GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Cardiff and Vale UHB

Annual Quality Report

2023 – 2024

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Foreword from Chair and CEO

We are pleased to present our Annual Quality Report for 2023- 2024. This report provides a comprehensive overview of our ongoing commitment to delivering the highest quality standards of care and services to our patients, their families and the wider community.

At the heart of our mission lies an unwavering duty of quality. This duty compels us to continuously evaluate and enhance the care that we provide, ensuring it is safe, effective, timely, equitable and patient-centred.

In this report you will find detailed accounts of our achievement, challenges and the strategies that we have implemented to overcome them. We have focused on the critical areas including patient safety, clinical effectiveness, operational delivery and patient experience, guided by the principles of transparency, accountability and continuous improvement.

Our commitment to quality is reflected in the collaborative efforts of our dedicated staff, who work tirelessly to uphold the values of the organisations and to care for our population. Their professionalism, compassion and resilience has been instrumental in navigating the complexities and challenges that we have faced in the past year. We acknowledge that the care we have provided sometimes falls short of the standard that the population should expect, and that the legacy of the pandemic means that people continue to wait far too long for treatment. We remain steadfast in our dedication to foster a culture of excellence, where quality improvement is integral to everything we do

In September 2023, following a period of co-production and consultation with our colleagues and stakeholders, our refreshed Strategy, Shaping Our Future Wellbeing, was approved by the Board. The refreshed strategic objectives are:

- Putting People First
- Providing Outstanding Quality
- Delivering in the Right Places
- Acting for the Future

The Strategy aims to bolster our unwavering commitment to rectifying disparities in access and health outcomes. It encompasses the implementation of robust care models, a focus on quality, adoption of innovative healthcare technologies, digitisation research and development, modern infrastructure, and adherence to best practice. These multifaceted endeavours are essential to realising our ambitions and effectively serving the needs of our communities The Strategy is underpinned by a number of programmes that are designed to deliver the improvements in health care provision and outcomes set out in the Duty of Quality and using the six enablers in the Health and Care Quality Standards to support this.

We extend our heartfelt thanks to our colleagues and partners in health and to the people who have used our services and who have provided us with feedback and information that allows us to shape our services. Together we will continue to strive for improvements in the care that we provide.

Introduction from the Medical Director, Nurse Director and the Executive Director of Allied Health Therapies and Health Sciences and Community Development.

The Duty of Quality was implemented from 1st April 2023 with the aim to improve the quality of health services and improve the outcomes of the people in Wales. The Duty places a statutory requirement on us to actively monitor progress on the improvement of quality services and outcomes and routinely share this information with our population.

This report enables us to be held to account by the public for the care we provide considering quality in its broadest sense. The Health and Care Quality Standards are a set of standards developed to ensure good quality care and services provided by the NHS in Wales. They include six domains of quality and six quality enablers, which together provide a high-level framework for planning, decision-making, delivery, and monitoring of health services. We have used these domains to structure this report. While it is impossible to for us to include information about every service we provide, it is our hope that that the report provides a transparent account of our commitments to deliver safe, timely, effective, efficient, equitable and patient-centred care. This report references documents and information that are in the public domain, including reports to Health Board committees and reports from external organisations. We are reviewing how we make these resources easier for the public to access in the near future, but for the purpose of the 2023/24 Annual Quality Report, we have included links to more detailed reports and documents throughout.

A Whole System View of Quality

Our Quality, Safety and Experience Committee provides assurance to the Board on the setting of local organisational quality and safety standards and advice to assist it in meeting its responsibilities with regards to the quality and safety of health services. Our Clinical Governance structures have evolved to support the principles of the Duty of Quality to provide a continuous focus on the quality-of-care provision and an ongoing focus on driving improvements in care and outcomes. The scale and diversity of the services provided by the organisation requires a transformative approach to improving quality.

To support us in implementing a whole systems approach to quality we have developed two key multi-professional forums:

The Clinical Effectiveness Committee ensures that we are delivering effective evidence-based care, that we can demonstrate the quality of this care and that we can target improvements where the care we are providing does not meet the standard that our population should expect. The Clinical Effectiveness Committee oversees the outcomes of the National Clinical Audit and Outcome Review Programme, that in 2023/24, comprised forty-one audits incorporating long term conditions, surgical specialities, cancer, paediatrics and maternity and measures the quality of care in both hospital and community settings comparing ourselves with other health organisations nationally. The Committee also oversees the implementation of evidence-based guidance from both National Institute of Clinical Excellence (NICE) and Health Technology Wales (HTW).

The Clinical Safety Group was implemented to triangulate emerging themes and risks in each of our Clinical Boards with the individual clinical advisory groups that function in the Health Board, and which deliver strategy and develop policy to ensure quality in their field. These groups include:

- Blood Transfusion
- Decontamination Group
- Consent Group
- Dementia Group
- End of Life Care
- IRMER (Ionising Radiation (Medical Exposure) Radiations)
- Medicines Safety Executive
- Medical Devices Group
- Falls Delivery Group
- Learning from Mortality Group
- NatSSIPs Two (National Safety Standards for Invasive Procedures) (being reconvened in 2024)
- Nutrition and Hydration Group
- Pressure Damage Group
- Research Governance
- Resuscitation (RADAR)
- Sepsis (being reconvened in 2024)
- Transition Group (convened in 2024)
- Health Care Associated Thrombosis Group

The Clinical Safety Group is supporting Health Board-wide learning from events, inspections and peer reviews, ensuring that recommendations and risks identified in individual clinical areas are shared across the entire Health Board and are used to inform the work of the clinical advisory groups.

Leadership, Workforce and Culture

The People and Culture Plan was launched in January 2022. It sets out the actions we will take over three years, with a clear focus on improving the wellbeing, inclusion, capability and engagement of our workforce. As a Health Board we are committed to being a 'great place to train, work and live'. We need to attract, train, deploy and develop people to maximise their potential and meet the health and care needs of our population. The Plan supports and focuses on three of the enabling Quality Standards, leadership, culture and workforce:

Shaping Our Future
Workforce

Strong leadership is a pre-requisite for the development and sustainability of a strong patient safety culture. The Health Board People and Culture Plan identifies the need to have leaders in the health care system who embody inclusive, collective and compassionate leadership and identifies a range of accessible opportunities that will be developed for leaders and managers at all levels to enhance their skills.

The Plan aims to have a workforce that feels valued and supported wherever they work.

To ensure we can deliver high quality, compassionate care, and have an inclusive culture where the diversity of our people is representative of our local population, we need to continue to think differently about how we attract and recruit our current and future workforce. Maximising opportunities to attract candidates with the right values and behaviours through a widening access framework, a new careers website and increasing the range of apprenticeship opportunities available and ensuring we are an inclusive employer to create diversity within our workforce. We will support multi-professional and multi-agency working through integration of Health and Social Care Services and the development of alternative workforce models to deliver a seamless, co-ordinated approach with partners based on outcomes that matter to the person and recruit and retain the right people with the right skills. We will invest in education and learning to deliver the skills and capabilities needed to meet the future needs of the people we care for and support our people to progress their careers. We are working to ensure we have a sustainable workforce in sufficient numbers to meet the health and social care needs of our population

Learning, Innovation, Improvement and Research Shaping Change

We recognise the fact that making significant changes to improve and extend the overall quality of the broad range of services and support offered to citizens and colleagues will necessitate 'change' in different areas and at different levels. This ranges from the well-established and recognised 'improvement' activity, that helps drive efficiency and effectiveness through service and operational

optimisation, to the development and adoption of 'step-change' innovative solutions, as well as the roll-out of strategic organisational programmes. Acknowledging the critical and linked role of learning, education, innovation and improvement, underpinned by robust research and development, as an enabler for quality across our system.

Information

We have developed a Digital Strategy to support a five-year roadmap for how digital technology will enable the transformation of clinical services as set out in our Strategy Shaping Our Future Wellbeing. The Strategy recognises that by collecting timely and accurate data we will understand how our system works. We will be able to follow patients through their care pathways, learning how we can make them more efficient and ensuring their journeys are safe. The ability to collect and record patient outcomes means that we can compare ourselves to other organisations nationally to ensure that we are providing quality outcomes.

Commissioned Services

Until 2024 the Welsh Health Specialised Services Committee (WHSSC) was responsible for the joint planning of specialised and tertiary services on behalf of Local Health Boards in Wales, until it was superseded by the Joint Commissioning Committe. (JCC). We provide a number of these commissioned services for the population of Cardiff and Vale, and the wider region and work closely with WHSSC to ensure the quality of these services.

The Children's Hospital for Wales incorporates a number of services including the paediatric intensive care unit, neonatal unit and paediatric surgery. In 2023 –2024 each of these services has been subject to additional monitoring by WHSSC, because of capacity pressures that have impacted on the quality of care that we are able to provide. The availability of both paediatric intensive care beds and neonatal cots and challenges around the retention and recruitment of the workforce, in particular registered nurses have meant there are occasions when we have been unable to provide the care in the Childrens Hospital for Wales. Significant work was undertaken over the financial year to improve the recruitment position, which included the appointment of internationally educated Registered nurses.

External Inspection

Healthcare Inspectorate Wales inspects NHS services in Wales and regulates independent health care providers against a range of standards, policies, guidance and regulations to highlight areas requiring improvement. The health and care quality standards are embedded and form a framework for the inspections, reports and recommendations reports.

In 2023 /2024 inspections have been undertaken across a diverse range of services provided by the Health Board including, the University Dental Hospital, ward A7 gastroenterology, the Emergency Unit and Maternity Services at UHW. In addition, inspections were undertaken in Hafan y Coed mental health unit and a diagnostic imaging review. In 2023, we introduced a digital quality assurance tool which supported greater transparency and oversight of improvement plans developed to meet the recommendations. We also developed several bespoke digital audit tools to support internal inspection to assure the sustainability of the improvements put in place to address HIW recommendations.

Our Clinical Safety Group is used to provide oversight of cross cutting themes that emerge from HIW inspections and ensure health board wide learning and improvement rather than pockets of good practice.

Safe Care

Our healthcare system is a high quality, highly reliable and safe system that avoids preventable harm, maximising the things that go right and learning from when things go wrong to prevent them occurring again. People's health, safety and welfare are actively promoted and protected; risks are identified and monitored and where possible, risks to safety are reduced or prevented. We promote and protect the wellbeing and safety of children and adults who become vulnerable or at risk at any time. Where children or adults may be experiencing or are at risk of abuse or neglect, we take appropriate, timely action and report concerns.

Nationally Reportable Incidents

We are proud of our transparent and open approach to report, review and learn from patient safety incidents. Incidents that are deemed to have caused the most significant harm to patients are reported externally to the Wales NHS Executive, allowing additional scrutiny. External reporting also supports national learning from these events through robust and transparent reviews of the care provided to help us to identify the factors that contributed

Between 1st April 2023 and 31st March 2024, we reported 134 Nationally Reportable Incidents (NRIs). Despite the criteria for NRIs to be related to severe or catastrophic harm, the majority are subsequently re-categorised following a full investigation.

Inpatient Suicides - WARRN

Following several suicides of individuals who were cared for in the inpatient mental health setting, a review of the risk assessment process was undertaken, and a new formulation-based risk assessment process implemented. The Wales Applied Risk Research Network (WARRN) risk assessment is a formulation-based technique for the assessment and management of serious risk (e.g. violence to others, suicide, etc.) for users of mental health Services.

The WARRN risk assessment has been gradually adopted as the risk evaluation and safety-planning technique for all seven Health Boards in Wales. It was implemented in parallel with an education package and nationally clinicians have reported increased skills in the domains of clinical risk formulation, safety-planning and communication. The associated use of a "common-language" created by having all NHS Health Boards in Wales using the same risk assessment process has been reported as facilitating the communication of safety-planning.

Fetal Monitoring within the Midwifery Led Unit (MLU)

Changes to the Health Board's approach to Cardiotocography (CTG) monitoring have been implemented in response to learning from patient safety incidents. The changes brought our practice in line with guidance from both NICE and Welsh Risk Pool. From 1st February 2024, CTG monitoring for intrapartum fetal heart concerns is no longer undertaken within the Midwifery Led Unit. All women requiring CTG monitoring are instead transferred to the Consultant Led Unit to expedite any necessary additional care in a responsive clinical environment.

Pressure Damage

Pressure damage is the most frequently reported patient safety incident across the Health Board. A thorough review of all cases ensures that we consider if there were any opportunities missed that would have prevented the pressure damage occurring or would have reduced the severity. We have implemented scrutiny panels in all our Clinical Boards to ensure that we capture all potential learning. The scrutiny panels have identified delays in risk assessment and re-assessment as a theme. We use a digital clinical audit and inspection tool in the Health Board called Tendable and pressure damage risk assessment compliance audits have been included in the suit of tools available on this system to allow clinical areas to audit and review their compliance.

An Annual Nationally Reportable Incident Report for 2023/24 was reported to the Quality and Patient Safety Committee in May 2024 and can be read at:

NRI Report 2023/24- Quality Safety and Experience Committee May 2024

Never Events

Never Events are significant and largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. All Never Events are reported externally to NHS Executive due to their significance. We reported six Never Events during 2023/24. Thorough reviews of each of these incidents are informing national work to reduce Never Events and has also led to Health Board improvements.

The current perioperative pathway is reliant on multiple patients' systems including more than one digital system and paper records, the transfer of information between each system increases the potential for error. The Surgery Clinical Board are currently working towards implementing a revised surgical database that will incorporate all parts of the patient pathway thereby reducing the need to transcribe information between systems and thereby reduce the risk of transcription errors. In the interim a protocol is being developed to standardise the approach to communicate amendments and cancellations to planned interventional procedures.

Never Events that relate to malfunctioning medical devices are reported through Wales Surgical Materials Testing Laboratory to undertake testing and analysis of products. In addition, any faulty product will be reported through the Medical and Healthcare products Regulatory Agency (MHRA) to inform national themes and support product recall where required.

Procurement of equipment has an important role in the eradication of Never Events, ensuring equipment that supports standardised check lists and clinical investigation.

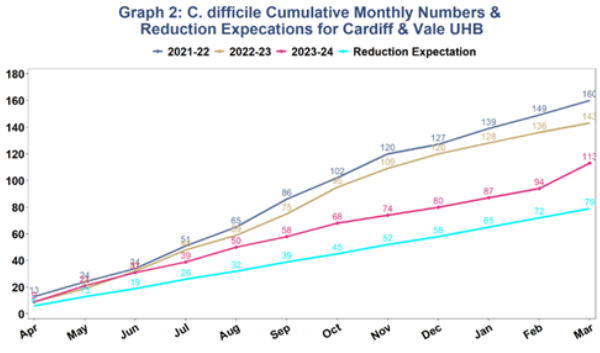
Procurement of radio-opaque neurology swabs has been implemented to ensure that these products can be identified on radiological examination. A revised protocol was implemented to safeguard against the potential for retained non-radio opaque swabs while an alternative product was being sourced. A procurement exercise within dental services has standardised the procurement of dental swabs.

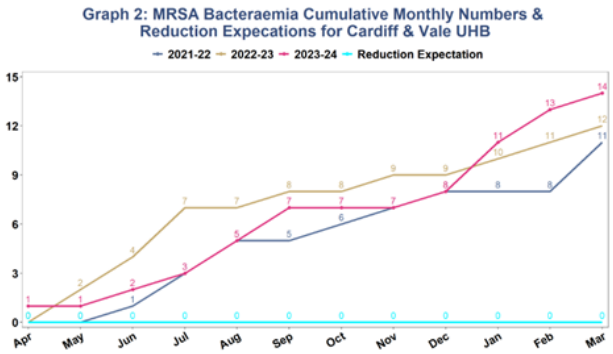
In 2023 the National Safety Standards for Invasive Procedures (NatSSIPs 2) was published, building on previous standards published in 2015 and intended to enable safe, reliable and efficient care to every patient who has an invasive procedure. We are refreshing our previous NatSSIPs Group and bringing together colleagues from workforce development and digital teams along with clinical colleagues from specialties that undertake invasive procedures to build on exisiting work to ensure the safe delivery of invasive procedures.

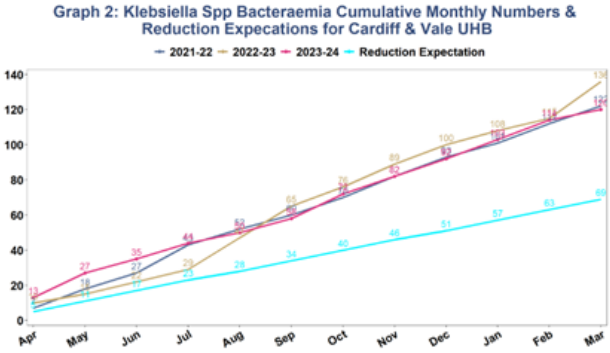
The Never Event position was reported to the Quality, Safety and Experience Committee in July 2024 and can be read at: Never Event Report 2023/24- Quality Safety and Experience Committee July 2024

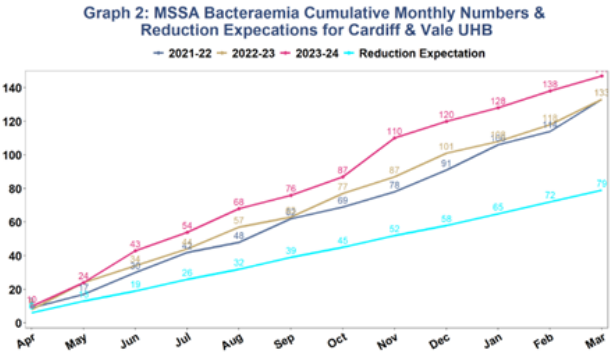
Infection Prevention and Control

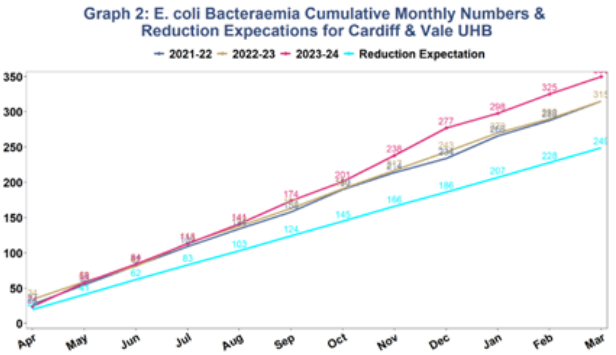
Infection Prevention and Control is a practical, evidence-based approach to preventing both patients and health care staff from being harmed by avoidable infections. It affects all elements of healthcare including hand hygiene, surgical site infections, injections safety and anti-microbial resistance. Welsh Government publish reduction targets each year to support a sustained reduction in the incidence of these bacteraemia. Every case is reviewed to understand if the care that we have provided has contributed to these infections.

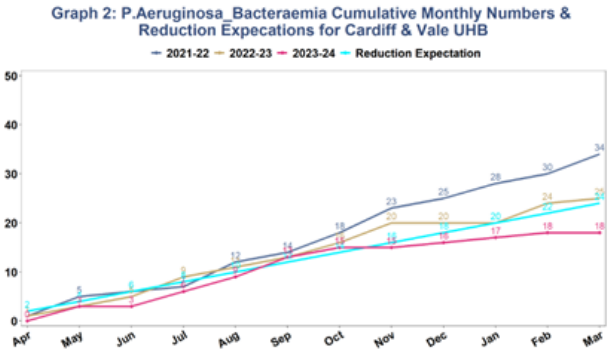












A significant amount of work was undertaken across the Health Board to support the necessary reduction in Clostridium difficile (C.difficile) cases. Every case in 2023/24 was reviewed by a multi-disciplinary team including an Infection Prevention and Control Nurse, a Public Health Wales or an Anaerobic Reference Unit Specialist Scientist, a Microbiology Consultant and a Pharmacist to identify learning. The Executive Medical Director and Executive Nurse Director chaired reviews with the clinical teams to identify areas of good practice and areas of improvement. This work results in a significant improvement and the Health Board exceeding the reduction expectation and we reported the lowest rate in Wales.

We have seen an increase in Methicillin-Susceptible Staphylococcus Aureus (MSSA) cases with 159 cases reported during the year, which equates to a rate of 31.45 per 100,000 population, exceeding the target of 20 per 100,000 by 57%. The approach taken to reducing C.difficile cases is now being replicated for each case of MSSA. There has been

increased auditing of both peripheral and central venous cannula insertion and maintenance by the Infection Prevention and Control Team and Aseptic Non-Touch Technique (ANTT) continues to be rolled out across the Health Board.

Work previously undertaken in Primary Care to support effective urine sampling and prescribing for urinary tract infections had resulted in a significant reduction in Escherichia coli (E. coli), however in 2023/24 we reported 345 cases which equates to 68.24 cases per 100,000 population above the target of 67 per 100,000. The appointment of a Primary Community and Intermediate Care Infection Prevention and Control Nure will further support this work.

The Infection Prevention and Control Team have also worked across the Health Board to agree the cleaning products used in clinical areas, to ensure the effective decontamination of medical devices including ultrasound probes and sourcing alternative pre-operative skin cleansing products due to a national shortage of products.

A report into infection prevention and control was reported to the Quality Safety and Experience Committee in September 2023 and can be read at:

Infection Prevention and Control -Quality Safety and Experience Committee September 2023

Reports to Prevent Future Deaths

A Prevention of Future Deaths Report is made by HM Coroner to relevant authorities to attempt to prevent future deaths from causes identified during an inquest. The report identifies areas where action is needed to protect lives. Forty-one Prevention of Future Deaths Reports were issued to health organisations across Wales in 2023/24 and two reports were issued to Cardiff and Vale UHB.

In response to the reports issued directly to the Health Board, we have worked with clinical teams to put in place improvements.

Prison health care:

A review of health care workforce at HM Prison Cardiff was undertaken in response to a Prevention of Future Deaths Report and has resulted in the appointment of a Head of Healthcare to provide senior leadership to the healthcare team. There has been the development of standardised processes to support effective and safe communication between agencies and organisations relating to individuals with complex mental and physical health care needs. A Food and Fluid Policy was developed between the Health Board and HMP Cardiff to develop explicit responsibilities for staff in the management of prisoners who are suspected of, or who are refusing food and fluids.

Safe sleeping Arrangements for infants:

The Health Board Community Maternity and Health Visiting services have built in a number of formal opportunities to discuss safe sleeping arrangements, risk reduction and Infant death risk reduction with new parents between twenty-eight weeks of pregnancy and up to sixteen weeks after the baby is born.

The reports and the Health Board response can be accessed in the links below:

Prevention of future deaths report - Courts and Tribunals Judiciary November 2023

Prevention of future deaths report - Courts and Tribunals Judiciary March 2024

Patient Safety Solutions

Where potential safety issues are identified nationally, organisations such as NHS Wales, NHS England or the Medicines and Healthcare Products Regulatory Agency (MHRA), will issue Patient Safety Alerts to healthcare organisations to allow them to put in place appropriate actions and mitigation to eradicate or reduce the risk to patients. We receive and respond to these alerts to ensure that any identified patient safety risks are reduced.

Emergency Steroid Therapy:

Adrenal insufficiency is a rare disorder which can lead to adrenal crisis, particularly when critical time medication is delayed or omitted. A Patient Safety Notice was issued in 2021 which required organisations to ensure patients with adrenal insufficiency are identified and that the signs and symptoms of adrenal insufficiency and crisis are recognised. In 2023 we recognised that we needed to strengthen the measures that had been put in place across the Health Board. A multi-professional group was convened to oversee further actions. The recently compiled All Wales list of time-critical medications has been used as a basis for a relevant 'Inform, Ask & Act' campaign to ensure colleagues across the Health Board are aware of the necessity of these medicines, including patients on steroids. Various resources have been produced, including posters for cascade across the Health Board. There have been several education and training events undertaken and planned. An adrenal insufficiency training day for both doctors and nurses planned for September 2024 and the topic is being incorporated into the routine training for junior doctors in the Health Board.

Alerts relating to critical time medications are being developed and built into the Electronic Prescribing and Medication Administration (EPMA) system that will be implemented in the Health Board later this year and the All Wales Medicines Safety Group have produced a policy which will support the empowerment of patients who are able to take their own steroids to do so when in hospital and we are seeking to introduce this into the Health Board.

NRFit®

Following a Safety Notice from NHS Wales, we implemented the NRFit® connection system for spinal and epidural injections.

There is a risk of serious harm or death when medications are given via the incorrect route. While the risk of these errors can be reduced through measures such as checklists, training, and labelling of syringes and despite the efforts of all staff, errors can still occur. Both intravenous (directly into the bloodstream) and neuraxial (spinal and epidural) medication is given using syringes and other equipment which uses the Luer connector. Therefore, a medication intended to be administered directly into a vein could potentially be given in error via a spinal route, if there is no physical barrier preventing inadvertent wrong-route administration. To address this issue, healthcare and industry has developed a neuraxial-specific connector known as 'NRFit®. NRFit syringes are easily identifiable and other products will not connect to a standard intravenous device therefore reducing the risk of accidental wrong route administration.

Falls

Falls remain a patient safety priority, and inpatient falls are one of the more frequently reported patient safety incidents.

Falls occur more frequently as we age but are not inevitable. There are many things that can be done to reduce the risk of falls, both at home and when in hospital. Falls can not only cause physical injury, but also affect an individual's confidence and independence.

We are working to enhance the falls prevention programmes available in the community, developing it in collaboration with citizens, community groups, local authorities and third sector organisations. The programme is designed to support people to 'age well', encouraging physical activity, social connection and reducing the risk of falls and ensures equitable access to these services for all communities across Cardiff and the Vale of Glamorgan.

We know that falls can also occur when patients are in hospital and we are working to reduce avoidable inpatient falls, as well as improving the management of falls which do occur. We participate in the National Audit of Inpatient Falls each year, submitting data relating to the care of patients who sustained a hip fracture as a result of a fall while an inpatient. We have piloted a training programme for staff which includes education on assessing a patient's risk of falls, supporting staff to identify ways of reducing recognised risks safely assessing and caring for patients who have fallen. This training has received excellent feedback, and we are aiming to roll out this training more widely. Sometimes when a person falls, we need to use special equipment to lift them from the floor safely. We are reviewing this equipment to make sure that it can be quickly transported to a fallen patient when needed.

Timely

Our healthcare system ensures people have access to the high-quality advice, guidance and care they need quickly and easily, in the right place, first time. We care for those with the greatest health need first, and where treatment is identified as necessary, we treat people based on their identified and agreed clinical priority.

The Legacy of Covid-19 has profoundly impacted our ability to deliver care in a timely manner. We have had to reevaluate the way we provide have delivered a number of services and the flow of patients through our care. We have made some very significant improvements in several clinical pathways including stroke, emergency and unscheduled care and hip fracture, but we recognise that our population continue to wat too long for planned and diagnostic procedures.

Stroke Care

Stroke is a life changing event and the fourth highest cause of death in Wales, as well as being the leading cause of disability. Getting emergency stroke care right is crucial in reducing the disabling impact of stroke. Stroke clinical standards include timely scanning (within one hour of arrival), specialist assessment and timely treatment with thrombolysis (clot-busting treatment) or thrombectomy (clot removal), where appropriate, as well as admission to a Stroke Unit within four hours. Patients treated with thrombolysis and thrombectomy are likely to recover better with less lasting effects affects following the stroke as well as having improved survival rates.

The ability of the Stroke Service to meet these clinical standards at University Hospital of Wales (UHW) was significantly affected by the Covid-19 pandemic. Necessary reorganisation of the Emergency Department footprint and admission processes led to a deterioration in performance against key indicators in the emergency assessment pathway for stroke, with significant variation. At UHW in December 2022, 44.8% of patients were scanned within one hour of arrival, 50% had their swallow function assessed within four hours and only 6.2% of patients were directly admitted to the Stroke Unit within four hours. Thrombolysis rates were variable and at their lowest in March 2023, 3.6%.

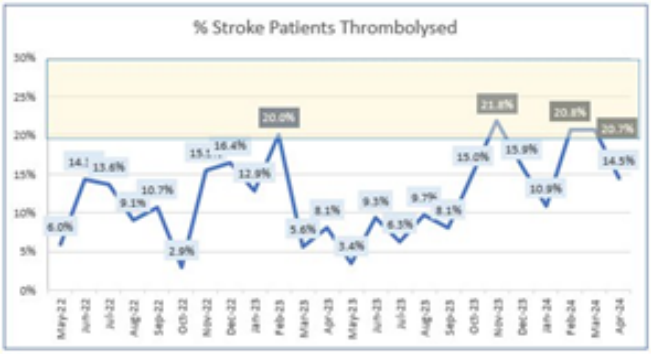
To improve performance, the Stroke Team identified several areas for improvement. From February 2023, the 18 beds in the Acute Stroke Unit were protected to ensure that they were kept for stroke patients. Senior clinical decision makers were redirected, when possible, to provide oversight and support to patients presenting to the Emergency Department with signs of stroke. Emergency Department staff were trained on swallow screen assessment to ensure this was completed according to the clinical standards.

In late 2023, Brainomix eStroke, an artificial intelligence supported image interpretation software, was implemented allowing immediate virtual review of scans

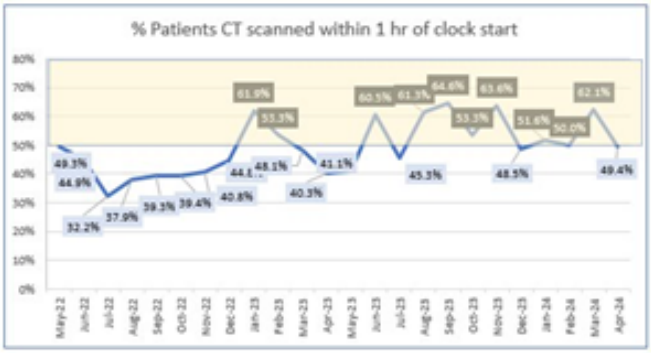
which supports timely treatment decisions. The optimal stroke imaging pathway was implemented to standardise the approach to radiology imaging to support treatment decisions. Adoption of the extended thrombolysis treatment window was introduced increasing the number of patients eligible for this treatment.

Performance against key indicators of the optimal stroke pathway is measured via the Sentinel Stroke National Audit Programme (SSNAP) and monitored by the NHS Wales Executive Performance and Assurance (P&A) Team and the Health Board's Operations and Performance Team. Key partners in this improvement work included the stroke multidisciplinary team, emergency and acute medicine and radiology colleagues and patient flow and site services.

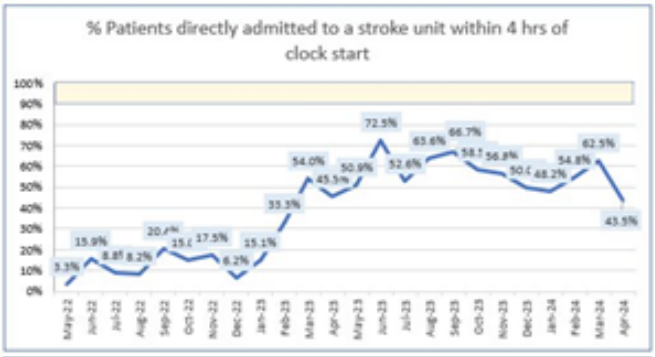
The Stroke Team also worked with Welsh Ambulance Service Trust (WAST) to pilot a pre-hospital video triage in stroke. The initial symptoms of stroke can sometimes mimic other conditions, and at other time the symptoms can be subtle. Timely diagnosis and treatment is invaluable in minimising the long-term effects of stroke and ensuring a good recovery. We worked with colleagues in WAST to start the stroke pathway in the patient's home. Paramedics were able to contact a stroke consultant on a secure video call to support in the assessment of the patient. This allowed quick decisions to be made about the most appropriate place for patients to be treated. Some patients were then conveyed directly to the Regional Stroke Centre bypassing their local Emergency Department.



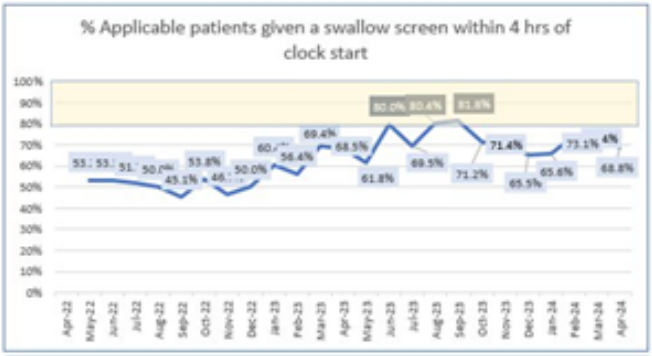
SSNAP A grade: consistent 20% thrombolysis rate, 90% of eligible patients thrombolysed. 45 minute QIM (DU) 1 hour standard (SSNAP)



SSNAP A grade: consistent 50% scanned within 1 hour, 95% within 12 hours with a median time of <1hr



SSNAP A grade: consistent 90% admitted within 4 hours with a median time of <2hr. 90% of patients to spend 90% of their UHW stay on the stroke unit

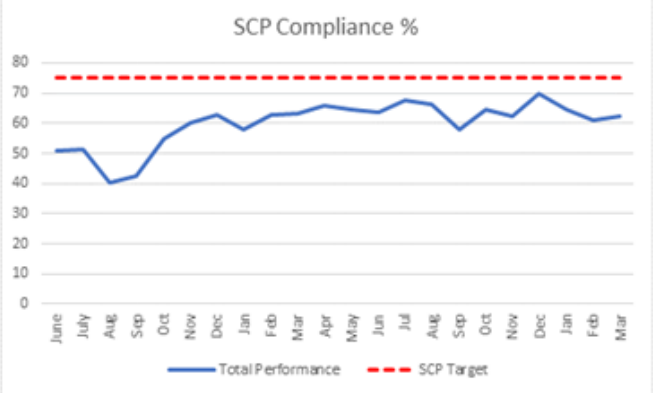


SSNAP A grade: consistent 80% screened within 4 hours, 80% formal assessment within 72 hours

Cancer Care

Providing timely diagnosis and treatments to people with cancer is of paramount importance to ensure the best outcomes for these individuals. The Suspected Cancer Pathway (SCP) was introduced in Wales in 2019 and sets a standard that Health Boards should ensure that the majority of their patients receive their diagnosis in a timely manner and commence their treatment within 62 days from the first point that cancer is clinically suspected. Equally, meeting this standard means that patients who commence on this pathway, but whose investigations demonstrate that they do not have cancer, will be reassured promptly. We have continued to improve performance in relation to the 62-day standard and by the end of March 2024, 62.3% of patients referred with symptoms suspicious received their care in line within the 62-day standard.

Ensuring parity of care for patients who have an incidental finding of cancer as those referred to the Health Board under the SCP is important. This year, Cancer Services introduced safeguards to ensure that anyone with a radiological investigation, or a pathology test that is suspicious of cancer, will be identified without delay by the Cancer Team. These patients are referred to the most appropriate clinical team and are tracked through their diagnostic journey until they are either discharged or commence treatment.



Cellular Pathology

Cellular Pathology is the examination of cells and tissue taken from the body during surgical procedures in theatres, out-patient clinics, General Practitioner (GP) clinics or at post-mortem examination. These tests are undertaken to diagnose cancer and other conditions.

Cellular pathology reporting times remain longer than they should be, and this means that patients are waiting too long for diagnosis which can in some cases lead to delays in starting treatment. Work has been undertaken in the past two years to address delays in the cellular pathology process. The service has moved from a five to a seven-day service and procured additional immuno-histopathology platforms to increase the capacity of the service. Some histopathology work has been outsourced to external companies or other NHS organisations to help to manage the volume of tests and to support the timely reporting of results.

Delays in microtomy, the action of processing tissues and creating slides, continues to require further improvement. The pathology department are currently recruiting to specialist microtomy posts

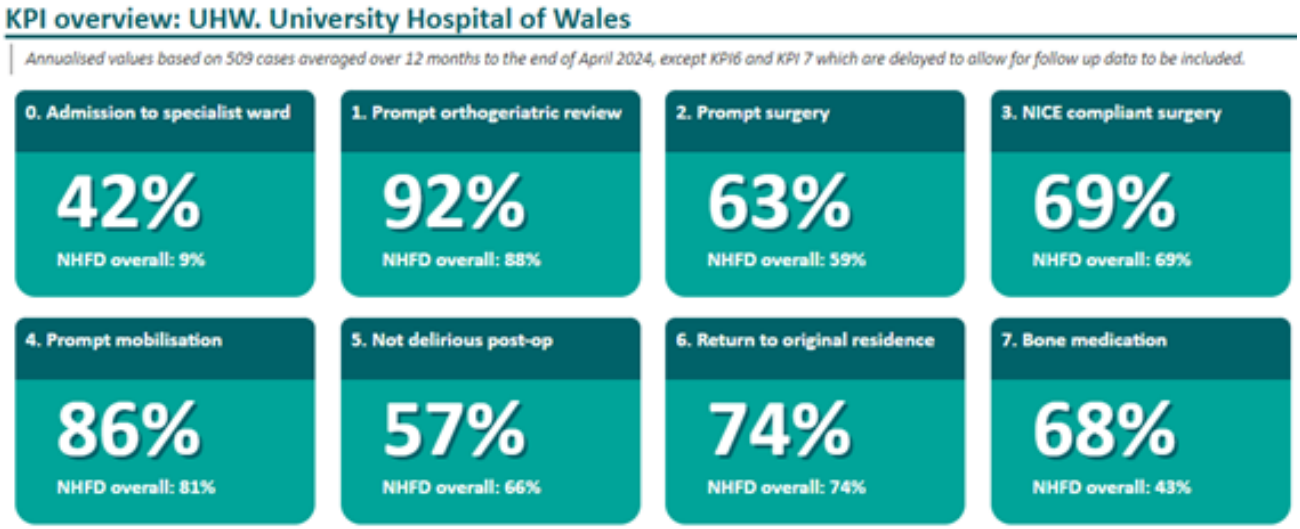
and are exploring technological options to automate some of the microtomy process. The team are visiting Toyota in 2024 to learn from their methods and practices to support the most efficient and productive ways of working and to then translate this learning into practice in the Health Board. There is continuing scrutiny and oversight of performance to ensure that performance improves and patients receive the outcome of investigations without delay.

Hip Fracture

Hip fracture is the most common reason for an older person to require admission to hospital for emergency surgery. Improvements in hip fracture care nationally, means that the number of patients who died in the month following a hip fracture has halved since 2007. The National Hip Fracture Database is a national audit programme that measures the care provided to patients with hip fractures against a number of evidence-based standards. Adherence to these standards is improving the clinical outcomes, reducing the length of stay in hospital and increasing the number of people returning to their homes following a hip fracture.

The prompt admission to a specialist ward is vital so that patients can reach the care of a specialist multidisciplinary team who will progress their assessment and perioperative care. In 2022 only 3% of patients were admitted to a ward within 4 hours, but the redesign of the hip fracture pathway now means that 42% of patients are admitted within this time scale. The number of patients who had prompt surgery increased from 59% in 2022 to 63% in 2023.

There is a continuous focus on performance against the hip fracture pathway at all levels of the organsiation and we recognise that there is a requirement for us to further improve our compliance against the standards to ensure that the care of patients is optimised.



Planned Care and Diagnostics

We have worked hard to reduce our waiting lists across planned care. Improvements have been made despite the challenging operational pressures across the Health Service and the unprecedented breadth of industrial action. Our delivery of service change has been led through our planned care programme and this includes close regional working across Southeast Wales in specialities such as Ophthalmology, Orthopaedics and Endoscopy. The total number of patients waiting for treatment on a Referral to Treatment (RTT) waiting list has increased to 147,620 in March 2024. One of the key ministerial priorities was the reduction in the number of patients waiting over two years for treatment. The Health Board was able to meet the standard of having less than 3% of the waiting list waiting over two years in December. We made further progress over winter, reducing this to less than 2% in March. This meant we had 2,681 patients waiting on RTT waiting lists more than two years; we were pleased to reduce the number of specialities reporting these long waits from 14 to 7 over the year. We know patients are still waiting too long and we continue to make this a priority for the coming year.

Despite our reductions in extremely long waiting patients (over two years), the number of patients waiting over 52 weeks for treatment has increased to 31,124. Within our outpatient clinics we have been concerned at the high number of patients who are awaiting a follow-up appointment. We know that there is potential clinical risk within this cohort of patients and have been working hard to improve the position. Each follow-up has a target date; in April 2024 over 54,000 patients had waited over twice as long as their target date. This number has reduced to 28,000 in March 2024. Whilst still far too high, there is a concerted effort to reduce all follow-up delays during 2024/25.

Cardiff and Vale Health Board are developing the Surgical Hub at Llandough Hospital. The plan is to be live from September 2024 and the Health Board will have dedicated and ring-fenced theatre time and a day-case ward to focus on sustainably increasing our capacity. The unit will be for day-case procedures predominantly and as such will be a unit which will be able to accommodate high volumes of patients. As this develops, we are expecting to treat up to 5,000 patients per year through this unit. This will enable us to increase our capacity supporting managing the long waiting times that our patients are currently experiencing.

Effective

Our healthcare system ensures decision-making, care and treatment reflects evidence-based best practice, to ensure that people receive the right care to achieve the optimal and possible outcomes that matter to them. We design transformative, evidenced-based, whole-of-life pathways that cover prevention, care and treatment, rehabilitation and embed these into local service delivery.

National Clinical Audit

Welsh Government have mandated a series of national clinical audits which are used to measure and drive improvements in health care services in Wales and across the UK, by measuring and benchmarking against national standards. The audit programme includes conditions such as cancer, long-term conditions, including diabetes and respiratory disease, maternity and paediatric, surgical specialities and specialties including kidney disease and intensive care.

The Health Board Clinical Effectiveness Committee oversees the outcomes and improvements associated with the audits and these reports can be accessed here:

Bi Annual National Clinical Audit Report- Quality Safety and Experience Committee September 2023

Clinical Effectiveness Committee Report May 2024 Quality, Safety and Experience Committee

In 2023 we published the UHB clinical audit strategy which set out a commitment to use clinical audit to support a quality management system, to provide assurance about the services we provide and informing quality improvement. The Health Board audit process operates on a tiered system:

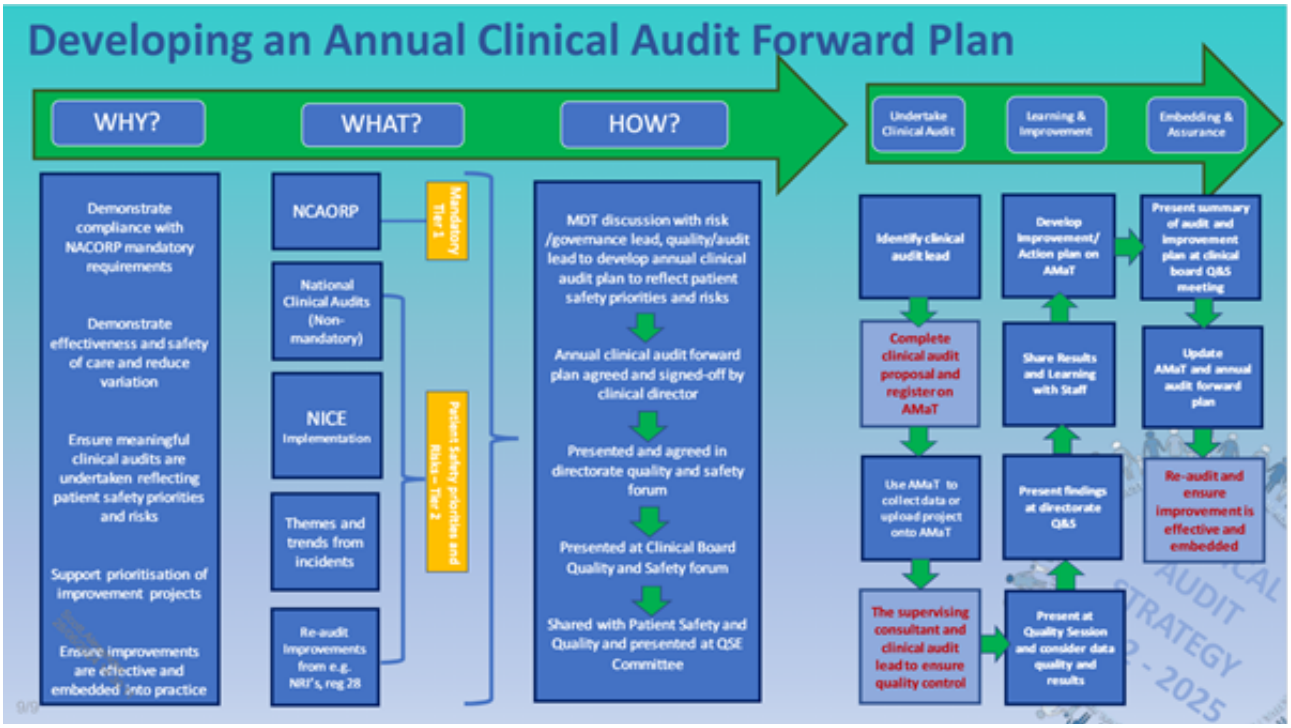
Tier 1 - Mandated national clinical audit set out in the National Clinical Audit and Outcome review Programme;

Tier 2 - All other national and local clinical audits undertaken to address patient safety and quality priorities;

Tier 3 - Local clinical audit undertaken for other reasons such a revalidation and professional development purposes.

We implemented a digital clinical audit and assurance platform in late 2022 and in 2023/24 worked with colleagues across the Health Board to train and support them in using the platform. Standardising the approach to audit and providing the right digital tools has enabled staff to develop and implement audit programmes aligned to their quality priorities. In November 2023 there were 175 audits scheduled across the organisation to provide assurance about the quality of care we provide.

Clinical Audit Forward Plans- Audit Committee November 2023



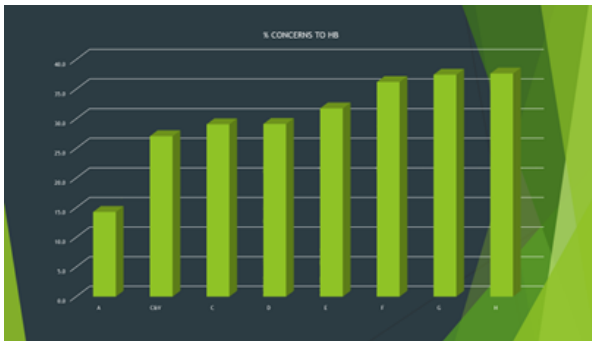
Medical Examiner

The Medical Examiner Service, which is independent of Health Boards in Wales, currently provides scrutiny of all in-patient deaths that are not investigated by HM Coroner. Scrutiny is undertaken by a Medical Examiner (ME) who is an experienced doctor with additional training in death certification.

The ME will notify the Health Board in relation to cases where they believe there should be further consideration or where the family have raised concerns about the care their relatives have received. A multi-professional mortality screening panel has been established to consider the ME notifications and to agree the terms of further investigation or review.

Themes and trends from ME notifications are fed into the various clinical advisory groups in the Health Board to allow them to develop strategy and policy that will deliver the necessary improvements and service development. Feedback from relatives is fed into the Civica patient experience platform so that it is accessible to clinical areas to ensure learning.

The ME shares data with health organisations on a quarterly basis and demonstrates that 27.1% of cases receiving independent scrutiny result in a notification back to the Health Board.



Tendable

The Tendable ward audit system was introduced in 2020 and was pre-dominantly used by our nursing colleagues to audit and inspect the care that they provided on wards and in other clinical environments. The tool is now used more widely by the multi-disciplinary team. The digital platform allows health care colleagues to measure the care that they provide against a set of standards. These standards include completion of patient documentation and risk assessments, infection prevention and control, management of peripheral and central venous lines and nutrition and hydration.

429

Total no. of locations set up in Tendable, with significant number not used.

1179 Live Registered Users

232

No. of areas set up in our core audit programme

~36

On average 36 Executive Walkaround audits are completed each year, covering core audit areas and more.

Welsh Nursing Care Record

The Welsh Nursing Care Record is a digital system that is transforming the way that nurses store and access patient information. The benefit of a digital record is that nurses can easily access historical records and share information across the clinical teams within the Health Board. The system has been piloted in several clinical areas and has shown benefit and will be rolling it out to all in-patient areas in 2024/25.

Access to digital risk assessments means that there is a wealth of patient information available to inform quality improvement and strategy. This can include analysing information in risk assessment of individuals who sustain a fall as an in-patient to understand common themes including prescribing of specific medications or conditions or poor eyesight. This allows us to further understand these risks and to change the way we provide care to mitigate these risks.

Quality Driven Decision Making

Making decisions about how the services we provide are delivered, how services should evolve and how resources should be allocated should always be done through a quality lens. This process should consider the health and care quality standards assessing the effect of strategic decisions on the quality and safety of the health care systems.

We are currently developing a quality driven decision-making policy to support a standardised approach to the application of this process, endorsing a formal quality impact assessment for all strategic decisions made across the Health Board.

Maternity Services

Maternity services across the UK and locally have been under significant scrutiny over the past twenty-four months. In March 2022, the second and final report by Donna Ockenden into the Maternity Services at Shrewsbury and Telford NHS Trust was published and outlined 89 recommendations that all Trusts and Health Boards in the UK should adhere to. In July 2023, the Wales Maternity and Neonatal Safety Support Programme (MatNeoSSP) Wales published its first report; Improving Together for Wales, into Maternity and Neonatal Services across Wales. The report outlined 16 priority areas with 110 recommendations.

In November 2022 Health Inspectorate Wales (HIW) attended the Maternity Unit at the University Hospital Wales for an unannounced inspection and undertook a further unannounced review in March 2023. HIW identified a number of areas where improvements were required as well as recognising areas of good practice. A combined inspection report was published in June 2023 that made a number of recommendations to the Health Board.

As well as developing an improvement plan to address the local HIW findings, a review of the recommendations of the two national reports was undertaken to identify required improvements or development and the UHB committed significant additional investments into maternity and neonatal services to support these improvements.

The full report can be read at: University Hospital of Wales | Healthcare Inspectorate Wales (hiw.org.uk)

The additional investment has been used to increase midwifery establishments and to fill all existing vacancies. The recruitment of specialist neonatal nurses to support the Transitional Care Unit and support the care of babies in the most appropriate setting ensuring that families are not separated.

The development of the maternity dashboard and further work to extend the dashboard to neonatal services supports a data informed approach that provides real time information on the quality and safety of service provision in perinatal services.

The reconfiguration of the maternity department ensures improved experience for women with increased single rooms available to ensure improved privacy and dignity. The appointment of a Preceptorship Lead Midwife and the redesign of the induction programme now means that newly qualified midwives have additional support for the first year of training.

A full report of progress against Ockenden, MatNeo SSP and the HIW recommendations was reported to the October 2023 Quality Safety and Experience Committee. You can read the full report at Maternity Update Quality Safety and Experience Committee October 2023

Person-centred

Our health care system meets peoples' needs and ensures that their preferences, needs and values guide decision-making that is made in partnership between individuals and the workforce. We care about the well-being of individuals, their families, carers, and our colleagues. We ensure that everyone is always treated with kindness, empathy and compassion and we respect their privacy, dignity and human rights. We are committed to working better together to put people and their families at the centre of decisions, seeing them as experts working alongside professionals to get the best outcome and experience.

Patient Experience

We are committed to providing quality services in line with our strategic objectives and committed to improving patient experience. Whilst every effort is made to do what is right for our patients, there have been times when we have got it wrong, and it is essential that we learn from their experience. 'Patient experience' encapsulates all aspects of our clinical and non-clinical care including the care environment, staff attitude and communication, team working, access issues, involvement in decisions about treatment choices and our ability to be responsive and resolve problems quickly. It is also about treating patients with honesty, dignity, and respect. It applies across all services provided to patients in the Health Board.
We currently send up to 1,000 texts each day which includes contacting 600 patients randomly selected from general hospital activity, 200 people who have attended our Emergency Department and 200 patients who have accessed Mental Health Services. This Information helps us to understand the experience of the people who use our services allows us to put in place improvements.

In response to feedback, we have introduced contact cards for each consultant to hand to patients to make navigating our health systems and contacting their health care team easier and we have introduced a digital system to keep patients attending the Ophthalmology Departments updated to appointment waiting times.

Many people who have been cared for as inpatients have told us that they felt bored and isolated during their stay. In response we have developed digital library trolleys which were initially being used on five wards and are now being spread to other areas. These trolleys are being supported by volunteers and include radios, books and portable DVD players and discs as well as a number of spiritual resources including an audio Quran, audio Bible, large print Bibles, Buddhism mindfulness cards and prayer mats.

Safe at Home

Safe@Home is a multi-agency, multi-professional urgent response service designed to provide an immediate and safe alternative to ambulance conveyance and avoidable hospital admissions. The service which started in January 2024 enables individuals to remain at home and receive the care that they require there. The service is focussed on supporting frail elderly individuals who present with infections, or those that have had a fall but have not sustained a serious injury. This group of patients are at risk of long hospital admissions which can present additional risks.

SIRAN (Safety Incident Response Accreditation Network)

The Mental Health Clinical Board were proud to achieve their SIRAN accreditation in March of this year after a year-long process. SIRAN is a quality improvement and accreditation network for mental health organisation's patient safety incident review process. The Network endorses a set of standards in particular increasing the involvement of patients and their families, allowing them to add their reflections to review reports and to pose specific questions and influence the terms of reference of each review

Daring to Dream

Nearly half of all adults in Wales are estimated to be living with at least one longstanding illness. Of those, the lives of more than half are either somewhat or severely limited by their illness.

Daring to Dream, a charity that focuses on emotional support for adult patients, has helped transform spaces within the University Hospital Wales for the emotional wellbeing of those in our care. Quiet Rooms in hospitals are very important spaces. They are the rooms used for difficult conversations with patients and their families and it is vital that they are comforting for those in need. To support the emotional health of patients, there are now multiple re-furbished quiet rooms within the hospital in General Surgery, Critical Care, Nephrology, and Cardiology. The newest quiet room within the hospital can be found in the Department of Integrated Medicine.

Often drab and uncomfortable, Daring to Dream helps turn quiet rooms into spaces where patients, families, and colleagues can feel at ease after receiving distressing news. Spaces where people can feel and express their emotions openly benefit the mental health of anyone that needs its calming presence.

Efficient Care

Our health care system takes a value-based approach to improve outcomes that matter most to people in a way that is as sustainable as possible and avoids waste. We make the most effective use of resources to achieve best value in an efficient way. We only do what is needed and undertake treatments that ensure any interventions represent the best value that will improve outcomes for people.

See on Symptoms and Patient Initiated Follow up (SOS and PIFU)

To help us provide high-quality, patient-centred outpatient care, we have adopted two new approaches in some of our clinics – See on Symptoms (SOS) and Patient-Initiated Follow-Up (PIFU):

See on Symptoms: SOS is designed for patients with short-term, stable conditions who are expected to improve over time. Patients on this pathway are instructed to contact us if they experience worsening symptoms or have any concerns.

Patient-Initiated Follow-Up: The PIFU pathway is designed for patients with chronic or long-term conditions who require ongoing monitoring. Instead of having follow-up appointments scheduled at fixed intervals by the healthcare team, patients on the PIFU pathways are given flexibility to schedule appointments when they need them, based on their circumstances and symptom progression.

SOS and PIFU have significant benefits for patients, giving autonomy to manage appointments and seek care when needed, without the burden of unnecessary appointments. This, in turn, allows the clinical team to allocate their time more effectively, reducing waiting times and ensuring patients can be seen promptly when needed.

With an unnecessary out-patient appointment costing the Health Board around £160, avoiding unnecessary appointments allows us to use this money elsewhere to improve our services. There is also an environmental benefit to the wider population through reduced unnecessary travel to appointments with the associated carbon emissions. SOS and PIFU are better for patients, better for clinical teams and better for the planet.

Safe Care

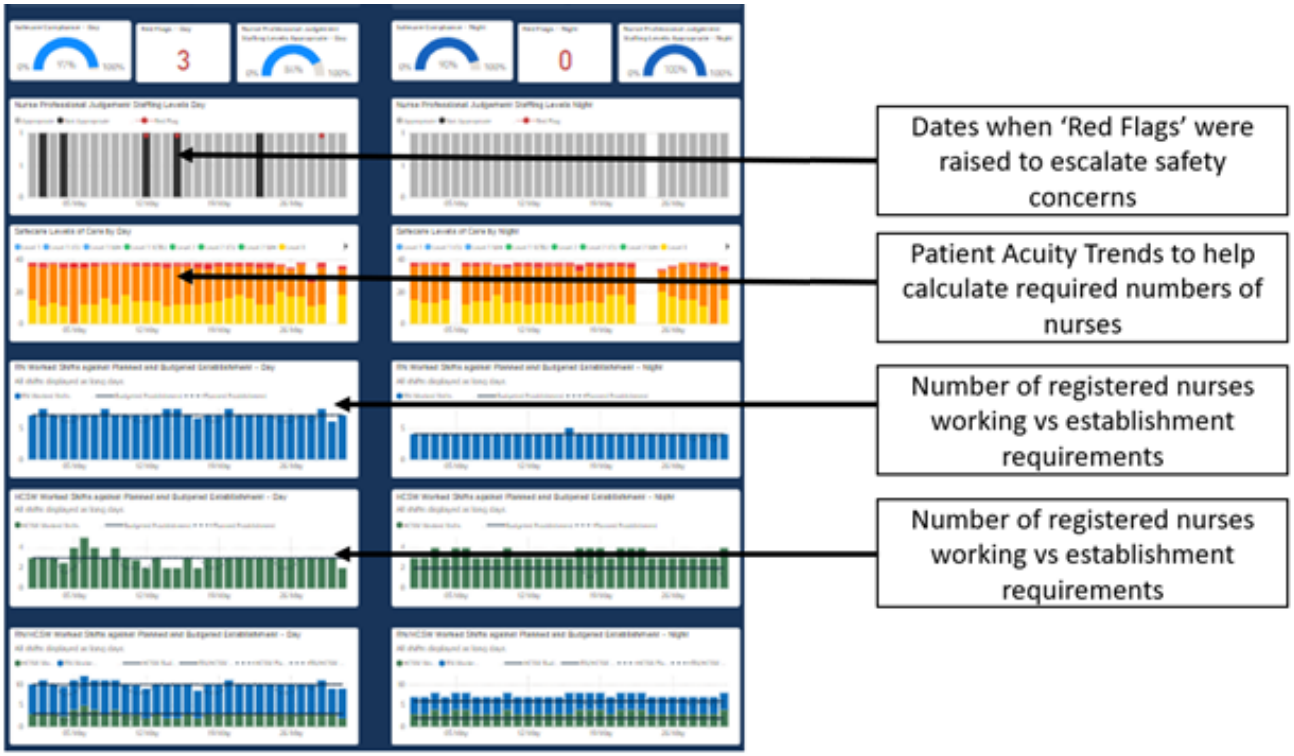
The Nurse Staffing Levels (Wales) Act became law in 2016 and requires health organisations in Wales to ensure appropriate and safe nurse staffing levels. The Act requires us to be able to triangulate nurse staffing levels in Acute Medicine and Surgical in-patient areas considering the acuity of the patients being cared for.

We use a digital platform called Safe Care to help us to monitor staffing levels and to escalate risks in areas where staffing falls below the required level. Safe Care is now used on all relevant wards and has demonstrated 90% compliance with the Act's requirements. The platform has allowed much greater scrutiny of rostering practice and identified variation in study leave and annual leave provision. Having access to this information supports much more efficient rostering.

Health Pathways

Community health pathways and hospital pathways are designed to standardise care across a condition specific pathway of care including assessment, management and referrals between the community and the hospital setting. Pathways ensure that care is provided in line with evidence based guidance including NICE and ensures an efficient use of resource by supporting the provision of care in the right place, at the right time and by the right people.

These pathways are used across the Health Board to ensure equitable access to evidence-based care.



Equitable

Our healthcare system provides everyone with an equal opportunity to attain their full potential for a healthy life which does not vary in quality by organisation providing care, location where care is delivered or personal characteristics (such as age, gender, sexual orientation, race, language preference, disability, religion or beliefs, socio-economic status, political affiliation). We embed equality and human rights in our health care system.

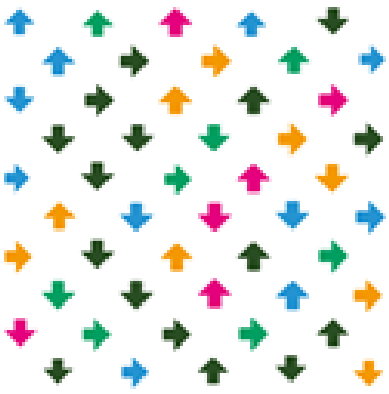
Equity, Equality, Experience and Patient Safety Framework

The Equity, Equality, Experience and Patient Safety Framework was published in 2023 setting out an ambition to deliver equitable and excellent preventative clinical service. We will achieve this by reducing variation in health outcomes, access to services and the quality of services that people receive and to ensure that we have a workforce that is representative of the population.

A support pack was published alongside the framework, which is designed to help our colleagues think through how they can make a difference in reducing variation in the care that we provide to different populations.

Initial areas of Focus for Cardiff and the Vale University Health Board

The Health Board have identified a number of projects that have strategic importance to delivering on the Equality, Equity, Experience and Patient Safety agenda. These are summarised below. This list is not exclusive, but guides the organisation to deliver on strategically important work. If local teams wish to make service improvements this should be supported.



We will achieve this by:

- **Identify** - recognising that individual services might not meet the needs of all people;
- **Intelligence for Action** - by using the data and information available to us to start to measure these disparities;
- **Interventions Tailored to Need** – putting in place services that meet the need of the local people.

Cardiff and Vale Health Inclusion Service (CAVHIS)

Health inclusion is an approach aimed at readdressing extreme health and social inequities among the most vulnerable and marginalised in a community. The concept of health inclusion typically encompasses people experiencing homelessness, vulnerable migrants, sex workers, Gypsies, Roma Travellers (GRT) and those in contact with the Criminal Justice System. These marginalised populations share common overlapping risk factors for poor health that include poverty, adverse life experiences, discrimination, violence, and complex trauma. These risk factors, accompanied with multiple barriers and negative experiences when attempting to access health and care services, result in significantly poorer health outcomes, putting those affected beyond the extreme end of the gradient of health inequalities.

CAVHIS is a Health Board service for groups that face significant challenges when attempting to access health and social care services. Support includes Public Health screening for asylum seekers and refugees, including GP registration and access to medical care for up to 3-4 months, whilst individuals are supported in transitioning into traditional primary care.

The Homelessness Team was established in 2019 to provide therapeutic intervention, support, and treatment to people with complex support needs within homelessness services. The team is made up of clinicians and practitioners

Average age of death for homeless **men is 45 and 43 for women** (ONS, 2021).

In 2021, across England and Wales, there were an estimated **741 deaths** of people experiencing homelessness. The estimated number of deaths among homeless people has **increased by 54%** since records began in 2013 (ONS, 2021).

Study revealed that **68% of street-based sex workers** interviewed meet the criteria for post-traumatic stress disorder – this is in the same range as victims of torture and combat veterans undergoing treatment (Litchfield et al., 2010).

Annual number of people dying whilst under probation services in Wales **increased exponentially by 194%** between 2018/19 and 2020/21 (PHW 2023). Accidental drug deaths were the leading cause of death.

Gypsy, Roma and Traveller people face life expectancies **between 10 and 25 years shorter** than the general population (Friends, Families, Travellers 2021).

An international systematic review found that among adult asylum seekers and refugees, the prevalence of **PTSD was 31.46%** and **depression was 31.5%**, compared to the general population which is 3.9% for PTSD and 12% for depression (Blackmore et al., 2020).

from several different organisations that include Cardiff and Vale Drug and Alcohol Service (CAVDAS), Dyfodol, South Wales Police, Probation, Cardiff Council (Housing and Adult Social Care) and the Department of Work and Pensions. The Team focusses on delivering in-depth assessments leading to person-centred co-ordinated support and treatment plans.

A Young Person Team was set up in 2021 to focus on the 16–24-year-old age group, presenting to the homeless service with significant complex needs. The service provides a transition social worker, mental health and substance use professionals, case co-ordinators and offers therapeutic interventions, including counselling and substance use support. The Team is based with the Area Planning Board funded Cardiff and Vale Drug and Alcohol Service.

ELAN

The ELAN team was initially developed in 2003 to provide specialist maternity support within Ely and Llanederyn where there were higher levels of deprivation. Within a year the services had been expanded to meet the need of all overlooked groups in Cardiff and the Vale and provide support relating to substance abuse, teenage pregnancies severe mental health issues, homelessness and learning disabilities.

The team provides an enhanced service seven days a week providing all antenatal and postnatal care by named midwives to a caseload of around 35 women. The support includes individualised parent education provided in the home.

Vaccinations Information

Vaccines are the most effective way of preventing many infectious diseases and they prevent millions of deaths worldwide each year. We see variation in uptake of vaccinations, including childhood vaccination across Cardiff and Vale, with lower uptake often associated with areas of greater deprivation

In 2023 increased rates of Measels were noted across the UK. Work undertaken by the Health Board Public Health Team included working in partnership with schools where MMR vaccine uptake was below 90% to improve uptake and to provide factually accurate information about vaccinations.

NHS Staff Survey

The NHS Wales Staff Survey 2023 saw a response rate of 21.4% from staff across the Health Board. Although this is disappointing in terms of levels of participation, the feedback received from 3,662 colleagues will be important in helping the UHB understand the current experiences of those working within the organisation.

In the week following the release of the over-arching organisational results in February 2024, the Chief Executive Officer worked with the Communications Team to share, in full, what had been received. This aligned with the messaging leading up to the staff survey, promising that the UHB would be open and transparent in sharing results, and work with colleagues to understand and act upon feedback received.

The UHB is keen to work in a collaborative and inclusive way, and colleagues have been asked to become part of a 'Staff Survey Task Group' where results can be shared, discussed and ideas for improvement can be generated and acted upon. The first meeting of the Group will take place in June 2024.

Next steps with the survey results will be to assess the level of analysis that can be extrapolated from the data in the format provided, which will be shared with Clinical Boards and Directorates. The People and Culture Team are working with Clinical Boards to support understanding or, further engagement in, and actions required following results. The UHB are conscious that the long timescales currently seen could impact on trust in the Staff Survey process, and future engagement in the NHS Wales Staff Survey, therefore communication and engagement will continue throughout 2024.

The UHB have also introduced a consistent approach to cultural assessments, using the Culture and Leadership Programme created by NHSEI, The King's Fund and The Centre for Creative Leadership. This approach is being adopted in a prioritised and targeted way, owned at a local level and supported by organisational expertise. The results of the cultural assessments are being collated to support a wider organisational understanding, and to inform actions required to make improvements or amplify successes.

Welsh Language

We have published a Welsh Language for In-patients Policy this year to ensure that we consistently meet our statutory requirements to provide patients with an active choice on whether they wish to communicate in Welsh or English.

To be able to meet this commitment, we will record Welsh language skills for every member of staff and clinical areas will be able to utilise the Welsh Language skills of their staff to provide the best level of service for patients who prefer to speak Welsh. Staff will be encouraged to wear the "*Iaith Gwaith*" to identify themselves as Welsh speakers. All patients will be

asked their preferred language which will then be recorded on the Patient Management System.

HIW undertook an unannounced inspection on the Renal Wards, B5 and T5, in March 2023 and recommended that further work was required to ensure that an active offer of provision of health care in both Welsh and English was made. In response Welsh language greeting cards were placed by all telephones to support staff to be able to answer the phone and greet callers in Welsh. The wards have reviewed all patient information leaflets to ensure provision in Welsh and English and undertook a review of all signage to ensure that it was bilingual.

You can read the full report and improvement plan at: 20230706UHWNephrologyEN.pdf (hiw.org.uk)

Tobacco

Smoking is highly damaging to health and is the cause of death for around half of long-term smokers. It remains the single largest cause of preventable ill health and 13% of the population in Wales and 12% in Cardiff and Vale are smokers. There is significant variation in smoking rates across different populations in Wales with 22.4% of adults from the most deprived groups of Wales smoking compared to 6.6% in the least deprived, and the proportion of individuals with long-term mental health conditions who smoke is 31%.

Smoking Cessation support is available to everyone in Cardiff and Vale; Help Me Quit community services are available to deliver smoking cessation support, providing behavioural support and nicotine replacement therapy on a one-to-one basis and through group support. Pharmacies across Cardiff and Vale, but particularly in areas of deprivation, are delivering smoking cessation support to the communities for whom smoking is having the most impact. Public Health practitioners are providing support to schools and education settings and youth services in the most deprived areas to deliver smoking prevention education.

Help Me Quit - Denise's Story (youtube.com)

Looking Forward 2024 /2025

The Health Board is committed to delivering the highest quality care, treatment and intervention and addressing unfair differences in access and outcome. We recognise that currently we are not providing the quality of services we could or should, so patients and staff do not have the best experience or outcomes.

We have launched Shaping Our Future Wellbeing, the Cardiff and Vale University Health Board's 2023-2025 strategy: In our strategy we commit to providing outstanding services which are equitable, timely and safe and where people are treated with kindness and are supported to achieve the outcomes that matter to them.

We will seek to eradicate avoidable harm in each of the four strategic objectives, Putting People First, Providing Outstanding Quality, Delivering in the Right Places and Acting for the Future

In 2024 we will launch the Quality Excellence programme to deliver an effective quality management system through the building of capacity and capability across the domains of quality planning, quality control and assurance and quality improvement activities underpinned by leadership practices that foster a culture of learning. The programme will provide a particular focus on several areas that we have determined are our clinical priorities.

Shaping Our Future
Quality Excellence