Quality Committee

Tue 24 June 2025, 14:00 - 15:30

Agenda

14:00 - 14:05
5 min

1. Standing Items

1.1. Welcomes, Introductions, & Apologies

Ceri Phillips

1.2. Declarations of Interest

Ceri Phillips

1.3. Minutes of the Quality Committee Meeting held on 13.05.2025

Ceri Phillips

1.3 - Draft Quality Public Minutes 13.05.2025.pdf (10 pages)

1.4. Action Log – Following the meeting held on 13.05.2025

Ceri Phillips

1.4 - Quality Committee Actions following 13.05.2025.pdf (1 pages)

1.5. Chair's Action taken since last meeting

Ceri Phillips

14:05 - 15:00
55 min

2. Items for Review & Assurance

2.1. Deep Dive – Nationally Reportable Incidents (NRIs)

25 mins *Alex Scott / Angela Hughes*

2.1 - Nationally reportable Incidents 2024.pdf (7 pages)

2.2. Prevention of future deaths update - Ref: 1051 and Ref: 1553

10 mins *Jason Roberts / Angela Hughes*

2.2 Prevention of future deaths update (1).pdf (4 pages)

2.3. IP&C Position Update

15 mins *Jason Roberts / Yvonne Hyde*

2.3 - IPC Public Quality meeting June 2025.pdf (13 pages)

2.4. Clinical Effectiveness Committee Report

5 mins *Alex Scott*

2.4 - CEC assurance report Jan-March 2025.pdf (12 pages)

15:00 - 15:10
10 min

3. Items for Approval / Ratification

3.1. Policies

No policies for approval

3.2. Regional Health Protection Partnership

5 mins *Claire Beynon*

- 3.2a - 250624 Regional HP partnership plan _QSE.pdf (3 pages)
- 3.2b - Cardiff and Vale_Health Protection Plan_2024-2026_Final 10032025.pdf (26 pages)

3.3. Vale Food Strategy

5 mins *Claire Beynon / Louise Denham*

- 3.3a - Update for Vale Food Strategy QSE Committee June 2025 FINAL CB 1.pdf (4 pages)
- 3.3b - Update for Vale Food Strategy June 2025.pdf (4 pages)
- 3.3c - DRAFT Vale Food Strategy May 2025_final.pdf (30 pages)

15:10 - 15:10
0 min

4. Items for Noting & Information

4.1. Minutes from Clinical Board QSE Sub Committees

Jason Roberts

- 4.1.1 - CD&T QSE Minutes 24.4.25.pdf (14 pages)
- Minutes of the Medicine Clinical Board16 April 25 v2.pdf (6 pages)

4.2. Joint Commissioning Committee Quality Safety and Outcomes Sub-Committee Highlight Report

Ceri Phillips

- 4.2 - QSO Highlight Report March 2025.pdf (8 pages)

4.3. Internal Audit Report for Noting – Follow Up Health Roster System

Jason Roberts

- 4.3 follow up health roster system final internal audit report.pdf (17 pages)

15:10 - 15:10
0 min

5. Items to bring to the attention of the Committee

Ceri Phillips

15:10 - 15:10
0 min

6. Agenda for the Quality Committee Private Meeting

Ceri Phillips

i. *Private Minutes & Actions*

ii. *Any Urgent / Emerging Themes – Verbal (Confidential Discussion)*

15:10 - 15:15
5 min

7. Any Other Business

Ceri Phillips

15:15 - 15:15
0 min

8. Review of the Meeting

Ceri Phillips

15:15 - 15:15
0 min

9. Date & Time of Next Meeting:

Ceri Phillips

5th August 2025 at 2pm via MS Teams

15:15 - 15:15
0 min

10. Declaration

"To consider a resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest [Section 1(2) Public Bodies (Admission to Meetings) Act 1960]"

Minutes of the Public Quality Committee

Held on 13th May 2025 via MS Teams

To view the meeting: CAVUHB Quality Committee 13.05.2025

Chair:		
Ceri Phillips	CP	Committee Chair / UHB Vice Chair
Present:		
Rhian Thomas	RT	Committee Vice Chair / Independent Member – Capital & Estates
Mike Jones	MJ	Independent Member – Trade Union
In Attendance		
Aled Roberts	AR	Associate Medical Director Patient Safety and Clinical Effectiveness
Jason Roberts	JR	Executive Nurse Director
Paul Bostock	PB	Chief Operating Officer
Vicki Burrell	VB	Senior Service Improvement Programme Manager
Matt Phillips	MP	Director of Corporate Governance
David Fluck	DF	Executive Medical Director
Angela Hughes	AH	Assistant Director of Patient Experience
Claire Beynon	CB	Executive Director of Public Health
Emma Cooke	EC	Executive Director of AHPs, Health Scientists and Community Services Development
Jo Harrall	JH	Senior Programme Manager Quality Excellence and Learning
Jessica Castle	JC	Director of Operations – Specialist Services Clinical Board
Rim Al-Samsam	RAS	Clinical Board Director – Mental Health
Catherine Twamley	CT	Interim Director of Nursing – Specialist Services Clinical Board
Thomas Holmes	TH	Interim Clinical Board Director – Specialist Services
Michael Stephens	MS	Interim Clinical Board Director – Specialist Services
Tara Robinson	TR	Interim Deputy Director of Nursing – Mental Health
Suzanne Wood	SW	Consultant in Public Health Medicine
Karen Gillespie	KG	Acute Oncology Clinical Nurse Specialist - Medicine
Observers		
Lauranne Cullen	LC	Regional Director for Llais
Natasha Goswell	NG	Deputy Executive Nurse Director
Bevan Howells	BH	NHS Graduate Management Trainee
Secretariat		
Rachel Chilcott	RC	Corporate Governance Officer
Apologies		
Steve Riley	SR	Independent Member – Local Community
Alexandra Scott	AS	Assistant Director of Quality and Patient Safety

QC 25/05/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the meeting in English & Welsh.	**ACTION**
QC 25/05/002	**Apologies for Absence** Apologies for absence were noted.	
QC	**Declarations of Interest**	

25/05/003	No declarations of interest were raised.	
QC 25/05/004	**Minutes of the Committee meeting held on 01.04.2025** The minutes of the Committee meeting held on 01.04.2025 were received. **The Committee resolved that:** a) The minutes of the meeting held on 01.04.2025 were approved as a true and accurate record of the meeting.	
QC 25/05/005	**Action Log following the Meeting held on 01.04.2025** The Action Log following the Meeting held on 01.04.2025 was received. **The Committee resolved that:** a) The Action Log from the meeting held on 01.04.2025 was noted.	
QC 25/05/006	**Committee Chair's Actions** No Chair's Actions were raised.	
	Items for Review & Assurance	
QC 25/05/007	**Specialist Services Clinical Board – Assurance Report** A patient story was presented to the Committee about a gentleman's journey through neuro rehab after suffering a subarachnoid haemorrhage. He highlighted the kindness and support received from various multidisciplinary professionals, the importance of therapeutic engagement, and his progress in regaining his independence. The Interim Director of Nursing – Specialist Services Clinical Board (IDN-SSCB) presented the report and slides to the Committee which detailed the arrangements, progress and outcomes within the Specialist Services Clinical Board in relation to the quality, safety and patient experience agenda over the past 12 months. The Committee Vice Chair (CVC) asked whether there were any challenges or concerns with the Joint Commissioning Committee (JCC) services. The CVC reflected on the previous year's Internal Audit report which made recommendations to their Terms of References (ToRs) and asked whether the implementation of AMaT had made a difference. The IDN-SSCB responded that the AMaT system was being used, but it primarily held individual action plans. There was a piece of work ongoing to create a single comprehensive action plan across the organisation which corresponded with themes. Regarding commissioning services, the Director of Operations – Specialist Services Clinical Board (DO-SSCB) described the two biggest areas of concern: 1. Cardiac Surgery Activity – they were not delivering the volume of activity commissioned due to staffing issues, leading to long waiting times and associated mortality and morbidity risks. This was listed as high on the risk register. 2. JACIE Accreditation for Bone Marrow Transplant (BMT) and CAR-T Services – the current facilities did not meet the required standards, and there were ongoing discussions with Welsh Government (WG) about reproviding these facilities. An	

	inspection was due in September 2025, and failure to re-accredit could impact the delivery of the services. The Executive Medical Director (EMD) asked whether there was an improvement plan in place for the MRSA and MSSA issues. The EMD highlighted the use of AMaT and felt it was not being fully utilised. He noted that there was a medical examiners module on the system, which may be useful for their mortality dashboard. There was the need for help with the risk management module to create local risk registers which fed up into the corporate risk register. The IDN-SSCB highlighted the efforts made to manage MRSA and MSSA infections amongst nephrology patients, particularly those associated to the line infections: • The focus last year was on improving the line management – full review of patient pathway, the treatment room on B5 was redesigned, bespoke line insertion packs, education of ANTT and sterile procedures, the development of formal competency-based learning and assessments, and the redesign of care plans. A lot of this had been rolled out to Critical Care. • Challenges remained however, and they were an outlier due to the huge increase of patients with lines over the past 5-7 years. The Interim Clinical Board Director – Specialist Services (IMCBD-SS-MS) added that renal failure patients on haemodialysis often had permanent tunnel lines for dialysis for long periods of time. The goal was to transition them to fistulas, but the prevalence of lines had increased globally. With around 200 patients dialysing permanently with lines, there was a disproportionate incidence of bacteraemia. The task was to minimise these cases whilst acknowledging the numbers would be higher than the UHB's standard. The Director of Corporate Governance (DCG) noted that Corporate Governance utilised the AMaT system already being used in the clinical governance space. They were the only health organisation in the UK to develop a risk register module, but it was now down to capacity to input all the data. **The Committee resolved that:** 1) The contents of the report was noted, in particular the highest risk areas for SSCB include: - Critical Care infrastructure - Maintaining JACIE accreditation in haematology - Access to renal theatre lists - Risks aligned with Epilepsy Services - Cardiac Surgery waiting lists	
QC 25/05/008	**Quality Indicators Report** The Assistant Director of Patient Experience (ADPE) presented the Quality Indicators Report and slides which provided assurance in relation to several quality, safety and patient experience priorities. It provided data through the end of April 2025 where available and detailed ongoing actions to drive necessary improvements. Additionally, it included exception reporting to highlight emerging trends and issues related to quality and patient safety. The CC noted concern about 'Never Events' which were critical quality metrics for the Cabinet Secretary. The trend was negative and prompted the need for clarification on measures being taken to address these.	

	The ADPE responded that it was challenging as the definition of 'Never Events' was subjective. The key was to ensure the same type of 'Never Event' didn't reoccur. Robust reviews were essential, and each event was thoroughly examined. The EMD highlighted that the high reporting culture indicated a strong safety culture. They needed to focus on harm caused - 'Never Events' were often process driven, and recent theatre reviews would help to improve processes. The Executive Nurse Director (END) noted this had been discussed in IQPD so WG were aware. He referred to the issue with the WHO checklist, and noted they now had a WHO collaborative which did a significant amount of work in reducing and mitigating the number of 'Never Events' and had been spread across the organisation. The END noted that the UHB used a just culture and ensure there was a robust improvement plan and learning from incidents. It was reassuring that people were not afraid to report when things went wrong. **The Committee resolved that:** 1) The assurance provided by the report was noted.	
QC 25/05/009	**Learning From Mortality** The Associate Medical Director Patient Safety and Clinical Effectiveness (AMDPSCE) presented the report to the Committee which highlighted the extensive work on learning from mortality in CAVUHB, in partnership with the medical examiner, coroner, and other partners. It detailed the digitisation of death reporting processes, the scrutiny of deaths by the Medical Examiner service, the review of referred cases, and the Learning from Mortality Group. They were looking to use AMaT the Morbidity & Mortality (M&M) module to document conversations and learning. The focus was on improving end-of-life care, lost to follow-up, managing deteriorating patients, and adhering to the Mental Capacity Act (MCA). The CC acknowledged the alignment with other initiatives and the integration into the Shaping Our Future Quality Excellence (SOFQE) Framework. It was crucial that learning was implemented to prevent future mistakes and delays, and to enhance overall service quality and outcomes. The EMD noted that it was now about disseminating the learning throughout the organisation. **The Committee resolved that:** a) The summary of Mortality Scrutiny being undertaken within CAVUHB was acknowledged; b) The learning efforts and partnerships in place to embed learning arising from mortality scrutiny and subsequent internal UHB review was recognised.	
QC 25/05/010	**Invited Service Review (IRS) of Cardiff and Vale University Health Board (UHB) Mental Health Services** The Clinical Board Director – Mental Health (CBD-MH) and the Interim Deputy Director of Nursing – Mental Health (IDDN-MH) shared the report and slides and highlighted the following: • During 2021-22, the Royal College of Psychiatrists (RCP) was invited to review the high inpatient suicide rates at the UHB and revealed significant areas for improvement.	

	• Key changes in the Clinical Board included: enhanced risk assessment training, better family engagement, implementation of open dialogue, improved care planning and formulation, therapeutic engagement, continuity of care, Mental Health Act (MHA) diagnosis and treatment training, training around observation levels, accreditation with SIRAN, 3 members of the QSE team were Peer National Reviewers. The CVC highlighted that the paper referred to potential implications because of the changes in practices for the staffing model, the funded Nursing Establishment in inpatient wards, and recruitment to senior clinical roles. The IDDN-MH responded that they were aligning their nursing establishment with QNWA standards to address activities they were currently unable to perform. Significant changes and a cultural shift towards a co-produced approach to improvements had occurred since the serious incidents. They were working closely with stakeholders, the lived experience team, and care groups to embed these changes, focusing on compassion, safety and community engagement in care development and decision making. The ADPE noted that the work with lived experience groups had been crucial in shaping plans, and this approach could benefit all clinical boards by providing valuable insights into patient experiences. She suggested discussing this outside of the meeting. The CBD-MH informed the Committee that she had recently attended an open dialogue course which was eye-opening. By combining open dialogue, lived experience and family engagement into a unified project, it shifted the focus to empower patients and families to take charge of their treatment. The END highlighted the following: • The improvements in risk assessments, care planning and formulation, and therapeutic engagement, all required more staff and time. • They were mitigating in-hospital mental health staffing levels by using primary care and community funds. However, they needed to redirect these funds back to their intended areas. • A business case for £6m would be presented to the Value & Benefits Realisation Group (VBRG) to address this. • Despite financial challenges, they were committed to improving staffing levels and will regularly bring updates back to the Quality Committee on their progress. The CC suggested that a progress update on the improvement plan to come back to the Committee in August's meeting. **The Committee resolved that:** 1) The contents of the report was noted.	
QC 25/05/011	**Shaping Our Future Quality Excellence Framework** The END introduced the item and noted that as part of the strategic framework, they had focused on eradicating avoidable harm and brilliant basics. They faced big challenges including patient waiting times and Infection Prevention & Control (IP&C). The Quality Excellence Framework Programme Board had several projects aligned with these challenges. The Senior Programme Manager Quality Excellence and Learning (SPMQEL) presented slides to the Committee and highlighted the following:	

	• The SOFQE Programme aimed to improve key quality areas, shifting from variable to consistent and repeatable care and outcomes. It focused on eradicating avoidable harm across various domains, not limited to patient harm. • They had a monthly Programme Board led by the END who was the Senior Responsible Officer (SRO), who managed, coordinated and prioritised projects. • There were four current operational projects which included the Quality Management System Project, the Hospital Acquired Infections Project, the Lost To Follow-up Project, and the Acute Deterioration Project. Additionally, they were incorporating a medicine safety project. The Programme Board agreed that morning to incorporate a Medicine Safety Project into this work. • Three of these projects aligned with the NHS Exec Safe Care partnership work, using local and national guidance. The Executive Director of Public Health (EDPH) asked whether any projects addressed equity and data collection for protected characteristics. The SPMQEL responded that currently there was not anything specific, but each project had a significant data and digital element. She suggested discussing this with the END at the following Programme Board. The EMD agreed that all the projects needed to consider these issues, and equity needed to be applied as a lens to all projects. The END agreed with the EDPH's request to include equity was integrated into all their work. The END thanked the team for their significant efforts in driving the programme forward. This framework would support quality, innovation and transformation within the organisation, and addressed key themes like deteriorating patient, medicines management and patient lost to follow-up issues. They would continue to report on progress. The ADPE noted the following: • They lacked sufficient data on equity, and whilst they collected equity data through Civica during redress cases, complaints or claims, it was often incomplete. • They needed to capture this data for everyone in the system. • They should view this as a programme-wide lens, as evidence showed that people with particular characteristics were adversely affected. The CC thanked the team for their excellent work. **The Committee resolved that:** 1) The Shaping Our Future Quality Excellence Framework was noted.	
QC 25/05/012	**Discharge Advice Letters** The AMDPSCE presented the report with the Committee and highlighted the following: • There was a lot of variances in the quality and completeness of Discharge Advice Letters (DALs) issued across the organisation, which was crucial for patient care continuity. • DALs should include diagnosis, care and treatment details, medication changes, investigations, critical information for patients and GPs, and necessary follow-ups. • DALs were managed through the Welsh Clinical Portal (WCP), owned by Digital Healthcare Wales (DHCW), which led to data ownership issues.	

	• The Electronic Prescribing and Medicines Administration (EPMA) would hold DALs in the future, which allowed data ownership and quality reporting. • Efforts were being made to raise awareness through Clinical Boards and QSE Committees. • The Surgical and Medical Clinical Board's ward standards required DALs to be completed, printed and given to patients before discharge. • Education for resident doctors focused on creating focused and relevant DALs. • Ongoing work to improve DALs processes, create dashboards, and Standard Operating Procedures (SOPs). The EDPH suggested that Public Health Wales (PHW) had a behavioural support team that specialised in writing letters to prompt action, which may be helpful for improving DALs. The CC suggested that updates on the progress of this work come back to the Committee at a future date. **The Committee resolved that:** 1) The contents of the report was noted.	
QC 25/05/013	**Board Assurance Framework (BAF)** The DCG presented the Board Assurance Framework (BAF) and highlighted the following: • The BAF outlined the strategic risks that could prevent the UHB from achieving their organisational strategy. • There were four strategic objectives and six strategic risk themes, divided into two categories: service delivery (quality and health equity), and enabling risks (people, digital, infrastructure, and sustainability). • Each Committee should consider how to incorporate the relevant strategic risks into their agendas. For this Committee, the focus was on the quality and health equity strategic risks. The DCG asked the Committee how best to use the BAF to address these strategic objectives and seek assurance on their risks. The EDPH highlighted the need for equity to be at the forefront of people's minds, rather than bringing specific items. The EMD emphasised the need to ensure all actions within the BAF were aligned with what was discussed during these Committee meetings. The CVC suggested a retrospective review the past 12 months of Committee contents to identify which elements were related to the BAF. The DCG noted the focus should instead be on the Forward Plan and meetings between the Chair and Lead Executives. He suggested an annual discussion on the BAF at the Committee to serve as a sense check. The Chief Operating Officer (COO) noted that not enough attention was paid to the BAF and the Corporate Risk Register. The DCG responded that the BAF was a standing item on the UHB Board agenda, but it was requested for the BAF to be reviewed by the Committees.	

	The DCG noted that the corporate risk register also went to Board, but the key was to integrate this into their Strategic Leadership Team (SLT) meetings. Incorporating all of the risks into a single point of truth on AMaT was crucial. The END noted that SOFQE was the main driver and framework for quality, and they needed to ensure the BAF aligned. The END praised the BAF for being very readable and easy to navigate. He agreed that they needed to socialise this within the organisation, as it was the main document clarifying their strategic and corporate risks. It was suggested that the CC, the DCG, and the Corporate Governance Officer (CGO) meet to discuss the Forward Plan and how it aligned to the BAF. **The Committee resolved that:** 1) The BAF was discussed and noted.	
	Items for Approval / Ratification	
QC 25/05/014	**Policies** UHB 529 - Policy for the Management of Suspected and Proven Neutropenic Sepsis in Adults The Acute Oncology Clinical Nurse Specialist – Medicine (AOCNS-M) presented the policy for approval to the Committee. The EDPH asked whether the introduction of a policy would change how people were treated upon arrival. The AOCNS-M responded with the following: • The recommendation stemmed from various reports which suggested all UHBs should have a policy. • When the Oncology service was developed, collaboration issues between oncology and haematology, due to neutropenic haematology patients, delayed the policy's progress. • Regarding clinical management, the team had been audited against NICE guidance when patients come through the front door. The recommendation to have a policy had driven continued work, and health pathways had also contributed. The END noted that CAVUHB not having a neutropenic policy had been a huge clinical concern. Whilst many patients were managed at Velindre, their limited beds meant Cardiff-based patients often defaulted to UHW. **The Committee resolved that:** 1) The policy was approved.	
QC 25/05/015	**Suicide and Self-Harm Prevention Strategy** The EDPH explained that this was the second Suicide and Self-Harm Strategic Plan for CAV, which built upon the first plan from 2020 to 2024. It was developed in partnership with a wide range of partners. The EDPH noted that higher rates of suicide were seen in more deprived areas, particularly amongst unemployed men aged 25 to 44.	

	The Consultant in Public Health Medicine (CPHM) highlighted the following: • This was a five-year plan with a one-year delivery plan • In 2023, there were 56 registered suicides. From 2020-2022, there were 822 admissions for self-harm. • An event in October 2024 developed a vision and eight objectives with stakeholders, including those with lived experience and those bereaved by suicide. • The draft strategic plan went to consultation from February to April 2025 and received 20 responses and offers for help. • The National Suicide Prevention and Self Harm Strategy was launched on April 1st, 2025. • The strategic plan aligned with the national strategy and included the outline vision and eight priority areas. The EDPH clarified that this strategy had previously gone to Senior Leadership Board (SLB) for discussion and consultation. The CVC noted that there was no direct reference to the prison population within the plan. Given the challenging environment and higher instances of suicide in prisons, she asked whether it was covered elsewhere within the strategy. The EDPH responded that they had recently undertaken a health needs assessment for the prison population. The CPHM confirmed that the Prison Governor was spoken to and included within the consultation phase. There was not any specific feedback from them. However, many elements like training, development, and creating safe spaces covered the prison population. The CVC suggested that if there was any learning or nuance around the prison population, whether it could feed into the strategy after the one-year delivery plan. The CPHM confirmed that they would create two-year implementation plans up to the end of 2030. They would ensure there was prison representation at the workshop planned for Q4. The Senior Service Improvement Programme Manager (SSIPM) asked how they would measure the success of the strategy. The CPHM responded that most of the outcome measures were listed at the end of the implementation plan document, and that there were both qualitative and quantitative measures for each of the 8 strategic objectives with specific measures for each. **The Committee resolved that:** 1) The Cardiff and Vale of Glamorgan Suicide Prevention and Self-Harm Strategic Plan 2025-2030 and the first-year delivery plan 2025-26 was approved.	
	Items for Noting & Information	
QC 25/05/016	**Minutes from Clinical Board QSE Sub-Committees, the Safeguarding Steering Group (SSG), and the Infection Prevention and Control Group (IPCG)** **The Committee resolved that:** 1) The minutes were noted.	
QC	**Primary Care Eye Health Needs Assessment**	

25/05/017	**The Committee resolved that:** 1) The update was noted.	
	Items to bring to the attention of the Committee	
QC 25/05/018	*No items.*	
	Agenda for Private QSE Meeting	
QC 25/05/019	*i) Minutes and Action Logs from the Private QSE Committee on 01.04.2025* *ii) Any Urgent / Emerging Themes – Verbal Update*	
	Any Other Business	
QC 25/05/020	*No items.*	
	Date & Time of Next Meeting:	
QC 25/05/021	24th June 2025 at 2pm via MS Teams	

Action Log

Public Quality Committee

Update for meeting 24th June 2025
(Following the meeting held on 13th May 2025)

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
Actions					
QC 25/05/010	**Invited Service Review (IRS) of Cardiff and Vale University Health Board (UHB) Mental Health Services**	For progress made against the improvement plan to return to the Quality Committee in August 2025.	**05/08/2025**	Rim Al-Samsam / Tara Robinson	**COMPLETED** *Added to the Forward Plan for August's Quality Committee.*
QC 25/05/012	**Discharge Advice Letters (DALs)**	For an update on the progress of the work to come back to the Committee at a future date.	**16/09/2025**	Aled Roberts	**COMPLETED** *Added to the Forward Plan for September's Quality Committee.*
QC 25/05/013	**Board Assurance Framework (BAF)**	To conduct a review of the Quality Committee's forward plan to ensure alignment with the strategic objectives and the Board Assurance Framework.	**24/06/2025**	Ceri Phillips / Matt Phillips / Rachel Chilcott	**COMPLETED** *Meeting scheduled for the 27th May 2025.*
Actions referred to Board / Committees					
Actions referred FROM Board / Committees					

Report Title:	Nationally Reportable Incidents			Agenda Item no.	2.1	
Meeting:	Quality Committee	Public Meeting	x	Meeting Date:	24.06.2025	
		Private Meeting				
Status:	Assurance	x	Approval		Information	
Lead Executive	Executive Medical Director Executive Nurse Director					
Report Author:	Assistant Director of Quality and Patient Safety					

Background and current situation:

One hundred and fifty-three patient safety incidents occurred in 2024 that met the criteria for national reporting. Nationally Reportable Incidents are a subcategory of patient safety incidents that require reporting to the NHS Wales Performance and Improvement as they are assessed as causing serious harm or above at the point of reporting. In addition, there are a number of patient safety incidents that require reporting regardless of the level of harm attributed to the patient. These include:

- Never events
- Suspected mental health homicides;
- Suspected suicide or self-inflicted death in any clinical setting; or during authorised or agreed leave, following recent planned discharge, or following unplanned leave/discharge; and
- Maternal, perinatal and infant deaths.

Nationally Reportable Incidents (NRI) are categorised at the point of reporting. The following table demonstrates the categories of NRIs that occurred during 2024. Neonatal NRIs remain the highest reported category accounting for 28% of NRIs and a further 6% categorised under unexpected death / neonatal deaths. In 2023 reporting requirements for perinatal deaths changed resulting in a significant increase in the number of NRIs reported by the organsiation. Avoidable pressure damage accounted for 16% of all NRIs occurring in 2024 and was the second highest category.

CVU UHB top 10 NRI categories occurring by volume (incident dates...

NRI category	Total
Neonate	38
Pressure ulcer developed or worsened during care in this clinical care area/caseload	22
Unexpected death	22
Treatment or procedure issues	16
Clinical assessment, clinical diagnosis	14
Access to services or admission delayed	5
Diagnostic testing - Radiology	5
Diagnostic testing - Pathology	4
Communication issues	3
Patient injury	3
Slip, trip or fall	3

MBRRACE
Forty-one incidents that met the criteria for undertaking a national perinatal mortality review tool as determined by the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE), were reported as NRIs in 2024. The criteria for reporting include all late fetal losses from 22 weeks gestation, still births from 24 weeks gestation and neonatal deaths for babies born from 20 week gestation who die within 28 days and maternal deaths within one year of childbirth.

The greatest proportion of the MBRRACE NRIs were still births (intra uterine deaths occurring 24 weeks gestation onward). Use of the Perinatal Mortality Review Tool (PMRT) ensures a standardised approach to perinatal mortality reviews across the NHS. It requires that all aspects of care provision are robustly reviewed and informs a comprehensive report published once a year. The UHB holds a monthly Perinatal Mortality Review Forum (PMRF) with a dedicated multidisciplinary team, where all stillbirths are reviewed and the PMRT is completed. All neonatal deaths are reviewed via the Cardiff and Vale neonatal mortality review forum, and at the All-Wales neonatal mortality forum, where the final grading for each case is assigned.

A paper reported to the committee in November 2024 demonstrated that the majority of MBRRACE cases identified that there had been no clinical concerns identified in the maternal and neonatal care or where there was learning identified as part of the perinatal review process, it would not have changed the clinical outcome. In response to the MBRRACE reportable NRIs, improvement work has included a quality improvement project to improve thermoregulation at for the newborn with ongoing monitoring of compliance of the developed standards; the development of guidance to standardise the observation of women administered opiods during induction of labour and the implementation of electronic plotting of symphysis fundal height along with the review of referral pathway for growth scans.

Never Events
Never Events are adverse medical events that are serious and largely preventable; they include wrong site surgery, wrong implant or prothesis, retained foreign objects and administration of medication by the wrong route.

<u>Wrong site procedure</u>
During 2024 there were five cases of wrong site procedures. Four of the incidents were associated with local anaesthetic procedures.

In response to the incidents, a procedure has been developed to standardise the administration of Fascia Iliac Block (FIB) a local anaesthetic nerve block procedure undertaken to reduce pain in patients who have suffered a hip fracture. While training had previously been available, there was not an explicit requirement for resident doctors to be trained prior to undertaking the procedure. The local policy standardises the process across the entire UHB and the requirement for simulation training and a competency assessment prior to undertaking the procedure. The training will be hosted and coordinated by the medical education depstment several times each year to ensure accessibility and sustainability.

The WHO checklist is an international set of surgical safety checks aimed at decreasing errors and adverse incidents and increasing teamwork and communication in surgery. A WHO checklist collaborative has been formed comprising surgeons, anesthetists, scrub practitioners and clinicians from other areas undertaking invasive procedures, including dental hospital and cardiology. The group is reviewing the implementation of the WHO checklist including agreeing to a set of mandated principles that will support the effective deployment of the WHO checklist and specifies roles and responsibilities.

<u>Wrong Prothesis</u>

Two Never Events related to the implantation of wrong size prothesis were reported in 2024. While implantable devices can, in some cases be identified and made available prior to the commencement of surgery, this is not always possible and as a result implant verification should occur at the appropriate point in a surgical procedure. Patient safety learning reviews identified that strengthened implant verification was required as well as improved stock management.

Scan for Safety is a national initiative that uses digital barcodes to identify individual products and also individual patents. Where possible devices should be specified prior to the surgical list and scan for safety will allow pre-operative checks to take place against the pre-determined prothesis list. Scan for safety is currently being implemented in main theatres and will support improved stock management and pre operative prosthetic checks. The work undertaken by the WHO collaborative will review the specific questions set out as part of the check process to ensure that checks of device type, laterality, size, expiry date, sterility and compatibility are checked at the correct point in a procedure with real time documentation.

Nasogastric (NG) Tube placement

The UHB nasogastric tube insertion policy clearly sets out the requirement for confirmation of correct placement of of the nasogastric tube following insertion and should be documented each time before introducing anything into the tube. Confirmation of placement should be undertaken by testing the pH of aspirate or undertaking a chest x-ray prior to introducing anything into the tube e.g. water, medications and feed. A patient safety learning review identified that value of introducing a further check after moving or rolling a patient. The NG tube policy will be updated and training amended to include this additional step. Furthermore, health professionals are required to be trained in order to be able to place an NG tube but not to administer medications, etc. via an NG tube. The UHB training programme will be reviewed to agree proportionate training for all staff involved in the care of patients with an NG tube and not restricted to just those who insert the device. The review of training will also include a review of the current education for resident doctors to confirm placement via chest X ray.

An NG tube documentation audit has been developed and is hosted on the UHB Tendable system. There is evidence of very good uptake of NG audits across neurosciences and critical care, the two areas that have reported patient safety incidents relating to NG tubes in recent years with further independent audit that is being undertaken by the dietetics team across both neurosciences and critical care. In addition, the critical care directorate developed a local NG safety procedure for use in the department with a video training resource to accompany the procedure.

Wrong route medication

Safeguards to prevent administration of medication via the wrong route have been implemented in recent years. These include the use of purple enteral syringes for the administration of medications via oral or nasogastric route and yellow syringes for the administration of medication via a neuraxial route. These specialist syringes are not compatible with equipment used to administer medications via other routes, preventing incorrect connection and administration.

Despite these safeguards, staff have been able to prepare and administer medications via the wrong route on two occasions. On both occasions medication was administered via the wrong route despite a two-person check when staff selected the incorrect equipment to prepare the medication. A project initiation document has developed to support the review of the two person check for the administration of controlled drugs and this work will now be progressed as part of the wider medication safety programme in the particular context of controlled medications. The project will include a review of current practice, health board process and education provision and a review of the existing evidence around the efficacy of two people checks.

Endoscopy

A number of Nationally Reportable Incidents were reported in 2024 that related to endoscopy services and gastroenterology. Delays in planned surveillance procedures for patients who were

already identified as being at risk was a theme across many of the Incidents. The timely delivery of surveillance endoscopy was impacted during the pandemic. A number of patients were diagnosed with malignant disease and the delays in their endoscopy had to be considered as a contributory factor.

During 2023 and 2024, a programme of work to review the gastroenterology clinical validation processes, to ring fence capacity to complete the surveillance backlog and to open additional endoscopy capacity was undertaken. The endoscopy improvement work has been successful in eradicating the historical surveillance backlog.

Further improvement work in endoscopy includes a review of the scheduling of endoscopy procedures under general anaesthetic, the development of a procedure to identify and provide patient centered care to patients with additional needs to ensure equity of provision and experience and a review of the application of the urgent suspected cancer flag.

Shaping Our Future
Quality
Excellence

Shaping our Future Quality Excellence Programme (SoFQE) has been implemented to drive a health board wide programmes of improvement priority areas that have emerged as a result of patient safety incidents. Projects that sit under the SoFQE programme board include the care of the deteriorating patient, lost to follow up, infection prevention and control and medication safety. The projects deliver health board wide improvements programmes each led by a Senior Responsible Officer.

Lost to Follow UP
Variation in procedures to refer, validate and process referrals into secondary and tertiary care and the management and scheduling of subsequent clinical appointments and interventions has been associated with a number of patient safety incidents where patients have been subject to delays or omissions in their clinical pathways. Thematic review of associated patient safety incidents identified risks associated with referrals into the Health Board, internal referrals, and the management of outpatient pathways.

The SoFQE programme implemented a Lost to Follow Up project board to address the risks associated with continuity of patient pathways. The programme is divided into three stages, with the first ensuring that every clinic attendance has a defined clinic outcome and a specified next stage to the clinical pathway. The use of patient initiated follow up and see on symptoms will be broadened to empower patients to be able to initiate their clinical reviews attendances as they required as part of stage one.

The second stage of the project will implement a single electronic referral into the Health Board and then there will be a review of internal referral processes.

In response to several incidents relating to delays in clinical pathways for patient with suspected cancer the Health Board Cancer Services has implemented a process to track all patients referred with suspected cancer from the the point of their referral to the commencement of treatment. Furthermore, this work also encompasses the tracking of all radiological and pathology results that identify possible malignancy. These results have a digital flag applied by the radiology and

pathology departments at the point that the results are published and Cancer Services then track progress on the clinical pathway ensuring expected and incidental findings are managed in a timely fashion.

Care of the Deteriorating Patient
Patients in both inpatient care and unscheduled have regular observations undertaken and when these demonstrate a clinical deteriorate, there is a stratified approach to escalating concerns about their clinical condition, which includes review by the Patient @ Risk Team (P@RT). Several incidents were reported in 2024 where clinical deterioration was not recognised in a timely manner or was not escalated appropriately.

The implementation of National Early Warning Score (NEWS) 2, a revised escalation protocol, will be implemented across the organisation in July 2025. The rollout of this guidance will be accompanied by a programme of online and face-to-face training for all clinical staff. The implementation date will align with the induction of the foundation and specialist resident doctors. An audit of compliance will be undertaken six months following implementation. Early Warning scores in maternity and paediatric services will then be implemented by September 2025.

The development of a UHB critical time clinical results protocol is being undertaken to standardise the clinical response and escalation from laboratory medicine of results that have time critical implications. Previously protocols were in place for haematology, biochemistry and microbiology and varied according to whether the patient was an inpatient or in the community. The development of the protocol will standardise the approach across all areas and ensure a back stop when clinical teams are not immediately available.

Infection Prevention and Control
The UHB saw an increase in the number of Clostridium difficile (C diff) and Methicillin Sensitive Staphylococcus aureus (MSSA) cases in the year 2024/25 above the previous year. The SoFQE has implemented a programme board that will focus on the development of an infection control dashboard that supports improved understanding of the factors that are contributing to the observed increase in infections.

A communication campaign has been launched to reinforce a set of core principles that support an evidence-based approach to minimising infection control risk. These principles include hand hygiene, uniform standards, and the effective delivery of aseptic non-touch techniques. Executive scrutiny review of all C diff and MSSA cases is undertaken to ensure senior leadership. Each of these reviews are supported by the muti-professional team including the infection prevention and control team, microbiology and epidemiology.

Medication Safety
An electronic Prescribing and Medications Administration (ePMA) system will be implemented across the UHB from June 2025 commencing in three pilot areas before wider implementation. EPMA allows for systems controls to be implemented including:

- Accessing patient records by scanning wristbands to prevent administration of medications to the wrong patient
- Systematic documentation of venous thromboembolism risk assessments prior to administration of anticoagulation.
- Recording of medication allergies
- Recognition of medication contraindications

The medication safety project board will focus on strengthen measures to ensure the safe effective and timely prescribing and administration of medications in particular, thromboprophylaxis, Insul Opiates and eradication of unintentional omitted medication doses.

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

This report provides an overview of 153 patient safety incidents in 2024 that met the criteria for National Reporting in NHS Wales. These include serious harm events and specific categories such as never events, suicides, maternal and neonatal deaths.

Key Highlights:

- **Perinatal Incidents**: Accounted for 36% of NRIs, with stillbirths being the most common. Reviews are conducted through the Perinatal Mortality Review Tool (PMRT) and forums.
- **Never Events**: Included wrong site procedures, wrong prosthesis, and medication errors. Actions taken include standardised training, WHO checklist implementation, and digital safety systems.
- **NG Tube Safety**: Policy updates and training enhancements were introduced following incidents involving incorrect placement.
- **Endoscopy Delays**: Backlogs from the pandemic led to delayed diagnosis. A successful programme has now cleared the backlog and introduced further improvements.
- **Shaping Our Future Quality Excellence (SoFQE)**: A strategic programme addressing systemic issues such as:
    - **Lost to Follow-Up**: Improving referral and appointment tracking.
    - **Deteriorating Patient Care**: Implementing NEWS2 and escalation protocols.
    - **Infection Control**: Addressing rises in C. diff and MSSA with dashboards and campaigns.
    - **Medication Safety**: Rolling out electronic prescribing (ePMA) to improve safe effective and timely prescribing

Appendices *(Please list any appendices that will accompany this report)*

n/a

Recommendation:

The Committee is requested to: **NOTE**

a) The emerging themes from the Nationally Reportable Incidents
b) The assurance provided by the improvement work associated with these themes

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

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

Five Ways of Working (Sustainable Development Principles) considered:

Prevention		Long term		Integration		Collaboration		Involvement	

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

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

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

Report Title:	Prevention of future deaths update - Ref: 1051 and Ref: 1553			Agenda Item no.	2.2
Meeting:	Public Quality Committee	Public	★	Meeting Date:	24 June 2025
		Private			
Status *(please tick one only):*	Assurance	★	Approval	Information	
Lead Executive:	Executive Nurse Director				
Report Author (Title):	Assitant Director of Patient Experience				

Main Report

Background and current situation:

Prevention of Future Deaths (PFD) report is a formal decision issued by a coroner when they believe that action should be taken to prevent future deaths

Purpose of a PFD

- **Identify Risks**: The primary goal is to highlight risks or issues identified during an inquest that could lead to future deaths if not addressed.
- **Recommend Actions**: The report suggests actions to mitigate these risks, directed at relevant organisations, authorities, or individuals.

Legal Basis

- **Coroners and Justice Act 2009**: Under Paragraph 7 of Schedule 5, this act mandates coroners to issue PFD reports when they identify a risk of future deaths.
- **Regulations 28 and 29**: These regulations outline the procedures for issuing and responding to PFD reports.

Process

Inquest Findings: During an inquest, if the coroner identifies factors that could lead to future deaths, they decide to issue a PFD report.
Response Requirement: The recipients must respond within 56 days, detailing the actions they will take or explaining why no action is necessary.

Publication

- **Transparency**: PFD reports and responses are typically published on the Chief Coroner's website to ensure transparency and public awareness

These reports can lead to significant changes in policies, procedures, and practices to enhance public safety.

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

The Committee has previously been informed of two Prevention of Future Deaths (PFD) reports. This paper aims to provide an update on the actions taken in response to the PFD'S

First PFD Report: Silencing Alarms at Central Monitors

This report addressed the issue of silencing alarms at a central monitor without visually checking the patient. Although we have responded to the PFD, it was recognised that this issue has broader implications across the health board. Consequently, we have evaluated the functionality of telemetry with central monitors throughout the University Health Board (UHB).

This evaluation was also shared across Wales, as it pertains to all health boards. The progress of this work is being monitored through the Directors of Nursing Meetings.

Actions Taken:

- **Standard Configuration**: All areas with central telemetry are to be configured uniformly. Critical alarms cannot be silenced without a visual observation of the patient.
- **System Amendments**: Following several meetings with our Clinical Engineering Department and the monitor manufacturer, Philips, further amendments have been made to the system to mitigate the risk of this type of incident recurring. These actions include:
- **Alarm Reminder Settings**: Two alarm reminder (re-alarm) settings are available for "All inoperable alarms" and "Yellow + red alarms." Once set, a silenced alarm will reactivate after 2 minutes if the alarm condition is not resolved. Yellow + red alarms already have the re-alarm setting enabled in CVUHB. Our immediate action after the incident was to classify ECG leads off/lead set unplugged alarms as yellow alarms. This ensures staff can prioritise confirmed red alarm conditions, such as cardiac arrest alarms. Staff are reminded to address a lead-off scenario if the alarm is acknowledged but the issue persists.
- **Telemetry Unit Configuration**: The alarm configuration for telemetry units is managed by the central station. Changes were completed within the Cardiothoracic areas on November 22, 2024, by Philips and the CVUHB Clinical Engineering team.
- **Monitor Configuration Adjustments**: The next stage involves adjusting the monitor configurations to match the central station and telemetry configuration. Clinical Engineering will visit clinical areas to install these configurations on the monitors. This will be done in phases to maintain patient safety. All clinical wards in the Cardiothoracic Directorate were completed by December 2024.
- **Assessment and Evaluation**: After resolving the immediate Regulation 28 actions, we assessed and evaluated the configurations across all patient monitoring in CVUHB. This provided a more robust understanding of the current configurations. The changes implemented in the Cardiothoracic areas (yellow priority for leads off/unplugged and re-alarm for the same) are applicable across the Health Board.
- **Progress and Future Plans:**
- **Replacement of Central Monitors**: Six new central monitors have been appropriately configured. In UHW, all cardiac areas, T4, and Children's areas have been reconfigured. In UHL, the ECU (Enhanced Care Unit) was completed, and the plan is to complete all areas in a phased approach by the end of March 2026.
- This work remains ongoing but has been clinically prioritised and is progressing well.

The second PFD was issued in relation to a sad death in St David's Hospital

Evidence was taken from nurses at St David's that there remains a lack of confidence in both qualified nursing staff, healthcare assistants and healthcare support workers in the use of and implication of risk assessments around falls, and the use of and importance of enhanced supervision and the Enhanced Supervision Document. The coroner expressed concern that unless more training is provided and refreshed frequently, there is a risk of future deaths occurring, particularly given the cohort being nursed at that hospital and the turnover of staff.

This PFD also has implications across the UHB and responded with the organisational actions being taken. The Health Board has undertaken significant work to mitigate the risk of future deaths occurring under similar circumstances.

Key Issues and Actions

Falls Prevention and Management

- **Training Expansion**: Training sessions were conducted at St David's Hospital, with 59% of qualified nurses completing the training. The target is to achieve 85% compliance by year-end.
- **Multifactorial Risk Assessments (MFRAs)**: Improved completion and quality of MFRAs, with a 25% improvement observed post-training.
- **Prompt Response to Falls**: Introduction of action cards and a new process enabling ward staff to contact the Emergency Unit Consultant or Senior Registrar for support after a patient falls.
- **Digital MFRA**: Implementation of a digital version of the MFRA within the Welsh Nursing Care Record (WNCR) to enhance data collection and focus on fall risk reduction actions.

Bedrails

- **Ultra-Low Beds**: Deployment of ultra-low beds with integral rails across all general inpatient areas.
- **Bedrail Risk Assessments**: Mandatory part of nursing inpatient risk assessments, with a multidisciplinary task and finish group established to audit and update bedrail procedures.

Enhanced Supervision

- **Education Programmes**: Pilots of education programmes delivered to over ninety staff, with resources included in the newly registered nurse preceptorship programme.
- **Policy Development**: A task and finish group is updating the enhanced supervision framework and developing a new policy for robust governance.

Ongoing Work and Monitoring

- **Falls Training**: Continues to be rolled out across the University Health Board (UHB), with positive impacts observed.
- **Bedrails Procedure**: Improvement work and audits are ongoing, with representation at the WNCR All-Wales bedrails risk assessment task and finish group.
- **Enhanced Supervision**: A steering group chaired by the Deputy Executive Nurse Director is overseeing the work.

The Health Board has made considerable progress in addressing the concerns raised in the PFD report on an organisational basis, with ongoing efforts to improve falls prevention, bedrail safety, and enhanced supervision. The work remains a priority and is being closely monitored to ensure continued improvement and patient safety.

Recommendation:

The Committee is requested to:

A) acknowledge the assurance provided by the report.

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

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn.	

3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation, and improvement and provide an environment where innovation thrives	

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

Impact Assessment: *Please state yes or no for each category. If yes, please provide further details.*
Risk: Yes
The review of compliance with recommendations will be undertaken
Safety: Yes
The Ombudsman provides an independent scrutiny of cases
Financial: Yes
The ombudsman can offer financial redress to people raising concerns
Workforce: n/a
Legal: n/a
Reputational: Yes
There is significant reputational risk from public interest reports
Socio Economic: n/a
Equality and Health: n/a
Decarbonisation: n/a

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

Chilcott Rachel
20/06/2025 09:20:36

Healthcare Associated Infection Improvement Goals 2024/25 update

Jason Roberts – Executive Nurse Director

Yvonne Hyde – Head of Nursing IP&C

- Welsh Health Circular (2024)038 *AMR & HCAI IMPROVEMENT GOALS FOR 2024-2025* was received by the Health Board in late September 2024.
- The Welsh Health Circular sets out the improvement goals for 2024/25 reflecting on the data from the previous year and the new targets set out in the new AMR national action plan.

Healthcare Associated Infection Improvement Goals set for CAV UHB 2024/25

- *C'diff* toxin positive – <65 Hospital onset cases & <48 Community onset cases
- SAUR – <55 Hospital onset cases
- *Ecoli* – Fewer cases than in 2023/24 i.e. <345 cases
- PAER – 10% less Hospital onset cases, i.e. <7 cases
- *Kleb. Sp*. – Fewer cases than 2023/24, i.e. <120

CAV 1st April 2024 to 31st March 2025
Total number of cases

Health board	C. difficile	S. aureus bacteraemia	E. coli bacteraemia	Klebsiella spp bacteraemia	P. aeruginosa bacteraemia
AB	225	142	285	94	32
BCU	274	134	401	104	19
CAV	210 (112)	183 (69)	286 (83)	120 (47)	41 (27)
CT	131	100	266	86	11
HD	150	98	272	80	20
SB	205	97	170	90	13

All Wales position 1st April 2024 to 31st March 2025

Health board	Rate per 100,000 population				
	C. difficile	S. aureus bacteraemia	E. coli bacteraemia	Klebsiella spp bacteraemia	P. aeruginosa bacteraemia
AB	46.19	31.74	63.15	19.31	7.05
BCU	51.30	26.01	77.75	19.65	3.61
CAV	40.52 (2nd)	35.31 (6th)	55.18 (1st)	23.15 (4th)	7.91 (6th)
CT	35.39	29.34	81.52	23.07	3.14
HD	47.41	34.27	97.90	27.05	6.18
SB	70.58	33.62	57.49	31.05	4.62

C. difficile


Additional filters for Chart 1.
Select HB
Cardiff and Vale UHB
Select organism
C. difficile
2023/24
2024/25
Cumulative
Apr
May
Jun
Jul
Aug
Sept
Oct
Nov
Dec
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Mar
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20/06/2025 09:20:36

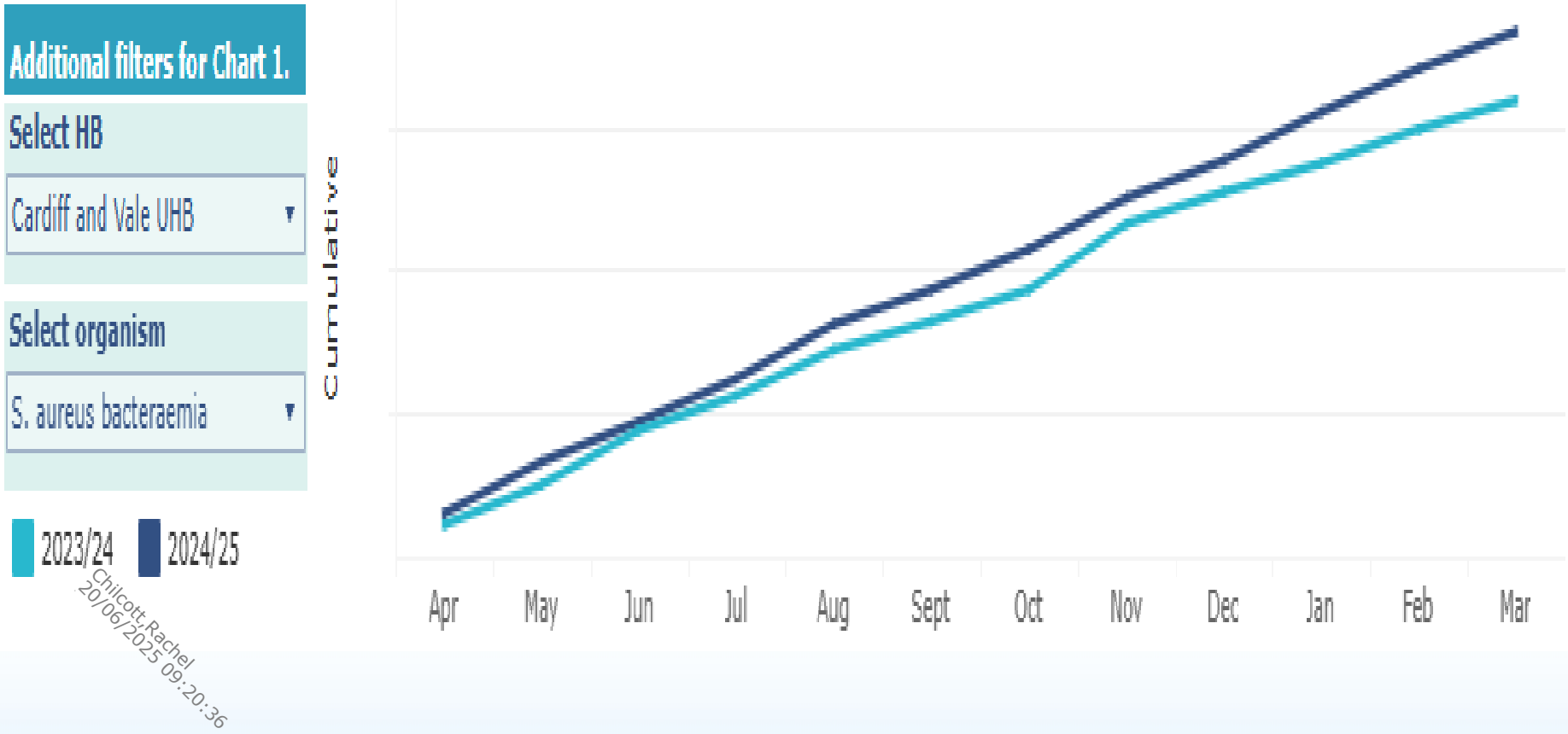
C. difficile year end position 24/25

- 2nd in Wales 2024/25
- The number of Hospital onset cases for the target period is 64% more than the 2023/24 period (88% total increase)
- Similar picture across the UK
- Welsh Government confirm most cases are not linked
- 53% of cases were Hospital onset (highest transmission in Wales)
- Small isolated clusters and 1 outbreak.
- 35/164 cases have had recurrent infection
- Treatments available in CAV are: Vancomycin, Fidaxomicin, Faecal Microbiota Transplantation

C’diff, so what are we doing?

- Patient’s progress is reviewed 2- 3 times a week by an IPCN and/or Microbiology registrar
- Focused on national cleaning standards
- Education programme agreed and accessibility being implemented
- Executive oversight of root cause analysis of cases
- Share the Start Smart Stay Focused audit data with Clinical Boards, electronic prescribing is being implemented across CAVUHB in 25/26
- Focus on timely cleaning of bed spaces between discharge and admission of patients
- Analysing the data to inform next steps
- Treat the patients with *C’diff* toxin negative the same as toxin positive and include in clusters when linked by WGS
- Analyse recurrence data incl. treatment and isolation etc to identify areas for improvement

SAUR


Additional filters for Chart 1.
Select HB
Cardiff and Vale UHB
Select organism
S. aureus bacteraemia
2023/24
2024/25
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Cumulative
Apr
May
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S. aureus year end position 24/25

- MSSA/MRSA combined reduction expectation
- 4th highest rate of MRSA in Wales per 100,000 population (the lowest up to Jan ‘25)
- Highest rate of MSSA in Wales per 100,000 population. Data is presented per 100,000 population by Welsh Government
- 69 of 183 cases are Hospital onset, an increase of 15%
- 38% of hospital onset cases are line related i.e. intravascular devices inserted in patients to deliver treatment
- No themes identified across clinical boards

SAUR, so what are we doing?

- Review each case with microbiology
- Ensure patients are decolonised as per guidance
- Screening on admission audited for compliance
- Executive oversight of root causes of cases to understand risk factors and areas for improvement
- Line access group – standardisation of practice/products/education
- There is a focus on ANTT moving forward
- The development of a community IPCN - to review CO cases, working in collaboration with community teams to provide education and training
- In collaboration with product suppliers and clinical colleagues to provide optimal preparation pre line insertion

The Welsh Health Circular outlining the required reductions for 2025/26 has not yet been received by the Health Boards

Below is the position to date – April to end of May 2025

C'diff	MRSA	MSSA	E.COLI	Kleb sp.	PAER	SAUR
33	5	21	43	15	2	26
38.10 (2nd)	5.77 (6th)	24.25 (2nd)	49.65 (1st)	17.32 (1st)	2.31 (1st)	30.02 (4th)


GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board
Brilliant Basics
for Quality Excellence
Chillcott Rachel
20/06/2025 09:20:36

Report Title:	Clinical Effectiveness Committee Bi-annual Report				Agenda Item no.	2.4
Meeting:	Quality Safety and Experience Committee		Public	x	Meeting Date:	24.06.2025
			Private			
Status *(please tick one only):*	Assurance	x	Approval		Information	
Lead Executive:	Executive Medical Director, Executive Nurse Director					
Report Author (Title):	Head of Patient Safety and Quality Assurance					

Main Report

Background and current situation:

The Health Board Clinical Effectiveness Committee (CEC) was established in December 2019 and has strengthened since 2022 to ensure greater involvement from Clinical Boards, specialties and clinical audit leads. The National Clinical Audit and Outcome Review Programme is a mandated programme of 40 national clinical audits that support measurement of quality against defined evidence-based standards, national benchmarking and quality improvement. The Clinical Effectiveness Committee is held bi-monthly, and audits are grouped and presented in themes supporting involvement of the Clinicals Boards and affiliated services that are aligned to the audit Speciality being presented.

This paper will summarise the National Audits presented at CEC in January and March 2025

National Joint Registry (NJR)
The NJR collects data on primary joint replacements and revisions, providing insights into revision rates and implant performance. The registry helps in identifying high-performing implants and encourages their use. The audit showed that the revision rates for hip and knee replacements at Cardiff and Vale UHB are within national averages, with improvements noted over recent years. Specific issues such as higher-than-expected infection rates were addressed, with historical outbreaks being a contributing factor.

Discussion Points
Revision Rates: The revision rates for hip and knee replacements are within national averages, indicating overall good performance.
Infection Rates: Higher-than-expected infection rates were noted, particularly due to historical outbreaks. It was discussed that the theatres in CAVOC UHL are considered to be substandard for joint replacement surgery due to the fabric of the building.

Improvement Actions:
Infection Control: Implement stricter infection control measures and improve facilities to reduce surgical site infections.
Data Utilisation: Continue using NJR data to identify and use high-performing implants

While there has been some improvement in infection rates, infection remains a significant area of concern. As a surgical team, they have implemented a wide range of evidence-based measures within their control to optimise patient outcomes.

These include:

- Pre-operative optimisation of patients, including diabetic control, anaemia management, and weight reduction where appropriate
- Mandatory pre-operative showering using antimicrobial wash
- Enhanced perioperative antibiotic protocols
- Standardisation of skin preparation techniques

Strict theatre discipline and consultant-led operating.

An ongoing area of concern however is the theatre environment which is felt to be limiting further progress. Issues around ventilation, temperature control, flooring, and general wear and tear in key theatre spaces have been well-documented previously and noted by the British Orthopaedic Association (BOA) in 2021, during a visit to investigate a higher-than-expected infection rate in knee replacements.

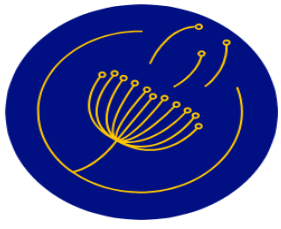
The surgical team have raised that investment is needed to improve physical infrastructure and in the ventilation systems in CAVOC as there is clear evidence linking air quality to infection risk in arthroplasty.

Work is ongoing with microbiology and infection prevention colleagues to mitigate risks. A bid was submitted to Welsh Government to apply for funding for improvement building works, Welsh Government undertook a prioritisation exercise of all capital cases across Wales, only three from C&V were prioritised and unfortunately this bid was not progressed as the priority for additional theatres is going to be at Llantrisant Health Park. Therefore, an alternative option is being explored to help address the current challenges faced, this is still in discussion.

National Audit Care at the End of Life (NACEL)
The National Audit of Care at the End of Life (NACEL) is a national comparative audit of the quality and outcomes of care experienced by the dying person and those important to them during the last admission leading to death in acute hospitals, community hospitals and mental health inpatient providers in England, Wales and Jersey. NHS Benchmarking Network has been commissioned by HQIP to provide NACEL since 2017.

The audit assesses the quality of end-of-life care in hospital settings. At the time of presenting the report, results from the last audit undertaken in 2024 were awaited. Key areas of focus include communication with patients and families, decision-making involvement, and individualised care plans. The UHB did not participate in the family and carer survey in 2024 as a result of information governance challenges. Cardiff and Vale UHB performed well in providing specialist palliative care and individualised care plans but identified areas for improvement in early communication and decision-making. Ongoing efforts include increasing education for healthcare professionals.

A new initiative is being rolled out across the Health Board this spring – **'Every Moment Matters**' is an initiative introduced to support patients receiving end of life care and their loved ones during a deeply personal and significant time. A symbol has been developed to discreetly identify to all staff from clinical to housekeeping, that a patient is receiving end-of-life care. The symbol is only displayed with the consent of the patient or their family and when their care follows the All Wales Care Decisions Guidance for Last Days of Life. By recognising the symbol, colleagues and visitors can help ensure a respectful and dignified experience for patients and their loved ones. This symbol initiative was piloted on B7 at UHW and W2 at UHL. It was rolled out across the Health Board during Spring 2025.



Only inpatient admission deaths are captured in the national audit, which limits the assurance that can be gained around care provision to patients admitted via unscheduled care who are awaiting a bed whist remaining in EU, this has been raised at a national level. A workstream, known as REACT, has been developed looking at increasing presence of EoL specialist staff within the Emergency Unit to improve care and outcomes for patients dying within the department. The objective is that these patients can be turned around quickly and get earlier access to palliative care in EU or have their return to their own home expedited if they wish to receive end of life care there rather than in hospital.

NACEL will also feature a spotlight audit of mental health inpatient providers. The mental health audit ran as part of the main audit in 2018, as a spotlight audit in 2021 and will run again as a spotlight audit in 2025. This spotlight audit is intended to build a national picture of care delivered to dying patients and those important to them, and support healthcare providers and policy makers identify areas for improvement. The audit is open to all Mental Health inpatient providers in England, Wales and Jersey. This is the first time C&V have undertaken this spotlight audit in Mental Health, the Mental Health Clinical Board are underway with completing this audit.

Although UHB results are largely in line with national results, the above chart shows that UHB areas for improvement include communication with the dying person, involvement of the patient and family in decision making and staff support. The data for this audit was collected in 2022 and presented in 2023, so the impact of Covid on staff training and development may have been a considering factor. It is expected that the new symbol initiative, as well a focus on staff education, will help address this.

Areas where C&V performed well were providing individualised care plans and having a dedicated specialist palliative workforce.

Learning Points:
Communication and Decision-Making: Early communication with patients and families and involvement in decision-making need improvement.

Individualised Care Plans: The use of individualised care plans is strong, but there is room for improvement in documenting and acting on patient wishes.

Recommendation	Action	Progress
Increase education in end of life care for healthcare professionals	Re establish Nursing and AHP study days EOLC teaching for Foundation Doctors EOLC teaching for IMT Doctors Mandatory EOLC training for all clinical staff?	102 hours 2023 55 hours 2024 SIM training Feb 2024, Feb 2025 and April 2025 HEIW appointed person to develop multiprofessional competency framework for PELOC, then develop possible mandatory training
Re establish role of TEP in Healthboard	Work with PART	Task and Finish group established. All Wales TEP developed including PIL, meeting to consider how to adopt in C&V
Continue use of All Wales CDG for Last days of life using updated version 2023	Disseminate version 12 to wards when available	In use
Continue use of All Wales DNACPR form and new competency framework for completion by registered healthcare professionals (sect 5)	Implement competency framework	Nursing leads aware. SOP for healthboard in development by palliative care and resus team

Improvement Actions:
Education and Training: Increase education for healthcare professionals on end-of-life care, focusing on communication and decision-making. HEIW have appointed to a role to develop a multi-professional competency framework which is role and experience specific. It is hoped that this will form part of mandatory training for online learning. Work is underway with Marie Curie to support volunteers sitting with and supporting individuals who do not have family able to be with them at the end of life.
Symbol Implementation: Roll out the symbol indicating end-of-life care across the health board to improve awareness and sensitivity.
Family and Carer Surveys: Implement family and carer surveys to gather feedback and improve care.

The Palliative Care Team are undertaking an audit of medical Examiner feedback to measure care against the Wales End of Life Quality Statement. The audit is being used to inform service provision including the appointment of a health care support worker who will support ward staff in the provision of dignified and person-centred end of life care.

National Emergency Laparotomy Audit (NELA) Year 9
The data presented extended from December 2021 to March 2023. There were 360 patients (100% case ascertainment and data completeness of 98.9%) included in in the local dataset. The adjusted mortality rate for the Health Board was 8.4% within the 95% interval (6-12.2%). Mortality rate has increased from 6.5% to 8.4% from the last audit but remains under the national average of 9%. Mortality reviews will be undertaken to understand the higher rate of mortality from the last report.

The audit evaluates the care of patients undergoing emergency laparotomy, focusing on timely interventions and outcomes including:

- Involvement of senior clinicians preoperatively and intraoperatively
- Timey transfer to theatre
- Post operative admission to critical care for higher risk patients
- Timely administration of antibiotics for those with signs of infection.

Results
The proportion of patients receiving antibiotics in the first hour - year 9 - 21.43 % compared to the national average of 18% national, and the proportion of patients meeting a three hour standard was 43.29% compared to a 36.26% national average.

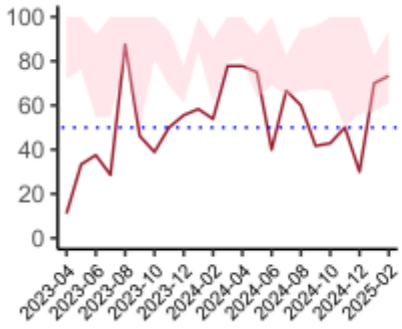
The proportion of patients receiving antibiotics in the first 3 hours - year 9 - 43.29% (36.26% national). The UHB performs above the national average for this standard. Efforts are ongoing to address these issues, including collaboration with the sepsis group and critical care teams.

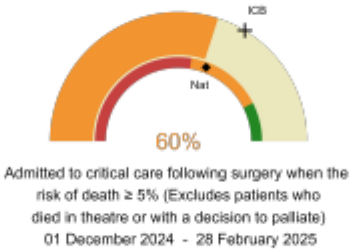
Time to Theatre
53.9% of patients arrived in theatre within the required time, below the national average of 67.1%. The reason for this was competition for the CPOD theatres, demand increased by the presence of the MTC service. Positively, the average time to theatre in a septic patient from decision to operate to arrival in theatre is a median of 1.775 hours, those who are more delayed are those who are booked as a lower urgency (Cat 2b patients).

CT Scanning
89% of patients had a CT scan before theatre, C&V perform well against this as most CTs are not outsourced as they are for other centers. 79% of these CTs were reported by a Consultant Radiologist prior to surgery, they were reported but by an SpR, the consultant then reviewed the SpR's report but this was often after the patient had had their surgery and so this did not count for the audit data. Nationally, 91% of patients had a CT scan before surgery, but because there's a lot of outsourcing, only 58% of them had a report by an in-house radiologist.

Pre-operative assessment
86% of patients who were deemed to have a 5% risk of death were assessed prior to surgery by a consultant surgeon and consultant anaesthetist and 83% of patients had a pre-operative risk assessment undertaken. 82% of patients had a consultant surgeon and consultant anaesthetist in theatre when their risk of death was 5% or higher.

Admission to critical Care
33.5% of patients whose risk of death was calculated as 5% or higher and 42.6% of patients whose risk of death was calculated as 10% were admitted to critical care post operatively during the audit period. 0.8% of patients during the audit period had an unplanned admission to the ward. The most recent hospital level report demonstrates that this position has improved and 60% of patients with a risk of over 5% were admitted to critical care in Quarter 3 of 2024/25.





Admitted to Critical Care (risk of death ≥ 5%)

National mean 61%
ICB mean 67%
Number of patients included 35
Data completeness 100%

Length of Stay
Post operative length of stay had increased from the last audit to this years audit from 14 to 17 days (median LOS is 11.5 days) national average is 16 days – the data was skewed by a couple of long stay patients.

Frailty assessment

96.1% of patients over 65 received a frailty assessment and 85.1% of those who were over 65 assessed as being frail and those over 85 were assessed by a geriatrician led multi-disciplinary team.

Area of Improvement

- Mortality reviews regarding higher rate of mortality in last report.
- Ongoing work with critical care – database for referrals, review and admission.
- Deep dive into the long stay patients to determine any preventable actions.
- **Emergency Laparotomy**: The committee discussed the need for improved sepsis management and the impact of critical care capacity on patient outcomes it was agreed that work would be undertaken in partnership with the sepsis group regarding timely antibiotic administration.

Sentinel Stroke National Audit Program

The Sentinel Stroke National Audit Plan (SSNAP) annual report was last published in November 2024, providing scrutiny of stroke care across the UK in 2023/24. SSNAP also produces

prospective organisational level reports on a quarterly basis. The audit highlighted that the hospital is scanning stroke patients promptly, however, there is room for improvement in achieving the highest standards. C&V are not scanning enough patients within the required timeframe, reasons

for this include competing priorities for CT scans within a busy Emergency Department, the same scanner is also being used for trauma patients.

The Health Board's performance around the timely admission of patients to the specialist stroke

unit has improved significantly as a result of ring fence protected beds, but there remains variability in performance. Organisations that perform well are those with regionalised stroke centres with pathways geared towards priority admission to protected beds.

There are continued challenges in delivering thrombolysis within the required timescales, with the hospital falling in the lower half of performance metrics. In comparison to dedicated stroke centres with dedicated thrombolysis space, patients attending EU with stroke symptoms are reliant on appropriate bed/trolley space for treatment which in a busy EU department can be a challenge within the required timeframe. The number of patients for whom thrombolysis is a treatment option has grown significantly as the thrombolysis window has been extended from 4.5 to 9 hours from

the onset of symptoms. The introduction of virtual stroke review is supporting the ability for senior clinical input and decision making.

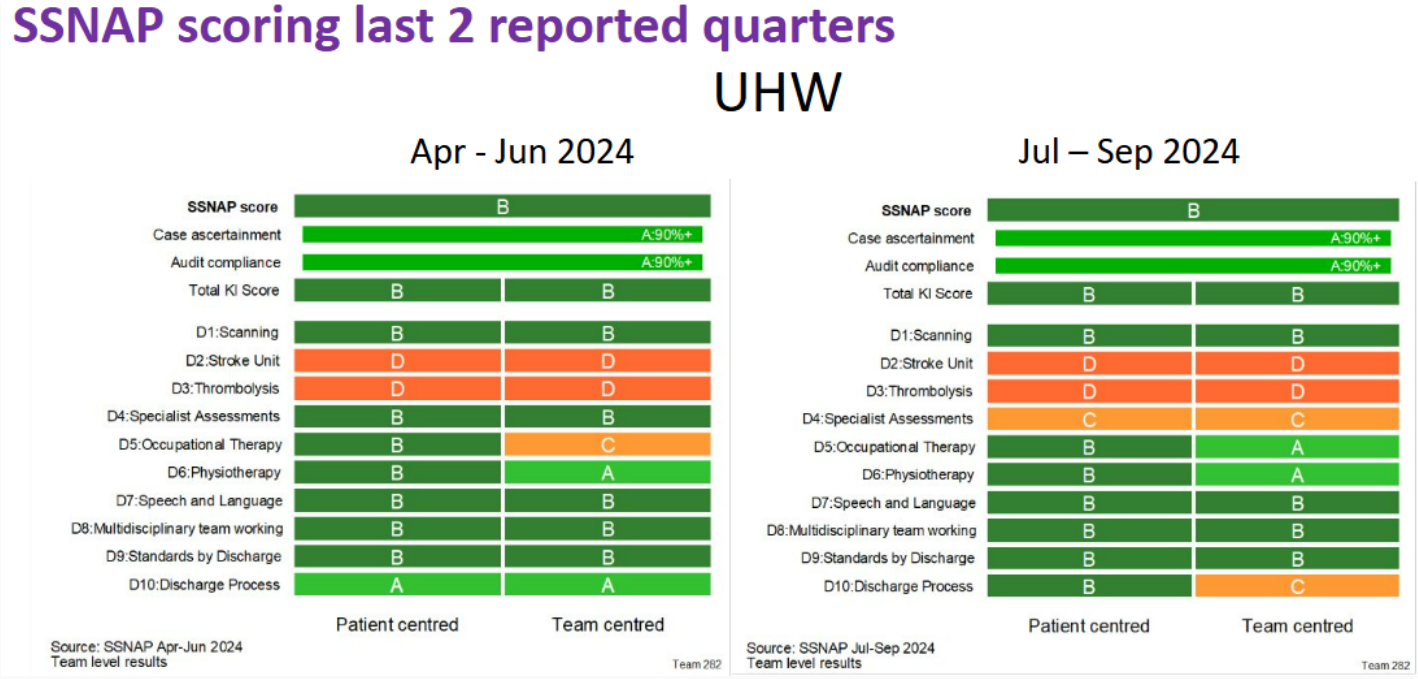
The Health Board is performing well around the provision of specialist assessments, but there is variability in the timing of these assessments. This includes senior access to a consultant, stroke specialist nurse and access to swallow assessment, for example. What is crucial to improving this

is how quickly patients can be admitted to the stroke unit, and if patients cannot get to a stroke bed as quickly as we would like, there needs to be a focus on getting the consultant to the patient more quickly.

Occupational therapy, physiotherapy, and speech and language therapy are generally performing well, with speech and language therapy scoring particularly high due to seven-day service provision.

New SSNAP Data Set:

- The new SSNAP data set focuses more on imaging, hyper-acute stroke management, and rehabilitation intensity.
- There is a new measure for senior clinical decision-maker assessment within one hour of arrival, which the hospital is currently achieving for about 7% of patients.
- Rehabilitation is now measured by the activity within therapy sessions, aiming for 3 hours of motor rehabilitation therapy daily.



Learning and Improvement Actions

Business Case Approval:

The Health Board has approved a business case to recruit additional consultant resources,

resident doctors, and clinical nurse specialists to improve stroke management at the front door and throughout the patient pathway. By having dedicated stroke staff (clinicians and CNSs), there will be better access to specialist clinical staff and not being reliant on the intaking clinical team. The aim is to have a 24/7 model which would see a resident stroke doctor on-call all day every day to improve early stroke management. This includes plans to enhance the TIA service to provide emergency assessment. The recruitment of additional staff and the establishment of a dedicated stroke team at the front door are expected to improve the speed and accuracy of stroke diagnosis and treatment. It is anticipated that will lead to improvements in thrombolysis resulting in improved overall outcome for stroke patients.

Thrombectomy Service:
A new thrombectomy service is set to commence in the summer of 2025, which will serve as the South Wales Centre for Thrombectomy. This will involve taking external referrals and will be measured by SSNAP. The new thrombectomy service will provide advanced treatment options for stroke patients, potentially reducing disability and improving survival rates as patients will no longer need to travel to another centre to have this treatment.

Alignment with Neurosciences:
Stroke services will align with neurosciences and move into the specialist services clinical board, which is expected to enhance coordination and resource allocation. Aligning stroke services with neurosciences will streamline processes and improve access to specialised care. The reorganisation will lead to more efficient use of resources and better patient outcomes.

Digital Opportunities:
There is a need to explore digital solutions to reduce the data collection burden on clinical auditors, potentially through integration with digital patient notes. Overall, the audit findings and subsequent actions indicate a strong commitment to improving stroke care, with significant potential benefits for patient outcomes and service efficiency.

National Maternity and Perinatal Audit (NMPA)

The National Maternity and perinatal audit was last published in 2022 reporting data from 2018/19 from across England, Wales and Scotland. The report presented information about the care and outcomes from 89% of eligible births. The outcomes of the reports had been previously reported to the Clinical Effectiveness Committee and were brought back to provide an update on areas of improvement.

Data quality challenges associated with inconsistent data capture methods and definitions (e.g., Office of National Statistics vs. National Maternity and Perinatal Audit) impact on the quality of the Health Board data. The maternity directorate are transitioning to the use of BadgerNet digital maternity system (with an anticipated go-live mid-June 2025) to standardise data collection. Staff were receiving training on data collection to improve the accuracy of the Health Board dataset, including breast feeding data. Increased caesarean rates had been observed, with a rise from 25% in 2022 to 35% in 2024. The increase in caesarean births has been observed across both England and Wales linked with maternal choice. Work is underway across the Health Board to review caesarean rates with consideration given to the time of day

MatNeo Safety Improvement Programme (MatNeo SIP)

The MatNeo Safety Improvement programme was implemented in 2023 to drive improvements across both maternity and neonatal services across Wales. The appointment of safety champions changed in 2025 for these roles to be brought back in house. Specific roles will be implemented to support delivery of local improvements and the national work.

Priority areas for improvement in 2025 include the delivery of the Maternity Early Warning Tool (MEWS) and the Newborn Early Warning Track and Trigger 2 (NEWTT2). The UHB has fully implemented NEWTT2 and will have delivered MEWS by September 2025. The implementation of the Birmingham Symptom specific Obstetric Triage System (BSOTS), a maternity triage system that consists of a prompt and brief assessment of women when they present with unexpected problems will provide a standardised way of determining clinical urgency to support triage.

National Neonatal Audit Programme (NNAP)
The National Neonatal Audit plan (NNAP) assesses whether babies admitted to neonatal units in the UK receive consistently high-quality care in relation to the audit measures. The audit is run by the

Royal College of Paediatrics and Child Health (RCPCH). It is commissioned by the Healthcare Quality Improvement Partnership (HQIP).

The latest report was published on 10 October 2024 and includes data collected between 1st January 2023 and 31 December 2024.

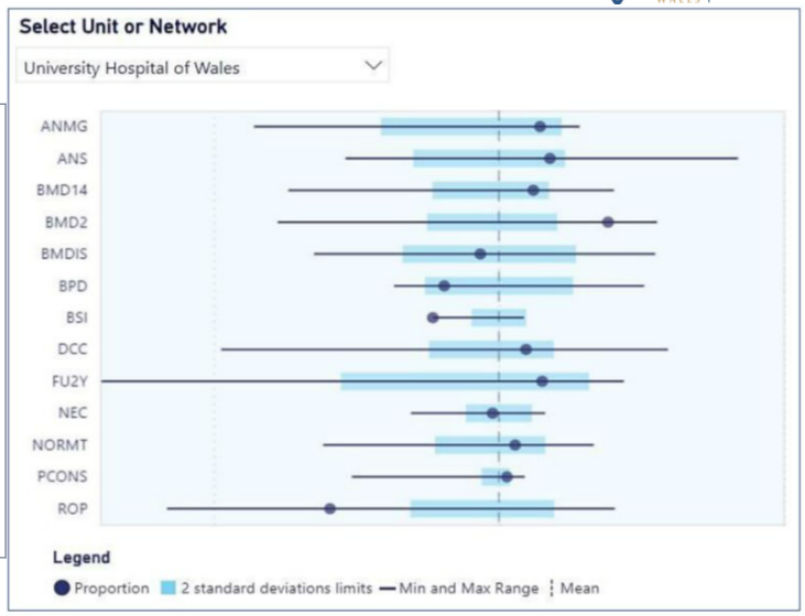
The Health Board performance compared with the UK average for all measures other than later blood stream infections (BSIs) and retinopathy of prematurity (ROP) screening. In both ROP and blood stream infections the organisation was a negative outlier.

Bloodstream infections (BSI) – The Health Board rates were at 20% whereas the national rate was below 5%. The Executive team were informed and action plans developed to address. Improvement actions included a dedicated departmental lead and core team, regular meetings, improved staff ratios, staff education, spot audits, handwashing, Bare Below the Elbow, the development of standard operating procedures for cleaning clinical equipment, environment, storage areas, parent leaflets and raising overall awareness. An 'FBI' badge has been developed 'Fighting Bacterial Infection' to help raise staff awareness. Significant improvements were seen in BSI rates in the second half of 2023 and into 2024. The Infection prevention and control improvement plan was reported through the Health Board MatNeo Oversight Group chaired by members of the Executive Team.

Retinopathy of prematurity (ROP) screening - There is strict criteria for when premature babies should be screened by an ophthalmologist in the unit and the audit standard was that 80% should be screened on time, C&V were at 50%. That guidance and the screening window was changed in 2022 and this was not reflected in local policy for when babies were referred to an ophthalmologist. Once this was recognised, this was rectified to ensure a robust referral pathway. After review it was noted that despite this, most babies had been referred within the agreed window and so did not come to harm. Improvements included a training package on screening guidelines for nursing staff, a screening process on admission and improved data collection/Badgernet education.

NNAP 2023 - Adjusted data

Antenatal magnesium administration
Antenatal steroid administration
Breastmilk on day 14
Breastmilk on day 2
Breastmilk at discharge
Bronchopulmonary dysplasia (chronic lung disease)
Bloodstream infection
Deferred cord clamping
Two-year follow-up
Necrotising enterocolitis
Normal temperature on admission
Parental consultation within 24 hours
Retinopathy of prematurity



Performance is shown with a blue dot positioned on a horizontal line for each measure, with **better performance oriented to the right-hand** side. The blue bar indicates two standard deviations either side of the overall proportion.

National Perinatal Mortality Review Tool (PMRT)

The perinatal Mortality Review Tool (PMRT) is a nationally required reporting systems for all babies are born from 24 weeks gestation and sadly die within 28 days of birth. The Cardiff and Vale data includes only those babies born in the organisation and not those transferred to the neonatal unit after birth.

Data collection issues in the 2023 data resulted in over reporting of mortality cases and significant under reporting of cases of congenital anomalies (20% rather than 56%), a factor that has a significant impact on mortality. Data issues were reported to the MBRRACE, however beyond the deadline for report amendments.

All mortality cases will be subject to a multi-disciplinary mortality review and care is graded from A – D where A means that there were no issues in care identified, B identified incidental learning that did not impact the outcome, C identified learning that might have had an impact on the outcome and D identifies aspects of care that led to the clinical outcome. One case was identified as a grade C with all other cases graded as A and B.

Overall grading of neonatal care (PMRT)

Perinatal deaths reviewed	Gestational age (completed weeks) at birth				
	24-27	28-31	32-36	37+	Total
A – The review group concluded that there were no issues with care identified from birth up to the point that the baby died	0	1	1	1	3
B – The review group identified care issues which they considered would have made no difference to the outcome of the baby	1	1	1	2	5
C – The review group identified care issues which they considered may have made a difference to the outcome of the baby	0	0	1	0	1
D - The review group identified care issues which they considered were likely to have made a difference to the outcome of the baby	0	0	0	0	0

Mortality trends – **Stabilised and adjusted Mortality Rates** – Cardiff and Vale appear in the higher risk zone but data inaccuracies affect interpretation.

- **Trend over 5 to 10 years** – mortality rates have remained relatively stable, there has been a slight improvement in non-congenital anomaly deaths.

- **Cause of death (2023)** - 56% due to congenital anomalies, others include infection, HIE and NEC.

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

The Clinical Effectiveness Committee received presentations on;

National Joint registry
National Audit of Care at the end of life
National Emergency Laparotomy Audit
Sentinel Stroke National Audit Plan
MatNEo Safety Improvement programme
National Neonatal Audit
National Perinatal Mortality Review Tool (PMRT)

National Neonatal Audit Programme (NNAP)
National Maternity and Perinatal Audit (NMPA)

Data collection remains a challenge in a number of areas including across perinatal and maternity services – the move to Badgernet clinical system will be beneficial in standardising data collection within maternity.

The UHB was an outlier for late onset infection rates in the neonatal unit and neonatal retinopathy of prematurity screening. In both areas significant improvement work has resulted in improvements in practice reflected in audit data.

Recommendation:

The Committee is requested to:
A) **NOTE** the Assurance provided by the national audit data and some of the areas of improvements covered in the report.

Link to Strategic Objectives of Shaping our Future Wellbeing: *Please tick as relevant*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

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

Impact Assessment:
Risk: Yes/No
Safety: Yes/No
Financial: Yes/No
Workforce: Yes/No
Legal: Yes/No
Reputational: Yes/No

Socio Economic: Yes/No	
Equality and Health: Yes/No	
Decarbonisation: Yes/No	
Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Report Title:	Health Protection Regional Partnership Plan 2024-6			Agenda Item no.	*3.2*
Meeting:	Quality Committee	Public	X	Meeting Date:	24 June 2025
		Private			
Status *(please tick one only):*	Assurance		Approval	X	Information
Lead Executive Title:	Claire Beynon, Executive Director of Public Health				
Report Author (Title):	Annie Ashman, Deputy Director of Public Health				

Main Report
Background and current situation:

The health board has a statutory duty to respond to threats to our population posed by communicable disease and environmental health hazards. In March 2022, following the initial response to the COVID-19 pandemic, Welsh Government published *Together for a Safer Future: Wales's long-term COVID-19 transition from pandemic to endemic*. It set out the principles of the continued response to COVID-19 and other respiratory infections. Under this plan, health boards were required to implement a public health approach to health protection, protecting the most vulnerable in our society from serious disease. Health boards are specifically required to focus on protecting the vulnerable by: enabling access to preventative services, vaccination and treatment; maintaining capacity to respond to localised outbreaks and in high-risk settings; retaining effective surveillance systems to identify any deterioration in the situation; preparing for the possible resurgence of COVID-19 and increases in other respiratory viruses; and having robust plans around disease elimination targets, increasing prevention, testing and management.

In Cardiff and Vale, a regional health protection partnership was developed from the working arrangements set up during the pandemic response, building on the good working relationships with partners during that time. The model is built upon the principles and relationships that exist within the region, and which will continue to influence service delivery and further strengthen the important work that each partner is achieving; this can only strengthen existing relationships and resilience.

The strategic aim of the partnership is to deliver an effective health protection system, which adds value to existing services and the systems established during the COVID-19 pandemic, and is able to prevent, treat, and mitigate risk associated with an all-hazard remit.

The first regional health protection partnership plan for 2023/4 focused on developing a sustainable model for communicable disease control. Feedback from partnership members was that partnership working arrangements had added value to the work that they were already doing, and that there had been many benefits in working collaboratively, particularly around reaching inclusion health groups and in responding to cases and clusters of disease in the health board area.

<u>Current situation</u>

The plan for the second and third years of the partnership builds on existing work around responding to communicable diseases, but also considers the role of the system in responding to environmental threats and civil contingencies. The actions for the coming year have been developed in partnership with other agencies, including local authorities, Public Health Wales and the third sector.
Key actions for the period to the end of March 2026 include:

- Strengthen relationship with primary care
- Review governance and operational structure requirements to support model, including meeting frequency, identifying project support to action
- Development of communications and engagement strategy

- Scoping of how partnership can add value to the response to environmental hazards (including both CBRN risks and incidents, and climate change) and setting principles for engagement
- Strengthening of third sector relationships and engagement
- “No wrong front door” approach
- Develop and test pandemic response plan

The plan has been approved by the Amplifying Prevention Board and Strategic Leadership Board.

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

This paper provides the Committee with a briefing on this important plan. Failure to prepare for, and respond to, health protection hazards presents risk to the health of our population and to health board resources

It is important to note that effective management of health protection issues can impact positively on reducing health inequalities in our population. Although there are threats to everyone from communicable disease and environmental hazards, characteristics of certain individuals, groups and settings may place them at higher risk of exposure, or experiencing poorer outcomes. In many cases, the pre-existing inequalities in our population have been exacerbated by COVID-19. Recognition of those at higher risk, and action to protect them, is key to our regional planning and our targeted approaches.

Recommendation:

The Committee is requested to:

a) APPROVE the Health Protection Regional Partnership Plan.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please place an “X” in the below boxes as relevant.

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

Five Ways of Working (Sustainable Development Principles) considered

*Please place an “**X**” in the below boxes as relevant*

Prevention	X	Long term	X	Integration	X	Collaboration	X	Involvement	X

Quality Impact Assessment Completed?:

*Please place an “**X**” in the below boxes as relevant. Any queries, please contact Alexandra.scott3@wales.nhs.uk*

Yes – ***(please provide completed QIA document)***		No – ***(Please provide reasoning, e.g. not required)***	X	Not required

Impact Assessment:

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

Risk: No

Safety: No

Financial: Yes

The health board currently receives just over £1 million of dedicated health protection funding from Welsh Government, and needs to provide evidence for assurance of a robust plan for mitigating communicable disease and environmental threats.	
Workforce: No	
Legal: No	
Reputational: Yes	
There is reputational risk attached to failure to prepare and respond appropriately to health protection threats and failure to meet the health board's statutory obligations.	
Socio Economic: No	
Equality and Health: No	
Decarbonisation: No	
Approval/Scrutiny Route *(please note anywhere else this paper has been before):*	
Strategic Leadership Team	Date: 15 May 2025

Cardiff and Vale Health Protection Plan 2024/26

VALE of GLAMORGAN
BRO MORGANNWG

CARDIFF
CAERDYDD

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

Shared Regulatory Services
Gwasanaethau Rheoliadol a Rennir

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1. Introduction To The Cardiff And Vale Health Protection Plan

This Cardiff and Vale Health Protection Plan has been developed by local partner organisations to describe how they work together to prevent and mitigate risk from communicable disease and environmental threats to health. Whilst partner organisations have always worked together to control and mitigate these risks, the response to the COVID-19 pandemic saw unprecedented levels of joint working and much has been learned as a result. This plan builds upon that learning and outlines a sustainable model for regional working to take us into the future.

The Cardiff and Vale Health Protection partnership is a complex and maturing system, within which some partners deliver statutory roles and functions, and where many operating practices are well established and proven to be effective. This plan describes how we intend to build on those existing relationships and use our experience of the pandemic response, to strengthen the regional system and add value by functioning in an even more integrated way and improve population health outcomes. As a partnership, we agreed that our initial focus during the first year of the plan (2023/24) would be to develop a sustainable model for communicable disease control, but moving into the second and third years, there will be consideration of the role of the partnership in the response to environmental hazards and Civil Contingencies.

There is a range of added value work in this plan which is supported through current funding arrangements. The model is built upon the principles and relationships that exist within the region, and which will continue to influence service delivery and further strengthen the important work that each partner is achieving; this can only strengthen existing relationships and resilience.

1.1 Background

Welsh Government's transition plan, *Together for a Safer Future: Wales' long-term COVID-19 transition from pandemic to endemic* was published in March 2022. It set out the principles of the continued response to COVID-19 and other respiratory infections. Under this plan, Health Boards were required to implement a public health approach to respiratory viruses, including COVID-19, protecting the most vulnerable in our society from serious disease, focusing on:

- Protecting the vulnerable by enabling access to preventative services, vaccination and treatment.
- Maintaining capacity to respond to localised outbreaks and in high-risk settings.
- Retaining effective surveillance systems to identify any deterioration in the situation.
- Preparing for the possible resurgence of COVID-19 and increases in other respiratory viruses.
- Have robust plans around, for example, BBV elimination targets, increasing prevention, proactively screening for and managing TB, including in international students, and testing and management of HIV.

In December 2022, Welsh Government set out an ambition for 2023/4 to be a transition year, where the services and structures put in place by regional partners to manage the pandemic were scaled back, and the experience of the pandemic response should be built upon to establish a more resilient system for managing ‘all-hazard’ health protection risks. Public Health Wales (PHW) continues to assess risks and threats, provide guidance and develop training materials and support for health protection teams across Wales, and continues to provide the acute health protection response through the All Wales Acute Response (AWARe) duty team in conjunction with Environmental Health Officers in local authorities. Standard Operating Procedures (SOPs) support interplay between the national team, AWARe and regions. Welsh Government has continued to fund a national surge team to assist the PHW AWARe team during 2023/24, and will evaluate and determine the best model for this team going forward.

Welsh Government has committed to co-producing a National Framework for Health Protection, which will take account of the Report of the Independent Review of the Health Protection System in Wales and the accompanying implementation plan, both of which were published on 7 February 2023.

1.2 Partner organisations and teams contributing to the Cardiff and Vale Health Protection Partnership

The systems approach to health protection in the Cardiff and Vale Region will be delivered in partnership between a range of statutory organisations including Cardiff and Vale University Health Board (UHB), Cardiff Council (CC), Vale of Glamorgan Council (VoGC), Shared Regulatory Services (SRS) and Public Health Wales (PHW). The system is more extensive than this however, and includes all organisations, teams and services that play a role in preventing and managing the risks posed by communicable disease and environmental hazards, such as third sector organisations (appendix 1). The partnership will need to be supported by a number of enabling functions within contributing organisations (box 1) and form links with relevant national partner organisations (box 2).

Box 1: Enabling Functions within contributing organisations

- Digital services – and Digital Health Care Wales (DHCW)
- Organisational Information Governance Leads
- Procurement services
- Waste management services
- Estates Services

Box 2: National Partners

- Welsh Government
- UK Government Home Office
- UK Health Security Agency (UKHSA)
- Care Inspectorate Wales (CIW)
- Food Standards Agency Wales

1.3 Cardiff and Vale Health Protection (Communicable Disease) Partnership Governance

The Cardiff and Vale Health Protection Partnership brings together a complex and established range of programmes and services, which have pre-existing governance systems and operational procedures, with the aim of adding value to the regional health protection response (figure 1). The Health Protection Partnership Forum (developed from the Regional Public Health Response team set up for the COVID-19 response, and previously known locally as the operational 'Bird Table') provides the forum to identify opportunities to collaborate, coordinate and enhance operational delivery. The Health Protection Partnership Forum will report through the Amplifying Prevention Board to the two Public Service Boards. Immunisation services are provided by the UHB, governance oversight is provided by the UHB via the Operational and Strategic Immunisation Groups to the Senior Leadership Board and Quality Safety and Experience Committee; an Immunisation Service lead will be part of the Health Protection Partnership Forum to ensure operational continuity.

Similarly, the UHB Infection Prevention and Control Team reports via UHB governance structures, but participates in the Health Protection Partnership Forum to ensure operational links are maintained. The UHB provides clinical support and delivery for certain partnership programmes (i.e. Viral Hepatitis, HIV and TB) and so these will report to both UHB and Partnership governance routes. Responsible Officer members from the Amplifying Prevention Board will ensure Chief Executive Officers and Leaders are briefed on the development of the Health Protection Partnership and any escalated concerns via the Leadership Group.

Reflections from partners on the first year of the partnership plan and working arrangements included the need to revisit governance and operational structures going forwards, and this forms part of this year's action plan.

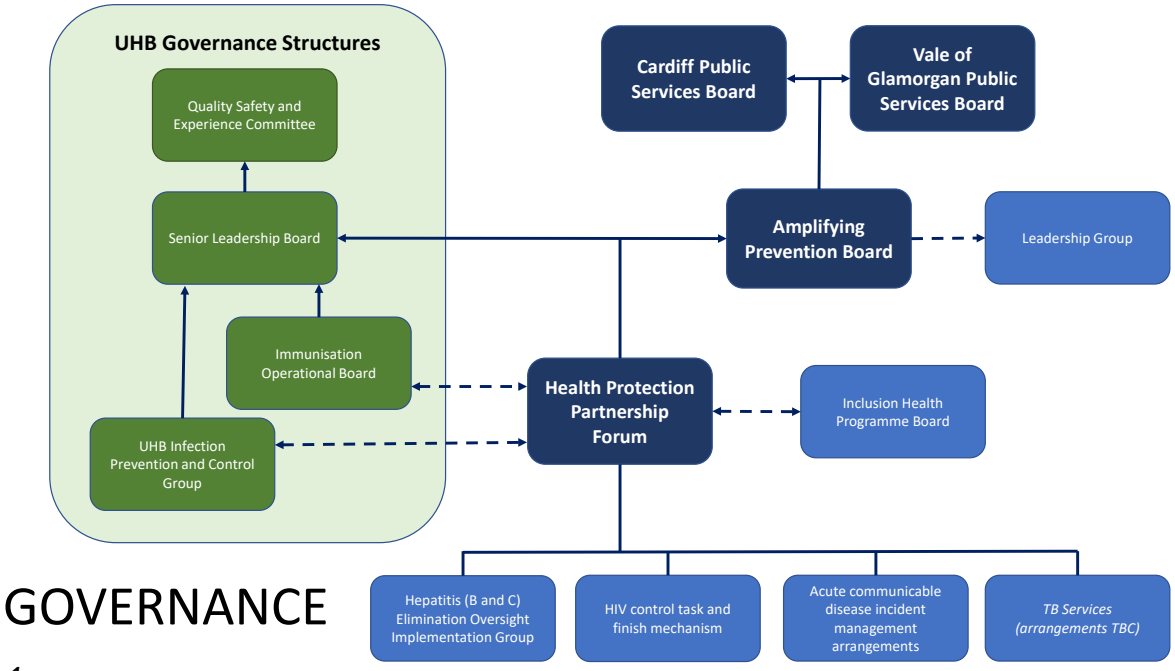


Figure 1

1.4 Key Frameworks and Plans

A regionally coordinated approach to health protection will operate in line with the full range of legislation, frameworks and plans that govern delivery for constituent organisations. The following are of particular relevance in relation to health protection:

- The Communicable Disease Outbreak Plan for Wales
- National Immunisation Framework for Wales
- National Framework for Health Protection (when published)
- Roles and Responsibilities document from WG (when published)
- Operational Delivery plans for each constituent organisation

2. The Role of the Cardiff and Vale Health Protection Partnership

2.1 Population served

Cardiff is the capital city of Wales and is continuing to grow faster than any other capital city in Europe. In population terms, it is the largest city in Wales with a population of 370,000 and also the most ethnically diverse. Population alone however, does not fully represent Cardiff's significance as a regional trading and business centre as the population swells by approximately 70,000 daily with commuters and visitors. Cardiff is the seat of government and the commercial, financial and administrative centre of Wales. Cardiff boasts one of the most vibrant city centres in the UK and on a typical weekend, Cardiff's night time economy can attract over 40,000 people and sometimes more than 100,000 when the city's Principality Stadium hosts international events. The city also has a large student population and is an asylum seeker Home Office initial assessment and dispersal area.

The Vale of Glamorgan covers 33,097 hectares with 53 kilometres of coastline, and has a population of over 130,000 residents. The area is predominantly rural in character, but contains several urban areas of note such as Barry, Penarth, Dinas Powys and the historic towns of Cowbridge and Llantwit Major. Barry is the largest town, a key employment area and popular seaside resort. The rural parts of the Vale provide a strong agricultural base together with a quality environment, which is a key part of the area's attraction. The area includes Barry Docks and Cardiff International Airport. The Vale of Glamorgan has seen significant growth in its older population, which is predicted to continue.

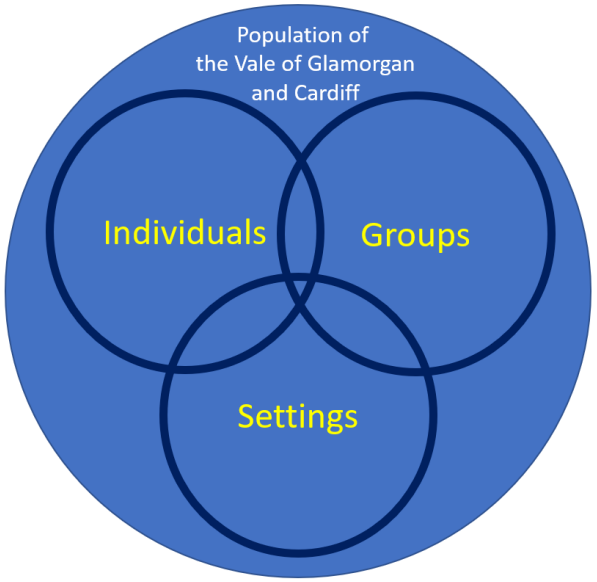
Persistent inequalities are evident in the populations of Cardiff and the Vale of Glamorgan, linked to differing experiences of the wider determinants of health (such as education, housing and income) throughout life. These inequalities mean there is a 7.6 year gap in life expectancy between men experiencing least and most deprivation, and a 13.3 year difference in healthy life expectancy; for women the gaps are 6.3 and 16.9 years respectively. Many of these differences are preventable and inherently unfair, and are termed inequities. The COVID-19 pandemic has further exacerbated inequities in our population. All partners have pledged to work collectively to improve the experience for our population and reduce inequities.

The Cardiff and Vale Health Protection Partnership will work to prevent, control and mitigate risk from infectious disease and environmental hazards for the people who live and work in the region. Whilst all members of the population are potentially at risk from communicable disease, we recognise that certain characteristics of individuals, groups and settings may place them at higher risk of exposure to infectious disease, the impacts of environmental hazards, or of experiencing poorer outcomes. Such higher risk characteristics can also co-exist (figure 2). Recognition of individuals, groups and settings at higher risk will inform regional planning and our targeted approaches.

Cardiff and Vale integrated health protection system – who is it for?

People who live and work in Cardiff and the Vale of Glamorgan

- General risk of infectious disease



Higher risk:

- **Individuals** – e.g. children, pregnant women, older people, those who are immunosuppressed, people travelling from countries with higher risk of infectious disease
- **Groups** – e.g. asylum seeker/refugees, street homeless, people experiencing deprivation, some ethnic minority groups
- **Settings** – e.g. care homes, hospitals, special schools, schools, Higher Education/Further Education, prisons

Figure 2

2.2 Functions

The Cardiff and Vale Health Protection Partnership aims to deliver diagnosis/ testing, treatment (including vaccination) and public health risk management for an 'all hazards' communicable disease remit, on a background of working to prevent and reduce risk from infectious disease and strengthen infection prevention and control practice. In conjunction with this is the need to establish timely surveillance and effective systems for communication (figure 3) on 'requests to cooperate' and Part 2A Orders.

2.3 Strategic Aims and Objectives for 2024/26

2.3.1 Strategic Aim

To deliver an effective health protection system in partnership in Cardiff and Vale of Glamorgan, which adds value to existing services and the systems established during the COVID-19 pandemic, and is able to prevent, treat, and mitigate risk associated with an all hazard communicable disease and environmental hazard remit.

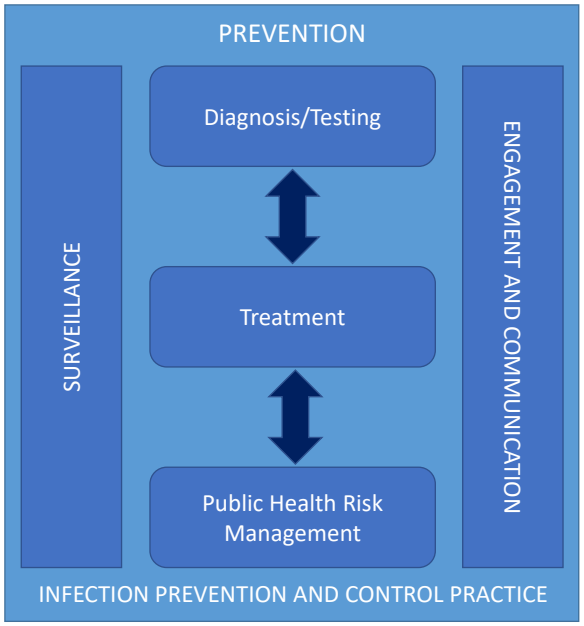


Figure 3

2.3.2 Strategic Objectives

To achieve this, partner organisations will deploy relevant resource to:

- Monitor surveillance reports to identify trends and risks
- Protect our local population through safe, innovative, timely, person-centred and equitable immunisation delivery, maximising uptake in the process
- Provide access to diagnosis, sampling, testing and treatment that is timely and effective
- Respond appropriately to cases and clusters of infectious disease and environmental incidents, and implement actions to mitigate risk and control spread
- Ensure that processes are in place to manage communicable disease outbreaks, in line with the Communicable Disease Outbreak Plan for Wales
- Supporting the development of health inclusion services delivering primary care to health inclusion groups (groups with the worst health outcomes), which will increase access to health protection services
- Enhance partnership working opportunities between primary care and health protection services
- Ensure vulnerable settings such as health and social care, prisons and other critical services, are supported by appropriate advice and helped to implement guidance on prevention and management of communicable disease outbreaks
- Signpost those impacted by infectious disease to sources of support if required, including those needing to isolate
- Deliver clear and effective communication

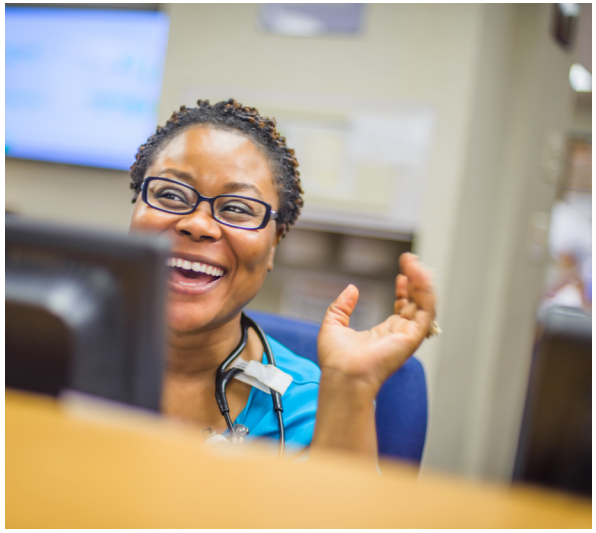
to the public and professionals in response to communicable disease and environmental incidents, programmes and campaigns

- Prepare for possible COVID-19 urgent and future pandemic scenarios
- Minimise wider harm incurred through our response to outbreaks or epidemics
- Employ robust quality improvement principles and tools to learn from experience, innovate and adopt best practice and continuously improve outcomes for our population

2.3.3 Guiding criteria and principles

Welsh Government has indicated that regions across Wales should develop integrated health protection teams which meet the following criteria:

1. Multi-disciplinary health protection teams will work on the Health Board footprint, with Health Boards and local government working in partnership to respond to health protection measures and threats
2. An 'all-hazards' approach to health protection will be supported by all partner agencies, recognising there will be peaks of activity through the year according to national and regional demand
3. Teams will have a mix of skills and experience to:
   - Respond to Covid waves within a Covid Stable environment and deliver on the national approach for respiratory viruses
   - Have plans in place to scale up in the event of Covid Urgent/future pandemic scenario, within the context of a national framework
   - Respond to outbreaks and wider threats using agreed processes in the Communicable Disease Outbreak Control Plan for Wales
   - Deliver on the National Immunisation Framework for Wales, ensuring high take up and equity of access
   - Undertake wider health protection work delivering a local approach under national frameworks and guidance, for example to support those seeking refuge in Wales, support messaging in schools, provide support to care homes and work on TB and Hepatitis elimination
   - Work together locally and nationally to support and deliver work to address equity of access and opportunity



The Cardiff and Vale Health Protection Partnership has initially focused on establishing a system-wide and sustainable approach to communicable disease management, but in the second and third years of the plan will also consider where the partnership can add value to existing arrangements for responding to environmental risks and incidents. In addition, partners in Cardiff and Vale have agreed to work collectively to the following principles:

1. We will focus on adding value to the system, building on existing arrangements and learning from our pandemic partnership response
2. Our regional partnership will proactively identify opportunities to share resource across services where possible, and support staff to take on a mixed and broad range of functions up to the limits of their competence and registration

This plan identifies the actions which need to be taken to deliver added value in addition to existing and statutory functions.

3. Cardiff and Vale Health Protection Partnership Planning Framework

As during 2023/24, the following planning framework will again be adopted to inform the work programme for the remainder of 2024/26, and develop the plans and processes that will deliver the added value of a comprehensive and integrated system to prevent and manage communicable disease within the Cardiff and Vale Region; it is anticipated that the framework will continue to inform partnership work in succeeding years.

3.1 Surveillance

Communicable disease surveillance data for the most frequently occurring communicable diseases in Wales is produced by Public Health Wales's Communicable Disease Surveillance Centre. Other surveillance data is produced at a UK, European and global level. National surveillance data will be used in combination with regional service use data to identify and respond to concerning trends and manage risk.

3.2 New/acute cases, incident and outbreak response

3.2.1 Existing operational practice

New cases of infectious disease may present to any healthcare setting, although the majority will present to primary care services. Many infectious diseases are mild and self-limiting and do not require further clinical or public health management. Depending on the disease and its presentation, a number of teams and services across the UHB may be involved in diagnosing and treating the condition. Likewise, any public health action (such as contact tracing, prescription of prophylaxis, advice on exclusion from school/work) may be taken by a range of teams. Table 1 provides a high-level summary of the lead teams or organisation by condition, although in practice it is much more nuanced and complex.

A number of communicable diseases are notifiable because of potentially serious sequelae to individual and population health. (The list of notifiable diseases can be found here.) Registered medical practitioners must notify any of the diseases on this list to the Proper Officer of the Local Authority or the Health Protection Team. In practice in Wales, all notifiable diseases should be notified via AWARe.

AWARe is usually the first point of contact for queries in relation to the public health management of communicable disease for both professionals and the general population. The Specialist Health protection teams follow nationally agreed guidance and SOPs to manage risk.

Specialist Health Protection would usually lead the initial investigation of clusters of communicable disease, although Local Authority officers may be the initial responder for gastrointestinal incidents, including in care homes, schools and early years settings. Incidents are often managed in collaboration between partners, particularly PHW Specialist Health Protection and Environmental Health (SRS). (See section 3.4.3 for a description of care sector support)

If an outbreak is declared, partners will follow the approach outlined in the Communicable Disease Outbreak Plan for Wales.

PHW Specialist Health Protection provides on out of hours health protection service to manage newly occurring, significant incidents overnight, at weekends and bank holidays.

Table 1 Mapping of lead services and teams for specific diseases

Functions	COVID	Core response to communicable diseases	Hep B	Hep C	TB	HIV	STI	High consequence infections*
Sampling/ Diagnosis	PC/UHB	PC/UHB	PC/ UHB	PC/ UHB	TB	UHB	DOSH	ID
Treatment	PC/UHB	PC/UHB	ID	ID	TB	ID/DOSH	DOSH	ID
Public Health Management	SRS/UHB/ PHW	PHW/SRS	PHW/SRS	PHW/SRS	TB /PHW/SRS	ID/DOSH	DOSH	PHW/SRS/UHB

**There is DOSH involvement, as well as infectious disease service involvement, for Mpox cases*

Key:
PHW = Public Health Wales Health Protection
SRS = Shared Regulatory Services
UHB = General Health Board Services
PC = Primary Care Contractor Services
ID = UHB Infectious Disease Service
TB = UHB Integrated TB service
DOSH = UHB Department of Sexual Health

3.3 Planned/preventative infectious disease management

3.3.1 Vaccination and Immunisation

3.3.1.1 Existing operational practice

Cardiff & Vale UHB employs a multi-team approach to deliver the routine immunisation schedule for Wales and the requirements of the National Immunisation Framework for Wales. This inclusive approach encompasses School Nursing teams, General Medical Services (GMS), Community Pharmacy, as well as more specialised teams like CAVHIS (Cardiff & Vale Health Inclusion Service), the Prison Health teams and DOSH (Department of Sexual Health).

The Health Board Core Immunisations team has taken on a pivotal role in vaccination and immunisation for the UHB. Since meeting the unprecedented demands posed by the COVID-19 pandemic, the role of the team has evolved from a mass vaccination team to apply the learning across the wider immunisation programmes. The team continues to deliver Winter respiratory vaccination programmes and COVID-19 booster programmes as well as supplementing other commissioned routine

vaccination programmes and providing outbreak immunisation.

Vaccination and immunisation are integral components within the partnership. They serve a dual purpose - proactively limiting and preventing the spread of serious illnesses and diseases, and reactively responding to health or disease outbreaks. This approach not only safeguards individual health but also plays a vital role in curbing the transmission of diseases within communities.

Public Health Wales's Vaccine Preventable Disease Programme (VPDP) supports the delivery of immunisation programmes across Wales, including producing detailed surveillance data to monitor uptake. Vaccination leads within the UHB, including in the UHB's Public Health Team, use this data to steer and target local strategy and delivery; in particular this data is used to direct action to tackle low uptake and inequity of uptake.

3.3.1.2 Added value partnership developments

Partner organisations worked closely together during the pandemic to support Covid-19 vaccine uptake in general, and equity of access for all eligible populations, through a range of approaches. This partnership response has been continued, with a focus on increasing uptake and reducing inequity of childhood vaccinations. The partnership response has been part of the 'Amplifying Prevention' approach adopted by partners following publication of the Annual Report of the Director of Public Health for Cardiff and the Vale of Glamorgan (2020) which was published in September 2021. Detailed work in 2024/26 is focussing on MMR vaccine uptake in particular, due to the threat posed to the local area by significant outbreaks of measles in England.

3.3.2 Hepatitis B/C

3.3.2.1 Existing operational practice

Hepatitis B prevention services mainly involve the delivery of the Hepatitis B vaccination and also Needle Syringe Programmes in our community. In contrast Hepatitis C involves case finding/testing and treatment services. This includes: Primary Care (GP practices; Cardiff and Vale Health Inclusion Service; and the Department of Sexual Health); Secondary Care (including the Infectious Diseases Service; Mental Health and Substance Misuse services); Independent Community Pharmacies; third sector organisations; HMP Cardiff and hostels.

3.3.2.2 Added value partnership developments

In order to respond to the Welsh Health Circular on the elimination of Hepatitis B and C (WHC/2023/01), a Cardiff and Vale Hepatitis (B and C) Joint Recovery Plan was created in partnership. The delivery of this is overseen by the Cardiff and Vale of Glamorgan Hepatitis B and C Elimination Oversight Implementation Group. This feeds directly into the Health Protection Partnership Forum. Within the Recovery Plan are several strategic actions to include: exploring options for referral pathways for hepatitis B vaccination for identified high risk individuals, and ensuring opt out testing protocols are implemented across treatment and support services for Hepatitis C.

3.3.3 HIV

3.3.3.1 Existing operational practice

HIV testing is available in all clinical sites in Cardiff & Vale, but is a universal offer for attenders of sexual health clinics, infectious diseases outpatients and antenatal screening. It is recommended for those with clinical indicator conditions in primary care, acute medical admissions and outpatient medical consultations along with prior to cytotoxic chemotherapy treatments.

Outpatient HIV treatment is provided in two sites in Cardiff & Vale, at the Department of Sexual Health at the Cardiff Royal Infirmary and additionally at Infectious Diseases at UHW. Specialised inpatient treatment is at UHW under Infectious Disease.

The Welsh HIV Action Plan 2023-2026 covers a range of important actions for health boards including reduction of late diagnoses, improved access to testing, delivering excellent HIV services that support people to engage with care and reducing health care HIV stigma. Both HIV services contribute to national late diagnoses reviews and multidisciplinary meetings.

Sexual health services also deliver Pre and Post-Exposure Prophylaxis (PrEP) services to ensure those at risk of HIV acquisition can take medications to prevent transmission.

3.3.3.2 Added value partnership developments

There is an outreach team at the Department of Sexual Health to support engagement with care, working collaboratively and flexibly with other services and agencies including the Cardiff & Vale Health Inclusion Service, mental health services, drug and alcohol services, blood-borne virus services and third sector organisations. The aim is that all people living with HIV are able to take effective treatment, live healthy lives and become non-infectious, with the aim of eliminating HIV transmission in Wales by 2030, as per the UNAIDS goals.

Fast Track Cardiff is a collaboration between the UHB, Cardiff Local Authority, Cardiff University, people living with HIV and people thought to be at high risk of HIV. This group has been established with the aim of co-producing service change and implementing the HIV Action Plan for Wales 2023 to 2026. One of their main current priorities is HIV Stigma.

There are plans to formulate a delivery response across Cardiff & Vale UHB to specific actions in the HIV Action Plan which need further work, where the UHB is the responsible body for implementation, although the details are not finalised at present as this requires a co-ordinated response across Clinical Boards.

[1] *www.bhiva.org/file/5f68c0dd7aefb/HIV-testing-guidelines-2020.pdf Appendix 1, Pg 26*

There are also plans to work with probation services to offer TB screening by working in collaboration with CAVHIS, and the blood-borne virus and sexual health teams, to create an integrated screening service.

3.3.4 Tuberculosis (TB)

3.3.4.1 Existing operational practice

Cardiff & Vale UHB has an integrated TB Service, coordinated from within the Medicine Division, but with contributions from both secondary and community services including those from Public Health Wales. Service provision and future development plans are in line with the recommendations identified in the Elimination of TB Action Plan for Wales 2024-2030 (still in its draft form).

Cardiff & Vale UHB TB service provides a comprehensive service which offers prompt clinical review of any symptomatic individuals. Screening for active TB and latent TB infection screening is offered to all newly arrived asylum seekers and refugees, adults and children, as part of the initial health assessment at Cardiff and Vale Health Inclusion Service. Cardiff and Vale Health Inclusion Service identifies and refers those who are symptomatic or have positive mantoux or quantiferon tests to the TB service for further investigation and management.

PHW Specialist Health Protection team, UHB TB service and UHB Local Public Health Team collaborate in response to complex TB cases involving extensive contact tracing and follow up action. Local Authority Environmental Health Officers (Shared Regulatory Services) are also involved where there is a risk in the wider community or workplace concerns (for sites where the local authority is the enforcing authority for health and safety legislation), providing their expert knowledge and statutory public health powers; the Health and Safety Executive would be engaged with other workplaces.

3.3.4.2 Added value partnership developments

The TB service will continue to raise awareness among health care professionals in all sectors of the signs and symptoms of TB, including the necessity to consider TB as a potential diagnosis. The following actions are planned to either provide or enhance provision of measures to improve awareness of TB in targeted groups or the general local population:

- Review the position regarding re-instatement of TB screening of students at international colleges and universities within Cardiff and Vale, particularly with regard to students from high TB prevalence countries.
- Develop an outreach service which collaboratively works alongside Health Inclusion services, accessing hard to reach populations such as those who are homeless, in hostels or prison who we know have an increased risk of TB transmission.
- Develop automatic flags for GP systems to identify new entrants/registrants at increased risk of TB, and requiring TB and other multi-pathogen screening.
- Further develop systems to identify and refer possible cases

3.3.5 COVID/ Acute Respiratory Infection (ARI) and Winter Preparedness

3.3.5.1 Existing operational practice

The Health Board Core Immunisation team is responsible for the planning and administration of COVID vaccines. This is primarily carried out through designated vaccination centres. These centres have consistently surpassed the target of 75% vaccination coverage since its establishment. As part of their approach, the team collaborates closely with General Medical Services (GMS) and community pharmacy colleagues. This collaboration is crucial in meeting the extensive immunisation needs and, importantly, in ensuring equitable access to vaccination opportunities for all.

Influenza vaccination is coordinated via a mixed model. School nursing teams take the lead for school-aged children, while General Medical Services (GMS) teams deliver vaccination to infants and adults. The Health Board Core Immunisation team oversee the delivery of flu across the providers, providing opportunities to supplement and/or offer alternative delivery models where necessary to improve vaccination uptake within a programme, cohort or community. The team also plays a lead role in immunising the health and social care workforce. They also offer support to partners in the form of 'mop-up'/catch-up capacity (addressing inequities), allowing GMS and school nursing colleagues to redirect their resources towards other essential work programmes.

ARIs have the potential to cause significant disruption in closed settings. The partnership response to these is described elsewhere in this document.

3.3.5.2 Added value partnership developments

In the context of winter preparedness, the partnership remains active in exploring opportunities to support underrepresented groups, including through collaboration and engagement with third sector services. There is a continuous education focus to ensure that citizens have the knowledge to make informed decisions.

3.4 Supporting people at higher risk from infectious disease

3.4.1 Individuals

Some people are at higher risk of contracting infectious disease, or be more likely to experience serious outcomes, as a result of individual factors such as age, pregnancy or being immunosuppressed. A range of actions can be taken to prevent infection and minimise the risk to these individuals, ranging from personal behaviours like hand washing to treatments such as prophylactic antibiotics and immunisation. Such actions are usually part of the clinical management of specific conditions, and so form part of the core business of medical teams

3.4.2 Groups

Certain groups of people are at increased risk communicable disease due to factors experienced by that group. Within our region, Health Inclusion groups have been identified as a priority.

3.4.2.1 Health Inclusion Groups - Existing operational practice

Cardiff and Vale Health Inclusion Service (CAVHIS) is a Health Board managed service for groups that have some of the poorest health outcomes and face significant challenges when attempting to access health and social care services. It is situated in the centre of Cardiff and managed by the Primary, Community and Intermediate Care (PCIC) Clinical Board.

The service began as Cardiff Health Access Practice (CHAP) and was resourced to provide health screening to newly arrived people seeking asylum who were placed in Cardiff for Home Office initial assessment. The service has been developed over the past three and a half years and re-branded in September 2021 with the aim of delivering an integrated service with cross sector partners providing a flexible model of care to traditionally excluded groups.

The current developing model provides evidence-based health and public health screening, primary care services and support via co-located third sector partners for:

- newly arrived people seeking asylum under section 98 of the Immigration and Asylum Act 1999
- Individuals under section 95 who are not yet ready to transition to traditional GMS
- people under Home Office refugee resettlement programmes,
- survivors of trafficking and those who are destitute and facing 'No recourse to public funds'.

The service also provides limited urgent primary care for multiply excluded single homeless individuals via outreach clinics into various frontline hostels, and an Alternative Treatment Scheme – primary care for individuals who due to episodes of violent behaviour, after formal risk assessment, are judged to need a security presence.

The longer-term vision of the service is to develop, in partnership with local authority and third sector services, provision of an 'Integrated and Co Located Health Inclusion Service'.

3.4.2.2 Health Inclusion Groups - Added value partnership developments

A portion of the health protection Welsh Government funding last year was therefore allocated to further strengthening the health protection function within CAVHIS. Health protection funding in 2023/24 was primarily aimed at strengthening outreach, by equipping a van to offer clinical services, a point of care testing machine and staff to provide sexual health outreach and service user engagement. It has also been used to secure both adult and paediatric Infectious Disease Consultant sessions within the CRI to further improve access to such specialist advice and an outreach role is also planned.

3.4.3 Settings

The COVID-19 pandemic demonstrated how vulnerable certain settings are to communicable disease risk. Such settings include prisons, houses of multiple occupancy, asylum seeker accommodation, hostels and special schools. However, the greatest risk and poorest outcomes were experienced by care homes. As a region, we intend to work to ensure that the care sector is appropriately supported to reduce the risk of communicable disease incidents through good IPC practice, and to manage incidents when they occur.

3.4.3.1 Support to care settings – Existing operational practice

A number of partnership teams support the care sector. The Health Protection Partnership Team, which is staffed by Environmental Health Officers and experienced former contact tracers (now Health Protection Officers), supported the sector throughout the pandemic. They have formed strong relationships with settings across both local authorities and will often be contacted by homes who have concerns about respiratory illness. Single cases of respiratory illness are managed with advice. If there are two or more linked cases, the setting should report through to the PHW AWARe team, the incident is logged on Tarian and the Care Home SOP is followed. If COVID is confirmed in the setting, the SRS Health Protection Team will provide ongoing management of the incident; all other respiratory pathogens are managed by PHW.

Single cases or clusters of other infectious diseases are usually reported to AWARe. In the case of gastrointestinal disease, the SRS Communicable Disease team would be involved to provide advice and organise testing; they would also provide follow up to the setting until the incident is over. The same team would also be engaged if Legionella was suspected to be a causative organism.

A number of other partnership teams also support the care sector:

- Cardiff Social Service team
- Vale of Glamorgan Social Services team
- UHB Nurse Assessor Team
- UHB IP&C Team

In addition, Care Inspectorate Wales acts as regulator to both nursing and residential homes, and would be involved when concerns are raised. The Health and Safety Executive would also be involved where poor infection prevention and control measures were putting staff at risk in nursing homes; the same concerns in residential care homes would be investigated by the SRS Communicable Disease Team, which enforces health and safety legislation in this setting.

Similarly, a number of organisations are involved in providing training opportunities to care sector organisations, including PHW, Health Education and Improvement Wales (HEIW) and both Local Authorities.

A daily incident log is circulated to relevant PHW, SRS and Local Authority Teams. Multi-agency meetings are arranged as necessary to discuss specific incidents and concerns. Regular multi-agency oversight meetings have also been re-established in Cardiff Local Authority area.

3.4.3.2 Support to care settings – added value partnership developments

A partnership multiagency group has been convened to coordinate partnership support to care homes, and share best practice. Contributors include PHW Specialist Health Protection, PHW Healthcare Associated

Infection, Antimicrobial Resistance and Prescribing Programme (HARP) Team, SRS, representatives from both Cardiff and Vale of Glamorgan Councils, and a number of UHB teams including the Community Specialised Services Team, LPHT, Infection Prevention and Control Team (IP&C), Nurse Assessor Team and Hospital Discharge team.

3.5 Scaling Up

All regional partner organisations have existing business continuity plans to be enacted in the event of emergency situations. As a partnership, we also have experience of working collaboratively to deliver a pandemic response. During 2024/26, we will continue work started during 2023/24 to develop a repository of relevant documents and procedures that were used during the pandemic as a 'grab bag' that could be drawn on rapidly in a future pandemic or COVID Urgent scenarios. We also intend to undertake further scenario planning to test our regional responses as a tool to develop a shared understanding of the role of each organisation in a future emergency. This work would involve close collaboration with health board emergency planning colleagues and would need to be set in the context of national pandemic planning, with consideration of links with the civil contingencies arrangements.

3.6 Engagement and Communication

Communication professionals from all partner organisations are key members of the health protection response team for both acute and planned responses. There were established linkages between partnership communications teams which were further strengthened during the COVID-19 response; the ability to mobilise communication rapidly across the partnership is a positive legacy of the pandemic response. As noted previously, in general the Public Health Wales Communication Team will take the lead for communications to both public and professionals in relation to acute communicable disease incidents and outbreaks. Depending on the topic and situation, any of the local partner organisations may lead communications related to planned communicable disease related activity. Partner reflections on the first year of the plan have included the need for an external and internal communications strategy for the partnership, which will form part of this year's strategic action plan.

4. Strategic Action Plan

This year's action plan includes actions identified by partnership members as priorities for the period ahead, in addition to those actions not fully completed in the lifetime of the previous plan and therefore carried over.

Action Area	Action	Lead	Timescale	Measure of success
New/acute case response	Complete the scope and develop extended roles for Health Protection Officers	SRS Service Lead	September 2025	Roles described
	Update and extend SOP to map out main contacts for each organisation and key settings	Health Protection Manager	September 2025	SOP complete
	Expand suite of SOPs to guide regional response to "all hazard" acute cases, identifying project support to action	Health Protection Manager/ Consultant in Public Health	September 2025	SOP complete
	Develop a model for contact tracing support for a variety of settings for the benefit of the partnership health protection response, taking into account the available national resource	SRS Service Lead/ Health Protection Manager/ Consultant in Health Protection	September 2025	Roles and requirements clearly described
	Strengthen relationship between partnership and primary care, specifically around clarifying the "ask" in terms of support for health protection cases and incidents (prescribing of prophylaxis, etc) and the differing responses required in working hours and out of hours	Consultant in Health Protection/ Consultant in Public Health	September 2025	Action complete
Governance, monitoring and enabling functions	Review governance and operational structure requirements to support model, including meeting frequency, identifying project support to action	Consultant in Health Protection/Director of Public Protection/Consultant in Public Health / Health Protection Manager	December 2025	Requirements reviewed
	Identify digital and data needs of partnership, in terms of information sharing to improve cross-working and collaboration, and feed into Clinical Digital Design Group	Community Specialised Services	December 2025	Partnership needs fed into group discussions and plans

Action Area	Action	Lead	Timescale	Measure of success
Governance, monitoring and enabling functions *(continued)*	Development of communications and engagement strategy for partnership, including both external and internal communications activities and consideration of patient and public involvement in partnership planning and activities	Senior Communication and Engagement Officer	September 2025	Strategy in place
Environmental incident response	Scoping of how partnership can add value to the response to environmental hazards (including both CBRN risks and incidents, and climate change) and setting principles for engagement	Consultant in Health Protection/Director of Public Protection/Consultant in Public Health / Health Protection Manager	March 2026	Action complete
Planned/ preventative management	Implement actions for 2024/25 and 2025/26 identified in Hep B/C Elimination Plan	Consultant in Public Health	March 2026	Actions delivered
	Identify priority delivery areas for Cardiff and Vale from the HIV Action Plan for Wales 2023-2026	Clinical Director or HIV Lead Consultant for Dept of Sexual Health / Consultant in Public Health/ Director of Public Health	September 2025	Priorities identified
	Implement priority regional actions for 2023/24, identified in 'Elimination of Tuberculosis: An Action Plan for Wales 2023-2030'	Lead TB Clinical Nurse Specialist/ All Wales TB Nurse Consultant	March 2026	Priorities identified and implemented
	Strengthening of relationships with third sector, including consideration of role of third sector in streamlining and facilitating engagement with underrepresented groups, improving availability of services and equitable access to them, engagement with community anchor institutions, and consideration of role of third sector in supporting acute incidents/ future pandemic scenarios building on experiences from COVID-19	Consultant in Health Protection/Director of Public Protection/Consultant in Public Health / Health Protection Manager	September 2025	Improved working relationships and pathways in place

Action Area	Action	Lead	Timescale	Measure of success
Planned/ preventative management *(continued)*	Increased collaboration between services targeting the same populations for screening/testing/treatment, to avoid duplication of effort/ fatiguing patients with multiple contacts, and to ensure a "no wrong front door" approach, including sharing of resources such as outreach van	CAVHIS/DOSH/TB/BBV/ Community Specialised Services	September 2025	Improved collaborative working
	Deliver actions identified in Health Protection business case to support health inclusion groups	CAVHIS Clinical Director	March 2026	Actions delivered
	Support PHW in their work to implement actions identified as requiring collaborative working with health boards identified in Communicable Disease Inclusion Health Programme Strategic Workplan 2024-2027, including TB in inclusion health groups and actions arising from pending scoping review of likely impact of climate change on inclusion health groups	Consultant in Public Health	March 2026	Actions delivered
	Provide improved support to individuals in contact with probation services	Task and Finish Group	September 2025	Action plan in place
	Scoping of opportunities to work more closely with specific settings, to include early years settings and universities, identifying infectious disease risks and mitigating through education, information, testing and vaccination	SRS Service Lead / Health Protection Manager/ Consultant in Public Health	September 2025	Scoping complete and actions identified
	Continue to disseminate and promote educational opportunities for care settings providers, including dissemination of IP&C workbooks, with a view to increasing confidence in infection prevention and control	SRS Service Lead / Health Protection Manager	March 2025	Action complete
Scaling up	Confirm regional plans to scale up the regional health protection response in the event of a COVID Urgent or future pandemic scenario, and hold pandemic planning workshops.	Consultant in Health Protection/Director of Public Protection/Consultant in Public Health/ Emergency Planning Lead	May 2025	Action complete
	Develop document repository containing key resources for future COVID Urgent/ pandemic situations	Consultant in Health Protection/Director of Public Protection/Consultant in Public Health	May 2025	Plans complete

5. Key Performance Indicators/ Targets

Metric	Baseline	Target
Four year-olds up to date with all routine immunisations	81.2%*	Increasing uptake to return to pre-pandemic levels and overtake them – target of 84.9% by Q4 2025/26
Uptake of MMR 2nd dose in five-year-olds	85.8%*	Increasing uptake to return to pre-pandemic levels and overtake them – target of 89.3% by Q3 2025/26
Uptake of flu vaccine in clinically at-risk groups (6 months – 64 years of age)	36.2%**	Increasing uptake of winter respiratory vaccinations with an upward trajectory towards national targets.
Uptake of influenza and COVID-19 vaccine in health board employees with direct patient contact	37%** for flu, 41% for COVID-19.	Increasing uptake of winter respiratory vaccinations with an upward trajectory towards national targets – 70% target for flu by Q4 2024/25, 75% target for COVID-19 by Q4 2025/26
Coverage of COVID-19 vaccine in all eligible people	61.83%***	Increasing uptake of winter respiratory vaccinations with an upward trajectory towards national targets.
Uptake of HPV vaccine (one dose) by age 15	59.9%*	Increasing uptake towards national target of 90%.
Re-engagement of people with HCV who have not completed treatment and achieved sustained virological response	297 individuals on the re-engagement list	267 on re-engagement list by Q4 2024/25

*COVER quarterly report 150 (January-March 2024)
** IVOR report (April 2024)
*** PHW COVID-19 Surveillance Summary (February 2024)

APPENDIX 1: Mapping of organisations, teams and lead roles contributing to the Health Protection Partnership in Cardiff and Vale Region

Organisation	Lead roles with responsibility for Communicable Disease	Contributing Teams
Cardiff and Vale UHB	Executive Director of Public Health*	Immunisation and Testing Team (including Immunisation Coordinators)
	Executive Director of Nursing	Infection Prevention Control Team
	Health Board Clinical Lead for Microbiology*	Integrated TB Team
		Infectious Disease Team
		Pharmacy/Medicines Management
		Blood Borne Virus Team
		Cardiff and Vale Health Inclusion Service (CAVHIS)
		Department of Sexual Health (DoSH)
		School Nursing Team
		Local Public Health Team
		Substance Misuse
		PRIMARY CARE (commissioned services) – General Medical Services and Community Pharmacy
		UHB Communications Team***
Cardiff Council		Corporate Health and Safety Team
		Social Services
		Cardiff Council Communications Team***
Vale of Glamorgan Council		Corporate Health and Safety Team
		Social Services
		Vale of Glamorgan Council Communications Team***
Shared Regulatory Services**	Director of Public Protection*	Health Protection Partnership Team
		Communicable Disease Team
		Port Health Team
		Food Safety Team

Organisation	Lead roles with responsibility for Communicable Disease	Contributing Teams
Public Health Wales	Consultant in Communicable Disease Control (CCDC)*†^/Consultant in Health Protection (CHP)*†	Regional Health Protection Team
		All Wales Acute Response Team (AWARe) (National Resource)
		Microbiology Services
		Communicable Disease Surveillance Centre (CDSC) (National Resource)
		Vaccine Preventable Disease Programme (National Resource)
		Healthcare Associated Infection and Antimicrobial Resistance Programme (HARP) (National Resource)
		Inclusion Health Team (National Resource)
		Public Health Wales Communications Team (National Resource)***
Third Sector		Cardiff Third Sector Council (C3SC)
		Glamorgan Voluntary Services (GVS)
		Hepatitis C Trust
		Glitter Cymru
		Pride Cymru
		Terrance Higgins Trust
		Substance Misuse Services
Cardiff University		

* Core member of an Outbreak Control Team, as described in the Communicable Disease Outbreak Plan for Wales
** Shared Regulatory Services provide a key link to relevant teams in both local authorities
*** Communication Teams work collaboratively to support health protection aims. In general, the Public Health Wales Communication Team will take the lead for communications to both public and professionals in relation to acute communicable disease incidents and outbreaks.
† Proper Officer for the Local Authority
^ Port Medical Officer

Report Title:	Vale Food Strategy			Agenda Item no.		3.3
Meeting:	Quality Committee	Public	X	Meeting Date:	24/06/25	
		Private				
Status:	Assurance		Approval	X	Information	
Lead Executive:	Claire Beynon, Executive Director of Public Health					
Report Author:	Louise Denham, Food Vale Coordinator					

Background

Food Vale is the Vale of Glamorgan's sustainable food partnership, hosted within the Public Heath Team, Cardiff and Vale UHB. Since 2016, Food Vale has been working with a wide range of partners to build a healthy and sustainable food system in the Vale of Glamorgan. As part of this, we have established a cross-sector Steering Group to help guide this work with representatives from directorates across Vale of Glamorgan Council, Glamorgan Voluntary Services, Cardiff and Vale University Health Board Dietetics, FareShare Cymru, Glamorgan Smallholders, Big Fresh Catering, Natural Resources Wales and Cywain.

Food Vale is part of a national network of food partnerships as part of the Sustainable Food Places (SFP) programme, led by Soil Association, Sustain and Food Matters, with national partners Food Sense Wales coordinating action at the Wales-level. Aligned to the strategic priorities of the Good Food and Movement Strategy, the Cardiff and Vale UHB Shaping Our Future Well-being (2023-2025) and the Vale of Glamorgan Public Service Board, Food Vale has worked collaboratively to progress against the 6 key issues in the SFP framework using a place-based approach (Figure 1).

Figure 1: 6 Key Issues of the Sustainable Food Places Framework

We are seeing a rise in diets lacking diversity, that are high in fat, sugar or salt with excess or inadequate nutrients and dietary components, or a high proportion of ultra-processed foods. In the Vale, 35% of adults aged 16+ report eating at least five portions of fruit and vegetables a day[i], and **46% of 11-16-year old's report that they eat no fruit and veg at all each day**[ii]. The percentage of children aged 3-7 reported to eat at least one portion fruit and veg every day is 89% and 70% respectively[iii].

There are a range of far-reaching adverse health outcomes associated with poor diets, contributing to lower life expectancy and earlier onset of ill health. These include dental caries, type 2 diabetes, cardiovascular disease and some cancers. In the Vale, approximately **17% of 5-year-olds are overweight or obese** and **57% of adults are overweight or obese in the Vale**[iv]; conditions which in turn are strongly associated with several

other health risks and which are projected to cost the Welsh NHS over £465 million per year by 2050 - a cost to society and the economy of £2.4 billion[v].

This is being further exacerbated by the increasing levels of deprivation caused by a combination of inflation and the cost of living crisis. One in five children in the Vale (nearly 5,000) were reported to be living in relative low-income households in 2022/23[vi], and the level of adults aged 16+ living in households in material deprivation doubled between 2019-2023[vii].

Furthermore, because deprivation intersects with many other issues, adverse impacts are disproportionately experienced amongst our most vulnerable groups, leading to systematic differences in health ('health inequalities') that are judged to be unfair and avoidable.

To tackle these problems, it is necessary to work in partnership looking beyond traditional interventions that target individual behaviour and adopt a whole systems approach, addressing the wider economic, social and commercial factors that make it harder to eat healthily (as outlined in Figure 1). Food Vale achieves this by taking an asset-based approach which, on the ground, includes activities such as reconnecting people with their food through growing, cooking and sharing food, and working with partners to develop higher quality school meals.

Current Situation

In 2023, Food Vale began wide stakeholder and community engagement across the local food system to shape the vision for the future, identify priorities for change and co-produce a five-year Vale Food Strategy fit for our future generations.

Over 100 people joined at in-person engagement events (including a workshop targeting young people, and another targeting farmers) where attendees used the three horizons model a tool promoted by Welsh Government and the Future Generations Office to help people think, and better plan for an uncertain future and to think about what the food system is like at present, what our vision for 100 years' time would be, and how we might take steps now to achieve that long term vision.

The outcome of these events, alongside the findings from additional engagement with over 500 people on their experiences of accessing food in the Vale of Glamorgan, were then assessed to integrate other relevant plans and programmes of work, including but not limited to: Good Food and Movement Framework for Cardiff and the Vale of Glamorgan (2024-2030) the Good Food and Movement Implementation plan, the Vale PSB Wellbeing Plan 2023-2028, the Vale of Glamorgan Council's Project Zero Climate Change Challenge Plan 2021 - 2030, Vale of Glamorgan Council Corporate Plan 2025-2030, as well as reflecting wider national priorities outlined in 'Healthy Weight, Healthy Wales: Our long-term strategy to prevent and reduce obesity in Wales', Cymru Can – The Strategy for the Future Generations Commissioner for Wales 2023 - 2030 and the recently published Wales Community Food Strategy.

Following this, we were able to establish our good food goals, desired outcomes, and have agreed 30 actions that the partnership will collectively achieve before 2030. Progress will be measured against each action every quarter, and an annual report will be produced to track progress against priority indicators and key performance indicators.

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

1. The Vale Food Strategy outlines a vision where diet-related illness and resulting health inequities are prevented and tackled further upstream, and shares how we will work together to achieve this vision through ambitious goals, clear outcomes and practical actions.
2. The Vale Food Strategy has drawn on community engagement and has been developed by the cross-sector Food Vale Steering Group.
3. The Vale Food Strategy is integrated with other relevant plans and programmes of work e.g. Good Food and Movement Framework and Implementation Plan for Cardiff and the Vale of Glamorgan (2024-2030).

Recommendation:			
The Committee is requested to: a) APPROVE the Vale Food Strategy 2025-2030			
Link to Strategic Objectives of Shaping our Future Wellbeing: *https://shapingourfuturewellbeing.com/*			
Putting People First 1. **Click the objective above to view more detail.**	X	Providing Outstanding Quality 2. **Click the objective above to view more detail.**	
Delivering in the Right Places 3. **Click the objective above to view more detail.**		Acting for the Future 4. **Click the objective above to view more detail.**	

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

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

Impact Assessment:
Risk: No
Safety: No
Financial: No
Workforce: No
Legal: No
Reputational: No
Socio Economic: No
Equality and Health: Yes – an EHIA is currently being undertaken, cross-referenced with the recent EHIA conducted for the Good Food and Movement Framework.
Decarbonisation: Yes – this work strongly supports the decarbonisation agenda
Welsh Language: Yes

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

[i] National Survey for Wales, data combined from 2021-22 and 2022-3
[ii] The School Health Research Network (SHRN) Survey Data Children's Health & Well-being Dashboard
[iii] Data for the Cardiff and Vale University Health Board 2020-2021 Lifestyles of children aged 3-7 by health board
[iv] Vale of Glamorgan Well-being Assessment 2022

[v] https://www.gov.wales/sites/default/files/consultations/2019-01/consultaton-document_0.pdf
[vi] VOG Council Corporate Plan 2025-2030
[vii] Percentage of people living in households in material deprivation by local authority

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

Vale Food Strategy 2025 – 2030

Louise Denham – Food Vale Coordinator
Cardiff and Vale Public Health Team
Louise.Denham@wales.nhs.uk

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

FOOD Vale BWYD Yfro

Llunio ein Llesiant i'r Dyfodol
Shaping Our Future Wellbeing

Who is Food Vale?

- Food Vale is the Vale of Glamorgan's sustainable food partnership, working with community groups, organisations and businesses to build a thriving, healthy and sustainable food system in the Vale.
- We are hosted within the Public Heath Team, and our cross-sector Steering Group includes representatives from Vale of Glamorgan Council, Glamorgan Voluntary Services, Cardiff and Vale University Health Board Dietetics, FareShare Cymru, Glamorgan Smallholders, Big Fresh Catering, Natural Resources Wales and Cywain (Mentera).
- We are also part of a growing number of food partnerships under the Sustainable Food Places (SFP) programme who are using a systems-led and place-based approach to progress against the 6 key issues in the SFP framework

Food Governance and Strategy
Taking a strategic and collaborative approach to good food governance and action.

Good Food Movement
Building public awareness, active food citizenship and a local good food movement.

Healthy Food for All
Tackling food poverty, diet related ill-health and access to affordable healthy food.

Sustainable Food Economy
Creating a vibrant, prosperous and diverse sustainable food economy.

Catering and Procurement
Transforming catering and procurement and revitalizing local and sustainable food supply chains.

Food for the Planet
Tackling the climate and nature emergency through sustainable food and farming and an end to food waste.

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

Why we need a Vale Food Strategy

- A rise in poor diets is leading to increasing adverse health outcomes, contributing to lower life expectancy and earlier onset of ill health. These adverse impacts are disproportionately experienced amongst our most vulnerable groups, leading to health inequalities.
- To address the wider economic, social and commercial factors that make it harder to eat well, we need to work in partnership and adopt a whole systems approach.
- The Vale Food Strategy outlines a vision where diet-related illness and resulting health inequities are prevented and tackled further upstream, and shares how we will work together to achieve this vision through ambitious goals, clear outcomes and practical actions.

2023 - Community and stakeholder engagement

- Three in-person events using Three Horizons Model, including a workshop targeting young people, and another targeting farmers
- Online survey on experiences of accessing food in the Vale of Glamorgan
- Food Vale Steering Group workshops

2024 - Strategic alignment

- Integrated with key local strategies and programmes of work.
- As well as reflecting wider national priorities:
  - Healthy Weight, Healthy Wales: Our long-term strategy to prevent and reduce obesity in Wales
  - Cymru Can – The Strategy for the Future Generations Commissioner for Wales 2023 - 2030
  - Wales Community Food Strategy

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

FOOD Vale BWYD YFro

2025 - Draft strategy produced

- Identified our good food goals, desired outcomes, and 30 actions that the partnership will collectively achieve before 2030. Example actions include:
  - *Developing and implementing healthy food advertising policies*
  - *Collaborate with partners to map, identify and address areas with high concentrations of fast food outlets across the Vale*
  - *Support roll out of accessible, free and enjoyable opportunities to learn about nutrition and develop cooking skills across the Vale*
- Approved by Food Vale Steering Group and wider key partners, including VOGC Senior Leadership Team

2025-2030 - Measuring progress

Progress will be measured through the following:

- Quarterly updates against each action, including ad-hoc qualitative case studies.
- An annual report will be produced to track progress against priority indicators.
- An analysis to track systems change before and after the duration of the strategy.

Draft Vale Food Strategy

2025-2030

May 2025

Glossary

Throughout this document, words marked **in bold** have been provided with a corresponding definition here.

Access to good food – *access may be effected by a person's financial circumstances, location, mobility, health, or other cultural and social factors.*

Agro-ecological or **agroecology –** *Agroecological food systems are food production systems that apply both ecological (the relationship between plants, animals, humans and the environment) and social concepts and principles (e.g. gender equality, fair pay and working condition) to the design and management of sustainable food and farming systems.*

Carbon sequestration – *the long-term storage of carbon in plants, soils, geologic formations, and the ocean, occurring both naturally and as a result of human activities*

Cash-first approach – *a local approach to food insecurity which prioritises income-focused crisis support by means of cash payments, or vouchers if cash payments aren't available, and advice and support to maximise income.*

Community Supported Agriculture – *Partnerships between farmers (or a growing project) and the local community.*

Circular Food Economy - *A circular economy for food mimics natural systems of regeneration so that waste does not exist, but is instead feedstock for another cycle.*

Food deserts - *Geographic areas lacking direct access to affordable and healthy fresh fruits and vegetables.*

Food Security – *The measure of an individual's ability to access food that is nutritious, safe, and sufficient in quantity. This can be measured at a national, community, or individual level.*

Food System – *The food system is a complex web of activities involving production, processing, transport, and consumption of food. Issues concerning the food system include the governance and economics of food production, its sustainability, the degree to which we waste food, how food production affects the natural environment and the impact of food on individual and population health.*

Good food – *For the purposes of this document, when we talk about 'Good Food', we mean, food that is safe, nourishing, healthy, environmentally sustainable and culturally appropriate.*

Health inequalities - *Systematic differences in health between groups that are judged to be unfair and avoidable.*[i]

Household food insecurity - '*Household food insecurity' (sometimes just referred to as 'food insecurity') is defined as the "uncertainty about future food availability and access, insufficiency in the amount and kind of food required for a healthy lifestyle, or the need to use socially unacceptable ways to acquire food."*

Income poverty – *When people struggle to meet daily needs, such as food, shelter, sanitation and healthcare, despite being in employment.*

Local food - *'Local food' is difficult to define geographically. For the purposes of this document, local food may refer to food within the limits of Vale of Glamorgan, the Cardiff Capital Region, or Wales.*

Lower Super Output Areas (LSOAs) – small geographic areas designed to have a similar population size, used in the Welsh Index of Multiple Deprivation (WIMD). There are 1,896 LSOAs in Wales each with a population of about 1,500 people.

Material Deprivation - *The enforced inability (rather than the choice not to do so) to pay unexpected expenses, afford a one-week annual holiday away from home, a meal involving meat, chicken or fish every second day, the adequate heating of a dwelling, durable goods like a washing machine, colour television, telephone or car, being confronted with payment arrears (mortgage or rent, utility bills, hire purchase instalments or other loan payments*

Public plate – *Food served by public institutions e.g. in schools, hospitals and care homes, often referred to in relation to its potential to harness the power of purchase to secure public health, social justice and ecological integrity.*

Regenerative agriculture – *A holistic approach to farming which seeks to improve the land and surrounding environment by increasing biodiversity and resilience.*

Sustainability - *meeting the need of the present without compromising the ability of future generations, encompassing environmental, social and economic aspects.*

Waste hierarchy - *Sets out the order in which options for waste management should be considered based on environmental impact. It is a useful framework that has become a cornerstone of sustainable waste management*

Well-being Economy - one that prioritises the wellbeing of our people and our planet

Acronyms

CAVUHB – Cardiff and Vale University Health Board

CCC – Climate Change Committee

CFS – Community Food Strategy

GHG(s) – Greenhouse Gas(es)

HFSS – High in Fat, Sugars or Salts

IPCC - Intergovernmental Panel on Climate Change

LDP – Local Development Plan

LSOAs – Lower Super Output Areas

LULUCF – Land Use, Land Use Change and Forestry

PSB – Public Services Board

SFP – Sustainable Food Places

SLM – Sustainable Land Management

VOG – Vale of Glamorgan

VOGC – Vale of Glamorgan Council

Contents

Foreword

Food connects us—to each other, to our health, to our environment and to the land we call home. In the Vale of Glamorgan, we are proud of the foundations we've already built: working with passionate farming communities, thriving local food producers, and inspiring community-led initiatives that have helped start to shape a vibrant, growing local good food movement. From embedding local produce into school menus to hosting food trails that showcase our local food businesses, we've shown what's possible when we work together.

Food is one of the most powerful ways in which we can support our health and well-being, as individuals and communities, both now and for future generations. Yet today, not everyone has equal access to good food, and too many face adverse health outcomes as a result, including physical manifestations such as obesity and diabetes, as well as impacts on mental well-being. This strategy recognises both the challenges and the opportunity to reconnect food with well-being, and aligns firmly with the principles set out in Cardiff and Vale UHB's Good Food and Movement framework.

Commented [LD(aVU-PH1]: Link pending

We also recognise that food carries meaning beyond good nutrition alone—it shapes our identity, tells our stories, and brings us together. Whether through shared meals, and connecting with local produce, or grass roots school and community growing projects, the social and cultural power of food helps strengthen the fabric of our communities and promotes a well-being economy when it comes to food production and supply. Through this strategy, as well as the Council's Vale 2030 - Corporate Plan, we commit to building strong communities with a bright future.

Our farming sector is also at the heart of our approach. The land and those who steward it are essential to any vision of good food. We must support farmers to thrive, not just as food producers but as key partners in protecting nature, tackling climate change, and sustaining local economies. This strategy recognises that we can only move forward by working closely with our farmers and growers, valuing their knowledge, and investing in a future that works for them and the land as part of the Vale's Project Zero ambitions.

We acknowledge that there are limitations—no single strategy can solve every challenge, and many issues extend beyond our local control. However, by balancing ambition with what is realistic and achievable, we believe that we can make meaningful progress and create lasting change.

This strategy reflects our shared vision for a food system that is fairer, healthier, and more sustainable. It outlines an ambitious yet practical path forward—guided by clear goals, measurable outcomes, and collaborative action—while celebrating our achievements to date and everything that makes the Vale such a unique and vibrant place.

Together, we can build a food system that truly works for people, place, and planet.

Claire Beynon
Director of Public Health
Cardiff and Vale University Health Board

Rob Thomas
Chief Executive
Vale of Glamorgan Council

1. Why do we need a local food strategy?

There is a lot to be proud of already when it comes to our local food system in the Vale, as the examples in the Foreword illustrate. This strategy provides an opportunity to build on these strong foundations, setting out a trajectory towards our shared vision for the future through ambitious goals, clear outcomes and practical actions.

Food is a tool for wider positive change

Our **food system** exists at the intersection of many different issues; from climate change and planetary health, to public health and diet-related illnesses. Whilst this renders it a very complex and multifaceted subject, there is also therefore huge potential for the food we eat to have positive effects on our environment and health, which can reduce health care costs.

The Vale Food Strategy 2025-2030 sets out how – by working in partnership and thinking strategically – we can harness the potential of food as a tool for wider positive social, economic and environmental outcomes on a local and regional scale.

People want change in their local food system

The National Citizen Manifesto, developed by the *Food, Farming and Countryside Commission* and due to be launched later in 2025, shows that people want change: with increased leadership across the four nations, healthier food environments, more connected communities, stronger standards, better support for farmers. The contributions captured during the public engagement carried out as part of the development of this Strategy echo this sentiment, and Food Vale will continue to listen to local communities to ensure we can respond to the change that is desired.

Future proof

National Infrastructure consists of those facilities, systems, sites, information, people, networks and processes necessary for a country to function and upon which daily life depends. In the UK, there 13 Critical National Infrastructure Sectors; food is one of them.

Our current food system is extremely fragile and vulnerable to shocks from wider political, economic, health, social, military and environmental events[1]. This includes extreme weather events such as drought, flooding and extreme heat which are becoming increasingly frequent and are already causing shortages and increases in the price of commodities. Additional examples include the disruptions to food supplies caused by the Covid-19 pandemic, food inflation resulting from the war in Ukraine and subsequent cost of living crisis. Current and future global geo-political instability will also continue to have an impact on our food systems. By valuing diversity (across all areas of the food system), improving our understandings of local needs and building local capacity and networks, this Strategy will seek to make a stronger, more resilient local food system. We acknowledge that there may be restrictions to what we can do due to limited resources and the lack of a long-term national food strategy. We also, however, anticipate that this might not always be the case. For example, in 2022 Scotland adopted the Good Food Nation Act which placed legal duties on local authorities and health boards to produce and report on food plans. The Vale Food Strategy will help us focus on the areas where we can have most impact, as well as enabling us to adapt to future changes in legislation.

2. About Food Vale

Food Vale is a partnership of dedicated individuals, community groups, organisations and businesses working together to build a thriving, healthy and sustainable food system in the Vale. The partnership is hosted within Cardiff and Vale University Health Board's Public Health Team, and has established a cross-sector Steering Group to help guide this work with representatives from directorates across Vale of Glamorgan Council, Glamorgan Voluntary Services, Cardiff and Vale University Health Board Dietetics, FareShare Cymru, the Vale of Glamorgan Public Service Board, Glamorgan Smallholders, Big Fresh Catering, Natural Resources Wales and Cywain.

We are part of a growing network of food partnerships taking a place-based, systems approach to healthy and sustainable food under the UK-wide Sustainable Food Places (SFP) programme. Across Wales, 22 food partnerships already exist, 10 of which are active members of the Sustainable Food Places programme. Food Vale is able to connect with and learn from food partnerships from across all four nations, especially with other food partnerships from across Wales through Food Sense Wales – the national delivery partner of SFP in Wales.

Since first convening in 2017, Food Vale has hosted festivals, run food trails, invested in community food growing projects and food pantries, supported cookery and nutrition skills workshops and gone on to achieve the Bronze Sustainable Food Places award. We also work closely with partners at all levels to ensure that food is embedded in wider strategic work. Anyone can be a part of the Food Vale partnership: once every three months, we host an in person gathering to give everyone the chance to connect, share ideas, and form a collective voice for change.

The Vale of Glamorgan Public Services Board brings together the county's public service leadership and decision makers to improve the well-being of people in the Vale today, and for future generations. The partnership's objectives, actions and priority workstreams are articulated in their Well-being Plan 2023-2028 with links to our work supporting the achievement of all three objectives (a more resilient and greener Vale, a more active and healthier Vale, and a more equitable and connected Vale). PSB members and Cardiff & Vale UHB Public Health Team, have recently published a six-year regional framework and two-year implementation plan entitled 'Good Food and Movement', which all PSB partners are signed up to achieving. In support of healthy weight, and through taking a whole system approach, the vision for Good Food and Movement is to create environments, settings and opportunities that enable good food and movement for everyone.

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Food Vale supports calls from the Future Generations Commissioner for Welsh Government to develop a national food resilience plan to ensure equal access to local, affordable, healthy, and sustainable diets framed within the Well-being of Future Generations Act.

Food Vale would like to thank everyone who has contributed to this strategy, and all those who continue to work – in whatever way they choose – to help us build a healthy and sustainable food system in the Vale.

3. National Context

Wales has devolved political responsibility and accountability for a number of food-related areas of legislation and policy, including: education, environment and planning, economic development, public health, and agriculture. The work of food partnerships and the proposed actions and outcomes outlined in this document align well with these areas.

The food system is vital for the delivery of the Well-being of Future Generation's (Wales) Seven National Well-being Goals. Food has been identified as a priority area of focus in the Future Generation Commissioner's Well-being of Future Generations strategy 'Cymru Can', stating that "from farm to fork, food is critical to achieving Wales' well-being goals from the health of our people and our planet". The Commissioner plans to work with public bodies to integrate sustainable food policies within their well-being plans, including developing community food plans, to make improvements at a local, place-based level.

The Welsh Government have recently published the Wales Community Food Strategy (CFS) as their commitment to encourage the production and supply of locally-sourced food in Wales. An overview of the priority Welsh Government policies and activities which directly support the agri-food industry, natural resource management, and wider food related policies across the span of its work for health, education, sustainability, communities and the economy are outlined in the 2024 Food Matters: Wales publication. In addition to this, since 2022 Welsh Government's Tackling Poverty team have been supporting the cross-sector, systems-led work of food partnerships across Wales. The Welsh Government's ambition to shift the population's diet closer to the Eatwell Guide is captured through their 10 year-strategy Healthy Weight, Healthy Wales, focussed on preventing and reducing obesity. Additionally, the new High Fat Salt Sugar (HFSS) Regulations which are expected to be implemented from 2026 will restrict the ways in which HFSS foods can be promoted.

In 2024, How Could Wales Feed Itself by 2035? a report from the Wales Net Zero 2035 Challenge Group[1] highlighted how the food system is critical to our success in addressing climate change, the nature crisis and ensuring the well-being of Wales. Public procurement is recognised as a powerful tool with two pieces of legislation introduced in 2023 to provide opportunities for change: the Social Partnership and Public Procurement Act (Wales) and the UK Procurement Act. The Net-Zero Wales Carbon Budget 2 2021-2025 is shaped by its statutory reporting commitments, IPCC and CCC recommendations and includes policies and proposals related to Public Sector, Waste Management, Land Use, Land Use Change and Forestry (LULUCF), Agriculture, Industry and Business, Residential Buildings, Transport, Electricity and Heat Generation.

The Welsh Government recognise the importance of agriculture and sustainable food production as well as the important interlinked social and cultural aspects of farming in Wales. The Sustainable Land Management (SLM) objectives were established in the Agriculture (Wales) Act. The SLM objectives are: sustainable production of food and other goods; mitigating and adapting to climate change; maintain and enhance the resilience of ecosystems and the benefits they provide; conserve and enhance the countryside and cultural resources and promote public access to and engagement with them, and to sustain the Welsh language and promote and facilitate its use. The Sustainable Farming Scheme which is currently in the final stages of co-design at the time of writing this strategy, will help achieve these objectives and will reward farmers for actions which align with them.

[1] A group of independent experts selected from across academia, public and private institutions established in 2023 to deliver on a specific commitment in the formal Co-operation Agreement between the Welsh Government and Plaid Cymru.

4. Spotlight on the Vale

Land Use, Waste and the Climate and Nature crises

- The Vale of Glamorgan has a rich agricultural heritage with 75% (24,788Ha) of its land being farmed (in 2020)[ii]. Whilst recent local data for the breakdown by usage is not available, national data for across Wales is likely to be a fair representation, which in 2024 was: permanent grassland 62%, rough grazing 14%, new grassland 9%, arable crops including horticulture 6%, and other land (including farm woodland, buildings and land not for agricultural purposes) 9%[iii]. Only 0.1% of land in Wales is used to grow fruit and vegetables – enough to supply one quarter of a portion per person per day. To produce '5 a day' for the Welsh population would need 29 times more land[iv].

- The suitability of agricultural land for food production depends on climate, site and soil factors, and is categorised into different grades, with Grade 1 indicating high-yielding land with little or no limitations for agricultural use, to Grade 5 as very poor, low quality agricultural land. In the Vale, 7% of our agricultural land is classed as Grade 2; 14.2% is Grade 3A, 35.7% as 3B and 17.8% is Grade 4 (with negligible Grand 1 and Grade 5)[2].

- Following their declaration of a climate and nature emergency, the PSB produced their Climate Emergency Charter, setting out their key actions for managing and limiting the impacts of climate change, this has been revised and in 2025 a new climate and nature emergency charter published. The Council's plan to achieve net-zero by 2030 is captured through the Climate Change Challenge Plan Project Zero. The Director of Public Health's Annual Report 2022 'Recall of the Wild' acknowledged the importance of biodiversity for human health.

- In the 'Let's Talk about Life in the Vale' residents survey 2023, 68% of respondents were concerned with the climate emergency and 65% were concerned with the nature emergency[3]. Carbon emissions in the Vale were measured at 7.97 tonnes per person in 2022, a fall on previous years, but still 1.47 tonnes higher than the Welsh average[v].

- Addressing the environmental impact of our local food system, including opportunities for increasing **carbon sequestration**, will require adopting sustainable land management practices. Positive progress will be made by working through the Sustainable Farming Scheme and with local farmers and landowners to diversify, and adopt organic, **agro-ecological**, regenerative and/or wildlife-friendly practices. This will generate improvements in productivity, air, water, soil health and biodiversity; reductions in pests and diseases; as well as potentially leading to healthier foods and improvements in farm incomes. This Food Strategy recognises that agriculture is an industry itself which is highly vulnerable to the climate crisis[vi].

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[2] Under Paragraph 4.10.1 of Planning Policy Wales states that land of grades 1, 2 and 3a is the best and most versatile, and should be conserved as a finite resource for the future
[3] Either 'very' or 'fairly' concerned

- Other important ways we can address the climate and nature crisis through our local food system include increasing food literacy to support more sustainable diets, and implementing the **circular food economy** e.g. through community recycle/reuse/compost. Since 2017/18 the Vale's recycling rate (including food) has increased from 63.2% to 70.4%, exceeding the statutory recycling rates set by Welsh Government.[vii]

Local Food Economy

- Shifting to a healthier, more local and sustainable food system makes economic sense: the current 'hidden' external costs of our food system, such as health costs, environmental costs, natural capital degradation, GHG emissions and food loss and waste, are estimated to be £40bn–£96bn per year[viii].
- The food sector in Wales has grown rapidly in recent years, valued at £9.3billion in 2023[ix]. Food-related economic activities in the Vale of Glamorgan include farming and other primary production, manufacture, retail, catering and hospitality. In 2023 there were 5,000 employed in the Accommodation and Food Services industry in the Vale. The local retail sector is seeing a shift away from retail towards leisure (food, beverage, and entertainment).
- The bulk of livestock production from commercial farms in Wales (likely representative of the Vale) comes from Cattle (Beef and Dairy) and sheep, followed by arable with a smaller concentrated production from poultry (meat and/or eggs) on some units. Agriculture is also important culturally, particularly in the Vale, where the majority of farms are small-scale family-run farms which support the prosperity and well-being of rural communities.
- There are 1251 food businesses registered with the Food Standards Agency. Most businesses (94.2%) in the Vale are classed as micro-businesses (0-9 employees)[x], and there is a small but growing number of horticultural business operations, as well as small-scale food and drink producers, who are demonstrating commitments to sustainable practices as well as innovations in low-carbon methods.
- Food and farming businesses have faced many challenges relating to the 'triple challenge' of Covid-19, climate change and Brexit. The associated changes to trade deals, regulations and immigration policies resulting from Brexit have caused staffing and skills gaps, challenges related to increases in the costs of energy[xixii], supply chain gaps, as well as challenges around access to markets and lack of local supply chain infrastructure for primary producers.
- More spend allocated to local food businesses can improve not only the financial sustainability of these businesses but also the local economy overall. Research shows that for every £1 spent with a local small or medium-sized business, around 63p remains in the local economy. This extends to investments into farming – a 2017 report from Development Economics[xiii] calculated that for every £1 invested in farm support, £7.40 is returned to the economy.
- A key way that public bodies can strengthen our local food economy is by prioritising local, sustainably produced food through public procurement. Sustainable and ethical sourcing of food and drink products along with supporting the local economy and employment is embedded into the Vale of Glamorgan Councils Procurement Policy and Strategy. Public sector food procurement in Wales is worth approximately £84.7 million per annum, with Local Government and NHS Wales together accounting for more than 80% of that. Whilst procurement models have traditionally excluded small and local suppliers (currently, 94% of veg in Welsh schools comes from outside of Wales, and none of it is organic[xiv]), there has been recent progress towards more local and sustainable procurement with a focus on social value and local wealth creation. This will have the added benefit of reducing our dependency on imports via increasingly fragile global food supply chains, therefore significantly improving our food security[xv].

Community and health

- The health of our local populations, the food they eat and deprivation levels are strongly interrelated. According to the Welsh Index of Multiple Deprivation, 3 **Lower Super Output Areas** (LSOAs) in the Vale are in the top 10% most deprived areas in Wales, with 7 more in the next 10% (all of which are in Barry). A further 13 LSOAs are in the 30-50th most deprived, including areas typically considered rural such as Dinas Powys 3, St Athan 1 and Llantwit Major 6[xvi].
- A combination of inflation, wage stagnation and real-terms cuts to benefits is increasing deprivation levels, further exacerbated by the global Covid-19 pandemic and Cost of Living Crisis. One in five children in the Vale (nearly 5,000) were reported to be living in relative **low-income households** in 2022/23[xvii], and the level of adults aged 16+ living in households in **material deprivation** doubled between 2019-2023[xviii].
- In the 2024 Vale Food Insecurity survey, 4% of adults reported going hungry because they did not have enough to eat; 14% struggled to have enough food; and 12% worried about having enough food. 33% cited high food cost as the biggest challenge when accessing food, followed by location/distance of places to get food (17%), availability of food (17%), budgeting priorities (17%) and availability of preferred foods (16%)[xix]. Amongst the top responses to 'what would help them access, cook and eat good food' was 'more opportunities to grow your own food' and 'cooking workshops'. The Priority Places for Food Index[4] identified that many areas in the Vale are high priority for supermarket proximity and accessibility, indicative of **food deserts**[xx]**.**
- There are about 20 food banks and community food initiatives offering free or low-cost food across the Vale[5]. Between 2023-24 the number of food parcels distributed in the Vale of Glamorgan increased by 2,064 parcels (24%) to 8,662 - the highest increase across Wales. Many initiatives report that they are struggling to meet demand – with Trussell Trust Food banks experiencing a 64% increase in demand in 2023.
- Because healthier foods tend to be more expensive than foods that are high in fat, sugar or salt (HFSS)[xxi], we are seeing a rise in diets lacking diversity, with excess or inadequate nutrients and dietary components, or a high proportion of ultra-processed foods. In the Vale, 35% of adults aged 16+ report eating at least five portions of fruit and vegetables a day[6], and worryingly 46% of 11-16-year olds report that they eat no fruit and veg at all each day[xxii]. The percentage of children aged 3-7 reported to eat at least one portion fruit and veg every day is 89% and 70% respectively[xxiii].
- There are a range of far-reaching adverse health outcomes associated with poor diets, contributing to lower life expectancy and earlier onset of ill health. These include (but are not limited to) dental caries, type 2 diabetes, cardiovascular disease and some cancers[xxiv] as well as emerging evidence of adverse impacts on the gut microbiome[xxv] and impacts on mental health and behaviour[xxvi]. Approximately 17% of 5-year-olds are overweight and 57% of adults are overweight or obese in the Vale; conditions which in turn are strongly associated with several other health risks and which are projected to cost the Welsh NHS over £465 million per year by 2050 - a cost to society and the economy of £2.4 billion[xxvii].

[4] Identifies neighbourhoods that are most vulnerable to increases in the cost of living and which have a lack of accessibility to cheap, healthy, and sustainable sources of food
[5] A directory of these schemes is available on the Food Vale webpage 'Where can I get support?'.
[6] National Survey for Wales, data combined from 2021-22 and 2022-3

- Food insecurity intersects with many other issues[7], causing adverse impacts to be disproportionately experienced amongst our most vulnerable groups, leading to systematic differences in health (‘**health inequalities’**) that are judged to be unfair and avoidable, and which are expected to increase.
- This strategy recognises that, to tackle these problems, traditional interventions that target individual behaviours and decisions are unlikely to be sufficient on their own, and instead strategic change addressing the wider economic, social and commercial factors that make it harder to eat healthily will be required.

[7] For example, socio-economic status, geography, as well as characteristics listed under the Equality Act 2010 such as age, gender, race, disability, sex, sexual orientation and religion and beliefs.

5. Voices from the Vale

Although authored by Food Vale, this Food Strategy is the culmination of many years of conversations with partners across our local food system.

The new five-year strategy has been co-designed to reflect the Vale of Glamorgan's unique opportunities, challenges, communities and economy.

When we first started out on developing a local food strategy, we decided that we wanted it be characterised by the following:

- **Ambitious** – *thinking into the long term, not getting caught in the trap of short-term thinking*
- **Place-based** - *reflecting our local challenges and opportunities, and existing policies/strategies*
- **Inclusive** – *capturing the shared values of all partners of issues relating to food and farming*
- **Realistic** – *something that all our partners could sign up to, not something that just sits on the shelf*

These values together with the national Well-being Goals and the five ways of working are at the heart of what we do. The five ways of working - Involvement, Prevention, Collaboration, Long-term, and Integration are evident across all our objectives and have been integral to how we have developed our plan.

To launch the process, over 60 people joined together in November 2023 in Barry Memo Arts Centre to discuss the future of food and farming in the Vale. Attendees used The Three Horizons (3H model) – a tool that is widely promoted by Welsh Government and the Future Generations Office to help people think, and better plan for uncertain future(s) – to think about what the food system is like at present, what our vision for 100 years' time would be, and how we might achieve that vision. This was followed by two further engagement events in 2024: one which we invited students from across the Vale to input on the future of their local food system, and another aimed at local food producers to gain their insights on what needs to be done.

The outcome of these events, alongside the findings from additional engagement with over 500 people on their experiences of accessing food in the Vale of Glamorgan, informed the first draft of the strategy. Whilst these conversations will continue as more partners are brought into the discussions, the input we have had so far has highlighted many overlapping themes, which you will see reflected in our Good Food Goals and Desired Outcomes. The Desired Outcomes will be used as indicators of the success of our strategy. There is a comprehensive action plan with key partners to work towards achieving the vision.

6. What do we want food and farming to look like in the Vale in 100 years' time?

"In the year 2124, the Vale of Glamorgan is home to a sustainable local food system that is healthy, thriving, fair, globally responsible, regenerative and resilient, that actively supports our health and well-being, restores nature and tackles the climate emergency.

Everyone has the resources to access food that is safe, enjoyable, nourishing, seasonal, healthy and culturally appropriate, and can access the spaces and opportunities they need to learn and develop skills in growing, cooking and nutrition.

Everyone is able to shape their local food system, and is committed to playing their part in co-creating a healthy and sustainable food system for all. Communities have the skills and tools they need to build a resilient food culture, and our key institutions lead by example by serving good food in schools, hospitals and workplaces.

In the year 2124, good food has been designed into our spaces, with a vibrant local food economy, and the people who grow, make, sell and serve our food are valued, respected and supported."

7. Good Food Goals

- **Fair and Healthy**
    - Everyone in the Vale can access food that supports their health and well-being
- **Circular food economy**
    - Food is produced and consumed in a way that minimizes our use of the world's resources, contributes to food security, cuts waste and tackles the climate and nature emergency
- **Community resilience**
    - Communities have the skills and tools they need to build a resilient food culture

8. Desired outcomes by 2030

1	Enjoyable, nourishing, healthy; and culturally appropriate food can be accessed by all.
2	People in the Vale see a greater proportion of healthy and sustainable food messages across physical and digital spaces.
3	More local businesses are growing, producing, selling and serving healthy and sustainable food in the Vale, and these businesses are supported and valued.
4	More food is produced locally by businesses adopting organic, **agro-ecological**, regenerative and/or wildlife-friendly practices.
5	More healthy and sustainable food served on the **public plate** by harnessing local supply chains.
6	Food waste is minimised and managed according to the **waste hierarchy**.
7	People in the Vale will have more opportunities to learn about and develop skills in growing, cooking and nutrition.
8	People in the Vale will have more opportunities to grow their own fruit and vegetables, cook and eat together.
9	There are more opportunities for more voices to be heard in the local good food movement, with more opportunities to influence the food system.

9. Actions

Desired Outcomes	Actions	Suggested lead delivery partner(s)	Timeline	Alignment with Well-being Goals
Enjoyable; nourishing; healthy; and culturally appropriate food can be accessed by all.	1. Work to gain further understanding of lived experience of food insecurity across the Vale and highlight key opportunities to help tackle health inequalities and improve **access to good food** locally.	Food Vale Insecurity Working Group	Short term	*Resilient, Healthier, More Equal, Cohesive communities, Globally responsible*
	2. Explore options to adopt a **cash-first approach** to tackling food insecurity: providing financial assistance directly to residents in crisis, including to people without recourse to public funds.	Food Vale Insecurity Working Group, Vale of Glamorgan Council	Medium term	*Resilient, Healthier, More Equal*
	3. Expand and strengthen existing services and initiatives aimed at those at risk of or experiencing food insecurity.	Food Vale Insecurity Working Group, CAVUHB Public Health Team, CAVUHB Public Health Dietetics, Big Fresh Catering Ltd, Vale of Glamorgan Council	Ongoing	*Resilient, Healthier, More Equal, Cohesive communities, Vibrant culture and thriving Welsh language*
	4. Encourage healthier and more sustainable food and drink offerings in convenience stores, vending machines, hot food takeaways or other local retail settings	CAVUHB, CAVUHB Public Health Dietetics, Food Vale	Ongoing	*Resilient, Healthier, Globally responsible*
	5. Encourage partners to sign up to become Real Living Wage and Real Living Hours Accredited employers for all staff and agency workers.	Food Vale	Long term	*Prosperous, Resilient, More Equal*
A greater proportion of healthy and sustainable food-related messages	6. Develop and implement Healthier Advertising policies where possible to restrict High Fat Sugar Salt advertising across owned/managed sites and assets; gaining insight from communities, young people and wider stakeholders to inform policy change; and explore an agreed definition of 'sustainable' advertising.	Vale of Glamorgan Council, CAVUHB Public Health Team	Medium to long term	*Healthier*
	7. Use varied communication channels (social media, newsletters and posters etc) in English, Welsh and community languages to raise awareness of nutritious and sustainable food.	Vale Food Insecurity Working Group, Vale of Glamorgan Council, Food Vale, CAVUHB	Ongoing	*Resilient, Healthier, Vibrant culture and thriving Welsh language, Globally responsible*
	8. Collaborate with partners to map, identify and address areas with high concentrations of fast food outlets across the Vale, particularly where linked to deprivation, and advocate for supportive legislative change from Welsh Government.	CAVUHB Public Health Team, Vale of Glamorgan Council	Medium term Medium to long term	*Healthier, More equal, Cohesive communities*

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More businesses are growing, making, selling and serving healthy and sustainable food in the Vale and these businesses are supported and valued.	9. Champion local businesses which are growing, making, selling and serving food that is good for people, place and planet, and signpost to wider support and opportunities.	*Food Vale,* Vale of Glamorgan Council*, Cywain*	*Ongoing*	*Prosperous, Resilient, Healthier, Cohesive communities, Vibrant culture and thriving Welsh language, Globally responsible*
	10. Explore opportunities to improve local food supply chain infrastructure, considering facilities for incubator support, business skills training, business promotion, food waste and food packaging collections and the potential development of an agri-hub.	Food Vale, Vale of Glamorgan Council	Medium term	*Prosperous, Resilient, Healthier, Cohesive Communities, Vibrant culture and thriving Welsh language, Globally responsible*
	11. Support on-farm diversification and innovation to add value to products to facilitate the implementation of a fair and just transition to the Sustainable Farming Scheme in the Vale.	Food Vale, Vale of Glamorgan Council		*Prosperous, Resilient, Vibrant culture and thriving Welsh language, Globally responsible*
	12. Identify Local Development Plan (LDP) policies which impact on good food and farming and explore opportunities to strengthen focus where appropriate as part of the Replacement Local Development Plan.	Vale of Glamorgan Council, Food Vale, CAVUHB Public Health Team	Short term	*Prosperous, Resilient, Healthier*
More food is produced locally by businesses adopting	13. Support existing and prospective local commercial horticultural projects in the Vale to increase the volume of veg produced and find routes to market, with consideration of how activities can align to existing standards as well as other food, waste, energy systems to optimise impact.	Food Vale, Vale of Glamorgan Council	Ongoing	*Prosperous, Resilient, Healthier, Globally responsible*

organic, **agro-ecological**, regenerative and wildlife-friendly practices.	14. Work with partners, landowners (including the Council), existing producers and new agricultural practitioners to explore opportunities to - improve access to land, infrastructure and skills to meet local food demands through local knowledge transfer and peer-learning/mentor programmes. - enhance biodiversity and mitigate/adapt to climate change - Decrease the use of pesticides on partner land, verges and parks.	Food Vale, Vale of Glamorgan Council, Local Nature Partnership	Medium term	*Prosperous, Resilient, Healthier, Cohesive communities, Globally responsible*
More healthy and sustainable food on the **public plate** by harnessing local supply chains.	15. Work with procurement colleagues to *i) maximise the social value; ii) minimise the environmental impact of; and iii) create more opportunities to include local, small-scale producers within*, public-sector food contracts.	Food Vale, Vale of Glamorgan Council, Big Fresh, CAVUHB, VOGC Economic Regeneration	Ongoing	*Resilient, Healthier, Globally responsible, Prosperous, More equal*
	16. Develop training for all staff involved in food procurement, from procurement teams to catering staff, to raise awareness of the health, carbon, climate and biodiversity impacts of procurement, in order to build knowledge, skills, leadership and trust around local food and seasonality.	Food Vale.	Long term	*Resilient, Healthier, Globally responsible*
	17. Reaffirm the Vale of Glamorgan commitment to being a Fairtrade County and support local towns and communities and work with Town and Community Councils in achieving Fairtrade status.	Vale Fairtrade Community Groups, Food Vale,	Short term	*More equal, Connective communities, Globally responsible*
Food waste is minimised	18. Engage with residents, businesses, organisations and settings such as schools to raise awareness of food waste and recycling via social media campaigns and Community Recycling Champions.	Vale of Glamorgan Council, Food Vale	Ongoing	*Resilient, Globally responsible*
	19. Work with key partners to review waste contracts and identify key opportunities for reducing, reusing and recycling more food and packaging waste in the Vale according to the Waste Hierarchy.	Vale of Glamorgan Council, Food Vale	Medium term	*Resilient, Globally responsible*
	20. Develop a mechanism for food waste to be redistributed as compost to community food growing projects.	Vale of Glamorgan Council, Food Vale	Medium term	*Resilient, Cohesive communities, Globally responsible*
More	21. Conduct a feasibility study to explore potential for developing shared-use community kitchen spaces in the Vale, and draw on	Food Vale	Short term to medium term	*Healthier, More equal, Cohesive communities, Vibrant*

opportunities to learn about and develop skills in growing, cooking and nutrition as well as the meaning of sustainable food and farming.	findings to implement measures that address need and enable community groups to develop new spaces/make use of existing spaces for the purposes of cooking and eating together.			*culture and thriving Welsh language*
	22. Support roll out of accessible, free and enjoyable opportunities to learn about nutrition and develop cooking skills across the Vale.	Food Vale, CAVUHB Public Health Dietetics	Ongoing	*Healthier, More equal, Vibrant culture and thriving Welsh language*
	23. To address skills and staff shortages, audit existing relevant local knowledge and skills across the food system and work with partners to address identified gaps	Food Vale	Long term	*Prosperous, resilient, healthier*
	24. As part of a Whole School Approach to food, encourage more opportunities to learn about good food (e.g. through farm visits, food growing and cooking activities) and encourage schools to link these to targets relating to their action plans for the Welsh Network of Health and Well-being Promoting Schools (WNHWPS) and Eco Schools programme.	Food Vale, Healthy Schools, Big Fresh, Vale of Glamorgan Council, Healthy Schools, Eco Schools, Local Nature Partnership, CAVUHB Public Health Dietetics	Medium term	*Healthier, Cohesive communities, Vibrant culture and thriving Welsh language, Globally responsible*
People in the Vale will have more opportunities to grow their own fruit and vegetables, cook and eat together	25. Map existing allotments and community growing spaces in the Vale to identify access barriers and unmet needs. Use these findings to implement strategic measures that improve participation and address challenges — with the aim of expanding community growing spaces.	Food Vale, Social Farms and Gardens, Vale of Glamorgan Council, Town and Community Councils	Short to Medium term	*Healthier, Cohesive communities, Globally responsible and Resilient*
	26. Encourage and support communities to take advantage of existing food growing and cooking opportunities, as well as developing new opportunities where appropriate.	Food Vale	Ongoing	*Healthier, Cohesive communities, Vibrant culture and thriving Welsh language*
	27. Ensure all four town placemaking plans incorporate a positive narrative and actions around building and supporting sustainable food networks locally and work with communities to implement actions.	Food Vale, Vale of Glamorgan Council	Short term	*Cohesive communities*
More opportunities for more	28. Work with partners to achieve the Silver Sustainable Food Places Award.	Food Vale	Short term	*Prosperous, Resilient, Healthier, More equal, Cohesive communities, Vibrant*

voices to be heard in the local good food movement, and to influence to food system.				*culture and thriving Welsh language, Globally responsible*
	29. Develop a workplan for, and identify two key focus areas to contribute to, the Gold Sustainable Food Places Award submission.	Food Vale	Long term	*TBD*
	30. Continue to create spaces where people can connect with one another and form a collective voice for wider change in their local food system, with attention paid to voices from our younger generations and groups who may be underserved or frequently unheard e.g. through the quarterly network gatherings.	Food Vale	Ongoing	*Cohesive communities*

1. Appendix 1 – Strategic Alignment

The Vale Food Strategy has been drafted to strengthen synergies with existing policies and programmes at both the local and national level.

Outcome	Alignment
Enjoyable, nourishing, healthy; and culturally appropriate food can be accessed by all.	**Local Policy** **Our Well-being Plan 2023 - 2028** Step 13: "*Improve health and well-being across the Vale with a particular focus on levels of physical activity, diet, vaccine take up and screening.*" Step 14: *"Tackle health inequities as part of an integrated and collaborative programme of work, ensuring greater engagement and a more targeted preventative approach to reach those most in need".* Step 16: *"Provide information and support to assist our communities and our staff to deal with the impacts of the costs of living e.g. rising food, energy and travel costs".* Step 17: *"Maximise opportunities through existing programmes of work and funding streams to address inequities and improve opportunities for those living in areas of deprivation e.g. Flying Start and employability and training programmes."* Step 19: *"Support work to tackle food poverty recognising the close links to environmental well-being and health"* **Good Food and Movement Framework and Implementation Plan 2024/2026** System Priority: Accessible and affordable; activities, programmes and services that support and enable movement and good food; *Action 15 Improve access to good food.* System Priority: Food environment that supports and enables good food for all; *Action 9: Improve availability of good food* System Priority: Knowledge, skills and confidence of the workforce to; teach, embed, signpost and role model; Action 12: *Maximise the potential of early years settings to enable young children to be physically active and access good food.* **Project Zero Climate Change Challenge Plan 2021-2030** *"Work through the PSB and Food Vale to implement the Move More Eat Well Plan and to promote buying local produce and shopping locally"* **CAVUHB Shaping Our Future Well-being (2023-2025)** Priority: Focus on minimising inequity in healthy behaviours, preventative services, access to clinical services, and health outcomes, to reduce current unfair, unjust differences experienced by people in the Health Board's communities **Vale of Glamorgan Local Development Plan 2011-2026** Objective 10: To ensure that development within the Vale of Glamorgan uses land effectively and efficiently and to promote the sustainable use and management of natural resources. **Vale of Glamorgan Replacement Local Development Plan 2021-2036 (forthcoming)** Objective 4 - Placemaking

	National policy Cymru Can – The Strategy for the Future Generations Commissioner for Wales 2023 - 2030 Healthy Weight, Healthy Wales: Our long-term strategy to prevent and reduce obesity in Wales Wales Community Food Strategy UK Government 'National Food Strategy' (forthcoming)
A greater proportion of healthy and sustainable food-related messages in the environment	**Local Policy** **Good Food and Movement Framework and Implementation Plan 2024/2026** System Priority: Policy and legislation to support and enable movement, active travel and good food**;** *Action 2: Reduce unhealthy food and drink advertising* and *Action 1: Embed good food and movement into the design of our places, spaces and buildings* **National policy** Healthy Weight, Healthy Wales: Our long-term strategy to prevent and reduce obesity in Wales UK Government 'National Food Strategy' (forthcoming) Wales Community Food Strategy
More businesses are growing, making, selling and serving healthy and sustainable food in the Vale (and these businesses are supported?)	**Local Policy** **Project Zero Climate Change Challenge Plan 2021-2030** "*Work within Food Vale to obtain Sustainable Food City status and promote businesses that have sustainable practices*" **Good Food and Movement Framework and Implementation Plan 2024/2026** System Priority: Accessible, inclusive and safe public spaces for movement, play and food growing; *Action 6: Increase local food production through identifying suitable land and opportunities for community and commercial food growing* **Vale of Glamorgan Council Corporate Plan 2025-2030** Deliver a Food Strategy for the Vale and work with local food producers and the agricultural sector to support local supply chains and actions which underpin the sustainability of our rural communities. **Vale of Glamorgan Local Development Plan 2011-2026** Objective 8: To foster the development of a diverse and sustainable local economy that meets the needs of the Vale of Glamorgan and that of the wider South East Wales Region. **Vale of Glamorgan Replacement Local Development Plan 2021-2036 (forthcoming)** Objective 2 - Improving Mental and Physical Health and Well-being Objective 9 - Building a Prosperous and Green Economy **National policy** Cymru Can – The Strategy for the Future Generations Commissioner for Wales 2023 - 2030

	Vision for the Food and Drink Industry from 2021 Wales Community Food Strategy Net-Zero Wales Carbon Budget 2 2021-2025 Sustainable Farming Scheme UK Government 'National Food Strategy' (forthcoming)
More food is produced locally according to organic, agro-ecological, regenerative and wildlife-friendly practices.	**Local Policy** **Our Well-being Plan 2023 - 2028** "*Improve the health of our eco systems and recognise the importance of biodiversity and the need to raise awareness and understanding about the nature emergency*." **Good Food and Movement Framework and Implementation Plan 2024/2026** System Priority: Accessible, inclusive and safe public spaces for movement, play and food growing; *Action 6: Increase local food production through identifying suitable land and opportunities for community and commercial food growing* System Priority: Policies, structures and incentives in our settings to enable movement and good food **Vale of Glamorgan Biodiversity Forward Plan (forthcoming)** **Vale of Glamorgan Nature Recovery Action Plan (NRAP)** Promote protection and management of habitats through sustainable farming schemes. Raise awareness of the effects of agricultural pollution and campaign for its reduction Work with landowners to restore and retain natural habitats on their land Hedgerow management **Vale of Glamorgan Local Development Plan 2011-2026** Objective 4: To protect and enhance the Vale of Glamorgan's historic, built, and natural environment. Objective 10: To ensure that development within the Vale of Glamorgan uses land effectively and efficiently and to promote the sustainable use and management of natural resources. **Vale of Glamorgan Replacement Local Development Plan 2021-2036 (forthcoming)** Objective 5 – Protecting and Enhancing the Natural Environment **Vale of Glamorgan Green Infrastructure Strategy(forthcoming)** Strategic Objective 2 - Enhance Biodiversity and Increase Ecosystem Resilience: develop a resilient and better-connected ecological network that supports net biodiversity gains to underpin nature recovery. **Natural Resources Wales South Central Wales Area Statement: Building Resilient Ecosystems** **National policy** Cymru Can – The Strategy for the Future Generations Commissioner for Wales 2023 - 2030

	Sustainable Farming Scheme Wales Community Food Strategy UK Government 'National Food Strategy' (forthcoming) Natural Resources Wales: Our corporate plan to 2030: nature and people thriving together: Nature underpins vibrant rural communities, with a direct relationship between nature and sustainable agriculture, woodlands and those that manage the land. This relationship must be nurtured if Wales is to maintain clean water, productive soils, food supplies and fibre.
More healthy and sustainable food served on the public plate by harnessing local supply chains.	**Local Policy** **Project Zero Climate Change Challenge Plan 2021-2030** *"The Big Fresh Catering Company which serves nearly 2 million meals a year will take steps to further reduce its impact on the environment"* and "*Review procurement arrangements to support less food miles, less packaging and waste*" and *"Revise the procurement policy and strategy and train staff on more sustainable procurement to reduce consumption and encourage a circular economy" and "Explore social and environmental clauses in contracts which place an increased focus on local supply chains and business, with a commitment to supporting the foundation economy".* **CAVUHB Shaping Our Future Well-being (2023-2025)** Priority: Maximise the Health Board's contribution to the Foundational Economy Priority: Deliver the Health Board's carbon emissions targets and fully support active and sustainable travel for staff and visitors to patients. Promote, reward and embed successful waste reduction as part of our quality programme of continuous improvement. **Good Food and Movement Framework and Implementation Plan 2024/2026** System Priority: Policies, structures and incentives in our settings to enable movement and good food **Vale of Glamorgan Council Corporate Plan 2025-2030** Deliver a Food Strategy for the Vale and work with local food producers and the agricultural sector to support local supply chains and actions which underpin the sustainability of our rural communities. **Vale of Glamorgan Council's Procurement Policy and Strategy** Approach all procurement decisions through the lens of the Well-being of Future Generations Act – by applying the Five Ways of Working, considering our well-being objectives and how we can maximise contribution to the seven well-being goals **National policy** Cymru Can – The Strategy for the Future Generations Commissioner for Wales 2023 - 2030 Healthy Weight, Healthy Wales: Our long-term strategy to prevent and reduce obesity in Wales Wales Community Food Strategy
Food waste is minimised	**Local Policy** **Project Zero Climate Change Challenge Plan 2021-2030** *"Review procurement arrangements to support less food miles and less packaging and waste"* and "*Promote and facilitate food waste recycling for residents, business and schools*" and *"Develop campaigns to change behaviour e.g. to reduce single use plastics and packaging and to increase reuse, recycling and composting"*

	CAVUHB Shaping Our Future Well-being (2023-2025) Priority: Deliver the Health Board's carbon emissions targets and fully support active and sustainable travel for staff and visitors to patients. Promote, reward and embed successful waste reduction as part of our quality programme of continuous improvement. **Vale of Glamorgan Waste Management Strategy (2022-2032)** Create network of Community Recycling Champions in schools, Council Buildings and local businesses **National policy** Towards Zero Waste: Our Waste Strategy Net-Zero Wales Carbon Budget 2 2021-2025
More opportunities to learn about and develop skills in growing, cooking and nutrition	**Local Policy** **Our Well-being Plan 2023 - 2028** Step 6: "Maximise opportunities to access funding and align activities to increase capacity, skills and resource to deliver priorities within Vale and the wider region". Step 8: "Promote positive behaviour changes and enable a greater understanding of our impact on the environment across our organisations and communities with a focus on energy, the circular economy, food, biodiversity and travel." **Good Food and Movement Framework and Implementation Plan 2024/2026** System Priority: Policy and legislation to support and enable movement, active travel and good food; *Action 3: Explore potential for developing community and commercial shared-use kitchens in identified locations across the Vale of Glamorgan*. System Priority: Policies, structures and incentives in our settings to enable movement and good food **National policy** Healthy Weight, Healthy Wales: Our long-term strategy to prevent and reduce obesity in Wales Wales Community Food Strategy
People in the Vale will have more opportunities to grow their own fruit and vegetables, cook and eat together	**Local Policy** **Project Zero Climate Change Challenge Plan 2021-2030** **"**Work with community groups and through the Green Infrastructure Plan to encourage people to grow their own fruit and vegetables" **Our Well-being Plan 2023 - 2028** Step 12: *"Participate in a more integrated approach to the public sector estate (buildings and land holdings) to improve service delivery and our work on climate change and nature."* **Good Food and Movement Framework and Implementation Plan 2024/2026** System Priority: Accessible, inclusive and safe public spaces for movement, play and food growing; *Action 6: Increase local food production through identifying suitable land and opportunities for community and commercial food growing.* System Priority: Social norms, culture and community values; *Action 23 Building understanding of local community assets in relation to food/nutrition/food growing and movement/sport/play through Shared Prosperity Funded projects, and Identifying, supporting and growing community leaders*

	Vale of Glamorgan Green Infrastructure Strategy (forthcoming) Strategic Objective 4 - Improve Social Cohesion: maximise opportunities for GI to support social initiatives and bring communities together **National policy** Cymru Can – The Strategy for the Future Generations Commissioner for Wales 2023 - 2030 Wales Community Food Strategy
More opportunities for more voices to be heard in the local good food movement, with more opportunities to influence to food system.	**Local Policy** **Our Well-being Plan 2023 - 2028** Step 5: "*Increase levels of engagement at all ages, particularly with those who may be disengaged and those who may be seldom heard, including through cultural activities*" Step 7: *"Engage with and involve our children and young people to better understand their concerns and aspirations for the future and ensure that services reflect their views and needs."* **National policy** Cymru Can – The Strategy for the Future Generations Commissioner for Wales 2023 - 2030 Wales Community Food Strategy

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Minutes of the Clinical Diagnostics and Therapeutics Clinical Board Quality, Safety and Patient Experience Sub-Committee

Held on 24th April 2025

Present:		
Helen Luton (Chair)	HL	Director of Nursing/Multi Professional Teams
Sarah Lloyd	SL	Director of Operations
Becca Jos	BJ	Deputy Director of Operations
Kim Atkinson	KA	Clinical Director of Allied Health Professions
Rhys Morris	RM	CD&T R&D Lead/Director of MPCE
Seetal Sall	SS	Point of Care Testing Manager
Paul Williams	PW	Quality and Safety Lead, Medical Physics
Sarah Clements	SC	Head of Adult Speech and Language Therapy
Nicholas Denny	ND	Organisational Learning Facilitator - Mortality Lead
Alana Adams	AA	Principal Pharmacist Medicines Information and Advice
Carole O'Shea	CO	Deputy Site Superintendent Radiographer
Suzanne Rees	SR	Lead Nurse for CD&T
Jo Fleming	JF	Quality Lead, Radiology
Susan Beer	SB	Public Health Wales Representative
Julia Dinley	JD	Head of Speech and Language Therapy
Alison Lewis	AL	Patient Safety Coordinator
Edward Chapman	EC	Head of Clinical Engineering/ Medical Devices Officer/Assistant Director of Therapies and Health Sciences
Sue Lawless	SL	Laboratory Service Manager, Haematology
Sian Jones	SJ	Directorate Manager, Laboratory Services
Chisom Uwaezuoke	CU	Senior Nurse, IPC Team
Melissa Melling	MM	Head of Medical Illustration
Ella Antebi	EA	Safeguarding Team
Kate Blower	KBl	Shaping Change Team
Nigel Roberts	NR	Laboratory Service Manager, Biochemistry
Secretariat:		
Helen Jenkins	HJ	Business Support Manager
Apologies:		
Adam Christian	AdC	Clinical Board Director
Alicia Christopher	AC	General Manager, Radiology & Medical Physics/ Clinical Engineering
Sion O'Keefe	SO	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Jonathan Davies	JD	Health and Safety Adviser
Bill Salter	BS	Lead Staff Representative
Sandra Watts	SW	Senior Nurse for EPMA, Pharmacy
Jamie Williams	JW	Senior Nurse, Radiology
Elaine Lewis	EL	General Manager, Pharmacy
Scott Gable	SG	Laboratory Service Manager, Cellular Pathology
Yvonne Hyde	YH	IP&C Team Representative
Tracy Wooster	TW	Sister, Outpatients

Debra Woolf	DW	Sister, Outpatients
Timothy Banner	TB	Clinical Director, Pharmacy
Ruth Lang	RL	Office Manager, AWTTC

Item No	Agenda Item	Action
PRELIMINARIES		
CDTQSE 25/078	**Welcome & Introductions** HL welcomed everyone to the meeting.	
CDTQSE 25/079	**Apologies for Absence** Apologies for absence were noted.	
CDTQSE 25/080	**Minutes of the previous meeting** The minutes of the previous meeting were received. **The Group resolved that:** a) The minutes of the previous meeting held on 27th February 2025 were accepted as an accurate record.	
CDTQSE 25/081	**Matters Arising/Action Log** The action log was received and it was noted that a number of the actions had been completed. The outstanding actions were updated as follows: *CDTQSE 24/250 Changes to Medical Examiner Process* Keeley Baker to be invited to present at the next meeting. *CDTQSE 24/277 Learning from Incidents Relating to Pathology Delays* The NRIs are due to be closed and the themes will be presented to the group in a forthcoming meeting alongside the improvements that have been made including the Lean work that is being undertaken by Toyota. *CDTQSE 25/047 LIMS Risk Assessment* The risk assessment is not yet completed as discussions are still being held around deployments. *CDTQSE 25/054 TDSI Issues in CRI* BJ escalated the issues but no progress has been made. It has been advised that this is a BT Network issue but no mitigation has been suggested for keeping staff safe in the interim whilst this is being resolved.	**KB** **SG** **BJ**

	CDTQSE 25/050 UHB Pressure Ulcer Group Discussions are being held amongst Directors of Nursing around reinstating this group but no decision taken as yet. *CDTQSE 25/074 CD&T Staff Recognition* This is currently under discussion in the Clinical Board but there is no firm plan at present. **The group resolved that:** a) The updates to the outstanding actions were noted.	
6 DOMAINS OF QUALITY		
SAFE		
CDTQSE 25/082	**Concerns and Compliments Report** In March 2025, the key themes for formal concerns related to: - difficulties in cancelling and arranging appointments; - delays in the signing of death certificates; - Waiting times - Equality related concerns The key themes from compliments were: - Positive patient experience - Excellent clinical treatment There has been positive feedback noted in the Civica reports in recent weeks, with named colleagues who have provided a positive patient experience. **The group resolved that:** a) The new Medical Examiner process and the impact on the Bereavements team will be presented to the next meeting.	
CDTQSE 25/083	**National Reportable Incidents** A breakdown of open incidents relating to this Clinical Board was circulated. 1 new incident relates to a Radiology miss involving the outsourcing provider is currently being investigated. Whilst not reported against this Clinical Board, Therapies staff have reported incidents where they have identified deteriorating patients that are not being monitored as they should. JF noted a new recent NRI in Radiology relating to a benign parotid tumour that was not reported on previous imaging in 2014 and 2022 and turned malignant when the patient presented this year.	

	The Group resolved that: a) A number of the incidents on the report are nearing closure.	
CDTQSE 25/084	**Duty of Candour Cases/Claims/LFERs** JF will present the case where a PICC line had been used in Radiology and became blocked and the patient was required to have a new line inserted. **The Group resolved that:** a) The case will be presented to the next meeting.	**JF**
CDTQSE 25/085	**Risk Register Updates** SS noted that there has been a delay with procurement in relation to the blood gas tender. This is a new risk that has been added to the Point of Care Testing team risk register. SS will submit the updated risk register for review by the Clinical Board. JF noted that risk assessments relating to Radiology access to anaesthetics and GA ERCPs are being completed. A risk assessment is also being produced relating to the RISP programme in terms of global worklist issues. This means that Cardiff and Vale UHB will be unable to view images from other Health Boards and vice versa until all Health Boards have implemented the new RISP system. This will impact on clinicians who regularly view images from tertiary centres. **The Group resolved that:** a) There is a plan to migrate risk registers to the AMAT system. This will allow the risk registers to be live documents and provide more transparency. It is unclear how this will link to areas that use the Q-Pulse system for their risk assessments.	**SS**
CDTQSE 25/086	**Patient Safety Alerts** **The Group resolved that:** a) There were no patient safety alerts received.	
CDTQSE 25/087	**Medical Device/Equipment Risks** An action has arisen from the Medical Equipment Group relating to emergency stop buttons on equipment and the need for relevant departments to ensure that operators are clear on how to restart kit. **The Group resolved that:**	

	a) All relevant areas to confirm assurance to EC.	**All**
CDTQSE 25/088	**Point of Care Testing** SS noted that a safety memo has been circulated in relation to the issue that the Point of Care Testing team lost connectivity with blood gas machines sited across the Clinical Boards. The impact was no patient data could be transported into Welsh Clinical Portal. The mitigation is to ensure that when using a POCT blood gas machine, to ensure all results are documented, as they should be written in the patient record. The POCT team can use the central lab which have backup analysers if needed. They have also collaborated with the supplier and the digital team to tray and retransmit as much data as possible, however the situation is ongoing. **The Group resolved that:** a) SS will discuss with BJ outside of the meeting why the POCT machines are not under the remit of Pathology IT Team.	
CDTQSE 25/089	**IP&C/ Decontamination Issues** SR is undertaking scoping work to identify those staff in the Clinical Board that need ANTT training. An All-Wales Decontamination Group for US probes has been set up. The group are undertaking audits in the UHB and are writing an SOP around the decontamination of ultrasound equipment. **The Group resolved that:** a) The updates on IPC and decontamination issues were noted.	
CDTQSE 25/090	**Safeguarding Update** Ella Antebi, Safeguarding Team attended to present the Mental Capacity Act audit results. The audit aimed to evaluate the UHB's compliance with the Mental Capacity Act, identifying both positive and negative themes in practice. The primary objective was to determine how the safeguarding team could better support workforces to enhance compliance and improve practices. The methodology involved physical visits to wards across multiple sites, including UHW, Llandough, Barry, and St. David's. The team analysed case notes from September to November last year. Out of 180 records reviewed, 71 met the inclusion criteria, and 114 involved decisions where the Mental Capacity Act's process should have been applied, though it was not always clearly followed. Whilst CD&T-specific data was not included, any relevant case notes from their visits were incorporated into the broader review.	

	The overall results demonstrated: 53% of capacity judgements were made without assessment. Of the patients included, 95% were not given support to make decision. Lack of documented support was high across all patient groups except, mental disorder. In addition to the 19/66 patients for whom DoLS referrals were made, a further 1 in 10 were likely to meet criteria for DoLS so may have been unlawfully deprived. 73% clearly documented and evidenced the reason for doubting mental capacity. Despite the limited improvements shown by the audit, there were areas and individuals that demonstrated evidence of exceptionally good understanding and application of the MCA. The following recommendations were suggested from the audit: The results to be shared at Clinical Board QSE meetings and each area to develop action plans to address areas of concern. All Clinical Boards to ensure representation at the MCA Focus Group. The MCA Policy for the UHB needs to outline roles and responsibilities for staff and clear guidance of the process to follow. Staff to be supported and encouraged to attend training provide by the MCA team. The MCA Team to review proformas for documenting capacity assessments and best interest decisions. Improved DoLS awareness and resources for staff and training. 7-minute briefings to be developed in relation to when to doubt capacity, role of the MCA team and how to document a capacity assessment. Processes to be in place for making patients and carers aware of their rights and best practice in relation to MCA and consent. **The Group resolved that:** a) HL will consider how an action plan can be developed for this Clinical Board as a non-ward based Clinical Board. b) A nominated person needs to be identified in the Clinical Board to access audit information on AMAT.	

	c) Presentation slides and link to MCA resources to be circulated.	
CDTQSE 25/091	**Consent Issues** **The Group resolved that:** a) There were no consent issues to report.	
CDTQSE 25/092	**Health and Safety/Staff Wellbeing** PW raised the issue of contractors repairing and servicing equipment in Medical Illustration who are are not returning the required health and safety forms. It was noted that JD is undertaking UHB wide work relating to contractors and suggested that he is contacted for advice. Due to replacement works to the sub-station, there have been instances of restricted access to the emergency road outside of the Medical Physics department which has impacted on equipment being transported into the department. There is also an issue of contractors parking on the emergency road which is blocking access to the dry riser for the Tertiary Tower. **The Group resolved that:** a) EC has escalated the issue to the Project Manager as this could impact on delivery of services and is also a fire risk.	
CDTQSE 25/093	**Regulatory Compliance** HL thanked the teams to Cellpath and Haematology for their hard work in preparing for the recent UKAS assessments visits. It was also noted that Nuclear Medicine and Radiology have updated the action plan from the HIW inspection in a timely manner and closed a number of the actions. **The Group resolved that:** a) The minutes of the Regulatory Compliance Group meeting were shared with this group.	
TIMELY		
CDTQSE 25/094	**Waiting Times Performance** Radiology is continuing to reduce their 8-week breaches and are currently reporting 8396 patients waiting over 8 weeks. There have recently been significant challenges with downtime of equipment and this may have an impact on next month's figures. In terms of Therapies 14-week targets, Speech and Language Therapy continue to reduce their 14-week breaches. Other	

	areas in Therapies that have been reporting breaches are experiencing an increase in their figures. Cellpath continues to reduce its turnaround times for cancer diagnosis. **The Group resolved that:** a) Waiting times performance is monitored and discussed in detail in the directorate performance review meetings.	
EFFECTIVE		
CDTQSE 25/095	**Feedback from UHB QSE Committee** The minutes from the meeting held in February were circulated. The Medicine Clinical Board presented their patient story and annual report. An update was provided on the Safeguarding Action Plan. A Gastro surveillance update was presented. **The group resolved that:** a) HL suggested that the Speech and Language Therapy patient story will be presented to the Committee when CD&T are required to attend to present its annual report.	
CDTQSE 25/096	**Research and Development** RM reported that the Joint Research and Governance Group is being held next week. If there are any issues to be raised to contact him. The next R&D Forum is not yet scheduled. **The Group resolved that:** a) Any volunteers to present at the next Forum to contact RM.	
CDTQSE 25/097	**Service Improvement Initiatives** **Overview of projects in CD&T Clinical Board** KB, Change Partner reported on projects being undertaken in the Clinical Board. Last year, work was undertaken with the Immunophenotyping Team looking at key changes they could make to improve their turnaround times for Myeloid Leukaemia. The changes have resulted in a 15% improvement in turnaround times for results delivered in under 48 hours. Furthermore, turnaround times	

	under 72 hours have seen a 19% improvement and for results within 14 days. Therapies were supported in integrating the Paediatric Therapies team from the Children and Women's Clinical Board into the Therapies directorate within CD&T. A programme was designed and a vision set up. Workstreams have been outlined and the next step will look at benefits realisation. The Haematology laboratory have requested support to understand their biggest challenges in the team and the impact of each of the challenges. A workshop has been held and recommendations provided. Support will be provided to Speech and Language Therapy which is linked to their patient story. A key piece of work that the Shaping Change Team are supporting is the Gloves Off Campaign which has seen a 15% reduction in gloves ordered since the launch in January. The pilot was undertaken in Critical Care and a UHB launch will be held in May. Data is being collated and this will inform the priority areas for focus and the support that will be needed from teams. KA asked if there has been any impact in terms of hand hygiene. KB responded that one of the posters specifically addresses this. Critical Care hand hygiene audits identified that the department maintained their hand hygiene scores and there has been no negative impact. This is being monitored and there is clear guidance for staff in terms of appropriate hand hygiene. HL emphasised the need to raise awareness of the campaign to patients, as they have raised concerns when they have been seen by staff who are not wearing gloves. **The Group resolved that:** a) The support and work undertaken in Therapies and Laboratories has been valuable. b) Any individuals in teams keen to support the Gloves Off campaign or any areas that have concerns to contact KB.	
CDTQSE 25/098	**Information Governance/Data Quality** **The Group resolved that:** a) There were no issues to report.	
CDTQSE 250/99	**HIW/Llais Reports and Improvement Plans** **The Group resolved that:**	

	a) There were no reports or improvement plans to be received.	
CDTQSE 25/100	**Policies, Procedures and Guidance (including NICE Guidance)** **The Group resolved that:** a) There were no new policies and procedures to be received.	
EFFICIENT		
CDTQSE 25/101	**Feedback from Directorate QSE Meetings** **The Group resolved that:** a) There were no issues to escalate.	
CDTQSE 25/102	**Clinical/Internal Audits** **The Group resolved that:** a) There were no further audits to report.	
CDTQSE 25/103	**Sustainability** The Clinical Board is due to meet with the new Environmental Service Improvement Manager. This meeting will hopefully inform the work that needs to be documented in the Clinical Board Quality Improvement and Efficiency Plan. The ICU Recipe Book has been shared with the CD&T Green Group and teams were asked to consider any shared learning and initiatives that can be replicated. Dietetics have moved away from single use syringes to reusable alternatives. This work is being widened to Paediatric Dietetics. Cedar participated in the Foodwise Project nominated in the Sustainability Awards in the Improvement and Innovation category. It was also noted that the SPRI project, involving Clinical Engineering and Pharmacy has also been nominated for a Sustainability Award. This replates to the project to develop a product that reduces greenhouse gases in Maternity Theatre. **The Group resolved that:** a) The updated from the CD&T Green Group was noted.	
EQUITABLE		

CDTQSE 25/104	**Feedback from Clinical Board Inclusion Ambassadors Group** Discussions are being held around refreshing the Inclusion Ambassador's Group with the UHB Equality Adviser. **The Group resolved that:** a) The meetings have been paused whilst discussions are underway to determine the way forward.	
CDTQSE 25/105	**Equality and Diversity Issues** Sexual harassment training is available for all staff and managers to support an All Wales Policy and Procedure that is being developed. **The Group resolved that:** b) Training sessions can be booked via ESR.	
PERSON CENTRED		
CDTQSE 25/106	**Patient Story – Speech and Language Therapy** Sarah Clements, Head of Adult Speech and Language Therapy presented a patient story entitled Working Together to Improve Safe Eating and Drinking. The story is based on a 76-year-old patient named John. Sarah was initially asked by the Patient Quality Safety Team to review John's case due to an informal concern that was received related to an incident during his hospital care. Although the concern primarily involved nursing, it also related to eating and drinking. Sarah met with John's wife and son, who shared their story with her, and she has their permission to present it. John was a devoted husband and father He enjoyed Italian food and shared an enthusiasm for cruising the world with his wife. At age 76, he was admitted to UHW in May 2024 due to his declining health. He was well known to the hospital staff because of the impact of his dementia on his ability to eat and drink. He also suffered heart failure. He had previously been assessed in 2022, where a video fluoroscopy, revealed that when he swallowed thin fluids like water, tea, and coffee, a significant amount was entering his lungs. For 3 years, John managed at home with recommendations agreed by his family and medical team and this included thickened fluids and a softer, bite-sized level 6 diet. Upon his admission in April 2024 at UHL, he was reassessed due to his dementia. This revealed behavioural habits which included tendencies to eat rapidly and take large mouthfuls in quick succession, that often resulted in choking episodes if he was not monitored. He exhibited a prolonged oral phase of	

chewing with poor oral clearance on more solid foods and needed prompting to swallow.

Due to his poor cognition, he could not adapt and remember strategies to swallow safely. His distracted demeanour, paired with reduced insight into his difficulties, made eating and drinking in a busy hospital ward particularly challenging. He needed dedicated support to ensure he slowed down, took appropriately sized bites, and swallowed safely. John retained a strong cough and responded positively to verbal and visual reminders.

The Speech and Language Therapy recommendations included continuing with thickened fluids from an open cup with small sips with only small amounts of drink poured into the cup and avoiding leaving full cups within reach as he would consume them too quickly. He was on a level 4 pureed diet via a teaspoon which worked well.

John could drink independently but required close supervision for all food and drink with reminders to take small amounts ensure each mouthful was fully swallowed. Additionally, he needed to be alert, sitting upright, and monitored for signs like a gurgling or wet voice, in which case the Speech and Language Therapist would review him. The importance of regular mouth care was emphasised to reduce complications of aspiration.

John was not suitable for a PEG or NG tube and the overall aim was to maintain his safety when eating and drinking whilst supporting his independence where possible.

Sarah described the experience of John's wife as she navigated his healthcare journey, focusing on her hands-on role in his care. As a feeding peg would not be suitable for John, she took on the responsibility of feeding him pureed food at the hospital, visiting twice daily for 5 months, despite having a job. John began to improve with visible weight gain and was due to return home. However, there were instances of lapses in care by ward staff, such as leaving water within John's reach despite the clear instructions.

John was due to be discharged in the coming days and an unsettling comment was made by a nurse about how they allow him to feed himself when she was not present as they felt he was losing his independence, and this left his wife stunned and she queried why they were not following the recommendations.

The following morning, 22nd September 2024, his wife had an engagement so did not attend to feed him. She returned that late afternoon and received a call informing her that John had difficulty breathing, became unconscious and passed away. Overwhelmed with guilt, whilst she holds the hospital staff in high regard, she wonders whether John was left to feed himself

	independently and if she had attended that morning whether he would still be alive. The feeding recommendations were clearly marked and the whole ward aware of them, so his wife questions why these were not followed. It is suspected that the nursing staff simply did not understand the consequence of their actions. It is concerning to note that there are many patients in the UHB like John. Another story was presented relating to Glynn. Glynn was 85 years old and died whilst an inpatient in November 2021. He also had dementia and experienced previous episodes of choking and changes with his cognition. He was assessed by the Speech and Language Therapy team and recommendations were made to minimise the risks of him choking. The summary from his inquest stated that Glynn was not monitored as recommended. As a consequence, the nurse noted a loss of consciousness and Glynn choked during his meal and resuscitation was unsuccessful. Post Coroner's Court, The Mental Health directorate were tasked with a plan of action. The Senior undertook a Root, Cause, Analysis and the challenge was made that whilst the Speech and Language Team provided comprehensive notes, these are lost and communication relies upon verbal handovers, but this information also gets lost. Their solution involves multiple processes (8 pages long) to ensure awareness and accessibility and use of swallow recommendations. Whilst there are some improvements, significant risks remain. There are significant numbers of concerns, coroner inquests, Datix reports, audits, patient stories that show the harm that occurs in this UHB when recommendations have not been sought or followed and there is a need for change. It is important for all staff to understand that when they choose an action to ignore or not follow recommendations, that they also choose the consequences of that action, and in many cases, this leads to considerable harm. The patient story was presented to the Nutrition and Hydration Steering Group in February. SC has applied to the Shaping Change for support and mentoring of a UHB wide project focusing on working together to improve safe eating and drinking practices for those with increased risk. This involves co production working with nursing staff, patients and their families. **The Group resolved that:** a) This was a powerful patient story highlighting a lack of awareness of this problem across the UHB. There needs to be universal ownership for a patient's nutrition and hydration needs.	

	b) It was suggested that this will be a challenging, continuous project and the way forward is to start by scoping out the problem. c) HL will discuss with the Nurse Director to suggest this story is presented to the Clinical Board Directors of Nursing.	
CDTQSE 25/107	**Patient Experience Feedback** **The Group resolved that:** a) HL will circulate the Civica reports when they are received.	**HL**
CDTQSE 25/108	**Internal/External Awards** **The Group resolved that:** a) There were no further nominees or award winners to report.	
CDTQSE 25/109	**Good News Stories** Nothing further to report.	
ITEMS TO RECEIVE/NOTE FOR INFORMATION		
CDTQSE 25/110	Regulatory Compliance Group Minutes CD&T Health and Safety Group Minutes	
ANY OTHER BUSINESS		
CDTQSE 25/111	Podiatry is scheduled to present the patient story at the next meeting.	
CDTQSE 25/115	**Date & time of next Meeting** The next meeting will be held on 29th May 2025 at 2pm via Teams	

Minutes of the Medicine Clinical Board
Quality, Safety & Experience Committee Meeting
Held on 16 April 2025 14:30 – 16:00, Via MS Teams

	Attending	Apologies
MCB Operations/ Nursing Directors & Deputy Directors	Barbara Davies, (Chair) Katja Empson	Jane Murphy, Claire Main, Mike Bond, Jesse Ayertey, Hannah Mastafa
Clinical Directors	Aneurin Buttress	Richard Lea, Lyndsey MacDonald, Richard Marsh, Siobhan Lewis, Sharon Jones, Tom Pembroke, Neera Agarwal
Patient Safety Team		Cath Evans
Consultants	Tim Ayres, ED	
Staff-side		Jonathan Strachan-Taylor
Pharmacy		Dave Mcrae
Head of Quality & Clinical Gov.		Sian Rowlands
Quality & Governance Lead	Kath Prosser	
Consultant Nurse Practitioner, ED	Marianne Jenkins	
General Managers		Dan O'Donnell, Vicci Page
Lead Nurses	Ceri Richards-Taylor, Ceri Martin	Wayne Parsons, Dave Pitchforth
Senior Nurses	Harriet Foley, Claire O'Keeffe, Beth Jones, Sue Eshel	
Senior Nurse, Resuscitation	Angela Jones	
Professional & Practice Development Nurses	Liz Vaughan	Sam Hughes
IP&C	Derek King, Sarah Wright	Chisom Uwaezuoke, Hibaq Musa
Organisational Learning Facilitator, Mortality Lead	Nicholas Denny	
Safeguarding	Pippa Johnson	
I&I	Molly Baker	
Secretariat	Sheryl Gascoigne	

Item No	1. Standing Items	Action
MCBQSE/ 2025/30	**Welcome and Introductions** – were undertaken. **To receive the minutes of the previous meeting held on 19/2/25** – the minutes were accepted as an accurate account of the meeting. **Action Log** – was updated. **Declarations of Interest** – none declared.	
2. ITEMS FOR REVIEW AND ASSURANCE		
MCBQSE/ 2025/31	**Patient Story, delivered by Beth Jones, Specialised Medicine** Feeback was received from a patient following a colonoscopy procedure undertaken 14th April 2025. To patient praised care and advised everyone was kind to her. The patient feedback on four separate occasions she was asked who would be collecting her and if it would be her husband to which she advised it would be her wife. This reflects staff were making assumptions regarding the patient. 97% of staff had completed their equality and diversity training. DP is arranging a session for staff to raise awareness of today's diverse society and not to make assumptions. **The group resolved:** this was not a formal complaint; it was shared to raise awareness. **Action**: to note the above.	
MCBQSE/ 2025/32	**Compliments** – none to share this month. **Family feedback Medical Examiners Reports** – all to note for information.	

	MCB Concerns – 72 formal active concerns, the majority of which are within Acute and Emergency Medicine. There were 51 for closure last month. 59% performance regarding responding within 30 days. Some concern themes are communication; lack of respect; insufficient or incorrect treatment or assessment; attitudes and behaviour; lack of care. **Claims** – there are a significant number of claims going through Welsh Risk Pool. **Learning** - improvement plans should be owned and shared through this forum. **Training** – Welsh Risk Pool require evidence of 85% compliance with, for example, falls training. A trajectory could be shown; however, it is recognised the challenges of achieving this target is significant. **The group resolved/ Action:** to note the above.	
MCBQSE/ 2025/33	**Infection Prevention and Control (IP&C) Year End Report** 40 days since the previous bacteraemia outbreak. *C difficile* outbreak on LSW, ground floor 2. Waiting for this to be officially closed. • DMT scores – all except endoscopy at UHL, MCB wards remain compliant for the last 4-week period. • HCAI reduction goals – new cases of all reduction goal organisms in March 25. • Reduction goal for *E. coli.* has been achieved and there has been a 40% reduction in *E. coli.* over the past year. **MCB position based on end of year figures**: • 71% increase with *Pseudomonas.* • 42% increase with *C. difficile.* • 36% increase with SAUR Bacteraemia • 26% Increase *with Klebsiella* • 40% reduction with *E. coli.* • There are 17 outstanding RCA's. Wards visits/outbreaks/IP&C engagement – best performing wards are C4S and CF. Wards with highest concerns regarding IP&C are East 2 and A7. Wards most improved - unscheduled care; LSW ground floor, ward 2; C7. **Brilliant Basics** has been brought in to focus on uniform standards, hand hygiene, cleaning, bare below the elbow etc. ***C. difficile* position** – there were 60 cases of *C. difficile across* MCB during 2024-2025. This represented an increase of 42% based on the previous year (+25 cases). UHW/UHL have increased prevalence. Other sites matched previous year figures. 12% RCAs outstanding (mainly March). 88% of RCAs completed. The standard is variable, medical input has improved to 52% (37% 2023-24). Improvement seen with hand hygiene, cleaning and the inclusion of audit. HPV post infection improved from 26% to 58%. Significant bed capacity has been lost regarding IP&C. **Themes regarding lessons learnt** 43% highlighted delay in *C. difficile* detection. 36% identified issues with IP&C, cleaning and hand hygiene. 16% highlighted poor audit. Risk factor for *C. difficile* infection – 80% of patients who developed *C. difficile* had had antibiotics before that. 65% of the 80% had received Tazacin. **The group resolved**: to note the above. **Actions from discussion**: DK to share the *C. difficile* Report with this group.	Derek King
MCBQSE/ 2025/34	**Hospital Health Pathways (HHP),** update delivered by Tim Ayres	

	Background - HHP is an online repository of locally agreed clinical pathways covering a range of clinical presentations, including assessment, management and referral options for patients in Cardiff and Vale. There are approximately 70 pathways on HHP. **Evaluation of HHP** – need to show it is a useful product. Currently 'click' data is collected. There is a plan to start a brief Focus Group type survey for residents in Medicine and the ED, looking at their awareness of HHP and its utility at the start and end of rotation. **The group resolved**: to note the above. **Actions from discussion**: Molly Baker and Tim Ayres will discuss HHP usage further outside the meeting.	Molly Baker/ Tim Ayres
MCBQSE/ 2025/35	**Mental Capacity Act (MCA)Audit Feedback**, update delivered by Pippa Johnson 2nd annual audit from the last financial year **Audit criteria** – as all MCA requirements are statutory, the standard was set at 100%. 71 of the 180 sets of randomly selected records met the inclusion criteria. **Across all Clinical Boards, it was found that**: A comprehensive mental capacity assessment was completed in 21% of cases, with 16% on an MCA proforma or consent form 4. In MCB this figure was much lower at only 2%, with MCA evidence absent in 69% of cases. **Common errors across overall audit including**: 13% functional test left entirely blank. 13% writing the same for all sections, eg 'Dementia'. 20% single sentence of evidence only 20% **Results** • Using paper proforma's of PARIS assessment tab increased accuracy to 60% adequate documentation, compared to 25% in free text entries. This was not consistent across all proformas. • Overall, less than 1/5 MCAs showed evidence of people being supported to make decisions. In MCB this was only 5%. • Overall, around 1/3 cases showed evidence of how BID was reached, and consultation was had with relevant parties. Less than 1/10 discussed a variety of options including the option of 'no treatment' or 'no change'. **Overall themes** • **Reason to doubt** – lack of identification of reason to doubt mental capacity; therefore, MCA process not instigated. • **Deprivation of Liberty** (DoLS) – failure to identify DoLs and carry out the associated capacity assessment. The records found that one in ten additional patients were deprived of their liberty, however, were not under DoLs. • **Documentation** – findings support the idea that use of a proforma improved quality of documentation relating to MCA. • **Support to make decision** – 95% of patients were not given support. • **Training** – some correlation between investment in staff training and improved MCA documentation. **Summary of documentation** • Developed a Mental Capacity Policy. DoLS training is available. • Developed new 7-minute briefings, available on SharePoint. • Developed a patient/ public vision about to increase knowledge. **Next Steps** • Each Clinical Board to produce an action plan for meeting recommendations. **The group resolved**: see the actions below.	Pippa Johnson

	Action 1: PJ will send the presentation to KP to be shared with these minutes. **Action 2**: BD, KE and JM to discuss how best to take the MCA work forward and to provide Pippa or Chloe with the name of the person who will do this. This person would then attend the MCA Focus Group.	Barbara Davies Katja Empson Jane Murphy Medicine full slides for circulating.pptx 2024 MCA Audit Report FINAL.docx
MCBQSE/ 2025/36	**Safeguarding Audit –** undertaken 5/11/24. Quality Assurance Audit undertaken with overview from safeguarding leads. 20 randomly selected AS1s generated from within MCB (Oct 23 – Oct 24). **Out of the 20 forms looked at:** 20/20 – adult at risk name; gender; date of birth was all recorded correctly. 16/20 – sufficient information to determine concerns and risks. 14/20 – ethnicity recorded. 15/20 – identified the nature of the concern clearly. 15/20 – had sufficient evidence of diagnosis/ clinical presentation. 17/20 – consent issues addressed appropriately. 18/20 – consent boxes completed, and capacity recorded. 1/20 – identified this was a repeat referral, 1/20 identified it was not. **Strengths** • Clear documentation around referral reasons. • Clear picture of clinical presentation. • Consent established in 18/20 AS1s • Sufficient information to determine risks. **Areas for improvement** • Family history needs further exploration. • Poor documentation around repeat referrals. **Next steps** • Audit to be shared with MCB and ward teams. • Support from Lead/Senior Nurses to ward teams to ensure high quality referrals submitted. • Share sample AS1 developed by safeguarding team to support. • Education on completing forms continues with teams. • Ensure ward teams aware of who their HLP is. • Safe safeguarding updates in QSE meetings. • A lot of ward staff do not have access to PARIS and may not know that they can phone for information. **The group resolved**: overall, the audit showed good results. **Actions from discussion**: to note the above.	
3 ITEMS FOR APPROVAL/ RATIFICATION		
MCBQSE/ 2025/37	**National Reportable Incidents (NRIs)** – there are 23 open NRI's. Closure dates were breached: IM – 2, SM – 8, EU – 1. **NRIs for closure**: both were avoidable health care associated pressure damage. **Integrated Medicine - ID68686**	

	Patient was self-caring and was admitted for a chest drain and complained of having a sore bottom. On day three, an unstageable area to the sacrum was seen. Welsh Nursing Records were recently implemented on this ward. Documentation has improved in terms of checking patients' skin integrity. **Integrated Medicine - ID83229** – category 3 pressure damage. Patient was admitted with a known pre-existing category 2 that developed into category 3. The patient was non-concordant with repositioning which was well documented. The patient was not nursed on an aria pro mattress on admission. Consideration could have been given to a higher specification mattress. **The group resolved**: to note the above.	
MCBQSE/ 2025/38	**Learning from Events** **CN/UHW/DCIQ1917** – clinical negligence claim regarding a 60-year-old lady who attended ED on 4/12/21 having collapsed at home. The patient was considered to have an upper respiratory tract infection, underwent a good period of observation, was prescribed medication and discharged home. Three days later the patient represented with worsening symptoms following another collapse at home. The patient was given antibiotics and referred to ENT who noted a dry discharge from the ear and diagnosed an ongoing left ear infection with perforation of the eardrum. A CT scan confirmed the ear infection had extended to the brain in the form of a subdural empyema and was referred to Neurosurgery for drainage. **Incident**: it is alleged there was a failure to diagnose and treat the patient's subdural empyema when first presented at the ED on 4/12/21 leading to the patient enduring 5 further days of pain and suffering a seizure on 9/12/21. It was considered that if the patient had been seen by an ENT doctor, then consideration could have been given for a CT scan earlier. **Conclusion**: expert opinion is being sought from a Consultant Neurologist for further input. It is of the view this is a low value claim, and the causative allegations relate to a further 5 days of avoidable PSLA. Subdural empyema is difficult to diagnose and are not necessarily the first diagnosis that would be considered on initial presentation. **Actions from discussion:** to note the above.	
4 ITEMS FOR NOTING AND INFORMATION		
MCBQSE/ 2025/39	**Patient Safety Alerts/MDAs/ISNs** - Safety Memo: Expired Equipment - Safety Memo: IV Paracetamol shortage - Safety Memo: Stop before you block and Surgical consent - MHRA Safety Round Up **Actions from discussion:** to note the above.	
MCBQSE/ 2025/40	**Medicines Safety Briefing for Healthcare staff March 2025** **The group resolved/Actions from discussion**: for noting.	
MCBQSE/ 2025/41	**Minutes from Directorate QSE Groups and Chairs Reports/Exceptions**: - Acute & Emergency Medicine minutes 11/3/25 (await minutes; next meeting not scheduled until May 2025) - Integrated Medicine, UHW (await minutes) - Integrated Medicine, UHL next meeting May 2025 - EUG last meeting 18/12/24. Next meeting to be confirmed. **The group resolved**: to note the above. **Action from discussion:** none	
MCBQSE/ 2025/42	**Minutes from QSE Sub-Groups** **H&S Meeting –** the fire policy has changed. South Wales Fire Service will only respond to a fire alarm at UHW/UHL, when the alarm has been validated. **The group resolved**: to note the above. **Action from discussion:** none.	
MCBQSE/	**Feedback from UHB QSE Committee**	

2025/43	**Gastro surveillance update -** has been provided by Paul Bostock. There has been a significant improvement.	
MCBQSE/ 2025/44	**Prevention of Pressure Damage booklet** – this has been updated. All agreed the sign off of this updated booklet. **The group resolved**: to note the above **Action from discussion:** LV will share this updated booklet with wards. The updated version shows as 2025.	Liz Vaughan
5. ANY OTHER BUSINESS/ DATE AND TIME OF NEXT MEETING		
MCBQSE/ 2025/45	**Date and time of next meeting** – 21 May 2025 14:30 Teams meeting	

Agenda Item
6.2.1

Joint Commissioning Committee

Quality Safety and Outcomes Sub-Committee Highlight Report

Dyddiad y Cyfarfod / Date of Meeting	20/05/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Maxine Evans, Interim Corporate Governance Officer
Cyflwynydd yr Adroddiad / Report Presenter	Mandy Rayani, Lay Member
Noddwr yr Adroddiad / Report Sponsor	Carole Bell, Director of Nursing and Quality

Pwrpas yr Adroddiad / Report Purpose	For Noting Choose an item.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
N/A		Choose an item.

1. SITUATION/BACKGROUND

This report had been prepared to provide a summary of the key issues considered by the Joint Commissioning Committee Quality, Safety and Outcomes sub-committee at its meeting on 31 March 2025.

Key highlights from the meeting are reported in Section 3.

2. PURPOSE

The Purpose and Role of the Joint Committee and the sub-committees are set out in Paragraphs 2.18 and 2.20 of the JCC Standing Orders.

The Quality and Safety Outcomes Committee Terms of Reference can be found here.

3. HIGHLIGHT REPORT

RAG Rating	Highlight
Alert / Escalate	• Members commented on the importance of developing a video tour for the Mother and Baby Unit and agreed to highlight this in the Chairs report, and to provide feedback to the HB that provides this service.
Advise	• Members were advised that further work was being undertaken on the Quality Newsletter to align it with the JCC communications strategy. This was close to being completed and will be referred to as a Quality Bulletin. • Members received an update on the escalation status of the Paediatric Critical Care Unit (PCCU) and the Neonatal Intensive Care Unit (NICCU) at the Children's Hospital for Wales. The following points were noted: ○ Improvements in the governance structure including key appointments and regular meetings to ensure clearer oversight and accountability. ○ Introduction of a dashboard to accurately capture activity and cot availability. ○ Key improvements demonstrated in neonatal mortality and national benchmarking in areas such as retinopathy, prematurity screening and infection rates. ○ Positive feedback from patient and families highlighting the improvements in care and the importance of ongoing work to maintain these improvements. ○ Clear expectations and requirements for de-escalation improved understanding of what was being asked and once established the service was able to provide the necessary information and assurance. • Members received the Welsh Kidney Network (WKN) report which provided a briefing on the current Quality and Patient Safety issues within the WKN commissioned services. The following points were noted: ○ Oxa 48 e-coli infection identified on a kidney ward and the challenges related to this outbreak. Although this primarily affects kidney patients, it may become a broader infection control concern. It was noted that the environment had been a contributing factor. An

RAG Rating	Highlight
	infection prevention and control meeting is arranged to discuss and agree a consistent approach across Wales. ○ The WKN meetings with the three providers of BCUHB, CVUHB and SBUHB and how the wider JCC will be made aware and kept informed of this issue. This would be highlighted in the QSO Chairs report to the JCC. ○ The diversity of dialysis providers and whether this poses any challenges in terms of applying a uniform approach to protocols and standards. It was confirmed that the renal community work very closely, sharing clinical input and that infection prevention and control issues are driven by the clinical teams within the renal centres. • The Director of Commissioning for Specialised Services provided updates on various specialist services including: ○ The continued challenges in engagement with Salford Royal Hospital obesity services. This will continue to be escalated. Meanwhile, additional capacity has been secured in South Wales. ○ Improvements in plastic surgery waiting times, the data for March 2025 was still pending, but the target of 104 weeks is likely to be achieved. There was insufficient capacity to make any significant in-roads into achieving 52 weeks targets. ○ Prostate-Specific Membrane Antigen (PSMA) due to the ongoing production challenges with Positron Emission Tomography Imaging Centre (PETIC) in CVUHB. A clinical update was provided advising that undertaking clinical revalidation with all the PMSA PET requests has been agreed with a view to shared decision making, noting that these scans were not mandated according to NICE guidance, therefore, the suggested triage involves categorising patients into high, intermediate, and lower risk groups. This positive progress was welcomed. ○ South Wales Specialist Auditory Implant Device Service and the continued lack of progress. This will form part of a broader conversation however there was an action plan in place and the requirements were more visible. • A report for the Commissioning for Ambulance and 111 services was received. The quality and safety dashboard, which includes high-level reports on quality domains was highlighted. In addition: ○ The establishment of a new clinically led 'National Ambulance Patient Handover Improvement Implementation Group.' The work of this group will be

RAG Rating	Highlight
	a key enabler in supporting the JCC in reducing its emergency ambulance services associated risks around utilisation of capacity. ○ The new ambulance performance framework and introduction of new categories was noted which included a purple category for incidents of cardiac and respiratory arrest. ○ High rate of 111 call abandonments and whether the service can cope with demand. The JCC has yet to assess whether it provides sufficient or effective call handling and clinical capacity as a formal strategic demand and capacity review of the 111 system has not yet been conducted. A detailed analysis of the GDPR breaches within the Ambulance and 111 report was requested to understand the causes. ○ A deep dive on Ambulance services, including a patient story, was scheduled for June 2025 where several issues can be addressed. • The Director for Mental Health and Vulnerable Groups report was presented. The following points were highlighted: ○ Improvements in High Secure services through the introduction of positive interaction program (PIP) at Ashworth, reducing long-term segregation numbers, noting that Broadmoor and Rampton were implementing similar strategies. ○ Environmental issues at Caswell Medium Secure Unit and Ty Llewellyn, including lack of seclusion facilities. SBUHB has appointed an independent assessor to undertake an independent review of their mental health services. The JCC needs to stay cited on the work of this review to help with informing strategic commissioning decisions. ○ Inpatient numbers have risen within eating disorder services. Noting ongoing discussions to enhance gatekeeping processes. ○ Plans for two newly commissioned perinatal beds for North Wales patients located in Chester, by October 2025.
Assure	• Members heard a story from a patient's specific experience of the Tonna Mother and Baby Unit stating the challenges she faced as a mother with physical health disabilities. It was noted that the Unit worked hard to address the environment and accessibility issues and the staff's willingness to listen and adapt. To minimise anxiety for patients, the Unit is now planning to produce booklets with

RAG Rating	Highlight
	photographs of the unit and to introduce phone calls between staff and patients prior to admission to discuss and prepare for their stay. A video tour was also planned, however due to resources this has not been possible. The Chair thanked her for her sharing her personal story and wished her well for the future. • Members received the risk register as at 31 January 2025, highlighting the risks relating to the Quality Safety and Outcomes assigned for monitoring and scrutiny purposes. The following areas were highlighted: ○ Cardiac Device Services, the Chair inquired whether this risk was specific to North Wales or if it represented a broader issue concerning engagement within the service. It was clarified that the service was safe, and the engagement issues relate to the provider. The risk was likely to be resolved by the next meeting. ○ Paediatric Intensive Care Beds and Neonatal Infection Control which had been covered in the earlier presentation. Whilst these remain on the Risk Register as risks scoring 20, these should also be updated by the time of the next meeting. It was noted however there appeared to be some underlying issues that could be related to the environment. The infections rates appeared to be higher than national averages despite good compliance with infection control measures. ○ Neurosurgery Sustainability, noting that this risk had been de-escalated from 16 to 8. It was queried if this was premature as the funding had been allocated but the overall sustainability of the service was dependent on successful recruitment. The matter around when a risk is mitigated from a commissioner perspective and becomes a provider risk/issue was discussed. It was suggested that this topic could be addressed in a JCC strategy session since the JCC still needed to conclude their discussions around risk appetite. ○ C&VUHB Neurosciences Staffing issues/level was queried as the description around the risk being addressed by the rehabilitation strategy was due for consideration by the JCC in Quarter three 2024/2025 but this has now passed. It was agreed to review this outside of the meeting and provide an update at the next meeting.
Inform	• The forward plan of business for the next twelve months was presented noting that it was a work in progress and would be used to support Agenda planning for future meetings.

RAG Rating	Highlight
	• A report outlining recent incidents and concerns reported to the JCC from provider and commissioned services covering the period January 2025 – February 2025 was received. • An update on the Regulator Report (Healthcare Inspectorate Wales (HIW) / Care Quality Commission (CQC) regulatory activity was provided noting the ongoing collaboration with HIW to improve reporting and assurance processes.
Appendices	None

4. ASSESSMENT

Objectives / Strategy	
Dolen i Amcan (au) Strategol CBC Link to JCC Strategic Objectives(s)	Improve Equity and Population Health Ensure Quality
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A More Equal Wales
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Whole-systems Perspective If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality**	Person Centred If more than one applies please list below: Equitable

(*Duty of Quality Statutory Guidance (gov.wales)*)	
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: N/A
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☒	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please include rationale below: N/A
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Joint Committee as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. RECOMMENDATIONS

The Joint Committee is asked to:

- **Note** the highlights outlined in Section 3 of this report.

Follow-up: Implementation of Health Roster System

Final Internal Audit Report

January 2025

Cardiff & Vale University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

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

Contents

Review reference:	CVU-2425-06
Report status:	Final
Fieldwork commencement:	19 September 2024
Fieldwork completion:	21 October 2024
Draft report issued:	24 October 2024
Debrief meeting:	21 October 2024 and 18 November 2024
Management response received:	6 January 2025
Final report issued:	7 January 2025
Auditors:	Lucy Jugessur, Deputy Head of Internal Audit
Executive sign-off:	Rachel Gidman, Executive Director of People and Culture Jason Roberts, Executive Nurse Director
Distribution:	Lianne Morse, Deputy Director of People and Culture Jonathan Pritchard, Assistant Director of People Resourcing Paul Jones, E-Rostering Manager Carys Fox, Director of Nursing Strategic Nursing and Midwifery Workforce Emma Davies, Nurse Staffing Levels Lead
Committee:	Audit and Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement

NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - please note

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit and Assurance Committee.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with Cardiff & Vale University Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system

Executive Summary

Purpose

The overall objective of this audit was to provide the Health Board with assurance regarding the implementation of the agreed management actions from the Implementation of Health Roster System (CVU 2324-09) review that was reported as part of our 2023/24 work programme.

Overview of findings

Management have made some progress in addressing the recommendations, and the management actions detailed in the initial Final Internal Audit Report.

Of the nine recommendations made, five of them have been closed, including one of the high priority recommendations. There is a Safecare dashboard in place which records the Safecare compliance for day and night.

One recommendation is partially complete with the high recommendation having moved down to low.

The remaining three recommendations, with two highs and a medium priority, have not moved. Whilst we can see some actions have been implemented, the underlying issues have not been addressed as there are still a considerable number of rosters not being produced on a timely basis. In addition, rosters are not being consistently verified and finalised. The auto-rostering functionality uptake has improved but is still below the Health Board's target.

Follow-up Report Classification

		Trend
Limited 	**Follow up:** All high priority recommendations implemented and progress on the medium and low priority recommendations.	⇔

Progress Summary

Previous Matters Arising		Previous Priority Rating	Direction of Travel	Current Priority Rating
1	Rostering procedure requires updating	Low	⇑	Closed
2	Roster process is not timely	High	⇔	High
3	HealthRoster system segregation of duties	Medium	⇑	Closed
4	Auto-rostering functionality uptake	Medium	⇔	Medium
5	Annual leave requests	Low	⇑	Closed
6	Annual leave interface	Low	⇑	Closed
7	Incorrect working hour balances	High	⇑	Low
8	Roster verification and finalisation	High	⇔	High
9	Safecare census missing patient data	High	⇑	Closed

1. Introduction

1.1 The follow-up review of 'Implementation of Health Roster System' was completed in line with the 2024/25 Internal Audit Plan for Cardiff and Vale University Health Board (the 'Health Board'). The opinion provided through this review is a key component, which will inform the Head of Internal Audit's Annual Opinion.

1.2 This was a follow-up review of the original report that was issued in November 2023. This identified nine issues and resulted in an overall assurance rating of 'Limited Assurance'.

1.3 The Lead Executive Directors for this review are the Executive Director of People & Culture and the Executive Nurse Director.

Audit Risks

1.4 The potential risks considered in the original review were as follows:

- Late preparation and agreement of rosters may impact the work life balance of staff;
- Ineffective rostering arrangements may impact high quality standards of care and create an exposure to greater clinical risks; and
- Inadequate management oversight of the rostering process may result in inefficient rostering arrangements, which may impact patient safety, staff wellbeing and increase the financial burden on the Health Board.

2. Findings

2.1 The table below provides an overview of progress in implementing the previous internal audit recommendations:

Original Priority Rating	Number of Recommendations	Implemented / Obsolete (Closed - No Further Action Required)	Action Ongoing (Further Action Required)	Not implemented (Further Action Required)
High	4	1	1	2
Medium	2	1	-	1
Low	3	3	-	-
Total	**9**	**5**	**1**	**3**

2.2 Full details of recommendations requiring further action are provided in the **Management Action Plan** in **Appendix A**.

Appendix A: Management Action Plan

Previous Matter Arising 2: Roster process is not timely (Operation)		
Original Recommendation		Original Priority
Arrangements should be put in place to ensure that rosters are created, approved and published in line with the roster timetable.		**High**
Management Response	Target Date	Responsible Officer
The Corporate Nursing Team (working with the e-rostering team) are producing monthly reports for Roster Managers, Senior and Lead Nurses. The reports contain information on rosters that have not been approved or not approved in accordance with the rostering timetable. Recently these reports have been sent to Clinical Board DoN requesting that more focus is placed on the importance of publishing the roster 6 weeks in advance. Compliance will be monitored monthly via the Rostering KPI dashboard.	31/03/2024	Emma Davies, Senior Nurse, Nurse Staffing Levels Paul Jones, E-Rostering Manager Directors of Nursing, Clinical Boards
Current findings		**Residual Risk**
Weekly notifications are sent to remind staff that the rostering timetable needs to be complied with. Reports are sent to Roster Managers, Lead and Senior Nurses and Clinical Board Director of Nurses. Roster reviews have been undertaken with a number of the wards and one of the areas that is considered within the reviews is 'whether the rosters are partially and fully approved on time'. We were provided with a report, and it highlighted the number of rosters on time, late and unapproved for the seven Clinical Boards and the Corporate Division for the roster periods 31st March to 18th August 2024. During that period there were 2780 rosters and of these 1370 (49%) were late and 154 (6%) were still unapproved at the time of our audit. Below is a table of the numbers of on time, late and unapproved rosters for that period:		• Late preparation and agreement of rosters may impact the work life balance of staff; • Ineffective rostering arrangements may impact high quality standards of care and create an exposure to greater clinical risks.

Clinical Board	On time	Late	Unapproved	Grand Total
Specialist Services	260	239	31	530
Surgical	249	242	14	595
Medicine	207	238	44	489
Mental Health	146	241	15	402
Children & Women	188	166	23	377
CD&T	102	147	13	262
PCIC	92	83	13	188
Corporate	12	14	1	27

Conclusion: This recommendation is not completed.

New Recommendations		Priority
2.1	Rosters need to be published on time in line with the roster timetable and also approved.	High

Management Response		Target Date	Responsible Officer
2.1	In response to many rosters not being published 6 weeks before they commence, a new monthly report has been developed to identify both the number and percentage of wards/departments who are not issuing their rosters on time for each Clinical Board. This is presented at the Nursing and Productivity Group each month to ensure	1 April 2025	Carys Fox / CB Directors of Nursing

	this is being performance managed by the Clinical Board Directors of Nursing. However, due to the current way that theatre lists are configured, this means that the same target for peri-operative staff cannot be included at this time but will however aim to achieve this same objective but over a longer period.		

Previous Matter Arising 4: Auto-rostering functionality uptake (Operation)		
Original Recommendation		Original Priority
The E-Roster Team should continue to liaise with the Roster Managers and ensure that the rules and parameters within the HealthRoster system are up to date and working effectively to improve the effectiveness and uptake/utilisation of the "auto-roster" functionality.		**Medium**
Management Response	Target Date	Responsible Officer
• The e-rostering team have just undertaken roster reviews with approx. 45 ward areas, this was an in-depth review which took 50 days in total. The team are working with Roster Managers daily to ensure the rules and parameters they need are built into the HealthRoster system. The aim is to build confidence in the function, change behaviours and increase the number of rosters that are created using the auto-roster functionality. The improvement will be monitored monthly through the KPI dashboard. • The e-rostering Leads (3x band 6) are aligned to CBs to ensure that Roster Managers have the appropriate level of support to use the system to its full potential, including auto rostering.	31/03/2024	Paul Jones, E-Rostering Manager Roster Managers, Clinical Boards
Current findings		**Residual Risk**
Roster reviews have been undertaken with the wards and it was evidenced that the usage of the auto-roster functionality was discussed within these reviews. The e-rostering Leads have been aligned to the Clinical Boards to provide support as required. We were advised by the E-Rostering Manager that to produce a roster it has been agreed that: • 25% of roster completion should be undertaken via requests from the staff; • 50% of roster completion should be through auto-rostering; and • The remaining 25% of roster completion should be then completed by the Rostering Manager.		• Ineffective rostering arrangements may impact high quality standards of care and create an exposure to greater clinical risks; and • Inadequate management oversight of the rostering process may result in inefficient rostering arrangements, which may impact patient safety, staff wellbeing and increase the

We were provided with a report of all rosters for the roster dates 31st March to the 18th August 2024 and it showed the % of rosters that had been auto-rostered. There were 2780 rosters and the average % of rosters that had been auto-rostered were 38% for all these rosters. We note that this is an improvement on the percentage of auto-rostering at the time of our original audit, but still falls short of the agreed 50% target. **Conclusion:** This recommendation is not completed.		financial burden on the Health Board.

New Recommendation(s)		**Priority**
4.1	The E-Roster Team should continue to liaise with the Roster Managers and ensure that the rules and parameters within the HealthRoster system are up to date and working effectively to improve the effectiveness and uptake/utilisation of the "auto-roster" functionality.	**Medium**

Management Response		**Target Date**	**Responsible Officer**
4.1	Although the auto rostering feature has been made available for all areas, take up has been limited due to individual work life balance agreements not being up to date in the Health Roster system. CB Directors of Nursing will request all areas who are not using the auto roster feature to contact the E-Rostering team to ensure all WLB agreements are current and can therefore improve the capability of publishing usable rosters.	1 April 2025	Carys Fox / CB Directors of Nursing

Previous Matter Arising 7: Incorrect working hour balances (Operation)		
Original Recommendation		Original Priority
Arrangements should be put in place to ensure that staff balances are being managed adequately to ensure that staff are working their contracted hours and are not owing or being owed excessive hours.		**High**
Management Response	Target Date	Responsible Officer
Embedding an effective rostering culture is one of the UHB's top priority and the system will support drive the efficiency. Corporate Nursing, People & Culture and Clinical Boards have worked together to reach an agreement on how we will support managers to embed effective rostering principles and achieve this priority.		
• Monthly e-rostering reports were piloted in October, every DoN has received a report for their Clinical Board, detailing every member of staff who has an owing time balance between 24 and 100 hours. Lead Nurses are validating this data and rostering the outstanding hours as appropriate. Progress will be monitored on a quarterly basis.	31/03/2024	Emma Davies, Senior Nurse, Nurse Staffing Levels
• For time balances owed over 100 hours the E-Rostering Team are undertaking regular reviews of rosters. Any staff member that owes over 100 hours will be discussed and validated with the Roster Manager. Changes will be made in the system to correct the balance and any genuine time balances will be rostered by the Roster Manager.	31/03/24	Paul Jones, E-Rostering Manager
• A Rostering Dashboard has been created that provides high level data in relation to rostering KPIs. This will be developed into a more intuitive tool once the DataHub has been implemented. The dashboard will help monitor the agreed KPIs and will provide assurance that effective rostering is being embedded into the UHB and efficiencies are being achieved through the HealthRoster system.	31/03/24	Paul Jones, E-Rostering Manager
Current findings		**Residual Risk**
The Corporate Nursing Team have produced a Nurse Staffing Dashboard and there is a report of 'Staff with a time imbalance of >18 hours (Current Roster)'.		• Ineffective rostering arrangements may impact high quality standards of care

Corporate Nursing have reviewed all Nurses that had more than 18 hours and produced reports showing this data. They worked with Senior and Lead Nurses to address it. Reports have continued to be produced showing the excess hours and are shared with the wards. The E-Rostering team cleansed all the rosters to ensure that there were no staff with over 100 hours balance. In cases where there are staff with over 100 hours balance the E-Rostering team will investigate the reasons for it and address accordingly. Although the management actions have been actioned and we can see improvements have been made, there are still cases whereby staff have excessive hours. **Conclusion:** This recommendation is partially completed.		• and create an exposure to greater clinical risks; and • Inadequate management oversight of the rostering process may result in inefficient rostering arrangements, which may impact patient safety, staff wellbeing and increase the financial burden on the Health Board.

New Recommendation(s)		**Priority**
7.1	E-Rostering team need to continue to work with Corporate Nursing to ensure that staff balances are being managed adequately.	**Low**

Management Response		**Target Date**	**Responsible Officer**
7.1	There have been some significant improvements in managing the hours owed but it is accepted that this needs to be performance managed on an ongoing basis within the Clinical Boards. However, it needs to be noted that there will be a number of situations such as staff on sick leave and maternity leave who will be unable to work the hours back within specific timeframes.	Ongoing	Carys Fox/CB Directors of Nursing

Previous Matter Arising 8: Roster verification and finalisation (Operation)		
Original Recommendation		Original Priority
Arrangements should be put in place to ensure that Roster Managers are finalising shifts in a timely manner. staff balances are being managed adequately		**High**
Management Response	Target Date	Responsible Officer
A monthly report is sent to Roster Managers to inform them how many unverified shifts they have outstanding, any outstanding shifts are escalated to the DoN 3 days and 1 day before the payroll is run. It has been agreed with the Executive Director of Nursing that any shifts that have not been verified in time will not be processed for Payroll, this has been communicated to all Roster Managers. Unverified shifts are no longer a KPI that the Health Board intends to use. The number of unverified shifts will be closely monitored by the e-rostering team and if it becomes problematic it will be escalated to DoNs, Corporate Nursing team and the EDoN.	31/03/2024	Paul Jones, E-Rostering Manager Directors of Nursing, Clinical Boards
Current findings		**Residual Risk**
There is a weekly report produced of unverified shifts which are sent to Roster Managers to advise them of the need to verify the shifts. In addition, an email is sent along with a report of all unfinalised shifts to the Clinical Board Director of Nurses confirming the dates that the shifts need to be finalised by for them to be paid on the next payrun. Rosters being finalised at least weekly is included within the roster reviews. We were provided with a report of all unverified shifts for the period April to October 2024 for the seven Clinical Boards and the Corporate Division. It was highlighted that there are 6716 shifts that had not been verified for that period. Below is a table of the unverified shifts by Clinical Board and the Corporate Division:		Inadequate management oversight of the rostering process may result in inefficient rostering arrangements, which may impact patient safety, staff wellbeing and increase the financial burden on the Health Board.

Clinical Board	April 2024	May 2024	June 2024	July 2024	August 2024	September 2024	October 2024	Grand Total
Medicine	17	344	200	153	202	224	187	1327
Specialist Services	27	155	41	90	89	210	161	773
Children & Women	22	373	71	163	54	134	149	966
Surgery	6	74	27	99	12	34	127	379
Mental Health	33	188	738	211	130	51	67	1418
PCIC	0	16	82	26	9	27	37	197
CD&T	0	59	65	51	958	1	11	1145
Corporate	1	78	136	133	146	0	17	511

Conclusion: This recommendation is not completed.

New Recommendation(s)		Priority
8.1	Roster Managers should ensure that they are finalising shifts in a timely manner. Clinical Board Director of Nurses need to emphasise the importance to the Roster Managers of finalising the shifts.	**High**

Management Response		Target Date	Responsible Officer
8.1	Although the verification of bank and agency shifts is no longer an issue, the verification of substantive shifts within the Clinical Boards requires improvement. A report is now presented monthly at NPG to identify the number of shifts that are not approved by the payroll deadline and then have to be cancelled. The report will	1 April 2025	CB Directors of Nursing

	enable the Executive Director of Nursing to performance manage this issue on an ongoing basis. A further communication will be developed and sent to all Ward Sisters and Charge Nurses explaining that the deadlines need to be complied with as it delays the payments to their staff and also results in them having to do additional work by re-entering the shift on health Roster and then verifying.		

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure. **Follow up:** All recommendations implemented and operating as expected
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved. **Follow up:** All high priority recommendations implemented and progress on the medium and low priority recommendations.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved. **Follow up:** No high priority recommendations implemented but progress on most of the medium and low priority recommendations.
	**Unsatisfactory assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved. **Follow up:** No action taken to implement recommendations

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership