Public Trust Board

Thu 27 November 2025, 10:00 - 13:00

Trust Headquarters, Nantgarw, CF15 7QZ

Agenda

10:00 - 10:15
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 25th September 2025

Sara Moseley, Chair

1.4.0 DRAFT Public Trust Board Minutes 25.09.2025 (v3SM).pdf (9 pages)

1.5. Public Action Log

Sara Moseley, Chair

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

1.6. Matters Arising

Sara Moseley, Chair

1.6.1. Cancer Patient Tracking List (PTL) Data update

Anne Carey, Chief Operating Officer

1.6.1 Matters Arising - Cancer PTL Data Summary - Board Actions.pdf (10 pages)

10:15 - 10:25
10 min

2. KEY REPORTS

2.1. Chair's Report

Sara Moseley, Chair

2.1.0 Chair's update Trust Board 27.11.25 v5.pdf (7 pages)

2.2. Chief Executive's Update (verbal)

Carl James, Interim Chief Executive Officer

**verbal item*

10:25 - 11:35
70 min

3. QUALITY, SAFETY & PERFORMANCE

3.1. Performance Management Framework (September 2025)

Led by:

- Carl James, Executive Director of Strategic Transformation, Planning and Digital/Deputy Chief Executive Officer
- Anne Carey, Chief Operating Officer
- Nicola Williams, Executive Director of Nursing, AHP & Health Science & Dr Jacinta Abraham, Executive Medical Director
- Sarah Jenkins, , Interim Executive Director OD & Workforce,
- Carl Taylor, Chief Digital Officer,
- Lauren Fear, Director of Place, Portfolio & Partnerships
- Matthew Bunce, Executive Director of Finance

3.1.0a 27.11.25 Trust Board SEPT PMF Data 2025 PowerPoint final version 042.pdf (37 pages)
3.1.0b Trust Board - SACT overview and context - November Board - FINAL.pdf (9 pages)
3.1.0c Month 7 Finance Report Cover Paper - Trust Board 27.11.2025.pdf (13 pages)
3.1.0d Appendix 1 - M7 VELINDRE UNHS TRUST FINANCIAL POSITION TO OCT 2025 - TRUST BOARD 27.11.2025.pdf (33 pages)
3.1.0e Appendix 2 - nVCC Project Finance Paper (Oct 25) FINAL.pdf (16 pages)

3.2. VUNHST Risk Register

Non Gwilym, Interim Director of Corporate Governance

3.2.0 TRR - Public TRR - TB - November 2025 -V03.pdf (8 pages)
3.2.0a Appendix 1 - TRR - TB - November 2025 - V04.pdf (9 pages)

3.3. Board Assurance Framework

Non Gwilym, Interim Director of Corporate Governance

3.3.0 BAF Cover Paper - TB - NOVEMBER -2025 V02.pdf (8 pages)
3.3.0a BAF Overview November 2025.pdf (7 pages)
3.3.0b BAF 01 - SERVICE CAPACITY- V02.pdf (6 pages)
3.3.0c BAF 02 - QUALITY -TB.pdf (7 pages)
3.3.0d BAF 03 - RDI -TB.pdf (5 pages)
3.3.0e BAF 04 - UNIVERSITY STATUS TB.pdf (3 pages)
3.3.0f BAF 05 - SUSTAINABILITY - TB.pdf (5 pages)
3.3.0g BAF 06 -CULTURE - for TB.pdf (5 pages)
3.3.0h BAF 07 - DIGITAL- TB.pdf (6 pages)
3.3.0i BAF 08 - GOVERNANCE TB.pdf (5 pages)
3.3.0j BAF 09 - FINANCE TB.pdf (17 pages)
3.3.0k BAF 10 - TRANSFORMATION TB.pdf (4 pages)
3.3.0l BAF11 - WORKFORCE TB.pdf (5 pages)

3.4. Integrated Medium Term Plan (IMTP) update (verbal)

Carl James, Interim Chief Executive Officer

**verbal item*

10 minute comfort break

11:35 - 11:55
20 min

4. HOSTED SERVICES

4.1. Health Technology Wales (HTW) Annual Report

Susan Myles, Director, Health Technology Wales

4.1.0 HEALTH TECHNOLOGY WALES_ANNUAL REPORT 2025_AW5.pdf (29 pages)
4.1.0a HEALTH TECHNOLOGY WALES_ANNUAL REPORT 2025_WELSH_AW4.pdf (29 pages)

4.2. Commitments of Expenditure (NWSSP) Exceeding CEO Limit

Alison Ramsey, Director of Finance and Corporate Services, NWSSP

- 4.2.0a NWSSP - Fleet Modernisation - Nov 2025 - Velindre Trust Board.pdf (8 pages)
- 4.2.0b Appendix 1 - Fleet Modernisation Programme Business Case - NWSSP - Q3 - 2025.pdf (58 pages)
- 4.2.0c Nov 2025 GP Locum Hub Commitment of Expenditure Cover Paper updated.pdf (6 pages)
- 4.2.0d Locum Hub Wales Commitment of Expenditure Over Chief Exec Limit.pdf (9 pages)
- 4.2.0e Nov 2025 Procurement benchmarking Commitment of Expenditure updated.pdf (6 pages)
- 4.2.0f Commitment of Expenditure Over Chief Exec Limit (1) AdviseInc.pdf (8 pages)

11:55 - 12:05
10 min

5. COMMITTEE ESCALATIONS

Sara Moseley, Chair

5.1. Public Quality, Safety & Performance Committee Highlight Report (13/11/2025)

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

- 5.1.0 Public QSP Highlight Report 13th November 2025 (VM).pdf (7 pages)
- 5.1.0a Appendix 1 QUARTER 2 2025-26 Integrated QS Report 4.11.25.pdf (64 pages)

5.2. Public Strategic Development Committee Highlight Report (09/09/2025)

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

- 5.2.0 TRUST BOARD PUBLIC SDC HIGHLIGHT REPORT 09.09.2025 v1.pdf (6 pages)

12:05 - 12:20
15 min

6. CONSENT FOR APPROVAL

Sara Moseley, Chair

6.1. Trust Policies for Approval

Sarah Jenkins, Interim Executive Director of People and Organisational Development

- Smoke-free policy
- Adverse weather policy
- Mental wellbeing Guidance for Employees / Managers

- 6.1.0a Board-Committee-Report-Template Smoke free policy_Trust Board_Nov 2025.pdf (6 pages)
- 6.1.0b WF56 Smoke Free Policy_v6_June 24_Approval Gov 2025.pdf (8 pages)
- 6.1.0c Trust Board Adverse Weather Policy27.11.25.pdf (6 pages)
- 6.1.0d Appendix 1 Adverse Weather Policy WF13 v.2.pdf (14 pages)
- 6.1.0e Trust Board_Cover Paper_Mental Wellbeing Guidance_27.11.25.pdf (6 pages)
- 6.1.0f Eng VNHST Staying Well Plan - Guide for All Staff V1 April 2025.pdf (2 pages)
- 6.1.0g Eng VNHST Staying Well Plan - Full Version Template V1 April 2025.pdf (5 pages)
- 6.1.0h Eng Mental Wellbeing - guidance for employees V2 April 2025.pdf (9 pages)
- 6.1.0i Eng Mental Wellbeing - Guidance for Managers V2 April 2025.pdf (13 pages)
- 6.1.0j Eng VUNHST Stress Risk Assessment V2 April 2025.pdf (10 pages)
- 6.1.0k Managers Resource Leaflet V3 (3).pdf (1 pages)

6.2. Chair's Urgent Actions

Non Gwilym, Interim Director of Corporate Governance

- 6.2.0 PUBLIC Chairs Urgent Action Report NOV 2025 v1.pdf (4 pages)

12:20 - 12:35
15 min

7. CONSENT FOR NOTING

Sara Moseley, Chair

7.1. Trust Seal Report

Non Gwilym, Interim Director of Corporate Governance

- 7.1.0 Trust Seal Report 19.09.2025-26.11.2025.pdf (3 pages)

7.2. Public nVCC Project Scrutiny Sub-Committee Highlight Report (18/09/2025)

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

7.2.0 TRUST BOARD PUBLIC nVCC PROJECT SCRUTINY SUB-COMMITTEE HIGHLIGHT REPORT 18.09.2025.pdf (4 pages)

7.3. Local Partnership Forum Highlight Report (23/09/2025)

Sarah Jenkins, Interim Executive Director of People & Organisational Development

7.3.0 Highlight Report for LPF For Trust Board Meeting 27 November 2025 v1.pdf (3 pages)

7.4. Trust-wide policy approvals update

Non Gwilym, Interim Director of Corporate Governance

7.4.0 TRUST WIDE POLICIES APPROVED UPDATE NOV 2025.pdf (5 pages)
7.4.0a APPENDIX 1 - IPC03 NHS Wales 2023 Model Policy ANTT V3_JUN 25.pdf (32 pages)
7.4.0b APPENDIX 2 - IPC 05 - NIPCM Policy Document June 2025 - FINAL.pdf (2 pages)
7.4.0c APPENDIX 3 - IPC10 Hand Hygiene Policy_v7 SEP 25.pdf (21 pages)
7.4.0d APPENDIX 4 - IPC21 Management of Respiratory Infection_v5_Sep 25 combined.pdf (18 pages)
7.4.0e APPENDIX 5 - IG13 Confidentiality Breach Reporting Policy 2025.pdf (13 pages)
7.4.0f APPENDIX 6 - IG02 Data Protection_V3 SEP 25.pdf (16 pages)
7.4.0g APPENDIX 7 - IG01 Records Management Policy v3 SEP 2025.pdf (12 pages)
7.4.0h APPENDIX 8 - GC01 Policy on Policies_v3_SEP 25.pdf (35 pages)
7.4.0i APPENDIX 9 - PP 01 Trust Fire Safety Policy v.6.0 (v.C)_NOV 25.pdf (12 pages)
7.4.0j APPENDIX 10 - PP01a VUNHST Principles of Fire Safety v.02_NOV 25.pdf (15 pages)

7.5. Strategic Partnership update

Lauren Fear, Director of Place, Portfolio and Partnerships

7.5.0 Strategic Partnerships Update - Trust Board - Nov 25 -3.pdf (6 pages)
7.5.0a Appendix 1 - RJC ToR_Endorsed by RJC.pdf (11 pages)
7.5.0b Appendix 2 - Cardiff Health Partners Prospectus_Eng.pdf (17 pages)

7.6. Advanced Therapies Wales (ATW) Programme Annual Report

Jacinta Abraham, Executive Medical Director, Alan Prosser, Director of Welsh Blood Service and Rachel Savery, Head of Programme (Advanced Therapy Wales)

7.6.0 ATW Annual Report 2024-5 v0.3.pdf (8 pages)

12:35 - 12:40
5 min

8. COMMITTEE ANNUAL REPORTS 2024-2025

Sara Moseley, Chair

8.1. Quality, Safety & Performance Committee Annual Report

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

8.1.0 QSP Committee Annual Report 2024-25.pdf (19 pages)

12:40 - 12:40
0 min

9. ANY OTHER BUSINESS

Sara Moseley, Chair

**Prior approval required by Chair.*

12:40 - 12:40
0 min

10. DATE OF NEXT MEETING

Sara Moseley, Chair

The next meeting will be held on **29th January 2026** at 10:00 in the Trust Headquarters, 2 Charnwood Court, Parc Nantgarw, Cardiff.

CF15 7QZ

12:40 - 12:40
0 min

11. CLOSE

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).

12:40 - 12:40
0 min

12. Items for private board discussion

- Minutes and action of the private Board held on 25th September 2025
- TrAMs update
- Private Risk Register
- Inquest Update
- Leadership, Workforce Culture and Priorities
- Shared Services Governance Arrangement
- Committee escalations
- Update on Chief Executive and Executive Director Portfolios
- Chair's urgent actions
- Commitments of Expenditure exceeding CEO limit
- Lease approval (NWSSP)
- Committee highlight reports for noting

MINUTES PUBLIC TRUST BOARD MEETING
VELINDRE UNIVERSITY NHS TRUST
25th September 2025 11:00-13:30

PRESENT	
Sara Moseley	Chair
Lindsay Foyster	Vice Chair
Gareth Jones	Independent Member
Prof. Andrew Westwell	Independent Member
Vicky Morris	Independent Member
Hilary Jones	Independent Member (remotely)
David Donegan	Chief Executive Officer
Carl James	Executive Director of Strategic Transformation, Planning & Digital / Deputy CEO
Nicola Williams	Executive Director of Nursing, Allied Health Professionals & Health Scientists
Lauren Fear	Director of Place, Portfolio and Partnerships
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 her first Board meeting and no apologies were noted.	
1.2.0	**In Attendance:** The Chair extended a warm welcome to the following additional attendees: • Llinos Madeley, Interim Head of Corporate Governance • Bethan Davis (HEIW) – Simultaneous Welsh Translation • Ben Leijokari-Olosunde, Aspiring Board Members Programme Member	
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 24th July 2025** The following amendments were noted: *Page 5 item 3.2.0* – Amend date to April 2026.	

	Subject to the amendment noted above, the Trust Board was content that the minutes were otherwise accurate reflections of proceedings.	
1.5.0	**Action Log** The Trust Board was content to close all actions marked as 'propose to close', with the exception of Action 45 (this was not closed and is discussed further below). The following updates were provided for actions remaining open: ***Action 3 (item 7.1.4 – 23.05.2024 meeting*)** – Non Gwilym advised that work is ongoing; changes to the wording of the remit of the Audit Committee had been accepted by the Committee, in addition to the remit of the Strategic Development Committee and nVCC Project Scrutiny Sub-Committee. Comments received at a meeting regarding the remit of the Project Board had been accepted, with a view for this action to be closed at November's Trust Board. It was agreed to update the target date. ***Action 45 reopened (item 3.1.0 – 22.05.2025 meeting)*** – It was agreed to reopen this action as elements of the action are noted for future completion. Anne Carey indicated that the output of the Cancer Patient Tracker List (PTL) would regularly be visible in the Performance Report, allowing a review of how pathways are being delivered. It was also noted that the Performance Report would evolve to provide more granular detail as part of an ongoing learning process. The Chair requested an update on how patient experience would be captured along outcome measures in relation to the PTL, emphasising the importance of measuring improvements in both outcomes and patient experience. ***Action 49 (item 3.1.0 – 25.07.2025 meeting)*** – Sarah Morley advised that additional information relating to PADR compliance had been included in the report for this cycle. It is also the intention to provide additional links to further detail for the November Board cycle. ***Action 51 (item 4.4.0 – 25.07.2025 meeting)*** – Non Gwilym advised that the Welsh Language team had been approached regarding Welsh Language compliance standards; benchmarking with other Health Boards is to be undertaken in relation to conducting all committees bilingually. This matter will be considered via the Governance Assurance and Risk Group and an update will follow at the November meeting. The Trust Board **agreed** the status of all open actions.	**NG** **AC** **SfM** **NG**
1.6.0	**Matters Arising** Sara Moseley, Chair	
	Non Gwilym outlined several points of clarification raised prior to the meeting by Board members: • The need to review wording around Workforce transformation in the Terms of Reference of the Research, Development & Innovation Committee. • Corrections to the Cancer Research Partnership documentation regarding references to the Trust (exclusion of “University” in organisation name). • An incorrect date had been observed in the Trust Seal Report. Non Gwilym confirmed that this had been corrected and republished ahead of the meeting.	

2.0.0	**KEY REPORTS**	
2.1.0	**Chair's Report** Sara Moseley, Chair The Chair covered her activity since commencing in post on the 1st September 2025 and highlighted the following: • Her intention to move at pace to get to know the organisation and its partners, in addition to attending inspirational sessions with Nursing and Research teams. • Ensuring and early focus on people and culture and on support for governance and accountability • Attendance at the Chairs' Peer Group meeting, noting the upcoming staff survey and the need for Board support and staff engagement. • The current external political environment, including NHS priorities and change and manifesto developments ahead off the May 2026 election and the need for Board awareness and preparedness. • Recognition of system-wide pressures affecting commissioners, partners, patients and carers, suggesting that future updates could focus on specific service areas for improved Board insight. Feedback in this regard was welcomed. • Independent Member interviews had been undertaken on the 5th and 8th of September, which had included a strong pool of candidates, all of which possessed direct experience of the Trust's services. The Trust's recommendations following interview have been shared with the Cabinet Secretary and a decision is expected imminently. 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 matters for the period August-September 2025: • Acknowledgement of recent staff changes, thanking the previous Chair (Donna Mead) following the conclusion of her tenure, Lindsay Foyster for her role as acting Chair during August and welcoming Sara as the new Chair. • The announcement of Carl James as Deputy Chief Executive for the next two years, in addition to the appointment of Lauren Fear as Director of Place, Portfolio and Partnerships, also for a period of two years. • The appointment of a new interim Executive Director for People and Organisational Development, Sarah Jenkins, who will commence in post on the 1st October. • Acknowledgement that this would be the current Executive Director of Organisational Development & Workforce, Sarah Morley's final Trust Board meeting, thanking her for her contribution as she retires at the end of October. • Ongoing internal and external activities, including his role as National Lead Chief Executive for cancer. Lindsay Foyster added her gratitude to Board members for their support during her period as Acting Chair. The Trust Board **NOTED** the content of the CEO's update report.	

DRAFT

3.0.0	**QUALITY, SAFETY & PERFORMANCE**	
3.1.0	**Performance Management Framework (July 2025)** Led by Carl James, Executive Director of Strategic Transformation, Planning and Digital/Deputy Chief Executive Officer, Anne Carey, Chief Operating Officer, Dr 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, Lauren Fear, Director of Place, Portfolio and Partnerships and Matthew Bunce, Executive Director of Finance Lauren Fear introduced the Performance Management Framework (PMF), advising that the automation of the current PMF would be paused until the implementation of all quality metrics is complete. Lauren also reported that Workforce and Wellbeing assurance had been reduced from Level 4 to 3, due to stagnant sickness levels and issues with culture and inclusion. Updates will follow. Nicola Williams stated that significant work is underway regarding pressure ulcer management, including drafting in external support from a tissue viability nurse due to current staff absence. The focus is prevention, risk management and reporting. Lauren Fear reported an increase in violence and aggression incidents in both the Welsh Blood Service and Cancer Service, attributing part of the rise to greater awareness and higher training rates leading to more reporting. A recent deep dive into the issue had been undertaken, with detailed findings to be shared following further review. Anne Carey advised that while emergency Radiotherapy patients are being seen on time, there are ongoing challenges with urgent patient pathways due to their complexity. Improvements are expected once the paperless system is fully implemented, which will help eliminate delays caused by paper-based processes. Anne added that the Patient Tracker List (PTL) would be transformational, allowing clear tracking of patient pathways and identification of bottlenecks. SACT (Systemic Anti-Cancer Therapy) performance remained good, with ongoing efforts to improve efficiency, with the PTL expected to support these improvements. Good overall performance had been maintained in the Welsh Blood Service overall, reporting strong results in the Red Cell Laboratory and time-expired platelets metrics. However, it was noted that these areas remain fragile due to legacy IT systems in the Red Cell laboratory and the daily volatility in managing platelets, requiring ongoing attention from the team. An improvement plan for the Red Cell Laboratory will focusing on workforce, training, and updating IT systems, with a national Laboratory Information Management System planned to replace the outdated system. Sarah Morley advised the following relating to Workforce KPIs: • Statutory and Mandatory training remains above target at 86% across the organisation, with targeted improvements for lower performing areas. • PADR (Performance Appraisal Development Review) remains above 80%; a revised process and paperwork have been in place for several months. It was suggested that better understanding of lower performing areas would be beneficial. • Sickness levels are at 5.09% (year to date), therefore not yet meeting the internal target of 4.7%. Action plans are in place, focusing on hotspot areas. It	

	is hoped that new leadership and targeted actions will enable the target to be reached by March 2026, informed by this year's staff survey. Carl Taylor reported one significant Business Continuity incident during the period, involving the Welsh Clinical Portal system; however, it was noted that the trend of such incidents is decreasing. Carl also advised on the upcoming migration from Windows 10 to Windows 11 across the Trust, for which the team is well-prepared. Cyber security also remains a key theme for the Board, with strengthened arrangements including an expanded cyber security team, action plan and additional capital investment sought from Welsh Government. Matthew Bunce explained that Welsh Government had agreed to an overall NHS Wales deficit position of £173 million for the year, mainly from Health Boards. By July, the reported deficit was £103 million, with significant financial risk and challenge reported. Matthew also highlighted that only 43%-50% of planned savings schemes across Wales had been developed, making delivery of the agreed position challenging. Should savings targets be unmet or activity plans not remain on track, the financial position will be impacted. Financial Key Performance Indicators were reported as follows: • Revenue position – On track with IMTP planning assumptions for break-even. • Capital position – Planning to spend within the capital resource limit. • PSPP – On track to receive the 30-day payment target for 95% of invoices. • Savings targets – all plans in place and agreed. • Variable pay – Progress shown towards reducing agency spend and variable pay. Lauren Fear reported that the introduction of the CAFM (Computer Aided Facilities Management) system across the Estates service has significantly supported performance in Planned Preventative Maintenance (PPM). Lauren advised that as a result of CAFM implementation, the Executive team had seen 100% achievement across PPM levels in the latest figures, attributing this improvement largely to the new system and positive staff feedback. Lauren added that the Welsh Government's consultation on the strategic decarbonisation plan is ongoing and that the emissions KPIs in the dashboard will need to be reviewed in light of this plan. The Trust Board: • **NOTED** the Performance Management Framework for assurance purposes. • **CONCURRED** with the levels of assurance noted in the report. • **NOTED** the appended finance report.	
3.2.0	**VUNHST Risk Register** Led by Non Gwilym, Interim Director of Corporate Governance Non Gwilym presented the risk register, highlighting ongoing work to review and manage risks and divisional oversight. The report also provided detail and outcomes from audits carried out in respect of static risks and sub-threshold risks. The importance of divisional leadership in managing risks was emphasised, with feedback that their involvement at committee level increases confidence in risk management.	

	Lindsay Foyster raised concerns regarding static risks, suggesting earlier review at six months rather than waiting twelve months, which Non agreed to consider for future practice. However, the Chair reiterated that it is the responsibility of all colleagues to undertake this. In relation to Risk 3735 it was queried whether the workshop arranged for the 3rd September 2025 referenced in the cover paper had gone ahead and a SMART action plan developed. Carl Taylor confirmed that the workshop had gone ahead and explained deployment order changes across Health Boards and current scheduling, with reassurance from recent successful deployments elsewhere. It was agreed to continue to monitor and update the Risk Register, with actions to improve review frequency and divisional engagement. The Trust Board: • **NOTED** the risks in the quality and safety domain with a score of 12 and risks in other domains with a score of 15 and above. • **NOTED** the static risks and sub-threshold risk audits.	
3.3.0	**Board Assurance Framework (BAF)** Led by Non Gwilym, Interim Director of Corporate Governance Non Gwilym provided an update on the Board Assurance Framework (BAF) related assurance processes, highlighting ongoing work to manage and review risks, including static risks, and their audit. The importance of reviewing static risks more proactively was recognised and it was agreed that this should be embedded in committee discussions. The need to align the BAF with strategic objectives and to ensure that actions and controls are current and effective was noted. Matthew Bunce noted an accuracy issue regarding the summary of the financial sustainability risks, advising that while the action score is listed as 16, the actual current score is 12. It was agreed to update this. The Trust Board: • **NOTED** the current status of the Board Assurance Framework. • **DISCUSSED** the plan to move forward with the Board Assurance Framework.	**NG**
4.0.0	**COMMITTEE ESCALATIONS**	
4.1.0	**Public Audit Committee Highlight Report (02/09/2025)** Led by Gareth Jones, Independent Member and Chair of the Audit Committee Gareth Jones highlighted one item of escalation following the September meeting of the Audit Committee: • Unresolved issues with the **Digital Health and Care Records (DHCR) project**, in particular that the transition to the new system had resulted in some loss of previous functionality in terms of patient records. • Funding for the next phase (phase two) of the project had not yet been secured and, while workarounds are currently in place, this will result in impact on productivity.	

	• Ongoing collaboration will address these issues and an update will be provided at the next meeting. Anne Carey added that outstanding elements from the first phase and key elements from the second phase had been identified and that weekly meetings had been set up with the Programme Manager to pragmatically progress the next phase. It was agreed that an update would be provided at the November meeting on the progress and clarity regarding the funding and next steps for the project, as there are a number of moving parts and more information is expected to be available by then. The Trust Board **NOTED** the content of the report and actions being taken.	**CT**
4.2.0	**Public Quality, Safety & Performance Committee Highlight Report (11/09/2025)** Led by Vicky Morris, Independent Member and Chair of the Quality, Safety & Performance Committee Vicky Morris highlighted one item of escalation, following the September meeting of the Quality, Safety & Performance Committee: Culture & Inclusion Report, particularly regarding the employee voice. Vicky emphasised the Committee's recognition of the need for a comprehensive Board discussion to understand the action plan in place to hear the patient voice and to ensure their effectiveness. It was noted that the overall level of assurance was influenced by the de-escalation of employee voice to Level 2. The Trust Board **NOTED** the key deliberations and highlights from the meeting of the Quality, Safety & Performance Committee and agreed levels of assurance in relation to the issues noted above.	
5.0.0	**CONSENT ITEMS FOR APPROVAL**	
5.1.0	**Amendments to Standing Orders, Scheme of Delegation and Standing Financial Instructions** Led by Non Gwilym, Interim Director of Corporate Governance and Matthew Bunce, Executive Director of Finance The Trust Board **APPROVED:** • 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 Circular WHC 2025/012 – Updates to NHS Wales SFIs for public procurement reforms ***(Appendix 3).***	
5.2.0	**Talbot Green Infrastructure – Revised Approach** Led by Lauren Fear, Director of Place, Portfolio and Partnerships	

	Lauren Fear advised that the Talbot Green Infrastructure is currently undergoing strategic realignment following Welsh Government feedback. The Trust Board **APPROVED** 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 2025/2026 financial year, to meet funding and strategic deadlines.	
6.0.0	**CONSENT ITEMS FOR NOTING**	
6.1.0	**Trust Seal Report** Led by Non Gwilym, Director of Corporate Governance (Interim) The Trust Board **NOTED** the Trust Seal Report for the period 22nd May 2025 – 18th September 2025.	
6.2.0	**Public nVCC Project Scrutiny Sub-Committee Highlight Report (16/07/2025)** Led by Hilary Jones, Independent Member and Chair of the nVCC Project Scrutiny Sub-Committee The Trust Board **NOTED** the nVCC Project Scrutiny Sub-Committee Highlight Report.	
6.3.0	**Culture and Inclusion Report** Led by Sarah Morley, Executive Director of Organisational Development & Workforce The Trust Board **NOTED** the Culture and Inclusion Report, also noting that further discussion would take place during the private session.	
6.4.0	**Wales Infected Blood Support Scheme (WIBBS) Annual Report 2024-25** Led by Lauren Fear, Director of Place, Portfolio and Partnerships A question was raised as to the governance route for the WIBBS Annual Report. Lauren Fear confirmed the route had been as it had been in previous years, with the Annual Report being received at the Velindre Shared Services Committee, as the WIBBS scheme is run by Shared Services and chaired by a Trust Executive (Lauren Fear). The Annual Report had then also been shared with the Trust Board for assurance purposes, as was the case in today's meeting. The difference with other years is due to the change in timing of the Velindre Shared Services Committee, which was now taking place following the Trust Board meeting. It was therefore agreed that Lauren Fear would confirm to the Trust Board whether there had been any further changes or amendments to the report, following the Velindre Shared Services Partnership Committee meeting. Secondly that the governance route was considered again prior to next year's report. The Trust Board **NOTED** the Wales Infected Blood Support Scheme (WIBBS) Annual Report 2024-2025 for assurance purposes.	**LF**
6.5.0	**Strategic Partnership Update** Update on the Cardiff Health Partners including Cardiff Cancer Research Partnership Led by Lauren Fear, Director of Place, Portfolio and Partnerships The Trust Board **NOTED** the Strategic Partnership Update.	

7.0.0	**COMMITTEE ANNUAL REPORTS 2024-2025**	
7.1.0	**Strategic Development Committee** Led by Lindsay Foyster, Vice Chair and Committee Chair The Trust Board **NOTED** the content of the Strategic Development Committee Annual Report.	
7.2.0	**New Velindre Cancer Centre (nVCC) Project Scrutiny Sub-Committee Annual Report** Led by Hilary Jones, Independent Member and Committee Chair The Trust Board **NOTED** the content of the nVCC Project Scrutiny Sub-Committee Annual Report.	
8.0.0	**ANY OTHER BUSINESS**	
	Sara Moseley, Chair No prior notice of any other business had been received.	
9.0.0	**DATE OF NEXT MEETING**	
	The next public meeting will take place on Thursday, 27th November 2025.	
10.0.0	**CLOSE**	

DRAFT

ACTION LOG	Column1	Column2	Column3	Column4	Column5	Column6	Column7
MEETING DATE	**AGENDA ITEM**	**Action number**	**ACTION**	**LEAD**	**DEADLINE DATE**	**UPDATE (including date)**	**STATUS**
23.05.2024			**REVISIONS TO SCHEDULE 3 OF TRUST STANDING ORDERS**				
	7.1.4	**3**	Terms of Reference for relevant Committees to be amended to include reference to requirements to demonstrate quality-led decision-making through receipt of Quality Assessments (at Committees where strategic decisions are undertaken).	Interim Director of Corporate Governance	**~~26/09/2024~~** **~~27/03/2025~~** **~~22/05/2025~~** **~~24/07/2025~~** **~~25/09/2025~~** **January 2026**	**November 2025** To be undertaken as part of wider review of Board and Committee development exercise. **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	**OPEN**
22.05.2025	**3.1.0**		**PERFORMANCE MANAGEMENT FRAMEWORK**				
		45	Report noting measures implemented and improvements evidenced regarding the long-standing risk regarding emails being received by clinicians and related benefits of the Go Paperless project. Provide update at a future Board meeting, noting the difference made by visibility of the patient pathway.	Chief Operating Officer Chief Operating Officer	**~~24/07/2025~~** **25/09/2025**	**November update:** Update on Cancer PTL data to be provided at November's Board meeting. **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.	**REOPENED AT SEPTEMBER MEETING - PROPOSE TO CLOSE AT NOVEMBER MEETING**
25.07.2025	**3.1.0**		**PERFORMANCE MANAGEMENT FRAMEWORK**				
		49	Facilitate monitoring progress of PADR levels, understanding differences between high and lowperforming 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	**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	**November update -** Benchmarking exercise undertaken by Welsh Language Manager. EMB to consider options at December meeting prior to GAR Group and Board decision. **September update** - Guidance sought from Welsh Language Manager - matter to be considered through Governance Assurance and Risk Group. Update to follow at November Board meeting.	**OPEN**
25.09.2025	**3.3.0**		**Board Assurance Framework (BAF)**				
		52	Correct accuracy issue in summary of financial sustainability risks; action score is listed as 16, however the current score is 12.	Interim Director of Corporate Governance	**27/11/2025**	Completed.	**PROPOSE TO CLOSE**
25.09.2025	**4.1.0**		**Public Audit Committee Highlight Report (Committee Escalations)**				
		53	Provide an update on the progress and clarity regarding funding and next steps for the Digital Health Care Record project.	Chief Digital Officer	**27/11/2025**	Phase 1 project has been closed. Scope for the next phase of DHCR has been agreed and monthly meetings are now established with the single record product team in DHCW who are now responsible for future development. The DHCW team is continuing to be funded by additional funding from WG	**PROPOSE TO CLOSE**
25.09.2025	**6.4.0**		**WIBBS Annual Report (Wales Infected Blood Support Scheme)**				
		54	Confirm to the Board whether any further changes have been made to the report following the Shared Services Partnership Committee meeting.	Director of Place, Portfolio and Partnerships	**27/11/2025**	**November update** - The report was received at the Shared Services Committee on 30th September. No amendments were requested. Therefore the report received at the September Board meeting will now be published.	**PROPOSE TO CLOSE**

Ymddiriedolaeth GIG Prifysgol Felindre Velindre University NHS Trust

Cancer PTL Data

Technoleg Iechyd Cymru Health Technology Wales

Gwasanaeth Gwaed Cymru Welsh Blood Service

Gwasanaeth Canser Felindre Velindre Cancer Service

Partneriaeth Cydwasanaethau Shared Services Partnership

Health Board breakdown per pathway

Average referrals per month

AB =111	C&V= 51
CTM= 61	SW=32

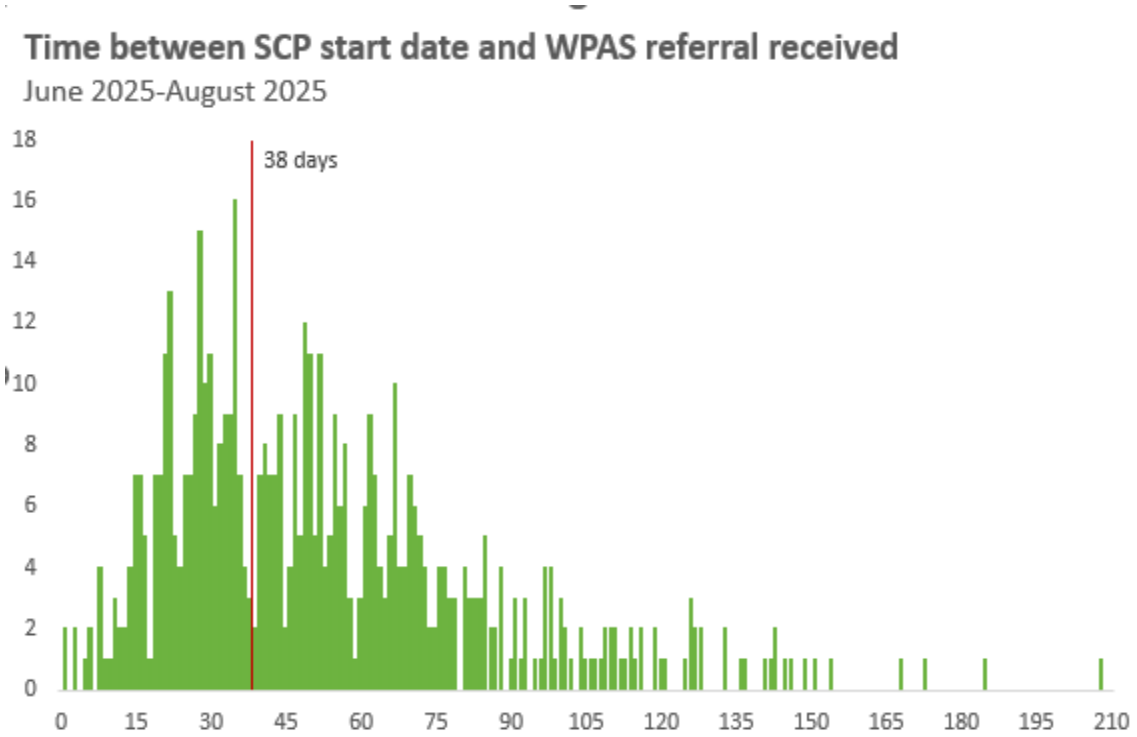
Number and % referrals for each HB Tumour site	ABHB Percentage referrals	CAV Percentage referrals	CTM Percentage referrals	SBUHB Percentage referrals	NULL Percentage referrals	Total Percentage referrals
Breast	25.45%	5.49%	33.88%	15.31%	6.67%	21.12%
Colorectal	17.07%	17.07%	20.22%	13.27%	4.44%	16.63%
Lung	13.77%	21.34%	15.85%	14.29%	4.44%	15.29%
Urological	16.77%	16.46%	9.84%	15.31%	11.11%	14.68%
Upper Gastrointestina	12.28%	17.07%	6.01%	17.35%	11.11%	12.38%
Head & Neck	3.29%	7.32%	3.83%	3.06%	40.00%	6.19%
Skin	5.69%	3.66%	2.19%	13.27%	0.00%	5.10%
Gynaecological	3.59%	6.10%	6.01%	3.06%	6.67%	4.73%
Uncertain Neoplasm	0.30%	1.83%	0.55%	4.08%	0.00%	1.09%
Unknown	0.00%	1.22%	0.55%	0.00%	11.11%	0.97%
Leukaemia/Lymphom	1.50%	0.61%	0.55%	0.00%	0.00%	0.85%
Neurological	0.30%	1.83%	0.00%	1.02%	2.22%	0.73%
Soft Tissue Tumours	0.00%	0.00%	0.55%	0.00%	0.00%	0.12%
Soft tissue/Bone	0.00%	0.00%	0.00%	0.00%	2.22%	0.12%

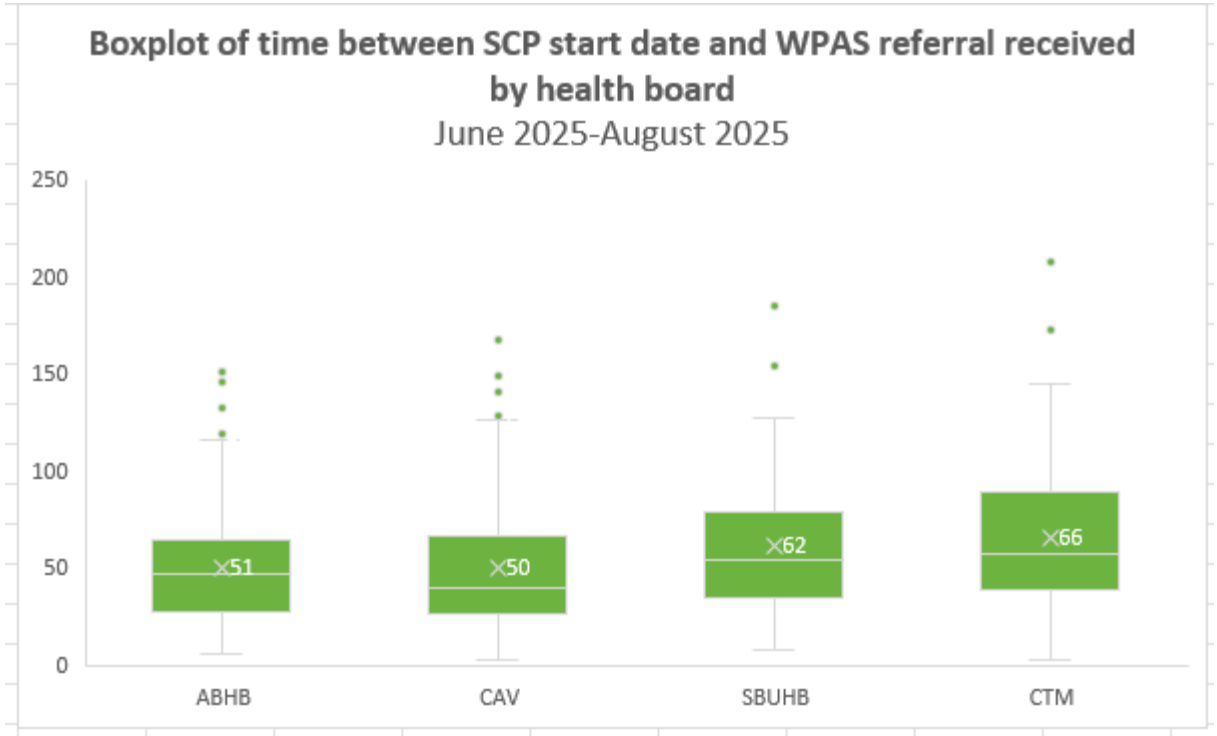
Number of days at point of referral to VCS

	ABHB		CAV		CTM		SBUHB			
Tumour site	Count	Average	Count	Average	Count	Average	Count	Average	Total Count	Total Average
Lung	46	52.2	35	48.3	30	74.0	14	53.9	125	56.5
Urological	36	66.5	26	73.8	15	76.1	10	106.4	87	74.9
Upper Gastrointestinal	31	37.6	27	40.9	11	50.4	12	55.6	81	43.1
Colorectal	27	51.8	25	40.3	23	85.1	5	46.0	80	57.4
Breast	26	32.0	9	42.6	8	19.5	2	21.0	45	31.4
Gynaecological	11	60.6	10	74.7	10	45.7			31	60.4
Head & Neck	9	41.4	9	42.9	6	52.8	3	54.3	27	45.9
Leukaemia/Lymphoma	5	103.8	1	14.0	1	109.0			7	91.7
Skin	1	21.0	1	37.0	2	36.5	1	86.0	5	43.4
Uncertain Neoplasm	1	42.0	3	19.3	1	62.0	4	35.0	9	33.6
Neurological	1	16.0	3	38.7					4	33.0
Unknown primary			1	50.0					1	50.0
NULL			1	78.0					1	78.0
Soft Tissue Tumours					1	44.0			1	44.0
Grand Total	194	51	151	50	108	66	51	62	504	55

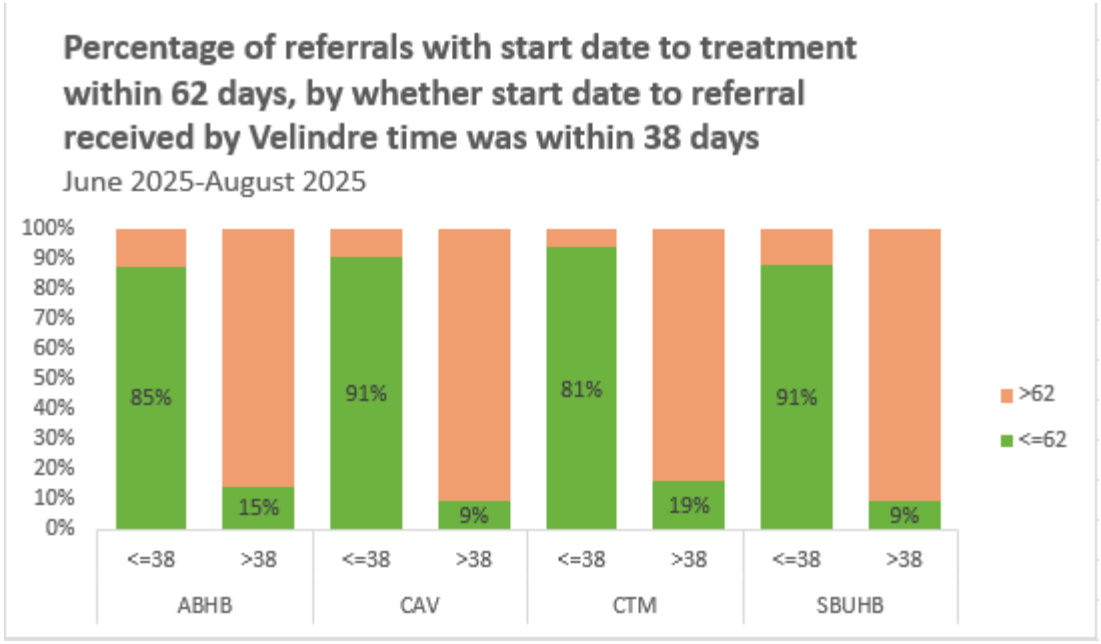
Breakdown per Health Board

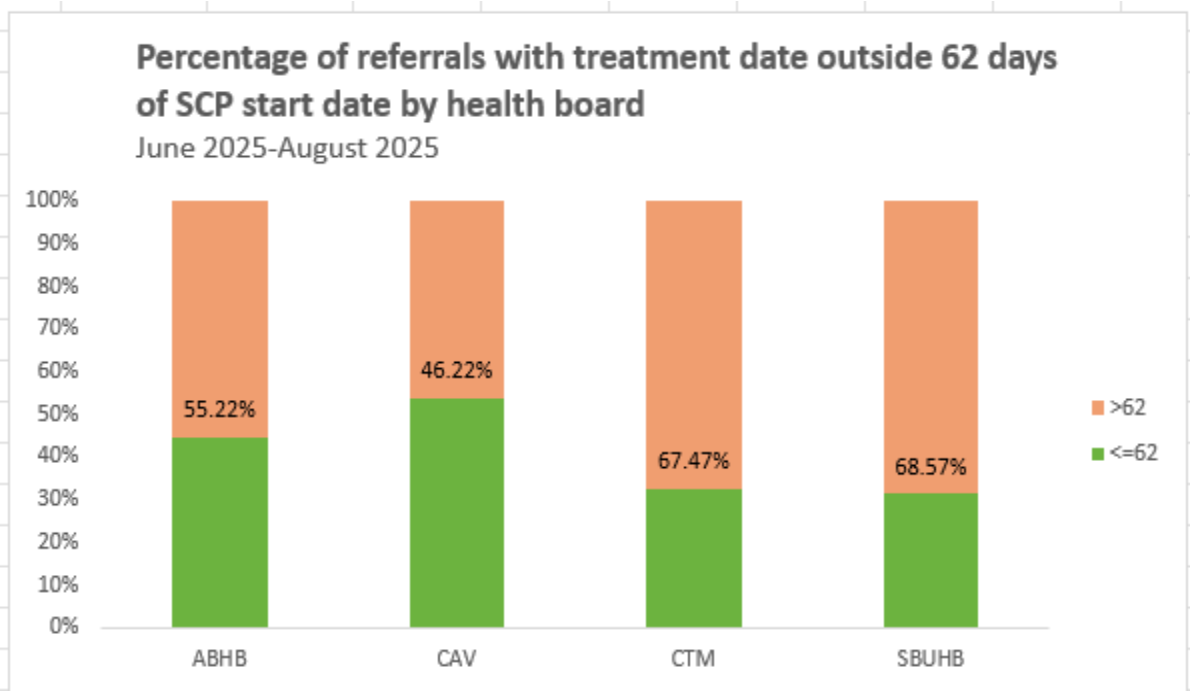
Against 38day milestone



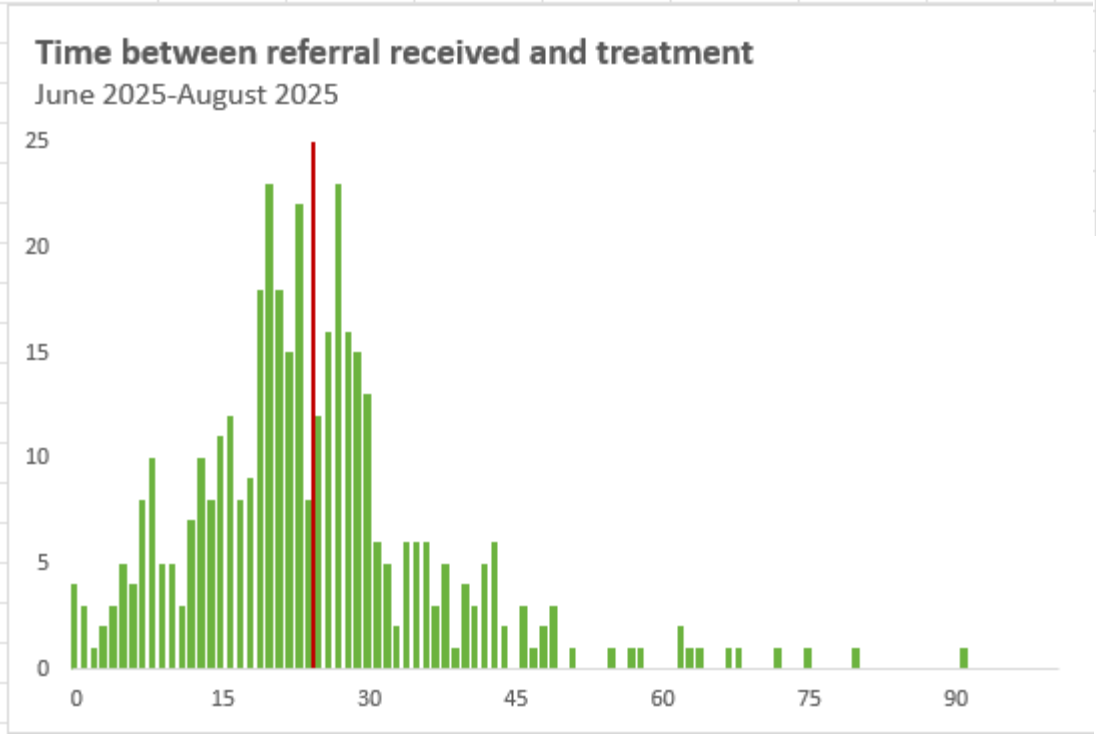


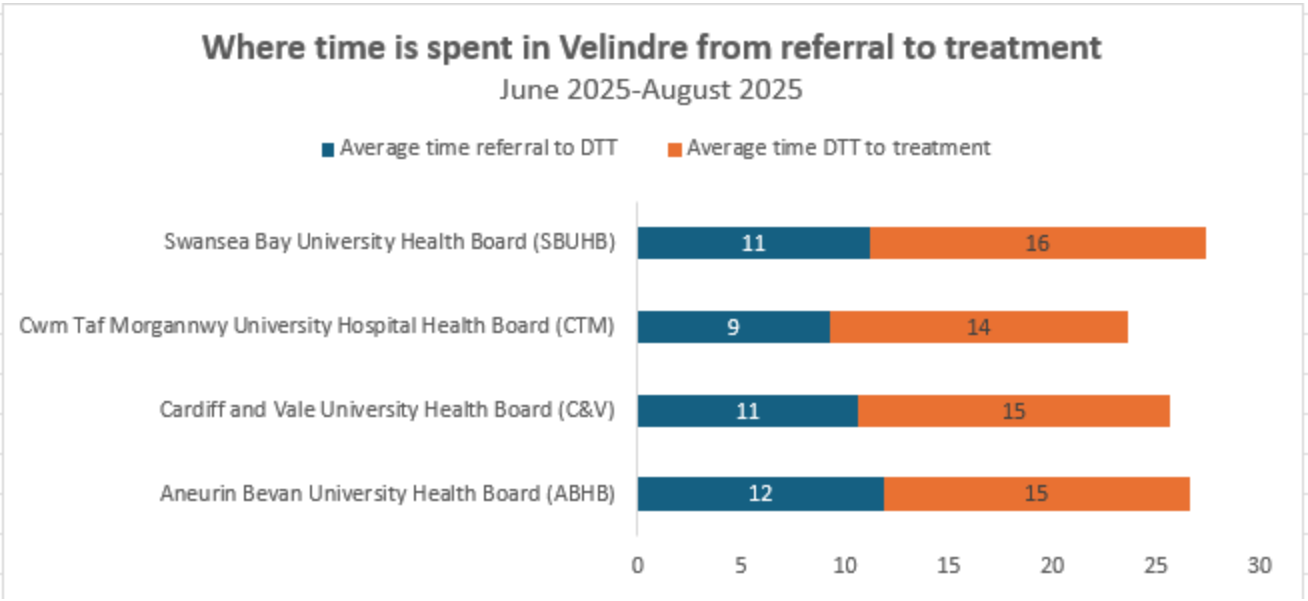
SCP Performance @ VCS





Post referral to VCS





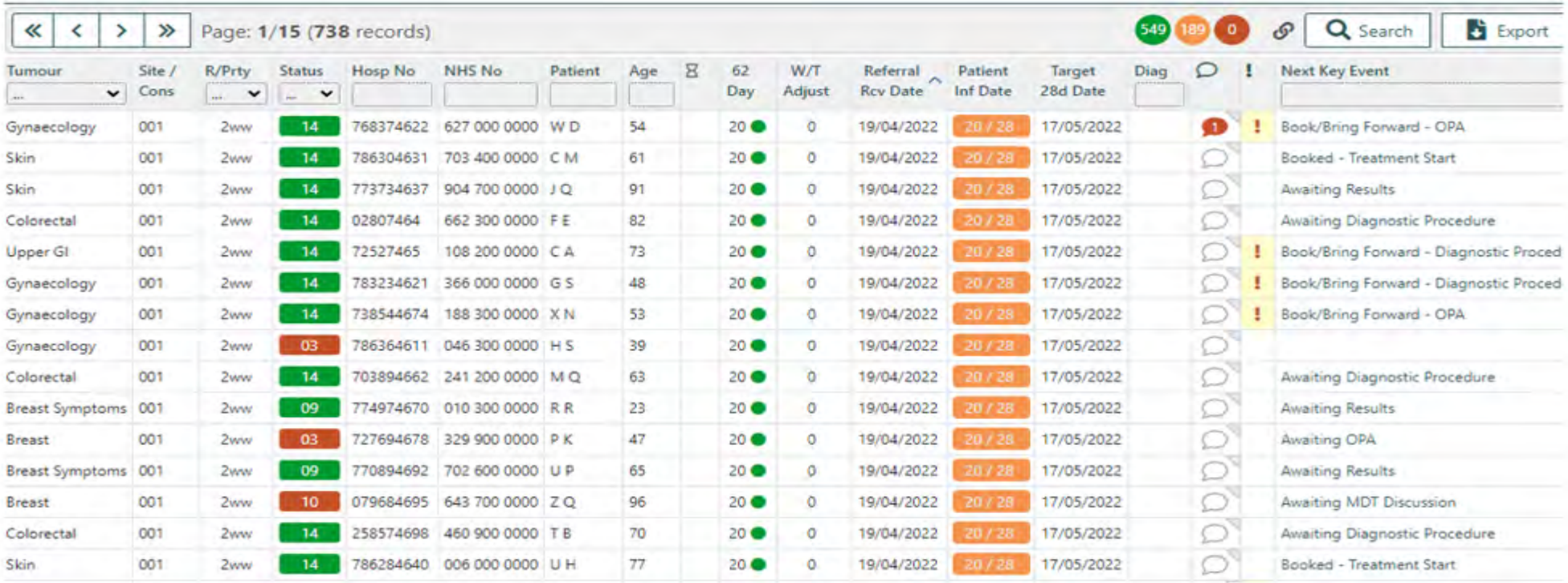
1. average = 26 days
2. aim to get this <24days
3. remove the tail ~ 40% of patients
4. Bring the DTT decision to MDT/ Post MDT

Next Steps

- Agree data requirement to populate 62day PTL with each of the HBs
- Urology needs Urgent work - supported by DHCW and Urology CIN.
- Quick wins
  - Breast looks like it could be improved relatively easily
  - Variation across the HBs / local best practice to share

Resources available to help = Shared PTL

- PTL enables system focus on the SCP (0-62day)
- Shared PTL for the SCP/ 62day component (inc SCP patients not being referred to vCS)
- Visibility of patients from HBs to VCS



Page: 1/15 (738 records) 549 189 0 Search Export

Tumour	Site / Cons	R/Prty	Status	Hosp No	NHS No	Patient	Age	62 Day	W/T Adjust	Referral Rcv Date	Patient Inf Date	Target 28d Date	Diag	Next Key Event
Gynaecology	001	2ww	14	768374622	627 000 0000	W D	54	20	0	19/04/2022	20 / 28	17/05/2022		Book/Bring Forward - OPA
Skin	001	2ww	14	786304631	703 400 0000	C M	61	20	0	19/04/2022	20 / 28	17/05/2022		Booked - Treatment Start
Skin	001	2ww	14	773734637	904 700 0000	J Q	91	20	0	19/04/2022	20 / 28	17/05/2022		Awaiting Results
Colorectal	001	2ww	14	02807464	662 300 0000	F E	82	20	0	19/04/2022	20 / 28	17/05/2022		Awaiting Diagnostic Procedure
Upper GI	001	2ww	14	72527465	108 200 0000	C A	73	20	0	19/04/2022	20 / 28	17/05/2022		Book/Bring Forward - Diagnostic Proced
Gynaecology	001	2ww	14	783234621	366 000 0000	G S	48	20	0	19/04/2022	20 / 28	17/05/2022		Book/Bring Forward - Diagnostic Proced
Gynaecology	001	2ww	14	738544674	188 300 0000	X N	53	20	0	19/04/2022	20 / 28	17/05/2022		Book/Bring Forward - OPA
Gynaecology	001	2ww	03	786364611	046 300 0000	H S	39	20	0	19/04/2022	20 / 28	17/05/2022		
Colorectal	001	2ww	14	703894662	241 200 0000	M Q	63	20	0	19/04/2022	20 / 28	17/05/2022		Awaiting Diagnostic Procedure
Breast Symptoms	001	2ww	09	774974670	010 300 0000	R R	23	20	0	19/04/2022	20 / 28	17/05/2022		Awaiting Results
Breast	001	2ww	03	727694678	329 900 0000	P K	47	20	0	19/04/2022	20 / 28	17/05/2022		Awaiting OPA
Breast Symptoms	001	2ww	09	770894692	702 600 0000	U P	65	20	0	19/04/2022	20 / 28	17/05/2022		Awaiting Results
Breast	001	2ww	10	079684695	643 700 0000	Z Q	96	20	0	19/04/2022	20 / 28	17/05/2022		Awaiting MDT Discussion
Colorectal	001	2ww	14	258574698	460 900 0000	T B	70	20	0	19/04/2022	20 / 28	17/05/2022		Awaiting Diagnostic Procedure
Skin	001	2ww	14	786284640	006 000 0000	U H	77	20	0	19/04/2022	20 / 28	17/05/2022		Booked - Treatment Start

IDEAL PATHWAY

62-DAY CANCER PATHWAY

STAGE	TIMEFRAME	DESCRIPTION
Referral	Day 0	Initial referral following suspicion of cancer
First Appointment	Day 1–14	Patient's first clinical consultation
Diagnostic (FDS Standard)	*Day 14–28*	*Investigations including imaging and biopsy*
MDT Discussion	Day 28–35	Multidisciplinary team reviews case and plans treatment
Referral to Cancer Centre	Day 35–38*	Transfer to Surgical /Oncology centre for treatment
Treatment	Day 38–62	max **24days** post centre referral to start of first definitive treatment

Diolch

TRUST BOARD	
CHAIR'S UPDATE REPORT	
DATE OF MEETING	27 November 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	Helen Rees-Jones, Executive Assistant
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:

- Update on VUNHST Chief Executive
- NHSBT Board Dinner, Clayton Hotel, Cardiff, 29th September
- Continued introductory meetings with Exec Team / Independent Members (throughout September and October) and patient representative David Cogan
- Introductory meetings with other NHS Wales Chairs (throughout October)
- Independent Members' Group, 2nd October
- Meet and greet with COO and VCS tour, 2nd October
- More Than Just Words, Stakeholder Event, 9th October – Metropole Hotel, Llandrindod Wells
- Cabinet Secretary official opening of Velindre @ Nevill Hall Radiotherapy Unit, 16th October
- Employee Excellence Awards, 21st October – Cornerstones, Cardiff
- Board Development Session, 23rd October
- One to one meeting with Cabinet Secretary Jeremy Miles
- nVCC site visit 31st October
- Topping Out Ceremony, 18th November - nVCC
- Independent Members meeting 20th November– Cardiff

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Update on VUNHST Chief Executive

Carl James has taken up the role of Trust interim Chief Executive following David Donegan's departure from the role. We want to thank David for his contribution during his time with the Trust.

Dr Jacinta Abraham, the Trust's Medical Director, will become the Deputy Chief Executive. Both have previous experience of undertaking these roles within the Trust.

The Trust is committed to an ambitious programme of transformation and improvement, with the needs of our patients and donors at the centre of everything we do. We deeply value and appreciate the ongoing dedication and commitment of all our colleagues throughout the organisation, whose efforts are vital to our continued success.

3.2 Engagement with NHS Blood and Transplant Board

I joined colleagues at the Welsh Blood Service in a meeting with members of NHS Blood and Transport Board. The visit provided a valuable opportunity to share best practice, explore common challenges, and discuss future plans for blood and transplant services across the UK. Strategic conversations around workforce, quality and safety, supply chain resilience, and innovation were had, and coming together highlighted the shared commitment of both organisations to delivering high-quality, donor and patient focused services and working collaboratively to meet the evolving needs of the NHS.

3.3 Continued introductory meetings with Board members (Executive and Independent Members) and Chair of the Trust's Patient and Carer Partnership Board

I continued to meet with all members of the Executive team, learning about individuals' roles and responsibilities and how they contribute to the workings of the Trust. During this period, we welcomed Ceri Doyle as our newest Independent Member. I have also continued to meet with the Board's Independent Members to understand the areas that they champion and to discuss our objectives as we begin to work together.

It was also a privilege to meet the Chair of the Patient and Carer Partnership Board David Cogan and hear about the wonderful work that the Board is doing to ensure that patient and carer voices are integrated into structures, decision making and planning processes within the organisation. Our Patient Story today is, as a result of those discussions. I will also be attending the next meeting of the Board in a few weeks' time.

3.4 Introductory meetings with other Welsh Chairs

I continue to meet with NHS Wales Chairs to discuss collective challenges we all face.

3.5 Visit to Velindre Cancer Centre

I was privileged to be invited to a staff meet and greet and tour around Velindre Cancer Centre in October. I met with Anne Carey, our Chief Operating Officer and was then shown around our existing facilities and briefly met the various teams and departments that collectively offer the outstanding services that we provide. I spent time with the facilities staff, medical secretaries and the clerical staff who are

the contact point for so many of our patients. I was inspired by all the amazing staff that we have that work at the centre and am assured that we have the best resources in place to assist with provision of the best outcomes to our patients and their families.

3.6 More Than Just Words Stakeholder event

Welsh Language Manager Jo Williams and I represented the Trust at the *"Mwy na Geiriau/More Than Just Words"* stakeholder conference in Llandrindod Wells. The Welsh Government's *Mwy na Geiriau* framework aims to embed the Welsh language in health and social care so that people can access the care that they deserve and require.

During the event, we heard from a Velindre patient who spoke about the value and comfort of receiving care from her nurse in Welsh and how difficult it was to receive that provision consistently.

The day's discussions provided an opportunity to appreciate the work happening across the sector to bring the framework to life, and to reaffirm the Trust's commitment to delivering services that reflect the linguistic needs of our communities.

3.7 Cabinet Secretary official opening of Velindre @ Nevill Hall Radiotherapy Unit

I met with the Cabinet Secretary for Health and Social Care, Jeremy Miles MS and members of the Aneurin Bevan University Health Board at the official opening of the Velindre @Nevill Hall Radiotherapy Unit - a state-of-the-art facility designed to enhance cancer care across South East Wales. The Unit cares for breast cancer, prostate cancer and palliative radiotherapy patients who meet a set of clinical criteria and is an extension of our Cancer centre in Cardiff. It will reduce waiting times and travelling time for patients in the locality.

Patients from across South East Wales and Powys who are referred for radiotherapy at Velindre Cancer Service will receive their treatment at either the Velindre Cancer Centre in Whitchurch or the Velindre @ Nevill Hall Radiotherapy Unit, depending on clinical need and appointment availability.

I want to thank everyone for their commitment to delivering this project which is supporting the transformation of cancer services and care for the communities we serve.

3.8 Employee Excellence Awards

I was proud to have attended the Trust's annual Employee Excellence Awards, hosted this year by Sean Holley, one of our Charity Ambassadors.

It was humbling to see so many deserving nominees and winners and a great opportunity for me to meet so many of our workforce in such positive circumstances.

Thank you to everyone involved in arranging the event, and to the individuals who spoke to me about themselves, and to the Communications team for filming and posting their stories.

3.9 Board Development Session

During our October Board Development session, we discussed our future plans for Board development, governance and culture. We also held a session on assurance training and about our approach to managing the Trust's portfolio of programmes and projects.

It was a varied, informative agenda session and I would like to thank all colleagues for their participation and contributions.

3.10 One to One meeting with the Cabinet Secretary (Welsh Government)

I had my first one to one meeting with Cabinet Secretary Jeremy Miles MS, where my objectives as Chair were confirmed. I am now working with Board colleagues to ensure that we are aligned for the rest of the year. Jaqueline Totterdell, the new Chief Executive of NHS Wales, and Director General of Health and Social Care joined us and is especially interested in hearing from us about how we play a convening role in cancer research across Wales.

3.11 nVCC Site Visit

I was fortunate to be able to join members of the new Velindre Cancer Centre project team for a tour of the site of the new centre, and to see at first-hand the fantastic progress that is being made. Many construction milestones have already been achieved as we get ever closer to opening the new home of the cancer service in Spring 2027. I am incredibly proud of the progress made so far and am thankful to everyone working so passionately to bring this project to life.

3.12 Topping Out Ceremony

The custom of "topping out" a new building is of Scandinavian origin and involves a tree spruce being placed at the top of a new building – a tradition that signifies that the final beam in the build has been fitted.

Topping out the new Velindre Cancer Centre in the company of the Trust project team, the fantastic Sacyr construction team, colleagues from the Acorn consortium, Welsh Government and local political representatives including the local Member of the Senedd and local councillors provided a moment to reflect – reflect and recognise the dedication and collaboration that have brought us this far in delivering what will be a world-class cancer care with the care and support of our patients and staff at its very core.

3.12 Independent Members Meeting

The Independent Members group face to face in November to consider a range of issues facing the Trust, and specifically the configuration and structure of the Board's Committees.

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.

4 RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

TRUST BOARD

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

DATE OF MEETING	27/11/2025
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. Carl James, Executive Director of Strategic Transformation, Planning and Digital/Deputy Chief Executive Officer 2. Anne Carey, Chief Operating Officer 3. Nicola Williams, Executive Director of Nursing, AHP & Health Science & Dr Jacinta Abraham, Executive Medical Director 4. Kate Hannum, Director VCS 5. Alan Prosser, Director WBS, 6. Sarah Jenkins, , Interim Executive Director OD & Workforce, 7. Carl Taylor, Chief Digital Officer, 8. Lauren Fear, Director of Place, Portfolio & Partnerships 9. Matthew Bunce, Executive Director of Finance
APPROVED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital/Deputy Chief Executive Officer

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

RECOMMENDATION / ACTIONS	**The Trust Board is asked to take ASSURANCE from the Performance Management Framework for the month of September 2025.**

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
WBS SLT/ Performance Review	(8/10/2025)
VCS Tri / Performance Review	(22/10/2025)
Quality Safety and Performance Committee	(13/11/2025)

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS
The report has been considered and endorsed at the VCS and WBS Performance Review meetings, Executive Management Board and the QSP Committee and is presented to the Quality Safety and Performance Committee for assurance on the Trust's performance for the month of September 2025.

The following matters of note were discussed at EMB and are recorded here to aid the QSP Committee in receiving this report with that context laid out.

- **Section 1** now includes an overall High-level Quality Performance Summary table with a selection of the most critical Quality and Performance KPIs taken from the full PMF Scorecards in Section 3. Section 2 includes a number of slides 'by exception' reports
- **Radiotherapy** the high level of RT referrals (228) occurred in the month of September were managed successfully
- **SACT** following the application of the Welsh Government breach recording methodology, the reported SACT Non-emergency and Emergency performance has decreased. We will continue to shadow report to ensure that the care provided to patients is not impacted and continues to benchmark well with other services across Wales.
- **WBS** overall performance remains positive for September with improvements in Stem Cell collection and Time expired platelets
- **Workforce and OD** shows continued strong performance against Statutory and Mandatory training and an improving PADR trend towards full yearend compliance. However, there are a number of 'hot spots' where staff sickness remains high, impacting on performance against the Trust-wide target
- **Digital and FRESH** continue to show improvements
- **The Performance Management Framework** (PMF) Scorecards, in Section 3, are now based on 'domains' in the Quality Dashboard, namely Safe, Timely, Effective, Efficient, Equitable and Person Centred (STEEEP).

In addition, the following matter was discussed at the QSP Committee for escalation to Trust Board.

- The Chief Operating Officer took QSP through a detailed presentation on changes to the recording of SACT performance, regarding Single Cancer Pathway, the next steps to be taken and meetings reporting back to QSP Committee. ***See Performance slide deck.***

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]	**Level 3 – Actions for symptomatic, contributory and root causes, impact from actions and emerging outcomes**
Digital Services [Trend – decreased from 4]	**Level 3 - Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes**
Estates, Infrastructure and Sustainability [Trend – Increase from 3-4 29th Sept EMB]	**Level 4 – Increased extent of impact from actions**
\Health and Safety [Trend – Increase from 2-3 29th Sept EMB]	**Level 3 – Actions for symptomatic, contributory and root causes, impact from actions and emerging outcomes**
Financial Performance [Trend – stable at 4]	**Level 4 – Increased extent of impact from actions**

APPENDICES	
	Not Applicable

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**
OMB	**Operational Management Board**
SMART	**Relating to goal setting "Specific, Measurable, Achievable, Relevant, Timely"**
SPC	**Statistical Process Control Charts**
WBS SLT	**Welsh Blood Service Senior Leadership Team**
VCS Tri	**Velindre Cancer Service Triumvirate**
VAI	**Velindre Acquired Infections**
VUNHST	**Velindre University NHS Trust**
WHC	**Welsh Health Circular**
WHO	**World Health Organisation**

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

1.1 Overall High-Level Quality Performance Summary

A selection has been made of the most critical Quality Performance Management Framework (PMF) Key Performance Indicators (KPIs), taken from the full PMF Scorecards. This Trust-wide Scorecard table (presented below) is followed by a number of PowerPoint slides highlighting certain issues 'by exception'.

1.2 Work has commenced to propose the full range of quality and safety metrics that need to be in place at Board level. 35 KPIs have been included, and this work will be concluded by January after going through governance cycle for approval e.g. RT 30-day mortality data collection and Inpatient mortality benchmarking target

Quality Domain	Trust-wide Safety Scorecard			Performance as at Month 6 (September)			Compliance against Target or Standard		Slide Ref
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Safe	Total Number of Velindre Acquired Infections (VAIs) across all bacteraemia types **(WHC 2024 (38) target)** Cumulative 25/26 versus 24/25	**National**	**Monthly**	**23/24 Base 13**	**<13 24/25**	**3 25/26**	✓	➔	
	SACT 30 Day Mortality Benchmark	**Curative**	**Monthly**	**2.00%**	**2.00%**	**0.06%**	✓	➔	
	SACT 30 Day Mortality Benchmark	**Palliative**	**Monthly**	**2.00%**	**2.00%**	**1.24%**	✓	➔	
	Inpatient Mortality Target under development/to be agreed	**Inpatient**	**Monthly**	**TBA**	**TBA**	**4**			
	Number of National Reportable Incidents	**National**	**Monthly**	**0**	**0**	**0**	✓	✓	
	WBS Serious Adverse Blood Reactions & Events (SABRE) incidents reported to regulator / licensing authority	**Local**	**Monthly**	**0**	**0**	**2**	✗	➔	**Minor Variance**
	Overdue Actions from open Serious Adverse Blood Reactions & Events (SABRE) / Serious Adverse Event or Reaction (SAEARs) actions	**Local**	**Monthly**	**New**	**<5%**	**10.6%**	✗	🡻	Pages 18-24
	Number of incidents triggering Duty of Candour	**National**	**Monthly**	**0**	**0**	**1**	✗	➔	**Minor Variance**

Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving 🡹 stable ➔ fluctuating 🡹🡻 deteriorating 🡻

Quality Domain	Trust-wide Timeliness Scorecard			Performance as at Month 6 (September)			Compliance against Target or Standard		Slide Ref
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Timely	Scheduled Radiotherapy Patients Treated 80% within 14 Days and 100% within 21 Days	National	Monthly	29% 47%	80% 100%	82% 21days	✗	🡻	Pages 9-12
	Urgent Symptom Control Radiotherapy Patients Treated 80% within 2 Days and 100% within 7 days	National	Monthly	6% 50%	80% 100%	86% 7 days	✗	🡲	Pages 9-12
	Emergency Radiotherapy Patients Treated 80% within 1 day and 100% within 2 days	National	Monthly	94% 100%	80% 100%	100% 2 days	✓	🡹	
	% Patients Beginning Non-Emergency SACT within 21 days NEW WG TARGET FROM SEPT	National	Monthly	98%	98%	67%	✓	🡹🡻	Pages 13-17
	% Patients Beginning Emergency SACT within 5 days NEW WG TARGET FROM SEPT	National	Monthly	100%	98%	75%	✓	🡹	Pages 13-17
	WBS Turnaround times – antenatal	Best Practice	Monthly	96%	90%	93.2%	✓	🡻	
	WBS Turnaround times – Red Cell Reference Serology	National	Monthly	70%	90%	85%	✗	🡻	Pages 18-24
	WBS Turnaround times – Foetal RHD Screening	Best Practice	Quarterly	New	90%	100%	✓	🡲	
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving 🡹 stable 🡲 fluctuating 🡹🡻 deteriorating 🡻									

Quality Domain	Trust-wide Effectiveness Scorecard			Performance as at Month 6 (September)			Compliance against Target or Standard		Slide Ref
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Effective	Number of Cancer Pathway of Care Delays	National	Monthly	1	0	3	✗	🡲	Minor Variance
	Clinical demand for red cells met (% manufactured to issued)	Best practice	Monthly	104%	100%	97%	✗	🡻	Minor Variance
	Clinical demand for platelets met (% manufactured to issued)	Best practice	Monthly	133%	100%	112%	✓	🡻	
	New stem cell volunteers	National	Monthly	3341	333	467	✓	🡹	
	New Apheresis Donors	Local	Quarterly	21	14	14	✓	🡻	
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving 🡹 stable 🡲 fluctuating 🡹🡻 deteriorating 🡻									

Quality Domain	Trust-wide Efficient Scorecard			Performance as at Month 6 (September)			Compliance against Target or Standard		Slide Ref
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 24	Target	Actual	In Month Position	Cumulative data trend	
Efficient	% uptime of critical digital systems (% availability by service, excl. planned maintenance windows)	Local	Monthly	N/A	99%	N/A	✓	→	
	Financial Balance – achievement of Trust forecast (£k) in line with revenue expenditure profile	National	Monthly	£0	£0	£4k	✓	↑↓	Minor Variance
	Trust expenditure (£k) on Bank and Agency staff against target budget profile	National	Monthly	£180k	£180k	£236k	✗	↑↓	Page 31
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↑↓ deteriorating ↓									

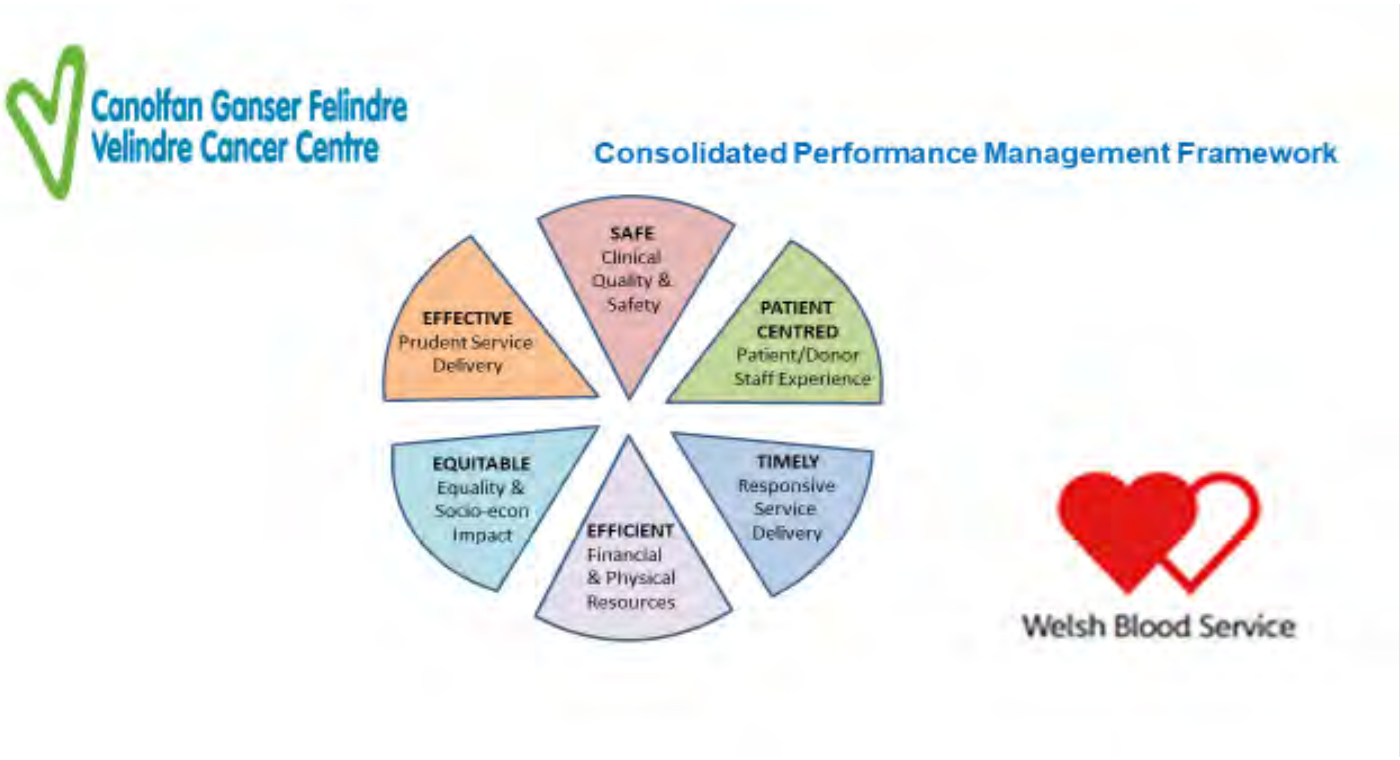
Quality Domain	Trust-wide Equitable Scorecard – Trust-wide position			Performance as at Month 6 (September)			Compliance against Target or Standard		Slide Ref
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Equitable	Diversity of Workforce – % Black, Asian and Minority Ethnic people	Local	Quarterly	5.18%	6%	7.15%	✓	→	
	Diversity of Workforce – % People with a Disability within workforce	Local	Quarterly	4.63%	22%	6.64%	✗	↑	
	% of Workforce who have declared Welsh Language Listening/Speaking capability	National	Quarterly	89.37%	100%	95.81 %	✗	↑	Minor Variance
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↑↓ deteriorating ↓									

Quality Domain	Trust-wide Experience Scorecard			Performance as at Month 6 (September)			Compliance against Target or Standard		Slide Ref
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Person Centred	% of Patients Who Rate Experience at VCS as good or very good	Prof. Std.	Monthly	95	85%	96%	✓	→	
	% of 'formal' VCS concerns responded to within 'Putting things right' regulations timescale	Local	Monthly	100	85%	100%	✓	→	
	Blood donors that rate their experience as excellent	UK Blood Services	Monthly	95%	85%	88.8%	✓	↑	

	Resolution of WBS formal concerns within 'Putting Things Right' regulations timescale	**National**	**Monthly**	**100%**	**100%**	**100%**	✓	➔	
	% Personal Appraisal Development Reviews (PADR) compliance staff appraisal carried out by managers	**Prof. Std.**	**Monthly**	**73%**	**85%**	**81%**	✗	↑↓	Page 25
	% Rolling average Staff sickness levels	**National**	**Monthly**	**6.22%**	**3.54% 4.70%**	**5.11%**	✗	↑	Page 25
	Number of Incidents of violence and aggression to staff Trust-wide for 2025/26	**Local**	**Monthly**	**N/A**	**27 25/26**	**2 Sep 25 cum**	✗	↓	**Minor Variance**
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving ↑ stable ➔ fluctuating ↑↓ deteriorating ↓									

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

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

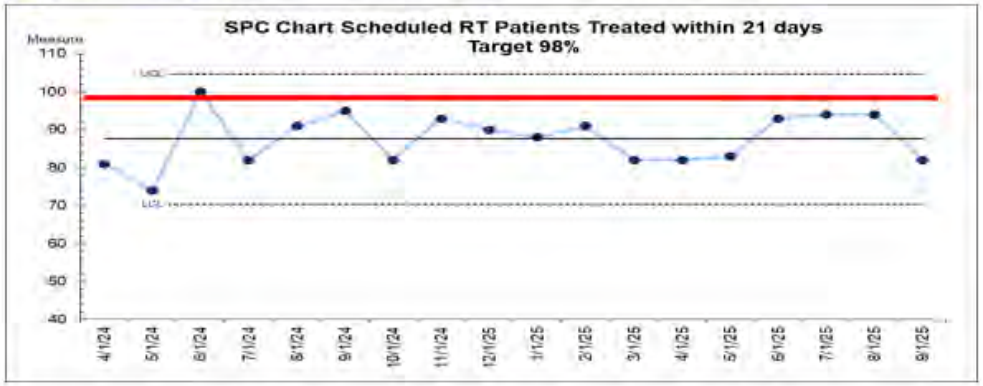


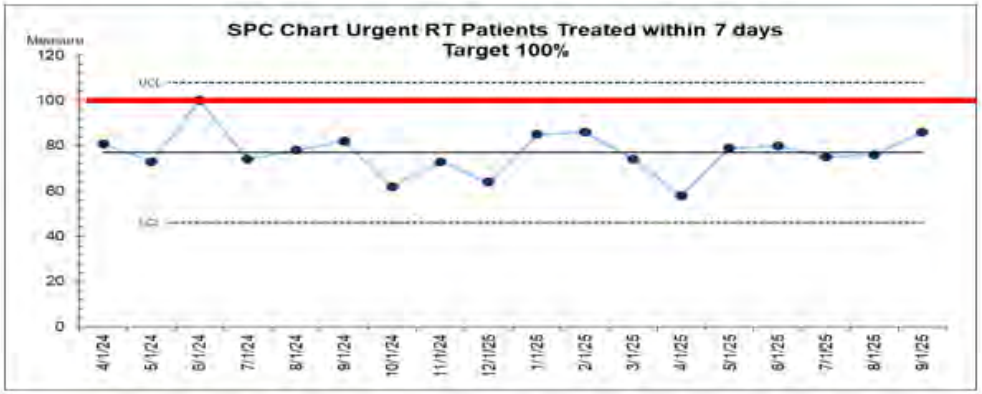
2.2 The following PMF PowerPoint slides highlight the key issues for the attention of the Trust Board, (on an exception basis), identified and discussed by the previous Executive Management Board and Quality Safety and Performance Committee meetings.

2.3 Velindre Cancer Service

Radiotherapy Waiting Times activity

September 2025





Performance update: September

All Wales Quality Metrics Group consensus in RT that **no suspensions** will be allocated to pathways and breaches to be reported as avoidable and unavoidable

- 100% emergency patients treated within target: 2 days
- Scheduled performance against 21-day target was 82%
- Urgent scheduled care performance 86% increase from 76% in august
- Elective delay performance was 97%
- Planned linac capacity up to 76hrs per day
- Overall linac uptime 98.27% including at V@NHHRU
- Planned pre-treatment CT capacity up to 24.5hrs per day including V@NHHRU

Radiotherapy Waiting Times activity

September 2025

Update from last month

- V@NHHRU fully operational with breast, prostate and palliative in line with business case. Activity is managed as part of total radiotherapy activity for VCS.
- Planning commenced on upgrade of LA6, capacity at V@NHHRU being utilised for breast patients

Risks/issues

- Fragility of existing fleet (LA7, LA8) due to aging equipment and consequential breakdown of linacs. Additional capacity sourced from V@NHHRU and LA1 where instances occur.
- LA1 is out of support and is only used if LA7 or LA8 is broken down.

Mitigation

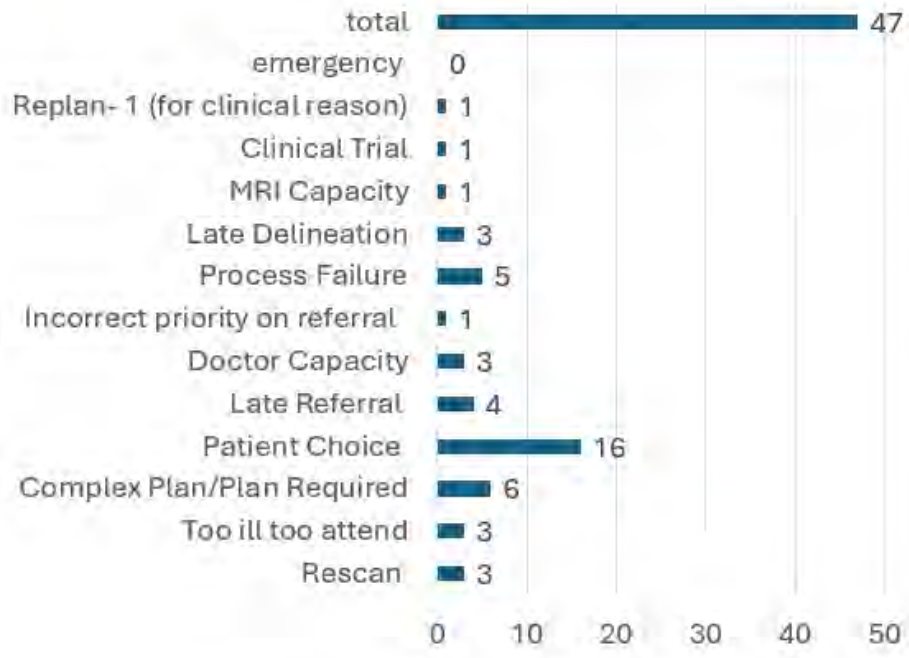
- The implementation of Aria Core Insights through IRS will result in more sophisticated pathway analysis and reporting and targeted improvement proposals
- Implementation of Carepath for Radiotherapy IR(ME)R practitioners – improved visibility of the pathway
- Weekly MDT capacity planning meeting to review any capacity concern and forecast planning for following week
- Where demand exceeds capacity, all referrals are submitted through escalation for clinical prioritisation.

Actions for next month

- V@NHHRU project closure October 2025
- Validated and unvalidated performance for RT to be presented in October following decision at All Wales Quality Metrics group
- Income – Review of EHFRT – Prostate under discussed with commissioners awaiting formal decision in relation to decrease in fractionation and increase in complexity leading potential loss of income due contract currency.

September 2025

Radiotherapy - breaches



Actions:

- Service level pathway development identifying best practice and efficiencies is ongoing, this has been integral to the development of Carepath
- Linac service days have been streamlined to ensure all available clinical capacity is available
- Additional resource allocated to be escalated where there is a risk to capacity
- 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

Linac Utilisation September 2025

Treatment machine	No. patients	Number of fractions	Active days in range	Mean Daily Fractions	Median Daily Fractions	Range
LA2TrueBeam	115	569	22	25.9	25.5	13 to 40
LA3Halcyon	80	585	21	27.9	27	23 to 35
LA4TrueBeam	103	475	21	22.6	23	16 to 27
LA5Halcyon	13	497	21	23.7	23	8 to 35
LA6Halcyon	78	400	14	28.6	28	24 to 41
SRU1Ethos	54	323	21	15.4	13	7 to 30
SRU2Ethos	45	210	17	12.4	15	1 to 26
LA7Synergy	99	398	21	19	17	14 to 31
LA8Synergy	105	457	23	19.9	21	1 to 36

SACT Definitions and timings

September 2025

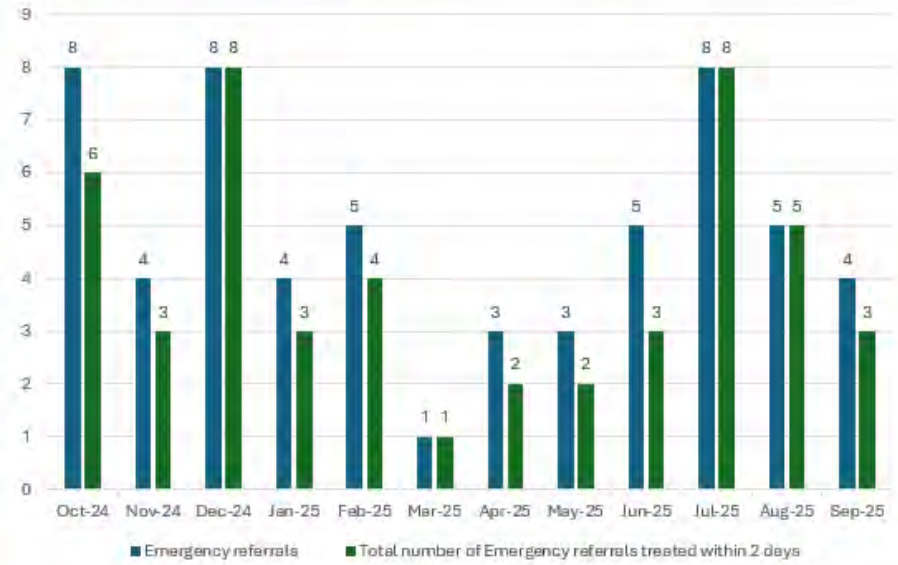
	Type	Timings	definition
Priority 1	emergency	emergency (within 48 hours)	Patients with cancer types that tend to rapidly clinically decompensate and respond well to SACT including small cell lung cancer, germ cell tumours, lymphoma and small subsets of ovarian and breast cancer
Priority 2	**Urgent**	within 14 days (for Curative, Palliative/Disease Control, Haematology remission and Neoadjuvant intent)	**Curative** – patients receiving SACT as first definitive treatment and so include primary chemotherapy patients and chemo-RT patients with radical intent **Priority 2: Neo-adjuvant** – those receiving SACT prior to definitive treatment **Priority 2: Palliative -** those receiving treatments that are not curative but can prolong life and reduce symptoms
Priority 3:	**Routine**	within 21 days (for adjuvant intent)	**Adjuvant -** all patients receiving systemic chemotherapy post definitive treatment.

Priority 1 - SACT Breach data Emergency waiting times

September 2025

	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Emergency referrals	8	4	8	4	5	1	3	3	5	8	5	4
Emergency Compliance	100%	100%	100%	75%	80%	100%	67%	100%	40%	100%	100%	75%
Total number of Emergency referrals treated within 2 days	6	3	8	3	4	1	2	2	3	8	5	3

	Breach reasons	Action
Patient 1	Capacity Ward.	Pathway reviewed with Head and Neck SST leads. Low number of patients may be admitted to FF Ward depending on regimens. Working on SOP to support management and escalation of 'urgent' and 'emergency patients' - Draft to be considered SACT Delivery Group November 2025.



Priority 2,3 - SACT Non-emergency waiting times activity

September 2025

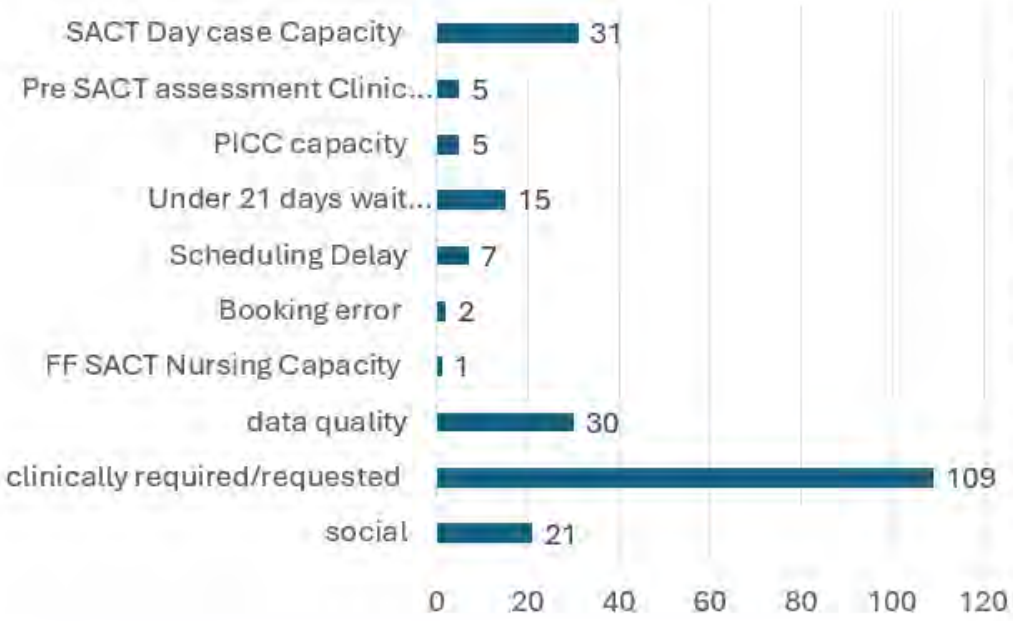
	Aug-25	Sep-25
(P2): Primary Definitive referrals	29	36
Total Breaches	-	18
% Within 14 days	-	**50%**
(P2): Neo-Adjuvant referrals	63	52
Total Breaches	10	25
% Within 14 days	**44%**	**52%**
(P2): Palliative referrals	243	238
Total Breaches	77	152
% Within 14 days	**40%**	**36%**
(P3): Adjuvant referrals	79	84
Total Breaches	**28**	**28**
% Within 21 days	**61%**	**67%**

September – changes in the way SACT performance has been recorded and reported has been made for September following agreement at an All Wales SACT meeting in September to fully adopt the Welsh Government recommendations with regards to the application of clock stops/suspensions in a patient pathway (WHC 2024 (07) , and in distinguishing performance against the SACT clinical quality priority performance indicators (July 2022)

For comparative purpose, the August position has been adjusted to reflect these changes (with no suspensions/stop clocks) and the overall 21-day position showed an improvement from August 61%, to 67%. This remains below the 98% target and a deep dive against the improvement plan for SACT is underway and will be completed, alongside the development of an improvement trajectory during Q3.

December 2025, anticipated new mandatory guidance in line with Decision to treat (DTT) pathway.

SACT Breach data: breakdown by reasons (Sept 25)



There is work underway to set out a recovery trajectory for SACT performance addressing the root cause issues for patient breaches. This will be managed via the newly established performance structures. This work will dovetail with the work starting with Health Boards, as part of the Regional Cancer workplan.

Clinical breaches to be reviewed by the clinical leads of the service and to be broken down to SST level

Proactive management of the waiting lists using the electronic PTL and introduction of a PTL management approach, as part of the performance and structure changes within VCS, will support intervention and mitigation of breaches

SACT Updates/Actions

September 2025

Update from last month

- National SACT workshop held 17th September to agree pathway monitoring and reporting.
- Reporting at VCS in line with P1/P2/P3 national priorities
- SACT workshop took place 24th September 2025. agreements for:
  - Model for nurse-led pre SACT consent and education cl
  - Development of F2F Independent prescriber led clinic/service

Mitigation

- Patient Pathway Visibility - mitigations in place for the lack of visibility of patients with Cancer PTL (SACT view)
- PTL to introduce PTL management processes in VCS
- Workforce recruitment – HEIW commissioner by Trust to undertake SACT workforce review reporting through to nVCC workstreams.

Key risks/issues

- **Capacity Constraints:** Limited treatment, pre-assessment, and booking capacity may delay patient access.
- **Data & Digital Gaps:** issues with data quality and digital systems hinder effective scheduling and tracking.
- **Workforce Shortages:** Insufficient trackers and ACPs risk bottlenecks and reduced oversight

Actions for next period

- Work ongoing with DHCW to implement Hospital Initiated referral. Digital – work in progress with DHCW to deliver of Hospital Initiated Referrals (**HIR**) into VCS by Q3
- PTL: discussions with local health boards via COO network to support pathway implementation across the region
- Cancer improvement plan and Clatterbridge recommendations to be consolidated and progress reviewed

2.5 Welsh Blood Service

WBS PMF – Key Improvements for September 2025

Gwasanaeth Gwaed Cymru
Welsh Blood Service

Stem Cell Collections

- In September, the Welsh Bone Marrow Donor Registry exceeded its target by completing five collections instead of the planned three, bringing the cumulative total well above target.

Recruitment of Stem Cell Volunteers

- In September, 465 swab and 126 blood sample collections contributed to new stem cell donor recruitment (Target = 333). The increase in new donors is largely due to the adoption of the swab method, with 2025/26 recruitment already above target.

Mixed or minority ethnicity donors now make up 4.2% of the volunteer stem cell panel, up from 1.6% in January 2024, compared to the Wales census benchmark of 6.2%.

Time Expired Platelets

- Wastage fell to **5%** in September (target = 10%), marking the lowest level in over a year.
- Evidencing early positive impact of the new platelet planning tool supporting platelet manufacturing decisions developed by the Data & Insights team to optimise the use data.

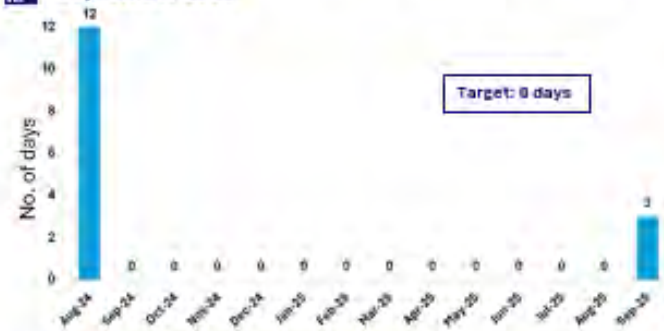
Ymddiriedolaeth GIG Prifysgol Felindre
Gofal ardderchog, dysgu ysbrydoledig, pobl iachach

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

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

Gwasanaeth Gwaed Cymru
Welsh Blood Service

September 2025



Key Issues / Risks:

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

Updates on last month:

- All clinical demand was met for O, A & B+ groups.
- O-negative stock level fell below 3 days on three occasions due to the Laboratory Information Management System roll-out in ABUHB, which increased hospital stock holding.
- Red Blood Cell demand (% manufactured to issued) reached 97%, just below the 100% target. This is within tolerance and helped rebalance the age of stock.

Action / Mitigation Underway:

- Daily Resilience meetings to ensure immediate operational responses and mitigate any arising issues.
- Monthly Blood Supply Chain Planning Group meetings with focus on medium and long-term planning.
- Operational Assurance Framework in development - first iteration by Qtr. 4.
- Working with Health Technology Wales on donor recruitment & retention study; bid submission Qtr. 3.

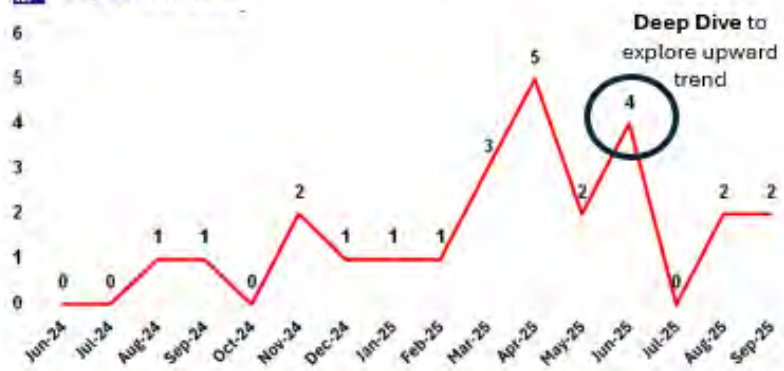
Forecast / Next Month:

- Performance remains good and closely aligned with red cell demand.
- If required, additional clinics will be scheduled in October to boost collections.

WBS Incidents Reported to Regulator / Licencing Authority

Gwasanaeth Gwaed Cymru
Welsh Blood Service

September 2025



- **SABRE 144:** A donor was not deferred as expected due to local (WBS) guidance being absent within a specific section of the DSG (Donor Selection Guidelines).
- **SABRE 145:** A donor was bled too soon following an MMR vaccination. This was a chance discovery; the donor is a member of staff and recognised the error during training.

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

Both incidents have been risk reviewed, made safe, and are under investigation (Confirmatory Reports due in October 2025).

No patient harm occurred from any event.

Action / Mitigation Underway:

- A June 2025 review found most historical SABRE reports relate to donor eligibility or transcription errors – both of this month's incidents align with that trend.
- Work is underway to simplify donor eligibility assessments, including developing a digital tool to assess travel related risks.
- Improvements to laboratory result reporting are in progress, focussing on updating the aging digital system (SERIF). The new Laboratory Information Management System, planned for March 2026, will help reduce transcription errors.

Quality Assurance – Incidents & Audits

September 2025

Gwasanaeth Gwaed Cymru
Welsh Blood Service

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

➡ **1** exceeding target date for closure (in reporting month)	Target: 0
⬆ **0** that remains overdue at month end	Target: 0
⬇ **10.6%** overdue actions from open incident action plans	Target: <5%

Quality (GMP) Incidents:

⬆ **3** exceeding target date for closure (in reporting month)	Target: 0
➡ **5** that remain overdue at month end	Target: 0
⬇ Age of oldest open overdue incident – **107 days**	No target set

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

⬇ **1** from internal audits in the last month	No target set
➡ **0** from external audits in the last month	No target set
⬇ **10.4%** overdue actions from open audit action plans	Target: <5%

Action / Mitigation underway:

- Maintain regular monitoring and direct follow-up with action owners.
- Continue weekly reminders and address delays.
- The oldest open overdue incident has since been closed by the Health & Safety Manager.
- New Lead Nurse position will play a pivotal supporting role (interviews planned in December 2025).

Key:

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

Red Cell Reference Serology Turnaround Times

Gwasanaeth Gwaed Cymru
Welsh Blood Service

Note: Target updated to align to RCI User Guide in April 2025 (90% in 5 working days).

Updates on Last Month:

- Performance fell short of the 90% target, with 85% of results issued within five working days.
- The shortfall in performance was partly attributable to limited staffing capacity, with 55% of the workforce (6 out of 11 scientists) still in training (December 25 – October 27).
- Workload rising; Data & Insights analysis to be completed (Dec 25) and workforce plan in development with POD support.

Key Issues / Risks:

- Workforce capacity issues.
- Outdated digital system (SERIF) requiring manual data entry.
- Process inefficiencies.

Action / Mitigation Underway:

- Immediate Improvement Plan in progress to address urgent issues while medium/long-term solutions advance.
- Lean-based initiative underway to reduce inefficiencies and optimise workflows; countermeasures in place, benefits will take time to embed.
- Updates to the existing digital system (SERIF) - 3 – 6 months.
- Implementation of new Laboratory Management System to replace SERIF scheduled in March 2026.

Forecast / Next Month:

- Performance is expected to improve as mitigation measures take effect.

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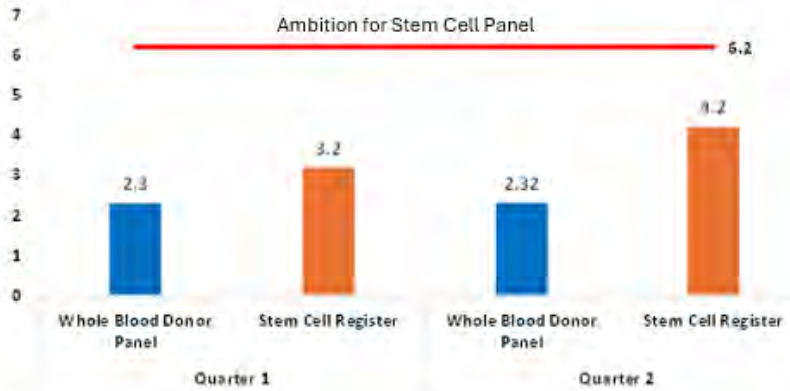
Inclusion across Whole Blood / Stem Cell Donor Panels

Gwasanaeth Gwaed Cymru
Welsh Blood Service

September 2025



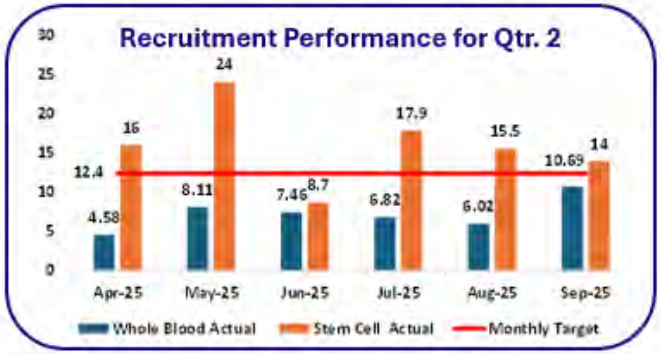
Key Issues / Risks:

- Less diverse panels reduces the likelihood of finding compatible matches for patients from minority ethnic backgrounds, especially for stem cell and rare blood type needs.

September 2025 recruitment split by gender:

Whole Blood
Male: 61%
Female: 39%

Stem Cell
Male: 42%
Female: 58%



UK Census Benchmark (Wales): 6.2%

This is a long-term ambition that will be achieved over time

- Whole Blood Donor Panel: In Qtr. 2 **2.32%** of panel did not identify as 'White' (remained the same).
- Stem Cell Volunteers: In Qtr. 2 **4.2%** of register did not identify as 'White' (increase of 1%).

Forecast / Next Quarter:

- A targeted recruitment project is underway to align donor profiles with the specific blood type needs of sickle cell patients, ensuring a reliable supply of compatible blood.
- Performance is expected to improve slightly in Qtr. 3, driven by the implementation of higher recruitment targets.

New Whole Blood Donors (Quarterly Reporting)

Gwasanaeth Gwaed Cymru
Welsh Blood Service

September 2025

Work underway to review current target to ensure it reflects requirements.

Key Issues / Risks:

- Prioritising known blood groups and focusing on existing donor engagement to balance supply and demand reduces both appointment availability and opportunities

Action / Mitigation Underway:

- Increase appointment opportunities at locations ideal for new donors (schools, businesses, educational settings) – approach proven successful in north-west Wales.
- Prioritising stem cell recruitment in September reduced resources for blood donation promotion, though the medium-term goal is to convert stem cell volunteers into blood donors.
- Exploring a research study on donor recruitment & retention and their impact on maintaining a stable and sufficient donor base (Qtr. 2 onwards).

Updates on Last Quarter:

- 1,862 new whole blood donors were recruited in Qtr. 2, against a target of 2,750.
- New donor recruitment should be compared to the same quarter in previous year, due to seasonal variation – Qtr. 2 2025/26 shows an increase of 585 donors against Qtr. 2 2024/25.

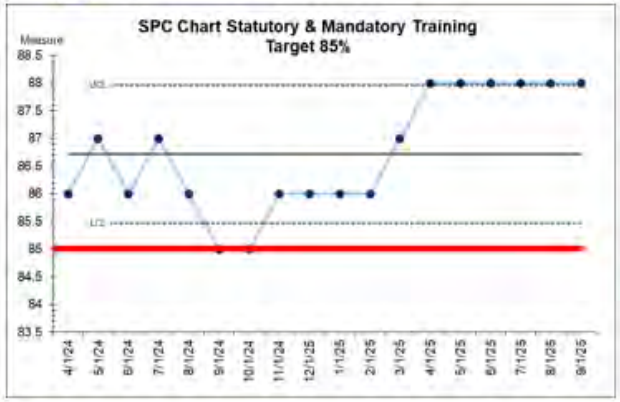
Forecast / Next Quarter:

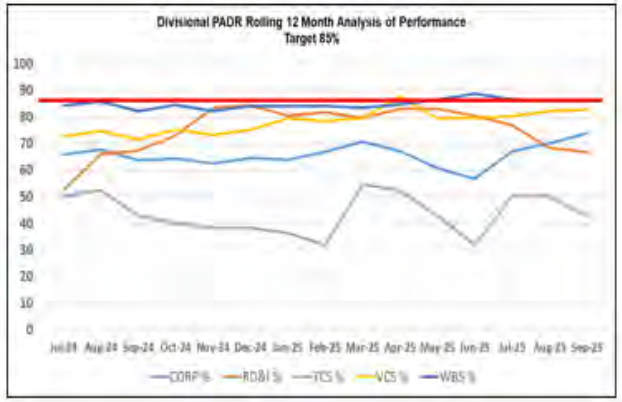
- Performance is not expected to increase significantly while prioritising known blood groups. New donor recruitment is expected to continue to be below target next quarter.

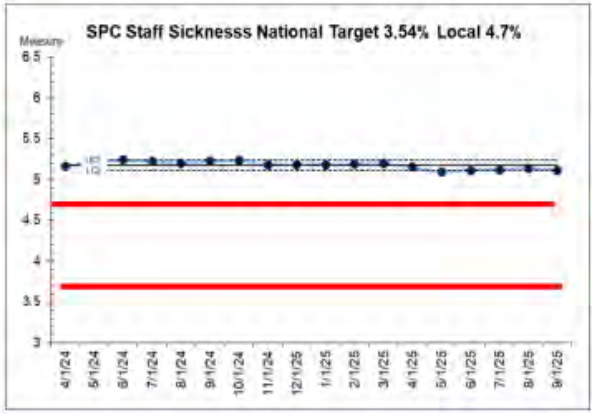
2.6 Workforce and Wellbeing

Workforce, Wellbeing & Organisational Development

September 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** –An improving trend noted, with engagement in further 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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2.7 Digital Services

Digital Services

September 2025

Updates on Last Month:

- Service performance – Our performance remains above the agreed percentage for both Incidents and Requests. However, there was a slight decrease in incident closure performance and an increase in request closure performance.
- % of user satisfaction continues to surpass the targets at 98%
- One significant incident raised in September, Storage failure with the WBS BECS system resulting in failed reporting links.(Resolved).

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 continues this month. Including migration from Windows 10 to Windows 11.
- Award the Digital review to supplier and start the review.

Action / Mitigation Underway:

- Procurement in place to review the Digital demand and capabilities. Investigating the demand between business as usual and project work required, to mitigate future capacity issues.

Key Issues / Risks:

- Capacity v Demand of requests on the IMTP, to be agreed in October.

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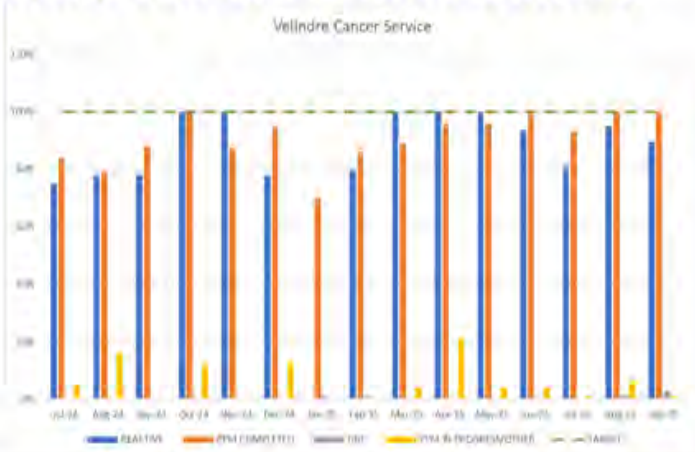
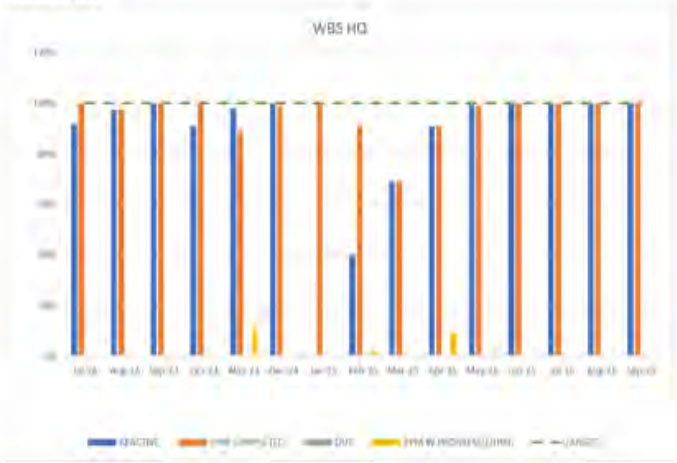
2.8 Estates Infrastructure and Sustainability

Estates and Infrastructure

September 2025





Updates on Last Month:

- VCS – 100% PPM – Reactive – 90%
- WBS HQ – 100% PPM Reactive 100%
- Trust HQ – 100% PPM Reactive – 100%
- Dafen – 100% PPM Reactive – 100%
- Wrexham – 100% PPM Reactive – 100%
- Bangor – 100% PPM Reactive – 100%

Forecast / Next Month: October 2026

- 363 PPMs planned for VCC
- 105 PPMs planned for WBS sites.
- 11 PPM planned for Nantgarw

Action / Mitigation Underway:

- All sites have now been successfully updated on the new CAFM system, ensuring full integration with existing operational processes and achieving compliance above the benchmark for September in PPM across all Trust Sites. Reactive tasks were reported at 90% in VCS this month.

Key Issues / Risks:

- Development updates on the CAFM system are being monitored via a work platform and are expected to be completed by March 2026. Monthly progress meetings taking place.
- An action plan has been developed by the CAFM provider, and the Trust is closely monitoring progress through monthly meetings with the system provider.

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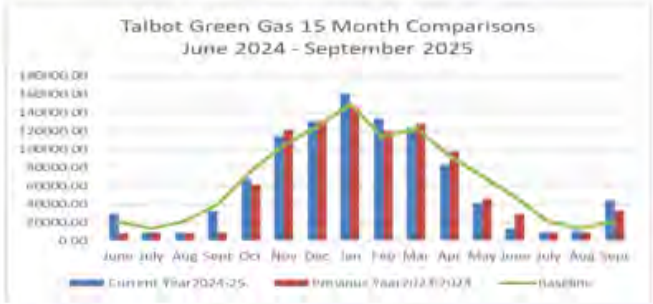
Estates Sustainability

September 2025

Gas– Talbot Green



Electricity – Trust HQ

Updates on Last Month:

- **Gas consumption** increased across the Trust in line with the cooling autumn temperatures and heating coming on
- **Electricity consumption** remains steady across the Trust.
- **Staff engagement events** were held highlighting energy and waste reduction initiatives, including: The Great Big Paper Cut campaign/Promoting correct segregation of waste across Trust sites/Encouraging reduction of single-use plastics in catering areas
- **Food waste bins** introduced at Talbot Green and North Wales sites, with new liquid-collection bins rolled out at VCS dining rooms.

Forecast / Next Month:

- **Waste management**: Recycling rates expected to improve following compactor repair; food waste collection expanded at additional sites.
- **Cost monitoring** continues through WEOG; potential price increases to be mitigated through operational efficiency and staff engagement.
- Continued focus on long-term sustainability initiatives, including LED lighting upgrades, renewable energy planning, and circular procurement practices.

Action / Mitigation Underway:

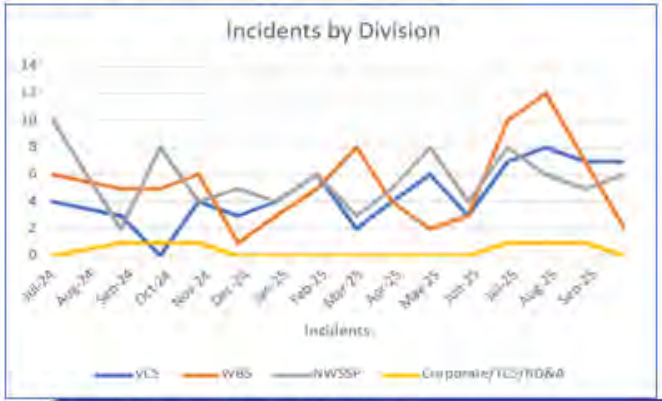
- Internal energy audits and ongoing BMS monitoring to identify hotspots and reduce consumption.
- **LED lighting upgrades** with motion and daylight sensors in identified areas, work started
- **Compactor at VCS repaired**; food waste bins rolled out at multiple sites.
- **Renewable energy feasibility study** planned for next quarter.
- **Electric vehicle charger up and running** (awaiting install of staff/donor charger at Talbot Green)
- **Staff engagement campaigns** on energy saving and correct waste segregation.

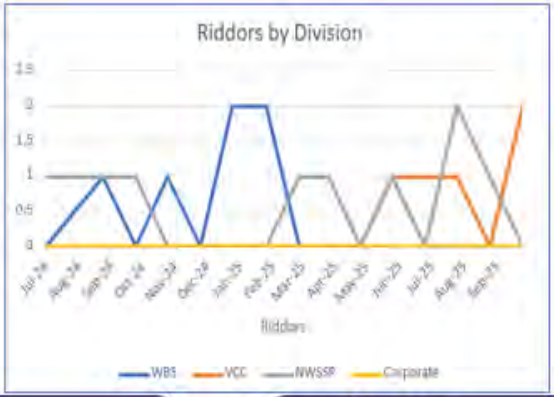
Key Issues / Risks:

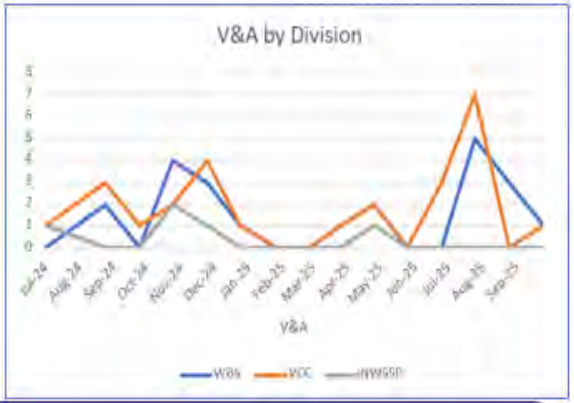
- **High energy costs**: Electricity and gas prices remain elevated; monitored through the Welsh Energy Operational Group (WEOG).
- **Recycling performance**: The new waste contract is in place, but initial compactor failure at VCS and the contractor has reduced recycling and increased general .
- **Operational demand**: noticing increase in gas across the Trust, in line with previous years, due to heating being turned on,

Health & Safety

September 2025







Updates on Last Month: Total of incidents

- **NWSSP - 6**
- **VCS - 8**
- **WBS – 2**
- **MIM (Trust Managed) - 0**
- **RIDDOR– 2**

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 – Reviewing potential **additional training solutions**, such as blended learning and refresher modules, to help address compliance shortfalls.

- Continued engagement with divisional leads and workforce teams to prioritise attendance and track compliance more closely.

WBS – Development of a new **venue risk assessment template** based on square meterage per chair and environmental risk factors.

We have amended the KPI's to reflect cumulative figures in the score card and will look to add in severity levels next month

Forecast / Next Month:

NWSSP -

VCS – Despite strong efforts, current projections show that patient manual handling training compliance is expected to reach approximately 79% by the end of March 2026. Further options and alternative delivery methods are being explored to improve accessibility and compliance rates.

WBS – A Task and Finish Group has been established to review and update risk assessments for external blood collection venues following several venue-specific safety concerns.

- The group is reviewing space allocations, electrical safety (including RCD protection), and manual handling controls for equipment setup and dismantling.

Key Issues / Risks:

NWSSP - Ensuring Church Village and Glangwili hub align to HSG65 process within NWSSP.

VCS – Training compliance remains below target, with resource and operational pressures affecting availability for training.

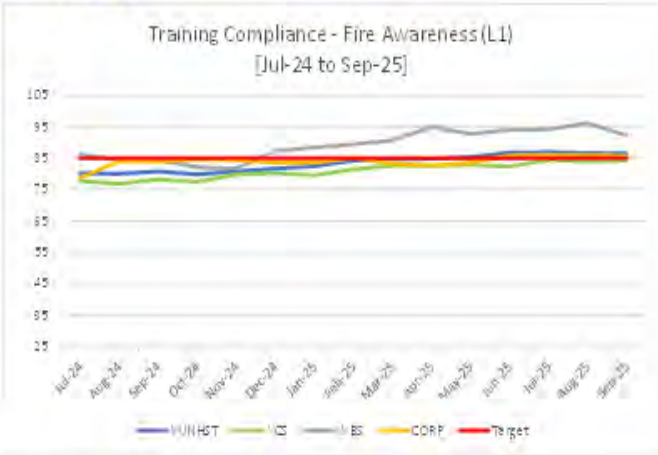
Ongoing monitoring of Sharps incidents – a meeting has been held with the divisional lead to review incident trends and the Sharps Improvement Plan, which will be implemented over the next 18 months. This will remain under close review through Datix monitoring.

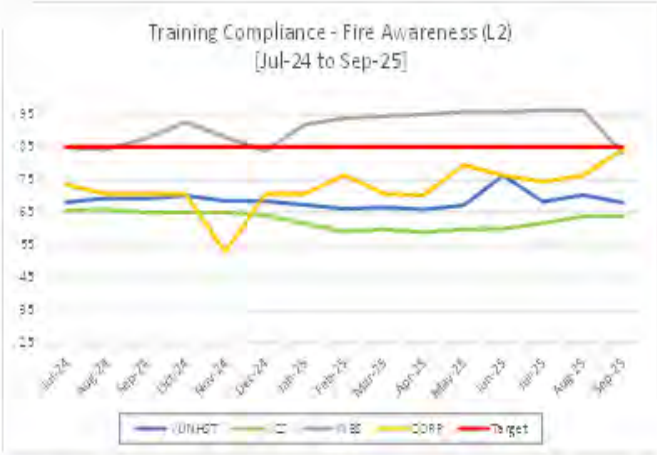
WBS - Some existing venues may not meet new safety standards once assessments are completed, potentially impacting collection schedules.

•Additional guidance may be required for staff on assessing venues and managing exceptions.

Fire Safety

September 2025





Updates on Last Month:

STRATEGIC
- Work to develop more interactive fire training material
- Continuation with development of fire safety protocols [Q4 (March 2026)]
- Submission annual fire safety audit submitted early September 2025

VCS
- Continued improvement in fire safety training compliance for both L1 and L2 training
- Evacuation drills undertaken in non-clinical areas in line with agreed schedule.

WBS
- Continued improvement in fire safety training compliance for L1 and L2 training
- Work with BDT on electrical safety at venues.

Corporate
- Further conversation on n-VCC fire strategy

Forecast / Next Month:

STRATEGIC
- Continuation with development of fire safety protocols [Q4 (March 2026)]
- Continued engagement with WOD around improving delivery of fire safety training / development of 2026 perspectus

VCS
- Continued improvement in fire training compliance
- Remedial works on fire dampers to commence

WBS
- Continued improvement in fire training compliance
- Remedial works on fire dampers to commence

CORPORATE
- Further work on FRA actions.

Action / Mitigation Underway:

VCS

Review of fire risk assessments ongoing against schedule – 23 migrated to new FARS / 9 in date and due for migration by 31 March 2026.
- Draft of revised emergency evacuation strategy issued for consultation

WBS
- Setting up more fire safety training sessions for BDT staff (September to November 2025)

CORPORATE
- Review of FRA highlighting non-compliances

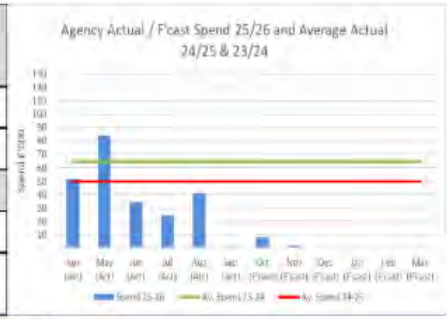
Key Issues / Risks:
- Continued low compliance for fire safety training [VUNHST]
- Need for evacuation drills and exercises in all Services
- Ongoing issues around closure of risks identified in fire risk assessments / further education on new FARS fire risk assessment module
- Alignment of emergency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

2.9 Finance

Financial Performance

September 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	5	4						
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	4.608	5.811						
Target £28.588m CEL		0.915	1.565	2.594	3.880	4.608	5.8108						



Updates on Last Month:

- The Trust has reported a small year to date underspend of £0.004m at the end of September 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

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3. IMPACT ASSESSMENT

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

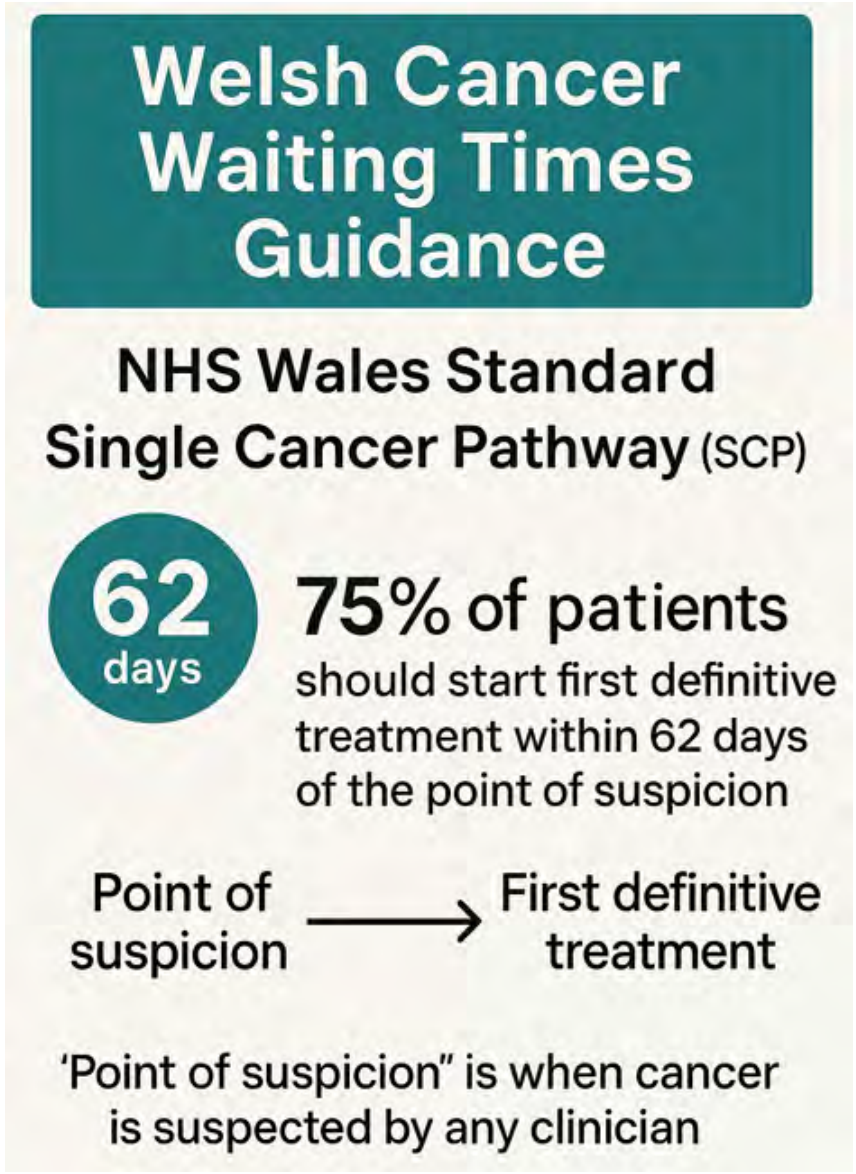
4. RISKS

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	

Performance Reporting – SACT

November 2025

Suspect Cancer Pathway (SCP)



Reporting and Accountability for the delivery of the SCP sits within the HealthBoard from where the 'point of suspicion' was recorded – even if a patient is referred to a specialist cancer centre such as VCS

December '20

SCP - Welsh Cancer Waiting Times

- **not a legal mandate**; it is a **national performance target set by Welsh Government and implemented through NHS Wales policy guidance**.

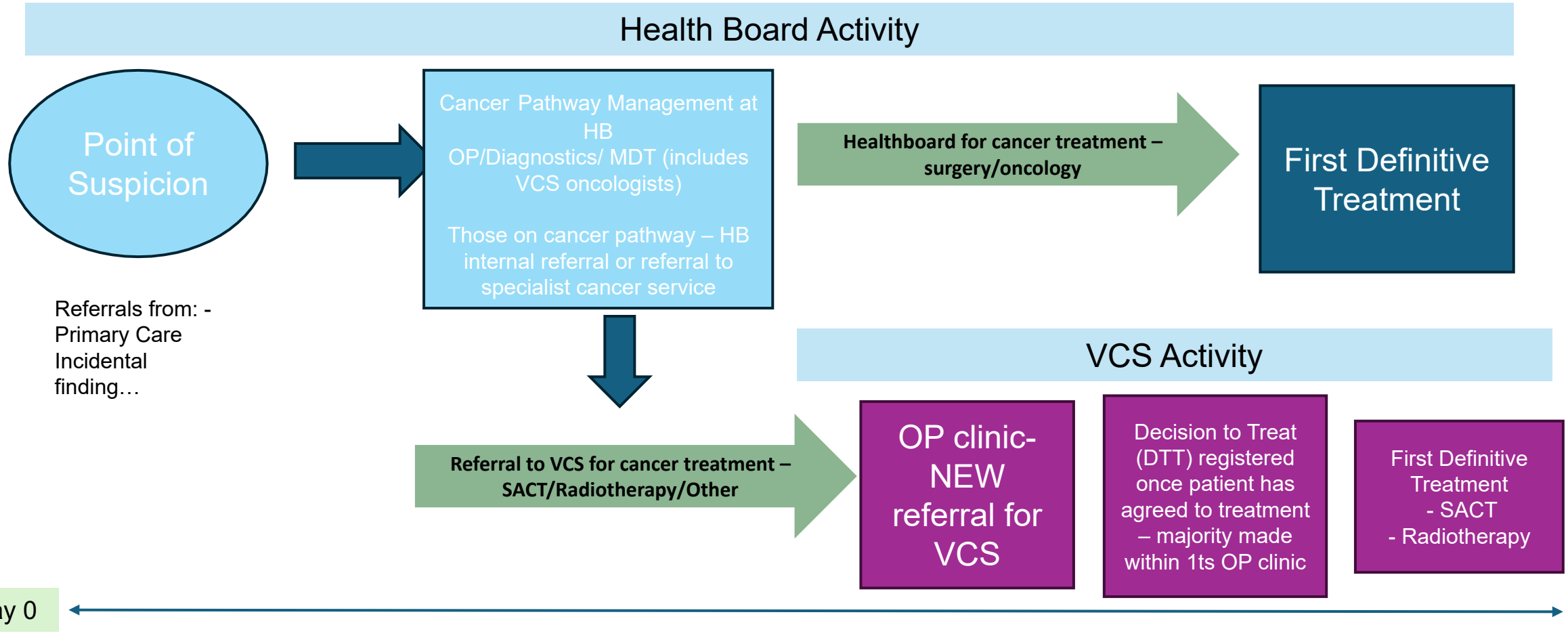
- defined in **Welsh Health Circulars** as a **compliance/action requirement for NHS organisations**, but it does not carry statutory enforcement like legislation.

☑ **WHC/2024/07 – Suspected Cancer Pathway Guidelines** **Issued:** April 2024

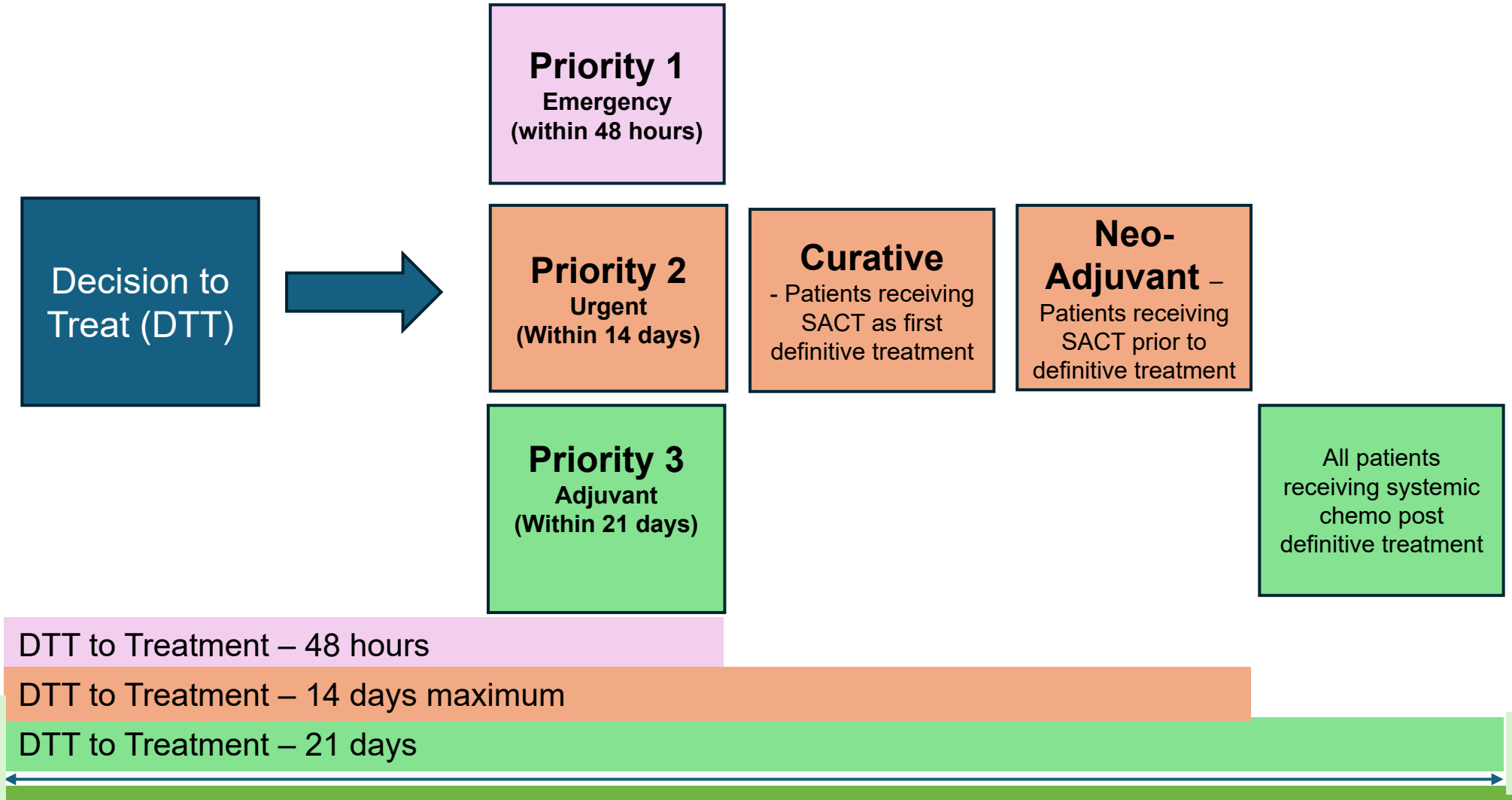
- Pathway continue outcomes
- Unavailable for >60day consecutive days

"Recording and reporting of pathways will reflect the actual time experienced by patients"

SCP Pathways and Velindre Cancer Services



SACT Quality Performance Indicators



SACT Quality Performance Indicators

	Type	Timings	definition
Priority 1	**Emergency**	emergency (within 48 hours)	Patients with cancer types that tend to rapidly clinically decompensate and respond well to SACT including small cell lung cancer, germ cell tumours, lymphoma and small subsets of ovarian and breast cancer
Priority 2	**Urgent**	within 14 days (for Curative, Palliative/Disease Control, Haematology remission and Neoadjuvant intent)	**Curative** – patients receiving SACT as first definitive treatment and so include primary chemotherapy patients and chemo-RT patients with radical intent **Priority 2: Neo-adjuvant** – those receiving SACT prior to definitive treatment **Priority 2: Palliative -** those receiving treatments that are not curative but can prolong life and reduce symptoms
Priority 3:	**Routine**	within 21 days (for adjuvant intent)	**Adjuvant -** all patients receiving systemic chemotherapy post definitive treatment.

SACT Performance Shift – September 2025

Prior to September 2025	September Reporting 2025
Only the **21-day treatment standard** was reported and this was applied to **all patients treated** within the month	Activity split out across the three Priority areas
No split of activity into the three Priority criteria	Removal of 'clock stops'
Application of 'clock stops' to patient pathways for breaches in the standard who were deemed to have had valid reasons why the patient could not have been treated in this timeframe	Performance calculated from referral and not Decision to Treat
Performance calculated from referral and not Decision to Treat	

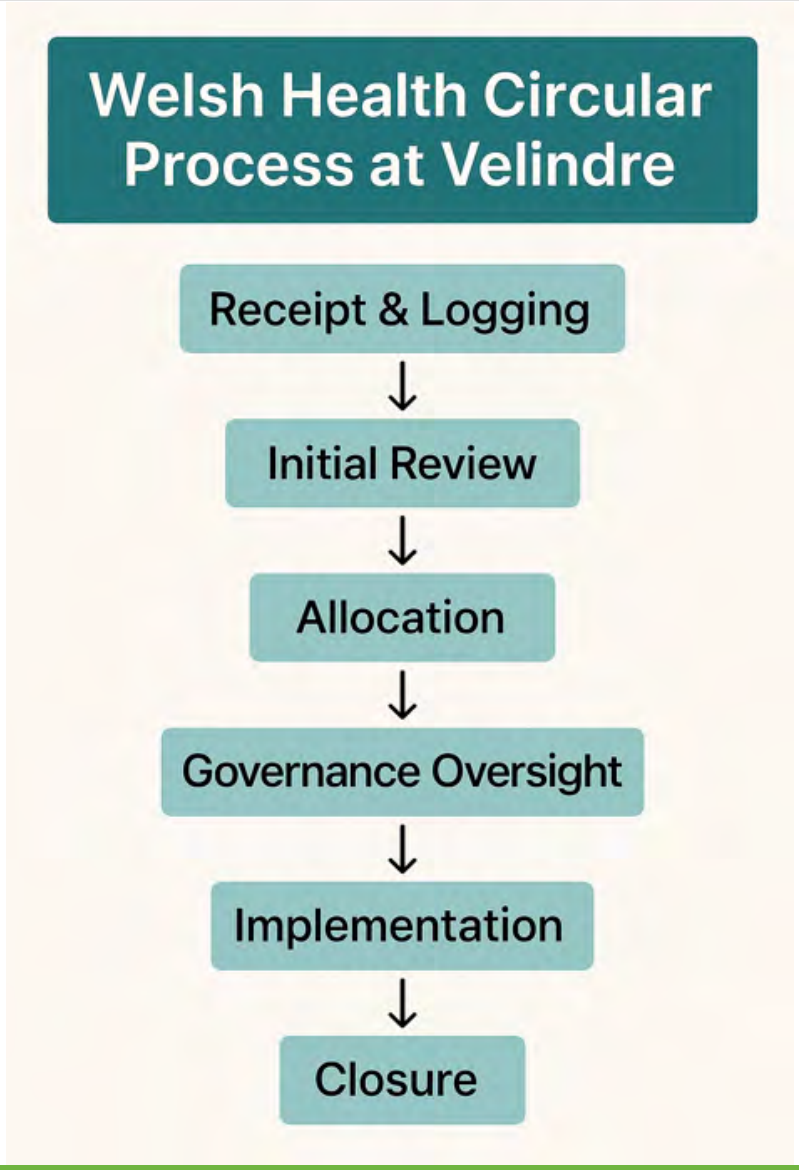
The impact of the changes to performance following the application of the SACT rules in reporting performance reduced compliance following primarily the removal of the 'clock stops'.
At 21 days this reduced the compliance of 97% to 67%.

	Sep-25	Sept 2025 - shadow
(P2): Primary Definitive referrals	36	**36**
Total Breaches	18	**1**
% Within 14 days	50%	**97%**
(P2): Neo-Adjuvant referrals	52	**52**
Total Breaches	25	**13**
% Within 14 days	52%	**75%**
(P2): Palliative referrals	238	**238**
Total Breaches	152	**50**
% Within 14 days	36%	**79%**
(P3): Adjuvant referrals	84	**84**
Total Breaches	28	**2**
% Within 21 days	67%	**97%**

Implementation of Waiting List Management at VCS

		Completion Due
Operational Management	Implementation of new Directorate Structures at VCS with commencement of new Triumverate teams	December 2025
PTL	Development of Patient Tracking List operational management to support waiting list oversight and proactive management of patients through their pathway	December 2025
	Development of data and insights capacity and capability to support waiting list management and reporting across all patient pathways	Quarter 4
	Development of Dashboards utilising Patient Tracking List to support waiting list management by the operational teams	Quarter 4
Waiting List Management	Development of waiting list management SOPs with associated training and development of staff in waiting list management	January 2026
	Development of Trust and VCS performance framework with regards to waiting list management	December 2025
	Review of roles and responsibilities across all teams to ensure clarity of accountability and responsibility in waiting list management	January 2026-March 2026

Expected process



TRUST BOARD

FINANCE REPORT FOR THE PERIOD ENDED 31ST OCTOBER 2025 (M7)

DATE OF MEETING	27/11/2025
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	INFORMATION / NOTING
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Claire Bowden – Head of Financial Planning & 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 October 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, although has had to agree a significant loss in recurrent income with Hywel Dda UHB. • The Trust has agreed with Commissioners an uplift to LTA values of 1.77% which amounts to £1.548m in 2025-26 less £0.825m 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. Whilst the Trust had previously assumed a 1.5% uplift to LTA values for 2026-27 and 2027-28, it is now understood that no uplift will be provided in respect of 2026-27. • 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, they have now confirmed that no commitment will be made this year and therefore the case will be re-provided along with any new services as part of the 2026/27 IMTP process. • 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.

- 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 £0.002m as at 31st October 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 October 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	**24/11/2025**
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	

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

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

1. SITUATION / BACKGROUND

1.1 The attached report outlines the financial position and performance for the period to the end of October 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	(0.002)	0.002	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	0.509	8.338	19.006
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	95.0%	96.4%	95.0%

2.2 Revenue Budget

The core Trust has reported an in month overspend of £0.002m leading to a **year to date underspend of £0.002m** position as at 31st October 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

During 2024-25 LTA activity performance underachieved against the income growth target set by c£0.240m, which resulted in marginal income not matching the level of service investment that was made to support capacity within VCS. As LTA activity year to date has improved in 2025/26, it is no longer flagged as a financial risk but will continue be monitored closely against plan.

A 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. The expectation to month 6 has been a shortfall of between £0.500m and £0.750m during 2025-26, after mitigations are put in place, such as holding of vacancies. A review of the impact and forecast position has been undertaken during October. This has resulted in £0.300m being phased into the actual position and forecast over the remaining months of the year, offset by a number of small reductions in several non pay spend areas. A risk of a further £0.200m cost pressure remains.

In addition, the Trust wrote to its commissioners on the 8th August requesting funding support of £0.278m for the additional recurrent costs that have emerged since the FBC and the go live date where the first patient was treated on 19th June 2025. The Trust was informed at the Commissioners' meeting on 17th June that they will not support these additional costs and will be formally writing back to the Trust of this intention in due course.

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 £0.825m 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£0.200m which will be removed recurrently in 2026-27. Whilst the Trust had previously assumed a 1.5% uplift to LTA values for 2026-27 and 2027-28, it is now understood that no uplift will be provided in respect of 2026-27.

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, they have now confirmed that no commitment will be made this year and therefore the case will be re-provided along with any new services as part of 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 September 2025 the Trust (core) achieved a compliance level of **95.0%** (September 97.2%) of Non-NHS supplier invoices paid within the 30-day target. The Trust year to date compliance (including hosted) is **97.4%** compared to the target of 95%.

2.4 Reserves

The financial strategy for 2025-26 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. In July,

£0.345m of the reserve was 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 activity risk associated with the Radiotherapy Satellite unit, 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 a number of 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 and a number of adjustments / requests made during the annual review of requirements in October have been accommodated.

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. The revised OBC will incorporate the Enabling Works and laboratory modernisation, with the appointed Supply Chain Partner leading design development. It has been agreed with WG that the Enabling Works section will be to FBC standard. The updated OBC must be submitted by the end of the 2025/26 financial year to align with WG funding timelines and strategic priorities.

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. The Trust has submitted its requests which have been passed by WG Capital Colleagues to the Cabinet Secretary for Health and Social Care for consideration.

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 £0.002m** for October 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	12
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	Recipients are provided with detail on the risks and any actions required from them to mitigate / remove the risk are highlighted.
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Individual risks to be managed with the financial envelope for 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 31ST OCTOBER 2025

TRUST BOARD
27/11/2025

1. Introduction

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

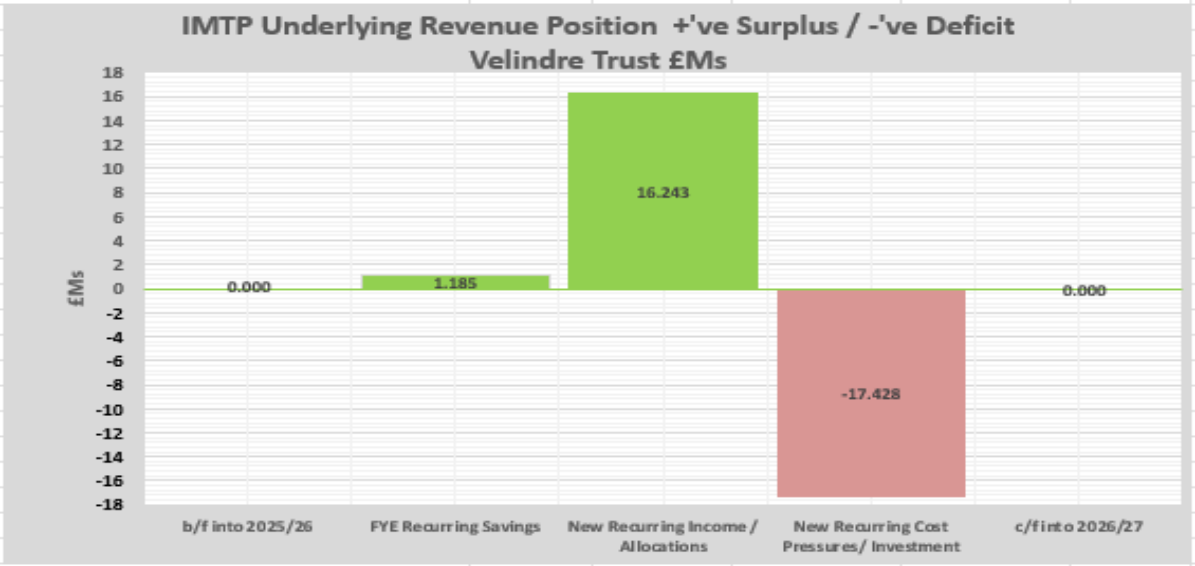
The draft Trust IMTP Financial Plan for the period 2025-2028 was set within the following context:

- 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	(0.002)	0.002	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	0.509	8.338	19.006
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	95.0%	96.4%	95.0%

Performance against Planned Savings Target

	Unit	Current Month £m	Year to date £m	Year End Forecast £m
Efficiency / Savings	Variance	(0.064)	(0.184)	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 £0.825m 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. Whilst the Trust had previously assumed a 1.5% uplift to LTA values for 2026-27 and 2027-28, it is now understood that no uplift will be provided in respect of 2026-27.

Capital

The approved Capital Expenditure Limit (CEL) for the year ended 31st March 2026 is **£18.843m**.This represents all Wales Capital funding of **£16.843m**, and Discretionary funding of

£2.000m. The Trust reported total Capital spend to 31st October 2025 is £8.338m, with all funds expected to be fully spent during 2025-26. The year end forecast in the table above is higher by £0.163m which relates to the nVCC Enabling Works and will be requested from the QRA funding held by WG.

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

	Opening CEL	Movement	Current CEL
	£m	£m	£m
All Wales Capital:			
nVCC Enabling Works	4.012	-0.329	3.683
nVCC Enabling Works QRA*	0.000	0.332	0.332
nVCC Project	11.059	-4.683	6.376
nVCC Project QRA - Enabling Works HV Intake	0.000	0.257	0.257
nVCC Project QRA - MIM	0.000	0.068	0.068
nVCC Project QRA - MIM*	0.000	0.150	0.150
Integrated Radiotherapy Solution (IRS)	2.040	-0.640	1.400
Velindre @ Nevill Hall Radiotherapy Centre (RSC)	1.200	-0.520	0.680
Whitchurch Hospital Site Disposal	0.840	0.000	0.840
Whitchurch Hospital Site Disposal - contingency*	0.000	0.300	0.300
WBS HQ Continuity Business Case OBC/FBC fees	2.142	-1.142	1.000
WBS Fleet Replacement Programme	0.364	0.241	0.605
DPIF - RISP	0.000	0.214	0.214
DPIF - Blood Establishment Computer System (BECS) replacement	0.416	0.000	0.416
DPIF - Welsh Histocompatibility & Immunogenetics Service (WHAIS)	0.185	0.000	0.185
DPIF - Electronic Prescribing & Medicines Administration (EPMA)	0.086	0.000	0.086
WBS Plasma for Fractionation	0.000	0.030	0.030
Non-Radiology Ultrasound Replacement	0.000	0.048	0.048
Radiology Ultrasound Replacement	0.000	0.132	0.132
VPAG Funding - Equipment	1.000	-0.959	0.041
Total All Wales Capital Programme	**23.344**	**-6.501**	**16.843**
Discretionary Capital	**2.000**	**0.000**	**2.000**
Total CEL	**25.344**	**-6.501**	**18.843**
** QRA budget held by WG*			

PSPP

During October 2025 the Trust (core) achieved a compliance level of **95.0%** (September 97.2%) of Non-NHS supplier invoices paid within the 30-day target which gives a cumulative year to date position of **96.4%**. The Trust year to date compliance (including hosted) is **97.4%** compared to the target of 95%.

Efficiency / Savings

An in-depth review of the Trust's savings 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 October 2025 shows the year to date planned savings of £1.247m were **underachieved by £0.184m**. **Actual delivery to date is therefore £1.063m**.

All savings schemes are now identified and RAG rated green, although there remain some challenges in achieving the full values currently planned, in particular the achievement of recurrent saving schemes with the savings target for 2025-26 being achieved via replacement schemes that are non-recurrent in nature. This will potentially impact the Trust underlying position.

Revenue Position

Cumulative Breakeven				Forecast Breakeven		
Type	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)	Full Year Budget (£m)	Full Year Forecast (£m)	Forecast Variance (£m)
Income	(153.521)	(155.113)	1.592	(263.881)	(263.881)	0.000
Pay	62.284	61.976	0.308	102.879	102.879	0.000
Non Pay	91.237	93.134	(1.897)	161.001	161.001	0.000
Total	**0.000**	**(0.002)**	**0.002**	**0.000**	**0.000**	**0.000**

The overall position against the profiled revenue budget to the end of October 2025 is **an underspend of £0.002m**, 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. Signed LTAs are in place with all organisations, although, as previously mentioned, the Trust has had to agree a significant loss in recurrent income with Hywel Dda UHB.

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 of £0.310m (which could rise by a further £0.090m) and ENIC cost pressure £0.345m, 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

£0.825m, 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 (£1.592m overachieved)			
Type	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)
Core Income - HB / WHSSC	66.798	66.832	-0.034
Nice/ High Cost Drugs	40.186	39.970	0.215
WBS Wholesale Blood Products	18.162	18.167	-0.004
WBS Transplantation Services	0.008	0.015	-0.008
WBS Blood Components	0.574	0.666	-0.092
Home Care Drugs	1.281	1.391	-0.110
Private Patient	1.793	2.252	-0.459
VCC Over Activity	4.119	4.618	-0.499
Velindre @ Neville Hall RU	2.022	1.335	0.687
IRS Programme	0.707	0.707	-0.000
Radiation Protection	0.696	0.742	-0.047
Staff Recharges	3.752	3.669	0.082
One Wales Palliative and EOL Care	0.746	0.780	-0.035
Velindre Charity	1.064	1.449	-0.385
Other Charity	0.340	0.158	0.182
RD&I*	2.948	3.202	-0.254
HTW	1.003	0.876	0.127
Other Operating Income	7.322	8.282	-0.959
Total	153.521	155.113	-1.592

*RD&I full year budget includes £2.259m of Velindre Charity income.

The variance reported against the Velindre @ Nevill Hall RU income is offset by a similar expenditure variance which is not part of the above income table. This will be amended during November. The correct overall variance reflected later in this report is a shortfall of £0.300m, with additional risk of a further £0.200m also highlighted.

The profile of income due from charities other than the Trust is being reviewed during November to determine whether the variance is due to timing issues or a shortfall in anticipated funding.

An adjustment to the 2025/26 income has been made this month to reflect the pass through by the Trust's Commissioners of 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 been confirmed at 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 along with other service developments as part of 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 previously confirmed non-recurrent funding to support the Trust during 2025-26. The Trust has been liaising with its Policy Lead for clarification of future year's funding and has been given a clear indication that the funding will not be provided in 2026/27. This will lead to a new 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 Executive Director of Finance is to re-approach the policy lead for further engagement.

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 £0.825m 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£0.200m which will be removed recurrently in 2026-27. Whilst the Trust had previously assumed a 1.5% uplift to LTA values for 2026-27 and 2027-28, it is now understood that no uplift will be provided in respect of 2026-27.

To ensure Commissioners fund the total cost of Velindre running cancer services from 2026-27 there needs to be agreement from all Commissioners to change the commissioning principles for Velindre from 'historic shares' based on activity and NICE consumption in 2004-05 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. The Trust DdoF has begun conversations with its three main Commissioners, however, it is unlikely to reach agreement in time to recharge on an actual activity basis for 2026/27. Any change to the LTA activity will need to be cost neutral to the Trust. Latest position is an LTA / Commissioning Task and Finish Group is being established to ensure consistent principles and processes across organisations with WG policy being that this is an area for commissioners and providers to develop and there would not be national direction or policy.

A 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. The expectation to month 6 was a shortfall of between £0.500m and £0.750m during 2025-26, after mitigations have been put in place, such as holding of vacancies. A review of the impact and forecast position has been undertaken during October. This has resulted in £0.300m being phased into the actual position and forecast over the remaining months of the year, offset by a number of small reductions in several non pay spend areas. A risk of a further £0.200m cost pressure remains.

In addition, the Trust wrote to its Commissioners on the 8th August requesting funding support of £0.278m for the additional recurrent costs that have emerged since the FBC and the go live date where the first patient was treated on the 19th June 2025. The Trust was informed at the Commissioners meeting on the 17th June that they will not support these additional costs and will be formally writing back to the Trust of this intention in due course.

The tables below set out the projected year end LTA income performance based on data to 30th September 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 forecast increase in contract income of £0.709m against the 2024-25 out-turn and plan set at IMTP stage), split across organisations as shown below:

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	-0.038	0.827	-4%	-0.050	0.012
Swansea Bay (7A3)	0.455	-0.012	0.443	-3%	-0.034	0.023
Cardiff & Vale (7A4)	16.048	2.806	18.854	18%	2.470	0.337
Cwm Taf Morgannwg (7A5)	14.285	2.029	16.314	15%	1.767	0.262
Aneurin Bevan (7A6)	19.812	2.961	22.772	15%	2.873	0.088
Powys (7A7)	1.080	0.246	1.326	22%	0.177	0.069
NHS Wales Joint Commissioning Committee	2.259	0.096	2.355	4%	-0.142	0.238
Total	**54.803**	**8.088**	**62.891**	**15%**	**7.061**	**1.027**

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 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. Should marginal income overachieve then it will be held to support the underlying cost pressures and within VCS in particular the RSU underachievement risk, rather than be utilised for re-investment.

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	0.197	6.102	3%	0.022	0.175
Radiotherapy Delivery	13.508	-0.196	13.311	-1%	-0.174	-0.023
Nuclear Medicine	1.031	-0.040	0.991	-4%	-0.032	-0.008
Radiology Imaging	3.149	0.722	3.870	23%	0.646	0.076
Preparation for Systemic Anti-Cancer Therapy	2.918	0.866	3.784	30%	0.659	0.207
Delivery of Systemic Anti-Cancer Therapy	6.884	1.941	8.825	28%	1.926	0.015
Ambulatory Care Services	1.405	0.429	1.834	31%	0.367	0.062
Outpatient Services	10.455	3.836	14.291	37%	3.443	0.393
Inpatient Admitted Care	6.162	0.332	6.494	5%	0.203	0.129
Contract Adjustments	3.388	0.000	3.388	0%	0.000	0.000
Total	**54.803**	**8.088**	**62.891**	**15%**	**7.061**	**1.027**

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	3,851	- 65	-2%	3,794	57
Radiotherapy Delivery	53,586	48,685	- 4,901	-9%	50,060	- 1,375
Nuclear Medicine	1,738	1,567	- 171	-10%	1,528	39
Radiology Imaging	9,103	14,750	5,647	62%	14,002	748
Preparation for Systemic Anti-Cancer Therapy	25,262	37,624	12,362	49%	37,202	422
Delivery of Systemic Anti-Cancer Therapy	31,867	47,856	15,989	50%	47,751	105
Ambulatory Care Services	7,874	10,427	2,553	32%	9,701	726
Outpatient Services	59,960	91,272	31,312	52%	91,043	229
Inpatient Admitted Care	9,072	10,004	932	10%	9,652	352
Contract Adjustments	-	-	-	0%	-	-
Total	**202,378**	**266,036**	**63,658**	**31%**	**264,733**	**1,303**

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	1,035	-167	-14%	963	72
Swansea Bay (7A3)	1,200	1,270	70	6%	1,162	108
Cardiff & Vale (7A4)	60,809	83,572	22,763	37%	82,794	778
Cwm Taf Morgannwg (7A5)	59,964	74,093	14,129	24%	74,013	80
Aneurin Bevan (7A6)	74,098	98,954	24,856	34%	99,839	- 885
Powys (7A7)	3,619	5,345	1,726	48%	5,003	342
NHS Wales Joint Commissioning Committee	1,486	1,767	281	19%	959	808
Total	**202,378**	**266,036**	**63,658**	**31%**	**264,733**	**1,303**

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 UHB 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 six 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 were:

1. Plasma for Medicines: Implementation of the Welsh Government Policy for the collection, processing and supply of plasma for the manufacture of Immunoglobulin and Albumin products;
2. Red Cell Immuno-haematology Laboratory: £0.196m for additional capacity 24/7 for the Red Cell Immuno-haematology Laboratory;
3. Haemoglobin S screening: £0.070m for implementation of Haemoglobin S (HbS) testing to comply with national guidance;
4. Blood Component Development: £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;
5. Buccal Swab Pathway: £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;
6. Blood Donation Team Resilience: £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 has inevitably been forced to make some investment at financial risk. The cases were re-submitted to JCC on 8th October, for consideration of funding as part of the 2026-27 IMTP process, however the Trust is awaiting confirmation from JCC on the governance process for considering these cases for funding. It is understood that there is likely to be a high-level discussion of risks by JCC which will then inform priorities for the Specialist Services Commissioning Group to consider on November 27th. WBS colleagues have asked how they will feed into this process.

The Trust Medical Director has recently briefed the Deputy Chief Medical Officer (DCMO) regarding the Infected Blood Inquiry (IBI) report recommendations. WBS colleagues are progressing work on the Blood Transfusion related recommendations, and the DCMO is expected to visit WBS laboratories on 1st December. Prior to this, in October Jeremy Griffith, WG, visited the WBS Talbot Green site. Following the visit, Jeremy shared his intention to recommend the tour to other senior Welsh Government officials, including the Cabinet Secretary, and noted several key WBS priorities: including the WBS digital transformation projects, refurbishment plans for the centre at Talbot Green, and the plasma collection ambitions.

As previously advised, the Trust has assumed that Welsh Government and / or Joint Commissioning Committee (JCC) will fund the Phase 2 (Option 2 Apheresis collection of Plasma) which will not be progressed until funding is approved.

Pay Highlights / Key Issues

An adjustment to the 2025/26 income has been made this month to reflect the pass through by the Trust's Commissioners of 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.

In addition to 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.

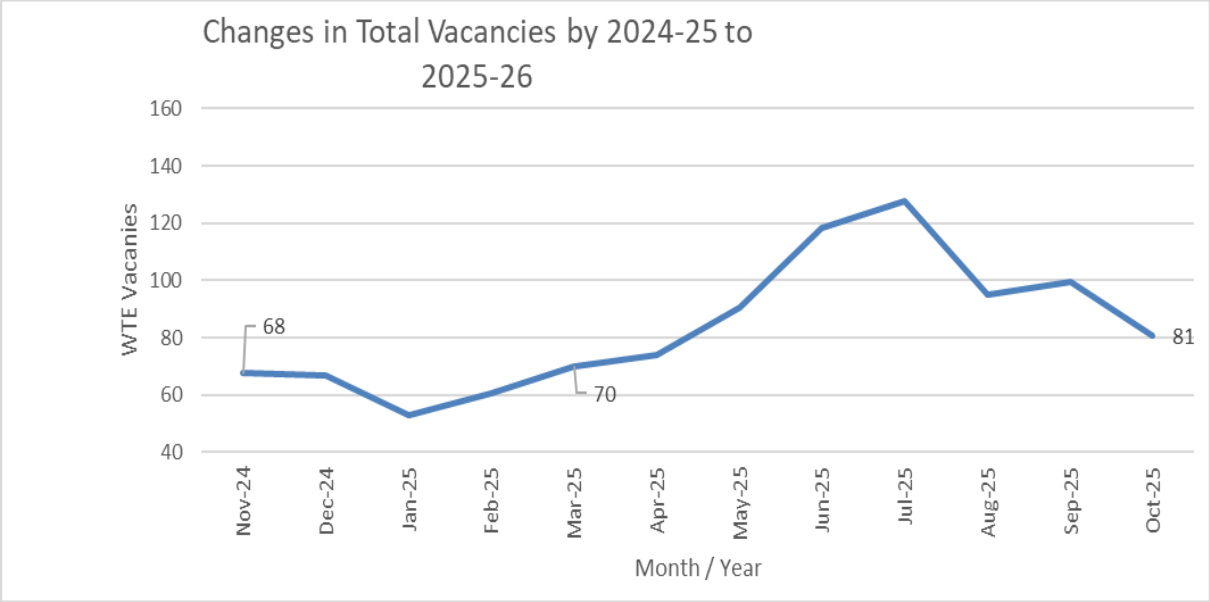
The remainder of the Trust reserves and previously agreed unallocated investment funding is held in month 12 and will be released into the position to match spend as it occurs throughout the year.

3.1 Pay Spend Trends (Run Rate)

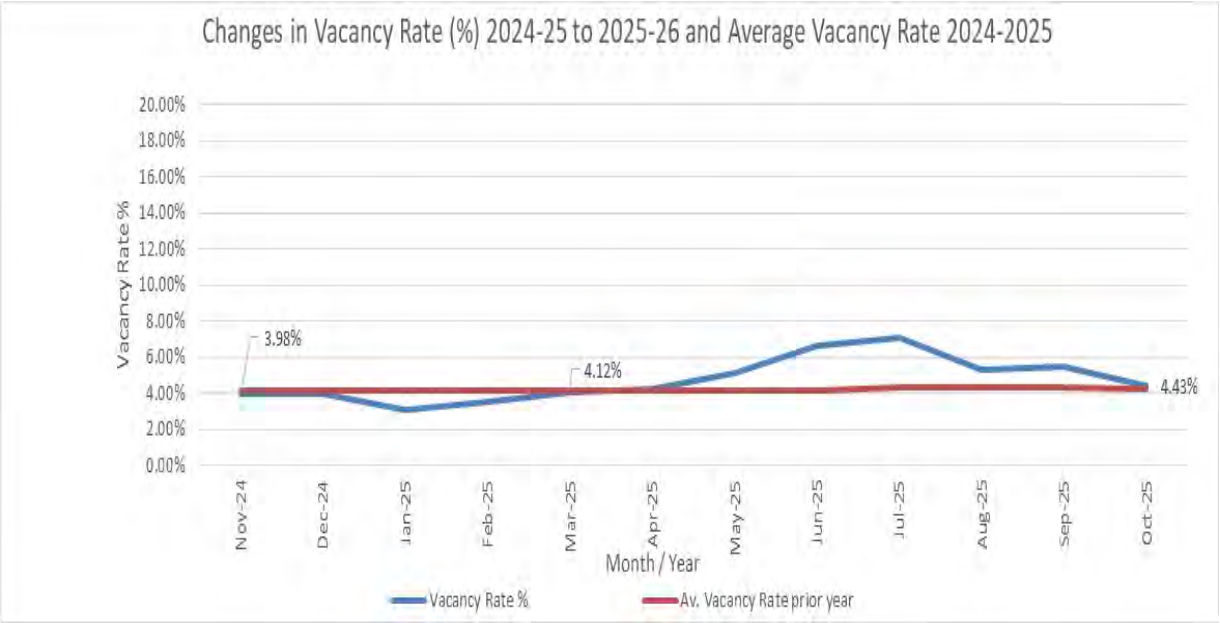
As of October 2025, the current staff in post is 1,737 WTE (September 1,709). The number of vacancies is 81 WTE (September 99), which represents a vacancy rate of 4.4% (5.5% August) against the budget of 1,818 WTE. The vacancy gap is largely being met using overtime or bank staff and is also supporting 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 are keen in future months to only utilise agency posts where options to fill via bank and fixed term contracts are not possible, and there is an unavoidable service need.

The largest number of vacancies are seen within VCS: 48 WTE, less than the 69 WTE reported in September. This movement is largely caused by a change in reporting to ensure those posts backfilled during long term sickness or maternity absence do not result in an overstatement of the number of vacancies. Vacancies are spread across many other services, particularly Allied Health Professionals (9 WTE), Medical (13 WTE), and Additional Clinical Services (14 WTE), offset by overestablishment in Nursing & Midwifery (10 WTE).

WBS currently are reporting 7 WTE vacancies. Healthcare Scientist posts are currently overestablished (5 WTE) while funding from related business cases to JCC has been requested. These are offset by Additional Clinical Service vacancies (10 WTE) which are currently being recruited to.

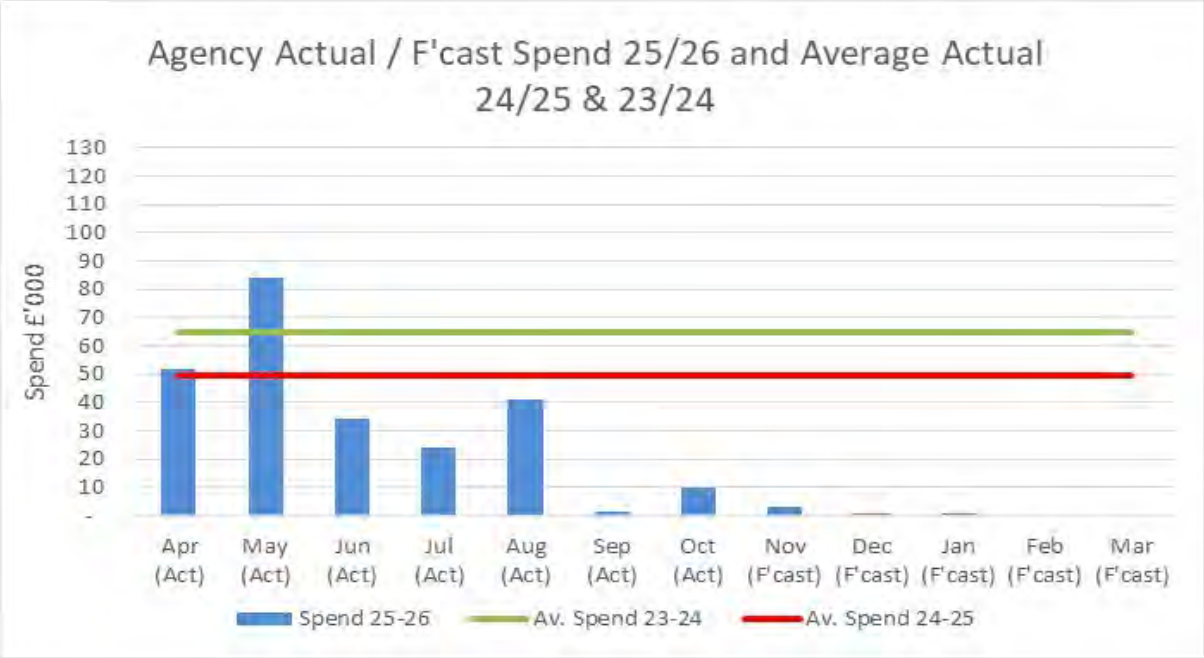


The total Trust vacancies as of October 2025 are 81 WTE (September 99 WTE): VCS (48 WTE), WBS (8 WTE), Corporate (11 WTE), R&D (12 WTE), nVCC (0 WTE) and HTW (2 WTE).



The spend on agency for October 2025 was **£0.010m** (September £0.001m) with a year end outturn forecast currently of **£0.251m** (£0.596m 2024/25). In line with the Value & Sustainability agenda and Finance & Investment Enhanced monitoring arrangements the Trust has made significant progress in moving away from the dependence on agency staff. Minimal, exceptional spend is forecast only where service needs can only be met via this option.

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



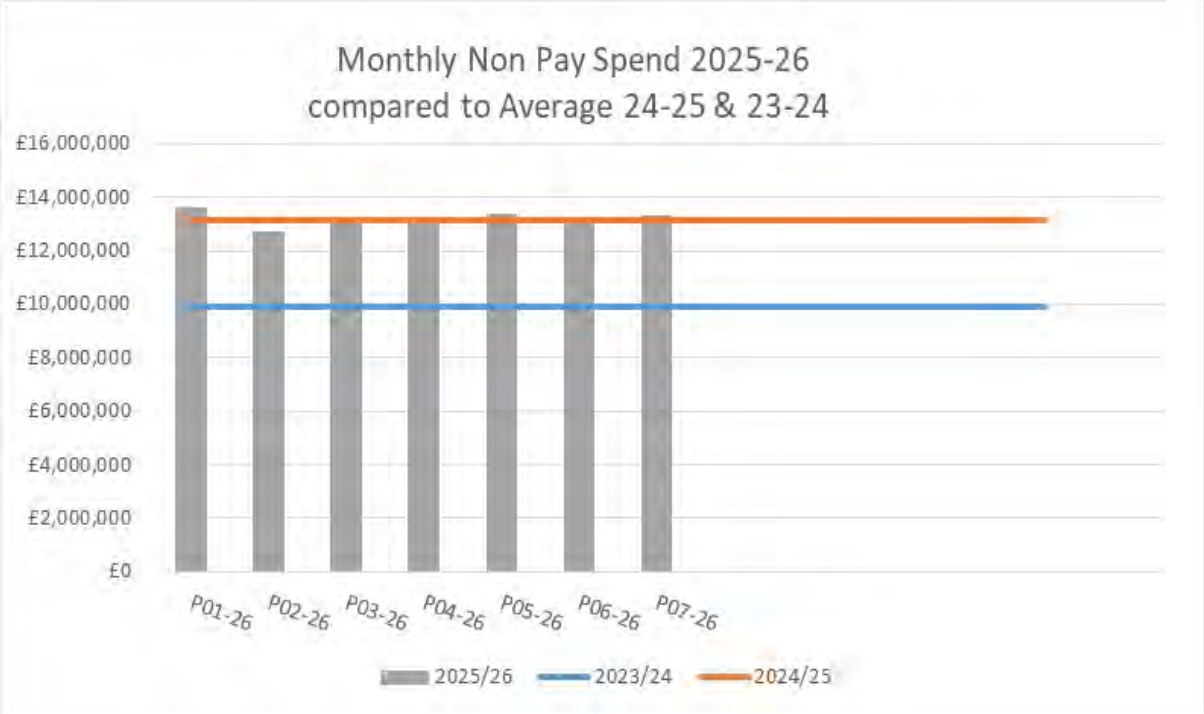
The largest area of agency spend relates to Allied Health Professionals, with agency staff utilised to support additional Capacity in Radiotherapy linked to the Velindre@ Nevill Hall Radiotherapy unit, and Therapies to support sickness. There continues to be some reliance on temporary staff to support vacancies, with the ambition that this will cease as posts continue to be filled. The agency expenditure forecast is therefore held broadly in line with the planning assumptions in the 2025-26 IMTP and is on track, although some areas anticipate there may be urgent service needs that will not always be met without agency / locum support.

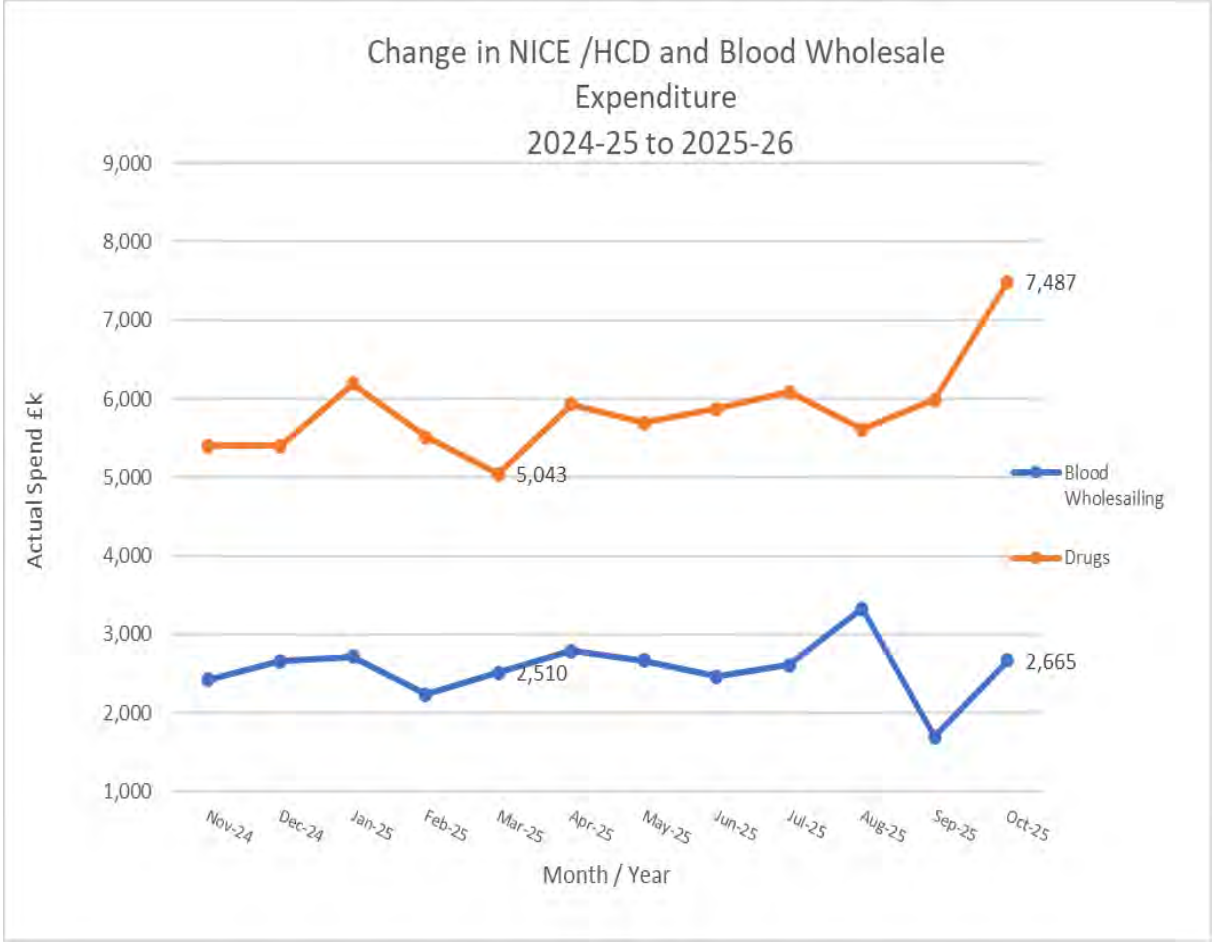
3.2 Non Pay

Non-Pay average spend for 2024/25 was £13.1m per month which was a £3.2m 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 £13.201m. NICE and HCD drugs (£6.095m) and blood wholesale average costs to date (£2.603m) have increased which will be offset by an income increase via recharges to Health Boards. Non-Cash (Impairment charges) are lower by (-£0.677m), mainly due to the charge incurred on the nVCC Asda works during 2024/25. 'Other' charges average costs are generally comparable at this time. The average Establishment expenses are comparable with 2024/25 but may show an increase when quarter two invoices are received and compared with estimates made to date.

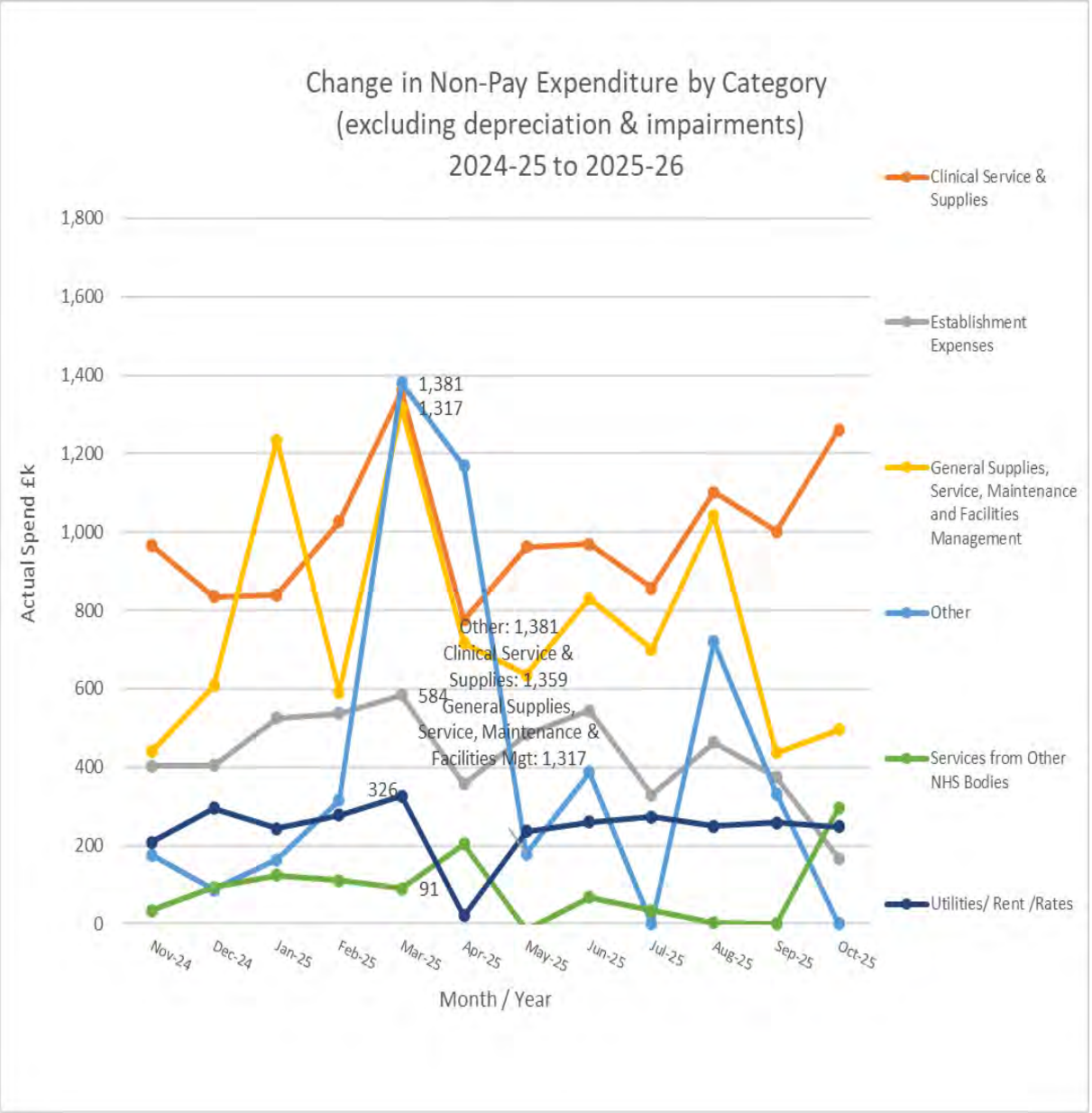
The graphs provided below show the change in non-pay spend split by expenditure category over the period from April 2025 to March 2026 compared to the average spend across the financial year 2023/24 and 2024/25.





Blood wholesaling costs are demand led and therefore difficult to predict. The reduction seen in September included an adjustment relating to August which was required due to an inaccuracy in August reporting caused by system issues.

The increase in drugs expenditure is split between high cost drugs £1.2m and general drugs £0.4m. The high cost drugs increase is being reviewed with Pharmacy colleagues to assess the impact on the full year forecast. The general drugs increase is partly caused by under reporting of c£0.228m in September; with the remainder also being reviewed but currently anticipated to be linked to increased activity.



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

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.

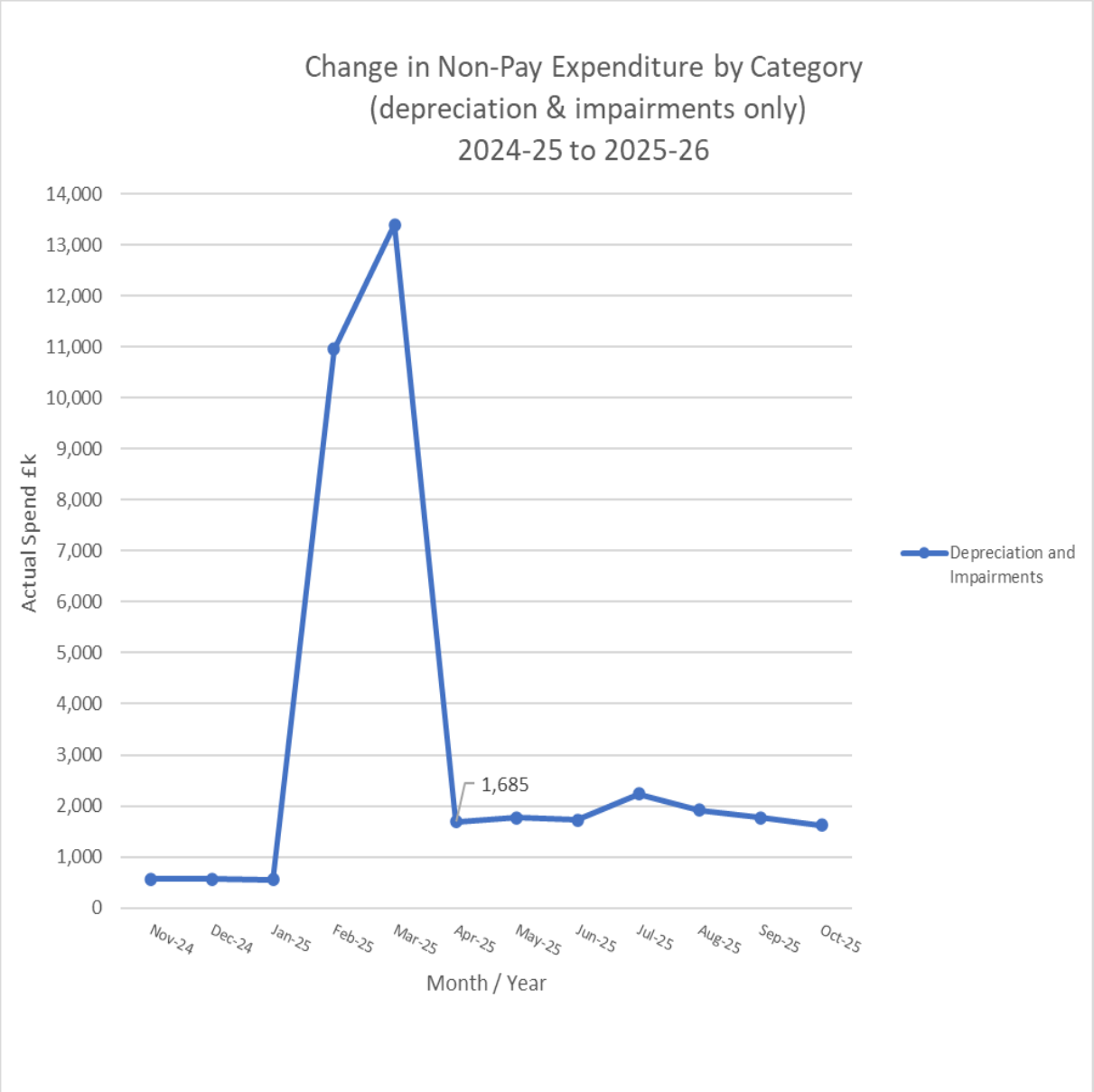
The increase in other spend in March 2025 relates to an increase in a provision for future cessium disposal costs. The reduction seen in May 2025 relates to a provision for legal costs of £1.184m which was made in error in April

and has been corrected in May. A reduction is again seen in July which is due to the reimbursement of legal costs by WRP of £1.369m, with further legal costs being recognised in August, as reflected above.

Establishment expenses have reduced in month 7 due to recovery of some VAT (£0.173m) previously paid to HMRC as a result of an annual review exercise. This has been treated as a reduction in expenditure.

The fluctuation in spend seen in the value of Services from Other NHS Bodies is in relation to the DHCW SLA charges and will be reviewed in month 8 to ensure the costs are accurately recorded each month. This requires an accounting adjustment: the value of the SLA has not been subject to change during the month.

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 October 2025 is an achievement of £1.063m against a year to date plan of £1.247m. Current expectation is that the annual savings target will be achieved although this is not without risk.

The saving schemes identified at the start of the year as part of the IMTP were created using smart actions to strengthen accountability, monitor progress and delivery.

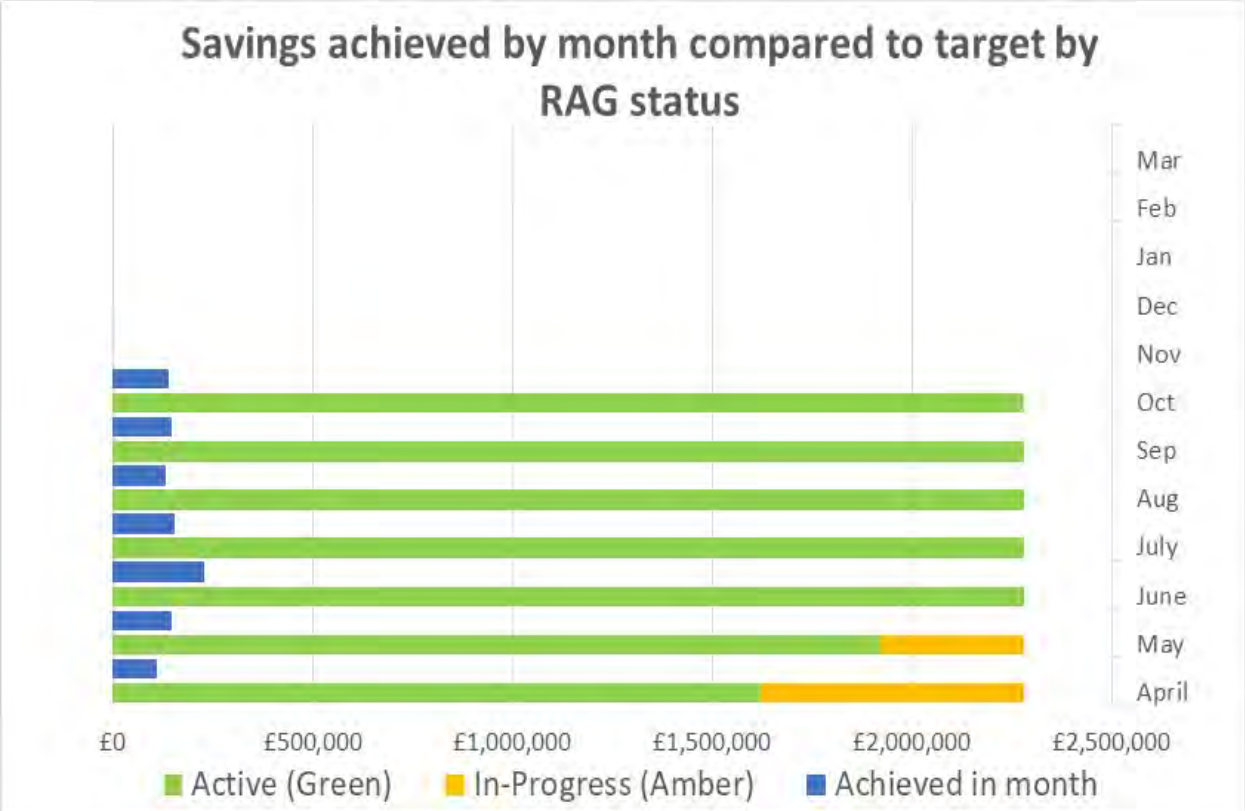
The Trust is currently on track to deliver the Trust savings target, however there is some risk of full delivery against recurrent savings schemes which are currently being replaced by non-recurrent schemes. Whilst this will ensure the target is met for this year it poses a risk to the Trusts underlying financial position.

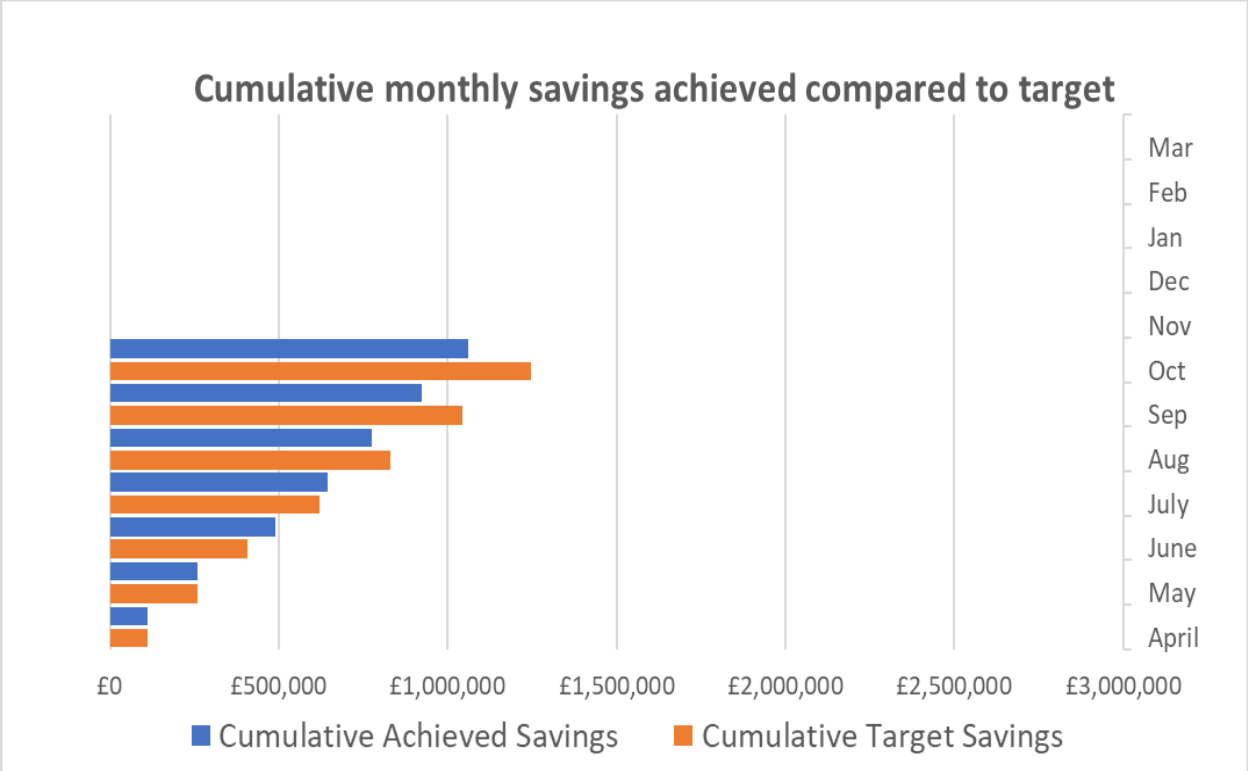
Savings performance is reported through the monthly Divisional finance reports and discussed / monitored via the VCS Divisional Triumvirate / OMB and WBS SMT. In addition, a monthly finance and performance review meeting is being established where Execs will review saving performance ensuring early sight of underperformance or issues.

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	537	395	(142)	1,043	0
			74%		100%	
WBS TOTAL SAVINGS	705	418	399	(19)	705	0
			95%		100%	
CORPORATE TOTAL SAVINGS	302	174	199	25	302	0
			114%		100%	
RD&I TOTAL SAVINGS	230	118	70	(48)	230	0
			59%		100%	
TRUST TOTAL SAVINGS	2,280	1,247	1,063	(184)	2,280	0
			85%		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	8	8	0	15	0
Establishment Vacancy Control	VCS	R	Green	150	87	37	(50)	150	0
Establishment Vacancy Control	VCS	NR	Green	100	58	25	(33)	100	0
Procurement Supply Chain Contracting Cost Reductions	VCS	R	Green	50	24	0	(24)	50	0
Review of SLAs to mitigate / reduce service support	VCS	R	Green	30	17	17	0	30	0
3rd party SACT provision (medicines at home)	VCS	R	Green	150	76	76	0	150	0
3rd party SACT provision (medicines at home)	VCS	NR	Green	70	41	40	(1)	70	0
Establishment Vacancy Control	WBS	R	Green	100	56	58	2	100	0
Procurement Supply Chain Contracting Cost Reductions	WBS	R	Green	100	17	0	(17)	100	0
Optimised level of stock retention	WBS	NR	Green	150	150	125	(25)	150	0
Demand planning: collections (aspheresis price saving)	WBS	R	Green	40	21	23	2	40	0
Demand planning: processing volumes	WBS	NR	Green	60	35	35	0	60	0
Process efficiencies	WBS	R	Green	30	12	30	18	30	0
Process efficiencies	WBS	NR	Green	20	8	20	12	20	0
Establishment Vacancy Control	Corporate	R	Green	50	30	30	0	50	0
Energy cost reduction	Corporate	R	Green	85	49	49	0	85	0
Establishment Vacancy Control	RD&I	R	Green	30	12	0	(12)	30	0
Establishment Vacancy Control	RD&I	NR	Green	50	24	0	(24)	50	0
Add Establishment Vacancy Control	VCS	NR	Green	128	66	22	(44)	128	0
Add Establishment Vacancy Control	WBS	NR	Green	55	35	32	(3)	55	0
Add Establishment Vacancy Control	Corporate	NR	Green	67	37	37	0	67	0
Add Establishment Vacancy Control	RD&I	NR	Green	30	12	0	(12)	30	0
Total Saving Schemes				**1,560**	875	664	(211)	1,561	0
Income Generation									
Private Patients Increased Fees Upon Renewed Contract	VCS	R	Green	150	68	85	17	150	0
Private Patients Income Overachievement	VCS	NR	Green	150	68	85	17	150	0
Maximising income - operational services	VCS	R	Green	50	24	0	(24)	50	0
Sale of Plasma	WBS	R	Green	50	30	21	(9)	50	0
Interest on bank income above budget	Corporate	NR	Green	100	58	83	25	101	0
R&D Commercial Income Generation	RD&I	R	Green	120	70	70	0	120	0
Sale of Plasma	WBS	NR	Green	100	54	54	0	100	0
Total Income Generation				**720**	372	398	26	721	0
TRUST TOTAL SAVINGS				**2,280**	**1,247**	**1,063**	**(184)**	**2,283**	**0**
						85%		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. In July, £0.345m of the reserve was 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:

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, this has since been confirmed that no commitment will be made this year. The Trust re-submitted the service growth investments to our Commissioners on the 22nd October in line with the IMTP governance timeline process for 2026/27. Early indication already is that the Trust is very unlikely to receive any support.

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 were re-submitted on 8th October 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.

Velindre @ Nevill Hall Radiotherapy Unit Income Shortfall – *likelihood: medium, value £0.200m*

A risk has emerged 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. The expectation to month 6 has been a shortfall of between £0.500m and £0.750m during 2025-26, after mitigations are put in place, such as holding of vacancies. A review of the impact and forecast position has been undertaken during October. This has resulted in £0.300m being phased into the actual position and forecast over the remaining months of the year, offset by a number of small reductions in several non pay spend areas. A risk of a further £0.200m cost pressure remains.

In addition, the Trust wrote to its commissioners on the 8th August requesting funding support of £0.278m for the additional recurrent costs that have emerged since the FBC and the go live date where the first patient was treated on the 19th June 2025. The Trust was informed at the Commissioners meeting on the 17th June that they will not support these additional costs and will be formally writing back to the Trust of this intention in due course.

Non Delivery of Mitigations to Recover the Increase in the Welsh Risk Pool Risk Share Cost *– likelihood: medium, value £0.310m - £0.400m*

NWSSP have provided an additional forecast of the risk share costs to organisations which has resulted in an increase for the core Trust of between £0.310m and £0.400m. 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, £369k recurrently from 2026/27*

It is understood that there the restructure will not result in a financial pressure in 2025/26. However, there will be an ongoing need once all posts are filled, to confirm the value and identify 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.

Funding Not Available to Support Costs of Re-banding Band 2-3 Healthcare Support Workers

This is a new addition to the financial risks reported this month. Costs for 2025/26 are currently estimated as follows:

- Back payment - £0.062m
- Recurrent additional costs - £0.035m

Estimates are currently being reviewed in line with those calculated by other NHS Wales organisations. It is hoped that funding will be provided by Welsh Government, but until this is confirmed, the additional costs are considered a financial risk.

Opportunities

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*

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*

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.

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 @M8 £m	Full Year Forecast Spend £m	Year End Variance 2025/26 £m
All Wales Capital Programme					
nVCC Enabling Works	3.683	2.167	1.516	3.846	(0.163)
nVCC Enabling Works QRA*	0.332	0.000	0.332	0.332	0.000
nVCC Project	6.376	3.476	2.900	6.376	0.000
nVCC Project QRA - Enabling Works HV Intake	0.257	0.000	0.257	0.257	0.000
nVCC Project QRA - MIM	0.068	0.000	0.068	0.068	0.000
nVCC Project QRA - MIM*	0.150	0.000	0.150	0.150	0.000
Integrated Radiotherapy Solution (IRS)	1.400	1.041	0.359	1.400	0.000
Velindre @ Nevill Hall Radiotherapy Centre (RSC)	0.680	0.312	0.368	0.680	0.000
Whitchurch Hospital Site Disposal	0.840	0.141	0.699	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	1.000	0.002	0.998	1.000	0.000
WBS Fleet Replacement Programme	0.605	0.000	0.605	0.605	0.000
DPIF - RISP	0.214	0.000	0.214	0.214	0.000
DPIF - Blood Establishment Computer System (BECS) replacement	0.416	0.317	0.099	0.416	0.000
DPIF - Welsh Histocompatibility & Immunogenetics Service (WHAIS)	0.185	0.154	0.031	0.185	0.000
DPIF - Electronic Prescribing & Medicines Administration (EPMA)	0.086	0.000	0.086	0.086	0.000
WBS Plasma for Fractionation	0.030	0.024	0.006	0.030	0.000
Non-Radiology Ultrasound Replacement	0.048	0.000	0.048	0.048	0.000
Radiology Ultrasound Replacement	0.132	0.000	0.132	0.132	0.000
VPAG Funding - Equipment	0.041	0.000	0.041	0.041	0.000
Total All Wales Capital Programme	16.843	7.634	9.209	17.006	(0.163)
Discretionary Capital	2.000	0.704	1.296	2.000	0.000
	18.843	8.338	10.505	19.006	(0.163)
** QRA budget held by WG*					

The approved 2025-26 Capital Expenditure Limit (CEL) for the year ended March 2026 is currently £18.843m (2024-25 £35.076m). This includes All Wales Capital funding of £16.843m, and discretionary funding of £2.000m. Some changes have recently been made following the Trust's review of CEL requirements by 31st October 2025, which is an annual exercise led by Welsh Government. This includes a significant reduction in relation to nVCC financial requirements in 2025/26 at the request of the Project Team. Further changes to other items are possible as Welsh Government colleagues review the remaining additional funding requests made by the Trust via this exercise.

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, with a total of £1.000m required in 2025/26. Welsh Government have amended the allocation for 2025/26 and confirmation as to whether the value will be reprofiled in 2026/27 is awaited.

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 revised OBC will incorporate the Enabling Works and laboratory modernisation, with the appointed Supply Chain Partner leading design development. It has been agreed with WG that the Enabling Works section will be to FBC standard. The updated OBC must be submitted by the end of the 2025/26 financial year to align with WG funding timelines and strategic priorities.

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 has also received an award letter for both revenue and capital funding for phase 1 of the plasma fractionation case.

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. The Trust has submitted its requests which have been passed by WG Capital Colleagues to the Cabinet Secretary for Health and Social Care for consideration.

Performance to date

The actual expenditure to October 2025 on the All-Wales Capital Programme schemes was £7.634m: this is broken down between spend on the nVCC schemes of £6.684m, Whitchurch Hospital Site Disposal £0.141m, Velindre@ Nevill Hall Radiotherapy Unit £0.312m, WBS HQ OBC £0.002m, BECS £0.317m, WHAIS £0.154m, and WBS Plasma for Fractionation £0.024m.

The spend on the Discretionary Capital programme was £0.704m. Where schemes are agreed and funding is in place, leads are encouraged to progress schemes to aid service delivery / improvements and ensure items are delivered well before the end of 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 October 2025	Movement from 1st April to 31 October 2025	Forecast Closing Balance at 31 March 2026
Non-Current Assets	**£'m**	**£'m**	**£'m**	**£'m**
Property, plant and equipment	311.793	311.837	0.044	311.837
Intangible assets	11.160	9.497	(1.663)	9.497
Trade and other receivables	1,350.042	1,350.106	0.064	1,350.106
Other financial assets	0.000	0.000	0.000	0.000
Non-Current Assets sub total	1,672.995	1,671.440	(1.555)	1,671.440
Current Assets				
Inventories	31.666	31.749	0.083	31.749
Trade and other receivables	592.821	598.286	5.465	604.595
Other financial assets	0.000	0.000	0.000	0.000
Cash and cash equivalents	15.206	22.994	7.788	15.490
Non-current assets classified as held for sale	0.000	0.000	0.000	0.000
Current Assets sub total	639.693	653.029	13.336	651.834
TOTAL ASSETS	2,312.688	2,324.469	11.781	2,323.274
Current Liabilities				
Trade and other payables	(253.207)	(261.586)	(8.379)	(261.586)
Borrowings	(1.530)	(1.456)	0.074	(1.456)
Other financial liabilities	0.00	0.00	0.000	0.00
Provisions	(364.179)	(728.362)	(364.183)	(728.362)
Current Liabilities sub total	(618.916)	(991.404)	(372.488)	(991.404)
NET ASSETS LESS CURRENT LIABILITIES	1,693.772	1,333.065	(360.707)	1,331.870
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)	(998.694)	363.743	(998.694)
Non-Current Liabilities sub total	(1,474.802)	(1,110.634)	364.17	(1,110.634)
TOTAL ASSETS EMPLOYED	218.970	222.431	3.461	221.236
FINANCED BY:				
Taxpayers' Equity				
General Fund	0.000	0.000	0.000	0.000
Revaluation reserve	36.469	39.926	3.46	39.926
PDC	162.684	162.685	0.001	161.490
Retained earnings	19.817	19.820	0.003	19.820
Other reserve	0.000	0.000	0.000	0.000
Total Taxpayers' Equity	218.970	222.431	3.461	221.236

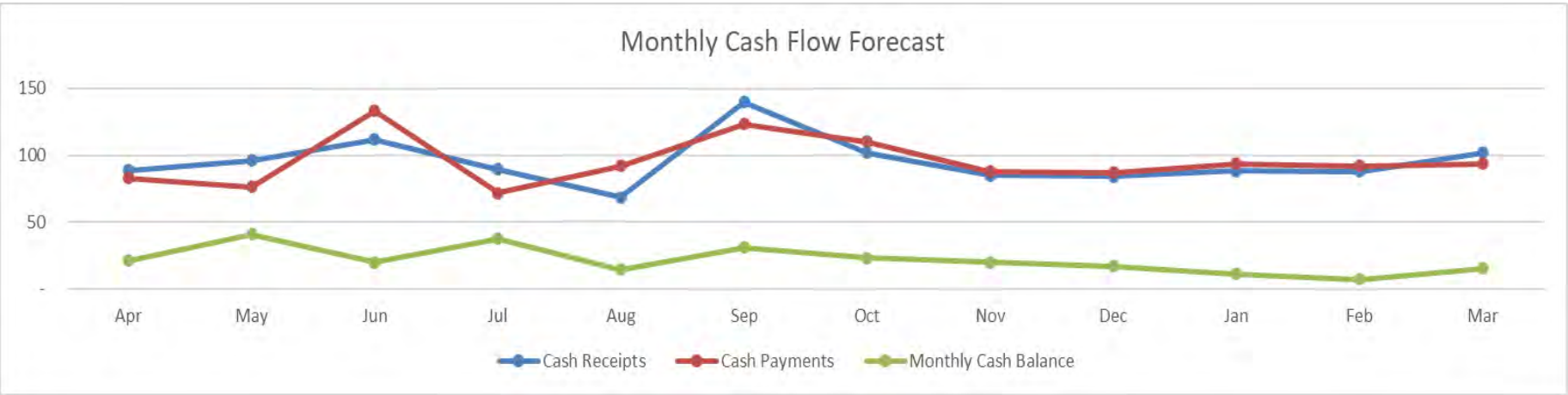
9. CASH FLOW (Includes Hosted Organisations)

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													
Income from other Welsh NHS Organisations	49.990	55.994	45.475	48.706	53.298	81.394	65.498	52.967	53.667	54.667	55.967	52.964	670.587
WG Revenue Funding	29.236	33.465	64.624	27.572	11.458	49.581	29.267	24.767	24.267	26.267	25.767	26.267	372.538
Short Term Loans													0.000
PDC												0.000	0.000
Interest Receivable	0.163	0.119	0.142	0.136	0.129	0.152	0.107	0.155	0.155	0.155	0.155	0.155	1.723
Sale of Assets													0.000
Other	9.452	6.736	1.583	13.156	3.690	8.651	7.162	6.930	6.155	7.155	5.930	22.687	99.287
TOTAL RECEIPTS	**88.841**	**96.314**	**111.824**	**89.570**	**68.575**	**139.778**	**102.034**	**84.819**	**84.244**	**88.244**	**87.819**	**102.073**	**1,144.135**
PAYMENTS													
Salaries and Wages	30.118	42.171	41.742	41.568	47.485	49.601	45.924	44.440	44.440	44.440	44.440	44.440	520.809
Non pay items	52.934	34.043	86.348	29.681	43.433	72.051	62.065	41.100	40.150	42.850	41.100	41.609	587.364
Short Term Loan Repayment													0.000
PDC Repayment		0.000										1.194	1.194
Capital Payment	0.000	0.000	5.038	0.387	0.890	1.481	2.165	2.500	2.500	6.500	6.500	6.500	34.461
Other items													0.000
TOTAL PAYMENTS	**83.052**	**76.214**	**133.128**	**71.636**	**91.808**	**123.133**	**110.154**	**88.040**	**87.090**	**93.790**	**92.040**	**93.743**	**1,143.828**
Net cash inflow/outflow	5.789	20.100	(21.304)	17.934	(23.233)	16.645	(8.120)	(3.221)	(2.846)	(5.546)	(4.221)	8.330	
Balance b/f	15.183	20.972	41.072	19.768	37.702	14.469	31.114	22.994	19.773	16.927	11.381	7.160	
Balance c/f	20.972	41.072	19.768	37.702	14.469	31.114	22.994	19.773	16.927	11.381	7.160	15.490	



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	(30.520)	(31.352)	(0.832)	(49.379)	(49.379)	0.000
RD&I	0.209	0.165	(0.045)	0.440	0.440	0.000
WBS	(13.658)	(13.658)	0.000	(23.678)	(23.678)	0.000
Sub-Total Divisions	**(43.969)**	**(44.844)**	**(0.876)**	**(72.617)**	**(72.617)**	**0.000**
Corporate Services Directorates	(9.487)	(8.605)	0.882	(15.725)	(15.725)	0.000
Delegated Budget Position	**(53.457)**	**(53.449)**	**0.006**	**(88.342)**	**(88.342)**	**0.000**
nVCC	(0.078)	(0.082)	(0.004)	(0.096)	(0.096)	0.000
Health Technology Wales	(0.141)	(0.141)	0.000	(0.183)	(0.183)	0.000
Trust Income / Reserves	53.675	53.675	0.000	88.622	88.622	0.000
Trust Position	**0.000**	**0.002**	**0.002**	**0.0000**	**0.000**	**0.000**

The in month position for the core Trust is an overspend of £0.002m, leading to a year to date **underspend of £0.002m.** 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	**58.515**	**58.874**	**0.359**	**98.707**	**99.066**	**0.359**
Expenditure						
Staff	37.154	37.398	(0.245)	60.787	61.032	(0.245)
Non Staff	51.882	52.827	(0.946)	87.299	87.413	(0.114)
Sub Total	**89.035**	**90.226**	**(1.190)**	**148.086**	**148.444**	**(0.359)**
Total	**(30.520)**	**(31.352)**	**(0.831)**	**(49.379)**	**(49.379)**	**0.000**

VCS Key Highlights/ Issues:

The reported financial position for Velindre Cancer Services as at the end of October 2025 was an **overspend of (£0.831m)** 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 7 represents a year to date overachievement of **£0.359m** which is largely a result of overachievement of additional activity income (offset by underachievement of activity in Velindre@Nevill Radiotherapy Unit) and Private Patient income.

During 2024-25 LTA activity performance underachieved against the income growth target set by c£0.240m, which resulted in marginal income not matching the level of service investment that was made to support capacity within VCS. As LTA activity year to date has improved in 2025/26, it is no longer flagged as a financial risk but will continue be monitored closely against plan.

A 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. The expectation to month 6 was a shortfall of between £0.500m and £0.750m during 2025-26, after mitigations have been put in place, such as holding of vacancies. A review of the impact and forecast position has been undertaken during October. This has resulted in £0.300m being phased into the actual position and forecast over the remaining months of the year, offset by a number of small reductions in several non pay spend areas. A risk of a further £0.200m cost pressure remains.

VCS have reported a year to date overspend of **£(0.245)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 7 was **£(0.946)m** overspent which includes overspends of £0.096m for nursing stores items, £0.143m for postage costs, £0.197m for legal provisions, £0.331m for general drugs, and £0.141m for the pathology SLA. 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	**21.582**	**21.998**	**0.416**	**36.126**	**36.542**	**0.416**
Expenditure						
Staff	11.766	11.775	(0.008)	19.389	19.397	(0.008)
Non Staff	23.474	23.882	(0.408)	40.416	40.823	(0.408)
Sub Total	**35.241**	**35.657**	**(0.416)**	**59.805**	**60.220**	**(0.416)**
Total	**(13.658)**	**(13.659)**	**0.000**	**(23.678)**	**(23.678)**	**0.000**

Key Highlights/ Issues:

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

WBS recognised an overachievement of **£0.416m** on income due predominantly to an increase in activity for the bone marrow registry (£0.237m), sale of plasma (£0.091m) and exportation (£0.071m).

Regarding the first item, 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 showing positive improvement now, although, 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 it was recognised that the target was too high and was partly funded on both a recurrent and non-recurrent basis as part of the 2025-26 IMTP process thus reducing the target for this year.

Staff underspend of **£0.008m** to date is due to an increased CIP (savings target), along with advance recruitment and appointments made at risk without identified funding source, offset by some vacancies within the service, and the release of a year end accrual in respect of time off in lieu, and overtime costs. 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 (**£0.408m)** as at the end of month 7. The largest cost pressure is the divisional savings target, partly offset by activity related performance.

Corporate

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**3.007**	**3.659**	**0.653**	**5.571**	**6.223**	**0.653**
Expenditure						
Staff	9.873	9.181	0.691	16.687	15.996	0.691
Non Staff	2.621	3.083	(0.462)	4.609	5.953	(1.344)
Sub Total	**12.494**	**12.264**	**0.229**	**21.296**	**21.949**	**(0.653)**
Total	**(9.487)**	**(8.605)**	**0.882**	**(15.725)**	**(15.725)**	**0.000**

Corporate Key Highlights / Issues:

The reported financial position for the Corporate Services division at the end of October 2025 was an **underspend of £0.882m** 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. There has also been a significant recovery of previously VAT paid to HMRC, as a result of an annual review exercise.

Several vacancies within the division has resulted in a year to date underspend and is offsetting the use of agency and the divisional savings target. However, this is unlikely to continue with additional staffing requirements currently being reviewed.

Non-pay overspend is again expected and largely relates to divisional CIP target and additional non pay spend currently processed via the Corporate Management budget. 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	**2.948**	**3.202**	**0.254**	**5.330**	**5.584**	**0.254**
Expenditure						
Staff	2.346	2.565	(0.218)	4.126	4.344	(0.218)
Non Staff	0.392	0.473	(0.081)	0.764	0.800	(0.036)
Sub Total	**2.739**	**3.038**	**(0.299)**	**4.890**	**5.144**	**(0.254)**
Total	**0.209**	**0.165**	**(0.045)**	**0.440**	**0.440**	**0.000**

RD&I Key Highlights / Issues

The reported financial position for the RD&I Division at the end of October 2025 was an **overspend of (£0.045m)** 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**	**0.037**	**0.037**	**0.023**	**0.060**	**0.037**
Expenditure						
Staff	0.066	0.096	(0.030)	0.096	0.126	(0.030)
Non Staff	0.012	0.022	(0.010)	0.023	0.030	(0.007)
Sub Total	**0.078**	**0.118**	**(0.040)**	**0.119**	**0.156**	**(0.037)**
Total	**(0.078)**	**(0.081)**	**(0.003)**	**(0.096)**	**(0.096)**	**0.000**

nVCC Key Highlights / Issues

The reported financial position for the nVCC Programme at the end of October 2025 is a minor underspend of £0.003m, with a year end forecast of breakeven.

A fuller financial analysis is included in appendix 2.

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	**1.003**	**0.876**	**(0.127)**	**1.723**	**1.596**	**(0.127)**
Expenditure						
Staff	1.079	0.961	0.119	1.794	1.676	0.119
Non Staff	0.064	0.056	0.008	0.111	0.103	0.008
Sub Total	**1.143**	**1.017**	**0.127**	**1.906**	**1.779**	**0.127**
Total	**(0.141)**	**(0.141)**	**0.000**	**(0.183)**	**(0.183)**	**0.000**

HTW Key Highlights / Issues

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

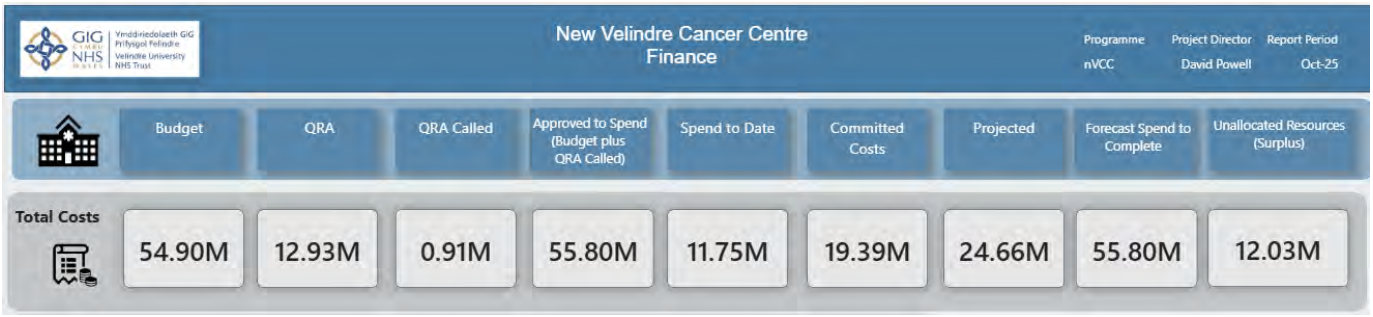
1.1 The purpose of this report is to provide a financial update to the new Velindre Cancer Centre (nVCC) Project Board outlining spend to date against the Welsh Government (WG) approved/indicative budget as of **October 2025**.

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 **OCTOBER 2025** is set out below:



- The in-year **financial position** for **OCTOBER 2025** is:

  - **CAPITAL** in-year spend of **£4.562m**, with a forecast outturn of **c£8.712m** based on run-rates and financial plan.

nVCC Project Capital Budget & Spend Summary 2025-26

	Year to Date			Financial Year		
	Budget Oct-25	Spend Oct-25	Variance Oct-25	Annual Budget	Annual Forecast	Annual Variance
	£	£	£	£	£	£
EW FBC Project	2,167,096	2,167,096	0	3,940,331	4,102,917	-162,586
nVCC FBC Project	2,394,837	2,394,837	0	4,609,282	4,609,282	0
	4,561,933	**4,561,933**	**0**	**8,549,613**	**8,712,199**	**-162,586**

  - **REVENUE** in-year spend of **£0.082m**, with a forecast outturn of **c£0.142m** based on run-rates and financial plan.

REVENUE	Year to Date			Financial Year		
	Budget Oct-25	Spend Oct-25	Variance Oct-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	69,561	69,923	-362	119,247	119,247	0
Project Delivery Support Costs	12,030	12,104	-74	23,000	23,000	0
nVCC Revenue Total	**81,591**	**82,027**	**-437**	**142,247**	**142,247**	**0**
REVENUE TOTAL	**81,591**	**82,027**	**-437**	**142,247**	**142,247**	**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 in the approved FBC is **£78.662m capital** and **£2.412m revenue** for the nVCC Project.

A summary breakdown of funding is shown below:

Capital Budget: £69.719m consisting of:

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

Revenue Budget: £2.412m consisting of:

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

Enabling Works Budget: £8.943m consisting of:

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

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.

3.4 As a result of the Trust and Welsh Government reassessment of the QRA allocation, the capital funding has been **reduced to £72.902m.** It should be noted that the QRA is reviewed on a quarterly basis.

3.5 A summary breakdown of the estimated revised funding is shown below:

Total funding

EW Project		
	FBC Addendum	£7,575,600
	Original FBC	£96,000
	QRA	£1,367,400
		£9,039,000
nVCC Project		
	Equipment	£32,540,286
	Transactions(Resource Costs)	£14,507,885
	Deep Clean	£272,000
	IRS Implementation	£5,071,000
	QRA	£11,471,460
		£63,862,631
		£72,901,631

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£55.8m. The projected spend is £55.8m leading to a breakeven position. The spend forecast is made up of actual spend of c£11.751m, contractual commitments of c£19.4m and projected spend to completion of c£24.7m. The projected spend element of c£24.7m is primarily equipment (c£24.1m).

4.3 It should be noted that as at October the Trust has commitments of c£8.4m for major medical equipment with purchase orders raised in September 2025.

4.4 The Project had reserves as per the FBC of c£18.7m and into the second year of the construction phase and to date has only called down £0.909m of the QRA, which represents 4.9% of the agreed reserves. In September 2025, the Trust reviewed the QRA and reduced the risk exposure by c£5.8m. Therefore, the Project retains reserves of c£12.03m. The risk exposure was reduced in respect of major equipment; design elements and disruption of works. The retained reserve reflects a prudent provision for the remainder of the contract term.

4.5 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: Oct-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	All Selected								
	7.58M	1.46M	625K	8.20M	6.03M	1.78M	387K	8.20M	839K
Equipment	All Selected								
	32.54M	2.58M	0	32.54M	114K	8.48M	23.94M	32.54M	2.58M
Transactions (Resource Costs)	Design & Construction								
	2.61M	444K	59K	2.67M	1.15M	1.45M	59K	2.67M	385K
MIM (Construction Costs)	0	3.56M	225K	225K	183K	42K	0	225K	3.33M
Deep Clean	272K	156K	0	272K	0	0	272K	272K	156K

EW Project – **as of October 2025**

4.6 The overall financial position is an approval to spend of c£8.200m, which is set out below:

EW Project

FBC Addendum	£7,575,600
Original FBC	£96,000
QRA Called	£528,800
	£8,200,400

4.7 The overall financial position is set out below:

	FBC Funding	Costs Incurred	Costs Incurred to Date	Commitments	Projected Costs
		2024-25	Oct-25	Oct-25	Oct-25
EW Project					
Pay	£153,116	£153,116	£0	£0	£0
6MVA Supply - National Grid	£576,000	£480,000	£35,919	£60,081	£0
Supply Chain Fees	£645,800	£323,268	£137,522	£185,011	£0
Non Works Costs	£0	-£113,202	£0		£113,202
Asda Works	£1,776,000	£2,008,269	£0		-£232,269
Walters Design & Build	£0	£116,260	£21,873		-£138,133
S278 works on Longwood Drive	£3,317,549	£288,858	£1,576,508	£1,255,452	£196,731
Offsite Habitat Creation (SW Corner)	£717,335	£434,292	£125,155	£157,888	£0
HV Intake Room	£627,600	£161,286	£270,120	£125,615	£70,579
Rural Path	£75,000	£0	£0		£75,000
TCAR Habitat	£72,000	£0	£0		£72,000
Revised Emergency Access	£240,000	£0	£0		£240,000
Enabling Works FBC Reserves	£0	£9,921	£0		-£9,921
TOTAL EW PROJECT	**£8,200,400**	**£3,862,068**	**£2,167,096**	**£1,784,047**	**£387,189**
QRA funding	£1,367,400				£1,367,400
HV Intake Room Drawdown	-£160,800				-£160,800
Asda Final AccountDrawdown	-£368,000				-£368,000
Sacrificial Cable	-£96,000				-£96,000
S278 Works					£0
Addn funding	£96,000				£96,000
	£838,600	**£0**	**£0**	**£0**	**£838,600**
TOTAL nVCC EW FUNDING	**£9,039,000**	**£3,862,068**	**£2,167,096**	**£1,784,047**	**£1,225,789**

4.8 The overall financial position of the EW Project is spend to date is c£6.029m, with commitments of c£1.784m and projected costs of c£0.387m.

4.9 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 has recently been reviewed and adjusted to reflect the current risks within the Enabling works.

Financial Risks

4.10 The QRA reflects the risks being managed by the EW Project as at October 2025.

nVCC Project – **as of October 2025**

4.11 The overall financial position is an approval to spend of c£47.604m, which is set out below:

nVCC Project

Equipment	£32,540,286
Transactions(Resource Costs)	£14,507,885
Deep Clean	£272,000
QRA Called	£284,000
	£47,604,171

4.12 The overall financial position is set out below:

	FBC Funding	Costs Incurred	Costs Incurred to Date	Commitments	Projected Costs
		2024-25	Oct-25	Oct-25	Oct-25
nVCC MIM Activties					
Project Management Office	£3,325,884	£1,181,156	£629,704	£1,515,024	£0
Design & Construction Workstream	£2,606,271	£629,664	£523,309	£1,453,298	£0
Equipment, Commissioning and Migration Workstream	£3,722,193	£372,839	£347,396	£3,001,958	£0
Digital Workstream	£1,935,417	£113,756	£158,325	£1,663,336	£0
Engagement & Communications Workstream	£380,688	£159,689	£83,737	£137,262	£0
Commercial Activity Group	£2,242,432	£621,540	£386,318	£1,234,574	£0
Strategic Reserves			£0	£0	£0
Project Delivery	£295,000	£117,988	£99,652	£77,360	£0
Major Medical Equipment	£10,676,400	£0	£0	£8,194,000	£2,482,400
Other Equipment	£12,385,200	£0	£51,353	£62,000	£12,271,847
IM&T infrastructure	£5,359,802	£0	£62,790	£128,960	£5,168,052
Digital	£433,415	£0	£0	£0	£433,415
Digitisation of Health Records	£3,685,469	£0	£0	£100,000	£3,585,469
Non Works Costs	£272,000	£0	£0	£0	£272,000
MIM Construction Costs	£225,000	£130,434	£52,252	£42,314	£0
PROW Diversions	£59,000			£59,000	£0
TOTAL nVCC PROJECT	**£47,604,171**	**£3,327,065**	**£2,394,836**	**£17,669,086**	**£24,213,184**
QRA funding	£11,471,000				£11,471,000
Asda Traffic Management Drawdown	-£225,000				-£225,000
PROW Diversions	-£59,000				-£59,000
	£11,187,000	**£0**	**£0**	**£0**	**£11,187,000**
TOTAL nVCC MIM FUNDING	**£58,791,171**	**£3,327,065**	**£2,394,836**	**£17,669,086**	**£35,400,184**
IRS Implementation	£5,071,000	£963,000	£1,081,000	£3,027,000	£0
TOTAL nVCC MIM FUNDING	**£63,862,171**	**£4,290,065**	**£3,475,836**	**£20,696,086**	**£35,400,184**

4.13 The overall financial position of the nVCC Project is spend to date is c£5.722m, with commitments of c£17.669m and projected costs of c£24.213m.

4.14 The QRA available for the nVCC Project is c£11.187m and reflects the unallocated resources for the Project. It should be noted that the QRA has recently been reviewed and adjusted to reflect the current risks within the project.

Financial Risks

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

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

5.1 The in year financial position for **OCTOBER 2025** is reporting an **overspend** position due to the additional funding required for Enabling works that will be requested from the QRA funds available.

- **CAPITAL** in-year spend of **£8.550m**, with a forecast outturn of **c£8.712m** 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 Oct-25	Year to Date Spend Oct-25	Year to Date Variance Oct-25	Financial Year Annual Budget	Financial Year Annual Forecast	Financial Year Annual Variance
	£	£	£	£	£	£
Enabling Works						
Enabling Works Pay	0	0	0	0	0	0
6MVA Supply - National Grid	35,919	35,919	0	131,919	131,919	0
Supply Chain Fees	137,522	137,522	0	218,855	218,855	0
Non Works Costs	0	0	0	0	0	0
Asda Works	0	0	0	0	0	0
Walters Design & Build	21,873	21,873	0	21,873	21,873	0
S278 works on Longwood Drive	1,576,508	1,576,508	0	2,859,374	3,021,960	-162,586
Offsite Habitat Creation (SW Corner)	125,155	125,155	0	283,043	283,043	0
HV Intake Room	270,120	270,120	0	395,735	395,735	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	29,533	29,533	0
Enabling Works Capital Total	**2,167,096**	**2,167,096**	**0**	**3,940,331**	**4,102,917**	**-162,586**
New Velindre Cancer Centre						
Project Management Office	729,356	729,356	0	1,274,377	1,274,377	0
Design & Construction	523,309	523,309	0	859,613	859,613	0
MIM (Construction Costs)	52,252	52,252	0	60,000	60,000	0
Equipment, Commissioning and Migration	347,396	347,396	0	755,355	755,355	0
Medical and Other Equipment Procurement	51,353	51,353	0	113,353	113,353	0
Digital	158,325	158,325	0	346,663	346,663	0
IM&T & Digital Procurement	62,790	62,790	0	291,750	291,750	0
Engagement & Communications	83,737	83,737	0	139,409	139,409	0
Commercial Activities Group	386,318	386,318	0	677,372	677,372	0
Strategic Reserves	0	0	0	91,389	91,389	0
nVCC Capital Total	**2,394,837**	**2,394,837**	**0**	**4,609,282**	**4,609,282**	**0**
CAPITAL TOTAL	**4,561,933**	**4,561,933**	**0**	**8,549,613**	**8,712,199**	**-162,586**

- **REVENUE** in-year spend of **£0.142m**, with a forecast outturn of **c£0.142m** based on run-rates and financial plan

The detailed revenue financial position is set out below:

REVENUE	Year to Date Budget Oct-25	Year to Date Spend Oct-25	Year to Date Variance Oct-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	69,561	69,923	-362	119,247	119,247	0
Project Delivery Support Costs	12,030	12,104	-74	23,000	23,000	0
nVCC Revenue Total	**81,591**	**82,027**	**-437**	**142,247**	**142,247**	**0**
REVENUE TOTAL	**81,591**	**82,027**	**-437**	**142,247**	**142,247**	**0**

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

Work Packages are outlined below:

- **Supply Chain Fees** – **spend of £0.138m -** costs associated with advisory support provided by WSP (£0.124m); MDA Consult Ltd (£0.009m); and Escrow fees (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 £1.577m -** costs associated with the highway improvement works on Longwood Drive agreed with Cardiff County Council. Works costs c£1.559m and advisory costs c£0.018m.
- **Off-site Habitat** – **spend of £0.125m -** costs associated with the offsite habitat creation required as part of the EPSL.
- **HV Intake Room – spend of £0.270m** - costs associated with the design and build of the HV intake room. Works costs are c£0.264m.
- **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 £1.397m.** Reflects the Project posts and a run rate of c£0.200m per month.

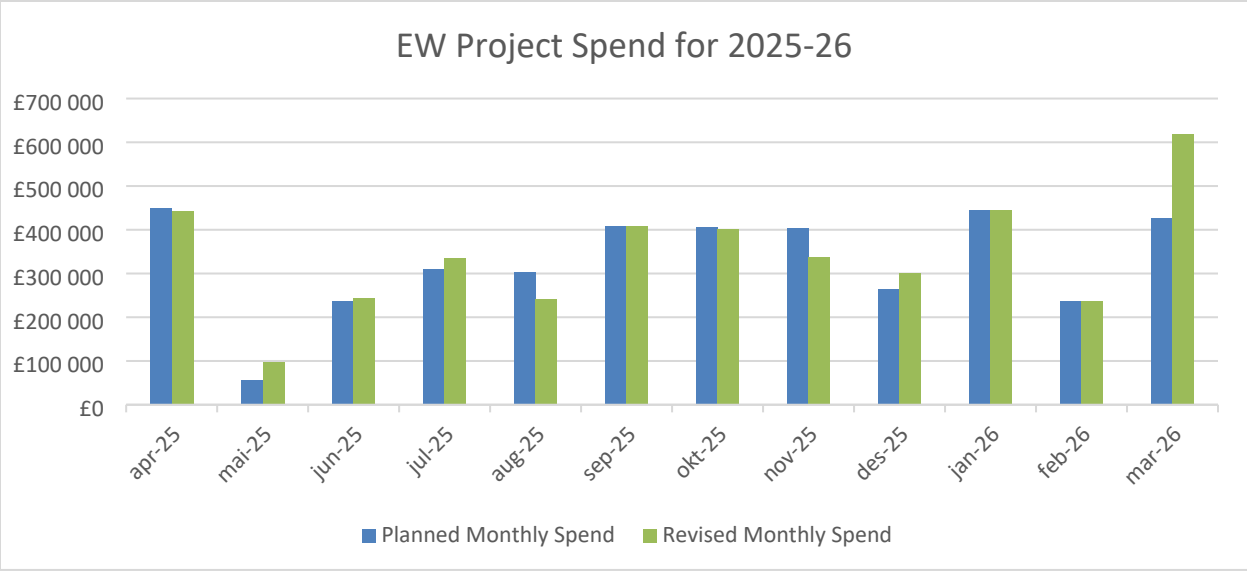
Work Packages are outlined below:

- **Project Delivery –** costs associated with the running of the Project Office and spend is **£0.100m.**
- **Capability Review – spend £0.050m.**

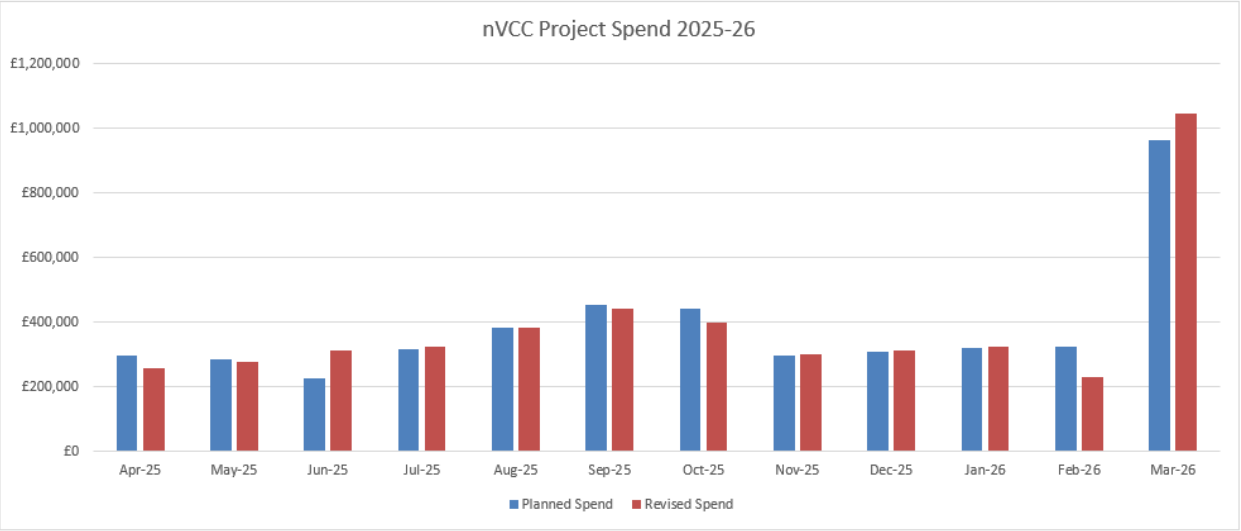
- **RDD Process** – **spend of £0.162m** for the reviewable design data process as RIBA stage design is finalized with Project Co.
- **Construction Phase – spend of £0.198m** for the services provided by the Authority Construction Surveyor.
- **Equipment Advisers & purchases – spend of c£0.090m** for equipment advice and Radiation dosage meters and consultation site visits.
- **Digital equipment procurement – spend of c£0.063m** mainly for Switches and the Mizaic report for the Digitalisation of Health records Programme.
- **Engagement and Communications – spend of c.£0.012m** for 3D Flythrough presentations.
- **Project Management Advisers – spend of c£0.100m** for the SRO; Project Control and Risk Management support.
- **Professional Advisers – spend of £0.205m** 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 below outlines the Enabling works actual capital spend to **OCTOBER 2025 is £2.167m**. The actual run-rate is **in slightly lower** than planned spend due to work completed earlier than schedule for the National Grid.



The graph below outlines the nVCC actual capital spend to **OCTOBER 2025 is £2.395m**. The actual run-rate is **in slightly lower** than planned spend due to a delay between the MIM construction costs spend and the QRA budget call down.



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

- For **OCTOBER 2025** the capital spend forecast outturn is **£8.712m** as a result of the full financial review conducted**;** and
- WG are due to **approve** the revised CRL for the Project(s).

5.6 The CRL position is outlined below:

EW Project

Period 2025-26	CRL awaiting approval £m	Actual & Forecast Spend £m	Variance £m
Apr-25	0.450	0.442	0.008
May-25	0.055	0.096	-0.041
Jun-25	0.236	0.245	-0.008
Jul-25	0.311	0.334	-0.023
Aug-25	0.302	0.241	0.062
Sep-25	0.408	0.408	0.000
Oct-25	0.405	0.401	0.004
Nov-25	0.402	0.337	0.065
Dec-25	0.264	0.300	-0.036
Jan-26	0.444	0.444	0.000
Feb-26	0.236	0.236	0.000
Mar-26	0.427	0.619	-0.192
TOTAL	3.940	4.103	-0.163

nVCC Project

Period 2025-26	CRL awaiting approval £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	0.314	0.314	0.000
Jul-25	0.323	0.323	0.000
Aug-25	0.383	0.383	0.000
Sep-25	0.440	0.440	0.000
Oct-25	0.399	0.399	0.000
Nov-25	0.302	0.302	0.000
Dec-25	0.310	0.310	0.000
Jan-26	0.325	0.325	0.000
Feb-26	0.230	0.230	0.000
Mar-26	1.047	1.047	0.000
TOTAL	4.609	4.609	0.000

6. QUANTIFIED RISK ASSESSMENT (QRA)

6.1 The **Original QRA position was £18.7m** as per the FBC and approved by Welsh Government. The revised position is now **c£12.935m** following the bi-monthly review conducted with Welsh Government. This reduction of £6m reflects the negating of the risks to the project, particularly in the procurement of the Category 2c equipment allocation.

6.2 The Project has utilised **c£0.91m** of the QRA and the funding has been provided by WG.

6.3 The remaining QRA is **c£12.059m with the profiling set out in the below:**

REVISED QRA (SEPT 25)	2024-25	2025-26	2026-27	2027-28	TOTAL
REVISED NVCC QRA - MIM (SEPT 25)		£150,000	£3,156,000		£3,306,000
REVISED NVCC QRA - MIM (SEPT 25)		£0	£4,828,800	£3,085,200	£7,914,000
REVISED EW QRA (SEPT 25)		£332,400	£506,200	£0	£838,600
TOTAL QRA	**£0**	**£482,400**	**£8,491,000**	**£3,085,200**	**£12,058,600**

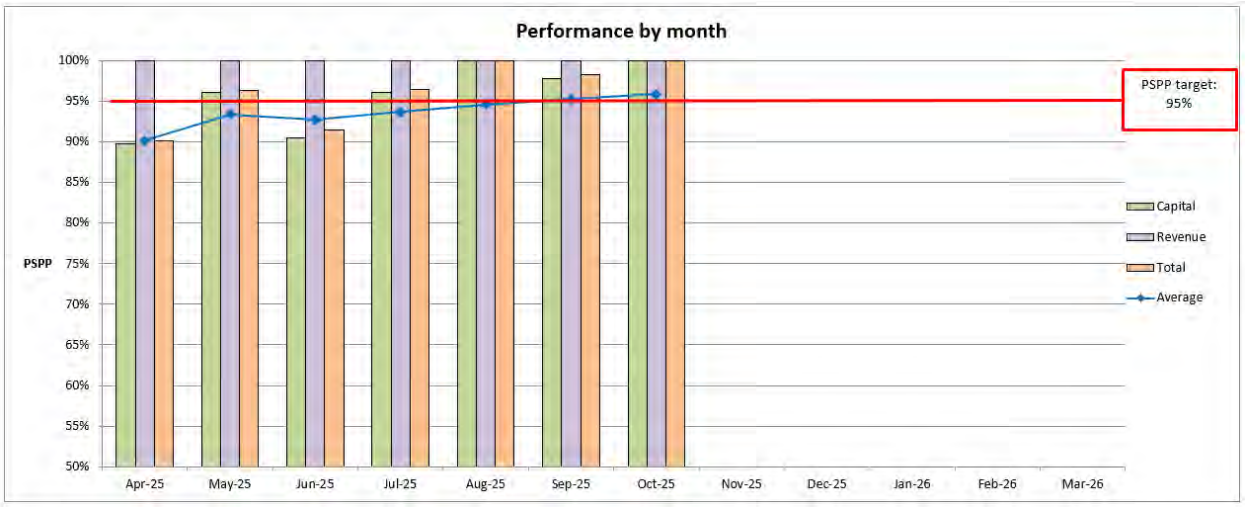
6.4 The Project reviews the QRA on a quarterly basis and the risks quantification re-assessed.

7. PUBLIC SECTOR PAYMENT POLICY

7.1 For **OCTOBER 2025,** the PSPP performance was **100%** and the PSPP target was **achieved**. Of the 49 invoices for payment, 49 invoices were processed within the 30-day deadline.

7.2 The average PSPP performance to date for 2025-26 is **96%**.

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	27 November 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 Board with a summary of activity related to the status of the risks and associated movement.
RECOMMENDATION / ACTIONS	The Trust Board is asked to: • **NOTE** the risks in the quality and safety domain with a score of 12 and risks in other domains with a score of 15 on the Risk Register. • **NOTE** the assurance level 3.

COMMITTEE / GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING	
COMMITTEE OR GROUP	**DATE**
Velindre Cancer Service Divisional Team	Data shared
Welsh Blood Service Senior Leadership Team (WBS SLT)	08.10.2025
Executive Management Board	27.10.2025
Quality, Safety and Performance (QSP) Committee	13.11.2025
This paper takes into consideration the feedback from VCS and WBS teams on their respective risks. The Executive Management Board discussed the risks reporting on the Trust Risk Register in line with the current discussions in the organisation. Additionally, the Executive Management Board supported a review of the Trust Risk Appetite. Benchmarking activity has taken place in other NHS Wales organisations and a further discussion is schedule for the December Audit Committee. QSP received the paper for assurance, noting the current position and changes to the Trust Risk Register since the last reporting period. The committee requested clarity around the governance in respect of target dates which are imminently due or have passed.	

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 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.

During this reporting cycle five risks have been removed from the Public Trust Risk Register.

Risk 3735 – VCS Risk
'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'

The current risk score has reduced from 20 to 9 due to National mitigation in place - Data Migration across Health Boards (HBs) have started, Proof of Concept in place for HBs that have gone live, Auto forwarding has been agreed but needs to be deployed when HD has gone live. VCC are on track for meeting their current milestones

Risk 3645 – Corporate risk
'There is a risk to quality/cost/delivery plan for the RISP National Programme and VUNHST local implementation as a result of the lack of a Global Worklist Image Viewer for access to prior patient images being provided by the programme leading to Our inability to access prior imaging from other HB's as a tertiary oncology treatment provider putting services & treatment of patients at significant risk. This would lead to a delay in the programme and VUNHST local implementation whilst this is resolved.'

The National RISP Programme is tracking as Amber/Red and local programme as Amber.

Risk closed as the mitigation and risk is being monitored via Risk ID 3735 (detailed above). Three years of data migration estimated to be completed by Jan 2026 in reediness for Velindre's Go live date. due to Velindre's plan to go live in January the POC does not provide the required mitigation however the Auto Forwarding rule will support and mitigate clinical risk.

Risk 3699 – VCS risk
' There is a risk that patient will not receive Tissue Viability advice and care, as a result of capacity issues. This may lead to patients and staff not being able to access Tissue Viability advice and support.'

Risk title was updated and score reduced from 15 to 9. updated score reflects the likelihood of occurrence "expected to occur at least monthly". Risk score reduced due to

the actions within the ward improvement plan targeting themes surrounding pressure ulcer management and prevention.

Risk 3562 – VCS risk
' There is a risk to patient safety as a result of uncertainty around process and ownership for reviewing and actioning blood tests results which may lead to an omission or delay in undertaking a remedial clinical intervention.'

Current risk reviewed, likelihood reduced to reflect low level of incidences relative to high volume of blood tests undertaken on a daily basis.

T and F Group Lead has completed Closure Report. SOP developed to support wider professional blood sign off and agreement in principle that SSTs will undertake work associated with pre-SACT assessment clinics in near real time. Most impactful recommendations of the T and F group require resource, which has not been identified by group. Report, with outstanding recommendations, for submission to Operational Management Board

Risk 3785 – WBS risk
'There is a risk to Quality and Safety as a result of relocating Procurement Stores from Welsh Health Supplies (Bridgend Stores) to Newport Welsh Health Supplies (IP5), leading to disruption/delay in supply.'

Reviewed current score and reduced to 5 in light of mitigation in place.

WBS Stores currently hold three months' worth of stock for South Wales and North Wales.

All stock is receipted into Stores via the goods-in area.

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

Risk
Risk 3747 – VCS risk
'There is a risk to patient safety as a result of insufficient capacity within the SACT day case service leading to increased waits for SACT treatments beyond the 21 day non-emergency standard.'

A Surge Capacity action Plan was developed and discussed with the relevant clinical teams. The medics did not have capacity to support the plan due current workload. The plan is to explore opportunities and implement actions at pace to support mitigation of the current and future capacity gap. This will include exploration of additional capacity across

Pharmacy, nursing and pre SACT assessment in the short term. The SACT expansion business case is currently in development, and this will be updated to reflect the current growth of 14%. This will ensure sustainable additional capacity is planned for and the VCS has the appropriate workforce across all areas to deliver this capacity safely and efficiently. In addition, there will be a focus to expedite high benefit protocols which will support even balance of activity across the week to ensure optimisation of all available capacity. This will include implementation of new ways of working and transformation of the current SACT Pathway.

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

- A total of 12 risks reporting onto the public Trust Risk Register.
- 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.
- Eleven with a score over 8 or above reported in other domains.
    - None on the VCS register
    - Three on WBS register
    - Five on the Corporate risk register.

2.3 Risk Themes

Quality and Safety Risks

Patient Safety (Velindre Cancer Service, VCS):

- Risks due to uncertainty around reviewing and actioning blood test results, potentially leading to omissions or delays in clinical intervention.
- Insufficient capacity in the SACT day case service, causing increased waits for treatments.
- Lack of access to Tissue Viability advice due to staff absence, impacting patient care.

Welsh Blood Service (WBS):

- Risks from pre- and post-examination processes affecting patient care quality.
- Independent result entry and authorisation, risking incorrect results being reported.
- Manual workarounds due to outdated IT systems, increasing the risk of errors and patient harm.
- Aged Laboratory Information System (SERIF) affecting safe service operation.

Performance and Service Sustainability

Radiation Services:

- Delays in Health Boards adopting the Philips RISP solution, impacting Velindre's implementation and national deployment.

WBS and Corporate:

- Loss of electrical supply at Llantrisant site, risking loss of service and production.
- Relocation of procurement stores, risking disruption or delay in supply.

- Demand for digital services exceeding team capacity, risking delivery of initiatives and staff wellbeing.
- Delays in national digital programmes (RISP/WLIMS/EPMA), impacting clinical model and transition plans.

Digital and IT Risks
Corporate and WBS:

- Lack of integration between digital systems (e.g., FEDIS and NHS Wales Digital Applications), leading to reporting errors and suboptimal care.
- Delays in the WLIMS 2.0 go-live date, causing additional demand on legacy systems.
- National digital programmes not delivered to time/cost/quality, disrupting clinical and transition plans.
- Lack of a Global Worklist Image Viewer in the RISP National Programme, risking access to prior imaging and patient treatment.

Financial Sustainability
WBS:

- Formal dispute against BECS procurement process, risking substantial legal and administrative costs.

Corporate Governance and Assurance
Corporate:

- Risks to clinical and corporate governance due to current assurance and reporting arrangements for hosted services.
- Quality, performance, and workforce risks from demand for digital services exceeding capacity.

3 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, took take place on 26th September 2025.

The group is 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.

Meetings on the relevant issues have taken place 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. The update at the last meeting was that DHCW do not have capacity to support.
- Liaise with NWSSP Procurement to explore a national procurement option.
- Establish a Risk System Teams Channel and Group to meet bi-monthly. This is in place now.
- Nominate representatives from each organisation. Representatives from VUNHST have been identified across the 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.

4 SUMMARY OF MATTERS FOR CONSIDERATION

The Trust Board is asked to **NOTE** the risks in the quality and safety domain with a score of 12 and risks in other domains with a score of 15 and above in advance of the Trust Board's consideration of the Risk Register.

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.

5 RISKS

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

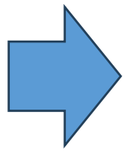
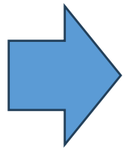
TRUST RISK REGISTER
Trust Board – November 2025 reporting cycle

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).

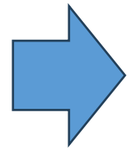
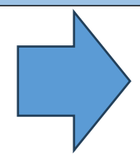
SECTION 1 – Current Trust Risk Register

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	3747 *New to TRR	VCS	Safety	Interim General Manager	There is a risk to patient safety as a result of insufficient capacity within the SACT day case service leading to increased waits for SACT treatments beyond the 21 day non-emergency standard.	**20** (4x5)	**12** (3x4)	**6** (3x2)		A Surge Capacity Action Plan will be developed to explore opportunities and implement actions at pace to support mitigation of the current and future capacity gap. This will include exploration of additional capacity across Pharmacy, nursing and pre SACT assessment in the short term. The SACT expansion business case is currently in development, and this will be updated to reflect the current growth of 14%. This will ensure sustainable additional capacity is planned for and the VCS has the appropriate workforce across all areas to deliver this capacity safely and efficiently. In addition, there will be a focus to expedite high benefit protocols which will support even balance of activity across the week to ensure optimisation of all available capacity. This will include implementation of new ways of working and transformation of the current SACT Pathway.	Update 11.11.25 Risk reviewed with Director of Cancer Services and Head of Planning, Performance, and Supportive Services. Risk title updated to reflect the risk of a delay in SACT treatment. Risk score updated (decreased from 15 to 12) to reflect the likelihood of occurrence in line with the Trust Risk Matrix "may occur weekly". Risk reviewed with Director of Cancer Services and Head of Planning, Performance, and Supportive Services. Risk title updated to reflect the risk of a delay in SACT treatment. Risk score updated to reflect the likelihood of occurrence - updated to "probable, meaning may occur weekly" Update 12.09.2025 - the Surge action plan was developed, and the proposal was discussed with the relevant clinical teams. unfortunately, the medics did not have the capacity to support the plan due to current workload.
	15+ Risks in other domains										

	No risks reporting in this section										
	Welsh Blood Service										
	12+ Risks in the Quality and Safety domains										
2	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 23.12.25		1. Introduction of LIMS to mitigate the risk of manual transcription errors *Due date: 23.12.25*	05.11.25 The risk still remains significant as the mitigating action (implementation of LIMS in Transplantation Services) is the only action that will reduce this risk score
3	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)		1. Update and add pre-determined comments to standardise reports and minimise transcription. 2. Training of laboratory staff for report writing	14.11.25 Progress on actions was halted whilst awaiting a decision on whether SERIF updates would be approved. Following rejection of the SERIF updates, progress has recommenced, change control

								Expected date: 012.12.25		*Due date:12.12.2025*	managing the change has been extended to 30/11/25 to account for the pause, actions have been updated in this risk to mirror this. No change to risk Action 1: Change control opened- matter discussed with Transfusion Laboratory Managers. Extension to completion of coded comments to align with closure date of change control. Exemption report submitted due to limited resources preventing comments being added to system Action 2: Delay in updating the report comments and initiation of change control. Exemption report submitted due to limited resources preventing comments being added to system Extension to action added. Another extension added to align with CC- Verto PR000571 opened to manage 10.10.2025 Extension added to actions- exemption report for PR000571 submitted. Resources unavailable to input the information at present Report comment entry into SERIF commenced but still incomplete. No change to risk
4	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) Expected Due date: 31.12.25		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 5. Application workstream - build of environments, database and interfaces	27.10.25 WHAIS in-house developed IT applications are built using legacy FoxPro and DOS based technology that is no longer supported. There is only one FoxPro developer within WBS Digital Services team and there is limited ability to access agency resource with required level of FoxPro expertise. This may lead to inability to provide one or more WTAIL services, if unable to respond to urgent IT incidents or system failures and inability to develop existing WTAIL IT systems due to lack of availability of appropriate FoxPro expertise within Digital Services team. 06.10.2025

										1. TVN and nurse educators to develop educational suite re. pressure damage and tissue viability to ensure an ongoing resource	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 SBAR for project extension has gone to SLT. Go-live Date for the WHAISIT project has been estimated as end of Feb 2026. No impact on risk scoring at this time.
	15+ Risks in other domains										
5	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: 07.02.26	⇨	1. Review of risk assessment required *Due date: 07.02.2026*	13.11.25 Further remedial works carried out on 08/11/2025. No further electrical works are required at this point in time. Works highlighted that an additional air conditioning unit is required in one of the Digital Comms Room. Digital have been made aware of this. 09.10.2025 Risk assessed, no change to risk level. 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.
6	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: 20.01.26	⇨	1. Validation of upgrade/ Replacement 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*: 20.01.26	06.11.25 No change to risk- point 6 in mitigation actions has been reviewed and the risk deemed to high to proceed. All other mitigations to continue to progress. 10.10.2025 Risk assessed, no change to risk rating. Project meeting scheduled for 07.10.2025. Communication between Digital Services and RCI made to understand current SERIF system & its capabilities. No progression on work currently. Risk remains the same.

7	3388 07/05/2024	WBS	Quality	Director of Welsh Blood Service	There is a risk to Quality and Performance as a result of reporting errors and limited accessibility of reports due to no interfaces between the Fetal D IT System (FEDIS) and NHS Wales Digital Applications, leading to suboptimal antenatal care.	**16** (4x4)	**16** (4x4)	**2** (2x1) Expected date: 28.11.25		1. Develop and validate interface between FEDIS and eMPI+WRRS when available Due date: 27.04.26	10.11.25 Stable/No movement - work ongoing with DHCW to complete the demographic and reporting integrations (managed under PR000553). There have been some issues on the DHCW side encountered during SIT testing. These have yet to be fully resolved, and have resulted in further slippage of the project timelines. CPG have approved an extension of the implementation timeline to go-live 27/04/2026, to avoid a resource conflict with the WHAISIT Project. due date extended to 27/04/2026 in line with updated project timelines (to avoid clash with WHAISIT) 06.10.2025 Stable/No movement - work ongoing with DHCW to complete the demographic and reporting integrations (managed under PR000553). No further update/changes from the previous update below (22/09/2025)
Corporate											
15+ Risks in other domains											
8	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: 31.12.2025*	12.11.25 Digital deep dive at EMB and SDC in November. Commenced digital diagnostic on 10.11.25 and will report back to EMB in January 2026 10.10.2025 Paper submitted to EMB in August 2025 proposing the plan, which was noted. The plan has additional plan compared to the original plan. Engaged with a third part for a diagnostic Action 1: Paper submitted to EMB in august 2025 proposing the plan, which was Noted. 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.

9	3646 15.04.2025	Corporate	Performance and Service Sustainability	Chief Digital Officer	There is a risk to that the WLIMS 2.0 go-live date will be delayed due to delays in the national programme timeline causing an impact on realising project outcomes and additional demand for further development of existing legacy systems.	**16** (4x4)	**20** (4x5)	**6** (2x3) Expected date: 31.03.26		1. Participating in national planning for LIMS across NHS Wales. Local plans are ready to test on LIMS 2.0. 2. Agree the new launch date with WBS Futures Programme. 3. Mitigation plan in place with existing SERIF system.	12.11.25 Planning for January to March go live. This remains high risk. Helen Thomas (CEO of DHCW) took a paper to DDAT Board regarding congestion in digital planning quarter 4. 15.10.2025 A continuation of delays within the national LIMS programme is impacting the ongoing risk to the implementation of LIMS BT services before the end of 2025/26. An internal review of the existing SERIF system is in progress to determine the viability of a small number of prioritised improvements to functionality, which will mitigate some of the immediate risk
10	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: 30.11.25		1. Annual accounts and accountability report to be approved by Trust Board. 2. Assurance mapping to be reviewed and completed by end of June 2025 3. WG review of current arrangements to be concluded by end of July 2025 *Due date: 30.11.25*	05.11.25 Annual Report presented at AGM. Assurance mapping underway in n response. Awaiting WG report. 10.10.25 Annual Report presented at AGM. Assurance mapping underway in n response. Awaiting WG report.
11	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: 31.12.25		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: 31.12.2025*	05.11.2025 Escalated to DHCW for the FEDIS and WHAIS systems. Plans have been received, yet to be accepted by the service. The service would like the plans accelerated if possible. 10.10.2025 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.
12	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	**16** (4x4)	**16** (4x4)	**8** (4x2) Expected date: 31.03.26		Risk reviewed. Likelihood reduced from 4 to 3 due to the change note for RISP, resetting the date of EPMA project starting. *Review date: 31.03.2026*	05.11.25 EPMA has commenced and is on track. RISP is high risk for a January go live due to national data migration. WLIMS is high risk as the system has not passed testing nationally. 10.10.2025

TRUST RISK REGISTER

					National DHCW programmes of concern for the Trust are RISP/WLIMS/EPMA.						EPMA risk reduced as the contract is signed with Better. Project initiated as planned in October. RISP is still high risk. Go/no go decision will be made on 22.10.2025 whether to go live in January 19th 2026. WLIMS is still high risk for a January to March 2026 go live for WBS. the contingency plan is to develop Serif.

TRUST RISK REGISTER

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

ID & DATE OPENED	DIRECTORATE	RISK DOMAIN	RISK OWNER		INHERENT RATING	CURRENT RATING	TARGET RATING	RATING CHANGE SINCE LAST REPORTING PERIOD	PROGRESS SINCE LAST REPORTING PERIOD
3735 16.07.2025	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. Velindre implementation may be impacted by delays in other organisations ahead of Trust in national deployment plan.	**15** (5x3)	**9** (3x3)	**4** (2x2)	↓	The current risk score has reduced from 20 to 9 due to National mitigation in place - Data Migration across Health Boards (HBs) have started, Proof of Concept in place for HBs that have gone live, Auto forwarding has been agreed but needs to be deployed when HD has gone live. VCC are on track for meeting their current milestones
3645 15.04.2025	Corporate	Multiple risk domains ce and service sustainability - Quality -Performance and	Executive Director of Strategy and Planning	There is a risk to quality/cost/delivery plan for the RISP National Programme and VUNHST local implementation as a result of the lack of a Global Worklist Image Viewer for access to prior patient images being provided by the programme leading to Our inability to access prior imaging from other HB's as a tertiary oncology treatment provider putting services & treatment of patients at significant risk. This would lead to a delay in the programme and VUNHST local implementation whilst this is resolved. The National RISP Programme is tracking as Amber/Red and local programme as Amber. Project ID-V02-04	**20** (5x4)	**20** (5x4)	**6** (2x3)	Risk closed	Recommendation that this Risk can be closed following correct governance route as this mitigation and risk is being monitored via Risk ID 3735. 3yrs of data migration estimated to be completed by Jan 2026 in reediness for Velindre's Go live date. due to Velindre's plan to go live in January the POC does not provide the required mitigation however the Auto Forwarding rule will support and mitigate clinical risk.
3699 *New to TRR	VCS	Safety	CIU Ward Manager	There is a risk that patient will not receive Tissue Viability advice and care, as a result of capacity issues. This may lead to patients and staff not being able to access Tissue Viability advice and support.	**15** (3x5)	**9** (3x3)	**4** (3x5)	↓	05.11.25 Risk title updated and score reduced from 15 to 9. updated score reflects the likelihood of occurrence "expected to occur at least monthly". Risk score reduced due to the actions within the ward improvement plan targeting themes surrounding pressure ulcer management and prevention. TVN business case approved at scrutiny - next steps for employment currently being actioned with expected start date end of November

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 for reviewing and actioning blood tests results which may lead to an omission or delay in undertaking a remedial clinical intervention.	**20** (4x5)	**8** (4x2)	**8** (4x2)		09.11.2025 Current risk reviewed, likelihood reduced to reflect low level of incidences relative to high volume of blood tests undertaken on a daily basis. T and F Group Lead has completed Closure Report. SOP developed to support wider professional blood sign off and agreement in principle that SSTs will undertake work associated with pre-SACT assessment clinics in near real time. Most impactful recommendations of the T and F group require resource, which has not been identified by group. Report, with outstanding recommendations, for submission to Operational Management Board 17.09.2025 Draft SOP with comments from SACT Operational Group key stakeholders received by LP - revisions to be made to include the comments. Action 1: Extract from T and F group Highlight Report May 2025. Priority: Extend blood sign-off permissions on WCP – SoPs and training, permissions granted. Expected to be commencing at the beginning of July. 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.
3785 14.08.2025 *New to TRR	WBS	Performance and Service Sustainability	Head of Planning and Performance Services	There is a risk to Quality and Safety as a result of relocating Procurement Stores from Welsh Health Supplies (Bridgend Stores) to Newport Welsh Health Supplies (IP5), leading to disruption/delay in supply.	**15** (5x3)	**5** (5x1)	**5** (5x1)	3785 14.08.2025 *New to TRR	04.11.25 Reviewed current score and reduced to 5 in light of mitigation in place. October 2025 WBS Stores currently hold three months' worth of stock for South Wales and North Wales. All stock is receipted into Stores via the goods-in area. All stock is receipted into Stores via the goods-in area.

Trust Board	
BOARD ASSURANCE FRAMEWORK UPDATE	
DATE OF MEETING	27 November 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 Place, Portfolio and Partnerships • Nicola Williams, Director of Nursing and • Anne Carey, Chief Operating Officer • Sarah Jenkins, Director of OD and Workforce • Jacinta Abraham, Medical Director • Matthew Bunce, Director of Finance • Carl Taylor, Chief Digital Officer
APPROVED BY	Non Gwilym, Interim Director of Corporate Governance
EXECUTIVE SUMMARY	This paper provides the Trust Board with the latest updates to the Board Assurance Framework.
RECOMMENDATION / ACTIONS	The Trust Board is asked to: • **NOTE** the status of the Board Assurance Framework which has a current assurance rating of 2.
COMMITTEE / GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING	

COMMITTEE OR GROUP	DATE
Executive Management Board	27.10.2025
Strategic Development Committee	04.11.2025
Quality, Safety and Performance (QSP) Committee	13.11.2025

EMB reviewed and noted paper.

Strategic Development Committee: the committee welcomed the proposal to refresh the At a Glance Document and the detailed document outlining changes to the 11 Strategic Risks. The Appendix 2 of this paper now includes the Executive summary and target dates for all 11 Strategic Risks.

Quality, Safety and Performance Committee received the paper for assurance, noting the design of the strategic risks in the BAF against the strategic goals rather than strategic objectives, highlighting that some strategic risks (3,5,6 and 10) do not have any above threshold operational risks aligned in this reporting cycle.

There was discussion about the gaps in controls in the BAF and associated risks. BAF leads will review this during the next cycle and a deep dive analysis is required on Controls specifically.

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	Board Assurance Framework at a Glance
2	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, eleven strategic risks were agreed by Trust Board in March 2025, aligned to strategic objectives. 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.

2.2 Since the last Trust Board meeting, the following work has been undertaken or is in development:

- All strategic risks have been reviewed, including scrutiny of actions and assurance levels across the BAF.
- A regular monthly review schedule is now in place with Executive Directors and wider teams.

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

3. EXECUTIVE SUMMARIES

Part of the monthly review cycle includes Executive leads summarising the strategic risk, included here for review:

BAF01

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.

BAF02

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.

BAF03
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.

BAF04
Controls have been identified. All controls reporting as preventative and as being managed resulting in a current rating of 3.

BAF05
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.

BAF06
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.

BAF07

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.

BAF08

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. All on track for Audit Committee consideration in December.

- The Trust is waiting for the publication of the Welsh Government's review of the hosting arrangements for Shared Services.
- Policy on Policies was approved by QSP in September.
- Plans to consider a new Board Development programme discussed at October meeting.
- Awaiting plan for structured assessment.

BAF09

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 several key financial controls. Where these controls are partially effective or not effective actions are being taken to improve the effectiveness of the control and where this achieves the anticipated improvement in control the assurance from that control is increased.

Risk score trend: The risk score has remained static since the last period, however, given the significant emerging cost pressures the risk score may need review in future months.

BAF10

VUNHST has a substantial programme of transformation over the next five years, totalling more than £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. This should lead to improved prioritisation, resourcing, benefit delivery and the reduction of transformation related risks at an organisational level.

BAF11

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 been reviewed in October 2025 and is proposed to reduce from 12 to 9. The reduction is proposed following the information submitted under the Supply and Shape review paper which demonstrates several key metric improvements in all areas mitigating the risk.

The Trust has advanced workforce planning through targeted initiatives, including the successful launch of the Nevill Hall Radiotherapy Unit and development of Welsh language capabilities. Recruitment and retention efforts have yielded a 4% FTE growth and reduced turnover, supported by enhanced employer branding and digital recruitment strategies.

Education and learning initiatives show strong compliance with statutory training and growing PADR engagement, while leadership development is being realigned with national frameworks.

Financially, agency reliance is decreasing, with a 96% drop in agency spend since August 2025.

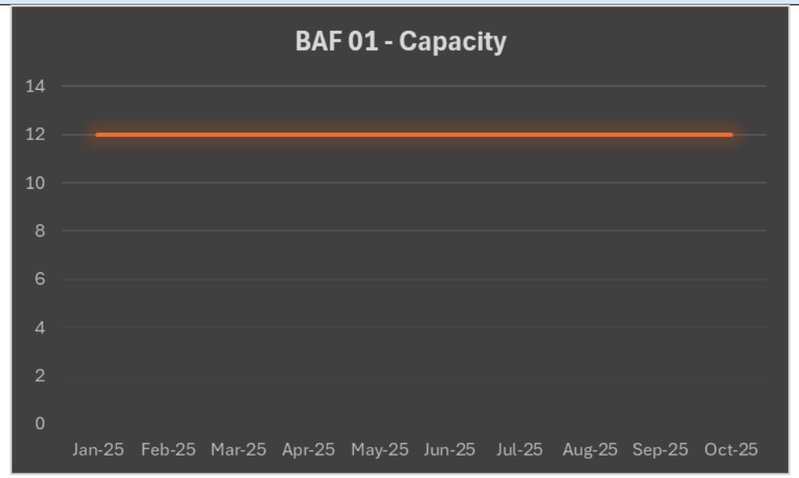
4 IMPACT ASSESSMENT

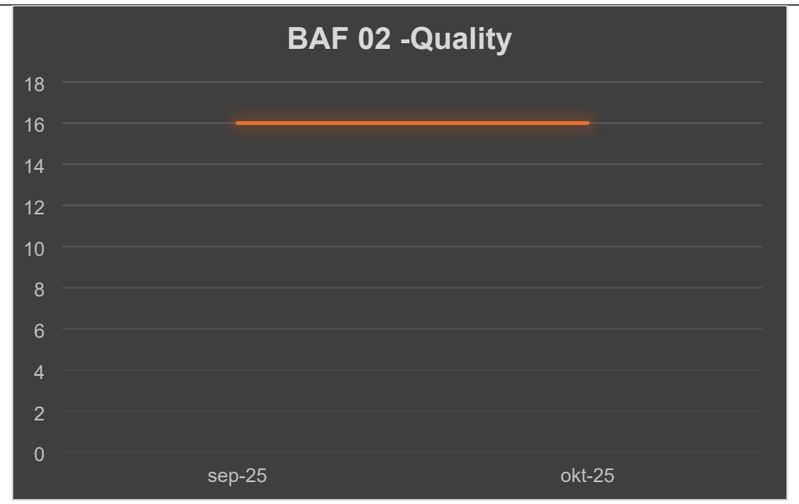
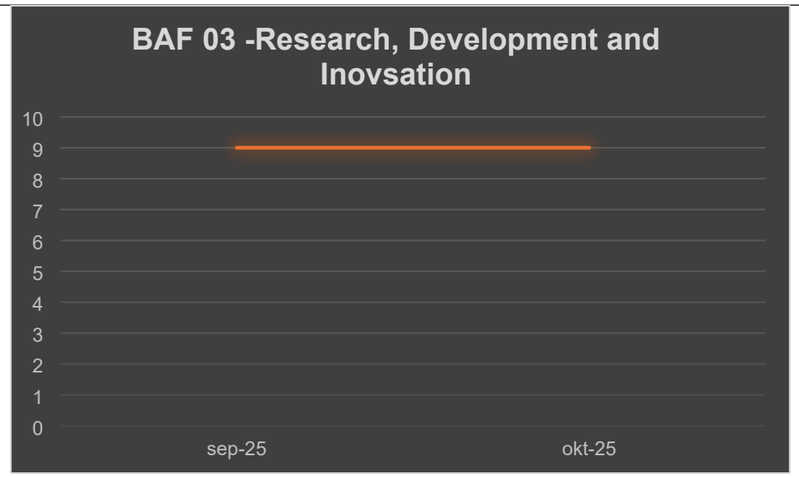
RELATED TRUST STRATEGIC GOAL(S)	Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals. Please indicate here

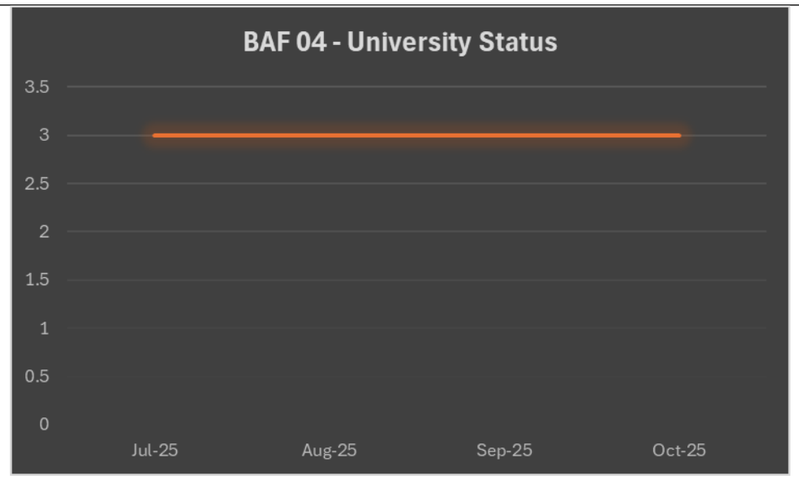
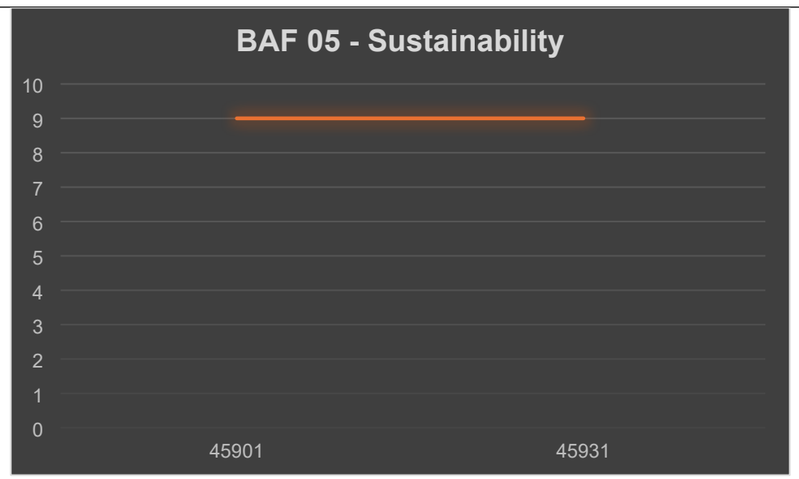
Please tick all relevant goals: . Outstanding for quality, safety and experience ☒ . An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ . A beacon for research, development and innovation in our stated areas of priority ☐ . An established '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

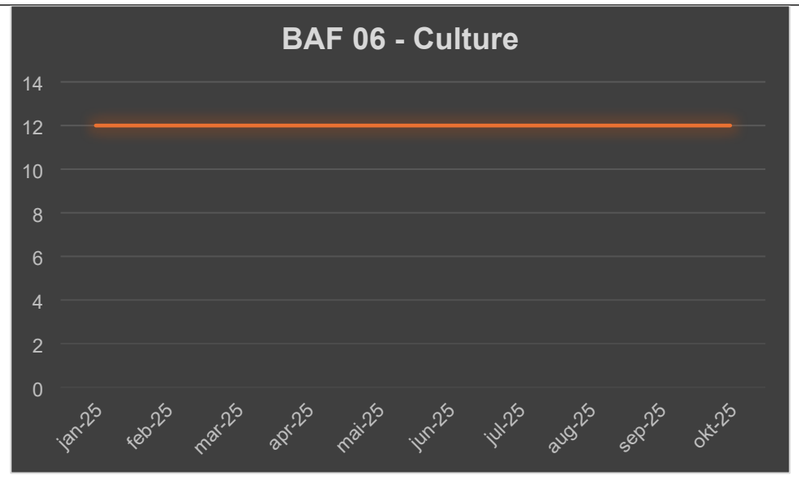
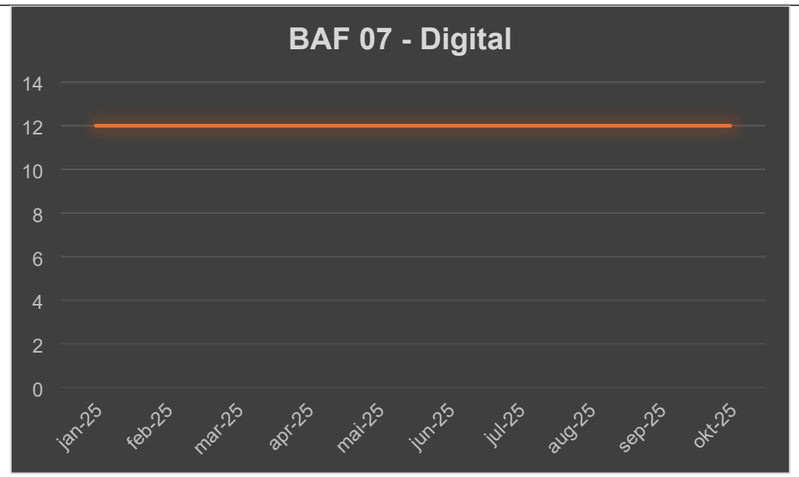
3 RISKS

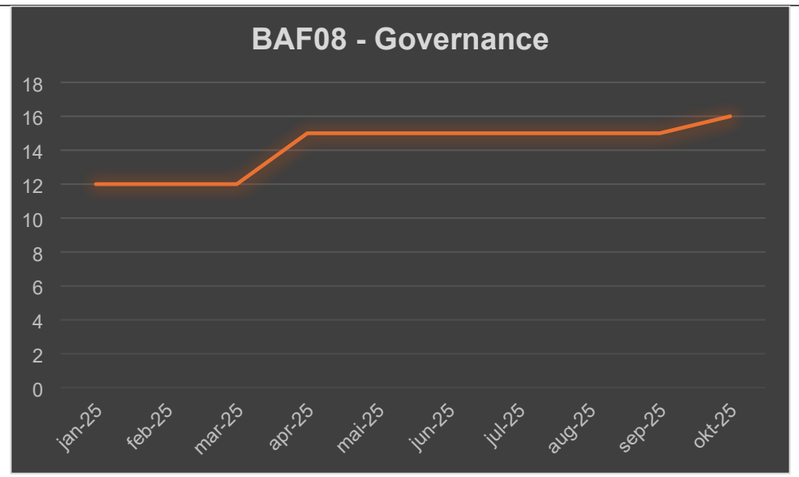
ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes
WHAT IS THE RISK?	The strategic Risks outlined in the BAF are informed by the Trust's active management and reporting of its operational risks.
WHAT IS THE CURRENT RISK SCORE	n/a
BY WHEN?	Ongoing
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
All risks must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

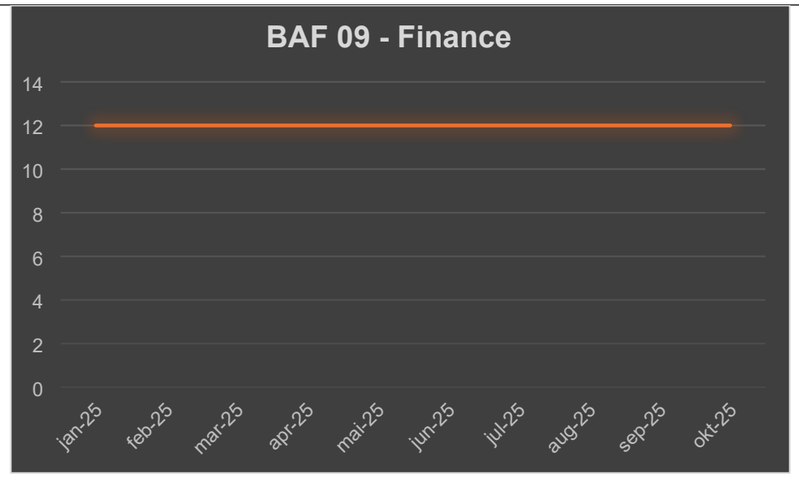
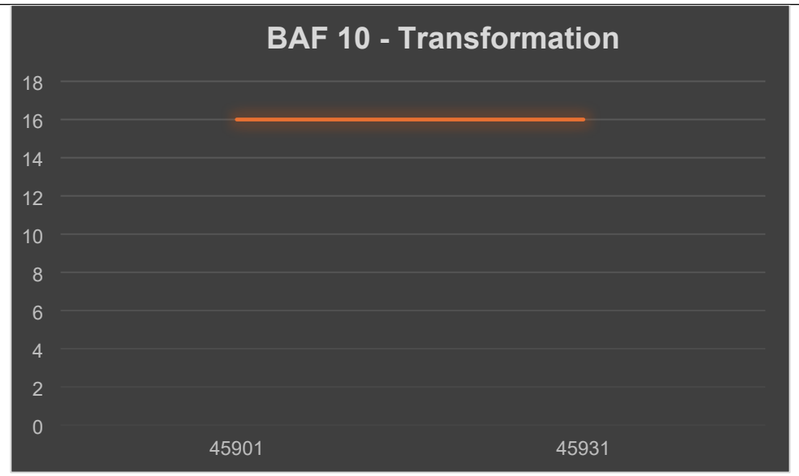
RISK ID	STRATEGIC RISK	STRATEGIC GOAL/ ENABLER	INITIAL RISK SCORE (I X L)	CURRENT RISK SCORE (I X L)	CURRENT RISK SCORE (I X L) Plus expected date	CURRENT RISK TREND	ASSURANCE RATING	TRUST RISK REGISTER CORRESPONDING RISK
01	There is a strategic risk of failure to deliver timely, safe, effective and 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)	8 (2x4)		2	– **3562** Uncertain process and ownership for reviewing and accessing blood test results – **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. – **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. – **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.
					Date will be reviewed at the end of quarter 2	**Executive Summary:** WBS - position is stable and has been sustained for several months. The position continues to be monitored via the Blood supply Chain Group. VCS – delivery of the patient care across 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.		

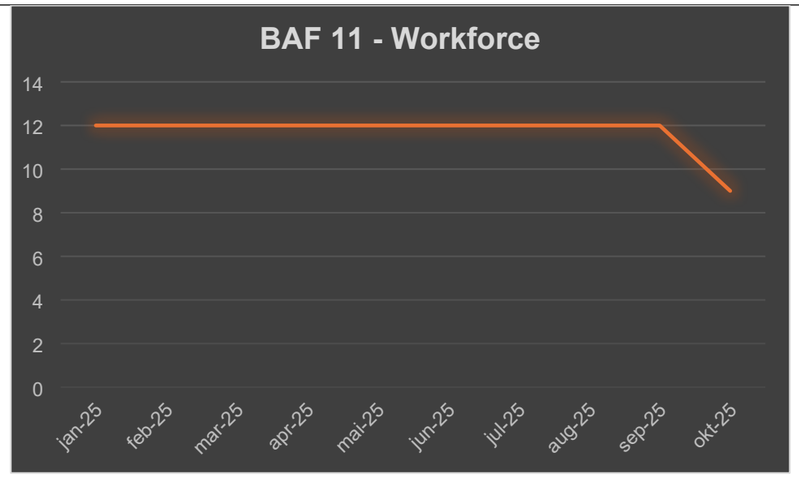
02	There is a strategic risk that the quality of patient/donor/population outcomes and/or experience across the services managed by the Trust may be adversely impacted due to increasing demands, complexities and the need for significant service transformation.	An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed, expectations.	20 (4x5)	16 (4x4)	9 (3x3)		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.
					April 2028	**Executive Summary:** Considerable enhancements made to health and safety processes. However, there is an increase of Duty of Candor incidents within VCS and repeated themes and trends within both divisions identifying the need for robust learning and improvement mechanisms.		
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)	6 (2x3)		5	There are no associated risks on the Trust Risk Register
					August 2030	**Executive 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	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)	3 (1x3)		6	There are no associated risks on the Trust Risk Register
					July 2025	**Executive Summary:** Controls have been identified. All controls reporting as preventative and as being managed resulting in a current rating of 3.		
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)	4 (2x2)		4	There are no associated risks on the Trust Risk Register

						Executive 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	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	16 (4x4)	12 (4x3)	6 (2x3)		3	There are no associated risks on the Trust Risk Register
					March 2027	**Executive 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	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)	8 (2x4)		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 – **3643** Patient safety risk due to an aged Laboratory Information System – **3633** risk to Quality and Performance and Service Stability as a result of the lack of capacity of Digital Health and Care Wales

					June 2026	**Executive 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.		– **3632** risk to Quality and Performance and Service Stability as a result of National Digital Programmes managed by Digital Health and Care Wales (DHCW) – **3667** Private risk – **3757** Private risk – **3765** Private risk
08	There is a strategic risk that the organisational and clinical governance arrangements do not provide appropriate mechanisms and culture to achieve our medium to long term objectives.	Governance	16 (4x4))	16 (4x4)	8 (2x4)		3	– **3656** Quality of current assurance and reporting arrangements in hosted services
					April 2026	**Executive 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. All on track for Audit Committee consideration in December. The Trust is waiting for the publication of the Welsh Government's review of the hosting arrangements for Shared Services. Policy on Policies was approved by QSP in September. Plans to consider a new Board Development programme discussed at October meeting. Awaiting plan for structured assessment.		

09	There is a strategic risk that the Trust becomes financially unsustainable if it does not secure sufficient funding for the provision of services and does not maximise its use of resources. Unwarranted variation could impact the value and effectiveness of the care our patients and donors receive.	Financial	16 (4x4)	12 (4x3)	8 (2x4)		6	– **2249** Service disruption due to number of time limited funded posts
					April 2026	**Executive Summary:** There are a range of factors that impact on the finance sustainability and long term value risk. We prevent, mitigate or detect impact on this risk through a number of key financial controls. Where these controls are partially effective or not effective actions are being taken to improve the effectiveness of the control and where this achieves the anticipated improvement in control the assurance from that control is increased. Risk score trend: The risk score has remained static since the last period, however, given the significant emerging cost pressures the risk score may need review in future months.		
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)	6 (2x3)		3	There are no associated risk on the Trust Risk Register
					September 2026	**Executive 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.		

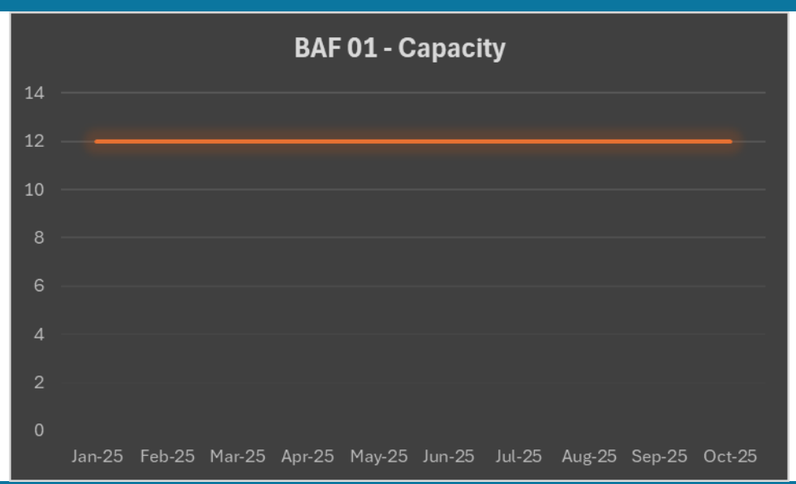
11	There is a strategic risk to the Trust's ability to effectively deliver quality services and achieve our medium to long term objectives if we are unable to develop and maintain of an optimised workforce supply and shape	Workforce	16 (4x4)	9 (3x3)	6 (2x3)		4	- **3634** Capacity issues for digital services
					March 2029	**Executive 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 been reviewed in October 2025 and is proposed to reduce from 12 to 9. The reduction is proposed following the information submitted under the Supply and Shape review paper which demonstrates a number of key metric improvements in all areas mitigating the risk. The Trust has advanced workforce planning through targeted initiatives, including the successful launch of the Nevill Hall Radiotherapy Unit and development of Welsh language capabilities. Recruitment and retention efforts have yielded a 4% FTE growth and reduced turnover, supported by enhanced employer branding and digital recruitment strategies. Education and learning initiatives show strong compliance with statutory training and growing PADR engagement, while leadership development is being realigned with national frameworks. Financially, agency reliance is decreasing, with a 96% drop in agency spend since August 2025.		

SECTION 1 – Summary

RISK ID	**01**	**REVIEW DATE**	October 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
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 Assurance Rating	**Current Review Period**	2
	Previous Review Period	3
Rationale for Assurance Rating	The risk which will be discussed at Private Board	

KEY CONTROLS	**SOURCES OF ASSURANCE**

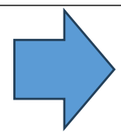
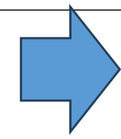
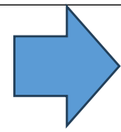
ID	KEY CONTROLS	OWNER	PREVENTATIVE	MITIGATING	DETECTIVE	FIRST LINE OF DEFENCE • *functions that own and manage risk* • *Self-assurance*	SECOND LINE OF DEFENCE • *Functions that oversee or specialise in risk management* • *Internal oversight/specialist control teams*	THIRD LINE OF DEFENCE • *Functions 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. Raise shortage plan at Trust Board level when relevant	Welsh Government intervention would be invoked when necessary National Red Cell and Platelet shortage plans
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 WBS Senior Leadership Team and VCS Divisional Team then 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. WBS Senior Leadership Team and VCS Divisional Team then 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 – Divisional Team, 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 – Divisional Team, 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	
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	
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	TBC by Welsh Govt as yet to be scoped		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 across NHS Wales, Revised focus with new Deputy Chief Medical Officer on delivery and commitment, including revised Terms of Reference, membership and task and finish groups. Good progress being made against Leadership and governance arrangements and Education and training workstreams. WBS and Blood Health National Oversight Group have highlighted that Digital Connectivity and a review of workforce supporting transfusion laboratory services across Wales are particular areas that need focus across NHS Wales.	09.10.25	Trust risk being drafted and will be considered in Private Board,	This action is under review and will transfer to BAF XX regarding Trust wide Quality and Safety

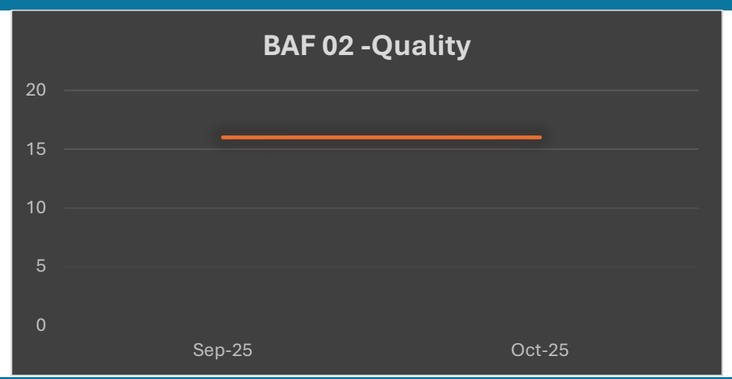
01.03	Capacity and demand business cases across a number of operational areas within WBS have been produced and submitted to JCC for consideration. These include Red Cell Immuno-haematology workforce due to increases in demand Collection team resilience to support demand fluctuations and prevent service 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 26		Business case discussions between the Trust and commissioners took place in February 2025. None of the cases were supported. October 2025 Resubmitted business cases to JCC for consideration in the IMTP planning cycle.	09.10.2025	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 October 2025 Asked for cases to be considered and are expecting them to feature in the planning round	
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		Outreach baseline measured, pathway mapping undertaken by LEAD Practitioner now complete, activity reforecast based on 2025 activity levels. Initial discussion with HBs via COOs meeting	09.10.2025	Understand the operational requirement and the scope/ appetite within HBs. Linked to the Cancer PTL, HIR and Digital Front Door.	Understanding of the operational model within nVCC and outreach locations, as well as the staffing models to support
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		Demand & Capacity undertaken at Service level currently i.e. SACT and Radiotherapy. To date this work has been limited due to the level of data available, meaning discrete work required. However, with the advent of the Cancer PTL & the 'go paperless' initiative more reliable information is becoming available to help drive this agenda and maximise productivity.	09.10.2025	Strengthen the Business Intelligence information linked to performance, capacity & demand and understanding patient flow. This will enable more effective management of resources and service provision.	Will ensure that teams have the information to enable understanding of their services, and can manage capacity & demand more effectively.

SECTION 1 – Summary

RISK ID	**02**	**REVIEW DATE**	October 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, the need for significant service transformation and external factors.	**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



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	3	3	**9**

Expected date to reach Target Risk Score April 2028

SECTION 3 – Effectiveness, Controls and Assurance

Overall Assurance Rating	**Current Review Period**	3
	Previous Review Period	3
Rationale for Assurance Rating	Trust wide the assurance level is 3, which takes into account the variation across the two clinical divisions. 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 Services Divisional Team and the introduction of new divisional performance structures to support the operationalisation of the Cancer PTL both internally and across SE regional, moving to a shared PTL.	Executive Management Board & Quality, Safety & Performance Committee Peer Benchmarking.	Internal Audit, HIW, HEIW and Regional Cancer Meeting
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 Divisional 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 divisional Team/Integrated 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 divisional Team/Integrated 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 divisional Team/Integrated 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 divisional Team/Integrated 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 data is currently reported through the organisation.		
The required quality metrics (including mortality) are not currently included in Performance Management Report up Board level.		
VCS Cancer Data Dashboard not in place.		

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	
3306 WBS	There is a risk of loss of performance and sustainability, as a result of a loss of electrical supply leading to a loss of service and production at Welsh Blood services Llantrisant.	15	

3785 WBS	There is a risk to Quality and Safety as a result of relocating Procurement Stores from Welsh Health Supplies (Bridgend Stores) to Newport Welsh Health Supplies (IP5), leading to disruption/delay in supply.		
3725	Private risk relating to Whitchurch site		
2705	Private risk relating to CCTV		
3534	Private risk relating to vulnerable persons work plan		
3730	Private risk relating to Whitchurch site		
3731	Private risk relating to Whitchurch site		

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	Initial priorities for reporting to Board agreed and will be implemented during the November cycle. Further development work required in respect of required metrics.	October 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. Training plan and programme developed. Implementation to start in November.	October 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	Trust PROMS system went live in September. It is anticipated that reporting will commence early 2026.	October 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	EPMA contract signed and implementation planning underway.	October 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. Escalation to Welsh Government undertaken	October 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. Regulatory assessment undertaken	October 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. An increase to 1.9% from 0.1% of VCS patients provided feedback in September 2025. New national People Experience framework being implemented on target for completion by April 2026 as noted.	October 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 outcome.	October 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. Benchmarking and Peer Review being incorporated into service redesign and performance, where possible.	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.	

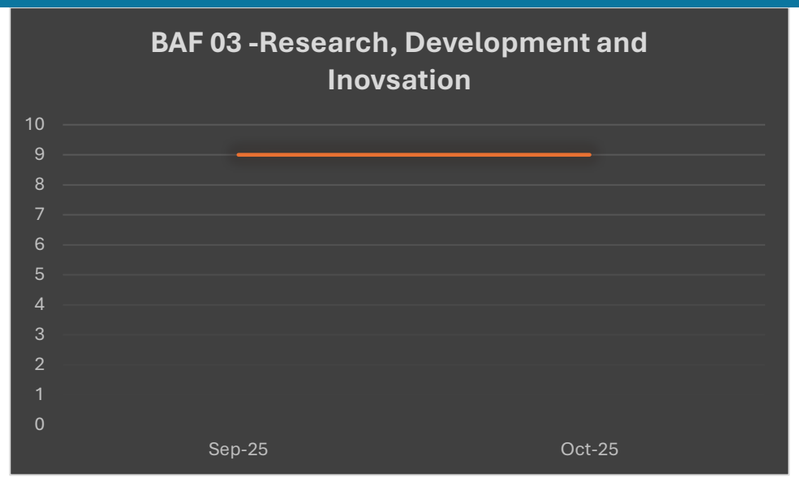
02.10	To refresh and relaunch Trust patient safety framework.	Director of Nursing, AHP and Health Science	End of Dec. 2025	4	Current framework requires review in light of structural changes and strengthening of accountabilities and responsibilities for quality and safety outcomes and experience.	August 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**	October 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



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 Assurance Rating	**Current Review Period**	5
	Previous Review Period	5
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		

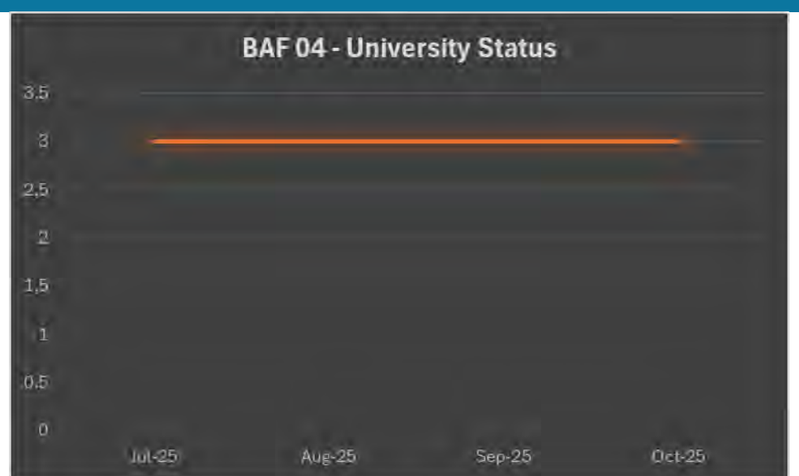
SECTION 5 – ACTION PLAN
(IMTP Priority Improvement Actions and TAF Actions)

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 have commenced. Benchmarking meeting between Velindre University NHS Trust and The Clatterbridge Cancer Centre NHS Foundation Trust is scheduled for 26 November 2025. Velindre University NHS Trust representatives will include: - Research active oncology consultants - Research Service Governance and Non-Clinical Delivery staff - Research Service Clinical Delivery staff - Research Finance Business Partnering staff - Velindre Cancer Research Strategic staff	October 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. Work is underway to finalise the list of standard operating procedures and associated work instructions, along with assigning authors and timelines for production.	October 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 is to be submitted through Trust governance infrastructure. The Strategic Cancer R&D Team, Research Finance Business Partnering staff, and the Research Service Team are developing a sustainable funding model. The approach is focusing on mapping workforce input to research output, evidencing value through benchmarking, and expanding commercial income to achieve sustainability.	October 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**	October 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
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 Assurance Rating	**Current Review Period**	6
	Previous Review Period	6
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.	

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)

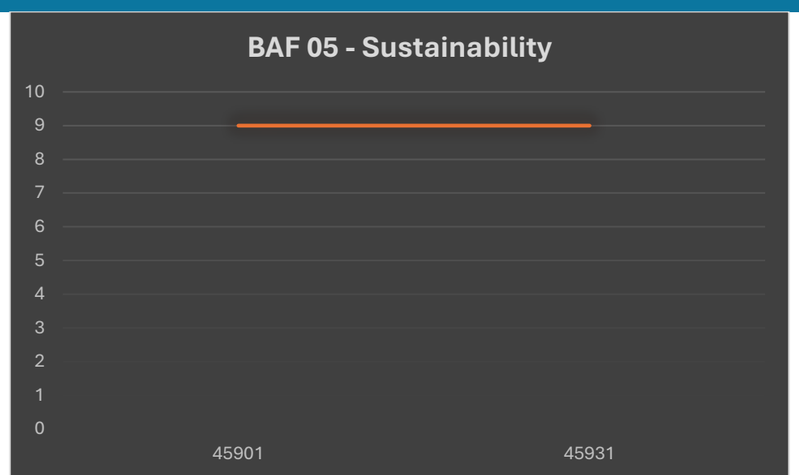
ACTION REF	ACTION	OWNER	DUE DATE	ASSURANCE LEVEL	PROGRESS UPDATE	DATE OF UPDATE	IMPACT OF CHANGE ON RISK	DETAIL IMPACT ON ASSURANCE LEVEL/CONTROL WHEN COMPLETE
04.01	Review Board membership	Director of Corporate Governance Director of Corporate	1 October 2025	6	Review will take place during September alongside new Chair and Independent Members Group.	October 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 Partnership 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.	October 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**	October 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



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 Assurance Rating	**Current Review Period**	4
	Previous Review Period	4
Rationale for Assurance Rating	An assurance level of 4 for sustainability reflects that robust governance, policies are in place. The Climate Action Board provides regular oversight, supported by ISO 14001 certification (surveillance audit passed in October 2025), sustainability internal audits, and active working groups driving progress across all key themes. Clear reporting, engagement, and delivery against sustainability objectives demonstrate strong assurance and continuous 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	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.	October 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.	October 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.

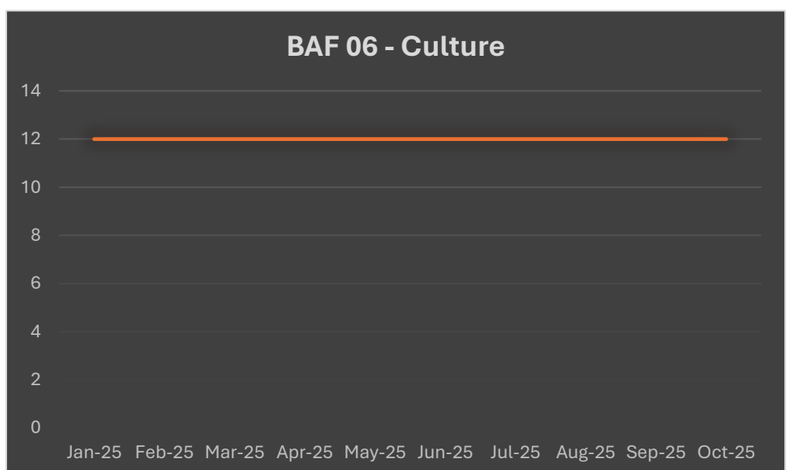
5.3	Include sustainability and Well-being of Future Generations duties in all job descriptions and recruitment materials	Trust Sustainability Manager /Workforce Lead	31/12/2025	2	Review of current job descriptions underway prior to developing draft wording prepared for future recruitment packs.	October 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**	October 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 Assurance Rating	**Current Review Period**	3
	Previous Review Period	
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 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.
Further work is required to fully develop control C5.		

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		Quarter 2 report will be going to the Healthy and Engaged Steering Group on 28.10.2025. 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.	October.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		Quarter 2 report will be going to the Healthy and Engaged Steering Group on 28.10.2025. 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.	October.2025		
06.07	Commence the Values and Behaviour framework project	OD Specialist	December.25		Following Board discussion there will be piece on values and behaviours at the next Board Development Session in October continuing the conversation around culture. 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.	October.25		
06.10	Monitor Welsh Language Standards, working with Divisions on improvement plans	Assistant Director of Workforce Planning	Complete		14/10/2025: Welsh Language standards are monitored through Trust wide governance quarterly to EMB and summarised thought the Trust's annual report, that is scrutinised approved by Trust Board.	October 25	Move to Control	Assurance level 4 – monitoring for the Welsh Language Standards is part of business as usual.
CLOSED ACTIONS								

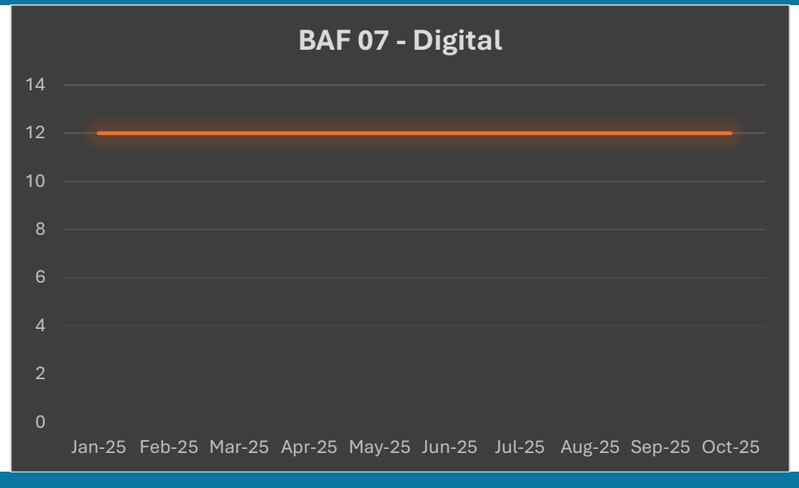
06.01	Undertake analysis of current employee voice mechanisms and develop an engagement action plan to improve voice mechanisms and encourage a culture of speaking up across the Trust.	OD Specialist	Mar 25		Feedback from staff showed a desire to have clearer information about how to Speak Up. A video 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**	October 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 Assurance Rating	**Current Review Period**	3
	Previous Review Period	3
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**

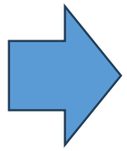
ID	KEY CONTROLS	OWNER	PREVENTATIVE	MITIGATING	DETECTIVE	FIRST LINE OF DEFENCE • *functions that own and manage risk* • *Self-assurance*	SECOND LINE OF DEFENCE • *Functions that oversee or specialise in risk management* • *Internal oversight/specialist control teams*	THIRD LINE OF DEFENCE • *Functions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

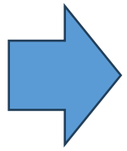
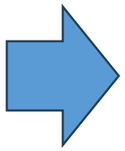
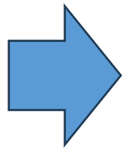
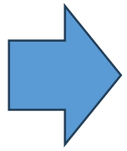
C9	Prioritisation and change framework to manage service requests	Carl Taylor			X	Trust Digital governance reporting Digital Programme Board	EMB / Cyber Action Plan / QSP Committee	Internal Audit / Cyber Resilience Unit
C10	Levels of unsupported applications/ legacy systems	Carl Taylor		X		Trust Digital 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
C15	Establish strategy, policies and guidance for the implementation and maintenance of AI technology	Carl Taylor/ Clinical and Scientific Strategy Board	X	X		Clinical and Scientific Strategy Board/ Digital Programme Board/ Caldicott Guardian, SIRO, DPO	EMB / Strategic Development Committee/ Quality, Safety and Performance Committee	Internal Audit/ CRU?/ DDaT Leadership Board
C16	Trust Information Governance	Matthew Bunce (SIRO)	X	X	X	IQSG, Divisional Quality and Safety Hubs, Divisional Directors	EMB / Performance Committee, Independent Member for IG/Digital	Internal Audit/ CRU?/ DDaT Leadership Board, ICO, Welsh Government

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**	

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.	**15**	
3633	There is a risk to Quality and Performance and Service Stability as a result of the lack of capacity of Digital Health and Care Wales to integrate VUNHST digital systems into the National Architecture on a timely basis leading to delays in the Trusts ability to introduce new digital systems to support its strategic objectives. In particular integration for the IRS, WHAIS, FEDIS projects has had to be escalated to the DHCW Executive for resolution.	**12**	
3632	There is a risk to Quality and Performance and Service Stability as a result of National Digital Programmes managed by Digital Health and Care Wales (DHCW) not being delivered to time/cost/quality for use by the Velindre Trust leading to disruption of the clinical model and the plan to transition services to the new Velindre Cancer Centre. The National DHCW programmes of concern for the Trust are RISP/WLIMS/EPMA.		
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**	
3667 WBS	Private risk relating to vulnerable hardware	**15**	New risk
3757	Private risk relating to BECS	**20**	New risk
3765	Private risk relating to relating to BECs	**20**	New 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
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	October 2025	Digital Design Authority will guide digital transformation	The level of assurance should increase from 3-4 for C13, C15 and C16
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	October 2025	Will contribute to reduction in likelihood of risk	C9 would move to Effective

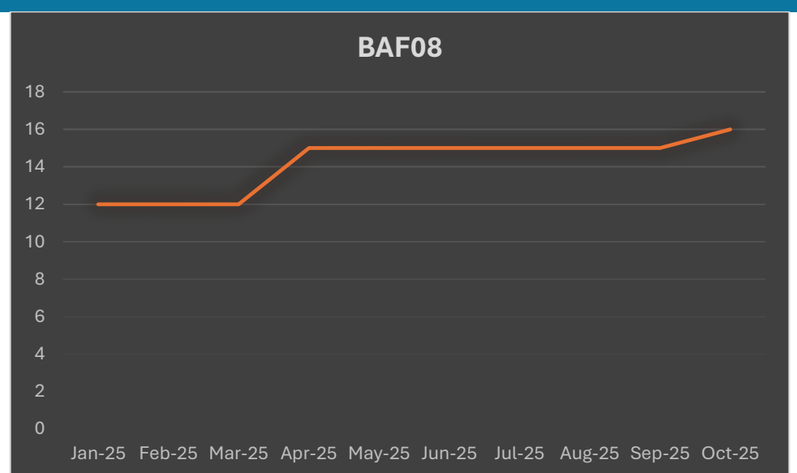
07.03	Reviewing control framework with Head of Information Governance for cross-check and alignment	Carl Taylor	Sep 25		Initial review undertaken and updates will be collated for September 25 BAF	Oct 25	Will contribute to reduction likelihood of risk Controls C15 and C16 are included in the BAF	Additional assurance for C11, C13

SECTION 1 – Summary

RISK ID	08	**REVIEW DATE**	October 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. All on track for Audit Committee consideration in December.

The Trust is waiting for the publication of the Welsh Government's review of the hosting arrangements for Shared Services.

Policy on Policies was approved by QSP in September.

Plans to consider a new Board Development programme discussed at October meeting.

Awaiting plan for structured assessment.

SECTION 2 – Risk Scores

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

Expected date to reach Target Risk Score: April 2026

SECTION 3 – Effectiveness, Controls and Assurance

Overall Assurance Rating	**Current Review Period**	3
	Previous Review Period	3
Rationale for Assurance Rating	Policy on Policies approved by QSP in September meeting and Levels of Assurance training completed along with Board Development session in October. Other significant developments in progress for EMB consideration October/November before December Audit committee, but completion hasn't been achieved. Prioritising Board paper templates, minute taking principles and risk policy development.	

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.
Risk Policy under review Board development programme under review	Third line of defence in respect of C4 - Board Development Programme	Refreshed programme to be discussed by Board on 23 October 2025.

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	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
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.	Oct 2025	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.	Oct 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	Policy under review. EMB consideration of draft planned for October/November 2025 before Audit Committee consideration.	Oct 2025	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.

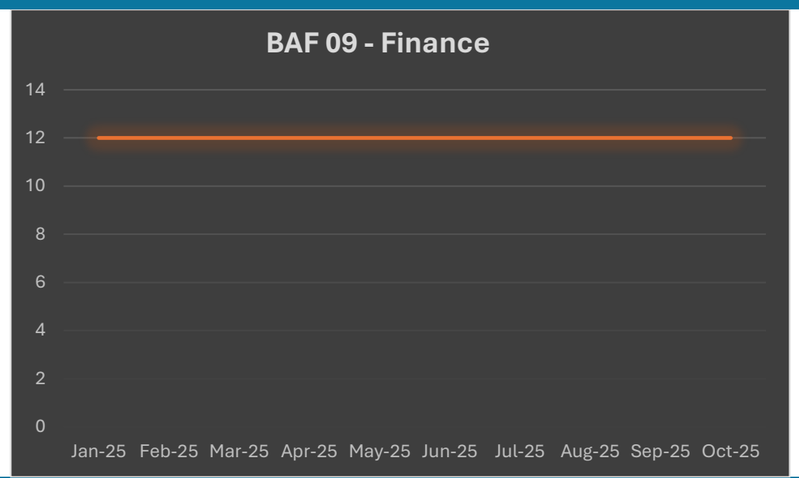
08.04	Ensuring accountability and ownership is in the right place, supported by effective structures, and is empowering for those delivering and those leading the delivery of high-quality services today and shaping our services for the future	Director of Corporate Governance	24/25		GAR Group meeting to consider draft of Corporate Governance Manual, including new Board/Committee template and instructions in July 2025.	Oct 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 considered by end of October 2025.	Oct 2025	Board assured that scope of Committees' work referencing requirements of Duty of Quality effectively.	All ToR uptodated 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 Professionals and Health Scientists	Nov-25	4	Initial discussions resulting in changes of requirement re: Duty of Quality reporting in Board/Committee paper template. Assurance level awareness training complete. Board training 23 October 2025.	Oct 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 complete. Awareness raising exercise underway.	Oct 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.
08.08	Prepare paperwork outlining concerns and solutions to improve hosted services governance in advance of distribution of WG review	Director of Corporate Governance	Nov.25	2	Executive discussion in advance of October Board Development	Oct 2025	None – but it will allow us to respond quickly to the WG report. Urgent issues will require escalating.	Clarity on priorities to refresh governance of hosted services.

SECTION 1 – Summary

RISK ID	**09**	**REVIEW DATE**	03.10.2025	**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

Executive Summary
There are a range of factors that impact on the finance sustainability and long term value risk. We prevent, mitigate or detect impact on this risk through a number of key financial controls. Where these controls are partially effective or not effective actions are being taken to improve the effectiveness of the control and where this achieves the anticipated improvement in control the assurance from that control is increased.

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 Assurance Rating	**Current Review Period**	6
	Previous Review Period	6
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 is being considered aligned with the 2026/27 IMTP financial plan which should support an increase in 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	Monthly Finance and Performance Meetings	Executive Director of Finance		X		Executive Budget Holders / Divisional Directors	Divisional Finance Reports, and Performance; Finance Business Partners	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 Services & Accounting			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 Services & Accounting			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 Services & Accounting	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 Services & Accounting			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 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. Additional system and process controls have been established which has in part mitigated data issues, however, weakness remains, specifically in relation to the Radiotherapy IRS implementation which is being addressed with Service and Business Intelligence.	LTA Activity performance monitoring process currently not providing assurance that all activity is being captured and monitored against Commissioner contracts. Whilst SACT service concerns have been addressed, the ongoing IRS implementation for Radiotherapy services remains a concern, though being addressed between Finance, Service and Business Intelligence.	F7

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

DATIX RISK REF		CURRENT RISK RATING	RISK TREND
	There are no risks related to this BAF		

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 VBHC programme of work to identify areas of unwarranted variation and actions to improve	EDoF / DDoF/COO	Delivery over 24/25-26/27	4	VBHC 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 now operational for Prostate, Lung and Neuro-oncology. Communication Plan in place to support with adoption. Work underway to deploy within wider Urology, CUP and Palliative care as part of phase 2• 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 for denosumab subcutaneous injections is being refined prior to opening for all eligible patients, improving outcomes while releasing resource for more complex treatments. • Data quality improved for historical open pathways, addressing clinical risk Financial evaluation of projects supported via TDABC. • Training, communication & engagement - communication strategy in place, training & engagement sessions undertaken; further staff members undertaking Swansea University Value in Health course Non-recurrent funding secured to develop a national pathway for people with Genetic Haemochromatosis to become blood donors. This reduces demand within the health boards and improves the supply of blood	8/10/25	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

						donations whilst being more convenient for the individuals involved.			

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 took place to present the current financial position and discuss disinvestment options and financial recovery.	08.10.2025	Identification of opportunities for new savings initiatives and disinvestments / choices along with enhanced scrutiny via the establishment of the Finance and performance monthly review 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

					A monthly finance and performance review meeting will be established from November.			

09.03	Development and review of Financial Control Procedures			6	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	10.10.2025	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
			Year 3					

					completion date of December 2025. FCP4 Year End Closedown Procedure has been reviewed and updated. The Bank Mandate has been reviewed and updated. FCP1 Budgetary Control Procedure has been reviewed and updated. The Financial Accounting team are continuing to review the FCPs and this exercise will now be completed by the end of November 2025.			
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	Dec 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.	08.10.2025	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. Responses to specific queries have been submitted to insurers and comments asked to be received within 14 days of issue. Awaiting confirmation of meeting dates from insurers – this is expected to be end of October 25.			

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 Integrated Radiotherapy Solution. Oracle approval hierarchy within the Oracle financial system updated 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.	08.10.2025	Mitigate the risks of non-compliant procurement and improve budgetary control procedures by ensuring clear accountability for spend.	Control 15 - Major Capital Programmes monitoring will improve from PE to E and assurance will change from IA to PA

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	08.10.2025	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

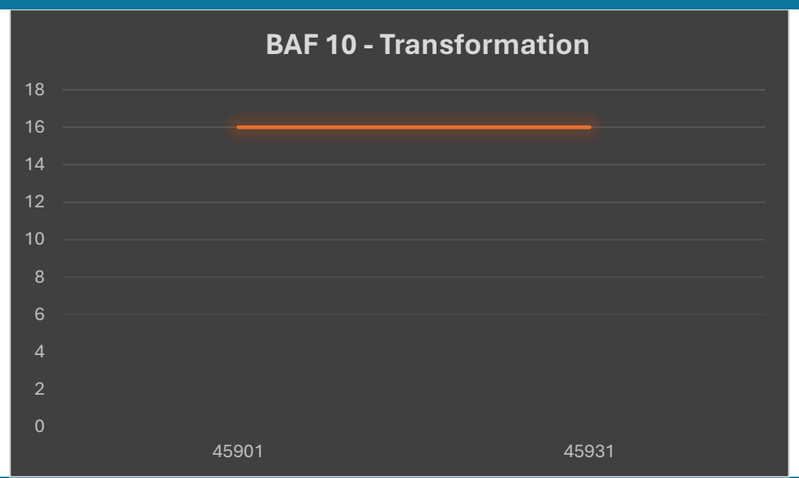
					LTAs, in particular to better reflect the resources consumed in delivering specialist services. The DoFs' view was WG should take a leadership role around NHS contract re-basing and agreed to seek a view from WG. Senior Finance team to re-initiate contract rebase discussions with commissioners with first meeting scheduled for the 10th October 2025.			
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		April 2026	Finance workshop with Executive team took place on the 18.08.2025 where the current financial position was presented and to discuss disinvestment options and financial recovery. Ongoing work with initial review captured as part of the 2026 IMTP process.	08.10.2025	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).				Having met most of its objectives, the scope of the programme has widened to Anaemia Management. A national pathway is in place with compliance monitored for pre-operative anaemia. A pathway is under development for post-operative anaemia, work ongoing with the 3Ps programme to incorporate an anaemia screen where appropriate at the Waiting Well stage.	8/10/25	The impact of the programme is mostly felt within the Health Boards as patient outcomes are improved including a reduced post operative LOS, reduction in readmissions and mortality 1 year post treatment.	Control 11 - VBHC effectiveness

SECTION 1 – Summary

RISK ID	**10**	**REVIEW DATE**	October 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



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 Assurance Rating	**Current Review Period**	3
	Previous Review Period	3
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. **Complete** • Discussion at Board Development Sessions **Due 23/10/2025** • Discussions with LF and Exec colleagues **Complete**	• The executive is engaged and are leading the portfolio and understanding is increasing. **Partially Complete** • Reports are received at EMB. **November EMB onwards**	• 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. **Ongoing Activity**	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 **Partially complete**	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. **Initial Prioritisation Tool Complete**	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 **Base Dashboard in place for Projects and IMTP Deliverables**	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	21.10.2025 Portfolio Handbook 80% complete			
10.2	Carry out Portfolio Prioritisation and Phasing	Gavin Bryce	October 2025	2	21.10.2025 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			

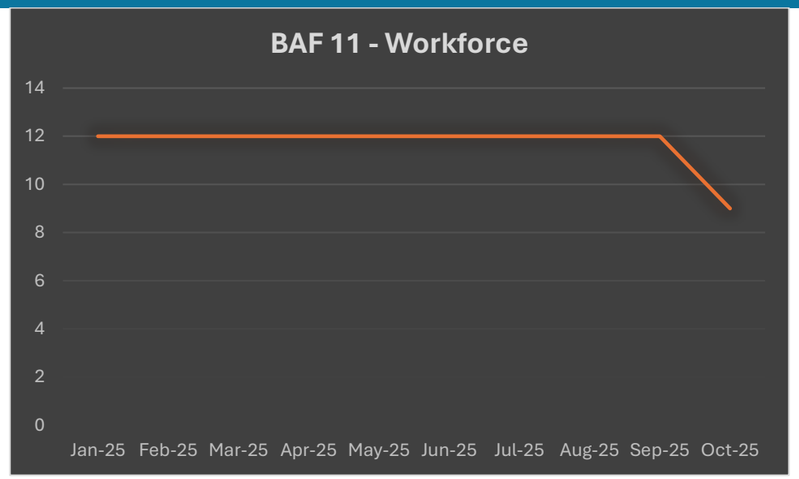
10.4	Carry out Benefits Management and Realisation plan	Gavin Bryce	November 2025	2	08.08.2025 Not started			
10.5	Establish Effective Portfolio Reporting	Gavin Bryce	September 2025	4	08.08.2025 Effective Power BI dashboard in place 90% of data correct work ongoing to improve compliance with incremental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

SECTION 1 – Summary

RISK ID	11	**REVIEW DATE**	October 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 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 been reviewed in October 2025 and is proposed to reduce from 12 to 9. The reduction is proposed following the infromation submitted under the Supply and Shape review paper which demonstrates a number of key metric improvements in all areas mitigating the risk.

The Trust has advanced workforce planning through targeted initiatives, including the successful launch of the Nevill Hall Radiotherapy Unit and development of Welsh language capabilities. Recruitment and retention efforts have yielded a 4% FTE growth and reduced turnover, supported by enhanced employer branding and digital recruitment strategies.

Education and learning initiatives show strong compliance with statutory training and growing PADR engagement, while leadership development is being realigned with national frameworks.

Financially, agency reliance is decreasing, with a 96% drop in agency spend since August 2025.

SECTION 2 – Risk Scores

	LIKELIHOOD	IMPACT	TOTAL
INHERENT RISK	4	4	**16**
CURRENT RISK	3	3	**9**
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 Assurance Rating	**Current Review Period**	4
	Previous Review Period	3
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.	

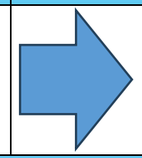
KEY CONTROLS						SOURCES OF ASSURANCE		
ID	**KEY CONTROLS**	**OWNER**	**PREVENTATIVE**	**MITIGATING**	**DETECTIVE**	**FIRST LINE OF DEFENCE** • *functions that own and manage risk* *Self-assurance*	**SECOND LINE OF DEFENCE** • *Functions that oversee or specialise in risk management* *Internal oversight/specialist 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 intents of Workforce Planning - 'Planned and Sustained Workforce' and ‘Skilled and Developed People’	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 robust polices and processes in place to support effective recruitment and selection in a fair and consistent way.	Reports to EMB, Committees and Trust Board	Internal Audit Reports
C5	Workforce Planning - training and skills development for managers and service leads.	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
C6	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

C9	Dedicated Workforce Planning Team and supporting infrastructure in place for the Trust, that is able to support service leads in the review, design and implementation of comprehensive workforce plans.	Amanda Jenkins	X	X	X	Regular monitoring at divisional groups, as well as integrated POD, Finance and Service Leads oversight, through the Strategic Workforce Planning Group.	Reports to EMB, Committee and Trust Board.	Internal and External Audit

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.
Leadership and Management Development programmes require further analysis, which is underway, to support the wider improvements in workforce planning and ensure the skills of the growing workforce are being best utilised.	NA / People Development Group in place, ToR reviewed in September 2025 to make these more robust and encompassing Leadership and Mangement Programme updates.	No actions identified as currently at level 2 assurance – scoping the requirements. Further actions will be added when these have been identified.

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. 13.10.2025 Governance mechanisms for strategic workforce planning in the Trust set up in collaboration with Workforce, Finance and Service Leads.	October 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.	October 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.	Assurance Level 6 - this is now part of BAU within the Trust and sustained improvements are being made as detailed in the workforce metrics reported within the Supply and Shape Assurance Paper to Quality, Safety and Performance Committee.
	11.3	Implementation of the Attraction and Resourcing Project	Assistant Director of Workforce Planning	Complete	2	Initial implementation completed. Financial agreement for ongoing resource agreed as part of the IMTP. Project to become part of BAU for POD.	October 2025	The Trust will be able to reach a wider audience outside of current NHS job boards, improve employer branding and support targeted recruitment campaigns. This in turn will improve the workforce metrics across the Trust, growing our workforce and reducing turnover as we become an employer of choice.	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 27.01.2025 EMB endorsed the NRP, implementation underway. 14.10.2024 A number of successful actions have been completed including implementation of Restorative Clinical Supervision, Bitesize Compassionate Leadership training and embedding the 'Belong Thrive, Stay' Toolkit across both divisions.	October 2025	The Retention Programme is part of a broader initiative aimed at addressing the challenges faced in NHS Wales workforce, with an immediate emphasis on Nurse retention. The aim of the of the programme is to improve retention of our workforce as a key plank of our current and future workforce supply.	
CLOSED ACTIONS								

ANNUAL REPORT 2024/25

Technoleg Iechyd Cymru
Health Technology Wales

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

START

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Our partners

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

Ariennir gan **Lywodraeth Cymru** Funded by **Welsh Government**

FOREWORD

Welcome to the Health Technology Wales (HTW) Annual Report which describes the work that we have done during 2024/25 to improve health and social care in Wales.

This was another busy and successful year during which we were able to balance our commitments to selecting, appraising and promoting the adoption of novel evidence-based non-drug technologies with taking on new roles to support the innovation ecosystem in Wales and beyond.

During 2024/25, we considered 58 new topic referrals from across the health and care communities and published 8 new HTW guidance documents. Topics ranged from the use of digital tools for diabetes management, through to the role of robot-assisted gynaecological surgery in the treatment of benign disease. Since 2017, HTW has now published a total of 52 pieces of evidence-based guidance and 299 topic exploration reports. The results of the 2023/24 Adoption Audit indicate there is a high level of awareness of HTW guidance within the NHS Wales health system and that HTW guidance is having a significant impact on decision-making by clinical teams in their use and adoption of novel non-drug technologies.

Public and Patient Involvement (PPI) continues to be central to all aspects of the work of HTW. During 2024/25, 12 non-drug technology topics were considered by the HTW PPI Standing Group, whose input included patient surveys, testimonials and research reports to support the appraisal process. The impact of the HTW PPI Group has continued to spread beyond Wales through its involvement in the work of the International Network of Agencies for Health Technology Assessment (INAHTA) and through its contribution to important international publications. During 2024/25, this included the authoring of a chapter in a book on conducting PPI in HTA.

Artificial intelligence (AI) is playing an increasingly important role in the non-drug medical technology sector. During 2024/25, HTW was involved in collaborating with partners in the UK to develop guidelines and a checklist for the appraisal of AI in healthcare as well as with European partners in developing guidelines for assessing digital technologies. Published national guidance in 2023/24 highlighted the role of AI in supporting the pathological diagnosis of prostate cancer and in the undertaking of endoscopy to diagnose gastro-intestinal cancers.

During 2024/25, HTW continued to develop UK-wide collaborations and working partnerships. The Innovative Devices Access Pathway (IDAP) pilot is a national venture that brings together expertise from England (MHRA, NICE, DHSC, NHSE), Scotland (SHTG) and Wales (HTW). This initiative aims to promote transformative medical technologies that address unmet clinical needs in the NHS and to bring them to market in a timely and accelerated manner.

FOREWORD

During 2023/24, 8 technologies were selected to enter the IDAP pilot pathway. A new partnership was established, during 2024/25, with the National Institute for Health and Care Research (NIHR). This will ensure that evidence gaps identified by HTW during its assessment and appraisal of non-medicine health technologies are considered in the future by NIHR as potential subjects for UK national research projects.

Engaging with local, national and international stakeholders remained a cornerstone of the success of HTW during 2024/25. Local engagement through the HTW Stakeholder Forum helped to support and guide the work of HTW to ensure that it continues to be of greatest value to the communities it serves. We have continued to work closely with partners in the Health and Care Research Wales (HCRW) Evidence Centre to ensure that the decisions made by NHS and Social Care leaders and Ministers to tackle care challenges in Wales are supported by the best available evidence. We have continued to build on already established links with the Lifesciences Industry through the work of our Industry User Group and through strengthening our collaborations with the Lifesciences Hub Wales and the Bevan Commission.

We are grateful to Welsh Government for their continued support of the work of HTW. During the spring of 2024, HTW was commissioned by Welsh Government to lead the development of an evidence-based advisory report to strengthen the MedTech ecosystem in Wales. The report, that was submitted to Welsh Government in December 2024, 'MedTech: improving life for Welsh citizens' comprised 22 recommendations, with supporting evidence, gathered with wide stakeholder involvement and engagement, on the means to improve collaborative working, better horizon scanning and topic identification. The need to ensure robust governance structures, supported by clinical, patient, public and academic involvement around the optimal identification, appraisal and adoption of MedTech in Health and Social care in Wales, was also identified.

During 2024/25, HTW was able to successfully deliver the objectives that had been outlined in the five-year Strategic Plan published in 2021. We also continued to develop our vision to become a world class HTA organisation that ensures health and care technologies with the most promise to improve people's lives and offering the greatest value are recognised and adopted in Wales. We hope that you enjoy reading this annual report and we look forward to continuing to work with you in realising our vision.

Professor Peter Groves
Former Chair
Health Technology Wales

Dr Susan Myles
Director
Health Technology Wales

CEO MESSAGE

Velindre University NHS Trust is proud to host and support the team at HTW on behalf of Welsh Government and the whole of NHS Wales. Health Technology Wales has continued to publish national guidance on non-medicine health technologies with the potential to transform healthcare in Wales throughout the year.

Health Technology Wales is uniquely placed to explore and recommend the way in which NHS Wales can optimise its use of technology.

This year has seen a particular focus on the identification and appraisal of non-medicine health technologies that use AI to diagnose or treat health conditions. As well as carrying out appraisals on technologies such as AI assisted endoscopy for gastrointestinal cancer, HTW has played a key role in developing methods for the appraisal of these technologies which may benefit many conditions.

This is an area of huge importance for cancer care, as the technology to diagnose or treat different forms of cancer continues to evolve at a rapid pace. The scale of the potential for this technology to transform services is vast. However, as HTW has shown, it is vitally important that rigorous methods are in place to appraise the clinical and cost effectiveness of these technologies.

As ever the national guidance published by HTW has covered a wide breadth of health conditions affecting the population of Wales, including cancer, diabetes and liver disease.

As well as continuing to publish national guidance on non-medicine health technologies, HTW has been a collaborating partner of the Health and Care Research Wales Evidence Centre, carrying out rapid evidence reviews on topics ranging from child health to the role of allied health professionals in neonatal services.

In 2025/26 HTW will continue to support the work of the NHS and Welsh Government in tackling key health priorities and establishing a world-class medical technology strategy.

As we welcome Professor Keith Lloyd as the new HTW Appraisal Panel Chair, we would also like to take this opportunity to thank Professor Groves for his tenure as Chair of HTW. Professor Groves' knowledge and experience of health technologies has been instrumental in the growth and continued success of HTW. We wish him all the best in his future endeavours.

David Donegan
Chief Executive Officer
Velindre University NHS Trust

Donna Mead
Chair
Velindre University NHS Trust

HTW STRATEGIC PLAN 2021-2025

Better Health - Evidence Driven

The HTW Strategic Plan 2021-2025 sets out the organisation's immediate, medium and long-term strategic goals and objectives.

VISION: To develop a world-class HTA organisation that facilitates the identification, appraisal and adoption of health technologies that offer most promise to deliver improved health outcomes and value for the people of Wales.

MISSION: To drive improvements in population health and care services by applying the best available evidence to inform decisions on the appropriate use of health technologies in Wales.

Key achievements in delivering our 2024/25 priority objectives are set out below:

Expand HTW's topic identification, prioritisation and selection efforts

- Worked with the new national All-Wales Clinical Effectiveness Group (AWCEG) to review the list of Interventions Not Normally Undertaken (INNUs) across all Welsh health boards to identify potential topics to progress for further evidence appraisal
- Reviewed NICE Interventional Procedures Guidance (IPG) to identify topics with demonstrated efficacy and safety and consider if any are appropriate to progress to full evidence appraisal, investigating their clinical and cost-effectiveness for Wales
- Continued to run targeted topic call campaigns inviting topic referrals for HTW consideration
- Considered topics registered by technology developers on the NHS Innovation Service which could be of interest for health and care organisations in Wales
- Identified topics for appraisal as a result of work to support the Small Business Research Initiative (SBRI) cancer call

Maintain increased HTW evidence appraisal and guidance output

- 8 pieces of guidance published in 2024/25
- 8 topics progressed to evidence appraisals during reporting period
- 54 Topic Exploration Reports (TERs) published

Support time-critical health and social care policy decision making

- Continued to conduct rapid evidence reviews as a Collaborating Partner of the Health and Care Research Wales Evidence Centre
- Continued to support the Individual Patient Funding Request (IPFR) panels across Wales with evidence reviews to inform their decision making

Roll-out the HTW technology adoption audit function and pilot the adoption audit process for NICE medical technologies guidance

- 11 pieces of HTW guidance and three pieces of NICE guidance audited as part of the 2023/24 HTW Adoption Audit
- Encouraging response rates with participation by all local health boards, the Welsh Ambulance Services University NHS Trust, Velindre University NHS Trust and the NHS Wales Joint Commissioning Committee
- Responses indicate that awareness of HTW guidance is high (79%) clarity of HTW guidance recommendations is good (96%) and HTW guidance is having some form of impact in the majority of cases (72%)

Improve and publish HTW's methods and processes

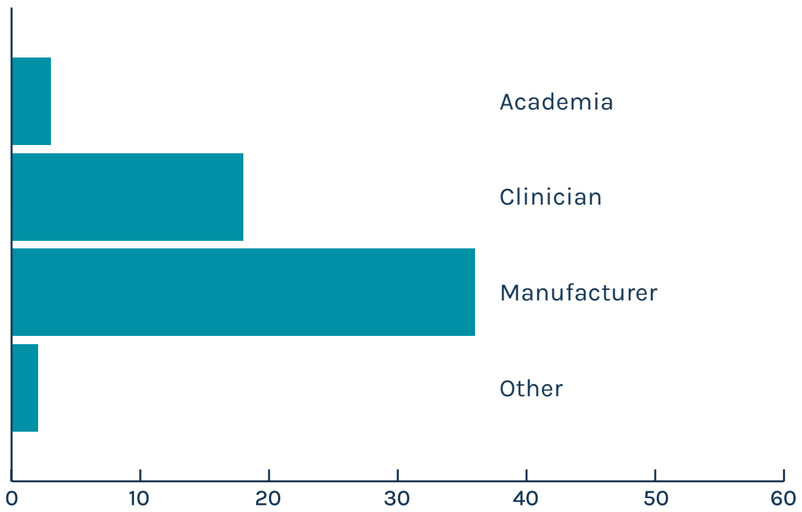
- Worked to develop guidelines for the appraisal of AI technologies in health and care services
- Initiated work to strengthen consideration of equality, diversity and inclusion (EDI) principles in both our strategic and operational work
- Worked in partnership with National Institute for Health and Care Research (NIHR) to ensure that evidence gaps identified during HTW's appraisal process are shared, so that they may be addressed
- Continued to support the work of the pan-UK Innovative Devices Access Pathway (IDAP) that aims to identify potentially transformative care technologies and offer them support to navigate their path through regulatory and HTW processes with the aim of expediting their adoption and the benefits they offer
- Contributed to the production of a White Paper which addresses environmental sustainability considerations within HTA methods and processes in partnership with international INAHTA partners

TOPIC IDENTIFICATION

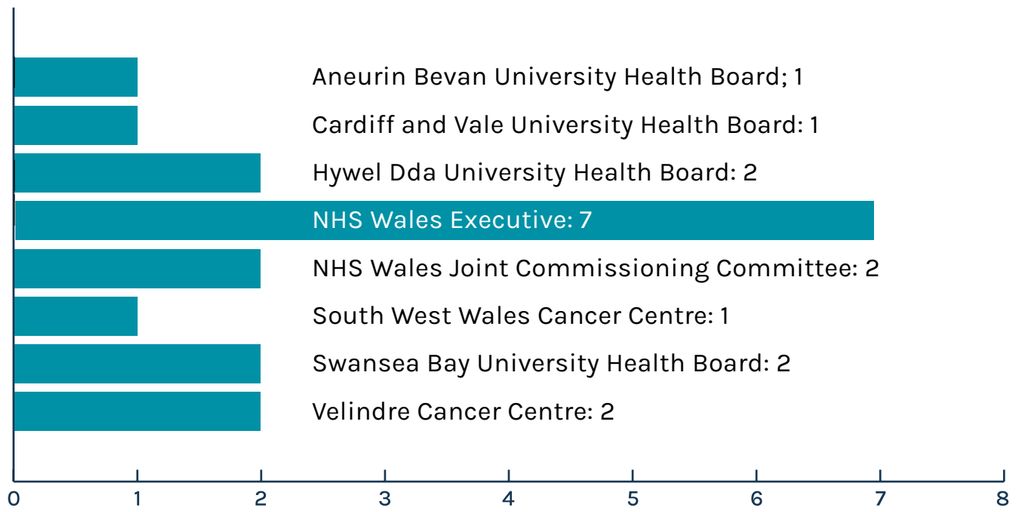
58
Topics proposed to HTW in 2024/25

551
Topics proposed to HTW since 2017

Source of topic referrals in 2024/25



Breakdown of topics referred from the NHS in 2024/25



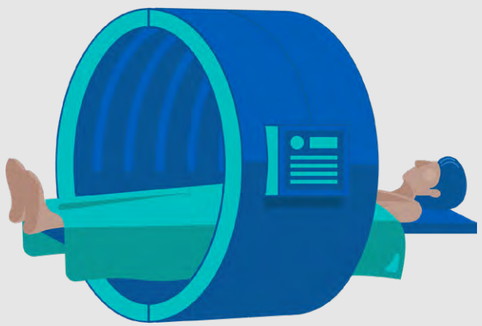
We have produced an animation to explain the criteria required for submitting a topic for appraisal. To find out more watch our animation **here.**

DRIVING AI INNOVATION IN HEALTHCARE

Artificial intelligence (AI) offers huge potential to transform the way health conditions are diagnosed and treated in Wales.

Throughout 2024/25 HTW has published guidance on pioneering AI technology and played a key role in the development of guidelines for appraising AI technologies. Going forward HTW will continue to identify and appraise AI health technologies. Here are some examples of how HTW made a difference in AI in 2024/25:

- Working in collaboration with clinical partners, HTW's team of health services researchers developed the AI checklist. These guidelines aim to ensure rigor and transparency in the appraisal of AI technologies, and that any guidance is based on the best available evidence on clinical and cost effectiveness. Since developing the checklist, our researchers have presented it to the HTAi Conference in Seville, World EPA Congress in Amsterdam, the Welsh Government AI Commission for Health and Social Care and the Small Business Research Initiative.
- HTW has been actively involved in the Horizon Europe programme. As part of the project a survey was carried out among members on HTW's methods for assessing digital health technologies. As part of the European Digital Health Technology Assessment (EDiHTA) project HTW were interviewed about methods for assessing digital health technologies.
- As a member of the AI Commission for Health and Social Care, HTW has attended meetings and working groups throughout the year, offering its insight on the potential for AI technologies in health care and how to gather evidence on the clinical and cost effectiveness of these technologies.
- Throughout 2024/24 HTW has published national guidance on non-medicine health technologies that use AI. These have included:
- Artificial intelligence assisted tools for prostate cancer diagnosis using whole slide biopsy images
- AI-assisted endoscopy for gastrointestinal cancer
- Digital tools for diabetes management



APPRAISAL

8

Topics progressed to evidence appraisals in 2024/25

8

Pieces of HTW guidance published in 2024/25

52

Pieces of HTW guidance published since 2017

Find out more

Would you like to find out more about the Health Technology Wales topic appraisal process? To raise awareness about how the process works we have created an animated video which you can watch here.

GET INVOLVED

Do you know about a technology or model of care and support in health or social care that Health Technology Wales could appraise?

Anyone can suggest a topic and we are keen to receive suggestions from people with a wide range of backgrounds, including the general public.

To suggest a topic complete our online form here.

CHAMPIONING EQUALITY AND DIVERSITY

As part of our commitment to ensuring that equality, diversity and inclusion (ED&I) forms part of our core business at HTW, we are developing an action plan that aligns with Velindre University NHS Trust's strategic equality plan, and as part of this work we have been considering how our evidence appraisals should take account of equity within research. To this end, we are in the process of developing an ED&I process for evidence appraisal review. Learning from other HTA and evidence review organisations, this process will draw expertise from our existing Patient and Public Involvement Standing Group to identify and then report areas of inequity and considerations for diverse patient groups with each evidence review. We are excited to develop and trial this process in 2025/26 .

HTW WELCOMES NEW APPRAISAL PANEL CHAIR

We are pleased to introduce the new Chair of the Health Technology Wales Appraisal Panel, Professor Keith Lloyd.

The role of the HTW Appraisal Panel is to consider the HTW evidence appraisals within the context of NHS and social care in Wales and to produce HTW national guidance based on this evidence.

The panel also helps HTW to identify upcoming topics for appraisal, evaluates the uptake of HTW guidance and facilitates stakeholder engagement.

Keith Lloyd is a Professor of Psychiatry at Swansea University and Director of its Institute of Life Science with a long-standing interest in innovation, wellbeing and health.

He was Pro Vice Chancellor for medicine, health and life science at Swansea University and before that head of the Swansea University medical school. Prior to joining the university, he was head of what is now Health and Care Research Wales.

Keith has also worked with the James Lind Alliance on public and patient perspectives in research priority setting and with the Cochrane collaboration.

Professor Lloyd continues to work clinically as a psychiatrist in Swansea.

Susan Myles, Director of Health Technology Wales

> We are delighted to welcome Professor Lloyd as the new Chair of the Health Technology Wales Appraisal Panel.
>
> He has invaluable experience both in clinical and academic settings and an excellent understanding of the health and care landscape in Wales.
>
> We look forward to seeing how he helps to shape the important work of our Appraisal Panel and, in turn, the impact he makes on the identification, appraisal and adoption of innovative health technologies across Wales.

Keith Lloyd, HTW Appraisal Panel Chair

> As Chair of the HTW Appraisal Panel I look forward to helping develop at pace national guidance on innovative health technologies with real world impact that work for Wales.

TEAM BIDS FOND FAREWELL TO CHAIR WHO PLAYED VITAL ROLE IN HTW'S DEVELOPMENT

We would like to take this opportunity to extend our thanks and gratitude to Professor Peter Groves, whose tenure as Chair of Health Technology Wales has sadly come to an end.

Professor Groves was appointed as HTW Chair in 2018 and in 2021 his term as Chair was extended by the then Minister for Health and Social Services, Eluned Morgan MS.

Under his tenure the organisation has become an internationally respected health technology assessment (HTA) body working in partnership with stakeholders across the UK and globally.

Since being established in 2017 HTW has published more than 50 pieces of national guidance on non-medicine health and care technologies. It is playing a key role in identifying technologies that could address Welsh Government health priorities and is at the forefront of developing appraisal methods for artificial intelligence (AI) health technologies.

Professor Groves' extensive experience as a Consultant Interventional Cardiologist and in medical technology use has enabled him to be a driving force behind the development of the organisation and his insightful approach to the assessment of health technologies will be greatly missed.

Speaking about his experience as HTW Chair, Peter Groves said: "It has been a great privilege to be part of HTW's journey from fledgling HTA body to an organisation whose work continues to have major impact on the lives of people in Wales.

"The identification of innovative health technologies is key to solving some of the greatest challenges facing healthcare providers in Wales. Meanwhile HTW's robust evidence-based approach to the appraisal of these technologies is more important than ever as the sector continues to rapidly evolve.

"I would like to thank my colleagues at HTW and our partners across the health and care sectors for their dedication, hard work and support for the organisation since it was established. I wish them every success in the future"

In addition to being HTW Chair, Professor Groves is also Chair of the National Institute for Health and Care Excellence (NICE) Appeal Panel, and previous Chair of the Medicines and Healthcare products Regulatory Agency (MHRA) Devices Expert Advisory Committee and the NICE Medical Technologies Advisory Committee.

In May 2024 we were proud to announce that Peter had been awarded a fellowship by the Learned Society of Wales in recognition of his outstanding contributions to medicine and learning in Wales.

> **Peter has played a central role in the development of HTW as an organisation, providing invaluable input to the appraisal process, due to his extensive clinical experience and expertise in medical technologies.**
>
> **He will be greatly missed as HTW Chair and we wish him all the best in all his future endeavours.**
>
> Dr Susan Myles, Director of HTW

GUIDANCE IMPACT

551
topics proposed to HTW since 2017

73
topics progressed to evidence appraisal

52
pieces of national guidance published

OUR RECOMMENDATIONS

Our national guidance recommendations fall into three main categories:

Routine adoption:

The evidence supports the adoption of that technology for a general population.

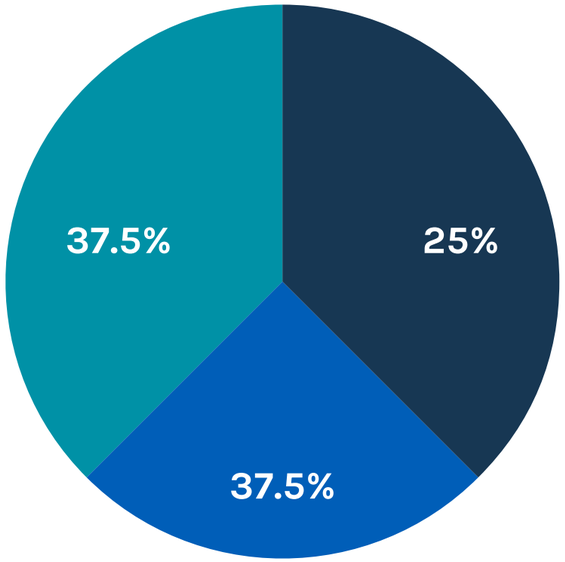
Selective adoption:

The evidence supports the adoption of that technology in a specific subset of the general population.

Insufficient evidence to support adoption:

There is not enough evidence to support the adoption of that technology.

2024/25



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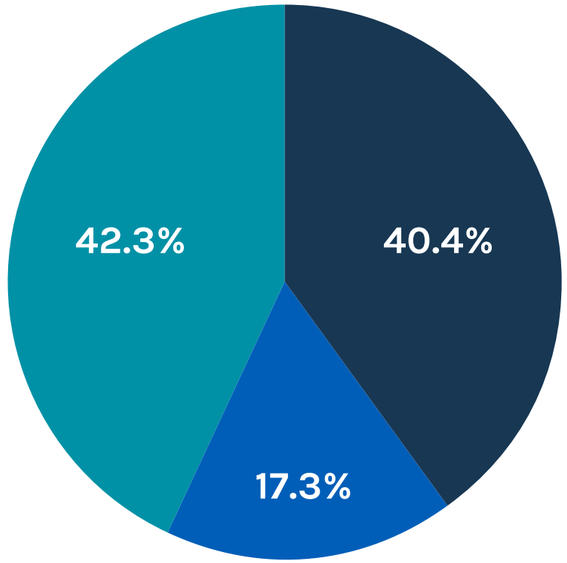


NATIONAL PARTNERSHIP DRIVES EVIDENCE GENERATION

HTW has launched a new partnership with the National Institute for Health and Care Research (NIHR) to help ensure that evidence gaps identified during health technology assessments are addressed.

This national partnership is an important step in informing evidence generation for non-medicine health and care technologies.

HTW carries out health technology assessments of non-medicine health and care technologies and produces national guidance on the clinical and cost effectiveness of the technology, including recommendations for adoption in Wales.

The assessment process involves evaluating the evidence that already exists on the technology and producing an Evidence Appraisal Report (EAR) which is used to formulate the HTW guidance recommendations.

The EARs and guidance documents highlight any evidence gaps that exist. This could include research recommendations that outline the need for studies comparing the technology to standard care, or those assessing long term outcomes. These will now be shared with NIHR to inform future research commissioning. Evidence generated from high quality studies is necessary to ensure technologies delivered to patients are safe and effective.

The NIHR is funded by the Department of Health and Social Care with investments from each of the Devolved Administrations, including Health and Care Research Wales, to improve health through research. It works in partnership with the NHS, universities, local government, other research funders, patients and the public to fund and deliver health and care research.

> This partnership provides an important opportunity to better highlight gaps in the evidence that exists for the adoption and use of non-medicine health and care technologies.
>
> Identifying and addressing evidence gaps will mean that more potentially life-changing technologies can be adopted by health and care providers.
>
> We look forward to further developing our partnership with the NIHR and finding new ways to share knowledge and information together.
>
> **Professor Peter Groves,**
> Former Chair of Health Technology Wales

LIST OF GUIDANCE PUBLISHED IN 2024/25

JANUARY 2025 | CATHETER LOCKING SOLUTIONS

DECEMBER 2024 | DIGITAL TOOLS FOR DIABETES MANAGEMENT

DECEMBER 2024 | ROBOT-ASSISTED BENIGN GYNAECOLOGICAL SURGERY

DECEMBER 2024 | ELF TEST (ENHANCED LIVER FIBROSIS)

NOVEMBER 2024 | ADVANCED PARAMEDIC PRACTITIONERS

AUGUST 2024 | ARTIFICIAL INTELLIGENCE ASSISTED TOOLS FOR PROSTATE CANCER DIAGNOSIS USING WHOLE SLIDE BIOPSY SLIDES

JULY 2024 | FLOSEAL IN THE TREATMENT OF EPISTAXIS

JULY 2024 | AI-ASSISTED ENDOSCOPY FOR GASTROINTESTINAL CANCER

APPRAISAL CASE STUDY

AI ASSISTED ENDOSCOPY IN THE DETECTION OF LOWER GASTROINTESTINAL CANCER AND PRE-CANCEROUS LESIONS

What did we do?

HTW considered the use of artificial intelligence (AI) for the detection of lower gastrointestinal (GI) cancer and pre-cancerous lesions. Colonoscopy is a test, using a flexible lighted tube and camera, to identify any areas of concern in the lower GI tract. The use of AI to assist endoscopists during this test is known as computer aided detection (CADe). Improved detection and removal of adenomas and other pre-cancerous lesions can reduce the incidence of cancer in future. We appraised the clinical and economic evidence on the topic, publishing an Evidence Appraisal Report and HTW Guidance in June 2024.

Who with?

This topic was proposed by an endoscopist working in NHS Wales. We partnered with Velindre University NHS Trust to hold focus groups exploring patient, family and carer perspectives on the use of AI in healthcare and specifically for this purpose. During the consultation period, we received feedback from the clinical lead of the National Endoscopy Programme, gastroenterologists and a manufacturer.

What were the reactions?

Stakeholders believed the review to be of high quality and felt that the appropriate evidence had been reviewed and conclusions drawn. The topic proposer congratulated the HTW team on ‘an excellent and thorough evaluation’.

What did people learn?

The evidence review showed that the use of CADe improved the detection of adenomas, polyps and sessile serrated lesions compared with standard colonoscopy, without considerable increases to withdrawal time. Economic modelling suggested that CADe is also cost effective compared with standard colonoscopy.

What difference did this make?

The HTW Appraisal Panel recommended that the evidence supports the routine adoption of CADe colonoscopy for the detection of lower GI cancer and pre-cancerous lesions. They also recommended the collection of data on the real-world implementation and effectiveness of CADe.

APPRAISAL CASE STUDY

DIGITAL TOOLS FOR DIABETES MANAGEMENT

What did we do?

HTW conducted a rapid review to address the following research question:

What is the clinical and cost effectiveness of digital platforms for personalised diabetes management to inform decision making in the NHS?

A rapid review was undertaken of relevant databases since 2008 of the clinical evidence, health economics and patient, carer, and family perspectives relevant to Wales. A cost-utility analysis developed by HTW considered the cost effectiveness of digital platforms in the NHS Wales context, although the analysis focused on MyWay Diabetes.

National guidance and the Evidence Appraisal Report (EAR) on digital tools for diabetes management was published in December 2024.

Who with?

We engaged with several stakeholder groups during the development of this appraisal. During the consultation period, we received feedback from clinical leads, consultants, academics in research and university lecturers and professors.

What did we learn?

Digital platforms were associated with improvements in glycaemic control (HbA1c and fasting plasma glucose), healthcare resource use (e.g., fewer GP and A&E visits per year), body weight (statistically significant reduction in weight), reduction in cholesterol levels, and positive patient reported outcome measures. HTW also received a patient submission from Diabetes UK Cymru and positive results from the qualitative literature review.

HTW updated the published economic analysis for people with type 2 diabetes who do not require insulin. The HTW analysis found the platform to be more effective but more costly than usual care. The resulting ICER of £4,577 per quality-adjusted life year (QALY) gained is lower than the cost effectiveness threshold of £20,000 per QALY, suggesting that the digital diabetes platform is cost effective. In probabilistic sensitivity analysis, the digital platform was found to have a 97% probability of being cost effective at a threshold of £20,000 per QALY. However, the uncertainty in this conclusion will be underestimated.

What were the reactions?

An earlier draft of this topic was presented in Seville at the 2024 HTAi Annual Meeting as a poster. The poster closely aligned with the theme of digital health solutions. The abstract was then published in the International Journal of Technology Assessment in Health Care (IJTAHC) (PD115, Abstract No 437).

What difference did it make?

The evidence suggests there are clear benefits of using digital platforms to aid self-management among people with Type 2 diabetes. Studies reporting on HbA1c found statistically significant and clinically important benefits (according to relevant NICE clinical guidelines) of using digital platforms.

> The Health Technology Wales (HTW) process is a great initiative to enable new products or services to be evaluated in an unbiased way covering both qualitative, quantitative and health economic aspects. It is very difficult to get new innovations commissioned and implemented in healthcare due to lack of streamlined process and budget, but the HTW process helps provide a clear recommendation that can be used to support commissioning decisions and stakeholder conversations.
>
> The process did take longer to complete than expected but with a good result.
>
> **Debbie Wake**
> CEO and Chief Medical Officer
> MyWay Digital Health

The HTW Appraisal Panel concluded that the evidence supports the routine adoption of the MyWay Diabetes digital platform for personalised management, education, and support for people with type 2 diabetes. Economic modelling suggests MyWay Diabetes is cost effective compared with standard care in people with type 2 diabetes who do not require insulin.

ENHANCED LIVER FIBROSIS TEST FOR THE ASSESSMENT OF LIVER FIBROSIS IN PEOPLE WITH METABOLIC DYSFUNCTION-ASSOCIATED STEATOTIC LIVER DISEASE

What did we do?

HTW considered the use of the Enhanced Liver Fibrosis (ELF) Test to diagnose advanced liver fibrosis in people with metabolic dysfunction-associated steatotic liver disease (MASLD, formerly known as non-alcoholic fatty liver disease). Liver disease occurs when the healthy tissue of the liver becomes scarred due to the build-up of fat in the liver. The scarring is known as fibrosis. Liver disease is often silent and not detected until end-stage liver disease has been reached. Advanced fibrosis is the point at which liver disease can be halted but not entirely reversed. The ELF test is a blood test that can detect advanced liver fibrosis and could be used with another non-invasive test, the Fibrosis-4 test, to screen people for liver fibrosis and reduce unnecessary referrals to hepatology. We appraised the clinical and economic evidence on the topic, publishing an Evidence Appraisal Report and HTW guidance in October 2024.

Who with?

This topic was proposed by the manufacturer of the ELF test, who asked us to consider whether the cut-off for diagnosing advanced fibrosis should be lowered and whether the ELF test should be used with the Fibrosis-4 test to screen for advanced fibrosis in primary care. During the consultation period, we received feedback from a consultant in chemical pathology, a lead hepatology nurse and a doctor who had conducted a previous systematic review of the ELF test.

What were the reactions?

Stakeholders believed the review to be of high quality and felt that the appropriate evidence had been reviewed and conclusions drawn.

What did people learn?

The evidence review showed that lowering the ELF cut-off for diagnosing advanced liver fibrosis was appropriate, but that there was not enough evidence to decide whether using the ELF test with the Fibrosis-4 test would reduce unnecessary referrals. Economic modelling suggested that reducing the ELF cut-off was likely to be cost-effective.

What difference did this make?

The HTW Appraisal Panel recommended that the lower cut-off for the ELF test be routinely adopted to diagnose advanced fibrosis in people with MASLD. The Appraisal Panel noted that evidence for combining the ELF test with the Fibrosis-4 test was promising but did not recommend routine adoption. The guidance was endorsed by the British Society of Gastroenterology (BSG), including the Liver Section Committee, placed on their website, and promoted to BSG members.

APPRAISAL CASE STUDY

CATHETER LOCKING SOLUTIONS

What did we do?

HTW conducted a rapid review to address the following research question: What is the clinical and cost effectiveness of non-antibiotic, antimicrobial and anticoagulant catheter locking solutions in the prevention of catheter-related complications? We also conducted a new cost-utility analysis to estimate the cost effectiveness of KiteLock, TauroLock and TauroLock-U25.000 in Wales. This resulted in the publication of national guidance and an Evidence Appraisal Report (EAR) on catheter locking solution.

Who with?

We engaged with several stakeholder groups during the development of this appraisal. During the consultation period, we received feedback from clinical leads, consultants, academics in research and university lecturers and professors.

What did we learn?

A lower rate of central line associated bloodstream infections was found across the different locking solutions. For catheter patency, occlusion and thrombosis, outcomes were broadly mixed with varying statistical significance. Generally, the number of repairs or replacements needed were lower in the TauroLock and TauroLock-U25.000 groups when compared to the respective comparator groups. Both KiteLock and TauroLock-U25.000 were found to demonstrate a lower usage of recombinant tissue plasminogen activators (rt-PA). One RCT reported a lower number of hospital admissions when using TauroLock.

Our economic analysis indicated that TauroLock may be less costly and more effective than the modelled comparators for children receiving home parenteral nutrition, chemotherapy, or stem cell transplant and for adults receiving home parenteral nutrition or haemodialysis. KiteLock was also estimated to be less costly and at least as effective as select comparators for children receiving home parenteral nutrition and for adults receiving home parenteral nutrition or haemodialysis. KiteLock was not cost effective against heparin in haemodialysis; nor was TauroLock-U25.000 cost effective against TauroLock-HEP500. The cost effectiveness of KiteLock was most sensitive to the choice of modelled inputs and assumptions.

What were the reactions?

Stakeholders believed that the review followed clear methodology and conclusions were drawn from appropriate interpretation of the evidence.

What difference did it make?

HTW published guidance which partially supports the use of non-antibiotic, antimicrobial, anticoagulant catheter locking solutions for the prevention of catheter-related complications.

TauroLock should be considered for children receiving home parenteral nutrition, chemotherapy or stem cell transplantation and for adults receiving home parenteral nutrition or dialysis. The evidence does not support the case for routine adoption of TauroLock-U25.000. There is greater uncertainty in the evidence for KiteLock 4%, and, while it shows promise, the current evidence is insufficient to support routine adoption.

LATEST ADOPTION AUDIT REPORT SHOWS HTW GUIDANCE IS HAVING AN IMPACT ACROSS WALES

Adoption of HTW guidance is key to ensuring that there is access to evidence-based technologies and models of care and support and that their anticipated benefits are realised for people in Wales.

HTW carries out an annual adoption audit in partnership with stakeholders, which aims to assess the impact of its guidance across Welsh care systems.

The 2023/24 HTW Adoption Audit Report focused on 11 pieces of HTW guidance and three pieces of NICE Medical Technologies Evaluation (MTEP) guidance. It achieved the best response rate to date and revealed high levels of awareness of HTW guidance.

Key findings from the adoption audit include the following:

- Responses from organisations where the guidance was relevant indicate that awareness of the guidance is high (79%), clarity of guidance recommendations is very good (96%), and guidance is having an impact in the majority of cases (72%). These figures are consistent with, or an improvement on last year's audit.
- While the clarity of the guidance was reported as high, there were some instances where organisations did not fully understand the remit of HTW guidance. There were comments around the lack of information on where funding and extra resources would come from, and questions around implementation of the technology, which is not within the remit of HTW guidance.
- Generally, HTW guidance that recommends routine adoption of a technology was adhered to. Though there were a few examples where organisations had not adhered to the recommendation or were unsure if they would.
- For HTW guidance that "partially supports" routine adoption, organisations generally either did not feel the guidance was sufficient to change commissioning policy or clinical practice, or were unsure.
- All three pieces of NICE guidance audited recommended the use of a technology. The impact on decision-making of the three pieces of guidance was variable, ranging from no impact to major impact.

To read the HTW 2023/24 Adoption Audit Report in full click here.

> ***HTW plays an important role in helping to ensure that the most effective and cost-effective health technologies are available to the people of Wales. This report clearly demonstrates the significant impact HTW's guidance is having within our healthcare sector. It is also really pleasing to hear that this audit achieved the highest response rate so far, which demonstrates the continuous improvements being made to the HTW adoption audit process.***
>
> **Judith Paget**
> Director General for Health and Social Services
> and NHS Wales Chief Executive

> ***NICE has a great relationship with Health Technology Wales (HTW) . We've worked closely with them over the years particularly in the area of evaluating uptake. HTW have undertaken audits on NICE MedTech and diagnostic guidance in Wales, providing us with valuable insights and intelligence that we would otherwise would not have been able to obtain.***
>
> **Dr Julie Vile**
> Nice Implementation Consultant (Wales)
> National Institute for Health and Care Excellence (NICE)

PPI ACTIVITIES IN 2024/25

Patient and public involvement (PPI) forms an integral part of the HTW appraisal process and provides vital information about the impact of health technologies and models of care on the lives of patients and care service users.

HTW works closely with patient groups across the UK to ensure that we learn from the experiences of patients, carers and their families and that their feedback helps inform the guidance we publish.

Highlights from HTW's PPI work in 2024/25 include:

- PPI undertaken for all new topics
- 6 literature reviews, 1 patient submission, 2 patient surveys, 1 research report from patient organisations and patient testimonials
- PPI Standing Group (PPISG) meetings held quarterly to determine PPI mechanisms, oversight of ongoing PPI activities, plain language summaries and evolving PPI processes and tools
- HTW continues to input into international PPI work, including a patient webinar through INHATA
- HTW's PPI Manager Contributed PPI recommendations to the development of an advisory report to support the Welsh MedTech ecosystem
- PPISG members were consulted in the development of this advisory report
- A PPISG representative and PPI Manager presented on HTW's flexible PPI approaches to the HTAi Annual Meeting in June 2024
- PPI Manager attended the first annual EMRAG (Ethnic Minority Research Advisory Group) conference at the University of South Wales
- Engagement with Cardiff Met University by giving a presentation to graduating students on the role PPI in health technology assessment
- The PPISG underwent successful new member recruitment and welcomed four new members who are quickly becoming a valuable asset to PPISG, Assessment Group and Appraisal Panel. Welcome to Bob McAlister, John Gallanders, Julie Hepburn and Tony Esmond

PPI publication

HTW completed their chapter submission for the second edition on conducting PPI in HTA, which is due for publication in the summer of 2025. This chapter has been accepted for publication. The chapter will cover HTW's unique approaches to undertaking PPI.

PAYING TRIBUTE TO ORIGINAL PPI GROUP MEMBERS

HTW has had the great privilege to work with and benefit from the expertise of our Patient and Public Involvement Standing Group (PPISG) since its formation in 2018. This year we bid farewell to our original group members as their tenure as PPISG members comes to an end. These members have been instrumental in shaping our PPI processes, tools and documents and have worked tirelessly to develop a PPI process that is being recognised worldwide. Over their tenure, our members have achieved the following:

- The development of our PPI Mechanism Tool and the unique approach to making sustainable, flexible and fit for purpose PPI decisions
- The creation of patient education tools on HTA, including a webinar and animation
- Attended and presented HTW's work at HTAi conferences
- Spoken about HTW and PPI at universities and NHS trusts
- Taken part in online and in person focus groups for various topics and technologies
- Shaped patient representation on HTW committees and boards
- Contributed to publications on HTW's PPI work

It has been our pleasure to work with these talented individuals. While their tenure at HTW has ended and PPISG undergoes new membership representation, we will always be grateful to our original membership and excited for what lies in store for each of them in the future. To Alan, Catherine, Emma, Karen, Kiana, Louise, Sarah and Sian, we give our sincere thanks and best wishes.

> I am so sad to be leaving HTW but my memories are all positive. I was able to give a presentation to Cardiff University of my role at HTW. I also attended a focus group with Velindre Hospital Friends Group on Artificial intelligence. It was very well received and I met some amazing people. I think there is a very strong group now who have been recruited. I wish them all the best. I wanted to make a difference and I feel as though I have.

Sian Jones

> It has been an honour to serve on the PPI Standing Group since its establishment. The group has worked with the PPI Manager to understand best practices in patient involvement in HTA, co-create and pilot processes and modify based on feedback from patient representatives, HTW researchers and the appraisal committee. A flexible system has been developed that responds to the capacities of patient groups and draws on HTW research skills. This is unique and we can be proud to say that patient involvement at HTW is world-leading.

Dr Karen Facey

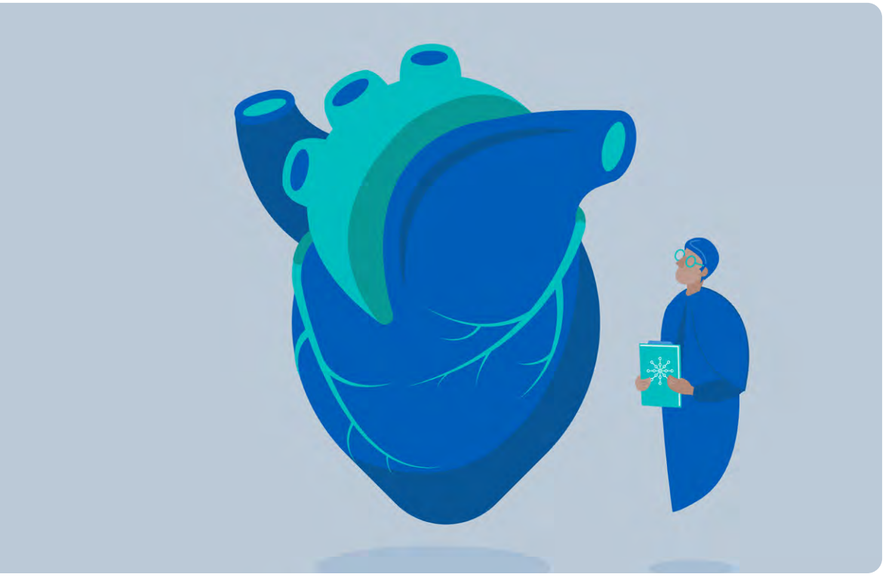
> Working with Health Technology Wales as a Public Partner has been an absolute privilege. As a member of both the Assessment Group and the Public and Patient Involvement (PPI) Standing Group, I have been afforded the opturnity to contribute to trailblazing work in the development of PPI processes for health technology assessments (HTAs). This has been achieved through true partnership work and co-production and ensures that HTAs consistently benefit from the voice of 'experts by experience' – patients, carers and their families, and the organisations that support them. On a personal level, I have been struck by the professionalism and hard work of the team, coupled with a warmth and friendliness, which has made the, often complex, topics discussed accessible, inviting and welcoming meaningful contributions from a lay perspective. I have felt well supported and truly valued in my role, and it is clear that involving the public and patients is not just a tick-box exercise, but is recognised as integral to the work of the organisation.

Sarah Peddle

MEDTECH: IMPROVING LIFE FOR WELSH CITIZENS

In 2024 HTW produced an advisory report to support the development of the MedTech ecosystem for Wales. The project involved working in close collaboration with our stakeholders to produce a set of key recommendations.

HTW was commissioned by Welsh Government (WG) in Spring 2024 to lead the rapid development of an advisory report to identify possible actions to strengthen the MedTech ecosystem in Wales. In December 2024 a report, along with a detailed Supporting Evidence Companion document, was submitted to WG outlining proposals and recommendations to strengthen and bring greater coherency to the MedTech ecosystem in Wales.



How did we do this?

HTW, supported by Urban Foresight (UF) consultancy, utilised a mixed-methods pragmatic approach to develop the report recommendations. A Programme Board that comprised senior representatives from organisations across the Wales MedTech ecosystem, as well as Llais Wales (on behalf of patient and public partners) and WG, provided oversight.

Primary research was undertaken using a multi-method approach to engage experts through interviews, focus groups, meetings, workshops and a roundtable event. Over 180 stakeholders from more than 28 organisations were consulted across Wales, England, Scotland, Northern Ireland and the Republic of Ireland, working across health and social care at variety of stages of the MedTech and innovation lifecycle.

Secondary desk-based research was conducted to gain a detailed understanding of the Welsh MedTech landscape and the wider context that it sits in. Papers, authored by HTW, UF and external partners, summarised detailed evidence around 12 targeted topics. For example, the current Welsh, UK and international MedTech context, Welsh innovation adoption opportunities, horizon scanning for medical technologies, value-based procurement, and artificial intelligence in MedTech.

Key themes emergent from the primary and secondary research were used to draft recommendations. These were then updated and finalised based on stakeholder consultation feedback from a patient and public involvement session in October 2024 and a sense-checking workshop held in November 2024.

Recommendations

Twenty-two recommendations, across 3 pillars and six cross-cutting themes, identify areas of perceived need, as well as opportunities, for future focus and work across the MedTech ecosystem in Wales. Pillars and cross-cutting themes relate to:

- Pillar 1 - MedTech lifecycle and ecosystem framework – collaborative working
- Pillar 2 - Horizon scanning, topic identification, and selection
- Pillar 3 - Regulation and governance.
- Cross-cutting themes: patient and public involvement; equity and diversity; academic involvement; finance; sustainability and data.

WORKING IN PARTNERSHIP WITH THE HEALTH AND CARE RESEARCH WALES EVIDENCE CENTRE

HTW was appointed a collaborating partner of the Health and Care Research Wales (HCRW) Evidence Centre in 2023.

The centre aims to provide Welsh Government Ministers and other decision makers with vital research evidence to tackle health and social care challenges facing Wales.

In 2024/25 HTW worked on the following rapid reviews:

- What is the most effective method of delivering 'Making Every Contact Count' training? A rapid review
- Factors associated with overweight or obesity in children under five years old: a rapid review
- Rapid review of allied professionals working in neonatal services

> It has been a pleasure to work with HTW colleagues in the Health and Care Research Wales Evidence Centre, both this year and now for a total of four years. Their work is of the highest standard and has made vital contributions to key government / NHS policy areas such as regarding childhood obesity and for the newly launched women's health strategy for Wales.
>
> **Professor Adrian Edwards**
> Director of the Health and Care Research Wales Evidence Centre

RAPID REVIEW CASE STUDY:
FACTORS ASSOCIATED WITH OVERWEIGHT OR OBESITY IN CHILDREN UNDER FIVE YEARS OLD

What did we do?

HTW conducted a rapid review of systematic reviews on factors associated with overweight or obesity in children under five years old. An information pack was published containing a full report, outcomes map, executive summary, lay summary and infographic in September 2024.

Who with?

HTW collaborated with the Health and Care Research Wales Evidence Centre to produce this work for the Welsh Government Public Health and Inequalities team, to help inform the 'Healthy Weight, Healthy Wales' strategy. We engaged with several different stakeholder groups from Welsh Government during the development of this rapid review.

What did we learn?

A wide range of factors were associated with child overweight or obesity. Most of the high-certainty evidence related to overweight and not obesity. The high-certainty evidence shows that there are certain things that could support children to have a healthier weight. Two examples are:

1. Helping women living with overweight (who are thinking about, or trying to get pregnant) to lose weight.
2. Providing opportunities for children of working mothers to eat healthier foods and be more physically active.

There is also some moderate-certainty evidence about other things, which may help. Examples include promoting breastfeeding and reducing consumption of sugary drinks.

What were the reactions?

A stakeholder of this rapid review reported that "the findings of the above research evidence review and the associated Eppi-Map have helped to inform the 2024-2026 delivery plan for the 'Healthy Weight Healthy Wales Strategy'.

"The overarching goal of this strategy is to prevent and reduce obesity, with a particular focus on childhood obesity in pre-school age children. Understanding the underlying causes of childhood obesity will help us to make informed decisions regarding the design and implementation of interventions. This will be crucial in formulating strategies to reduce the prevalence of childhood obesity and improve the overall health of pre-school-age children in Wales.

"The Welsh Future Generations Act is also relevant here. This legislation mandates that public bodies in Wales consider the long-term consequences of their decisions on the well-being of the population, the environment, culture, and communities. The evidence generated through this research aligns with the objectives of this act by addressing long-term health and well-being concerns"

What difference did it make?

This work helped to inform the 'Healthy Weight Healthy Wales' strategy'. This review is the first up-to-date review that we are aware of that focuses on factors and their impact on weight status were studied in children under five years old.

WORKING IN PARTNERSHIP WITH THE HEALTH AND CARE RESEARCH WALES EVIDENCE CENTRE

RAPID REVIEW CASE STUDY: ALLIED HEALTH PROFESSIONALS IN NEONATAL UNITS

What did we do?

HTW carried out a rapid review of the impact of Allied Health Professionals (AHPs) embedded in neonatal services on outcomes. An information pack was published containing a full report, executive summary, lay summary and infographic in July 2024.

Who with?

HTW collaborated with the Health and Care Research Wales Evidence Centre to produce this work for Health Education and Improvement Wales. This review was intended to inform those responsible for AHP staffing in neonatal services.

What did we learn?

There was low-certainty evidence that having AHPs within neonatal services led to improvements in gross motor skills and earlier oral feeding for young infants. The results from studies of the impact of nutrition support teams in neonatal units were too inconsistent to draw any conclusions.

There was moderate-certainty evidence that early care and support by AHPs leads to shorter lengths of stay in hospital and earlier oral feeding, as well as small improvements in general cognitive and physical abilities compared to neonatal teams without AHPs.

There was very little directly relevant evidence on AHPs embedded in neonatal services and few AHP early intervention trials in the UK. Further UK-based research is needed to better understand the best way to integrate AHPs in neonatal services

What were the reactions?

A stakeholder of this rapid review confirmed:

"....that the findings of the research review helped to inform the Strategic Perinatal Workforce Plan (SPWP) programme of work and those responsible for staffing in neonatal services in Wales. The review findings also helped to influence the appointment of an AHP Clinical Lead to the Maternity and Neonatal Clinical Network within the NHS Executive. This appointment is expected to help provide evidence of patient and financial benefits for future workforce planning. The review findings will also help strengthen business cases to enhance AHP staffing within neonatal units to workforce recommendation levels, and inform future budget requests and recommendations, as well as recruitment strategies.

"Finally, the review also highlighted areas where future good quality research evidence, including economic evaluations, are needed."

What difference did it make?

The rapid review findings helped to inform the Strategic Perinatal Workforce Plan and neonatal AHP staffing decisions in Wales.

SUPPORTING SUSTAINABILITY IN HEALTHCARE

Whilst the primary goal of health care systems is to prevent and cure disease, they are also major polluters, in turn contributing to the onset of disease. The healthcare sector is responsible for about 5% of the global carbon footprint, and if it were a country, it would be the fifth largest emitter on the planet.

Globally, there is an increasing acknowledgement of the environmental impact that healthcare systems and health technologies have, which has led to an increasing interest amongst HTA agencies around the assessment and inclusion of environmental impact within HTA.

HTW has been involved in the INAHTA environmental sustainability learning group since 2022, more recently joining a voluntary group of 22 other HTA specialists at 15 INAHTA member agencies to produce a White Paper with the goal of advancing discussion and application of Environmental Impact Assessment (EIA) in HTA.

An EIA is part of a policy tool which aims to quantify the environmental impact of a technology. It can be an important decision-making tool around the use of health technologies, helping to identify and potentially remove comparatively environmentally harmful technologies. Various aspects along a technology lifecycle can be captured within EIA, and this can be incorporated in HTA under a life-cycle approach, whereby the production and disposal of a technology is considered, or under a more refined approach, which considers only the impact of a technology during its use in practice.

Whilst EIA is already one of the domains of HTA, methods for undertaking such an assessment are still in their infancy. Consensus needs to be agreed on the duration of time over which environmental impacts should be considered within HTA, and which environmental factors are most relevant for inclusion, whilst noting that inclusion of some factors over others may bias decision making against otherwise environmentally viable options.

The White Paper has recently been published on the INAHTA website, and it can be accessed here.

SPREADING THE WORD

Throughout 2024/25 we attended national and international events to promote the benefits of evidence based assessment of health and care technologies:

May 2024

IPFR Workshop
An important part of our work is to support NHS health boards in responding to individual patient funding requests (IPFR)s. The IPFR Workshop is hosted annually by the All-Wales Therapeutics and Toxicology Centre (AWTTC).

June 2024

MediWales Connects
This annual event brings together NHS colleagues, industry representatives and researchers from across Wales and beyond. We hosted an exhibition stand at MediWales Connects and our then Chairman Professor Peter Groves gave a presentation on how HTW's work contributes to the life cycle of MedTech innovations.

2024 INAHTA Congress
The International Network of Agencies for Health Technology Assessment (INAHTA) is a global network of HTA agencies that supports health system decision making that affects over 1 billion people in 33 countries worldwide. As a member of INHATA HTW collaborates with international colleagues to share best practice.

HTAi 2024 Annual Meeting
A delegation of health service researchers attended the HTAi (Health Technology Assessment International) 2024 Annual Meeting in Seville, Spain, and presented posters on topics ranging from digital platforms for personalised management of diabetes to patient expectations for the use of artificial intelligence in healthcare.

September 2024

INSIA membership meeting and conference
HTW Director Susan Myles, a board member of INSIA (International Network for Social Intervention Assessment) attended the INSIA membership meeting along with the Health Technology Wales Communications Manager who presented a communications plan for the organisation

October 2024

MediWales Members Showcase
The annual MediWales showcase event provides an opportunity for MediWales members to showcase the MedTech innovations they have developed and seek input from fellow innovators.

November 2024:

Annual Allied Health Professionals (AHP) Conference
The AHP Conference focuses on the impact of allied health professionals in Wales. We hosted an exhibition stand and met with allied health professionals, including physiotherapists, dieticians, occupational therapists and speech therapists.

December 2024

Giant Health Event
This two-day event featured talks from NHS leaders and innovators from across the spectrum of health technology innovation. We took part in the NHS national AI conference which highlighted the rapid development of AI-assisted health technologies.

OUR TEAM

The work in this annual report has been delivered by the Health Technology Wales team.

Our team comprises of 26 people including health services researchers, health economists, information specialists, communication specialists, project managers and administrators. We come from a broad range of backgrounds and skillsets and collectively have extensive experience in both the public and private sectors. The team is supported by the invaluable contributions of our external committee members who continue to ensure our work meets the needs of the health and care sectors in Wales.

Dr Susan Myles
Director

Dr David Jarrom
Principal Researcher, Health Services Research

Matthew Prettyjohns
Principal Researcher, Health Economics

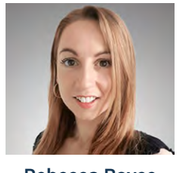
Lisa King
Senior Programme Manager

Nathan Bromham
Senior Health Services Researcher

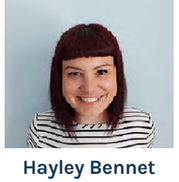
Dr Sian Cousins
Senior Health Services Researcher

June Price
Business Operations Manager

Katie McDermott
Project Manager



Rebecca Boyce
Health Economist



Hayley Bennet
Health Economist

Ryan Miller
Senior Health Economist

Jessica Williams
Health Services Researcher

Dr Claire Davis
Health Services Researcher

Dr Clare England
Health Services Researcher

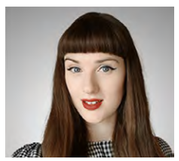
Leona Batten
Health Services Researcher

Charlotte Bowles
Health Services Researcher

Antonia Needham-Taylor
Health Services Researcher

Dr Greg Hammond
Health Services Researcher

Alice Evans
Patient and Public Involvement Manager



Rebecca Shepherd
Project Support Manager

Diana Milne
Communications Manager

Elise Hasler
Information Specialist

Jenni Washington
Information Specialist

Mafalda Gordo
Business Support and Communications Assistant

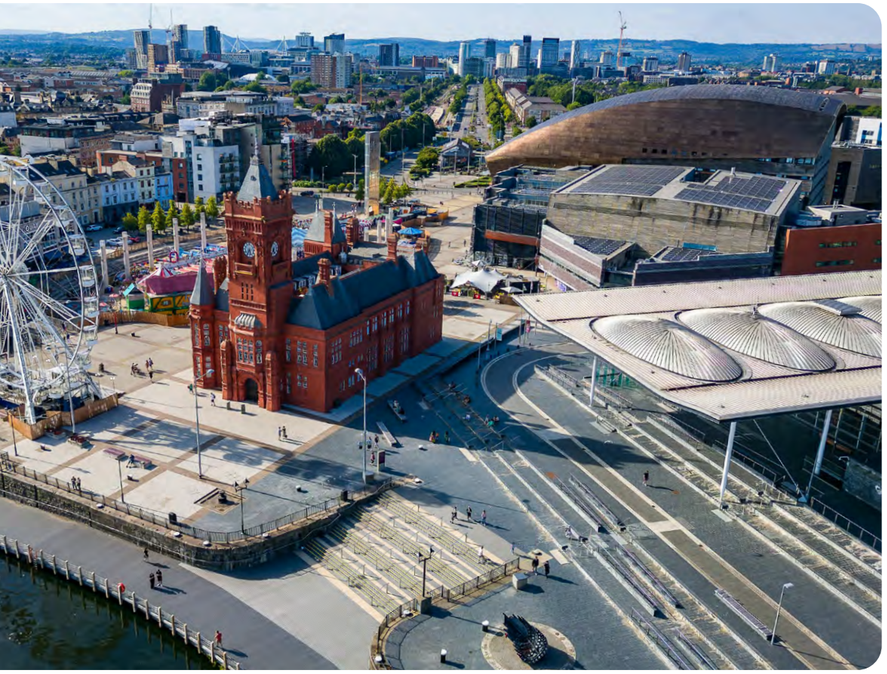
Llinos Jones
Welsh Language Translator

Caron Potter
Executive Assistant

BUDGET DELIVERY

HTW has successfully delivered against its Strategic Plan for 2021–2025 which sets out its immediate and medium-term strategic goals and objectives.

The Welsh Government awarded HTW £1,517,000 to fund its core work. HTW secured additional income of £132,426 to fund its work as a collaborating partner of the Health and Care Research Wales Evidence Centre. HTW was also awarded £100,000 by Welsh Government for MedTech Strategy Advisory Work.



Reporting modest underspend to date, due to a team member being seconded. On target to deliver within budget during 2025/26.

Supporting 22.5 full time equivalent posts and a headcount of 26.

Allocation of our budget to 88 % staff costs and 12% non-staff costs.

A five-year award secured in FY2023/24 to act as a collaborator in the new Welsh evidence centre.

Do you know about a technology or model of care and support in health or social care that HTW could appraise? Anyone can suggest a topic for appraisal. To take part visit our website.

Technoleg Iechyd Cymru
Health Technology Wales

healthtechnology.wales

Health Technology Wales (HTW), Velindre University NHS Trust Headquarters,
Unit 2 Charnwood Court, Park Nantgarw, CF15 7QZ, United Kingdom

ADRODDIAD BLYNYDDOL 2024/25

Technoleg Iechyd Cymru
Health Technology Wales

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

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Ein partneriaid

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

Ariennir gan **Lywodraeth Cymru**
Funded by **Welsh Government**

RHAGAIR

Croeso i Adroddiad Blynyddol Technoleg Iechyd Cymru (HTW) sy'n disgrifio'r gwaith rydym wedi'i wneud yn ystod 2024/25 i wella iechyd a gofal cymdeithasol yng Nghymru.

Roedd hon yn flwyddyn brysur a llwyddiannus arall lle llwyddom i gydbwyso ein hymrwymiadau i ddewis, arfarnu a hyrwyddo mabwysiadu technolegau seiliedig ar dystiolaeth newydd nad ydynt yn feddyginiaethau, gyda chymryd rolau newydd i gefnogi'r ecosystem arloesi yng Nghymru a thu hwnt.

Yn ystod 2024/25 gwnaethom ystyried 58 o atgyfeiriadau pwnc newydd o bob rhan o'r cymunedau iechyd a gofal a chyhoeddwyd 8 canllaw HTW newydd a oedd yn mynd i'r afael â phynciau yn amrywio o ddefnyddio offer digidol ar gyfer rheoli diabetes i rôl llawdriniaeth gynaecolegol â chymorth robotiaid wrth drin clefydau anfalaen. Ers 2017 mae HTW wedi cyhoeddi 52 o ganllawiau seiliedig ar dystiolaeth a 299 o adroddiadau archwilio pwnc. Mae canlyniadau adroddiad archwiliad mabwysiadu 2023/24 yn dangos bod lefel uchel o ymwybyddiaeth o ganllawiau HTW o fewn system iechyd GIG Cymru a bod canllawiau HTW yn cael effaith sylweddol ar benderfyniadau a wneir gan dimau clinigol wrth iddynt ddefnyddio a mabwysiadu technolegau newydd nad ydynt yn feddyginiaethau.

Mae Cynnwys Cleifion a'r Cyhoedd (PPI) yn parhau i fod yn ganolog i bob agwedd ar waith HTW. Yn ystod 2024/25 cafodd 12 pwnc technoleg nad ydynt yn feddyginiaethau eu hystyried gan Grŵp Sefydlog PPI HTW, y mae ei fewnbwn yn cynnwys arolygon cleifion, tystiolaethau ac adroddiadau ymchwil i gefnogi'r broses arfarnu. Mae effaith Grŵp PPI HTW wedi parhau i ledaenu y tu hwnt i Gymru trwy ei gyfranogiad yng ngwaith Rhwydwaith Rhyngwladol yr Asiantaethau ar gyfer Asesu Technoleg Iechyd (INAHTA) a thrwy ei gyfraniad i gyhoeddiadau rhyngwladol pwysig. Yn ystod 2024/25, roedd hyn yn cynnwys awduro pennod mewn llyfr ar gynnal PPI mewn asesiadau technoleg iechyd (HTA).

Mae deallusrwydd artiffisial (AI) yn chwarae rhan gynyddol bwysig yn y sector technoleg feddygol nad yw'n feddyginiaeth. Yn ystod 2024/25 bu Technoleg Iechyd Cymru yn cydweithio â phartneriaid yn y DU i ddatblygu canllawiau a rhestr wirio ar gyfer arfarnu AI ym maes gofal iechyd a hefyd gyda phartneriaid Ewropeaidd mewn datblygu canllawiau ar gyfer asesu technolegau digidol.

Amlygodd canllawiau cenedlaethol a gyhoeddwyd yn 2023/24 rôl AI mewn cefnogi diagnosis patholegol canser y prostad ac wrth gynnal endosgopi i wneud diagnosis o ganserau gastroberfeddol.

Yn ystod 2024/25 parhaodd HTW i ddatblygu cydweithrediadau a phartneriaethau gwaith ledled y DU. Mae'r rhaglen beilot Llwybr Mynediad at Ddyfeisiau Arloesol (IDAP) yn fenter genedlaethol sy'n dwyn ynghyd arbenigedd o Loegr (MHRA, NICE, DHSC, NHSE), yr Alban (SHTG) a Chymru (HTW). Nod y fenter yw hyrwyddo technolegau meddygol trawsnewidiol sy'n mynd i'r afael ag anghenion clinigol sydd heb eu diwallu yn y GIG a'u dwyn i'r farchnad mewn modd amserol a chyflym.

Yn ystod 2023/24 dewiswyd 8 technoleg i ymuno â llwybr peilot IDAP. Sefydlwyd partneriaeth newydd yn ystod

RHAGAIR

2024/25 gyda'r Sefydliad Cenedlaethol dros Ymchwil Iechyd (NIHR), a fydd yn sicrhau bod bylchau mewn tystiolaeth a nodwyd gan HTW yn ystod ei asesiad a'i arfarniad o dechnolegau iechyd nad ydynt yn feddyginiaethau yn cael eu hystyried yn y dyfodol gan NIHR fel pynciau posibl ar gyfer prosiectau ymchwil cenedlaethol y DU.

Parhaodd ymgysylltu â rhanddeiliaid lleol, cenedlaethol a rhyngwladol yn gonglfaen llwyddiant HTW yn ystod 2024/25. Fe wnaeth ymgysylltu lleol trwy Fforwm Rhanddeiliaid HTW gynorthwyo i gefnogi ac arwain gwaith HTW er mwyn sicrhau ei fod yn parhau i fod o'r gwerth mwyaf i'r cymunedau y mae'n eu gwasanaethu. Rydym wedi parhau i weithio'n agos gyda phartneriaid yng Nghanolfan Dystiolaeth Ymchwil Iechyd a Gofal Cymru er mwyn sicrhau bod y penderfyniadau a wneir gan arweinwyr y GIG a Gofal Cymdeithasol a Gweinidogion i fynd i'r afael â heriau gofal yng Nghymru yn cael eu cefnogi gan y dystiolaeth orau sydd ar gael. Rydym wedi parhau i adeiladu ar gysylltiadau sydd eisoes wedi'u sefydlu â'r Diwydiant Gwyddorau Bywyd trwy waith ein Grŵp Defnyddwyr Diwydiant a thrwy gryfhau ein cydweithrediadau â Hwb Gwyddorau Bywyd Cymru a Chomisiwn Bevan.

Rydym yn ddiolchgar i Lywodraeth Cymru am ei chefnogaeth barhaus i waith HTW. Yn ystod gwanwyn 2024 comisiynwyd HTW gan Lywodraeth Cymru i arwain datblygiad adroddiad cynghorol seiliedig ar dystiolaeth i gryfhau ecosystem technoleg feddygol yng Nghymru. Roedd yr adroddiad a gyflwynwyd i Lywodraeth Cymru ym mis Rhagfyr 2024, 'Technoleg Feddygol: gwella bywyd i ddinasyddion Cymru', yn cynnwys 22 o argymhellion gyda thystiolaeth ategol, a gasglwyd gyda chyfranogiad ac ymgysylltiad eang gan randdeiliaid, ar y modd i wella cydweithio, sganio'r gorwel yn well a nodi pynciau. Nodwyd hefyd yr angen i sicrhau strwythurau llywodraethu cadarn, wedi'u cefnogi gan gyfranogiad clinigol, cleifion, y cyhoedd ac academaidd yn ymwneud â nodi, arfarnu a mabwysiadu yn y modd gorau dechnoleg feddygol ym maes Iechyd a Gofal Cymdeithasol yng Nghymru.

Yn ystod 2024/25, llwyddodd HTW i gyflawni'r amcanion a amlinellwyd yn y Cynllun Strategol pum mlynedd a gyhoeddwyd yn 2021. Gwnaethom hefyd barhau i ddatblygu ein gweledigaeth i ddod yn sefydliad HTA o'r radd flaenaf sy'n sicrhau bod technolegau iechyd a gofal sydd â'r addewid mwyaf i wella bywydau pobl ac sy'n cynnig y gwerth mwyaf yn cael eu cydnabod a'u mabwysiadu yng Nghymru. Gobeithiwn y byddwch yn mwynhau darllen yr adroddiad blynyddol hwn ac edrychwn ymlaen at barhau i weithio gyda chi i wireddu ein gweledigaeth.

Professor Peter Groves
Cyn Gadeirydd,
Technoleg Iechyd Cymru

Dr Susan Myles
Cyfarwyddwr
Technoleg Iechyd Cymru

NEGES Y PRIF SWYDDOG GWEITHREDOL

Mae Ymddiriedolaeth GIG Prifysgol Felindre yn falch o letya a chefnogi'r tîm yn HTW ar ran Llywodraeth Cymru a GIG Cymru gyfan. Trwy gydol y flwyddyn mae Technoleg Iechyd Cymru wedi parhau i gyhoeddi canllawiau cenedlaethol ar dechnolegau iechyd nad ydynt yn feddyginiaethau sydd â'r potensial i drawsnewid gofal iechyd yng Nghymru.

Mae Technoleg Iechyd Cymru mewn sefyllfa unigryw i archwilio ac argymell y modd y gall GIG Cymru wneud y defnydd gorau o dechnoleg.

Eleni, gwelwyd ffocws penodol ar nodi ac arfarnu technolegau iechyd nad ydynt yn feddyginiaethau sy'n defnyddio deallusrwydd artiffisial (AI) i ddiagnosio neu drin cyflyrau iechyd. Yn ogystal â chynnal arfarniadau ar dechnolegau megis endosgopi â chymorth AI ar gyfer canser y llwybr gastroberfeddol, mae HTW wedi chwarae rhan allweddol mewn datblygu dulliau ar gyfer arfarnu'r technolegau hyn a allai fod o fudd ar gyfer llawer o gyflyrau.

Mae hwn yn faes sy'n bwysig dros ben ar gyfer gofal canser, gan fod y dechnoleg i wneud diagnosis o wahanol fathau o ganser yn parhau i esblygu'n gyflym. Mae maint y potensial i'r dechnoleg hon drawsnewid gwasanaethau yn enfawr. Fodd bynnag, fel y mae HTW wedi'i ddangos, mae'n hollbwysig bod dulliau trylwyr ar waith i arfarnu effeithiolrwydd clinigol a chost-effeithiolrwydd y technolegau hyn.

Fel bob amser, mae'r canllawiau cenedlaethol a gyhoeddwyd gan HTW wedi ymdrin ag ystod eang o gyflyrau iechyd sy'n effeithio ar boblogaeth Cymru, gan gynnwys canser, diabetes a chlefyd yr afu/iau.

Yn ogystal â pharhau i gyhoeddi canllawiau cenedlaethol ar dechnolegau iechyd nad ydynt yn feddyginiaeth, mae HTW wedi bod yn bartner cydweithredol i Ganolfan Dystiolaeth Ymchwil Iechyd a Gofal Cymru, gan gynnal adolygiadau tystiolaeth cyflym ar bynciau yn amrywio o iechyd plant i rôl gweithwyr proffesiynol perthynol i iechyd mewn gwasanaethau newyddenedigol.

Yn 2025/26 bydd HTW yn parhau i gefnogi gwaith y GIG a Llywodraeth Cymru mewn mynd i'r afael â blaenoriaethau iechyd allweddol a sefydlu strategaeth technoleg feddygol o'r radd flaenaf.

Wrth i ni groesawu'r Athro Keith Lloyd fel Cadeirydd newydd Panel Arfarnu HTW, hoffem hefyd fanteisio ar y cyfle hwn i ddiolch i'r Athro Groves am ei gyfnod fel Cadeirydd Panel Arfarnu HTW. Mae gwybodaeth a phrofiad yr Athro Groves o dechnolegau iechyd wedi bod yn allweddol i dwf a llwyddiant parhaus HTW. Dymunwn y gorau iddo yn y dyfodol.

David Donegan
Prif Swyddog Gweithredol
Ymddiriedolaeth GIG Prifysgol Felindre

Donna Mead
Cadeirydd
Ymddiriedolaeth GIG Prifysgol Felindre

CYNLLUN STRATEGOL 2021-2025 HTW

Gwell Iechyd - Wedi'i Ysgogi gan Dystiolaeth

Mae Cynllun Strategol 2021-2025 HTW yn nodi nodau ac amcanion strategol uniongyrchol, canolig a hirdymor y sefydliad.

GWELEDIGAETH: Datblygu sefydliad HTA o'r radd flaenaf sy'n hwyluso'r gwaith o nodi, arfarnu a mabwysiadu'r technolegau iechyd sy'n cynnig yr addewid mwyaf i roi gwell canlyniadau iechyd a gwerth i bobl Cymru.

CENHADAETH: Ysgogi gwelliannau yng ngwasanaethau iechyd a gofal y boblogaeth drwy gymhwyso'r dystiolaeth orau sydd ar gael i lywio penderfyniadau ynglŷn â defnydd priodol o dechnolegau iechyd yng Nghymru.

Mae cyflawniadau allweddol mewn cyflawni ein hamcanion blaenoriaeth ar gyfer 2024/25 wedi'u nodi isod:

Ehangu ymdrechion o ran nodi, blaenoriaethu a dethol pynciau HTW

- Gwnaethom weithio gyda Grŵp Effeithiolrwydd Clinigol Cymru Gyfan (AWCEG) cenedlaethol newydd i adolygu'r rhestr o Ymyriadau Nas Cyflawnir Fel Arfer (INNU) ar draws holl fyrddau iechyd Cymru i nodi pynciau posibl i'w symud ymlaen ar gyfer arfarniad tystiolaeth pellach
- Adolygwyd Canllawiau Gweithdrefnau Ymyrrol (IPG) NICE i nodi pynciau ag effeithiolrwydd a diogelwch profedig ac ystyried a oedd unrhyw rai yn briodol i symud ymlaen i arfarniad tystiolaeth llawn, gan ymchwilio i'w heffeithiolrwydd clinigol a chost-effeithiolrwydd i Gymru
- Parhawyd i gynnal ymgyrchoedd galwad am bynciau wedi'u targedu yn gwahodd atgyfeiriadau pynciau i'w hystyried gan HTW
- Ystyriwyd pynciau a gofrestrwyd gan ddatblygwyr technoleg ar Wasanaeth Arloesi'r GIG a allai fod o ddiddordeb i sefydliadau iechyd a gofal yng Nghymru
- Nodwyd pynciau i'w harfarnu o ganlyniad i waith i gefnogi galwad canser Menter Ymchwil Busnesau Bach (SBRI)

Cynnal allbwn cynyddol arfarnu tystiolaeth a chanllawiau HTW

- Cyhoeddwyd 8 canllaw yn 2024/25
- Symudwyd 8 pwnc ymlaen i arfarniad tystiolaeth yn ystod y cyfnod adrodd
- Cyhoeddwyd 54 o Adroddiadau Archwilio Pwnc (TER)

Cefnogi gwneud penderfyniadau polisi iechyd a gofal cymdeithasol sy'n hanfodol o ran amser

- Parhawyd i gynnal adolygiadau tystiolaeth cyflym fel Partner Cydweithredol Canolfan Dystiolaeth Ymchwil Iechyd a Gofal Cymru
- Parhawyd i gefnogi'r paneli Ceisiadau Cyllido Cleifion Unigol (IPFR) ledled Cymru gydag adolygiadau tystiolaeth i lywio sut y maent yn gwneud penderfyniadau

Cyflwyno swyddogaeth archwiliad mabwysiadu technoleg HTW a pheilota'r broses archwilio mabwysiadu ar gyfer canllawiau technolegau meddygol NICE

- Archwiliwyd 11 o ganllawiau HTW a thri chanllaw NICE fel rhan o Archwiliad Mabwysiadu 2023/24 HTW
- Cyfraddau ymateb calonogol gyda chyfranogiad gan bob bwrdd iechyd lleol, Ymddiriedolaeth GIG Prifysgol Gwasanaethau Ambiwlans Cymru, Ymddiriedolaeth GIG Prifysgol Felindre a Phwyllgor Comisiynu ar y Cyd GIG Cymru
- Mae'r ymatebion yn dangos bod ymwybyddiaeth o ganllawiau HTW yn uchel (79%), bod eglurder argymhellion canllawiau HTW yn dda (96%) a bod canllawiau HTW yn cael rhyw fath o effaith yn y rhan fwyaf o achosion (72%)

Gwella a chyhoeddi dulliau a phrosesau HTW

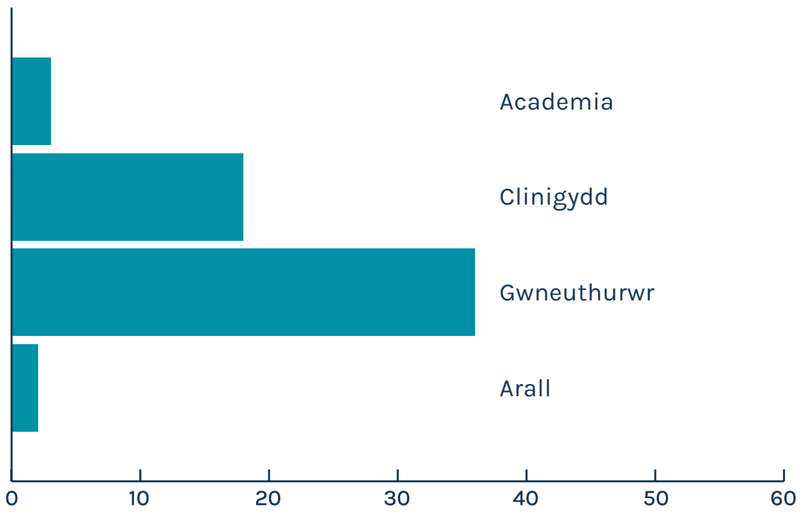
- Gweithiwyd i ddatblygu canllawiau ar gyfer arfarnu technolegau AI mewn gwasanaethau iechyd a gofal
- Dechreuwyd gwaith i gryfhau ystyriaeth o egwyddorion cydraddoldeb, amrywiaeth a chynhwysiant (EDI) yn ein gwaith strategol a gweithredol
- Gweithiwyd mewn partneriaeth â'r Sefydliad Cenedlaethol dros Ymchwil Iechyd a Gofal (NIHR) i sicrhau bod bylchau tystiolaeth a nodwyd yn ystod proses arfarnu HTW yn cael eu rhannu, fel y gellir mynd i'r afael â hwy
- Parhawyd i gefnogi gwaith Llwybr Mynediad at Ddyfeisiau Arloesol (IDAP) y DU gyfan sydd â'r nod o nodi technolegau gofal a allai fod yn drawsnewidiol a chynnig cefnogaeth iddynt lywio eu llwybr trwy brosesau rheoleiddio a phrosesau HTW gyda'r nod o gyflymu eu mabwysiadu a'r buddion a gynigir ganddynt
- Cyfrannwyd at gynhyrchu Papur Gwyn sy'n mynd i'r afael ag ystyriaethau cynaliadwyedd amgylcheddol o fewn dulliau a phrosesau HTA mewn partneriaeth â phartneriaid rhyngwladol INAHTA

NODI PYNCIAU

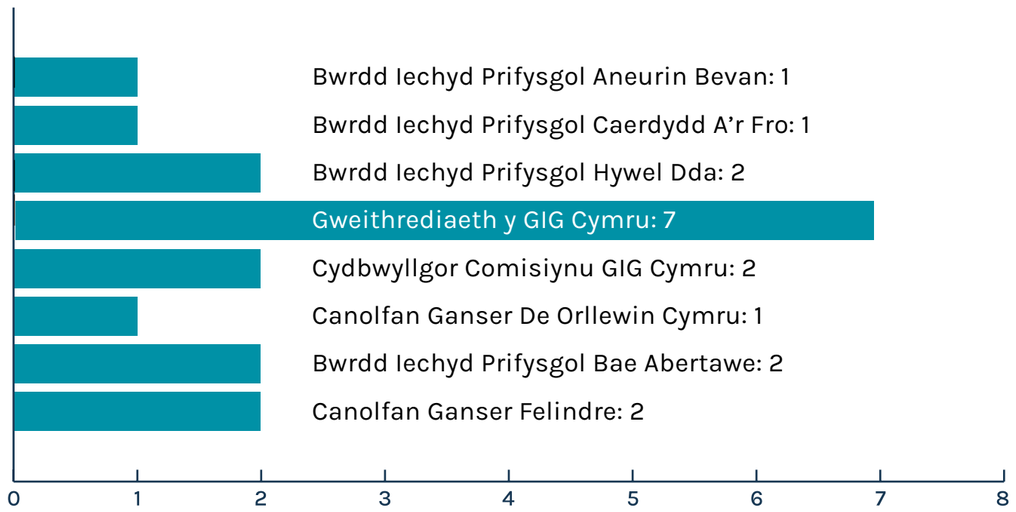
58
Pynciau a gynigiwyd i HTW yn 2024/25

551
Pynciau a gynigiwyd i HTW ers 2017

Ffynhonnell atgyfeiriadau pynciau yn 2024/25



Dadansoddiad o bynciau a atgyfeiriwyd gan y GIG yn 2024/25



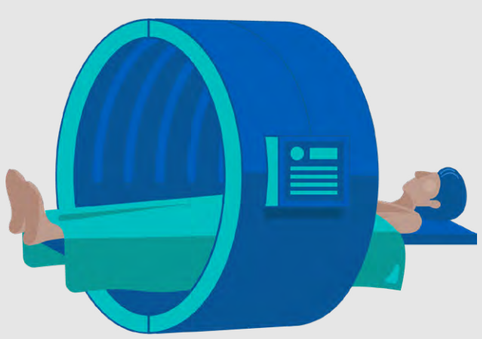
Rydym wedi creu animeiddiad i esbonio'r meini prawf sy'n ofynnol ar gyfer cyflwyno pwnc i'w arfarnu. I gael gwybod mwy gallwch wylio ein hanimeiddiad **yma.**

YSGOGI ARLOESEDD AI MEWN GOFAL IECHYD

Mae deallusrwydd artiffisial (AI) yn cynnig potensial enfawr i drawsnewid y ffordd y mae cyflyrau iechyd yn cael eu diagnosio a'u trin yng Nghymru.

Trwy gydol 2024/25 mae HTW wedi cyhoeddi canllawiau ar dechnoleg AI arloesol ac wedi chwarae rôl allweddol mewn datblygu canllawiau ar gyfer arfarnu technolegau AI. Yn y dyfodol bydd HTW yn parhau i nodi ac arfarnu technolegau iechyd AI. Dyma rai enghreifftiau o sut y gwnaeth HTW wahaniaeth ym maes AI yn 2024/25:

- Gan weithio ar y cyd â phartneriaid clinigol, datblygodd tîm ymchwilwyr gwasanaethau iechyd HTW y rhestr wirio AI. Nod y canllawiau hyn yw sicrhau trylwyredd a thryloywder wrth werthuso technolegau AI, ac mae unrhyw ganllawiau yn seiliedig ar y dystiolaeth orau sydd ar gael ynghylch effeithiolrwydd clinigol a chost-effeithiolrwydd. Ers datblygu'r rhestr wirio, mae ein hymchwilwyr wedi'i chyflwyno i Gynhadledd HTAi yn Seville, Cyngres EPA y Byd yn Amsterdam, Comisiwn AI ar gyfer Iechyd a Gofal Cymdeithasol Llywodraeth Cymru a'r Fenter Ymchwil Busnesau Bach.
- Mae HTW wedi bod yn rhan weithredol o raglen Horizon Europe. Fel rhan o'r rhaglen cynhaliwyd arolwg ymhlith aelodau ar ddulliau HTW ar gyfer asesu technolegau iechyd digidol. Fel rhan o brosiect Asesiad Technoleg Iechyd Digidol Ewropeaidd (EDiHTA) cyfwelwyd â HTW ynghylch dulliau ar gyfer asesu technolegau iechyd digidol.
- Fel aelod o'r Comisiwn AI ar gyfer Iechyd a Gofal Cymdeithasol, mae HTW wedi mynychu cyfarfodydd a gweithgorau trwy gydol y flwyddyn, gan gynnig ei fewnwelediad i botensial technolegau AI mewn gofal iechyd a sut i gasglu tystiolaeth ar effeithiolrwydd clinigol a chost-effeithiolrwydd y technolegau hyn.
- Trwy gydol 2024/24 mae HTW wedi cyhoeddi canllawiau cenedlaethol ar dechnolegau iechyd nad ydynt yn feddyginiaethau sy'n defnyddio AI. Mae'r rhain wedi cynnwys:
- Offer â chymorth deallusrwydd artiffisial ar gyfer diagnosis canser y prostad gan ddefnyddio delweddau biopsi sleidiau cyfan
- Endosgopi â chymorth deallusrwydd artiffisial ar gyfer canser gastroberfeddol
- Offer digidol ar gyfer rheoli diabetes



ARFARNU

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Pynciau a symudwyd ymlaen i arfarniadau tystiolaeth yn 2024/25

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Canllawiau HTW a gyhoeddwyd yn 2024/25

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Canllawiau HTW a gyhoeddwyd ers 2017

Dysgu mwy

Hoffech chi ddysgu mwy am broses arfarnu pynciau Technoleg Iechyd Cymru? Er mwyn codi ymwybyddiaeth am sut mae'r broses yn gweithio rydym wedi creu fideo ar ffurf animeiddiad y gallwch ei wylio yma.

CYMRYD RHAN

Wyddoch chi am dechnoleg neu fodel gofal a chymorth ym maes iechyd neu ofal cymdeithasol y gallai Technoleg Iechyd Cymru ei werthuso?

Gall unrhyw un awgrymu pwnc ac rydym yn awyddus i dderbyn awgrymiadau gan bobl o ystod eang o gefndiroedd, gan gynnwys y cyhoedd.

I awgrymu pwnc, cwblhewch ein ffurflen ar-lein yma.

HYRWYDDO CYDRADDOLDEB AC AMRYWIAETH

Fel rhan o'n hymrwymiad i sicrhau bod cydraddoldeb, amrywiaeth a chynhwysiant (ED&I) yn rhan o'n busnes craidd yn HTW, rydym yn datblygu cynllun gweithredu sy'n cyd-fynd â chynllun cydraddoldeb strategol Ymddiriedolaeth GIG Prifysgol Felindre, ac fel rhan o'r gwaith hwn rydym wedi bod yn ystyried sut y dylai ein harfarniadau tystiolaeth ystyried tegwch ym maes ymchwil. I'r perwyl hwn, rydym yn y broses o ddatblygu proses ED&I ar gyfer adolygu arfarniadau tystiolaeth. Gan ddysgu oddi wrth sefydliadau HTA a chyrff adolygu tystiolaeth eraill, bydd y broses hon yn defnyddio arbenigedd o'n Grŵp Sefydlog Cynnwys Cleifion a'r Cyhoedd presennol i nodi ac yna adrodd ar feysydd o anghydraddoldeb ac ystyriaethau ar gyfer grwpiau cleifion amrywiol gyda phob adolygiad tystiolaeth. Rydym yn edrych ymlaen yn eiddgar i ddatblygu a threialu'r broses hon yn 2025/26.

CROESAWU CADEIRYDD NEWYDD Y PANEL ARFARNU

Mae'n bleser gennym gyflwyno Cadeirydd newydd Panel Arfarnu Technoleg Iechyd Cymru, yr Athro Keith Lloyd.

Rôl Panel Arfarnu HTW yw ystyried arfarniadau tystiolaeth HTW yng nghyd-destun y GIG a gofal cymdeithasol yng Nghymru a chynhyrchu canllawiau cenedlaethol HTW yn seiliedig ar y dystiolaeth hon.

Mae'r panel hefyd yn helpu HTW i nodi pynciau y gellir eu harfarnu yn y dyfodol, gwerthuso'r defnydd o ganllawiau HTW ac yn hwyluso ymgysylltiad â rhanddeiliaid.

Mae Keith Lloyd yn Athro Seiciatreg ym Mhrifysgol Abertawe ac yn Gyfarwyddwr ei Sefydliad Gwyddor Bywyd gyda diddordeb ers amser mewn arloesedd, lles ac iechyd ym meysydd technoleg feddygol a thechnoleg chwaraeon.

Bu'n Ddirprwy Is-ganghellor ar gyfer meddygaeth, iechyd a gwyddor bywyd ym Mhrifysgol Abertawe a chyn hynny roedd yn bennaeth ysgol feddygol Prifysgol Abertawe. Cyn ymuno â'r brifysgol, roedd yn bennaeth ar yr hyn sydd bellach yn Ymchwil Iechyd a Gofal Cymru.

Mae Keith hefyd wedi gweithio gyda Chynghrair James Lind ar safbwyntiau cleifion a'r cyhoedd mewn gosod blaenoriaethau ymchwil a gyda chydweithrediad Cochrane.

Mae'r Athro Lloyd yn parhau i weithio'n glinigol fel seiciatrydd yn Abertawe.

Susan Myles, Cyfarwyddwr Technoleg Iechyd Cymru

> Rydym wrth ein bodd yn croesawu'r Athro Lloyd fel Cadeirydd newydd Panel Arfarnu Technoleg Iechyd Cymru.
>
> Mae ganddo brofiad amhrisiadwy mewn lleoliadau clinigol ac academaidd a dealltwriaeth ragorol o'r maes iechyd a gofal yng Nghymru.
>
> Edrychwn ymlaen at weld sut y bydd yn helpu i siapio gwaith pwysig ein Panel Arfarnu ac, yn ei dro, yr effaith y mae'n ei chael ar nodi, arfarnu a mabwysiadu technolegau iechyd arloesol ledled Cymru.

Keith Lloyd, Cadeirydd y Panel Arfarnu

> Fel Cadeirydd Panel Arfarnu HTW, rwy'n edrych ymlaen at helpu i ddatblygu'n gyflym ganllawiau cenedlaethol ar dechnolegau iechyd arloesol gydag effaith yn y byd go iawn sy'n gweithio i Gymru.

TÎM YN FFARWELIO Â'R CADEIRYDD A CHWARAEODD RÔL HOLLBWYSIG YN NATBLYGIAD HTW

Hoffem achub ar y cyfle hwn i fynegi ein diolch i'r Athro Peter Groves, y mae ei gyfnod fel Cadeirydd Technoleg Iechyd Cymru wedi dod i ben.

Penodwyd yr Athro Groves yn Gadeirydd HTW yn 2018 ac yn 2021 estynnwyd ei gyfnod fel Cadeirydd gan y Gweinidog Iechyd a Gwasanaethau Cymdeithasol ar y pryd, Eluned Morgan AS.

O dan ei arweiniad mae'r sefydliad wedi dod yn gorff asesu technoleg iechyd (HTA) uchel ei barch yn rhyngwladol sy'n gweithio mewn partneriaeth â rhanddeiliaid ledled y DU ac yn fyd-eang.

Ers ei sefydlu yn 2017 mae Technoleg Iechyd Cymru wedi cyhoeddi dros 50 o ganllawiau cenedlaethol ar dechnolegau iechyd a gofal nad ydynt yn feddyginiaethau. Mae'n chwarae rôl allweddol mewn nodi technolegau a allai fynd i'r afael â blaenoriaethau iechyd Llywodraeth Cymru ac mae ar flaen y gad mewn datblygu dulliau arfarnu ar gyfer technolegau iechyd deallusrwydd artiffisial (AI).

Mae profiad helaeth yr Athro Groves fel Cardiolegydd Ymyriadol Ymgynghorol ac mewn defnyddio technoleg feddygol wedi ei alluogi i fod yn rym ysgogol y tu ôl i ddatblygiad y sefydliad a gwelir eisiau ei ddull craff o asesu technolegau iechyd yn fawr.

Wrth siarad am ei brofiad fel Cadeirydd HTW, dywedodd Peter Groves: "Mae wedi bod yn fraint fawr bod yn rhan o siwrnai HTW o gorff HTA ifanc i sefydliad y mae ei waith yn parhau i gael effaith fawr ar fywydau pobl yng Nghymru.

"Mae nodi technolegau iechyd arloesol yn allweddol i ddatrys rhai o'r heriau mwyaf sy'n wynebu darparwyr gofal iechyd yng Nghymru. Yn y cyfamser, mae dull cadarn HTW, sy'n seiliedig ar dystiolaeth, ar gyfer arfarnu'r technolegau hyn yn bwysicach nag erioed wrth i'r sector barhau i esblygu'n gyflym.

"Hoffwn ddiolch i'm cydweithwyr yn HTW a'n partneriaid ar draws y sectorau iechyd a gofal am eu hymroddiad, eu gwaith caled a'u cefnogaeth i'r sefydliad ers ei sefydlu. Rwy'n dymuno pob llwyddiant iddynt yn y dyfodol"

Yn ogystal â bod yn Gadeirydd Technoleg Iechyd Cymru, mae'r Athro Groves hefyd yn Gadeirydd Panel Apêl y Sefydliad Cenedlaethol dros Ragoriaeth mewn Iechyd a Gofal (NICE), ac yn gyn-Gadeirydd Pwyllgor Cynghorol Arbenigol Dyfeisiau yr Asiantaeth Rheoleiddio Meddyginiaethau a Chynhyrchion Gofal Iechyd (MHRA) a Phwyllgor Cynghorol Technolegau Meddygol NICE.

Ym mis Mai 2024 roeddem yn falch o gyhoeddi bod Peter wedi derbyn cymrodoriaeth gan Gymdeithas Ddysgedig Cymru i gydnabod ei gyfraniadau rhagorol i faes meddygaeth a dysgu yng Nghymru.

> **Mae Peter wedi chwarae rôl ganolog yn natblygiad HTW fel sefydliad, gan roi mewnbwn amhrisiadwy i'r broses arfarnu oherwydd ei brofiad clinigol helaeth a'i arbenigedd mewn technolegau meddygol.**
>
> **Bydd colled fawr ar ei ôl fel Cadeirydd HTW a dymunwn y gorau iddo yn y dyfodol.**
>
> Susan Myles, Cyfarwyddwr HTW

SIARTIAU CYLCH GYDAG ARGYMHELLION CANLLAWIAU

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Pynciau sydd wedi'u cynnig i HTW ers 2017

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Pynciau aeth ymlaen i'r cam arfarnu tystiolaeth

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Canllawiau cenedlaethol wedi'u cyhoeddi

EIN HARGYMHELLION

Mae ein hargymhellion canllawiau cenedlaethol yn perthyn i dri phrif gategori:

Mabwysiadu fel mater o drefn:

Mae'r dystiolaeth yn cefnogi mabwysiadu'r dechnoleg honno ar gyfer y boblogaeth yn gyffredinol.

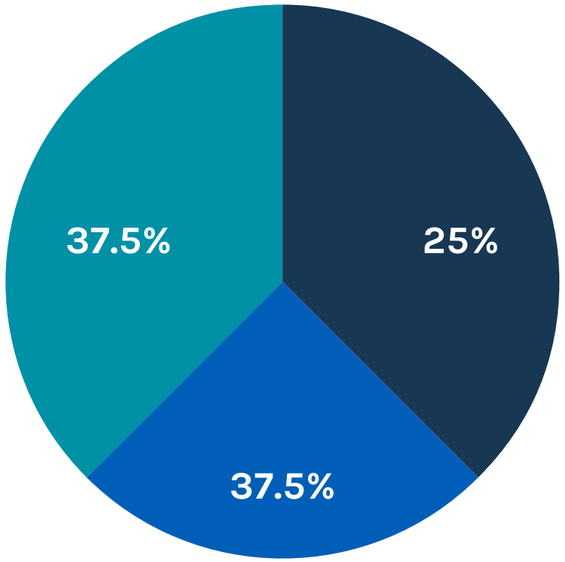
Mabwysiadu dewisol:

Mae'r dystiolaeth yn cefnogi mabwysiadu'r dechnoleg honno mewn is-set benodol o'r boblogaeth yn gyffredinol.

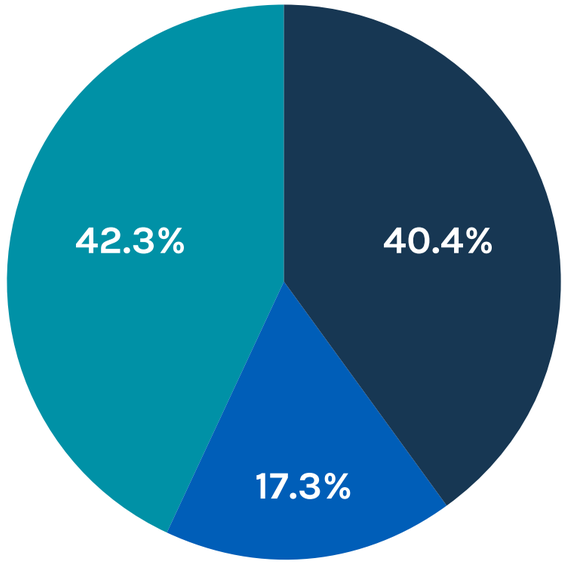
Dim digon o dystiolaeth i gefnogi mabwysiadu:

Nid oes digon o dystiolaeth i gefnogi mabwysiadu'r dechnoleg dan sylw.

2024/25



2017-2025



PARTNERIAETH GENEDLAETHOL YN YSGOGI CYNHYRCHU TYSTIOLAETH

Mae HTW wedi lansio partneriaeth newydd gyda'r Sefydliad Cenedlaethol ar gyfer Ymchwil Iechyd a Gofal (NIHR) er mwyn helpu i sicrhau yr eir i'r afael â bylchau mewn tystiolaeth a nodwyd yn ystod asesiadau technoleg iechyd.

Mae'r bartneriaeth genedlaethol hon yn gam pwysig mewn llywio cynhyrchu tystiolaeth ar gyfer technolegau iechyd a gofal nad ydynt yn feddyginiaeth.

> Mae'r bartneriaeth hon yn gyfle pwysig i amlygu'n well fylchau yn y dystiolaeth sy'n bodoli ar gyfer mabwysiadu a defnyddio technolegau iechyd a gofal nad ydynt yn feddyginiaeth.
>
> Bydd nodi a mynd i'r afael â bylchau mewn tystiolaeth yn golygu y gall darparwyr iechyd a gofal fabwysiadu mwy o dechnolegau a allai newid bywydau.
>
> Edrychwn ymlaen at ddatblygu ein partneriaeth â'r NIHR ymhellach a dod o hyd i ffyrdd newydd o rannu gwybodaeth a dealltwriaeth gyda'n gilydd.
>
> **Yr Athro Peter Groves,**
> Cyn-gadeirydd Technoleg Iechyd Cymru

Mae HTW yn cynnal asesiadau technoleg iechyd o dechnolegau iechyd a gofal nad ydynt yn feddyginiaeth ac yn cynhyrchu canllawiau cenedlaethol ar effeithiolrwydd clinigol a chost-effeithiolrwydd y dechnoleg, gan gynnwys argymhellion ar gyfer eu mabwysiadu yng Nghymru.

Mae'r broses asesu yn cynnwys gwerthuso'r dystiolaeth sydd eisoes yn bodoli ar y dechnoleg a chynhyrchu Adroddiad Arfarnu Tystiolaeth (EAR) a ddefnyddir i lunio argymhellion canllawiau HTW.

Mae'r dogfennau EAR a'r canllawiau yn tynnu sylw at unrhyw fylchau sy'n bodoli mewn tystiolaeth. Gallai hyn gynnwys argymhellion ymchwil sy'n amlinellu'r angen am astudiaethau sy'n cymharu'r dechnoleg â gofal safonol, neu'r rheini sy'n asesu canlyniadau hirdymor. Bydd y rhain nawr yn cael eu rhannu gyda Sefydliad Ymchwil Iechyd a Gofal Cymru er mwyn llywio comisiynu ymchwil yn y dyfodol. Mae angen tystiolaeth a gynhyrchir o astudiaethau o ansawdd uchel i sicrhau bod technolegau a ddarperir i gleifion yn ddiogel ac yn effeithiol.

Ariennir NIHR gan yr Adran Iechyd a Gofal Cymdeithasol gyda buddsoddiadau gan bob un o'r Gweinyddiaethau Datganoledig, gan gynnwys Ymchwil Iechyd a Gofal Cymru, i wella iechyd trwy ymchwil. Mae'n gweithio mewn partneriaeth â'r GIG, prifysgolion, llywodraeth leol, cyllidwyr ymchwil eraill, cleifion a'r cyhoedd i ariannu a chyflawni ymchwil iechyd a gofal.

LIST OF GUIDANCE PUBLISHED IN 2024/25

IONAWR 2025		DATRYSIADAU CLOI CATHETER
RHAGFYR 2024		OFFER DIGIDOL AR GYFER RHEOLI DIABETES
RHAGFYR 2024		LLAWFEDDYGAETH GYNAECOLEGOL ANFALAEN Â CHYMORTH ROBOT
RHAGFYR 2024		PRAWF ELF (FIBROSIS YR AFU/IAU UWCH)
TACHWEDD 2025		YMARFERWYR PARAFEDDYGOL UWCH
AWST 2024		OFFER Â CHYMORTH DEALLUSRWYDD ARTIFFISIAL AR GYFER DIAGNOSIS CANSER Y PROSTAD GAN DDEFNYDDIO DELWEDDAU BIOPSI SLEIDIAU CYFAN
GORFFENNAF 2024		FLOSEAL YN NHRINIAETH EPISTACSIS
GORFFENNAF 2024		ENDOSGOPI Â CHYMORTH AI AR GYFER CANSER Y LLWYBR GASTROBERFEDDOL

GUIDANCE CASE STUDY

ENDOSGOPI Â CHYMORTH DEALLUSRWYDD ARTIFFISIAL I GANFOD CANSER Y LLWYBR GASTROBERFEDDOL A BRIWIAU CYN-GANSERAIDD

Beth wnaethom?

Ystyriodd HTW ddefnydd deallusrwydd artiffisial (AI) ar gyfer canfod canser y llwybr gastroberfeddol isaf (GI) a briwiau cyn-ganseraidd. Prawf yw colonosgopi, sy'n defnyddio tiwb hyblyg wedi'i oleuo a chamera, i nodi unrhyw ardaloedd sy'n peri pryder yn y llwybr gastroberfeddol isaf. Gelwir y defnydd o AI i gynorthwyo endosgopyddion yn ystod y prawf hwn yn ganfod â chymorth cyfrifiadur (CADe). Gall canfod a chael gwared ar adenomâu a briwiau cyn-ganseraidd eraill yn well leihau nifer yr achosion o ganser yn y dyfodol. Fe wnaethom arfarnu'r dystiolaeth glinigol ac economaidd ar y pwnc, a chyhoeddi Adroddiad Arfarnu Tystiolaeth a Chanllaw HTW ym mis Mehefin 2024.

Gyda phwy?

Cynigiwyd y pwnc hwn gan endosgopydd sy'n gweithio yn GIG Cymru. Fe wnaethom weithio mewn partneriaeth ag Ymddiriedolaeth GIG Prifysgol Felindre i gynnal grwpiau ffocws yn archwilio safbwyntiau cleifion, teuluoedd a gofalwyr ar ddefnyddio AI mewn gofal iechyd ac yn benodol at y diben hwn. Yn ystod y cyfnod ymgynghori, cawsom adborth gan arweinydd clinigol y Rhaglen Endosgopi Genedlaethol, gastroenterolegwyr a gwneuthurwr.

Beth oedd yr ymatebion?

Roedd rhanddeiliaid yn credu bod yr adolygiad yn un o ansawdd uchel ac yn teimlo bod y dystiolaeth briodol wedi'i hadolygu a bod casgliadau wedi'u llunio. Fe wnaeth cynigydd y pwnc longyfarch tîm HTW ar 'werthusiad rhagorol a thrylwyr'.

Beth ddysgodd pobl?

Dangosodd yr adolygiad tystiolaeth fod defnyddio CADe wedi gwella'r gallu i ganfod adenomâu, polypau a briwiau danheddog gwastad o'i gymharu â cholonosgopi safonol, heb gynnydd sylweddol yn yr amser tynnu. Awgrymodd modelu economaidd fod CADe hefyd yn gost-effeithiol o'i gymharu â cholonosgopi safonol.

Pa wahaniaeth wnaeth hyn?

Argymhellodd Panel Arfarnu HTW fod y dystiolaeth yn cefnogi mabwysiadu colonosgopi CADe fel mater o drefn ar gyfer canfod canser y llwybr gastroberfeddol isaf a briwiau cyn-ganseraidd. Argymhellodd hefyd gasglu data ar weithrediad ac effeithiolrwydd CADe yn y byd go iawn.

ASTUDIAETH ACHOS ARFARNIAD

OFFER DIGIDOL AR GYFER RHEOLI DIABETES

Beth wnaethom?

Cynhaliodd HTW adolygiad cyflym i fynd i'r afael â'r cwestiwn ymchwil canlynol: Beth yw effeithiolrwydd clinigol a chost-effeithiolrwydd platfformau digidol ar gyfer rheoli diabetes wedi'i bersonoleiddio i lywio penderfyniadau yn y GIG?

Cynhaliwyd adolygiad cyflym o gronfeydd data perthnasol ers 2008 o'r dystiolaeth glinigol, economeg iechyd a safbwyntiau cleifion, gofalwyr a theuluoedd sy'n berthnasol i Gymru. Ystyriodd dadansoddiad cost a defnyddioldeb a ddatblygwyd gan HTW effeithiolrwydd cost platfformau digidol yng nghyd-destun GIG Cymru, er bod y dadansoddiad yn canolbwyntio ar MyWay Diabetes. Cyhoeddwyd canllaw cenedlaethol ac Adroddiad Arfarnu Tystiolaeth (EAR) ar offer digidol ar gyfer rheoli diabetes ym mis Rhagfyr 2024.

Gyda phwy?

Gwnaethom ymgysylltu â sawl grŵp rhanddeiliaid yn ystod datblygiad yr arfarniad hwn. Yn ystod y cyfnod ymgynghori, cawsom adborth gan arweinwyr clinigol, meddygon ymgynghorol, academyddion mewn ymchwil a darlithwyr ac athrawon prifysgol.

Beth wnaethom ddysgu?

Roedd platfformau digidol yn gysylltiedig â gwelliannau mewn rheolaeth glycemig (HbA1c a glwcos plasma ymprydio), defnydd adnoddau gofal iechyd (e.e. llai o ymweliadau â meddygon teulu ac adrannau damweiniau ac achosion brys y flwyddyn), pwysau'r corff (gostyngiad pwysau ystadegol arwyddocaol), gostyngiad mewn lefelau colesterol, a mesurau canlyniad a adroddwyd gan gleifion cadarnhaol. Derbyniodd HTW gyflwyniad claf gan Diabetes UK Cymru hefyd a chafwyd canlyniadau cadarnhaol o'r adolygiad llenyddiaeth ansoddol.

Diweddarodd HTW y dadansoddiad economaidd cyhoeddedig ar gyfer pobl â diabetes math 2 nad oes angen inswlin arnynt. Canfu dadansoddiad HTW fod y platfform yn fwy effeithiol ond yn fwy costus na gofal arferol. Mae'r ICER canlyniadol o £4,577 fesul blwyddyn bywyd wedi'i haddasu yn ôl ansawdd (QALY) a enillir yn is na'r trothwy cost-effeithiolrwydd o £20,000 fesul QALY, gan awgrymu bod y platfform diabetes digidol yn gost-effeithiol. Mewn dadansoddiad sensitifrwydd tebygolrwydd, canfuwyd bod gan y platfform digidol debygolrwydd o 97% o fod yn gost-effeithiol ar drothwy o £20,000 fesul QALY. Fodd bynnag, bydd yr ansicrwydd yn y casgliad hwn wedi'i danamcangyfrif.

Beth oedd yr ymatebion?

Cyflwynwyd drafft cynharach o'r pwnc hwn fel poster yng Nghyfarfod Blynyddol HTAi 2024 yn Seville. Roedd y poster yn cyd-fynd yn agos â thema datrysiadau iechyd digidol. Yna cyhoeddwyd y crynodeb yn yr International Journal of Technology Assessment in Health Care (IJTAHC) (PD115, Crynodeb Rhif 437).

Pa wahaniaeth wnaeth hyn?

Mae'r dystiolaeth yn awgrymu bod buddion clir i ddefnyddio platfformau digidol i gynorthwyo hunanreolaeth ymhlith pobl â diabetes math 2. Canfu astudiaethau sy'n adrodd ar HbA1c fuddion ystadegol arwyddocaol a phwysig yn glinigol (yn ôl canllawiau clinigol perthnasol NICE) o ddefnyddio platfformau digidol.

Daeth Panel Asesu HTW i'r casgliad bod y dystiolaeth yn cefnogi mabwysiadu platfform digidol MyWay Diabetes fel mater o drefn ar gyfer rheolaeth, addysg a chefnogaeth wedi'i phersonoleiddio i bobl â diabetes math 2. Mae modelu economaidd yn awgrymu bod MyWay Diabetes yn gost-effeithiol o'i gymharu â gofal safonol mewn pobl â diabetes math 2 nad oes angen inswlin arnynt.

> Mae proses Technoleg Iechyd Cymru (HTW) yn fenter wych i alluogi i gynhyrchion neu wasanaethau newydd gael eu gwerthuso mewn ffordd ddiduedd gan ystyried elfennau ansoddol, meintiol ac economeg iechyd. Mae'n anodd iawn cael cynhyrchion arloesol newydd i gael eu comisiynu a'u rhoi ar waith mewn gofal iechyd oherwydd diffyg proses a chyllideb symlach, ond mae proses HTW yn helpu i ddarparu argymhelliad clir y gellir ei ddefnyddio i gefnogi penderfyniadau comisiynu a sgyrsiau â rhanddeiliaid.
>
> Cymerodd y broses yn hirach i'w chwblhau nag a ddisgwyliwyd ond gyda chanlyniad da.
>
> **Debbie Wake**
> Prif Swyddog Gweithredol a Phrif Swyddog Meddygol MyWay Digital Health

PRAWF FFIBROSIS YR AFU/IAU UWCH AR GYFER ASESU FFIBROSIS YR AFU/IAU MEWN POBL Â CHLEFYD YR AFU/IAU STEATOTIG SY'N GYSYLLTIEDIG Â CHAMWEITHREDIAD METABOLAIDD

Beth wnaethom?

Ystyriodd HTW ddefnydd Prawf Ffibrosis yr Afu/Iau Uwch (ELF) i wneud diagnosis o ffibrosis yr afu/iau uwch mewn pobl â chlefyd yr afu/iau steatotig sy'n gysylltiedig â chamweithrediad metabolaidd (MASLD), a elwid gynt yn glefyd yr afu/iau brasterog nad yw'n gysylltiedig ag alcohol. Mae clefyd yr afu/iau yn digwydd pan fydd meinwe iach yr afu yn cael ei chreithio oherwydd croniad braster yn yr afu/iau. Gelwir y creithiau yn ffibrosis. Yn aml, mae clefyd yr afu/iau yn dawel ac ni chaiff ei ganfod nes bod y clefyd wedi cyrraedd cam terfynol. Ffibrosis uwch yw'r pwynt lle gellir atal clefyd yr afu/iau ond nid ei wrthdroi'n llwyr. Prawf gwaed yw'r prawf ELF a all ganfod ffibrosis yr afu/iau uwch a gellid ei ddefnyddio gyda phrawf anfewnwthiol arall, y prawf Ffibrosis-4, i sgrinio pobl am ffibrosis yr afu/iau a lleihau atgyfeiriadau diangen i'r adran hepatoleg. Fe wnaethom arfarnu'r dystiolaeth glinigol ac economaidd ar y pwnc, gan gyhoeddi Adroddiad Arfarnu Tystiolaeth a Chanllaw HTW ym mis Hydref 2024.

Gyda phwy?

Cynigiwyd y pwnc hwn gan wneuthurwr y prawf ELF, a ofynnodd i ni ystyried a ddylid gostwng y terfyn amser ar gyfer diagnosio ffibrosis uwch ac a ddylid defnyddio'r prawf ELF gyda'r prawf Fibrosis-4 i sgrinio am ffibrosis uwch mewn gofal sylfaenol. Yn ystod y cyfnod ymgynghori cawsom adborth gan feddyg ymgynghorol ym maes patholeg gemegol, prif nyrs hepatoleg a meddyg a oedd wedi cynnal adolygiad systematig blaenorol o'r prawf ELF.

Beth oedd yr ymatebion?

Roedd rhanddeiliaid yn credu bod yr adolygiad yn un o ansawdd uchel ac yn teimlo bod y dystiolaeth briodol wedi'i hadolygu a chasgliadau wedi'u llunio.

Beth ddysgodd pobl?

Dangosodd yr adolygiad dystiolaeth fod gostwng y terfyn amser ELF ar gyfer diagnosio ffibrosis yr afu/iau uwch yn briodol, ond nad oedd digon o dystiolaeth i benderfynu a fyddai defnyddio'r prawf ELF gyda'r prawf Fibrosis-4 yn lleihau atgyfeiriadau diangen. Awgrymodd modelu economaidd y byddai lleihau'r terfyn amser ELF yn debygol o fod yn gost-effeithiol.

Pa wahaniaeth wnaeth hyn?

Argymhellodd Panel Arfarnu HTW y dylid mabwysiadu'r terfyn amser isaf ar gyfer y prawf ELF fel mater o drefn i wneud diagnosis o ffibrosis uwch mewn pobl â MASLD. Nododd y Panel Arfarnu fod tystiolaeth ar gyfer cyfuno'r prawf ELF â'r prawf Ffibrosis-4 yn addawol ond nid oedd yn argymell mabwysiadu hyn fel mater o drefn. Cafodd y canllaw ei gymeradwyo gan Gymdeithas Gastroenteroleg Prydain (BSG), gan gynnwys Pwyllgor Adran yr Afu/Iau, cafodd ei roi ar ei gwefan, a'i hyrwyddo i aelodau BSG.

DATRYSIADAU CLOI CATHETR

Beth wnaethom?

Cynhaliodd HTW adolygiad cyflym i fynd i'r afael â'r cwestiwn ymchwil canlynol: Beth yw effeithiolrwydd clinigol a chost-effeithiolrwydd datrysiadau cloi cathetr nad ydynt yn wrthfiotigau, gwrthficrobaidd na gwrthgeulyddion mewn atal cymhlethdodau sy'n gysylltiedig â chathetr? Gwnaethom hefyd gynnal dadansoddiad cost a defnyddioldeb newydd i amcangyfrif cost-effeithiolrwydd KiteLock, TauroLock a TauroLock-U25.000 yng Nghymru. Arweiniodd hyn at gyhoeddi canllaw cenedlaethol ac Adroddiad Arfarnu Tystiolaeth (EAR) ar ddatrysiad cloi cathetr.

Gyda phwy?

Gwnaethom ymgysylltu â sawl grŵp rhanddeiliaid wrth ddatblygu'r arfarniad hwn. Yn ystod y cyfnod ymgynghori cawsom adborth gan arweinwyr clinigol, meddygon ymgynghorol, academyddion mewn ymchwil a darlithwyr prifysgol ac athrawon.

Beth wnaethom ddysgu?

Canfuwyd cyfradd is o heintiau llif gwaed sy'n gysylltiedig â llinell ganolog ar draws y gwahanol ddatrysiadau cloi. Ar gyfer cadw catheter yn agored, achludiad a thrombosis, roedd y canlyniadau'n gymysg ar y cyfan gydag arwyddocâd ystadegol amrywiol. Yn gyffredinol, roedd nifer yr atgyweiriadau neu orfod gosod datrysiadau newydd yn is yn y grwpiau TauroLock a TauroLock-U25.000 o'u cymharu â'r grwpiau cymharu priodol. Canfuwyd bod KiteLock a TauroLock-U25.000 yn dangos defnydd is o actifadyddion plasminogen meinwe ailgyfunol (rt-PA). Adroddodd un RCT nifer is o dderbyniadau i'r ysbyty wrth ddefnyddio TauroLock.

Dangosodd ein dadansoddiad economaidd y gallai TauroLock fod yn llai costus ac yn fwy effeithiol na'r cymaryddion a fodelwyd ar gyfer plant sy'n derbyn maeth trwy wythïen yn y cartref, cemotherapi, neu drawsblaniad celloedd bonyn ac ar gyfer oedolion sy'n derbyn maeth trwy wythïen yn y cartref neu hemodialysis. Amcangyfrifwyd hefyd bod KiteLock yn llai costus ac o leiaf mor effeithiol â chymaryddion dethol ar gyfer plant sy'n derbyn maeth trwy wythïen yn y cartref ac ar gyfer oedolion sy'n derbyn maeth trwy wythïen yn y cartref neu hemodialysis. Nid oedd KiteLock yn gost-effeithiol yn erbyn heparin mewn hemodialysis; ac nid oedd TauroLock-U25.000 yn gost-effeithiol yn erbyn TauroLock-HEP500. Cost-effeithiolrwydd KiteLock oedd fwyaf sensitif i'r dewis o fewnbynnau a rhagdybiaethau a fodelwyd.

Beth oedd yr ymatebion?

Credai rhanddeiliaid fod yr adolygiad yn dilyn methodoleg glir a bod casgliadau wedi'u llunio o ddehongliad priodol o'r dystiolaeth.

Pa wahaniaeth wnaeth hyn?

Cyhoeddodd HTW ganllawiau sy'n rhannol gefnogi'r defnydd o ddatrysiadau cloi cathetr nad ydynt yn wrthfiotigau, gwrthficrobaidd na gwrthgeulyddion ar gyfer atal cymhlethdodau sy'n gysylltiedig â chathetr. Dylid ystyried TauroLock ar gyfer plant sy'n derbyn maeth trwy wythïen yn y cartref, cemotherapi neu drawsblaniad celloedd bonyn ac ar gyfer oedolion sy'n derbyn maeth trwy wythïen yn y cartref neu ddialysis. Nid yw'r dystiolaeth yn cefnogi'r achos dros fabwysiadu TauroLock-U25.000 fel mater o drefn. Mae mwy o ansicrwydd yn y dystiolaeth ar gyfer KiteLock 4%, ac, er ei fod yn dangos addewid, nid yw'r dystiolaeth gyfredol yn ddigonol i gefnogi ei fabwysiadu fel mater o drefn.

ADRODDIAD ARCHWILIAD MABWYSIADU DIWEDDARAF YN DANGOS BOD CANLLAWIAU HTW YN CAEL EFFAITH LEDLED CYMRU

Mae mabwysiadu canllawiau HTW yn allweddol i sicrhau bod yna fynediad at dechnolegau a modelau gofal a chymorth sy'n seiliedig ar dystiolaeth a bod eu buddion disgwyliedig yn cael eu gwireddu i bobl yng Nghymru.

Mae HTW yn cynnal archwiliad mabwysiadu blynyddol mewn partneriaeth â rhanddeiliaid gyda'r nod o asesu effaith ei ganllawiau ar draws systemau gofal Cymru.

Canolbwyntiodd Adroddiad Archwiliad Mabwysiadu 2023/24 HTW ar 11 o ganllawiau HTW a thri chanllaw Gwerthuso Technolegau Meddygol (MTEP) NICE. Cafodd y gyfradd ymateb orau hyd yma a datgelodd lefelau uchel o ymwybyddiaeth o ganllawiau HTW.

Mae canfyddiadau allweddol yr archwiliad mabwysiadu yn cynnwys y canlynol:

- Mae ymatebion gan sefydliadau lle'r oedd y canllawiau'n berthnasol yn dangos bod ymwybyddiaeth o'r canllawiau yn uchel (79%), mae eglurder argymhellion y canllawiau yn dda iawn (96%), ac mae canllawiau'n cael effaith yn y rhan fwyaf o achosion (72%). Mae'r ffigurau hyn yn gyson â, neu'n welliant ar archwiliad y llynedd.
- Er bod eglurder y canllawiau wedi'i adrodd fel uchel, roedd rhai achosion lle nad oedd sefydliadau'n deall yn llawn gylch gwaith canllawiau HTW. Roedd sylwadau ynghylch y diffyg gwybodaeth ynglŷn ag o ble y byddai cyllid ac adnoddau ychwanegol yn dod, a chwestiynau ynghylch rhoi'r dechnoleg ar waith, nad yw o fewn cylch gwaith canllawiau HTW.
- Yn gyffredinol, dilynwyd canllawiau HTW sy'n argymell mabwysiadu technoleg fel mater o drefn. Er hynny, roedd ychydig o enghreifftiau lle nad oedd sefydliadau wedi cadw at yr argymhelliad neu lle nad oeddent yn siŵr a fyddent yn gwneud hynny.
- Ar gyfer canllawiau HTW sy'n "cefnogi'n rhannol" fabwysiadu fel mater o drefn, yn gyffredinol nid oedd sefydliadau'n teimlo bod y canllawiau'n ddigonol i newid polisi comisiynu neu arfer clinigol, neu roeddent yn ansicr ynglŷn â hynny.
- Argymhellodd pob un o'r tri chanllaw NICE a archwiliwyd y dylid defnyddio'r dechnoleg. Roedd effaith y tri chanllaw ar wneud penderfyniadau yn amrywiol, o ddim effaith i effaith fawr.

I ddarllen Adroddiad Archwilio Mabwysiadu 2023/24 HTW yn llawn cliciwch yma.

> ***Mae gan HTW rôl bwysig mewn helpu i sicrhau bod y technolegau iechyd mwyaf effeithiol a chost-effeithiol ar gael i bobl Cymru. Mae'r adroddiad hwn yn dangos yn glir yr effaith sylweddol y mae canllawiau HTW yn ei chael o fewn ein sector gofal iechyd. Mae hefyd yn bleser mawr clywed bod yr archwiliad hwn wedi cyflawni'r gyfradd ymateb uchaf hyd yma, sy'n dangos y gwelliannau parhaus sy'n cael eu gwneud i broses archwilio mabwysiadu HTW.***
>
> **Judith Paget**
> Cyfarwyddwr Cyffredinol Iechyd a Gwasanaethau Cymdeithasol a Phrif Weithredwr GIG Cymru

> ***Mae gan NICE berthynas wych â Thechnoleg Iechyd Cymru (HTW). Rydym wedi gweithio'n agos gydag ef dros y blynyddoedd yn enwedig ym maes gwerthuso'r defnydd. Mae HTW wedi cynnal archwiliadau ar ganllawiau technoleg feddygol a diagnostig NICE yng Nghymru, gan roi mewnwelediadau a gwybodaeth werthfawr i ni na fyddem wedi gallu eu cael fel arall.***
>
> **Dr Julie Vile**
> Ymgynghorydd Gweithredu NICE (Cymru)
> Sefydliad Cenedlaethol dros Ragoriaeth mewn Iechyd a Gofal (NICE)

GWEITHGAREDDAU PPI YN 2024/25

Mae cynnwys cleifion a'r cyhoedd (PPI) yn rhan annatod o broses arfarnu HTW ac mae'n rhoi gwybodaeth hollbwysig am effaith technolegau iechyd a modelau gofal ar fywydau cleifion a defnyddwyr gwasanaethau gofal.

Mae HTW yn gweithio'n agos gyda grwpiau cleifion ledled y DU i sicrhau ein bod yn dysgu gan brofiadau cleifion, gofalwyr a'u teuluoedd a bod eu hadborth yn helpu i lywio'r canllawiau a gyhoeddir gennym.

Mae uchafbwyntiau gwaith PPI HTW yn 2024/25 yn cynnwys:

- PPI yn cael ei gynnal ar gyfer pob pwnc newydd
- 6 adolygiad llenyddiaeth, 1 cyflwyniad gan glaf, 2 arolwg cleifion, 1 adroddiad ymchwil gan sefydliadau cleifion a geirdaon cleifion
- Cynhaliwyd cyfarfodydd Grŵp Sefydlog PPI (PPISG) bob chwarter i benderfynu ar fecanweithiau PPI, goruchwylio gweithgareddau PPI parhaus, creu crynodebau iaith glir ac esblygu prosesau ac offer PPI
- Mae HTW yn parhau i gyfrannu at waith PPI yn rhyngwladol, gan gynnwys gweminar cleifion trwy INHATA
- Cyfrannodd Rheolwr PPI HTW argymhellion PPI i ddatblygiad adroddiad cynghorol i gefnogi ecosystem technoleg feddygol Cymru
- Ymgynghorwyd ag aelodau PPISG wrth ddatblygu'r adroddiad cynghorol hwn
- Rhoddodd gynrychiolydd PPISG a Rheolwr PPI gyflwyniad ar ddulliau PPI hyblyg HTW i Gyfarfod Blynyddol HTAi ym mis Mehefin 2024
- Mynychodd Rheolwr PPI gynhadledd flynyddol gyntaf EMRAG (Grŵp Ymgynghorol Ymchwil Lleiafrifoedd Ethnig) ym Mhrifysgol De Cymru
- Ymgysylltwyd â Phrifysgol Met Caerdydd trwy roi cyflwyniad ar rôl PPI mewn asesu technoleg iechyd i fyfyrwyr oedd yn graddio
- Cynhaliodd y PPISG broses lwyddiannus o recriwtio aelodau newydd a chroesawodd bedwar aelod newydd sy'n dod yn asedau gwerthfawr i PPISG, y Grŵp Asesu a'r Panel Arfarnu. Croeso i Bob McAlister, John Gallanders, Julie Hepburn a Tony Esmond

Cyhoeddiad PPI

Cwblhaodd HTW ei bennod ar gyfer yr ail argraffiad ar gynnal PPI mewn HTA sydd i'w gyhoeddi yn haf 2025. Mae'r bennod hon wedi'i derbyn i'w chyhoeddi. Bydd y bennod yn ymdrin â dulliau unigryw HTW o ymgymryd â PPI.

TALU TEYRNGED I AELODAU GWREIDDIOL Y GRŴP

Mae HTW wedi cael y fraint fawr o weithio gyda, ac elwa gan, arbenigedd ein Grŵp Sefydlog Cynnwys Cleifion a'r Cyhoedd (PPISG) ers ei ffurfio yn 2018. Eleni rydym yn ffarwelio ag aelodau gwreiddiol y grŵp wrth i'w cyfnod fel aelodau PPISG ddod i ben. Mae'r aelodau hyn wedi bod yn allweddol wrth lunio ein prosesau, offer a dogfennau PPI ac maent wedi gweithio'n ddiflino i ddatblygu proses PPI sy'n cael ei chydnabod ledled y byd. Dros eu cyfnod fel rhan o'r grŵp mae ein haelodau wedi cyflawni'r canlynol:

- Datblygu ein Hoffer Mecanwaith PPI a'r dull unigryw o wneud penderfyniadau PPI cynaliadwy, hyblyg ac addas at y diben
- Creu offer addysg cleifion ar HTA, gan gynnwys gweminar ac animeiddiad
- Mynychu a chyflwyno gwaith HTW mewn cynadleddau HTAi
- Siarad am HTW a PPI mewn prifysgolion ac ymddiriedolaethau'r GIG
- Cymryd rhan mewn grwpiau ffocws ar-lein a wyneb yn wyneb ar gyfer gwahanol bynciau a thechnolegau
- Siapio cynrychiolaeth cleifion ar bwyllgorau a byrddau HTW
- Cyfrannu at gyhoeddiadau ar waith PPI HTW

Mae wedi bod yn bleser gennym weithio gyda'r unigolion talentog hyn. Er bod eu cyfnod yn HTW wedi dod i ben a bod PPISG yn cael aelodau newydd, byddwn bob amser yn ddiolchgar i'n haelodaeth wreiddiol ac yn edrych ymlaen yn fawr at weld beth fydd pob un ohonynt yn ei wneud yn y dyfodol. I Alan, Catherine, Emma, Karen, Kiana, Louise, Sarah a Sian, rydym yn diolch o waelod calon ac yn dymuno'r gorau i chi.

> Rydw i mor drist i fod yn gadael HTW ond mae fy atgofion i gyd yn gadarnhaol. Llwyddais i roi cyflwyniad i Brifysgol Caerdydd ar fy rôl yn HTW. Hefyd mynychais grŵp ffocws gyda Grŵp Cyfeillion Ysbyty Felindre ar Ddeallusrwydd Artiffisial. Cafodd hwn groeso da iawn a gwnes gyfarfod â phobl ryfeddol. Rwy'n credu bod grŵp cryf iawn wedi cael ei recriwtio nawr. Rwy'n dymuno'r gorau iddynt. Roeddwn i eisiau gwneud gwahaniaeth ac rwy'n teimlo fy mod i wedi gwneud hynny.

Sian Jones

> Mae wedi bod yn anrhydedd gwasanaethu ar y Grŵp Sefydlog PPI ers ei sefydlu. Mae'r grŵp wedi gweithio gyda'r Rheolwr PPI i ddeall arferion gorau mewn cynnwys cleifion mewn HTA, cyd-greu a pheilota prosesau a'u haddasu yn seiliedig ar adborth gan gynrychiolwyr cleifion, ymchwilwyr HTW a'r pwyllgor arfarnu. Mae system hyblyg wedi'i datblygu sy'n ymateb i alluoedd grwpiau cleifion ac yn defnyddio sgiliau ymchwil HTW. Mae hyn yn unigryw a gallwn ddweud yn falch bod cynnwys cleifion yn HTW yn arwain y byd.

Dr Karen Facey

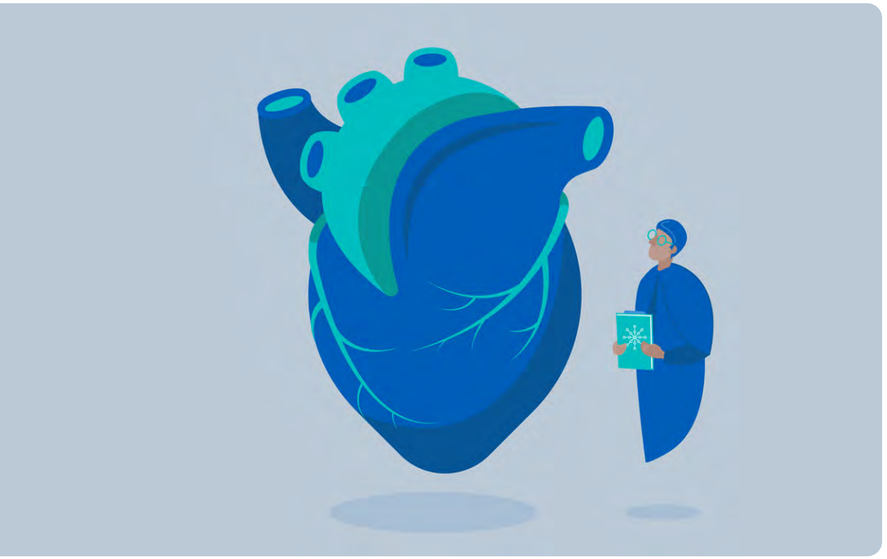
> Mae gweithio gyda Thechnoleg Iechyd Cymru fel Partner Cyhoeddus wedi bod yn fraint aruthrol. Fel aelod o'r Grŵp Asesu a'r Grŵp Sefydlog Cynnwys Cleifion a'r Cyhoedd (PPI), rydw i wedi cael y cyfle i gyfrannu at waith arloesol wrth ddatblygu prosesau PPI ar gyfer asesiadau technoleg iechyd (HTA). Cyflawnwyd hyn trwy waith partneriaeth gwirioneddol a chyd-gynhyrchu ac mae'n sicrhau bod HTA yn elwa'n gyson gan lais 'arbenigwyr trwy brofiad' - cleifion, gofalwyr a'u teuluoedd, a'r sefydliadau sy'n eu cefnogi. Ar lefel bersonol, gwnaed argraff arnaf gan broffesiynoldeb a gwaith caled y tîm, ynghyd â chynhesrwydd a chyfeillgarwch sydd wedi gwneud y pynciau a drafodwyd, sy'n aml yn gymhleth, yn hygyrch, yn groesawgar ac yn ddeniadol i gyfraniadau ystyrlon o safbwynt lleyg. Rwy'n teimlo fy mod wedi cael fy nghefnogi'n dda ac yn cael fy ngwerthfawrogi'n wirioneddol yn fy rôl, ac mae'n amlwg nad ymarfer ticio blychau yn unig yw cynnwys cleifion a'r cyhoedd, ond ei fod yn cael ei gydnabod fel rhan annatod o waith y sefydliad.

Sarah Peddle

TECHNOLEG FEDDYGOL: GWELLA BYWYD I DDINASYDDION CYMRU

Yn 2024, cynhyrchodd HTW adroddiad cynghorol i gefnogi datblygiad ecosystem technoleg feddygol Cymru. Roedd y prosiect yn cynnwys gweithio mewn cydweithrediad agos â'n rhanddeiliaid i gynhyrchu set o argymhellion allweddol.

Yn ystod gwanwyn 2024 comisiynwyd HTW gan Lywodraeth Cymru i arwain datblygiad cyflym adroddiad cynghorol i nodi camau gweithredu posibl er mwyn cryfhau ecosystem technoleg feddygol yng Nghymru. Ym mis Rhagfyr 2024, cyflwynwyd adroddiad, ynghyd â dogfen Gydymaith Tystiolaeth Ategol fanwl, i Lywodraeth Cymru yn amlinellu cynigion ac argymhellion i gryfhau a dod â mwy o gydlyniant i ecosystem technoleg feddygol yng Nghymru.



Sut wnaethom hyn?

Defnyddiodd HTW, gyda chefnogaeth ymgynghoriaeth Urban Foresight (UF), ddull pragmatig dulliau-cymysg i ddatblygu argymhellion yr adroddiad. Goruchwyliwyd hyn gan Fwrdd y Rhaglen a oedd yn cynnwys uwch gynrychiolwyr o sefydliadau o bob rhan o ecosystem technoleg feddygol Cymru, yn ogystal â Llais Cymru (ar ran partneriaid cleifion a'r cyhoedd) a Llywodraeth Cymru.

Cynhaliwyd ymchwil sylfaenol gan ddefnyddio amrywiaeth o ddulliau i ymgysylltu ag arbenigwyr trwy gyfweliadau, grwpiau ffocws, cyfarfodydd, gweithdai a digwyddiad bwrdd crwn. Ymgynghorwyd â dros 180 o randdeiliaid o dros 28 o sefydliadau ledled Cymru, Lloegr, yr Alban, Gogledd Iwerddon a Gweriniaeth Iwerddon, a oedd yn gweithio ar draws maes iechyd a gofal cymdeithasol ar wahanol gamau o gylch bywyd technoleg feddygol ac arloesi.

Cynhaliwyd ymchwil desg eilaidd i gael dealltwriaeth fanwl o dirwedd technoleg feddygol Cymru a'r cyd-destun ehangach y mae'n rhan ohono. Fe wnaeth papurau, a ysgrifennwyd gan HTW, UF a phartneriaid allanol, grynhoi tystiolaeth fanwl yn ymwneud â 12 pwnc wedi'u targedu. Er enghraifft, cyd-destun technoleg feddygol presennol Cymru, y DU a rhyngwladol, cyfleoedd mabwysiadu arloesedd Cymru, sganio'r gorwel ar gyfer technolegau meddygol, caffael seiliedig ar werth, a deallusrwydd artiffisial mewn technoleg feddygol.

Defnyddiwyd themâu allweddol a ddaeth i'r amlwg o'r ymchwil sylfaenol ac eilaidd i ddrafftio argymhellion. Yna diweddarwyd a chwblhawyd y rhain yn seiliedig ar adborth ymgynghori â rhanddeiliaid o sesiwn cynnwys cleifion a'r cyhoedd a gynhaliwyd ym mis Hydref 2024 a gweithdy gwirio synnwyr a gynhaliwyd ym mis Tachwedd 2024.

Argymhellion

Mae dau ar hugain o argymhellion, ar draws 3 philer a chwe thema drawsbynciol, yn nodi meysydd o angen canfyddedig, yn ogystal â chyfleoedd, ar gyfer ffocws a gwaith yn y dyfodol ar draws ecosystem Technoleg Feddygol yng Nghymru. Mae pileri a themâu trawsbynciol yn ymwneud â'r canlynol:

- Piler 1 - Cylch bywyd a fframwaith ecosystem technoleg feddygol - gweithio ar y cyd
- Piler 2 - Sganio'r gorwel, nodi a dewis pynciau
- Piler 3 - Rheoleiddio a llywodraethu
- Themâu trawsbynciol: cynnwys cleifion a'r cyhoedd; tegwch ac amrywiaeth; cynnwys academaidd; cyllid; cynaliadwyedd a data

GWEITHIO MEWN PARTNERIAETH Â CHANOLFAN DYSTIOLAETH YMCHWIL IECHYD A GOFAL CYMRU

Penodwyd HTW yn bartner cydweithredol Canolfan Dystiolaeth Ymchwil Iechyd a Gofal Cymru yn 2023.

Nod y ganolfan yw darparu tystiolaeth ymchwil hollbwysig i Weinidogion Llywodraeth Cymru a gwneuthurwyr penderfyniadau eraill i fynd i'r afael â'r heriau iechyd a gofal cymdeithasol sy'n wynebu Cymru.

Yn 2024/25, gweithiodd HTW ar yr adolygiadau cyflym canlynol:

- Beth yw'r dull mwyaf effeithiol o gyflwyno hyfforddiant 'Gwneud i Bob Cyswllt Gyfrif'? Adolygiad cyflym
- Ffactorau sy'n gysylltiedig â gorbwysau neu ordewdra mewn plant dan bump oed: adolygiad cyflym
- Adolygiad cyflym o weithwyr proffesiynol perthynol i iechyd sy'n gweithio mewn gwasanaethau newyddenedigol

> Mae wedi bod yn bleser gweithio gyda chydweithwyr HTW yng Nghanolfan Dystiolaeth Ymchwil Iechyd a Gofal Cymru, eleni ac erbyn hyn am gyfanswm o 4 blynedd. Mae eu gwaith o'r safon uchaf ac wedi gwneud cyfraniadau hollbwysig i feysydd polisi allweddol y llywodraeth / GIG megis ynghylch gordewdra plentyndod ac ar gyfer y strategaeth iechyd menywod a lansiwyd yn ddiweddar ar gyfer Cymru.
>
> **Yr Athro Adrian Edwards**
> Cyfarwyddwr Canolfan Dystiolaeth Ymchwil Iechyd a Gofal Cymru

ASTUDIAETH ACHOS ADOLYGIAD CYFLYM: FFACTORAU SY'N GYSYLLTIEDIG Â GORBWYSAU NEU ORDEWDRA MEWN PLANT DAN BUMP OED

Beth wnaethom?

Cynhaliodd HTW adolygiad cyflym o adolygiadau systematig ar ffactorau sy'n gysylltiedig â gorbwysau neu ordewdra mewn plant dan bump oed. Cyhoeddwyd pecyn gwybodaeth yn cynnwys adroddiad llawn, map canlyniadau, crynodeb gweithredol, crynodeb lleyg a ffeithlun ym mis Medi 2024.

Gyda phwy?

Cydweithiodd HTW â Chanolfan Dystiolaeth Ymchwil Iechyd a Gofal Cymru i gynhyrchu'r gwaith hwn ar gyfer tîm Iechyd y Cyhoedd ac Anghydraddoldebau Llywodraeth Cymru, er mwyn helpu i lywio strategaeth 'Pwysau Iach, Cymru Iach'. Gwnaethom ymgysylltu â sawl gwahanol grŵp rhanddeiliaid o Lywodraeth Cymru wrth ddatblygu'r adolygiad cyflym hwn.

Beth wnaethom ddysgu?

Roedd ystod eang o ffactorau'n gysylltiedig â gorbwysau neu ordewdra ymhlith plant. Roedd y rhan fwyaf o'r dystiolaeth sicrwydd uchel yn ymwneud â gorbwysau ac nid gordewdra. Mae'r dystiolaeth sicrwydd uchel yn dangos bod yna rai pethau a allai gefnogi plant i fod yn bwysau iachach. Dwy enghraifft yw:

1. Helpu menywod sy'n byw gyda bod dros bwysau (sy'n ystyried, neu'n ceisio beichiogi) i golli pwysau.
2. Darparu cyfleoedd i blant mamau sy'n gweithio fwyta bwydydd iachach a bod yn fwy corfforol egnïol.

Mae yna hefyd rywfaint o dystiolaeth sicrwydd cymedrol am bethau eraill, a allai helpu. Mae enghreifftiau'n cynnwys hyrwyddo bwydo ar y fron a lleihau'r defnydd o ddiodydd siwgrog.

Beth oedd yr ymatebion?

Adroddodd rhanddeiliad yn yr adolygiad cyflym hwn fod "canfyddiadau'r adolygiad tystiolaeth ymchwil uchod a'r Map Eppi cysylltiedig wedi helpu i lywio cynllun cyflawni 2024-2026 ar gyfer 'Strategaeth Cymru Iach Pwysau Iach'.

"Nod cyffredinol y strategaeth hon yw atal a lleihau gordewdra, gyda ffocws penodol ar ordewdra plentyndod mewn plant cyn oed ysgol. Bydd deall achosion sylfaenol gordewdra plentyndod yn ein helpu i wneud penderfyniadau gwybodus ynghylch cynllunio a gweithredu ymyriadau. Bydd hyn yn hollbwysig wrth lunio strategaethau i leihau nifer yr achosion o ordewdra plentyndod a gwella iechyd cyffredinol plant cyn oed ysgol yng Nghymru.

"Mae Deddf Cenedlaethau'r Dyfodol Cymru hefyd yn berthnasol yma. Mae'r ddeddfwriaeth hon yn gorchymyn bod cyrff cyhoeddus yng Nghymru yn ystyried canlyniadau hirdymor eu penderfyniadau ar lesiant y boblogaeth, yr amgylchedd, diwylliant a chymunedau. Mae'r dystiolaeth a gynhyrchwyd trwy'r ymchwil hwn yn cyd-fynd ag amcanion y ddeddf hon trwy fynd i'r afael â phryderon iechyd a lles hirdymor"

Pa wahaniaeth wnaeth hyn?

Helpodd y gwaith hwn i lywio'r strategaeth 'Pwysau Iach Cymru Iach'. Yr adolygiad hwn yw'r adolygiad cyfoes cyntaf yr ydym yn ymwybodol ohono sy'n canolbwyntio ar ffactorau a'u heffaith ar statws pwysau a astudiwyd mewn plant dan bump oed.

GWEITHIO MEWN PARTNERIAETH Â CHANOLFAN DYSTIOLAETH YMCHWIL IECHYD A GOFAL CYMRU

ASTUDIAETH ACHOS ADOLYGIAD CYFLYM: GWEITHWYR PROFFESIYNOL PERTHYNOL I IECHYD MEWN UNEDAU NEWYDDENEDIGOL

Beth wnaethom?

Cynhaliodd HTW adolygiad cyflym o effaith Gweithwyr Proffesiynol Perthynol i Iechyd (AHP) sydd wedi'u hymgorffori mewn gwasanaethau newyddenedigol ar ganlyniadau. Cyhoeddwyd pecyn gwybodaeth yn cynnwys adroddiad llawn, crynodeb gweithredol, crynodeb lleyg a ffeithlun ym mis Gorffennaf 2024.

Gyda phwy?

Cydweithiodd HTW â Chanolfan Dystiolaeth Ymchwil Iechyd a Gofal Cymru i gynhyrchu'r gwaith hwn ar gyfer Addysg a Gwella Iechyd Cymru. Bwriad yr adolygiad oedd hysbysu'r rheini sy'n gyfrifol am staffio AHP mewn gwasanaethau newyddenedigol.

Beth wnaethom ddysgu?

Roedd tystiolaeth sicrwydd isel bod cael AHP o fewn gwasanaethau newyddenedigol yn arwain at welliannau mewn sgiliau motor bras a bwydo babanod ifanc yn gynharach drwy'r geg. Roedd canlyniadau astudiaethau o effaith timau cymorth maeth mewn unedau newyddenedigol yn rhy anghyson i ddod i unrhyw gasgliadau.

Roedd tystiolaeth sicrwydd cymedrol bod gofal a chymorth cynnar gan AHP yn arwain at gyfnodau byrrach yn yr ysbyty a bwydo'n gynharach drwy'r geg, yn ogystal â gwelliannau bach mewn galluoedd gwybyddol a chorfforol cyffredinol o'i gymharu â thimau newyddenedigol heb AHP.

Ychydig iawn o dystiolaeth uniongyrchol berthnasol oedd ar AHP wedi'u hymgorffori mewn gwasanaethau newyddenedigol ac ychydig o dreialon ymyrraeth gynnar AHP a gynhaliwyd yn y DU. Mae angen ymchwil bellach yn y DU i ddeall yn well y ffordd orau o integreiddio AHP mewn gwasanaethau newyddenedigol.

Beth oedd yr ymatebion?

Cadarnhaodd rhanddeiliad yn yr adolygiad cyflym hwn:

"....bod canfyddiadau'r adolygiad ymchwil wedi helpu i lywio rhaglen waith y Cynllun Gweithlu Amenedigol Strategol (SPWP) a'r rheini sy'n gyfrifol am staffio mewn gwasanaethau newyddenedigol yng Nghymru. Helpodd canfyddiadau'r adolygiad hefyd i ddylanwadu ar benodiad Arweinydd Clinigol AHP i'r Rhwydwaith Clinigol Mamolaeth a Newyddenedigol o fewn Gweithrediaeth y GIG. Disgwylir i'r penodiad hwn helpu i ddarparu tystiolaeth o fuddion i gleifion ac yn ariannol ar gyfer cynllunio'r gweithlu yn y dyfodol. Bydd canfyddiadau'r adolygiad hefyd yn helpu i gryfhau achosion busnes i wella staffio AHP o fewn unedau newyddenedigol i lefelau a argymhellir ar gyfer y gweithlu, a llywio ceisiadau ac argymhellion cyllideb yn y dyfodol, yn ogystal â strategaethau recriwtio.

"Yn olaf, tynnodd yr adolygiad sylw hefyd at feysydd lle mae angen tystiolaeth ymchwil o ansawdd da yn y dyfodol, gan gynnwys gwerthusiadau economaidd."

Pa wahaniaeth wnaeth hyn?

Helpodd canfyddiadau'r adolygiad cyflym i lywio'r Cynllun Gweithlu Amenedigol Strategol a phenderfyniadau staffio AHP newyddenedigol yng Nghymru.

CEFNOGI CYNALIADWYEDD MEWN GOFAL IECHYD

Er mai prif nod systemau gofal iechyd yw atal a gwella clefydau, maent hefyd yn llygrwyr mawr, gan gyfrannu at ddechrau clefydau. Mae'r sector gofal iechyd yn gyfrifol am tua 5% o ôl troed carbon byd-eang, a phe bai'n wlad byddai'n bumed allyrrwr mwyaf ar y blaned.

Yn fyd-eang, mae cydnabyddiaeth gynyddol o'r effaith amgylcheddol sydd gan systemau gofal iechyd a thechnolegau iechyd, sydd wedi arwain at ddiddordeb cynyddol ymhlith asiantaethau HTA ynghylch asesu a chynnwys effaith ar yr amgylchedd o fewn HTA.

Mae HTW wedi bod yn rhan o grŵp dysgu cynaliadwyedd amgylcheddol INAHTA ers 2022, gan ymuno'n fwy diweddar â grŵp gwirfoddol o 22 o arbenigwyr HTA eraill mewn 15 o asiantaethau aelodau INAHTA i gynhyrchu Papur Gwyn gyda'r nod o hyrwyddo trafodaeth a chymhwyso Asesiad o'r Effaith Amgylcheddol (AEA) mewn HTA.

Mae AEA yn rhan o offeryn polisi sydd â'r nod o fesur effaith amgylcheddol technoleg. Gall fod yn offeryn pwysig i wneud penderfyniadau ynghylch defnyddio technolegau iechyd, gan helpu i nodi a chael gwared o bosibl ar dechnolegau sy'n gymharol niweidiol i'r amgylchedd.

Gellir cynnwys amrywiol agweddau ar hyd cylch oes technoleg mewn AEA, a gellir ymgorffori hyn mewn HTA o dan ddull cylch oes, lle mae cynhyrchu a gwaredu technoleg yn cael ei ystyried, neu o dan ddull mwy mireiniedig, sy'n ystyried effaith technoleg yn unig yn ystod ei defnydd ymarferol.

Er bod AEA eisoes yn un o feysydd HTA, mae dulliau ar gyfer cynnal asesiad o'r fath yn dal i fod yn eu dyddiau cynnar. Mae angen cytuno ar gonsensws ynghylch hyd y cyfnod y dylid ystyried effeithiau amgylcheddol o fewn HTA, a pha ffactorau amgylcheddol sydd fwyaf perthnasol i'w cynnwys, gan nodi y gallai cynnwys rhai ffactorau dros eraill ragfarnu gwneud penderfyniadau yn erbyn opsiynau a fyddai fel arall yn amgylcheddol hyfyw.

Cyhoeddwyd y Papur Gwyn yn ddiweddar ar wefan INAHTA, a gellir ei weld yma.

LLEDAENU'R GAIR

Trwy gydol 2024/25, fe wnaethom fynychu digwyddiadau cenedlaethol a rhyngwladol i hyrwyddo manteision asesu technolegau iechyd a gofal yn seiliedig ar dystiolaeth:

Mai 2024

Gweithdy IPFR

Rhan bwysig o'n gwaith yw cefnogi byrddau iechyd y GIG i ymateb i geisiadau cyllido cleifion unigol (IPFR). Cynhelir y Gweithdy IPFR yn flynyddol gan Ganolfan Therapiwteg a Thocsicoleg Cymru Gyfan (AWTTC).

Mehefin 2024

MediWales Connects

Mae'r digwyddiad blynyddol hwn yn dwyn ynghyd gydweithwyr y GIG, cynrychiolwyr diwydiant ac ymchwilwyr o bob rhan o Gymru a thu hwnt. Cynhaliom stondin arddangos yn MediWales Connects a rhoddodd ein Cadeirydd ar y pryd, yr Athro Peter Groves, gyflwyniad ar sut mae gwaith HTW yn cyfrannu at gylch bywyd arloesiadau technoleg feddygol.

Cyngres INAHTA 2024

Rhwydwaith byd-eang o asiantaethau HTA sy'n cefnogi gwneud penderfyniadau system iechyd sy'n effeithio ar dros 1 biliwn o bobl mewn 33 o wledydd ledled y byd yw'r Rhwydwaith Rhyngwladol o Asiantaethau ar gyfer Asesu Technoleg Iechyd (INAHTA). Fel aelod o INHATA, mae HTW yn cydweithio â chydweithwyr rhyngwladol i rannu arfer gorau.

Cyfarfod Blynyddol HTAi 2024

Mynychodd dirprwyaeth o ymchwilwyr gwasanaeth iechyd Gyfarfod Blynyddol HTAi (Asesiad Technoleg Iechyd Rhyngwladol) 2024 yn Seville, Sbaen, a chyflwyno posteri ar bynciau yn amrywio o blatfformau digidol ar gyfer rheoli diabetes wedi'i bersonoleiddio i ddisgwyliadau cleifion ar gyfer defnyddio deallusrwydd artiffisial mewn gofal iechyd.

Medi 2024

Cyfarfod a chynhadledd aelodaeth INSIA

Mynychodd Cyfarwyddwr HTW, Susan Myles, aelod o fwrdd INSIA (Rhwydwaith Rhyngwladol ar gyfer Asesu Ymyrraeth Gymdeithasol), gyfarfod aelodaeth INSIA ynghyd â Rheolwr Cyfathrebu Technoleg Iechyd Cymru a gyflwynodd gynllun cyfathrebu ar gyfer y sefydliad.

Hydref 2024

Arddangosfa Aelodau MediWales

Mae digwyddiad arddangos blynyddol MediWales yn rhoi cyfle i aelodau MediWales arddangos yr arloesiadau technoleg feddygol y maent wedi'u datblygu a cheisio mewnbwn gan gyd-arloeswyr.

Tachwedd 2024

Cynhadledd Flynyddol Gweithwyr Proffesiynol Perthynol i Iechyd (AHP)

Mae Cynhadledd AHP yn canolbwyntio ar effaith gweithwyr proffesiynol perthynol i iechyd yng Nghymru. Gwnaethom gynnal stondin arddangos a chyfarfod â gweithwyr proffesiynol perthynol i iechyd, a oedd yn cynnwys ffisiotherapyddion, dietegwyr, therapyddion galwedigaethol a therapyddion lleferydd.

Rhagfyr 2024

Digwyddiad Iechyd Enfawr

Roedd y digwyddiad deuddydd hwn yn cynnwys sgyrsiau gan arweinwyr y GIG ac arloeswyr o bob rhan o sbectrwm arloesi technoleg iechyd. Gwnaethom gymryd rhan yng nghynhadledd AI genedlaethol y GIG a amlygodd ddatblygiad cyflym technolegau iechyd â chymorth AI.

EIN TÎM

Mae'r gwaith yn yr adroddiad blynyddol hwn wedi'i gyflawni gan dîm Technoleg Iechyd Cymru.

Mae 26 o bobl yn ein tîm gan gynnwys ymchwilwyr gwasanaethau iechyd, economegwyr iechyd, arbenigwyr gwybodaeth, arbenigwyr cyfathrebu, rheolwyr prosiectau a gweinyddwyr. Rydym yn dod o ystod eang o gefndiroedd a setiau sgiliau ac mae gennym brofiad helaeth yn y sectorau cyhoeddus a phreifat. Cefnogir y tîm gan gyfraniadau amhrisiadwy ein haelodau pwyllgor allanol sy'n parhau i sicrhau bod ein gwaith yn diwallu anghenion y sectorau iechyd a gofal yng Nghymru.

Dr Susan Myles
Cyfarwyddwr

Dr David Jarrom
Prif Ymchwilydd, Ymchwil Gwasanaethau Iechyd

Matthew Prettyjohns
Prif Ymchwilydd, Economeg Iechyd

Lisa King
Uwch Reolwr Rhaglen

Nathan Bromham
Uwch Ymchwilydd Gwasanaethau Iechyd

Dr Sian Cousins
Uwch Ymchwilydd Gwasanaethau Iechyd

June Price
Rheolwr Gweithrediadau Busnes

Katie McDermott
Rheolwr Prosiect

Rebecca Boyce
Economegydd Iechyd

Hayley Bennet
Economegydd Iechyd

Ryan Miller
Uwch Economegydd Iechyd

Jessica Williams
Ymchwilydd Gwasanaethau Iechyd

Dr Claire Davis
Ymchwilydd Gwasanaethau Iechyd

Dr Clare England
Ymchwilydd Gwasanaethau Iechyd

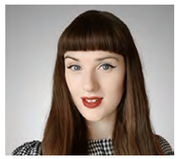
Leona Batten
Ymchwilydd Gwasanaethau Iechyd

Charlotte Bowles
Ymchwilydd Gwasanaethau Iechyd

Antonia Needham-Taylor
Ymchwilydd Gwasanaethau Iechyd

Dr Greg Hammond
Ymchwilydd Gwasanaethau Iechyd

Alice Evans
Rheolwr Cynnwys Cleifion a'r Cyhoedd



Rebecca Shepherd
Rheolwr Cymorth Prosiect

Diana Milne
Rheolwr Cyfathrebu

Elise Hasler
Arbenigwr Gwybodaeth

Jenni Washington
Arbenigwr Gwybodaeth

Mafalda Gordo
Cynorthwyydd Cymorth Busnes a Chyfathrebu

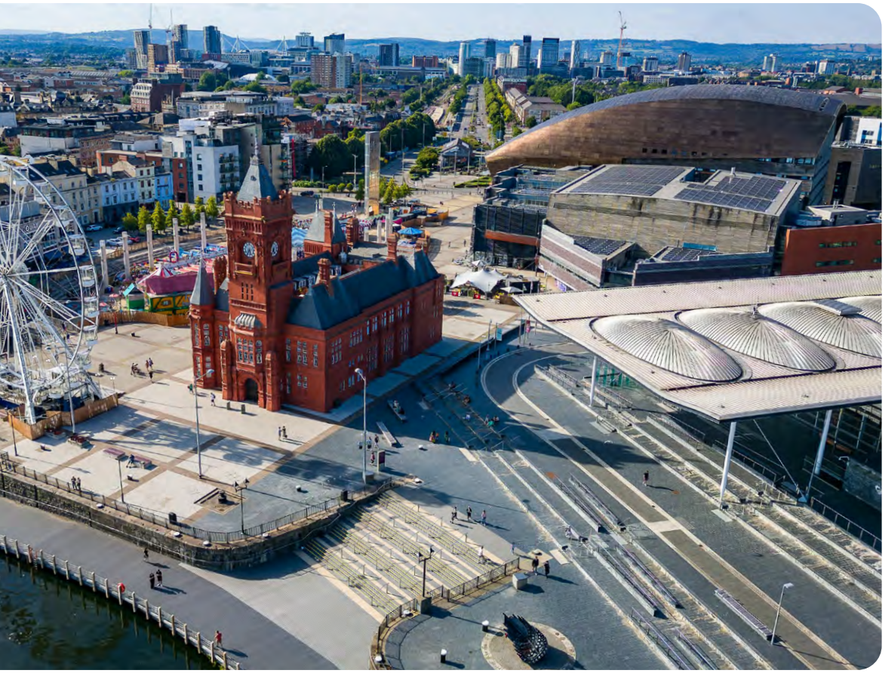
Llinos Jones
Cyfieithydd Cymraeg

Caron Potter
Cynorthwyydd Gweithredol

CYFLAWNI YN ERBYN Y GYLLIDEB

Mae Technoleg Iechyd Cymru wedi cyflawni'n llwyddiannus yn erbyn ei Gynllun Strategol ar gyfer 2021–2025 sy'n nodi ei nodau ac amcanion strategol tymor byr a chanolig.

Dyfarnodd Llywodraeth Cymru £1,517,000 i HTW i ariannu ei waith craidd. Sicrhaodd HTW incwm ychwanegol gwerth £132,426 i ariannu ei waith fel partner cydweithredol i Ganolfan Dystiolaeth Ymchwil Iechyd a Gofal Cymru. Dyfarnwyd £100,000 hefyd i HTW gan Lywodraeth Cymru ar gyfer Gwaith Cynghorol ar Strategaeth Technoleg Feddygol.



Adrodd tanwariant cymedrol hyd yma, oherwydd bod aelod o'r tîm wedi'i secondio. Ar y trywydd cywir i gyflawni o fewn y gyllideb yn ystod 2025/26.

Cefnogi 22.5 o swyddi cyfwerth ag amser llawn a chyfanswm o 26 aelod staff.

Dyrannu ein cyllideb i 88% o gostau staff a 12% o gostau nad ydynt yn gostau staff.

Dyfarniad pum mlynedd wedi'i sicrhau ym mlwyddyn ariannol 2023/24 i weithredu fel cydweithiwr yn y ganolfan dystiolaeth newydd i Gymru.

Wyddoch chi am dechnoleg neu fodel gofal a chymorth ym maes iechyd neu ofal cymdeithasol y gallai HTW ei arfarnu? Gall unrhyw un awgrymu pwnc ar gyfer ei arfarnu. I gymryd rhan, ewch i'n gwefan.

Technoleg Iechyd Cymru
Health Technology Wales

healthtechnology.wales

Technoleg Iechyd Cymru (HTW), Pencadlys Ymddiriedolaeth GIG Prifysgol Felindre, Uned 2 Charnwood Court, Parc Nantgarw, CF15 7QZ, Y Deyrnas Unedig

TRUST BOARD	
NWSSP Fleet Modernisation and Optimisation Programme Programme Business Case	
DATE OF MEETING	27/11/2025
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Choose an item
REPORT PURPOSE	INFORMATION / NOTING
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Tim Knight, Assistant Head of NWSSP Service Improvement, Transformation Management Office
PRESENTED BY	Jonathan Irvine, Director of Procurement, Supply Chain, Logistics, Transport and Laundry Services
APPROVED BY	Non Gwilym, Director of Corporate Governance (Interim)
EXECUTIVE SUMMARY	This Programme Business Case sets out the approach to modernising approximately 40% of the NWSSP Supply Chain Logistics and Transport fleet, with a focus on rightsizing and optimising vehicle use to improve efficiency, sustainability, and service delivery. The programme team seeks approval to proceed with the phased procurement of 124 BEV/ULEV vehicles over five years, at an estimated capital cost of £7.33 million (excluding VAT). To support the continued business justification of the programme, Annual Business Justification Cases (BJCs) will be submitted to secure funding. This allows flexibility to adjust vehicle numbers and capital requirements based on fleet condition and operational priorities. This staged approach will ensure alignment with infrastructure readiness and evolving service needs, and it should be noted that

	charging infrastructure costs are excluded from this case, as they are currently being funded separately through the Welsh Government's Targeted Estates Fund (TEF).
RECOMMENDATION / ACTIONS	The Trust Board is asked to **NOTE** the NWSSP Fleet Modernisation and Optimisation Programme – Programme Business Case prior to annual Business Justification Cases being submitted for approval of related expenditure.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
NWSSP Managing Director/Director of Finance	07/11/2025
Shared Services Partnership Committee	14/11/2025

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS
The Fleet Modernisation and Optimisation Programme Business Case was approved for submission to Welsh Government by the Shared Services Partnership Committee on the 14 November 2025.

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

APPENDICES	
Appendix 1 (Attached)	Fleet Modernisation Programme Business Case – NWSSP – Q3 - 2025

1. SITUATION

The current NWSSP fleet faces a range of challenges that impact service quality, operational efficiency, and long-term sustainability. Ageing vehicles, rising maintenance costs, and evolving regulatory requirements have highlighted the need for a modern, reliable, and environmentally sustainable fleet.

There are currently 306 vehicles within the NWSSP Supply chain logistics and transport fleet, completing over 4 million miles per year. The Vehicles are depreciated over 7 years in line with the Manual for Accounts, however their utilisation varies significantly, with 30 vehicles completing in excess of 30,000 miles last year, whilst there were also 50 vehicles that completed less than 10,000 miles over the same period, representing the opportunity for optimisation.

Additionally, there are currently (as of 16/10/25) 25 Vehicles within the fleet that are 10 years or older and that have been kept in service because they remain operationally fit for purpose.

1. BACKGROUND

The Fleet Modernisation and Optimisation Programme is being established to achieve a 10 year vision through two sequential five-year programmes, and the Programme Business Case in Appendix 1 sets out the delivery of the first of these. To achieve the Programme Vision and also the objectives detailed in the NHS Wales Decarbonisation Strategic Delivery Plan, as of April 2025, NWSSP need to modernise the current fleet through the procurement of replacement vehicles that meet the future modern standard, wherever practicably possible. Therefore, any vehicles procured from this point need to be either Battery Electric Vehicles (BEV) or Ultra-Low Emission Vehicles (ULEV) where possible.

There are additional issues that come with an ageing fleet, and one of which is that all vehicles older than 9 years old may not be compliant with the European Emission's vehicle emissions standard, which regulates the acceptable limits of exhaust emissions from new vehicles. Though not fully compliant, or sustainable, the vehicles can still be driven for as long as they pass the emissions test as part of their MOT and NWSSP as 27 such vehicles that remain in service. Increasing maintenance and fuel costs further still, whilst increasing our carbon footprint.

2. ASSESSMENT

To identify a preferred option, a long list of 28 options were appraised during the development of this Programme Business Case, ranging from maintaining the current fleet to its full modernisation in a condensed time period. The preferred option is to replace all vehicles that are either Beyond Economical Repair (BER),or have reached their replacement profile and have increasing maintenance costs that render their continued service unsustainable. The vehicles will be replaced with either leased (where this cost option is most viable), rented under the Welsh Government Commercial Delivery Framework (WGCD) arrangement for Hire iii/iv framework or owned dependant on operational requirements and they will be replaced gradually through annual tranches.

While the Benefit-Cost Ratio of 0.35 for this option is below the conventional threshold and the Net Public Social Value of -£5,481,232.27 (Discounted) is negative, the programme delivers substantial qualitative and non-cash releasing benefits, including improved air quality, reduced carbon footprint, improved service provision, and enhanced public perception.

This programme directly supports the delivery of the NHS Wales Decarbonisation Strategic Delivery Plan and aligns with the Transportation initiatives 17 to 22. The objectives will also play a part in delivering on Welsh Government's Net Zero Strategic Plan for 2030, and the submission of annual Business Justification Cases will ensure that the realisation of the 10-year vision remains aligned with the wider national priorities.

Additionally, this Programme also aligns to NWSSP's longer term strategic goals, to lead on climate action, invest boldly in transformation, and deliver sustainable, socially responsible services. It contributes to broader public sector objectives, including the Well-being of Future Generations Act (2015), A Healthier Wales, the Duty of Quality, and the Transforming Access to Medicines Programme (TrAMs).

3. SUMMARY OF MATTERS FOR CONSIDERATION

The preferred option to be progressed is to replace all vehicles that are BER or no longer economically sustainable whilst conducting a review of both fleet optimisation and maintenance arrangements, to ensure that the fleet is appropriately rightsized against the operational need and that the servicing arrangements represent value for money.

It should be noted, and emphasised, that the Fleet Modernisation Programme is not solely about replacing ageing, inefficient and non-sustainable vehicles with energy efficient alternatives, it is equally about rightsizing the fleet and optimising operational procedures, ensuring the right vehicle is on the right route, carrying the right load, and only travelling when necessary. By embedding this optimisation into the programme, NWSSP aims to reduce unnecessary mileage, improve vehicle utilisation, and enhance operational resilience whilst reducing the environmental impact of service delivery, and also the associated revenue costs.

Benefits have been captured in a programme Benefits register, and also a benefits realisation map. Additionally, the benefits have been profiled and appraised accordingly and assume that 100% of new vehicles will be BEV. The total potential benefit to be realised from a cash releasing perspective is £3,792,943 prior to the application of optimism bias which can be seen within the Net Public Social Value (NPSV) and Benefits Cost Ratio (BCR) section within the Programme Business Case. These figures have been approved by our finance team and are dependent on the options selected and the number of vehicles replaced.

The total potential benefits of the optimisation alone are not quantified at this point, but this should improve the Benefit Cost Ratio of the programme at no additional cost. The cash releasing elements of the benefits associated with the fleet optimisation come from reduced fuel costs from less milage, and also having fewer vehicles to mobilise, insure and maintain. A five percent reduction in fleet milage and size would deliver estimated annual revenue savings of £105,345 if achieved.

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*	08 - Financial Sustainability and Long Term Value
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☒ Timely ☒ Effective ☒ Equitable ☐ Efficient ☒ Patient Centred ☒
	The efficiency (optimisation) and reliability (modernisation) of the fleet has a direct impact on the quality, safety and operational sustainability and effectiveness of health and care services. Delivering many of the clinical and pathological testing for analysis, essential goods and products needed to allow for the highest standards of care provision to patients in Primary and Unscheduled Care. This modernisation programme improves the efficiency of the existing fleet, reducing the cost per mile, whilst also removing all carbon emissions at the tail pipe for the vehicles being replaced. The new vehicles will reduce vehicle downtime through effective rightsizing and therefore increase operational efficiency, resilience, and timeliness,

	whilst also beginning to align the NWSSP fleet to both the Welsh Government's Net Zero Strategic plan and the NHS Wales Decarbonisation Strategic Delivery plan.
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.*	Yes - Fully completed and signed QIA Enclosed The QIA has been completed within the development of the Programme Business Case, which has been approved by SSPC and the stakeholders present. Details of the programmes alignment to the Duty of Quality are explained under Business Strategy and Aims within the Programme Business Case (Appendix 1).
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Yes Air quality improvements from replacing ICE vehicles with ULEVs/BEVs directly benefit communities in polluted, deprived areas, helping reduce health inequalities, especially respiratory and cardiovascular conditions. This supports better access to health and mental health services by improving the environment in which services are delivered. The programme could create new job opportunities in EV maintenance, infrastructure, and logistics, therefore through inclusive recruitment and training, it supports people from disadvantaged backgrounds to access better employment and career progression. Offers upskilling and retraining for existing NHS staff helping them adapt to new technologies and improve long-term earning potential.
TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT	

The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated. Please indicate whether any of the matters outlined in this report impact the Trust's Wellbeing goals: YES - Select Relevant Goals below	
If yes select the relevant goals: • A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities. ☐ • A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience. ☐ • A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health ☐ • A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances ☐ • A Wales of more Cohesive Communities - Attractive, viable, safe and well-connected communities. ☒ • A Wales of Vibrant Culture and Thriving Welsh Language -Promoting and protecting culture, heritage and the Welsh language, encouraging people to participate in the arts, and sports and recreation. ☐ • A Globally Responsible Wales – Consideration of whether an action may make a positive contribution to global well-being ☒	
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	Source of Funding: Welsh Government Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Capital Funding** **Scale of Change** Please detail the value of revenue and/or capital impact: £7.33m **Type of Change** **Business as Usual Improvement**

	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*	Yes - please outline what, if any, actions were taken as a result
	The EQIIA has been completed and it was fed back that the project team had clearly given careful consideration to the protected characteristics, providing both comprehensive and thoughtful analyses.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

5. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	*[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?	Choose an item
	[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	

NWSSP Fleet Modernisation & Optimisation Programme

PROGRAMME BUSINESS CASE (PBC) - HIGH VALUE (OVER £2 MILLION VALUE OF PROCUREMENT)

Capital Investment/Purchase Request

NWSSP

Supply Chain Logistics and Transport

Programme leads:

SRO:	Tony Chatfield
Programme Manager:	Tim Knight
Finance Business Partner:	Claire Watkins/Jane Tyler
Procurement Lead:	Ian Emptage
Head of Service:	Tony Chatfield
Estates:	Stuart Douglas

Governance Route:

	Name	Signature	Date
Prepared by:	Tim Knight	T Knight	24/10/2025
Reviewed by:	Ian Rose	I Rose	05/11/2024
Approved by:	Programme Board	P Board	24/10/2025
Approved by:	Jonathan Irvine	J Irvine	05/11/2025
Approved by:	Alison Ramsey	A Ramsey	05/11/2025
Approved by:	Neil Frow	N Frow	07/11/2025
Approved by:	Shared Services Partnership Committee	SSPC	14/11/2025
Noted by:	Velindre Trust Board		

Following the submission to Velindre Trust Board for noting, this Programme Business Case was submitted to Welsh Government on the XX/XX/XX to formally request the capital investment outlined.

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Strategic Assessment

The Fleet Modernisation Programme is being established to achieve a 10 year vision through two sequential five year programmes. Delivering outcomes which reduce carbon emissions and annual revenue costs through the adoption of Battery Electric Vehicles (BEV) and Ultra Low Emission Vehicles (ULEV) wherever practicably possible. Alongside vehicle replacement, the programme will fully optimise the fleet, looking to improve maintenance and route planning arrangements, route frequency, load requirements, fleet size and vehicle suitability.

This programme directly supports the delivery of the NHS Wales Decarbonisation Strategic Delivery Plan and aligns with the Transportation initiatives 17 to 22. The objectives will also play a part in delivering on Welsh Government's Net Zero Strategic Plan for 2030, and the submission of annual Business Justification Cases will ensure that the realisation of the 10-year vision remains aligned with the wider national priorities.

This Programme also aligns to NWSSP's longer term strategic goals, to lead on climate action, invest boldly in transformation, and deliver sustainable, socially responsible services. It contributes to broader public sector objectives, including the Well-being of Future Generations Act (2015), A Healthier Wales, the Duty of Quality, and the Transforming Access to Medicines Programme (TrAMs).

Executive Summary

This Programme Business Case sets out the approach to modernising approximately 40% of the NWSSP Supply Chain Logistics and Transport fleet, with a focus on rightsizing and optimising vehicle use to improve efficiency, sustainability, and service delivery. The programme seeks approval to proceed with the phased procurement of 124 BEV/ULEV vehicles over five years, at an estimated capital cost of £7.33 million (excluding VAT).

Annual Business Justification Cases (BJCs) will be submitted to secure funding, allowing flexibility to adjust vehicle numbers and capital requirements based on fleet condition and operational priorities. This staged approach ensures alignment with infrastructure readiness and evolving service needs. Charging infrastructure costs are excluded from this case, as they are currently being funded separately through the Welsh Government's Targeted Estates Fund (TEF).

Strategic Case Summary

There are currently 306 vehicles within the NWSSP Supply chain logistics and transport fleet, completing over 4 million miles per year. Utilisation of the fleet varies significantly, however, representing the opportunity for optimisation. 30 vehicles completed in excess of 30,000 miles last year, whilst over 50 vehicles completed less than 10,000 miles over the same period.

Under NWSSP's current accounting policy, ICE vehicles are to depreciate to a capital asset value of zero over 7 years, and Battery Electric Vehicles (BEV) over 5 years (both on a straight line depreciation), and are then listed for replacement.

NWSSP had previously forecast increased depreciation rates against BEVs due to uncertainties within the emerging market and evolving technologies. That said, the existing BEV vehicles within the fleet are about to reach their 5 year life and continue to perform well, and for that reason the BEV capital depreciation period for the purpose of this programme will be brought to 7 years for new assets in line with the ICE fleet. This adjustment remains in line with Chapter 7 of the manual accounts, which states that vehicles should depreciate over 7 years unless we believe and can evidence otherwise, and has been confirmed with Velindre Trust.

Additionally, there are currently (as of 16/10/25) 25 Vehicles within the fleet that are 10 years or older and that have been kept in service because they remain operationally fit for purpose.

There are risks that come with an ageing fleet, and one of which is that all vehicles older than 9 (27 Vehicles) may not be compliant with the European Emission's vehicle emissions standard, which regulates the acceptable limits of exhaust emissions from new vehicles. A proportion of these will be replaced within year one of the programme, and those that are not can still be driven for as long as they pass the emissions test as part of their MOT.

It should be noted, and emphasized, that the Fleet Modernisation Programme is not solely about replacing ageing, inefficient and non-sustainable vehicles with energy efficient alternatives, it is equally about rightsizing the fleet and optimising operational procedures, ensuring the right vehicle is on the right route, carrying the right load, and only travelling when necessary. By embedding this optimisation into the programme, NWSSP aims to reduce unnecessary mileage, improve vehicle utilisation, and enhance operational resilience whilst reducing the environmental impact of service delivery, and also the associated revenue costs.

Economic Case Summary

A long list of 28 options were appraised, ranging from maintaining the current fleet to its full modernisation in a condensed time period. The preferred option is to replace all vehicles, on an annual basis, and that are either Beyond Economical Repair (BER), or have reached their replacement profile and have increasing maintenance costs that render their continued service unsustainable. The vehicles will be replaced with either leased (where this cost option is most viable), rented under the Welsh Government Commercial Delivery Framework (WGCD) arrangement for Hire iii/iv framework or owned dependant on operational requirements.

While the Benefit-Cost Ratio of 0.35 is below the conventional threshold and the Net Public Social Value of -£5,481,232.27 (Discounted) is negative, the programme delivers substantial qualitative and non-cash releasing benefits, including improved air quality, reduced carbon footprint, and improved service provision enhanced public perception.

The preferred option to be progressed is to replace all vehicles that are BER or no longer economically sustainable whilst conducting a review of both fleet optimisation and maintenance arrangements, to ensure that the fleet is appropriately rightsized against the operational need and that the servicing arrangements represent value for money.

The potential benefits of the optimisation are not quantified at this point, but this should improve the Benefit Cost Ratio of the programme at no additional cost. The cash releasing elements of the benefits associated with the fleet optimisation come from reduced fuel costs from less milage, and also having fewer vehicles to mobilise, insure and maintain. A five percent reduction in fleet milage and size would deliver annual revenue savings of £105,345 if achieved.

Commercial Case Summary

The programme will be delivered through established procurement frameworks, ensuring value for money and market competitiveness. Early engagement with suppliers has confirmed capacity and interest, and commercial risks are manageable within existing contractual structures.

Financial Case Summary

Financial modelling confirms that lifecycle costs are lower than maintaining the existing fleet, with long-term savings in reduced fuel costs and reduced maintenance costs.

Management Case Summary

Robust governance arrangements are in place, with oversight from the Fleet Programme Board and support from NWSSP and relevant stakeholders. Risks have been identified and mitigated through a comprehensive risk management plan. Benefits realisation will be tracked through KPIs including emissions reduction, service uptime, and user satisfaction.

Strategic Case

Organisational Overview

NHS Wales Shared Services Partnership (NWSSP) delivers a wide range of high quality, professional, technical and administrative services to NHS Wales working with wider public services, including Welsh Government.

NWSSP is an integral part of NHS Wales supporting delivery of services to the staff and patients of Health Boards, Trusts and Special Health Authorities in Wales. We also provide a range of services to primary care: GP practices, dentists, opticians and community pharmacies and services to the Citizens Voice Body, Llais, via a service level agreement.

The responsibility of the NWSSP fleet belongs to NHS Wales Supply Chain Logistics and Transport (SCLT), which forms part of the Procurement Services Division within NWSSP.

Within SCLT, the Health Courier Service (HCS) provides a wide range of medical logistics services including support to local communities, health boards and trusts, clinical networks and primary care services. HCS employs 361 people deploying a fleet of some 306 vehicles which transport goods such as pathology material,

blood products, pharmacy supplies (including Medicines Resilience Products), controlled drugs, nuclear medicine and radioactive isotopes, mail, laundry, and medical records covering over 4m miles per year. Additionally, the COVID-19 pandemic saw our distribution increase significantly with over 2.4 billion items of PPE being distributed to unscheduled, Primary and Social Care, and it's noted that future PPE stockholding will rely on a robust transport model to allow future stock rotation to avoid wastage and write off.

The 306 vehicles consist of 40 BEV and 266 ICE, or 198 owned and 108 leased, with an average age of 4 years and an annual maintenance cost of £0.460m. HCS closely monitor their fleet utilisation, mileage undertaken, and fuel spend via their fleet system, covering over a minimum of four million miles per year and costing £1.2m (Inc VAT) in fuel (NWSSP Annual Accounts 24/25).

Electric Miles v Diesel Miles per month – Q1 25/26

	Electric Miles	Diesel Miles	Total Miles
April 2025	22,771	283,596	306,368
May 2025	22,008	335,350	357,358
June 2025	25,592	327,270	352,862

The vehicles are equipped with a fleet system that accurately records C02 output by vehicle registration, allowing HCS to report its carbon footprint. This confirms that we release a minimum of 650 tonnes of CO2 emissions, which would require approximately 29,500 fully established trees to absorb each year based on 250g of CO2 emissions per mile.

Approval of this Programme Business Case will allow for the staged modernisation and optimisation of the existing fleet, replacing conventional Internal Combustion Engine (ICE) vehicles for Electric Vehicles (EVs) or Ultra Low Emissions Vehicles wherever practicably possible, allowing for the continued delivery of services to both clinical and non-clinical front-line services of NHS Wales. This will be done in parallel with a fleet optimisation project, that will form part of this programme's project dossier, and set to ensure the fleet is rightsized against the service need.

Additional cash releasing, non-cash releasing, quantitative and qualitative benefits will also be released through the requested investment. These are to include, but not limited to, sustainability, efficiency, improved value for money and productivity.

To guide the initial scope, support decision making, and set the strategic direction, the following Programme Vision has been developed:

Programme Vision:
To have a fully operational fleet which meets the requirements of the NHS Wales Decarbonisation Strategic Delivery Plan whilst continuing to deliver on the existing

requirements of the health organisations within NHS Wales, including those functions that are internal to NWSSP, and in addition to being able to support the continuously evolving needs of primary, secondary, and community care provision. Therefore, the fleet should consist of Battery Electric Vehicles (BEV) and Ultra Low Emissions Vehicles (ULEV) wherever practicably possible, and will need to be, fully optimised to safeguard value, supported by the necessary infrastructure to allow for consistent service delivery, and maintained in line with industry standards to preserve vehicle longevity.

Business strategy and aims

To achieve the Programme Vision and also the objectives detailed in the NHS Wales Decarbonisation Strategic Delivery Plan, as of April 2025, HCS need to modernise the current fleet through the procurement of replacement vehicles that meet the future modern standard, wherever practicably possible. Any vehicles procured from this point need to be either Battery Electric Vehicles (BEV) or Ultra-Low Emission Vehicles (ULEV) where possible.

To support this, the Fleet Modernisation Programme forms part of the NWSSP Integrated Medium Term Plan 2025-28 (ref: P2501), and it also aligns to the Duty of Quality and NWSSP Strategic Outcomes. The below table highlights two examples of this alignment, and all other examples can be seen in appendix 1:

Table 1: NWSSP Strategic Outcomes and Duty of Quality (DoQ)

NWSSP Outcomes	Relatable DoQ Domains and Enablers	Fleet Modernisation Approach & Activity
Our Value - We will lead the way and command of others the changes required to address the climate change emergency and achieve decarbonisation targets	1 – Leadership 2 – Safe 6 – Effective 11 – Whole Systems Approach	Optimisation of the fleet will demonstrate our commitment continuous improvement from a sustainability perspective. A Fleet Replacement Profiling process has been developed to ensure vehicles are appropriately replaced with BEVs and ULEVs only.
Our Value - We will make bold investment decisions that drive transformation and add value	1 – Leadership 4 – Timely 7 – Information 11 – Whole Systems Approach	Optimisation of the fleet will drive efficiency centred transformation through improved route planning and reduced vehicle miles. The development of the Fleet Replacement Profiling enables considers investment into transformation of the current fleet, improving value for money and vehicle longevity.

Additionally, the business case will contribute to the delivery of the following All Wales Capital Planning Investment Objectives:

Table 2: Fit with All Wales Capital Planning (AWCP) Objectives

Fit with investment AWCP objectives	
Objective	Response
Objective 1: Ensure quality, safety and operational sustainability of health and care services, prioritising areas with the greatest health and care needs, reducing inequalities to facilitate high standards of care.	The efficiency (optimisation) and reliability (modernisation) of the fleet has a direct impact on the quality, safety and operational sustainability of health and care services. Delivering many of the clinical and pathological testing for analysis, essential goods and products needed to allow for the highest standards of care provision to patients in Primary and Unscheduled Care.
Objective two Support the shift in focus towards prevention by providing more integrated services, in convenient and accessible settings for the population to take more responsibility for their own health & wellbeing.	A fit for purpose, right sized and optimised fleet, will be ready to support this shift in focus. Utilising the newly procured vehicles to deliver the essential goods required for effective service delivery to the convenient and accessible locations suggested.
Objective three Transform services through innovation, technology, and improved ways of working, to delivery more efficient processes to support resilience, improved experiences, and outcomes.	The telematics, Quartix, fitted into the vehicles, working alongside our fleet system FleetCheck and logistics scheduling system Cleric will allow for the smarter delivery of services, enabling HCS to make data lead decisions that support streamlined service delivery and fleet optimisation, bridging potential gaps in the supply chain and improving outcomes for both care providers and patients.
Objective four Deliver value for money by increasing the efficiency and quality of the estate, while improving the effectiveness of services for the population and workforce, targeting investment in long term priorities, aligning to environmental strategies, whilst minimising nugatory spend.	This modernisation programme improves the efficiency of the existing fleet, reducing the cost per mile, whilst also removing all carbon emissions at the tail pipe for the vehicles being replaced. The new vehicles will reduce vehicle downtime through effective rightsizing and therefore increase operational efficiency and resilience, whilst also beginning to align the NWSSP fleet to both the Welsh Government's Net Zero Strategic plan and the NHS Wales Decarbonisation Strategic Delivery plan.

Alignment with Programmes and Projects within the strategic portfolio.

To maximise value and ensure coherence with broader organisational objectives, it is important to consider how this programme aligns with other ongoing and planned initiatives. The following table highlights relevant programmes and projects within the strategic portfolio, demonstrating areas of synergy, potential collaboration, and opportunities to leverage existing resources and expertise.

Table 3: Alignment with Programmes and Projects within strategic portfolio

Project/Programme/Initiative	Alignment	Benefit
TrAMs/Radio Pharmacy	Clinical Safety and patient care	Improved fulfilment
Targeted Estates Fund	Supports Infrastructure Development	Enables Charging
Homecare Medicines/Radio Pharmacy	Clinical Safety and patient care	Reduced Hospital Visits, Improved Fulfilment
PPE Preparedness Programme and Clinical Countermeasures	Supporting the reaction planning and emergency preparedness.	Increased state of readiness.
NWSSP Accommodation Strategy	Operational efficiency	Fleet Optimisation
Continued development of National Distribution Centre	Logistics Optimisation and cost efficiency	Centralised distribution and improved resilience
IMTP* Dependant on annual planning process.	Strategic Planning	Delivery of strategic outcomes
Laundry	Consistent service delivery	Infection Control, Patient Care

Other relevant strategies

Additionally, the fleet replacement programme also aligns with the: Ministerial group on accountability, ministerial advisory group on performance and productivity, Duty of candour, A Healthier Wales, NHS Wales planning framework 25-28, improving Performance Together.

It should also be noted that any ICE based vehicles procured to replace the existing fleet must meet the European Emission's vehicle emissions standard, which regulates the acceptable limits of exhaust emissions from new vehicles. There are two standards within this, and they are Euro 5 and Euro 6 and further details can be seen within the Business Needs section below.

In summary, the awareness of, and alignment of the programme with, overarching national and organisational priorities ensures a clear strategic direction and maximises the potential for successful delivery. The above demonstrates that the programme aligns strongly with these priorities and this knowledge provides a solid foundation for the subsequent appraisal of options, supporting informed decision-making throughout the business case process.

The Case for Change

The current fleet faces a range of challenges that impact service quality, operational efficiency, and long-term sustainability. Ageing vehicles, rising maintenance costs, and the noted evolving regulatory requirements have highlighted the need for a modern, reliable, and environmentally sustainable fleet.

The modernisation and optimisation of the fleet are both essential activities that must take place to ensure that the fleet can continue to meet service demands, whilst supporting organisational and national objectives, and delivering value for money.

To support this, and safeguard the delivery of the programme vision and desired outcomes, the following section sets out the key spending objectives of the programme.

Spending objectives

Table 4: The programmes spending objectives align to the following drivers for intervention.

Driver	Spending Objective
Effectiveness	SO1: To improve the quality of public services by delivering better social outcomes through reduced NHS Wales carbon emissions and investment in BEV and ULEV technology.
Efficiency	SO2: To become a more efficient and data-driven service provider by optimising fleet usage, and ensuring the right vehicle is on the right route with the right load, supported by enhanced telematics and route planning systems to determine the appropriate fleet size.
Efficiency	SO3: To improve service delivery and operational resilience by investing in modern, fit-for-purpose vehicles that reduce downtime, improve reliability, and lower annual revenue costs (to include fuel and maintenance).
Economy	SO4: To improve the use of government funding by spending on innovative technologies, reducing annual fuel and maintenance costs.
Economy	SO5: To reduce the cost of public services by installing and expanding charging infrastructure that enables the transition to BEVs and supports future fleet growth.
Economy	SO6: To ensure equitable access to fleet resources across Wales and stimulate local economic growth through regional vehicle conversion, maintenance, and support services.
Compliance	SO7: To meet statutory, regulatory or organisational requirements and accepted best practice such as health and safety legislation, UKAS, Good Distribution Practice standards, Welsh Government's Net Zero Strategic Plan and NHS Wales Decarbonisation Strategic Delivery Plan.

Replacement	SO8: To safeguard business continuity through the re-procurement of up to 300 BEV or ULEV vehicles (leased or owned), aligned to an optimised fleet profile that reflects service demand, vehicle condition, and operational efficiency.

Existing arrangements

Prior to its transfer to NWSSP in 2015, HCS was originally part of the then Welsh Ambulance Services Trust (WAST) Fleet Strategy (1998-2015). This aimed to ensure that the fleet was as modern, efficient, reliable and effective as possible whilst maximising asset life cycles without incurring excessive maintenance and running costs due to vehicle age.

Since its transfer, HCS has benefitted from Welsh Government capital funding for the continued replacement of fleet vehicles. In addition, capital funding has been provided to allow for the purchase of Electrical Vehicle (EV) fleet, and additional vehicles, typically from year end capital slippage, on an ad hoc basis, and which has been identified from other NHS Wales capital programmes funded by Welsh Government.

Currently HCS, within Supply Chain and Logistics & Transport, operates a fleet of 306 vehicles, consisting of 198 owned and 108 leased/long term rental. The fleet comprises of a range of vehicles including:

Table 5: Types of vehicles in the current fleet

Vehicle Type	Number of vehicles
Standard Van – Small/Medium/Large	224
Emergency Rapid Response Vehicles (Blue Light capable)	12
HGV – 7.5t and over	25
Other Vehicles	45
Total	306

Since 2021 HCS have also seen an introduction of Electric Fleet, to include Medium Wheelbase Vans. There are currently 40 BEVs (13%) within the fleet and an additional 6 Plug-in Hybrid Electric Vehicles ((PHEV)2%), which represent 15% of the fleet combined and are Medium Wheel Base (MWB) vehicles. These Vehicles, and the required charging infrastructure, are procured using Welsh Government capital funding.

It should be noted that the move to Long Wheel Base (LWB) BEVs has been more challenging due to manufacturer availability and issues with chassis weight.

The table below indicates the recent profile of vehicle purchases and shows the variance in numbers of vehicles purchased in previous years.

Table 6: Recent years profile of vehicle purchases

Vehicle Type	2020/21	2021/22	2022/23	2023/24	2024/25	Total

MWB*	3	8	0	0	0	11
LWB*	10	3	0	0	0	13
Luton	4	1	0	0	0	5
HGV*	1	0	0	0	0	1
Blue Light	1	5	0	0	0	6
EV/Hybrid	6	22	0	0	17	45
Specialist	0	0	3	3	2	8
Total	25	39	3	3	19	89

*M/LWB = Medium/Long Wheel Base HGV = Heavy Goods Vehicle.

To enable the use of Battery Electric Vehicles (BEVs), and their further integration into service delivery, NWSSP have installed 38 Twin chargers (76 spaces) across NWSSP sites in Wales. These were procured in phases, with the contract being awarded to Pod Point for most of the chargers. The Pod Point EV chargers are provided with the accompanying software that records all usage data, which aids with managing the fleet locations and will support with fleet optimisation. In addition to Pod Point, several chargers installed at IP5 Newport were procured through a separate supplier, Intelligent Charging Systems (ICS) and a breakdown of charging availability at each NWSSP site can be seen below:

Table 7: Number of EV chargers and parking bays

Site	Units	7Kw Bays	22Kw Bays	Total Bays
ALDER HOUSE	2	4	0	4
BRIDGEND STORES	2	4	0	4
CHARNWOOD COURT	1	2	0	2
CWMBRAN & BRECON HOUSE	3	6	0	6
DENBIGH STORES	2	4	0	4
IP5 NEWPORT	16	20	12	32
MATRIX HOUSE	4	6	0	6
PICKETSTON	2	4	0	4
WESTPOINT	4	8	0	8
Grand Total	**36**	**58**	**12**	**70**

In addition to this, NWSSP are planning to install 28 additional bays at Matrix House prior to the end of the 2025-26 financial year.

Table 8: Planned number of EV chargers and parking bays

Site	Units	7Kw Bays	22Kw Bays	Total Bays
Matrix House Planned	8	12	2	14

On the basis that the planned installation within Matrix House goes ahead, then HCS will have 84 charging bays available for overnight charging of the fleet, and across all NWSSP sites. Though in some cases, their utilisation will not always be possible dependant on the charger location and its distance from the vehicle's existing base. Efforts will be made to rectify this through the programme's delivery, and relevant cost implications, such as through the changing of employee base locations, will be factored into the appropriate risk costings.

Considering the current BEV vehicles located at each of the sites, NWSSP HCS have capacity for an additional 30 BEV within their fleet, in terms of charging spaces, and prior to the additional 14 spaces being installed in Matrix House at the end of 25/26.

Table 9: Existing BEVs and total bays available

Site	Total Bays	Existing BEVs	Total Bays Available
ALDER HOUSE	4	4	0
BRIDGEND STORES	4	4	0
CHARNWOOD COURT	2	0	2
CWMBRAN & BRECON HOUSE	6	8	-2
DENBIGH STORES	4	3	1
IP5 Newport	32	5	27
MATRIX HOUSE	6	2	4
PICKETSTON	4	0	4
SAMLET ROAD*	5	5	-5
WESTPOINT	8	9	-1
Grand Total	**70**	**35**	**30**

*NWSSP will be coming out of Samlet Road in March 2026, so the available bays are shown as a negative figure to account for those vehicles being reintegrated into other sites.

As the programme progresses, additional charging infrastructure will need to be procured using Welsh Government capital funding, to allow for the continued adoption of BEVs. This will be initially, and potentially longer term, funded through the Targeted Estates Fund (TEF), or other potential alternatives. At the point that either TEF or any alternatives are not available, the Fleet Modernisation Programme will raise separate projects to deliver this within its dossier.

Maintenance Arrangements

HCS operates a Planned Preventative Maintenance (PPM) scheme, reflective of that of WAST, where every vehicle dependant on role type undergoes a safety inspection at a set number of days. Where vehicles are not under warranty, maintenance itself is provided through WAST, at an average cost of £2,023 per Internal Combustion Engine (ICE) vehicle or £974 per BEV.

The benefits of this planned preventative maintenance approach are that:

- Workshop loading can be planned enabling resources to be matched to workload
- Operational managers have advance notice of vehicle extraction
- All aspects of vehicle and equipment maintenance can be co-ordinated reducing the number of times fleet recalls a vehicle
- Improved efficiencies and less downtime
- Reduced cost through protracted servicing intervals
- Reduced unplanned maintenance and improved reliability.

Telematics and Fleet Management

Additionally, HCS utilise an Asset/Fleet Management System (FleetCheck) and vehicle telematics System (Quartix) to monitor the lifecycle and utilisation of the entire fleet. It incorporates all fixed costs and variable operating expenses, as well as details of vehicle age, mileage, service history, compliance, incidents/accidents and Co2 output. This data is updated monthly, to allow annual reporting into EFPMS, as expected under Welsh Government Decarbonisation Initiative 18. This annual information will be essential when reviewing fleet optimisation.

Depreciation and Fleet Replacement Profile Review.

Once procured, and as per our current accounting policy, there is a straight-line depreciation over the vehicles useful economic life, which is 5 years for BEV and 7 years for ICE vehicles. These time periods set the vehicle replacement profile, and following which, the vehicle can be listed for replacement.

The fleet modernisation programme intends to explore this fleet replacement profile model to see where it can be improved and extended, further demonstrating the commitment of HCS and NWSSP to offer value for money. The current BEVs within the fleet are approaching 5 years in age, and are still very much operational. This suggests that we should move the replacement profile of BEV to 7 years, in line with ICE, maximising potential value, and the benefits and risks within the programme business case will be costed on that basis.

Business needs – current and future

For NWSSP to operate effectively it must have a fleet capable of delivering a high-quality and reliable service. The fleet must support the service in their work by providing a fit for purpose environment for the workforce and associated transport requirements.

To be compliant with the NHS Wales Decarbonisation Strategic Delivery Plan, as of April 2025, HCS need to modernise the current fleet through the procurement of replacement vehicles that meet the future modern standard of primarily Battery Electric Vehicles (BEV) and where that is not possible Ultra-Low Emission Vehicles (ULEV) as a minimum, wherever practicably possible.

Additionally, any ICE based vehicles procured to replace the existing fleet must meet the European Emission's vehicle emissions standard, which regulates the acceptable limits of exhaust emissions from new vehicles. There are two standards within this, and they are Euro 5 and Euro 6. Euro 5 focused on reducing carbon dioxide (CO2) emissions, while Euro 6 primarily targets nitrogen oxide (NOx) emissions, particularly for diesel vehicles. Euro 6 compliance is now a mandatory requirement when purchasing ICE vehicles only, and one that is mitigated when procuring BEV and ULEV. This standard was established to regulate the levels of pollutants from vehicles, reduce air pollution and mitigate climate change. For a vehicle to be Euro 6 compliant, diesel vehicles must not emit more than 0.08g/km of NOx while petrol should not exceed 0.06g/km, as of September 2015.

NWSSP currently (as of October 2025) have twenty-seven vehicles older than 2016 that are not Euro5 standard, these vehicles can continue to be used so long as they continue to pass their MOT emissions analysis. Of these twenty-five vehicles, eight remain fit for purpose, six are classed as Beyond Economical Repair (BER) and the remaining eleven required £47,243.22 in maintenance costs last year. Therefore, those vehicles that are either BER or have increased maintenance costs are being suggested for replacement as part of the year one Business Justification Case, which has already been submitted to Welsh Government (Aug 2025).

The fleet is rightsized above requirements, prior to optimisation, with vehicle rotation used to allow for routine maintenance and servicing to be completed without impacting service delivery. There is a limited percentage of spare fleet however, and where vehicles are BER, this has an impact on operational resilience and efficiency, reducing our ability to provide consistent fulfilment and increasing the required milage of the remainder of the fleet.

Looking ahead, NWSSP must operate a fleet that is not only low on emissions, but also fully optimised, right sized, and capable of supporting the evolving needs of NHS Wales. This includes ensuring that the right vehicle is on the right route, carrying the right load, and only travelling when necessary, maximising efficiency while safeguarding service continuity.

The future fleet must be agile, scalable, and supported by robust digital infrastructure, including telematics, predictive maintenance, and intelligent scheduling. These capabilities will enable data-led decision making, improve vehicle utilisation, and reduce unnecessary mileage, but care must be taken not to replace the existing fleet vehicles while they remain fit for purpose. To support this a fleet replacement profile* (Appendix 2) has been developed, which ensures that only vehicles that are no longer fit for purpose or Beyond Economical Repair (BER) are being replaced.

Additionally, as models of care continue to shift, and demand for responsive, reliable logistics increases, the fleet must be positioned to support decentralised services, community-based care, and time-critical deliveries. This will require a modern, resilient fleet that is environmentally compliant, operationally efficient, and aligned to the wider strategic goals of NHS Wales and Welsh Government.

** The replacement profiling process can assess both ICE and BEV, considering vehicle age, Net Book Value, mileage, annual maintenance costs, the internal condition assessment score, and the expected emissions standard, with BEVs including a battery health assessment to ensure that it is above 80%.*

Scope and service requirements

To address the identified service gaps and support the continuum of need, from core (essential) requirements to desirable and optional enhancements, the programme will focus on the following outputs and key activities:

In Scope:

- NWSSP Supply Chain Logistics and Transport Fleet: The programme is limited to the modernisation of the NWSSP logistics and transport fleet.
- Procurement of New Vehicles: Acquisition of vehicles that meet current and future operational requirements, including BEV/ILEV and Leased or Owned as appropriate.
- Decommissioning of Old Fleet Vehicles: Safe and efficient removal of outdated vehicles from NWSSP service.
- Infrastructure Development for BEV Adoption: Implementation of the necessary infrastructure (such as charging stations) to support the transition to BEV and other potentially emerging technologies.
- Fleet Optimisation Review: Comprehensive assessment of vehicle location, utilisation, routing, load, capacity, and suitability, with recommendations for improvement and optimum fleet size (further detail on Page 29).
- Maintenance Arrangements Review: Evaluation and potential enhancement of maintenance contracts, including renegotiation with existing providers or consideration of bringing maintenance in-house.
- Staff Training: Delivery of targeted training to ensure staff are equipped to operate and maintain new fleet technologies and processes.

These activities are designed to ensure the project delivers essential improvements, supports organisational objectives, and provides flexibility to adapt to future needs.

Out of Scope

The following areas are excluded from this programme:

- Fleet vehicles belonging to other health organisations: Only the NWSSP Supply Chain Logistics and Transport fleet is included; vehicles managed by other health organisations are not within scope.
- Non-fleet related infrastructure (e.g. Telematics devices, Moving & Handling Equipment): The programme will not address infrastructure outside of fleet operations, operational requirements, or vehicle maintenance needs.
- Heavy Goods Vehicles (HGVs) in Programme 1 (Years 1–5): HGVs are excluded from the initial phase of the programme and will be considered separately in future phases.

By clearly defining what is in and out of scope, the programme can ensure a focused approach to addressing the service gaps and operational needs, enabling targeted investment and resource allocation, setting the foundation for delivering tangible and demonstrable improvements. The following section outlines the main benefits expected from the fleet modernisation programme and how these will support both organisational objectives and service users.

Main Benefits

The main benefits associated to the spending objectives will start to be released from the time that the first vehicle becomes operational, which would likely be in March 2026 pending approval of the previously submitted BJC. In most cases

these will continue to compound for the lifetime of the vehicle and the main benefits are as follows:

Table 10: Main Programme benefits

Benefit	Benefit Class	To realise?	Beneficiary
B1	Quantifiable	To achieve a reduction in emissions of approximately 250g per mile per BEV, from 31 March 2026. Offsetting 310 tonnes per year when all 124 vehicles are operational (14,100 mature trees)	Welsh Population
B5	Cash Releasing	To reduce fuel costs by approximately £3321 per ICE vehicle replaced with BEV.	NWSSP – HCS
B6	Cash Releasing	To reduce annual maintenance costs by £1049 per ICE vehicle replaced with BEV.	NWSSP – HCS

The Programme team have profiled each of the identified benefits accordingly and the profile cards for both B1 and B5 can be seen in appendix 3, demonstrating the largest part of the potential benefits realisation.

While the Programme is expected to deliver significant benefits, it is also important to recognise and address potential risk, safeguarding the successful delivery. The following section outlines the main risks associated with the Fleet Modernisation Programme, and also some potential contingencies to move them to a residual state.

Main Risks

Table 11: Main Programme risks

Risk Category	Risk Description	Risk Rating	Contingency
Vehicle Replacement	Capital requirements not supported	High	Reduced vehicle replacement – this will impact the vehicle efficiency and reliability due to increased downtime and maintenance costs. Compromising service delivery. This risks the decarbonisation strategy as being undeliverable.
	Market Forces mean suitable chassis or vehicle types are not available, whether it be through market development or	High	Review options to rotate fleet to optimise vehicle usage and allocate BEV/ULEV to maximise reductions in carbon emissions while the market catches up.

Risk Category	Risk Description	Risk Rating	Contingency
	worldwide supply chain issues		
	Crown Commercial Discounts changes, or conversion costs increase adjusting indicative costing.	High	Explore alternative suppliers or reduce number of vehicles procured within guidelines.
Infrastructure	Fluctuation/increased energy prices.	Medium	Utilise NWSSP site energy where possible or accept.
	Electricity outage preventing charging on site.	Medium	Drivers carry fuel cards to be able to use external chargers.
Workforce	Organisational Change Plan (OCP) Costs to transfer staff bases	Medium	Due to the replacement of vehicles, a cost may emerge to OCP staff to alternate bases. This may result in contract changes, base changes for the staff and re-scheduling. There is a risk that the funding required is higher than anticipated resulting in insufficient funding.

In addition to the risks identified, it is important to recognise the constraints that may influence the programme's delivery and outcomes.

Constraints

Constraints are the fixed limitations or requirements that the programme must operate within. The following section outlines the key constraints that must be managed to ensure the programme remains on track:

Infrastructure Constraints

- The adoption of BEV across the fleet will be constrained by the organisational and relevant site charging capacities. We are not looking to procure BEV vehicles where there is not existing charging infrastructure within our estate.
- There is a limit to the amount of charging bays available under the current building supply arrangements, any additional bays would

require upgrade works and additional costs through the Electricity Distribution Network Operator.
- Reliance on access to other NHS Partner infrastructure may be limited, as their fleet will be reliant on its use, and it may not always be available.
- Where we would revert to using external commercial charging infrastructure, this will come at an increased revenue cost in comparison to using internal charging infrastructure.

Vehicle and Technology
- Lead time for vehicle supply will be a potential constraint on this programme and we will need to be mindful of this through the annual process.
- Vehicle Range – Vehicles will have a maximum range and we need to consider this through the procurement process and understand the requirements once operational.
- Vehicle technology may not be able to meet the functional requirements, in that they should be "non-smart" and have the capability to stop charging when full to prevent battery depreciation if left on overnight.
- Load capacity (potentially towing) – The vehicles procured will need to have enough load capacity to support the fleet optimisation initiatives that sit within this programme.
- Charging compatibility – Vehicles will need to be compatible with already installed charging infrastructure.

Finance and capital planning –
- Annual Business Justification Case being rejected and capital request not being authorised.
- Timing of annual Business Justification Case Approval by Welsh Government and the release of requested capital.

People and capabilities
- BEV Training will need to be completed by relevant drivers, to include charging requirements and Range confidence sessions.
- BEV training will need to be completed by those that are asked to maintain the fleet, currently WAST, though this is to be reviewed through the programme.
- Route planners, Fleet Managers and schedules need a more in depth approach to BEV technology, to understand load capacity and the impact on range.

Policy and regulatory
- The NHS Wales Strategic Delivery plan mandates that all new medium and large freight vehicles procured after April 2025 must be BEV or ULEV, acting as a constraint particularly in the large vehicle space due to availability and cost.
- Local planning considerations need to be considered for infrastructure development on NWSSP sites.
- Procurement regulations and policy must be followed to ensure compliance.

- Resource across the programme and project delivery teams could compromise the programme team's ability to meet milestones on time.

Operational and strategic

- Operational constraints due to current estate capability to handle future BEV infrastructure, which may require changes to driver bases, shift patterns, and daily routes in line with optimisation.
- The approach to asset management and telematics analysis to support operational planning may need to change.
- Strategic constraints come from the ability to align the programme to broader goals, the approach to change management, and interdependencies with other organisations and their available infrastructure, capacity from grid via DNO's and risks that some sites may need cross checking against local Town Planning/Development areas for consent to change.

Alongside the constraints, it is also important to consider the key dependencies that could influence the programme's success.

Dependencies

Dependencies are the external and internal factors that must be in place or delivered by others to enable successful programme delivery. The following section outlines the key dependencies that must be managed to ensure the programme progresses as planned

Infrastructure Dependencies

- Charging infrastructure – We are dependent on the planned delivery of charging infrastructure to Matrix House which is being funded through Targeted Estates Fund. Charging Infrastructure projects would fall within the programme should they be required and at times that they are not delivered through the targeted estates fund.
- Energy supply and management – we are dependent on the future energy supply upgrades being installed where possible.
- Layout Planning and site/organisational readiness – The sites proposed to support BEV adoption need to have the required space to support overnight and potentially daytime charging, considering locality to buildings and structures from a fire prevention perspective.

Operational Dependencies

- Fleet Optimisation – The fleet optimisation project is essential to ensure the programme delivers maximum value for money, making the best use of the existing and new vehicles.
- Vehicle availability and lead times – vehicles need to be delivered in enough time for the retrofit work to take place prior to be made operational before the end of that financial year to remove any risk of vesting.
- Retrofit availability and lead times. Retrofit need to be completed in enough time for vehicles to become operational before the end of that financial year.
- Vehicle suitability (Range and load requirements) – procured vehicle need to have sufficient range under maximum load to deliver on the

intended routes, with potential range reductions forecasted into the vehicle profile.
- Maintenance and servicing Arrangements (who, where, what, why how, and can they?) −The programme needs to ensure sufficient maintenance structures are in place to safeguard operational resilience, the longevity of the fleet, and the representation of value for money.

People and Capabilities

- Upskilling workforce − We are dependant that training is delivered prior to the new fleet becoming operational.
- License Suitability − We are dependent on the drivers having the suitable license to drive new vehicles, especially where adjustments are made to suit capacity.
- Change management and cultural buy in acts a prerequisite for the successful implementation of the programme.

Strategic Alignment

- Alignment to NWSSP Strategic goals and delivery of the NWSSP Strategic Outcomes.
- Stakeholder engagement with relevant boards and bodies, to include Shared Services Partnership Committee, NWSSP Senior Leadership Group and the local partnership forum.
- Trade Union Partnerships and people side consultancy and continued involvement.

Finance

- Accurate costing model, to include cost breakdown against vehicles and conversion costs, infrastructure where required.
- Approval of the annual business justification Cases and requests for capital within each financial year.
- The timely delivery of approved capital to allow for procurement and conversion prior to the relevant years end.

In summary, the Strategic Case has demonstrated a clear case for change, and one that aligns with organisational objectives. It has also set out the key factors for successful delivery, such as spending objectives, risks, constraints and dependencies.

Economic Case

The Economic Case sets out the rationale for investment in the modernisation of the HCS fleet, demonstrating that the proposed approach delivers the best value for money in terms of costs, benefits, and wider impacts, whilst considering the related risks which could impact the cost of delivery and overall benefits realisation.

It evaluates the available options for transitioning from ICE vehicles to BEV and ULEV, owned or leased, and assesses the different options and their impact against the spending objectives, critical success factors, and options framework, through a comparative analysis.

The preferred option will be justified through a robust appraisal of economic efficiency, considering whole life costs, benefits realisation, risk costings, and the

potential for reinvestment of realised benefits. The case will also demonstrate the Net Social Public Value (NSPV) and Benefit Cost Ratio (BCR), at discounted and undiscounted rates, and accounting for optimism bias, to support our commitment to informed decision-making throughout the programme lifecycle.

The options with the two highest Benefits Cost Ratios will also be costed separately with both owned and leased vehicles as an option for procurement, ensuring the option represents the best value for money possible.

Additionally, fleet optimisation and maintenance reviews will take place against all options, and initial expectations are that there will be no costs associated with these. The fleet optimisation benefits are not included in the Net Public Social Value or Benefit Cost Analysis for this reason, and if needs be these activities could be completed prior to the procurement of any vehicles.

Critical success factors (CSFs)

To support the delivery of the Programme, this section outlines the critical success factors essential to the programme's success. These include strategic alignment, stakeholder engagement, Roles and Responsibilities, and the ability to deliver economic sustainability.

Identifying and managing these factors will help ensure the programme achieves its intended outcomes and delivers long-term value.

Table 12: Critical Success Factors

Critical Success Factors	Broad Description
CSF 1 - Strategic Fit and Business Need	There needs to be a clear strategic vision to in place to act as a motivator for delivery and a bearing for programme direction. This vision needs to provide a holistic fit and synergy with other relevant strategies, programmes and projects.
CSF 2 – Planning and Delivery	Well-constructed plans need to be developed to safeguard programme delivery and benefits realisation. Timelines to delivery should be fully utilised to help articulate progress and the adoption of RAG statuses should be used to highlight progress against defined tolerances.
CSF 3 – Roles and Responsibilities	Clearly defined Roles and Responsibilities need to be defined to ensure that everyone knows what is expected of them. Assurances need to be sought around confirmation of understanding and a mechanism to delegate/share responsibilities should be built in where possible.
CSF 4 – Economic Sustainability	To ensure that Economic Sustainability is considered within all decisions made, to include, but not limited to: Value for Money, Whole life Cost, Resource Utilisation, Service Continuity, Fleet Optimisation and having a consistent and robust approach to vehicle replacement.

CSF 5 - Value for Money	The procurement process must be followed when acquiring new vehicles and the market comprehensively tested to ensure that the vehicles that are either purchased or leased represent value for money, both to NWSSP and the Welsh Public.
CSF 6 – Stakeholder Engagement	Communication to all impacted stakeholders should be prioritised and transparency should be given once key decisions have been made. The adoption of a robust communications plan is key to this delivery, together with the support of the Business Change Manager.
CSF 7 – Proactive Risk and Issue Management	In order to minimise interruptions to service delivery, or missing key delivery dates and milestones, it is essential that the Risk and Issues Management Approach are adhered to and that all involved stakeholders recognise their roles and responsibilities within this, responding promptly.
CSF 8 – Charging Infrastructure / Infrastructure readiness	The Charging Infrastructure must be available prior to new BEV vehicles going operational, and ideally prior to the procurement process starting. The charging infrastructure needs to be accessible, tested and reliable.
CSF 9 – Data and Telematics	Available data and telematics must be used to fully understand the "as is" prior to being used to support fleet optimisation, ensuring that the right vehicles are on the right routes at the right time whilst carrying the most appropriate load, weight and quantity of goods.
CSF 10 – Operational Adoption / Readiness	All vehicles need to match to the operational need against relevant routes, considering range and load prior to going operational, and enabling their integration with minimal disruption. Cost effective Maintenance arrangements need to be in place prior to the vehicles becoming operational.
CSF 11 – Operational Resilience	Decisions regarding fleet replacement and optimisation should be centred around business continuity and operational resilience in the first instance, considering the avoidance of supply chain interruptions and routine maintenance arrangements within this.

Building on these Critical Success Factors, a long list of options was developed to explore different ways the programme could achieve its intended outcomes.

Long listed Options

The long list generated consisted of the following 28 options which varied across speed of adoption, type of vehicle to be utilised, and whether the vehicles are owned, leased or a mix of both.

In addition to the approach used to replace the fleet vehicles, all options include the Fleet Optimisation Review and also the complete review of the maintenance

arrangements within their dossiers. These additional aspects will be outlined in more detail following the identification of the shortlist.

The initial longlist can be seen in appendix 4.

While other options were considered for inclusion in the long list, those selected were judged to best meet the critical success factors. They also offer a balanced approach to the phased modernisation of the fleet, considering key constraints and dependencies, such as charging infrastructure and capital requirements.

A SWOT (Strengths, Weaknesses, Opportunities, and Threats) analysis was completed for each of the 28 options.

SWOT Analysis

The SWOT analysis for each option included advantages, recorded against the Strengths and Opportunities, and a review of the disadvantages, recorded against the Weaknesses and Threats. Following this, a conclusion on how well the option meets the agreed Spending Objectives and CSFs was created, and Full details are documented within the project files and are available on request.

Table 13: Long List SWOT analysis (Appendix 5)

					Strengths	Weaknesses	Opportunities	Threats	Conclusion
		Potential Scopes	Option	Description	Advantages	Disadvantages	Advantages	Disadvantages	Against SO's and CFS's
)ption 1	1	Do Nothing	Do Nothing	Retain all ICE v	No Capital Requireme	Increased Revenue Cos	Could reinvest cap	Vahicles could car	This option does not meet
)ption 2	2	Do Minimum 1	Only replace	Retain all ICE v	Minimal Annual Capit	Increased Revenue Cos	To reinvest capital	Vahicles could car	This option fails to meet S
)ption 3	3	Do Minimum 2	Only replace	Retain all ICE v	Minimal Annual Rever	Increased Revenue Cos	To reinvest capital	Vahicles could car	This option fails to meet S
)ption 4	4	Do Minimum 3	Only replace	Retain all ICE v	Minimal Annual Rever	Increased Revenue Cos	To reinvest capital	Vahicles could car	This option fails to meet S
)ption 5	5	Do Minimum 4	Only replace	Keep serviceab	Allows the fleet ot be r	Initially Increased Reve	To reinvest capital	Vahicles could car	This option fails to meet S
)ption 6	6	Do Minimum 5	Only replace	Keep serviceab	Allows the fleet ot be r	Initially Increased Reve	To reinvest capital	Vahicles could car	This option fails to meet S

The insights gained from the SWOT analysis provided a structured understanding of the programme's internal strengths and weaknesses, as well as external opportunities and threats.

Preferred Way Forward (Shortlist Creation)

These findings informed the development of a comparative analysis, enabling a more robust visual evaluation of the long-listed options against key criteria.

Comparative Analysis

All 28 Options were assessed against the stated Spending Objectives (SOs) and Critical Success Factors (CSFs) to identify potential solutions and begin the shortlist generation. The below image is a snapshot of this exercise against the eventual shortlisted options.

Table 14: Shortlist Spending Objective comparison

	Option 1	Option 7	Option 16	Option 25
SO1	N	In Part/Potentially	Y	Y
SO2	In Part/Potentially	In Part/Potentially	Y	Y
SO3	N	N	Y	Y
SO4	N	In Part/Potentially	Y	N
SO5	N	In Part/Potentially	In Part/Potentially	Y
SO6	N	In Part/Potentially	Y	Y
SO7	N	N	Y	Y
SO8	N	N	Y	Y
CSF 1	Y	Y	Y	Y
CSF 2	Y	Y	Y	Y
CSF 3	Y	Y	Y	Y
CSF 4	Y	Y	Y	Y
CSF 5	Y	Y	Y	Y
CSF 6	Y	Y	Y	Y
CSF 7	Y	Y	Y	Y
CSF 8	Y	Y	Y	N
CSF 9	N	Y	Y	Y
CSF 10	N/A	Y	Y	Y
CSF 11	N	Y	Y	Y

To further help the identification of a suitable shortlist, and the preferred way forward, the below definitions were created against the stated headings to give us an options framework.

Scope – To modernise the entire HCS fleet over the next five years, transitioning from internal combustion engine (ICE) vehicles to battery electric vehicles (BEV) and ultra-low emission vehicles (ULEV) where feasible. This will be implemented nationally, excluding at this time heavy goods vehicles (HGV).

Service Solution – The solution involves adopting BEV/ULEV vehicles, primarily small and medium-sized vans, supported by the installation of appropriate charging infrastructure. All vehicles will be equipped with telematics to enable fleet optimisation and will integrate seamlessly with existing fleet management systems.

Service Delivery – The fleet will consist of a mix of owned and leased vehicles. Maintenance will continue to be provided by WAST where capable, with alternative providers considered where lease or purchase agreements do not include maintenance. Vehicle deployment will be optimised based on vehicle capacity and route requirements.

Implementation – This phase of the modernisation programme will be delivered over five years, aligned with vehicle replacement profiles and maintenance lifecycles. Any changes will be managed proactively, with stakeholder engagement central to the process. Communication will be transparent and timely, especially with directly affected areas. Risks, issues, dependencies, and constraints will be actively managed by the programme team to support informed decision-making.

Funding – Annual funding will be requested from Welsh Government based on the identified replacement needs for that year. For leased vehicles, funding may be sourced from available revenue generated through benefits realised from

earlier BEV adoption. Where necessary, additional revenue will be sought from Welsh Government.

All of the 28 options within the longlist were then compared against each of the headings within the options framework helping to identify the most appropriate potential options (shortlist). The results of which were summarised in a table similar to that seen below:

Table 15: Summary of shortlist against the options framework

	Option 1	Option 7	Option 16	Option 25
Scope	Discontinued	Carried Forward	Preferred Way Forward	Preferred Way Forward
Servcie Solution	Discontinued	Carried Forward	Preferred Way Forward	Preferred Way Forward
Service Delivery	Carried Forward	Preferred Way Forward	Preferred Way Forward	Preferred Way Forward
Implementation	Discontinued	Carried Forward	Preferred Way Forward	Preferred Way Forward
Funding	Preferred Way Forward	Carried Forward	Preferred Way Forward	Carried Forward
Summary	Discontinued	Carried Forward	Preferred Way Forward	Carried Forward

As a final step in the shortlisting process, all options within the longlist were scored against how well they met the Spending Objectives, Critical Success Factors and the Options Appraisal.

Table 16: Scoring of shortlists against SOs, CSFs and Options appraisal.

	Option 1	Option 7	Option 16	Option 25
SO & CSF Total	8.5	13.5	18.5	17
Option Appraisal	1.5	3	5	4.5
Total	10	16.5	23.5	21.5

In addition to the Do Nothing option, those scoring the highest within each different approach were also taken forward into the preferred way forward shortlist.

Shortlisted Options

The shortlist taken forward can be seen below:

Table 17: Shortlist options

Option Category	Option Number	Appraisal Score	Option Heading	Number of Vehicles
BAU	Option 1	10	Do Nothing	0
Do Minimum	Option 7	16.5	Only replace vehicles with BEV/ULEV mix when Beyond Economical Repair (Leased and Owned)	50
Intermediate (Preferred Way forward)	Option 16	23.5	Replace ICE with a Mixture of BEV & ULEV (Leased and Owned), as BER or meeting Replacement Profile criteria.	124
Do maximum	Option 25	21.5	Replace all ICE with a mixture of BEV/ULEV	306

			(Leased and Owned) within 5 years.	

To support the preferred way forward, and regardless of the preferred option selected, the below projects will also be completed within the Programme Project Dossier (see Management Case), and the Fleet Manager, or appropriate other, will become the project executive. These optimisation and maintenance review projects will happen in all cases, and irrelevant of which option is selected.

Fleet Optimisation Review – April 2026 to March 2029.

A fleet optimisation project will be implemented to ensure the right vehicle is matched to the right route across Wales. This approach considers vehicle size, range, and capacity, ensuring each route is covered efficiently within an allocated shift, inclusive of driver breaks. Regional depot utilisation will be maximised to reduce dead mileage and improve operational responsiveness. The fleet will also be effectively right sized against the optimised milage requirements, with additional vehicles being procured if needs and excess vehicles being repurposed or decommissioned if required.

The optimisation will be underpinned by route modelling and simulation tools, which is within the capabilities of the current system, enabling data-driven decisions on vehicle allocation and route planning. These tools will factor in road type, demand, and shift constraints to ensure coverage is maximised while maintaining compliance with working time regulations. Vehicle right-sizing will also be applied to align fleet configuration with actual service needs, reducing fuel use, driver hours, and maintenance costs.

A phased implementation will begin with data collection and analysis, followed by simulation and pilot testing in selected regions aligned to those depot's that require optimisation most urgently. Feedback from drivers and depot managers will inform refinements before national rollout. This approach supports cost-efficiency, sustainability, and improved service delivery, while aligning with broader strategic goals and operational priorities.

Maintenance Arrangements Review – April 2026 to March 2029

In addition, and again regardless of the preferred option selected, a review of currently outsourced maintenance arrangements will be undertaken to assess whether alternative models could offer improved value, responsiveness, or integration with depot operations. This will include evaluating in-house servicing options, regional partnerships, and hybrid models, allowing us to compare the operational requirements against the providers capabilities. The benefits of this could include reduced servicing costs, increased fleet availability and reduced downtime.

Where the review of maintenance arrangements determines additional costs to the programme, though not expected at this stage, this will be raised under a separate BJC that outlines the request for additional capital. We are not in the

position to do that at this stage, as this is entirely dependent on the result of the fleet optimisation review.

Benefits appraisal

Benefits have been captured in a programme Benefits register, and also a benefits realisation map. Additionally, the benefits have been profiled and appraised accordingly and assume that 100% of new vehicles will be BEV. Those that have a cash releasing aspect have been approved by our finance team and the details can be seen below.

Table 18: Cash benefits

Benefit	Field	Category	To realise?	Beneficiary
B1	Wider Benefits	Quantifiable	To achieve a reduction in emissions of approximately 250g per mile per BEV, from 31 March 2026	Welsh Population
B2	Indirect Public Sector Benefits	Qualitative	Improve air quality in congested areas and in and around hospitals.	Welsh Population
B3	Direct Public Sector Benefits	Quantifiable	Improve driver safety, monitoring driver behaviours and reducing accidents/vehicle milage	HCS Staff, General Public.
B4	Direct Public Sector Benefits	Cash Releasing	Potential to reduce percentage of leased vehicles within the fleet.	NWSSP – HCS
B5	Direct Public Sector Benefits	Cash Releasing	To reduce annual fuel costs by approximately £412,000.	NWSSP – HCS
B6	Direct Public Sector Benefits	Cash Releasing	To reduce annual maintenance costs by £130,000	NWSSP – HCS
B7	Wider Benefits	Qualitative	To reduce noise pollution by between 4 and 10 decibels for each vehicle on the road.	Welsh Population
B8	Direct Public Sector Benefits	Non-Cash Releasing	To reduce vehicle downtime by 85 days	NWSSP – HCS

The primary cash releasing benefits against this project come from the reduction in fuel and maintenance costs (B5 and B6). The have been calculated as per the below, and prior to the application of optimism bias:

Table 19: Reduced maintenance and fuel savings

Benefit Number	Benefits Description	Vehicles Impacted	Benefit per BEV	Time Horizon	Total Benefit
B6	Reduced Maintenance costs	124	£1,049.05	7 Years	£910,575.00
B5	Fuel Savings	124	£3,320.70	7 Years	£2,882,368.00

The total potential benefit to be realised from a cash releasing perspective is £3,792,943.00 prior to the application of optimism bias which can be seen within the Net Public Social Value (NPSV) and Benefits Cost Ratio (BCR) section below. However, this is dependant on the options selected and the number of vehicles replaced.

Risk Assessment

The identified risks have been reviewed, and those that are relevant have been costed and totalled against each of the shortlisted options, and to include the increased maintenance costs that are likely to be incurred as a result of doing nothing:

Table 20: Risks costing breakdown by vehicle.

Risk Number	Risk Description	Cost per vehicle/Driver per year	Optimisim Bias	Probability /liklihood
420	Increased Insurance Costs	£232.11	20%	85%
422	Interuption in supply (power cut)	£224.94	20%	5%
495	Base location Change (Infrastructure)	£1,226	20%	50%
	Doing Nothing - Increased Maintenance	£1,223.23	20%	90%

Having assessed the key risks associated with the programme, it is now important to evaluate the overall value and economic viability of the proposed options. The following section presents the Net Public Social Value and Benefits Cost Ratio, providing a quantitative assessment of the programme's expected benefits relative to its costs.

Net Public Social Value and Benefits Cost Ratio (Owned)

The programme team have prepared the economic appraisals for the short listed options, demonstrating the Net Public Social Value and Benefits Cost Ratio against each of the shortlisted options.

The total risk and benefit costs have been calculated over a 7 year time horizon per vehicle procured, as this is the minimum forecasted life of each asset (though benefits are likely to compound over a much longer period on average, providing the vehicles remain serviceable). The costs have been calculated annually, as the proportion of new vehicles that enter the fleet increases, and then consolidated to give a total risk cost and benefit value that considers the while life cost of every vehicle.

Following this an optimism bias of 20% has been applied to risks and deducted from benefits accordingly, and then used to calculate the Net Public Social Value and Benefits Cost Ratio. The results of this process are as follows:

Table 21: Net Public Social Value and Benefit Cost Ratio (owned)

	Option 1	Option 7	Option 16	Option 25
Vehicles Replace over 5 years	0	50	124	198
	Undiscounted £	Undiscounted £	Undiscounted £	Undiscounted £
Cost in the appraisal of social value				
Total Direct Public Costs (to Originating Organisation)	£0.00	£2,956,250.00	£7,331,500.00	£11,706,750.00
Capital	£0.00	£2,956,250.00	£7,331,500.00	£11,706,750.00
Revenue	£0.00	£0.00	£0.00	£0.00
Total Risk Costs	£2,277,556.40	£1,910,417.63	£1,376,753.20	£916,934.56
Capital	£0.00	£0.00	£0.00	£0.00
Revenue	£2,277,556.40	£1,910,417.63	£1,376,753.20	£916,934.56
Total of Costs	£2,277,556.40	£4,866,667.63	£8,708,253.20	£12,623,684.56
Benefits in Appraisal of Social Value				
Total Direct Public Sector Benefits	£0	£1,223,530.00	£3,034,354.40	£4,845,178.80
Cash Releasing Benefit (CRB)	£0	£1,223,530.00	£3,034,354.40	£4,845,178.80
Non Cash Releasing Benefit (NCRB)	£0			
Total Value of Benefits	£0.00	£1,223,530.00	£3,034,354.40	£4,845,178.80
Net Social Value	-£2,277,556.40	-£3,643,137.63	-£5,673,898.80	-£7,778,505.76
Discounted Rate @ 3.5%	-£1,794,444.01	-£3,279,508.17	-£5,481,232.27	-£7,679,899.38
Benefits Cost Ratio (BCR)	0.00	0.25	0.35	0.38

Initially, the Fleet Modernisation Programme appears to represent poor value for money, in that the costs outweigh the cash releasing benefits, and the Benefit Cost Ratio of less than 1.0. That said, in line with the HM treasuries green book guidance, this programme delivers strategic value beyond monetised metrics, and these come in the form of Decarbonisation, and associated improvements to air quality public health, together with improved fulfilment, service reliability, public perception and trust to name a few.

Additionally, it is clear from the above, with a BCR of 0.0, that if we took the decision to do nothing, then this would represent less value for money that taking any of the other options, further justifying the case for change. Though the existing fleet could continue to deliver without the procurement of new vehicles for the next year, or more, this would significantly impact out benefits realisation and also compromise our ability to achieve the targets set out within the Wales Decarbonisation Strategic Delivery Plan.

Net Public Social Value and Benefits Cost Ratio (Leased)

To ensure the selection of the best option, the programme team have also completed a value appraisal against the whole life cost of leasing the vehicles to be replaced, instead of to own them as shown in the section above. The table below shows this comparison:

Table 22: Net Public Social Value and Benefit Cost Ratio (leased)

		Owned		Leased	
Option		Option 16	Option 25	Leased Option 16	Leased Option 25
	Vehicles Replace over 5 years	124	198	124	198
		Undiscounted £	Undiscounted £	Undiscounted £	Undiscounted £
Cost in the appraisal of social value					
1	Total Direct Public Costs (to Originating Organisation)	£7,331,500.00	£11,706,750.00	£0.00	£0.00
1.1	Capital	£7,331,500.00	£11,706,750.00	£0.00	£0.00
1.2	Revenue	£0.00	£0.00	£9,150,976.80	£14,612,043.60
4	Total Risk Costs	£1,376,753.20	£916,934.56	£1,376,753.20	£916,934.56
4.1	Capital	£0.00	£0.00	£0.00	£0.00
4.2	Revenue	£1,376,753.20	£916,934.56	£1,376,753.20	£916,934.56
5	Total of Costs	£8,708,253.20	£12,623,684.56	£10,527,730.00	£15,528,978.16
Benefits in Appraisal of Social Value					
6	Total Direct Public Sector Benefits	£3,034,354.40	£4,845,178.80	£3,034,354.40	£4,845,178.80
6.1	Cash Releasing Benefit (CRB)	£3,034,354.40	£4,845,178.80	£3,034,354.40	£4,845,178.80
6.2	Non Cash Releasing Benefit (NCRB)				
9	Total Value of Benefits	£3,034,354.40	£4,845,178.80	£3,034,354.40	£4,845,178.80
	Net Social Value	-£5,673,898.80	-£7,778,505.76	-£7,493,375.60	-£10,683,799.36
	Discounted Rate @ 3.5%	-£5,481,232.27	-£7,679,899.38	£0.00	£0.00
	Benefits Cost Ratio (BCR)	0.35	0.38	0.29	0.31

The comparison shows that options to lease vehicles are between 32% and 37% more expensive than to own, and this is when considering the whole life cost on a like for like comparison and does not consider any excess milage or wear and tear charges for leased vehicles (which can be costly).

The market test was very limited when requesting quotes to lease vehicles for 5 years with an allowance of 150,000 miles, with only two suppliers responding. Therefore, the leased vehicle costs are based on quotes received from Lex Autolease, and they are not able to quote for more than 100,000 miles of leased usage for an electric vehicle. This would mean that NWSSP either return the vehicle after 100,000 miles or paying expensive excess mileage premiums. The cost is therefore based on returning the vehicle at this point and hiring a new one.

We would expect in the future the company will get to a point where they will quote for a higher mileage and we would expect the cost would reduce at that point. This will continue to be reviewed through the submission of annual BJCs.

Preferred Option

The preferred option is option 16, which is to replace ICE with a Mixture of BEV & ULEV (Leased and Owned), as vehicles become BER or as suggested when the fleet replacement profiling criteria are met (detailed below).

The figures used to calculate the Net Public Social Value can be seen below:

Table 23: Net Public Social Value Table for Preferred Option (Option 16)

NPV @ 3.5% p.a.						
YEAR:	2025/26	2026/27	2027/28	2028/29	2029/30	Total
Total Direct Costs (£ 000s):						
Capital	£ 1,005,125	£ 1,537,250	£ 2,246,750	£ 1,359,875	£ 1,182,500	**£ 7,331,500**
A: Total Capital Costs (Annual)	£ 1,005,125	£ 1,537,250	£ 2,246,750	£ 1,359,875	£ 1,182,500	**£ 7,331,500**
B: Total Capital Costs (Cumulative)	£ 1,005,125	£ 2,542,375	£ 4,789,125	£ 6,149,000	£ 7,331,500	
Total Risk Costs (£ 000s):						
Insurance		£ 3,354	£ 8,484	£ 15,981	£ 20,519	**£ 171,251**
Interruption in Power Supply		£ 191	£ 484	£ 911	£ 1,170	**£ 9,762**
Change of Base		£ 10,421	£ 26,359	£ 49,653	£ 63,752	**£ 293,627**
Increased Maintenance - Fleet not replaced		£ -	£ 20,917	£ 28,624	£ 52,844	**£ 672,654**
Subtotal Revenue Costs	£ -	£ 13,966	£ 56,243	£ 95,168	£ 138,284	**£ 1,147,294**
Adjust for Optimism Bias	£ -	£ 16,759	£ 67,492	£ 114,202	£ 165,940	**£ 1,376,753**
Benefits of Appraisal of Social Value (£ 000s):						
Reduced Maintenance		£ (17,834)	£ (45,109)	£ (84,973)	£ (109,101)	**£ (910,575)**
Fuel Savings		£ (56,452)	£ (142,790)	£ (268,977)	£ (345,353)	**£ (2,882,368)**
Subtotal Revenue Costs	£ -	£ (74,286)	£ (187,899)	£ (353,950)	£ (454,454)	**£ (3,792,943)**
Adjust for Optimism Bias	£ -	£ (59,429)	£ (150,319)	£ (283,160)	£ (363,563)	**£ (3,034,354)**
C: Total Revenue Costs (Annual)	£ -	£ (42,669)	£ (82,827)	£ (168,958)	£ (197,623)	**£ (1,657,601)**
D: Total Revenue Costs (Cumulative)	£ -	£ (42,669)	£ (125,496)	£ (294,454)	£ (492,077)	
E: Total Costs (Annual) (=A+C)	£ 1,005,125	£ 1,494,581	£ 2,163,923	£ 1,190,917	£ 984,877	**£ 5,673,899**
F: Total Costs (Cumulative) (=B+D)	£ 1,005,125	£ 2,499,706	£ 4,663,629	£ 5,854,546	£ 6,839,423	
Discount factor @ 3.5%	1.000	0.966	0.934	0.902	0.871	
Net Present Cost (Annual)	£ 1,005,125	£ 1,444,039	£ 2,020,045	£ 1,074,139	£ 858,264	**£ 5,481,232**
Net Present Cost (Cumulative)	£ 1,005,125	£ 2,449,164	£ 4,469,210	£ 5,543,349	£ 6,401,612	
TOTAL NET PRESENT VALUE (NPV) =	**£ 5,481,232**					

Option 16 has the highest Benefit Cost Ratio (BCR), at 0.35, and therefore represents a more viable solution. Though only slightly lower than the BCR seen in option 25, option 16 has the right balance of risk and reward in comparison to our appetite and allows for the effective management of our risks and dependencies (such as charging infrastructure development and staff training) against the desired timeline, and without compromising delivery.

This option also allows us to lease or own vehicles dependant on which option represents the best value at the time of the annual BJCs submission.

Fleet Replacement Profile

To support the preferred option whilst safeguarding the delivery of value, the fleet replacement profiling process (Appendix 2) has been developed. This ensures that we are only replacing vehicles that are no longer fit for purpose or Beyond Economical Repair (BER).

The replacement profiling process can assess both ICE and BEV, considering vehicle age, Net Book Value, mileage, annual maintenance costs, the internal condition assessment score, and the expected emissions standard, with BEVs including a battery health assessment to ensure that it is above 80%.

Following the assessment, any vehicles that have been identified as no longer fit for purpose will be considered for internal redeployment, to see if they can be moved to a shorter route instead of being decommissioned. Where an internal redeployment is not possible, any suitable vehicles will be replaced within the existing fleet under the modernisation programme and then offered to other NHS Wales Organisations for their own use prior to decommissioning.

All decisions regarding the decommissioning of vehicles will be reviewed and approved by the Head of HCS following the fleet replacement process completion. Only when vehicles have been approved for decommissioning will any request for replacement vehicles be made and it is not the intention of this programme to increase the fleet size and associated annual revenue costs.

Sensitivity Analysis

To assess the robustness of the economic appraisal, a sensitivity analysis was conducted on key variables, including capital requirements and benefits realisation. The analysis tested how changes in these assumptions would affect the Net Present Social Value (NPSV) and Benefit Cost Ratio (BCR) for each shortlisted option.

For example:

- Direct Capital Costs: Increasing direct capital costs by 10% reduced the BCR for Option 16 from 0.35 to 0.32 but it remained above the threshold for value for money. A 40% Increase reduced the BCR to 0.26. In each case, option 16 was 0.02 lower than option 25.

- Benefits Realisation: If benefits were 10% lower than forecast, the BCR for Option 16 decreased to 0.31, from 0.35, but it continued to outperform option 7, though the gap shortened from 0.1 to 0.08.

- Benefits Realisation: If benefits were 40% lower than forecast, the BCR would be 0.21 for option 16, but it continued to outperform option 7, this time with a gap of 0.06.

The results indicate that Option 16 is resilient to reasonable changes in key assumptions and continues to represent the best value for money whilst being achievable considering our constraints and dependencies, and under a range of scenarios. The calculations above, were done including 20% optimisation bias in addition to any adjustment.

Commercial, Financial and Management Cases - Overview

The following sections provide a short overview of how the preferred option is supported by the Commercial, Financial and Management cases.

Commercial Case Overview

The Commercial Case supports the preferred option by providing a flexible, compliant procurement strategy that enables phased fleet replacement. Using established frameworks (The Procurement Partnership Ltd for purchases and Crown Commercial Service RM6268 for leases), NWSSP can secure vehicles and conversions efficiently while maintaining value for money and delivery assurance.

Annual market testing ensures competitive pricing and alignment with operational needs. Procurement is timed to match approved funding cycles, with contingency built in to manage lead times and conversion delays. This approach balances agility, governance, and strategic alignment with decarbonisation goals.

Financial Case Overview

The Financial Case supports the preferred option as it demonstrates long-term value for money through reduced fuel and maintenance costs. While the Benefit Cost Ratio is below 1.0 and initial capital investment is high, this is typical of fleet replacement programmes.

It supports national decarbonisation goals, improves air quality and public health, and enhances service reliability, fulfilment, and public trust. These wider benefits justify investment and reinforce the case for change.

Annual Business Justification Cases will secure funding, ensuring flexibility and alignment with infrastructure readiness. The financial model accounts for capital and revenue impacts, depreciation, and asset treatment, supporting a sustainable and cost-efficient transition.

Management Case Overview

The Management Case is particularly supportive of the preferred option, as it is more straightforward to implement than the do maximum (Option 25) alternative, with the inherent risks appearing more manageable in line with the noted constraints and dependencies.

This option aligns well with current organisational and divisional capacity and capabilities, enabling effective oversight, timely delivery, and greater confidence in achieving the intended benefits while minimising disruption. The submission of annual Business Justification Cases will also help to safeguard value for money and demonstrate the continued business need, and therefore, the programme will be able to remain adaptable based on the evolving economic and technological landscapes.

This does however come with the caveat that should any proportion of the capital BJC submitted annually be unsuccessful, that the planned replacements will roll forward to the next years BJC.

Commercial Case

The Commercial Case outlines the proposed procurement arrangements required to deliver the fleet modernisation programme, supporting the organisation's commitment to decarbonisation, cost efficiency, and improved service delivery.

Procurement Strategy and route

Vehicle Replacement and Conversion (Owned)

The proposed procurement strategy for both vehicle supply and conversion is a direct award via The Procurement Partnership Ltd (TPPL) Vehicle Purchase Framework – Lot 2: Light Commercial Vehicles up to 5t. This framework includes 24 pre-approved suppliers and permits the purchase of vehicles and associated conversion services under a single lot. This avoids the need to split the procurement across multiple frameworks or contracts, reducing duplication, minimising delay and mitigating compliance risks.

To ensure transparency and value for money, a market testing exercise will be carried out prior to each annual Business Justification Case (BJC). Procurement will obtain indicative costs from multiple suppliers on the framework and benchmark these against pricing on the Crown Commercial Service's Fleet Portal. Suppliers will also be asked to provide indicative conversion costs based on the required specifications to assess feasibility and value across vehicle types.

Once final vehicle makes and models are confirmed for a given financial year, NWSSP will conduct a direct award for that year's required vehicles, based on funding confirmed through the approved BJC. This approach will be repeated annually, allowing NWSSP to retest the market each year to ensure pricing remains competitive, value for money is achieved and supplier performance remains high. This model also retains flexibility to adapt to evolving operational needs, vehicle technologies and Welsh Government policy.

This approach balances immediate delivery assurance with commercial agility and fiscal responsibility over the medium term. It supports accurate budgeting, allows for proactive supplier engagement, and aligns with NWSSP's commitment to governance, transparency, and best practice procurement.

Vehicle Replacement (leased)

Where leased vehicles are required, NWSSP will procure them via the Crown Commercial Service RM6268 Framework: Vehicle Lease, Fleet Management and Salary Sacrifice Car Schemes. This framework has been selected as it explicitly allows for the leasing of modified or converted vehicles, whereas many other leasing frameworks only support the leasing of standard chassis vehicles with no modifications. This is essential to meet the operational requirements of Health Courier Services, which often require refrigeration, racking, tail lifts or other specialist conversions.

For each financial year and subject to the approval of Welsh Government funding through the annual Business Justification Case (BJC), NWSSP will undertake a market testing exercise. Indicative lease and conversion costs will be requested from all relevant suppliers on the RM6268 framework. These will be benchmarked against chassis prices available on the CCS Fleet Portal, with conversion costs applied separately to create full-life lease cost comparisons. This approach ensures transparency, value for money and alignment with public sector procurement standards.

Once the required vehicle types are confirmed and market testing is complete, NWSSP will direct award to the most suitable supplier based on availability, delivery lead times, pricing and alignment with operational needs. This process will be repeated annually, ensuring the programme remains flexible and can respond to changes in fleet requirements, vehicle technologies or funding availability.

It is important to note that leasing arrangements are subject to longer lead times, particularly where vehicles require third-party conversions. This has been evidenced in prior procurement exercises and will need to be carefully factored into vehicle planning and funding timelines.

This leasing approach provides NWSSP with an agile, compliant and cost-effective procurement mechanism, enabling phased fleet modernisation while safeguarding service delivery, financial control and strategic alignment with decarbonisation and sustainability goals.

Timescales

The delivery lead time for vehicles will depend on the chosen supplier's capacity and the availability of chassis, both of which remain subject to confirmation and ongoing market conditions.

Procurement activity will formally commence once the required vehicle types have been agreed and Welsh Government funding has been confirmed through the annual Business Justification Case. This approach ensures alignment with budget approvals and avoids premature contractual commitments before funding is secured.

The procurement timescales will vary depending on whether the vehicles are purchased or leased:

For vehicle purchases, procurement will be conducted via direct award under The Procurement Partnership Ltd (TPPL) Vehicle Purchase Framework – Lot 2, which enables the purchase of both vehicles and required conversions under a single lot. This route is typically more streamlined, as the framework facilitates bundled supply and conversion, supporting faster turnaround times from award to delivery.

For vehicle leases, procurement will be undertaken through the Crown Commercial Service RM6268 Framework: Vehicle Lease, Fleet Management and Salary Sacrifice Car Schemes, which allows for modified and converted vehicles. Leasing has historically involved longer lead times, due to the added complexity of third-party conversions and capacity constraints within the lease supply chain. These extended timescales will be factored into programme planning and supplier selection decisions.

All procurement and delivery activity must be completed within the financial year, as Welsh Government capital funding must be fully spent by 31 March 2026. This deadline includes vehicle delivery and conversion works. Timely planning, early engagement with suppliers, and close coordination with operational teams will be critical to meeting this requirement.

The primary risks to delivery timescales are vehicle lead times and conversion build slot availability. These risks will be actively managed through early supplier engagement, regular progress monitoring, and ongoing communication between Procurement, Fleet, and Programme teams to ensure mitigation actions can be taken promptly where delays are anticipated.

Charging mechanism

A purchase order will be raised only after completion of all required governance documentation, including the framework call-off agreement, Procurement Outcome Report (POR) and approval of the relevant Business Justification Case (BJC).

This ensures no financial commitment is made until all internal and external approvals are in place, supporting compliance and reducing financial risk.

Payments will follow the terms of the relevant framework (TPPL or CCS RM6268) and where staged payments apply (e.g. for conversions), these will be agreed in advance and reflected in the contract and purchase order.

Key contractual arrangements

All procurement under this programme will be conducted via direct awards using pre-approved frameworks: TPPL Lot 2 for purchases and CCS RM6268 for leases. Contracts will be formalised through the relevant framework call-off agreements, and all activity will comply with the terms and conditions set out within each framework.

There may be a mix of purchase and lease contracts, depending on operational needs and the availability of funding in each financial year. This will be confirmed as part of the annual planning and approval cycle.

The primary contractual risk relates to the timely delivery of converted vehicles within the required financial year, particularly given current market pressures on chassis availability and conversion lead times. These risks will be monitored and mitigated through early supplier engagement and tight procurement timelines.

For purchases, vehicles will be treated as capital assets and depreciated in line with NHS Wales accounting policy. Leased vehicles will be reviewed to determine appropriate accounting treatment, in line with relevant lease classification rules.

Personnel implications

A general declaration of interest has been completed at this stage, with no personnel implications associated with the potential contractual arrangements, at this stage, or within the wider programme.

At the time that contracts are being awarded, this declaration will be refreshed to provide a more informed position.

Accountancy treatment

The accountancy treatment of the fleet modernisation programme will depend on the procurement route, ownership model, and the nature of the assets and services acquired. The following considerations apply:

Capital vs Revenue Expenditure

- Capital Expenditure: The purchase of BEVs/ULEVs and installation of EV charging infrastructure will typically be treated as capital assets, subject to depreciation over their useful life.
- Revenue Expenditure: Ongoing costs such as vehicle leasing, maintenance, energy supply, and fleet management services will be treated as revenue expenditure and accounted for in-year.

Asset Ownership and Leasing

- If vehicles are purchased outright, they will be recognised as assets and depreciated over their expected life (e.g., 5–7 years).
- If vehicles are leased, the costs will be treated in line with IFRS16 guidance.

Whole-Life Costing

- The programme will adopt a whole-life cost approach, ensuring that both capital and operational costs are considered in the procurement and financial planning stages.

Depreciation and Residual Value

- Vehicles and infrastructure assets will be depreciated in line with the organisation's accounting policies.
- Residual values will be estimated based on based a straight line depreciation.

Financial Case

The financial case demonstrates the overall funding strategy of the Fleet Modernisation Programme, demonstrating that the preferred option, which is the phased replacement of ICE vehicles with either owned or leased BEV/ULEV alternatives, represents the best value for money.

The case provides a review of capital and revenue expenditure together with a summary of year on year capital funding requirements.

Annual Business Justification Cases will be submitted to secure funding, ensuring that the programme remains adaptable to evolving needs.

Capital and revenue requirements

Overall affordability and funding

The asset and capital expenditure plans included in our IMTP contain a rolling fleet replacement programme with the assumption that all vehicles will be replaced at the end of their useful economic life. The funding required for the vehicle

replacement programme poses a risk regarding increased maintenance and/or lease costs and business continuity if funding for new vehicles cannot be approved on a recurrent basis.

The financial tables below, prepared for the preferred option, assume all 124 vehicles that are purchased or leased will be BEV, but there is a dependency on the charging infrastructure being in place to enable this, which current gap of approximately 50 charging bays, but this will fluctuate as older BEV vehicles reach their replacement profile and become decommissioned.

All new vehicles are assumed to become operational on 1st April at the beginning of the financial year following purchase.

Impact on income and expenditure account

The whole life costs in the tables below show the impact of purchasing battery electric vehicles over diesel vans is anticipated to release significant revenue savings of £4.8m from reduced fuel and maintenance costs only partially offset by a small increase in insurance premiums. It is estimated that any purchase of ULEV vehicles instead of BEV would realise 60% of the fuel savings, but none of the reduction in maintenance costs.

Table 24: Cost and Funding for the Recommended Option

Recommended Option		Year 1	Year 2	Year 3	Year 4	Year 5	Total
Numbers							
16	Vehicle Purchases	17	26	38	23	20	124
16	Capital Requirements (£'s excluding VAT)	£1,005,125	£1,537,250	£2,246,750	£1,359,875	£1,182,500	**£7,331,500**

Revenue Costs/Savings are included as annual and there may be a part year effect depending on the date the vehicles become operational.

Table 25: Capital and Revenue expenditure for the Recommended Option

	Recommended Option	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33	33/34	34/35	Total
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
	Capital Expenditure											
	Capital Requirements (£'s including VAT)	1,206	1,845	2,696	1,632	1,419	0	0	0	0	0	8,798
	Total Capital Costs	**1,206**	**1,845**	**2,696**	**1,632**	**1,419**	**0**	**0**	**0**	**0**	**0**	**8,798**
	Revenue Expenditure											**0**
	Maintenance (annual saving)	0	-18	-45	-85	-109	-130	-112	-85	-45	-21	-650
	Insurance (annual cost)	0	3	8	16	21	24	21	16	8	4	122
	Fuel (annual Saving)	0	-56	-143	-269	-345	-412	-355	-269	-143	-66	-2,059
	Total Revenue Costs/(Savings)	**0**	**-71**	**-179**	**-338**	**-434**	**-517**	**-446**	**-338**	**-179**	**-83**	**-2,587**
	Total Expenditure											**0**
	Total Project Costs (Capital & Revenue)	**1,206**	**1,774**	**2,517**	**1,294**	**985**	**-517**	**-446**	**-338**	**-179**	**-83**	**6,211**
	Funding											**0**
	Capital funding	1,206	1,845	2,696	1,632	1,419	0	0	0	0	0	8,798
	Revenue funding	0	-71	-179	-338	-434	-517	-446	-338	-179	-83	-2,587
	Total funding	**1,206**	**1,774**	**2,517**	**1,294**	**985**	**-517**	**-446**	**-338**	**-179**	**-83**	**6,211**

This table can be seen in a larger format in appendix 6.

Revenue Generation

The revenue generation projection comes from the sale of the decommissioned vehicles through auction. The anticipated value is expected to be £1400 per vehicle as a minimum.

Table 26: Revenue Projections for the Recommended Option

Recommended Option		Year 2	Year 3	Year 4	Year 5	Year 6	Total
Revenues							
1	Sales and other Revenue	-23,800	-36,400	-53,200	-32,200	-28,000	-173,600

Net effect on prices and confirmation of stakeholder support

There is potential to deliver cost reductions for health boards through passing on the revenue savings either by a reduction in SLA charges or an increased distribution, and this will be assessed continually based on fleet optimisation and programme benefits realisation.

Impact on balance sheet

The Programme Business Case assumes there will be no increase to the number of vehicles at this time and it hopes to achieve a reduction through the optimisation process, but it should be noted that based on the development of Transport Services since they transferred to NWSSP in 2015, services have more than trebled in size, and further expansion for new services, such as Radio pharmacy, is likely in the future.

Battery electric vehicles are depreciated over 5 years rather than the 7 years for diesel vans. It should be noted that we have limited funding for depreciation and additional non-cash funding will be required from Welsh Government over and above the baseline funding if capital funding is approved. It is assumed within our plan that the IFRS 16 Right of Use capital funding required will be available in line with projected funding requirements submitted to Welsh Government.

Management Case

This Management Case sets out the delivery arrangements for the Fleet Modernisation Programme, ensuring that it is implemented effectively, on time, and within budget. Introducing the governance structures, project management methodology, risk and issue management processes, and the approach to benefits realisation. These arrangements are designed to provide assurance to stakeholders and funders that the investment will be managed professionally and deliver the expected outcomes.

Programme and project management governance arrangements

The delivery arrangements of this programme will operate in line with the Programme Business Case and required governance routes.

The Programme has been formally established in line with best practice (Managing Successful Programmes) to be overseen and managed by the NWSSP Transformation Management Office (TMO).

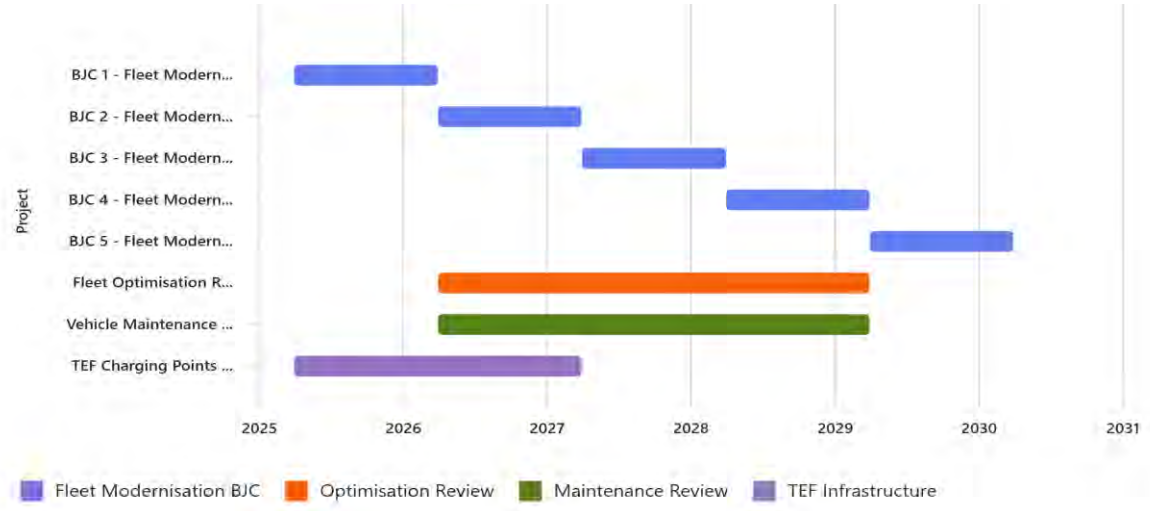
The Programme Governance/Board is as follows:

Tony Chatfield (NWSSP - HCS) - SRO
Jonathan Nettleton (NWSSP - Corporate Services)
Ian Emptage (NWSSP - Procurement Services)
Claire Watkins (NWSSP - Finance)
Jane Tyler (NWSSP - Shared Services)
Gemma Matuszczyk (NWSSP - Finance)
Simon Russell (NWSSP-SES)
Gordon Darroch (NWSSP - Transport Manager)
Gildas Griffiths (NWSSP - Health Courier Services)
Joseph Price (NWSSP – Health Courier Service)
Ian Rose (NWSSP - PPI - TMO) – Programme Assurance
Tim Knight (NWSSP - PPI - TMO) – Programme Manager

Programme Plan

In the first instance, the approval of the Programme Business Case will require no immediate release of capital, though it will allow for the submission of annual Business Justification Cases (BJCs). The annual BJCs will formally request the capital and revenue requirements for that year.

To support the subsequent requests for capital from Welsh Government, a programme plan has been developed to deliver the required benefits and outcomes through a number of tranches, which can be seen here:



The tranches are to include a dossier of projects that will be managed in line with PRINCE2 best practice. The project dossier is subject to change dependant on the delivery of dependencies that are be managed externally to the programme, such as charging infrastructure which is currently being delivered through the Targeted Estates Fund, though it currently includes the following projects:

Table 27: Programme Dossier

Project Name	Major Products	Outcomes	Start Date	End Date
Fleet Modernisation BJC - 25/26	ULEV/BEV Vehicles	Decarb/image	01/04/25	31/03/26
Fleet Optimisation Review	Improved Route planning and vehicle utilisation	Decarb/ Revenue savings	01/04/26	31/03/29
Vehicle Maintenance Review	Improved, Maintenance arrangements and capabilities	Decarb/Milage/ Revenue savings	01/04/26	31/03/29
Fleet Modernisation BJC 26/27	ULEV/BEV Vehicles	Decarb/image	01/04/26	31/03/27
Fleet Modernisation BJC 27/28	ULEV/BEV Vehicles	Decarb/image	01/04/27	31/03/28
Fleet Modernisation BJC 28/29	ULEV/BEV Vehicles	Decarb/image	01/04/28	31/03/29
Fleet Modernisation BJC 29/30	ULEV/BEV Vehicles	Decarb/image	01/04/29	31/03/30
TEF-Charging Points – Estates – External Project	BEV Charging Points – Denbigh/Matrix	Charging Capacity	01/04/25	31/03/26
Potential-EV Infrastructure	BEV Charging Points	Charging Capacity	If needed	If needed

following loss of TEF				

As seen above, and to ensure timely delivery of only the required amount of fleet replacement vehicles, prior to the end of the financial year, those projects relating to the actual replacement of fleet vehicles will be run annually and a programme transition plan has been created to support this.

The Programme Business Case and annual Business Justification Cases will be required to travel along specific governance routes as they move towards approval.

Governance

The Programme Business Case will take the following governance route to overall approval:

- Endorsement via Programme Board
- Approved by NWSSP Director of Finance and NWSSP Director of Procurement
- Approved by NWSSP Managing Director
- Approved by Shared Services Partnership Committee
- Noted by Velindre Trust Board
- Approved by Welsh Government

Once the Programme Business Case has been approved, a Business Justification Case (BJC) will be submitted year-on-year against the annual fleet replacement projects to deliver those Milestones by the 31 March of each financial year. The annual cycle will be as follows:

- BJC development
- BJC approval
- Capital funding secured
- Procurement
- Conversion
- Delivery of fleet replacement

Approval/endorsement of the annual Business Justification Cases will follow Welsh Government's governance route for Capital funding as follows, and when anticipated capital requirements are less than £1m before VAT:

- Endorsement via Programme Board
- Approved by NWSSP Director of Finance and NWSSP Director of Procurement
- Noted by NWSSP Senior Leadership Group
- Approved by NWSSP Managing Director and SSPC Chair of the Board
- Approved by Welsh Government

At times that the annual Business Justification Case requires capital that is greater than £1m (before VAT), the following, alternative governance route will need to be followed:

- Endorsement via Programme Board
- Approved by NWSSP Director of Finance and NWSSP Director of Procurement
- Approved by NWSSP Managing Director
- Noted by NWSSP Senior Leadership Group
- Approved by Shared Services Partnership Committee
- Approved by Velindre Trust Board
- Approved by Welsh Government

Any changes to previously approved aspects of the Programme Business Case or BJCs will be managed through the appropriate change management arrangements.

Programme and Project Change

Internal changes impacting the delivery of the programme will follow NWSSP's TMO change control procedure:

- Exception report
- Change control log
- Approval by the Programme Board

Where that change is between NWSSP and an externally contracted supplier, the appropriate governance route will need to be followed in addition to the above and leading to:

- A fully completed and signed Change Control Notice between NWSSP and the supplier.

NWSSP Procurement Services will manage or support with any contractual or commercial changes or issues as required.

Changes will also be managed individually, within the projects that make up the dossier and dependant on their impact.

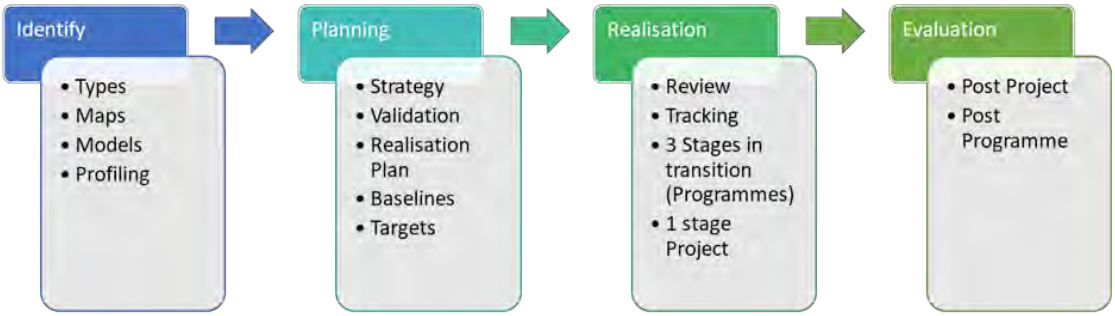
Business Change Management – People Side

The programme recognises that meaningful change requires workforce involvement, engagement and empowerment. Through targeted training, clear communication, and inclusive planning, staff will be supported to adopt with confidence to the new technologies, processes and expectations. This people first approach will help to ensure that NWSSP are able to deliver a sustainable transformation with its workforce at its heart.

Benefits Realisation arrangements

A benefits realisation plan has been developed to ensure the outcomes are achieved upon approval, and these have been reviewed and approved by finance partners where needed and have informed the economic and financial case accordingly.

Benefits outlined within this business case have baseline measures and have been mapped (Appendix 3) and profiled accordingly, all of which is available on request and details the anticipated benefits, benefit owner, timescales, and metrics available to track progress.



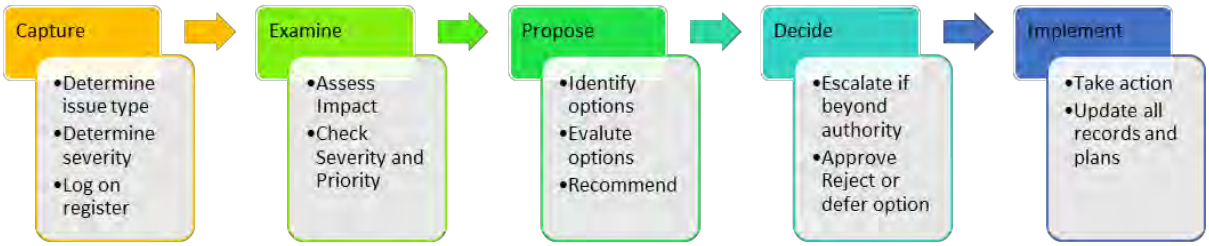
Regular reviews through reporting to Programme Board will help to ensure that benefits are monitored and are on track to deliver to expectation. Where this is not possible, risks and issues will be raised and managed accordingly.

Risk management arrangements

A Programme Risks, Actions, Issues and Decisions (RAID) Log will be maintained throughout the programme and will include all RAID information for the programme and annual BJC projects.

Risks and issues will be overseen by the Programme/Project Managers and Programme Team whilst being recorded within the programme RAID log.

Risks and issues will be managed in line with the NWSSP risk protocol at both programme and project level and reported to Programme Board by exception, however any risk/issues that have a direct impact to the delivery of the Programme will be escalated to Programme Board and recorded within the Programme risk register/issues log.



Having discussed the approach to the management of both Benefits and Risks, the following section outlines the programme assurance arrangements that will provide oversight, ensure compliance with governance standards, and offer independent scrutiny to support successful delivery.

Programme assurance

The Programme is managed within the NWSSP Transformation Management Office (TMO) and will follow Velindre approved programme management best practices aligned to Managing Successful Programmes (MSP).

Monthly Programme Board meetings have been established to monitor progress against time, cost, quality, scope, and benefits realisation, which the Programme Business Case (PBC) and annual BJCs will drive.

Bi-monthly reports will be produced and reviewed by the Shared Service Partnership Committee highlighting progress against time, cost, quality, benefits, risks and issues.

Decisions will be recorded within the programme RAID log throughout the lifecycle of the projects/programme. Decisions will be managed at project level in line with the agreed tolerances however any project level decisions that require additional governance will be escalated to the Programme Board for approval. Programme Board decisions will be managed and reviewed at the monthly meetings.

Mandatory attendance is required by either Tony Chatfield (SRO), or approved delegate. Mandatory, or Delegated attendance is required by the Programme Manager, Finance Lead and Procurement Lead, and as stated in the relevant Terms of Reference.

Quality assurance will be monitored through the established processes at all stages of the programme/annual projects. Programme Board leads representing Finance, Procurement and Health Courier Services will sign-off and approve the routes taken to obtain funding, procure the vehicles fairly and complicitly, and ensure that the vehicles are fit for purpose aligning with the deliverables in scope year on year.

A lessons learned log will be utilised to ensure continuous improvement, inform decision-making, knowledge sharing and the avoidance of repeating mistakes throughout the delivery of the programme.

These assurance arrangements will provide ongoing oversight and confidence that the programme remains on track to deliver its intended outcomes effectively and efficiently. A further review of performance will be completed through Post Implementation Reviews against each project.

Post implementation and evaluation arrangements

Given the organisations approach to business cases and benefit management, a Post Implementation Review (PIR) will be completed after six months of project closure or full benefit realisation, whichever happens first.

The PIR will review the performance of planning, time, cost, quality, scope, risks, benefits, KPIs, lessons learned, documentation, communication and change management.

Once completed, the PIR will follow the governance route for approval:

- reviewed by TMO Project Assurance
- approved by the Project Executive or Senior Responsible Owner (SRO)
- submitted to Formal SLG for noting

This approach provides an accurate reflection of the benefits delivered by the programme and associated projects, while allowing sufficient time for new organisational changes to embed withing the division. Additionally, this approach allows for a culture of continuous improvement to establish within the programme team itself, and between the delivery of each project.

Tolerances, Contingency Arrangements and Plans

When managing risks the Programme will follow the approved approach of identify, assess, plan and monitor whilst building in contingency for time, budget, or resources to the mitigation plans for individual risks. Issues will be managed via exception and in line with NWSSP risk/issue management protocol. Contingency built in through risk management will be utilised when resolving any issues impacting the Programme tolerances.

Time tolerance of 2 Months has been agreed by the Programme Board, against the commencement of the procurement process within each year, and delays exceeding this tolerance will be treated as an urgent exception resulting in the programme being paused and an assessment of the impact to be undertaken which could lead to re-planning of milestones if required. A minimum of 60 days of contingency time has been factored into the schedule through each stage (year) of the programme for the procurement of standard vehicles, and this is reduced to a 30-day contingency when procuring refrigerated vehicles due to the additional time required for conversion.

Budget contingency will be incorporated into the programme to account for financial uncertainties, emerging risks, and potential scope adjustments by allocating a tolerance of 7.5% within the overall programme budget, informed by NWSSP Finance and NWSSP Procurement. Regular financial reviews will support management of the contingency within each year.

Contingency will be built into the programme scope by incorporating defined scope tolerances and flexible delivery parameters to accommodate potential changes, emerging requirements, such as adjustable BEV/ULEV and Owned/Leased ratios.

Additional flexibility will be achieved through utilising the fleet replacement profiling to prioritise critical vehicle replacements with an additional 25% carry over year on year, reviewing and adjusting the criteria within dependant on the appetite for risk within that year and the economic landscape.

Overall Summary

This business case offers a strategically aligned proposal that aligns strongly with national decarbonisation and social agendas. Though the Benefits Cost Ratio and Net Public Social Value against the preferred option is low, this is made up for by the delivery of significant non-cash releasing, qualitative, quantitative benefits that are not fully captured in the economic appraisal.

With all five cases developed, the fleet modernisation programme demonstrates economic sustainability whilst offering significant cash releasing benefits against annual revenue costs and safeguarding the national distribution of goods essential to the delivery of effective care.

The fleet modernisation programme has been subjected to financial scrutiny and approval and is also supported by robust procurement and delivery arrangements, and we ask for your approval to proceed.

End of Document

Appendices to follow

Appendix

Appendix 1 - NWSSP Strategic Outcomes and Duty of Quality (DoQ)

Table 1: NWSSP Strategic Outcomes and Duty of Quality (DoQ)

NWSSP Outcomes	Relatable DoQ Domains and Enablers	Fleet Modernisation Approach & Activity
Our Value - We will lead the way and command of others the changes required to address the climate change emergency and achieve decarbonisation targets	1 – Leadership 2 – Safe 6 – Effective 11 – Whole Systems Approach	Optimisation of the fleet will demonstrate our commitment continuous improvement from a sustainability perspective. A Fleet Replacement Profiling process has been developed to ensure vehicles are appropriately replaced with BEVs and ULEVs only.
Our Value - We will make bold investment decisions that drive transformation and add value	1 – Leadership 4 – Timely 7 – Information 11 – Whole Systems Approach	Optimisation of the fleet will drive efficiency centred transformation through improved route planning and reduced vehicle miles. The development of the Fleet Replacement Profiling enables considers investment into transformation of the current fleet, improving value for money and vehicle longevity.
Our Value - We will utilise our resources efficiently and make a positive impact on a social and sustainable basis.	8 – Efficient	The BJC for this financial year is investing in technologically enhanced vehicles resulting in lower carbon emissions, reduced fuel costs and maintenance, reduced noise pollution and improved air quality.
Our Value - We will spearhead opportunities to grow investment in the foundational economy across Wales as an increasing proportion of our supply chain.	2 – Safe 5 – Culture 6 – Effective 9 – Equitable	By deploying an increased number of BEVs there will be opportunities to utilise services from across Wales in areas of maintenance, EV charging, and EV charging Infrastructure.
Our Services We will drive innovation, setting the standard for good practice, and	6 – Effective 2 – Safe 3 – Workforce 7 – Information	The development of the Fleet Replacement Profiling drives innovation within current fleet management and the adoption of FleetCheck. The replacement

enhance our processes through automation.		profiling enhances the process via clearly defined criteria, which will become best practice for NWSSP, and prevent the decommissioning of any fit for purpose vehicles.
Our Services We will be data driven, sharing intelligence with our partners to influence decision making across NHS Wales.	4 – Timely 6 – Effective 7 – Information 8 – Efficient	The Fleet Replacement Profiling process is driven by the data required through the defined criteria. The fleet management System FleetCheck, will support data led decision making as HCS improves efficiency measures.
Our People We will create opportunities for our current and future staff to maximise their potential and nurture our talent pipeline	3 – Workforce 5 – Culture 10 – Person Centred 12 – learning, Improvement & Research	The introduction of additional BEVs will create opportunities for drivers to be trained to use modern technology.
Our People We will increase the diversity of our workforce and advance the use of the Welsh Language in all that we do	3 – Workforce 5 – Culture 9 – Equitable	Welsh Language signage and briefings will be used wherever needed.
Our People We will promote physical, social, mental, and financial wellbeing throughout the organisation to support our staff.	1 – Leadership 2 – Safe 9 – Equitable 10 – Person Centred	The investment in contemporary and modern vehicles will provide a fit for purpose working environment for the drivers across the organisation promoting improved physical, social, mental, and financial wellbeing.
Our People We will listen and learn from our staff to co-produce innovative solutions with our partners	1 – Leadership 3 – Workforce 5 - Culture	Staff involvement has been integral to the development of this BJC and opinions on selected options will be taken and included as part of solutions development and wider planning activities. Additional change Management actions are planned to be undertaken to support this, and wider service adoption.

Appendix 2 - Fleet Replacement Profile

Does the predicted annual depretiation of a new asset exceed the cost of maintenace for the last finaincial year, or rolling 12 months of the existing asset?

ICE
Will the vehicle be older than 8 years at the time of replacement?
Is the capital asset value currently zero?
Is the milage over 250,000?
Is the vehicle condition score 4 or higher?
Is the vehicle failing the Euro6 emissions standard?

BEV
Will the vehicle be older than 6 years at the time of replacement?
Is the capital ssset value currently zero?
Is the milage over 250,000?
Is the vehicle condition score 3 or higher?
Are the results of the battery health assessment 80%?

If yes to all the above, please continue to the below. If two or more answers are no, then it is suggested that the vehicle is kept for another year.

Is it possible to switch this vehicle to a lower milage route?
Are we able to offer this vehicle to health organisations to put on to lower milage route?

Is it possible to switch this vehicle to a lower milage route?
Are we able to offer this vehicle to helth organisations to put on to lower milage route?

If no to the above then a discussion about the vehicles replacement should be scheduled.

Appendix 3 - Benefit Profile Card

Benefit Profile Card; B1:

Item	Description
Reference Number	B1
Description of Benefit or Disbenefit	Transitioning from internal combustion engine vehicles to BEV vehicles will significantly reduce vehicle emissions such as nitrogen oxide and particulate matter. This will improve air quality in traffic-heavy areas, as unlike diesel vans, EVs produce zero tailpipe emissions and help protect vulnerable populations at hospitals. Additionally, this transition is expected to reduce emissions by approximately 250 grams per mile, resulting in a maximum annual carbon reduction of 650 tonnes, and dependant on the BEV/ULEV split.
Programme Objective Supported	Fully compliant fleet according to the requirements of the NHS Wales Decarbonisation Strategic Plan.
Benefit Category/s	Compliance and decarbonisation.
Business KPIs affected	TBC
Current Baseline	Current ice fleet emission rate – 250g per mile per ICE. (750 tonnes PA)
Benefit Realisation Costs	Cost of replacing current ICE vehicles with BEV/ULEV vehicles.
Capabilities required for benefit realisation	Realising this benefit will require new capabilities in BEV/ULEV fleet management, emissions monitoring and charging infrastructure operations, as well as enhanced change management for workforce adoption.
Outcomes required for benefit realisation	The required outcomes include full deployment of BEVs, installed charging infrastructure, staff training completed, and emissions reporting system in place.
Business Changes required for benefit realisation	The business changes required for benefit realisation is a transition from ICE to EV fleet operations, new charging and maintenance procedures, updated procurement and emission reporting processes and driver behaviour adaption.
Related risks and issues to full benefit	Related risks and issues to full benefits are delays in EV procurement, inadequate charging infrastructure, low driver adoption and failure to accurately measure emissions reductions.
Dependencies	The realisation of this benefit depends on timely EV procurement, charger installation, Capital funding, energy capacity availability and accurate emissions tracking system.
Responsible person for realisation (BCM)	Tony Chatfield
Benefit Owner	Tony Chatfield
Operational Beneficiary	NWSSP/HCS
Measures	Reduction in total fleet CO2 emissions (Tonnes/year) % reduction vs baseline year % of fleet transitioned to electric vehicles Average emissions per mile

Benefit Profile Card; B2:

Item	Description
Reference Number	B5
Description of Benefit or Disbenefit	Transitioning to an EV fleet will significantly reduce fleet fuel expenditure. Electricity costs per mile are typically lower that diesel or petrol and EVs offer higher energy efficiency. This benefit aims to reduce annual fuel costs by approximately £2,882,368 by replacing fossil fuel usage with lower cost electric charging supporting long term budget efficiency and Welsh Governments net zero strategic plan and NHS Wales decarbonisation strategic delivery plan.
Programme Objective Supported	Replace existing vehicles that have reached their (ICE/BEV) year fleet replacement profile and are no longer fit for purpose with either Electric Vehicles or Ultra Low Emissions Vehicles, increasing our operational resilience whilst reducing our carbon emissions and our fuel/maintenance costs, and to meet the expectations of the NHS Wales Decarbonisation Strategic Delivery Plan.
Benefit Category/s	Cash Releasing
Business KPIs affected	Fuel cost per mile Total fuel spends
Current Baseline	Annual fuel cost per vehicle before transition to EV.
Benefit Realisation Costs	The benefit realisation costs include EV procurement, installation of charging infrastructure, smart energy management software and staff training.
Capabilities required for benefit realisation	Required capabilities include EV fleet and energy management, smart charging infrastructure oversight, accurate fuel cost tracking and driver training to maximise efficiency and cost savings.
Outcomes required for benefit realisation	Outcomes required include reduced fossil fuel use, fully deployed and operational EV's efficient use of charging infrastructure active cost tracking and EV energy lower than previous fuel spend.
Business Changes required for benefit realisation	The business changes for this benefit include adapting procurement and budgeting to electricity use, updating driver refuelling behaviour and integrating EV cost tracking into operational and finance processes.
Related risks and issues to full benefit	Risks to full fuel cost saving include high electricity rates, unreliable infrastructure, dual fleet inefficiencies, poor charging behaviour and weak energy cost tracking.
Dependencies	Procurement of BEV
Responsible person for realisation (BCM)	Daniel Sinderby/Tim Knight
Benefit Owner	Tony Chatfield
Operational Beneficiary	NWSSP/HCS
Measures	Annual fuel cost (£) Cost per mile (£) % reduction in fuel costs EV charging cost per vehicle EV charging cost per Mile Total fuel spends

Appendix 4 – Options – Long List

	Option
Option 1	Do Nothing
Option 2	Do Minimum - Only replace vehicles when beyond repair (Owned)
Option 3	Do Minimum - Only replace vehicles when beyond repair (Leased)
Option 4	Do Minimum - Only replace vehicles when beyond repair (Leased and Owned)
Option 5	Replace ICE with BEV/ULEV mix when Beyond Economical Repair (Owned)
Option 6	Replace ICE with BEV/ULEV mix when Beyond Economical Repair (Leased)
Option 7	Replace ICE with BEV/ULEV mix when Beyond Economical Repair (Leased and Owned)
Option 8	Replace ICE with BEV as needed (Owned)
Option 9	Replace ICE with BEV as needed (Leased)
Option 10	Replace ICE with BEV as needed (Leased and Owned)
Option 11	Replace ICE with ULEV as needed (Owned)
Option 12	Replace ICE with ULEV as needed (Leased)
Option 13	Replace ICE with ULEV as needed (Leased and Owned)
Option 14	Replace ICE with a Mixture of BEV & ULEV (Owned)
Option 15	Replace ICE with a Mixture of BEV & ULEV (Leased)
Option 16	Replace ICE with a Mixture of BEV & ULEV (Leased and Owned)
Option 17	Replace all ICE with BEV (Owned)
Option 18	Replace all ICE with BEV (Leased)
Option 19	Replace all ICE with BEV (Leased and Owned)
Option 20	Replace all ICE with ULEV (Owned)
Option 21	Replace all ICE with ULEV (Leased)
Option 22	Replace all ICE with ULEV (Leased and Owned)
Option 23	Replace all ICE with a mixture of BEV/ULEV (Owned)
Option 24	Replace all ICE with a mixture of BEV/ULEV (Leased)
Option 25	Replace all ICE with a mixture of BEV/ULEV (Leased and Owned)
Option 26	Phased transition: ICE - ULEV - BEV (Owned)
Option 27	Phased transition: ICE - ULEV - BEV (Leased)
Option 28	Phased transition: ICE - ULEV - BEV (Leased and Owned)

Appendix 5 - SWOT Analysis

					Strengths	Weaknesses	Opportunities	Threats	Conclusion
		Potential Scopes	Option	Description	Advantages	Disadvantages	Advantages	Disadvantages	Against SO's and CFS's
Option 1	1	Do Nothing	Do Nothing	Retain all ICE v	No Capital Requiremen	Increased Revenue Cost	Could reinvest capit	Vehicles could carry	This option does not meet any of the programmes spending objectives.
Option 2	2	Do Minimum 1	Only replace	Retain all ICE v	Minimal Annual Capital	Increased Revenue Cost	To reinvest capital ir	Vahicles could carry	This option fails to meet SO1, SO2, SO3, SO6, and SO7.
Option 3	3	Do Minimum 2	Only replace	Retain all ICE v	Minimal Annual Revenu	Increased Revenue Cost	To reinvest capital ir	Vahicles could carry	This option fails to meet SO1, SO2, SO3, SO6, and SO7.
Option 4	4	Do Minimum 3	Only replace	Retain all ICE v	Minimal Annual Revenu	Increased Revenue Cost	To reinvest capital ir	Vahicles could carry	This option fails to meet SO1, SO2, SO3, SO6, and SO7.
Option 5	5	Do Minimum 4	Only replace	Keep serviceab	Allows the fleet ot be re	Initially Increased Reven	To reinvest capital ir	Vahicles could carry	This option fails to meet SO1, SO2, SO3, SO6, and SO7.
Option 6	6	Do Minimum 5	Only replace	Keep serviceab	Allows the fleet ot be re	Initially Increased Reven	To reinvest capital ir	Vahicles could carry	This option fails to meet SO1, SO2, SO3, SO6, and SO7.
Option 7	7	Do Minimum 6	Only replace	Keep serviceab	Allows the fleet ot be re	Initially Increased Reven	To reinvest capital ir	Vahicles could carry	This option fails to meet SO1, SO2, SO3, SO6, and SO7.
Option 8	8	Intermediate 1	Replace ICE	Replace only Bl	Meets Welsh Decarb St	Benefits not released as	ULEV Zone compliar	Dependancy on Nat	This option meets all of the spending objectives.
Option 9	9	Intermediate 2	Replace ICE	Replace only Bl	Meets Welsh Decarb St	Benefits not released as	ULEV Zone compliar	Dependancy on Nat	This option meets all of the spending objectives.
Option 10	10	Intermediate 3	Replace ICE	Replace only Bl	Meets Welsh Decarb St	Benefits not released as	ULEV Zone compliar	Dependancy on Nat	This option meets all of the spending objectives.
Option 11	11	Intermediate 4	Replace ICE	Replace only Bl	Meets Welsh Decarb St	Benefits not as great as	ULEV Zone compliar	New emerging techr	This option meets all of the spending objectives.
Option 12	12	Intermediate 5	Replace ICE	Replace only Bl	Meets Welsh Decarb St	Benefits not as great as	ULEV Zone compliar	New emerging techr	This option meets all of the spending objectives.
Option 13	13	Intermediate 6	Replace ICE	Replace only Bl	Meets Welsh Decarb St	Benefits not as great as	ULEV Zone compliar	New emerging techr	This option meets all of the spending objectives.
Option 14	14	Intermediate 7	Replace ICE	Replace only Bl	Meets Welsh Decarb St	Benefits better than ULE	ULEV Zone compliar	Partly dependant or	This option meets all of the spending objectives.
Option 15	15	Intermediate 8	Replace ICE	Replace only Bl	Meets Welsh Decarb St	Benefits better than ULE	ULEV Zone compliar	Partly dependant or	This option meets all of the spending objectives.
Option 16	16	Intermediate	Replace ICE	Replace only Bl	Meets Welsh Decarb St	Benefits better than ULE	ULEV Zone compliar	Partly dependant or	This option meets all of the spending objectives.
Option 17	17	Do Maximum 1	Replace all I	Replace all ICE	Meets Welsh Decarb St	Increased initial capital	ULEV Zone compliar	New emerging techr	This option meets all of the spending objectives.
Option 18	18	Do Maximum 2	Replace all I	Replace all ICE	Meets Welsh Decarb St	Increased initial capital	ULEV Zone compliar	New emerging techr	This option meets all of the spending objectives.
Option 19	19	Do Maximum 3	Replace all I	Replace all ICE	Meets Welsh Decarb St	Increased initial capital	ULEV Zone compliar	Dependancy on Nat	This option meets all of the spending objectives.
Option 20	20	Do Maximum 4	Replace all I	Replace all ICE	Meets Welsh Decarb St	Increased initial capital	ULEV Zone compliar	Dependancy on Nat	This option meets all of the spending objectives.
Option 21	21	Do Maximum 5	Replace all I	Replace all ICE	Meets Welsh Decarb St	Increased initial capital	ULEV Zone compliar	Dependancy on Nat	This option meets all of the spending objectives.
Option 22	22	Do Maximum 6	Replace all I	Replace all ICE	Meets Welsh Decarb St	Increased initial capital	ULEV Zone compliar	New emerging techr	This option meets all of the spending objectives.
Option 23	23	Do Maximum 7	Replace all I	Replace all ICE	Meets Welsh Decarb St	Benefits better than ULE	ULEV Zone compliar	Partly dependant or	This option meets all of the spending objectives.
Option 24	24	Do Maximum 8	Replace all I	Replace all ICE	Meets Welsh Decarb St	Benefits better than ULE	ULEV Zone compliar	Partly dependant or	This option meets all of the spending objectives.
Option 25	25	Do Maximum 9	Replace all I	Replace all ICE	Meets Welsh Decarb St	Benefits better than ULE	ULEV Zone compliar	Partly dependant or	This option meets all of the spending objectives.
Option 26	26	Do Maximum 10	Phased tran	Gradual transit	Meets Welsh Decarb St	Increased initial and lon	Easier to roll out pe	New emerging techr	This option meets all of the spending objectives.
Option 27	27	Do Maximum 11	Phased tran	Gradual transit	Meets Welsh Decarb St	Increased initial and lon	Easier to roll out pe	New emerging techr	This option meets all of the spending objectives.
Option 28	28	Do Maximum 12	Phased tran	Gradual transit	Meets Welsh Decarb St	Increased initial and lon	Easier to roll out pe	New emerging techr	This option meets all of the spending objectives.

Appendix 6 – Financial Table

Recommended Option	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33	33/34	34/35	35/36	36/37	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Capital Expenditure													
Capital Requirements (£'s including VAT)	1,206	1,845	2,696	1,632	1,419	0	0	0	0	0	0	0	8,798
Total Capital Costs	**1,206**	**1,845**	**2,696**	**1,632**	**1,419**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**8,798**
Revenue Expenditure													**0**
Maintenance (annual saving)	0	-18	-45	-85	-109	-130	-130	-130	-112	-85	-45	-21	-911
Insurance (annual cost)	0	4	10	19	24	29	29	29	25	19	10	5	201
Fuel (annual Saving)	0	-56	-143	-269	-345	-412	-412	-412	-355	-269	-143	-66	-2,882
Total Revenue Costs/(Savings)	**0**	**-70**	**-178**	**-335**	**-430**	**-513**	**-513**	**-513**	**-443**	**-335**	**-178**	**-83**	**-3,591**
Total Expenditure													**0**
Total Project Costs (Capital & Revenue)	**1,206**	**1,774**	**2,518**	**1,297**	**989**	**-513**	**-513**	**-513**	**-443**	**-335**	**-178**	**-83**	**5,206**
Funding													**0**
Capital funding	1,206	1,845	2,696	1,632	1,419	0	0	0	0	0	0	0	8,798
Revenue funding	0	-70	-178	-335	-430	-513	-513	-513	-443	-335	-178	-83	-3,591
Total funding	**1,206**	**1,774**	**2,518**	**1,297**	**989**	**-513**	**-513**	**-513**	**-443**	**-335**	**-178**	**-83**	**5,206**

TRUST BOARD	
GP Locum Hub Commitment of Expenditure Exceeding Chief Executive's Limit	
DATE OF MEETING	**27 November 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	Lisa Williams, NWSSP Assistant Director of Employment Services
PRESENTED BY	Gareth Hardacre, NWSSP Director of Workforce, Organisational Development and Employment Services
APPROVED BY	**Choose an item**
EXECUTIVE SUMMARY	Locum Hub Wales is a digital platform used by GP Practices across Wales as a result of Ministerial commitment to GP Practices in 2019. A contract extension for 2 years is required to enable a system wide assessment, including the arrangements for the All-Wales Locum Register, the new Primary Care Workforce Information System (PCWIS), the profile model for the People Portal (previously Electronic Staff Record) and outcome of the user research exercise. This will allow sufficient time to complete planned user research, engage stakeholders meaningfully, and ensure any future procurement is informed by robust evidence and aligned with national and ministerial priorities.
RECOMMENDATION / ACTIONS	Trust Board approval is being sought for this additional extension cost value of £271,494.58 as this will take the total contract value over £1m.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Shared Services Partnership Committee	14/11/2025
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The approach has been approved by the Shared Services Partnership Committee at its meeting on 14 November 2025	
APPENDICES	
1	Commitment of Expenditure Form

1. SITUATION

Extension is required to the GP Locum Hub contract. Trust Board approval is being sought for the additional expenditure commitment.

1. BACKGROUND

Locum Hub Wales is a digital platform used by GP Practices across Wales as a result of Ministerial commitment to GP Practices in 2019. Practices post and book Locum coverage on a daily basis to ensure uninterrupted care delivery in the community. Critical to this service is ongoing compliance with capturing GP Practice Locum workforce activity for the purpose of the Wales General Medical Practice Indemnity Scheme. Additionally, practices advertise and appoint permanent staff using the system. It is interoperable with existing NHS Wales primary care infrastructure and is an ongoing data source to fulfil Welsh Government's commitment to evidence-based strategic decisions and publication of quarterly statistics. There are no alternative digital solutions.

Approvals for this scheme took place in 2019 under the original Open OJEU process under the Public Contract Regulations (PCR) (2015). The total awarded value was £759,021.78. This included the option to extend for an additional 3 years. In April 2022, the contracted requirement for continued hosting, maintenance and support for GP Advertising (also provided by GPUK) was incorporated into the contract for Locum Hub via Change Control Notice (approved 27th September 2022), increasing the contract value by £136,643.14. The additional 3 years have been exhausted and will expire on 18th December 2025.

2. ASSESSMENT

The Welsh Government supports a temporary contract extension of two years (+1+1). This extension will ensure continuity of service to GP Practices locum management, fulfil General Medical Indemnity Scheme requirements and enable evidence-based strategic planning. A full tender process is not feasible at this time; the extension ensures a robust and tested solution while broader and possibly complementary workforce and digital transformation strategies are developed. The total cost of this extension is £271,494.58. This was approved by NHS Wales Shared Services Partnership on 14th November 2025. These costs comply with Public Contract Regulations (PCR) (2015).

The contract extension for 2 years will enable a system wide assessment, including the arrangements for the All-Wales Locum Register, the new PCWIS, the profile model for the People Portal (previously Electronic Staff Record) and outcome of the user research exercise. This will allow sufficient time to complete planned user research, engage stakeholders meaningfully, and ensure any future procurement is informed by robust evidence and aligned with national and ministerial priorities.

3. SUMMARY OF MATTERS FOR CONSIDERATION

The options considered are set out in the appended Commitment of Expenditure Form.

4. IMPACT ASSESSMENT

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

	Equitable ☐ Efficient ☐ Patient Centred ☐
	Click or tap here to enter text
QUALITY IMPACT ASSESSMENT	Choose an item
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	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	There is no direct impact on resources as a result of the activity outlined in this report.
	Source of Funding: Welsh Government

	Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Revenue** **Scale of Change** Please detail the value of revenue and/or capital impact: No impact on Trust resources – expenditure is met by WG budget through NWSSP. **Type of Change** **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text**
EQUALITY IMPACT ASSESSMENT	Not required - please outline why this is not required
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report. **Click or tap here to enter text**

5. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	Risks relating to the procurement are set out in the appended Commitment of Expenditure form
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

COMMITMENT OF EXPENDITURE EXCEEDING CHIEF EXECUTIVE'S LIMIT / BUSINESS JUSTIFICATION

SCHEME TITLE	Locum Hub Wales Contract
DIVISION / HOST ORGANISATION	NHS Wales Shared Services Partnership - Employment Services
DATE PREPARED	19 November 2025
PREPARED BY	Lisa Williams, NWSSP Assistant Director of Employment Services
SCHEME SPONSOR	Gareth Hardacre, NWSSP Director of Workforce, Organisational Development and Employment Services

All Divisional proposals must be consistent with the strategic and operational plans of Velindre University NHS Trust.

1. DESCRIPTION OF GOODS / SERVICES / WORKS

Locum Hub Wales is a digital platform used by GP Practices across Wales as a result of Ministerial commitment to GP Practices in 2019. Practices post and book Locum coverage on a daily basis to ensure uninterrupted care delivery in the community. Critical to this service is ongoing compliance with capturing GP Practice Locum workforce activity for the purpose of the Wales General Medical Practice Indemnity Scheme. Additionally, practices advertise and appoint permanent staff using the system. It is interoperable with existing NHS Wales primary care infrastructure and is an ongoing data source to fulfil Welsh Government's commitment to evidence-based strategic decisions and publication of quarterly statistics. There are no alternative digital solutions.

Approvals for this scheme took place in 2019 under the original Open OJEU process under the Public Contract Regulations (PCR) (2015). The total awarded value was £759,021.78. This included the option to extend for an additional 3 years. In April 2022, the contracted requirement for continued hosting, maintenance and support for GP Advertising (also provided by GPUK) was incorporated into the contract for Locum Hub via Change Control Notice (approved 27th September 2022), increasing the contract value by £136,643.14.

The additional 3 years have been exhausted and will expire on 18th December 2025.

The Welsh Government supports a temporary contract extension of two years (+1+1). This extension will ensure continuity of service to GP Practices locum management, fulfil General Medical Indemnity Scheme requirements and enable evidence-based strategic planning. A full tender process is not feasible at this time; the extension ensures a robust and tested solution

while broader and possibly complementary workforce and digital transformation strategies are developed. The total cost of this extension is £271,494.58. This was approved by NHS Wales Shared Services Partnership on 14th November 2025. These costs comply with Public Contract Regulations (PCR) (2015). All values exclude VAT.

The contract extension for 2 years will enable a system wide assessment, including the arrangements for the All-Wales Locum Register, the new PCWIS, the profile model for the People Portal (previously Electronic Staff Record) and outcome of the user research exercise. This will allow sufficient time to complete planned user research, engage stakeholders meaningfully, and ensure any future procurement is informed by robust evidence and aligned with national and ministerial priorities.

Approval is being sought for this additional extension cost value of £271,494.58 as this will take the total contract value over £1m.

1.1 Nature of contract: Please indicate with a (x) in the relevant box	First time	☐	Contract Extension	☒	Contract Renewal	☐

1.2 Period of contract including extension options:	
Expected Start Date of Contract	19/12/2019
Expected End Date of Contract	18/12/2025
Contract Extension Options **(E.g. maximum term in months)**	24 months

2. STRATEGIC FIT (*Host organisations are not required to complete Section 2)*

2.1 OUR STRATEGIC PILLARS This scheme should relate to at least one of the Trust's five strategic pillars. Please mark with a (x) in the box the relevant pillars for this scheme.	
Goal 1: Be recognised as a pioneer in blood and transplantations services across Europe.	☐
Goal 2: Be a recognised leader in specialist cancer services in Europe.	☐

Goal 3: Be recognised as a leader in stated priority areas of research, development and innovation.	☐
Goal 4: An established 'University' Trust which provides highly valued knowledge and learning for all.	☐
Goal 5: An exemplar of sustainability that supports global well-being and social value.	☐

2.2 INTEGRATED MEDIUM TERM PLAN		
Is this scheme included in the Trust Integrated Medium Term Plan?	**Yes**	**No**
	☒	☐
If not, please explain the reason for this in the space provided.		

2.3 SHAPING OUR FUTURE WELLBEING OBJECTIVES This scheme should relate to at least one of the Trust's wellbeing objectives. Please mark with a (x) in the box the relevant objectives for this scheme.	
Reduce health inequalities, make it easier to access the best possible healthcare when it is needed and help prevent ill health by collaborating with the people of Wales in novel ways.	☒
Improve the health and well-being of families across Wales by striving to care for the needs of the whole person.	☐
Create new, highly skilled jobs and attract investment by increasing our focus on research, innovation and new models of delivery.	☐
Deliver bold solutions to the environmental challenges posed by our activities.	☐
Bring communities and generations together through involvement in the planning and delivery of our services.	☐
Demonstrate respect for the diverse cultural heritage of modern Wales.	☐
Strengthen the international reputation of the Trust as a centre of excellence for teaching, research and technical innovations whilst also making a lasting contribution to global well-being.	☐

FIVE WAYS OF WORKING (SUSTAINABLE DEVELOPMENT PRINCIPLES) CONSIDERED

Please mark with a (x) in the box the relevant principles for this scheme.

Click **here** for more information

Prevention	☒	Long Term	☒	Integration	☐	Collaboration	☒	Involvement	☐

3. OPTIONS CONSIDERED

Include 'business as usual' i.e. 'do nothing'

3.1 Please state alternative options considered and reasons for declining
1. Do Nothing: Under this option, the current contract will expire on 18 December 2025 with no replacement or extension. However, there remains an ongoing requirement to support the deployment of locum and contracted workforce across GP practices. A critical component of this service is ensuring continued compliance with the Wales General Medical Practice Indemnity Scheme, which mandates accurate and timely capture of locum workforce activity. Choosing to do nothing would result in: • Loss of infrastructure and support for locum and contracted workforce deployment. • Non-compliance with indemnity scheme requirements. • Loss of data source for Welsh Government or Strategic stakeholders • Disruption to service continuity and operational risk. **Conclusion:** This option does not support business continuity and is therefore not considered viable. **2. New Procurement:** This option was previously explored during 2024–25. The service requirements are highly bespoke, and any new supplier solution would require an estimated lead time of 18 to 24 months for development and implementation. Given the planned implementation of Primary Care Workforce Intelligence System (PCWIS), operational complexity and time constraints, initiating a full tender process at this stage is not feasible. Proceeding with procurement now would risk service disruption and compromise continuity. **Conclusion:** While a new procurement remains a future consideration, it is not a viable short-term solution. An extension of the current arrangement ensures continuity with a proven solution while broader workforce and digital transformation strategies are developed. **3. Contract Extension:** This option supports IMTP objectives and Welsh Government strategy and was approved by NHS Wales Shared Services Committee on 14th November 2025. This extension will provide the necessary stability to support a system-wide assessment of future requirements. This review will consider: • the ongoing requirement for the service. • digital and workforce strategies • whether continuation should mirror the current model; and • potential value in expanding a service beyond General Medical to other contractor services.

This extension enables meaningful stakeholder engagement, ensures alignment with national and ministerial priorities, and allows time to gather robust evidence to inform a future procurement strategy. **Conclusion:** This option supports business continuity, strategic alignment, and evidence-based planning. It is the preferred and most viable option at this time.

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option
The contract extension for 2 years will provide continued access to 368 GP Practices to manage Locum shift requirements, direct negotiation of shift fees to support financial and workforce sustainability ensuring continued delivery of care within local communities. Additionally, it allows for system wide assessment, including the arrangements for the All-Wales Locum Register, the new PCWIS, the profile model for the People Portal (previously Electronic Staff Record) and outcome of the user research exercise. This will allow sufficient time to complete planned user research, engage stakeholders meaningfully, and ensure any future procurement is informed by robust evidence and aligned with national and ministerial priorities.

5. RISKS & MITIGATION

5.1 Please state risks of not proceeding with the scheme	**5.2 Please state any mitigation to reduce the risk if the scheme is not approved**
• Loss of infrastructure and support for locum and contracted workforce deployment. • Non-compliance with indemnity scheme requirements. • Loss of data source for Welsh Government or Strategic stakeholders • Disruption to service continuity and operational risk.	The Scheme is aligned to IMTP objectives and was approved by NHS Wales Shared Services Partnership Committee on 14th November 2025.

6. PROCUREMENT ROUTE

6.1 How is the contract being procured? Please mark with a (x) as relevant.			
Competition		**Single source**	
3 Quotes	☐	Single Quotation Action	☐
Formal Tender Exercise	☐	Single Tender Action	☐
Mini competition	☐	Direct call off Framework	☐
Find a Tender (replaces OJEU Public Contract regulations 2015 still apply)	☒	All Wales contract	☐
The original tender was completed via the Find a Tender process. This is an extension to the original tender process as listed in 6.2			
Click here for link to Procurement Manual for additional guidance			
6.2 Please outline the procurement strategy			
The original Locum Hub agreement was let via an Open OJEU process under the Public Contract Regulations (PCR) (2015). Contract referenced above dated 19th December 2019. In April 2022, the contracted requirement for continued hosting, maintenance and support for GP Advertising (also provided by GPUK) was incorporated into the contract for Locum Hub via Change Control Notice. The contract extension for 2 years will enable a system wide assessment, including the arrangements for the new PCWIS, the profile model for the Electronic Staff Record and outcome of the user research exercise. This extension complies with the Public Contract Regulations (PCR) (2015). This was confirmed following advice from NWSSP Legal & Risk Services. Approval is requested for additional funding to cover the costs of a 2-year contract extension. This scheme will remain with the existing supplier in accordance with the original contract terms.			

6.3 What is the approximate time line for procurement?
• Contract Extension Additional Spend Approval: 27th November 2025 • Modification Notice to be issued: w.c. 1st December 2025 • Contract Commencement: 19th December 2025

6.4 PROCUREMENT ROUTE APPROVAL

The Head of Procurement / Delegated Authority has approved the preferred procurement route	
Head of Procurement Name:	Jonathan Irvine NWSSP Director of Procurement, Supply Chain, Logistics, Transport and Laundry Services
Signature:	
Date:	19/11/2025

Maximum expected whole life cost relating to the award of contract	**Excluding VAT (£k)** £1,167,159.50	**Including VAT (£k)** £1,400,591.40 (This Scheme excludes VAT)
The nature of spend	**Capital** ☒	**Revenue** ☒
Please note that as per requirement above, the whole life cost is included, which capital and revenue spend. However, the approval is for revenue only as the capital is already spent against original contract.		
How is the scheme to be funded? Please mark with a (x) as relevant. Existing budgets ☐ Additional Welsh Government funding ☒ Other ☐		

If you have selected 'Other' – please provide further details below:

7. FINANCIAL ANALYSIS

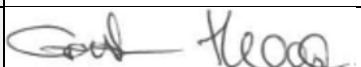
PROFILE OF EXPENDITURE

EXPENDITURE CATEGORY	Year 1 (exc. VAT) £k	Year 2 (exc. VAT) £k	Year 3 (exc. VAT) £k	Total Future Years (exc. VAT) £k	Total (exc.VAT) £k	Total (inc. VAT) £k
Original Contract					759,021.78	910,826.14
Change Control Notice (CCN) 2022					136,643.14	163,971.77
Contract Extension (2 years)	130,526.24	140,968.34			271,494.58	325,793.50
Overall Total					**1,167,159.50**	**1,400,591.41**

8. PROJECT MANAGEMENT (if applicable)

What are the management arrangements associated with this scheme? E.g. PRINCE 2	• PRINCE 2

9. DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE

The Lead Director, by providing email confirmation, to seek Board approval is making a declaration that all procurement procedures, standing orders and standing financial instructions requirements have been appropriately discharged and observed and that where relevant, appropriate advice and confirmation has been obtained to that effect. Procurement Services retain this confirmation electronically in the tender file.	
Lead Director Name:	Gareth Hardacre
Signature:	
Service Area:	NWSSP Director of Workforce, Organisational Development and Employment Services
Date:	19/11/2025

10. APPROVALS RECEIVED

List and include date of approvals received in support of this scheme.

Divisions	Date of Approval:
Business Planning Group or local equivalent	27/11/2024
Divisional Senior Management Team	07/10/2024
Executive Management Board	

Host Organisations	Date of Approval:
NWSSP / NHS Wales Shared Services Partnership Committee	14/11/2025
HTW – Senior Management Team	

TRUST BOARD	
Procurement Dashboard – Benchmarking and Analytics Commitment of Expenditure Exceeding Chief Executive's Limit	
DATE OF MEETING	**27 November 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	Andrew Smallwood, NWSSP Assistant Director of Procurement Sourcing
PRESENTED BY	Jonathan Irvine, NWSSP Director of Procurement and Health Courier Services
APPROVED BY	**Choose an item**
EXECUTIVE SUMMARY	NWSSP-Procurement Services has worked with AdviseInc for the past nine years on both price benchmarking and procurement dashboard tools, and in the past three (3) years switching to Platform+. The current contract with AdviseInc, has come to the end of its initial two (2)-year term and the optional one year extension has also been taken, with the contract due to expire in November 2025. The contract was awarded via the G-Cloud 12 Framework, with no notable issues reported over the duration of the contract. Market research has indicated the possibility of other existing solutions that may be able to fulfil the requirements of NWSSP. However, in order to realise the possible savings available to NHS Wales, it is critical for work to take place with an existing provider for which familiarity with the system exists.

	Due to the above noted benefits, it is proposed to renew the contract with AdviseInc, utilising the compliant route to market available via the G-Cloud 14 Framework.
RECOMMENDATION / ACTIONS	The NWSSP Scheme of Delegation set out in the Trust Standing Orders requires Trust Board approval for NWSSP expenditure > £250k. The Trust Board is requested to approve this contract renewal cost value of £450k and in doing so to also authorise the Chief Executive to approve the purchase order.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Shared Services Partnership Committee (via Chairs Urgent Action)	18/11/2025
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The approach has been approved by the Shared Services Partnership Committee via Chairs Urgent Action on 18 November 2025.	

APPENDICES	
1	Commitment of Expenditure Form

SITUATION

The AdviseInc Procurement Dashboard – Benchmarking and Analytics suite of tools have been used by the NWSSP Procurement Service to deliver savings over many years. The Trust Board is requested to approve the commitment to renew the contract with a commitment over three years of £450k excluding VAT.

1. BACKGROUND

NWSSP-Procurement Services has worked with AdviseInc for the past nine (9) years on both price benchmarking and procurement dashboard tools, and in the past three (3) years switching to Platform+.

Platform+ has proven itself to be pivotal in identifying and helping deliver savings in support of the Value and Sustainability Group's aims. During the current financial year, procurement teams have recorded savings of £1.5m Cash Releasing and £612k Cost Avoidance, through utilisation of the platform. As well

as this, usage of the platform is continuing to increase across Procurement Services, with the recorded monthly sessions across teams increasing monthly so far within this financial year.

2. ASSESSMENT

The current contract with AdviseInc, has come to the end of its initial two (2)-year term and the optional one (1) year extension has also been taken, with the contract due to expire in November 2025. The contract was awarded via the G-Cloud 12 Framework, with no notable issues reported over the duration of the contract.

Market research has indicated the possibility of other existing solutions that may be able to fulfil the requirements of NWSSP. However, in order to realise the possible savings available to NHS Wales, it is critical for work to take place with an existing provider for which familiarity with the system exists.

Due to the above noted benefits, it is proposed to renew the contract with AdviseInc, utilising the compliant route to market available via the G-Cloud 14 Framework.

3. SUMMARY OF MATTERS FOR CONSIDERATION

The options considered are set out in the appended Commitment of Expenditure Form.

4. IMPACT ASSESSMENT

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

QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below** Safe ☐ Timely ☐ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☐ **Click or tap here to enter text**
QUALITY IMPACT ASSESSMENT	**Choose an item**
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	**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	There is no direct impact on resources as a result of the activity outlined in this report.
	Source of Funding: Welsh Government Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Revenue** **Scale of Change** Please detail the value of revenue and/or capital impact: No impact on Trust resources – expenditure is met by WG budget through NWSSP. **Type of Change** **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text**
EQUALITY IMPACT ASSESSMENT	Not required - please outline why this is not required
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report. **Click or tap here to enter text**

5. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	
WHAT IS THE CURRENT RISK SCORE	
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	

ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Choose an item
All risks must be evidenced and consistent with those recorded in Datix	

COMMITMENT OF EXPENDITURE EXCEEDING CHIEF EXECUTIVE'S LIMIT / BUSINESS JUSTIFICATION

SCHEME TITLE	PROCUREMENT DASHBOARD – BENCHMARKING AND ANALYTICS
DIVISION / HOST ORGANISATION	NWSSP
DATE PREPARED	18/11/2025
PREPARED BY	Andrew Smallwood, NWSSP Assistant Director of Procurement Sourcing
SCHEME SPONSOR	Jonathan Irvine, NWSSP Director of Procurement and Health Courier Services

All Divisional proposals must be consistent with the strategic and operational plans of Velindre University NHS Trust.

1. DESCRIPTION OF GOODS / SERVICES / WORKS

NWSSP-Procurement Services has worked with AdviseInc for the past nine (9) years on both price benchmarking and procurement dashboard tools, and in the past three (3) years switching to Platform+.

Platform+ has proven itself to be pivotal in identifying and helping deliver savings in support of the Value and Sustainability Group's aims. During the current financial year, procurement teams have recorded savings of £1.5m Cash Releasing and £612k Cost Avoidance, through utilisation of the platform. As well as this, usage of the platform is continuing to increase across Procurement Services, with the recorded monthly sessions across teams increasing monthly so far within this financial year.

The current contract with AdviseInc, has come to the end of its initial two (2)-year term and the optional one (1) year extension has also been taken, with the contract due to expire in November 2025. The contract was awarded via the G-Cloud 12 Framework, with no notable issues reported over the duration of the contract.

Market research has indicated the possibility of other existing solutions that may be able to fulfil the requirements of NWSSP. However, in order to realise the possible savings available to NHS Wales, it is critical for work to take place with an existing provider for which familiarity with the system exists.

Due to the above noted benefits, it is proposed to renew the contract with AdviseInc, utilising the compliant route to market available via the G-Cloud 14 Framework.

1.1 Nature of contract: Please indicate with a (x) in the relevant box	First time	☐	Contract Extension	☐	Contract Renewal	☒

1.2 Period of contract including extension options:	
Expected Start Date of Contract	01/12/2025
Expected End Date of Contract	30/11/2028
Contract Extension Options **(E.g. maximum term in months)**	N/a

2. STRATEGIC FIT (*Host organisations are not required to complete Section 2)*

2.1 OUR STRATEGIC PILLARS This scheme should relate to at least one of the Trust's five strategic pillars. Please mark with a (x) in the box the relevant pillars for this scheme.	
Goal 1: Be recognised as a pioneer in blood and transplantations services across Europe.	☐
Goal 2: Be a recognised leader in specialist cancer services in Europe.	☐
Goal 3: Be recognised as a leader in stated priority areas of research, development and innovation.	☐
Goal 4: An established 'University' Trust which provides highly valued knowledge and learning for all.	☐
Goal 5: An exemplar of sustainability that supports global well-being and social value.	☐

2.2 INTEGRATED MEDIUM TERM PLAN		
Is this scheme included in the Trust Integrated Medium Term Plan?	**Yes**	**No**
	☐	☐

If not, please explain the reason for this in the space provided.

2.3 SHAPING OUR FUTURE WELLBEING OBJECTIVES This scheme should relate to at least one of the Trust's wellbeing objectives. Please mark with a (x) in the box the relevant objectives for this scheme.	
Reduce health inequalities, make it easier to access the best possible healthcare when it is needed and help prevent ill health by collaborating with the people of Wales in novel ways.	☐
Improve the health and well-being of families across Wales by striving to care for the needs of the whole person.	☐
Create new, highly skilled jobs and attract investment by increasing our focus on research, innovation and new models of delivery.	☐
Deliver bold solutions to the environmental challenges posed by our activities.	☐
Bring communities and generations together through involvement in the planning and delivery of our services.	☐
Demonstrate respect for the diverse cultural heritage of modern Wales.	☐
Strengthen the international reputation of the Trust as a centre of excellence for teaching, research and technical innovations whilst also making a lasting contribution to global well-being.	☐

FIVE WAYS OF WORKING (SUSTAINABLE DEVELOPMENT PRINCIPLES) CONSIDERED

Please mark with a (x) in the box the relevant principles for this scheme.

Click **here** for more information

Prevention	☐	Long Term	☐	Integration	☐	Collaboration	☐	Involvement	☐

3. OPTIONS CONSIDERED

Include 'business as usual' i.e. 'do nothing'

3.1 Please state alternative options considered and reasons for declining
The proposed direct award maintains the use of the current system, as the system is already in place and fully embedded in current ways of working. To change to another system now would be labour and time intensive, involving implementation, all staff training as well as system updates. Therefore, the proposed direct award is the most cost effective and efficient solution, considering

that the Platform+ system continues to fulfil the requirement well with no issues or problems reported. Benchmarking shows that NHS Wales's pricing is competitive compared with the standard pricing for the Platform+ system, with typical pricing for the platform averaging over £400,000.00 per annum for the number of Health Board / Trusts required.

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option
This is the most compliant route to market for this system, which can only be provided via one supplier. Previously, the current contract was procured via G-Cloud 12.

5. RISKS & MITIGATION

5.1 Please state risks of not proceeding with the scheme	**5.2 Please state any mitigation to reduce the risk if the scheme is not approved**
There were no known risks for this approach identified– use of the system is embedded within the organisation, therefore, there are no potential risks regarding implementation or usage.	

6. PROCUREMENT ROUTE

6.1 How is the contract being procured? Please mark with a (x) as relevant.	
Competition	**Single source**
3 Quotes ☐	Single Quotation Action ☐
Formal Tender Exercise ☐	Single Tender Action ☐
Mini competition ☐	Direct call off Framework ☒
Find a Tender ☐ (replaces OJEU Public Contract regulations 2015 still apply)	All Wales contract ☐
Click here for link to Procurement Manual for additional guidance	
6.2 Please outline the procurement strategy	
Sustainability elements including ethical employment in supply chain and the Modern Slavery Act and Decarbonisation were evaluated within the framework criteria. In addition, AdviseInc will be requested to share their Modern Slavery Statement and Carbon Reduction Plan for information. The system has delivered proven benefits to the Foundational Economy to date, by facilitating the identification of spending trends within the Welsh economy. Well-being of Future Generations Goals are addressed below.	
6.3 What is the approximate time line for procurement?	
Direct award awaiting approval.	

6.4 PROCUREMENT ROUTE APPROVAL

The Head of Procurement / Delegated Authority has approved the preferred procurement route	
Head of Procurement Name:	Andy Smallwood
Signature:	
Date:	18 November 2025

7. FINANCIAL ANALYSIS

Maximum expected whole life cost relating to the award of contract	**Excluding VAT (£k)** **450**	**Including VAT (£k)** **540**
The nature of spend	**Capital** ☐	**Revenue** ☒
How is the scheme to be funded? Please mark with a (x) as relevant. Existing budgets ☒ Additional Welsh Government funding ☐ Other ☐		
If you have selected 'Other' – please provide further details below:		

PROFILE OF EXPENDITURE

EXPENDITURE CATEGORY	**Year 1 (exc. VAT) £k**	**Year 2 (exc. VAT) £k**	**Year 3 (exc. VAT) £k**	**Total Future Years (exc. VAT) £k**	**Total (exc.VAT) £k**	**Total (inc. VAT) £k**
Annual charge	150	150	150	-	450	540

Overall Total	150	150	150	-	450	540

8. PROJECT MANAGEMENT (if applicable)

What are the management arrangements associated with this scheme? E.g. PRINCE 2	Existing management arrangements

9. DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE

The Lead Director, by providing email confirmation, to seek Board approval is making a declaration that all procurement procedures, standing orders and standing financial instructions requirements have been appropriately discharged and observed and that where relevant, appropriate advice and confirmation has been obtained to that effect. Procurement Services retain this confirmation electronically in the tender file.	
Lead Director Name:	Jonathan Irvine
Signature:	
Service Area:	Procurement Services
Date:	18 November 2025

10. APPROVALS RECEIVED

List and include date of approvals received in support of this scheme.

Divisions	**Date of Approval:**
Business Planning Group or local equivalent	
Divisional Senior Management Team	
Executive Management Board	

Host Organisations	**Date of Approval:**

NWSSP / NHS Wales Shared Services Partnership Committee	18/11/2025
HTW – Senior Management Team	

TRUST BOARD	
PUBLIC QUALITY, SAFETY & PERFORMANCE COMMITTEE HIGHLIGHT REPORT	
DATE OF MEETING	27th November 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 13th November 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 13TH NOVEMBER 2025

3.1 Triangulated themes

The following triangulated themes were identified:

- **Finance and Digital Integration:** Emerging emphasis on financial sustainability and digital transformation, with links to the IMTP.
- **Culture and Communication:** Importance of communicating change effectively, maintaining staff morale and fostering a culture that supports efficiency and improvement.
- **Governance Structure:** Ongoing focus on improving governance, including committee structures, directorate/divisional effectiveness and clarity in reporting lines.

- **Data and Dashboards:** Need for better data dashboards and relevant information to support effective decision-making and governance.
- **Paperwork Volume:** Concern about excessive paperwork in meetings, with a requirement to streamline and focus on relevant information needed for the aim of the report.
- **Committee Interconnection:** Recognition that similar papers are discussed across multiple committees, suggesting a need for better coordination and governance review.

3.2 Further Information

Board members who are not members of the Committee and would like further detail of the Quality, Safety and Performance (QSP) Committee are able to access the agenda and papers for the November 2025 QSP Committee meeting at: https://velindre.nhs.wales/about-us/quality-safety-performance/quality-safety-performance-2025/quality-safety-amp-performance-committee-13-11-2025/

3.3 Summary of Committee Highlights

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

ALERT / ESCALATE	**Performance Management Framework (PMF) Report and Supporting Analysis - SACT** The Trust has adopted new Key Performance Indicators for SACT (Systemic Anti-Cancer Therapy) performance reporting, following updated Welsh Health Circular guidance and national standards (2024). These changes have led to a significant drop in reported performance figures; however, this is due to the new measurement approach rather than any actual decline in service quality or patient care. The new methodology no longer allows clinical pauses, which affects reported compliance rates. Shadow monitoring confirms that underlying service levels remain consistent with previous years. The Committee were advised the reported decrease in performance is due to the revised methodology being implemented, rather than an 'actual' deterioration of service. Steps are being taken to manage communications and ensure a transparent transition to the new indicators. Regular updates will be provided.
ADVISE	**Finance Report for the Period Ended 30th September 2025** The Committee discussed the Finance Report in detail, as follows: • The Trust is on track to deliver its in-year financial plan, with all key performance indicators met and expected year-end balance. • Shortfall in recurrent savings (£120k off target at month 6) creates a structural challenge for next year. • This year NHS Wales faces a £190m system-wide deficit; no additional cash uplift is expected, and future funding is uncertain.

- Tactical planning underway, including reviewing service provision, new service requests and efficiency/productivity opportunities.
- Workforce costs and effectiveness, benchmarking and culture highlighted as critical factors in managing financial challenges.
- Risks around radiotherapy activity income and capacity discussed, with opportunities identified for income generation and service expansion.
- Long Term Agreement risk and possible changes to the anticipated Welsh Government 2026/2027 funding uplift present significant risks, with a projected £1.7m deficit in year one of the next plan.

The Committee **agreed** the applied **assurance level 4**.

2025-2026 Quarter 2 Trust Quality and Safety Report

The Committee received the Quarter 2 report (attached at appendix 1). The following key points were noted:

- Strong complaints compliance (improved to 88.9% in Quarter 2 (84.6% in Quarter 1 - against national target of 75%), with no new Ombudsman investigations being opened.
- Overall, the number of complaints across the Trust has increased, with an 86% increase in the last year. An increase has been seen across both divisions (71% in VCS, 71% in WBS). A full deep dive analysis is being undertaken.
- There has been a 162% increase in open redress cases between Q2 2024/25 (8) and Q2 2025/26 (21) and an 81% increase in open inquests between Q2 2024/25 (11) and Q2 2025/26 (20).
- The Trust continues to have low incidences of healthcare acquired infections.
- Pressure ulcer improvement work is continuing but close ongoing scrutiny required.
- A Regulation 28 inquest outcome has been received in relation to regional dietetic support. An improvement plan is in place to address the issues identified from the investigation.

The Committee **agreed** the **assurance level 4** which remains stable due to current data limitations.

Putting Things Right Regulations Amendment: 'Listening to People NHS Wales, Complaints, Incidents and Redress Process' Impact Assessment

The Trust is preparing for the newly titled 'Listening to People' regulations, which are a revision of the Putting Things Right 2011 regulations and take effect from the 1st April 2026. The revision introduces a more compassionate, person-centred approach to complaints and redress.

	Key challenges were discussed and include meeting a shorter 120-day redress timescale, managing increased financial limits for redress which will increase the number of redress cases and reduce the numbers of claims, increased requirement for the commissioning of external expert reports and the requirement for an 'in person' meeting for all concerns. The Committee were advised that these revisions do require some additional resources to implement fully which will be included in the IMTP. A Trust wide group has been established to ensure the organisation is fully prepared to implement the revised regulations by 1st April 2026. Given that the Trust is currently in the planning phase, and the national guidance is still awaited the current **assurance is currently at level 1.** **Swansea Bay Maternity and Neonatal Review Gap Analysis** The Committee Trust discussed the Swansea Bay maternity & neonatal lessons learnt report and the identified learning opportunities, focusing on strengthening data quality, governance and compassionate complaint handling. Actions include developing a single source of validated data, supporting staff with trauma-informed approaches and clarifying ownership of recommendations for implementation. It was agreed that there needs to be a detailed Board development discussion in respect of how the Trust can embed this learning in all that it does going forward.
ASSURE	**Workforce Supply and Shape & Associated Finance Risks** The Committee received a revised formatted six-monthly workforce supply and shape report, which provided improved clarity on actions, outcomes, and progress. Highlights included a strategic focus on long-term workforce transformation and the need to align financial resources, with the Committee noting that the assurance level for leadership and management had been reduced due to gaps identified against a new framework. Positive trends were reported in education, attraction and retention metrics, while areas for improvement included PADR compliance and attendance at leadership development, with digital dashboards and 24/7 learning tools in development to support these. The Welsh language skills baseline has been established, and compassionate leadership training has been rolled out, showing early positive impact. Induction attendance drop-off is under review, with future actions to be reported. All workforce initiatives are being integrated with broader culture and education strategies. The Committee **agreed** the **assurance level 3**

Performance Management Framework (PMF) Report and Supporting Analysis

Velindre Cancer Service

- Radiotherapy metrics now align with national standards, with minimal impact from new guidance. Ongoing focus on productivity and waiting list management aims to enhance operational effectiveness and reporting consistency.

Welsh Blood Service

- Strong performance in stem cell collection and stock management, with support provided to English services. Efforts continue to improve donor diversity and address screening challenges, including digital solutions. Overdue incident actions have been resolved.

Workforce and Wellbeing

- Emphasis on managerial leadership and PADR compliance, with integration into broader culture work. Assurance levels adjusted to reflect progress. Need for improved induction attendance and ongoing monitoring noted.

Digital Services

- Successful Windows migration and launch of a digital diagnostic project. Assurance remains at level 3 due to risk profile, with continued focus on team capacity and capability.

Estates, Infrastructure, and Sustainability

- Assurance levels improved due to new management system (CAPAM) and robust maintenance. Health and safety assurance increased, and sustainability performance remains high, supported by strong management and staff engagement.

Financial Performance

- Financial performance remains strong, with the highest assurance level maintained.

Trust Risk Register

The Trust Risk Register was reviewed for assurance, with no significant new risks identified. Key risks are being actively managed, including nurse education and Radiology data migration. Some risk scores have been reduced following divisional review. One new risk was included in error and will be corrected. Risk management processes remain effective and up to date.

The Committee **agreed** the applied **assurance level 3**.

	Quarter 2 IMTP Deliverables The Committee received the quarterly IMTP (Integrated Medium Term Plan) report, outlining performance against planned deliverables. For Q1, there were 17 outstanding deliverables, of which 11 were completed in Q2, leaving 6 still outstanding. In Q2, there were 25 deliverables, with 7 completed to date. The discussion emphasised the need for sharper clarity on commitments, realistic planning, and transparent tracking. There was a focus on aligning IMTP deliverables with the Board Assurance Framework to assess materiality and risk, noting some discrepancies in reporting timelines and status. Suggestions included improving information flow, aligning RAG ratings and assurance levels, and refining the process for next year to address resource, accountability and culture. The Committee **agreed** the assigned **assurance level 3**. **Board Assurance Framework** The Committee reviewed the Board Assurance Framework (BAF), confirming its alignment with strategic goals and noting that while some areas such as research & development, sustainability, culture, and transformation have no risks above the reporting threshold, work is ongoing to strengthen the culture risk entry. The importance of linking gaps in controls and assurance to specific actions was emphasised, and the Committee agreed the BAF **level of assurance** remaining at **2**.
INFORM	**Velindre Cancer Service - Patient Story** The Committee received a patient story which highlighted positive care and identified process gaps in MSCC management, prompting agreement on the need for improved staff training, regional collaboration and consideration of a clinical audit to support pathway consistency. **Healthcare Inspectorate Wales (HIW) - Review of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Decisions for Adults in Wales - Audit Assurance Update** The DNACPR presentation covered progress on action plans, noting most recommendations are complete but some await evidence for closure. Discussions focused on ensuring patient access to information, the need for training to address broader end-of-life care wishes and plans to confirm these aspects.

	NHS WALES SHARED SERVICES PARTNERSHIP **Transforming Access to Medicine (TrAMs) Update** The TrAMs report update focused on strengthening programme board governance with more senior, strategic representation, addressing tight business case timeline and ensuring workforce planning and stakeholder engagement are robust and well-communicated. **Pharmacy Technical Services Update** The pharmacy update confirmed the medicines unit at IP5 is fully compliant with its licence, regular KPI reviews are in place, and no outstanding issues were reported, resulting in an identified **assurance level 6.** **The Committee ENDORSED the following Annual Report:** • Quality, Safety & Performance Committee **The Committee NOTED the following Annual Reports:** • Health Technology Wales Annual Report • Advanced Therapies Wales Annual Report **The Committee APPROVED the following Trust policies:** • PP01 Fire Safety Policy • PP01.0 Fire Safety Protocol - Principles of Fire Safety **The Committee ENDORSED the following policies:** • All Wales Anti-Sexual Harassment Policy • All Wales Short Term Protection of Earnings Guidance • All Wales Medical Appraisal Policy • Exit Interview Procedure
APPENDICES	Quality and Safety Quarter 2 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 13th November 2025.

Velindre University NHS Trust Quality and Safety Report Quarter 2 2025-2026

(1st July 2025- 30th September 2025)

WHAT IS QUALITY?

The Health & Social Care (Quality Engagement) (Wales) Act 2020 was implemented from 1st April 2023. This law includes the Duty of Quality and defines quality as the following:

'Continuously, reliably and sustainably meeting the needs of the population we serve'.

This is not limited to the effectiveness of health services; the safety of health services; and positive experience of service users.
The 12 Quality Standards are used across the trust which help deliver against the 6 quality domains:

Trust Approach

The Trust has a network for all teams to communicate, which is mainly made up of staff from across the Trust. These included our Divisional Quality Hubs, Integrated Quality & Safety Group, Quality, Safety & Performance and Executive Management Board providing assurance to the Trust Board and the population of Wales on the Trust's commitment to the Duty of Quality.

The Trust infrastructure is supported by a range of digital tools and systems to assist with monitoring, collaborating and reporting on the services the Trust supplies across Wales.

With this infrastructure, quality information can be shared effectively and timely. This can also help identify best practices, risks, areas of improvement or just for reporting purposes.

1. INTRODUCTION AND EXECUTIVE SUMMARY

The Trust's Q2 integrated quality & safety report provides analysis of key outcomes, activity, learning and improvement during Q2 and, where possible, provides themes, trends and comparative data. The report provides assurance in relation to key legislative requirements including Putting Things Right Regulations (2011) & Health and Social Care (Quality and Engagement) (Wales) Act (2020), and maintain a strong focus upon learning and improvement, to ensure the continued provision of Safe, Timely, Effective, Efficient, Equitable and Person-Centred Care

Quality & Safety Indicators Overview

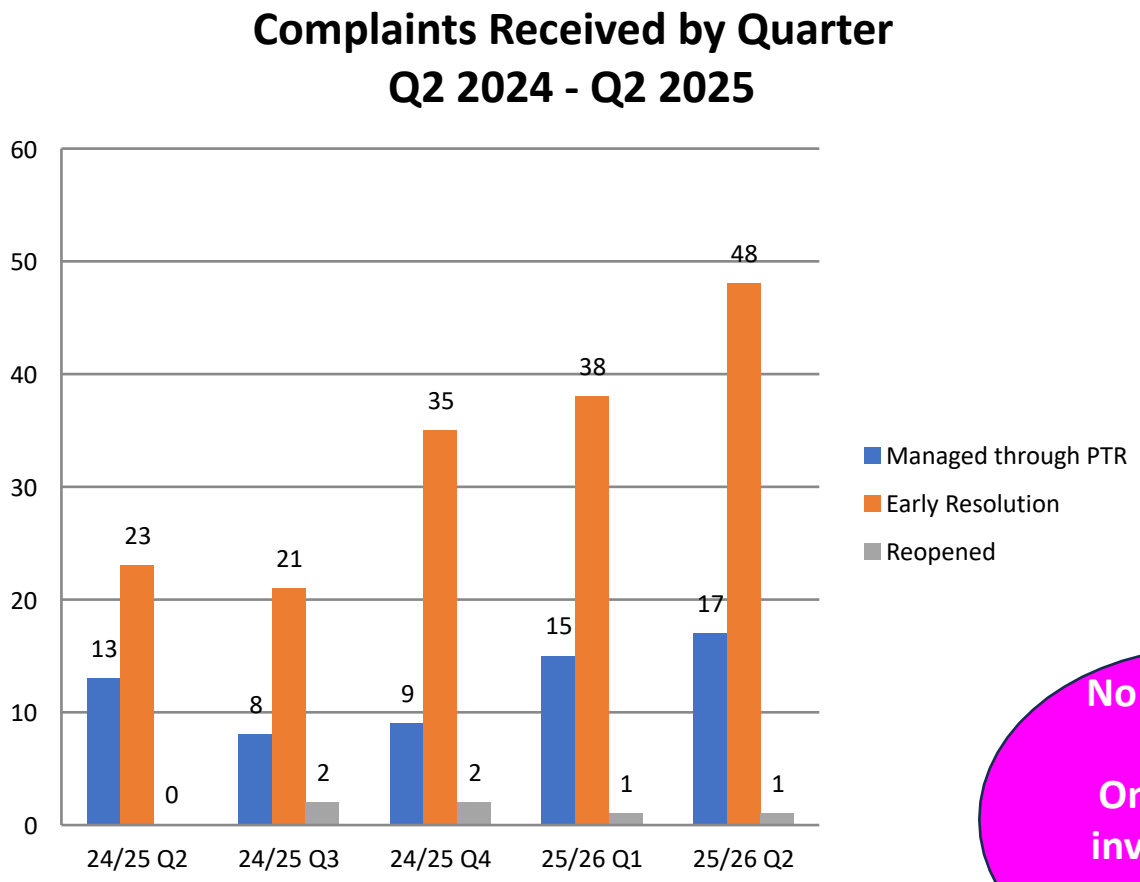
Q2 2025/26 | Q2 2024/25

	Q2 2025/26	Q2 2024/25
Putting Things Right Formal Complaints	17	13
Putting Things Right Compliance	88.9%	93.6%
Early Resolution Complaints	48	23
New Redress	6	0
New Inquest	1	4
Ombudsman cases	0	0
Incidents	628	530
Duty of Candour Incidents	3	3
Nationally Reportable Incidents	0	0
Safeguarding Duty to Report	3	4
Concern Reopened	1	0
Welsh Blood Service satisfaction	95%	99%
Velindre Cancer Service satisfaction	94 %	100%
Incidents open over 30 days	220	110

2. COMPLAINTS – TRUST OVERVIEW

Figure 1 shows an overall increase of 86% in formal and early resolution complaints since quarter 2 2024/25. A full deep dive will be undertaken.

Figure 1



Complaints resolved within 30 working days:

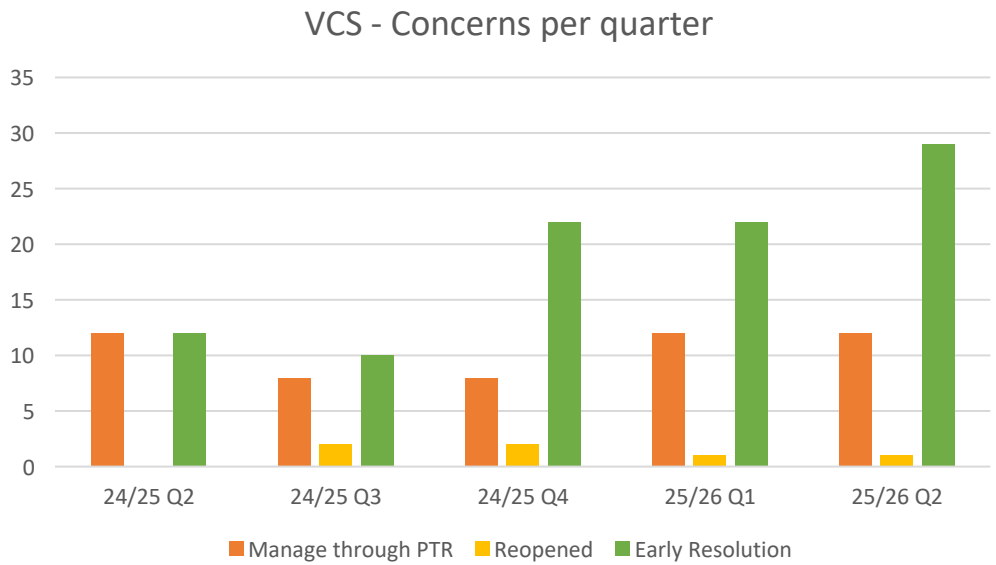
- **Q2** 24/25 93.6%
- **Q3** 24/25 75%
- **Q4** 24/25 50%
- **Q1** 25/26 84.6%
- **Q2** 25/26 88.9%

Q2 overview

- **88.9%** of complaints were Resolved within 30 working days
- **87.5%** of complaints were acknowledged within the 5 working day target
- **1** Complaint reopened
- **No new Public Services Ombudsman investigations opened since Q3 2023-24**
- **5** Complaints remain open within PTR timescales
- **65** New complaints

2.1 CONCERNS– VELINDRE CANCER SERVICE

Figure 2



Enquiries

Figure 3

Complaints

Of **45,107** patient attendances, **0.093%** resulted in a complaint.

71% increase seen in total concerns within the last year.

41 Total New Complaints raised

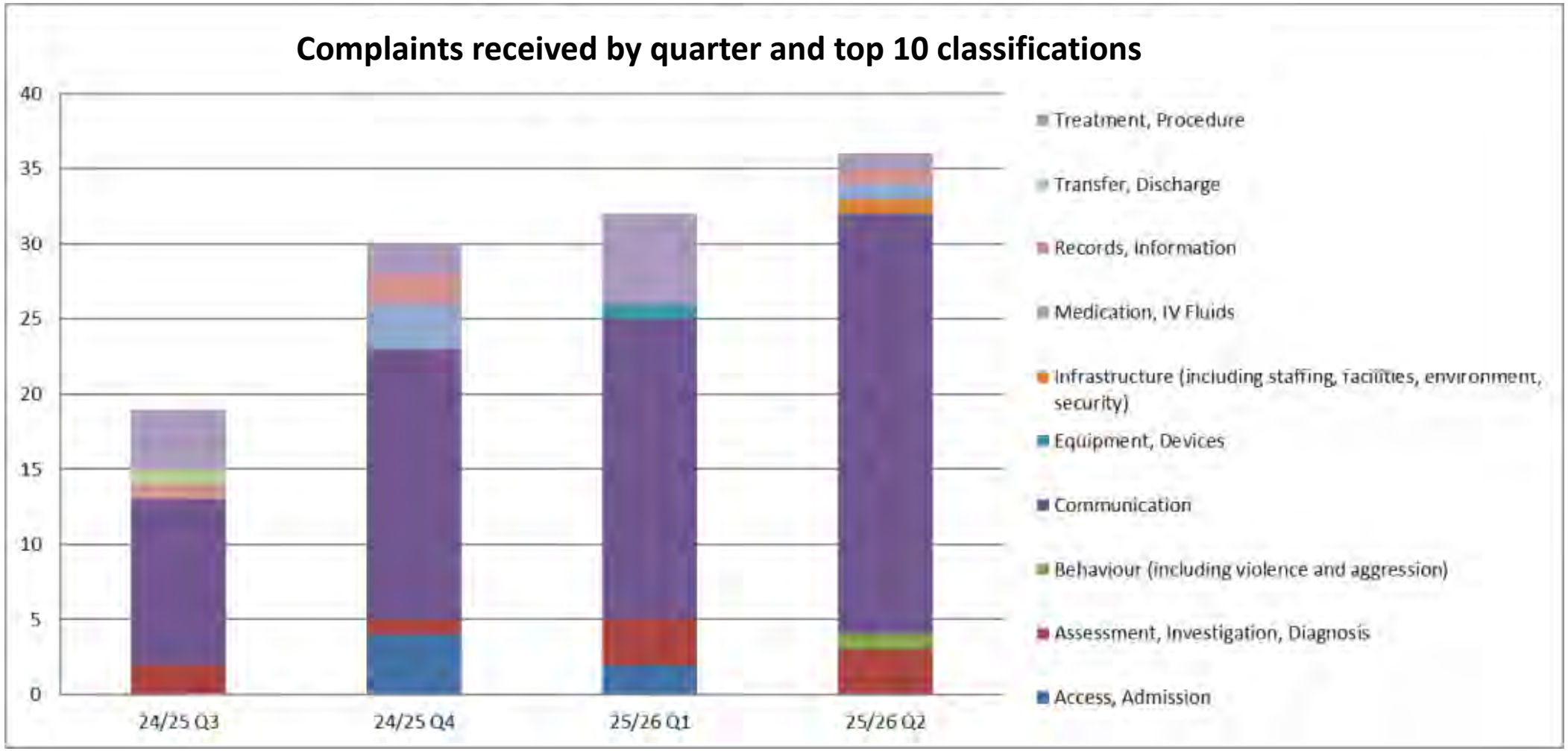
29 complaints managed as Early Resolution

12 complaints managed formally

1 complaint reopened

Q1 25/26	Q2 25/26
12 Enquiry received	**15** Enquiry received

Figure 4


Complaints received by quarter and top 10 classifications
40
35
30
25
20
15
10
5
0
24/25 Q3
24/25 Q4
25/26 Q1
25/26 Q2
Treatment, Procedure
Transfer, Discharge
Records, Information
Medication, IV Fluids
Infrastructure (including staffing, facilities, environment, security)
Equipment, Devices
Communication
Behaviour (including violence and aggression)
Assessment, Investigation, Diagnosis
Access, Admission

2.1 CONCERNS – VELINDRE CANCER SERVICE CONT.

ANALYSIS

- Many “Communication” concerns relate to the communication surrounding the patients clinical care e.g., understanding of diagnosis, planned treatment, or monitoring plan.
- A small number of these concerns have been raised by family members after the patient has died.
- Most of the communication concerns relate to consultations within outpatient appointments and have been resolved through early resolution where the patient and clinician have had further opportunity to discuss the patient’s questions and concerns. This correlates with themes identified through patient feedback and incident where clinic lists are overbooked.
- No clinical harm has been identified in any of the concerns raised.

A smaller number of the communication concerns relate to the communication and management of appointments. The number of concerns related to this have decreased since Q1 due to the improvements undertaken in SACT Bookings Team with the development and appointment of the SACT Scheduling and Performance Manager role, and an improvement plan.

A small number concerns relate to staff attitude towards patients and colleagues. These are not related to one department or staff group. This figure is comparable when looking at previous quarters. Each case has been managed in line within the departments involved.

LEARNING AND IMPROVEMENTS IDENTIFIED FROM VELINDRE CANCER SERVICE COMPLAINTS

SACT Pathway transformation work, led by the SACT nursing team, is under way. An initial workshop was held in Quarter 2 2025/26 with representation from each Site-Specific Team. The aim is to move away from a consultant-led model. The agreed workstreams are:

- Nurse-led Pre SACT consent and education clinic
- Further expansion of VAP clinic
- Development of face-to-face Independent Prescriber led clinics (this will support patients who require face to face appointments but do not need a consultant review)
- Consultant/ medical led face to face reviews.

This will see patients allocated for the appropriate level of review . This will result in patients having the appropriate length of time with their reviewer and will allow consultants to manage the complex patients.

A project plan with timescales being developed.

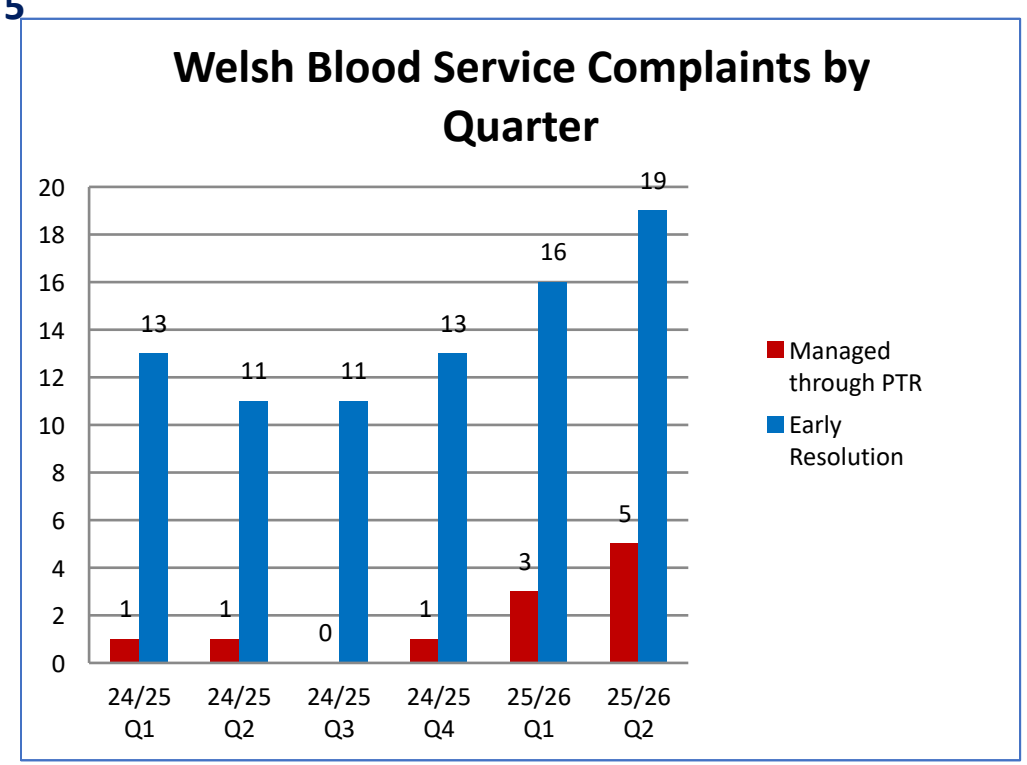
A copy of clinic letters are now routinely being sent to all patients (with consent). This allows patients and their families to revisit and reflect on the information they were given verbally in clinic. This is a Trust Quality Priority for 2025-26.

During Quarter 3 2025/26, Velindre Cancer Service will work with the Patient and Carer Partnership Board on ways to strengthen inclusion with family and carers.

Velindre Cancer Service will undertake a benchmarking exercise with other cancer centres on the type of concerns that are received.

2.2 COMPLAINTS – WELSH BLOOD SERVICE

Figure 5



24
Total New Complaints raised

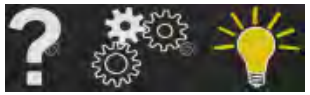
19
Resolved through Early Resolution

5
Formal PTR

0
reopened

0.1% of 23,216 registered donors complained about the service they received

71% increase in concerns in the last year



2.2 COMPLAINTS – WELSH BLOOD SERVICE CONT.

ANALYSIS

The main themes and opportunities for improvement related to **appointments, communication issues, clinical assessment/ treatment and Attitude & Behaviour** mainly within donor collection teams. These concerns continue to be spread across a variety of teams and locations.

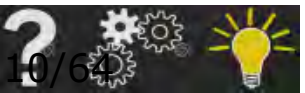
LEARNING AND OUTCOMES

Further learning and improvement areas following concerns have led to:

WBS are actively exploring a secondary point of care testing method using venous rather than capillary samples.

In Q2, WBS identified communication challenges with donors whose first language is neither Welsh nor English, resulting in confusion around donation deferrals. To improve donor understanding and experience, the Donor Experience Manager will conduct site visits to Collection teams, delivering targeted Language Line training and support.

Training on managing difficult conversations is currently being delivered by the Workforce Department to enhance staff and donor interactions. Mindfulness sessions are scheduled across Wales from October to December, supporting staff wellbeing and donor care. A compassionate leadership programme, developed with the Workforce Department, is planned for rollout to all Blood Donation managers in January. Subject to stable stock levels, bitesize learning on staff demographics and team collaboration is expected to launch in early 2026. Additional learning opportunities to improve donor experience are welcomed for future consideration.



4.1 VELINDRE CANCER SERVICE – PATIENT EXPERIENCE

11%
Felt the time they waited was longer than expected

94%
Were overall satisfied with their care

89 of 836 patients completed the Friends and Family Survey

This equates to a feedback rate of **2%** of scheduled appointments

747 of 836 **patients completed the Patient Experience Survey**

A small number of responses concerned poor communication around appointment scheduling, difficulty contacting departments by telephone, and long waiting times in outpatients' settings

97% felt they were treated with dignity and respect

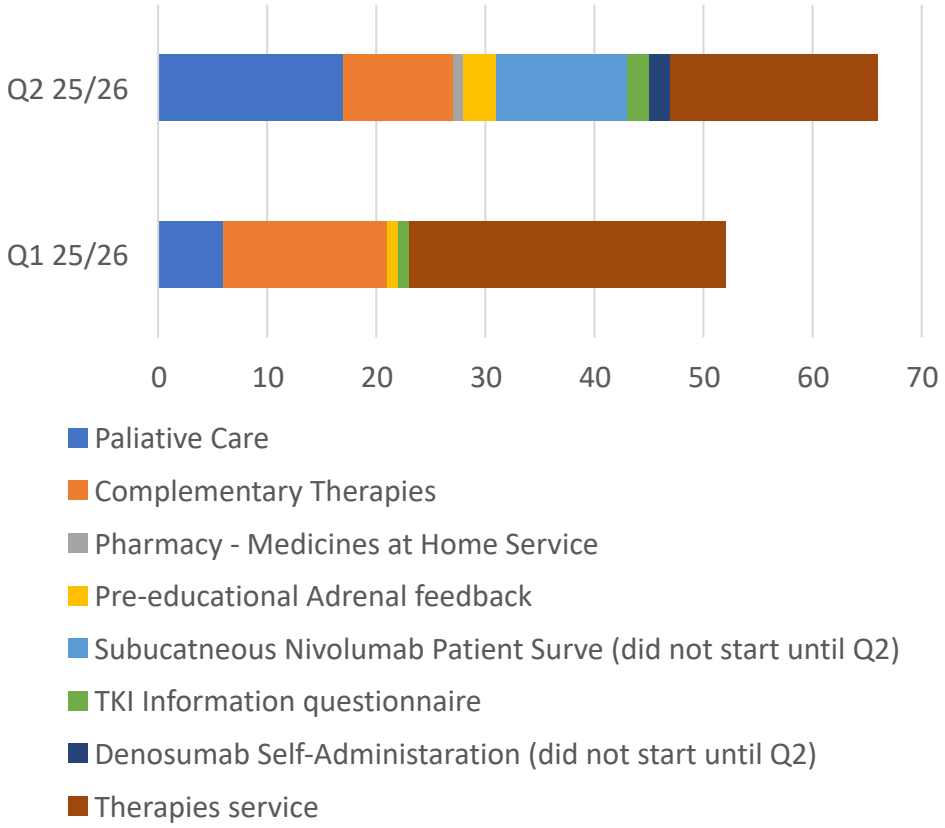
7%
Felt their care was not always explained in a way they understood

Heat map for the National Patient Experience Survey at VCS

Figure 6

Service	Responses	3 - Was the time you waited:	4 - Did you feel well cared for?	5 - Were you treated with dignity and respect?	7 - Were you able to communicate in your preferred language?	8 - Did you feel that you were listened to?	9 - Were you involved as much as you wanted to be in decisions about your care?	10 - Were things explained to you in a way you could understand?	11 - How would you rate your overall experience?	Overall
		People's Experience Survey (PES)	People's Experience Survey (PES)	People's Experience Survey (PES)	People's Experience Survey (PES)	People's Experience Survey (PES)	People's Experience Survey (PES)	People's Experience Survey (PES)	People's Experience Survey (PES)	
Clinical Trials	16	95	100	100	100	100	100	98	98	99
Medicine	6	88	94	94	100	89	83	94	92	92
Nuclear Medicine	5	100	100	100	73	93	80	93	95	92
Nursing	109	84	91	94	98	91	88	92	91	91
Outpatients	55	77	91	96	98	93	88	92	94	91
Palliative care	1	100	100	100	100	100	100	100	100	100
Radiology	6	100	94	94	100	94	94	94	83	94
Radiotherapy	130	91	97	98	100	98	96	96	96	97
Radiotherapy/Brachytherapy	1	100	100	100	100	100	100	100	100	100
SACT	418	90	94	97	99	95	93	93	94	94
	Overall	**89**	**94**	**97**	**99**	**95**	**92**	**93**	**94**	**94**
	Benchmarks	**85**	**85**	**85**	**85**	**85**	**85**	**85**	**85**	

Figure 7 Velindre Cancer Service
Bespoke Service / Department Evaluation Surveys



Two national surveys are used within Velindre Cancer Service - the new All Wales 'Patient Experience Survey', consisting of **22** questions, and 'VCC Friends & Family', consisting of **8** questions.

Figure 7 represents PES responses. there are also several surveys and questionnaires that have been created through the CIVICA platform to evaluate and seek feedback on a particular service or aspect of care / treatment. These surveys can help inform service improvements and development, as well as evaluate new services to test and learn their impact and ensure continuous refinement.

836 patients provided feedback across both national surveys. A further **68** patients undertook a bespoke survey **totalling 904 patient feedback surveys received for Quarter 2. This is an increase of 132% from Q1 2025/26 (390).**

This equates to a patient feedback rate of **2%** of scheduled appointments. It must be noted that some patients, such as those receiving radiotherapy have a daily appointment for several weeks.

There is a continued focus on increasing patient feedback within Velindre Cancer Service. An action plan has been developed with Head of Communications and is being worked through to increase capacity and capability to collect patient feedback and consider different ways of engagement across the Cancer Service.

4.1 VELINDRE CANCER SERVICE – PATIENT EXPERIENCE CONT.

We asked
You said
Together we have

You Said	Together We Have
Can we have somewhere closer to radiotherapy to buy refreshments?	The barista coffee bar opened in Radiotherapy reception in September 2025

Through capturing more patient feedback, it provides us with an opportunity to do meaningful “you said, we did” as an ongoing improvement cycle such as the successful opening of the radiotherapy coffee bar that opened as a direct result of patient feedback received

Wall of Thanks

To LA6 ,Thank you for making me feel so welcome and teaching me everything. Couldn't be this amazing without you!

Just to say thank you to all the lovely nurses on CDU for making a difficult time so much easier

To the amazing nursing team, I appreciate all your support and kindness shown throughout my treatment. You have all been brilliant. Thank you!

Just wanted to share some positive patient feedback A patient was talking to me, who expressed several times the positive experience she had of Pharmacy and wanted to thank the whole team for all their work and for providing treatment that has prolonged her life. She was sincerely appreciative for all that you do and have done for her over the course of her treatment.

I would not be where I am today without your help and support. Sending you this with gratitude, respect and love

thank you very much for this morning, I felt a lot better after talking to you. I will look into the information you have provided. Many thanks

Many Thanks for your welcoming Smiles, friendships and professionalism over the past 6 weeks

4.1 VELINDRE CANCER SERVICE – PATIENT ENGAGEMENT

We asked
You said
Together
we have

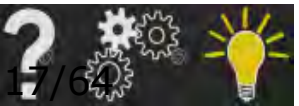
Patient and Carer Partnership Board continues to meet monthly

Topics	Output
Improving awareness and engagement with research, innovation and clinical trials (focus group session)	Engagement plan required including review of current web pages
Reasearch, Development and Innovation Strategy	Involvement in shaping the RDI funding bid
Increasing diversity within volunteers and board members	Development of stakeholder list and targeted plan to inform stakeholders of opportunities etc.
Use of QR Coded Wristbands in Palliative Medicine	Continued involvement with feasibility study and roll out
Velindre Oncology Academy Curriculum	Members integral member of Curriculum development
VUNHST Investigation Template	Feedback considered when finalising template
Collaborative Centre for Learning, Research and Innovation (CCfLRI)	Attendance at stakeholder event to scope out potential opportunities for engagement, education etc.
Therapeutic Apheresis Stakeholder Event	Engagement with stakeholders and collaboration discussions on future delivery model
Patient Representation on VCS key meetings/Trust Committees	Chair of PCPB attended IQSG to assess appropriateness for patient representation. Ongoing discussions regarding VCS structures

4.1 VELINDRE CANCER SERVICE – PATIENT ENGAGMENT TEAM CONT.

Q2 Engagement Activities

- 1 School Visit – Victory for Velindre
- 1 Velindre Voices Newsletters
- 3 Young Ambassadors Newsletters
- Call 4 Concern Co-Production Interviews (ongoing)
- Attend Anywhere Focus Groups and Survey (ongoing)
- 2 Patient and Carer Partnership Board Meetings
- 1 Patient Partner Teacher at Fundamentals in Cancer Care
- 1 Patient Story at Foundations in Cancer Course
- Patient Story at Immunotherapy Study Day
- Chair of PCPB attended stakeholder panel for VCS new roles
- 1237 Volunteer Hours

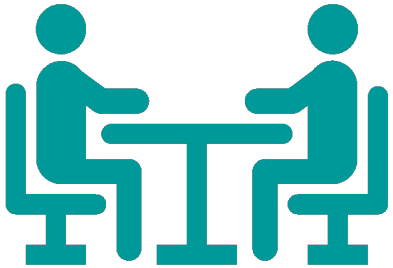


Formal Consultation Activities/Llais Engagement

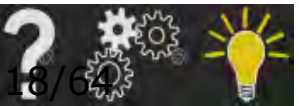
Monthly meetings with Head of Patient Engagement and Llais continue, with WBS Head of Performance and Planning to join bimonthly from quarter 3.

Notification of change of service at Nevill Hall Hospital due to urgent estates work required due to aerated concrete. Formal liaison with ABUHB and Gwent Llais.

Support given to ABUHB Formal Consultation on Clinical Strategy Development.



LLAIS
Eich llais mewn iechyd a gofal cymdeithasol | Your voice in health and social care



4.2 WELSH BLOOD SERVICE – DONOR EXPERIENCE

The Welsh Blood Service values all donor feedback received in helping to understand both successes and further opportunities to improve. We capture, analyse and trend our donor experience feedback, and share it, along with actions taken in response, with our donors, their families and staff in line with the requirements of the Duty of Quality. These are the results of the Civica Surveys and digital on-session feedback forms.

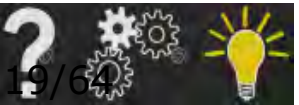
98%
Were overall satisfied with their care

16% (3,633) of 23,216 donors provided feedback

100%
Said the service was Compassionate & Caring

100% found the service to be Friendly & Welcoming

100% said staff were Helpful & Knowledgeable



4.2 WELSH BLOOD SERVICE – DONOR EXPERIENCE CONT.

Figure 8

	Responses	1 - On a scale of 1-5 how satisfied are you with your overall experience within the collection clinic to	2 - Based on today's visit did you find staff welcoming & friendly?	3 - Based on today's visit did you find staff helpful & knowledgeable?	4 - Based on today's visit did you find staff professional, compassionate & caring?	5 - Based on today's visit do you feel you were treated with dignity & respect?	6 - Based on today's visit were you provided with enough information about the donation process?	7 - Based on today's visit did you receive adequate emotional & physical support?	8 - Based on today's visit did you find a good standard of hygiene & cleanliness?	9 - Based on today's visit did you feel safe?	10 - Based on today's visit do you feel you were offered quality of care?	11 - Based on today's visit are you satisfied with the venue & facilities?	12 - Based on today's visit were you satisfied with the snacks and beverages available to you?	Overall
Bangor Team	548	99	100	100	100	100	100	100	99	100	100	100	100	100
Donation Clinic (TG)	5	95	100	100	80	80	100	100	100	100	100	100	100	96
East A	409	98	99	100	100	100	100	100	100	100	100	98	98	99
East B	523	98	100	100	100	100	100	100	100	100	100	98	99	100
East C	705	98	100	100	100	100	100	100	100	100	100	100	98	100
West Team	621	99	100	100	100	100	100	100	100	100	100	100	100	100
Wrexham Team	841	99	100	100	100	100	100	100	100	100	100	98	100	100
	Overall	**98**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**99**	**100**
	Benchmarks	**95**	**95**	**95**	**95**	**95**	**95**	**95**	**95**	**95**	**95**	**95**	**95**	

4.2 WELSH BLOOD SERVICE – DONOR ENGAGEMENT

Welsh Blood Service undertakes an additional monthly email survey to evaluate donor satisfaction from initial contact to post-donation experience. The goal is to improve donor retention. Survey results are reviewed, and the overall satisfaction score is reported to Welsh Government. As part of our questionaries, we ask respondents several questions about the service we provide. They are asked to score these services, with **10** being totally satisfied and **1** being totally dissatisfied.

Q1 Satisfaction Scores for those who had successfully donated		Q1 Satisfaction Scores for those who had incomplete donations	
90.2% (1244) Overall, Donor Satisfaction		86% (1391) Overall, Donor Satisfaction	
Bangor (107) 91.6%	Wrexham (179) 91.6%	Bangor (128) 82.8%	Wrexham (201) 87.6%
East (689) 87.7%	West (269) 95.2%	East (766) 84.2%	West (296) 91.9%

Q2 Satisfaction Scores for those who had successfully donated		Q2 Satisfaction Scores for those who had incomplete donations	
92.8% (2141) Overall, Donor Satisfaction		88.2% (2380) Overall, Donor Satisfaction	
Bangor (195) 91.8%	Wrexham (313) 90.1%	Bangor (216) 87.5%	Wrexham (355) 85.4%
East (1150) 92.3%	West (483) 96.3%	East (1286) 86.9%	West (355) 85.4%

4.2 WELSH BLOOD SERVICE – DONOR ENGAGEMENT CONT.

Response Summary – About the respondents

2,427 Completed Responses

93.8% would donate again (10/10)

91.8% Net Score (70+ world class)

17-87 Age range

1090 Male (45.6%)

216 Bangor (9.1%)

355 Wrexham (14.9%)

523 West (22.0%)

57 Average Age

1302 Female (54.4%)

430 East A (18.1%)

410 East B (17.2%)

446 East C (18.7%)

National Satisfaction Scores (for successfully completed donations)

Satisfaction Scores of 9 or 10

92.8% National Satisfaction

Bangor 91.8%

Wrexham 90.1%

East 92.3%

West 96.3%

Welsh Blood Service Wall of Thanks

East B- Staff were absolutely fabulous and lovely to talk to. Will be back

East A - All the staff was pleasant and professional. I found Aron on teas at the end of the process such a delight

Bangor- I always love donating and all the staff are great

Wrexham- Fantastic as usual. All the staff were great! Keep up the good work

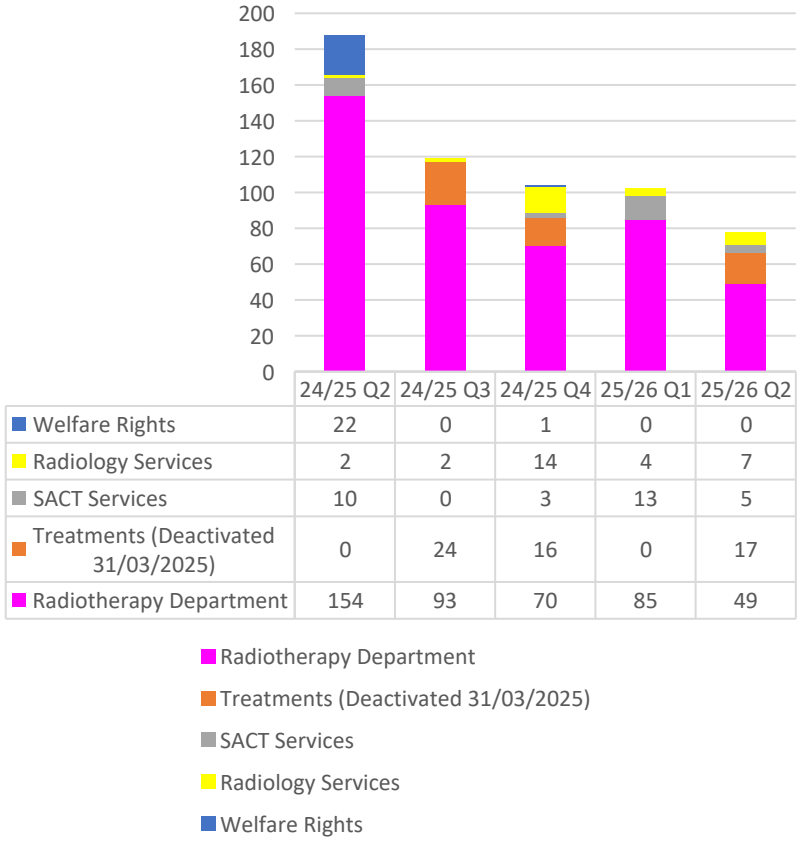
West Team - Nothing can or could have been done better. Staff are knowledgeable, helpful, friendly and all fantastic at what they do

East C - Everything was great, honestly don't know what more could be done

4.3 TRUST OVERVIEW – COMPLIMENTS

Figure 9

Compliments Received Trust-wide (Top 5 Services)

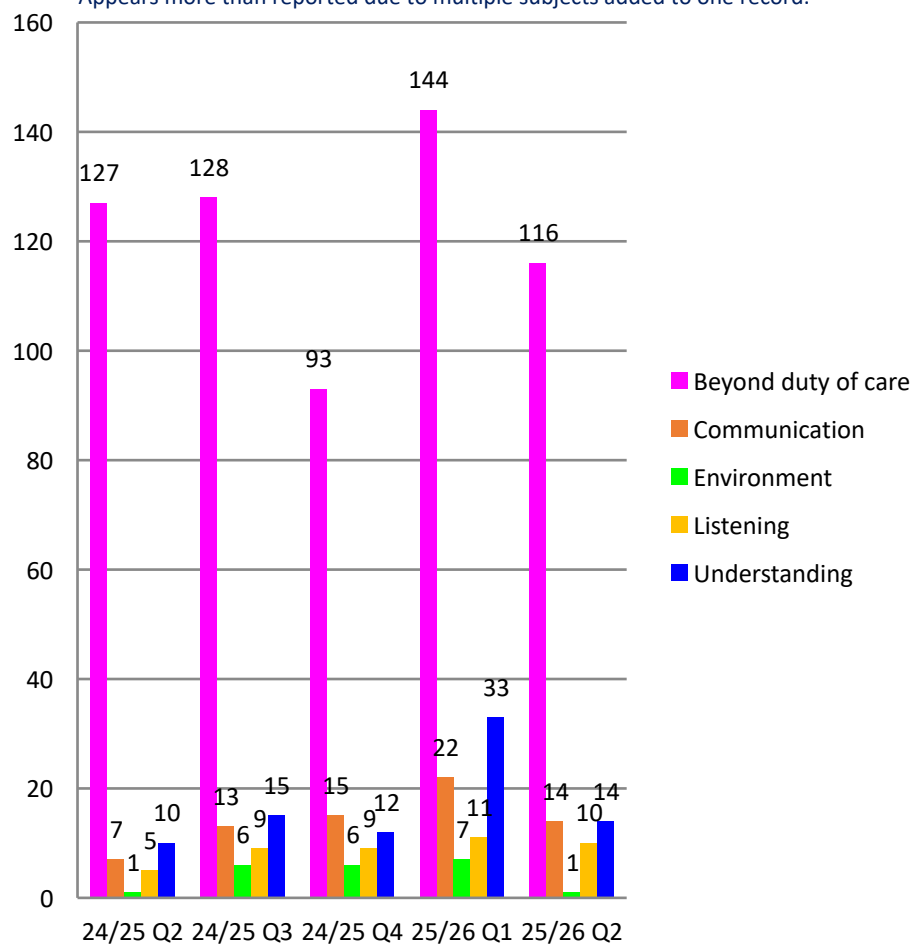


	24/25 Q2	24/25 Q3	24/25 Q4	25/26 Q1	25/26 Q2
Welfare Rights	22	0	1	0	0
Radiology Services	2	2	14	4	7
SACT Services	10	0	3	13	5
Treatments (Deactivated 31/03/2025)	0	24	16	0	17
Radiotherapy Department	154	93	70	85	49

Figure 10

Compliments Received by Subject (Q2 2024-25 to Q2 2025-26)*

*Appears more than reported due to multiple subjects added to one record.



145 Compliments were recorded on Datix

12 were recorded for Welsh Blood Service

131 were recorded for Velindre Cancer Service

2 were recorded for Corporate

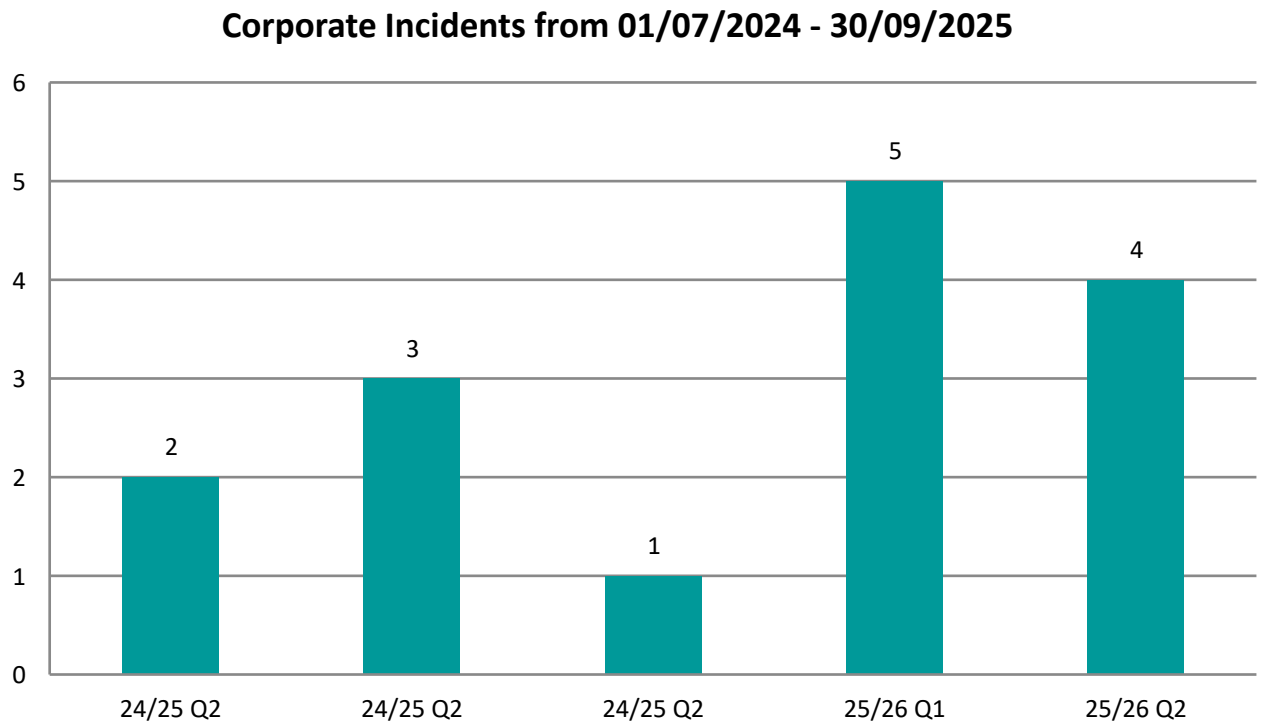
Work is being undertaken in WBS to increase recording compliments on Datix.

5. INCIDENTS – CORPORATE SERVICES

Patient and donor safety incidents are any unintended or unexpected incidents, which could have, or did, lead to harm for one or more patients/donor's receiving healthcare. Incidents are all reported incidents being reviewed at service level, through Quality and Safety leads and the Quality and Safety Hubs.

Q2 Trust Incident Summary

Figure 11



Two incidents remain open over 30 days. Most reported category being non-medical equipment. All incidents were no harm incidents.

Analysis of incidents is provided by division.

5.5 VELINDRE CANCER SERVICE – INCIDENTS

Figure 12

Figure 11 shows an increase in the number of incidents open over 30 days across the Cancer Service. Work is ongoing with departments to improve this, including regular reports and incident management training and education. Head of Nursing to start during Quarter 3, and General Managers to start in Quarter 4, this will provide robust oversight and a set mechanism for escalation should incidents over 30 days go over an acceptable level.

Figure 13

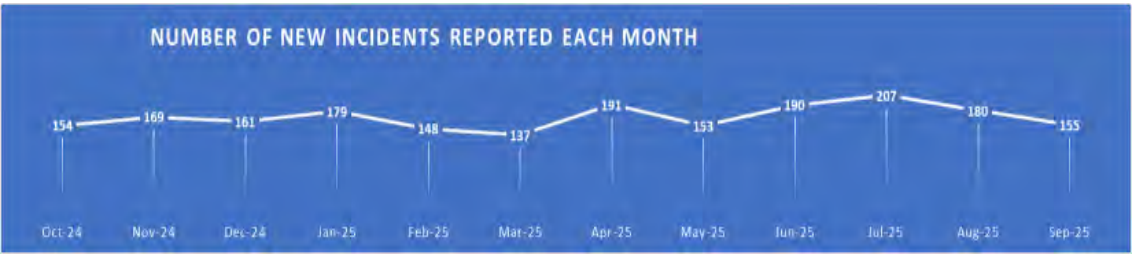


Figure 12 shows regular fluctuation in the number of incidents reported each month. 542 incidents were reported in quarter 2 which equates to 1.2% of total recorded patient attendances.

Figure 14

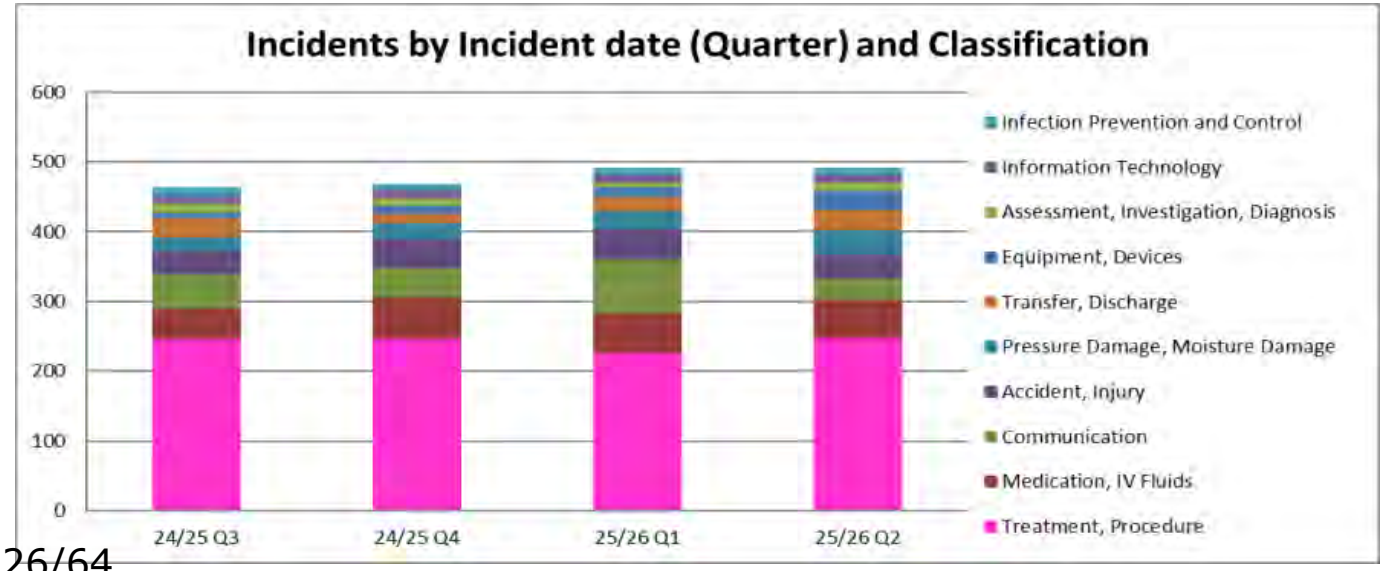


Figure 13 identifies that the highest number of incidents related to **'Treatment and Procedure'** which is in keeping with previous reporting periods. The majority of these relate to no harm incidents associated with a known machine issue in Radiotherapy and is a Trust requirement to record on the Datix system.

5.2 INCIDENTS – DUTY OF CANDOUR

34 Incidents were reported as having caused moderate harm

3 Incidents Triggered the Duty of Candour

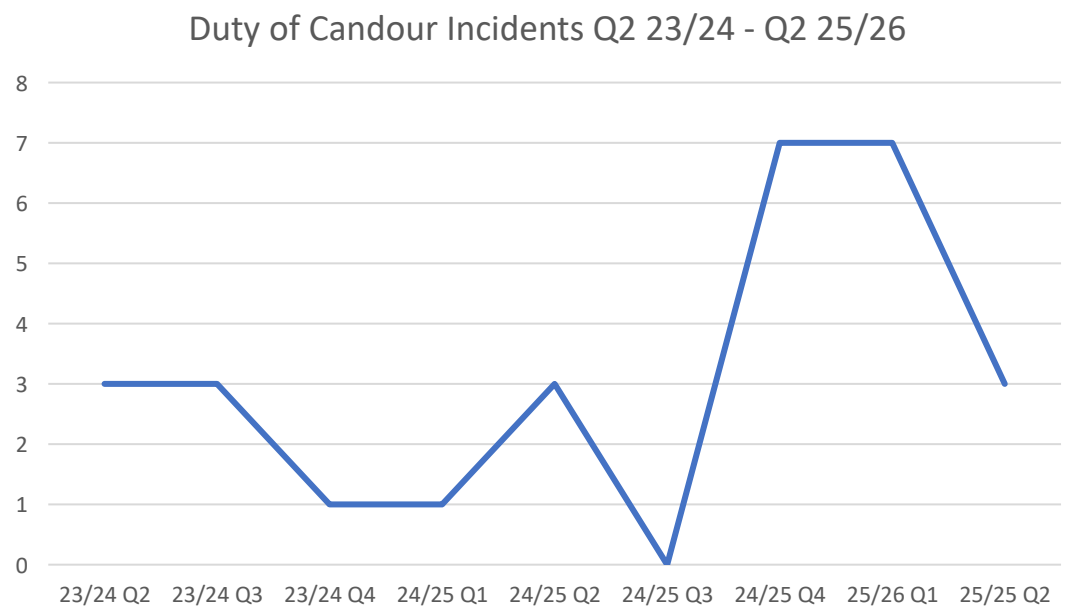
No Incidents were reported as causing severe harm

Figure 15

Reporter's initial harm assessment	Manager's interim harm assessment	Number of Incidents Regraded
Moderate	None	7
Moderate	Low	24
Moderate	Moderate	2
Low	Moderate	1

Harm Assessment Grading of Incidents
Following initial management review with appropriate clinical review, the incidents grading was revised as demonstrated in Figure 14.
Support is provided by Datix leads to reporters regarding appropriate grading of incidents.

Figure 16



ANALYSIS

As shown in Figure 15, the Trust has seen a decrease in incidents triggering the Duty of Candour since the last quarter.

3 incidents were identified as potentially causing moderate harm. This equates to 0.5% of all incidents raised during the quarter, and 0.006% of all scheduled appointments.

5.2 INCIDENTS – DUTY OF CANDOUR CONT.

Themes identified from Duty of Candour incidents – (new and closed during the period)

Learning and Improvements

Scheduling of radiotherapy appointments. This is a repeated theme within incidents including Duty of Candour incident.	Radiotherapy department are updating training and competency packages, revising the radiotherapy quality assurance checks, and reviewing ARIA paperless process.
Medication safety including prescribing, reconciliation, and administration.	Working group established to work through an improvement plan developed from themes identified in First Floor ward medication incidents. The group comprises of pharmacy, medical, nursing, quality and safety, practice educators, and palliative care.
Poor communication and transfer of care between VUNHST, Health Boards, Primary Care, and the patient .	A copy of clinic letters are now routinely being sent to all patients (who consent). This will allow patients and their family to revisit and reflect on the information they were given verbally in clinic. This is a Trust Quality Priority for 2025-26.
	Project in place to progress the implementation of Hospital Initiated Referral Solution. This is the national electronic referral solution. Initial indication of implementation is Quarter 4 2025-26.

8 Make It Safe Meetings

2 Speedy Cascades circulated

5.2 INCIDENTS – DUTY OF CANDOUR CONT.

Themes identified from Duty of Candour incidents closed during the period (and previously reported through QSP)

Lack of clarity around venous monitoring during SACT administration	Urgent review and update of current extravasation policy through benchmarking of national and local extravasation policies and practice.
Email communication use for clinically urgent information	Working with DHCW on adapting and utilising the “red flag” notification within Welsh Clinical Portal as a form of communicating urgent radiology results as opposed to email communication.
Consultant and outpatient clinic capacity	SACT Pathway transformation work will see the most appropriate type of appointment allocated i.e. consent appointment with SACT nurse, virtual or face to face with an independent prescriber, or a medical review. This will result in patients having the appropriate length of time with their reviewer

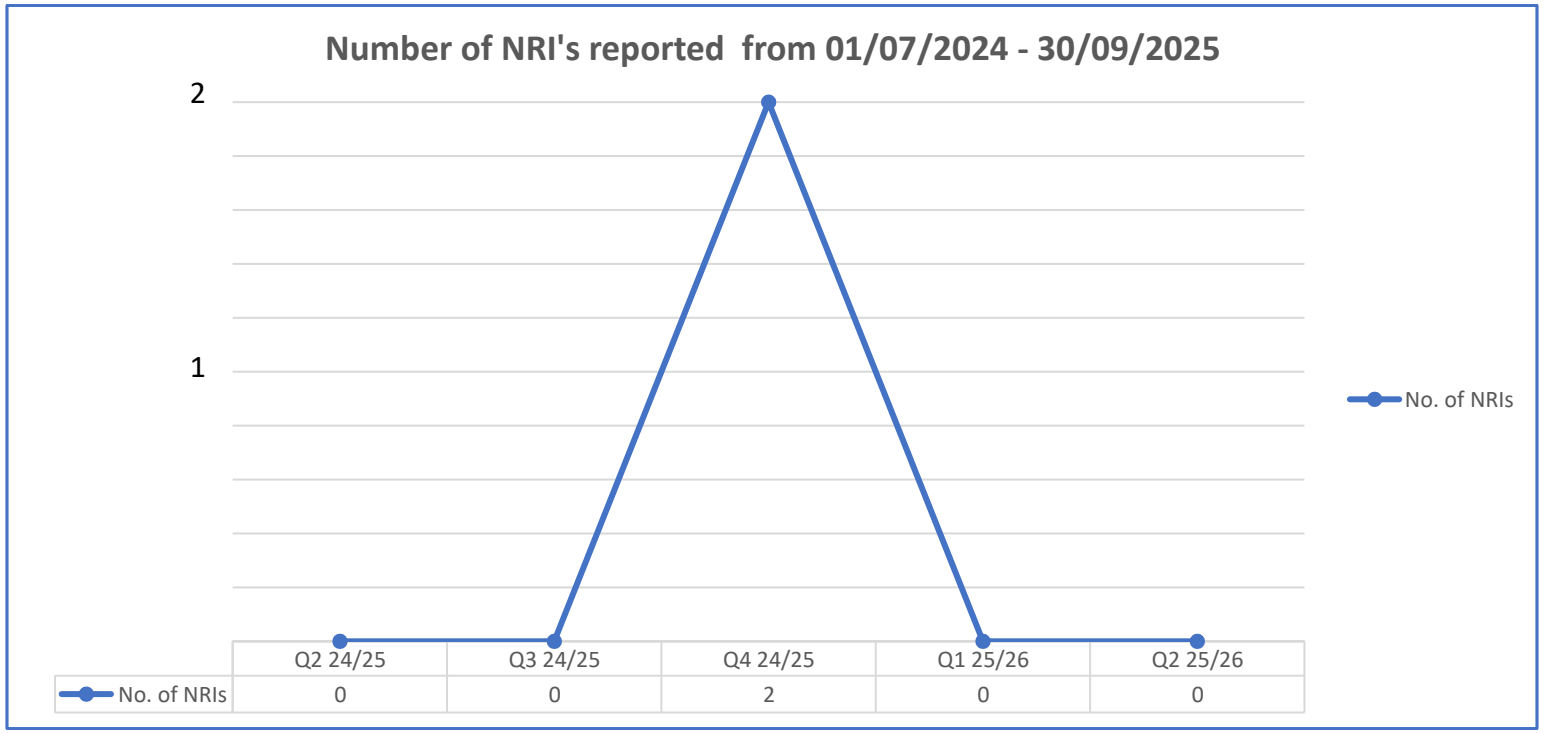
5 Duty of Candour investigation concluded

2 Learning From Event Reviews (LFER) submitted

5.2 NATIONAL REPORTABLE INCIDENTS (NRI)

0 Nationally Reportable Incidents

Figure 17



Severe Harm:
A service user experiences a permanent disability or loss of function and the NHS care did or may have contributed.

Death:
A service user dies and the NHS care did or may have contributed to the death.

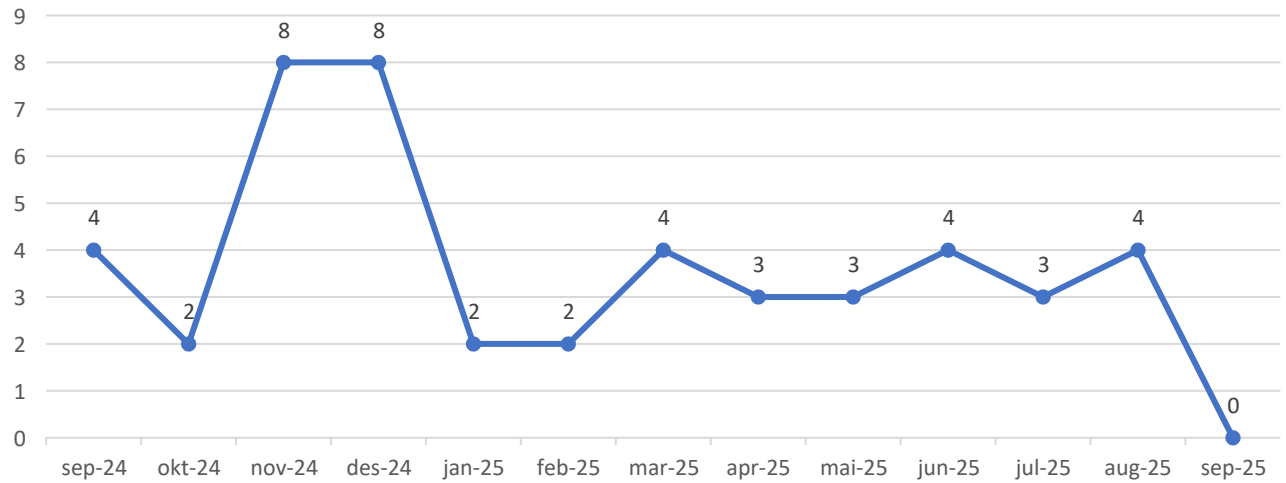
5.3 IONISING RADIATION (MEDICAL EXPOSURE) REGULATIONS (IR(ME)R) REPORTABLE INCIDENTS

Radiotherapy Physics led investigations:
2 due to known issues with XVI on set imaging equipment. We have recently implemented a process change after discussions with Elekta which should reduce likelihood of one of the recurring faults – this is under review.
1 due to known issue with the Halcyon linac's on set imaging system.

Radiotherapy Service-led investigations:
2 Accidental planning Computed Tomography scans – where an individual has received an exposure in error when no exposure of any kind was intended. Both occasions the Radiotherapy Referral in ARIA was completed for the incorrect patient.
1 patient received **3** or more imaging exposures in a single fraction – due to the incorrect reference CT being used.

As seen in Figure 17, **7** Significant Accidental or Unintended Exposures (SAUE) under the Ionising Radiation (Medical Exposure) Regulations IR(ME)R were reported to Health Inspectorate Wales (HIW) – On August 21st 2024, there was a change to HIW IRMER notification criteria guidance resulting in an increase in the number of incidents meeting reporting requirements.

Figure 18 **Significant Accidental or Unintended Exposures reported under IR(ME)R**



RT Physics have long standing mitigations to deal with the Elekta imaging fault, which have been discussed in depth with the UK Health Security Agency (UKHSA). This will improve when the Linacs are replaced.

5.3 IONISING RADIATION (MEDICAL EXPOSURE) REGULATIONS (IR(ME)R) REPORTABLE INCIDENTS CONT.

LEARNING

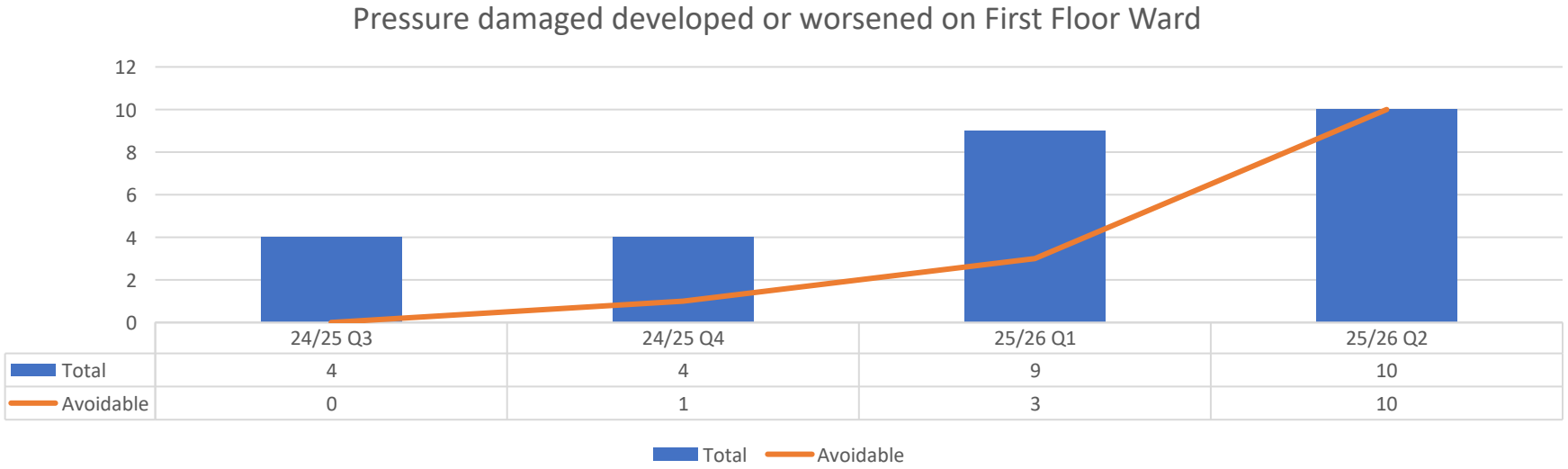
Accidental Computed Tomography scan – Following the change from requesting Radiotherapy via the patient record in WCP to requesting Radiotherapy via the paperless pathway in ARIA, there is an increased risk in creating a request for radiotherapy for the incorrect patient due to Consultant Clinical Oncologist workflows in outpatient clinics.

Prior to the launch of paperless working a risk assessment for Radiotherapy Request was completed and on review this type of error was not included in the risk assessment.

In addition, there was a missed opportunity to identify that the incorrect patient had attended for a planning CT as safety barriers within the current workflow, asking the patient which site is being treated and discussing the risks and benefits of the planning CT were not sufficient in this instance.

5.5 VELINDRE CANCER SERVICE – INCIDENTS CONT.

Figure 19

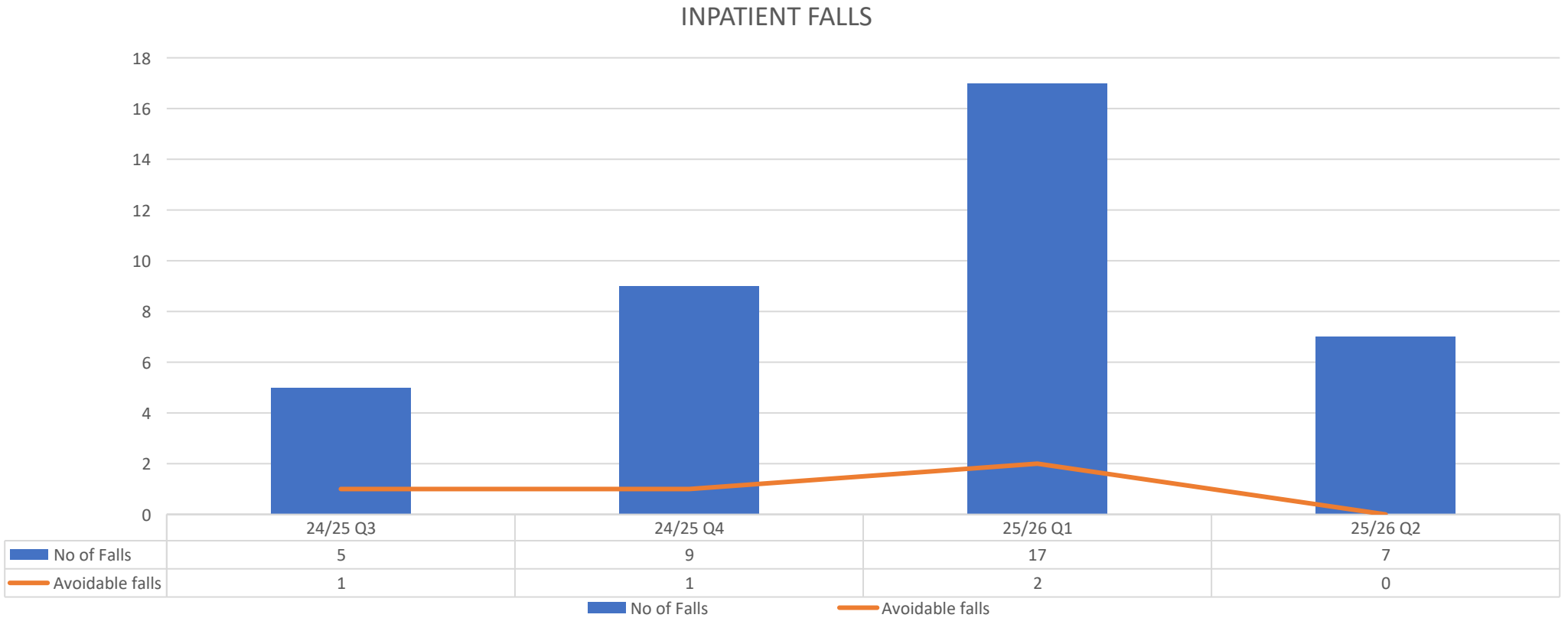


Figures 18 shows an increase in pressure damage that developed or worsened whilst an inpatient in Velindre Cancer Service. All 10 incidents have been investigated and discussed in monthly Pressure Ulcer Learning Panels – all identified as being avoidable. Improving the prevention and management of pressure damage is a priority for VCS in quarter 3.

- External Tissue Visibility Nurse expertise from October 2025 to undertake a review and provide staff training around prevention, early recognition, decision making, and management.
- A ward improvement plan in place.
- Urgent review of staff shift allocation is currently being undertaken to ensure that there is an even distribution of experienced nurses and newly qualified nurses across day and night shifts.
- The Healthcare Support Worker allocation has been increased to ensure sufficient staff to meet all care needs.
- Increased visibility and support from senior nurse on the ward.

5.5 VELINDRE CANCER SERVICE – INCIDENTS CONT.

Figure 20

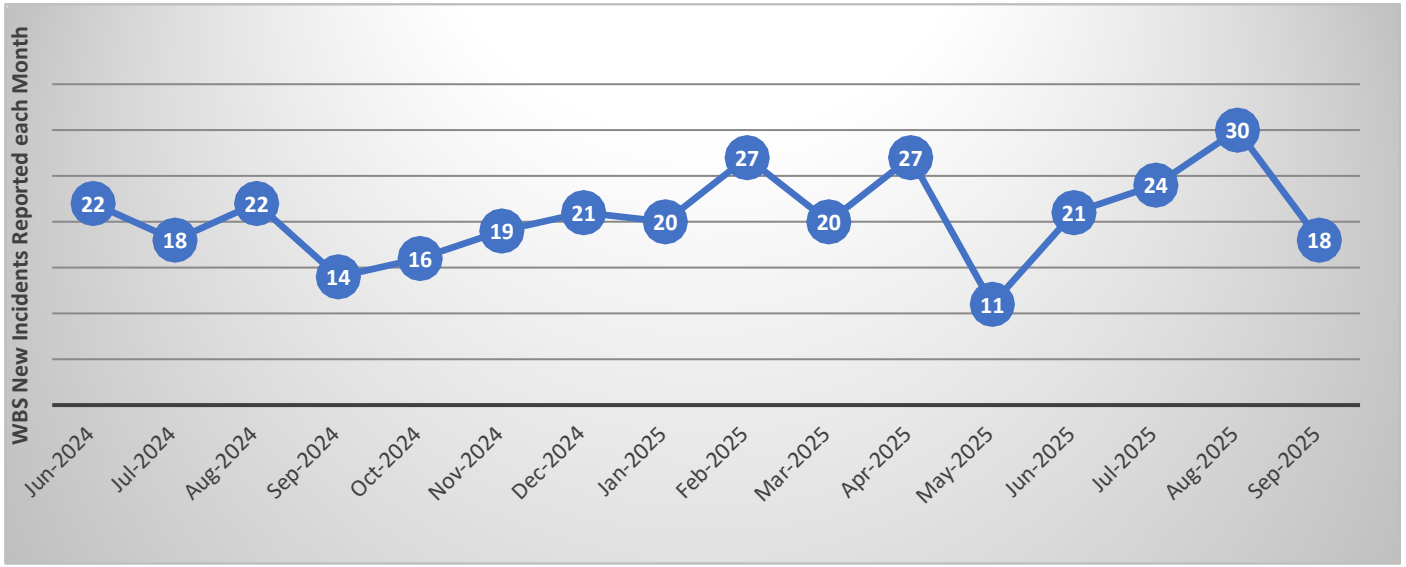


The number of inpatient falls have fluctuated with no clear trend. All discussed in the Falls Learning Panel and all identified to be unavoidable – meaning that healthcare was not identified as a factor in the fall. No patient harm resulted from the falls.

5.6 WELSH BLOOD SERVICE – INCIDENTS

Incidents which may result in harm to patients, donors or staff are reported in Datix Cymru

Figure 21



ANALYSIS

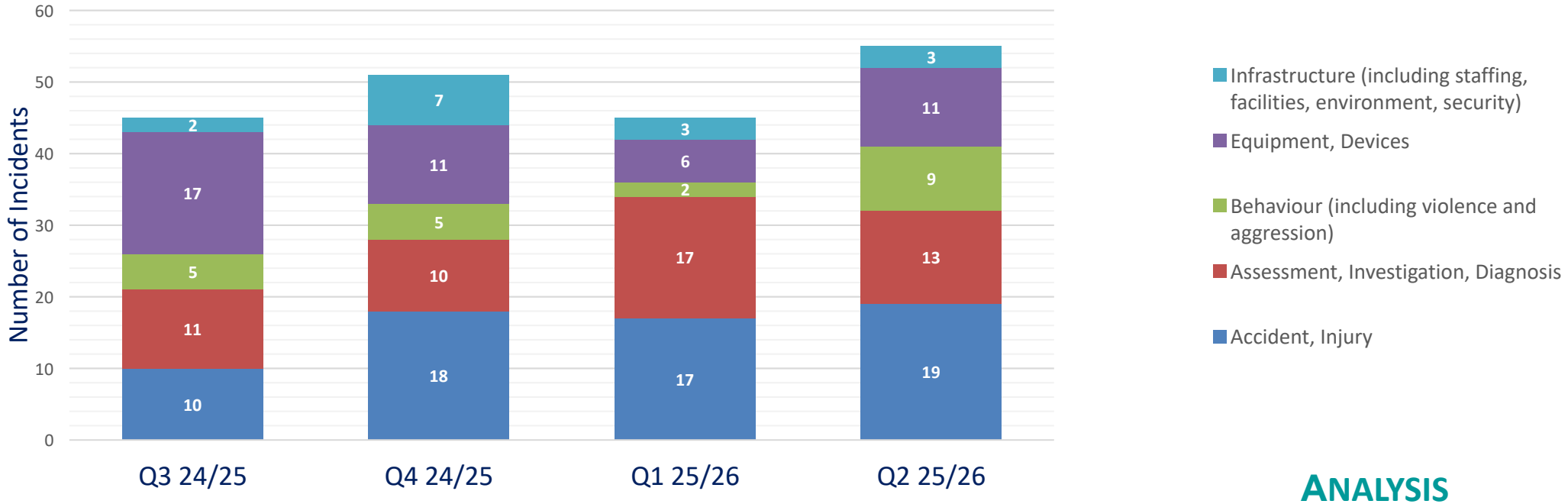
Figure 20 shows variability in the number of incidents reported in Quarter 2; there are no specific contributory factors, there are low numbers of events over a wide range of classifications. Overall, the number of reports remains low, with no significant trends identified; monitoring of reports for trends is continuous.

OVERDUE ACTIVITY

The number of incidents exceeding the 30 day target date for closure has **decreased significantly**, from 25 overdue in July to 5 overdue in September; the **Q2** average was **6** overdue. The reason for improved performance may be due to an increased focus via inclusion of this metric in performance metrics framework measures introduced in April 2025.
However, the number of **overdue actions has gradually increased this quarter,** peaking at **23** (September). This decline in performance may be attributable to a number of actions being assigned within specific areas, combined with a limited resource to complete those actions.

5.6 WELSH BLOOD SERVICE – INCIDENTS CONT.

Figure 22 Incidents by theme (top 5) – Quarterly comparison



ANALYSIS

As seen in Figure **21**, the most frequently reported themes in **Q2** are consistent with previous quarters:

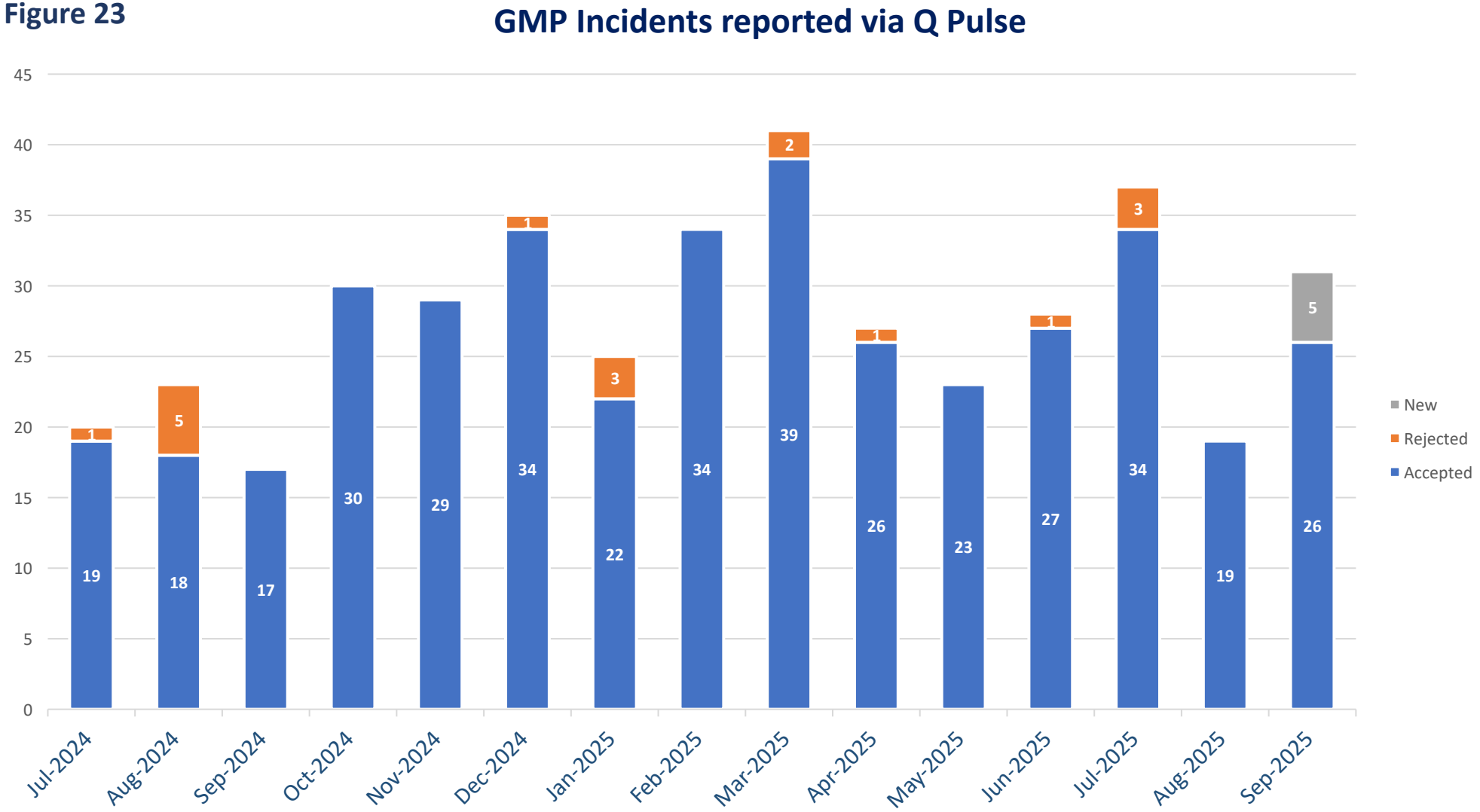
- Accidental injury (19) - no themes identified.
- Assessment, investigation, diagnosis (13) - usually related to 'late donor information', which is subjective to each donor. No theme identified.
- Equipment and devices (11) - no themes identified.
- Behaviour (9) – 5 of these relate to interactions with members of the public (non-donors being aggressive towards Blood Donation Teams staff).

All events were assessed as low/no harm and have been fully investigated, with no significant trends identified, other than the previously reported issues with complexity of donor assessment (see slides on SABRE reporting for outcomes and lessons learnt). More information on accidental injury reports can be found in the Health and Safety section of the report.

5.6 WELSH BLOOD SERVICE – INCIDENTS CONT..

Good Manufacturing Practice (GMP) Incidents are reported into the Q-pulse electronic Quality Management System and monitored as a critical part of the overall Quality Management System (QMS), in line with regulatory standards.

Figure 23



5.6 WELSH BLOOD SERVICE – INCIDENTS CONT.

ANALYSIS

Figure 22 shows **79** GMP incidents were reported in **Q2** (2025-26), compared to **74** in **Q1** (2025-26).

The highest number of reports relate to **laboratory errors (33).**

19/33 laboratory errors are associated with the previously reported trend in manual transcription errors within antibody screening reports (RCI and Molecular Genetics Laboratories).

As previously reported, the significant trend in manual transcription errors has been subject to a holistic root cause analysis investigation and barrier analysis, however the manual nature of the process is such that errors will still occur from time to time.

Errors made prior to new barriers being introduced are still being identified (at the point another sample is received from the same patient). These are formally recorded in QPulse; no new causes have been identified.

LEARNING AND OUTCOMES

Transcription errors in manual processes are not unexpected, however the complexity of manual reporting processes, combined with an ageing and underdeveloped IT system, and an inadequate verification process have been identified as the main causes of these errors.

Contributory factors include high workload and operational pressures, working environment, senior staff changes and skill gaps (caused by absence of experienced staff). Additional resource has been introduced at a more senior level within the RCI Laboratory to specifically analyse and review reports prior to issuing them.

A systematic review will be undertaken to evaluate current data entry and verification processes, with a focus on further preventative measures that could be introduced.

The Laboratory reporting system (SERIF) is being upgraded to auto-populate certain information into the laboratory report from the patient's computerised record; this should help reduce transcription errors. Standardised comments are also being introduced within this system to standardise comments.

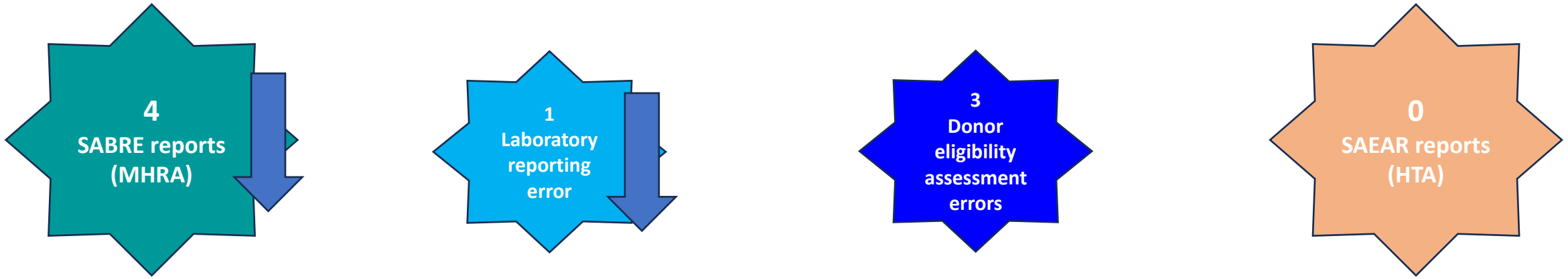
5.6 WELSH BLOOD SERVICE – EXTERNALLY REPORTED INCIDENTS (SABRE)

ANALYSIS

4 adverse events were reported to MHRA via the Serious Adverse Blood Reactions & Events (SABRE) portal compared with **13** in **Q1**.

All events were reviewed and investigated, and root cause analyses and corrective actions have been reviewed by relevant members of the divisional Integrated Quality and Safety Hub before submission to the Regulatory body.

No serious adverse events or adverse reactions (SAEARs) were reported to the Human Tissues Authority (HTA).



5.6 WELSH BLOOD SERVICE – EXTERNALLY REPORTED INCIDENTS (SABRE) CONT.

ANALYSIS

Themes identified from SABRE events

Failure to defer donors taking contraindicated medication is a common cause of donor selection errors (3), and this trend has been previously recognised.

In one case, additional information regarding a contraindicated drug had not been applied across the whole guideline, due to lack of a formal process for introducing local produced (WBS) guidance.

Difficulties in interpreting the donor selection guidelines for medication and travel risk is a common cause of donor eligibility assessment errors.

The frequency of error compared to the number of donors assessed is small, but each event presents a risk to patient safety if the risk is not identified and managed effectively.

Learning and improvements

Discussions are taking place at a national (UK) level regarding the challenges with assessing donor travel to seek enhanced tools or guidance from frontline screeners.

These incidents are included as learning scenarios during the Clinical RN meetings and lessons learnt continue to be disseminated across all Blood Donation teams for inclusion in daily briefing discussions.

WBS continue to engage with an external provider to develop a digital tool that supports correct decision making. The tool is due to be trailed with Screeners in Q3, to assess its effectiveness.

The process for introducing local guidance (designed to assist correct decision making) shall be reviewed and if this process is to continue it shall be formalised.

5.6 WELSH BLOOD SERVICE – EXTERNALLY REPORTED INCIDENTS (SABRE) CONT.

ANALYSIS

Themes identified from SABRE events

A discrepancy was identified between Rhesus typing results reported for the same patient. The error was a reporting error, rather than a testing error, and there was no direct impact on the patient as compatible units were issued.

The manual nature of the antibody screening reporting process is cause for error from time to time and root cause is known to be process/system related.

The overall rate of error is estimated to be 1-2% of reports issued.

Learning and improvements

Root cause analysis identified a lack of comprehensive standard operating procedures providing sufficient guidance for staff regarding consideration of a patient's previous transfusion history, additional testing requirements and handling anomalous results. In addition, experiential knowledge and support has been lost following the retirement of a key staff member.

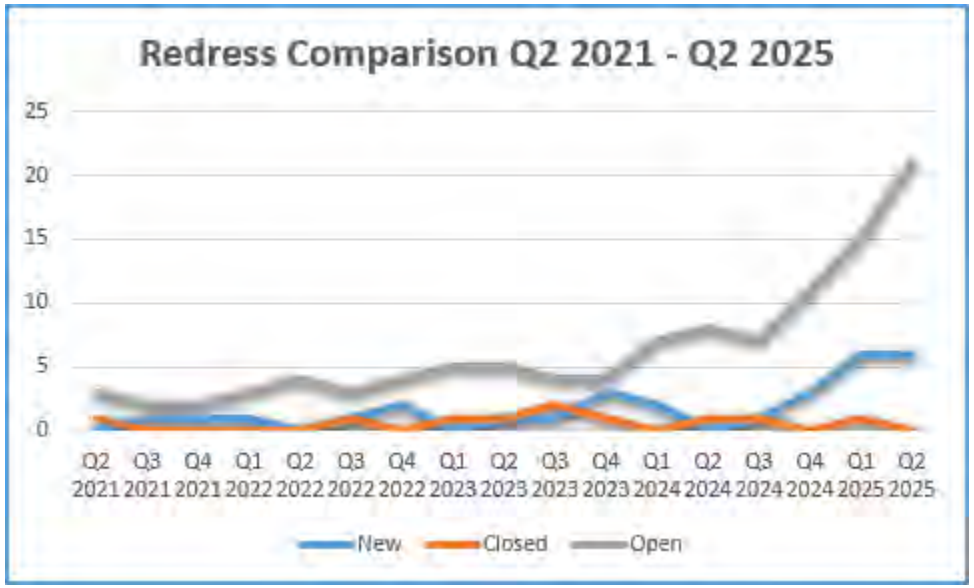
Additional guidance is being added to the Standard Operating Procedures. this is being written in clear and precise language to aid comprehension, and unnecessary information is being removed.

There will be a systemic review of the actions already introduced that are intended to minimise errors. This review will examine effectiveness and the reasons why errors continue to occur, accepting that until a fully automated process can be introduced errors are likely to happen occasionally.

6. REDRESS

ACTIVITY

Figure 24



As demonstrated in Figure 24, Q2 has seen a further rise in Redress cases. The increase has been growing since the introduction of the Duty of Candour.

6 new Redress cases opened

1 offer accepted

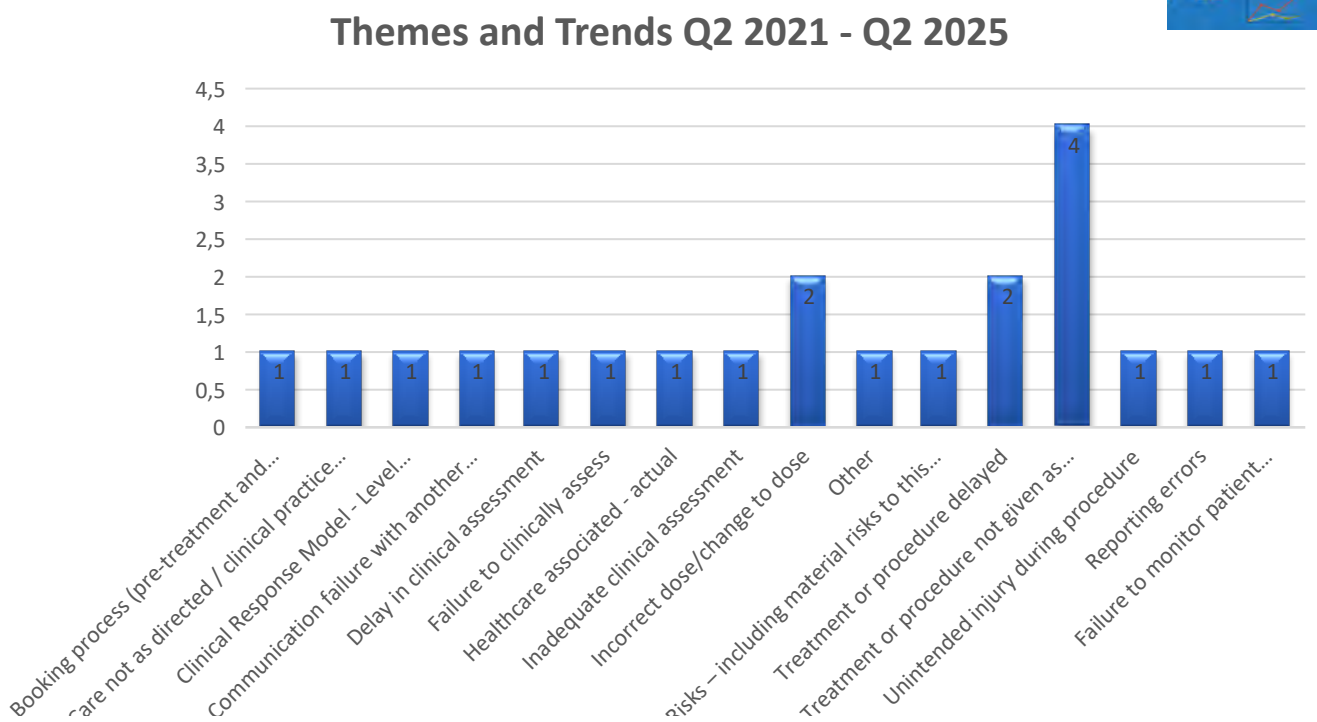
1 Qualifying liability admitted

0 cases closed

16 cases remain under investigation

No themes were apparent in Redress cases at the end of Q2 2025/26

Figure 25



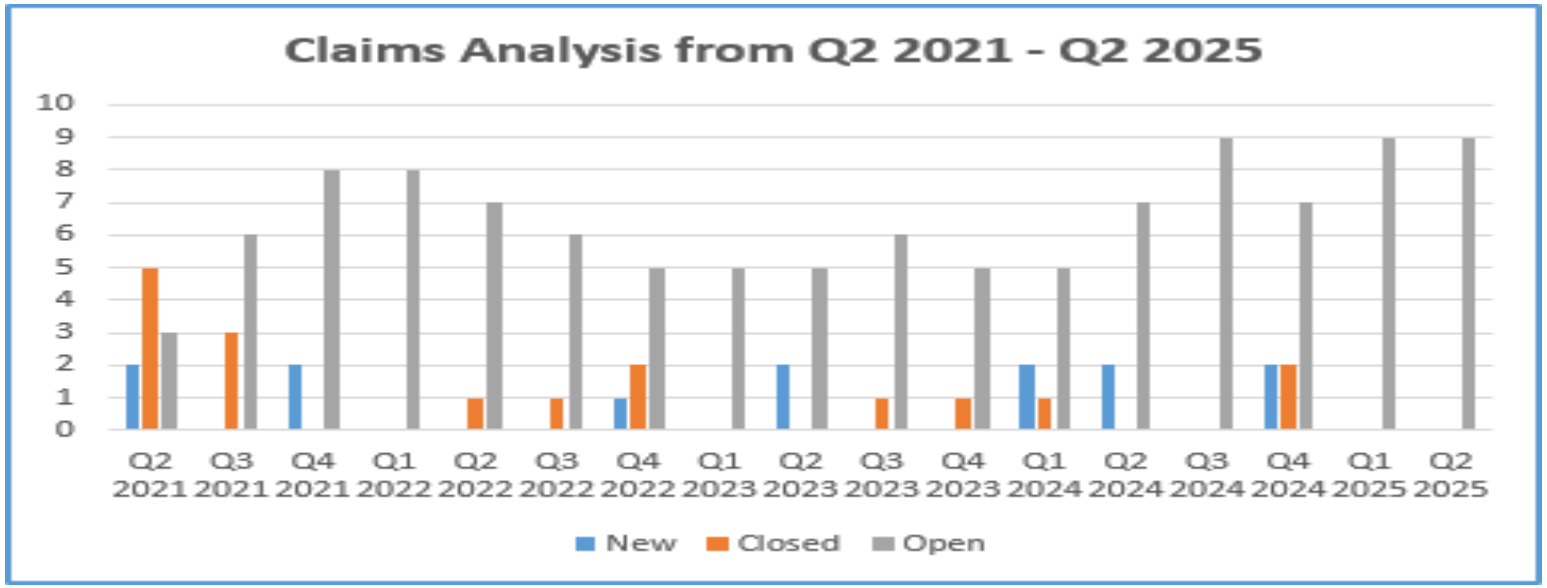
4 claims under the 'treatment or procedure not give as directed' category, demonstrate a theme of missed opportunities in clinical decision-making and adherence to care protocols, resulting in deviations from established treatment pathways and communication standards

1 'Learning from Events' Report was approved by the Welsh Risk Pool indicating that the Trust continues to demonstrate assurance of Redress processes and that learning continues to be a priority for the Trust

7. CLAIMS

The graph provides an illustration of the claim activity in comparison to previous quarters

Figure 26



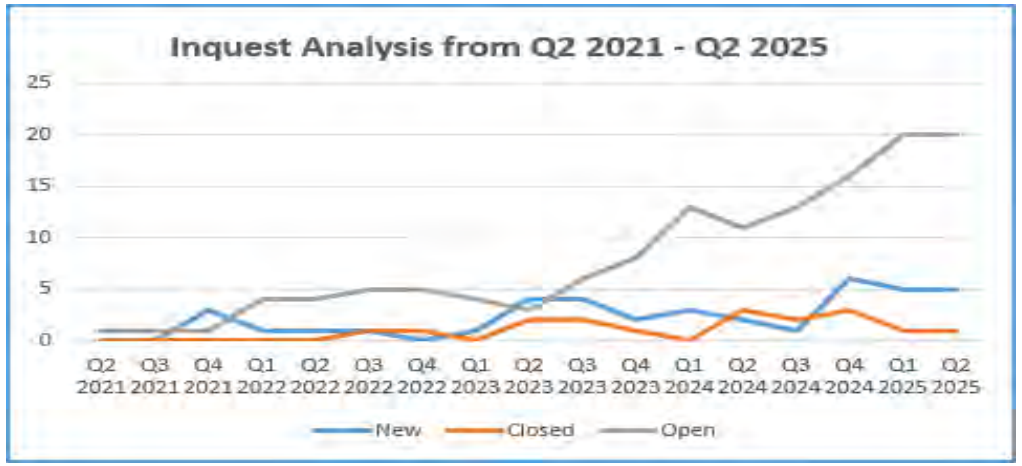
Financial Liability: The Trust's estimated financial liability for claims is £2,198,332.00.

In the event the Trust were to settle its current caseload, the Trust's liability is £203,000.00.

8. INQUESTS

Figure 27 shows there has been a rise in inquests being opened during the reporting period, no trends, themes, risks or issues have been identified relating to the new inquests.

Figure 27



Regulation 28 – Prevention of Future Deaths

An inquest took place during quarter 2 related to dietic provision. Attended by representatives from both Velindre University NHS Trust and a Local Health Board.

Outcome

The coroner concluded the patient died from natural causes. Failings in care were identified but were not causative of death—no finding of causative failure or neglect. However, the Trust was issued with a Regulation 28 Report - a formal notice issued by a coroner in England and Wales when, following an inquest, they believe that action should be taken by a person or organisation to prevent future deaths arising from the same circumstances.

Areas identified for improvement by the coroner are as follows:

1. Improve co-working within disciplines when sharing the care of patients who require hospital and community dietetic care.
2. Ensure that when care is shared, the respective teams can access each other's records.
3. Develop guidelines for monitoring the adequacy of dietetic assessments over the phone, and a minimum standard set for face-to-face consultations

Next Steps

Regulation 28 report received and requirement for organisation to respond within the statutory 56-day period. Review and update the VCS dietetic improvement plan to address coronial concerns. Ongoing support and debrief for staff involved; outcomes and improvement plans to be reported through governance channels to the Trust Board.

9. MORTALITY CONT.

Figure 28

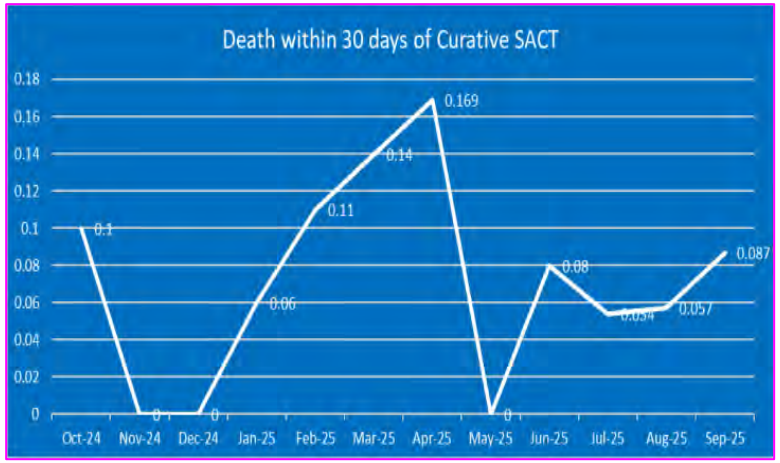


Figure 29

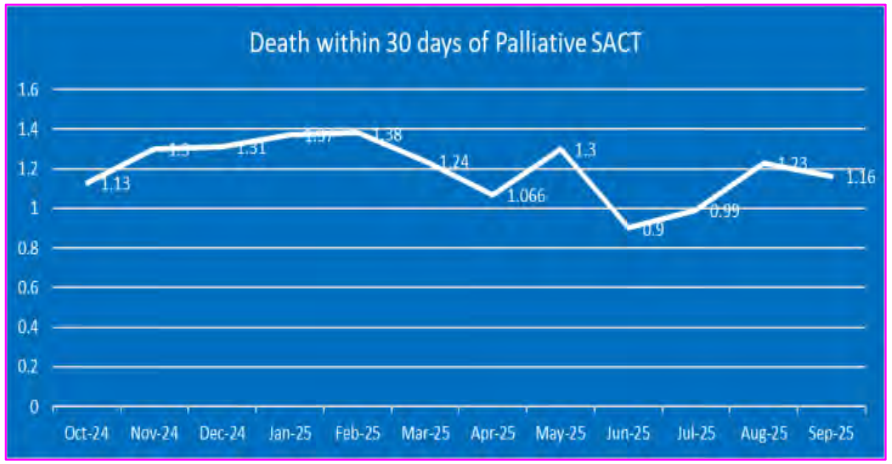
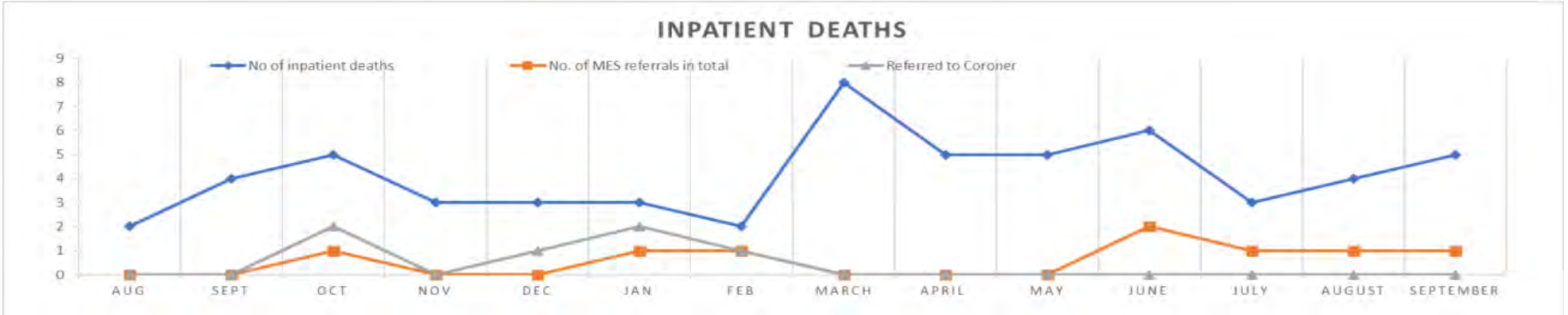


Figure 30

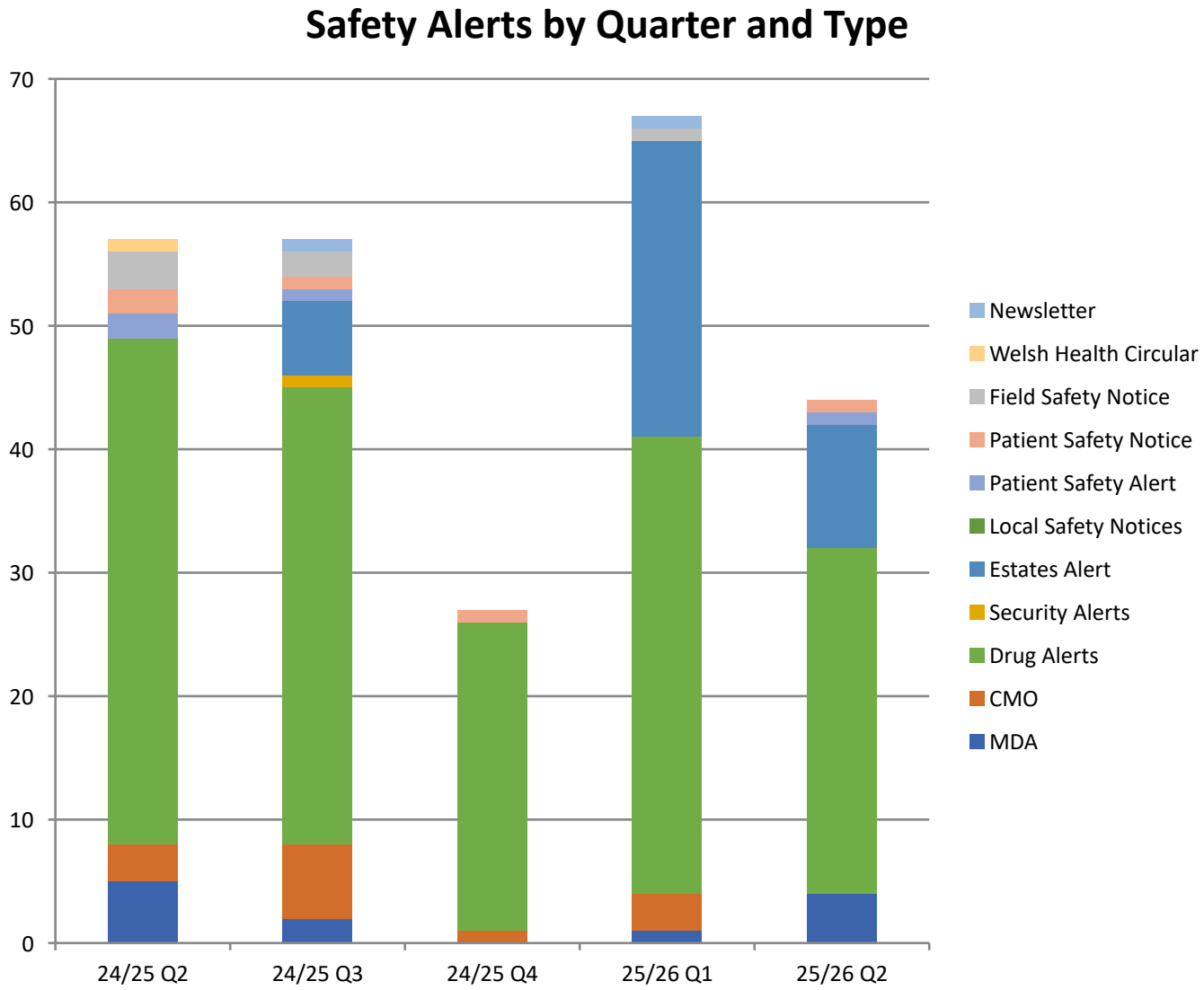


ANALYSIS

- SACT mortality data is collected and reported monthly. Although there is no available benchmark for curative or palliative SACT, a 2% 30-day mortality rate from the 2008 NCEPOD report is commonly used, and VCS remains below it.
- All SSTs now review deaths within 30 days of SACT, 30 days of palliative radiotherapy, and 90 days of radical radiotherapy.
- Radiotherapy mortality data validity issues are being addressed by VCS and Data and Insight teams with aim to resolve this in Q3 2025/26. However, the 30- and 90-day radiotherapy mortality data is being reviewed by the mortality and site specific teams.
- All inpatient deaths were reviewed within the VCS Inpatient Mortality Review meetings and independently by the Medical Examiner Service (MES).
- The Cancer Service is compliant with all aspects of the MES – reviewing cases referred to VCS and feeding back findings and identifying learning. One case received from the MES for further review due to medication incident - This is being managed as a Duty of Candour incident and discussed in section 5.2 . No other cases of harm identified from SST or inpatient mortality reviews.
- Plan in quarter 3 and 4 to strengthen the mortality governance structure with an overarching service wide mortality meeting to ensure learning is shared across the division, quality improvement projects appropriately identified and supported, and the outcomes more meaningful.

10. SAFETY ALERTS

Figure 31



ANALYSIS

44 Safety alerts were received.
Drug/pharmaceutical alerts continue to be the highest number of alerts received in the Trust. The drug alerts relate to medicine recalls and stock issue notifications from suppliers.

THEMES AND OUTCOMES

The most common theme for Safety Alerts were medication shortages and medication discontinuations. Any of these alerts that were applicable to the Trust were addressed with e.g. stock checking and using the recommended alternatives. There were other alerts received in Q2, these were for information only:

- Estates Alerts
- Medical Device Alerts
- Patient Safety Notices
- Patient Safety Alerts

POSITIVE ASSURANCE

The Safety Alerts module on Datix Cymru was implemented on 1st April 2025. The Trust has been using this module, one of few across Wales, which involves using the Datix to send out emails to the divisions. The divisions then review and respond to the alert stating if they are compliant or not. Standard operating procedure and training session have been made available across the divisions. All alerts were managed and closed within the quarter.

11. EXTERNAL INSPECTIONS AND AUDIT

Pharmacy Technical Services Quality Assurance Audit

The National Lead for Pharmacy Quality Assurance for Wales undertook a Good Manufacturing Practice (GMP) audit of the aseptic unit, according to the WHC/2024/004 guidelines at Velindre Cancer Centre on the 5th and 6th of June 2025.

In total **299** standards were reviewed and graded as follows, with the red deficiencies directly linked to the Pharmaceutical Quality System (PQS) and the resource within the pharmacy technical services team.

Original Findings – June 2025			
Audit Assessment	Deficiency requiring action plan developed within 6 months and deficiency corrected within 9 months	Yellow	93
	Deficiency requiring action plan developed within 3 months and deficiency corrected within 6 months	Amber	52
	Deficiency requiring immediate action, an action plan developed within 24 hours of receipt of final report	Red	7

Quarter 2 progress: **Figure 32**

Progress against remedial actions			
Progress	Closed (complete)	Blue	79
	On track	Green	64
	May deliver late	Amber	1
	Likely to deliver late (planned)	Purple	4
	Likely to deliver late (unplanned)	Red	4

An action plan has been developed and accepted to address identified deficiencies; **143** of **152** actions are either completed or on track to complete on time as of September 2025.
9 actions may or are likely to deliver late due to some activities identified as more complex than originally anticipated, but a comprehensive plan exists to monitor these. There are no identified risks to patient safety from the 9 actions. Senior pharmacy team are meeting fortnightly to actively monitor and manage the action plan.

There is evidence of improvement in quality indicators with a reduction in open Pharmaceutical Quality Incidents from **122** in March 2025 to **41** in September 2025.

7 levels rating: Level 3 (Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes)

Llais - Enhancing Cancer Care Experience

Between 1 September 2024 and 31 December 2024, Llais Cardiff and Vale regional team undertook engagement to understand people's experiences of living with cancer in Cardiff and the Vale of Glamorgan. We are committed to ongoing learning and improvement across Velindre Cancer Service and based on the representation themes identified in the report we will reflect the findings and improvements identified through our internal governance structure.

Patient-Centred Communication

- Top priority: Improve patient communications based on feedback and incidents.
- Rolling out 'SAGE & THYME' advanced communication skills training for all clinical staff.

Coordinated Care & Accessibility

- Transforming services for easier patient navigation.
- Welfare rights team supports patients with benefits, grants, and feedback collection.

Continuity & Single Point of Contact

- Strengthening the keyworker model (Clinical Nurse Specialist) for holistic, individualised care.

Inclusive Access

- Commitment to accessible information (Welsh, BSL, Easy Read, Braille, audio).
- Ongoing engagement with diverse communities and young people.

Integrated Working

Improving multi-professional collaboration and patient pathways across health boards.

Emotional & Mental Health Support

- Clinical psychology, counselling, and complementary therapies available throughout the patient journey.
- Partnerships with Maggie's Centre and local support groups.

12. INFORMATION GOVERNANCE

Introduction – Information Governance can be considered as the way in which an organisation manages the information processes and procedures and forms a key component of integrated governance and assurance arrangements along with Clinical Governance, Risk Management, Research Governance, Financial Governance and Corporate Governance. It formally links information rights, data quality management, records management, information management, information sharing, information security (including cyber security), risk management, ethics, openness and transparency into an integrated approach and covers a wide spectrum of requirements including procedures and processes to ensure data integrity, availability, security and confidentiality and the collection, storage and dissemination of information.

Incidents and Investigations – Total number of incidents for the quarter **plus** a 2 year run graph displaying the themes and trends.

Root Cause Analysis – Where the cause of the incident is not immediately clear, the Head of IG will conduct a more in depth investigation.

Reported to the ICO – It is a legal requirement to report certain types of incident to the ICO (where a personal data breach is likely to result in a high risk to the rights and freedoms of individuals). RCA will also be conducted as a matter of course.

Subject Access Requests – The legal right for a data subject to request their own data, the Trust must respond within 1 month of the date of request, unless the request is complex or technical in its nature, in which case a further 2 months may be granted.

Data Protection Impact Assessments – It is a requirement to report activity to Senior Trust Management via established governance routes so that Assurance is gained that the Trust is complying with its statutory legal obligations. The IG Toolkit assesses annual compliance with this requirement.

Training Attainment – the minimum standard for compliance in NHS Wales is 85%, the compliance (%) is reported as at 1st January annually and may affect CAG status.

Incidents – 1st July – 30th September 2025

Figure 33

Service	DATIX Incidents	Incidents Reported outside DATIX	Total Incidents	Reported to ICO	Investigation			Investigation			
					Low Risk / No Harm	Root Cause Analysis	Total	DATIX Open	DATIX Closed	Total	IG Complete
Corporate Services	2	0	2	0	2	0	2	1	1	2	2
Velindre Cancer Services	9	0	9	0	8	0	9	5	4	9	9
HTW	0	0	0	0	0	0	0	0	0	0	0
WBS	3	0	3	0	3	0	3	1	2	3	3
TCS/NVCC	0	0	0	0	0	0	0	0	0	0	0
NWSSP	11	0	11	1	9	0	11	2	9	11	11
Total Trust	**25**	**0**	**25**	**1**	**22**	**0**	**25**	**9**	**16**	**25**	**25**

Figure 34

Analysis Table for Incidents – 1st July – 30th September 2025

Reason	Number of incidents	VCC	Corporate	WBS	NWSSP	Total
Misdirection	5	2	0	0	3	5
Unauthorised access	5	0	0	0	5	5
Unauthorised disclosure of records	8	3	1	2	2	8
Communication between teams	1	1	0	0	0	1
Physical Security	4	3	1	0	0	4
Lost records	2	0	0	1	1	2
Total Trust	**25**	**9**	**2**	**3**	**11**	**25**

Figure 35

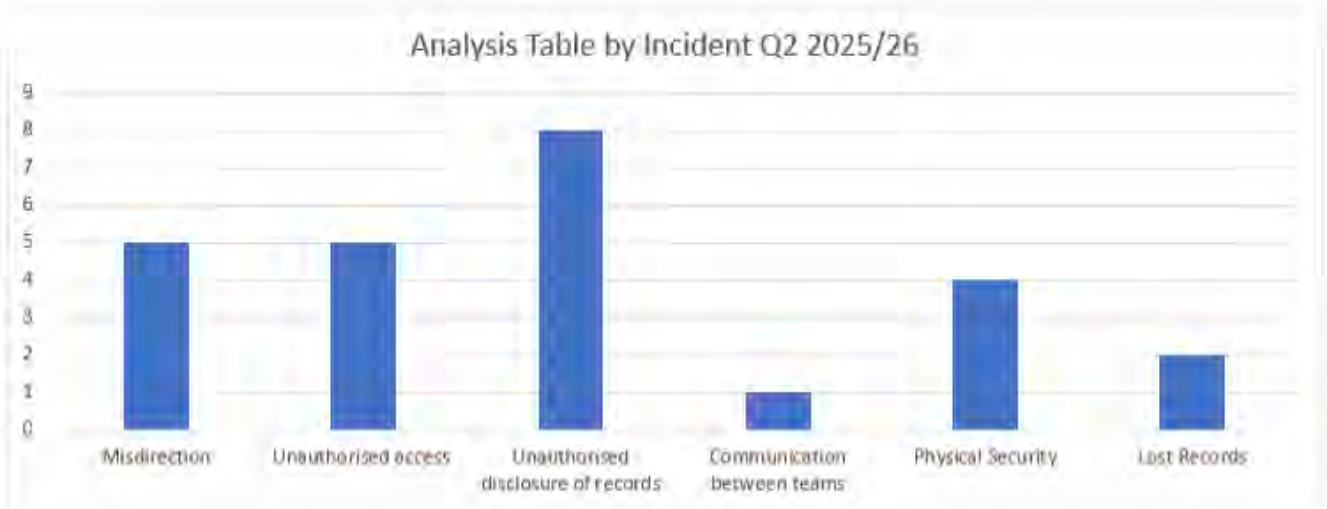


Figure 36

VCS (Medical Records) Subject Access Requests – 1st July – 30th September 2025

Month	Number of requests	Requests in Progress	Completed in Statutory timeframe	Requests breached	Cancelled	Total	Percentage compliance
May	22	1^	20	0	1^^	22	100%
June	23	1^	22	0	0	23	100%
July	25	1^	23	0	1*	25	100%
August	22	2^	20	0	0	22	100%
September	24	11^	13	0	0	24	100%

^ x11 requests awaiting evidence of right of access or further documentation from requester (x6 in September)
^^ x1 request unable to disclose due to duty of confidentiality to NOK
* x1 request unable to disclose due to patient passing away

Figure 37

Corporate (Non-Medical Records) Subject Access Requests – 1st July – 30th September 2025

Month	Number of requests	Number of requests completed within statutory timeframe	Percentage compliance
July	0	0	N/A
August	1*	0	100%
September	4**	0	100%

* x1 request extended due to need to sift through 1,000s of emails
** x1 request from NWSSP

Figure 38

WBS (Donor Records) Subject Access Requests – 1st July – 30th September 2025

Month	Number of requests	Number of requests completed within statutory timeframe	Percentage compliance
July	21	21	100%
August	7	7	100%
September	14	14	100%

Figure 39

NWSSP Subject Access Requests –1st July – 30th September 2025

Month	Number of requests	Requests in Progress	Completed in Statutory timeframe	Requests breached	Total	Percentage compliance
July	1	0	1	0	1	100%
August	0	0	0	0	0	N/A
September	2	1	1	0	2	50% (one still within deadline)

Figure 40 **2025/26 Trust DPIA/Legitimate Interest Assessment Activity**

Quarter		DPIA's Commenced	VCS	WBS	Corporate	TCS	RD&I	NWSSP (includes LIA)	Completed in Quarter (for entire Calendar year including DPIA commenced in previous quarters)
Q3 2024/25		16	8	2	4	1	1	No data	9
Q4 2024/25		19	4	5	0	1	0	9	22 (includes 6 x LIA by NWSSP)
Q1 2025/26		33	9	7	6	3	2	6	16 (Includes 1 All-Wales and 4 NWSSP)
Q2 2025/26		30	8	7	8	0	0	7	23 (Includes 4 NWSSP)

Figure 41

Training Statistics by Division for the Trust – 1st July – 30th September 2025

% Compliance Standards	% attainment
Standard	85%

Division	% attainment		
	July	August	September
Corporate	88.42	87.55	86.26
HTW	95.65	90.91	95.45
NVCC	78.13	96.88	96.88
NWSSP	91	91.17	91.64
RD&I	81.43	85.92	85.92
VCS	85.82	86.57	86.76
WBS	94.14	93.51	93.87
Trust Overall	88.03	88.60	88.68

Figure 42

2025/26 All-Wales DPIA Activity

Quarter	DPIA's Commenced	Completed in Quarter		Ongoing
Q4 2024/25	16	0		16
Q1 2025/26	TBC	TBC		TBC

Figure 43

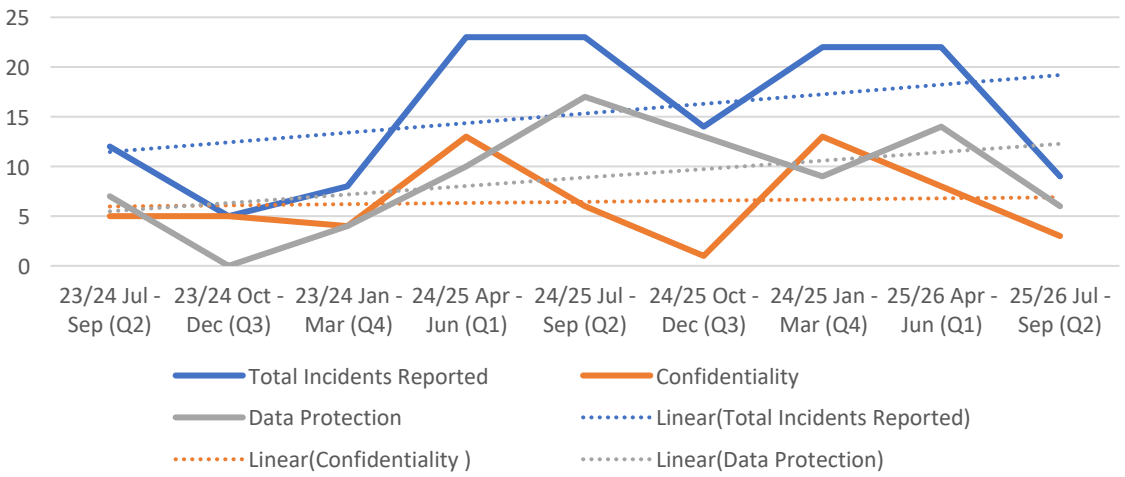


Figure 44

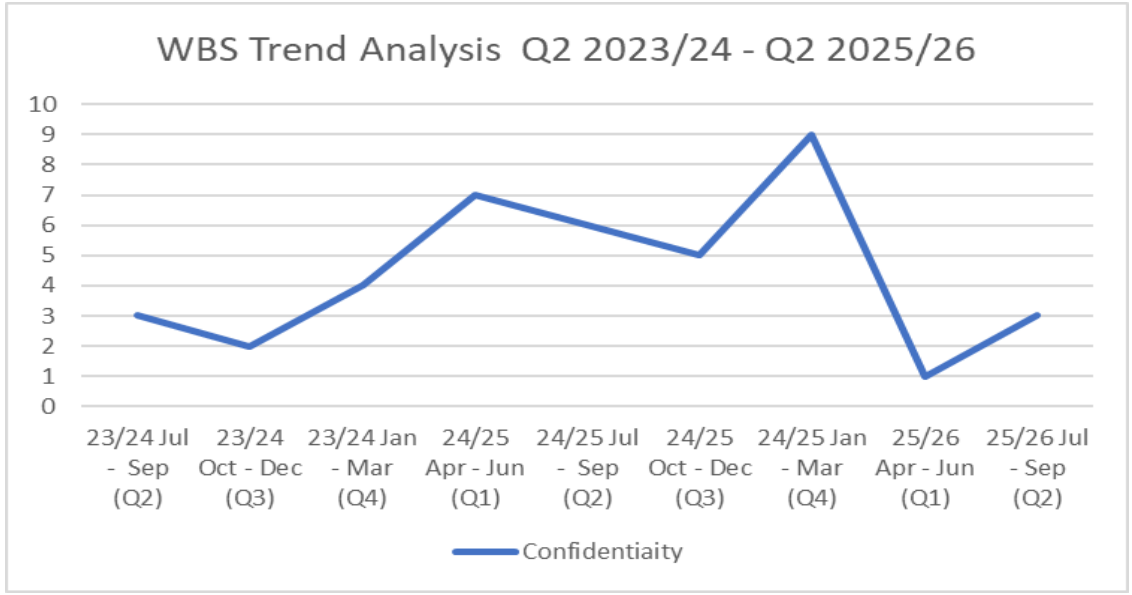


Figure 45

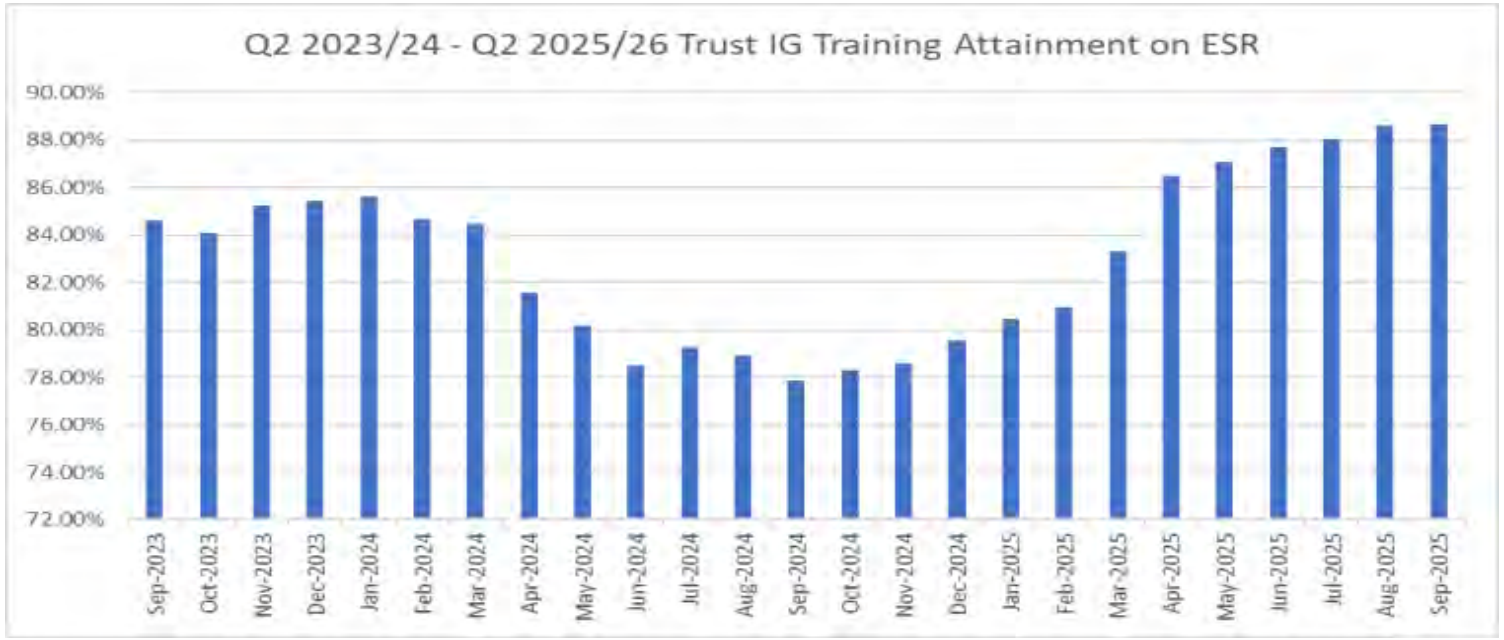


Figure 46

Assurance and Analysis

Positive assurance
1. **Training:** a. Training continues to be delivered via ESR/inductions and specific workshops, it continues to have a positive impact, intent is to continue to deliver training in this style for the remainder of 2025/26. b. IG Training compliance at 30th Sep 2025 for the Trust is 88.68 % and increase from the previous quarter which was 87.68% (minimum standard is 85%), 2. **Email** – Updated All-Wales IG Policies are being adopted by the Trust and undergoing socialisation at the time of writing. A new AI Policy is in production. 3. **SAR compliance** – Steady across the Trust, 100% 4. **DPIA's** – Across the Trust (includes all divisions and hosted bodies) 22 DPIA's and 2 DPA's were approved in Q2 2025/26. 5. **NDR** – HOIG as chair of IGMAG continues to push forward with an agreed all-Wales position in relation to data sharing across Wales in relation to the NDR, a new Data Governance Group is being set up – Chair selected in September 2025. 6. **All-Wales DPIA templates** – DPIA templates and processes alignment work remains underway led by IGMAG.
Risks to compliance with Legislation, Policies, Procedures and Standards and mitigation activity
1. **Compliance Risk** – Risk of non-compliance with minimum M&S standards for IG and Cyber Security training on ESR significantly mitigated. 2. **TAF Risk** – DPO continues to reviewed TAF 05 with CDO, recent work took place in September 2025. 3. **Overall IG Risk** – Cyber risk remains overriding risk in line with the current threat environment, risk level is such that SIRO/CG will continue to discuss at All-Wales basis on 20 Oct 25. 4. **Training Risk Mitigation** – The recent SMSC workshop which had an IG presentation significantly mitigated training risk. However, concerns do exist on the understanding of "confidentiality" in all its forms across the Trust as a result of ongoing IG investigations. Assess further work needed.
Analysis, themes and learning
1. **Incidents** – Overriding theme in Q2 remains constant; unauthorised access/disclosure, misdirection and interestingly physical security are the common themes, Physica security should be the focus for Q3 2025/26. All incidents remain avoidable. 2. **ICO Reported incidents** – No reported incidents in Q2.

3. **Training** – Training compliance in Q1 remains consistent in that compliance meets the minimum requirement for the Trust (85%). 4. **DPIA** – Remains the main methodology to assess compliance with *data protection by design and default* and address risk and information rights. 5. **Triangulation** – Training compliance correlates with incidents. Points 1&3 above demonstrates that increased training and awareness can reduce incidents.

Safe	Timely	Effective	Efficient	Equitable	Person Centred
Evidence that Staff recognise their responsibilities in respect of Legislation, Codes of Practice and Trust Policy.	All incidents, reports and SAR's are submitted and/or responded to within required timescales.	All IG incident reports have been completed appropriately and where feedback is received it is acted upon.	IG support is accessed at the correct point in any process (data protection by design and default) and where needed for incident management	The principles of Caldicott, Confidentiality and Data Protection are based on the European Convention on Human Rights and Article 8 of the Human Rights Act 1998.	Evidence that the Caldicott and data protection principles have been adhered to in all reports made across the Trust. A fair approach has been taken in relation to allegations of any wrongdoing by members of Staff

Healthcare Associated Infections

Figure 47

	C. difficle	MRSA	MSSA	E.coli	P. aeruginosa	Klebsiella sp.
2024-2025	3	0	0	1	0	1
Q1 2025-26	0	0	0	1	0	0
Q2 2025-26	0	0	0	2	0	0

Assurance

Healthcare Acquired Infections – Two E. coli bacteraemia infection during Quarter 2, both deemed Velindre Acquired. Upon completing the RCA and MDT discussion, learning identified was for the timely review of broad spectrum antimicrobial therapy when sensitivities from specimens known.

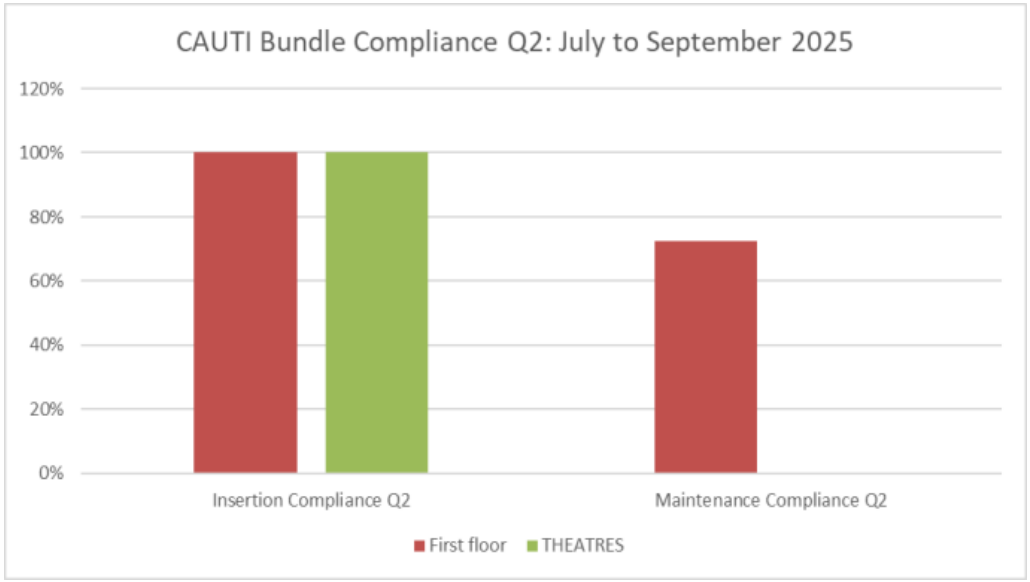
Clostridioides *difficile* - The IPC and Quality team are leading the Cancer centre in a piece of work to raise awareness and education on Clostridioides *difficile* and correct management of specimens, this work links in with the IPC team work for International Infection Prevention Awareness. Information gathering will continue for the first 18 months of a 5-year project, with the next working group on 18th November.

13. INFECTION PREVENTION AND CONTROL CONT.

Compliance to CAUTI Urinary Catheter Bundles:
The urinary catheter bundles compliance continues, for First Floor Inpatient ward and Theatre department, no issues identified.

There have been no infections related to urinary catheters April to September 2025.

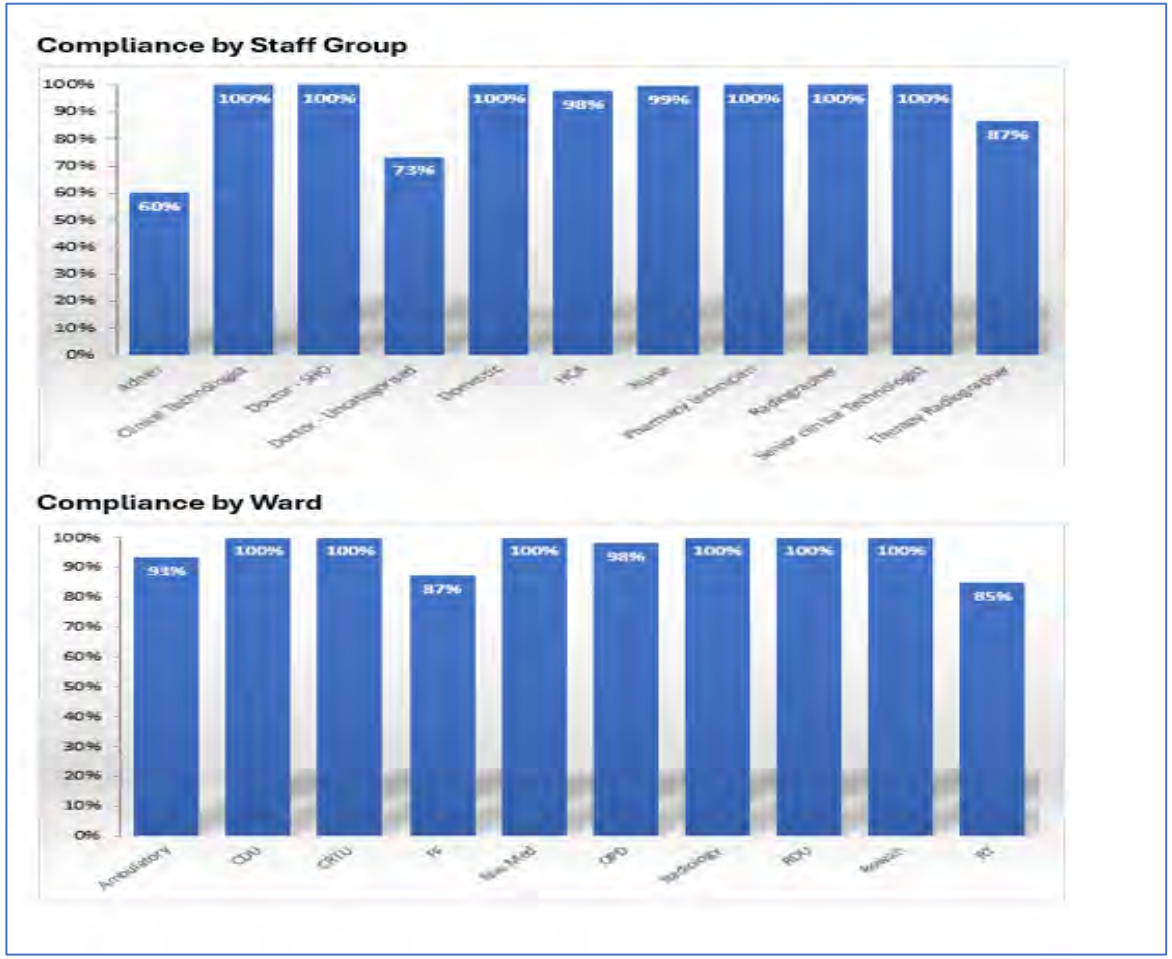
Figure 48



Hand Hygiene compliance

Hand Hygiene audits continue to be undertaken across the Trust. The IPC Team continue to undertake spot checks to validate Hand Hygiene practice. Any non compliance is discussed at time of audit and education provided.

Figure 49



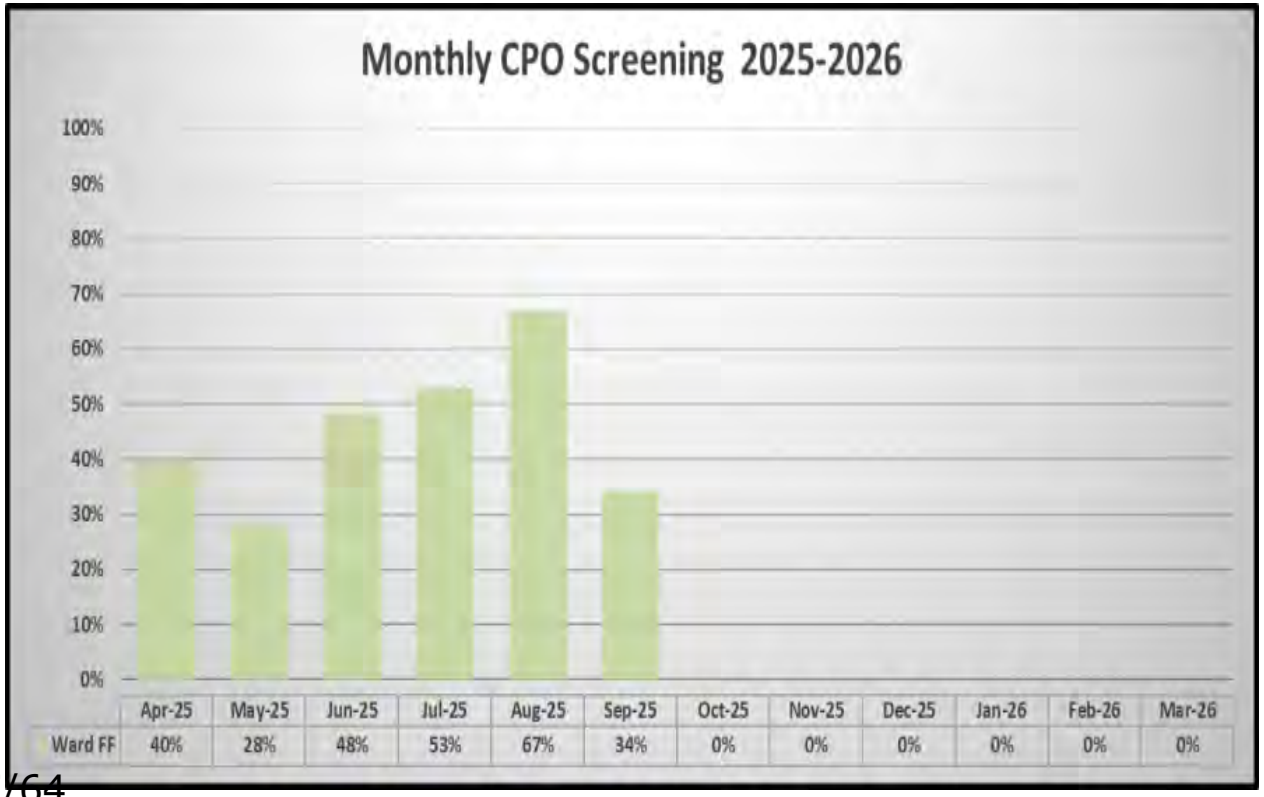
Overall compliance – **95%**

Compliance with screening for Carbapenemase Producing Organisms (CPO)

With the continued rise in multi-drug resistant organisms (MDROs) across Wales, routine screening for CPOs on all patient admissions remains a critical requirement under national policy. Since compliance monitoring began in April 2023, consistent implementation has proven challenging. Despite ongoing efforts, embedding this practice into daily workflows has not yet reached expected levels.

The Infection Prevention and Control Team (IPCT) is actively collaborating with ward teams to reinforce the importance of timely CPO screening and to identify barriers to compliance. Comparative benchmarking indicates that other cancer centres outside Wales have successfully integrated CPO screening into routine admission processes, achieving high compliance without significant issues.

Figure 50



Staff vaccination campaign commenced 8th September 2025. Update to date:

Figure 51

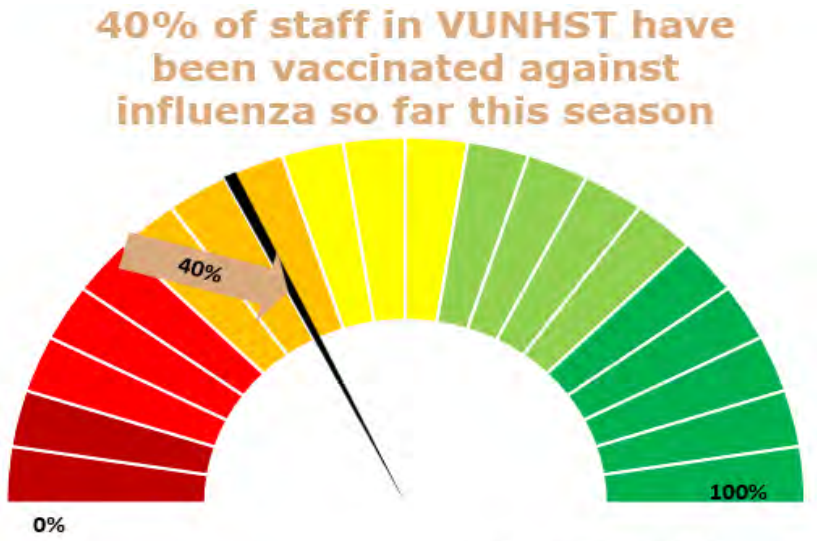


Figure 52

Deprivation of Liberty Safeguards

Safeguarding and Public Protection Activity

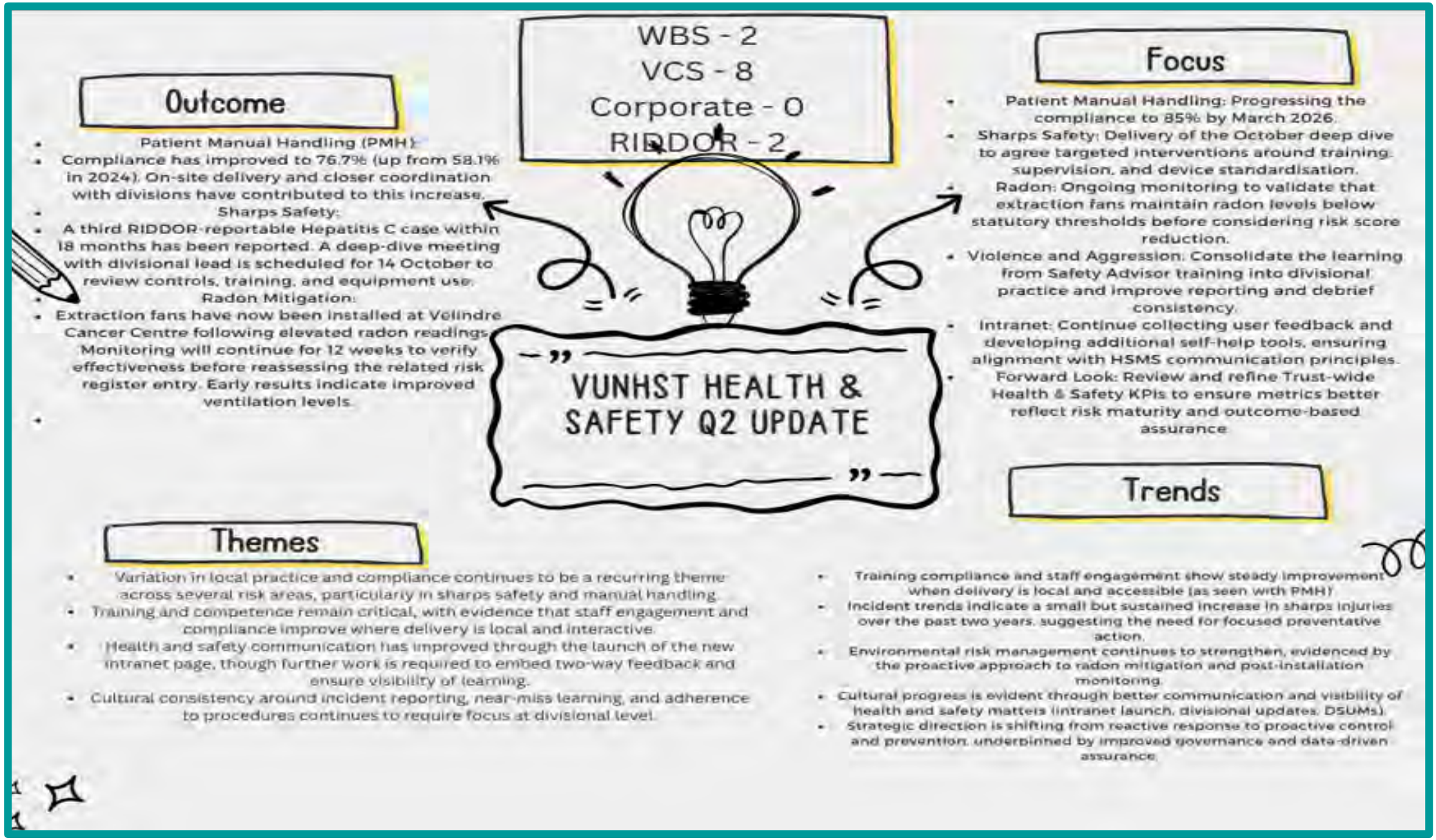
6 applications for Deprivation of Liberty Safeguards (DoLs) was made during Quarter 2. This is an increase when compared with the same time-period for the previous two years.

Duty to Report to Local Authorities

Figure 53

As shown in figure 53, 3 Duty to Reports a child or adult at risk were submitted to Local Authorities. This included one raised by the **Welsh Blood Service,** which related to a report submitted in **Quarter 1.** The team were able to provide additional information of concerns relating to neglect and financial hardship, and this has triggered an adult at risk process**.**

Figure 54


WBS - 2
VCS - 8
Corporate - 0
RIDDOR - 2
VUNHST HEALTH & SAFETY Q2 UPDATE
Outcome
Patient Manual Handling (PMH):
Compliance has improved to 76.7% (up from 58.1% in 2024). On-site delivery and closer coordination with divisions have contributed to this increase.
Sharps Safety:
A third RIDDOR-reportable Hepatitis C case within 18 months has been reported. A deep-dive meeting with divisional lead is scheduled for 14 October to review controls, training, and equipment use.
Radon Mitigation:
Extraction fans have now been installed at Velindre Cancer Centre following elevated radon readings. Monitoring will continue for 12 weeks to verify effectiveness before reassessing the related risk register entry. Early results indicate improved ventilation levels.
Focus
Patient Manual Handling: Progressing the compliance to 85% by March 2026.
Sharps Safety: Delivery of the October deep dive to agree targeted interventions around training, supervision, and device standardisation.
Radon: Ongoing monitoring to validate that extraction fans maintain radon levels below statutory thresholds before considering risk score reduction.
Violence and Aggression: Consolidate the learning from Safety Advisor training into divisional practice and improve reporting and debrief consistency.
Intranet: Continue collecting user feedback and developing additional self-help tools, ensuring alignment with HSMS communication principles.
Forward Look: Review and refine Trust-wide Health & Safety KPIs to ensure metrics better reflect risk maturity and outcome-based assurance.
Themes
Variation in local practice and compliance continues to be a recurring theme across several risk areas, particularly in sharps safety and manual handling.
Training and competence remain critical, with evidence that staff engagement and compliance improve where delivery is local and interactive.
Health and safety communication has improved through the launch of the new intranet page, though further work is required to embed two-way feedback and ensure visibility of learning.
Cultural consistency around incident reporting, near-miss learning, and adherence to procedures continues to require focus at divisional level.
Trends
Training compliance and staff engagement show steady improvement when delivery is local and accessible (as seen with PMH).
Incident trends indicate a small but sustained increase in sharps injuries over the past two years, suggesting the need for focused preventative action.
Environmental risk management continues to strengthen, evidenced by the proactive approach to radon mitigation and post-installation monitoring.
Cultural progress is evident through better communication and visibility of health and safety matters (intranet launch, divisional updates, DSUMs).
Strategic direction is shifting from reactive response to proactive control and prevention, underpinned by improved governance and data-driven assurance.

16. QUALITY PRIORITIES 2025-26

The quality priorities and targets for **2025/2026** are outlined in the table below. These have been discussed and agreed upon throughout the year, with input from various Trust and Divisional meetings across the organization.
Both Divisions are developing improvement plans in order to monitor the progress of each priority.

SAFE	TIMELY	EFFECTIVE	EFFICIENT	EQUITABLE	PERSON CENTRERD

PRIORITY 1.

IMPROVE PATIENT & DONOR COMMUNICATIONS

HOW WE WILL IMPROVE OUR PERFORMANCE

a) Ensure 100% of letters following appointments are sent out to patients (unless the patient has opted out) by the end of March 2026.
b) Ensure 100% of letters on the document management system (DMS) are consistently approved and sent within 30 working days by the end of December 2025.
c) Improve patient communications regarding disease management and treatment.
d) Improve patient and donor appointment communications.

HOW IMPROVEMENTS WILL BE MEASURED AND MONITORED

a) Regular audits to ensure that a copy of all clinic letters are sent to patients who have not opted out of receiving a copy.
b) Regular audits of the Document Management System to ensure all clinic letters are authorised and sent within 30 working days of the appointment.
c) By March 2026, achieve a 25% reduction in the number of concerns where treatment communication regarding patient treatment/outcomes is identified as a theme.
d) By March 2026, achieve a 25% reduction in the number of concerns/feedback where appointment communication is identified as a theme.

PRIORITY 2.

STRENGTHEN QUALITY AND SAFETY INFASTRUCTURE

HOW WE WILL IMPROVE OUR PERFORMANCE

a) Ensure all levels of patient / donor safety investigations are robust and undertaken by trained investigators at the appropriate levels.
b) Ensure feedback and support is provided to all staff involved in the incident.
c) Develop a Trust wide accreditation plan – with clear trajectory to having nationally / internally recognised accreditation across all core services.
d) Strengthen the quality and safety infrastructure at a service level, including the development of core quality standards and metrics and clinical risk management
e) Continue to strengthen the quality and safety culture across the organisation, including psychological safety

HOW IMPROVEMENTS WILL BE MEASURED AND MONITORED

a) By the end of December 2025, undertake sample audits of all patient / donor safety investigations at each level.
b) By the end of September 2025, introduce staff surveys to identify areas of improvement.
c) Achieving at least two new accreditations during 2025/26 as well as maintaining existing accreditations.
d) By end September 2025, undertake a review of quality and safety governance structures through each service area to board.
e) Staff survey 25/26 results regarding psychological safety

16. QUALITY PRIORITIES 2025-26 CONT.

SAFE | TIMELY | EFFECTIVE | EFFICIENT | EQUITABLE | PERSON CENTRERD

PRIORITY 3.

IMPROVE PATIENT & DONOR SAFETY

HOW WE WILL IMPROVE OUR PERFORMANCE

a) Reduce the harm from sepsis through early identification and treatment.
b) Reduce harm related to urgent clinical information being circulated via email.
c) By September 2025, fully implement 'Call for Concern' in Velindre Cancer Service.
d) Ensure that 100% of bloods taken within Velindre Cancer Service are reviewed within 48 hours.
e) We will introduce Haemoglobin S testing to detect the presence of sickle-cell trait in specific whole blood donations.
f) WBS to review specialist red cell immunohematology (RCI) services.

HOW IMPROVEMENTS WILL BE MEASURED AND MONITORED

a) By end of September 2025:
   - Consistently achieve >90% of patients who meet the local criteria of suspected sepsis to be screened within one-hour and given antibiotics within one-hour of diagnosis.
   - Conduct monthly audits to measure compliance against key performance indicators.
   - To reduce the number of incidents related to sepsis recognition and management.
b) By end of December 2025, there will be processes in place to eliminate the need to send clinical information via email, and the number of incidents resulting in patient harm as a result is reduced to zero.
c) To develop an implementation plan and monitor via the Trust regulatory tracker.
d) By end of December 2025, reduce to zero the number of incidents reported where omission or delay in reviewing bloods is identified as a contributory factor.
e) All blood donations used for the treatment of sickle-cell disorder or for neonates will be tested and confirmed as negative for Haemoglobin S by the end of December 2025.
f) RCI service response times will meet all nationally agreed targets by the end of March 2026.

PRIORITY 4.

IMPROVE OPPORTUNITES TO GATHER AND LEARN FROM PEOPLES FEEDBACK

HOW WE WILL IMPROVE OUR PERFORMANCE

a) Develop and implement feedback methods aimed at increasing feedback from people with additional needs.
b) Improvements to the mechanisms for staff to support people to speak up safely and with confidence.
c) Increase opportunities to gather patient and donor feedback through utilising SMS messaging, by end June 2025.

HOW IMPROVEMENTS WILL BE MEASURED AND MONITORED

a) Regular audits of our accessible feedback channels, adjusting our strategy based on continuous evaluation.
b) To commence data analysis to identify themes by the end of September 2025.
c) To compare data each quarter on percentage of service user feedback received.

VCS Quality Priority Updates

Priority 1. Improve patient communications

- A copy of clinic letters are now routinely being sent to all patients (who consent). This allow patients and their family to revisit and reflect on the information they were given verbally in clinic.
- Letters approval within 30 days on Document Management System report being reviewed fortnightly by Clinical Director and Head of Planning and Performance. There has been a concerted effort in the management of letters that has translated to a significant improvement that continues to be monitored.
- SACT Pathway Transformation work beginning in Quarter 3 will see patients allocated for the appropriate level of review. This will result in patients having the appropriate length of time with their reviewer and will allow consultants to manage complex patients.
- SACT appointment communication is improving due to the appointment of a SACT Scheduling and Performance Manager and development of an improvement plan in Quarter 2. This will be monitored to ensure continued improvement through concerns, feedback, and incidents.
- VCS have commissioned Velindre Oncology Academy to deliver “SAGE & THYME” advanced communication skills training to all clinical staff

Priority 2. Strengthen quality and safety infrastructure

- Roll out of investigation training to start during Quarter 3 planned with an ongoing programme of training and support for clinical and non-clinical staff to undertake proportionate investigations.
- Strengthening of quality and safety infrastructure has begun during quarter 2 with the planning of the new governance structure from floor to board. This will be developed further during quarter 3 with the appointments of directorate triumvirates.
- Service level quality metrics to be defined during Quarter 3.

Priority 3. Improve patient safety

- Throughout Quarter 2 VCS has been 100% compliant with patients being screened for sepsis and 100% compliant for patients being treated with antibiotics within the required timeframe. This has been achieved throughout targeted education on the new NEWS 2observation chart including the required escalation response. Resident doctor induction training has been amended to be held on first day of attendance at VCS, this ensures 100% attendance. Ongoing monthly audits continue.
- Call for concern implementation being led nationally by NHS Performance and Improvement with a delivery date of September 2027. Pilot to be implemented in Q4. Engagement work currently being undertaken to understand the information our population would like on Call for Concern, and the route of referral.
- During quarter 1 and 2, a service improvement project has been underway to improve the process for reviewing bloods in a timely manner. This will be implemented during quarter 3 and 4 and includes utilising digital solutions and the wider MDT.

Priority 4. Improve opportunities to gather and learn from people's feedback

- There has been a concerted effort through quarter 2 on improving the opportunities for and the amount of patient feedback received which is yielding positive results. Further work required during quarter 3 in conjunction with Experience, Engagement, and Communications colleagues.

WBS Quality Priority Updates

Priority 1. Improve donor communications

- Welsh Blood Service Communications & Donor Engagement Team have developed a plan

Priority 2. Strengthen quality and safety infrastructure

- Roll out of investigation training to start during Quarter 3 planned with an ongoing programme of training and support for clinical and non-clinical staff to undertake proportionate investigations.
- Service level quality metrics to be defined during Quarter 3.

Priority 3. Improve donor safety

- Introduction of Haemoglobin S testing: funding has been secured for 2025/26. A Briefing paper approved by Director of WBS and Trust Executive Director of Finance. The tender has been issued, with a closing date 24/10/2025.
- RCI service response times – this is not specifically included in our IMTP: data gathering for the OCP baseline is scheduled to complete in Q3 2025/26. Implementation of contractual changes related to OCP scheduled in Q4 2025/26.

Priority 4. Improve opportunities to gather and learn from people's feedback

- The establishment of a Donor and Advocate Forum has progressed, with over 2,500 expressions of interest from donors and advocates. Following internal and external consultation the plan will be a collaborative model that integrates donor feedback, community partnerships, and digital engagement. The initiative is now positioned to pilot targeted engagement activities by Q4.
- The Donor Experience "Hub" will follow progress in establishing a Donor Advocate Forum as detailed above which is due to complete in Q4 2025-26

18. FOCUSED IMPROVEMENTS FOR QUARTER 3

FOCUSED IMPROVEMENTS FOR QUARTER 3, 2025-2026

Quarter 2 2025/26

1. Both divisions to develop smart action plans against the quality priorities.
2. To consider opportunities to improve capability and capacity to collect patient and donor feedback.
3. Commence Quality & Safety audits of concerns (open and closed), incidents, safety alerts, claims, redress, inquests and the Quality & Safety Regulatory Tracker.
4. Explore opportunities to share learning and feedback with staff across the Trust.
5. Develop a Trust wide Always on Reporting – in line with the Duty of Quality legislation.

Quarter 3 2025/26

1. Further work is required to develop smart action plans against the quality priorities.
2. Undertake an overarching review of all concerns in the last 12 months to identify if specific themes are attributed to the increased activity.
3. To continue to improve capability and capacity to collect patient and donor feedback.
4. To further explore opportunities to share learning and feedback with staff across the Trust by relaunching the Trust Learning Framework in December 2025.
5. To commence Velindre University NHS Trust Proportionate Investigation training across the Trust.
6. To establish a preparedness group for the revised Putting Things Right Regulations.

TRUST BOARD	
HIGHLIGHT REPORT FROM THE CHAIR OF THE PUBLIC STRATEGIC DEVELOPMENT COMMITTEE	
DATE OF MEETING	27 November 2025
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Christine Sion, Business Support Officer
PRESENTED BY	Lindsay Foyster, Independent Member and Chair of the Strategic Development Committee
EXECUTIVE SPONSOR APPROVED	Carl James, Executive Director of Strategic Transformation, Planning and Digital
REPORT PURPOSE	FOR NOTING

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

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

1. PURPOSE

1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the Public Strategic Development Committee held on 9th September 2025

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

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

2. HIGHLIGHT REPORT

ALERT / ESCALATE	**Digital Programme Board Highlight Report** The Committee considered the Digital Programme Highlight Report. ***Key Points Raised in Discussion:*** i. It was noted that the Microsoft renewal will present a cost pressure within the IMTP, and that there will be negotiations with Microsoft. ii. A query was raised on when the items on Alert would be considered by the DPB and EMB, and whether an update would be brought back to the next SDC meeting. It was confirmed that the item is included in the action log and, due to scheduling, will be reviewed in November. The Committee **NOTED** the contents of the Digital Programme Highlight report.
ADVISE	**IMTP Planning 2026–29** The Committee received an update on the IMTP 2026-29 planning and welcomed the early engagement and alignment of strategic risks with IMTP development. ***Key Discussion Points:*** i. Shared Services alignment is progressing, with statutory and service extension issues discussed with their Director of Planning.

	ii. IMTP publication date revised from April to July 2026 with the development timetable to be updated to reflect the date change. iii. Welsh translation will follow final government approval, with bilingual publication on the website. iv. IMTP will be used as a live management tool from 1 April 2026, with performance monitoring already underway. v. Financial planning challenges were discussed, including a flat cash position due to committed growth funding and delayed allocation letters. The financial plan will be updated in early 2026, with a clear distinction between assumptions and confirmed figures. The Committee **APPROVED** the IMTP development timetable, subject to amendments. **Strategic Development Committee Effectiveness Survey Report** The Committee considered the findings of the Committee Effectiveness Survey. ***Key Points Raised in Discussion:*** i. The Committee noted that 7 out of 16 individuals completed the survey, approximately 44% and concern was raised about participant engagement. It was noted that this issue had also been discussed at the Audit Committee. ii. It was suggested that the Committee consider distinguishing between core members and regular attendees when conducting surveys, as different groups may offer varied perspectives. The value and purpose of survey feedback should be clearly defined, and efforts should be made to help participants understand the importance of engaging with these surveys. The Committee **APPROVED** the Strategic Development Committee effectiveness survey report, subject to the amendments suggested. The Committee **APPROVED** the **Strategic Development Committee Annual Report**.
ASSURE	**Cardiff Health Partners and Cardiff Cancer Research Partnership Update** The Committee received an update on the strategic collaboration between Velindre University NHS Trust, Cardiff and Vale UHB, and Cardiff University. The Cardiff Cancer Research Partnership (CCRP) is progressing towards formal launch, with legal and financial agreements, including the PMO funding model agreed at executive level and scheduled for governance approval in November 2025. Cardiff Health Partners (CHP) will build on this foundation to ensure consistency across the wider framework.

Key Discussion Points:

i. A prospectus is being developed with PwC and Life Sciences Hub for presentation at the Wales International Investment Summit, highlighting facilities such as Cardiff Edge and the National Genomic Centre.
ii. The importance of comprehensive innovation district mapping was noted.
iii. Future communications will focus on research benefits for staff and patients, including clinical impact and patient stories.
iv. Assurance mechanisms for governance and financial oversight will be reviewed.

The Committee **NOTED** the update and endorsed the proposed next steps for the November 2025 governance cycle.

Talbot Green Infrastructure – Approach to Business Case

The Committee received an overview of the Talbot Green Infrastructure (TGI) Programme and the change in approach to the business case:

The strategic importance of securing funding from Welsh Government prior to the upcoming election was emphasised. The critical role of the Wound Centre in ensuring the safety and resilience of Wales' blood supply chain was highlighted. The existing facility, although regulated, was originally built to factory standards and requires urgent upgrade to meet hospital building specifications. The proposed development will enable flexible laboratory space, support automation and advanced therapies, and future-proof transfusion and transplantation services.

Key Points Raised in Discussion:

i. It was confirmed that the Wound Centre is planned to become a permanent donor centre and support advanced therapies and plasma for medicines, not just a temporary decant site. This would avoid the need for an extension, saving significant costs, and aligns with the service's growth needs.
ii. The decision to purchase the Wound Centre will be considered by the Trust Board as part of the business case, and the Committee will be involved in the process.
iii. The use of change in "scope" in the recommendation was queried, and it was agreed that "approach" is more accurate to avoid ambiguity.

The Committee:

- **ENDORSED for APPROVAL** the revised **approach** in line with Welsh Government direction to submit an OBC, with the Enabling Works section to FBC standard. This will be submitted by the end of the 2025/26 financial year to meet funding and strategic deadlines.

- **NOTED** that the identified savings stem from the decision to purchase the Welsh Wound Centre rather than construct an extension for decanting purposes. The content of the business case will remain subject to Board consideration, with Strategic Development Committee (SDC) serving as the route for its progression.

Board Assurance Framework (BAF) Assurance Report
The Committee considered the BAF Assurance Report, noting that several risk scores remain static and will be reviewed by the Executive Management Board to ensure alignment with the Trust's strategic direction. The BAF will be reviewed alongside the IMTP for the next reporting year.

Key Discussion Points:

i. The Committee acknowledged improvements in the framework's accessibility and usability, and stressed the importance of applying it in practice.
ii. Concerns were raised about static or rising risk scores, prompting a call for urgent review and reassessment of mitigation actions.
iii. Inclusion of target risk dates was welcomed, with a recommendation for the Board to review its risk appetite.
iv. A correction was made to the finance sustainability risk score (O9), adjusted from 16 to 12, with a caution that it may rise due to financial pressures.

The Committee **NOTED** the BAF status and commended the Corporate Governance team for their progress.

Velindre Cancer Service (VCS) Futures Assurance Report
A workshop held on 5 August 2025 with nVCC colleagues focused on aligning programme oversight and closing workstream gaps. Improvements since include standardised risk management, weekly coordination meetings between BAU and nVCC teams, and an invitation to the nVCC SRO to join the VCS Futures Programme Board to enhance governance.

The key discussion points included:

i. Concerns were raised about the outreach project's slow progress and lack of governance clarity. AC explained the project is being rescoped, with outreach now prioritised operationally. A closure report will be brought back to confirm governance arrangements.
ii. The report lacked an assurance level on the front sheet. It was agreed future reports will include this.

The Committee **NOTED** the contents of the report.

	Welsh Blood Service Futures Assurance Report The Committee: i. **NOTED** the contents of this report and the Assurance it provides. ii. **ENDORSED** the proposed assurance level of 3 for the report, with all members in agreement. **Value-Based Healthcare (VBHC) Programme Update** The Committee received an update on the VBHC Programme, noting steady progress supported by strong governance, regular audit, and collaboration with national partners. A recent internal audit gave reasonable assurance, with all recommendations being addressed. ***Key Discussion Points included:*** i. The importance of PROMS data in understanding patient experience and informing care pathways was emphasised. Integration with the Welsh Clinical Portal and broader patient experience data is a future goal. ii. The team was encouraged to align VBHC work with emerging productivity standards from Welsh Government. iii. Clear communication with patients about PROMS usage and feedback mechanisms was recommended. iv. Expansion of home-based treatments, such as Velindre's unique denosumab delivery via community pharmacies, was highlighted as a growth area. The Committee **NOTED** the continued progress of the programme and expressed interest in future impact updates.
INFORM	There were no items to inform the Trust Board
APPENDICES	**NOT APPLICABLE**

TRUST BOARD	
Smoke-free Policy	
DATE OF MEETING	27/11/2025
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	Sue Price, Senior People and OD Business Partner
PRESENTED BY	Sarah Morley, Executive Director of People and OD
APPROVED BY	Sarah Morley, Executive Director of Organisational Development & Workforce
EXECUTIVE SUMMARY	The existing Smoke Free policy has been updated as part of the policy update cycle. It reflects the latest employment legislation position.
RECOMMENDATION / ACTIONS	Board are asked to approve this policy revision

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
EMB	28/07/2025
QSP	11/09/2025
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS In January 2025, this policy was reviewed and considered by colleagues within the People and OD team. The policy has been reviewed by and accepted by EMB and QSP.	
7 LEVELS OF ASSURANCE	

ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	**Select Current Level of Assurance**
APPENDICES	
	Smoke-free Policy

1. SITUATION

The Smoke-free policy is due for review within the cycle of policy reviews. The policy is assigned to the People and OD team and has been updated by a member of this team. It now requires approval by the Trust Board in line with Trust governance arrangements.

2. BACKGROUND

The Smoke-free policy has been in existence for a number of years. The policy was last updated in 2019 (version 5). This revision (version 6) takes account of the latest changes in employment legislation and the Trust's values.

3. ASSESSMENT

The Smoke-free policy is overdue for review and approval. There were no legislative changes that impacted this policy and therefore the policy group gave priority to updating policies with a legislative impact.

4. SUMMARY OF MATTERS FOR CONSIDERATION

The review resulted in the policy largely remaining unchanged. Clarity was provided in the policy about the restriction of smoking on any of Velindre's sites or sites where we provide services as well as the restriction on smoking wearing Velindre uniform, due to the conflict of image it presents against our purpose.

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)	04 - Organisational Culture

For more information: STRATEGIC RISK DESCRIPTIONS	
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply Safe ☐ Timely ☐ Effective ☐ Equitable ☒ Efficient ☐ Patient Centred ☒ The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021).
QUALITY IMPACT ASSESSMENT *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** 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:	Yes

For more information: *https://www.gov.wales/socio-economic-duty-overview*	Click or tap here to enter text. An EQIA has been completed. There were no equality impacts identified.

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

FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Source of Funding: **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Choose an item** **Scale of Change**

	Please detail the value of revenue and/or capital impact: Click or tap here to enter text **Type of Change** Choose an item Please explain if 'other' source of funding selected: Click or tap here to enter text
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Yes - please outline what, if any, actions were taken as a result
	[An EQIA has been completed. There were no equality impacts identified.
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

None associated.

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

WF 56

SMOKE-FREE POLICY

Executive Sponsor & Function:	Executive Director of OD and Workforce
Document Author:	Senior People and OD Business Partner
Approved by:	Workforce and OD Committee
Approval Date:	June 2024
Date of Equality Impact Assessment:	4th June 2024
Equality Impact Assessment Outcome:	No impact identified
Review Date:	June 2026
Version:	6

C O N T E N T S

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2. **Scope of Policy**

3. **Aims and Objectives**

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   3.2 Objectives

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   4.2 Managers
   4.3 Staff
   4.4 Volunteers, Contractors, Service Providers, Patients, Donors, Visitors and the Public

5. **Implementation and Policy Compliance**

6. **Getting Help**

   6.1 Help Me Quit
   6.2 Time Off to Attend Smoking Cessation Sessions

7. **Information and Details of Relevant Legislation**

8. **Instruction and Training**

9. **Equality Impact Assessment**

1. Policy Statement

This Smoke-Free Policy ensures the rights of everyone to breathe Smoke-Free air on all Velindre University NHS Trust premises. The policy recognises that the Trust has a responsibility to promote public health to all its staff, workers, patients, donors and visitors.

The aim of this policy is to protect all staff, workers and those who use or access the services of or attend the premises owned, leased or used by Velindre University NHS Trust from exposure to second-hand smoke and to ensure compliance with the Smoke-Free provisions of the Smoke-Free Premises etc. (Wales) Regulations 2018.

2. Scope of Policy

The Smoke-Free Policy applies to all staff, without exception, and will form part of the Trust's Terms and Conditions of Employment. This policy also applies to those organisations hosted by the Trust. Therefore, all Velindre University NHS Trust staff are expected to comply with the Smoke-Free Policy.

The Smoke-Free Policy also applies to all workers of external agencies, voluntary workers/ volunteers, students, contractors, patients, donors, bank workers and visitors to any Trust premises, grounds and all Trust vehicles.

Smoking is prohibited in all Trust premises, grounds (owned, leased and hired) and vehicles, with no exceptions. Restrictions include all areas up to the premise's boundaries, including car parks and vehicles parked in them, outdoor seating areas, walkways etc. Any employee etc. wishing to smoke, using any tobacco or electronic cigarette related products, during the working day or while on Trust premises must leave the Trust grounds to do so. Trust staff are not permitted to smoke at the entrance to Trust premises or non-fixed locations where staff and workers carry out their work.

The Smoke-Free Policy applies to all tobacco products and electronic cigarettes / vaping machines.

3. Aims and Objectives

3.1 Aims

The aim of the Smoke-Free Policy is to promote a Smoke-Free environment in all premises, grounds and property occupied by the Trust, to ensure compliance with current Smoke-Free legislation, and to encourage staff and workers to give up smoking by role modelling positive health and wellbeing behaviours to the communities we serve.

3.2 Objectives

The Trust wishes to set a positive example to the communities we serve by;

- making non-smoking the normal practice in all Trust premises, grounds and vehicles;
- promoting health and wellbeing, by encouraging and assisting staff and workers to make a lifestyle choice to give up smoking to reap the health benefits;
- offering smoking cessation support to staff and workers to give up smoking;

- fulfilling the Trust Board's legal duty of care to all its staff and workers to provide a safe working environment.

4. Responsibilities

4.1 Executive Lead

Overall responsibility for the implementation of the Smoke-Free Policy and review rests with the Chief Executive Officer (CEO) and the Executive Team.

The CEO, through delegated powers, shall ensure that all staff and workers are aware of the Smoke-Free Policy and of their role in the implementation and monitoring of it.

4.2 Managers

All managers are responsible for ensuring that the staff they line manage comply with the Smoke-Free Policy.

All managers are responsible for supporting their staff who bring the Smoke-Free Policy to the attention of those in breach of it.

All managers are responsible for supporting any staff who wish to quit smoking by providing reasonable time off during working hours, to access support including Occupational Health or smoking cessation courses. Managers must agree any time in advance and attendance will be subject to the needs of the service.

Managers are responsible for monitoring the Smoke-Free Policy in their departments.

4.3 Staff

All staff have a duty to fully comply with the Smoke-Free Policy.

Staff must not smoke when visibly wearing a Trust name badge or uniform, regardless of their location.

Staff wishing to smoke during their working hours, must do so away from Trust premises and grounds (including immediately outside the entrance of Trust premises) and can only do so during their official unpaid break times. Additional smoking breaks must not be taken outside of official unpaid break times. Managers are responsible for ensuring that all staff have equitable access to unpaid breaks.

Staff are encouraged, where appropriate (in line with the implementation plan), to inform any individual who is seen smoking on Trust premises, including in Trust vehicles etc., that the Trust has a Smoke-Free Policy. Staff should politely remind individuals of the Smoke-Free Policy, but they should not enter into discussion regards its value or merits and on no account enter into an argument or debate.

Staff have a responsibility to be available for work during their paid contracted hours and to not be away from their work on unauthorised breaks. Staff who are found to be taking additional unauthorised smoking breaks, during their paid contracted hours, may be liable to disciplinary action.

Staff must not assist patients or donors in leaving the premises, to smoke.

4.4 Volunteers, Contractors, Service Providers, Patients, Donors, Bank Workers, Visitors and the Public

All of the above are required to fully comply with the Trust's Smoke-Free Policy.

5. Implementation and Policy Compliance

The Smoke-Free Policy aims to achieve its objectives by ensuring that all staff are aware of the importance of the policy and of their responsibility to ensure its effective implementation.

The Trust will ensure that the selling or promoting of tobacco products and e-cigarettes are prohibited on all of its premises. The Trust will not directly invest in tobacco related subsidiaries.

In accordance with relevant legislation the Trust will, at no time, accept sponsorship from tobacco or e-cigarette companies or, tobacco, e-cigarette related companies. The advertising and sales of tobacco or e-cigarette related products will not be allowed on Trust premises, grounds or in any of its publications.

The Trust will treat all patients, irrespective of whether they smoke or not. The Trust is fully committed to helping and supporting staff and workers who wish to stop smoking. All staff who have contact with patients, donors etc. irrespective of discipline or pay band, should, where necessary, remind them that they are not permitted to smoke on Trust premises. A polite explanation should be given regarding the Trust's Smoke-Free Policy and a request made to refrain from smoking on the premises. Staff should not place themselves at risk of abuse, whether it is verbal or physical. If verbal or physical abuse occurs as a consequence of them implementing the Smoke-Free Policy, the perpetrator will be subject to the Trust's Policy on Violence and Aggression, in line with the zero-tolerance approach.

The Smoke-Free Policy recognises that secondhand smoke in the workplace adversely affects the health of staff and workers The Trust respects an individual's right to smoke but balances this against our duty to prevent them from smoking on Trust premises and to prevent the introduction of carcinogenic substances, which have been proven to have a negative impact on the health and wellbeing of those individuals who are exposed to them.

The Trust recognises that authorised officers from the relevant Local Authorities serving the Trust's premises, have the power to enter, to establish whether the Smoke-Free legislation is being enacted, in accordance with the law. They also have the power to issue fixed penalty notices to those whom they believe are committing, have committed or are allowed to commit an offence under the legislation.

The Trust encourages its staff and workers to refrain from smoking, as set out in the Smoke-Free Policy. In respect of our staff, the Trust is fully committed to working with them to promote and encourage them to take all reasonable steps to maintain and improve their health and wellbeing. As representatives of the Trust all staff also have a duty to role model positive health and wellbeing behaviours, as one of our primary objectives is to improve the

health and wellbeing of the population we serve. Therefore, all staff who wish to stop smoking and request support to do so will be given access to smoking cessation support.

6. Getting Help

Staff who are finding it difficult to stop smoking or comply with the requirements of the policy should discuss the issues with their line manager for initial support. Staff are also encouraged to check the Trust's intranet site for details of support which is available to them. The main sources of support available in Wales are set out below:

6.1 Help Me Quit

Help Me Quit are available to support individuals on every step of their Smoke-Free journey. Support is available in:

- Meetings with other smokers (research shows that this is the best way to stop smoking);
- One to one appointments. These may be face to face or over the telephone.
- Community venues;
- Hospitals; and
- Pharmacies.

Help Me Quit provides free telephone support on 0800 085 2219 or at www.helpmequit.wales or email helpmequit@wales.nhs.uk
Help Me Quit - Find Services in your Local Area

The Trust supports the 'Stoptober Campaign' and annually provides information, to encourage Trust staff to stop smoking.

Advice and support is also available from your GP or your Community Pharmacist.

6.2 Time Off to Attend Smoking Cessation Sessions

The Trust will provide staff with a maximum of six hours paid time off, over a timeframe of eight weeks (pro rata if working part-time), to attend smoking cessation sessions. This does not include any time taken to travel to the appointment, which must be made in the individual's own time. Smoking cessation sessions must be face to face consultations, with a stop smoking advisor. All sessions must be documented and signed off by the individual's line manager, who will discuss the time off required, to ensure that it fits with service delivery needs. The line manager will be expected to monitor the time taken.

Alternatively, the staff member's GP or Community Pharmacist can also offer help and support.

7. Information and Details of Relevant Legislation

Smoking is the UK's leading cause of preventable death and the main cause of premature death in Wales. The provision of a Smoke-Free environment provides a clear and effective message about the importance that Velindre University NHS Trust places on this issue. As an NHS Trust dedicated to cancer treatment and provision of transplantation services, we recongise our key role in promoting smoking cessation. Smoking causes around 5,000 deaths each year in Wales (around one in every six of all deaths in people aged 35 and over) and costs the Welsh NHS an estimated £302 million per year N(Welsh Government 2018).

Passive smoking (breathing other people's tobacco smoke) has been medically proven to cause lung cancer and heart disease in non-smokers, as well as many other illnesses and minor conditions. At this time the impact of breathing in other people's e cigarette smoke is not known, as research findings are not currently available.

The Trust has a legal duty to protect and minimise the risks to staff, workers and visitors on Trust premises and grounds, from the harmful effects of exposure to secondhand smoke as directed by the ***Smoke-Free Premises etc. (Wales) Regulations 2018.***

The Health and Safety at Work Act 1972 places a duty on employers to *'…provide and maintain a safe working environment which is, so far as is reasonably practical, without risk to health and adequate as regards facilities and arrangements for their welfare at work'*.

Action to tackle the harm caused by smoking continues to be a priority for the Welsh Government.

The Well-being of Future Generations Act 2015 is encouraging all public sector organisations to ensure that wellbeing planning across communities will limit the impact of tobacco on individuals, now and in the future.

The ***Public Health (Wales) Act 2017*** **the and** Smoke-free Premises and Vehicles (Wales) Regulations 2020 reduced exposure to second-hand smoke, by introducing legislation to make it an offence to smoke in the outdoor areas of school grounds, children's playgrounds, hospital grounds and outdoor care settings for children. To take this forward a ***Tobacco Control Delivery Plan for Wales 2017-2020*** has been developed with the key focus being on improving access to smoking cessation services and promoting Smoke-Free environments.

The Welsh Government announced an ambitious strategy in July 2022 for tobacco control in Wales, with a vision to create a smoke-free Wales by 2030.

8. Instruction and Training

Should a service user ignore the Trust's Smoke-Free Policy, they should be advised that the Trust has the right to refuse them access to Trust services. Should they continue to smoke, they should be asked to leave the Trust's premises. Should the individual refuse to leave and become violent or aggressive (verbal or physical), the employee should seek support for colleagues nearby and report the incident in accordance with the Trust's *Management of Violence and Aggression Policy.*

All new staff and workers of the Trust should be made aware of the Trust's Smoke-Free Policy during their induction, to ensure that there is a safe working environment for all.

If a member of staff or worker is found smoking on Trust premises and they continue to do so, after being reminded of the Smoke-Free Policy, they should be advised that it is an offence for the Trust to let them do so. The staff member or worker should also be advised that they are committing an offence by smoking in a smoke-free environment. The should be asked politely to stop smoking. Where an employee fails to comply with the Smoke-Free Policy, the Trust may invoke the Disciplinary Policy. Alternative arrangements may be in place for bank workers or contractors meaning they are unable to continue to carry out work for the Trust.

9. Equality Impact Assessment

A summary of the outcome of the Equality Impact Assessment has been screened for relevance to equality. No potential negative impacts have been identified.

TRUST BOARD	
Adverse Weather Policy	
DATE OF MEETING	27 November 2025
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	CLAIRE BUDGEN, OD SPECIALIST
PRESENTED BY	Sarah Jenkins, Executive Director of People and OD
APPROVED BY	Sarah Morley, Executive Director of Organisational Development & Workforce
EXECUTIVE SUMMARY	This policy informs staff of the procedure to follow if they cannot attend work, will be late attending work or are delayed in returning from annual leave, due to adverse weather conditions, and when adverse weather arises whilst in work.
RECOMMENDATION / ACTIONS	**To Approve the policy.**

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board	**28.7.25**
Quality, Safety and Performance Committee	**11.9.25**
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	**Select Current Level of Assurance**
APPENDICES	
1	Adverse Weather Policy, January 2025

1. SITUATION

The Adverse Weather policy is due for review within the cycle of policy reviews. The policy is assigned to the People and OD team and has been updated by a member of this team. It now requires approval by the Trust Board in line with Trust governance arrangements.

2. BACKGROUND

The Adverse Weather Policy has been in existence since 2018. This revision takes account of changes in nomenclature since then.

3. ASSESSMENT

There were no legislative changes that impacted this policy. The changes that have been made are:

- Updated Document Formatting and Cover
- Managers' Responsibilities – added 'to agree reasonable adjustments with staff with disabilities in advance of adverse weather events' in line with updated EQIA
- Home Working Policy replaced by Hybrid Working Toolkit
- Grievance Policy replaced by Respect and Resolution Policy
- Other minor formatting and language updates

4. SUMMARY OF MATTERS FOR CONSIDERATION

The Trust Board is asked to approve this policy.

5. IMPACT ASSESSMENT

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

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	**Choose an item**
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.*	**Choose an item** The QIA tool should be completed to support any proposal for a strategic decision to be made and be presented with the proposal to the appropriate decision-making forum. The QIA tool does not replace the need for the proposal; it accompanies it. As a minimum, decisions made by the Board or by Committees of the Board are considered strategic and should be assessed for their impact on Quality through the lens of the Health and Care Quality Standards. This culture and discipline of quality-driven decision-making should also permeate the organisation to more broadly promote good decision-making practice.

SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Yes
	Completed as part of EQIA.

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

FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Yes - please outline what, if any, actions were taken as a result
	On launch, Managers to be reminded about the need to agree Reasonable Adjustments for staff with disabilities if their ability to attend work in person could be impacted by adverse weather

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

6. RISKS

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

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

Ref: WF13

ADVERSE WEATHER POLICY

Executive Sponsor & Function	Director of OD & Workforce
Document Author:	Claire Budgen, Head of Organisational Development
Approved by:	Trust Board
Approval Date:	
Date of Equality Impact Assessment:	23 January 2025
Equality Impact Assessment Outcome:	Actions Detailed in EQIA
Version:	2

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Policy Statement

Velindre NHS Trust is appreciative and conscious of the effort that employees make in attending work during adverse weather conditions. Some staff may experience difficulty-attending work but the Trust emphasises that no employee should risk their personal health and safety or that of others, when endeavouring to attend their work place.

1. Purpose

The adverse weather policy intends to inform staff of the procedure to follow if they cannot attend work, will be late attending work or are delayed in returning from annual leave, due to adverse weather conditions, and when adverse weather arises whilst in work.

2. Scope

Without exception, this procedure applies to all employees of the Trust to include those within hosted organisations, those with honorary contracts, agency staff, bank, temporary and fixed term staff, secondees and students.

3. Aims and objectives

The adverse weather policy intends to inform staff of the procedure to follow if they cannot attend work, will be late attending work or are delayed in returning from annual leave, due to adverse weather conditions, and when adverse weather arises whilst in work. This policy is designed to ensure that appropriate measures are taken to support staff during adverse weather conditions. If such conditions do occur and show due regard for their health and safety, as well as endeavouring to provide adequate levels of service to patients/service users.

4. Roles and Responsibilities

5.1 Individual Employee Responsibilities

- to familiarise themselves with the provisions within this policy, particularly when adverse weather is forecast;
- to keep abreast of weather warnings, forecasts and plan ahead;
- to make every reasonable effort possible to attend their place of work (or an alternative office where possible) during adverse weather conditions. Reasonable effort to attend work includes the use of public transport, walking where appropriate and car sharing. NB. If employees decide to “car share”, this is an agreement between those employees and not an instruction from the Trust;
- to consider their personal health & safety and that of others when taking actions under this policy;
- to access advice from the emergency services via the media and any available advice from the Trust;
- Should maintain contact with their workplace throughout any period of absence.

5.2 Manager Responsibilities

- Ensure business continuity during times of adverse weather;
- Ensure all staff are aware of the department’s business continuity plans in the event of adverse weather
- Make all staff aware of this policy when adverse weather is forecast;
- Treat all employees fairly and consistently;
- Agree reasonable adjustments with employees with disabilities in advance of adverse weather events occuring

- Ensure adequate communication takes place with their staff where adverse weather arises;
- Have regard for the Health and Safety of staff;
- Support staff who work long hours to maintain services during adverse weather;

5. Procedure for reporting non / late attendance

Where employees are unable to attend their place of work or will be late attending due to adverse weather conditions, they must notify their manager [or if unavailable, the nominated deputy]. Please also refer to the Business Continuity Plan [if necessary] at the earliest opportunity. The following information should be provided:

- The reason for non-attendance/lateness, including issues where the All Wales Special Leave policy could apply;
- The attempt made by the employee to arrive on time;
- The amount of time that the adverse situation is expected to continue for;
- Raise any issues relevant to that day's work.

Special consideration should be given to staff with disabilities or who are pregnant, dependent upon individual circumstances and in line with current legislation.

6. Deteriorating weather conditions

If weather conditions appear to be worsening, or adverse weather conditions occur when members of staff are already in their workplace, any decision to send staff home will be taken by the appropriate level of management as defined in Appendix 1. Managers should raise any concerns about weather conditions known to the Chief Executive or Director of the division or hosted organisation as soon as possible.

Decisions will be dependent on:

- Employee's journey to their home (i.e. distance, mode of transport etc.);
- Staffing requirements across the Division/hosted organisation;
- Reports obtained on road conditions, weather reports, public transport etc.;
- Employee circumstances;
- Business and service continuity and provision of essential services.

Employees working at another location other than their usual place of work should contact their line manager to discuss their return home, or to their usual place of work, as soon as they feel their own health and safety may be at risk.

In exceptional circumstances, where employees are unable to return home due to worsening weather conditions, alternative solutions will be sought which may include the provision of accommodation in appropriate cases. Approval must be agreed in advance by appropriate level of management as defined in the Decision Making Responsibilities Schedule Appendix 1.

See also FAQ's ***Appendix 2***.

7. Communications

Communications should be coordinated in liaison with the organisational Communications Team in relation to updates, local conditions and hazard alert warnings including levels (i.e. Red, Amber or Yellow). This information is then to be cascaded out within Divisions/Hosted Organisations as appropriate and in line with their business continuity plans.

8. Organisational decision making

It is recognised that the circumstances whereby this policy will become operational may mean that normal reporting and communication arrangements are compromised. As such, Organisations should devise and publicise local arrangements. See ***Appendix 1*** for the decision making responsibilities schedule.

Local arrangements will be in line with the organisations Adverse Weather Business Continuity Plans, which will include arrangements for operational delivery, resources and estates including building closures and what arrangements are in place for staff during adverse weather.

9. Payment of Employees

(i) Employees who, due to adverse weather, are unable to attend their workplace for all or part of their shift may be able to make up this time within a reasonable period agreed by the line manager and employee. Alternatively, they may be given the opportunity to take the time off as annual leave or unpaid leave. Where accrued, time off in lieu may be taken and where a flexitime scheme is in operation, the provisions of that scheme may be used if agreed by the line manager.

(ii) Where adverse weather is predicted, it may be possible in some instances for a manager to consider and agree in advance that an employee may work from home. Any requests to work from home will be subject to the manager satisfying themselves that the employee has the appropriate equipment and sufficient work to undertake and that it is assured that all health & safety requirements (as per theHybrid Working Toolkit) are adhered to.

(iii) Where the decision is taken* to send employees home early due to adverse weather conditions, they will be paid as if they had completed their contracted hours of work.

(iv) Staff who work in excess of their normal hours will normally only receive time off in lieu for the additional hours. The decision to pay staff for additional hours is a matter for the appropriate Director and must be agreed in advance.

(v) Staff who remain on site beyond the end of their shift but are not working will not be paid for those additional hours nor receive time in lieu.

Staff, who despite their best efforts are unable to attend for work, should be available for telephone advice where appropriate.

*Decisions for Divisions/hosted organisations will be made in line with the Decision Making Responsibilities as outlined in ***Appendix 1*** and local Business Continuity Plans, including provision of essential services.

See also ***Appendix 2*** FAQ's for further information.

10. Working at another base within Velindre NHS Trust or a Hosted Organisation

Where employees are unable to attend their normal place of work, but are able to attend another appropriate workplace within the Trust, and able to carry out their normal duties or other duties required by the Trust they can do so with the agreement of the relevant manager as per the schedule of authority in Appendix 1. Arrangements must be made in advance for staff to attend another base within Velindre NHS Trust or a Hosted Organisation, where this is not possible e.g. without prior notice it may not be possible to accommodate this option, staff should refer to their line manager.

11. Adverse weather and the all Wales Special Leave Policy

The Special Leave policy covers a number of potentially relevant situations, which may arise due to adverse weather. These can relate to the policy's provisions on "emergency carers

and dependants leave" and leave to manage an "unexpected crisis". In such cases, employees are able to apply for Special Leave, initially limited to 1 day. Decisions on approval or otherwise will take account of the circumstances of each case on an individual basis, including the foreseeability of the adverse weather and school closures.

Where the employee has prior knowledge of a potential disruption in their personal circumstances i.e. school closure, then special leave will not apply and the expectation will be for the employee to make alternative arrangements.

12. Records Management

A record of all episodes of failing to attend will be taken and kept on the employee's personal file and employees may be required to make a statement of the circumstances that prevented them from attending work.

If there is evidence to suggest that an employee has repeatedly not made appropriate efforts to attend work during adverse weather conditions, and this is supported by records on their personal file, this matter may be taken up though the All Wales Disciplinary Policy.

13. Grievances

If an employee disagrees with how this policy has been applied by their line manager, they should first make reasonable efforts to resolve the disagreement informally; failing which they can consider using the All Wales Respect and ResolutionPolicy.

14. Equality

The Trust is committed to ensuring that, as far as is reasonably practicable, the way it provides services to the public and the way it treats its employees reflects their individual needs and does not discriminate against individuals or groups.

The Trust has undertaken an Equality Impact Assessment (EQIA) and received feedback on this policy and the way it operates. The Trust wanted to know of any possible or actual impact that this procedure may have on any groups in respect of gender (including maternity and pregnancy as well as marriage or civil partnership issues) race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or other protected characteristics.

The assessment ideintifed actions that would mitigate any potential unfavourabel impact on equality groups and to ensure that the Trust meets its responsibilities under the equalities and human rights legislation.

15. Resources

The implementation and management arrangements associated with this policy do not present any significant resource implications to the Trust.

16. Implementation

The Peopleand OD Team will maintain this policy. Please refer to section 5 for further information in relation to the responsibilities in connection with this policy.

17. Audit and Monitoring

This policy will be subject to the normal Peopleand OD audit processes and procedures

18. Distribution

The policy will be available via the Trust's Intranet Site and from the People and OD approved policy intranet page. Where staff do not have access to the intranet, their line manager must ensure that they have access to a copy of this policy.

19. Review

The People andOD Department will review the operation of the policy as necessary and at least every 3 years.

20. Further Information

Further information and support is available from the Peopleand OD Department.

21. References

- All Wales Special Leave Policy;
- WF 35 – Annual Leave and Bank Holiday Policy;
- Hybrid Working ToolkitWF 23 – Flexible Working Policy and Procedure;
- Local Flexi-Time Procedures/Protocols;
- All Wales Respect and ResolutionPolicy;
- All Wales Disciplinary Policy;

Appendix 1

DECISION MAKING RESPONSIBILITIES

DIVISIONS

In the event of adverse weather conditions any decisions to send employees home or advise them not to attend work will be taken as follows: -

Corporate Headquarters	By the Chief Executive or in their absence by the nominated deputy
Velindre Cancer Service	By the Director of Cancer Services or in their absenceby the nominated deputy.
Welsh Blood Service	By the Director of Welsh Blood Service or in that person's absence by the nominated deputy. Departmental managers have discretion in this matter, but, if possible, should discuss the situation with either the Director or deputy prior to making any decision.

HOSTED ORGANISATIONS

NHS Wales Informatics Services (NWIS)	By the Director of NWIS or in that person's absence, by the nominated Deputy. Please refer to the NWIS Business Continuity Plan
NHS Wales Shared Service Partnership	By the Director of Service or in that person's absence, by a nominated Deputy.

Appendix 2

FAQs

This aim of the policy is to ensure that appropriate measures are taken to support staff during adverse weather conditions. The policy sets out the procedure which applies to all staff should they be unable to attend work, be late attending work or are delayed in returning from a business meeting, annual leave etc. due to adverse weather conditions.

It should be noted that the extreme adverse weather conditions do not occur frequently. To ensure that all staff are treated in a fair and consistent manner the following FAQs have been produced to respond to the queries previously raised by staff and managers.

Q 1. If I cannot attend work because of the adverse weather, will I be paid?

A 1. Yes if;

- You work from home or at another Trust location as an alternative.
- You are sent home from work as a result of the Organisation's decision.
- You have agreed with your manager to repay the time within a reasonable timeframe.
- You take annual leave or flexi leave

A 1. Not if;

- You choose not to attend an alternative location if available.
- You have no annual leave available
- You would breach the relevant flexi time protocol in respect of debited hours (hours owed).

Q 2. What should I do if I have agreed for my employee to work from home?

A 2. If your employee has the facility to work from home, then they should have previously completed an ad hoc home working risk assessment. If not, confirm the requirements of the assessment with them over the phone or ask them to complete the form electronically and sign retrospectively upon their return. Ensure that they remain contactable throughout the day and have sufficient work to undertake.

Q 3. What should I do if I have agreed for my employee to work from another Trust location?

A 3. Ensure that they inform you of the exact location, a contact number and where in the premises that they are located during this period. Ensure that they are aware of the emergency procedures at that location.

Q 4. My member of staff is unable to attend work due to cancellation of public transport. What do I do?

- Can they attend work by some other mode of transport?;
- Can they attend work later that day?;
- Are they able to work from home?

- Are they able to work an alternative day or additional hours to repay the time?

A 4. Yes

- agree working arrangement between you and the individual ensuring that if agreement is made for the member of staff to work from an alternative base facilities are available for the member of staff to undertake work;
- ensure contact is made regularly;
- ensure appropriate health & safety regulations are adhered to at all times.

A 4. No

Advise the employee that they need to record the absence as annual leave, flexi leave, unpaid leave or agree for them to work the time back within a reasonable timeframe.

Managers may refer to on-line resources in relation to the location of the employee's home and/or public transport facilities available before advising on an agreed method of absence.

N.B Deliberate failure to attend work in such incidents may involve referral to the all Wales Disciplinary Policy

Q 5. My employee cannot attend work as their child's school is closed / childcare arrangements have been affected. What do I do?

All parents are entitled to request time off for dependants, however there is no legal right to paid time off. Consider;

- Was there any advance warning of this adverse weather? e.g.
    a. Warnings published on national or local sites (inc. intranet);
    b. Potential school closures published on their websites.

A 5. Yes

If staff were aware in advance, as per the all Wales Special Leave Policy, then paid special leave is not applicable.

A 5. No

Staff are expected to make contingency plans for the second day; take annual/flexi leave or agree to work the time back within a reasonable timeframe.

N.B. In all situations however, as per the statutory legislation, employees are entitled to take a reasonable amount of unpaid leave

Q 6. What is my responsibility as an employee in respect of attending work during a period of adverse weather?

A 6. All employees have a responsibility to make every reasonable effort possible to attend their place of work during adverse weather conditions, taking account of advice available from the Trust/hosted organisations, as appropriate, emergency services, media etc. It is stressed that no employee should risk their personal health and safety when endeavouring to attend their workplace during a period of adverse weather.

Q 7. What actions does the Trust consider an employee should take when "making every reasonable effort to attend my place of work during adverse weather conditions"?

A 7. The policy confirms that making every reasonable effort will include, using public transport, car sharing and walking. Some areas of the Trust, which employs frontline clinical and support staff provide appropriate transport for these staff, to assist them to get into work during periods of adverse weather. Where the Trust is providing transport, the managers will liaise with the relevant employees to make them aware of the transport arrangements, including pick up location, time etc. as well as the contingency plan should the Trust be unable to transport them home again, at the end of their shift / contracted hours.

Q 8. What if I make an assessment of the weather conditions and decide that it is not safe for me to make my way into work?

A 8. The Trust accepts that individual employees may wish to undertake a risk assessment to determine whether it is safe and reasonable for them to make their way into work, during a period of adverse weather. It is the Trust's position that employees should not take unacceptable risks with their personal health & safety when taking actions under the Adverse Weather Policy.

Where staff decide that it is not safe to attend work, in accordance with the Adverse Weather Policy they are required to either; make up the time within a reasonable period, as agreed with their line manager or take annual leave or take unpaid leave or take accrued time off in lieu or take flexi time (where the latter two schemes are in operation).

Q 9. Will I get paid if the Trust decided to close my workplace?

A 9. If it was agreed and it was appropriate in the circumstances that an employee continued to undertake their work from home and they did so, they will be paid for their normal contractual hours on the days the workplace was closed. If they chose not to work from home they will be required to either; make up the time within a reasonable period as agreed with their line manager or take annual leave or take unpaid leave or take accrued time off in lieu or take flexi time (where the latter two schemes are in operation).

If an employee attended work for part of the day or attempted to attend work, they should be paid as if they had completed their contracted hours of work in accordance with the policy. For those staff who due to the adverse weather were unable to attend their workplace for their shift / contracted hours on this date, they will be required to make up the time within a reasonable period or take the time off as annual/unpaid leave or take flexi time if a scheme is in operation.

If an employee was unable to work and this was 'wholly attributable' to the fact that a decision had been made to close a workplace, the employee should receive their normal pay.

Q 10. My manager contacted me at home prior to the commencement of my shift and told me not to come into work due to the adverse weather. Will I still be paid for this day or am I required to take annual leave?

A 10. If an employee was contacted by their manager and explicitly told not to come into work, the manager has in effect made a decision to close that department / workplace. This situation will therefore be managed as a temporary "lay off" period. In accordance with the legislation the employee will be entitled to receive their normal pay for that shift.

However, if the manager discussed and agreed with the employee that they could work from home and they did so, they would also be entitled to receive their normal pay for that shift.

Q 11. I was unable to get into work, and I do not have any annual leave which I can take for this day. I will therefore have to work back the time. Over what time period am I expected to work back the hours?

A 11. The employee should discuss this matter with their line manager and agree a reasonable period which that reflects the needs of the service and the employee's personal circumstances. It is recommended that in normal circumstances the employee should work the time back within a 12-week period.

Q 12. Will I get paid if I come into work and I am subsequently sent home by my line manager?

A 12. This will depend on the circumstances.

Where the decision is taken to send employees home early due to adverse weather conditions, they will be paid as if they had completed their contracted hours of work.

However, where the manager has discussed and agreed with the employee that they are able to work from home and have sufficient work to undertake, the employee will only be entitled to be paid for the day if they undertake the work agreed. If they chose not to work from home they will be required to either; make up the time within a reasonable period as agreed with their line manager or take annual leave or take unpaid leave or take accrued time off in lieu or take flexi time (where the latter two schemes are in operation).

Q 13. Will I get paid if I come into work and I make the decision to go home, due to deteriorating weather?

A 13. As it is the employee who is making the decision to go home, in these circumstances they will be required to either; make up the time within a reasonable period as agreed with their line manager, take annual leave, take unpaid leave, take accrued time off in lieu or take flexi time (where the latter two schemes are in operation).

However, if it was agreed and it was appropriate in the circumstances that the employee continued to undertake their work from home and they did so, they will be paid for their normal contractual hours.

Q 14. How will annual leave booked by staff be dealt with if the office is subsequently closed?

A 14. Employees who booked leave for days that the office is subsequently closed will be expected to take the leave for these days. Annual leave cannot be withdrawn unless there was a requirement for the individual to attend work and they were able to do so.

Q 15. Am I entitled to apply for paid special leave as my child's school was closed due to the adverse weather?

A 15. In accordance with the NHS Wales Special Leave Policy, if this was a foreseeable consequence of an advance "yellow" and/or "red" weather warnings, or notification of such school closures were published in advance, employees are not eligible to apply for special leave.

Q 16. If I had agreed to work overtime or additional hours, but I was unable to get into work because of the adverse weather, am I still be entitled to receive payment for the unworked hours?

A 17. In these circumstances the employee will not be entitled to receive pay for overtime that was not worked.

Q 18. What payment will I receive if due to adverse weather conditions I was late getting into work?

A 18. In these circumstances the employee will be paid as if they have started work at their normal contractual time.

Q 19. What happens if I am sick and unable to attend for work?

A 19. Employees who are unwell during adverse weather are required to comply with the relevant reporting arrangements and will be managed in accordance with the Sickness Absence Policy. These employees would continue to be recorded as being off on sick leave until they are fit.

Appendix 3

Weather Warnings - What do the colours mean*?

The Met Office issues weather warnings, through the National Severe Weather Warning Service, when severe weather has the potential to bring impacts to the UK. These warnings are given a colour (yellow, amber or red) depending on a combination of both the impact the weather may have and the likelihood of those impacts occurring.

Yellow Warning: Yellow warnings can be issued for a range of weather situations. Many are issued when it is likely that the weather will cause some low level impacts, including some disruption to travel in a few places. Many people may be able to continue with their daily routine, but there will be some that will be directly impacted and so it is important to assess if you could be affected.

Amber Warning: There is an increased likelihood of impacts from severe weather, which could potentially disrupt your plans. This means there is the possibility of travel delays, road and rail closures, power cuts and the potential risk to life and property. You should think about changing your plans and taking action to protect yourself and your property. You may want to consider the impact of the weather on your family and your community and whether there is anything you need to do ahead of the severe weather to minimise the impact.

Red Warning: Dangerous weather is expected and, if you haven't already done so, you should take action now to keep yourself and others safe from the impact of the severe weather. It is very likely that there will be a risk to life, with substantial disruption to travel, energy supplies and possibly widespread damage to property and infrastructure. You should avoid travelling, where possible, and follow the advice of the emergency services and local authorities.

*This information was obtained from the Met Officer March 2018, please check the Governments Met Office Site for any updates

https://www.metoffice.gov.uk/guide/weather/warnings

TRUST BOARD	
Mental Wellbeing Guidance for Employees Mental Wellbeing Guidance for Managers	
DATE OF MEETING	27/11/2025
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	Natalie Stroud, Wellbeing Project Coordinator
PRESENTED BY	Sarah Jenkins, Interim Executive Director of Organisational Development & Workforce
APPROVED BY	Sarah Morley, Executive Director of Organisational Development & Workforce
EXECUTIVE SUMMARY	The existing Stress, Mental Health Policy was reviewed and Guidance Documents replaced it in April 2025. Both documents are updated with up-to-date and relevant resources and best-practice guidance and are in line with our People Strategy.
RECOMMENDATION / ACTIONS	Trust Board are asked to approve this policy revision

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
EMB	28/07/2025
QSP	11/09/2025
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS In August 2024, this policy was reviewed and considered by colleagues within the People and OD team. The policy has been reviewed by and endorsed by EMB and QSPC.	
7 LEVELS OF ASSURANCE	

ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	**Select Current Level of Assurance**
APPENDICES	
	1. Mental Wellbeing Guidance for Employees 2. Mental Wellbeing Guidance for Managers 3. Stress Risk Assessment 4. Staying Well at Work Plan 5. Manager Resource Leaflet

1. SITUATION

The Stress, Mental Health Policy is due for review within the cycle of policy reviews. The policy is assigned to the People and OD team and has been updated by a member of this team. It now requires approval by the Trust Board in line with Trust governance arrangements.

2. BACKGROUND

The Stress, Mental Health Policy has been in existence for a number of years. After review, the People and OD Team recommended two guidance documents to replace the policy, one for employees and another for managers.

3. ASSESSMENT

The policy was overdue for review and approval. There were no legislative changes that impacted this policy and therefore the policy group gave priority to updating policies with a legislative impact.

4. SUMMARY OF MATTERS FOR CONSIDERATION

The review resulted in the change from policy to guidance and updating the resources and guidance to align with the people strategy, grounded in the Five Ways to Wellbeing Model and informed by HEIW best practice guide to health and wellbeing.

5. IMPACT ASSESSMENT

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

QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☐ Patient Centred ☐
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021).
QUALITY IMPACT ASSESSMENT *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.*	Yes - Fully completed and signed QIA Enclosed
	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:	Yes

For more information: *https://www.gov.wales/socio-economic-duty-overview*	Click or tap here to enter text. An EQIA has been completed. There were no equality impacts identified.

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

FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Source of Funding: **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Choose an item** **Scale of Change**

	Please detail the value of revenue and/or capital impact: **Click or tap here to enter text** **Type of Change** **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text**
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Yes - please outline what, if any, actions were taken as a result
	[An EQIA has been completed. There were no equality impacts identified.
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

None associated.

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

Estimation Read Time = 10 Minutes

Guide to Completing the Staying Well at Work Plans –**All Staff**

1. Important guide for all Staff

- **Why?** We want to support and promote wellbeing, acknowledge different ways of working and different strategies people use to support their wellbeing. We hope these Staying Well Plans are tailored to take account of individual needs and individual factors including gender, ethnicity, culture, age, sexuality, spirituality and ability. This can be an opportunity for you to share any concerns and for you and your manager to regularly consider your wellbeing.

- **Confidential.** This tool is confidential and should be stored in line with Information Governance Policies. Please complete this somewhere where you are able to have confidential conversations.

- **It is not a contract.** This is a plan to help managers support their employees and for employees to feel comfortable asking for support for their wellbeing. However, no employee will be blamed or in trouble if they do not follow the plan they have created or if they do not disclose something they later choose to disclose.

- **For all employees**. You might be someone who has previously experienced or currently lives with mental health or physical health conditions. Or you might be someone who hasn't. It is important that everyone completes this plan as we know that health and wellbeing can fluctuate for anyone.

- **Who completes it and when?** We know that different services work in different ways. You may complete this form with you line manager or your supervisor, it is up to your team how this best fits. We recommend separate meetings to complete this form either as part of the induction when you start or in planned meetings if you are existing member of staff. We generally recommend that these plans are introduced early.

- **Comfortableness**. It may take several months to complete the staying well plans as you start to feel more comfortable. Not every question needs to be answered straight away, the plan can be added to over time. You manager will be aware that the document does not need to be completed in one meeting.

- **Share what feels comfortable and safe to do so.** While it can be useful to think about support early on, it may be that some elements of your wellbeing you do not feel comfortable sharing initially with you manager or at all. This is okay, this plan is to support you. There may be other forums, networks or staff members you can gain support from.

- **Wellbeing is different for all**. We know that experiences of looking after our health and wellbeing are individual. We all have different backgrounds, different ways of understanding

Estimation Read Time = 10 Minutes

wellbeing and different ways of working and supporting ourselves. Managers have been advised to be led by you and what works for your wellbeing but if it feels comfortable you can ask them for tips or ideas.

- **Actions may arise from this document**, for example, requesting certain equipment to do a job effectively. These actions must be agreed upon by both yourself and the manager and information shared with others as appropriate. This does not apply to reasonable adaptations in line with physical, mental and learning needs that employees are entitled to under equality and diversity policies. Please seek guidance from your manager.

- **The plan should be made with you and your manager present and time agreed to review the form in the future. A copy should be seen by both you and your manager before being saved securely as a confidential document. This is the responsibility of your manager.**

If after completing this form specific:

a. Wellbeing support would be useful, please see our support options https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/Health-and-Wellbeing.aspx
b. Occupational Health support, please see: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/Occupational-Health.aspx
c. Specific guidance on equality related queries and specific networks/forms, please see relevant information on the Equality and Diversity Pages https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/Equality,-Diversity-and-Inclusion.aspx
d. If you have any questions about this plan, please contact the wellbeing team healthandwellbeing@wales.nhs.uk

Staying Well at Work Plan (SW@WPs)

What is it?

A plan that can help people to stay well at work, taking into account individual needs and preferences and supporting managers and staff to have meaningful conversations together around health and wellbeing.

It is:

- Confidential
- A flexible plan that can be changed and added to over time
- Completed together by an employee and their manager
- Tailored to the individual's needs and preferences

It is not: A formal contract.

The staying well plan helps an employee and their manager to identify what can help them (physically and mentally) stay well in work. When we feel unwell, it's normal to find it difficult to do the things that might make us feel better. This plan will remind you what those things are, help you to stay well and support your manager to talk to you when you need support. However you will not be blamed or in trouble if you find it difficult to stick to this plan.

This guide outlines:

a) The questions that make up the staying well plan
b) Examples of possible ideas (please note this is not an exhaustive list and different people will find different ideas and strategies useful)
c) The rationale behind asking these questions

We would recommend…

1. Read the form and send to the individual(s) you are managing.
2. Read the separate **manager and employee's guides**, whichever applies.
3. In practice, completing the Staying Well Plan is likely to take at least 30minutes and would need to be revisited
4. That the plan is stored securely by a manager in line with Data Protection Governance polices.
5. If you have questions about the Staying Well Plan, email People and Organisational Development
6. If after completing this form specific:
    a. Wellbeing support would be useful, please see our support options https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/Health-and-Wellbeing.aspx
    b. Occupational Health support, please see: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/Occupational-Health.aspx
    c. Specific guidance on equality related queries and specific networks/forms, please see relevant information on the Equality and Diversity Pages https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/Equality,-Diversity-and-Inclusion.aspx
    d. If you have any questions about this plan, please contact the wellbeing team healthandwellbeing@wales.nhs.uk

e. For referrals to the staff psychologist form can be found here and https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/Today-is-Time-to-Talk-Day-2023.aspx

1. Starting a new role, or recently taken on a new responsibility? What helps you to settle in?

1. Staying Well Plan

Click or tap here to enter text.

- **Changing jobs and settling into a new role can make us feel nervous or worried. It's useful for your manager to know what could make this process easier.** E.g. Being shown around where you will be working, having regular 1:1s with your manager or mentor, shadowing or talking to colleagues, linked in with specific networks or groups etc.

2. How can your manager support you to stay healthy and well at work?

Click or tap here to enter text.

- **Your wellbeing is important to us. We want you to feel happy and supported in work so it's helpful for you to tell us how to do that**. E.g. Meeting your manager regularly, getting supportive feedback on your work, being told about changes that impact you, adapting your working patterns or requesting equipment to make things easier etc.

3. How do you like to work?

Click or tap here to enter text.

- **We all like to work differently. It helps your manager to know how best to communicate with you.** E.g. Do you prefer to talk to your manager face to face, on the phone or by email? Do you like instructions verbally or in writing? How do you like to find out about deadlines? Do you like to work alone or with others?

4. What makes it harder to stay well in work?

Click or tap here to enter text.

- **Our health fluctuates and can be affected by many different things** e.g. noise, stress, change, workload, relationships with others, not feeling valued or listened to, not feeling safe, difficulties outside of work (childcare, caring responsibilities, relationships) etc.

5. How do you know if you are feeling unwell at work?

Click or tap here to enter text.

- **When we are not feeling well it can be difficult to recognise what is going on. It can be helpful to think about some of normal signs before we become unwell to be prepared.**
  - Physical sensations, e.g. headaches, nausea, extreme tiredness, lack of concentration, teary.
  - Emotional changes - feeling very 'up and down' emotionally, feeling more angry/irritated/scared/sad/frustrated/anxious than is usual for you
  - Changes in thought patterns, Racing thoughts, Overthinking, Finding it harder to make decisions, Speaking less to colleagues or friends at work, Changes in work patterns (staying late, coming in earlier, coming in late to work)
  - There may also be specific signs related to any health conditions you are living with.

6. If you become unwell at work, how should we managers approach you about this?

Click or tap here to enter text.

- **It is important to us that we support your wellbeing.** We know that people have different preferences for talking about their health and we want to do this in a sensitive and supportive way.

7. What action can you take if you start to feel unwell either at home or in work? What can your manager do to support you?

Click or tap here to enter text.

- **It is important to think about what you and your manager can do to support your wellbeing.** E.g. taking a break, talking to someone you trust, taking some leave, asking your line manager for support, accessing the wellbeing service, finding things you enjoy to do at home, seeing friends, etc. These might be short term or long term strategies/adjustments.

- **We all like to work differently. It helps your manager to know how best to communicate with you.** E.g. Do you prefer to talk to your manager face to face, on the phone or by email? Do you like instructions verbally or in writing? How do you like to find out about deadlines? Do you like to work alone or with others?

8. Is there anything else we could do to support your wellbeing, personal development? Learning Style.

Click or tap here to enter text.

- Space to discuss anything else you think it would be useful.

Ymddiriedolaeth GIG Prifysgol Felindre Velindre University NHS Trust

GET TO YOU'RE YOUR EMPLOYEE WELLBEING SERVICES

For more information on the support and services available to you here at Velindre NHS Trust please visit

The Health & Wellbeing Centre

https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/Health-and-Wellbeing.aspx

Includes referral pathways for immediate support, health and wellbeing champions, activities, councelling, therpaies, staff psychologist, and 1-1 signposting sessions.

Mental Wellbeing at Work – Guidance for Employees

Document Author: Natalie Stroud, Wellbeing Project Coordinator.

Approval Date: 26.9.24

Date of Equality Impact Assessment: 6.8.24

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1. Introduction

Velindre University NHS Trust are committed to encouraging staff to improve their health and wellbeing and recognises that staff act as role models to the community they serve in promoting and preventing ill health. The Trust believes that it is the joint responsibility of managers and individual employees to work together to encourage healthier lifestyles and life choices and support each other in the workplace.

Mental health is a continuum, we think it's important to understand mental health as not just the absence of illness, but as a broad concept that applies to us all. The World Health Organisation agrees. It defines mental health as:

"Our mental health falls on a continuum, ranging from excellent mental health to severe symptoms such as panic attacks or major depressive episodes". https://delphis.org.uk/mental-health/continuum-mental-health/

Velindre University NHS trust highlights the 'our wellbeing matters' tools and guidance for supporting your wellbeing. https://heiw.nhs.wales/files/weds-staff-health-and-wellbeing/our-wellbeing-matters/. We have pledged to being a mindful employer and has created a people strategy that emphasises how your employer plans to put your wellbeing at the heart of the organisation.

MINDFUL EMPLOYER

https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/People-Strategy--Being-an-Employer-of-Choice.aspx?web=1.

We also recognise:

- The link between home and the workplace and creating balanced working lives.
- That the causes or contributors of stress may often lie outside the workplace.
- That we have a duty to identify particularly vulnerable groups and have appropriate measures in place for their support.
- The potential negative effects on their work performance that employees on prescribed medication may experience.
- Whilst some people will acknowledge their experience of mental health issues in a frank and open way, others fear that stigma will jeopardise any opportunity to gain employment or development.
- Given appropriate support, the vast majority of people who have experienced mental ill health continue to work successfully as do many with ongoing issues.

3. Roles and Responsibilities

The Trust is committed to supporting those who are experiencing stress and mental health issues, whatever the cause. Providing training and good management at work has benefits that extend beyond the workplace into all areas of life; helping to promote positive mental health.

Employees.

Apply ways of wellbeing to maintain health, being aware of their own well-being and seek advice and support when necessary
Learn to recognize and act on signs of stress in themselves and others
Advise their manager or Wf&OD of any work-related issues/difficulties that are causing stress, which may affect their health and/or wellbeing, or has the potential to do so, and participate positively in determining solutions. If the stressors have arisen from circumstances outside of work, employees are encouraged, where possible to discuss these with their manager so that appropriate assistance and flexibility can be considered
Where possible, take account of the impact of their lifestyle in terms of controlling stressors. adopting healthy life style habits
Co-operate with their manager in the undertaking of any risk assessments and implementing any necessary control/resolution measures
Be supportive of colleagues through any difficulties
Accept opportunities for training when recommended
Accept opportunities for counselling if appropriate
Understand that bullying and harassment is unacceptable behaviour and to report any concerns to their line manager or Wf&OD.

4. Stress

'Stress' is defined by the Health and Safety Executive (HSE) as: "the adverse reaction people have to excessive pressure or other types of demand placed on them". However, HSE also makes a clear distinction between stress and pressure, recognising that pressure does not always lead to stress and is often motivational, providing the positive drive to achieve objectives at work.

Imagine everyone has a metaphorical "stress bucket" that can hold a certain amount of stress before overflowing. This bucket represents the combined stressors and challenges that a person experiences in their daily life.

The stress bucket model is a helpful tool to think about stress and capacity, and how can you use healthy release strategies to empty your bucket.

Everyone can in principle experience stress, as no one is immune. Stress is something that can happen when we are in a position where we perceive we cannot cope with the demands facing us. Work-related stress exists when people perceive they cannot cope with what is asked of them, at work.

Stress is very individual. What might be stressful for one person may not be for another. This does not mean that one person is stronger or weaker than the other, but that we are all different. We are all conditioned differently from birth, we have different life experiences, personalities, states of health and we are all unique individuals.

Effective stress management needs to include understanding, locating and minimising your identified stressors. Completing the stress risk assessment below with someone is an invaluable tool of understanding your stress and the document also contains useful take home tools and tips to support you. Please refer to the useful resources for more support options.

https://nhswales365-my.sharepoint.com/:w:/r/personal/natalie_stroud_wales_nhs_uk/Documents/Draft%20SRA.docx?d=w13e870050bd74cffa049c1f30636b64f&csf=1&web=1&e=2omyWp

5. Mental Health & Wellbeing

One in four people in the UK will have a mental health problem at some point. While mental health problems are common, most are mild, tend to be short-term and are normally successfully treated, with medication, by a GP. Mental health is about how we think, feel and behave. Anxiety and depression are the most common mental health problems. They are often a reaction to a difficult life event, such as bereavement, but can also be caused by work-related issues. Work can also aggravate pre-existing conditions, and problems at work can bring on symptoms or make their effects worse.

Whether work is causing the health issue or aggravating it, employers have a legal responsibility to help their employees. Like any other safety or health hazard at work, work-related mental health issues must be assessed to measure the levels of risk to staff. Where a risk is identified, steps must be taken to remove it or reduce it as far as reasonably practicable so please inform your manager.

Being proactive by protecting your mental wellbeing, striving to achieve a work life balance and knowing where to go for support when you need it can

- Prevent burnout
- Prevent stress related health problems
- Increase productivity
- Increase energy and enjoyment
- Provide opportunities for personal growth
  https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/MENTAL-HEALTH-%26-WELLBEING.aspx

6. Financial Wellbeing

Financial well-being is about a sense of security and feeling as though you have enough money to meet your needs. It's about being in control of your day-to-day finances and having the financial freedom to make choices that allow you to enjoy life. Worrying about money can affect your mental health and well-being, and poor mental health can make managing money harder. There are many organisations that can provide advice, useful tools and support to help you deal with your finances. Accessing help and advice early can help you to avoid running into financial difficulty.

https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/FINANCIAL-WELLBEING(1).aspx

7. Social Wellbeing

Social wellbeing consists of sharing, developing, and sustaining of meaningful relationships with others. This allows you to feel authentic and valued and provides a sense of connectedness and belonging.

For example, when you work on a team over a period of months, or years, even remotely, you have an opportunity to get to know more about your colleagues than just their skills with a spreadsheet. Some become good acquaintances. You share glimpses of your personal lives and develop routines or inside jokes. They ask you about your sick pet or kid. They notice if you're not there.

Some become friends. You have deeper conversations, about how you got to where you are, or about your hopes and aspirations for the future. You likely see them on bad days when you can lend a hand and on great days when they return the favor. Both of these types of relationships contribute to social well-being by bringing enjoyment and allowing you to be seen, appreciated, and valued for yourself.

https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/SOCIAL-WELLBEING(1).aspx

8. Physical Wellbeing

Physical wellbeing has a direct impact on our overall wellness, the intranet has information and resources on healthy eating, keeping active and sleep to support your wellness journey.

Health is not only about diet & exercise it's dealing with health challenges, helping others through those challenges & this guidance aims to provide you with those tools to get informed, get and provide support to colleagues.

Navigating health challenges at work could be impacting how happy, confident and successful you feel at work. You are not alone, talking to your manager and the wider team on how your needs have changed is important to gain back control of your wellness in work. You can seek information and support on Menopause, women's health, pelvic health, diabetes, arthritis, mens health, MSK pain, health anxiety, heart health, cancer, pregnancy & lifestyle choices here https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/PHYSICAL-HEALTH-%26-WELLBEING.aspx

Healthy habits include taking the stairs, getting adequate amounts of sleep, or thinking positive thoughts throughout the day. Together, many small healthy habits like these make a big difference in well-being. A healthy lifestyle, after all, just consists of many small healthy behaviours. Individually, habits are not difficult to adopt. The challenge comes from doing them consistently over time and making them a natural part of an everyday routine.

9. Immediate Support Options

Urgent Support If you need to talk to someone urgently about your mental health, or you're concerned about a family member, call NHS 111 and select option 2 to be placed in direct contact with a mental health worker in your area.

Alternatively you can access 24/7 free confidential support through our Employee Assistance Programme 0330 380 0658. You can view and access a range of support from text helplines, to counselling and self-help videos and resources below.

https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/GET-HELP-NOW.aspx

Psychological and wellbeing services – we offer an in-house Clinical Psychology Service for Staff and Teams for individual emotional and psychological support in the context of difficulties in the workplace or when things outside of work are challenging and impacting on our ability to do your role. The service is also able to meet with teams who require support and help with interpersonal or work-related challenges.

Staff do not require permission from a manager to be able to self-refer.

https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/Today-is-Time-to-Talk-Day-2023.aspx

We also offer 1-1 signposting sessions where individuals needing support or information about wellbeing concerns can book or pop along to a drop-in session. These sessions provide the opportunity to explore support options, find information and take back control of their wellbeing with guidance from the wellbeing coordinator.

https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/Signposting-Sessions.aspx

10. Looking after yourself

Every individual can protect and improve their own wellbeing by exploring how to identify stressors early, learning your most effective coping skills and knowing where to go for support. Below are some exercises below to support you to understand your own wellness so you have the tools at home and at work.

Staying Well at Work Plan

Ask yourself these questions, whether you've been in your post a while or brand new. You can communicate these to your manager or use it as a personal reflection. These tools allow you to place your wellbeing as a priority,

1. Starting a new role, or recently taken on a new responsibility? What helps you to settle in?
2. How can your manager support you to stay healthy and well at work?

3. How do you like to work?
4. What makes it harder to stay well in work?
5. How do you know if you are feeling unwell at work?
6. If you become unwell at work, how should we managers approach you about this?
7. What action can you take if you start to feel unwell either at home or in work?
8. What is your learning style? Do you learn better watching, doing, reading?

The Five Ways to Wellbeing

Think about how you are already bringing these wellbeing themes into your everyday life, now ask yourself is there anymore you can do to improve how you connect with people, get active, learn, take notice or give back.

How do these things differ in work from your home life, can you bring more connection into work by joining a social network? Get more active by taking the stairs etc? Ask to join a course on something of interest other than necessity. Take notice of a great piece of work and celebrate yourself, providing give a friendly ear to a colleague who is stressed.

When you think about what you are doing for your own wellbeing at home or in work, you can often see how this can impact on your family, friends and colleagues and drive even more positive change.

Wellbeing Theme	Message	At home	At work
Connect	Make time to connect with work colleagues, friends and family to enrich your days. Building solid and varied social connections in your life can increase your feelings of happiness and self-worth.		
Be Active	Being active makes you feel good, helps reduce stress, improves sleep and keeps you healthy. What you do with your body can have a powerful effect on your mental wellbeing.		
Keep Learning	Learning something new can be fun, make you feel good and build your confidence. Step out of your comfort zone and you will learn things you never knew that you never knew.		
Take Notice	Take time for yourself, notice things around you, notice others and savour the moments. Happiness can be right in from of you if you pause for a moment.		
Give	Acts of kindness, helping others or even volunteering can make you feel happier. Giving can be like gold dust for our mental wellbeing.		

Workplace wellbeing Top tips

Don't over commit	Take Breaks	Stay Organized
Know your options	Take pride in your work	Plan for healthy habits

11. Health and Wellbeing Champions

Health and Wellbeing Champions are individuals who work at all levels of the NHS, from all demographics and roles, who will promote, identify and signpost their colleagues to local and national health and wellbeing support offers. This is intended to be taken on as a responsibility in addition to their day-to-day role.

What they do -

- Raising awareness of wellbeing activities and initiatives.
- Challenging the stigma around mental health.
- Actively listening and signposting colleagues to support.
- Building trust, demonstrating compassion, and respecting confidentiality.
- Collaborating with other champions to share best practices.

Health and Wellbeing champion example activities
- organising weekly park runs amongst colleagues.
- sharing healthy recipes amongst colleagues.
- actively listening to colleagues when appropriate.
- sharing knowledge of support options available to colleagues.
- heading up a hobby network for colleagues such as knitting, gardening etc.
- mental health first aider.
- menopause buddy.

How to find your Health and wellbeing champions, they often wear badges and lanyards to highlight what they offer. You can find a list or pledge to become a champion here.
https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/Wellbeing-Champion.aspx

12. Wellbeing Spaces and Activities

Both Velindre Cancer Centre and Welsh Blood Service have wellbeing spaces that are available for staff to use if they feel overwhelmed, or just need some quiet time. These spaces are open to all and do not need booking.

The wellbeing activities throughout the trust vary, but services such as complementary therapies, arts in health and health and wellbeing roadshows. Information for what is available for staff can be found here.

https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/SOCIAL-WELLBEING(1).aspx

13. Resources (Microsoft Edge may be required to access some of these pages on personal devices)

Mental Health Continuum Model	https://delphis.org.uk/mental-health/continuum-mental-health/
Employee Assistance Program	https://vivup.yourcareeap.co.uk/UK/EAP-Products.awp?P1=oA==&P2=SIwdW5Y=&P3=2&AWPID379839E4=1140F82A499B3B2AEE64A6EB603BFB20A725E0E9
Canopi	https://canopi.nhs.wales
Health and Wellbeing Centre including immediate support Mental Health/Physical Health/Financial/Social Wellbeing	https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/Health-and-Wellbeing.aspx
Immediate Support Options	https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/GET-HELP-NOW.aspx
Signposting Mind Map	https://nhswales365.sharepoint.com/:b:/r/sites/VEL_Intranet/SiteAssets/SitePages/Health-and-Wellbeing/wellbeing-mindmap-hyperlinks.pdf?csf=1&web=1&e=VNfmoe
The People Strategy	https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/People-Strategy--Being-an-Employer-of-Choice.aspx?web=1
Agile Working policy/ Respect and Resolution Policy/ Mindful Employer Charter/ All Wales Sickness Absence Policy/ Flexible Working Policy/ Working Time/ Regulations Policy/ Dignity at Work Process/ Employment Break Scheme/ Carers Policy/ Smoke Free Policy/ Substance Misuse at Work Policy	https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/Workforce-(HR)-Policies-and-Procedures.aspx
Speaking Up safely	https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/Speaking-up-Safely.aspx?web=1
Mindful employer	http://www.mindfulemployer.net/support/links-library/
Mind	www.mind.org.uk
Menopause	https://www.themenopausecharity.org/
Stress Bucket Model	https://www.psychologytoday.com/au/blog/everyday-resilience/202307/buckets-full-of-stress
Our Wellbeing Matters	https://heiw.nhs.wales/files/weds-staff-health-and-wellbeing/our-wellbeing-matters/.

Mental Wellbeing at Work – Guidance for Managers

Executive Sponsor & Function: Sarah Morley, Executive Director of OD and Workforce

Document Author: Natalie Stroud, Wellbeing Project Coordinator.

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1.Introduction

Trust Strategy and Vision

Our people strategy describes how we will create a workforce we need to deliver our vision of excellent care, inspirational learning and healthier people. Wellbeing is one of the Trust's main priorities, and we will ensure our staff feel valued and supported through the following actions.

- Support managers and staff to hold wellbeing and attendance conversations
- Provide effective work/life balance offers as we develop our agile and hybrid working arrangements
- Offer flexible career opportunities to meet changing needs
- Ensure our staff have access to appropriate support for mental and physical health concerns
- Deliver fair rewards and recognition, including addressing pay gaps across protected characteristics
- Continuously listen to staff and foster a culture of care, compassion and inclusivity in line with our values
- Demonstrate exemplar employment practices with a clear focus on equality, diversity and inclusion.

Velindre University NHS Trust has pledged to being a mindful employer and has created a people strategy that emphasises how we put wellbeing at the heart of the organisation. https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/People-Strategy--Being-an-Employer-of-Choice.aspx?web=1.

Wellness in the workplace

Mental health is a continuum, and it's important to understand mental health as not just the absence of illness but as a broad concept that applies to us all. The World Health Organisation agrees. It defines mental health as:

'So mental health is not a binary state – you are not either mentally healthy or ill. Our mental health falls on a continuum, ranging from excellent mental health to severe symptoms such as panic attacks or major depressive episodes'. https://delphis.org.uk/mental-health/continuum-mental-health/

2. Purpose

This document serves to promote an organisational culture of individual and peer responsibility for the management of workplace stress, in which stress is not seen as a sign of weakness or a reflection of an employee's ability to perform within their job role, and in which staff feel able to speak freely about stress and seek help or support.

The Trust is committed to supporting employees who are experiencing stress and mental health issues, whatever the cause. Providing training and good management at work has benefits that extend beyond the workplace into all areas of life; helping to promote positive mental health..

Velindre University NHS Trust seeks to have an organisational culture that is both supportive and empowering, with a management style that reflects this culture. Staff are also encouraged to take personal responsibility for themselves at work and support others to do the same, the aim is to nurture a health working environment for all to flourish.

The guidance will assist with the identification of measures already in place to reduce stigma of mental ill health, tackle stress and identify, through risk assessments, areas in need of further development. The guidance will be subject to regular review and will therefore be amended in line with legislation changes.

3. Management Standards

Roles and responsibilities

HSE Management standards dictate that employees have adequate information and support from their colleagues and superiors, they are not subjected to unacceptable behaviours e.g. bullying at work, they understand their role and responsibilities and the organisation engages them frequently when undergoing an organisational change and there are systems in place locally to respond to any individual concerns.

As managers, knowing your role in an employee's wellness journey is an integral part of successful leadership. Legally you have a duty of care under Health and Safety at Work Act 1974 and Health and Safety Regulations 1999 to undertake risk assessments. Ethically, you're a responsible for understanding your employees' differences to anticipate and prevent situations that could have detrimental effect on individual's personal and working life. Lastly, you are responsible economically by doing all you can to decrease absence, recruitment costs, and increase productivity within your teams. The best practice guide to wellbeing published by Health Education and Improvement Wales in April 2024 is an invaluable resource to support your employees.

https://nhswalesleadershipportal.heiw.wales/health-and-wellbeing/organisations

Leadership Style

Leadership styles play a pivotal role in shaping workplace culture and influencing employee wellbeing. No single style is suitable for all situations; the key is to find a style that suits the matter to hand, in light of the individual's needs, the team's dynamics and the organisation's goals.

Leaders need to be adaptable, empathetic, and mindful of their approach's impact on their team's mental and emotional health.

Notably leadership style is flexible, the four Leadership Styles of the Situational Leadership Model (Hersey and Blanchard), explains how the goal is to match the leadership style to the needs of the individual and the task, while empowering people to grow their competence and commitment.

Style 1 – Directing (high directive behaviour and low supportive behaviour)

Style 2 – Coaching (high directive behaviour and high supportive behaviour)

Style 3 – Supporting (high supportive behaviour and low directive behaviour)

Style 4 – Delegating (low supportive behaviour and low directive behaviour)

Example:

- A task needs to be completed by all staff; this is a brand new experience for your team so directing would be appropriate here.
- As the staff learn more about the task, it adds unforeseen pressure to their workload so coaching would be appropriate here.
- The task is now part of the everyday role although for one individual it has some impact on their stress levels, supporting would be the best approach.
- While others have taken to the new task with no added stress or pressure to their role, delegating is appropriate here.

Your approach should match the situation and the individual, this requires attention and understanding of your employees. Sitting down with an employee and having a conversation using the staying well at work plan or stress risk assessment could dictate which management style is appropriate for you to adopt.

Compassionate Leadership

Compassionate leadership involves a focus on relationships through careful listening to, understanding, empathising with and supporting other people, enabling those we lead to feel valued, respected and cared for, so they can reach their potential and do their best work. There is clear evidence that compassionate leadership results in more engaged and motivated staff with high levels of wellbeing, which in turn results in high-quality care (West 2021).

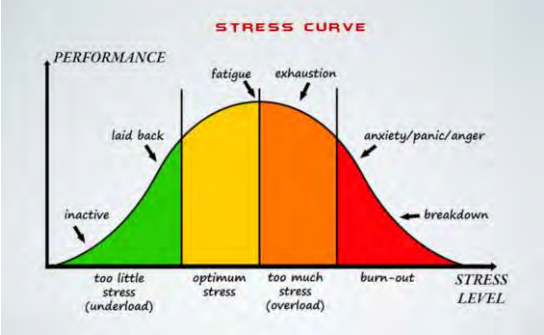
How do compassionate leaders behave? They empathise with their colleagues and seek to understand the challenges they face; they are committed to supporting others to cope with and respond successfully to work challenges; and they are focused on enabling those they lead to be effective and thrive in their work. Compassionate leaders don't have all the answers and don't simply tell people what to do, instead they engage with the people they work with to find shared solutions to problems.

Developing compassionate leadership approaches helps leaders hold crucial conversations about inclusion, ensuring they hear and reflect deeply on what staff are telling them and then take necessary action to help address inequities and discrimination in the workplace.

4. Stress

Identifying Stress

Stress is a physical and mental response to a perceived challenge or threat. It involves the release of stress hormones such as adrenaline, which prepare the body for action. Stress can help a person cope with a difficult situation, but too much stress can exceed the person's resources and harm their health.



Stress is not always negative; the absence of stress can also be damaging as some stress is useful in the workplace. The stress curve describes how an underload of stress can lead to boredom, inactivity, and low productivity and an overload of stress, can lead to burnout. Psychologists use the term 'Eustress' to describe good stress and its positive benefits on health, motivation, performance and mental wellbeing.

The body gives us early warning signs that we may be suffering from stress. These can be likened to the lights showing in a car when there is a problem like low fuel or oil, lights left on etc. In the car we tend not to ignore the warning but, when we are busy, we will ignore our own early warning signs, often to our cost.

These signs might include becoming anxious, tearful or withdrawn. You can help your employees to recognise these warnings and try to adopt some of the coping strategies described within the Stress Risk Assessment.

https://nhswales365-my.sharepoint.com/:w:/r/personal/natalie_stroud_wales_nhs_uk/_layouts/15/Doc.aspx?sourcedoc=%7B13E87005-0BD7-4CFF-A049-C1F30636B64F%7D&file=Draft%20SRA.docx&action=default&mobileredirect=true&DefaultItemOpen=1&login_hint=Natalie.Stroud%40wales.nhs.uk&ct=1722613580591&wdOrigin=OFFICECOM-WEB.START.EDGEWORTH&cid=aac720f2-c136-431c-9dd8-a4782154fcf5&wdPreviousSessionSrc=HarmonyWeb&wdPreviousSession=23344ec0-5808-40fd-aade-f25a23930e2d

Rapid mood changes	Excessive self-medication
Lack of energy	Muscle tension
Inability to concentrate	Eating disorders
Inability to make decisions	Sleep disorders
Wake up worrying	Chest pains
Panic attacks	Skin problems

Irritability	Low self confidence
Difficulty in thinking	Low self esteem

If you suspect an employee is experiencing stress, talk to that individual and suggest filling in the stress risk assessment together. If not, explore if the employee would like to do this activity with someone else. If you are their perceived cause of stress, do not take it personally and use the appropriate channels to address any issues highlighted to you. These stress risk assessments are confidential and can only be shared where an employee consents.

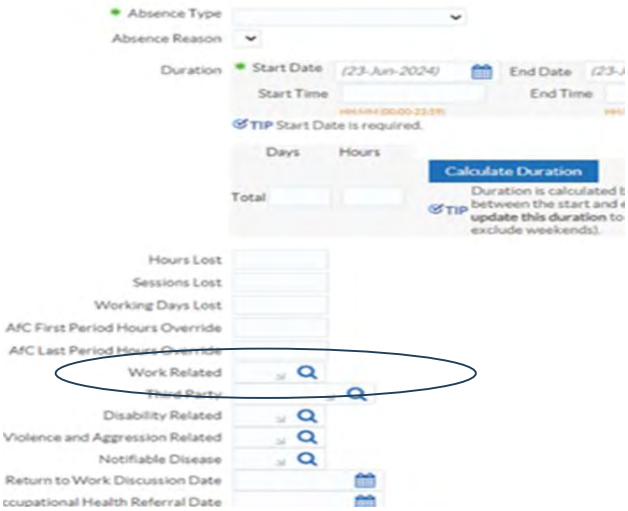
Using a compassionate conversation to uncover and identify stressors inside and outside the workplace, allowing for a solution-focused conversation. These could be actions that prevent future episodes of stress and ultimately support your employee to overcome their current situation. Often the conversation itself can be a relief, please see the wellbeing conversation guide by Health Education and Improvement Wales.

https://heiw.nhs.wales/support/colleague-health-and-wellbeing/wellbeing-conversation-guide/

Reporting

If stress has been suspected or identified, keep an audit trail of your actions. If your conversation results in no further action needed, then monitor the situation and check in. However, if the conversation results in a stress risk assessment please keep a record of how many completed, it may be required for audit purposes. Stress risk assessments then can be stored on the electronic personal file, unless the employee prefers to have it saved centrally with the People and OD team.

If the employee is sick due to stress and the individual has reported s as work-related, please fill in the appropriate boxes on ESR (see below).



5. Supporting

Supporting an employee during a period of high stress or a period of mental ill health will depend on the circumstance and the individual, however being prepared can have a significant impact on how you can provide support for your employee.

Preparation tips

- Practise talking and listening sensitively.
- Have a basic knowledge of mental health.
- Know what support and guidance the organisation can offer internally and externally.
- Know how the law relates to mental health at work.
- Encourage staff to raise any mental health or stress concerns by raising awareness.
- Be open to what support and workplace changes are available to staff, for example if someone needs a quieter place to work than in an open plan office, investigate what other options could be made available and discuss them with the individual.
- Discuss with Occupational Health how to deal with mental health sensitively and fairly.

Lets talk

Paul Gilbert system refers to the physiological responses involving physical calming, attachment, caring, and interpersonal connection. This system is closely linked to social connection, affection and kindness. It plays a crucial role in reducing threat responses to feared stimuli and activating feelings of safety, bonding and trust. When having a conversation first focus on soothing that individual. To do this:

- talk to them in private
- be flexible about when and where you talk
- approach the conversation in a positive and supportive way.

Focus on listening and allowing that individual to feel safe and supported, before talking about solutions. The conversation should be led by the individual, ask how they would like to move forward and then discuss how you can support them to do this.

Support Options

Urgent Support - If you need to talk to someone urgently about your mental health, or you're concerned about a family member, call NHS 111 and select option 2 to be placed in direct contact with a mental health worker in your area.

Alternatively, you they can access 24/7 free confidential support through our Employee Assistance Programme 0330 380 0658. You can view and access a range of support from text helplines, to counselling and self-help videos and resources below.

https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/GET-HELP-NOW.aspx

Psychological and wellbeing services - we offer an in-house Clinical Psychology Service for Staff and Teams for individual emotional and psychological support in the context of difficulties in the workplace or when things outside of work are challenging and impacting on our ability to do your role. The service is also able to meet with teams who require support and help with interpersonal or work-related challenges.

https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/Today-is-Time-to-Talk-Day-2023.aspx

Wellbeing Services - We also offer 1-1 signposting sessions where individuals needing support or information about wellbeing concerns can book or pop along to a drop-in session. These sessions provide the opportunity to explore support options, find information and take back control of their wellbeing with guidance from the wellbeing coordinator.

https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/Signposting-Sessions.aspx

Employee Assistance Programme – Vivup offers 24/7 free confidential support and counselling, self-help and podcasts.

https://vivup.yourcareeap.co.uk/UK/EAP-Products.awp?P1=oA==&P2=SIwdW5Y=&P3=2&AWPID379839E4=461B0B7D794257A4E979FE00561E5D84AC10E761

More information can be found on the intranet Health and Wellbeing Centre.

https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/Health-and-Wellbeing.aspx

Wellbeing suggestions

- Seek connection from others.
- Self-care, do something for yourself.
- Diaphragmatic breading.
- Mindfulness.
- Be in nature.
- Whatever activity brings you peace and calmness.

Wellbeing Spaces and Activities

Both Velindre Cancer Centre and Welsh Blood Service have wellbeing spaces that are available for staff to use if they feel overwhelmed, or just need some quiet time. These spaces are open to all and do not need booking.

The wellbeing activities throughout the Trust vary and include services such as complementary therapies, arts in health and health and wellbeing roadshows. Information for what is available for staff can be found here.

https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/SOCIAL-WELLBEING(1).aspx

6. Step by step guide to supporting an employee experiencing stress

Commented [CB(HoOD1]: How does this table relate to what we are advising mangers?

- Start an audit trail by keeping detailed records.
- Seek appropriate support from the People and Relationships team or your own manager.
- Speak to the individual to establish the nature of the problem.
- Seek advice from the People and Relationships team about an immediate referral to occupational Health, staff psychologist or Employee Assistance Programme, if appropriate.
- Carry out Stress Risk Assessment with employee using a Compassionate Leadership approach.
- Seek to identify possible solutions and agree an action plan (optional to use Staying Well at Work Plan).
- Recognise that management and the member of staff have responsibilities and work together to overcome the concerns.
- If problem results in sickness and it has been identified as work-related, report it as such on ESR.
- Monitor, review Stress Risk Assessment/Staying Well at Work Plan and support the member of staff to avoid recurrence.

7. Training

Manager training

Managing Wellbeing and Stress is one of the modules of the Fundamentals of Management programme that all managers are required to complete.

Wellbeing Awareness training

A range of opportunities are publicised through the Wellbeing pages of the intranet including a range of useful ESR modules and workshops. These are training modules you should complete yourself and encourage your teams to complete. Development options from Trades Unions will also be publicised through the intranet.

Commented [CB(HoOD2]: Can you add the name of the module here?

8. Managing your own stress

Understanding your own stress

The stress felt by managers can cascade to employees, impacting wellbeing, retention, and performance. Research shows that stress management is actually a key leadership skill. Managers who do it effectively can see improved relationships with their team, better conflict resolution, and enhanced project management skills.

Imagine everyone has a metaphorical "stress bucket" that can hold a certain amount of stress before overflowing. This bucket represents the combined stressors and challenges that a person experiences in their daily life.

The stress bucket model is a helpful tool to think about stress and capacity, and how can you use healthy release strategies to empty your bucket.

Tips and Tools

Granted, managers have many demands on their time, but taking simple steps to manage stress can have wide reaching benefits. A few ideas include:

- Pay attention to the physical warning signs of stress: This can include aches and pains, chest pain, exhaustion or trouble sleeping, high blood pressure, muscle tension, jaw clenching or stomach problems.
- Strengthen support networks: Social and emotional support from friends, family, neighbours, and other groups can increase one's ability to cope with stressful situations. Support can also include seeking professional help from psychologists and other mental health professionals.
- Combat stigma by becoming an advocate: Opening up about one's own personal experiences with mental health challenges can have a huge impact on destigmatising mental health in the workplace. It shows employees that it's OK not to be OK.
- Take care of physical health: Staying physically healthy can improve emotional well-being. Eating healthy, getting enough sleep and exercising are all important ways to cope and combat stress.
- Exercise emotional self-awareness, then respond: Understanding the sources of frustration and anxiety is important to recognizs before taking the appropriate steps to respond. Identifying emotions, then appraising a situation, can help target a specific response.

  Stress in the workplace is unavoidable. But how leaders manage stress will play a critical part in determining the mental health of their teams. Managers who enact strategies to reduce their own stress will be better equipped not just to lead, but to be the greatest advocate for employee mental health and wellbeing.

9.Resources

Mental Health Continuum Model	https://delphis.org.uk/mental-health/continuum-mental-health/
Health and Wellbeing Centre	https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/Health-and-Wellbeing.aspx
Stress Bucket Model	https://www.psychologytoday.com/au/blog/everyday-resilience/202307/buckets-full-of-stress
Stress	http://www.hse.gov.uk/stress/index.htm www.isma.org.uk
Stress Risk Assessment	https://nhswales365-my.sharepoint.com/:w:/r/personal/natalie_stroud_wales_nhs_uk/_layouts/15/Doc.aspx?sourcedoc=%7B13E87005-0BD7-4CFF-A049-C1F30636B64F%7D&file=Draft%20SRA.docx&action=default&mobileredirect=true&DefaultItemOpen=1&login_hint=Natalie.Stroud%40wales.nhs.uk&ct=1722613580591&wdOrigin=OFFICECOM-WEB.START.EDGEWORTH&cid=aac720f2-c136-431c-9dd8-a4782154fcf5&wdPreviousSessionSrc=HarmonyWeb&wdPreviousSession=23344ec0-5808-40fd-aade-f25a23930e2d
Mental Health and Wellbeing	https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/MENTAL-HEALTH-%26-WELLBEING.aspx
Our wellbeing matters	https://heiw.nhs.wales/files/weds-staff-health-and-wellbeing/our-wellbeing-matters/.
Immediate Support Options	https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/GET-HELP-NOW.aspx

Physical Health and Wellbeing	https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/PHYSICAL-HEALTH-%26-WELLBEING.aspx
Financial Wellbeing	https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/FINANCIAL-WELLBEING(1).aspx
Social Wellbeing	https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/SOCIAL-WELLBEING(1).aspx
Signposting Mindmap	https://nhswales365.sharepoint.com/sites/VEL_Intranet/_layouts/15/AccessDenied.aspx?Source=https%3a%2f%2fnhswales365.sharepoint.com%2fsites%2fVEL_Intranet%2f_layouts%2f15%2fdownload.aspx%3fSourceUrl%3dhttps%253a%2f%2fnhswales365.sharepoint.com%2fsites%2fVEL_Intranet%2fSiteAssets%2fForms%2fAllItems.aspx%3fid%3d%2fsites%2fVEL_Intranet%2fSiteAssets%2fSitePages%2fHealth-and-Wellbeing%2fwellbeing-mindmap-
HEIW Best Practice Guide	. https://nhswalesleadershipportal.heiw.wales/health-and-wellbeing/organisations
HEIW Wellbeing Conversation Guide	https://heiw.nhs.wales/support/colleague-health-and-wellbeing/wellbeing-conversation-guide/
The people strategy	https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/People-Strategy--Being-an-Employer-of-Choice.aspx?web=1
Agile Working policy Respect and Resolution Policy Mindful Employer Charter; All Wales Sickness Absence Policy; Flexible Working Policy; Working Time Regulations Policy; Dignity at Work Process;, Employment Break Scheme; Carers Policy; Smoke Free Policy; Substance Misuse at Work Policy; and	https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/Workforce-(HR)-Policies-and-Procedures.aspx
Speaking Up safely	https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/Speaking-up-Safely.aspx?web=1
Mindful employer	http://www.mindfulemployer.net/support/links-library/
Mind	www.mind.org.uk
Employee Assistance Program	https://vivup.yourcareeap.co.uk/UK/EAP-Products.awp?P1=oA==&P2=SlwdW5Y=&P3=2&AWPID379839E4=1140F82A499B3B2AEE64A6EB603BFB20A725E0E9

STRESS RISK ASSESSMENT ACTION PLAN

To be used alongside the Wellbeing Guidance for Employees and Managers.

The Velindre NHS trust Stress Risk Assessment (SRA) is based on The Health and Safety Executive (HSE) Management Standards which cover six key areas of work that, if not properly managed, can result in poor health, lower productivity and increased accident and sickness absence rates. The purpose of the Stress Risk Assessment is to identify and manage factors that can lead to increased stress. By completing the SRA the manager and employee are discussing, acting and following-up by monitoring the risks and lessening them. When completing the form you may wish to refer to the Stress Risk Assessment Aid which defines the management standard, suggests possible questions and identifies potential control measures.

If employee is not comfortable filling this out with line manager – please contact people and relationships and the form will be filled in and stored confidentially.

Information on Stress

What is stress?

There are many definitions of stress and this is one example: "Stress is a mental and physical response by an individual to an inappropriate level of pressure whether real or perceived", (Raymond & Wilson 1999).

Everyone can in principle experience stress, as no one is immune. Stress is something that can happen when we are in a position where we perceive we cannot cope with the demands facing us. Work-related stress exists when people perceive they cannot cope with what is asked of them, at work.

Stress is very individual. What might be stressful for one person may not be for another. This does not mean that one person is stronger or weaker than the other, but that we are all different. We are all conditioned differently from birth, we have different life experiences, personalities, states of health and we are all unique individuals.

The individual nature of stress

Factors to take account of when considering an individual's stress response include:

• Personality • Where they live • Where they work • Family • Lifestyle • Beliefs • Education • Attitude to life etc.

Often, stress occurs due to an individual's expectation of both themselves and others.

The warning signs

The body gives us early warning signs that we may be suffering from stress. These can be likened to the lights showing in a car when there is a problem like low fuel or oil, lights left on etc. In the car we tend not to ignore the warning but, when we are busy, we will ignore our own early warning signs, often to our cost. These signs might include becoming anxious, tearful or withdrawn. Learn to recognise your own warnings and try to adopt some of the coping strategies described here.

Responsibilities

In most circumstances, it is the manager who completes the SRA with the employee. Employees are strongly encouraged to discuss their concerns with their line manager as this is the person usually best placed to support the employee. The SRA is a collaborative process which can identify steps for the employee and manager to take. If however an employee feels unable to complete this process with their line manager then they can approach their line manager's line manager. If that isn't appropriate they can contact HR or Trade Union for advice. The form does not need to be sent to Occupational Health, however it may be helpful to include details of the issues raised and actions taken when a referral to Occupational Health is being considered.

Action Plan Stages

Preparation

If you feel stressed, you can approach your line manager and request that a SRA is completed. Alternatively, a Line Manager can suggest undertaking a SRA if they are concerned about the employee's wellbeing. If a manager is aware that a major change is about to impact on their team, they may wish to undertake a team SRA in advance to ensure that appropriate support is put in place proactively.

Discussion

Stress affects people differently and at different times. Sometimes you may feel reluctant to discuss how you are feeling because you don't want to be seen as weak, however being open with your Line manager will help your Line manager understand what you are feeling and will help to ensure that appropriate support is available.

Action Plan

The action plan follows on from the discussion. Each potential source of stress: demands, control, support, relationships, role and change should be considered although in some cases they may not all be relevant. The Employee and Line manager can explore what actions/adjustments are already in place and agree

further actions/adjustments. These may include action for the manager or for the employee, as we each have a responsibility to take steps to look after our own wellbeing. For further information and examples of potential solutions please see accompanying document.

Follow-up

It is essential that the SRA is not a one off action, a review date must be agreed to ensure that the actions taken remain suitable. Regular monitoring allows for the discussion to continue. It may be a process of trial and error. Sometimes action doesn't have the desired affects and amendments need to be made. The process is ongoing. Also people's circumstances change, more stressors could be identified or resolved. It is just as important to recognise and discuss resolved stressors to continue learning.

More information

- HSE management standards http://www.hse.gov.uk/stress/what-to-do.html
- Health and Wellbeing Centre https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/Wellbeing-and-Engagement.aspx
- Policies and procedures https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/Workforce-(HR)-Policies-and-Procedures.aspx

Risk Assessment For ……Filled out with Manager or other …… Department……..Date…….

Type of Stressor	Specific causes of workplace stress identified within each category	Existing workplace support and adjustments already in place	Further action to be taken	Who will ensure the action is done? Review Date
Demands				
Control				
Change				
Role				
Relationships				
Support				

Reason for follow up……Filled out with manager or other……Department……Date……..

Type of Stressor	Any newly identified Stressors (if applicable)	Outcome of action taken	Any further follow ups	By Whom
Demands				
Control				
Change				
Role				
Relationships				
Support				

TAKE HOME TIPS & TOOLS

Locating the cause of stress

Relax, sit down and list all the issues that are currently causing you concern. It is easy to blame one thing alone when things are going wrong but if you are honest with yourself, there are likely to be many things that are contributing to making you feel as you are.

Try to group these into similar types as there are often links between issues. What originally seemed to be totally unrelated problems may have the same underlying cause. You will not be able to tackle everything on your list at once, but you should be able to work out a plan for dealing with each of them in turn.

Consider the questions 'how do I spend my time' and 'how would I like to spend my time'. It is quite easy when we have too much to do and feeling short of time, to lose sight of the goals we are trying to achieve and end up just muddling through. To prioritise the items on your list, ask yourself the following questions:

- Is this something I must do?
- Is it something I should do? Or
- Is it something I would like to do?

Must means must, should contains options and want is a free choice. Consider situations that waste your time make changes where possible, learn to avoid unnecessary activities, delegate where applicable, schedule time for specific activities.

Rank the problems and deal with some of the smaller ones first, to quickly reduce the list and at the same time reduce your stress.

Try to tackle only one thing at once, consider all possible alternative solutions, including doing nothing and for each solution consider all the pros and cons. Once you decide on a course of action, set yourself realistic targets, or you may only add to your stress.

Doing a small amount of a large task on a regular basis, can make it easier to deal with. Be totally honest with yourself – are your expectations of both yourself and others too high? Do you actually cause yourself stress by demanding too much of yourself? Make your course of action sensible and reasonable and once devised try to stick to it.

Many of the situations that we have to deal with both at work and in our personal lives cannot be changed, but it is possible to change the way in which we deal with them or think about them.

Learn to accept the things you cannot change and only spend energy on what would be beneficial to change. We often worry unnecessarily about things we cannot influence, causing ourselves stress and wasting energy that could have been focused elsewhere.

A balanced diet

Change to diet can have beneficial results and can also reduce the effects of stress. Try to eat a balanced diet, always have breakfast, and eat regularly. Research has shown that those people who skip breakfast are often far more tired at the end of the day.

Eat complex carbohydrates such as pasta, wholemeal bread, jacket potatoes etc., rather than refined carbohydrates, (e.g. Sweet biscuits, crisps, cake). Complex carbohydrates really can help prevent mood swings.

Avoid too many saturated fats and eat plenty of fresh fruit and vegetables, as increased vitamin C will boost your immune system. Reduce caffeine consumption, avoid drinking alcohol for the wrong reasons and most importantly, drink water to ensure you are not dehydrated. These measures provide very positive steps you can take to help yourself, by replacing bad habits with good habits.

Take time to relax

Ensure you relax when you are not working. When you are suffering from stress, relaxation may be the last item on your priority list, even if it is the top of your wish list.

There are many ways you can help yourself and the simplest, is to separate work from leisure – remember, most of us are not paid to work at home. Having a period of relaxation every day is vital to give yourself time to switch off and recharge. Relaxation is different things to different people but this should be something you enjoy and that fits into your life. This could be reading, watching TV, listening to music, meditation, having a soak in the bath etc. The act of relaxation is a very necessary part of life.

Deep breathing is an excellent way of calming down and can be done anywhere and at any time. Draw in a deep breath whilst thinking ‘RE and exhale long and deep whilst thinking LAX’. Even just stop what you are doing and take one DEEP breath. Close your eyes and for a minute or two think of somewhere pleasant.

Control your worries

Keep your worries into perspective. Can you remember what you were worrying about this time last year? Probably not! Many of us waste a lot of time and create a lot of stress for ourselves, worrying about unimportant things in the ‘what if’ cycle.

Instead of worrying about the 'what if', ask yourself what the probability of that thing actually happening and consider if you are wasting energy on something that may not happen. We all have an inner voice that directs our thoughts or actions and it may be necessary to question what the inner voice tells us. For example if a work colleague snaps at you, your inner voice tells you to snap back whereas if you think about the situation, your colleague may be having a bad day and you will only add to it by snapping back. Is it worth getting worked up about it? And do not forget that one of the best stress busters is – laughter.

Using and soothing your muscles

Often at the end of the working day, exercise is the last thing on your mind. Research has however shown that twenty minutes of exercise, three or four times a week can be very beneficial in managing stress. Individuals report feeling recharged, sleep better and feeling fitter which in turn can build up self-esteem.

Holidays away from work are vital, even if you do not travel further than your home. Make the most of your days off by relaxing and get as far away from your work routine as possible.

A good night's sleep is vital to stay healthy, particularly so in times of stress. Unfortunately, many people experience insomnia when suffering from stress. If this happens to you consider aromatherapy oils, a hot milky drink, or a warm bath before going to bed. Caffeinated drinks can also disturb sleep patterns. Deep breathing and relaxation exercises can also be beneficial, as may gentle exercise such as a short walk. If you can't sleep reading or listening to music can help make you feel sleepy.

Using your time well

Do you miss deadlines or arrive late at meetings? This may be due to the fact that you have too many things to do but it could also be a result of how you manage your time.

Time can be wasted in a variety of ways i.e., do you:

- Get side-tracked by unimportant things?
- Stay chatting on the phone after all the important issues have been fully discussed?
- Have trouble delegating?
- Take on just too much?
- Try to do too many tasks at once?
- Go to meetings where there are no formal agendas, let alone positive outcomes?

If any of the above applies to you, here are some suggestions as to what you might do:

- Think of situations where you waste time and how you could alter them;
- Learn to drop unimportant activities; learn to say “no” or delegate;
- Schedule some time daily when you will not be interrupted;
- Have a “to do list” of goals that are really achievable.

Learn to say no

Many of us say ‘yes’ when we really want to say ‘no’. It is not always easy to say what we really mean and poor communication is frequently a cause of stress at work.

If you are under a great deal of pressure, you may find yourself being aggressive towards others and similarly, you may find yourself agreeing to do something because it seems the easy, or only, solution. This in turn will make your to do list even longer and increase stress levels as you feel frustrated and annoyed with yourself for making things worse.

Learning to be assertive (not aggressive) can assist with this problem. Assertion is based on a philosophy of personal responsibility and an awareness of the rights of other people. It is all about the ability to negotiate, having the confidence to say what you really want or do not want, but remembering this must not be at the expense of others.

In many work roles we try to oblige and accept tasks without question. It is only when a burden gets unmanageable; we either complain or try to achieve the impossible. When given a task, ask yourself ‘is this really mine?’ If the task is yours but you already have more than you can cope with, talk to your manager before it becomes a problem.

Dealing with Bullying, Harassment and Fear at Work

Bullying and/or harassment can both be possible sources of stress and this type of inappropriate behaviour will not be tolerated by the Trust.

If you believe that you are being harassed or bullied:

- Make a record of what has been happening and when;
- If you feel comfortable, explain to the person that their behaviour is not welcome
- Look on the Trust's Intranet for the All Wales Dignity at Work Process and the respect and resolution toolkit https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/Respect-and-Resolution-Toolkit.aspx

If you do nothing, the stress you are experiencing may get worse. Some occupations have the potential for both physical and verbal violence and it is important that you share any fears you may have with your manager. Although there will be risk assessments in place covering violence in the workplace, you should ensure that any new risks identified are discussed with your manager and included in the next risk assessment review.

Work versus home life

With the long hours many employees work plus the demands of home, they have less and less time to enjoy being with friends and family, let alone having time for themselves.

Individuals should communicate with those at home and at work to discuss any problems they have and how things might be changed. Often, when an individual is under excessive pressure, they do not tell anyone how they are feeling, leading to them becoming even more frustrated when others add to their problem without being aware.

If you have problems with work-life balance, seek support from your manager or your family and consider any possible alternatives such as job sharing, unpaid leave, flexible working hours etc.

Support

There may be a point in all our lives when we need the help and support of other people. If you ever feel that you just cannot cope any more or are unsure of which way to turn, consider talking your problem over with someone. Your choice of a person to confide in is very important.

If the problem is being caused within the workplace, you could discuss this with your manager, Workforce & OD, the Trust's Employee Assistance Programme, Occupational Health department or your union representative. Close friends and family can be very helpful but do consider they may have problems of their own.

If you feel that your problem is so intimate that you cannot discuss this with any of the above people, you should consider seeking professional help. Your GP could help with this, or you could contact one of the many external agencies who deal with both general and specific issues.

Immediate support options https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/GET-HELP-NOW.aspx including 111.

24/7 free confidential counselling service https://vivup.yourcareeap.co.uk/UK/EAP-Products.awp?P1=oA==&P2=xBcuZQ==&P3=2

Health & wellbeing centre to find out what support options are right for you https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/Health-and-Wellbeing.aspx

For urgent mental health support call **NHS 111** and press **OPTION 2**

The service is available for people of all ages, 24 hours a day, 7 days a week in all areas of Wales to ensure those in need of support can access it quickly when they need it most.

Not urgent but actively seeking support ?

---

vivup

03303800658 Vivups 24/7 Confidential helpline and access to counselling and resources for you and your family

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canopi.nhs.wales.uk Free and confidential mental health support for NHS and social care staff across Wales

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

If you are looking for support with work or cancer related issues impacting you or your team at work, you can find the link to the Clinical Psychology for Staff and Teams Request Form **here**

Your wellness is important to us at Velindre University NHS Trust - we want to ensure that you have access to the support you need when you are off work.

Contact **healthandwellbeing@wales.nhs.uk** for any Health & Wellbeing support queries.

Keep this leaflet at hand and scan the QR code to have the tools to take care of your mental health, physical health, financial wellbeing and social wellbeing.

Microsoft Edge Required to Access

TRUST BOARD

CHAIR'S URGENT ACTION MATTER REPORT

DATE OF MEETING	27 November 2025
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	**TO RATIFY**
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Kay Barrow, Corporate Governance Manager
PRESENTED BY	Non Gwilym, Interim Director of Corporate Governance
APPROVED BY	Non Gwilym, Interim Director of Corporate Governance
EXECUTIVE SUMMARY	This report details Chair's Urgent Actions taken between the **19/09/2025 – 20/11/2025.** There was one (1) urgent item of business for the Trust Board that was considered via Chairs Urgent Action during this period: 1. Low Vision Aid Supply and Recycling Services Business Justification Case and Commitment of Expenditure No objections to approval were received in respect of the item of business considered, although one matter was raised and is detailed in the report.
RECOMMENDATION / ACTIONS	To **RATIFY** the Chairs Urgent Action taken between the **19/09/2025 – 20/11/2025.**

GOVERNANCE ROUTE	
Trust Board Members – Via Email	**13/10/2025**: Low Vision Aid Supply and Recycling Services Business Justification Case and Commitment of Expenditure

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS
The Trust Board **APPROVED** the item of business considered via Chair's Urgent Action.

7 LEVELS OF ASSURANCE – N/A

APPENDICES – N/A

1. SITUATION

This paper provides the Trust Board with an overview of key decisions and outcomes considered via Chair's Urgent Action between the **19/09/2025 – 20/11/2025.**

2. BACKGROUND

2.1 In accordance with the Trust Standing Orders, there may occasionally, be circumstances where decisions, which would normally be made by the Board, need to be taken between scheduled meetings and it is not practicable to call a meeting of the Board. In these circumstances, the Chair and Chief Executive, supported by the Interim Director of Corporate Governance, as appropriate, may deal with the matter on behalf of the Board – after first consulting with at least two other Independent Members. The Interim Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Board for consideration and ratification. Where issues are included in the Schedule of 'Expected Urgent Decisions' and prior approval is sought from the Board, these issues will not be reported here.

2.2 Chair's Action may not be taken where either the Chair or the Chief Executive has a personal or business interest in an urgent matter requiring decision. In this circumstance, the Vice-Chair or the Executive Director acting on behalf of the Chief Executive will take a decision on the urgent matter, as appropriate.

3. ASSESSMENT/SUMMARY OF MATTERS FOR CONSIDERATION

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

3.1 Low Vision Aid Supply and Recycling Services Business Justification Case and Commitment of Expenditure

The Trust Board were sent an email and Chair's Urgent Action Report on the **13th October 2025** in relation to the **Low Vision Aid Supply and Recycling Services** that required urgent approval.

During the approval process it was highlighted that parts of Section 5 – Impact Assessment – were left uncompleted. This matter was raised with NWSSP colleagues and in response provided assurance that Section 5 will be completed as far as practically possible as a Hosted Service.

The Trust Board was requested to:

- **APPROVE** the contract renewal for the **Low Vision Aid Supply and Recycling Services** for the **total sum of £6,140,856.00**.

- **NOTE** that following Trust Board Approval, NWSSP will raise a Purchase Order for the initial contract period to June 2030.

Recommendation Approved by:

- Sara Moseley, Chair
- David Donegan, CEO
- Andrew Westwell, Independent Member
- Hilary Jones, Independent Member

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)	04 - Organisational Culture
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	This action is by exception and with prior approval from the Chair. The provision to permit this urgent action is to allow for quick decisions to be made where it is not practicable to call a Board meeting and to avoid delays that could affect service delivery and quality.
QUALITY IMPACT ASSESSMENT	Not required - not a strategic decision
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Not required

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience.
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	Financial impact was captured within the documentation considered by the Board.
EQUALITY IMPACT ASSESSMENT	Not required
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Legal impact was captured within the documentation considered by the Board.

3 RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

TRUST BOARD

TRUST SEAL REPORT: 19TH SEPTEMBER 2025 – 21ST NOVEMBER 2025

DATE OF MEETING	27 November 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 **(19th September 2025 – 21st November 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	

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 **(19th September 2025 – 21st November 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
1st October 2025	Counterpart Lease relating to units 4 and 5 Charnwood Court, Heol Billingsley, Parc Nantgarw, Cardiff, CF15 7QZ, between Treforest Trustee (Jersey) Ltd and Treforest Nominee (Jersey) Limited as Trustees of the Treforest Unit Trust (as Landlord) and Velindre University NHS Trust (as tenant).	Carl James (Acting CEO) and Sara Moseley (Chair)
23rd October 2025	Habitat Management Licence between the County Council of the City and County of Cardiff and Velindre University NHS Trust.	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	27 November 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 Strategic Development Committee with details of the key issues considered by the nVCC Project Scrutiny Sub-Committee held on 18th September 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** • **Site Engagement**: Site tours have resumed and are well-attended, aligning with visible construction progress. • **Feedback Capture**: The potential to gather qualitative feedback from site visits was discussed. While survey responses are limited, consistent questions are being used across engagement activities. Current KPIs may not fully capture this insight. • **External Recognition**: Emphasis was placed on linking the project to broader external opportunities and recognition. • **Water Infrastructure Assurance**: The importance of water infrastructure and safety was highlighted. External experts from Shared Services are providing assurance beyond internal oversight. • **Smart Hospital Standards**: Work is ongoing to define smart hospital standards and assess capacity. The Sub-Committee was briefed on a meeting with the New Hospital Programme Executive Team regarding digitally enabled hospitals. Specifications are expected to be shared once received. The nVCC Project Scrutiny Sub-Committee **NOTED** the **nVCC Project Highlight Report** and the **Amber Project status** for the reporting period. **Interdependencies Report** • **Outreach Project**: The Committee expressed concern over the Outreach Project's limited progress. Items marked "in development" require clearer narrative and assurance, especially those critical to nVCC operational readiness. The current tabular format was deemed insufficient, and a more proactive reporting approach was recommended. • **Assurance for Day-One Readiness**: The Committee emphasised the need for clearer assurance around critical interdependencies, particularly those essential for nVCC's day-one readiness in April 2027. It reaffirmed its role in providing assurance to the Strategic Development Committee and the Board. • **Clarification on Outreach and Workforce Transformation**: These areas are actively managed and under review, with no current risks flagged to the nVCC opening. The team welcomed guidance on reporting detail and acknowledged the need for clearer articulation of progress and dependencies. • **Improvement Areas Identified**: - Unified view of programme goals; Defined scope boundaries; Clear identification of key dependencies and assurance detail; and Appropriate committee oversight.

	• **Governance and Reporting Review**: A review of governance and reporting structures was proposed to ensure proper tracking of interdependencies, especially workforce transformation. A more integrated presentation was recommended. • **Next Steps**: The group agreed to continue discussions offline to clarify expectations for future interdependencies reporting and ensure the Committee receives appropriate assurance. The Sub-Committee **NOTED** the VCS Futures Assurance Report, with the understanding that further discussion will be taken offline to clarify expectations for future interdependencies reporting.
INFORM	**Communication and Engagement Update Report** • **Site Complaints Management**: The Committee sought assurance that site-related complaints (e.g. noise, working hours) are being addressed promptly and respectfully. The team confirmed strong collaboration with Sacyr and real-time issue resolution. • **Public Engagement**: The possibility of offering site tours to public groups was considered. While current tours are limited to staff due to construction constraints, future community engagement was acknowledged as valuable. • **Strategy Review**: A commitment was made to continue reviewing the communications strategy to ensure it remains effective and appropriate. The Sub-Committee **NOTED** the Communication and Engagement update report. **nVCC Project Scrutiny Sub-Committee Annual Report** The Sub-committee **APPROVED** the nVCC Project Scrutiny Sub-Committee Annual Report, subject to a future review of the Terms of Reference. **Terms of Reference Update** • Concerns were raised regarding the clarity and scope of the Committee's Terms of Reference, particularly a clause allowing scrutiny activities as directed by the Trust Board. Members questioned whether this wording was sufficiently precise and highlighted ambiguity around the term "constituent projects,"

	which may reflect legacy language from the Committee's previous role. • **Proposal for Broader Review**: The Chair acknowledged these concerns and proposed a broader review of the Terms of Reference to clarify the Committee's remit, reporting responsibilities, and expectations around the nature of reports received. The Committee **DID NOT** endorse the proposed amendments to the terms of reference for approval, choosing to conduct a more thorough review before resubmission.
APPENDICES	None.

TRUST BOARD	
HIGHLIGHT REPORT FROM THE CHAIR OF THE LOCAL PARTNERSHIP FORUM	
DATE OF MEETING	27 November 2025
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Olayinka Sokoya, Executive Support Assistant
PRESENTED BY	Sarah Morley, Executive Director of OD and Workforce
EXECUTIVE SPONSOR APPROVED	Sarah Morley, Executive Director of OD and Workforce
REPORT PURPOSE	FOR NOTING

ACRONYMS	
LPF	Local Partnership Forum
SLT	Senior Leadership Team
VCS	Velindre Cancer Service
WBS	Welsh Blood Service

1. PURPOSE

1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the Local Partnership Forum held on 23 September 2025.

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

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

2. HIGHLIGHT REPORT

ALERT / ESCALATE	Nothing to escalate to Trust Board
ADVISE	Nothing to advise to Trust Board
ASSURE	Nothing to assure
INFORM	The Local Partnership Forum considered the following matters at the meeting: **Social Partnership Duty Annual Report** • Discussion on the challenges in releasing the appointed Social Partnership Lead from their substantive post were discussed. • Concerns about partnership principles and staff burnout were raised by trade union representatives. • **NOTED** the Social Partnership Lead - Update on Role. **Workforce Risks Update** • Strategic and operational workforce risks were reviewed, including recruitment, retention, succession planning, and cultural development. Assurance was provided that risks are being monitored and mitigated, with updates captured through the governance cycle. • **NOTED** the content of the paper in relation to the management of operational workforce risks aligned to the strategic workforce risks and mitigations. **Workforce Performance** • Sickness absence rates, turnover, PADR compliance, and training metrics were reported. • Improvements in headcount, turnover, vacancy rates, and agency spend were noted. • The Minimising Employee Harm Programme has significantly reduced the duration of disciplinary and grievance processes. **Culture and Inclusion** • The new Velindre Culture Framework was introduced, consolidating initiatives under five key pillars. Assurance scores indicate ongoing progress, with a need for a more cohesive strategy for employee voice.

	• The Workforce Race Equality Standard (WRES) Report highlighted disparities in appointment rates and increased reports of harassment among Black and Minority Ethnic staff. Positive action initiatives and a Race Staff Network are being established. • **NOTED** the content of the Culture and Inclusion Report. **Staff Awards Update** • A record 221 nominations for the Staff Excellence Awards were received. • **NOTED** the verbal update. **Staff Wellbeing Services Overview** • Updates were provided on staff wellbeing services, including counselling, occupational health, peer support, and a new digital wellbeing platform. • Positive feedback and reductions in sickness absence were reported. **Velindre Cancer Service (VCS) Restructure Update** • The first phase of the VCS restructure is nearly complete, with most SLT posts confirmed and recruitment for new leadership roles underway. • A communications plan is being developed to keep staff informed. Induction for new appointees is planned for readiness by January 2026. • **NOTED** the verbal update **New Velindre Cancer Centre (nVCC) Update** • Progress on the nVCC build was shared, highlighting improved facilities, green credentials, and community benefits. • Staff site visits and a workforce steering group are being organised to support recruitment and change management. • Patient services are expected to begin by mid-April 2027. • **NOTED** the verbal update regarding the progress with the nVCC.
APPENDICES	None

TRUST BOARD

TRUST WIDE POLICIES APPROVED UPDATE

DATE OF MEETING	27 November 2025
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
REPORT PURPOSE	FOR NOTING
PREPARED BY	Kay Barrow, Corporate Governance Manager
PRESENTED BY	Non Gwilym, Interim Director of Corporate Governance
EXECUTIVE SPONSOR APPROVED	Non Gwilym, Interim Director of Corporate Governance
EXECUTIVE SUMMARY	The purpose of this report is to provide an update to the Trust Board regarding the status of the Trust wide policies and to advise of those that have been approved during the period **September 2025 to November 2025.**
RECOMMENDATION / ACTIONS	The Trust Board is asked to **NOTE** the policies that have been approved during the period **September 2025 to November 2025.**

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
• Executive Management Board	26/08/2025 29/09/2025
• Quality, Safety and Performance Committee	11/09/2025 13/11/2025

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

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

- IPC03 – All Wales ANTT Policy
- IPC05 – National Infection Prevention & Control Manual (NIPCM)
- IPC10 – Hand Hygiene Policy

• IPC21 – Management of Respiratory Infection 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 • PP01 – Fire Safety Policy • PP01a – Fire Safety Protocol – Principles of Fire Safety
7 LEVELS OF ASSURANCE – N/A
APPENDICES

Appendix 1	IPC03 – All Wales ANTT Policy
Appendix 2	IPC05 – National Infection Prevention & Control Manual (NIPCM)
Appendix 3	IPC10 – Hand Hygiene Policy
Appendix 4	IPC21 – Management of Respiratory Infection Policy
Appendix 5	IG13 – Confidentiality Breach Reporting Policy
Appendix 6	IG02 – Data Protection and Confidentiality Policy
Appendix 7	IG01 – Records Management Policy
Appendix 8	GC01 – Policy and Procedure for the Management of Trust Wide Policies and Other Trust Wide Written Control Documents
Appendix 9	PP01 – Fire Safety Policy and Fire Safety Protocol – Principles of Fire Safety
Appendix 10	PP01b – Fire Safety Protocol – Principles of Fire Safety

1. SITUATION/BACKGROUND

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

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

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

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

Appendix	Policy Title	Policy Lead / Function	Approving Body	Effective Date
1	IPC03 – All Wales ANTT Policy	Executive Director of Nursing, AHP & Health Science	Quality, Safety & Performance Committee	11/09/2025
2	IPC05 – National Infection Prevention & Control Manual (NIPCM)	Executive Director of Nursing, AHP & Health Science	Quality, Safety & Performance Committee	11/09/2025
3	IPC10 – Hand Hygiene Policy	Executive Director of Nursing, AHP & Health Science	Quality, Safety & Performance Committee	11/09/2025
4	IPC21 – Management of Respiratory Infection Policy	Executive Director of Nursing, AHP & Health Science	Quality, Safety & Performance Committee	11/09/2025
5	IG13 – Confidentiality Breach Reporting Policy	Executive Director of Finance	Quality, Safety & Performance Committee	11/09/2025
6	IG02 – Data Protection and Confidentiality Policy	Executive Director of Finance	Quality, Safety & Performance Committee	11/09/2025
7	IG01 – Records Management Policy	Executive Director of Finance	Quality, Safety & Performance Committee	11/09/2025
8	GC01 – Policy and Procedure for the Management of Trust Wide Policies and Other Trust Wide Written Control Documents	Director of Corporate Governance (Interim)	Quality, Safety & Performance Committee	11/09/2025
9	PP01 – Fire Safety Policy	Director of Place, Portfolio and Partnerships	Quality, Safety & Performance Committee	13/11/2025
10	PP01b – Fire Safety Protocol – Principles of Fire Safety	Director of Place, Portfolio and Partnerships	Quality, Safety & Performance Committee	13/11/2025

3. IMPACT ASSESSMENT

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

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

	Each policy will be individually assessed to ensure compliance with EIA requirements.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Not complying with Trust policy and procedure can result in legal challenges from staff at Employment Tribunal. Not complying with legislative requirements could result in fines and prosecutions against the Trust from respective government agencies.

4. RISKS

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

Model Policy
Aseptic Non-Touch Technique (ANTT®):
A national, standardised approach to aseptic technique

Date to be reviewed:	April 2026	No of pages:	32
Original Author job title(s):	Healthcare Associated Infection & Antimicrobial Resistance & Prescribing Programme (HARP), Public Health Wales (PHW) In Consultation with: • All Wales ANTT Steering Group • Higher Education Institute (HEI) sub-group • The Association for Safe Aseptic Practice • HCAI Delivery Board		
Responsible dept. / director:	HARP IP&C Team, Public Health Wales		
Approved by:	The all-Wales ANTT Steering Group & HEI sub-group The Association of Safe Practice (ASAP) HARP, Public Health Wales HCAI Delivery Board, Public Health Wales		
Original Date approved:	07 June 2019		
Original Effective Date (live):	04 July 2019		
Version:	FINAL Version 1 - 04 July 2019 FINAL Version 2 - July 2019 FINAL Version 3 – March 2023 FINAL Version 3 – Updated June 2025 to incorporate Addendum to the 2023 Model Policy: Aseptic Non-Touch Technique (ANTT®) – Interim Adoption of ANTT® Clinical Practice Framework v6.4 (2024)		
Date of Review	December 2022		
Date Verification form (1) completed:	24th March 2023		

Documents to be read alongside this model policy:	ANTT® Principles[1] NHS Scotland's National Infection Prevention and Control Model Policies NIPCM -on-line[2] Welsh Health Circular 2022/014 Amr-hcai-improvement-goals-for-2021-2023.(Welsh Government 01 March 2022)[3] Welsh Code of practice for the Prevention of Infection (Welsh Government, May 2014) Code-of-Practice [18] WHC 2015-26 ANTT Implementation (Welsh Government, 5th June 2015)[19] WHC 2015-47 ANTT Follow up (Welsh Government, 9th Oct. 2015)[20] epic 3: National Evidence-Based Guidelines for the Prevention of Healthcare-Associated Infections in Hospitals in NHS Hospitals in England (Loveday et al, 2014)[9] The Royal Marsden Hospital Manual of Clinical Nursing Procedures 10th Edition (2020)[7] Procedures - Royal Marsden Manual (rmmonline.co.uk) National Institute of Clinical Excellence (NICE) Infection prevention and control of healthcare-associated infections in primary and community care (2017)[11] Healthcare-associated infections: prevention and control in primary and community care | Guidance | NICE

Executive Summary:
This model policy outlines the current national standardised approach for raising clinical standards of aseptic technique and achieving asepsis in non-invasive and invasive clinical procedures. The aim is to provide a standardised approach termed Aseptic Non-Touch Technique (ANTT®) and to reduce variation in aseptic technique and practice across Wales in the prevention of healthcare associated infections (HCAI). As agreed previously by Executive Nurse Directors, the intention is that this model policy is adopted as national policy by Health Boards and Trusts, including primary care and other health care organisation i.e., Care homes and independent hospitals within Wales. This policy requires relevant managers and leaders to organise and support its implementation and ongoing evaluation. This will ensure relevant clinical staff are appropriately trained and competency assessed in ANTT® so that it is embedded into everyday asepsis practice.
This ANTT Model policy was first published in July 2017, Emergency ANTT added in July 2019, version 3 /2023 all links refreshed, circulated for comment minor amendments and comments updating of appendices including ANTT Accreditation, terminology and updated framework information added into the appendix

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ADDENDUM to the 2023 Model Policy: Aseptic Non-Touch Technique (ANTT®) – Interim Adoption of ANTT® Clinical Practice Framework v6.4 (2024)

1. Introduction

Asepsis is generally considered to mean 'Freedom from pathogenic material in sufficient quantity to cause infection'.[14] During clinical procedures, the goal of asepsis is to prevent patient contamination by creating an environment that is low in microbe volume by using only sterile devices, materials and maintaining aseptic technique.

Aseptic technique is a core nursing and medical skill but is also used by other allied healthcare professionals (AHP) and healthcare support workers. The standard of aseptic technique practice can be inconsistent, and if not undertaken correctly may be instrumental in causing a healthcare-associated infection (HCAI) within primary, community, secondary and out of hospital care.

Historically, aseptic technique has been seen to be confusing and ambiguous with practice terms and principles having different meanings for different users. This has led to inconsistency and some substandard practices.

In the challenge to reduce HCAI, 'Aseptic Non-Touch Technique' (ANTT®) is used internationally as a safe and effective practice framework for aseptic technique for all aseptic clinical procedures.[19,20]

The Association of Safe Aseptic Practice (ASAP), in collaboration with Public Health Wales and supported by Welsh Government, have been providing ANTT® Resources practice and implementation support to all healthcare workers across Wales since June 2015.

Standardising aseptic technique with ANTT® across Wales will reduce variability in practice and further raise standards for the greater benefit of patients.

Welsh Government has directed all healthcare organisations to 'roll-out' ANTT® competency training to all relevant staff within their organisation.(WHC/2015/026) [19] The principles of ANTT® align with the principles of prudent healthcare[26] and a 'One Wales' agenda, Once For Wales approach. The need for asepsis, especially in the use of invasive procedures and wound management, is evidenced in the epic3 Guidelines.[9]

What is ANTT®?

The ANTT® Approach is an International Campaign designed to promote a clear understanding of asepsis and the essential elements of aseptic technique. This approach is a three-way 'partnership' between patients/service users, healthcare professionals and healthcare organisations, to actively promote the essential '6 Actions for Safe Aseptic Technique' (Appendix 4).

The ANTT® Practice Framework was originated by Stephen Rowley (2001),[15] and is defined as, *'A specific type of aseptic technique with a unique theoretical and clinical practice framework'.*[15]

The framework is applicable to all non-invasive and invasive clinical procedures including major surgery, the insertion and maintenance of indwelling medical devices, wound management and all primary, community and out of hospital-based care that requires aseptic practice.

ANTT® Practice Framework developments and dissemination are overseen by The Association for Safe Aseptic Practice (ASAP), a non-profit non-governmental organisation (NGO). The ASAP is working in partnership with NHS Wales and Public Health Wales to standardise aseptic technique across as a national standard and provides Welsh healthcare staff with updates to all ANTT® resources as they are reviewed and developed. The current resources and full ANTT® can be found following this link ANTT - Public Health Wales A summarised version is given in Rowley et al (2010).[16]

ASAP can be contacted for on-going support on practice and implementation issues via www.antt.org.

2. Purpose

The purpose of this national model policy is to support the implementation of the ANTT® practice framework to enable standardisation of technique and 'practice language' for all aseptic procedures. ANTT® must be embedded into every day clinical procedures as part of a robust commitment to reducing the risks of HCAI and need for antimicrobial prescribing to improve patient safety. Welsh Government set HCAI annual reduction expectations for *Clostridioides difficile*, *Staphylococcus aureus* bacteraemia and Gram-negative bacteraemia as well as expectations for antimicrobial prescribing. These expectations align to the ambitions outlined in the addendum to the 5 year UK National Action Plan (NAP) and the 20 year vision to achieve future reductions that include positively impacting on MRSA, MSSA Blood Stream Infections (BSI), Urinary Tract and Surgical Site Infection (SSI) rates. Compliance with ANTT® supports Health Boards/Trusts in reducing these and other HCAI's whilst improving patient experience and outcomes.

3. Aims and Objectives

This model policy provides a widely adopted evidence-based framework for establishing ANTT® as the safe and effective technique for all aseptic procedures in healthcare organisations across Wales.

Objectives are:

- To identify the role of ANTT® in the reduction of HCAI
- To identify key roles and responsibilities in ANTT® implementation

- To describe the implementation and uses of ANTT®
- To identify the principles of ANTT® and its application to practice
- To outline the requirements for learning and competency assessment for staff undertaking clinical aseptic procedures
- Provide resources and toolkit to support ANTT® in practice
- To be relevant in acute, community and primary care settings, including emergency out of hospital care

4. Scope of the Policy

This model policy is applicable in all settings that provide healthcare to patients and/or service users and to all healthcare workers (HCW) who perform a clinical procedure that requires an aseptic technique.

5. Roles and Responsibilities within Organisations

The Board and Chief Executive Officer (CEO) has ultimate responsibility for Infection Prevention and Control within Health Boards and NHS Trusts. This responsibility, together with responsibility for ANTT® is delegated to the Executive Team under the leadership of the Executive Director of Nursing.

5.1 The Executive Director of Nursing

- Has overall responsibility to ensure that ANTT® is fully implemented and effectively sustained within their organisation[19,20]
- Will ensure that this and local ANTT® policy/procedures are adhered to
- Will nominate an organisational lead for ANTT®
- Will review progress and report to the Board on ANTT® implementation and maintaining compliance in all groups of HCW's
- Will ensure there are adequate financial resource

The operational and professional responsibility lies with the individual performing the procedure.

5.2 Senior Clinical Leads, Departmental and Nurse Managers will

- Be responsible for the effective implementation and monitoring of compliance with ANTT®, ensuring appropriate action is taken when staff fail to comply with policy and required training
- Identify an ANTT® lead and key trainers and assessors for their area of responsibility
- Ensure additional resources and/or equipment is available to facilitate the HCW undertaking the theory and practice of ANTT®
- Facilitate completion of the All-Wales e-learning programme for ANTT® by all HCWs involved in aseptic procedures e.g., protected work time and access to a computer
- Facilitate completion of competency assessment for all HCWs undertaking any type of aseptic procedure
- Monitor and report on competency level of the team and report to the appropriate risk committee

- Support HCWs in achieving compliance with all statutory and mandatory training, including Standard Infection Prevention and Control Precaution (SICP) mandatory training
- Bring this model policy to the attention of all health professionals or workers involved in ANTT® including educational and specialist roles
- Embed ANTT® into routine aseptic practice and all teaching of clinical procedures that require asepsis

5.3 Healthcare Workers (HCWs) will

- Have a responsibility to be familiar with NIPCM policies[2] and adhere to this model policy and other relevant local IPC policies to reduce the risk of transmission of infection
- Always act in the patients' best interest
- Perform invasive and other procedures in accordance with the principles and process of ANTT® (appendices 2-5) and this policy.
- Take personal responsibility for attendance at mandatory training or completion of relevant e-learning and act in accordance with the Welsh Code of Practice for the Prevention and Control of Healthcare Associated Infections[18] in Wales
- Be accountable for their practice in accordance with their job description and professional codes of conduct, for example, NMC The Code - The Nursing and Midwifery Council[12] and GMC Good Medical Practice[8]
- Undertake the required ANTT® training and competency assessment if performing any aseptic clinical procedures
- Embed ANTT® into all aseptic practice

5.4 Primary and Community Care Healthcare Staff, including Welsh Ambulance NHS Trust (WAST)

In any out of hospital care settings (e.g., Community Nursing, Primary Care, Long Term Care Facilities, Welsh Ambulance Service) there may be challenges in the application of ANTT® principles relating to equipment and the environment. A local risk assessment (Appendix 7) should be undertaken to assess how the principles can be adopted and any adaption (if necessary) should be documented, minimising patient risk. Resources to assist with this risk assessment are available within the ANTT Framework on Public Health Wales website ANTT Framework.

Whilst recognising the application of ANTT® in challenging situations, it is still possible to aim to minimise patient risk by applying ANTT® '4 Actions for Safe Aseptic Technique' (Appendix 3). Tools and resources specific to community settings and ambulance staff can be accessed via this link Appendix 6 provides an example template for 'Ambulance Peripheral Cannulation Guideline'.
See also 8.6 – Emergency ANTT®

ANTT® principles will be applied and adapted to the management of chronic wounds. While it is recognised some chronic wound procedures e.g., leg

ulcer cleansing and dressing in a patients' own home, can be simplified, the aim is always asepsis, with the aim being not to introduce any further microorganisms into the wound. Guidance should be sought from the Tissue Viability Nurse on aspects that do require ANTT®.

5.5 Consultant Medical Staff will

- Undertake the required ANTT® training and competency assessment
- Be competent and keep your professional knowledge and skills up to date
- Comply with the Good Medical Practice Framework.[8] GMC Good medical practice
- Be responsible for ensuring their junior doctors and teams adhere to and embed the principles of ANTT® and undertake the required training and competency assessment

5.6 Infection Prevention and Control Team (IPCT), Tissue Viability Nurse (TVN), Continence Teams and Intravenous Access Teams

These specialist teams will participate in the National ANTT® Steering Group supporting ANTT® rollout across Wales. They have a pivotal role in assisting relevant organisational teams to coordinate ANTT® implementation, ensure training in their specialist fields conforms to ANTT principles as well as risk-management and evaluating effectiveness of its use.

The IPCT will:

- Provide expert advice in accordance with this policy
- Support managers and staff with the implementation of ANTT®
- Provide information, advice, and training to enable managers and users to undertake necessary risk assessment
- Support investigations in areas with specific risk to advise on safe practice
- Ensure local or adapted procedures/policy remains consistent with the evidence-base for safe practice and review/update local policy and procedures at least every 3 years
- Identify areas for improvement and report to Infection Prevention and Control Managers, local Infection Prevention and Control Committee, and local Clinical Risk or Patient Safety, Health and Safety and national groups
- Support education and training programme for ANTT® across primary and secondary care
- Report any impact of compliance identified during investigations related to an HCAI, in line with Duty of Quality and Duty of Candour. [29, 30] Assurance around shared learning from such investigation will be reported to the relevant governance, quality, and safety groups.

5.7 Nominated ANTT® Lead will

- Provide local leadership for the roll-out of ANTT®

- Participate in PHW-led all-Wales ANTT® Steering Group to enable sharing of best practice from and within their organisation
- Provide guidance to their organisation on future developments, e.g., primary care roll out, updated resources, standardised packs
- Ensure that all local training, policies, procedures, and guidelines are ANTT® compliant

5.8 Nominated Key-Trainers/Facilitators from each clinical area or professional group will:

- Facilitate completion of All Wales ANTT® e-learning training by all HCWs involved in aseptic processes
- Provide supplementary electronic/paper ANTT® training and competency assessment to relevant staff within their department
- Keep accurate records of staff trained
- Instil a culture for asepsis and of ANTT® practice across their clinical area/professional group
- Ensure compliance with ANTT® practice is achieved, challenging unsafe practice appropriately
- Maintain own compliance with ANTT® competence and practice
- Identify and support additional resources needed for compliance with ANTT® key principles
- Identify and address challenges and share areas of good practice via the Quality, Safety and Experience structures

5.9 Procurement Leads

Prior to purchase of any re-usable patient equipment, discussion must take place with manufacturers, local infection prevention and control leads, and local decontamination leads, where applicable, to ensure that such items can be safely decontaminated within the organisation. Equipment in use is required to facilitate ANTT® e.g., insertion packs, trays, trolleys. These should be made readily available and accessible across the organisation. There should be rationalisation and standardisation of equipment choices across Wales to help reduce practice variation in aseptic technique.

5.10 Higher Education Institutes (HEI):

Universities across Wales will work to standardise their curriculum regarding teaching and learning competencies in ANTT® for all healthcare professional students e.g., nursing, medical, podiatry, paramedics, and allied health in respect of ANTT®, at the point of registration.

6. Implementation of ANTT®

The implementation of ANTT® will require:

- Executive level commitment
- A robust ANTT® training and assessment programme
- Equipment and appropriate resources
- Raising ANTT® awareness across the whole organisation
- A locally agreed ANTT® audit programme

- External audit programme, as agreed with ASAP and HARP, PHW
- Robust monitoring and recording processes for compliance
- Key reporting mechanisms on impact or harm

6.1 ANTT® Accreditation for Healthcare Providers:

ANTT Accreditation Guide 2023 (PHW NHS. Wales) overseen freely by ASAP, provides healthcare organisations with a mechanism to demonstrate effective clinical governance for aseptic technique, and commitment to infection prevention and patient safety. This can be useful to demonstrate an organisations hard work in infection prevention to external regulators, patients/service users, and the public.

There are three levels of accreditation: Bronze, Silver, and Gold.

- ANTT Bronze Accreditation Workbook
- ANTT Silver Accreditation Workbook
- ANTT Gold Accreditation Workbook

Accreditation criteria is based upon the following pre-requisites for safe and best practice:

- ANTT® Policy
- ANTT® Education
- ANTT® Assessment
- ANTT® Monitoring

For support with ANTT® Accreditation please contact enquiries@antt.org

7. Training:

Wales commenced ANTT® programme roll out in June 2015(WHC/2015/026) [19] Substantial progress has been made across Wales despite limited resources to support this; however, all organisations are required to continue to aim for 100% compliance for those who will be performing procedures (regardless of job title) requiring the principles of aseptic technique.

As new employees join the organisation, compliance with ANTT® should be mandated as part of their induction programme.

Priority for training should be given to staff working within augmented care units, staff carrying out invasive procedures, and all new employees.

Professional registrants must recognise their accountability in accordance with their own code of conduct,[8,12] e.g. The Code (Nursing and Midwifery Council 2015)[12] states that nurses must have a good knowledge base before performing any clinical procedure, should be trained appropriately, and have achieved competency within their clinical area. The General Medical Council (Good medical practice-English 2014 (gmc-uk.org))[8] states that doctors must recognise and work within the limits of their competence, provide good standards of practice of care and keep professional knowledge and skills up to date.

- All HCWs across Wales who are involved in aseptic procedures will complete the nationally agreed ANTT® training in the principles and theory for ANTT® prior to competency assessment i.e., current e-learning module at learning@ NHS Wales: https://learning.wales.nhs.uk/
- ANTT® will also be taught locally within departments by means of trained key-trainers/facilitators/assessors, using ANTT® resources: ANTT resources (antt.org) within an implementation framework set out by the local organisation
- All taught procedures involving asepsis will be undertaken using ANTT®
- All HCWs performing ANTT® must be assessed as competent in the application of ANTT® utilising either the Standard ANTT® Competency Assessment tool (CAT) Standard CAT v1.5 or the Surgical Assessment tool Surgical CAT v2
- It is recommended that ANTT® competency assessment should be undertaken within 3 months of completing the ANTT® e-learning programme
- HCW's performing aseptic procedures must maintain their ANTT® competency with at least three-yearly practical competency assessment, monitored via local annual appraisal process and entered to ESR
- HCW's have an individual responsibility to ensure their competencies are maintained and must inform their line manager of any obstacles preventing them to achieve this, or lapse in competency
- Should a HCW change specialties or commence a new post within the HB/Trust requiring competence in different skill sets, the need for further ANTT® training/assessment must be risk assessed and agreed with their line manager. Advice can be sought from the local ANTT® Lead

For staff who are unable to access ANTT® eLearning programmes through either ESR or Learning@Wales, arrangements need to be made for electronic/paper educational resources, which must include the main principles of ANTT®.

It is acknowledged there remains a period of time when not all staff performing aseptic technique will have undergone the appropriate training and assessment in ANTT®. Therefore, existing aseptic practice skills, may be used to ensure service delivery is not affected, following individual local risk assessment with intention of becoming compliant as soon as practically possible.

8. Important basic infection prevention practice for aseptic technique:

This resource is not intended as a comprehensive educational tool, however, as well as providing an outline of the ANTT® Framework (see

appendix 9), some important general aspects of aseptic technique are outlined below.

8.1. Use of Standard Infection Prevention and Control Precautions (SIPCP) such as hand hygiene:

A pre-requisite to safe ANTT® is compliance with standard infection control precautions (SICP's):

SICPs should be performed in line with epic3 Guidelines[9] and the Scottish National Infection Prevention and Control Manual (NIPCM)[2] which is the resource adopted for use for healthcare in Wales. The 10 elements of SICP are:

- Patient Placement
- Hand Hygiene
- Respiratory cough and Hygiene
- Personal Protective Equipment
- Safe management of care equipment
- Safe management of care environment
- Safe management of linen
- Safe management of blood and body fluid spillages
- Safe disposal of waste
- Occupational safety: Prevention and Exposure management (e.g., sharps)

Key elements related to ANTT practice are hand hygiene, safe care of equipment and the environment, appropriate safe use of PPE and waste disposal.

8.2. Hand Hygiene

Hand hygiene is the single most effective way of preventing HCAI and cross infection from direct and indirect contact.[2,9,21] It is essential that hands are effectively decontaminated in accordance with the World Health Organisation (WHO) "MY five Moments of Hand Hygiene"[21] WHO SAVE LIVES Clean YOUR Hands. Technical Reference Manuel 2009 prior to, during (as required) and after all aseptic procedures are performed.

8.3. Use of personal protective equipment (PPE)

Gloves and other PPE provide a barrier between microorganisms on hands, clothing, and the susceptible sites but must be used in conjunction with good hand hygiene and donning and doffing technique.

Gloves use for ANTT:

- Must be donned and used as intended, changed at appropriate frequency and between procedures, and removed with care to prevent shedding or spreading of microorganisms
- Are non-sterile gloves for Standard-ANTT® procedures e.g., preparing and delivering intravenous medication, attaching

parenteral nutrition, venepuncture, and cannulation, as per local policies
- Are Sterile gloves for Surgical ANTT® procedures such as surgery, urinary catheterisation, or central venous catheter insertion

Aprons and Other PPE (aprons, gowns, masks, face protection) should be worn according to NIPCM and associated infection.

8.4. Environmental / Air contamination

Airborne particles in the clinical space will contain a range of microorganisms including those from the patient/service user, staff, and other sources. These have increasingly been shown to present a risk of transmission of a range of infections. Sensible precautions can be taken to reduce the risk of particle contamination of the aseptic site during ANTT procedures including:

- Preparation of drugs to be undertaken in an appropriate designated area away from the bedside and sink
- Where available, ANTT procedures i.e., changing of wound dressings, insertion of medical devices should be undertaken in a dedicated fit for purpose treatment/dressing/examination room away from the patients' bed area
- Do not undertake ANTT® when air particle movement levels are likely to be at their highest e.g., ward/department cleaning, adjacent to portable electric fans or close to open windows or building refurbishment
- Do not undertake ANTT® following recent bed making or patient undressing/dressing
- Advise patient of cough/sneeze etiquette e.g., use of tissues

8.5. Pre-requisite support of effective aseptic technique

The risk of microbiological contamination during ANTT® procedures can be reduced by important pre-requisite measures including:
- Effective environmental cleaning
- Safe storage of procedure equipment
- Compliance with decontamination procedures and policies
- Ergonomically designed clinical preparation areas
- Rationalisation and standardisation of procedure and equipment choices e.g., procedure packs, trays

8.6. Emergency ANTT

For WAST frontline emergency staff, including advanced paramedic practitioners, paramedics, advanced technicians, technicians, urgent care services staff, sub-contracted emergency staff, non-NHS organisations, Bank, and agency frontline staff.

The use of ANTT® is widespread within acute hospitals, yet ANTT's simple but robust practice principles are equally effective in the most challenging

and emergency situations and environments. Emergency life-saving time-critical procedures undertaken in the out of hospital environment justify reason for reduced compliance with all the principles of ANTT® and therefore Emergency ANTT® is the pragmatic approach to ANTT®, focusing specifically on:

- What is possible to deliver at that moment
- Prioritise the points at which 'Key-Parts' and 'Key-Sites' interact (the moments microbes can transfer)
- Dynamic risk assessment to determine preparation steps, and if they cannot be delivered, the most essential components of aseptic technique are prioritised first
- Recording the ANTT applied during the procedure e.g., Standard, emergency, surgical

The intention is not to dilute ANTT® or reduce standards, but to focus the practitioners' attention to the most important elements of safe practice first, in relation to time, setting and equipment permitting.

Emergency ANTT® should only be selected following risk assessment of the situation, for example: 'Do I have the time, the equipment, and the environment to apply Standard or Surgical ANTT?'
If the answer is 'yes' – use Standard or Surgical ANTT If
the answer is 'no' – use Emergency ANTT

It is important for the practitioner to document and handover when emergency ANTT is used and clarify if asepsis was maintained or compromised due to the 'emergency' situation. WAST have introduced the ANTT coded colour labels, which will be applied to any invasive procedures performed to alert receiving staff of ANTT procedures used (see Appendix 7).

9. ANTT Resources

9.1. ANTT® Procedure Guidelines

These simple picture-based procedure guidelines are a highly effective way for the organisation to make practice expectancy explicit, setting out procedure sequence and equipment. They should be displayed prominently in relevant clinical areas.

9.2. ANTT Approach Educational PowerPoint

'The ANTT-Approach' is an International Campaign designed to promote the essential elements of aseptic technique. This approach is a three-way 'partnership' between patients, HCWs and healthcare organisations to actively promote the essential '6 Actions for Safe Aseptic Technique' to be used every time.

Three posters simplify this framework:

- Patient poster – Appendix 3
- Clinical Staff Poster – Appendix 4
- ANTT® Clinical Practice Framework poster – *Appendix 5*

9.3. Steps for ANTT® procedure – see Appendix 2

10. Dissemination and Implementation

This revised and updated policy will be implemented via the following routes:

- Circulation to all Health Board/Trust Executive leads, IPCT leads, WAST leads, Primary & Community Care leads, HCAI DB
- Available via local Health Board/Trust Document library
- Available via PHW/HARP website
- Available to all HCWs via local Health Board/Trust intranet

Each Health Board/Trust is responsible for the full implementation of this revised policy and must ensure all relevant staff have access to the policy.

11. Audit and Monitoring of ANTT® Implementation

Monitoring will be undertaken through:

- The percentage of staff that have completed ANTT® theory and ANTT® Competency Assessments through ensuring records are updated centrally on ESR
- Audit observation of clinical practice and aseptic procedures
- Targeted patient feedback
- Documentation/policy review
- As part of the Improvement Cymru initiatives (Previously known as 1000 plus lives) e.g., bundle use and catheter-associated urinary tract infection (CAUTI) prevention, peripheral venous catheter (PVC) and central venous catheter (CVC) care, prevention of surgical site infection (SSI)
- Identifying impact and compliance levels of ANTT® on investigating HCAI, e.g., *Staphylococcus aureus* bacteraemia or surgical site infection (SSI), CAUTI through root cause analysis (RCA) and post-incident review (PIR)
- Annual IPC rolling programme of audit, including external audit by ASAP or ad hock audits by HARP team
- Target audit programmes, where deemed necessary following incident or outbreak
- Required changes in practice identified and actioned
- ANTT® accreditation

Any 'lessons learnt' should be shared locally and nationally across Wales to support and promote best practice.

12. Policy Conformance / Non-Compliance

If any Health Board employee fails to comply with this policy, the matter may be dealt with in accordance with their workforce and OD polices. The action taken will depend on the individual circumstances and will be in accordance with the appropriate disciplinary procedures. Under some circumstances, failure to follow this policy could be considered gross misconduct.

13. Distribution

The all-Wales policy will be available on the PHW/HARP internet site and via local Health Board/Trust Intranet site. Where staff do not have access to the intranet, their line manager must ensure that they have access to a current paper copy of this policy.

14. Review

This policy will be reviewed every 2 years or if guidance changes.

15. Legislation

The Control of Substances Hazardous to Health (COSHH) Regulations 2002 (as amended), Health and Safety Executive, L5 (6th edition) 2013. Welsh Government Health and Care Standards 201529. The 2023 Health and Social Care (Quality and Engagement) (Wales) Act 2020.[30]

16. Equality

An Equality Impact Assessment has been undertaken at an all-Wales level on completion of version 1 (July 2017), Version 2 review (June 2019) and version 3 review (December 2022) with no change required.

A Verification report has been completed for HARP, Public Health Wales to support version 3 (December 2022).

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18. APPENDICES

Appendix 1: Definitions / Glossary

Asepsis
Freedom from pathogenic material in sufficient dose to cause infection.

Aseptic field
A working area that has been rendered aseptic to reduce the risk of contamination of procedure equipment.

Aseptic Technique
A generic term and variable process for describing the precautions taken to reduce the risk of infection during invasive clinical procedures.

Aseptic Non-Touch Technique (ANTT®)
A specific type of aseptic technique with a unique theoretical and clinical practice framework (NICE 2012).

Decontamination
Removing, or killing pathogens on an item or surface to make it safe for handling, re-use or disposal by cleaning, disinfection and/or sterilisation.

Direct contact transmission
Spread of infectious agents from one person to another by direct skin-to-skin contact.

Disinfectant
A cleaning chemical used to remove infectious agents from objects and surfaces.

Disinfection
A process, for example using a chemical disinfectant, to reduce the number of infectious agents from an object or surface to a level that means they are not harmful to your health.

Hand Hygiene (HH)
HH is the single most important procedure for preventing the spread of HCAI. Effective HH is essential to ANTT® and must take place prior to and after all invasive techniques. HH applies to hand washing, antiseptic hand wash, antiseptic hand rub or surgical hand antisepsis.

Healthcare-associated Infection (HCAI)
Any infection acquired by a person as a consequence of healthcare interventions regardless of where care is delivered.

Indirect contact transmission – The spread of infectious agents from one person to another via a contaminated object.

Invasive device – A device which penetrates the body, either through a body cavity or through the surface of the body. Central Venous Catheters (central line), Peripheral/ Arterial Lines and Urinary Catheters are examples of invasive devices.

Invasive Procedures
A medical/nursing procedure that invades (enters) the body, usually by cutting or puncturing the skin or by inserting instruments into the body cavity.

Microorganism (microbe) – Any living thing (organism) that is too small to be seen by the naked eye. Bacteria, viruses, and some parasites are microorganisms.

Mode of transmission – The way that microorganisms spread from one person to another. The main modes or routes of transmission are airborne (aerosol) transmission, droplet transmission and contact transmission.

MRSA – Strains of the infectious agent (bacterium) *Staphylococcus aureus* that are resistant to many of the antibiotics commonly used to treat infections.

Personal Protective Equipment (PPE)
Equipment a person wears to protect themselves from risks to their health or safety, including exposure to infections e.g., disposable gloves and disposable aprons.

Spore
A form that some types of bacteria take under certain environmental conditions. Spores can survive for long periods of time and are very resistant to heat, drying and chemicals.

Sterile
Free from all live bacteria or other microorganisms.

Sterilisation
The procedure of making some object free of all germs, live bacteria, or other microorganisms (usually by heat or chemical means).

Appendix 2: Steps to an ANTT® procedure

Step 1.	ANTT® risk assessment: Does this procedure need the ANTT® principles applied? Is a Standard or Surgical-ANTT® required? Gain patient's consent and explain procedure Draw curtains around patient or take to appropriate room
Step 2	Decontaminate hands
Step 3	Clean trolley/tray with appropriate detergent wipe Gather equipment including alcohol hand rub
Step 4	Create suitable working environment. If procedure is performed at the bedside, ensure no cleaning or bed making are ongoing within the area for at least 30 minutes. Ensure windows are closed and no fans are on
Step 5	Decontaminate hands
Step 6	Apply single use disposable apron
Step 7	If required open dressing pack/sterile drape
Step 8	Open and prepare all equipment on the tray/trolley. Keep all equipment within their packaging. Identify Key-Parts
Step 9	Decontaminate hands
Step 10	Apply gloves if required
Step 11	Perform procedure using ANTT®
Step 12	Remove gloves and aprons and other PPE
Step 13	Dispose of waste
Step 14	Decontaminate hands
Step 15	Take patient back to the bedside if required and ensure patient is comfortable
Step 16	Clean trolley/tray/environment
Step 17	Decontaminate hands

Appendix 3: ANTT® Patient Poster

ASAP The Association for Safe Aseptic Practice

ANTT® Aseptic Non Touch Technique

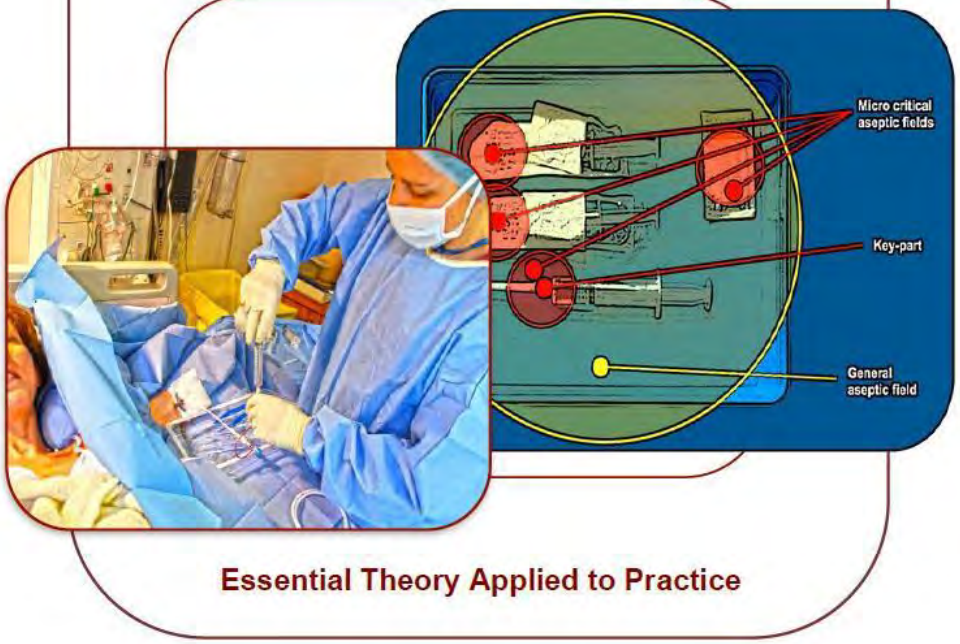
MRSA Action UK

Appendix 4: ANTT® Clinical Staff Poster

Appendix 5: ANTT® Clinical Practice Framework Poster:

ANTT®
Aseptic Non Touch Technique
www.antt.org

Aseptic Non Touch Technique
The ANTT Clinical Practice Framework
...for all invasive Clinical Procedures from Surgery to Community Care



Essential Theory Applied to Practice

First, do no harm

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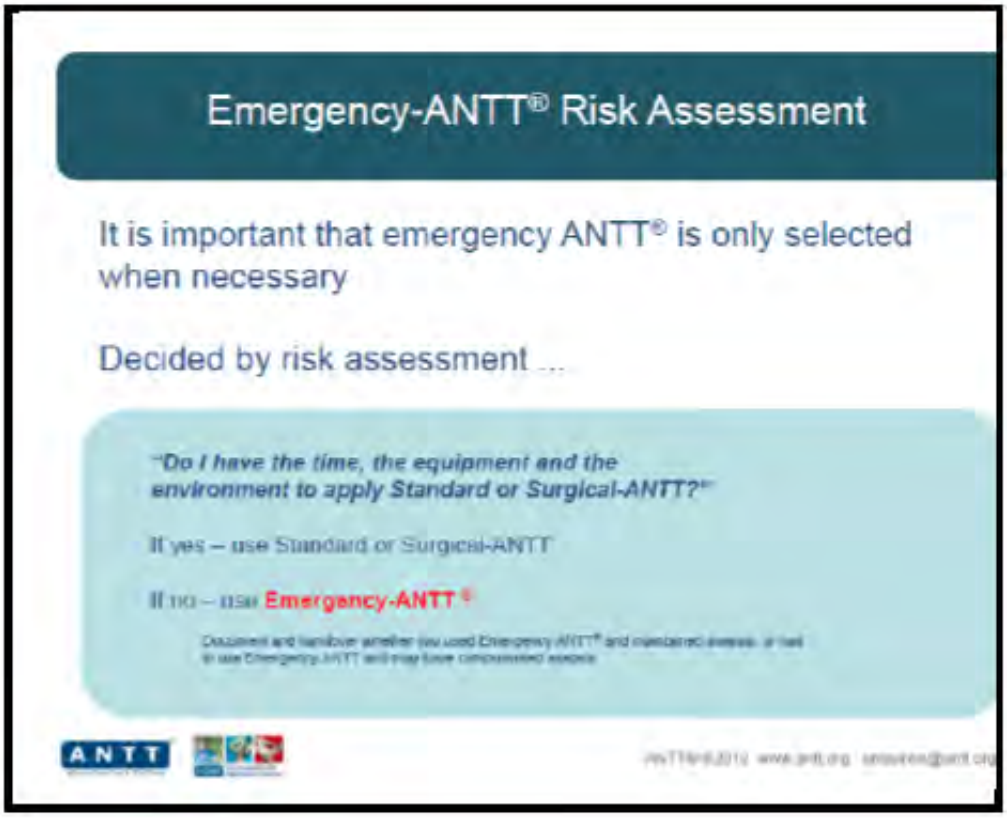
Appendix 6: Example template for Ambulance Staff: Peripheral Cannulation Guideline (2017)

Appendix 7: Emergency ANTT Risk Assessment



Use of colour coded labels to alert receiving healthcare staff of ANTT procedure used:

Red Label applied to the procedure site. **ANTT not performed in optimal conditions. Date.**

Green Label applied to the procedure site. **ANTT performed in optimal conditions. Date.**

Appendix 8: Standard Terminology

Aseptic technique is historically confused with ambiguous terms used interchangeably. The ANTT® Practice Framework defines aseptic practice explicitly:

- *Sterile Technique*

ANTT® does not use the word "sterile" for describing technique; due to the natural multitude of organisms in the atmosphere, it is not possible to achieve a true sterile technique in any setting. The term sterilized is used to identify products and equipment that have been sterilized. However, once opened to air equipment and products are said to be aseptic.

- *Asepsis / Aseptic technique*

The term 'asepsis' means, '*Freedom from pathogenic material in sufficient quantity to cause infection'*. It is possible to achieve asepsis in health care delivery by taking steps to reduce patient contamination. Aseptic technique is a generic term for aseptic practice and has no explicitly defined practice framework.

- *Aseptic Non-Touch Technique (ANTT®)*

ANTT® is a specific type of aseptic technique with a unique theoretical and clinical practice framework.[10,11,12] The ANTT® Practice Framework includes a set of Principles and Safeguards that, if followed, will ensure asepsis for all types of invasive procedures 'from the operating theatre to the community setting'. It is based on a novel concept termed 'Key-Part and Key-Site Protection'.

The 'ANTT-Approach' involves a combination of methods aimed at achieving and supporting best practice aseptic technique; including the ANTT® Practice Framework, a set of ANTT® Guidelines for the most common invasive procedures and a standard implementation process.

- *Non-Touch Technique*

Non-touch technique is not a technique in itself. It is however an important component of ANTT®.

Appendix 9: ANTT® Practice Framework outline

This model policy is not intended as an educational tool for ANTT®. It is important that Practice Leads refer to the full ANTT® Practice Framework available on the www.antt.org or Public Health Wales on ANTT Framework
A snapshot of the framework is outlined below:

- The aim of ANTT® is always asepsis (see appendix 8)

- Key-Parts are the critical parts of any equipment that come into contact with Key-Sites; any liquid infusion; or with any other active Key-Parts connected to the patient via a medical device. If contaminated during a procedure, Key-Parts provide a route for the transmission of pathogens onto or into the patient and present a significant infection risk.

- Key-Sites: open wounds, including insertion and puncture sites for invasive medical devices.

- There are two types of ANTT® (Surgical and Standard) determined by a simple ANTT® Risk Assessment:

- Standard-ANTT® is used for procedures that are technically simple to achieve asepsis. Typically, such a procedure will be of short duration and involve few small Key-Parts and Key-Sites. In Standard-ANTT, primarily non-touch technique and individual Micro Critical Aseptic Fields protect Key-Parts.

- Surgical-ANTT® is required for procedures that are technically complex to achieve asepsis, are of longer duration, involve large open-sites and large or numerous Key-Parts. In contrast to Standard-ANTT, in Surgical-ANTT, Key-Parts are managed on one main Critical Aseptic Field (sterile drape) and sterile gloves are essential.

- Aseptic Fields in ANTT®: the type of aseptic field and how it is managed is dependent upon the type of ANTT® being utilized.

ANTT® uses three types of aseptic field:

✓ Critical Aseptic Field: a large sterile drape that is managed 'critically'
✓ Micro Critical Aseptic field: sterilized caps and covers etc. including the inside of some equipment packaging
✓ General Aseptic Field: A disinfected plastic tray, suitable sized single-use cardboard tray. NB: General Aseptic Fields are not relied upon to maintain asepsis. They are used to promote asepsis whilst Key-Parts within them are protected by Micro Critical Aseptic Fields. (See above).

A pre-requisite to safe ANTT® is compliance with standard infection prevention and control precautions:

ADDENDUM to the 2023 Model Policy: Aseptic Non-Touch Technique (ANTT®) – Interim Adoption of ANTT® Clinical Practice Framework v6.4 (2024)

Effective Date: June 2025

Review date: To be aligned with the next scheduled review of the Model Policy or upon national policy update.

Purpose:
This addendum provides interim guidance to incorporate the updated ANTT® Clinical Practice Framework v6.4 (2024) ANTT Framework v6.4 into local practice, ensuring alignment with the most current evidence-based standards while awaiting formal national policy revision.

Background:
The Association for Safe Aseptic Practice (ASAP) released the ANTT® Clinical Practice Framework v6.4 in 2024. This version provides enhanced clarity, updated terminology, and a more robust clinical governance model for aseptic technique. It is internationally recognised and aligns with the principles of the 2023 Model Policy.

Scope:
This addendum applies to all healthcare professionals and support staff involved in aseptic procedures across Velindre University NHS Trust. It supplements the 2023 Model Policy and should be read in conjunction with it.

Key Interim Updates:
The following elements from the ANTT® Framework v6.4 are to be adopted immediately:

- Terminology Alignment: Use of updated and standardised terms (e.g., avoid "sterile technique"; use "Surgical-ANTT" and "Standard-ANTT").
- Risk Assessment Tool: Apply the ANTT® Risk Assessment model (Framework Fig. 6) to determine the appropriate technique.
- Clinical Governance: Adopt the "4 C's" model (Concern, Clarity, Competency, Compliance) to strengthen local governance.
- Aseptic Field Management: Follow the updated definitions and use of Critical, Micro Critical, and General Aseptic Fields.
- Procedure Guidelines: Refer to the latest ANTT® Procedure Guidelines available at www.antt.org or via local intranet.
- Hand Hygiene and Environmental Controls: Reinforce the updated rationale and evidence base for environmental hygiene and hand decontamination.

Implementation:

- All departments must review local procedures and training materials to ensure alignment with the Framework v6.4.
- Key trainers and ANTT® leads should incorporate the updated framework into competency assessments and audits.
- Staff should be made aware of the changes via internal communications, training sessions, and posters.

Monitoring:

- Compliance with this addendum will be monitored through existing audit mechanisms.

National Infection Prevention & Control Manual (NIPCM)

1. SITUATION/BACKGROUND

The NIPCM was first published on 13 January 2012, by the Chief Nursing Officer (CNO (2012)1), and updated on 17 May 2012 (CNO(2012)01-update).

As highlighted in the Welsh Health Circular (WHC/2018/20), Healthcare organisations are required to reduce the burden of antimicrobial resistance and healthcare associated infections and improve the quality of patient care through embedding infection prevention and control practices in everyday activity including more prudent and effective antimicrobial prescribing.

Model policies for Infection Prevention and Control for Standard Infection Control Precaution Precautions and Transmission-based Precaution Policies previously developed by Public Health Wales have been superseded by the adoption of the Scottish National Infection Control Manual (NICM). Public Health Wales have teamed up with NHS Scotland to host and utilise the electronic NIPCM to ensure all healthcare organisations in Wales have access to consistent, current, and standardised policies to support practice.

The e-manual has been adopted for use by all healthcare organisations and is based on systematic reviews of literature and policies from Health Protection Scotland. The recommendations for practice made in the NIPCM are based on real-time reviews of the current scientific literature (for example Medical Journals) and best practice. Any major changes identified in the scientific literature may lead to a change being made to the NIPCM.

Link to the manual:
https://phw.nhs.wales/services-and-teams/harp/infection-prevention-and-control/nipcm/

It is a practice guide for use in Wales. When used, it helps reduce the risk of Healthcare Associated Infection (HAI) and ensure the safety of those in the care environment – those being cared for, as well as staff and visitors.

2. POLICY AIMS

It aims to:

- make it easy for care staff to apply effective infection prevention and control precautions
- reduce variation, promote standardisation, and optimise infection prevention and control practices throughout Wales
- help reduce the risk of HAIs
- help align practice, monitoring, quality improvement and scrutiny

The NIPCM is an evidence-based manual which is intended for use by all those involved in care provision. The manual contains information on:

- Chapter 1 Standard Infection Control Precautions (SICPs)
- Chapter 2 Transmission Based Precautions (TBPs)
- Chapter 3 Healthcare Infection incidents, outbreaks, and data exceedance
- Chapter 4 Infection Control in the Built Environment and Decontamination

It is planned to further develop the content of the manual.

It is a practice guide for use in Wales which can help reduce the risk of Healthcare Associated Infection (HCAI) and ensure the safety of those being cared for, staff and visitors in the care environment.
It aims to:

- Make it easy for care staff to apply effective infection prevention and control precautions.
- Reduce variation and optimise infection prevention and control practices throughout Scotland.
- Help reduce the risk of Healthcare Associated Infection (HCAI).
- Help align practice, monitoring, quality improvement and scrutiny.

WHAT IS IN THE APPENDICES?

The Appendices can be used as practical implementation of the NIPCM and contain graphical representations (for example, diagrams and charts) that can be used along with the contents of the NIPCM. Many of the Appendices can be printed off as posters for local use.

3. EQUALITY IMPACT ASSESSMENT

This policy has been screened for relevance to equality. No potential negative impact has been identified.

Ref: IPC 10

Hand Hygiene Policy

Executive Sponsor & Function	Executive Director of Nursing, Allied Health Professionals & Healthcare Scientists
Document Author:	Infection Prevention and Control
Approved by:	Quality, Safety and Performance Committee
Approval Date:	11 September 2025
Date of Equality Impact Assessment:	June 2025
Equality Impact Assessment Outcome:	This policy has been screened for relevance to equality. No potential negative impact has been identified.
Review Date:	September 2028
Version:	7

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ABBREVIATIONS

ABHR	Alcohol based hand rub
ANTT	Aseptic Non Touch Technique
BBE	Bare below the elbow
COSHH	Control of Substance Hazardous to Health
HCAI	Healthcare associated infection
HCW	Healthcare worker
IPC	Infection prevention and control
IPCT	Infection Prevention and Control Team
IPCMG	Infection Prevention and Control Management Group
SCIPs	Standard Infection Control Precautions
WBS	Welsh Blood Service
WHO	World Health Organization

1 POLICY STATEMENT

1.1 The term hand hygiene used in this document refers to all of the processes, including hand washing and hand decontamination achieved using other products, e.g. alcohol-based hand rub (ABHR).

1.2 It is Velindre University NHS Trust policy to promote, provide and maintain a healthy and safe environment for the employees, patients, donors and visitors. The Trust's aim is therefore to promote hand hygiene within the clinical environment, in order to reduce the number of HCAIs to an absolute minimum, thus promoting patient safety via a zero tolerance to non-compliance or poor practice.

1.3 This policy aims to provide evidence-based guidance that will identify the responsibilities individuals, the correct application of the procedure and compliance requirement.

2 SCOPE OF POLICY

The policy applies to all staff, in all locations of Velindre University NHS Trust, including those with honorary contracts and student placement.

3 AIMS AND OBJECTIVES

3.1 The aim of this policy is to provide comprehensive guidance on all aspects of hand hygiene to help prevent the spread of HCAI. Objectives include:

- Identifying correct provision of facilities
- Use and provision of appropriate products
- Required level of education and training for Trust staff, patients, donors and visitors
- Managers accountabilities and responsibilities
- Necessary monitoring of compliance through audit and reporting
- Use of quality improvements methods to improve and maintain hand hygiene compliance
- Description of the required processes
- Importance and responsibility of healthcare workers (HCWs) to decontaminate hands at the point of care in the reduction of HCAI.

4 RESPONSIBILITIES

It is the responsibility of every member of staff working in the health care setting to ensure adequate hand hygiene is performed where appropriate

4.1 The Chief Executive

The Chief Executive has overall responsibility to ensure this policy is adhered to while the operational authority for appropriate and timely hand hygiene practice lies with the individual user and clinical/departmental managers. Compliance will be measured using observations and audits.

4.2 Director of Nursing, AHP's & Healthcare Scientists

The Director of Nursing, AHP's & Healthcare Scientists has delegated Executive responsibility for Prevention and Control of Infection and is accountable for this to the Trust Executive Management Board. These responsibilities include ensuring that the organisation receives competent infection prevention and control advice and that adequate Infection Prevention and Control training, and monitoring is in place. This includes Hand Hygiene.

4.3 Departmental Managers/ Clinical Directors / Clinical Managers

Departmental Managers, Clinical Directors and Clinical Managers are accountable and responsible for:

- Ensure that all staff receive annual instruction/education on the principles of hand hygiene and SICPs.
- Ensure that an up-to-date, evidence-based hand hygiene policy is easily available to all staff.
- Maintain accurate and up to date training compliance records.
- Monitoring compliance with this policy and taking immediate corrective action if non-compliance is identified.
- Ensure participation in surveillance and audit programmes at local level and provide active support for presentation and improvement of hand hygiene compliance results.
- Monitoring and enforcing Bare Below Elbow (BBE) standards in all clinical settings at all times.
- Ensuring there are sufficient, trained and competent hand hygiene champions within departments who can ensure staff remain compliant with training, training is recorded on ESR, and monthly compliance audits are undertaken.
- Ensuring that adequate resources are in place for hand hygiene. This includes liaison with the estates and operational services teams.
- Providing sufficient approved hand decontamination products including paper towels, liquid soap, alcohol sanitiser and skin moisturiser.
- Making hand hygiene facilities readily available for all to use.
- Undertake a risk assessment to optimise patient/ donor and staff safety, consulting expert infection prevention and control guidance if/ as required related to application of this policy.
- Support staff to correct any action or intervention that may have resulted in transmission of infection.
- Ensure any staff with hand health concerns, including any skin irritation related to occupational hand hygiene or those who have become ill due to occupational exposure are appropriately referred e.g. Occupational Health, health and safety manager in the first instance.
- Health and Safety should be informed where the cause is considered to be work related since it may require reporting under RIDDOR.
- Ensure posters featuring when and how to perform hand hygiene are displayed.
- Ensuring appropriate use of gloves.

4.4 All staff – (providing direct care in a health care setting) must:

- Apply the principles of SICPs. All staff have a responsibility to ensure that they undertake adequate hand hygiene and encourage others who have patient contact to do so.
- Ensure all other staff/agencies apply the principles of SICPs.
- Explain to patients, donors and visitors any infection control requirements such as hand hygiene.
- Encourage patients, donors and visitors to question lack of hand hygiene by HCWs.
- Always practice the 5 moments of hand hygiene.
- Always remain bare below elbow within clinical areas.
- Always practice hand hygiene in line with required standards.
- Understand and apply the principles in this policy.
- Attend mandatory or update infection prevention and control education sessions.
- Highlight to colleagues any breaches in hand hygiene practices observed.
- Communicate the hand hygiene/ infection prevention and control practices to be carried out by colleagues, those being cared for, relatives and visitors, without breaching confidentiality.

- Do not provide care while at risk of transmitting infectious agents to others; if in doubt, they must consult their line manager, occupational health department, infection prevention and control team (IPCT) or health protection team.
- Encourage patients/ donors/ visitors to decontaminate their own hands appropriately.
- Provide patients with opportunities and supplies for hand hygiene after using toilets, before and after eating or drinking.
- Report to their manager inadequate facilities, equipment or products and deficits in their own knowledge or training.
- Report any incidents of non-compliance with hand hygiene that may have resulted in cross contamination.
- Report any illness which may be as a result of occupational exposure, to the line manager and the occupational health department (if applicable).
- Not provide direct patient/ donor care while infectious as this could cause harm. If in any doubt consult with your manager, General Practitioner, occupational health department or IPCT.
- Consider the elements of SICPs such as hand hygiene as an objective within staff continuing professional development ensuring continuous updating of knowledge and skills. Be aware of, and participate in, hand hygiene campaigns.
- Staff must inform managers immediately if their hands become sore or dermal integrity is breached.

4.5 Infection Prevention and Control Team (IPCT) will:

- Provide expert proactive and reactive information and advice to staff, patients, donors, relatives and carers in respect of healthcare associated infections and hand hygiene.
- Ensure the effective auditing of infection prevention practices, including hand hygiene.
- Review the hand hygiene policy in line with national guidelines.
- Review, in collaboration with others, the status of the environment including facilities for promoting and supporting effective hand hygiene.
- Facilitate IPC champions, ensuring they are empowered to continually raise the standards of infection prevention and control, including hand hygiene.
- Ensure training is available for all groups of staff. Set the training and education standards for hand hygiene and ensure delivery of a robust train the trainer programme for hand hygiene.
- Act as a contact for guidance and support when advice relating to hand hygiene is required.
- Investigate incidents of non-compliance relating to hand hygiene.
- Undertake regular validation hand hygiene audits within the Trust and feedback audit results to managers within a timely manner.
- Ensure compliance with the principle of bare below the elbow forms part of the IPC hand hygiene audit and will be included in audit feedback.
- Provide support and advice to staff on maintaining good hand skin health (Appendix 3).
- Provide advice on individual risk assessments for performing hand hygiene and the site and provision of ABHR.
- Provide advice on the provision, type and site of hand wash sinks and facilities.
- Provide support to departmental hand hygiene champions so that they can audit staff adherence to hand hygiene and BBE.
- Provide support on the wards/ departments to monitor standards and compliance, identifying areas of concern and risk, and escalating concerns so that appropriate management action can be taken to maintain the highest standards via the divisional IP&C Groups or Trust Infection Prevention Control Management Group (IPCMG) as necessary.

4.6 Patient, Donor and Visitor, involvement

Patients, donors and visitors should be seen as partners in good hand hygiene practice though they are not the responsible for HCAI reduction. Therefore:

- Patients must be offered the opportunity to decontaminate their hands as they require but especially on arrival at clinical areas and after toileting and before and after consumption of food or drink.
- Those with invasive devices insitu should be encouraged to clean their hands frequently and be advised not to touch these sites whilst the devices are in place.
- Relatives and visitors should be given the opportunity and be actively encouraged to decontaminate their hands, either by washing with soap and water or ABHR:
    - Before/upon and after entering clinical areas
    - Before and after visiting patients in isolation
    - Before and after participating in any form of patient care or contact
    - When leaving the ward or department
- Hand hygiene compliance data should be displayed for patients, visitors and donors to view in the clinical areas.

4.7 Distribution

The policy will be available via the Trust intranet site and from the IPCT. Where the staff do not have access to the intranet their line manager must ensure that they have access to a copy of this policy.

5 DEFINITIONS

Hand hygiene - aims to remove transient micro-organisms carried on the hands (acquired by direct contact with the environment and/or with other people) and/or reduce resident micro-organisms (living permanently on the hands as part of normal flora).

Bare Below Elbow - is Welsh Government national standard requirement to improve the effectiveness of hand hygiene performed by HCWs. The effectiveness of hand hygiene is improved when: skin is intact, nails are natural, short and unvarnished; hands and forearms are free of jewellery (with the exception of a plain wedding band) and sleeves are above the elbow.

6 IMPLEMENTATION/POLICY COMPLIANCE

6.1 Best Practice

Hand hygiene is considered the most important practice in reducing the transmission of infectious agents that cause HCAIs.

Hand washing sinks must only be used for hand hygiene and must not be used for the disposal of other liquids.

6.1.1 Before performing hand hygiene

- Expose forearms (BBE).
- Remove all hand and wrist jewellery (a single, plain metal finger ring is permitted but should be removed (or moved up) during hand hygiene.
- Bracelets or bangles, such as the Kara which are worn for religious reasons, should be able to be pushed higher up the arm and secured in place to enable effective hand hygiene which includes the wrists.
- Ensure fingernails are clean and short, and do not wear artificial nails or nail varnish/ gel.
- Cover all cuts or abrasions with a waterproof dressing.

6.1.2 When to perform hand hygiene

Hand hygiene is considered the single most important infection control activity in all clinical or care settings.

Hands should be decontaminated at a range of times in order to prevent HCAI. The most important times during care delivery and daily routines when this should occur are described in **'5 moments for Hand Hygiene'**.

- Before patient contact (and before entering an isolation room)
- Before a clean / aseptic task is undertaken.
- After body fluid exposure risk
- After patient contact
- After contact with the patient environment (and before leaving an isolation room)

Even if gloves have been worn, hand hygiene **must** be performed before and after donning & doffing gloves. Hands can still become contaminated whilst wearing or on removal of gloves, and so must be cleaned appropriately.

It should also be noted that hand hygiene will have to be performed **between tasks on the same patient.**

The point of care is the crucial moment for hand hygiene. The point of care represents the time and place at which there is highest likelihood of transmission of microorganisms from the hands of HCW's to patients and donors.

In addition to the critical moments there are situations/occasions where hand hygiene should be performed to reduce the risk to patients/ donors and HCWs. Examples of additional situations when hands must be decontaminated are:

- Before commencing work/after leaving a work area.
- Before preparing, handling or eating food.
- Before and after handling/administering medicines.
- Before entering/ leaving laboratory area.
- Between tasks on the same patient if there is a risk of contamination from one site to another.
- Following handling of patient notes or equipment.
- After handling contaminated laundry and waste, including sluice room activities.
- After visiting the toilet.
- Before and after leaving isolation rooms/bays.
- After cleaning equipment or the environment.
- Personal contamination e.g. blowing your nose, sneezing/coughing into your hand.
- After removing personal protective equipment including gloves.
- Ensure any cuts / broken skin are covered with a waterproof dressing.

Wash hands with liquid soap and water if:

- Hands are visibly soiled or dirty.
- Caring for patients with vomiting and/ or diarrhoea.
- Where infection with a spore forming organism e.g. *Clostridioides difficile* or with a gastroenteritis virus e.g. Norovirus is suspected/proven, hand hygiene must be carried out with liquid soap and water although it can be followed by ABHR. In all other circumstances, use ABHRs for routine hand hygiene during care. Where running water is unavailable, or hand hygiene facilities are lacking, staff may use hand wipes followed by ABHR and should wash their hands at the first opportunity.

For how to wash hands, see Appendix 1.
For how to hand rub, see Appendix 2.

6.1.3 Hand hygiene and jewellery

It has been shown that contamination of jewellery, particularly rings with stones and/or jewellery of intricate detail, can occur (Trick et al 2013, epic 3, 2014). Jewellery must be removed when working in clinical care settings to prevent the spread of microorganisms by contact with contaminated jewellery.

- Staff providing care and those in the clinical setting must remove jewellery at the start of the working day.
- It is acceptable to wear plain wedding bands however these must be moved/removed when hand hygiene is being performed in order to reach the bacteria which can harbour underneath them and dried effectively.
- Medi Alerts for staff where possible should not be in the form of bracelets due to the potential impact to hand hygiene

The wearing of plaster casts or splints can affect hand washing therefore the staff member cannot decontaminate their hands effectively and should not be undertaking clinical duties. A risk assessment with the manager and occupational health is required for staff working in clinical areas.

6.1.4 Hand care

Hand care is important to protect the skin from drying and cracking. Cracked skin may harbour microorganisms and broken areas can become contaminated, particularly when exposed to blood and body fluids. The frequent use of some hand hygiene agents may cause damage to the skin and alter normal hand flora. Skin damage and dryness is generally associated with the detergent base of the preparation and/ or poor hand washing technique e.g. application of soap to dry hands, or inadequate rinsing of soap from the hands. The irritant and drying effects of liquid soap and antiseptic soap preparations have been identified as one of the reasons why HCWs fail to adhere to hand hygiene guidelines (epic 3, 2014) (Appendix 3).

- Hand moisturiser can be applied to care for the skin on hands. However, only individual tubes of hand moisturiser for single person use or hand moisturiser from wall mounted dispensers should be used. Communal tubs must be avoided as these may contain bacteria over time, and lead to contamination of hands. Moisturisers used should not affect the action of hand hygiene products or the integrity of gloves.
- Adequate hand drying plays a critical step in the hand hygiene procedure by removing any remaining residual moisture that may facilitate transmission of microorganisms. Hands that are not dried properly can become dry and cracked, leading to an increased risk of harbouring microorganisms. Dry hands thoroughly after hand washing, using disposable paper towels.
- Report any skin problems and/ or sensitivities to the hand decontamination products supplied to your Manager and Occupational Health in order that appropriate skin care can be undertaken and the risks of harbouring microorganisms while providing care for others can be avoided.

6.1.5 Surgical hand antisepsis

Surgical scrubbing/ rubbing applies to those undertaking surgical and some invasive procedures. The most commonly used products contain Chlorhexidine gluconate or povidone-iodine. Products containing these agents act by lifting transient micro-organisms from the skin and destroying both transient and some resident micro-organisms. These should be used when a prolonged reduction in numbers of resident flora is required for invasive procedures (surgical aseptic non touch technique (aseptic non touch technique

(ANTT®)) requiring maximal sterile barrier precautions, e.g. central line insertion, surgery etc.).

- Perform surgical scrubbing/ rubbing before donning sterile theatre garments or at other times, e.g. before inserting central vascular access devices.
- Remove all hand and wrist jewellery.
- Single-use nail brushes must only be used for decontaminating nails.
- ABHR can be used between surgical procedures if licensed for this use.

Follow the technique in Appendix 5 for surgical scrubbing.
Follow the technique in Appendix 6 for surgical rubbing.

6.2 Bare below the elbow (BBE)

All staff will adopt a "bare below the elbows" dress code whenever they are engaged in a direct patient/ donor care activity (All Wales NHS Dress Code), to ensure adequate hand hygiene can be performed when working in clinical areas. This will allow hands to be decontaminated easily and thoroughly.

- Remove all wrist watches, wrist and hand jewellery (with the exception of a plain wedding ring) at the beginning of each clinical shift before regular hand decontamination begins.
- Staff should not wear rings with ridges or stones as they harbour bacteria and interfere with the wearing of gloves (rings may also provide a site for contact dermatitis).
- If a plain metal wedding ring is worn; these must be moved/remove when performing hand hygiene in order to reach bacteria which can harbour underneath it.
- Ensure nails are kept short (nail varnish, gel or false nails must not be worn).
- Work clothes should not go past the elbow. Coats should be removed, and long sleeves should be rolled up exposing the wrists and elbows.
- The wrists should be included when washing the hands; forearms should be included if they have been contaminated.
- Ensure cuts and abrasions are covered with a waterproof dressing.

All staff should be prepared to approach their colleagues if they are not complying with BBE.

6.3 Hand hygiene facilities

In order to reduce the associated risks of Legionellosis and *Pseudomonas aeruginosa* contamination a hand wash sink/ basin should only be used for that purpose (Appendix 6) ABHR will be supplied and used in accordance with the World Health Organization (WHO) and:

- Will be available at the point of care and either free standing for use on trolleys or wall mounted sited at key points in all clinical environments.
- Will be available at entrances to all clinical environments and in areas within the facility which have been risk assessed as safe from theft or misuse e.g. canteen entrance, key entry points of the building or department that are observed.
- Wall mounted containers will be kept clean as per operational cleaning schedule with particular attention paid to the outlet nozzle to prevent build-up of product.
- ABHR supplies must be stored in accordance with COSHH regulations.
- Patients unable to wash their hands should be offered assistance to do so, especially after toileting and before eating. This can be aided by the use of hand wipes available within the clinical areas.

6.4 Hand hygiene supplies

The availability of supplies for hand hygiene is essential.

- Hand hygiene products (e.g. liquid soap, antiseptic hand wash solution and ABHR), should preferably be wall mounted in easy to use, and easy to clean, dispensers that contain single use, disposable cartridge sets, particularly in clinical or communal care areas. In some non-acute community care settings free standing bottles of liquid soap are acceptable.
- Wall mounted moisturising cream should be available in all clinical areas.
- Nozzles of solution bottles/containers should always be clean and free of any congealed product. Bottles should not be reused and the 'topping up' of bottles that contain solutions should not occur.
- Soft, user friendly disposable paper towels for hand drying, dispensed from a wall mounted, easy to use clean holder.
- Supplies of paper towels and other hand hygiene supplies should always be stored in a clean dry area prior to use.
- Foot operated waste bins must be available at point of hand hygiene.
- Estates and operation services staff are important partners in ensuring that hand hygiene facilities are adequate and that supplies are mounted appropriately.
  Any issues with the hand hygiene supplies should be brought to the attention of operational services manager.

6.5 General Good Practice

- Effective communication between all members of the health care team is imperative for patient safety.
- Health and safety issues, related to staff, patients/ donors and visitors should also be considered in relation to products used for hand hygiene, e.g. drips or spillages from ABHR and any risks of slips, falls or ingestion of products. Risk assessments should be carried out locally to highlight/manage relevant issues.
- Control of Substances Hazardous to Health (COSHH) and product data sheets should be referred to in order to ensure safe use of/exposure to products being used for hand hygiene.

6.6 Maintaining quality

Velindre University NHS Trust actively supports the WHO 5 Moments (Appendix 7) and other initiatives to improve and maintain standards of hand hygiene. Promotional materials produced by the Trust must be visible in all clinical areas and clearly displayed. Staff should act as role models and be able to demonstrate on-going commitment to hand hygiene.

Observational audits of compliance utilising validated audit tools e.g. WHO 'Your 5 moments for hand hygiene' (Appendix 7) are carried out by departmental staff and Welsh Blood Service (WBS) teams overseen and trained by the IPC team. The IPC team process and feedback the observational audit results at both Velindre Cancer Centre & WBS on a monthly basis. Audits of hand hygiene facilities and BBE are undertaken by the IPCT and WBS team and are reported via the Infection Prevention and Control Management Group (IPCMG). Departmental audits are undertaken and fed back through divisional IPC meeting in both WBS and VCC, as are IPCT validation audit results, and then to IPCMG. Results for VCC are also uploaded onto the Trust Performance Dashboard.

As a quality indicator, poor compliance will be highlighted and an action plan for improvement agreed with the manager of the area.

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8 GETTING HELP

8.1 Further information and support

Velindre IPCT: 02920196129

9 RELATED POLICIES

This policy should be read in conjunction with:

- All Wales NHS Dress Code https://www.gov.wales/sites/default/files/publications/2019-03/all-wales-nhs-dress-code-free-to-lead-free-to-care.pdf

- National Infection Prevention and Control Manual. Available at https://phw.nhs.wales/services-and-teams/harp/infection-prevention-and-control/nipcm/

10 INFORMATION, INSTRUCTION AND TRAINING

10.1 Training

- All staff working in clinical areas need to be trained in hand hygiene.

11 MAIN RELEVANT LEGISLATION

- The Health and Social Care Act. (2008) 'Code of Practice for the NHS on the Prevention and Control of Health Care Associated Infections and Related Guidance'. 2015 update. Department of Health.

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Appendix 1 – How to Wash Your Hands

How to Handwash?

WASH HANDS WHEN VISIBLY SOILED! OTHERWISE, USE HANDRUB

Duration of the entire procedure: 40-60 seconds

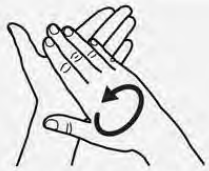
0

Wet hands with water;

1

Apply enough soap to cover all hand surfaces;

2



Rub hands palm to palm;

3

Right palm over left dorsum with interlaced fingers and vice versa;

4

Palm to palm with fingers interlaced;

5

Backs of fingers to opposing palms with fingers interlocked;

6

Rotational rubbing of left thumb clasped in right palm and vice versa;

7

Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;

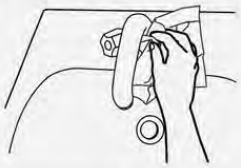
8

Rinse hands with water;

9

Dry hands thoroughly with a single use towel;

10



Use towel to turn off faucet;

11

Your hands are now safe.

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WHO acknowledges the Hôpitaux Universitaires de Geneve (HUG), in particular the members of the Infection Control Programme, for their active participation in developing this material.

Appendix 2 – How to use Alcohol Handrub

How to Handrub?

RUB HANDS FOR HAND HYGIENE! WASH HANDS WHEN VISIBLY SOILED

Duration of the entire procedure: 20-30 seconds

1a

1b

Apply a palmful of the product in a cupped hand, covering all surfaces;

2

Rub hands palm to palm;

3

Right palm over left dorsum with interlaced fingers and vice versa;

4

Palm to palm with fingers interlaced;

5

Backs of fingers to opposing palms with fingers interlocked;

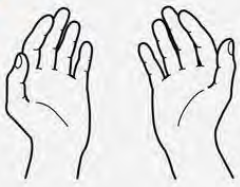
6

Rotational rubbing of left thumb clasped in right palm and vice versa;

7

Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;

8



Once dry, your hands are safe.

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May 2009

Appendix 3 - Hand Health and Skin Care

Care is required to protect the hands from the adverse effects of hand decontamination practice. The frequent use of some hand hygiene agents may cause damage to the skin and alter normal hand flora. Skin damage and dryness is generally associated with the detergent base of the preparation and/or poor hand washing technique e.g. application of soap to dry hands, or inadequate rinsing of soap from the hands. The irritant and drying effects of liquid soap and antiseptic soap preparations have been identified as one of the reasons why HCWs fail to adhere to hand hygiene guidelines (epic 3, 2014).

In order to achieve effective hand hygiene, it is important to look after the skin and fingernails. Sore hands are associated with increased colonisation by potentially pathogenic micro-organisms and increase risk of transmission. Damaged or dry skin leads to loss of a smooth skin surface and increases the risk of skin colonisation with resistant organisms such as Meticillin-resistant *Staphylococcus aureus* (MRSA). Continuing damage to the skin may result in cracking and weeping, exposing the HCW to increased infection risk, which can lead to sickness absence due to dermatitis.

Skin care, through the appropriate use of hand lotion or moisturisers added to hand hygiene preparations, is an important factor in maintaining skin integrity, encouraging adherence to hand decontamination practices and assuring the health and safety of HCWs. Only use the products available in the clinical areas, as these have been specifically designed not to interact with the soaps and ABHR.

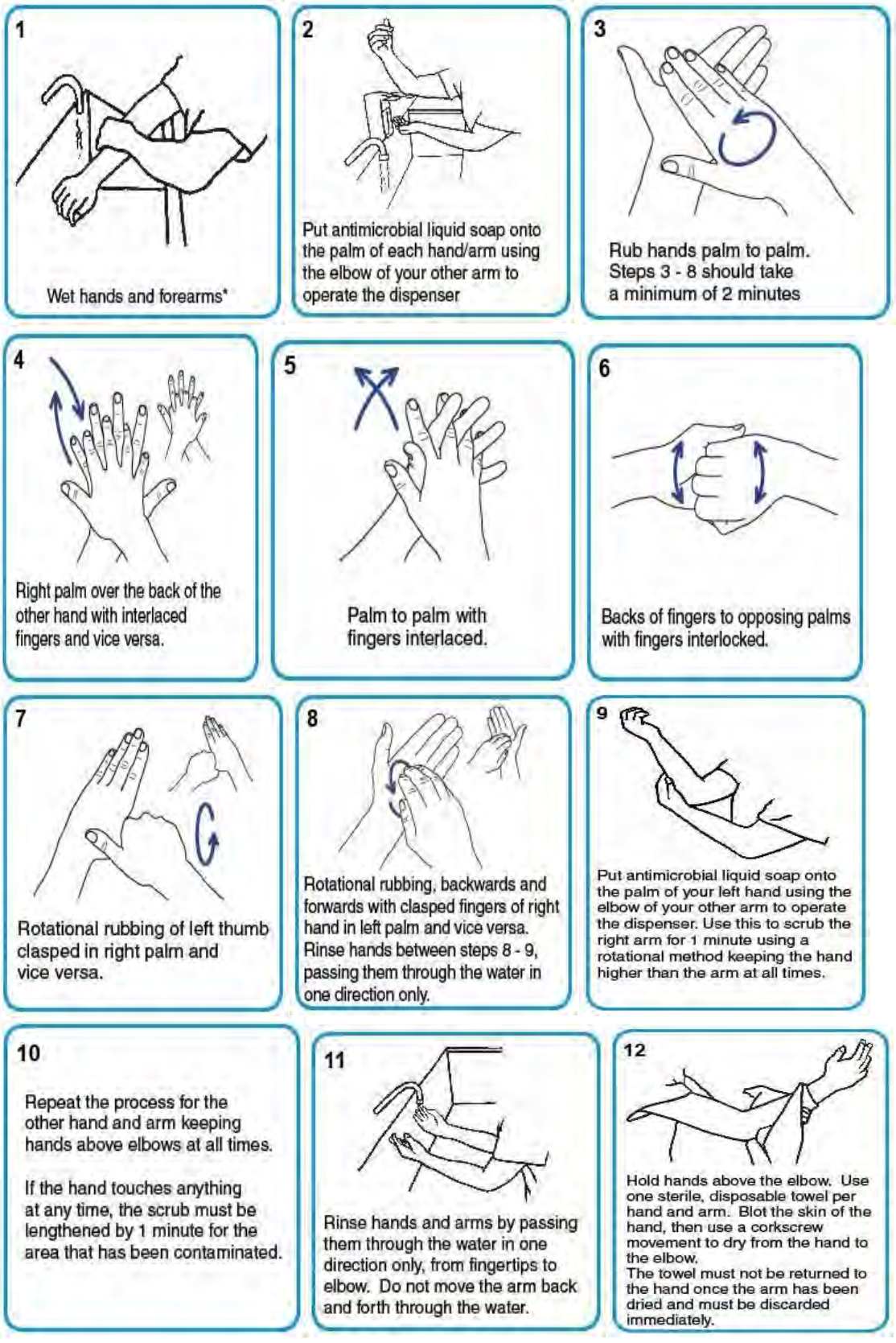
To maintain skin health:

- It is essential that only approved soap products are used, and that staff carefully follow correct hand hygiene techniques.
- Drying (pat don't rub etc.)
- Use ABHR containing an emollient.
- Staff with acute or chronic skin lesions/conditions/reactions or possible dermatitis **must** seek advice from the Occupational Health Department at the time that they have the problem.
- Cuts and abrasions must be covered with a water-impermeable dressing, prior to clinical contact.
- All clinical areas must ensure that adequate supplies of wall-mounted moisturiser are available for staff use. This is more cost-effective than sickness-absence due to damaged skin.
- Staff should regularly use moisturiser to maintain skin integrity. The most effective use of moisturiser is before breaks and at the end of a shift, when it can be left on the hands for a greater period of time.
- Use gloves appropriately and change frequently.

Appendix 4 – Surgical Scrubbing

Step by step images for surgical hand preparation technique using antimicrobial soap

Undertake Appendix 1 prior to starting scrub.



Appendix 5 – Surgical Rubbing

Appendix 4: Surgical Rubbing

The hand rubbing technique for surgical hand preparation must be performed on clean, dry hands.

On arrival in the operating theatre and after having donned theatre clothing (cap/hat/bonnet and mask), hands must be washed with soap and water.

After the operation when removing gloves, hands must be rubbed with an alcohol-based formulation or washed with soap and water if any residual talc or biological fluids are present (e.g. the glove is punctured).

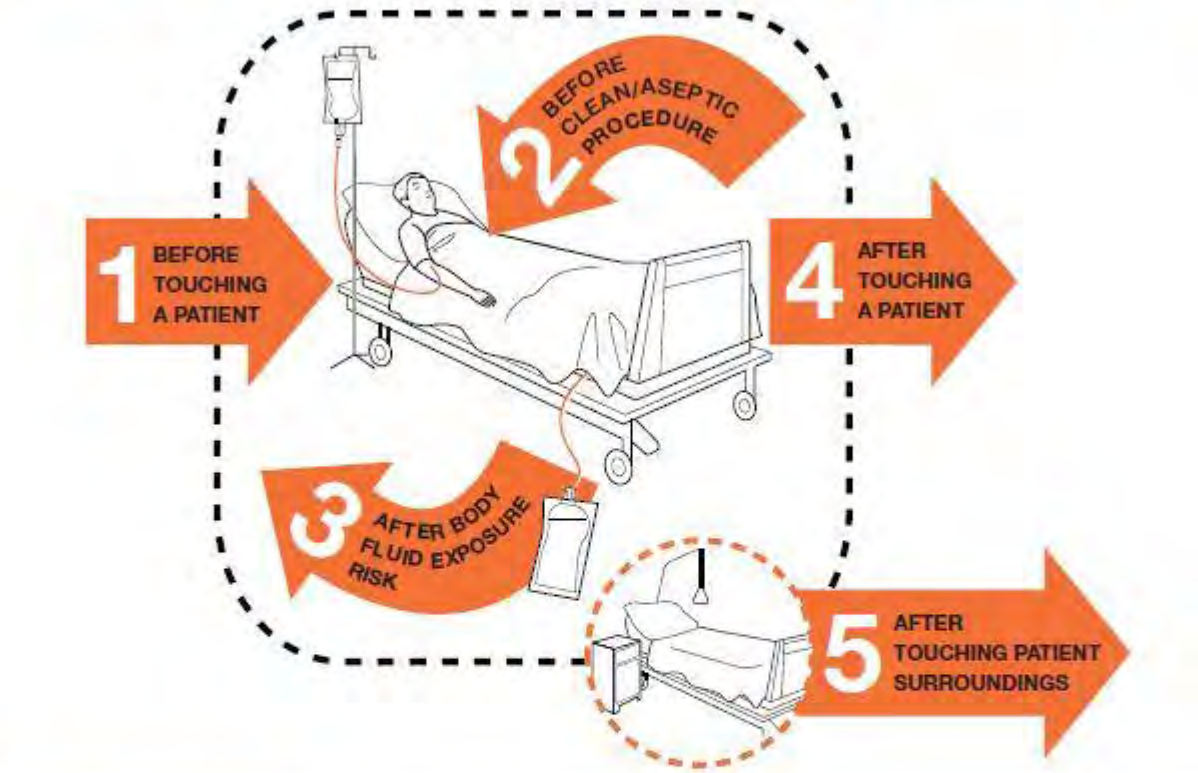
Surgical procedures may be carried out one after the other without the need for hand washing. provided that the hand rubbing technique or surgical hand preparation is followed (images 1-15).

Appendix 6 – Use of the Hand Wash Basin

- Hand washing sinks should not be fitted with plugs in order to avoid them filling with water, hand hygiene should be performed under running water.
- Mixer taps or thermostatic mixer valves are preferred to provide the correct temperature of water for performing hand hygiene.
- The tap must not directly expel/drain water straight down the plug hole. It should be sited appropriately to ensure water hits the sink basin as it flows out, otherwise aerosols from the drainage system can splash back onto the user.
- Do not dispose of body fluids or any other fluids in the clinical wash-hand basin – use the sluice in the dirty utility area.
- Do not use hand wash basins for storing used equipment awaiting decontamination or wash any patient equipment in hand wash basins.
- Taps can be wrist, elbow or automatically operated, Velindre Cancer Centre will replace automatic taps with wrist or elbow operated during clinical area development or refurbishment in accordance with its Water Safety Action Plan.
- Do not touch the spout outlet when washing hands.
- Hand wash sinks must not have an overflow.
- Use all hand wash stations regularly of flush in accordance with the Legionella management scheme.
- Ensure correct clean and dirty separation is maintained along with use of sink free zones for high risk procedure areas, for example, where intravenous drugs are being prepared.
- Hand wash sinks must conform to standards as uneven or damaged surfaces may harbour microorganisms.
- Hands free (i.e. pedal operated) waste receptacles should be close at hand.
- Designated hand hygiene sinks should be clearly labelled ‘hand hygiene only’.
- Advise patients that sinks should not be used for anything other than hand hygiene: i.e. not for cleaning teeth or drinking water and should not be used for storage of patients soap etc.

Appendix 7 - WHO Five Moments for Hand Hygiene

Your 5 Moments for Hand Hygiene



1	BEFORE TOUCHING A PATIENT	WHEN?	Clean your hands before touching a patient when approaching him/her.
		WHY?	To protect the patient against harmful germs carried on your hands.
2	BEFORE CLEAN/ ASEPTIC PROCEDURE	WHEN?	Clean your hands immediately before performing a clean/aseptic procedure.
		WHY?	To protect the patient against harmful germs, including the patient's own, from entering his/her body.
3	AFTER BODY FLUID EXPOSURE RISK	WHEN?	Clean your hands immediately after an exposure risk to body fluids (and after glove removal).
		WHY?	To protect yourself and the health-care environment from harmful patient germs.
4	AFTER TOUCHING A PATIENT	WHEN?	Clean your hands after touching a patient and her/his immediate surroundings, when leaving the patient's side.
		WHY?	To protect yourself and the health-care environment from harmful patient germs.
5	AFTER TOUCHING PATIENT SURROUNDINGS	WHEN?	Clean your hands after touching any object or furniture in the patient's immediate surroundings, when leaving – even if the patient has not been touched.
		WHY?	To protect yourself and the health-care environment from harmful patient germs.

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Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Ref: IPC 21

INFECTION PREVENTION AND CONTROL MEASURES FOR ACUTE RESPIRATORY INFECTIONS (ARI) FOR HEALTH AND SOCIAL CARE SETTINGS - WALES

Executive Sponsor & Function	Executive Director of Nursing and Service Improvement
Document Author:	Senior Infection Prevention & Control Nurse
Approved by:	Quality, Safety and Performance Committee
Approval Date:	11 September 2025
Date of Equality Impact Assessment:	August 2022
Equality Impact Assessment Outcome:	This policy has been screened for relevance to equality. No potential negative impact has been identified.
Review Date:	September 2028
Version:	5

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales

Infection Prevention and Control Measures for Acute Respiratory Infections (ARI) for Health and social Care Settings - WALES

2025 Version 4.0

Version Control

Version	Author	Date	Changes
1	HARP IPC team	May 2022	Amended for use in Wales by health and social care teams, from original document prepared by NHSE & IPC team
2	Consultant nurse HCAI, IPC HARP.	November 2023.	Review of isolation. Testing
3	Consultant nurse HCAI, IPC HARP	November 2024	4.2 Isolation guidance reviewed CV-19. Links updated.
4	Consultant Nurse HCAI, IPC HARP.	October 2025	4 use of RPE. 4.1 source control amended to all Winter respiratory infections. Links updated.

**The term patient is used to denote any individual being cared for in a health or care setting therefore includes service users, care home residents for example*

Acknowledgement: Amended for use in Wales by health and social care teams, from original document prepared by NHSE & IPC team May 2022.

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**The term patient is used to denote any individual being cared for in a health or care setting therefore includes service users, care home residents for example*

1. Introduction

This guidance outlines the infection prevention and control (IPC) principles and minimum precautions required to prevent transmission of viral Acute Respiratory Infection (ARI) including SARS-CoV-2 (COVID-19) Influenza (Non - High Consequence Infectious Disease strain e.g. Avian influenza) and Respiratory Syncytial Virus (RSV), within healthcare settings in Wales.

While Human metapneumovirus, Human parainfluenza and rhinovirus are not usually considered to be of public health concern, they can be significant and also spread within healthcare settings especially in vulnerable patients/residents/service users. Hence the introduction of the RSV vaccination programme introduced in Wales in September 2024.

This guidance is of a general nature. Healthcare organisations in Wales may adopt practices that differ from those recommended/stated in this IPC guidance. However, organisations are responsible for ensuring safe systems of work, including managing the risk associated with infectious agents through the completion of risk assessments using the Hierarchy of Controls as a basis. They must also consider the specific conditions of each individual place of work and comply with all applicable legislation and regulations, including the Health and Safety at Work etc. Act 1974 and Health and Safety Executive (HSE) guidance on use of PPE and RPE.

Appendix 17 of NIPCM Wales: Risk Assessment Principles for Health and Care Settings – Hierarchy of Controls Appendices - Public Health Wales (nhs.wales).

The following link may also be helpful: About Hierarchy of Controls | Hierarchy of Controls | CDC.

Risk Assessment Tools:

- Criteria for completing a local risk acute inpatient area
- Criteria for completing a local risk primary care and outpatient settings
- Criteria for completing a local risk social care

Where an unacceptable risk of transmission remains following the hierarchy of controls risk assessment, it may be necessary to consider the use of Respiratory Protective Equipment (RPE) for patients being cared for with respiratory infectious agents, in a wider range of clinical situations than those outlined in this guidance.

All health and social care organisations must make sure that appropriate supplies and training in use of Personal Protective Equipment (PPE) including fit testing for the use of RPE (where required) is in place to implement this IPC Guidance.

This guidance should be read in conjunction with NIPCM - Public Health Wales, which describes the application of Standard Infection Prevention and Control Precautions (SICPs), and Transmission Based Precautions (TBPs).

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All health and social care staff must be familiar with the principles of SICPs and TBPs for preventing the spread of infection in health and social care settings.

The elements of SICPs are:

- *Patient placement and assessment for infection risk (screening /triaging/ testing).
- Hand hygiene.
- Respiratory and cough hygiene.
- Personal Protective Equipment (PPE).
- Safe management of the care environment.
- Safe management of patient care equipment.
- Safe management of healthcare linen.
- Safe management of blood and body fluids.
- Safe disposal of waste (including sharps).
- Occupational safety: prevention and exposure management.

TBPs are the additional measures to SICPs that may be required when caring for *patients with known / suspected infection or colonisation, these are:

- Assessment for infection risk and patient placement.
- Assessment for infection risk and management of contacts.
- Safe management of patient care equipment in an isolation/cohort area.
- Safe management of the care environment.
- PPE: including Fluid Repellent Surgical Masks (FRSM) respiratory protective equipment (RPE), eye protection, gloves, aprons/gowns etc.
- Aerosol generating procedures (AGPs) and associated PPE – (see Appendix 2).
- Care of the deceased.

The IPC principles in this document apply to health and social care settings in Wales. This includes mental health and learning disabilities, primary care, maternity, and paediatrics as well as the social care sector including care homes (this list is not exhaustive).

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2. General information

2.1. Infectious period

- SARS CoV-2 (COVID-19) - Individuals are infectious around 2 days before symptom onset to 10 days after. People are most infectious during their symptomatic period, usually in the first 5 days (after the day they took the positive test or from the day symptoms started). However, children and young persons under 18 years old are most infectious in the first 3 days.
- Influenza (Flu) – May be infectious 1 day before onset of symptoms, peaks after 1-2 days of symptoms and then declines, so that infectivity is very low after 7 days in adults. It is more likely to spread to others in the first 5 days after onset of symptoms. The time from exposure to developing the first symptom (incubation period) is usually 1 to 3 days.
- Other ARI – (RSV, Metapneumovirus, H. Influenza, human parainfluenza, rhinovirus) - Have similar incubation and transmission periods. May be infectious 1 to 2 days before onset of symptoms and is more likely to spread to others in the first 5 days. The time from exposure to developing the first symptom (incubation period) is typically 2-5 days but can be as long as 8 days.

Severely immunocompromised individuals may remain infectious for a longer period of time, even in the absence of symptoms. Refer to section 4.3 duration of precautions, for further information.

2.2. High risk groups/individuals

Individuals who are immunosuppressed or have certain medical conditions may be at higher risk of contracting ARI or at higher risk of serious illness and complications. A clinical risk assessment is required for those individuals considered to be high risk, COVID-19 treatments | GOV.WALES.

Additionally, individuals who are unvaccinated or partially vaccinated for COVID-19 or unvaccinated for Flu or RSV (in older adults, infants and pregnant women) are at higher risk of infection and serious illness.

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2.3. High risk settings

High risk settings for ongoing transmission of ARI are those that cannot mitigate the risk of transmission through the application of the hierarchy of controls (HoC) for example care homes.

Setting-specific risk assessment tools (acute sector, community / primary care and care home sector) are available to support organisations in applying the HoC - ARI - Acute Respiratory Infections - Public Health Wales.

Managing risk using PPE - Using personal protective equipment (PPE) to control risks at work - HSE.

3. Triaging and Testing for Acute Respiratory Viral Infection

3.1. Triaging/assessment of infection risk in primary and secondary care

Triaging including travel history within all healthcare facilities should be undertaken to enable early recognition of patients with acute respiratory viral infections. Triage should be undertaken by clinical staff who are trained and competent in the application of clinical case definitions as soon as possible on arrival and used to inform patient placement.

Patients with respiratory infection symptoms should be assessed in a segregated area, ideally a single room, and away from other patients pending their test result.

At times of high levels of respiratory infectious illness, it may be worth segregating unscheduled / emergency admissions into respiratory and non-respiratory pathways, ensuring that separation of patients (single room assessment areas ideally), ventilation and use of FRSM masks by all staff are optimised in the respiratory pathway.

In care homes, residents need to be assessed for ARI symptoms and local policy for management followed.

3.2. Testing

Testing for patients, and residents should be as local policy/guidance.

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3.3. Cohorting

Infectious patients/ residents should ideally be isolated in single rooms away from others. Where infectious cases exceed single room capacity cohorting of patients/ residents may be implemented and should be according to infecting organism. Cohort nursing is a dedicated area in which a group of *patients with the same infection are placed together. In a care home, this may mean caring for residents with the same infection on the same floor.

*Patients with different infections should not be cohorted together and where a patient tests positive for more than one ARI e.g., Flu and COVID-19 then single room isolation should be prioritised.

In hospital, to ensure the most appropriate clinical care for patients, cohort areas should be set up within the specialty area where the required clinical care is best provided. Patients should not be moved to a "respiratory ward" cohort area simply on the basis of a test result but may need to be moved if clinically they require enhanced respiratory management.

4. Additional infection prevention and control measures for ARI in healthcare settings

The application of SICPs and TBPs as per chapters 1 and 2 of the NIPCM - Public Health Wales should be followed. Refer to A to Z of pathogens for pathogen specific information and Appendix 11 for guidance on patient placement and the use of RPE, NIPCM Appendices.

4.1 Respiratory Protective Equipment (RPE)

PPE must still be used in accordance with SICPs when using Respiratory Protective Equipment (RPE) Where it is not reasonably practicable to prevent exposure to a substance hazardous to health (as may be the case where healthcare workers are caring for patients with suspected or known airborne micro-organisms) the hazard must be adequately controlled by applying protection measures appropriate to the activity and consistent with the assessment of risk. If the hazard is unknown the clinical judgement and expertise of IPC/HP staff is crucial, and the precautionary principle should apply.

RPE, for instance FFP3 and facial protection, must be considered when:

- A patient is admitted with a known/suspected infectious agent/disease spread wholly or partly by the airborne route
- Carrying out aerosol generating procedures (AGPs) on patients with a known/suspected infectious agent spread wholly or partly by the airborne or droplet route

Appendix 1 of this guidance describes the personal protective equipment (PPE) required when providing direct care for suspected or confirmed ARI patients.

As a minimum, contact and droplet precautions should be applied when caring for patients with known or suspected ARI. In specific circumstances airborne precautions should also be applied, for example, when performing AGPs, and in high-risk settings. Appendix 2 of this guidance has an

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updated ACP list as published in the NIPCM England from 14th April 2022.

4.2. Source control

Cough etiquette/respiratory hygiene can be defined as source control measures intended to contain respiratory secretions in order to limit transmission of respiratory pathogens spread by droplet or airborne routes, especially during seasonal outbreaks of viral respiratory tract infections. (Standard Infection Precautions Literature Review Cough etiquette)

Mask wearing is a form of source control that can be applied to staff, patients, residents and visitors in healthcare settings during winter months when respiratory viruses are generally at their peak. The requirement for *patients to wear a facemask must never compromise their clinical care, such as when oxygen therapy is required or cause distress e.g. paediatric/mental health settings.

Infection prevention and control in the context of coronavirus disease (COVID-19): A living guideline makes a strong recommendation (based on very low certainty of evidence) that in areas of known or suspected community or cluster of COVID-19 transmission, universal masking is recommended in health and social care facilities

Health and social care staff

Health and Social care staff should continue to maintain source control by wearing FRSM (TYPE IIR) when working in respiratory care pathways and when clinically caring for patients suspected/confirmed of having Acute Respiratory Infections.

All other clinical care areas, outside of designated respiratory care pathways, universal masking should be applied when there is known or suspected cluster transmission of ARI e.g., during an incident / outbreak, universal masking should also be considered in settings where patients are at high risk of infection due to immunosuppression e.g. oncology/haematology. This should be guided by local risk assessment. This includes primary and community care staff.

FRSM are not required in non-clinical areas e.g. offices, social settings. Where patients are supported in community settings e.g. mental health/learning disabilities support in the community, staff are not routinely required to wear masks, similar to public health messaging in these settings, unless this is their personal preference.

Approved transparent face masks are now available to purchase for use in place of an FRSM (Type IIR) if needed following a risk assessment. Any product must be an NHS Wales Shared Services Partnership (NWSSP) approved product that meets the national technical standard. They are not intended for routine use and must be worn in accordance with manufacturer instructions for use (IFU).

Inpatients

Non-infectious inpatients are not required to wear a FRSM unless this is a personal preference. However, in settings where patients are at high risk of infection due to immunosuppression e.g. oncology/haematology, non-infectious patients may be encouraged to wear a FRSM following a local risk assessment.

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Inpatients with **suspected or confirmed ARI** should be provided with a FRSM (Type II or Type IIR) on admission. This should be worn in multi-bedded bays and communal areas e.g. waiting areas for diagnostics, if this can be tolerated and is deemed safe for the patient.

FRSM are not required to be worn by **suspected or confirmed ARI** patients in single rooms unless a visitor enters, or the room door is required to remain open. Patients with **suspected or confirmed ARI** transferring to another care area should wear a facemask (if tolerated) to minimise the dispersal of respiratory secretions and reduce environmental contamination. Patients should be provided with a new FRSM **at least** daily or when wet, soiled or damaged.

The requirement for patients to wear a facemask must never compromise their clinical care, such as when oxygen therapy is required, or cause distress e.g., paediatric/mental health settings.

Outpatients/primary care

Outpatients with **suspected or confirmed ARI** should wear a facemask/covering, if tolerated, or offered a facemask on arrival.

Visitors

Visitors and individuals accompanying patients to appointments are not routinely required to wear a facemask/covering unless this is a personal preference. If visiting an area where there is a high risk of respiratory infection, as part of the risk assessment a facemask, and IPC precautions will be advised prior to them entering the clinical area, posters should be on display to advise. There will be occasions for example in inpatient settings where patients are at high risk of infection due to immunosuppression e.g., oncology/haematology, where visitors may be asked to wear a facemask following a local risk assessment.

4.3. Duration of precautions

TBPs should only be discontinued in consultation with clinicians (including microbiology/IPC team) and should take into consideration the individual's test results (if available), transmissibility of the pathogen and resolution of clinical symptoms: A-Z Pathogens - Public Health Wales.

4.3.1. Stepping down precautions if the patient is staying in hospital

COVID-19:

- Most people will no longer be infectious after 5 days, it is therefore advised that TBPs and isolation should continue for at least 5 days. It is important to note that some patients may be infectious for longer.

- A locally decided protocol based on advice from medical directors, nursing directors and/or directors of infection prevention and control should be used to determine if isolation of inpatients with COVID-19 is needed after 5 days.

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- For inpatients, TBPs and isolation is recommended for at least five days after the onset of symptoms (or their first COVID 19 test), provided the clinical criteria described later in the document have been met.

Influenza:

For in-patients, and residents TBPs/isolation should continue for at least 5 days after the onset of symptoms (or their first positive flu test if they do not have any symptoms), provided the clinical criteria below have been met.

Other ARI – (RSV, H. metapneumovirus, Human parainfluenza, rhinovirus): A-Z Pathogens - Public Health Wales.

For inpatients and residents' transmission-based precautions/isolation should continue up to 7-8 days after the onset of symptoms (or their first positive test if they do not have any symptoms), provided the clinical criteria below have been met.

Note: Where a patient or resident or service user tests positive for more than one ARI e.g. Influenza and COVID-19 then stepping down precautions needs to be assessed against transmission risks and clinical criteria.

Clinical criteria:

- Clinical improvement with at least some respiratory recovery
- Absence of fever (temperature greater than 37.8°C) for 48 hours without the use of medication
- No underlying severe immunosuppression

A cough or a loss of, or change in, normal sense of smell or taste (anosmia), may persist in some individuals with COVID-19 for several weeks, and are not considered an indication of ongoing infection when other symptoms have resolved.

For clinically suspected ARI patients who have tested negative for COVID-19 and have not been tested for other ARI's and whose condition is severe enough to require hospitalisation, the isolation period should be measured from the day of admission.

Re-testing is not required for patients who have tested positive for other ARI pathogens (flu, RSV etc) unless there is underlying immunosuppression. These cases should be considered in consultation with clinicians (including microbiology/IPC team).

Note: This guidance does not apply if there are any additional indications for ongoing isolation and transmission-based precautions (for example MRSA carriage, C. difficile infection, diarrhoea).

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4.3.2. Severely immunocompromised patients/residents

It is possible for severely immunocompromised patients or residents to remain infectious for prolonged periods, even if they do not display any symptoms of ARI. There should be a locally decided protocol based on advice from medical directors, nursing directors, directors of infection prevention and control and GPs should be used to determine if isolation of inpatients with COVID-19 is needed after 5 days.

For all ARI including COVID-19 in severely immunocompromised patients' resolution of symptoms should not be used as a marker of decreased infectiousness and these patients should be isolated in side (single) rooms, cubicles or cohorted and a step-down protocol agreed with the local Microbiology / IPC team.

4.3.3. Outpatients/primary care

Patients who are known or suspected to be positive with a respiratory pathogen and whose treatment cannot be deferred should receive care from services who are able to operate in a way which minimises the risk of spread of the virus to other patients. If required advice can be sought from Health Board/Trust IPC Teams or Health Protection Teams.

To support primary care specific risk assessment, tools are available to support organisations in applying the HoC here: Criteria for completing a local risk primary care and outpatient settings.

4.3.4. Care home or other non-acute healthcare settings

For those with symptoms of ARI – no test results:

- Symptoms of a respiratory infection, with high temperature or not feeling well enough to do their usual activities. It is best practice to avoid communal areas for the recommended exclusion period.
- This should be maintained until they no longer have a high temperature or no longer feel unwell.
- Note that those in vulnerable groups who may benefit from antiviral treatments will need to be tested –Patient testing framework for autumn/winter 2023 (WHC/2023/037) | GOV.WALES.
- Consideration needs to be given to health and wellbeing of residents while in isolation and contact maintained with family and friends. Refer to Care Home Infection Prevention and Control Manual (CH IPCM) - Public Health Wales

For those residents with a positive COVID-19 test result:

- Stay away from others (isolation in own room) for a minimum of 5 days after the day of positive result from taking the test.
- Access appropriate treatments as quickly as possible if they are eligible: COVID-19 treatments | GOV.WALES.

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- Avoid contact with other people who are eligible for COVID-19 treatments for example immunocompromised for 10 days after a positive test.
- After 5 days, the resident can return to their normal activities if they feel well and no longer have a high temperature without the use of medication such as paracetamol.

Residents who have tested positive for COVID-19 do not need to stay away from others for more than 10 days regardless of symptoms.

4.3.5. High risk / vulnerable patients

- Precautions/isolation should continue up to 10 days after the onset of symptoms (or their first positive COVID-19 test if they do not have any symptoms), provided the clinical criteria below have been met.
- Clinical improvement with at least some respiratory recovery.
- Absence of fever (temperature greater than 37.8°C) for 48 hours without the use of medication.
- No underlying severe immunosuppression.
- It is possible for severely immunocompromised patients to remain infectious for prolonged periods, even if they do not display any symptoms of ARI.
- If a patient / resident is severely immunosuppressed consideration should be given to increasing the isolation period for to at least 14 days. Particularly if other residents are also in the highly immunosuppressed category.

To support setting specific risk assessment tools are available to support organisations in applying the HoC here: Criteria for completing a local risk social care.

5. Surveillance and monitoring / outbreak management / reporting

Ongoing surveillance of Severe Acute Respiratory Illness (SARI) should continue within healthcare settings and for hospital/organisation onset cases (staff and patients/individuals).

Positive cases of COVID-19 and Flu identified after admission who fit the criteria for a healthcare associated infection (HCAI) should trigger a case investigation. If two or more cases are linked in time and place, an outbreak investigation should be undertaken Outbreak Management - Public Health Wales

COVID-19 and Flu are notifiable organisms/diseases. Further information on reporting can be found here: The Health Protection (Notification) (Wales) Regulations 2010.

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6. IPC considerations for contacts of cases (inpatients)

Inpatients who are considered contacts of COVID-19/Flu cases (not part of an outbreak) are no longer required to isolate if they are asymptomatic. Asymptomatic testing of inpatients may be used as part of the actions agreed by an Outbreak Control Team (OCT) to monitor contacts and mitigate risks if the patient remains in hospital or other care setting e.g. LFD or rapid antigen testing or local protocol.

If symptoms occur contacts should be tested as per local policy/guidance and isolated or cohorted with other symptomatic contacts of the same case.

7. Occupational health, vaccinations and IPC considerations for health and care staff

Systems should remain in place to ensure vaccination policies are implemented as advised by occupational health/public health teams.

The vaccination status of staff may be considered when making staffing decisions for areas where suspected or confirmed COVID-19/Flu patients/individuals are cared for.

A risk assessment is required for health and social care staff who may be at high risk of complications from COVID-19 or Flu and, also, may be available for anti-viral treatments.

Staff who have symptoms of a respiratory tract infection including a high temperature or do not feel well enough to go to work or carry out normal activities, is advised to stay at home and notify their employer as soon as possible. They are to avoid contact with other people.

When they no longer feel unwell and do not have /not had a high temperature without the use of medication such as paracetamol and are ready to return to work they may wish to discuss with their employer ways to minimise any risk as some may still be infectious. This may include undertaking a risk assessment if the staff member works with patients whose immune system means that they are at higher risk of serious illness despite vaccination.

Symptomatic staff should avoid contact with people both in the healthcare setting and in the general community. Bank, agency and locum staff should follow the same deployment advice as permanent staff.

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Appendix 1: Personal protective equipment (PPE) required while providing direct care for patients with suspected or confirmed acute respiratory infection (ARI) (including COVID-19)

Before undertaking any procedure, staff should assess any likely blood and body fluid exposure risk and ensure PPE is worn that provides adequate protection against the risks associated with the procedure or task being undertaken.

If there is no direct contact with the patient or their environment, gloves and aprons/gowns are not required.

Refer to NIPCM Wales:

- Appendix 6 - Guidance on donning (putting on) and doffing (removing) PPE.
- Appendix 15 - Selection of Personal Protective Equipment (PPE) by Healthcare Workers (HCWs) during the provision of patient care.

PPE required by transmission/exposure	Disposable gloves	Disposable/reusable fluid-resistant apron/gown	FRSM/RPE	Eye/face protection (goggle/visor)
Droplet PPE	Single use	Single use apron or fluid-resistant gown if risk of extensive spraying/splashing	Single use FRSM Type IIR for direct patient care[1]	Single use or reusable[1]
Airborne PPE (When undertaking or if AGPs are likely)[3] Or if an unacceptable risk of transmission remains following application of the hierarchy of controls[4]	Single use	Single use fluid-resistant gown	Single use FFP3[2] or reusable respirator/powered respirator hood (RPE)	Single use or reusable[2]

1*FRSM can be worn sessionally (includes eye/face protection) if providing care for cohorted patients. All other items of PPE (gloves/gown) must be changed between patients and/or after completing a procedure or task.

2 - RPE can be worn sessionally (includes eye/face protection) in high-risk areas where AGPs are undertaken for cohorted patients (see footnote 4). All other items of PPE (gloves/gown) must be changed between patients and/or after completing a procedure or task.

3- Consideration may need to be given to the application of airborne precautions where the number of cases of respiratory infections requiring AGPs increases and patients cannot be managed in single or isolation rooms.

4 - Where a risk assessment indicates it, RPE should be available to all relevant staff. The risk assessment should include evaluation of the ventilation in the area, operational capacity, and prevalence of infection/new SARS-CoV-2 variants of concern in the local area. The hierarchy of controls can be used to inform the risk assessment. Staff should be provided with training on correct use.

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Appendix 2: Aerosol generating procedures (Current Aerosol Generating Procedures List for Healthcare)

Aerosol generating procedures (AGPs) are medical procedures that can result in the release of aerosols from the respiratory tract. The criteria for an AGP are a high risk of aerosol generation and increased risk of transmission (from patients with a known or suspected respiratory infection).

The list of medical procedures that considered to be aerosol generating and associated with an increased risk of respiratory transmission is:

- Awake* bronchoscopy (including awake tracheal intubation).
- Awake* ear, nose, and throat (ENT) airway procedures that involve respiratory suctioning.
- Awake* upper gastro-intestinal endoscopy.
- Dental procedures (using high speed or high frequency devices, for example ultrasonic scalers/high speed drills).
- Induction of sputum.
- Respiratory tract suctioning.**
- Surgery or post-mortem procedures (like high-speed cutting / drilling) likely to produce aerosol from the respiratory tract (upper or lower) or sinuses.
- Tracheostomy procedures (insertion or removal).

*Awake including 'conscious' sedation (excluding anaesthetised patients with secured airway)

** The available evidence relating to respiratory tract suctioning is associated with ventilation. In line with a precautionary approach, open suctioning of the respiratory tract regardless of association with ventilation has been incorporated into the current (COVID-19) AGP list. It is the consensus view of the UK IPC cell that only open suctioning beyond the oro-pharynx is currently considered an AGP, which means that oral/pharyngeal suctioning is NOT an AGP.

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Gweithio gyda'n gilydd i greu Cymru iachach

Working together for a healthier Wales

Ymddiriedolaeth GIG Prifysgol Felindre Velindre University NHS Trust

Ref: IG13

CONFIDENTIALITY BREACH REPORTING POLICY

Executive Sponsor & Function:	Executive Director of Finance
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1. AIM

The aim of this policy is to ensure that the Trust reports all breaches which may take place in accordance with legislation, ICO Guidelines, NHS Wales Guidelines, Welsh Government Guidelines and best practice.

Achievement of these aims will detail how the Trust meets its legal obligations. It will further the commitment of the Trust to process all information in a manner that is aligned with applicable legislation. It will promote openness and demonstrate increased transparency of decision making thereby building public trust and confidence.

The policy also aims to provide all employees of the Trust with a framework in which to ensure that any breach is handled in accordance with current legislation, guidelines and best practice.

2. POLICY STATEMENT AND OBJECTIVES

Velindre University NHS Trust is responsible for protecting the information it holds and is legally required under data protection legislation to ensure the security and confidentiality of all patients, donors, staff and service users personal data being processed in the Trust.

This policy puts in place a standardised management approach throughout the Trust, it's respective divisions and associated organisations in the event of a personal data breach incident to ensure all such incidents are dealt with: -

- Effectively and efficiently;
- Recorded and reported in a consistent manner;
- Responsible officers and managers are alerted;
- To facilitate onward investigation; and
- To learn lessons to reduce the likelihood of a recurrence.

As such, this Policy sets out the high-level intent of the Trust and recognises the diversity of the respective Divisions and associated organisations under its control.

3. SCOPE OF THE POLICY

The Policy applies to all staff employed within the Trust regardless of status i.e. permanent, temporary, bank, agency, honorary contract holders and volunteers who process patient, donor, staff and service user personal data.

4. AIMS OF THE CONFIDENTIALITY BREACH REPORTING POLICY

The aim of this policy is to set out a clear process for the reporting of all personal data breaches and to ensure appropriate actions are taken in terms of communication and follow up to minimise the impact of any reported incidents.

4.1 Definitions

A personal data breach incident is a breach of security that leads to the accidental or unlawful destruction, loss, alteration, unauthorised disclosure of, or access to personal data transmitted, stored or otherwise processed. Data Breach incidents can be categorised[1] into three well-known security principles: -

- "Confidentiality breach" - where there is an unauthorised or accidental disclosure of, or access to, personal data.
- "Availability breach" - where there is an accidental or unauthorised loss of access to, or destruction of, personal data.
- "Integrity breach" - where there is an unauthorised or accidental alteration of personal data.

Although not an exhaustive list, some common examples of a personal data breach incident, includes: -

- Accessing computer systems fraudulently, unlawfully without authorisation or using/sharing other employee NADEX logins, passwords, smart cards etc.
- Disclosing confidential information to individuals who have no legitimate right of access e.g. bogus callers, individuals not involved in service delivery and written requests from unauthorised requesters.
- Misdirection of email, faxes, letters and documents.
- The loss of paper files and computer print outs containing personal data.
- The loss of mobile/hardware devices due to crime or an individual's carelessness e.g. laptops, CDs, memory sticks, mobiles, iPads etc.
- The use of unauthorised systems and software such as Non-Corporate Communication Channels (NCCCs) (e.g. WhatsApp and similar) for business

4.2 Reporting Arrangements

Whenever a suspected personal data breach incident has occurred, it is imperative staff report the incident to their line manager without delay and at the latest within 24 hours of discovery and follow the Trust's Incident Reporting and Investigation Policy (including Serious Incidents) recording as much detail as possible of the incident into the Trust's Incident Reporting System, Datix.

More serious personal data breach incidents must be reported to key Trust staff e.g. Head of Information Governance (HOIG) and Data Protection Officer (DPO), Senior Information Risk Owner (SIRO), Caldicott Guardian, Chief Digital Officer, and the Information Governance (IG) Department. Early notification and preparation are key to dealing with management and investigation of reported personal data breach incidents to enable the Trust to meet its statutory obligations.

4.3 Personal Data Breach Investigation

The objective of any breach investigation is to identify what actions the Trust, its respective divisions and associated organisations need to take to first prevent a recurrence of the incident and second to determine whether the incident needs to be externally reported (i.e. to the Information Commissioner's Office).

[1] Guidelines on Personal data breach notification under UK GDPR 2018 - Article 33

Key to preventing any recurrence is to ensure the Trust, it's respective divisions and associated organisations learn from reported incidents, and where applicable, share lessons learnt and consider any trends and identify areas for improvement.

4.4 Incident Classifications

Personal data breaches should be classified according to severity of risk to such data in the table illustrated in **Appendix A**.

The Trust must have in place the appropriate means to regularly review personal data breach incidents which are and where necessary, cascaded within the appropriate Trust Board, Hosted Body, Divisional and associated organisational forums and Senior Leadership Teams.

4.5 Notifying individuals or other parties

Depending on the seriousness of the personal data breach, the Trust Board, Hosted Body, Divisions and/or associated organisations may be required to inform some or all of the following:

- The individuals concerned;
- The Information Commissioner's Office (ICO);
- Trust, Hosted Body, Divisional and Associated Organisational Senior Management, including the Chief Executive;
- Welsh Government (No surprises reporting);
- Associated organisations i.e. other NHS Wales Health Boards and Trusts;
- NHS Wales Counter-Fraud where fraud may be suspected
- Police.

Consideration must always be given to informing the individuals concerned or the next of kin of the affected individuals when information about them has been lost or inappropriately placed in the public domain.

4.5.1 Method of Notification

The method of notification will vary depending on the type and scale of the personal data breach and the availability of contact details of affected individuals.

In considering the most appropriate method of notifying a personal data breach, the Trust, Hosted Body, Divisions and/or associated organisations must ensure that no further confidential data is disclosed, i.e. sending notifications to the wrong home or email addresses.

4.5.2 The Information Commissioners Office (ICO)

The Trust, Hosted Body, Divisions and/or associated organisations will inform the ICO if the breach involves personal data and:

- Has been assessed in line with the ICO data breach reporting guidelines; or
- A statement is to be made to the Welsh Government and/or a media announcement is to be made; or
- The breach is likely to enter the public domain, to enable the ICO to prepare for any enquiries they might get.

There should be a presumption to report to the ICO where there is a large volume of personal data placed at risk, or the release of personal data could cause a significant risk of individuals suffering substantial harm. Every case must be considered on its own merits, however if unsure whether to report or not, then the presumption should be to report the breach.

The attached scoring system, at **Appendix B**[2], should be used to assist in determining the severity of an incident. Examples of applying the scoring system can be found at **Appendix C**.

Reporting to the ICO must be undertaken, without undue delay, and within **72 hours** of the Trust becoming aware of the personal data breach. Where notification is not made within 72 hours, it must be accompanied with reasons for the delay.

5. RESPONSIBILITIES

All staff have a role to play to ensure a safe and secure workplace and staff must be aware of this Policy to ensure care is taken at all times to protect information and avoid a personal data breach incident.

5.1 Managerial Accountability and Responsibility

The **Chief Executive** of the Trust has overall responsibility for ensuring compliance with applicable legislation and regulation.

The Trust has a legal obligation to appoint a **Data Protection Officer**, whose role is to undertake tasks to ensure appropriate measures are in place that safeguards personal data from accidental or unlawful destruction, loss, alteration, or unauthorised disclosure in accordance with data protection legislation. The Trust's Head of Information Governance is the appointed Data Protection Officer.

Directors of Hosted Bodies and Divisions within the Trust are responsible for ensuring the Policy is implemented within their individual organisation, and must ensure: -

- Their organisation complies with this policy;
- Ensuring all staff and contractors are aware of the requirements incumbent upon them;
- Delegating the day-to-day responsibility to information governance leads and groups as defined by the Hosted Body/associated organisations and as appropriate to their needs.

The Trust has dedicated **Information Governance champions** in respective divisions and associated organisations. These roles will act as a first point of contact for receiving personal data breach incident notifications and act as an advisor to other managers and employees within their respective areas on compliance with the data protection legislation.

All staff are required to comply with this Policy and respect the personal data and privacy of others in their day to day working practice. Staff must ensure that

[2] Department for Health model as outlined in the Checklist Guidance for Reporting, Managing and Investigating Information Governance Serious Incidents Requiring Investigation.

appropriate protection and security measures are taken to protect against unlawful or unauthorised processing of personal data, and against the accidental loss of, or damage to all personal data.

Non-compliance with this Policy and any employee who is found to compromise security or confidentiality of the Trust, its patients, donors, staff and/or service users may be subject to the Trust Disciplinary Policy.

6. LEGISLATION AND STANDARDS

This Policy is written in accordance with current legislation as well as relevant codes of practice and standards that include, but are not limited to, the following:

Human Rights

- European Convention on Human Rights
- Human Rights Act 1998

Rights to Privacy

- Investigatory Powers Act 2016
- Protection of Freedoms Act 2012
- Lawful Business Practice Regulations 2000

Data Protection

- Data Protection Act 2018 (includes UK GDPR)
- Freedom of Information Act 2000
- Environmental Information Regulations 2004
- Computer Misuse Act 1990
- Access to Health Records Act 1990
- Data (Use and Access) Act 2025

Online Privacy

- UK Privacy and Electronic Communications Regulations (PECR)
- UK Privacy and Electronic Communications Amendment 2012 (Cookie Law)

Relevant Codes of Practice and Standards include, but are not limited to, the following:

- Caldicott Principles
- Information Security ISO27001
- Information Commissioners Codes of Practice
- ICO's Employment Information Guidance
- Common Law Duty of Confidence

7. TRAINING AND AWARENESS

All new staff must attend an IG induction session upon appointment where appropriate training is given. This must be provided at the earliest opportunity and without delay.

Awareness sessions are scheduled regularly across the Trust and will inform staff of their responsibilities in relation to confidentiality of data, Freedom of Information Act

2000, Data Protection Act 2018 and Records Management in line with Section 46 Code of Practice on the Management of Records (FOI 2000). **All staff are required to have undertaken appropriate training before being given access to Trust systems.**

8. EQUALITY

In accordance with the Trust's Equality policy, this policy will not discriminate, either directly or indirectly, on the grounds of gender, race, colour, ethnic or national origin, sexual orientation, marital status, religion or belief, age, union membership, disability, carer's status, offending background or any other personal characteristic.

9. GOVERNANCE AND REPORTING

Compliance with this policy (and supporting procedures) will be monitored by the Head of Information Governance. An internal audit on the Trust's arrangements in relation to breach reporting will be scheduled in line with the Trust's internal audit strategy.

For assurance, details on FOI activity will be reported to the Quality, Safety and Performance Committee, as well as the Senior Information Risk Owner (SIRO).

The policy will be reviewed every 3 years, unless where it will be affected by major internal or external changes such as:

- Legislation;
- Practice change or change in system/technology; or
- Changing methodology.

10. CONTACTS

A copy of this policy and other policies and procedures referenced are available on the Trust's Intranet site. The Information Governance team is available to provide advice, guidance and support and can be contacted via e-mail on VelindreInformationGovernance@wales.nhs.uk.

11. FURTHER INFORMATION

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

- Information Governance Policy
- Data Protection & Confidentiality Policy
- Freedom of Information Act Policy
- Records Management Policy
- Information Security Policy
- Email and Instant Messaging (EIM) Use Policy

In addition there will be underlying divisional, associated organisational protocols and procedures in place to support Trust wide policies.

Appendix A

Information Governance Risk Table

Domain Impacts on	Insignificant	Minor	Moderate	Major	Catastrophic
	Loss of or unauthorised access to: • A single record containing *special categories of personal data • Less than 5 records containing less *special categories of personal data e.g. demographics.	Loss of or unauthorised access to: • Less than 5 records containing *special categories of personal data. • Less than 20 records containing less *special categories of personal data e.g. demographics. Minimal impact on reputation and little or no expenditure required to recover.	Loss of or unauthorised access to: • Less than 20 records containing *special categories of personal data • Less than 300 records containing less *special categories of personal data e.g. demographics. Moderate impact on reputation (local press coverage) and costs – expenditure required to recover. Reportable to ICO.	Loss of or unauthorised access to: • Less than 200 records containing *special categories of personal data. • Less than 1000 records containing less *special categories of personal data e.g. demographics. Major impact on reputation (regional press coverage) and costs – significant expenditure required	Loss of or unauthorised access to: • Over 1000 records containing *special categories of personal data • Record(s) containing **highly sensitive personal data. • More than 1000 records containing less *special categories of personal data e.g. demographics. Huge impact on reputation and costs –

	Short term embarrassment or harm caused. Complaint possible. Able to deal with using internal mechanisms.	Short term embarrassment or harm caused. Complaints possible. Able to deal with using internal mechanisms.	Short term embarrassment or harm caused. Complaints likely. May involve external regulatory bodies. Potential for ICO fine.	to recover. Reportable to ICO. Short term embarrassment or harm caused. Complaints very likely. Likely to involve external regulatory bodies. Potential for ICO fine.	unable to recover situation. Reportable to ICO. Significant long term, permanent harm, damage or death to patients may occur. Complaints inevitable. Very likely to involve external regulatory bodies. Likelihood of ICO fine.

**special categories of personal data are defined in Data Protection Legislation as 'personal data consisting of information as to data relating to health or sexual orientation information, religion, race or ethnic origin, political opinion, trade union membership, genetic, and biometric data where processed to uniquely identify an individual.

**Highly sensitive personal data includes the NWIS defined list of 'highly sensitive information' which are sexually transmitted diseases, human fertilisation & embryology, HIV & AIDS, termination of pregnancy and gender reassignment and for the purposes of risk assessment also includes other information of a higher sensitivity which, if released, would put individuals at significant risk of harm or distress for example child or adult protection information.

SCORING SYSTEM
FOR CATEGORISING OF PERSONAL DATA BREACHES

The scoring system should be followed step by step. A baseline score will establish the base categorisation level for the incident. This score will then be modified as the following sensitivity factors are applied:

- Low – reduces the base categorisation
- Medium – has no effect on the base categorisation
- High – increases the base categorisation

1. Establish the baseline scale of the incident. If unknown, estimate the maximum potential scale point.

Baseline Scale	
0	Information about less than 10 individuals
1	Information between 11-50 individuals
1	Information between 51-100 individuals
2	Information between 101 – 300 individuals
2	Information between 301 – 500 individuals
2	Information between 501 – 1,000 individuals
3	Information between 1,001 – 5,000 individuals
3	Information between 5,001 – 10,000 individuals
3	Information between 10,001 – 100,000 individuals
3	Information over 100,001+ individuals

2. Identify which sensitivity characteristics may apply and the baseline scale point adjust accordingly.

Low: For each of the following factors reduce the baseline score by 1	
-1 for each	No clinical data at risk
	Limited demographic data at risk e.g. address not included, name not included
	Security controls / difficulty to access data partially mitigates risk
Medium: The following factors have no effect on baseline score	
0	Basic demographic data at risk e.g. equivalent to telephone directory
	Limited clinical information at risk e.g. clinic attendance, ward handover sheet

High: For each of the following factors increase the baseline score by 1	
+1 for each	Detailed clinical information at risk e.g. case notes
	Particularly sensitive information at risk e.g. HIV, STD, Mental Health, Children
	One or more previous incidents of a similar type in the past 12 months

	Failure to securely encrypt mobile technology or other obvious security failing
	Celebrity involved or other newsworthy aspects or media interest
	A complaint has been made to the Information Commissioner
	Individuals affected are likely to suffer significant distress or embarrassment
	Individuals affected have been placed at risk of physical harm
	Individuals affected may suffer significant detriment e.g. financial loss
	Incident has occurred or risk incurring a clinical untoward incident

3. Determine final score. Where adjusted scale indicates the incident is level 2 or above, it should be considered for reporting to the ICO.

Final Score	
1 or less	Considered to be non-reportable to ICO
2 or more	Should be considered for reporting to the ICO

Appendix C

EXAMPLES OF CATEGORISING PERSONAL DATA BREACHES USING SCORING SYSTEM

Example A

Imaging system supplier has been extracting identifiable data in addition to non-identifying performance data. A range of data items including names and some clinical data and images have been transferred to the USA but are being held securely and no data has been disclosed to a third party.		
Baseline scale factor	3 (estimated)	
Sensitivity factors	-1	limited demographic data
	0	limited clinical information
	-1	data held securely
	+1	sensitive images
	+1	data sent to USA deemed newsworthy
Final score level 3 so incident is deemed to be reportable		

Example B

Information about a child and the circumstances of an associated child protection plan has been faxed to the wrong address.		
Baseline scale factor	0	
Sensitivity factors	-1	no clinical data at risk
	0	basic demographic data
	+1	sensitive information
	+1	information may cause distress
Final score level 1 so incident is deemed non-reportable		

Example C

Two diaries containing information relating to the care of 240 midwifery patients were stolen from a nurse's car.		
Baseline scale factor	2	
Sensitivity factors	0	basic demographic data
	0	limited clinical information
Final score level 2 so incident is deemed to be reportable		

Example D

A member of staff took a ward handover sheet home by mistake and disposed of it in a public waste bin where it was found by a member of the public. 19 individual's details were included.		
Baseline scale factor	1	
Sensitivity factors	-1	limited demographic data
	0	limited clinical information
	+1	security failure re disposal of data
Final score level 1 so incident is deemed non-reportable		

Ymddiriedolaeth GIG Prifysgol Felindre Velindre University NHS Trust

Ref: IG02

DATA PROTECTION & CONFIDENTIALITY POLICY

Executive Sponsor & Function:	Executive Director of Finance
Document Author:	Head of Information Governance
Approved by:	Quality, Safety and Performance Committee
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1. AIM

The aim of this Policy is to set out the key areas of responsibilities and the Trusts commitment to ensuring the organisation treats all personal data lawfully and correctly.

For the purposes of this Policy, the Trust takes the view that the principles of confidentiality apply to all personal data, whether employee, patient, donor and/or service user held on computer or held manually and whether communicated verbally, electronically or in writing.

The policy also aims to provide all employees of the Trust with a framework in which to ensure that processing of all data is dealt with lawfully and in conjunction with this policy.

2. POLICY STATEMENT AND OBJECTIVES

Velindre University NHS Trust (the Trust) regard the lawful and correct processing of personal data (including patient, donor and staff) by the Trust as vital for maintaining confidence between those with whom the Trust deal and itself. The Trust shall take all reasonable steps to ensure that it treats all personal data in accordance with this Policy.

This Policy sets out the high level intent of the Trust and recognises the diversity of the respective Divisions and associated organisations under its control.

3. SCOPE OF THIS POLICY

This Policy applies to all personal data being processed within the Trust, its divisions and Hosted Bodies regardless of how the data is being accessed, created, handled, received and/or stored.

4. DATA PROTECTION AND CONFIDENTIALITY – LEGISLATION AND STANDARDS

This Policy provides all employees of the Trust with a framework to ensure all personal data is acquired, stored, processed and transferred in accordance with associated legislation, namely Data Protection Legislation, NHS standards [i.e. Caldicott Principles], and associated guidance issued by UK Government, Department of Health, Welsh Government, Information Commissioners Office (ICO) and other professional bodies.

4.1 Overview of Data Protection Legislation

Data Protection Legislation is about the rights and freedoms of living individuals, and particularly their right to privacy in respect of their personal data. It stipulates that those who record and use any personal data must be open, clear and concise about why personal data is being collected, and how the data is going to be used, stored and shared. The most common way to provide this information is in a Privacy Notice.

4.1.1 Personal Data

The definition of Personal Data within the Data Protection Act 2018 is: Any information relating to an identified or identifiable natural person (Data Subject). An identifiable natural person is one who can be identified, directly or indirectly, by reference to an identifier such as a name, an identification number, location data, online identifier or to one or more factors specific to the physical, physiological, genetic, mental, economic, cultural or social identity of that natural person.

In practical terms it may include information necessary for employment such as staff member's names and addresses and details for payment of salary or a patient/donor record. Personal data may also include what is termed as special categories of personal data which is defined further in Section 4.1.3.

4.1.2 Processing of Personal Data

The processing of personal data is lawful only if ONE of the following six lawful bases of processing of personal data applies:

- The Data Subject has given consent to the processing of his or her personal data for one or more specific purposes;
- Processing is necessary for the performance of a contract to which the Data Subject is party or to take steps at the request of the data subject prior to entering into a contract;
- Processing is necessary for compliance with a legal obligation to which the controller (The Trust) is subject;
- Processing is necessary to protect the vital interests of the Data Subject or another natural person (to safeguard life)
- Processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the Controller (The Trust)
- Processing is necessary for the purposes of the legitimate interests pursued by the Controller (The Trust) or by a third Party (Processor as defined in Data Protection Law), except where such interests are overridden by the interests or fundamental rights and freedoms of the data subject which require protection of personal data, in particular where the data subject is a child.

Any information which falls under the definition of personal data and is not otherwise exempt, will remain confidential. In accordance with The Data Protection Act, all personal data should only be processed in accordance with the six lawful bases for processing, on a need to know basis and all outputs must be treated carefully and disposed of in a secure manner. Staff must not disclose personal data outside their line of duty without a justified and lawful reason.

4.1.3 Special Categories of Personal Data

The Trust and its respective divisions and hosted organisations will, at times, be required to process special categories of personal data. Special category Personal Data is defined in the Data Protection Act as the processing of personal data revealing racial or ethnic origin, political opinions, religious or philosophical beliefs, or trade union membership, and the processing of genetic data, biometric data for the purpose

of uniquely identifying a natural person, data concerning health or data concerning a natural person's sex life or sexual orientation.

4.1.4 The Seven Principles

The Trust shall comply with Data Protection Principles contained within the Data Protection Act 2018 in that Personal Data shall be: -

- Lawfully, Fairly and Transparently processed
- Collected for specified, explicit and legitimate purposes and not processed further in a manner that is incompatible with these purposes
- Adequate, relevant and limited to what is necessary in relation to the purpose for which it is processed
- Accurate and where necessary kept up to date
- kept in a form which permits identification of data subjects for no longer than is necessary
- Processed in a manner that ensures appropriate security of the personal data including protection against unlawful or unauthorized processing and against accidental loss, destruction or damage using appropriate technical and organizational measures

The Seventh (7^{th}) Data Protection principle is accountability, the Trust is accountable for the personal data it processes, likewise all Staff employed by the Trust whether they are employees, students, volunteers or contractors are personally accountable for the personal data that they process.

4.2 Information Security

The Trust will take appropriate technical and organisational steps to ensure the security of personal data and manage the risks from internal and external threats.

The Trust will promote good security practice and awareness. All staff working for and/or on behalf of the Trust will use the NHS Wales computer and respective Trust network(s) [i.e. the Public Sector Broadband Aggregation (PSBA)] responsibly and will comply with the Trust Information Security policy together with relevant divisional/associated organisational directions and guidance.

All personal data stored within the Trust must have the appropriate safeguards and systems in place that protects against unlawful or unauthorised processing of personal data, and against the accidental loss of, or damage of personal data.

4.3 Encryption

Encryption technology is adopted within the Trust to adequately protect any personal data from unauthorised disclosure, whether by theft or accidental loss and minimising the impact of any inappropriate disclosure, whilst in transit or for those staff working offsite.

The Trust is fully committed to complying with relevant industry standards and NHS guidance in relation to a strong encryption strategy. Each division/associated organisation is to take responsibility for ensuring that all services have a sufficient encryption strategy in place to adequately mitigate the risk associated with each process.

4.4 Closed Circuit Television (CCTV)

CCTV cameras are situated across various Trust premises for the purposes of crime prevention and detection and to help improve the security for our staff, service users and visitors.

To comply with legislation and Surveillance Camera Code of Practice 2021, it is essential that the location of CCTV cameras is carefully considered to ensure they do not infringe on clinical/treatment areas. Where CCTV cameras are situated, signs must be erected indicating their presence and posted in prominent positions, ensuring all staff, visitors and service users are aware they are entering an area that is covered by CCTV cameras. These signs must also include details on the purpose, organisation and responsible officer's contact details.

4.4.1 Processing of Images

Images, which are not required for the purpose(s) for which the CCTV cameras are being used, should not be retained for longer than is necessary. While images are retained, it is essential that their integrity be maintained, whether it is to ensure their evidential value or to protect the rights of people whose images may have been recorded. It is therefore important that access to and security of the images is controlled in accordance with the requirements of Data Protection Legislation.

Where images are required for evidential purposes in legal or NHS disciplinary proceedings, the Trust reserves the right to make a Data Recording. Any data recordings taken must have appropriate encryption techniques considered and deployed. The Trust will take a considered approach to the taking of data recordings and any such recordings will only be conducted on the basis that there is a suspected breach of either an NHS Wales policy or legislation. On deciding whether such analysis is appropriate in any given circumstances, full consideration is given to the rights of the employee.

4.5 Information, Transfer and Security

The use of telecommunication methods [i.e. post, fax, email, instant messaging, SMS Text and videotelephony] and/or data transportation methods [i.e. offsite transfer, laptops, USB sticks, CDs] as a means to transfer and communicate personal data without the appropriate controls being applied is regarded by the Trust as an insecure method of transferring confidential patient, donor and/or staff information.

Staff must pay particular attention with any need to transfer and communicate personal data via any form of telecommunication and/or data transportation methods, and the Trust expects this type of information to be communicated with care.

It is the responsibility of all members of staff, and in accordance with Trust Policies together with relevant divisional/associated organisational directions and guidance, to exercise their judgement to ensure suitable precautions are being applied to the transmission of all personal data.

The Digital Services department implement data loss prevention (DLP) and portable device control via Antivirus tools to manage the security of data transportation methods (as above). If you are still required to transport Trust data via the methods listed above, these must be encrypted.

The use of NCCCs (e.g. WhatsApp/Facebook Messenger) is prohibited for the processing of personal data of patients, Staff and Service Users for business purposes in all formats including imagery and voice unless permitted in limited circumstances by the Information Governance team.

4.6 Misdirection

Misdirection is the term associated with the accidental sending of personal data via methods to include emails, instant messaging, SMS, letters and faxes. Irrespective of whether the personal data is sent internally or externally; misdirection is one of the main risks to the Trust. Accidental misdirection may result in a breach of confidentiality if the content identifies patients, donors or staff members.

In accordance with Trust Policies together with relevant divisional/associated organisational directions and guidance, **all staff** must ensure that appropriate protection and security measures are taken, to protect against unlawful or unauthorised disclosure of personal data, when there is a need to covey any personal data to internal or external parties'.

Staff must ensure that the correct recipient details are always selected to avoid the potential consequences of misdirection and/or accidental disclosure of personal data.

4.7 Social Media

Social media is a term for websites based on user participation and user-generated content. These media provide a number of benefits for the Trust as they are recognised as a valuable tool and provide another platform in which to engage with patients, donors and service users, to promote the Trust and its services. It is the responsibility of all members of staff to comply with the NHS Wales Social Media Policy.

4.8 Information Sharing

The Trust recognises the need to share personal data for the benefit of the users of the service. Such sharing may take place between the public services as well as appropriate private and third sector service providers. Sharing must take place legally, safely and with confidence to ensure public services are maintained and to improve standards and efficiency.

The Wales Accord for the Sharing of Personal Information (WASPI) is a framework under which information sharing protocols are formed where a regular sharing of personal data is to take place. The Trust has 'signed up' to use this framework and therefore in all instances of regular information sharing an Information Sharing Protocol should be adopted using the WASPI model.

Where personal data is to be shared as part of a commercial contract between the Trust and Suppliers, WASPI will not apply. In such circumstances, a Data Processing Agreement (sometimes known as a Data Sharing Agreement) may be required in addition to the Contract between the Trust and the Supplier. The Head of Information Governance is to be consulted at the beginning of the commercial relationship so that Data Protection requirements can be identified as early as possible within the

proposed project. This is known as Data Protection by Design and by Default and is a legal requirement.

4.9 Monitoring/Auditing access to Personal Identifiable Data

The Trust reserves the right to monitor/audit staff's access to personal data via Trust systems. The Trust will use appropriate system audit functionality (to include the National Intelligent Integrated Auditing Solution) to detect potential misuse of access rights whereby employees may have abused their access rights to view personal data that they may not be entitled to view.

Any employee who is found to have abused their access rights may be subject to the Trust's Disciplinary Policy.

5. SUBJECT ACCESS REQUESTS

Data Protection Legislation establishes a framework of rights and duties that are designed to safeguard personal data. Individuals (known as data subjects) or their representatives, have a right to apply for access to information held about them, and in some cases, information held about others.

This is known as a Subject Access Request (SAR) and requests for information may be made verbally or in writing.

Where a request is made verbally, it may be because some disabled people find it difficult to communicate in writing and may therefore have difficulty making a SAR. The Trust has a legal duty to make reasonable adjustments for such a person if they wish to make a Subject Access Request.

Reasonable adjustments could include treating a verbal request for information as though it were a valid Subject Access Request. If the request is complex, The Trust is to document it in an accessible format and to send it to the disabled person to confirm the details of the request.

The Trust may have to respond in a particular format that is accessible to the disabled person, such as Braille, large print, email, or audio formats. If an individual thinks that the Trust has failed to make a reasonable adjustment, they may make a claim under the Equality Act 2010.

Information about making a claim is available from the Equality and Human Rights Commission.

Where a request is made to access the records for a deceased person's health record, then the Access to Health Records Act 1990 is applicable.

The respective divisional/associated organisational leads should be notified of all requests, as these personnel are responsible for ensuring that all requests are handled appropriately, and in accordance with Data Protection Legislation.

The Head of Information Governance is available to provide professional and technical advice/guidance relating to the SAR process should it be required.

5.1 Charging

Information is provided **free of charge**. However, the Trust, and its associated organisations can charge a 'reasonable fee' when a SAR is manifestly unfounded or excessive, particularly if it is repetitive.

Charging a reasonable fee can be applied to requests for further copies of the same information. However, it does not mean a charge can be applied to all subsequent access requests. Fees are to be charged based on the administrative cost of providing the information.

5.2 Time Compliance

Information must be provided without delay and at the latest within **one month** of receipt. Where requests are complex or numerous, the Trust and its associated organisations can extend the period of compliance by a further two months. If this is the case, the respective organisations must inform the individual within one month of receipt of the request and explain why the extension is necessary.

5.3 Appeal Process

If an individual believes that the Trust has not complied with this Policy or acted otherwise then in accordance with Data Protection Legislation, the individual has a right to refer their concerns to the ICO. However, in the first instance, individuals should be offered the right to state a complaint. All complaints should be dealt with at the lowest level, therefore in many cases a complaint can be processed with support from the respective divisional/hosted organisational leads.

6. ROLES AND RESPONSIBILITIES

The policy applies to all employees and contractors working for, or on behalf of the Trust. Everyone working for or with the NHS who records, handles, stores, or otherwise comes across information has a personal common law duty of confidence to individuals referred to in that information.

6.1 Managerial Accountability and Responsibility

The **Chief Executive** of the Trust has overall responsibility for ensuring compliance with applicable legislation and regulation.

The Trust has a legal obligation to appoint a **Data Protection Officer**, whose role is to undertake tasks to ensure that all personal data is being processed in accordance with this Policy and Data Protection Legislation. The Head of Information Governance is the Trust's appointed Data Protection Officer.

Directors of Hosted Bodies and Divisions within the Trust are responsible for ensuring that the Policy is implemented within their individual organisation, and must ensure: -

- everyone managing and handling personal data understands they are contractually responsible for following good Data Protection and Caldicott practice;
- everyone managing and handling personal data is appropriately trained to do so; and

- methods of handling personal data are clearly described.

NHS Standards stipulate the Trust is required to have in place identified "**Caldicott Guardians**" with responsibilities for agreeing and monitoring protocols, and the movement and approval of the uses of patient and donor data within and external to the Trust. The Trust's Caldicott Guardians are as below for its divisions:

Velindre University NHS Trust – Medical Director
Velindre Cancer Service – Clinical Director
Welsh Blood Service – Medical Director

The Trust has dedicated **Information Governance champions** in respective divisions and Hosted Bodies. These roles act as a first contact for receiving Data Protection queries and act as an advisor to other managers and employees within their respective areas.

Digital System managers responsible for the major information and clinical systems throughout the Trust will ensure that their systems meet the specifics within the data protection notification. They will also be responsible for notifying the respective leads within their organisation, of any changes to their system which may impact on Data Protection.

All staff are required to respect the personal data and privacy of others and must ensure that appropriate protection and security measures are taken against unlawful or unauthorised processing of personal data, and against the accidental loss of, or damage to all personal data. Staff must adhere to all confidentiality requirements as described by the Trust and ensure that any access and use of personal data is only ever for the purposes of fulfilling NHS duties.

Any employee who is found to compromise security or confidentiality of the Trust, its patients, donors, staff and/or service user's personal data may be subject to Trust Disciplinary Policy.

6.2 Reporting of Data Protection & Confidentiality Breaches

The Trust takes any potential breach of Data Protection Legislation and confidentiality very seriously. All staff have a responsibility to report any breach of this nature immediately. The Trust, divisions and associated organisations must have a mechanism for reporting incidents and these must be investigated in line with local procedures. Any reporting must be made in conjunction with the Trust Confidentiality Breach Reporting Policy. Staff not reporting incidents of this nature may be subject to the Trust's disciplinary policy.

6.3 Contracts of Employment

All contracts of employment must include a data protection and general confidentiality clause. Agency, contractors and non-contract staff working on behalf of the Trust are subject to the same rules, these clauses must be outlined in any honorary contract agreements issued prior to commencing work with the Trust.

6.4 Procurement

When considering procuring platforms that will by their very nature process personal data, the Head of Information Governance is to be consulted at the outset of the proposed project, this is because a risk assessment will need to be undertaken to assess the risk to the rights and freedoms of individuals known as Data Subjects. This process is called a Data Protection Impact Assessment.

It is a legal requirement to undertake this activity when;

- The proposed platform is new, novel or involves processing of large amounts of personal data

It is also considered to be best practice for other projects involving the processing of personal data.

7. BREACHES OF THIS POLICY

Any suspected breaches of this Policy will be taken seriously and investigated through the Trust's Disciplinary Policy. Breaches of data protection and confidentiality could be a criminal offence and/or gross misconduct and may lead to dismissal.

8. TRAINING, AWARENESS AND PRACTICAL CONSIDERATIONS

The Trust demonstrates that employees understand their responsibilities to ensure that personal information is protected and processed in accordance with the applicable procedures, taking into account the related security requirements.

8.1 Training

The Trust will ensure that adequate training is provided for all staff involved with processing of personal data and that qualified expertise is available for consultation. All new starters (to include non-contracted staff and those on fixed term contracts) to the Trust will be given Information Governance awareness training upon appointment, to include compliance with Data Protection Legislation, Records Management and Cyber Security training, as part of the Trust induction process.

Refresher training must be undertaken every two years following initial completion of training.

8.2 Awareness

Situational awareness is a key requirement in ensuring that members of Staff comply with Data Protection Legislation. Examples of such awareness are:

- Data Protection and Information Governance Policies
- Caldicott Principles
- Being aware of their contribution to the effectiveness of data protection and information management policies, including the benefits of improved information management performance
- The implications of not conforming with the Trust's data protection and information management policies.

8.3 Practical Considerations

In a fast moving technological world, training and awareness are linked to the practical considerations that context provides. Trust employees are working in a way which is completely different to a "normal" way of working with more remote working than ever before. The following are considerations that members of Staff must think about when remote working in relation to Data Protection and Confidentiality:

- Removable media – Staff are only to work within the confines of Trust policies relating to the use of removable media, if a member of Staff is permitted to use it, they are to keep the removable media device secure at all times, they are personally responsible for its safekeeping.
- Home Wi-Fi – Member of Staff are to ensure that the password to their home Wi-Fi device is not the factory setting. The password should be set to one that is only known to them and difficult to guess.
- The Data Protection Act –Applies at all times, no matter where the member of Staff is located; Wales, the UK or indeed worldwide.
- Information – It is immaterial whether the information is hard copy or electronic, information is still to be protected at all times, as a member of Staff this responsibility is shared by all. This includes within the home – hard copy or electronic information is not to be left unattended and be available where it may be seen by unauthorised personnel (this includes family members).
- Situational Awareness – Staff are to be mindful of their locations in terms of where they are working, are they near a window which permits their screen to be seen, could they be overheard or is the work they are doing far too sensitive for their location (including at home)?If any of these apply, staff must either move position or if movement cannot be mitigated, the staff member should not attempt to carry out the work.
- Screen Sharing – When sharing a screen as part of video conferencing, staff are to be mindful of what other participants can see. They are to close all applications prior to the call – this includes e-mails, document folders, documents names, the list is not exhaustive
- Locking access to the electronic device – All staff should operate on a need-to-know basis, this includes access to information by colleagues and family members. To safeguard information, it is imperative that ctrl/alt/del is pressed to lock the screen whenever the machine is not attended. It should be noted that most devices within the Trust are set to lock automatically at the 5 minute point, but within that 5 minutes, an intruder may be able to access information, presenting high risk to not only patient confidentiality but the individual's and the Trust's compliance with Data Protection Legislation. The way to protect information in this setting is to lock the screen immediately when the user steps away from their machine.

The Information Governance team are the professional source of advice and guidance for the Trust. Should a member of Staff have concerns or wish to raise any issues related to practical considerations, it is strongly recommended that they contact them prior to undertaking any activity.

Guidance on the procedures necessary to comply with this Policy should be made available from the respective divisions and associated organisations of the Trust or on its web pages. Managers will be responsible for ensuring that all their staff are made aware of Trust policies and standards.

Links to the ICO website also provides a valuable source of information.

9. COMPLAINTS

Anyone whose data is processed by the Trust is entitled to make a complaint if they are unhappy with the way their data has been processed.

Data Protection complaints are that same as any other complaint, however, the individual handling the complaint will be the Head of Information Governance who may need to undertake an investigation into the facts surrounding the complaint prior to responding to the complainant.

Members of Staff are to provide the following address for any individual who wishes to complain to the Trust about how their data has been handled:

Mr Ian Bevan via
VelindreInformationGovernance@wales.nhs.uk
Head of Information Governance
Velindre University NHS Trust
2, Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff / Caerdydd
CF15 7QZ
Tel / Ffon - 029 20196161

It should be noted that an individual has the right not to complain to the Trust, but to the Information Commissioner's Office (ICO) by writing to:

Information Commissioner's Office – Wales
2nd Floor
Churchill House
Churchill Way
Cardiff
CF10 2HH

Tel: 0330 414 6421
Email: wales@ico.org.uk

10. GOVERNANCE AND REPORTING

Compliance with this policy (and supporting procedures) will be monitored by the Head of Information Governance. An internal audit on the Trust's arrangements in relation to the Act will be scheduled in line with the Trust's internal audit strategy.

For assurance, details on Data Protection and Confidentiality activity (including complaints) will be reported to the Quality, Safety and Performance Committee, as well as the Senior Information Risk Owner (SIRO).

An annual Caldicott review and audit will be carried out, by associated organisations within the Trust, in respect of the way patient and/or donor information is managed and recommendations for progress established.

The Trust notifies details of the personal data it processes to the Information Commissioner for inclusion on the register of Data Controllers. The notification is reviewed annually by the Trust. The register is maintained by the ICO and is available in the public domain for inspection by anyone.

The policy will be reviewed every 3 years, unless affected by major internal or external changes such as:

- Legislation;
- Practice change or change in system/technology; or
- Changing methodology.

11. REFERENCES – SPECIFIC APPLICABLE LEGISLATION AND STANDARDS

This Policy is written in accordance with current legislation as well as relevant codes of practice and standards that include, but are not limited to, the following:

Human Rights

- European Convention on Human Rights
- Human Rights Act 1998

Rights to Privacy

- Investigatory Powers Act 2016
- Protection of Freedoms Act 2012
- Lawful Business Practice Regulations 2000

Data Protection

- Data Protection Act 2018 (incudes UK GDPR)
- Freedom of Information Act 2000
- Environmental Information Regulations 2004
- Access to Health Records Act 1990 (where not superseded by Data Protection Legislation)
- Health & Social Care Act 2012
- Data (Use and Access) Act 2025

Online Privacy

- UK Privacy and Electronic Communications Regulations (PECR)
- UK Privacy and Electronic Communications Amendment 2012 (Cookie Law)

Relevant Codes of Practice and Standards include, but are not limited to, the following:

- Caldicott Principles
- Information Security ISO27001
- Information Commissioners Codes of Practice
- ICO's Employment Information Guidance
- Common Law Duty of Confidence

12. EQUALITY

In accordance with the Trust's Equality policy, this Policy will not discriminate, either directly or indirectly, on the grounds of gender, race, colour, ethnic or national origin, sexual orientation, marital status, religion or belief, age, union membership, disability, carer's status, offending background or any other personal characteristic.

As a result this policy will make reasonable adjustments for disabled people where they request their data under the Subject Access Request Process.

Further details are contained within Section 5 of this Policy.

13. CONTACTS

For further advice and/or assistance on how to ensure individual, divisional and associated organisational compliance with this Policy, please contact: -

Ian Bevan
Head of Information Governance
Velindre University NHS Trust HQ
2, Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ
Email – VelindreInformationGovernance@wales.nhs.uk

Tel – 029 2031 6161

14. FURTHER INFORMATION

This Policy should be read in conjunction with the following Trust policies:

- Information Governance Policy
- Confidentiality Breach Reporting Policy
- Records Management Policy
- Freedom of Information Act Policy
- Data Quality Policy
- Information Security Policy
- Email and Instant Messaging (EIM) Use Policy
- NHS Wales Internet Use Policy
- Social Media Policy

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Ref: IG01

RECORDS MANAGEMENT POLICY

Executive Sponsor & Function:	Executive Director of Finance
Document Author:	Head of Information Governance
Approved by:	Quality, Safety and Performance Committee
Approval Date:	11th September 2025
Date of Equality Impact Assessment:	10th June 2025
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1. AIM

The aim of this policy is to ensure that all types of records (regardless of the fact whether they are paper or electronic), administrative as well as medical, are properly controlled, accessible, available, archived, and disposed of in line with national guidelines.

This policy applies to all records the Trust, its divisions and associated organisations hold regardless of how these are accessed, created, handled, received and/or stored, and shall include **all types of media** including (but not limited to) records in paper or electronic form, databases, software, video and sound media.

2. POLICY STATEMENT AND OBJECTIVES

The Velindre University NHS Trust Records Management Policy sets out the key areas of responsibility and affirms the Trusts commitment to achieving high standards in records management. This Policy sets out the high level intent of Velindre University NHS Trust and recognises the diversity of the respective Divisions and associated organisations under its control.

As a public body we are required by law to manage our records appropriately; namely in accordance with regulations such as the Data Protection Act 2018, Section 46 Code of Practice on the Management of records issued under the Freedom of Information Act 2000, Environmental Information Regulations 2004, Public Records Act 1958, Local Government Act 1972, Inquiries Act 2005, Constitutional Reform and Governance Act 2010 and the re-use of Public Sector Information Regulations 2015 that set out specific requirements in relation to the creation, management, disposal, use and re-use of records.

3. SCOPE OF THE POLICY

This is a Trust-wide Policy and applies to all staff and personnel operating under the auspices of the Trust, including employees, locums, contractors, temporary staff, students, service user representatives, volunteers and partner agency staff.

This Policy applies to the three identified types of information processed, transmitted and maintained by the Trust, its divisions and hosted organisations. These are:

- Health and Social Care records (“clinical” records about patients, donors, service users and carers)
- Staff records (“corporate” records about staff)
- Management records (“corporate” records about the Trust)

4. RECORDS MANAGEMENT

Records management is vital to the delivery of our services and supports consistency, continuity, efficiency and productivity and helps us deliver our services in a uniform and equitable manner.

Trust records are our corporate memory and support policy formation and managerial decision-making, protecting the interests of the organisation and the rights of service users, staff and members of the public who interact with the Trust and its respective Divisions and/or associated organisations under its control.

The Trust aims to balance our commitment to openness and transparency with our responsibilities. So we will create and manage records efficiently, make them accessible where possible, protect and store them securely and dispose of them safely at the right time. This policy will provide the Trust with a baseline to improve records management enabling seven main objectives to be delivered, these being:

- **Accountability** – that adequate records are maintained to account fully and transparently for all actions and decisions.

- **Quality** – that records are complete and accurate and the information they contain is reliable and its authenticity can be guaranteed.

- **Accessibility** – that records and the information within them can be efficiently retrieved by those with a legitimate right of access, for as long as the records are held by the organisation.

- **Security** – that records will be secure from unauthorised or inadvertent alteration or erasure, that access and disclosure will be properly controlled and audit trails will track all use and changes. Records will be held in a robust format which remains readable for as long as records are required.

- **Retention and disposal** – that there are consistent and documented retention and disposal procedures to include provision for permanent reservation of archival records.

- **Training** – that all staff are made aware of their record-keeping responsibilities through generic and specific training programmes and guidance.

- **Performance measurement** – that the application of records management procedures are regularly monitored against agreed indicators and action taken to improve standards, as necessary.

4.1 Key Principles of Records Management

Effective records management will help ensure that we have the right information at the right time to make the right decisions. Information is essential to the delivery of high quality evidence-based health care on a day-to-day basis and an effective records management service ensures that such information is properly managed and is available:

- To support patient, donor care and continuity of care;
- To support day to day business which underpins the delivery of care;
- To support evidence based clinical practice and improvements in clinical effectiveness through research;
- To support financial, administrative and managerial decision making;
- To meet legal requirements, including subject access requests from patients, representatives or their carers, donors and staff under the Data Protection Act 2018 (UK GDPR);

Good record keeping ensures:

- Staff are able to work with maximum efficiency without having to waste time locating information;
- Where appropriate, there is an audit trail which enables any record entry to be traced to a named individual with a given time/date with the knowledge that all alterations are recorded and can be similarly traced; (NB. health records should never be altered – incorrect information may be crossed through, but remain legible, and additional information inserted)
- Those using the record following another staff members use can see what has been done, or not done, and why; and
- Any decisions made can be justified or reconsidered at a later date.

To ensure that the key principles of the Policy are adhered to, the Trust operates a standard approach to the management of information in line with the Code of Practice on the management of records issued under Section 46 of the Freedom of Information Act 2000, these are:

- Create
- Assure
- Use
- Store
- Access
- Share
- Publish
- Dispose

4.2 Records Creation

This policy relates to all operational records. Operational records are defined as information created or received in the course of business and captured in a readable form in any medium and providing evidence of the functions, activities and transactions. These records should not be considered personal property, but corporate assets. Staff are to note that records related to official business generated on a non-corporate communication channel (NCCC) are considered business records. The use of NCCCs for business reasons is forbidden unless permitted in limited circumstances by the Information Governance team, however, any records generated on NCCCs are subject to this policy.

This list is not exhaustive, but they include:

- Administrative records; (including personnel, letters, memos, estates, financial and accounting records, contract records, litigation and records associated with complaint-handling)
- Health records (including those concerning patients and donors);
- Theatre Registers and all other treatment registers that may be kept;
- X-ray and imaging reports, outpatient records and images;
- Photographs, slides, and other images;
- Microform (i.e. fiche/film), audio and video tapes; and
- Records in all electronic formats - computer databases and their output, including disks etc, and all other electronic records including databases maintained for personal/research purposes.
- CCTV Images and recordings for the purposes of prevention and detection of crime and the health, safety and security of Staff

All records created in the course of the business of the Trust are corporate records and are public records (where defined) under the terms of the Public Records Acts 1958 and 1967 (An Act of parliament which reduces the time that public records may be made available to the public from 50 years under the Public Records Act 1958 to 30 years) and the Constitutional Reform and Governance Act 2010. This will include emails and other electronic records.

4.3 Records Maintenance (Assure)

The principle of Assure means that we must ensure that our processes are robust enough to protect all information as much as is physically possible. This allows the Trust to assure our patients, donors and service users that our processes are robust enough to safeguard information securely.

Whilst system security in relation to of electronic systems may not provide 100% protection against complex hacking, as an organisation we can mitigate the risk of inadvertent disclosure of information by following a high standard of documentary security, both in the physical and electronic sense, within our daily working practices.

In the same way that the Trust ensures that the data and information it creates is safeguarded securely, the same measures of protection are to be applied for information received within the organisation. All information should only be accessed on a need-to-know basis. By compartmentalising information access, the risk of inadvertent disclosure by unauthorised Staff is reduced. Staff who have access to information are to safeguard it appropriately.

4.4 Records Retrieval (Use)

Accurate recording and knowledge of the content and location of all records is essential if relevant information is to be located quickly and efficiently. Systems will be reviewed and developed as necessary to ensure that as a record moves around the organisation, an audit trail is created and systems are recommended to record the following (minimum) information:

- the item reference number or other identifier;
- a description of the item (e.g. file title);
- it's location i.e. a person, unit, department or other; and

- the date of transfer.

4.5 Records Storage

Whilst there are many options available for Information Asset Owners to follow, the crucial element is the ability to access information easily and quickly which relies on the logical storage of information. The Code of Practice on the management of records issued under section 46 of the Freedom of Information Act 2000 provides a high level overview in terms of what the Secretary of State for Digital, Culture, Media and Sport expects from Public Bodies. The ICO provides more granular guidance in relation to the entire subject of Records Management in its Section 46 - Code of Practice for Records Management . In relation to the storage of Medical Records, the NHS Wales Records Management Code of Practice for Health and Social Care 2022 is to be used by Trust Staff. The Information Governance team are available to provide advice and guidance to Staff.

If staff have recorded any information on NCCCs for official purposes, these must be stored and transferred and stored onto a corporate channel without delay. Upon completion of transfer, the record must be deleted from the NCCC immediately.

4.6 Records Access

Information within the Trust is a corporate asset, but given the nature of its business, the principle of 'need to know' underpins access to information. Staff are not, under any circumstances to access records where there is no business need to do so.

4.7 Sharing of Records

Sharing information is a business-critical function of the Trust. However, it must be done compliantly and in a structured way. Data Protection legislation states that may only be shared with the consent of the originator of the information. Specifically information is not to be shared to third party organisations without prior approval. Prior to any approval to share data, data protection legislation requirements must be met. The ICO's Data Sharing Code of Practice is the underpinning guidance in terms of considering the sharing of personal data. Whenever personal data is to be shared, the advice of the HoIG is to be sought at the beginning of the process.

4.8 Publishing Records

The Communications department are responsible for the public facing aspect of the Trust. The Trust has its own website, which is accessible by the general public.

Information within the website is to meet the high-quality standards of the Trust and should only be published after it has been ascertained that the information does not breach any current legislation (including the Freedom of Information Act 2000) with regards to appropriate content, security and sensitivity.

The Trust adheres to data protection legislation and our Privacy Notice is contained on the website. When requested, staff are able to forward a hyperlink to the Privacy Notice to stakeholders and other third parties.

4.9 Retention and Disposal of Records

Information held by the Trust is to be for explicit and legitimate purposes. It must also be adequate, relevant, accurate and necessary. These are the six principles for the

management of information within the Trust. When creating the information, it is prudent practice to estimate the whole life disposition of the information.

It is a requirement that all Trust records are retained for a minimum period of time for legal, operational and safety reasons. The length of time for retaining records will depend on the type of record and its relation to the Trust's functions.

The Trust has adopted the retention periods set out in the NHS Wales Records Management Code of Practice 2022.

The Trust contracts a confidential waste disposal company, to dispose of physical information securely. All documents must be placed in the receptacles provided which are emptied regularly by the Contractor.

4.10 Data Quality

The Trust will ensure an Executive level focus on data quality and will actively encourage an organisation wide approach to its management. The Data Quality Policy contains more information.

4.11 Security, Confidentiality and Data Protection

The Trust has a legal duty of confidence to service users and staff and a duty to maintain professional ethical standards of confidentiality. Everyone working for or with the Trust and record, handle, store or views personal data, has a common law duty of confidence – even after the death of the service user, or after an employee or contractor has left the Trust. (i.e. duty of confidentiality is for life)

4.12 Contracting out Information Storage and Retrieval

Where off-site storage is used appropriate security measures must be assured after consultation with the HoIG so that both clinical and legal obligations are met, this includes a mandatory requirement to complete and maintain a Data Protection Impact Assessment (DPIA) for all records stored off-site in line with Section 4.4 of the Records Management Code of Practice for Health and Social Care 2022.

4.13 Information Asset Owners and Registers

The Trust is fully committed to identifying all recognisable bodies of information held on paper or electronic media that are required to support the work of the organisation. To identify all records of information that we hold about our patients, donors, staff and service users (incl. families, friends, etc) each division/hosted organisation are required to develop and assemble an appropriate Information Asset Register (IAR) under the authority of the Information Asset Owner (IAO).

Information Asset Owners (IAO) are accountable for ensuring that the risks to and the opportunities for the asset are monitored, The IOA does not need to be the creator or primary user of the asset, but they must understand its value to the Trust. The UK Cabinet Office has specific guidance for IAOs:
https://www.gov.uk/government/publications/information-asset-owner-role-guidance

The IAO in their role must:

- Be senior/responsible individuals involved in running the relevant Service area.
- Understand what information is held, what is added and what is removed, how information is moved, and who has access and why.
- As a result they are able to understand and address risks to the information and ensure that information is fully used within the law for the public good.
- Provide a written judgement of the security and use of their asset annually to the SIRO via the Head of Information Governance to support the audit process.

IAOs will be trained upon appointment. The training is aimed at updating those who may have been trained previously, whilst providing training for those who have not been trained previously to the same standard.

The IAR is a compulsory component of the Trust's Information Governance framework, as the identification of where and how records are being kept can then enable the Trust, its respective divisions and hosted organisations to better assess the risks associated with how information is being collected, stored and disposed, thereby ensuring compliance with Data Protection Legislation and associated standards.

5. ROLES AND RESPONSIBILITIES

The Trust recognises its corporate responsibility and commitment to compliance with Records Management requirements; as stated within statutory provision and good practice guidance, and to further raise staff awareness of good Records Management practice.

The Trust's Quality, Safety and Performance Committee is responsible for approving the content of this Policy.

5.1 Managerial Accountability and Responsibility

The **Chief Executive** of the Trust as the **Accounting Officer** has overall responsibility for ensuring compliance with applicable legislation and regulation.

Respective **Senior Information Risk Owners (SIRO)** shall represent any relevant information risk to the Trust Board.

Directors of Hosted Bodies and Divisions within the Trust are responsible for ensuring that the policy is implemented within their individual organisation. They will nominate departmental representatives, who will liaise with the respective Information Governance Leads on the management of records in that division.

Within the Trust there are **Caldicott Guardians** who have responsibility at respective organisational level for ensuring the care of patient/donor data.

The Trust, divisional and hosted organisational **Information Governance champions** are responsible for co-ordinating records management in their respective organisations and identifying key corporate records and providing

guidance and advice on their management and retention. Details of your local champions can be found on the Information Governance intranet page.

5.2 Individual Responsibility

All members of staff are responsible for any records which they create or use. This responsibility is established by law and in the contract of employment with the Trust. Furthermore, as an employee of the NHS, any records which are created by any employee or contractor of the Trust are public records. It is the responsibility of all staff to ensure that appropriate records of their work in the Trust are kept and managed in keeping with this policy and with any guidance subsequently produced on behalf of the Trust.

Everyone working for or with the NHS who records, handles, stores, or otherwise comes across information has a personal common law duty of confidence to individuals referred to in that information. Data Protection Legislation places statutory restrictions on the use of personal data, including health information.

The Data Protection and Confidentiality Policy contains practical considerations which members of Staff are to follow when processing information within the remit of this Policy.

6. LEGISLATION AND STANDARDS

The need to improve NHS records managements and for the Trust to re-consider current practices has arisen from statutory provisions and good practice guidance's that include but is not limited to:

- Data Protection Legislation
- Freedom of Information Act 2000
- Environmental Information Regulations 2004
- Public Records Acts 1958 and 1967
- Caldicott Principles
- Records Management: NHS Code of Practice
- The Lord Chancellor's Code of Practice under Section 46 of The Freedom of Information Act 2000 (superseded by the Secretary of State for Digital, Culture, Media and Sport – Code of Practice on the management of records issued under Section 46 of the Freedom of Information Act 2000)

The Trust recognises that specific procedures within divisions and associated organisations may vary and that this policy should therefore be considered in conjunction with any such policies and/or procedures and not read in isolation.

7. TRAINING AND AWARENESS

The Trust will ensure that adequate training is provided raising the awareness of staff responsibilities for records management and that qualified expertise is available for consultation via the Head of Information Governance.

8. GOVERNANCE AND REPORTING

It is the duty of all staff to record and report any incidents or 'near misses' involving records or personal data (including the unavailability and loss) in line with the Trust and divisional and/or associated organisational incident reporting policies/procedures.

The Trust's Head of Information Governance will report a summary of incidents via the Executive Management Board (EMB) to the Quality, Safety and Performance Committee (QSPC) on a quarterly basis via Senior Information Risk Owner (SIRO) so that the Trust Board has an oversight on any breaches of Records Management Policy.

The Committee will further brief the Trust Board as appropriate.

9. AVAILABLE GUIDANCE

Guidance on the procedures necessary to comply with this policy should be made available from the respective divisions and associated organisations of the Trust or on its web pages. Managers will be responsible for ensuring that all their staff are made aware of Trust policies and standards.

Links to the Information Commissioner's Office (ICO) website also provide a valuable source of information. For staff (e.g. Line managers, departmental administrative support and People and OD employees) responsible for the processing, retention and disposal of employee records, the ICO's guidance on Employment practices and data protection is further recommended reading in conjunction with Trust policies.

10. HEALTH AND CARE STANDARDS

This Policy and processes described enable the Trust to comply with The Health and Care Quality Standards, namely the Information Standard:

> "*Our healthcare system ensures information is available and shared appropriately for all who need it. We turn data to knowledge by triangulating quantitative and qualitative performance, experience and outcome measures to understand the quality of services, efficacy of improvement work and impact of decisions made. We monitor, report and escalate indicators through our governance structures to ensure that appropriate action is taken at every level in terms of learning, improvement and accountability."*

11. EQUALITY

In accordance with the Trust's Equality policy, this policy will not discriminate, either directly or indirectly, on the grounds of gender, race, colour, ethnic or national origin, sexual orientation, marital status, religion or belief, age, union membership, disability, carers status, offending background or any other personal characteristic.

12. CONTACTS

For further advice and/or assistance on how to ensure individual, divisional and associated organisational compliance with this policy, contact: -

Head of Information Governance
Velindre University NHS Trust
2 Charnwood Court,
Parc Nantgarw,
Cardiff,
CF15 7QZ,
Tel – 029 2031 6951
Email – VelindreInformationGovernance@wales.nhs.uk

13. Further Information

This Policy should be read in conjunction with the following Trust policies:

- Information Governance Policy
- Data Protection & Confidentiality Policy
- Freedom of Information Act Policy
- Data Quality Policy
- Information Security Policy
- Procedure for Media, Filming, Recording and Photography, for and within the Trust
- Email and Instant Messaging Use (EIM) Policy
- Mobile Phone Policy
- Records Management Code of Practice for Health and Social Care

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

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POLICY AND PROCEDURE FOR THE MANAGEMENT OF TRUST WIDE POLICIES AND OTHER TRUST WIDE WRITTEN CONTROL DOCUMENTS

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1. INTRODUCTION AND AIM

1.1 Velindre University NHS Trust, subsequently referred to in this policy as the 'Trust', has a statutory duty to ensure that appropriate policies and supporting strategies procedures, protocols, or guidelines (referred to collectively as other Written Control Documents) are in place. Policies and other Written Control Documents help ensure that the Trust complies with legislation, meets mandatory requirements, and provides services that are evidenced-based, safe and sustainable, enabling all staff to fulfil their roles safely and competently to provide effective and appropriate care and services for patients, donors and their colleagues.

1.2 Policies describe the Trust's guiding principles that underpin its decisions, behaviours and actions for everything it does. A Policy statement is a public commitment of our intent. Other written control documents translate these principles into more detailed instructions or guidance including individual responsibilities

1.3 Policies and other Written Control Documents provide the Trust with a clear governance framework to operate within and provide a process of internal control. They define what the organisation does and how it is done, support effective decision making and delegation and provide guidance for staff to follow.

1.4 To ensure the Trust delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, it will develop and describe its "ways of working" in Policies and other Written Control Documents. In this regard, the Trust has approved the Policy and Procedure for the Management of Trust Wide Policies and other Trust Wide Written Control Documents (GC01), commonly referred to as the "*Policy on Policies"*.

1.5 Through this Policy the Trust ensures that there is a process whereby all policy documentation is consistent in format, compilation and dissemination. In addition, there is an effective process for managing and reviewing policies and any other written control documents on a regularised basis, to ensure that documentation remains legally compliant and actions are undertaken in a safe and efficient manner.

1.6 The principles of the policy management process including individual responsibilities for developing and reviewing policies and other written control documents, is summarised in the flow chart on page 7.

2. OBJECTIVES

2.1 This Policy ensures consistency in the format, compilation, approval and dissemination of all Policies and other Written Control Documents, so that they are:

- Developed and reviewed when required;
- "Owned" – each document will have an owner who has responsibility for making sure that it is regularly reviewed and kept up to date;
- Written in plain language so that they can be understood, and people are clear of what is expected;
- Subject to an Impact Assessments where required;

- Recorded, stored and archived in accordance with the Trust's Records Management Policy;
- Appropriately co-produced and consulted on;
- Considered and approved at the appropriate level within the Trust by the appropriate advisory group, forum, sub-committee or committee (with delegated powers and authority to do so);
- Shared with staff and stakeholders where required;
- Supported by appropriate learning, education and development where required; and,
- Available to the public, in line with Freedom of Information Act requirements and the Trust's Publication Scheme.

3. SCOPE

3.1 This Policy is applicable across the whole of the Trust in all locations. It applies to all Employees and Independent Board Members. The term "Employees" includes all those who have a contract of employment or honorary contract with the Trust.

3.2 Any reference in this Policy to the Trust should also be applied to any services or programmes that the Trust hosts such as the NHS Wales Shared Services Partnership (NWSSP), Health Technology Wales (HTW) and Advancing Therapies Wales (ATW).

3.3 This policy applies to all Trust wide Policies and other Trust wide Written Control Documents which fall within the definitions contained in this policy, both clinical and non-clinical.

3.4 Where written control documents relate to a single Directorate or Division and there is no wider impact on the Trust, they may be approved by the relevant Senior Management/Leadership Management Team.

3.5 In addition to the responsibilities detailed within the Policy, staff also have a responsibility for making sure that they meet the requirements of their role profiles and any other responsibilities delegated to them, which includes the development, review, publication and implementation of Policies and other Written Control Documents within their role.

4. POLICIES AND OTHER WRITTEN CONTROL DOCUMENT PROCESS AND FLOWCHART

4.1 The reason to develop a new or review an existing Policy or Written Control document can come from a variety of sources, i.e. legislation, national guidance, external reviews, audits, to clarify/improve working practice, to mitigate an identified risk or to adopt an all Wales Policy or other Written Control Document. It is up to managers of a service, staff or function to recognise when a Policy or other Written Control Document is required to minimise risk to patients, donors, staff and the organisation. An example is, as a result of an investigation following incident reporting, which recommends additional system controls to prevent the risk of reoccurrence of a similar incident. This can equally apply to action required following the investigation of a complaint and claims management.

4.2 The first step in the development/review of a Policy or other Written Control Document is the completion of the Document Approval Checklist. The Document Approval Checklist must be completed when the Policy or other Written Control Document is multi-disciplinary and/or multi-agency in nature. The Document Approval Checklist must also be completed for all Wales or jointly developed Policies and other Written Control Documents.

4.3 Any local Written Control Document, which is a local/divisional procedure or guideline which sets out the requirements for staff in a discrete department or professional group and does not have wider implications across the Trust, may not require a Document Approval Checklist. Further clarity can be sought from the Corporate Governance Team.

4.4 The overarching rationale for completion of the Document Approval Checklist is to aid the responsible document author (see section 10) in being clear about the reason for the document, the potential impacts of the document and the support required to facilitate the implementation of the document. It is best practice to consider these prior to developing or reviewing all Policies or Written Control Documents.

4.5 Whilst most Policies and other Written Controls Documents are developed internally for internal use within the Trust, there will be occasions when a Policy or other Written Control Document requires to be developed jointly with another organisation, for example, a Local Authority or other partner agencies. These must follow the process as Trust only Policies and Written Control Documents (page 7).

4.6 Some Policies and other Written Control Documents are issued on an all Wales basis with the expectation of local adoption. These documents must also be subject to formal adoption for use in the Trust (refer to section 6).

4.7 When the requirement for a developing a new or reviewing an existing Policy or other Written Control Document arises, it is recommended that contact is made with the Corporate Governance Manager, subsequently referred to as the 'Policy Process Manager', who will able to provide advice and support about each stage of the Policy and other Written Control Document development/review process.

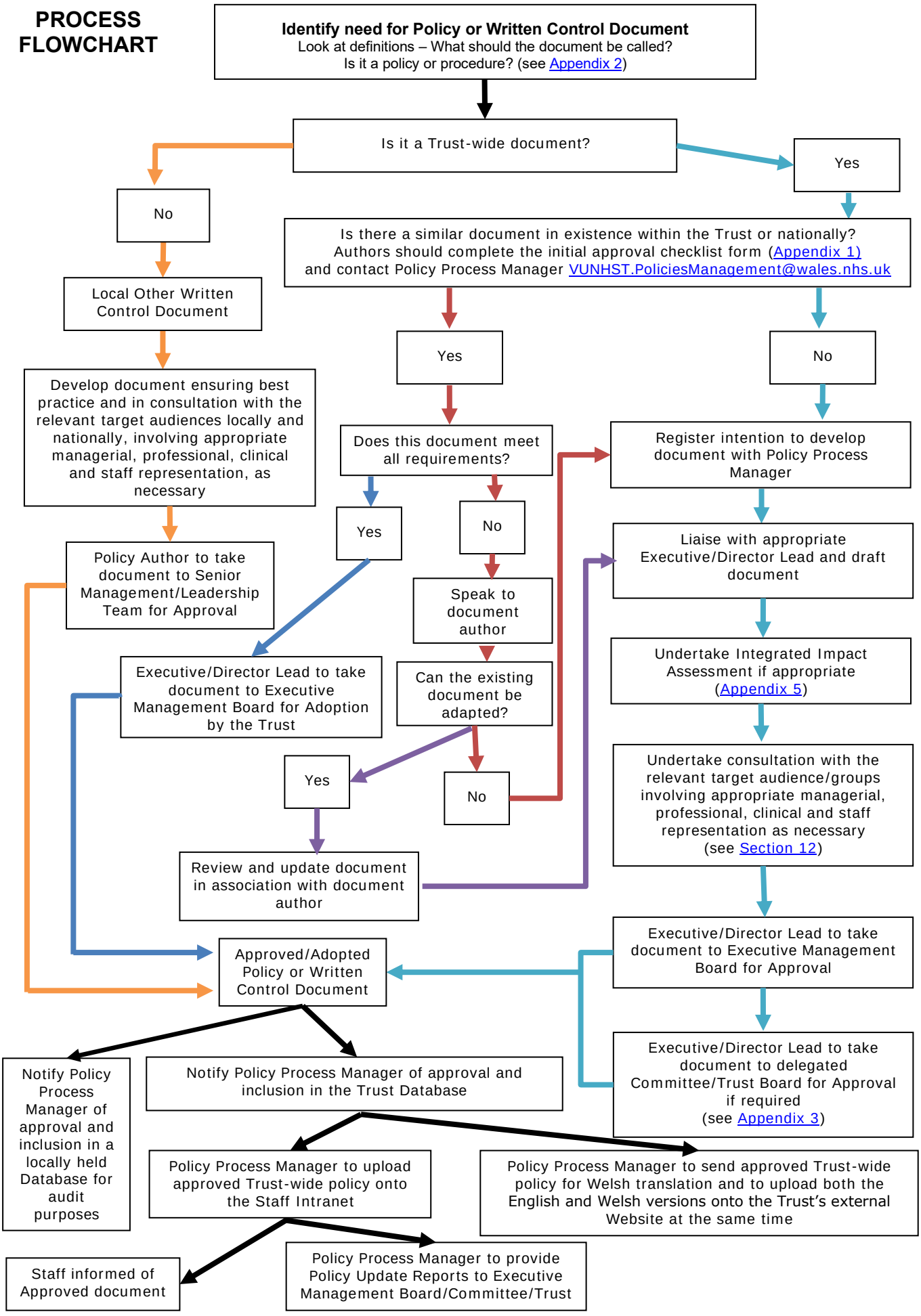
4.8 The most important thing to note is that the development of a new or review of an existing Policy and other Written Control Document must not be undertaken in isolation and that it must be owned and overseen by the appropriate advisory group, forum, sub-committee or committee. Policies and other Written Control Documents are best developed/reviewed in collaboration with others to ensure that the final document is one that is in line with current legislation, guidance and evidence and can be implemented seamlessly within the organisation.

4.9 In addition, Strategies and Policies only must be sponsored by an Executive/ Director. If not already identified, the advisory group, forum, sub-committee or committee must nominate an author who will be responsible for ensuring that the process outlined in this policy is adhered to, starting with the completion of the Document Approval Checklist (Appendix 1).

4.10 All policies will be subject to and Equality Impact Assessment and a Quality Impact Assessment.

4.11 The flow chart on the following page explain the steps to be taken when considering the development of a Policy or Written Control Document. It is important that appropriate engagement and consultation takes place. In the case of employment policies, (excluding those enforced from Welsh Government following national negotiations and other “All Wales policies”), staff representatives and management will jointly negotiate a draft policy for submission to the appropriate Committee for approval. If there are any issues that cannot be resolved at Committee level, the Policy will be brought to the Trust Board for final consideration and approval.

4.12 The development of Policies and other Written Control Documents must not be undertaken in isolation and will be based on sound evidence, and take account of current legislation, mandatory requirements and national/professional guidance. Sources of information used should be appropriately referenced.


PROCESS FLOWCHART
Identify need for Policy or Written Control Document
Look at definitions – What should the document be called?
Is it a policy or procedure? (see Appendix 2)
Is it a Trust-wide document?
Yes
No
Is there a similar document in existence within the Trust or nationally?
Authors should complete the initial approval checklist form (Appendix 1)
and contact Policy Process Manager VUNHST.PoliciesManagement@wales.nhs.uk
Local Other Written Control Document
Yes
No
Develop document ensuring best practice and in consultation with the relevant target audiences locally and nationally, involving appropriate managerial, professional, clinical and staff representation, as necessary
Does this document meet all requirements?
Register intention to develop document with Policy Process Manager
Yes
No
Policy Author to take document to Senior Management/Leadership Team for Approval
Liaise with appropriate Executive/Director Lead and draft document
Speak to document author
Executive/Director Lead to take document to Executive Management Board for Adoption by the Trust
Undertake Integrated Impact Assessment if appropriate (Appendix 5)
Can the existing document be adapted?
Yes
No
Undertake consultation with the relevant target audience/groups involving appropriate managerial, professional, clinical and staff representation as necessary (see Section 12)
Review and update document in association with document author
Executive/Director Lead to take document to Executive Management Board for Approval
Approved/Adopted Policy or Written Control Document
Executive/Director Lead to take document to delegated Committee/Trust Board for Approval if required (see Appendix 3)
Notify Policy Process Manager of approval and inclusion in a locally held Database for audit purposes
Notify Policy Process Manager of approval and inclusion in the Trust Database
Policy Process Manager to upload approved Trust-wide policy onto the Staff Intranet
Policy Process Manager to send approved Trust-wide policy for Welsh translation and to upload both the English and Welsh versions onto the Trust's external Website at the same time
Staff informed of Approved document
Policy Process Manager to provide Policy Update Reports to Executive Management Board/Committee/Trust

5. DEFINITIONS

5.1 Policies and other Written Control Documents are essential in the delivery of a high quality and safe health services and to ensure the Trust operates within the law. They form an integral element of the governance and assurance framework by which the Trust regulates its activities to achieve its goals and are used as reference points to assist staff in their day to day working.

5.2 Terminology across the range of documentation can often be confusing for both those that develop the documents and to those that use them. Clear definitions for these terms, highlighting the differences and similarities and the appropriate use of each is provided Appendix 2.

6. WHO CAN APPROVE THESE DOCUMENTS AND WHERE ARE THEY PUBLISHED?

6.1 The Standing Orders set out a Scheme of Delegation for the Trust and for organisation-wide documents. Strategies are a matter on which Trust Board approval is required. Certain key policies also require approval by the Trust Board (see Appendix 3) whilst others are delegated to the appropriate advisory group, forum, sub-committee or committee or Executive based Group (see Appendix 3). Any delegated approvals must also be submitted through the relevant Executive Sponsor to the Policy Process Manager. A copy of the relevant minute confirming the approval may be required. Documents that have not gained the required approval **will not be published.**

6.2 **Directorate and Division Specific Documents:** Where written control documents relate to a single Directorate or Division and there is no wider impact on the Trust, they may be approved by the relevant Senior Management/Leadership Management Team. Such documents will still need to be recorded in a suitable database at a local level and subjected to strict version control, issued with a unique reference number and meet the standards set within this policy. There must also be a clearly documented audit trail to indicate where and by whom the document has been considered.

6.3 Some “All Wales” policies are developed by the Welsh Government or by Health Boards and Trusts working together. For some of these documents the Trust must adopt them. Where this is the case, they will be reported to the appropriate advisory group, forum, sub-committee or committee or Trust Board so that there is a record of their adoption.

6.5 Once approved, centrally recorded documents are published on the Trust Intranet and Internet sites by the Policy Process Manager. Under limited circumstances it may be necessary to redact [remove or hide] information from a document prior to publication on the website e.g. direct dial telephone numbers within the Business Continuity Policy. The advisory group, forum, sub-committee or committee approving the document will determine if it is necessary to redact information prior to publication. Where this has been agreed it will be made clear within the body of the text on the document made available.

6.6 The diverse nature of health care means there will be a large number of policies and other Written Control Documents in place. Some will apply across the Trust and be relevant to all staff, and others will be specific to certain areas or activities.

6.7 For ease of reference, all policy documentation will be listed and numbered under a series of headings. An index of Policies and other Written Control Documents will be maintained as part of the on-line database that is in place and maintained to manage the review process. The database will become the central register for all Policies and other Written Control Documents in the Trust.

7. WHO CAN PROVIDE ADVICE ON WHAT TO DO AND HOW DO WE KNOW WHAT DOCUMENTS HAVE ALREADY BEEN DEVELOPED?

7.1 The Director of Corporate Governance is responsible for making sure that the Trust has arrangements in place to ensure effective development and management of Policies and other Written Control Documents.

7.2 The Corporate Governance Manager is part of the Corporate Governance team and undertakes the function of Trust-wide "Policy Process Manager", who can provide advice and assistance on any aspect of document development and review. They can be contacted via the generic Policy email account VUNHST.PoliciesManagement@wales.nhs.uk

7.3 The Policy Process Manager maintains a register of all documents that are centrally recorded and will be able to advise if a document already exists. All of these documents are also published on the Trust's Intranet and can be found through either the A-Z Listing or by searching on key words. Most documents are also published on the Trust's website.

7.4 The Policy Process Manager will arrange for approved documents and the accompanying Equality Integrated Impact Assessment (if applicable) to be published on the intranet/internet as appropriate within ten working days of receipt from the policy author or advisory group, forum, sub-committee or committee Secretariat.

7.5 Where an approved document is a Trust-wide policy, the Policy Process Manager will arrange for the Welsh translation of the policy prior to publishing the English and Welsh versions on the website in line with the requirements of the Welsh language standards.

8. WHAT ARE THE ROLES AND RESPONSIBILITIES OF EXECUTIVE/DIRECTOR LEADS

8.1 The Chief Executive, as Accountable Officer, has overall responsibility for ensuring the Trust has appropriate Policies and other Written Control Documents in place to ensure the Trust works to best practice and complies with all relevant legislation.

8.2 The delegated responsibilities of Executive/Director Leads are set out in the Scheme of Delegation. They have responsibility for:

- making sure that appropriate Policies and Written Control Documents are produced and kept up to date by identifying a document author (including reallocating responsibility if the author leaves or moves to another role);
- personally checking for accuracy of content prior to submission to an advisory group, forum, sub-committee or committee for approval;
- maintaining a list of these Policies and Written Control Documents, supported by the Policy Process Manager and making sure that these documents are up to date;
- making sure that there are arrangements in place to capture as appropriate, respond to and review documents when external organisations, e.g. Health and Safety Executive, Royal Colleges, publish new and updated information which require action by the Trust;
- making sure that consultation has taken place and an Integrated Impact Assessment, which includes the equality and health impact assessments, have been completed where necessary. Where these have not been undertaken a reason for this will be provided;
- making sure that any training requirements specific to the document have been referenced; and,
- making sure that where a process of audit and/or review has been agreed this is maintained and reported on.

9. WHAT ARE THE RESPONSIBILITIES OF DOCUMENT AUTHORS?

9.1 Authors are employees who have been given the task of writing or reviewing Policies and Written Control Documents. Employment documents should always have at least two authors i.e. a management representative and a staff representative. Authors must:

- liaise with Executive/Director Leads to make sure Policies and Written Control Documents are implemented appropriately and, where necessary, compliance with these documents is formally audited;
- make sure that documents are reviewed in line with the review date or as a result of changes to practice, organisational structure or legislation;
- work with the Executive/Director Lead and the Policy Process Manager to make sure that appropriate engagement and consultation has taken place with the relevant individuals and groups;
- inform the Executive/Director Lead of any learning, education or development needs and resource implications which must be considered before approval can take place;
- undertake the necessary impact assessments, including equality and health impact assessments, in consultation with the Equality, Diversity and OD Manager and Equality Integrated Impact Assessment (EQIA) Group, as required (Appendix 5);
- consider the findings and make sure that appropriate action has been taken in response to equality and health impact assessments.
- send the approved document to the Policy Process Manager for publication within ten working days of approval.

9.2 Authors are responsible for the review of their documents. If an author leaves the Trust or takes up another post, the responsibility for the ongoing maintenance of the

document is taken on by their replacement. Where no direct role replacement is appointed, responsibility reverts to the post holder's line manager. The Executive/Director Lead will be informed of the situation to allow them to identify a replacement author if it is not appropriate for the responsibility to stay within that department.

10. POLICY DEVELOPMENT

10.1 Each Trust-wide policy will be sponsored by a lead Executive. At Directorate/ Departmental level, Policies and other Written Control Documents will be sponsored by the appropriate Director/Head of Department. The Director of Corporate Governance will ensure that all Policies and Other Written Control documents are reviewed and appropriately monitored.

10.2 The development of new Policies and other Written Control Documents, or the amendment of existing documentation, will be overseen by the appropriate lead Executive/Director. They will be responsible for ensuring that content and scope are fit for purpose before being presented for approval.

10.3 When the need for a new policy document arises, the Policy Process Manager should be informed before preparation commences to ensure there is not a Policy or other Written Control Document already in existence locally or nationally on the same or similar subject, thus avoiding duplication of effort. Authors should complete the initial Document Approval Checklist (Appendix 1) and send to the generic Policy email account VUNHST.PoliciesManagement@wales.nhs.uk

10.4 Once the need and type of Policy or other Written Control Document is identified, the process for production and approval must follow that contained within this Policy. A flowchart depicting this process is set out on page 7.

10.5 The language used should be plain English, using short sentences and where possible avoiding technical terms. If technical terms are used, they should be explained using a glossary or footnotes. In accordance with the requirements of the Data Protection Act 2018, the names of individuals will not be contained within policies and other written control documents. Individuals with particular responsibilities will be identified by their job title only.

10.6 All Policy and Written Control Document development should be undertaken in line with current legislation, national and professional guidance. Documentation should also be based on sound evidence and be appropriately referenced.

10.7 **Quality Impact Assessment and Health Care Standards**
All new Policies require a Quality Impact Assessment. All Policies and other Written Control Documents should outline how they contribute to compliance with the Health and Care Standards and should also indicate to which Standards this area of activity is linked.

10.8 **Well-being of Future Generations (Wales) Act 2015**
The Well-being of Future Generations (Wales) Act 2015 is about improving the social, economic, environmental and cultural well-being of Wales. As a listed body, we are mandated to assess our long-term impact, work better with people and

communities and each other, look to prevent problems and take a more joined-up approach. This will help us to create a Wales that we all want to live in, now and in the future. To make sure we are all working towards the same vision, the Act puts in place seven well-being goals:

- 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
- A Globally Responsible Wales

The Act also lists the 5 Ways of Working:

- Long Term
- Collaboration
- Prevention
- Involvement
- Integration

All Policies and other Written Control Documents must consider provisions and demonstrate that all key goals were considered in the development of the document.

Each Well-being Goal and the 5 Ways of Working are incorporated into the Integrated Impact Assessment, refer to Appendix 5 for further detail. All documentation is required to highlight how it contributes to at least one Well-being Goal and assesses the whether the documentation adheres to the 5 Ways of Working.

10.9 **Equality Integrated Impact Assessment**

The Equality Act 2010 requires the undertaking of various impact assessments and all Trust Policies and other Written Control Documents will require the completion of these before the document is consulted upon. The impact assessments are a process to find out whether a ‘policy’ will affect people differently on the basis of their 'protected characteristics': age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion, sex or sexual orientation and if it will affect their human rights. It also takes account of Welsh Language issues. It is designed to ensure that the Trust is taking into consideration the needs of all individuals who work for it and/or access its services.

The Trust has adopted an integrated approach to impact assessment, which combines the equality and health assessment alongside environmental impacts, Welsh Language whilst assessing the document against the requirements within the Well-being of Future Generations (Wales) Act 2015 and the Socio-Economic Duty.

A health impact assessment is a process that considers how the health and well-being of a population may be affected by a proposed action, be it a policy, programme, plan, project or a change to the organisation or delivery of a particular public service. Some impacts of policies on health may be direct, obvious and/or intentional, whilst others may be indirect, difficult to identify and unintentional. A

health impact assessment is a systematic, objective, flexible and practical way of assessing both the potential positive and negative impacts of a proposal on health and well-being and suggests ways in which opportunities for health gain can be maximised and risks to health minimised. Health impact assessment looks at health in its broadest sense, using the wider determinants of health as a framework.

Where another Written Control Document has been developed in support of a policy it may not be necessary to undertake a further Integrated Impact Assessment. If an Integrated Impact Assessment has not been completed the reason for this will be explained at the beginning of the document. Where an Integrated Impact Assessment has been completed the impact will be included in the document.

10.10 **Environmental Management**

The Trust is accredited to the Environmental Management System (EMS) ISO 14001:2015 which is the internationally recognised standard for managing the environment. The EMS provides a framework for managing environmental impacts associated with the Trust's activities.

The system applies to both the public and private sectors and demonstrates that the organisation has a formal system in place for managing the environment.

The system is based on the principle of continual improvement and requires the Trust to demonstrate this by the use of Key Performance Indicators and progress towards environmental objectives and targets. This framework allows an organisation to understand, describe and control its significant impacts on the environment, reduce the risk of potentially costly pollution incidents, ensure compliance with environmental legislation and continually improve its business operations.

An environmental impact assessment is undertaken as part of the Integrated Impact Assessment process and is an assessment of the possible positive or negative impact that a proposed project may have on the environment, together consisting of the natural, social and economic aspects.

The purpose of the assessment is to ensure that decision makers consider the ensuing environmental impacts when deciding whether to proceed with a project. Advice on areas that require an environmental impact assessment can be obtained from the Trust's Environmental Development Officer.

11. DOCUMENT FORMAT

11.1 A document template has been developed to provide guidance on what information should be contained in which policy/other written control document along with some standard clauses that can be used as appropriate (Appendix 4) and indicates fields that are mandatory. It also contains the standard front cover which is to be applied to Trust Policies and other Written Control Documents, together with some specific points regarding formatting. See Appendix 4 and the Policies Intranet page.

11.2 This Template must be used for all Trust-wide, Divisional or multi-departmental documents. Where a document is only applicable within a single Department or, for example consists of a flow chart, an alternative format is acceptable and a "basic

template" is also shown below. As a minimum the principles listed below must still be followed:

- Document must have a clear heading.
- The scope and objectives must be defined.
- The status of the document must be clear e.g. guidance/mandatory requirement.
- Instructions/guidance must be logically recorded.
- Date of approval shown.
- Date of review shown.
- Author's details.
- Pages numbered.

11.3 The language used for all documents should be plain English, using short sentences and where possible avoiding technical terms. If technical terms are used, they should be explained using a glossary or footnotes.

11.4 Policies and other written control documents will not be routinely translated into other languages. However, where staff are aware that this may cause difficulty for patients, donors or their families, they will ensure that the content is explained to them by an interpreter or translated if necessary.

11.5 In accordance with the requirements of the Data Protection Act 1998, the names of individuals will not be contained within policies and written control documents. Individuals with particular responsibilities will be identified by their job title only.

11.6 If the Trust is adopting an externally approved document it will not need reformatting providing it meets the standards set above. These documents will be given a reference number, recorded and uploaded as if they were a Trust document.

12. ENGAGEMENT AND CONSULTATION

12.1 Policies and other Written Control Documents must not be written in isolation.

12.2 Engagement and consultation on all Policies and other Written Control Documents should take place with the target audience including appropriate stakeholder, service user/carer, managerial, clinical and staff representation. Where appropriate, documents should be co-produced with that target audience.

12.3 The Trust has a range of mechanisms to involve patients, carers, donors and members of the public in its work. This will strengthen the stakeholder involvement with the Trust and demonstrate our commitment to working with the local community and develop our services and policies jointly. Where appropriate, the relevant patient and donor Engagement Leads should be contacted.

12.4 When a final draft has been developed the formal consultation can start. The consultation period should allow enough time to enable the key stakeholders to have had an opportunity to consider and input into the consultation. If necessary, the Policy Process Manager can provide advice.

12.5 The policy author should send the document and Integrated Impact Assessment (if applicable) to the Policy Process Manager who will arrange for the documents to be uploaded onto the Trust's Policy Page on the Intranet. They will also make sure that they are brought to the attention of appropriate stakeholders in a timely manner. This will include the Community Health Council in accordance with mutually agreed principles.

12.6 The author, in association with the appropriate Executive/Director lead, must document the consultation arrangements and provide assurance to the approving advisory group, forum, sub-committee or committee that this has been conducted thoroughly and that comments have been incorporated into the policy or written control document where appropriate. The groups/individuals consulted will be clearly identified in the report presented to the approving advisory group, forum, sub-committee or committee.

13. REVIEW PROCESS

13.1 The Policy or other Written Control Document Author who owns the Policy or Written Control Document is responsible for ensuring it remains in line with current legislation, guidance and evidence and therefore is required to review the Policy or other Written Control Document in light of new or updated legislation and/or guidance (NICE, Professional bodies) as it is published.

13.2 All Policies and Written Control Documents should be reviewed on a minimum cycle of three years. With the exception that a small number of documents need to be reviewed annually (and this requirement will be identified in individual documents by their authors). Sometimes, a document which was subject to a three-year cycle will also need to be reviewed earlier in the light of changing practice or Welsh Government guidance/ policy changes / legislation / evidence, etc. However, if no revisions have occurred in the preceding three years, it must be subject to the full Policy or other Written Control Document process. The author of the individual document is responsible for ensuring this takes place.

13.3 Nine months prior to the review date, the Policy Process Manager will contact the document author who owns the Policy or other Written Control Document to notify them that their document is due for reviewing. The author, in conjunction with the Executive/Director lead who owns the Policy or other Written Control Document, is responsible for ensuring that the document is reviewed by the review by date. If it is foreseen that the review date will not be met, the approving advisory group, forum, sub-committee or committee must receive assurance that the current version of the Policy or other Written Control Document is still fit for purpose and agree an extension of up to a maximum of six months. Any material or significant changes to an existing Policy or Written Control Document will require it to be re-approved by the approving advisory group, forum, sub-committee or committee following the Policy and other Written Control Document process.

13.4 Until a document is reviewed, it will remain the extant policy document of the Trust until replaced. It is the responsibility of the policy author to ensure that documents are reviewed in line with their review dates.

13.5 Organisational change can lead to more than one version of a document on a given subject area existing. In such instances the author will take steps to develop a single version of the document. Should this not be achieved prior to the document reaching three years post approval it will be archived.

13.6 To assist Executive/Director leads to maintain an oversight of the documents approaching three years post-approval, a bi-annual report will be sent to the Executive Management Board and relevant advisory group, forum, sub-committee or committee by the Policy Process Manager providing a summary of the position.

13.7 **Interim Policy Review:** Where a document requires only a small amendment which is not material to the aims or objectives of the document, e.g. to reflect a change in working practice, content of supporting documents etc, an interim review may be undertaken. This will be agreed in advance with the Policy Process Manager to ensure that the completion of an interim review does not expose the Trust to an increased level of risk. The change will be reported to the next available meeting of the Approving Body.

13.8 **Extending Review Dates:** The Policy Author will be contacted to let them know their document is due for review nine months before the review date. The Policy Author, in conjunction with the Executive/Director lead who owns the Policy or other Written Control Document, is responsible for ensuring that the document is reviewed before the expiry date. If the expiry date will pass, the Approving Body (Appendix 3) must receive assurance that the current version of the Policy is still fit for purpose. The Approving Body must then agree an extension of up to a maximum of six months. Any significant changes to an existing Policy will require it to be re-approved by the Approving Body by following the Policy process.

13.9 **Minor Changes to an Existing Policy:** If the amendments are minor, then a 'tracked-change' Word version of the Policy will need to be submitted for approval to the Approving Body. The Equality Integrated Impact Assessment must be checked to see if it requires updating in line with the changes.

Global consultation is not required if there are minimal changes; however, assurance must be given that the Policy Author has consulted with applicable colleagues.

13.10 **Change from Policy to another type of Written Control Document:** If during the review process it is identified that a Policy can be changed to another type of Written Control Document, i.e. Procedure, Protocol, Guidelines, etc. the Policy Author, in conjunction with the Executive/Director lead who owns the Policy or other Written Control Document, will need to provide evidence / justification for such a change to the Approving Body by following the Policy process. Once the Approving Body has approved the change, the new Written Control Document Approving Body will be amended to reflect the document status.

14. PUBLICATION, DISSEMINATION AND DISTRIBUTION

14.1 The Policies and other Written Control Documents which are approved through the Scheme of Delegation for the Trust are centrally managed through the Corporate Governance Department. A Trust Policy database is in place and once a document

has been entered onto the database, approved and published on the internet, this should be regarded as the only official Trust version for dissemination to and use by Trust employees.

14.2 Where a Policy or Written Control Document has been superseded, the archived copy will be held on file by the Policy Process Manager but will no longer be available via the internet. The Trust is required to keep a record of all archived, out of date Policies and other Written Control Documents, in line with WHC (2000) 071 for the Record and Records Management Policies.

14.3 Each department/service which develops/reviews Policies and other Written Control Documents must set up their own local document management system. This must hold all current and out of date Policies and other Written Control Documents. All out of date documents must be kept for **a period of 30 years in line with the WHC (2000) 071 For the Record.**

14.4 All policies and other written control documents that have been ratified appropriately must be forwarded to the Policy Process Manager within ten working days of approval. They will then ensure that the document is:

- Added/updated on the Trust Policy database;
- Cascaded in line with the Trust's communications system;
- Included within the Executive Management Board and Trust Board regular reporting;
- Uploaded onto the intranet;
- Included in the Freedom of Information Publication Scheme.

14.5 The Trust's intranet site will be the primary location for all Policies and other Written Control Documents to ensure that staff can access the most up to date versions. Where hard copies need to be circulated, these should be downloaded from the intranet site by the appropriate Line Manager.

14.6 All documents will be subject to version control and archived in line with legal requirements. Once revised Policies and other Written Control Documents are approved, the Policy Process Manager will e-mail the author/policy lead to inform them in order that they can ensure appropriate dissemination to their staff.

14.7 Once issued, individual Line Managers will be responsible for ensuring that all staff are aware of the revisions and that any out of date versions are taken out of local circulation. Each Directorate/Department will put in place a robust controlled documentation system to ensure that records of distribution of policies and other written control documents are maintained.

14.8 Information on new and revised policies will be cascaded in line with the Trust's communications system. Where appropriate other communication channels may be used to inform staff of policy development (for example, inclusion with payslips).

14.9 It is the responsibility of the author of a Policy or Written Control Document to ensure that when a document is revised, a copy of the original is forwarded to the Policy Process Manager for audit purposes.

14.10 The Director of Corporate Governance will ensure that the register of all Policies and other Written Control Documents is reported bi-annually to the Executive Management Board, relevant advisory group, forum, sub-committee or committee and Trust Board.

15. TRAINING

15.1 All Executive/Director leads will work with the Executive Director of Organisational Development and Workforce to ensure that there is an ongoing training programme for all staff that incorporates the implementation of Policies and other Written Control Documents. Key subject areas will be included at local induction and as part of staff development processes.

15.2 Line Managers must ensure that new starters are aware of this policy, induction arrangements and of their individual departmental processes.

15.3 It is the responsibility of individual Line Managers to inform the Executive Director of Organisational Development and Workforce of the requirement where specific staff training needs are identified, particularly in relation to the implementation of new or updated documents.

15.4 Executive/Director leads will ensure that responsibilities for policy development are clearly outlined in each individual Job Description, in accordance with their role.

16. IMPLEMENTATION AND POLICY COMPLIANCE

16.1 Any advice required on implementation of this policy should be obtained via the Policy Process Manager.

16.2 All policies should be part of the Trust and/or Directorate/Department auditing process to ensure that they:

- have been implemented effectively;
- are fit for purpose; and
- are being complied with.

16.3 Information regarding the frequency of the monitoring arrangements should be included within the main policy document. If appropriate, questionnaires can be used for staff feedback to evaluate any policy and supporting written control documentation.

16.4 It will be necessary to ensure that all documents are being produced, vetted, approved and disseminated in accordance with this policy. Periodical ‘spot checks’ will be carried out in all areas to ensure that all policies and other written control documents comply with this policy.

16.5 Where documents are submitted for publication but do not meet the pre-publication requirements they will be **not be published**. Such documents will be returned to the Executive Sponsor for action.

17. REVIEW PERIOD

17.1 This policy will be reviewed every three years, or sooner should the author or legal requirements deem it to be relevant or required.

18. ACKNOWLEDGEMENTS

18.1 This policy has been developed following benchmarking with the following:

Aneurin Bevan University Health Board, (ABUHB001) Policy and Procedure for the Management of Policies, Procedures and other Written Control Documents

Cardiff and Vale University Health Board, (UHB 001) Management of Policies, Procedures and Other Written Control Documents Policy

Hywel Dda University Health Board, (190) Written Control Documentation Policy and Procedures

Public Health Wales, (PHW47/TP01) Policies, Procedures and Other Written Control Documents Management Procedure

Swansea Bay University Health Board, (HB76) Policy for the Management of Health Board Wide Policies, Procedures and Other Written Control Documents (WCD)

APPENDIX 1

DOCUMENT FOR APPROVAL CHECKLIST

This form should be completed and approval to proceed obtained before you start producing your document. The Equality and Health Impact Assessment, known as the Equality Integrated Impact Assessment, should also have been started and any Welsh Language requirements considered.

To be completed by document author.

1. Proposed/existing title of document

2. 'Owning group' – which advisory group, forum, sub-committee or committee will own the document?

Name of Group		**Chair of Group**		
Please indicate (further details may be requested if applicable)	**Internal Trust Group**		**Yes**	**No**
	Multi-Agency Group		**Yes**	**No**
	Regional Group		**Yes**	**No**

3. What type of document are you proposing/adopting/reviewing? Please select

Policy		**Strategy**		**Procedure**		**Guideline**	
Protocol		**Other**	**Please describe**				

New		**Existing**	

4. Which category will it be/is it?

Clinical		**Corporate**	

If it is a corporate document will/does it impact on patient/donor care?

Yes		**No**	

5. What is the reason for developing/adopting/reviewing this document?
Please tick the box that is most relevant. If there are no relevant boxes, please tick other and ensure that you specify the reason in the box

	Insert tick for most relevant
Improve/standardise clinical care/organisational procedures	
In response to complaint, incident or claim	
In response to alerts, safety notifications, WHCs, etc.	
Re-organisation of service/department	
New/amended legislation	
All Wales documents / national guidance documents to be adopted for use	
Replacing/updating existing written control documents. If so, which ones (Please include policy reference and full name:	
Other (please specify):	

6. What will be/is the aim of the document? What risks are being mitigated?

7. Which other written control documents will be/are relevant to the document?

Document Number	**Document Name** List all document names and numbers that are relevant to this document

8. **What will be/is the scope of this document?**
What service area is covered by the document? Who does it affect? What patient groups? What professional groups or individuals does it affect? What competence is required by staff to use this procedure, e.g. completion of specific training, e-learning, formal qualification, competency framework, is required from users of the procedure?

9. Collaboration with Key stakeholders – What staff groups/professional groups/clinical specialities/services will be/are responsible for implementing/complying with this document?

These key stakeholders' will need to be involved in the development/adoption/review of the document to eliminate any barriers to its implementation prior to approval (see policy for guidance).

10. Collaboration with others

Involvement is an essential component of developing/adopting/reviewing the document.

Please indicate which of the following need to be considered when developing/reviewing this document

Compliance with legislation / regulation / alert	**Please tick √**
Consent	
Deprivation of Liberty Safeguards (DOLS)	
Mental Capacity Act (MCA)	
Mental Health Act	
Safeguarding	
Data Protection/Records Management and Information Governance	
Welsh Language	
Counter Fraud	
Equality, Diversity and Inclusion	
Socio Economic Duty	
National Safety Standards for Invasive Procedures (NatSSIPs)	
Alert/NCEPOD	
Interested Parties	
NICE Guidance	
Patient/Donor Information	
Training / Learning and Development	
Legal	
Financial	
Workforce	
Medicines Management	
Medical Devices	
Infection Prevention & Control	
Business Continuity / Emergency Planning / Major Incident	
Health and Social Care (Quality and Engagement) (Wales) Act 2020	

11. Who will be/is the sponsoring Executive/Director Lead and date they agreed to own this document?

Job Title	
Date	

12. Who will be/is the lead author/main contact for this document?
An individual's name and details will need to be provided as a contact for this document for any queries arise both during development and after approval.

Name	
Job Title	
Email Address	

Date of Completion:		**Name of person completing this form**	
Chair of the Owning Group:		**Signature of the Chair of the Owning Group:**	

PLEASE SEND COMPLETED CHECKLIST FORM TO THE POLICY PROCESS MANAGER VUNHST.PoliciesManagement@wales.nhs.uk

APPENDIX 2

TYPES OF WRITTEN CONTROL DOCUMENTS (DEFINITIONS)

Written Control Document – Is a supporting strategy, procedure, protocol, guideline or standard referred to collectively as other Written Control Documents within this Policy.

Strategy - A strategy is a broad statement of an approach designed to accomplish the desired objectives or goals and can be supported by other Written Control Documents. Strategies are always organisational wide and required to be approved by the Board via the Scheme of Delegation.

Policy – A written statement of intent, describing the broad approach or course of action that the Trust is taking with a particular issue. Policies are underpinned by evidenced based procedures and guidelines and are mandatory. Policy documents may be used to support the Trust during legal action.

The formulation of policies allows the Trust to produce formal agreements, which clearly defines the commitment of the organisation and the obligations of individual staff.

Procedure - A standardised method of performing clinical or non-clinical tasks by providing a series of actions to be conducted in an agreed and consistent way to achieve a safe, effective outcome. This will ensure all concerned undertake the task in an agreed and consistent way. These are often the documents detailing how a policy is to be achieved.

Procedures can be written as part of a policy document (in which case they are mandatory) or as ‘stand-alone’ documents (in which case they are discretionary).

Where procedures are formulated utilising evidence-based knowledge and best practice guidelines, they must include reference of any researched evidence used.

‘Stand-alone’ procedures give the user the means to carry out specific tasks. This may be within the overall control framework of the organisation or to regulate activities to achieve a quality outcome. ‘Stand-alone’ procedures do not have the same status in law as a policy; however, failure to follow a specific procedure may prejudice the successful defence of a claim against the organisation.

Protocol - A written code of practice, including recommendations, roles and standards to be followed, which can also include details of competencies and delegation of authority.

Protocols are different from policies as they lack the ‘mandatory’ element and by allowing for professional judgement, individual cases and competency to play a role they are flexible working documents.

Within a protocol it must be clear by whose authority is it being implemented, what the scope of the protocol is and what procedure is to be followed if practice is to be outside of the protocol.

In the case of clinical protocols, clinicians must be advised in every document that it is for their guidance only and the advice should not supersede their own clinical judgement.

Guidelines - Give general advice and recommendations for dealing with specific circumstances. They differ from procedures and protocols by giving options of how something might be carried out. They are used in conjunction with knowledge and expertise of the individual using them.

Guidelines are not prescriptive. However, whilst guidelines are not mandatory, it could prove difficult to defend a case where agreed guidelines had not been followed.

National Clinical Guidelines - The National Institute Health and Clinical Excellence (NICE) defines guidelines as:

> *"systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances. Research has shown that if properly developed, disseminated and implemented, guidelines can lead to improved patient care" (NICE 1999).*

Standards - The Royal College of Nursing definition is:

> *"to provide a record of service or representation of care which people are entitled to experience, either as a basic minimum or for use as a measure of excellence" (RCN 1997)*

> The Health and Care Standards define standards as:
> *"Standards are a means of describing the level of quality health care organisations are expected to meet or to aspire to. The performance of organisations can be assessed against this level of quality" (Welsh Government 2015).*

Standard statements are accompanied by a description of the structure and process needed to attain specified observable outcomes.

Standards are not generally prescriptive; it could prove difficult to defend a case if a standard is not adhered to.

CLASSIFICATION OF DOCUMENTS

Clinical – Clinical Written Control Documents relate to the care and treatment of patients within the organisation and offer an evidence-based approach to making a series of clinical decisions for patients with a given condition.

Corporate – Corporate Written Control Documents relate to the management of the organisation and formulate the organisation's response to known situations and circumstances.

Employment – Employment Written Control Documents relate specifically to the management of employees (however defined) within the organisation and are a written source of guidance on how a wide range of issues should be handled within an employing organisation, incorporating a description of principles, rights and responsibilities for managers and employees.

APPENDIX 3

DOCUMENTS RESERVED FOR APPROVAL BY THE TRUST BOARD AND OR ONE OF ITS COMMITTEES, GROUPS OR FORUMS

AREAS COVERED	DOCUMENT SPONSOR	ENDORSING GROUP	ENDORSING BODY	APPROVING BODY
Standing Orders	**Director of Corporate Governance**	**Executive Management Board**	**Audit Committee**	**Trust Board**
Risk Management Board Assurance Framework	**Director of Corporate Governance**	**Executive Management Board**	**Audit Committee**	**Trust Board**
Citizen Engagement & Involvement Partner & Stakeholder Engagement Corporate Governance	**Director of Corporate Governance**	**Executive Management Board**	**Quality, Safety & Performance Committee**	**Trust Board**
Policy and procedure for the management of Trust wide policies and other Trust wide written control documents	**Director of Corporate Governance**	**Executive Management Board**	**-**	**Quality, Safety & Performance Committee**
Standing Financial Instructions Financial Procedures Financial Management Financial Governance Commissioning Arrangements	**Executive Director of Finance**	**Executive Management Board**	**Audit Committee**	**Audit Committee**
Information Governance Health Records	**Executive Director of Finance**	**Executive Management Board**	**-**	**Quality, Safety & Performance Committee**
All aspects of Workforce and Organisational Development including Wellbeing, Equality, Diversity & Human Rights (including all-Wales workforce policies on behalf of the Trust Board). Welsh Language	**Executive Director of Organisational Development and Workforce**	**Executive Management Board**	**Local Partnership Forum** **Quality, Safety & Performance Committee**	**Trust Board**
Clinical Audit & Effectiveness Inquests Clinical Strategy	**Medical Director**	**Executive Management Board**	**-**	**Quality, Safety & Performance Committee**

AREAS COVERED	DOCUMENT SPONSOR	ENDORSING GROUP	ENDORSING BODY	APPROVING BODY
Research & Development Innovation Intellectual Property	**Medical Director**	**Executive Management Board**	**-**	**Research, Development & Innovation Sub Committee**
Medicines Management Civil Contingency/Emergency Planning Arrangements	**Chief Operating Officer**	**-**	**-**	**Executive Management Board**
Major Incident Plan/Business Continuity	**Chief Operating Officer**	**Executive Management Board**	**Strategic Development Committee**	**Trust Board**
Quality, Safety and Performance of patient and service user centred healthcare Patient Experience including Complaints, Incidents & Litigation Safeguarding Human Tissue Act	**Executive Director of Nursing, Allied Health Professionals & Health Sciences**	**Executive Management Board**	**-**	**Quality, Safety & Performance Committee**
Infection Prevention & Control	**Executive Director of Nursing, Allied Health Professionals & Health Sciences**	**Infection Prevention & Control Management Group**	**Executive Management Board**	**Quality, Safety & Performance Committee**
Nursing Services Nutrition Allied Health Professional Services Health Sciences	**Executive Director of Nursing, Allied Health Professionals & Health Sciences**	**-**	**-**	**Executive Management Board**
Integrated Medium Term Plan Performance Management Framework	**Director of Strategic Transformation, Planning & Digital**	**Executive Management Board**	**Strategic Development Committee**	**Trust Board**
Digital Infrastructure and Digital Delivery Health & Safety Performance Arrangements Estate Plans	**Director of Strategic Transformation, Planning & Digital**	**Executive Management Board**	**-**	**Quality, Safety & Performance Committee**

AREAS COVERED	DOCUMENT SPONSOR	ENDORSING GROUP	ENDORSING BODY	APPROVING BODY
Strategy Planning Sustainability/Environment Management	**Director of Strategic Transformation, Planning & Digital**	**Executive Management Board**	**-**	**Strategic Development Committee**
Investments Fundraising Bequests Donations	**Executive Director of Finance**	**Executive Management Board**	**-**	**Charitable Funds Committee (in conjunction with Charitable Fund Trustees)**

APPENDIX 4

POLICY OR WRITTEN CONTROL DOCUMENT TEMPLATE

Ref: ( )

(DOCUMENT TITLE)

Executive Sponsor & Function

Document Author:

Approved by:

Approval Date:

Date of Quality Impact Assessment:

Date of Equality Impact Assessment:

Equality Impact Assessment Outcome:

Review Date:

Version:

TEMPLATES FOR DOCUMENTS

The template and control sheet should be used by anyone wishing to formulate any written control system. Documents should be formatted in line with Corporate Style as follows:

Electronic format	Microsoft Word - PDF Read only
Front cover	Corporate template
Audit trail	Use Policy process
Body text	Arial 12
Headings	Arial 12 (UPPER CASE)
Tables and charts	Arial (size as appropriate)
Use of bold	Headings only
Alignment	Justified
Line spacing	Body text single
Paragraph spacing	One line between paragraphs. Two lines between main sections.
Underlining	None
Contents page Contents page if >3 pages	As template Use judgement - help reader to find relevant information more easily.
Staff Names	Use titles rather than names.
Logo	Use Trust logo.
Headers and footers	Arial 9
Margins	Top and bottom of page 2.5cm, sides 2.5cm.
Document Title	To be included in the header on every page
Page numbering	To be included in the footer (e.g. page x of x)
Bullets	• Use standard bullets only, as they do not always format across different systems.
Abbreviations	State in full in first usage with abbreviation in brackets.
Printing	A4/double sided.
Referencing	All reference material should be listed in full at the end of every document in Harvard style.
Glossary of terms	As all policy documents are subject to the Freedom of Information Act, they need to be user friendly as they are documents that can be held up to public scrutiny. Therefore, all abbreviations, jargon and specific wording must be clearly explained to the reader.
Version Control	Reference Number provided by the Corporate Governance Manager. Documents to state 'Draft' whilst in development.

COMPONENTS OF A POLICY

All Policies must include the following headings as a minimum

Introduction/Aim	What is the purpose of the document? What is it about? Why is it needed? This should include where necessary reference to external regulations or other relevant guidance. This may require information relating to audit, risk management, quality and safety.
Objectives	What will the document achieve?
Scope/Area of Application	Exactly who the policy applies to and the consequences for non-compliance where appropriate: • All staff? • Directorate/Clinical Department/Corporate Department specific?
Roles and Responsibilities	• Who is responsible for implementation? • Which groups of staff are able to carry out the procedures required? • What action points does the document raise? • Who is responsible for ensuring action points are undertaken? • Who is accountable if the responsibilities are not followed?
Main Body	Show how the document aims and objectives will be achieved. Reference evidence appropriately.
Resources	Are there any resource issues in order for the document to be implemented? Financial/Time/Training – these must be identified as if there are no resources the document will not be achievable.
Training	• Are there any training issues and if so, who is responsible for the training programme? • Who will keep a record of those members of staff who have been trained? • Will there be update training? How often? If the document compliance is not carried out for any length of time at what stage will the person cease to be authorised to carry out that policy? Where appropriate, specify the grade and required education and training of staff implementing the document.

Implementation and Policy Compliance	How will the document be implemented? • Action Plan? • Timescales? • What level of training should they have? This will be the main part of the policy, generally divided into sections and describe in detail what has to be done in order to comply with the policy and achieve the policy objective. The document needs to set out how compliance with the policy is to be measured and reported.
References	Policies must be based on sound evidence and be appropriately referenced. Name any recognised relevant professional body, for example the source of your evidence base. Where appropriate, specify what is required to be documented in patients' notes. Clinical policies should also include a review of the evidence used and a reference list of that evidence.
Health and Care Standards	This section should outline how the policy or written control document contributes to compliance with the Health and Care Standards and should also indicate to which Standards this area of activity is linked.
Integrated Impact Assessment	Has an equality and health impact assessment been carried out? If 'no' the reason for this will be explained at the beginning of the document. If 'yes' the impact will be included in the document and appended. Explain how the document promotes equality of opportunity and/or good relations between different groups. For further information contact the Equality, Diversity and OD Manager
Environmental Impact	Does an Environmental Impact Assessment need to be carried out? For further information contact the Trust's Environmental Development Officer.
Audit	This is required to ensure that the document is appropriate and achievable and that there is compliance with the document by staff. An audit tool must therefore be built into the policy document.
Review	Generally, 3 years unless legislation requires differently – check with Corporate Governance Manager.

Getting Help	Details of the specific office or department to contact for interpretations, resolution of problems and other special situations.
A policy may also need to contain the following additional components	**Related Policies and/or written control documents** Where other policies are relevant these should be listed. **Information, Instruction and Training** This section is relevant where instruction, training and supervision is necessary for to meet the policy requirements. It should detail when, how often and by whom the action will be taken and any requirement for keeping training records should be indicated. **Main Relevant Legislation** A list of the relevant statutory provisions which influence the organisation's operation in relation to the policy.

CHARACTERISTICS OF POLICIES AND WRITTEN CONTROL DOCUMENTS

The overall goal is for the design to be simple, consistent and easy to use.

Writing Style:

- Factual - accuracy should be double checked
- Should not provide information that may be quickly outdated
- If an acronym is used, it should be in full initially
- Not excessively technical, must be simple enough to be understood by a new member of staff

Policies should:

- Be written in clear, concise and simple language wherever possible
- Identify the rule rather than how to implement the rule
- Be based on sound evidence and be appropriately referenced.
- Be readily available and their authority should be clear.
- Indicate designated "experts" who can interpret documents and resolve problems
- Represent a consistent, logical framework for action

Written Control Documents should:

- Be clear in terms of how the procedure helps the organisation achieve its aims and objectives.
- Be developed with the client/patient/relative/carer/objective in mind. Well-developed and thought-out procedures provide benefits to the procedure user.
- Involve users in their development where appropriate to engender a sense of ownership

Design and Layout of Policy and Written Control Documents

- Use Arial text
- Number paragraphs and pages
- Generous use of white space
- Structure the presentation so that the reader can quickly focus on the aspect of policy relevant to the decision in hand
- Headings need to be consistent, e.g. location on each page, type size, bold etc.
- Footer should contain: the page number

APPENDIX 5

Equality Impact Assessment Process and Form

The Equality Act 2010 requires the undertaking of equality and health impact assessments and all Trust policies will require the completion of such before the policy is consulted upon. This is a process to find out whether a 'policy' will affect people differently on the basis of their 'protected characteristics': age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion, sex or sexual orientation and if it will affect their human rights. It also takes account of Welsh Language issues. It is designed to ensure that we are taking into consideration the needs of all individuals who work for us and/or access our services.

The Integrated Impact Assessment (IIA) is a process that considers how the health and well-being of a population may be affected by a proposed action, be it a policy, programme, plan, project or a change to the organisation or delivery of a particular public service. Some impacts of policies on health may be direct, obvious and/or intentional, whilst others may be indirect, difficult to identify and unintentional. The IIA is a systematic, objective, flexible and practical way of assessing both the potential positive and negative impacts of a proposal on health and well-being and suggests ways in which opportunities for health gain can be maximised and risks to health minimised. HIA looks at health in its broadest sense, using the wider determinants of health as a framework. This will ensure that any negative or indirect discrimination which could be an outcome of the policy, etc. is identified and risk assessed, linking to the Trust Risk Management Policy and Strategy. All final policies must include reference to the Integrated Impact Assessment that has been undertaken.

Where a procedure or other written control document has been developed in support of a policy it may not be necessary to undertake a further Integrated Impact Assessment. If an IIA has not been completed the reason for this will be explained at the beginning of the document. Where an IIA has been completed, the impact will be included in the document.

IIAs will be published as part of the consultation process and they will be available on our internet and intranet sites alongside the relevant policy or written control document.

One of the key requirements is the need to involve stakeholders in the process, whether internal or external. This ensures that any potential areas for discrimination are identified and solutions are sought to prevent discrimination.

In addition, the Trust's IIA process also includes the Welsh language and carers as well as adopting a human rights-based approach, ensuring dignity and respect are also evaluated in the process.

An Equality Impact Assessment form must be completed as part of the assessment process. Prior to attending the EQIA Group meeting the policy author/lead will be required to complete and forward the first page of the Integrated Impact Assessment form to the Equality, Diversity and OD Manager.

To arrange for your policy or written control document to be assessed please contact the Trust's Equality, Diversity and OD Manager VUNHST.Equality&Diversity@wales.nhs.uk

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Ref: PP01

FIRE SAFETY POLICY

Executive Sponsor & Function:	Director of Place, Portfolio and Partnerships
Document Author:	Trust Fire Safety Manager
Approved by:	Quality, Safety and Performance Committee
Approval Date:	13 November 2025
Date of Equality Impact Assessment:	January 2025
Equality Impact Assessment Outcome:	No negative impact
Review Date:	November 2028
Version:	06

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1. Policy Statement

1.1. To provide an unequivocal statement of fire safety policy applicable in any premises owned, managed or under the control of Velindre University NHS Trust (hereby referred to as "the Trust") or its hosted services excluding a single private dwelling.

2. Purpose

2.1. To ensure that the Trust and its hosted services comply with their Statutory duties under the *Regulatory Reform (Fire Safety) Order 2005 (as amended by the Fire Safety Act 2021) (the Order)* and their Mandatory duties under the Welsh Assembly Government's *NHS Wales Fire Safety Policy* (issued under cover of WHC (2006)74) and *(W)HTM 05 – Fire safety in the NHS (Firecode).*

2.2. This policy outlines the roles and responsibilities at all levels for the prevention of fire and, if a fire occurs, the need for early detection/alert, containment and evacuation of those at risk to a place of safety in preference to attempting to tackle the fire.

3. Scope

3.1 This policy applies wherever The Trust or its hosted services have a duty of care to service users, staff or other individuals.

4. Aims and Objectives

4.1. This policy aims to minimise the incident of fire throughout all activities provided by or on behalf of The Trust or its hosted services.

4.2. Where fire occurs, this policy aims to minimise the impact of fire and unnecessary fire alarm activations on building users, the delivery of services, the environment and assets.

4.3. This policy also aims to, so far as reasonably practicable reduce the number of unnecessary fire alarm activations in premises owned, managed or under the control of the Trust or its hosted services.

5. Roles and Responsibilities

5.1. *All staff, contract staff and volunteers (including contractors, bank staff and staff from other organisations)*

5.1.1. Whilst on premises owned, managed or under the control of the Trust or its hosted organisations, all staff, contractors and volunteers should:

- make sure they are aware of and understand their role and responsibilities regarding the prevention of fire and response to fire;
- take reasonable care for themselves and others who may be affected by their acts or omissions at work;
- comply with the Trust's fire safety protocols and fire procedures and those set by others such as landlords etc;

Paper copies of this document should be kept to a minimum and checks made with the electronic version to ensure the version to hand is the most recent.

- participate in fire safety training and fire evacuation exercises in accordance with section 7;
- inform their manager of any work situation, defect or other failing that represents a serious or imminent danger.

  Where necessary, report deficiencies and/or shortcomings in fire safety arrangements to the appropriate person(s) such as line manager, Fire Wardens, estates/facilities etc;
- report fire incidents and false alarm signals in accordance with Trust's protocols and procedures;
- always ensure the promotion of fire safety to help reduce the occurrence of fire and unwanted fire alarm signals;
- set a high standard of fire safety by personal example so that members of the public, visitors and students when leaving Trust premises take with them an attitude of mind that accepts good fire safety practice as normal.

5.2. *Trust Board*

5.2.1. The Trust Board holds overall accountability for fire safety and discharges the responsibility for fire safety through the Chief Executive.

5.2.2. The Board must assure itself that the requirements of current fire safety legislation, the Welsh Government's fire safety policy for the NHS in Wales and the objectives of relevant fire safety guidance including, where appropriate, Welsh Health Technical Memorandum ((W)HTM) 05 ["Firecode"] are being met.

5.2.3. The Trust Board will:

- discharge its responsibilities as a provider of healthcare to ensure that suitable and sufficient governance arrangements are in place to manage fire-related matters;
- provide appropriate levels of investment in the estate and personnel to facilitate the implementation of suitable fire safety precautions;
- facilitate the development of partnership initiatives with stakeholders and other appropriate bodies in the provision of fire safety where reasonably practicable.

5.3. *Chief Executive*

5.3.1. On behalf of the Board, the Chief Executive is responsible for ensuring that current legislation relating to fire and/or general building safety is complied with and appropriate, fire safety guidance is implemented in all premises owned, occupied or under the control of the Trust.

5.3.2. The Chief Executive discharges the day-to-day operational responsibility for fire safety through the Board Level Director (FIRE).

5.4. *Board Level Director (FIRE) - Director of Place, Portfolio and Partnerships*

5.4.1. The Board Level Director (FIRE) is responsible for ensuring that fire safety issues are highlighted at Board level; this responsibility extends to the proposal

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of programmes of work relating to fire safety for consideration as part of the business planning process and the management of the fire-related components of the capital programme and future allocation of funding.

5.4.2. At an operational level the Board Level Director (FIRE) will:

- ensure that the Trust has in place a clearly defined fire safety policy and relevant supporting protocols and procedures;
- seek assurance that all work that has implications for fire precautions in new and existing Trust buildings is carried out to a satisfactory technical standard and conforms to all prevailing statutory and mandatory fire safety requirements (including Firecode);
- seek assurance that all proposals for new buildings and alterations to existing buildings are referred to the Fire Safety Manager before building control approval is sought;
- seek assurance that all passive and active fire safety measures and equipment are maintained and tested in accordance with the latest relevant legislation/standards, and that comprehensive records are kept;
- seek assurance that suitable arrangements are in place regarding cooperation between other employers where two or more share Trust premises;
- seek assurance through senior management and line management structures that full staff participation in fire training and fire evacuation drills is maintained;
- ensure that agreed programmes of investment in fire precautions are properly accounted for in the Trust's annual business plan;
- ensure that an annual audit of fire safety and fire safety management is undertaken, and the outcomes communicated to the Trust Board;
- fully support the Fire Safety Manager function.

5.4.3. In line with delegated authority, the Board Level Director (FIRE) devolves day-to-day fire safety duties to the Fire Safety Manager.

5.5. *Fire Safety Manager*

5.5.1. The Trust Fire Safety Manager is responsible for developing and implementing an effective fire safety management system on behalf of the Trust and acting as the focus for all fire safety matters across the Trust.

5.5.2. At an operational level the Fire Safety Manager is responsible for:

- the development, implementation, monitoring and review of the organisation's fire safety management system;
- the development, implementation and review of the organisation's fire safety policy and protocols;
- reporting of non-compliance with legislation, policies and procedures to the Board Level Director (FIRE);
- raising awareness of all fire safety features and their purpose throughout the Trust;

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- providing expert advice on fire legislation;
- providing expert technical advice on the application and interpretation of fire safety guidance, including Firecode;
- the assessment of fire risks within premises owned, occupied or under the control of the Trust including the undertaking and recording and of fire risk assessments and development of action plans;
- ensuring that risks identified in the fire risk assessments are included in the Trust's risk register as appropriate;
- the operational management of fire safety risks identified by the risk assessments;
- the development, implementation and review of the organisation's fire emergency action plan including the preparation of fire prevention and emergency action plans where appropriate and integration with Major Incident Plan(s) developed by divisions;
- ensuring that requirements related to fire procedures for less-able staff, patients and visitors are in place;
- the development, delivery and audit of an effective fire safety training programme;
- the investigation and reporting of all fire-related incidents and fire alarm actuations in accordance with Trust policy and external requirements;
- monitoring, reporting and initiating measures to reduce false alarms and unwanted fire signals;
- liaison with the enforcing authorities on technical issues;
- liaison with managers and staff on fire safety issues;
- liaison with NHS Wales Shared Services Partnership (NWSSP) – Specialist Estates Service who act as the Trust's Authorising Engineer (Fire);
- monitoring the inspection and maintenance of fire safety systems to ensure it is carried out;
- ensuring that suitable fire safety audits are undertaken, recorded and the outcomes suitably reported;
- providing a link to the relevant Trust committees;
- ensuring an appropriate level of management is always available by the establishment of Emergency Response Teams for Trust sites or premises.

5.6. *Local Management*

5.6.1. Heads of service and departmental managers have responsibility for:

- monitoring fire safety within their respective workplaces and ensuring that contraventions of fire safety precautions do not take place;
- ensuring local fire risk assessments are maintained up to date and where identified as the risk owner, ensure that risks identified in the fire risk

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assessments are included in Divisional and/or Departmental risk registers as appropriate.

- notifying the Fire Safety Manager and others of any proposals for “change of use”, including temporary works that may impact on the risk assessment, within their area;
- reporting any defects in the fire precautions and equipment in their area and ensuring that appropriate remedial action is taken;
- ensuring that local emergency action plans are developed, brought to the attention of staff and adequately rehearsed to ensure sufficient emergency preparedness.
- This duty includes the identification of any staff or regular visitors who may require additional resources and/or support in the event of evacuation and where necessary, ensure that a personal emergency evacuation plan (PEEP) is discussed and developed.
- ensuring that local emergency action plans are revised in response to changes, including temporary works, which may affect response procedures;
- ensuring the availability of a sufficient number of appropriately trained staff at all times to implement the local fire emergency action plan;
- ensuring that the duties outlined in this document and relevant fire safety instructions are brought to the attention of staff through local induction and ongoing staff briefings;
- ensuring that every member of their staff attends fire safety training and the opportunity to participate in emergency drills and exercises as set out in the Trust’s fire safety training matrix.

  This duty includes making sure that staff receive other specialist training relevant to their general role and responsibilities including medical gas training; evacuation aid training; patient manual handling training; incident reporting training etc.
- ensuring that all new staff, on their first day in the ward/department, are given basic familiarisation training within their workplace, to include:
  - local fire procedures and evacuation plan
  - means of escape
  - location of fire alarm manual call points
  - fire-fighting equipment
  - any fire risks identified;
- keeping a record of staff induction and attendance at fire safety training;
- ensuring staff at all levels understand the need to report all fire alarm actuations and fire incidents as detailed in the fire safety protocols;
- ensuring that the staff record is completed and returned denoting how this document has been brought to the attention of staff;
- where appropriate, ensuring that sufficient Evacuation Wardens (named persons) and/or Evacuation Coordinators (nominated persons) are identified and appointed for their specific areas of responsibility.

This duty includes considering if an individual needs additional support as part of their PEEP.

5.7. *Evacuation / Fire Wardens and Evacuation Coordinators*

5.7.1. Based on the size and complexity of the building, an appropriate number of Fire / Evacuation Wardens (named persons) for non-clinical areas or Evacuation Coordinators (nominated persons) for clinical areas and areas using hybrid working should be appointed. Although they do not have an enforcing role, the Wardens/Coordinators will report issues or concerns regarding local fire safety to their head of service or departmental managers and if necessary, to the Fire Safety Manager.

5.7.2. In order to maintain safe environments, protect people and services, wardens/evacuation coordinators will:

- act as the focal point on fire safety issues for the local staff;
- organise and assist in the fire safety regime within local areas;
- raise issues regarding local fire safety with their line management;
- support line managers in their fire safety issues.

5.7.3. In the event of fire or other emergency, the warden/coordinator will

- take initial control of the incident and direct the local response;
- ensure that that staff and others in the area are aware of the incident;
- determine whether evacuation is necessary and commence the evacuation if/when appropriate;
- ensure that the fire alarm system has been activated and that the response team have been notified;
- initiate the local emergency action and evacuation plans;
- where applicable, liaise with the site Response Team on their arrival and inform them of actions taken.
- support with post-incident investigations.

6. Equality

6.1. The Trust is committed to ensuring that, as far as is reasonably practicable, the way it provides services to the public and the way it treats its employees reflects their individual needs and does not discriminate against protected characteristics [age, disability, sex/gender, sexual orientation, gender reassignment, marriage/civil partnership, pregnancy/maternity, race, religion, socio-economic and Welsh language].

6.2. The Trust has undertaken an Equality Impact Assessment [EQIA] and received feedback on this policy and the way it operates. The Trust wanted to know of any possible or actual impact that this procedure may have on any protected characteristics identified within the Equality Act 2010.

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6.3. The assessment found that there was ***no impact*** to the equality groups mentioned. Where appropriate the Trust will make plans for the necessary actions required to minimise any stated impact to ensure that it meets its responsibilities under the equalities and human rights legislation.

With regard to fire safety, the Trust recognises that during some religious festivals, there is a use of candles and lights, therefore naked flames, i.e. Advent/Christmas and Diwali, the Trust would recommend that staff, patients, donors and visitors, that wish to celebrate use electronic (battery powered) candles; additionally, any electronic main adapter lights are subject to PAT [Portable Appliance Testing] testing.

7. Training – (*Full guidance is provided in the fire safety training protocol*)

7.1. All staff must receive fire safety training appropriate to their role and responsibilities. The Trust has undertaken a Training Needs Analysis for fire safety which requires:

- All new starters receive essential fire safety information as part of their local induction and attend VUNHST Croeso training;
- All new starters undertake essential fire safety training ***within 1 month*** of their start date;
- Staff undertake the appropriate refresher training as follows:
  - VCS Clinical staff and WBS Blood Collection Team staff - *Annually*
  - Non-clinical staff – *3-yearly*
  - Evacuation/Fire Wardens (named persons), Evacuation Co-ordinators (nominated persons) and Fire/Emergency Response Team members - *Annually*

7.2. In support of fire safety training, all staff should participate in a fire evacuation drill/exercise once every *12 months as a minimum*.

8. Resources

8.1. The implementation and management arrangements associated with this policy do not present any significant resource implications to the Trust.

9. Implementation

9.1. The Trust Board expects those tasked with managing aspects of fire safety to:

- diligently discharge their fire safety responsibilities as benefits their position;
- have in place a clearly defined management structure for the delivery, control and monitoring of fire safety measures;
- have in place a programme for the assessment and review of fire risks;
- develop and implement appropriate protocols, procedures, action plans and control measures to mitigate fire risks, comply with relevant legislation and, where practicable, codes of practice and guidance;

- develop and disseminate appropriate fire emergency action plans pertinent to each department/building/area to ensure the safety of occupants, protect the delivery of service and, as far as reasonably practicable, defend the property and environment;
- develop and implement a programme of appropriate fire safety training for all relevant staff.
- Require all staff to complete their fire safety training (including participation in emergency drills and exercises) as outlined under section 7; and
- develop and implement monitoring and reporting mechanisms appropriate to the management of fire safety.

10. Audit and Monitoring

10.1. The Trust Board will monitor the implementation of this policy through:

- periodic review of fire and Unwanted Fire Signal (UwFS) reports;
- periodic reviews of fire safety training records;
- periodic review of fire service notices and communications;
- receipt of annual fire safety audit report;
- periodic independent reviews of fire safety by NWSSP – Specialist Estates Services.

11. Policy Conformance / Non-Compliance

11.1. If any Trust employee fails to comply with this policy, the matter may be dealt with in accordance with the Trusts Disciplinary Policy. The action taken will depend on the individual circumstances and will be in accordance with the appropriate disciplinary procedures. Under some circumstances failure to follow this policy could be considered to be gross misconduct.

12. Distribution

12.1. The policy will be available via the Trust Intranet site. Where staff do not have access to the intranet their line manager must ensure that they have access to a copy of this policy.

13. Review

13.1. The Fire Safety Manager and Trust Health, Safety and Fire Safety Management Board will review the operation of the policy as necessary; at least once every ***12 months***.

14. Legislation

14.1. The main Acts and Regulations, which relate to premises owned, managed or under the control of the Trust or its hosted organisations are:

- The Regulatory Reform (Fire Safety) Order 2005
- The Fire Safety Act 2021

- The Building Safety Act 2022
- The Health and Safety at Work etc Act 1974
- The Building Act 1984
- The Housing Act 2004
- The Equality Act 2005
- The Fire and Rescue Services Act 2004
- The Construction (Design and Management) Regulations 2015
- The Smoke-Free Premises etc. (Wales) Regulations 2007
- The Management of Health and Safety at Work Regulations 1999 (as amended)
- The Dangerous Substances and Explosive Atmospheres Regulations 2002

15. Further Information

15.1. *Contact*

Further information and support is available from the Trust Fire Safety Manager (robin.weaver@wales.nhs.uk) on 07976 417285.

15.2. *Key guidance*

The Firecode suite of documents (Health Technical Memorandum 05 - fire safety in the NHS) builds upon the Welsh Assembly Government's Fire Safety Policy statement. Firecode comprises:

- 05-01: Managing healthcare fire safety (Welsh Edition).
- 05-02: Guidance in support of functional provisions for healthcare premises
- 05-03: Operational provisions (Parts A to L)

The Trust will also implement:

- Other Health Technical Memorandums
- Relevant Department of Health and NWSSP - Facilities Services Health Building Notes

Firecode relates mainly to premises classified as 'healthcare' buildings (such as premises where patients are provided with medical care by a clinician.) and a majority of the premises that the Trust manage, occupy or use fall outside this definition. Therefore, the Trust will also adopt the relevant HM Government Fire Risk Assessment Guidance document relevant for the property type, including:

- Offices & Shops
- Places of Assembly (small)
- Places of Assembly (large)
- Sleeping Accommodation

Additionally, the Trust will also adopt the necessary Health and Safety Executive Approved Codes of Practice and Guidance Documents and other Approved Codes of Practice (i.e. British Standards).

15.3. *Supporting Documents*

In support of this policy, a number of fire safety protocols have been developed that support implementation of this policy, including:

- Fire Safety and Risk Management System
- Fire prevention including the management of arson
- Fire risk assessment/audit strategy
- Emergency planning and procedures
- Fire safety training including training needs analysis and strategy for delivery
- Development of local fire safety information including fire strategies, fire manuals, fire drawings and information for attending fire crews
- Fire safety during construction and refurbishment projects
- Unnecessary fire alarm activations
- Passive fire protection
- Maintenance of fire safety systems and equipment.

16. References

16.1. HEALTH TECHNICAL MEMORANDUM 05-01 FIRECODE: Guidance in support of functional provisions for healthcare premises (Various publication dates) - Wales edition.

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Ref: PP01b

FIRE SAFETY PROTOCOL
PRINCIPLES OF FIRE SAFETY

Executive Sponsor & Function:	Director of Place, Portfolio and Partnerships
Document Author:	VUNHST Authorised Person (Fire)
Approved by:	Quality, Safety and Performance Committee
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1 STATEMENT OF INTENT

1.1 This protocol is intended to support Velindre University NHS Trust [referred to in this policy as the 'Trust'] and its staff in complying with their duties under the *Regulatory Reform (Fire Safety) Order 2005* by providing detail on how fire safety is delivered and the alignment with broader Emergency Preparedness, Response and Resilience [EPRR] objectives.

2 DOCUMENT SCOPE

2.1 This protocol applies wherever the Trust or its hosted services have a duty of care to patients / donors, staff or others who may be affected by its activities.

3 AIMS & OBJECTIVES

3.1 The primary aim is to demonstrate the tactics adopted by the Trust to avoid the potential harm and loss that fire can cause by:

a) making sure that the Trust does everything possible to avoid the occurrence of fire in any "space" [site or premises (including those shared with others)] which it owns, occupies, or manages; and

b) based on the risk, in the event of a fire, have in place the necessary procedures, systems and equipment to protect all building users for the duration of the incident.

3.2 In addition to the primary obligation to protect life, the key objectives are to ensure that the Trust continues to:

a) provide and sustain safe and resilient "spaces".

b) ensure that staff understand the potential risk of fire and are supported to work safely in a resilient way.

c) provide and sustaining safe and resilient services.

d) ensure that the Trust works in a sustainable way by reducing the risk of a fire causing environmental damage.

e) The protocol illustrates the holistic approach to ensuring fire safety adopted by the Trust.

4 ROLES & RESPONSIBILITIES

4.1 All staff should refer to VUNHST fire safety policy (PP01) with regard to their roles and responsibilities for fire safety.

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5 FIRE SAFETY PRINCIPLES

5.1 OVERVIEW

Response to fire is based on three phases:

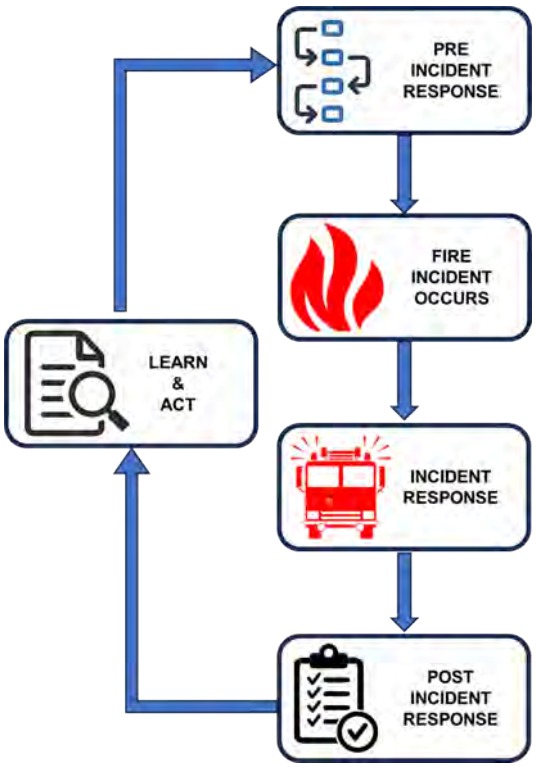

Figure 1 - Fire Safety Principles: Phases of Response

1. ***Pre-incident response ["Business as Usual"]*** which reflects the things that the Trust does to comply with the law and the "day to day" response to the risk of fire; it based on the *PLAN-DO-CHECK-ACT* model and has four components:
   1) Anticipate & Assess
   2) Plan & Prepare
   3) Manage & Prevent
   4) Validate & Review
2. ***Incident response*** which identifies what procedures, systems, and equipment that the Trust provides in its premises to respond to the occurrence of fire and limit the impact of fire if it occurs; it relies on four inter-related responses:
   a) Detect, Alert & Warn

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b) Contain & Supress

c) Evacuate

d) Extinguish / Incident Close-Out

3. ***Post Incident response*** which looks at how the Trust will recover from a fire and how they would use the experiences from an incident and other occurrences such as near-misses [lessons learnt] to make the necessary improvements and changes to reduce the risk of reoccurrence; it ties in with the PLAN-DO-CHECK-ACT ["Business as usual"] approach adopted Pre-fire and has three phases:

   a) Recover

   b) Investigate & Learn

   c) Review

5.2 PRE-INCIDENT RESPONSE ["BUSINESS AS USUAL"]

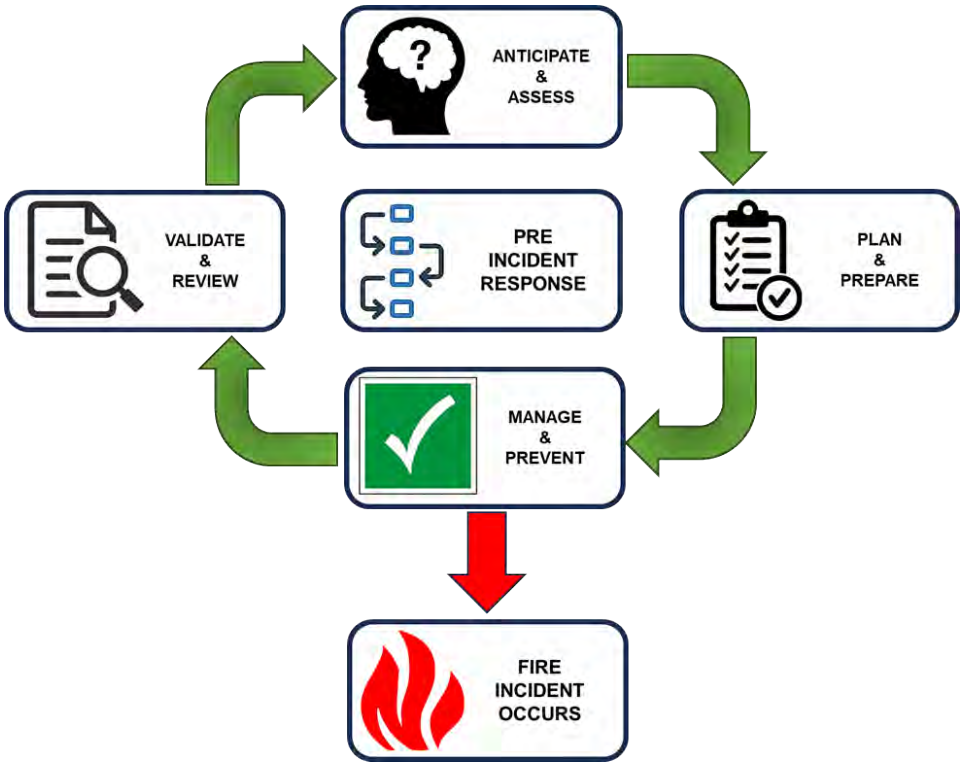

Figure 2 - Pre-Incident ["Business as Usual"] Response(s)

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5.2.1 Anticipate and Assess

The Trust recognises that fire is foreseeable as they cannot guarantee that all of the spaces they provide will totally free from the risk of fire. All spaces have potential fire "hazards" [any ***source***, ***situation*** or ***act*** with the potential to result in a fire] and "risks" [the combination of the likelihood of the occurrence of fire and consequence(s) as the result of fire that are considered to be foreseeable and which have an effect on life, asset(s), service delivery, the environment, reputation and/or compliance].

Therefore in order for the Trust to act appropriately, they must have a process of identifying fire hazards and evaluating the risk(s) arising from them through fire risk assessment.

The assessment process also considers the adequacy of existing policies, procedures, systems, and equipment, and determine whether the risk is acceptable without further action or not.

The Trust will:

- identify, acknowledge, and understand the potential fire hazards and risk(s) in all of its premises.
- undertake regular fire risk assessments in accordance with article 9 of the Fire Safety Order and relevant best practice / guidance.
- ensure that other risk assessments and other activity which influence fire (such as Dangerous Substances and Explosive Atmospheres, Business Impact Assessments, project risk assessments and the need to learn lessons from incidents and near misses) are in place and, where appropriate, referenced in fire risk assessments.
- develop appropriate action plans based on SMART principles to ideally eliminate but definitely mitigate against the identified fire hazards and risks.
- ensure that identified risks have owners with access to the necessary resource (effort, time, and money) to bring the risk of fire to a level which is tolerable and ***as low as reasonably practicable*** ["ALARP" – weighing the risk against the resource required to mitigate it].

5.2.2 Plan & Prepare

It is a legal requirement that the Trust has appropriate plans and procedures to respond to serious and imminent danger [including fires] and that these plans and procedures are communicated to and understood by staff and other building users.

The Trust will:

- develop an appropriate fire safety policy supported by relevant protocols and local procedures.
- develop localised fire strategies [supported by fire safety manuals and fire safety drawings] for each site to identify how this outline strategy is applied.

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- consult with the fire and rescue service to develop an attendance and response plan and also consider any other information that they may require i.e., specific detail of operational hazards and risks, salvage information etc.
- based on the understanding of the potential fire hazards and risks and in accordance with Statutory and Mandatory duties, develop appropriate emergency plans and evacuation procedures which ideally eliminate but definitely mitigate the potential impact of fire.

  Where identified, consideration must be given to anyone who may not be able to respond in the same way and/or who may require additional assistance and support as a result of impairment or disability through the development of *Personal Emergency Evacuation/Egress Plans* [PEEPs] and any reasonable adjustments will be made to accommodate the identified need.
- develop and review a Training Needs Analysis [TNA] to ensure that employees have access to and receive the necessary training, information, and instruction, including:
  - details of the hazards and risk(s) that they could be exposed to
  - how identified hazards and risk(s) should be managed including detail of relevant policies, procedures, and protocols.
  - the Trust's duties and their duties under the fire safety order
  - their role and responsibilities with regard to fire safety
  - details of the relevant emergency plans and evacuation procedures for the area(s) they work in
  - any additional information [such instruction in use of evacuation aids, additional duties of strategic, tactical, and operational responses etc.]

5.2.3 Manage and Prevent

Whilst the Trust invest in making sure that their premises have the appropriate fire safety systems and equipment [outlined under the Incident Response phase below], current fire safety legislation states that the risk of a fire is kept *as low as reasonably practicable* and that the management of potential risks and the prevention of fire minimises the potential outcomes of fire [harm to people and reputation and loss of assets as well as enabling us to maintain the delivery of services].

The Trust will:

- ensure that all potential hazards and risk(s) are either eliminated or appropriately managed/controlled in accordance with their policies, protocols, and local procedures.
- develop a set of key performance indicators [KPIs] through which compliance with statutory and mandatory obligations and Trust policies, protocols and procedures can be monitored.

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- ensure that regular workplace inspections are undertaken, recorded and non-compliances are reported, and action monitored.
- ensure that any near-miss incidents [an occurrence not resulting in harm but having the potential to do so] are recorded, investigated and action taken to reduce likelihood of recurrence.
- ensure that all fire safety equipment and systems are subject to regular test, inspection and maintenance as identified by the manufacturer and/or relevant Standards, guidance, or current best practice.

5.2.4 Validate & Review

In order to confirm that its plans, protocols, and procedures remain relevant, the Trust has a legal duty to periodically test and review them to identify any shortfalls, changes etc. and then update and renew them.

The Trust will:

- have a regime of regular inspection and audit to monitor progress against action plans and KPIs.
- conduct and submit annual fire safety audit in line with WHTM05 requirements.
- test emergency plans and evacuation procedures through regular drills and exercises and, where possible, invite the fire and rescue service and other external responders to periodically participate in joint exercises.
- for key sites, invite the fire and rescue service to undertake familiarisation visits and Compliance audits.
- support the Authorising Engineers (Fire) to undertake regular independent reviews of fire safety.
- based on the outcomes of the above and/or lessons learnt and/or changes in legislation, guidance and best practice, review/update and refresh existing assessments, policies, protocols and procedures . to make sure that they remain robust and relevant.

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5.3 INCIDENT RESPONSE

In the “Incident Response” phase, the predetermined emergency plans, evacuation procedures and relevant fire precautions will be put into action to deal with the incident and make sure that building occupants are protected from harm and the damage to premises is kept to a minimum in order to support the continuity and recovery of services as quickly as possible.

Where human intervention is required, staff are trained to take the most appropriate action first i.e., close the door to affected area and verbally alert those around them and/or raise the alarm through other means.

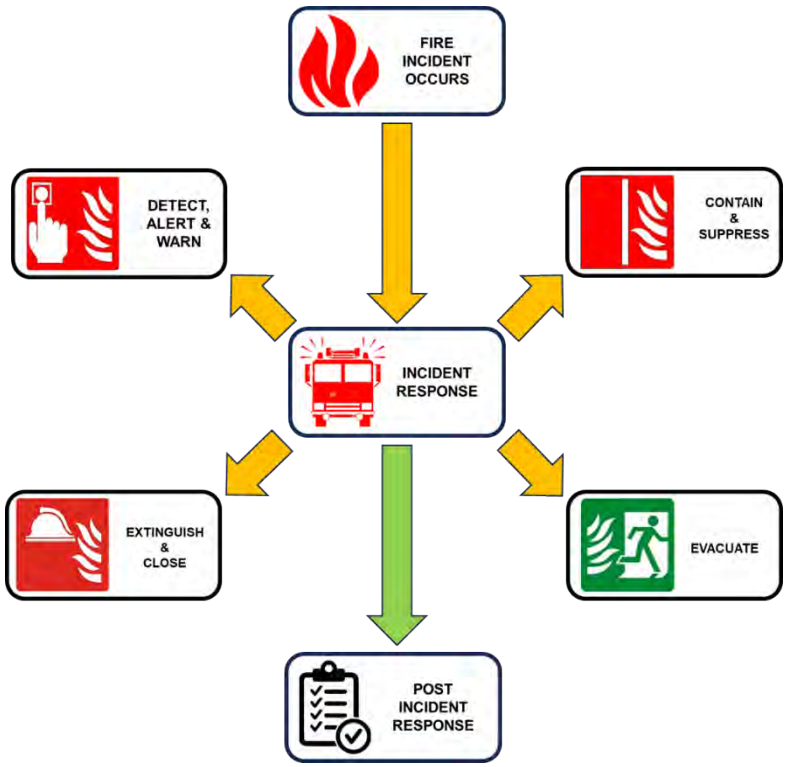

Figure 3: "Incident Response"

5.3.1 Detect, Alert and Warn

- If a fire is suspected or occurs, it should be detected as soon as possible by:
  - People
  - Fixed fire detection

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- Successful detection allows anyone in immediate danger and those who need to respond to be alerted including the fire and rescue service and other emergency services. This can be achieved:
  - Verbally
  - By activation on nearest fire alarm call point
  - By use of telephone to either alert internally or directly to the emergency services.
- Other building users not directly affected by the fire can also be warned by the site's fire alarm system:
  - Verbally
  - Audible alerting devices
  - Visual alerting devices
- An emergency "999" Call is made to the fire and rescue service to notify them of the fire incident and to request immediate attendance and support.

  A majority of sites have monitored fire alarm/security systems whereby an automated call is made to an Alarm Receiving Centre for onward notification to the fire and rescue service; however, during normal hours of occupancy, a direct voice "999" call should also be made to conform incident or unnecessary alarm activation.

  So far as is reasonably practicable (if *safe* and *possible* to do so), the cause of the activation is investigated and further information provided to the fire and rescue service to allow them to decide the level and speed of response (i.e. if the cause of the activation cannot be easily determined, the fire and rescue service *may* decide to send a lower level of response in line with current national fire service guidance).

5.3.2 Contain and Supress

- Through design and the consideration of fire-resistant construction [walls, floors etc.], passive and active measures, the "fire" [including smoke and fume] can be contained to the smallest possible area for the longest period of time.
- Where installed, fixed suppression systems [sprinklers / automatic gaseous suppression] will be activated to control and slow down [supress] the growth and spread of the fire.
- A site Response Team will assume tactical control of the internal response and make sure that relevant emergency plans [including evacuation procedures] have been instigated with the same aims as containment above [with life safety taking precedence].

  At the same time, the site's business continuity plans will also be brought into action to ensure that the delivery of service can be reinstated as soon as possible.

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5.3.3 Evacuate

- In line with the relevant emergency plans and evacuation procedures (as explained under plan & prepare above), anyone placed at risk to being alerted to or warned of a potential fire will evacuate using the local evacuation procedures to a place of safety.

  Depending on their needs and abilities, building users will either evacuate to:

  - An internal place of [relative] safety which has sufficient physical separation [fire-resisting walls, doors, floors etc], distance and time, OR
  - An external place of safety which is a safe distance away from the building.

5.3.4 Extinguish and Incident Close-Out

- As required under the Fire Safety Order, the Trust must provide appropriate first-aid fire-fighting equipment [fire extinguishers] based on risk and in accordance with relevant Standards and best practice.

  However, the fire safety policy [PP01] states that building users should not use fire extinguishers unless it is both necessary [the fire is obstructing an escape route and there are no alternative routes available] and safe [fire is small, contained and in its initial stages with little or no smoke] to do so.

- The fire and rescue service, having been notified will attend site with primary objective of dealing with the fire once all building users are accounted for and have safely evacuated.

  The site Emergency Response Team will liaise with, support and hand over control and command of the incident to the fire and rescue service and other emergency services as outlined in the pre-determined attendance and response plan.

- The Trust must also provide sufficient information and knowledge to support the emergency services in tackling the fire safely including salvage information to ensure that they protect assets identified as being important or difficult/impossible to replace or presenting a significant risk to delivery of services.

Paper copies of this document should be kept to a minimum and checks made with the electronic version to ensure the version to hand is the most recent.

5.4 POST INCIDENT RESPONSE

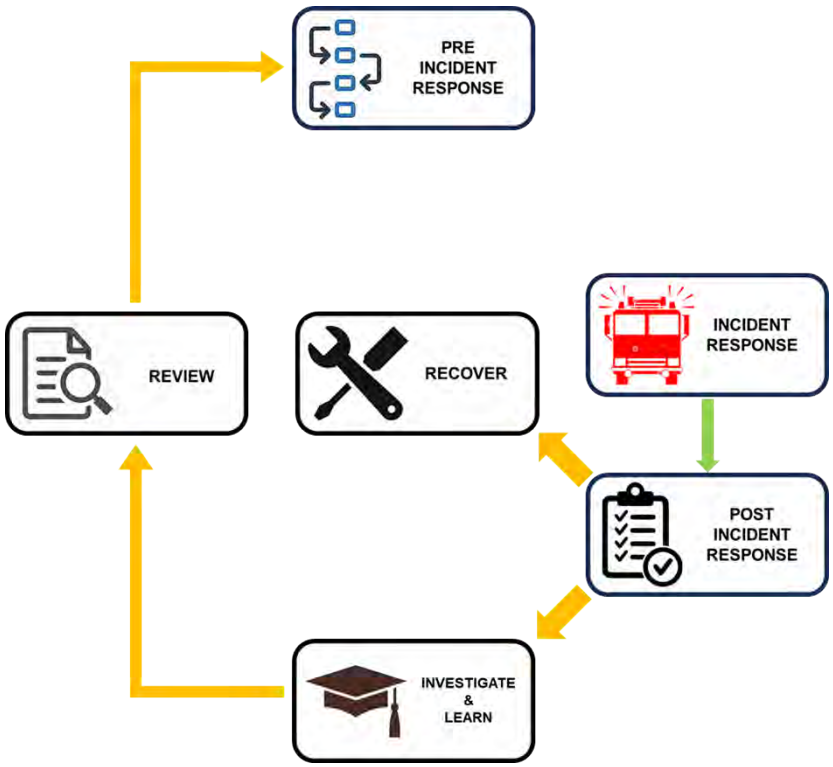

Figure 4: Post Incident response

5.4.1 Recover

- Ongoing implementation of Business Continuity plans to support prioritised re-establishment of services and activity as quickly and efficiently as possible.
- Key sites may develop a salvage plans which assist the fire and rescue service to plan their firefighting, and where possible recovery, activities to best protect the continuity of care, delivery of service and high value/importance assets.

5.4.2 Investigate & Learn

- Internal investigation of incident and reporting to relevant Groups. Committees and Boards. This will include regular updating of any internal incident reports.
- Support and contribute to any investigations undertaken by external stakeholders [fire and rescue service, police, Health & Safety Executive etc.]
- identification of any lesson learnt which must to be fed back into the “Business as Usual” cycle to support improvement and/or reduce the risk of recurrence in the future.

Paper copies of this document should be kept to a minimum and checks made with the electronic version to ensure the version to hand is the most recent.

5.4.3 Review

- Following an incident (including near-misses), the Trust will review relevant policies, protocols, and procedures as well as relevant risk assessments, strategies, and associated information [manuals, drawings etc.] to ensure that they remain robust and relevant.

6 FIRE SAFETY PROTOCOLS

6.1 In order to support the implementation of the fire safety policy [PP01] and this documents, the Trust has the following protocols which provide specific guidance:

- PP01A: (PLAN, MANAGE & PREVENT) Fire Prevention & Prevention of Arson
- PP01B: (PLAN, MANAGE & PREVENT) Fire Risk Assessment & Audits
- PP01C: (PLAN, MANAGE & PREVENT) Fire Safety Information & Drawings
- PP01D: (PLAN, MANAGE & PREVENT) Fire Safety Training
- PP01E: (RESPONSE) Means of Detection & Warning
- PP01F: (RESPONSE) Containment & Suppression
- PP01G: (RESPONSE) Means of Escape
- PP01H: (RESPONSE) Evacuation & Shelter
- PP01J: (RESPONSE) Means of Fighting Fire & Fire Service Intervention

7 EQUALITY IMPACT ASSESSMENT

7.1 The Trust is committed to ensuring that, as far as is reasonably practicable, the way it provides services to the public and the way it treats its employees reflects their individual needs and does not discriminate against individuals or groups [protected characteristic groups].

7.2 The Trust has undertaken an Equality Impact Assessment and received feedback on the fire safety policy [PP01] which this strategy supports and the way it operates. The Trust wanted to know of any possible or actual impact that this strategy may have on any groups in respect of gender (including maternity and pregnancy as well as marriage or civil partnership issues) race, disability, sexual orientation, Welsh language, religion or belief, transgender, age, or other protected characteristics.

7.3 The assessment found that there was either positive or no impact to the protected characteristic groups mentioned. Where appropriate the Trust will make plans for the necessary actions required to minimise any stated impact to ensure that it meets its responsibilities under the equalities and human rights legislation.

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8 RELATED POLICIES

8.1 This protocol supports the implementation of the following VUNHST policies:

- Fire Safety policy (PP01)
- Business Continuity and Emergency Planning Policy (PP06)
- Security Policy (PP02)

9 RELEVANT LEGISLATION

9.1 This protocol supports the implementation of the following legislation:

- The Regulatory Reform (Fire Safety) Order 2005
- The Fire Safety Act 2021
- The Building Safety Act 2022
- The Health and Safety at Work etc. Act 1974
- The Management of Health and Safety at Work Regulations 1999 (as amended)
- The Civil Contingencies Act 2004

10 REFERENCES

- (W)HTM 00 – Policies and principles of healthcare engineering
- The Firecode (Health Technical Memorandum 05 - fire safety in the NHS) suite of documents builds upon the Welsh Assembly Government's Fire Safety Policy statement; Firecode comprises:
  - 05-01: Managing healthcare fire safety (Welsh Edition)
  - 05-02: Guidance in support of functional provisions for healthcare premises
  - 05-03: Operational provisions (Parts A to L)
- HM Government Fire Risk Assessment Guidance documents -:

  The following premises types are covered:

  - Offices & Shops
  - Places of Assembly (small)
  - Places of Assembly (large)
  - Sleeping Accommodation

  https://www.gov.uk/government/collections/fire-safety-law-and-guidance-documents-for-business

Paper copies of this document should be kept to a minimum and checks made with the electronic version to ensure the version to hand is the most recent.

11 GETTING HELP

Further information and support are available from the VUNHST Fire Safety Manager (robin.weaver@wales.nhs.uk) on 07976 41728

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TRUST BOARD	
STRATEGIC PARTNERSHIPS UPDATE	
DATE OF MEETING	27/11/25
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	INFORMATION / NOTING
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Lauren Fear, Director of Place, Portfolio & Partnerships
PRESENTED BY	Lauren Fear, Director of Place, Portfolio & Partnerships & Dr Jacinta Abraham, Executive Medical Director
APPROVED BY	Lauren Fear, Director of Place, Portfolio and Parnerships
EXECUTIVE SUMMARY	This strategic partnerships update will focus on the following recent developments: • South-East Wales Regional Joint Committee • Cardiff Health Partners • South-East Wales Cancer Programme • A Future Cancer Strategy for Wales – Cancer Alliance Roundtable
RECOMMENDATION / ACTIONS	Trust Board to NOTE the update

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Following on from September and October Board and Committee governance cycle on these matters (Regional Joint Committee and Cardiff Health Partners)	Sept 2025

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

South-East Wales Regional Joint Committee

The Terms of Reference was brought to the Trust Board in September. It was noted that the Trust's full name needed to be corrected.

Cardiff Health Partners

In addition, the development of Cardiff Health Partners was discussed in the Research, Development and Innovation Committee and in the Strategic Development Committee in September. It was agreed in Strategic Development Committee that there be a further shaping discussion for the whole Board in the October Board Development meeting. The update was also noted in Trust Board in September.

At the Board Development meeting, the thematic areas were discussed of: Brain Therapies, Cancer and Precision Medicine Infrastructure. The Board discussed the inputs to the work from across the whole Trust, including Cardiff Cancer Research Partnership, the new Cancer Centre and Collaborative Centre for Research, Learning and Innovation and Advanced Therapies Wales. Future development had also been explored with Plasma for Medicines and Health Technology Wales. The approach to governance was also discussed and it was agreed that it was important to progress the work quickly in order to structure the arrangement for the medium term.

APPENDICES	
1	South-East Wales Regional Joint Committee Terms of Reference
2	Cardiff Health Partners Prospectus

1. CONTENTS

This strategic partnerships update will focus on the following recent developments:

- South-East Wales Regional Joint Committee
- Cardiff Health Partners
- South-East Wales Cancer Programme
- A Future Cancer Strategy for Wales – Cancer Alliance Roundtable

2. UPDATE ON RECENT DEVELOPMENTS

2.1 South-East Wales Regional Joint Committee (RJC)

2.1.1 The first meeting was held on 19th November. The Terms of Reference had been approved by the three member Health Boards, Aneurin Bevan University Health Board, Cardiff and Vale University Health Board, and Cwm Taf Morgannwg University Health Board, in September Board meetings. The associate members, Powys Teaching Health Board and Velindre University NHS Trust, had noted the Terms of Reference. Since then, the Terms of Reference have been shared with the Welsh Government and the Cabinet Secretary for Health and Social Care has provided some updates which, for completeness, the RJC endorsed in the meeting and are being referred to the Health Boards for approval. The version endorsed, with changes tracked in red, are included in Appendix 1.

2.1.2 As stated in the Terms of Reference, the purpose of the RJC is to enhance collaboration, reduce inequalities, and promote sustainable healthcare services across the regional footprint and represents a significant step towards integrated regional health governance through collaborative leadership and shared accountability among the constituent health boards and associate members.

2.1.3 As well as endorsing the Terms of Reference, the first meeting agenda included appointing a Chair, which was agreed to be Jonathan Morgan, Chair of Cwm Taf Morgannwg University Health Board. Updates were provided on the current work programmes, including the Cancer Programme, and future work programmes was discussed.

2.1.4 The future work programme discussion was informed by a workshop prior to the RJC. The group discussed the focus areas for the RJC, including: improving patient experience and outcomes; strategic alignment and shared narrative; regional collaboration and economies of scale; tackling commissioning issues and infrastructure support.

2.1.5 The following actions were agreed and there will be regular updates shared with the Trust Board as the partnership working progresses:

Areas to Progress in Next 12 months	Action
Deliver on existing commitments	Regional Director to work with Programme leads to ensure clarity of objectives for each of the existing programmes in the next 12 months
Develop a framework on how we commission and contract at a regional level	Development of draft operating framework for the Joint Committee to be explored at the next workshop
Develop a shared narrative on regional ambitions and what we are delivering to show the Joint Committee is operating as a collective	Principles and narrative to be developed for agreement at the next Joint Committee
Develop a process to identify greatest opportunities for regional services	Mapping of existing clinical service planning and development of approach to regional clinical service prioritisation to come to next Joint Committee Workshop
Progress work on a regional digital plan	Regional workshop planned for early December

2.1.6 The Health Boards will be sharing the papers and video recording of the RJC on their websites and the Trust will do the same.

2.2 Cardiff Health Partners (CHP)

2.2.1 As outlined in the previous governance section, there has been much discussion across the Trust Board on the development of this important strategic partnership. As outlined, the first deliverable was an initial prospectus to support a launch as part of the Wales Investment Summit on 1st December. The prospectus is attached in Appendix 2.

2.2.2 Wendy Larner, Cardiff University President and Vice Chancellor, will be representing the CHP in a Life Sciences Hub Panel, as part of the Investment Summit. In parallel, there will be a joint press release from the three organisations and an internal communication process.

2.2.3 As discussed in the October Board Development session, the next steps on the governance and structure of the partnership need to be progressed at pace. In addition, the pipeline of engagement and further investment opportunities. The priority, for completion in the new year, however is the governance and structure.

2.3 South-East Regional Cancer Programme

2.3.1 To briefly note to the Board, that the work progresses well across our regional priorities and the join up to the national priorities, including Ministerial Advisory

Group recommendations for cancer. The Programme Board continues to start each time with a patient story, linked to the programme of work and then reviews the core regional performance data. In addition, the regional benefits tracking of the Velindre @Nevill Hall investment and the delivery of the regional clinical assumptions of the new Velindre Cancer Centre, in terms of SACT and outpatient outreach, will be core regular agenda items. As the regional workstreams continue to progress, the impact on patient outcomes of the work will be a focus for the Programme Board. Further updates and detail will be shared with the Board over the coming months.

2.4 A Future Cancer Strategy for Wales – Cancer Alliance Roundtable

2.4.1 A Senedd Roundtable was organised by the Wales Cancer Alliance on 11th November. The purpose of the meeting was to start a national conversation about the rationale and considerations around a long-term cancer strategy for Wales. Attendees included political party health and policy spokespeople; patient; NHS national cancer leadership; NHS delivery partners and stakeholders; and representatives from the third sector (members of the Wales Cancer Alliance).

2.4.2 The outputs from the meeting will be published as a report and follows on from the Wales Cancer Alliance manifesto for the 2026 Senedd elections. The Alliance has worked with the International Cancer Benchmarking Partnership and Cancer Research UK to produce a framework to mark the components of the successful cancer strategy. The Trust, working with the Cancer network, will have a central role in the development of this approach.

2.4.3 The report will be shared with key stakeholders in draft and then published prior to the Senedd elections. The Trust Board, through the Strategic Development Committee, will be involved in this process.

3. SUMMARY OF MATTERS FOR CONSIDERATION

3.1 The Trust Board is asked to NOTE the update.

4. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: **Choose an item**	
If yes - please select all relevant goals:	
• Outstanding for quality, safety and experience	☒
• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations	☒

• A beacon for research, development and innovation in our stated areas of priority ☒ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	**Choose an item**
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below** Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒

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 ☐

SOUTH-EAST WALES REGIONAL JOINT COMMITTEE (RJC)

TERMS OF REFERENCE & OPERATING ARRANGEMENTS

Introduction	**1.** On 2 April 2025, the Cabinet Secretary for Health and Social Care directed Aneurin Bevan University Health Board, Cardiff and Vale University Health Board, and Cwm Taf Morgannwg University Heath Board to establish a Regional Joint Committee (RJC) to exercise the facilitation and oversight of regional planning to drive effective collaboration and regional working. This direction is given pursuant to the Welsh Ministers' power in section 12(3) of the National Health Service (Wales) Act 2006. **2.** For the purpose of these terms of reference, the three organisations comprising the RJC will be referred to as the health boards. **3.** To enhance collaboration in integrated care, representatives from Powys Teaching Health Board and Velindre University NHS Trust will be Associate Members of the RJC. **4.** Additionally, a Welsh Government Official is to receive a standing invitation to observe all meetings of the Committee. This will usually be a member of the Health, Social Care, and Early Years Executive Directors Team. This will provide the Cabinet Secretary with confidence that there is an appropriate level of oversight and assurance from the Welsh Government in place. **5.** The RJC is expected to bring greater focus on: • regional planning and delivery of service models. • improved outcomes and a reduction in inequalities in access. • potential for service transformation, including new workforce models. • establishing new relationships and/or resetting existing relationships. • exploring regional solutions to advance sustainable service provision • providing coordinated support to the health boards.
Status	**6.** The RJC is to be established under the powers vested in Welsh Ministers under Section 12 of the National Health (Wales) Act 2006 which allows: (1) Welsh Ministers to direct a Local Health Board to exercise in relation to its area: (a) functions which were transferred to the National Assembly of Wales (now Welsh Government following the Government of Wales Act 2006) by the Health Authorities (Transfer of Functions, Staff, Property, Rights and Liabilities and Abolition) (Wales) Order 2003 (S.I. 2003/813 (W.98)), (b) such other of their functions relating to the health service as are specified in the direction. (2) The functions which may be specified in directions under subsection (1) include functions under enactments relating to mental health and care homes. (3) The Welsh Ministers may give directions to a Local Health Board about its exercise of any functions.

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Accountability, Responsibility and Authority	**7.** The RJC is established by, and ultimately accountable to, the Boards of Aneurin Bevan UHB, Cardiff and Vale UHB and Cwm Taf Morgannwg UHB. **8.** As a joint committee of the three Health Boards, the RJC is not a separate legal entity from each of the LHBs. **9.** The RJC shall report to each Board on its activities, to which it is formally accountable in respect of the exercise of the functions carried out on their behalf. **10.** The three Health Boards remain accountable for planning, securing and delivering health services to their respective populations with respective Chairs ultimately accountable to the Cabinet Secretary for Health and Social Care. **11.** Each Health Board has delegated authority to the RJC for the exercise of certain functions, as set out within these Terms of Reference. **12.** These RJC Terms of Reference form a schedule of each Health Board's own Standing Orders and have effect as if incorporated within them. **13.** Where Health Boards have delegated functions to the RJC, each Health Board shall be bound by the decisions of the Joint Committee in accordance with the Schedule of Powers delegated to the RJC (**Appendix A**).
Purpose of the RJC	**14.** The RJC has been established to: (a) Provide collective leadership for the regional planning, commissioning, and delivery of services for the three health boards, considering the service challenges, financial challenges and population health needs of all three organisations. (b) Establish a regional approach to the development of clinical services planning, aligned to regional population health needs assessments, to develop and deliver sustainable services in terms of achieving quality and outcome measures, workforce and financial sustainability. (c) Identifying priorities for the three health boards, where a regional approach will deliver benefit. (d) Explore how the benefits of a regional health economy are harnessed to best serve the south-east Wales population of over 1.5million. (e) Reduce unwarranted variation and inequality in health outcomes, access to services and experience at a regional population level.
Objectives of the RJC	**15.** In-line with delegated levels of authority and accountability (**Appendix A**), the RJC will specifically: a) Develop a regional programme of work, aligned to individual Health Board plans, Welsh Government priorities and any Ministerial Directions, to ensure the benefits of a regional health economy for a population of over 1.5million are realised. b) Review baseline activity, based on individual Health Board clinical services plans, focusing on cost efficiencies, quality, and service fragility. c) Develop and oversee an approach to prioritisation of capital programmes which underpin the regional health economy approach.

	d) Consider and prioritise the regional projects included within the regional programme of work, approving Business Cases and identifying and agreeing to any further projects to be included in the regional programme. e) Seek assurance that projects deliver against their outcomes and timescales, and deliver against the quality measures and programme benefits, as identified in their PIDs and or Business Cases. f) Provide a vehicle to progress work programmes within the remit of the RJC without unnecessary recourse elsewhere to ensure pace. g) Seek assurance that integrated impact assessments are undertaken of all planned service change programmes and embedded in the ways of working of the RJC. h) Develop, implement and evaluate the required governance framework to deliver the regional programme of work, underpinning the RJC. i) Consider any audit and review related activity relevant to the work of the RJC to inform learning and improvement.
Partnership Principles	**16.** As a strategic partnership of the three Health Boards in the region, the RJC will adopt and embed the following four partnership principles into its business and operating arrangements. The RJC will be: a) A partnership with a system focus which seeks to collectively agree the outcomes it wants for its combined population. b) A partnership that is a system enabler. c) A low bureaucracy, high trust partnership. d) A partnership of constructive behaviors.
Chairing Arrangements	**17.** The Chair of the RJC will be drawn from one of the Chairs of the three health boards and this position will rotate amongst the three chairs on an annual basis at the meeting of the RJC in October of each year. **18.** The other two health board Chairs will jointly become vice chairs of the RJC and will agree who deputises and presides at a meeting in the absence of the Chair.

Membership	**19.** The RJC shall have the following members drawn from the three health boards, as follows: • Chairs of Aneurin Bevan UHB, Cardiff and Vale UHB and Cwm Taf Morgannwg UHB (3) • Vice Chairs, or 1 nominated Independent Member, of each of Aneurin Bevan UHB, Cardiff and Vale UHB and Cwm Taf Morgannwg UHB (3) • Chief Executives of Aneurin Bevan UHB, Cardiff and Vale UHB and Cwm Taf Morgannwg UHB (3) • 1 nominated Executive Director from each of Aneurin Bevan UHB, Cardiff and Vale UHB and Cwm Taf Morgannwg UHB (3) **20.** With the permission of the Chair of the RJC, the members of the RJC set out above may nominate a substitute, equivalent Board Member (as defined above) to attend a meeting that they are unable to attend. The substitute may speak and vote on their behalf. The decision of the Chair regarding the authorisation of nominated substitutes is final.
Associate Membership	**21.** The RJC shall have the following associate members, attending meetings on an ex-officio basis, without voting rights: a) A nominated Board Member of Powys Teaching Health Board (1) b) A nominated Board Member of Velindre University NHS Trust (1) **22.** With the permission of the Chair of the RJC, the associate members of the RJC set out above may nominate a substitute to attend a meeting that they are unable to attend. The substitute may speak on their behalf. The decision of the Chair regarding the authorisation of nominated substitutes is final.
In Attendance	**23.** At the discretion of the Chair of the RJC, the RJC may invite others to attend meetings, where this would assist it in its role and in the discharge of its duties. This may include, but is not limited to: a) Employees of the three Health Boards as appropriate. b) The Senior Responsible Officers of RJC programmes. c) Representatives from the Health and Care system, including NHS Bodies and Local Authorities. d) Representatives from the Voluntary, Community and Social Enterprise sector. e) Representatives of Llais. **24.** The RJC will take account of its responsibility to actively encourage the engagement and, where appropriate, involvement of citizens and stakeholders in the work of the RJC (whether directly or through the activities of bodies such as Llais) and to demonstrate openness and transparency in the conduct of business. **25.** A Welsh Government Official will receive a standing invitation to observe all meetings of the RJC.

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Accountable Officers	**26.** Chief Executives of Health Boards are designated Accountable Officers, in-line with *Managing Welsh Public Money*, and hold several personal responsibilities. Accountable Officers have a personal responsibility for: propriety and regularity of the public finances delegated to them; affordability and sustainability; value for money; management of opportunity and risk; learning from feedback; and accounting accurately. **27.** The Chief Executive, as the Accountable Officer, of each respective Health Board is included within the membership of the RJC to ensure any decisions delegated from Boards to the RJC do not undermine the personal responsibilities Accountable Officers hold. **28.** Accountable Officers will need to be cognisant of their responsibilities, as set out within *Managing Welsh Public Money (MWPM)* and their respective Accountable Officer Memorandums, ensuring principles are applied to decision making, including: a) MWPM 3.8.5 – "There are sensitivities about the role of the Accounting Officer in a public body which is governed by an independent board, e.g. a charity or a company. The Accounting Officer, who will normally be a member of the board, must take care that his or her personal responsibilities do not conflict with his or her duties as a board member. In particular, the Accounting Officer should vote against any proposal which appears to cause such a conflict; it is not sufficient to abstain." b) MWPM 3.8.6 – "Moreover, if the chair or board of such a public body is minded to instruct its Accounting Officer to carry out a course inconsistent with the standards in box 3.1, then the Accounting Officer should make his or her reservations clear, preferably in writing…."
Working with Llais (Citizen Body for Health and Social Care)	**29.** In exercising its responsibilities, the RJC shall ensure arrangements are in place to engage and co-operate with representatives of Llais as appropriate. **30.** Part 4 of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 (2020 asc 1) (the 2020 Act) places a range of duties on Local Health Boards and Trusts in relation to the engagement and involvement of Llais in their operations, which are extended to the activities of the RJC. **31.** The RJC will ensure it is clear who will assume responsibility for engaging and co-operating with Llais when planning, developing, considering proposals for service change, in-line with delegated levels of authority.
Delegated Functions and Powers	**32.** When exercising any Delegated Functions, the RJC will ensure that it acts in accordance with, and that its decisions are informed by, the relevant policies and procedures which have been developed by the three health boards to support those functions and to inform the commissioning, provision and delivery of any relevant services. **33.** Within the framework approved by each Health Board and set out within these RJC Terms of Reference, and subject to any directions that may be given by the Welsh Ministers; the RJC may make arrangements for

	certain functions to be carried out on its behalf, so that regional planning and delivery may be carried out effectively and in a manner that secures the achievement of its aims and objectives. In doing so, the RJC must set out clearly the terms and conditions upon which any delegation is made. **34.** The RJC's determination of those matters that it will retain, and those that will be delegated to others shall be set out in **Appendix A**: a) Schedule of matters reserved for the RJC; and a b) Scheme of delegation to joint sub-Committees and others; all of which must be formally adopted by the RJC and approved by Health Boards as a schedule to their own Standing Orders.
Sub-Committees, Groups and Panels	**35.** The RJC may and, where approved by the LHB Boards jointly, or directed by Welsh Ministers, must appoint joint sub-Committees of the RJC either to undertake specific functions on the RJC's behalf or to provide advice and assurance to others (whether directly to the Joint Committee, or on behalf of the Joint Committee to each LHB Board and/or its other committees). **36.** This may also extend to: a) Programme and Project Governance – Established to provide a framework for managing and controlling programmes and projects. b) Expert Panels – Established to review and make technical recommendations on specific subjects which generally consist of experts with relevant knowledge and experience within a particular field. c) Advisory Groups – Established to provide advice over an issue/range of subject matters which generally consists of an external chair and internal and/or external stakeholders to make recommendations on a specific issue. **37.** The RJC shall determine a governance structure that meets its own advisory and assurance needs and in doing so the needs of the three Health Boards. These would be set out within agreed Terms of Reference and Operating Arrangements, agreed by the RJC.

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Meetings	*Scheduling meetings* **38.** The RJC will ordinarily meet quarterly, and, as a minimum, shall meet on three occasions each year. Additional meetings may be convened on an exceptional basis at the discretion of the Chair. **39.** The three Health Boards may ask the RJC to convene further meetings to discuss issues on which they want RJC advice, subject to the agreement of the Chair. *Quoracy* **40.** In order for a meeting to be quorate there must be at least six members in attendance, which shall include: a) An Independent Member (Chair or Vice Chair) and an Executive member (CEO or other executive) from each of the three health boards. **41.** If any member of the RJC has been disqualified from participating in an item on the agenda, because of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum. Nominated deputies who have been authorised by the Chair shall count towards quorum. **42.** If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken. *Voting* **43.** The RJC will ordinarily reach conclusions by consensus. If this is not possible, the Chair may call a vote. Only members of the RJC Committee (or nominated substitute as set out in section 20) may vote; each Member is allowed one vote. The result of the vote will be recorded in minutes **44.** Where there is no consensus, the Chair of the RJC will refer the decision to each Board of the three respective Health Boards for further consideration and will invoke the dispute process (**Appendix B**) if required thereafter. **45.** Should a decision be referred to the three respective Health Boards as set out in section 44, the outcome of all three decisions will be reported to the next meeting of the RJC and recorded in minutes. *Papers and notice* **46.** A minimum of seven clear days' notice of all meetings is required, which shall comprise venue, time and date of the meeting, together with an agenda of items to be discussed. Supporting papers must be distributed at least five clear working days ahead of the meeting.

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47. On occasion it may be necessary to arrange urgent meetings at shorter notice. In these circumstances the Chair will give as much notice as possible to members. Urgent papers shall be permitted in exceptional circumstances at the discretion of the Chair.

Virtual attendance

48. It is for the Chair to decide whether the RJC will meet virtually. Where a meeting is not held virtually, the Chair may nevertheless agree that individual members may attend virtually. Participation in a meeting in this manner shall be deemed to constitute presence in person at such a meeting. How a person has attended a meeting shall be specified in the meeting minutes.

Recordings of meetings

49. Except with the permission of the Chair, no person admitted to a meeting of the RJC shall be permitted to record the proceedings in any manner whatsoever, other than in writing.

Minutes

50. The minutes of meetings will be formally taken in the form of key points of debate, actions and decisions and a draft copy circulated to the members of the RJC together with the action log as soon after the meeting as practicable. The minutes shall be submitted for agreement at the next meeting where they shall be signed by the Chair.

Governance support

51. Governance Advice and Secretariat support for the RJC will be provided by the organisation from which the Chair is elected and will therefore rotate between the three Health Boards on an annual basis.

Interpretation

52. Where there is doubt as to the applicability or interpretation of the RJC's terms of reference and operating arrangements, the Chair of the RJC, with advice from the nominated Governance Advisor, shall have the final say, provided that the decision does not conflict with rights, liabilities or duties as prescribed by law.

Confidential information

53. Where confidential information is presented to the RJC all attendees will ensure that they treat that information appropriately considering any confidentiality requirements and information governance principles.

Openness and Transparency

54. As far as is practicably possible and appropriate, the RJC will meet in public to promote openness and transparency. A public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed on each Health Boards website, where the papers supporting the public part of the agenda will be available.

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	55. There will be occasions when some of the RJC's business is more appropriately considered in private session; this is to ensure that any business considered is not prejudicial to public interest, commercial sensitivities and data protection. **56.** The final decision on whether business should be discussed in private or public session shall be made by the RJC Chair, having taken advice from the nominated Governance Advisor.
Conflicts of interest	**57.** Conflicts of interest will be managed in accordance with relevant policies and procedures and shall be consistent with the three health boards' respective statutory duties and applicable national guidance. **58.** Where individual RJC members identify an interest in relation to any aspect of RJC business set out in the meeting agenda, that member must declare anhealth interest at the start of the meeting. RJC members should seek advice from the Chair before the start of the meeting if they are in any doubt as to whether they should declare an interest at the meeting. **59.** All declarations of interest made at a meeting must be recorded in the Joint Committees minutes. **60.** It is the responsibility of the Chair, on behalf of the RJC, to determine the action to be taken in response to a declaration of interest declared. Where the Joint Committee Chair declares a personal interest, any decision on the action to be taken shall be made the Vice-Chair designated for that meeting.
Disputes	**61.** Where a dispute arises between the three health boards, which is connected to the operation of the RJC and its work, this shall be resolved in accordance with the dispute resolution procedure at **Appendix B**.

Behaviours and Conduct	**62.** Members will be expected to behave and conduct business in accordance with: a) The policies, procedures and governance documents that apply to their respective Health Board. b) Any collectively developed procedures or codes. c) The Values and Standards of Behaviour Framework of NHS Wales. d) The Nolan Principles. **63.** Members must demonstrably consider equality diversity and inclusion implications of the decisions they make. **64.** Within the constraints of these Terms of Reference, RJC Members will act in the best interests of the population of the south-east Wales region, rather than representing the individual interests of an individual health board.

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Reporting Arrangements	**65.** A copy of the meeting minutes of each meeting of the RJC, along with a summary report, shall be shared with the three Health Boards for information and assurance. The report shall set out matters discussed and pertinent issues, together with any recommendations and any matters which require disclosure, escalation, action or approval. **66.** There will be regular joint reporting through existing accountability meetings between the three Health Board Chairs and the Cabinet Secretray for Health and Social Care.
Review	**67.** The RJC will review its effectiveness at least annually on its work in discharging its responsibilities, delivering its objectives and complying with its terms of reference. The outcome of this will be included within the standing report to the three Health Boards set out in 65. **68.** These terms of reference, including membership and chairing arrangements, will be reviewed at least annually and more frequently if required. **69.** Any proposed amendments to these terms of reference will be submitted to the three Health Boards for approval.

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Cardiff
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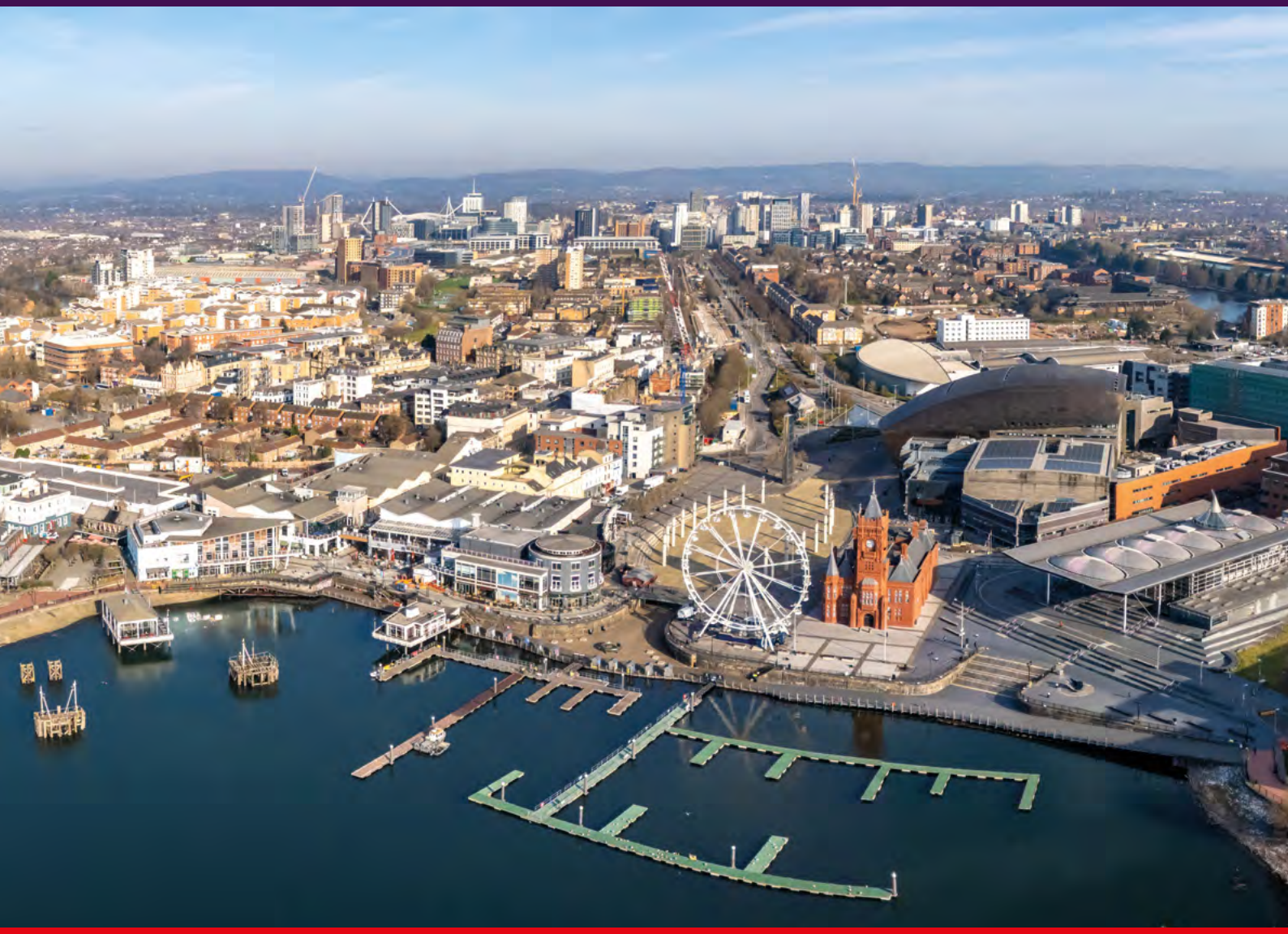
Cardiff Health Partners

Health Innovation, Anchored in Cardiff, Connected for Global Impact



CARDIFF UNIVERSITY
PRIFYSGOL CAERDYDD

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Cardiff and Vale
University Health Board

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

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Introduction

We are delighted to introduce Cardiff Health Partners (CHP).

As leaders of our respective organisations, we and our teams have been working closely together on CHP and are excited about the opportunities this partnership brings and the transformative impact it will have on our region.

CHP represents a new era, a bold, strategic, and collaborative vision: three organisations coming together with a shared commitment to improving health outcomes, driving innovation, and creating lasting benefits for our patients and communities. By combining our expertise, resources, and passion, we believe this partnership will not only strengthen healthcare delivery but also foster research excellence, economic growth, and social wellbeing across the region.

This is more than a partnership. It is a promise to work collectively for the greater good. We will work collaboratively, with our industry partners, to serve as a catalyst for positive change, setting new standards for collaboration and impact.

Thank you for taking the time to explore this prospectus. We look forward to working together to make this vision a reality.

Warm regards,

Carl James
Interim CEO, Velindre University NHS Trust

Wendy Larner
President and Vice-Chancellor, Cardiff University

Suzanne Rankin
CEO, Cardiff and Vale University Health Board

Executive Summary

Cardiff Health Partners is the vehicle for health innovation, anchored in Cardiff and connected for global impact.

We are a strategic partnership between Cardiff University, Cardiff and Vale University Health Board, and Velindre University NHS Trust that aligns discovery science, clinical care, education, and industry partnerships to accelerate innovation into practice, improve health equity, and drive inclusive economic growth and regeneration.

What do we want to achieve?

Cardiff Health Partners is designed to turn collaboration into results, with an initial focus on globally recognised competitive strengths including Cancer, Brain Therapies, and Precision Medicine - linking assets and capabilities across the partnership into coherent testbeds and pathways. The model reduces barriers through shared governance, streamlined research delivery, and federated data access.

The outcome is a gateway for collaboration, faster routes from researchers, to clinicians, to patients, and a workforce trained across academic, clinical, and industry settings. This is health improvement and economic growth and regeneration, delivered together.

Why now?

The proposition is industry-ready and impact-driven. Cardiff Health Partners will transform health equity through enabling service delivery closer to the patient; it will improve the health and wellbeing of the population in Cardiff and beyond through strategic use of technology and promote regional growth and regeneration through creating high-quality jobs and attracting inward investment.

We have at our disposal key assets across Cardiff, ranging from cutting edge research centres to education spaces, dedicated trials and experimentation infrastructure to large scale implementation capabilities.

Early wins such as cutting-edge Huntington's disease treatments, successes in novel trials to treat cancer, and spinouts such as Draig Therapeutics, all underpinned by modern data sharing, demonstrate pace, partner readiness, and delivery credibility.

Now is the moment to back a connected partnership that turns strategic alignment into measurable outcomes for patients, the economy, and society.

Our strategic vision:

Health Innovation, anchored in Cardiff, connected for Global impact

What do we want to achieve?

Through investing in our immediate priorities, there will be a direct impact to the health of our population and the economy.

What are our priorities for investment?

We have three current thematic priorities for investment.

Next-generation cancer care

The Cardiff Cancer Research Partnership (CCRP) has launched multiple early and late phase cancer clinical trials, including industry-led and translational studies. Acting as a gateway for trial portfolios across Wales, the Partnership streamlines access and collaboration.

We are seeking support to scale up CCRP, including investment in collaborative centres at the Sir Martin Evans Building, Cardiff University, and the new Velindre Cancer Centre to drive discovery, learning and innovation. This investment will accelerate and expand our ability to discover and test new treatments for cancer.

Brain therapies

Cardiff is home to a distinctive set of imaging capabilities at CUBRIC (Cardiff University Brain Research Imaging Centre) and is among a select group of global centres delivering first-in-human intracranial advanced therapies, supported by world-class imaging, genomics, and surgical expertise.

We are seeking investment in refurbishing and expanding the Haydn Ellis building at Cardiff University, to improve our discovery and education capabilities.

Precision medicine capabilities

Cardiff brings together Advanced Therapy Medicinal Products (ATMP) delivery and a national genomics backbone to accelerate precision medicine - linking MRI-guided neurosurgery, the Wales Genomic Health Centre at Cardiff Edge, a flagship innovation campus in South-East Wales, and federated data and biobanks to move from discovery to adoption at pace.

We want to establish a new precision medicine centre of excellence at Cardiff Edge. We also want to build more operating theatres and novel imaging and laboratory facilities at University Hospital of Wales, and expand the trial, imaging, integrated data, and biobank infrastructure, strengthening existing capabilities to improve how we translate, experiment, and implement novel precision medicine innovations.

What will this achieve?

Through investing in these areas, we will:

1. Improve the health and well-being of the population in Cardiff and beyond
2. Improve equity of health access and outcomes by creating innovations, technologies and approaches that can assist in the delivery of care closer to home and reduces the carbon footprint
3. Establish Cardiff as a centre of excellence with credible expertise, facilities and networks that draws the best people, ideas and opportunities
4. Establish Cardiff as a centre of research excellence and opportunity with early emphasis on Cancer, Brain Therapies, and precision medicine
5. Create opportunities for high value, rewarding careers and employment opportunities that sustains the partnership and adds value to South-East Wales

We're delighted to be a member of Cardiff Health Partners, working to deliver innovations that improve health and wellbeing not just for the people of Wales but for the world, and at the same time improving economic prosperity for our country.

This partnership gives us the fastest route to improving outcomes for the patients who are at the heart of our ambitions.

Wendy Larner
Vice-Chancellor, Cardiff University

Strategic Context

There is national precedent, We have local ambition

Across the UK, Wales, and Cardiff, there is a unique context and environment which can be leveraged through investment to deliver significant impact.

What is the context for the UK?

Over the past decade, the UK's life sciences sector has established itself as a world-leading cluster spanning pharmaceuticals, biotechnology, medical technology, and digital health. The sector now contributes around £80 billion annually to the UK economy, supported by a well-developed innovation ecosystem comprising world-class universities, research institutes, and industry hubs such as the Oxford-Cambridge Arc and the Golden Triangle (London, Oxford, Cambridge). University spinouts also play a pivotal role in the ecosystem.

Government-backed initiatives, including the **Life Sciences Sector Plan** and previous Sector Deals, have encouraged collaboration between academia, industry, and the NHS, resulting in increased R&D investment, innovation, and international competitiveness.

As organisations look to the future, there are several key megatrends impacting current thinking, such as personalised and precision medicine, digital health and AI, cell and gene therapies, sustainability, supply chain resilience, and workforce development.

How does Wales and Cardiff perform?

Wales faces pressing challenges in health outcomes, regional inequality, and economic resilience. The health of the population in Wales is poor compared to many other areas within the UK, with high incidence of cardiovascular disease and cancer at a young age and marked inequity of health between communities, who live geographically close to each other. Life expectancy within Wales is the second lowest within the four nations, at 79.6 years compared to the UK average of 81.2 years.*

At the same time, UK and Welsh strategies prioritise life sciences, translational research, and data-driven care. The UK Clinical Research Delivery reforms, emerging UK-wide standardisation of research setup, and Welsh commitments to precision medicine and advanced therapies create a favourable policy environment. This is highlighted through recent groundbreaking research innovations, such as gene therapy to slow Huntington's disease progression and QuicDNA's novel liquid biopsies to streamline treatment decisions in lung cancer.

*Data for 2023 sourced from NOMIS Annual Population Survey and the ONS.

Wales has committed to become a Marmot nation** through Wellbeing of Future Generations Act (2015), enshrining principles in legislation and adopting them to create a fairer society for all, leading to improved health and reduced inequalities. Welsh government policy aims to transform the healthcare system, working towards a "Healthier Wales". It has established integrated health boards which are able to be more responsive to the community needs and moving from:

- Illness to Prevention.
- Analogue to Digital.
- Hospital to Community.

The Welsh life sciences sector has seen strong industrial growth in recent years, coupled with innovative and active research. In 2022, the sector reached a record £2.85 billion in turnover, employing more than 13,000 people.

However, there are difficulties. The pathway from research to clinical application is fragmented and siloed. In addition, other opportunities are missed due to a lack of integration, coordination, and scalable infrastructure.

**https://www.gov.wales/wales-become-worlds-first-marmot-nation-tackle-health-inequalities

How do we improve population health through CHP?

Cardiff Health Partners will be the catalyst in Wales for bringing about the transition that is agreed and well described.

It will push the frontiers of medicine, as it has already done, which will not only deliver improvements to health outcomes, but will retain our talent and bring investment to Wales with prosperity as well as ambition to our communities.

It will facilitate the transition of our services to be centred around our communities to drive the three strategic shifts outlined above, utilising the talent within the University and NHS to transform our delivery and focus.

It will support, inspire, educate, and train our children to equip them to be the workforce of the future, with rewarding careers that enable them to support their families and communities and enable Wales to prosper.

Where is Cardiff across key socio-economic factors?

We've benchmarked ourselves against the UK. The lower-than-average economic performance coupled with the high smoking rate and lower life expectancy prove the need for Cardiff Health Partners and widescale regeneration to build more prosperous communities.

Economic

4.5%
Unemployment rate in South-East Wales
UK average*: 4.6%

23.6%
Economic inactivity rate in South-East Wales
UK average*: 20.9%

£20,233
GDHI per capita in South-East Wales
UK average*: £25, 411

Social

£204,160
Median house price for residential property in South-East Wales
UK average*: £321,899

5.1
CO2 emissions per capita in South-East Wales
UK average*: 5.9

757
Population density** in South-East Wales
UK average*: 1806

Health

13.0%
Rate of smoking prevalence in South-East Wales
UK average*: 11.6%

79.6 years
Life expectancy in South-East Wales
UK average*: 81.2 years

0.68
Infant mortality rate in South-East Wales
UK average*: 0.71

*Data for 354 local authorities across the UK was used to calculate UK average
**Calculated using 2021 Census data

The analysis highlights the region's strengths, such as the lower population density and reduced CO2 emissions, which contribute to a better quality of life and a lower cost for establishing businesses. The economic analysis reveals significant opportunities for growth in the area.

A qualitative assessment of the **strengths** and **opportunities** of the region was also conducted.

Strengths

- Our analysis of socio-economic indicators reveals that progress across all economic, social and health metrics is consistent with national trends.
- Cardiff nurtures a highly skilled workforce through strong academic-industry partnerships. The collaboration between clinicians, researchers, and educators fosters rapid translational research and innovation. More specifically, the number of research, engineering and technology professionals in South-East Wales has risen by 45%, significantly outpacing the UK average increase of 19%. This suggests a strong presence of specialised skills essential for advancing life sciences and innovation-driven businesses.
- Cardiff hosts an integrated network of pioneering facilities, including the Cardiff Edge Life Science and Tech Park, Wales Genomic Health Centre, a cutting-edge new Cancer Centre at Velindre, and the only children's hospital in Wales. This comprehensive infrastructure supports cutting-edge research and innovation across genomics, cancer care, and precision medicine. Neurosciences in particular is commended in the Life Sciences Sector Plan.

Opportunities

- It is potentially more profitable for life science businesses to operate in South-East Wales, compared to other cities. Areas with similar health partnerships, such as Bristol and Edinburgh, report lower turnover per life science business (£8 million and £12 million respectively), whilst Cardiff reports £14 million.
- Other health partnerships, like those in Manchester and Bristol, show the power of combining technology and AI with strong collaboration across academia, clinical practice, and industry. This synergy boosts research, drives economic growth, and highlights the untapped potential for further progress for CHP.

An overview of Cardiff Health Partners

Health Innovation, anchored in Cardiff, connected for Global impact.

What is CHP?

We are a strategic partnership between Cardiff University, Cardiff and Vale University Health Board and Velindre University NHS Trust.

We align **discovery** science, **healthcare**, **education**, and **industry** partnerships to accelerate innovation into practice, improve health and equity, and drive inclusive economic growth and regeneration.

By connecting world-class research with frontline delivery and a strong regional life sciences base, we act as the engine of a place-based strategy that reduces fragmentation, speeds translation, and makes Wales a partner of choice for research, innovation, investment, and talent.

The outcome is a gateway for **collaboration**, faster routes from **researcher to patient**, and a **workforce** trained across academic, clinical, and industry settings. This is health improvement and economic growth, delivered together.

Who are the three founding organisations?

Velindre University NHS Trust provides blood and cancer health services, as well as other services, to the people of Wales. The new Velindre Cancer Centre is due to open in 2027, and this state of the art clinical facility will house one of the leading suites of devices to provide radiotherapy treatments. It is also based on strong sustainability principles, including being all electric and leveraging renewable energy sources.

Cardiff University's biomedical and life sciences research is at the forefront of tackling global health challenges through discovery, innovation, and collaboration. Supported by cutting edge assets, including the Brain Research Imaging Centre (CUBRIC) and the Medicines Discovery Institute, it has unlocked new insights into cancer, neuroscience, infection, regenerative medicine, and genomics.

Cardiff and Vale University Health Board is one of the largest NHS organisations in Europe, serving nearly half a million people and providing specialist services. It hosts the Wales Genomic Health Centre and is responsible for the only children's hospital in Wales.

How do we work?

1. **Aligned Strategy and Vision**

We are anchored to our principles and steadfast in our approach to create a better, healthier and more prosperous future.

We are confident that the foundations we are creating will address health inequality, economic disparity and deliver projects that are truly needed by our population.

2. **Collaboration is at the heart of what we do**

3. **We are building an inclusive ecosystem**

4. **Fusing healthcare research, industry, and academia, with patient care**

> **I see Cardiff Health Partners as the means to optimise the opportunity to bring, collaborate, amplify and accelerate access to the life-changing benefits of these new interventions and treatments for the people of South-East Wales as well as globally.**
>
> **Suzanne Rankin**
> CEO, Cardiff and Vale University Health Board

What are our goals?

1

Stimulate innovation

Rapidly translate research into practice, focusing on precision diagnostics, early detection, prevention, and advanced therapies.

2

Accelerate health for our community and reduce inequity

Tackle health inequalities and ensure fair access to cutting-edge care for all communities.

3

Drive economic growth and regeneration

Stimulate high-value employment, SME growth, and inward investment.

4

Enable translational research

Bridge discovery science and clinical practice, getting new therapies to patients faster.

5

Develop a future ready workforce

Build and retain an interdisciplinary, skilled workforce through integrated education and professional development.

6

Foster regional collaboration

Maximise resources and build shared centres of excellence across Wales.

What does this mean in more detail?

Through a collaborative approach, Cardiff Health Partners will act as a unique transformational vehicle for South-East Wales.

Why now?

The positioning of the partnership will enable the organisations to leverage multiple policy levers and funding sources including the UK Government's £86 billion investment in science and technology, and the Regional Innovation Fund.

There are opportunities aligned with UK Government 2025 Industrial Strategy's eight primary sectors, particularly the synergy between Advanced Manufacturing, Clean Energy and Digital and Technologies, and the increased role that Universities will play in driving and delivering regional growth. Additionally, the Life Sciences Sector Plan highlights our role in supporting commercial studies, including four new catalytic centres launched this year in Women's Health, Virology, Vision and AI in Social Care.

The opportunity is time-sensitive and South-East Wales needs to capitalise on areas where it already has a competitive advantage and is beginning to lead the way:

We are uniquely positioned to deliver on the government's ambition to accelerate innovation and regional and national growth in Life Sciences.

How are we measuring our success?

- Adoption of evidence-based innovations into everyday care
- Life expectancy inequalities across the region
- GVA across Cardiff and the surrounding region
- Jobs created
- Inward investment attracted (number and value)
- Number of collaborative research projects (number and value)
- Number of clinical trials (number and value)
- Workforce development metrics (training, retention, diversity)

CHP represents a transformative opportunity for South-East Wales—bringing together innovation, clinical excellence, and community impact. It's not just about investment; it's about shaping a future where the region leads the way in integrated health partnerships.

Carl James
Interim CEO, Velindre University NHS Trust

What assets do we have?

We have a wide range of assets at our disposal. This includes, but is not limited to, the following:

Cardiff Edge Life Science and Tech Park
Home to the new national Wales Genomic Health Centre, with potential co-location for regional cellular pathology, creating standardised human tissue molecular diagnostic pathways. There is an exciting opportunity to develop modular precision medicine manufacturing capabilities with industry partners, alongside Cytiva and Llusern Scientific as sitting tenants.

Velindre Cancer Centre
A state-of-the-art clinical facility with a Collaborative Centre for Learning, Research & Innovation as a CHP hub, due to open in 2027.

Cardiff University Campuses
Enabling discovery science, pre-clinical research, and digital innovation. Expertise in cancer, neuroscience, and regenerative medicine is complemented by cutting-edge work in data science, imaging, and ethics. Innovation spaces like sbarc|spark connect social science researchers with public and private partners.

Heath Park Campus
Provides seamless, person-centred care across the full health continuum, from prevention and primary care to acute services, rehabilitation and end of life support, driven by innovation and equity for the population it serves at the largest teaching hospital in Wales.

Federated Data, Imaging, and Biobank Platform
Ambitious Wales-wide programme to develop skills, harmonise consent, governance, and interoperable access for translational research.

Through collaboration, we can bridge research and patient care—driving innovation, improving outcomes, and ensuring that NHS practice is grounded in the best available evidence. Our researchers can work with busy clinicians of all professions to enhance health care systems and delivery of patient care.

Steve Riley
Pro Vice-Chancellor, College of Biomedical and Life Sciences, Cardiff University

Thematic Priorities

Three thematic areas have been developed as initial priorities for investment. Each of these thematic areas is core for the short-term success of CHP.

Initial thematic priorities

1

Next-generation cancer care

The Cardiff Cancer Research Partnership has launched multiple early and late phase cancer clinical trials, including industry-led and translational studies. Acting as a gateway for trial portfolios across Wales, the Partnership streamlines access and collaboration.

2

Brain therapies

Cardiff is home to a distinctive set of imaging capabilities at CUBRIC (Cardiff University Brain Research Imaging Centre) and is among a select group of global centres delivering first-in-human intracranial advanced therapies, supported by world-class imaging, genomics, and surgical expertise.

3

Precision medicine capabilities

Cardiff brings together ATMP delivery and a national genomics backbone to accelerate precision medicine, linking MRI-guided neurosurgery, the Wales Genomic Health Centre at Cardiff Edge, and federated data and biobanks to move from discovery to adoption at pace.

Research and innovation pipeline

Cardiff Health Partners has packaged investment asks across the end-to-end research and innovation pipeline: discovery, experimental medicine, development, trials, adoption, and scale. We will be the conduit linking academia, industry, and the NHS so capital reaches the right stage at the right time.

This pipeline ensures investments reinforce each other, cut time to impact, and give partners a clear route to engage. Current asks are mapped to the pipeline to guide co-investment from government, industry, and other funders.

Discovery	Translation	Experimentation	Implementation	Education
Tackles grand healthcare challenges.	Moves research findings into practical applications.	Focussed on proving the science works.	Brings innovations into NHS delivery, delivering to the patient.	Embeds innovation into workforce training, so future professionals can scale impact.
	Cardiff Edge fit out and lease	Trial, imaging, data and biobank Infrastructure and trials	Additional operating theatres at UHW	Discovery, Innovation and Collaborative Centre at nVCC
	CCRP Scale up			
		Haydn Ellis and Sir Martin Evans refurbishment and investment		

Next generation cancer care

Researching and delivering the next generation of treatments for complex cancer.

Cardiff is home to leading clinical and academic cancer research expertise, both in laboratory science and clinical trials. Cardiff Health Partners leverages these strengths, combining them with capabilities in genomics, diagnostics, data science and NHS cancer services to take cancer treatment to the next level.

A new specialist Velindre Cancer Centre, a short walk from Cardiff Edge, hardwires collaboration across discovery, development, and delivery. The nearby University Hospital of Wales provides national expertise, within walking distance to key discovery and translational research institutes, including the Cardiff Experimental Cancer Medicines Centre, Wales Cancer Bank, and Medicines Discovery Institute. Together, these form the Cardiff Cancer Innovation District (CCID). With cancer rates above the UK average, Cardiff is a real-world testbed to trial and scale new ways of preventing, diagnosing, and treating cancer.

Spotlight on... Cardiff Cancer Research Partnership

The tripartite is designed to improve outcomes, deliver world-class research, enable advanced therapies, and create a structured pipeline from discovery to clinical application. CCRP has a vibrant and sustainable pipeline of trial activity. Progress to date has been strong but expansion is limited by current space and workforce capacity.

What physical, human and innovation assets are required to realise the vision?

- Establishment of a discovery, innovation and collaborative centre at the new Velindre Cancer Centre for learning, research, and innovation
- Establishment of Cardiff Cancer Discovery Centre at the Sir Martin Evans building, for co-located world-class preclinical & translational research
- Additional trial beds and workforce expansion for scale up of CCRP, across Cardiff and Vale University Health Board and Velindre University NHS Trust
- Investment in infrastructure across Cardiff Cancer Innovation District, to improve physical connectivity
- Investment in R&D and industry engagement, expanding the gateway for commercial partners and business development

By working together, we are translating our discoveries into new cancer treatments and providing opportunities for cancer patients in Wales to access a range of novel treatments that would not otherwise be available in the principality.

We are committed to developing links with industry to scale up and bring exciting new pipelines of treatments through to the clinic for patient benefit.

Dr Jacinta Abraham, Executive Medical Director, Velindre University NHS Trust

Brain therapies

Driving breakthroughs in Brain Science and Mental Health.

Brain therapies refer to a spectrum of advanced medical and neurotechnological interventions aimed at treating neurological and neurodegenerative conditions. Bringing together expertise in genomics, neuroscience, psychiatry, and data science to tackle some of society's most urgent challenges, such as dementia, schizophrenia, movement disorders, bipolar disorder, neuroinflammatory disease and neurodevelopmental disorders. Our work focuses on translating genetic discoveries into real-world personalised and advanced therapies.

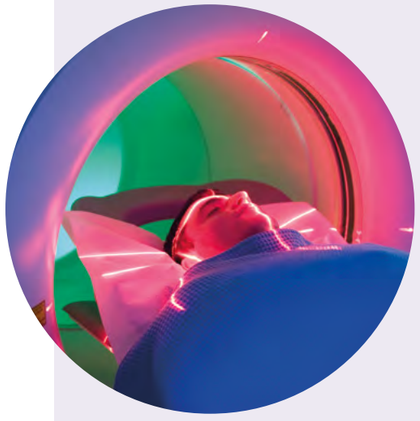
Cardiff is emerging as a global centre for first-in-human intracranial advanced therapies, where treatments are delivered directly to the brain. This is supported by CUBRIC and the Medicines Discovery Institute, offering world-class imaging, genomics, and surgical expertise.

Spotlight on... Intercranial Advanced Therapies

These therapies target neurological and neurodegenerative conditions using intracranial delivery methods. Cardiff is one of a select few global centres delivering first-in-human (FIH) intracranial ATMPs (Advanced Therapy Medicinal Products). Whilst we have the knowledge and capability to deliver these therapies, in order to scale up there is a need for additional infrastructure.

What physical, human and innovation assets are required to realise the vision?

- Comprehensive redevelopment of the Haydn Ellis building to establish a world-class research institute that supports both academic research and industry collaboration.
- Investment in expansion of inpatient beds and outpatient facilities for intracranial Advanced Therapies.
- R&D investment for Cardiff to be seen as the one-stop-shop for first in human intracranial AT clinical trials.
- Additional staff in the form of technicians and training fellows to deliver operations and training.



There has been an amazing advance by Professor William Gray and his team within the Advanced NeuroTherapies Centre - part of Cardiff Health Partners.

The team have delivered a groundbreaking gene therapy through complex neurosurgery all performed within a dedicated MRI scanner at University Hospital of Wales. The specialist team at UHW are unique in the UK, only one of two centres in Europe and five worldwide delivering this trial. They are also currently delivering other gene therapy trials for neurological diseases.

David Fluck, Executive Medical Director, Cardiff and Vale NHS University Health Board

Precision medicine capabilities

Tailoring prevention and treatment strategy for our population's health.

Precision medicine uses genetic testing, data analytics, and biomarkers to understand how different people respond to disease and therapy, improving outcomes and efficiency. Precision medicine relies heavily on the ability to collect, integrate, and analyse large-scale genomic, imaging, clinical, and biobank data. Our priority is to build a federated data, imaging, and biobank capability that enables secure, interoperable access across institutions, bridging discovery science to clinical application at pace.

Spotlight on… Cardiff Edge and Regional Pathology

Cardiff Edge is the leading dedicated life science and tech campus in Cardiff and South-East Wales region. With 320,000 square foot of expansion space, it offers a unique opportunity to create an exemplar life sciences ecosystem connecting business, academia and NHS laboratory facilities at a single location. The first lab-enabled facility is planned to be developed imminently.

Regional Cellular Pathology Service, develop the required infrastructure, co-located with the Wales Genomic Health Centre, creating a strong foundation for a Precision Medicine Centre of Excellence, to transform the existing service at a regional level and support the transition to the digital pathology programme.

What physical, human and innovation assets are required to realise the vision?

- Investment in Cardiff Edge, for the development of a new cutting-edge laboratory for regional cellular pathology services and industrial space for biomanufacturing
- Expansion of a biobank and improved digital support, through establishing a harmonised, federated data and sample infrastructure
- Additional operating theatres at University Hospital of Wales, to improve capacity in the short term
- Funding dedicated to R&D, for AI tools, innovative data pilots, and establishing industry partnerships

We are energised by the once in a generation opportunity that Cardiff Health Partners presents: to ignite academic life sciences across Cardiff and the wider Welsh ecosystem, creating a vibrant hub of discovery and innovation.

Illumina is fully committed to supporting Cardiff Health Partners in their mission to establish Wales as a global leader and destination for genomic healthcare excellence.

Illumina

Successes to date

Cardiff is already delivering firsts and forging proof points. Each success is a small step which fuse together to realise CHP's strategic vision.

Huntington's Disease Treatment

A recent trial of a new treatment found that patients receiving it experienced 75% less progression of the disease overall. The Advanced Neurotherapeutics Centre (ANTC), funded by Health and Care Research Wales, is the only centre in the UK that can perform the surgeries included in the trial – utilising world leading neurosurgical expertise in the delivery of gene therapies to the brain.

This has significant scale potential, helping to improve the quality of life for a devastating condition.

Modern Data Sharing

The Haematology AML Research Unit at Heath Park provides a leading example of how integrated, consented datasets and biobank samples can drive real-world translational research.

Utilising assets such as Cardiff University Biobank and the Centre for Trials Research it delivers on local partnerships with industry as well as contributing to major global partnerships such as the HARMONY Alliance. This commitment to openness and sharing speeds up translational science, bringing benefits to patients faster.

Spinouts

Draig Therapeutics is a recent spin out from Cardiff University. This clinical stage biotechnology company is based in Cardiff and is focussed on developing transformative therapies for neuropsychiatric disorders.

They are backed by a strong network of investors and launched with one of the largest Series A funding rounds in UK biotech history. This work will deliver transformative therapeutic benefits for patients with Major Depressive Disorder.

Cancer Trials at Cardiff

To date, several Cardiff Cancer Research Partnership (CCRP) trials have opened, with a strong future pipeline of complex trials in both solid tumour and blood cancers. These include two trials from Health Care Research Wales' national BioNTech portfolio, demonstrating the key role the CCRP is playing in enabling entire industry trial portfolios to be brought to and delivered in Wales, rather than just individual trials.

Cardiff Health Partners builds on a strong foundation of globally impactful cancer research within its partners. For example, the Velindre-led FAKTION trial led to the development of a drug which recently became routinely available to NHS breast cancer patients, while CCRP was the largest UK recruiter to the Monumental 6 trial of a bispecific antibody therapy for patients with multiple myeloma.

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QuicDNA study

Lung cancer is currently the third most common cancer in Wales, with the majority of patients only being diagnosed at an advanced stage. Through a recent study led from Cardiff, and conducted across Wales, a new test has been developed, utilising liquid biopsy of circulating tumour DNA in the blood, rather than a solid tissue biopsy, to identify genetic changes that can be rapidly and precisely targeted for treatment. This less invasive approach to obtaining a sample has been found to deliver results on a faster turnaround time. We can now ensure patients get treatment that they need sooner, saving lives.

Cardiff University chose to step forward to turn research into reality, to make health, wealth and opportunity their mission. Their ambition is not just words but work, not just vision but resolve. That's what you see in Draig Therapeutics - science rooted in excellence, brought to life by leadership, powered by partnership, and aiming for more than profit - aiming for impact.

Cardiff University doesn't imagine change, it makes it. Draig Therapeutics is the proof - living, breathing, ready for the future.

Dame Kate Bingham
Managing Partner, SV Health Investors

Outcomes and Impact

What does success look like in 2035?

Our ambition as Cardiff Health Partners is for:

- That Cardiff is recognised as a true Centre of Excellence in Brain Therapies, and for its excellence in precision medicine (building on its recognised strength in genomics)
- Our partners are recognised in their innovative approach translating cutting edge research into routine cancer care and treatments
- Creation of a workforce pipeline, with widened participation, to attract more people to work on cutting edge research and clinical practice, supporting hybrid portfolio careers in clinical, academic and entrepreneurial settings
- That the above talent and assets are embedded into the wider health and life sciences ecosystem in the region
- A dedicated landing zone welcomes top talent and bold ideas to experiment, collaborate, and accelerate innovation in a dynamic, impact-driven environment
- Health inequalities in Cardiff and region will be actively reduced through inclusive interventions that ensure access to care and research participation
- Healthcare to be delivered closer to the patient (routine care)

By investing in Cardiff Health Partners, the region will see significant benefits.

We are expecting to spend approximately £500m on infrastructure, and a further approx. £350m on human capital, and research & development needs over the next ten years. Cardiff Health Partners would lead to a significant economic contribution of between £785m and £813m in GVA and 10,440 – 10,840 jobs between 2025-2035. This investment will unlock additional benefits, beyond the monetary impact, extending and improving healthcare metrics across South-East Wales.

Methodology

Contribution to GDP is measured in terms of Gross Value Added (GVA). GVA is a monetary measure of the value an organisation creates during its production process. It is the difference between the price of its products (outputs) and the price of the inputs it uses in producing these (or intermediate consumption).

GVA is an alternative term for GDP at factor cost, which is GDP before taxes and subsidies on products. As such, GVA is the company-level equivalent of GDP.

CCRP is developing the next generation of cancer research and enabling translation of new discoveries into the clinic for patient benefit.

For example, the CCRP's ATTEST trial gives NHS patients in South-East Wales access to pioneering virus vector technology, founded on Cardiff University research, that selectively infects cancer cells, producing an immune-modulating drug from inside the tumour cells.

Awen Gallimore
Professor, Cardiff University

£785m – £813m

Estimated impact on GVA between 2025 - 2035

10,440 – 10,840 FTES

Estimated impact on employment between 2025 - 2035

Assumptions:

- Expenditure between labour and capital varies. Economic effects are presented as ranges
- It has been assumed that 31.8% of the proposed capital expenditure will leak-out internationally. This is based upon the % of UK imports relative to GDP
- Investment asks have been uplifted 2% annually to model for inflation
- The economic input data for sectoral spending is derived from Supply-Use Tables provided by the ONS

Limitations:

- Due to data availability, 2022 Supply-Use tables from the ONS were used to estimate the 10-year impact
- The analysis has been conducted on a gross basis. It does not take additionality (deadweight, leakage,) into consideration of the overall contribution
- These estimates are based on high level estimates of expenditure and are subject to change
- There has not been a full interrogation of the investment asks

Summary and.... what comes next?

Cardiff Health Partners...

offers an exciting, scalable platform with near-term readiness and long-term durability. It brings a coherent pipeline of opportunities across discovery hubs, clinical trial expansion, infrastructure (including digital and data), and workforce development - anchored by flagship, co-located assets with national reach.

Investment will catalyse system-wide benefits: improved population health and access to innovation; stronger regional productivity creating high-value jobs; and an internationally visible ecosystem that accelerates partnerships and inward investment.

Cardiff Health Partners will deliver the ambitions of the Well-being of Future Generations Act, Welsh Government's Economic Mission, and the UK Life Sciences Industrial Strategy.

It will transform:

- Health equity through enabling health service delivery closer to the patient
- Delivery of health improvement at scale through strategic use of technology
- Regional growth and regeneration by creating high-quality jobs and attracting inward investment

We are currently seeking investment in...

Next-generation cancer care

To scale up Cardiff Cancer Research Partnership, as well as establish a discovery and collaborative centre at the Sir Martin Evans Building and a discovery, innovation and collaborative centre at the new Velindre Cancer Centre for learning, research, and innovation. This investment will enable additional discovery and translation of new treatment for cancer.

Brain Therapies

To refurbish and expand the Haydn Ellis building at Cardiff University, to improve our discovery and education capabilities.

Precision medicine capabilities

To establish a new centre of excellence at Cardiff Edge, build more operating theatres at University Hospital of Wales, and expand the trial, imaging, data, and biobank infrastructure, to improve how we translate, experiment, and implement novel precision medicine innovations.

What are we doing now?

We will continue to progress, accelerate and scale our ambitions - underpinned by robust implementation plans and clear investment requirements.

If you're interested to learn more, you can find our website here...
cardiffhealthpartners.org.uk

Now is the time to back a connected, partnership that turns strategic alignment into outcomes for patients, the economy, and society.

"Cardiff Health Partners represents exactly the kind of bold, collaborative innovation that defines the Cardiff Capital Region. It's an investment not only in medical innovation and economic growth, but in improving the health, wellbeing and life chances of people across South-East Wales and beyond.

Mike Brough
Director of Economic Growth,
Cardiff Capital Region

Cardiff
Health Partners

Partneriaid Iechyd
Caerdydd

cardiffhealthpartners.org.uk

Year One Annual Report

Delivery Plan for Advanced Therapies in Wales

September 2024 - August 2025

Co-ordinated by

Advanced Therapies Wales | Therapiau Datblygiedig Cymru

Introduction

Welcome to the first Annual Report of the Delivery Plan for Advanced Therapies in Wales. We have outlined activity and progress made over the last year, from the plan's endorsement in September 2024 by the Advanced Therapies Wales (ATW) Programme Board and its subsequent launch in January, once endorsed by Welsh Government.

We've highlighted successes and challenges along with the ongoing work associated with each Goal and Theme, and would like to thank our teams, collaborators and our patient and public partners for their help and dedication. The contents of the following pages demonstrate the impact of our collective contributions and we look forward to engaging many more of you as we continue to shape a dynamic, inclusive ecosystem moving forward into year two.

Advanced Therapies Wales | Therapiau Datblygiedig Cymru

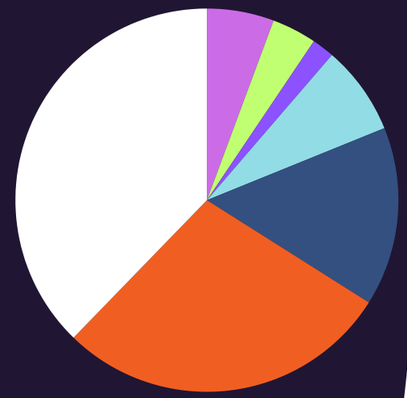
Midlands-Wales Advanced Therapy Treatment Centre

Advanced Therapies Wales (ATW) is the only programme of its kind in the UK, and this innovative approach has generated the ability to garner systemwide and strategic support in this rapidly growing advanced therapy medicinal products (ATMPs) field, creating a single point to coalesce expertise and offer national support.

With an annual budget of £0.5 million, the programme works across Wales to support the development and adoption of a wide range of advanced therapies, but does not cover the cost of the therapies themselves. Our funding supports a range of activities and substantive posts, including the core team and externally commissioned specialist roles embedded across health boards to enable ATMP delivery.

We act as a central hub, bringing together resources, coordinating activities, and nurturing collaboration across the sector, maintaining strong links with both Welsh & UK Governments developing end-to-end NHS pathways. We also support research, serving as a key interface for industry and commercial partners.

ATW spend from Sept 24 - Aug 25



ATW co-leads the Midlands and Wales Advanced Therapy Treatment Centre (MW-ATTC) with University Hospitals Birmingham NHS Foundation Trust as one of four UK centres, making up the Advanced Therapy Treatment Network (ATTC). Coordinated by Cell and Gene Therapy Catapult (CGT Catapult) and the National Institute for Health and Care Research (NIHR), the ATTC has a UK-wide remit to accelerate advanced therapy clinical trials within the NHS, to strengthen trial readiness, to build workforce capacity and capability that enhances the UK's attractiveness as a location, aligning activities with NHS England's 10 year health plan. The overall allocation is £17.9 million from 2024–2028, with MW-ATTC receiving £3.3 million, of which £1.3 million comes to Wales.

MW-ATTC is leading the Public and Patient Involvement and Engagement (PPIE) workstream. The aim is to address the current gap in ATMP-specific PPIE activity by raising public awareness, promoting equitable access, and co-developing a patient charter to support greater understanding and participation in ATMP clinical trials.

"I'd like to say how good I think the Delivery Plan is, really thorough, easy to digest, with accessible information, focused and ambitious. A helpful and much-needed roadmap"

Vision

Working together within the Advanced Therapies global ecosystem, to deliver the benefits of these therapies to improve the health, wellbeing and prosperity of the people of Wales.

Strategic approach

The development and delivery of the Advanced Therapies sector in Wales is multifaceted. To achieve the goals of the SOI, coordinated collaboration and engagement with key stakeholders and partners is required (including NHS organisations, academia, industry and others) to establish an effective pathway to enable efficient delivery of these therapies.

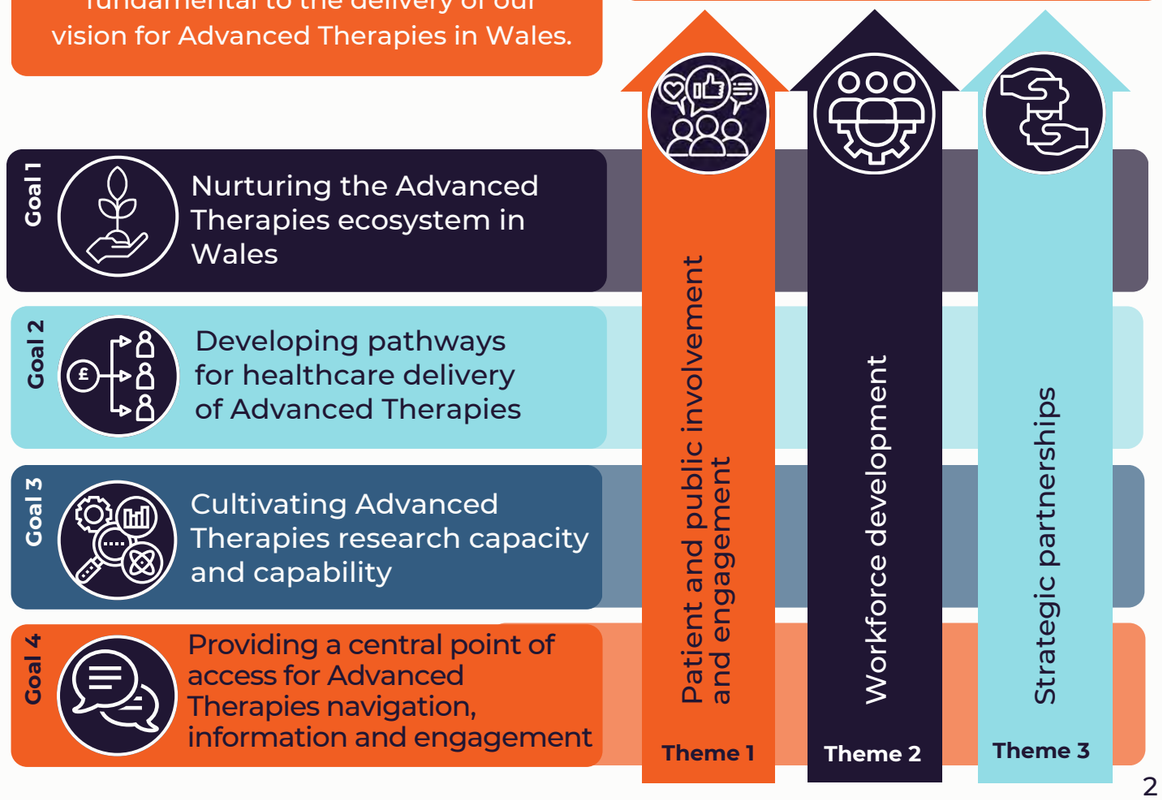
Ensuring alignment and contribution to regional and national policies, objectives and ambitions is vital to successful delivery.

Goals

This Delivery Plan is centred around four key goals, which are considered fundamental to the delivery of our vision for Advanced Therapies in Wales.

Themes

The successful delivery of the four goals are reliant on the cross cutting development of the three themes.



Goal 1

Nurturing the Advanced Therapies ecosystem

Supporting growth in the Advanced Therapies ecosystem through enhancing and aiding opportunities for development and increased awareness.

Risk status GREEN

Social media posts 36

Key Activities

1. Translational research funding

ATW provided £24,000 to the Advanced Therapies Multi-Disciplinary Research Group (MDRG), who awarded grants to four small-scale projects through a competitive process which are due to report back with results in January 26. Co-hosted with Cardiff Experimental Cancer Research Centre (ECMC) and the Advanced Neurotherapies Centre (ANTC), the group has grown to 143 members from academia, health, and industry with the monthly meetings exploring three rotating themes: Neurology, Oncology, and Regenerative Medicine.

2. Regional and National collaboration

A Quarterly Regional Meeting, co-led by ATW and MW-ATTC was launched. Comprising of NHS and university partners from Cardiff and Vale University Health Board (CAVUHB), Velindre University NHS Trust (VUNHST), and institutions in Oxford, Nottingham, Leicester, Cambridge, Southampton, Bristol and Birmingham. The meetings provide an opportunity to share intelligence on clinical trials, align regional efforts, and escalate risks to the ATTC network. Despite receiving no direct funding, partners are engaged, reflecting a strong sense of shared purpose.

3. Funding clinical roles

ATW and MW-ATTC jointly funded key clinical posts including: Consultant ATMP Pharmacist, Research Nurse in Neurodegenerative Indications, ATMP Clinical Trials Manager, Clinical Lead, and Specialist Registrar in Neurosurgery.

ATW has created the UK's first national Advanced Therapies Clinical Expertise Forum, which will formally convene 2025-26. Members include specialists in nursing, oncology, haematology, apheresis, regulatory affairs, and workforce planning and will be funded sessionally, with roles reviewed and rotated annually. The forum will provide advice on service design, workforce planning, business cases, regulatory compliance and infrastructure development.

4. Pharmacy readiness

ATW has engaged in national work led by the Welsh Government Chief Pharmacy Officer to assess pharmacy service preparedness for ATMPs. This informs Welsh Government decision-making and ensures alignment with the Medicines and Healthcare products Regulatory Agency's 2025 Point of Care Manufacture guidelines. Findings will be published in the 2026 Annual report, with clear recommendations to strengthen pharmacy infrastructure and workforce readiness across Wales, aligning with national and regional initiatives such as the Translational Advanced Medicines Service (TrAMS).

5. Patient engagement

ATW has hosted a series of roundtables with MW-ATTC, Gilead Sciences, and Life Sciences Hub Wales. They have brought together clinicians, researchers, policymakers, and patient advocates to address topics including CAR-T delivery, Good Manufacturing Practice (GMP) facility planning, trial inclusivity, and specialist training. Each has generated actionable recommendations that now guide programme priorities.

Challenges

- Sustaining small and large-scale projects relies on securing long-term funding beyond the typical one-year cycle.
- Ambition to establish a GMP facility in Wales, will require substantial cross-sector investment supported by long-term policy planning.
- Consistent engagement and production of robust, evidence-based insights within an evolving healthcare landscape at a time when finance, capacity, and resources are extremely constrained across key partner organisations.

Next 12 months

- Draft paper for GMP facility to define objectives and resources
- Repeat MDRG funding initiative
- Recruit for roles of Advanced Therapies Clinical Expertise Forum
- Develop outline business case for Therapeutic Apheresis Service
- Develop clinical expertise forum to enhance clinical leadership
- Develop business case for aseptic staff - Hemgenix delivery
- Develop business case to enable adoption of Spherox
- Visit Miltenyi Biotec to expand Prodigy platform capability
- Support aligning local research with system-wide readiness

6. Case Study

Therapeutic Apheresis Services

Apheresis services are critical to the delivery of advanced therapies. An Apheresis Review commissioned by ATW in 2023 identified significant gaps in infrastructure and workforce capacity across the nation. The review set out recommendations for an All-Wales service model to address these limitations and enhance national readiness. ATW convened a collaborative project in 2024 involving health boards, clinicians, and patients to refine and progress preferred options for a sustainable future model.

Endorsed by the ATW Programme Board and the Regional and Specialised Services Provider Planning Partnership, the project ensures alignment with national priorities and addresses both current and anticipated service needs.

Importantly, the approach is holistic, extending beyond ATMPs to strengthen the wider strategic and financial case for investment.

To capture consensus on a preferred service model, targeted clinician and patient engagement days are planned for 2025. Our approach has gained national recognition and has been endorsed as a blueprint for potential replication across the UK, both for the initial review and for proposed future service provision.

Goal 2

Developing pathways for healthcare delivery of Advanced Therapies

Supporting institutional readiness to ensure timely healthcare delivery through innovative collaborations.

Risk status GREEN

Social media posts 4

Key Activities

1. National coordination

In June 2025, ATW and the NHS Wales Joint Commissioning Committee (NWJCC) signed a Memorandum of Understanding which formalises collaborative arrangements developed over recent years, enabling cross-sector expertise to work together more effectively.

2. Delivery to patients

Currently, 14 therapies have been approved by the National Institute for Health and Care Excellence (NICE) for 17 indications. In Wales, three haemato-oncology therapies are delivered through the South Wales Blood and Marrow Transplant Team (SWBMT) at CAVUHB, where more than 100 patients have now received Chimeric Antigen Receptor T-Cell (CAR-T) treatment. Not all therapies are available in Wales, and some Welsh patients receive treatment elsewhere in the United Kingdom.

3. Horizon scanning

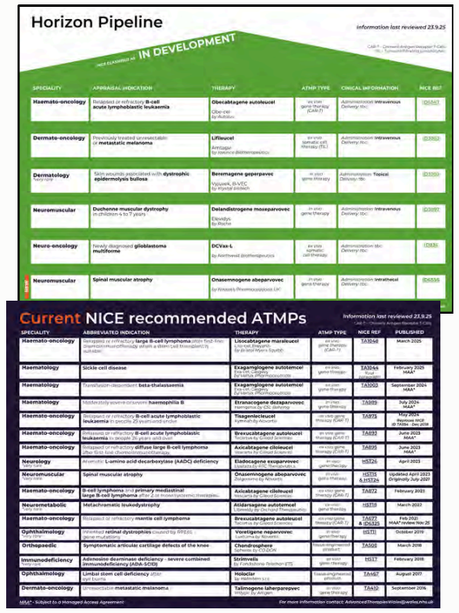
Over the last year publication of the Horizon Scanning Snapshot has been established. Produced every six months, it supports planning and NHS readiness. ATW has worked with the All-Wales Therapeutics and Toxicology Centre (AWTTC) and the NWJCC to create this document, which provides early intelligence on therapies nearing market entry and awaiting NICE approval. The snapshots have become a key resource for commissioners, clinicians, and service planners, and are published each March and September.

4. Practicalities of adoption

The ATW Adoption working group is now co-chaired by Professor Iolo Doull of NWJCC and Vicky Le Grys of CAVUHB. The group helps healthcare providers implement NICE recommended therapies and identifies the resources needed for consistent delivery in standard care settings.
ATW has also facilitated the introduction of gene therapy for haemophilia by convening multidisciplinary progress meetings led by the ATMP Consultant Pharmacist, who identified and addressed implementation challenges and supported readiness across pharmacy, clinical, and commissioning teams.
ATW has also collaborated with colleagues at VUNHST and Welsh Blood Service (WBS) to develop models of care that enable more local delivery of complex therapies with specialist support and explored service expansion to meet current unsustainable demand and growing future needs.

5. System wide collaboration

ATW and the AWTTC have jointly developed a governance proposal to support the integration of complex and novel therapies into routine practice, enabled by the creation of the “Coalition of the Willing,” a national multi-stakeholder working group. This UK first, working on mapping of the complex therapy pathway, has produced a national proposal for introducing complex therapies into standard care in Wales. It addresses evolving requirements by providing a modified whole-system pathway that meets governance, infrastructure, regulatory, and workforce needs including service redesign, national policy, and capital planning.



Challenges

- Limited dedicated resources. ATW working with Health Boards and partners to address workforce allocation and operational support. Gaps in pharmacy and aseptic services, being targeted through investment and service redesign.
- Cleaning and linking datasets to develop more integrated digital systems, supporting timely decision-making to enable real-time data sharing and collaboration.
- Coordinated planning across Health Boards, commissioners and clinical teams required to reduce fragmentation.

Next 12 months

- Develop an innovative commissioning support model for efficient movement through to delivery.
- Prepare paper on pharmacy readiness for ATMPs
- Continued coordination of national complex pathway solutions, moving to proof of concept stage.
- Continued facilitation and support to contribute to and/or develop multidisciplinary clinical solutions.
- Digital needs- articulating the ask
- Launch open access version of ATMP Commissioning Dashboard

6. Case Study

Advanced Therapies Commissioning Dashboard

Developed by the ATMP Outcomes Programme at NWJCC, the Advanced Therapies Commissioning Dashboard has been launched.

It provides a clear picture of access to advanced therapies in Wales, showing how many have been commissioned with demographic insights into who is receiving them. This is building understanding and will highlight potential barriers or inequalities.

Retrospective data on diffuse large B-cell lymphoma patients in Cardiff has been analysed, which is the main group eligible for CAR-T therapy, ahead of an all-Wales rollout. Early findings indicate patients present at an older age compared to international benchmarks. Scoping on innovative payment models to support sustainable commissioning has also begun.

The dashboard will be expanded to capture clinical and patient-reported outcomes, enabling real-world evaluation of their impact. It will also explore what information matters most to the public, with the aim of creating a transparent, open-access version. This work will contribute to a case study for the ATMP Coordination group led by the UK’s Department of Health and Social Care.

Goal 3

Cultivating Advanced Therapies research capacity and capability

Supporting research and innovation acceleration in Wales, nationally and internationally to increase capacity and capability.

Risk status GREEN

Social media posts 109

Key Activities

1. Knowing our strengths

ATW has commissioned a mapping and review exercise of advanced therapies research in Wales, covering both pre-clinical studies and clinical trials. It will highlight current strengths and gaps, identify opportunities for growth, inform strategic planning, and help shape research priorities. Insights will also feed into broader infrastructure assessments, including requirements for GMP facilities and align with the UK Government's Life Sciences Sector Plan.

2. Sharing learning

In addition to the previously mentioned Advanced Therapies MDRG, ATW provides collaborative research space with The Research, Development and Innovation Working Group, chaired by Professor Steve Conlan of Swansea University. The group meets quarterly providing a platform for knowledge sharing, building trial capacity, and promotes collaborative research opportunities.

3. Research activity support

ATW funds the ATMP Consultant Pharmacist who supports clinical research delivery, as well as other posts involved in advanced therapies research centres. This includes funding consultant time and a research nurse at the ANTC, who have been leading first-in-human trials for Huntington's disease. Funding has also supported trial administrators for the Cardiff Cancer Research Hub (CCRH) and cystic fibrosis studies to facilitate early-phase advanced therapy trials.

ATW further supported pre-clinical research, awarding a £10,000 grant to PhD student Rosie Mundy at the Wales Applied Virology Unit at Cardiff University for her work on the Ad10 viral platform, which has already resulted in a published paper.

4. Achieving shared goals

Through the Wales Cancer Industry Forum, which includes a patient representative, ATW has partnered with AstraZeneca to incorporate industry insights into pathway mapping. The programme also collaborates with partners through initiatives such as roundtables with Gilead Sciences, also maintaining strong relationships with Amgen, Cytiva, and the Association of the British Pharmaceutical Industry (ABPI). ATW has also aligned with the wider United Kingdom ecosystem by implementing recommendations from the Lord O'Shaughnessy review to strengthen commercial trial delivery and through engagement with the ATTC Industry Advisory Group.

5. Research intelligence and information

ATW has helped develop a process for open trial recruitment and site selection. Working with colleagues in Health and Care Research Wales (HCRW) and ATTC network, opportunities are shared across Wales, with dedicated support provided to clinical teams in site selection to widen engagement. Connecting with other national and funded research initiatives in Wales has enabled increased collaboration and value for money. There is regular engagement with the ANTC, Cardiff ECMC (both adult and paediatric), SWBMT Team, CCRH, Betsi Cadwaladr University Health Board (BCUHB) Clinical Trials Unit and many other specialist teams.

Challenges

- Sustained engagement from stakeholders essential to ensure mapping and review process progresses. It may also highlight workforce and infrastructure gaps that will require investment or policy action.
- Ensuring that horizon scanning and mapping outputs are thorough and reliable is critical for informing future planning and strategic decision-making. Collaboration with industry and academic partners remains vital, though resource intensive.

Next 12 months

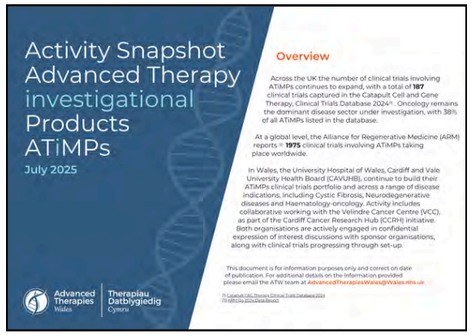
- Utilise information in the research baseline review to develop appropriate model for Wales and publish.
- Support continuing research collaboration in advanced therapies by facilitating and funding activity where possible
- Identify new activity or developments to ensure that the Welsh offer can be capitalised upon.
- Continue to provide intelligence and information to enhance capitalisation of opportunities and collaborative working.

6. Case Study

Activity Snapshot Advanced Therapy investigational Products (ATiMPs)

The Advanced Therapy Investigational Medicinal Products Clinical Trial Activity Snapshot has been launched. Produced collaboratively by ATW, CAVUHB, and VUNHST, using data from CGT Catapult database, with input from the Research, Development and Innovation Working Group and HCRW.

The bi-annual snapshot, provides an up-to-date overview of open and follow-up clinical trials across Wales, helping stakeholders identify strengths, gaps, and opportunities. It has supported planning, provided transparency and enhanced equitable patient access. Joint authorship ensures the data is accurate, relevant, and directly useful to research teams and partners, making it a valuable tool for strengthening research capacity.



Goal 4

Providing a central point of access for Advanced Therapies navigation, information and engagement

Developing high quality, up to date and easily accessible information to support navigation of the Advanced Therapies landscape.

Risk status GREEN

Social media posts 135

Key Activities

1. Committed resources

The ATW Communication and Engagement Strategy has been developed. It outlines how the programme will produce targeted communications, stakeholder engagement, and inclusive messaging. To support this work, a full-time Communications Officer post has been funded until March 2026.

2. Increasing visibility and online prescence

Social media activity has increased, and the new ATW website is being developed. It is being designed as a central access point and resource hub with dedicated pages covering all stakeholder groups.
Targeted social media and media campaigns have helped grow the audience. Post information is captured and aligned to the goals and themes in the delivery plan.
Targeted emails on events and funding opportunities are shared to relevant stakeholders, as well as the distribution of the Horizon Scanning Snapshot and the ATiMP Activity Snapshot.

3. Engagement

ATW has developed and maintains a calendar of events, and now coordinates monthly MDRG meetings. The Advanced Therapies Annual Conference in London has become a regular fixture and in 2025, ATW joined with Life Sciences Hub Wales for a joint stand. ATW and MW-ATTC hosted a roundtable on patient and family perspectives. Professor Liam Gray also attended as a clinical representative.

Events hosted

- Delivery Plan launch
- ATTC & Gilead Sciences CAR-T workshop
- ATW Symposium

Events with stand or presentations

- Friends of Cyrmu Sickle Cell and Thalassaemia Day
- Genomics Strategic Workforce plan launch
- UK Medicines Information Conference
- Precision Medicine Showcase
- Velindre Medical Engagement Day
- Advanced Therapies UK Congress
- HCRW Faculty Showcase
- Glen Wells Visit
- Velindre Working Together Conference
- MediWales Connects Conference

Events attended

- Drug Discovery Conference
- HCRW Conference
- Wales Rare Care Centre for Wales
- UCL Advanced Therapies Symposium
- Advanced Therapies Integrates North
- Advanced Neurotherapies Centre launch
- NHS Wales Confederation Conference
- Wales Cancer Research Conference (sponsor)
- Wales Scientific Advisory Committee Conference
- Huntington's Disease Centre Summer Event
- Scientific Showcase Advanced Cellular Therapy
- UK Clinical Research Facility (UKCRF) and Biomedical Research Centres (BRC) Conference
- Resilience Launch

Challenges

- Sustaining engagement with diverse stakeholders requires ongoing coordination, resources, and considerable time.
- Developing and maintaining responsive digital infrastructure to support a centralised access point requires forging strong links and progressing NHS Wales' digital maturity.
- Collecting and integrating robust evaluation and feedback from engagement activities to inform future planning of relevant, value-added activities.

Next 12 months

- Grow ATW online presence and platforms to enable signposting, support and easy access to information.
- Increase reach and visibility to promote activity of the community, both online and in person.
- Process and share outputs from Symposium roundtable reports and develop next steps for each.
- Continually assess and develop approach to remain useful, relevant, and innovative.

4. Case Study

3rd ATW national Symposium

Launched in 2023 as a small stakeholder event, it has matured into a flagship annual gathering for clinicians, researchers, industry, patients, and policymakers. The 2025 event saw an almost two-fold increase in delegate registrations, highlighting its expanding reach and influence.

The theme of patient and public involvement and engagement took centre stage this year and included a patient speaker. There was a 'lessons learned' session from the Infected Blood Inquiry emphasising the importance of patient involvement in achieving fully informed consent. In the afternoon four workshop discussions were held which focused on different areas of work within the delivery plan.

This year poster displays and stands were a new feature and all feedback received was positive. The event was recognised as a catalyst for new collaboration and a model of inclusive practice.

"Congratulations on yesterday's event, very impressed with the range of speakers, presentation content and the networking "

Patient and public involvement and engagement

Risk status GREEN
Social media posts 24

Theme 1

Key Activities

1. Representation

ATW have retained their two lay-representatives on the programme board until March 2027. They have provided valuable insight in preparation and review of documentation and producing content for the new ATW website.

2. Raising the patient and public voice

ATW have collaborated closely with patient advocate Jemin Popat, who brings lived experience of beta thalassemia with his expertise as an entrepreneur and presenter. The partnership began in November 2024 when ATW presented at an event organised by the charity Friends of Cymru Sickle Cell and Thalassaemia, inspiring a shared commitment to rethinking patient engagements. Since then, Jemin has presented at the ATW Symposium 2025, the Cross-Party Group on Medical Research, and MediWales Connects 2025, supported by ATW through honoraria. Building on this collaboration, a documentary-style video project is being developed with Jemin to share lived experiences, highlight the challenges of navigating rare conditions, and showcase the life-changing potential of advanced therapies.

3. Practical considerations

ATW has established a strong partnership with Kerry-Ann Holder, Consultant Clinical Psychologist and Head of Service for Children, Young People and Family Psychology at CAVUHB, who also presented at the 2025 Symposium. Kerry-Ann highlighted a lack of structured psychological support for patients, families, and staff in the ATMP pathway, recognising it should be included in service design. A proposal for a large-scale research project with Cardiff University's Doctorate in Clinical Psychology programme has been developed, to inform a Psychology Strategy for Advanced Therapies in Wales, addressing this currently unmet need.

4. Partnership working

ATW and MW-ATTC have worked with ATMP Engage and Genomics Partnership Wales to align public involvement with national priorities. They attended the July 2025 Genomics Café to present ongoing work on the Equity of Access for ATMPs report and the Raising Public Awareness of ATMP strategy, alongside co-producing the ATMP Patient Charter.

Next 12 months

- Host patient and clinician engagement events for Apheresis Report.
- Monitor progress of Equity of Access Report and continue stakeholder events.
- Develop and launch documentary-style video project with patient advocates.
- Explore additional community-based engagement initiatives, with a focus on amplifying voices of underserved or underrepresented groups.
- Develop and launch the Advanced Therapies Engagement Network, which will meet tri-annually.
- Publish draft Patient Charter for ATMPs

Workforce development

Risk status GREEN
Social media posts 56

Theme 2

Key Activities

1. Cytiva manufacturing workshop

In December 2024, a two day CAR-T manufacturing workshop was delivered by Cytiva at WBS hosted by ATW. It provided hands-on training for 14 delegates across pharmacy, clinical, and nursing roles. ATW supported logistics, venue provision, and delegate engagement.

"The hands-on demo was really good. Plenty of time for questions. It was exciting and very useful to see the background production pathways."

2. Partnerships in precision medicine

ATW and Health Education and Improvement Wales (HEIW) have co-designed a long-term workforce model for advanced therapies alongside the Genomics Workforce Plan activity. This includes funding a Clinical Lead and Digital Technologist role to support capacity building.

3. Expanding understanding

ATW has funded several learning visits including: NHS Blood and Transplant by pharmacy teams, and to CAVUHB to learn more about maintaining Qube equipment. There was a scoping visit to Exmoor's GMP facilities which has informed planning for a potential Welsh facility. The 2025 Symposium also featured a dedicated training and education roundtable, which generated actions for workforce planning and education.

4. Supporting clinical trial set-up

Professor Thistlethwaite, Director of the Innovate Manchester Advanced Therapy Centre Hub (iMATCH) delivered a session on Tumour-Infiltrating Lymphocytes (TILs) and T-Cell toxicity management to CCRH and wider stakeholders. This supported the set-up of the TILs clinical trial at CCRH.

Next 12 months

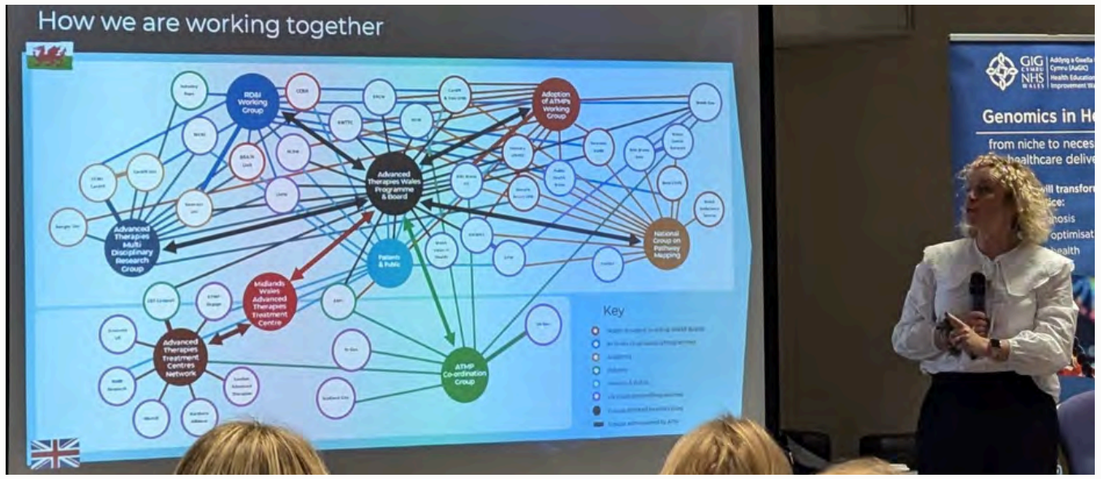
- Delivery of 2nd Cytiva manufacturing workshop in Swansea
- Recruit HEIW clinical lead for workforce development
- Expand delivery of targeted training opportunities, including advanced therapy workshops and online learning modules, to equip multidisciplinary teams with the specialist skills required for both clinical and research delivery.
- Strengthen workforce planning in collaboration with national partners to identify gaps, support the development of career pathways, and build sustainable models for training, recruitment, and retention.

Theme 3

Strategic partnerships

Risk status GREEN
Social media posts 32

Key Activities



1. Partnership working

ATW's Relationship with Life Sciences Hub Wales (LSHW) has strengthened, holding a joint stand at Advanced Therapies UK Conference in London, with LSHW representing both partners at Advanced Therapies Integrates Conference in Edinburgh and British Society of Gene and Cell Manufacturing Conference to maintain UK wide visibility.

2. Industry engagement

ATW hosted a roundtable with Gilead Sciences to address inequities in CAR-T delivery. The outcomes were widely shared and followed up at the ATW Symposium. The programme also contributed to the Genomics, Precision Medicine and Advanced Therapies (GPMAT) group through the Wales Cancer Industry Forum, and has supported initiatives such as Quick DNA (QuicDNA), a liquid biopsy project.

3. Regional and national conversations

ATW supported Wales' input into the Voluntary Scheme for Branded Medicines Pricing, Access and Growth (VPAG), securing recognition for ATMPs within national funding. Collaboration with AWTCC and NWJCC has extended horizon scanning and adoption pathways. There has been UK wide participation with Department for Health and Social Care through the UK ATMP Coordination Group enabling regular dialogue with colleagues in Scotland and Northern Ireland. Collaboration with CAVUHB on CAR-T and Huntington's disease trials, with VUNHST on pioneering TIL therapies, also been involved in establishing Cardiff Cancer Research Partnership, and development of Cardiff Health Partners, exploring infrastructure requirements.

Next 12 months

- Continue to collaborate with the Welsh Government, AWTTC, and national stakeholders to shape policy, funding, and adoption pathways for emerging therapies.
- Strengthen regional engagement with health boards and clinical teams to expand trial delivery, enhance coordination, and embed innovative service models.
- Work with TrAMS programme to develop aseptic hub planning
- Work with BCUHB and SBUHB to strengthen early-phase therapy support.

Key dependencies update

Balancing commissioning Advanced Therapies treatment delivery in Wales or commissioning outside for highly specialised disease indications	The ATMP Outcomes Programme is underway, being led by NWJCC and is key to addressing this dependency. Resource requirements dependent on patient population numbers.
Securing funding for Advanced Therapies infrastructure and service delivery requirements	Apheresis service review and paper outlining the requirements for a GMP facility in Wales and pharmacy considerations are underway with partners, business cases to follow.
Existing NHS Wales Pharmacy infrastructure including aseptics and other associated programmes	Infrastructure reviews underway as above, with targeted investment proposals and workforce planning with HEIW and local pharmacy leads.
Availability of in-patient and out-patient facilities to deliver ATMPs in standard care setting or clinical trial space	Site readiness assessments being conducted, with recommendations feeding into capital planning and service redesign managed through the ATW Adoption of ATMP's working group. Psychological support plan to be developed in 2025/26.
Apheresis capacity across Wales and UK	Following apheresis service review and paper outlining requirements, preferred service model development underway to prepare outline business case.
Regulatory compliance for working with or administrating Advanced Therapies	ATW supporting with shared learning from early adopter sites and updated guidance. Specialist lead in ATW clinical expertise forum. Infrastructure reviews underway, with targeted investment proposals and workforce planning with HEIW and local pharmacy leads.
Ability to increase the number of clinical trials involving Advanced Therapies being undertaken in Wales	ATW supporting ATTC network in the clinical trial acceleration, streamlined study set-up processes with HCRW and R&D leads.
Developing a fully integrated human tissue pathway	"Coalition of the Willing," a national multi-stakeholder working group established. National oversight panel due to be in place by end of 2026.

Conclusion

There has been significant progress for the advanced therapies sector in Wales over the last year, driven by a shared commitment to innovation, equity, and collaboration. Across the goals and cross-cutting themes, tangible outcomes have been delivered which lay the foundations for future work. This progress reflects the collective effort of many. ***ATW and MW-ATTC extend our sincere thanks to all the individuals and teams who have contributed to delivering these achievements.***

TRUST BOARD	
Quality, Safety & Performance Committee 2024-2025 Annual Report	
DATE OF MEETING	27th November 2025
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	APPROVE
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Liane Webber, Business Support Officer/ Committee Secretariat
PRESENTED BY	Non Gwilym, Director of Corporate Governance (Interim)
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Science
EXECUTIVE SUMMARY	This annual report summarises the key areas of business activity undertaken by the Quality, Safety & Performance Committee (QSP) during the period 1st April 2024-31st March 2025. It reflects the Committee's role in developing and monitoring the Trust's quality, safety, and performance agenda, and provides assurance to the Board in line with Standing Order 4.3.2.
RECOMMENDATION / ACTIONS	The Trust Board is asked to **APPROVE** the Quality, Safety & Performance Committee 2024-2025 Annual Report.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
7 LEVELS OF ASSURANCE – N/A	
APPENDICES	
Appendix 1	Quality, Safety and Performance Committee Annual Report 2023-24
Appendix 2	Quality, Safety and Performance Committee Effectiveness Survey

1. SITUATION

Under Standing Order 4.3.2, each Sub-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 Quality, Safety & Performance Committee between 1st April 2024-31st March 2025.

2. BACKGROUND

The Quality, Safety & Performance Committee Annual Report (attached in ***Appendix 1***) summarises the key areas of business activity undertaken by the Quality, Safety & Performance Committee during the 2024-25 financial year and reflects the Committee's key role in the development and monitoring of the Trust's quality, safety and performance agenda.

3. IMPACT ASSESSMENT

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

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Choose a domain/domains. Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
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	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 *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	There are no specific legal implications related to the activity outlined in this report.

4. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

APPENDIX 1

Quality, Safety & Performance Committee 2024-2025 Annual Report

1. Introduction and Background

This report summarises the key areas of business activity undertaken by the Quality, Safety & Performance Committee during the period 1st April 2024-31st March 2025.

The Committee met bi-monthly to oversee quality, safety and performance matters, including workforce, finance, and digital areas. The Committee continued to mature, focusing on continuous improvement, enhanced assurance mechanisms, and streamlined reporting formats.

2. Membership, Quoracy and Attendance

The Committee met seven times during the year. Membership and attendance continued in line with the approved Committee Terms of Reference. Attendance was strong across Committee members and Trust officers and is detailed in the table below:

Committee Members	9 May 2024	9 July 2024	11 July 2024	12 Sept 2024	11 Nov 2024	16 Jan 2025	13 Mar 2025	Attendance %
Vicky Morris (Chair) *Independent Member*	✓	✓	✓	✓	✓	✓	✓	100%
Prof. Donna Mead *Chair of the Board*	×	✓	✓	✓	✓	✓	✓	86%
Stephen Harries *Independent Member*	×	✓	✓	✓	✓	✓	×	71%
Hilary Jones *Independent Member*	✓	✓	✓	✓	✓	✓	×	86%
Lindsay Foyster *Independent Member*	≠	≠	≠	✓	✓	✓	✓	100%

Trust Officers	9 May 2024	9 July 2024	11 July 2024	12 Sept 2024	11 Nov 2024	16 Jan 2025	13 Mar 2025	Attendance %
Nicola Williams (Exec Lead) *Executive Director of Nursing, AHPs and Health Science*	×	✓	✓	✓	✓	✓	✓	86%
Jacinta Abraham *Executive Medical Director*	✓	✓	✓	✓	✓	✓	✓	100%
Lauren Fear *Director of Corporate Governance & Chief of Staff*	✓	✓	✓	✓	✓	✓	✓	100%
Steve Ham *Chief Executive Officer*	✓	≠	≠	≠	≠	≠	≠	100%
Matthew Bunce *Executive Director of Finance*	×	✓	✓	✓	✓	✓	✓	86%
Sarah Morley *Executive Director of Organisational Development & Workforce*	✓	✓	×	✓	✓	✓	✓	86%
Carl James *Executive Director of Strategic Transformation, Planning & Digital*	×	×	×	✓	✓	×	✓	43%
Anne Carey *Chief Operating Officer*	≠	≠	≠	≠	✓	✓	✓	100%

≠ Member/Officer not in post at the time of the meeting - percentage represents attendance whilst in post.

3. Agenda Planning and Action Log

Agendas were set in line with the Committee's approved Cycle of Business, with progress monitored via an Action Log. Papers were disseminated in advance and published on the Trust website, ensuring transparency and accountability.

4. Committee Terms of Reference

The Quality, Safety & Performance Committee Terms of Reference and Operating Arrangements were last approved on 9th May 2024. They are currently under review and will be presented to the Committee for approval in due course.

5. Public Quality, Safety & Performance Committee Activity

5.1 Seven Levels of Assurance

The Committee placed a growing emphasis on applying and reviewing the seven levels of assurance ratings to key reports and areas of performance. Members challenged the appropriateness of assigned assurance levels, sought evidence to support improvements, and requested adjustments where necessary to reflect progress or ongoing risks. This focus enabled the Committee to provide clearer, more transparent assurance to the Board, demonstrating that areas of strength and those requiring further action were being actively monitored and addressed. The increasing use of assurance levels also supported more consistent reporting and helped drive continuous improvement in governance and accountability across the Trust.

5.2 AMaT Action Tracker

The Committee maintained a strong focus on the AMaT action tracker as a key tool for monitoring and driving progress on quality, safety, and audit actions across the Trust. Regular updates were received on the status of actions logged within AMaT, with members scrutinising overdue items, challenging responsible leads on barriers to completion, and seeking assurance that actions were being addressed in a timely and effective manner. This proactive oversight ensured that learning from audits and incidents was translated into tangible improvements, and that the Committee could provide robust assurance to the Board regarding the Trust's commitment to continuous quality and safety improvement.

5.3 Standing Agenda Items

5.3.1 Patient, Donor and Staff Stories

Each meeting began with a patient, donor, or staff story, framing discussions around lived experience.

Patient Stories:

The Committee regularly heard from patients of Velindre Cancer Service, including powerful letters and feedback from patients and families. These stories highlighted the empathy, respect, and exemplary care provided by staff, as well as the impact of psychological support on patient resilience and wellbeing. Patient stories also drew

attention to the importance of communication, timely appointments, and the positive effects of service improvements such as new treatment pathways and support services

Specific examples included a letter from the wife of a patient, which was shared to emphasise the value of compassionate care, and a patient's account of the benefits of psychological support during cancer treatment

Donor Stories:

The Welsh Blood Service shared stories about donor engagement initiatives, such as a new system where donors receive a text message when their donation is sent to a hospital. This innovation was well received and improved the overall donor experience. The introduction of West Nile Virus testing was also highlighted, which led to significant improvements in donor satisfaction and supply chain efficiency

Donor stories were used to showcase the impact of service improvements and the importance of recognising and responding to donor feedback

Staff Stories:

Staff stories focused on wellbeing, resilience, and the positive impact of organisational support. The Committee heard about the success of staff wellbeing initiatives, the importance of a supportive culture, and the role of leadership in addressing issues such as bullying, harassment, and discrimination.

The Committee also received feedback from staff surveys, which informed ongoing action plans to improve staff engagement, inclusion, and workplace culture. Staff experiences were used to highlight the benefits of targeted interventions and the need for continuous improvement in staff support and development

5.3.2 Trust Risk Register

Throughout the year, the Committee demonstrated a robust and proactive approach to risk management by consistently scrutinising the Trust Risk Register at each meeting. Members engaged in detailed discussions, not only reviewing the status of all reportable risks but also undertaking formal 'deep dives' into selected high-priority or emerging risks to ensure a thorough understanding of their causes, mitigations, and potential impacts.

The Committee paid particular attention to static risks - those where the current risk rating remained unchanged despite mitigation efforts - by challenging executive leads to provide clear action plans, timelines, and evidence of progress. This included a focus on workforce supply, SACT capacity, and operational risks, with assurance sought on the effectiveness of controls and the timeliness of risk reduction.

The Committee also monitored the alignment of the Risk Register with the Trust Assurance Framework and strategic objectives, ensuring that risk management was fully integrated into the organisation's governance processes. These actions provided the Board with enhanced assurance that risks are being actively managed, escalated

appropriately, and that the Committee is diligent in its oversight responsibilities, driving continuous improvement in risk governance across the Trust.

5.3.3 Trust Assurance Framework

The Committee maintained a strong focus on the Trust Assurance Framework (TAF), recognising its central role in providing assurance to the Board on the management of strategic risks and the achievement of organisational objectives. The Committee regularly reviewed the TAF, ensuring that it was aligned with the Integrated Medium Term Plan (IMTP) and that strategic objectives were clearly mapped to risk controls and assurance mechanisms.

Members challenged the completeness and clarity of the framework, seeking improvements in the articulation of assurance levels, the inclusion of stakeholder engagement and patient voice, and the consistency of the “three lines of defence” model. The Committee also monitored progress on actions to address gaps in assurance and requested regular updates on the development of the TAF, demonstrating a commitment to continuous improvement and robust governance.

5.3.4 Performance Management Framework (PMF) Report and Supporting Analysis

The Committee regularly reviewed the Performance Management Framework (PMF), focusing on key performance areas across the Trust. Assurance ratings were applied, and areas needing improvement, such as SACT capacity, were identified and monitored, ensuring that performance issues were addressed promptly and that the Board received clear, data-driven assurance on organisational performance.

5.3.5 Workforce Supply and Shape and Associated Finance Risks

Workforce supply and shape remained a key area of focus across the year, with regular discussions on recruitment, retention, and workforce planning. Particular attention was given to addressing long-term sickness absence, reducing agency spend, and improving vacancy rates. Action plans were monitored to ensure the Trust had the right staff, with the right skills, in the right place, and progress was tracked against the People Strategy and national workforce frameworks. This proactive approach supported both service delivery and staff wellbeing across the organisation

5.3.6 Finance Report

The Committee engaged in regular, detailed discussions of the Finance Report at each meeting, ensuring close oversight of the Trust’s financial position, performance, and associated risks. Members reviewed key areas such as Long-Term Agreements (LTAs), pay awards, agency spend, and the achievement of savings targets, with particular attention given to pressures arising from non-recurrent savings and funding uncertainties. The Committee triangulated financial data with workforce and service delivery information, challenged assumptions, and monitored the impact of financial decisions on frontline services. This rigorous approach provided assurance to the Board that financial management was robust, risks were being actively managed, and the Trust remained focused on delivering value and sustainability.

5.3.7 Integrated Quality and Safety Group (IQSG) Highlight Report

The IQSG highlight report was a regular standing item, providing the Committee with oversight of key outcomes, assurance, and progress on quality and safety responsibilities, including compliance with legislative and national requirements. However, it was agreed that, from April 2024, this report would no longer be included as a standing item. Routine IQSG highlights are now reported to the Executive Management Board and divisional leadership teams, and only significant exceptions or urgent issues are escalated to the Committee. All other matters will be covered through a quarterly comprehensive Quality and Safety report. This change has streamlined reporting, reduced duplication, and ensured the Committee's focus remains on key assurance and improvement areas across the Trust.

5.3.8 Quality & Safety Quarterly Reports

The quarterly Quality & Safety reports became a key feature of the Committee's assurance process, providing a comprehensive and data-driven overview of quality and safety performance. These reports consolidated information from across the Trust, and highlighted key outcomes, learning, and areas for improvement in each quarter. The Committee used these reports to monitor trends, track progress against action plans, and ensure that both positive developments and ongoing challenges, such as compliance with regulatory standards, patient safety incidents, and service improvements, were clearly identified and addressed, strengthening the Committee's ability to provide timely and effective assurance to the Board on the Trust's quality and safety agenda

5.3.9 Integrated Medium-Term Plan (IMTP)

Throughout the year, the Committee maintained a strong and consistent focus on the Integrated Medium-Term Plan (IMTP), recognising its central role in aligning operational delivery with the Trust's strategic objectives and statutory requirements. Progress against IMTP actions was reviewed quarterly, with detailed scrutiny of completion rates, milestone articulation, and the effectiveness of plans to address any areas that were off track.

Members challenged executive leads to ensure that lessons learned from previous cycles were being applied to improve future planning and that the IMTP was being fully integrated into the Trust Assurance Framework for enhanced oversight and assurance. The Committee also monitored how IMTP priorities were reflected in divisional and corporate action plans, ensuring that key risks, dependencies, and resource requirements were identified and managed proactively. This approach enabled the Committee to maintain a clear line of sight on the delivery of the Trust's medium-term goals, provide robust assurance to the Board, and support continuous improvement in both planning and performance management across the organisation

8.1.9 NHS Wales Shared Services Partnership - Transforming Access to Medicine / Clinical Pharmacy Technical Services Update

The Committee received regular updates from NHS Wales Shared Services Partnership (NWSSP) on the Transforming Access to Medicine (TrAMs) and Clinical Pharmacy Technical Services programme. These reports provided detailed

information on the progress of new pharmacy infrastructure projects, including the development and submission of business cases to Welsh Government, project timelines, and key milestones.

The Committee discussed the impact of these developments on pharmacy capacity, service delivery, and patient experience, as well as the transition from infusion to subcutaneous injection for certain treatments to improve efficiency. The reports also covered national initiatives, such as the influenza vaccination programme, and highlighted collaborative work with health boards to strengthen supply chain resilience and ensure continuity of medicines provision. By scrutinising these updates, the Committee ensured that risks and opportunities associated with pharmacy transformation were identified and managed, and that the Trust remained aligned with national best practice and innovation in medicines management.

8.1.10 NHS Wales Shared Services Partnership - Implementation of Duty of Quality Update

The Committee received updates from NHS Wales Shared Services Partnership (NWSSP) on the implementation of the Duty of Quality, which came into force in April 2023. These updates outlined the progress made in embedding the Duty of Quality across both clinical and non-clinical services, highlighting the steps taken to ensure compliance with legislative requirements and to promote a culture of continuous improvement. The Committee discussed how NWSSP was supporting the Trust and other health organisations in meeting their new statutory responsibilities, including the development of reporting mechanisms, assurance processes, and quality improvement initiatives. By scrutinising these updates, the Committee ensured that the Trust remained aligned with national expectations and that the principles of the Duty of Quality were being actively integrated into everyday practice.

8.1.11 Highlight Report from the new Velindre Cancer Centre (nVCC) Programme Scrutiny Sub-Committee

The nVCC Programme Scrutiny Sub-Committee (known during the period as Transforming Cancer Services) meets on a monthly basis. A highlight report giving an overview of the key issues considered at each meeting and associated actions taken is provided to the Quality, Safety & Performance Committee for information.

8.1.12 Highlight Report from the Research, Development and Innovation (RD&I) Sub-Committee

The Research, Development and Innovation (RD&I) Sub-Committee meets on a quarterly basis. A highlight report giving an overview of the key issues considered at each meeting and associated actions was provided to the Committee.

8.2 Policies and Procedures

8.2.1 The Committee **APPROVED** the following policies and procedures during the period:

<u>Health & Safety</u>

- Management of Violence & Aggression Policy
- Safe Use of Display Screen Equipment (DSE) Policy

- Safer Manual Handling Policy
- Control of Substances Hazardous to Health (COSHH) Policy
- Policy for Management of Latex and Latex Allergy
- Medical Gas Piped Systems Policy
- High Voltage Electricity Supply Systems using a Contractor as the Authorised Person
- High Voltage Electrical Supply System Operational Policy
- Electrical Low Voltage Policy
- Ventilation Policy

Infection Prevention & Control (IPC)
- Framework Policy for Infection Prevention and Control
- Transport of Specimens Policy

Workforce / Organisational Development
- All Wales NHS Dress Code
- Annual Leave Policy
- Redundancy and Security of Employment Policy
- Recruitment and Selection Policy

Safeguarding & Patient Safety
- Safeguarding & Public Protection Policy
- Policy for the Management of Safeguarding Allegations/Concerns about Practitioners and those in a Position of Trust
- National Policy on Patient Safety Incident Reporting and Management

Information Governance / FOI
- Freedom of Information/Environmental Information Regulations Standard Operating Procedure

8.2.2 The following policies were **ENDORSED** by the Committee:

Planning, Performance & Estates
- Trust Claims Policy
- Handling Concerns Policy
- NHS Wales Red Cell Shortage Plan

The Committee maintained close oversight of policy compliance throughout the year, receiving regular updates on the proportion of Trust policies that were up to date and actively monitoring progress. Notably, policy compliance improved from 45% in March 2023 to 54.87% in March 2024, reflecting the Committee's focus on strengthening governance and ensuring that policies and procedures remain current and effective.

Where policies were overdue for review, the Committee requested targeted action plans and held responsible leads to account for timely completion. This proactive approach provided the Board with assurance that the Trust is committed to maintaining a robust and up-to-date policy framework, supporting high standards of quality, safety, and regulatory compliance across all areas of operation.

9. Triangulated Meeting Themes

Across the year, the Committee identified and discussed a range of triangulated meeting themes that reflected the interconnected challenges and priorities facing the Trust. Key themes included the effective management and reporting of risk, with a particular focus on workforce supply and shape, SACT (Systemic Anti-Cancer Treatment) capacity, and operational pressures.

The Committee also highlighted the importance of maintaining quality and patient experience, recognising staff resilience and dedication despite workforce constraints. Digital capability and its impact on clinical delivery, patient and donor safety, and risk management were recurring topics, as were the challenges of implementing new stretch targets and managing increasing service pressures and complexity. Other themes included the need for further refinement in the application of the seven levels of assurance framework, ongoing issues with communication and appointment management, and the impact of manual workarounds.

These triangulated themes provided a holistic view of the Trust's performance, supporting the Committee's assurance role and driving continuous improvement across all areas of quality, safety, and service delivery

10. Discussions held in Part B Private Committee

There is facility for the Committee to consider reports that contain commercially sensitive or potentially identifiable/sensitive information in Part B Private Committee.

During the year, the Private Quality, Safety and Performance Committee considered a range of confidential matters, including updates on the Infected Blood Inquiry and associated organisational preparations, as well as sensitive financial and operational risks facing the Trust. The Committee also reviewed the Cyber Security Strategic Plan Annual Progress Report and the Claims and Inquest Annual Report, ensuring appropriate assurance levels were applied. In addition, the Committee discussed specific risk register items, and issues relating to the nVCC site.

Throughout, the Committee maintained a focus on patient safety, organisational resilience, and compliance with national guidance, while ensuring that sensitive or commercially confidential information was handled appropriately in line with governance requirements.

11. Reporting the Committee's Work/Highlight Report

The Chair of the Committee reports the key issues discussed at each of its meetings by way of a Highlight Report to the Trust Board. The Highlight Report provides the facility for the Committee to alert/escalate; advise; assure; or inform its overarching Committees in relation to quality, safety, performance and strategic matters.

12. Quality, Safety & Performance Committee Annual Effectiveness Survey

In line with its commitment to continuous improvement and good governance, a comprehensive effectiveness review was carried out following completion of the reporting period. This review sought to evaluate how well the Committee fulfilled its

remit, identify areas of strength, and pinpoint opportunities for further development. The findings from this review will inform the Committee's ongoing efforts to enhance its impact and ensure robust oversight of quality, safety, and performance. A detailed analysis of the effectiveness survey results can be found in the attached appendix.

APPENDIX 2

Committee Effectiveness Survey

An annual Committee effectiveness survey was conducted following completion of the reporting period. Members were invited to answer a range of questions designed to assess the Committee's focus, engagement, working practices, effectiveness, and leadership. The survey combined quantitative satisfaction ratings with opportunities for qualitative feedback, providing a comprehensive overview of the Committee's performance and areas for development identified over the past year.

Quantitative Results: Analysis of satisfaction ratings shows that Committee members are generally positive about engagement and operational aspects, with the highest scores in areas such as Committee working and clarity of roles. However, several areas received lower satisfaction scores, particularly those related to the breadth of the Committee's remit, agenda management, and the quality and focus of meeting papers.

Qualitative Feedback: The most frequently mentioned themes in free text responses were 'agenda', 'papers', and 'remit'. Respondents consistently highlighted concerns about the Committee's wide-ranging remit, which often leads to lengthy agendas and insufficient focus on key priorities. There were repeated calls for a more streamlined agenda and clearer prioritisation of business. The quality and length of meeting papers were also noted as areas needing improvement, with suggestions to make documents more concise and focused on key risks and actions.

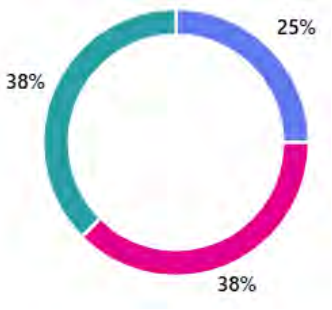
Opportunities for Improvement: The feedback indicates a strong desire for the Committee to:

- Refine its remit to enable enhanced focus on priority areas.
- Streamline agendas to ensure sufficient time and attention for critical topics.
- Improve the quality and succinctness of meeting papers to support effective decision-making.

Conclusion: While the Committee is viewed as engaged and operationally effective, addressing the above areas will further strengthen its impact and ensure it continues to meet the needs of its members and the organisation.

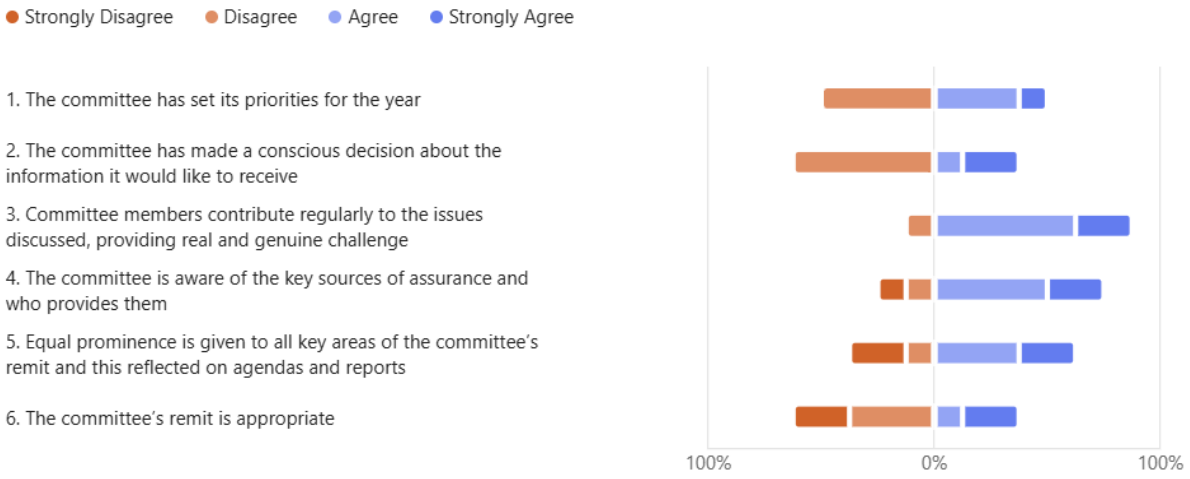
1. Please select your role on the committee:

Independent Member	2
Executive Team Member	3
Other	3



2. THEME 1: COMMITTEE FOCUS

Please rate your satisfaction with the following aspects of the committee:



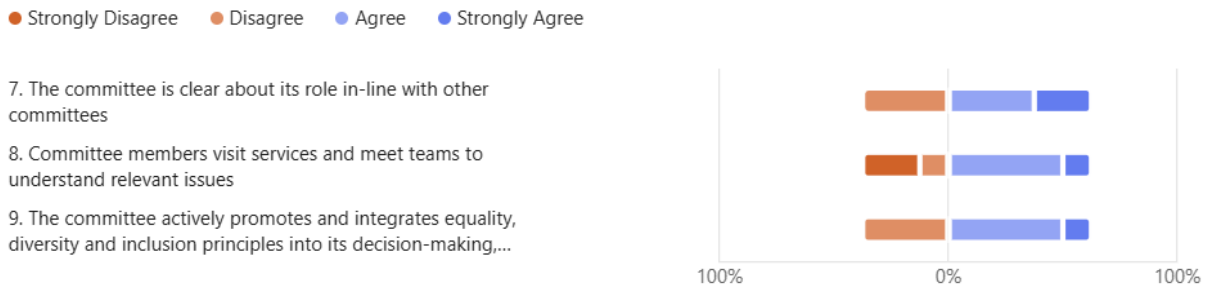
3. If you would like to elaborate on statements 1-6 above, particularly where you have selected 'disagree' or 'strongly disagree', please do so here. Please make clear which statement (s) you are discussing in the free text:

- The Committee's agenda is so wide ranging that it's difficult to see any priority
- Difficult to answer the above since i am only involved with specific parts of the committee related to NWSSP and have has no involvement with setting strategic priorities/agendas etc. Most of the questions i receive in committee are not relevant to the quality agenda or quality assurance within SSPC. There is not an appropriate option for these questions, should there be a 'not-applicable' option unless the view of the committee is that I should be able to respond to all these, in which case my responses for some of the questions would be 'strongly disagree' - but I don't think it would be appropriate to respond on that basis.
- My only thinking is that the is a big agenda and while everything is covered, my sense is that the agenda could benefit from being separated out a bit more. In my previous organisation, we had Performance and Finance committee, Quality & Safety Committee and Workforce was also a separate committee. It provided the opportunity for different lens.
- Remit feels too broad and the information provided is often too detailed and the papers can be approx 15.

- 5&6 The Committee's remit is too large and this leads to lengthy agendas, where some key areas, such as workforce / people and culture do not always get sufficient attention. It is therefore also hard to state that the Committee has clear priorities or has made a conscious decision about all the information it receives.

4. THEME 2: COMMITTEE ENGAGEMENT

Please rate your satisfaction with the following aspects of the committee:



5. If you would like to elaborate on statements 7-9 above, particularly where you have selected 'disagree' or 'strongly disagree', please do so here. Please make clear which statement (s) you are discussing in the free text:

- There is difficulty in what should go to QSP and what should go to SDC.
- more safety walkabouts should be undertaken across the year by all members.
- See my response in Q3 above, you may want to consider a N/A response being available. I cannot answer the first question as i have has no discussion on this matter where VUNHST itself is concerned, I have had a single very useful meeting recently, the first with the chair in the past 4+ years as MD, I have had meetings with committee administration teams and email exchanges but nothing constructive or focussed on mutual understanding of the SSP quality agenda. I have not had any other direct interactions with committee members with regard to visiting SSP services, though I have issued multiple invitations. Regarding Q9 i cannot answer this question since i have had no involvement.
- 9. Whilst an EQIA would be expected regarding papers involving strategic decisions, there is such an enormous agenda that I have rarely heard EDI principles being explicitly considered in decision-making.

6. THEME 3: COMMITTEE WORKING

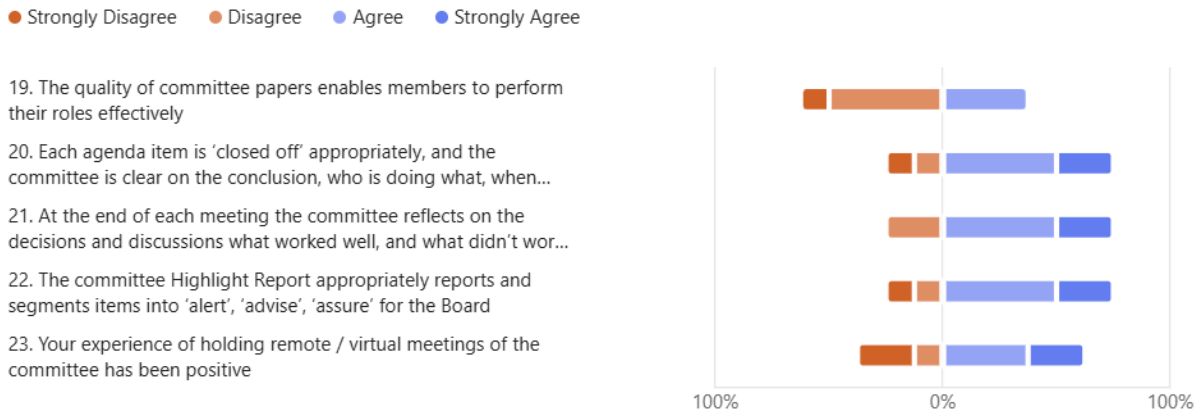
Please rate your satisfaction with the following aspects of the committee:

7. If you would like to elaborate on statements 10-18 above, particularly where you have selected 'disagree' or 'strongly disagree', please do so here. Please make clear which statement (s) you are discussing in the free text:

- Timeliness of actions is not good and dates are frequently having to be changed. The discussion in committee has recognised this and a request for execs to ensure realistic timescales are set and then achieved.
- Again i feel that a NA answer would have been more appropriate an option than the disagree options for some of these questions. specifically i would note (q16) that i never get the agenda, or papers, but i also never receive any notes or discussions following committees so when i do not know if there are outstanding actions for me from the meeting since I am never briefed. I am unable to say whether i might be able to contribute constructively to other areas of the Trust Agenda since i have no idea what is on the agenda.
- The risk discussion is a bit repetitive and I suspect that is because we don't have the opportunity, due to the pressure of the large agenda, to deep dive more. the Trust's strategic objectives are very high level and the links to the divisions need further clarity to enable discussions.
- 12. we need to further develop our maturity on this 13. there is a discussion emerging about what the Trust's strategic priorities are - this isn't always clearly or consistently referenced 15. I don't think that this always happens - quality and timeliness of some papers still needs to improve. Being succinct with key points rather than providing lots of at times unnecessary detail 16. timescales in the action log often seem to slip 17. remit, and therefore agendas as a result, is far to big. Holding extra meetings to deal with the business is not the solution, the amount of business needs to be reduced.

8. THEME 4: COMMITTEE EFFECTIVENESS

Please rate your satisfaction with the following aspects of the committee:



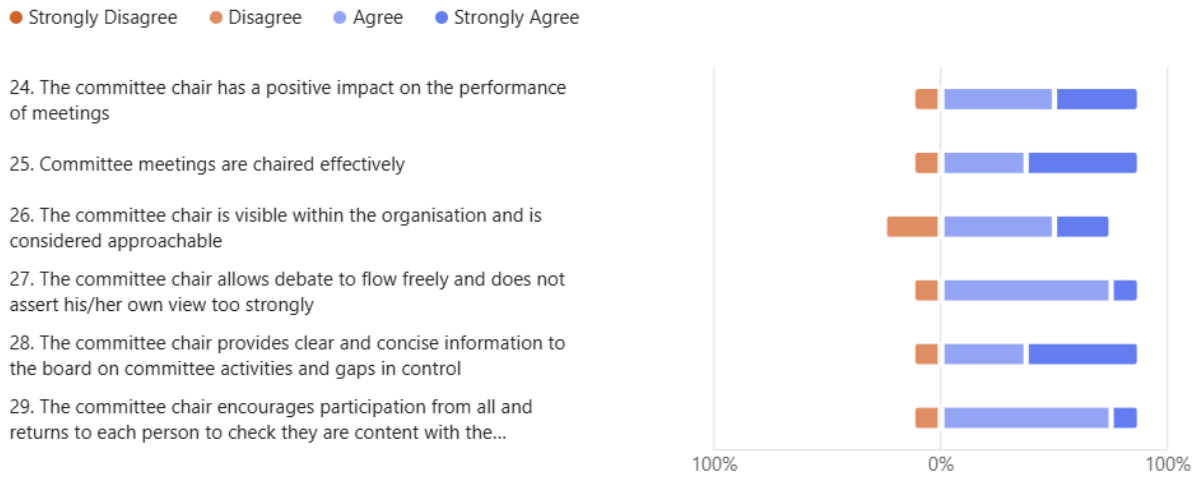
9. If you would like to elaborate on statements 19-23 above, particularly where you have selected 'disagree' or 'strongly disagree', please do so here. Please make clear which statement (s) you are discussing in the free text:

- A more metric and bench-marked approach to the information received at QSP would provide greater objective information and insight to the Committee
- As above some of these disagree responses relate to the fact that i have no involvement, for example i am not present at the end of the meeting so i dont know if the reflection/expectation discussion for agenda item outcomes is appropriate, and since i do not get the minutes of notes even relating to the papers i bring it is difficult for me to provide the committee with assurance when i dont know if they are assured or not (accepting that some of my papers come for noting/information only). So far NWSSP has not been given any training in levels of assurance so until the latest meeting had not routinely completed this section. I note that training is now being provided and it will undoubtedly take some time for our use of this framework to bed in. i have marked strongly disagree to the last 2 questions since Q22is a huge issue as i dont get any outcomes from the committee and q23 i would say that being virtual in a hybrid meeting is a significant disadvantage, particularly as i dont work with most of the people on the committee on a day to day basis and no-one introduces themselves when asking questions and it is impossible to know who is asking questions or commenting if they are sitting round a table in the room. Fully virtual works since everyone's title is displayed and 'hands up' functionality works well. The one time I was able to be in the room was a more positive experience.
- Papers still need work, the templates are long and repetitive.
- 19. see comments above 21. there is reflection space at the end of a meeting, although often brief due to time constraints and focussed on assurance rather than process of the meeting itself, which would be helpful to include 23. most meetings are in person and preferred that way.

10. THEME 5: COMMITTEE LEADERSHIP

**NB The Committee Chair will not answer questions 24-29 but will be asked to reflect separately, following consideration of this assessment.*

Please rate your satisfaction with the following aspects of the committee.



11. If you would like to elaborate on statements 24-29 above, particularly where you have selected 'disagree' or 'strongly disagree', please do so here. Please make clear which statement (s) you are discussing in the free text:

- Please note these are all questions i dont think i can answer since i never attend a full meeting and the one meeting i have had with the chair has been very constructive.
- Vicky is a strong Chair and manages the meeting well within the constraints of the unwieldy remit of the Committee.

12. Is the behaviour of all members/attendees at Committee meetings courteous and professional?

Please select one option below:

13. What should the committee start, stop and/or continue to do?

- Start having a more focussed agenda.
- Continue to evolve the robust governance below QSP level and continue to evolve papers to be more succinct, distilling the key risks, actions and improvements journey required on the subject matter, so that assurance can be gained to advice the Board.
- The development of a quality dashboard with clearly defined benchmarked metrics would be helpful.
- The committee needs to focus more on the 'patient' and less on the governance of the committee itself.
- Come to a clear agreement as to what you need from SSP, be open about understanding our services, i did say when i first started i was happy to provide background briefings/visits. Treat SSP as an integral member of the committee eg include in papers, where appropriate Provide agendas without us continually having to chase, Include us in discussion when making changes to paper formats provide us with training so we can meet your expectations provide us with feedback and outcomes from committees.
- Stop the long papers.
- Within the context of a review of our current Board Committee structure and remit, in my view the Committee needs to have a smaller remit and therefore enabling some areas to have an enhanced focus. I think that patient and donor experience needs more exposure in gaining assurance on the quality and safety of our services.

14. Are there any learning or development opportunities the committee should consider for its members?

- Consideration of TOR over the next few months to ensure that we have adequate oversight on key Quality and Safety issues on behalf of the Board
- The committee runs well and is chaired well. It is the reports / data that feeds into the committee that could be strengthened by a more benchmarked metric approach.
- Committee members need better understanding of the items that come to committee eg I work in NWSSP and the committee has little understanding of the role of the Pharmacy in NWSSP.
- Refresh our individual role descriptions / purpose at the meeting - this is something that would be helpful for all committees.
- I think exposure to what QSP Committees do elsewhere (English Trusts as well as NHS Wales Health Boards) benchmarking and from that being able to consciously inform its remit, priorities and the information it needs to receive.