Public Board Meeting

Thu 29 May 2025, 09:30 - 15:30

Woodland House, Coed Y Bwl

Agenda

09:30 - 09:40
10 min

1. Welcome & Introductions

Charles Janczewski

09:40 - 09:40
0 min

2. Apologies for Absence

Charles Janczewski

09:40 - 09:40
0 min

3. Declarations of Interest

Charles Janczewski

09:40 - 09:40
0 min

4. Minutes of the Board meeting held 27.03.2025

Charles Janczewski

4 Minutes of the Public Board Meeting 27.03.2025.pdf (15 pages)

09:40 - 09:40
0 min

5. Actions – following meeting held on: 27.03.2025

Charles Janczewski

5. Action Log - Public Board (2) (1).pdf (2 pages)

09:40 - 14:20
280 min

6. Items for Review and Assurance

6.1. Patient Story – “The Care I Received was Fantastic” (15 MINUTES)

Jason Roberts

6.2. Chair’s Report & Chair’s Action taken since last meeting (10 MINUTES)

Charles Janczewski

6.2 Chairs Board report May (1).pdf (8 pages)

6.3. Chief Executive Officer Report (15 MINUTES)

Suzanne Rankin

6.3 CEO Board Report May Final copy.pdf (5 pages)

6.4. Finance & Performance Committee Chairs Report (10 MINUTES)

John Union / Catherine Phillips

6.4 Finance Chairs Report 21.05.2025.pdf (6 pages)

6.5. Board Assurance Framework (10 MINUTES)

Matt Phillips

6.5 BAF Board Cover Report.pdf (3 pages)
6.5a BAF.pdf (35 pages)

6.6. Chairs' reports from Committees of the Board:

Matt Phillips

1. *People & Culture – 06.05.2025*
2. *Mental Health Legislation – 29.04.2025*
3. *Charitable Funds – 18.03.2025*
4. *Quality – 13.05.2025*

6.6.1 P&C Chairs Report 06.05.25.pdf (4 pages)
6.6.2 - Quality Committee Chairs Report 13.05.2025.pdf (4 pages)
6.6.3 - Mental Health Legislation Committee 29.04.2025.pdf (5 pages)
6.6.4 - CFC Chairs Report 18.03.2025.pdf (4 pages)

6.7. Joint Commissioning Committee Update (40 MINUTES)

Suzanne Rankin / JCC

6.7a JCC session for Board.pdf (7 pages)
6.7b JCC Annual Update CandV v.6 ns.pdf (27 pages)

6.8. BREAK – 10 MINUTES

6.9. Strategic Planning, Commissioning and Partnership Update (10 MINUTES)

Catherine Phillips

6.9 Strategic Planning Commissioning and Partnerships Update (1).pdf (9 pages)

6.10. Integrated Performance Report: (75 MINUTES)

Catherine Phillips / Claire Beynon / Paul Bostock / Rachel Gidman / Jason Roberts / David Thomas

- *Finance*
- *Public Health*
- *Operational Performance*
- *People & Culture*
- *Quality, Safety & Experience*
- *Digital*

6.10 C&V IPR Corporate Header May 2025.pdf (15 pages)
6.10a C&V Integrated Performance Report May 2025.pdf (48 pages)

6.11. LUNCH – 30 MINUTES

6.12. Ministerial Advisory Group - NHS in Wales Performance and Productivity report (30 MINUTES)

Paul Bostock / David Fluck

6.12 Ministerial Advisory Group P&E (1).pdf (4 pages)

6.13. Nurse Staffing Report (10 MINUTES)

Jason Roberts

6.13 Nurse Staffing Report Covering Report.pdf (3 pages)
6.13a Nurse Staffing Report (May report 2025) Final - Adult, Paeds.pdf (22 pages)

14:20 - 15:20
60 min

7. Items for Approval / Ratification

7.1. 2025/26 Draft Capital Plan (10 MINUTES)

Catherine Phillips

7.1 Annual Capital Plan 2025-26 Board 28.05.2025.pdf (7 pages)

7.2. NHS Long Term Agreements (LTAs) and Financial Approach for 2025/26 (10 MINUTES)

Catherine Phillips

7.2 Long Term Agreements 2025-26 Report to Board Final.pdf (5 pages)

7.3. Theatres Review Action Plan (30 MINUTES)

Paul Bostock

Supporting Documents can be located in the documents folder.

7.3 Theatres May 25.pdf (3 pages)
7.3a Public Board Theatre briefing May 2025.pdf (8 pages)
7.3b Theatres Service Review Report April 25.pdf (22 pages)

7.4. Annual CHC Uplift Paper (5 MINUTES)

Catherine Phillips

7.4 CHC Fees Uplift 2025-26 (3).pdf (4 pages)

7.5. Microsoft Enterprise Agreement (5 MINUTES)

David Thomas

Supporting Documents can be located in the documents folder.

7.5 Enterprise Agreement Report 29 05 25 DT1 (1).pdf (2 pages)

15:20 - 15:20
0 min

8. Items for Noting and Information

8.1. Corporate Risk Register

Matt Phillips

Supporting Documents can be located in the documents folder on AdminControl and the Cardiff and Vale UHB website

8.1 CRR Board Report - May 2025.pdf (3 pages)

8.2. Cardiff and Vale UHB Draft Annual Report 2024-25

Matt Phillips

Supporting Documents can be located in the documents folder on AdminControl and the Cardiff and Vale UHB website

8.2 CVUHB Draft Annual Report 2024-25 Covering Report.pdf (3 pages)

8.3. Reports from Advisory Groups and Joint Committees:

Matt Phillips

These reports can be located in the supporting documents folder on AdminControl & the Cardiff and Vale UHB website.

1. *Joint Commissioning Committee (JCC)*
2. *Local Partnership Forum (LPF) Annual Report*
3. *Local Partnership Forum Report - 10.04.2025*

8.4. Committee, Advisory Group and Joint Committee Minutes:

This report can be located in the supporting documents folder on AdminControl & the Cardiff and Vale UHB website.

1. *Local Partnership Forum 13.02.2025*

15:20 - 15:20
0 min

9. Agenda for Private Board Meeting:

i. *Approval of Private Board minutes*

ii. *Organisation Redesign – Tricordant Proposal*

iii. *Legal Update*

iv. *Llantrisant Health Park – Outline Business Case*

v. *Approval of Private Committee minutes*

15:20 - 15:20
0 min

10. Any Other Business

10.1. Mike Jones – Ten Y Fan Thanks

Mike Jones

10.2. Review of the meeting

Charles Janczewski

10.3. Date and time of next meeting:

Thursday 31 July 2025 – Woodland House – *Coed Y Bwl*

15:20 - 15:20
0 min

11. Declaration for Private Board:

To consider a 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 [Section 1(2) Public Bodies (Admission to Meetings) Act 1960]

Minutes of the Public Board Meeting
Woodland House, Coed Y Bwl
27 March 2025

Chair:		
Charles Janczewski	CJ	University Health Board Chair
Present:		
Claire Beynon	CB	Executive Director of Public Health
Paul Bostock	PB	Chief Operating Officer
Joanne Brandon	JB	Director of Communications, Arts, Health Charity and Engagement
Emma Cooke	EC	Executive Director of AHPs, Health Scientists & Community Services
Lauranne Cullen	LC	Regional Director - Llais
David Fluck	DF	Executive Medical Director
Mike Jones	MJ	Independent Member – Trade Union
Lianne Morse	LM	Deputy Director of People & Culture
Sara Moseley	SM	Independent Member – Third Sector
Catherine Phillips	CP	Executive Director of Finance
Ceri Phillips	CP	University Health Board Vice Chair
Matt Phillips	MP	Director of Corporate Governance
Suzanne Rankin	SR	Chief Executive Officer
Steve Riley	SR	Independent Member – University
Jason Roberts	JR	Executive Nurse Director
David Thomas	DT	Director of Digital & Health Information
Rhian Thomas	RT	Independent Member – Capital & Estates
Lani Tucker	LT	Chair of the Stakeholder Reference Group
John Union	JU	Independent Member – Finance
Rachna Upadhya	RU	Independent Member
Observers:		
Natasha Goswell	NG	Deputy Executive Nurse Director
Members of the Public		
Secretariat:		
Nathan Saunders	NS	Senior Corporate Governance Officer
Apologies:		
David Edwards	DE	Independent Member – ICT
Rachel Gidman	RG	Executive Director of People & Culture
Akmal Hanuk	AH	Independent Member – Local Community
Susan Lloyd Selby	SL	Independent Member – Local Authority

Reference	Agenda Item	Action
UHW 25/03/001	**Welcome & Introductions** The UHB Chair welcomed everybody to the meeting in English and Welsh.	
UHW 25/03/002	**Declarations of Interest** No declarations were noted.	
UHW 25/03/003	**Minutes of the Board Meeting held 30.01.2025** The Minutes of the Board Meeting held 30.01.2025 were received. **The Board resolved that:**	

	a) The minutes of the Board Meeting held 30.01.2025 were **approved** as a true and accurate record of the meeting pending the one amendment.	
UHW 25/03/004	**Actions – Following Meeting held 30.01.2025** All actions were received and reviewed. **The Board resolved that:** a) The Actions – Following Meeting held 30.01.2025 were **noted.**	
UHW 25/03/005	**Patient Story – There's Always Someone to Talk to** The Patient Story was received. The Executive Nurse Director (END) introduced the video and explained that it provided the Board with a mother's account of their child who was born with Tuberous Sclerosis Complex (TSC) and had a number of seizures daily as well as a diagnosis of autism. The video outlined the challenges that came with the child's autism and noted the support received from the All-Wales Tuberous Sclerosis (TSC) Clinic where both parents were tested and found to not have the defective gene. The mother highlighted the fact that there was always somebody to talk to at the clinic who could explain things and listen which was a great service to have and provided reassurance and guidance to deal with the day to day challenges. The UHB Chair thanked the Team for compiling the video and asked to relay the Board's thanks to the mother who had been so open with their experience. The Executive Director of AHPs, Health Scientists & Community Services (EDAHC) noted that the TSC Clinic, located at the All Wales Medical Genomics Service (AWMGS) in Cardiff was a great example of the good work undertaken around Tuberous Sclerosis Complex. **The Board resolved that:** a) The Patient Story was **noted.**	
UHW 25/03/006	**Chairs Reports & Chairs Action taken since last meeting:** The Chairs Report was received. The UHB Chair advised the Board that he would take the report as read and highlighted key points which included: • The Board had taken steps to strengthen arrangements in the Finance and Performance Committee and all Independent Board members would be included as members of the Committee with effect from 1 April 2025. • The ongoing challenges around the Annual Plan and it was noted that an entire Board Development session had been dedicated to discussions around the submission of the Annual Plan for 2025/2026 with the Board being engaged with and understanding the key plan priorities and commitments, in addition to discussing the areas of challenge and risk the Annual Plan presented which would be discussed later on in the meeting. • Diary Highlights including:	

	- Climate Emergency Leadership Day Spread and Scale Academy - Visit to the Maternity Unit • A Spotlight story outlining all the great work undertaken by the Veterans' NHS Wales Service (VNHSW). • Fixing the Common Seal/Chair's Action and other signed Documents since the last Board meeting. **The Board resolved that:** a) The report was **noted.** b) The Chair's Actions undertaken were **approved** c) The application of the Health Board Seal and completion of the Agreements detailed within the report was **approved.**	
UHW 25/03/007	**Chief Executive Officer (CEO) Report** The CEO Report was received. The CEO advised the Board that she would take the report as read and noted that it was a detailed report that centred a lot around two of the Health Boards strategic objectives: • Putting People First: The CEO advised the Board that the ambition was to support the People and Culture Plan to improve colleague experiences. Progress was made in reducing disparities for ethnically diverse colleagues, guided by the Anti-racist Wales Action Plan (ArWAP) and the Workforce Race Equality Standard (WRES), aiming for an anti-racist Wales by 2030. Collaboration with the Welsh Government (WG) received positive feedback, especially on representation and progression. A different approach was applied to sharing the 2023 Staff Survey results, using Staff Focus Groups to create a "safe space" for open dialogue. This led to understanding drivers of poor colleague experience and agreeing on improvements. Engagement improved, with 977 more colleagues participating in the survey. Work continues to address cultural issues, with targeted intervention by the Executive Team to resolve long-standing behaviours and poor team dynamics. This demonstrates commitment to organizational values, team wellbeing, and the link to patient safety and quality of care. Confidence is expressed in being on the right track, with gratitude to colleagues for their support • Delivering in the Right places: The CEO advised the Board that focus had been placed on supporting the Digital Roadmap to transform working methods and improve care models. Key initiatives included developing a Programme Business Case for infrastructure investment, implementing an Electronic Health Record, and enhancing digital maturity. She added that open Calendars would improve efficiency and transparency, and Co-Pilot Deployment would utilise AI tools for administrative tasks. It was noted that the Digital Eyecare Solution had been implemented in ophthalmology, with plans for a regional and national roll-out.	

	The CEO concluded that a £4.4 million investment from Welsh Government would accelerate Wi-Fi coverage and provide end-user devices. **The Board resolved that:** a) The Strategic Overview and Key Executive Activity to provide assurance described in the report were **noted.**	
UHW 25/03/008	**Board Assurance Framework** The Board Assurance Framework (BAF) was received. The Director of Corporate Governance (DCG) reminded the Board that any changed made were highlighted throughout the document via tracked changes. He added that an action taken from the last meeting was ensure the document was dynamic and noted that as the Health Board developed the new BAF and Committee structure, it would start to draw some strategic risks into the Forward Plan to appear at Committee meetings which would be really helpful and provide assurance to the Board that risks were being looked at in the relevant places. **The Board resolved that:** a) The risk themes regarding the delivery of Strategic Objectives detailed on the BAF were **reviewed** and **noted.** b) Each relevant Committee Chair would discuss with their Executive lead the inclusion of the BAF relevant to their Committee on their Committee Forward Plan.	
UHW 25/03/009	**Chairs Reports from Committees of the Board:** The UHB Chair invited Chairs of the Committees to provide any updates from the previous meetings held. **People & Culture Committee:** The Independent Member – Third Sector (IMTS), Chair of the People & Culture Committee advised the Board that she would take the paper as read and noted that the Committee focused on the BAF at each meeting, particularly in relation to staffing and noted that it linked into the rest of the Annual Plan and Strategy in terms of quality. She added that workforce control and staffing numbers were looked at in detail at the last meeting and drew the Board's attention to those figures. **Mental Health Legislation:** The UHB Vice Chair, Chair of the Mental Health Legislation Committee noted that the purpose of this report was to highlight the key issues which were raised and discussed at the Mental Health Legislation Committee meeting held on the 128th of January 2025. He added that in relation to the team's effectiveness in handling the complexity of Mental Capacity Act (MCA) queries, the Committee had been informed that the team was managing capacity, but they may need to reassess and consider Welsh Government (WG) funding to extend capacity, which was under ongoing review. **Audit & Assurance:** The Independent Member – Capital & Estates (IMCE), Chair of the Audit & Assurance Committee advised the Board that she would take the paper as read and highlighted the work undertaken by the Corporate Governance Team around Internal Audit Trackers, which had been migrated digitally onto the Audit Management and Tracking (AMAT) system.	

	Digital & Infrastructure: The Independent Member – ICT (IMICT), Chair of the Digital & Infrastructure Committee advised the Board that it was the first meeting held under its new title and noted that the meeting focussed on the Capital Programme and Digital. He added that the Committee would continue to focus on the strategic plan for digital whilst picking up information governance issues as well. **Quality:** The UHB Vice Chair, Chair of the Quality Committee advised the Board that the intention of the Committee was to try and work its way out of existence by providing exceptional quality in all aspects and so because the Health Board did not, the Committee had an important role to play. He added that focus on the Medical Clinical Board had taken place at the last meeting and noted the good work undertaken on reduction of hospital acquired infection rates which would positively impact Length of Stay (LoS). **Finance & Performance:** The Independent Member – Finance (IMF) advised the Board that the Chairs Report highlighted the month 10 position and noted that a meeting had been held a week previously which highlighted the month 11 position. He noted that the end of year deficit £27.7 would be achieved, in part due to the enhanced controls put in at the month 5 position. **The Board resolved that:** a) The Chairs Reports were **noted**.	
UHW 25/03/010	**Strategic Planning, Commissioning and Partnership Update** The Strategic Planning, Commissioning and Partnership Update was received. The EDF advised the Board that she would take the report as read and noted that it provided the Board with an update on key areas of strategic planning, commissioning, and partnership work programme to give the Board assurance that actions agreed in the annual work programme or Annual Plan were being progressed and risks around delivery were being managed. The Independent Member -Third Sector (IMTS) asked how data around Primary Care would be improved, particularly around the integration between Primary Care and Community Care. The CEO responded that there needed to be a stronger contractual arrangement around that data. The Executive Director of AHPs, Health Scientists & Community Services (EDAHC) advised the Board that the ambition was to move to an integrated care system and noted that Teams were looking at different areas, teams were getting smaller and could start making data sharing much easier (more around clusters). She added that it was all about getting right leadership into the space. The UHB Chair thanked the EDF for the report noting that it was very concise and easy to understand. **The Board resolved that:** a) The progress being made across the Strategic Planning, Commissioning and Partnership portfolio was noted.	

UHW 25/03/011	**Consultant Job Planning** The Consultant Job Planning paper was received. The Executive Medical Director (EMD) advised the Board that he would take the report as read and provide the relevant context. It was noted that the information had been received by the Senior Leadership Board earlier in the year for review and that a guide to non-clinical time was currently with the Medical Workforce Advisory group who would review and complete the paper at the next monthly meeting and discuss. It would then be taken back to SLB for agreement before passing to the People and Culture Committee. The EMD concluded that the purpose of Consultant Job Planning was to allow all clinical boards to carry out an assessment of clinical demand and understanding future demand and how the Health Board could meet and/or attenuate that and provide safe staffing levels. He added that there had been great improvement in the job planning processes within the Health Board with some areas of exceptional delivery. The UHB Vice Chair noted the complexity around job planning across the organisation and noted that there were opportunities to go where the people across the organisation were. **The Board resolved that:** a) The paper for implementation in order to provide the strategy and plan for job planning within CAVUHB (detailed in the accompanying paper) was approved. b) The aim stated at the end of the paper to have 90% of consultants and SAS doctors with agreed job plans on Allocate by June 2025 was approved.	
UHW 25/03/012	**Integrated Performance Report** The Integrated Performance Report was received. **<u>Population Health:</u>** The Executive Director of Public Health (EDPH) advised the Board she would take the paper as read and highlighted the key areas which included: • Vaccination Rates: it was noted that there was a focus on the importance of improving vaccination rates among staff and the local population and that whilst COVID vaccination rates were above the Welsh average, flu vaccination rates among staff were still low at 36%. • Healthy Weight – The serious problem of overweight and obesity was highlighted, which was a major risk factor for numerous diseases. An emphasis for the need for initiatives to address the issue was discussed, as 60% of adults in the local population were overweight or obese • Smoking: The board noted that 13% of the local population are smokers, with 70% of them wanting to quit. The importance of encouraging people to use the "Help Me Quit" service was emphasised to increase their chances of quitting successfully.	

The UHB noted that some of the figures within the report stated 2022/23.

The EDPH responded that data for childhood obesity was reported annually and so that was latest information available.

She added that in relation to adult obesity, that also came annually and so there would be a gap in the data before the next survey was commissioned. Jan – date of some of the figures. 22/23.

Operational:

The COO advised the Board he would take the paper as read and would highlight key areas which included:

- Urgent and Emergency Care: it was noted that the Health Board had come out of the winter relatively well and saw a reduction in the number of patients waiting 12 hours in the Emergency Unit (EU) and an improvement was observed in the average ambulance handover time.

- Hospital Flow and Discharge: it was noted that the proportion of beds occupied by long length-of-stay patients had fluctuated in recent months as additional beds were opened and closed in line with the Health Boards operational plan.

  The number of delayed pathways of care had reduced since the high point in February 2024.

- Cancer: it was noted that the January Single Cancer Pathways compliance had closed at 65% and that the same was expected for February 2024.

  The COO advised the Board that there was confidence in a 75% target being achieved by June 2025.

- Planned care: it was noted that a lot of focus had been put onto planned care and that 2400 patients had waited longer than 2 years for their treatment however that was the best position noted since July 2024.

  It was noted that the 45 patients had been waiting over 3 years for treatment but that their care was complex and required a lot of planning.

  The COO advised the Board that updated figures would be provided at the next meeting.

  He added that the Planned Care Programme was revising its approach Outpatient Transformation and included the appointment of a Clinical Lead for Outpatients and alignment with the national Clinical Implementation Networks (CINs) to drive best practice.

  The use of See on Symptoms (SOS) and Patient Initiated Follow-up (PIFU) pathways was an important tool in the management of follow-up services and the Health Board continued to develop their use across services with additional clinical support from specialties who had successfully implemented those pathways.

The COO concluded that waiting list data would be received by the Finance & Performance Committee moving forward. **ACTION**

- Diagnostics: it was noted that the data was not included in the paper but that improvements had been made with week on week reductions on the waiting lists for non-obstetric ultrasound.

People & Culture:

The Deputy Director of People & Culture (DDPC) advised the Board she would take the paper as read and would highlight key areas.

- Sickness: it was noted that an MDT approach was in place on sickness and absence and that monitoring of the data was taking place on a monthly basis to see improvements and being reported to the People & Culture Committee.

- Retention: it was noted that retention rates continued to improve with the Health Board sat at a healthy range of 7-9% and noted a significant improvement in nursing.

- Management and Leadership Development: it was noted that a comprehensive review of management development materials and training was underway to ensure alignment with organisational priorities and strategic objectives.

- Building Workforce Planning Expertise: it was noted that a draft programme of work for 2025/26 was currently under development, and would describe the priorities for building workforce planning capability and expertise across the Health Board. This would initially focus on refining short term resource planning, i.e. improving efficiency of current workforce resource and developing operational workforce plans to support the IMTP planning process.

The Independent Member – Trade Union (IMTU) asked if the Team know how many people have been off over the past 3-6 months with flu and if it correlated to the low vaccination rates.

The DDPC responded that it was a timely question because the workforce team were working with the Public Health Team to look at sickness data around respiratory illness.

She added that the current average was around 152 WTE per month which was a significant figure.

The IMTU asked how often the exit interview data was calculated.

The DPPC responded that it was done quarterly, and so refreshed figures would be available at the next meeting.

Quality

The END advised the Board that he would take the paper as read and would highlight key issues which included:

- The Quality Committee maintained close oversight of key quality, safety, and patient experience metrics. Regular performance reviews enabled the committee to assess outcomes and provide strategic recommendations for continuous improvement.

- Complaint Resolution - A greater emphasis was placed on early triaging and prompt resolution of concerns to prevent escalation. Under the updated 2025 guidelines, a higher volume of inquiries were now resolved on the same day. However, persistent challenges—such as extended wait times and communication barriers—required targeted interventions.

- Infection Control Measures - Rising Infection Rates were noted with an increase in C. difficile and P. aeruginosa cases which had prompted executive-led oversight to strengthen infection control measures and enhance outbreak response protocols.

  The END advised the Board that an antimicrobial action plan was in place to identify and implement necessary improvements.

- Nationally Reported Incidents (NRIs) - In February 2025, 19 NRIs and one Never Event were reported.

- Mortality – The EMD advised the Board he would take the report as read and noted that the graph was available within the report and showed the themes.

The UHB Chair asked when the last deep dive was Infection, Prevention & Control (IPC) measures was received at the Quality Committee.

The END responded that IPC data was received at every Quality Committee and that a specific deep dive had taken place recently.

It was noted that there was another point to raise around Prevention of Future Deaths (PFD) which was not included within the report.

The END noted that there were currently 345 open inquests and that the Health Board had 15 to answer to over the next month.

He added that over the past 2 years, 26 PFDs were issued across Wales and that the Health Board had received 3 of those:

- One related to an incident in Cardiff prison with the conclusion that recommendations and improvements needed to be taken through the Quality Committee.

- Another related to silencing of alarms in the cardiology unit where a Patient then died and so the Health Board had reported improvements to the coroner which they were happy with and it was noted that the Health Board had taken further step as there were lots of patient alarms.

- The final one related to the death of gentleman who had fallen in St. Davids Hospital and had been received from the coroner within the last 7-10 days and was being reviewed and recommendations looked at.

The END added that PFD was on the agenda for the Quality Committee. ACTION

The CEO asked for the END to provide assurance that there were no outstanding PDFs and noted that the concerns team dealt with them in a timely manner.

The END confirmed that there were no outstanding PFDs.

	Digital: The Director of Digital & Health Intelligence (DDHI) advised the Board that he would take the report as read. He noted that the report continued to provide Key Performance Indicators (KPIs) in terms of incidents and IT requests and noted a downward trend and improvement in response rates. It was noted that the implementation of Microsoft Teams Phone Calls would help with organisational efficiency as well as reducing costs. The DDHI concluded that the Digital Foundations piece was being developed and would be received by the Board later in the year. ACTION. **The Board resolved that:** a) The year to date position against key organisational performance indicators for 2024-25 and the update against the Operational Plan programmes was noted.	
UHW 25/03/013	**Safeguarding Annual Report 2023/24** The Safeguarding Annual Report 2023/24 was received. The CEO asked if it has been received by the Quality Committee. The END responded that it had been to the Safeguarding Steering Group, the Quality Committee and now onto Board. The UHB Chair noted their concern at the amber/red outcomes within the report. The END responded that all of the work was undertaken in partnership with Local Authority Colleagues and could not be done with their input. He added that the report had been discussed through the Regional Safeguarding Board for Cardiff and the Vale. The UHB Chair asked that the END's opinion was on how the Health Board worked in partnership. The END responded that the Health Board worked very well with partners and provided very effective work. **The Board resolved that:** a) The information enclosed in the report was considered b) The performance and direction of the safeguarding agenda was approved.	
UHW 25/03/014	**Annual Plan 2025/26** The Annual Plan 2025/26 was received. The EDF reminded the Board that on 14th February 2025, the Health Board submitted an accountable officer letter to Welsh Government confirming that due to ongoing sustainability challenges, the Health Board would be submitting an Annual Plan within a three-year context to balance the immediate system challenges with the health and care needs of our population.	

She added that the plan was presented in the context of a significantly challenging operating environment and aimed to respond effectively to those challenges in the short term whilst laying the foundations for a sustainable future.

The Board was advised that an assessment against the Cabinet Secretary Enabling Actions and indication of anticipated opportunity was also included within the plan document, with the vast majority of actions assessed as "adoptable", with rationale for those actions more difficult to achieve in the current context.

It was noted that the Annual Plan, which detailed the first year of execution of the strategy, was developed through engagement with clinical boards and corporate teams, with regular Board Development Sessions and frequent dedicated Planning Sessions with the Senior Leadership Board.

The Board were advised that a Rapid Planning Event in December 2024 brought together around 200 leaders within the organisation to support development of key principles and priorities for our 2025/2026 plan.

The Board held a discussion on the Annual Plan 2025/26 led by the EDF which covered several important aspects:

- **Submission of the Annual Plan:** The board supported the submission of the annual plan to Welsh Government by the 31st of March 2025.
- **Efforts to Reduce Financial Deficit:** There was a strong emphasis on making every effort throughout the year to move the forecast financial deficit of £58.2 million as close as possible to the £9.1 million financial control total allocated.
- **Reprioritisation of Activities:** The board discussed taking all opportunities to deprioritise activities identified as key financial drivers of the deficit position. Each opportunity was to be reviewed, evaluated, and implemented before the end of quarter 1 of 2025/26, where appropriate and possible.
- **Savings Opportunities:** The board highlighted the need to continuously identify, explore, and vigorously pursue savings opportunities throughout the year to ensure full delivery of a minimum of £30 million cash-releasing savings as per the plan.
- **Strategic Planning and Collaboration:** The importance of strategic planning and collaboration with other health boards and stakeholders was emphasised.
- **Diagnostic Services:** The diagnostic services were specifically mentioned, with a focus on reducing the backlog and improving efficiency. The board discussed the need for additional sessions and support to meet the diagnostic demands.

The EDF emphasised the that the strategic priorities were the Health Boards to meet and stressed the importance that the Annual Plan was owned by the Health Board.

She added that there may be some overlap with ministerial priorities.

It was noted that despite the well-compiled plan, the financial concerns needed to be addressed, particularly the challenges in achieving the required savings

	and managing the budget deficit to ensure the successful implementation of the plan. The Chair of the Stakeholder Reference Group (CSRG) asked if the Health Board were submitting the plan knowing it would be rejected by Welsh Government. The EDF responded that because the plan was in the deficit, the plan would be deemed un-approvable by WG but noted that that had been the position for over 4 years and so the Health Board had to show a way to progress. She added that the reality was that WG had provided the Health Board with a control total and even if it could hit that total, the plan would still be un-approvable, and that finance needed to be seen in the context of everything else. The IMF noted that the "Summary of our Quality Improvement and Efficiency Plan Ambitions for 2025/2026" identified a lot of "TBC" and asked if that meant they had not been worked up sufficiently at that stage. The EDF responded that it was appropriate to have those under some of the headings because a lot of the numbers were set at targets as opposed to definite numbers. The COO advised the Board that the organisation was being put on notice that a restructure would be taking place which was one of the key areas that came from the Rapid Planning Event held in December 2024. He added that work would commence on that process moving into April 2025. The IMF noted that the deadline for the supporting letter was Monday 31st and asked what the nature of the letter would be. The UHB Chair responded that the letter would be shared with all Board members. He added that the recommendations noted in the report needed to be changed because the Board were not able to approve the annual plan and suggested changing to: **The Board resolved that:** a) The board supported the submission of the annual plan to Welsh Government in line with the requirements to do so by the 31st of March 2025.	
UHW 25/03/015	**Llantrisant Health Park (LHP) & Regional Endoscopy Plan** The Llantrisant Health Park (LHP) & Regional Endoscopy Plan was received. The EDF advised the Board that the project was planned to be completed by September 2027 and there was a strategic plan to create the required capacity for the health park which involved ensuring that the infrastructure, staffing, and resources were adequately prepared to support the operations once the health park was completed. She emphasised the need for that detailed strategic planning to ensure the successful implementation and operation of the health park which included addressing potential challenges, resource allocation, and coordination with various departments and stakeholders.	

	The UHB Chair noted the uncertainty, the challenges and the complexities associated with the Llantrisant Health Park project and other operational aspects such as the Endoscopy services, particularly about the capacity to meet the demand. **The Board resolved that:** a) The overall position in respect of regional service planning and the recent direction from the NHS Wales Chief Executive was noted b) The documents that were prepared as an initial response were noted. c) The local assessment / position statement was noted and endorsed d) The commitment to commission additional capacity and associated growth as set out in the plan, from the LHP facility from 2027/28 with a commitment to maximising internal efficiencies and detailed workforce planning as a part of the developing regional plans was endorsed e) A delegation to Chair and CEO to give final sign off on the endoscopy plan (subject to no changes to finance and activity numbers) when final revisions have been made was endorsed.	
UHW 25/03/016	**Standing Orders Update** The Standing Orders Update was received. The DCG advised the Board that there was a need to ensure that the standing orders were aligned with the latest governance requirements and best practices. He added that it included updating the standing orders to reflect any changes in legislation, regulatory requirements, and organisational policies and emphasised the importance of clear and transparent decision-making processes, as well as the need for regular reviews to ensure that the standing orders remained relevant and effective. **The Board resolved that:** a) The changes to Standing Orders were approved. b) The change to the scheme of delegation to reflect Standing Orders was noted.	
UHW 25/03/017	**End of Life Business Case** The End of Life Business Case was received. The COO advised the Board that the case had been to the investment group twice and formed part of the Health Boards strategy to move care into the community. The COO emphasised the need for a comprehensive approach to end-of-life care, highlighting the importance of providing compassionate and dignified care for patients in their final stages of life. He noted that there was a focus on improving the coordination of services across different departments and ensuring that patients and their families received the necessary support and information. **The Board resolved that:** a) The Palliative and Supportive Care Business Case was approved.	
UHW 25/03/018	**Annual Equality Report** The Annual Equality Report was received.	

	The EDPC advised the Board that the Public Sector Equality Duty, as set out under the Equality Act 2010, required the Health Board to report annually on its progress against its strategic equality objectives. She added that the Annual Equality Report captured organisational progress in meeting the objectives between April 2023 – March 2024 and noted that it would be the final report outlining progress against the Strategic Equality Plan: Caring about Inclusion 2020-2024. The next iteration of the report would outline our progress against the Health Board's Strategic Equality Objectives and Plan: Shaping Our Inclusive Culture 2024-2028, which was approved by the People & Culture Committee and Board in March 2024. **The Board resolved that:** a) The Annual Equality Report 2024 for publication on the Health Board's website was approved.	
UHW 25/03/019	**Primary Care Eye Health Needs Assessment** The Primary Care Eye Health Needs Assessment was received. **The Board resolved that:** a) adequate assurance had been provided to meet the requirement as set out in the Optometry Directions for the Health Board to prepare a Cardiff and Vale Eye Health Needs Assessment, to be published by the end of March 2025, and which was an evolving document to be reviewed every 3 years.	
UHW 25/03/020	**Corporate Risk Register** The Corporate Risk Register was received. **The Board resolved that:** a) The Corporate Risk Register was **noted.**	
UHW 25/03/020	**Audit Wales Structured Assessment 2024** The Audit Wales Structured Assessment 2024 was received. **The Board resolved that:** a) Audit Wales Structured Assessment 2024 was **noted.**	
UHW 25/03/021	**Audit Wales Annual Audit Report 2024** The Audit Wales Annual Audit Report 2024 was received. **The Board resolved that:** a) The Audit Wales Annual Audit Report 2024 was noted.	
UHW 25/03/022	**Reports from Advisory Groups and Joint Committees** The Reports from Advisory Groups and Joint Committees were received. **The Board resolved that:** a) The Reports from Advisory Groups and Joint Committees were **noted**.	
UHW 25/03/023	**Committee, Advisory Group and Joint Committee Minutes:**	

	The Committee, Advisory Group and Joint Committee Minutes were received. **The Board resolved that:** a) The Committee, Advisory Group and Joint Committee Minutes were **noted.**	
UHW 25/03/024	**Any Other Business** No other business was raised.	
	Time & Date of the next Meeting: 27 March 2025 at Woodland House, Coed Y Bwl.	

ACTION LOG

Public Board Meeting

27 March 2025

MINUTE REF	SUBJECT	AGREED ACTION	DATE DUE	LEAD	STATUS / COMMENT
Actions					
UHW 25/03/012	**Digital Foundations**	Digital Foundations piece to be developed and received by the Board later in the year.	25.09.2025	David Thomas	**ACTION IN PROGRESS** On Forward Plan for September's Board Meeting.
UHW 25/03/012	**Integrated Performance Report (IPR) - Operational**	Planned care: Updated figures on 52, 104 week waits to be provided at the next Board meeting	29.05.2025	Paul Bostock	**ACTION COMPLETE** On the IPR for May Board and all future IPR
UHW 25/03/012	**Integrated Performance Report – People & Culture**	Exit Interview data to be provided to the Board via the IPR at future meetings.	29.05.2025	Rachel Gidman	**ACTION COMPLETE** On the IPR for May Board and all future IPR
Actions referred <u>TO</u> Committees of the Board/Board Development					
UHW 25/03/012	**Integrated Performance Report (IPR) - Operational**	Waiting list data would be received by the Finance & Performance Committee moving forward.	21.05.2025	Paul Bostock	**ACTION COMPLETE** F&P Committee received data via IPR at meeting held 21.05.2025
UHW 25/03/012	**Integrated Performance**	Preventable Future Deaths (PFDs) to be received by the Quality Committee	24.06.2025	Jason Roberts	**ACTION IN PROGRESS** On Forward Plan for June's Quality Committee meeting.

	Report (IPR) - Quality				

Report Title:	**Chair's Report to Board**				Agenda Item no.	6.2	
Meeting:	**Public Board**		Public	X	Meeting Date:	**29 May 2025**	
			Private				
Status *(please tick one only):*	Assurance		Approval	X	Information		X
Lead Executive Title:	**Chair of the Board**						
Report Author (Title):	**Head of Corporate Governance**						

Main Report
Background and current situation:

1. **SITUATION/BACKGROUND**

This report aims to provide an update to the Board on relevant matters in my capacity as Chair of the Health Board, where I highlight key areas of activity including Board business and topical areas of interest.

2. **SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING**

2.1 Board and Committee Membership

A. I am delighted to announce that the Cabinet Secretary has re-appointed the following Independent Members for a further 4 years:

- Ceri Phillips in the role of Vice-Chair
- David Edwards as the Independent Member for Information Communication & Technology
- Mike Jones as the Independent Member for Trade Union.

All three are valuable Board Members and I am grateful for their support and commitment to continue working with the Board.

B. I am delighted to announce the Cabinet Secretary for Health and Social Care has appointed Clive Curtis as a new Independent Member of the Board for 4 years from the 2 June 2025. Clive joins us from Glamorgan Voluntary Services where he worked for 25 years and has a wealth of experience in the Third and Public Sectors. I look forward to welcoming him to the Board at our next Board meeting.

2.2 Board Development Session – 24 April 2025

During the Board Development session, the following items were discussed:

1. Cyber Security – an update was provided on cyber security arrangements

2. Patient Safety Walkarounds – the Board received an update on the model of Patient Safety Walkarounds and discussed how the Health Board can make best use of these moving forward.

3. Integrated Performance Report – Full review of performance

4. NHS Confederation – awareness raised of the political landscape in Wales.

5. 2025-2026 Annual Plan update

6. Update on regional working- the Board discussed this following ministerial directive to set up a Joint Regional Committee for South Wales.

2.3 Diary Highlights since the last Board Meeting

Visit to Maelfa Wellbeing Hub, Cardiff

I was delighted to visit the District Nursing Team at the Maelfa Wellbeing Hub in April with Jenny Rathbone, MS and Jason Roberts, Executive Nurse Director. The team do tremendous work and it was very insightful to learn about the great work that they do in the Community.

Lipid Unit – University Hospital Llandough

I was delighted to visit the Lipid Unit based at Llandough Hospital in March which is the largest Low-Density lipoprotein (LDL) Apheresis Centre within the UK.

The unit was established in 1990 due to an interest in lipid management from the then Medical Biochemist Dr Stephanie Matthews. Lipoprotein Apheresis was initiated by becoming a sister centre to The Hammersmith Hospital in London for a dual centred study. Some 35 years later, the unit is flourishing with 4 Lipoprotein Apheresis beds treating daily for patients with severe Familial hypercholesterolaemia to prevent cardiovascular disease progression.

Lipoprotein apheresis is a method of removing LDL (bad) cholesterol and other fats from the blood similar to a dialysis machine. Lipoprotein apheresis is considered for patients who have tried all cholesterol lowering drug treatment but still have a high LDL cholesterol level and progressive cardiovascular disease.

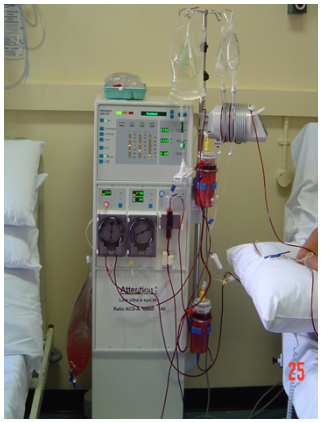
Lipids/cholesterol are fatty, waxy, or oily compounds that are essential for the body. However, if you have elevated levels or have an inherited high cholesterol such as familial hypercholesterolaemia then your risk of cardiovascular disease and early onset of cardiac events such as angina, stroke and heart attach increase exponentially. Most people can be treated with medication such as statins but patients with genetic changes will need further treatment which if treated to target guidelines can greatly reduce cardiovascular risk and events.

HELP lipoprotein Apheresis machine

Since opening the team have treated over 50 patients travelling from Eastbourne to Pembroke, patients visit every 2 weeks to receive a gruelling apheresis treatment but knowing it considerably reduces their risk of cardiovascular events. Patients who attend do so for many years, enabling the team to build up a huge rapport with them, as they do with each other.

The unit is now lead by Professor Dev Datta, and 4 nurses who have over 48 years of working lipid experience accumulated, all with a background experience in cardiology. The unit is the only one of its kind in Wales. The Unit offers 2 different treatment option for lipoprotein apheresis (as shown below) which is unique to the UK and offers treatment diversity for all patients referred to for lipoprotein apheresis. The unit currently has 17 patients from age 30 – 75 years, some who have had treatment for over 30 years having cardiovascular events in their 2nd or 3rd decade of life.

DALI lipoprotein Apheresis machine



Due to the extensive increase in lipid lowering therapies and the recognition by novel lipid lowering successful studies, the unit also offers other not so demanding but lifelong therapies. The team educate and support patients commencing on injectable therapies which with a combination of medications, can bring cholesterol levels to previously unrealistic target guidelines and reduce a patient's risk of a cardiac event to an extremely low level.

Three different types of injectables are offered in individual clinic settings in the Lipid Unit. The clinics are Nurse led. Patients are supported and reviewed on a regular basis ensuring that their health and wellbeing is met at all times. The Unit also perform other biochemistry testing and treatments such as weekly magnesium infusions, iron infusions and hormone testing.
The unit is a very happy sociable setting, offering support, education and treatments for patients aiming for their lives to continue free of risk and illness. Patients are reassured and confident that their lives can continue where not so long ago they would need countless admissions and interventions to keep them alive.

The lipid unit is proud and committed to helping, educating and supporting patients and their families. They are not just dealing with patients but many of their family members who can and are affected with this silent killer, hence family testing is required, which is also a service that the team also provides.

Vice-Chair report on visit to the Podiatry Service

Podiatry
Podiatreg
Promoting Foot Health
Hyrwyddo Iechyd Traed

I recently had the pleasure of meeting team members of CAV Podiatry services, part of the Therapies directorate. The passion for their profession and the difference they are making to their patients was palpable.
Podiatrists prevent, diagnose, and treat problems affecting the foot, ankle and leg. They see patients with a range of conditions that require medical, surgical, or palliative intervention, or rehabilitation and preventative care. Podiatrists play an essential role in managing general health conditions, including a range of systemic conditions such as diabetes, that can affect the lower limb. The podiatry service provides a wide range of outpatient and community services for both adults and children throughout Cardiff and the Vale of Glamorgan including a small in-reach service supporting the Southeast Wales vascular centralisation.

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board
Cyfarwyddiaeth Therapïau
Therapies Directorate

I was impressed by the ambition held by this small team who are clearly focused on delivering value-based healthcare (VBH), demonstrated by their robust strategic plan that outlines their specific contributions to our UHB strategic priorities. The podiatry services IMTP was used by the Integrated Planning Group as an exemplar for the UHB. The leadership team are passionate about aligning practices to the Allied Health Professionals (AHP) framework for Wales and influencing and guiding podiatric practices across Wales via the professional network.

Safe, effective, high-quality services were on display during my visit and the team were keen to showcase particular initiatives that highlight their innovative culture.

Quick change, a collaboratively produced interactive animation enhancing the promotion and encouragement of daily movement in children, including improving strength and balance. Developed by Podiatry and the local public health team, quick change has been launched in schools across Cardiff and the Vale of Glamorgan. It is widely recognised that 1 in 4 children suffer MSK pain, with foot pain being the most common MSK problem in ages 10-13 years. Acting for the future is an essential priority of the podiatry service with quick change, part of a programme of prevention projects the service is working on to support people to live healthier lives.

The burden of living with diabetes and the complications that can occur are well known to the podiatry staff who lead the UHB diabetes foot service. Prompt access to an expert health care professional (HCP) for people living with diabetes who experience a 'foot emergency' is essential, building on the success of the diabetic foot 'walk-in' clinic. The introduction of diabetic foot emergency early triage (**DFEET**) clinics provides a 'one stop shop' for all assessments, diagnostics and care including prescribing, by their independent prescribing podiatrists. This has supported delivery of care within NICE NG19 guidelines of 48 hours and demonstrated one of the best healing rates for diabetes related foot ulcers in England and Wales. Improved patient outcomes and changes to service delivery in this pilot project also demonstrate the significant cost savings that could be made to the UHB with reallocation of resources, reducing duplication and reducing the need for hospital admission. The impact of this work, a Bevan exemplar project, was recently recognised in the international **Journal of Wound Care Awards 2025** where **DFEET** won the best diabetic foot intervention.

A keen focus on **value-based healthcare** within the podiatry service has led to a service redesign of the musculoskeletal (**MSK**) podiatry provision by identifying patient, technical, allocative and social value. This has enabled a reduction in variation in pathological specific clinical pathways, identification and elimination of interventions of limited or no value and, reduction in variation in the provision of orthotics within the service. Efficiency has been facilitated through increased productivity and higher quality personalised interventions.

Workforce redesign was evident throughout, ensuring all team members value and impact is maximized, evidenced by the introduction of point of care ultrasound (**POCUS**) and corticosteroid injections for foot and ankle pathologies. This will significantly reduce waiting times and improve clinical outcomes. Again, offering a 'one stop shop', will reduce the need to be seen by other departments and HCPs. Similarly, reallocation of resources to the podiatry service will also release cost savings to the UHB, with care closer to home, provided by the right person at the right time.

A Service Level Agreement with Cardiff Metropolitan University allows the podiatry service to deliver undergraduate education in the Allied Clinical Health Hub to podiatrists and other healthcare professionals in training. This includes providing **P**odiatry **A**ccessible **C**are for **E**veryone (**PACE**), a clinical offering co-designed with patient and public involvement to offer access to podiatry interventions that do not meet the criteria for NHS care. Delivered by undergraduate students under supervision by UHB staff also provides an opportunity for income generation to the UHB.

NIHR | National Institute for Health and Care Research

The podiatry service established its research and development (R&D) strategy 5 years ago with focus on both portfolio and commercial R&D. The progress in this area was epitomised last year by the successful application for funding via **Research for Patient Benefit (RfPB).** Run in collaboration with CEDAR, **HELPP** is a feasibility study to develop personalised treatment pathways for relief of plantar heel pain using a sequential multiple assignment randomised trial (SMART) study design. It is hoped this will further support their development of efficient pathways to improve patient reported outcomes and deliver value-based healthcare within the service. The podiatry service boasts involvement in research studies in all elements of its service provision including podopaediatrics and diabetes related foot disease. This is an ever-expanding aspect of the services and continues to develop staff, income generate and improve patient outcomes.

For more information of our Podiatry Service please see Podiatry - Keeping Me Well

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 - Fixing the Common Seal/Chair's Action and other signed Documents since the last Board meeting

The **common seal** of the Health Board has been applied to **4** documents since as listed below;

Seal No.	Description of documents	Background Info/value
1115	HoT Lease Renewal for Unit 1 & 2 Bridge Road Treforest 5 Years from 16th Oct 2024	£267,500 per annum + VAT
1116	Lease of part of the former West Services Building, Grand Avenue, Ely	N/A
1117	Loudoun Square - Dental Service - Underlease	£8200 pa
1118	Loudoun Square - Dental Service - License to Alter	N/A

The following **12 x Legal Documents** are reported as having been signed on behalf of the Health Board;

Date Signed	Description	Background info/value

04.03.25	WEQAS Unit 1 Refurbishment	£147,853.98 (excluding VAT)
05.03.25	DC24136 UHW Heulwen South Roof Covering	£85,682.94 (excluding VAT)
04.03.25	DC24128 UHW Haematology B1-C1	£56,317.27 (excluding VAT)
06.03.25	DC24073 - UHW Water Mains	£447,730.64 (excluding VAT)
11.03.25	DC24110 - UHW Block 10 Ward Block A (URGENT ROOFING)	£488,258.88 (excluding VAT)
13.03.25	DC24023 - UHL Nuclear Medicine Office This refurbishment is critical to provide a compliant clinical environment for the drawing up and disposal of Radiopharmaceuticals	£44,737.12 (excluding VAT)
18.03.25	DC24142 - UHW Outpatients Steel Profiled Roof Refurbishment urgent refurbishment of the steel profiled roof at UHW Outpatients. The existing roof covering has reached the end of its life, causing water ingress and interrupting service delivery.	£302,394.44 (excluding VAT)
12.05.25	Heads of Terms for Lease Renewal - Unit 4, Parc Ty Glas The lease renewal is for Unit 4, Parc Ty Glas, Cardiff. The term of the lease is 5 years, commencing on 31/07/2025	£48,118 (excluding VAT)
26.03.25	Lease of part of the former West Services Building, Grand Avenue, Ely	N/A
10.04.25	Loudoun Square - Dental Service - Underlease	£8200 pa
10.04.25	Loudoun Square - Dental Service - Licence to Alter	N/A
15.04.25	Contracts for the provision of clinical psychology education and training services by Cardiff and Vale University Health Board (CAVUHB) on behalf of Health Education and Improvement Wales (HEIW) require sign off	N/A

The following **1 x Chairs Actions** have been taken on behalf of the Health Board; The Board is requested to ratify these decisions in accordance with Standing Orders;

Date Received	Chairs Actions Details	Background Information	Date Approved
24.04.25	Regional Endoscopy Plan April 2025	The Regional Endoscopy Plan outlines the collaborative efforts of Aneurin Bevan, Cardiff and Vale, and Cwm Taf Morgannwg University Health Boards to deliver high-quality, sustainable	28.04.25

		endoscopy services in South East Wales. The plan includes a demand and capacity assessment for the next four years and proposes the development of joint capacity, including a new facility at Llantrisant Health Park (LHP)	

Recommendation:

The Board is requested to:

a) **NOTE** the report.
b) **APPROVE** the Chair's Actions undertaken.
c) **APPROVE** the application of the Health Board Seal and completion of the Agreements detailed within this report.

Link to Strategic Objectives of Shaping our Future Wellbeing:
https://shapingourfuturewellbeing.com/

Putting People First **Click the objective above to view more detail.**		Providing Outstanding Quality **Click the objective above to view more detail.**	
Delivering in the Right Places **Click the objective above to view more detail.**		Acting for the Future **Click the objective above to view more detail.**	

Five Ways of Working (Sustainable Development Principles) considered
Please place an "X" in the below boxes as relevant

Prevention		Long term		Integration		Collaboration	X	Involvement	

Saunders,Nathan
14/07/2025 14:46:53

Report Title:	**Chief Executive's Report to Board**				Agenda Item no.	6.3
Meeting:	Public Board		Public	x	Meeting Date:	29 May 2025
			Private			
Status *(please tick one only):*	Assurance	X	Approval		Information	
Lead Executive:	Chief Executive					
Report Author (Title):	Head of Corproate Governance					

Main Report

1. INTRODUCTION

As we enter the new financial year, I will update the Board on the position of the Annual Plan for 2025-2026 and give Board assurance that work is continuing to deliver the Strategy Shaping our Future Wellbeing and the associated strategic objectives we must deliver to fulfill the vision.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING

2.1 Annual Plan 2025-2026

As set out in my March Board report, the planning context for the 25-26 Annual Plan is extremely challenging. The Annual Plan was submitted to Welsh Government in March as required, which set out a number of caveats which were discussed at length during the last Board meeting.

Following submission Welsh Government returned the plan on the basis that it was unsupportable and unacceptable as a result of the financial plan and requested the Health Board (HB) review this and provide an updated position by the 9 May which has been completed. Feedback on the wider content of the plan is yet to be received.

The original plan set a forecast outcome of £58.2 million deficit position by the end of March 2026. Confident savings plans have been identified in the sum of £25.264m at the point of drafting this report. Collaborative work continues with Senior Leaders across the HB to de-risk the original £30m savings plan. A finance summit held on the 30 April & 1 May contributed to the de-risking of the savings plan and identified opportunities for further improvement. This focus will continue, and opportunities will be interrogated and confidence strengthened so that when possible and with the Board's agreement the forecast can be improved.

In addition, the Executive Team have now had the first Targeted Intervention meeting with Welsh Government on the 15 April where the Annual Plan and performance against key indicators of strategy and planning were discussed. The Escalation Framework which will set out the requirements for the HB to move towards de-escalation will be articulated by Welsh Government and is yet to be received. The HB is committed to move out of escalation as soon as possible and work is underway with the Strategic Leadership Team, the Board and stakeholders to achieve this.

2.2 Ministerial Advisory Group (MAG) Report

The HB is grateful for the work undertaken by Sir David Sloman and his MAG colleagues commissioned by the Cabinet Secretary to review performance and productivity in Wales and we welcome the findings and note the response of Welsh Government largely accepting in full or in part the recommendations made.

The Report is helpful and will work together with Welsh Government and NHS Executive colleagues and relevant stakeholders to implement the recommendations that have been agreed. Specifically in relation to Recommendation 8 made explicitly for the HB, I can confirm that work has progressed in relation to reducing the Non-Obstetric Ultrasound backlog and improvements are being made with a reduction in patients waiting from a high of 9,496 waiting over 8-weeks in September 2024 to 7,371 in March 2025. There is a trajectory in place to clear the Non-Obstetric Ultrasound backlog and assurance is provided to Board that there is a plan in place to clear the Non-Obstetric Ultrasound backlog by the end of March 2026. Further updates will be provided to Finance & Performance committee.

2.3 Strategic Objectives

Putting People First

Theatres Comprehensive Service Review: As set out in my last report, Board will be aware of the work undertaken to address cultural issues across the HB. One of the departments of concern has been the Operating Department at University Hospital Wales. The Chief Operating Officer commissioned a comprehensive service review which was published earlier this month into those concerns. The Report sets out a range of serious issues relating to leadership, clarity in roles and responsibilities, ineffective communication, and behaviours inconsistent with the values of the organisation alongside estate and infrastructure issues. Of particular concern a lack of compliance with safety measures, consent procedures and the World Health Organisation (WHO) Surgical Safety Checklist.

The Chief Operating Officer will present the Report with a detailed brief later in the Board meeting. The findings outlined by the Report are deeply concerning and extremely disappointing, it is not an easy read. I personally apologise to any patient, family member or colleague who has been adversely affected by the issues raised or has been anxious about the findings.

I accept the findings of the report and give assurance to patients, colleagues, the Board, Welsh Government and stakeholders that I will work with colleagues to address the issues at pace, articulate a clear plan of action and remediation and improve safety for all. Regular updates on progress will be provided to the relevant sub-committees and Board.

The reputation of the HB and its approach to protecting the safety and dignity of patients during surgical intervention has been severely damaged and I acknowledge my accountability and responsibility for that. I understand that there is now a lot of work to be done to regain the trust of those who rely on us when they are most vulnerable and in need of the HBs expertise, care and compassion and I commit to work alongside colleagues in a purposeful way to regain the confidence of all.

Staff Survey 2024: Part of the work I have been doing to understand and address team and cultural issues has been around the Staff Survey. One of the ways in which we are trying to create a different dialogue in the organisation is to give the opportunity for safe spaces where authentic and honest conversations can take place via Staff Survey Focus Groups. I am grateful to all colleagues who have joined these sessions and found the time to share feelings and observations so freely and with passion. I have found these sessions extremely insightful and powerful.

The sessions are now evolving into a broader platform for meaningful team-led engagement, where future agendas and discussions are shaped by colleagues and a dedicated Teams channel has been launched to support continuous dialogue, idea sharing, and connection. Additional sessions are planned for 2025/26 to embed this new way of engaging as a core feature of organisational

culture change. I encourage anybody with an interest to support this work to join these sessions. It would be particularly good to see more healthcare professionals in the room.

International Nurses Day 2025: I was delighted to see all the great celebrations across the HB to celebrate International Nurses Day this year. The compassionate care I know nurses, healthcare support workers and midwives are providing across the HB, within nurse-led clinics, in people's homes and in the wider community contributes significantly to achieving outstanding quality for patients. The commitment from nurses to providing personalised, safe and equitable care with kindness and compassion has a massive effect not only on the lives of the patients, but also for their families and their loved ones. It was great to see the video from Deputy Executive Nurse Director Natasha Goswell recognising the great nurses we have in the team in her update International Nurses Day 2025.

I am immensely proud of all the the great work that nurse do to support patients inside and outside of the health setting. I'm aware that some nursing colleagues have really excelled in doing some truly great things including cardiac rehabilitation nurses running with patients at Park Runs, palliative care nurses launching Every Moment Matters to bring enhanced dignity to end-of-life care and, critical care nurses leading the Gloves Off campaign to reduce unnecessary plastic glove use. It was also fantastic to see Madeline Watkins named Royal College of Nursing Wales Nurse of the Year for the great work she has undertaken with older adults experiencing psychosis and the national recognition given to Caroline Trezise for her support of bowel cancer patients.

It is humbling to see the compassion, innovation and care all my nursing colleagues bring every day. I thank you for all that you do every single day.

Providing Outstanding Quality

CAVUHB Library Services: There has been some great work underway to improve the quality of services offered by the Library Services Team. The Library Services Team support health professionals in delivering high quality patient care by ensuring colleagues have access to the latest, reliable information and the necessary knowledge to find and use research in their practice and to make changes that improve services.

At the start of 2024 the Library Services Team made a commitment to grow their literature search service in recognition of the lack of time available to practitioners to find trustworthy evidence-based materials, and to keep abreast of the ever-increasing volume of healthcare research.

This has been extremely successful thus far: the number of searches carried out for colleagues increased from 41 in 2023 to 116 in 2024 showing a 183% increase and a total of 327.25 hours being spent carrying out searches. What is great to see is that the Service is being used by an array of colleagues including doctors, nurses and midwives, allied health professionals, pharmacists as well as administrators and managers. A study from 2022 (Edwards C *et al*) showed that each hour spent by a librarian saves a healthcare professional 3.85 hours. This means that in 2024 the health board saved 1,259.91 hours of team time finding information that was used for quality improvements such as: service development and planning; research projects and publication; development of guidelines and policies; complex patient care; as well as clinical audits.

The team has received overwhelmingly positive feedback as set out below:

"The team helped us to formulate a guideline ensuring we were using all available latest literature on topic. This service is invaluable when we are working clinically & trying to update guidelines"

"More effective and pragmatic use of therapist time, contributed to the development of a new group for patients, contributed to wider service developments"

"The literature search helped to inform the design of qualitative research in an ongoing clinical trial. The results from the research will help us better understand how surgical teams can effectively adopt and implement a new procedure"

The work undertaken here highlights the commitment to quality improvement and the strategic approach being taken to ensure the delivery of outstanding services within the HB and I pass on my thanks to all.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1Supreme Court Ruling

Following the UK Supreme Court's ruling clarifying the definition of "sex" in the Equality Act 2010 I wanted to make Board aware that as a large and diverse organisation, Cardiff and Vale University Health Board is committed to providing a lawful, safe and inclusive environment and we will take time to consider the practical implications for the HB seeking to be sensitive and respectful to the needs of all.

My commitment is that I will work with the appropriate stakeholders, seeking policy guidance from Welsh Government to ensure that all patients and members of the team have appropriate access to facilities that meet their needs and preserve their dignity. I will keep Board informed of this matter as this is worked through.

The Board is requested to:

NOTE the Strategic Overview and Key Executive Activity to provide assurance described in this report.

Link to Strategic Objectives of Shaping our Future Wellbeing: *Please tick as relevant*			
Putting People First Click the objective to view more detail		Providing Outstanding Quality Click the objective to view more detail	
Delivering in the Right Places Click the objective to view more detail		Acting for the Future Click the objective to view more detail	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention	x	Long term	x	Integration	x	Collaboration	x	Involvement	x

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: No

Safety: No
Financial: No
Workforce: No
Legal: No
Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation: No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Report Title:	Finance & Performance Committee – Chairs Report				Agenda Item no.		6.4
Meeting:	Name of Committee		Public	x	Meeting Date:		29.05.25
			Private				
Status:	Assurance	x	Approval		Information		
Lead Executive:	Executive Director of Finance						
Report Author:	Senior Corporate Governance Officer						

Background and current situation:

The purpose of this report is to highlight the key issues which were raised and discussed at the Finance & Performance Committee meeting held on **21 May 2025.**

The aim of the report is to provide assurance to the Board on the matters discussed at the Committee around the financial and operational situation of the Health Board.

Executive Director Opinion and Key Issues to bring to the attention of the Board:

The Committee considered several important items of business at the meeting and a brief synopsis of those items are set out in this report:

FINANCIAL REPORT – MONTH 1 POSITION (INCLUDING SAVINGS TRACKER)

The Committee was advised that the month 1 position had been measured against the £58.2m deficit, £49.1m over the control total target of £9.1m.

It was noted that following discussions with the Welsh Government, several steps were outlined and submitted on May 9th to address the deficit which included:

- **Step 1:** Ensure full delivery of a recurrent £30m savings programme to de-risk the £58.2m plan.
- **Step 2:** Drive further savings to achieve a full target of £60.5m, leading to a deficit position of £27.7m, no worse than the deficit position achieved in 2024-25.
- **Step 3:** Move closer to a deficit control total of £9.1m
- **Step 4:** Deliver a sustainable financial balance over a three-year period.

This meant that the overall financial position in month 1 being reported was a £6.096m deficit which was £0.420m over and above the planned deficit in month 1.

It was noted that the £0.420m was broken down as a savings programme deficit of £0.432m and an operational position surplus by £0.012m.

The Committee was advised that the savings programme deficit was driven by the current shortfall against the £30m savings programme and that at the end of month 1, £24.8m of schemes had been identified, leaving a shortfall against the savings target of £5.2m that was currently profiled across the year.

It was noted that the planned deficit profile would be reduced as the larger schemes started later in the year.

It was noted that whilst there had been that operational surplus of £12,000 it would be imperative to maintain the position throughout the year and ensure that all operational pressures were managed and mitigated throughout the year which would be undertaken through revised Clinical Board performance reviews and weekly Strategic Leadership Team meetings.

- **Workforce Position**

The Committee were provided detail on the workforce position, comparing month 1 expenditure in 25/26 to the same period in 24/25 which highlighted the growth in that area.

It was noted that workforce expenditure would be monitored month by month as the Health Board moved through the financial year and information would be presented to the Committee because a large part of delivery of the plan was around reducing workforce and the pay bill.

- **Non-pay**

Non-pay expenditure was identified as a primary driver behind the Health Boards deficit financial position in 2024/25 and the Committee were provided with information that reported year-to-date growth versus 2024/25.

It was noted that the Health Board had reported £93.7m of non-pay expenditure in month 1, which was an increase of 7.9% in the same period in the previous year. The large part of the increase was driven by expenditure in the following areas:

- Secondary Care & GP Prescribing
- Price and demand in Continuing Healthcare (CHC)
- Additional Commissioning cost including WHSCC under Healthcare Provided Services.

- **Savings**

The Committee was advised that at month 1, the Health Board had identified circa £25.1m (83%) of green and amber savings to deliver against the £30m savings target. Red schemes of £8.6m were also identified and continued to be reviewed for progression to green/amber where possible.

It was noted that the reported gap of £5.2m in identified savings incorporated red schemes and the unidentified balance and that red schemes were not included in accordance with the instruction from Welsh Government those red schemes be excluded from the Monthly Monitoring Returns savings tables.

The Committee were reminded that when the plan was supported back in March 2025, £7m of savings plans had been identified and that following the financial summit which took place in April 2025, £24m had now been identified showing a significant improvement.

- **Risks**

The Committee was advised that the key risk which fed into the Health Boards Corporate Risk Register was the failure of the Health Board to deliver a breakeven position by 2025/26 year end with a current planned deficit of £9.1m and a forecast out-turn against the planned deficit of £58.2m.

It was noted that the Health Board submitted its draft plan at the end of March 2025 there was an inherent risk in achieving the £58.2m planned deficit due to a £23m gap in identified savings against the £30m target.

Since the submission of the plan the savings gap had fallen to £5.2m at the end of month 1 due to an acceleration in savings identified.

It was noted that the savings gap of £5.2m would lead to an annual deficit of £63.4m in 2025/26 if further savings or mitigating actions were not identified as the year progressed.

- **Underlying Deficit**

The Committee was advised that the underlying deficit had deteriorated in recent years due to a combination of underlying deficit brought forward, recurrent cost pressures (including inflation), under-delivery of recurrent savings and demand-driven pressures in 2025/26.

It was noted that the underlying deficit of £59.9 had been brought into 25/26 and that the underlying deficit would reduce to £58.2 million if the current plan was fully delivered on a recurrent basis

- **Cash Position**

The Committee was advised that the Health Board would need to request strategic cash support from Welsh Government to cover the level of deficit finalised for 2025/26.

It was noted that the monthly monitoring returns to Welsh Government identified assumed cash allocations yet to be confirmed with the value of those unconfirmed allocations at month 1 being £139.2m.

That level of unconfirmed allocation combined with the forecast financial deficit (£58.2m) would need to be managed by the Health Board if it remained outstanding as the year progressed.

- **Public Sector Payment Compliance**

The Committee was advised that the public sector payment compliance performance was above the target of 95% and that performance for the month to the end of April 2025 was 96.5% for the year to date.

- **Capital Resource**

It was noted that the Health Board's approved capital resource limit was £34.387m which comprised of £15.227m discretionary funding and £19.160m towards specific projects (including Decarbonisation Funding, Lift Refurbishment and Pentyrch Surgery).

The Committee was advised that the programme was planned and monitored through the Health Board's Capital Management group and that the analysis of spend against planned schemes would be provided at future Committee meetings.

OPERATIONAL PERFORMANCE UPDATE

- **Urgent and Emergency Care** - the Committee were advised that a there had been a similar number of attendances in April 2025 compared to April 2024, with slightly reduced admissions through major streams.

It was noted that a challenging Easter period had led to a dip in performance, but 12-hour waits were down.

- **Delayed Pathways of Care** – it was noted that there were 150 delayed patients in April 2025, 35 fewer than the previous year and that there had been no significant improvement in the number of patients staying in hospital for 7 or 21 days.

- **Cancer Care** – it was noted that the March performance against the Single Cancer Pathway was 68.7% but it was expected to be lower in April due to increased referrals and issues in the prostate pathway.

The Committee was advised that there would be a focus on improving the urology cancer pathway.

- **Planned Care** – it was noted that focus has been driven on delivering Q1 targets, ensuring the number of patients waiting over two years did not increase.

The Committee was advised that there were plans to address three-year waits in ophthalmology and spinal with solutions expected by July and September 2025.

- **Diagnostics** – the Committee was advised that there had been a slight delay in non-obstetric ultrasound trajectory due to Easter pressures, but it was expected to be back on track by the end of May 2025.

It was noted that equipment breakdowns had led to significant loss of CT and MRI capacity, impacting patient appointments.

2025/26 DRAFT CAPITAL PLAN

- **Discretionary Capital Allocation** - it was noted that the Health Board's discretionary capital allocation for 2025-26 had been increased to £17 million and that the funding was crucial for addressing backlog maintenance and other essential schemes.

- **Targeted Estates Investment Fund** – The Committee was advised that the Health Board had been awarded an additional £7.8m over two years from the Targeted Estates Investment Fund however it required the Health Board to provide a 30% contribution.

It was noted that while the Health Board could have spent two or three times that amount, the discretionary allocation limited the ability to offer the full 30% contribution and so as a result, some schemes would be pulled into slippage bids for the next year to maximise the use of those funds.

- **Prioritised Business Cases** – it was noted that several business cases had been prioritised, including the expansion and refurbishment of the ITU the development of hybrid theatres, and the review of bone marrow transplant services due to JC accreditation requirements.

The Committee was advised that those projects were initially rejected due to their combined cost, but the teams had worked to combine them into a more affordable plan within the Welsh Government allocation.

- **Pre-existing Schemes** – it was noted that the capital plan included pre-existing schemes such as lift and electrical infrastructure refurbishment, digital schemes, and decarbonisation projects and that those projects had allocated funding and were part of the ongoing capital management efforts.

- **Operational Schemes** – it was noted that there was a pre-commitment to moving the cardiology ward, which was the final piece of work related to repatriating cardiothoracic surgery back from University Hospital Llandough (UHL).

- **Governance and Monitoring** – the Committee was advised that the prioritisation process for capital projects involved input from clinical boards and the Health Board to ensure that the most critical needs were addressed.

It was noted that the Capital Management Group would closely monitor the reported over-commitment and address any issues that arose to ensure that the capital plan remained on track

REGIONAL PARTNERSHIP BOARD (RPB) QUARTERLY UPDATE

The Committee was advised that the RPB oversaw various funding streams totalling just over £21m, with the Health Board acting as the banker for the region, including the Health Board footprint, two local authorities, and third sector providers.

- **Performance and Budget** – it was noted that the RPB came in on budget across all funding streams for the year 2024-25.

The Committee was advised that for the year 2025-26, the RPB had a budget of just over £19 million, with an agreed over-allocation of £330,000. This over-commitment would be managed across the partners, with anticipated slippage expected to cover the variance.

- **Regional Integration Fund (RIF)** – it was noted that the RIF was the largest fund within the RPB, with a five-year lifespan and two years remaining. There was significant work underway to ensure effective performance and to plan for the end of the funding stream.

The Committee was advised that the potential withdrawal of the fund posed a substantial risk to the Health Board and local authorities.

- **Third Sector Funding** – it was noted that the RPB aimed to support third sector services with around 20% of the overall fund. However, that target was not currently being met, which was a concern for the Strategic Leadership Group (SLG).

- **Future Reporting** – the Committee was advised that the RPB would continue to provide six-monthly reports to the committee, with updates on the economic impact assessment and the progress of the RIF

ANNUAL CHC UPLIFT PAPER

The Committee was reminded that the Health Board provided an annual uplift to Continuing Healthcare (CHC) packages, which were a statutory requirement and that the total expenditure on the packages was around £100m.

- **Proposed Uplift** – it was noted that for 2025-26, a 6.4% increase in the CHC rate had been proposed, which was assessed to have an impact of £6.1 million on the Health Board. This increase was fully provided for in the Health Board's current financial plan.

- **Alignment with Local Authorities** - the proposed rate aligned with the local authority rates already communicated to providers for April 2025.

- **Risks of Not Uplifting** – the Committee were advised that if the uplift was not provided, there could be disputes over care packages, difficulties in placing patients, and an increase in spot purchase arrangements, which would affect patient flow and discharge from hospitals.

- **Parallel Work** – it was noted that there was ongoing work to manage demand and decrease the overall CHC cost base, which would run in parallel with the uplift.

THE COMMITTEE RECEIVED THE FOLLOWING ITEMS FOR INFORMATION AND NOTING:

- Monthly Monitoring Return – Month 12
- Annual Committee Report
- Urgent & Emergency Care: Flow out of Hospital – Audit Wales Report

Recommendation:

The Board is requested to:

a) **NOTE** the contents of the report.

Link to Strategic Objectives of Shaping our Future Wellbeing:
https://shapingourfuturewellbeing.com/

Putting People First 1. **Click the objective above to view more detail.**		Providing Outstanding Quality 2. **Click the objective above to view more detail.**	x
Delivering in the Right Places 3. **Click the objective above to view more detail.**	x	Acting for the Future 4. **Click the objective above to view more detail.**	

Five Ways of Working (Sustainable Development Principles) considered									
Prevention		Long term		Integration		Collaboration	x	Involvement	x

Quality Impact Assessment Completed?				
Yes – (***please provide completed QIA document***)		No – ***(Please provide reasoning, e.g. not required)***	x	Not required.

Impact Assessment:
Risk: n/a
Safety: n/a
Financial: n/a
Workforce: n/a
Legal: n/a
Reputational: n/a
Socio Economic: n/a
Equality and Health: n/a
Decarbonisation: n/a
Welsh Language: n/a

Approval/Scrutiny Route *(please note anywhere else this paper has been before):*	
Committee/Group/Exec	Date:

Report Title:	Board Assurance Framework				Agenda Item no.	6.5	
Meeting:	Board		Public	X	Meeting Date:	29 May 2025	
			Private				
Status *(please tick one only):*	Assurance	X	Approval		Information		
Lead Executive Title:	Director of Corporate Governance						
Report Author (Title):	Director of Corporate Governance						

Main Report
Background and current situation:

The Board Assurance Framework (BAF) provides the Board with information on the key Strategic Risks that could impact upon the delivery of the Health Board's Strategy. It comprises 6 risk themes that are applicable to every one of the 4 strategic objectives.

The 2 delivery focused risk themes are:

1. Quality
2. Health Equity

And there are 4 key enabling risk themes:

3. People
4. Digital
5. Infrastructure
6. Sustainability

While each risk theme is relevant to every strategic objective, they are connected both with a strategic portfolio and a Committee of the Board to provide an appropriate thread from the strategy through delivery and into performance, and a means of assurance and scrutiny through Committees and into Board.

Executive Director Opinion and Key Issues to bring to the attention of the Board:

As is routine, all changes (bar the trend graphs) are shown as track changes.

There have been no changes to overall net risk scores.

The BAF has now appeared or is on the forward plan for all relevant committees. As a reminder these are:

Risk Theme	**Committee**
Quality	Quality
Health Equity	Quality
People	People and Culture
Digital	Digital and Infrastructure
Infrastructure	Digital and Infrastructure
Sustainability	Finance and Performance

The Execs discussed the strategic portfolio work on 22 May and agreed that the BAF would provide a useful, ongoing point of review for all planned activity within the programmes.

Assurance is provided by:

- Discussion with Executive Directors on progress being made against the management and mitigation of risks which they lead upon on the BAF.
- Discussion at the various Committees of the Board on the risks allocated to them for review.
- The burgeoning strategic portfolio work being led by Executives.

Recommendation:

The Board is requested to:

- **Review and note** the risk themes regarding the delivery of Strategic Objectives detailed on the attached BAF.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please place an "X" in the below boxes as relevant.

1.	Putting People First **Click the objective above to view more detail.**	X	2.	Providing Outstanding Quality **Click the objective above to view more detail.**	X
3.	Delivering in the Right Places **Click the objective above to view more detail.**	X	4.	Acting for the Future **Click the objective above to view more detail.**	X

Five Ways of Working (Sustainable Development Principles) considered

*Please place an "**X**" in the below boxes as relevant*

Prevention	X	Long term	X	Integration	X	Collaboration	X	Involvement	X

Quality Impact Assessment Completed?:

*Please place an "**X**" in the below boxes as relevant. A blank QIA and guidance on how to complete a QIA can be found by clicking the link here:* ***Quality Impact Assessment Information***

Yes – (***please provide completed QIA document***)		No – ***(Please provide reasoning, e.g. not required)***	X	There is no impact on the Duty of Quality

Impact Assessment:

*Please state **yes** or **no** for each category.* ***If yes please provide further details.***

Risk: No

Safety: No

Financial: No

Workforce: No

Legal: No

Reputational: No

Socio Economic: No - *Useful Guidance on the application of the Socio-Economic Duty can be found at the following link: The Socio-economic Duty: guidance | GOV.WALES*

Equality and Health: No - *Useful guidance on the completion of an EHIA can be found at the following link: EHIA toolkit - Cardiff and Vale University Health Board (nhs.wales)*

Decarbonisation: No
Welsh Language: No

Approval/Scrutiny Route *(please note anywhere else this paper has been before):*	

Board Assurance Framework

Updated 29 May 25

Introduction

The Board Assurance Framework (BAF) is the tool and document that seeks to articulate what strategic risks an organisation has identified that will, if not addressed, prevent it from delivering its strategy.

There is no definitive format, and it is intended that the below pages present in as clear a manner as possible the alignment between CAVUHB's 4 strategic objectives, the strategic portfolios that are led by the Executives in order to turn the strategy into delivery over the course of the strategy, the strategic risks that have been defined to best articulate the major themes that could prevent the delivery of the strategy, and the Board's Committees that are charged with seeking assurance on and scrutinising the delivery of each strategic objective.

While each strategic risk aligns to a Committee, the risks themselves are applicable to all 4 strategic objectives and have a whole organisation perspective and impact. Each has a risk appetite as determined by the Board.

Each risk seeks to identify the potential cause and effect of a manifestation of the risk becoming an issue. This 'uncontrolled' assessment makes use of a simple 5 x 5 scoring guide for likelihood against impact:

Likelihood / Impact	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Severe (5)
Almost Certain (5)	5	10	15	20	25
Likely (4)	4	8	12	16	20
Moderate (3)	3	6	9	12	15
Unlikely (2)	2	4	6	8	10
Rare (1)	1	2	3	4	5

Each risk is then assessed for the different controls and assurance measures or mechanisms that are in place, as well as identifying where there may be gaps in these facets. Once these have been applied a new assessment, using the above scoring system again, is then made.

However, the BAF is not a definitive mechanism or science. It is a vehicle for the organisation to articulate and expose some of the strategic level impacts on delivering the strategy, and for the Board and Committees to pull through and scrutinise those elements that are appropriate.

Finally, the BAF seeks to articulate the activity taking place relevant to each risk for assurance.

This document looks to capture and present this information so that the Board and members of the public can see all of the above information, the trends in scoring, the actions being undertaken and every change made to the document between one Board meeting and the next through the use of track changes.

Shaping Our Future Wellbeing

Strategic Framework

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Strategic Framework						
Strategy	**Putting People First**	**Providing Outstanding Quality**			**Delivering in the Right Places**	**Acting for the Future**
Strategic Portfolio	Shaping Our Future People & Culture	Shaping Our Future Population Health & Place Based Partnerships	Shaping Our Future Quality, Value & Sustainability	Shaping Our Future Clinical Services	Shaping Our Future Infrastructure	Shaping Our Future Generations
Strategic Risk Theme	People	Quality			Digital	Sustainability
		Health Equity			Infrastructure	
Committees	People and Culture Committee	Quality Committee			Digital and Infrastructure Committee	Finance and Performance Committee
		Mental Health Committee				
	Audit & Assurance					

Shaping Our Future Wellbeing

Strategic Objectives

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Strategic Objectives			
Putting People First	**Providing Outstanding Quality**	**Delivering in the Right Places**	**Acting for the Future**
We will be a great place to train, work and live, where we listen to and empower people to live healthy lives. By 2035, colleagues would recommend us a great place to work, our workforce will reflect the diversity of our communities and more people will be living healthier lives.	We will provide outstanding services which are equitable, timely and safe, where people are treated with kindness and are supported to achieve the outcomes that matter to them. We will have reduced inequities in prevention, improved access to clinical services and clinical outcomes.	By 2035 we will be using real time integrated data to inform joint decision making and multi-disciplinary team working, giving people access to and ownership of their data to enable them to manage their health and wellbeing. We will be well on our journey to provide care in the right place, in facilities that are fit for purpose, flexible and promote recovery.	We will work to ensure that what we do today does not compromise the wellbeing of our future generations. We will protect the environment and develop and use new technologies, treatments and techniques to provide the best possible health outcomes and sustainable health care into the future. By 2030 we will have reduced the Health Board's carbon footprint by 34% and will have increased our research and clinical innovation activities.
People will feel valued, developed, supported and engaged. We will have an inclusive culture where the diversity of the Health Board's people will be representative of the Health Board's local populations. Through our integrated population health improvement programme, we will enable and empower people to live healthy lives and reduce their risk of ill health.	Focus on minimising inequity in healthy behaviours, preventative services, access to clinical services, and health outcomes, to reduce current unfair, unjust differences experienced by people in the community Deliver outstanding quality of care every time - from the most complex care for the most critically ill to routine care that prevents and protects against ill health and disease – addressing physical and mental health needs. Achieve the best outcomes for patients in line with what matters most to them, their families and carers. Develop the Health Board's approach to continuous quality to improvement and make the best use of the Health Board's resources.	To achieve digital maturity enabling the Health Board to connect and communicate, supporting shared decision making in the planning and delivery of health care services. Refresh and deliver the Health Board's programme for creating integrated health and care facilities in our local communities where people can access the information and support they need under one roof. With Cardiff University and NHS partners, develop the Health Board's plans for ensuring hospitals providing acute care are fit for the future. Develop more shared infrastructure with public and private sector partners to get best value for the Health Board's investment.	Develop and expand the Health Board's research, teaching and innovation portfolios in collaboration with Cardiff University and other partners. Contribute to the development of and adopt cutting-edge and novel treatment, techniques and technologies where they deliver improved patient outcomes and improved value. Maximise the Health Board's contribution to the foundational economy Deliver the Health Board's carbon emissions targets and fully support active and sustainable travel for staff and visitors to patients. Promote, reward and embed successful waste reduction as part of our quality programme of continuous improvement.

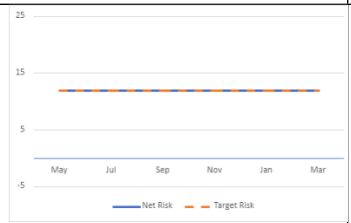
Saunders,Nathan
14/07/2025 14:46:53

Shaping Our Future Wellbeing

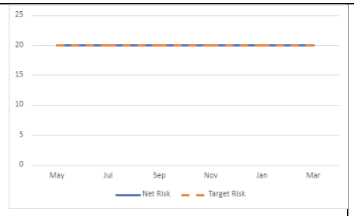
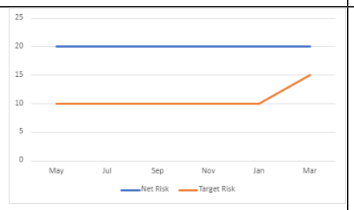
Risk Overview

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

What will prevent Cardiff and Vale University Health Board from delivering its strategy?
If any of the below risk themes cannot be controlled, then the strategic objectives are unlikely to be met.

Strategic Risk	Risk Appetite / Target Risk	Gross Risk *(no controls)*	Net Risk *(after controls)*	Trend	Context	Executive Lead(s)
Quality	Cautious / **10**	**25**	**15**		Our ultimate priority - to continuously, reliably, and sustainably meeting the needs of the population that we serve. Our organisation will focus on delivering assurance on the six domains of quality with the ultimate aim of providing outstanding care to our patients. We will strive to deliver Safe; Timely; Effective; Efficient; Equitable and Person-Centred Care.	Exec Dir Nursing Exec Medical Dir Exec Dir AHPs and Health Science Chief Operating Officer
Health Equity	Open / **12**	**16**	**12**		One of our two statutory responsibilities as a Health Board is to improve the health and well-being of our local population. The overall aim of our strategy is: 'Working together, we will help improve lives so that by 2035 people are healthier and unfair differences in health outcomes are reduced.' The goal is to improve health outcomes by reducing inequity in indicators of healthy behaviours and increasing the use of preventative services and access to clinical services.	Exec Dir Public Health
People	Open / **10**	**20**	**16**		The most important asset of any organisation. Through the delivery of the People and Culture Plan, our strategy will be delivered with a key focus on these core People risks: Attract, Recruit, Retain | Culture | Wellbeing	Exec Dir People

Risk Overview

Digital	Cautious 20	25	20		Data is integral to our strategy. It empowers informed decision making about what we need to do, why, when and how we perform. Delivering our digital and data transformation road map will introduce actionable insights and capabilities that enable clinicians and patients in any setting delivery of safe, high-quality care, improving productivity, efficiency and communication through person centric digital solutions. The security, management and accessibility of data is essential.	Dir Digital
Infrastructure	Open 10	25	20		The Health Board has the largest hospital in Wales, a footprint across dozens of locations and integrated service locations with key partners. We must shape our future infrastructure to ensure facilities are fit for the delivery of modern healthcare, intelligent integration takes place with partners and the service is delivered in the right locations for our population.	Exec Dir Finance
Sustainability	Cautious 10	20	15		Sustainable, efficient services are a legal requirement, improve quality and ensure a sustainability of service for now and future generations. By articulating the strategy through the integrated mid-term plan and the proper alignment of resources and consideration of the environment the Health Board will meet its statutory duty and ensure value in delivery.	Exec Dir Finance

Risk Appetite

Avoid	Avoidance of risk and uncertainty is a key organisation objective	Open	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (VFM)
Minimal	Preference for ultra-safe delivery options which have a low degree of inherent risk and only for limited reward potential	Seek	Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk)
Cautious	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential reward	Mature	Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust

Strategic Risks – Quality

Strategic Risk	Strategic Portfolio	Exec Leads	Committee	Date Added
Quality	Shaping our Quality, Value & Sustainability	Exec Dir Nursing | Exec Medical Dir | Chief Operating Officer Exec Dir Therapies and Health Science	Quality	30 Sep 24

Risk

Delivering outstanding quality and eliminating avoidable harm is the ultimate priority of the Health Board, however, constraints associated with capacity, Capacity, , governance and leadership to deliver measurable success across each of the six domains of quality impacts on the ability to deliver quality all the time and for the entire population

Cause	Impact
Safe – avoiding harm to service users and staff Risk to delivering safe care is increased due to demand pressures, workforce shortages, aging physical estate, lack of digital technology and variation across the organisation.	**Safe** The UHB continues to see a number of same cause patient safety incidents, complaints, redress cases and claims where the harm to patients is potentially avoidable. These ~~incidents~~ include health care associated infections, failure to ensure continuity in clinical pathways, failure to recognise the deteriorating patient, failure to escalate, issues wiith ~~and~~communication and Never Events. The health, safety and welfare of our staff is not universally maintained.
Timely – providing care within an appropriate timescale to avoid harmful delays Ability to deliver timely care is significantly impacted by the backlog of referrals following the covid-19 pandemic and the mismatch between demand and recurrent capacity within many clinical services	**Timely** Long waiting times for planned care and diagnostics means care is delivered at inappropriate timescales with a potential consequence of progression of disease, worsening wellbeing and associated psychosocial impact on patients and families. Care is ultimately costlier to provide.
Effective - providing services based on scientific evidence and refrain from providing treatments and services that do not benefit patients Ability to deliver effective care is impacted by workforce pressures, outdated systems and process, particularly related to digital technology, clinical coding and aging physical environments. The challenge in accessing real time data to track care against a robust evidence base means that the organisation is dependent on retrospective data to inform its response to quality risk	**Effective** Benchmarked data associated with national clinical audits demonstrates that we don't universally benchmark in the top 30% of organisations nationally for performance and outcomes. The pressure on estates, workforce capacity and wellbeing will impact on our ability to provide care in line with evidence base.
Efficient - avoiding waste that does not add value to the patient or the desired outcome Risk to delivering efficient care is caused by outdated systems and process, particularly related to digital technology and aging physical environments and workforce efficiency	**Efficient** The Health Board is not meeting some of its productivity and efficiency ambitions, including in relation to outpatients and length of stay. Care may be being delivered which does not provide value to the patient, wider population and health economy. Care can be duplicative and wasteful. Care is often delivered with a disproportionate focus on intervention vs prevention. Constraints around workforce availability results in a reliance on non UHB staff to provide core .
Person Centred - providing care that is respectful and responsive to patient's values and needs In order to reduce the risk of not delivering person centred care the organisation must seek understanding of our population, empower patients, seek options to receive feedback and develop a responsive culture.	**Person Centred** The Health Board is striving to deliver care that meets the patients right to empathy, compassion, privacy, dignity and respect. In some areas patient experience is below our ambition, for example in the Emergency Department which is below the 85% target in all but one measure. The Health Board is seeking to ensure patients and families views are sought and play a role in improving services.
Equitable - Our health care system provides everyone with an equal opportunity to attain their full potential for a healthy life We embed equality and human rights in our health care system. We design services that meet the needs of our local population.	**Equitable –** Our health outcomes between different population groups (e.g. most deprived and least deprived and different ethnic groups indicate that we have more work to do on this aspect of quality. We have developed an 'Equity, Equality and Patient Safety Framework for the Health

Strategic Risks – Quality

		Board' this describes a framework for change, provides examples of best practice from across the world, and finally outlines the key actions each Clinical Board has committed to. For example, our data collection of protected characteristics is poor, and each Clinical Board will need to make improvements in this area. Using a co-production approach supports equity.	
Uncontrolled Risk			
Impact: 5	Likelihood: 5	Gross Risk: 25	Target Risk: 10

Controls	Assurances
Safe – Corporate Quality and Safety team have oversight of all UHB patient safety incidence, the Duty of Candour supports systematic scrutiny of all incidents reported as having caused moderate harm and above. Quality and safety Committee and the groups that report into the committee provide oversight of emerging trends. The clinical safety group brings together the clinical boards and clinical advisory groups to support the development of strategy and policy to deliver quality aligned to current risk. **Timely**- Planned Care programme and Operational Performance meetings delivering on plans to reduce waiting times. Patients prioritised in line with Health Board criteria – Urgent and Emergency Care; Cancer and Time-Critical; planned (in referral order). Recovery plans ~~being developed~~ are in place for diagnostic long waits such as endoscopy and non-obstetric ultrasound. **Effective –** The Clinical Effectiveness Committee provides oversight of national clinical audit outcomes and improvements and implementation of NICE and HW guidance. Clinical Boards are bringing an overview of their local arrangements to providing continuous focus of national audit data and use it to transform clinical pathways as has been done in stroke and hip fracture. **Efficient –** operational programmes in planned care and urgent and emergency care focused on delivering best practice. Benchmarking and use of GIRFT central to programme. Productivity and Efficiency ambitions in place and monitored. **Person Centred –** Value Based Healthcare programme supporting projects and programmes focused on delivering value to patients. **Equitable –** We monitor performance against the actions outlined in the Equity, Experience and Patient Safety Framework and Action Plan. This goes to Quality Committee every six months. Our Cardiff and Vale Health Inclusion Service (CAVHIS) supports the most vulnerable people experiencing 'cliff edge' health inequalities, but there is more to do to support this population and reach out to the next level of people experiencing health inequalities. Investment has been agreed to support this expansion. Implementation of this Business Case will need to be reviewed periodically.	• Clinical Board Performance Meetings • Integrated Performance Report • QSE • Clinical Effectiveness Committee • Clinical Safety Group • Risk registers • Executive Reviews • People and communities experience framework • CIVICA • Benchmarking Information (Clinical) • Get It Right First Time • Peer Reviews • HIW and external assurance • PSOW REPORTS • WRP assessments • Equity, Equality, Experience and Patient Safety Framework and Action Plan at Quality Committee • Assurance of CAVHIS Business Case Implementation in 2024/25

Strategic Risks – Quality

Progress against the implementation of our co-production approach will also be important for improvements to equity. Our Shaping our Future Quality Excellence Programme is focussing on developing a Quality Management System for the UHB and on improving performance against specific quality challenges; Hospital Acquired Infections, Acute Deterioration, Lost to Follow-up and Medication Errors.	
Gaps in Controls	**Gaps in Assurances**
Lack of funding available for deliver planned care performance standards recurrently Both the clinical safety group and the clinical effectiveness groups are relatively new forums, and the Clinical Board quality and Safety governance needs to mature further to deliver a quality management system. Many local improvements aligned to patient safety incidents are within the gift of the clinical boards ~~t~~to facilitate, however there are complex health board wide or national improvements for example delivery of scan for safety, implementation of a medical device register, whole system approach to observation and escalation that are dependent on resource Poor data collection on protected characteristics across the organisation.	• Approach to Quality Statements • Quality Outcome Framework • Resource for widespread health board wide improvements • Data improvements that will improve data monitoring of protected characteristics at the local level e.g. National Data Repository, a Population Health Management System for Wales and use of the NHS App in Wales

Risk Post-Controls and Mitigation

Impact: 5	Likelihood: 3	Net Risk: 15

Actions

What	Lead	By	Update
Deliver stroke improvement plan to address quality concerns in acute stroke pathway	PB	31/12~~03~~/25	• Business case approved for stroke model, funding to be released from Q4 2024/25 • Delays in recruitment for agreed stroke post • Recruitment is now underway to the additional posts, but it will be some time before all posts are in place. There is continued focus on stroke performance and a real increase in regional working to deliver sustainable models moving forwards.
Develop 6 goals workstream four objectives to transform continuity of care, hospital flow and length of stay	PB	31/05/2025	• UHB launch of Reducing Time In Hospital in November – completed • 6 goals programme reframed for 25/26 to include two workstreams, one focused on secondary care and one primary. Detailed plan developed and will be signed off in Q1

Strategic Risks – Quality

Develop and deliver improvement plan for cancer and long waiting patients, including a plan to reduce diagnostic waiting times.	PB	31/03/265	• Delivery against revised trajectories is monitored internally and by WG • Challenging position in select specialities including ophthalmology • End of year positions in Cancer and 104 weeks for 24/25 good in comparison to recent years but still too long and not in line with WG expectations. Revised plans in place to deliver reduction during 2025/26 •
Develop and deliver long term proposal for ITU capacity – Strategic Outline Case in production	PB	31/1203/25	• ~~SOC in development and due to WG in March 2025~~ The design development continues. However, discussions are ongoing with WG in relation to a combined ITU/Haematology and Hybrid theatres schemes. • Interim plan for releasing capacity on 3rd floor in progress through discretionary capital programme – ~~relies on moving cardiology~~ Work to C1 to ~~accomodate~~accommodate Cardiology from C3 has commenced and is due to complete ~~Ocober~~October 2025, releasing capacity ahead of~~n~~ the ITU work
Development of a Quality Outcomes Framework- To support a data informed approach to quality	JR/ RS	31.06.25	• Meetings underway with corporate teams to agree quality indicators • Work to extrapolate data relating to patient safety incidents commenced • Plan to develop a first draft by Q1 with digital support by June 2025 • Publication of a UHB mortality dashboard • Publication and analysis of clinical board and directorate mortality dashboards
Development of the Quality prospectus to populate the quality academy – Up skill staff across the clinical boards in patient safety review technique, improvement planning and clinical governance	JR	31.03.25~~6~~	• PSLR training developed • Improvement plan training in development • Human factor prospectus planning • Development of a quality academy • Accredited audit training in place
Monitoring of the Equity, Equality, Experience and Patient Safety Action Plan and progress against actions by Clinical Boards	CB	Every six months	• Paper for Quality Committee on progress against the action plan. • Early discussions with Public health around equity measures as part of the quality outcome framework

Strategic Risks – Health Inequity

Strategic Risk	Strategic Portfolio	Exec Lead	Committee	Date Added
Health Inequity	Shaping our Population Health and Place Based Partnerships	Executive Director of Public Health	Quality	29 July 2021

Risk

There is a risk that lack of investment in prevention, primary care and community services coupled with a deterioration in the wider determinants of health will adversely impact our statutory duty to improve the health and well-being of our local population and our strategic ambition to reverse the historic trend in widening inequality in life expectancy for men and women living in Cardiff and Vale.

Cause

- People in the most deprived areas die earlier on average and live more of their lives in poor health; this is well recognised and deeply entrenched, but it is preventable.
- People living in poverty are getting sicker and accessing services later. For the most deprived groups, EU attendances are nearly twice as high and emergency admissions more than double that the least deprived.
- In 2021 the *undiagnosed* diabetes rate was double for those in the bottom Indexed of Multiple Deprivation (IMD) quintile compared to the top. This presents a challenge for the NHS in finding those with an unmet need for healthcare.
- Greater illness and poorer access to care (the inverse care law) contribute to worse health outcomes. This impacts directly on the gap in life expectancy between the most and least deprived groups.
- Our organisation has set the strategic intention to shift spending from reactive care in hospitals to more prevention and proactive care in the community setting – but secondary care has attracted a greater share of NHS spending, meaning that prevention, primary care and community services have received a smaller share. This must be addressed for the sustainability of the organisation. Locally we call this left shift, a 'shift upstream' towards prevention.
- Spending on prevention, and in primary and community settings had a superior return on investment when compared with acute hospital services.
- There is strong evidence that areas that invest more in prevention and community care see 15 per cent lower non-elective admission rates and 10 per cent lower ambulance conveyance rates together with lower average activity for elective admissions and EU attendances.
- Changing both the distribution of resources and the operating model to deliver integrated, preventative care closer to home are the strategic priorities of the

Impact

- We can reduce premature mortality, reduce social disparities, and reduce the absolute time in ill health. This in turn reduces the burden on the Health Board and social care while enabling our population to be more productive in our working lives, so strengthening the local economy. This is the desired outcome for individuals, families and the public purse.
- Risk factors interact and multiple aspects of disadvantage come together, increasing the disease burden and widening equity gaps.
- The key population groups with multiple vulnerabilities include:
  - Some minority ethnic groups, especially some people in Black and Asian populations
  - People living in (or at risk of) deprivation and poverty
  - People in insecure/low income/informal/low-qualification employment, especially women
  - People who are marginalised and socially excluded, such as people who are homeless and other inclusion health groups
- Areas with higher unemployment have greater incidence of suicide; and people living in the most deprived areas experience the largest increase in mental illness and self-harm.
- Health inequalities are estimated to cost £3-4 billion annually in Wales through higher welfare payments, productivity losses, lost taxes, and additional illness
- The total annual cost associated with inequality in hospital service utilisation to the NHS in Wales is estimated to be £322 million, equivalent to 8.7% of the total hospital service expenses, driven largely by higher service use among people living in the more deprived areas compared to those living in the least deprived (PowerPoint Presentation (nhs.wales))
- There is a moral and financial sustainability imperative to address health inequalities in our Health Board.

organisation as described in the strategy, because they are derived from the changing needs of the population.

- Health inequalities are well documented across the UK, with a recurrent pattern of worsening outcomes linked to factors such as deprivation and ethnicity; these inequalities are evident for many chronic and acute conditions.
- Health inequalities arise in three main ways:
- structural issues, e.g. income, employment, education and housing
- unhealthy behaviours due to the environment, social norms and income levels
- inequitable access to, or experience of, services, which can be a result of discrimination due to inaccessible services, public information or healthcare sites that may be relevant/pertinent to particular needs.
- Differential experience of the wider determinants of health across the life course mean that disadvantage experienced in childhood is often compounded and exacerbated through adult life, and often passes inter-generationally.
- The 'Inverse Care Law' has been recognised for over 50 years, with those experiencing disadvantage consistently experiencing more challenges in accessing health services. Inequity of access to healthcare continues to be evident in Cardiff and the Vale of Glamorgan.
- The UHB also has a role as a care provider, employer and regional Anchor Organisation to positively impact the wider determinants of health for employees, patients and residents and to advocate for improvements to the wider determinants of health with other statutory partners.
- Lack of capacity to deliver evidence-based interventions at scale to tackle health behaviours e.g. smoking, diet, physical activity, alcohol, that drive the huge disparities in health outcomes we see across Cardiff and Vale.
- Lack of capacity to undertake more substantial work on the wider determinants of health with partners.
- Lack of investment in prevention, primary and community services, e.g. health visitors (UK staff shortages) and public health consultants (Faculty recommends 15 for a population of 500,000).

Uncontrolled Risk			
Impact: 4	Likelihood: 4	Gross Risk: 16	Target Risk: 12

Controls	Assurances

Strategic Risks – Health Inequity

1. Statutory duty • The Health Board has a statutory duty: to improve the health and well-being of the local population. • The Socio-economic Duty places a legal responsibility on public bodies in Wales when they are taking strategic decisions to have due regard to the need to reduce the inequalities of outcome resulting from socio-economic disadvantage. • **2. Role as an Employer** • In our Equality, Inclusivity and Human Rights Policy, we have an active programme, which sets out the organisational commitment to promoting equality, diversity and human rights in relation to employment, and ensuring staff recruitment is conducted in an equal manner • Our Strategic Equality Objectives and Plan 'Shaping our Inclusive Culture 2024-2028, has a number of key delivery objectives and is premised on the basis of embedding equality, diversity and human rights, and Welsh language, into UHB business processes. • All our Executives have taken up a leadership role as an Inclusion Ambassador covering different characteristics, including those specified in the Equality Act 2010 Staff have been signposted to resources to help them to cope with the cost-of-living crisis **3. Our Strategy and Plans** • The refreshed UHB Strategy 'Shaping our Future Well-being' shines a light on the issue of equity at the strategic level • The Cardiff and Vale long-term public health plan 2024 – 2035 sets out how the UHB intends to achieve its ambitions of increasing life expectancy, reducing inequity and shifting more focus to prevention • 'Shaping our Inclusive Culture 2024-2028' is closely aligned with the UHB Shaping our Future Well-being. • Through our PSB and RPB plans we already prioritise areas of work to tackle inequalities and the refreshed needs assessments for both PSBs and RPB have further identified collective actions. • The future UHB organisational direction agreed at the recent rapid planning event supports the 'shift upstream' by committing to develop an Integrated Community Health System, underpinned by care pathways that begin with prevention; prevention is a 'brilliant basic' • The establishment of a Strategic Diabetes Programme Board is a key element to reducing health inequalities and has an aim to identify those with undiagnosed diabetes in areas of deprivation across Cardiff and Vale. 4. **Public Health Priorities to reduce health inequalities** • As a team we have agreed three immediate priorities that will influence health inequalities (and other work that we will need to bring forward when capacity allows): - preventing obesity (focus 0-5 years) - reducing smoking rates (dependent on a new business case) - increasing levels of vaccination (using an outreach model to reduce inequity in uptake).	Board papers Committee papers to Quality Committee e.g. updates on Equity, Equality, Experience and Patient Safety Framework. Committee papers to People and Culture and Quality and Safety Committees e.g. updates on Welsh Language Standard. Risk Registers Integrated Performance Report Papers to SLB

Strategic Risks – Health Inequity

Gaps in Controls	Gaps in Assurances
	Monitoring data (e.g. on protected characteristics) Population Health Management System to reduce inequalities by identifying those at risk

Risk Post-Controls and Mitigation			
Impact: 4	Likelihood: 3	Net Risk: 12	

Actions			
What	**Lead**	**By**	**Update**
Embed a 'Socio-economic Duty' way of thinking into strategic/operational planning, *beyond* complying with our statutory duty, and to always consider the unintended consequences of our actions	Claire Beynon/ Rachel Gidman	2025/26	• We plan to strengthen the strategic response to the Socio-economic Duty, ensuring actions are systematically applied. • The EHIA process is being reviewed on an All Wales basis with the view of creating a Once for Wales approach. C&VUHB will contribute to the development and implementation. The Health Board are also exploring opportunities as to how the EHIA process can be better embedded into governance processes and to make the process more user-friendly. • Our UHB will continue to work collaboratively with our stakeholders to shape our services and culture.
Within the UHB and through our PSB and RPB partnerships, continue to develop and deliver a suite of focused preventative actions to tackle inequalities in health Saunders,Nathan 14/07/2025 14:46:53	Claire Beynon	March 2026~~5~~	• Work to tackle inequalities needs to take place over prolonged time periods. In 2025/26 w~~W~~e will continue to work with PSB and RPB partnerships ~~on~~to address the three priority areas where we know we can make a significant impact on reducing health inequalities: smoking, vaccination and obesity. The Amplifying Prevention Board, held jointly with Local Authority partners, provides governance oversight of this collective action and works to remove any blocks to collective action. • The Head of Equity and Inclusion is a member of the Public Sector Equality Network, improving the collaboration between public sector organisations in the area. • A~~We are restarting a~~ second round of MMR vaccine catch-ups is underway. Immunisers are going directly in to schools with lower uptake to reduce barriers to access and reach groups less engaged with the childhood immunisation schedule. The aim is to protect education from the impact of a Measles outbreak as this would exacerbate health inequalities. This outreach approach is being extended to reach other communities where uptake is lower. • We are doing this also with the use of a vaccination van. This is being deployed in areas of lower uptake, to support outreach efforts and to offer opportunistic vaccination in the context of large community/ cultural/ religious gatherings.

			• The community delivery model of vaccination is continuing, and the measure of distance radius of vaccination from home and focus has been reviewed to further enhance the proximity of the offer.
			• Additionally, a data sharing agreement with Cardiff Council will support a more targeted, timely and intelligence driven approach and enable a more active role played by schools in monitoring and promoting vaccination.
			• The same intelligence driven approach is being used for analysing inequities of childhood vaccination in primary care and it will help us support General Practices in targeting and following up children in areas or communities with lower uptake.
			  • The Health Improvement Officer is developing community profiles as part of the action plan to work to address the health inequalities experienced by ethnic minorities and boost our understanding and ability to engage and build trust. This is a joint position with Cardiff Council and the ~~UHB~~Public Health Team funded directly from a Welsh Government annual grant.
			  • An 'Equity, Equality, Experience and Patient Safety' action plan was developed, covering 24 initial actions across the Clinical Boards that have strategic importance to delivering on the Equality, Equity, Experience and Patient Safety agenda. This was approved by Board in May 2024. Progress on the actions is reported to Quality Committee on a 6-monthly basis. The most recent update in November 2024 commented on the successful establishment of face to face antenatal education sessions for non-English speaking families as part of the community of midwifery programme of classes, and highlighted various awards won by teams with respect to the equality agenda such as the 'project search' program, designed to support young adults with learning disability/autism in gaining employment which was recognised with awards at the Project Search awards in Blackpool and the National HR awards in London. Work continues to meet targets in the existing plan, especially in relation to data collection. Additionally, work seeking to identify any additional new actions to add to the plan has begun. A further update ~~will be provided in 6 months time~~is due at the end of June.
			• The UHB's Community Smoking Cessation Services aim to ensure that clinic provision aligns to areas know to have higher smoking prevalence in order to reduce barriers to service access. Further work is planned to improve outreach e.g. with housing association tenants. A communication campaign has been running since January 2025 which has targeted groups with higher smoking prevalence. Partner organisations have shared smoking cessation promotional materials and resources in order to extend reach.

Improve the routine data collection in relation to equality and inequity across the UHB.	Claire Beynon	March 2026~~5~~	~~There are improvements that need to be made in~~In 2025/26 there is an ongoing need to improve the routine collection of protected characteristics in order to support the introduction of new indicators. This will need to be addressed by each Clinical Board. Patient feedback is essential to improving service quality. Since October 2022, the UHB has collected most routine feedback via electronic surveys, accessed by SMS link, QR code and URL. We currently survey up to 1000 patients who have attended an outpatient appointment or following discharge as an inpatient every day; this includes the Emergency Unit (200), Mental Health (200) and the routine survey which randomly selects

			from all other clinical areas (600). As part of ongoing development, the routine survey has been translated into the top ten most frequently used languages, including BSL, English and Welsh. All surveys also collect information on protected characteristics, although this is not compulsory. A range of methods is used to gather feedback with the aim of ensuring all patients have the opportunity to contribute, including: • Website hosted surveys • Kiosk surveys • Tablet surveys • Postal surveys and paper-based feedback forms • Telephone surveys • SMS surveys • Focus groups • Patient stories • Bespoke The All Wales Peoples Experience Framework was launched in April 2025. The new Pes survey was implemented in May 2025 at the Health Board. ~~will be launched in 2025/26. At the same time there will be a roll out of an all wales national survey which will be translated into different languages to enable accessibility.~~

Strategic Risks – People

Strategic Risk	Strategic Portfolio	Exec Lead	Committee	Date Added
People	Shaping our People and Culture	Rachel Gidman	People and Culture	30 Sep 24

Risk

If we do not have the right people, the right culture and a healthy, effective workforce then we will not be able to provide the services to the population that we are required to and on which people depend.

Cause	Impact
1. Attract Recruit Retain • The increased demand across the NHS and Social Care has left a shortage in some professions and the sustained pressures have impacted negatively on wellbeing and retention. • National shortages in some professions have made it difficult to attract people with the right skills/experience and in the numbers required. • Attraction, recruitment and retention is also being affected by the negative image that is portrayed that NHS staff do not receive the right remuneration for the work that they do. The Industrial Action over the last couple of years has not helped the national reputation of the NHS as an employer. • People now think differently about work and what is important to them.	• Higher levels of sickness absence • Lack of management capacity to support staff appropriately; - Higher levels of turnover; - Low morale and poor staff engagement; - Increased reliance on temporary workforce e.g. bank, agency, locums, etc; - Reduced capacity to undertake appraisals, identify development needs, and focus on talent management and succession planning. - Lack of capacity to upskill and develop our current workforce. - Reduction in uptake of student training places and higher attrition rates, resulting in a reduction of graduates. • Potential negative impact on quality of care & safety. Inability to expand services as required due to lack of staff with the relevant experience, skills, etc.
2. Culture • There is a belief within the organisation that the current climate is high in bureaucracy and low in trust. • Staff reluctant to engage with the case for change as they are overwhelmed with system pressures, change and ongoing demands. • Staff are not feeling involved in, or understanding the part their role plays for the case for cultural change due to lack of communication filtering through all levels of the UHB. • Additional complexities as colleagues continuously respond to the challenges of the pandemic, making involvement in, and response to change complex and challenging.	• Staff morale may decrease • Increase in absenteeism and/or presenteeism • Difficulty in retaining and recruiting staff • Potential decrease in staff engagement • Increase in formal employee relations cases / respect and resolution • Transformation of services may not happen due to staff reluctance to drive the change through improvement work. • Patient experience ultimately affected. • UHB credibility as an employee of choice may decrease • Staff experiencing fatigue and burnout making active and positive engagement in change challenging and buy-in difficult to achieve. • Existing inequalities exacerbated • Not realising the opportunities within workforce sustainability

Strategic Risks – People

3. Wellbeing • Lack of integration and understanding of importance of wellbeing amongst managers • Impact upon manager wellbeing of balancing staff and service needs • Conflict between demands of service delivery and staff wellbeing • Exposure to psychological impact of increasingly complex and challenging demands of care • Inability to deliver care to required standard due to short staffing (moral injury / moral distress) • Ongoing demands over an extended period of time • Cost of living • Financial climate	• Values and behaviours of the UHB will not be displayed due to high pressure environments, and potential for exacerbation of existing poor behaviours • Operating on reduced staff levels in clinical areas due to sickness absence and/or staff shortages • Mental health and wellbeing of staff will decrease, existing MH conditions exacerbated • Clinical errors will increase • Staff morale and productivity will decrease • Job satisfaction and happiness levels will decrease • Increase in sickness levels • Patient experience will decrease • Increased referrals to Occupational Health and Employee Wellbeing Services (EWS) • Increased referrals for higher level psychological support • UHB credibility as an employer of choice may decrease • Potential exacerbation of existing health conditions Impact on retention (negative) and attraction of staff into healthcare

Uncontrolled Risk			
Impact: 5	Likelihood: 4	Gross Risk: 20	Target Risk: 10

Strategic Risks – People

Controls	Assurances
• The People and Culture Committee provide more scrutiny and assurance to Board. • People and Culture Plan in place with a robust governance structure monitoring delivery against the agreed priorities.. • Monthly Executive Review meetings with Clinical Boards • Strategic oversight meetings, e.g. NPG, MWAG and introduction of MPG (Medical Performance group) • Cardiff and Vale UHB refreshed strategy: Shaping Our Future Wellbeing • Talent management and succession planning framework • Values based recruitment / appraisal • Strategic Equality Plan • Anti-Racist Action Plan • Workplace Race Equality Standards (2024) • Welsh Language Standards • Patient experience score cards • Raising concerns procedure/Speaking up Safely. • Widening Access Framework • New Starter Surveys and Exit Questionnaires/interviews • Nursing Staff in Post Forecasting to identify potential risks in advance Adoption of consistent, evidence-based approach to Culture and Leadership via the NHSE Culture and Leadership Programme Staff survey	• Robust monitoring of People and Culture Plan KPI's at the People and Culture Committee and Board. (1) • Quarterly IMTP/Annual Plan updates to WG. • WG JET and IQPD • Effective partnership working with Trade Union colleagues (WPG, LNC, LPF). • Internal Audit on Staff Wellbeing, Culture and Values (Sept 2022) report (3); • Engagement of staff side through the Local partnership Forum (LPF) (1) Matrix of measurement now in place which will be presented in the form of a highlight report to Committee (1) • Internal monitoring and KPIs within the OH&EHWS (1) • Wellbeing champions normalising wellbeing discussions (1) • VBA focussing on individual wellbeing and development (1) • Successful retention of the gold (and platinum) Corporate Health Standard awards via the 'Enhanced Status Checks' in March 2023 • Substantive funding identified to maintain on a permanent basis the enhanced EWS service from April 2023 • Development of a new and permanent OD Manager - Wellbeing and Engagement role • Taking Care of Carers Audit and Action Plan to become part of Business as usual (3) • Internal audit on Staff Wellbeing, Culture and Values (September 2022) Report and implementation of Management Actions (3) • Trade unions insight and feedback from employees (2) • Working with HEIW as part of the Financial Wellbeing (FWB) task and finish group to develop a FWB strategy for NHS staff in Wales (2)

Strategic Risks – People

Gaps in Controls	Gaps in Assurances
Agreed Retention Plan for all staff. Retention & OD Lead for the UHB • Workforce supply affected by National Shortages. No leadership / management principles as a UHB (currently align with HEIW compassionate leadership principles) • No organisational cultural dashboard • Staff shortages / industrial action leading to movement of staff and high demand for cover • Transparent and timely Communication especially to staff who do not have digital access • Continued increase in manager referrals to Occupational Health • EWS seeing an increase in staff presenting with more complex issues, including a rise in referrals needing a wellbeing check due to the presentation of high risk in the referral • No Colleague Health and Wellbeing Framework	Capacity to respond to requests for cultural and transformation work Effective measures of culture / engagement • Organisational acceptance and approval of wellbeing as an integral part of staff's working life balanced against demand and flow • Awareness and access of employee wellbeing services, particularly for staff without email / internet access • Clarity of signposting and support for managers and workforce

Risk Post-Controls and Mitigation		
Impact: 4	Likelihood: 4	Net Risk: 16

Actions			
What	**Lead**	**By**	**Update**
Consult, finalise and launch the Widening Access framework.	Jonathan Pritchard	January 2025 Complete	• Presentations and consultation undertaken with Staff Representatives and Clinical Board Management Teams. • Follow up meetings with Clinical Board managers arranged to identify work placements/opportunities. • Local areas of deprivation / community hubs identified and programme of visits for 2025 developed. • Framework implemented and won 'Recruitment Initiative of the Year at national HR Awards

Agreed Retention Framework to support retention for all staff groups, aligned to HEIW Principles and HEIW Nurse Retention Plan. Attract, Recruit and Retain is one of the key three themes of the People and Culture Action Plan which is monitored on a monthly basis to ensure good progress.	Claire Whiles	JulyMay 2025	• The All Wales self-assessment was due on the 31 March 24. The organisation completed and submitted. • A review of 3 frameworks in development identified cross-cutting themes. This has resulted in the development of an over-arching framework including retention, health and wellbeing and organisational development. This will be consulted upon in March and April, and presented in May 2025 for approval Currently sense-checking approach in light of existing demands and pressures to assess prioritisation of framework development, e.g. OD&Culture; Leadership & Management. Retention and OD Lead part of HEIW Community of Practice to ensure learning across Wales brought into UHB.
To develop management and leadership development where compassionate and inclusive leadership principles will be at the core of all the programmes.	Claire Whiles	June 2025	• Management programmes continue to be delivered and evaluated using the Kirkpatrick model (introduced Q1 2024) • Compassionate Leadership masterclasses developed via 'train the trainer' session with Professor Michael West. Delivered regularly. Ongoing review and evaluation in place. • General Manager programme postponed due to action taken regarding non-essential trainingsuccess profile developed and competencies currently in development to shape training needs analysis and programme development. Programme to commence Resume April June 2025. • A leadership development pathway is in development and will be aligned with UHB objectives and organisational need. Leadership post recruitment November 2024 was unsuccessful, post to be reviewed and readvertised April planned for scrutiny May 2025. • Continuing to workWorking closely with HEIW to align leadership principles to 4-nations work on leadership and management competencies. Focus on management development April-June 2025, focus on managing attendance and wellbeing. • All programmes underpinned by compassionate and inclusive leadership principles. Planned work with HEIW and Professor Michael West to identify monitoring and evaluation measures to underpin development and cultural imporvementimprovement work. • Connected to Isle of Wight and Portsmouth NHS Trusts to identify key learning around the Culture and Leadership Programme. • Compassionate Leadership Pledge has been signed by the Board. Roll-out plan in development to support meaningful adoption at a local level, exploring tie-in to team assessment and ward accreditation.

			• Thorough TNA will be required to support effective leadership and management development. Looking at Management Passport for all managers to ensure underpinning knowledge. • ~~Proposal for experiential leadership programme for managers at Band 7 level agreed by HEIW f. AVUHB to pilot and evaluate~~Self, Team and Team of Teams pilot leadership programme delivered to Peri-Natal Colleagues April 2025, evaluation currently taking place. Programme funded by HEIW..
Equality, Diversity and Inclusion	Claire Whiles	~~March 2025~~September 2025	• Continue to ~~M~~monitor the delivery of the Strategic Equality Objectives and Plan through annual reporting. • Equality Policy has been reviewed and updated, ~~to be shared with Stakeholders for comment January 2025 prior to further consultation and engagement.~~
Welsh Language Standards being implemented.	Claire Whiles	March 2025	• Continue to improve capture of Welsh language skills data through 'making every contact count' approach (i.e. Staff Survey roadshows). • Resolve the three Standard Enforcement Investigations currently open with the Welsh Language Commissioner. • Continue to communicate and deliver Welsh language learning opportunities with Dysgu Cymraeg Caerdydd.
Inclusion - Nine protected Characteristics	Claire Whiles	March 2025	• Development of UHB's LGBTQ+ Action Plan, stage one engagement underway with representatives from LGBTQ+ network. • Initial meeting held with Welsh Government to develop actions following the Health Board's Workforce Race Equality Standards Report. UHB's Anti-racist Action Plan to be reviewed once WRES actions agreed. • Follow up meeting with Welsh Government scheduled for February 2025 to discuss next steps with WRES.
Commissioning model / whole team approach introduced in People and Culture to ensure managers / teams can request support / advice / guidance and training which is delivered / supported by the most appropriate team / individuals and/or external partners. Includes representation from ECOD, People Services, Wellbeing Services, Equity and Inclusion.	Claire Whiles	~~June~~ August 2025	• People and Culture Team working in collaboration with HEIW and Professor Michael West to review and improve culture and leadership programme implementation, monitoring and evaluation. Measures to be established and lessons learnt internally and via NHS England to be under-taken. Meeting with Portsmouth and Isle of Wight NHS Trusts April 2025. • P&C MDT established and reviewing organisational requirements in interim. • Priority cultural work currently identified and allocated by Chief Operating Officer, EDofP&C and appropriate Executive Directors. Elements of work paused due to Service Review requirements.

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			• A review of 3 frameworks in development identified cross-cutting themes. This has resulted in the proposed development of an over-arching framework including retention, health and wellbeing and organisational development.Currently sense-checking approach in light of existing demands and pressures to assess prioritisation of framework development, e.g. OD&Culture; Leadership & Management ~~This will be consulted upon in March and April, and presented in May 2025 for approval.~~
The People and Culture Team will identify insights from workforce data, including themes emerging from EWS, OH, People Svcs, Culture work and Staff Survey, to shape strategic and operational response to themes / emerging trends. This will also be informed by working in collaboration with Clinical Boards.	Claire Whiles	June 2025	• Developments required to P&C Dashboard to ensure include all relevant measures, e.g. OH and EWS KPIs. Working with HEIW to improve dashboard reporting. • OH KPIs regularly reported to WG and KPIs adjusted to align with Welsh Government guidelines (i.e. calendar days). Collaboration review scheduled for August 2025. • Internal audit of OH Services ~~postponed due to department re-location, to commence Q1 2025~~moved to Quarter 3, 2025 at request of Audit Team. • NHS Wales Staff Survey 2024 results received and analysis under-way. Communication and engagement plan in place for 2025/26 • OPAS database to be implemented within EWS to support effective reporting and user experience. Licences to be procured in April 2025. •
1. Enhance communication methods across UHB - Social media platform - Regularity and accessibility of information and resources Improve website navigation and resources	Claire Whiles	July ~~May~~ 2025	• A review of 3 frameworks in development identified cross-cutting themes. This has resulted in the development of an over-arching framework including retention, health and wellbeing and organisational development. ~~This will be consulted upon in March and April, and presented in May 2025 for approval.~~Currently sense-checking approach in light of existing demands and pressures to assess prioritisation of framework development, e.g. OD&Culture; Leadership & Management • To establish wellbeing area within Viva Engage
2. Training and education of management - Integrate wellbeing into all parts of the employment cycle (recruitment, induction, training and ongoing career) Enhance training and education courses and support for new and existing managers	Claire Whiles	July~~ne~~ 2025	• Colleague and Manager wellbeing included in all management and leadership programmes, induction. • Will be included within leadership and management principles development and leadership programme development as above. • Management training under review and refresh to focus on wellbeing and keeping people well at work. ~~Training to commence~~Managing Attendance at Work training reviewed and re-launched April 2025, supported by digital learning.

Strategic Risks – People

			• Leadership ~~development and talent~~ and Management role to be re-advertised May~~April~~ 2025, role will enable distinct focus on development of existing and future leaders and managers. • Ward Manager Programme and General Manager Programme in development to commence June 2025. Look to expand to ensure nulti-disciplinary learning opportunities.
Wellbeing interventions and resources to be evidence based, targeted, reviewed and evaluated.	Claire Whiles	September~~June~~ 2025	• EWS continue to offer evidence based interventions and review and enhance offer, e.g. Spring; EMDR • Operating model review and 3 year plan to be developed to support delivery of the People and Culture Plan and organisational priorities • A review of 3 frameworks in development identified cross-cutting themes. This has resulted in the development of an over-arching framework including retention, health and wellbeing and organisational development. ~~This will be consulted upon in March and April, and presented in May 2025 for approval. Will contain sections on data driven decision making, and monitoring and evaluation.~~Currently sense-checking approach in light of existing demands and pressures to assess prioritisation of framework development, e.g. OD&Culture; Leadership & Management • Improvement required across UHB to ensure consistency of offer, e.g. Trauma response / psychologist intervention / evidence based practice. • Staff Fast Track Trauma Pathway under review due to increase in waiting times, draft paper for initial consideration ~~April 2025~~to be discussed May 2025. • Trauma Risk Management (TRiM) proposal presented at Senior Leadership Board for feedback, business case in development for presentation Quarter 1 2025. • Review of EWS and OH service based upon direction of 'Brilliant Basics' to align to organisational priorities and support reduction in waiting times. To follow collaboration review (September 2025)

Strategic Risks – Digital

Strategic Risk	Strategic Portfolio	Exec Lead	Committee	Date Added
Digital	Shaping our Future Digital Services	Director Digital and Health Intelligence (D&HI)	Digital and Infrastructure	4 October 2022

Risk

CAVUHB has legacy and deficit in human resources, skills and capability, infrastructure, applications and informatics. The digital estate has grown but the supporting resource has not. Without resourcing our Digital and Data transformation plans and Roadmap we risk the achievement of our SOFW objectives

Cause	Impact
CAVUHB IT and digital services are known to be historically underfunded resulting in a legacy and deficit in infrastructure, applications and informatics capability that has built up over at least a decade (e.g. our core applications for UEC, inpatients and outpatients were developed in-house c20 years ago). There are plans to rectify these issues however they are unachievable with the current resource (people, finance) allocation We have some capability in human resources but insufficient capacity or funding to execute the digital and data transformation plans and road map. Existing resources are fully consumed with tactical short-term on the day-to-day urgency of UHB operational needs Recruitment of suitably skilled D&HI staff is a national challenge as well as affecting CAV. This often requires the use of interim agency support in key areas, especially whilst we continue with legacy solutions as we are tied to old technologies. This of itself diminishes further our existing capacity as resources need to be familiarised with the technical environment and then supervised. Historically CAV has looked to provide much of its core IT and digital services inhouse. This is not always necessarily the optimum route however 'legacy lock' and the resource to support forward plans keeps us where we are. Meanwhile with new initiatives the technical estate grows and the gap between what we have and what we can support/refresh widens.	Colleagues need mobile, scalable, agile solutions that enable data collection and sharing. This is unachievable whilst we are locked into legacy. Legacy Lock makes improving our cyber posture more challenging (e.g. securing our data) The impact of not managing this risk is that the improvements in safety, quality, outcomes, productivity and financial efficiency that staff and patients expect from D&HI cannot be fully realised, therefore putting at risk the deliverability of the SOFW Strategy.

Strategic Risks – Digital

Uncontrolled Risk			
Impact: 5	Likelihood: 5	Gross Risk: 25	Target Risk: 20

Controls	Assurances
• Digital strategy approved by Board in 20/21 with roadmap for 21/22/23 - these will be refreshed by April 2025 • Roadmap to support the strategy shared with DHIC covering 2024/27 - these will be refreshed by April 2025 as part of the Digital Foundations PBC work • Digital components described in IMTP – focussed on in year national and clinical board priorities • £466K is being invested by CAVUHB in the development of a Digital Programme Business Case (PBC) to seek All Wales Major Capital Funding alongside a Business Justification case (BJC) for phase 1 of the 5 annual phases. This work will complete in 12 months. • The work will deliver a clear trajectory, costs and plans on how CAV will achieve its target of HIMSS[1] Level 3 in pursuit of its intention towards a modular EPR, consistent with national and regional initiatives. The capabilities the PBC and business justification cases will describe are harmonious with and would segue into any nationally agreed and funded EHR solutions through interoperability and concordance with the "All Wales" Infrastructure review. o Work is expected to begin Oct/Nov 2024. o This follows positive discussions with WG IIB and NHS CDIO,	• All Controls are shared and discussed with the DHI Committee which meets quarterly. • The Digital Foundations case was scrutinised and approved by the Investment Group and Strategic Leadership Board. • The Director D&HI shared the intentions of the Digital Foundations investment case and updated WG's chief digital officer, whilst the DoF has discussed with IIB Lead. Both are supportive of approach and our intentions • Recruitment and procurement is underway for the resource to produce the PBC and BJCs • Risk register articulates the risks of not being able to deliver digital solutions to support delivery of healthcare (1) • Internal audit report highlights the risk in delivering digital strategy citing the investment challenges that will prevent full implementation.

Gaps in Controls	Gaps in Assurances
Current annual discretionary funding is insufficient to cover the maintenance upkeep of the core infrastructure and there is no headroom for innovation	Unable to currently provide assurance that the finance will be provided

Risk Post-Controls and Mitigation		
Impact: 5	Likelihood: 4	Net Risk: 20

Strategic Risks – Digital

Actions			
What	**Lead**	**By**	**Update**
Internal investment case to support the Digital Foundations case approved	Director of DHI	Sept 25	Programme Business Case completed and shared with WG setting out detailed roadmap plans and the associated costs, funded accessed by annual Business Justification Cases to WG's Major capital budget. Statement of works produced against which a suitable external partner will be sought
Development of the Digital Programme Business case to support the digital foundations ambitions is underway.	Director of DHI	Dec 25	External partner identified and service procured which has enabled the works to commence on the Programme Business Case. Co-production approach with all ~~Clincial~~Clinical Boards and ~~corcreate~~corporate services involved via workshops taking place during May and June 2025.

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Strategic Risks – Infrastructure

Strategic Risk	Strategic Portfolio	Exec Lead	Committee	Date Added
Infrastructure	Shaping our Future Infrastructure	Exec Dir Finance	Digital and Infrastructure	12 November 2018

Risk

There is a risk that the condition and suitability of the UHB estate, IT infrastructure and Medical Equipment impacts on the delivery of safe, effective and prudent health care for the patients of Cardiff and Vale UHB.
The condition of facilities within our main hospitals and some community facilities are impacting on our ability to continue to provide the full range of services and provide the would like to commission from us. This is as a result of insufficient funding and resource to bring the estate up to the required condition in a timely way.

Cause	Impact
• Significant proportion of the estate is over-crowded, not suitable for the function it performs, or falls below condition B (assessed regularly on an all-Wales basis by NHS Shared Services Partnership). • Investment in replacing facilities and proactively maintaining the estate has not kept up the requirements, with compliance and urgent service pressures being prioritised. • Lack of investment in IT also means that opportunities to provide services in new and efficient ways are not always possible and core infrastructure upgrading is behind schedule. • Insufficient resource to provide a timely replacement programme, or meet needs for small equipment replacement • Lack of timely decisions regarding the development of strategic business cases required to address the significant estates challenges we face.	• The health board is not able to always provide services in an optimal way, leading to increased inefficiencies and costs. • Service provision is regularly interrupted by estates issues and failures. • Patient safety and experience is sometimes adversely impacted. • IT infrastructure not upgraded as timely as required increasing operational continuity and increasing cyber security risk • Medical equipment replaced in a risk priority order where possible, insufficient resource for new equipment or timely replacement • Staff facilities needed to support good staff wellbeing are inadequate in many areas.

Uncontrolled Risk

Impact: 5	Likelihood: 5	Gross Risk: 25	Target Risk: 15

Strategic Risks – Infrastructure

Controls	Assurances
• Estates strategic plan in place which sets out how over the next ten years, plans will be implemented to secure estate, which is fit for purpose, efficient and is 'future-proofed' as much as possible, recognising that advances in medical treatments and therapies are accelerating. This is being updated. • Statutory compliance estates programme in place – including legionella proactive actions, and time safety management actions. • The strategic plan sets out the key actions required in the short, medium and long term to ensure provision of appropriate estates infrastructure. • The annual capital programme is prioritised based on risk and the services requirements set out in the IMTP/annual plan, with regular oversight of the programme of discretionary and major capital programmes. The 2024/25 Capital Plan will be submitted for Board with the IMTP • Medical Equipment prioritisation is managed through the Medical Equipment Group and there is a process in place for rapid decision making if there is a urgent need to replace a piece of equipment. This part of the Capital Management Group agenda. • Business Case performance monitored through Capital Management Group every month and Finance & Performance Committee at each meeting, every month. • Welsh Government has asked all NHS organisations to provide a prioritised capital programme using a weighting framework developed by the Infrastructure Investment Board. The submission date is 31st March 2024. The Health Board's submission has been scrutinised and approved through the internal governance mechanisms and is coming to the Board on 28th March for oversight. • Discussion with Welsh Government regarding the Shaping Our Future Acute Hospital Programme Business Case is ongoing. We presented to a special Infrastructure Investment Board prior to Christmas where there was agreement to progress testing of options, including a phased approach to developing on the current UHW site. The scope of this work, which is being led jointly with Cardiff University, is currently being finalised for approval by Welsh Government. • In accordance with the prioritised plan the Board approved and submitted to Welsh Government the Tertiary Tower Business Case and the Vascular MTC Theatres Business Case. The Tertiary Tower Electrical Supply business case was approved by Welsh Government and the capital works is progressing. This will remove a single point of failure in the electrical system and provide greater resilience. The Vascular MTC Theatres business case is currently being updated to reflect that the original equipment supplier has withdrawn. A new supplier has been identified but the financial case will need to be updated to reflect the preferred solution, and any changes to costs due to the passage of time since the business case was originally approved. The business case for	• The estates and capital team is in constant dialogue with WG and continues to present business cases to secure the necessary capital to address the major short/medium term service estates issues. This has proven successful in the closing months of the financial year A significant amount of end of year funding has been secured, as in previous years, and this has enabled capital investment in critical digital infrastructure in particular. • The statutory compliance areas are monitored every month in the Capital Management Group to ensure that the key areas of risk are prioritised and reporting of estates risks to the Health and Safety Committee has been strengthened(1) • The Executive Director of Strategic Planning and the Director of Capital, Facilities and Estates meet regularly with the Welsh Government Capital Team to review the capital programme and discuss the service risks (3). • Regular reporting on capital programme and risks to Capital Management, Management Executive and Finance & Performance Committee (1) (2) • IT risk register regularly updated and shared with DHCW (2) • Health Care Standard completed annually (3) • Medical equipment risk registers developed and managed by Clinical Boards, reviewed at UHB medical equipment group (1) (2) • Finance and Performance Committee continue to oversee the delivery of the Capital Programme (1) • Timely decision making in relation to the Shaping Our Future Hospitals Strategic Outline Case (3)

the BMT, haematology, complex cancer and cancer research hub has been submitted to Welsh Government and a team made up of the three partners (Cardiff University, Velindre NHS Trust and Cardiff and Vale Health Board). • Welsh Government has also provided funding to enable the demolition of the Links Building at CRI which presented a health and safety risk. Additional car parking will be provided temporarily on the space created whilst the longer-term plan (subject to business case approval) for the Health and Wellbeing Centre at CRI comes to fruition.	
Gaps in Controls	**Gaps in Assurances**
• The current annual discretionary capital funding is not enough to cover all of the priorities identified through the risk assessment and IMTP process for the estate and digital infrastructure and medical equipment replacement services which requires the need to prioritise investment and resource allocation based on assessed level of risk and alignment with strategy and IMTP priorities. • In year requirements further impact and require the annual capital programme to be re-prioritised regularly. • Traceability of Medical Equipment • The Welsh Government current capital position is very compromised due to size of budget compared with estimated need which will impact significantly on the Capital Programme of the UHB. Not all business cases in the Welsh Government capital plan will be deliverable and the UHB needs to be mindful of the potential reputational risk of delays between OBC and FBC approvals with supply chain partners.	• The regular statutory compliance surveys identify remedial works that are required urgently, for which there is no discretionary capital funding identified, requiring the annual plan to be re-prioritised, or the contingency fund to be used. • Medical equipment is also subject to regulatory requirements, and therefore requires re-prioritisation during the year. • Despite the substantial end of year capital, the recurrent position remains unchanged. • Full condition surveys of all buildings have not been carried out so not possible to fully understand the condition of the estate.

Risk Post-Controls and Mitigation		
Impact: 5	Likelihood: 4	Net Risk: 20

Actions			
What	**Lead**	**By**	**Update**
Risks to infrastructure which have been identified are developed into robust plans for mitigation. These are prioritised through our annual planning work and identified	Geoff Walsh	Annual plan	The discretionary capital is prioritised to meet our annual plan. Prioritised plan is signed off by CMG and SLB and Board. Significant risks or financial requirements are raised regularly with Welsh Government to support when necessary. WG Targeted Estates Funding received which will address some of the highest risks identified on the CEF Risk Register. Schemes which received approval have been reported to CMG and SLB

Strategic Risks – Infrastructure

Where estate is no longer required for the provision of care or services a programme of decommission, disposal or demolition is undertaken to minimise the estate and infrastructure which the Health Board needs to maintain.	Geoff Walsh	Annual plan	Decommission priorities – Denbeigh and Carmarthen house have been vacated and planning permission is being sought for their demolition.~~and Rookwood decant & reprovision~~ CEF are working with the Specialist Clinical Board on options to re-locate ALAS and deliver a single site option for the service Disposal plans – Whitchurch has been transferred into the ownership of the Velindre NHST~~and~~ Rookwood ~~sites~~ the UHB have indentified a preferred bidder following a comprehensive disposal exercise and are working with them to develop the proposal, including Heads of Terms etc. ~~Demolition plans – Linc building CRI~~ The Links Building at CRI has been demolished
A condition survey will be undertaken to understand in detail the status of the Health Board estate with a view to inform a future investment priorities and estate needs.	Geoff Walsh	December 2025	The scope and plan for the condition survey have been shared with and supported by Welsh Government. Funding is pending and this work is anticipated to be undertaken in the next 12 months. The site survey work is continuing and the delivery of the completed survey remains on programme
An acute infrastructure group is overseeing the short – medium term priorities and a programme of work is progressing Shaping Our Future in the Community Programme Board oversees the capital infrastructure requirements for community based care and a prioritised business case pipeline is in place. This work dovetails with the RPB 10 year capital plan and the Cardiff PSB Asset Management Group.	Geoff Walsh	Ongoing	~~The group continues to meet to oversee the priorities and development of a number of business cases that have been prioritised to ensure they progress in a timely way to address significant infrastructure risks.~~ Following a review of the governance arrangements for the management and oversight of capital projects etc, it has been agreed to step down the AIB and introduce Project Boards for major schemes with less complex and lower value scheme reporting directly to CMG

Strategic Risks – Sustainability

Strategic Risk	Strategic Portfolio	Exec Lead	Committee	Date Added
Sustainability	Shaping our Future Generations	Exec Dir Finance	Finance and Performance	1 April 2022

Risk

If the organisation cannot produce a balanced 3-year plan or a balanced IMTP in any year it will breach its statutory financial duty and will be limited in the ability to deliver on the strategy and so the services to the population that the organisation serves.
If the organisation cannot protect the environment and take the steps required of it regarding waste, carbon footprint and other deliverables, it will not be an efficient service and will jeopardise the health of future generations.

Cause	Impact
Finance The UHB has to manage its operational budget. In the absence of a 3 year approved IMTP the UHB works to One Year Operational Plans from year to year. These still require significant savings achievements within each financial year irrespective of a deficit year end projection. Decarbonisation The UHB has to achieve 16% and 34% emission savings from a 2018/19 baseline by 2025 and 2030, respectively, aligned with Welsh government targets. Additionally, the "Shaping Our Future Wellbeing" strategy targets a 40% reduction in directly controlled emissions by 2027. In the last calculated emission report, total emissions increased by 7% to 217,000 tonnes, while emissions under our control reduced by 7%. CAVUHB is not on track to achieve the 16% reduction target set by the Welsh government for 2025. To meet the aims outlined by UHB in the strategy, we must reduce emissions under our control by 10% annually starting since 2023/24. Climate Impacts: The world has breached the 1.5°C pathway set by the Paris Agreement in 2024. Growing evidence shows that the magnitude of climate impacts is increasing day by day, and Cardiff is projected to be one of the most affected cities in the UK. The Welsh government has made it mandatory for UHB to submit an annual qualitative report on climate adaptation.	Breach of statutory duties, escalation. Unable to deliver a balanced year-end financial position. Reputational loss. Inefficient or reduced service delivery Decarbonisation: • UHB will not achieve its targets for decarbonisation in its current pathway and this will render UHB answerable to Welsh Government. • Reputational loss due to not achieving Shaping Our Future Wellbeing" strategy's target of 40% reduction in directly controlled emissions by 2027. • If the yearly emission reduction pathway is not designed and followed it will lead to risk of spending more at a later time to meet the set-out targets. Climate Impacts: • Initial sift of evidence and analysis shows that, given Cardiff's growing older population along with increased climate impact, vulnerability in the region is set to rise. This translates into more hospital admissions, increased patient flow, and ultimately, increased healthcare delivery costs for UHB. • Operationally, given the aging assets and assets exposed to weather events, there will be increased physical impacts on UHB's assets. • As comprehensive risk assessment has not been conducted, and a climate adaptation plan to mitigate the risks is not in place, UHB's understanding of its climate risks is limited and capacity to adapt are limited.

Strategic Risks – Sustainability

Currently, UHB has not undertaken a comprehensive assessment of current and future climate risks. This renders UHB vulnerable to unidentified climate risks that have a direct impact on healthcare delivery and its financial situation.			
Uncontrolled Risk			
Impact: 5	Likelihood: 5	Gross Risk: 25	Target Risk: 10

Controls	Assurances
Additional expenditure is being authorised within the governance structure and the UHB Scheme of Delegation. Financial Plan submitted to Welsh Government in March 2024 explaining inability to deliver financial balance over the three-year period 2024-2027. Themed Savings programme managed through fortnightly Sustainability Board chaired by CEO aligned to the National Value and Sustainability Board Decarbonisation A decarbonisation action plan is in place to deliver decarbonisation actions aligned with the NHS Wales Decarbonisation Strategic Delivery Plan 2021-2030. SusQI has been implemented to embed sustainability in Q&I projects. The Welsh Government has mandated yearly reporting, such as Decarbonisation Co-Ordination Reporting and Emission Reporting, along with all other health boards in Wales. Climate Impacts The Welsh Government has made it mandatory to report qualitatively on progress regarding climate adaptation. A task and finish group has been established to identify pathways for climate risk assessment and climate adaptation pathways.	The financial position is reviewed by the Finance & Performance Committee which meets monthly and reports into the Board (1) Financial performance is a standing agenda item monthly on Senior Leadership Board with escalation to Management Executives Meeting (1) Financial performance is monitored by the Management Executive (1). Assurance from internal audit annual review of core financial controls including budgeting and planning. Sustainability Programme Board in place, chaired by the Chief Executive. Additional measures implemented IY as set out in actions below Decarbonisation plan is developed annually and overseen by Finance and performance committee

Strategic Risks – Sustainability

Initial conversations are being held with the MET Office to collaborate and conduct a comprehensive Multi-Risk Assessment, starting with the impacts of heatwaves on our operations.	
Gaps in Controls	**Gaps in Assurances**
Decarbonisation The current financial landscape doesn't allow UHB to meaningfully develop plans to hit NHS Wales targets or the targets set out by the strategy. Given the complexity of decarbonisation actions across various departments of the UHB, there is a lack of continuous, robust monitoring. This would require the reestablishment of a digital climate change program dashboard, setting of qualitative and quantitative KPIs aligned with targets, and a seamless data collection process for all decarbonisation actions. Sustainability needs to be embedded in decision-making. The business plan template needs to capture sustainability from decarbonisation and climate risk perspectives and should be given appropriate weight. Climate Impacts Given the nascent stage of climate adaptation in UHB, it needs more resources to be properly explored and established. As climate risk exacerbates all existing risks, it ultimately strains UHB's finances in the future if not acted upon appropriately now. Climate Impacts needs to be included in appropriate risk registries, and risk thresholds needs to be set.	A working group or delivery group needs to be established, comprising staff who are owners of decarbonisation actions, to highlight progress and barriers.

Risk Post-Controls and Mitigation			
Impact: 4	Likelihood: 5	Net Risk: 20	

Strategic Risks – Sustainability

Actions			
What	**Lead**	**By**	**Update**
Savings plan for 2024/25 implemented.	Catherine Phillips	~~End FY~~	~~Further schemes are being progressed to improve the expenditure run rate entering 2024/25.~~ ~~A wide-ranging set of measures applying moratoriums to a wholesale spectrum of expenditure has been implemented. Any derogations from this will require Exec level approval. An Exec programme team has been established and will meet daily for the rest of the FY to oversee this enhanced grip and control/~~
The 25/26 Quality Improvement and Efficiency Plan has been developed as part of the 2025-26 financial plan~~is presented today..~~	Catherine Phillips/ Paul Bostock	Ongoing during 2025-26 Financial Year~~March 2025~~	SLT will continue to monitor the 'go further options' for the UHB. Each Clinical Board will present to SLT for 30 minutes each month on how they have progressed toward their 2025-26 QIEP targets following rapid planning events in December 2024 and April 2025. ~~SLB and SPB work and plan delivery issues identified the need to undertake the rapid planning event and work more strategically with the leadership team of the organisation to work on long term sustainability. This will support next years plan and the future model of delivery for the organisation.~~ ~~As part of the annual plan a quality improvement plan will be developed and implemented to deliver the 2025/26 savings programme.~~ A monitoring function for all plan aspects has been ~~is being~~ developed and is being utilised in the Finance & Performance Committees during 2025-26.~~will be introduced at F&P Apr 25~~ The monitoring reports also support all other fora in which the QIEP delivery is being discussed and supported.
The emission gap between the health board's current emission pathway and targets set by the Welsh government and the SOFW strategy is widening. Hence, the emission reduction targets, and pathway need to be reviewed.	Catherine Phillips	September 2025	~~Currently a~~A Sustainability Program Board ~~is being~~has been established to review and monitor progress of decarbonisation actions.

Report Title:	People & Culture Committee – Chair's Report				Agenda Item no.	6.6.1
Meeting:	Board		Public	x	Meeting Date:	29.05.2025
			Private			
Status *(please tick one only)*:	Assurance	x	Approval		Information	
Lead Executive:	Director of Corporate Governance					
Report Author (Title):	Corporate Governance Officer					

Main Report
Background and current situation:

The purpose of this report is to highlight the key issues which were raised and discussed at the People & Culture Committee meeting held on the 06th May 2025.

Executive Director Opinion and Key Issues to bring to the attention of the Board:

The Committee considered several important items of business at the meetings and a brief synopsis of some of the items discussed are set out in this Report.

Staff Story – People Safety
The staff story was introduced by the EDPC, who presented Amie Roberts, a clinical scientist for medical physics. Amie shared her experience collaborating with the health & safety team, highlighting the integration of people safety into the clinical world. The story emphasized the impact on patients and the challenges faced by staff when informing patients about issues with scanning services.

Board Assurance Framework – Wellbeing
The Board Assurance Framework – Wellbeing was presented to the committee with the following points highlighted:

- CAV UHB were operating under intense financial pressure
- Collaboration on Occupational Health with Cwm Taf Morgannwg University Health Board has led to better turnaround times for management referrals and pre-placement clearances.
- A new triage system and improved standard operating procedures were implemented.
- Review of the operating model to support both proactive and reactive needs.
- Preparing for the Safe, Effective, Quality Occupational Health Service (SEQOHS) assessment.
- Waiting times for counselling reduced from 77 days to approximately 20-30 days.
- Workshops tailored to address burnout and trauma, with a 90% clinical improvement rate for guided self-help.
- High demand for trauma interventions, leading to increased waiting times.
- Digitizing self-referral processes and developing a three-year strategic plan.
- Embedding wellbeing into leadership, management, and system design.
- Targeting hotspot areas and improving cultural and leadership programs.
- CAV need to maintain momentum, address waiting times for trauma-related services, and ensure a proactive and integrated approach to support colleagues.

Managing Sickness & Availability
A paper on managing sickness & availability was discussed with the following points highlighted:

- A multidisciplinary team had developed an improving well-being and attendance action plan, involving people services, occupational health, the well-being team, and organizational development and culture.
- The sickness absence target was set at 5.5%, with the cumulative position for February 2025 at 6.32%. Each clinical board has individual targeted action plans to help reduce sickness.
- The managing attendance at work training was relaunched, focusing on understanding the policy, effective and compassionate conversations, and making reasonable adjustments. Two sessions are run monthly, with additional sessions for hotspot areas.
- Digitalizing training, providing module-based refresher training, and developing myth-busting FAQs and top tips.
- Ensuring accurate recording on the system, especially for medic sickness and return to work meetings.
- Developing a well-being and culture framework to support managers on retention, cultural improvements, staff engagement, and leadership.
- Monthly sickness panels, performance reviews, and audit procedures.

- Each clinical board has monthly sickness panels, identifies hotspot areas for targeted intervention, and provides additional support where needed.
- From December to the recent report, long-term sickness reduced from 615 to 450 employees, attributed to data cleansing, sickness panels, and supporting ill health retirement processes.
- The long-term sickness rate in January was 4.28%, reduced to 3.70%. The overall sickness rate is on a trajectory to improve.
- Emphasis on reducing the sickness rate below 5.5%, with some areas already at 4%.
- The training has been more directive to ensure proper policy implementation, causing some frustration but necessary for improvement.
- Efforts to maintain Ward sisters' supervisory status to improve their ability to manage sickness.
- Conduct an audit of existing processes, including return to work meetings and the application of the policy.
- Develop more detailed tracking by area to identify hotspot areas and overlap with patient safety and well-being.

Key Workforce Performance Indicators
The Key Workforce Performance Indicators were presented with the following highlighted:

- The turnover rate continued to improve which attributed to multifaceted efforts influencing retention, including well-being, staff experience, engagement, and environment.
- VBA position had deteriorated with a significant improvement last year due to clinical boards' focus through performance reviews. Executive colleagues will emphasize the importance of meaningful appraisals going forward.
- Sickness absence had improved significantly for March 2025, with a peak in winter months and expected improvement as we move into summer. The cumulative rate is also improving.
- Agency staff had saw a reduction in spend which attributed to enhanced scrutiny and significant reduction in nursing and medical agency use.
- The exit questionnaire data currently shows November, but the team is analysing the quarter 4 position, which will be available next month. Team of 8 will transfer across to the medical resourcing team
- The staff bank currently run by Medax Healthcare is transferring into the health board on June 2nd, with a team of eight joining the medical resourcing team and the wider people and culture team.

Health & Safety Update
The Health & Safety Update was presented with the following points highlighted:

- Total RIDDOR incidents for the last financial year: 78, an improvement from previous years but slightly disappointing due to a spike in January, February, and March.
- Over 70 injury incidents: 70 out of 78, which is 88% of RIDDOR incidents, significantly higher than the UK average of 70%.
- General positive increases across various training metrics compared to previous years.
- Fire safety training has dipped slightly, but efforts are ongoing to improve this through new training methods.
- South Wales Fire and Rescue service now only responds to confirmed fires, with exemptions granted for seven sites including Barry, CRI, Cardiff Edge, Saint David's, Maelfa, Rookwood, and Saint Mary's pharmacy unit.
- Significant changes in procedures for sites like UHW and UHL due to the new response policy.
- Total fire incidents for the last financial year: 8, with the last incident involving smoke from a vehicle's internal electrics.
- Three fire incidents reported in the current year, including smouldering Fibre Board, an overheated fan, and a melted sandwich maker due to improper placement.
- Historical data shows a decrease in fire incidents over the years, with a notable reduction during the COVID period.

Clinical Board Spotlight – Primary, Community & Intermediate Care (PCIC)
The PCIC Team presented and highlighted the following points:

- PCIC is responsible for commissioning primary care services (GPs, dental, community pharmacies, optometrists) and providing community and intermediate care services (district nurses, community resource teams, safer home, specialist teams like HMP Cardiff, sexual health, health protection).
- Serves a population of over 540,000 across Cardiff and the Vale.
- Development of an enhanced model of care program aligned with the primary care model for Wales and the six goals program.
- Integration of community care systems to deliver seamless care from routine access to crisis response.
- **Workforce**:
- PCIC have 947 whole-time equivalents, with a headcount of over 1200 staff.
- Band 5 and 6 with the largest workforce bands, majority female, with many working less than full-time.
- 25% of workforce were aged 55 and above.
- Primary Care Contractors included 55 GP practices, 102 community pharmacies, 59 optometrists, 61 dental providers.

- Contractors manage their own recruitment and retention.
- **Performance Indicators**:
- Sickness absence current position was just over 6%, but aimed to reduce to 5.75%.
- VBAs: Just under 76% but aiming for 85%.
- Statutory and mandatory training was just under 84%.
- Welsh language compliance had increased from 38% to 68%.
- Turnover had reduced from just under 13% to just over 10%.
- **Organisational Development and Cultural Hotspots**:
- Focus on building capacity and capability within senior management and operational leadership teams.
- Addressing issues in HMP, Cav 24/7, and DOSH.
- **Staff Survey Action Plan**:
- Themes: Employee engagement, negative experiences, burnout.
- Reviewing and refreshing the action plan due to low response rates.
- **Areas of Good Practice**:
- Standard induction plan for new staff.
- Compendium of primary care roles.
- Succession planning in general practice nurse training.
- Enhanced community care with multi-agency team within safe at home.
- **Priorities and Actions**:
- Scrutiny of temporary pay and workforce, effective rostering, vacancy scrutiny, organizational restructure, service reconfiguration.
- Focus on health and well-being of workforce, generational workforce challenges, sustainability of services.
- An away day planned in June for PCIC & Mental Health Clinical Board

Policies – The Employment Pension Contributions Alternative Payment Policy was approved.

The following items were noted:
- Health, Safety & Fire Risk Register
- Annual Chairs Report

The Supreme Court Ruling -0 Definition of Sex
It was noted the document was currently in a draft format and would be discussed at a future meeting.

Recommendation:

The Board is requested to:

a) Note the contents of the Report.

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

1 Putting People First	x	2. Providing Outstanding Quality	x
3. Delivering in the Right Places	x	4. Acting for the Future	x

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant

Prevention	x	Long term	x	Integration	x	Collaboration	x	Involvement	x

Impact Assessment:
Please state yes or no for each category. If yes please provide further details.

Risk: No

Safety: No
Financial: No
Workforce: No
Legal: No
Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation: No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Saunders,Nathan
14/07/2025 14:46:53

Report Title:	Quality Committee – Chairs Report			Agenda Item no.	6.6.2	
Meeting:	Board	Public	X	Meeting Date:	29/05/2025	
		Private				
Status:	Assurance	X	Approval		Information	
Lead Executive:	Director of Corporate Governance					
Report Author:	Corporate Governance Officer					

Background and current situation:

The purpose of this report is to highlight the key issues which were raised and discussed at the Quality Committee meeting held on the 13th of May 2025.

The papers to this meeting, outlining all of the detail on the below items, can be found on the Cardiff and Vale UHB website linked here.

Executive Director Opinion and Key Issues to bring to the attention of the Board

The Committee considered a number of important items of business at the meetings and a brief synopsis of some of the items discussed are set out in this Report.

Specialist Services Clinical Board – Assurance Report: - A Patient Story was presented to the Committee about a gentleman's journey through neuro rehab after suffering a subarachnoid haemorrhage. He highlighted the kindness and support received from various multidisciplinary professionals, the importance of therapeutic engagement, and his progress in regaining his independence.

The Committee was presented with the Assurance Report which detailed the clinical governance arrangements within the Clinical Board in relation to Quality, Safety and Patient Experience (QSPE) agenda over the past 12 months.

Regarding commissioning services, it was explained that the two biggest areas of concern for the Specialist Services Clinical Board were:

- Cardiac Surgery Activity
- JACIE Accreditation for Bone Marrow Transplant (BMT) and CAR-T Services

The Committee were informed that the Clinical Board were using AMaT, but that it primarily held individual action plans. There was a piece of work ongoing to create a single comprehensive action plan across the organisation which corresponded with themes.

Efforts were made to manage MRSA and MSSA infections amongst nephrology patients, particularly those associated with line infections:

- The focus last year was on improving the line management. Challenges remained however, and they were an outlier due to the huge increase of patients with lines over the past 5-7 years.
- Renal failure patients on haemodialysis often had permanent tunnel lines for long periods, which increased the incidence of bacteraemia.
- The goal was to transition these patients to fistulas, but with around 200 patients using lines, minimising these cases remained a challenge.

Quality Indicators Report: The Committee were presented with the Quality Indicators Report and slides which provided assurance in relation to several quality, safety, and patient experience priorities.

The Committee discussed the prevalence of 'Never Events' and the measures being taken. The key was to ensure that the same type of 'Never Event' did not recur and so robust reviews were essential, and each event was thoroughly examined. It was highlighted that a strong reporting culture indicated a strong safety culture.

The Committee were informed that this had recently been discussed in IQPD so the Welsh Government (WG) was aware. WHO checklists were discussed, and it was noted that they now had a WHO collaborative which did a significant amount of work in reducing and mitigating the number of 'Never Events' and had been spread across the organisation.

Learning from Mortality: - The Committee were presented with the report which highlighted the extensive work on learning from mortality in CAVUHB, in partnership with the medical examiner, coroner, and other partners. It detailed the digitisation of death reporting processes, the scrutiny of deaths by the Medical Examiner service, the review of referred cases, and the Learning from Mortality Group. They were looking to use AMaT the Morbidity & Mortality (M&M) module to document conversations and learning. The focus was on improving end-of-life care, lost to follow-up, managing deteriorating patients, and adhering to the Mental Capacity Act (MCA).

It was emphasized that learning was implemented to prevent future mistakes and delays, and to enhance overall service quality and outcomes.

Invited Service Review (IRS) of Cardiff and Vale University Health Board (UHB) Mental Health Services: - The Committee were presented with the report and slides which highlighted the following:

- During 2021-22, the Royal College of Psychiatrists (RCP) was invited to review the high inpatient suicide rates at the UHB and revealed significant areas for improvement.
- Key changes in the Clinical Board included: enhanced risk assessment training, better family engagement, implementation of open dialogue, improved care planning and formulation, therapeutic engagement, continuity of care, Mental Health Act (MHA) diagnosis and treatment training, training around observation levels, accreditation with SIRAN, 3 members of the QSE team were Peer National Reviewers.

The Committee were informed that significant changes and a cultural shift towards a co-produced approach had occurred since the serious incidents, with a focus on compassion, safety, and community engagement in collaboration with stakeholders, the lived experience team, and care groups.

It was noted that work with lived experience groups was crucial and could benefit all clinical boards.

The following was highlighted by the Executive Nurse Director (END):

- The improvements in risk assessments, care planning and formulation, and therapeutic engagement, all required more staff and time.
- They were mitigating in-hospital mental health staffing levels by using primary care and community funds. However, they needed to redirect these funds back to their intended areas.
- A business case for £6m would be presented to the Value & Benefits Realisation Group (VBRG) to address this.
- Despite financial challenges, they were committed to improving staffing levels and will regularly bring updates back to the Quality Committee on their progress.

Shaping Our Future Quality Excellence Framework: - The Committee were presented slides about the Shaping Our Future Quality Excellence Framework which outlined the

aims, governance structure, and associated projects. They discussed the focus on eradicating avoidable harm and the alignment with the NHS Executive Safe Care partnership work.

It was suggested that even though there were not any specific projects which addressed equity and data collection for protected characteristics, it should be used as a lens for all of their work.

Discharge Advice Letters: - The Committee were presented with the Discharge Advice Letters (DALs) report which highlighted the following:

- There was a lot of variances in the quality of DALs issued across the organisation, which was crucial for patient care continuity.
- DALs should include diagnosis, care and treatment details, medication changes, investigations, critical information for patients and GPs, and necessary follow-ups.
- DALs were managed through the Welsh Clinical Portal (WCP), owned by Digital Healthcare Wales (DHCW), which led to data ownership issues.
- The Electronic Prescribing and Medicines Administration (EPMA) would hold DALs in the future, which allowed data ownership and quality reporting.
- Efforts were being made to raise awareness through Clinical Boards and QSE Committees.
- The Surgical and Medical Clinical Board's ward standards required DALs to be completed, printed and given to patients before discharge.
- Education for resident doctors focused on creating focused and relevant DALs.
- Ongoing work to improve DALs processes, create dashboards, and Standard Operating Procedures (SOPs).

Board Assurance Framework: - The Committee were provided with a summary of the function of the Board Assurance Framework (BAF), and discussed how they would like the strategic objectives to be discussed in Committee meetings going forward.

It was suggested that the Chair, Director of Corporate Governance, and the Corporate Governance Officer review the Forward Plan and its alignment with the BAF and strategic objectives.

Policies: - the following policies were approved by the Committee:

i) UHB 529 – Policy for the Management of Suspected and Proven Neutropenic Sepsis in Adults

Suicide and Self-Harm Prevention Strategy: - the Committee were presented with the Suicide and Self-Harm Prevention Strategy and highlighted the following:

- This was a five-year plan with a one-year delivery plan
- An event in October 2024 developed a vision and eight objectives with stakeholders, including those with lived experience and those bereaved by suicide.
- The draft strategic plan went to consultation from February to April 2025 and received 20 responses and offers for help.
- The National Suicide Prevention and Self Harm Strategy was launched on April 1st, 2025.
- The strategic plan aligned with the national strategy and included the outline vision and eight priority areas.

The Committee were informed that whilst the prison population wasn't referred to directly, the Prison Governor and colleagues were included in the consultation phase. However, many elements like training, development, and creating safe spaces covered the prison population. The team would ensure that there was prison representation in a workshop in Q4.

The Committee were informed that most of the outcome measures were listed within the implementation plan document, and that there were both qualitative and quantitative measures for each of the 8 strategic objectives with specific measures for each.

Minutes from Clinical Board QSE Sub-Committees, the Safeguarding Steering Group (SSG), and the Infection Prevention & Control Group (IPCG): - The Committee noted the Clinical Board QSE Sub-Committee.

Primary Care Eye Health Needs Assessment: - The Committee noted the report.

Recommendation:

The Board is requested to:

a) **Note** the contents of the report.

Link to Strategic Objectives of Shaping our Future Wellbeing:
https://shapingourfuturewellbeing.com/

Putting People First 1. **Click the objective above to view more detail.**		Providing Outstanding Quality 2. **Click the objective above to view more detail.**	X
Delivering in the Right Places 3. **Click the objective above to view more detail.**	X	Acting for the Future 4. **Click the objective above to view more detail.**	

Five Ways of Working (Sustainable Development Principles) considered

Prevention		Long term		Integration		Collaboration	X	Involvement	X

Quality Impact Assessment Completed?

Yes –		No –	X	n/a

Impact Assessment:

Risk: No
Safety: No
Financial: No
Workforce: No
Legal: No
Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation: No
Welsh Language: No

Approval/Scrutiny Route *(please note anywhere else this paper has been before):*

Committee/Group/Exec	Date:

Report Title:	Mental Health Legislation Committee – Chairs Report			Agenda Item no.		6.6.3
Meeting:	Board		Public	X	Meeting Date:	29/05/2025
			Private			
Status:	Assurance	X	Approval		Information	
Lead Executive:	Director of Corporate Governance					
Report Author:	Corporate Governance Officer					

Background and current situation:

The purpose of this report is to highlight the key issues which were raised and discussed at the Mental Health Legislation Committee meeting held on the 29th April 2025.

The papers to this meeting, outlining all of the detail on the below items, can be found on the Cardiff and Vale UHB website linked here.

Executive Director Opinion and Key Issues to bring to the attention of the Board:

The Committee considered a number of important items of business at the meetings and a brief synopsis of some of the items discussed are set out in this Report.

Mental Capacity Act Monitoring Report and DoLS Monitoring: - The Committee were presented with the report which provided a general update on current issues related to the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). The MLA and DoLS indicators included, but were not limited to:

- MCA Team Audit 2024/25
- Mental Capacity Act Monitoring Actions (January – March 2025)
- Mental Capacity IMCA Referral type
- Awareness Raising / Training Sessions
- Mandatory MCA Training
- MCA Practitioner Led Training – 2024/25
- MCA Team Advice and Support
- MCA Team Resources for Staff
- Deprivation of Liberty Safeguards Monitoring Actions
- Referrals and Assessments

The Committee was made aware of the following:

- The new proformas were more detailed and followed the MCA process. It prompted the essential questions to ensure a robust capacity assessment, and it was supported by optional training on the practical application of the MCA. The form was being finalised at present.
- Withdrawals of DoLS often occurred when patients were discharged or moved between wards, however the DoLS team were working on reusing assessments for similar ward moved. Detailed breakdowns of DoLS withdrawal types may be included in future reports.
- The promotion of DoLS assessments were focused on wards where there were patients who may lack capacity to consent to their admission. Issued with referrals were addressed with wards to help target training. DoLS resources would be sent to all inpatient wards to encourage discussions and improve understanding.
- Following the MCA Audit, the MCA team felt that Clinical Boards needed to take more direct responsibility for improving practices and had encouraged Clinical

Boards to develop their own action plans to help with implementation. Action plans would be overseen by the MCA team.

The Court of Protection (COP) process was discussed, as it was felt that some senior decision makers prefer to defer the responsibility of risky decisions to the COP. The issue would be discussed by the Corporate Governance team and fed back.

The Committee were informed that the mandatory training for medical and dental staff was still below 50%. It was noted that the issue had been raised with the Executive Medical Director and was being addressed as part of a broader approach to all mandatory training.

Mental Health Act Monitoring Exception Report: - The Committee were presented with the Mental Health Act (MHA) Monitoring Exception Report to the Committee which provided a summary of the below:

- Use of the MHA
- Fundamentally defective applications and reports
- Section 136 - A&E and CAMHS
- Nearest relatives discharge requests
- Development sessions
- Audits

The Committee were provided with a summary of the following reported during the quarter:

- Two fundamentally defective report
- The use of Section 136s had decreased.

The Committee were informed that whilst the Right Care Right Person (RCRP) initiative aimed to reduce admission rates for Section 136 cases, it was too early to definitively link the decrease in admission rates to the RCRP initiative. They would continue to monitor to identify any trends.

Mental Health and Wellbeing Strategy / Suicide and Self-Harm Prevention Strategy: - The Committee were provided with the following verbal update:

- Both strategies were expected to be launched on the same date, however Welsh Government (WG) decided to launch the Suicide and Self-Harm Prevention Strategy early to give it its own parity.
- The Suicide and Self-Harm strategy emphasised six key areas: listening and learning, involving lived experiences, prevention, empowerment, support, equipping services, and responding. A distinct focus was on giving self-harm equal importance with suicide.
- The Mental Health and Wellbeing Strategy was expected to launch by the end of the month.
- The last local strategy meeting for the previous Suicide and Self-Harm Strategy was held recently, and implementation of the new strategy would begin soon.
- A significant challenge was the lack of third-sector provision for self-harm, which would be addressed through a commissioning strategy with various partners.

The Committee noted that a detailed briefing would be provided at the following meeting.

MHA / DoLS Interface: - The Committee were presented with the report which discussed the interface issues between the MHA and DoLS, including the impact on patient flow, transfer requests, and Section 117 aftercare costs.

The Committee were informed that the MHA was intended solely for the assessment and treatment of mental health, and that a physical health issue could only be treated under the MHA if it arose from a mental health condition.

It was noted by the Committee that the issue ought to be addressed and shared with other Committees, as further work was needed to understand the full implications for the organisation.

The following major concerns for the Mental Health Clinical Board were highlighted to the Committee:

1. Rising Continuing Healthcare (CHC) costs and limited CHC provision created a challenging position. It was crucial to avoid rerouting patients quickly to avoid costs and ensure patient care was appropriate. This situation could significantly impact mental health services.
2. The capacity to meet and deliver additional requirements was a concern – these included obligations under Section 117 for care and treatment planning allocations.
3. The overall system was under considerable pressure, and any additional demands would only increase this. Balancing finances, patient safety, governance, and meaningful delivery of services under new rules was a significant challenge.

The Committee noted that this was a process change which involved deciding whether patients should follow the DoLS or the MHA route. Key metrics to monitor included the detention rate and Section 117 activity, particularly in care homes. Data would be gathered to understand the impact of more patients transitioning to Section 3 and the associated costs. Monitoring these metrics would help assess the overall impact and facilitate discussions.

It was suggested that data and analysis around this topic be incorporated into the Exception Report.

It was suggested that the Director of Corporate Governance speak with Legal and Risk departments to understand how relevant updates were communicated to the appropriate teams.

Mental Health Measure Monitoring Reporting including Care and Treatment Plans Update Report: - The Committee was presented with the Monitoring report which provided further information on the UHB Mental Health Measure performance. The performance measures included, but were not limited to:

- Part 1a – target: 28-day referral to assessment compliance target of 80% (Adult) and (Children & Young People)
- Part 1b – target: 28-day assessment to intervention compliance target of 80% (Adult) and (Children & Young People)
- Part 2 – Care and Treatment Planning (over 18) and (Children & Young People)
- Part 3 – Right to request an assessment by self-referral
- Part 4 – Advocacy – standard to have access to an IMHA within 5 working days

The Committee noted that the plan was to invest more into the 111 Press 2 national helpline to provide rapid access to mental health services, aiming to reduce demand on other services. Whilst Part 1 assessment provisions were satisfactory and successful, CAV were experiencing an unusual rise in referrals, unlike other areas in Wales. This increase may require additional investment.

In response to a query around why CAV were experiencing a higher demand compared to the rest of Wales, the following was highlighted:

- There weren't specific reasons identified for the rise in referrals, though structural changes in the primary care liaison service may have contributed.
- Socioeconomic factors such as benefits, finances, and community connections were likely to influence the increase.
- The focus on future commissioning work would be on addressing these socioeconomic challenges, allowing services to concentrate more on care and treatment.
- Further detail would be sought from discussions with stakeholders across Cardiff.

Sub-Committee Meeting Minutes: - The Committee received the Sub-Committee meeting minutes for noting.

Annual Report of the Mental Health Legislation Committee 2024/25: - The Committee noted the Annual Report.

Recommendation:

The Board is requested to:

a) **Note** the contents of the report.

Link to Strategic Objectives of Shaping our Future Wellbeing:
https://shapingourfuturewellbeing.com/

Putting People First 1. **Click the objective above to view more detail.**		Providing Outstanding Quality 2. **Click the objective above to view more detail.**	X
Delivering in the Right Places 3. **Click the objective above to view more detail.**	X	Acting for the Future 4. **Click the objective above to view more detail.**	

Five Ways of Working (Sustainable Development Principles) considered

Prevention		Long term		Integration		Collaboration	X	Involvement	X

Quality Impact Assessment Completed?

Yes – ***(please provide completed QIA***		No – ***(Please provide reasoning, e.g. not required)***	X	n/a

document)				

Impact Assessment:
Risk: No
Safety: No
Financial: No
Workforce: No
Legal: No
Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation: No
Welsh Language: No

Approval/Scrutiny Route *(please note anywhere else this paper has been before):*	
Committee/Group/ Exec	Date:

Report Title:	Charitable Funds Committee – Chair's Report			Agenda Item no.		6.6.4	
Meeting:	Board		Public	X	Meeting Date:	29/05/2025	
			Private				
Status:	Assurance	X	Approval		Information		
Lead Executive:	Director of Corporate Governance						
Report Author:	Corporate Governance Officer						

Background and current situation:

The purpose of this report is to highlight the key issues which were raised and discussed at the Charitable Funds Committee meeting held on the 18th March 2025.

The papers to this meeting, outlining all of the detail on the below items, can be found on the CAVUHB website linked here.

Executive Director Opinion and Key Issues to bring to the attention of the Board:

The Committee considered a number of important items of business at the meetings and a brief synopsis of some of the items discussed are set out in this Report.

Health Charity Financial Position & Investment Update: - The Committee were presented with the report which provided information on the year-to-date financial performance of the Health Charity for the period 1st April 2024 to the period 31st January 2025, and assessed the forecast position of the Charity including commitments already made.

The following key issues were highlighted to the Committee:

- The value of the Charitable Funds has decreased by £0.059m from 1st April 2024 to 31st January 2025. This incorporated net expenditure of £0.356m over income and a gain in the Investment Portfolio value of £0.297m. In the current market environment, the Investment Portfolio is highly volatile.
- The General Reserve was forecast to be in deficit by £0.753m at 31st March 2025.

Additionally, the key points were the following:

- The projected deficit on the General Fund in this and future financial years.
- The impact of the Investment Portfolio that results from the request to support the cashflow of the Charity.
- The on-going restructure of the Charity Team and the Financial Framework which aims to enhance future resilience and sustainability of the General Funds and the Funds Held on Trust as a whole.

Regarding the Rookwood sale, it was noted that they were dealing with the Charity Commission around the restrictions on selling property received as charitable donations. Legalities, paperwork and bureaucracy had caused uncertainty, but they hoped the sale would occur within the calendar year.

The Committee were informed that current projections suggested that the deficit may not be fully repaired until around 2033-35, considering market volatility. The CFC must decide between a gradual, sustained repair to avoid destabilising other funds and activities, or a more radical solution with its own implications.

Food Sense Wales fund: - The Committee were presented with the annual status report on the Food Sense Wales (FSW) fund and highlighted key areas of work including building

a positive food culture, catalysing local and sustainable procurement, and advocating for good food policy.

The Committee were informed that the current staffing was stable, and all employees were in continual employment. There were reserves of around £65,000 to cover any potential redundancies.

It was noted that measuring outcomes was challenging due to the complexity of the food system. Key indicators included the growth in horticulture across Wales, monitoring household food insecurity and fruit and vegetable consumption.

Regarding food poverty and insecurity, the following was highlighted:

- The cross-government collaborative on this work was one The team worked with both the social justice team and the food division in Welsh Government (WG) to create more value in local supply chains and build jobs.
- The focus was on building household and community food resilience, addressing the root causes of food insecurity and ensuring resilience in the event of a global crisis.
- Key indicators from WG were being used to monitor progress.
- The report by Timothy Lang highlighted the importance of resilience at the community level in case of disruptions like electricity outages, logistic system bugs, or floods.

Reporting Feedback on Successful CFC Bids: - Wales Transplant Games – The Committee were presented with a report on the Wales Transplant Games, which highlighted the funding provided for participation and the benefits to patients and staff. The increase in participants and the support from WG and Popham Kidney Support was noted.

The Committee were informed that there was a long-term commitment of £8000 a year, which formed part of the forecast general reserve deficit. Even if there had been underspending in previous years, the funds returned to the general reserve.

Over 25k Endowment Expenditure Approvals: -

Cardiology Research Fund 9161 – RSA-PACE Clinical Study: - The Committee were presented with the proposal in which the Cardiology Research Fund had requested funding for a fixed-term post to support an existing full-time clinical research fellow for 12 months.

The Committee suggested approving the request subject to a paper being circulated to the Committee which detailed the confirmation sought from the EMD and team for support, confirmation that other sources of funding had been exhausted, and that there was a fair process of appointment -

Mental Health Services for Older People - Payne Legacy 9737 - Transformation and Development Lead: - The Committee was presented with a funding request for £67,719 for a Band 7 Arts Therapist post out of the Payne Legacy 9737 fund. The remaining balance of the fund would be £397,691 after funding the post.

The Committee suggested approving the request subject to the Director of Communications seeking confirmation from the team around whether the employment risks to the organisation had been worked through, and whether consideration had been given to other options of utilising the legacy fund which could deliver a bigger impact (e.g. third sector organisations or fundraising).

Responsible Gaming Policy: - The Committee was presented with the Responsible Gaming Policy for ratification, which was required to ensure responsible gambling through

the staff lottery. The policy had been through consultation and governance processes, with input from Public Health and Corporate Governance.

The Committee were informed that a draft had been submitted to the Charity Commission who were satisfied.

The Committee reviewed the policy for ratification.

Terms of Reference: - the Committee was informed that the Director of Corporate Governance was suggesting an amendment to the CFC Terms of Reference (ToR) to allow for the attendance of any executive director to satisfy the quorum requirements. This would be presented at Board meeting the following week.

The Committee provided their support.

Health Charity Fundraising Report: - The Committee was presented the report for noting.

Staff Benefits Group Report: - The Committee was presented the report for noting.

Recommendation:
The Board are requested to: a) **Note** the contents of the Report.

Link to Strategic Objectives of Shaping our Future Wellbeing: *https://shapingourfuturewellbeing.com/*			
Putting People First 1. **Click the objective above to view more detail.**		Providing Outstanding Quality 2. **Click the objective above to view more detail.**	
Delivering in the Right Places 3. **Click the objective above to view more detail.**		Acting for the Future 4. **Click the objective above to view more detail.**	

Five Ways of Working (Sustainable Development Principles) considered									
Prevention	X	Long term	X	Integration	X	Collaboration	X	Involvement	X

Quality Impact Assessment Completed?				
Yes – (***please provide completed QIA document***)		No – ***(Please provide reasoning, e.g. not required)***		n/a

Impact Assessment:
Risk: No
Safety: No

Financial: No	
Workforce: No	
Legal: No	
Reputational: No	
Socio Economic: No	
Equality and Health: No	
Decarbonisation: No	
Welsh Language: No	
Approval/Scrutiny Route	
Committee/Group/Exec	Date:

Saunders,Nathan
14/07/2025 14:46:53

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

Shaping Our Future Wellbeing

Joint Commissioning Committee

CAVUHB Board meeting

May 2025

NHS Wales Joint Commissioning Committee

- Hosted by Cwm Taf Morgannwg LHB, the JCC commissions contracted Specialist, Ambulance and complex Mental Health services for all Welsh patients
- JCC represents all 7 NHS Wales local health boards in this responsibility and is accordingly funded by each of the LHBs in proportion to their resident's consumption of service.
- Some financial risk is shared by the LHBs to mitigate short term swings in activity or for exceptionally high cost cases.
- The 7 Chief Executive Officers of the LHBs ultimately constitute 'the Committee'.

Cardiff and Vale UHB's engagement

- Cardiff and Vale University Health Board (CAVUHB) plays a dual role in the healthcare system for specialised services, acting both as a commissioner (through its funding for, and membership of,JCC) and a provider of services (to JCC).
- CAVUHB places £187.17m of its resource (2024-25 value) with the Joint Commissioning Committee (JCC) to spend on specialised services for CAVUHB residents.
- CAVUHB receives £381.2m annually (2024-25 value) from JCC for the provision of specialist services to Welsh residents (including C&V residents)

Strategic Influence and Governance

- For JCC-commissioned services - Engagement directly with JCC team.
- For non-JCC services - Engagement with multiple LHBs
- Review via an internal Tertiary Service Development Group and the UHB Senior Leadership Board.
- Escalate through Regional Partnerships and Chief Executive Management Team for strategic alignment.

Commissioning Challenges

- Inconsistent commissioning arrangements and historic contracting models.
- Limited availability of capital to support new services and changing standards for existing services.
- Underdeveloped commissioning arrangements for many tertiary services.
- Absence of a holistic NHS Wales strategy for tertiary services.
- Standing conflict of interest when inability of LHB commissioners to agree investments impacts C&V UHB's provider services.
- Changes in committee structures affecting oversight and scrutiny of business.

Provider Challenges

- Regular liaison between UHB provider arm and JCC commissioner arm has not been as effective as it could be - Need to re-establish robust and regular commissioner/provider interfaces.
- Over half of tertiary services are not commissioned by JCC, posing risks for delivery and sustainability
- Greater clarity of shared risk mitigation when resource is not available to invest in services under pressure
- Contracting framework reform and re-costing of services is balanced alongside LHB direct contracting reform

Discussion Points for the Board

1. How do we ensure whole pathway commissioning for value-based care?
2. How can we jointly manage risk between provider and commissioner?
3. What steps are needed to bridge the commissioning gap for non-JCC services?
4. How can we move forward contract framework reform in lock-step with services directly commissioned by LHBs ?

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Annual Health Board Engagement with the NHS Wales Joint Commissioning Committee (JCC)

'The Centre of Excellence for Collaborative Commissioning'

Ian Green - Chair
Huw George - Interim Chief Commissioner
Stacey Taylor - Director of Finance and Value
Georgina Galletly – Director of Corporate Planning & Strategy

Aim of session

- About the Joint Commissioning Committee;
  - Who we are
  - What we do

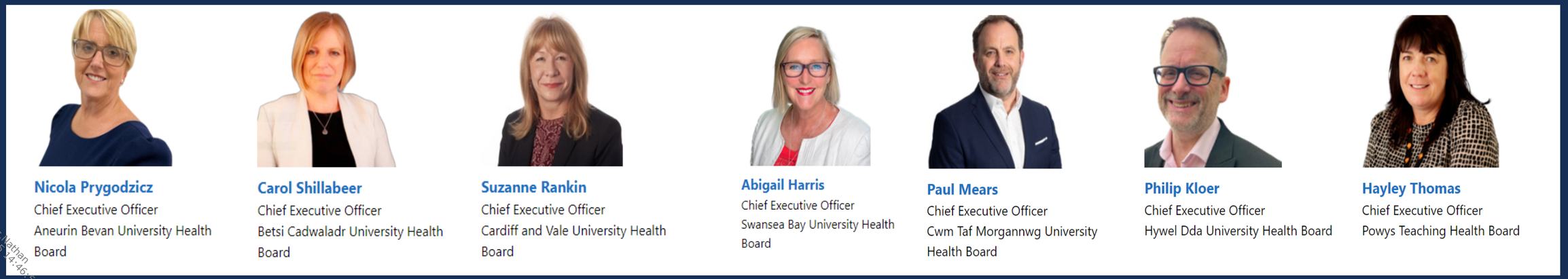
- Focus to date;
  - Establishment – Governance & Recruitment
  - Transition
  - Organisational Change
  - Business Continuity - Development of IMTP & Assurance

- Focus for the Future;
  - Implementation of new structure
  - Commissioning Strategy
  - Commissioning Framework – Value & Transformation
  - Deliver the Foundational Annual Plan 2025/2026
  - Continue to strengthen collaboration with HBs through the CCLG

About the Joint Commissioning Committee

The NHS Wales Joint Commissioning Committee (NWJCC) is a Joint Committee of the seven Health Boards acting collectively on their behalf. However, individual Health Boards are ultimately accountable to their population and other stakeholders for the provision of the services commissioned by the NWJCC for the residents in their area.

Health Board Chief Executive Officers



Nicola Prygodzicz
Chief Executive Officer
Aneurin Bevan University Health Board

Carol Shillabeer
Chief Executive Officer
Betsi Cadwaladr University Health Board

Suzanne Rankin
Chief Executive Officer
Cardiff and Vale University Health Board

Abigail Harris
Chief Executive Officer
Swansea Bay University Health Board

Paul Mears
Chief Executive Officer
Cwm Taf Morgannwg University Health Board

Philip Kloer
Chief Executive Officer
Hywel Dda University Health Board

Hayley Thomas
Chief Executive Officer
Powys Teaching Health Board

About the Joint Commissioning Committee

NHS Wales Joint Commissioning Committee Chair

Ian Green OBE

Accountable directly to the Cabinet Secretary for Health & Social Care in respect of their performance as Chair of the JCC. Has a bi-lateral relationship with each of the Chairs of the 7 HBs

Susan Elsmore

Paul Worthington

Nia Roberts

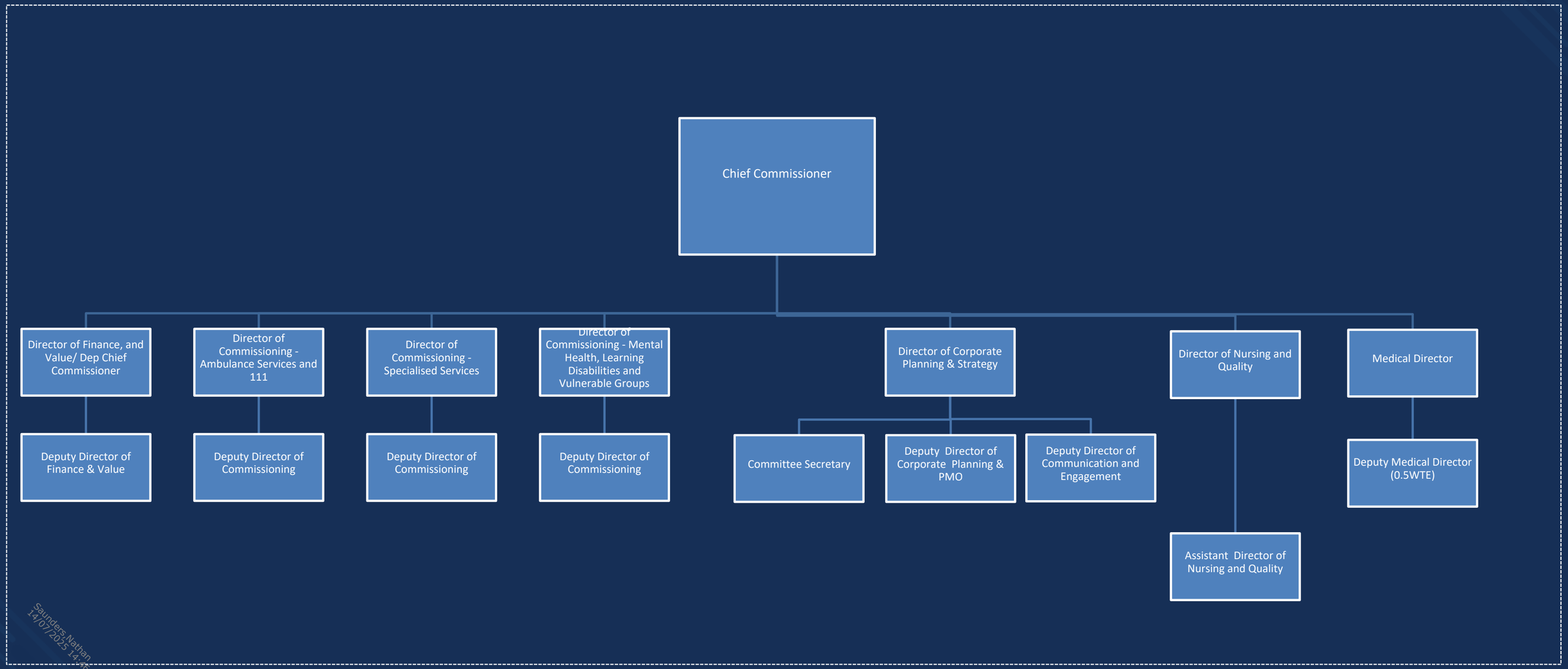
Shameem Nawaz

Mandy Rayani

NHS Wales Joint Commissioning Committee Lay Members

Responsible to the Committee Chair for discharging their roles as Lay Members of the JCC and are appointed by the Cabinet Secretary for Health & Social Care

High Level Structure



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Core Services

Ambulance Services / NHS 111 Wales

- Emergency Medical Services (999)
- Non-emergency Patient Transport Services
- Emergency Medical Retrieval and Transfer Services
- Adult Critical Care and Transfer Service
- NHS 111 Wales

Specialised Services

- Cancer and Blood Disorders
- Cardiac Conditions
- Renal
- Neurosciences
- Women and Children

Mental Health, Learning Disabilities and Vulnerable Groups

- Secure Mental Health
- Child & Adolescent Mental Health Services
- Welsh Gender Service
- Sexual Assault Referral Centres

Networks

- Welsh Kidney Network and Traumatic Stress Wales

Additionally

- Services where there is agreement between the Local Health Boards that they should be arranged on a regional and national basis and other services as directed by the Welsh Ministers.

Establishment

Governance

- Regulations, Directions, Standing Orders, Standing Financial Instructions, Hosting Agreement, Memorandum of Agreement

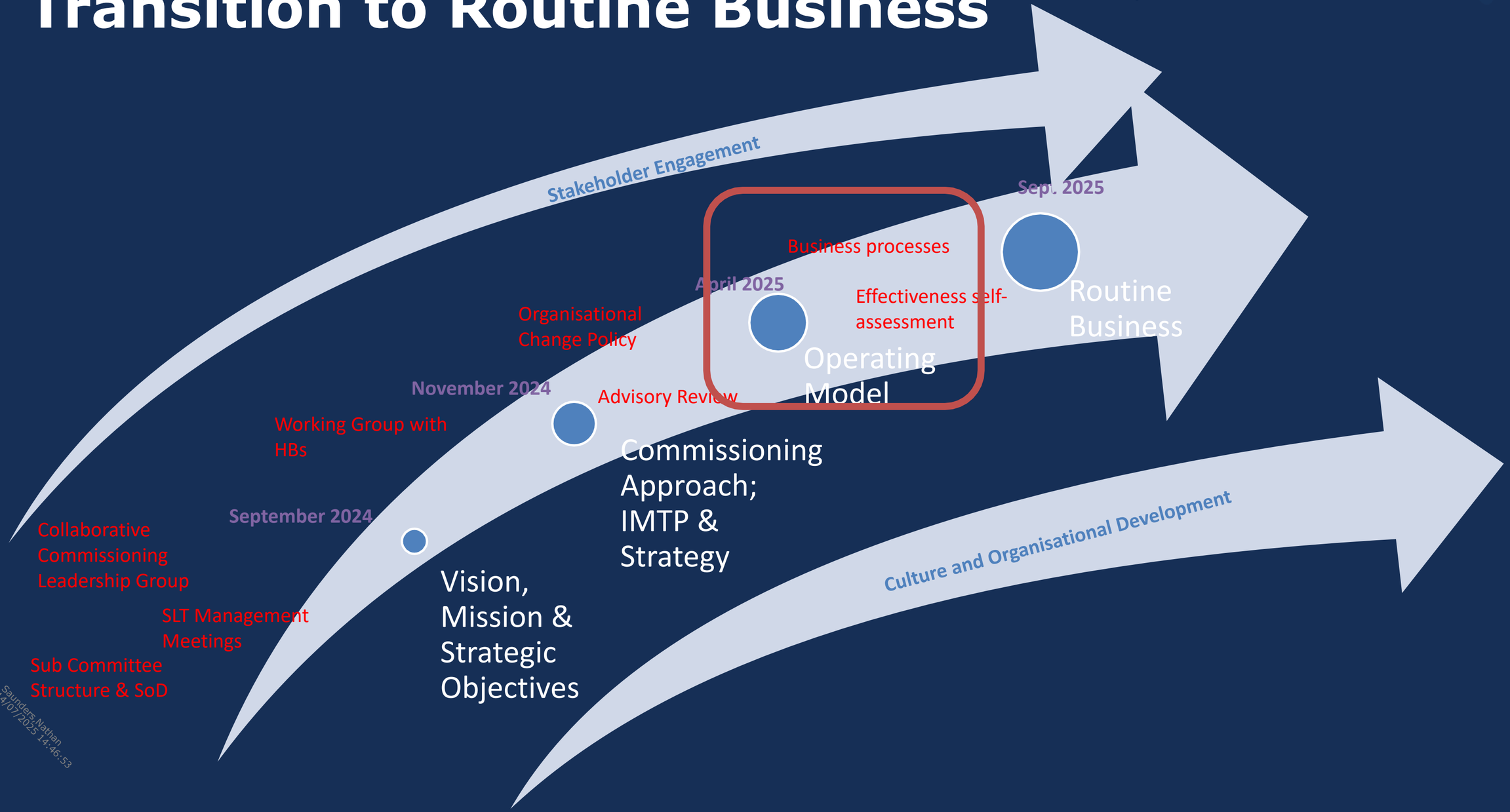
Recruitment

- Chair & Lay Member, Chief Commissioner & Senior Leadership Team Recruitment

Strategic Direction

- Vision, Mission, Strategic Objectives & Values and Behaviours

Transition to Routine Business



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Annual Health Board Engagement with the NHS Wales Joint Commissioning Committee (JCC)

Strategic Objectives

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Cyd-bwyllgor Comisiynu Joint Commissioning Committee

Maximise Value

Through our expertise and advice, determine where resources are best focussed and prioritised to inform choices that support the improvement of patient outcomes and commission appropriate services where value is demonstrated

Reduce Duplication

Apply value based health principles to reduce unwarranted variation to identify and maximise opportunities for collaborative commissioning in Wales and strengthen sustainable service provision

Facilitate Integration

Through effective engagement and collaboration, provide the key mechanism to support regional and national integration for commissioning services for the people of Wales

STRATEGIC OBJECTIVES ROADMAP

Ensure Quality

With a commissioning approach that is fostered in a quality management system, provide quality outcome, evidence-based service specifications for commissioned services and monitor delivery against these

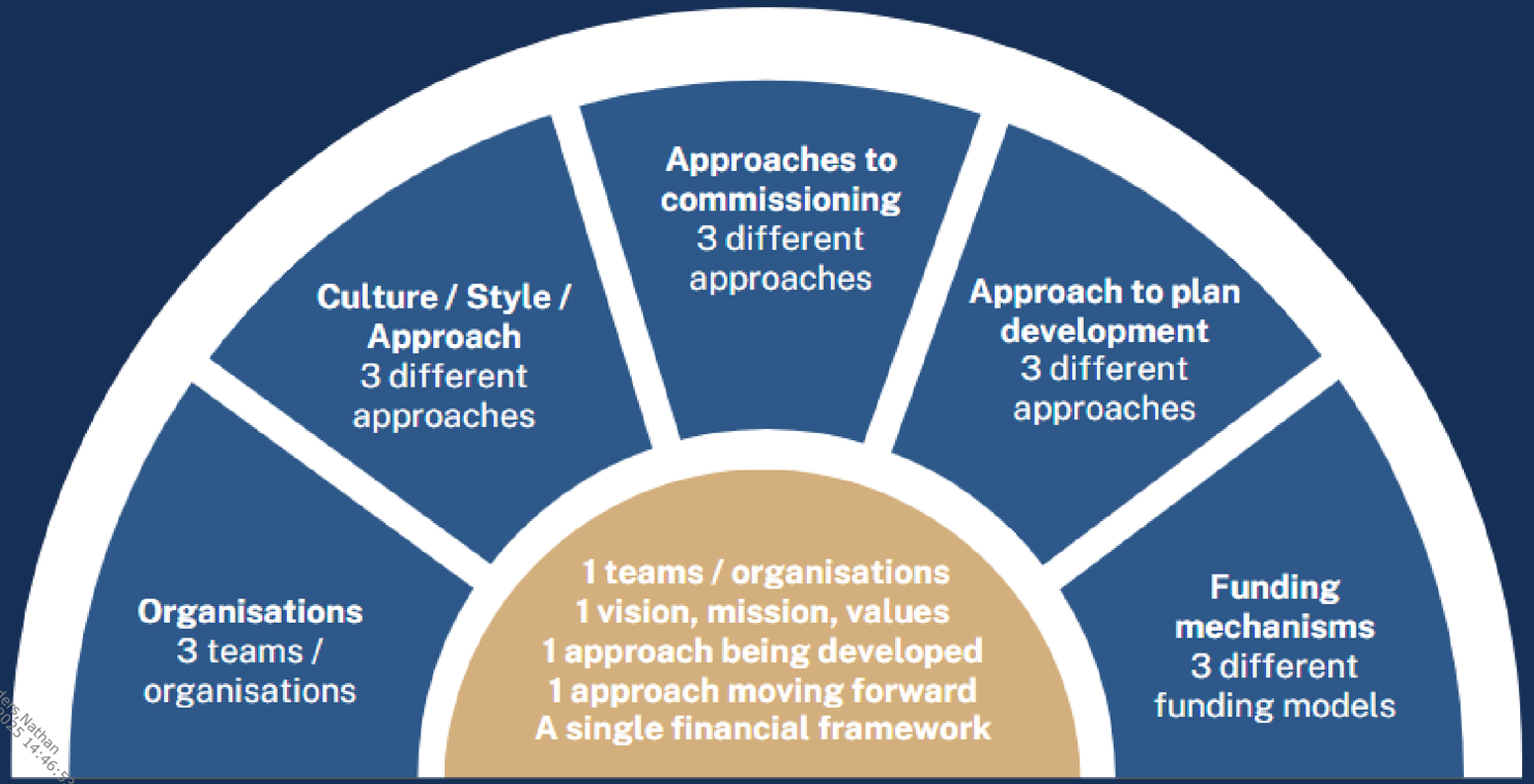
Improve Equity and Population Health

With patient engagement, undertake population needs assessments and horizon scanning to ensure that people are able to access the right service when they need it whoever they are and wherever they live in Wales

Values and Behaviours

Business Continuity – IMTP

Developing the NWJCC Approach



Before April 2024

April 2024 Onwards

Business Continuity Assurance

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Joint Committee

- **Formal Public meetings** - bi-monthly, assurance report to HBs via Board secretary for inclusion on Board agendas
- **Private Development sessions –** bi-monthly

Sub-Committees

- **Quality Safety & Outcomes Sub- Committee -** assurance report will be via the JCC and DONs for inclusion on HB QPS sub-committee agendas
- **Planning , Performance and Finance committee** – assurance report will be via the JCC
- **CTM UHB Audit and Risk Committee** – assurance report via the JCC

CTMUHB Safeguarding Committee - DON attends

Chief Commissioner

- Director General NHS Wales
- NHS Wales CEO meeting

Chair

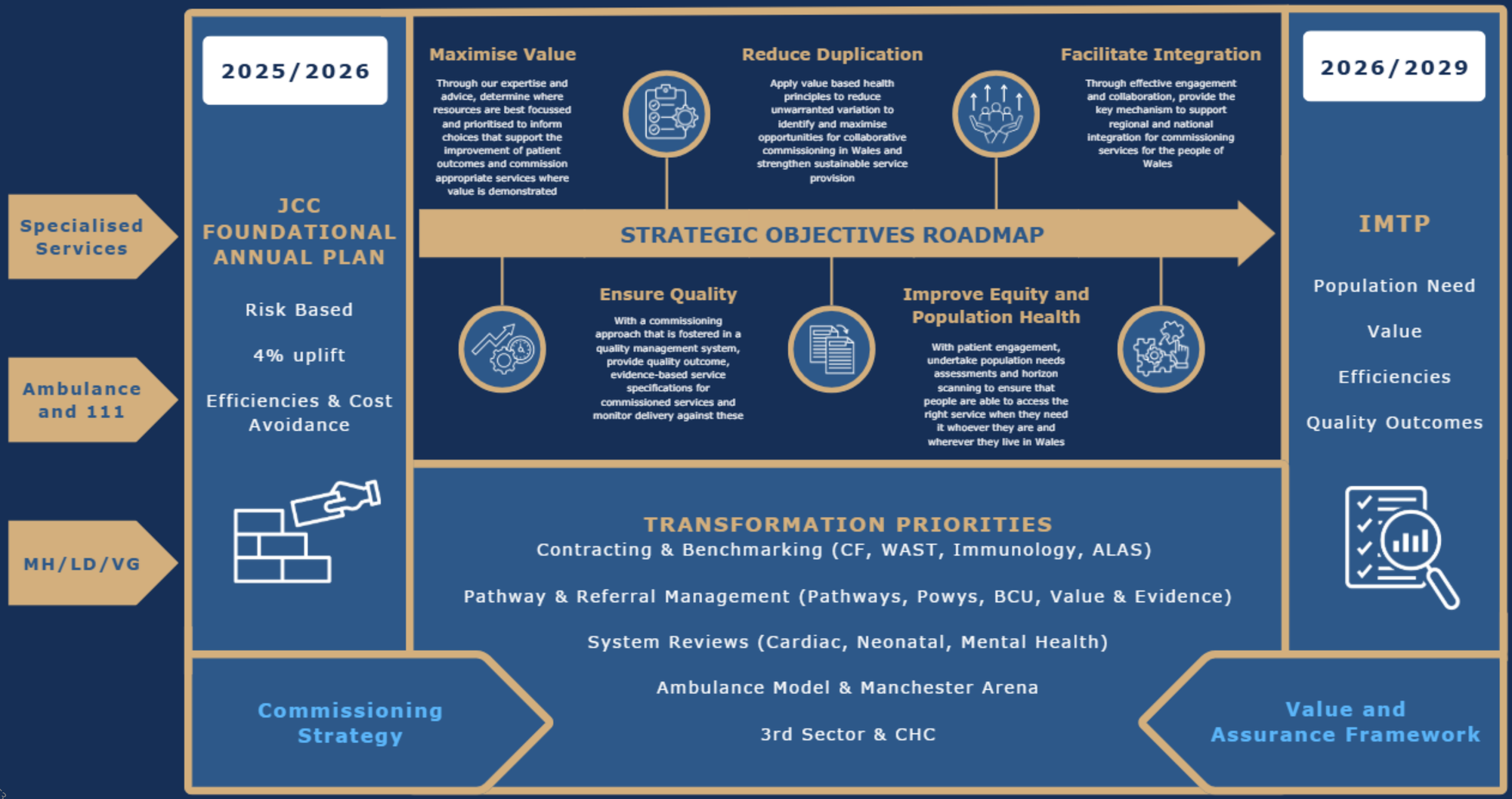
- NHS Wales Chairs Meeting

- **Annual HB Board meetings** – the JCC Provide a strategic presentation to HB Board meetings/Development sessions annually

- **Professional peer group meetings**

- **WG policy leads/NWJCC Officer meetings**

2025/2026 Foundation Plan on a p



Annual Health Board Engagement with the NHS Wales Joint Commissioning Committee (JCC)

The 2025/2026 Foundation Plan was constructed around the following commitments:

a) A programme of transformation focussed on 8 key strategic priorities;

b) Annual workplans for each of the commissioned areas (aligned to one of the key strategic priorities);

c) The collaborative management of risk inherent within the plan;

d) Core Business/Business as usual.

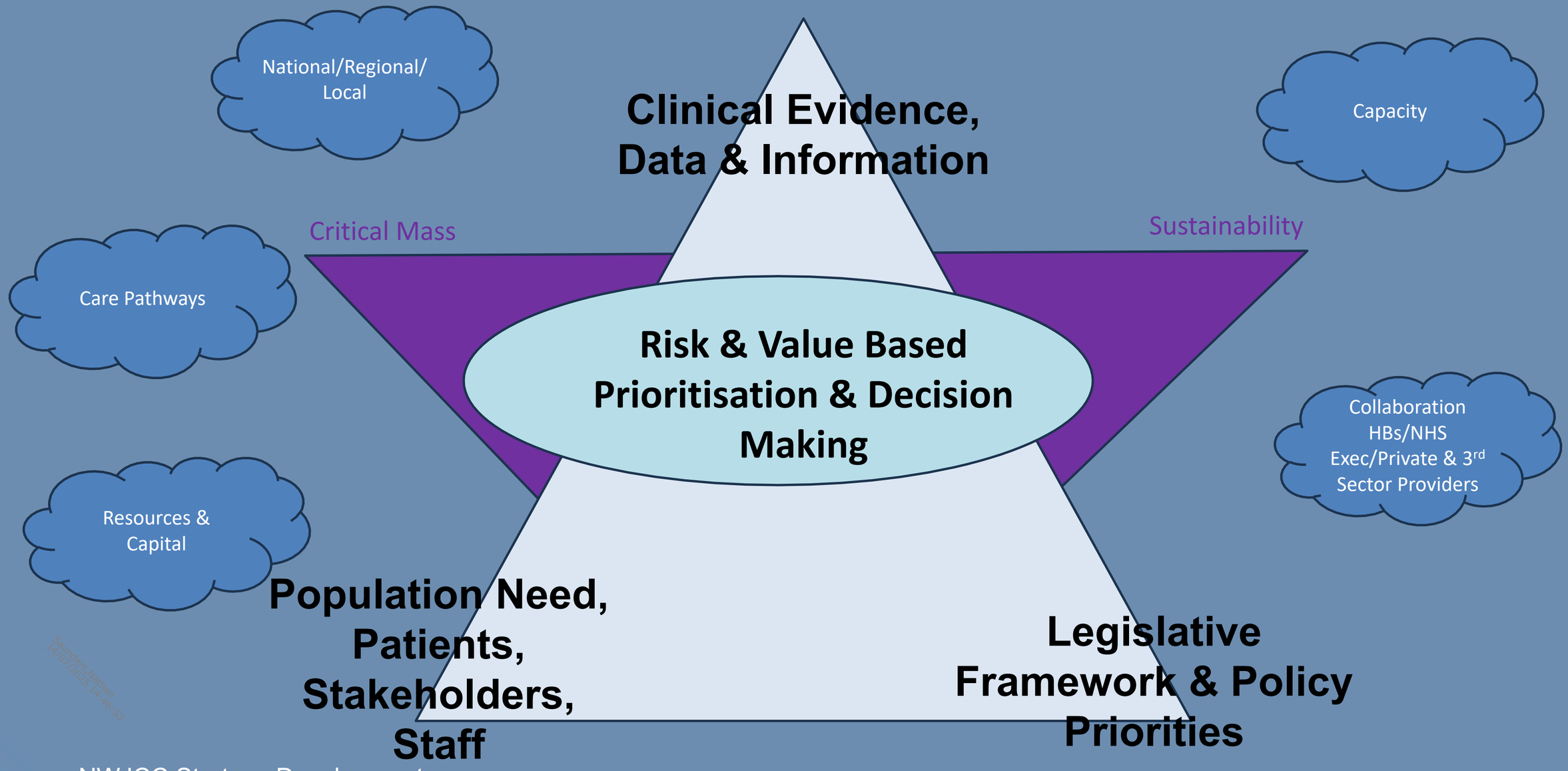
Unique Identifier	STRATEGIC PRIORITY	JCC LEAD	CCLG LEAD
SP1/2	Strategy development/ Centre of Excellence for Collaborative Commissioning	Huw George Georgina Galletly	Victoria Oxley
SP3	Increased Population Health perspective	Iolo Doull	N/A
SP4	Strategic System Service Reviews		
SP4.1	• Neonatal	Mel Wilkey	Lee Davies
SP4.2	• Cardiac	Mel Wilkey	Rob Holcombe
SP4.3	• Ambulance model	Ross Whitehead	TBC
SP4.4	• Mental health	Adrian Clarke	Marie Davies
SP5	Pathways and Referral Management	Stacey Taylor	Stephen Powell
SP6	Manchester Arena Inquiry Response	Ross Whitehead	
SP7	Benchmarking and contracting	Stacey Taylor	Nicola Johnson
SP7.1	• ALAS		
SP7.2	• Cystic Fibrosis		
SP7.3	• Ambulance		
SP7.4	• Immunology		
SP8	Voluntary Sector/CHC	Withdrawn – not funded TBC	

2025/2026 Foundation Plan Implementation & Deliverables

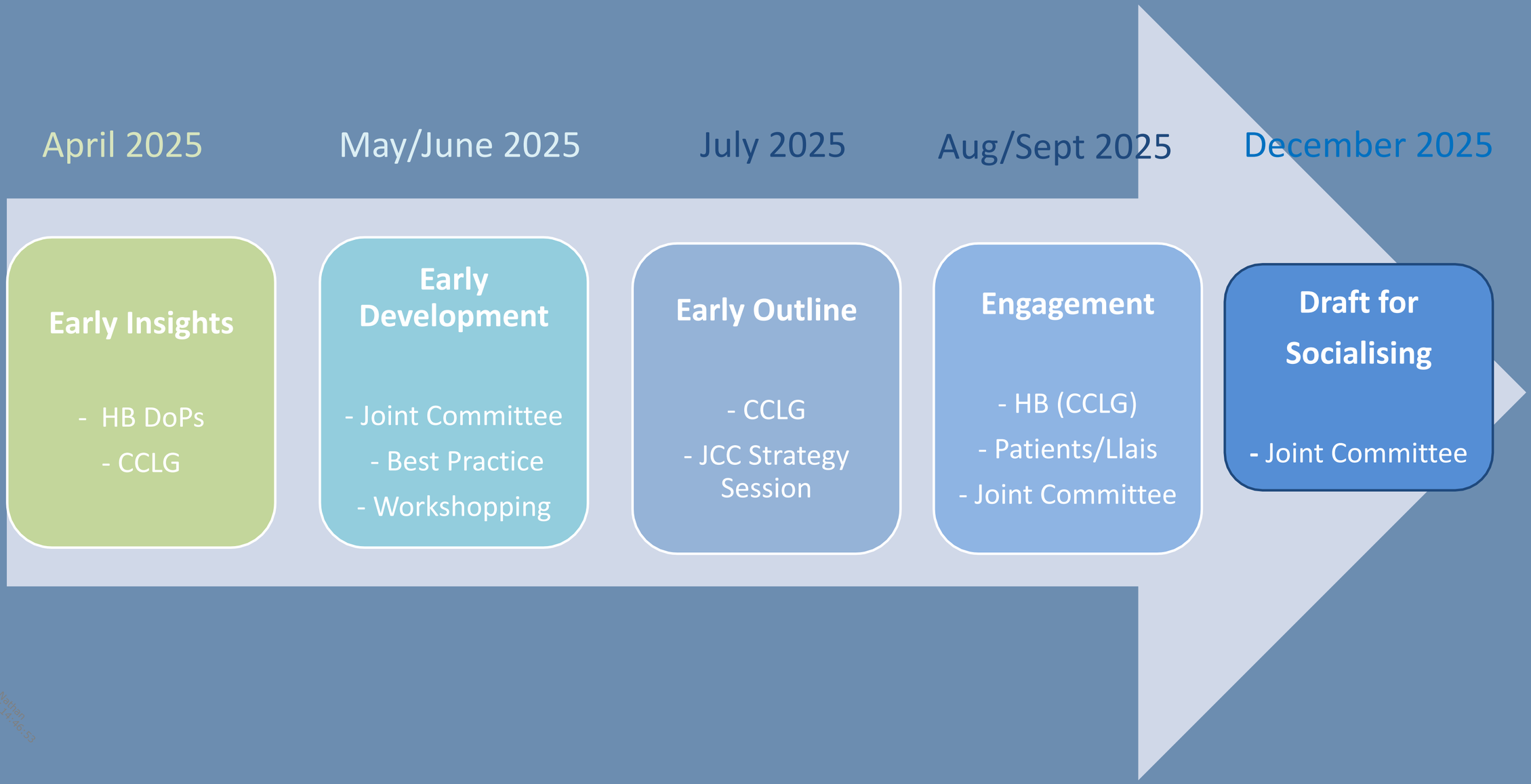
Cyd-bwyllgor Comisiynu Joint Commissioning Committee

Strategic Priority	Strategy Development/ Centre of Excellence SP1/SP2	Increased Population Health SP3	Strategic Service Reviews SP4	Pathways & Referral Management SP5	Manchester Arena Inquiry Response SP6	Benchmarking & Contracting SP7	CHC/Voluntary Sector SP8
Outcome							
Deliverable/s	• **Develop 5/10 Year Strategy for NWJCC** • Strategy Document for Joint Committee approval • Framework to support Joint Committee decision-making • Q1 • Q2 • Etc	• **Population health based commissioning will underpin the work undertaken by the NWJCC through an increased population health perspective** • Sessional time secured from a public health consultant as AMD in the NWJCC • Q1 • Q2 • Etc	• **Strategic Service Review to determine the optimal service configuration to ensure efficient, sustainable model to support outcomes for patients** • **4.1 Cardiac** • **4.2 Neonates** • **4.3 Ambulance Model** • **4.4 Mental Heath** • Report to Joint Committee to include recommendations for future service provision • Q1 • Q2 • Etc	• **Develop a Framework for referrals to English providers to ensure value, quality and equity** • Agree and implement new commissioning delivery models • Referral Framework • Q1 • Q2 • Etc	• **Informed commissioner response to the 106 recommendations from WAST** • Formal response to WAST approved by Joint Committee • Q1 • Q2 • Etc	• **Services commissioned by the JCC will be compared to those elsewhere in Wales and the UK to ensure cost parity, access equity and performance equality** • Immunology • Cystic Fibrosis • Ambulance • ALAS • Q1 • Q2 • Etc	• ***Between plan endorsement and implementation planning, the request to JCC has been withdrawn by Welsh Government.***
Milestones							

Key Components of Strategy;

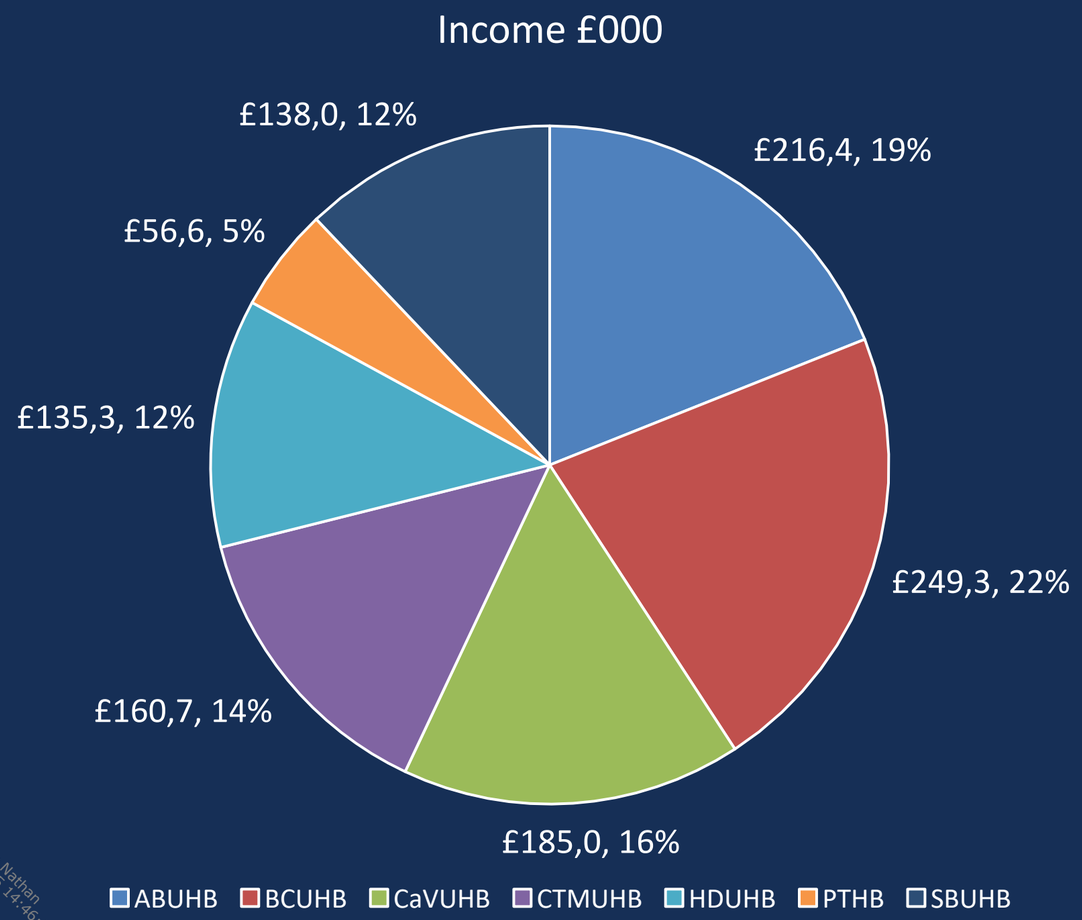


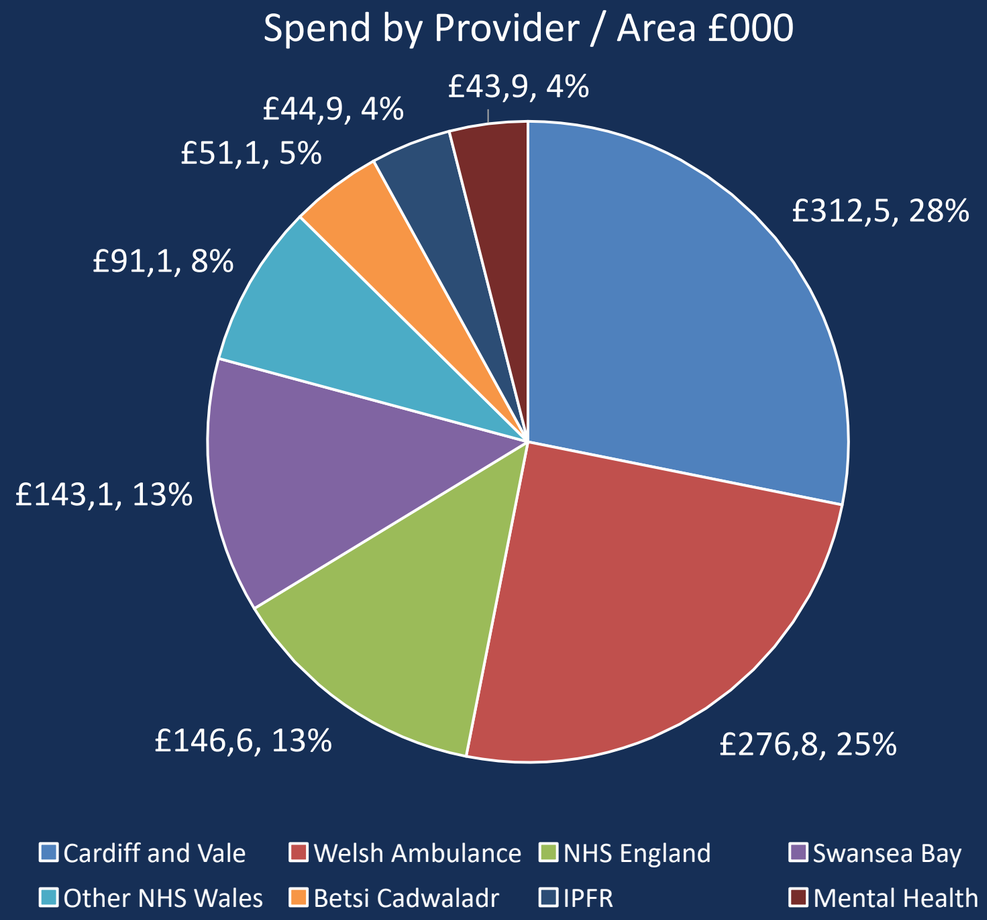
Engagement & Timescales



Source of Funds and Spend

NWJCC Annual Budget £1.14bn





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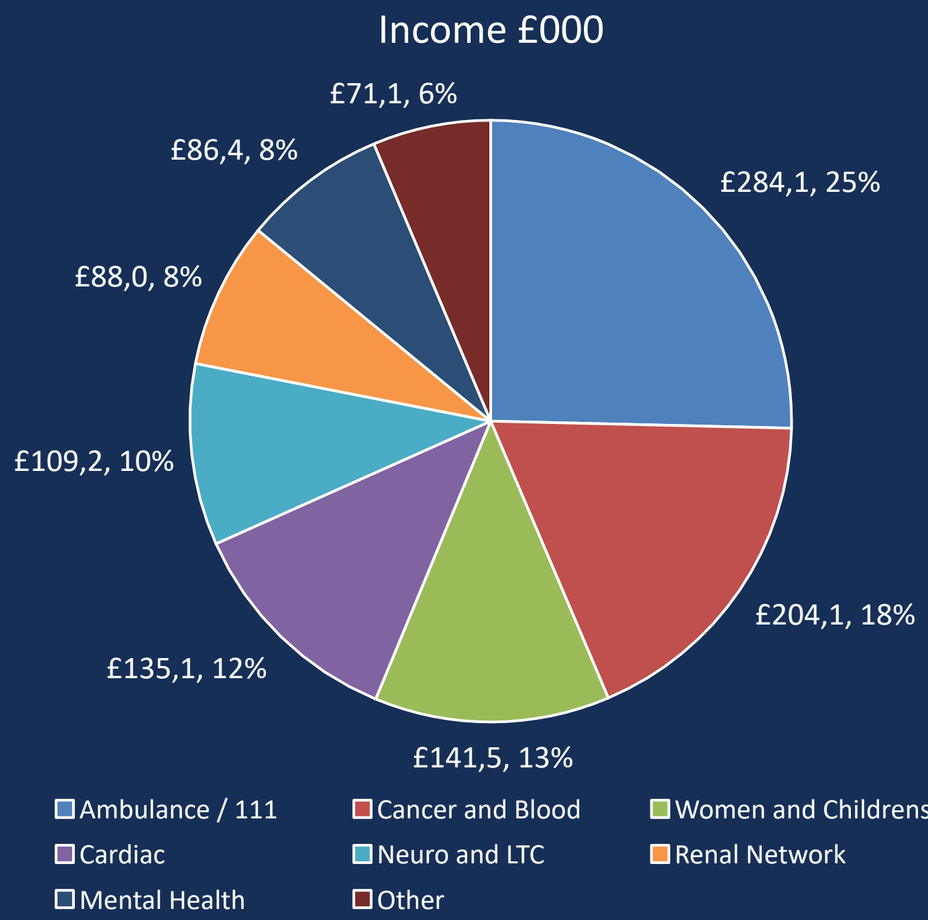

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Cyd-bwyllgor Comisiynu
Joint Commissioning Committee

Cardiff and Vale University Health Board - key challenges and opportunities

- Equity
- New and fragile services
- Services reviews
- Cost of agreements
- Provider focus

CAV Provided JCC Risks that will be TREATED from current resources

Strategic Priorities	Management	Residual Risk	Actions
• Paediatric Strategy	Includes: ➢ Paediatric Respiratory ➢ Paediatric Rehabilitation ➢ Paediatric HDU ➢ Paediatric Cardiology ➢ Paediatric Gastroenterology ➢ Paediatric Ophthalmology ➢ Workforce Sustainability ➢ Outreach Models ➢ Neonatal Phase 2 Utilise existing funding within the plan and transfers from Long Term Agreements (LTAs) as appropriate		Residual funding left in the paediatric strategy allocation. Some of this activity is tied into the LHB LTAs, so will include some transfers of funding from Health Board to NWJCC Commissioning. Residual funding and LTA transfers may not be sufficient to cover fully commissioned services, so there may be cost pressures or the need to manage demand within this workstream. **Neonatal Phase 2** is one of the key strategic priorities to commence in 2025-2026, but will have longer term outcomes to be agreed and delivered through 2026-2029 IMTP and beyond. This programme of work will include: ➢ Neonatal Intensive Care ➢ Neonatal Workforce ➢ Neonatal Infection Control ➢ Neonatal Cot Availability (SBU) ➢ Maternity (HB Commissioned), ➢ Neonatal (JCC Commissioned), ➢ Transitional care (HB Commissioned); and ➢ Transport (JCC Commissioned).
• Cardiac Review	Review of Cardiac need, capacity, capability and sustainability across South Wales to reflect shift from cardiac surgery to interventional cardiology, reflecting additionality. To include: ➢ Cardiac Review – phase 2 ➢ Interventional Cardiology Capacity		Cardiac programme to be established and is one of the strategic priorities for 2025-2026. Outcomes and deliverables to be agreed, but likely to extend into 2026-2029 IMTP considerations. Thoracic to be considered in conjunction following the Welsh Government decision not to invest capital in development of a thoracic centre for South Wales in Swansea Bay alongside the PHW proposal to extend lung screening.

CAV Provided Risks that will be TOLERATED within current resources

Manage through workplan	Management	Residual Risk	Actions
• Endoscopy • Cardiac Physiology • Neuroendocrine tumours (NETs) Sustainability • Speciality Auditory Hearing Service Waiting Times • Paediatric Radiology Service • Paediatric Pathology • Cardiac Rehabilitation Capacity • BMT	To be managed through the workplan in conjunction with the services. Next steps to be developed and considered for inclusion in 2026-2029 IMTP.		Monitor risk as part of ongoing performance and contract monitoring. Risks to be managed through commissioning teams and escalated to SSCG as appropriate and on to CCLG and the 2026-2029 IMTP as required. Work with services to develop proposals for consideration for inclusion in future plans and recommendations for potential investment or decommissioning/transfer of services if appropriate.

Risks that will be TRANSFORMED in the longer term

Services not a priority for 2025-2026	Management	Residual Risk	Actions
• National Acute Porphyria • Specialist Rehabilitation Strategy • Intestinal Failure	Service developments will not be prioritised during 2025/2026, but will remain on the workplan. Risks to be monitored through the Commissioning Teams. Service redesign and efficiency work to continue if capacity allows.		Monitor risk as part of ongoing performance and contract monitoring. Risks to be managed through commissioning teams and escalated to SSCG as appropriate and on to CCLG and the 2026-2029 IMTP as required. Work with providers on service redesign and efficiency and if required, develop proposals for consideration for inclusion in future plans and recommendations for potential investment.

Risks that are OUT OF SCOPE for the NWJCC in 2025/26

Out of Scope	Management	Residual Risk	Actions
• Transfer of Services ➢ New services proposed for JCC commissioning by providers ➢ Regional commissioning	Providers to manage risks bi-laterally with LHB commissioners in the first instance. Need to understand the new regional delivery responsibilities of the NHS Executive and how this impacts on regional commissioning.		NWJCC will not transfer in any new services in 2025-2026. Commissioning intentions will be developed for the IMTP for 2026-2029 and transfers of service will be considered as part of the IMTP process including engagement with providers on sustainability and current contracting constraints. Engage with NHS Executive to understand their developing role in regional delivery and impacts on planning and commissioning .

Focus for the future

- Implementation of new structure
- Deliver the Foundational Plan 2025/2026
- Development of Strategy
  - Commissioning Framework – Value & Transformation
- Engagement & collaboration with Health Boards - Collaborative Commissioning Leadership Group
- Provider clarity on relationship

Diolch / Thank You

AM WRANDO / FOR LISTENING

Report Title:	**Strategic Planning, Commissioning and Partnership Update**			Agenda Item no.	6.9
Meeting:	Public Board	Public	X	Meeting Date:	29.05.2025
		Private			
Status *(please tick one only):*	Assurance	x	Approval	Information	
Lead Executive Title:	Executive Director of Finance & Interim Executive Director of Planning Executive Director of Allied Health Professionals, Health Scientists, Community Services Development				
Report Author (Title):	Executive Director of Finance & Interim Executive Director of Planning Executive Director of Allied Health Professionals, Health Scientists, Community Services Development				

Main Report
Background and current situation:

This report provides the Board with an update on key areas of strategic planning, commissioning, and partnership work programme. Its purpose is to give the Board assurance that actions agreed in our annual work programme or Annual Plan are being progressed and risks around delivery are being managed - it includes relevant updates in relation to the following areas:

- Strategy development and delivery,
- Integrated Medium Term Plan (IMTP)/Annual Planning
- Regional and tertiary services planning work programme
- Engagement for service change
- Commissioning
- Partnership planning

Executive Director Opinion and Key Issues to bring to the attention of the Board:

1. Strategic Portfolios and plans

All portfolio boards will be established by the end of June. Key requirements for these first meetings include; confirming terms of reference including attendance and frequency and confirming scope. Annual plan delivery mapping has been completed to identify actions that are strategic initiatives which should also be included in scope and has been shared with SROs for review.

Portfolio resources, including tools, guidance and templates have been developed with the support of the Shaping Change team to support consistent portfolio management with support made available to Executive SRO's from planning and teams as required.

Key dates include a Management Executive Steering Committee on the 22nd May where status updates will be provided and any support required ongoing will be discussed. A full update will then be provided to the July Board.
A number of strategic plans and their development will be included within the scope of the portfolios to include infrastructure (estates and digital) and clinical services plans.

2. Annual Plan 2025/2026

On 31st March 2025, the Health Board submitted its Annual Plan for 2025/2026 to Welsh Government, which included a £30 million savings ambition to achieve a forecasted £58.2 million deficit. The plan fell short of the £9.1 million financial control total set by Welsh Government, leading to its return on 11th April as "unsupportable and unacceptable."

The Health Board was asked to undertake urgent work to de-risk the financial position and to consider choices to go further to reduce the deficit.

The CEO submitted a letter on 9th May to provide an update on the plan position and update on the points raised in the letter. Whilst more work has been undertaken since plan submission to increase confidence in savings plans, including a Senior Leadership Board Financial Delivery Summit, there remains a £7m range in best and worst case delivery to fully de-risk the savings plan and deliver the £58.2m deficit position.

We will continue to urgently work through this position as a Senior Leadership Board, maintaining our collective focus on the challenge.

3. Regional Planning – Southeast Wales *(Shaping our Future Clinical Services Portfolio)*

The priority areas for the South East Wales regional partnership in 25/26 are -

- Progression of Llantrisant Health Park
- Regional Ophthalmology
- A South-Central regional stroke service
- A regional Pathology service- with a focus on microbiology
- Development of a cancer programme for the region

<u>Local Governance arrangements</u>

Locally, a Cardiff and Vale specific SEW regional planning board, chaired by the Executive Medical Director, has been established to oversee the health board's role as a part of the regional portfolio. This board is responsible for:

- Monitoring and guiding CAVUHB’s role in regional programmes.
- Ensuring clarity and coordination across internal planning structures.
- Identifying and managing risks, interdependencies, and resource needs.
- Recommend future commissioning and delivery models for regional services.

The terms of reference have now been approved by the Senior Leadership Board and the planning board meets monthly ahead of regional Executive Oversight Board meetings.

SEW regional Joint Committee

On 2 April 2025 the Cabinet Secretary wrote to the Chairs of ABUHB, CTMUHB and CVUHB directing them to establish the “South East Wales Health Boards - Regional Joint Committee” in order to: exercise the facilitation and oversight of regional planning to drive effective collaboration and regional working; and offer stronger strategic leadership, foster collaboration, and provide a robust governance framework to accelerate and enhance the planning and delivery of services.

The Directors of Corporate Governance for the 3 UHBs will lead on producing a terms of reference (TORs) to be taken for respective Boards approval in September with a view to the first Joint Committee meeting taking place in October, in line with the Cabinet Secretaries direction for the Committee to be established in Q3.

An initial discussion was had by CEOs and some Executives of the 3 Health Board's at the Regional Oversight Board on 29th April regarding membership and scope. A draft TORs has been written, and discussions continue between Directors of Corporate Governance on the nature of key elements like membership and voting.

Work will take place with the Assistant/Directors of Planning on the principles of the Joint Committee and the scope of work that it will cover.

Llantrisant Health Park (LHP)

The LHP programme is now moving into delivering what is in effect an outline business case (OBC) with the expectation this is delivered by the end of May. Welsh Government has clarified what they consider to be essential components of this OBC. It will require the support of all partner Boards.

A full business case (FBC) will follow in September. In parallel to this the region is collectively working to develop regional radiology and orthopaedic plans and these will formal critical components of the FBC (alongside the regional endoscopy plan which the Board considered in March and the Chief Executive and Chair subsequently took chairs action on in April). The timeline to ensure the LHP can be delivered by December 2027 is challenging and teams across the three organisations are working to ensure all plans and cases are developed and are subject to appropriate governance and with robust engagement.

Regional Ophthalmology

The regional programme successfully delivered its objective of ensuring that as of 31 March 2025 no stage 1 across the region was waiting over 95 weeks and no stage 4 patient was waiting over 104 weeks for cataract surgery. This followed significant non recurrent investment by Welsh Government in January to support this. Moving into 2025/26 the programme is focused on both maintaining this waiting list position and is in the final stages of agreeing a provider plan between partners. Locally, leadership is provided through the Planned Care programme. There is a workshop in May to commence development of longer-term plans for Ophthalmology across the region building on the success of the cataracts planning and delivery.

Stroke

Cardiff & Vale and Cwm Taf Morgannwg UHB's continue to build on the recent stroke summit which collectively agreed a strategic direction of travel which will focus on working together to (1) maintain an acute stroke service within CTM, and (2) develop UHW as a Comprehensive Regional Stroke Centre (CRSC) for specialised care, including thrombectomy. The two providers will work collaboratively to development regional workforce plans to reduce the risk of service fragility across the region and ensure that the region can respond to the National Stroke Standards as they are released.

Pathology

Regional partners recognise that embarking on a significant change programme such as regional cellular pathology modernisation is a significant ask and will require appropriate resourcing. Partners have agreed what the regional desired change

management model needs to look like and further work across planning, finance and operational colleagues is now taking place to understand how this can be implemented in an affordable manner. Regional partners further agreed that when the above work has taken place there is the need to provide all partners Boards with a detailed briefing on the proposed programme due to the size, scale and complexity of the planned work.

4. CAVUHB & VUNHST Partnership (*Shaping Our Future Clinical Services Portfolio aligned to Future Generations Portfolio***)**

Both organisations are committed to developing sustainable provider models of care that will maximise; workforce development, research integration and estates infrastructure. This has included, until recently, a strategic outline case (SOC) for BMT, Haematology and Complex Oncology (to include capacity for the Cardiff Cancer Research Hub).

The Welsh Government has confirmed that they are unable to support the SOC and have instead asked for a standalone BMT capital scheme to be developed, meaning this will now proceed as a standalone CAVUHB capital scheme.

In response to this, a joint provider planning framework has been developed setting out an intention to continue to develop integrated models of care between the two providers. The framework moves to formalise the partnership to address the evolving landscape of complex oncology and advanced therapies ensuring that efforts are aligned efforts across both organisations while interfacing with local, regional, and national planning structures including; NHS Executive Cancer Network, National Advanced Therapies Wales Programme. Cardiff Health Partners, SEW regional planning, Specialised Provider Planning Partnership. Key deliverables in the first year include:

- Baseline assessment of current services and pathways.
- Evaluation of new care models and resource optimisation.
- Agreed joint model of care and associated business cases.
- Clear commissioning arrangements and regional/national collaboration opportunities.

The work will be supported by the new Deputy Medical Director at VUHNST whose role will be to enable a more strategic overview of services and support more productive regional working, they will be supported by a shared planning lead.

5. Regional and Specialised Services Provider Planning Partnership *(Shaping our Future Clinical Services Portfolio)*

The specialised services partnership with Swansea Bay UHB, known as the Regional and Specialised Services Provider Planning Partnership (RSSPPP), continues to meet monthly. Below is a summary of the progress across the provider partnership portfolio:

Hepato-Pancreato-Biliary (HPB) Surgery

- Following the NHS Wales Joint Commissioning Committee's (NWJCC) decision not to prioritise the HPB Shared Delivery Network (SDN) for inclusion in their IMTP, discussions were held with the Chief Executive Management Team (CEMT) to establish whether the referring Health Boards would include a provision within their IMTPs to fund the establishment of the SDN. .

- Following discussion, the referring Health Boards have declined to fund the SDN, and the CEMT has requested HPB is referred back for consideration by the JCC. In the meantime, the HPB Programme Board agreed to begin scoping phase 2 – shared directorate to determine if this can be achieved without funding for the network.
- As part of the work to establish the SDN, the HPB Programme is developing a referral protocol for patients with severe acute pancreatitis to support admissions to the two specialist centres and ensure cost recovery for the complex specialist care provided. All referrals received into the two specialist centres will be documented going forward.

Specialised Infectious Diseases Services

- The multidisciplinary inter-organisational workshop, initially scheduled for December 6th, has been postponed due to insufficient attendance. It has now been rescheduled for June 24th, 2025.

Gynecologic Oncology Surgery

- In response to a request from SBUHB for support with its gynecologic oncology surgery service, the team have worked with the clinical and operational teams in both organisations to identify short, medium and long term actions to ensure that all patients in South and West Wales have access to a safe, effective and sustainable service, on a sustainable footing. A proposal will be presented to the next meeting of the RSSPPP for consideration.

6. Commissioning

Governance

Interim governance arrangements have been established, standing down existing tactical and strategic commissioning groups replacing them with one monthly commissioning meeting, chaired by the Deputy Director of Finance. This arrangement maxmises capacity across the strategic commissioning and contracting team and ensures regular reporting through the Strategic Leadership Team. Importantly, it will interface with internal commissioning and planning groups (including planning for specialised services) and external meetings including provider service level agreement (SLA) meetings with the newly formed NWJCC.

Commissioning Intentions

The Strategic Leadership Team have endorsed the proposal to retain the 2025–2028 Commissioning Intentions and use this year to redesign the process for 2027–2030

The Strategic Commissioning and Planning team will work to align commissioning intentions with the planning cycle and improve the process to maximise the population needs assessment, improve engagement and clinical leadership. This approach will be tested through the CAVUHB Intergrated Planning Group with approval through Strategic Leadership Team.

NWJCC

Terms of reference for NWJCC commissioning groups and Provider SLA interface meetings are due to be received within the next month. The commissioning and contracting teams will work closely with colleagues in the clinical boards, strategic

and operational planning to ensure appropriate representation from across the organisation ensuring these individuals are included in the monthly commissioning group meeting and are responsible for providing appropriate briefs ahead of commissioning and provider SLA meetings.

Velindre Cancer Centre

The new Velindre Cancer Centre building work is ongoing and currently on schedule to open in Spring 2027.

Radiotherapy Satellite Unit (RSU) costs have been updated since the initial business case. There are £240k inflationary uplifts & £240k of additional posts/ costs identified which were not in the first business case. The inflationary uplift is in line with full business case (FBC) assumptions and accepted by commissioners. Work is being undertaken to understand the additional £240k in terms of workforce, case complexity and projected volumes. The building will be handed over to ABUHB on 02/05/25 with the first patient scheduled to be scanned on 04/06/25.

IPFR

The IPFR Team are responding to recommendations set out in an Ombudsman report relating to the use of the All Wales Prior Approval Policy.

The IPFR Highlight Report for Quarter 4 is available.

Adult Learning Disability Services

Welsh Government requested proposals for the use of £110k additional non-recurrent funding for 2025/26 in relation to people with a Learning Disability. The CAVUHB proposal includes the development of an enhanced liaison nursing function for learning disabilities, strategic posts supporting cross-sector integration, and ongoing efforts to improve equity of access within primary and secondary care. The use of this funding is designed to complement and extend existing activity, allowing limited resources to be used as effectively and sustainably as possible.

7. Engagement for Service Change

Primary Care Mental Health Liaison Service (PCMHLS)

A 9-week engagement period was held to discuss the plans to direct the PCMHLS resource into 111#2. An online and offline offer was made to the public to provide their feedback which included teams and in-person events. A survey was also publicised to provide the opportunity to feedback.

All concerns raised were in relation to issues that the team already anticipated, such as waiting times for 111#2 and for members of the public to still have access to in person appointments. Both issues have been mitigated.

Public Services Engagement and Insight Group

The group is now established and meeting bi-monthly.

Strategic Plans

We are currently in the planning phase for the delivery part of the Babies, Children and Young People Plan. This will extend over the Summer into September when we will have a target programme of engagement with schools.

We will shortly be planning our engagement programme for the Mental Health Clinical Services Plan as the scope and approach are confirmed.

Work continues to develop engagement plans to underpin both SEW regional planning portfolio, with a specific focus on the Llantrisant Health Park and the CAVUHB and VUNHST provider partnership in anticipation of developing clinical models.

Continuous Engagement

As part of our continuous engagement, we are considering the use of our "Shaping our Future Wellbeing" website and how we can potentially create a central point of engagement data that can be used to inform work.

Engagement activity will have a dedicated agenda item at each IPG meeting which will help to add awareness and scrutiny to plans.

8. Cardiff & Vale Regional Partnership Board *(Shaping our Population Health and Place Based Partnerships portfolio)*

The Health Board continues to play an active role in the Regional Partnership Board (RPB) and over the last quarter there has been a focus on the following areas:

1) Phase 1 of developing an Integrated Community Care System is in progress and focusing on delivery of four main workstreams:
    - Development of an Urgent Treatment Centre in Barry Community Hospital
    - Development of the community hospital and community bed model as part of the suite of resources supporting people to remain in their communities
    - Development of our crisis response capability to prevent avoidable admissions to EU and hospital
    - Development of our 'connected communities' model of care, delivering proactive coordinated care closer to home for individuals with complex need

The first phase of this is under development and will be overseen by the Population Health and Places portfolio.

2) 50-day challenge

The Care Action Committee 50-day challenge has now concluded and has delivered some significant improvements locally, supporting admission avoidance and timely discharges:

a. **10% fewer emergency medical admissions for people >75** - there were 125 fewer >75 emergency medical admissions than expected through January and February (approx. 10% less than the expected winter peak based on trend analysis from Lightfoot)

b. **A 37% reduction in the number of EU attendances from care homes** (excluding sheltered and mental health homes) related to falls. Numbers decreased from 35 in March '24 to 22 in March '25:
c. **99.7% of people** clinically optimised had a D2RA pathway allocated
d. **95% of people** were allocated to a pathway within 1 day of admission
e. **A 33% reduction in Pathway of Care Delay assessment delays**. From the baseline position of 153 in Mar '24 to 102 in Mar '25
f. **A 23% reduction in total Pathway of Care Delays** from our baseline position in March-24.

3) Digital Care Region

This programme is driving the development of integrated care records through the development of a Shared Care Viewer, enabling team members to view records across a number of systems across our partner organisations, enabling better coordination of care. The Viewer has now gone live for the Vale Community Resource Service and Neurodevelopmental Services. The next areas of development are supporting discharge arrangements and safeguarding, enabling organisations to work more closely together to improve safety, efficiency and quality of care.

Recommendation:

The Board is requested to:

(a) **Note** the progress being made across the Strategic Planning, Commissioning and Partnership portfolio

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please place an "X" in the below boxes as relevant.

Putting People First 1. **Click the objective above to view more detail.**	x	Providing Outstanding Quality 2. **Click the objective above to view more detail.**	x
Delivering in the Right Places 3. **Click the objective above to view more detail.**	x	Acting for the Future 4. **Click the objective above to view more detail.**	x

Five Ways of Working (Sustainable Development Principles) considered

*Please place an "**X**" in the below boxes as relevant*

Preventi	x	Long term	x	Integration	x	Collaboration	x	Involvement	x

o n										

Quality Impact Assessment Completed?: *Please place an "**X**" in the below boxes as relevant. A blank QIA and guidance on how to complete a QIA can be found by clicking the link here:* ***Quality Impact Assessment Information***				
Yes – (***please provide completed QIA document***)		No – ***(Please provide reasoning, e.g. not required)***		*Comment here*

Impact Assessment: *Please state **yes** or **no** for each category.* ***If yes please provide further details.***
Risk: No
Safety: No
Financial: No
Workforce: No
Legal: No
Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation: No
Welsh Language: No

Approval/Scrutiny Route *(please note anywhere else this paper has been before):*	
Committee/Group/Exec	Date:

Report Title:	C&V Integrated Performance Report			Agenda Item no.	6.10
Meeting:	C&V UHB Board	Public	X	Meeting Date:	29.05.2025
		Private			
Status *(please tick one only):*	Assurance	x	Approval	Information	
Lead Executive:	Claire Beynon, Jason Roberts, Rachel Gidman, Paul Bostock, Catherine Phillips, David Thomas				
Report Author (Title):	Information Manager				

Main Report
Background and current situation:

Background and current situation:

The updates in this report bring the report in line with the National Performance Framework for 24/25, the UHBs Annual Plan priorities and recently submitted trajectories to Welsh Government for delivery of the National Performance priorities.

Finance

The Board agreed and submitted a draft financial plan to the Welsh Government at the end of March 2025. A summary of the draft financial plan submitted is provided in Table 1.

Table 1: 2025/26 Draft Plan

Planning Assumption	(£m)
Brought Forward Underlying Deficit	59.900
2025/26 Demand/Cost Growth/Investments	51.100
Draft Deficit	**111.000**

Additional Allocations	(22.768)
Savings Plans	(30.000)
Final Planned Deficit	**58.233**

The submitted plan projects a deficit for the financial year and therefore a failure of the UHB's statutory requirement to deliver a balanced financial plan over a 3-year rolling period. This also prevents Ministerial approval of the plan.

At month 1, the UHB is reporting an overspend of £6.096m comprised of the following:

- £5.676m planned deficit
- £0.432m unachieved savings deficit
- £0.012m favourable operational surplus against plan.

There was a shortfall of £5.186m against the £30.000m savings programme target at month 1. This will lead to a further £5.186m overspend against the planned £58.2m deficit if further schemes are not identified and delivered as the year progresses.

Public Health

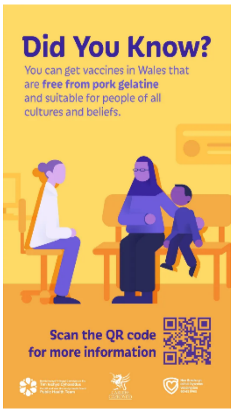
Immunisations

COVID-19 and influenza

- The COVID-19 Spring Booster Campaign has started, it has currently delivered 4,850 vaccines to a total eligible population of 57,435 in Cardiff and the Vale for an uptake of 8.4% which is currently below the Welsh average of 17.2%. We are prioritising housebound and care home residents at the beginning of this campaign; this explains the slightly lower volumes at the start of our campaign in comparison to other Health Boards.

Childhood immunisations

- Quarter on Quarter (Q4 to Q4) comparisons showed an **improvement of 3.2% year on year of children up to date with vaccination at age 4**, increasing from 79.1% to 83.3%, still lower than pre-pandemic levels, but showing initial signs of an upward trend.
- The vaccination team attended a multi-faith event scheduled in Cardiff for mid-April at Grange Pavilion to offer information and deliver vaccines with the immunisation Van present.
- The vaccination team is finalising plans to offer the option of gelatine flu vaccinations in schools alongside the regular nasal flu formulation to all pupils during the Autumn-Winter campaign of 2025/26.
- At the Welsh Immunisation Conference 2025 that took place in Swansea in May 2025 the Cardiff and the Vale Vaccination Team and its partners in both local authorities have been awarded the **2025 Vaccination Saves Lives Team Award as Best Team in Wales.**
- In collaboration with Cardiff Council, we started a posters and animations campaign to inform our communities that gelatine free vaccines are available. Below are some examples of the posters which are translated in the most popular six languages used across Cardiff and Vale.



Healthy weight - Good Food and Movement

- Healthy weight in reception year children aged 4/5 increased to 77.5% (2022/23). This is the same as the English average for the same period (77.5%). This was above the Welsh average of 74.3%. Steps are being taken to increase healthy weight locally through the creation of the Good Food and Movement Framework (2024-2030) which will include the 0-5 age range.
- Work to progress action aligned to our Good Food and Movement Framework (2024-2026) and current Implementation Plan has continued by the Public Health Team with a wide range of partners. Highlights include:
    - Second phase of research into the barriers and facilitators for breastfeeding have been commissioned by the Public Health Team, increasing the reach of women asked for their views and shaping ongoing work in this area.

- Report finalised for the Vale of Glamorgan Shared Prosperity Funded Project which mapped community led activity and gained insight from community led groups. Recommendations are being considered.
- Ongoing work with both Local Authorities to restrict the advertising of High Fat, Sugar, Salt (HFSS) foods and drinks. In Cardiff, HFSS advertising is to be restricted following in-contract negotiations and will no longer displayed on the bus stops located on the UHW site.

Healthy weight - Weight management services

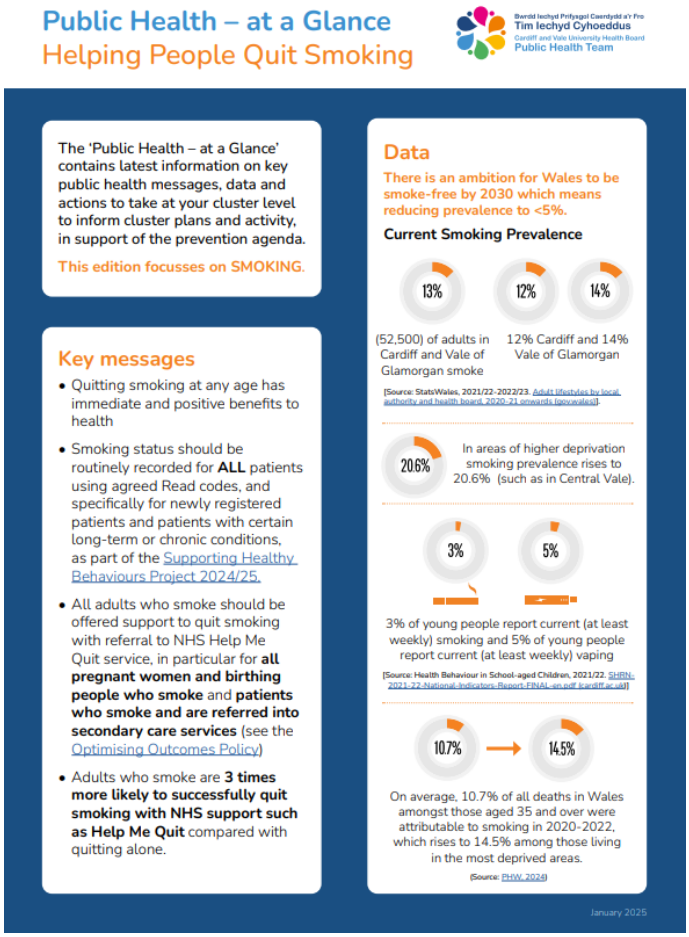
- An increase of 10% for L2 weight management service was achieved over the year. This was due to the development of newly qualified staff being able to increase clinical case load to full capacity. Note 4 WTE Dietitians are delivering on this target. Foodwise for Life at L1 of the pathway continues to be optimised to support achieving 1.5% target.
- An increase of 10% for L3 is not achievable within current service constraints. Increased demands for these services are due to the introduction of injectable therapies which is consistently out stripping capacity. Risk assessment completed, business case previously submitted, and a paper was presented to SLB to progress this work.

Healthy weight - Diabetes

- Third meeting of the Diabetes Strategic Programme Board, facilitated and led by Public Health. Good representation and engagement from across the Health Board. Progress was made on the next steps for the 'Maximising Health Outcomes Report' recommendations, with an agreed actions for named leads to explore implementation of each recommendation and to report back to the next meeting.
- There remains a gap with regards to programme management support. This is currently in train with the Shaping Change team but resource to directly support the work to the diabetes SPB is yet to be confirmed.
- Diabetes 'deep dive' session for RPB due in June 2025 – plans in development for workshop with partners.

Tobacco

- Information about enforcement of no smoking legislation on hospital premises is now included in the Corporate Induction Programme for the health board. This means that all new starters to the organisation will be informed about the enforcement. Good communication is key to ensuring that no one smokes on hospital premises, and therefore no one receives a fixed penalty notice of £100.
- A summary of smoking cessation data, messaging and actions has been developed and circulated to primary care clusters, a sample page is included here:



Operational Performance

Urgent and Emergency Care

April saw a decrease in attendances at the Emergency Unit from last month, and a small drop in the number of 12-hour EU waits. The most recent data from April shows a slight deterioration in ambulance performance with a small increase average handover time and the number of 2-hour waits reported. EU activity data has been added to the accompanying IPR. EU total reportable attendances and Majors attendances in April 25 were similar in volume to April 24, however, admissions from EU were reduced. We will continue to track and report these metrics throughout 25/26.

Measure	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
Reportable attendances	11,484	12,102	11,930	11,773	10,926	11,567	12,628	11,922	11,468	10,756	10,237	12,193	11,659
UHW Majors attendances	5,958	6,247	5,933	5,962	5,792	5,968	6,352	6,219	6,011	5,710	5,453	5,998	5,876
Reportable EU admissions	1,922	1,833	1,847	1,865	1,778	1,768	1,823	1,831	1,829	1,676	1,502	1,658	1,754

Following increased bed closures in March due to Norovirus, April has seen an overall reduction in closed and empty beds related to Norovirus, Flu and Covid-19. One outbreak in-month saw the number of closed beds increase, impacting flow and contributing to a small number of 24-hour EU waits and 3-hour ambulance holds. Bed closures on the acute sites continue to be monitored and reported to the organization daily through the 'hot reports'.

Despite these challenges, the UHB is still the best performing Health Board in Wales regarding ambulance handover delays, and we continue to make ambulance handovers an operational priority.

Performance against the standards within the National Falls and Fragility Fracture Audit Programme (FFFAP) remains improved from our historic trends. Time to specialist beds for hip fracture and stroke patients remain an operational priority and we are conducting regular analysis of breaches to improve

implementation of the pathways. For hip fracture patients we saw improvements in compliance with the 4-hour standard for admission to a specialist ward through last year and performance in Q1 is improved from last year where it dipped below 30%. Despite seasonal pressures, monthly compliance in March was 40%, against the national annualized average of 8.8%.

We continue to measure our performance against the acute stroke pathway on a daily and weekly basis, through the hot report and COO led operational meetings. The UHB has held a further stroke summit continuing our focus on the stroke pathway. We are also working with colleagues in the NHS Executive around what KPIs will be the focus in Wales. We will continue to update Finance & Performance Committee and Board on the impact of the changes. Our analysis of the latest data has shown that our door-to-ward performance improved again in March, while the percentage of patients receiving their CT scan within 1 hour improved. Time to CT scan is one of the metrics which has been revised in the new SSNAP dataset, and performance against the new 20-minute standard has varied from 17.7% - 8.5% since October 2024, with 16.7% of patients scanned within 20 minutes in March, an improvement from February's performance. In March our thrombolysis rate was 7.5%, while our thrombectomy rate improved to 4.5%. We have recently conducted an internal review of reperfusion rates against high performing months and the same period last year. We continue to work closely with colleagues in NHS Executive regarding thrombolysis and thrombectomy rates.

Hospital Flow and Discharge

The proportion of beds occupied by long length-of-stay patients has fluctuated in recent months as additional beds have been opened and closed in line with our operational plan. The number of pathway of care delays (POCD) remains a national focus and has reduced since the high point in February 2024. Seasonal pressures and associated operational challenges in January and February 2025 saw the number of delays increase although not to the volume seen last year. The February and March census showed 163 delays across all patient groups, with a drop in April to 150 patients. This is an improvement from April 2025 (185) in line with our commitment.

In addition to the monthly POCD census, patients with a length of stay >7 and >21 days in acute beds forms part of our weekly 'hot' reporting and end of month snapshots are provided in the IPR. We have seen the number of long-length-of stay reduce from high point in January associated with season pressures. At the time of writing there are c400 patients with a length of stay over 21 days across our acute wards.

Measure	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
7 day LOS on Acute Wards (snapshot)	57.7%	56.8%	55.2%	55.2%	55.5%	58.0%	58.5%	59.4%	57.3%	62.3%	60.5%	59.4%	56.2%	57.8%
21 day LOS on Acute Wards (snapshot)	32.9%	32.0%	29.3%	29.4%	30.9%	32.6%	31.8%	31.4%	30.9%	35.5%	37.3%	34.0%	34.0%	33.4%

Cancer

Our Single Cancer Pathway compliance has remained above 60% since September 2023 and we reported compliance of over 70% for August, September and October 2024.

In March, our most recently reported position improved from February and 68.7% of patients with Cancer received their first definitive treatment within 62 days. The SCP standard of 75% was met in seven tumour sites: Brain/CNS, Gynae, Haematology, Head and Neck, Endocrine, Sarcoma and Skin.

We continue to treat from the backlog and anticipate that April performance will drop as a result of an increase in referrals.

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
SCP referrals	2146	2192	2027	2291	2000	2272	2486	2214	1914	2416	2150	2381

The cancer PTL is tracked daily through Cancer services and operational teams, with weekly oversight of KPIs by the Cancer Delivery Group. We recently held the second 'stocktake' session for teams to share their actions plans to consistently deliver the capacity required to meet the outpatient, diagnostic and treatment standards. Further sessions are planned in Q1 as we continue to support teams to right size their cancer capacity.

Planned Care

The numbers of patients waiting on an RTT waiting list has reduced during Q4. We continue to focus on long-waiting cohorts and Cancer pathways with weekly scrutiny against the national standards and ministerial ambitions.

At the end of March, we delivered our revised commitment to Welsh Government, by reducing the number of patients waiting 2-years for treatment to 1,632. This was a significant reduction from the previous month and is the lowest number of 2-year waits reported since July 2021 as long waits increased following the Covid-19 pandemic. Challenge for Q1 is to hold the position.

We are clear that there are still too many patients waiting too long for treatment across a number of key services and continue to work to reduce the length of time patients are waiting for treatment. Four- year waits were eradicated in September 2024, and we have maintained this position. The number of patients waiting over 3-years reduced to 38 in March 2025, with the number of specialties with 3-year waits remaining reduced to two (Ophthalmology and Spines).

We utilised non-recurrent financial resource from Welsh Government to drive the improvements through Q4. As forecast, our position deteriorated in April 2025, and we reported 2,036 2-year and 46 3-year waits at the end of the month. We have secured additional funding to reduce back to our March 2025 position by the end of Q1 this year and continue to work with Welsh Government, NHS Wales and the NHS Executive to drive further reductions of the number of waiting patients.

Last year we did not deliver our commitment to reduce 52-week outpatient waits to fewer than 9000. Our work to eliminate 3-year outpatient waits and reduce the number of 2-year waits has improved outpatient waiting times, but we continue to see high volumes of 52-week outpatient waits within some of our treatment specialties where we are focusing on reducing long waits across the pathway.

We continue to address outpatient waits through activity, validation and pathway redesign to ensure only those who need secondary care intervention are referred. This is not a UHB wide issue, and we have seen a reduction in the number of specialties reporting 52-week waits. We continue to work with specialties, particularly in Paediatrics, Medicine and Specialised services, to reduce to or maintain their outpatient waits below 52 weeks.

Our Planned Care Programme is revising its approach Outpatient Transformation; this includes the appointment of a Clinical Lead for Outpatients and alignment with the national Clinical Implementation Networks (CINs) to drive best practice. The use of See on Symptoms (SOS) and Patient Initiated Follow-up (PIFU) pathways is an important tool in the management of follow-up services and we continue to develop their use across our services with additional clinical support from specialties who have successfully implemented these pathways. SOS, PIFU and utilization of outpatient clinics will be an area of significant focus as we move into 25/26.

Diagnostics

The waiting list position for Diagnostics deteriorated through Q1 and Q2, with particular challenges in Radiology and Endoscopy. As part of the £2.8m community diagnostic hub investment to improve imaging waiting times we will continue to use mobile solutions. Since September, we have seen a

small improvement in the 8-week position with reductions in Endoscopy and non-obstetric ultrasound during Q3, continued into Q4.

Endoscopy capacity has been focused on Cancer, Urgent and long waiting surveillance patients. The service has an improvement plan, with additional theatre and insourcing capacity, aligned to a longer-term workforce plan to further address the deterioration in the length of wait. The number of 8-week waits increased through the first half of the year, albeit at a slower rate than last year. November saw the first reduction in the number of 8-week waits for the first time since February 2023. To clear the backlog of patients and create enough core capacity is going to require significant investment and support from Welsh Government. Looking forwards, consideration is being given to scale of the opportunity that might be available through the Llantrisant Health Park regional proposals.

At the end of March 2025, 13,825 patients had waited 8 weeks or longer for their treatment, equating to 55.1% of patients on a diagnostic waiting list. The reduction in recent months has been driven by an improved Endoscopy and non-obstetric ultrasound, with the continued reduction from February to March the result of further improvement in NOUS position. Our March position is in line with our commitment to Welsh Government.

Diagnostic		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Longest wait (weeks)	Median wait (weeks)	Total waiting list	% under 8w	% over 8w
Cardiology	Myocardial Perfusion Scanning	15	20	23	15	15	12	5	3	0	1	0	0	1	0	1	100.0%	0.0%
	Echo Cardiogram	4	0	0	0	0	2	1	0	0	0	0	0	7	2	795	100.0%	0.0%
	Dobutamine Stress Echocardiogram	22	10	25	21	6	17	0	1	0	0	0	0	5	1	55	100.0%	0.0%
	Stress Test	1	3	1	0	0	0	0	1	0	0	0	0	5	2	24	100.0%	0.0%
	Blood Pressure Monitoring	0	0	0	0	0	0	0	0	0	0	0	0	6	1	50	100.0%	0.0%
	Heart Rhythm Recording	0	3	0	0	0	0	0	0	0	0	0	0	7	1	198	100.0%	0.0%
	Diagnostic Angiography	78	71	33	30	56	66	55	55	52	48	40	24	24	8	46	47.8%	52.2%
	Trans Oesophageal Echocardiogram	5	2	0	0	0	3	0	0	0	0	0	0	4	1	13	100.0%	0.0%
	Cardiac CT	151	134	107	36	14	6	3	6	8	7	3	5	7	4	69	92.8%	7.2%
	Cardiac MRI	203	198	214	209	217	215	186	184	195	183	163	159	82	10	268	40.7%	59.3%
	Diagnostic Electrophysiology (EP Stud	2	2	2	0	0	0	0	0	0	0	1	1	13	13	1	0.0%	100.0%
Diagnostic Endoscopy	Cystoscopy	160	119	122	147	94	93	100	100	128	158	166	142	86	7	297	52.2%	47.8%
	Colonoscopy	1536	1565	1626	1712	1788	1892	1949	1995	1992	1992	1735	1758	135	35	2229	21.1%	78.9%
	Flexible Sigmoidoscopy	1120	1131	1176	1195	1246	1271	1320	1319	1302	1280	1142	1125	112	46	1288	12.7%	87.3%
	Gastroscopy	2499	2603	2692	2761	2864	2949	2979	2845	2748	2565	2234	2277	138	38	2707	15.9%	84.1%
	Bronchoscopy	19	25	14	14	11	12	12	13	17	14	13	13	146	15	24	45.8%	54.2%
Imaging	Fluoroscopy	37	30	45	30	30	34	26	15	6	9	4	7	17	2	91	92.3%	7.7%
Neurophysiology	Nerve Conduction Studies	0	0	0	0	0	1	0	0	0	0	0	0	7	3	90	100.0%	0.0%
	Electromyography	0	1	0	0	0	0	0	0	0	0	0	0	5	2	44	100.0%	0.0%
Physiological Measurement	Urodynamic Tests	35	74	76	58	57	71	69	88	74	95	74	70	59	6	183	61.7%	38.3%
	Vascular Technology	0	0	0	0	0	2	2	0	0	0	0	12	10	3	147	91.8%	8.2%
Radiology	MRI	1116	1045	892	974	1054	1019	865	716	882	944	662	792	113	5	2681	70.5%	29.5%
	Non-Obstetric Ultrasound	7773	8130	8808	9036	9462	9469	9114	9153	9315	8711	7808	7371	59	12	11857	37.8%	62.2%
	CT	21	26	20	14	24	27	14	8	24	48	22	56	67	2	1779	96.9%	3.1%
	Nuclear Medicine	38	53	62	72	78	49	44	54	27	33	19	13	15	3	143	90.9%	9.1%
Total		14835	15245	15938	16324	17016	17210	16744	16556	16770	16088	14086	13825			25080	44.9%	55.1%

The above table shows the scale of the impact that long waits for endoscopy and non-obstetric US are having on performance, while a number of modalities report zero or small numbers of patients waiting over the 8-week standard.

Mental Health

Demand for adult and children's Mental Health services remains high, including an increased presentation of patients with complex mental health and behavioural needs. Part 1a compliance for adults has, as forecast, remained low throughout last year as a result of capacity issues within the team. An additional WTE has been in post since October and two further WTE positions have been appointed to, we have seen the increased in capacity leading to improved performance as we moved through Q4 and into Q1 25/26. Our Part 1b compliance remains strong with >99% of patients receiving interventions within 28 days on the vast majority of months. Part 2 compliance remains challenged, an improvement trajectory has been shared with NHS Executive colleagues, with Part 1 service developments supporting improvements.

For children and young people, Part 1a remains compliant, our latest information from March 2025 shows 100% of assessments were completed within 28 days. Part 1b has made a strong return to compliance in September, as per our forecast and compliance with the 80% standard has since been maintained. As part of the improvement work, we have seen the size of waiting list and average wait reduce.

Primary and Community Care

We continue to see a high number of GP practices in high escalation (level 3 and 4), reflecting the pressures on all parts of our health system, although this has reduced from the exceptionally high levels seen through last year. Our primary care teams continue to support practices as required.

Through this year greater visibility will be brought the activity carried out in Primary and Community Care. Work is ongoing to provide high level data across a number of services; this data will be updated as available and is intended to demonstrate the volume of activity undertaken through primacy and community care services. The latest available data shows over 2.8 million GP appointments have been offered so far this year in Cardiff and the Vale, and over 8 million items issued via prescription.

GMS activity		February 2025	Year to date 24/25
	Calls to GP surgeries	349,039	4,169,902
	GP appointments offered	227,689	2,867,528
	Items issued via presciption	646,263	8,003,919

Source: Primary Care Information Portal. Note: *The analyses and associated visualizations presented within this tile of the Primary Care Information Portal (PCIP) are a product of source data that has been provided at the initial stages of a quality improvement process and as such the completeness, accuracy, and validity of this source data (and hence any analyses/visualizations derived from such data) cannot be guaranteed. Please note there is a lag in receiving this national dataset.*

We continue to see high utilisation of our Urgent Primary Care Centers across Cardiff and the Vale. Total utilization across all 6 sites was 91% in March, with 3,743 consultations in month. Utilisation for 25/26 was 92%, with 50,669 consultations throughout the year.

Our community teams and integrated services continue to support patients out of hospital, including 18,065 District Nursing visits in March 2025 – over 5,800 more than our reported attendances to the EU in the same period. These services continue to provide vital support to patients in the community allowing them to remain at home and reducing the demand for secondary cares services.

Community and Integrated Service teams	March 2025	Year to date 24/25
District Nursing visits to patients	18,065	210,833
Cardiff CRT and Vale CRS - Patients supported to avoid hospital admission	43	535
Cardiff CRT and Vale CRS - Patients supported with early discharge from hospital	114	1190
Cardiff CRT and Vale CRS - Patients supported with Therapy in the community	445	5251
Patients supported by Community Nursing to remain at home	3,617	42,617
Wound healing service referrals	91	1148
Continence service referrals	224	2582

People and Culture

Improving Wellbeing and Attendance:

A multi-disciplinary team (MDT) approach has been adopted, bringing together People Services, Wellbeing, Organisational Development (OD) & Culture, Employee Wellbeing and Occupational Health to drive improvements in wellbeing and attendance. A high-level action plan has been developed, and a task and finish group has been established to oversee its implementation. Each Clinical/Service Board has also developed an individual, detailed and targeted action plan to reduce sickness absence in their respective areas.
The following actions have been taken forward:

- The Managing Attendance at Work training has been revised and relaunched with 2 sessions per month available. One session is reserved for the Clinical Boards to identify targeted hot spot areas. The training focuses on 3 key areas:
  - Understanding and implementing the attendance policy
  - Effective conversations around attendance
  - Making reasonable adjustments to support staff
- A digitalised version of the training is in development as well as a digital module-based refresher training.
- Work is ongoing to ensure all absence is accurately recorded on the ESR/HealthRoster system. A specific piece of work is being undertaken to improve the recording of absence for medical staff and a communication has gone out from the Medical Director to all Clinical Boards.
- Each Clinical/Service Board are running monthly sickness panels to monitor attendance at work. These panels are chaired by a senior member of the Clinical Board. Terms of Reference and a standardised Agenda have been developed for these sickness panels to ensure consistency.
- Sickness absence will be reviewed at monthly Executive Reviews and a standardised data set has been developed to support the reviews.

Management and Leadership Development

- A comprehensive review of existing management development materials and training is being undertaken, this will identify any gaps in existing programmes.
- The OD Team has met with colleagues from Isle of wight and Portsmouth Hospitals University Trusts to learn from their implementation of the Culture and Leadership Programme.
- A draft outline of the General Manager Programme and the Band 7 Clinical Manager Programme has been developed and is due to be shared with key stakeholders in readiness for programme commencement in Summer 2025.

Building Workforce Planning Expertise:

- A programme of work for 2025/26 is being finalised for building workforce planning capability and expertise across the Health Board. This will include short term resource planning, i.e. improving efficiency of our current workforce resource, developing operational workforce planning capability across the Health Board to support the IMTP planning process and managers accessing foundation level workforce planning training.
- Review of the Education Commissioning process is currently being undertaken to improve the process for 2025/26.
- It has been agreed that Strategic Workforce Planning will be included as part of the General Managers Leadership Development Programme. Details are being discussed currently.
- Work is continuing to improve the accuracy of our workforce data, in particular the vacancies that are reported through ESR. This is an essential part of workforce planning. Pilot exercise across Mental Health Clinical Board is currently being scoped out.
- Work is continuing to develop a Health Board Strategic Workforce Planning SharePoint site, which will hopefully be launched in early June 2025.

Quality, Safety, and Experience (QSE) Update

Overview

The Integrated Performance Report for Cardiff and Vale Health Board for the period of March and April 2025 provides a comprehensive analysis of key performance metrics aligned with the Quadruple Aim of Quality, Safety, and Experience. This report highlights significant achievements, areas of concern, and recommendations for improvement.

Performance Highlights

1. **Concerns and Enquiries**

- Concerns Received: The Health Board received 418 concerns during March and April 2025. Of these, 388 were closed, with 74% closed within 30 working days, including Early Resolution. Additionally, 18% were closed within 2 days.
- Enquiries and Compliments: The Health Board received 572 enquiries and 119 compliments, indicating active engagement with patients and stakeholders.
- Active Concerns: There are currently 302 active concerns, with the top themes being clinical treatment and assessment, appointment issues, and communication.

2. **Duty of Candour**

- Incidents Reported: From December 2024 to April 2025, 10,755 incidents were reported across the Health Board. The Duty of Candour was triggered on 53 occasions in this period, highlighting areas such as avoidable pressure damage, falls, missed diagnoses, and medication errors.

3. **Patient Feedback**

- Survey Responses: The Civica system surveyed up to 1000 patients daily, with a response rate of 16%. In April, 14,326 texts were sent, resulting in 2,081 completions (15% response rate).
- Satisfaction: 84% of respondents who were discharged during March and April rated the service between 8-10 on a scale of 0-10.

4. **Patient Safety**

- Incidents Reported: In April 2025, 1,747 patient safety incidents were reported, with the majority being none or low harm. Falls and pressure damage remain the top reported incidents.
- Never Events: The cumulative number of Never Events is increasing, prompting initiatives such as the WHO checklist collaborative and education on NG tube management.

5. Mortality Rates

- Inpatient Mortality: The number of inpatient deaths per 1000 bed days was 4.1 in April 2025, consistent with seasonal trends.
- Emergency Unit Mortality: The rate was 14.21 per 10,000 attendances.
- Medical Examiner Reviews: 19.9% of cases reviewed by the Medical Examiner were returned for further consideration, with feedback primarily from bereaved families.

6. Infection Control

- Clostridioides difficile: 131 cases were reported, exceeding the reduction expectation.
- MRSA and MSSA: 16 MRSA cases and 91 MSSA cases were reported, both exceeding reduction expectations.
- E. coli and Klebsiella species: E. coli cases saw a 19% reduction from the previous year, while Klebsiella species cases increased by 2%.
- Pseudomonas aeruginosa: 41 cases were reported, a 128% increase from the previous year.

7. Other Key Metrics

- National Reportable Incidents: 82 incidents remain open for 90 days or more.

Recommendations for Improvement

1. Concerns and Enquiries

- Increase Closure Rate: we have Implemented strategies to improve the closure rate of concerns within 30 working days, aiming to exceed the Welsh Government target of 75%.

2. Patient Feedback

- Increase Response Rate: Implement initiatives to boost patient survey response rates, such as follow-up reminders and incentives for participation.
- Actionable Insights: we aim to utilize patient feedback to drive actionable improvements in service delivery, focusing on areas with lower satisfaction scores.

3. Patient Safety

- Preventive Measures: We aim to strengthen preventive measures for falls and pressure damage through targeted interventions and staff training.

4. Mortality Rates

- Mortality Review: Conduct detailed reviews of inpatient and emergency unit mortality rates to identify trends and implement corrective actions.
- Family Engagement: Increase engagement with bereaved families to gather insights and improve patient-centred care approaches.

5. Infection Control

- Targeted Interventions: Develop targeted interventions to reduce infection rates, particularly for Clostridioides difficile, MRSA, and MSSA.

Digital & Health Intelligence

Recognising the importance of digital and data as core enablers to the way we want to work and deliver our services in future, we are including Digital (and data) as part of the set of core services to be included in the Integrated Performance Report. The latest IT service desk metrics are contained within the Integrated Performance Report showing both service requests (additional services) and incidents (where something is not working).

Digital Foundations programme business case

This initiative is to develop a five-year Digital Programme Business Case (PBC) to seek All Wales Major Capital Funding alongside annual Business Justification cases (BJCs) for each phase of the case

The work will deliver a clear trajectory, costs and plans on how we will achieve our target of a minimum digital maturity level as per HIMSS EMRAM Level 3 (equivalent) in pursuit of our intentions towards a full Electronic Patient Record (EPR), consistent with national and regional initiatives

Activity update

- Core team of 2 plus input from senior D&HI staff, clinical and operational stakeholders
- Criteria for and shortlist of Year 1 Business Justification Cases (BJCs) agreed
- Data gathering requests in progress to support BJCs
- Clinical Board presentations progressing
- Kick off meets and workshops with a range of clinical and non-clinical staff arranged - instrumental in informing Digital Foundations plans.
- Years 2 to 5 BJCs will be derived working in co-production with stakeholders
- Partner in place to support the work
- Digital roadmap workshop with senior stakeholders have commenced
- Zero base of digital spend across UHB underway
- Benefits statement work in process for EU Workstation replacement
- Patient comms (digital letters) – market research to inform solutions & pricing

Plan

We are working to tight timescales:

- Socialisation of draft cases August - September
- Submission to Value and Benefits Realisation Group – September – October
- Socialisation with Welsh Government – October onwards

Dependencies

- Continuity of core team and partner resources
- Support and engagement from
- Clinical Boards
- CAVUHB Staff – clinical and operational
- Finance
- CEF
- Digital & Health Intelligence senior management team
- DHCW
- Other partners (eg regional partners including AB UHB, CTM UHB)

We are continuing to develop additional KPI figures and supporting information including:

- % Wi-Fi coverage across main clinical sites.
    - Wi-Fi coverage information has now been introduced into the Wi-Fi Upgrade Project reporting, a dashboard is in draft at this time).
- % staff access to devices and systems
    - 2,500 additional staff NADEXs and MS Licences have been purchased, and large-scale deployments have started. The M365 is working with local departments and to ensure adoption by colleagues.
- No of BI products available/in use
    - Continues to be investigated.
- No of dashboards/viewers available/in use
    - Continues to be investigated.
- % uptime of core systems availability
    - Core systems information is currently limited to hardware, as the applications classed as core are still being agreed. PMS and EU Workstation as well as Paris have separate reporting and availability information.
- Staff Service Desk satisfaction information.
    - Ivanti currently only offers a staff escalation process for feedback or praise. Efforts are underway to develop a formal questionnaire and call satisfaction measurement process.

Windows 11

Work is currently underway to setup a designated Windows 11 Project Team to work solely on the project. A Project Manager and Technical Lead have been appointed and vacancies for Digital Support Officers advertised. The plan is to upgrade the majority of the 12,500 devices and to replace 4,500 desktop PCs and 230 laptop devices by end of October 2025 via centrally provided capital funding.

The team are currently scoping the requirements per department with a view to upgrading a small number of nominated devices to ensure that all bespoke software used is functioning as expected with the Windows 11 Operating System.

Detailed lists of devices from the CD&T Clinical Board and the Specialist Services Clinical Board have been supplied to the Project Manager and these will be the areas where the early adopters of Windows 11 will be sourced.

CAVUHB Wi-Fi Project

The Wi-Fi project is a comprehensive initiative aimed at enhancing digital connectivity across all wards and departments. The project involves installing new infrastructure, including switches and fibre backbone, to provide high-speed internet in healthcare settings.

Initially focusing on ePMA clinical areas, the project has expanded to include additional areas related to Capital, Estate, and Facilities (CEF), such as catering, portering, and cleaning services. Regular communication with staff ensures that the Wi-Fi implementation aligns with operational requirements and enhances the overall user experience.

Remote Desktop Server Upgrades

The Remote Desktop Server Upgrades project has now been successfully completed and transitioned into Business as Usual (BAU). All the legacy RDS servers have been decommissioned, significantly

reducing cyber risks across the Health Board. This milestone represents a major achievement in improving the organisations digital security posture and operational efficiency.

Telecommunications

The implementation of Microsoft Teams is planned for later this year, aiming to enhance collaboration and communication across the organisation. This strategic rollout will integrate with existing digital platforms and provide a seamless experience for users.

CAV Telecoms have also started progression of several other projects that had dependencies on the SIP (Digital Telecoms) framework. These projects are now gaining momentum, with expected improvements in operational workflows and clinical communications across the Health Board.

Data Insights

The Business Intelligence team continue to develop data products and associated dashboards to replace the externally produced viewers in 6 Goals and the Emergency Unit. Additional Business Intelligence capacity is being realised through two additional roles currently being filled. Development of the new nationally mandated data sets for the start of FY25/26 have been completed and work is on track to deliver the new dashboards in Qtr 2 25/26.

Recommendation:
The Board are requested to: **A) NOTE** the year-to-date position against key organisational performance indicators for 2024-25 and the update against the Operational Plan programmes.

Link to Strategic Objectives of Shaping our Future Wellbeing: *Please tick as relevant*			
Putting People First **Click the objective above to view more detail.**	X	Providing Outstanding Quality **Click the objective above to view more detail.**	X
Delivering in the Right Places **Click the objective above to view more detail.**	X	Acting for the Future **Click the objective above to view more detail.**	X

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention	x	Long term		Integration	x	Collaboration		Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes/No
N.A
Safety: Yes/No
N.A
Financial: Yes/No
N.A
Workforce: Yes/No
N.A
Legal: Yes/No
N.A
Reputational: Yes/No
N.A
Socio Economic: Yes/No
N.A
Equality and Health: Yes/No
N.A
Decarbonisation: Yes/No
N.A
Welsh Language: Yes/No
N.A

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Cardiff and Vale
Integrated Performance Report

2024/25

May 2025

Report Contents

Click on a hyperlink to navigate directly to the section required

Section 1: Cabinet Secretary Priorities

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The Cabinet Secretary for Health and Social Services has set out National Programmes of work covering the priority areas of delivery. These priority areas are:

- Enhanced Care in the Community, with a focus on reducing delayed pathways of care
- Primary and Community Care, with a focus on improving access and shifting resources into primary and community care
- Urgent and Emergency Care, with a focus on delivery of the 6 goals programme
- Planned Care and Cancer, with a focus on reducing the longest waits
- Mental Health, including CAMHS, with a focus on delivery of the national programme

Further to these priority areas the Welsh Government and NHS Wales have identified 8 Key Performance Indicators across Urgent and Emergency Care, Cancer, Diagnostics, Elective Care and Mental Health Services.

Section 1 provides an overview of the Health Board performance of the Key Performance Indicators outlined by Welsh Government and Health Board commitments related to the delivery of the priority areas.

For a more in-depth view on performance for each priority, please follow the links in the NHS Performance Report column.

Section 1: Cabinet Secretary Priorities

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Priority	Aim	C&V Commitment	Commitment to meet national standard?	By When	In Month Performance against C&V commitment	Link in Performance Report
Enhanced Care in the Community	**Measure:** Number of delayed transfers of care. **National standard/ambition:** 12 month reduction trend **Reporting period:** Monthly	**Reduction against 23/24**	**Yes**	**Mar-25**	**150** Apr-25	Hyperlink to section
Primary and Community Care	**Measure:** General Medical Services – Number of GP practices achieving core access standards **National standard/ambition:** 100% **Reporting period:** Annual – in month position for information	**100%**	**Yes**	**Mar-25**	**98.2%** **Apr-24**	Hyperlink to section
	Measure: General Dental Services - % of contract value fulfilled **National standard:** 30% of contract value by end Q2, 100% Q4 **Reporting period:** Monthly	**25% Q1 50%Q2 75% Q3 100% Q4**	**Yes**	**Mar-25**	**98.5%** (Apr-24 to Mar-25)	Hyperlink to section
Urgent and Emergency Care	**Measure:** Number of patients who spend 12 hours or more in all major and minor emergency care facilities from arrival until admission, transfer or discharge **National standard/ambition:** 20% reduction by September 2024, further 20% reduction by March 2025 **Reporting period:** Monthly	**670 Sept-24 532 Mar-25**	**Yes**	**Mar-25**	**887** Apr-25	Hyperlink to section
	Measure: Number of ambulance patient handovers over 1 hour **National standard/ambition:** 30% reduction by December 2024 **Reporting period:** Monthly	**232**	**Yes**	**Dec-24**	**462** Apr-25	Hyperlink to section

Performance Key: Meeting standard / trajectory | off target/trajectory

Section 1: Cabinet Secretary Priorities

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Priority	Aim	C&V Commitment	Commitment to meet national standard?	By When	In Month Performance against C&V commitment	Link in Performance Report
Mental Health	**Measure:** Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS for people age under 18 years **National standard/ambition:** 80% by end of December 2024 **Reporting period:** Monthly	**80%**	**Yes**	**Dec-24**	**99%** Mar-25	Hyperlink to section
	Measure: Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS for adults age 18 years and over **National standard/ambition:** 80% by end of December 2024 **Reporting period:** Monthly	**99%**	**Yes**	**Dec-24**	**51.3%** Mar-25	Hyperlink to section

Performance Key: Meeting standard / trajectory | off target/trajectory

Section 1: Cabinet Secretary Priorities

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Priority	Aim	C&V Commitment	Commitment to meet national standard?	By When	In Month Performance against C&V commitment	Link in Performance Report
Planned Care and Cancer	**Measure:** Number of patients waiting more than 52 weeks for a new outpatient appointment **National standard/ambition:** 40% reduction by end of September 2024, 0 by end of March 2025 **Reporting period:** Monthly	**16,004** Sep-24 **15,925** Mar-25	**No**		**15,185** Mar-25	Hyperlink to section
	Measure: Number of patients waiting more than 104 weeks for referral to treatment **National standard/ambition:** 0 by end of December 2024 **Reporting period:** Monthly	**4,447** Dec-24	**No**		**1,632** Mar-25	Hyperlink to section
	Measure: Percentage of patients starting their first definitive treatment within 62 days from point of suspicion (regardless of the referral route) **National standard/ambition:** 60% by end of December 2024, 70% by end of March 2025 **Reporting period:** Monthly	**70%** Mar-25	**Yes**	Dec-24	**68.7%** Mar-25	Hyperlink to section
	Measure: Number of patients waiting more than 8 weeks for a specified diagnostic **National standard/ambition**: 95% of patients waiting less than 8 weeks by end of December 2024 **Reporting period:** Monthly	**14,796** Dec-24	**No**		**14,750** Apr-25	Hyperlink to section

Performance Key: Meeting standard / trajectory | off target/trajectory

Section 2: Cardiff and Vale Performance Report

The Performance Report section provides detail of UHB performance across the quadruple aims.

Detail on what is included under each quadruple aim is provided below.

A summary of performance is provided against the priority UHB ambition under each aim, including detail of annual plan commitments. Performance against the relevant NHS Performance Frameworks measures is provided under each aim.

National Performance Framework monitoring data is available from DHCW showing performance across all Welsh Health Boards and Trusts (where relevant). This information can be accessed by clicking here.

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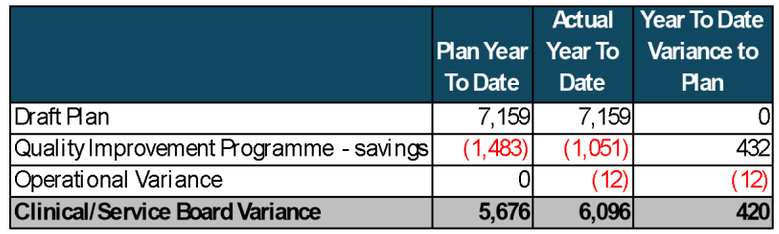
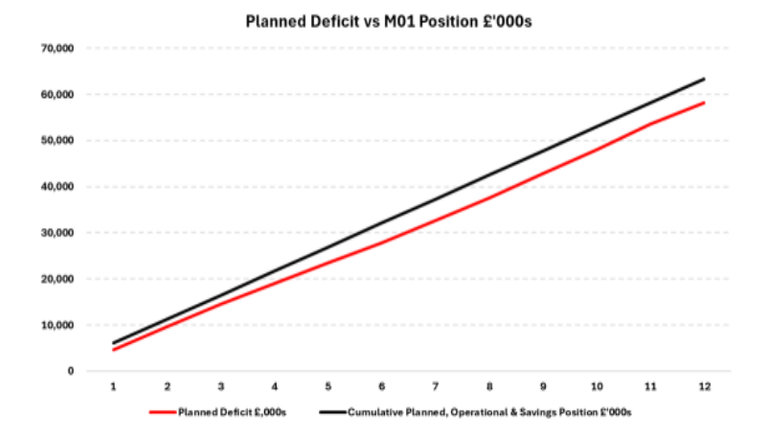
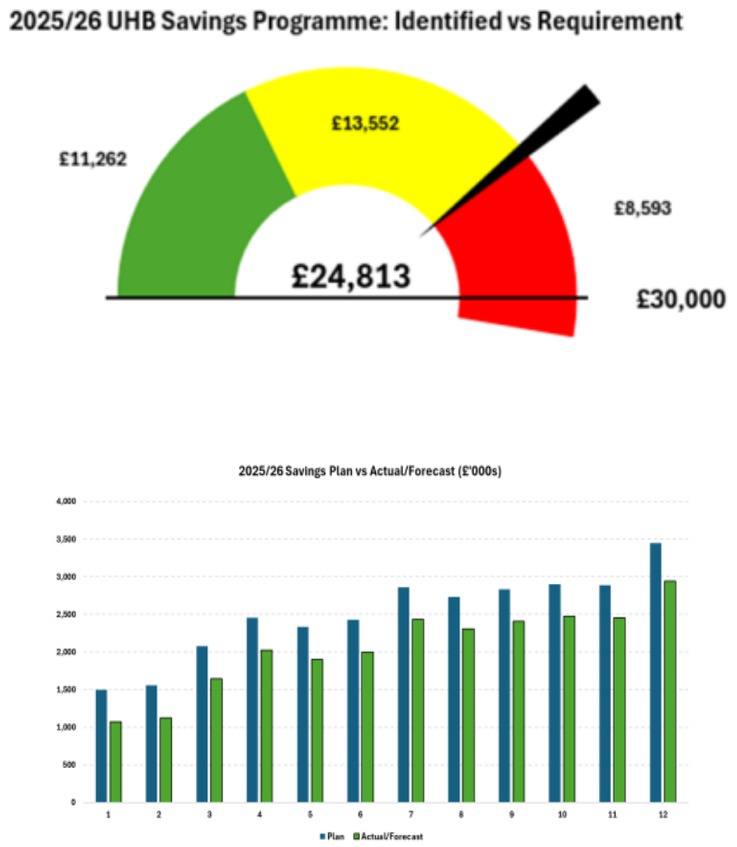
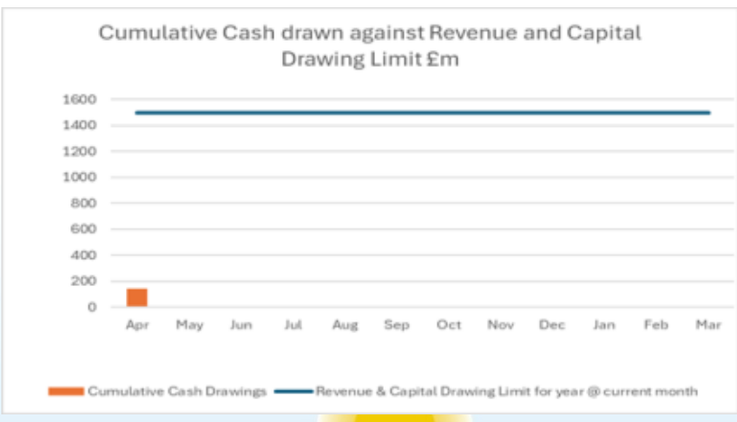
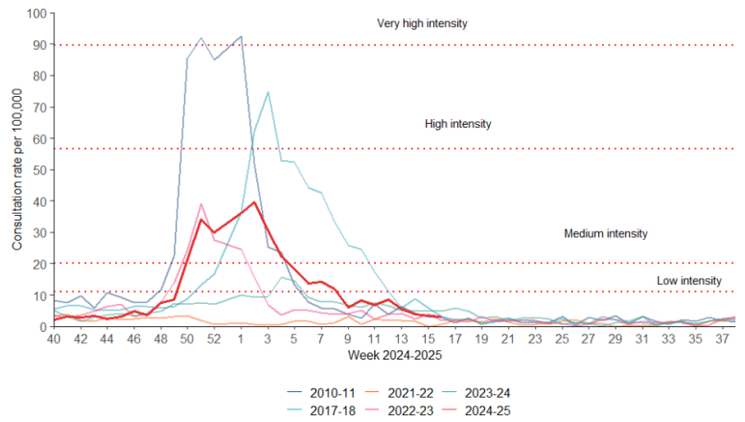
Number	Aim	Contents
Aim 1	People in Wales have improved health and well-being with better prevention and self-management	Public Health
Aim 2	People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement	Urgent and Emergency Care Inpatient Flow, Discharge and Front Door Alternatives to Admission Community and Urgent Primary Care Priority Services RTT Waiting Times Planned Care Cancer, Diagnostics and Therapies Primary and Community Care Whole System Evaluation and Supporting Patients Whilst Waiting Mental Health
Aim 3	The health and social care workforce in Wales is motivated and sustainable	People and Culture
Aim 4	Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation, enabled by data and focused on outcomes.	Quality, Safety and Experience Financial Performance

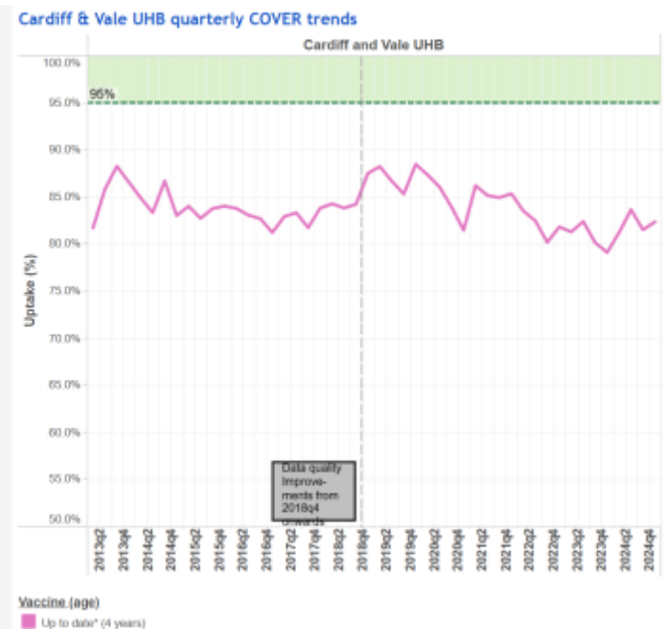
Financial Performance

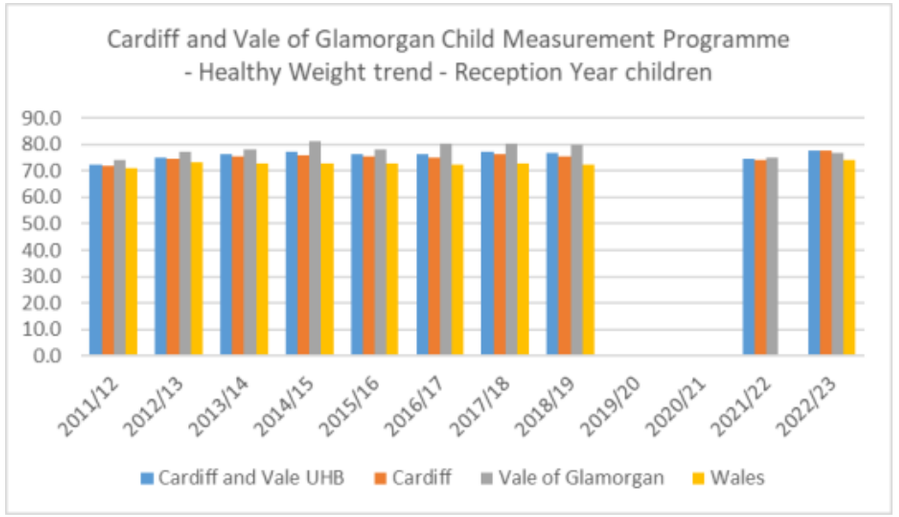
Priority	Performance Summary	Reported Period	Data
Deliver 2025/26 Draft Financial Plan	**The UHB's Financial Plan in 2025/26 reflected the following key components:** **Planning Assumption** / **(£m)** Brought Forward Underlying Deficit: 59.900 2025/26 Demand/Cost Growth/Investments: 51.100 **Draft Deficit: 111.000** Additional Allocations: (22.768) Savings Plans: (30.000) **Final Planned Deficit: 58.233** The resulting planned deficit of £58.2m was approved by the UHB for submission for Welsh Government (WG) and the draft plan was submitted at the end of March 2025. This is £49.1m over the Welsh Government control total target of £9.1m. The submitted plan projects a deficit for the financial year and therefore a failure of the UHB's statutory requirement to deliver a balanced financial plan over a 3-year rolling period. This also prevents Ministerial approval of the plan. The overall position at month 1 was a £6.096m deficit as outlined in the graph to the right.	April 2025	
Return to financial balance and approved IMTP status	£58.2m underlying deficit by end of 2025/26 financial year. The UHB is reporting savings gap of £0.432m and a broadly balanced operational variance at Month 1. The savings gap would lead to an increase in the underlying deficit in 2025/26 if further savings or mitigating actions are not identified as the year progresses.	April 2025	
Management of operational budget pressures	Failure to adequately manage budget pressures. This is the responsibility of the primary budget holders. £0.012m operational surplus reported at month 1. A number of additional urgent control actions were implemented in January 2025 to slow expenditure run rates and eliminate unnecessary expenditure. This included a daily Programme Management Office (PMO): • Authorisation for any necessary remaining agency expenditure • Authorisation for any necessary variable bank expenditure • Authorisation for any training (outside the statutory training required for professional registration or clinical training to ensure patient safety).	April 2025	**Measure** / **RAG** / **Trend** / **Target** Management of operational budget pressures. This is the responsibility of the primary budget holders. £0.012m operational surplus reported at month 1. / **A** / " / Operational Spend to be maintained within Budgets

	Priority	Performance Summary	Reported Period	Data
	Delivery of recurrent £30.0m savings target	At Month 01, the UHB had identified circa £24.8m (83%) of green and amber savings to deliver against the £30.0m savings target. Red schemes of £8.6m are also identified and continue to be reviewed for progression to Green/Amber where possible. The second chart illustrates that the profile of the UHB's 2025/26 savings programme is skewed towards the end of they ear.	April. 2025	
	Remain within Cash Limit	The UHB will require cash support from WG for the 25/26 planned deficit of £58.2m along with likely movements in working capital from the 2024/25 balance sheet. The closing cash balance at the end of April 2025 was £1.624m. The cumulative cash drawn at the month end against the UHBs cumulative annual cash drawing limit is illustrated by the graph to the right	April 2025	

Priority	Performance Summary	Reported Period	On target?	Data

Health Protection	**Seasonal respiratory infections**
	
	Immunisation – COVID-19 and influenza
	• The Covid-19 Spring booster campaign started at the beginning of April. As of the 24th of April it has delivered 4,850 vaccines to a total eligible population of 57,435 in Cardiff and the Vale for an uptake of 8.44%, which is below the current Welsh average of 17.18%.
	
	Surveillance
	• Influenza activity is now at low intensity levels. GP consultations for influenza-like illness and confirmed case numbers have decreased in the current week, as has test positivity.
	• XEC remains the most prevalent variant of Covid-19 in Wales
	• RSV has returned to baseline levels
	• Hospital incidents and outbreaks
	  • There is currently **1** Covid-19 outbreaks and **1** incident in hospitals in C&V UHB; and **0** influenza outbreaks and **0** incidents.
	  • Since the start of the 2025/26 financial year, in C&V UHB there have been **2** influenza incidents or outbreaks, with **0** bed days lost. In the same period there have been **7** Covid-19 incidents or outbreaks, with **86** bed days lost. Combined, influenza and Covid-19 incidents and outbreaks have led to the **loss of 86 bed days**, representing an estimated opportunity cost of **£43,000** to the UHB
	• Staff sickness absence
	  • Month of April 2025:
	  • **2,768 full time equivalent calendar days*** were reported as sickness absence by C&V UHB staff due to respiratory conditions (S15), cough, cold or flu (S13)
	  • The estimated loss in productivity due to this absence is **£298,000†**
	
	* Because of the way absence is recorded on ESR these figures include weekends and non-working days
	† Salary costs for staff reporting sickness absence
		Week 16	Below target	Wales COVID-19 vaccination surveillance weekly report.pdf
				
				Weekly COVID-19 vaccination report by health board
				https://www2.nphs.wales.nhs.uk/CommunitySurveillanceDocs.nsf/3dc04669c9e1eaa880257062003b246b/cf7a9a9adcddbb0a8025866b003a51a1/$FILE/Wales%20COVID-19%20vaccination%20surveillance%20weekly%20report.pdf
				
				 
				
				Source: PHW weekly ARI summary (new from Nov 2024)

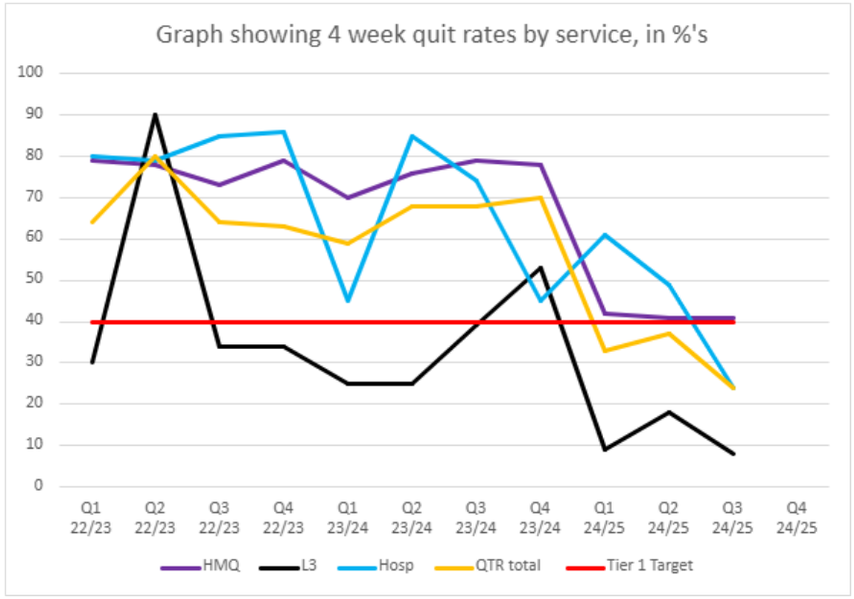
Priority	Performance Summary	Reported Period	On target?	Data
Health Protection	**Routine childhood immunisation** • 82.3% of children are up to date with vaccination at age 4, which although an improvement is below the target of 95% and a Welsh average of 85.7%, uptake of all childhood vaccinations at age 5 is 83.3% which is still below the Welsh average of 88.1%.	Oct-Dec 2024	Below target	 Source quarterly COVER data
Health Protection	**Health Protection System** • The first Cardiff and Vale Health Protection Plan (2024) was fully signed off via partnership governance processes (completed April 2024) • An updated action plan for 2024/26 is complete and going through approval processes. It further strengthens the agreed approach and has been produced in collaboration with partners across the regional system, seeking views on where the partnership has added value and where there is still the opportunity for further collaborative working. • Planning for future pandemic response is underway, with workshops gathering learning from COVID-19 now complete. The UHB will participate in Exercise Pegasus, a Tier 1 exercise recently announced by UK government, in the autumn of 2025, and in Exercise Solaris on 30 April	Q4 2024/25	On target	*n/a*

Priority	Performance Summary	Reported Period	On target?	Data
Health Improvement	**Healthy weight:** • 77.5% of reception aged children in Cardiff and Vale of Glamorgan are categorised as healthy weight (Child Measurement Programme, 2022/23) this is in line with the English average. Data produced annually. • 40% of adults in Cardiff and Vale of Glamorgan are a healthy weight, as compared to 36% of the Welsh average (NSfW, 2021/22+2022/23); 39% are eating five portions of fruit/vegetables a day, compared to 30% in Wales (NSfW, 2021/22+2022/23) and 68% are meeting physical activity guidelines of being active for at least 150 minutes per week, as compared to 57% in Wales (NSfW, 2021/22+2022/23)*. There are no comparable data in other UK countries due to different methodologies being used. • Differences remain between our most and least deprived communities with levels of healthy weight lower, and consumption of fruit and vegetables/physical activity levels also lower in the most deprived areas of Cardiff and Vale. **Weight management services** • An increase of 10% for L2 weight management service was achieved over the year. • An increase of 10% for L3 is not achievable within current service constraints. Increased demands for these services are due to the introduction of injectable therapies which is consistently out stripping capacity.	Q4 2023/24	**Healthy weight:** On target **Weight management services:** Below target	

Priority	Performance Summary	Reported Period	On target?	Data
Health improvement	**Diabetes** • Percentage of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes • Slight increase since January 2025 in CVUHB and across Wales. Whilst overall completion rates is c. 46%, some processes (e.g. HbA1c check) are substantially higher percentage uptake compared to others (e.g. urine albumin) - some of this may be the way the data are collected rather than actual lack of care process completion. Ongoing work planned to improve low uptake of care processes, and also examine data more closely.	Mar 2025	Below target	Slight increasing trend– March 2025 46.27% CVUHB

For areas of underperformance please see cover paper for details on actions being taken. Note that the diabetes performance measure is listed under Quadruple Aim 2

Priority	Performance Summary	Reported Period	On target?	Data

Health Improvement	**Tobacco**
	• 13% of Cardiff and Vale of Glamorgan smoke.
	• NHS Wales Performance Measure - Percentage of adult smokers who make a quit attempt via smoking cessation services - Target = 5% annually.
	• In Quarter 3 - 24/25 (the most up to date data received) 0.5 % of smokers set a firm quit date. This is below target. 24 % of these quit smoking at 4 weeks. CO Validated (in total from Help Me Quit [HMQ], Pharmacy Level 3 and Hospital Smoking Cessation Service combined) . This is a reduction from the previous quarter. This breaks down by service as follows:
	  • HMQ community – 41% of Treated Smokers had quit smoking at 4 weeks (target achieved)
	  • Level 3 Pharmacy –8% of Treated Smokers had quit smoking at 4 weeks (target not achieved)
	  • Hospital Service - 24% of Treated Smokers had quit smoking at 4 weeks (target not achieved)
	• CO validation was re introduced for quits in April 24 by Welsh Gov. This has resulted in a drop in recorded 4 week quits. In Q3 there were an additional 27 self-reported quits that have not been included in reporting across all services. Pharmacy L3 have reported 18 self-reported quits and the Hospital service reported 9 that have not been recorded.
	• Starting in January 2025, a varied programme of commissioned communications activity has been delivered supported by colleagues in the health board communications and public health teams. The final elements of the campaign are expected to be delivered in the coming weeks and we will receive a final report.
	• A new Smoking Cessation Adviser started in post at the beginning of Dec. They will work with pregnant women and birthing people and will be part of the Help Me Quit community team at the Public Health Team. We will keep this model under close review. An ‘opt out’ model is now being implemented. During Q4 143 pregnant people indicated that they were smokers on the UHB online pregnancy booking form. Smokers are automatically referred to the Specialist Maternity Smoking Cessation Practitioner. HMQ data is not currently available on number of treated smokers for Q4 to allow a comparison with previous opt in model. More pregnant smokers are now receiving a brief intervention than under the previous model.
		Q3 24/25	Smokers setting qu it date:
			
			Below target for percentage of adult smokers who make a quit attempt
			
			Below target for 4 week quits
				

For areas of underperformance please see cover paper for details on actions being taken

Smoking and substance misuse

NHS Wales Performance Framework measures

No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend			
1.	Percentage of adult smokers who make a quit attempt via smoking cessation services	2024/25	0.8% (per quarter) National target is 1.25% per quarter, 5% per year	0.5% Below target	**Q1**	**Q2**	**Q3**	**Q4**
					0.5%	0.5%	0.5%	
2.	Percentage of adult smokers who make a quit attempt via smoking cessation services who are CO-validated as quit at 4 weeks. ***CO validated quits are being recorded from 1.4.24 as per guidance from Welsh Gov.***	2024/25	40%	24% Below target	**Q1**	**Q2**	**Q3**	**Q4**
					33%	37%	24%	
3.	Percentage of people who have been referred to health board services who have completed treatment for substance misuse (drugs and alcohol)	2024/25	4 quarter improvement	32.8% Below Target	**Q1**	**Q2**	**Q3**	**Q4**
					32.8%			

Chair's objectives

No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend			
n/a	% of pregnant people undergoing CO testing at their initial booking appointment	2024/25	100%	94% Below target Average for 23/24: 90%	**Q1**	**Q2**	**Q3**	**Q4**
					92%	94%	94%	Awaited
n/a	% of pregnant smokers who are referred to smoking cessation support following initial booking assessment	2024/25	100%	100% Meeting target	**Q1**	**Q2**	**Q3**	**Q4**
					16%	15%	16%	100%

Immunisation and vaccination

NHS Wales Performance Framework measures and Chair's objectives

No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend			
4.	Percentage of children who are up to date with the scheduled vaccinations by age 5 ('4 in 1' preschool booster, the Hib/MenC booster and the second MMR dose)	Oct-Dec 24	95%	83.3% Below target	**Jan-Mar**	**Apr-Jun**	**Jul-Sept**	**Oct-Dec**
					84.1%	85.8%	85.2%	83.3%
5.	Percentage of children receiving the Human Papillomavirus (HPV) vaccination by the age of 15 *Applicable during: 01.04.2023 - 30.06.2023 and 01.01.2024 - 31.03.2024 (still awaiting data for the 2024 HPV campaign)* ***(still awaiting end of campaign data for the 2024 HPV campaign)***	1 January 2024 to 30 June 2024	90%	67.1% Below target	**Q1**	**Q2**	**Q3**	**Q4**
						62.1%		67.1%
6.	Percentage uptake of the influenza vaccination amongst adults aged 65 years and over *Applicable during: 01.09.2024 - 31.03.2025* ***(autumn booster campaign underway)***	1 Sep 24 to 31 Mar 25	75%	70.2% Below target	**26/11/24**	**31/12/24**	**04/02/2025**	**20/3/25**
					61.2%	66.9%	69.7%	70.2%
7.	Percentage uptake of the COVID-19 vaccination for those eligible *Applicable during: Spring Booster 01.04.2025 - 30.06.2025 Autumn Booster 01.09.2025 - 31.03.2026* ***(spring booster campaign underway)***	1 Apr 2025 to 30 Jun 2025	75%	% Below target	**24/04/25**			
					8.44%			

Weight Management Services

Chair's objectives – ***to note measures updated for 24/25***

No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend			
n/a	Increase L2 service capacity (against current service standard – Q1 24/25) by 10% by the end of Q4 24/25 *(note figures are now displayed as quarterly for ease of interpretation)*	Mar 25	10% increase on Q1 24/25 (=1,584)	n/a	**Q1**	**Q2**	**Q3**	**Q4**
					290	236	356	483 (increase of 60%)
n/a	Increase L3 service capacity (against current service standard – Q1 24/25) by 10% by the end of Q4 24/25 *(note figures are now displayed as quarterly for ease of interpretation)*	Mar 25	10% increase on Q1 24/25 (=176)	n/a	**Q1**	**Q2**	**Q3**	**Q4**
					30	36	42	35 (unable to do without investment)

Diabetes

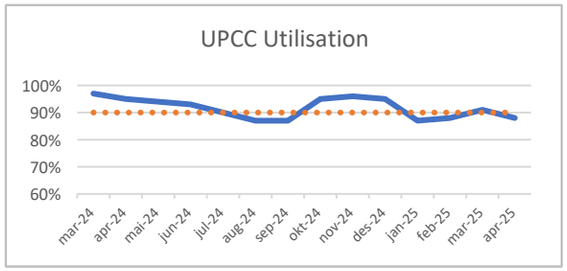
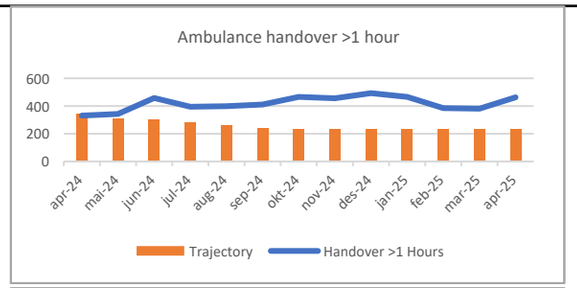
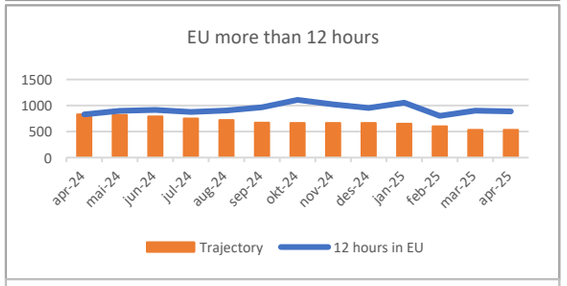
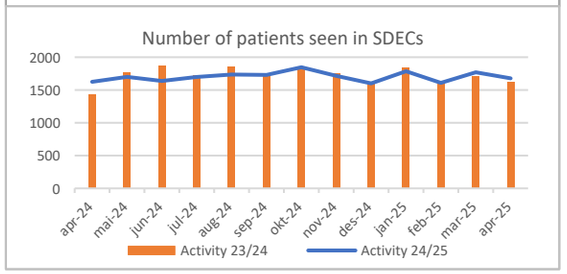
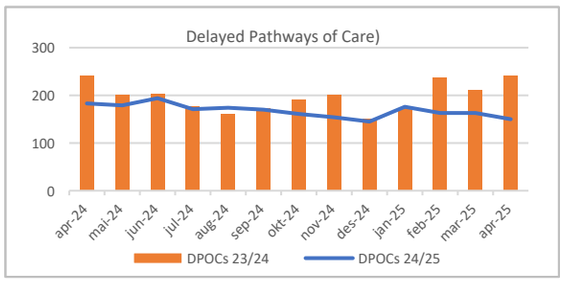
NHS Wales Performance Framework measure

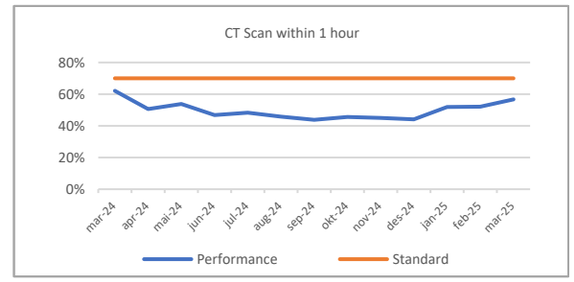
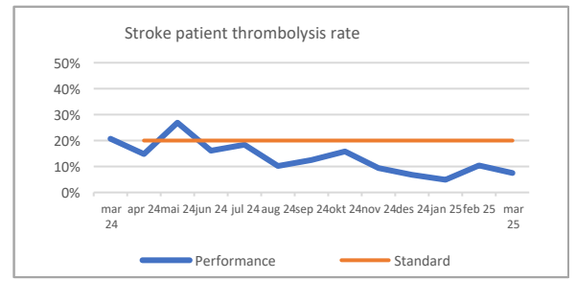
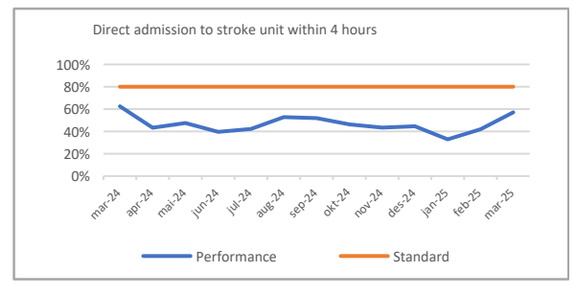
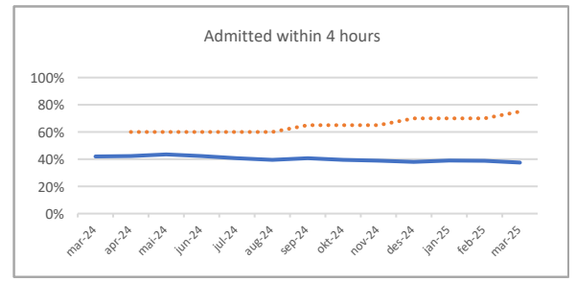
No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend
12.	Percentage of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes	See Quadruple Aim 2, measure no. 12			

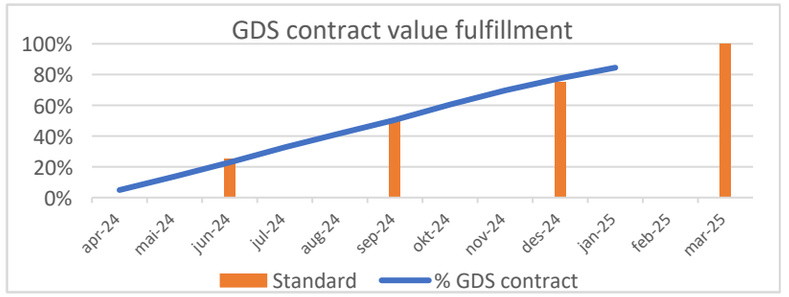
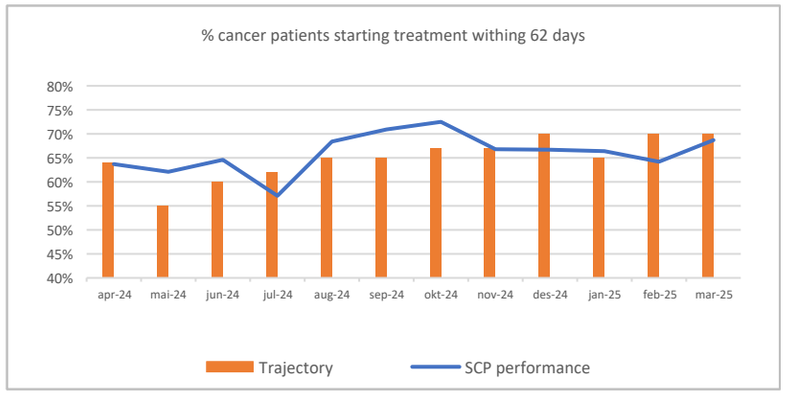
Screening

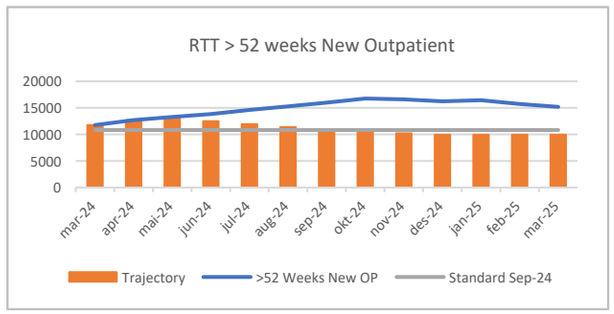
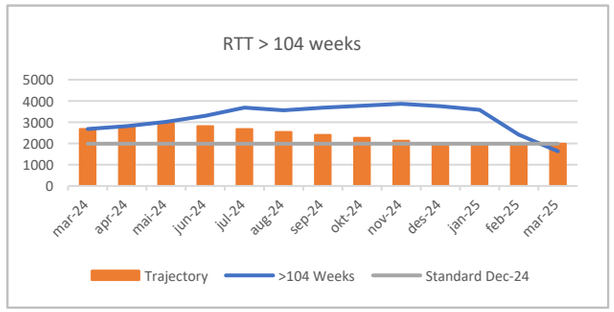
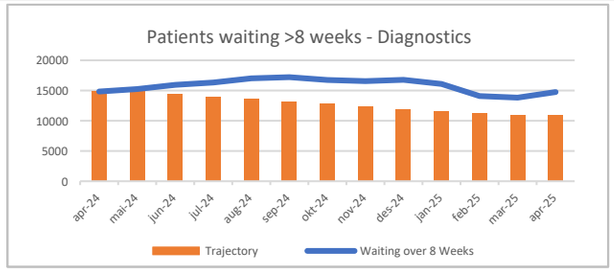
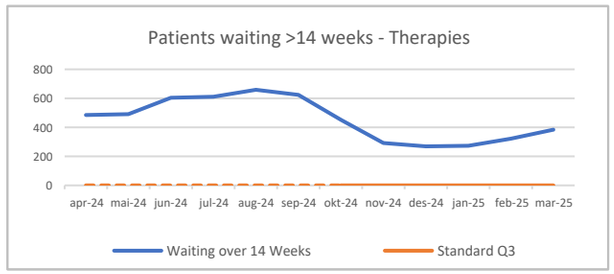
NHS Wales Performance Framework measures

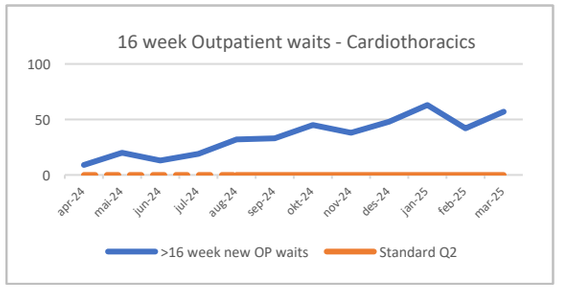
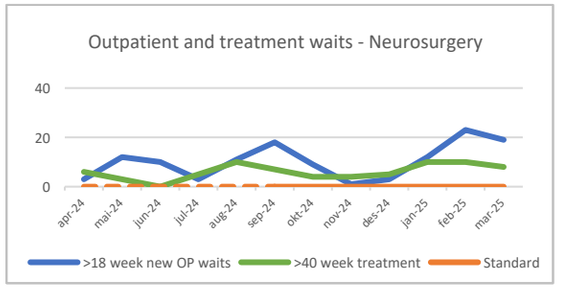
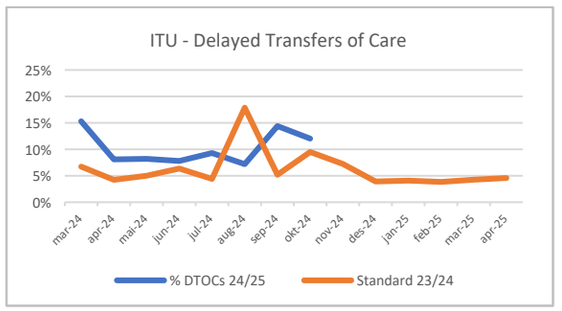
No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend
8.	Percentage of patients offered an index colonoscopy procedure within 4 weeks of booking their Specialist Screening Practitioner assessment appointment	Feb-25	90%	**10.0%** Below standard	Nov-24: 12.30%; Dec-24: 7.40%; Jan-25: 3.00%; Feb-25: 10.00%
9.	Percentage of well babies entering the new-born hearing screening programme who complete screening within 4 weeks	Dec-24	90%	**79.8%** Above standard	Sep-24: 99.20%; Oct-24: 98.40%; Nov-24: 97.60%; Dec-24: 79.80%
10.	Percentage of eligible new-born babies who have a conclusive bloodspot screening result by day 17 of life	Mar-25	95%	**96.4%** Above standard	Dec-24: 96.90%; Jan-25: 96.20%; Feb-25: 95.10%; Mar-25: 96.40%

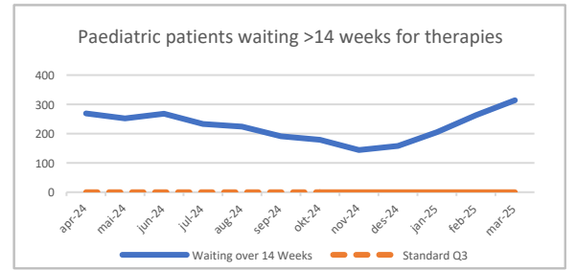
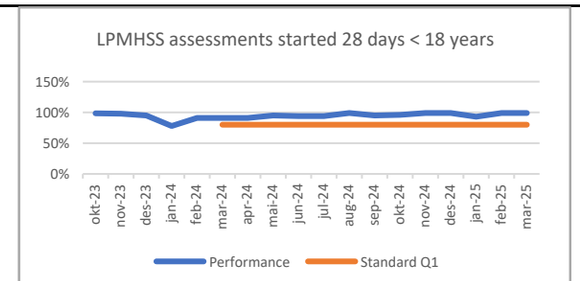
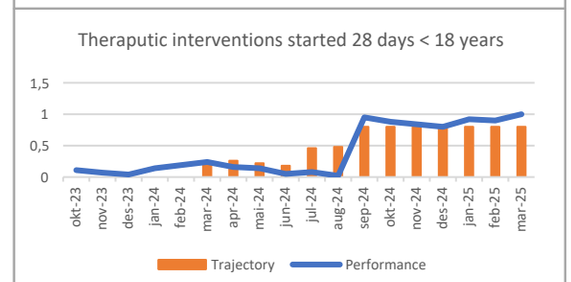
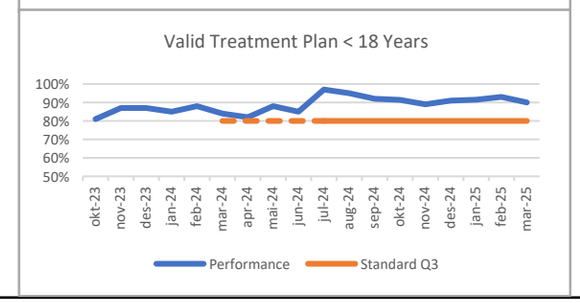
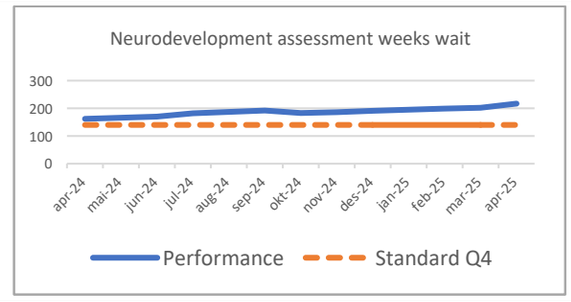
Priority	Performance Summary	Reporting Period	Performance against standard	Data
Primary, Community and Out of Hospital Care	**Urgent Primary Care Centre Utilisation – Maintain 90% utilisation** In March utilisation was 91%, this is above our commitment	Apr-25	88% utilisation Below standard	
	Safe@home referrals – Increase to 6 accepted referrals per day in Q1 to 30 per day in Q4 Q1 - 200 referrals were accepted by S@H – Capacity to accept 6 referrals per day from July 2024. Next update end of Q4 by end of Q1	Q1	200 accepted referrals Q1 Below standard	
	Community visits – 95% of face-to-face visits within 8 hours Q4 to date 96% compliance with 8-hour standard	Apr-25	96% Above standard	
Emergency Department and Same Day Emergency Care	**Ambulance handover delays – eliminate 2-hour delays. Reduce lost minutes per arrival to <20. National Commitment to reduce 1-hour delays by 30% by December** In April we reported 42 2-hour ambulance delays, above our ambition of 0 In April we reported 462 1-hour ambulance delays, above our trajectory to reduce by 30% by Q3. In March lost minutes per arrival increased to 30	Apr-25	42 2-hour delays Above standard 462 1-hour delays Above standard 30 minutes lost/arrival Above standard	 
	ED waits - No patients waiting >24 hours in ED, 93% of patients waiting <12 hours in ED in Q1 (94% Q2, 95% Q3, 95% Q4) In April we reported a decrease in patients waiting 12-hours in EU compared to March. This equates to 92.4% of attendances waiting less than 12-hours and below our ambition for Q4	Apr-25	92.4% patients <12h Below standard	
	SDEC units – Increase attendances compared to the same period 23/24 In April we reported a decrease in activity compared to March, but above our April 2024 activity. A drop in medical SDEC has been noted and the team have identified a potential underreporting of attendances which is being investigated – attendances are forecast to increase	Apr-25	1678 SDEC attends Below standard	
Reducing time in hospital and Continuity of Care	**Length of stay - <20% patients in acute beds to have a LOS >21 days, <40% patients in acute beds to have a LOS >7 days** This data is a monthly snapshot taken at on the final Friday of each month. At the end of April 57.8% of patients in acute beds had a LOS of >7 days, 33.4% >21 days – a small decrease from March's snapshot but above our ambition	Apr-25	57.8% >7d Above standard 33.4% >21d Above standard	
	Pathway of Care Delays – Reduction in number of POCD compared to same period in 23/24 In April 2025 the number of POCDs was 150 – this is below the number of delays reported in March 2025	Apr-25	150 Below standard	

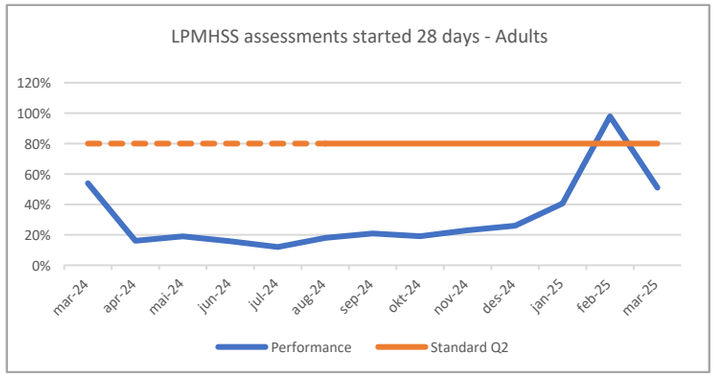
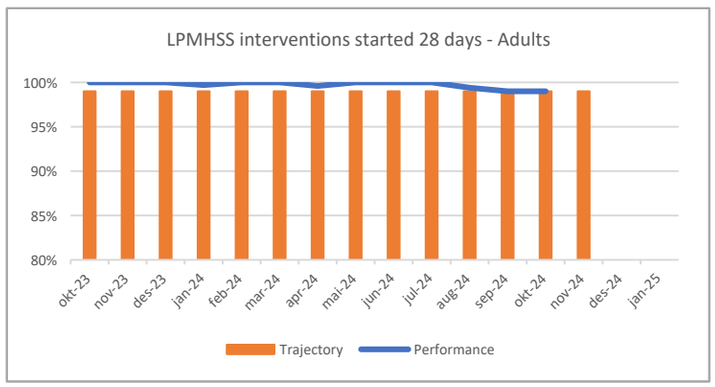
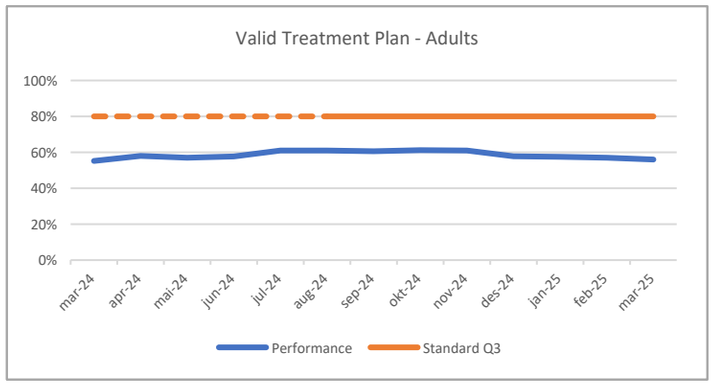
Priority	Performance Summary	Reporting Period	Performance against standard	Data
High Impact Pathways - Stroke	**CT scan – 70% of patients scanned within 1 hour of arrival at EU** In March 56.7% of patients were received their CT scan within 1 hour of arrival at EU, below our ambition. **Thrombolysis – 20% thrombolysis rate** In March 7.5% of stroke patients were thrombolysed, a decrease from previous months but below our ambition. We are clinically reviewing internally and working with colleagues from NHS Executive **Admission – 80 % of patients admitted directly to the stroke unit within 4 hours** In March 57.1% of patients were admitted directly to the Stroke Unit within 4 hours. Door-to-ward pathways continue to be impacted by operational pressures within the Emergency Unit, but February's performance is improved from January Our door-to-ward and CT Stoke performance measures are below our ambitions for performance on the stroke pathway. We have seen considerable improvements compared to last year – a business case for development of the service has been approved and will allow more sustainable improvements to be embedded Overall Stroke performance is assessed through the Sentinel Stroke National Audit Programme (SSNAP) – which uses metrics across the whole patient pathway. In the most recent assessment period UHW received a grade B. The SSNAP criteria have changed for this year and will be reflected in the 25/26 IPR	Mar-25	56.7% CT Below standard 7.5% Thrombolysis Below standard 57.1% Door-to-ward Below standard	  
High Impact pathways – Hip fracture	**Hip Fracture Door to Ward time – 60% of patients admitted to the ward within 4 hours Q1, 65% Q2, 70% Q3, 75% Q4** Door to Ward time is the first KPI used by the National Hip Fracture Database to monitor national performance across the patient pathway. In March our annualised compliance showed 39.5% of patients were admitted to the ward within 4 hours. This is below our ambition but well above the national average of 8.8%.	Mar-25	39.5% (Annualised) Below standard	

Priority	Performance Summary	Reporting Period	Performance against standard	Data
Primary and Community Care	**GMS access – 100% of practices achieving core access standards** In March 100% of practices met the standard – the official data is provided annual but our monthly tracking data will be updated here for information **GDS access – 25% of contract value by end Q1, 50% Q2, 75% Q3, 100% Q4** At the end of March 98.5% of the contract value had been delivered. **Pharmacy access – 95% of practices providing Clinical Community Pharmacy Service (CCPS) in Q1, 10% increase PIP sites each Quarter** In January 100% of practices were providing CCPS services **Optometry – 95% of practices providing WGOS1+2** All practices are currently providing WGOS 1&2	Mar-25 Jan-25	100% At standard 98.5% At standard (Apr-24 - Mar-25) 100% Above standard 100% Above standard	
Cancer	**Single Cancer Pathway – 70% of patients to receive their first definitive treatment within 62 days by Q3, as per nationally submitted trajectory** In March 68.7% of patients received their first definitive treatment within 62 days. This is below our ambition – extended narrative within the accompanying paper.	Mar-25	68.7% At standard, but below SCP standard of 75%	

Priority	Performance Summary	Reporting Period	Performance against standard	Data
Outpatient and Treatment waiting times	**Outpatient waiting times – Reduction in the number of patients waiting 52 weeks for a first outpatient appointment** In March there were 15,185 patients waiting 52 weeks for their first outpatient appointment. This is above the Welsh Government ambition. Improvement actions for planned care are outlined in the cover paper **Treatment waiting times – Reduction in the number of patients waiting 104 weeks for treatment** In March there were 1,632 patients waiting 104 weeks for treatment. This is below our revised commitment to Welsh Government. We are currently reviewing our trajectories for reducing the number of long waiting patients aligned to our ongoing demand and capacity work and additional funding released by Welsh Government to further reduce the number of patients waiting over 104 weeks	Mar-25	15,185 patients Above standard 1,632 patients Below standard	 
Diagnostics and Therapies Saunders,Nathan 14/07/2025 14:46:53	**Diagnostics – Reduction in the number of patients waiting over 8 weeks for a specified diagnostic** In April 14,750 patients were waiting over 8 weeks for a specified diagnostic, A increase from March but above our trajectory, A diagnostic update was brought to the most recent Board development session and the key specialties and actions are outlined in the cover paper **Therapies – No patients waiting over 14 weeks for Therapy – Q3** In April 475 patients were waiting over 14 weeks for therapies, a increase from March and above our commitment for Q3. Breaches are concentrated in OT, Dietetics and Physiotherapy and team are working to bring the specific services back into balance. Physiotherapy has seen a significant reduction in waits over the past two months	Apr-25	14,750 patients Diagnostics Above standard 475 patients Therapies Above standard (Q3)	 

Priority	Performance Summary	Reporting Period	Performance against standard	Data
Waiting times	**Cardiothoracic Surgery – Reduce wait for outpatients to <16 weeks Q2, reduce wait to treatment to <52 weeks Q2** In March there were 57 patients waiting over 16 weeks for a new outpatient appointment and 19 patients waiting over 52 weeks for surgery. **Neurosurgery – Reduce wait for treatment to <40 weeks Q3, reduce wait for outpatients to <18 weeks Q4** In March there were 23 patients waiting over 11 weeks for a new outpatient appointment and 8 patients waiting over 40 weeks for surgery. Both improved from February	Mar-25	57 Outpatients Above standard 19 patients Treatment Above standard 8 patients Treatment Above standard	 
Intensive Care Unit	**Delayed Transfers of Care – Reduce the % DTOC bed occupancy against the same period in 23/24** October saw a decrease in ITU DTOCs compared to September and our performance remained above our ambition to reduce from 23/24 levels due to increased operational pressures through the month. Data for Q4 is currently unavailable, the service are working to provide this dataset	Oct-24	12.0% Above standard	

Priority	Performance Summary	Reporting Period	Performance against standard	Data
Paediatric waiting times	**New Outpatient waits – 0 patients waiting over 52 weeks for outpatients in Q1** In March there were 0 patients waiting over 52 weeks for a new outpatient appointment **Therapy waits – 0 patients waiting over 14 weeks for Therapies in Q3** In March there were 314 paediatric patients waiting over 14 weeks for Therapies (85 in Dietetics and 120 in Occupational Therapy)	Mar-25	0 Meeting standard 314 Above standard	
Emotional Health and Wellbeing	**Percentage of Local Primary Mental Health Support Service (LPMHSS) assessments undertaken within (up to and including) 28 days from the date of receipt of referral for under 18s – 80% compliance with the Standard of <28 days in Q1** In March 99% of assessments were completed within 28 days **Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by Local Primary Mental Health Support Service (LPMHSS) for under 18s – 80% compliance with standard in Q3** In March 100% of interventions were started within 28 days, this is above the standard for Q3 and in line with the forecasts for the early part of this year **Percentage of patients with a valid Care and Treatment plan – 80% compliance with standard in Q3** In March 90% of patients had a valid Care and Treatment Plan, above our ambition	Mar-25	99% Part 1a Above standard 100% Part 1b Above standard 90% Part 2 Above standard	  
Neurodevelopment	**Neurodevelopment assessment - Reduce the longest wait to 140 weeks in Q4** In February the longest wait for a neurodevelopment assessment was 199 weeks, this is above our ambition for delivery in Q4	Apr-25	217 Above standard (Q4)	

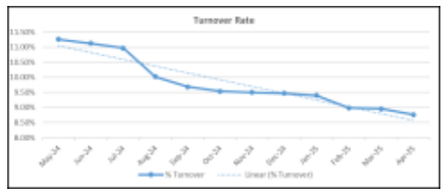
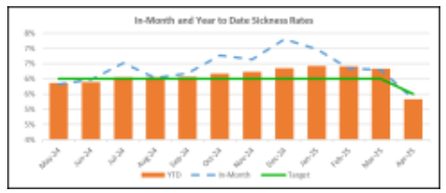
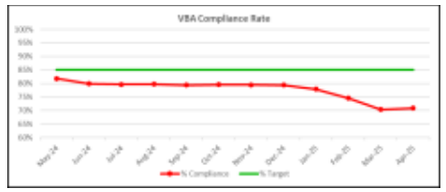
Priority	Performance Summary	Reporting Period	Performance against standard	Data
Mental Health Measures – Part 1a	**Percentage of Local Primary Mental Health Support Service (LPMHSS) assessments undertaken within (up to and including) 28 days from the date of receipt of referral for adults aged 18 years and over – 80% compliance with the Standard of <28 days in Q2** In March 51% of patients received their assessment within 28 days – this is above the standard we are looking to achieve by the end of Q2. Referrals to the service remain high.	Mar-25	51% Part 1a Below standard (Q2)	
Mental Health Measures – Part 1b	**Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by Local Primary Mental Health Support Service (LPMHSS) for adults – 80% compliance with standard in Q1** In March 99% of therapeutic interventions were started within 28 days of assessment, above the standard and in line with our trajectory submitted to Welsh Government.	Mar-25	99% Part 1b Above standard	
Mental Health Measures – Part 2	**Percentage of patients with a valid Care and Treatment plan – 80% compliance with standard in Q3** In March 56% of patients had a valid Care and Treatment plan, a small decrease from April following focused work from the teams. Performance remains below the standard for Q3 – the RAMP protocol and Part 1 schemes have been approved though the Mental Health Liaison Committee to support longer term improvements in compliance	Mar-25	56% Part 2 Below standard (Q3)	

No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend
11.	Percentage of GP practices that have achieved all standards set out in the National Access Standards for In-hours	2023/24	100%	**100%** Above standard	19/20: 93.4%; 20/21: 95.0%; 21/22: 96.5%; 22/23: 98.2%
12.	Percentage of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes	Mar-25	Improvement compared to the same month in the previous year	**46.3%** Above standard	Dec-24: 45.40%; Jan-25: 45.30%; Feb-25: 45.50%; Mar-25: 46.30%
13.	Percentage of the primary care dental services (GDS) contract value delivered (for courses of treatment for new, new urgent and historic patients)	Apr-24/Mar-25	A month on month increase towards a minimum of 30% contract value delivered by 30 September 2024 and 100% by 31 March 2025	**98.5%** Above standard	Dec-24: 77.60%; Jan-25: 84.50%; Feb-25: 90.20%; Mar-25: 98.50%
14.	Number of consultations delivered through the Pharmacist Independent Prescribing Service (PIPS)	Mar-25	Increase compared to the same month in the previous year	**2,465** Above standard	Dec-24: 2390; Jan-25: 2329; Feb-25: 2440; Mar-25: 2465
15.	Percentage of Local Primary Mental Health Support Service (LMPHSS) assessments undertaken within (up to and including) 28 days from the date of receipt of referral for people aged under 18 years	Mar-25	80%	**99%** Above standard	Dec-24: 99%; Jan-25: 93%; Feb-25: 99%; Mar-25: 99%
16.	Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by Local Primary Mental Health Support Service (LPMHSS) for people aged under 18 years	Mar-25	80%	**100%** Above standard	Dec-24: 80%; Jan-25: 92%; Feb-25: 90%; Mar-25: 100%
17.	Percentage of Local Primary Mental Health Support Service (LPMHSS) assessments undertaken within (up to and including) 28 days from the date of receipt of referral for adults aged 18 years and over	Mar-25	80%	**51.3%** Below standard	Dec-24: 26.0%; Jan-25: 40.6%; Feb-25: 97.9%; Mar-25: 51.3%
18.	Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by Local Primary Mental Health Support Service (LPMHSS) for adults aged 18 years and over	Mar-25	80%	**99.4%** Above standard	Dec-24: 100.0%; Jan-25: 99.4%; Feb-25: 100.0%; Mar-25: 99.4%
19	Percentage of emergency responses to red calls arriving within (up to and including) 8 minutes	Apr-25	65%	**51%** Below standard	Jan-25: 49%; Feb-25: 62%; Mar-25: 50%; Apr-25: 51%
20.	Median emergency response time to amber calls	Apr-25	12 month reduction trend	**01:58:55** Above standard	Jan-25: 02:04:11; Feb-25: 01:50:49; Mar-25: 01:46:41; Apr-25: 01:58:55

No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend
21.	Median time from arrival at an emergency department to triage by a clinician	Mar-25	15 minutes or less	**8** Below standard	Dec-24: 10 | Jan-25: 8 | Feb-25: 10 | Mar-25: 8
22.	Median time from arrival at an emergency department to assessment by a clinical decision maker	Mar-25	60 minutes or less	**64** Above standard	Dec-24: 78 | Jan-25: 62 | Feb-25: 68 | Mar-25: 64
23.	Percentage of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge	Apr-25	Improvement compared to the same month in the previous year, towards the national target of 95%	**62.7%** Below standard	Jan-25: 63.2% | Feb-25: 62.5% | Mar-25: 66.2% | Apr-25: 62.7%
24.	Number of patients who spend 12 hours or more in all hospital major and minor emergency care facilities from arrival until admission, transfer, or discharge	Apr-25	Reduction compared to the same month in the previous year, towards the national target of zero	**887** Above standard	Jan-25: 1054 | Feb-25: 801 | Mar-25: 901 | Apr-25: 887
25.	Percentage of patients starting their first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route)	Mar-25	12 month improvement trend towards a national target of 80% by 31 March 2026	**68.7%** Below standard	Dec-24: 66.7% | Jan-25: 66.4% | Feb-25: 64.2% | Mar-25: 68.7%
26.	Number of patients waiting more than 8 weeks for a specified diagnostic	Apr-25	0	**14,750** Above standard	Jan-25: 16088 | Feb-25: 14086 | Mar-25: 13825 | Apr-25: 14750
27.	Percentage of children (aged under 18 years) waiting 14 weeks or less for a specified Allied Health Professional therapy	Mar-25	100%	**72%** Below standard	Dec-24: 86.24% | Jan-25: 82.00% | Feb-25: 76.66% | Mar-25: 71.58%
28.	Number of patients (all ages) waiting more than 14 weeks for a specified therapy	Apr-25	0	**475** Above standard	Jan-25: 273 | Feb-25: 322 | Mar-25: 384 | Apr-25: 475
29.	Number of patients (all ages) waiting more than 14 weeks for audiology	Mar-25	0	**308** Above standard	Dec-24: 117 | Jan-25: 195 | Feb-25: 248 | Mar-25: 308

No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend
30.	Number of patients waiting more than 52 weeks for a new outpatient appointment	Mar-25	0	**15,185** Above standard	Dec-24: 16227; Jan-25: 16439; Feb-25: 15725; Mar-25: 15185
31.	Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%	Feb-25	Reduction compared to the same month in the previous year	**19,694** Below standard	Nov-24: 18940; Dec-24: 20232; Jan-25: 20017; Feb-25: 19694
32.	Number of patients waiting more than 104 weeks for referral to treatment	Mar-25	0	**1,632** Below standard	Dec-24: 3754; Jan-25: 3581; Feb-25: 2414; Mar-25: 1632
33.	Number of patients waiting more than 52 weeks for referral to treatment	Mar-25	Month on month reduction towards the national target of zero by 30 June 2025	**32,763** Above standard	Dec-24: 35712; Jan-25: 35008; Feb-25: 33246; Mar-25: 32763
34.	Percentage of children and young people waiting less than 26 weeks to start an ADHD or ASD neurodevelopment assessment	Mar-25	80%	**10%** Below standard	Dec-24: 10%; Jan-25: 9%; Feb-25: 10%; Mar-25: 10%
35.	Percentage of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health	Mar-25	80%	**75%** Below standard	Dec-24: 69%; Jan-25: 71%; Feb-25: 73%; Mar-25: 75%

Measure		Internal standard	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Trend
Outpatients	% DNAs - New appointments	5%	10.9%	9.5%	9.1%	9.7%	9.7%	10.0%	9.9%	9.9%	10.1%	10.3%	9.6%	9.7%	10.5%	
	% DNAs - Follow-up appointments	5%	13.0%	11.6%	11.8%	11.9%	11.4%	11.8%	11.9%	11.6%	11.8%	12.0%	12.1%	12.3%	12.5%	
Endoscopy	% room utilisation	90%	91%	78%	79%	89%	81%	74%	74%	68%	78%	75%	83%	82%	88%	
	% utilisation (activity points available)	95%				84%	81%	80%	83%	85%	87%	85%	84%	81%	84%	
Theatres	Average turnaround time (minutes)	10	16.7	17.1	18.6	16.3	17.0	16.0	18.9	19.9	15.9	16.2	15.9	16.0	16.9	
	% of theatre session utilisation	95%	73%	84%	84%	81%	80%	75%	79%	83%	84%	75%	88%	85%	87%	
	% in session utilisation	85%	78%	79%	78%	78%	77%	77%	80%	80%	82%	78%	79%	79%	77%	
	<24 hour elective cancellations	N/A	212	243	289	247	309	249	190	363	198	217	315	295	347	
	% theatre activity as Daycase	TBC - will be added following confirmation of GIRFT dataset														
	'High Volume Low Complexity' volume	TBC - will be added following confirmation of GIRFT dataset														
Waiting list	Total RTT waiting list volume	N/A	147,620	149,805	150,199	151,888	153,560	153,673	155,063	156,194	154,994	154,605	153,519	151,069	151,226	
Inpatient	Delayed pathways of Care - Mental Health	217	41	38	39	34	29	36	26	26	32	29	30	30	27	
	Delayed Pathways of Care - non-Mental Health		170	145	140	160	142	138	144	135	130	115	146	133	136	
	7 day LOS on Acute Wards (snapshot)	<40%	57.7%	56.8%	55.2%	55.2%	55.5%	58.0%	58.5%	59.4%	57.3%	62.3%	60.5%	59.4%	56.2%	
	21 day LOS on Acute Wards (snapshot)	<20%	32.9%	32.0%	29.3%	29.4%	30.9%	32.6%	31.8%	31.4%	30.9%	35.5%	37.3%	34.0%	34.0%	
Urgent and Emergency	Reportable attendances	N/A	11,489	11,484	12,102	11,930	11,773	10,926	11,567	12,628	11,922	11,468	10,756	10,237	12,193	
	UHW Majors attendances	N/A	6,041	5,958	6,247	5,933	5,962	5,792	5,968	6,352	6,219	6,011	5,710	5,453	5,998	
	Reportable EU admissions	N/A	1,880	1,922	1,833	1,847	1,865	1,778	1,768	1,823	1,831	1,829	1,676	1,502	1,658	
	SDEC attendances	N/A	1,715	1,625	1,700	1,638	1,699	1,736	1,730	1,847	1,716	1,601	1,786	1,609	1,770	

Priority	Performance Summary	Reported Period	Data
Turnover	The overall trend is downwards since May-24; the rates have fallen from 11.26% at May-24 to 8.76% in Apr-25 UHB wide. This is a net 2.50% decrease, which represents 368 WTE fewer leavers. The top 5 reasons recorded for leaving are; 'Voluntary Resignation - Other/Not Known', 'Retirement Age', 'Voluntary Resignation – Relocation', 'Voluntary Resignation – Promotion' and 'Voluntary Resignation - Work Life Balance'.	April 2025	
Sickness Absence	The monthly sickness rate for Apr-25 was 5.34%. The 12-month cumulative rate has settled over the past year, and is 6.36% at Apr-25 (an increase of 0.13% by comparison with the rate at Apr-24).	April 2025	
Statutory and Mandatory Training	The overall compliance rates rose marginally for Apr-25 to 82.19%, 2.81% below the overall target. The compliance for Capital, Estates & Facilities, All-Wales Genomics Services, Clinical Diagnostics & Therapeutics and Corporate Executives are above the 85% target; and Children & Women's, PCIC and Specialist Services are above 80% compliance. The compliance with Fire training has risen, to 71.61% for Apr-25 . The compliance for all of the Clinical Boards is below the 85% compliance target.	April 2025	 
Values Based Appraisal	VBA compliance has risen slightly for Apr-25 to 70.87%. None of the Clinical Boards have reached the 85% target rate%.	April 2025	
Employee Relations	As can be seen in the graph the number of employee relations cases the People Services team are supporting has risen in the past 12 months and the number of disciplinary cases remains above the UHB Target. The People Services Team continue to analyse trends of employee relations cases to develop bespoke training packages or additional toolkits/support services where appropriate.	April 2025	

Section 2: Performance Report	Quadruple Aim 3: People and Culture	
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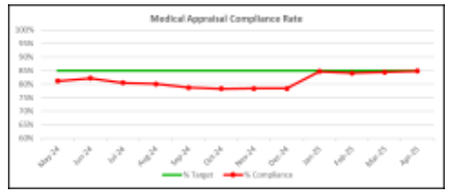
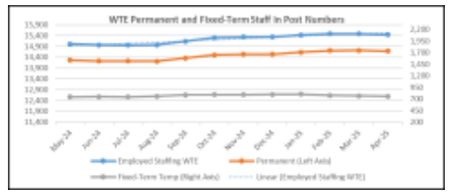
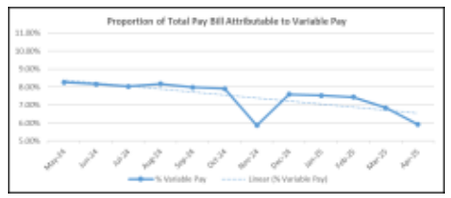
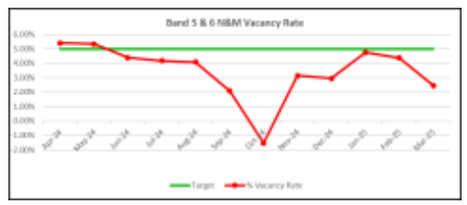
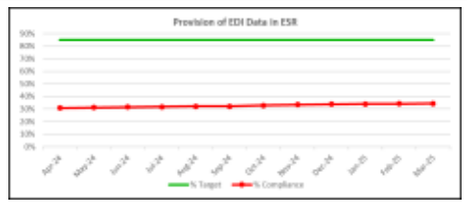
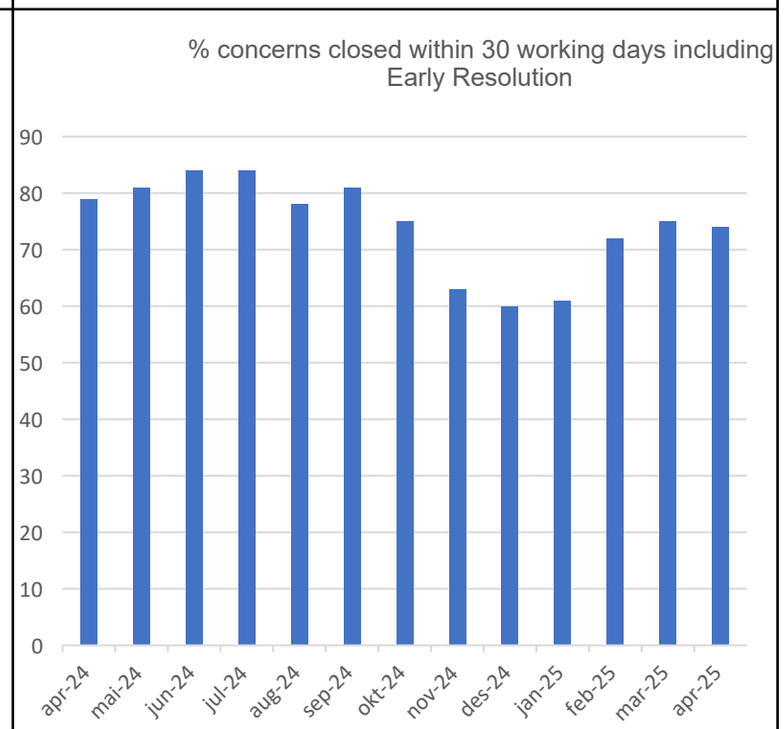
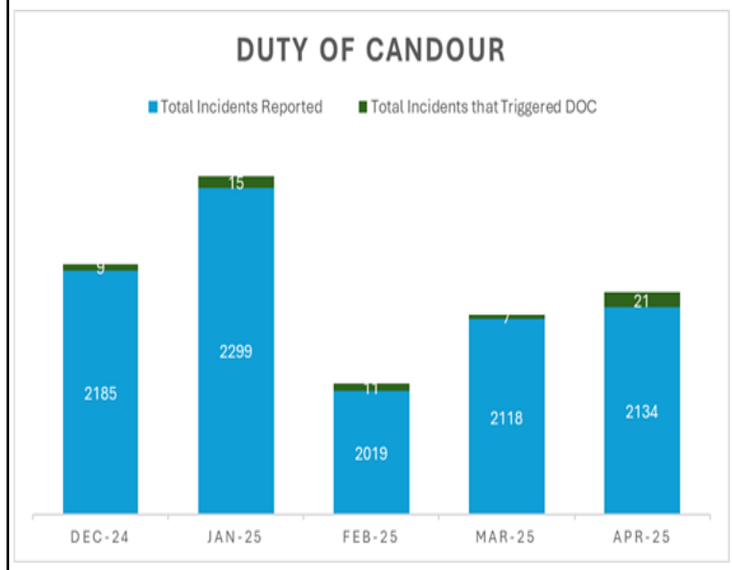
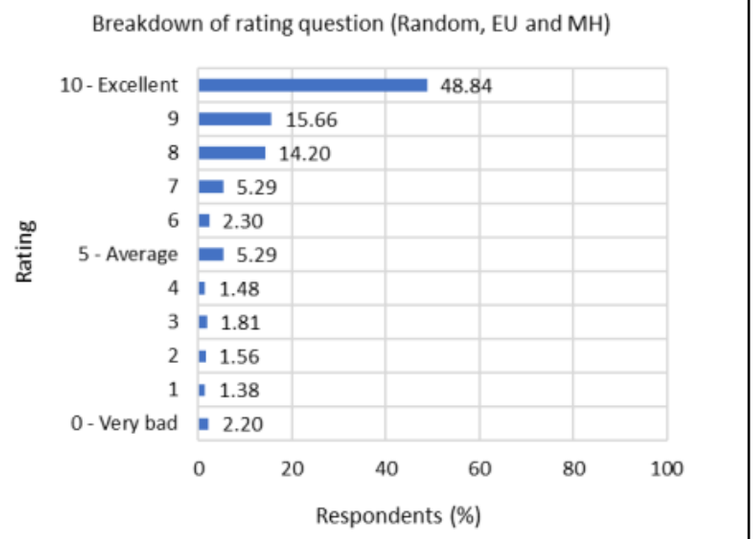
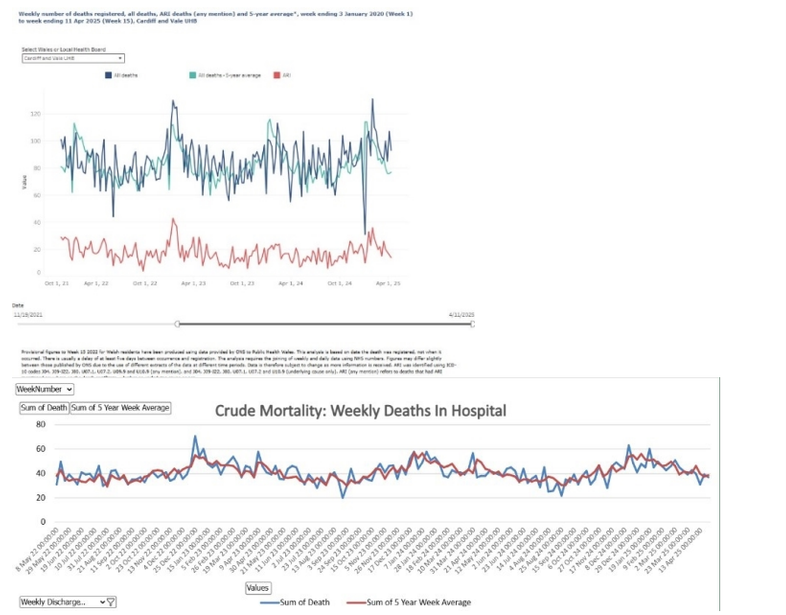
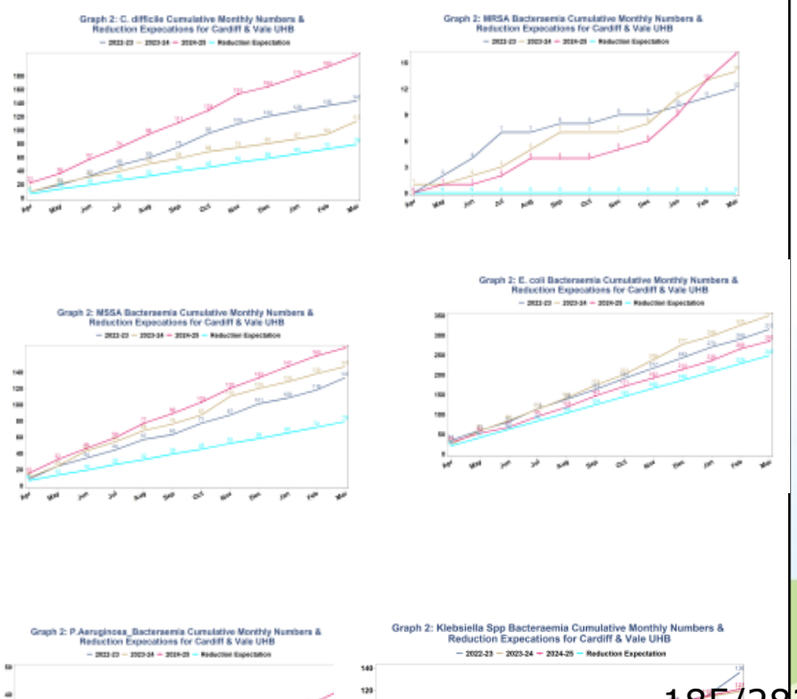
Priority	Performance Summary	Reported Period	Data
Job Plans	The vast majority of clinicians have now engaged with job planning and have a job plan in the system. 44.33% have an agreed job plan that has been signed off within the past 12 months, and a further 21.55% have an agreed job plan that was last reviewed and signed off before May-24.	April 2025	
Medical Appraisals	The rate of compliance with Medical Appraisal rose slightly to 84.81% for Apr-25, slightly below the 85% target.	April 2025	
Staff in Post	The overall Health Board Staffing Numbers have increased in the last 12 months by 434WTE, to 15,446.94 WTE at Apr-25. This is the 2nd month where the WTE staffing has fallen since Feb-25, which was the highest number in the past 12 months. As can be seen both the WTE staff on both permanent and temporary contracts has fallen.	April 2025	
Variable Pay (Bank, Agency, Overtime..)	The trend of proportion of the pay bill spend on variable pay (Bank, Agency, overtime etc.) continues to fall. At May-24 the percentage was 8.26% of the total spend on pay, but in Apr-25 had fallen to 5.92%. It must however be borne in mind that the total pay bill is increasing. There was no notable reduction in the quantity of variable pay in Nov-24, the dip on the chart is as a consequence of the total pay bill including payment of pay award and arrears.	April 2025	
Staff Winter Vaccination Programme	By the end of Mar-25 35.28% of staff have received the flu vaccine, and 28.29% of staff have received the COVID-19 vaccine. The winter vaccination programme for 2025-26 will commenced in the autumn.	April 2025	
Agency Spend as % of Total Pay Bill	The proportion of the total pay bill attributed to Agency has risen for Apr-25 by comparison with Mar-25, but the overall trend remains downwards. At May-24 the percentage was 0.93% of the total spend on pay, and has fallen to 0.39% at Apr-25. It must however be borne in mind that the total pay bill is increasing.	April 2025	

Priority	Performance Summary	Reported Period	Data
Time to Hire	The All-Wales target for recruitment Time to Hire (the time interval between vacancy creation and successful candidate ready for start date) is 71 days, and the NHS Wales average is 61.5 days. The figure for Cardiff & Vale uHB for Apr-25 was 87.6 days.	April 25	
Time to Shortlist	The All-Wales target for recruitment Time to Shortlist (the time interval between vacancy closure and shortlisting completion) is 3 days, and the NHS Wales average is 9.1 days. The figure for Cardiff & Vale uHB for Mar-25 was 5.1 days.	April 2025	
Exit Questionnaire Completion	The People Resourcing Team commenced a new process in Sep-23 whereby staff leavers received an direct email inviting them to complete an exit questionnaire, in the hope of seeing an improvement in the return rate, to a target of 30%. At Nov-24 the return rate was 25%.	November 2024	
Nursing & Midwifery Band 5 & 6 Vacancy Rates	The vacancy rate is the difference between the funded establishment WTE and the sum of the staff in post WTE represented as a percentage of the funded establishment WTE. At Mar-25 the rate was 2.47%, by comparison with a nominal 5% target. The swing between Oct-24 and Nov-24 was significantly impacted by validation of ESR position data.	March 2025	
Provision of EDI Data in ESR	This measure shows the percentage of staff who have recorded all of their Marital Status, Nationality, Ethnicity, Disability, Sexual Orientation, Religion and Country of Birth in ESR. At Mar-25 34.46% have recorded all of their EDI data. Country of Birth has the poorest compliance rate.	March 2025	
Percentage of Staff with Welsh Skills Levels 2 – 5 Recorded in ESR	This measure shows the percentage of staff who have recorded their Welsh Skills in ESR at level 2 (Foundation) through to level 5 (Proficient). 47% of staff have not recorded their Welsh Skills in ESR, and a range of activities are being undertaken to improve this. At Mar-25 6.56% of staff have identified their Welsh Skills as between level 2 and level 5.	March 2025	

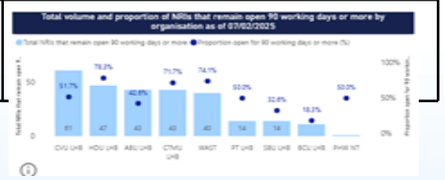
No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend
36.	Percentage of sickness absence rate of staff	Mar-25	12 month reduction trend (6%)	**5.49%** Below standard	Dec-24: 7.29%; Jan-25: 6.97%; Feb-25: 6.31%; Mar-25: 5.49%
37.	Turnover rate for nurse and midwifery registered staff leaving NHS Wales	Mar-25	Rolling 12 month reduction against a baseline of 2019-20 (7-9%)	**8.98%** Above standard	Dec-24: 9.47%; Jan-25: 9.40%; Feb-25: 8.98%; Mar-25: 8.96%
38.	Agency spend as a percentage of the total pay bill	Mar-25	12 month reduction trend	**0.17%** Below standard	Dec-24: 0.41%; Jan-25: 0.63%; Feb-25: 0.63%; Mar-25: 0.17%
39.	Percentage headcount by organisation who have had a Personal Appraisal and Development Review (PADR)/medical appraisal in the previous 12 months (excluding doctors and dentists in training)	Mar-25	85%	**71.19%** Below standard	Dec-24: 79.30%; Jan-25: 78.28%; Feb-25: 75.12%; Mar-25: 71.19%

Priority	Performance Summary	Reporting Period	Performance against standard	Data
Concerns 30 day performance	**Welsh Government target for responding to concerns is 75% within 30 working days** **During March and April 25, the Health Board:** •Received 418 Concerns •Closed 388 concerns •74% closed within 30 working days (including Early Resolution) • 18% closed under Early Resolution (within 2 days including day of receipt) •Received 572 Enquiries •Received 119 Compliments •We currently have 302 active concerns **Top 3 themes and trends** •Clinical Treatment and Assessment •Concerns around appointments (waiting times/cancellations) •Communication	March and April 25	60 %	
Duty of Candour	**Key Updates:** •During December 24 to April 2025 10,755 incidents have been reported across the Health Board. •We continue to support DOC awareness sessions across Primary and Secondary care. •Since Dec 1st, 2024, we have triggered the DOC on 53 occasions. •We have conducted internal audits of the process and compliance. **Themes and Trends for Triggered Duty of Candour:** · Avoidable pressure damage. · Avoidable falls. · Patients lost to follow-up. · Failure to prescribe or administer appropriate medication. · Administration of incorrect medication. · Missed opportunities to diagnose	*Dec 2024 to April 25*	n/a	

Priority	Performance Summary	Reporting Period	Performance against standard	Data
Patient Feedback – Civica	The system went live on Friday 28th October 2022 and we are currently surveying up to 1000 patients daily via text, 600 chosen randomly from general hospital activity, 200 from EU activity and 200 from Mental Health activity. **Over the past 12 months, we have sent over 181,000 texts** and are seeing a response of 16%. In April, we sent 14,326 texts and had 2,081 completions (15% response). Of those respondents who were discharged during March/April and answered the rating question: Using the scale of 0-10 where 0 is bad and 10 is excellent, 84% were satisfied with our service. Currently, our response rate overall is 16% and whilst it's our understanding that this is higher than many organisations, we will be focussing on improving this over the next year	Mar/Apr 2025		
Ppatient Safety	There were 1747 patient safety incidents reported in April 2025, the majority reporting none and low harm. The top reported incidents continue to be falls and pressure damage. Pressure damage is the top reported NRI to NHS Executive, pressure damage scrutiny panels are now in most Clinical Boards to review the findings of pressure damage reviews and the associated improvement actions to ensure improved learning and better outcomes. The UHB Never Event position is challenging with an increasing cumulative rolling number over a rolling 12-month period. A WHO checklist collaborative has commenced in the peri operative directorate to review checking processes. In addition, further work has commenced to review education around NG tubes insertion and management and Delivery of fascia iliac block.	March 2025		

Priority	Performance Summary	Reporting Period	Performance against standard	Data
Tier 1 Mortality	The development of the Inpatient mortality dashboard now supports monitoring of a range of mortality indicators and allows oversight of the impact of a number of variables including length of stay, number of ward movers and number of The number of inpatient deaths per 1000 bed days was 4.1 in April 2025 with rates varying between 3.0 (Aug 2024) and 5.4 (Jan 25) in the past 12 months. This rate is in line with the normal reduction in mortality following a winter peak seen in previous non-covid years. Emergency Unit mortality was 14.21 per 10 000 attendance in April 2024 All deaths that occur in hospital or within Cardiff and Vale of Glamorgan that are not referred to HM Coroner are subject to independent scrutiny by the Medical Examiner. 19.9% of Cardiff and Vale cases reviewed by the Medical Examiner were returned to the UHB for further consideration. Comparable with return rates across Wales which vary from 17.8-25.5%. The referral rate was stable at 19.9% for both Q3 and Q4 2024/25. The most common reason for the ME to return cases was due to the UHB approach to delivering patient centred care with much of the feedback coming from bereaved families.	April 2025		
Infection Control	*Clostroides difficile* - The reduction expectation for this period is 79 cases, thus the number of cases is 131 over the reduction expectation. CAV UHB have the 2nd lowest rate of the 6 acute Health Boards in Wales, though we have had almost double the number of cases we had last year. Work is continuing to identify why an increase has been seen MRSA - The reduction expectation for this period is 0 cases, thus the number of cases is 16 over the reduction expectation. Of the 6 Acute Health Boards, CAVUHB has the 5th highest rate per 100,000 population. The number of cases is equal to the same period 2023/34 MSSA - The reduction expectation for this period is 79 cases, thus the number of cases is 91 over the reduction expectation resulting in the highest rate per 100,000 population across all acute Welsh Health Boards E.coli - The reduction expectation for this period is 249 cases, thus the number of cases is 36 over the reduction expectation however, the total for the 2024/25 financial year (Apr 24 - Mar 25) to 285 cases, which is 19% less than the equivalent period in 2023/24 and the lowest rate per 100,000 population *Klebsiella spec's* - In Mar 2025, there were 19 cases of E. coli Bacteraemia in Cardiff & Vale UHB. This brings the total for the 2024/25 financial year (Apr 24 - Mar 25) to 285 cases, which is 19% less than the equivalent period in 2023/24, the total for the 2024/25 financial year (Apr 24 - Mar 25) to 121 cases, which is 2% more than the equivalent period in 2023/24	April 25		

No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend
40.	Percentage of episodes clinically coded within one reporting month post episode discharge end date	Feb-25	12 month improvement trend	**42.3%** Below standard	Nov-24: 62.40%; Dec-24: 64.00%; Jan-25: 56.00%; Feb-25: 42.30%
41.	Percentage of all classifications' coding errors corrected by the next monthly reporting submission following identification	Mar-25	90%	**34.7%** Below standard	Dec-24: 17.30%; Jan-25: 16.00%; Feb-25: 40.20%; Mar-25: 34.70%
42.	Percentage of calls ended following WAST telephone assessment (Hear and Treat)	Apr-24	17% or more	**16.1%** Below standard	Jan-24: 17.00%; Feb-24: 15.30%; Mar-24: 15.00%; Apr-24: 16.10%
43.	Number of Pathways of Care delayed discharges	Apr-25	12 month reduction trend	**150** Above standard	Jan-25: 176; Feb-25: 163; Mar-25: 163; Apr-25: 150
44.	Percentage of health board residents in receipt of secondary mental health services who have a valid care and treatment plan for people aged under 18 years	Mar-25	90%	**90.2%** Above standard	Dec-24: 91.1%; Jan-25: 91.5%; Feb-25: 92.9%; Mar-25: 90.2%
45.	Percentage of health board residents in receipt of secondary mental health services who have a valid care and treatment plan for adults 18 years and over	Mar-25	90%	**55.7%** Below standard	Dec-24: 57.8%; Jan-25: 57.5%; Feb-25: 56.7%; Mar-25: 55.7%
46.	Number of service user feedback experience responses completed and recorded on CIVICA,figures lower for this period due to system failure.	Jan/Feb 25	(Some system issues)	↑ **5731**	In January and February we sent 31,162 texts

No.Reducing trend	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend
47.	Cumulative number of laboratory confirmed bacteraemia cases: *Klebsiella* sp and; *Pseudomonas aeruginosa*	Apr-25	*Klebsiella sp* - 100 *P. aeruginosa* – 31	**120** **41** Above standard	Not on trajectory to achieve the reduction expectation number On trajectory to achieve the reduction expectation number
48.	Cumulative rate of laboratory confirmed bacteraemia cases per 100,000 population: *E.coli* and; *S.aureus* (MRSA and MSSA)	Apr-25	*E. coli* – 67 cases per 100,000 population *S. aureus* – 20 cases per 100,000 population	**56.57 cases per 100,000 population** **36.20 cases per 100,000 population** Above standard	On trajectory to achieve the reduction expectation rate Not on trajectory to achieve the reduction expectation rate
49.	Cumulative rate of laboratory confirmed *C.difficile* cases per 100,000 population	Apr-25	25 cases per 100,000 population	**41.54 cases per 100,000 population** Above standard	Not on trajectory to achieve the reduction expectation rate
50.	Percentage of confirmed COVID-19 cases within hospital which had a definite hospital onset (>14 days after admission)	Apr-25	Reduction compared to the same month in the previous year	**52.17%** On standard	Nov-24: 30.30% | Dec-24: 38.30% | Jan-25: 45.10% | Jan-25: 52.17%
51.	Percentage of ophthalmology R1 appointments attended which were within their clinical target date or within 25% beyond their clinical target date	Apr-25	12 month improvement trend towards national target of 95%	**61.76%** Below standard	Jan-25: 64.30% | Feb-25: 64.78% | Mar-25: 61.86% | Apr-25: 61.76%
52	Number of ambulance patient handovers over one hour	Apr-25	0	**462** Over standard	Jan-25: 466 | Feb-25: 385 | Mar-25: 381 | Apr-25: 462
53.	Percentage of ambulance patient handovers within 15 minutes	Apr-25	Improvement compared to the same month in the previous year, towards the national target of 100% within 15 minutes	**11.24%** Below standard	Jan-25: 10.62% | Feb-25: 10.46% | Mar-25: 11.38% | Apr-25: 11.24%
54.	Number of National Reportable incidents that remain open 90 days or more	Apr-25	12 month reduction trend	**82**	

Shaping Our Future
Digital
Services

Digital & Health Intelligence

Microsoft | Power BI

Ivanti Management Report & WiFi Improvement Project

Last data refresh:
07/05/2025 11:11:15 UTC

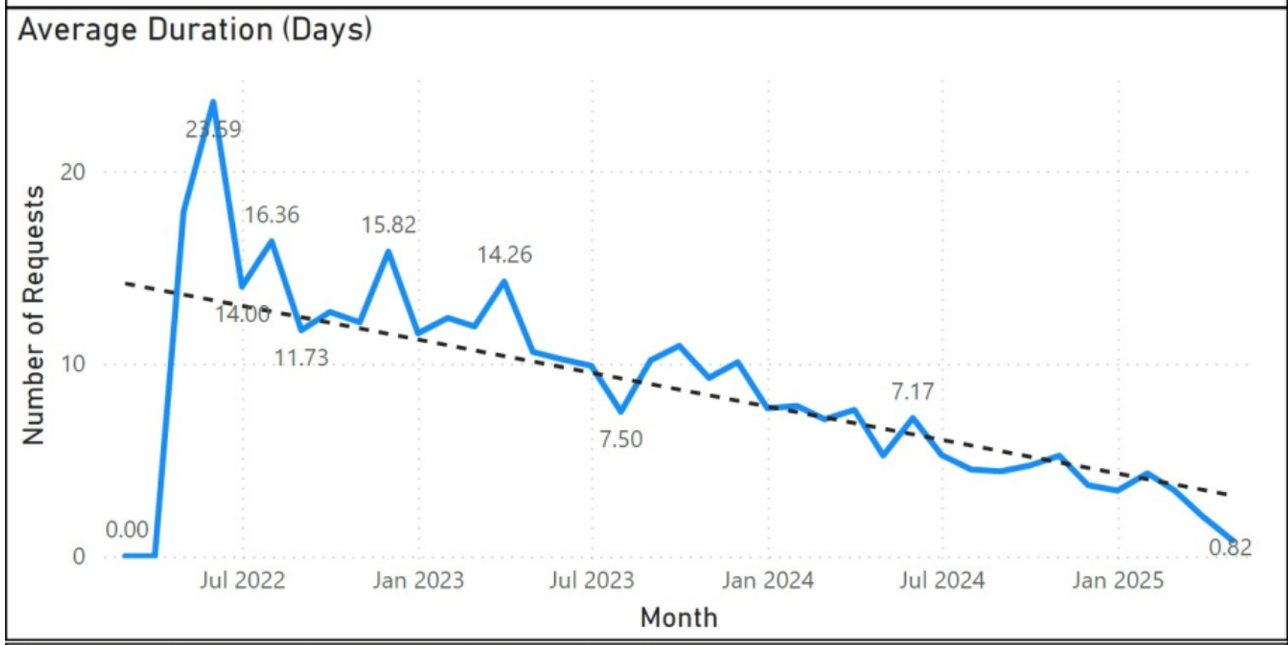
Downloaded at:
07/05/2025 11:43:05 UTC

Executive Scorecard

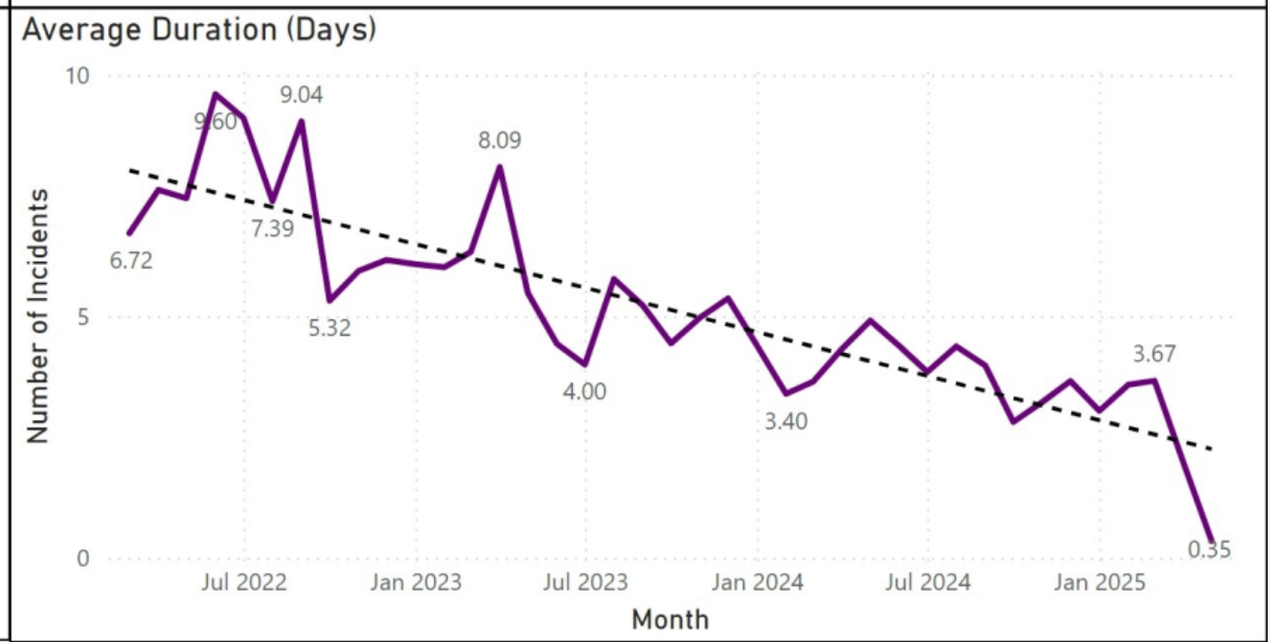
Year 2024		Current Year		Current Month	
Incidents	**Requests**	**Incidents**	**Requests**	**Incidents**	**Requests**
39321 Incidents Opened	50046 Requests Opened	14403 Incidents Opened	19707 Requests Opened	455 Incidents Opened	684 Requests Opened
38839 Incidents Closed	45423 Closed Requests	13540 Incidents Closed	16290 Closed Requests	315 Incidents Closed	150 Closed Requests
482 Remaining Open	4623 Remaining Open	863 Remaining Open	3417 Remaining Open	140 Remaining Open	534 Remaining Open
3.91 Avg Duration (Days)	5.67 Avg Duration (Days)	3.03 Avg Duration (Days)	3.25 Avg Duration (Days)	0.35 Avg Duration (Days)	0.82 Avg Duration (Days)

Executive Trending

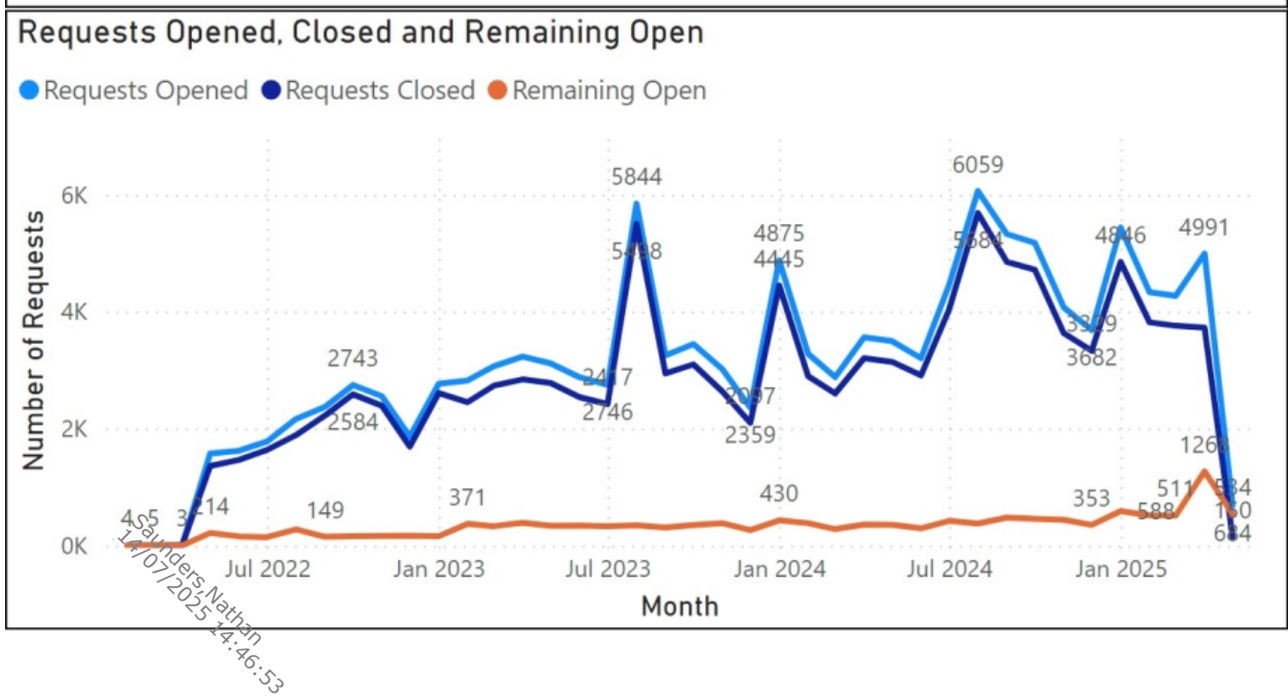
Requests (new and additional items)



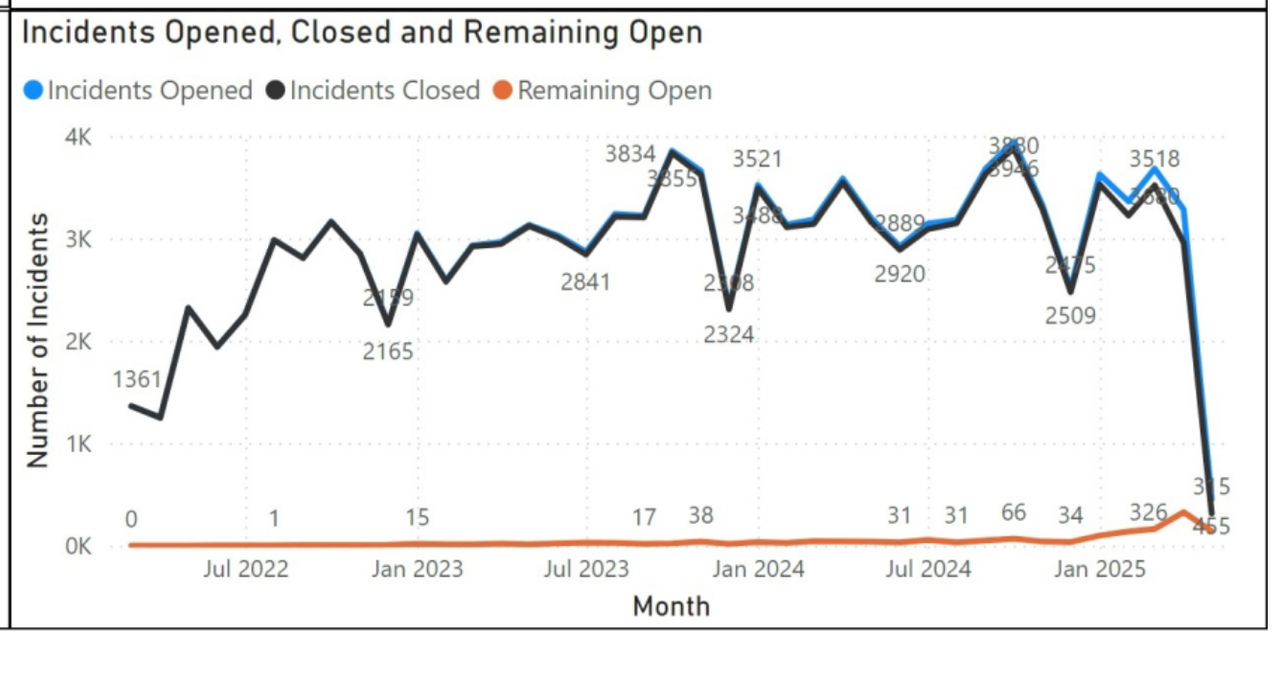
Incidents (something that was working no longer works)



Requests Opened, Closed and Remaining Open



Incidents Opened, Closed and Remaining Open

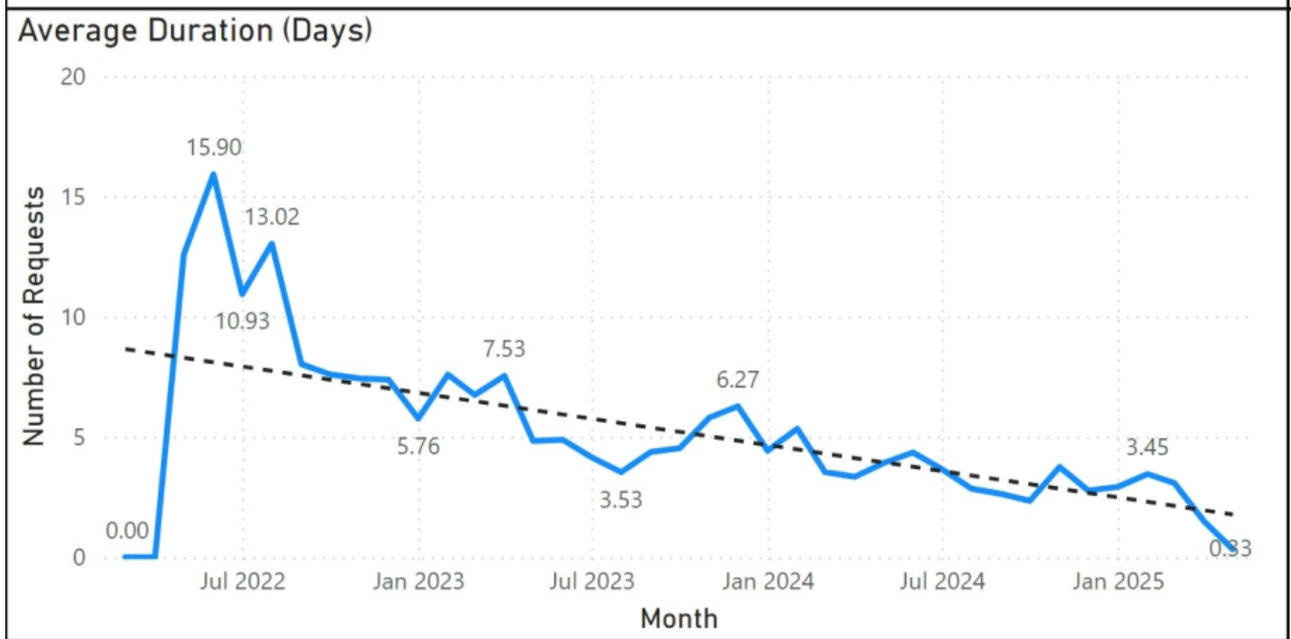


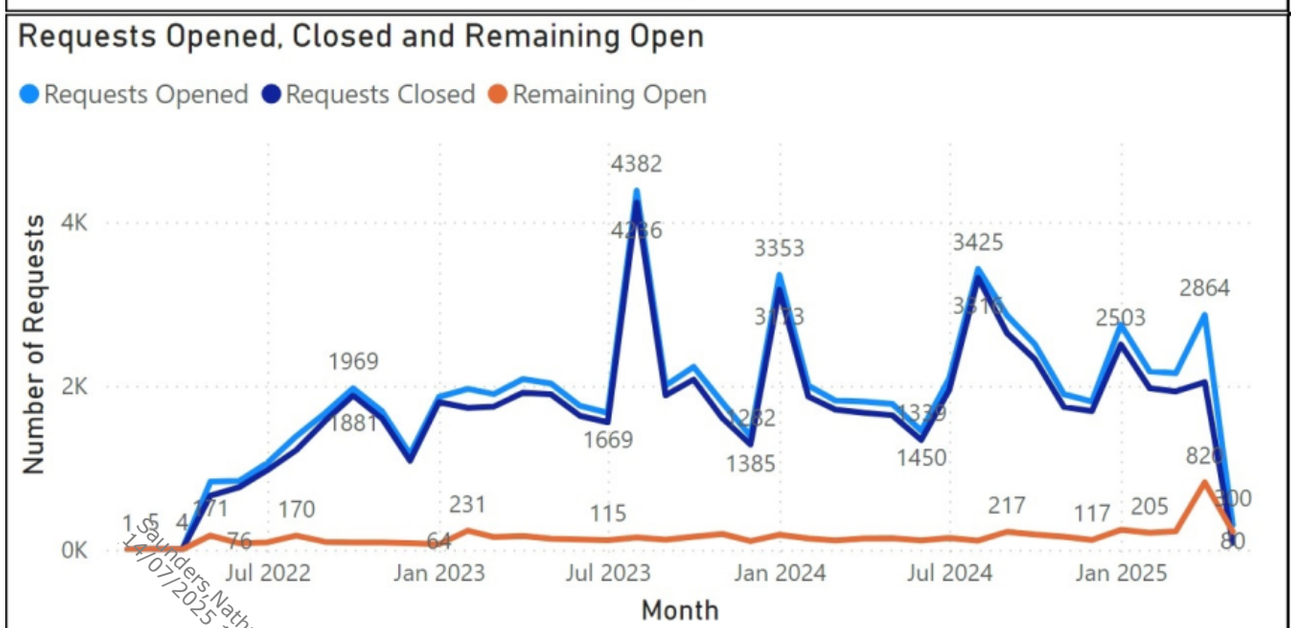
Service Desk Scorecard

Year 2024		Current Year		Current Month	
Incidents	**Requests**	**Incidents**	**Requests**	**Incidents**	**Requests**
18242	26786	6231	10234	165	300
Incidents Opened	Requests Opened	Incidents Opened	Requests Opened	Incidents Opened	Requests Opened
18229	25050	5888	8526	95	80
Incidents Closed	Closed Requests	Incidents Closed	Closed Requests	Incidents Closed	Closed Requests
13	1736	343	1708	70	220
Remaining Open	Remaining Open	Remaining Open	Remaining Open	Remaining Open	Remaining Open
4.16	3.52	4.46	2.71	0.46	0.33
Avg Duration (Days)	Avg Duration (Days)	Avg Duration (Days)	Avg Duration (Days)	Avg Duration (Days)	Avg Duration (Days)

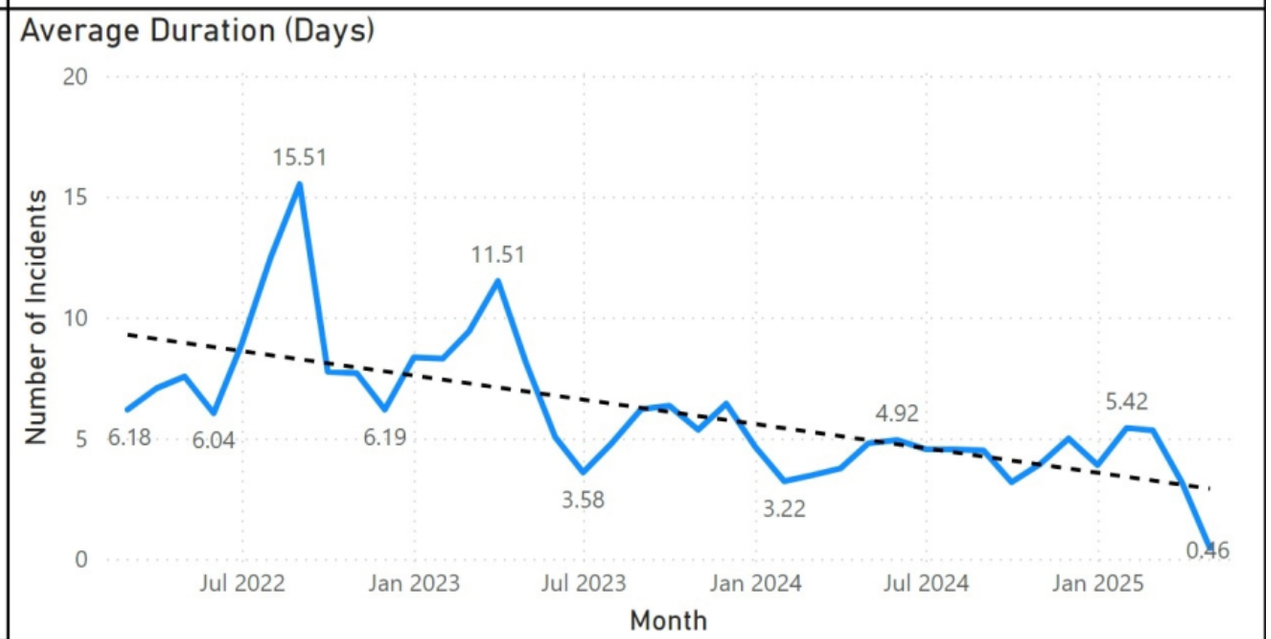
Service Desk Trending

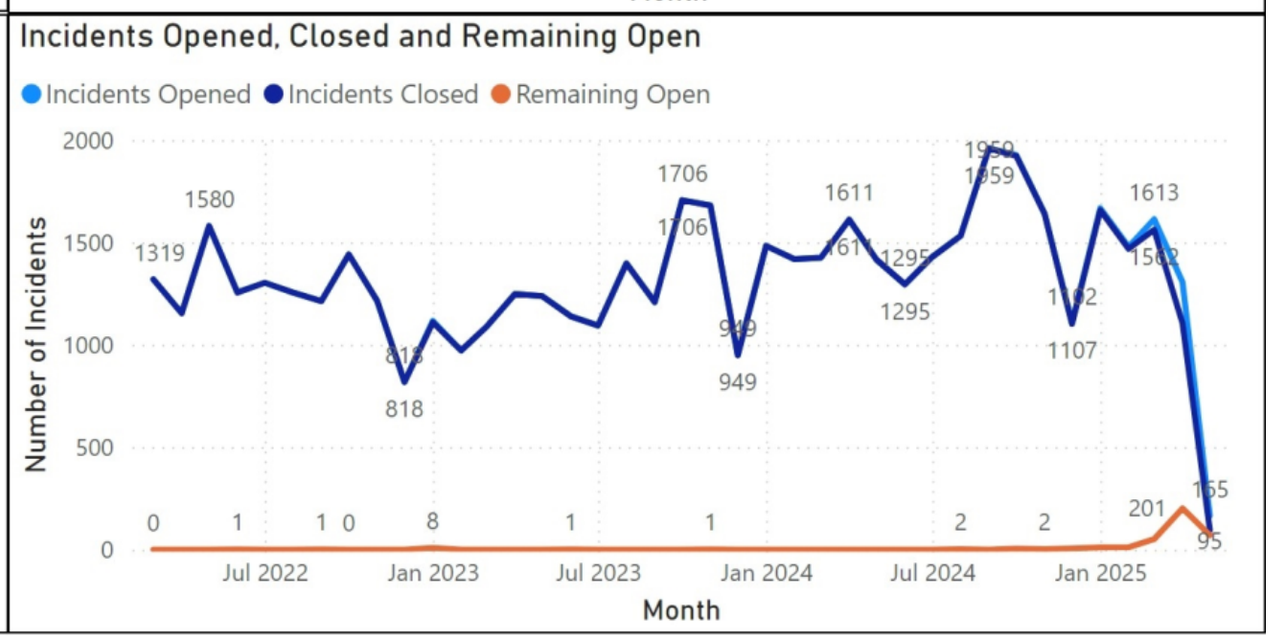
Requests (new and additional items)





Incidents (something that was working no longer works)





Service Desk Calls – May 2025

Created by Year
- 2025

Created by Month
- January 2025
- February 2025
- March 2025
- April 2025
- May 2025

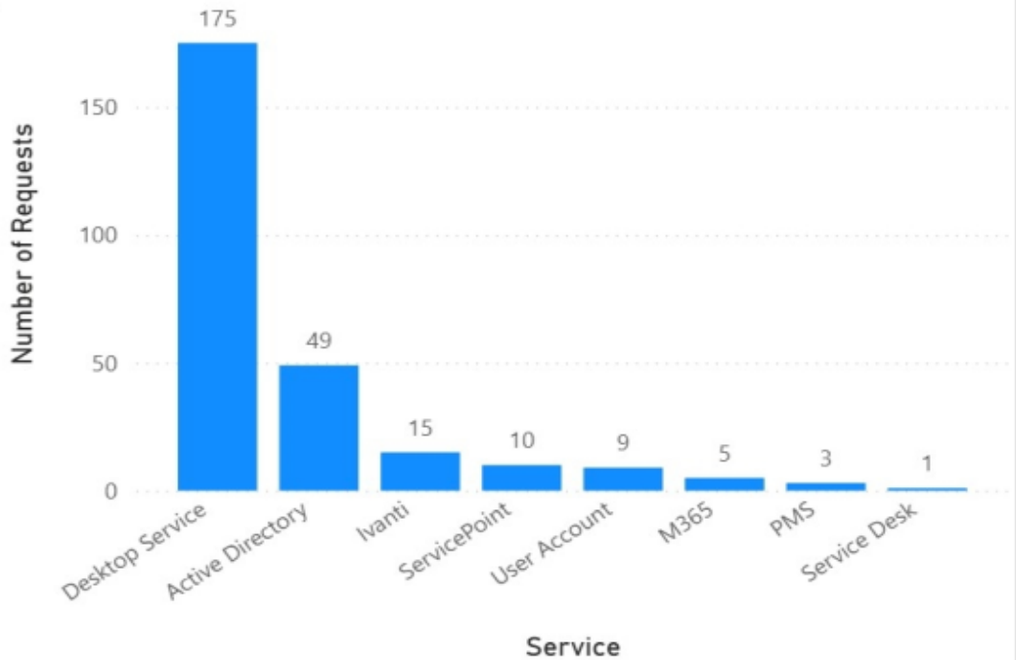
OwnerTeam
- Badgernet
- BI Applications and Warehouse
- Business Intelligence & Informatics
- Clinical Exceptions
- Digital Integration Development
- Digital Services Management (DSM)
- ePMA IT
- EUD
- IM&T Security
- Information Governance
- IT Procurement
- M365
- Network
- Paris
- Pending Approval

304	82	182
Requests Opened	Closed Requests	Remaining Open
0.33	66	6
Duration (Days)	Older than 30 Days	Pending Approval

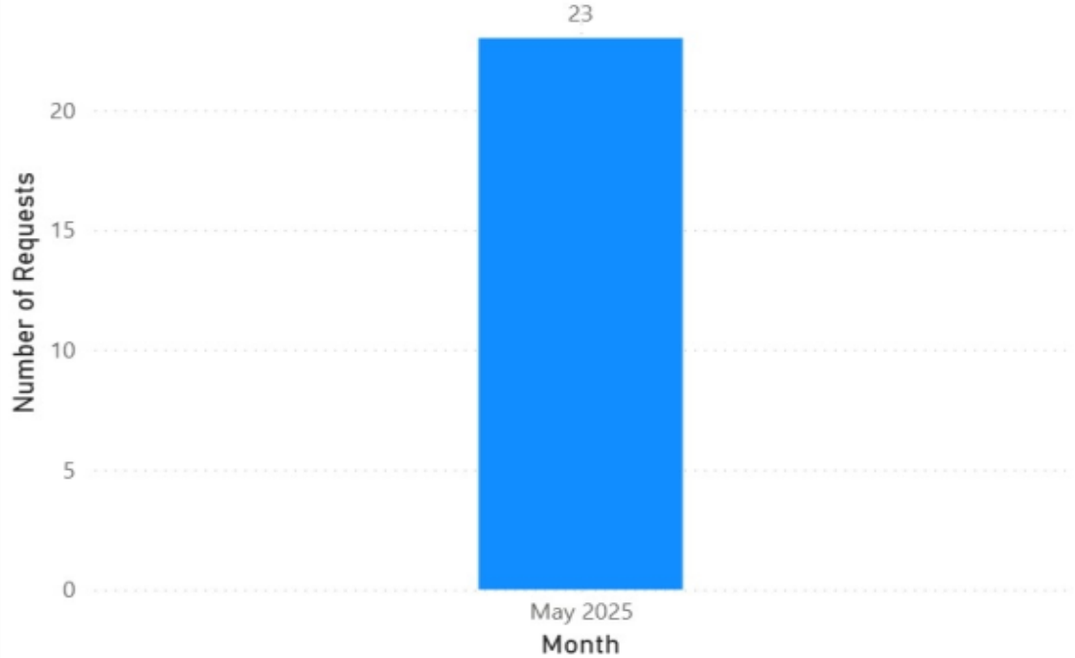
IT Procurement Requests

Status

Number by Service



Automation Requests



Incidents for Service Desk – May 2025

Date by Year

Date By Month

- March 2022
- April 2022
- May 2022
- June 2022
- July 2022
- August 2022
- September 2022
- October 2022
- November 2022
- December 2022

OwnerTeam

- BI Applications and Warehouse
- Business Intelligence & Informatic
- ePMA IT
- EUD
- IM&T Security
- ISM Admin
- M365
- Network
- Paris

Site

- At Home
- CRI
- Llandough
- Rookwood
- UHL
- UHW
- Whitchurch

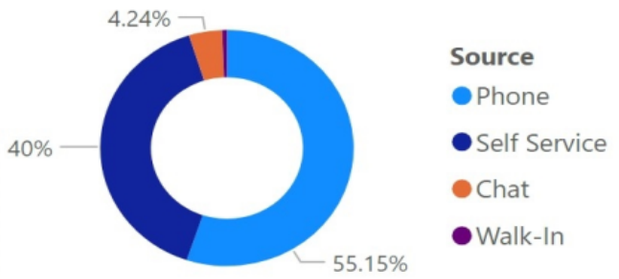
165
Incidents Opened

95
Incidents Closed

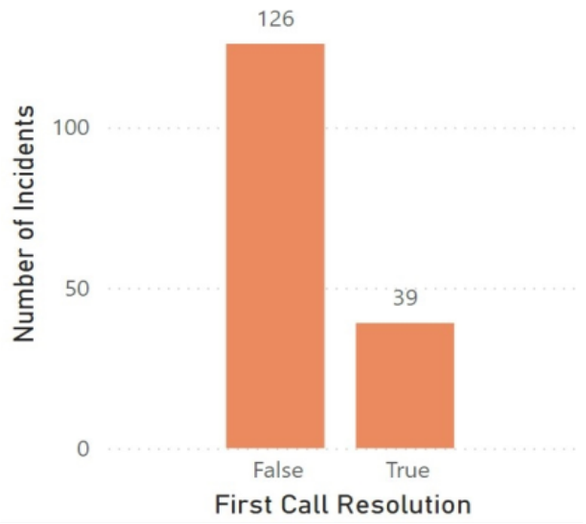
0.39
Avg Duration (Days)

70
Older then 30 Days

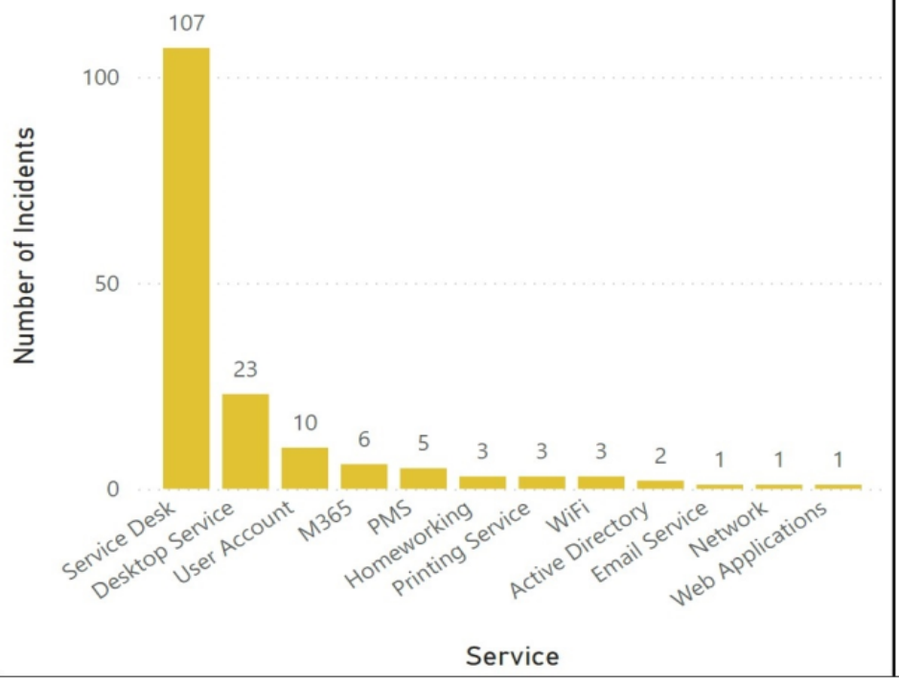
Incidents by Source



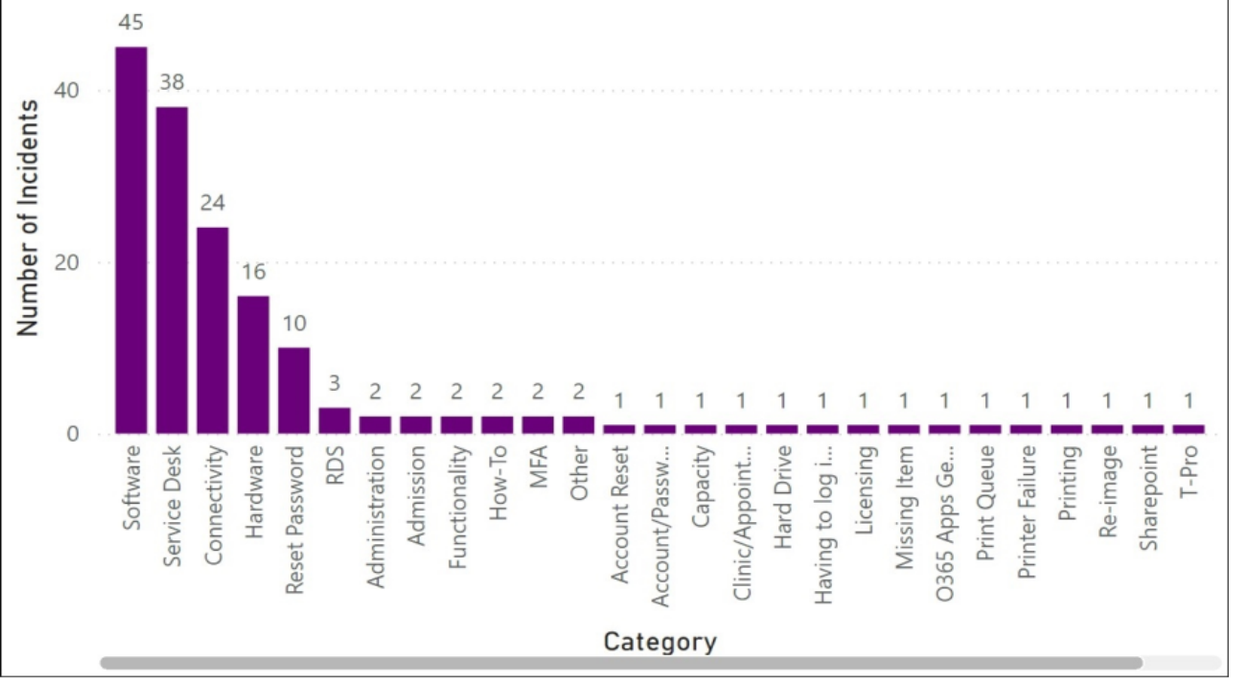
First Call Resolution



Incidents by Service



Incidents by Category



Shaping Our Future
Digital Services

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

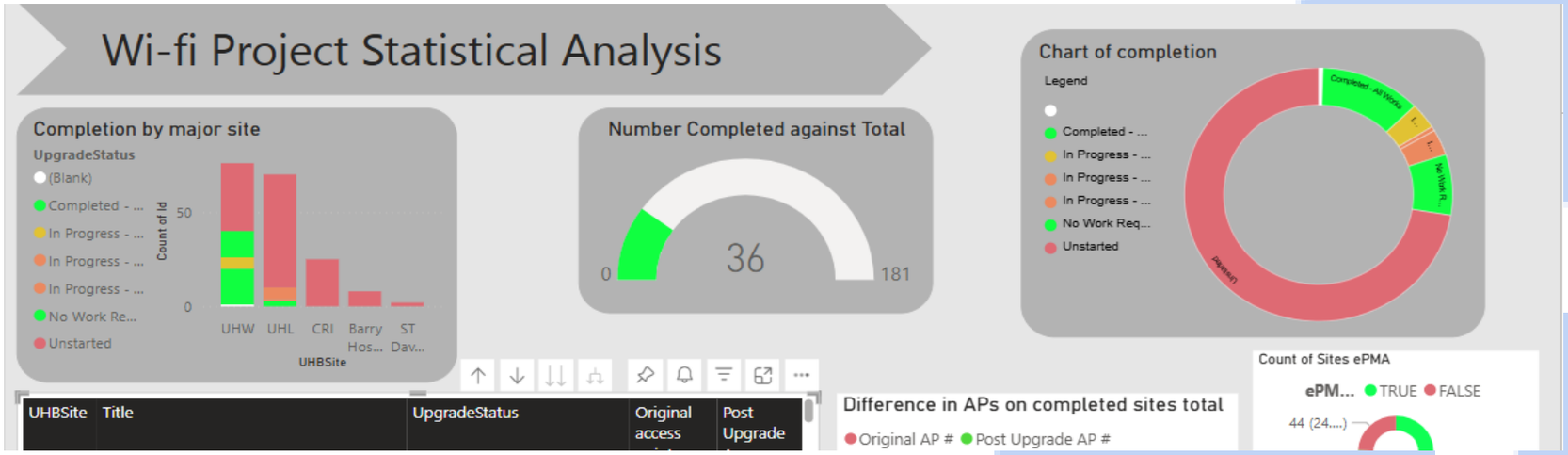
Current metrics on Wi-Fi improvement

Total areas:	Total areas complete	% total of areas complete
181	37	20%

Total ePMA areas	Total areas complete	% total of areas complete
137	37	27%

Total wider Wi-Fi/CEF areas	Total areas complete	% total of areas complete
44*	0	0%

*excluding CEF 25% 2025/2026 period



Shaping Our Future
Digital Services

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

Timelines: Phase 3

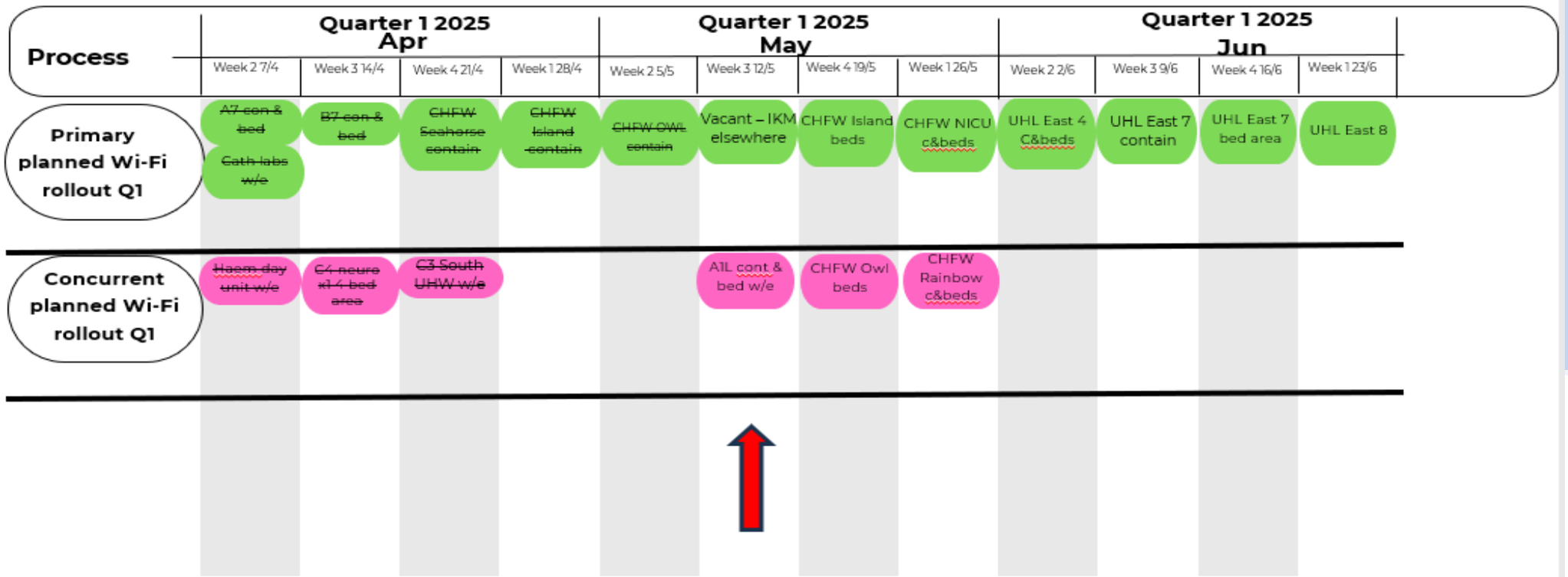
(31st March – 30th June 2025)

CAVUHB Wi-FI Project

Implementation plan

Key
*Strikethrough means ward completed

Gantt Chart
Q1 2025



Report Title:	*Ministerial Advisory Group - NHS in Wales Performance and Productivity report*			Agenda Item no.	6.12	
Meeting:	Board	Public	X	Meeting Date:	29th May 2025	
		Private				
Status:	Assurance	x	Approval		Information	x
Lead Executive:	Chief Operating Officer					
Report Author:	Director of Operational Planning and Performance					

Background and current situation:

This paper provides an overview of the Ministerial Advisory Group on Performance and Productivity which has recently published its final report. This external independent expert panel was commissioned by the Cabinet Secretary for Health and Social Care to undertake a review of the Performance and Productivity in NHS Wales. Chaired by Sir David Sloman, former NHS England Chief Operating Officer, the Ministerial Advisory Group (MAG) was tasked with providing assurance on the effectiveness of current arrangements alongside recommendations on what could be improved. The scope of the review included planned care, diagnostics, cancer and urgent and emergency care.

The report (*which can be found in the supporting documents folder on AdminControl for Board Members)* was set in the context of the major challenges facing the NHS in Wales including increased demand, rising costs and outcomes in Wales falling behind internal comparators. The MAG also highlighted the relative scarcity of productivity data and analysis within the healthcare system.

The MAG was comprised of a range of clinical and operational leaders from across the NHS in England and Wales. The group aimed to ensure its work was clinically led, data driven and evidence based.

The MAG engaged with a number of stakeholders across NHS Wales, this included a visit to the University Hospital of Wales in Cardiff on 22nd January 2025. During this visit the MAG met with the Health Board's Executive team to discuss the purpose of the visit and they were provided with a brief from our Chief Executive, Suzanne Rankin. Follow this, the MAG divided into smaller groups and held a number of "walk arounds" and stakeholder discussions with clinical and operational leaders in planned care, diagnostics and urgent and emergency care. During this time Suzanne also held a 1:1 with the chair of the MAG.

The MAG report was submitted to the Cabinet Secretary and then published, alongside a Welsh Government response, on 29th April 2025. In total there are 29 recommendation (34 individual actions) each with a timescale of between 3 and 12 months. The full list of recommendations can be found in the MAG report which is provided as an appendix and the summary presentation that accompanies this paper *(also found in the supporting documents folder on AdminControl for Board Members)*

- WG have accepted all of the recommendations – 23 in full, 11 in-part
- The Health Board have responsibility for delivering 19 – 8 in full, 11 in-part.
- The breakdown of recommendations across the themes are:
    - Planned Care – 8
    - Diagnostics – 3
    - Cancer – 5
    - Urgent and Emergency Care – 6
    - Operating Model and Accountability – 4
    - Measuring Productivity – 3

- Digital and Data – 2
- Regions and Capital – 3

On reviewing the recommendations that fall under the responsibility of the Health Board it is reassuring that the majority relate to actions that are already underway. Many of the actions have significant crossover with, or are a duplication of, previous policy and guidance. For example, in planned care these include actions such as reducing referrals, validating patients, improving theatre utilisation and improving treat in turn rates. It should also be noted that there is also crossover and duplication between many of the MAG recommendations and the Cabinet Secretary Enabling Actions that formed part of the NHS Planning Guidance for 2025/26. The MAG report does, however, contain a number of additional actions which the Health Board has not previously been tasked with, as well as providing a clear and challenging timescale for delivery of all actions. This renewed clarity and focus, whilst being challenging to deliver, does provide us with an opportunity to drive improvements that we know need to be made.

Whilst the MAG report is largely written generically, with the recommendations being applicable to all Health Boards, there is one which is solely the responsibility of Cardiff and Vale:

Recommendation 8
Cardiff and Vale University Health Board should be required to submit a clear plan detailing how it intends to clear its Non-Obstetric Ultrasound backlog over the course of 2025/26. Timescale – within 3 months.

This action is currently “green” with a plan already in place for Non-obstetric Ultrasound which includes the use of the independent sector.

The overall approach to delivering the actions is being developed. Given the fundamental nature of many of them, they must be owned and driven through our clinical and operational teams, as such they will form a key part of Clinical Board business and performance management moving forwards. To that end, initial feedback on progress has been sought from Clinical Board as part of the May Executive Reviews. The support to deliver on the recommendations will form a key responsibility of the established programmes within these areas. For example, the planned care actions will become an integral part of the planned care delivery groups, and the urgent and emergency care actions will be monitored through the 6 goals programme.

An initial assessment undertaken by the Director of Operational Planning and Performance to look at deliverability of the actions. Whilst the majority of actions have challenging timescales they should be considered as “green” and will be progressed at pace. There are four which are likely to prove challenging and are therefore considered “amber” at this time.

1. *Develop a plan to reduce referrals to traditional outpatients in high volume specialities (advice and guidance) – 3 months*
    - This is within the current plan but if a reduction in outpatients in the 3 month timescale is expected this could present a challenge against the backdrop of increasing demand
2. *Regions should develop a plan to create a regional pathology service which is safe, sustainable and fit for the future – 6 months*
    - Programme Board is in place and this is a key priority for CD&T. Further work required to confirm deliverables within 6-months.
3. *No ambulance handover will exceed 45 minutes, with a focus on achieving the 15-minute target wherever possible – 6 months*
    - Current C&V red line is 60 minutes and is not always achieved, moving to 45 minutes will be a significant challenge

4. *NHS Wales should commission from DHCW a comprehensive roadmap.... No health board should move forward with any EMR or App development until the roadmap is established.*
    - This could be considered at odds with our current digital foundation programme developed. Consider if further clarity is required from WG.

It should be noted that Welsh Government are developing a MAG delivery plan and CEOs will be invited to a monthly system leadership meeting with the Cabinet Secretary to discuss progress. In lieu of that being available at this time, a C&V internal report will be developed that can be shared with Senior Leadership Team (SLT) and Board for future meetings. Consideration is being given as to how best present this and ensure there is congruence and avoid duplication in reporting. This is important given many of the recommendations are already reported in a number of areas such as annual plan monitoring, operational programmes and the Quality Improvement and Efficiency Plan (QIEP).

Executive Director Opinion and Key Issues to bring to the attention of the Board:

- The MAG report includes a number of recommendations for which the Health Board will need to progress at pace.
- Many of these recommendations are already in progress and/or form part of established workstreams.
- The national approach for reporting on the MAG delivery plan has not yet been agreed. A local approach will be developed in the short term.
- There will be significant focus from within WG on the delivery of the recommendations and the Health Board must assure itself of progress

Recommendation:

The Board are requested to:

a) NOTE the contents of the paper, the MAG report, WG response and the accompany Power Point Presentation

Link to Strategic Objectives of Shaping our Future Wellbeing:

https://shapingourfuturewellbeing.com/

Putting People First 1. **Click the objective above to view more detail.**	Providing Outstanding Quality 2. **Click the objective above to view more detail.**
Delivering in the Right Places 3. **Click the objective above to view more detail.**	Acting for the Future 4. **Click the objective above to view more detail.**

Five Ways of Working (Sustainable Development Principles) considered

Prevention		Long term		Integration		Collaboration		Involvement	

Report Title:	**Annual Assurance Report on Compliance with the Nurse Staffing Levels (Wales) Act**		Agenda Item no.			6.13
Meeting:	Executive Board		Public	X	Meeting Date:	29th May 2025
			Private			
Status:	Assurance	X	Approval		Information	X
Lead Executive:	Executive Nurse Director					
Report Author:	Nurse Staffing Levels Lead					

Background and current situation:

The Nurse Staffing Levels (Wales) Act 2016 (the 2016 Act) became law in March 2016. The 2016 Act requires health service bodies to make provision for appropriate nurse staffing levels and ensure that they are providing sufficient nurses to allow the nurses' time to care for patients sensitively.

Section 25A of the 2016 Act relates to the Health Boards' overarching responsibility, requiring Health Boards to ensure they have robust workforce plans, recruitment strategies, structures, and processes in place to ensure appropriate nurse staffing levels across their organisation. The process of determining the nurse staffing levels on wards under section25B of the 2016 Act across Cardiff and Vale UHB is well established. In addition, the Executive Director of Nursing requests clinical areas outside of section 25B to undertake a review of their nurse staffing levels in line with this timetable to provide assurance of compliance with section 25A of the 2016 Act.

Section 25B and 25C identifies wards where there is a duty to calculate nurse staffing levels using a prescribed methodology and maintain nurse staffing levels. The methodology and processes used across the Health Board are described within the body of the report.

Section 25E requires Health Boards to submit an Annual Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act 2016. The assurance report enclosed covers the reporting period from April 6th 2024 to April 5th 2025. This report is part of a three-yearly assurance cycle that will be presented to the Welsh Government in October 2027.

Executive Director Opinion and Key Issues to bring to the attention of the Board

During this reporting period, Cardiff and Vale UHB have demonstrated a clear commitment to upholding the principles of the Nurse Staffing Levels (Wales) Act 2016. The Health Board has continued to focus on ensuring patient safety and quality of care through appropriate nurse staffing. Despite ongoing challenges in maintaining nurse staffing levels, both in the short and long term, the Health Board has made some progress. This is evidenced by an increase in the number of shifts assessed as having appropriate nurse staffing levels. Highlights of the reports include:

Establishment Review Process

The nurse staffing levels were reviewed for all section 25B areas, with one instance of recalculation occurring outside the bi-annual review process. The establishment review process was informed by professional judgment, patient acuity, and knowledge of quality indicators.

Quality Indicators

During the reporting period there has been a change to the reporting criteria to include moderate levels of harm. This has not resulted in a significant increase in the number of incidents reported.
Close monitoring of quality indicators is required as challenges surrounding the Datix management system and data extraction persist. The Health Board continues to evolve its processes in line with national guidance through the All-Wales Nurse Staffing Programme.

Supernumerary Status of the Ward Sister and Charge Nurses
Ward Sisters and Charge Nurses should remain supernumerary to enable effective clinical leadership. However, workforce challenges have sometimes required them to work within direct care staffing numbers, efforts are being taken to ensure the supernumerary status is maintained.

Operational and Strategic Measures
A wide range of operational, strategic, and escalation measures have been implemented to mitigate risks when staffing levels fall below the established standard. These include the daily use of SafeCare, effective escalation pathways through the nursing workforce hub, adaptive rostering, and long-term solutions to ensure the ongoing availability of nurses.

Recommendation:

The Board is requested to:

a) Receive the annual assurance report as per the requirements of the Nurse Staffing Levels (Wales) Act 2016.

b) Note the nurse staffing establishments detailed in the appendix, undertaken as part of bi-annual recalculations.

c) Note the reasonable steps taken to monitor and maintain nurse staffing levels at a time of significant organisational pressure.

Link to Strategic Objectives of Shaping our Future Wellbeing:

https://shapingourfuturewellbeing.com/

Putting People First 1. **Click the objective above to view more detail.**	X	Providing Outstanding Quality 2. **Click the objective above to view more detail.**	X
Delivering in the Right Places 3. **Click the objective above to view more detail.**		Acting for the Future 4. **Click the objective above to view more detail.**	

Five Ways of Working (Sustainable Development Principles) considered

Prevenți		Long		Integration		Collaboration		Involvement	

o n		te r m							

Quality Impact Assessment Completed?				
Yes – (***please provide completed QIA document***)		No – ***(Please provide reasoning, e.g. not required)***		

Impact Assessment:
Risk: No
Safety: Yes
Yes-triangulated methodology used to determine nurse staffing levels, quality indicators are reviewed as part of this process. Further details can be found within the report.
Financial: Yes
Potential impact: Details included in the report regarding the proposed business case which will follow the organizational financial governance process.
Workforce: Yes
Yes significant- specific details included within the report.
Legal: Yes
The Nurse Staffing Levels (Wales) Act 2016 was enacted in March 2016. This report is part of the compliance requirements set forth by the 2016 Act.
Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation: No
Welsh Language: Yes

Approval/Scrutiny Route *(please note anywhere else this paper has been before):*	
Committee/Group/ Exec	Date:

Annual Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act: Report for Board/Delegated Committee			
Health board/trust	Cardiff and Vale University Health Board		
Date annual assurance report is presented to Board	Reporting period April 6th 2024 - April 5th 2025 Date this report presented to Board: 29th May 2025 *This annual report refers only to year 2024/2025* but this report forms part of the 3 yearly assurance report that will be presented to Welsh Government in October 2027 for the *reporting period from April 2024- April 2027,*		
	Adult acute medical inpatient wards	**Adult acute surgical inpatient wards**	**Paediatric inpatient wards**
During the last year the lowest and highest number of wards	**19-20**	**18**	**2**
During the last year the number of occasions (wards where section 25B applies) where the nurse staffing level has been reviewed/ recalculated outside the bi-annual calculation periods	**1** An out-of-cycle review of the nursing establishment for the Stroke Rehabilitation Unit was conducted in August 2024.	**0**	**0**
The process and methodology used to calculate the nurse staffing level.	**Nurse Staffing Levels Calculation Process at Cardiff and Vale UHB** The process for calculating nurse staffing levels at Cardiff and Vale University Health Board (UHB) is well-established and follows the prescribed method outlined in Section 25C of the Nurse Staffing Levels (Wales) Act 2016. This triangulated approach is documented using the All-Wales recording template, which is reviewed and signed off through the nursing structure, from Ward Sister or Charge Nurse to the Executive Director of Nursing (designated person). **Professional Judgement** In line with the Nurse Staffing Levels (Wales) Act 2016, professional judgement exercised by the designated person when determining nurse staffing levels must take into account a comprehensive range of clinical and contextual factors. These include the qualifications, competencies, and ongoing professional development needs of nursing staff; the impact of temporary staff on continuity and scope of care; patient complexity and turnover; ward layout and environment; cultural and linguistic needs; and the contributions of the multi-professional team. This judgement is guided by evidence-based tools, national standards, and best practice. Ward Sisters/Charge Nurses, in collaboration with Lead Nurses, Senior Nurses, and the Clinical Board Director of Nursing, apply their detailed knowledge and expertise of the clinical area to		

support these assessments. Their input is documented using the All-Wales recording template and reviewed during bi-annual establishment reviews, where further professional discussion informs final staffing decisions.

Patient Acuity

Patient acuity is assessed using the Welsh Levels of Care acuity tool, with patients assigned an acuity score twice within a 24-hour period. The digital platform SafeCare facilitates live operational decisions regarding nurse staffing and patient acuity. This platform has significantly improved data capture and monitoring. Trends in patient acuity are closely monitored and reported using a Power BI dashboard, providing greater insights into patient needs. SafeCare is utilised in all Section 25B wards and additional areas, including the assessment unit, critical care unit, and mental health services.

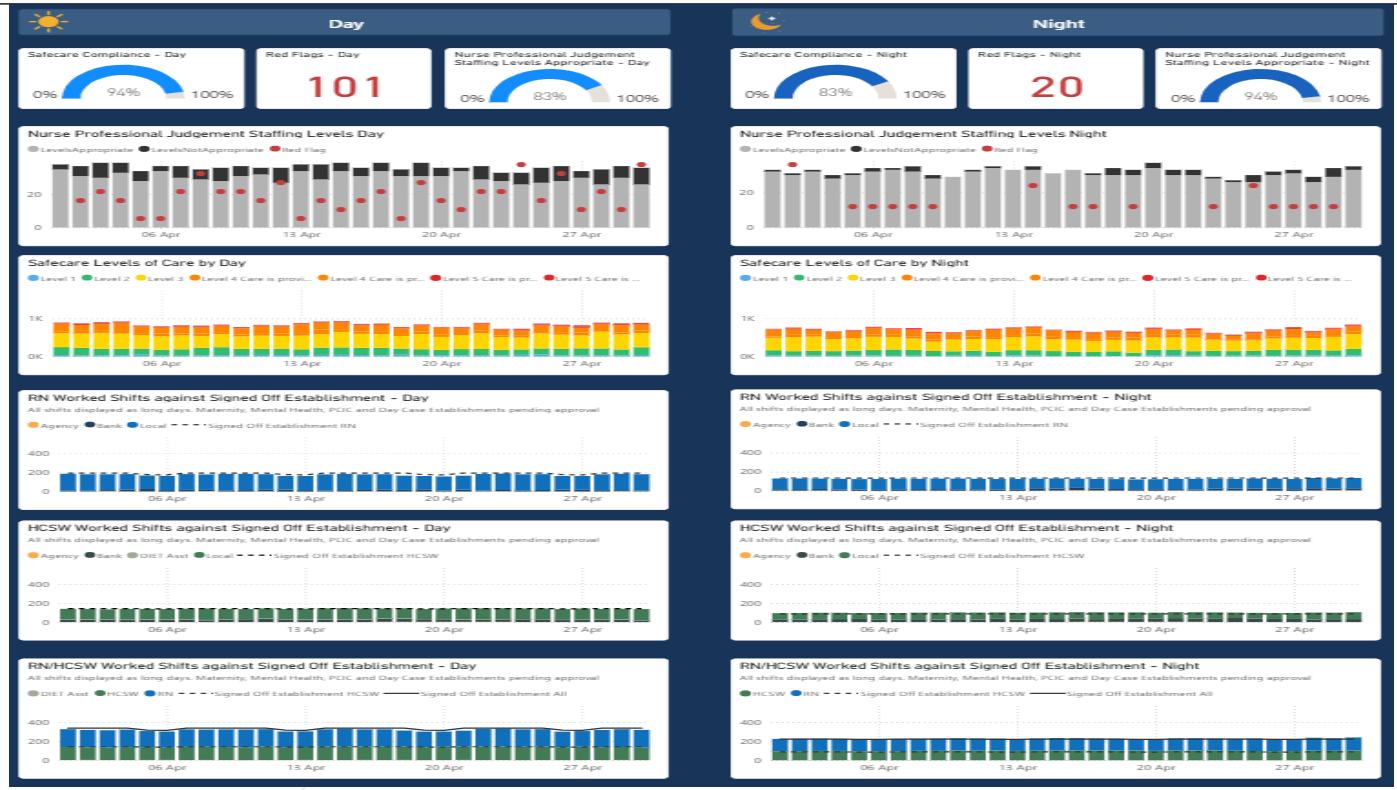
Quality Indicators

As part of the establishment review process and bi-annual calculations, the Ward Sister/Charge Nurse, through to the Director of Nursing, considers circumstances where patient well-being is sensitive to the care provided by nurses. This information is shared with the designated person. Quality indicators reviewed include:

Acute Medical/Surgical Inpatient Wards: Patient falls, pressure ulcers, and medication errors.
Paediatric Inpatient Wards: Pressure ulcers, medication errors, and infiltration/extravasation injuries.
Complaints about care provided by nurses are also considered.

Infographic and Dashboard Insights

The infographic below is an example of the SafeCare Power BI dashboard, which consolidates data from all wards under Section 25B of the 2016 Act for the previous month. It presents key information such as SafeCare compliance during both day and night shifts, patient acuity levels, nurse staffing levels, and the professional judgement of the nurse in charge regarding staffing appropriateness. The dashboard is accessible to Ward Sisters, Charge Nurses, Directors of Nursing, and members of the Executive Team, supporting review at both directorate and individual ward levels. By providing close to real-time data, the dashboard offers valuable insights into emerging trends, enabling timely responses and informed discussions around nurse staffing.



Application of Uplift for Staff Absences

For wards designated under Section 25B the 2016 Act, a 26.9% uplift is applied to account for staff absences (e.g., sickness and annual leave) prior to triangulation. This figure, established in 2011 and endorsed by Nurse Directors, is based on evidence to ensure consistency across Wales.

During the recent establishment review, it was identified that the Cystic Fibrosis Unit had an uplift of 24% applied, which was not aligned with the agreed standard. This discrepancy was escalated to the Clinical Board and has since been addressed, with the uplift now corrected and funded at 26.9%.

Community wards continue to be uplifted at 24%, resulting in a variance from the standard applied to inpatient wards. This issue was highlighted during the review, and work is ongoing across the Medicine Clinical Board to assess service requirements in accordance with workforce planning principles and service delivery needs.

Further significant improvements have been achieved across nursing in the monitoring of staff unavailability, supported by the utilisation of HealthRoster data through Power BI dashboards. These dashboards are now fully automated and updated every 24 hours, providing nurse leaders with accurate, real-time data on annual leave utilisation and sickness absence. This enhanced access to reliable information is shaping strategic discussions within nursing and informing more effective and responsive deployment of the nursing workforce.

Supernumerary Status of Ward Sisters and Charge Nurses

In line with the Statutory Guidance supporting the Nurse Staffing Levels (Wales) Act 2016, Ward Sisters and Charge Nurses should remain supernumerary to both the planned roster and the signed-off establishment. This is fundamental to enabling effective clinical leadership, oversight of patient care, and the provision of support to nursing teams in delivering safe, high-quality care. However, due to ongoing workforce challenges and short-notice staff absences, Ward Sisters and Charge Nurses have been required to work within the nurse staffing rosters. While necessary at times to mitigate immediate patient safety risks, this practice impacts their ability to fulfil their leadership responsibilities. It is important to emphasise that this only occurs on an exceptional, short-notice basis, following the consideration of all other mitigation measures. Robust mechanisms are in place to monitor and report the frequency of such redeployments. Over the past month, there has been a renewed focus on maintaining the supernumerary status of Ward Sisters and Charge Nurses to strengthen clinical leadership and ensure the delivery of consistently high-quality care by nursing teams.

The annual presentation of Nurse Staffing Levels was delivered to the Board on 28th November 2024. Establishments have been reviewed in line with the spring cycle, and the updated, signed-off establishments are provided in Appendix 1. Appendix 1 specifically details the establishments for wards designated under Section 25B of the Nurse Staffing Levels (Wales) Act 2016. A summary of the amendments to establishments is also presented in the table below for ease of reference. Please note that the table reflects changes to the establishments, rather than amendments to the underlying calculations.

Ward	Reason for Establishment Change
A2	No change to the establishment however Ward A2 is now included as a 25B ward during Spring 2025 due to the model of care provided on the ward.
Lakeside Ward 3 (Previously B2 Link)	Change in location and reduction in beds from 23 to 19.

C4 Stroke	Uplift to the establishment required for the 24/7 thrombectomy service.
Lakeside Ward 1	The ward has undergone a change in skill mix, characterised by a reduction in dietetic assistant positions and an increase in registered nurse (RN) staffing levels. This adjustment reflects the rising acuity and complexity of patient care needs.
A7	Change in skill mix in Autumn 2024 to increase Band 6 establishment. Establishments recalculated and adjusted in Spring 2025 to include this uplift.
Cystic Fibrosis Unit	Previously calculation discrepancy when applying the headroom, 26.9% headroom applied.
East 4	Ward Closed in August 2024. Winter Ward located on East 4 based on IACU model of care and therefore not considered a 25B Ward.
Stroke Rehabilitation Centre	Changed in August 2024 to reflect an increase in the nursing establishment due to patient acuity and professional judgment of the nursing team.
C1	Increased in HCSW at night and slight increase in the shift length for the registered nurse on the short shift.
B4 Neurosurgery	Reduction in bed capacity during the reporting period from 34 beds to 29 beds.
Poly-Trauma Unit	Uplift required for ortho-plastic dressing clinic which is staffed by the ward nursing team.
B6 Surgical Ward	Reduction in 9 beds and therefore reduction in establishment required.
C5 (Prev. West 6)	Relocation from UHL to UHW, increase in bed numbers from 24 to 34 beds.
West 1	Reduction in Spring 2024 due to reduction in 6 beds.
West 4 (Previously West 3)	Change during the Autumn review 2024; Change in location and increase in 2 beds, change in skill mix required.
CAVOC	Change in Autumn 2024 review. Reduction in staffing over the weekend and at night due to theatre activity and same day discharges.

Across Cardiff and Vale University Health Board, the Executive Director of Nursing undertakes a review of the nursing establishments for areas not designated under Section 25B of the Nurse Staffing Levels (Wales) Act 2016. A summary of the key points arising from these discussions is provided below.

Mental Health

Mental Health services remain designated under Section 25A of the Nurse Staffing Levels (Wales) Act 2016. Previous Nurse Staffing Level reports to the Board have highlighted the ongoing challenges in aligning Mental Health nursing establishments with the available financial envelope.

Further engagement has taken place through the recent establishment reviews. The Executive Director of Nursing has professionally agreed the current rostered establishments, acknowledging that they are uplifted above the approved budgeted levels. This variance has, to date, been managed within the Clinical Board through the utilisation of underspends and existing vacancies across other services.

Future planning work has been undertaken to model proposed rosters for Mental Health services. Further professional review of the proposed workforce models is required to ensure they are robust, sustainable, and aligned with service needs. If professionally agreed by the Executive Director of Nursing, it is recognised that implementation of these proposals would result in additional financial requirements for the Health Board. To ensure Executive Board oversight, the Clinical Board is in the process of preparing a detailed paper outlining the proposed changes and the associated financial implications.

Primary Care

The nursing establishments for Primary Care and Community services have undergone a review as part of the spring cycle establishment reviews. Key issues identified during the review included the evaluation of establishments for specific services, such as the Department of Sexual Health and nursing staff within Her Majesty's Prison (HMP), both of which necessitate a thorough assessment of their respective workforce models following updated needs assessments in each area. Furthermore, the All-Wales Community Nurse Specification was discussed, with particular emphasis on the strategic direction and Further Faster funding which focused on increasing capacity at weekends to support the growing complexity of patients and a shift to a robust 24 hour enhanced community care model. The Director of Nursing highlighted the importance of reviewing service needs to determine whether such adjustments would constitute the most efficient and effective use of resources within the current staffing and financial constraints.

Emergency and Assessment Unit

As part of the strategic effort to review nurse staffing unavailability and areas of high reliance on temporary staffing, a comprehensive review will be undertaken in the Emergency and Assessment Unit. This review will focus on the nursing establishments to ensure they remain appropriate in light of recent organisational changes and relocations. The review will be conducted promptly, with the findings presented to the Executive Director of Nursing for professional agreement on the establishments.

Informing patients	The Nurse Staffing Levels (Wales) Act 2016 requires Local Health Boards and Trusts to make arrangements to inform patients of the nurse staffing levels. To support compliance, the Health Board has implemented the All-Wales Informing Patients templates, ensuring information is displayed bilingually and consistently across all wards. Frequently Asked Questions (FAQs) have also been provided to Ward Sisters and Charge Nurses. In addition, the nurse staffing levels are formally presented to the Board on a biannual basis, aligned with the All-Wales reporting cycle and these reports are publicly available on the Cardiff and Vale UHB website. Monitoring of compliance is undertaken through the digital audit platform, Tendable, where specific audit questions have been developed. In April 2025, 25 audits were completed, with an overall compliance rate of 87.3%. Key areas for improvement include improving the visibility of staffing information on wards and ensuring the bilingual FAQs are readily available.

Section 25E (2a) Extent to which the nurse staffing level has been maintained

As the nurse staffing level is defined under the NSLWA as comprising of both the planned roster *and* the required establishment, this section should provide assurance of the extent to which the planned roster has been maintained *and* how the required establishments for Section 25B wards have been achieved/maintained during the period of this annual report

Extent to which the required establishment has been maintained within <u>adult acute medical and surgical wards.</u>

	Number of Wards:	RN (WTE)	HCSW (WTE)
Required establishment (WTE) of adult acute medical and surgical wards <u>calculated</u> during first cycle (May 2024)	**38**	**832.63**	**642.44**
WTE of required establishment of adult acute medical and surgical wards <u>funded</u> following first (May 2024) calculation cycle	**38**	**832.63**	**642.44**
WTE Supernumerary band 7 sister/charge nurse (funded but excluded from planned roster)	**38**		
Required establishment (WTE) of adult acute medical and surgical wards <u>calculated</u> during second calculation cycle (Nov 2024)	**37**	**814.73**	**629.32**
WTE of required establishment of adult acute medical and surgical wards <u>funded</u> following second (Nov 2024) calculation cycle	**37**	**814.73**	**629.32**

	WTE Supernumerary band 7 sister/charge nurse (funded but excluded from planned roster)	**WTE: 37**		
	Required establishment (WTE) of adult acute medical and surgical wards <u>calculated</u> during first cycle (May 2025)	**38**	**849.21**	**638.01**
	WTE of required establishment of adult acute medical and surgical wards <u>funded</u> following first (May 2025) calculation cycle	**38**	**849.21**	**638.01**
	WTE Supernumerary band 7 sister/charge nurse (funded but excluded from planned roster)	**WTE: 38**		

<u>All Wales Paragraph</u>

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within the data for this report.

<u>Cardiff and Vale UHB Update</u>

Cardiff and Vale UHB routinely includes both the previous reporting cycle and the most recently approved establishments in its annual assurance report. In line with the All-Wales assurance template, the report covers two previous reporting cycles (6 April 2024 – 5 April 2025) as well as the current establishments approved by the Executive Director of Nursing, ensuring the Executive Board is fully informed.

Under Section 25B of the Nurse Staffing Levels (Wales) Act 2016, only adult and paediatric acute medical and surgical inpatient wards are included. Areas such as the Emergency Unit, Critical Care, Rehabilitation Units, and Same Day Surgical Decision Units are excluded, as are emerging services like the Integrated Assessment Care Unit, which support patients not requiring acute care.

This year's winter ward, operating as an integrated assessment unit, is not included under section 25B of the 2016 Act but has a professionally agreed establishment. Conversely, Ward A2 now meets the requirements under section 25B of the 2016 Act due to its patient profile and model of care. These changes - driven by evolving service models and

	clinical need - help explain year-on-year variation in reported numbers of Registered Nurses and Healthcare Support Workers (HCSWs).			
Extent to which the required establishment has been maintained within <u>paediatric inpatient wards</u>		**Number of Wards:**	**RN (WTE)**	**HCSW (WTE)**
	Required establishment (WTE) of paediatric inpatient wards <u>calculated</u> during first cycle (May)	**2**	**106.24**	**25.02**
	WTE of required establishment of paediatric inpatient wards <u>funded</u> following first (May) calculation cycle	**2**	**106.24**	**25.02**
	WTE Supernumerary band 7 sister/charge nurse (funded but excluded from planned roster)	**WTE: 2**		
	Required establishment (WTE) of paediatric inpatient wards <u>calculated</u> during second calculation cycle (Nov)	**2**	**106.24**	**25.02**
	WTE of required establishment of paediatric inpatient wards <u>funded</u> following second (Nov) calculation cycle	**2**	**106.24**	**25.02**
	WTE Supernumerary band 7 sister/charge nurse (funded but excluded from planned roster)	**WTE: 2**		
	Required establishment (WTE) of paediatric inpatient wards <u>calculated</u> during first cycle (May)	**2**	**106.24**	**25.84**
	WTE of required establishment of paediatric inpatient wards <u>funded</u> following first (May) calculation cycle	**2**	**106.24**	**25.84**
	WTE Supernumerary band 7 sister/charge nurse (funded but excluded from planned roster)	**WTE: 2**		

All Wales Paragraph

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within the data for this report.

Cardiff and Vale UHB Update

The two paediatric wards covered under Section 25B of the Nurse Staffing Levels (Wales) Act 2016 fully participate in establishment reviews. A 26.9% uplift is applied to the planned rosters to support staffing establishments. In addition, each ward has a supernumerary Ward Sister/Charge Nurse.

There has been a slight increase in HCSW WTE required on Gwdihw Ward otherwise no significant change to the establishments during the reporting period.

Extent to which the planned roster has been maintained within adult acute medical and surgical wards

	Total number of shifts	Shifts where planned roster met and appropriate	Shifts where planned roster met but not appropriate	Shifts where planned roster not met but appropriate	Shifts where planned roster not met and not appropriate	Data completeness
TOTAL	22703	*59.07%*	*7.2%*	*23.7%*	*10.1%*	*85%*

Data Entry and Compliance

Staffing data is recorded in SafeCare by the Nurse in Charge at the start of each day and night shift. This data above covers the period from 1 April 2024 to 31 March 2025. During this period, data was submitted for 85% of all shifts. Day shift compliance remains consistently high at over 90%, while night shift compliance continues to require some improvement and remains a key area of focus.

Staffing Appropriateness (Professional Judgement)

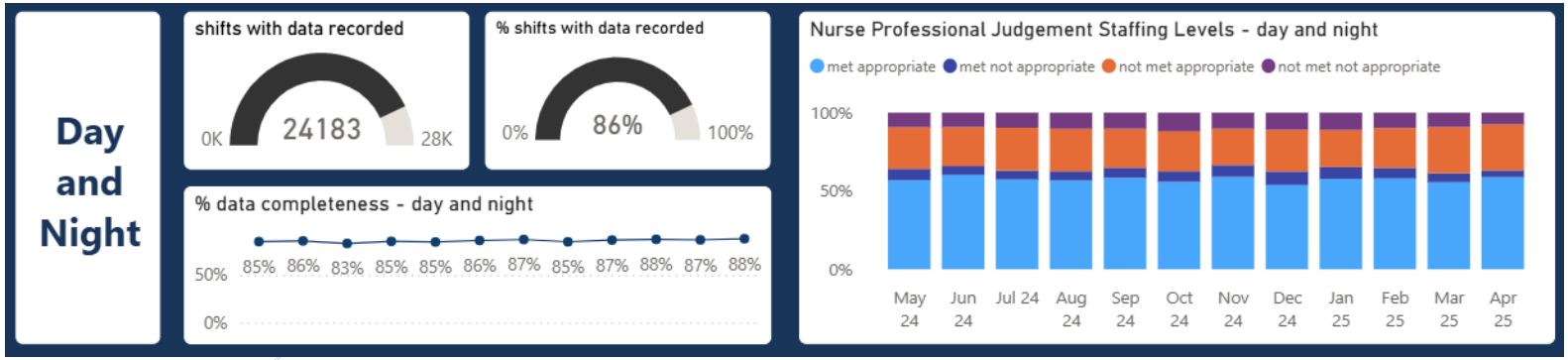
The professional judgment of nursing teams is recognised as essential in assessing safe staffing levels. On 82.77% of shifts, the Nurse in Charge judged staffing levels to be appropriate for delivering safe and effective care. This marks an

improvement from 77.3%, as reported in May 2024. In some cases, a roster may be unmet but still considered appropriate - examples include bed closures for infection prevention and control, lower patient acuity, or specialist service requirements.

In contrast, 17.3% of shifts were assessed as having inappropriate staffing levels, irrespective of whether the roster was met. While this represents a reduction from 22.7% reported in May 2024, the challenges faced by nursing teams during these shifts are fully acknowledged. These shifts are now under enhanced review, alongside any red flags raised in SafeCare, by the Nursing Workforce Hub. The Hub also monitors upcoming short-term rosters to proactively reduce the risk of unsafe staffing levels.

Data Visibility and Quality Assurance

Nursing dashboards continue to be available to teams via SharePoint, providing visibility of shift-level data. This supports local quality assurance and informs the establishment review process. An example of the dashboard is shown below.



Extent to which the planned roster has been maintained within paediatric inpatient wards

	Total number of shifts	Shifts where planned roster met and appropriate	Shifts where planned roster met but not appropriate	Shifts where planned roster not met but appropriate	Shifts where planned roster not met and not appropriate	Data completeness
TOTAL	*1424*	*28.38%*	*1%*	*61.6%*	*9%*	*99%*

	Paediatric Staffing and Professional Judgement As in adult services, the professional judgment of paediatric nursing teams is essential in determining whether staffing levels are safe and appropriate. Across paediatric services, 89.98% of shifts were assessed as appropriate by the Nurse in Charge. A significant proportion of these shifts were recorded as appropriate despite the roster not being met. Reasons include those also seen in adult services- such as bed closures and changes in patient acuity but also reflect the fast-paced nature of paediatric care and the rapid changes in patient condition and complexity. The senior nursing team actively reviews the deployment of nurses across all areas of the Children's Hospital for Wales, including specialist and high-acuity settings, to respond to the varied and complex needs of the patient population. In total, 10% of shifts were assessed as inappropriate, with 9% of these occurring when the roster was not met. Data completeness across paediatrics is excellent, with 99% of shifts recorded in SafeCare over the year, reflecting that the system is well embedded and consistently used in these clinical areas.
Process & systems for capturing data on the extent to which the planned roster has been maintained on wards where section 25B applies.	**All Wales Paragraph** *NHS Wales is committed to utilising a national informatics system that can be used as a central repository for collating data to evidence the extent to which the nurse staffing levels have been maintained and to provide assurance that all reasonable steps have been taken to maintain the nurse staffing levels required. Extensive work has been undertaken across NHS Wales to implement a national informatics system to enable health boards/trust to meet the reporting requirements of the Act and follow the Once for Wales approach to ensure consistency.* *Each health board/trust committed to implementing RL Datix (formally Allocates) Safecare system, with each organisation having implemented this system to their section 25B wards.* **Cardiff and Vale UHB Update** As outlined above, SafeCare is well embedded across Cardiff and Vale UHB, with strong compliance in system usage. The platform has now been rolled out to over 90 clinical areas, including Mental Health, Community Hospitals, Neonatal Intensive Care (NICU), and Critical Care. SafeCare plays a central role in daily operational decision-making, supporting the assessment of nurse staffing levels. Senior and lead nurses undertake daily reviews to monitor safe staffing and identify any areas of concern. SafeCare also underpins decision-making within the Nursing Workforce Hub, offering a comprehensive organisational overview of nurse staffing status and enabling timely interventions.

	Significant progress has also been made by the Corporate Nursing Team to establish a long-term reporting solution that aligns with the requirements of the Nurse Staffing Levels (Wales) Act 2016. Integration of HealthRoster data now allows for daily updates to nursing workforce dashboards, providing near real-time visibility of staffing levels across the organisation. These dashboards not only meet statutory reporting requirements but also facilitate informed and ongoing professional nursing dialogue.
Process for maintaining the Nurse staffing level	In recent months, there have been significant developments in the daily oversight of nurse staffing. At the start of this calendar year, a Nursing Workforce Hub was established. Led by a Director of Nursing, a Senior Nurse and supported by clinical board Senior or Lead Nurses, the hub operates Monday to Friday, providing central oversight of staffing levels across the organisation. It reviews all temporary staffing requests, 'red flags' raised in SafeCare and is empowered to make professional staffing decisions in response to critical staffing gaps. During weekends, a Senior or Lead Nurse on call undertakes this function to ensure continuity. While still in its early stages, the Nursing Workforce Hub is evolving and will continue to develop to support nurse staffing decisions. In parallel, there has been a significant organisational focus on recruitment, with available data indicating a reduction in nursing vacancies. When combined with daily staffing reviews, this has led to a notable decrease in agency nurse staffing usage in recent months. Where temporary staffing remains necessary, efforts have been made to convert shifts to bank staffing, promoting both cost-effectiveness and continuity of care. Detailed evidence has been presented to the Executive team on a weekly basis, outlining the breakdown of substantive and temporary staff usage in relation to signed-off establishments. This reporting highlights areas where establishments are not being met and ensures that trends are closely monitored throughout this period of transition. During the reporting period, there has also been a strong emphasis on the availability and optimisation of the substantive workforce, monitored through the Nursing Productivity Group. A series of rostering efficiency sessions have been developed and delivered to Senior Nurses, Lead Nurses, and Ward Managers. These sessions focus on achieving a balanced distribution of annual leave, effective management of sickness and study leave, and the utilisation of the allocated headroom of 26.9%. The availability of robust data from Health Roster has been integral to these discussions. A dashboard has been created to monitor rostering trends within each clinical area, enabling informed local management and continuous improvement. To further support this work, and in alignment with the Cardiff and Vale UHB Operating Framework, a Rostering Principles and Good Practice Guide has been developed and agreed by the Directors of Nursing. This guide offers practical information on SafeCare usage and a quick-reference summary of the operating framework, both in and out of hours.
Section 25E(2b) Impact on care due to not maintaining the nurse staffing levels on adult acute medical and surgical inpatient wards	

Incidents of patient harm with reference to quality indicators and complaints about nursing care	Avoidable hospital acquired pressure damage (grade 3, 4 and unstageable).	Falls resulting in moderate harm, serious harm or death (i.e. level 3, 4 and 5 incidents).	Medication administration errors resulting in moderate harm, severe harm, death & never events (i.e. level 3, 4, 5 and never events incidents).	Any complaints received about nursing care (Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR))
	TOTAL	**TOTAL**	**TOTAL**	**TOTAL**
Number of incidents/complaints closed during the current reporting period . (Please note these may include incidents/complaints opened prior to this reporting period).	21	6	2	1
Number of incidents/ complaints occurring when the nurse staffing level (planned roster) had not been maintained	3	1	1	1
Number of those incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor	0	0	1	1
Number of incidents/complaints occurring when the nurse staffing level (planned roster) had been maintained	18	5	1	0
Number of those incidents/complaints when the nurse staffing level was deemed to have been a contributing factor, even when planned roster had been maintained.	0	0	0	0

All-Wales Paragraph

Based on a review of the Health Boards/Trusts first 3 yearly reports and feedback from operational leads on their experience completing the reports; an SBAR was presented to the Executive Nurse Directors and CNO in 2021, which included a series of recommendations to improve and refine the reporting process. Following this a sub-group of the All-Wales Nurse Staffing Group was set up to improve and refine the reporting process to standardise reporting and be in

line with the Duty of Candour set out in the Quality & Engagement Act (2020), with the aim of broadening the scope of incidences of harm to provide more meaningful data, by including moderate risk falls and medication administration error incidents.

The work of the Reporting Sub-Group included a review of the measures for the adult medical and surgical inpatient wards and these were presented to the Executive Nurse Directors in August 2023. The changes to the adult wards measures were agreed, with the intention that the amended measures come into effect at the beginning of the next reporting period i.e. April 2024.

Since EDoNs agreed the recommendations in August 2023 it became apparent that the way data is being captured on Datix to meet the reporting requirements of the Duty of Candour (DoC), which came into force in April 2023, may impact our data collection under the duties of the NSLWA.

Previously, we anticipated that the changes in the reporting criteria to include moderate levels of harm would increase overall reporting, however, following this clarification this anticipated increase may not be seen.

It must be noted that previous NSLWA reports have reported on the actual harm sustained without validation, as opposed to the number of incidents found to be resulting from an act or omission when in receipt of NHS Care. To align with patient safety incident reporting to Welsh Government all future NSLWA reports, as from April 2024, will report on closed patient safety incidents which have been validated with a level of harm moderate or above (as per patient safety incident definition) and whether the nurse staffing levels contributed to the incident.

The quality indicators for the adults in-patient wards will be as follows:

- *Avoidable hospital acquired pressure damage (grade 3, 4 and unstageable).*
- *Falls resulting in moderate harm, serious harm or death (i.e. level 3, 4 and 5 incidents).*
- *Medication administration errors resulting in moderate harm, severe harm, death & never events (i.e. level 3, 4, 5 and never events incidents).*
- *Any complaints received about nursing care (Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR))*

The data to be reported for each of the above will be:

- *Number of incidents/complaints closed during the current reporting period. (Please note these may include incidents/complaints opened prior to this reporting period).*
- *Number of incidents/ complaints occurring when the nurse staffing level (planned roster) had not been maintained*
- *Number of those incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor*
- *Number of incidents/complaints occurring when the nurse staffing level (planned roster) had been maintained*

- *Number of those incidents/complaints when the nurse staffing level was deemed to have been a contributing factor, even when planned roster had been maintained.*

Cardiff and Vale UHB Update

The data in the above template is provided from incidents recorded within the Datix system. There are significant complexities in extracting the data from this system and it involves a manual process with a number of different field options. There is therefore some concern regarding the data, despite significant efforts to ensure all incidents are captured consistently across the UHB and in line with the All-Wales approach to reporting. This has been raised as part of the All-Wales Nurse Staffing Programme and discussions are taking place to explore opportunities to create an All-Wales dashboard within datix to report on these metrics. This would provide greater assurance and consistency on the data being reported. This was reported in the previous annual assurance report.

Pressure Damage

The data presented on hospital-acquired pressure damage has been derived by filtering incidents that meet the following criteria: pressure ulcers that developed or worsened during care within this clinical area, categorised as Grade 3, Grade 4, or Unstageable, and assessed as avoidable.

As previously highlighted, there are concerns that some incidents may not have been fully captured. If key data fields were incomplete, the incident may have been excluded from the dataset. To support improved accuracy and monitoring, the data has been reviewed, and a dedicated dashboard has been recently developed in Datix in collaboration with the Patient Safety Team based on the updated All-Wales reporting criteria.

During the current reporting period, **21** avoidable hospital-acquired pressure ulcers at Grades 3, 4, or Unstageable have been reported. Of these, three occurred during periods when nurse staffing levels were not fully maintained. However, none of these incidents identified staffing levels as a contributing factor, regardless of whether the roster was adhered to. This is a reduction on the number reported in the previous annual assurance report which reported 30 incidents, three of which occurred when the nurse staffing levels was not maintained and in one of these cases the nurse staffing levels was believed to be a contributory factor.

Each incident meeting the above criteria undergoes a structured focus review and is presented at Clinical Board Scrutiny Panels, where learning and actions are identified and shared across the relevant clinical areas.

In two reported cases of hospital-acquired pressure damage, discrepancies were identified between the structured responses to the nurse staffing questions and the information in the associated focus reviews. These inconsistencies have been discussed with the Senior Nurse responsible for the relevant clinical area. The reported figures are based on the nurse staffing questions within Datix, with an acknowledgment of the limitations and potential risks of having multiple sources of data from the focus reviews and nurse staffing questions.

Falls

The falls data presented is based on closed incidents of moderate harm, severe harm or death. Only those falls that have been reported as relating to nursing care has been recorded as advised by the All-Wales Nurse Staffing Programme. Despite moderate harm being included, an increase in the number of falls being reported has not been seen. During this reporting period 6 falls are recorded based on the above criteria and this is the same number recorded in the previous annual assurance report when moderate harm falls was not included. Explanations for this is likely due to some of the reporting criteria which is summarised in the All-Wales paragraph.

During the current reporting period there is one incident where a fall occurred resulting in harm on the above criteria when the nurse staffing levels was not maintained. It was not believed to have been a contributory factor.

Medication Errors

In the two cases reported above, both incidents involved the omission of medication. Given the low number of such cases, each was individually reviewed. One of these incidents occurred in 2022 and was closed during the current reporting period. Although the question “Is this incident related to nursing care?” was answered as “No,” the investigation revealed concerns about nurse staffing levels during the shift in question. These concerns had been escalated to the Senior Nurse on Call and may have influenced decision-making at the time. Due to the timing of the incident, nurse staffing rosters could not be retrospectively reviewed; therefore, the investigation findings have been used to support its inclusion in this report. Several actions and learning points arose from this incident, which were monitored by both the Patient Safety Team and the Clinical Board.

Complaints

One complaint met the reporting criteria and occurred on a ward to which Section 25B of the Nurse Staffing Levels (Wales) Act 2016 applies during the reporting period. While the complaint referred to aspects of nursing care, the Datix field asking whether it related to nursing care was marked as “No.” The information presented in the table above is based on the investigation findings and professional judgment regarding whether the complaint meets the reporting threshold.

Historically, there have been inconsistencies in how complaints are reported across health boards, due to the lack of a clear operational definition within the statutory and operational guidance. To address this, significant work has been undertaken by the Reporting Subgroup of the All-Wales Nurse Staffing Group, resulting in the development of new guidance. The Concerns Team in Cardiff and Vale UHB has actively contributed to these discussions, and efforts are ongoing to improve consistency and clarity in future reporting.

Section 25E(2b) Impact on care due to not maintaining the nurse staffing levels on paediatric inpatient wards					
Incidents of patient harm with reference to quality indicators and complaints about nursing care	**Avoidable hospital acquired pressure damage (grade 3, 4 and unstageable).**	**Falls resulting in moderate harm, serious harm or death (i.e. level 3, 4 and 5 incidents).**	**Medication administration errors resulting in moderate harm, severe harm, death & never events (i.e. level 3, 4, 5 and never events incidents).**	**infiltration and extravasation injuries**	**Any complaints received about nursing care (NOTE: Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR)**
	TOTAL	**TOTAL**	**TOTAL**	**TOTAL**	**TOTAL**
Number of incidents/complaints closed during the current reporting period. (Please note these may include incidents/complaints opened prior to this reporting period).	0	0	0	0	0
Number of incidents/ complaints occurring when the nurse staffing level (planned roster) had not been maintained	0	0	0	0	0
Number of those incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor	0	0	0	0	0
Number of incidents/complaints occurring when the nurse staffing level (planned roster) had been maintained	0	0	0	0	0
Number of those incidents/complaints when the nurse staffing level was deemed to have been a contributing factor,	0	0	0	0	0

even when planned roster had been maintained.					

All-Wales Paragraph

The work of the Reporting Sub-Group, mentioned previously, included the measures for the paediatric inpatient wards and these were presented to the Executive Nurse Directors in August 2023, along with the amended measures for the adult medical and surgical wards. The changes to the paediatric measures were agreed, with the intention that the amended measures come into effect at the beginning of the next reporting period i.e. April 2024.

The quality indicators for the paediatric inpatient wards will be as follows:

- *Avoidable hospital acquired pressure damage (grade 3, 4 and unstageable).*
- *Falls resulting in moderate harm, serious harm or death (i.e. level 3, 4 and 5 incidents).*
- *Medication administration errors resulting in moderate harm, severe harm, death & never events (i.e. level 3, 4, 5 and never events incidents).*
- *Infiltration and extravasation injuries*
- *Any complaints received about nursing care (Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR))*

The data to be reported for each of the above will be:

- *Number of incidents/complaints closed during the current reporting period. (Please note these may include incidents/complaints opened prior to this reporting period).*
- *Number of incidents/ complaints occurring when the nurse staffing level (planned roster) had not been maintained*
- *Number of those incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor*
- *Number of incidents/complaints occurring when the nurse staffing level (planned roster) had been maintained*
- *Number of those incidents/complaints when the nurse staffing level was deemed to have been a contributing factor, even when planned roster had been maintained.*

Cardiff and Vale UHB Update

During the review of incidents recorded in Datix, one incident was identified on a paediatric ward covered by Section 25B of the 2016 Act, relating to an extravasation injury. However, the incident was documented as not being related to nursing care. The focused review which was undertaken by the clinical team confirmed that there were no concerns regarding nursing care in this case. As a result, the incident has not been included in the table above. No other incidents meeting the reporting criteria were identified across the paediatric 25B wards.

	Section 25E (2c) Actions taken if the nurse staffing level is not maintained (or maintained but not appropriate *)

Actions taken if the nurse staffing level <u>was not</u> maintained in wards where section 25B applies	During this reporting period, there has been an improvement in the number of shifts where nurse staffing levels were assessed as appropriate. However, despite this progress, over one-sixth of shifts were still deemed to have inappropriate nurse staffing levels. **Actions Taken in Response to Not Maintaining Established Nurse Staffing Levels** Actions taken to address nurse staffing level issues are varied and comprehensive. Within clinical boards, these actions are reviewed during daily staffing 'huddles,' and efforts to mitigate short staffing are communicated across directorate teams. SafeCare provides staff with the opportunity to raise 'Red Flags' when there are concerns about nurse staffing in clinical areas. These Red Flags are reviewed by the Nursing Workforce Hub, which offers an organisational overview and considers the use of temporary staff or the redeployment of nursing staff as needed. **Actions taken when nurse staffing levels are not maintained include:** • **Escalation Process:** Clear escalation from ward-based clinical staff to the Senior Nurse, Nursing Workforce Hub, and Director of Nursing. • **Risk Mitigation:** Redeployment of staff across clinical areas to mitigate risks. • **Enhanced Supervision Review:** Enhanced supervision requirements are reviewed, and opportunities to cohort appropriate patients are considered to maintain patient safety. Senior and Lead Nurses regularly review all patients requiring enhanced supervision. • **Bed Management:** The number of beds is reviewed, by Senior and Lead Nurses and bed closures are considered if appropriate, particularly in paediatrics. Nurse staffing concerns are shared with the operational site team along with the Director of Nursing for the Clinical Board. • **Leadership Integration:** The Ward Sister/Charge Nurse is integrated into the planned roster if there is unmitigated risk in a clinical area. • **Communication Channels:** Open communication channels have been developed, including a monthly Senior Leadership Nurse forum to ensure ongoing strategic concerns can be quickly escalated. The introduction of the 'work in confidence' platform ensures staff can raise concerns anonymously. • **Roster Review:** Rosters are initially reviewed by the ward manager and subsequently approved by a senior nurse. Bank shifts are made available at the time of roster publication to ensure optimal fill time. In the event of short-term staffing gaps, the roster is re-evaluated, and opportunities to adjust staffing are explored to maintain adequate coverage.
	Section 25A: Duty to have regard to provide sufficient nurses
Requirements of Section 25A	Section 25A of the Nurse Staffing Levels (Wales) Act 2016 places a duty on Local Health Boards and NHS Trusts in Wales to: *"Have regard to the importance of providing sufficient nurses to allow the nurses time to care for patients sensitively*."

(NB: Section 25A refers to the Health Boards/Trusts overarching responsibility to ensure appropriate nurse staffing levels in any area where nursing services are provided or commissioned, not only wards where section 25B applies)	**Evidence of the nursing workforce planning undertaken to maintain nurse staffing levels includes:** • **Focused Recruitment Events:** Recruitment events held across various settings, including participation in student streamlining events. • **HealthCare Support Worker Recruitment:** Specific recruitment events targeting HealthCare Support Workers. • **Strategic Nursing Workforce Planning:** A Director of Nursing is responsible for overseeing strategic nursing workforce planning, working with key stakeholders such as Health Education Improvement Wales and ensuring robust processes for appropriate student allocation to areas with vacancies. • **Assistant Practitioner Role:** Introduction of the Assistant Practitioner role, supported by an educational programme. Many assistant practitioners have gained registration with the Nursing and Midwifery Council to become registered nurses. • **Additional Roles:** Consideration of additional roles to support patient care, such as pharmacy technicians and diet assistants. • **Rostering Practices Review:** Monthly reports to clinical boards reviewing rostering practices. • **Restorative Clinical Supervision:** Implementation of a restorative clinical supervision programme and strategy for the health board, initially focusing on newly qualified nurses. • **Internal Career Development Scheme:** Introduction of an internal career development scheme providing opportunities for Band 2 and Band 5 staff to advance their careers through internal transfers, enhancing clinical skills, knowledge, and professional goals. • **Strategic Direction:** Guidance provided through key groups such as the Nursing Productivity Group and Nursing Midwifery Board. Across Cardiff and Vale UHB, the process to review and monitor nurse staffing levels is well established. The Executive Director of Nursing oversees a comprehensive review of all nursing establishments, not limited to those in 25B areas. The methodology for this review is detailed in the "Process and Methodology Used to Calculate the Nurse Staffing Level" section of this template.
	Conclusion & Recommendations
Saunders,Nathan 14/07/2025 14:46:53	During this reporting period, Cardiff and Vale UHB has demonstrated a clear commitment to upholding the principles of the Nurse Staffing Levels (Wales) Act 2016, particularly in ensuring patient safety and quality of care through appropriate nurse staffing. While challenges in maintaining nurse staffing levels persist, both in the short and long term, the Health Board has made measurable progress, evidenced by an increase in the number of shifts assessed as having appropriate nurse staffing levels. A wide range of operational, strategic, and escalation measures have been implemented to mitigate risks when staffing levels fall below the established standard. These include the daily use of SafeCare, effective escalation pathways

	through the nursing workforce hub and adaptive rostering. In parallel, the organisation has strengthened its long-term workforce planning through targeted recruitment, the introduction of new roles, and career development initiatives, alongside starting new support mechanisms such as restorative clinical supervision. Lessons learned from incident investigations and learning events have further informed improvements in practice. Close monitoring of quality indicators are required as the challenges surrounding the datix management system and how data is extracted is an ongoing challenge. The Health Board continues to evolve its processes in line with national guidance, through the All-Wales Nurse Staffing Programme. Across Cardiff and Vale UHB nursing establishments are supported by robust, evidence-based processes that are regularly reviewed and refined. These processes enable the organisation to respond dynamically to service pressures, acuity changes, and workforce challenges, ensuring safe and effective care delivery. **The Board is asked to:** Receive the report as assurance that the statutory requirements relating the Nurse Staff Levels (Wales) Act 2016 have been fulfilled. Note the funded nurse staffing establishments detailed in appendix 1, undertaken as part of bi-annual recalculations.

Report Title:	Capital Plan 2025-26			Agenda Item no.	7.1
Meeting:	UHB Board	Public	√	Meeting Date:	28th May 2025
		Private			
Status *(please tick one only):*	Assurance		Approval √	Information	
Lead Executive Title:	Director of Finance				
Report Author (Title):	Director of Captial, Estates and Facilities				

Main Report
Background and current situation:

The purpose of this report is to provide the Board with a comprehensive overview of the Health Board's proposed Capital Programme for the financial year 2025/26 and request for final approval.

Capital Resource Limit and Amendments

The UHB receives an allocation of Capital funding from Welsh Government (WG) via their Capital Resource Limit (CRL). In December 2024 WG issued written correspondence to the UHB confirming an increase in Discretionary Capital funding across Wales in 2025/26, to £100m from the previous £83.791m. The UHB has benefited by £2.129m with a revised discretionary capital allocation of £17m.

A targeted estates investment fund (TEF) has been introduced as a continuation of the successful Estate Facilities Advisory Board (EFAB) scheme and provides the opportunity for Health Boards to bid for funding to support priority projects in prescribed categories. The WG have 'ring fenced' £40m for each of the next two financial years and the UHB submitted bids of circa £13m over the 2 years recognizing that, as in similar years a 30% contribution was required from its own discretionary capital budget.

Capital Estates and Facilities worked closely with the respective clinical boards, in addition to undertaking a thorough review of the risk register to determine the proposed schemes to be progressed via the funding. Capital Management Group (CMG) and the Senior Leadership Board (SLB) considered the proposed schemes at their meetings in March 2025 and agreed the appropriate level of UHB contribution prior to the formal submission to WG on the 31st March 2025. Fig1, below, summarises the value of the approved schemes per category and the UHB's contribution of £1.773m in 2025/26 & £1.563m in 2026/27.

Fig.1

C&VUHB - TEF Funding Approvals									
	2025-26	WG Cont	HB Cont	2026-27	WG Cont	HB Cont	Total WG Cont	Total HB cont	Overall total
Fire	0.876	0.613	0.263	0.526	0.368	0.158	0.981	0.421	**1.402**
Infrastructure	2.959	2.071	0.888	2.703	1.892	0.811	3.963	1.699	**5.662**
Decarbonisation	0.450	0.315	0.135	0.890	0.623	0.267	0.938	0.402	**1.340**
Mental Health	0.352	0.246	0.106	0.141	0.099	0.042	0.345	0.148	**0.493**
Infection Prevention Control	0.461	0.323	0.138	0.361	0.253	0.108	0.575	0.247	**0.822**
Decontamination	0.811	0.568	0.243	0.590	0.413	0.177	0.981	0.420	**1.401**
Total	**5.909**	**4.136**	**1.773**	**5.211**	**3.648**	**1.563**	**7.784**	**3.336**	**11.120**

The 2025/26 discretionary capital budget available following the removal of the TEF contribution is £15.227m.

The CRL is a live document which is updated as, business cases are approved, national funded programmes are identified or where the cash flows for projects are adjusted, and is monitored by the UHB Capital Management Group (CMG) at their monthly meeting.

WG All Wales Prioritisation Process

The limited availability of All Wales Capital Funding to support major capital schemes resulted in health boards across Wales submitting a schedule of schemes prioritised against a set of criteria provided by WG. Cardiff & Vale UHB submitted a schedule including some 23 bids which included Acute, Community and Primary Care projects in addition to the Digital Programme Business Case.

WG advised that it was supporting the development of the Digital Business Case, albeit the funding would be made available from an alternative funding source

Following a thorough scrutiny process, the WG Infrastructure Investment Group (IIB) resolved that only a relatively small number of the 182 proposals submitted across Wales could be progressed. The UHB has been advised to focus on exploring and progressing the following business cases further, for which, WG have indicated that funding will be available to progress the business case(s):

- ITU Expansion & Refurbishment
- Hybrid / Major Trauma Theatres UHW
- Review of BMT (To meet JACIE Recommendations)

Moreover, with the support from WG, the UHB are exploring an opportunity to develop a scheme which brings the 3 aforementioned schemes together in one facility, which may provide better value for money. A feasibility exercise is being undertaken which will culminate in a budget cost being developed and further discussion with WG to agree a preferred way forward.

Table 1 below, indicates the income identified on the CRL for 2025/26, which includes the funding allocated for the approved All Wales Capital schemes in addition to the Discretionary capital allocation. The table currently indicates no receipts from the sale of properties, however, CEF are currently considering options for the rationalization of the estates which may generate some income later in the year.

Table 1 – Capital Funding

Description	Funding		
	Major Capital	Disc Cap	O'Turn
	£k	£k	£k
Lift Refurbishment and Upgrade, UHW	4,213		**4,213**
Electrical Infrastructure, Tertiary Tower Block at UHW	516		**516**
RISP Programme	1,957		**1,957**
Decarbonsation funding - Solar Canopy Car Park	3,098		**3,098**
Rhydlafar Surgery	4,900		**4,900**
			0
Diagnostic Programme	0		**0**
Digital Fund	0		**0**
Targeted Estate Fund	4,136	1,773	**5,909**
	18,820	**1,773**	**20,593**
Discretionary Capital Allocation		15,227	**15,227**
	0	**15,227**	**15,227**
	18,820	**17,000**	**35,820**

UHB Discretionary Capital Prioritisation Process

As part of the UHB annual planning process Clinical and Service Boards submitted schemes for funding support against the available unallocated budget. The unallocated budget is determined after the annual commitments and 'roll over' schemes are taken into consideration.

Given the limited availability of both 'All Wales' Capital and Discretionary Capital the UHB undertook a prioritization exercise using an agreed criteria. The schemes identified were then scored independently by strategic service planning, operational planning and Capital Planning (CEF). The initial draft prioritisation schedule was presented to SLB on 20th March 2025 to ensure that the logic applied and the direction of travel was supported by the group. It was resolved that the plans for the priority schemes continue to be developed with the input of the respective clinical boards.

Appendix 1 identifies the schemes which scored highest following a final review and taken forward into consideration against the available funding. It was also resolved that the Digital schemes, such as the Windows 11 roll out replacement programme and the Wi-Fi upgrade continues at pace.

Early indicative budget costs were included in the proposal which was presented to SLB in March 2025, which anticipated an overcommitment of £0.497m. The SLB supported the proposal, on the basis that CMG continue to monitor the development of the schemes, and if required, address the overcommitment by considering options such as reducing the backlog allocations or utilising the contingency allowance

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Table 3 – UHB Wide Priority Schemes

Discretionary Capital Prioritisation
(For consideration from Unallocated Allocation)

Clinical Board	Capital Prioritisation 2024/25	£m	Comments
Digital	Resource for PC replacement windows 11 (12 month programme)	0.500	Reviewed with Digital original £0.250m was for a 2 year programme
Digital	Wi-Fi Upgrade year 1 (24 month programme)	0.744	Reduced by £0.350m Wifi devices purchased in 24/25
Digital	Medical Records Scanners x 2	0.350	Brought forward WiFi devices in 24/25 to enable procurement of scanners
Totals		**1.594**	

Clinical Board	Capital Prioritisation 2025/26	£m	Comments
CD&T	St Marys Pharmacy / UHL Aseptic Suite	0.350	From Prioritisation List requires design & tender
	Ward B5 Refurbishment	0.500	To support short term plan
	Ward C3 Refurbishment	0.100	Expansion for winter pressure 25/26
	Alder Ward (Hafen y Coed) UHL	0.120	Water ingress into floors HIW inspection
Totals		**1.070**	

Capital Prioritisation Summary

	£m
Unallocated	2.167
Capital Prioritisation 2024/25 Rollover Schemes	1.594
Capital Prioritisation 2025/26	1.070
Total	2.664
Overcommittment	0.497

Scheme to be developed

Scheme Name	Comments
Regional Ophthalmology UHL	Included in Draft Plan
Estates transformation programme (planning)	Included in Prioritisation List
ECC - Urgent Treatment Centre Barry	Included in Prioritisation List
Riverside Community Hub	Included in Prioritisation List
Medicine Strategic Plan - Lakeside Wing	Included in Prioritisation List
CAVHIS - Phase 2	Included in Prioritisation List
Physiotherapy UHW (linked to medicine plans)	Included in Prioritisation List
POAC (linked to medicine plans)	Included in Prioritisation List
ECC - Safe@Home St Davids	Included in Prioritisation List
Additional Cath labs	Included in Prioritisation List
New Born Screening	Anticipating Welsh Government funding
WICIS	Included in Prioritisation List
ALAS relocation (part of Rookwood Sale)	Included in Prioritisation List
Paediatric Emergency Department (Noah's Ark)	Included in Prioritisation List
Teenage Cancer Trust (TCT) Unit Refurbishment (charity funded)	Included in Prioritisation List
Immunisation relocation (part of Rookwood site)	Included in Prioritisation List
Estate Rationalisation	Included in Prioritisation List
Joint equipment store	Included in Prioritisation List
Radiology Digital Telephony	Included in Prioritisation List
3D Printing in Surgery	Included in Prioritisation List
ICNNS team relocation	Included in Prioritisation List

Draft Capital Programme 2024/25

At their meetings held in March 2025, the CMG & SLB determined that the UHW C1 Cardiology Relocation scheme remained a priority scheme and supported the commitment of £3.140m from the 2025/26 discretionary capital programme as the scheme was dependent upon the completion of the enabling works to the Lakeside Wing and B2 Link which were recently completed in the latter part of the 2024/25 financial year.

The UHB Board at their meeting in March 2025 supported the annual plan which included the following detailed programme as shown in Table 4 below which is currently forecasting an overcommitment of £0.497m against current available allocation, noting the responsibility of the CMG to monitor the progress and manage the spend against the budget.

At present, £1m contingency remained in the plan, however, this carries a significant risk given the position in the year.

Table 4 – Draft Expenditure Programme

Description	Major Capital	Discretionary Capital	Reprovided 2024/25	Outturn
Major Capital Construction				
Lift Upgrade (BJC)	4.213		(0.045)	4.168
Tertiary Tower Electrical Infrastructure	0.516	1.062		1.578
RISP Programme (Digital)	1.957	0.082		2.039
Decarbonisation Funding	3.098		(0.708)	2.390
Pentyrch Surgery	4.900		(0.165)	4.735
Cardiology Relocation (C1 UHW)		3.140		3.140
Enabling Project Work			0.344	0.344
CRI Car Park Enabling			0.140	0.140
Diagnostic Programme				
Digital Fund				
Targeted Estate Fund (30% contribution)	4.136	1.773		5.909
WEDINOS			0.050	0.050
Reprovision from 2024/25			0.584	0.584
Major Capital Business Cases				
Park View Wellbeing Hub (FBC)				
CAVOC Theatre (OBC)				
Hybrid/MTC Theatres (FBC)				
SARC (OBC)				
Wellbeing Hub Cogan (OBC)				
CRI Safeguarding (FBC)				
CRI Wellbeing Centre (OBC)				
BMT (SOC)				
ITU Refurbishment (BJC)		0.075		0.075
Ophthalmology UHL (BJC)		0.100		0.100
Roofs UHW (BJC)		0.040		0.040
Water Main UHW (BJC)		0.040		0.040
Capitalisation of Salaries		0.865		0.865
UHB Revenue to Capital		1.015		1.015
Estate Statutory Compliance		2.800		2.800
Backlog Estates		0.500		0.500
Upgrade CHP UHW		0.500		0.500
Lift 8 & 9		0.041		0.041
Backlog IM&T		0.500		0.500
Backlog Medical Equipment		1.000		1.000
PIE Requests		0.100		0.100
Contingency		1.000		1.000
Unallocated funding		**2.367**	(0.200)	**2.167**
Totals	**18.820**	**17.000**	**0.000**	**35.820**

The draft plan includes an allocation for the cardiology relocation (C1 UHW) £3.140m, contingency £1.000m and Project Initiation Enquiry Process (PIE) £0.100m.

Executive Director Opinion and Key Issues to bring to the attention of the Board:

- The draft capital programme & prioritisation 2025/26 has been endorsed by Capital Management Group at their meeting held on the 17th March 2025 and supported by the Senior Leadership Board thereafter on the 20th March 2025.
- At the time of issuing the report, the Finance & Performance Committee were yet to consider the proposed plan
- The draft capital programme identifies, **Overcommitment £0.497m** subject to the delivery of the priority schemes in the current financial year
- Capital Management Group will continue to monitor the development of the schemes and manage the spend profile accordingly to ensure that the UHB meet their statutory obligation to WG and deliver the CRL within the agreed parameters by the end of the financial year.

Recommendation:

The Board is requested to:

a) **NOTE:** the content of the paper and in particular the prioritisation process undertaken.
b) **SUPPORT:** the draft capital plan 2025/26
c) **APPROVE** the plan, recognising that the reported overcommitment will be closely monitored and addressed by the Capital Management Group

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please place an "X" in the below boxes as relevant.

1. Putting People First **Click the objective above to view more detail.**		2. Providing Outstanding Quality **Click the objective above to view more detail.**	√
3. Delivering in the Right Places **Click the objective above to view more detail.**	√	4. Acting for the Future **Click the objective above to view more detail.**	√

Five Ways of Working (Sustainable Development Principles) considered

*Please place an "**X**" in the below boxes as relevant*

Prevention		Long term	√	Integration		Collaboration		Involvement	

Quality Impact Assessment Completed?:

*Please place an "**X**" in the below boxes as relevant. Any queries, please contact Alexandra.scott3@wales.nhs.uk*

Yes – (***please provide completed QIA document***)		No – ***(Please provide reasoning, e.g. not required)***		*Comment here*

Impact Assessment:

*Please state **yes** or **no** for each category. **If yes please provide further details.***

Risk: Yes
Lack of capital funding to deliver the scheme has implications on clinical service delivery.
Safety: No
Financial: Yes
As above. The UHB will continue engagement with Welsh Government to determine and potential additional funding available.
Workforce: No
Legal: Yes

Statutory obligations require investment and the lack thereof can lead to exposure to risk and legal challenge
Reputational: Yes
The UHB's ability to reduce waiting times and deliver services in an appropriate setting being cognisant of patient's privacy and dignity.
Socio Economic: No
Equality and Health: Yes
Increasing the overall reliability of the Lifts will ensure clinical staff are able to appropriately perform intensive clinicals activities.
Decarbonisation: Yes
Although not been specifically, new equipment installed will be more energy efficient.

Approval/Scrutiny Route *(please note anywhere else this paper has been before):*	
Capital Management Group	Date:17th March 2025
Senior Leadership Group	Date: 20th March 2025
Finance Committee	Date: 21st May 2025
UHB Board	Date: 28th May 2025

Report Title:	NHS Long Term Agreements (LTAs) and Financial Approach for 2025/26			Agenda Item no.	7.2
Meeting:	Board	Public	X	Meeting Date:	29.05.2025
		Private			
Status *(please tick one only):*	Assurance		Approval x	Information	
Lead Executive:	Executive Director of Finance				
Report Author (Title):	Assistant Director of Finance				

Main Report
Background and current situation:

Context

The Health Board (HB) holds several Long-Term Agreements (LTAs) with other NHS bodies in support of:

- The provision of secondary regional, tertiary and specialised services to commissioning organisations by C&V UHB to other commissioners
- The commissioning of secondary regional, tertiary and specialised services for the Cardiff and Vale resident population from other provider organisations

The LTAs are generally agreed through signed documents known as the 'Heads of Agreements' (HoAs) which include sections covering:

General Terms
Financial Baselines and Contracting Framework
Activity Baselines and Performance Framework, linked to Welsh Government (WG) Measures
Information Requirements and Governance
Quality & Patient Safety Considerations
Escalation and Dispute Framework

In line with Health Board Standing Financial Instructions (SFIs), WG consent limits do not apply to inter-NHS Contracts [Procurement and Contracting for Goods and Services, Section 11.6.4]

LTAs between NHS Wales organisations generally rollover from year to year after review for financial, activity and performance targets.

For the 2025/26 contracting year, Welsh Government required confirmation in writing by 28th February 2025 that financial terms had been agreed between organisations. All LTA values have been agreed with respective HBs and NHS Wales Joint Commissioning Committee (NWJCC) for 2025/26. The contract documents are awaiting signature.

This paper is seeking to:

- Provide assurance that the contract agreements with NHS Wales for 2025/26 are in place
- Note the agreed financial baselines
- Obtain approval of delegated Board authority, for the LTAs to be agreed and signed by the Chief Executive Officer

Contract Baselines for 2025/26

Table 1 - Draft LTAs as a Provider (Income)

Organisation	Mechanism	Draft Value (£m)
NWJCC	Signed LTA	323.604
Aneurin Bevan	Signed LTA	39.154
Cwm Taf Morgannwg	Signed LTA	33.450
Hywel Dda	Signed LTA	6.788
Swansea Bay	Signed LTA	4.161
Powys	Signed LTA	1.777
NHS England	Signed LTA	3.409
Herefordshire & Worcestershire ICB	Signed LTA	0.234
TOTAL		**412.577**

The HB's provider LTAs are broadly summarised as:

- Health Boards – secondary regional and tertiary flows into Cardiff and Vale in line with custom and practice of historic referral pathways
- NWJCC – specialised regional and national services provided for Wales, commissioned in line with its Joint Committee approved Integrated Commissioning Plan (ICP)
- NHS England – tertiary and specialised services supporting some Herefordshire and South West England flows, as well as emergency care

Table 2 - Draft LTAs as a Commissioner (Expenditure)

Organisation	Mechanism	Draft Value (£m)
NWJCC	Risk Share	190.625
Velindre (VCC)	Signed LTA	40.383
Cwm Taf Morgannwg	Signed LTA	18.256
- Child and Adolescent Mental Health Services (CAMHS)	SLA	0.132
Swansea Bay	Signed LTA	2.911
- Sub-contracts	Signed LTA / Non-LTA Bills	2.147
Aneurin Bevan	Signed LTA	1.287
Hywel Dda	Signed LTA	0.402
UH Bristol & Weston NHSFT (UHB Only)	Signed LTA	0.237
TOTAL		**256.380**

The HB's commissioner LTAs are broadly summarised as:

- Health Boards – secondary regional and tertiary flows out of Cardiff and Vale in line with custom and practice of historic referral pathways, largely the Western Vale population into Princess of Wales Hospital.
- Velindre – regional and specialised cancer services, including high-cost cancer drugs
- NWJCC – specialised regional and national services in line with the ICP (including Emergency Ambulance Services Committee (EASC) ambulance, transport and first responder services. Also includes non-emergency patient transport services (NEPTS) as well).
- England – emergency flows and occasional pathways into Bristol

It should be noted that NWJCC Commissioning arrangements are not subject to a signed LTA document. An all-Wales Health Board collective 'Risk Share' agreement operates, as agreed through the Joint Committee (JC). Separate governance arrangements receive and approve the respective ICP / Integrated Medium Term Plan (IMTP) annually.

Contracts with NHS England / English ICBs / English Trusts will be subject to change due to the recent announcement of NHS England being brought back into the Department of Health and Social Care (DHSC). Therefore, the organisational contractual responsibility is currently under review and likely to change.

Other Draft LTAs

There are also several other Service Level Agreements (SLAs) managed within delegated limits and arrangements across the organisation which are outside the scope of this paper. This includes arrangements for screening, microbiology and laboratory services. In addition, other provider-to-provider arrangements, such as outsourcing, are also managed separately with different governance arrangements.

2025/26 LTA Financial Framework

Prior to 2024/25, the Health Board LTAs were transacted under a temporary financial framework agreed by Directors of Finance (DoFs). This was implemented to mitigate significant activity changes and the financial impact due to the pandemic. In 2024/25 the framework returned to the extant rates in place prior to the pandemic (NWJCC returned to extant rates in 2023/24) and this will continue in 2025/26.

Executive Director Opinion and Key Issues to bring to the attention of the Board:

The Health Board's IMTP provides for both the baseline and core expected financial performance assumptions across the LTAs, as well as the impact of known changes, such as agreed service developments, repatriations and disinvestments.

A number of material baseline adjustments are anticipated during the financial year associated with WG Allocation adjustments. These are expected to be cost neutral and largely associated with NWJCC commissioning arrangements and directed funding.

LTA performance and risk assessment on this, including recovery, will feature as part of routine reports and discussion through Finance and Performance Committee.

The scheme of delegation regarding contract authorisation and further variation is contained in table 4 below.

Table 4 - The approach to variation and settlement:

Cost neutral adjustments, including transfers of service, and Allocation changes	Agreed and actioned by the lead senior manager / finance business partner (no limit)
Adjustments within budget, agreed IMTPs / ICPs, or delegated limits	Agreed and actioned by the lead senior manager / finance business partner (no limit)
Year-end performance and variation settlement invoices per LTA terms and the 25/26 LTA Financial Framework Agreement	<£125k DoF approval or per delegated limits >£125k Chief Executive approval (no limit)

Exceptional baseline changes outside of budget and IMTP / ICPs	<£125k DoF approval or per delegated limits >£125k Chief Executive approval >£500k Board approval (incl. Chairs Action)
Year-end performance and variation settlement invoices outside of LTA terms and the 25/26 LTA Financial Framework Agreement	<£125k DoF approval or per delegated limits >£125k Chief Executive approval >£500k Board approval (incl. Chairs Action)

Recommendation:

The Board are requested to:

Note the current Long-Term Agreements and their indicative baseline values for 2025/26

Approve delegated Board authority for the LTAs to be agreed and signed by the Chief Executive

Approve delegated Board authority for in-year LTA baseline changes and variation / settlement invoices to be agreed as set out in the Executive Director Opinion (Table 4)

Note that LTA financial performance as both provider and commissioner feature as part of reports into the Finance & Performance Committee.

Link to Strategic Objectives of Shaping our Future Wellbeing:
https://shapingourfuturewellbeing.com/

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

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant

Prevention	X	Long term	x	Integration		Collaboration	x	Involvement	

Impact Assessment:
Please state yes or no for each category. If yes please provide further details.

Risk: Yes/No

No

Safety: Yes/No

No

Financial: Yes/No

Yes – the Cardiff & Vale UHB LTAs are key contractual and financial arrangements supporting the delivery of healthcare across Wales.

Workforce: Yes/No

No

Legal: Yes/No

No	
Reputational: Yes/No	
Yes	
Socio Economic: Yes/No	
No	
Equality and Health: Yes/No	
No	
Decarbonisation: Yes/No	
No	
Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
Finance Committee (Presentation for awareness)	

Report Title:	**Public Board Theatre Briefing**			Agenda Item no.	7.3	
Meeting:	Board	Public	x	Meeting Date:	29/05/25	
		Private				
Status:	Assurance	x	Approval		Information	
Lead Executive:	Chief Operating Officer					
Report Author:	Chief Operating Officer					

Background and current situation:

The purpose of this paper to share the contents of the comprehensive theatre service review that was published on the 7 May 2025.

And to brief the Cardiff and Vale University Health Board on the actions taken so far in relation to concerns raised within the review and the timescale for the implementation of the remaining recommendations.

The Service Review was robust and detailed and as a resulted uncovered a number of concerning themes, ranging from failures of leadership practice, variable compliance with policies and procedures, and poor culture all of which is impacting upon behaviours and psychological safety of colleagues.

There are **66** recommendations made in total that sit under 9 main themes with patient and staff safety and experience and theatre efficiency being added to the 7 original areas of focus.

6 recommendations needed immediate action and the progress against these are detailed in the paper.

As to be expected there has been considerable focus and scrutiny both internally and externally placed on the Health Board, and briefings have taken place with the cabinet secretary for Health and WG officials. A media briefing was also held on the day the review was published.

Following the publication of the review a number of actions, in addition to addressing the 6 immediate concerns, have taken place or are in hand:

- Creation of a dedicated senior Theatre Leadership team comprising of
  - Consultant Anaesthetist
  - Deputy Director of Nursing
  - Director of Operations
  - Senior People & Culture Support
  - Senior Shaping Change support
- 5 face to face staff (including medical staff) briefings led by Chief Operating Officer across all theatre suites in the Health Board
- 1 consultant only briefing led by Medical Director, Clinical Board Director of Surgery and Chief Operating Offer
- UHW Site visit by the Chief Medical Officer & Chief Nursing Officer for Welsh Government
- HIEW support to look at education and training requirements
- Intention to review the opportunity to move more theatre lists to the Llandough surgical hub and close down theatres at UHW where there is very poor infrastructure and environmental issues

- Review all of the estate and infrastructure issues and agree a plan with Welsh Government for short, medium and long term solutions
- Weekly oversight group led by COO, Medical Director, Executive Director of Nursing
- Draft improvement plan to be in place by end of May
  - To be shared with Welsh Government and HIW
- The full improvement plan to be published by the end of June
  - The full improvement will be co-produced with the theatre staff
- Internal Audit have been commissioned to undertake a review of the UHB quality governance processes and the effectiveness of the current arrangements

Executive Director Opinion and Key Issues to bring to the attention of the Board:

The internal commissioning and public publication of the comprehensive service review for theatres should give assurance of just how seriously the Health Board takes the issues raised by the staff who work there. As soon as the scale of the issues became clear following the internal staff survey in the summer of 2024 action was taken.

It is an uncomfortable read and it is also apparent that many of these issues are cultural and long standing and that the governance an oversight of theatres within the surgical clinical board and overall organisation has not been strong enough. It is also apparent that there was a reluctance for senior leaders to deal with some of these issues. There is now need to be a period of reflection to understand why this was case.

The estate and infrastructure issues cannot be overstated. Many of the operating theatres in UHW are from the original build in 1971. The size and layout of many of the theatre suites, recovery bays and the high-volume short stay surgical unit does not allow for efficient and productive patient flow. There are inadequate storage facilities for the types of equipment now used in modern day surgical techniques. There are frequent estate issues due to water ingress, ventilation failures, temperature control issues, all which is not unexpected from an estate over 50 years old.

The disruption this causes in running efficient operating theatres occurs almost daily.

Recommendation:

The Board are requested to note the contents of this report, the comprehensive service review and the draft improvement plan.

Link to Strategic Objectives of Shaping our Future Wellbeing:

https://shapingourfuturewellbeing.com/

Putting People First 1. **Click the objective above to view more detail.**	x	Providing Outstanding Quality 2. **Click the objective above to view more detail.**	x
Delivering in the Right Places 3. **Click the objective above to view more detail.**	x	Acting for the Future 4. **Click the objective above to view more detail.**	x

Five Ways of Working (Sustainable Development Principles) considered									
Prevention		Long term		Integration		Collaboration		Involvement	

Quality Impact Assessment Completed?				
Yes – (***please provide completed QIA document***)		No – ***(Please provide reasoning, e.g. not required)***		

Impact Assessment:
Risk: Yes
Safety: Yes
Financial: Yes
Workforce: Yes
Legal: No
Reputational: Yes
Socio Economic: n/a
Equality and Health: Yes
Decarbonisation: No
Welsh Language: /No

Approval/Scrutiny Route *(please note anywhere else this paper has been before):*	
Committee/Group/Exec	Date:

Public Board Theatre Briefing – May 2025

1. Purpose

The purpose of this paper to share the contents of the comprehensive theatre service review that was published on the 7 May 2025.

And to brief the Cardiff and Vale University Health Board on the actions taken so far in relation to concerns raised within the review and the timescale for the implementation of the remaining recommendations.

2. Background

In May 2023 an engagement event was held in the All Nations Centre with all the theatre (perioperative) staff to hold a theatre operational reset workshop.

The Chief Operating Officer led a session where the purpose was to discuss how to move on from how many operations were undertaken in COVID v the number of operations undertaken pre-COVID and to instead look ahead at the challenges and opportunities to increase the number of operations undertaken and to reduce the waiting times for patients. At the time, it was estimated that if theatres could run 95% of the time then an additional 2,000 operating lists could be created.

There was also the opportunity to discuss the theatre plans for both UHW and UHL which, at the time, included:

- Hybrid Theatre Business Case
- Cardiff & Vale Orthopaedic Centre (CAVOC) Theatre Business Case
- University Hospital Llandough (UHL) plan to become CAVOC + high volume low complexity surgical centre
- Cardiothoracic move to University Hospital Wales (UHW)

During the reset workshop some of the challenges to delivery of increasing the number of theatre sessions were also explored which included:

- Workforce
  - Ensuring there was enough staff
  - Exploring new roles
- The right culture
  - Adherence to UHB Values and expected behaviours
- Flexibility of staff working patterns
  - Not having rigid shift patterns
- Training and Development
  - Equipping staff with the right skills and capabilities
- Career progression

The discussion included the need for an ambitious programme of improvement to make Cardiff & Vale UHB a magnet for staff to want to come and work and develop their careers.

This first part of this improvement work started in the summer of 2023 with the commencement of a compassionate cultural leadership programme led by People and Culture Team.

Due to all of the changes planned at the time for University Hospital Llandough, it was agreed that the cultural leadership programme would be rolled out there first. As part of the discovery phase an internal staff survey was undertaken and leadership at UHL was strengthened and a new clinical director for the surgical centre was appointed. No major concerns were identified at the time.

Once this work was completed the same methodology was applied to University Hospital Wales and staff were invited to complete an internal staff survey in the summer of 2024.

However, it became very clear once the results were collated in September 2024, that UHW staff were not in the same place as UHL. Many staff had used the free text box to express dissatisfaction and unhappiness with the leadership of theatres, the lack of career progression, off duty allocation and the lack of transparency with regard to decision making. The free text comments also cited a number of individuals multiple times in regard to conduct issues and poor behaviour.

Other areas of concern that were identified included poor theatre efficiency with late starts, early finishes and high numbers of patient cancellations. Staff turnover at c38% of new recruits in theatres leaving with 2 years of appointment in some staff groups, and concerns about feeling safe to speak up.

The findings gave a very clear perception of a disengaged workforce with low morale.

At this point, the Chief Operating Officer halted the cultural leadership programme and commissioned an internal comprehensive service review led by Emma Cooke, Executive Director of Allied Health Professionals, Health Science and Community Development and Helen Luton, Director of Nursing for Clinical Diagnostics and Therapeutics Clinical Board.

They were appointed to undertake the service review on the basis they had no conflict of interest and had not had any line management responsibly of theatres.

3. Comprehensive Service Review

The review commenced on the 24 October 2024, and the Chief Operating Officer wrote to all Staff members in UHW Theatres setting out the reasons for the review with the main focus being:

- values & behaviours
- leadership & management capability
- UHW theatres leadership structure and roles and responsibilities
- team dynamics
- communication & engagement
- fairness & equity
- staff turnover

Initially it was anticipated that the review would take 12 – 16 weeks to complete but the timescales were extended due to the number of staff who came forward wishing to contribute.

In total 113 staff took part in the review and the review was given to the Chief Operating Officer on the 29/4/25 and shared with the staff on the 7/5/25.

During the course of the review being undertaken, some details were shared by a staff member(s) with Wales on line repeating some of the historical allegations that been made in the staff survey as well as some new issues subsequently that came to light.

These issues included:

- **Allegations of the general public being allowed to observe patients undergoing surgery.**
    - This is being dealt with as a formal investigation, and the outcome of this investigation at the end of May 2025

- **Allegations of racism by an individual member of staff**

  In February 2023, an anonymous letter was sent to the Executive Director of Nursing, alleging racism by an individual member of staff. A thorough investigation ensued, during which the member of staff was temporarily redeployed.

  At least 11 members of staff were interviewed and in October 23 it was concluded that there was no evidence to support this allegation, and no further action was taken.

  Where the review sought other perspectives, it is clear that there is not a pervasive or ubiquitous concern regarding racism and many overseas staff stated they felt well supported.

- **Allegations of drug misuse**

  In July 2022 a member of staff was found to have amphetamines in their locker. the member of staff was suspended and a police investigation was undertaken. The police issued a caution as it was deemed of personal use and an internal disciplinary process was undertaken. No further issues identified in the review

4. **Findings & Recommendations**

The Service Review was robust and detailed and as a resulted uncovered a number of concerning themes, ranging from failures of leadership practice, variable compliance with policies and procedures, and poor culture all of which is impacting upon behaviours and psychological safety of colleagues.

There are **66** recommendations made in total that sit under 9 main themes with patient and staff safety and experience and theatre efficiency being added to the 7 original areas of focus.

Of the 66 recommendations it was felt **6** required immediate attention. These are listed below with an update on the actions taken to date:

Recommendation 1.h

Explore security options to make the female changing area a more secure place to leave belongings.

Action to Date:

This recommendation has been expanded to review the security of the entire complex. Work is underway to ensure that there the access doors in and out of theatres remain locked at all times and only authorised personnel can access using the swipe card system. This is on track to be completed by the end of May 2025.

Recommendation 8.a

Audit adherence to policies and procedures for consent and 'WHO Checklist', ensure standardised application across all theatres and provide update training as required.

Action to Date:

Significant progress has been made with this recommendation. Before the review had been published a WHO checklist safety collaborative initiative had been commenced, led by Dr Abrie Theron – Clinical Board Director for Surgery and Clare Wade, Director of Nursing for Surgery.

Since the review the organisation has reaffirmed its zero tolerance to non-compliance with the WHO safety check lists and reset its expectations regarding the 5 key steps Team Brief, Sign In, Time Out, Sign Out, Debrief.

A joint letter from the Executive Medical Director, Executive Director of Nursing and Executive Director of Allied Health Professionals, Health Science and Community Development has been sent to all users of theatres and areas where interventional procedures take place (cardiac cath labs etc), setting out the clear expectations of each of the team members and how to escalate any concerns with non-compliance of the process.

A widespread organisation communication cascade started on the 27/5/25 and will run for three weeks which will include staff briefings, across all of the clinical boards where the WHO checklist is used and also to brief all admission units/ward staff on the safety checks that are required before anyone is brought to theatre or a procedure room.

Recommendation 8.b

Examine the management of paediatric cases operated on in Mains Upper and determine whether the current arrangement of recovery in the adult recovery area aligns with the Royal College of Anaesthetists' Guidelines (Chapter 10: Guidelines for Provision of Paediatric Anaesthesia Services 2025). Assess the measures taken to safely manage children. Investigate what is required to fully utilise Children's Hospital for Wales to ensure that paediatric cases are operated on and recovered within Children's Hospital for Wales.

Action to Date:

Changes have now been made to the area that children are admitted to if they require surgery outside of the Children's Hospital for Wales (CHFW). They are now longer admitted in to the Theatre Admissions Lounge (TAL) but instead directly to the recovery bed where they will return post operatively. The curtains have also been changed to make it very clear it is the designated paediatric area of main recovery.

Further discussions are taking place on what would be required to manage more children in the CHFW. Some of the constraints include the number of emergency operating lists in the CHFW. It is very unlikely that all children will be able to be operated on in CHFW, for example the small number of neurosurgery cases and the duplication of highly specialised and very expensive equipment required would make this impractical.

Recommendation 8.e

Create standard operating procedures for the setup and standardisation of anaesthetic rooms throughout the department, where feasible.

Action to Date:

Significant progress has been made with this recommendation. Ultimately, the anaesthetic rooms need to be refurbished to make the layout identical which requires cupboards etc to be removed. In the meantime, the Standard Operating Procedure (SOP) has been reviewed and equipment and drugs has been standardised across the suites. Colour coded trays and trolleys are also being rolled out to improve the safety further whilst a longer-term plan to refurbish is being worked up.

Recommendation 8.h

Standard Operating Procedures and schedules for the theatre deep cleaning rota, including weekend protocols that are standardised across all theatre suites

Action to Date:

The SOPs and cleaning schedules have been reviewed and are in the process of now being updated to ensure there is consistency across all of the theatre suites. There is an issue about different staff groups being responsible for the cleaning in different theatre suites which is being addressed. However, in terms of the cleaning standards that they are required to achieve this will be completed by the end of May 25.

Recommendation 8.j

Charitable bid to the Staff Lottery Fund to refurbish the staff room, including new furniture, fridges and a dishwasher

Action to Date:

A funding stream has been identified which includes the use of some UHB discretionary capital for the infrastructure works and charitable funds for some of the more aesthetic aspects such as furniture etc.

A schedule of works is being drawn up and the staff are being encouraged to co-produce the design.

Although there is not currently a date to commence works, progress is being made.

5. Actions and Timescales Following the Publication of the Review

As to be expected there has been considerable focus and scrutiny both internally and externally placed on the Health Board, and briefings have taken place with the cabinet secretary for Health and WG officials. A media briefing was also held on the day the review was published.

Health Inspectorate Wales have also written to the Health Board **(see appendix A)** requesting a meeting to discuss their concerns and to seek assurance around the actions that are being put into place.

Following the publication of the review a number of actions, in addition to addressing the 6 immediate concerns, have taken place or are in hand:

- Creation of a dedicated senior Theatre Leadership team comprising of
    - Consultant Anaesthetist
    - Deputy Director of Nursing
    - Director of Operations
    - Senior People & Culture Support
    - Senior Shaping Change support
- 5 face to face staff (including medical staff) briefings led by Chief Operating Officer across all theatre suites in the Health Board
- 1 consultant only briefing led by Medical Director, Clinical Board Director of Surgery and Chief Operating Officer
- UHW Site visit by the Chief Medical Officer & Chief Nursing Officer for Welsh Government
- HIEW support to look at education and training requirements
- Intention to review the opportunity to move more theatre lists to the Llandough surgical hub and close down theatres at UHW where there is very poor infrastructure and environmental issues
- Review all of the estate and infrastructure issues and agree a plan with Welsh Government for short, medium and long term solutions
- Weekly oversight group led by COO, Medical Director, Executive Director of Nursing
- Draft improvement plan to be in place by end of May (**see appendix b)**
    - To be shared with Welsh Government and HIW
- The full improvement plan to be published by the end of June
    - The full improvement will be co-produced with the theatre staff
- Internal Audit have been commissioned to undertake a review of the UHB quality governance processes and the effectiveness of the current arrangements

6. Summary

The internal commissioning and public publication of the comprehensive service review for theatres should give assurance of just how seriously the Health Board takes the issues raised by the staff who work there. As soon as the scale of the issues became clear following the internal staff survey in the summer of 2024 action was taken.

It is an uncomfortable read and it is also apparent that many of these issues are cultural and long standing and that the governance an oversight of theatres within the surgical clinical board and overall organisation has not been strong enough. It is also apparent that there was a reluctance for senior leaders to deal with some of these issues. There is now need to be a period of reflection to understand why this was case.

The estate and infrastructure issues cannot be overstated. Many of the operating theatres in UHW are from the original build in 1971. The size and layout of many of the theatre suites, recovery bays and the high-volume short stay surgical unit does not allow for efficient and productive patient flow. There are inadequate storage facilities for the types of equipment now used in modern day surgical techniques. There are frequent estate issues due to water ingress, ventilation failures, temperature control issues, all which is not unexpected from an estate over 50 years old.

The disruption this causes in running efficient operating theatres occurs almost daily.

However, there is an absolute determination to address all 66 recommendations made in the service review and for Cardiff & Vale Theatres to be the employer of choice for staff to develop their skills and expertise within the extensive range of surgical interventions this health board provides.

7. Recommendations

The Board are requested to note the contents of this report, the comprehensive service review and the draft improvement plan.

Theatre Service Review

Introduction

During the Summer of 2024 an internal staff survey was undertaken with staff that worked in University Hospital of Wales (UHW) Theatres. This was part of the cultural diagnostic and support following a similar process in University Hospital Llandough (UHL) earlier that year. The free text comments were concerning and related to conduct issues, poor behaviour and gave a clear perception of a disengaged workforce with low morale. Theatre efficiency and staff turnover were also a concern. Paul Bostock the Chief Operating Officer commissioned a comprehensive service review.

The Chief Operating Officer requested that the following areas were included in the comprehensive service review:

1. Values & behaviours
2. Leadership & management capability
3. UHW theatres leadership structure roles and responsibilities
4. Team dynamics
5. Communication & engagement
6. Fairness & equity
7. Staff turnover

1. Process

The Chief Operating Officer appointed Emma Cooke, Executive Director of Allied Health Professionals, Health Science and Community Development and Helen Luton, Director of Nursing for Clinical Diagnostics and Therapeutics Clinical Board to undertake the comprehensive service review. The reviewers were selected as they had no conflict of interest and had not had any line management responsibly of theatres. Emma Cooke as Executive Director Allied Health Professionals and Health Science has professional responsibility for Operating Department Practitioner workforce and was therefore aware of any 'registrants' fitness to practice concern reported to the Health Care Professions Council (HCPC).

The reviewers met with 113 individuals from all professional groups within theatres, including Nursing, Theatre Assistants, Porters, Operating Department Practitioners, Managers, Surgeons and Anaesthetists. Additionally, they spoke with 11 senior leaders responsible for Main Theatres. This included teams from the Surgical Clinical Board and Perioperative Directorate, as well as the Chair of Staff Side, Head of Patient Safety, and Assistant Medical Director for Patient Safety. The team also consulted with leadership teams from similar theatre departments in England to inform their recommendations.

The review team operated from a small private office off the main corridor in Main Theatres Upper, coordinating dates and times with the Perioperative Directorate. Different days and times were scheduled over four months to accommodate as many people as possible, including sessions outside of regular hours. Additionally, several individuals contacted the review team directly, leading to meetings either in person outside the main department or via Teams. A QR code was provided to the Consultant Anaesthetists for booking virtual appointments. Although emails were sent to senior surgical colleagues outlining the purpose of the review and instructions on how to participate, there was some confusion concerning whether surgeons working in Upper Mains Theatres could take part in the review. Since no surgeons had participated, the Clinical Board Director of Surgery contacted the

Clinical Directors to ensure that surgeons met with the reviewers, thereby securing representation from all surgical specialties operating within Mains Theatres Upper.

The meetings were open to anyone working in UHW Main Theatres, the vast majority of those that met the reviewers worked or had worked in Main Theatres Upper and therefore the **report focusses on Mains Theatres Upper.**

The review team introduced themselves and stated the purpose of the review. It was important to clarify that the review was informal, as staff were initially hesitant to participate due to concurrent events.

Some set questions were used to guide the review team in line with the terms of reference, but the interaction was more conversational in approach. The time taken with individuals varied from 20 minutes to over 2 hours. People were also given the opportunity to send additional information to the reviewers or have another meeting. The review team have studied audits, e-mails and documents to get a rounded view.

In the Main Theatres UHW, Upper Floor, there are 294 staff members, excluding the Education and Management Teams. Out of these 294 staff members, 201 are registered professionals, either with the Health Care Professions Council (HCPC) or the Nursing and Midwifery Council (NMC) and they are either anaesthetic, scrub or recovery practitioners. The remaining staff consists of Theatre Assistants, Health Care Support Workers, and Porters. Additionally, there are over 100 Anaesthetic Consultants. There are 13 surgical specialities and emergency theatres operating in Upper Mains Theatres.

The theatre teams are divided into three areas: Recovery, Anaesthetics, and Scrub. Each team is led by a Clinical Lead, supported by Deputies.

Certain staff groups engaged with the reviewers more frequently than others, likely due to the challenges of being released from theatres during ongoing operations. To address this issue, the review team scheduled sessions in the late afternoon and early evening to meet with staff as lists concluded. Despite these efforts, the review team was only able to engage with up to 37% of any single team.

The review team was aware that such a review might cause stress or anxiety to the team members and therefore directed them to the employee well-being service or Canopi for support.

Findings will be presented in accordance with the terms of reference established by the Chief Operating Officer, Paul Bostock.

- Values & behaviours
- Leadership & management capability
- UHW theatres leadership structure roles and responsibilities
- Team dynamics
- Communication & engagement
- Fairness & equity
- Staff turnover

During the review process, an article was published in Wales Online detailing the culture and alleged events within UHW Theatres. This review was also mentioned in the article. Although the reviewers did not specifically investigate the claims made in the article, some colleagues chose to discuss them.

Concurrently with the review, an independent investigation was commissioned by Paul Bostock into the allegations about allowing the public to watch operations. Anecdotally, the reviewers observed an increase in the number of colleagues willing to participate in the review after the article's publication. Many expressed frustrations regarding the timing of the article's release, as the described events were historical and some believed they had already been addressed. Overall, there was a sense that their concerns were being acknowledged following the commissioning of the review.

2. Values and Behaviours

2.1 The review found a broad cross section of behaviours from those that were consistent with the Heath Boards Values and those that were not. The team heard how colleagues supported and motivated each other with genuine acts of compassion such as support around difficult conversations, clinical situations and personal difficulties. We heard that especially during the Covid pandemic everyone pulled together.

2.2 The reviewers reported hearing from some colleagues who felt undervalued and not treated with compassion by their managers and other colleagues. Some individuals shared more with the reviewers than they had initially intended, finding the experience unexpectedly 'therapeutic'. This indicates that such opportunities to share concerns were limited and that individuals did not feel psychologically safe to express their views. Instances were noted where individuals were spoken to in a belittling manner when they made mistakes in front of others, which negatively affected psychological safety within the team. This behaviour was reported across all professional groups regardless of role or seniority.

2.3 The reviewers heard examples of where people behaved in a dysregulated way including shouting, displaying overtly confrontational body language, using language that falls below expectable standards in reasonable discourse including swearing and outright criminal behaviour including theft and illegal drugs found in staff lockers. The theft for example has resulted in female staff not being able to leave anything of value in the changing room due to the regularity of the theft. The reviewers heard examples of money, phones, computers and clothing going missing. This has clearly created an atmosphere of fear, a breach of personal trust and has gone a long way to destroy the bonds which allow people to work effectively together. It also could explain why personal belongings including bags are found in clinical areas.

2.4 A general lack of courtesy across the department was described. Several colleagues shared the difficult clinical cases they deal with and that this isn't always recognised. There is a drive to get the next case on the table, regardless of how difficult the previous may have been for the team. In addition, people reported that they aren't always checked in on after difficult days.

2.5 The review team heard from several colleagues that felt they weren't listened to. To the point where some felt there was no point in raising things with the Theatre Manager as nothing was ever done. When things had been raised staff were sometimes labelled as troublemakers.

2.6 The reviewers heard examples of where colleagues were actively discouraged from being Staff Side representatives by the Theatre Manager.

2.7 There was also a level of cynicism shared by several staff about whether the review would make any difference to long-standing issues as previous attempts to change culture or manage behaviour had not made any noticeable difference to staff working in the department.

2.8 There is a lack of respect to and from managers. There were examples given from several staff that when staff asked the Theatre Manager for something that could not be accommodated, they were told “if you don’t like it, you know where the door is”. There were also examples of where managers at all levels were shouted at and questioned, in a way that was disrespectful and not in keeping with values and behaviours of the UHB. These behaviours appear to go unchallenged.

2.9 There was a lack of trust cited by some and concerns raised over lack of confidentiality. Some shared with us that they would not raise concerns as they were fearful of repercussions. There were also concerns about when addressing poor behaviour there would be counter claims of bullying and therefore things were not addressed.

2.10 There were examples of not taking personal responsibility, cupboards not being stocked at the end of shift ready for the next day, equipment not returned when borrowed or not looked after appropriately. The coffee room fridges not being kept clean and tidy and generally not cleaning up after yourself was noted. That said the coffee room is in a general state of disrepair with uncomfortable seating which doesn’t foster an atmosphere of feeling valued.

2.11 On joining the department most people said they were supported and trained with kindness and compassion. In particular, the internationally recruited nurses felt they were very well supported.

2.12 Several Clinical Leads described not feeling safe within the department, there is a lack of trust between some colleagues and a sense that decisions won’t be supported by the Senior Leads and therefore people described feeling vulnerable and unsafe.

2.13 There is a perception that there are no consequences for poor behaviour and no boundaries. The reviewers heard that there was an investigation into illegal drugs being found in a staff locker and despite this many were unhappy that there appeared to be no consequences, and their colleague remained in the workplace. It was also noted that the advice given by People Service was not always strong enough or consistent.

2.14 There was a concern among colleagues about feeling undervalued and the prioritisation of efficiency over safety, many raised the issue of inadequate breaks, with some believing the Clinical Board would not support stopping lists to ensure breaks were taken. Anaesthetic staff often lacked a resident doctor, preventing them from taking breaks. There was a push to do more with fewer resources, suggesting there is a need to return to basic principles for safe staffing. Simple things such as having clean scrubs in the correct size for the start of your shift was included as an example of how staff could feel more valued. Although there was a perception of prioritising efficiency over safety, many colleagues reported challenges with the operational efficiency of the theatres. These challenges included late starts, frequent overruns, and some lists having fifty percent fewer patients compared to pre-COVID levels.

2.15 From the people the review team met with some said that people came to work to do a good job and, there were a proportion that really enjoyed working in the department despite its challenges, but stated things had got worse over recent years. Some people stated they felt very proud of the work they do. Whilst the reviewers heard about the number of vacancies in the department and that staff are regularly leaving, there were several colleagues that had worked in the department for over 20 years.

2.16 There was a concern about the behaviour across all professional groups in Cardiac Theatres that was not observed in other areas. Despite interventions being implemented to address these behaviours, some persisted. While it is acknowledged that Cardiac Theatres is a stressful and complex

environment with high pressure, it did not appear to be a compassionate place to work. Staff reported that working in thoracic theatres provided a break and a more compassionate environment. Over the years, it has been challenging to recruit and retain cardiac scrub nurses, despite them being all band 6.

3. Leadership and Management Capability

3.1 Clinical Board:

3.1.1 There is a general lack of understanding regarding the role and members of the Surgical Clinical Board. It was suggested that it would be beneficial for the Clinical Board to have a presence in the department, considering the pressures to improve theatre productivity and the current financial constraints affecting staff wellbeing and their sense of being valued. Some individuals expressed similar sentiments towards the Executive Team and indicated the importance of the Chief Operating Officer visiting the department to engage with the team.

3.1.2 In more recent months the Clinical Board Leadership team has been more present in the department.

3.2 Directorate:

3.2.1 It was acknowledged that there has been an unavoidable lack of consistency in the Directorate leadership team over recent years. This has been challenging for all team members and has impacted the service. As a result, individuals have had to cover multiple roles at times, which has been demanding and affected their wellbeing and ability to effectively fulfil their responsibilities. The last period of stable leadership was just before and during the first wave of the Covid Pandemic.

3.2.2 There is lack of role clarity and blurring of roles between the General Manager post and the Lead Nurse. This is mainly due to the reporting arrangements of the Theatre Manager, who is a nurse, to both posts. Operationally to the General Manager and professionally to the Lead Nurse.

3.3.3 The Perioperative Directorate comprises approximately 826.35 full-time equivalent staff and operates with a budget of £60 million. This directorate oversees various units including the Pre-operative Assessment Unit, Sterile Services, Resuscitation Services, Pain Service, as well as managing 39 theatres across two locations: University Hospital for Wales and University Hospital of Llandough. Additionally, it encompasses the Children's Hospital of Wales.

3.2.4 There had been several engagement sessions historically with the General Manager and Lead Nurse in both UHL and replicated in UHW which were helpful and a means for staff to voice any concerns they had. These had stopped with a change in General Manager.

3.3 Department:

3.3.1 There are 9 Clinical Leaders with varying levels of experience and team sizes, with some managing as many as 50 staff members, while others oversee teams with as few as 15 members.

3.3.2 The Clinical Leaders report to the Theatre Manager. They are responsible for the safe and effective running of their Theatre, Anaesthetic Practitioners or Recovery Team. Although we heard that they do not participate in the 6,4,2 process for planning theatre lists, some Clinical Leads believed this would be helpful in the planning of lists, manage expectations and prevent 'overruns' or allow adequate time to staff lists where 'overruns' are anticipated. During the COVID pandemic they were involved in this process but weren't sure why it had subsequently changed.

3.3.3 The time Clinical Leaders spend on clinical versus non-clinical duties varies from 50:50 to 25:75, influenced by historical practices rather than team size. Some leaders take work home due to covering clinical gaps, affecting their non-clinical time. Theatre staff, anaesthetists, and surgeons observed that some Clinical Leaders are not sufficiently visible in clinical settings and should be more present in theatres to monitor standards and behaviour, rather than staying in the office.

3.3.4 The team size and the number of theatres overseen vary among Clinical Leaders, with some managing significantly smaller teams than others. There is no consistent evidence that Clinical Leads routinely perform 'Intentional Rounding' during the day to proactively address patient needs, support staff, and ensure adherence to standardised protocols and safe practices in all theatres.

3.3.5 There was a perspective that over the last few years UHW has taken on additional tertiary and regional responsibilities such as Major Trauma Centre, vascular centralisation, and generally more complex cancer work. However, the necessary resources to support development of the estate (such as a hybrid theatre) or additional staffing have not followed. The reviewers were informed about the challenges related to gaining access to theatre time. This may also affect CEPOD (emergency theatre) lists where semi-urgent cases are scheduled instead of true Category 1 emergency cases.

3.3.6 Theatre efficiency was often a topic of discussion, lists frequently start late, experience challenges with sending for the next patient, and do not achieve effective turnaround times between cases. Frequent overruns were observed, impacting staff well-being and their sense of being valued.

4. UHW theatres leadership structure roles and responsibilities

The current structure was shared see link below.

Copy of Perioperative Care Structure and Meetings Structure v3.xlsx

4.1 It was clear that there was no consistent reporting structure for Theatres. The Theatre Manager reports to the Lead Nurse and General Manger. It was not clear to the reviewers what was reported to the Lead Nurse and what was reported to the General Manager. The lack of clarity in this reporting structure was likely to have been exacerbated by the unavoidable changes in leadership roles and subsequent interim arrangements over the past 3 years. The reviewers heard to have a more consistent approach regular meetings were in place between the Theatre Manager, Lead Nurse and General Manager.

4.2 The Theatre Manager was not at work during the review and despite being made aware of the review chose not to take part. The reviewers were made aware that since the Theatre Manager had not been at work several outstanding HR processes including Work Life Balance requests and Respect and Resolution processes had come to light. These processes had not been escalated to the Directorate Team despite regular meetings. This suggests that the lack of clarity between the three roles possibly resulted in things that should have been escalated weren't. As the reviewers were unable to speak to the Theatre Manager, they are unable to conclude whether this was a deliberate act not to inform, a capability issue or a result of an inconsistent reporting structure.

4.3 The ambiguity of the reporting structures has resulted in a lack of clarity of roles and resulted in the Theatre Manger not following policies and procedures. The reviewers heard that this resulted in staff involved in the outstanding processes experiencing considerable stress, not knowing where to go for help to resolve the issues, which has resulted in not feeling valued, affected their wellbeing and, in some cases, has resulted in people being on sick leave. During the time of the review the Interim Lead Nurse has quickly resolved the outstanding processes, which has resulted in people feeling able to return to work.

4.4 The reviewers heard that the Theatre Manager and Clinical Leads did not demonstrate consistent leadership and management of theatres. There were examples of poor rota practices and no control measures in place for the use and monitoring of overtime. There was a general feeling that the previous high standards of dress code, compliance with health and safety checks and following standing operating procedures were no longer led from the top.

4.5 The role of the Theatre Coordinator is a newly created role within the department and has replaced the Duty Manager role. The Duty Manger role was previously covered by the existing Clinical Leaders on a rota basis. Several surgeons and anaesthetists commented on the improvement in the co-ordination and running of theatres since this role was created. There is a lack of understanding of the role across the practitioner workforce, and this has led to some tensions within the Clinical Lead team, with some actively sabotaging the role. This was not helped by the Theatre Manager not being supportive of the role, a point which was well known in the department and informed the Theatre Coordinator on their first day in the role that they didn't see a need for the role and were not supportive.

4.5 The Clinical Leaders manage teams of varying sizes and workload distribution within their theatres; this disparity appears to be inequitable. The anaesthetic clinical lead role has the largest and a more complex workload, covering the anaesthetic practitioners that work across mains theatre upper and carry the bleep to attend all resus and major trauma calls. In addition, they also manage the scope room. The role of the band 6 staff in supporting the Clinical Leads (Band 7) across the department lacks clarity, with some undertaking management tasks to assist the Clinical Lead while others are engaged entirely in clinical roles. Clinical Leaders reported feeling caught between their team and the Theatre Manager, indicating that they were often unable to make decisions without consulting the Theatre Manager first.

4.6 There is a lack of accountability and ownership which has led to a drop in standards. Anaesthetic rooms are not 'owned' by anyone and consequently as practitioners are not in the same room for days at a time, they are not left stocked and ready for the following day, leading to delays. Cleaning standards have also dropped as has adhering to uniform policies and infection, prevention and control practices. Many people spoke of the 'old school' Matrons who maintained these standards. Many people described this drop in standards but either felt unable to address it or felt it wasn't their place to.

4.7 The Education Team are small for the size of the Directorate, with one Band 7 and three Band 6's covering UHW, UHL and Children's Hospital for Wales. They are well liked but their roles are not clearly understood by everyone with an expectation from some that they should be more visible in the clinical areas supporting new starters and not just managing students and marking coursework. This would be difficult to achieve with the current structure and ways of training. In a similar size organisation, the Education Team was twice the size.

4.8 The roles and responsibilities of the Assistant Service Managers and who they report to is unclear with the Lead Nurse managing their sickness but the Service Manager and Theatre Manager managing operational issues.

5. Team Dynamics

5.1 There is a tension between the Clinical Leaders, perhaps driven by the divide that was created during the COVID pandemic with those that were managing the emergency 'amber stream' compared with those that managed the 'green elective stream'. There is also a divide between those that are supportive of the Theatre Manager and those that are newer in post and perhaps don't have the same loyalty and feel that they were not supported by them. Amongst the Clinical Leaders there is a sense that they will look after their team first rather than what's best for the department and supporting their colleagues, a reluctance to move staff was cited as an example of how they work in silo's.

5.2 There appears to not always be good teamwork between anaesthetists, surgeons and scrub teams with a dynamic of working against each other in relation to sending for patients. With Anaesthetists and Surgeons keen to send for patients to ensure most effective use of the lists with scrub teams perceived as being obstructive at times. On the other hand, the scrub team feel that they are not consulted with, and breaks are not considered. There isn't a sense of a shared vision for the theatre and a shared purpose of why they are there.

5.3 The reviewers heard mixed views from the team around effective theatre utilisation. It doesn't appear that everyone has a shared vision for what they are trying to achieve. There is frustration on both sides about the effectiveness of sending for patients with anecdotal reports of patients waiting for long times in the 'TAL Lounge' which some believe isn't an appropriate environment for patients to wait, while others see that they are waiting regardless of where and that being close to theatres would maintain momentum of the lists and prevent patients being cancelled that are at the end of a list. The number of cases undertaken compared to before the COVID Pandemic was reported on some lists as being almost half.

5.4 Lists often start late which is a frustration for some of the team. The review team were told that the coffee room is busy at the start of the shift, with a perception from some that work doesn't start until there has been a coffee / breakfast break. This may be because of breaks being difficult to take once a list has started.

5.5 The Theatre Coordinator role is Monday to Friday, at weekends there used to be a Theatre Manager on call, this no longer happens and the Band 6 Scrub Practitioner from either CEPOD (emergency) or Trauma theatre carries the phone and keys. This was reported to be very stressful as the band 6 is also clinical.

5.6 After 6pm, the process for sending patients reverts to a paper-based system as reception staff are off duty. The portering team used to work out of the reception area out of hours but this had been stopped as the area was not looked after and there was access to patient records.

5.The volume and nature of work in Trauma and CEPOD theatres were identified as an issue for some, with CEPOD theatres being utilised for semi-elective cases. Trauma and Major Trauma Centre (MTC) theatres operate until 8 pm, with overnight trauma and MTC cases managed by the CEPOD theatre. There were concerns regarding how MTC cases are handled overnight and issues related to the skill mix of the available scrub team. The review team received reports indicating difficulties in supporting surgeons with specific trauma procedures, such as fitting an external fixator or mounting a guide wire,

due to unfamiliarity with the complex equipment required for certain cases. Instances were cited where some cases were postponed until the following morning, affecting the subsequent day's schedule. It was observed that the MTC theatre is primarily used for bony trauma cases, while any general surgical or neurosurgical trauma is handled on the CEPOD lists. This situation has been a source of tension between the two teams.

5.8 The review team heard from several Anaesthetists and Anaesthetic Practitioners that they often work through their breaks leading to theatre policy not being adhered to by drinking and eating in the anaesthetic room.

5.9 Several people shared that Anaesthetic Practitioners are not always in theatre for the whole of the operation, rather spending the time in the anaesthetic room, on their phones. Several people reported they had observed staff watching 'Netflix'. When asked if this was challenged there were mixed responses, but largely it was not addressed at the time. The Clinical Lead was made aware but there was not a visible change in this behaviour.

5.10 There is a notable lack of trust within the department, particularly felt by the Clinical Leaders. Individuals expressed concerns about potential accusations when addressing poor behaviour, leading to a perception of an unsafe environment. Instances of insubordination were reported examples were given included people refusing a reasonable request from a manager, citing work-related stress, and leaving the department.

5.11 Staff have reported concerns about speaking up within the department due to potential negative consequences, such as difficulties with annual leave approval or consideration for overtime opportunities. Addressing inappropriate behaviour, including adherence to infection prevention and control practices, is not consistently enforced. Examples of non-compliance include improper mask usage, failure to follow "bare below the elbow" protocols, and wearing jewellery or nail varnish. These issues were observed across all staff groups, including senior leadership. It was noted that staff felt hesitant to challenge colleagues from different professions regarding adherence to standards, with doctors typically only addressing fellow doctors and nurses addressing fellow nurses. Additionally, there was an impression that Clinical Leaders faced challenges in addressing the scheduling of theatre lists.

5.12 There is a feeling across the department of a lack of confidentiality, examples ranged from reasons colleagues were off sick were well known, details of HR process being shared across departments and with other Health Boards and Private Hospitals.

6.Communication and Engagement

6.1 There was a general view that the staff surveys were used as a way for individuals to target people. That people hid behind the anonymity of the survey. There have also been previous anonymous letters sent to regulators about individuals that caused stress and anxiety without knowing who had made allegations. The reviewers heard that an idea of a 'Suggestion Box' for staff to share improvement ideas was used in a similar way which was not helpful and had to be removed.

6.2 Team meetings for the whole department were not evident to the review team. Audit days are used infrequently for the entire team, including anaesthetists. Positive feedback was received when a

joint session was conducted. It was observed that staff often remained in the coffee room during scheduled audit sessions. For theatre staff, there does not appear to be a formal agenda for audit sessions, and attendance is not monitored. To ensure equal opportunity for attendance, it is necessary to rotate staff so that emergency theatres not stood down for audit sessions are covered by other teams.

6.3 During the review period and following the publication of the Wales Online article, the Chief Operating Officer issued a letter titled 'Private and Confidential' to all team members to update them on the scope of the review. This letter was printed and displayed in corridors, which raised concerns among some staff as they felt that visitors and patients could see it, potentially creating a negative impression. In response to the article and the issues it highlighted, most staff expressed their upset, questioning why someone would go to the press given that many of the identified issues were historical and the review was intended to provide everyone with the opportunity to voice their perspectives.

6.4 Many staff members historically do not have UHB email accounts, so WhatsApp has been adopted as the primary communication tool, resulting in staff carrying phones in clinical areas. Facebook is also used through a closed page to share updates. Some staff members have opted out of WhatsApp and Facebook groups, which means they often miss important communications.

6.5 There is seldom feedback when Datix's are raised and often take a lengthy period to resolve. Equally when things have gone well there is a lack of positive feedback and encouragement given and little opportunity for celebrating success as a team.

6.6 Communication regarding patients' clinical information is not always shared with portering and Health Care Support Worker staff, such as infection prevention and control information not being provided prior to sending for a patient. This can leave colleagues feeling vulnerable and undervalued. There are inconsistencies in the instructions given to teams about following procedures; for example, sometimes patients should not be brought to the department without a signed consent form, while other times colleagues are instructed to bring them regardless. The same inconsistency applies to pregnancy tests. These issues can undermine confidence in the team and create an impression that procedures are optional. This has also contributed to patient safety incidents.

7. Fairness and Equity

7.1 Most people working in the department believe there is no racism and are proud of its multicultural nature. The workforce is diverse across all professional groups, with strong representation at all levels, including leadership roles.

7.2 When the reviewers met with internationally educated nurses who joined the department over the last 4 years, they described how they were made to feel welcome and supported through their induction and generally enjoyed working in the department. Internationally educated nurses who have worked in the department for longer and may have applied for jobs independently rather than part of an organised overseas recruitment programme had differing experiences and, in some cases, less support and reported the perception of being treated differently compared to other colleagues.

7.3 There were several individuals who commented that there had been too much overseas recruitment and that there could be misunderstandings and differences in roles and responsibilities compared to where people had worked previously. However, how this manifested was in some cases inappropriate and disrespectful and should be managed through UHB policies and processes. There

were also comments about internationally educated nurses not speaking English in shared spaces which left others feeling uncomfortable and may be confusing for patients.

7.4 Some colleagues chose to address the allegations reported in the 'Wales Online' article regarding the ‘suspension’ of a staff member who allegedly commented that a group of Indian nurses required name badges because they "all looked the same." It was acknowledged that inappropriate and racist remarks had been made, with some individuals noting that these issues had been addressed. Most people who chose to discuss this did not consider the individual in question to be inherently malicious, suggesting that the comments might have been taken out of context and perceived as 'banter’. However, such behaviour does not align with the UHB's values and expectations for conduct, particularly for a senior leader. Initially, this incident was managed informally, and it required an anonymous letter to prompt a formal investigation.

7.5 At the Clinical Lead (Band 7) level there is diversity although how colleagues are supported and developed for senior leadership roles was not always clear to the reviewers.

7.6 The review team received feedback from certain groups expressing concerns regarding perceived favouritism toward certain nationalities. Specifically, the allocation of overtime appeared to some individuals to be influenced by whether they shared the same nationality as those responsible for assigning the overtime.

7.3 There are work life balance arrangements in place for some that are generally long-standing agreements. Whereas for others there is an understanding that they won’t be agreed so there is little point in submitting a request. Examples were shared where people had chosen to leave the department because reasonable requests to accommodate childcare arrangements could not be supported. There were also examples shared where work life balance requests were handled badly and without compassion and in some cases, this resulted in a period of absence due to the stress and anxiety caused by the process.

7.4 There appears to be limited flexibility for staff to attend short notice medical appointments once rotas are finalised, due to the need to ensure lists are covered. As a result, some staff choose to take sick leave for the day rather than negotiate a shift change. In some cases, this leads to individuals taking a week off instead of one day, as they believe it will be treated as a single episode - “so may as well take the week”.

7.5 There is a perception that sickness is not managed effectively by both managers and the team, who feel that HR advice is not always sufficient, placing the responsibility on managers to use discretion. Some individuals mentioned inconsistency in applying the policy, leading to perceived inequity. People with experience in other public and private organisations noted that sickness management in those settings was policy-driven, ensuring fairness and clarity in processes, with access to appropriate support. This was contrasted with their experiences in Theatres.

7.6 Staff express concerns about feeling obligated to stay when a list is overrunning, despite external commitments. There is often insufficient support from other parts of the department during these times. Conversely, when lists finish early, staff are not allowed to go home early and may spend time in the coffee room until their shift ends.

7.7 The reviewers observed ambiguity in the distinction between Band 2 and Band 3 Theatre Assistants (TAs). While it was explained that Band 3 TAs are responsible for training new staff, it was noted that the individuals conducting this training may not possess appropriate behaviour despite their extensive experience. Additionally, it was identified that some Band 2 TAs were involved in cascade training.

There appears to be an overlap in responsibilities between Band 2 and Band 3 TAs, which may result in Band 2 TAs feeling undervalued.

7.8 The review team heard about the good opportunities for development from some of the registered staff within the unit including how they had been offered secondments.

7.9 There is a perception that nurses have easier access to training compared to Operating Department Practitioners (ODPs). While internal management of training opportunities is consistent, obtaining funding for ODP training from Education Culture and Organisational Development poses additional challenges for the Education Team.

7.10 Rostering practices identified that certain rotas were not compliant with working time directives. Examples shared with the review team included regularly working more than 37.5 hours a week, limited rest time between day and night shifts, and an over-reliance on overtime to fill rotas. Additionally, there were occurrences where shifts had been altered after the roster was published without consultation, leaving staff feeling undervalued and expecting flexibility that is not reciprocated when they need to change shifts.

7.11 Theatres regularly used overtime before new scrutiny measures were implemented. The review team found that the approval and allocation process for overtime was unclear. Despite a monitoring system within the Directorate and monthly overtime reports required from Theatre Managers to the General Manager and Lead Nurse, compliance was not achieved in Mains Theatre Upper despite reminders. The reviewers are uncertain if this was due to capability issues or a deliberate decision to not adhere to UHB policy and procedures.

7.12 The responsibility of carrying the bleep within the anaesthetic practitioner workforce can be assigned to either band 5 or band 6 practitioners. In other UHBs, this role is typically performed by a band 6. The review team noted that this role can be demanding both physically and mentally. Staff often miss hot and cold debriefs as they difficult to attend around their responsibilities in theatre and may not receive follow-up support after a challenging day.

8. Staff Turnover

8.1 There were varying perspectives on the reasons behind staff departures from the department. Some individuals believe that there is a lack of career progression within the department, prompting people to seek employment at other University Health Boards (UHBs) where the work is perceived to be less complex and demanding. It appears that the only Band 6 roles available within the department are managerial positions (Deputy Clinical Leaders) or roles within the Education Team, as opposed to clinical Band 6 roles available at other UHBs. This situation is not new, and it was unclear to the reviewers whether this accurately reflects the wider context across Wales. Theatre staff in a similar sized English Trust have reported similar issues with retention and career progression. They created additional Band 6 post which resulted in people feeling there were limited opportunities for advancement to Band 7. Therefore, pay and banding do not appear to resolve retention problems.

8.2 At the University Hospital of Wales (UHW), additional Band 6 posts were supported by the Directorate leadership team across the theatre suites, and 10 additional posts were advertised. However, it remains unclear whether these measures had any impact on retention. Notably, when these positions were advertised, no external candidates applied.

8.3 Staff recruited through student streamlining often leave after fulfilling their 2-year commitment to return to England. This issue is not unique to theatres or Cardiff and should be considered in workforce planning.

8.4 Staff members were leaving due to their work-life balance requests not being accommodated. Internationally educated nurses were informed by the recruitment agency that 12-hour shifts would be available, which is currently not the case. The review team learned of the challenges staff face in arranging childcare due to the shift patterns, yet a formal work-life balance request had not been submitted as it was perceived that the response from the theatre manager would be negative, leading to a view that making such requests would be futile.

8.5 A review of staff turnover data indicates a fluctuating pattern, with a current downward trend. Turnover rates range between 8-14%, which is higher than the average for the UHB (8.95% target is between 7-9%). For band 5 roles, turnover reaches up to 20%. Theatres Trend of Turnover.xlsx

8.6 Very few staff have completed exit interviews in recent years. From the ten exit interviews conducted between September 2023 and the present day, it appears that people left for better work opportunities, such as higher pay, better work-life balance, and more training opportunities. Other reasons included retirement, relocation, pursuing education, and career changes. When asked what might have influenced them to stay, staff indicated that improved management and support, including more understanding management and assistance when needed, as well as more flexible working opportunities, would have been beneficial. Additionally, an increase in pay or enhanced career progression opportunities might have influenced decisions to remain. Some respondents also cited improved working conditions, such as better changing facilities and a staff room.

8.7 The high turnover rate among Anaesthetic Practitioners has raised concerns regarding competence. Specifically, new staff members are often inducted by junior staff who may not possess the same level of experience as their predecessors. Anaesthetic colleagues reported to the review that the absence of experienced people is significantly felt, leaving them feeling vulnerable or exposed.

8.8 ODP training encompasses all aspects of theatre work. However, upon starting at Cardiff and Vale, they must choose a specific area to focus on, resulting in the gradual loss of skills in the other areas. Maintaining these skills could provide flexibility to support colleagues during breaks and cover over runs and opportunities for career advancement. The practicality of gaining and maintaining competence in multiple areas would need further exploration for both ODP and nursing staff.

8.9 The reviewers met with a Senior Nurse from University College London Hospitals NHS Foundation Trust (UCLH), who has also participated in the NHSE Theatre Staffing Review. He shared the UCLH Strategic Workforce Plan for Theatres, which outlines the approach to training, retaining, and reforming the theatre workforce for the future. He detailed a phased strategy to modernise the workforce, including training staff to work across the specialist areas within the Perioperative Directorate i.e. scrub and anaesthetics or recovery and pre-assessment. This has created training opportunities, promoted career progression, and ensured flexibility. This initiative aims to make staff feel valued and encourage them to remain within the Trust rather than seek external opportunities, thereby reducing reliance on temporary staff and minimising short-notice cancellations.

8.10 Several colleagues indicated to the review team that there is insufficient psychological support. Efforts such as the TRIM program are being implemented, but challenges persist in this area. Coordinating hot debriefs is often challenging, and organising cold debriefs is even more difficult, particularly when trying to gather colleagues across professional groups, especially if some staff do not have email addresses. There was an opinion that additional investment in psychological support is required. There was inconsistency regarding when staff were checked in on after incidents or emotionally difficult cases. The use of simulation training was suggested to replicate emotionally challenging situations and discuss them, which is not currently implemented within the department.

9. Patient and Staff Safety and Experience

9.1 A significant number of people the review team spoke to report that what they have experienced at work over a protracted period has had a profound and negative effect upon them. Culture and its relation to patient and clinical safety is paramount. The culture within Mains Theatre Upper is not safe, it is not an open and transparent safety culture where people all feel able to speak up freely and are respected and valued.

9.2 During the review period, the reviewers were informed of several Nationally Reportable Incidents (NRIs) that occurred in the Main Theatres Upper. Recognising the influence of culture on team collaboration and patient safety, the reviewers requested the patient safety team to summarise the themes from these incidents for consideration as part of the review.

9.2.1 The effectiveness of adhering to the 'WHO Checklist' at all stages and determining who is responsible for its completion was questioned in several incidents.

9.2.2 Reviewers learned from colleagues that application of policies and procedures frequently change, causing confusion and non-compliance. For instance, patients sometimes leave the ward without a signed consent form or a current pregnancy test. During the review, two incidents occurred where patients went to theatre without a signed consent form.

9.2.3 Several NRIs highlighted insufficient challenging of poor practices within the theatre environment. It was noted that a lack of leadership in motivating staff to address sub-optimal practices, while not directly contributing to patient incidents, was identified during investigations. It was found that estates issues were not escalated to the Clinical Board.

9.2.4 One NRI identified there was no standardised practice for measuring bowel and that the paper ruler used was not added to the count.

9.3 The review of Datix incidents indicates that most were low harm; however, there is some concern about the robustness of incident management and actions. This may be related to the time available for incident managers to thoroughly review and take preventative actions in their areas. There was a vacancy in the Governance Lead post for six months, resulting in a backlog of incidents. The current Governance Lead is new to the position and is working hard to get on top of incidents. However, the quality and safety of the department should not rest with one person and the management of incidents and subsequent preventative actions should be managed more locally.

9.4 The department's repair and cleanliness standards are below what is expected for a modern theatre suite. There are significant delays in fixing leaks and essential equipment. Poor theatre lighting in some theatres makes operations challenging, while cluttered corridors highlight insufficient storage. Leaks in corridors may reduce patient confidence. People shared that there had been several occasions when pigeons were found in trauma theatre or on the theatre corridor. An infection outbreak in one specialty triggered Infection Prevention Control (IPC) audits, revealing issues with theatre practices.

9.5 The changing rooms currently require repairs. During the review, one of the three toilets in the female changing room was found to be out of order. There is no designated quiet area for private conversations with staff. The coffee room needs improvement in cleanliness and maintenance, as it contains broken chairs and the fridges are not properly maintained and are described as unclean.

9.6 Reviewers received copies of 'Tendable' audits from the theatre suites. Only one Infection Protection Control audit has been completed for Mains Theatre Upper since early 2025. Audits are typically completed by the Education Team or Theatre Managers. Reviewers were unclear about the Clinical Leaders' role in auditing, possibly due to their heavy clinical workload.

9.7 The reviewers heard that paediatric patients are recovered in main adult recovery areas, out of hours and for some elective cases such as neurosurgery despite having a theatre suite in Children's Hospital for Wales. This was not raised as a concern by the recovery staff, but some surgeons were uncomfortable about this arrangement, and it is not compliant with best practice guidelines. Chapter 10: Guidelines for the Provision of Paediatric Anaesthesia Services 2025 | The Royal College of Anaesthetists

9.8 Several IT systems are involved in a patient's pathway through theatres, and instances of duplication that could lead to errors were identified. The department's lack of IT equipment can cause delays in printing and delivering post-operative notes to recovery. There have been cases where patients returned to wards without receiving printed post-operative notes.

9.9 Some individuals have raised concerns about the use and functionality of 'Theatreman'. The system has been described as difficult to update in real-time regarding theatre attendance. Certain specialities use 'Bluespier', which provides additional functionalities such as operation notes, audit capabilities, and PROMs. This results in duplication with 'Theatreman'.

9.10 There were reports of old, damaged, and rusty equipment across the department. Additionally, there were instances where there was not sufficient equipment for all theatres, and staff frequently had to search for necessary equipment. Stock levels are not maintained; there are no minimum or maximum stock levels, leading to shortages of basic equipment including scrubs. The light in theatre 5 is outdated and inadequate for the work performed, requiring the use of mobile lights to supplement the main light. Although a maintenance request has been submitted, there is no clear timeline for its replacement. The process for obtaining new equipment appears to be lengthy, with examples such as a surgeon requesting a set of retractors for over 3 years without clarity on why they have not been purchased or who is responsible.

9.11 There is variation across the anaesthetic rooms making it more difficult to find equipment and drugs when working in an unfamiliar theatre.

9.12 There is currently no suitable waiting area for families who need to attend theatres. Additionally, the room designated for delivering sensitive news is inadequate for its intended purpose.

9.13 The initial training program for nurses within the department has been characterised as demanding, with minimal dedicated study time and predominantly self-directed learning. The Agored Cymru postgraduate training was developed by the Clinical Lead for Education due to insufficient support and funding for commissioning a Level 7 perioperative care module in Wales run by a Higher Education Institute (HEI). This training is designed to enable nurses to work as anaesthetic practitioners, with modules also covering scrub and recovery. The program is self-directed, utilising a workbook with competencies that require sign-off. There is concern that nurses with additional learning needs may not receive adequate support. It is also noted that the Agored Cymru training for nurses working in anaesthetics may be non-transferable to other University Health Boards (UHBs).

9.14 The reviewers have observed that neighbouring UHBs do not employ nurses in the anaesthetic practitioner role due to the absence of post-graduate qualifications necessary for developing anaesthetic skills in line with the British Anaesthetic and Recovery Nurses Association. (UK Training

Courses - British Anaesthetic & Recovery Nurses Association). Nurses are supernumerary for 6 months while they complete the training, whereas Operating Department Practitioners (ODPs) typically have a 3-month supernumerary induction period. The education team marks the workbooks, but there is no agreed marking scheme across all the modules. Colleagues noted that signing off competencies can be challenging when not supported by an assessor with the appropriate level of experience. Some members of the Education Team have received support to complete postgraduate qualifications in education, although funding this has been difficult. There is limited opportunity for classroom-based learning or simulation training, which would be more accessible if the course were delivered by a HEI.

10. Theatre Efficiency.

10.1 The review team received feedback from colleagues about inefficiencies and redundancies in theatre schedules. Various delays were identified at the start of lists due to patients not being on the correct ward or ready, insufficient theatre porters to collect patients, theatres not being prepared, and some colleagues arriving late. There is interest in adding additional lists; however, due to current vacancies in practitioner roles, it is recommended to review current start and finish times before considering additional lists.

10.2 Managing overruns is often challenging. Some are anticipated and can be planned for, relying on staff to work additional hours. Unexpected overruns pose difficulties for the team, especially when they have pre-existing commitments outside of work. There is limited flexibility in the system to cover these situations. It is recommended to review start and finish times to identify consistent overruns and inefficiencies, so that shifts can be scheduled appropriately to cover the lists.

10.3 There is a perception that in certain lists, there is a lack of proactive measures to call the next patient. Additionally, when requested to do so, some colleagues are perceived to act in a manner that intentionally delays calling the next patient. With reports that sometimes colleagues ‘go missing’ or collecting stock can take an overly long time

10.4 The reviewers heard that around 15:00 there is hesitation to send for a patient due to concerns about the list over-running. The discussions that ensue about whether the patient could be sent for also contributes to the delays.

10.5 The number of recovery bays is insufficient for the number of theatres, causing delays in starting the next case. Additionally, there are delays at the end of a list, resulting in Anaesthetists having to recover patients due to the unavailability of a Recovery Practitioner. There is a draft procedure that outlines when and how one recovery practitioner can care for two patients appropriately, but the reviewers were unsure if this had been implemented.

DRAFT The procedure for effective staffing resources.docx

10.6 Clinical Leaders are not involved in the 6,4,2 process of scheduling which may make staffing lists more challenging. How Rosters are populated may not always align with the 6,4,2 process, potentially leading to shifts being changed after the roster is published. A 'back-to-basics' approach was suggested to ensure safe staffing for theatre lists, which might result in list closures.

10.7 The workload of Porters varies throughout the day. A dual role involving Health Care Support Workers (HCSW) in recovery was initially explored but lacked adequate support before implementation. Staff felt that the planning was insufficiently thorough, and consequently, they were

asked to choose between the two roles after a brief period. This dual role functions effectively in Lower Mains Theatres.

11. Conclusion

Over the past few years, there has been a systemic failure within the Mains Theatres Upper Leadership Team, Perioperative Directorate and the Surgical Clinical Board. The focus on improving theatre efficiency without adequately understanding the underlying culture within Mains Theatre Upper has negatively impacted staff and patients. This has resulted in a culture where behaviour does not align with Health Board values and falls below accepted moral and ethical standards. Some colleagues have expressed disappointment and frustration with this prevailing culture but feel unable to effect change.

The department is staffed with highly skilled, experienced, and knowledgeable individuals. There are, however, concerns regarding the potential loss of this valuable expertise. The specialisation of roles in scrub, anaesthetics, and recovery has led to a lack of workforce flexibility. The size of the department makes fostering a cohesive team culture with a shared purpose challenging. While some scrub and recovery teams have successfully established such a culture, it remains inconsistent across the entire department.

There have been multiple opportunities where concerns have been raised to the Executive, Surgical Clinical Board, Perioperative Directorate, People and Culture and Staff Side where people have failed to act. When staff surveys and HR processes have been undertaken and action plans implemented there has been a lack of oversight on how these were being managed and staff in Mains Theatre Upper report no discernible difference in the culture. This has resulted in a lack of confidence and trust with leadership and management and a feeling that there is no point raising concerns as they will not be acted on or raising concerns outside of the management structure, for example anonymous reports to regulators.

There is an overwhelming feeling that the Theatre Manager and some of the Clinical Leads are unfair and inequitable in how the department has been lead / managed. Issues are not routinely escalated to the Directorate Team. There has been a failure to follow policies and procedures which has enabled behaviours to go unchecked, and this has resulted in a breakdown of trust within the team and towards management. This has led to people feeling let down and unsafe within the workplace. There is also a lack of leadership capacity and experience and therefore managers of the department are not equipped to manage the longstanding behaviours and culture within the department. There is a lack of clarity in the leadership structure, with multiple reports. Both the Clinical Leads and the team express feeling unsafe and there is a breakdown of trust within the team.

The culture and environment people have experienced at work over a protracted period has had a profound and negative effect upon them. Culture and its relation to patient and clinical safety is paramount. The culture within Mains Theatre Upper is not safe, it is not an open and transparent safety culture where people all feel able to speak up freely and are respected and valued. This has had an impact on patient safety with several Nationally Reported Incidents occurring in Mains Theatre Upper within the last year.

Colleagues do not feel that their work is valued within the Perioperative Directorate or the wider organisation. People rarely visit the department so there is a disconnect between theatres and the rest of the hospital.

The department is under substantial pressure to deliver, particularly since the end of the pandemic. There has been a significant focus on what was being delivered rather than on how this was being achieved.

A leadership restructure is necessary to define roles and responsibilities clearly. It is important to allocate time for audit and training to support staff development and feel valued. Clinical leaders require the same protected supervisory status as their counterparts in wards, ensuring they are visible throughout the theatre suite.

Investment in training, including the Education Team, is necessary to develop a workforce that can work flexibly across the theatre suite and maximise Operating Department Practitioner expertise and training. A strategic vision for education and training within the directorate and improved links with HEIW and HEIs is essential to develop postgraduate courses that could support staff retention.

To re-build trust within the team a great deal of support and oversight will be required from the Surgical Clinical Board, Perioperative Directorate, People Services and Staff Side. A trauma informed approach should be considered with the support from a psychologist. To change culture will take time and engagement from all involved. The team will need to play a significant role in this, but strong and consistent leadership will be needed.

12. Recommendations

1. Values and Behaviours
    a. Some individuals' values and behaviours need to be managed via UHB policies and procedures.
    b. Share the HCSW code of conduct to support individuals to be aware of the code.
    c. To share with colleagues how to raise concerns internally, share 'Speaking Up Safely'. Consider support from HCPC and NMC on culture, the code and when to report to the regulator.
    d. Cultural action plan and programme of delivery to be developed by the Clinical Board with support from People and Culture including the Education, Culture and Organisational Development Team to improve the culture, trust and psychological safety within the department.
    e. Consider support from a psychologist on a substantive basis to support colleagues through trauma informed approach in a similar way to that of critical care and major trauma. Further roll out of TRIM
    f. Adherence to values and behaviours of the UHB and consequences for those that do not. Support for the team to feel safe and confident to challenge when values and behaviours are not in line with what is expected.
    g. Celebrate success - feedback to the team when they receive positive feedback.
    h. Explore security options to make the female changing area a more secure place to leave belongings.
    i. Investigate measures to ensure sufficient availability of scrubs for staff who require them, preventing access by colleagues not assigned to the theatre environment.
    j. Focused programme of work to address the culture in Cardiac Theatres and develop leadership capacity and capability required to tackle poor behaviours.

2. Leadership & Management Capability
    a. Radical restructure of the practitioner role across the department and the wider Directorate to provide flexibility across the suite and have a multi-skilled workforce to provide a sustainable and resilient service. Similar to the work undertaken by University College London Hospital.
    b. Conduct a comprehensive review of the Directorate and departmental leadership and management structure, including the Clinical Lead workforce and the Education Team, to ensure clarity in roles and responsibilities within the management team. Benchmark with equivalent sized services.
    c. Offer a comprehensive leadership and management development program, along with a support package for the current leadership team in Mains Theatre Upper, to strengthen their ability to implement cultural and behavioural changes throughout the department. This will encompass leadership training focused on compassion.
    d. Review expectations and competencies for the clinical leaders, set clear expectations of the role and support them to manage. Identify areas where there may be capability issues and implement targeted programs to address these gaps.
    e. Define the expectations for Clinical Leads regarding the allocation of time between clinical and non-clinical duties. Investigate how supervisory status could be structured and the appropriate use of this time, such as participating in 'intentional rounding', providing team support, teaching, management of clinical incidents including DATIX, ensuring breaks are taken, and performing audits using the 'Tendable' platform.
    f. Improved visibility of the Directorate and Clinical Board Management team within the department including attendance at audit sessions.
    g. Ensure the effective utilisation of audit sessions by having meaningful activities planned for all team members who are scheduled to work. Attendance should be mandated.
    h. Sickness panels supported by People and Culture colleagues, to be conducted to ensure consistent approach, with regular attendance by clinical leads or deputies.
    i. A senior advisor from people services should be allocated to theatres to provide consistent advice for the leadership team.
    j. Explore collective leadership training. There is evidence to suggest that traditional hierarchical leadership model is clearly failing in healthcare. It is becoming increasingly evident that the interdependencies in healthcare require more collective leadership. To have a more inclusive approach to leadership, one that is typified by shared responsibility and accountability and a focus on collective impact rather than individual achievement.
    https://www.ucd.ie/collectiveleadership/
    https://www.ucd.ie/collectiveleadership/resourcehub/toolkit/

3. UHW Theatres Leadership Structure Roles and Responsibilities
    a. Appoint substantively to provide stability in team.
    b. Review of the workload of the clinical leaders to assess the feasibility of making them supervisory in line with their ward-based colleagues. Share with the team what is expected of the Clinical Leaders in their non-clinical time.
    c. Clearly define roles and responsibilities and ensure accountability for fulfilling them across the workforce. Consider developing a training needs analysis to support the development of all staff.

d. Ensure the competency framework for clinical leaders is current and accurately reflects the requirements of the role, providing a clear pathway for their development.
e. Review the Education Team structure and workload. Work with HEIW and HEI to develop and commission Level 7 post graduate qualification for Perioperative Care Module to support the development of a multi-skilled theatre practitioner workforce. Benchmark with other units, such as University College London Hospital.

4. Team Dynamics
   a. Support the Clinical Leaders work collaboratively to ensure the safe operation of the department, under the supervision of Mains Theatre Upper Theatre Manager.
   b. Review the role of the Education Team and develop clear purpose, roles and responsibilities to be communicated across the Directorate.
   c. Evaluate the balance between flexibility across the suite and the advantages of having a discreet team. Consider a comprehensive re-evaluation of the roles and functions of scrub, anaesthetics, and recovery teams. Additionally, explore the potential for leveraging the skills from across Cardiothoracic Service to support cardiac theatres.
   d. Review how the theatre manager/ coordinator role is covered at weekends and whether this should be a role that is supervisory.

5. Communication & Engagement
   a. Implement regular team meetings for all staff to improve communication and engagement
   b. Consider reinstating the General Manager /Lead Nurse drop-in sessions on a regular basis
   c. Regular meetings with General Manager, Lead Nurse and Theatre Manager with set agenda
   d. Regular meetings with General Manager, Lead Nurse, Theatre Manager and the Clinical Leaders
   e. Consider implementing the use of team briefs across the entire suite to enhance teamwork. This approach could be beneficial in celebrating successes, addressing concerns such as the impact of staff sickness in specific areas, and checking in with staff, particularly following challenging cases.
   f. Verify who has UHB email accounts and ensure that all individuals have access. Consider alternative methods of mass communication, such as Theatres SharePoint Site, Viva Engage or Teams channels, instead of relying solely on WhatsApp.
   g. Provide colleagues with the necessary clinical information about patients that is pertinent to their role for maintaining safety of both staff and patients.

6. Fairness & Equity
   a. Conduct a comprehensive review of rostering practices, including an analysis of shift times and their correlation with late finishes, late starts, and early finishes. Specifically, assess the feasibility of implementing 12-hour shifts within the Recovery Team.
   b. Promote a culture that supports colleagues in managing their work-life balance. Review all current work-life balance requests in accordance with the needs of the service to ensure appropriate coverage on all shifts.
   c. Review process for how ODP's can access Advance Practice Training in line with Nurses, AHPs and Health Scientists to support development and training.

d. Review the roles of the Band 2 and Band 3 Theatre Assistants, clearly distinguishing between them. Identify opportunities for Band 2 development within the department.
e. Review how the anaesthetic practitioner workforce supports the resus team and major trauma calls and what skill set is required to support.

7. Turnover
   a. Explore use of 'stay' conversations to help with retention and encourage the completion of exit questionnaires/ interviews
   b. Assess the training and induction processes for Operating Department Practitioners (ODP). Identify how training can be effectively utilised to ensure proficiency in multiple roles, such as scrub and anaesthetic positions. Conduct benchmarking against other centres to gain insights into the practical application of dual roles.
   c. Protect study days and audit sessions.
   d. Compare the roles and responsibilities and number of band 6 roles in other organisations of similar size and complexity and share the findings with the team.

8. Patient and Staff Safety and Experience
   a. Audit adherence to policies and procedures for consent and 'WHO Checklist', ensure standardised application across all theatres and provide update training as required.
   b. Examine the management of paediatric cases operated on in Mains Upper and determine whether the current arrangement of recovery in the adult recovery area aligns with the Royal College of Anaesthetists' Guidelines (Chapter 10: Guidelines for Provision of Paediatric Anaesthesia Services 2025). Assess the measures taken to safely manage children. Investigate what is required to fully utilise Children's Hospital for Wales to ensure that paediatric cases are operated on and recovered within Children's Hospital for Wales.
   c. Conduct an equipment stock take and set up a replacement program with support from Clinical Enginering. Strengthen and develop the role of the Medical Devices Safety Officer within the Directorate.
   d. Clinical Directors of each Surgical Specialty to collaborate with Theatres to standardise surgical equipment and devices where feasible and safe. With assistance from procurement, establish minimum and maximum stock levels to ensure essential items are always available, use 'Scan for Safety' to manage stock efficiently and maintain traceability of consumables.
   e. Create standard operating procedures for the setup and standardisation of anaesthetic rooms throughout the department, where feasible.
   f. Consider wider use and implementation of 'Tendable' to monitor compliance against standards and procedures including use of PPE. This would give more oversight to the Directorate and Clinical Board. IPC colleagues, Clinical Board Director of Nursing, Directorate Lead Nurse and Decontamination Lead to support ad hoc patient safety walk arounds and audits against standards.
   g. Regular training should be carried out to ensure that all staff maintain skills and competencies. This needs to include night staff.
   h. Standard Operating Procedures and schedules for the theatre deep cleaning rota, including weekend protocols that are standardised across all theatre suites

i. The family room requires refurbishment. Explore options for charitable funding to improve the environment for relatives waiting. This space could also be used for staff to pray or take some quiet time when not in use.
j. Charitable bid to the Staff Lottery Fund to refurbish the staff room, including new furniture, fridges and a dishwasher.
k. The cultural and leadership work will help to strengthen the team to feel safe and empowered to speak up and challenge where policies and procedures are not followed.
l. Review the IT systems in use across the theatre pathway and assess if they are fit for purpose, explore what it would take to get one system used by all to avoid duplication.
m. Review training on offer for new starters is the course transferable and does it cater for all learners. Explore working with HEI's and HEIW on commissioning a post graduate level 7 perioperative care module.

9. Theatre Efficiency
    a. Review the start time of the theatre day and how staff are allocated. Ensure that all team members are responsible for patients arriving in the department on time. Consider using the recovery area in the morning for patients to wait before surgery. Consider if Theatre Assistants, Healthcare Support Workers and Recovery Practitioners can assist in collecting patients from the wards.
    b. Review reinstating the dual role of porter / HCSW.
    c. Identify consistent overruns and inefficiencies and review rosters to plan shifts for late finishes.
    d. Conduct a review of theatre utilisation and compare it to pre-COVID levels. Identify the reasons for any differences, determine the expected downtime between cases, and establish a reasonable number of cases to include on a list in line with best practice standards for cases per session and GIRFT (Getting it Right First Time). Share this analysis with the team to ensure that expectations are clearly defined.
    e. Explore how all theatres can work collaboratively to support efficiency including how Children Hospital for Wales is staffed on weekends and bank holidays.
    f. Review the draft procedure for effective staffing resources and implement to help support the handover of patients to recovery practitioners to minimise delays at the end of lists
    g. Clinical leaders to be involved in scheduling of lists to aid roster management. Explore how the publishing of rosters could align to the 6,4,2 process
    h. Review provision and access to computer and printers across the suite to support efficient working.

Emma Cooke, Executive Director of AHPs, Health Science and Community Development

Helen Luton, Director of Nursing for Clinical Diagnostics and Therapeutics Clinical Board

Report Title:	Care Provider Fee Uplift Required for 2025/26			Agenda Item no.	7.4
Meeting:	Board	Public	√	Meeting Date:	29 May 2025
		Private			
Status *(please tick one only):*	Assurance		Approval √	Information	
Lead Executive:	Executive Director of Finance / Executive Director of Nursing				
Report Author (Title):	Assistant Director of Finance (PCIC, MED, MH) & RPB				

Main Report
Background and current situation:

Background

The Health Board maintains commissioning responsibility for patients placed in care packages who meet the key Continuing Healthcare (CHC) criteria that the primary reason for a placement or package is a health need. CHC requirements are underpinned by key legislation and case law.

CHC can be provided in any setting outside hospital, such as in a person's own home, in a care home, hospice or in a prison and is part of the continuum of care and support that an individual with complex needs may move in and out of. Packages cost the UHB circa £100m in expenditure per annum, managed across PCIC, Mental Health and Children & Women Clinical Boards.

The significant contribution that health and social care providers make to ensure the health and well-being of vulnerable people in our community is recognised. The Health Board has always sought to maintain positive working relationships with providers and to ensure that they are supported as best as possible within the resources available.

Each year the UHB provides an uplift to the weekly fees of ongoing and new placements to recognise the increasing costs of provision, including pay and non-pay inflation. Historically, this has followed the line of passing on general uplifts received from Welsh Government in the main Allocation Letter. In recent years, the UHB has also had to respond to commitments made by Government even where explicit supporting funding has not been allocated.

The Local Authorities (LAs) and the UHB liaise over the approach to fee setting via Regional Commissioning Board discussions. The long-term aim of each of the Cardiff and Vale commissioners remains moving toward a joint approach to the commissioning of care and support services. Whilst it is recognised that there are different practices, processes and structures in each organisation, commissioners continue to work together to share information and discuss their position in relation to fee uplift requirements.

Applying the same percentage uplift to the whole sector, regardless of the rates paid for specific care packages, may not always be appropriate as a result of differing settlements with Welsh Government. As such, individual partners may apply a differential uplift where they consider that to be appropriate.

The lead around price uplifts varies subject to the package and commissioning arrangement between the UHB, the LAs and NWJCC (CCAPS). Historically, prices set by each partner have been accepted by other partners in terms of their contributions.

Welsh Government Code of Practice and Engagement

In 2024/25, Welsh Government published a new code of practice to underpin a national framework for commissioning care and support. This was issued under section 145 of the Social Services and Well-being (Wales) Act 2014 and came into force September 2024.

National framework for commissioning care and support: code of practice

- The Code of Practice sets out in Standard 7 the requirement to work collaboratively to understand fair and sustainable costs of delivering care to inform decisions relating to fee setting.

- Standard 7 & 8 refer to transparent and consistent approaches when setting fees, ensuring that they are assessing fair and sustainable costs of care and ensuring public value.

- Contractual uplifts must include appropriate inflation mechanisms to keep pace with rising costs and ensure flexibility in financial regulations to meet specific needs.

- Standard 8 also requires statutory partners to confirm their fee rates to providers before the start of each financial year.

- Statutory partners should, where appropriate, including through the RPB, pool resources to enable effective delivery of shared plans.

In planning for 2025/26, a series of engagement meetings to discuss fee setting and to hear about some of the key challenges and concerns facing providers were held. This was done in parallel to work undertaken by the LAs to assess cost of care changes. Issues highlighted included, for example, RLW costs and competitive pay increases, the impact of employers NI, Return on Capital Employed (ROCE) and the need to continue investing to modernise care homes (e.g. Digital).

The UHB has advised providers on a potential fee uplift position in advance of April, but noting this was subject to the financial plan and due governance.

Real Living Wage

The CHC uplift must now consider one of the key pledges in the Welsh Government's Programme for Government; to pay social care workers in Wales the Real Living Wage (RLW). The RLW rate for Wales effective from 1 April 2025 is £12.60, an increase of 5%.

The RLW is an important step in not only recognising the vital role of social care workers in Wales but also addressing the challenging recruitment and retention issues and pressurised working conditions within the care sector.

The commitment from WG is to fund the difference between the Real Living Wage and the National Living Wage in social care, as set out below:

Implementing the Real Living Wage for social care workers in Wales | GOV.WALES

WG have advised that the funding of this policy will by definition be non-recurrent, as the gap between the rates will be assessed each year. This was initially set out in the 2024/25 Allocation letter – "Funding for the Real Living Wage (the impact of the policy on Social Care) will be dealt with as a non-recurrent allocation, addressed in year."

Whilst settled in the prior year, there remains some uncertainty around the RLW allocation assumptions in the UHB 2025/26 position and financial plan which should be noted.

The calculation of the RLW and the impact to providers is complex. There has not been a fully open book approach between the Health Board, Local Authorities (LAs) and care providers to determine rates of pay etc. but a weighted uplift has been assumed within the below proposal consistent with 2024/25.

Employers' NI

The impact of both the employers' NI rate increase (1.2%) and also the threshold change to £5,000 is a largely unavoidable inflationary cost for providers. There is precedent in considering this cost in the uplift assumptions and Local Authorities have also recognised it in their provider offer letters. There has been no explicit WG funding to support the impact of employers' NI on commissioned services at this point. Assessments will vary by provider, depending on their workforce structures and pay arrangements, but a weighted uplift has been assumed within the below proposal.

Wider Context

The UHB faces a significant financial deficit and must balance overall financial and operational risks, whilst meeting WG policy expectations. Quality, Improvement and Efficiency Plans (QIEP) continue to develop across Clinical Boards, seeking to manage the growing CHC demand and cost base. It is important to note that these plans need to run in parallel to uplift mechanisms, working in partnership with care providers over difficult choices whilst ensuring robust commissioning arrangements and value.

Proposal

It is proposed to offer care providers a **6.4% uplift** on UHB-led packages. The assessed financial impact is **£6.1m**, subject to demand, which is fully provided for in the current UHB financial plan. The proposed uplift aligns closely to the LA uplifts with consideration of RLW, CPI and Employers' NI implications.

Application of the uplift with providers will be subject to ongoing absolute price assurances and VFM testing, and may only be applicable to baseline rates as opposed to additional hours or equipment agreements. Where existing rates are considered reasonable already, e.g. due to a recent spot purchase agreement, an uplift may not be reflected or may be partly reflected through negotiation.

Where joint care packages are provided between health and social care, it would prove challenging to restrict or amend the uplift from that already offered by the Local Authorities because providers will not accept differential uplifts for both elements of the package and hence the LA rate will be paid. Due to UHB / LA alignment, this is not expected to be a material issue. Final NWJCC (CCAPS) rates will also be paid consistent with the NHS Wales approach.

Subject to Board approval, Providers would be formally notified of the uplift rate where applicable by the Assistant Director of Finance.

Executive Director Opinion and Key Issues to bring to the attention of the Board:

This paper is brought to Board following consideration and support at Finance & Performance Committee.

There is an ongoing risk to sustainability of care providers and availability of care packages if fees paid are not reflective of business costs and inflationary pressures. This has a potential consequential impact on services available to the population of Cardiff and Vale as well as the ability to maintain flow out of hospital.

There is a risk that providers may not accept the uplift rate and the UHB will see a rise in 'exceptional requests' at spot purchase prices or run into disputes.

The Health Board is required by WG to make an adequate uplift to care providers with consideration of the RLW policy position and the updated Code of Practice set out in the report.

The proposed uplift is provided for in the current deficit financial plan alongside volume growth assessments, and application remains subject to appropriate VFM testing and benchmarking.

Quality, Improvement and Efficiency Plans within Clinical Boards around CHC need to progress alongside uplifts, to ensure opportunities to manage demand and the overall cost base are realised.

Recommendation:

Board is requested to:

- **APPROVE** the 2025/26 annual uplift that should be offered to care providers at 6.4%, noting this is within the growth provisions of the current financial plan.
- **NOTE** that joint packages of care may vary from this in line with Local Authority increases already offered, to be risk managed against growth provisions.
- **NOTE** the risk that providers may not accept the new rates and/or that negotiation by exception may be required subject to market forces, benchmarking and VFM tests

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

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

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention		Long term	√	Integration	√	Collaboration	√	Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: /No
Safety: /No
Financial: Yes
The cost of this uplift is contained within the Health Board's financial plan.
Workforce: /No
Legal: No
Reputational: Yes
The Health Board must ensure reasonable uplifts for these commissioned services are provided
Socio Economic: No
Equality and Health: No
Decarbonisation: No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Saunders,Nathan
14/07/2025 14:46:53

Report Title:	Microsoft Enterprise Agreement – extension for a further year			Agenda Item no.	7.5	
Meeting:	Board	Public	x	Meeting Date:	29th May 2025	
		Private				
Status:	Assurance		Approval	X	Information	
Lead Executive:	Director of Digital & Health Intelligence					
Report Author:	Director of Digital & Health Intelligence and Deputy Director of IT					

Background and current situation:

In November 2021 Digital Health and Care Wales (DHCS) was requested by the All-Wales License Management Group and the Directors of Finance Group to establish a renewal of the existing All Wales Microsoft Enterprise Agreement (EA).

In May 2022 the Enterprise Agreement was approved by All NHS Wales Organisations before final approval from the DHCW Special Health Authority Board (as the Contracting Authority) and Welsh Government.

In securing the EA, all NHS Wales organisations agreed to the EA period of five (5) years with an option at the end of year three (3) to terminate. If the option at year three (3) was not taken to terminate, the EA would run for the full period of five (5) years.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

The existing Enterprise Agreement commenced in July 2022 for a period of 3 years (plus up to 2 more years). In discussion with DHCW and all other NHS Wales organisations, the decision has been made to extend the EA for a further one year to June 2026.

In the meantime, work is taking place to negotiate and agree a new Enterprise Agreement to commence in July 2026 when it is intended to have achieved a better agreement for all NHS Wales organisations.

Contract Period:

We are approaching the fourth year anniversary of the 5 year Enterprise Agreement which requires sign off with DHCW, as contracting authority, to enact the year 4 contract extension.

The Costs:

Based on the current numbers provided by DHCW, the new financial year costs will be a total of £4,306,090 which is an increase of £526,499 on financial year 24/25. This includes further additional licences procured to ensure that all CAV staff have an email account and are therefore licenced. It also includes the increase in core licence costs for year 4 of the Enterprise Agreement (noting reduced discounts and add-ons for licences relating to applications that are outside of the EA (eg CoPilot).

Recommendation:

The Board are requested to:

a) To note and approve the fourth year of the M365 Enterprise Agreement relating to Cardiff and Vale University Health Board's licencing requirements.

Link to Strategic Objectives of Shaping our Future Wellbeing:

https://shapingourfuturewellbeing.com/

Putting People First		Providing Outstanding Quality	
1.		2.	

Click the objective above to view more detail.		**Click the objective above to view more detail.**	
Delivering in the Right Places 3. **Click the objective above to view more detail.**		Acting for the Future 4. **Click the objective above to view more detail.**	

Five Ways of Working (Sustainable Development Principles) considered									
Prevention		Long term		Integration		Collaboration		Involvement	

Quality Impact Assessment Completed?				
Yes – (***please provide completed QIA document***)		No – ***(Please provide reasoning, e.g. not required)***		

Impact Assessment:
Risk: n.a
Safety: n.a
Financial: n.a
Workforce: n.a
Legal: n.a
Reputational: n.a
Socio Economic: n.a - ***Useful Guidance on the application of the Socio-Economic Duty can be found at the following link: The Socio-economic Duty: guidance | GOV.WALES***
Equality and Health: n.a
Decarbonisation: n.a
Welsh Language: n.a

Approval/Scrutiny Route *(please note anywhere else this paper has been before):*	
Committee/Group/Exec	Date:

Report Title:	Corporate Risk Register				Agenda Item no.	8.1	
Meeting:	Board Meeting		Public	x	Meeting Date:	29th May 2025	
			Private				
Status *(please tick one only):*	Assurance	x	Approval		Information		x
Lead Executive (**Title**):	Director of Corporate Governance						
Report Author (**Title**):	Corporate Archivist and Records Management Manager						

Main Report

Background and current situation:

The Corporate Risk Register ("the Register") has been developed to provide the Board with an overview of the key operational risks from the Clinical Boards and Corporate Directorates.

The Register includes risks which are rated 20 (out of 25) and above but, it may also include risks of a lower score when required to inform the Board of specific risks with the potential to affect the achievement of UHB strategic objectives.

The register can be located in the supporting documents folder on AdminControl and the Cardiff and Vale UHB website.

Our risk registers have traditionally been managed using an Excel spreadsheet. However, the Corporate Governance team is working to streamline and digitise this process across the Health Board by implementing a new Risk module within the AMaT (Audit Management and Tracking) system. As early adopters of this evolving module, we have had the opportunity to trial its functionality and participate in regular workshops to provide valuable feedback for system enhancements. These improvements will help create a more robust system for all Clinical Boards and Directorates.

In parallel, comprehensive project plans and implementation schedules have been developed in collaboration with the Shaping Change Team and the Medicine Clinical Board to ensure a smooth transition throughout the Health Board. Our goal is to make the transition as seamless and manageable as possible, while minimizing any impact on workloads. To date trails have been conducted with Medicine Clinical Board, Capital and Estates, Health & Safety and Emergency Planning Response & Resilience (EPRR) with demonstrations provided to Local Public Health, Decarbonisation, Cinical Safety Group, All Wales Medical Genomics Service (AWMGS) in and aim to all joining the trial phase to gather robust data to demonstrate effectiveness prior to health board wide roll out via a Task and Finish Group.

Appendices (located in the suppporting documents folder):

1. Corporate Risk Register
2. CEF – Corporate Risk Register

Executive Director Opinion and Key Issues to bring to the attention of the Board:

The Corporate Governance Team ("the Team") continue to work alongside Clinical Boards and Corporate Directorates to ensure that risks are clearly defined and appropriately scored in line with the Health Board's Risk Management and Board Assurance Framework Strategy and associated procedures.

The Team's predominant focus of support to Clinical Boards/Corporate Directorates has been to provide advice and guidance to risk leads/risk owners in their assessment and management of complex risks, and the refinement of their internal risk management processes. In addition, the Team continue to support

requests from senior risk managers to deliver risk assessment and risk management training to their teams and newly appointed risk managers.

The Board should note that Clinical Board risks are also monitored and scrutinised at Monthly Clinical Board Review meetings. Clinical risk is addressed through the Clinical Safety Group governance framework.

The risks presented in the register can be viewed through a lens of cause and effect. There is an identifiable pattern from a cause perspective that predominantly falls into estate and infrastructure risks with a proportion that also fall under the umbrella of workforce. In line with monitoring the financial position, 6 new finance risks have been identified which have been incorporated into the Corporate Risk register

The Capital, Estates, and Facilities (CEF) risk register is now reported by discipline and has been introduced so that risks can also be identified in general terms, due to volume these are now provided in a separate appendix.

The Director of Corporate Governance continues to review the risk register in order to establish a coherent structure of risk moderation and engagement across the Health Board. Work is ongoing to work with Clinical Boards and other areas to refine the risk register in parallel to Clinical Board reviews etc.

Work continues to pilot an electronic risk reporting system via the Audit Management and Tracking (AMAT) system with the early adopters of the Risk Module. The roll out of the pilot has been extended to corporate teams with an aim to have 14 teams utilising the system by the end of June.

Summary of updates within May 2025 Risk Register

Board/Directorate	**Info**
All Wales Medical Genomics (AWMGS)	1 Removed, no further risks to report
Children and Woman (C&W)	1 New, 9 Risks with various updates
Capital Estates & Facilities (CEF)	Updates throughout
Finance	2 Removed, 6 New added
Medicine CB	2 Removed, 4 New added
Primary, Community and Intermediate Care (PCIC)	5 Removed, 4 New added
Specialist Services	Updates throughout
Surgery CB	1 New risk added

ASSURANCE is provided by:

- Ongoing discussions with Clinical Boards and the Corporate Directorates regarding the scoring of risk.
- The presence of risk registers in CB and Corporate planning functions e.g. Capital and Investment decisions.
- The programme of education and training that is being implemented by the Corporate Governance team to ensure that the Health Board's Risk Management policy is engrained and followed within Clinical Boards and Corporate Directorates.
- Increasing routine dialogue on risk issues between Clinical Board/Corporate Directorate Risk Leads and the Team.
- The Reasonable Assurance rating provided by Internal Audit for the Health Board's Risk Management processes.
- Mapping of risk across departments and directorates and aligning it to the evolving strategy and planning work.
- Imminent introduction of digitalised platform to track and manage all risks ratings providing increased awareness through dashboards and data reports.

Recommendation:

The Board is requested to:

Note the Corporate Risk Register and the work in this area which continues to progress.

Link to Strategic Objectives of Shaping our Future Wellbeing: *Please place an "X" in the below boxes as relevant.*			
1. Putting People First **Click the objective above to view more detail.**	X	2. Providing Outstanding Quality **Click the objective above to view more detail.**	X
3. Delivering in the Right Places **Click the objective above to view more detail.**	X	4. Acting for the Future **Click the objective above to view more detail.**	X

Five Ways of Working (Sustainable Development Principles) considered *Please place an "X" in the below boxes as relevant*									
Prevention	X	Long term		Integration		Collaboration		Involvement	

Quality Impact Assessment Completed? *Please place an "X" in the below boxes as relevant. A blank QIA and guidance on how to complete a QIA can be found by clicking the link here:* ***Quality Impact Assessment Information***				
Yes – (***please provide completed QIA document***)	X	No – ***(Please provide reasoning, e.g. not required)***	X	*Not required*

Impact Assessment: *Please state **yes** or **no** for each category.* ***If yes please provide further details.***
Risk: Yes
The management and maintenance of the Health Board's Corporate Risk Register contributes to the Health Board's Risk Management processed and procedures.
Safety: No
Financial: /No
Workforce: No
Legal: No
Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation: No
Welsh Language: No

Approval/Scrutiny Route *(please note anywhere else this paper has been before):*	
Committee/Group/Exec	Date:

Report Title:	The CAVUHB Draft Annual Report 2024-2025				Agenda Item no.	2.3	
Meeting	Board		Public	x	Meeting Date:	20.05.2025	
			Private				
Status:	Assurance	x	Approval		Information	X	
Lead Exec	Director of Corporate Governance						
Report Author	Senior Corporate Governance Officer						

Main Report
Background and current situation:

The purpose of this report is to provide assurance to Board Members that the Cardiff and Vale University Health Board Annual Plan process is taking place with a draft version of the document available to Board Members to review prior to endorsement at the special public Board meeting taking place on 25 June 2025.

In accordance with Welsh Government and HM Treasury Guidance, the Health Board has produced the Annual Report and Annual Accounts for the financial reporting period 2024-2025

The draft Annual Report incorporating the Accountability Report (including the Governance Statement), and Draft Remuneration Report were submitted to Welsh Government and Audit Wales on the 9 May 2025 as a single unified document.

Following comments from Welsh Government and input from Audit Wales, the Annual Report will be received by the Audit & Assurance Committee on 25 June for endorsement to the Board who will also be meeting on 25 June 2025.

The Annual Report will then be formally presented at the Health Board's Annual General Meeting on 16 July 2025 to the public.

Board members are asked to specifically consider the Accountability Section of the Annual Report (which can be located in the supporting documents folder on AdminControl), the purpose of which is to report to the Senedd in respect of the key accountability requirements and captures the following key areas:

- Part Performance Report & Part 2 Accountability report
- Part 2b Remuneration and Staff Report
- Part 2c Senedd Cymru / Welsh Parliament Accountability and Audit Report
- Part 3 Audited Financial statements (Annual Accounts)

The Annual Accounts outline the financial performance up to year end 31st March 2025, these are captured in chapter 3 of the Annual Report.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

The Annual Report (**which can be located in the support documents folder on AdminControl**) has been reviewed at each stage of its development as outlined below:

Date	Task
28 April	Draft Annual reported to Management Executive
2 May	Draft Accounts submitted to Welsh Government and Audit Wales

9 May	Draft Performance Report Overview, Accountability Report (including the Governance Statement), and the draft Remuneration Report submitted to Welsh Government and Audit Wales
20 May	Audit Committee – for review
9 May – 30 June	Window for final amendments - Comments back from Welsh Government and Audit Wales incorporated for approval of the final draft Annual Report by Audit Committee on 25 June 2025
25 June	**Special Audit Committee meeting** – recommend Board approval of the final draft Annual Report

The comments received on the draft versions of the report will as always be welcomed as they will enable the document to be further refined prior to the Audit & Assurance Committee meeting on 25 June 2025.

Recommendation:

Note the Annual Report & Accounts for 2024-2025 - Appendix 1

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

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

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant

Prevention	Long Term	Integration	Collaboration	Involvement
		X	X	X

Impact Assessment:

Please state yes or no for each category. If yes please provide further details.

Risk: No
Safety: No
Financial: Yes – Primary Financial Documents of the UHB
Workforce: No
Legal: No
Reputational: Yes - Primary Financial Documents of the UHB
Socio Economic: No
Equality and Health: No
Decarbonisation: No

Approval/Scrutiny Route:

Committee/Group/Exec	Date:
