

Local Partnership Forum

Wed 18 June 2025, 12:00 - 14:00

MS Teams



Chair: Rachel Gidman

Agenda

12:00 - 12:03 1. Welcome and Apologies

3 min

Rachel Gidman

12:03 - 12:05 2. Apologies for Absence

2 min

Rachel Gidman

12:05 - 12:07 3. Declarations of Interest

2 min

Rachel Gidman

12:07 - 12:12 4. Minutes of the Meeting held on the 10th April 2025

5 min

Rachel Gidman

 4. LPF minutes 10.04.2025.pdf (8 pages)

12:12 - 12:17 5. Action Log

5 min

Rachel Gidman

 5.LPF Action Log 10.04.2025.pdf (3 pages)

12:17 - 12:42 6. Chief Executive's Report

25 min

Verbal Update Rachel Gidman

12:42 - 13:02 7. Director of Public Health Annual Report

20 min

Annie Ashman

 7. DIRECTOR_PUBLIC_HEALTH_REPORT.pdf (58 pages)

13:02 - 13:22 8. Culture & Leadership Programme

20 min

Rebecca Corbin

13:22 - 13:42 9. People and Culture Plan Priorities - Wellbeing & Availability of Staff

Blyddyn Louise
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20 min


Katrina Griffiths


 9. People and Culture Plan Priorities - Wellbeing and Availability of Staff.pdf (5 pages)

13:42 - 13:52 10. Integrated Performance Report

10 min


Claire Beynon, Jason Roberts, Rachel Gidman, Paul Bostock and Catherine Phillips

 10. C&V IPR Corporate Header May 2025.pdf (15 pages)

 10.1 C&V Integrated Performance Report May 2025.pdf (48 pages)

13:52 - 13:54 11. Clinical Board Local Partnership Forum Annual Report

2 min

 11. Clinical Board LPF Annual Report 2025.pdf (13 pages)

13:54 - 13:56 12. Review of the Meeting (items to be brought to the attention of the Board)

2 min

13:56 - 13:58 13. Any other business previously agreed with the Co-Chairs

2 min

13:58 - 14:00 14. Future Meeting Arrangements

2 min

Wednesday 6th August at 10am via MS Teams with a staff rep pre meet at 8:45am

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LOCAL PARTNERSHIP FORUM MEETING
Thursday 10th April 2025 at 10am, via Teams

Present

Peter Hewin	BAOT/UNISON (Co-Chair)
Rachel Gidman	Executive Director of People and Culture (co-chair)
Paul Bostock	Chief Operating Officer
Rachel Pressley	Head of People Assurance and Experience
Mike Jones	Independent Member - Trade Union
Emma Cooke	Director of Therapies & Health Science
Lorna McCourt	UNISON
Bill Salter	UNISON
Cyrille Legras	UNISON
Lianne Morse	Deputy Director of People and Culture
Claire Whiles	Assistant Director of OD, Wellbeing & Culture
Mathew Thomas	UNISON
Katrina Griffiths	Associate Director of People and Culture
Philip Dore	RCN
Katherine Davies	RCN
Jonathan Strachan-Taylor	GMB
Annie Ashman	Deputy Director of Public Health

In attendance

Izzy Turner	Student on work experience with People and Culture
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Apologies

Dawn Ward	Chair of Staff Representatives – BAOT/UNISON
Suzanne Rankin	Chief Executive
Claire Beynon	Executive Director of Public Health
Jennifer Lavington	CSP
Matt Phillips	Director of Corporate Governance
Bill Salter	UNISON
Joanne Brandon	Director of Communications, Arts, Health Charity and Engagement

Secretariat

Louise Blunsdon	People Assurance and Experience Coordinator (Minutes)
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LPF 25/014 WELCOME AND APOLOGIES

Peter Hewin (PH) welcomed everyone to the meeting, noting Izzy Turner who has joined on work experience from Exeter University. Apologies for absence were noted.

Mike Jones (MJ) noted that the last LPF meeting had been Fiona Salter's last before she retired. He suggested sending a letter of thanks from the LPF for her contribution as RCN Trade Union representative and participation in the Forum. PH supported the suggestion, and Rachel Gidman (RG) agreed to draft the letter for review by PH and herself before sending it to Fiona.

Action: RG

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LPF 25/015 DECLARATIONS OF INTEREST

There were no declarations of interest made in respect of agenda items.

LPF 25/016 MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting held on 13 February were reviewed and approved with minor amendments.

- **LPF 25/003** Mathew Thomas (MT) raised the issue of staff within Capital Estates and Facilities not having email addresses. Paul Bostock (PB) commented that he thought this issue had been resolved but agreed to discuss with David Thomas.
Action: PB
- **LPF 25/003:** MT highlighted the need for clarity on the annual leave principles, specifically the requirement for 80% of leave to be booked by December 1st. He mentioned that there was a consensus in the previous meeting that the annual leave year is from April 1st to March 31st. RG agreed that there was a consensus. PH requested that the minutes are updated for accuracy.
Action: LB

MT and PH raised concerns about the visibility of Outlook calendars, particularly regarding confidentiality and data protection issues. They mentioned that clinical teams were worried about the negative impact on their efficiency due to the visibility of their calendars.

PH mentioned that the implementation date of the Outlook calendar visibility had been postponed to allow for further discussions about confidentiality and data protection issues.

PB agreed to discuss the concerns with David Thomas, who is leading that part of the agenda, and provide clarity on the next steps.

Action: PB

Staff survey discrepancies: Claire Whiles (CW) agreed to clarify the notes in the minutes regarding engagement scores.

Action: CW

Workforce Race Equality Standards: RG noted the need to correct the terminology from "workplace" to "workforce" in relation to the WRES.

Action: LB

LPF 25/017 ACTION LOG

The action log was noted and the following updates provided:

- **LPF 25/003 (Interpretation of the Annual Leave Principles):** PH explained that a meeting with Jason Roberts has been scheduled to discuss and reach a common understanding as it was felt that LM's response was inaccurate. LM explained that she met with the rostering and corporate nursing team and responded to trade union colleagues based on those discussions. LM added that her interpretation was incorrect and apologised for the

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misunderstanding. PH thanked LM and requested the meeting is prioritised so that a common understanding can be reached.

Action: Carys Fox

LPF 25/018 CHIEF EXECUTIVE UPDATE

The CEO report was delivered by The Chief Operating Officer. The key points included:

- PB thanked staff for their contribution and efforts as we transition out of the Winter period.
- Infrastructure issues – PB acknowledged the poor state of the infrastructure and specific examples were provided. Suzanne Rankin has been vocal about these issues with the Welsh Government. Funding is often spent on essential but non-visible improvements such as boilers and drains. PB explained there is a commitment to lobbying hard for infrastructure improvements, with priorities including ITU, vascular hybrid theatre, and bone marrow transplant facilities.
- Finance - the financial difficulties were addressed, noting that we continue to spend more money than is received. PB explained that other Health Boards have managed to stop the rate of overspend and received additional support from Welsh Government, but Cardiff and Vale UHB struggle to explain its ongoing deficit, which complicates receiving financial support. The current deficit is approx. £58 billion which assumes a £30 million savings program, but we are still far from reaching this target. PB mentioned the need to continue with some controls that were put in place in January.
- Overtime - There are exceptional circumstances where overtime is allowed e.g unplanned theatre overruns but planned overtime requests require formal approval through the PMO. RG confirmed for the Forum that the terms and conditions for overtime apply to all staff. PB explained that the organisation encourages staff to utilise bank shifts first rather than overtime, as bank can be cheaper, however that it is ultimately the individual's choice whether to work additional hours.

Katherine Davies (KD) highlighted the need for clear communication to ward managers so that they are aware that staff can be paid for exceptional circumstances. RG agreed to work with Heads of People and Culture to reiterate the message locally and ensure clear communication. RG explained that the message has already been communicated but the Heads of People and Culture will work collaboratively with the Clinical Boards to ensure the message is conveyed and interpreted consistently.

Action: RG

- Organisational Redesign: PB discussed the need for an organisational redesign to focus more on community, primary care, and mental health services. He mentioned that the current structure is very secondary care-focused and needs to be reoriented. A 6-month process for staff involvement in designing the new structure was discussed.

RG expressed the importance of reorganising for success and sustainability adding that a letter has been sent to the Welsh Government requesting expertise to assist with the redesign. RG noted that effective communication and engagement are crucial to alleviate staff fears and ensure clarity.

LM reassured Trade Union colleagues that they will be involved in every step of the organisation redesign adding that the Organisational Change Policy will be followed, including discussions with affected staff. A phasing plan is being drafted to outline the steps / details. Once approved by the Executive team, the plan, along with the timelines, will be shared in writing for better understanding. MT thanked LM for the comments around involving the Trade Unions. He acknowledged that the upcoming changes could be significant and challenging and emphasised the need for strong partnership to achieve desired outcomes.

PH thanked PB for his time at a recent meeting with TU representatives to discuss this, noting that the early engagement was very helpful. He reiterated the support for sustainability, the need for change and acknowledged the necessary process. PB explained that the redesign is necessary regardless of the financial situation and the primary goal is to shift focus from secondary care to primary, community, and mental health care. This involves designing a clinical model of care for patients and service users, and understanding the corporate support needed to deliver it. The redesign will include non-Clinical Board functions as well. PB also discussed the need to improve the booking systems to reduce inconsistencies, cancellations, and DNA rates.

PF 25/019 HIGH LEVEL STAFF SURVEY RESULTS 2024

Claire Whiles (CW) presented the Staff Survey results from the survey undertaken in October 2024.

The key points included:

- The importance of the staff survey was noted, and it was acknowledged that staff experience affects wellbeing, safety, retention, and service quality.
- The 2024 staff survey results showed an increase in participation up to 26.8%, The responses were mainly online. The paper survey return rate was lower than expected. Participation rose in all Clinical Boards except one area, and we achieved the highest response rate among the larger Health Boards.
- The engagement index fell from 72% to 71.1%, indicating a concern. CW noted the biggest drop related to involvement in changes affecting work. CW emphasised the importance of staff participation in organisational redesign to ensure they are part of the process.
- Themes of improvement and concern were highlighted and the findings by sub theme were also presented. A concern was expressed about burnout, the health and safety climate and raising concerns and morale relating to work pressures. CW explained how the findings in the report align to UNISONS safe staffing report.
- The importance of local analysis and understanding at the clinical board level was noted. It was mentioned that addressing local priorities is necessary for effective staff engagement and improvement.
- Dashboard access is now being shared across Clinical Boards with the Heads of People and Culture and the OD and Culture team available for support. The team are looking at the narrative comments to provide further insights to the statistics.
- Clinical boards are reviewing their results to inform localised priority actions. Efforts are being made to introduce a feedback loop to teams, ensuring they understand the actions taken based on the staff survey findings and the outcomes being implemented.
- Ongoing support will continue to be provided from a People and Culture perspective with targeted interventions for hotspots and areas of concern.

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- The importance of working together in partnership was emphasised as well as ensuring there is communication on how colleagues can raise concerns safely and a commitment to sharing learning from areas showing positive change

PH thanked CW for the presentation, noting it made the data easier to understand. He highlighted the encouraging uptick in work-life balance, attributing it to the efforts made but expressed a concern about burnout and behaviours in the workplace, acknowledging the challenges ahead.

MT emphasised the importance of maintaining staff engagement, highlighting the significance of focus groups. He raised the concern that failing to deliver on promises to staff could lead to disengagement. MT requested information on when Trade Union lead reps can access the breakdown of survey results by Clinical Boards. CW explained that survey results were shared with Clinical Boards last Wednesday evening, and names are being provided to enable access to the dashboard. CW noted that 3 staff survey focus groups are planned for this year and acknowledged the need to demonstrate the "you said, we did" approach continuously.

LPF 25/020 PEOPLE AND CULTURE PLAN PRIORITIES

Lianne Morse (LM) presented the People and Culture priorities. The key points included:

- The 3 main priorities were presented:
 - **Improving Wellbeing and Availability to Work:** - the aim is to support colleagues and reduce absence rates with a goal to achieve a 5.5% absence rate by the end of the 12-month period. Also, there is a plan to implement E-rostering for the medical and dental workforce.
 - **Management and Leadership Development** – the aim is to standardise our people practices and ensure that the advice and training provided is consistent, giving managers the confidence to make informed decisions. The example of the development of the General Managers Programme was provided.
 - **Build Workforce Planning Expertise** – We are in the resource planning stage, which involves addressing immediate needs for the next 12 months. The goal is to train and develop managers to understand the importance of workforce planning. By the end of the 12 months, the aim is to transition to operational workforce planning, looking ahead 12 months to assess workforce supply and demand. Additionally, the team is working on improving data accuracy. LM explained that updates will be brought to the group regularly to show how we are improving and measuring against KPIs.

MT explained that since 2018 the All Wales managing attendance training has been delivered in partnership and although he acknowledged the need for change, he expressed a concern regarding the significant redesign of the training. MT provided the example that key messages promoting well-being and compassionate leadership have been removed from the training and commented that the new training might be taking a step backward in terms of well-being. He queried why such a significant change in managing attendance training was made without trade union involvement.

LM explained that feedback from managers regarding the policy has been received and responded to, adding that compassionate leadership is inherent in everything we do and that labelling it explicitly is unnecessary. LM commented that the policy is there to be progressed, and managers should use their discretion, which involves knowing the individual in their team. LM explained that the previous approach was not right and led to the change but assured the group that compassion

will still be a thread in the training and expressed the desire to continue delivering the training in partnership. RG explained that the approach was intentional, and it was done to provide assurance that the team was delivering the necessary content and to support the development of junior colleagues. It was explained that the approach has been delivered through a multidisciplinary team, including education, HR, and EDI. It focuses on being directive around policy while also ensuring necessary conversations are conducted in a compassionate manner

PB highlighted that the policy has not changed, but its application has and expressed the view that discretion amongst managers can lead to an inconsistent approach. He explained that the Health Board has lower vacancies compared to other Health Boards, but a higher sickness rate and questioned whether the staff are genuinely sicker or if there are cultural or behavioural issues at play. PB stressed the need to support staff to return to work and manage those with cultural or behavioural issues. The importance of being fair to staff who come to work was also mentioned. Emma Cook (EC) suggested there was inconsistency in managing sickness across the organisation and expressed the importance of having a clear structure that is delivered compassionately. Katherine Davies (KD) highlighted the importance of looking at the underlying causes of sickness, suggesting that the problem may not be the staff themselves but other factors causing them to be off sick. KD also expressed a concern over staff coming to work when they are not well, which can make others unwell. They provided an example of an employee with long COVID who returned to work on a phased return but caught COVID again from colleagues who came to work knowing they had COVID.

PB acknowledged that some employees may not be physically ill but feel unable to come to work due to their work environment. He explained that the organisation is looking at hotspots and gave the example of healthcare support workers who have a high sickness rate. PB explained that he does not want people to come to work who have infectious symptoms. The expectation is to have a sickness rate of approx. 5% and the goal is to support those who need it and manage those who should be at work. RG informed the group they are gathering information to understand why some employees are off sick and emphasised the importance of supporting managers with the right education to address these issues and find solutions.

PH acknowledged the arguments presented and reiterated that staff side has always recognised that absence from work creates additional strain on those who are working and that the goal of managing attendance is to get people back to work as quickly as possible with necessary adjustments. PH noted MT's efforts in developing the training in partnership and expressed concern about the sudden removal of the Michael West values, which have been central to People Services' ethos. PH commented that this feels contrary to the principles of social partnership and made the case for discussions rather than presenting a fait accompli. PH reiterated the importance of a commitment to social partnership, especially during challenging times

RG re-iterated that the UHB uses the All Wales Managing Attendance at Work Policy, but that additional focus has been placed on how the training was delivered and the interpretation of the Policy. RG added that the training has not started yet but that senior members of the People Services team will be directly involved in delivering it. RG emphasised the need to balance the training and work in partnership adding that discretion can be included in the training but should not lead to everyone doing what they want. The training should be directive to support managers and involve practical aspects. RG suggested discussing the policy further outside the meeting.

Action: RG /PH

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LPF 25/021 INTEGRATED PERFORMANCE REPORT

The Integrated Performance Report was received by the LPF and taken as read, with the following additional information provided:

Public Health

Annie Ashman (AA) provided the following updates:

- There had been suboptimal COVID-19 and flu vaccination uptake among staff
- Mpox virus –the risk to the UK is now assessed as very low.
- Work is taking place on a new no smoking enforcement model to address concerns raised by staff and the public health team about people smoking on hospital sites.

Quality and Safety

RG informed the group that the LPF clashes with the Nursing Productivity Group which meant that Jason Roberts could not attend or send a deputy. She asked if the LPF dates could be looked at to enable him to attend some meetings.

Action: LB

People and Culture:

LM informed the group:

- Sickness rates peaked in December but are now returning to normal as we move into Spring.
- Turnover is improving, with March data showing slight decreases and significant improvements in nursing, midwifery, estates, ancillary, and healthcare support workers.
- Enhanced scrutiny measures are ongoing, and there will be continuous monitoring of agency and variable pay spend, as well as monthly monitoring of staff in post to assess workforce stability and growth.

PH queried whether enhanced scrutiny measures still include any restrictions on training. LM explained there are not any restrictions, but the ask is for managers to be sensible around study leave. Cyrille Legras (CL) asked if there is any written information available on the study leave allowance for employees. LM explained there is for statutory and mandatory training but for other training this is unique to the post. CW informed the group that the Study Leave Procedure is due to be reviewed. The Procedure does not specify the amount of time allocated for each member of staff, and an element of discretion from managers is involved. The TUs will be involved with the review. It was agreed this discussion would be delegated to the Employment Policies Sub Group as part of the review process.

PB suggested setting out the principles for managers and staff regarding managing statutory training and to be clear about what is reasonable. This guide would help ensure consistency across clinical boards and address concerns about discretion leading to different practices and would be a clear process for training requests.

RG informed the group there is a plan to create a booklet to guide new employees and help identify the regulatory, mandatory, and statutory requirements for each role. This will help clarify what is expected from them and facilitate the creation of a training needs analysis. The goal is to ensure that the right people are in management courses and to develop a more mature approach to training and development as part of the "brilliant basics" initiative for this year.

LPF 25/022 LOCAL PARTNERSHIP FORUM ANNUAL REPORT

The LPF noted the Local Partnership Forum Annual Report.

LPF 25/023 WORKFORCE PARTNERSHIP GROUP ANNUAL REPORT

The LPF noted the Workforce Partnership Group Annual Report.

LPF 25/024 LOCAL PARTNERSHIP FORUM WORKPLAN 2025-2026

The LPF noted the Local Partnership Forum Workplan 2025-2026.

LPF 25/025 WELSH HEALTH CIRCULAR 017 IMPLEMENTATION OF THE NON PAY AGREEMENT

The LPF noted the report on the non pay agreement. Katrina Griffiths (KG) informed the group that this has been through LPF before, but it has been reformatted following a request from the Welsh Government

LPF 25/026 REVIEW OF THE MEETING

No comments were raised.

LPF 25/027 ANY OTHER BUSINESS

CL requested an update on the VERS applications. RG explained that 5 applications will be going through the Remuneration and Terms of Service Committee at the end of April. LM added that there appears to be a disconnect between the application being submitted by the member of staff and the manager sending it through to the People and Culture team. LM explained that additional comms may be required to ensure the individual is being kept informed and is aware of the process.

Action: LM/ RP

Jonathan Strachan Taylor (JST) requested confirmation around the rule that local procedures do not override All Wales policies. PH stated that this has already been clarified within the meeting. RG added that as a member of the national forums, she has a voice and wouldn't let issues pass nationally if she had a problem with them.

LPF 25/028 FUTURE MEETING ARRANGEMENTS

The next meeting will be held remotely on Wednesday 18th June from 12pm with a staff representatives pre-meeting at 10:45am.

Local Partnership Forum – Action Log

MINUTE	DATE	SUBJECT	AGREED ACTION	ACTIONED TO	STATUS
ACTIONS IN PROGRESS					
LPF 25/003	13.02.2025	Minutes of the Previous meeting	To provide clarification on the interpretation of the annual leave principles	Carys Fox	<p>LM sent an explanation email after speaking with the Nursing and E-Rostering team. Since sending the email LM has confirmed that what was sent was not accurate and has escalated the action to Carys Fox, to arrange to meet with TU colleagues to explain the process in more detail.</p> <p>19/5: A meeting has taken place between Carys Fox, Emma Davies, Natasha Goswell and Peter Hewin. Suggestions for a way forward were considered and discussions will continue.</p>
COMPLETED ACTIONS					
LPF 25/016	10.04.2025	Minutes of the Previous meeting	To correct the terminology used in the LPF minutes dated 13/2/5 from workplace to workforce in relation to the WRES	Louise Blunsdon	The minutes dated 13/2/25 have been updated to read Workforce Race Equality Standards

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LPF 25/016	10.04.2025	Minutes of the Previous meeting	To clarify the minutes from the LPF meeting dated 13/2/25 regarding the staff survey engagement scores	Claire Whiles	Minutes have been amended.
LPF 25/016	10.04.2025	Minutes of the Previous meeting	To clarify with David Thomas if all staff within CEF have received an email address	Paul Bostock	PB advised that email addresses are available to all staff.
LPF 25/016	10.04.2025	Minutes of the Previous meeting	To send a letter of thanks to retired Trade Union representative Fiona Salter	Rachel / Gidman Rachel Pressley	The letter has been sent.
LPF 25/016	10.04.2025	Minutes of the Previous meeting	Discuss the concerns about Outlook calendar visibility with David Thomas and provide clarity on the next steps.	Paul Bostock	PB advised that David Thomas has confirmed the plans for Outlook and this has been shared with Staff side.
LPF 25/018	10.04.2025	Chief Executive Update	To work with the Heads of P&C to reiterate the message regarding overtime	Katrina Griffiths	Katrina Griffiths has confirmed that the work has taken place.

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			payments to ensure consistency		
LPF 25/020	10.04.2025	People and Culture Plan Priorities	To discuss the All Wales managing attendance training further	Rachel Gidman / Peter Hewin	Further discussion has taken place at the WPG on the 12/5/25.
LPF 25/021	10.04.2025	Integrated Performance Report	To review future LPF meeting dates to allow attendance from the Executive Nurse Director	Louise Blunsdon	Jason Roberts will attend on the 6/8/25 and the February LPF will be moved to a later time.
LPF 25/021	10.04.2025	Integrated Performance Report	Study leave procedure	Rachel Pressley	The issues raised were delegated to the Employment Policies Sub Group (EPSG) as part of the scheduled review of the procedure. The next EPSG meeting is scheduled for July 2 nd 2025.
LPF 25/027	10.04.2025	Any Other Business	To strengthen the communication around the VERS application process	Lianne Morse / Rachel Pressley	The process has been reviewed to ensure the People Assurance and Experience Team will acknowledge and provide information regarding the next steps

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Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Tim Iechyd Cyhoeddus
Cardiff and Vale University Health Board
Public Health Team



GIG
CYMRU
NHS
WALES

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

Director of Public Health Report

Prioritising the Early Years – Investing for the Future



DIRECTOR OF PUBLIC HEALTH REPORT 2024_V3.0
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Acknowledgements

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Thanks also to all of our colleagues from Cardiff and Vale University Health Board, Cardiff Council, Vale of Glamorgan

Council, Glamorgan Voluntary Services and Cardiff Third Sector Council who contributed their time and expertise to having conversations with us and providing case studies, photos, allowed for diagrams and data to be shared.

This report was inspired by The Academy of Medical Sciences report 'Prioritising early childhood to promote the nation's health, wellbeing and prosperity'. Thank you to the report's authors and particularly to Angel Yiangou and Eliza Kehoe.



Foreword

Never before have we had so much knowledge and understanding of how important early childhood moments and years are to the health of our wider society.

As Executive Director of Public Health for Cardiff and the Vale, I have chosen for my first report to focus on children aged 0-5 years – the ‘early years’ - recognising that we have the opportunity to create healthy conditions in this period that can have lasting impacts, both now and into the future.

We are fortunate regionally to have immense energy, innovations and experience around child health and wellbeing. Integrating our efforts and using a public-health approach with data and evidence, with staff, parents and young people themselves, could help us reach even higher. We know partners in the region are committed to creating the best start for children and young people, from our Joint Area Plan for 2023-2028.

A recent report by the Academy of Medical Sciences summarised all the evidence that prioritising early years can improve the nation’s health and prosperity; this report is a call to action, highlighting the importance of investing at this critical time in a child’s life. We know children were among the most affected by the COVID-19 pandemic, but there is still a chance to shift our focus and invest in their health now.

It is my hope that these findings provide the inspiration and evidence so we can explore what is working well locally and highlight improvements for action.

My report describes the state of health in the early years, identifying recommendations to address vaccine-preventable diseases, healthy weight, oral health, and breastfeeding. I look forward to hearing your feedback and to working with people across Cardiff and Vale in implementing our recommendations. To give children in Cardiff and Vale the best and healthiest start in life.



Claire Beynon
Executive Director of Public Health

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Cardiff and Vale University Health Board Youth Board Foreword

As a Youth Health Board member, I believe deeply in the importance of investing in health during the early years of life.

Through my studies as a medical student, I've had the privilege of learning from midwives and health visitors about the profound impact these early years have on a child's development, future health, and overall well-being.

They have shown me how early health influences physical, cognitive, and emotional development, all of which shape a child's future potential. The early years are a sensitive period where children's brains and bodies are highly responsive to the quality of care and support they receive. Ensuring every child has the best possible start can lead to healthier, more resilient adults, while lack of investment in these years can hinder growth and opportunities later in life. Therefore, giving children a strong start in life is a crucial responsibility that we all share.

However, not every child begins life on equal footing. Children from low-income or minority backgrounds often face barriers to accessing essential resources like healthcare, nutritious food, safe housing, and educational opportunities, which can negatively affect their development. As someone from an ethnic minority and low socioeconomic background myself, I have seen the reality of these disparities first-hand and understand the lasting impact they can have on a child's life. These gaps in health investment in the early years can create a cycle where disadvantaged children grow up facing more health and social

challenges, limiting their life outcomes and widening inequalities.

Addressing these disparities requires a collaborative, cross-sector approach. Early years settings and schools play a key role by fostering supportive environments and early education programmes; the third sector, including charities and community organisations, can provide resources and outreach to support families in need; and local and policing authorities can help maintain safe communities where children can grow and play without fear. Healthcare providers, midwives, and health visitors are also essential, as they can monitor and support children's health from birth. Each sector has a role in ensuring all children, regardless of background, can grow up in environments that nurture their development and health.

The recommendations in this report are a much-needed call to action, emphasising the urgency of doing more to support health in the early years. Investing in these years isn't just an investment in individual children but an investment in a healthier, more equitable society. I am excited to see these recommendations put into practice and to witness the positive change they can bring to early childhood health and well-being.



Athika Ahmed
Youth Board Member

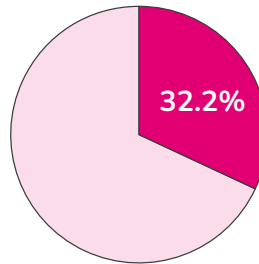
Early Years at a Glance

Population estimates mid-2022¹

31,492
0 – 5 year olds

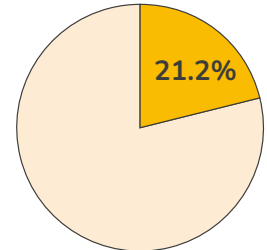


Children aged 5 who have had tooth decay in Cardiff and Vale³



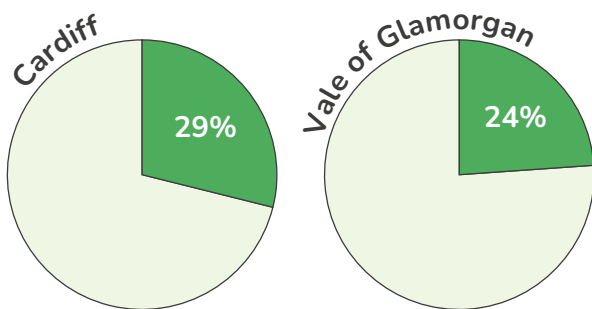
Tooth decay is a preventable condition affected by nearly a third of all 5-year olds. This is higher in our disadvantaged communities.

Children aged 4 or 5 in Cardiff and Vale either overweight or obese⁴



Over a fifth of children aged 4 or 5 are overweight or obese. This rises in our disadvantaged communities

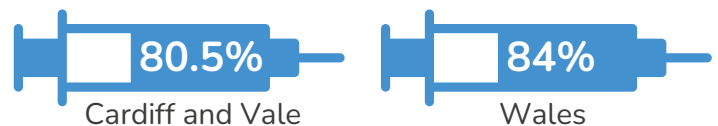
Percentage of Children 0-15 years old living in Relative Poverty (2022/23)²



Immunisations

Childhood vaccination targets not met⁶

% of children at age 4 up to date with all scheduled vaccines (2022-2023)

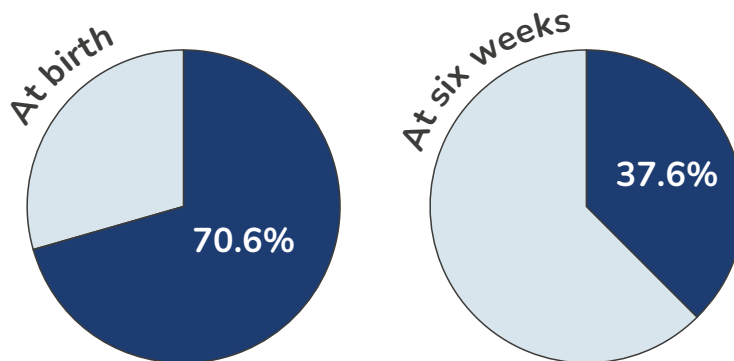


The majority of routine childhood vaccinations programmes do not meet the 95% coverage target set by the World Health Organisation, and this has led to preventable infectious diseases and death.

Breastfeeding

Less than 40% of babies are breastfed at six weeks⁵

Exclusive breastfeeding (Cardiff and Vale – quarterly October - December 2023)



The World Health Organisation recommends exclusive breastfeeding for the first six months of life

¹ <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/estimatesofthepopulationforenglandandwales>

² <https://endchildpoverty.org.uk/child-poverty-2024/>

³ <https://phw.nhs.wales/services-and-teams/dental-public-health/files/oral-health-intelligence/cardiff-and-vale-uhb/>

⁴ <https://phw.nhs.wales/services-and-teams/child-measurement-programme/cmp-2022-23/>

⁵ <https://stats.wales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Primary-and-Community-Activity/Breastfeeding/breastfeedingquarterlyrates-by-age-lhb>

⁶ <https://phw.nhs.wales/topics/immunisation-and-vaccines/cover-national-childhood-immunisation-uptake-data/cover-archive-folder/annual-reports/vaccine-uptake-in-children-in-wales-cover-annual-report-2023/>

Young Persons' Voice

As part of preparing this report we visited the Health Board's Youth Board to ask them about their experiences and thoughts about vaccinations, good food and movement, oral health and breastfeeding.

We used the Thorn, Bud, Rose Framework.



Thorn: A challenge around the topic

Bud: A new idea or an opportunity

Rose: A highlight, something that works well or is positive.



Thorn: Lack of appointments for dentists so parents will not receive guidance for their children on how to look after oral care at such young ages.



Bud: Increase number of free NHS appointments especially across weekends so that parents are more likely to be able to take children to them.



Rose: Parents can gain knowledge about how to brush their children's teeth and prevent any further dental problems.



Thorn: Immunisations may be given in a place far away from urban areas and in some areas it is unlikely to have cars.



Bud: Make immunisations available in more local GP surgeries or community centres so people do not have to travel so far to the main place to receive immunisations.



Rose: Places for immunisations are now in walking distances are so much more accessible.



Thorn: Picky eaters! Major issue especially for younger kids, I vividly remember only wanting to eat fries and bread.



Bud: Encourage wider variety of food from as early as possible. Make food options cheaper so they are as accessible as unhealthy options.



Rose: Whenever I discovered a new food that I liked I was generally happy and felt like I had unlocked something new.

Some of the other comments included:

“lack of knowledge about vaccines and being healthy – talks could be given in schools on the importance.”

“make letters from public health services more child friendly e.g. including pictures, icons and more colour. This would make it easier for them to read the information and also be more engaging.”

“School allows all children to try new fruit and drink milk. Schools have thriving breakfast clubs which encourage healthy options.”

“Encouraging children to ride their bikes, scooters to school.”

“Primary schools play time involves running around and letting out energy. High school – it's not cool to act like that anymore – teens just chill!”

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Chapter One

Health and Wellbeing in the Early Years

Introduction

Every child deserves to thrive. Investing in the early years creates a foundation for life-long health and wellbeing.

The gap in health outcomes between our most and least deprived communities continues to grow and requires sustained attention and action. Health inequalities impact families across generations, affecting individual wellbeing and community prosperity. Focussing efforts on parents, babies and young children gives us the chance to provide the conditions which can promote good mental and physical wellbeing with the benefits experienced into adulthood.

The health of the UK population is worsening – between 1960 and 2020, the ranking of life expectancy in the UK fell from 7th to 23rd amongst OECD (the Organisation for Economic Co-operation and Development) member countries⁷

What affects the health and wellbeing of our children?

There are many factors which affect our health and how we live. The 'socio-ecological model'⁸ overleaf (Figure 1.) helps us understand and consider the range of influences and describes each 'layer' (like an onion). To improve the health and wellbeing of our young children and families, we need to think about the positive conditions that are needed to create good health in each layer and how we influence them. For example: in the physical environment layer, we need to ensure that everyone has affordable and healthy food near to where they live and all children have the opportunity to play and be active.

Making changes to these wider factors (instead of only considering individual behaviours) will give us a better chance to improve the health of our children and families. However, no single organisation can tackle these factors alone; it will require working together across many sectors and organisations, all working together towards a shared goal.



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Cultural norms and ideologies

Language, myths, assumptions, mindset, beliefs all influence how we raise our children, such as how we feel about vaccinations, breastfeeding or screentime for our children.

Policy

Laws, policies, regulations such as food advertising, maternity/paternity rights, family benefits.

Physical environment

Streets we live on, parks our children play in, access to facilities and shops for healthy food, and the safety of the spaces where we walk, scoot, cycle.

Organisations and institutions

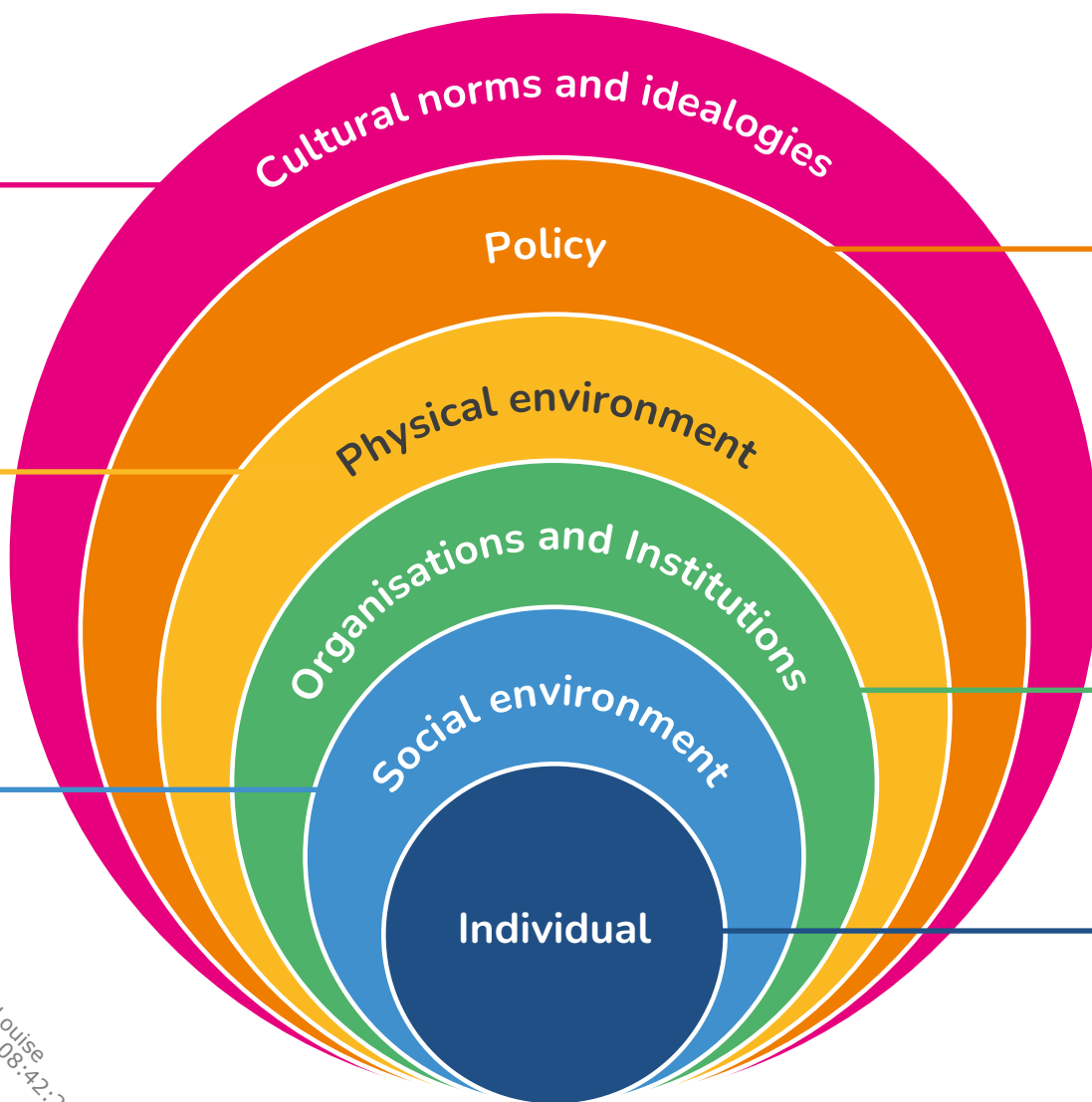
Such as healthcare, early years settings, pre-schools, childminders, workplaces, faith organisations, charities, clubs the extent to which they encourage, support, enable all influence our lives.

Social environment

Individual relationships, families, support groups, social networks.

Individual

Individual capabilities, motivations, opportunities, knowledge, needs, behaviours, physical and mental health and wellbeing.



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Figure 1. Based on the socio-ecological model^B

How poverty affects outcomes for our children

The effects of poverty on children's health can be seen even before birth. Children born to parents living in poverty are more likely to be of a lower than average weight at birth which is linked to poorer outcomes in later life. These children are also less likely to survive the first year of life and to suffer from asthma and other childhood diseases. Children in poverty are more likely to have poor mental health and are at higher risk of psychological distress.

Children growing up in poverty on average do less well in education. Gaps open up early in a child's life, even before they start school, and these gaps persist and widen. Children from lowest income families are less likely to achieve education benchmarks aged 11, make slower progress in secondary school, and are much less likely to attend higher education. This has an impact on levels of educational attainment and later job opportunities and wages.

In addition to the costs to an individual of child poverty, it also places costs on society. Having so many families and children in poverty draws costs from other government budgets. Poorer physical and mental health impacts the NHS, poorer educational attainment reduces workforce skills, and additional public services are needed to cushion the effects of living in poverty.⁹

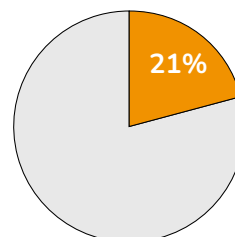
Information from the Child Poverty Action Group states that in 2023 the basic cost (excluding rent and childcare) to bring up a child to aged 18 was estimated at £76,000 for a couple and over £122,000 for a lone

parent. The cost is higher for lone parents as they cannot achieve some economies of scale that can help couples. For a family not in work, benefits cover less than half of what a family with two children requires. Three times more children were living in extreme poverty in 2022 compared to 2019. The cost to our society- through things like increased healthcare needs, lower educational achievement, and reduced future earnings, was estimated at £39 billion in 2023. That's close to £600 for every person in the UK.⁹ However, child poverty is not inevitable. Making sure every child gets a good start in life is crucial in ensuring the best possible outcomes for families and for society.

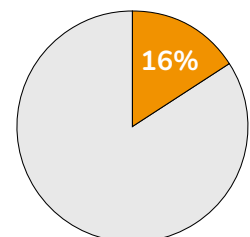
The child mortality rate in Wales is 70% higher for children in the most deprived groups than the least deprived children.¹⁰

In Wales, Senedd Research¹⁰ reported:

- There is a clear association between childhood deprivation and being unemployed and/or living in poverty as an adult, with the links between these at UK level being amongst the strongest of European countries.
- In 2023 in Cardiff 21% of children under the age of 16 years were living in Relative Low-Income families with 16% of children under the age of 16 years in Vale of Glamorgan¹¹.



Cardiff



Vale of Glamorgan

School readiness

The term 'school readiness' refers to a measure of a child's cognitive, social, and emotional readiness to begin formal schooling.

Being ready to begin school is associated with many positive outcomes, therefore improving school readiness is vital. Children with low school readiness need additional support from schools for learning, developing required social and academic skills, and catching-up with their school-ready peers. Children who are not ready for school can take many years to catch up with their class mates, if ever. This can contribute to widening inequalities.

Therefore, identifying the factors that contribute most significantly to a child's readiness to start school is crucial to their future health and wellbeing, and that of society.

There are many factors which may affect a child's school readiness, such as: eligibility for free school meals, low school attendance in early years (e.g. nursery), extremely low birth weight. Increased poverty and the cost of living crisis are also likely to result in lower school readiness and decreased educational attainment.¹²

Those children who are not school-ready find it difficult to catch up and can be affected later in their education. A recent UK study following 60,000 children found that those who were not school-ready were nearly 2.5 times more likely to be persistently absent from school¹³, affecting their life chances and health into adulthood. The importance of the early years to set children up for success at school and beyond is vital as it is for their health and wellbeing.

Research indicates that attending early years childcare settings promotes school readiness and contributes to later school attainment and positive life outcomes into adolescence.¹⁴ As well as affecting cognitive and educational outcomes, there is clear evidence that early years childcare experience can have long-term positive consequences for socio-emotional development.

In Wales, school readiness data stopped being published in 2019. As an important indicator of future health and wellbeing, re-establishing this for monitoring and to contribute to evidence of any interventions will be of importance.



Why prioritise and invest in the early years?

The first five years of life shape lifelong health, yet we face growing evidence that the health of our young children is under increasing pressure.¹⁵

The time to act is now. This year's report highlights the importance of health in the early years – which for this purpose, includes the first five years of a child's life, as it is becoming apparent that health in the early years is increasingly under threat¹⁵.

Intervening earlier can also be easier than when a person is older and may already have started to have negative health outcomes from less healthy eating habits, a lack of physical activity or not having good oral health care in place for example.

Investing in early years yields powerful returns for society. When we create the right conditions for health from the start- through good services, supportive environments, and fair access to opportunities we significantly improve outcomes for children, families and communities. Evidence shows that early investment brings substantial economic and social returns.

For example, every **£1 invested in supervised toothbrushing programmes generates £3 in returns** through reduced treatment costs, better health outcomes, and improved life chances.¹⁶

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Services can make a real difference for children and their families, if delivered at the right time and in the right way. Some families struggle to get support and by improving services and help we can maximise their health outcomes now and later in life.

This is our opportunity to focus on the importance of investing in children and understand what the early years looks like across Cardiff and the Vale and make recommendations for future action.



What is our national and local context?

Wales has a strong policy landscape to promote and develop health, wellbeing and opportunities for babies and children through world leading national legislation such as the Wellbeing of Future Generations Act (2015)¹⁷ which requires public bodies to think about the long-term impact of their decisions. This offers a huge opportunity to make a long-lasting positive change to current and future generations.

Both Cardiff and the Vale of Glamorgan's Public Services Boards (PSB) Wellbeing plans highlight the importance of having the best start in life with Cardiff's aim of:

'a great place to grow up'¹⁸ and the Vale of Glamorgan plan aiming to build on their objective **'to give children the best start in life'**¹⁹ recognising the importance of the early years.

In October 2023, Cardiff became the first city in the UK to be formally recognised a UNICEF Child Friendly City (CFC)²⁰, recognising that Cardiff is embedding a child rights-based approach across local strategy, policy, service delivery and public space. Key to the work of a Child Friendly City is the involvement of children, young people and families in having a say on the design and delivery of services and wider decision making. Public Services Board partners have worked to implement a number of ambitious projects, initiatives and actions to ensure children and young people, across the city, are able to claim their rights and address the barriers which may limit their life chances.

Our regional Joint Area Plan 2023-2028 was developed by the Cardiff and Vale Regional Partnership Board with partners from the NHS, councils and third sector - has a goal of:

"a better start for children and young people".²¹

The Regional Partnership Board's priorities for babies, children and young people are delivered by the Starting Well Partnership which includes membership from social services, education, the Health Board, and third sector. The partnership is using the NEST (Nurturing, Empowering, Safe and Trusted) Framework to reflect and improve the way services support the wellbeing and mental health of babies and children, seeing them within the context of their families, communities and societies they are in. The Framework will help to assess where services are currently at against a range of themes, and plan together how to make improvements.

A specific piece of work is the Early Years Pathfinder, a national programme of work designed to bring a more coherent and joined up approach to the delivery and support for young children and families. Locally this has been delivering support across the Cardiff and the Vale to support and upskill the workforce around neurodiversity, perinatal and infant mental health, children looked after with additional learning needs and the childcare workforce and additional needs/ additional learning needs.

Complementing the work on young children's mental health, is a project introduced by the Vale of Glamorgan Healthy and Sustainable Pre-School Scheme within pre-school settings. The scheme teamed up with Barnardos to deliver the PATHS® Programme for Schools (UK version), which supports young children to grow into adults with a healthy understanding of themselves and their relationships with others.

Children in their earliest years are navigating an unfamiliar landscape of experiences and relationships, some which bring immediate joy, others which bring confusion, contradiction and discomfort. Through these experiences children develop skills which they will continue to use throughout their lives. Using stories, puppets, games and activities, children explore their emotions and feelings, and relationships with the significant others in their lives. The success of this programme enabled two Vale of Glamorgan childcare settings to join only four others across the UK to achieve 'Model Pre School Status'. It offers an opportunity for children to develop skills across all areas of their lives, helping them grow into secure, confident adults.

Local partners have collaborated to develop a scheme that, if funded, could support families with children experiencing child poverty targeted at areas of most need in Cardiff and the Vale. "Building Futures: Action on Child Poverty at the Edge of Care in Cardiff and the Vale of Glamorgan" focuses on accessible, joined up services and collaborative working. For more information on the proposal see Appendix 1.

The Health Board as an organisation is committed to improving the outcomes for children, and has been developing a new children and young persons plan; 'Our Babies, Children and Young Persons Plan to 2035'. The ambition of the plan is to deliver outstanding care for babies' children and young people ensuring outcomes and experience for all that compare with the highest performing peer organisations. Delivering seamless, timely, and specialised care to every baby, child and young person, ensuring no one is left behind.

There is a large early years workforce supporting and improving the health of our families and young children from health services, education, third sector and other childcare settings. Integration and collaboration between services and sectors working with our children and their families is challenging and complex. The two case studies over the next pages describe two pieces of work which are helping to promote and integrate services and data.



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CASE STUDY 1



Integrating and collaborating between early years services, using Summary Care Viewer (SCV)

Many departments and organisations provide services for children in their early years who live in Cardiff and Vale of Glamorgan. They all use different digital/data systems to record patient notes and information, and traditionally those data systems don't talk to each other.

A new programme initiated by the Regional Partnership Board will connect health and care data systems together and display key information into a Summary Care Viewer, pulling it together for different teams/organisations and sectors to view. For our early year's workforce, this would mean that health visitors, GPs, the Emergency Unit, and care planning teams would have access to live information on the Summary Care Viewer. It will ensure that the right information is available in the right place, at the right time and to the right staff, supporting the improvement of outcomes for patients, service users and carers.

This will mean that services are more integrated and connected with each other, we will have a more informed workforce who can make faster and safer decisions, and it will reduce duplication and save time.

This is a huge programme of work which will take time to complete, so it will begin with testing and piloting in two areas, one of which is within health and care teams who support children referred to neurodevelopmental pathways. At present staff rely on phone calls and emails to discover if a child has been referred to the Neurodevelopmental service and at what position the child is on the waiting list. It is anticipated that by surfacing this data in the Summary Care Viewer will save time spent obtaining the data and help staff to target referrals more effectively.

Once the pilots are complete, the intention is to focus on urgent care services for at risk children.

The vision for this is that NHS staff will be provided access via the Summary Care Viewer to local authority child data when a child presents in an urgent care setting and local authority staff will be given access to view details of appropriate and relevant urgent care events for the children they are responsible for.



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CASE STUDY 2



Improving integration between primary and secondary care for children, through Paediatric Integrated Clinics (PIC)

Traditionally, children will first see a doctor at their local GP surgery (primary care), who will make a referral to an appointment with a specialist such as a paediatrician, who is usually based in the hospital (secondary care).

Paediatric Integrated Clinics is a new approach which provides joined up care close to home, avoids over-medicalising problems and empowers families. It brings the specialist teams to the local community and improves integration between primary and secondary care in early years.

The approach brings together a multi-disciplinary team, including a paediatrician who triages all GP referrals and requests for advice from the cluster (a group of GPs in a geographical area) of GPs in that community. Paediatric clinics are held in GP surgeries, with joint consultations by the paediatrician with a GP from the GP practices in the cluster. Multi-disciplinary team meetings are also held, with representation from local health visitors and school nursing teams, ensuring that there is input and joined up working across the family, social and educational context. These Multi-disciplinary Teams are open to any cluster GP to join ad-hoc for advice. This joined up working reduces waste and enables getting things right first time.

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The new Paediatric Integrated Clinics approach began in one GP cluster area, and has seen extremely positive results:

- Halved the demand for new appointments
- Reduced missed appointments (previously 15%, now 6%)
- Reduced waiting list (previously 26-36 weeks, now 8 weeks)
- Estimated return on investment is £2.40 for every £1 spent

The Paediatric Integrated Clinics have also improved the patient experience, with improved ease and equity of access, as patients are not having to travel to hospitals which may be far from their home. This may mean children and families miss less school or work. Consultations in the GP practice are also more relaxed. Professional feedback suggests that clinicians value the much-strengthened relationships, mutual learning and partnership working. Schools and social care have also appreciated easier joint working around particularly vulnerable patients.

The new Paediatric Integrated Clinic approach is being spread and scaled to the whole of Cardiff and the Vale, cluster by cluster.

We want to ensure we're getting services right and explore opportunities to enhance conditions for children to live, grow, play and learn in supportive environments. We all have a responsibility for our children's health and wellbeing and partnership working is only way to achieve this aim.

What to prioritise?

The Academy of Medical Sciences¹⁵ gave examples of key areas where they believe action could be taken quickly to improve outcomes including:

Childhood vaccinations

Good food and movement

Oral health

Supporting breastfeeding

Investment in these areas early on can pay dividends into improved physical health in adulthood, decreasing the impact and demand on health services. This report therefore dedicates a chapter to each topic. The local data demonstrate the need for urgent action in these areas and demonstrates how working collaboratively produces the best outcomes for babies, young children and their families.

There are many examples of innovative and collaborative approaches to create the conditions for children, young people and families to flourish in Cardiff and the Vale of Glamorgan. Some examples are highlighted in further case studies throughout the report.

Recommendation

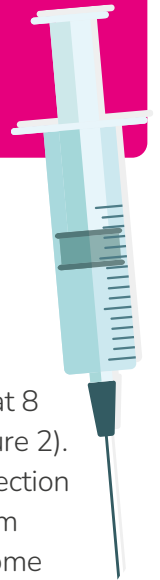
Explore options for improving intelligence on inequalities in child development and school readiness between population groups, including collaboration if appropriate with Digital Health Care Wales.



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Chapter Two

Childhood Vaccination



Why are childhood vaccinations important?

Vaccines are one of the most successful public health interventions of all times, second only to sanitation and clean water for their impact on saving lives.

They are the only measure that ever managed to eradicate a human disease so that nobody would have to be affected from it again. The first vaccine, against smallpox, was invented by Edward Jenner in 1796. **It proved so successful that it eventually led to the disappearance of a disease that had killed 300 million people in the 20th century alone.**

Since then a wide range of very effective vaccinations have been developed. The schedule for vaccination in Wales begins at 8 weeks and continues into older age²² (Figure 2). Today every child in Wales is offered protection from 14 diseases (15 with Chickenpox from January 2025) before they turn 5, but in some cases they are already protected before birth by maternal immunity which, like in the case of vaccines for respiratory syncytial virus or whooping cough, passively covers the newborn while their immune system is still maturing.

Road map of vaccinations for babies and children aged 0 to five years

At 12 weeks:

- 6-in-1
- Pneumococcal (PCV)
- Rotavirus

At 8 weeks:

- 6-in-1
- Men B
- Rotavirus

At 16 weeks:

- 6-in-1
- Men B

At 12 to 13 months:

- Men B
- Pneumococcal (PCV)
- MMR
- Hib/Men C

At 2 and 3 years old and all school aged children on 31 August:

- Influenza (annually from September)

At 3 years and 4 months:

- 4-in-1
- MMR

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Figure 2. Source: Public Health Wales, 2024. Information about vaccinations for babies and children aged 0 to 5 years.

Vaccines are so effective that they have unfortunately become the victim of their own success. Measles, before the introduction of a vaccine, infected hundreds of thousands of people, killing 100 children every year in the UK alone. While it used to infect 80% of the population in childhood, thanks to vaccination it has now become so uncommon that most people have never met anyone who had it and may grow to believe it has disappeared.

This has allowed complacency to grow among our population, meaning that in the UK in recent years, the percentage of children receiving their recommended vaccinations has steadily declined²³. Lower rates of vaccination in the population mean there is an increased risk of highly infectious childhood diseases spreading, such as measles. Measles has been controlled, but not eradicated, and it remains one of the most infectious diseases known to humanity. As immunity wanes, so grows the risk of dangerous outbreaks. In Wales recently we had two, one in Cardiff in the winter of 2023 and in Gwent in 2024. Outbreaks in unvaccinated communities can result in lengthy school closures, periods of isolation of up to a month, permanent disabilities and even death.

Vaccination remains one of the most important ways of protecting our own health and well-being and that of others. It is a form of personal, family and social responsibility towards the most vulnerable members of our communities. This includes small children that cannot yet be vaccinated, the frail and the elderly, but also those among us who are undergoing cancer therapy, who have weak immunity or received an organ transplant.

In Cardiff and Vale most childhood vaccines are given in GP practices, except the nasal flu spray in 4 year olds and older, and the HPV (human papillomavirus) vaccines, which are given in school.



To reach children who missed their scheduled vaccination or who moved to Cardiff and the Vale recently, the Health Board, in collaboration with partner organisations organises catch-up campaigns. Here those who have missed their scheduled vaccinations are given the opportunity to get up to date. These have often been offered in a range of locations, including schools and at community vaccination centres. Similar campaigns have recently taken place for Measles, Mumps and Rubella vaccines to improve coverage in some schools and communities.

In April 2024, 81% of 4-year-old children in Cardiff and Vale were up to date with all scheduled vaccines. This is lower than the Welsh average of 85%, and although there was a rise in the last quarter of 2023/24, the overall trend has shown a decline in uptake in recent years which accelerated during the COVID Pandemic. (Figure 3²⁴.)

This is well below the World Health Organisation (WHO) target of 95% of children needing vaccination to achieve protection against e.g measles.

Cardiff and Vale UHB quarterly COVER trends

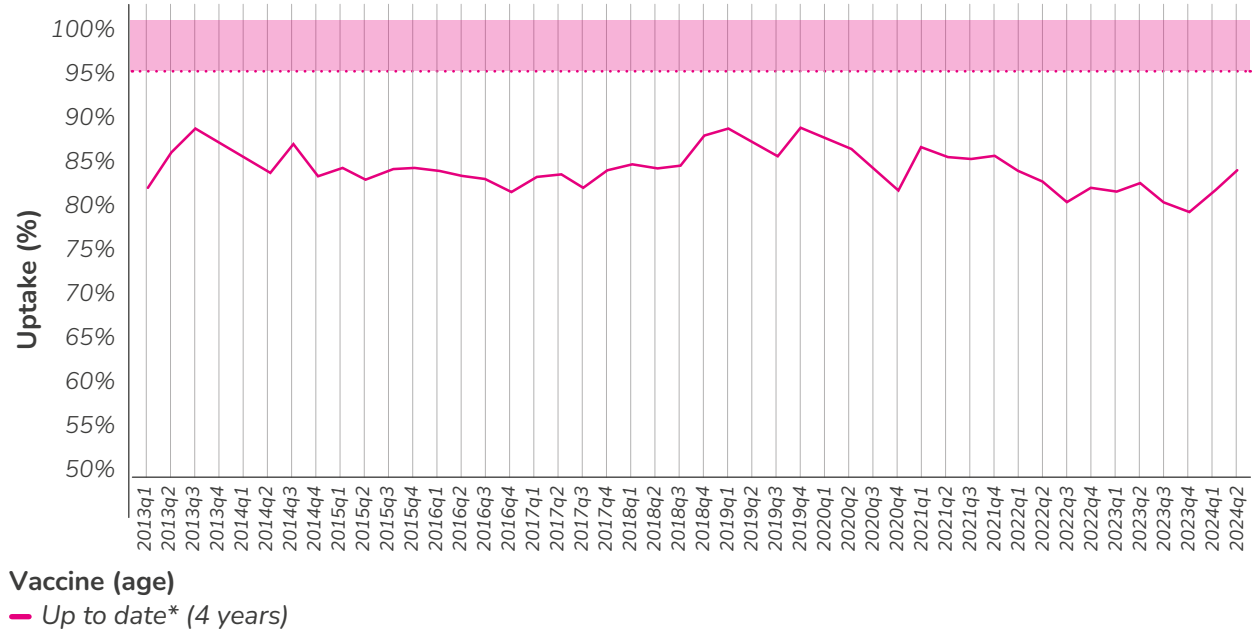


Figure 3. All vaccines up to date at 4 years old, 2013/14 - 2023/24, Cardiff & Vale.

Vaccine uptake is generally lower in areas of higher deprivation and where there are higher concentrations of ethnic minority communities.

Work is underway, as described in the next section, to explore and address barriers to access or other factors that may affect uptake. Figure 4 shows the unequal distribution of uptake in Cardiff and the Vale and it highlights areas of particularly low uptake in the South-Eastern Neighbourhoods of Cardiff City where deprivation and ethnic diversity is higher²⁴.

Figure 4 confirms this inequality by showing the variation in uptake of the first MMR (Measles, Mumps and Rubella) dose by GP cluster level¹⁶. The target for uptake is 95%, and many areas are below this with some of the Middle Super Output areas (MSOAs) within the clusters as low as 60%.



Uptake in Cardiff and Vale UHB GP Clusters (Apr 2024-Jun 2024)

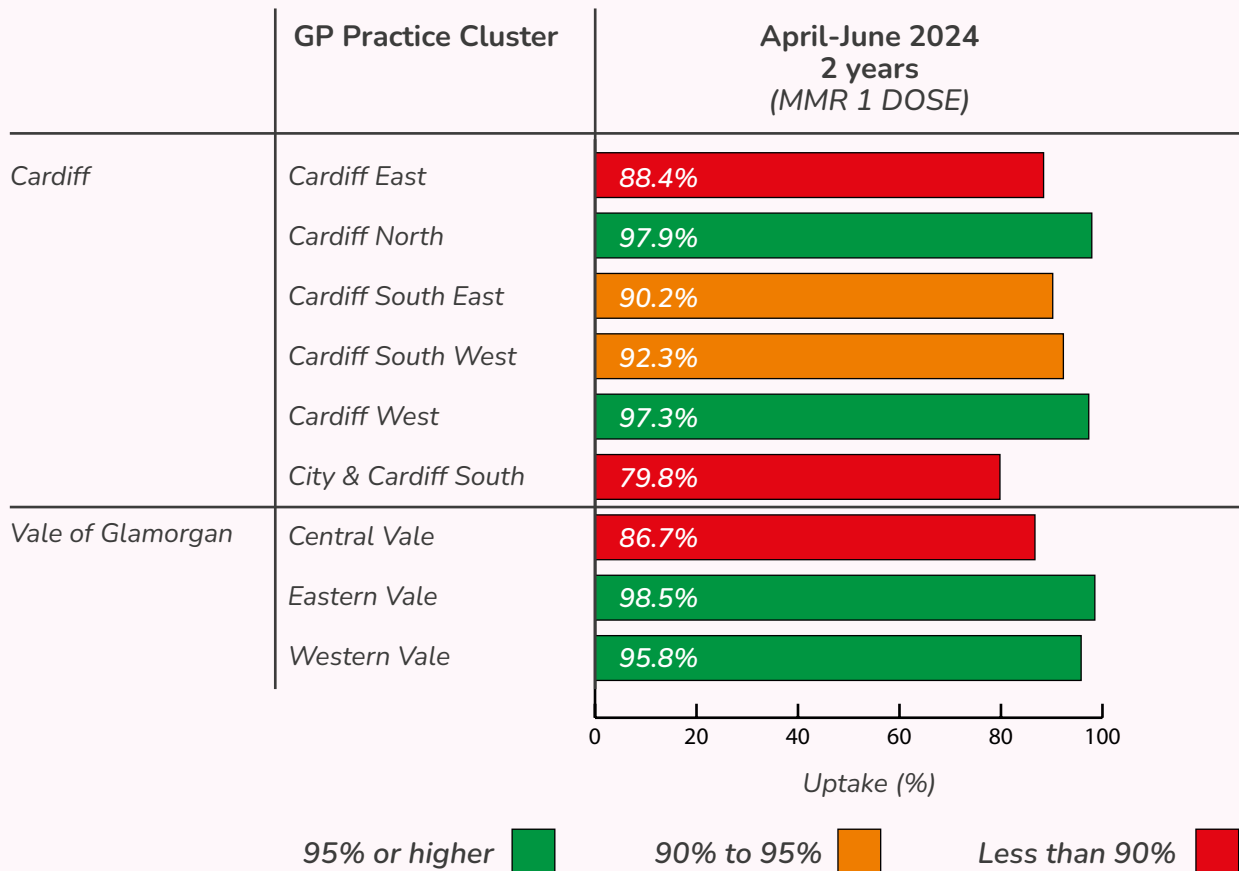


Figure 4. MMR 1 uptake for children turning 2 years old, Apr 2023 - Jun 2024

Barriers and actions to address them

There are many barriers to and factors affecting uptake of vaccinations in children. A model to explain these was developed by the World Health Organisation (WHO).²⁵ It divides barriers in three main categories:

Convenience if accessing vaccinations is not easy and accessible it can be a barrier.

Complacency people might not see the need for vaccinations as they don't know of people in their community with the disease it prevents.

Confidence not having the knowledge about why vaccines are important or the confidence to know they are safe.

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During our conversations with communities in 2024 about childhood vaccinations, local families shared important insights about their needs and experiences. Our communities emphasised the importance of having reliable, culturally appropriate information available through trusted local networks to help counter misinformation.

Community members highlighted specific concerns about gelatine-containing vaccines and many shared they weren't aware that gelatine-free alternatives existed. The current system of having to specifically request these alternatives and book specific appointments created unnecessary barriers for families wanting to make this choice.

Working together with local communities, we have updated consent forms to clearly explain the gelatine-free vaccine options. Campaign materials have also been developed in partnership with community members to share this information through existing trusted networks and spaces where families already gather and connect.



Figure 5. Source: Example of campaign materials developed, Cardiff and Vale UHB, 2024.

A Childhood Immunisation Action Plan for Cardiff and Vale was developed in 2023, based on the principles of the National Immunisation Programme for Wales and designed to address the '3 C's' by taking a multi-factorial approach. Some examples of action include:

Data informed approaches: tailored support for GP practices where uptake is particularly low has been put into place, including production of a toolkit and templates, and contacting families by trained call handlers to encourage them to take up vaccination.

Community-based vaccination provision: childhood vaccination is being offered at community events, and at mass vaccination centres. MMR vaccine catch-up sessions have been offered at schools across Cardiff and Vale where uptake is less than 90% of pupils.

Leverage support from community leaders: events delivered which engaged leaders in delivering key messages to the community, including an event during Ramadan which saw over 300 people from ethnic minority communities attend to hear about screening and vaccination.

Engage with stakeholders and community representatives to understand needs, and the most appropriate ways to meet needs: 'lunch and learn' sessions with interpreters, supported by the UHB's Multi-cultural Link Workers have provided opportunities for community members to discuss vaccinations and ask questions about them.

Develop and cascade communication and information resources: several new resources have been developed, with several tailored to specific communities such as ethnic minority groups.

CASE STUDY 3



Partnership working to increase childhood vaccinations in an area of low uptake.

In 2023/24 the South West Primary Care Cardiff cluster agreed to focus on increasing the uptake of childhood immunisation rates. Two significant pieces of work helped to achieve this: checking records and inviting patients for catch up appointments using multiple communication methods; and holding a community event where vaccinations were offered.

The first project was a three-month quality improvement project, aimed to bring children under 5 years up to date with any vaccinations they may be missing. The initial process involved checking the records to ensure the GP held records aligned with the Child Health records held by the Health Board to establish the baseline of children missing vaccinations. Initial reports identified 267 children under 5 in the cluster missing vaccines, after data cleansing this reduced to 215 children.

This highlighted the significance of data quality when dealing with vaccination. A 20% discrepancy within the vaccination records is a significant factor that can hinder targeted efforts to vaccinate and hide the true level of immunity in the community.

GP practices then invited families to bring their children for catch up appointments, using different communication methods including phone calls, letters, texts, reminders through Health Visitors, and holding a drop-in clinic. A campaign promoting childhood immunisation was promoted through social media, GP TV screens, on websites and at community events.

The project was a success, reducing the number of children aged 5 still missing their vaccines from 215 to 120. The South West Cluster have shared their methods and learning with other clusters, as well as the resources (invite letters, FAQ sheets, and communications campaign resources). South West Primary Care Cluster intend to repeat the same process bi-annually.



The community event was a Halloween party which brought the communities together, and also offered the chance for health advice and an opportunity for children to receive vaccinations. **During the event school nurses administered the flu vaccination to 89 children, 22 immunisations were administered, and over 20 patient records checked for accuracy.**

Recommendations

To improve the level of uptake of childhood vaccinations, we need to:

Provide community-based vaccination opportunities, and make it easier for families to access children's vaccinations conveniently.

Ensure the gelatine-free flu vaccine is available at all vaccination opportunities for our early years (GP, and schools settings).

Work with communities with lower uptake of early childhood vaccinations to support and address vaccine hesitancy using methods such as face-to-face information sessions and tailored communications.

Work more closely with GP practices where uptake is particularly low to provide tailored support aimed at improving uptake.

Engage with and influence the national process of development of a single Welsh Immunisation System (WIS) for all vaccines in order to improve data access, quality and completeness.



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Chapter Three

Good Food and Movement - Why is it Important?

Good food and movement in our early years contributes to health, happiness, social, development, and even academic achievement.

Active children are healthy, happy, school ready and sleep better. Being active in the early years helps build relationships and social skills, maintain health and weight, contributes to brain development and learning, improves sleep, develops muscles and bones, and encourages movement and co-ordination.²⁶

Children are often active when they play. There are many additional benefits of playing, such as improved self-esteem and learning to manage our emotions through opportunities to express ourselves in a safe way.²⁷

A healthy diet in early childhood has many benefits: helping children to grow; prevent against obesity²⁸; improve oral health; strengthen immune system; support brain development; and even improve concentration and behaviour which can result in higher academic performance.²⁹

The benefits and harms from our early years track into later childhood and adulthood. Children who are living with overweight or obesity at age 4 to 5 years are more likely to still be when they reach the end of primary school and are five times more likely to go on to live with obesity in adulthood.³⁰ We need to act now to improve the health of our children in Cardiff and the Vale of Glamorgan.



What affects food and movement in our early years?

The options and opportunities we all have available to us affect how healthy and active we are. Our society is often awash with unhealthy food options, and many neighbourhoods have few opportunities for children to play safely, and be active.

Unhealthy food options are in the spotlight. Aggressive advertising aimed at children and fun promotions in supermarkets cast unhealthy options in a starring role in children's minds. Healthier food options get lost in the background or are pushed entirely offstage. We need to set the stage for health for all children.³¹

What surrounds us shapes us. The streets we live on, parks our children play in, the safety of the spaces where we walk, scoot or cycle all affect how active we are. Our childcare settings also have a big part to play in establishing a life-long enjoyment of moving. We need to focus on creating communities where our children can run and play, walk to school, play outside, and cycle safely, and be active.

All children deserve to be treated fairly and have the same chances to thrive and be healthy, no matter where they live. Many families do not have access to the things children need to be healthy. Unfairness around weight starts early. In a classroom of 30 children aged 4 to 5 years-olds in Cardiff and the Vale of Glamorgan, more children from our disadvantaged communities are categorised as overweight or obese (8 out of 30) as shown in Figure 6, than those in our less disadvantaged communities (5 out of 30).



Unfair differences can also be seen between ethnicities on a Wales wide basis with Asian or Asian British children more likely to be a healthy weight than White or Black, Black British, Caribbean or African children.

In a class of 30 children aged 4-5, 5 are living with overweight or obesity in our less disadvantaged areas.

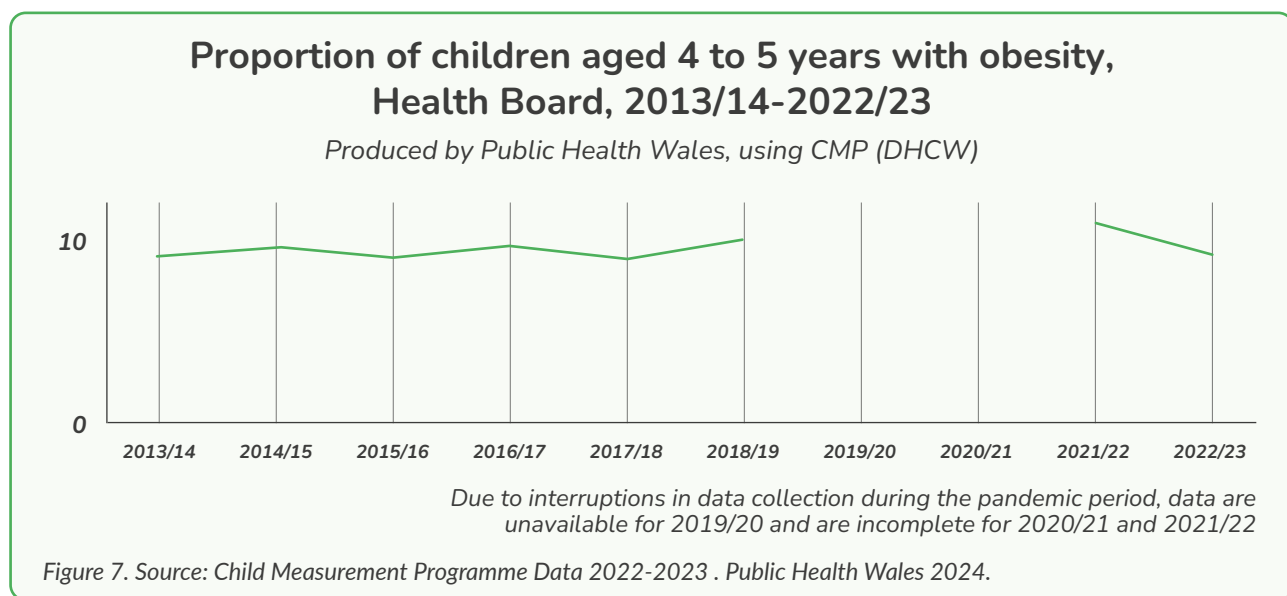


This rises to 8 in our more disadvantaged areas.

Figure 6. Source: Child Measurement Programme Data 2022-2023, Public Health Wales, 2024.

Families are up against a flood of unhealthy food options, and our children don't have enough opportunities to be active and play. We can improve children's health by improving the flow of affordable, healthy food options and set up our streets and schools so that children can run and play.

We have seen a slight reduction in the proportion of children aged 4 to 5 years with obesity in Cardiff and the Vale of Glamorgan³² (Figure 7), but there is little room for complacency, as we still have much higher levels than other parts of the UK and amongst countries with similar economic status.³³



What can we do?

Child obesity is a national emergency in Cardiff and the Vale of Glamorgan, and the UK, but we can tackle this and help all children to be healthy with concrete steps that are within our reach as a society.

Reductions in population level child obesity levels has been achieved in Amsterdam, where they reduced the prevalence of 2–18-year-olds with overweight or obesity from 21% to 18.7% in a five-year period. The programme aimed to improve children's physical activity, diet and sleep through action in the home, neighbourhood, school and city. Working across sectors for multilevel impact.

Locally, we need to make sure that we are driving change across all of the influences (see layers of the onion in Figure 1). Traditional approaches have focused on promoting and modifying individual behaviours, for example to promote healthy diets or physical activity. However, as the responsible factors extend far beyond individual behaviour, change is needed across the layers of influence.

To make these changes need we can not rely solely on one sector or organisation.

We need to join together, and it needs to be everyone's business. We are all part of the solution- health, local government, third sector, sport, leisure, private sector, planning, transport, police and more!

Current action

The new Good Food and Movement Framework was shaped by a wide range of ideas, perspectives and voices from across Cardiff and the Vale of Glamorgan.

It describes our approach, where we will prioritise our collective efforts, and how we will work together to create change to enable good food and movement in Cardiff and the Vale of Glamorgan over the next six years. The Framework and first Implementation Plan (2024-2026) recognise the importance of early years, and many actions will impact upon or relate specifically to the early years.

There is so much to share beyond the stories and examples in this report. The case studies below are just two examples of local work which are helping to shape our early years settings, and redesign local policies.



CASE STUDY 4



Creating conditions for outdoor play in our early year's settings

Playing, learning and having fun outdoors helps improve health, wellbeing and resilience. It also gives children the opportunity to develop a life-long appreciation of the natural world and has a positive impact on educational attainment.

We want to increase outdoor play opportunities for our young children in Cardiff and the Vale of Glamorgan. Many children attend childcare settings, such as childminders, playgroups, nurseries, and school-based nurseries. These settings can enable, support and promote our young children to be active, such as through outdoor play.



Cardiff Council and Vale of Glamorgan Play Teams, Cardiff and Vale Public Health Team, and Play Wales came together to increase the opportunities for outdoor play within early years settings. The project involved:

- Play Wales brought a group of early years settings together in a focus group to develop the tools, templates and resources that settings would benefit from to provide and support outdoor play.
- From this, they developed and published an Outdoor Play Toolkit for staff and settings, with practical ideas and tips and policy ideas.
- An online webinar was offered to a range of early years settings to talk them through using the toolkit, enabling staff to create conditions for children to play outdoors.
- The toolkit has been printed and widely shared with early years settings.
- Its use and impact will be evaluated by Sheffield University.

The work was complemented by improved play equipment at sheltered accommodation, and a wider public campaign on 'World Play Day' emphasising the benefits and importance of play and outdoor play.



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CASE STUDY 5



Changing advertising policies to promote healthier advertising

Very young children see, understand, and remember advertising³⁵ and children as young as three can easily identify corporate logos, especially McDonalds, Disney and car brands.³⁶

It's not just brand recognition we need to worry about. Advertisements can influence what we buy and what we eat. People who are more aware of adverts that feature foods and drinks that are high in fat, sugar and/or salt (HFSS) consume a greater level of HFSS food and drink products. Children's exposure to HFSS adverts can lead to; strong brand awareness, stronger preferences for HFSS foods and drinks; more snacking and over consumption as well as HFSS food replacing healthier foods. Exposure to HFSS advertising is also unequal across society, with those in our disadvantaged communities more likely to report having seen HFSS advertising. The food and drink sector have huge budgets for marketing and advertising, spending a huge £175 million on Out of Home (OOH) Outdoor advertising in 2021 in the UK³⁷ (across a variety of mediums).



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The powerful marketing tactics that put unhealthy food centre-stage need to be minimised. Reducing local HFSS advertising and allowing more space for healthier food and drink advertising is one step in the right direction to improving children's health.

Cardiff and Vale University Health Board, Cardiff Council, and the Vale of Glamorgan Council have come together and committed to reducing the advertising of HFSS food and drinks on their owned and run advertising sites. Some of the work so far has included:

- Bringing the organisations together to discuss and share challenges and get a better understanding of the push back from commercial advertising agencies.
- Learning from elsewhere. Other Local Authorities from across the UK have successfully developed Healthier Advertising policies and are now restricting HFSS advertising and creating space for healthier advertising. Their policies are based on 'swapping out' HFSS foods and drinks. This means that all Food and Drink companies can

still advertise, but that adverts need to feature healthy foods and drinks. Transport for London recently evaluated the impact of the introduction of Healthier Advertising Policy across the network, which showed an association between the implementation of restrictions, and the reductions in average household weekly purchases of energy, sugar, and fat from HFSS food and drink products. This is estimated to be around 1,000 fewer calories in average weekly household purchases of energy from HFSS food and drink products.

- Understanding our advertising landscape. We have been mapping and monitoring HFSS advertising on bus stops across Cardiff and Vale.
- Describing the problem. [This is one street in Cardiff city centre.](#) We asked children in a local primary school to react to what they see. It is a powerful visual of the problem.



Scan the QR code to watch the video



- Understanding what the public think about food and drink advertising in their community, and what the effects of reducing it may be. The PHIRST evaluation team will evaluate our local work in Cardiff and Vale. The results will be used to help inform our local policies.

Next steps will be to develop policies to help restrict the advertising of unhealthy food and drink, creating more space for healthier advertising, and improving children's health.

There is lots of excellent local action, ranging from services and schemes which support and enable children and families to enjoy good food and movement, to changes at the environment and policy level. Some are mentioned below, to give a flavour of the breadth, but it is by no means exhaustive.

At an individual and social level, health visitors play a key role in supporting families enjoy good food and movement. They offer advice and support on healthy weaning, introduction to solids sessions, breastfeeding advice and support groups, and assessment and advice on child development and physical literacy. Flying Start teams provide extra help and support for parents in specific communities on a range of issues, such as feeding, weaning, sleep routines, and more.

Services such as NYLO (Nutrition for Your Little One) support families with children under 5 in Cardiff and the Vale of Glamorgan to build confidence in providing a healthy balanced diet alongside the promotion of active play. AFAL (Active Families, Active Lives) supports children and young people aged 2-18 years to manage their health and weight. PIPYN (Pwysau Iach Plant Yng Nhymlu) supports families with children aged 3-7 years from minority ethnic communities in south Cardiff. Community cookery courses and nutrition information courses also provide community members with confidence, knowledge and skills to cook affordable and healthy food. Play Teams develop and deliver play opportunities for children and young people, including younger children provision, such as pre-school family sessions.

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There is a lot of support to our early years settings to ensure they offer the children in their care the best start in life.

The Healthy and Sustainable Pre-school Scheme is a national accreditation scheme for pre-school settings, supporting settings to embed health and wellbeing within its day to day life, working on a range of topics including physical activity and play, nutrition and oral health. A range of training opportunities are delivered to the early years workforce by many partners, such as nutrition training, physical literacy, play and many more. The Gold Standard Healthy Snack Award recognises childcare settings providing healthy snacks and drinks in a safe and happy eating environment.

Many teams and organisations are involved in creating physical environments which enable children to be active, ranging from putting play cubes in community spaces, improving play equipment, closing streets for play, developing inclusive and safe playgrounds and improving walking and cycling infrastructure.

Recommendations

Review local strategic plans and policies to identify opportunities to maximise support for good food and movement, for example, strengthening strategic policies within the Local Development Plan (LDP).

Develop a shared understanding of current resource and training available and explore the opportunities and challenges for the early years workforce to; have healthy conversations, promote food related benefits and embed play and physical literacy.

Collaborate with communities and partners to identify and improve public spaces for play in targeted areas.

Undertake insight work to develop a public campaign on the importance of outdoor play.

Advocate for 'Healthy Start' vouchers to be automatically provided, rather than having to apply for this.



Chapter Four

Oral Health

The importance of oral health in the early years

A child's mouth is of huge importance to their early development. It supports nutrition, speech and language development, and social interaction. Even though primary (baby) teeth are naturally lost as a child grows, the health of these teeth is important. They help a child to consume a varied diet, allow them to smile with confidence, and make space for, and guide, permanent (adult) teeth.

Dental caries (tooth decay) occurs when sugars from food and drink interact with bacteria in tooth plaque. This produces acid, which causes cavities to form in teeth. The two main behaviours associated with dental caries in young children is having a diet high in free sugar and poor oral hygiene.

In the short term, untreated dental caries can lead to pain and infection. Longer term, it is linked with poor oral health in later life and negative effects on physical and emotional development.

The extraction of decayed teeth is the most common reason for hospital admissions in young children. Dental caries in young children are often difficult to treat. The children are too young to safely co-operate with standard dental treatment in a general dental practice setting. As a result, many will need to be treated in specialist settings and treatment may need to be conducted under general anaesthesia.



The proportion of children with dental caries in the UK has fallen in recent decades. In Cardiff and Vale in 2007/08 in a class of 30 five-year-old children, 12 had dental caries. By 2022/23 this had fallen to 10 out of 30 (Figure 8).³⁸

Prevalence of dental caries experience in 5-year-olds in Wales and CVUHB 2007/08 to 2022/23

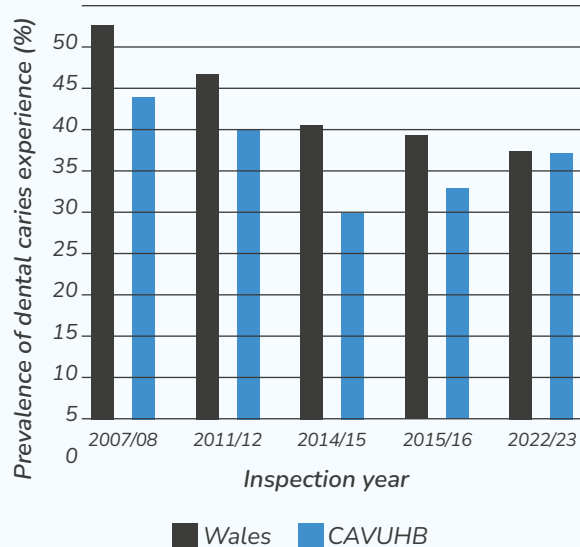
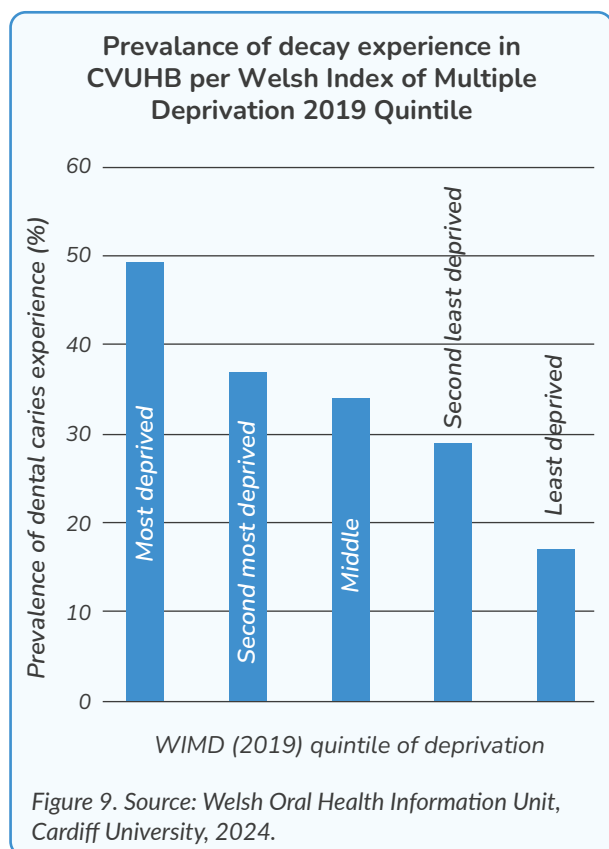


Figure 8. Source: Dental epidemiological inspection of school year one (5-year-old) children in Wales 2022/23. Cardiff University, 2023.

However, whilst fewer children have dental caries, the severity of untreated dental caries amongst affected children has increased in the Cardiff and Vale area since 2007/08³⁸. Since dental caries is a condition that affects the more disadvantaged groups in our society more greatly, dental decay is increasingly becoming a disease of deprivation. (Figure 9).³⁹



The impact of poor oral health is felt by the child and their family members. In Cardiff and Vale, 1 in 3 families who have a child affected by dental caries report that it has negatively affected their quality of life.

Dental Service Access by 0-5 year-old children

Most dental patients are seen in the General Dental Services (GDS), also known as high street dental practices. In addition to the GDS, the Health Board's Community Dental Service and Cardiff Dental Hospital also provide dental care to children living in the Health Board area. Due to the impact of the pandemic and other factors, a smaller percentage of children can access dental care now compared to the pre-pandemic period.

The National Institute for Health and Care Excellence (NICE) guidance⁴⁰ recommends that children are recalled for check-ups (assessment) at intervals of 3 months to 12 months depending on the child's oral health status. Only 35% of 0-5 year old children were able to access dental care in 12 months prior to March 2024 (Table 1).⁴¹ Most of the children who accessed dental care were from the least deprived quintiles (Figure 10).⁴¹ This figure includes those who only accessed urgent dental care in that period.

Age Group (year)	Mid-year 2023 population estimates	Number of 0-5 year old children seen in 12 months in 2023/24	% of the population seen
0	4693	146	3%
1	5183	1117	22%
2	5059	2022	40%
3	5275	2237	42%
4	5411	2431	45%
5	5543	2933	53%
0-5 yr old children total	31164	10886	35%

Table 1. Percentage of 0-5 year old children seen in primary dental care is low.

Out of those 0-5 year old children who were seen in Primary Dental Care in 2023/24, the majority were from the least deprived areas

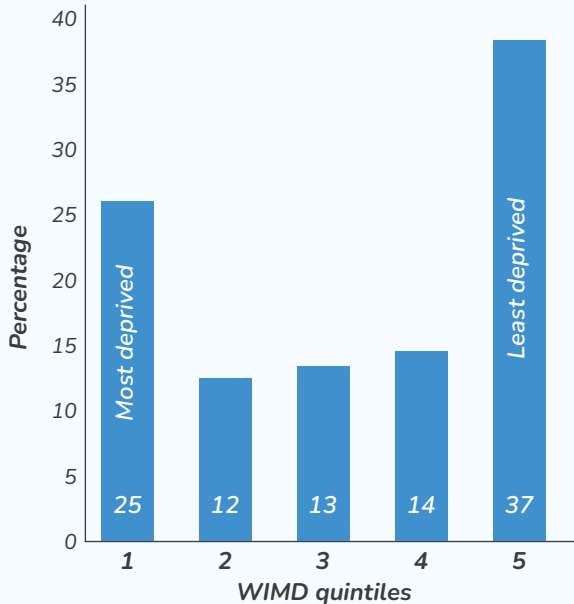


Figure 10. Source: Welsh Oral Health Information Unit, Cardiff University, 2024.

In Cardiff and the Vale over the course of a year (2022/23), 1379 children were referred to hospital (2022/23)⁴² and community dental services for management of tooth decay. Many of these children need multiple teeth extracted under general anaesthesia.

Current actions to improve oral health

[Designed to Smile \(D2S\)](#) is a targeted, evidence based national programme to improve the oral health of children living in deprived areas in Wales. The case study for this chapter gives further details of this programme.

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Children are now prioritised for dental access

The Health Board holds a ‘waiting list’ of people living in Cardiff and Vale of Glamorgan who want to access regular dental care. Currently Health Board prioritises children over adults for dental check-ups. care. An [Electronic Dental Access Portal \(DAP\)](#) is being developed by the Digital Health and Care Wales team which is being implemented in Quarter 3 of 2024/25. Health Board’s ‘centralised waiting list’ will be transferred to the DAP.

As a part of the Welsh Government’s dental reform programme in Wales, there is intention to include delivery of prevention through the dental practice setting, improve access through greater use of skill mix and to ensure limited capacity of dental access is based on need.

Monitoring of dental health of 5-year-old children

Tooth decay is included in the Public Health Outcomes Framework (PHOF). The Dental Epidemiology Programme in Wales includes a plan for regular dental inspection of school year 1 children in Wales that provides oral health trends. The Health Board’s Community Dental Service collects data from randomly selected primary schools in the Health Board area which provides picture of dental health of 5-year-olds in the Health Board.

CASE STUDY 6



Designed to Smile – preventative oral health care in education settings

[Designed to Smile \(D2S\)](#) is a national preventative programme which aims to improve the oral health of children in Wales. It's delivered by the Community Dental Services in partnership with education and childcare settings and early years health professionals.

In areas of higher need, nurseries and primary schools are offered support from the Designed to Smile team to run a supervised toothbrushing programme. In the 2023-24 academic year, 73% (127 out of 174) of eligible settings participated, with 5,273 young children aged 2-5 years old (nursery to reception age) taking part.⁴³

Trained staff also visit eligible schools across Cardiff and the Vale twice a year to apply fluoride varnish to children's teeth. This year, 94% (77/84) of eligible settings participated, with 3,006 young children aged 3-5 years old receiving the varnish (nursery and reception-age). Where signs of decay are noted when giving fluoride varnish, a card is sent home to the parent or guardian recommending they access dental care. For those who are not registered with a dental practice, an email address is provided to join the centralised waiting list for an NHS dentist. Key oral health messages are also included around toothbrushing and healthier eating.

The Designed to Smile programme also includes:

- Giving training cups and toothbrushing home packs to children. 14,257 children in Cardiff and Vale were estimated to have received a pack from their nursery and school this year⁴³.
- Resources such as lesson plans for teachers to introduce information on oral health and healthy eating to children.
- Oral health training for relevant staff such as health visitors and midwives ensuring consistent key messages and signposting for oral health and dental care. The training includes Lift the Lip, a way for parents or guardians to check their children's teeth in the presence of a health professional to check for early signs of tooth decay.
- Providing oral health information and activities and distribute toothbrushing packs to the children at the Food and Fun School Holiday Enrichment sessions during the summer holidays.

Further information is available on [D2S Annual Monitoring Reports](#).



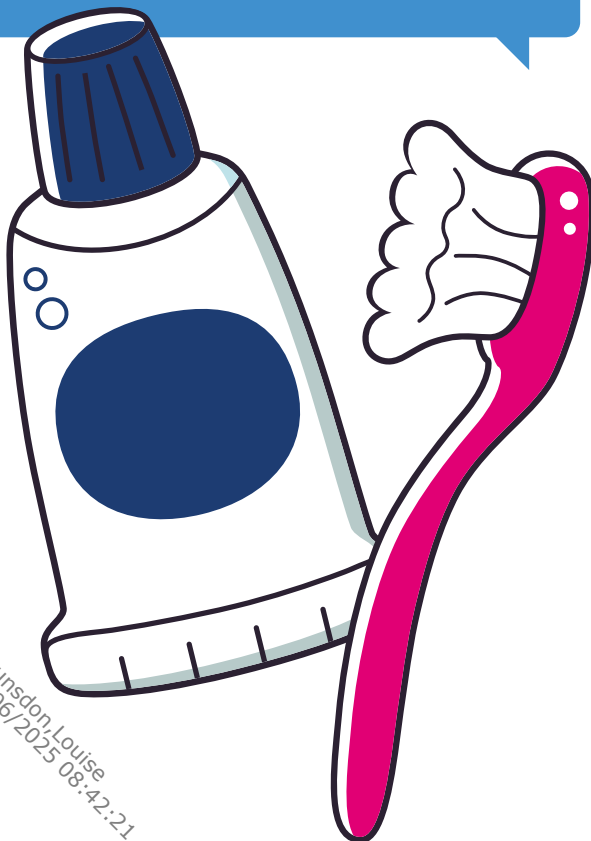
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A Bright Start Nursery who are participating in the scheme said:

“When new parents/child start at the setting we discuss with them about the ‘Design to Smile’ scheme and provide them with a leaflet about the scheme. Design to Smile also attend the setting every few months to provide advice and answer any questions we may have, and to replenish any required equipment, toothbrushes, toothpaste needed”.



“The children are happy to be involved. At tooth brushing time we bring out the toothbrush train, the children recognise their names and are given their toothbrushes, before we commence”.



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This chapter has shown that whilst there are areas of action around improving support for young children’s oral health, more could be done to prevent dental caries in young children, particularly in those groups who are more likely to experience worse oral health. Designed to Smile has good uptake but there are still eligible settings which aren’t participating, meaning children there aren’t getting the benefits of supervised brushing or fluoride varnishing. As these settings are eligible due to being in areas of higher need, the reasons for refusal by the primary schools and nurseries should be explored so there is a better understanding of the barriers for participating and overcoming these.

Oral health is closely linked with higher intake of sugary foods and drinks. In the Good Food and Movement chapter, the role of the wider environment is explored and the case study around healthier food advertising shows the influence of our surroundings shaping our choices. A healthier food environment will support our children to have better oral health.

Accessing preventive dental care before treatment is required should be prioritised. The numbers of children experiencing dental caries is very high. Preventive dental care (not just reactive) pathways should be created between dental services and health and social care teams. The Designed to Smile team and other health professionals that come in contact with 0-5 year old children should be able to refer children for timely dental assessment and preventive care. To achieve this, capacity within primary care dental services will need to be created for this so that referral of children to hospital and specialist dental service can be reduced. One way of creating some capacity in dental services is by investing in dental therapists and nurse workforce.

Almost all children 0-5 year old children can be seen and treated by dental therapist and nurse team within the Health Board’s salaried or community dental service and high street dental practices (general dental service).

A better understanding and regular monitoring of how young children are accessing dental services is needed to inform improvement plans. The Primary care team in the Health Board should work with the system partners, especially Welsh Government and NHS Business Services Authority, so that dental services access data for children is regularly analysed by smaller age groups and deprivation. Another key area for improving uptake of preventive dental services and oral health care is to understand the ‘lived experience’ of children and parents. The ‘voice’ of families to inform local oral health plans and programmes will provide insight into how best to make progress in improving oral health of young children.

Recommendations

Explore reasons for eligible primary schools and nurseries for not participating in the Designed to Smile programme.

Explore how to create more capacity within primary care for proactive co-ordinated preventive dental care for children.

Monitor the dental service access rate and inequity in access for children including 0-5 year old children.

Understand the experiences of families on challenges to accessing regular preventive dental care.

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Chapter Five

Breastfeeding

Creating the conditions to support breastfeeding in Cardiff and the Vale of Glamorgan.

Success in breastfeeding is not the sole responsibility of a woman – the promotion of breastfeeding is a collective societal responsibility.⁴⁴

Why is breastfeeding important?

There are benefits to both parent and baby of breastfeeding. These last into adulthood. Breastfeeding gives complete nutrition to a baby and provides early protection against diarrhoea and respiratory infections, reduces the risk of hospitalisation and protects against middle ear infections in under two's.⁴⁵

It promotes healthy brain development and in later life it reduces the risk of obesity and chronic diseases and abnormal alignment of teeth.⁴⁵ In mothers, breastfeeding lowers the risk of breast cancer, ovarian cancer, cardiovascular disease, and type 2 diabetes.⁴⁶



Breastfeeding also supports relationship building between mothers and babies and increases Intelligence Quotient (IQ) in babies and school achievement levels. This can increase adult earning potential, helping babies have the best chances of a healthy productive life well into their later years⁴⁷. Because of its strong positive effect, it is a highly cost-effective area of public health focus with a moderate increase in breastfeeding rates modelled at saving over £17million a year for the UK.⁴⁸

Families face various pressures when making infant feeding decisions, including the rising cost of living and food prices. While breastfeeding can help reduce household costs, we recognise that infant feeding choices are complex and personal. For families using formula, support is available through schemes like Healthy Start, which provides vouchers towards essential foods, which includes formula milk. However, we understand that current voucher values may not fully meet families' needs given rising costs.

The World Health Organisation recommends exclusive breastfeeding for the first 6 months of life with continued breastfeeding up till 2 years with foods introduced from 6 months⁴⁹. Across Wales there are significant variations in breastfeeding initiation and length of feeding which contributes to health inequity across our population.

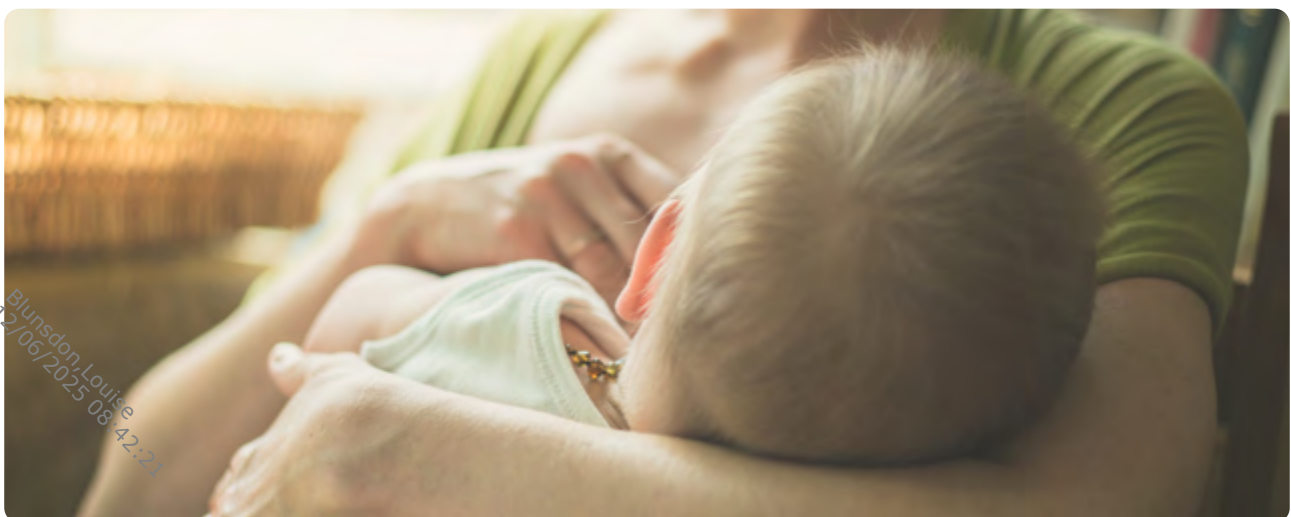
How to create supportive environments for breastfeeding?

As with other topics in this report, the influences for breastfeeding are complex and cannot be tackled on one level alone. The Academy of Medical Sciences highlight that there are a number of structural barriers to increasing rates including “gender inequities, a lack of consistent quality care in the healthcare environment, adverse social infant feeding norms and embedded inequalities, and poor accommodation of women’s reproductive rights in the labour market.”¹⁵

Creating environments that support breastfeeding requires understanding how policies, culture, communities, and individual experiences interconnect, and recognising that sustainable change starts with structural foundations that enable and empower communities and individuals.

For example, barriers such as maternity benefits for working women and workplaces not having policies or facilities to support breastfeeding women to continue to breastfeed upon return to work impact on breastfeeding initiation and continuation.⁴⁶

Strong policy, supportive organisations, communities and families are essential building blocks for breastfeeding. At the policy level, a number of factors are important: breastfeeding rights should be protected; parental leave is necessary; investment is needed in community services and robust regulation of formula marketing must be implemented. These policies come alive through our diverse communities, where local attitudes shape acceptance, peer networks offer crucial support, and accessible services meet families where they live. Organisations then translate these policies into practical support, from baby-friendly healthcare settings to workplace facilities for expressing milk, and from welcoming community venues to early years settings that champion infant feeding choices. This interconnected system ensures that strategic vision translates into real-world support for families.

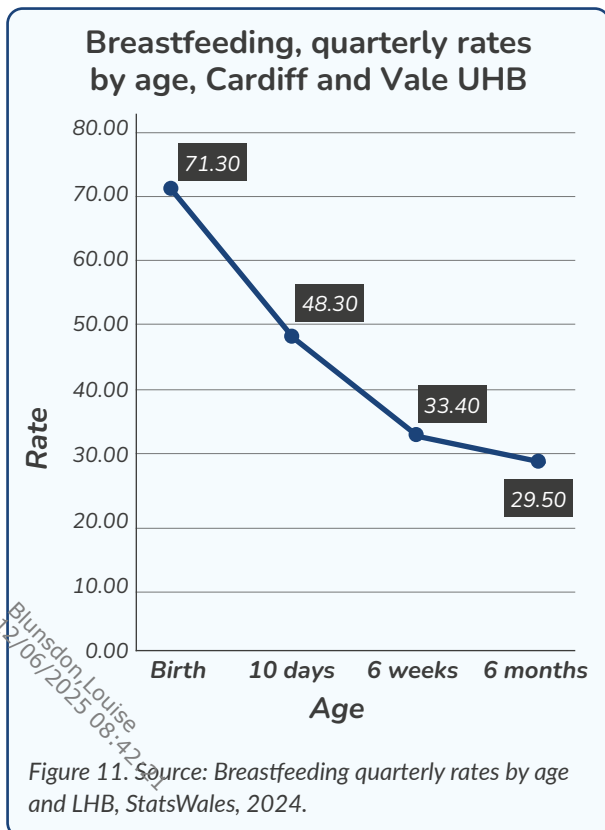


Local Picture

The All Wales Breastfeeding Action Plan has a goal of ‘More babies in Wales will be breast-fed, and for longer, and the current inequalities in breastfeeding rates between groups will be reduced’⁵⁰.

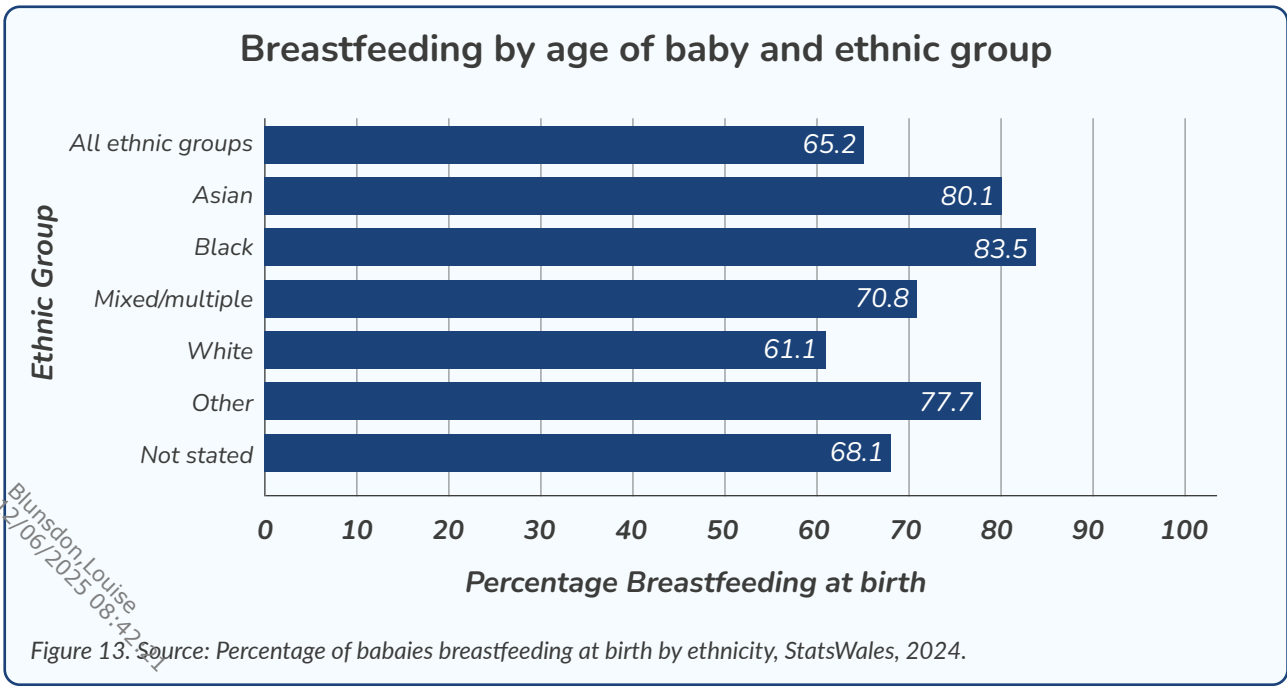
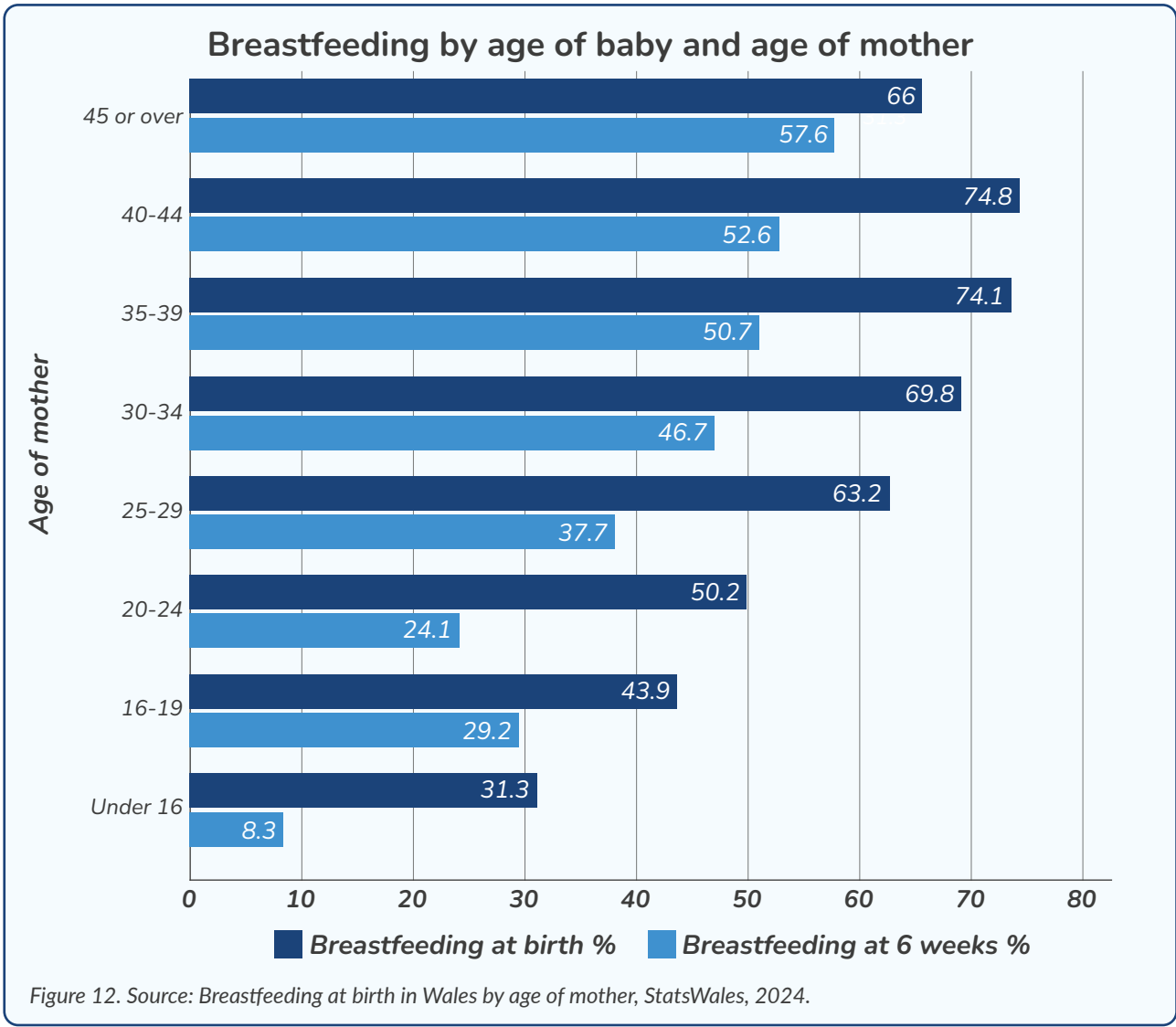
It aims to create settings and environments with an inclusive and positive ethos towards breastfeeding including workplaces. Action 6 of the All Wales Breastfeeding Action Plan states “Each health board will provide a coordinated support model which is inclusive of health professionals, peer supporters, professional education and community led services”.⁵⁰

In Cardiff and Vale 71% of babies were recorded as being exclusively breastfed at birth dropping to 33% at 6 weeks then to 30% at 6 months in the quarter January – March 2024 (Figure 11).⁵ Despite continued work to promote and support breastfeeding in Cardiff and the Vale of Glamorgan, these inequities have persisted.



Research into the likelihood of initiating and continuing breastfeeding shows strong links to: the age of the mother; if the mother is living in a deprived area; and ethnicity. These differences having the potential to widen health inequalities.^{51,52} This is reflected in the picture across Wales with younger mothers aged 16-19 years much less likely to breastfeed at birth than mothers in their thirties (Figure 12).⁵ Babies from Black or Asian backgrounds are around 20% more likely to be breastfed at birth than those from White backgrounds (Figure 13).⁵ A strong correlation between living in areas of deprivation and initiation of breastfeeding can also be seen across Wales (Figure 14).⁵ The intention to breastfeed is linked to the number of times mothers had previously given birth. Across Wales the more times you’ve given birth, the less likely mothers are to intend to breastfeed dropping from 70% for first-time mothers to 56% of mothers who had given birth multiple times.





Any breastfeeding at birth by Multiple Deprivation quintile

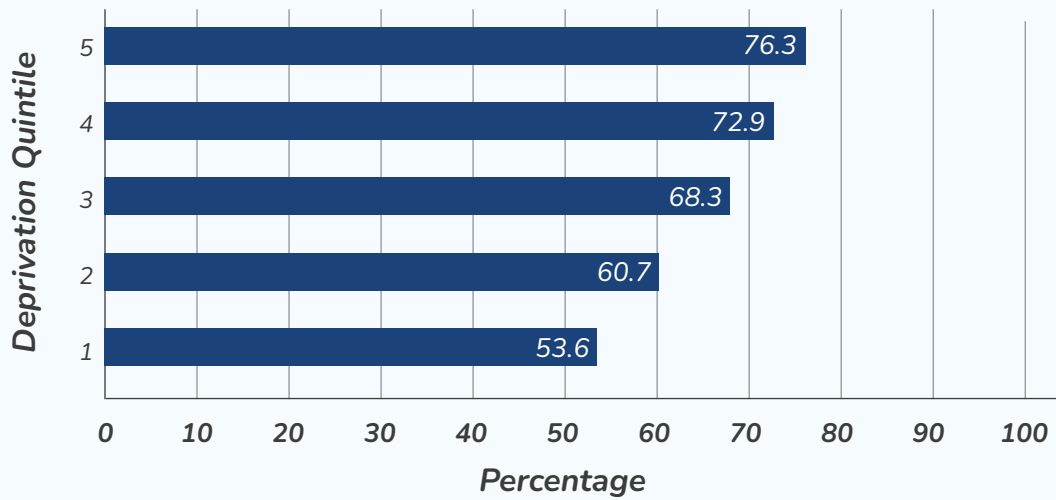


Figure 14. Source: Any breastfeeding at birth by Multiple Deprivation quintal Percentage, StatsWales, 2024.



£17 million a year

Savings for the UK modelled on a moderate increase in breastfeeding⁴⁸

£44 - £88 per month

Cost of feeding a 10 week old baby branded infant formula in 2023⁵³



Average monthly attendance at breastfeeding support groups in Cardiff and Vale (Sept 2023 – Aug 2024)

Average referrals per month to Infant Feeding Team

(Sept 2023 – Aug 2024)



What are we doing?

Ante-natal Support

The Cardiff and Vale Maternity Services run on-line breastfeeding workshops that any pregnant mother can attend. The Vale Flying Start Maternity Team also provide a face to face breastfeeding workshop that is open to all pregnant mothers across Cardiff and Vale.

Pregnant Women who live in a Flying Start area of Cardiff and Vale can receive two antenatal home visits by their health visitor and community nursery nurse, this enables the conversations regarding infant feeding to begin early.

Post-natal Support

Maternity

The Maternity Service’s Seren Team runs three specialist breastfeeding clinics a week for babies up to 28 days old. They also provide breastfeeding support at home. There are a number of Breastfeeding Network volunteer “Helpers” that work in collaboration with health care professionals within the maternity unit providing early postnatal support to breastfeeding mothers.

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Health Visiting

Breastfeeding mothers are welcome to attend any one of our three breastfeeding support groups in Cardiff and Vale. A breastfeeding support group is a collaborative environment where mothers and partners can share experiences and provide mutual support and encouragement. Groups organised by the Health Visiting Service are led by trained community staff nurses and community nursery nurses. Women requiring infant feeding specialist support will be referred to the Infant Specialist Feeding Team which runs a weekly clinic and offers home visits.

Peer Support

Cardiff and Vale have two Peer Support Groups that are run by The Breastfeeding Network "Helpers". When available the Helpers will support the health visiting run groups alongside the health professionals attending the groups.

Specialist Support

Support for people with complex issues is provided by a Specialist Midwife based in the Cardiff and Vale Health Inclusion Service (CAVHIS) who provide appropriate and culturally sensitive care. Care is planned through the use of interpreting services throughout antenatal, birth and postnatal period, to provide safe and effective care to women.

CASE STUDY 7



Understanding cultural norms and ideologies on breastfeeding

To understand the influences for mothers in Cardiff and the Vale around breastfeeding, a new piece of research was commissioned for this report. The research used a mixed method approach used an e-survey and interviews to explore the barriers and facilitators to breastfeeding experienced by local mothers and potential recommendations for future practice. **A summary is presented below and the full report is available [here](#).**

33 people completed the survey.
Of these respondents:

45% had breastfed before

82% indicated that they had planned to breastfeed

12% women planned to combination feed

3% woman planned to use formula or had no plan.

In response to a question which asked if they were currently breastfeeding their baby:

3% had not breastfed at all

12% were combination feeding

64% were exclusively breastfeeding

21% had breastfed but stopped.

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People told us:

The enablers to breastfeeding were health benefits to baby, cost, and convenience.

I knew the health benefits for both of us and also the importance of bonding

Don't need to pack bottles and can feed on the go

[Breastfeeding] support group so vital to my [breastfeeding] journey

Had loads of support once I asked for it. But felt like I had to ask for the support.

The main challenges were around how mothers access information, for example support groups and the perception of what the support groups are.

They told me about this [support group] but I didn't feel like I needed the support like that... I didn't realise it was kind of like this where you can just have a coffee and stuff

People told us that social media platforms had been helpful and should perhaps be considered when signposting to services.

Responses provided in this study have also highlighted the greater need for emotional support for those that did not have a natural birth (e.g. c-section) or experienced other complications.

When unwell with sepsis I was admitted as an emergency to [the hospital] - there was no consideration of how to manage my exclusively breastfed baby.

The largest percentage of people not breastfeeding are a younger demographic (under 19 years old). Further work focussing on ascertaining the views and lived experience of these mothers would be beneficial.

Recommendations from the breastfeeding research

Provide information to those who are pregnant earlier on breastfeeding, its benefits and the available support using social media channels where information is often sought

Increase opportunities to provide proactive support to breastfeeding mothers including those who may struggle with breastfeeding due to circumstances such as additional medical needs

Further research with more mothers especially those that are less likely to breastfeed to include social and family influences and support networks.

Chapter Six

Summary and Recommendations in Full

Giving children the best start in life in Cardiff and Vale

This report has described the state of health in the early years in Cardiff and Vale – highlighting what is working well, as well as what gaps and inequalities we know we need to address to give children the best start in life in the area.

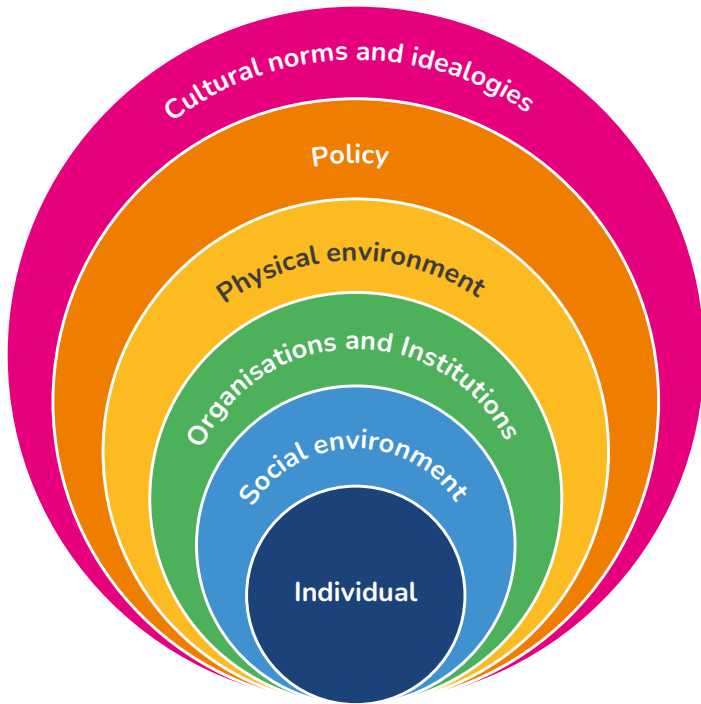
My recommendations, to colleagues and partners in the NHS, local authorities, third sector and wider, set out practical steps that we could take to act on our ambitions to improve the health and wellbeing of children.

As you read this, I would ask you to consider what you could do, individually, in your team or service, or in your family or community, recognising success will require action in all places and at all levels.

We look forward to working with you in discussing and acting upon these recommendations and to working towards giving children and young people the start in life they need and deserve.



Recommendations



General

Explore options for improving intelligence on inequalities in child development and school readiness between population groups, including collaboration if appropriate with Digital Health Care Wales.

Owner: Cardiff and Vale Public Health Team, Education, Health visiting and paediatric colleagues

Layer: Organisations and Institutions

Vaccinations

Provide community-based vaccination opportunities, to make it easier for families to access children's vaccinations conveniently.

Owner: Cardiff and Vale University Health Board

Layer: Organisations and Institutions

Ensure the gelatine-free flu vaccine is equally available at all vaccination opportunities for our early years (GP, and schools settings).

Owner: Cardiff and Vale University Health Board

Layer: Policy

Work with communities with lower uptake of early childhood vaccinations to support and address vaccine hesitancy using methods such as face-to-face information sessions and tailored communications

Owner: Cardiff and Vale University Health Board together with partner organisations and communities

Layer: Cultural norms

Engage with and influence the national process of development of a single Welsh Immunisation System (WIS) for all vaccines in order to improve data access, quality and completeness.

Owner: Cardiff and Vale University Health Board

Layer: Organisations and Institutions

Work more closely with GP practices where uptake is particularly low to provide tailored support aimed at improving uptake

Owner: Cardiff and Vale University Health Board

Layer: Organisations and Institutions

Good Food and Movement

Review local strategic plans and policies to identify opportunities to maximise support for good food and movement, for example, strengthening strategic policies within the Local Development Plan (LDP).
Owner: Good Food and Movement Leadership and Enabling Change Group
Layer: Policy

Develop a shared understanding of current resource and training available and explore the opportunities and challenges for the early years workforce to; have healthy conversations, promote food related benefits and embed play and physical literacy.
Owner: Cardiff and Vale Public Health Team, together with a wide range of partners
Layer: Organisations and Institutions

Collaborate with communities and partners to identify and improve public spaces for play in targeted areas.
Owner: Cardiff and Vale Public Health Team with Public Health Dietetics and PIPYN Reference Group
Layer: Physical environment

Undertake insight work to develop a public campaign on the importance of outdoor play
Owner: Cardiff and Vale Public Health Team with partners including Play Wales and play teams
Layer: Cultural norms

Advocate for 'Healthy Start' vouchers to be automatically provided, rather than having to apply for this.
Owner: Cardiff and Vale Public Health Team
Layer: Policy

Oral Health

Explore reasons for eligible primary schools and nurseries for not participating in the Designed to Smile programme.
Owner: Cardiff and Vale University Health Board
Layer: Organisations and Institutions

Explore how to create more capacity within primary care for proactive co-ordinated preventive dental care for children.
Owner: Cardiff and Vale University Health Board
Layer: Organisations and Institutions

Monitor the dental service access rate and inequity in access for children including 0-5 year old children.
Owner: Cardiff and Vale University Health Board
Layer: Organisations and Institutions

Understand the experiences of families on challenges to accessing regular preventive dental care
Owner: Cardiff and Vale University Health Board
Layer: Individual

Breastfeeding

Provide information to those who are pregnant earlier on breastfeeding, its benefits and the available support using social media channels where information is often sought

Owner: Cardiff and Vale University Health Board Wales and play teams

Layer: Individual

Further research with more mothers especially those that are less likely to breastfeed to include social and family influences and support networks.

Owner: Cardiff and Vale Public Health Team

Layer: Social environment

Increase opportunities to provide proactive support to breastfeeding mothers including those who may struggle with breastfeeding due to circumstances such as additional medical needs

Owner: Cardiff and Vale University Health Board

Layer: Organisations and Institutions

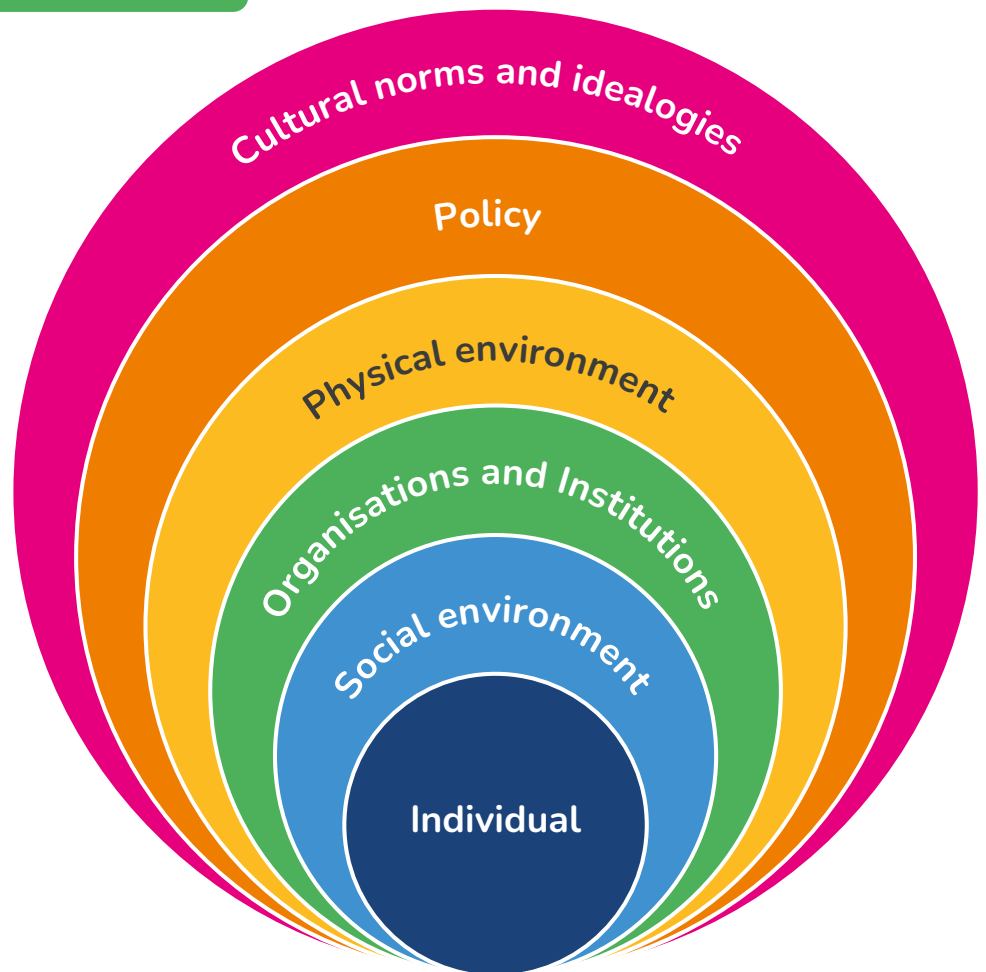


Figure 1. Based on the socio-ecological model⁸

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Appendix One

Building Futures

Action on Child Poverty at the Edge of Care in Cardiff & the Vale of Glamorgan

This bid was prepared by a range of partners across Cardiff and the Vale of Glamorgan to address child poverty. Whilst it was unsuccessful it is important to recognise that addressing child poverty would improve the health of the population.

Child poverty has emerged as a key risk factor for children entering care with strong evidence of an association between growing up in poverty and childhood adversities. To better support families, more effective coordination of social work, health and public health, schools, public and community services is needed.

Addressing the needs of those on the 'edge of care' is important because it prevents those at-risk of entering care from the adverse life-long consequences of being in care, including poorer educational attainment, mental health and physical health. This disadvantage also extends into the child's adult life, creating a cycle of intergenerational poverty

The proposed project set out to complete a detailed systems analysis of child and family support services available to those on the 'edge of care'. This analysis would help to inform recommendations for integration of services and changes in the way the services are provided to better meet the needs of the families accessing support and a shift to more preventative action rather than crisis response.

A collaborative approach would focus on two target areas with the highest levels of deprivation in Cardiff and the Vale of Glamorgan. Ely and Caerau in Cardiff and Gibbonsdown, Court and Buttrills in the Vale of Glamorgan using a two-step approach.

1. Locality system analysis. To improve knowledge of what demands are currently placed on services, what unmet need there is, what is available to families currently and how effective this support is. A wide range of sources of information will be used including learning from best practice, practitioners and those using services.
2. Identifying opportunities for change and producing recommendations for system change initiatives. Testing ideas and user-focussed design.

The learning from these areas and improvements would go on to shape wider service design.

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Appendix Two

Update on Previous Director of Public Health Report

Recall of the wild: Reconnecting with and restoring nature for biodiversity and health

Following publication of [Recall of the Wild](#) in December 2023, actions have been taken to meet the recommendations:



Ecological surveys at four Health Board hospital sites: these were commissioned by the Local Public Health Team at University Hospital of Wales, University Hospital Llandough, Barry Hospital and St David's Hospital. These have provided us with an understanding of the biodiversity at each site, along with proposing recommendations for the enhancement and improved land management of green areas to enable us to restore and reconnect with nature.



Biodiversity enhancements at sites: following the ecological surveys, and site visits with co-ordinators from the Vale of Glamorgan and Cardiff Local Nature partnerships, proposals have been presented to and approved at the Senior Leadership Board for enhancements of green areas at sites.

Vale Public Services Board Nature Charter development: Working with the Vale Public Services Board (PSB), and Natural Resources Wales (NRW), we have developed a Climate and Nature Charter. This is a renewal of the pre-existing Climate Charter to incorporate nature-focused commitments, encouraging public organisations to restore biodiversity and improve opportunities for nature connections.

RSPB Nature Prescriptions: We are going to be working with the RSPB to bring their nature prescriptions scheme to the Cardiff and Vale UHB area. This will provide new opportunities for Healthcare Professionals to signpost people to nature-based activities to improve their health and wellbeing. The scheme is already successful in Scotland and England, with this being the first time it will be provided in Wales.





Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Tim Iechyd Cyhoeddus
Cardiff and Vale University Health Board
Public Health Team



GIG
CYMRU
NHS
WALES

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

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Report Title:	Improving Attendance at Work Update			Agenda Item no.	9
Meeting:	Local Partnership Forum	Public	X	Meeting Date:	18.06.25
		Private			
Status <i>(please tick one only):</i>	Assurance	X	Approval	Information	X
Lead Executive Title:	Executive Director of People and Culture				
Report Author (Title):	Associate Director of People & Culture				

Main Report

Background and current situation:

In 2025/26 our emphasis will be on getting the *Brilliant Basics* right, ensuring a strong foundation with a focus around three key themes:

- **Improving Wellbeing and Attendance** - targeted action to reduce staff absence and increase workforce availability by proactively supporting employee health and wellbeing
- **Management and Leadership Development** – support our managers to manage well
- **Build Workforce Planning Expertise** - ensuring that senior leaders are trained in workforce planning principles, enabling strategic decision-making across all departments.

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

In relation to Improving Wellbeing and Attendance, the UHB has set a sickness absence target of <5.5% for 2025-26, with measures being put in place to support the achievement of this goal. The cumulative position for January 2025 was 6.32%

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 have 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.
- 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.
- Primary reason for absence is Anxiety, Stress and Depression – Considerations in relation to targeted wellbeing interventions and preventative methods to reduce impact and support sustained attendance. Promotion of the Stress Risk Assessment.

- Sickness absence will be reviewed at monthly Executive Reviews and a standardised data set has been developed to support the reviews.
- A draft OD, Wellbeing, and Culture framework has been developed and is currently out for consultation and feedback. This framework aims to support managers in key areas, including:
 - Staff retention
 - Team cohesion and performance
 - Cultural improvement
 - Staff engagement and wellbeing
 - Management and leadership development
- Efforts are being made to reduce workplace incidents by improving safety training and awareness. Ongoing RIDDOR performance is still well under what was reported for the last financial year. Six incidents reported since the last IPR submission taking the total to 65 this financial YTD. Maintaining this performance will result in ~70 for the year as opposed to 96 that were reported last year.

The total number of Long-Term Sickness Cases reported from ESR at the end of December 2024 was 615. As of 6th June 2025, the People Services Team were reporting 342 Long Term Sickness cases, which is a reduction of 273 cases.

Clinical/Service Board Updates

All Clinical/Service Boards have individual actions plans in place, an overview of some of these actions are identified below:

The Clinical Diagnostics and Therapeutics Clinic Board have established and embedded monthly sickness panels, with a targeted focus on high-impact areas including Outpatients, Patient Administration and Phlebotomy Services. Training needs have been identified and Managing Attendance at Work (MAAW) training sessions have been arranged for 'hotspot' areas. There is a focus on signposting to resources and clear promotion of available support tools including, Stress Risk Assessment, Occupational Health referral routes, Access to Work and flexible working pattern reviews, with a preventative focus prior to reaching formal review prompts.

The Children and Women Clinical Board have focussed sickness panels on Admin and Clerical as well as Additional Clinical Services as sickness rate were highest in these staffing groups. Sickness is reducing with the sickness rate for Admin and Clerical being the lowest it has been since May 2024. Targeted training has been provided for hotspot areas. Deep dives are being undertaken into other areas of high sickness, including Health Visiting, Medical staffing.

The Mental Health Clinical Board identified 4 'hot spot areas' with high volumes of agency/overtime/bank use. A deep dive into the sickness rates identified that Alder, Oak, Beech and Cedar wards had cumulative sickness rates of over 6.00%. All actions listed above have been implemented and additional sickness panels are taking place. All ward managers will attend the re-launched sickness training and Lead Nurses are attending the wards to support with ensuring return to work meetings are undertaken.

The Specialist Services Clinical Board have identified Critical Care as an area of focus with Support & Appraise meetings taking place every 3 weeks. In addition, monthly Sickness Panels are taking place across the Clinical Board, there is focus on improving return to work meeting compliance. A specific process has been developed for Critical Care to ensure return to work meetings are undertaken.

Capital, Estates and Facilities have introduced monthly sickness panels to monitor attendance and discuss all long-term sickness and any frequent short-term sickness. Catering and Housekeeping have been identified as 'hot spot' areas and additional monitoring is in place. Through the above

Panels, specific training needs in relation to managing sickness absence. In addition to Managing Attendance, specific actions are in place for recruitment and retention.

Medicine Clinical Board identified 3 'hot spot areas' with high volumes of agency/overtime/bank. A deep dive into the sickness rates identified that the Emergency Unit, Assessment Unit and MEAU had cumulative sickness rates of over 8.00%. All actions listed above have been implemented and additional sickness panels are taking place as well as 'apprise and support' meetings to follow up on any actions identified during the sickness panels. Additional training has been provided. Managing Attendance at Work resources communicated within the Clinical Board including, Stress Risk Assessments, Employee Wellbeing Service Care Pathway, events & workshops. Medicine CB has seen a steady decrease of cumulative sickness since January.

Regular updates will be provided to the Committee as we progress through the year to show progress against the overall sickness absence target.

Recommendation:

The Local Partnership Forum is requested to:

- **Note and discuss** the contents of the report

Link to Strategic Objectives of Shaping our Future Wellbeing:

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

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

Five Ways of Working (Sustainable Development Principles) considered

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

Prevention		Long term		Integration		Collaboration		Involvement
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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
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Impact Assessment:

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

Risk: Yes/No

Please include the detail of any Risk Assessments undertaken when preparing and considering the content of this report and, where appropriate, the nature of any risks identified. (If this has been addressed in the main body of the report, please confirm)

Safety: Yes/No

Are there any Staff or Patient safety implications associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)

Financial: Yes/No

Are there any Financial implications associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)

Workforce: Yes/No

Are there any Workforce implications associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)

Legal: Yes/No

Are there any legal implications that arise from the content and proposals contained within this report? If so, has advice been sought and what was the outcome? (If this has been addressed in the main body of the report, please confirm)

Reputational: Yes/No

Are there any reputational risks associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)

Socio Economic: Yes/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](#)

The Socio-Economic Duty is designed to encourage better decision making, ensuring more equal outcomes. Do the proposals within this report contain strategic decisions, such as setting objectives and the development of services. If so has consideration been given to how the proposals can improve inequality of outcome for people who suffer socio-economic disadvantage? Please include detail.

(If this has been addressed in the main body of the report, please confirm)

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

Equality Health Impact Assessments (EHIA) are typically undertaken when developing or reviewing Health Board strategies, policies, plans, procedures or services. Do the proposals contained within the report necessitate the requirement for an EHIA to be undertaken? If so, please include the detail of any EHIA undertaken or the plans are in place to do so.

(If this has been addressed in the main body of the report, please confirm)

Decarbonisation: Yes/No

There are a number of ways by which carbon emissions can be avoided through the operations of CVUHB. These include:

- A focus upon preventing ill health in our population
- Saving energy or increasing throughput.
- Value based healthcare. Being prudent by not over-treating/intervening. Avoid delivering low-value interventions.
- Patients empowered to manage their conditions, utilising See on Symptoms and Patient Initiated Follow Ups to reduce unnecessary outpatient appointments.
- Service delivery in the most appropriate setting, e.g. in a community setting rather than an acute setting.
- Reducing waste – for example use non-sterile gloves only when needed, manage use-by dates to avoid throwing out good products, recycle and reuse.

Does the subject matter of your paper risk any of the above not being achieved?

Welsh Language: Yes/No

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

Committee/Group/Exec

Date:

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Blunsdon, Louise
12/06/2025 08:42:21

Report Title:	C&V Integrated Performance Report			Agenda Item no.	10
Meeting:	Local Partnership Forum	Public		Meeting Date:	18.6.2025
		Private	X		
Status <i>(please tick one only):</i>	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 Integrated Performance Report has been updated for this Board Development session as outlined in the Paper brought to Board and F&P Committee last month. The updates 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

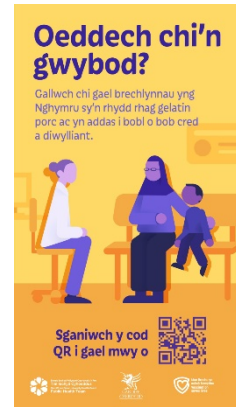
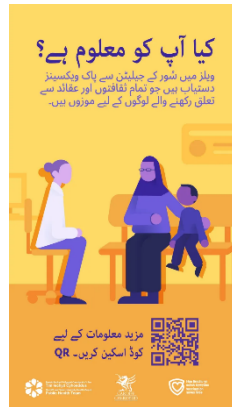
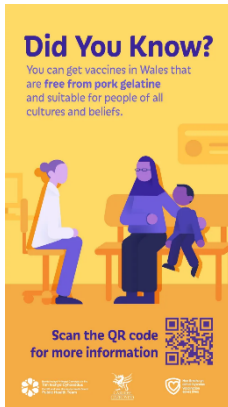
Immunisations

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 be 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 outstripping 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 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:

Blunsdon, Louise
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The 'Public Health – at a Glance' contains latest information on key public health messages, data and actions to take at your cluster level to inform cluster plans and activity, in support of the prevention agenda.

This edition focusses on SMOKING.

Key messages

- Quitting smoking at any age has immediate and positive benefits to health
- Smoking status should be routinely recorded for **ALL** patients using agreed Read codes, and specifically for newly registered patients and patients with certain long-term or chronic conditions, as part of the [Supporting Healthy Behaviours Project 2024/25](#).
- All adults who smoke should be offered support to quit smoking with referral to NHS Help Me Quit service, in particular for **all pregnant women and birthing people who smoke and are referred into secondary care services** (see the [Optimising Outcomes Policy](#))
- Adults who smoke are **3 times more likely to successfully quit smoking with NHS support such as Help Me Quit** compared with quitting alone.

Data

There is an ambition for Wales to be smoke-free by 2030 which means reducing prevalence to <5%.

Current Smoking Prevalence

13%

(52,500) of adults in Cardiff and Vale of Glamorgan smoke

12% Cardiff and 14% Vale of Glamorgan smoke

[Source: StatsWales, 2021/22-2022/23, Adult Mortality by Local Authority and Health Board, 2020-21 onwards (accessed 31/03/24)]

20.6% In areas of higher deprivation smoking prevalence rises to 20.6% (such as in Central Vale).

3%

5%

3% of young people report current (at least weekly) smoking and 5% of young people report current (at least weekly) vaping

[Source: Health Behaviour in School-aged Children, 2021/22, SHS, 2021-22 National Indicators Report: FPH4 (en and sc) (PHF.ac.uk)]

On average, 10.7% of all deaths in Wales amongst those aged 35 and over were attributable to smoking in 2020-2022, which rises to 14.5% among those living in the most deprived areas.

[Source: PHW, 2023]

January 2025

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 in to 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 behavioral 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 prescription	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.

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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

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.

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.

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.

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.

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.

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.

Other Key Metrics

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

Recommendations for Improvement

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%.

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.

Patient Safety

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

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.

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.

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Recommendation:

The Local Partnership Forum 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

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

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

Prevention	<input checked="" type="checkbox"/>	Long term	<input type="checkbox"/>	Integration	<input checked="" type="checkbox"/>	Collaboration	<input type="checkbox"/>	Involvement	<input type="checkbox"/>
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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:

Approved for use
 2025 08:42:21

Cardiff and Vale Integrated Performance Report

2024/25

May 2025

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Report Contents

1. [Cabinet Secretary Priorities](#)

2. [Cardiff and Vale Performance Report](#)

Click on a hyperlink to navigate directly to the section required

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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.

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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	<p>Measure: Number of delayed transfers of care.</p> <p>National standard/ambition: 12 month reduction trend</p> <p>Reporting period: Monthly</p>	Reduction against 23/24	Yes	Mar-25	150 Apr-25	Hyperlink to section
Primary and Community Care	<p>Measure: General Medical Services – Number of GP practices achieving core access standards</p> <p>National standard/ambition: 100%</p> <p>Reporting period: Annual – in month position for information</p>	100%	Yes	Mar-25	98.2% Apr-24	Hyperlink to section
	<p>Measure: General Dental Services - % of contract value fulfilled</p> <p>National standard: 30% of contract value by end Q2, 100% Q4</p> <p>Reporting period: Monthly</p>	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	<p>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</p> <p>National standard/ambition: 20% reduction by September 2024, further 20% reduction by March 2025</p> <p>Reporting period: Monthly</p>	670 Sept-24 532 Mar-25	Yes	Mar-25	887 Apr-25	Hyperlink to section
	<p>Measure: Number of ambulance patient handovers over 1 hour</p> <p>National standard/ambition: 30% reduction by December 2024</p> <p>Reporting period: Monthly</p>	232	Yes	Dec-24	462 Apr-25	Hyperlink to section

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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	<p>Measure: Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS for people age under 18 years</p> <p>National standard/ambition: 80% by end of December 2024</p> <p>Reporting period: Monthly</p>	80%	Yes	Dec-24	99% Mar-25	Hyperlink to section
	<p>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</p> <p>National standard/ambition: 80% by end of December 2024</p> <p>Reporting period: Monthly</p>	99%	Yes	Dec-24	51.3% Mar-25	Hyperlink to section

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Performance Key: Meeting standard / trajectory off target/trajectory

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	<p>Measure: Number of patients waiting more than 52 weeks for a new outpatient appointment</p> <p>National standard/ambition: 40% reduction by end of September 2024, 0 by end of March 2025</p> <p>Reporting period: Monthly</p>	<p>16,004 Sep-24</p> <p>15,925 Mar-25</p>	No		<p>15,185 Mar-25</p>	Hyperlink to section
	<p>Measure: Number of patients waiting more than 104 weeks for referral to treatment</p> <p>National standard/ambition: 0 by end of December 2024</p> <p>Reporting period: Monthly</p>	<p>4,447 Dec-24</p>	No		<p>1,632 Mar-25</p>	Hyperlink to section
	<p>Measure: Percentage of patients starting their first definitive treatment within 62 days from point of suspicion (regardless of the referral route)</p> <p>National standard/ambition: 60% by end of December 2024, 70% by end of March 2025</p> <p>Reporting period: Monthly</p>	<p>70% Mar-25</p>	Yes	Dec-24	<p>68.7% Mar-25</p>	Hyperlink to section
	<p>Measure: Number of patients waiting more than 8 weeks for a specified diagnostic</p> <p>National standard/ambition: 95% of patients waiting less than 8 weeks by end of December 2024</p> <p>Reporting period: Monthly</p>	<p>14,796 Dec-24</p>	No		<p>14,750 Apr-25</p>	Hyperlink to section

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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](#).

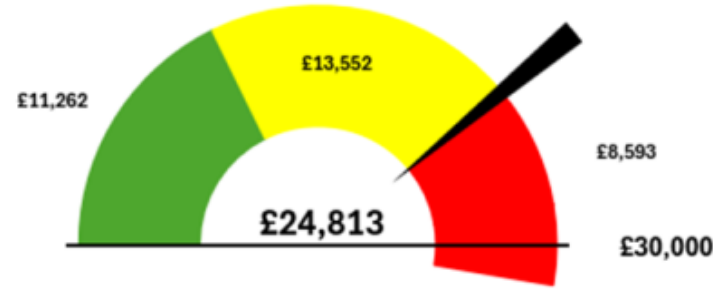
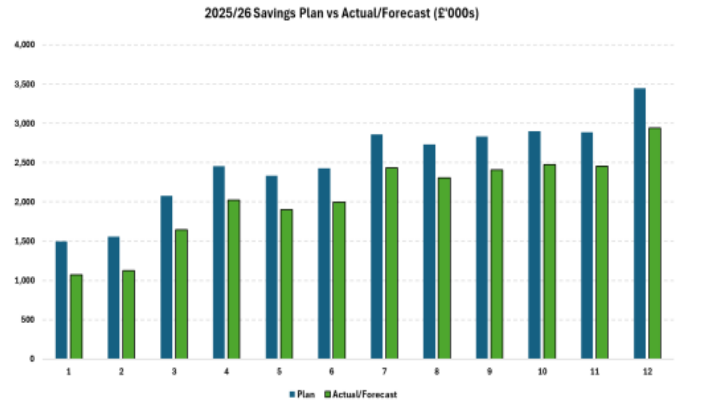
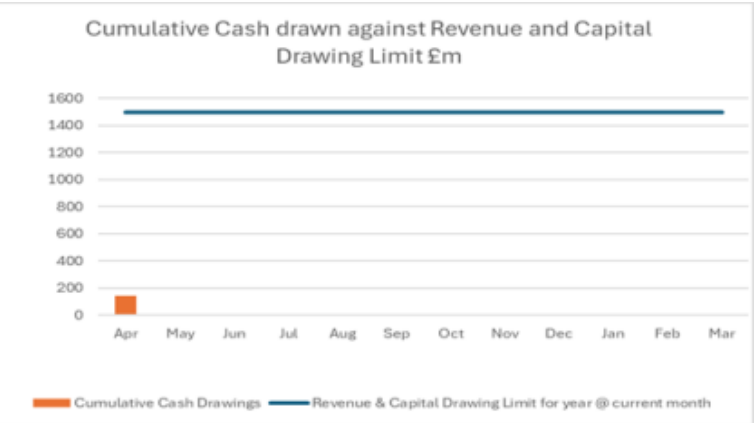
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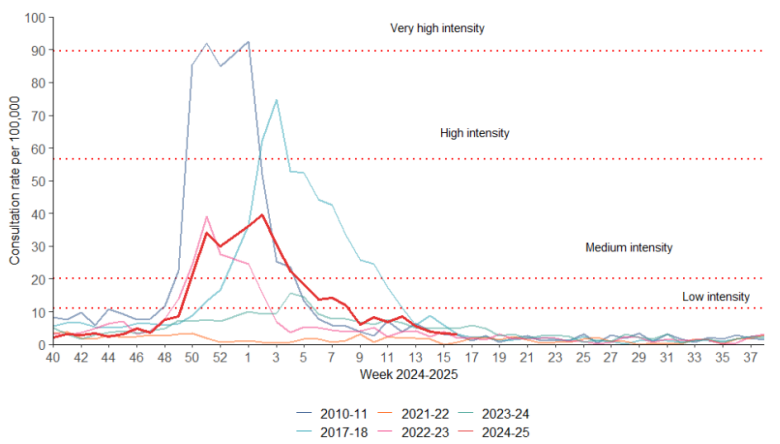
Number	Aim	Contents
Aim 1	People in Wales have improved health and well-being with better prevention and self-management	Public Health
Aim 2	People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement	Urgent and Emergency Care 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

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	Priority	Performance Summary	Reported Period	Data																																				
Financial Performance	Deliver 2025/26 Draft Financial Plan	<p>The UHB's Financial Plan in 2025/26 reflected the following key components:</p> <table border="1"> <thead> <tr> <th>Planning Assumption</th> <th>(£m)</th> </tr> </thead> <tbody> <tr> <td>Brought Forward Underlying Deficit</td> <td>59.900</td> </tr> <tr> <td>2025/26 Demand/Cost Growth/Investments</td> <td>51.100</td> </tr> <tr> <td>Draft Deficit</td> <td>111.000</td> </tr> <tr> <td colspan="2"> </td> </tr> <tr> <td>Additional Allocations</td> <td>(22.768)</td> </tr> <tr> <td>Savings Plans</td> <td>(30.000)</td> </tr> <tr> <td>Final Planned Deficit</td> <td>58.233</td> </tr> </tbody> </table> <p>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.</p> <p>The overall position at month 1 was a £6.096m deficit as outlined in the graph to the right.</p>	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	April 2025	<table border="1"> <thead> <tr> <th></th> <th>Plan Year To Date</th> <th>Actual Year To Date</th> <th>Year To Date Variance to Plan</th> </tr> </thead> <tbody> <tr> <td>Draft Plan</td> <td>7,159</td> <td>7,159</td> <td>0</td> </tr> <tr> <td>Quality Improvement Programme - savings</td> <td>(1,483)</td> <td>(1,051)</td> <td>432</td> </tr> <tr> <td>Operational Variance</td> <td>0</td> <td>(12)</td> <td>(12)</td> </tr> <tr> <td>Clinical/Service Board Variance</td> <td>5,676</td> <td>6,096</td> <td>420</td> </tr> </tbody> </table>		Plan Year To Date	Actual Year To Date	Year To Date Variance to Plan	Draft Plan	7,159	7,159	0	Quality Improvement Programme - savings	(1,483)	(1,051)	432	Operational Variance	0	(12)	(12)	Clinical/Service Board Variance	5,676	6,096	420
	Planning Assumption	(£m)																																						
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	Plan Year To Date	Actual Year To Date	Year To Date Variance to Plan																																					
Draft Plan	7,159	7,159	0																																					
Quality Improvement Programme - savings	(1,483)	(1,051)	432																																					
Operational Variance	0	(12)	(12)																																					
Clinical/Service Board Variance	5,676	6,096	420																																					
	Return to financial balance and approved IMTP status	<p>£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.</p>	April 2025	<p>Planned Deficit vs M01 Position £'000s</p>																																				
	Management of operational budget pressures	<p>Failure to adequately manage budget pressures. This is the responsibility of the primary budget holders. £0.012m operational surplus reported at month 1.</p> <p>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):</p> <ul style="list-style-type: none"> • 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	<table border="1"> <thead> <tr> <th>Measure</th> <th>RAG</th> <th>Trend</th> <th>Target</th> </tr> </thead> <tbody> <tr> <td>Management of operational budget pressures. This is the responsibility of the primary budget holders. £0.012m operational surplus reported at month 1.</td> <td style="background-color: yellow;">A</td> <td style="text-align: center;">"</td> <td>Operational Spend to be maintained within Budgets</td> </tr> </tbody> </table>	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																												
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	Priority	Performance Summary	Reported Period	Data
	<p>Delivery of recurrent £30.0m savings target</p>	<p>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.</p> <p>The second chart illustrates that the profile of the UHB's 2025/26 savings programme is skewed towards the end of they ear.</p>	<p>April. 2025</p>	<p>2025/26 UHB Savings Programme: Identified vs Requirement</p>  <p>2025/26 Savings Plan vs Actual/Forecast (£'000s)</p> 
<p>Blunsdon-Louise 12/06/2025 08:42:21</p>	<p>Remain within Cash Limit</p>	<p>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.</p> <p>The closing cash balance at the end of April 2025 was £1.624m.</p> <p>The cumulative cash drawn at the month end against the UHBs cumulative annual cash drawing limit is illustrated by the graph to the right</p>	<p>April 2025</p>	<p>Cumulative Cash drawn against Revenue and Capital Drawing Limit £m</p> 

Priority	Performance Summary	Reported Period	On target?	Data
Health Protection	<p>Seasonal respiratory infections</p> <p>Immunisation – COVID-19 and influenza</p> <ul style="list-style-type: none"> 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%. <p>Surveillance</p> <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> Month of April 2025: <ul style="list-style-type: none"> 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† <p>* Because of the way absence is recorded on ESR these figures include weekends and non-working days † Salary costs for staff reporting sickness absence</p>	Week 16	Below target	<p>Wales COVID-19 vaccination surveillance weekly report.pdf</p> <p>Weekly COVID-19 vaccination report by health board https://www2.nphs.wales.nhs.uk/CommunitySurveillanceDocs.nsf/3dc04669c9e1eaa880257062003b246b/cf7a9a9adcd0bb0a8025866b003a51a1/\$FILE/Wales%20COVID-19%20vaccination%20surveillance%20weekly%20report.pdf</p>  <p>Source: PHW weekly ARI summary (new from Nov 2024)</p>

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Priority	Performance Summary	Reported Period	On target?	Data
Health Protection	<p>Routine childhood immunisation</p> <ul style="list-style-type: none"> 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	<p>Source quarterly COVER data</p>
Health Protection	<p>Health Protection System</p> <ul style="list-style-type: none"> 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

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Priority	Performance Summary	Reported Period	On target?	Data																																																																	
Health Improvement	<p>Healthy weight:</p> <ul style="list-style-type: none"> 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. <p>Weight management services</p> <ul style="list-style-type: none"> 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	<p>Healthy weight:</p> <p>On target</p> <p>Weight management services:</p> <p>Below target</p>	<table border="1"> <caption>Cardiff and Vale of Glamorgan Child Measurement Programme - Healthy Weight trend - Reception Year children</caption> <thead> <tr> <th>Year</th> <th>Cardiff and Vale UHB</th> <th>Cardiff</th> <th>Vale of Glamorgan</th> <th>Wales</th> </tr> </thead> <tbody> <tr><td>2011/12</td><td>72.0</td><td>70.0</td><td>71.0</td><td>70.0</td></tr> <tr><td>2012/13</td><td>74.0</td><td>72.0</td><td>73.0</td><td>72.0</td></tr> <tr><td>2013/14</td><td>75.0</td><td>73.0</td><td>74.0</td><td>73.0</td></tr> <tr><td>2014/15</td><td>76.0</td><td>74.0</td><td>75.0</td><td>74.0</td></tr> <tr><td>2015/16</td><td>76.0</td><td>74.0</td><td>75.0</td><td>74.0</td></tr> <tr><td>2016/17</td><td>76.0</td><td>74.0</td><td>75.0</td><td>74.0</td></tr> <tr><td>2017/18</td><td>76.0</td><td>74.0</td><td>75.0</td><td>74.0</td></tr> <tr><td>2018/19</td><td>76.0</td><td>74.0</td><td>75.0</td><td>74.0</td></tr> <tr><td>2019/20</td><td>76.0</td><td>74.0</td><td>75.0</td><td>74.0</td></tr> <tr><td>2020/21</td><td>76.0</td><td>74.0</td><td>75.0</td><td>74.0</td></tr> <tr><td>2021/22</td><td>76.0</td><td>74.0</td><td>75.0</td><td>74.0</td></tr> <tr><td>2022/23</td><td>77.5</td><td>75.0</td><td>76.0</td><td>75.0</td></tr> </tbody> </table>	Year	Cardiff and Vale UHB	Cardiff	Vale of Glamorgan	Wales	2011/12	72.0	70.0	71.0	70.0	2012/13	74.0	72.0	73.0	72.0	2013/14	75.0	73.0	74.0	73.0	2014/15	76.0	74.0	75.0	74.0	2015/16	76.0	74.0	75.0	74.0	2016/17	76.0	74.0	75.0	74.0	2017/18	76.0	74.0	75.0	74.0	2018/19	76.0	74.0	75.0	74.0	2019/20	76.0	74.0	75.0	74.0	2020/21	76.0	74.0	75.0	74.0	2021/22	76.0	74.0	75.0	74.0	2022/23	77.5	75.0	76.0	75.0
Year	Cardiff and Vale UHB	Cardiff	Vale of Glamorgan	Wales																																																																	
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C&V Priorities and Annual Plan Commitments

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Priority	Performance Summary	Reported Period	On target?	Data
Health improvement	<p>Diabetes</p> <ul style="list-style-type: none"> Percentage of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes <ul style="list-style-type: none"> 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

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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

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C&V Priorities and Annual Plan Commitments

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Priority	Performance Summary	Reported Period	On target?	Data																																																																														
Health Improvement	<p>Tobacco</p> <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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	<p>Smokers setting quit date:</p> <p>Below target for percentage of adult smokers who make a quit attempt</p> <p>Below target for 4 week quits</p>	<p>Graph showing 4 week quit rates by service, in %'s</p> <table border="1"> <caption>Approximate data from the 4-week quit rates graph</caption> <thead> <tr> <th>Quarter</th> <th>HMQ (%)</th> <th>L3 (%)</th> <th>Hosp (%)</th> <th>QTR total (%)</th> <th>Tier 1 Target (%)</th> </tr> </thead> <tbody> <tr><td>Q1 22/23</td><td>78</td><td>30</td><td>78</td><td>65</td><td>40</td></tr> <tr><td>Q2 22/23</td><td>75</td><td>90</td><td>75</td><td>75</td><td>40</td></tr> <tr><td>Q3 22/23</td><td>72</td><td>35</td><td>85</td><td>65</td><td>40</td></tr> <tr><td>Q4 22/23</td><td>78</td><td>35</td><td>85</td><td>65</td><td>40</td></tr> <tr><td>Q1 23/24</td><td>70</td><td>25</td><td>45</td><td>60</td><td>40</td></tr> <tr><td>Q2 23/24</td><td>75</td><td>25</td><td>85</td><td>68</td><td>40</td></tr> <tr><td>Q3 23/24</td><td>78</td><td>40</td><td>75</td><td>70</td><td>40</td></tr> <tr><td>Q4 23/24</td><td>75</td><td>55</td><td>45</td><td>70</td><td>40</td></tr> <tr><td>Q1 24/25</td><td>42</td><td>10</td><td>60</td><td>35</td><td>40</td></tr> <tr><td>Q2 24/25</td><td>42</td><td>18</td><td>48</td><td>38</td><td>40</td></tr> <tr><td>Q3 24/25</td><td>40</td><td>8</td><td>25</td><td>25</td><td>40</td></tr> <tr><td>Q4 24/25</td><td>40</td><td>8</td><td>25</td><td>25</td><td>40</td></tr> </tbody> </table>	Quarter	HMQ (%)	L3 (%)	Hosp (%)	QTR total (%)	Tier 1 Target (%)	Q1 22/23	78	30	78	65	40	Q2 22/23	75	90	75	75	40	Q3 22/23	72	35	85	65	40	Q4 22/23	78	35	85	65	40	Q1 23/24	70	25	45	60	40	Q2 23/24	75	25	85	68	40	Q3 23/24	78	40	75	70	40	Q4 23/24	75	55	45	70	40	Q1 24/25	42	10	60	35	40	Q2 24/25	42	18	48	38	40	Q3 24/25	40	8	25	25	40	Q4 24/25	40	8	25	25	40
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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			
					Q1	Q2	Q3	Q4
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	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	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	32.8%			

Chair’s objectives

No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend			
					Q1	Q2	Q3	Q4
n/a	% of pregnant people undergoing CO testing at their initial booking appointment	2024/25	100%	94% Below target Average for 23/24: 90%	92%	94%	94%	Await ed
n/a	% of pregnant smokers who are referred to smoking cessation support following initial booking assessment	2024/25	100%	100% Meeting target	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			
					Jan-Mar	Apr-Jun	Jul-Sept	Oct-Dec
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	84.1%	85.8%	85.2%	83.3%
5.	Percentage of children receiving the Human Papillomavirus (HPV) vaccination by the age of 15 <i>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)</i>	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 <i>Applicable during: 01.09.2024 - 31.03.2025 (autumn booster campaign underway)</i>	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 <i>Applicable during: Spring Booster 01.04.2025 - 30.06.2025 Autumn Booster 01.09.2025 - 31.03.2026 (spring booster campaign underway)</i>	1 Apr 2025 to 30 Jun 2025	75%	% Below target	24/04/25			
					8.44%			

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Weight Management Services

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

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

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			

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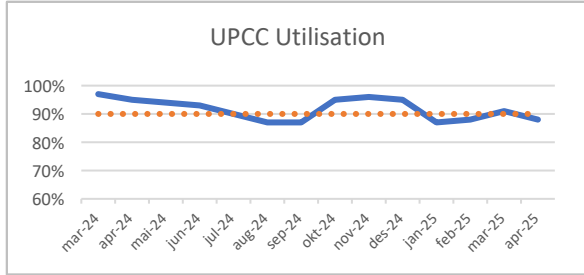
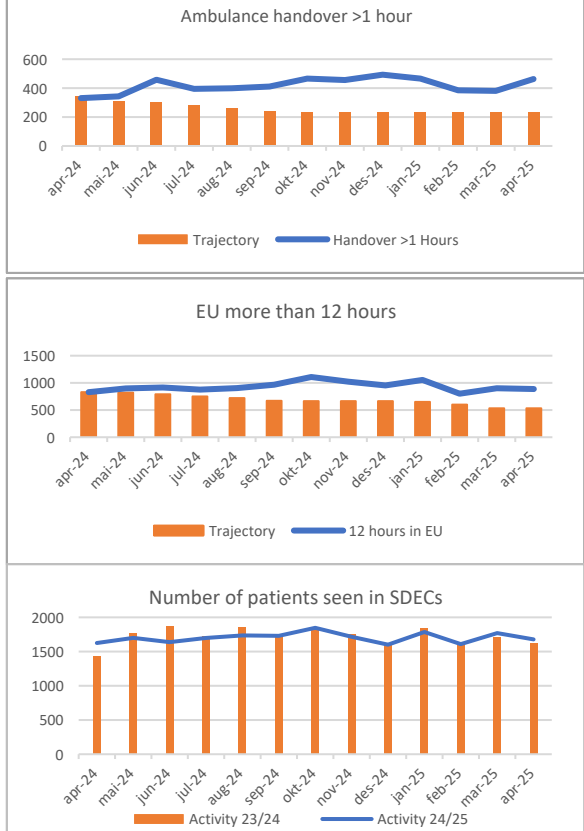
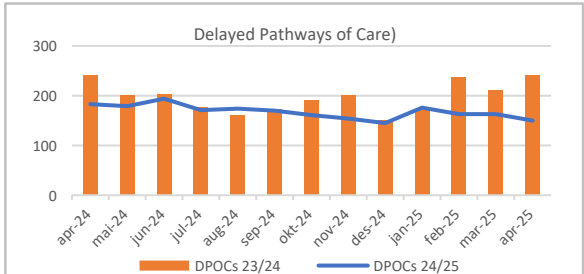


Screening

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	<table border="1"> <tr> <td>Nov-24</td> <td>Dec-24</td> <td>Jan-25</td> <td>Feb-25</td> </tr> <tr> <td>12.30%</td> <td>7.40%</td> <td>3.00%</td> <td>10.00%</td> </tr> </table>	Nov-24	Dec-24	Jan-25	Feb-25	12.30%	7.40%	3.00%	10.00%
Nov-24	Dec-24	Jan-25	Feb-25										
12.30%	7.40%	3.00%	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	<table border="1"> <tr> <td>Sep-24</td> <td>Oct-24</td> <td>Nov-24</td> <td>Dec-24</td> </tr> <tr> <td>99.20%</td> <td>98.40%</td> <td>97.60%</td> <td>79.80%</td> </tr> </table>	Sep-24	Oct-24	Nov-24	Dec-24	99.20%	98.40%	97.60%	79.80%
Sep-24	Oct-24	Nov-24	Dec-24										
99.20%	98.40%	97.60%	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	<table border="1"> <tr> <td>Dec-24</td> <td>Jan-25</td> <td>Feb-25</td> <td>Mar-25</td> </tr> <tr> <td>96.90%</td> <td>96.20%</td> <td>95.10%</td> <td>96.40%</td> </tr> </table>	Dec-24	Jan-25	Feb-25	Mar-25	96.90%	96.20%	95.10%	96.40%
Dec-24	Jan-25	Feb-25	Mar-25										
96.90%	96.20%	95.10%	96.40%										

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Priority	Performance Summary	Reporting Period	Performance against standard	Data
<p>Primary, Community and Out of Hospital Care</p>	<p>Urgent Primary Care Centre Utilisation – Maintain 90% utilisation In March utilisation was 91%, this is above our commitment</p> <p>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</p> <p>Community visits – 95% of face-to-face visits within 8 hours Q4 to date 96% compliance with 8-hour standard</p>	<p>Apr-25</p> <p>Q1</p> <p>Apr-25</p>	<p>88% utilisation Below standard</p> <p>200 accepted referrals Q1 Below standard</p> <p>96% Above standard</p>	 <p>UPCC Utilisation</p>
<p>Emergency Department and Same Day Emergency Care</p>	<p>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</p> <p>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</p> <p>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</p>	<p>Apr-25</p> <p>Apr-25</p> <p>Apr-25</p>	<p>42 2-hour delays Above standard</p> <p>462 1-hour delays Above standard</p> <p>30 minutes lost/arrival Above standard</p> <p>92.4% patients <12h Below standard</p> <p>1678 SDEC attends Below standard</p>	 <p>Ambulance handover >1 hour</p> <p>EU more than 12 hours</p> <p>Number of patients seen in SDECs</p>
<p>Reducing time in hospital and Continuity of Care</p>	<p>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</p> <p>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</p>	<p>Apr-25</p> <p>Apr-25</p>	<p>57.8% >7d Above standard</p> <p>33.4% >21d Above standard</p> <p>150 Below standard</p>	 <p>Delayed Pathways of Care</p>

Priority	Performance Summary	Reporting Period	Performance against standard	Data
<p>High Impact Pathways - Stroke</p>	<p>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.</p> <p>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</p> <p>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</p> <p>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</p> <p>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</p>	<p>Mar-25</p>	<p>56.7% CT Below standard</p> <p>7.5% Thrombolysis Below standard</p> <p>57.1% Door-to-ward Below standard</p>	<p>The data section for the High Impact Pathways - Stroke row contains three line charts. Each chart plots 'Performance' (blue line) against 'Standard' (orange horizontal line) from March 2024 to March 2025. The first chart, 'CT Scan within 1 hour', shows a performance of 56.7% in March 2025, which is below the 70% standard. The second chart, 'Stroke patient thrombolysis rate', shows a performance of 7.5% in March 2025, below the 20% standard. The third chart, 'Direct admission to stroke unit within 4 hours', shows a performance of 57.1% in March 2025, below the 80% standard.</p>
<p>High Impact pathways – Hip fracture</p>	<p>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%.</p>	<p>Mar-25</p>	<p>39.5% (Annualised) Below standard</p>	<p>The data section for the High Impact pathways – Hip fracture row contains one line chart titled 'Admitted within 4 hours'. It plots 'Performance' (blue line) against 'Standard' (orange horizontal line) from March 2024 to March 2025. The performance in March 2025 is 39.5%, which is below the 60% standard.</p>

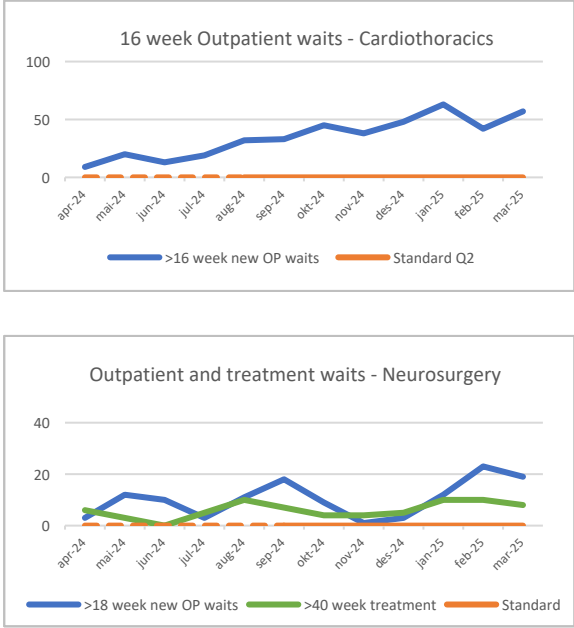
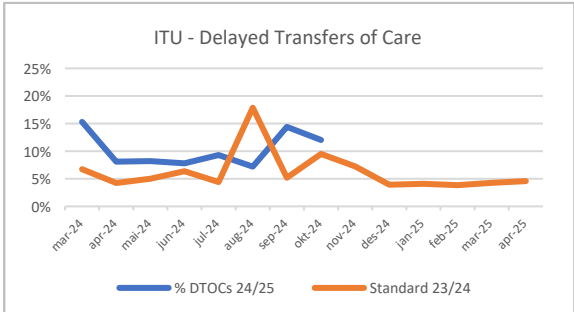
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Priority	Performance Summary	Reporting Period	Performance against standard	Data
Primary and Community Care	<p>GMS access – 100% of practices achieving core access standards In March 100% of practices met the standard – the official data is provided annual but our monthly tracking data will be updated here for information</p> <p>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.</p>	Mar-25	100% At standard	<p>GDS contract value fulfillment</p>
	<p>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</p> <p>Optometry – 95% of practices providing WGOS1+2 All practices are currently providing WGOS 1&2</p>	Jan-25	100% Above standard	
Cancer	<p>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.</p>	Mar-25	68.7% At standard, but below SCP standard of 75%	<p>% cancer patients starting treatment withing 62 days</p>

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Priority	Performance Summary	Reporting Period	Performance against standard	Data
<p>Outpatient and Treatment waiting times</p>	<p>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</p> <p>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.</p> <p>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</p>	<p>Mar-25</p>	<p>15,185 patients Above standard</p> <p>1,632 patients Below standard</p>	
<p>Diagnostics and Therapies</p>	<p>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</p> <p>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</p>	<p>Apr-25</p>	<p>14,750 patients Diagnostics Above standard</p> <p>475 patients Therapies Above standard (Q3)</p>	

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Priority	Performance Summary	Reporting Period	Performance against standard	Data
<p>Waiting times</p>	<p>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.</p> <p>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</p>	<p>Mar-25</p>	<p>57 Outpatients Above standard</p> <p>19 patients Treatment Above standard</p> <p>8 patients Treatment Above standard</p>	 <p>The first chart, '16 week Outpatient waits - Cardiothoracics', shows a blue line representing '>16 week new OP waits' fluctuating between approximately 10 and 60, consistently above an orange standard line at 0. The second chart, 'Outpatient and treatment waits - Neurosurgery', shows a blue line for '>18 week new OP waits' and a green line for '>40 week treatment', both fluctuating between 0 and 25, above an orange standard line at 0.</p>
<p>Intensive Care Unit</p>	<p>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</p>	<p>Oct-24</p>	<p>12.0% Above standard</p>	 <p>The chart 'ITU - Delayed Transfers of Care' shows a blue line for '% DTOCs 24/25' and an orange line for 'Standard 23/24'. The blue line starts at 15% in March 2024, drops to 8% in April, and then fluctuates between 5% and 18% through October 2024, remaining above the orange standard line which stays around 5%.</p>

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C&V Priorities and Annual Plan Commitments

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Priority	Performance Summary	Reporting Period	Performance against standard	Data
Paediatric waiting times	<p>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</p> <p>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)</p>	Mar-25	<p>0 Meeting standard</p> <p>314 Above standard</p>	
Emotional Health and Wellbeing	<p>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</p> <p>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</p> <p>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</p>	Mar-25	<p>99% Part 1a Above standard</p> <p>100% Part 1b Above standard</p> <p>90% Part 2 Above standard</p>	
Neurodevelopment	<p>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</p>	Apr-25	<p>217 Above standard (Q4)</p>	

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Priority	Performance Summary	Reporting Period	Performance against standard	Data																																																			
Mental Health Measures – Part 1a	<p>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</p> <p>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.</p>	Mar-25	51% Part 1a Below standard (Q2)	<p>LPMHSS assessments started 28 days - Adults</p> <table border="1"> <caption>Approximate data for LPMHSS assessments started 28 days - Adults</caption> <thead> <tr> <th>Month</th> <th>Performance (%)</th> <th>Standard Q2 (%)</th> </tr> </thead> <tbody> <tr><td>Mar-24</td><td>55</td><td>80</td></tr> <tr><td>Apr-24</td><td>20</td><td>80</td></tr> <tr><td>May-24</td><td>20</td><td>80</td></tr> <tr><td>Jun-24</td><td>18</td><td>80</td></tr> <tr><td>Jul-24</td><td>15</td><td>80</td></tr> <tr><td>Aug-24</td><td>18</td><td>80</td></tr> <tr><td>Sep-24</td><td>20</td><td>80</td></tr> <tr><td>Oct-24</td><td>18</td><td>80</td></tr> <tr><td>Nov-24</td><td>22</td><td>80</td></tr> <tr><td>Dec-24</td><td>25</td><td>80</td></tr> <tr><td>Jan-25</td><td>40</td><td>80</td></tr> <tr><td>Feb-25</td><td>95</td><td>80</td></tr> <tr><td>Mar-25</td><td>50</td><td>80</td></tr> </tbody> </table>	Month	Performance (%)	Standard Q2 (%)	Mar-24	55	80	Apr-24	20	80	May-24	20	80	Jun-24	18	80	Jul-24	15	80	Aug-24	18	80	Sep-24	20	80	Oct-24	18	80	Nov-24	22	80	Dec-24	25	80	Jan-25	40	80	Feb-25	95	80	Mar-25	50	80									
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Feb-25	95	80																																																					
Mar-25	50	80																																																					
Mental Health Measures – Part 1b	<p>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</p> <p>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.</p>	Mar-25	99% Part 1b Above standard	<p>LPMHSS interventions started 28 days - Adults</p> <table border="1"> <caption>Approximate data for LPMHSS interventions started 28 days - Adults</caption> <thead> <tr> <th>Month</th> <th>Trajectory (%)</th> <th>Performance (%)</th> </tr> </thead> <tbody> <tr><td>Oct-23</td><td>98</td><td>99</td></tr> <tr><td>Nov-23</td><td>98</td><td>99</td></tr> <tr><td>Dec-23</td><td>98</td><td>99</td></tr> <tr><td>Jan-24</td><td>98</td><td>99</td></tr> <tr><td>Feb-24</td><td>98</td><td>99</td></tr> <tr><td>Mar-24</td><td>98</td><td>99</td></tr> <tr><td>Apr-24</td><td>98</td><td>99</td></tr> <tr><td>May-24</td><td>98</td><td>99</td></tr> <tr><td>Jun-24</td><td>98</td><td>99</td></tr> <tr><td>Jul-24</td><td>98</td><td>99</td></tr> <tr><td>Aug-24</td><td>98</td><td>99</td></tr> <tr><td>Sep-24</td><td>98</td><td>99</td></tr> <tr><td>Oct-24</td><td>98</td><td>99</td></tr> <tr><td>Nov-24</td><td>98</td><td>99</td></tr> <tr><td>Dec-24</td><td>98</td><td>99</td></tr> <tr><td>Jan-25</td><td>98</td><td>99</td></tr> </tbody> </table>	Month	Trajectory (%)	Performance (%)	Oct-23	98	99	Nov-23	98	99	Dec-23	98	99	Jan-24	98	99	Feb-24	98	99	Mar-24	98	99	Apr-24	98	99	May-24	98	99	Jun-24	98	99	Jul-24	98	99	Aug-24	98	99	Sep-24	98	99	Oct-24	98	99	Nov-24	98	99	Dec-24	98	99	Jan-25	98	99
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Mental Health Measures – Part 2	<p>Percentage of patients with a valid Care and Treatment plan – 80% compliance with standard in Q3</p> <p>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</p>	Mar-25	56% Part 2 Below standard (Q3)	<p>Valid Treatment Plan - Adults</p> <table border="1"> <caption>Approximate data for Valid Treatment Plan - Adults</caption> <thead> <tr> <th>Month</th> <th>Performance (%)</th> <th>Standard Q3 (%)</th> </tr> </thead> <tbody> <tr><td>Mar-24</td><td>55</td><td>80</td></tr> <tr><td>Apr-24</td><td>58</td><td>80</td></tr> <tr><td>May-24</td><td>58</td><td>80</td></tr> <tr><td>Jun-24</td><td>58</td><td>80</td></tr> <tr><td>Jul-24</td><td>60</td><td>80</td></tr> <tr><td>Aug-24</td><td>60</td><td>80</td></tr> <tr><td>Sep-24</td><td>60</td><td>80</td></tr> <tr><td>Oct-24</td><td>60</td><td>80</td></tr> <tr><td>Nov-24</td><td>60</td><td>80</td></tr> <tr><td>Dec-24</td><td>58</td><td>80</td></tr> <tr><td>Jan-25</td><td>58</td><td>80</td></tr> <tr><td>Feb-25</td><td>58</td><td>80</td></tr> <tr><td>Mar-25</td><td>56</td><td>80</td></tr> </tbody> </table>	Month	Performance (%)	Standard Q3 (%)	Mar-24	55	80	Apr-24	58	80	May-24	58	80	Jun-24	58	80	Jul-24	60	80	Aug-24	60	80	Sep-24	60	80	Oct-24	60	80	Nov-24	60	80	Dec-24	58	80	Jan-25	58	80	Feb-25	58	80	Mar-25	56	80									
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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	<table border="1"> <tr> <td>19/20</td> <td>20/21</td> <td>21/22</td> <td>22/23</td> </tr> <tr> <td>93.4%</td> <td>95.0%</td> <td>96.5%</td> <td>98.2%</td> </tr> </table>	19/20	20/21	21/22	22/23	93.4%	95.0%	96.5%	98.2%
19/20	20/21	21/22	22/23										
93.4%	95.0%	96.5%	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	<table border="1"> <tr> <td>Dec-24</td> <td>Jan-25</td> <td>Feb-25</td> <td>Mar-25</td> </tr> <tr> <td>45.40%</td> <td>45.30%</td> <td>45.50%</td> <td>46.30%</td> </tr> </table>	Dec-24	Jan-25	Feb-25	Mar-25	45.40%	45.30%	45.50%	46.30%
Dec-24	Jan-25	Feb-25	Mar-25										
45.40%	45.30%	45.50%	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	<table border="1"> <tr> <td>Dec-24</td> <td>Jan-25</td> <td>Feb-25</td> <td>Mar-25</td> </tr> <tr> <td>77.60%</td> <td>84.50%</td> <td>90.20%</td> <td>98.50%</td> </tr> </table>	Dec-24	Jan-25	Feb-25	Mar-25	77.60%	84.50%	90.20%	98.50%
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77.60%	84.50%	90.20%	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	<table border="1"> <tr> <td>Dec-24</td> <td>Jan-25</td> <td>Feb-25</td> <td>Mar-25</td> </tr> <tr> <td>2390</td> <td>2329</td> <td>2440</td> <td>2465</td> </tr> </table>	Dec-24	Jan-25	Feb-25	Mar-25	2390	2329	2440	2465
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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	<table border="1"> <tr> <td>Dec-24</td> <td>Jan-25</td> <td>Feb-25</td> <td>Mar-25</td> </tr> <tr> <td>99%</td> <td>93%</td> <td>99%</td> <td>99%</td> </tr> </table>	Dec-24	Jan-25	Feb-25	Mar-25	99%	93%	99%	99%
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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	<table border="1"> <tr> <td>Dec-24</td> <td>Jan-25</td> <td>Feb-25</td> <td>Mar-25</td> </tr> <tr> <td>80%</td> <td>92%</td> <td>90%</td> <td>100%</td> </tr> </table>	Dec-24	Jan-25	Feb-25	Mar-25	80%	92%	90%	100%
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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	<table border="1"> <tr> <td>Dec-24</td> <td>Jan-25</td> <td>Feb-25</td> <td>Mar-25</td> </tr> <tr> <td>26.0%</td> <td>40.6%</td> <td>97.9%</td> <td>51.3%</td> </tr> </table>	Dec-24	Jan-25	Feb-25	Mar-25	26.0%	40.6%	97.9%	51.3%
Dec-24	Jan-25	Feb-25	Mar-25										
26.0%	40.6%	97.9%	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	<table border="1"> <tr> <td>Dec-24</td> <td>Jan-25</td> <td>Feb-25</td> <td>Mar-25</td> </tr> <tr> <td>100.0%</td> <td>99.4%</td> <td>100.0%</td> <td>99.4%</td> </tr> </table>	Dec-24	Jan-25	Feb-25	Mar-25	100.0%	99.4%	100.0%	99.4%
Dec-24	Jan-25	Feb-25	Mar-25										
100.0%	99.4%	100.0%	99.4%										
19.	Percentage of emergency responses to red calls arriving within (up to and including) 8 minutes	Apr-25	65%	51% Below standard	<table border="1"> <tr> <td>Jan-25</td> <td>Feb-25</td> <td>Mar-25</td> <td>Apr-25</td> </tr> <tr> <td>49%</td> <td>62%</td> <td>50%</td> <td>51%</td> </tr> </table>	Jan-25	Feb-25	Mar-25	Apr-25	49%	62%	50%	51%
Jan-25	Feb-25	Mar-25	Apr-25										
49%	62%	50%	51%										
20.	Median emergency response time to amber calls	Apr-25	12 month reduction trend	01:58:55 Above standard	<table border="1"> <tr> <td>Jan-25</td> <td>Feb-25</td> <td>Mar-25</td> <td>Apr-25</td> </tr> <tr> <td>02:04:11</td> <td>01:50:49</td> <td>01:46:41</td> <td>01:58:55</td> </tr> </table>	Jan-25	Feb-25	Mar-25	Apr-25	02:04:11	01:50:49	01:46:41	01:58:55
Jan-25	Feb-25	Mar-25	Apr-25										
02:04:11	01:50:49	01:46:41	01:58:55										

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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	<table border="1"> <tr> <th>Dec-24</th> <th>Jan-25</th> <th>Feb-25</th> <th>Mar-25</th> </tr> <tr> <td>10</td> <td>8</td> <td>10</td> <td>8</td> </tr> </table>	Dec-24	Jan-25	Feb-25	Mar-25	10	8	10	8
Dec-24	Jan-25	Feb-25	Mar-25										
10	8	10	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	<table border="1"> <tr> <th>Dec-24</th> <th>Jan-25</th> <th>Feb-25</th> <th>Mar-25</th> </tr> <tr> <td>78</td> <td>62</td> <td>68</td> <td>64</td> </tr> </table>	Dec-24	Jan-25	Feb-25	Mar-25	78	62	68	64
Dec-24	Jan-25	Feb-25	Mar-25										
78	62	68	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	<table border="1"> <tr> <th>Jan-25</th> <th>Feb-25</th> <th>Mar-25</th> <th>Apr-25</th> </tr> <tr> <td>63.2%</td> <td>62.5%</td> <td>66.2%</td> <td>62.7%</td> </tr> </table>	Jan-25	Feb-25	Mar-25	Apr-25	63.2%	62.5%	66.2%	62.7%
Jan-25	Feb-25	Mar-25	Apr-25										
63.2%	62.5%	66.2%	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	<table border="1"> <tr> <th>Jan-25</th> <th>Feb-25</th> <th>Mar-25</th> <th>Apr-25</th> </tr> <tr> <td>1054</td> <td>801</td> <td>901</td> <td>887</td> </tr> </table>	Jan-25	Feb-25	Mar-25	Apr-25	1054	801	901	887
Jan-25	Feb-25	Mar-25	Apr-25										
1054	801	901	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	<table border="1"> <tr> <th>Dec-24</th> <th>Jan-25</th> <th>Feb-25</th> <th>Mar-25</th> </tr> <tr> <td>66.7%</td> <td>66.4%</td> <td>64.2%</td> <td>68.7%</td> </tr> </table>	Dec-24	Jan-25	Feb-25	Mar-25	66.7%	66.4%	64.2%	68.7%
Dec-24	Jan-25	Feb-25	Mar-25										
66.7%	66.4%	64.2%	68.7%										
26.	Number of patients waiting more than 8 weeks for a specified diagnostic	Apr-25	0	14,750 Above standard	<table border="1"> <tr> <th>Jan-25</th> <th>Feb-25</th> <th>Mar-25</th> <th>Apr-25</th> </tr> <tr> <td>16088</td> <td>14086</td> <td>13825</td> <td>14750</td> </tr> </table>	Jan-25	Feb-25	Mar-25	Apr-25	16088	14086	13825	14750
Jan-25	Feb-25	Mar-25	Apr-25										
16088	14086	13825	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	<table border="1"> <tr> <th>Dec-24</th> <th>Jan-25</th> <th>Feb-25</th> <th>Mar-25</th> </tr> <tr> <td>86.24%</td> <td>82.00%</td> <td>76.66%</td> <td>71.58%</td> </tr> </table>	Dec-24	Jan-25	Feb-25	Mar-25	86.24%	82.00%	76.66%	71.58%
Dec-24	Jan-25	Feb-25	Mar-25										
86.24%	82.00%	76.66%	71.58%										
28.	Number of patients (all ages) waiting more than 14 weeks for a specified therapy	Apr-25	0	475 Above standard	<table border="1"> <tr> <th>Jan-25</th> <th>Feb-25</th> <th>Mar-25</th> <th>Apr-25</th> </tr> <tr> <td>273</td> <td>322</td> <td>384</td> <td>475</td> </tr> </table>	Jan-25	Feb-25	Mar-25	Apr-25	273	322	384	475
Jan-25	Feb-25	Mar-25	Apr-25										
273	322	384	475										
29.	Number of patients (all ages) waiting more than 14 weeks for audiology	Mar-25	0	308 Above standard	<table border="1"> <tr> <th>Dec-24</th> <th>Jan-25</th> <th>Feb-25</th> <th>Mar-25</th> </tr> <tr> <td>117</td> <td>195</td> <td>248</td> <td>308</td> </tr> </table>	Dec-24	Jan-25	Feb-25	Mar-25	117	195	248	308
Dec-24	Jan-25	Feb-25	Mar-25										
117	195	248	308										

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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	<table border="1"> <tr> <th>Dec-24</th> <th>Jan-25</th> <th>Feb-25</th> <th>Mar-25</th> </tr> <tr> <td>16227</td> <td>16439</td> <td>15725</td> <td>15185</td> </tr> </table>	Dec-24	Jan-25	Feb-25	Mar-25	16227	16439	15725	15185
Dec-24	Jan-25	Feb-25	Mar-25										
16227	16439	15725	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	<table border="1"> <tr> <th>Nov-24</th> <th>Dec-24</th> <th>Jan-25</th> <th>Feb-25</th> </tr> <tr> <td>18940</td> <td>20232</td> <td>20017</td> <td>19694</td> </tr> </table>	Nov-24	Dec-24	Jan-25	Feb-25	18940	20232	20017	19694
Nov-24	Dec-24	Jan-25	Feb-25										
18940	20232	20017	19694										
32.	Number of patients waiting more than 104 weeks for referral to treatment	Mar-25	0	1,632 Below standard	<table border="1"> <tr> <th>Dec-24</th> <th>Jan-25</th> <th>Feb-25</th> <th>Mar-25</th> </tr> <tr> <td>3754</td> <td>3581</td> <td>2414</td> <td>1632</td> </tr> </table>	Dec-24	Jan-25	Feb-25	Mar-25	3754	3581	2414	1632
Dec-24	Jan-25	Feb-25	Mar-25										
3754	3581	2414	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	<table border="1"> <tr> <th>Dec-24</th> <th>Jan-25</th> <th>Feb-25</th> <th>Mar-25</th> </tr> <tr> <td>35712</td> <td>35008</td> <td>33246</td> <td>32763</td> </tr> </table>	Dec-24	Jan-25	Feb-25	Mar-25	35712	35008	33246	32763
Dec-24	Jan-25	Feb-25	Mar-25										
35712	35008	33246	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	<table border="1"> <tr> <th>Dec-24</th> <th>Jan-25</th> <th>Feb-25</th> <th>Mar-25</th> </tr> <tr> <td>10%</td> <td>9%</td> <td>10%</td> <td>10%</td> </tr> </table>	Dec-24	Jan-25	Feb-25	Mar-25	10%	9%	10%	10%
Dec-24	Jan-25	Feb-25	Mar-25										
10%	9%	10%	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	<table border="1"> <tr> <th>Dec-24</th> <th>Jan-25</th> <th>Feb-25</th> <th>Mar-25</th> </tr> <tr> <td>69%</td> <td>71%</td> <td>73%</td> <td>75%</td> </tr> </table>	Dec-24	Jan-25	Feb-25	Mar-25	69%	71%	73%	75%
Dec-24	Jan-25	Feb-25	Mar-25										
69%	71%	73%	75%										

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Productivity and Efficiency measures

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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	

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C&V Priorities and Annual Plan Commitments

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Priority	Performance Summary	Reported Period	Data
Turnover	<p>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.</p> <p>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'.</p>	April 2025	
Sickness Absence	<p>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).</p>	April 2025	
Statutory and Mandatory Training	<p>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.</p> <p>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.</p>	April 2025	
Values Based Appraisal	<p>VBA compliance has risen slightly for Apr-25 to 70.87%. None of the Clinical Boards have reached the 85% target rate%.</p>	April 2025	
Employee Relations	<p>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.</p>	April 2025	

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C&V Priorities and Annual Plan Commitments

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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	<table border="1"> <caption>Job Plan Compliance Rate</caption> <thead> <tr> <th>Month</th> <th>% Target</th> <th>% Job Plan Agreed</th> <th>% Compliance</th> </tr> </thead> <tbody> <tr><td>Mar-24</td><td>80%</td><td>55%</td><td>35%</td></tr> <tr><td>Apr-24</td><td>80%</td><td>55%</td><td>35%</td></tr> <tr><td>May-24</td><td>80%</td><td>55%</td><td>35%</td></tr> <tr><td>Jun-24</td><td>80%</td><td>55%</td><td>35%</td></tr> <tr><td>Jul-24</td><td>80%</td><td>55%</td><td>35%</td></tr> <tr><td>Aug-24</td><td>80%</td><td>55%</td><td>35%</td></tr> <tr><td>Sep-24</td><td>80%</td><td>55%</td><td>35%</td></tr> <tr><td>Oct-24</td><td>80%</td><td>55%</td><td>35%</td></tr> <tr><td>Nov-24</td><td>80%</td><td>55%</td><td>35%</td></tr> <tr><td>Dec-24</td><td>80%</td><td>55%</td><td>35%</td></tr> <tr><td>Jan-25</td><td>80%</td><td>55%</td><td>35%</td></tr> <tr><td>Feb-25</td><td>80%</td><td>55%</td><td>35%</td></tr> <tr><td>Mar-25</td><td>80%</td><td>55%</td><td>35%</td></tr> <tr><td>Apr-25</td><td>80%</td><td>55%</td><td>35%</td></tr> </tbody> </table>	Month	% Target	% Job Plan Agreed	% Compliance	Mar-24	80%	55%	35%	Apr-24	80%	55%	35%	May-24	80%	55%	35%	Jun-24	80%	55%	35%	Jul-24	80%	55%	35%	Aug-24	80%	55%	35%	Sep-24	80%	55%	35%	Oct-24	80%	55%	35%	Nov-24	80%	55%	35%	Dec-24	80%	55%	35%	Jan-25	80%	55%	35%	Feb-25	80%	55%	35%	Mar-25	80%	55%	35%	Apr-25	80%	55%	35%															
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Medical Appraisals	The rate of compliance with Medical Appraisal rose slightly to 84.81% for Apr-25, slightly below the 85% target.	April 2025	<table border="1"> <caption>Medical Appraisal Compliance Rate</caption> <thead> <tr> <th>Month</th> <th>% Target</th> <th>% Compliance</th> </tr> </thead> <tbody> <tr><td>Mar-24</td><td>85%</td><td>80%</td></tr> <tr><td>Apr-24</td><td>85%</td><td>80%</td></tr> <tr><td>May-24</td><td>85%</td><td>80%</td></tr> <tr><td>Jun-24</td><td>85%</td><td>80%</td></tr> <tr><td>Jul-24</td><td>85%</td><td>80%</td></tr> <tr><td>Aug-24</td><td>85%</td><td>80%</td></tr> <tr><td>Sep-24</td><td>85%</td><td>80%</td></tr> <tr><td>Oct-24</td><td>85%</td><td>80%</td></tr> <tr><td>Nov-24</td><td>85%</td><td>80%</td></tr> <tr><td>Dec-24</td><td>85%</td><td>80%</td></tr> <tr><td>Jan-25</td><td>85%</td><td>80%</td></tr> <tr><td>Feb-25</td><td>85%</td><td>80%</td></tr> <tr><td>Mar-25</td><td>85%</td><td>80%</td></tr> <tr><td>Apr-25</td><td>85%</td><td>84.81%</td></tr> </tbody> </table>	Month	% Target	% Compliance	Mar-24	85%	80%	Apr-24	85%	80%	May-24	85%	80%	Jun-24	85%	80%	Jul-24	85%	80%	Aug-24	85%	80%	Sep-24	85%	80%	Oct-24	85%	80%	Nov-24	85%	80%	Dec-24	85%	80%	Jan-25	85%	80%	Feb-25	85%	80%	Mar-25	85%	80%	Apr-25	85%	84.81%																														
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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 2 nd 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	<table border="1"> <caption>WTE Permanent and Fixed-Term Staff in Post Numbers</caption> <thead> <tr> <th>Month</th> <th>Employed Staffing WTE</th> <th>Permanent (Left Axis)</th> <th>Fixed-Term Temp (Right Axis)</th> <th>Unrel (Fixed-term Staffing WTE)</th> </tr> </thead> <tbody> <tr><td>Mar-24</td><td>15,000</td><td>10,000</td><td>5,000</td><td>10,000</td></tr> <tr><td>Apr-24</td><td>15,000</td><td>10,000</td><td>5,000</td><td>10,000</td></tr> <tr><td>May-24</td><td>15,000</td><td>10,000</td><td>5,000</td><td>10,000</td></tr> <tr><td>Jun-24</td><td>15,000</td><td>10,000</td><td>5,000</td><td>10,000</td></tr> <tr><td>Jul-24</td><td>15,000</td><td>10,000</td><td>5,000</td><td>10,000</td></tr> <tr><td>Aug-24</td><td>15,000</td><td>10,000</td><td>5,000</td><td>10,000</td></tr> <tr><td>Sep-24</td><td>15,000</td><td>10,000</td><td>5,000</td><td>10,000</td></tr> <tr><td>Oct-24</td><td>15,000</td><td>10,000</td><td>5,000</td><td>10,000</td></tr> <tr><td>Nov-24</td><td>15,000</td><td>10,000</td><td>5,000</td><td>10,000</td></tr> <tr><td>Dec-24</td><td>15,000</td><td>10,000</td><td>5,000</td><td>10,000</td></tr> <tr><td>Jan-25</td><td>15,000</td><td>10,000</td><td>5,000</td><td>10,000</td></tr> <tr><td>Feb-25</td><td>15,000</td><td>10,000</td><td>5,000</td><td>10,000</td></tr> <tr><td>Mar-25</td><td>15,000</td><td>10,000</td><td>5,000</td><td>10,000</td></tr> <tr><td>Apr-25</td><td>15,446.94</td><td>10,000</td><td>5,446.94</td><td>10,000</td></tr> </tbody> </table>	Month	Employed Staffing WTE	Permanent (Left Axis)	Fixed-Term Temp (Right Axis)	Unrel (Fixed-term Staffing WTE)	Mar-24	15,000	10,000	5,000	10,000	Apr-24	15,000	10,000	5,000	10,000	May-24	15,000	10,000	5,000	10,000	Jun-24	15,000	10,000	5,000	10,000	Jul-24	15,000	10,000	5,000	10,000	Aug-24	15,000	10,000	5,000	10,000	Sep-24	15,000	10,000	5,000	10,000	Oct-24	15,000	10,000	5,000	10,000	Nov-24	15,000	10,000	5,000	10,000	Dec-24	15,000	10,000	5,000	10,000	Jan-25	15,000	10,000	5,000	10,000	Feb-25	15,000	10,000	5,000	10,000	Mar-25	15,000	10,000	5,000	10,000	Apr-25	15,446.94	10,000	5,446.94	10,000
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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	<table border="1"> <caption>Proportion of Total Pay Bill Attributable to Variable Pay</caption> <thead> <tr> <th>Month</th> <th>% Variable Pay</th> <th>Unrel (Variable Pay)</th> </tr> </thead> <tbody> <tr><td>Mar-24</td><td>8.26%</td><td>8.26%</td></tr> <tr><td>Apr-24</td><td>8.26%</td><td>8.26%</td></tr> <tr><td>May-24</td><td>8.26%</td><td>8.26%</td></tr> <tr><td>Jun-24</td><td>8.26%</td><td>8.26%</td></tr> <tr><td>Jul-24</td><td>8.26%</td><td>8.26%</td></tr> <tr><td>Aug-24</td><td>8.26%</td><td>8.26%</td></tr> <tr><td>Sep-24</td><td>8.26%</td><td>8.26%</td></tr> <tr><td>Oct-24</td><td>8.26%</td><td>8.26%</td></tr> <tr><td>Nov-24</td><td>8.26%</td><td>8.26%</td></tr> <tr><td>Dec-24</td><td>8.26%</td><td>8.26%</td></tr> <tr><td>Jan-25</td><td>8.26%</td><td>8.26%</td></tr> <tr><td>Feb-25</td><td>8.26%</td><td>8.26%</td></tr> <tr><td>Mar-25</td><td>8.26%</td><td>8.26%</td></tr> <tr><td>Apr-25</td><td>5.92%</td><td>5.92%</td></tr> </tbody> </table>	Month	% Variable Pay	Unrel (Variable Pay)	Mar-24	8.26%	8.26%	Apr-24	8.26%	8.26%	May-24	8.26%	8.26%	Jun-24	8.26%	8.26%	Jul-24	8.26%	8.26%	Aug-24	8.26%	8.26%	Sep-24	8.26%	8.26%	Oct-24	8.26%	8.26%	Nov-24	8.26%	8.26%	Dec-24	8.26%	8.26%	Jan-25	8.26%	8.26%	Feb-25	8.26%	8.26%	Mar-25	8.26%	8.26%	Apr-25	5.92%	5.92%																														
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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	<table border="1"> <caption>Agency Spend as % of Total Pay Bill</caption> <thead> <tr> <th>Month</th> <th>Agency Spend as % of Total Pay Bill</th> </tr> </thead> <tbody> <tr><td>Mar-24</td><td>0.93%</td></tr> <tr><td>Apr-24</td><td>0.93%</td></tr> <tr><td>May-24</td><td>0.93%</td></tr> <tr><td>Jun-24</td><td>0.93%</td></tr> <tr><td>Jul-24</td><td>0.93%</td></tr> <tr><td>Aug-24</td><td>0.93%</td></tr> <tr><td>Sep-24</td><td>0.93%</td></tr> <tr><td>Oct-24</td><td>0.93%</td></tr> <tr><td>Nov-24</td><td>0.93%</td></tr> <tr><td>Dec-24</td><td>0.93%</td></tr> <tr><td>Jan-25</td><td>0.93%</td></tr> <tr><td>Feb-25</td><td>0.93%</td></tr> <tr><td>Mar-25</td><td>0.93%</td></tr> <tr><td>Apr-25</td><td>0.39%</td></tr> </tbody> </table>	Month	Agency Spend as % of Total Pay Bill	Mar-24	0.93%	Apr-24	0.93%	May-24	0.93%	Jun-24	0.93%	Jul-24	0.93%	Aug-24	0.93%	Sep-24	0.93%	Oct-24	0.93%	Nov-24	0.93%	Dec-24	0.93%	Jan-25	0.93%	Feb-25	0.93%	Mar-25	0.93%	Apr-25	0.39%																																													
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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 a 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	

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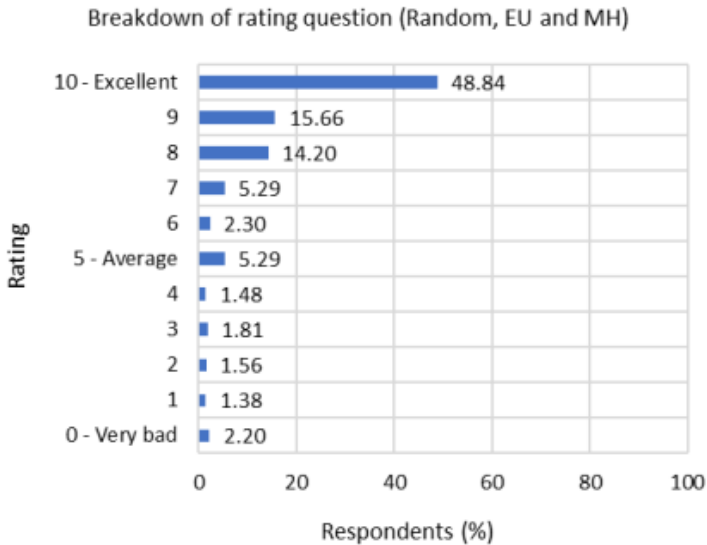
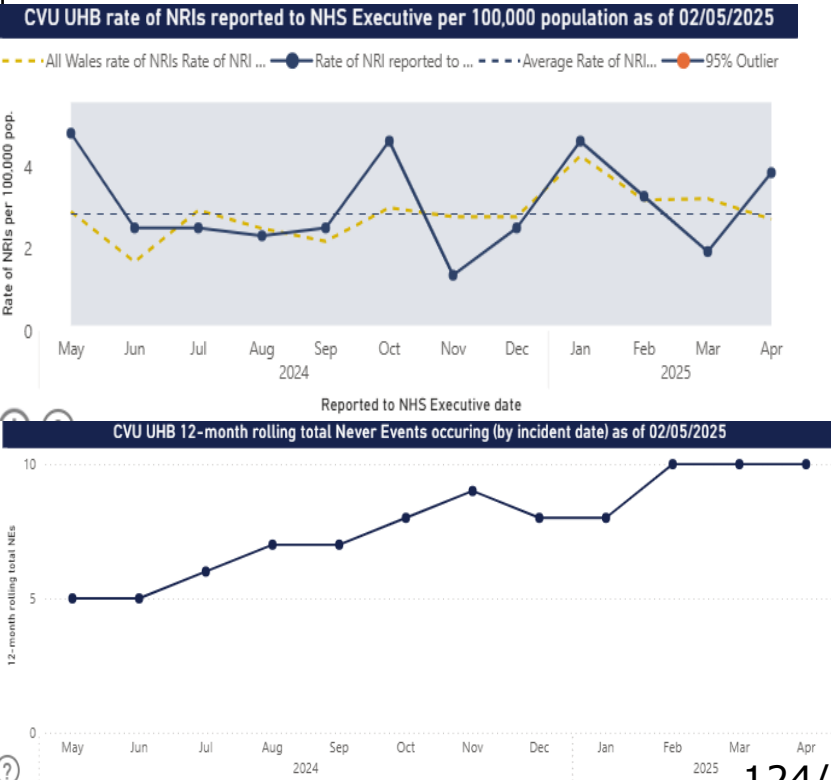
No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend								
36.	Percentage of sickness absence rate of staff	Mar-25	12 month reduction trend (6%)	5.49% Below standard	<table border="1"> <tr> <td>Dec-24</td> <td>Jan-25</td> <td>Feb-25</td> <td>Mar-25</td> </tr> <tr> <td>7.29%</td> <td>6.97%</td> <td>6.31%</td> <td>5.49%</td> </tr> </table>	Dec-24	Jan-25	Feb-25	Mar-25	7.29%	6.97%	6.31%	5.49%
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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	<table border="1"> <tr> <td>Dec-24</td> <td>Jan-25</td> <td>Feb-25</td> <td>Mar-25</td> </tr> <tr> <td>9.47%</td> <td>9.40%</td> <td>8.98%</td> <td>8.96%</td> </tr> </table>	Dec-24	Jan-25	Feb-25	Mar-25	9.47%	9.40%	8.98%	8.96%
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38.	Agency spend as a percentage of the total pay bill	Mar-25	12 month reduction trend	0.17% Below standard	<table border="1"> <tr> <td>Dec-24</td> <td>Jan-25</td> <td>Feb-25</td> <td>Mar-25</td> </tr> <tr> <td>0.41%</td> <td>0.63%</td> <td>0.63%</td> <td>0.17%</td> </tr> </table>	Dec-24	Jan-25	Feb-25	Mar-25	0.41%	0.63%	0.63%	0.17%
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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	<table border="1"> <tr> <td>Dec-24</td> <td>Jan-25</td> <td>Feb-25</td> <td>Mar-25</td> </tr> <tr> <td>79.30%</td> <td>78.28%</td> <td>75.12%</td> <td>71.19%</td> </tr> </table>	Dec-24	Jan-25	Feb-25	Mar-25	79.30%	78.28%	75.12%	71.19%
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Priority	Performance Summary	Reporting Period	Performance against standard	Data																												
<p>Concerns 30 day performance</p>	<p>Welsh Government target for responding to concerns is 75% within 30 working days</p> <p>During March and April 25, the Health Board:</p> <ul style="list-style-type: none"> •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 <p>Top 3 themes and trends</p> <ul style="list-style-type: none"> •Clinical Treatment and Assessment •Concerns around appointments (waiting times/cancellations) •Communication 	<p>March and April 25</p>	<p>60 %</p>	<p>% concerns closed within 30 working days including Early Resolution</p> <table border="1"> <caption>Monthly Performance Data (Estimated)</caption> <thead> <tr> <th>Month</th> <th>% Concerns Closed</th> </tr> </thead> <tbody> <tr><td>apr-24</td><td>79</td></tr> <tr><td>mai-24</td><td>81</td></tr> <tr><td>jun-24</td><td>84</td></tr> <tr><td>jul-24</td><td>84</td></tr> <tr><td>aug-24</td><td>78</td></tr> <tr><td>sep-24</td><td>81</td></tr> <tr><td>okt-24</td><td>75</td></tr> <tr><td>nov-24</td><td>63</td></tr> <tr><td>des-24</td><td>60</td></tr> <tr><td>jan-25</td><td>61</td></tr> <tr><td>feb-25</td><td>72</td></tr> <tr><td>mar-25</td><td>75</td></tr> <tr><td>apr-25</td><td>74</td></tr> </tbody> </table>	Month	% Concerns Closed	apr-24	79	mai-24	81	jun-24	84	jul-24	84	aug-24	78	sep-24	81	okt-24	75	nov-24	63	des-24	60	jan-25	61	feb-25	72	mar-25	75	apr-25	74
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<p>Duty of Candour</p>	<p>Key Updates:</p> <ul style="list-style-type: none"> •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. <p>Themes and Trends for Triggered Duty of Candour:</p> <ul style="list-style-type: none"> • 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 	<p>Dec 2024 to April 25</p>	<p>n/a</p>	<p>DUTY OF CANDOUR</p> <table border="1"> <caption>Duty of Candour Data</caption> <thead> <tr> <th>Month</th> <th>Total Incidents Reported</th> <th>Total Incidents that Triggered DOC</th> </tr> </thead> <tbody> <tr><td>DEC-24</td><td>2185</td><td>9</td></tr> <tr><td>JAN-25</td><td>2299</td><td>15</td></tr> <tr><td>FEB-25</td><td>2019</td><td>11</td></tr> <tr><td>MAR-25</td><td>2118</td><td>7</td></tr> <tr><td>APR-25</td><td>2134</td><td>21</td></tr> </tbody> </table>	Month	Total Incidents Reported	Total Incidents that Triggered DOC	DEC-24	2185	9	JAN-25	2299	15	FEB-25	2019	11	MAR-25	2118	7	APR-25	2134	21										
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Priority	Performance Summary	Reporting Period	Performance against standard	Data																								
<p>Patient Feedback – Civica</p>	<p>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%.</p> <p>In April, we sent 14,326 texts and had 2,081 completions (15% response).</p> <p>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.</p> <p>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</p>	<p>Mar/Apr 2025</p>		 <p>Breakdown of rating question (Random, EU and MH)</p> <table border="1"> <thead> <tr> <th>Rating</th> <th>Percentage</th> </tr> </thead> <tbody> <tr><td>10 - Excellent</td><td>48.84</td></tr> <tr><td>9</td><td>15.66</td></tr> <tr><td>8</td><td>14.20</td></tr> <tr><td>7</td><td>5.29</td></tr> <tr><td>6</td><td>2.30</td></tr> <tr><td>5 - Average</td><td>5.29</td></tr> <tr><td>4</td><td>1.48</td></tr> <tr><td>3</td><td>1.81</td></tr> <tr><td>2</td><td>1.56</td></tr> <tr><td>1</td><td>1.38</td></tr> <tr><td>0 - Very bad</td><td>2.20</td></tr> </tbody> </table>	Rating	Percentage	10 - Excellent	48.84	9	15.66	8	14.20	7	5.29	6	2.30	5 - Average	5.29	4	1.48	3	1.81	2	1.56	1	1.38	0 - Very bad	2.20
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<p>Patient Safety</p>	<p>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.</p> <p>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.</p> <p>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.</p>	<p>March 2025</p>		 <p>CVU UHB rate of NRIs reported to NHS Executive per 100,000 population as of 02/05/2025</p> <p>CVU UHB 12-month rolling total Never Events occurring (by incident date) as of 02/05/2025</p>																								

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Priority	Performance Summary	Reporting Period	Performance against standard	Data
<p>Tier 1 Mortality</p>	<p>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</p> <p>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.</p> <p>Emergency Unit mortality was 14.21 per 10 000 attendance in April 2024</p> <p>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.</p> <p>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.</p>	<p>April 2025</p>		<p>Weekly number of deaths registered, all deaths, All deaths (any mention) and 5-year average*, week ending 3 January 2020 (Week 1) to week ending 13 Apr 2025 (Week 15), Cardiff and Vale UHB</p> <p>Crude Mortality: Weekly Deaths In Hospital</p>
<p>Infection Control</p>	<p><i>Clostroides difficile</i> - 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</p> <p>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</p> <p>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</p> <p>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</p> <p><i>Klebsiella spec's</i> - 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</p>	<p>April 25</p>		<p>Graph 2: C. difficile Cumulative Monthly Numbers & Reduction Expectations for Cardiff & Vale UHB</p> <p>Graph 2: MRSA Bacteraemia Cumulative Monthly Numbers & Reduction Expectations for Cardiff & Vale UHB</p> <p>Graph 2: MSSA Bacteraemia Cumulative Monthly Numbers & Reduction Expectations for Cardiff & Vale UHB</p> <p>Graph 2: E. coli Bacteraemia Cumulative Monthly Numbers & Reduction Expectations for Cardiff & Vale UHB</p>

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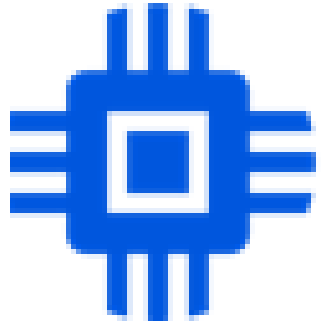
No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend								
40.	Percentage of episodes clinically coded within one reporting month post episode discharge end date	Feb-25	12 month improvement trend	42.3% Below standard	<table border="1"> <tr> <td>Nov-24</td> <td>Dec-24</td> <td>Jan-25</td> <td>Feb-25</td> </tr> <tr> <td>62.40%</td> <td>64.00%</td> <td>56.00%</td> <td>42.30%</td> </tr> </table>	Nov-24	Dec-24	Jan-25	Feb-25	62.40%	64.00%	56.00%	42.30%
Nov-24	Dec-24	Jan-25	Feb-25										
62.40%	64.00%	56.00%	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	<table border="1"> <tr> <td>Dec-24</td> <td>Jan-25</td> <td>Feb-25</td> <td>Mar-25</td> </tr> <tr> <td>17.30%</td> <td>16.00%</td> <td>40.20%</td> <td>34.70%</td> </tr> </table>	Dec-24	Jan-25	Feb-25	Mar-25	17.30%	16.00%	40.20%	34.70%
Dec-24	Jan-25	Feb-25	Mar-25										
17.30%	16.00%	40.20%	34.70%										
42.	Percentage of calls ended following WAST telephone assessment (Hear and Treat)	Apr-24	17% or more	16.1% Below standard	<table border="1"> <tr> <td>Jan-24</td> <td>Feb-24</td> <td>Mar-24</td> <td>Apr-24</td> </tr> <tr> <td>17.00%</td> <td>15.30%</td> <td>15.00%</td> <td>16.10%</td> </tr> </table>	Jan-24	Feb-24	Mar-24	Apr-24	17.00%	15.30%	15.00%	16.10%
Jan-24	Feb-24	Mar-24	Apr-24										
17.00%	15.30%	15.00%	16.10%										
43.	Number of Pathways of Care delayed discharges	Apr-25	12 month reduction trend	150 Above standard	<table border="1"> <tr> <td>Jan-25</td> <td>Feb-25</td> <td>Mar-25</td> <td>Apr-25</td> </tr> <tr> <td>176</td> <td>163</td> <td>163</td> <td>150</td> </tr> </table>	Jan-25	Feb-25	Mar-25	Apr-25	176	163	163	150
Jan-25	Feb-25	Mar-25	Apr-25										
176	163	163	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	<table border="1"> <tr> <td>Dec-24</td> <td>Jan-25</td> <td>Feb-25</td> <td>Mar-25</td> </tr> <tr> <td>91.1%</td> <td>91.5%</td> <td>92.9%</td> <td>90.2%</td> </tr> </table>	Dec-24	Jan-25	Feb-25	Mar-25	91.1%	91.5%	92.9%	90.2%
Dec-24	Jan-25	Feb-25	Mar-25										
91.1%	91.5%	92.9%	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	<table border="1"> <tr> <td>Dec-24</td> <td>Jan-25</td> <td>Feb-25</td> <td>Mar-25</td> </tr> <tr> <td>57.8%</td> <td>57.5%</td> <td>56.7%</td> <td>55.7%</td> </tr> </table>	Dec-24	Jan-25	Feb-25	Mar-25	57.8%	57.5%	56.7%	55.7%
Dec-24	Jan-25	Feb-25	Mar-25										
57.8%	57.5%	56.7%	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								

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No.Redu cing trend	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend								
47.	Cumulative number of laboratory confirmed bacteraemia cases: <i>Klebsiella</i> sp and; <i>Pseudomonas aeruginosa</i>	Apr-25	<i>Klebsiella</i> sp - 100 <i>P. aeruginosa</i> – 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: <i>E.coli</i> and; <i>S.aureus</i> (MRSA and MSSA)	Apr-25	<i>E. coli</i> – 67 cases per 100,000 population <i>S. aureus</i> – 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 <i>C.difficile</i> 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	<table border="1"> <tr> <td>Nov-24</td> <td>Dec-24</td> <td>Jan-25</td> <td>Jan-25</td> </tr> <tr> <td>30.30%</td> <td>38.30%</td> <td>45.10%</td> <td>52.17%</td> </tr> </table>	Nov-24	Dec-24	Jan-25	Jan-25	30.30%	38.30%	45.10%	52.17%
Nov-24	Dec-24	Jan-25	Jan-25										
30.30%	38.30%	45.10%	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	<table border="1"> <tr> <td>Jan-25</td> <td>Feb-25</td> <td>Mar-25</td> <td>Apr-25</td> </tr> <tr> <td>64.30%</td> <td>64.78%</td> <td>61.86%</td> <td>61.76%</td> </tr> </table>	Jan-25	Feb-25	Mar-25	Apr-25	64.30%	64.78%	61.86%	61.76%
Jan-25	Feb-25	Mar-25	Apr-25										
64.30%	64.78%	61.86%	61.76%										
52.	Number of ambulance patient handovers over one hour	Apr-25	0	462 Over standard	<table border="1"> <tr> <td>Jan-25</td> <td>Feb-25</td> <td>Mar-25</td> <td>Apr-25</td> </tr> <tr> <td>466</td> <td>385</td> <td>381</td> <td>462</td> </tr> </table>	Jan-25	Feb-25	Mar-25	Apr-25	466	385	381	462
Jan-25	Feb-25	Mar-25	Apr-25										
466	385	381	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	<table border="1"> <tr> <td>Jan-25</td> <td>Feb-25</td> <td>Mar-25</td> <td>Apr-25</td> </tr> <tr> <td>10.62%</td> <td>10.46%</td> <td>11.38%</td> <td>11.24%</td> </tr> </table>	Jan-25	Feb-25	Mar-25	Apr-25	10.62%	10.46%	11.38%	11.24%
Jan-25	Feb-25	Mar-25	Apr-25										
10.62%	10.46%	11.38%	11.24%										
54.	Number of National Reportable incidents that remain open 90 days or more	Apr-25	12 month reduction trend	82									

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Shaping Our Future

**Digital
Services**

Digital & Health Intelligence

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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

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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)

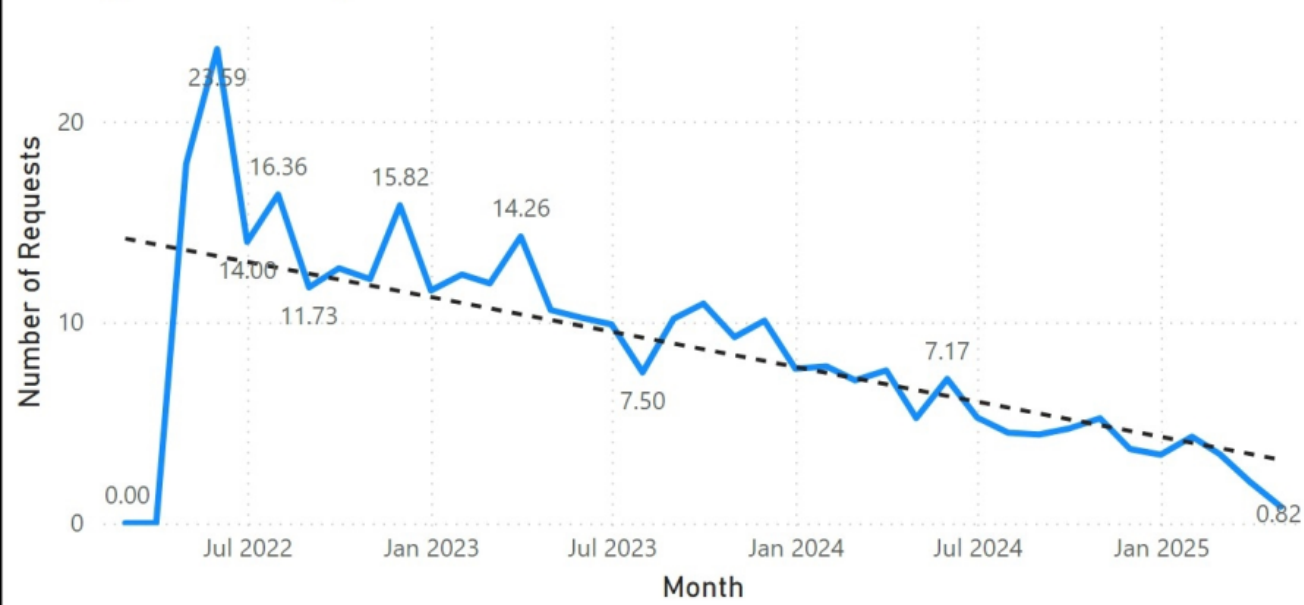
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 @lindsay.louise

Executive Trending

Requests (new and additional items)

Incidents (something that was working no longer works)

Average Duration (Days)



Average Duration (Days)



Requests Opened, Closed and Remaining Open

● Requests Opened ● Requests Closed ● Remaining Open



Incidents Opened, Closed and Remaining Open

● Incidents Opened ● Incidents Closed ● Remaining Open



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Service Desk Scorecard

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

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Service Desk Trending

Requests (new and additional items)

Incidents (something that was working no longer works)

Average Duration (Days)

Average Duration (Days)

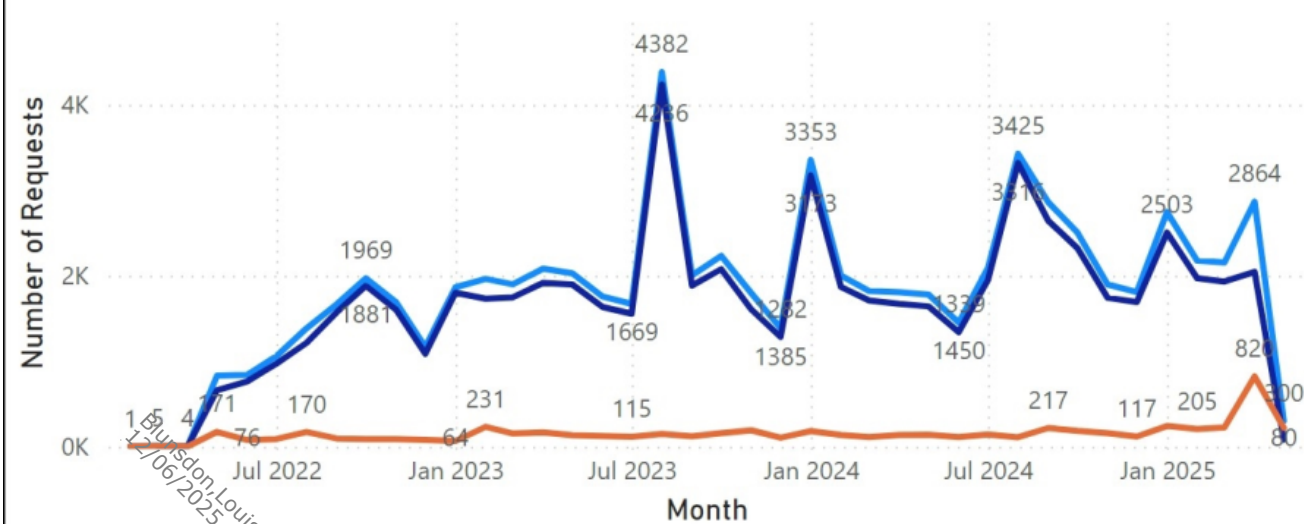


Requests Opened, Closed and Remaining Open

Incidents Opened, Closed and Remaining Open

● Requests Opened ● Requests Closed ● Remaining Open

● Incidents Opened ● Incidents Closed ● Remaining Open



Service Desk Calls – May 2025

Created by Year

- 2025

Created by Month

- January 2025
- February 2025
- March 2025
- April 2025
- May 2025

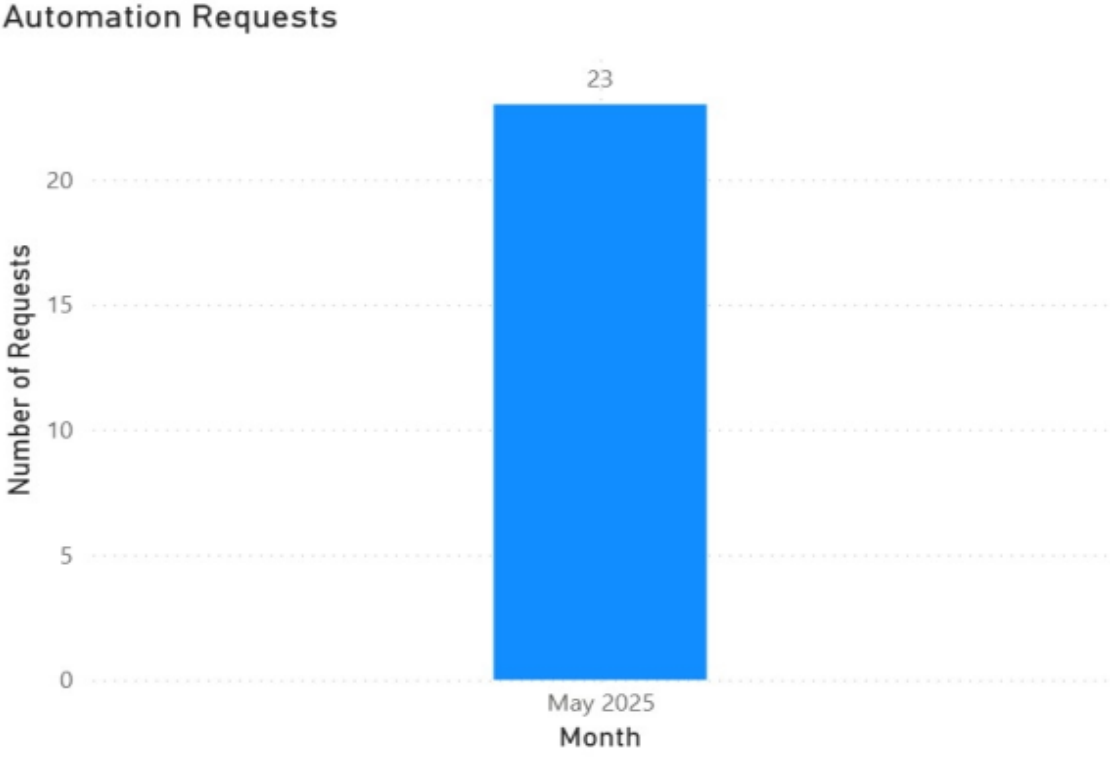
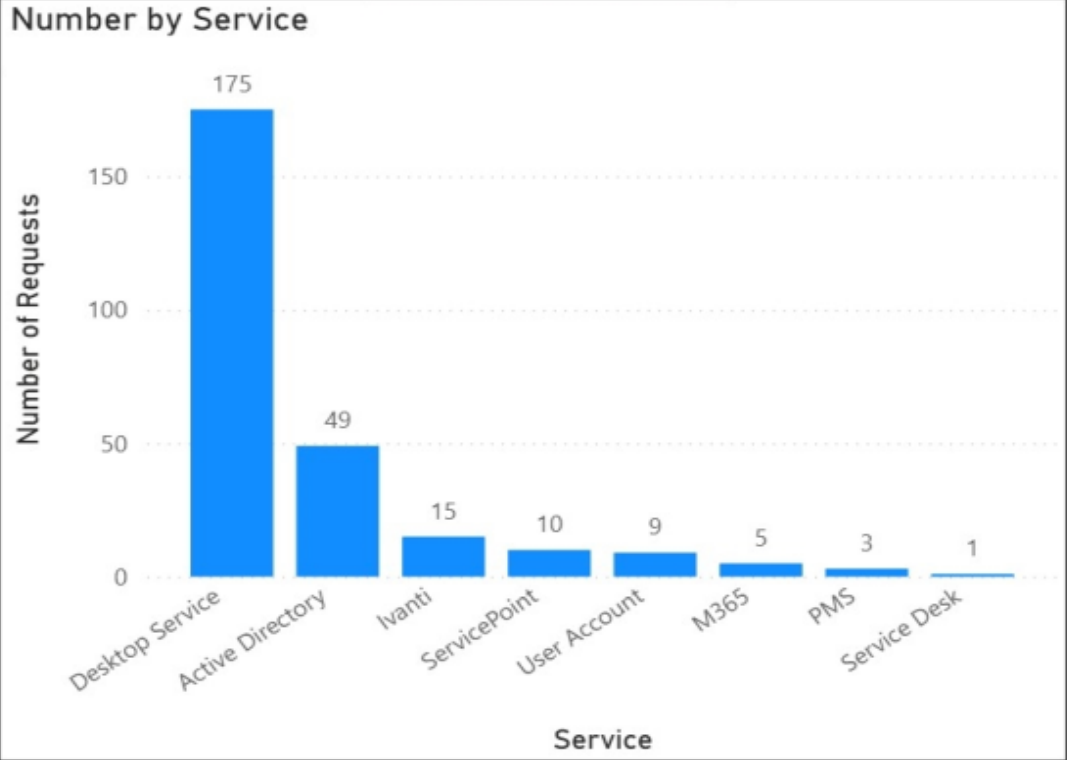
OwnerTeam

- 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 Requests Opened	82 Closed Requests	182 Remaining Open
-------------------------------	------------------------------	------------------------------

0.33 Duration (Days)	66 Older than 30 Days	6 Pending Approval
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IT Procurement Requests
Status



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Incidents for Service Desk – May 2025

Date by Year

Date By Month

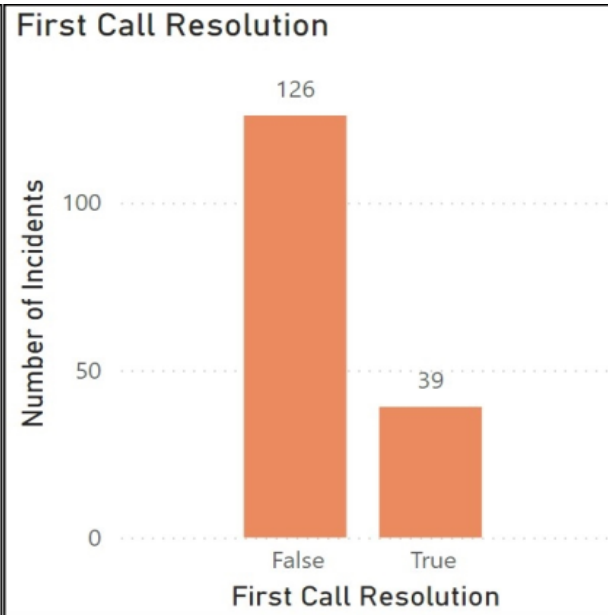
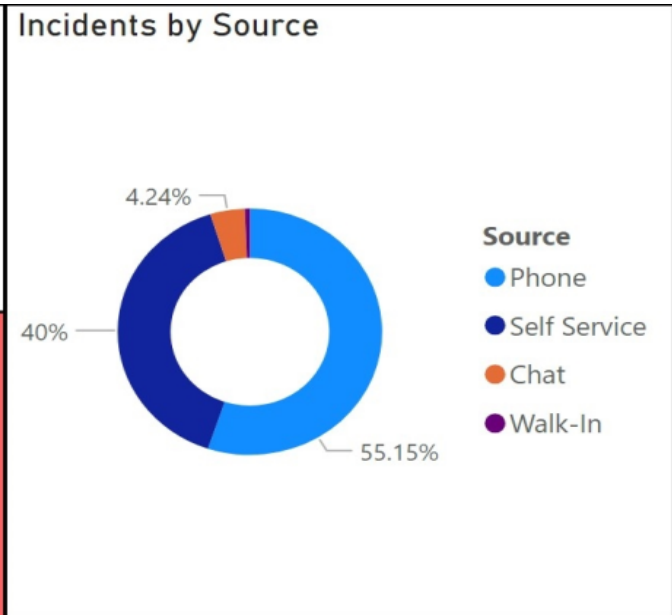
- March 2022
- April 2022
- May 2022
- June 2022
- July 2022
- August 2022
- September 2022
- October 2022
- November 2022
- December 2022

165
Incidents Opened

95
Incidents Closed

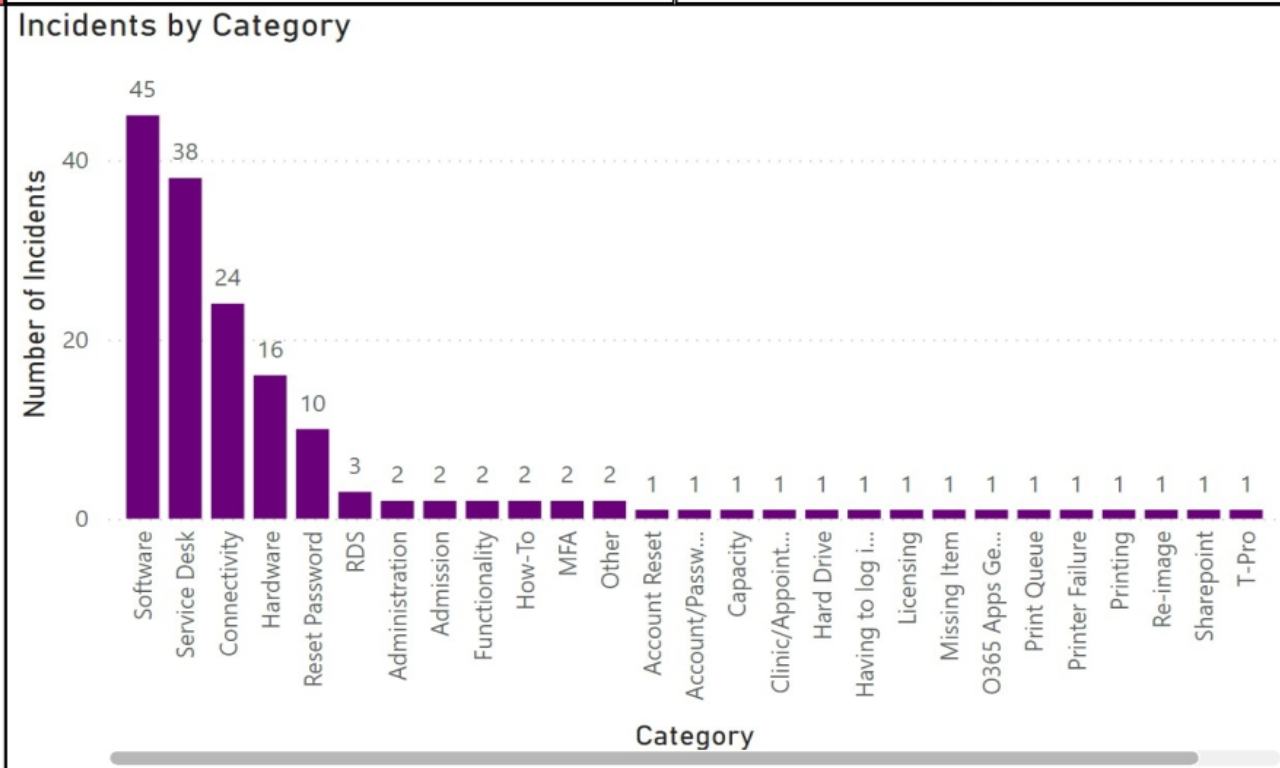
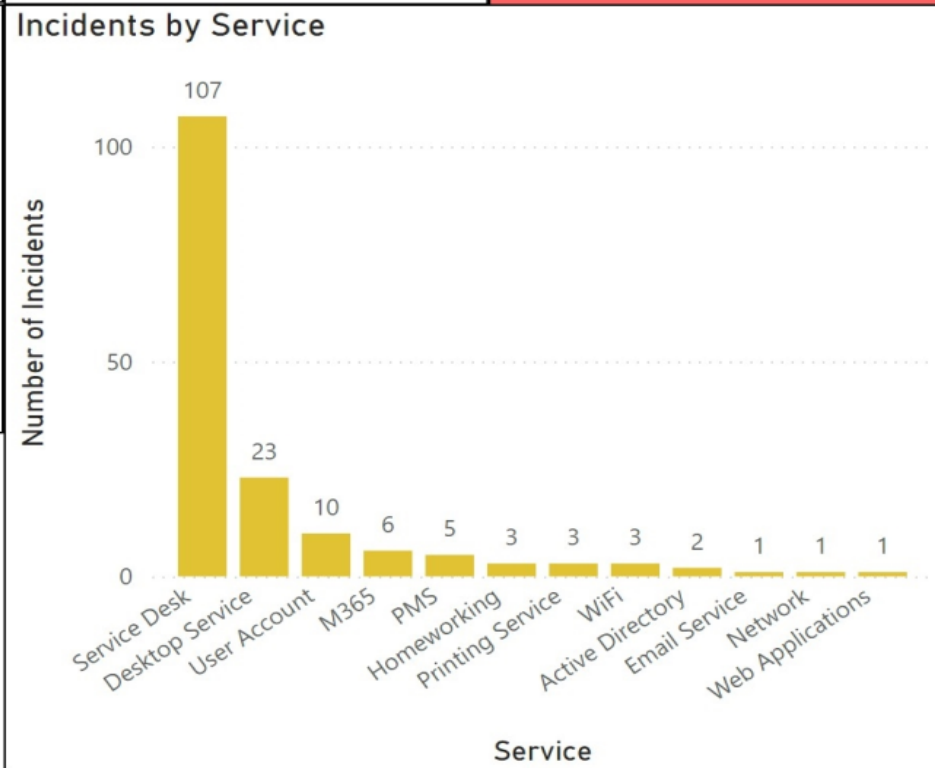
0.39
Avg Duration (Days)

70
Older then 30 Days



OwnerTeam

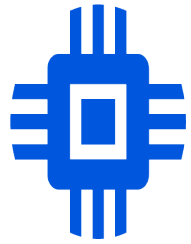
- BI Applications and Warehouse
- Business Intelligence & Informatio
- ePMA IT
- EUD
- IM&T Security
- ISM Admin
- M365
- Network
- Paris



Site

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

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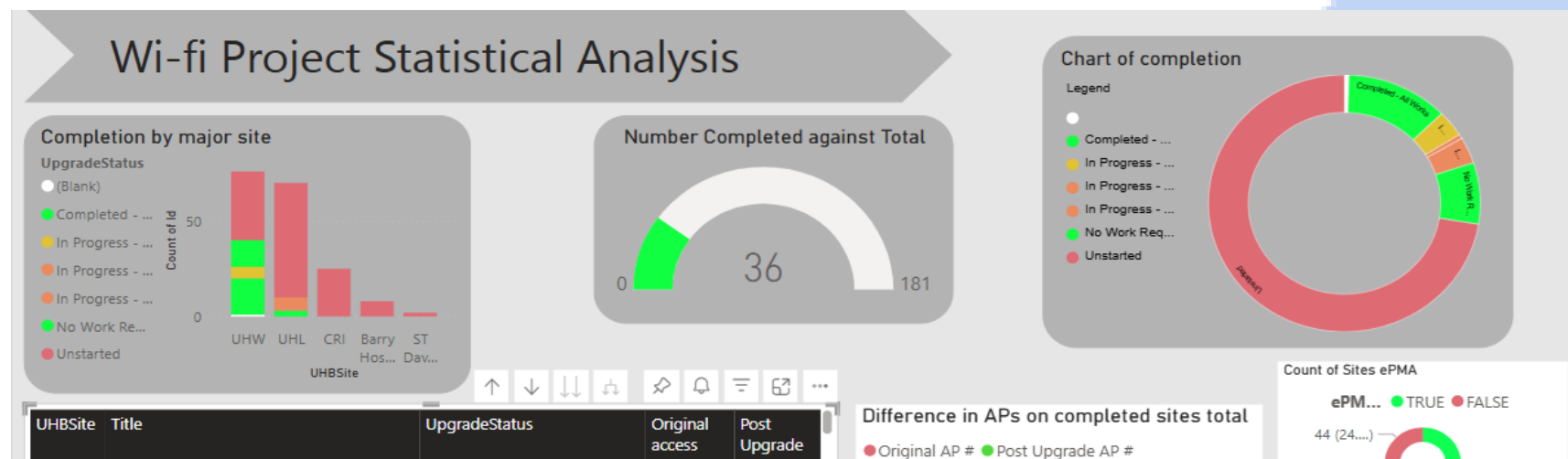
Current metrics on Wi-Fi improvement

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%

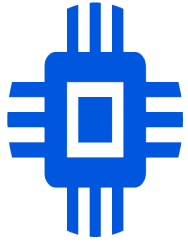
Total wider Wi-Fi/CEF areas	Total areas complete	% total of areas complete
44*	0	0%

**excluding CEF 25% 2025/2026 period*



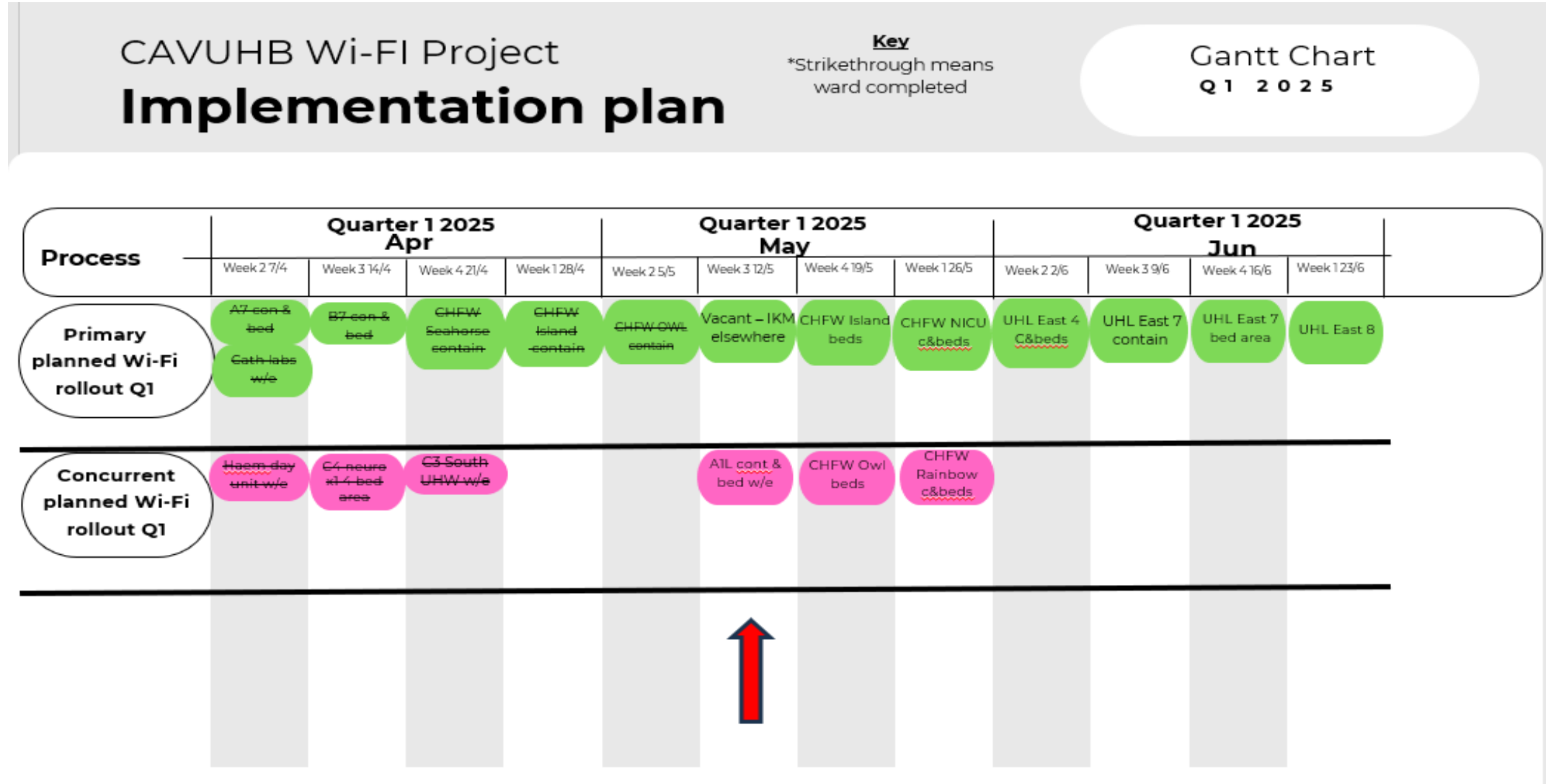
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Timelines: Phase 3

(31st March – 30th June 2025)



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Report Title:	Clinical Board Local Partnership Forums Annual Report		Agenda Item no.	
Meeting:	Local Partnership Forum	Public	x	Meeting Date:
		Private		
Status <i>(please tick one only):</i>	Assurance	Approval	Information	X
Lead Executive:	Chief Operating Officer / Chair of Staff Representatives			
Report Author (Title):	Head of People Assurance and Experience			

Main Report
Background and current situation:

INTRODUCTION

The University Health Board (UHB) has statutory duty to ‘take account of representations made by persons who represent the interests of the community it serves’. This is achieved in part by three advisory groups to the Board and the Local Partnership Forum (LPF) is one of these. This in turn has three sub-groups; the Workforce Partnership Group (WPG), the Employment Policies Sub Group and the Staff Benefits Group.

In addition, the UHB has established Clinical Board (CB) LPFs to enable ongoing dialogue, communication and consultation on service and operational management issues specific to CB areas. Each CB has a Lead Staff Representative who jointly chairs the CB LPF. Each CB LPF is required to report to the UHB LPF on at least an annual basis, but can escalate issues through the WPG if required.

This report provides a summary of activity for the year 2024/25.

PRINCIPLES

The CB LPFs provide a forum where key stakeholders can engage with each other to inform, debate and seek to agree local priorities on workforce and service issues. Each CB LPF aims to meet bi-monthly.

General principles:

- Trade Unions (TUs) and Management show joint commitment to the success of the organisation with a positive and constructive approach.
- They recognise the legitimacy of other partners and their interests and treat all parties with trust and mutual respect.
- They demonstrate commitment to security for workers and flexible ways of working.
- They share success – rewards must be felt to be fair.
- They practice open and transparent communication – sharing information widely with openness, honesty and transparency.
- They must demonstrate a commitment to work with and learn from each other.

All members of the CB LPF must:

- Be prepared to engage with and contribute fully to the CB LPF activities and in a manner that upholds the standards of good governance set for the NHS in Wales.
- Comply with their terms and conditions of appointment.

- Equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes.
- Promote the work of the CB LPF within the professional discipline they represent.

TERMS OF REFERENCE

The Terms of Reference (ToR) were reviewed in 2023 to create a standard set for all CBs and was approved by the UHB Local Partnership Forum. The main purpose and principles as set out in the Terms of Reference are:

- To establish a CB LPF that links into the main UHB LPF agenda.
- To establish a regular and formal dialogue between the CB Senior Management Teams (SMTs) and TUs on matters relating to workforce and service issues.
- To enable Employers and TUs to put forward issues affecting the workforce.
- To provide opportunities for TUs and Managers to input into service development plans at an early stage.
- To consider the implications on staff of service reviews and identify and seek to agree new ways of working.
- To consider the implications for staff of NHS reorganisations at a national or local level and to work in partnership to achieve the mutually successful implementation.
- To appraise and discuss in partnership the financial performance of the Clinical Board on a regular basis.
- To provide opportunities to identify and seek to agree quality issues, including clinical governance, particularly where such issues have implications for staff.
- To communicate to the partners the key decisions taken by the UHB and SMTs.
- To consider national developments in NHS Wales Workforce Strategy and the implications for the CB including matters of service re-profiling.
- To negotiate on matters subject to local determination.
- To ensure Staff Representatives are afforded reasonable paid time off to undertake TU duties.

CLINICAL BOARD LPF ACTIVITY 2023/4

Each LPF is co-Chaired by the Director of Operations and Lead Staff Representative. The membership of each LPF varies, depending on the make up of the Clinical Board, but consists of Trade Union representatives from that area along with Senior Managers/Service Leads, with representation from Finance and People Services as required. In 2024 a new LPF was established for Corporate areas.

Most of the LPFs meet on a bi-monthly basis, with the exception of Medicine which currently meets every month.

A number of common themes have been considered in all or several of the Clinical Board LPFs over 2024-25 including:

- The UHB financial position and response to it
- Equality, Diversity and Inclusion and Welsh Language
- Service change and transformation, including OCPs
- Staff moral and wellbeing
- Health and Safety in the context of the estate and unhealthy working environments.
- Agile working and flexible working.
- Performance/Service are updates including workforce KPIs
- Staff engagement and the staff survey
- Job evaluation

- The need for a compassionate leadership approach to attract and retain staff, and keep them well in work

In addition to the shared themes discussed throughout the year, there were a number of issues specific to that Clinical/Service Board discussed. The individual reports for each CB LPF are attached as Appendix 1.

ITEMS TO BE BROUGHT TO THE ATTENTION OF THE UHB LOCAL PARTNERSHIP FORUM:

The Social Partnership Duty requires organisations, in so far as is reasonable, to seek consensus or compromise with their recognised trade unions, or, where there is no recognised trade union, other worker representatives, when setting their well-being objectives and making decisions of a strategic nature about the reasonable steps they intend to take to deliver those objectives. In 2025/26 the UHB Partnership and Recognition Agreement will be updated to take this Duty into account. As part of this process the LPF terms of reference at a UHB and Clinical Board level will be reviewed to ensure they remain fit for purpose and relevant.

Cultural change cannot be achieved over night, and this year has once again been a year of extreme challenge due to added pressures of unprecedented financial challenges and service demands. Balancing the need to make financial savings with ensuring we have a safe and sustainable workforce to deliver patient care can be difficult but it is essential that we meet it head on and in partnership with our staff and Trade Unions. Partnership working at a Clinical Board and local level needs to continue to improve through earlier engagement and inclusion in the strategic planning and operational delivery of service plans.

Recommendation:

The Local Partnership Forum is asked to note the contents of this report

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 tick as relevant

Prevention		Long term		Integration		Collaboration		Involvement	
------------	--	-----------	--	-------------	--	---------------	--	-------------	--

Approval/Scrutiny Route:

Committee/Group/Exec	Date:

MEDICINE CLINICAL BOARD

The Medicine CB LPF is co-chaired by Jonathan Strachan-Taylor, Lead Staff Representative and Claire Main, Director of Operations for Medicine. Members are: the Director of Nursing and Deputy Director of Nursing, Deputy Director of Operations, Senior Finance Business Partner, Chair of Staff Side and Staff side Representatives, Head of People and Culture and the Clinical Board Director. General Managers, Lead/ Senior nurses also attend to ensure each area within medicine is represented

The Forum meets monthly but this is being reviewed as part of a wider piece of work to improve engagement with the forum and is now likely to run every 2 months.

The Medicine CB LPF provides a Forum to discuss a range of topics affecting staff within the board and is therefore flexible to reflect this. Recurrent themes include:

- Financial position of the clinical board and wider UHB
- Quality and Safety Update
- Staff Wellbeing Initiatives and Good news stories
- Job Matching training and Support
- Agile working, Annual Leave, Worklife Balance and decarbonisation
- Clinical board update on service changes and news to share and wider UHB changes to relocation of wards/ services
- Schwarz Rounds
- Workforce Metrics including VBA, medical appraisals, sickness, turnover, retire and return etc showing UHB targets and comparisons with averages and trends in local performance
- Apprentice schemes and opportunities
- Health and Safety walkarounds are encouraged and reported on
- and it's purpose as set out in the Terms of reference is agreed at the time of the report.

However we have agreed that we will review the purpose of these meetings to include frequency, style of meeting and key topics to discuss.

Medicine has had a change of management structure in the last 6 months and is recognised that this has seen an improvement in engagement with staff side and LPF meetings. The workshop arranged will now review how this improvement continues to develop a forum where open discussions can happen with staff, allowing people to raise concerns and issues in a "safe space" and embedding compassionate leadership.

Any modifications to terms of reference will be shared for approval.

The monthly meetings have been difficult to maintain and ensure a full attendance and engagement due to significant operational pressures and absences. It was also felt that because the meetings were every month it was felt that the impact of cancelling a monthly meeting was less but cumulatively this has had an impact.

SURGERY CLINICAL BOARD

The Surgery CB LPF is chaired by Rachel Thomas and Lead Staffside Representative for SCB.

Members are;

- Director of Operations
- Director of Nursing
- General Managers
- Directorate Managers
- Finance (as required)
- People Services (as required)

The Forum meets bimonthly:-

- February 2024 (didn't take place)
- April 2024
- June 2024
- September 2024
- December 2024 (didn't take place)

The Surgery CB LPF provides a Forum to Establish a regular and formal dialogue between the Surgery Management Team and the Trade Unions on matters relating to workforce and services issues as it's purpose as set out in the Terms of reference.

Significant issues which the Surgery CB Local Partnership Forum has considered during 2024 include:

- Implementation of the People and Culture Plan for 24/25 themes have been identified to help ensure people feel valued, support and engaged.
- Vanguard Theatres will leave at the end of August.
- The IMPT / workforce plan has been discussed many times throughout the year, there has been good partnership discussions and inclusion at LPF.
- Delays inputting Datix on the system.
- Now coroner can call any member of staff to Coroners Court. Staff attending coroner court or inquest to advise SCB so they can be offered right level of support.
- Respect and resolution training awareness sessions for staff implemented.
- Health and Safety has been discussed. Many of the working environments and conditions are areas of high concerns for trade unions and the wider Staff Side group.
- Need for a compassionate leadership approach frequently discussed with the aim to help support SCB in attracting and retaining staff by ensuring they are treated in the best way possible and to help keep Staff well in work.
- Staffing Levels have been a big concern for staff in light of the financial constraints
- Surgery Star Awards well received and plans in progress for hosting again this year.

MENTAL HEALTH CLINICAL BOARD

The MHCB LPF meets bi-monthly and is chaired by Dan Crossland, Director of Operations, Peter Hewin, Lead Staff Representative, and Cyrille Legras, Deputy Lead Staff Representative.

Members are composed of Staff Representatives from unions represented within the MHCB (primarily Unison RCN and BAOT) plus representatives from People Services (whom we are pleased to have now have join us regularly again) and Mental Health Service Managers (although representation from this group has not always been sufficient to reach quorum in recent months, which is an Action Point for the coming year).

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The MHCB LPF provides a Forum for Trade Unions to meet with Managers and People Services to consult, debate and negotiate on matters of importance to staff in their working lives.

Significant issues which the MHCB Local Partnership Forum has considered during 2024 include:

- Appointment of Deputy Lead Staff Representative, Cyrille Legras

Staff Side is grateful to the UHB and Clinical Board for supporting and funding this role, and to Dawn Ward, Chair of Staff Side, for her detailed research which provided the evidence-base for this development.

- Getting to Know You

Trade Unions and Senior Managers working in partnership to listen to staff and raise awareness of management actions to respond to their concerns – it is planned for these monthly events to extend to the community in the coming year.

- Clarification of Annual Leave Principles

Developing guidelines for staff and managers when requesting and allocating annual leave, in support of the Annual Leave Principles (subsection of the Rostering Principles agreed between the Director of Nursing and Trade Unions) and the UHB Annual Leave Procedure, emphasising that every effort should be made by all parties to avoid a situation whereby a member of staff is at risk of losing leave – this is currently a work in progress which we hope to have completed by the end of this leave year.

- IR case rates

People Services have advised us of an increasing trend in disciplinary action which the Partnership Forum is keen to turn around in readiness for the new all-Wales Disciplinary Policy which emphasises the just and learning culture.

- Organisational Change Process

Trade Unions are supporting staff through the OCP, aware that this is the first step in a significant transformation in community MH services which is necessary for sustainability to counteract the mismatch between demand and capacity.

- Overpayments

Work to mitigate the impact of significant overpayments insofar as possible, and to limit the possibility of recurrence.

- Poor estate

Lack of heating during the coldest period of winter, and sewage overflow, in one of our community venues, being of particular concern, but symptomatic of widespread disrepair and underinvestment.

- Smoking enforcement

We are working together as a task group for the expected new enforcement rules – supporting Hafan Y Coed particularly in this matter.

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PCIC CLINICAL BOARD

The Primary, Community and Intermediate Care (PCIC) Clinical Board Local Partnership Forum is chaired via rotation by the Staffside Lead Representative for PCIC, Lorna McCourt, and the Interim Directors of Operations, Clare Evans and Geraldine Johnston. Membership includes: representation from the Clinical Board Senior Management Team; Business Unit Leads or Deputies; wider Staffside representatives; and Planning and Delivery team representation. Other individuals may attend based on agenda items. The Forum meets bi-monthly but due to several meetings requiring rescheduling has met on 5 occasions in 24-25.

The PCIC LPF provides a Forum for key stakeholders to meet on a regular basis to discuss key priorities and progress of workforce and service considerations. The agenda is shaped by the central LPF Workplan 24-25 which was introduced to PCIC in September 2024, with a focus on: sharing updates from the Director of Operations and Lead Staffside Representative; considering the People and Culture action plan; considering equality and diversity implications; receiving updates from Business Units and their service areas; providing updates on Clinical Board progression against the IMTP and financial plans; reviewing formal engagement requests; receiving presentations; and engaging with wider partners.

Specific issues which the PCIC Local Partnership Forum considered during 2024-25 include:

- Financial sustainability focus, cost improvement programme schemes and impact on staff.
- Enhanced vacancy scrutiny and impact on service rates and staff wellbeing.
- Staffside representative site walk-around feedback.
- Business Unit restructuring under OCP process.
- Staff immunisation delivery model for 24-25.
- Staff survey results.
- CRI site safety and parking concerns. Ask Suzanne session was delivered live from CRI in November 2024.
- Welsh language competency recording improvements.
- Communications mechanisms in use across the Clinical Board.
- Overview of December 2024 rapid planning meetings provided.
- Sharing of messaging regarding staff overpayments, deadlines, and use of the SMA app.
- Job matching process and training.
- Sickness panel support and training.
- Planning for PCIC Celebratory Event and Staff Recognition Awards.

Examples of partnership working which have taken place in 2024/25 include:

- supporting areas with job matching queries.
- local policy support e.g hybrid working arrangements, agile working arrangements (in 2 areas, agreement signed off in partnership).
- Conducting safe space events throughout the clinical boards, (some events included People Services representatives), enabling open feedback to SMT.
- Advertising of staff survey, and importance of completion and submission.
- Organisational change, starting discussions with teams earlier than previous years.

PCIC LPF Terms of Reference were reviewed and agreed in the August 2024 meeting.

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CD&T CLINICAL BOARD

The CD&T Clinical Board LPF provides a forum to engage and communicate with TU representatives on matters relating to the workforce within the Clinical Board. It enables TUs to provide input on service plans at an early stage, appraise and discuss the financial performance and any issues related to quality and safety. In 2024 the work of the Group included a review of the Terms of Reference, the development of an annual work plan, standardising the agenda for the meeting and directorate presentations of their service plans.

Membership

The former Lead Staff Representative for CD&T Clinical Board, Steve Gauci retired in 2024 and Bill Salter was appointed as his replacement. The CD&T Clinical Board Local Partnership Forum is chaired jointly by Sarah Lloyd, Director of Operations and Bill Salter.

Members include:

- Adam Christian, Clinical Board Director
- Helen Luton, Director of Nursing
- Robert Gordon, Senior Finance Business Partner
- Louise Halliday- Jones, Head of People & Culture
- Menna Evans, People Services
- At least one representative from each Directorate at each meeting – e.g. Laboratory Medicine, AWTTTC, Radiology/Med Physics/Clinical Engineering & Cedar, Medical Illustration, Outpatients/ Patient Administration, Clinical Coding, Therapies, & Pharmacy.
- All CD&T staff side TU reps

Frequency of Meetings

The Forum meets bi-monthly.

Key Items of Discussion:

The Clinical Board acknowledged that agile working where viable, is an acceptable way of working and can also be used as a reasonable adjustment for providing support for staff with disabilities and long-term health conditions.

The Healthcare Support Worker Band 2/3 All Wales Agreement is still in progress and will particularly impact on Outpatient staff. When the All Wales Outpatient job descriptions are agreed, work will commence in Partnership around the framework for assessment.

The Clinical Board held 4 Workforce Reshaping Sessions where each directorate presented their workforce plans and the appropriate staffing levels and skillsets they require for the foreseeable future. Positive discussions were held on how departments are skill mixing and introducing new roles and routes for succession planning that may not have previously existed. There was a clear message that staff wellbeing and resilience was highly important to enable services to run efficiently.

The Clinical Board has put its 'Safe Space' work on hold. The UHB subsequently introduced the Speaking Up Safely Initiative and It was decided to promote this instead so that there is one consistent approach across the UHB.

There was a drive in the Clinical Board this year to encourage staff to complete their level of Welsh Language Skills onto ESR. In January 2024, the Clinical Board was reporting 37% compliance and in January 2025 reported a significant improvement to 69% compliance.

A Workforce Metrics report is produced for oversight on compliance against targets. The UHB placed particular focus on compliance against the VBA target this year, and by January 2025 the Clinical Board had increased its VBA compliance to 81.26%.

The Clinical Board's financial position is also presented. This year budget setting exercises are being undertaken with directorates to align their budgets closer with their operation plans.

There were difficulties in implementing Health Roster within the Clinical Board in the non-nursing areas. The full functionality of the system in terms of analytics and dashboards was not available for this Clinical Board.

Sustainability is a regular agenda item. The KidzMedz Cymru Project in Pharmacy and the Walking Aids Refurbishment Scheme in Physiotherapy were winners in the first NHS Sustainability Awards.

Staff Engagement

Walk rounds were undertaken in a number of departments to introduce Bill Salter to staff. The walk round held in the Cellular Pathology department, resulted in a positive outcome where Bill Salter arranged for the Chief Executive to visit the department.

The Outpatient Nursing team embarked on a culture and leadership programme and service review supported by the ECOD team and Staff Side. This was a difficult process but there was good engagement with staff and sound advice was provide by Partnership colleagues and the ECOD team.

The Therapies services set up an AHP LPF to allow in-depth discussions on local issues.

The staff survey results from 2023 were received however the low response rate impacted on the ability to obtain meaningful data. For the 2024 survey, Bill Salter and the Clinical Board Director of Nursing, with support from People Services, visited departments to encourage staff to complete the survey, to try to improve uptake.

The Pharmacy department at UHW experienced significant flooding on numerous occasions due to spells of wet weather. There was good support from Partnership colleagues for the staff working in poor conditions.

Service Developments

There has been good engagement with Partnership colleagues on service developments and reviews including:

- The Outpatient Transformation Work
- Weekend working in Health Records
- TRAMs OCP. A visit was undertaken with Sarah Lloyd, Steve Gauci and Bill Salter to IP5, the proposed site for TRAMs and they were impressed with the scale and fabric of the premises.
- 7 day working in Cellular Pathology
- The Mortuary refurbishment was a significant estates project undertaken in 2024 and is due for completion.

Complex digital projects are being implemented in the Clinical Board:

- Pharmacy is rolling out EPMA to its first ward in March.
- The new Laboratory Information Management System (LIMS) is progressing towards implementation in 2025.
- Work is progressing on the Radiology Information System Programme (RISP) which is due to go live in 2026.

SPECIALIST SERVICES CLINICAL BOARD

The Specialist Services CB LPF is chaired by Jessica Castle, Director of Operations and Bill Salter, Lead TU Rep.

Members are:

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- Cath Twamley, Director of Nursing
- James Leaves, Asst Dir of Finance
- Terrie Waites, Head of People & Culture
- Rachel Flay, People Services
- At least one representative from each Directorate at each meeting – e.g. DM, Lead Nurse, Senior Nurse, Service Manager (ALAS, Cardiac, Critical Care, Haematology, Major Trauma, Nephrology & Transplant, Neurosciences)
- All TU reps are also invited

The Forum meets bi-monthly.

The Specialist Services CB LPF provides a Forum to engage and communicate with TU reps on matters relating to the workforce within the Clinical Board, enable TUs to provide input on service plans at an early stage, appraise and discuss the financial performance and any issues related to quality and safety and its purpose as set out in the Terms of reference (attached).

Significant issues which the Specialist Services CB Local Partnership Forum has considered during 2024 include:

- Relocation of Cardiothoracic Services from UHL to UHW
- VBA compliance
- Staff Survey results
- People & Culture Plan
- Equality, Diversity & Inclusion
- IMTP
- Clinical Board Restructuring
- Job Matching
- Quality & Safety (inc Health & Safety) issues

Other significant matters discussed include a review of the Terms of Reference for the group, development of an annual work plan, standardising the agenda for the meeting and Directorate presentations of their service plans.



Partnership Forum
Terms of Reference.d



SSCB LPF Work Plan
2024-25.docx

CEF SERVICE BOARD

Membership:

Chairs Andrew Poole Head of Estates and Facilities

Mat Thomas Lead Staff Side Representatives

- Head of Estates and Facilities
- Head of People and Culture
- Head of Facilities
- Head of Estates
- Head of Retail services
- Head of Security & Portering
- Head of Ward Based Catering
- Finance Manager
- People Services Manager
- Staff Health and Safety Adviser
- Service Managers
- Service Sustainability & Efficiency Team Manager
- Trade Union Representatives

Key Topics Considered in 2024/25 include:

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- A new “Terms of Reference” was agreed.
- An Action Log was formalised for meetings and rolled out.
- We have introduced a new LPF reporting method for Heads of Service
- We have discussed many Topics over the last 6 meeting which include:
 - Digitally Ready workforce
 - Attract, Recruit & Retain people with the right skills
 - Anti-racist action plan
 - More Than Just Words
 - Putting People first
- We have discussed the importance of Mandatory Training and the excellent performance of CEF teams in maintaining this
- We have discussed Training and Education
- The beginning of 2025 we have seen a rebranding of the Service Improvement Programme team to its new name (SSET) Service Sustainability & Efficiency Team.
- At every LPF we have discussed the importance of how we deliver information as it is key to having a healthy, engaged work force.
- Need for a compassionate leadership approach has been discussed at every LPF to help support CEF in attracting and retaining staff by ensuring they are treated in the best way possible and to help keep Staff well in work.
- Health and Safety has been discussed. Many of the working environments and conditions are areas of high concerns for trade unions and the wider Staff Side group.
- The impact on Staff without access to work emails have been discussed on many occasions. There is a commitment to roll this out but there are still many staff without access to the online resources and benefits from not having one to date.
- In addition to the non-pay elements of the pay deal, the management approach to Flexible working, Industrial Claims and other policy and procedures have been discussed many times. There is a commitment to support staff through using the right approach and implement each of the All Wales and local policies and procedures as intended to make sure staff are being treated fairly and equally.
- The new My Health Passport and how to implement it has been discussed and there is an agreement to monitor its uptake across CEF.

Chair opinion / issues to bring to the attention of the UHB LPF

Mat Thomas – Staff Side Representative.

While there is still work to be done to fully embed the principles of compassionate leadership within some areas of CEF, positive progress has been made over the last 12 months. Staff continue to need more support from managers to prevent workplace disputes and absences, this will remain a priority for 2025/26 to help build better trust and working relationships between staff and their managers, and to address the financial challenges we will face in 25/26.

Partnership working has improved overall through earlier engagement with the lead representative and inclusion in strategic planning and operational delivery, however, there is always room for improvement, as some issues have been raised by staff and other Clinical Boards with the Trade Unions regarding communication, pay and being kept informed about changes.

Overall, I believe this year has seen the most significant improvement within CEF, and I have had many opportunities to share this success with Senior Managers across the Health Board and Executives.

Andrew Poole - Head of Estates & Facilities

I feel that the last year has established a good working relationship with both Staff Side and the Head of People and Culture, which will inform and enhance future strategies around staff wellbeing in the workplace.

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Discussions and collaboration within the LPF led to a number of key initiatives being launched and embedded relating to staff engagement through site walkabouts and meet & greets.

The importance of recognising the 2023 survey results despite the 2024 survey being launched was recognised within the LPF group and planning for the 2024 results has also taken place in conjunction with Staff Side. The LPF was clear on the importance of communicating out what actions CEF have or will take in relation to what feedback we have received from in-person discussions and survey results.

The LPF meetings has hosted guests to promote and endorse schemes such as Project Search and Widening Access, positively contributing to experiences and best practice in supporting these initiatives.

Issues to note:

One topic that has left staff feeling very disappointed is that some employees still do not have a work email, despite many promises that this issue would be resolved by the end of 2024, we have started 2025 with the same problem one we hope to rectify in the coming months.

It has been a full year since we lost our colleague Joe Monks, and it is important to note that Joe's contributions to CEF over the years are still being talked about today and many staff members continue to miss Joe deeply

CORPORATE AREAS LPF

The Corporate LPF is chaired by Dawn Ward Chair of Staff Side and Clive Morgan Managing Director of the All Wales Medical Genomics Service (AWMGS). The Forum had its inaugural meeting September 2024 and it has continued to meet bi-monthly.

Forum members are senior leaders within corporate functions and staff side lead representatives.

- AWMGS
- Strategy & Planning
- People & Culture
- Patient Safety & Quality/Corporate Nursing
- Health & Safety
- Finance & Performance
- IT/Digital
- Communications, Engagement and Health Charity
- Corporate Governance
- Staff Side Health and Safety Lead
- Staff Side Policy Lead
- Staff Side Vice Chair
- Staff Side Secretary
- Independent Member (Trade Unions)

Significant issues which the Corporate Local Partnership Forum has considered during 2024-25 include:

- Delivering the Shaping Our Future Well-Being strategy
- Local process for Organisational Change
- Intermediate Medium-Term Plan
- Delivery of the People & Culture Plan / Themes

- Health and Safety Update
- AWMGS Wellbeing Framework
- Staff Survey
- Equality Update
- Workforce Race Equality Standards
- Ambassador Roles
- Performance Reports (Workforce metrics, Quality & Safety, Health & Safety)

Round up:

AWMGS laboratory moved to Cardiff Edge before Christmas. Recognition that the staff engagement and planning stages were well managed and the move was successful.

The Finance team returned to streamlined practices to maximise efficiencies and were reporting an underspend.

The People & Culture Team have restructured to re-align with the Clinical Boards. There will be more support for targeted intervention to help managing attendance at work and with training on workforce planning.

The Corporate Governance team are using the co-pilot system to reduce workloads and modernise practices. The Speaking up Safely working in confidence platform is being launched before Christmas.

The Health & Safety Dept highlighted the work of the Case Management Team in addressing Violence Against Staff.

Maintaining staffs wellbeing was highlighted as a primary objective for all parties and the group would like to explore ways to highlight the work achieved within these areas. The Well-Being framework developed by AWMGS was highlighted and praised for its innovation.

Comments from Co-Chairs:

We are pleased to have the Corporate LPF up and running for staff working in these services. The forum is well attended, the membership is fully engaged and each area provides a short update prior to each meeting using the templates provided. A news bubble is produced which provides staff with a summary of the topical discussions and outcomes. Feedback suggests that staff in these areas value their representatives being engaged and consulted on local workforce issues ahead of change and this has opened up more opportunities for more constructive two-way dialogue which aligns with other areas within the Health Board.

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