Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

Cardiff and Vale University Health Board

GIG CYMRU NHS WALES

Cardiff and Vale UHB

Annual Quality Report

2024– 2025

Foreword from the Chair and Chief Executive

We are pleased to present our 2024/2025 Annual Quality Report, which sets out the progress made over the past year in delivering safe, effective, and person-centred care across Cardiff and Vale University Health Board. This report aims to provide a clear and honest account of the quality of our services, the improvements made and the areas where we continue to learn and grow. It is designed to be accessible to our patients, colleagues, partners, and communities, reflecting what matters most to them.

We recognise that this year has been marked by significant financial pressures with increased scrutiny that culminated in the organisation being put into targeted intervention. While we have continued our drive towards efficiency and improving our financial position, our commitment to quality and safety has remained steadfast. We have continued to invest in improvement, innovation and listening to the voices of those who use and deliver our services. This report provides an open and transparent account of the successes and the challenges faced as an organisation. It provides a candid account of patient safety incident themes, including Never Events, but also provides details of the work being undertaken to deliver improvements in care.

This year, in response to concerning feedback from staff working in our theatre services, we commissioned a comprehensive Theatre Review. This was a key step in understanding the issues raised and identifying actions to improve the working environment and patient experience in this critical area of care. While the report made for difficult reading, it has allowed us to focus on delivering the necessary improvements. We will continue to work with the peri-operative workforce throughout 2025/26 to deliver the quality that we have committed to.

We are proud of the progress made through our Quality Excellence Programme, which continues to drive forward improvements in clinical practice and patient outcomes. We also made significant strides toward the launch of our Electronic Prescribing and Medicines Administration (EPMA) platform during the financial year, which will significantly enhance medication safety and streamline care delivery.

Our commitment to research and development remains one of the cornerstones of our approach to quality. We continue to support innovation and evidence-based practice, ensuring that our services evolve to meet the needs of our population.

Finally, we would like to extend our heartfelt thanks to our Co-Production Group, whose partnership has been invaluable in shaping this report. Their input has ensured that the information presented is accessible, meaningful, and aligned with what our communities want to know.

Together, we remain focused on delivering high-quality care, learning from feedback, and working in partnership to improve health outcomes for all.

Suzanne Rankin
Chief Executive

Professor Charles Janczewski
UHB Chair

Introduction to the Cardiff and Vale Health Board Annual Quality Report

What This Report Tells You

Welcome to Cardiff and Vale University Health Board's Annual Quality Report for 2024/25. This report gives an overview of the care and services we have provided over the past year to people in Cardiff, the Vale of Glamorgan, and the wider region.

In 2023, we launched our 10-year strategy. It sets out our commitment to delivering outstanding care that is fair, timely, and safe. We aim to treat everyone with kindness and support them to achieve the outcomes that matter most to them. We are also working to reduce health inequalities and improve access to services and health outcomes.

This report looks at:

- The quality of care we have delivered
- How we have listened to staff, patients, and carers
- When, where, and how our services have been provided

The Duty of Quality

Since 2023, all NHS Wales organisations must follow the Duty of Quality—a law that ensures health services are always improving and providing the best possible care. You can learn more about this on the Welsh Government website

Why the Duty of Quality Matters

Better care – We must keep improving our services and treatments

Patient safety – Care must be safe and reliable

Listening to people – Feedback helps us make care more personal

Healthier lives – We want people in Wales to live well for longer

At Cardiff and Vale UHB, this means making sure everything we do is safe, effective, and focused on what matters to patients and their families. We know things don't always go perfectly, and when they don't, we learn from those experiences and make improvements to stop the same issues from happening again.

Working Together

This year, we are especially proud that this report was shaped and co- created with people who have used our services. Their voices and experiences helped guide what we have included and how we have presented it.

We have worked hard to make this report clear, inclusive, and accessible for everyone in our communities.

Thank You

We hope you find this report informative and easy to read. You can view a short clip of Rhys one of the co -production group for a brief summary here.

How is this document set out?

In Wales, we measure the quality of the care that we provide by considering the Health and Care Quality Standards. These are made up of six domains of quality and six quality enablers. These are a set of rules that help make sure NHS Wales services are safe, fair, and focused on patients (Figure 1).

Figure 1. Health and Care Quality Standards

The Quality Enablers are;

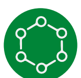
Leadership - This means making sure everyone knows what the organisation wants to do, so things are done the right way.

Culture - People work together to improve quality. They feel safe, supported, and included.

Workforce – Staff are valued and happy. They are confident and skilled to deliver safe care. They should have the right equipment and training to do a good job..

Data to Knowledge - Different pieces of information will help us to understand how good the services are, so we can learn and keep making things better.

Learning, improvement, and research - Find ways for everyone to learn from each other and from what works well.



Whole systems perspective - We make healthcare better for everyone by learning what works, checking if things are going well, and fixing problems.

The Domains of Quality are;

Safe – Ensuring that healthcare services do not cause harm to patients

Timely – Providing the right care at the right time

Efficient – Delivering well organised services that don't waste valuable resources

Effective – Delivering care in line with scientific knowledge and best practice to achieve best outcomes for patients

Equitable – (fair) – Delivering the same standard of care and ensuring the same outcomes for all people, regardless of where they live or their protected characteristics

Person centred - Treating people as individuals and involving them in decisions about their own healthcare

We have used both the **Domains of Quality** and the **Quality Enablers** to organise this report.

How will we make it easier for everyone to find and understand this information all year round?

We can't include every single service in this report, but we've tried to give a clear and honest picture of how we are doing in key areas. This report includes links to other documents and reports that are already available for the public to read. In the future, we want to make it even easier for everyone to find and understand this information.

We are working to create **'always on reporting'**. This means we'll be able to share important updates all the time - not just once a year - so people can see how we are keeping patients safe and improving services.

These are examples of what we will share with you through always on reporting.

- **Reporting safety incidents** – Healthcare staff record incidents or near misses that are investigated so that we can learn and prevent future problems
- **Tracking health outcomes** – The Health Board monitors data and information including infections rates, vaccinations uptake and patient outcomes including length of stay, mortality (death rates), and recovery.

- **Being open and honest when things go wrong** – The Health Board reports serious incidents to Welsh Government. When we make mistakes, we are open and honest with patients and their loved ones about what has happened and how we are working to prevent them from happening again
- **Checking healthcare performance** – The Health Board reports on waiting times to Welsh Government for services such as surgical operations and cancer treatment. Health Boards in Wales take part in national audits to check how well they treat certain health conditions. For example, they review care for stroke patients and people with hip fractures to see what is working well and what needs improvement. These audits help make treatments safer and more effective, ensuring better care for patients.

Our Quality Excellence Programme

Last year, we told you we were launching a new programme to help make our care even better. We are delighted to tell you that this work is well underway. We are working on five key areas which we have chosen specifically. We think that working on these areas will help us make the biggest difference to the quality and safety of our services. Link to video here to be added These are the five areas that we will be working on:

1. Quality Management System (QMS)

We are improving our Quality Management System to help us make sure our care is safe, consistent, and always improving.

Our Quality Management System will be a clear plan that helps us:

- to design high quality services,
- to develop methods of monitoring and where necessary, improving care.

2. Hospital Acquired Infections

We are working hard to stop people from getting infections while they are in hospital. Over the last year, we have reported increased rates of infections in people receiving healthcare either in our hospitals or in the community. There are many reasons for this.

Why are infections increasing?

We know that some medications, in particular antibiotics, can increase an individual's risk of developing infections. Other measures, including the cleanliness of the hospital environment and good hand hygiene can result in reduced infection rates.

What are we doing?

This project will support the design of systems that allow us to access improved data (information). This will improve our knowledge and understanding about health practices that keep people safe from infection.

Brilliant Basics campaign

One of the projects we have launched is our Brilliant Basics campaign. This reminds everyone to follow the core rules that help stop infections - like cleaning hands and keeping areas clean. You can read more about this later in this report.

In September 2025 the Health Board Quality Committee reported on the work that had been undertaken in the previous twelve months to reduce infection rates. You can listen to the discussion in our Quality Committee here

3. Acute Deterioration

In line with the whole of NHS Wales, we are improving the way that we can quickly identify when a patients' clinical condition is deteriorating (getting worse). Signs of clinical deterioration in patients can be very subtle and difficult to detect. The sooner that we recognise deterioration; the sooner action can be taken, and clinical staff can provide the best possible treatment to help the patient recover.

What is happening?

We are making changes to how we monitor patients and identify if their health is deteriorating.

We currently use a tool called the National Early Warning Score (NEWS), which uses measurements, including heart rate, blood pressure and temperature to calculate a score that is used to spot deterioration in the condition of adults. There are also different versions of this tool that we will use in caring for children, newborn babies up to the age of 28 days and pregnant women in labour.

What is changing?

NEWS 2 now includes the recognition of confusion as a sign that a patient might be clinically deteriorating. It also helps in identifying sepsis (a serious condition resulting from harmful bacteria in the blood which could cause death) in patients who have a suspected infection. The updated version is already being used in England. From July this year we have introduced this into all our adult clinical areas in the health board. By the end of the year, we expect that all the various tools will have been fully introduced into clinical practice.

What are we doing?

All clinical staff will receive training in the use of these tools. The training will prepare staff to understand the scoring and the correct actions to take when they recognise clinical deterioration in a patient.

Why does this matter?

By always using NEWS2 we can;
Spot early signs when a patient is getting worse (like sepsis or breathing problems)
Make sure staff know when to act
Help save lives
Improve communication between teams

4. Lost to follow up

When people are referred to a clinic by a General Practitioner (GP), they may require a series of appointments while undergoing tests or receiving treatments. When attending a clinic or a virtual (online) appointment, the doctor or other health professional will decide with the patient what will happen next. This might be arranging a further appointment, requesting tests or scans, or scheduling a procedure.

Occasionally, this communication can go wrong – an appointment letter can get lost in the post for example, or an electronic referral fails to reach the correct team. We are working on new ways to make sure patients are seen by the right person at the right time so that they don't get missed or 'lost' in the system.

We know that these issues with communication can cause harm if a patient's investigations or treatments are delayed. This is why we have been working on improving our systems to make errors less likely. The health board aims to ensure through this project, that every person that has contact with the health board has a very clear outcome following that contact.

This might include;

- booking their next out -patient clinic appointment, ensuring that they understand where and when that will be,
- scheduling a procedure or a surgical operation, clearly explaining what that entails,
- or it could mean discharging a person when care and treatment it is no longer required.

What are we doing?

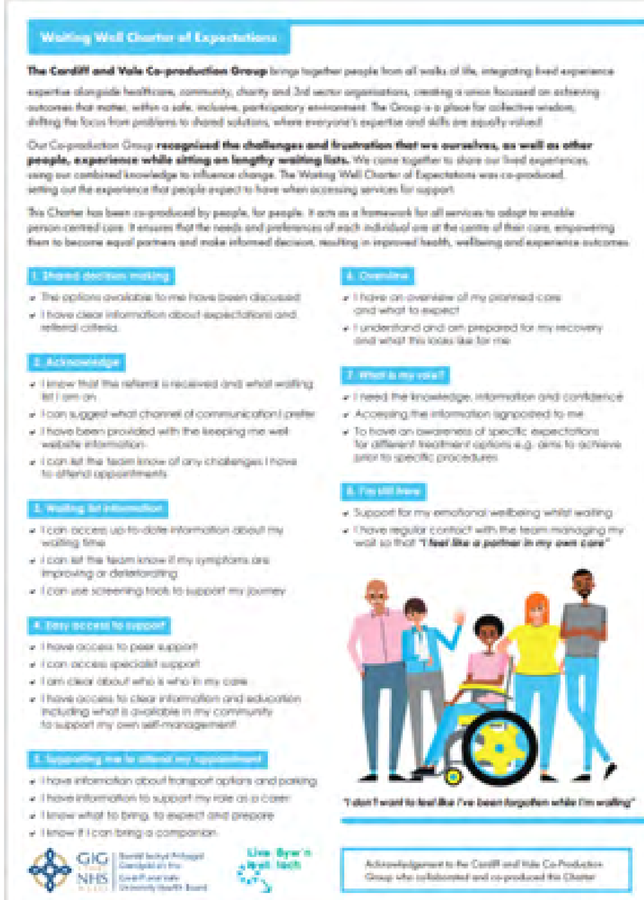
We are making the referral process (how patients are sent to the right service) the same for everyone. Where possible, we are trying to move away from paper-based referral letters as these can be more prone to problems, such as becoming lost in the post or damaged in transit.

We are also improving how we book follow-up appointments for patients who have been seen in outpatient clinics to ensure nobody is forgotten.

Waiting Well Charter

We know that being on a waiting list for investigations or treatments can be a worrying time. We are working with patients to make sure our systems are patient friendly.

The Waiting Well Charter (Figure 2) was developed by people using our services and helps us to communicate better and to make sure patients feel informed and supported while they wait.



Waiting Well Charter of Expectations

The Cardiff and Vale Co-production Group brings together people from all walks of life, integrating lived experience expertise alongside healthcare, community, charity and 3rd sector organisations, creating a union focussed on achieving outcomes that matter, within a safe, inclusive, participatory environment. The Group is a place for collective wisdom, shifting the focus from problems to shared solutions, where everyone's expertise and skills are equally valued.

Our Co-production Group **recognised the challenges and frustration that we ourselves, as well as other people, experience while sitting on lengthy waiting lists.** We came together to share our lived experiences, using our combined knowledge to influence change. The Waiting Well Charter of Expectations was co-produced, setting out the experience that people expect to have when accessing services for support.

This Charter has been co-produced by people, for people. It acts as a framework for all services to adopt to enable person centred care. It ensures that the needs and preferences of each individual are at the centre of their care, empowering them to become equal partners and make informed decision, resulting in improved health, wellbeing and experience outcomes.

1. Shared decision making
- The options available to me have been discussed
- I have clear information about expectations and referral criteria

2. Acknowledge
- I know that the referral is received and what waiting list I am on
- I can suggest what channel of communication I prefer
- I have been provided with the keeping me well website information
- I can let the team know of any challenges I have to attend appointments

3. Waiting list information
- I can access up-to-date information about my waiting time
- I can let the team know if my symptoms are improving or deteriorating
- I can use screening tools to support my journey

4. Easy access to support
- I have access to peer support
- I can access specialist support
- I am clear about who is who in my care
- I have access to clear information and education including what is available in my community to support my own self-management

5. Supporting me to attend my appointment
- I have information about transport options and parking
- I have information to support my role as a carer
- I know what to bring, to expect and prepare
- I know if I can bring a companion

6. Overview
- I have an overview of my planned care and what to expect
- I understand and am prepared for my recovery and what this looks like for me

7. What is my role?
- I need the knowledge, information and confidence
- Accessing the information signposted to me
- To have an awareness of specific expectations for different treatment options e.g. aims to achieve prior to specific procedures

8. I'm still here
- Support for my emotional wellbeing whilst waiting
- I have regular contact with the team managing my wait so that **"I feel like a partner in my own care"**

"I don't want to feel like I've been forgotten while I'm waiting"

Acknowledgement to the Cardiff and Vale Co-Production Group who collaborated and co-produced the Charter

Figure 2- Waiting Well Charter

5. Medication Safety

Medicines are one of the most effective tools to treat illness, but if not used correctly, can result in harm. Medication errors can happen at any stage; from the prescription to the giving of medication to a patient; even small mistakes can lead to harm. This project is making sure people get the right medicine, at the right time, in the safest way in our clinical areas.

What is the goal?

To make sure medicines are:
Safe
Work well
Fair for everyone

What are we focusing on?

We are looking closely at high-risk medicines, like:

- Insulin (treats diabetes)
- Opiates (strong painkillers)
- Thromboprophylaxis (medicines to stop blood clots)

Who is involved?

We are bringing together lots of specialised staff to help make this project a success.

Safe care

We keep people safe and healthy
We learn from mistakes to prevent them
We protect people who may be at risk
We act quickly to keep people safe

Nationally Reportable Incidents

Why is this important?

Cardiff and Vale University Health Board works hard to keep everyone safe in their care, however healthcare is associated with risk, including side effects from medications, risks relating to surgery and risks associated with the huge volume of patients cared for. While most people who are cared for by the health board have very good outcomes, there are occasions when incidents occur.

If it is considered that that a person might have experienced significant harm because of healthcare, a robust investigation will take place. If, through the investigation, it is established that the care fell below the necessary standard, processes to learn and improve will be put in place to try and prevent this from happening.

These serious events are called National Reportable Incidents. All health boards in Wales must report these to NHS Wales Performance and Improvement. This organisation pays particular attention to these types of incidents for the whole of Wales ensuring we can all learn and make improvements to keep our services safe.

In June 2025 the health board Quality Committee published a report about the Nationally Reportable Incidents that had occurred in the previous twelve months. You can read this report here.

What kind of incidents happened?

Stillbirths and neonatal deaths

All stillbirths or neonatal deaths are tragic events, regardless of whether they were expected or not. In each case, the care that had been provided through pregnancy and birth receives a full review by a team of clinicians to help us to understand if there was anything that could have been done differently. This also helps us to contribute to national programmes helping to improve maternity outcomes.

What are we doing?

While these reviews have shown that in many cases the care has not contributed to the sad event, they still allow opportunities to learn and improve care. Some of the changes that have been made because of learning from reviews include;

- Improving the way that the temperature of newborn babies is kept stable,

- Recording the growth of babies throughout pregnancy and ensuring access to growth scans when needed,
- Ensuring that all women who have an induction of labour have the same levels of monitoring particularly when they are prescribed strong pain killers.

In November 2024 the Health Board Quality Committee published a report about the findings of the Perinatal Mortality (death of a foetus or neonate around the time of delivery) Review Tools. You can read the full report here.

Endoscopy

Several incidents were reported in 2024/25 because patients waited too long for an endoscopy procedure (a medical investigation that involves examining the insides of the bowel or stomach with a camera). Some people who are at greater risk of developing bowel, oesophagus or stomach cancer will have regular investigations to check for unhealthy changes. Long waiting lists led to delays in inviting people back for these important checks and in several cases, there were delays in diagnosing and treating cancer.

What are we doing?

In the past year work has been undertaken to protect endoscopy appointments and to review the clinical checks of people on waiting lists. This work has been successful in ensuring that people who require ongoing surveillance (monitoring) checks now have these undertaken within the correct time scale. Further work is being undertaken to update the referral process, this is to ensure that complex endoscopy procedures can be done without delays. The work is also focussing on making sure the correct adjustments for people with additional needs are made so that the same standard of care is received by all patients attending the department.

Never Events

Never Events are very serious clinical errors that should never happen in healthcare because there should be checks and safety measures in place to prevent them. Even if no one is harmed, they are still taken very seriously.

Examples of Never Events:

- Undertaking a procedure or treatment on the wrong part of the body
- Unintentionally leaving something inside a patient after surgery
- Giving medicine via the wrong route

What happened this year?

In 2024/25, Cardiff and Vale University Health Board reported 13 Never Events. This is not the standard of care that we should be providing, and each case showed that the process of safety checks was not completed in a way that prevented the incidents.

Wrong site procedures

What happened?

There were five occasions when procedures were undertaken on the wrong site, with local anaesthetic injections being the most common error.

Stop Before You Block

Stop before you block is a step in a local anaesthetic (numbing) procedure that takes place immediately before a needle

is inserted. It is a moment for the clinicians undertaking the injections, and those supporting or helping them, to confirm the patient details, the correct procedure and the correct procedure site or side. If the patient is awake during the procedure, then they should be asked to confirm as much of this information as possible.

What are we doing?

Reviewing the never events highlighted that this safety check was often not being undertaken properly. A local safety procedure has been developed to ensure that all clinicians undertaking these anaesthetic procedures follow the same process. The procedure also sets out the need for all clinicians to undertake training and a competency assessment before they can undertake this anaesthetic injection.

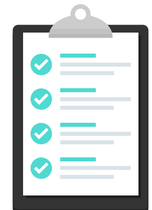
Nasogastric tubes

Nasogastric tubes are thin tubes inserted through the nose and into the stomach and are used to provide nutrition for people who might otherwise have difficulties in eating. Checking the correct placement of nasogastric tubes is important as it ensures that the tube has not been passed accidentally into the lung. Immediately after inserting a tube and before every episode of feeding the clinician should check the placement of the tube by testing the liquid that they can draw out of the tube.

What are we doing?

We are making our checking processes stronger to include additional checks to be undertaken after moving or rolling a patient. This will provide a safeguard if the tube is dislodged while moving the patient. We are also revising the training we provide to clinicians to ensure that as well as those that insert nasogastric tubes, we are providing education to clinicians that provide ongoing care for patients with tubes in place.

World Health Organisation checklist



The World Health Organisation (WHO) is an internationally recognised safety checklist used in theatres and similar environments to prevent errors. The WHO checklist also ensures that theatre teams are prepared for any complications that might occur during an operation. Undertaking detailed reviews of each never event allowed us to identify that there were areas of the WHO Checklist process that we could strengthen, being very clear about which healthcare professionals should be involved in each stage of the checklist.

What are we doing?

We have formed a WHO Checklist collaborative that includes anaesthetists, surgeons, scrub practitioners, anaesthetic practitioners and clinicians from other specialities. The collaborative is working together to strengthen the Health Board's WHO checklist process and to co-produce a way that the whole team can see and be involved in the completion of the WHO checklist.

Wrong size implant

Twice, the wrong size of an implant (called a prosthesis) was used in surgery. On one occasion the wrong device was selected prior to surgery and in the second case the incorrect part was selected during surgery.

What are we doing?

More robust safety checks have been put in place to check the device, the size and the expiry date in each procedure. We are also exploring how we can use technology called

Scan 4 Safety to strengthen these checks further. Scan 4 Safety allows the scanning of barcodes on devices that will be implanted into individuals and the barcodes on patient wristbands. This allows an accurate record of which devices are used for each person and are an added check to ensure that multi part devices are compatible.

What This All Means

The health board is working hard to make sure everyone is safe. They are:

- Giving better training
- Using smart tools like barcodes
- Making sure everyone engages with, and follows safety checks.

Preventing pressure ulcers: Using technology to improve care

What is a pressure ulcer?

Pressure ulcers – sometimes known as pressure sores or bedsores – happen when sustained pressure, friction, or shear restricts

blood flow to areas of the body, especially over bony parts like the heels, hips, or sacrum (the base of the spine). This lack of circulation can lead to skin breakdown and tissue damage. Pressure ulcers are very serious and can cause pain, discomfort and even death in severe cases.

Who is at risk of developing a pressure ulcer?

People who are immobile, unwell, or have poor nutrition or hydration are at greater risk of developing a pressure ulcer.

How can they be prevented?

The good news is that pressure ulcers are often, although not always, preventable. Regularly changing position, checking the skin, and helping people to eat and drink well all help reduce the risk. The presence of pressure ulcers is often seen as an important indicator of how well someone is being cared for. Preventing or treating pressure damage to the skin quickly is an important part of delivering safe and effective nursing care.

The Role of the District Nurse

District Nurses play a critical role in the community in caring for patient's skin. They provide nursing care in people's homes to those too ill to reposition themselves at home. Many patients might otherwise spend long periods sitting or lying down, putting them at higher risk of developing a pressure ulcer.

What are we doing?

Three district nursing teams have been trialling a digital application called "Minuteful for Wound". The 'app' allows nurses to take high-quality 3D pictures of pressure ulcers where they are automatically measured and stored. The information can then be securely shared with the Tissue Viability Nurses (Specialist wound nurses) or Senior nurses who can review the information remotely. This means expert input can be provided quickly, without needing to send the

patient to a hospital or clinic. It also allows better monitoring over time, supporting faster decisions about care and treatment.

What has happened so far?

Over 4,103 digital wound assessments were completed

356 infected wounds were identified

There have been improved healing rates

There have been fewer hospital admissions and reduced home visits

Patients reported feeling more involved and informed about their care, and district nurses reported increased confidence in the decisions they were making.

What will happen next?

The next phase will see all district nursing teams across the Cardiff and Vale area using the technology. Practice nurses in GP surgeries have also been involved in the testing of the app and work closely with community teams to improve access to timely, expert wound care. By using digital technology, we are helping ensure people receive the best possible care safely, quickly, and in the place they call home.

Safe Care in Mental Health Services

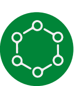
In patient suicide

After six inpatient suicides in 2021 and 2022, the Health Board asked the Royal College of Psychiatry to review the care given to those patients. The aim was to check if the care we provided met national standards, including proper record keeping and procedures. The report, published in 2025, found areas that required improvement, in particular, identification of risks, completion of risk assessments, and applying the Mental Health Act correctly. The review also found that the previous way of investigating patient safety incidents didn't include families or lead to clear recommendations.

What are we doing?

Since then, the health board has changed its approach to undertaking patient safety learning reviews. Importantly, patients and families are now involved in reviews. Because of the improvement in the way families are involved in investigations Mental Health services have earned Royal College of Psychiatry Safety Incident Response (SIRAN) Accreditation. In August 2025, the health board Quality Committee received an update on these improvements. You can watch the presentation here.

Patient Safety Alerts



Patient Safety Alert

PSA015 / 27 January 2023

Safe use of oxygen cylinders in areas without medical gas pipeline systems

To: **All NHS Chief Executives, Medical Directors, Directors of Nursing and Patient Safety Teams.**

During periods of extreme pressures, often exacerbated by a surge in respiratory-related conditions, the demand on supplies of oxygen cylinders, in particular the small size cylinders, increases in the NHS. This is due to the need to provide essential oxygen treatment in areas without access to medical gas pipeline systems.

This surge in demand increases the known risks associated with the use of medical gas cylinders, and introduces new risks, across three main areas:

- patient safety
- fire safety
- physical safety

English system and data: Wales is issuing this notice as a precautionary measure

A search of incidents reported to the National Reporting and Learning System (NRLS) and Learning From Patient Safety Events (LFPSE) service in the last 12 months identified 120 patient safety incidents, with themes that included:

- cylinder empty at point of use
- cylinder not switched on
- cylinders inappropriately transported
- cylinders inappropriately secured

Some reports describe oxygen delivery to the patient being compromised, leading to serious deterioration and cardiac or respiratory arrest. In addition, to ensuring the safe use of oxygen cylinders, there is also a need to conserve oxygen cylinder supply to ensure a robust supply chain process.

Actions

When: Actions to be completed by 27 January 2023

Who: Health Boards / Trusts with an Emergency Department and WAST (all organisations who use/administer oxygen therapy via cylinders).

Implementation should be co-ordinated by an executive lead (or equivalent role in organisations without executive boards) and supported by clinical leaders in respiratory medicine, emergency medicine, nursing and pharmacy and by estates colleagues.

1. The Chair of the medical gas committee, working with key colleagues including WAST regional teams, should review the NHS England 'Safe use of oxyge[n] cylinders' best practice guidance and ensure a risk assessment is undertaken in all escalation areas/transient areas where patients are being acutely cared for (either temporarily or permanently) without the routine ability to access medical gas pipeline systems.

Queries should be sent to:
www.patientsafety.wales.nhs.uk

What is a Patient Safety Alert?

NHS Wales will issue a Patient Safety Alert to highlight a new or important safety issue, and to set out actions that healthcare organisations must take. The health board has fully implemented all the important safety measures issued in 2024/25.

What are we doing?

A process is in place to issue internal safety notices or safety memos to get important safety information out to our staff. For example, in January we issued a safety memo to alert staff to changes with oxygen flowmeters – the devices used to measure the oxygen given to patients.

In 2025/26, we will improve how we monitor responses to safety alerts. We have a digital clinical governance system that we will use to communicate safety alerts. and where necessary audit the actions being taken across the health board.

In -patient falls

Why is this important?

Falls are a significant concern in all hospitals as they can lead to serious injuries for patients, increase recovery time and length of stay in hospital. Our in- patient wards and clinical areas are working hard to make sure patients get help quickly and safely if they fall. The importance of training staff to prevent and manage falls was highlighted by His Majesty's Coroner at an inquest into the sad death of a patient who sustained a head injury following a fall in one of our community hospitals.

What are we doing?

At St David's Hospital, a new system lets ward staff call senior doctors for advice when a patient falls out of the hours of 9-5pm. This is done through a system called Consultant Connect which allows doctors and nurses to communicate about patients even if they are not in the same room. It helps by:

- Stopping unnecessary ambulance trips
- Giving nurses guidance and reassurance that they are following the correct procedure
- Allowing patients to stay on the ward for safe monitoring

We are also using action cards on our wards, which give staff easy-to-follow steps and valuable information about where to find equipment and who to call for help when a patient falls.

We have developed a falls training package, which is delivered to nursing staff as part of our preceptorship (new starters) programme. This is also being rolled out to existing ward staff.

Preventing Falls in the Community

Why is this important?

The health board want to help people stay strong and safe at home, because falling is not inevitable and something that just happens as we get older. Staying fit and active has been shown to reduce the risk of falling.

To help communities stay fit and active, the health board has created The Live Well, Age Well programme which is run by expert coaches in local community spaces across Cardiff and the Vale.

Live Well, Age Well

This six-week programme helps people feel more confident and less afraid of falling. Each one-hour session includes:

1. Group discussions on healthy ageing
2. Mild to moderate exercises to boost strength and balance

Many people say they feel more confident, more active, and ready to take part in community activities after completing the course.

By focusing on quick hospital care and preventing falls at home, we can help people stay safe, independent, and active.

Listen to Michaels Story of how the course made a difference to his life.

Quotes from participants:

"I have felt a lot more confident since starting the course. The coaches have been very helpful. It's made me think of joining other courses"

"Enjoyed the mix of talks and exercise, and variety of exercises. Trainers were fantastic. I feel motivated to do more exercise"

Infection prevention and control- keeping our hospitals clean and safe

Why is this important?

During 2024/25 we reported an increase in the number of patients who were diagnosed with several infections while in our care. These infections include Clostridium difficile (C diff), Methicillin Sensitive Staphylococcus Aureus (MSSA) and Escherichia coli (E coli). There are several factors that can lead to the increase in these infections, including prescribing of antibiotics, hand washing and the cleanliness of healthcare environments.

What has happened?

Neonatal Unit Infection Prevention and Control

Between April 2024 and March 2025, the neonatal unit experienced increased rates of a bacterial infection called Methicillin Resistant Staphylococcus Aureus (MRSA). Eighteen babies were identified as having MRSA during this period, and screening showed that in some of the cases there was evidence of the infections passing between babies.

What are we doing?

Improvements were made to the neonatal unit environment, improving storage and cleaning equipment. The unit was emptied and cleaned with hydrogen peroxide vapour. Regular cleaning of the unit was increased to twice daily throughout this period and every cot space was deep cleaned on a weekly basis. The infection screening and testing of babies increased during the outbreak and screening of parents was commenced.

The last infection was reported in January 2025, and the outbreak was closed in April 2025. Audits or inspections undertaken by the Infection Prevention and Control, Housekeeping and Estates teams with the neonatal nursing team will continue to reduce the risk of further infection outbreaks.

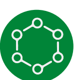
Renal Unit Infection Prevention and Control

In early 2025 we reported nine cases of a bacterial infection called Oxa-48 in the renal wards. It was noted that the screening of patients for infections when they were admitted to the ward was not always taking place.

What are we doing?

Weekly screening of all patients was commenced, and a patient information leaflet was developed to explain the importance of screening. All beds on the unit were stripped cleaned and inspected and monthly bed and mattress audits were put in place. Ward B5 was extended into the neighbouring ward to increase the space between beds and to increase the number of bathrooms and toilets available. No further cases have been reported since March 2025 and the outbreak was closed, however increased screening, inspections and audits continue.

Brilliant Basics campaign



At Cardiff and Vale University Health Board, everyone—not just doctors and nurses—play a role in keeping our hospitals safe.

Our **Brilliant Basics** campaign has 4 key areas of focus to make sure patients and staff stay healthy:

Our hands – Clean hands stop germs from spreading.

Our uniform – Wearing the right clothes helps keep the hospital safe.

Our technique – Doing things the right way protects patients.

Our standards – Always following the best practices keeps everyone safe.

We expect our staff to follow these golden rules-

CLEAN – Keep your hands germ-free

Wash your hands often, especially before and after touching a patient.

Gloves don't replace handwashing—wash hands even if you wear gloves.

No watches or jewellery—they can carry germs.

SMART – Wear your uniform the right way

Follow the dress code to keep the hospital clean.

No hoodies over uniforms—they bring in germs.

Wear clean scrubs and wash them properly.

Only wear scrubs at work, not outside.

SAFE – Take care when helping patients

Touch carefully—always use Aseptic Non-Touch Technique (ANTT).

Every touch matters—be careful when handling patients and equipment.

Follow the right steps for wound care, medicines, and other treatments.

Ask for help if you're unsure about a procedure.

SURE – Always aim for high standards

Do things the right way, even when busy.

Stay alert and report any problems.

Speak up if you see something unsafe.

Work together to keep hospitals clean and safe for everyone.

By following these simple rules, we can keep hospitals safe, protect patients, and stop germs from spreading. Everyone has a role to play!

Gloves Off campaign

On World Hand Hygiene Day in May, the health board launched Gloves Off! - a campaign to help hospital staff use fewer disposable gloves and focus on better handwashing. Sometimes, wearing gloves when they aren't needed can spread more germs instead of stopping them. It also creates a lot of waste.

Using fewer gloves helps in many ways:

Healthier skin – Wearing gloves too much can cause skin irritation.

Better handwashing – Washing hands properly is often safer than using gloves.

Less waste – Using fewer gloves helps protect the environment.

Saving resources – Hospitals can use money and supplies in smarter ways.

Better care for patients – Focusing on clean hands helps give kind and safe care.

By washing our hands properly and only using gloves when needed, we can keep hospitals cleaner, safer, and more welcoming for everyone.

You can find out more about the campaign by watching our Gloves Off video.

Cleaning Standards

We've been following national cleaning standards in our healthcare settings since before the Covid pandemic. New standards from the Chief Nursing Officer for Wales are expected soon, and we have already updated our cleaning routines in high-risk areas to reflect these changes.

What are we doing?

- Set up rapid response teams at UHW and UHL to deal quickly with infection risks like floods or outbreaks.
- Added an extra cleaning shift to increase how often clinical areas are cleaned.
- Created touch point teams across hospital sites to carry out checks and extra cleaning when needed.
- Introduced structured training for new housekeeping staff, with regular refresher sessions for current staff.

Cleanliness is a particular focus for Healthcare Inspectorate Wales during their inspection process. In October 2024, they visited two of our mental health wards and found some areas weren't clean enough. In response, ward and housekeeping teams did a walkaround, cleaned the areas, and introduced digital audits so nursing staff can regularly check and record cleanliness.

Safe medication-Electronic Prescribing and Medicines Administration (ePMA)

Why is this important?

During 2024/25 we have been preparing for the introduction of an electronic prescribing and medicines administration system, which will replace paper medication charts. This system will help us to improve the safety of medications within our hospitals. ePMA can tackle some of the problems with paper medication charts, such as unclear handwriting and missing charts. The system can also help us to give you the best medicines, for example it will warn your doctor if you are prescribed two medications that may interact (not work well) with each other.

What are we doing?

Changing from paper to electronic medication charts is a complicated process, especially in an organisation of our size. We have carefully designed a plan to roll out the system across our hospitals. Our kidney wards were the first to use the new system in June 2025. Learning from these wards will be used help us to roll out the system across our other wards later in the year.

As part of this work, we are updating the identification wristbands that patients wear in hospital. Adding a special square barcode allows us to scan the wristband before giving medicines, this acts as an extra check to make sure the right medicines are given at the right time. If you are on a ward where ePMA is being used, you may see staff using a device

Timely care

We provide care in the right place at the right time

We prioritise those with the greatest need

Safe at Home – Helping people get care at home

Safe at Home helps people in Cardiff and the Vale of Glamorgan get urgent medical care without going to hospital when it's safe to do so. This gives patients a better experience and helps emergency teams work more smoothly.

Who runs Safe at Home?

Safe at Home is a team effort between:
Cardiff and Vale University Health Board
Welsh Ambulance Services NHS Trust
Cardiff Council
Vale of Glamorgan Council
Since it started in last year, Safe at Home has helped over 1,000 people and saved over 9,200 hospital bed days.

Why is staying at home better?

For many people—especially those who are elderly or frail—staying at home for care can be safer. Long hospital stays can make people weaker, increase the chance of getting infections, and make it harder to stay independent. Safe at Home focuses on helping the people most at risk of staying in hospital for a long time.

Susan's Story

Susan, from Penarth, was referred to Safe at Home by NHS 111 Wales after a fall. She wanted to stay at home because she was afraid of getting weaker and losing her independence in hospital. Thanks to Safe at Home, Susan was able to recover in the comfort of her own home. By supporting people at home, Safe at Home helps patients stay safe, independent, and well, while also reducing pressure on hospitals.

You can read Susans story here

111 press 2 campaign

In March the health board launched an awareness campaign for the new 111 press 2 service, which is a free telephone service for those in urgent need of mental health support. The service is available 24 hours a day, 7 days a week. The service is accessed by dialling 111 and selecting option 2.

If you need urgent mental health support,

Call 111 and Press 2

Available 24/7

NHS 111 Wales

Effective care

We make decisions and provide care based on the best available evidence.

We give people the right care to help them achieve the best possible outcomes.

We design care pathways that support people throughout their whole lives and are based on research and best practice.

Research and Development (R&D)

Why is this important?

Research is vital in providing the evidence we need to transform services and improve outcomes, such as developing new models of care for our patients. Research is essential to improve healthcare.

What are we doing?

High quality research studies are carried out across numerous areas and disease sites within the health board contributing to service improvement. The R&D department support both commercial (meaning that a drug company or similar pays for the research) and non-commercial (paid for by the NHS, a university or charity) studies. The R&D office within Cardiff Joint Research Office (JRO) ensures studies meet high ethical and scientific standards and works closely with the research delivery team to deliver these studies to a high standard.

The benefits of delivering research can include breakthroughs enabling earlier diagnosis, more effective treatments and improved system design, all of which improve patient care and health outcomes. There is also benefit from increased patient and carer satisfaction and experience.

A recent participant satisfaction survey showed overwhelmingly positive feedback from those involved in the research.

Below are a few anonymised quotes from the survey responses.

"I felt listened to and valued throughout the study. It was empowering to know my experience could help others."

"The research team explained everything clearly. I always knew what to expect."

"Taking part gave me hope. Even if it doesn't help me directly, I know it's helping future patients."

Carrying out high-quality research helps us make sure our care is based on solid evidence, so patients get the best treatment possible. The health board is committed to using research to improve care, with a strong focus on patient experience, new ideas, and ongoing improvement.

Healthcare Inspectorate Wales (HIW)

HIW checks healthcare services to make sure they are safe and provide good care for patients. They can make announced or unannounced visits to our hospitals and other health facilities to see how well things are working. As well as making sure that we are meeting correct standards in our care and treatment, HIW also highlight where they find areas of excellent practice. When HIW spot issues or poor practice of a very serious concern they will issue what is called an 'immediate assurance' to the health board, meaning the health board must act immediately to put things right. For any other improvements, the health board must develop an improvement plan.

agic hiw Arolygiaeth Gofal Iechyd Cymru Healthcare Inspectorate Wales

Hospital Inspection Report (Unannounced)

Cedar and Alder Wards, Hafan y Coed Mental Health Unit, University Hospital Llandough, Cardiff and Vale University Health Board

Inspection date: 01, 02 and 03 July 2024

Publication date: 23 October 2024

agic hiw | Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Over the past year, HIW inspected several services, including:

- The Emergency Unit and Maternity Unit at UHW
- The Dementia Assessment Ward at Barry Hospital
- The Psychiatric Intensive Care Unit and Crisis Assessment Ward at Hafan y Coed, UHL
- Two Community Mental Health Teams

HIW gave helpful feedback, and the health board took action to make improvements.

For example:

- In one mental health ward, inspectors said we needed to better document medication side effects. We responded by updating our ward round template to include a scoring system developed by Liverpool University.
- During the maternity unit inspection, inspectors noted heating issues in the obstetric theatres. We quickly repaired the system and now check it regularly.
- Inspectors found that our medical physics treatment rooms, while clean, were outdated. We secured funding to refurbish the area.

Emergency Unit Improvements

Over the last two years, we've made big improvements to our assessment unit. We redesigned the space to handle more patients—going from 33 to 73—and created a more welcoming and efficient layout. New areas like a rapid assessment zone and a same-day emergency care unit help patients get quicker treatment. We also set up a virtual ward so some patients can stay at home while still getting care. Staff have been involved in the changes, with extra support and wellbeing activities to help them feel valued. When inspectors re-visited in March 2024, they were impressed with the progress, and the work was praised by the Quality Safety and Experience Committee.

These improvements help make our healthcare services safer and better for everyone

You can access the Health Care Inspectorate Wales inspection reports and improvement plans here.

Llais (meaning Voice)

Llais is an organisation that listens to people in Wales about their experiences with health and social care services. They collect feedback from patients and staff—including what went well and what could be improved—by visiting hospitals and other care settings. The health board have good connections with Llais. They have a representative who sits on our Quality Committee.

Following a visit, Llais send a report to the health board. The report outlines what they found we were doing well and where we need to improve. The health board share the feedback with the clinical board who draw up a plan to fix the things that need improvement. You can find out more about Llais here

In the past year, Llais have undertaken 22 visits within the health board including;

- The Endoscopy Unit at UHW
- The Neurology Ward, Day Unit and Outpatients at UHW
- The Stroke Rehabilitation Unit at UHL
- Pentwyn Community Mental Health Team
- The Out of Hours Service for Cardiff and Barry

And the following project-related visits:

- Living with cancer project
- Emergency Care Project
- Having a Baby Project

These are examples of improvements we have from the recommendations of Llais:

- We are making sure that the call bells are always in working order in the Stroke Rehabilitation Unit.
- We have conducted inspections at Pentwyn Community Mental Health due to reports of damp and were able to report that no damp was found.
- Patient information sent from the Endoscopy unit has been reviewed and updated.
- We have decluttered and made attempts to improve storage solutions on the Neurology Ward.
- Access and signage to the Neurology Day Unit have been reviewed. The health board is compliant with the Equality Act 2010 and the Public Sector Equality Duty. A sign will be put up in the waiting area to advise patients where they need to sit and wait.

A patient in the Endoscopy Unit said they felt they wouldn't be here today if it weren't for this service. This patient had been referred from their GP following a bowel screening test and were seen at the unit within 2 weeks of the GP visit

The waiting area and consulting rooms at the Neurology Day Unit were clean and tidy. The reception and nursing staff were friendly and welcoming

Patients at Out of Hours, Cardiff said the 111 service was quick and efficient. The call back on average was reported as between 5 minutes to one hour.

Patients at the Stroke Rehab Centre said the care provided by centre staff was of a high standard with staff being approachable and helpful. Activities were enjoyable and patients who could participate felt they were beneficial to their progress. One patient commented

"I can't praise them enough for what they have done"

Therapy staff were highly regarded.

Staff at Pentwyn Community Mental Health Team were friendly and welcoming and the environment was calm

A patient using the Out of Hours service at Barry Hospital was really pleased with the efficient service provided

Using NICE guidelines to ensure effective care

What is NICE?

NICE (National Institute for Health and Care Excellence) role in the NHS is develop standards and guidelines (advice) for healthcare professionals. This ensures that people get the best possible care and treatment.

What Does NICE Do?

- Gives clear advice to doctors, nurses, and care workers about what treatments and care work best.
- Checks new medicines and technologies to see if they are safe, effective, and good value for money.
- Creates guidelines to help treat illnesses and manage health conditions.
- Supports social care by offering advice on how to improve services for people who need help in their daily lives.
- Helps reduce variation in care across the country, so everyone gets high-quality treatment no matter where they live

The health board uses an electronic system to measure the delivery of NICE guidelines across all its services, and in 2025/26 we will ensure that this information is in the development of our Quality Management System.

Natalies' story

Natalie received a medicine called Abemaciclib as part of her treatment for breast cancer. Abemaciclib is a new medicine that was developed to prevent the spread of cancer cells in early breast cancer. Before this medicine was approved by NICE, it was only available through special agreements between the NHS and the company that makes it. These schemes allowed some patients to get the medicine before it was officially approved, often at a lower cost. If a patient didn't qualify through a scheme, their doctor could ask the health board to fund the treatment. This is called an "Individual patient funding request" and could be used when the doctor believed the patient had special circumstances and would benefit from the drug.

You can listen to Natalie's story here

Efficient care

We use a value-based approach to focus on what matters most to people.

We aim to improve health outcomes in a way that is sustainable and avoids waste.

We use our resources effectively and efficiently to get the best results.

We only do what is necessary and beneficial for the patient.

We choose treatments and interventions because they offer the best value and improve outcomes.

Value Based Health Care

What is Value Based HealthCare?

Value-Based Healthcare (VBHC) is about using healthcare resources fairly and wisely to give every person better health outcome and experience. In other words, VBHC is about using money and resources in a fair and smart way. The goal is to help people feel better and have a good experience with their care.

What does it focus on?

It puts the patient first.
The clinical team listen to what matters most to the patient.
Care is planned to meet the patient's goals.
We check if the care is working by looking at how much it helps the patient.

How do people work together?

Everyone in healthcare works as a team.
They share ideas and break down barriers between departments.
This helps give each person the right care for their needs.

Patient Reported Outcome Measures (PROMs)

What are PROMs?

PROMs are an important part of value-based healthcare. PROMs are sets of questions used across Wales that are sent to patients to help medical teams to understand how a person feels, how well they are living day to day, and how treatments have impacted their health over time.

What do they ask about?

Pain
Mood (like feeling sad or happy)
Daily activities (like walking, dressing, or eating)
Sleep
Energy levels

Why are PROMs important?

They help the healthcare team give better care. They make sure the healthcare team design the right service for those patients. They make sure the care is focused on what matters most to the patient.

What are we doing?

The health board is bringing in PROMs so that patients can feed back about the outcomes of their treatment. PROMs show how well a treatment is working from the patient's point of view. The health board encourage people using our services to always complete a PROMs assessment when requested. PROMs can also be completed by carers on a person's behalf if the person is unable to complete it themselves.

Improving the health of people with liver disease – an example of Value Based Healthcare

Why was this project important?

Liver disease is a major cause of death that is rising in the UK. In 2022, 8,368 people in Cardiff and Vale were living with advanced liver disease.

In the same year, people with liver disease in the Cardiff and Vale area spent a total of 6,251 days in hospital beds. This is a large number, and it shows how serious liver disease can be when it comes to how much care and hospital time people need.

A common and serious problem in advanced liver disease is malnutrition (meaning that patients don't get enough of the right food or nutrients). It makes people sicker and is strongly linked to survival.

Catching and treating poor nutrition early can make a big difference and help people live longer and feel better.

What are we doing?

The goal of this project is to help people with liver disease feel stronger and less frail using:

- Artificial feeding (special nutrition)
- Physiotherapy (exercise and movement support).

This treatment would normally take place in hospital. In this project though, this happens over 12 weeks in the patient's own home.

How did the project team do this?

They needed extra physiotherapy, nursing and dietician support to help support patients having their treatment at home. This was paid for from a special fund.

What were the results of this project?

- By treating patients in their own homes rather than the hospital it meant that there were 238 fewer hospital bed days used. This means that more beds are freed up for other patients who need urgent care.
- Patients completed PROMs and reported feeling better. If people stay out of hospital, it usually means they're doing well at home.
- It is estimated that 1.25 million pounds could be saved every year through this project.

You can learn more about the project by watching Sian's story.

These are some of the other things the patients involved in the project said -

"I had 100% more energy feeling better in myself, had more life in me and I could participate in more activities"

"I am pleased that I am more robust and in a better position for a liver transplant. That is down to this project"

"Even though it's taken some adjustment, dare I say it, I like this tube. I'm feeling much better"

Reducing our reliance on Agency Staff

Why is this important?

Staffing clinical services with healthcare professionals employed directly by the health board means that people accessing services are more likely to be seen by health care professionals;

- who have cared for them previously
- who are familiar with health board processes and procedures
- who are working in their chosen area of interest of expertise

Reducing the use of agency and bank staff also means that the health board is being more efficient in the way that it uses the money it is allocated to provide healthcare.

How are we doing?

Between January and March 2025 we achieved an average monthly saving of approximately £380,000 in the amount spent on agency nursing compared to the same period in the previous year.

The total amount spent on temporary nurse staffing (including bank and agency) has reduced by approximately £580,000 each month (based on average between January – July 2025 compared to the same period in 2024).

Theatres Improvement

Why is this important?

Following some concerning feedback from staff, gathered as part of a staff survey, the Executive Team commissioned a review of our theatre services. The review involved speaking to many staff, listening to their concerns and ideas for improvements. The review highlighted that some of the standards and processes fell well below what we should have been delivering.

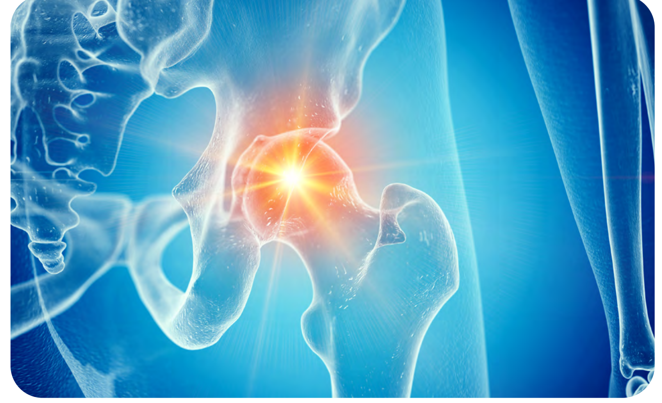
What are we doing?

The reviewers made a series of recommendations across a range of areas, including improving the use of the WHO surgery checklist, strengthening leadership within theatres, tackling values and behaviours which are not acceptable in our organisation, and making improvements to the physical environment in theatres across both staff and patient areas.

Making these improvements is a top priority for us and we have put in place an experienced team to lead this work, which is called the 'Theatres Together' project. Many improvements are already underway, including improving the security of the theatre areas, refurbishing the staff room and improving the main theatre children's recovery area.

In August 2025 we shared the first sections of the improvement plan at the health Board Quality Committee. You can listen to the discussion at the Quality Committee here.

Helping Hip Fracture Patients Recover Faster



Why is this important?

For many older people, fracturing a hip can change their life, making it hard to move and causing long hospital stays. Research shows that prompt surgery and movement help patients recover faster and keep their independence.

Over the past year, the health board have improved the way they treat hip fractures, helping patients get care more quickly.

What are we doing?

In August 2023, only 18% of hip fracture patients at University Hospital of Wales were admitted to the Trauma and Orthopaedic ward within four hours. Now, this number has increased to 40%, which is much better than the UK average of 9% and much better for our patients who can get treated sooner and begin their recovery quicker.

Working Together for Better Care

This success is because different teams are working closely together, including:

- Emergency Unit
- Radiology
- Trauma and Orthopaedics
- Orthogeriatrics
- Welsh Ambulance Service

Thanks to this teamwork, patients are getting faster treatment, helping them heal better and stay independent. You can read more about this here (Remarkable improvements in care for hip fracture patients at Cardiff and Vale University Health Board - Cardiff and Vale University Health Board)

Improvements in Maternity Pathways of Care

Why is this important?

In 2024/25, Cardiff & Vale University Health Board launched a maternity improvement project to make care safer and more responsive for women and families. A key part of this work was increasing the number of hours that senior doctors (Obstetric Consultants) are present in the maternity unit—from 68 to 84 hours each week. This change supports national recommendations, including those from the Ockenden Report, which called for more consultants to be available on-site and for care to be delivered directly by consultants rather than just overseen by them.

What are we doing?

The project also aimed to improve how patients are cared for day-to-day, with better supervision from senior staff, a stronger focus on safety, and less reliance on temporary doctors brought in at short notice. These changes are especially important because maternity care has

become more complex in recent years. For example, the number of Caesarean births rose from 12% in 2011 to 20% in 2021/22, and more than half of these were emergencies. This increase is linked to factors like older maternal age, more complex health needs, updated medical guidance—and in some cases, personal choice.

The maternity team also looked at how women move through the department, aiming to make sure they receive the right care at the right time. One area they focused on was the timing of labour inductions. Previously, inductions often happened late in the day, which led to more emergency Caesareans during the night and delays for planned procedures. These delays could affect the overall experience for patients. To improve this, the team introduced more consistent induction times and created a dedicated pathway for planned Caesarean births.

Since January 2025, there has been a steady improvement, with fewer delays in starting labour inductions. To keep things moving in the right direction, the Health Board is closely monitoring key areas such as how quickly patients are transferred to the labour ward, how often inductions or planned Caesareans are postponed, and how long women stay in hospital after induction.

After a long induction and emergency C-section with my first back in 2020, I was so blown away by the amazing staff and was so looked after - I opted again for an elective Section with our latest little girl. I am so glad I did because we had THE BEST TIME! I cannot rave enough about every member of staff I came across!

We just want to say a huge thank you to Jonathan and the team in theatres who helped deliver our baby girl safely last week. Everyone was brilliant with us and really put us at ease- after a busy day of emergencies they still managed to fit us in for our elective section after what I'm sure was a very long day for them! I was very nervous about the section but the whole team made us feel very safe- a special thanks to Jonathan who really calmed my nerves and talked me through everything that was happening. We had a really brilliant experience and will treasure the memories of our daughter's birth. Thanks for everything you do! "

Thank you for making my elective section so calm and easy (even if it was a day earlier than we expected), I felt very at ease the whole time and couldn't have asked for a better experience.

Person centred care

We make decisions together with people, based on their needs, preferences, and values.

We care about the wellbeing of individuals, families, carers, and staff.

We treat everyone with kindness, empathy, and compassion.

We always respect people's privacy, dignity, and human rights.

We work in partnership with patients and families, seeing them as experts in their own care.

Our goal is to achieve the best outcomes and experiences by working together.

Keeping Me Well

The Live Well Service

The Live Well Service is made up of an inter-disciplinary therapy team that deliver a range of group and individual interventions

to people with long-term conditions. They ensure that support and interventions are centred around the person and is focussed on their specific symptoms.

Why is this important?

Keeping well to minimise ill health and improve well -being is a priority for us all.

What are we doing?

The health boards therapies team have developed a special website with information that people can access to help keep themselves, their family members, or their friends well. The website is designed to provide information for all age ranges and was co- designed in partnership with service users with lived experience.

Who is the website useful for?

People preparing for treatment,
People managing a long-term health condition
People looking for the right service
People looking for advice on self-management, rehabilitation, and recovery.
You can look at the website through the Keeping Me Well link.

Care after death

Changes to the law

In September 2024, a change in the law meant that the care of all people dying in hospital and the community would be reviewed by an independent Medical Examiner (ME). The role of the Medical Examiner is to also work with the certifying medical practitioner to ensure that death certification is accurate. The ME service has been slowly introduced since 2022 to provide safeguards around the care that people received in the period before they die. This means that every death in hospital and in the community is looked at carefully unless His Majesty's Coroner is already involved.

Why Is This Important?

It provides safeguards about the care provided to people before they die.

It allows bereaved families to provide feedback about the care that their loved one had received.

It improves the accuracy of the information included on death certificates.

What are we doing?

Making the Death Certification Process Faster

The health board is working to speed up the time it takes to get a death certificate. Now, doctors can send information electronically, so the Medical Examiner can review it quickly. This helps families get the certificates they need without lengthy delays.

By improving this system, we are making sure that every death is checked properly and that families get the support they need as soon as possible.

Learning from Deaths

Feedback provided by the ME service from families who have experienced death of a loved one in our care has enabled our palliative care team to gain a deeper understanding of where improvement needs to be focussed. This has led to the introduction of a new healthcare support worker (HCSW) role to support staff, dying patients and their families on our wards. The role holder will be a vital link for patients and families helping to improve communication between them and the clinical team. It is hoped that this will provide families with more comfort and reassurance during this incredibly sad time. The health board is also developing an education programme to share best practice in end of life care for staff. We will continue to monitor the experience of the bereaved and will be able to report back on the progress of the HCSW role next year.

In May 2025, the health board's Quality Committee published a Learning from Mortality report providing details from the previous twelve months. You can hear about the report here.

Helping Patients at the End of Life

It is important for people to feel respected, cared for, and comfortable in their last days of life. As part of our committment to improve care for the dying and their families, the health boards palliative care team have introduced Every Moment Matters. The aim is to make our hospital wards quieter and more peaceful for dying patients and their families.

What are we doing?

- A new symbol will be used in hospital areas to show when a patient is receiving end-of-life care.
- Families can choose to display the symbol if they want to.
- The symbol helps remind staff, visitors, and other patients to be quiet and respectful.
- The symbol is only used with the patient's or family's permission.
- It follows official guidance to make sure patients get the best care possible.

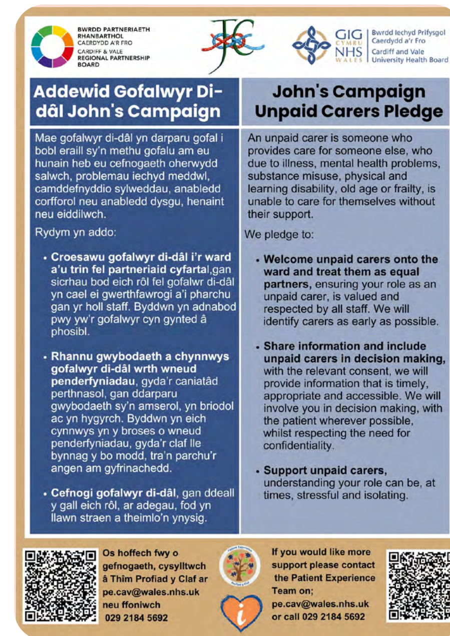
Why does this matter?

This project helps create a calm, private space for patients and their families. It may seem like a minor change, but it makes an enormous difference in making sure people feel respected, dignified and cared for, in their final days and moments. You can find out about this project here.

Carers

Cardiff and Vale Unpaid Carers Charter

The health board is committed to noticing, appreciating, and helping unpaid carers, making sure they get the support and tools they need to care for others, while also looking after themselves.



BWRDD PARTNERIAETH RHANBARTHOL CAERDYDD A'R FRO
CARDIFF & VALE REGIONAL PARTNERSHIP BOARD

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

Addewid Gofalwyr Di-dâl John's Campaign

Mae gofalwyr di-dâl yn darparu gofal i bobl eraill sy'n methu gofalu am eu hunain heb eu cefnogaeth oherwydd salwch, problemau iechyd meddwl, camddefnyddio sylweddau, anabledd corfforol neu anabledd dysgu, henaint neu eiddilwch.

Rydym yn addo:

- **Croesawu gofalwyr di-dâl i'r ward a'u trin fel partneriaid cyfartal**,gan sicrhau bod eich rôl fel gofalwr di-dâl yn cael ei gwerthfawrogi a'i pharchu gan yr holl staff. Byddwn yn adnabod pwy yw'r gofalwyr cyn gynted â phosibl.
- **Rhannu gwybodaeth a chynnwys gofalwyr di-dâl wrth wneud penderfyniadau**, gyda'r caniatâd perthnasol, gan ddarparu gwybodaeth sy'n amserol, yn briodol ac yn hygyrch. Byddwn yn eich cynnwys yn y broses o wneud penderfyniadau, gyda'r claf lle bynnag y bo modd, tra'n parchu'r angen am gyfrinachedd.
- **Cefnogi gofalwyr di-dâl**, gan ddeall y gall eich rôl, ar adegau, fod yn llawn straen a theimlo'n ynysig.

John's Campaign Unpaid Carers Pledge

An unpaid carer is someone who provides care for someone else, who due to illness, mental health problems, substance misuse, physical and learning disability, old age or frailty, is unable to care for themselves without their support.

We pledge to:

- **Welcome unpaid carers onto the ward and treat them as equal partners,** ensuring your role as an unpaid carer, is valued and respected by all staff. We will identify carers as early as possible.
- **Share information and include unpaid carers in decision making,** with the relevant consent, we will provide information that is timely, appropriate and accessible. We will involve you in decision making, with the patient wherever possible, whilst respecting the need for confidentiality.
- **Support unpaid carers,** understanding your role can be, at times, stressful and isolating.

Os hoffech fwy o gefnogaeth, cysylltwch â Thîm Profiad y Claf ar pe.cav@wales.nhs.uk neu ffoniwch 029 2184 5692

If you would like more support please contact the Patient Experience Team on; pe.cav@wales.nhs.uk or call 029 2184 5692

The Cardiff and Vale Unpaid Carers Charter promise to support people provide unpaid care to family or friends. It has four key goals:

Finding and Recognizing Carers – Making sure unpaid carers are noticed and get helpful advice, information, and support.

Better Support – Improving the care and help carers get, and training staff so they can do a better job.

Giving Carers More Choice – Sharing the right information at the right time so carers can make good decisions.

Working Together – The NHS, local councils, and charities teaming up to support unpaid carers.

Our Charter helps make life easier for carers, ensuring they feel valued and get the help they need.

Helping Unpaid Carers in Cardiff and Vale Hospitals

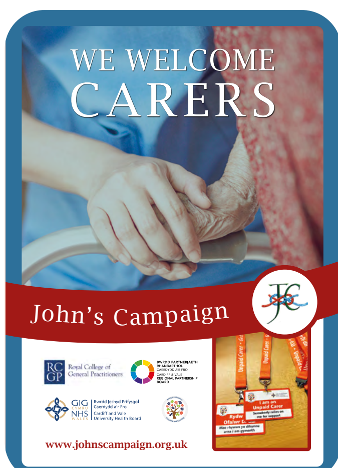
Why is this important?

Cardiff and Vale University Health Board wants to make sure unpaid carers feel welcomed and valued when visiting hospitals. Carers play a vital role in looking after people, helping them feel safe and respected when they are in hospital.

What are we doing?

John's Campaign is being slowly introduced across our hospital wards. John's campaign was originally used to help people with dementia ensure they could always have their carer present in hospital. However, the health board has decided to make it available to all patients with unpaid carers regardless of their diagnosis, recognizing how important carers are to patient care.

How the Campaign Works



First, four hospital wards are trying out John's ikCampaign and if it works well, more areas will start using it. Our carers lead checks each ward carefully before starting the campaign. Staff receive special training, and once they are ready, they get a plaque to show they are part of John's Campaign.

At the moment seven wards are using Johns campaign, and the health board is helping five more wards get ready to join. In time, it is hoped that this might even be spread to out-patients departments for those attending clinic appointments.

Key Promises

The health board follows the Social Services and Wellbeing (Wales) Act 2014, which means they promise to:

- Find and support unpaid carers early
- Listen to carers and keep them informed
- Welcome carers on hospital wards and help them keep caring if they want to—like helping with meals, personal care, or medicines.

By doing this, the health board is making sure unpaid carers feel included, valued, and supported while looking after their loved ones in hospital.

GP Unpaid Carers Accreditation Scheme

Why is this important?

Since many carers first turn to their GP surgery for help, the unpaid carers accreditation scheme ensures they are identified early, supported, and directed to helpful services.

What are we doing?

Each GP surgery in Cardiff and the Vale is asked to nominate a **Carers Champion**, who works with key staff to:

- Raise awareness of unpaid carers
- Make sure carers get support before they reach crisis
- Help carers find the right services

How does it work?

GP surgeries can earn a **Bronze or Silver award**. They must show evidence that they are doing the following;

1. Understand - Staff recognise carers' needs and respect confidentiality.
2. Inform - Carers are given useful information and an introduction to support services.
3. Identify - Carers are spotted early, ideally at their first GP visit.
4. Listen - Carers are heard, consulted, and supported by trained staff.
5. Support - Carers are helped and guided to additional services.

How are we doing?

This scheme helps carers feel valued and supported, ensuring they get the help they need early.

GP Surgeries have achieved Bronze level.

12 Surgeries are working towards Bronze accreditation

Surgery has reached Silver level.

Unpaid Carers Information Service

The Unpaid Carers Information Service is dedicated to supporting unpaid carers when they or the person they care for is in hospital. The aim of the service is to ensure unpaid carers know their rights and what support is available to them, both on the hospital site and within their community. The service is made up of two members of staff who cover all hospital sites but are usually based in one of the Information and Support Centres, at University Hospital of Wales, University Hospital Llandough, and Barry Hospital, or are contactable by phone or email .

Unpaid carer support role

The health board is in the process of implementing an exciting new role to support unpaid carers while those they care for are receiving in-patient hospital care. The role holder will support unpaid carers throughout the hospital admission right through to discharge providing emotional support, education and information.

This role aims to help unpaid carers have a better experience in hospital and during discharge. It makes sure they are involved in discharge planning and know what support is available. The person in this role will talk with carers on the wards to learn what is important to them. They will work with hospital staff, Social Services, and other organisations that support carers to build strong connections and improve teamwork. We will report back next year on the impact of this role.

Equitable care

Everyone should have an equal chance to live a healthy life, no matter who they are or where they live.

We treat everyone fairly and equally, regardless of their protected characteristics

We make sure equality and human rights are part of everything we do in healthcare

Co production

Why is this important?

Co-production is when people come together as equals to make decisions or create services that work for them all.

The health board is dedicated to working together with patients, families, staff, and communities to design better services. We believe the best care happens when we listen, learn, and build solutions together. By working with, and listening to people with real-life experience, we make sure our

services are safe, effective, and focused on what matters most to those who use them.

What are we doing?

The health board co production group play a huge part in shaping change within the health board. A group of over 300 people with lived experience of using health and care services, including those with long-term conditions and unpaid carers, meet regularly with health board staff to share ideas, provide feedback, and support and influence many projects. Their voices and experiences play a key role in making services more responsive, inclusive, and person-centred. Throughout this report there are many examples of how we have listened and collaborated with people in our communities to make changes for the better.

Virtual consultations for carers

Why is this important?

For unpaid carers, looking after loved ones is a full-time job. Many carers cannot leave home easily to attend hospital appointments either for themselves or the person they care for. This means they might suffer poorer health and well- being as a result. Sylvia's story powerfully illustrates the emotional and physical toll that unpaid caring can take. It is crucial that carers can look after their own health as well as the health of those they care for. However, as Sylvia explains, this has often been difficult—especially when trying to schedule outpatient appointments around her family's needs.

What are we doing?

The health board now offer virtual consultations through a system called T-pro, making it easier for carers to access healthcare. Importantly, as with in- person consultations, virtual consultations are conducted as private conversations between the patient and clinician.

T-Pro eClinic Manager lets doctors talk to patients using video and phone calls. This makes it easier for people who find it hard to visit hospitals, whether because of travel, money, or personal reasons. With T-Pro, they can talk to doctors from home, getting advice and support without leaving the people they care for.

Smooth Visits - Making Clinics Better for People with Autism

Why is this important?

For people who have autism and their families, attending hospital for appointments can be stressful. We want to make it easier and more comfortable for people with autism when they come to outpatient clinics.
Our therapies team are starting a small project to test this idea. We are beginning with the podiatry clinic (this is the foot care clinic).

What are we doing?

We want to train staff to understand autism better. We have a helpful training video already on our Electronic Staff Record (ESR) system (where our staff complete their online learning)

Next, we will work with our co-production therapies team. This means we will invite people with autism and their families to:

Tell us about their experiences at the clinic.

Share what went well and what was difficult.

Help us find ways to make things better for everyone.

Our goal is to help people with autism feel safe, understood, and supported when they visit the clinic.

If the project shows that it has made a difference, other clinical teams could adopt the principles for their own clinical areas and for other neuro developmental conditions.

Improving accessibility to our sites

Why is this important?

We recognise that for some people, moving around our hospital sites can be challenging.

What are we doing?

We have started a trial of 'Wheelshare' at the University Hospital of Wales, which is a system to improve wheelchair availability. Wheelchairs can be rented from self-service stations and are free for up to 6 hours.

Vaccinations

Why is this important?

Vaccines are the best way to stop many serious diseases and save millions of lives every year. In Cardiff and the Vale, not everyone takes up the offer to get vaccinated. There are many different reasons for this, although it is especially hard for those people who cannot leave their homes.

What are we doing?

Cardiff and Vale were the only health board to make sure people who cannot leave their homes (sometimes referred to as housebound) were prioritised for their Spring Covid-19 booster vaccines first.

Smoking

Smoking is the largest cause of early deaths that could be prevented in the UK. It raises the risk of cancer, heart disease, and strokes. Most people start smoking when they're young, and it's harder to quit later. The Welsh Government wants to make Wales smoke-free by 2030, meaning fewer than 5 in 100 adults will smoke.

Right now, 2% of 11 to 16 year olds and 13% of adults in Cardiff and the Vale smoke. By teaching people and preventing them from starting, we hope to bring these numbers down.

What are we doing?

The health board's Smoking and Tobacco Education and Prevention Service helps children and young people understand the risks of smoking and vaping. It gives them the knowledge and confidence to make healthy choices.

How We Help

We work with schools, youth groups, and professionals to create safe spaces where young people can make good choices. We do this by:

- Helping schools set up smoke-free policies and teach about smoking
- Running fun and interactive sessions on smoking, vaping, peer pressure, and where to get help
- Training teachers and youth workers so they have up-to-date information
- Creating and sharing useful materials for lessons and group work
- Running the "Smoke-Free Gates" program at primary schools and preschools
- Sharing smoke-free messages at events for young people and families
- Working with other groups to reduce the harm caused by smoking and vaping
- Listening to young people and involving them in how we design education

By working together, we want to create a healthier, smoke-free future for young people in Cardiff and the Vale of Glamorgan.

Public health screening

People experiencing homelessness offered vital TB checks

Almost 100 people experiencing homelessness took up the offer of vital checks for tuberculosis (TB) and bloodborne viruses (BBV) at two special clinics held in the heart of Cardiff. University College London Hospitals (UCLH) brought their 'Find and Treat' mobile unit to the Huggard Centre in March 2025, followed by a visit to Adams Court in the afternoon. Working together, the UCLH team, specialist clinical teams from the health board (including the Public Health Team) gave people the opportunity to have chest X-rays and blood tests to check for both active and latent TB, a serious but treatable bacterial infection. People were also offered tests for the BBVs hepatitis B, C and HIV, alongside access to specialist health advice and support. You can read more about it on the Cardiff and Vale UHB website

Looking Forward

As we move into the next year, Cardiff and Vale University Health Board remains committed to providing safe, effective, and compassionate care for all. Building on the progress made through our Quality Excellence programme, we will continue to improve, learn, and innovate across all services.

We aim to:

- Increase staff engagement
- Improve how we measure quality
- Embed proven improvement methods into everyday practice

Despite financial challenges, we will work together across clinical and corporate teams to keep quality and safety at the heart of our recovery plans. We will focus on value-based healthcare—improving outcomes while using resources wisely. Strong governance, clear reporting, and cost-effective care will guide our efforts. One of our key priorities is continuing the theatre review. This work will help:

- Improve surgical pathways
- Enhance patient flow
- Strengthen safety before, during, and after surgery

We will use staff and patient feedback, data insights, and national best practice to shape this work. Our goal is to ensure theatres run efficiently and fairly, giving patients timely access to high-quality care.

Together, these actions reflect our ongoing commitment to quality, sustainability, and transformation. We look forward to working with staff, patients, and partners to make excellence in care our core business.