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

Cardiff and Vale UHB

Annual Quality Report

2025 – 2026

Foreword from the Chair and Chief Executive

This Annual Quality Report reflects on what has been one of the most challenging years for Cardiff and Vale University Health Board. During the year, the organisation experienced escalation initially in relation to its financial position and subsequently in respect of operational performance and quality. These pressures brought into sharp focus areas requiring improvement and necessitated sustained scrutiny, enhanced external support, and strong, visible leadership at every level.

Quality escalation during the year was influenced, in part, by the publication of the theatres review, which identified serious concerns relating to leadership and culture, alongside specific clinical and patient safety issues. The Health Board has been clear that the findings of this review were unacceptable. In response, decisive action has been taken to address both the immediate risks identified and the deeper systemic factors that contributed to these concerns. This work has been underpinned by a strong and ongoing commitment to learning, openness, and transparency.

Central to our response has been the Health Board's statutory Duty of Quality, which requires continuous improvement in the quality of care and services we provide and places quality at the heart of decision-making. This duty has provided a clear and vital framework for our improvement journey, ensuring that safety, effectiveness, and person centred care are afforded equal priority alongside operational and financial considerations.

Despite the significant challenges faced, there have been important areas of progress. We wish to recognise the relentless hard work, professionalism, and resilience demonstrated by colleagues across the organisation, often in very difficult circumstances. Key safety improvements have been delivered, including the rollout of the National Early Warning Score 2 (NEWS2), supporting the early recognition of clinical deterioration and timely escalation for patients at risk. The implementation of an electronic prescribing and medicines administration system represents a major step forward in strengthening medicines safety and improving the reliability of care. We also acknowledge the exceptional work of our palliative care teams, who continue to provide high quality, compassionate care for patients and families at the end of life. We would like to extend our sincere thanks to all colleagues for their continued dedication, commitment, and compassion, both in caring for patients and in supporting one another. While we recognise that there is still much to do, we remain fully committed to delivering meaningful and sustainable improvement. Guided by our Duty of Quality, we will continue to strengthen leadership, improve culture, and embed safe, efficient, and effective practice across the organisation, with a clear and unwavering focus on eradicating avoidable harm and reducing unwarranted variation in outcomes for the people we serve.

Suzanne Rankin
Chief Executive

Kirsty Williams CBE
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 2025/26. 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.

We are progressing with our 10-year strategy which 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 University Health Board, 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

We continue to work with our partners in the Health Board to produce a report that is clear, inclusive, and accessible for everyone in our communities.

We hope you find this report informative and easy to read.

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.

Quality indicators

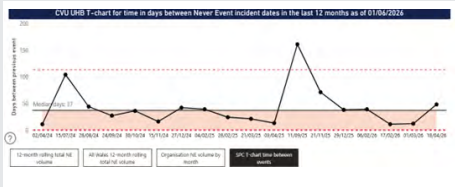
The Health Board has identified a core set of quantifiable indicators that we believe provide a clear and transparent reflection of the quality of care that we deliver across our services. These measures have been selected to give a balanced view of safety, effectiveness, and patient experience, and are supported by robust data collection and regular review. By monitoring performance against these indicators, we are able to identify areas of good practice as well as highlight where improvement is required. Where gaps are identified, targeted improvement work is underway, supported by evidence-based interventions and continuous oversight, to ensure that we deliver consistently high standards of care and improve outcomes for the populations we serve. Having accurate and reliable data to help benchmark the quality of care we provide and to monitor quality improvement is a priority for the Health Board and in 2026, we aim to strengthen this approach.

These indicators are captured in the dashboard and are represented throughout this report. They include:

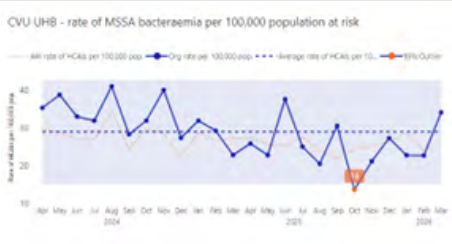
- The frequency of Never Events that occur within the Health Board. - Never Events are serious avoidable patient safety incidents
- Infection prevention and control incidents - These are broken down by specific infections and are a measure of aseptic practices, decontamination and effective prescribing.
- Inpatient mortality - This is a measure of the proportion of all inpatients that die in hospital. This measure allows scrutiny of patient outcomes and patient experience.
- People experience – This is calculated from all the surveys completed by patients who come into contact with our services, either as an inpatient or outpatient
- Single cancer pathway – This is a measure of the proportion of patients who are referred to the Health Board with symptoms suspicious of cancer and who are either discharged or commence treatment within 62 days of their referral.
- Emergency department performance – This is a measure of the proportion of patients who are treated in the Emergency Department within twelve hours of arriving
- Planned care performance – This is a measure of the proportion of the number of patients referred for a planned procedure who are seen within fifty two weeks.

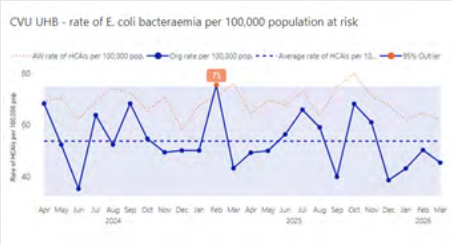
Safe

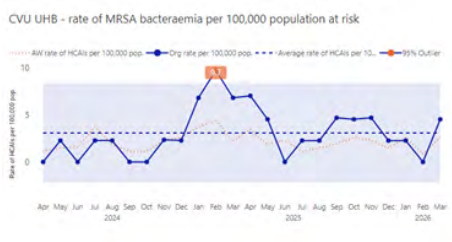
Never Events

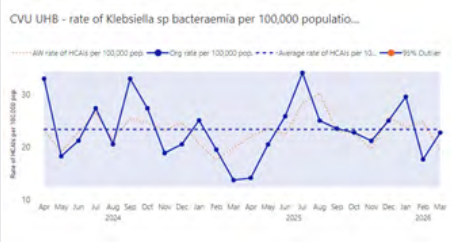


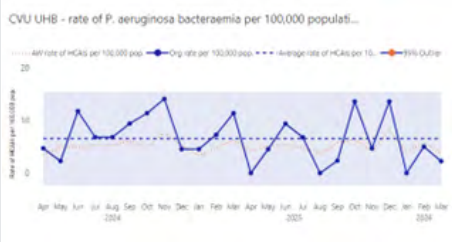
Infection Prevention and Control





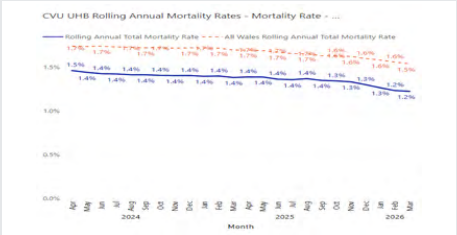






Effective

Crude annual rolling mortality rate %

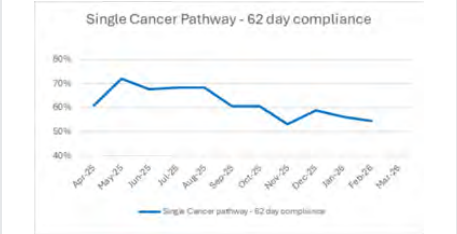


Person centred

People experience score

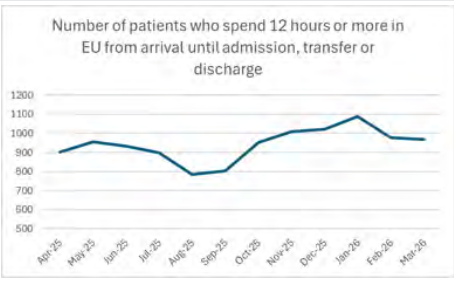
Timely

Single cancer Pathway



Timely

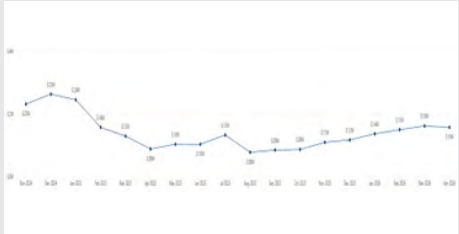
Emergency Department



Planned Care -

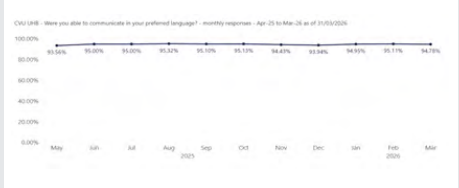
Efficient

Agency spend



Equitable

Preferred language



Safe care

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

Learning from incidents

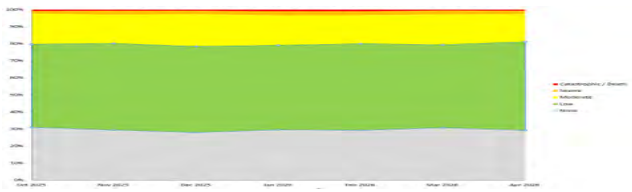
Across NHS Wales, there is a clear system for reporting and learning from things that go wrong in healthcare. These are called patient safety incidents and include any unexpected patient safety events, regardless of the level of harm. All incidents that occur in the Health Board are reviewed so that we can understand what happened, support those affected, and make care safer in the future.

In 2025/26, 25,430 incidents were reported and most of these incidents did not result in significant harm. Despite this, every incident reported provides an opportunity for the Health Board to understand what happened and to strengthen its processes.

Incidents by harm

The chart below shows the categories of harm recorded for each incident at reporting. It demonstrates that approximately 80% of incidents result in no harm or low harm. Despite the lower level of harm, the Health Board is still able to learn from these incidents, strengthen process and put systems in place to reduce risk. Around 20% of incidents result in moderate harm or above. Moderate harm is defined as an incident that can result in an increase in someone's treatment, increasing the length of stay in hospital or resulting in a return to surgery.

INC_PRES_04 - UHB Reporting Rates by Initial Harm (BarChart|DB)



Some incidents must always be reported nationally, to ensure additional independent scrutiny of each case and to support national learning across Wales. These nationally reportable incidents include all incidents that we consider have resulted in serious or catastrophic harm and all maternal, perinatal, infant and neonatal deaths, and any suspected suicide or self inflicted harm where the person was in hospital or had been recently discharged.

Reporting these events helps ensure openness, effective review, and national learning to improve safety for patients, families and staff across Wales.

Between April 2025 & March 2026, the Health Board reported 192 Nationally Reportable Incidents to the all-Wales organisation, NHS performance and Improvement.

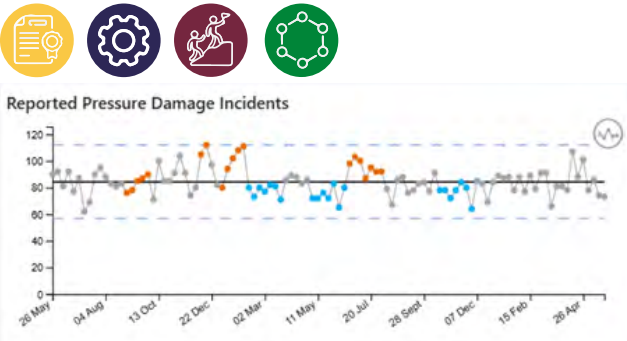
Perinatal mortality

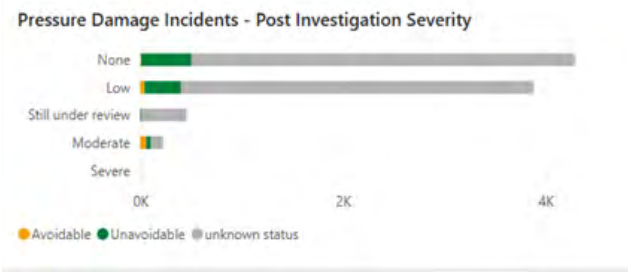
The largest proportion of nationally reportable incidents related to perinatal deaths in babies born from 22 weeks of gestation onwards, including neonatal deaths occurring in the first 28 days of life. Every one of these tragic cases was investigated by a specialist team including

Midwives, Obstetricians and Neonatologists. The national reviews examine the care provided during pregnancy, birth and afterwards and the results are fed into a wider national maternity data programme, MBRRACE-UK.

In 2025/26 39 cases were reviewed through this national process. 18 cases related to stillbirths and 4 late fetal losses and a further 11 cases related to the death of babies in the first 28 days following their birth. The review process is lengthy particularly when the parents choose to have postmortem examination. As a result not all reviews from 2025/26 are complete. However, 30 cases have been fully reviewed, and the vast majority do not identify any aspects of care that would have changed the very sad outcome.

Pressure damage





Pressure damage occurs when the skin and the tissue beneath it are damaged due to sustained pressure or friction. This pressure reduces blood flow to the affected area, causing the skin to break down. If left untreated, this damage can extend to deeper layers, including muscle. These injuries can be serious, slow to heal, and can affect a person's comfort, health, and wellbeing.

Preventing pressure damage is an important part of providing safe, high quality care. By working together across all parts of the Health Board, we can reduce the number of people who experience this type of harm and ensure care is consistent, safe, and based on best practice.

To improve patient safety, the Health Board has created a Pressure Damage Collaborative. This is a group of healthcare professionals from different services and specialties who are working together to help prevent pressure injuries.
The group will:

- Review data, trends, and reports from all services to understand where pressure damage is happening and why.
- Review the use of pressure relieving equipment across the Health Board.
- Review training and education provision to ensure the level of knowledge and skills to reduce the risk of pressure damage
- Standardise the scrutiny and oversight of pressure damage cases across the Health Board to ensure learning from these cases
- Embed standards and procedures to ensure that everyone in our care receives evidence based and safe care.

The development of a quality and safety dashboard is strengthening the way the Health Board can monitor the frequency of pressure ulcers, reporting the number of events that occur for every 1000 occupied bed days. This method of reporting will help to understand if the work of the pressure damage collaborative is having an effect.

Shaping our Future Quality Excellence

Shaping Our Future
Quality Excellence

The Shaping Our Future Quality excellence programme was launched in early 2025 to put in place structured improvement projects around themes from patient safety incidents and Nationally Reportable Incidents. In 2025 /2026 a medicines safety project has been added to the project and progress has been made with the existing projects.

Care of the deteriorating patient

Why is this important?

The Acute Deterioration project was created to implement the National Early Warning Score 2 (NEWS2). This is a standardised scoring system that uses routine physiological observations, such as blood pressure and respiratory rate to identify early signs of clinical deterioration and trigger a standardised and timely approach to call for clinical support. The project successfully implemented NEWS2 across acute, paediatric, maternity, mental health and primary care settings, training over 7000 clinical staff in the use of the tool.

What are we doing?

The focus has now shifted from introducing NEWS2 to auditing and reviewing it to ensure that it is used safely and effectively with a focus on ensuring that medical teams are able to respond in a timely manner to assess and treat patients who are deteriorating.

Further progress has been made in enabling patient and family escalation through Call for Concern and preparations for national Wellness Scoring. Martha's Rule was introduced in the UK following the death of 13 year old Martha Mills in 2021, who died from sepsis after repeated concerns raised by her parents were not acted on in time. Martha's Rule recognises the vital role that patients, families and carers play in identifying deterioration and ensures they can raise concerns and access a rapid clinical review when they feel something is not right. The introduction of Call for Concern provides a clear, consistent route for patients and families to voice worries and seek timely help, supporting early recognition of deterioration and reinforcing a culture where concerns are listened to, acted upon and valued as a core part of safe care.

Medicines safety

Why is this important?

The Medicines Safety Project started in 2025 to reduce avoidable harm from medicines and improve how medicines are managed across the Health Board.
The programme focuses on:

- Making sure there are clear systems in place to oversee, monitor, and improve safety around medicines.

- Improving how data (information) is collected and used
- Making processes more consistent
- Promoting a positive safety culture where learning is encouraged

What are we doing?

Work so far includes mapping out current processes (drawing or describing all the steps in a process from start to finish to identify any problems), analysing incidents, and gathering feedback from staff and patients.

This has helped identify why errors happen and provide a strong foundation for making targeted improvements to keep patients safer.

Lost to follow up

Why is this important?

In 2025 the Health Board strengthened its approach to preventing patients being lost to follow up as part of the Shaping Our Future Quality Excellence Programme. The Lost to Follow Up (LTFU) Programme was established following patient safety incidents that identified delays and disruptions in clinical care, in particular, patients remaining on open follow up pathways without clear outcomes, timely review, or safe discharge following attendance at outpatients' clinics.

What are we doing?

The project focused on standardising how we recorded the outcomes of each clinic attendance. All existing paper clinic outcome forms were reviewed across the entire organisation. This review, highlighting wide variation and ambiguity that contributed to patients remaining on inappropriate follow up pathways. Two multidisciplinary workshops led to the development of a single, standardised Clinical Outcome Form which was rolled out across the organisation in late 2025 with training for administrative staff.

The project is now focusing on auditing the management of outpatient clinics to ensure the outcomes of every attendance are recorded and actioned.

Quality Management System

Why is this important?

This year the Health Board has taken an important step forward in strengthening our approach to delivering the Duty of Quality through the implementation of a Quality Management System (QMS). A QMS provides a consistent, systematic way to plan, deliver, monitor and improve the quality and safety of care for the people we serve.

We already carry out many elements of a quality management system. This includes designing services using evidence based standards such as NICE guidance, taking

part in national audits to check that these standards are being met, and putting measures in place to improve care where needed. We now need to strengthen and formalise this approach so that it is embedded consistently across every area of the Health Board. This will help us to plan services more effectively, clearly identify where improvement is required, and maintain oversight and focus on improvement work.

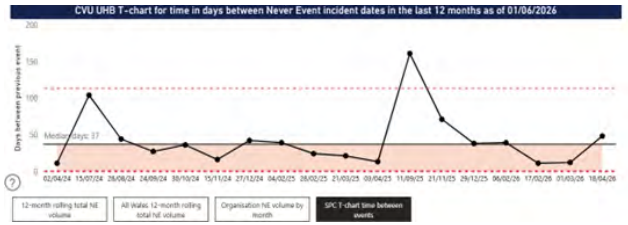
What are we doing?

The Health Board has worked with each of the Clinical Boards to complete a baseline assessment of their current arrangements for governance, risk, audit and assurance, and quality improvement. This has given us a shared understanding of strengths and priorities for improvement and has helped to create a more consistent approach across the organisation.

The Health Board was also successful in being selected to take part in national work to develop a QMS prototype. Through this programme, the Cardiology Directorate is working closely with colleagues in Swansea and the NHS Performance and Improvement team to co-design and test a quality management system aligned to national expectations and learning.

The learning from this work will inform the ongoing development and rollout of our organisational QMS, supporting continuous improvement and helping us to deliver safe, effective and person centred care.

Never Events



A Never Event is a serious patient safety incident that is considered preventable because there are clear national guidelines, safety checks and safeguards in place to stop it from happening. These checks and balances are built into everyday care, such as procedures, equipment design, staff training and multiple verification steps, specifically to reduce the risk of error.

These incidents should not happen if systems are working as intended. When a Never Event does occur, it is always reported and investigated in full, even when no harm is caused. This openness helps the Health Board and the wider NHS

in Wales understand what went wrong, strengthen safety systems, and reduce the risk of the same error happening again. The graph demonstrates the time between reporting Never Events, the greater the number of days between reported never events, the safer our systems.

Between April 2025 and March 2026, the Health Board reported seven Never Events. Four of these incidents related to safety checks in theatre, two were related to medicines safety and one case related to the post-operative management of Penrose drains. Each of these cases has been subject to a full investigation to examine processes and procedures and in each case the reviewers were able to identify areas that required strengthening. The table below shows some of the areas of improvement that have been implemented in response to the Never Event Investigations.

Development of a UHB WHO Surgical checklist and Team brief Tool

This work is standardising how the WHO checklist is completed, making roles and responsibilities clear and unambiguous.

Renewing the surgical count policy to strengthen the response and investigations that take place when there are discrepancies in the surgical count.

While there are formal counts that occur throughout a surgical procedure that support reconciliation of swabs and needles, the Health Board protocol did not provide robust guidance on the actions to take when discrepancies in the count were suspected outside of formal counts. The Surgical Count Policy is being strengthened, and training will be adjusted to accommodate this change.

Reviewing Scrub Practitioner training to build in opportunities for this professional group to shadow and work closely with surgeons.

The Royal College of Surgeons Good Surgical practice recognises the importance of effective team working encouraging reflection and learning from the multi-disciplinary team. The Scrub Practitioner training is being reviewed to explore opportunities for multi professional collaboration and mentoring.

Standardising the preparation of insulin infusions across the Health Board.

Reinforcing the national standards informed by the 2010 National Patient Safety Agency, Rapid Response Report, Safer Administration of Insulin.

Development of a standard operating procedure for the post-operative management of Penrose surgical drains.

The procedure supports the labelling and documentation on drains to ensure reconciliation of all drains when a patient has multiple drains in place.

Strengthening the protocol for the procurement of new theatre equipment.

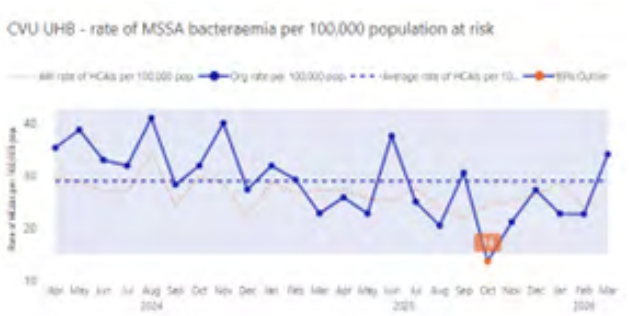
Ensuring that all new devices that are used in theatre are risk assessed and are incorporated into a formal checking and count process

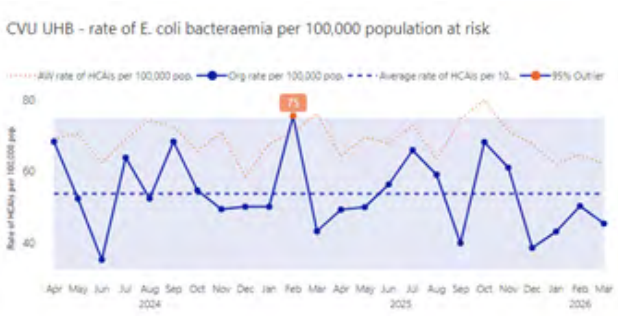
Duty of Candour

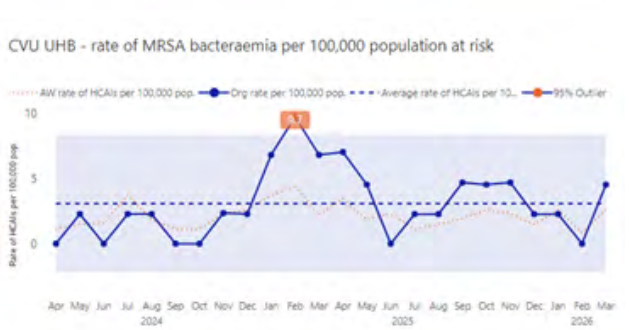
The Duty of Candour is a legal requirement for all healthcare providers in Wales to be open and transparent with patients when things go wrong in their care. The duty requires us to inform patients and/or their families about any unintended or unexpected incident that may have caused them moderate or severe harm or death.

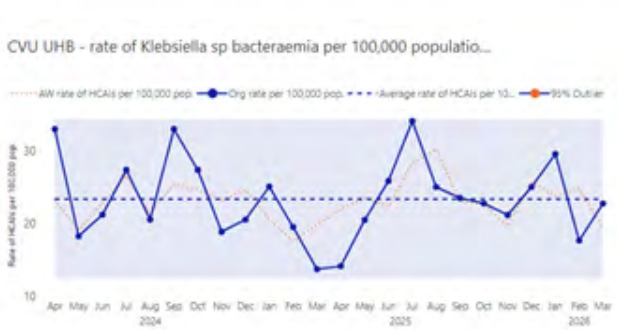
Putting things Right was the regulatory guidance we followed, this has now been replaced by Listening to People. This new guidance from NHS Wales details how to handle complaints, incidents and redress in all Health Boards and Trusts in Wales.

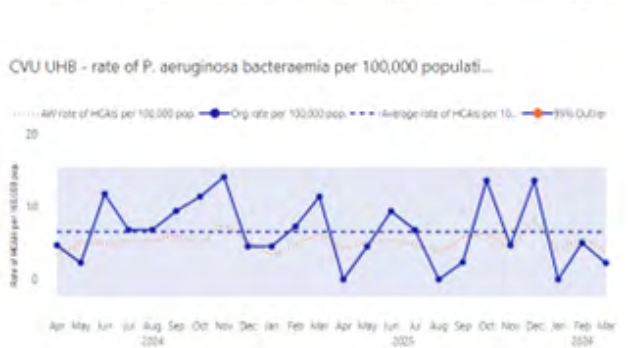
Managing Healthcare Associated Infections (HCAI)











Infection prevention and control

The Welsh Government Quality Statement: Infection Prevention and Control, requires Health Boards to embed infection prevention and control as a core part of delivering safe, high-quality care. This includes clear leadership, strong governance, and accountability at every level.

Health Boards must use data, audit, and surveillance to understand risks, monitor performance, and drive continuous improvement. This ensures the consistent delivery of evidence-based practice, safe environments, and effective management of infections and outbreaks.

Health organisations must also ensure their workforce has the skills and knowledge required, alongside timely systems for identifying and responding to risks, responsible antimicrobial use, and a focus on equitable, person centred care. Overall, there is a requirement to demonstrate continuous improvement, openness, and learning, ensuring infection prevention and control is fully integrated across all services and consistently protects patients, staff, and the public.

Executive infection prevention and control scrutiny panels

The Executive Director of Nursing and Executive Medical Director have chaired scrutiny panels to ensure learning from healthcare-associated *Clostridioides difficile (C. diff)* cases. These panels are attended by the multi-professional team, including the consultant, ward sister/charge nurse, microbiology, and the infection prevention and control team.

The aim is to understand whether there has been adherence to the required standards of care and to identify opportunities to prevent similar cases in the future. This year, the panels have refocused on cases of MRSA in recognition of increased occurrence and rates above the Welsh average.

Visual Infusion Phlebitis (VIP) score

The Visual Infusion Phlebitis (VIP) Score is a standardised clinical tool used to assess and monitor intravenous entry sites for early signs of infection. The tool grades the severity of inflammation from 0 to 5, helping clinical teams determine when continued monitoring is appropriate or when to remove the cannula to prevent complications.

This year, the Infection Prevention and Control team has monitored compliance with this tool through periodic audit and review of infections and has concluded that its use requires strengthening across the Health Board. When a cannula is inserted, a dedicated cannula pack should be used, and a sticker should be added to the notes to allow the duration of the cannula to be monitored.

Omissions in documentation can result in cannulas remaining in place for excessive periods, increasing the risk of *Staphylococcus aureus (S. aureus)* infections. The Infection Prevention and Control team is commencing work to improve compliance with the VIP score and the use of cannula stickers.

Escherichia coli (E.coli)

The Health Board is reporting the lowest rates of *E. coli* in Wales. Work underway in Primary Care has strengthened the accurate diagnosis of urinary tract infections caused by *E. coli* by standardising urine sample collection in general practice. Unnecessary treatment has been reduced through prescribing that is aligned with urine testing results.

Hydrogen peroxide vapour cleaning

Hydrogen peroxide vapour (HPV) cleaning is a versatile vapourised disinfectant used in healthcare settings for surface decontamination. HPV has been used to manage the spread of bacteria within healthcare settings and is deployed on-site in wards and clinical areas to decontaminate rooms and beds following individual cases or outbreaks of infection.

This process can be constrained by the rapid turnaround required for isolation rooms and beds to accommodate patients.

In the past year, the Infection Prevention and Control team has worked with housekeeping teams to create a dedicated HPV room. This facility will enable staff to remove potentially contaminated beds and equipment from wards for decontamination, replacing them quickly with cleaned beds. This approach reduces the risk of cross-infection while avoiding delays to patient admissions.

Standard operating procedures are being finalised, and the room will shortly become operational. While ward-based HPV cleaning remains necessary in some cases, this provides an efficient and effective alternative in many situations.

Aseptic Non-Touch Technique (ANTT)

Aseptic Non-Touch Technique (ANTT) is a structured approach used by healthcare professionals to prevent healthcare-associated infections (HCAIs) by maintaining asepsis during clinical procedures that bypass the body's natural defences. These include intravenous device insertion, urinary catheterisation, wound care, and phlebotomy.

All staff who undertake aseptic procedures must receive training every three years. This training is delivered online, followed by a face-to-face competency assessment.

In 2026, a new Electronic Staff Record system will be implemented, supporting improved reporting of training compliance and enabling a more targeted approach to addressing areas requiring additional training support.

Gloves off update

Why is this important?

The Gloves Off campaign is an award-winning initiative aimed at reducing the unnecessary use of disposable plastic

gloves. Over-reliance on these gloves can have a negative impact on hand hygiene amongst clinical staff. The campaign encouraged staff to "Think before you Glove" wearing disposable gloves only when coming into contact with blood or bodily fluids. Since its launch in May 2025 with Critical Care, more than 18 departments across the Health Board have adopted it.

What are we doing?

One of the newest areas to join the campaign is the Cystic Fibrosis ward at

University Hospital Llandough (UHL). The Ward Sister noticed that staff were putting on gloves automatically, even when they weren't needed. After seeing the Gloves Off campaign in action, she decided to introduce it on her ward.

To make the change safe and easy, the team focused on improving access to hand hygiene first. The ward already had corridor sinks, but the Ward Sister and her deputy ensured hand gel was available at every point of care. They placed gel dispensers outside every room and checked that each patient room had one inside too. This meant staff didn't have to choose between using gloves or hunting for hand gel.

They measured the impact by manually auditing procurement stubs because the official data wasn't readily available. Comparing July–October with the same period the previous year, the 10-bed unit used 130 fewer boxes of gloves. This resulted in less plastic waste, lower carbon emissions, and a drop in the use of other Personal Protection Equipment (PPE)—especially plastic aprons, which are often worn only because gloves are used.

The campaign didn't just save money and reduce waste —most importantly it also improved the patient experience. People with Cystic Fibrosis spend a lot of time in hospital, and the Ward Sister noticed that staff wearing gloves for everything made some patients feel cut off from others. By removing gloves for tasks that didn't involve bodily fluids, like switching off call bells or taking observations, staff were able to offer more natural, human contact. For many patients, feeling a real hand instead of latex helped them feel more connected to their care team and less like they were being treated as an infection risk.

Recently the UHB launched a new data dashboard so that all wards and departments can quickly see how many gloves they are using and how much they are spending. The Cystic Fibrosis Ward has reduced their glove use from £2.6k in 2024, with 86k gloves ordered to £1.8k in 2025, with 63k gloves ordered. This means they have reduced their glove use by 26.7%, resulting in a 30.8% cost saving.

Watch the Gloves Off campaign video here.

Nutrition and hydration: Improving safety and patient experience

Why is this important?

This year the Health Board made important improvements to how patients with food allergies, intolerances and special dietary needs are supported in hospital. These changes help keep people safe and make sure everyone receives food that is right for their health, culture and personal preferences.

What are we doing?

Dietary needs and preferences

When patients arrive on the ward, staff now record information about dietary needs and preferences on an electronic Nutrition and Hydration bed plan. This includes food allergies, food intolerances, religious or cultural food needs and special diets related to medical or health needs. This approach supports catering teams to provide safe, nutritious and suitable meals from the start.

Gluten free "Purple Box" on every ward

Some patients must avoid gluten to stay well. To support this, each ward now has a gluten free purple box kept in the ward kitchen. These boxes include food items and snacks that are suitable for patients who are unable to tolerate gluten and include gluten free biscuits, crackers, cereal bars, porridge oats and toast bags to prevent cross contamination. This initiative means that patients with Coeliac disease and other conditions can access safe snacks at any time during their stay.

Training for staff

All staff are encouraged to complete the NHS Wales Food Safety e-learning module. This training helps staff understand how to handle food safely and reduce the risk of accidental exposure to allergens.

Benefits for Patients

These improvements mean:

- Patients with allergies or special diets are safer
- Staff can provide suitable food more reliably
- Meals are better matched to personal, cultural and medical needs
- Patients feel more confident and supported

A short video was shared with staff showing how important safe food is to patients and families, and how small actions can make a big difference. You can watch this here-

Maternity - Path to safer beginnings

The *Path to Safer Beginnings in Wales* national assurance assessment was commissioned by the Welsh Government to provide an independent review of the quality, safety and responsiveness of maternity and neonatal services across Wales. The assessment drew on engagement with women, families and staff, alongside site visits and review of service delivery arrangements, to identify both areas of good practice and opportunities for improvement. The report highlighted a number of priority areas including strengthened national leadership and oversight, improving consistency and equity of care, enhancing clinical safety systems, ensuring sustainable staffing and environments for safe care, improving mental health and wellbeing support, strengthening neonatal service planning, and creating stronger systems for learning from feedback and lived experience.

The programme identifies eight national priorities that will be delivered over a three year period.

- Joined-up national leadership
- Universal offer of high-quality care
- Urgent attention to critical clinical safety systems
- Enough staff and the right spaces to care safely
- Support for mental health and wellbeing
- Improved planning and commissioning of neonatal care
- Listening and improving from feedback

Locally, the Health Board is developing a three-year improvement programme which will run in parallel with the national maternity and neonatal improvement programme in Wales. Building on the investment and governance arrangements established following publication of the Ockenden Review of maternity services at Shrewsbury and Telford Hospital NHS Trust, the Health Board will strengthen and extend this approach across the wider Perinatal Directorate. The programme will focus on reviewing and enhancing governance processes to provide greater assurance in relation to safety, quality, experience and outcomes for women, babies and families. Particular emphasis will be placed on strengthening oversight arrangements, improving multidisciplinary learning and ensuring robust systems are in place to support continuous improvement across maternity and neonatal services.

As part of this work, the Health Board will further develop its approach to quality intelligence and performance monitoring. Existing maternity and neonatal dashboards will be aligned to create a single perinatal dashboard, providing oversight of quality indicators across the entire perinatal pathway. This will support a more integrated understanding of outcomes, safety indicators and service pressures, while also incorporating findings from the maternity patient experience survey to ensure the voices and experiences of women and families are reflected within governance and quality improvement processes. The Health Board also recognises the importance of birth reflections as a valuable tool to support personalised care, learning and restorative conversations following birth experiences. Work will therefore be undertaken to expand access to birth reflections discussions, including upskilling members of the multidisciplinary team to enable these conversations to be routinely offered to all women receiving care.

Workforce sustainability remains a key priority for the Health Board. Recruitment of midwives is currently reliant predominantly on newly qualified staff, which has implications for the overall seniority and skill mix of the workforce. As a result, the Health Board will review workforce planning, recruitment and retention approaches to ensure an appropriate balance of experienced and senior midwives is maintained across services. In addition, the Health Board will continue to work collaboratively with the NHS Joint Commissioning Committee and partner Health Boards in response to the planned national reconfiguration of neonatal services in Wales. This may result in an increase in neonatal cot capacity within Cardiff and Vale University Health Board over future years, requiring continued partnership working and service planning to ensure safe, sustainable and high-quality neonatal care provision for the population served.

Recommendations of the Royal College of Psychiatrists

Following the publication of a report by the Royal College of Psychiatry in 2024 the Mental Health Clinical Board has focused on delivering the review's recommendations and improving the safety and quality of inpatient mental healthcare. There has been clear progress in how suicide risk is assessed and managed. A new, person centred approach to risk assessment is

now in place using the Welsh Applied Risk Research Network (WARRN). This supports better understanding of individual risk and encourages ongoing therapeutic engagement.

Staff have received Suicide Awareness and Mitigation Training, and patients identified as being at risk are now routinely supported to develop a co-produced safety plan. These changes are supported by updated policies and regular audit.

Care and Treatment Planning has also improved. Ward round processes have been strengthened, staff training has been expanded, and audit arrangements have been put in place to ensure plans are personalised, meaningful and developed with patients. This work supports clearer communication, better continuity of care and greater patient involvement in decision making.

Therapeutic engagement on inpatient wards has been strengthened. Ward activities have been re-established, staffing models have been improved, and regular one to one sessions with patients are now expected and monitored. Observation practice has been reviewed and updated, with a stronger focus on engagement and safety, and the new approach has been co-produced with people who have lived experience of services.

Important improvements have also been made to continuity of care. Clearer processes are now in place for patient transfers, discharge communication has improved, and services are aligned with NHS Wales Safe Discharge Standards. This includes follow up contact after discharge to provide additional support during a higher risk period.

Further progress includes stronger compliance with the Mental Health Act through updated policies and targeted learning for clinicians, alongside clearer expectations for diagnosis and treatment decisions. Engagement with families has been prioritised through a long term Family Engagement Project and a co-produced information sharing policy. The quality of serious incident investigations has improved significantly through achieving and retaining SIRAN accreditation, supported by clearer governance and the appointment of a dedicated Family Liaison Officer.

Overall, good progress has been made in delivering the recommendations of the Royal College of Psychiatrists' review. Many improvements are now part of everyday practice, with continued audit and oversight in place to support learning, assure quality, and sustain improvement over time. A progress report was presented to the Cardiff and Vale Quality Committee in March 2026, you can access this report here.

Keeping children safe in hospital

The Humpty Dumpty Falls Assessment in children's wards

We are rolling out the Humpty Dumpty Falls Risk Assessment across the Children's Hospital for Wales. The Humpty Dumpty Falls Scale is an evidence-based tool that evaluates the risk of falls in children. It allows our staff to identify risks and put in place actions to manage or reduce these risks, keeping children safer. Use of the tool will provide a more consistent approach to managing falls risk and improves communication with families around this important matter.

Humpty Dumpty Falls
PREVENTING FALLS. ENHANCING SAFETY.

Initially, the assessment will be completed on paper, but this will be part of the future roll out of electronic nursing records in the Children's Hospital.

The All-Wales Paediatric Cot and Bedrails (CoBRA) risk assessment in children's wards

The Health Board is also introducing the All-Wales Paediatric Cot and Bedrails (CoBRA) Risk Assessment across all children's wards. This is a validated (tried and tested) tool which helps staff quickly identify where a child should sleep while in hospital.

What the tool does

The assessment considers a range of factors that can affect a child's safety, including the age of the child, their development, the likelihood of them climbing or falling from a bed and any other risks of entrapment Staff complete the assessment on admission and update it if a child's condition or circumstances change.

Why it matters

Using this tool means that clinicians in the Children's Hospital for Wales are able to identify risk earlier and put in place appropriate safety measures including providing parents with links to the Lullaby Trust Safe Sleep advice. The tool also supports families in being more actively involved in keeping children safe in partnership with the clinical team.

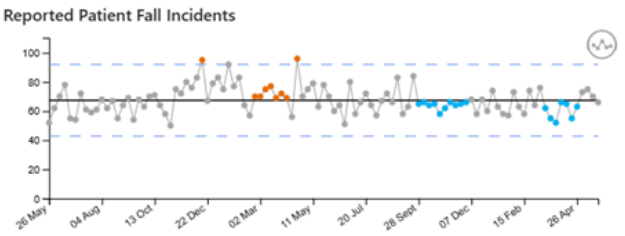
What's coming next

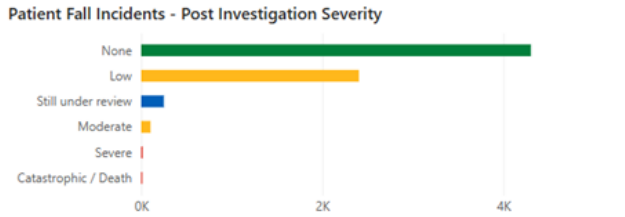
We are continuing to develop and strengthen how we assess and manage risk for children in our care. A new Paediatric Risk Assessment Booklet will be introduced across our children's wards. This will bring together a range of risk assessments into one place, including both new and updated tools. The booklet will cover areas such as patient handling, pressure ulcer prevention, nutrition, mouth care, food allergies and VIP (drip cannula) scoring, alongside the assessments already in use. By bringing these together, we aim to support a more joined-up and consistent approach to assessing risk and keeping children safe.

Falls

Preventing and managing inpatient falls

Falls prevention is the responsibility of all members of the Health Board's multi-disciplinary team. Managing the increased risk of falls posed by some medications, recognising conditions including low blood pressure, recognising falls risks posed by poor footwear or vision loss are all important in keeping individuals safe. We continue to work to reduce falls in our hospitals and to make sure people are cared for safely if a fall does happen. Falls





can cause injury, affect recovery and reduce a person's confidence and independence. For some people, especially older adults, a fall can have a serious impact on both physical and emotional wellbeing and may lead to a longer stay in hospital.

Our approach to preventing falls

In April 2025, the Health Board's Falls Prevention Procedure for patients staying in hospital was updated. This guidance helps staff to identify people who may be at higher risk of falling and to reduce avoidable risks in ward and care environments. The procedure also ensures that clinicians are able to continue to encourage and support safe movement and activity, helping people stay strong and independent. This approach balances prevention of falls with avoiding loss of strength and mobility from staying inactive.

Responding to falls

Not all falls can be avoided and ensuring that clinical teams are able to respond quickly and safely if a person falls, is vital to reduce harm. The procedure provides a clear protocol of how to assess patients in the immediate period following a fall, how to move people safely to avoid causing further injuries and the actions to undertake to prevent further falls. We have introduced falls action cards across all Health Board sites. These give staff simple, step by step guidance, supported by visual flowcharts, to help prevent falls and to take the right action if a fall happens.

Training and staff feedback

A falls training programme launched in 2024 has continued across the Health Board. The programme has been subject to ongoing review from the staff who have attended to ensure it reflects current best practice and that staff feel more confident in falls prevention and management following attendance.

Feedback has been very positive and colleagues from across the Health Board have reported increased skills, knowledge and confidence in both preventing falls and managing them safely when they occur.

Examples of staff feedback:

"Excellent content and training"

"I am confident now to do my falls and bone risk assessment"

"Excellent trainers and all the subjects discussed were very important in my work area"

"Excellent course. I found it super helpful"

Preventing falls in the community

While preventing falls in hospital is essential, many falls happen outside the hospital settings. More than 230,000 people over the age of 60 fall each year in Wales. Preventing falls in the community is a key part of helping people stay safe, well and independent at home.

A system approach to falls prevention

In June 2025, the Health Board coordinated an event bringing 50 people from healthcare, emergency services and the third sector together to share ideas and experiences in order to improve how we prevent and respond to falls in the community.

This workshop identified key challenges and led to the creation of four workstreams focused on:

- Improving access to clear information and support
- Strengthening telecare and local response services
- Supporting care homes and home care services
- Providing treatment closer to home after a fall

This combined effort has helped in developing a more collaborative approach to reducing the risk of falls and implementing a safer and more effective response when individuals do fall in the community.

Supporting people after a fall - Community Falls Pathway

To reduce the chance of further injury or other problems following a fall, it is important that the faller is safely assisted from the floor as soon as possible. We are working closely with the Welsh Ambulance Service and Cardiff Council to pilot an improved process for helping people who have fallen in their homes. This aims to get assistance to the faller as quickly as possible and provide at-home treatment where appropriate to avoid unnecessary hospital admissions. This pilot is an example of our efforts to provide more services and treatments at or near people's homes.

Working with care homes

Nursing and residential homes care for some of the oldest and most frail people in our community. Because of this, falls in care homes are common. The Health Board is working with local care homes to deliver additional training and education to their staff, as well as supporting the purchase of lifting equipment to help safely assist residents who have fallen.

Collecting information about falls in care homes has informed the development of action cards for care home staff. These cards help staff to quickly and safely assist a fallen resident, highlighting when an ambulance needs to be called or when other options are more appropriate, such as a district nurse visit to treat a minor wound.

Working with our communities

We are working closely with partners to co produce falls prevention approaches with people who use services. This includes collaboration with Live Well, Age Well, ensuring that prevention work:

- Reflects real life experiences
- Supports independence and wellbeing
- Is accessible, relevant and person centred

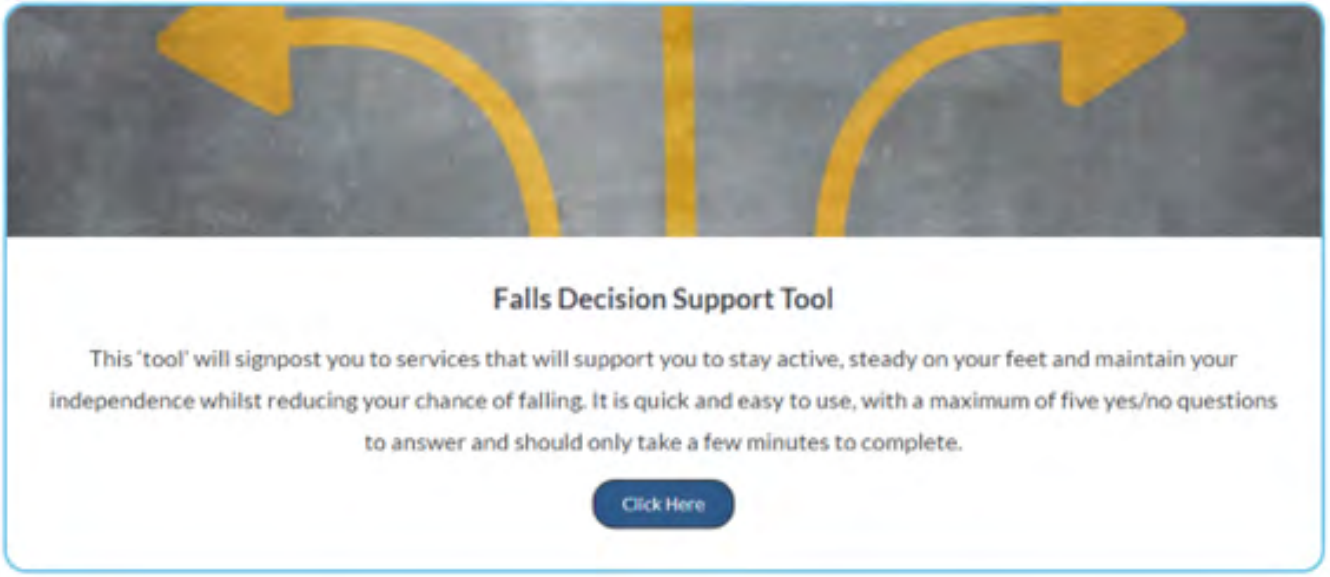
Raising awareness of falls

Within the Cardiff and Vale area, there are a wide range of services and organisations that can help people to maintain their independence and reduce the chance of fall-related injuries.

You may notice posters and leaflets at community locations across Cardiff and Vale promoting falls information and services. These include Telecare, which is available from the council and provides emergency alarms to support independent living, and Care & Repair, who undertake home adaptations to improve safety and allow people to live in their own homes for longer.

Falls Decision Support Tool

By answering a few simple questions, our new online tool will give you information and suggest classes that are relevant to you. It is available in Welsh and English at keepingmewell.com/cwympiadau or keepingmewell.com/falls



Call 4 Concern (C4C) – Information for patients and families

Call 4 Concern
A patient safety initiative

Martha's Rule was introduced in the UK following the death of 13 year old Martha Mills in 2021, who died from sepsis after repeated concerns raised by her parents were not acted on in time. Martha's Rule recognises the vital role that patients, families and carers play in identifying deterioration and ensures they can raise concerns and access a rapid clinical review when they feel something is not right. The introduction of Call for Concern provides a clear, consistent route for patients and families to voice worries and seek timely help, supporting early recognition of deterioration and reinforcing a culture where concerns are listened to, acted upon and valued as a core part of safe care. Further work is underway to deliver the wellness question, this is an additional check that will be undertaken when clinical staff are undertaking observations. It allows an opportunity for the patient to say how they are feeling.

The Call for Concern provides three mechanisms for patients and their families to be able to raise concerns.

Tier 1 – Patient wellness question

A simple question is added to the usual NEWS2 observation chart asking patients and families how the patient is feeling. This makes sure their views are heard first. If they are worried, this concern is passed straight to the nurse in charge. Similar questions are already used in maternity and children's services across Wales.

Tier 2 – Patient or family raised concern

If the patient or family is still worried, they can speak to the nurse in charge. If needed, the concern is quickly passed on to the doctor caring for the patient, so action can be taken by the clinical team.

Tier 3 – Call for an independent review

If concerns remain, the patient or family can call a dedicated phone number, shown in every ward, to request an urgent independent review. This will be carried out by the Patient at Risk Team or another experienced clinician. Tier 3 is planned to start on wards in the Health Board in July 2026, with a dedicated team preparing for this.

Monitoring

All actions and checks will be recorded using the Tendable app, which helps staff track safety checks, spot problems quickly, and make sure concerns are acted on to keep patients safe.

World Patient Safety Day (WPSD) 17th September 2025

World Patient Safety Day takes place every year on 17th September, with a different theme chosen to highlight an important area of patient safety. Wednesday 17th September 2025 marked the sixth annual World Patient Safety Day, focusing on the theme "Safe care for every newborn and every child." Every child has the right to safe, high-quality healthcare from the very beginning, yet newborns and young children face higher risks because they are still developing, have changing health needs and rely on adults to speak up for them. Some children may also struggle to access the care they need, which can increase the chance of harm. Even one safety incident can affect a child for life.

The 2025 slogan, "Patient safety from the start!", highlighted the importance of acting early to keep children safe throughout childhood. World Patient Safety Day aims to raise public awareness, improve understanding and encourage global action to reduce harm, led by the World Health Organisation.

To mark the day, a global webinar was held on 8 September, followed by local events on 17 September in both the Antenatal Clinic and the Children's Hospital for Wales foyer. These events featured stands from a wide range of services, including PIPYN (The Children and Families Programme, a pilot supported by Welsh Government's Healthy Weight: Healthy Wales strategy), NYLO (Nutrition for Your Little One, developed by Cardiff & Vale UHB Public Health Dietitians for families with children aged 5 and under), Get Cooking, Breastfeeding Support, Smoking Cessation, Perinatal Mental Health, Starting Well, Foodwise in Pregnancy, Design to Smile, and PART/Call4Concern. Throughout the morning, a variety of interactive activities were available for patients, families, and visitors to enjoy. The day was also promoted widely through staff screensavers and social media communications to help spread the message.

Effective care

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

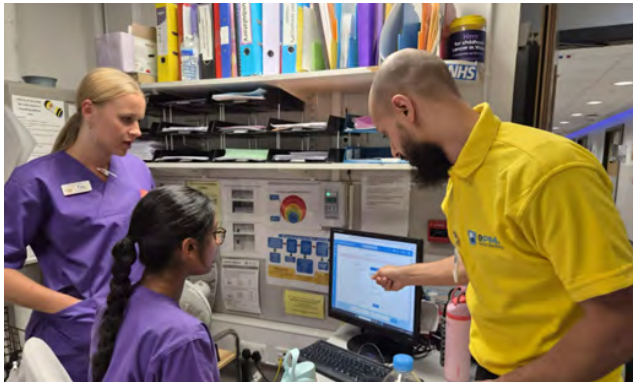
Electronic Prescribing and Medicines Administration (ePMA)

The roll out of Electronic Prescribing and Medicines Administration (ePMA) across the Health Board during 2025/26 represented a significant and rapid transformation in how medicines are managed in clinical areas. Implementation began in nephrology and transplant services in July 2025, before progressing at pace through a wide range of specialties including neurosciences, haematology, cardiothoracics, and the large-scale deployment across medicine and surgery at University Hospital of Wales.

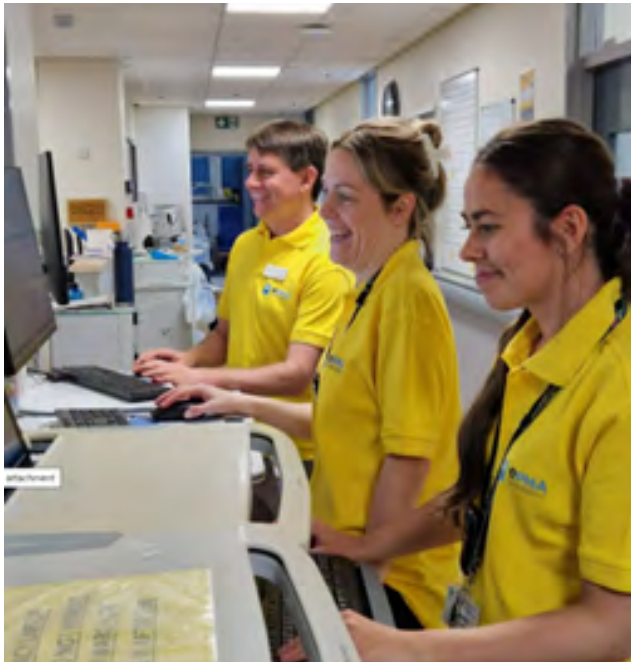
By early 2026, the system had been successfully extended to the Emergency Department, University Hospital Llandough, community hospitals and, notably, mental health inpatient services, marking the first implementation of ePMA within a mental health setting. This phased but accelerated approach enabled more than 85% of inpatient areas to go live within five months, demonstrating strong clinical engagement and organisational commitment to digital transformation.

An ePMA allows digital prescribing with automated checks for allergies and drug interactions and provides prescribing guidance and prompts. Medication administration is recorded at the patient's bedside and patient's wristbands are scanned to access their prescription chart, reducing the risk of wrong patient drug errors. The system allows scanning of medications where bar codes are available on medication packaging, this reduces the risk of wrong medication errors. The system is also reducing the risk of omitted medications through real-time tracking and alerts.

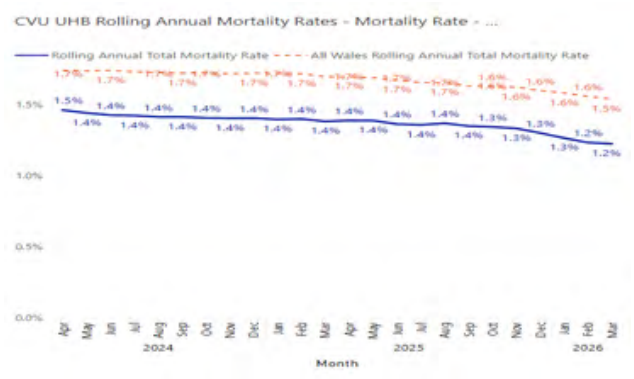
The introduction of ePMA has delivered clear benefits for quality and safety by improving the accuracy, visibility and timeliness of prescribing and medicines administration. During the year, over 680,000 medicines were prescribed and more than 2 million administered using the system, supported by safety features such as barcode scanning at the bedside, which was achieved in 93% of administrations. This has strengthened assurance around correct patient identification and reduced the risk of medication errors. The system has also enhanced communication and continuity of care, with over 10,000 discharge letters generated electronically and more than 5,000 staff trained to use the platform. Building on this progress,



ongoing work continues to focus on extending ePMA into additional services including intensive care, paediatrics and maternity, alongside planning for outpatient implementation. In parallel, efforts are being made to strengthen system resilience and sustainability through enhanced support arrangements, continued clinical and technical optimisation, and further integration with national digital systems to support safer, more consistent medicines management across all care settings.



Mortality



In September 2024 the Death Certification Reforms came into force, requiring all deaths that occur in hospital or in the community to be independently reviewed by either a Coroner or a Medical Examiner. Between 1st April 2025 and 31st March 2026, the Medical Examiner reviewed the death of 3780 people across Cardiff and Vale and provided the Health Board with feedback relating to 1045 of these reviews. The greatest proportion of these deaths occurred in either acute or community hospitals (50%) and a further 43% of deaths occurring in either individuals' own home or a nursing or residential home. The crude rolling twelve-month inpatient mortality rate between February 2024 and March 2026 fell from 1.5% to 1.2%.

Clinical care and patient safety

A key theme identified across our clinical care reviews is the importance of recognising and responding quickly to patients whose condition is deteriorating. Delays in diagnosis, escalation of care and treatment were noted in some cases. In addition, some patients experienced gaps in continuity of care, which in a small number of cases led to them being lost to follow-up between services.

Improving timely care remains a core priority. Delays in diagnosis, treatment, referral, transfer and admission have been highlighted through both case reviews and patient safety incident data. This learning is informing our Shaping Our Future – Quality Excellence Programmes, which aim to ensure that patients showing signs of deterioration are identified and treated promptly, and that care is safely coordinated across services from referral through to discharge.

Work is already underway to strengthen care in these areas. This includes

increasing advance care planning in community settings, introducing the All Wales Treatment Escalation Plan (TEP), and regularly reviewing Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions for inpatients and the implementation of NEWS2, which provides a standardised way of identifying and responding to patients who are becoming unwell. Full implementation is planned by September 2025. Together, these improvements will support earlier recognition of deterioration and more timely, appropriate care.

End of life care

Delivering high-quality end-of-life care remains an important focus. The Health Board has identified some variation in symptom control, including the management of pain and breathlessness, as well as in communication with patients and families and the overall experience of care, through the ME feedback. This highlights the need to ensure that care is consistently compassionate, person-centred and aligned with national standards.

The Wales Quality Statement for Palliative and End of Life Care, published in 2022, sets out clear expectations for safe, effective and timely care. To support this, we are undertaking a project to better understand end-of-life care from the perspective of bereaved families.

An end-of-life audit tool has been developed to identify areas where care may fall short. These include uncontrolled symptoms, unmet basic needs, inequitable access to care, and poor or unclear communication. The audit also highlights where care may be overly medicalised or where reversible clinical factors may not have been fully addressed, as well as situations where carers may experience distress, isolation or insufficient support. All relevant cases referred to the Medical Examiner are reviewed to identify themes and opportunities for learning.

One area for improvement identified through this work is the use of the Symptoms Early Warning Score (SEWS). This tool supports staff in recognising and responding to common end-of-life symptoms such as pain, agitation and breathing difficulties, helping to ensure consistent and effective symptom control. Work is underway to increase its use across services.

Targeted education and training resources are being developed based on audit findings, and plan to extend this work into community services over the coming year.

Learning, improvement and governance

In response to the themes identified, the Health Board has strengthened how it learns from care and improves services. This includes the introduction of structured mortality review processes, with multidisciplinary review panels, supported by a Learning from Mortality Group that oversees themes and shares learning across the organisation.

Education and training programmes have been expanded to address key areas such as mental capacity, DNACPR decision-making and the recognition of deterioration. Practical tools and guidance are also being developed to support staff in delivering safe and effective care.

This year a standardised mortality and morbidity (M&M) tool was developed and a mortality module added to the Health Board clinical governance system AMaT.

Throughout 2026 work will be undertaken with each directorate to embed the use of the mortality module and M&M tool.

Together, these actions are helping to ensure that learning is embedded across the organisation, leading to sustained improvements in patient safety, quality of care and patient experience.

Prevention of Future Death Reports

A Prevention of Future Deaths (PFD) report, also known as a Regulation 28, can be issued by a Coroner following an inquest or investigation into a death. The purpose of the report is to highlight concerns that if addressed, could prevent similar deaths in the future.

Between 1st April 2025 and 31st March 2026 the Health Board was issued with five PFD reports by the Coroner.

Documentation in Mental Health

In response to the Coroner's concerns about unclear guidance on information shared with patient families, the Health Board set out a series of specific actions. It co-produced new values-based guidance with families, carers, service users and clinicians to clearly define the distinction between information sharing and information gathering. This included practical instructions on when and how to record decisions. Revised patient and new family/carer information leaflets were developed explaining these processes and patients' rights in detail. A multi stakeholder working group was established to embed and disseminate the revised guidance across services and staff training to ensure consistent documentation.
The Health Board incorporated national guidance on information sharing for suicide prevention into local policy and scheduled organisational learning events to reinforce expectations with clinical leaders and staff. A co-produced family engagement project was commissioned to drive a cultural shift towards more proactive and compassionate involvement of families in care

Mitigation of estates and infrastructure risks and events.

The Coroner raised concerns about risks to patient safety arising from ageing hospital infrastructure—particularly vulnerabilities in electrical supply to critical care areas and the impact on critical care capacity. In response, the Health Board implemented a range of specific measures including developing an Electrical Failure Emergency Action Card with clear steps for managing power outages and patient evacuation. A formal Critical Care Escalation Plan was introduced to prioritise and manage bed capacity and patient flow, strengthening major incident preparedness through an updated plan with defined command structures and communication processes. Infrastructure risks through ongoing upgrades such as improvements to electrical systems and power supply resilience have been undertaken, alongside regular simulation exercises, staff training.

Oversight of Results in the Peri-operative Older Peoples Service

The Coroner raised concerns centred on the patient safety risks from reliance on a single Peri-operative Older Peoples Service (POPS) consultant and the potential for abnormal or urgent test results to be missed or not acted on promptly. In response, the Health Board introduced interim cross cover arrangements by escalating abnormal results to on call teams and relevant specialties. Plans to expand the POPS workforce and establish a formal cross cover rota are being progressed, and the discharge process has been strengthened through structured clinical notes uploaded to the Welsh Clinical Portal, supported by audit. Laboratory procedures for critical results have been strengthened to ensure clinicians are contacted.

Oversight of pacemakers

The Coroner's concerns related to unclear thresholds for referring patients from Cardiac physiology to Cardiology as well as gaps in physiologist knowledge of infective endocarditis and device-related infection risks. This issue combined contributed to delayed diagnosis. In response, the Health Board introduced a revised escalation protocol with mandatory referral triggers. Clinical assessment was strengthened through structured medical history sheets and required implant site checks. Regular audits of documentation and practices were implemented and targeted training on recognising serious illness and when to escalate was delivered. A comprehensive Standard Operating Procedure for managing unwell patients has been developed

A PFD report was also issued to all Health Boards in Wales to mitigate the risks of differences between adult and paediatric resuscitation trolleys. The Health Board is working with other health organisations in Wales to agree a solution to mitigate this risk.

National Emergency Laparotomy Audit (NELA)

The National Emergency Laparotomy Audit (NELA) supports the measurement and benchmarking of the quality of care provided to patients undergoing a laparotomy, a major abdominal surgical procedure undertaken to treat bowel obstruction, bleeding or infection.

The most recent NELA publication presents data from April 2023 to April 2024 which includes data relating to 276 patients that received care in the Health Board. Over half of the patients admitted for emergency laparotomy surgery are admitted through the emergency department 48% of them present with a predicted mortality rate of

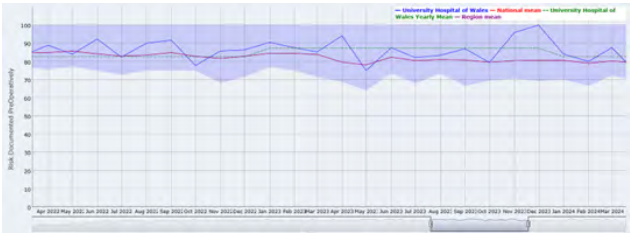
over 5% and 41% of the patient group are assessed as having significant frailty. The importance of the timeliness of the care that the Health Board deliver and ensuring the appropriate level of oversight are vital in ensuring the best outcomes for the patients.

NELA Results

The mortality rate of patients undergoing an emergency laparotomy in the Health Board was 7.2%, below the national average of 8.1% and a reduction from the previous year.

84.4% of patients are assessed prior to their surgery to calculate their predicted mortality risk. This allows the correct planning and resources to be allocated to the patients with the highest risk.

Proportion of patients that have their risk calculated before surgery



Of the patients who were assessed as having a mortality risk of over 5% , 97.2% had a consultant surgeon present in theatre, 82.6% had a consultant anaesthetist present and 81.3% had both present in theatre during surgery.

Proportion of patients that have a consultant surgeon and anaesthetist present in theatre

49.6% of high-risk patients are admitted to critical care following surgery, while this was below the national average, admission rates had increased from the previous year and the Health Board has continued to see and increase.

Proportion of high risk patients admitted to critical care

42% of patients that require immediate surgery arrive in theatre within the appropriate timescale

Proportion of patients requiring immediate surgery that arrive to theatre within the required timescale

The majority of patients receive a CT scan prior to going to surgery and the previous NELA standard required that a CT scan was undertaken and reported, however in 2023-2024 the standard changed to recommend that the radiologist and surgeon discuss the CT scan results. By April 2024 the Health Board had achieved this standard in 13.98% of patients, slightly higher than the national rate, however this rate has continued to improve and by October 2025 the yearly mean rate was 17.56% well above the national average of 13.8%

There is ongoing work to strengthen the recognition and treatment of infection

and sepsis, with a training programme for foundation year resident doctors, the roll out of NEWS 2 scoring and the development of an acute abdominal pathway to support the timely recognition and treatment of infections. NELA performance will continue to be monitored through the Surgery Clinical Board audit and quality and safety forums and at the Health Board Clinical Effectiveness Committee.

Why is clinical coding important?

Clinical coding allows the Health Board to analyse the care it provides and the outcomes of patients. By coding a clinical pathway we can understand the length of stay for a particular patient group, measure patient outcomes including survival rates, understand the rate of complications or additional interventions, including an unplanned return to theatre.

By using a standardised set of codes the data produced also allows the Health Board to benchmark itself against other similar organisations in the UK to understand the quality, effectiveness and safety of the care we are providing. At present delays in clinical coding mean that the Health Board's ability to utilise quality data is limited. In 2026/27 Welsh Government have set a target for the Health Board to have coded 95% of all patient cases within a month of their discharge.

In order to deliver the improvements in clinical coding to allow us to use the information effectively the Health Board appointed to a Senior Coder to supervise and train new staff and are developing clearer career pathways for clinical coders and are increasing the number of trainee clinical coders.

% of uncoded primary diagnosis for finished consultant episodes

Cardiology

A recent service review in cardiology highlighted areas of strong clinical practice alongside areas that required improvement or development. The review found that increasing demand, pressures on infrastructure and workforce, and inconsistent ways of working have affected staff experience and the delivery of care. Key improvement priorities include strengthening a respectful and supportive culture, improving leadership and management arrangements, increasing engagement with quality and safety processes, and ensuring services are planned to meet current and future demand. Addressing these areas will support safer, more consistent and person centred care for patients, while improving staff wellbeing, training and sustainability of the service.

Since the cardiology service review, a substantial programme of improvement has been delivered and is actively underway. Key actions already completed include the establishment of weekly

senior multidisciplinary clinical meetings, reinstated monthly Quality and Safety meetings, regular management walkrounds, strengthened consultant job planning governance, standardised core Supporting Professional Activities (SPA) allocation, and the introduction of named clinical supervision for resident doctors. Alongside this, further improvement work is progressing through the Foundations for Change programme, including Civility Saves Lives and Speaking Up Safely initiatives, development of hot and structured debriefing models, ongoing consultant job planning and Value Based Appraisal completion, reviews of demand and capacity, on call arrangements and outpatient pathways, improvements to governance

Healthcare Inspectorate Wales

Healthcare Inspectorate Wales is the independent regulator and inspectorate of healthcare in Wales. They inspect NHS services and regulate

independent healthcare providers against a range of standards, policies, guidance and regulations to highlight areas requiring improvement. The external assurance provided by HIW is vital in providing the Health Board with an independent view of the services we provide helping us to drive improvement.

In the last year, HIW have inspected the following services:

Maple Ward at Hafan Y Coed Mental Health Unit – University Hospital Llandough

Healthcare Inspectorate Wales (HIW) undertook an unannounced inspection of Maple Ward in April 2025 and found that patients were treated with dignity and respect, with effective therapeutic engagement, strong multidisciplinary input, and good systems supporting safe care, medicines management and governance processes. However, the inspection identified a number of areas requiring improvement, particularly relating to environmental safety, maintenance, infection prevention and control, and aspects of governance and communication. Key issues included limited access to nurse call systems in bedrooms, unresolved maintenance and IPC risks, blind spots affecting observation, and inconsistent documentation of fire risks and advocacy involvement.

In response, the Health Board implemented a range of improvement actions, including progressing estates works such as installing privacy screening and corridor mirrors, reviewing and addressing outstanding maintenance requests, strengthening IPC arrangements and audit processes (including clearer cleaning responsibilities and monitoring), introducing tools for medication side-effect monitoring, improving advocacy access and documentation, and enhancing risk assessment processes through training and the development of Positive Behaviour

Support plans. Additional actions focused on improving communication and visibility of senior leadership, increasing training compliance, and reinforcing governance oversight to support sustained quality improvement. You can read the full report and improvement plan here

Elizabeth Ward- St David's Hospital

HIW undertook an unannounced inspection of Elizabeth Ward in May 2025 and found that patients were treated with dignity and compassion, with strong multidisciplinary rehabilitation input and effective medication management supporting safe and person centred care; however, a number of improvement areas were identified relating to timeliness of care (notably call bell response delays), discharge planning due to inconsistent social services involvement, environmental cleanliness and infection prevention, staff training compliance (including urgent gaps in Basic Life Support), documentation (Deprivation of Liberty and mental capacity), and workforce governance including appraisals and mandatory training compliance.

The Health Board has implemented an improvement plan, including rapid action to increase basic life support training compliance, establishment of enhanced discharge coordination with local authorities and strengthened multi-disciplinary team oversight, introduction of routine audits and leadership visibility to improve call bell responsiveness, completion of environmental decluttering, deep cleaning and strengthened Infection prevention and control governance, which included appointment of a link nurse and putting in place enhanced audit processes. Improved staff training in safeguarding and mental capacity, reinforcement of equipment cleaning protocols, and initiatives to strengthen staff engagement and governance such as the "Leaders that Listen" framework and improved appraisal and training compliance monitoring. You can read the full report and improvement plan here.

Ionising Radiation (medical exposure) Regulations Inspection Report – University Hospital Llandough

Ionising radiation exposure refers to the use of radiation, such as X-rays, in medical imaging to diagnose or treat conditions; while it provides significant clinical benefit, it carries a small risk to patients and therefore must be carefully justified, optimised and controlled in line with IR(ME)R to ensure exposures are kept as low as reasonably practicable.

In July 2025 Healthcare Inspectorate Wales undertook a planned Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) inspection of Radiology services at University Hospital Llandough. The inspection identified overall good compliance with regulatory requirements, underpinned by established procedures, effective governance arrangements, and a consistently positive patient experience. The inspection highlighted strengths in risk management, infection control, safeguarding and audit processes, but also identified key areas for improvement to enhance safety and consistency, including

updating employer's procedures (notably for mini C-arm use, entitlement and patient identification), strengthening governance and documentation of diagnostic reference levels (DRLs), improving communication of benefits and risks to patients (particularly in mammography), clarifying processes for AI-supported clinical evaluation, and streamlining referral pathways. The associated improvement plan outlines a comprehensive and time-bound programme of work, including revision and formal ratification of procedures, development of clearer QA and DRL processes, improved patient information pathways, enhanced staff training and entitlement assurance, digitisation of referral systems, and actions to improve equality, communication and staff engagement, providing assurance of a structured approach to achieving full compliance and continuous quality improvement. You can read the full inspection report and improvement plan here.

Short Stay Surgical Unit – University Hospital of Wales

The unannounced HIW inspection of the Short Stay Surgical Unit at UHW undertaken in January 2026 found that patient experience was generally positive, with staff described as compassionate, respectful and supportive; however, this was offset by concerns regarding delays and cancellations of surgery, reduced weekend service provision, and a dated, congested environment with limited privacy and facilities. While areas such as sepsis management, equipment maintenance and overall care processes were effective, risks were identified in medicines management, environmental cleanliness particularly at weekends, infection control consistency, documentation and secure handling of patient information, several of which required immediate action. Governance arrangements were in place but not fully embedded, with notable workforce pressures, gaps in weekend staffing, and staff survey concerns regarding leadership culture, communication and morale.

An immediate improvement plan was implemented focusing on immediate patient safety issues, notably medication security, IPC and records management, alongside a comprehensive longer term improvement plan addressing capacity and patient flow, workforce and weekend provision, leadership and culture, training, and the care environment; delivery is being overseen through strengthened governance, audit, and executive level monitoring to ensure actions are implemented, sustained and embedded across the service. You can read the full report and improvement plan here.

Ward B1 Gynaecology – University Hospital of Wales

An unannounced HIW inspection of Ward B2 undertaken in February 2026 found that overall care was compassionate and delivered in a clean well-kept environment. The inspection team noted the stable workforce and clear governance arrangements, with effective escalation of deteriorating patients and appropriate use of translation services. However, some patients told the inspection team about delays in accessing pain relief, and limited availability of patient information and health promotion materials. While systems for safety, incident reporting and audit were established, improvements were required in documentation, reassessment of patient risks, including pressure damage and falls and the visibility of audit outcomes and aspects of IPC practice and training compliance.

An improvement plan has been implemented which included strengthening oversight through regular safety briefings, weekly review of patient feedback, enhanced audit and monitoring processes through the Tendable platform, and escalation through governance forums such as clinical risk meetings. Progress is being overseen by ward and senior nursing leadership, with routine monitoring, monthly audits and reporting mechanisms in place to ensure delivery and sustainability of improvements. You can read the full report and improvement plan here.

Minor Injuries Unit – Barry Hospital

Healthcare Inspectorate Wales undertook an unannounced inspection of the Minor Injury Unit at Barry Hospital in March 2026 and found that the service provides a positive patient experience, with timely access to care, high levels of patient satisfaction, and care delivered in a respectful, person centred manner supported by effective triage and communication processes. While arrangements for safe and effective care were largely in place, there were some areas of risk for improvement identified. These included a lack of awareness amongst some staff as to how to escalate operational and security issues , and environmental issues affecting infection prevention and control, and inconsistencies in medicines management and patient record keeping. Governance and leadership structures were established and supported by a positive team culture, but reduced operational management capacity, unclear accountability arrangements and workforce challenges limited effective oversight and service resilience.

The Health Board has developed an improvement plan to address these findings, focusing on strengthening operational governance, leadership capacity and escalation processes; improving site security and environmental safety; and ensuring more consistent documentation, medicines management and record keeping practices. Immediate patient safety concerns identified during the inspection were mitigated at the time through agreed actions, with the remaining actions subject to formal improvement planning, clear timescales and ongoing monitoring to ensure delivery and sustained compliance.

HIW also undertook an unannounced inspection in Mental Health Services for Older People in the University Hospital Llandough. At the point of publication of the Annual Quality report, this inspection report remains unpublished

The Health Board actively seeks opportunities to share and embed learning from Healthcare Inspectorate Wales (HIW) inspections beyond the specific areas in which they were undertaken, ensuring that improvements are applied consistently across the whole Health Board. In response to recommendations arising from several HIW inspections, we completed a Health Board–wide audit of medication storage. This enabled us to determine whether the issues identified were isolated or reflective of wider practice, and has led to a renewed emphasis on required standards, with a re-audit planned for later in 2026 to ensure sustained compliance. In addition, recognising that HIW frequently highlights the absence of public health literature in clinical areas, we are working in partnership with Public Health teams to agree a core set of resources that should be displayed, alongside any specialist materials relevant

to individual services. Finally, a further programme of work is underway to assess wards and clinical areas against accessibility standards, supporting a more inclusive environment for patients and visitors.

Stroke Care

Between April 2025 and March 2026, the Health Board has undertaken a significant programme of work to strengthen stroke services, with a particular focus on improving timely access to specialist assessment and life-saving treatment. A key milestone has been the establishment of the South Wales Thrombectomy Service at the University Hospital of Wales in July 2025, providing a regional mechanical thrombectomy service operating initially on a 9am to 5pm weekday model. This has been delivered through close collaboration between stroke, radiology, emergency medicine and critical care teams, and has enabled increasing numbers of patients across South Wales to be assessed and treated within a defined specialist pathway.

Early performance demonstrates steady referral volumes and growing procedural activity, alongside the development of robust governance arrangements and regional clinical engagement.

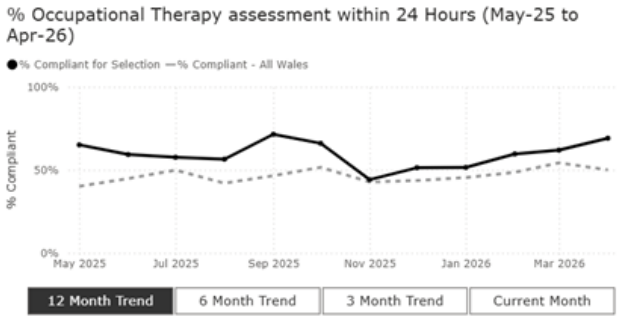
There has also been sustained work to improve the front door response to stroke, recognising the importance of rapid identification and treatment. This has included strengthening the emergency stroke assessment model through dedicated resident doctor and clinical nurse specialist rotas, increased consultant presence during core hours, and close partnership working with the Welsh Ambulance Service Trust to enhance pre-hospital assessment, including the introduction and expansion of video triage and pathway redesign. These changes are supported by ongoing quality improvement work with emergency department and radiology teams to reduce delays to imaging and treatment, and to improve recognition and escalation of suspected stroke.

Alongside improvements in urgent and hyperacute care, there has been a continued emphasis on delivering high quality care across the entire stroke pathway, recognising that optimal outcomes for individuals affected by stroke extend beyond the critical time dependent elements of care. This includes a focus on timely rehabilitation, early supported discharge, and coordinated multidisciplinary management to support recovery and longer term outcomes. There has also been a strong focus on improving pathway reliability and learning, including the introduction of systematic case review and Patient Safety Learning Reviews to identify missed opportunities for reperfusion therapies and drive improvement. This has been accompanied by enhanced audit, governance and multidisciplinary learning processes, with regular review of pathway performance and engagement across the regional stroke network.

Investment into stroke services has allowed recruitment into additional clinical positions to support specialist suspected stroke assessment with an aim to accelerate stroke pathways, including identification of patients suitable for either thrombolysis or thrombectomy. Performance against

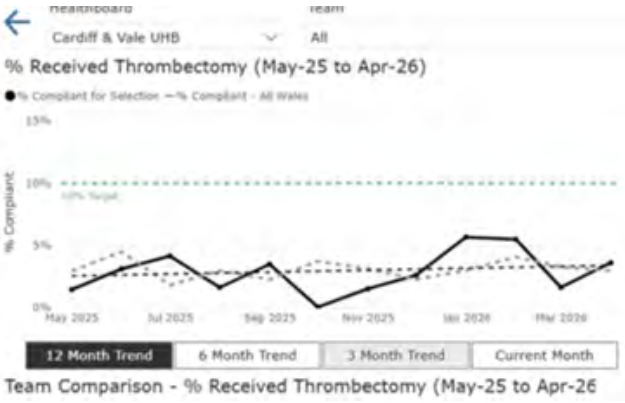
national audit standards, including Sentinel Stroke National Audit Programme (SSNAP), highlights ongoing challenges in achieving optimal treatment times and pathway flow. In October – December 2025 the Health Board received an SSNAP rating of D, with hyperacute assessment rated as E. While thrombolysis rates have improved and reached national targets in recent reporting periods, delays to treatment and variation in pathway performance remain areas of focus. The Health Board continues to use SSNAP data to identify priorities for improvement, with a clear emphasis on reducing time to imaging and treatment, increasing access to thrombectomy, and delivering a more consistent, high quality stroke service for patients.

Looking ahead, the Health Board will utilise the Welsh Government Quality Statement for Stroke (2026) to inform the development of its Stroke Delivery Plan for 2026/27. This will provide a structured framework to further strengthen services across the whole pathway, ensuring a sustainable, high quality, and equitable stroke service that meets the needs of the population.

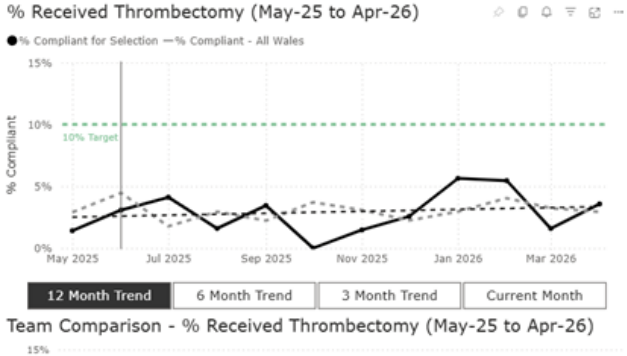


Team Comparison - % Occupational Therapy assessment within 24 Hours (May-25 to Apr-26)

Team Comparison - % Physiotherapy assessment within 24 Hours (May-25 to Apr-26)



Team Comparison - % Received Thrombectomy (May-25 to Apr-26



Team Comparison - % Received Thrombectomy (May-25 to Apr-26)

CYP2C19 Genetic Testing in Stroke Care

A service improvement project has been introduced at the University Hospital of Wales in Cardiff to explore how genetic testing can support better treatment for patients who have had a stroke or transient ischaemic attack (TIA). This work follows guidance from the National Institute for Health and Care Excellence (NICE), which recommends that patients starting the antiplatelet medication clopidogrel should be offered CYP2C19 genetic testing. This test helps identify how well a patient is likely to respond to the medication.

Clopidogrel is widely used to reduce the risk of further strokes by preventing blood clots. However, not all patients respond to

this medicine in the same way. Differences in a person's genes can affect how the body processes clopidogrel, meaning it may be less effective for some individuals. By using genetic testing, clinicians can better understand these differences and select the most appropriate treatment.

The project began in May and is a collaborative effort between the National Pharmacogenomics Group for Wales, the Stroke Team at the University Hospital of Wales, the All-Wales Medical Genomics Service, and the NHS Wales Stroke Implementation Network. This partnership is helping to embed genetic testing into routine stroke care. The evaluation is focusing on how quickly test results can be returned, how well different teams work together to deliver the service, and whether the results support improved prescribing decisions. The overall aim is to ensure that each patient receives the treatment most likely to be effective for them.
Early results indicates that genetic testing has the potential to improve treatment choice and support more personalised care, with the aim of reducing the risk of further strokes. The project is also supporting staff to develop their knowledge and confidence in using genomics in clinical practice, while strengthening collaboration across services. This work contributes to wider plans to expand the use of genomics within NHS Wales.

Using NICE guidelines to ensure effective care - Headroom Early Intervention in Psychosis Service

Why is this important?

Psychosis is a treatable mental health condition where people may experience changes in how they perceive or interpret the world around them. This might include hearing voices that others don't hear, having unusual beliefs, or finding it difficult to organise thoughts and speech. Psychosis affects around 1 in 100 people, with first episodes typically occurring in young adults aged 16-25, often during important life transitions like starting university or beginning careers.

Without proper early intervention, young people can face disrupted education, strained relationships, and reduced confidence in their abilities. However, with the right support, most people make a good recovery and go on to achieve their goals. Early intervention promotes recovery and dramatically reduces long-term impact. National Institute for Health and Care Excellence (NICE) guidelines CG178 and CG155 emphasize that specialized early intervention service are essential to improving outcomes, recommending rapid access to assessment and treatment to support recovery, minimise the duration of untreated psychosis, reduce hospital admissions, and enable individuals to maintain meaningful participation in education, employment and family life.

What are we doing?

The Headroom service delivers comprehensive early intervention in psychosis care across Cardiff and the Vale for young people aged 14-25. The service provides the full range of NICE-recommended interventions including cognitive behavioural therapy for psychosis (CBTp), family intervention, careful antipsychotic medication management, and physical health monitoring. We ensure that young people experiencing first-episode

psychosis receive rapid assessment and evidence-based treatment that addresses their clinical, social, educational, and vocational needs.

Working in partnership with our third sector partner Adferiad, the team provides holistic support that extends beyond clinical care to include community connections, social navigation, and peer support. Young people and families can access additional information and resources through Psychosis Wales (psychosis.wales), the national gateway for psychosis services in Wales.

The Health Board uses NICE guidelines to ensure our early intervention service delivers consistent, high-quality care that transforms lives and enables young people to achieve their goals.

Lloyd's Story (name has been changed but consent has been obtained to share story)

Lloyd was a 22-year-old university student when he experienced his first episode of psychosis, developing unusual beliefs that felt very real to him and required hospital admission for his safety. Following stabilisation, Lloyd received three years of comprehensive NICE-compliant care through the Headroom team. The team delivered specialised CBT for psychosis, family intervention involving his parents and sister, and carefully managed medication reduction. About 20% of people can successfully discontinue medication, and Lloyd achieved this after 15 months with full family support and structured relapse prevention planning. We provided ongoing physical health monitoring and comprehensive recovery support.

Lloyd's recovery was remarkable. He completed his undergraduate degree with 2:1 honours, achieved an MSc in International Relations, returned to club rugby, and remained well for two full years before successful discharge to his GP. Lloyd's journey from crisis to full recovery demonstrates how following NICE guidelines for early intervention transforms outcomes for young people with psychosis, enabling them to achieve their academic, social, and career goals.

BadgerNet rollout in Maternity and Badger Notes (digital patient-held notes)

Why is this important?

Last summer the Health Board launched the BadgerNet Maternity System along with the Badger Notes app and online portal. All women and maternity services were moved to the new digital system on the same day. This approach helped ensure that everyone had the same access to information from day one. The new system improves how easily information can be accessed, increases data quality, and allows both women and clinical teams to view maternity records in real time. All information is stored securely and can only be accessed with the correct login.

The full switch to the new system was supported by onsite teams who were available during the first four weeks. Their support made it easier for staff to learn how to use the new system and to quickly resolve any issues. Staff found this help extremely valuable.

There were some problems when transferring information from the old system, but these were identified and fixed quickly. As with any major change, a few challenges came up, and we dealt with them as they happened.

What are we doing?

The new system has already brought important benefits, such as being able to produce reports and information more quickly. Tasks that used to require a lot of manual work are now automatic. Senior teams have called this a "tangible improvement" in how easily and quickly they can access important information.

Feedback after the launch highlighted two key areas we are continuing to focus on. First, data quality remains important, as the system relies on consistent and accurate information being entered by staff. There are still some differences in how teams record data, but ongoing monitoring, support, and training are helping to improve this. Second, there were early issues with publishing clinical notes. Some staff saved notes without publishing them, which meant women could not see them in Badger Notes. Staff understanding of this has improved, and regular reminders will help keep this consistent.

The Digital and Quality Improvement Lead Midwife has been made permanent to support ongoing improvements to the system. There is a recognised need for this and potential other roles as the system continues to develop. Planned future changes include linking BadgerNet with Viewpoint (the radiology imaging system) and the new Laboratory Information System, depending on national and system-level compatibility.

The Health Board is also contributing to national audit programmes. This includes the Maternity Experience Programme, which sends text message surveys at 20 weeks, 36 weeks, shortly after birth, and during postnatal care. The National Maternity Data Dashboard is expected to go live in August 2026, with data submissions beginning in July 2026.

Theatres together

A review of Theatre Services was undertaken in response to staff feedback and was published in 2025. The report identified a number of areas where improvement was required within Main Theatres Upper. These included challenges relating to culture, leadership clarity, accountability and communication, which were impacting staff experience, workforce stability, theatre efficiency and aspects of patient safety. While many examples of committed staff and good practice were noted, the review highlighted opportunities to strengthen psychological safety, ensure more consistent management of behaviours and performance, improve equity in workforce practices, and address operational issues such as late starts and overruns. Variability in the reliability of safety processes, including use of the WHO checklist, was also identified. The review concluded that sustained improvement would be supported through clearer leadership arrangements, strengthened governance, continued investment in workforce development and education, and a trauma informed approach to rebuilding trust, safety and consistency across the theatres service.

The Theatres Together Programme was developed to deliver the improvements required in order to address the recommendations in the report.

The Theatres Together improvement programme has made substantial and measurable progress during 2025–26, delivering early improvements while establishing the foundations for sustained cultural, safety and operational change. The programme comprises 66 risk rated recommendations structured across five tranches and governed through a robust programme structure with executive oversight and regular assurance processes.

Patient Safety and Quality of Care

Real progress has been made to strengthen perioperative safety systems and assurance. A multidisciplinary WHO Surgical Safety Checklist Collaborative was established in May 2025, resulting in standardised principles, clearer expectations and improved audit processes. Continuous learning cycles are in place to strengthen reliability at "sign out" and further embed safe team behaviours.

Standard operating procedures have been introduced for the setup of anaesthetic rooms , deep clean schedules and paediatric care pathways, reducing variation and improving consistency across theatre suites. Enhanced audit infrastructure, including wider use of Tendable, is providing improved oversight of infection prevention, safety checks and clinical standards

Culture, Leadership and Workforce Experience

Cultural improvement is being addressed through the Embedding Culture Tranche, which runs throughout the programme. Progress includes improved senior leadership visibility, protected audit and education sessions, strengthened speaking up arrangements and consistent management approaches to sickness and wellbeing. Targeted leadership development is underway, with training aligned to compassionate and collective leadership models.

Staff engagement has been actively captured through surveys, daily pulse feedback and co production activity. Feedback consistently highlights strong teamwork, compassion and commitment to patient centred care, alongside ongoing pressures related to staffing and workload. This intelligence is being used to shape programme priorities and adjustments.

Theatre Efficiency and Operational Performance

A number of actions have focused on improving theatre efficiency and reliability, including reviews of rostering practices, strengthened theatre scheduling, greater clinical leader involvement in list planning and focused task and finish groups addressing late starts, overruns and utilisation. Early findings have informed system changes and are now being supported by the introduction of the AQUA theatre management system in January 2026

Data, Oversight and Sustainability

A new Theatres Together dashboard has been developed to support Board assurance, tracking programme delivery alongside workforce, quality, safety and efficiency metrics. Early trends indicate improving sickness, turnover and compliance with mandatory training, although further refinement is underway to isolate programme specific impact. Risks and issues are actively managed through formal governance, with several risks already reducing in severity following mitigation actions.

The Theatres Together programme continues with oversight from the Board.

Timely Care

Our healthcare system ensures people have access to the high-quality advice, guidance and care they need quickly and easily, in the right place, first time. We care for those with the greatest health need first, and where treatment is identified as necessary, we treat people based on their identified and agreed clinical priority. The Legacy of Covid-19 has profoundly impacted our ability to deliver care in a timely manner. We have had to reevaluate the way we provide have delivered a number of services and the flow of patients through our care. We have made some very significant improvements in several clinical pathways including stroke, emergency and unscheduled care and hip fracture, but we recognise that our population continue to wait too long for planned and diagnostic procedures

Urgent and Emergency Care

The Health Board has delivered a number of improvements in urgent and emergency care pathways during 2025-2026 despite a continued increase of almost 4% in demand. Primary and community care teams continue to be the foundation of our urgent and emergency care system. During 2025-2026 the Health Board provided over 206,000 district nursing visits providing care to individuals in their own homes or place or residence. Offering communities alternatives to attending hospital has been a focus through the year and this includes a significant increase in the number of patients who have been through the CAV 24/7 Single Point of Access. During February and March 2026, an average of 53% of these calls were managed without the requirement for onward referral.

Working with partners across Health and Social Care is of the highest organisational importance. Partnership working is embedded throughout the Health Board and includes daily operational meetings with Local Authority and Integrated Discharge Services. At the end of the year there were 156 patients who had delayed transfers out of hospital and total number of bed days that these patients were delayed in hospital had decreased by almost 30% when compared to the beginning of 2025.

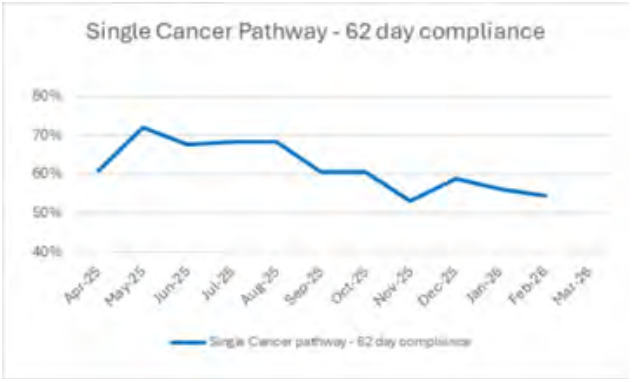
The implementation of the national "W-45" initiative, supporting handover of care from paramedics to emergency department staff within 45 minutes, gave the Health Board further opportunity to reduce ambulance handover delays. Through the delivery of this programme the Health Board saw a significant reduction in the number of ambulance handovers Exceeding one hour. This was achieved through a reorganisation of process and space within the emergency department along with increased clinical and operational oversight. The Health Board is proud to have the lowest number of 1-hour ambulance handovers in Wales and the lowest number of 12-hour emergency department waits. Whilst this performance has been celebrated, there remain too many people facing long waits in emergency pathways and our plans for 2026-2027 focus on reducing these further. Flow across the hospital and an increased Length of Stay have been identified as an essential area for improvement. CAVUHB

is currently not performing as one of the top organisations in the UK and this increases pressures across our teams and the wider Health and Social Care system. Improvements in this area will also provide scope for improvements in quality, outcomes and financial performance. To achieve these in 2026-2027 the Urgent and Emergency Care Programme will reorientate to three core workstreams covering Integrated Community Care, Optimising Acute Care and Frailty, and Improving Hospital Efficiency.

Cancer

Cancer delivery during the year has been variable, largely due to exceptional demand in key specialties, including dermatology, urology and lower gastrointestinal services. However, there has been a significant reduction of over 50% in the number of patients waiting longer than 62 and 104 days since the start of February. This improvement reflects the positive impact of actions taken to increase capacity and strengthen pathway compliance. The Health Board's focus for 2026–2027 is to sustain this progress by continuing to improve performance, fully implement national optimal cancer pathways, and achieve consistent delivery above the 70% target for the Single Cancer Pathway.

Image 20 – cancer patients' treatment within 62 days



Planned Care and Diagnostics

The Health Board has maintained a strong focus on reducing waiting times across planned care. Waiting list times are now at their lowest level since 2021. While this represents meaningful progress, patients are still waiting longer than we would expect, and continued effort is required to ensure timely assessment, diagnosis and treatment for the population of Cardiff and Vale.

Delivery during 2025–2026 was supported by additional activity across both local and national programmes. This included the use of insourcing and outsourcing arrangements, enabled through non-recurrent funding. These measures have contributed to improvements in access and reductions in long waits.

At the end of March 2026, there were 131,710 patients on the Referral to Treatment (RTT) waiting list, representing a reduction of approximately 19,500 compared to March 2025. However, the number of children waiting increased from 11,108 to 11,681 over the same period. Significant progress has been made in addressing the longest waits. The number of patients waiting over two years for treatment reduced to 338 by year-end, substantially lower than both the original annual plan forecast of 4,800 and the 1,632 patients waiting over two years in March 2025. The number of patients waiting over three years was reduced to zero. These achievements are important, reflecting a positive impact on patients and providing a stronger foundation for future service delivery.

Looking ahead to 2026–2027, CAVUHB will continue to focus on improving productivity and efficiency across planned care. Priorities include optimising outpatient services, theatres and diagnostic capacity. While these improvements alone will not

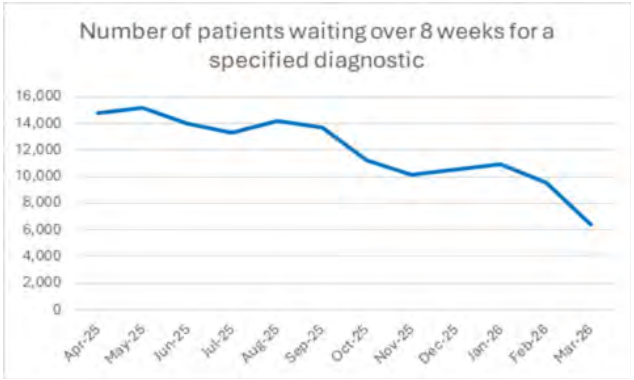
fully address ongoing demand and capacity gaps, work is progressing to develop sustainable, long-term solutions. This includes better use of digital technology, implementation of best practice pathways, and reducing unwarranted variation in care delivery.

Image 21– number of patients waiting longer than 52 weeks for a new outpatient appointment

Image 22 – number of patients with a total wait longer than two years

Waiting times for diagnostic tests have remained a sustained challenge, particularly in endoscopy and non-obstetric ultrasound services, reflecting ongoing demand and capacity pressures. In line with the original annual plan, it was anticipated that over 10,000 patients would be waiting longer than the 8-week target for diagnostic testing. Through a combination of increased activity and a strengthened focus on efficiency and productivity, the Health Board has delivered a significant improvement in performance over the year. By the end of March 2026, the number of patients waiting over 8 weeks had reduced to 6,432. This represents a reduction of more than 8,000 patients compared to the start of the year. While this progress is

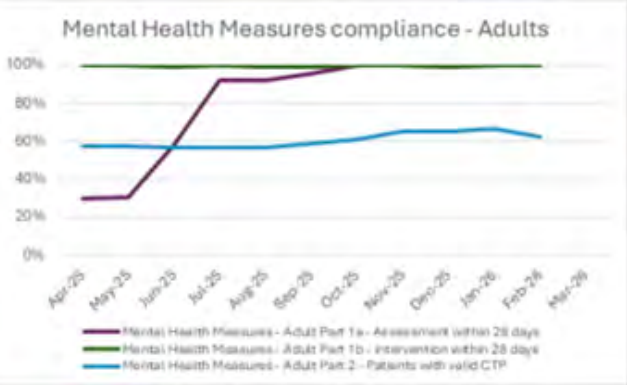
Image 21– number of patients waiting longer than 52 weeks for a new outpatient appointment



significant and demonstrates the impact of targeted recovery actions, further work is required to meet national expectations and ensure timely access to diagnostic services.

Mental Health

Demand for Mental Health services has continued to rise, with a record number of referrals received in October 2025. Despite this sustained increase in demand, performance against key Welsh Government access standards has remained strong across both adult and children's services. The Health Board has consistently achieved the 28-day assessment standard and the 28-day therapeutic intervention standard for all age groups, demonstrating resilience in maintaining timely access to care.



Progress has also been made in improving compliance with Care and Treatment Plans for adult patients. While the national standard has not yet been fully met, performance has improved over the course of the year, with a clear trajectory of improvement and a delivery plan in place to achieve compliance during 2026–2027.

Discharge Advice Letters (eDALs)

Discharge advice letters are generated following every hospital admission and provide essential information to general practitioners (GPs), including diagnosis, treatment, ongoing management plans, and medication. This communication is critical, as it enables GPs to continue prescribing and managing care in line with the treatment plans established by the specialist team.

Following several patient safety incidents, it was identified that a significant proportion of discharge advice letters were either incomplete or not shared with GPs. In addition, accessing compliance data was challenging, which limited the ability to monitor and improve performance.

The introduction of the ePMA system has enabled a more robust and systematic approach to the completion of discharge advice letters. Information is now generated through ePMA, supporting improved accuracy and facilitating ongoing monitoring of compliance. Clinical specialties receive monthly compliance reports, accompanied by lists of outstanding letters to support timely completion.

As a result, compliance has significantly improved, and the majority of discharge advice letters for patients discharged from clinical areas using ePMA now sent within the required timeframe. This has strengthened the safety of the discharge process and supports continuity of care within primary care settings.

Patient Centred Care

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

You can read the Health Board Patient Experience Annual Report here.

People's experience Survey

Over the past year, Cardiff and Vale University Health Board has continued to listens to, learns from and acts upon the experience of people who use our services, in line with the NHS Wales People's Experience Framework. A significant development was the introduction of the new People's Experience Survey (PES) in May 2025, which became the Health Board's main routine patient feedback tool. The survey was introduced across SMS, bedside and digital feedback methods, enabling the Health Board to collect more timely and meaningful feedback from patients and carers. The PES focuses on key aspects of person-centred care including dignity, communication, safety, involvement in decision-making and overall experience, and has been made available in the top 10 local languages, including BSL, to improve accessibility and inclusion. Since its introduction, over 29,000 survey responses have been received, with an overall patient satisfaction score of 84%, providing valuable insight to support quality improvement across services.

Alongside the new patient experience measures, the Health Board has worked collaboratively across services to ensure that feedback directly informs change and improvement. Initiatives over the year have included expanding bedside surveys into the Children's Hospital for Wales, developing digital storytelling to capture lived experiences, strengthening accessible communication support through interpreter technology and BSL services, and increasing volunteering, bereavement and unpaid carer support programmes. The Health Board has also embedded a strong "you said, we did" approach, using patient feedback to introduce practical changes such as ward welcomers, dementia companions, enhanced patient befriending, and improved information and support services. Collectively, these developments demonstrate the organisation's continued commitment to compassionate, person-centred care and to ensuring the voices of patients, families and carers remain central to service planning and improvement.

Supportive care at end of life

Why is this important?

The Supportive Care team have begun the rollout of the Wristband Initiative, a transformative piece of work helping patients at the end-of-life achieve a good death. There are 3,900 deaths annually within Cardiff and the Vale of Glamorgan. This figure is expected to increase to 5,000 in the next 10 years.

Dying patients spend 4-6 weeks in hospital in their last year of life. 89% of people with an end-of-life condition will use unscheduled care via the Welsh Ambulance Service, and 38% of these will go on to be admitted to hospital. There are 258 attendances to the Emergency Unit per 1000 people in their last year of life. Patients that understand they have an end-of-life condition generally prefer to be at home when they pass away. Despite 80% of people preferring to pass away in the comfort of their own home, approximately 46% will die in hospital.

About the Wristband Initiative

The Wristband Initiative involves suitable patients wearing a wristband with a QR code as a means of sharing important medical information to different healthcare professionals to access when they need it. The wristband is worn like a watch, with the QR code taking people to a personalised webpage with the patient information uploaded and kept updated by their healthcare team. This information is kept private, and only able to be accessed by also using the PIN code, also found on the wristband. Information is only shared with the patient's permission. The type of information likely to be uploaded might include; Important current and past medical illnesses and details of treatments they are receiving, medications, including any allergies, emergency contacts for both loved ones and the patient's healthcare team, information about what to do if the condition progresses, information on the patient's wishes and preferences - for example, some patients do not want to be readmitted to hospital unless there is a clear reason why some patients wish to include a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form.

Whenever healthcare information about the patient is needed, especially in an emergency, GPs, nurses or paramedics can scan the QR code on the wristband and link to the patient's individual website. Hospital care is often the default for deteriorating patients, and the information provided instantly with the wristband can help healthcare colleagues respect their wishes and provide the most appropriate care. Preliminary feedback so far has been outstanding. Patients have noted that they feel more confident to make the most of their remaining time knowing they will be well cared for with their wishes respected. "I've got on a bus because I know they'll have my information if I became poorly," said one patient. Another patient had commented that the paramedics they had met had felt it was very helpful.

Respecting the patient's wishes is critical to this project's success. In its first ten patients, it has already led to reduced hospital admissions, better contact with a patient's care delivery team, and ensured another patient was in their preferred place when their condition deteriorated and needed end-of-life care.

LLAIS
Eich llais mewn iechyd a gofal cymdeithasol | Your voice in health and social care

Llais is the independent statutory body established to represent the views and experiences of people using health and social care services across Wales. Through engagement, visits and feedback, Llais provides independent assurance and insight to support organisations in improving the quality, safety and experience of care, ensuring that learning is informed by the lived experience of patients, families and carers.

Learning from Llais continues to play an important role in supporting quality improvement across Cardiff and Vale University Health Board. During 2025/26, Llais undertook 19 standalone visits across a range of services including acute hospital wards, primary care, mental health services and specialist clinics. Services visited included Lansdowne Ward at St David's Hospital, Owl Ward at Noah's Ark Children's Hospital for Wales, Pendine Community Mental Health Team, Sexual Health Clinics at Cardiff Royal Infirmary and Barry Community Hospital, Ward West 2 at University Hospital Llandough, Ward C6 at the University Hospital of Wales, and Ward 2 within the Lakeside Wing. Feedback from these visits consistently highlighted examples of compassionate and person-centred care, while also identifying opportunities to improve access, the care environment and communication with patients and families.

In response to this feedback, the Health Board has undertaken a range of improvement actions including strengthening signage and accessibility across sites, enhancing cleaning and facilities standards, and improving communication and accessibility support for patients and families. Learning from Llais visits has also informed wider service redesign and the sharing of good practice across the organisation. Embedding real-time patient insight into governance and improvement processes supports the Health Board in meeting its Duty of Quality responsibilities and reinforces a culture of listening, learning and compassionate care. The feedback provided by Llais continues to help drive measurable improvements in patient experience, access and the quality of care provided across services.

Helping patients with swallowing difficulties

Why is this important?

The Adult Speech and Language Therapy Service has introduced a new treatment called Phagenyx to help patients with severe swallowing difficulties. These difficulties, known as dysphagia, are common in people who have been critically ill, had a stroke, or are undergoing neurological rehabilitation. Dysphagia can prevent people from eating or drinking safely for long periods, which can be distressing and may lead to medical complications or the need for long term tube feeding.

What difference did this make?

One of the most striking examples is Glodi, who developed severe swallowing problems after a stroke. He was unable to eat, drink, or swallow his saliva safely and

had been unable to take anything by mouth for 79 days. After completing the Phagenyx treatment, he made rapid progress—he was able to safely eat and drink again within 12 days and soon returned to a normal diet. This level of recovery is uncommon in typical stroke or rehabilitation pathways. Staff caring for him described the improvement as exceptional.

Other patients in the trial—including those with very complex conditions—also moved from being unable to take anything by mouth to being able to eat and drink again. Many reported feeling that their quality of life, dignity, independence and overall wellbeing had significantly improved.

What next?

Following these successful results, Cardiff and Vale University Health Board has approved the use of Phagenyx for suitable inpatients and has funded two systems for use at both UHW and UHL. This marks an important step forward in offering fair, evidence based rehabilitation for people with swallowing difficulties across our hospitals.

Glodi's story

Healthcare Support Worker role in end of life care

Last year, we shared news about an important new role within the palliative care team. The role was funded in partnership with Macmillan and the Supportive Palliative and End of Life Strategy, and we are pleased to update you that the postholder has now been in position for three months.

The Healthcare Support Worker role has been introduced to provide additional support to patients at the end of life, as well as to their families, on our inpatient wards. The aim is to strengthen communication between the clinical team and patients/families, and to offer practical and emotional support that can make a meaningful difference during this time. This may include offering a listening ear, providing comfort through a reassuring presence or a hand to hold, or helping a patient with a drink. These seemingly small acts often have the greatest impact on a patient's wellbeing and comfort at the end of life.

Although the role has only been in place for a short time, it has already had a significant impact, and the team has received extremely positive feedback from both patients and families.

Eye Retrieval Service – Giving the gift of sight

Why is this important?

Thousands of people across the UK are waiting for a corneal transplant, often for several years. Sight loss can affect independence, work, and quality of life. Eye donation can, restore or improve sight, helping people to live independently.

In October 2025, we launched the first Eye Retrieval Service in Wales at Cardiff and Vale University Health Board, marking a major step forward in corneal donation. The service is funded by NHS Blood and Transplant and was launched on World Sight Day. The service is led by two highly experienced nurses, who support corneal donation after death with care, compassion, and dignity. They work closely with

ward staff, mortuary teams and national specialist nurses to identify potential donors, check suitability, and sensitively support families at a difficult time.

Early identification is vital, as eye donation must take place within 24 hours of death. Improved staff awareness across hospital wards has supported timely referrals. Since the service began:

- 208 people were identified as clinically suitable donors
- 41 families agreed to donation
- 21 people donated their corneas, helping others regain sight.

Occupational Therapy front door service improvement (Emergency Unit, UHW)

Why is this important?

The front door of the hospital is a critical point in the patient journey. When people are seen early by the right professionals, they are more likely to return home safely and avoid unnecessary hospital stays.

Ensuring quick access to Occupational Therapists improves patient flow, reduces pressure on wards and supports people to stay independent.

What are we doing?

The Occupational Therapy service has increased therapist availability in the Emergency Unit, allowing earlier assessment and support. This helps avoid admissions where safe, promotes "home first" options and ensures patients are seen in the most appropriate setting—often closer to home. This improvement strengthens the whole system by supporting timely, effective care at the earliest stage

Patient experience of people living with cancer

Over the last year, the Health Board has been involved in a project to better understand the views of people with cancer and those who support them. This project has been funded by Macmillan Cancer Support and delivered by our Macmillan Project Manager, who has worked with hundreds of individuals and groups right across Cardiff and the Vale to make sure that everyone's views are included. The project asked about the non-clinical support given to people experiencing cancer, for example, help with completing benefits claims or support with travel to appointments. Important issues raised by those who spoke to us included:

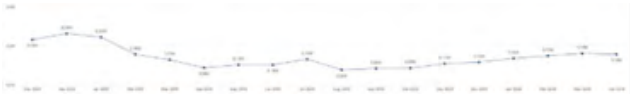
- Access to information in a suitable format
- Worries about the financial impact of cancer and treatment
- Practical concerns, such as travel to appointments and other caring responsibilities
- Ongoing support after cancer treatment is finished

We are now using this important feedback to help us design a new service to support people in Cardiff and the Vale of Glamorgan who are experiencing cancer.

Efficient

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

Agency Nurse Spend



Nurse led workforce improvement using data (information)

Why this work was needed

Previously information about nurse staffing, was held in individual records in each ward or department. This meant that there was no efficient way of recognising risks relating to staffing constraints or understanding where wards or clinics might have nursing staff additional to their requirements. The Health Board implemented a system called SafeCare to provide a real time Health Board wide view of the nurse staffing position in every clinical team. It allowed immediate recognition of how many nurses were required in each clinical area on each shift, taking into account the acuity of the patients in that area at that time and provides alerts when the actual staffing falls below this level.

A new nurse led approach was introduced. A digital analyst was placed directly within the Corporate Nursing Team and worked closely with nurses. Together, they created simple, easy to use screens that showed live staffing information in one place. This work later developed into a Nursing Workforce Hub. The Hub brought together staffing information from different systems so nurses and leaders could clearly see where support was needed. Nurses were involved throughout, giving feedback to make sure the information was useful and easy to understand.

The work made a significant difference to daily nursing practice. The use of nursing staffing data increased by more than 50%, the nursing agency spend reduced by over 70% which equated to monthly savings of around £700 000 in temporary staffing. There has been a reduction in safety concerns around staffing and some wards saw improved patient safety, including fewer patient falls. Nurses across the health Board. Reported feeling more confident and supported when making staffing decisions.

Staffing information is now used regularly by ward staff and senior leaders and the Workforce Hub is now part of everyday nursing work and supports safer, more sustainable staffing across the Health Board.

The Workforce Hub will continue to grow and be used for future staffing planning. New developments will support ward accreditation, workforce forecasting, and links with the Welsh Nursing Care Record. This nurse led approach is now being shared across NHS Wales.

Tertiary Services

The NHS Wales Joint Commissioning Committee (JCC) is a national NHS Wales body responsible for planning, commissioning and overseeing certain healthcare services that are best organised on an all Wales or regional basis rather than by individual Health Boards alone.

The JCC commission the Health Board to deliver a number of specialist services on a regional or all-Wales basis, these services include neurosurgery, renal and transplant, paediatric surgery, neonatal services, cardiac services. The JCC work with the Health Board to ensure the delivery of safe and effective services and to reduce risk.

JACIE accreditation is a recognised quality standard for stem cell transplantation and cellular therapy services. It demonstrates that a service meets internationally agreed standards for patient care, clinical practice, laboratory procedures and quality management, helping to ensure safe, high-quality and consistently effective care for patients undergoing stem cell transplantation and related treatments.

Ageing environmental infrastructure meant that Haematology outpatients fell below the standard required for accreditation. Work commenced in early 2026 to extend the Haematology outpatients and to deliver the improvements required to meet national standards. While the work remains ongoing, JCC will continue to oversee the risk this poses and has placed the services in an escalated level of monitoring.

The Health Board is commissioned to provide specialist auditory implant device services. Due to increased waiting times, JCC has placed the services in an escalated level of monitoring in October 2025 and continues to work with the health Board to reduce the risk of delays in assessment and treatment.

JCC Statement

The NHS Wales Joint Commissioning Committee (JCC) commissions services on behalf of the Seven Health Boards in Wales. Many of these are specialist services delivered through Cardiff and the Vale as a regional centre for the population of South Wales. We work closely with the operational teams and the Quality team to ensure these are delivered to the highest standards and in alignment with the Health Care standards.

Over the last year Cardiff and the Vale have shared several patient stories with the JCC and these have been further shared with the Joint Commissioning Committee and the Quality and Safety Outcomes committee. These have provided assurance supported discussion and demonstrated some excellent clinical practice in areas such as cystic fibrosis management and care.

The relationships and collaboration between the Health Board and the JCC have also resulted in some services needing closer support and collaboration from the JCC through an escalation process due to workforce issues capacity concerns and quality and safety standards. This has resulted positively in generation of quality improvement projects and the development of a far more robust reporting process in areas such as neonatal services.

This partnership enables Welsh residents to access the expertise and specialist services in the Health Board putting patients at the

heart of commissioned services. The Annual Quality report supports the quality of care provided and demonstrates the work being undertaken to further enhance and make improvements for patients and their families.

Services we commission

As well as providing a range of specialist services for Wales, the Health Board also commissions some services from other organisations. This allows us to provide services which meet the needs of our population.

When we commission services from another organisation, we have a responsibility under the Duty of Quality to ensure that these services are safe, timely, effective, efficient, equitable and person-centred. Meeting regularly with service providers helps us to check that the care they provide to our population is high quality. During 2026/27 we will strengthen our focus on the quality of commissioned services with the development of a quality framework, setting out how we can work with other organisations to jointly provide excellent quality services for our population.

One example of our commissioning is the substance misuse system in Cardiff and the Vale of Glamorgan. Through the Cardiff and Vale Area Planning Board (APB), the Health Board works in partnership with local authorities, South Wales Police and His Majesty's Prison and Probation Service to plan and commission a coordinated range of prevention, treatment and recovery services. These services are delivered by a mix of NHS, local authority and third-sector providers and are designed to support people affected by drug and alcohol use, including those with co-occurring mental health needs.

Commissioning through the APB enables a whole-system approach, ensuring that services are aligned, accessible and responsive to local need. We place a strong emphasis on quality, outcomes and service user experience, using shared performance frameworks and regular partnership forums to provide assurance and drive continuous improvement across the system.

Digital Appointment Letters – (Babies, Children and Young People's Plan 2035) Speech & Language Therapy

Traditional letters can be delayed or lost, increasing missed appointments and delaying care. Since November 2025, the Health Board have changed the way they are communicating with families and now send out digital appointment letters via text message. This enables quick confirmation or rescheduling and has already reduced the number of wasted appointments due to non-attendance by 4%. Staff also highlighted this as one of the most positive improvements of the year. The change has reduced printing and paper use while improving convenience for families. This change also supports the Health Board in achieving its sustainability goals

Embedding Sustainability in Wales's Sole Dental Hospital and School

Healthcare is a significant contributor to carbon emissions. NHS Dentistry accounts for approximately 3% of the NHS's total carbon footprint. To address this a Joint Sustainability Working Group mapped and planned projects in areas of waste and process inefficiencies. Students, NHS dental trainees, clinical and non-clinical staff undertook these projects. The aims of the project were to support and promote projects aimed at reducing waste and driving sustainable change, identify cost savings and reduction in carbon emissions associated with change, embed sustainability across all levels of dental education and raise awareness-build a culture of sustainable behaviour.

In one year, this project is expected to prevent 75 patient cancellations, saving 56 hours of theatre time and £43,290 in costs. The Decontamination Team (DSDU) has eliminating an unnecessary layer of paper wrapping and clinical packaging, resulting in annual cost savings of £1,670.50 and a reduction in carbon emissions of 1,761.17 kg CO2

In total 15 projects have been completed, improving service delivery, patient care, reduction of waste whilst meeting students' and trainees' educational requirements

New NHS Wales App Feature: View Your Referrals and Appointments

From January 2026, patients can use the NHS Wales App to see some of their hospital referrals and outpatient appointments. The app has been developed by the Digital Services for Patients and Public (DSPP) at Digital Health and Care Wales (DHCW). This update is part of ongoing work to make it easier for people in Wales to access their health information online.

What can the updated App do?

For certain referral pathways, adult patients will be able to see when their GP has referred them to hospital; this is for new referrals sent after 8 January 2026. Individuals can see details of their first outpatient appointment that appear once the referral has been accepted by the hospital . Patients can find contact details for the Health Board so they can ask to change or cancel an appointment and access helpful information, including waiting-time guidance and tips to look after yourself.

Unpaid carer support worker

The Unpaid Carer Support Worker, funded by the Cardiff and Vale Regional Partnership Board was appointed to support unpaid carers during the hospital discharge process, provide information and improve their overall experience, raise awareness of unpaid carers among staff and the public and to help carers access support both in hospital and in the community.

Since starting, the Support Worker has built strong links with ward managers, the hospital discharge team , adult mental health, palliative care teams, and third sector organisations such as Headways and Adferiad. They also work closely with the Unpaid Carer Teams in both local authorities.

Five wards in University Hospital Llandough (UHL) were chosen for focused support because they have a high number of carers involved. These include acute care of the elderly, stroke rehabilitation, spinal, and neurological wards.

So far, the Support Worker has had 151 interactions with carers of which 116 were first time interactions with 78 adult carers and 38 older adult carers. The support worker has also undertaken thirty five follow up interactions.

A drop in session for carers has also been implemented to enable them to receive support away from the ward. In addition, a referral process is now in place for carers or staff on wards not covered by regular visits.

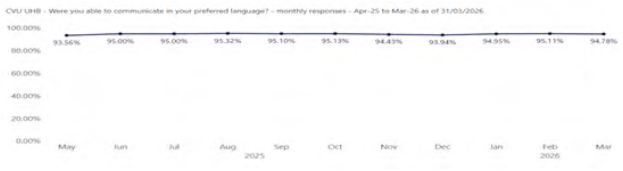
In 2026, the Support Worker will be promoting the drop in and referral routes to increase engagement and carrying out a Young Carer survey with staff to better understand challenges in identifying young carers and the reasons behind low referral rates

Equitable Care

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

Accessible Standards

Communication in preferred language



Providing patients with information in their chosen language and in formats that meet their communication needs is essential to delivering safe, effective and person-centred care. When patients are able to understand information about their health, treatment and care, they are better able to make informed decisions, provide valid consent, manage their conditions and feel fully involved in their healthcare journey. Accessible communication also helps to reduce inequalities and ensures that people are not disadvantaged because of language barriers, disability, sensory loss or communication needs.
To strengthen this approach, Cardiff and Vale University Health Board has been developing a new Accessible Information and Communication Standards Policy, aligned to the All-Wales Accessible Communication and Information Standards, which sets out clear expectations for identifying, recording and meeting patients' communication needs across all services. The Health Board has also introduced a range of supporting resources, including improved interpretation and translation services, accessible information guidance, interpreter devices and British Sign Language support. Importantly, our patient experience measures demonstrate that this work is making a positive impact, with over 94% of patients reporting that they were able to receive information in their preferred language.

Care pathway for Ketamine Related Health Problems

Why is this important?

A new pathway is being developed in the Health Board to help people get support sooner for ketamine related health problems. Ketamine use has increased, with Cardiff and Vale Alcohol Service (CAVDAS) seeing 53% more ketamine presentations since September 2024. Cardiff and Vale's Community Addictions Unit has also seen 73 people using ketamine more than once a week in the last year - a 60% rise compared to before 2024.

What are we doing?

The pathway, created by a multi-agency group is already having an impact. Ketamine can cause serious and permanent bladder and kidney damage, but staff now have tools to identify bladder problems earlier and are better prepared to support people with complex needs. A new schools programme, developed by CAVDAS and co-designed with people who have lived experience, is also giving Year 9 and 10 pupils important information about the risks of ketamine. Work on the pathway continues.

What next?

Future plans include closer links with urology specialists and dedicated support for under 18s through Children and Young Peoples' Mental Health Services (CAMHS). Area Planning Boards (APBs) - partnerships of local authorities, health boards, police, probation, housing, community safety teams, third sector organisations and people with lived experience are also introducing initiatives across Wales to address ketamine related harm. Through this joined-up approach, APBs coordinate prevention, early intervention, treatment and awareness activities to make sure people receive consistent, evidence based support.

Homelessness and Foot Care Outreach

Why is this important?

People experiencing homelessness often have serious foot problems associated with limited access to healthcare and transient living arrangements. These issues can affect mobility and impact on health. Without early care, foot problems can lead to infections, hospital admissions and even amputations. Improving access to foot care helps reduce harm and tackles significant health inequalities.

What are we doing?

The Podiatry team is working with Cardiff and Vale Health Inclusion Services to deliver proactive community outreach. By taking services directly to people who may struggle to attend clinics, we can assess problems earlier, provide prompt treatment and prevent complications. The focus is on prevention, improving mobility and supporting people to remain safe, well and independent.

Cultural Competence Certification

Why is this important?

Culturally competent care ensures that all patients feel respected, understood and able to access services without barriers. It strengthens equality, reduces health inequalities and helps staff deliver care that reflects the diverse communities they serve.

What are we doing?

The Therapies team at Cardiff Royal Infirmary have achieved Cultural Competence Certification through the Diverse Cymru scheme. Staff have developed greater understanding of equality, diversity and inclusion, sparking continued work to identify opportunities to improve services for all communities. This learning is shaping how future services are designed and delivered.

Musculoskeletal Physiotherapy In-Reach service

People in prison often have limited access to routine healthcare, which can delay treatment and worsen long term conditions. Improving accessibility supports better health, reduces inequalities and prevents avoidable deterioration.

A new in reach muscular skeletal physiotherapy service was launched at HMP Cardiff in Spring 2025. Bringing treatment directly into the prison reduces the need for offsite appointments and supports

people to live well within the prison environment. The service applies Prudent Healthcare principles and contributes to the Health Board's Strategic Equality Objective on accessibility.

The Learning Disability Liaison Service

Why is this important?

People with a learning disability experience significant health inequalities, including poorer outcomes and reduced life expectancy, with many dying over 20 years earlier than the general population. In inpatient settings, these inequalities can be particularly pronounced: people are more likely to have complex physical and mental health needs, experience communication barriers, and face delays in diagnosis and treatment. This can contribute to long hospital stays, with many remaining in inpatient care for extended periods, sometimes years, often due to gaps in community provision and discharge planning. Ensuring high-quality, person-centred inpatient care—supported by reasonable adjustments, effective communication, and early discharge planning—is essential to improving outcomes, reducing avoidable harm, and supporting people to receive care in the most appropriate setting.

What are we doing?

The Health Board have a dedicated Learning Disability Liaison Service whose role it is to support clinical staff in delivering safe, effective and equitable care, to the same standard that all of the patients within the Health Board should expect. The Health Board have a register of individuals with diagnosed learning disabilities. When an individual attends the emergency department or is admitted as an inpatient an electronic flag ensures that all clinical teams are informed of their learning disability and the flag also alerts the learning Disability Liaison team of their admission. The team will attend the clinical area to ensure that the appropriate assessments are being undertaken, that the relevant people involved in the ongoing care of the individual continue to be involved and that the individual or their advocates are supported to make decisions around their care. Two members of the Learning Disability Service have lived experience of a learning disability and are invaluable in supporting the development of easy-read information, supporting training and informing service improvements.

Ageing Well

Ageing Well takes a person-centred approach to supporting people to live well as they age, with a strong focus on prevention and population health improvement. This collaborative initiative aligns services and community assets to deliver a more integrated and sustainable model of care in response to an ageing population with increasing long-term conditions, complex multimorbidity and associated risks such as falls. Through a prevention-focused approach, interventions are offered earlier to maintain independence and wellbeing. A key component is Shared Decision Making (SDM), a collaborative process where healthcare professionals and patients work together to select tests, treatments or care plans, combining clinical expertise

with individuals' preferences, values and lifestyle goals to identify risk and connect people to evidence-based support. This is complemented by the Live Well, Age Well six-week programme, offering education, exercise and peer support delivered by rehabilitation coaches in partnership with leisure providers, alongside ongoing support through community activities facilitated by neighbourhood teams. Outcomes demonstrate strong impact, with 68% of participants in shared decision-making opting for community-based support, alongside reported improvements in health and wellbeing and consistently positive feedback, with all participants reporting positive change and recommending the programme.

Weight Management Service

Why is this important?

More people across Cardiff and the Vale are seeking help to manage their weight and improve their health. Rising rates of overweight and obesity affect long term wellbeing and increase pressure on NHS services. Ensuring timely access to the right support helps people make sustainable lifestyle changes and reduces future health risks.

What are we doing?

Registered dietitians provide personalised, community-based support tailored to people's goals and readiness to change. To meet growing demand, the service has expanded its offer, including new Healthy Weight Healthy Choices sessions. These help individuals understand available services, identify what matters most to them and choose support that best fits their needs.

Preventing smoking and vaping in schools

A Public Health Practitioner from the UHB Public Health Team has been working directly with Year 10 and 11 school children to raise awareness of the risks associated with smoking and vaping. The sessions were delivered as part of their Health and Social Care GCSE, linking directly to the unit on 'Promoting and Maintaining Health and Wellbeing'.

During the sessions, pupils learned about the differences between smoking and vaping and how to spot illegal or non-compliant vape products. They also focussed upon the legal limits on nicotine strength (maximum 20mg) and tank sizes and why vaping is becoming increasingly popular among children and young people.

The Welsh Government's ambition is to achieve a smoke-free Wales by 2030. Pupils were encouraged to share their own views and experiences, providing valuable insight into why vaping has become so widespread. One key message that resonated strongly with learners was how quickly nicotine affects the brain. Many pupils were genuinely surprised to learn how quickly dependence can develop.

Prevention is at the heart of public health. One of the key roles within the Public Health Team is delivering dedicated smoking and vaping prevention sessions

in schools across Cardiff and the Vale of Glamorgan. While schools frequently seek support for young people who already vape, the focus here is on early intervention and education before habits form.
By working together with schools, Cardiff and Vale Public Health aims to empower young people with accurate information, challenge misconceptions, and support Wales' journey towards a smoke-free future.

Syndrome Without A Name (SWAN) clinics- a unique clinic caring for people with rare diseases

Why is this important?

People with rare diseases often face long waits for a diagnosis, with many waiting more than five years. The SWAN Clinic was set up to improve this experience for patients in Wales by reducing uncertainty, increasing the chance of diagnosis, and improving coordination of care. The Health Board is pleased to confirm that the SWAN (Syndromes Without A Name) Clinic at University Hospital of Wales has secured ongoing funding following a successful three year pilot. The SWAN Clinic supports patients who are suspected of having a rare disease but do not yet have a confirmed diagnosis. It is currently the only clinic of its kind in the UK and brings together a wide range of specialists to provide coordinated, patient centred care.

Following an independent evaluation by the Centre for Healthcare Evaluation, Device Assessment, and Research (CEDAR), the clinic will now receive ongoing funding through the NHS Wales Joint Commissioning Committee. This will allow the service to continue beyond its initial Welsh Government funded pilot.

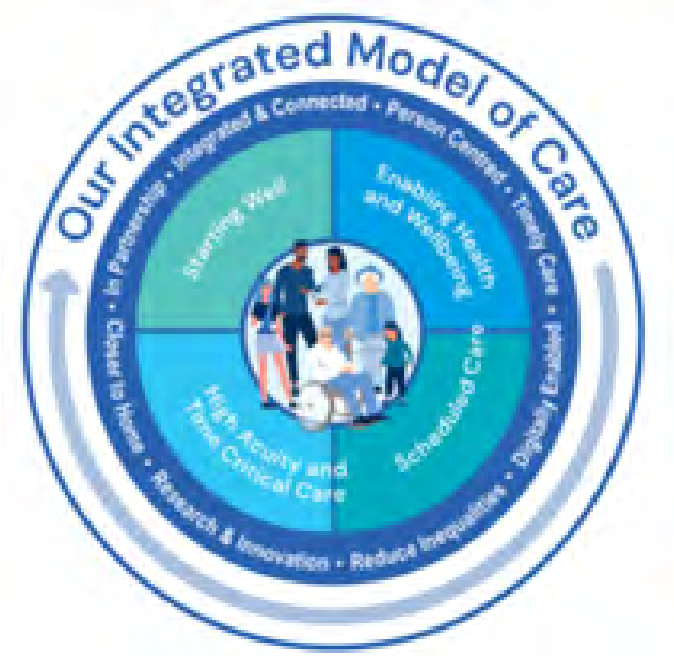
What difference does it make?

The evaluation found clear benefits for patients, even where a diagnosis had not yet been confirmed. Patients experienced changes to their care and treatment, felt listened to, and valued the time taken to fully explore their health concerns. The clinic's multidisciplinary approach was highlighted as key to providing a more joined up and effective pathway.

Patients shared very positive feedback, describing the clinic as reassuring and thorough, and saying it gave them hope and confidence that their condition was being actively investigated.

Healthcare staff also welcomed the continuation of the service. They highlighted the benefits of having protected time to explore complex cases in depth, improved coordination across specialties, and valuable learning opportunities in rare disease care.

Looking Forward



In 2026/27 we will launch the Health Board Clinical Services Plan. The Plan sets out how health services will develop over the next ten years, looking ahead to 2035. It responds to a clear and widely shared understanding that the health system cannot continue to work in the same way if it is to meet future needs. Demand for services is increasing, people are living longer with more complex needs, and health inequalities continue. Our Plan focuses on improving population health, preventing illness where possible, and making better use of community based and digital care so that hospital services are used when they are really needed.

The Health Board will continue to advance our quality improvement ambitions through the Shaping Our Future: Quality Excellence programme. With the inclusion of the implementation of Scan4Safety, utilising barcode scanning technology to strengthen the reconciliation of medical devices and equipment, thereby improving patient safety, traceability, and operational efficiency. We will also maintain progress across our existing programmes of work, with a continued focus on strengthening governance arrangements and enhancing safety across these critical areas. Alongside this, we will further develop our Quality Management System to support a whole-system approach to delivering consistently high standards of care across the organisation.

As the electronic prescribing and medicines administration (ePMA) system becomes embedded, we will maximise its potential by interrogating prescribing and administration practices. This will enable deeper insights into medication safety, supporting targeted improvements and reducing the risk of harm.

We will pursue these quality improvements whilst maintaining focus on meeting our statutory financial responsibilities, ensuring sustainability alongside excellence in care.