelines - Reporting through RD&I Integrated Performance Report. - RD&I Senior Core Team oversight. - RD&I Operational Management Group oversight.	Oversight through the Trust RD&I governance structures: - Executive Management Board - RD&I Sub-Committee - Quality, Safety & Performance Committee - Charitable Funds Committee	Reporting through: - Monthly meetings with HCRW Research Delivery Management - HCRW monthly returns - VPAG monthly returns to HCRW

C3	Benchmarking research activity (through OECI accreditation membership, UK peer cancer centre comparisons)	Head of R&D / research Delivery Manager				- Benchmarking allows the Trust to provide external performance standards comparisons and mitigates reputational risk from under-performance. - OECI local assessment and data returns and benchmarking output reports - Reporting through RD&I Integrated Performance Report. - RD&I Senior Core Team oversight. - RD&I Operational Management Group oversight.	Oversight through the Trust RD&I governance structures: - Executive Management Board - RD&I Sub-Committee	OECI peer review and international accreditation.
C4	Engagement with UK / National bodies	Executive Medical Director / Associate Medical Director for RD&I				- Ensures compliance with national standards and mitigates isolation from national networks. - Progress and Performance reported through RD&I Integrated Performance Report - Internal self-assurance. - RD&I Senior Core Team oversight. - RD&I Operational Management Group oversight.	Oversight through the Trust RD&I governance structures: - Executive Management Board - RD&I Sub-Committee - Monthly meetings with HCRW Research Delivery Management -	- MHRA Inspection Findings Reporting - HCRW / Welsh Government Annual Research Performance Review
C5	Cardiff Cancer Research Partnership (CCRP)	Cancer Research & Development Strategy Lead				- Enables joint planning and capacity building, mitigates duplication of effort. - Progress and Performance reported through RD&I Integrated Performance Report. - Internal self-assurance. - CCRP Clinical Operational Group - RD&I Senior Core Team oversight. - RD&I Operational Management Group oversight.	Oversight through the Trust RD&I governance structures: - Executive Management Board - RD&I Sub-Committee - CCRP Project Board	- Tri-Partite partnership board - Joint Executive Team Management meetings with Welsh Government. - Welsh Government
C6	Welsh Blood Service research governance	WBS Head of RD&I Services				- Strategy aligns WBS research with Trust strategy - Mitigates siloed WBS research activity - WBS Progress and Performance reported through RD&I Integrated Performance Report and monthly research reports. - Internal self-assurance. - WBS RD&I Group - RD&I Operational Management Group oversight.	Oversight through the Trust RD&I governance structures: - Executive Management Board - RD&I Sub-Committee	- Welsh Government oversight - Blood Service audits by MHRA, Human Tissue Authority

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

- Benchmarking with UK peer cancer centres to review optimal model for Research Service infrastructure and delivery within UK organisational structures. - Limited internal and independent audit of Research Service processes to date. - Financial sustainability due to dependence on multiple internal and external funding streams.		

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

DATIX RISK REF		CURRENT RISK RATING	RISK TREND
	There are currently no risks on the Trust Risk Register relating to this strategic risk		

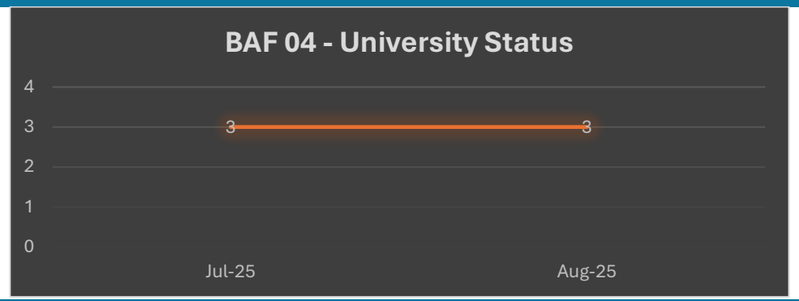
SECTION 5 – ACTION PLAN
(IMTP Priority Improvement Actions and TAF Actions)

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
03.01	Develop and implement a structured benchmarking programme with UK peer cancer centres to review optimal Research Service infrastructure, workforce, and delivery models. Align benchmarking outputs with OECI Designation criteria and partnership theme.	Associate Medical Director for RD&I / Head of R&D / Research Delivery Manager	December 2026		Initial discussions with Clatterbridge on delivery / finance models. Meeting being arranged to visit Clatterbridge	August 2025	Provides external reference points to shape Research Service structure; reduces risk of sub-optimal infrastructure	Assurance strengthened through comparative data, peer review evidence, and alignment to OECI standards.
03.02	Commission a programme of internal and independent audits of Research Service processes, including study set-up, delivery, and governance. Scope to cover compliance with UK Clinical Trials Regulation and ICH GCP E6(R3), coming into force in April 2026, linked to workforce development/training theme.	Head of R&D / Research Delivery Manager	March 2027		Mapping of SOP refresh and training requirements underway; draft framework developed for SOP suite and training.	August 2025	Identifies weaknesses early, reduces exposure at MHRA/OECI inspection	Assurance strengthened through regular audit cycles, embedding independent oversight.

03.03	Develop and implement a sustainable funding model for RD&I, reducing dependency on charitable and short-term funding streams. Link to financial sustainability theme and VPAG/charitable investment planning.	To be advised	Apr 2027		VPAG investment plan in place. Charitable Fund Integrated Bid 2026–29 submitted through Trust governance infrastructure.	August 2025	Reduces risk of financial instability and service interruption.	Assurance strengthened by predictable, recurrent funding sources and clearer accountability across multiple income streams

SECTION 1 – Summary

RISK ID	**04**	**REVIEW DATE**	August 2025	**Risk Title**	There is a strategic risk of failing to retain the Trust's University status.	**Risk Lead**	Non Gwillym

CORE ENABLER	University Status	**STRATEGIC GOAL**	An established University Trust which provides highly valued knowledge and learning for all
CURRENT SCORE TREND		**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

	LIKELIHOOD	IMPACT	TOTAL		LIKELIHOOD	IMPACT	TOTAL		LIKELIHOOD	IMPACT	TOTAL
INHERENT RISK	1	3	**3**	**CURRENT RISK**	1	3	**3**	**TARGET RISK**	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 collaboration 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 BAF 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
04.01	Review Board membership	Director of Corporate Governance Director of Corporate	1 October 2025	6	Review will take place during September alongside new Chair and Independent Members Group.	12 August 2025	Further review will provide assurance that the requirements regarding University Status are being met through Board membership.	Increase in score of assurance level.
04.02	Review of Academic Partnerhsip Board	Director of Corporate Governance Director of Corporate	1 October 2025	4	Review will take place during September alongside new Chair and Independent Members Group.	12 August 2025	Further review will provide clarity on purpose and structure of Academic Partnership Board.	Increase in score of assurance level.

SECTION 1 – Summary

RISK ID	**05**	**REVIEW DATE**	August 2025	**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 Place, Portfolio and Partnerships

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

SECTION 2 – Risk Scores

	LIKELIHOOD	IMPACT	TOTAL
INHERENT RISK	4	4	**16**
CURRENT RISK	3	3	**9**
TARGET RISK	2	2	**4**

Expected date to reach Target Risk Score

SECTION 3 – Effectiveness, Controls and Assurance

Overall Level of Effectiveness Assurance Rating (see definitions tab)	P.E.

Overall Assurance Rating	**Current Review Period**	4
	Previous Review Period	
Rationale for Assurance Rating		

KEY CONTROLS

ID	KEY CONTROLS	OWNER	PREVENTATIVE	MITIGATING	DETECTIVE

SOURCES OF ASSURANCE

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	Creating Wider Value: Our Organisational Approach	Trust Sustainability Manager		X		Performance reporting / highlight reports	Well-being Objectives alignment embedded in Trust governance – board papers Climate Action Board	ISO 14001:2015 External Audit NWSSP Internal Audit Audit Wales
C2	Sustainable Care Models	Trust Sustainability Manager		X		Review through Clinical Sustainability MDT Climate Action Board ISO14001:2015 Internal Audits Environment Policy / divisional Environmental Statements Enviromental Manual	Clinical Sustainability MDT EMB SLT Strategic Development Committee	NWSSP Internal audit Audit Wales
C3	Carbon Zero	Trust Sustainability Manager		X		Site based Sustainability Implementation Plans (SIPs) Site-level energy monitoring Enviromental Manual	Cynefin Fire, Risk, Estates, Sustainability and Health &0 Safety Group (FRESH) ISO14001:2015 Management Group Quality, Safety & Performance Committee	ISO 14001:2015 External Audit NWSSP Internal audit Audit Wales
C4	Sustainable Infrastructure	Trust Sustainability Manager	X			Capital projects – nVCC / TGI Project risk registers Site based Sustainability Implementation Plans	Capital Project Board/ nVCC Project Board Specialist engineering / sustainability consultants on nVCC project Reviewable Design Data Process	BREAM Excellent aiming for Outstanding standards in nVCC / TGI. ISO 14001:2015 External Audit NWSSP Internal audit Audit Wales
C5	Sustainable Infrastructure	Trust Sustainability Manager	X			Waste Management Policy Waste segregation and recycling at source Single-use plastic phase-out Site based Sustainability Implementation Plans Site level waste monitoring	ISO14001:2015 Management Group Cynefin Fire, Risk, Estates, Sustainability and Health &0 Safety Group (FRESH) ISO14001:2015 Management Group Quality, Safety & Performance Committee	ISO 14001:2015 External Audit NWSSP Internal Audit Waste contractor compliance audits
C6	Transition to a Renewable Future	Trust Sustainability Manager		X		Capital projects – nVCC / TGI Site based Sustainability Implementation Plans Building Management System (BMS) optimisation	Capital Project Board/ nVCC Project Board Specialist engineering / sustainability consultants on nVCC project Reviewable Design Data Process	BREAM Excellent aiming for Outstanding standards in nVCC / TGI. ISO 14001:2015 External Audit NWSSP Internal audit Audit Wales
C7	Connecting with Nature	Trust Sustainability Manager	X			Green Social Prescribing Partners Biodiversity Enhancement Plan (incl. in SIPs)	Climate Action Board Engagement Committees Activities	External biodiversity audits Internal Audit ISO 14001:2015 External Audit NWSSP Internal audit Audit Wales

C8	Greening Our Travel and Transport	Trust Sustainability Manager	X			Trust Travel Plan 2022 – 2027 Site based Sustainability Implementation Plans Cycle to Work Scheme	Annual Travel Survey ISO14001:2015 Management Group Cynefin Fire, Risk, Estates, Sustainability and Health &0 Safety Group (FRESH) ISO14001:2015 Management Group Quality, Safety & Performance Committee	ISO 14001:2015 External Audit NWSSP Internal audit Audit Wales
C9	Adaption to Climate Change	Trust Sustainability Manager	X			Climate risk assessments Site emergency preparedness plans Incorporation of adaptation measures in nVCC / TG projects Site based Sustainability Implementation Plans	Climate Action Board Health & Safety Meeting ISO14001:2015 Management Group Cynefin Fire, Risk, Estates, Sustainability and Health & Safety Group (FRESH) ISO14001:2015 Management Group Quality, Safety & Performance Committee	ISO 14001:2015 External Audit NWSSP Internal audit Audit Wales
C10	Our People as Agents for Change	Trust Sustainability Manager		X		Sustainability Induction and Training Staff engagement programmes Sustainability Staff awards	Healthy and Engaged Steering Group Fire, Risk, Estates, Sustainability and Health & Safety Group (FRESH)	ISO 14001:2015 External Audit

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.
Integration of sustainability into all governance and capital decision-making	Capital projects may be approved without consistent consideration of environmental impacts	5.1
Embedding sustainability in clinical pathways (new Clinical MDT not yet fully operational)	Under development and not yet integrated into standard practice	5.2
Inclusion of sustainability in all job descriptions	Not currently part of standard recruitment materials or role profiles; opportunity to align with Well-being of Future Generations requirements	5.3

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 BAF 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
5.1	Embed sustainability considerations into capital project decision-making processes, including mandatory environmental impact assessments in business cases	Trust Sustainability Manager / Capital Projects Lead	31/03/2026	3	Draft environmental impact assessment template developed. Discussions underway with Capital Project Manager.	05.09.2025	Reduces risk that capital projects progress without due consideration of environmental and sustainability factors.	Provides the Board with assurance that sustainability is systematically addressed in all investment and governance processes. Strengthens First and Second Line of Defence.
5.2		Trust Sustainability Manager/ Clinical Sustainability Leads	31/12/2025	2	MDT Terms of Reference drafted. Approval scheduled at Clinical & Scientific Strategy Board in September.	05.09.2025	Addresses risk that clinical practice does not consistently embed sustainability principles.	Converts an emerging control into a fully embedded process. Strengthens clinical governance assurance and reduces strategic risk.
5.3	Include sustainability and Well-being of Future Generations duties in all job descriptions and recruitment materials	Trust Sustainability Manager /Workforce Lead	31/12/2025	2	Review of current job descriptions underway prior to developing draft wording prepared for future recruitment packs.	05.09.2025	Addresses risk that sustainability is not embedded into organisational culture and staff responsibilities.	Ensures sustainability is reinforced as a core organisational value. Expands cultural and operational controls across the First Line of Defence.

SECTION 1 – Summary

RISK ID	**06**	**REVIEW DATE**	20.08.2025	**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

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 2025/26 on the organisational development plan to support the transition to nVCC.

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

SECTION 2 – Risk Scores

	LIKELIHOOD	IMPACT	TOTAL
INHERENT RISK	4	4	**16**
CURRENT RISK	4	3	**12**
TARGET RISK	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 • *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 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 BAF 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
06.05	Implement the actions of the Trust Strategic Equality Plan, including embedding the Anti-Racist Wales Action Plan in the Trust	Head of OD	31.03.2026		The 2024-25 SEP workplan has been closed and the new plan 2025-26 is in action. This is monitored through the Healthy and Engaged Steering Group and QSP. Q1 2025-26 reports were submitted to these groups.	20.8.25		

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. This is monitored through the Healthy and Engaged Steering Group and QSP. Q1 2025-26 reports were submitted to these groups.	20.08.2025		
06.07	Commence the Values and Behaviour framework project	OD Sp	31.3.25		The Values and Behaviours have been implemented across the Trust. This action should be closed and replaced with an action on embedding positive values and behaviours across the Trust.	20.8.25		
06.10	Monitor Welsh Language Standards, working with Divisions on improvement plans	Assistant Director of Workforce Planning			11/09/2025: Welsh Language standards are being monitored through Trust wide governance and summaries with an annual report that is approved by Trust Board.			
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 Polices 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	Deputy Director of People and OD						
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.	Assistant Director of Workforce Planning	April 2027		11.09.2025 An evaluation of the current leadership and management programmes of work has been undertaken with subsequent actions to develop new modules on leading a health			
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 – shared at Healthy and Engaged Steering Group July 2025. Wellbeing Metrics and Wellbeing Project Evaluation reports shared at Healthy and Engaged Steering Group July 2025.	20.08.25		

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 within the SEP Workplan 2025-26. EQIA report for 2024-25 which was shared at Healthy and Engaged Steering Group July 2025 Anti-racist e learning package launched April 2025 and compliance on track for year-end target.	20.08.2025		
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					
CLOSED ACTIONS								
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		

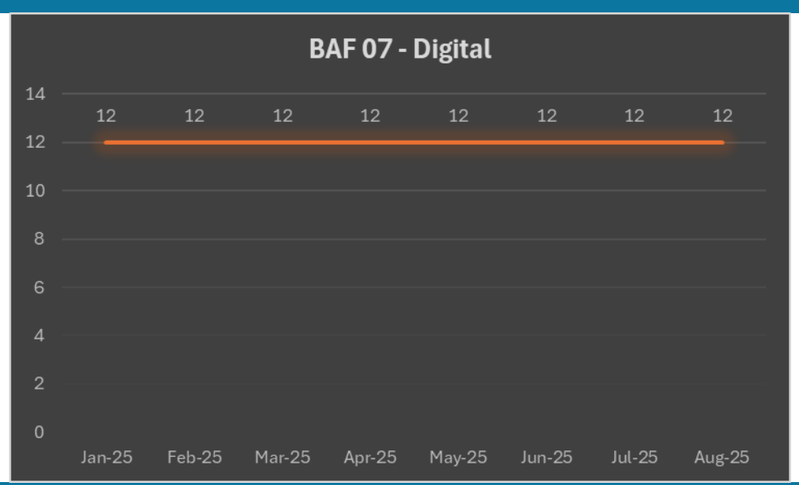
06.02	Embed the principles of the Social Partnership Duty into the Trust's strategic development and through the Trust Board cycles of business	Head of Workforce	Apr 25		06.12.2024 Session planned at Board Development on 17.12.2024. A Social Partnership update will be included. Following session, a meeting 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. 11/09/2025 - closed.	September 2025		
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**			

SECTION 1 – Summary

RISK ID	**07**	**REVIEW DATE**	15.08.2025	**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



CURRENT RISK SUMMARY

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 third lines of defence have been reviewed as some were previously not independent to the Trust.

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

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

Expected date to reach Target Risk Score	June 2026

SECTION 3 – Effectiveness, Controls and Assurance

Overall Level of Effectiveness Assurance Rating (see definitions tab)	PARTIALLY EFFECTIVE

Overall Assurance Rating	**Current Review Period**	3
	Previous Review Period	4
Rationale for Assurance Rating	Assurance Rating 3 was agreed through the Digital Annual Report process at QSP and continues to represent the overall digital position.	

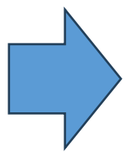
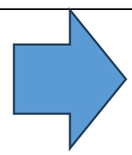
KEY CONTROLS	**SOURCES OF ASSURANCE**

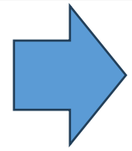
ID	KEY CONTROLS	OWNER	PREVENTATIVE	MITIGATING	DETECTIVE	FIRST LINE OF DEFENCE • *functions that own and manage risk* • *Self-assurance*	SECOND LINE OF DEFENCE • *Functions that oversee or specialise in risk management* • *Internal oversight/specialist control teams*	THIRD LINE OF DEFENCE • *Functions 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	**KEY CONTROLS**	**OWNER**	X			Tracking key outcomes and benefits map – aligned to Trust Digital Strategy - Digital Programme Board	EMB/ 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 / 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, BECS, EPMA	Carl Taylor	X			Staff feedback - KLAS Survey - Mandatory Training stats	EMB /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 / Strategic Development Committee/ QSP Committee	Internal Audit / Digital Communities Wales Accreditation
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 / 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 / Strategic Development Committee/ QSP Committee / Audit Committee	/ Internal Audit/ External Audit of Accounts
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 / Strategic Development Committee/ QSP Committee/	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 QSP Committee/	Internal Audit / Digital Communities Wales

C9	Prioritisation and change framework to manage service requests	Carl Taylor			X	Trust Digital governance reporting Digital Programme Board	EMB / Cyber Action Plan / 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 / SIRO Reports/ Strategic Development Committee/ QSP Committee/	Internal Audit / Cyber Resilience Unit
C11	Trust digital Governance	Carl Taylor		X		Review via Divisional SMT/SLT	EMB / 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 / 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 / SIRO Reports/ Strategic Development Committee/ QSP Committee	Internal Audit/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 / Strategic Development 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
3634 Corporate	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**	
3646 Corporate	There is a risk to PERFORMANCE AND SERVICE SUSTAINABILITY that the WLIMS2.0 go-live date will be delayed due to delays in the national programme timeline causing an impact on realising project outcomes and additional demand for further development of existing legacy systems. Project ID WO2-02 Risk ID R131	**20**	

3388 WBS	There is a risk to Quality and Performance as a result of reporting errors and limited accessibility of reports due to no interfaces between the Fetal D IT System (FEDIS) and NHS Wales Digital Applications, leading to suboptimal antenatal care.	**16**	
3585 WBS	There is a risk to PERFORMANCE & SERVICE SUSTAINABILITY as a result of the potential change of supplier, leading to a lengthy transition to a new system and insufficient time to absorb slippage due to immovable date. Project ID: W2-01	**20**	

SECTION 5 – ACTION PLAN
(IMTP Priority Improvement Actions and BAF 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	Dec 25	2	15.08.2025 Working with National Target Architecture programme to align targets. 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

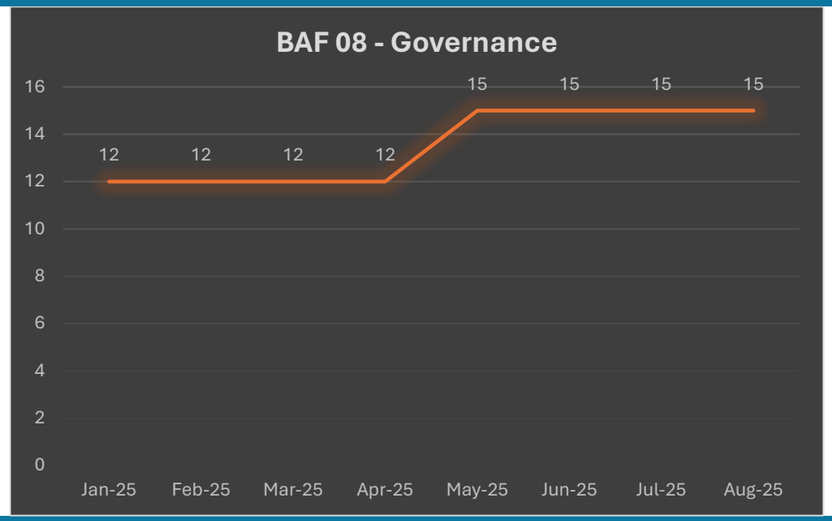
07.02	C9 - Prioritisation framework needs to be established for the Data and Insight Service	Carl Taylor	Sep 25	3	15.08.2025 Papers on Data and Insight in September 2025 and Priority going to EMB in August a 2025. Data and Insight formative paper due at SDC in Feb '24 Prioritisation paper presented to 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	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	Sep 25		Initial review undertaken and updates will be collated for September 25 BAF	Jun 25	Will contribute to reduction likelihood of risk	Additional assurance for C11 and C13

SECTION 1 – Summary

RISK ID	08	**REVIEW DATE**	August 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



CURRENT RISK SUMMARY

GAR programme met in July 2025 to consider next steps. Further focused work in development on standard operating procedure for minute taking (including decisions and actions), strengthening the BAF and reviewing policy and procedures in support of the Trust's management of risk.

The Trust awaits the distribution of the Welsh Government's review of the hosting arrangements for Shared Services.

Committees' effectiveness surveys to be launched in August and support the review of Committee Terms of Reference and Cycles of Business in advance of September cycle.

Policy on Policies to be considered by QSP on XX September.

Review of induction of new Chair key to support good governance. Plans underway to support for 1 September.

SECTION 2 – Risk Scores

	LIKELIHOOD	IMPACT	TOTAL		LIKELIHOOD	IMPACT	TOTAL		LIKELIHOOD	IMPACT	TOTAL
INHERENT RISK	4	4	**16**	**CURRENT RISK**	3	5	**15**	**TARGET RISK**	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	Developments in progress, but completion hasn't been achieved. Prioritising risk policy development, finalising BAF, Policy on Policies and revitalising our training offer on levels of Assurance and Duty of Quality will support an increase score by the next reporting period.	

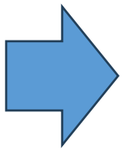
KEY CONTROLS	**SOURCES OF ASSURANCE**

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 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
C2	Annual Assessment of Board Effectiveness	Corporate Governance Manager			X	Annual Board Effectiveness Survey Annual Self- Assessment against the Corporate Governance in Central Governance Departments: Code of Good Practice 2017	Audit Committee Trust Board	Internal Audit Reports
C3	Board Committee Effectiveness Arrangements	Director of Corporate Governance	X			Internal Audit Review	Audit Committee Trust Board	Audit Wales Structured Assessment Programme / Reports 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 BAF 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 BAF 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	Director of Corporate Governance	Nov-24	3	External benchmarking now embedded into practice.	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	Director of Corporate Governance	Dec-24	2	GAR focused on improvements on decision/action reporting for minutes, refreshed risk policy and finalising BAF.	13.08.2025	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	Director of Corporate Governance	Sep-25	2	First phase due for completion by end of 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.

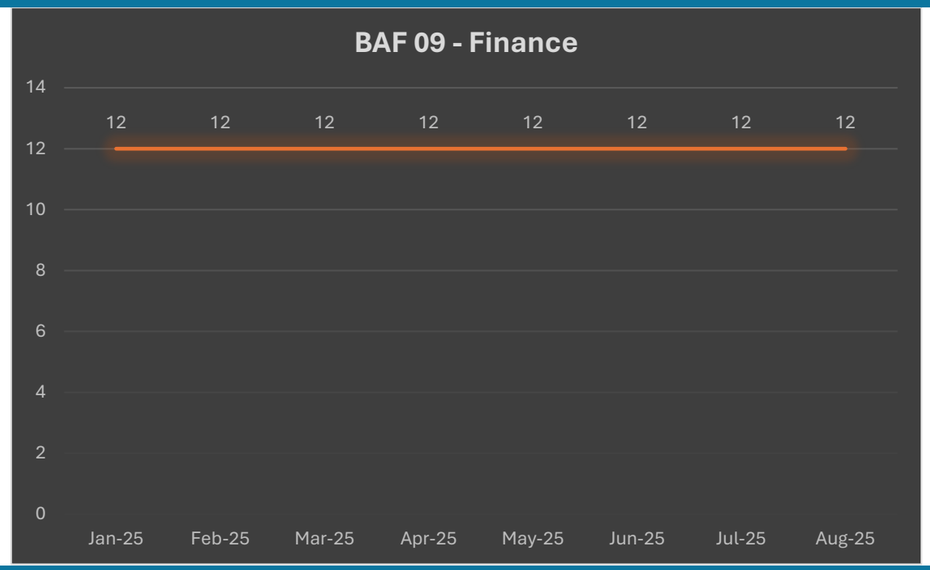
08.04	Ensuring accountability and ownership is in the right place, supported by effective structures, and is empowering for those delivering and those leading the delivery of high quality services today and shaping our services for the future	Director of Corporate Governance	24/25		GAR Group meeting 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.
08.05	Review Terms of Reference for all Board Committees capturing all requirements in relation to Duty of Quality.	Director of Corporate Governance	Sept-25	3	To be completed by end of September.	08/2025	Board assured that scope of Committees' work referencing requirements of Duty of Quality effectively.	All ToR uptodate and consistent in their interpretation of the Duty of Quality and its impact on Board Committee work.
08.06	Training programme to support Duty of Quality reporting, Quality Impact Assessment completion and Assurance Level awareness.	Director of Corporate Governance/Executive Director Nursing, Allied Health	Nov-25	4	Initial discussions resulting in changes of requirement re: Duty of Quality reporting in Board/Committee paper template. Discussion with assurance level trainer underway.	08/2025	Board assured that Trust business is compliant with the Duty of Quality statutory requirements.	All staff aware of purpose, driver and process for completing Quality Impact Assessments. Duty of Quality embedded in Board decision making process.
08.07	Coordinate policy review process and update Policy on Policies as standard operating procedure to support organisational development, compliance and awareness of policies	Director of Corporate Governance	Nov-25	3	First phase – report for consideration of September 2025 QSP meeting. Second phase – depending on outcome of QSP meeting to raise awareness of new Policy on Policies and implications for staff.	08/2025	Risk of non-compliance with national policies reduced. Policy updates timely.	All staff to be aware of latest policy updates and assured that information presented is up to date.

SECTION 1 – Summary

RISK ID	**09**	**REVIEW DATE**	15.08.2025	**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



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, however, given the significant emerging cost pressures the risk score may need review in future months.

SECTION 2 – Risk Scores

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

Expected date to reach Target Risk Score April 2026 in line with IMTP

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	3
		Rationale for Assurance Rating	Assurances and controls largely in place with policies and procedures supporting financial governance, however the emerging costs pressures and investment decisions are impacting on the Trusts financial sustainability. A proposed financial recovery plan with cut costing options and improved operations to be developed which is expected to increase the assurance rating and reduce the risk score.	

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*
FSLTV1	Divisional Financial Outturn	Head of Financial Planning & Reporting Head of Finance Business Partner Budget Holders			X	Budget holders, reports and training, Touch Point meetings	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, Touch point meetings	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, Touch Point meetings	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
FSLTV17	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
FSLTV18	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	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.
Scheme of Delegation and Governance Framework for All Major Capital Programmes	Investment Appraisal assurance process improvement to ensure high quality of business case submissions and education of organisation with regards to appropriate funding routes for service developments and initiatives	F6 (Controls); F4 (Assurance)
There is a need to be able to evidence use of medicines are providing the best value for patients	Medicines management requires more clarity on governance, decision making processes and financial implications including links between NWSSP, National forums and impact on local decision making in VCS.	F2
There are issues with the processes around LTA activity capture and mapping to currencies with some activity currently not being identified and charged to commissioners.	LTA Activity performance monitoring process currently not providing assurance that all activity is being captured and monitored against Commissioner contracts	F7

SECTION 4 – ASSOCIATED OPERATIONAL 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 ir 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. Finance workshop with Executive team in diary for 18.08.2025 to present the current financial position and discuss disinvestment options and financial recovery.	17.08.2025	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	9	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. The Accounts Receivable team have completed a review of the Unidentified Income suspense account, and all historic transactions have been cleared. The account now includes only 11 items, relating to the period 2024-2025, totalling £55k. Petty Cash FCP been updated, priority to review and update all FCPs following accounts submission. A plan is in place to review and update all FCPs, with a	10.09.2025	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

					completion date of December 2025. FCP4 Year End Closedown Procedure has been reviewed and updated. The Bank Mandate has been reviewed and updated.			
09.04	Development of Investment Appraisal process and prioritisation framework	EDoF / EDoSTP&D / DDoF / DDoP	Investment appraisal proces &	4	Presentation made to April 2024 EMB Shape for the development of criteria for assessing investment opportunities. This included Strategic Fit, Deliverability and Value and Sustainability. Next steps are to develop criteria aligned to the 3 areas identified.	17.08.2025	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	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. CCRH project group continues to meet with a financial model developed on 04.08.2025 which is currently under review Private Patients Income: Liaison Financial external consultants re-engaged for the first half of the financial year to support the Trust in completion of remaining financial / 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.	17.08.2025	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

					A revised charging tariff has been agreed with an implementation date of 1st July 2025. Contract negotiations have been arranged with those insurers that have specific queries and those involving payment of old debts.			
09.06	Develop Scheme of Delegation and Governance Framework for All Major programmes	EDoF / DDoF	Ongoing (required on approval of each major programme)	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. Commissioners rejected the prostate radiotherapy business case on the basis that current charges are based on the historic share basis. Discussion around NHS Wales contract rebasing at the July 2025 DoF meeting identified that C&V UHB were currently undertaking an exercise to rebase the activity & cost of their	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

					LTAs, in particular to better reflect the resources consumed in delivering specialist services. The DoFs' view was WG should take a leadership role around NHS contract re-basing and agreed to seek a view from WG.			
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:								
09.11	Divisions reviewing non-value adding clinical practice or processes and changing ways of working through Value-Based Healthcare approach.	Ddof, Divisional Directors		17.08.2025	Finance workshop with Executive team in diary for 18.08.2025 to present the current financial position and discuss disinvestment options and financial recovery.	April 2026	Mitigate financial cost pressure and risks to ensure financial sustainability	Control 6 - Financial Strategy / Medium Term Financial Plan / Budget Setting will become more effective and financial plans more sustainable further enhancing overall financial assurance
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**	14.08.2025	**Risk Title**	There is a risk that the scale and complexity of the change across the organisation may exceed the organisation's capacity to manage and execute effectively resulting in a failure to deliver on core strategic goals and an associated loss of benefits realisation which will impact on stakeholder confidence	**Risk Lead**	Director of Place, Portfolio & Partnerships

CORE ENABLER	Portfolio Delivery	**STRATEGIC GOAL**	Would Impact on all of the Trust Strategic Goals
CURRENT SCORE TREND	New Risk	**CURRENT RISK SUMMARY**	VUNHST has a substantial programme of transformation over the next five years, totalling in excess of £500million capital funding and associated service change. Although most of the main programmes and projects have their own governance arrangements there has been no overall portfolio management. Portfolio management is currently being implemented and this should lead to improved prioritisation, resourcing, benefit delivery and the reduction of transformation related risks at an organisational level.

SECTION 2 – Risk Scores

	LIKELIHOOD	IMPACT	TOTAL
INHERENT RISK	4	4	**16**
CURRENT RISK	4	4	**16**
TARGET RISK	2	3	**6**

Expected date to reach Target Risk Score	September 2026

SECTION 3 – Effectiveness, Controls and Assurance

Overall Level of Effectiveness Assurance Rating (see definitions tab)	PE
Previous Review Period	NA

Overall Assurance Rating	**Current Review Period**	3
	Previous Review Period	NA
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	Executive Leadership	Lauren Fear		X	X	• Meeting with all Executives to describe the benefits and business need for implementing portfolio management across the Trust. • Discussion at Board Development Sessions • Discussions with LF and Exec colleagues	• The executive is engaged and are leading the portfolio and understanding is increasing. • Reports are received at EMB.	• The executive are able to receive portfolio escalations and take positive action. • Effectiveness report after 12 months to EMB.
C2	Develop a Portfolio Governance Framework / Handbook	Gavin Bryce	X	X		Community of Practice for project, programme and portfolio staff commenced in June2025 with a view to improving standards and reducing inconsistencies in practice.	A Portfolio Governance / Handbook will set out the necessary Governance arrangements to ensure effective delivery of the Portfolio, or highlight areas for escalation to the Executive Management Board	The Strategic Development Committee will provide assurance to the Trust Board on the Portfolio Governance arrangements
C3	Portfolio Prioritisation and Phasing	Gavin Bryce	X	X	X	Develop the prioritisation tool for the portfolio.	A prioritisation exercise will determine which portfolio activities have the greater priority and should be resourced accordingly. This will be overseen by the Executive Management Board	The Executive Management Board, Strategic Development Committee will provide assurance to the Trust Board on the prioritisation and phasing arrangements
C4	Capacity & Resource Planning	Gavin Bryce			X	Following on from the prioritisation exercise a resource planning piece is necessary to identify the required verses actual resource availability. This will be overseen by the Executive Management Board	The Strategic Development Committee will provide assurance on Portfolio capacity and resourcing	Trust Board approval on Portfolio capacity and resourcing
C5	Benefits Management and Realisation plan	Gavin Bryce	X	X	X	Carry out a benefit baselining process to identify all benefits across the portfolio.	A portfolio benefits plan will be delivered so the portfolio benefit delivery can be managed and optimised and any threats to benefit delivery identified. This will be overseen by the Executive Management Board	The Strategic Development Committee will provide assurance to the Trust Board on the effectiveness of the Portfolios Benefits Management
C6	Effective Portfolio Reporting	Gavin Bryce	X	X	X	Design and develop a reporting dashboard for the portfolio	There are effective reporting arrangements in place for the Portfolio and regular reporting is being achieved. Reporting to EMB	The Strategic Development Committee will provide assurance to the Trust Board on the effectiveness of the Portfolios reporting.

C7								

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.
None	None	None

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

DATIX RISK REF		CURRENT RISK RATING	RISK TREND
N/A	There are currently no relevant risks on the Trust Risk Register	N/A	N/A

SECTION 5 – ACTION PLAN
(IMTP Priority Improvement Actions and BAF 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
10.1	Develop a Portfolio Governance Framework / Handbook	Gavin Bryce	September 2025	3	08.08.2025 Portfolio Handbook 80% complete			
10.2	Carry out Portfolio Prioritisation and Phasing	Gavin Bryce	October 2025	2	08.08.2025 Draft Prioritisation Framework complete requires approval before prioritisation exercise can be completed			
10.3	Carry out Capacity & Resource Planning	Gavin Bryce	December 2025	2	08.08.2025 Dependent on action above			

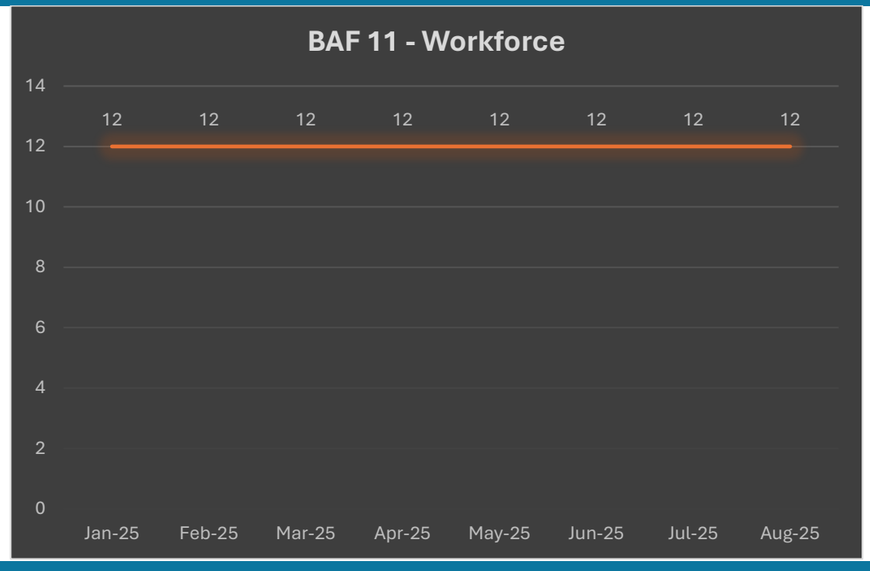
10.4	Carry out Benefits Management and Realisation plan	Gavin Bryce	November 2025	2	08.08.2025 Not started			
10.5	Establish Effective Portfolio Reporting	Gavin Bryce	September 2025	4	08.08.2025 Effective Power BI dashboard in place 90% of data correct work ongoing to improve compliance with incremental design improvements to dashboard.			

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



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, within the organisation, or granular at Multi-disciplinary team level. We are currently mitigating the risk in this area through effective strategic and operational workforce planning, with a focus on recruitment, retention and people development. 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.

SECTION 2 – Risk Scores

	LIKELIHOOD	IMPACT	TOTAL
INHERENT RISK	4	4	**16**
CURRENT RISK	4	3	**12**
TARGET RISK	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.	

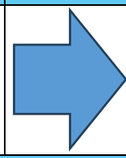
KEY CONTROLS	**SOURCES OF ASSURANCE**

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
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 10.07.2025 Workforce plans are in train throughout the Trust and progress noted via the Supply and Shape paper, most recent update to QSP 8th May and next update in November 2025. A specific paper on Workforce Planning progress will be brought to EMB and committees in September. 11.09.2025 Paper on Workforce Planning progress has been integrated into the new iteration of 'Supply and Shape' assurance paper. This is due to EMB in October and QSP in November.	September 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		
CLOSED ACTIONS								
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	4	Update: Appointment of Access to Work Coordinator confirmed August 2025 Appointment of Attraction and Resourcing Lead confirmed August 2025 11/09/2025 Completed		Having a dedicated team to support workforce planning across the Trust will ensure service leads are able to identify key workforce risks and are supported in developing action plans to deliver transformational change to mitigate these risks.	6 – outcome of the action realised in full. A dedicated Team is in place with support structures and assurance mechanisms to feedback to EMB and committees.

VELINDRE UNIVERSITY NHS TRUST BOARD	
PUBLIC AUDIT COMMITTEE **HIGHLIGHT REPORT**	
DATE OF MEETING	25th September 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 2 September 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 2 September 2025:

ALERT / ESCALATE	**Digital Health and Care Record Audit Report** Assurance rating: Reasonable/Limited The limited assurance and unresolved issues regarding the Digital Health and Care Record (DHCR) project, specifically the cessation of Phase 2 and its impact on patient information exchange and system functionality, should be escalated to the Trust Board for urgent attention. The lack of progress and dependency on external parties (Digital Healthcare Wales and Welsh Government funding) for DHCR delivery, as well as the associated risks to service continuity and data integration, require board-level escalation.

	The Committee **AGREED** that these issues cannot be left unresolved and must be clearly highlighted to the board for action.
ADVISE	**INTERNAL AUDIT** **Draft 2025/26 Internal Audit Plan** The 2025/26 internal audit plan covers both general audit work and a separate capital audit plan, with the latter funded by large capital projects and tied to individual project timelines. The plan includes reviews aligned to current risks and priorities, with recent changes reflecting committee requests and additional narrative clarifying arrangements between Velindre and NWSSP. There is a scheduled review of the Board Assurance Framework (BAF) and its alignment to the Trust Risk Register, with the plan to update this as the BAF risks have changed since the draft. The Committee **APPROVED** the 2025/26 internal audit plan and charter, subject to amendments highlighted regarding the alignment of risks in the BAF. **EXTERNAL AUDIT** **Final Accounts Addendum Report (Management Letter) 2024/25** The Final Accounts Addendum Report (Management Letter) 2024/25 was presented by Audit Wales as a follow-up to the main financial audit, covering issues identified during the audit that were not included in the initial ISA 260 report due to tight timescales. The report highlighted five matters: remuneration disclosures, related party disclosures, capital commitment disclosures, and IT controls, each with associated recommendations. All recommendations were accepted by management, and progress will be monitored as part of the 2025/26 audit work. The Committee **RECEIVED** the report and **NOTED** the report. **Amendments to the Standing Orders, Scheme of Delegation and SFI** The amendments to the Standing Orders, Scheme of Delegation, and Standing Financial Instructions (SFI) primarily address changes in procurement legislation, specifically the new Procurement Act 2023 and updated Public Contracts Regulations. Chapter 11 of the SFI, which covers procurement and contracting for goods and services, has been updated to reflect these legislative changes. The new requirements include increased transparency, such as mandatory publication of breaches on a public database accessible to all suppliers, raising the risk of challenges from suppliers if compliance is not maintained. The

	amendments emphasise the need for early engagement with procurement, robust contract registers, and improved planning to avoid non-compliance and associated risks. Ongoing education and reminders for staff are planned to ensure understanding and adherence to the updated requirements. The report highlights the importance of these changes and the operational impact on procurement processes across the organisation. The Committee **ENDORSED** the report for **APPROVAL** at Trust Board.
ASSURE	**Audit Action Tracker transition to AMaT** AMaT is a national system used to monitor and manage internal and external audit actions, replacing the previous Excel/email-based process. The Committee were asked to **NOTE**: Internal Audit Reports • 20 (35.7%) actions that have been 'Fully Complete (Awaiting Approval)' (Green Status) • 22 (39.3%) actions that are 'In progress' (Blue Status) • 2 (3.6%) actions that 'Partially Complete (Not Overdue) (Orange Status) • 7 (12.5%) actions that are 'Partially Complete (overdue)' (Purple Status) • 5 (8.9%) actions that are overdue (Red Status) **Trust Risk Register** The Audit Committee received assurance that the private risk register is actively used, when necessary, with information being inputted into the Datix system. The Committee **NOTED** the risks in the quality and safety domain with a score of 12 and risks in other domains with a score of 15 and above and **NOTED** the static risks and sub-threshold risk audits. **Board Assurance Framework** The Committee recognised that the current BAF version reflects significant recent work, including input from the Governance Assurance and Risk Group, and now covers all strategic risks as agreed by the Trust Board. There is a commitment to further develop the BAF, ensuring it provides clear assurance on risk management and aligns with board expectations and language. The Committee **NOTED** the status of the Board Assurance Framework and **DISCUSSED** the plan to move forward with the Board Assurance Framework.
INFORM	**INTERNAL AUDIT REPORTS**

	The Audit Committee received four internal audit reports, which reported the following levels of assurance: • **nVCC Appointment of Advisers** Advisory Review • **Digital Health and Care Record Audit Report** Assurance rating: Reasonable/Limited (escalated in this report) • **Integrated Radiotherapy Solution (Implementation Phase) Audit Report** Assurance rating: Reasonable • **nVCC Governance Audit Report** Assurance rating: Reasonable
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	25th September 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 11th September 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 11TH SEPTEMBER 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:

- The importance of hearing and systematising the voices of patients, donors, and staff, and improving how feedback and themes are gathered and analysed across the organisation.
- The need for a refreshed focus on people and culture, including staff stories, Trade Union and social partnership engagement, and the impact of organisational culture on all areas, including finance and change management.
- The significance of digital/data and insight prioritisation, with a need to collectively address this across committees.
- The challenge of evidencing positive outcomes and celebrating successes, not just focusing on areas for improvement.
- The maturity of plans and assurance processes, with a need to answer the "so what" question regarding the effectiveness of actions and assurance.
- The importance of co-production and enabling patients to share their experiences directly, not just through operational filters.
- The sustainability of services and models in the context of ongoing and future challenges.

3.2 Further Information

Board members who are not members of the Committee and would like further detail of the Quality, Safety and Performance (QSP) Committee are able to access the agenda and papers for the 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-11th-september-2025/

3.3 Summary of Committee Highlights

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

ALERT / ESCALATE	**Culture & Inclusion Report** The Committee received the first comprehensive Culture & Inclusion report, designed to consolidate updates on compassionate leadership, wellbeing, diversity and inclusion, values and behaviours, and employee voice, replacing previous fragmented reporting. The following key points were noted/discussed: • **Compassionate Leadership:** Embedded in training, with further work planned to align with upcoming national management competencies. • **Wellbeing:** A wellbeing service is established, including a clinical psychologist and project coordinator, with solid progress over the past year.

	• **Diversity & Inclusion:** Progress is tracked quarterly against the Strategic Equality Plan; recent reports have been reviewed with Welsh Government. • **Values & Behaviours:** Foundational work is complete, with ongoing consideration of further embedding and training. • **Employee Voice:** Multiple mechanisms exist (speaking up safely, staff survey action plans, new working confidence platform), but these are not yet integrated into a cohesive programme. The People's Experience Framework is being considered but not yet formalised. The importance of seeing evidence of outcomes, not just closed actions, was highlighted and the Committee raised concerns about the slow progress on employee voice, requesting a clear action plan with a timeline for achieving higher assurance. The Committee highlighted the need to systematise staff feedback, move beyond annual surveys, and adopt more frequent pulse surveys and triangulation with patient/donor feedback. The Committee agreed with the need for a stronger focus on people and culture, suggesting this should be escalated to the Board for a more comprehensive discussion, especially given the ongoing organisational changes. The direct link between staff experience and patient care, and the importance of leadership, compassionate management, and internal communications in fostering an open and engaged culture were strongly emphasised. The following levels of assurance were **agreed**: Compassionate Leadership.....**3** Psychological and Physical Wellbeing .....**3** Diversity and Inclusion .....**3** Values and Behaviours .....**3** Employee Voice **2**
ADVISE	**Finance Report for the Period Ended 31st July 2025** The Committee received the finance report which highlighted a significant loss of income due to changes in commissioning arrangements and contract rebasing, with a notable £340,000 reduction linked to NICE guidance and further impacts from unfunded business cases. Additional cost pressures exceeding £1 million have arisen since the IMTP was signed, including National Insurance increases, higher Welsh Risk Pool claims, and changes to hospital doctor contracts. The organisation is currently on track to meet its main financial targets, but faces ongoing risks related to income, staffing for the Satellite Centre, and activity growth.

The savings target will increase to 2.5% next year, with a focus on productivity and efficiency rather than direct cost-cutting.

There was a strong emphasis on the need for improved divisional scrutiny of finances, better tracking of patient pathways, and ensuring all activity is captured for income.

The group recognised the increasing strategic risk posed by the challenging financial environment, with calls for board-level discussion and potential escalation of the risk score.

The Committee **agreed** the **level 4 assurance** for the finance report, noting that this reflects the present situation, whilst also highlighting that the broader strategic risks and changing financial landscape require further discussion at Board level.

Performance Management Framework (PMF) Report and Supporting Analysis

The Committee reviewed the PMF, noting progress on automating performance metrics (with 40 of 125 metrics outstanding) and agreed to pause further automation until priorities, especially around quality metrics, are clarified.

There was a focus on improving quality metrics, including plans to add mortality and PROMs data, and to shift from static dashboards to trend-based SPC charts for better oversight.

Benchmarking challenges were discussed, particularly for Radiotherapy, with plans to introduce new KPIs across the Southeast region to provide a more comprehensive view of patient pathways.

The Committee emphasised the need for targeted interventions in areas such as PADR completion and sickness absence, requesting clearer action plans and reporting on these issues in future cycles.

Trust Risk Register

The Committee discussed ongoing improvements to the Trust Risk Register, including active review of all risks, alignment of risk management systems, and the need for a revised risk policy.

Concerns were raised about inconsistent risk scoring methods and the impact on commissioning and funding, with a call for a consistent, system-wide approach.

The importance of ensuring the Trust's requirements are reflected in any new all-Wales risk system was emphasised.

	The current **assurance level** remains at **3**, with further development and policy updates required before this level can increase. **Board Assurance Framework** The Board Assurance Framework (BAF) was reviewed, with recognition of progress in refining strategic risks and associated actions. Feedback from Audit and Strategic Development Committees emphasised the need for clearer links between controls, actions, and risk scores, as well as more dynamic updating of risk scores. There was a request for broader executive ownership and for the BAF to reflect named leads, not just a single owner. The Committee discussed aligning BAF content with IMTP strategic objectives and ensuring associated risks are clearly mapped. The Committee **agreed** the current **assurance level 2**, with agreement that further alignment, clarity on strategic objectives, and integration with committee structures are needed before this can increase.
ASSURE	**Noddfa Usage Review** The Committee received a presentation on the usage of the Noddfa Wellbeing Centre, following concerns raised in 2024. The Committee were assured that the funding received is being used as intended, specifically for the designated space and not for other purposes. The presentation outlined the journey from receiving the funds to the development and expansion of the space, highlighting initiatives that support staff well-being. The Committee noted the ongoing and future development areas for the space, and the continued alignment with the original intent of the funding. **Patient, Donor and Staff Stories Update** The Committee reviewed how patient, donor, and staff stories are used to drive improvements and learning, with successes such as increased marrow donor targets through school partnerships and donor awards highlighted, along with ongoing challenges like manual handling training compliance and subcutaneous port provision. The Committee discussed the need for better tracking and follow-up of actions arising from these stories, including using regulatory trackers and improving thematic analysis of feedback. Suggestions included involving patients and donors more directly, capturing stories at events, and considering follow-up stories to assess if improvements have made a difference.

The Committee agreed that more work is needed to ensure stories lead to consistent outcomes, **accepting the assigned Level 3 assurance**. The importance of moving beyond operational details to focus on cultural insights and genuine patient/donor voices was emphasised.

First-Floor Ward Pressure Ulcer and Inpatient Falls Theme Analysis

The Committee discussed the first-floor ward pressure ulcer and inpatient falls, noting a statistically significant rise in pressure ulcers and variable falls data, with contributing factors including the absence of a tissue viability nurse and gaps in staff capability. Immediate actions include a corporate nursing team review, enhanced audits, external support for tissue viability, and plans for a learning repository to ensure ongoing staff education.

The Committee **agreed** the assigned **Level 3 assurance**, reflecting that actions are underway, but outcomes are not yet consistent.

Trust Integrated Quality & Safety Quarter 1 Report

The Committee received the report, noting the following key points:

- 30 working day concerns compliance improved to 86.7% (national target 75%).
- The number of formal concerns increased in Welsh Blood Service (3 received), raising concerns about donor communications and deferrals.
- There have been no ombudsman referrals since late 2023.
- Patient / Donor satisfaction scores are positive - Welsh Blood Service (98%) (16% of donors provided feedback) and Velindre Cancer Service (94%) (0.7% of patients provided feedback) but survey response rates are low.
- Duty of Candour incidents increased for a second quarter (6 cases), with a theme identified as relating to VCS booking processes.
- There were no national reportable severe harm incidents.
- Redress and inquest activity has continued to increase which is consistent with national trends; a deep dive into redress delays is underway.
- Safeguarding reporting improved, especially for children at risk.
- Priorities include increasing patient/donor feedback collection, addressing infection prevention and control, CPO screening, and IPC training compliance.

The Committee **agreed** the **level 4 assurance**, noting improved reporting and collaboration, but highlighted that further progress depends on implementing automated quality dashboards.

	Quality & Safety Regulatory Tracker Update The Q&S Tracker discussion focused on improved management of action plans, with regular monthly updates now in place and increased local ownership at divisional level. The Committee noted the introduction of spot checks to ensure actions are evidenced, and highlighted that the tracker now provides clearer oversight for assurance, with further alignment to new structures underway. The Committee **agreed** the **assurance level 3**, reflecting ongoing improvements and the need for continued monitoring. **Duty of Quality & Duty of Candour Internal Audit reports** Internal audit reports on Duty of Candour and Duty of Quality were received; substantial assurance was given for Duty of Candour and reasonable assurance for Duty of Quality, with auditors praising strong implementation and transparency. The only improvement area noted was the need for a single version of quality data.
INFORM	**Welsh Blood Service - Donor Story** The Committee received details of improvements made following changes made to the pre donation travel screening questionnaire. Between March 2024 and July 2025, four formal concerns were received regarding the travel question in the donor eligibility quiz on the website. If a donor answered "no" to a question, they were redirected to an information page and could not return to the quiz, which could not be changed due to system limitations. The wording of the travel question was updated to be more relevant, and a step-by-step guide was added to help donors access the Disease Risk Index for countries visited. After these changes, no further concerns or negative feedback were received about this question. **Integrated Medium Term Plan (IMTP) Quarterly (Q1) Progress Report** The IMTP Q1 progress report was reviewed, confirming Trust approval and receipt of Welsh Government accountability conditions, which will be tracked and updated quarterly. A new portfolio dashboard now supports milestone tracking and will be further discussed at the next Board Development session. The Committee found the reporting format clear and helpful, **agreed** the **level 3 assurance**, and noted no significant concerns with current IMTP delivery.

	Policy Management Review and Compliance Status The Committee noted clear tracking of Trust and All Wales policies, ongoing work to address overdue items, and agreed to proceed with local updates if All Wales versions are delayed. Oversight of policy updates will continue, with several policies expected to be updated by the next cycle. The report was found helpful for monitoring compliance. **Trust Policies for Approval** The Committee **APPROVED** the following Trust policies: • IPC03 – All Wales Aseptic Non-Touch Technique Policy • IPC05 – National Infection Prevention & Control Manual (NIPCM) • IPC10 – Hand Hygiene Policy • IPC21 – Management of Respiratory Infection Policy • Wellbeing Guidance • WF13 - Adverse Weather Policy • WF55 - Smoke-Free Policy • IG13 - Confidentiality Breach Reporting Policy • IG02 - Data Protection and Confidentiality Policy • IG01 - Records Management Policy • GC01 - Policy and Procedure for the Management of Trust-Wide Policies and Other Trust-Wide Written Control Documents
APPENDICES	Quality and Safety Quarter 1 Report

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 11th September 2025.

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

TRUST BOARD

REVISIONS TO SCHEDULE 1 MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS WITHIN THE TRUST'S STANDING ORDERS; AMENDMENT TO STANDING ORDERS – SCHEDULE 3 – ANNUAL REVIEW COMMITTEE TERMS OF REFERENCE INTERIM AMENDMENTS TO CHAPTER 11 OF THE MODEL STANDING FINANCIAL FOR NHS TRUSTS

DATE OF MEETING	25/09/2025
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?	YES
PREPARED BY	Kay Barrow, Corporate Governance Manager
PRESENTED BY	Non Gwilym, Director of Corporate Governance (Interim) Matthew Bunce, Executive Director of Finance
APPROVED BY	Non Gwilym, Director of Corporate Governance (Interim) and Matthew Bunce, Executive Director of Finance
EXECUTIVE SUMMARY	The purpose of this report is to advise the Trust Board of: • revisions to Schedule 1 Model Scheme of Reservation and Delegation of Powers within the Trust's Standing Orders; • 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 Research, Development and Innovation Sub-Committee ***(Appendix 1)*** • interim amendments to Chapter 11 of the Model Standing Financial Instructions (SFIs) for NHS Trusts following the issue of Welsh Health Circular WHC 2025/012 – Updates to NHS Wales SFIs for public procurement reforms ***(Appendix 2)***.

	The Trust's Standing Orders, Scheme of Reservation and Delegation of Powers and Model Standing Financial Instructions will be updated to reflect the revisions following approval by the Trust Board.
RECOMMENDATION / ACTIONS	The Trust Board is asked to **APPROVE** the: • Revisions to Schedule 1 Model Scheme of Reservation and Delegation of Powers within the Trust's Standing Orders; • 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 Research, Development and Innovation Sub-Committee ***(Appendix 1 & 2)*** • Interim amendments to Chapter 11 of the Model Standing Financial Instructions (SFIs) for NHS Trusts following the issue of Welsh Health Circular WHC 2025/012 – Updates to NHS Wales SFIs for public procurement reforms ***(Appendix 3)***.

GOVERNANCE ROUTE

List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board	26/08/2025
Audit Committee	02/09/2025
Research, Development & Innovation Sub-Committee	09/09/2025

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

All matters were ENDORSED.

7 LEVELS OF ASSURANCE – N/A

APPENDICES

APPENDIX 1	Revised Terms of Reference and Operating Arrangements in respect of the Research, Development and Innovation Sub-Committee – Tracked Changes
APPENDIX 2	Terms of Reference and Operating Arrangements in respect of the Research, Development and Innovation Sub-Committee – Clean Copy
APPENDIX 3	Revised Chapter 11 of the Trust Model Standing Financial Instructions

1. SITUATION / BACKGROUND

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.

1.3 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. All Trust Board members and officers must be made aware of these Standing Orders and, where appropriate, should be familiar with their detailed content.

2. ASSESSMENT

2.1 NHS bodies in Wales must agree Standing Orders (SOs). These together with a set of Standing Financial Instructions (SFIs) and a scheme of decisions reserved to the Board, a scheme of delegations to officers and others, and a range of other framework documents, set out the arrangements within which the Board, its Committees, Advisory Groups and NHS staff make decisions and carry out their activities.

2.2 The Standing Orders and Standing Financial Instructions should be based on the model determined by the Welsh Government.

3. SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Repatriation of Pharmacy Rebate Income

3.1.1 A request is being made by the Executive Director of Finance to amend Schedule 1 Model Scheme of Reservation and Delegation of Powers within the Trust's Standing Orders increasing the approval limit of the Chief Executive Officer from £0.5m to £3m specifically for the repatriation of rebate income to NHS Wales Organisations and Welsh Government.

3.1.2 It is important to note that the Trust is not committing expenditure. NWSSP has historically undertaken the role of reclaiming pharmacy rebates on an NHS-wide basis and repatriating these to Health Boards and Trusts. This helps to achieve economies of scale rather than each organisation locally managing their own rebate process. Welsh Government will invoice NWSSP to recoup the rebate money and this reflects the pass-through funding arrangement. The largest rebate received is for a drug, Vertex, used to treat cystic fibrosis patients. NWSSP have an arrangement where the supplier provides a monthly rebate to NWSSP and then a 'true-up' exercise is taken at the end of the year to reflect the actual value/volume of drugs issued and to finalise the rebate value. The agreed monthly rebate value for 2025/26 is currently £2.5m.

3.1.3 The request for amendment to the Trust's Scheme of Delegation is required due to the introduction of the Invoice Exception Approval Workflow (IEA). Prior to the introduction of the new IEA workflow, the NWSSP Managing Director/Chair had approved these invoices due to their sole purpose being to repatriate funding to Welsh Government rather than a commitment of expenditure. As the Invoice Exception Workflow approval functionality has been deployed from 9th June 2025, these invoices will now be approved within the Oracle hierarchy.

3.1.4 The amendment required to the Financial Limits Table within Schedule 1 Model Scheme of Reservation and Delegation of Powers within the Trust's Standing Orders is highlighted in the table below will be updated to reflect the revisions following approval by the Trust Board:

FINANCIAL LIMITS				
(All values exclude VAT)				
Financial Limits	**Band**	**Revenue**	**Capital**	**Charitable Funds**
		£'000	**£'000**	**£'000**
Trust Board	N/A	No Limit	No Limit	0
Charitable Funds Committee	N/A	0	0	No Limit
Chief Executive	Exec Director	500	500	25
Executive Director of Finance	Exec Director	250	250	25
Deputy Chief Executive	Exec Director	150	150	5
Executive Director / Divisional Directors (VCS & WBS)	Exec Director	100	100	5
Utility Bills (Assistant Director of Estates)	8c	80	0	0

Financial Limits	Band	Revenue	Capital	Charitable Funds
		£'000	£'000	£'000
Deputy Director	9 / 8d	40	40	0
Heads of Department	8c / 8b	20	20	0
Senior Managers	8b / 8a	10	10	0
Delegated Budget Holders	Various	5	0	0
Delegated Charitable Fund Holders	Various	0	0	5
For Pharmaceuticals: VCS Divisional Director VCS Director of Operations Chief Pharmacist	Various	150	0	0
Blood Wholesale Products: Chief Executive Executive Director of Finance WBS Divisional Director WBS Medical Director WBS Deputy Director Head of Transfusion Laboratory Services	Various	800	0	0
For Pharmaceutical Rebates: Chief Executive	Exec Director	3,000	0	0

3.2 Research, Development & Innovation Sub-Committee Terms of Reference

3.2.1 The Trust Board approved the current Research, Development & Innovation Sub- Committee Terms of Reference in May 2024. At that time, the Committee agreed an annual review cycle for the Terms of Reference. The Sub-Committee considered a paper at its meeting in June 2025 and agreed to return to discuss further at its meeting in September 2025.

3.2.2 The amendments detailed in the Research, Development & Innovation Sub- Committee Terms of Reference ***(Appendix 1 & 2)***,were agreed via the Executive Lead and Chair of the Research, Development & Innovation Sub-Committee and **ENDORSED** by the Sub-Committee on 9th September 2025.

3.3 Interim Amendment to Chapter 11 Procurement and Contracting of the Trust's Standing Financial Instructions

3.3.1 The Welsh Government has updated Chapter 11 – Procurement and Contracting of the Model Standing Financial Instructions to comply with the Health Services (Provider Selection Regime) (Wales) Regulations 2025 and the Procurement Act 2023 (and associated subordinate instruments) These amendments supersede those issued in 2023.

3.3.2 Chapter 11 of the Trust's Model Standing Financial Instructions will be replaced with the version issued by the Welsh Government (**Appendix 1**).

3.4 The Trust Board is asked to **APPROVE** the:

- Revisions to Schedule 1 Model Scheme of Reservation and Delegation of Powers within the Trust's Standing Orders;
- 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 Research, Development and Innovation Sub-Committee ***(Appendix 1 & 2)***
- Interim amendments to Chapter 11 of the Model Standing Financial Instructions (SFIs) for NHS Trusts following the issue of Welsh Health Circular WHC 2025/012 – Updates to NHS Wales SFIs for public procurement reforms ***(Appendix 3)***.

4. IMPACT ASSESSMENT

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

	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*	*There are no socio-economic impacts linked directly to the activity outlined in this report.*
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	*There are no Trust Well-Being goal implications or impact linked directly to the activity outlined in this report.*
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*	*There is no direct equality impact in respect of this report.*
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	It is essential that the Trust complies with its standing orders and standing financial instructions.

5. 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**

Research, Development & Innovation (RD&I) Sub-Committee

Terms of Reference & Operating Arrangements

Reviewed:	~~29/~~04/~~2024~~09/2025
Approved:	~~14/05/2024~~
Next Review Due:	~~29/05/2024~~

1. INTRODUCTION

1.1 The Trust's standing orders provide that "The Board may and, where directed by the Assembly Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees".

1.2 The Quality, Safety & Performance Committee, Strategic Development Committee and Charitable Funds Committee have been established by the Board to assist in discharging its functions and meeting its responsibilities with regards to the quality, safety and performance of healthcare, strategic and organisational development and to make and monitor arrangements for the control and management of the Trust's charitable funds.

1.3 As part of the aforementioned Committee functions, the **Research, Development & Innovation (RD&I) Sub-Committee** has been established to act as the "front door" for all RD&I business at Board level and will perform the following functions on their behalf:

- oversee and maintains oversight of the RD&I Strategy on behalf of the Strategic Development Committee.
- oversee the development of an annual implementation plan that operationalises the Strategy and monitor the Division's performance and delivery on behalf of the Quality, Safety & Performance Committee.
- review and approve business cases for alignment with strategy and funding on behalf of the Charitable Funds Committee.

1.4 Research, Development and Innovation are defined as follows:

- **Research and Development**, from a healthcare perspective - refers to systematic investigation and study to generate new knowledge and insight to drive improved patient and donor care.
- **Innovation**, from a healthcare perspective - refers to the application of original research into new or improved health policies, practices, systems, products and technologies, services or delivery methods for improved patient and donor outcomes.

2. PURPOSE

2.1 The purpose of the RD&I Sub-Committee is to:

- Provide strategy and policy oversight for RD&I activities undertaken by the Trust reporting to the Strategic Development Committee.
- Ensure compliance to duty of quality legislation, reporting to the Quality, Safety and Performance Committee.
- Provide assurance on the performance of RD&I activity reporting to the Quality, Safety & Performance Committee.

- Promote and encourage a RD&I ethos and culture which is integral to the Trusts vision, mission and values including the identification of new and enhanced funding opportunities to grow the significance and reach of the Trust's RDI activities.

- Provide assurance to the Board in relation to the Trust's arrangements for ensuring compliance with the UK Policy Frameworks for Health & Social Care Research as amended from time to time.

- Consider relevant matters with reference to the parameters identified for risk appetite in relation to RD&I as set by the Board.

- Provide oversight of workforce transformation, ensuring alignment with the organisation's strategic intent for RD&I and the Clinical and Scientific Board Strategy, and will explicitly address both general and specific workforce development priorities.

- The RD&I Sub-Committee is underpinned and informed through the work of a number of Management Groups and Assurance Processes as set out in ***Appendix 1***.

3. DELEGATED POWERS AND AUTHORITY

With regards to its role in providing advice to the Board, the Committee will fulfil the following functions:

3.1 Strategy & Policy Development

- Promote and encourage a RD&I ethos and culture within the Trust.

- Oversee the development of all RD&I strategies and implementation plans ensuring the conduct of good quality projects within the Trust's portfolio of RD&I activity.

- Consider the strategic implications for the Trust from the findings arising from national developments, review, audit and/or inspection, and monitor the successful implementation of any actions required resulting from these findings.

- Ensure that matters of strategic development are escalated as appropriate to the Trust Strategic Development Committee and on to Trust Board for assurance and approval as required.

3.2 Strategy & Policy Approval

- Approve policies relevant to the business of the Committee as delegated by the Board.

- Scrutinise RD&I Business cases for any legal and / or ethical implications that need to be considered, accessed or financed. and to provide assurance on the quality and safety of RD&I related activity.. Ensure alignment of business cases with the Trust overarching ten-year strategy ***'Destination 2032'*** including the benefit / impact it will make for patients / donors / staff and service users. The Committee is also supported by the Advancing Radiotherapy Fund (ARF) / Advancing Radiotherapy Cymru (ARC) Programme BoardsBoard in scrutinising radiotherapy-based business case proposals and will assess, review and advise as appropriate.

3.3 **Monitoring and Review**

- The Sub-Committee will, in respect of its assurance role, seek assurance that research governance and innovation arrangements are appropriately designed, implemented and are operating appropriately to ensure the provision of a high-quality RD&I service.

- To achieve this, the Sub-Committee will need assurance that the following aspects of RD&I are being effectively managed:

    - The safety, rights, dignity and wellbeing of participants in ~~Innovation and Research development~~RD&I projects is above all other considerations.

    - There is clear, consistent strategic direction, strong leadership and transparent lines of accountability

    - The diversity of the organisation's patients, service users, donors and staff are valued in the active development of ~~Research, Development and Innovation~~RD&I activities as appropriate.

    - There is close collaboration with partner ~~NHW~~NHS Wales and higher education organisations to improve quality, promote joint working for best RD&I outcomes and avoid unnecessary duplication of functions. In this respect, the work of RD&I Sub-Committee will be reflected in the agenda and priorities of the Trust's Academic Partnership Board.

    - The organisation ensures compliance with appropriate legislation and regulation such as the UK Policy Framework for Health and Social Care Research 2017; the EU Clinical Trials Directive 2004 as amended; Good Laboratory Practice; Good Manufacturing Practice in manufacturing products for clinical trials; and Good Clinical Practice; in the conduct of all clinical Research and Innovation activities as appropriate.

    - Systems are in place to monitor compliance with regulatory requirements of the Trust as well as organisational standards and to investigate complaints and deal with irregular or inappropriate behaviour in the conduct of Research and Innovation activity.

    - ~~Research and Innovation~~RD&I investment and expenditure is accounted for and complies with audit requirements as well as the requirements of external funders or sponsors as appropriate.

    - The Committee will scrutinise research and/or innovation proposals and/or business cases that are seeking charitable funding PRIOR to submission to the Charitable Funds Committee~~, in order to provide assurance on the quality and safety of RD&I related activity.~~ (see 3.2 above),

    - When ~~research or innovation~~ RD&I findings have commercial potential, the Trust takes action to protect intellectual property (in accordance with Trust ~~IP/commercialisation policy~~RD&I Policy); and exploit research and innovation in collaboration with its ~~Research and Innovation~~ RD&I partners and, where appropriate, commercial Organisations.

3.4 **Access**

The Chair of the RD&I Sub-Committee shall have reasonable access to Executive Directors and other relevant senior staff.

4. MEMBERSHIP

Members

4.1 A minimum of ~~two~~three (3) members ~~to include~~, comprising:

~~Chair Independent member~~Three independent members of the Board ~~(University) or delegated Independent Board member~~

~~Two Independent Members of~~, to include the ~~Board~~ Chair.

The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

Attendees

4.2 In attendance

- Executive Director with responsibility for RD&I currently Medical Director
- Executive Director of Finance or nominated officer with RD&I funding responsibilities
- Associate Medical Director with responsibility for ~~R&D~~RD&I
- ~~Clinical Director (or Nominated Deputy) – Velindre Cancer Centre~~
- Executive Director of Nursing AHP and Health ~~Sciences~~Science
- Director of Corporate Governance
- Trust Head of Innovation
- Head of Velindre Cancer Research Strategy
- Trust Head of Research & Development
- Research Delivery Manager
- Senior Research Nurse Manager
- Research, Development and Innovation Finance Business Partner
- Clinical Representative ~~- Velindre Cancer Centre Strategic Leadership Team~~ from VCS Divisional Board
- ~~Representative –~~ Welsh Blood Service ~~SMT~~ Senior Leadership Team Lead for RD&I
- ~~Representative –~~Chair of the Welsh Blood Service ~~Lead Clinician for~~ RD&I Group
- ~~WBS RD&I Facilitation Lead~~
- ~~Service User/Lay Representatives~~
- Head of WBS Research, Development and Innovation Services
- Patient & Donor Representative

As a minimum, there must be at least 2 Executive/Board Directors in attendance from the following:

- Executive Medical Director
- Executive Director of Nursing, Allied Health Professionals and Health Science
- Executive Director of Finance

- Executive Director of Organisational Development & Workforce

Should any Executive/Board Director be unavailable to attend, they may nominate a Deputy with the agreement of the Chair, however these deputies will not count towards the quorum.

4.3 **By invitation**

The Sub-Committee Chair may extend invitations as required to the following:

- Head of Information Governance (in advisory capacity)
- Divisional Directors
- Representatives of stakeholder organisations

As well as others internal or external to the Organisation who the Sub-Committee consider should be in attendance, taking account of the matters under consideration at each meeting.

4.4 **Secretariat**

As determined by the Director of Corporate Governance.

4.5 **Member Appointments**

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.

4.6 **Support to Committee Members**

The Director of Corporate Governance on behalf of the Committee Chair shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role: and

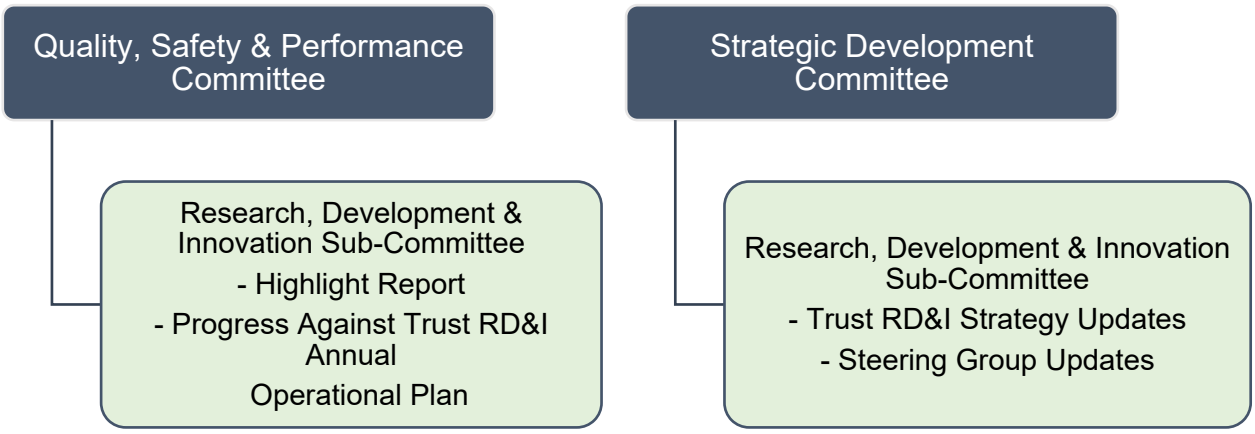
- Ensure the provision of a programme of Organisational ~~development~~Development for Committee members as part of the Trust's overall OD programme developed by the Director of Workforce and ~~Organisational Development~~ OD.

5. SUB-COMMITTEE MEETINGS

5.1 The Committee has, with approval of the Trust Board, established the:

- Research, Development & Innovation Sub-Committee

The Sub-Committee will have a dual reporting line to both the Quality, Safety and Performance Committee and the Strategic Development Committee as follows :



Although the Research, Development & Innovation Sub-Committee, is a sub-committee with dual reporting lines, it will both retain the delegated authority for decision making granted to the current committee by Trust Board. Further details regarding delegated powers and authority are set out in each of the Sub-Committee Terms of Reference.

The Research, Development & Innovation Sub-Committee is also accountable to the Trust Charitable Funds Committee in relation to ~~ensuring~~RD&I business cases ~~are aligned with RD&I strategy and Trust's strategic objectives.~~(see 3.2 above) Further details are set out in each of the respective Terms of Reference. In addition, the wider governance and accountability reporting arrangements in place at a divisional level that feed upwards into the RD&I Sub-Committee structure are also summarised at **Appendix 1**.

5.~~1~~2 **Quorum**

At least two independent members must be present to ensure the quorum of the Committee~~, one of whom should be~~. If the Committee Chair~~. If the Chair~~ is not present an agreement as to who will ~~Chair~~chair from the ~~Independent Members~~independent members in their absence.

As a minimum, there must be at least 2 Executive/Board Directors in attendance from the following:

- Executive Medical Director
- Executive Director of Nursing, Allied Health Professionals and Health Science
- Executive Director of Finance
- Executive Director of Organisational Development & Workforce

Should any Executive/Board Director be unavailable to attend, they may nominate a Deputy with the agreement of the Chair, however these deputies will not count towards the quorum.

5.~~2~~3 **Frequency of Meetings**

Meetings shall be held no less than four times a year and otherwise as the Chair of the Committee deems necessary – consistent with the Trust's annual plan of Board Business.

5.~~3~~4 **Withdrawal of individuals in attendance**

The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank 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 Quality, Safety and Performance Committee, Strategic Development Committee and Charitable Funds Committee for its performance in exercising the functions set out in these terms of reference.

6.3 The Sub-Committee shall embed the Trust's corporate objectives, priorities, and requirements, e.g., equality and human rights through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

Report formally, to the:

i. Quality, Safety & Performance Committee on the performance and delivery of RD&I quarterly.
ii. Strategic Development Committee Board on strategic development and updates to the RD&I Strategy quarterly report and
iii. Charitable Funds Committee to recommend for approval business cases aligned with the RD&I Strategy and Trust's overarching strategic objectives.

7.2 The Sub-Committee shall receive:

i. A briefing from the Executive Medical Director with responsibility for RD&I
ii. A quarterly RD&I Integrated Performance Report (following presentation at EMB)
iii. A quarterly Highlight Report from the Advancing Radiotherapy ~~Fund (ARF) and Advancing Radiotherapy~~ Cymru (ARC) ~~Boards~~Board on the activity of the programme.

7.3 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.

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.

9. REVIEW

9.1 These terms of reference and operating arrangements shall be reviewed annually by the Sub-Committee with reference to the Board.

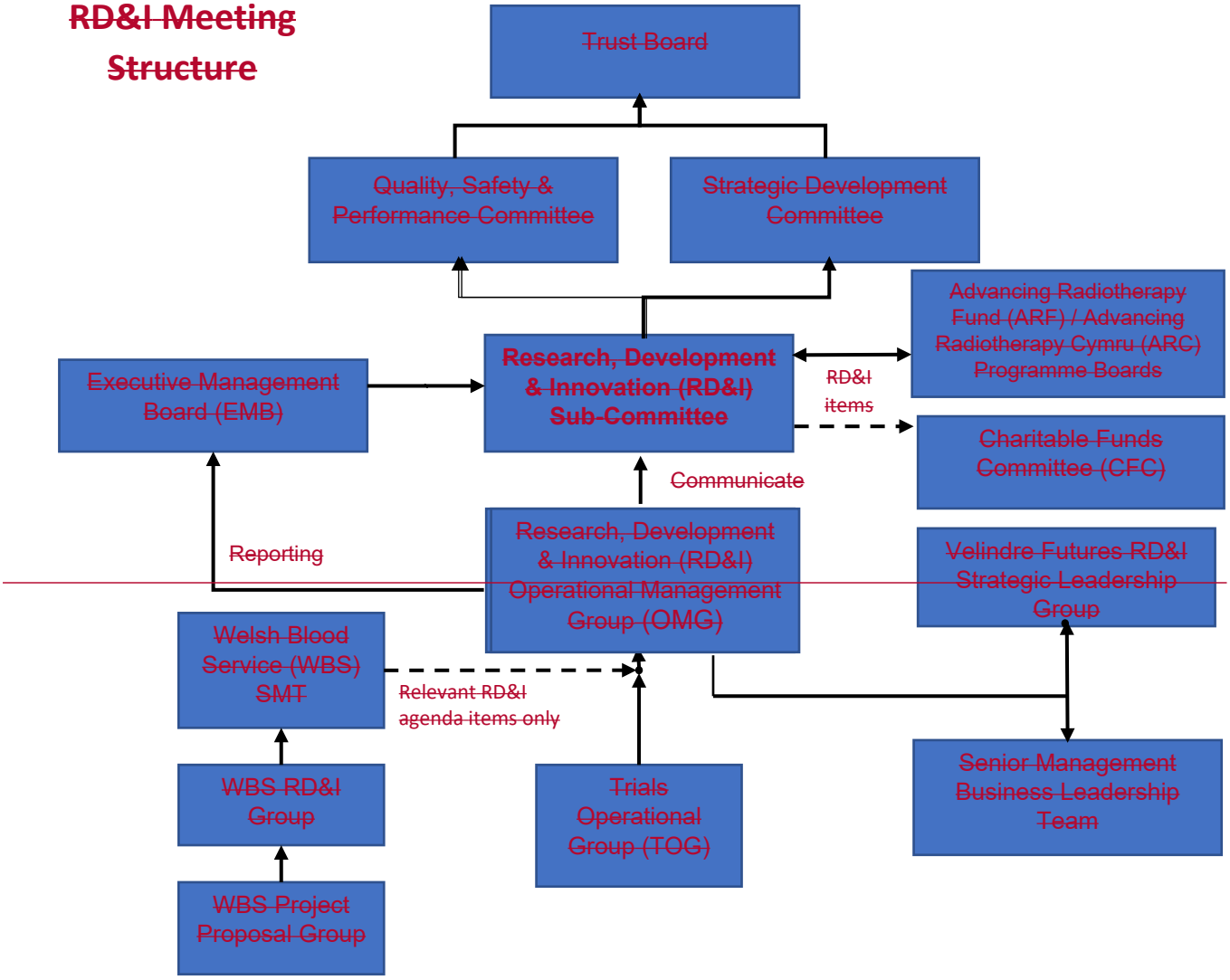
10. CHAIR'S ACTION ON URGENT MATTERS

10.1 There may, occasionally, be circumstances where decisions which would 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 as appropriate, may deal with the matter on behalf of the Board, after first consulting with two other Members of the Sub-Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Sub-Committee for consideration and ratification.

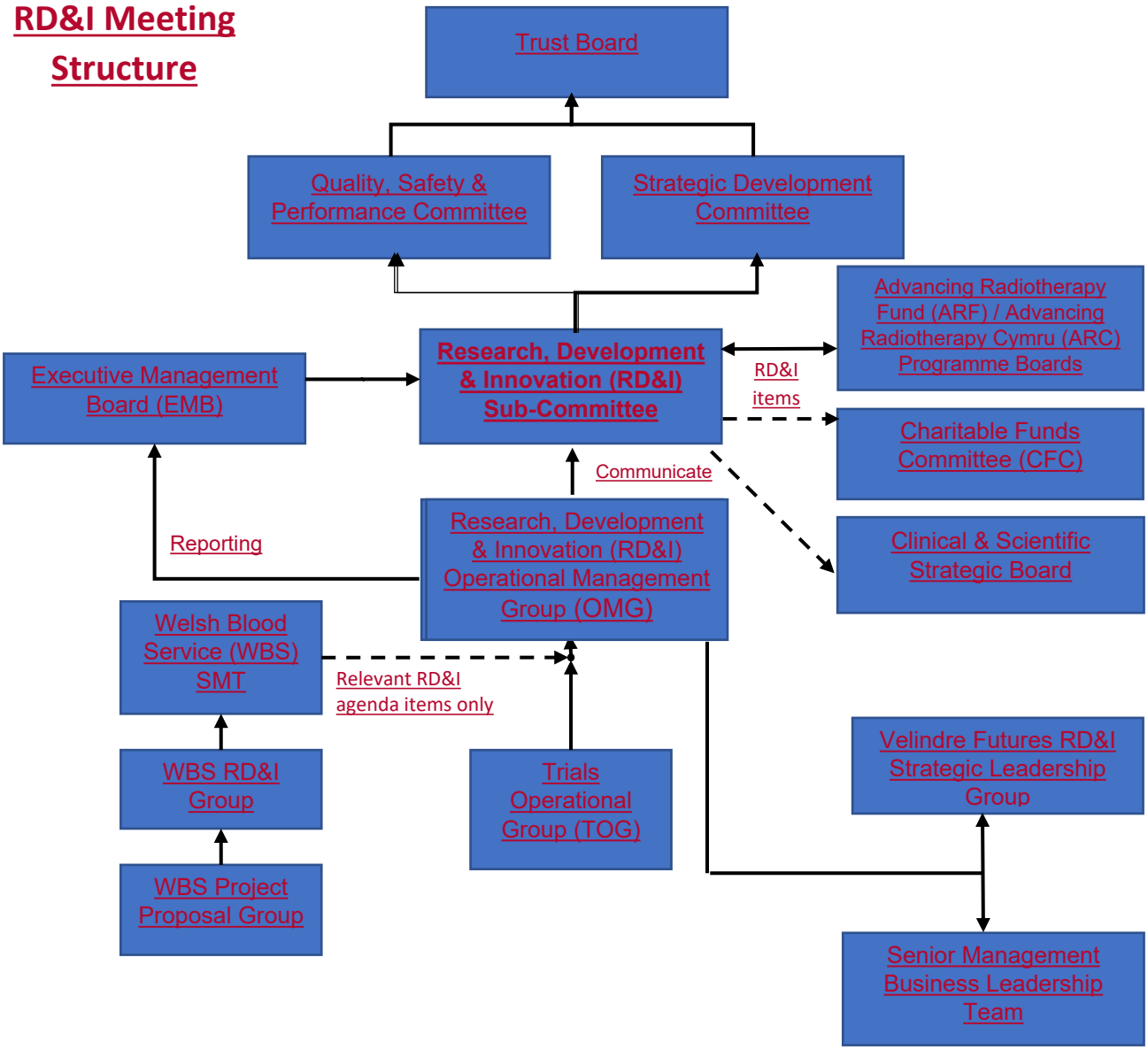
10.2 Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

APPENDIX 1

RD&I Meeting Structure



RD&I Meeting Structure



Research, Development & Innovation (RD&I) Sub-Committee

Terms of Reference & Operating Arrangements

Reviewed:	04/09/2025
Approved:	
Next Review Due:	

1. INTRODUCTION

1.1 The Trust's standing orders provide that "The Board may and, where directed by the Assembly Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees".

1.2 The Quality, Safety & Performance Committee, Strategic Development Committee and Charitable Funds Committee have been established by the Board to assist in discharging its functions and meeting its responsibilities with regards to the quality, safety and performance of healthcare, strategic and organisational development and to make and monitor arrangements for the control and management of the Trust's charitable funds.

1.3 As part of the aforementioned Committee functions, the **Research, Development & Innovation (RD&I) Sub-Committee** has been established to act as the "front door" for all RD&I business at Board level and will perform the following functions on their behalf:

- oversee and maintains oversight of the RD&I Strategy on behalf of the Strategic Development Committee.
- oversee the development of an annual implementation plan that operationalises the Strategy and monitor the Division's performance and delivery on behalf of the Quality, Safety & Performance Committee.
- review and approve business cases for alignment with strategy and funding on behalf of the Charitable Funds Committee.

1.4 Research, Development and Innovation are defined as follows:

- **Research and Development**, from a healthcare perspective - refers to systematic investigation and study to generate new knowledge and insight to drive improved patient and donor care.
- **Innovation**, from a healthcare perspective - refers to the application of original research into new or improved health policies, practices, systems, products and technologies, services or delivery methods for improved patient and donor outcomes.

2. PURPOSE

2.1 The purpose of the RD&I Sub-Committee is to:

- Provide strategy and policy oversight for RD&I activities undertaken by the Trust reporting to the Strategic Development Committee.
- Ensure compliance to duty of quality legislation, reporting to the Quality, Safety and Performance Committee.
- Provide assurance on the performance of RD&I activity reporting to the Quality, Safety & Performance Committee.
- Promote and encourage a RD&I ethos and culture which is integral to the Trusts vision, mission and values including the identification of new and enhanced funding opportunities to grow the significance and reach of the Trust's RDI activities.

- Provide assurance to the Board in relation to the Trust's arrangements for ensuring compliance with the UK Policy Frameworks for Health & Social Care Research as amended from time to time.

- Consider relevant matters with reference to the parameters identified for risk appetite in relation to RD&I as set by the Board.

- Provide oversight of workforce transformation, ensuring alignment with the organisation's strategic intent for RD&I and the Clinical and Scientific Board Strategy, and will explicitly address both general and specific workforce development priorities.

- The RD&I Sub-Committee is underpinned and informed through the work of a number of Management Groups and Assurance Processes as set out in ***Appendix 1***.

3. DELEGATED POWERS AND AUTHORITY

With regards to its role in providing advice to the Board, the Committee will fulfil the following functions:

3.1 Strategy & Policy Development

- Promote and encourage a RD&I ethos and culture within the Trust.

- Oversee the development of all RD&I strategies and implementation plans ensuring the conduct of good quality projects within the Trust's portfolio of RD&I activity.

- Consider the strategic implications for the Trust from the findings arising from national developments, review, audit and/or inspection, and monitor the successful implementation of any actions required resulting from these findings.

- Ensure that matters of strategic development are escalated as appropriate to the Trust Strategic Development Committee and on to Trust Board for assurance and approval as required.

3.2 Strategy & Policy Approval

- Approve policies relevant to the business of the Committee as delegated by the Board.

- Scrutinise RD&I Business cases for any legal and / or ethical implications that need to be considered, accessed or financed and to provide assurance on the quality and safety of RD&I related activity.. Ensure alignment of business cases with the Trust overarching ten-year strategy ***'Destination 2032'*** including the benefit / impact it will make for patients / donors / staff and service users. The Committee is also supported by the Advancing Radiotherapy Cymru (ARC) Programme Board in scrutinising radiotherapy-based business case proposals and will assess, review and advise as appropriate.

3.3 Monitoring and Review

- The Sub-Committee will, in respect of its assurance role, seek assurance that research governance and innovation arrangements are appropriately designed, implemented and are operating appropriately to ensure the provision of a high-quality RD&I service.

- To achieve this, the Sub-Committee will need assurance that the following aspects of RD&I are being effectively managed:

    - The safety, rights, dignity and wellbeing of participants in RD&I projects is above all other considerations.

    - There is clear, consistent strategic direction, strong leadership and transparent lines of accountability

    - The diversity of the organisation's patients, service users, donors and staff are valued in the active development of RD&I activities as appropriate.

    - There is close collaboration with partner NHS Wales and higher education organisations to improve quality, promote joint working for best RD&I outcomes and avoid unnecessary duplication of functions. In this respect, the work of RD&I Sub-Committee will be reflected in the agenda and priorities of the Trust's Academic Partnership Board.

    - The organisation ensures compliance with appropriate legislation and regulation such as the UK Policy Framework for Health and Social Care Research 2017; the EU Clinical Trials Directive 2004 as amended; Good Laboratory Practice; Good Manufacturing Practice in manufacturing products for clinical trials; and Good Clinical Practice; in the conduct of all clinical Research and Innovation activities as appropriate.

    - Systems are in place to monitor compliance with regulatory requirements of the Trust as well as organisational standards and to investigate complaints and deal with irregular or inappropriate behaviour in the conduct of Research and Innovation activity.

    - RD&I investment and expenditure is accounted for and complies with audit requirements as well as the requirements of external funders or sponsors as appropriate.

    - The Committee will scrutinise research and/or innovation proposals and/or business cases that are seeking charitable funding PRIOR to submission to the Charitable Funds Committee (see 3.2 above),

    - When RD&I findings have commercial potential, the Trust takes action to protect intellectual property (in accordance with Trust RD&I Policy); and exploit research and innovation in collaboration with its RD&I partners and, where appropriate, commercial Organisations.

3.4 **Access**

The Chair of the RD&I Sub-Committee shall have reasonable access to Executive Directors and other relevant senior staff.

4. MEMBERSHIP

Members

4.1 A minimum of three (3) members, comprising:

Three independent members of the Board, to include the Chair.

The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

Attendees

4.2 In attendance

- Executive Director with responsibility for RD&I currently Medical Director
- Executive Director of Finance or nominated officer with RD&I funding responsibilities
- Associate Medical Director with responsibility for RD&I
- Executive Director of Nursing AHP and Health Science
- Director of Corporate Governance
- Trust Head of Innovation
- Head of Velindre Cancer Research Strategy
- Trust Head of Research & Development
- Research Delivery Manager
- Senior Research Nurse Manager
- Research, Development and Innovation Finance Business Partner
- Clinical Representative from VCS Divisional Board
- Welsh Blood Service Senior Leadership Team Lead for RD&I
- Chair of the Welsh Blood Service RD&I Group
- Head of WBS Research, Development and Innovation Services
- Patient & Donor Representative

As a minimum, there must be at least 2 Executive/Board Directors in attendance from the following:

- Executive Medical Director
- Executive Director of Nursing, Allied Health Professionals and Health Science
- Executive Director of Finance
- Executive Director of Organisational Development & Workforce

Should any Executive/Board Director be unavailable to attend, they may nominate a Deputy with the agreement of the Chair, however these deputies will not count towards the quorum.

4.3 **By invitation**

The Sub-Committee Chair may extend invitations as required to the following:

- Head of Information Governance (in advisory capacity)
- Divisional Directors
- Representatives of stakeholder organisations

As well as others internal or external to the Organisation who the Sub-Committee consider should be in attendance, taking account of the matters under consideration at each meeting.

4.4 **Secretariat**

As determined by the Director of Corporate Governance.

4.5 **Member Appointments**

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.

4.6 **Support to Committee Members**

The Director of Corporate Governance on behalf of the Committee Chair shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role: and

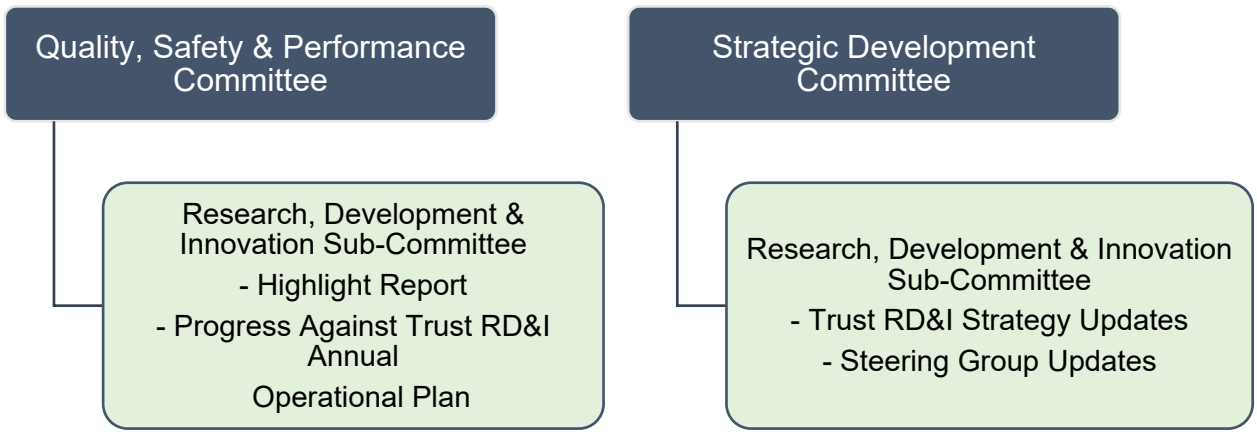
- Ensure the provision of a programme of Organisational Development for Committee members as part of the Trust's overall OD programme developed by the Director of Workforce and OD.

5. SUB-COMMITTEE MEETINGS

5.1 The Committee has, with approval of the Trust Board, established the:

- Research, Development & Innovation Sub-Committee

The Sub-Committee will have a dual reporting line to both the Quality, Safety and Performance Committee and the Strategic Development Committee as follows :



Although the Research, Development & Innovation Sub-Committee, is a sub-committee with dual reporting lines, it will both retain the delegated authority for decision making granted to the current committee by Trust Board. Further details regarding delegated powers and authority are set out in each of the Sub-Committee Terms of Reference.

The Research, Development & Innovation Sub-Committee is also accountable to the Trust Charitable Funds Committee in relation to RD&I business cases (see 3.2 above) Further details are set out in each of the respective Terms of Reference. In addition, the wider governance and accountability reporting arrangements in place at a divisional level that feed upwards into the RD&I Sub-Committee structure are also summarised at **Appendix 1**.

5.2 **Quorum**

At least two independent members must be present to ensure the quorum of the Committee. If the Committee Chair is not present an agreement as to who will chair from the independent members in their absence.

As a minimum, there must be at least 2 Executive/Board Directors in attendance from the following:

- Executive Medical Director
- Executive Director of Nursing, Allied Health Professionals and Health Science
- Executive Director of Finance
- Executive Director of Organisational Development & Workforce

Should any Executive/Board Director be unavailable to attend, they may nominate a Deputy with the agreement of the Chair, however these deputies will not count towards the quorum.

5.3 **Frequency of Meetings**

Meetings shall be held no less than four times a year and otherwise as the Chair of the Committee deems necessary – consistent with the Trust's annual plan of Board Business.

5.4 **Withdrawal of individuals in attendance**

The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank 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 Quality, Safety and Performance Committee, Strategic Development Committee and Charitable Funds Committee for its performance in exercising the functions set out in these terms of reference.

6.3 The Sub-Committee shall embed the Trust's corporate objectives, priorities, and requirements, e.g., equality and human rights through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

Report formally, to the:

i. Quality, Safety & Performance Committee on the performance and delivery of RD&I quarterly.
ii. Strategic Development Committee Board on strategic development and updates to the RD&I Strategy quarterly report and
iii. Charitable Funds Committee to recommend for approval business cases aligned with the RD&I Strategy and Trust's overarching strategic objectives.

7.2 The Sub-Committee shall receive:

i. A briefing from the Executive Medical Director with responsibility for RD&I
ii. A quarterly RD&I Integrated Performance Report (following presentation at EMB)

iii. A quarterly Highlight Report from the Advancing Radiotherapy Cymru (ARC) Board on the activity of the programme.

7.3 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.

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.

9. REVIEW

9.1 These terms of reference and operating arrangements shall be reviewed annually by the Sub-Committee with reference to the Board.

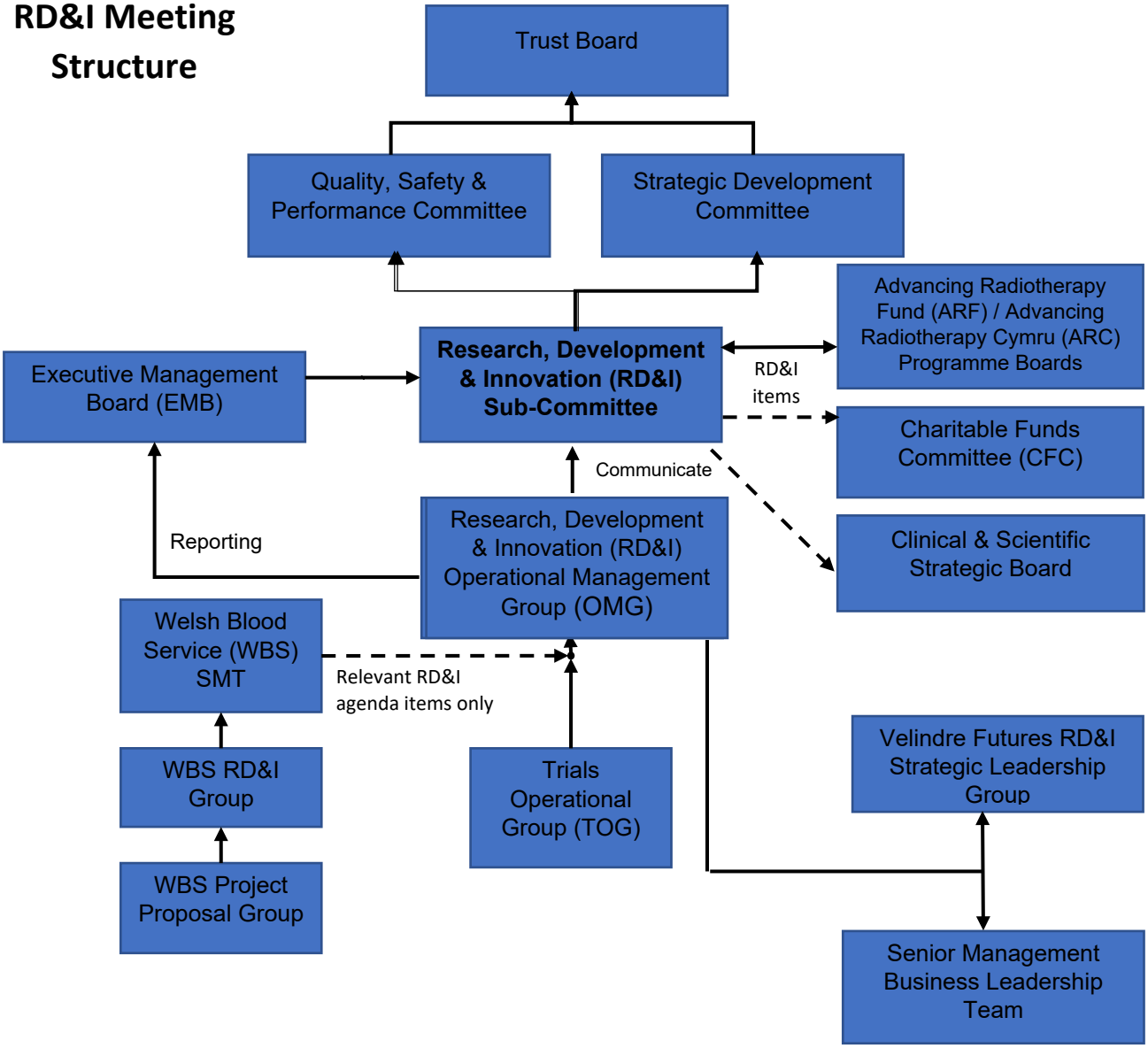
10. CHAIR'S ACTION ON URGENT MATTERS

10.1 There may, occasionally, be circumstances where decisions which would 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 as appropriate, may deal with the matter on behalf of the Board, after first consulting with two other Members of the Sub-Committee. The Director of Corporate Governance 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.

APPENDIX 1

RD&I Meeting Structure



11. PROCUREMENT AND CONTRACTING

Any instruction or summary of legislation in this chapter of the Trust's SFIs is neither legal advice nor statutory guidance, is not intended to be exhaustive, nor an authoritative statement of the law, nor is it intended to override existing legal obligations applicable to the Trust. The law is subject to constant change and the Trust should seek its own legal advice as appropriate as well as consult with NHS Wales Shared Services Partnership (NWSSP) Procurement Services.

In the event of any conflict between what is contained in legislation and the Trust's SFIs, the former shall prevail.

General Information

11.1 Procurement Services

11.1.1 While the Chief Executive is ultimately responsible for procurement, the service is delivered by NHS Wales Shared Services Partnership (NWSSP) Procurement Services ("**Procurement Services**").

11.1.2 Procurement staff employed by NWSSP provide a procurement support function to all health organisations in NHS Wales. Although NWSSP is responsible for the provision of a Procure to Pay service and provision of appropriate professional procurement and commercial advice, ultimate responsibility for compliance with legislation and policy guidelines remains with the Trust. Where the term 'procurement staff' or 'department' is used in this chapter it should be read as equally applying to those departments where the procurement function is undertaken locally and outside of Procurement Services, e.g.; 'Pharmacy' and 'Works', who undertake procurement on a devolved basis.

11.2 Policies and Procedures

11.2.1 Procurement Services shall, on behalf of the Trust maintain detailed policies and procedures for all aspects of procurement, including tendering and contracting processes. The policies and procedures shall comply with these SFIs, the NWSSP Procurement Manual (existing and future revised), and the Revised General Consent to enter Individual Contracts [included as Schedule 1 of these SFIs].

11.2.2 The Chief Executive is ultimately responsible for ensuring that the Trust's Executive Directors, Independent Members and officers within the organisation strictly follow procurement, tendering and contracting procedures.

11.2.3 NWSSP's Director of Procurement Services is responsible for ensuring that procurement, tendering and contracting policies and procedures are:

- kept up to date;
- conform to statutory requirements and regulations;
- adhere to guidance issued by the Welsh Ministers; and
- are consistent with the principles of sustainable development.

11.2.4 All procurement guidance issued by the Welsh Ministers should have the effect as if incorporated in these SFIs.

11.3 Legislation Governing Public Procurement

11.3.1 Legislation governs public sector procurement in the UK. From the 24 February 2025, the Procurement Act 2023 and associated subordinate instruments (together "**the 2023 Act**") and the Health Services (Provider Selection Regime) (Wales) Regulations 2025 and associated subordinate instruments (together "**the PSR Wales Regulations**") are the key pieces of legislation which governs public sector procurement in the UK. The PSR Wales Regulations only apply to certain health services ("**In-Scope Health Services**") and further detail these can be found in the Welsh Government's statutory guidance titled "Health service procurement: statutory guidance". Goods and services which are not In-Scope Health Services ("**Goods and Non-Health Services**") fall within the scope of the 2023 Act. `

11.3.2 Where specific instruction relates only to procurements undertaken under the PSR Wales Regulations, the words **'In-Scope Health Services Only'** will appear at the start of the instruction paragraph. Where specific instruction relates only to procurements undertaken under the 2023 Act, the words **'Goods and Non-Health Services Only'** will appear at the start of the instruction paragraph. If such references do not appear at the start of the instruction paragraph, all information detailed is applicable to the procurement regimes under both the PSR Wales Regulations and the 2023 Act, save for any bracketed instruction reference following a phrase to either regimes applicability. Any instruction or summary of legislation in the Trust's SFIs is neither legal advice nor statutory guidance, is not intended to be exhaustive nor an authoritative statement of the law, nor is it intended to override existing legal obligations applicable to the Trust. The law is subject to constant change and the Trust should seek its own legal advice as appropriate.

11.3.3 **'Goods and Non-Health Services Only'** The 2023 Act governs the procurement of Goods and Non-Health Services. The Welsh Government's Policy Framework and the Wales Procurement Policy Statement (WPPS) under section 14 of the 2023 Act also govern this area. A key objective of the legislation is to establish a flexible, accessible and equitable framework for public procurement in Wales that maximises social, economic, environmental and cultural outcomes for communities

across Wales. Legislation, policy, and guidance setting out procedures and requirements for awarding all forms of regulated contracts shall have effect as if incorporated in the Trust's SFIs. **In the event of any conflict between what is contained in the 2023 Act and the Trust's SFIs, the former shall prevail.**

11.3.4 **'In Scope Health Services Only'** The PSR Wales Regulations governs the procurement of In-Scope Health Services. Under this legislation, relevant organisations to which the PSR Wales Regulations apply must also have regard to the Wales Procurement Policy Statement (WPPS) under section 14 of the 2023 Act. They must also have regard to the statutory guidance issued by the Welsh Government which sets out how the PSR Wales Regulations should be adopted. One of the key objectives of this legislation is to ensure there is more flexibility when selecting providers for health services, with competitive tendering being one tool for the Trust to use when it is of benefit; alongside other routes that may be more proportionate, and which better enable the development of stable partnerships and the delivery of collaborative care. Legislation, policy, and guidance setting out procedures for awarding all forms of regulated contracts shall have effect as if incorporated in the Trust's SFIs. **In the event of any conflict between what is contained in the PSR Wales Regulations and the Trust's SFIs, the former shall prevail.**

11.3.5 All Directors and their staff are responsible for ensuring that all legal requirements in the area of public procurement are understood and fully complied with. The provisions set out in the 2023 Act, the PSR Wales Regulations, Welsh Procurement Policy Notices and all associated subordinate instruments are the model upon which all procurement exercises should be based.

11.3.6 Procurement advice should be sought in the first instance from Procurement Services. The commissioning of further specialist advice shall be jointly agreed between the Trust's and Procurement Services e.g., engagement of NWSSP Legal and Risk Services prior to 3rd party Legal Service providers.

11.3.7 All other relevant legislation, guidance and policy documents must also be observed, including but not limited to the following:

- Social Partnership and Public Procurement (Wales) Act 2023
- The Well-being of Future Generations (Wales) Act 2015
- Welsh Language (Wales) Measure 2011
- Modern Slavery Act 2015
- Bribery Act 2010
- Equality Act 2010
- Welsh Government's Code of Practice for Ethical Employment in Supply Chains.

- The Producer Responsibility Obligations (Packaging Waste) Regulations 2007
- Welsh Government 'Towards zero waste: our waste strategy'
- The Welsh Government Procurement Policy Framework, including:
    - Wales Procurement Policy Notes (extant at the time of undertaking the procurement exercise)
    - The Wales Procurement Policy Statement (WPPS) (section 14 of the Procurement Act 2023)

11.4 Procurement Principles and Objectives

11.4.1. The term "procurement" embraces the complete process from planning, sourcing to taking delivery of all works, goods and services required by the Trust to perform its functions, and furthermore embrace all building, equipment, consumables, and services including health services. Procurement further embraces contract and/or supplier management, including market engagement and industry monitoring.

11.4.2 **'Goods and Non-Health Services Only'** The legal and governing principles guiding 'covered procurement' under the 2023 Act, and incorporated into these SFIs include but are not limited to the following:

- Having regard to the objectives of delivering value for money; maximising public benefit; sharing information for the purpose of allowing suppliers and others to understand the authority's procurement policies and decisions; acting, and being seen to act, with integrity; and removing or reducing the barriers faced by SMEs.
- Ensuring equal treatment by treating suppliers the same, unless differences between the suppliers justify different treatment (and where different treatment of suppliers is justified, to take all reasonable steps to make sure the different treatment does not put a supplier at an unfair advantage or disadvantage).

11.4.3 **'In Scope Health Services Only'** The legal and governing principles guiding procurement of In-Scope Health Services under the PSR Wales Regulations, and incorporated into these SFIs include but is not limited to the Trust doing the following:

- Making decisions in the best interests of people who use the service by acting with a view to (1) securing the needs of the people who use the services; (2) improving the quality of the services; (3) improving efficiency in the provision of the services;
- Acting transparently, fairly, and proportionately;
- Having regard to the Welsh Government's Health service procurement: statutory guidance; and

- Having regard to the Wales Procurement Policy Statement published under section 14 of the 2023 Act.

11.5 Procurement Procedures

11.5.1 To help towards ensuring that the Trust is compliant with the legislation governing public sector procurement in the UK, and Welsh Ministers' guidance and policy, the Trust shall, through Procurement Services, ensure that it shall have procedures that set out:

a) requirements for, and exceptions to, formal competitive tendering (**'Goods and Non-Health Services Only'**);
b) tendering processes including post tender discussions;
c) requirements and exceptions to obtaining quotations (**'Goods and Non-Health Services Only')**;
d) evaluation and scoring methodologies; and
e) approval of firms for providing goods and services.

11.5.2 All procurement procedures must comply with all relevant legislation, the Welsh Ministers' guidance and the Trust's delegation arrangements and approval processes.

11.6 Notification to Welsh Government and consent from the Welsh Ministers

11.6.1 **Schedule 1** details the requirement and notification process for entering into contracts.

11.6.2 The provisions of Schedule 1 do not remove the requirement for the Trust to comply with Standing Orders, SFIs or to obtain any other consents or approvals required by law for the transactions concerned.

Planning

11.7 Sustainable Procurement

11.7.1 To further nurture the Welsh economy and in support of social, environmental, economic and cultural goals in Wales, the Trust must also be mindful to structure requirements ensuring Welsh companies have the opportunity to transparently and fairly compete to deliver services regionally or across Wales where possible and within the legislative framework. The principles of the Well-being of Future Generations (Wales) Act 2015 ("**the WBFG Act 2015**") should be adopted at the earliest stage of procurement planning.

11.7.2 For example, the WBFG Act 2015 requires affected public bodies to act in a manner which seeks to ensure that the needs of the present are met without

compromising the ability of future generations to meet their own needs. The WBFG Act 2015 also provides for a shared purpose through seven well-being goals for Wales which are indivisible from each other and explain what is meant by the well-being of Wales.

11.7.3 The seven well-being goals are:

- a prosperous Wales;
- a resilient Wales;
- a healthier Wales;
- a more equal Wales;
- a Wales of cohesive communities;
- a Wales of vibrant culture and thriving Welsh language; and
- a globally responsible Wales.

11.7.4 The WBFG Act 2015 puts in place a "sustainable development principle" which tells relevant public bodies how to go about meeting their well-being duty. Such bodies need to make sure that when making their decisions they take into account the impact they could have on people living in Wales now and in the future. The WBFG Act 2015 includes five principles that those public bodies need to think about to show they have applied the sustainable development principle, which by way of brief summary are as follows:

- Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives;
- Considering how the public body's well-being objectives may impact upon each of the well-being goals, on their other objectives, or on the objectives of other public bodies;
- The importance of involving people with an interest in achieving the well-being goals, and ensuring that those people reflect the diversity of the area which the body serves;
- The importance of balancing short-term needs with the need to safeguard the long-term needs; and
- How acting to prevent problems occurring or getting worse may help public bodies meet their objectives.

11.7.5 The Trust is required to consider the Welsh Government Guidance on Ethical Employment Practices in Public Sector Supply Chains and the Code of Practice on ethical employment in supply chains which includes aims to commit public, private and third sector organisations to a set of actions designed to eliminate modern slavery and support ethical employment practices.

11.7.6 The Trust shall make use of the tools developed by Welsh Government Commercial Delivery team in implementing the principles of the WBFG Act 2015. The Trust shall benchmark its performance against the WBFG Act 2015. As detailed in WPPN 005, for the procurement of all contracts over £25,000, Trust's are required to take into account the social, economic, environmental and cultural goals in the WBFG Act 2015 using the Sustainable Risk Assessment Template (SRA).

11.8 Small and Medium Sized Enterprises (SMEs), Third Sector Organisations (TSOs) and Supported Factories and Businesses (SFBs)

11.8.1 In accordance with the 'covered procurement' objectives in the 2023 Act, Welsh Government's commitments are set out in the current and subsequent versions of the WPPS, the Trust shall ensure that it provides opportunities for SMEs, TSOs and SFBs to quote or tender for contracts.

11.9 Planning Procurements

11.9.1 The Trust must ensure that all staff with delegated budgetary responsibility or who are part of the procurement process for goods, services and works are aware of the legislative and policy frameworks and requirements governing public procurement.

11.9.2 A process of planning all procurement exercises must be undertaken with the Procurement Services and appropriate representative from the service and other appropriate stakeholders, depending on the value, risk and complexity of the procurement). The purpose of a planning phase is to determine:

- the likely financial value of the procurement, including whole life cost;
- the likely 'route to market' which will consider the legislative and policy framework set out above;
- the availability of funding to be able to award a contract following a successful procurement process; and
- that the procurement follows current legislative and policy frameworks including Value Based Procurement.

11.9.3 The procurement specification should factor in the four principles of prudent healthcare:

- equal partners through co-production;
- care for those with the greatest health need first;
- do only what is needed; and
- reduce inappropriate variation.

For **‘Goods and Non-Health Services Only’** Value based outcome/experience/delivery principles must also be included where appropriate ensuring best value for money, sustainability of services and the future financial position. For **‘In Scope Health Services Only’** Value Based Healthcare should be considered under the Key Criteria ‘Value’ where this is appropriate and applicable. Value for money is defined as the optimum combination of whole-life cost and quality to meet the requirement (and is also a core objective of the 2023 Act).

11.9.4 Where free of charge services are made available to the Trust, Procurement Services must be consulted to ensure that any competition requirements are not breached, particularly in the case of pilot activity to ensure that the Trust does not unintentionally commit itself to a single provider or longer-term commitment. Regular reports on free of charge services provided to the Trust should be submitted by the Board Secretary to the Audit Committee.

11.9.5 Trusts are required to participate in all-Wales collaborative planning activity where the potential to do so is identified by the procurement professional involved in the planning process. Cross sector collaboration may also be required.

Joint or Collaborative Initiatives

11.9.6 Specialist advice should be obtained from Welsh Government’s Health and Social Care Finance department, and the opinions of Procurement Services and NWSSP Legal and Risk prior to external opinion being sought, where there is an undertaking to commence joint or collaborative initiatives which may be deemed as novel or contentious.

11.10 Procurement Process

11.10.1 Where there is a requirement for goods or services, the manager must source those goods or services from the Trusts’s approved catalogue. Where a required item is not included within the catalogue, advice must be sought from Procurement Services on opportunities to source those goods or services through public sector contract framework, such as those provided by the Welsh Government Commercial Delivery team, NHS Supply Chain or Crown Commercial Services. The use of suitable Welsh frameworks (where access is permissible) shall take precedence over frameworks led by public sector bodies outside of Wales.

11.10.2 **‘Goods and Non-Health Services Only’ -** In the absence of an existing suitable procurement framework to source the required item, a competition must be operated in accordance with the table below. The Trust must ensure the value of their requirement considers cumulative spend across the Trust for like requirements and opportunity for collaboration with other NHS Wales organisations**:**

TABLE 'Goods and Non-Health Services Only'

Goods/Services/Works Whole Life Cost Contract value **(figures excl. VAT)**	**Minimum competition** (1)	**Form of Contract**
Below £5,000	Evidence of value for money has been achieved	Purchase Order
£5,000 - £24,999	Evidence of 3 written quotations	Simple Form of Contract/Purchase Order
£25,000 plus to the prevailing Procurement Act 2023 threshold (2)	Advertised open call for competition. Minimum of 4 tenders received if available	Formal contract and Purchase Order
Over the prevailing Procurement Act 2023 threshold	Advertised open call for competition. Minimum of 5 tenders received if available or appropriate to the procurement route	Formal contract and Purchase Order
Contracts above £1 million	Welsh Government notification required (3)	Formal contract and Purchase Order

(1) Subject to the existence of suitable suppliers
(2) The Procurement Act 2023 - Schedule 1 – threshold amounts
(3) In accordance with the requirements set out in Schedule 1.

11.10.3 **'In Scope Health Services Only'** - In the absence of an existing suitable procurement framework to source the required item, Trusts are required to follow the most appropriate and proportionate procurement process as set out under the PSR Wales Regulations and the health service procurement: statutory guidance. Trusts should note that one of the key objectives of these regulations are to provide more flexibility when selecting providers for health services with competitive tendering being one tool for Trusts to use when it is of benefit; alongside other routes that may be more proportionate, with a view to enabling the development of stable supplier partnerships and the delivery of collaborative care. Legislation, policy, and guidance setting out procedures for awarding all forms of regulated contracts shall have effect as if incorporated in the Trust's SFIs.

11.10.4 Agreements awarded are required to deliver best value for money over the whole life of the agreement. Value for money is defined as the optimum combination of whole-life cost and quality to meet the requirement.

Competition Requirements

11.11 Procurement Thresholds

11.11.1 **'Goods and Non-Health Services Only'** The Trust must consider the minimum thresholds for quotes and competitive tendering arrangements when undertaking a procurement. The total value of the contract, whole life cost, over its entire period is the qualifying sum that should be applied (except in specific circumstances relating to aggregation and contracts of an indeterminate duration) as set out below, and in Schedule 1 of the 2023 Act.

11.11.2 **'Goods and Non-Health Services Only'** Advice from the Procurement Services must be sought for all requirements in excess of £5,000 (excluding VAT).

11.11.3 **'Goods and Non-Health Services Only'** The deliberate sub-dividing of contracts to fall below a specific threshold is strictly prohibited. Any attempt to avoid these limits may expose the Board to risk of legal challenge and could result in disciplinary action against an individual[s].

11.11.4 **'Goods and Non-Health Services Only'** Deliberate re-engagement of a supplier, where the value of the individual engagement is less than £5,000 (excluding VAT), must not be undertaken where the total value of engagements taken as a whole would exceed £5,000 (excluding VAT) and require competition.

11.11.5 **'In Scope Health Services Only'** There is no minimum threshold for application of the PSR Wales Regulations.

11.12 Designing Competitions

11.12.1 The budget holder or manager responsible for the procurement is required to engage with the Procurement team to ensure:

- required timescales are achievable.
- specifications are drafted which:
    - are fit for inclusion in competition documents;
    - are drafted in a manner encouraging innovation by the market;
    - are capable of being responded to and do not narrow competition;
    - deliver in line with legislative and policy frameworks;
    - include robust performance measures to effectively measure and manage supplier performance; and
    - consider the ability of the market to deliver.

11.12.2 Appropriate performance measures are included in agreements awarded, thus ensuring best value for money decisions taken that return maximum benefit for the organisation and ultimately the improvement of patient outcomes and wider

health and social care communities. **'Goods and Non-Health Services Only',** under the 2023 Act there is a requirement to set and publish at least 3 Key Performance Indicators (KPI's) for contracts above £5m, and to publish a notice on these at least annually during the term of the contract (note: this does not apply to 'light touch regime' contracts).

11.12.3 **'Goods and Non-Health Services Only'** Criteria for selecting suppliers and achieving an award recommendation must be evaluated on the basis of the "Most Advantageous Tender", which provides contracting authorities with greater flexibility to take into account wider social and environmental issues where that is decided to be relevant for the best solution. Such criteria must:

- be appropriately weighted;
- be transparent and proportionate;
- deliver value for money outcomes;
- fully explore complexity/risk; and
- consider whole life costs, including (where appropriate) the cost of change and / or end of life costs.

11.12.4 **'In-Scope Health Services Only'** Criteria for selecting suppliers and achieving an award recommendation must follow (where applicable) the provisions in the PSR Wales Regulations, regarding:

- Key Criteria (regulation 6);
- Basic Selection Criteria (regulation 22); and
- Exclusions (regulations 25 and 26)

Trusts are required to ensure the appropriate criteria is set with regards the selected procurement process, as set out under the PSR Wales Regulations and Health service procurement: statutory guidance".

11.13 Single Quotation Application (SQA) or Single Tender Application (STA) - 'Goods and Non-Health Services Only'

11.13.1 In exceptional circumstances, there may be a need to secure goods/services/works from a single supplier. This may concern securing requirements from a single supplier, due to a special character of the firm, or a proprietary item or service of a special character. Such circumstances may include:

- follow-up work where a provider has already undertaken initial work in the same area (and where the initial work was awarded from open competition);

- a technical compatibility issue which needs to be met e.g., specific equipment required, or compliance with a warranty cover clause;
- a need to retain a particular contractor for genuine business continuity issues (not just preferences); or
- when joining collaborative agreements where there is no formal agreement in place. Request for such a departure must be supported by written evidence from the Procurement Service confirming local agreements will be replaced by an all-Wales competition/National strategy.

11.13.2 Procurement Services must be consulted prior to any such application being submitted for approval. The Director of Finance must approve such applications up to £25,000, the Chief Executive or designated deputy, and Director of Finance, are required to approve applications exceeding £25,000. A register must be kept for monitoring purposes and all single tender actions must be reported to the Audit Committee.

11.13.3 In all applications, through Single Quotation Application or Single Tender Application (SQA or STA) forms, the applicant must demonstrate adequate consideration to the Chief Executive and Director of Finance, as advised by the Head of Procurement, that securing best value for money is a priority. The Head of Procurement will scrutinise and endorse each request to ensure:

- robust justification is provided;
- a value for money test has been undertaken;
- no bias towards a particular supplier;
- future competitive processes are not adversely affected;
- no distortion of the market is intended;
- an acceptable level of assurance is available before presentation for approval in line with the Trust's Scheme of Delegation; and
- an "or equivalent" test has been considered proving the request is justified.

11.13.4 Under no circumstances will Procurement Services endorse a retrospective SQA/STA, where the Trust has already entered into an arrangement directly.

11.13.5 As SQA or STA are only used in exceptional circumstances the Trust, through the Chief Executive, must report each, including the specifics of the exceptional circumstances and the total financial commitment, in sufficient detail to its Audit Committee. The report will include any corrective action/advice provided by the Chief Executive, Director of Finance or NWSSP Director of Procurement Services to prevent repeated inappropriate use of SQA or STA by the Trust.

11.13.6 The Audit Committee may consider further steps to be appropriate, such as:

- instruct a representative of the Trust to attend Audit Committee;

- escalate to the Board;
- request an internal Audit Review;
- request further training; or
- take internal disciplinary action.

11.13.7 No SQA/STA is required where the seeking of competition is not possible, nor would the application of the SQA/STA procedure add value to the process/aid the delivery of a value for money outcome. The Procurement Manual details schedule of departures from SQA/STA where competition not possible.

11.13.8 For performance monitoring purposes, Procurement Services will retain a central register of all such activity including SQA/STA's not endorsed by Procurement Services or any exceptional matters.

11.14 Disposals - 'Goods and Non-Health Services Only'

11.14.1 Disposal of surplus, obsolete equipment/consumables is also subject to the competition rules.

11.14.2 Obsolete or condemned articles and stores, which may be disposed of in accordance with applicable regulations and law at the prevailing time (e.g., Waste Electrical and Electronic Equipment (WEEE)) and the procedures of the Trust making use of any agreements covering the disposal of such items.

11.14.3 The Trust must obtain the best possible market price.

Approval & Award

11.15 Evaluation, Approval and Award

11.15.1 The evaluation of procurement competitions must be undertaken by a minimum of 2 evaluators from within the operational service of the Trust. Evaluation teams for competitions of greater complexity and value must be multi-disciplinary and reach a consensus recommendation for internal approval.

11.15.2 The internal approval of any recommendation to award a competition must follow the Board's Scheme of Delegation.

11.15.3 The communication of the external notification to the market to award the contract must be managed by the Procurement Service.

11.15.4 Information throughout the process must be handled and retained as 'commercial in confidence' and not shared outside of staff directly involved in the competition process.

11.15.5 All associated communication throughout the competition process must also be managed by the Procurement Service.

Implementation & Contract Management

11.16 Contract Management

11.16.1 Contract management is the process which ensures that both parties to a contract fully meet their respective obligations as effectively and efficiently as possible, in order to deliver the business and operational objectives required by the contract and in particular, to achieve value for money. The relevant budget holder shall oversee and manage each contract on behalf of the Trust so as to ensure that these implicit obligations are met. This contract management will include:

- retaining accurate records;
- monitoring contract performance measures;
- engaging suppliers to ensure performance delivery;
- implementing contractual sanctions in the event of poor performance in conjunction with advice from Procurement Services; and
- permitting stage payments as part of a formally agreed implementation/delivery plan which must be supported by written evidence issued by the budget holder.

11.16.2 Contract management on All Wales contracts will be provided by Procurement Services.

11.16.3 Advice on Contract Management best practice is available from Procurement Services.

11.17 Extending and Varying Contracts

11.17.1 **'Goods and Non-Health Services Only'**

11.17.1.1 Extending, modifying, or varying the scope of an existing contract is possible, if the provision to do so was included as an option in the original awarded contract, e.g., scope of requirement, further expenditure due to unforeseen circumstances, change in regulatory requirements, etc.

11.17.1.2 If there is no such provision, the 2023 Act defines such limitations. Further information on contract modifications can be found in sections 74-77 of the 2023 Act and in Guidance: Contract Modifications.

11.17.2 **'In-Scope Health Services Only'**

11.17.2.1 Modification of the scope of an existing contract is possible if the modification is clearly and unambiguously provided for in the original contract or framework agreement documents, or the original contract was awarded under Direct Award Process 1 and the modification does not render the contract 'materially different' in character.

11.17.2.2 If provisions set out in 11.17.2.1 are not met, the PSR Wales Regulations define limitations concerning modifications of contracts as being, the modification must be:

- solely a change in the identity of the provider however continues to meet the basic selection criteria, and there are no other considerable changes to the contract; or
- made in response to external factors beyond the control of the 'relevant authority' (as defined under section 10A of the National Health Service (Wales) 2006), and the provider, for example changes in patient or service user volume; changes in prices in accordance with a formula provided for in the contract documents and neither of these modifications render the contract or framework agreement materially different in character; or
- made at the discretion of the relevant authority and does not render the contract or framework agreement materially different in character and the cumulative change in the estimated lifetime value of the contract or framework agreement is under £500,000 or is under 25% of the estimated lifetime value.

11.17.3 Further approval is not required to extend an agreement beyond the original term/scope where prior approval was granted as part of the procurement process.

11.17.4 If there was no provision to extend, further approvals are required from the Trust budget holder and the Trust's Head of Procurement. Budget holders must also be mindful of the threshold under which the original contract was awarded. Any increase in the contract value may require a more senior level of approval in line with the Scheme of Delegation.

11.17.5 This ensures an appropriate identification and assessment of potential risks to the Trust's compliance of approvals being granted within the Scheme of Delegation and assurance that value for money continues to be delivered from public funds.

11.17.6 The budget holder must seek advice from Procurement Services in advance of committing further expenditure to ensure the contract is reflective of requirements. The budget holder must assess whether there is sufficient evidence to support the justification and whether the budget is available to support the additional requirements.

Transactional Processes

11.18 Requisitioning

11.18.1 The budget manager in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. The budget holder will source those goods (**'Goods and Non-Health Services Only'**) or services from the approved catalogue. Where a required item is not included within the catalogue, advice must be sought from the Procurement Services on opportunities to source those goods or services through public sector contract framework, such as those managed by Welsh Government Commercial Delivery team, NHS Supply Chain or Crown Commercial Services.

11.18.2 Where a required item is not on catalogue or on framework contract the budget manager shall request the Procurement Services to undertake quotation / tendering exercises (**'Goods and Non-Health Services Only'**) on their behalf in line with SFI 11.11 thresholds (**'Goods and Non-Health Services Only'**).

11.18.3 All orders for goods (**'Goods and Non-Health Services Only'**) and services must be accompanied by an official order number, available from the Procurement Department. In no circumstances must a requisition number be used as an order number.

11.19 No Purchase Order, No Pay

11.19.1 The Trust will ensure compliance with the 'No Purchase Order, No Pay' policy, the All-Wales policy which was introduced to ensure that Procure to Pay continues to provide high-class services on a 'Once for Wales' basis.

11.19.2 The policy ensures that a purchase order is raised at the beginning of a purchase in circumstances where a purchase order is required under the policy. This follows industry standard best practice as it provides a commitment as to what is likely to be spent. The supplier must obtain a purchase order number for their invoice in order for it to be processed for payment.

11.20 Official orders

11.20.1 Official Orders, issued following approved requisition and sourcing, must:

a) Be consecutively numbered;

b) State the Trust's terms and conditions of trade.

11.20.2 Official Orders will be issued on behalf of the Trust by Procurement Services.

SCHEDULE 1

GENERAL CONSENT TO ENTER INDIVIDUAL CONTRACTS

This schedule included as "General Consent to enter individual contracts" replaces all previous versions of Schedule 1 and should be read in conjunction with the revised Model Standing Financial Instructions (SFI's) issued in relation to Chapter 11 for Local Health Boards and NHS Trusts and Chapter 12 for Health Education and Improvement Wales (HEIW) and Digital Health and Care Wales (DHCW).

PROCESSES FOR NHS WALES CONTRACTS, AND INTERESTS IN PROPERTY

Paragraph 13 of Schedule 2 to the National Health Service (Wales) Act 2006 states as follows:

"(1) Subject to sub-paragraph (3), a Local Health Board may do anything which appears to it to be necessary or expedient for the purposes of or in connection with its functions.

(2) In particular it may—

(a) acquire and dispose of property,

(b) enter into contracts,

(c) accept gifts of property (including property to be held on trust, either for the general or any specific purposes of the Local Health Board or for any purposes relating to the health service).

(3) A Local Health Board may not do anything mentioned in sub-paragraph (2) without the consent of the Welsh Ministers (which may be given in general terms covering one or more descriptions of case)."

Section 10.1 of the NHS Wales Infrastructure Investment Guidance issued on 22 October 2018 ("**the Investment Guidance**") includes the following in relation to Local Health Boards:

"Contract approvals over £1m for individual schemes will be sought as part of the normal business case submission process where funding from the NHS Capital Programme is required. For schemes funded via discretionary allocations, a request for approval will need to be submitted to Chief Executive NHS Wales, copying in the Deputy Director of Capital, Estates & Facilities Division.

Detailed arrangements in respect of approval process linked to the acquisition and disposal of leases, where consent does not form part of the business case process are included in Welsh Health Circular WHC(2015)031. Organisations should ensure

that the monitoring arrangements and the requisite forms and returns are included as part of their own assurance arrangements."

This is also to be regarded as being applicable to HEIW and DHCW, which were both established after the two WHC's mentioned above were issued.

Section 10.2 of the Investment Guidance includes the following in relation to Trusts:

"Whilst formal Cabinet Secretary consent is not required for Trusts as detailed above, general consent arrangements are still applicable in terms of relevant transactions. Detailed requirements in terms of appropriate notifications were sent in the Welsh Health Circular referenced above."

Section 11 of the Investment Guidance also includes provision as to disposals and property protocols.

Welsh Health Circular WHC (2015) 031 issued 22 June 2015 includes arrangements for consent to acquire or dispose of a lease in property (where not covered by any business case approval process.

That WHC is also to be regarded as being applicable to HEIW and DHCW in the same way as it applies to LHBs.

Entering into contracts

This schedule confirms to all NHS Wales bodies that the authorisation and consideration of notified contracts and applications for the acquisition or disposal of a lease or any interest in property are delegated to the Director General, Health Social Care and Early Years.

The Director General may, as with any other matter relating to the operation of the NHS in Wales, brief the Cabinet Secretary for Health and Social Care on any arrangement of particular policy note, or with a novel, contentious or innovative nature.

Accordingly, any issues relevant to the exercise of the Cabinet Secretary for Health, and Social Care's consent will, as a matter of course, be drawn to his attention.

The process which NHS Wales bodies entering into contracts must follow is:

- All NHS contracts (unless exempt) >£1m in total to be notified to the Director General HSCEY prior to tendering for the contract;
- All eligible LHB and HEIW and DHCW contracts >£1m in total to be submitted to the Director General HSCEY for consent prior to award;

- All eligible NHS Trust contracts >£1m in total to be submitted to the Director General HSCEY for notification prior to award; and
- All eligible NHS contracts >£0.5m in total to be submitted to the Director General HSCEY for notification prior to award.

The requirement for consent does not apply to any contracts entered into pursuant to a specific statutory power, and therefore does not apply to:

i) Contracts of employment between LHBs, HEIW, or DHCW and their staff;

ii) Transfers of land or contracts effected by Statutory Instrument following the creation of LHBs, HEIW, or DHCW;

iii) Out of Hours contracts;

iv) All NHS contracts; that is where one health services body contracts with another health service body;

(v) Contracts entered into by HEIW for services which are the consequences of annual commissioning approved by the Cabinet Secretary e.g. annual education and training commissioning also do not require further Ministerial notification or consent; and

(vi) Contracts between £500k - £1 million (for noting) and £1 million + (for approval).

a) Wales Public Sector Framework Agreements e.g., Frameworks established by the Welsh Government's Commercial Delivery team or NWSSP (not exhaustive) – no written approval required to award contracts under these Frameworks through a direct award or mini competition.

b) Third-Party Public-Sector Framework Agreements e.g., Frameworks established by Crown Commercial Services, NHS Supply Chain (not exhaustive) – no further approval required to award contracts under these Frameworks through a direct award. Approval will however be required for award of contracts under these Framework Agreements through mini-competition or where the specification of the product/service required is modified from that stated within the Framework Agreement.

For non-capital contracts requiring DG approval, the request for approval or notification should be sent to Rob Eveleigh in the Financial Control and Governance team : Robert.Eveleigh@gov.wales

TRUST BOARD	
Talbot Green Infrastructure – Business Case Approach	
DATE OF MEETING	25 September 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	Sarah Richards, Head of Planning & Performance Services
PRESENTED BY	Lauren Fear, Director of Place, Portfolio, Partnerships
APPROVED BY	Lauren Fear, Director of Place, Portfolio, Partnerships
EXECUTIVE SUMMARY	The Talbot Green Infrastructure (TGI) programme, part of the Welsh Blood Futures portfolio, is undergoing strategic realignment following Welsh Government feedback. Although Welsh Government confirmed £2.142 million in capital funding in November 2024 to support an integrated Outline and Full Business Case, they have since requested a revised Outline Business Case only. During the last six months, the project has also been developing a package of Enabling Works to support phasing of programme. The Enabling Works package includes the purchase of the adjacent Welsh Wound Innovation Centre to streamline the decant process and reduce expenditure by removing the costly extensions to the existing site. It also includes the build of an Energy Centre, which is at the core of

	the rationale for the programme of required investment for resilience. The revised Outline Business Case will incorporate the Enabling Works and laboratory modernisation, with the appointed Supply Chain Partner, BAM, leading design development. A brief has been agreed, and BAM is producing a detailed proposal by the end of September. It has been agreed with Welsh Government that the Enabling Works section will be to Full Business Case standard. This will provide options for phasing of decision making going forwards. The updated Outline Business Case will be submitted by the end of the 2025/26 financial year to align with Welsh Government funding timelines and strategic priorities.
RECOMMENDATION / ACTIONS	Approve the revised approach to submit an Outline Business Case, with the Enabling Works section to Full Business Case standard. This will be submitted by the end of the 2025/26 financial year to meet funding and strategic deadlines.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board	26/08/2025
Strategic Development Committee	09/09/2025

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

Executive Management Board – ENDORSED

Strategic Development Committee – ENDORSED, With a change in wording in recommendation from - Endorse the revised "*scope*" to endorse the revised "*approach,*" which is reflected in the recommendation wording for Trust Board.

Full discussion on the approach and next steps. It was noted that the Trust's development of the Enabling Works programme has positively enabled flexibility in Welsh Government's options for decision making.

1. SITUATION

The Talbot Green Infrastructure (TGI) Programme, an initiative within the Welsh Blood Service Futures portfolio, is currently undergoing strategic realignment following feedback from the Welsh Government.

Although Welsh Government confirmed a capital funding allocation of £2.142 million in November 2024 to support the development of an integrated Outline Business Case and Full Business Case, they have since requested a reassessment of the programme's scope and delivery model. Specifically, Welsh Government has requested the Trust to submit an Outline Business Case only, with a focus on exploring cost-saving alternatives. This work has included exploring the potential utilisation of the adjacent Welsh Wound Innovation Centre to streamline the decant process and reduce overall expenditure.

2. BACKGROUND

The Talbot Green Infrastructure Programme was initiated to modernise the mechanical and electrical infrastructure at the WBS headquarters, ensuring compliance with Good Manufacturing Practice, and supporting future laboratory and clinical service delivery.

The Programme Business Case, approved by the Welsh Government in March 2021, outlined a two-phase approach:

- **Phase 1**: Sustainable Infrastructure
- **Phase 2**: Laboratory Modernisation

Welsh Government initially allocated £150,000 to support the development of the Outline Business Case for Phase 1. However, projected laboratory decant costs, estimated at £3 million, triggered a high-level feasibility review. As a result, the programme transitioned to a single-phase delivery model, integrating both Sustainable Infrastructure and Laboratory Modernisation to optimise resources and streamline implementation. This shift was accompanied by confirmation from Welsh Government to adopt an integrated Outline Business Case and Full Business Case approach.

The programme has progressed through several key milestones:

- Approval of the PBC in March 2021.
- Development of the Outline Business Case under the Build for Wales Framework.
- Transition to an integrated Outline Business Case / Full Business Case delivery model.

Initial designs and cost estimates provided by the appointed Supply Chain Partner, BAM, exceeded the available budget, prompting Welsh Government to request a reassessment. In response, the Trust explored alternative decant strategies, including the potential use of the Welsh Wound Innovation Centre, a Welsh Government-owned facility adjacent to the Talbot Green site, as a cost-effective solution to streamline the decant process and reduce overall expenditure.

3. ASSESSMENT

The Talbot Green Infrastructure Programme is now at a pivotal stage of development. Following direction from the Welsh Government, the Trust has been tasked with delivering a more cost-effective solution, prompting a reassessment of site utilisation and programme scope.

The Enabling Works package includes the purchase of the adjacent Welsh Wound Innovation Centre to streamline the decant process and reduce expenditure by removing the costly extensions to the existing site. It also includes the build of an Energy Centre, which is at the core of the rationale for the programme of required investment for resilience.

The revised Outline Business Case will incorporate the Enabling Works and laboratory modernisation, with the appointed Supply Chain Partner, BAM, leading design development. A brief has been agreed, and BAM is producing a detailed proposal by the end of September.

It has been agreed with Welsh Government that the Enabling Works section will be to Full Business Case standard. This will provide options for phasing of decision making going forwards.

The updated Outline Business Case will be submitted by the end of the 2025/26 financial year to align with Welsh Government funding timelines and strategic priorities.

4. SUMMARY OF MATTERS FOR CONSIDERATION

- **Strategic Realignment**: The Welsh Government has requested a reassessment of the programme's scope and delivery model, directing the Trust to submit an Outline Business Case only, rather than a combined Outline Business Case / Full Business Case.

- **Capital Funding Context**: Welsh Government previously confirmed a capital allocation of £2.142 million (November 2024) to support the programme, which now requires reconfiguration to meet revised expectations.

- **Cost Optimisation**: The proposed utilisation of the Welsh Wound Innovation Centre, adjacent to the Talbot Green site, offers a cost-effective alternative to new construction and simplifies the decant process.

- **Design Development**: A brief has been established for BAM, who have been given three weeks to develop a revised proposal integrating enabling works and laboratory modernisation.

- **Timeline Requirement**: The updated Outline Business Case will be submitted by the end of the 2025/26 financial year to align with Welsh Government funding timelines and strategic priorities.

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*	**Choose an item**
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below** Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒

QUALITY IMPACT ASSESSMENT	Not required - not a strategic decision
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not yet completed (Include further detail below why) Being completed as part of the development of the business case. **Click or tap here to enter text**

TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT

The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated. Please indicate whether any of the matters outlined in this report impact the Trust's Wellbeing goals:

YES - Select Relevant Goals below

If yes select the relevant goals:

- A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities. ☐
- A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience. ☒
- A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health ☒
- A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances ☐
- A Wales of more Cohesive Communities - Attractive, viable, safe and well-connected communities. ☐
- A Wales of Vibrant Culture and Thriving Welsh Language -Promoting and protecting culture, heritage and the Welsh language, encouraging people to participate in the arts, and sports and recreation. ☐
- A Globally Responsible Wales – Consideration of whether an action may make a positive contribution to global well-being ☒

FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Source of Funding: **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text**

	Type of Funding: Choose an item **Scale of Change** Please detail the value of revenue and/or capital impact: Click or tap here to enter text **Type of Change** Choose an item Please explain if 'other' source of funding selected: Click or tap here to enter text
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not yet completed - Include further detail below why
	Being completed as part of the Business Case
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

6. RISKS

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

TRUST BOARD

TRUST SEAL REPORT: 22ND MAY 2025 – 18TH SEPTEMBER 2025

DATE OF MEETING	25 September 2025
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	FOR NOTING
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Kyle Page, Business Support Manager
PRESENTED BY	Non Gwilym, Director of Corporate Governance (interim)
APPROVED BY	Non Gwilym, Director of Corporate Governance (interim)
EXECUTIVE SUMMARY	The contents of the Trust Board Seal Register have been approved by the Chair and the Chief Executive Officer of the Trust at every Seal Request **(22nd May 2025 – 18th September 2025)**.
RECOMMENDATION / ACTIONS	The Trust Board is requested to **NOTE** the contents of the Trust Board Seal Register included below as **Appendix 1.**
GOVERNANCE ROUTE	
N/A	
7 LEVELS OF ASSURANCE – N/A	
APPENDICES	
Appendix 1 – Seal Register	
ACRONYMS	
nVCC	New Velindre Cancer Centre

1. SITUATION/ BACKGROUND

1.1 The contents of the Trust Board Seal Register have been approved by the Chair and the Chief Executive Officer of the Trust at every Seal Request **(21st May 2025 – 18th September 2025)**.

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

2.0 ASSESSMENT/SUMMARY OF MATTERS FOR CONSIDERATION

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

3 IMPACT ASSESSMENT

<table>
<tr><td colspan="2">TRUST STRATEGIC GOAL(S)</td></tr>
<tr><td colspan="2">Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals:
NO</td></tr>
<tr><td colspan="2">If yes - please select all relevant goals:
• Outstanding for quality, safety and experience ☐
• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐
• A beacon for research, development and innovation in our stated areas of priority ☐
• An established 'University' Trust which provides highly valued knowledge for learning for all. ☐
• A sustainable organisation that plays its part in creating a better future for people across the globe ☐</td></tr>
<tr><td>RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF)
For more information: STRATEGIC RISK DESCRIPTIONS</td><td>10 - Governance</td></tr>
<tr><td rowspan="2">QUALITY AND SAFETY IMPLICATIONS / IMPACT</td><td>Select all relevant domains below</td></tr>
<tr><td>Safe ☒
Timely ☒
Effective ☒
Equitable ☐
Efficient ☒
Patient Centred ☐</td></tr>
<tr><td rowspan="2">SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:
For more information: https://www.gov.wales/socio-economic-duty-overview</td><td>Not required</td></tr>
<tr><td>Click or tap here to enter text</td></tr>
<tr><td>TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT</td><td>N/A</td></tr>
</table>

FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	A record that the Trust Board Seal Register has been approved by the Chair and the CEO of the Trust at every Seal request.

4 RISKS

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

Appendix 1 – Seal Register

Date	Document Details	Signed
28th July 2025	Deed of Adherence between the entities named in Schedule 1 and Velindre University NHS Trust (1) NHS Blood & Transplant and (2) Groupe Maco Pharma International.	David Donegan, CEO and Prof. Donna Mead, Chair
28th July 2025	Engrossment Lease for 19 Park Road, Whitchurch, Cardiff, between (1) Cardiff Community Housing Association Ltd and (2) Velindre University NHS Trust.	David Donegan, CEO and Prof. Donna Mead, Chair
28th August 2025	Deed of Collateral Warranty of digital services design and implementation engineer consultant in respect of new Velindre Cancer Centre in Whitchurch, Cardiff, Wales.	David Donegan, CEO and Lindsay Foyster, Acting Chair
28th August 2025	Deed of Collateral Warranty design and construction of the bunker in respect of new Velindre Cancer Centre in Whitchurch, Cardiff, Wales.	David Donegan, CEO and Lindsay Foyster, Acting Chair

Date	Document Details	Signed
28th August 2025	Deed of Collateral Warranty of digital services design and implementation engineer consultant in respect of the new Velindre Cancer Centre in Whitchurch, Cardiff (1) Velindre University NHS Trust and (2) Ingenieria y Consultoria Para el Control Automatico, SL.	David Donegan, CEO and Lindsay Foyster, Acting Chair
16th September 2025	nVCC Project Supplier Agreement – direct agreement among (1) Velindre University NHS Trust, (2) Sacyr Limited and (3) Becton Dickinson Dispensing UK Limited.	David Donegan, CEO and Sara Moseley, Chair

TRUST BOARD	
HIGHLIGHT REPORT FROM THE CHAIR OF THE NEW VELINDRE CANCER CENTRE (nVCC) PROJECT SCRUTINY SUB-COMMITTEE	
DATE OF MEETING	16th July 2025
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Christine Sion, Business Support Officer
PRESENTED BY	Hilary Jones, Independent Member and Interim Chair of the nVCC Project Scrutiny Sub-Committee
EXECUTIVE SPONSOR APPROVED	Carl James, Executive Director Strategic Transformation, Planning & Digital / Deputy Chief Executive
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 nVCC Project Scrutiny Sub-Committee held on 16th July 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 actions being taken.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for alert/escalation to Trust Board.
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, providing an update on progress during the reporting period. The following key highlights were noted: • **Overall Project Status** – The project was reported as Amber, primarily due to ongoing catch-up construction work. The western side of the building is currently 4–5 weeks ahead of schedule, while the eastern side is 4–5 weeks behind due to earlier delays in bunker works and concrete pours. With these works now complete, construction on the eastern side is expected to accelerate over the next six weeks. • **Enabling Works Delay** – Delays are anticipated due to external utility issues (DNO). However, this is not on the critical path, with 4–5 months of float available before any impact on the overall programme. • **Health and Safety** – Observations remain high, and incidents are relatively low. These do not appear to be systemic or indicative of broader health and safety concerns. • **Staff Engagement** – Staff engagement responses increased to 43 for the current period (covering two-thirds of the month), up from 30 in the previous quarter. QR codes have now been fully rolled out to encourage further staff and public feedback, with expectations that response numbers will continue to rise. • **Community Benefits** – Commentary was revised in line with previous requests. Sacyr has agreed to share cumulative investment in the local supply chain. Three complaints were received in May 2025, all related to extended working hours for concrete pours during hot weather; these have been addressed and closed. Clarification was provided that the 68 complaints listed in the report represent all complaints received since the start of construction and are now closed. • **Finance** – The project remains financially on track. QRA spend is currently £750,000 out of an £18.7 million allocation. Procurement decisions for the category 2C equipment package (including linear accelerators, major scanning equipment, and diagnostic kit) are expected to clarify the QRA and overall financial position. It was noted that the QRA graph, which shows a straight-line predicted spend, may not accurately reflect the unpredictable nature of QRA expenditure. The graph is intended to illustrate budget management, but its limitations were acknowledged. • **Plan on a Page (POAP)** – No material changes were reported since the last update. All key milestones remain visible and are

now subject to strict change control, requiring internal documentation and reporting to the project board.

The nVCC Project Scrutiny Sub-Committee **NOTED** the **nVCC Project Highlight Report** and the **Amber Project status** for the reporting period.

Interdependencies Report
The Sub-Committee received a verbal update on the status of the interdependencies between the nVCC Project and the VCS Futures which may impact upon the delivery of the nVCC Project.

The following key highlights were noted:

- **VCS Futures Programme Status** – The overall programme status for the period from June to early July was reported as **Amber**.
- **DHCR Phase 1** – This phase is now closed and considered complete. It is currently subject to audit to assess delivery against the original specification.
- **RISP, IRS and ePMA Projects** – These projects are currently rated **Amber**, primarily due to amendments in timescales and scope. However, budgets remain on track.
- **Satellite Radiotherapy Unit** – The unit is now open and operational. Consideration is being given to how it will be reported as it transitions to Business as Usual.
- **TrAMS Project** – The project requires rescoping. A formal request has been submitted to the SROs. The project has reached the outline business case stage nationally, with multiple papers under review by various committees. The Trust has responded as a provider and requested a change of scope, which has now been accepted by the National TrAMS Programme SROs. This update will be reflected in upcoming committee papers.
- **Regional AOS Project** – This project is currently rated Green. The outreach component will be rescoped to align with SACT and systemic therapies.
- **Research Bunker Project** – This project is in the planning stage. It is not dependent on charity funding. A business case for staffing is being developed, and equipment selection is underway.

The Sub-Committee **NOTED** the verbal update regarding the Interdependencies Report and **AGREED** that a copy of the report will be circulated to members for further review.

INFORM	**Communication and Engagement Update Report** The Sub-Committee received the Communication and Engagement update, outlining key activities undertaken during the reporting period. The following updates were noted: • **Community Engagement** – Regular community drop-in sessions continue; however, no residents attended during this reporting period. A resident meeting is scheduled for July, with a review of the engagement approach planned for August to explore alternative methods in response to low attendance. • **Staff Engagement** – Staff Teams calls remain consistent, with approximately 90–100 staff participating. These sessions will be reviewed over the summer. • **Summer Events** – Planned visits to Pontypridd and Bridgend are scheduled. Discussions are ongoing regarding linking activities in the Aneurin Bevan area with the opening of the satellite radiotherapy centre. • **Future Engagement Opportunities** – The team is exploring options to share information through libraries, including a potential winter library tour. Engagement opportunities with district general hospitals are also being considered. • **Ministerial Visit** – Thanks was extended to all involved in the successful Cabinet Secretary visit, noting the positive feedback received and the value of the video and social media coverage. **Feedback from the Cabinet Secretary Visit** The Sub-Committee received feedback on the recent Cabinet Secretary visit and the following key points were noted: • The visit included a structured presentation on the clinical service model, highlighting its benefits, research opportunities, and the flexibility and sustainability of the new building. This was followed by a guided site tour. The team's preparation was commended for the effective management of logistics under last-minute challenges. • Increased government confidence in the project was noted, with emphasis on the centre's role as a catalyst for broader improvements in cancer outcomes across South East Wales. The Cabinet Secretary's positive engagement and well-informed questions were highlighted as a reflection of genuine interest in the project. • The Communications Team was acknowledged for their outstanding work in preparing the presentation pack, which effectively summarised the building's design and progress. The pack was shared with the Cabinet Secretary and will be made

	available to committee members. It was suggested that elements of the pack could be used to enhance patient and staff engagement within the centre. • The project was described as being on a more stable footing than ever before, with steady progress toward the opening date. From a government perspective, the importance of maintaining momentum through to the nVCC completion date of April 2027 and beyond was emphasised.
APPENDICES	None.

Trust Board	
Culture and Inclusion Report	
DATE OF MEETING	25 September 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	Claire Budgen, Organisational Development Specialist
PRESENTED BY	Sarah Morley, Executive Director of Organisational Development and Workforce
APPROVED BY	Sarah Morley, Executive Director of Organisational Development & Workforce
EXECUTIVE SUMMARY	The People Strategy sets out a vision of having: **'Healthy and Engaged People**: 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 paper provides a report on progress towards achieving this vision. This is the first time all aspects of culture and inclusion have been reported in an integrated way. This offers the advantage of being able to understand how different activities and interventions work in conjunction with each other to build a positive culture. This paper complements the existing Building our Workforce (Supply and Shape) paper in providing assurance

	across all aspects of implementing the People Strategy.
RECOMMENDATION / ACTIONS	To **NOTE**

GOVERNANCE ROUTE

List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board	25.5.25
Quality, Safety and Performance Committee	11.9.2025

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

The composite report with five different aspects of Assurance was welcomed. The Quality, Safety and Performance Committee asked that the focus for the next period should be Employee Voice so that the Trust develops an agreed plan for improving staff engagement and Employee Voice. A gap in the report was noted relating to reasonable adjustments. This is now covered in paragraph 4.6.

The Committee also for the consideration of outcomes of the actions as described. Details of outcome measures will be brought to Quality, Safety and Performance Committee in the next iteration of this report.

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

Compassionate Leadership	3
Psychological and Physical Wellbeing	3
Diversity and Inclusion	3
Values and Behaviours	3
Employee Voice	2

APPENDICES

Appendix 1	Staff Survey Action Plan

1. SITUATION

1.1 The People Strategy sets out a vision of having:

'Healthy and Engaged People: 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 paper provides a report on progress towards achieving this vision.

1.2 This is the first time all aspects of culture and inclusion have been reported in an integrated way. This offers the advantage of being able to understand how different activities and interventions work in conjunction with each other to build a positive culture. This paper complements the existing Building our Workforce (Supply and Shape) paper in providing assurance across all aspects of implementing the People Strategy

2. BACKGROUND

2.1 The Trust has developed a Culture Framework to give a structure to this work. There are five areas with key actions against each, however there is a high degree of interconnectivity. Moreover, a positive culture emerges from consistent interplay of the disparate strands and it is important that issues are not regarded in isolation.

<table>
<tr><th colspan="2">VUNHST Culture Framework</th></tr>
<tr><td> 
</td><td>Strategic 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 and learning for all.
A sustainable organisation that plays its part in creating a better future for people across the globe.</td></tr>
</table>

2.2 In terms of formal governance, work under culture and inclusion is discussed and monitored through the Trust's Healthy and Engaged Steering Group. In addition, the Board Assurance Framework Risk 06 describes the strategic risk relating to Organisational Culture, '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, behaviours, systems and processes'. This is currently scored 12 with a target set of 6 by 2027.

3. ASSESSMENT

3.1` Compassionate Leadership – Assurance Level 3

The Trust Board adopted the Compassionate Leadership Pledge in September 2024. The seven principles extend beyond the traditional understanding of individual leadership and management development by including a focus on collective leadership, teamwork and equality, diversity and inclusion. Together with organisational level commitment to the principles in the Pledge, nine specific actions were agreed – progress noted below.

Compassionate Leadership Pledge Actions Sept 2024	Progress Q1 2025-26	Next Steps
Issue a staff communication to state that diversity and inclusion is an essential component of the Inspire Management Development Programme and the Croeso Induction programme.	**Completed** Our course literature shows that Fairness at Work, diversity and inclusion and Compassionate Leadership are integral to induction and management development.	Continue to consistently reference these in Inspire Programme and Croeso Inductions. Continue fostering PADR conversations using Compassionate Leadership Principles.
Submit a generic template for People Policies Equality Impact Assessments to the People Policies Review and Development Group which highlights the connection between Compassionate Leadership and inclusion.	**Completed** A generic template was submitted and put into practice 2024. This will be updated in line with the 2025 Annual Equalities data and to emphasise the connection between Compassionate Leadership and inclusion.	This will be updated in line with the 2025 Annual Equalities data and to emphasise the connection between Compassionate Leadership and inclusion.
Introduce Terms of Reference for staff Diversity networks. Launch networks and act on staff feedback.	**Completed** Terms of Reference have been agreed and shared with all Staff Networks. These are growing: the LGBTQ+, Race, Disability and Neuro Diversity are the most well developed at present.	Nurture emerging Staff Networks and work with them to gather staff feedback.
Reflect Compassionate Leadership principles in the emerging staff engagement framework so that it is clear how Compassionate Leadership supports employees having open two-way communication.	**Not Yet Complete** A staff engagement framework will be formalised in Q3. The Compassionate Leadership Principles are embedded from the outset of the Croeso Induction, Inspire Programme, and Fundamentals of Management Programme,	Work closely with stakeholders to have this framework in place by Q3 2025. It will set out mechanisms for two-way communication which build a culture of openness and psychological safety.

Compassionate Leadership Pledge Actions Sept 2024	Progress Q1 2025-26	Next Steps
	and are consistently reflected throughout all sessions of these programmes.	
Issue guidance to teams for holding Compassionate Leadership discussions and facilitate team-building activities and celebrate milestones and encourage cross-departmental projects and collaborations.	**Completed** Guidance was issued in 2024 and a bespoke Compassionate Leadership Bitesize session developed to support clinicians and staff in learning about the principles in a medium that suited their work demands. This session has been taken on board by HEIW and made available pan Wales. This bitesize session has been delivered a total of 8 times to Clinicians and also to the All Wales Finance Academy. A Lesson Planning Team has been formed comprising 2 Clinical Leads, 1 Leadership Facilitator, the Workforce Development Manager and the Staff Psychologist. This team has developed Velindre Standard generic slides which will be rolled out to teams.	This is now business as usual. Three further teams have requested this training and it will be delivered between August and December 2025.
Use the Nurturing and Kindness Behaviour indicators as a foundation for Board Development utilising self-assessment and group discussion to further embed those behaviours.	**Not Yet Complete**	This will be taken into account when developing the ED&I Board Development Programme later in 2025.

Compassionate Leadership Pledge Actions Sept 2024	Progress Q1 2025-26	Next Steps
Roll out training and briefings to embed the new Values and Behaviours so that all staff are aware of the content and benefits of the framework.	**Not Yet Complete** Sessions on using the Trust Values have been delivered where requested. A development programme to support culture change is being commissioned for rolling out to all staff during Q3 and Q4.	Initiate and complete the procurement exercise to commission a Trust-wide intervention which will embed the values and also support managers in challenging behaviours that do not align with the values
Implement the Trust Quality Priorities 2024-25, including implementing the Incident Management Framework and the Learning Framework	**Completed** These have been approved and launched with staff.	
Update leadership development activities to reflect shared decision making and responsibility.	**Not Yet Complete** HEIW are launching a Management Competency Framework for Wales in Q3 2025. We have mapped our existing Inspire Programme content against the framework and noted a small number of areas where additional content will be required to cover the full range of competencies. The framework emphasises shared decision-making through collaborative working and identifies	Embed content on Innovation and Improvement and Patient Outcomes and Experiences into the Inspire Programme.

Compassionate Leadership Pledge Actions Sept 2024	Progress Q1 2025-26	Next Steps
	integrity as a core value within its code of practice.	

3.2 **Psychological and Physical Wellbeing – Assurance Level 3**

The breadth of activity in wellbeing is set out in a Healthy and Engaged Workplan 2025-26 in the section on 'Offering information and support to enable staff to maintain their own wellbeing at work'. This plan ensures regular reviews of progress are built into the governance process.

The Staff Psychology Service is well established and provides a range of 1 to 1 support, signposting and resources. The Charities Together application of 2023 brought in funding for a two-year Wellbeing Project which started on 1 April 2024.

The objectives of the project have been embedded into the service plan, as below.

Staff Wellbeing Plan Theme	Progress 2024-25	Actions 2025-2026
Resources	The Wellbeing Project Coordinator was appointed from 1.4.24 for two years. Noddfa furnished and decorated. Health and Wellbeing information centre on the intranet updated and improved, positively received by staff. In person sessions introduced to signpost people to relevant resources. Vivup launched March 2024 and shows increased positivity scores for individuals attending counselling. Verbal feedback of users is predominantly positive.	Maintain and improve the content on the health and wellbeing intranet centre Provide Wellbeing Packs as resources for staff and managers. Link in with broader People and OD team to consider requests for wellbeing support from teams and managers. Secure funding for Wellbeing Coordinator from 1.4.26

Support Networks - peer to peer support for physical and psychological wellbeing	Health and Wellbeing Champions Network which brought together Mental Health First Aiders, Menopause Buddies and others was set up and 49 people have been trained. Teams with champions are more receptive to wellbeing initiatives and can implement activities such as walks and wellbeing Wednesdays locally. Feedback shows that greater clarity on roles and time commitment will help Champions be more proactive.	Recruit Men's Health Champions. Expand Health and Wellbeing Champions Network to ensure comprehensive coverage across the Trust. Issue explanatory information to communicate purpose of Health and Wellbeing Champions to managers and colleagues. Introduce Bright Ideas Pack to gather staff suggestions and gain support for wellbeing initiatives locally.
Wellbeing Culture	Positive feedback has been received on the interventions that have been offered during 2024-25. However, staff say that wellbeing support is not equitable, with some instances of disappointment or blame when an intervention is not available due to funding or capacity limitations.	Focus on Wellbeing as everyone's responsibility and driven by local staff. Issue communications (including videos) showing what can be done locally. Support Health and Wellbeing Champions to be proactive.
Training Workshops	Workshops delivered in 2024-25: • Stress Resilience • Menstrual Health Awareness • Menopause Awareness	New topics for 2025-26: • Thriving Not Surviving • Carers Awareness • Neurodiversity

	• Bitesize sessions for Health and Wellbeing Champions • Croeso Induction Session • Wellbeing Overview for Employees • Stress Awareness for Managers • Wellbeing at Nurse Induction • Reasonable Adjustments • Working within Cancer Services	Implement a standardised approach to evaluating the impact of wellbeing training.
Sickness data	Quantitative data identified and collated showing health and wellbeing levels of staff: • ESR S10 - anxiety, stress, depression, other psychiatric illnesses • NHS Staff Survey data • Leavers' trends • Return to work interview feedback • Vivup utilisation reports	Work with People and OD colleagues to increase qualitative data and triangulate results to give deeper understanding. Of the incidence and causes of employee sickness.
Interventions	Introduced in 2024-25: • In person support • Drop in wellbeing session • Yoga • Roadshows • Group Walks and talks • Newsletters and resources • Staying Well at Work Plan • Stress Risk Assessment • Wellbeing Guidance Documents	Combine range of interventions into a Staying Well at Work Package. Training of additional Mental Health First Aiders. Introduce wellbeing tools to enable healthy use of IT and social media. Clarify with POD & psychology the objectives of the active offers.

	• Drop in Mindfulness Session • Dog Therapy • Health and Wellbeing Branding • VR relaxation pilot	Evaluate these offers using a standardised measure to evaluate what is more effective.
One programme in the charity funded Wellbeing Project covers a number of themes – progress with this is shown below.		
A programme of menopause support leading to a reduction in in menopause symptoms	Menopause Buddies identified in VCS, WBS and Corporate services. Menopause Cafes offered in line with demand. Informal peer to peer support is active. Lightweight uniforms introduced for clinical staff. Explored option of having in-house medic-led menopause clinic. Costs exceeded charity allocation so therefore not progressed.	Provide Menopause Awareness training to any member of staff. Increase support to Menopause Buddies through Health and Wellbeing Champions networks.

3.3 **Diversity and Inclusion – Assurance Level 3**

Plans and progress in this area are set out in the Strategic Equality Plan Action plan. This includes our actions and progress with the national programmes of Anti-racist Wales and LGBTQ+ Action Plans.

In addition, the Trust has received the Workforce Race Equality Standard (WRES) Report for 2025 and is incorporating those findings with the Strategic Equality Plan actions.

The Trust's Policy Assurance Assessment for the Strategic Equality Plan Delivery for year end 2024-25 sits at 18 Amber and 1 Red which reflects an improvement over the previous six months. We will continue to work across all of the measures and in particular focus on how to engage with stakeholders and obtain feedback on our progress. This straddles staff and service delivery.

The WRES report highlighted two areas where the experience of minoritised staff has worsened:

- Bullying, harassment and discrimination and feeling they had equal opportunities to progress
- Likelihood of being appointed from a shortlist and worsening of the disparity ratio for low banded staff

This is echoed by analysis of Harassment, Bullying and Discrimination staff survey results and recruitment analysis completed in Q1. Measures in place to address harassment, bullying and discrimination are captured in the six actions in the Strategic Equality Plan Action Plan under the action 'Develop a positive organisational culture'. These have been replicated in the Trust Staff Survey Action plan (Appendix 1) under the area of Psychological Safety.

The Annual Equalities Report and the Gender Pay Gap Report for 2025 have been signed off by Trust Board.

3.4 **Values and Behaviours – Assurance Level 3**

The Trust Values of Caring, Respectful and Accountable are embedded into all employee policies, induction, leadership and management development and set the foundation of the annual Employee Excellence Awards. They are visible in day to day working life through posters, banners, email signatures and PowerPoint templates. They form an essential part of the recruitment process so that people who join us are already aligned with core values.

To further embed the values we are scoping a Trust-wide roll out of a development programme for all staff. This will give space for staff to identify the positive actions and behaviours that align with the Trust values and ensure everyone is focused on improving patient care and donor services.

3.5 **Employee Voice – Assurance Level 2**

There are foundation stones in place regarding Employee Voice and further work is planned for 2025-26 to develop a robust approach to seeking and utilising employees' feedback systemically.

A key component of Employee Voice is the Staff Survey Group which was set up in March 2025 and has the remit to:

- Disseminate NHS Staff Survey results in area of responsibility
- Support Divisional and Departmental Managers to hold action planning conversations with their team and to review progress over time
- Contribute to Trust level change in relation to the NHS Staff Survey results

During Q1 their work has produced a number of Departmental Action Plans which have been collated into two Divisional level plans, one for VCS and one for WBS. These plans sit alongside the Trust Action Plan and all three focus on the same areas for improvement:

- PADR
- Team time
- Psychological Safety

The Group meets monthly and will now focus on implementation and addressing common issues in staff experience, including addressing bullying, harassment and discrimination and responding to the WRES report.

The building blocks for Speaking Up Safely are in as below.

1. The intranet resources have been recently updated to reflect the processes in place for staff to use. This includes the 6 minute video that we to explain how it relates to everyone at work.

2. A specific update is being issued to staff on the first Wednesday of every month. In July this focused on the Speaking Up Safely Feedback Form, which is offering a point of feedback and suggestions on how to improve our Speaking Up Safely arrangements. Future topics for communications will include:

   - Introduction to the Independent Member Champion
   - Further exploration of staff views of what they need in work
   - Launch of Work in Confidence, with an All Staff teams call. It is important to see Heads of Departments supporting this alongside senior managers and front line staff
   - Staff Stories about using the process

3. The Role Profile for the Independent Member for Speaking Up Safely has been finalised. This will be advertised to all staff.

4. Work in Confidence is being launched to all staff in September 2025.

4. SUMMARY OF MATTERS FOR CONSIDERATION

4.1 The planning and governance framework around Culture and Inclusion has matured since 2024. There are three action plans in use at Trust and Divisional level offering clear view of work in hand, the Healthy and Engaged Action Plan, the Strategic Equality Plan Action Plan and the NHS Staff Survey Action Plan.

4.2 The Trust has developed an active approach to using the NHS Staff Survey results through the Staff Survey Group which will see real changes for staff coming into effect. It has opened up discussions on what matters to staff.

4.3 Staff networks have grown and we now have active groups for Race, LGBTQ+, Disability and Neuro Diversity. This will be instrumental in hearing from staff in order to reduce harassment, bullying and discrimination.

4.4 Progress with the Anti-racism Wales Action Plan is seen in the with the provision of training, policy work and staff network. Further steps will be required in light of the WRES report for 2025.

4.5 Progress with the LGBTQ+ action plan is seen in the activity of the staff network and celebration events. LGBTQ+ staff insights and experience will be collated to inform future work, including on reducing bullying and harassment, in Q2 and Q3.

4.6 Support for staff in accessing Reasonable Adjustments has been strengthened following a review of staff case studies which showed areas for further improvements. This resulted in giving guidance to managers on how to explore adjustments with individuals covering stress and physical barriers. IN relation to recruitment, improved guidance has been issued on how to agree reasonable adjustments for candidates coming for interview.

4.7 The next phase of Values and Behaviour work is under discussion at Executive level. This will result in a Trust-wide roll out of development to embed the Values and Behaviours consistently in day-to-day practice.

4.8 The least developed aspect of Culture and Inclusion is Employee Voice. The building blocks for Speaking Up Safely are there however further work is required to established systemic processes for employees' feedback to be designed into work. The People's Experience Framework sets out the need to acquire and use patient and service user feedback. This has to be aligned with listening to staff

feedback.

5. IMPACT ASSESSMENT

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

Risk 06 – Organisational Culture</td></tr>
<tr><td rowspan="2">QUALITY AND SAFETY IMPLICATIONS / IMPACT</td><td>Select all relevant domains below
Safe ☒
Timely ☐
Effective ☒
Equitable ☐
Efficient ☐
Patient Centred ☐</td></tr>
<tr><td>The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021).

[Please include narrative to explain the selected domain in no more than 3 succinct points].

Click or tap here to enter text</td></tr>
</table>

QUALITY IMPACT ASSESSMENT *The duty of quality requires quality-driven decision-making for all strategic decisions. The duty of quality is operationalised through the Heath and Care Quality Standards. Therefore, when making decisions about healthcare services, NHS organisations are required to consider the impact of that decision on the Health and Care Quality Standards.*	**Choose an item**
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	**Choose an item** *[* **Click or tap here to enter text**

TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT

The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated. Please indicate whether any of the matters outlined in this report impact the Trust's Wellbeing goals:

Choose an item

If yes select the relevant goals:

- A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities. ☐
- A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience. ☐
- A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health ☐
- A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances ☒
- A Wales of more Cohesive Communities - Attractive, viable, safe and well-connected communities. ☐
- A Wales of Vibrant Culture and Thriving Welsh Language -Promoting and protecting culture, heritage and the Welsh language, encouraging people to participate in the arts, and sports and recreation. ☒
- A Globally Responsible Wales – Consideration of whether an action may make a positive contribution to global well-being ☐

FINANCIAL IMPLICATIONS / IMPACT	**Choose an item**
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	**Choose an item**
	[In this section, explain in no more than 3 succinct points what the equality impact of this matter is or not (as applicable)].
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	**Choose an item**
	Click or tap here to enter text
	[In this section, explain in no more than 3 succinct points what the legal implications/ impact is or not (as applicable)].

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	**Choose an item**
WHAT IS THE RISK?	
WHAT IS THE CURRENT RISK SCORE	Insert Datix 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?	Insert Date
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	**Choose an item**
All risks must be evidenced and consistent with those recorded in Datix	

Issue arising from NHS Staff Survey	Action	Activities	Outcome	Completion Date	Open / Close	Q1 Progress
PDR/Appraisal was one of only two sub-themes which showed a decline since 2023, falling from 82.1% to 78.9%. The Trust target is 85%. There are clear actions in hand to develop PADR in the Trust which makes this achievable and realistic.	Implement the 2024 PADR Policy for all Agenda for Change staff.	Q1 Launch policy and forms with targetted communication to all managers.	PADR is seen as an enabler of working effectively and having clear objectives.	30.6.25	Closed	PADR policy and form launched to all managers and staff in April 2025.
		Q2 Ensure all managers have completed PADR training.		30.9.25	Open	PADR training is part of the Fundamentals of Management programme and is marked as essential for all line managers on ESR. This is driving completions.
		Q3 Take feedback from staff about how useful their PADR has been for them and feed findings back into communications.		31.12.25	Open	This feedback will be taken after six months in oepration.
		Q4 Make any required changes to PADR process to ensure it is an effective and meaningful process for all staff.		31.3.26	Open	The changes will be enacted after the feedback is collated. Any changes required to the PADR Policy will be proposed in early 2026.
Team time. The second of the two sub-themes which declined was Inclusion, which covers how you feel valued by your team, that team members are kind to one another and treat each other with respect. This sub-theme sits within the broader theme of Compassionate and Inclusive which is where the questions relating to discrimination sit.	Give managers the tools and insight to be able to run inclusive team meetings where the Trust values are embedded in discussions and actions.	Q1 Set up Divisional Staff Survey reps with access to the survey data and a template for holding team discussions. Require Divisional Level Staff Survey Action Plans to be submitted based on common template	To see an increase in the scores for the theme of Compassionate and Inclusive in the 2025 Staff Survey from the current rate of 76%.	30.6.25	Closed	The Staff Survey Group was set up in March 2025 and has enabled local reps to have access to the Staff Survey reports. A common template was provided plus other useful tools to allow managesr to hold discussions with their teams about the results and agree actions. NHS Staff Survey Action Plans for the Trust, VCS and WBS were tabled at the Helathy ndn Engaged Steering Group on 16.7.25.
		Q2 Provide Values and Behaviour workshops or other OD interventions to teams in line needs raised in Divisional staff survey action plans.		30.9.25	Open	A range of team support and development sessions have been delivered by the POD team in response to local issues. This will be enhanced during Q2 and Q3 as the action plans are put into practice.
		Q3 Collate examples of where Team Time has been prioritised and the impact it has had on feelings of inclusion to contribute to the You Said/We Did communications exercise in support of the roll out of 2025 survey		31.12.25	Open	This is a task for Q2 and Q3. The Staff Survey Group will be the focal point for gathering examples.
		Q4 Provide further support to teams which have not been able to prioritise team time.		31.3.26	Open	This is a task for Q2 and Q3. The Staff Survey Group will be the focal point for gathering examples.
Psychological safety has been selected as a topic in connection with reducing the incidence of bullying and harassment. Whilst the reported incidence of bullying and harassment through the staff survey has fallen between 2023 and 2024, it still features within the free text comments and therefore further work is needed to achieve a healthy working environment. Furthermore, new requirements regarding sexual safety at work are going to bring about changes in relation to policies and training which are intended to have a positive impact in this area. The theme for 'We are able to speak up' is the clearest indicator of psychological safety.	Implement the section of the Strategic Equality Plan action plan on developing a positive organisational culture.	1. Achieve 85% compliance with Anti-racist Wales e-learning package by March 2026.	Staff will feel safe, supported and respected which will enable them to thrive at work. Improved psychological safety will be reflected in staff survey results in 2025. A positive organsiational culture will lead to better services and lower costs (reduced turnover and sickness).Further reduction in percentages of staff reporting bullying and harassment via the NHS Staff Survey seen in the 2025 results. Qualitative feedback gained from staff relating to how the organisational culture has developed. Improved results for the theme of 'We are able to speak up' were seen between 2023 and 2024 and this will be further tracked in 2025.	31.3.26	Open	National training package launched on 1.4.25. Added to ESR requirements for all staff. So far, 69.96% of staff have completed it and on track to achieve target of 85% by 31.3.26
		2. Launch Sexual Safety Wales e-learning package once issued nationally and set pro rata target for compliance for year end.		31.3.26	Open	Sexual Safety Package not yet agreed nationally so roll out not commenced. Awaiting update from NHS Wales People Network regarding the approval of the policy and the training.
		3. Implement programme of manager training on how to create psychologically safe working environments, embedding the Trust Values and Behaviours and cascade to all managers by March 2026. Include a focus on enabling Speaking Up Safely. Align with the support and training delivered through the nVCC programme.		31.3.26	Open	The Trust Values and Behavioural Framework were agreed in April 2024. These have been embedded into all policies and processes for staff. Marketing tools have been circulated showing the values and logos - posters, banners, email signatures, and MS Teams backgrounds. Values are embedded in Croeso, Inspire and Fundamentals of Management. A number of Bitesize sessions have taken place considering the Values. Discussions are in hand on commissioning a Trust-wide roll-out of development for embedding positive behaviours into day to day practice.
		4. Agree a programme for Board Development including a Board Development Cultural Competence session in April 2025.		30.6.25.	Open	An initial scoping exercise has been completed. This is informing the planning taking place between the Executive Director and Independent Member Champion.
		5. Commission Work in Confidence and review effectiveness of Speaking Up Safely mechanisms and report back to Healthy and Engaged Steering Group in July 2025.		30.6.25	Open	Staff feedback in 2024 showed that people were not sure how to Speak Up. In response, the guidance on the intranet has been enhanced. A video has been produced for induction which is also available to everyone on the intranet. The Role Profile for the Independent Member Champion is ready for approval. To contiue to hear from staff, a feedback form has been set up on intranet which is asking for any suggestions or thoughts about any aspect of Speaking Up. This is supported by a regular monthly message going out to all staff to raise awareness of Speaking Up Safely. An anonymous reporting channel (Work in Confidence) has been procured which will be rolled out in September/October 2025.
		6. Update the Bullying Harassment and Discrimination review with the 2024 NHS Staff Survey data and from Staff Networks on their lived experience and ideas for reducing stigma, discrimination and bias. Report to Healthy and Engaged Steering Group on findings in July 2025.		30.9.25	Open	A structured exercise in gathering this feedback will run throughout September 2025. A Staff Network Leadership Develoment Session is being held to enable members to use their personal influence in a positive way and also to build a culture of listening to staff. The feedback from this exericise will be considered alongside other sources of information, such as the 2024-25 reports on Reasonable Adjustments and Women in STEM.
		7. Gender Pay Gap, Staff Survey and WRES data is shared with Divisions and taken into account in Trust and Division actions. The Staff Survey Group is established to focus this work, reporting into the Healthy and Engaged Seering Group each Quarter.		30.6.25	Open	The Gender Pay Gap and Staff Survey have already been shared with Divisions. The WRES report for 2025 will also be shared in order to support Staff Survey actions and SEP actions.
		8. A systematic evaluation and review of activities in the plan is actively undertaken each Quarter to learn what impact is being achieved which will help create conditions where staff feel more valued and respected at work.		30.6.25	Open	This will emerge from the Staff Survey Group monthly meeitngs. Now that the plans are in place, we will be abel to start to review actions and impact.

Issues arising from NHS Staff Survey			Shared Actions	Outcomes
PADR/Appraisal	Common Issues	Decline in staff feeling valued; inconsistent PADR experiences.	Ensure protected time for PADRs across all departments. Embed CPD discussions within PADRs. Use PADRs to celebrate achievements and set meaningful objectives. Encourage feedback on the usefulness of PADRs and adapt the process accordingly	
Team Time	Common Issues	Need for improved team cohesion, respect, and compassion	Schedule regular team meetings and peer-to-peer reflection time. Promote inclusive discussions and recognition of contributions. Share success stories and improvements through internal communications. Monitor and support departments struggling to prioritise team time.	
Psychological Safety	Common Issues	Increased reports of bullying/harassment from colleagues; low confidence in speaking up.	Promote open communication and safe reporting mechanisms. Collaborate with Trust Psychologist and WOD to enhance support. Introduce “Speaking Up Safely” leads or champions. Deliver training and awareness sessions (e.g. Respect & Resolution, Bitesize sessions). Leverage organisational support structures and peer networks.	

Activities	Outcome	Lead	Completion Date	Open /Close
Ensure staff and manager access to ESR and Training, ensuring Effective PADR training is undertaken.	All staff in VCS will have had a PADR within the last 12 months and there will be rolling plans in place, to ensure this compliance is maintained. Staff will be supported with training and development, where necessary.	Line Manager		
Team plans to ensure all staff have annual PADRs, with mid point review if/where possible.		Line Manager		
Directorate teams to develop improvement plans where applicable with their teams - to be monitored via Directorate assurance meetings and through Divisional Board		Directorate Tri		
Managers to ensure PADRs are meaningful and encompass training and development requirement. 2-way conversation designed around individual progression, development and support, tailored to the individual and aligned to service needs.		Line Manager		
Regular 1:1s with all staff - ensure these are booked in the diary in advance.	Engaged, happy workforce, who will feel valued and recognised for their work in the Trust. Staff will be aware of all important and relevant Trust information and news, and, as a result, will feel part of the wider Trust and feel valued and empowered.	Department Lead		
Regular reviews (possibly part of 1:1s) with staff on work tasks/load and capacity.		Line Manager		
Teams to consider informal team catch ups/huddles (more frequently than monthly), to keep teams informed of any changes/information that is pertinent to them.		Department Lead		
Teams to consider whether information could be disseminated in another way, rather than meetings e.g. newsletter, notice board.		Department Lead		
Quarterly team meetings - 'away days' to support team building.		Department Lead		
Regular departmental meetings in the diary - monthly, more formal than 'informal huddle'.		Department Lead		

Celebrate Success as a team and recognise individuals - standard item on team agendas (could be internal or external success - good news story).		Department Lead		
Ensure staff wellbeing is a standard item on any team agenda's - ensure staff are aware of the Trust's offering here.		Department Lead		
Clinical Director 'check ins' with staff re: welfare.		Clinical Director		
Divisional team drop in sessions - meet the Director		Divisional Tri		
Establishment of Divisional and Directorate comms plans - including weekly personalised updates for awareness and how to be involved		Divisioanal and Directorate Tri with Comms		
Teams to consider quick 'pulse surveys', periodically - temperature check on staff are feeling, so that approach can be adjusted accordingly.		Department Lead		
Managers to discuss all DATIX outcomes with affected staff, to ensure they have closure to the incident raised and understand the outcomes.	Staff will feel safe to raise concerns and will utlise the Trust's initiatives to raise these concerns in a safe environment, without fear. Staff will feel valued for raising concerns and will received appopriate feedback, when a concern is raised.	Line Manager		
Managers to share learning from incidents/events with all staff, implementing improvement plans where necessary.		Department Lead		
Staff wellbeing to be a standard point of discussion at 1:1s - safespace to share concerns.		Line Manager		
Ensure teams are aware of Trust inititaives (e.g. speaking up safely) and mechnaisms to raise concerns - raise in team meetings, 1:1s, noticeboards, newletters, wellbeing champion.		Line Manager		
Team outings e.g. informal meals/drinks		Teams		
Introduction of safety walkabouts to appreciate patient and staff experience with regards to quality and safety with opportunities to discuss issues/concerns		Divisional Tri		
Encourage informal catch up's/'a cuppa conversation' for staff to share any concerns		Line Manager		

Topic		2023	2024	2025 target	
PADR	**Theme - we are continuously learning and improving**	**69.20%**	**70.20%**	**71%**	
PADR	Q19a -In the last 12 months have you had a PADR?	82.10%	78.90%	83%	85% on ESR by 31.3.26
PADR	Q19b - If yes, to what extent did it help me improve how I do my job?	66%	63%	67%	
PADR	Q19c - It helped me agree clear objectives for my work.	82.20%	82%	83%	
Team Time	**Theme - we are compassionate and inclusive**	**76%**	**77.90%**	**79%**	
Team Time	Sub theme -Inclusion	75.10%	74.90%	76%	
Team Time	Q1h - I feel valued by my team	69.60%	73.10%	74%	
Team Time	Q15c - The people I work with are understanding and kind to one another	76.10%	74.80%	76%	
Team Time	Q15d - The people I work with are polite and treat each other with respect	78%	74.30%	79%	
Psychological Safety	**Theme - We are able to speak up**	**70.20%**	**72.10%**	**73%**	
Psychological Safety	Sub theme - Autonomy and Control	74.30%	76.80%	78%	
Psychological Safety	Sub theme - Raising Concerns	66.20%	67.30%	68%	
Psychological Safety	Sub theme - Negative experiences*	85.50%	88.10%	89%	
Psychological Safety	Compliance with Anti-racist Wales training	0.00%	0.00%	85%	on ESR by 31.3.26
Psychological Safety	Compliance with Sexual Safety training	0.00%	0.00%		To be determined once package is available

* Comprises 12 questions on Harassment, Bullying and Abuse (9,10,11,12) and 4 questions on Health and Safety (21b-e)

TRUST BOARD	
Wales Infected Blood Support Scheme Annual Report 2024 - 2025	
DATE OF MEETING	25/09/25
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	Mary Swiffen-Walker - Service Manager, Wales Infected Blood Support Scheme
PRESENTED BY	Lauren Fear, Director of Place, Portfolio and Partnerships
APPROVED BY	Lauren Fear, Director of Place, Portfolio and Partnerships
EXECUTIVE SUMMARY	Attached is the Wales Infected Blood Support Scheme Annual Report. It will also be noted at the Shared Services Committee on 30 September 2025. The Scheme is managed in Shared Services and the group governing the Scheme is chaired by the Trust's Director of Place, Portfolio and Partnerships.
RECOMMENDATION / ACTIONS	The annual report is for noting for ASSURANCE purposes.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
WIBSS Governance Group meeting	18th June 2025
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	

Approved by WIBSS Governance Group – including Welsh Government Policy.	
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 6 - Outcomes realised in full** Scheme subject to significant scrutiny as part of the Infected Blood Inquiry and judged to be delivering effectively for the beneficiaries.

3. IMPACT ASSESSMENT

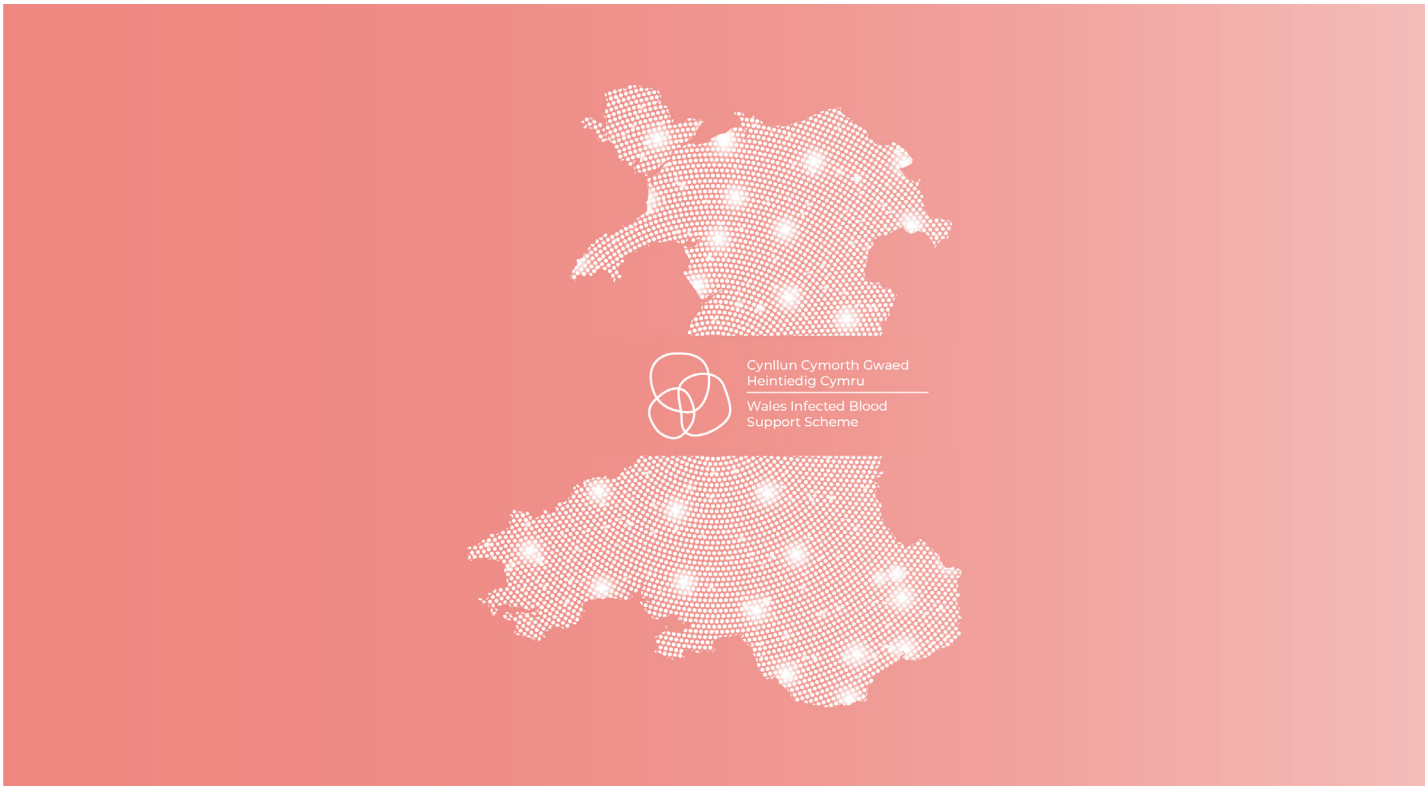
TRUST STRATEGIC GOAL(S)		
The purpose of the Scheme is to compensate and care for the beneficiaries, or their families, who have been impacted by Infected Blood previously provided by the NHS.		
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**	
	Safe	☒
	Timely	☒
	Effective	☒
	Equitable	☒
	Efficient	☒
	Patient Centred	☒
QUALITY IMPACT ASSESSMENT	The Scheme is subject to significant external scrutiny on quality.	
FINANCIAL IMPLICATIONS / IMPACT	Compensation provided by the Trust funded by Welsh Government.	
EQUALITY IMPACT ASSESSMENT	The Scheme is subject to significant external scrutiny on equality.	
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Legal advice obtained on all relevant matters.	

Cynllun Cymorth Gwaed Heintiedig Cymru

Wales Infected Blood Support Scheme

Wales Infected Blood Support Scheme

Annual Report 2024-25



Wales Infected Blood Support Scheme (WIBSS)

VELINDRE UNIVERSITY NHS TRUST

THROUGH

NHS WALES SHARED SERVICES PARTNERSHIP (NWSSP)

AND

VELINDRE CANCER SERVICE (VCS)

ANNUAL REPORT 2024/2025

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

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Shared Services Partnership

Gwasanaeth Canser Felindre
Velindre Cancer Service

Cynllun Cymorth Gwaed Heintiedig Cymru
Wales Infected Blood Support Scheme

Contents

Introduction

Established in October 2017, the Wales Infected Blood Support Scheme (WIBSS) aims to provide support to people who have been infected with Hepatitis C and/or HIV following treatment with NHS blood, blood products or tissue.

Taking over from the existing UK schemes (Eileen Trust, Macfarlane Trust, MFET Ltd, Skipton Fund and Caxton Foundation), now referred to as the Alliance House Organisations (AHOs), WIBSS aims to provide both a streamlined financial payment service and personalised support for Welsh beneficiaries. WIBSS also offers a dedicated Welfare Rights Service and a Psychology and Well-being Service.

As of 31 March 2025, WIBSS supports 231 beneficiaries, including bereaved spouses and partners. The welfare team and wellbeing and psychological team support is also provided to wider family members of our beneficiaries.

The Purpose of the Report

To provide an update on the finance and support services provided during 2024-25 as part of the Wales Infected Blood Support Scheme.

To detail the proactive work carried out by WIBSS during 2024-25

To look ahead to WIBSS priorities relating to 2025-26.

Key matters arising during 2024-25

The way in which WIBSS services are provided returned to normal during 2023-24 following some required adjustments, resulting from the COVID-19 pandemic. Although staff continued agile working, home visits and face-to-face appointments were reinstated. There were no major changes to the service, but the publication of the Infected Blood Inquiry Report on 20 May 2024, resulted in significant additional work for the team, including payment of additional interim compensation payments and the introduction of the Infected Blood Interim Estates Payments in October 2024. The setting up of the Infected Blood Compensation Authority (IBCA) by the UK Government, to administer the compensation payments, also involved significant involvement of the team.

Public Inquiry - The Infected Blood Inquiry

This is an independent public statutory inquiry established to examine the circumstances in which men, women and children treated by the National Health Service in the United Kingdom were given infected blood and infected blood products, since 1970. The Inquiry is Chaired by Sir Brian Langstaff.

WIBSS co-operated fully with the inquiry and responded to all Rule 9 requests within the required timeframe.

On 5 April 2023 the Chair published an interim report on compensation. The UK Government and devolved administrations stated that they would consider the recommendations in this report, alongside the recommendations made in the final report.

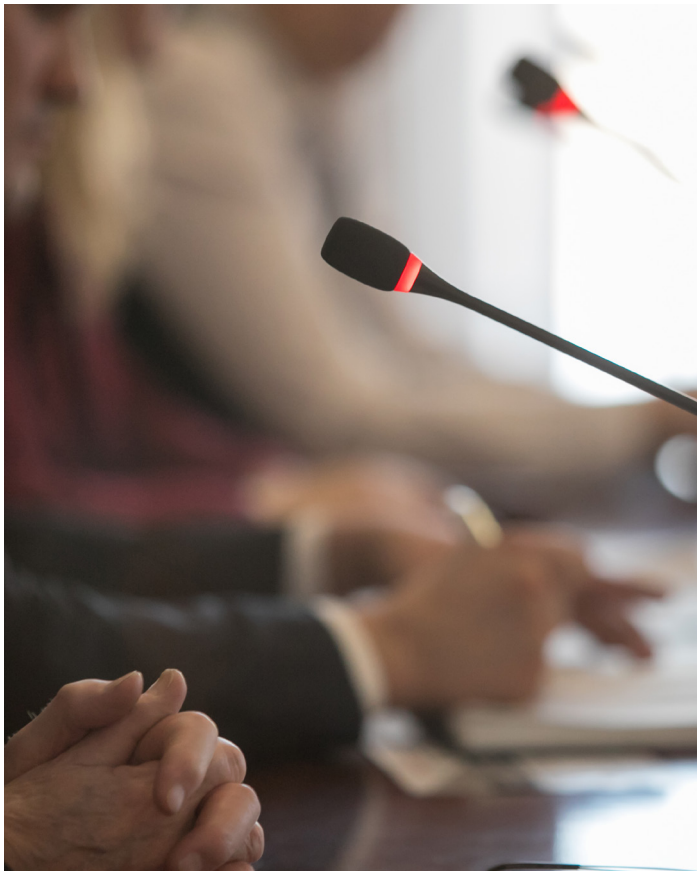
Second Interim Report | Infected Blood Inquiry

On 3 February 2023, the Inquiry Chair closed the Inquiry's public hearings, explaining that he would now be focused on writing his report. Some additional hearings were held in July 2023.

The Inquiry's final report was published on 20 May 2024.

The Inquiry Report | Infected Blood Inquiry

On 21 May, the UK Government announced a Compensation Scheme and the setting up of a new Arm's Length Body (ALB) to administer the compensation scheme, called the Infected Blood Compensation Authority (IBCA).



Infected Blood Compensation Scheme Summary - GOV.UK

The WIBSS website was updated with a link to the Infected Blood Compensation Authority landing page, the Final Report of the Infected Blood Inquiry Report and a link to information for the "worried well".

Publication of the final report and the announcement about the compensation scheme resulted in a significant increase in the number of calls to the WIBSS team from people known and unknown to us.

A Senedd debate was held on 4 June, in response to the Inquiry report and to discuss how it would apply to Wales. During the debate, there was a call for Welsh Government to agree to continue to make the regular payments to beneficiaries, even after they have received compensation, as some of the younger Hep C Stage 1 beneficiaries feel they may be worse off after the compensation is paid.

On 21st May, the Welsh Government, on behalf of the UK Government, asked WIBSS, to make further interim compensation payments of £210,000 before the end of June. These payments were to living "infected" beneficiaries only. Letters were sent to those affected.

Before the payments were made a second letter was issued to beneficiaries to explain what the payment was for and how it will impact any future compensatory amount. The payments were not to be means tested or carry any tax implications.

Payments relating to Hep B were to be picked up by the new Compensation Authority. The Welsh Government confirmed no changes would be made to the current criteria of WIBSS. WIBSS continued to consider applications from those who met the criteria of the scheme. As agreed, across the 4 UK Governments, all the support schemes closed to new applications on 31 March 25.

In August, the UK Government laid regulations to establish the Infected Blood Compensation Scheme, as required by the Victims and Prisoners Act 2024. These regulations will give the Infected Blood Compensation Authority (IBCA) the powers to pay compensation through the Core Route to infected persons, both living and deceased, as set out in the Infected Blood Compensation Scheme Summary: August 2024. The Government expected the IBCA to begin making payments to infected persons by the end of 2024, and this expectation was achieved.

On 24 October, IBCA launched the Infected Blood Interim Estates Payments (IBIEP). This was for estates of people who died when registered with a current Infected Blood Support Scheme (IBSS) or an Alliance House Scheme on or before 17 April 2024; the person who died, their bereaved partner or their estate had not already received an interim compensation payment of £100,000, and the person was living in the UK or Republic of Ireland at the time of their death. The Welsh Government, on behalf of the UK Government, asked WIBSS to administer these applications for those estates where the infected deceased was infected in Wales.

A total of 37 Estates applications were processed to 31st March 2025. 23 were successful, totalling £2,300,000, 6 were rejected due to ineligibility and a further 8 were in progress as at the year-end date.

In addition to this, WIBSS has regular meetings with Welsh Government, UK Cabinet Office and IBCA regarding the setting up and administration of the new body. Three data sharing agreements have been put in place to allow us to access the legacy data, the probate data and to share our data with IBCA, to enable it to start processing the compensation payments. In November, we wrote of all our beneficiaries to inform them that to enable the compensation service to be as simple as possible, WIBSS would share all the information we hold about recipients of WIBSS payments with IBCA. We stated the information we would share with IBCA would include details such as: name, address and contact information, the type and severity of infection, and payments received to date. We also offered them the option to notify us if they did not want their data to be shared.

WIBSS is a member of the Welsh Government's IBI Oversight Group which is tasked with ensuring that the recommendations are implemented in Wales where necessary. This includes 4 nations working. As part of this work WIBSS and Welsh Government meet with Haemophilia Wales regularly to hear firsthand the issues and concerns of our beneficiaries and work together to resolve these or escalate to the 4 nations policy meetings.

Governance Group

The Governance Group monitors the operational management of WIBSS and provides governance, leadership and accountability for the scheme, on behalf of Welsh Government (WG), through Velindre NHS Trust.

The WIBSS Governance Group is authorised to:

- Investigate or have investigated any activity within its Terms of Reference, and in performing these duties, shall have the right, at all reasonable times, to inspect any books, records or documents of the Trust, relevant to the Governance teams' remit, subject to any restrictions imposed by General Data Protection Regulations (GDPR).
- It can seek any relevant information it requires from any employee, and all employees are directed to co-operate with any reasonable request made by the Board.

It is empowered with the responsibility for:

- Reviewing and advising on the management of the WIBSS budgets, including running costs, the annual beneficiaries' budgets and provisions.
- Advising Welsh Government on rate changes and the potential financial and service implications of policy changes, both within Wales and other areas within the UK.
- Implementation of Welsh Government policy.
- Ongoing negotiation and partnership with Welsh Government to ensure the smooth running of the service.

The membership of the WIBSS Governance Group is as follows:

- Director of Place, Portfolio and Partnerships
  Velindre University NHS Trust (Chair)
- Welsh Government Finance Representative
- Director of Nursing
  Velindre Cancer Service
- Welsh Government Policy Representative
- Director of Planning, Performance and Informatics
  NWSSP
- Senior Welfare Rights Manager and Deputy WIBSS Manager
- WIBSS Service Manager
- Consultant Psychologist

During 2024-25 the Governance Group met twice on 6th June 2024 and 30th October 2024.

Financial Support

The scheme recognises that individuals living with hepatitis C and/or HIV face extra costs for things like insurance, travel insurance, care costs and travel costs to attend hospital appointments etc. Financial support is available for:

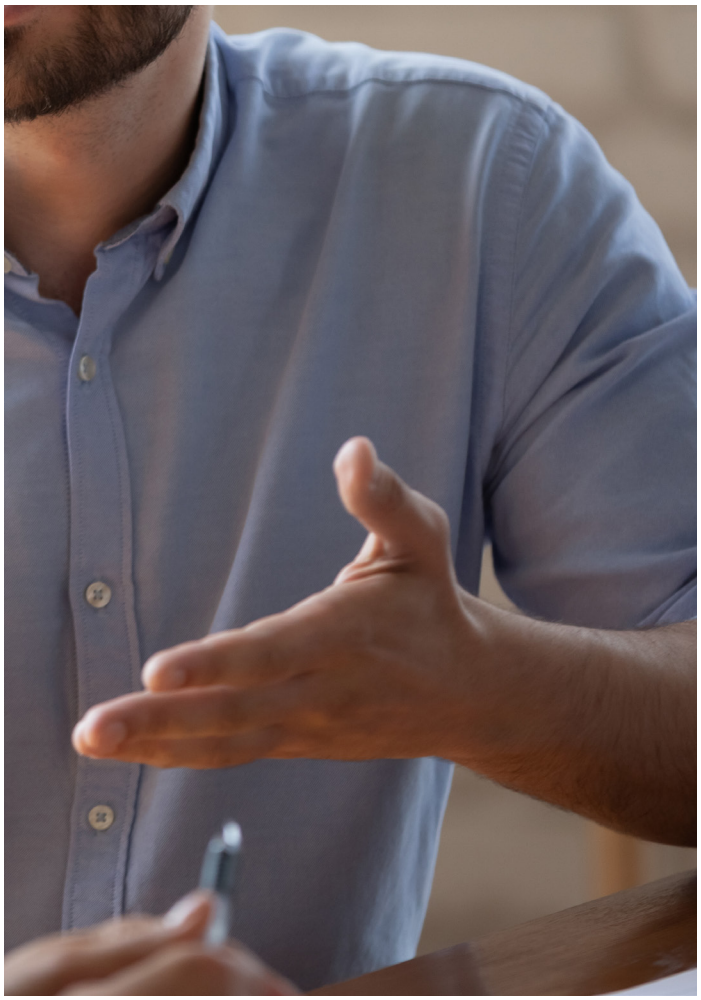
- Current members of the scheme
- Members of previous legacy schemes

There are varying levels of financial support available to beneficiaries of the scheme. These are set out in the Finance Section of this report and are also published on our website.

Home - WIBSS (wales.nhs.uk).

Appeals Process

If an application to join the scheme is unsuccessful, an applicant can appeal if they disagree with the outcome of their application. Appeals are heard by a panel of independent medical experts with relevant clinical or similar experience in the field.



An appeal will not be considered in cases where it is acknowledged that the applicant is not eligible under the current eligibility criteria, but the applicant disagrees with those criteria (in such cases, the application could only be reconsidered if the Welsh Government agreed to amend the eligibility criteria).

During 2024-25, one appeals panel was convened. It considered 4 appeals. The panel considered all the documentation received by WIBSS from the applicants and scrutinised the decision-making process of WIBSS. The panel then considered all the evidence. The panel also spoke to the appellants. Two of the appeals were successful and two were not.

Appeal 1

In the first case the panel felt the evidence around the receipt of a blood transfusion was unfortunately circumstantial, and the alleged reason for need for transfusion would be considered a low probability. The panel also considered the issue of receipt of Anti-D. The consensus was it could not uphold the appeal, based on the current criteria of WIBSS. The panel understands the use of Anti-D as a means of infection is currently under review by IBCA, and therefore, the appellant may be eligible for compensation from them.

Appeal 2

This appeal could not be upheld because there was insufficient evidence of a blood transfusion, and the panel did not feel that the procedure that allegedly led to a transfusion would routinely require a transfusion. In addition, the evidence that the appellant had been told by a Dr that a blood transfusion had taken place was considered by the panel to be unfortunately circumstantial. The panel did recommend that WIBSS try to locate the Dr in question, and if she was found and was willing to make a statement supporting the assertion that a blood transfusion took place, they would reconsider this appeal.

Appeal 3

The panel was of the unanimous view that the mechanism and type of injury, was highly likely to have resulted in a blood transfusion and that the appeal should be upheld.

Appeal 4

Again, the panel was unanimous that the mechanism and type of injury sustained gave rise to a reasonable probability of a blood transfusion having been required and the new witness statement was considered as additional supportive evidence. The appeal was, therefore, upheld.

All appellants were notified of the decision made by the panel.

Beneficiaries' activity 2024-25

There are 231 beneficiaries & bereaved partners registered for support through the scheme. This is broken down into the following groups. (Valid as at 31st March 2025).

Beneficiary Group	Number of registered Beneficiaries
Hepatitis C Stage 1	**36**
Hepatitis C Enhanced Stage 1+	**92**
Hepatitis C Stage 2	**35**
HIV	**2**
HIV & Hep C Stage 1 (Co-infected)	**1**
HIV & Enhanced Stage 1+ (Co-infected)	**13**
HIV & Hep C Stage 2	**2**
Bereaved Spouse/Partner	**50***
Child Payments	**20**

**2 beneficiaries are classified as both existing beneficiaries and as bereaved spouse/ partners.*

Payment Rates 2024-25

The levels of payments available to beneficiaries in 2024/25 are set out in the table below.

Beneficiary Group	Annual Payments
Hepatitis C Stage 1	**£22,905**
Hepatitis C Enhanced Stage 1+	**£34,736**
Hepatitis C Stage 2	**£34,736**
HIV	**£34,736**
HIV & Hep C Stage 1 (Co-infected)	**£47,150**
HIV & Enhanced Stage 1+ (Co-infected)	**£54,590**
HIV & Hep C Stage 2 (Co-infected)	**£54,590**
Child Payment; 1st Child	**£3,000**
Child Payment; 2nd & Subsequent Children	**£1,200**

WIBSS pay annual payments monthly or quarterly, depending on beneficiary preference. Payments are made on the 20th of the month. Where the 20th falls on a bank holiday or weekend, payment will be the nearest working day prior to the 20th.

One-off non-discretionary lump sum payments are also paid to successful new applicants to the scheme. Under Parity, a new applicant who is Hep C Stage 1 would be entitled to a £50,000 lump sum payment.

A beneficiary who moves from Hep C Stage1 to Hep C Stage 2 would receive an additional £20,000 lump sum payment.

A new applicant who had already progressed to Hepatitis C Stage 2 would receive a £70,000 lump sum payment.

A new applicant who has HIV would be entitled to a lump sum payment of £80,500. If they were co-infected HIV and Hep C Stage 1, the lump sum would be £80,500 + £50,000 = £130,500 and Stage 2 would be £80,500 + £70,000 = £150,500. A one-off non-discretionary lump sum payment of £10,000 is also paid to the bereaved spouse/partner/dependant relative or estate of a deceased infected beneficiary to assist with funeral costs.

WIBSS also make regular payments to bereaved spouses/partners/dependant relatives, of an infected beneficiary who has passed away. These payments are equal to 100% of the rate the deceased beneficiary was on at time of death for one year and 75% of the rate thereafter.

Child Payments 2024-25

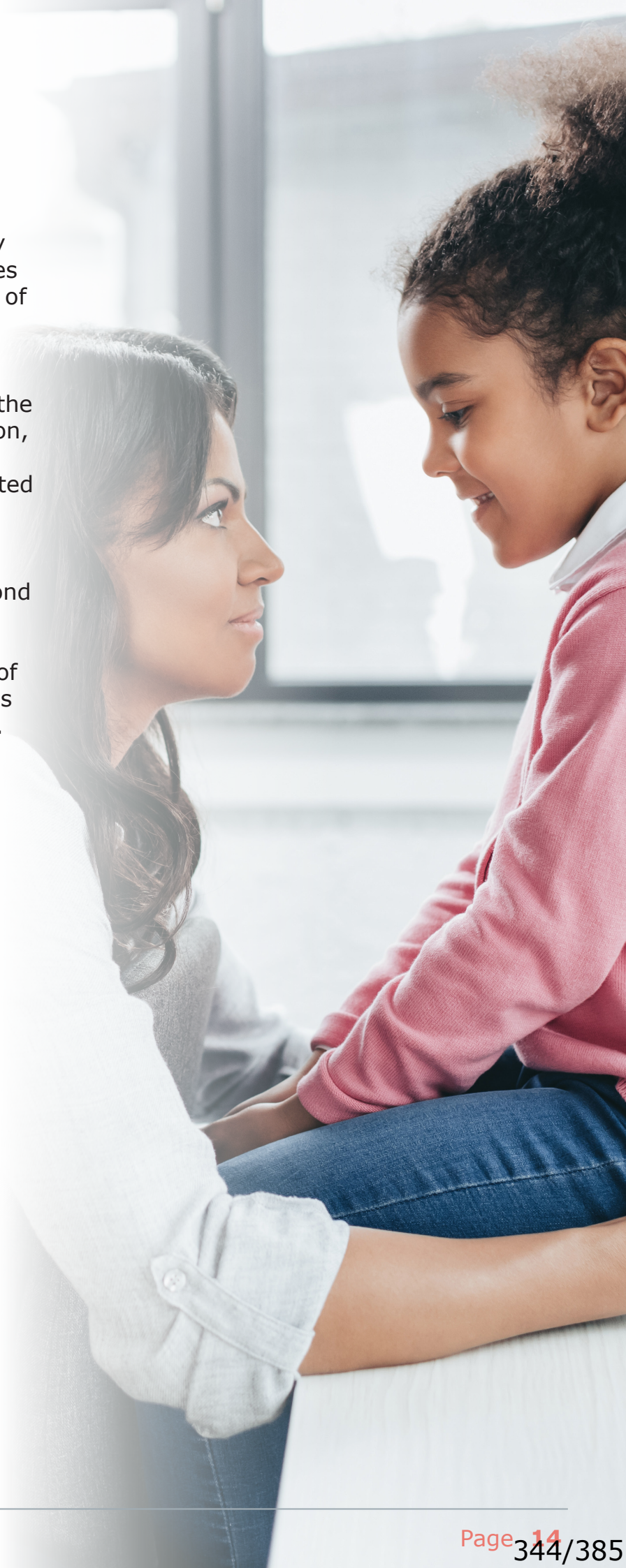
Child payments were introduced by Welsh Government, via WIBSS, with effect from 1st January 2023.

These discretionary payments are only available to those beneficiaries in Wales and via means testing to beneficiaries of EIBSS.

The payment is intended for the care and support of a child/children, up to the age of 18 or 21, if in full-time education, who are either the biological child or form part of the household of an infected beneficiary.

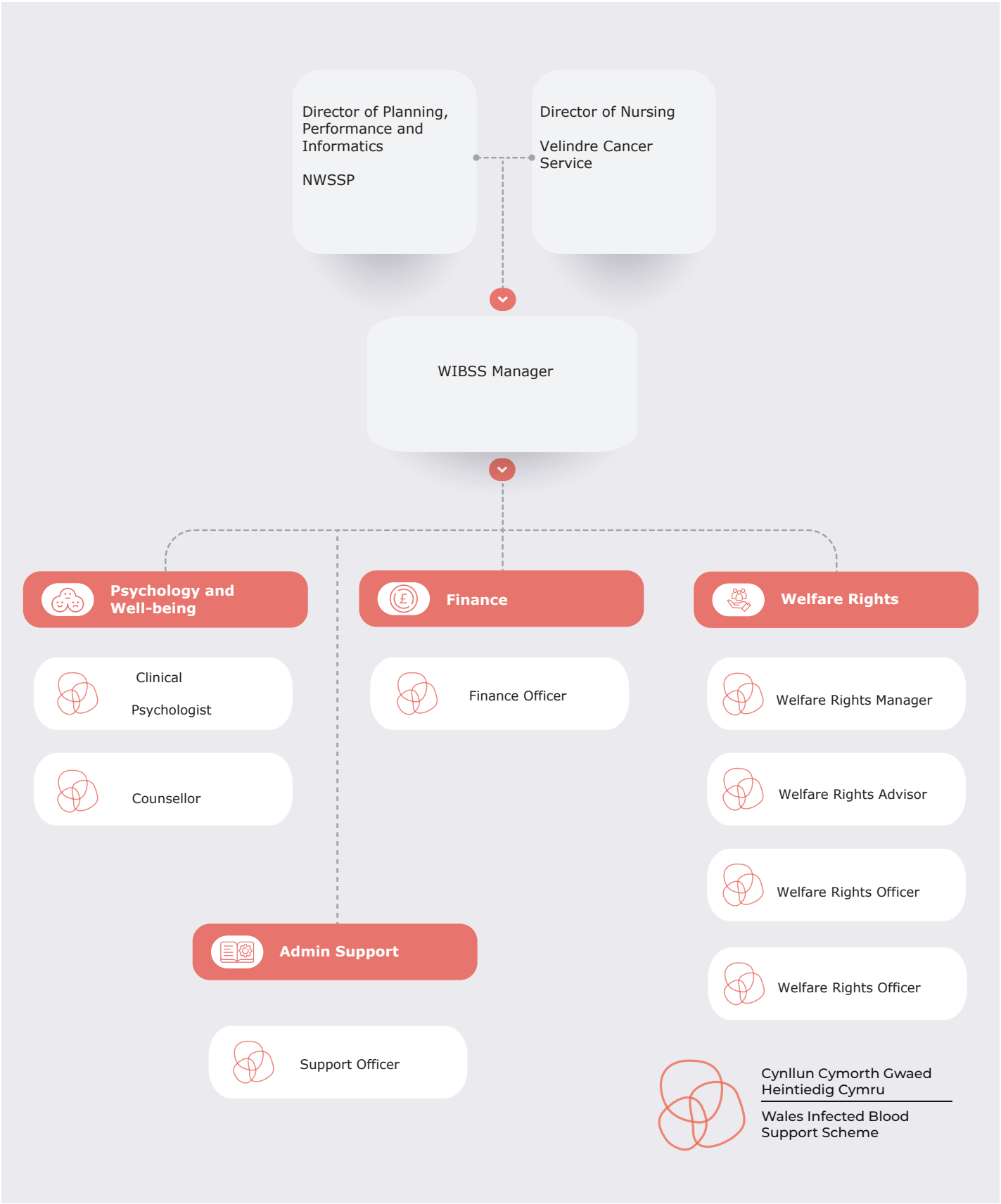
WIBSS child payments are £3,000 for the first child, and £1,200 for the second and subsequent children.

As at 31st March 2025, the total cost of child payments is £72,000. This relates to 30 children paid to 20 beneficiaries. Payments are being paid monthly or quarterly.



WIBSS Structure

The day-to-day WIBSS team consists of eight members of staff, led by the WIBSS Manager.



Financial Report

The table below summarises the claims expenditure for 2024-25, the comparative 2023-24 figures does not include the additional living infected or estates interim compensation payments that were announced in 2024/25.

The first announcement by UK Government on 17th August 2022 confirmed that an interim compensation payment of £100,000 would be paid to registered infected and bereaved partner beneficiaries of the UK Infected Blood Support Schemes. Following the publication of the Infected Blood Inquiry report on 21st May 2024, an additional £210K interim compensation payment was announced and would be paid to all the living infected beneficiaries.

These costs include widows and small grants payments.

WIBSS Claims Expenditure	2024-25	2023-24
No. of Beneficiaries	231	225
Regular Payments	£8,348,078	£7,789,344
£100K Interim Compensation Payments	£800,000	£700,000
£210K Additional Living Infected Compensation Payment	£38,850,000	£0
Estates Interim Compensation Payments and Legal Cost Reimbursement	£3,100,609	£0
Total Payments to Beneficiaries	**£51,098,687**	**£8,489,334**

Please note the figures above have been subject to in year movements i.e., new applications, deaths in year, moves from one stage to another, ad hoc requests etc.

NWSSP provide the Health and Social Services Finance Team within Welsh Government with regular updates on forecasts throughout the year. The administration of the scheme i.e., claims expenditure, is cost neutral to both NWSSP and Velindre Cancer Service, with Welsh Government funding the scheme in full.

Running Costs for 2024/25

A summary of the running costs for 2024-25 is set out below with a 2023-24 comparative:

WIBSS Running Costs	2024-25	2023-24
Pay	£297,177	£223,919*
Expenditure	£13,131	£13,880
Total	**£310,308**	**£237,799**

**The increase in pay costs for 2024/25 is due to the NHS pay award in October 2024, and due to savings in 2023/24 from vacant posts and maternity leave.*

Performance Report

WIBSS performance against Key Performance Indicators is set out below.

Descriptor of Key Performance Indicator	2024-25 Target	Status
Responding to Welsh Government & General correspondence within set time limits	Within 4 working days	100%
Responding to Freedom of Information requests within required deadlines	In line with Trust policy	100%
Dealing with applications within required timescales	Within 28 days from receipt of complete information	100%
Dealing with appeals within set time limits	Within 4 months of notification of intention to appeal. 4 appeals were lodged. Due to pressures within NHS Wales, it took longer than usual to convene an appeal panel due availability of the medical professionals required, so 1 of the appellants waited longer than the required timescale. She was, however, contacted regularly to keep her informed of progress.	75%
Payments made on a timely basis	100% of payments to be made 0-2 days before the due date	100%

Description of Key Welfare Rights Incidents	Status
Total Welfare Rights Cases opened in previous 12 monts	» 51
Income Generated for beneficiaries (1 April 2023–31 March 2024)	» £31,481
Outstanding outcomes March 2024	» 1 Universal Credit » 2 PIP renewal » 1 PIP » 1 Mandatory Recon
Appeals and onward Referrals	» 8 Referrals to WIBSS Wellbeing Service » 8 Mortgage Support letters » Referral to Southwest Advocacy Network » 1 PIP Appeal » 2 Social services referrals

New Applications for Financial Support

WIBSS received 33 applications in 2024-25.

Application Type	Applications Received	Outcome
Hepatitis C Stage 1	18	7 Accepted, 11 Declined
Hepatitis C Stage 1 (Deceased)	10	1 Accepted, 4 Awaiting further information, 5 Declined
Hepatitis C Stage 2	1	1 Declined
Hepatitis C Stage 2 (Deceased)	2	2 Awaiting further information
Hep C Stage 1+	2	2 Accepted
Total	**33**	**10 Accepted, 17 Declined & 6 Awaiting further information**

Where an application is declined, it will be because it does not meet the criteria set out in Wales Infected Blood Support Scheme Directions, or insufficient evidence has been provided to support the application.

To access the Directions, please visit the WIBSS Website:

Home - WIBSS (wales.nhs.uk).

The announcement regarding the interim compensation payments and the media coverage surrounding it, led to an increase in the number of queries about the service and new beneficiaries, who had been registered with one of the legacy schemes, but had not transferred to WIBSS in 2017 when the scheme was established.

Support and Assistance Grants Scheme

In 2024-25 we received 5 applications for support compared to 6 applications in 2023-24.

The level of small grant applications has remained consistent across both years.

Welfare Rights Service

Estates Applications

As stated above, in October 2024 the UK Government introduced a scheme to make interim compensation payments to estates of people who had been registered with a support scheme but passed away before receiving any compensation payment. The welfare team assisted with processing these estate applications by checking the application was completed properly, all the required evidence was included, recording the application onto a monitoring spreadsheet, checking the infected deceased was registered with a legacy scheme or IBSS, checking the with the probate office the probate matched and issuing the appropriate letters.

The welfare team also dealt with requests for support on how and where to find the application forms, how to apply for probate and what evidence was required to support an application.

Infected Blood Compensation Authority (IBCA)

The welfare team also received regular calls regarding IBCA. Beneficiaries were feeling frustrated about the perceived lack of information on what was happening, and some were concerned about the amount of compensation they might be offered, based on the calculator on the IBCA website. Beneficiaries also called us about IBCA updates they received, as they felt the updates were not always easy to understand. Some individuals were also calling regarding WIBSS "closing in" in January 2026. They were feeling very anxious about the changes and what it would mean for them. Where appropriate, the welfare team reminded people about the psychology service and recommended that people contact them if they needed support.

Key working

The welfare team continued to receive calls from individuals wanting help or advice on issues including the switch to Universal Credit, general benefit checks to ensure they are receiving benefits they are eligible for, with support to obtain medical records, and emotional support. If someone wanted emotional support, they would be signposted to the wellbeing and psychology service.

Newsletters

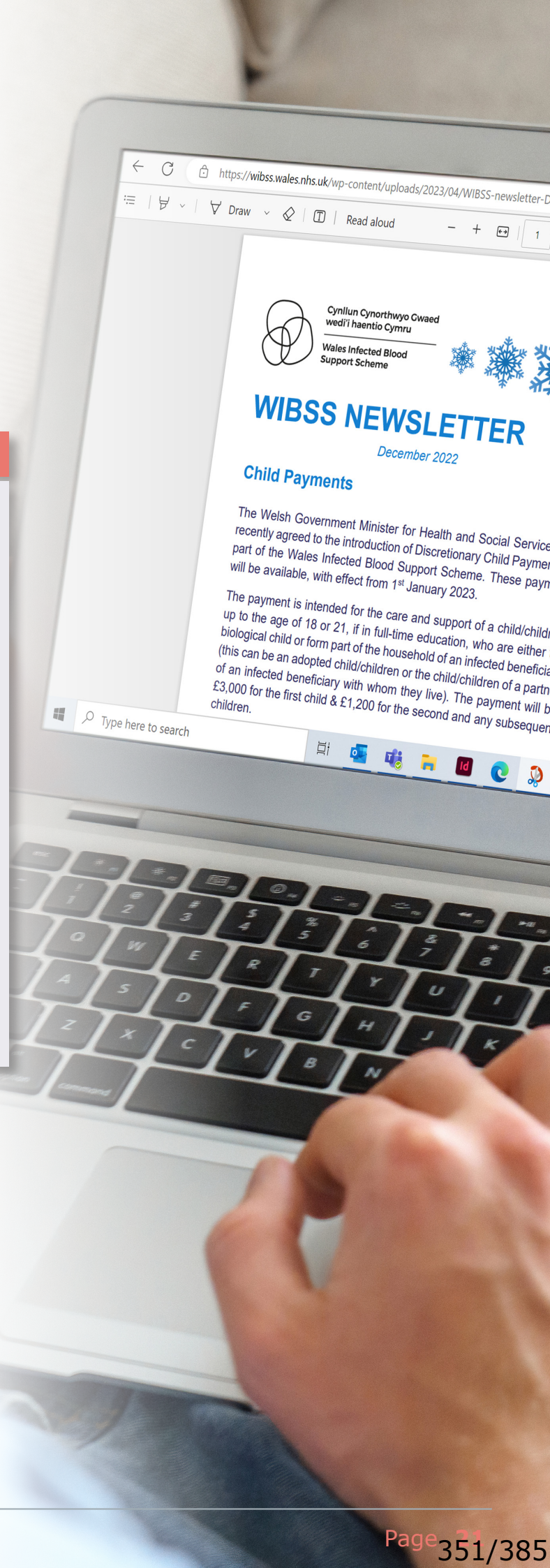
Newsletters are sent out quarterly to all beneficiaries unless they have opted not to receive them. These are sent out electronically or by post, depending on preference.

They are also available on the WIBSS website.

Home - WIBSS (wales.nhs.uk).

Newsletters this year covered:

- Revised Payment Rates
- Help with Energy and Water Costs
- Welfare Rights Support
- Psychology & Wellbeing Service
- Infected Blood Compensation Authority Updates
- WIBSS closing date
- Fraud and Scams Information
- Pension Credit
- Money Safety Information



Case Study A

Beneficiary A contacted WIBSS to discuss his support payments and winter fuel allowance.

We supported A in understanding his payments from WIBSS. We offered to complete a Quick Benefit Calculation. Following the completion of the calculation, A was advised that he could claim; Pension Credit, further Council tax reduction, as the current claim was incorrect, and Housing Benefit. A advised that he had attempted to claim Housing Benefit but was unsuccessful.

We supported A to put in a new Council Tax claim and a new Housing Benefit claim. Obtaining all the relevant evidence from A took time due to A's physical and mental health issues. Being in contact with A regularly meant that the team were able to identify that A seemed to be a likely target for financial abuse and required further assistance in the home. The Team advised A of their concerns and that they would make a referral to social services due to their concerns. A was advised on how to protect himself from further abuse and gained additional support to live in his own home.

Whilst the application for Pension Credit claim was successful, the Housing Benefit and Council Tax claims were discontinued due to A passing away before they were assessed.

Case Study B

Beneficiary B contacted WIBSS about a change in circumstances

A change in circumstances for Beneficiary B resulted in a change to Universal Credit (UC). The welfare team helped Beneficiary B to navigate the change. B was moving in with their partner. WIBSS supported the client emotionally as they were very anxious about the change to UC. They were worried about the WIBSS payments causing issues and about being worse off on UC.

The welfare team undertook a benefit check to inform B how much they would receive. A home visit was carried out to complete the application online.

The welfare team made sure DWP staff dealing with the UC were aware of the WIBSS payments and that they should be disregarded when assessing the application.

B was extremely anxious about attending the job centre due to limited available parking and being unable to walk very far. The welfare team supported B to get a home visit.

Psychology and Emotional Well-being Service

The team consists of a consultant clinical psychologist and a specialist counsellor who are highly experienced at working with those infected and affected by contaminated blood products. Since the scheme was established, they have worked hard to engage as many beneficiaries as possible of WIBSS, and those close to them, to access the psychology and counselling options that the service provides.

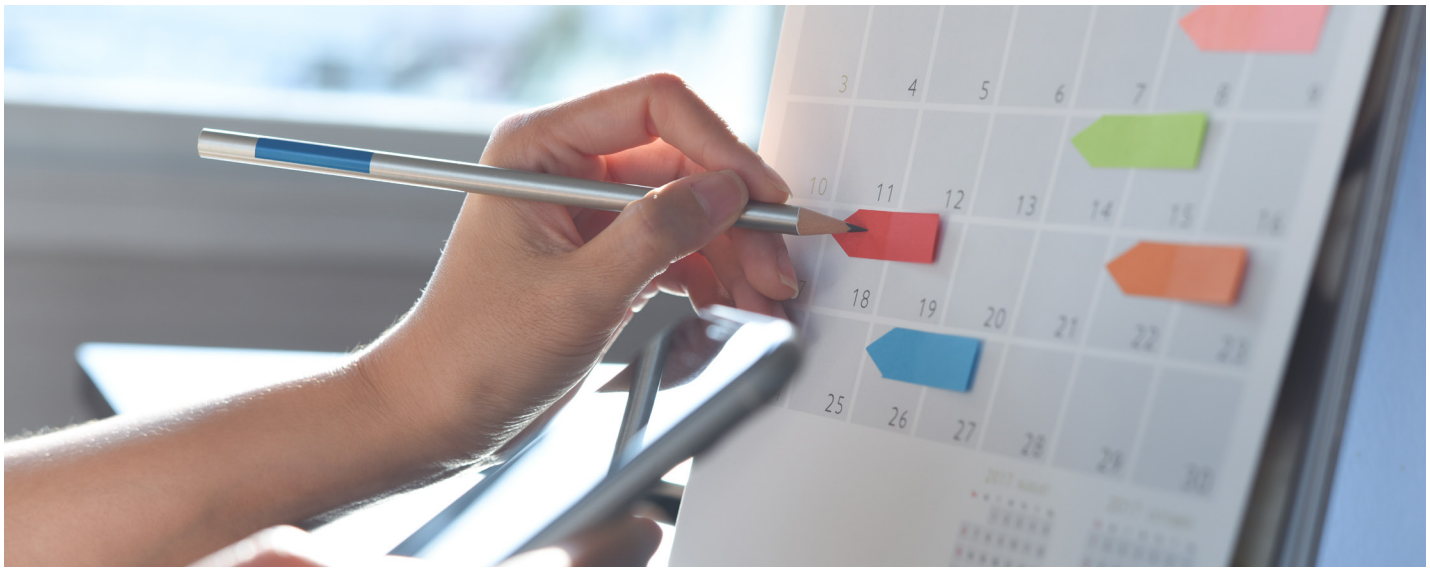
The team continue to receive self-referrals for emotional help and enquiries from external services and health care providers. We have easy to access referral routes and respond in a timely way. Post referral beneficiaries and those close to them, are offered an initial appointment to assess current emotional need and appropriateness for the service. We currently offer open ended intervention which is offered in a collaborative way, either in person, by telephone or video call.

The clinical priority in the previous year has been to support clients emotionally and psychologically through the conclusion of the Infected Blood Inquiry. Also, to forecast what the service can offer clients, and on a wider scale, beneficiaries and those close to them, on a group / community level if required, as we recognise the peer support that the process of the Inquiry has provided for some. We are currently in the process of considering how we can best capture ideas and thoughts from those infected and affected about the next steps regarding their emotional needs considering the proposed recommendations from the Infected Blood Inquiry, plans for compensation alongside the establishment of the IBCA.

Welsh Government are considering the continuation of the psychology and wellbeing part of the service post the closure of WIBSS. There is a strong recommendation from the scheme for this aspect of the service to remain in operation due to the lack of specialist psychological support offered by IBCA and the ongoing relationship that beneficiaries and those close to them have had with WIBSS.

Things we will do in 2025-2026

The workplan for 2025-2026 will include the following:



- Continue to deliver a responsive WIBSS service to existing beneficiaries.
- Keep beneficiaries informed of any decisions arising from the Inquiry recommendations that may impact on them.
- Work with the Welsh Government, Cabinet Office and IBCA to inform decisions regarding the expanding up of the new body and to facilitate the operation of the compensation process and the smooth transition of WIBSS into IBCA.
- Continue to administer the Infected Blood Estate Interim Payments on behalf of the Infected Blood Compensation Authority (IBCA), and administer the additional payments, to the estates, announced by UK Government on 21 July 2025.

Infected Blood Inquiry Additional Report: Oral Statement to Parliament - GOV.UK

Thank you for reading our Annual Report. If you would like to find out more, please visit our website, our social media channels, or use the contact details provide below:

Email

wibss@wales.nhs.uk

Phone

02920 902280

Mary Swiffen-Walker

Address

Wales Infected Blood Support Scheme,

4th Floor,
Companies House,
Crown Way,
Cardiff
CF14 3UB

This document was designed by the NWSSP Communications Team.
nwssp.communications@wales.nhs.uk

TRUST BOARD

Cardiff Health Partners and Cardiff Cancer Research Partnership Structure and Governance Update	
DATE OF MEETING	25th September 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	Rhydian Owen, Cancer Research and Development Cancer Lead Lauren Fear, Director of Place, Portfolio and Partnerships
PRESENTED BY	Jacinta Abraham, Executive Medical Director Lauren Fear, Lauren Fear, Director of Place, Portfolio and Partnerships
APPROVED BY	Jacinta Abraham, Executive Medical Director Lauren Fear, Lauren Fear, Director of Place, Portfolio and Partnerships
EXECUTIVE SUMMARY	**Cardiff Health Partners** The Trust, Cardiff and Vale University Health Board and Cardiff University are establishing a "Cardiff Health Partners" as a strategic partnership. This paper provides an introductory update. The next key milestone is to create a Prospectus to support a formal launch of the Partnership, including at the Welsh International Investment Summit in December. This will be shared through the next governance cycle in November. **Cardiff Cancer Research Partnership**

	The Cardiff Cancer Research Partnership (previously Hub) is the flagship project of Cardiff Health Partners. This paper provides an update on recent progress, the Partnership Agreement, the financial model and the internal launch. The Partnership Agreement will be brought for approval through the next governance cycle in November.
RECOMMENDATION / ACTIONS	To **NOTE** the update provided in this paper and to **NOTE** the next steps for the November governance cycle.

GOVERNANCE ROUTE

List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board	26/08/2025
Research, Development and Innovation Sub-Committee	04/09/2025
Strategic Development Committee	09/09/2025

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

Executive Management Board – *Noted*

Research, Development and Innovation Sub-Committee – *Noted*

Strategic Development Committee

- *Good discussion and the key conclusion was that the Committee would like more time to discuss and shape the opportunity of Cardiff Health Partners as a whole Board. It has since been confirmed that Cardiff Health Partners will therefore be part of the agenda for the October Board Development session.*

Also specifically discussed:

- *The Partnership Agreement for Cardiff Health Partners will be developed and brought to the Board for consideration early in the new year. The timing is linked to the initial scope and focus being developed over September to December – which will inform the way in which the Partnership Agreement should be structured. Secondly, finalising the Cardiff Cancer Research Partnership Agreement through the November governance cycle will enable appropriate sections and principles of that Agreement to also be used to form the Cardiff Health Partners Agreement.*

- *Further discussion on the Investment Summit in December and the Life Sciences led panel as part of the agenda. The Committee will be updated on this further in November.*

- *The Committee was assured that there is wide engagement and collaboration into Cardiff Health Partners across the Trust. This includes Welsh Blood Service, Health Technology Wales, Advanced Therapies Wales and the new cancer centre project.*

7 LEVELS OF ASSURANCE
n/a

Section 1 - Cardiff Health Partners

1.1 Trust, Cardiff and Vale University Health Board and Cardiff University are establishing a "Cardiff Health Partners" as a strategic partnership.

1.2 Its purpose is to pioneer collaborative health science Innovation today to make Wales fairer, healthier and more prosperous

Context

1.3 The context and motivation for the establishment of the Partnership includes:

- **Purposeful Catalytic Cross-Sector Collaboration**
  Leveraging regional co-location between Cardiff University, the Trust, and Cardiff and Vale University Health Board to build a connected health innovation ecosystem for Wales.

- **Focussed Enabler of Integrated Impact**
  Aligning discovery, innovation, and care around pre-clinical science, diagnostics, and precision medicine with cancer into a seamless pathway to real-world benefits by integrating research, clinical care, education and industry.

- **Regional and National Asset**
  Driving health improvement, research excellence, and economic growth for Wales anchored around the Cardiff Cancer Innovation District including Cardiff Edge and Velindre Cancer Centre (Campus).

- **Strategic Investment Vehicle**
  Creating opportunities for new partners and investment from public, private, and third sectors to accelerate discovery-to-impact while growing high-value jobs and capabilities in Wales.

- **Proven Academic-led Model**
  Inspired by and learning from models at King's Health Partners, Bristol, and Edinburgh BioQuarter.

Structure

1.4 Cardiff Health Partners operates through a collaborative governance structure, underpinned by an Executive Programme Board with representation from each founding organisation. Reporting into this Board is the Cardiff Health Partners Management and Development Group which plays a central operational role in ensuring the successful delivery, coordination, and progression of the Cardiff Health Partners strategic objectives.

1.5 There are currently three projects and two enabling projects underway which are forming part of Cardiff Health Partners initially:

- Cardiff Cancer Research Partnership – led by the Trust
- Intercranial Therapies Hub – led by Cardiff University
- Babies, Children and Young People – led by Cardiff and Vale University Health Board

Enabling Projects:

- Joint Research Office
- Data and sample sharing

1.6 The first action is for the Cardiff Health Partners to create a Prospectus, which will have a platform at the Wales International Investment Summit in December. This will be shared through the November governance cycle in the Trust.

1.7 There is a Trust Cardiff Health Partners Coordination Group being established in order to provide a vehicle for a collaborative approach in developing this work.

Objectives

1.8 The aims of the Partnership are being shaped and will further developed over the course of the work in September and October. The working draft includes:

- **Accelerate Innovation to impact**
  Accelerate precision diagnostics, early detection, prevention, and advanced treatments.

- **Improve Health outcomes and advance equity**
  Tackle inequalities and enable fairer access to innovative care across communities.

- **Drive Economic Regeneration**
  Stimulate high-value employment, support SME and life science sector growth, attract inward investment and position Wales as a world-class hub for health and life sciences.

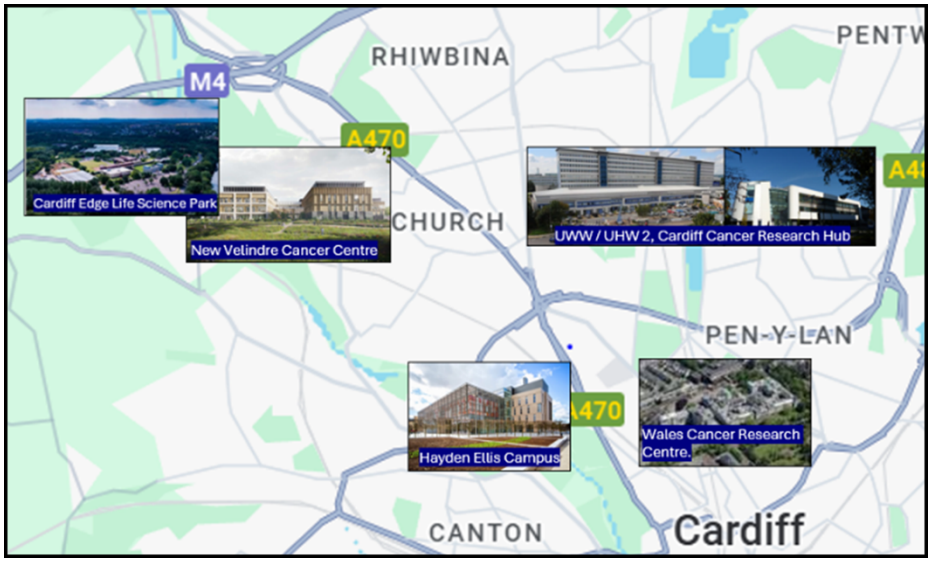
- **Enable Translational Research**
  Bridge discovery and clinical practice to get new therapies to patients faster.

- **Develop a Future-Ready Workforce**
  Build an interdisciplinary, skilled workforce through integrated education, collaborative training, and professional development programmes that attract and retain global talent.

- **Foster Regional Collaboration**
  Strengthen partnerships, maximise resources, and build shared centres of excellence across Wales.

Cardiff Innovation District

1.9 The development of a Cardiff Innovation District will further anchor and enable the place-based Partnership. The Innovation District includes the five-mile corridor linking Cardiff Edge, Heath Park, Velindre Cancer Centre, and Cardiff University. It therefore combines advanced imaging, genomics, biobanking, ATMP manufacturing and clinical trials and it creates further opportunities for critical mass for breakthroughs in prevention, diagnosis, treatment, and survivorship.



Investment Strategy

1.10 The upcoming work will include the development of an investment strategy for Cardiff Health Partners. The approach to funding will be deliberately aligned to the UK's science and technology investment to scale regional Research and Development. This is part of the UK Modern Industrial Strategy, including the Life Sciences sector Plan, launched in July 2025. The investment strategy is being designed to face into the Regional Innovation Fund mechanism. The leverage principles of the fund are to target a 1:3 public–private co-investment ratio to crowd in substantial private capital. The development of the investment strategy will be progressed in close collaboration with Welsh Government and the Life Sciences Hub.

Section 2 - Cardiff Cancer Research Partnership

2.1 The Cardiff Cancer Research Partnership is a partnership between the Trust, Cardiff and Vale University Health Board and Cardiff University. It is the exemplar project of Cardiff Health partners. The Cardiff Cancer Research Partnership which aims to:

- Improve clinical outcomes for its population by increasing patient access to research.
- Deliver world class cancer research in Wales.
- Develop a structured pipeline to bring new discoveries from the lab to the clinic.
- Develop the foundations for the delivery of advanced therapies.

Recent Progress

2.2 To date, the Cardiff Cancer Research Partnership has opened three commercially sponsored trials with a further 11 currently in setup or pre-setup. The forecasted patient number in the trial portfolio is 72% solid tumour, 28% haematology and therefore in line with the 2:1 ratio anticipated in the Strategic Investment Case. The trial activity is tracked and managed through the joint governance of the Partnership.

2.3 As set out in the Strategic Investment Case, the revenue model is intended to include income from both clinical trials and discovery and translational research grant awards. The Discovery Translation Research function was established in late 2024 and one of its key aims is to increase the number of Discovery

Translation Research grant applications developed in partnership between the three organisations, and with industry and other collaborators. This bid development and support function launched in early 2025 and to date, one large bid has been developed by the partnership. In addition a number of clinicians and academics are being supported to develop new grant applications and studies (e.g. via organising workshops, speeding up applications for data and patient sample use).

Partnership Agreement

2.4 A Heads of Terms agreement was reached in September 2024 between the three partners, which included approval at the Trust Board. This has subsequently been developed into a triparty legally binding agreement by a workstream within the Cardiff Cancer Research Partnership programme structure, which includes representation from the three partner organisations and NWSSP Legal & Risk.

2.5 The Trust's final comments are being coordinated to feed into a final draft by end of September. This will include engagement with the Independent Members for Legal and Research and Development. It is then intended to bring the Partnership Agreement for consideration for approval through the November governance cycle.

2.6 The Partnership Agreement provides an overarching framework for how the three partner organisations operate jointly as the Cardiff Cancer Research Partnership. Individual project-specific agreements will then agree responsibility, income share and intellectual property on an individual clinical trial or academic research study.

Financial Model

2.7 The final substantive matter to enable the completion of the Partnership Agreement was the financial model. This was agreed in principle through the joint executive governance in August. It was agreed that each partner will also continue to provide its staff time and facilities to undertake agreed Cardiff Cancer Research Partnership activities, but that the Project Management Office will be jointly funded by the three partners from 2026/7 onwards. The overall approach is the line with the Strategic Investment Case Principles.

Name, Website and Internal Launch Event

2.8 The change from "Hub" to "Partnership" is to reflect the fact that Cardiff Cancer Research Partnership activities (and patients and staff) flow across multiple sites rather than being primarily located at a single 'Hub'.

2.9 A website is currently being finalised, and an event scheduled on 17th September to formally 'launch' the Cardiff Cancer Research Partnership internally within the three organisations. Once these and the Partnership Agreement are in place, the Cardiff Cancer Research Partnership will then move from its 'setup' phase to 'fully operational' status.

3. IMPACT ASSESSMENT

<table>
<tr><th colspan="2">TRUST STRATEGIC GOAL(S)</th></tr>
<tr><td colspan="2">Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals:
YES - Select Relevant Goals below</td></tr>
<tr><td colspan="2">If yes - please select all relevant goals:
• Outstanding for quality, safety and experience ☒
• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒
• A beacon for research, development and innovation in our stated areas of priority ☒
• An established 'University' Trust which provides highly valued knowledge for learning for all. ☒
• A sustainable organisation that plays its part in creating a better future for people across the globe ☒</td></tr>
<tr><td rowspan="2">QUALITY AND SAFETY IMPLICATIONS / IMPACT</td><td>Select all relevant domains below</td></tr>
<tr><td>Safe ☒
Timely ☒
Effective ☒
Equitable ☒
Efficient ☒
Patient Centred ☒</td></tr>
<tr><td>QUALITY IMPACT ASSESSMENT</td><td>Will be finalised to bring alongside decision making in November governance cycle.</td></tr>
<tr><td>SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED</td><td>Will be finalised to bring alongside decision making in November governance cycle.</td></tr>
<tr><th colspan="2">TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT</th></tr>
<tr><td colspan="2">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</td></tr>
</table>

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	Financial model update Included
EQUALITY IMPACT ASSESSMENT	Will be finalised to bring alongside decision making in November governance cycle.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Partnership Agreement update included

TRUST BOARD	
Strategic Development Committee Annual Report	
DATE OF MEETING	25/09/2025
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	**FOR NOTING**
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Christine Sion, Business Support Officer / Committee Secretariat
PRESENTED BY	Non Gwilym, Director of Corporate Governance (Interim)
APPROVED BY	Non Gwilym, Director of Corporate Governance (Interim)
EXECUTIVE SUMMARY	This Strategic Development Committee annual report summarises the key areas of business activity undertaken by the Strategic Development Committee between 1 April 2024 and 31 March 2025.
RECOMMENDATION / ACTIONS	Strategic Development Committee is asked to **NOTE** the contents of the Strategic Development Committee annual report.

COMMITTEE / GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING	
COMMITTEE OR GROUP:	**Date**
N/A	
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS N/A	
ASSURANC RATING BY EXECUTIVE SPONSOR	**N/A**

APPENDICES	
1	**Strategic Development Committee Annual Report**

1. SITUATION

Under Standing Order 4.3.2, each Committee of the Board is required to submit an annual report ***"setting out its activities during the year and detailing the results of a review of its performance.***

This report details the key areas of business undertaken by the Strategic Development Committee between 1st April 2024 – 31st March 2025.

2. BACKGROUND

The Strategic Development Committee Annual Report (appendix 1) summarises the key areas of business activities undertaken by the Strategic Development Committee between 1 April 2024 and 31 March 2025. The Annual Report higlights some key developments endorsed by the Strategic Development Committee.

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)	N/A
QUALITY AND SAFETY IMPLICATIONS / IMPACT	N/A

SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Not required
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	Not applicable
FINANCIAL IMPLICATIONS / IMPACT	Not applicable
EQUALITY IMPACT ASSESSMENT	Not required
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Not applicable

4. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

STRATEGIC DEVELOPMENT COMMITTEE

ANNUAL REPORT (2024-2025)

Strategic Development Committee
Annual Report 2024-2025

1. Introduction and Background

This report summarises the key areas of business activity undertaken by the Strategic Development Committee between 01 April 2024 and 31 March 2025.

2. Role and Responsibilities

The purpose of the Strategic Development Committee is to provide evidence based and timely advice to the Board to assist it in discharging its functions and responsibilities with regard to the:

- Strategic direction
- Strategic planning and related matters
- Strategic Workforce
- Strategic Capital
- Organisational development
- Digital services, estates and other enabler services
- Sustainable development and the implementation of strategy through the spirit and intention of the well-being of future generations act
- Investment in accordance with Value-based healthcare

The Strategic Development Committee provides assurance to the Board in relation to strategic decision-making, ensuring it is supported with a robust understanding of risks in relation to the achievement of organisational goals and strategic objectives.

3. Agenda Planning Process

The Chair of the Committee, in conjunction with the Executive Director of Strategic Transformation, Planning and Digital, and Director of Corporate Governance, sets the agenda for the Committee meetings.

The venue, location and other administration arrangements are planned a year in advance. The secretariat for the meeting is provided by the Business Support Officer to the Executive Director of Strategic Transformation, Planning and Digital.

The Committee's agenda and meeting papers are disseminated to members six clear days prior to the committee date. All papers are accompanied by a cover sheet which provides a summary of key matters for consideration, and details on the action required.

4. Operating Arrangements

The Committee's Terms of Reference and operating arrangements are reviewed on an annual basis. The Strategic Development Committee on 15th May 2024:

- Reviewed and approved its Terms of Reference
- Approved the 2024-2025 Cycle of Business/Work Programme

5. Membership, Frequency and Attendance

The Committee's Terms of Reference specify that the Committee comprises a minimum of 2 members including:

Chair Independent member of the Board (Non-Executive Director)
One independent member of the Board (Non-Executive Directors)

The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

The Strategic Development Committee met on five occasions with attendance as follows:

Members	15.05.2024	18.06.2024	22.10.2024	05.12.2024	20.03.2025
Stephen Harries, Trust Vice Chair (Committee Chair up to October 2024)	✓	✓	✓	✓	✓
Lindsay Foyster, Independent Member (Committee Chair from October 2024)	N/A	N/A	X	✓	✓
Donna Mead, Trust Chair	✓	✓	✓	✓	✓
Gareth Jones, Independent Member	✓	✓	✓	X	✓
Andrew Westwell, Independent Member	✓	✓	✓	✓	✓

All Strategic Development Committee meetings were quorate.

6. Strategic Development Committee Activity

6.1 Work Programme / Action Log

The Committee Work Programme ensures that the Committee discharges its responsibilities in a planned manner. It assists with agenda planning and is updated during the year to ensure that the Committee considers any additional items which may arise during the year. In order to monitor progress and any necessary follow up action, the Committee has an Action Log that captures all agreed actions. This provides an essential element of assurance to the Committee and from the Committee to the Board.

6.2 Terms of Reference

In line with good practice, the Strategic Development Committee reviewed the Terms of Reference of the Committee at its meeting in May 2024. These were approved at the May 2024 Trust Board.

6.3 Key Achievements

The following Business Cases were endorsed by Strategic Development Committee:

- **Welsh Blood Service: Fleet Replacement Business Justification Case**

  This Business Justification Case (BJC) follows the submission to the Welsh Government (WG) of Velindre University NHS Trust's (VUNHST) Capital Priorities in March 2024. This case seeks financial support for the replacement of ageing vehicles within the Welsh Blood Service (WBS), Transport and Logistics Fleet.

  In 2018, WG invested to support the modernisation of the WBS Blood Collection Fleet as part of a wider holistic change programme. In line with the previous investment route and given the forecast future commitments on the limited discretionary capital monies available to VUNHST, funding for this scheme was sought through the WG All-Wales Capital Programme.

  The existing WBS vehicle fleet, due to its age profile, requires replacement. This will be a phased programme over three financial years commencing in 2025/26. This is required for the WBS to maintain service delivery and to ensure the continuation of supply and sufficiency of blood and wholesale products to Welsh hospitals. The estimated capital cost to procure this complete fleet replacement is circa £3m over 3 financial years. All ongoing revenue running costs will be absorbed by the WBS.

- **Electronic Prescribing and Medicines Administration (ePMA) Full Business Case**

  In Private, the committee endorsed for Trust Board approval the Electronic Prescribing and Medicines Administration (ePMA) Full Business Case, which supports the contract award to the successful supplier of the ePMA procurement process and the funding request to Welsh Government, for 'Phase II – Implementation' funding.

6.4 Items Endorsed by Strategic Development Committee

The following agenda items were endorsed by the Strategic Development Committee during the 2024–2025 period:

June 2024:

- Endorsed the Trust Well-Being of Future Generations Objectives, subject to suggested amendments.
- Endorsed the Strategic Development Committee Effectiveness Survey.
- Endorsed the Strategic Development Annual Report.
- *In Private*, endorsed the investment for the procurement and implementation of the digital Patient Reported Outcome Measures (PROMs) solution within Velindre Cancer Services.

October 2024:

- Endorsed the Funding Request for the Integrated Business Case for the Talbot Green Infrastructure Programme, for Trust Board approval.

March 2025:

- Endorsed the draft Integrated Medium-Term Plan (IMTP) 2025–2028, subject to incorporation of feedback received during the meeting.

- **Strategies:**
  In October 2024 the Strategic Development Committee endorsed the Welsh Blood Services Research, Development, and Innovation Strategy for Trust Board approval, subject to the minor amendments discussed by the Committee.

  In December 2024, the Updated Digital Strategy was endorsed for Trust Board approval, subject to the minor amendments discussed by the Committee.

- **Policies:**
  The Strategic Development Committee did not endorse any policies for 2024 – 2025.

6.5 Reporting Outside of Committee

Two Chair's Urgent Action Reports were considered outside of Committee during the 2024-2025 period:

- 17th May 2024 – Blood Establishment Computer System (BECS) Commercial Case
  - The Strategic Development Committee endorsed the BECS Commercial Case for submission to the Trust Board for approval via Chair's Urgent Action.
  - No objections to the proposed approval were received.

- 12th September 2024 – Clinical and Scientific Strategy:
  - The Strategic Development Committee endorsed the Clinical and Scientific Strategy for submission to the Trust Board for approval via Chair's Urgent Action.
  - One query was raised and subsequently addressed, as detailed in the report.
  - No objections were raised to the proposed approval.

7. Reporting the Committee's Work

The Chair of the Strategic Development Committee reports the key issues discussed at each of its meetings by way of a Highlight Report to the Board. The Highlight report provides a facility for the Committee to alert/escalate; advise; assure; or inform the Board in relation to Strategic Development matters. Committee papers, including minutes, are published on the Trust's internet pages.

8. Assurance to the Board

The Committee wishes to assure the Board that on the basis of the work completed by the Committee during 2024-2025, there are effective measures in place and there are no outstanding issues that the Committee wishes to bring to the attention of the Board over and above the risks and issues already raised in the Strategic Development Committee's Highlight Reports.

9. Committee Effectiveness

During the year the Committee has continued to review and revise its ways of working to optimise the need for a robust governance approach. The Committee continued to review its effectiveness thorough the year, to ensure effective use of time and ensure it fulfilled its role to provide assurance to the Board.

The Committee has engaged with a formal Committee Effectiveness Review Process which took place in August 2025.

TRUST BOARD	
nVCC Project Scrutiny Sub-Committee Annual Report	
DATE OF MEETING	18/09/2025
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	**FOR NOTING**
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Christine Sion, Business Support Officer / Committee Secretariat
PRESENTED BY	Non Gwilym, Director of Corporate Governance (Interim)
APPROVED BY	Non Gwilym, Director of Corporate Governance (Interim)
EXECUTIVE SUMMARY	This nVCC Project Scrutiny Sub-Committee annual report summarises the key areas of business activity undertaken by the nVCC Project Scrutiny Sub-Committee between 2024-2025.
RECOMMENDATION / ACTIONS	nVCC Scrutiny Sub-Committee is asked to **NOTE** the nVCC Project Scrutiny Sub-Committee Annual report.
COMMITTEE / GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING	
COMMITTEE OR GROUP:	**Date**
N/A	
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS N/A	
ASSURANC ERATING BY EXECUTIVE SPONSOR	**N/A**
APPENDICES	

1	nVCC Project Scrutiny Sub-Committee Annual Report

1. SITUATION

Under Standing Order 4.3.2, each Committee of the Board is required to submit an annual report ***"setting out its activities during the year and detailing the results of a review of its performance.***

This report details the key areas of business undertaken by the nVCC Project Scrutiny Sub-Committee between 1st April 2024 – 31st March 2025.

2. BACKGROUND

The nVCC Project Scrutiny Sub-Committee annual report (appendix 1) summarises the key areas of business activities undertaken by the nVCC Project Scrutiny Sub-Committee between 1st April 2024 – 31st March 2025. The annual report higlights some key developments endorsed by the nVCC Project Scrutiny Sub-Committee.

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)	N/A

QUALITY AND SAFETY IMPLICATIONS / IMPACT	N/A
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Not required
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	Not applicable
FINANCIAL IMPLICATIONS / IMPACT	Not applicable
EQUALITY IMPACT ASSESSMENT	Not applicable
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Not applicable

4. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

nVCC PROJECT SCRUTINY SUB-COMMITTEE

ANNUAL REPORT (2024-2025)

nVCC Project Scrutiny Sub-Committee
Annual Report 2024-2025

1. Introduction and Background

This report summarises the key areas of business activity undertaken by the nVCC Project Scrutiny Sub-Committee between 1 April 2024 and 31 March 2025.

2. Role and Responsibilities

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.

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. Agenda Planning Process

The Chair of the Committee, in conjunction with the Executive Director of Strategic Transformation, Planning and Digital and Director of Corporate Governance sets the agenda for the Committee meetings.

The venue, location and other administration arrangements are planned a year in advance. The secretariat for the meeting is provided by the Business Support Officer to the Executive Director of Strategic Transformation, Planning and Digital.

The Committee's agenda and meeting papers are disseminated to members six clear days prior to the committee date. All papers are accompanied by a cover sheet which provides a summary of key matters for consideration, and details on the action required.

4. Membership, Frequency and Attendance

The Committee's Terms of Reference specify that the Committee comprises a minimum of three members including:

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

The nVCC Project Scrutiny Sub-Committee met on fourteen occasions during this period. Three of the fourteen meetings were extraordinary private meetings. The attendance was as follows:

Meeting Dates	Stephen Harries	Gareth Jones	Hilary Jones	*Donna Mead	*Lindsay Foyster	*Andrew Westwell	*Vicky Morris
18/04/2024	No	Yes	Yes	Yes	No	No	No
16/05/2024	Yes	Yes	Yes	Yes	Yes	No	No
20/06/2024	Yes	Yes	Yes	Yes	No	Yes	No
25/06/2024 – Extraordinary Private Meeting	Yes	Yes	No	Yes	Yes	No	No
23/07/2024	Yes	No	Yes	Yes	No	Yes	No

20/08/2024 – Extraordinary Private Meeting	Yes	Yes	Yes	No	Yes	Yes	Yes
02/09/2024 – Extraordinary Private Meeting	*No meeting minutes recorded.*						
25/09/2024	Yes	Yes	No	No	No	Yes	Yes
17/10/2024	Yes	Yes	Yes	Yes	No	No	No
21/11/2024	Yes	Yes	Yes	Yes	No	No	No
19/12/2024	Yes	No	Yes	Yes	No	No	No
23/01/2025	Yes	Yes	Yes	Yes	No	No	No
20/02/2025	Yes	Yes	Yes	Yes	No	No	No
20/03/2025	Yes	Yes	Yes	Yes	No	No	No

*Donna Mead was not a member of the nVCC Project Scrutiny Sub-Committee but attended regularly. Additionally, Lindsay Foyster, Andrew Westwell, and Vicky Morris were also not members of the committee but attended occasionally.

5. nVCC Project Scrutiny Sub-Committee Activity

5.1 Work Programme / Action Log

The Committee Work Programme ensures that the Committee discharges its responsibilities in a planned manner. It assists with agenda planning and is updated during the year to ensure that the Committee considers any additional items which may arise during the year. In order to monitor progress and any necessary follow up action, the Committee has an Action Log that captures all agreed actions. This provides an essential element of assurance to the Committee and from the Committee to the Board.

5.2 Terms of Reference

The nVCC Project Scrutiny Sub-Committee reviewed the Terms of Reference in line with 5.1 final Full Business Case for Velindre Cancer Centre in September 2024.

5.3 Key Achievements

The nVCC Scrutiny Committee was directly responsible for assurance of the nVCC project, following practical completion of the contract in March 2024. The committee ensured robust governance arrangements were independently audited and subsequent recommendations implemented, on behalf of the Trust Board.

Key project milestones monitored and assured during the oversight year:

April 2024: Site setup and start of construction period

May 2024: nVCC earthworks commenced

Jun 2024: PwC External Governance Report received, with committee oversight on key recommendations and subsequent implementation plans

Jul 2024: Key Clinical Equipment (Cat 2C) procurement process agreement and launch

Aug 2024: Foundation concrete works start

Nov 2024: Reinforced concrete frame start

Dec 2025: Outstanding business case elements and benefit realisation obligations finalised and agreed with Welsh Government

Mar 2025: Permanent SRO appointed and full implementation of PwC recommendations for the governance, staffing and technical skill mix to deliver the project delivered

Whitchurch Hospital Business Justification Case

During this period the Sub-Committee also endorsed the parameters and preparatory steps for developing the Whitchurch Hospital Business Justification Case. While the case itself has not yet been approved, the Sub-Committee supported:

- Using the old Grange and Whitchurch football sites for ecological habitat.
- Retaining and supporting existing sports facilities, subject to Welsh Government agreement.
- Planning an 8–10 week stakeholder engagement exercise to inform the development of the case.
- Progressing “at risk” with professional advisor contracts to shape the available options.

This reflects a proactive and structured approach to shaping the future of the Whitchurch site, embedding environmental, community, and strategic considerations from the outset.

All in all, these achievements reflect the Sub-Committee's commitment to delivering strong governance, strategic clarity, and delivery readiness across the nVCC Project. Each decision has contributed to building the foundations for improved cancer care infrastructure and services, ensuring that progress remains accountable, inclusive, and aligned with the needs of patients, staff, and the wider community.

5.4 Items Endorsed by nVCC Project Scrutiny Sub-Committee

The following agenda items were endorsed by nVCC Project Scrutiny Sub-Committee in 2024 - 2025:

April 2024

- Extension of technical project management support for Enabling Works and nVCC Projects.
- Legal advisory support for the nVCC Project Financial Close and planning-related matters.
- Approval to procure services to complete RDD (excluding WSP advisors pending further clarification).
- Initiation of procurement for Lead Technical Advisor for nVCC Construction Phase.
- Award of non-committal contracts for legal and commercial services to support nVCC construction.
- Retrospective increase in commercial advisory contract to support final business case and assurance.
- Appointment of environmental services provider for off-site works.
- Procurement process for HV Intake Room Design and Build.
- Subject to Procurement Team approval:
    - Technical engineering advice for Asda S278 works.
    - Governance and team structure review.
    - Development of a Scheme of Delegation.

May 2024

- Endorsed the Whitchurch Land Transfer.

June 2024

- Approval of Committee Effectiveness and Annual Reports (April 2023 – March 2024).
- Procurement of Lead Technical Advisory support for nVCC Construction Phase.

- Procurement of Risk Assurance Technical Advisor for nVCC.
- Increase in commitment to spend for WSP UK Ltd.

July 2024

- Endorsed the nVCC Project Board Terms of Reference (in principle).
- Approved immediate recruitment to support programme delivery, with financial risk management.
- Endorsed the MIM Governance Protocol.
- Endorsed the parameters for developing the Whitchurch Hospital Business Justification Case:
    - Use of old Grange and football sites for ecological habitat.
    - Retention of existing sports facilities.
    - Subject to Welsh Government agreement.
- Endorsed the planning of a stakeholder engagement exercise to inform the development of the Business Justification Case.
- Approved progressing “at risk” with professional advisor contracts to shape the case.
- Endorsed competitive procurement for an Authority Construction Surveyor.

September 2024

- Endorsed updated Terms of Reference for the Sub-Committee.
- Approved revised Scheme of Delegation for Trust Board consideration.

December 2024

- Endorsed the nVCC Terms of Reference (in principle).

The nVCC Project Scrutiny Sub-Committee receive at regular intervals Finance Reports and Communication and Engagement Reports that are noted at the nVCC Project Scrutiny Sub-Committee meetings. These reports provide the nVCC Project Scrutiny Sub-Committee with the latest position on Communication and Engagement related to the Programme as well as the latest financial positions.

5.5 Reporting Outside of Committee

No reports have been considered out of committee this year.

6. Reporting the Committee’s Work

The Chair of the nVCC Project Scrutiny Sub-Committee reports the key issues discussed at each of its meetings by way of a Highlight Report to the Board. The Highlight report provides facility for the Committee to alert/escalate; advise; assure; or inform the Board in relation to nVCC Project Scrutiny Sub-Committee matters. Committee papers, including minutes, are published on the Trust's internet pages.

7. Assurance to the Board

The Committee wishes to assure the Board that on the basis of the work completed by the Committee during 2024-2025, there are effective measures in place and there are no outstanding issues that the Committee wishes to bring to the attention of the Board over and above the risks and issues already raised in the nVCC Project Scrutiny Sub-Committee's Highlight Report.

8. Committee Effectiveness

During the year the Committee has continued to review and revise its ways of working to optimise the need for a robust governance approach. The Committee continued to review its effectiveness thorough the year, to ensure effective use of time and ensure it fulfilled its role to provide assurance to the Board.

The Committee has engaged with a formal Committee Effectiveness Review Process which took place in August 2024.