



Llunio ein  
Gwasanaethau Clinigol  
i'r Dyfodol  
Shaping Our Future  
Clinical Services



GIG  
CYMRU  
NHS  
WALES

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

# SHAPING SERVICES FOR THE FUTURE, TOGETHER

*Our Clinical Services Plan  
2026-2035*



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# 1 Introduction

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Our Clinical Services Plan (CSP) sets the long-term vision and direction for clinical services delivered across Cardiff and Vale UHB through to 2035. It describes the role that clinical services will play in delivering our overarching organisational strategy, 'Shaping our Future Wellbeing', which aims to improve the health and wellbeing of the populations we serve by 2035, through four strategic priorities:

1. Putting people first

2. Providing Outstanding Quality

3. Delivering in the right places

4. Acting for the future

This plan is one of the most important strategic plans for the Health Board and guides priorities, decision making, changes to investment and partnerships across our health system. It acts as a framework for all of our services and specialities to develop their own detailed long term service plans. It is informed by our public health plan and drives the priorities in a range of other key long-term plans and programmes, including people and culture, digital and estates.

The central idea is that our CSP will create a **single, integrated model of care** that covers all of our services and meets the needs of all of our population. It is a deliberate move away from the traditional description of care as a series of clinical sectors and specialities.

The Plan starts by making the compelling case for change to our clinical services through to 2035. We describe the engagement that informed this Plan, how we co-designed its content, including the principles that guide it. The main section introduces and describes the single, integrated model of care and the four Care Domains that together will deliver this. We then describe how we will deliver the Plan, with a focus on the first three years.



## 2 A compelling case for change

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**As we look forward from 2026 to the next nine years the case for taking a radical approach to changing how our services deliver care has never been stronger.**

### **Rising levels of need**

We know that over the lifetime of this plan, the health needs of our population will continue to increase. Over the life of this Plan, 2026 to 2035, the latest local authority population projections show:<sup>i</sup>

- The number of people in our two local authorities will be among the fastest growing in Wales – the Vale of Glamorgan +7.3% and Cardiff +6%, compared to an all-Wales average of +3.7%
- This equates to over 10,000 more people in the Vale, and nearly 24,000 in Cardiff
- An increasing 0–4-year-old population (Cardiff +3.1% and Vale +1.9%), unlike most of the rest of Wales
- A rapidly ageing population, with the number of people aged 85 or over increasing by around 50% in the Vale and 40% in Cardiff, over 5,200 more people in this age group.

There are stark differences in the life expectancy between people living in our least and most deprived areas. If you live in one of our least deprived areas you can expect to live 8.3 years longer as a woman and 9.3 years longer as a man, than someone in one of our most deprived. Despite efforts to reduce this gap, it is actually increasing.

Health behaviours continue to drive ill-health and need. In many cases individual behaviours are the result of wider environmental and cultural conditions, such as the affordability or time available to be active or prepare healthy food; income; and housing conditions. Across Cardiff and Vale:

- 29% of children in Cardiff and 24% in the Vale live in poverty (after housing costs)<sup>ii</sup>
- 21% of reception age children are overweight or obese, with a clear deprivation gradient (from 17% in our least deprived communities, to 27% in our most deprived communities)<sup>iii</sup>
- 21% of adults are inactive (fewer than 30 minutes of physical activity each week)<sup>iv</sup>
- 18% of adults drinking over guidelines<sup>v</sup>
- 9% of mothers smoked during pregnancy<sup>vi</sup>
- Across Wales, 61% of adults report feeling lonely some or all of the time.<sup>vii</sup>

Uptake of key childhood vaccinations is concerningly low, increasing the risk of an avoidable infectious disease outbreak such as measles.

All of this points to sustained increases in the health needs of our population with significant growth in long-term conditions and multi-morbidity – with a doubling of the number of people living with 4 or more long term conditions by 2035. Cancer rates and mental health issues are all projected to increase.

## A health and care system under pressure

Rising population size and health need will drive continued increases in demand for health care. And these increases are being made on a health and care system that is under severe pressure. All services report being stretched to keep up with current demand. This is most obvious in urgent and emergency care services, where the Emergency Unit is frequently overwhelmed with numbers of patients, long lengths of stay for inpatients, difficulties and delays in discharge and limited alternatives to acute hospital care.

- Emergency Unit attendances increased by 7% over the two years to 2026.
- Practices continue to experience high call volumes and provide more than 230,000 appointments each month. Utilisation of the Community Pharmacy Ailments service increased by 47% during 2025/6.

- 111 calls from people in mental health crisis or requiring urgent support have increased by 41% during 2025/6.
- Cancer referrals have increase by 38% over the 3 years to 2025 and outpatient referrals by 10%.
- Planned care waiting lists and waiting times for planned care remain high, despite focused effort and attention on reducing them.

Our health and care system is under severe pressure. It is characterised by having to focus on reactive and crisis care, with bottlenecks and delays at multiple points along the care pathway. Patients and colleagues have to navigate and overcome disconnects and silos, which is stressful. We're not taking the opportunities to prevent illness/ crises, work proactively, and provide alternatives to hospital. Hospital is too often the default.

- Once admitted, patients stay in our hospitals too long. Our average length of stay for emergency patients is 2 days longer than our benchmark hospitals, and 3 days longer for scheduled care patients.<sup>viii</sup>
- If we carry on with today's model of care, we estimate that by 2035 we will need another 325 hospital beds and 3,600 more staff to cope with the predicted rise in demand – which is clearly undeliverable and unaffordable.<sup>ix</sup>

At the same time, productivity is falling and financial pressures are increasing. Between 2019/20 and 2024/25, there was a 21% drop in workforce productivity across our seven Clinical Boards.

Modelling shows we have the potential to improve productivity (e.g length of stay, theatre utilisation) by 8% and to deliver a 2% 'left-shift' of care from hospital to community and prevention. Together, these would mean we would be in financial balance, without them our deficit will continue to grow to as much as £560 million by 2030/31.<sup>x</sup>

## New treatments, therapies and technologies

We are at an exciting time in the development of new clinical treatments, therapies and technologies. Recent rapid advances in medical and digital technologies are expected to shift the dial toward early detection and prevention, reducing late-stage disease and the time patients spend in hospitals. These include:

- Advances in genomic medicine have already enabled personalised treatments based on an individual's genetic makeup, leading to targeted therapies for various diseases, including cancer and rare genetic disorders.
- The use of polygenic risk scores (PRS) will revolutionise the way we manage diseases and population health – allowing the population to be stratified by lifetime risk of conditions such as cancer and cardiovascular disease.
- Regenerative medicine will become more mainstream with technologies available to replace, regenerate or engineer damaged cells.
- The increasingly rapid development of cell and gene therapies will transform therapeutic outcomes of treating diseases. Immunotherapies such as checkpoint inhibitors and CAR-T cell therapy are transforming cancer treatment by harnessing the body's immune system to target and destroy cancer cells.



- The further development of sophisticated robotic-assisted surgeries linked to minimally invasive procedures will offer faster recovery.

We are well placed to take these opportunities. As Wales's largest provider of specialised services, we deliver a significant proportion of the country's highly specialised, low-volume and complex services on behalf of the wider Welsh population.

We have also recently established Cardiff Health Partners with Cardiff University and Velindre NHS Trust with aims that include; stimulating innovation, getting new therapies to patients faster and developing a future ready workforce. We are focusing on three themes:

- Driving breakthroughs in Brain Science and Mental Health
- Researching and delivering the next generation of treatments for complex cancer
- Tailoring prevention and treatment strategy for our population's health

Digital technology and capability are a crucial enabler to this Clinical Services Plan and how our services are able to transform through to 2035. The Digital Strategy (2025-2030) describes the Health Board's significant challenges from outdated digital infrastructure and fragmented systems.

The Welsh Government have a vision for an all-Wales Electronic Health Record (EHR) but this is at least five years away. The Digital Strategy describes a set of projects that aim to deliver improvements in:

- Interoperability and faster access to critical patient information
- Voice enabled clinical documentation
- Clinical decision support tools
- Predictive analytics

The ambition will be to build on these foundations and go further, to take advantage of the growing range of digital health opportunities that help shift the dial toward proactive joined up care.



## The case for a single, integrated model of care

It is clear that our Clinical Services Plan through to 2035 needs to be ambitious and radical. The clear consensus from all of our engagement and codesign with colleagues, our communities and partners is that the current model doesn't work.

This Plan sets a new direction for clinical services centred on creating a **single, integrated model of care** that improves population health, tackles inequalities and secures a sustainable future for services. This model:

- Prioritises getting upstream, by focusing on prevention and proactive care that reduces disease and crises starting at birth.
- Integrates care around the needs of people
- Is 'community by design' rather than hospital by default
- Embraces technological innovation
- Is delivered in partnership, with communities, Councils, Universities, Velindre and neighbouring Health Boards
- Develops our workforce to play their part in delivering this

Section 4 describes this new model of care in more detail.



# 3 Co-design and principles

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## Listening to our communities, our colleagues and partners

We started developing this Plan by engaging and listening to a wide range of people, including:

- A 20-week period of public engagement with over 50 different engagement activities across our communities.
- 13 weeks of engagement with staff and partners with more than 60 different opportunities to engage and explore what we had heard from the public, what matters most to colleagues and to test principles and emerging thinking on the new model of care
- Coproduction sessions with patients who currently access our services.
- Feedback from children, young people and families that recently informed the development of our plan for Babies, Children and Young People
- A wide range of other methods were used to ensure we could reach as many people as possible including digital (website, surveys, social media, podcasts), in-person (community hubs, events, libraries), and targeted sessions for specific groups.

This engagement identified a clear set of themes that people wanted this Plan to deliver:

- Improving access and care closer to home
- Digital access
- Improving integration & consistency of care
- Improving communication
- Delivering greater equity

## Co-designing our future model of care

We followed this engagement with two large co-design workshops, with more than 400 participants from across our organisation, partners, patients and members of our Youth Board.

At the first workshop we reflected on the feedback from our engagement, heard from a number of clinical services who are leading the way with innovation and improvement and co-designed 'Principles' that should inform and direct this Plan.

At the second workshop we focused on road testing and developing the four emerging Care Domains that make up our single, integrated model of care. Four mini-workshops were led by a clinical faculty representing the wider multi-disciplinary team. The consensus was that the Care Domains approach worked and we gathered most of the content that is reflected in the next section.

## Clinical Service Plan Principles

These principles have been co-produced and tested with the public, colleagues from across the organisation and our partners. They describe what is most important for this Plan, what guides the content and the underlying values that will govern its implementation. They are not aspirations, they are statements of intent.

1. People will receive timely and effective care whether facing an emergency, a planned procedure or a crisis, ensuring best possible outcomes.
2. People will be at the centre of their care, supported and empowered.
3. We will support people to live well and will focus on reducing health inequalities.
4. We will care for people's physical, mental, and social needs in all our services.
5. We will make it simpler for people to get help, with services better integrated, especially for those who need them most, fostering collaboration across teams and organisations we will deliver high quality care.
6. We will focus on community-based, digitally enabled care, reducing the need for hospital visits.
7. We will keep improving by listening, learning, and embedding research and innovation in everything we do.



# 4 A single, integrated model of care

**Widespread engagement and exploration of the future for clinical services in Cardiff and Vale has pointed towards integration being driving force that should frame the long-term development of our clinical services.**

Our Clinical Services Plan through to 2035 aims to create a single, integrated model of care that covers all of our services and meets the needs of all of the populations we serve. It is a deliberate move away from the traditional description of care as a series of clinical specialities and sectors.

Our single, integrated model of care will be organised around **four Care Domains**, which together will fulfil our co-designed principles and deliver the fundamental improvements and shifts we want to make in how care is planned and delivered and the impact it has on people's health and wellbeing.

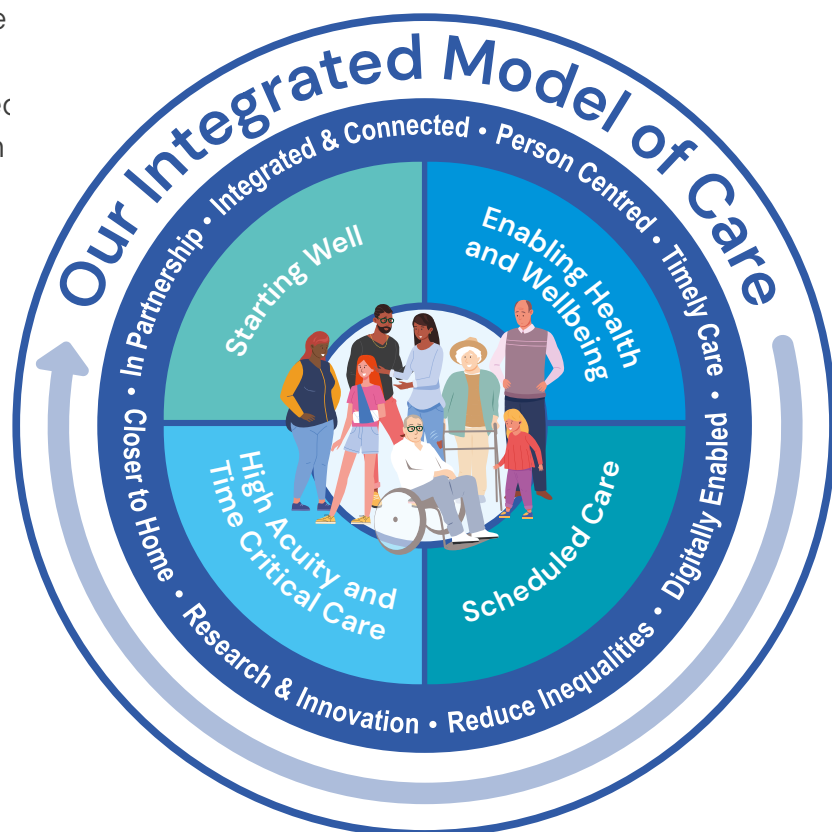
**The four Care Domains are:**

- A. Starting Well
- B. Enabling Health and Wellbeing
- C. Scheduled Care
- D. High Acuity and Time Critical Care

This chapter introduces and describes these Care Domains.

Each are made up of a small number of **components**, that together work to integrate care across all of our services and settings. The aim is that these components form the framework for all of our clinical services to develop their own more detailed long-term plans.

**All of our clinical services** will play a key role in delivering all of these Care Domains.



# A. Starting Well

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## Overview

The Starting Well domain outlines our commitment to ensuring that babies, children, young people and families in Cardiff and Vale enjoy the strongest possible foundation for lifelong health, wellbeing and opportunity. This domain is rooted in the guiding principles: supporting people to live well, reducing health inequalities, and placing children and families at the heart of everything we do.

Starting Well starts with women's health, specifically perinatal and neonatal services, community and hospital care for children, emotional wellbeing and neurodevelopmental support, family support, safeguarding and early help. These services will no longer operate as isolated, separate elements. Instead, they will be coordinated as a network designed around the physical, mental and social needs of children, ensuring that every interaction contributes to improved outcomes.

## Ambition

Our ambition is for every child in Cardiff and Vale to grow up healthy, safe and able to thrive supported by healthy families. We recognise that women's and girls' health before conception, during pregnancy and birth and throughout early childhood is fundamental to giving every child the best possible start in life. To realise this ambition, we will prioritise prevention and early intervention, providing timely, holistic support for women, babies and families before needs escalate and inequalities widen.

We will use our unique position in Wales to foster biological data (inc genomics and microbiomes) in early years health which will enable us to be more predictive, precise, preventative and more place aware (linking biology to environments and policy).

Community hubs will be central to achieving this ambition, acting as everyday engines of children's, women's and families health and wellbeing. These hubs will bring together primary care and community paediatricians, therapies, emotional wellbeing support, disability services, community nursing, health visitors, perinatal mental health and family support. They will form part of a seamless local network, closely connected to schools, early years settings, youth services and the Integrated Neighbourhood Teams. This anchors services where people live bringing health, education and

community support around women, children and their families rather than a single building or service.

In keeping with our principle of placing people at the centre of care, Starting Well will be co-produced with children, young people, women and families. Their input will influence service design, digital experiences and the outcomes we prioritise. Adopting a rights-led, gender informed and responsive approach we will ensure that women, children and their families are listened to, supported and empowered and that our system that learns and continually improves to improve outcomes and experience for future generations.

## **What the future looks like**

The Starting well domain has six components.

### **(i) Perinatal and neonatal care**

A high-quality, modern maternity and neonatal service will provide continuity from pregnancy through birth and postnatal care. Enhanced digital maternity records will facilitate personalised care planning and shared decision-making. Culturally competent and equitable services will address perinatal inequalities, ensuring support reaches those with the greatest need. Advances in genomics with personal digital genomic passports and newborn screening will increasingly allow earlier risk identification, personalised prevention and rapid diagnosis. Healthy diets will become personalised

through a greater understanding of microbiomes that will guide precision nutrition, and early biological markers will support proactive mental health interventions in children.

### **(ii) Starting well in the community**

Community-based, proactive prevention will be central to our approach. Building on the success of recently launched women's health hub, our Children Young Person and Family Plan and our 'Starting Well' partnership with local authority and third sector we will work as part of the Integrated Neighbourhood Teams in Community Hubs alongside schools and early years settings to identify needs earlier, intervene sooner and prevent avoidable deterioration. Universal emotional wellbeing support will be embedded in everyday environments, with clear, timely and equitable escalation Emotional Wellbeing and Mental Health Service or urgent care when necessary.

### **(iii) A digital front door for families**

Accessing help will be straightforward, with a single digital entry point guiding families to the right support first time. Features include self-referral, clear waiting-time information and AI-supported triage and guided education and self help. Trusted digital content co-designed with young people will enhance confidence and accessibility and a shared Children and Young People digital record will join up care across health, education and social care.

#### **(iv) A workforce designed around children and families**

Confident, skilled, multidisciplinary teams will be equipped for modern, community first care. Staff will be trained in digital skills, genomics, cultural competence, co-design, communication and partnership working. Integrated teams will work across homes, schools, hubs and hospitals to reduce fragmentation and improve outcomes.

#### **(v) Transition, independence and young adult support**

Seamless, youth centred transitions into adult services will begin early and continue up to age 25. Digital transition passports, joint clinics and coordinated planning will ensure young people feel supported, safe and empowered during this critical stage.

#### **(vi) Family support and community partnerships**

Families will collaborate to co-design the support that best meets their needs, from parenting support to emotional and practical help. Integrated safeguarding, shared information systems and robust partnerships will facilitate early risk identification and ensure consistent, coordinated responses.

### **Outcomes**

- Prevention and early intervention are embedded in the care of every child and family, reducing inequalities from the earliest years.
- Acting earlier in community settings prevents escalation into high-acuity or crisis care.
- Simple, clear and navigable pathways, supported by shared digital infrastructure and a “no wrong door” approach.
- Families experience a single, coordinated system, not multiple disconnected services.
- Strengthened local partnerships across health, education, social care and the voluntary sector, supporting integrated, high-quality care close to home.

# B. Enabling Health and Wellbeing

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## Overview

This Care Domain aims to help people live well for longer by preventing avoidable ill health, promoting wellbeing, intervening earlier and reducing unfair differences in outcomes. It reflects the national NHS reform direction: a stronger focus on prevention, new relationships with people and communities, and a decisive shift towards care delivered closer to home, supported by digital tools and integrated neighbourhood teams.

Enabling Health and Wellbeing will be delivered through primary, community and mental health services, working seamlessly with secondary care, local authorities, voluntary community and social enterprise (VCSE) partners and communities. This domain is rooted in the guiding principles: supporting people to live well, reducing health inequalities, keeping people at the centre of their care, which will increasingly be community based and digitally enabled.

## Ambition

The ambition is for everyone in Cardiff and Vale to have the best possible opportunity to live a healthy and fulfilling life, with outcome gaps driven by deprivation, disability, ethnicity and other factors narrowing over time. Prevention, early intervention and action on inequalities will be embedded in everyday practice across all services as a core expectation of high-quality care.

A whole-person approach recognises the interconnection of physical, mental and social needs. Care will become more proactive and personalised, helping people build knowledge, confidence and capability to manage their health and wellbeing, with targeted support for those who need it most.

## What the Future Looks Like

The Enabling health and wellbeing care domain has five components.

### (i) Preventing ill-health and reducing inequality

Our integrated care model will focus systematically on prevention and narrowing health inequalities across the life course. Population insight will inform need, target action and track impact, in collaboration with local authority and VCSE partners.

All clinical services will support healthier behaviours, increase uptake of screening and immunisation, and

strengthen self-management and supported independence. Approaches will prioritise quality, outcomes and responsiveness to community priorities.

## **(ii) Building the Integrated Neighbourhood Model**

Integrated Neighbourhood Teams (INTs) will become the organising unit for proactive, joined up care. Bringing together general practice, community services, mental health, specialist input from secondary care, social care, domiciliary care and VCSE partners, INTs will provide coordinated support for defined neighbourhood populations.

INTs will adopt a whole population approach, co-designed with local communities, and reduce fragmentation by eliminating unnecessary hand offs and duplication. Their focus will be both prevention and wellbeing, as well as timely, coordinated support for people with episodic, complex or multiple long-term needs.

## **(iii) Making it easier to access and navigate care**

We will implement a “no wrong door” approach supported by a digital front door, clear pathways and joined-up teams, so people are guided to the right help first time, especially those facing access barriers. Care will be organised around integrated pathways rather than organisational boundaries, dissolving divides between primary/community

and hospital services, and between physical and mental health.

This will reduce duplication, improve timeliness and support earlier intervention to prevent crisis and escalation.

## **(iv) Shifting care closer to home**

We will fundamentally change how and where care is provided, moving from hospital-centred, episodic models to an ‘an out of hospital’ approach. As prevention improves and neighbourhood teams mature, more care will be delivered in local communities and people’s homes. Community hub models and one-stop services (including diagnostics and planned care closer to home) will be expanded, alongside virtual and remote support models where safe and beneficial, reducing hospital visits.

Technology will enable this shift, supporting remote monitoring, virtual models of care, better access to information, supported self help and shared records. Care will be more convenient and responsive, while maintaining safety and quality.

## **(v) Genomics and innovation in prevention**

In the coming decade, genomics and related innovations will increasingly support earlier risk identification, precise diagnosis and targeted prevention for some conditions and population groups. Integration of

genomic advances will be based on demonstrable improvements in outcomes and reduction of inequalities, supported by governance, workforce capability and evaluation.

## Outcomes

- Prevention and inequality reduction are a standard part of every pathway and clinical team's work, making measurable improvements in our population's health.
- Care and capacity shifted into homes and communities, replacing emergency unit attendances and inpatient care.
- Integrated Neighbourhood Teams the default way of organising local, joined up care
- Improved patient activation and personalised care, with more people reporting confidence, knowledge and ability to manage their health and wellbeing.
- Simplified access through integrated pathways and a digital front door, with "no wrong door" support.



# C. Scheduled Care

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## Overview

This Care Domain sets out how we will deliver planned, non-emergency care in a way that is more personalised, preventative, digitally enabled and delivered as close to home as possible. It covers the full planned care pathway from referral and diagnostics, through outpatient assessment, prehabilitation, treatment, procedures and surgery, to recovery, follow up and long term condition management, as well as end of life care. This domain includes mental health and cancer.

Care will increasingly be delivered through streamlined, integrated pathways supported by Integrated Neighbourhood Teams, multidisciplinary teams and modern digital tools that reduce unnecessary appointments and support patients to manage their health more confidently. Hospital based care will remain essential for people with complex or specialised needs, but will sit within regionally networked models that improve equity, resilience and outcomes. This approach ensures that scheduled care is timely, proactive, standardised and high quality, while maximising productivity and reducing unwarranted variation.

## Ambition

Our ambition for Scheduled Care is to create a modern, high performing system that is increasingly planned, predictable and personalised. Care will be digitally enabled and delivered as close to home as possible, ensuring people have greater choice, control and timely access to safe, effective treatment.

Over the next decade, scheduled care will shift towards pre-emptive, community centred and remote first pathways, reducing unnecessary hospital visits and empowering people to manage elements of their care in ways that suit their lives. Digital tools including virtual assessment, surgical technology, AI supported diagnostics, automated waiting list management, optimised theatre and outpatient scheduling will increase productivity, reduce delays and support earlier diagnosis.

Community based diagnostic and treatment models will expand, supported by Integrated Neighbourhood Teams, enabling more routine procedures and follow-up care to take place outside hospital settings. When hospital-based care is required, it will be provided through resilient regional networks, ensuring equitable access to both routine treatment for those with predictable needs and specialised service expertise for people with rare or complex conditions.

By concentrating workforce, infrastructure, research capability and technology across regional centres, we will strengthen system resilience and improve outcomes. This transformation will deliver a scheduled care system that is faster, fairer, more personalised and more convenient, improving patient experience and supporting the health and wellbeing of our population.

## **What the future looks like**

The Scheduled care domain has five components.

### **(i) Scheduled care closer to home**

Most scheduled care will be provided either virtually or locally in neighbourhood and community settings, making appointments and procedures more accessible and minimising disruption to daily life. Travel to hospital will be uncommon, reserved for people with rare or complex conditions, injuries and illness requiring intervention.

Community Hubs serve as the primary venues for scheduled care, offering a seamless experience by integrating outpatient services, follow-up care, diagnostics, pre-operative assessments, minor procedures, and planned treatments. These community hubs foster multidisciplinary collaboration across primary, community, and secondary care and with our social care and third sector partners ensuring that pathways are reliable, accessible and uphold dignity.

### **(ii) Digitally enabled care**

Digital tools will be woven into every aspect of scheduled care, ensuring that patients are efficiently guided to the appropriate services from the outset. Digital care is the standard, but tailored support is always available for those who require it, making the process streamlined, reducing unnecessary appointments and making care more accessible. Digital tools will increase productivity, with the adoption of digital theatre scheduling, AI enabled decision support and real time operational and utilisation analytics.

### **(iii) Faster diagnosis**

Faster, reliable access to diagnostics will support earlier decision making, speed up treatment and improve outcomes. Community based diagnostics will be fully integrated into all of our neighbourhood and community hub models, supporting common pathways and standards of care, such as pre-operative optimisation. Increasingly, genomics will enable personalised and more precise diagnosis.

### **(iv) Networks delivering scheduled care**

Not all scheduled care needs to be delivered everywhere, some services are better provided and coordinated across a larger geographical footprint to ensure resilience that improve access, productivity and outcomes. For these services we will deliver care increasingly through networks than span geographical boundaries. These will be within Cardiff and Vale and through

our partnership with other Health Boards and Trusts in South East Wales region and our Specialised Services partnership with Swansea Bay University Health Board for those with the most complex and rare needs.

### **(v) A workforce designed to deliver**

Scheduled care will be delivered by multi-professional teams empowered to break down and work across traditional silos and boundaries, delivering care in the right setting at the right time. They will be able to work flexibly across community and hospital settings. They will be supported to work at the peak of their expertise, including advanced practice, digital skills and use of genomics. They will be trusted to innovate and make improvements to the care they provide.

### **Outcomes**

- Patients receive timely treatment from referral to treatment, meeting all national waiting time standards for cancer and planned care.
- Patients received personalised care, that is convenient and under their control
- Scheduled care is delivered closer to people's home where possible and integrated across all care settings
- Services are more efficient and productive ensuring timely equitable access for all our populations
- Consistent, standardised and high quality pathways in place for key specialities across South Wales.



# D. High Acuity and Time-Critical Care

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## Overview

High Acuity and Time Critical Care provides specialised, 24/7 multidisciplinary support for people with life threatening or rapidly deteriorating conditions. Care is delivered through medically led teams with the expertise and capability to respond swiftly and consistently across all settings. The most critically unwell are treated in specialist environments such as critical care and high dependency units, while people with urgent but less critical needs receive timely multidisciplinary assessment and management in hospital or community settings.

This care domain is a core part of the Cardiff and Vale system and contributes to our regional and national responsibility for the delivery of specialised services for the 3.16 million people in Wales and in some cases, England.

Spanning the full spectrum of urgent, emergency and specialised care, this domain supports people experiencing complex, life threatening or life limiting conditions, rapid clinical deterioration, time critical mental health crises and specialist needs at the end of life. The model emphasises early recognition, rapid intervention and coordinated escalation, ensuring people receive the right level of care the first time. It is grounded in person centred care, strong collaboration across organisational

boundaries, digitally enabled decision support and a commitment to ongoing research and innovation to continually improve outcomes.

## Ambition

Our ambition is to deliver high quality, evidence based care in the most appropriate setting, reducing avoidable hospital admissions, ensuring timely access to specialised services, and strengthening system-wide resilience. In line with our ambition this domain will focus on prevention, personalisation and integrated care, our model will increasingly identify deterioration earlier, intervene more swiftly and ensure that people receive the right level of care first time whether at home, in the community, or in advanced hospital settings.

Over the next decade, High Acuity and Time Critical Care will evolve into a highly responsive, digitally enabled and fully networked system. Predictive analytics, real-time monitoring and AI supported decision tools will help clinicians recognise early signs of deterioration and act promptly. Seamless collaboration across community and hospital services will reduce boundaries and create a consistent, equitable approach to urgent and complex care across Cardiff and Vale and the wider regions.

Multidisciplinary clinical teams will operate 24/7, providing senior oversight and ensuring rapid access to specialised diagnostics and therapeutics. This will ensure round-the-clock access to specialist expertise and a resilient, sustainable workforce. Our workforce will be designed to be sustainable, with a mix of skills and strong shared learning to support resilience, flexibility and equipped to deliver modern, high acuity care in diverse settings.

Advances in technology, new medicines, genomics and AI enabled decision support will become part of routine practice, enabling earlier intervention, faster diagnosis and more personalised treatment plans. These innovations will improve outcomes and reduce unwarranted variation.

Care will be organised through strong networks at local, regional, and national levels to provide consistent access to specialised services, especially for people with rare or complex conditions requiring time critical care. When hospital treatment is needed, it will take place in modern facilities designed for this purpose, ensuring patients benefit from skilled specialist teams and research opportunities. This approach strengthens the health system's resilience, supports standardised and specialist care pathways and creates service models prepared for the future.

This integrated, technologically advanced and sustainably staffed model will ensure earlier intervention, rapid response and high quality care across all settings protecting life, supporting recovery and improving outcomes for those with high acuity and time critical needs.

## **What the Future Looks Like**

The Time critical and Specialised care domain has five components.

### **(i) Early recognition and rapid response and management**

There will be radical improvements in early recognition of disease and ill-health through predictive analytics, continuous monitoring, enhanced early warning technologies and real time visibility across urgent and acute care settings. Digital tools will facilitate earlier identification of deterioration, supporting rapid and safe escalation of care. Consultant led assessment will be available 24/7, with clear, standardised pathways for high-risk conditions. Transfer, access and discharge criteria will be consistent throughout South Wales, ensuring fairness and reliability regardless of geographical location.

### **(ii) Multidisciplinary teams delivering 24/7 Care**

Expert senior decision makers, advanced practitioners, critical care teams, mental health professionals and diagnostic specialists will collaborate within a seamless 24/7 care model. Innovations in the regional workforce,

such as joint appointments, rotational roles and expansion of advanced practice, will enhance capability and support sustainable staffing. The culture will prioritise compassion, psychological safety and high-quality decision making under pressure.

### **(iii) Networks with centres of excellence for the most complex care**

As a provider of specialised services for Wales, Cardiff and Vale will continue to play a pivotal role in regional and all-Wales networks, ensuring that care for those with the most complex and time critical needs receive high quality care that is safe and consistent. This includes delivery of critical pathways such as major trauma, cardiac, neurosurgery, specialised rehabilitation. Shared data agreed standards and clear operational protocols will enable patients to access expertise swiftly, wherever they present. Working closely with commissioners and our partners will be crucial in supporting the development of these networks. It will be essential that our hospitals have the capacity and the appropriate environment to deliver this level of care into the future.

### **(iv) Standardised and equitable pathways**

All patients will experience consistent, high-quality pathways from the community to acute response, and onwards towards recovery. Integrated digital records, shared escalation criteria and effective communication

will support families in understanding their care journey and raising concerns promptly. Individuals with learning disabilities, cognitive impairment or other vulnerabilities will benefit from personalised adjustments, embedded as standard.

### **(v) Future facing services**

Leading edge research and innovation will be embedded in all of our services supported by our partnership with Cardiff University, Velindre and the life science industry (Cardiff Health Partners). The continued development of genomics and rapid molecular diagnostics will play a greater role in earlier diagnosis, metabolic crises and rare diseases. Digital and technological advancements will transform the way we deliver high acuity and time critical care. Remote monitoring, virtual specialist input and robotics assisted interventions will become commonplace. Modern, fit-for-purpose acute facilities are critical to ensuring those with acute, time critical and the most complex care are treated in a safe and timely way to deliver the best outcomes.

## **Outcomes**

- The right care is provided in the right place, services are able to give all their focus to patients with critical care needs whilst collaborating with neighbourhood and community teams

- The right care is provided at the right time with early recognition and diagnosis, minimal delays and time critical standards being met (e.g. sepsis, stroke)
- Care is provided consistently, regardless of time of day (24/7).
- Care is consistent across Cardiff and Vale and South Wales, supported by effective clinical networks.
- Research is rapidly translated into practice, bridging discovery science and clinical practice so patients receive new therapies faster.

## The four Care Domains and their Components

Starting Well	Enabling Health and Wellbeing	Scheduled Care	Specialised and Time Critical Care
Perinatal and neonatal care	Preventing ill-health and inequality	Scheduled care closer to home	Early recognition and rapid response and management
Starting well in the community	Building the Integrated Neighbourhood model	Digitally enabled care	Multidisciplinary teams delivering 24/7 care
A digital front door for families	Making it easier to access and navigate care	Faster diagnosis	Networks with centres of excellence for most complex care
A workforce designed around the needs of children and families	Shifting care closer to home	Networks delivering scheduled care	Standardised, equitable pathways
Transition, independence and young adult support	Genomics and innovation in prevention	A workforce designed to deliver	Future facing services
Family support and community partnerships			

Taken together, these four Care Domains form a single, integrated model of care that reshapes how we support people throughout their lives. They work collectively to shift the system towards prevention, early intervention, high-quality local care, and resilient specialist services. This unified model is designed to deliver our shared ambition for future services:

By 2035, Cardiff and Vale will have transformed how health and care are designed, delivered and experienced.

We will deliver a single, integrated model of care that improves population health, reduces inequality and unwarranted variation, and secures a sustainable future for services.

Services will be organised around people, not structures, with integrated neighbourhood teams, strong partnership and collaboration with our communities enabling holistic, joined-up care.

We will proactively shift care upstream, detecting and managing illness earlier and ensuring this is delivered closer to home, while strengthening specialist and high-acuity services so hospitals focus on what only hospitals can do in modern, fit for purpose facilities.

Our model of care will move from a reactive, hospital-centred model to one that is preventive, proactive and person-centred, with support provided in the right place, at the right time, focused on outcomes that matter to people.



# 5. Delivering our Clinical Services Plan

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This Plan sets out the compelling case for changing how we currently deliver clinical services, and sets a clear direction towards a new, integrated model of care. This section describes our approach to transitioning from our current model of care to deliver this Plan.

Our single integrated model of care is ambitious and this Plan will require a focused effort across the organisation and our partnerships to deliver in line with the principles we have set out. We will need the support and commitment of all our clinicians and clinical teams, the wider Health Board team and all of our partners. Everyone has a role to play.

## The first three years – setting a new direction

The following three priorities are designed to enable us to set a new direction for our Clinical Services, away from today's pressurised, reactive model – towards our new single, integrated model of care.

### Priority 1 – Creating capacity for sustainable change

Our first priority is to create the headroom that will give us the time and resource to invest in the long-term delivery of this Plan. The Case for change in section 3 described how our current system is under pressure and often gridlocked. One symptom of this, is a rising financial deficit, that if not

tackled will limit our ability to deliver our new long-term model of care.

While unlocking our system will need us to deliver all of the ambitions in this Plan, we know that we can make an immediate start by taking the biggest opportunities we have to improve day-to-day clinical service productivity. Modelling shows we have the potential to improve productivity (e.g length of stay, theatre utilisation) by 8%. In the early years of this Plan, we will give particular focus to:

#### (i) Reducing time spent in hospital

Focussing on ward process, reducing length of stay, strengthening clinical decision-making and accelerating discharge across our hospitals. This will reduce avoidable delays, improve patient outcomes and release capacity across the system.

#### (ii) Improving clinical service productivity

Engaging and supporting clinical services to meet and exceed benchmarked best practice and productivity. This includes our Theatres Together Programme, GIRFT standards, High Volume Low Complexity principles and performance, diagnostics and pharmacy. Diagnostic stewardship

### **(iii) Delivering services across regional footprints**

Working with partners to plan and deliver services across broader geographical footprints to ensure services are sustainable, deliver improved outcomes and reduce waiting times for care. This includes making it easier for people to choose faster treatment at different hospitals or shared elective centres like 'Llantrisant Health Park'.

Improving productivity in our services will enable us to invest more time and resource in the developing the preventive, proactive, community first services described in this Plan. Improving the overall financial health of our Health Board will support the long-term future investment we want to make in digital healthcare and our estate.

### **(iv) Prescribing efficiency & productivity**

We will ensure we have clear, standardised pathways that will be followed across our services to ensure optimal use of cost effective interventions. This will be underpinned by value based measures, and clearly defined indications monitored through digital governance systems.

## **Priority 2 – Changing the demand for health care**

The Case for change in section 3 also describes how the needs of our population will continue to increase,

which will drive increased demand for health care. While our model remains largely reactive and hospital centric, this could slow our ability to invest in alternatives to hospital care and make the redevelopment of University Hospitals Wales (UHW) harder to afford.

Our second priority is to start changing the demand for healthcare – taking actions that we know will reduce disease and developing the model of care alternatives to hospital. Modelling shows we have the potential to deliver a 2% 'left-shift' of care from hospital to community and prevention.

Working in partnership will be vital to our success here. In practice, 80% of people's health is determined by a wider set of determinants than health services, meaning we need to partner with Local Authorities, the third sector and communities to make a real difference.

### **(i) Implementing the Neighbourhood model**

A new neighbourhood focused model of care will be a key early building block that will start to change the demand for healthcare. In year 1 of this Plan, we will agree the local geographical footprint and restructure community services around these as a step towards forming single integrated teams for each – aligned with hospital specialists.

Our design is based on the evidence of how this model improves quality, reduces costs, reduces time attending and spent in hospitals and improves access to care.

## **(ii) Unified mental health model of care**

We are developing a unified mental health model of care as another key early building block. It responds to rising demand and acuity, fragmented pathways and inconsistent pathways across inpatient, community and crisis settings. The new model will support a shift in emphasis from reactive crisis response to proactive, preventative and community-first mental health care. The aim is to create a mental health system that is safer, more integrated, more predictable for patients and families and more supportive of our workforce.

## **(iii) Improving metabolic health**

Focussing on identifying and supporting those at risk of ill health sooner to improve healthy behaviours, health conditions and environmental factors that increase the risk of ill-health. By intervening early, we can prevent conditions such as chronic kidney disease, diabetes and heart disease from worsening and reduce pressure on health services.

## **Priority 3 – Design our Health Board to deliver this Plan**

How should we organise our Health Board to support the delivery of this Plan and our new integrated model of care? This has been the key question in an important parallel review, supporting the co-design of how the Health Board organises itself. Clinical and operational leaders from across the organisation have helped co-design a new long-term Operating Model, which follow shortly after approval of this Plan. Over time, this will include:

- A new structure designed to deliver the four Care Domains in this Plan and to integrate services and care across them
- Investing in strengthened clinical and operational leadership teams
- Enabling resources to be deployed and moved along care pathways, to improve outcomes and productivity
- Devolving decisions and accountability as close to delivery as possible
- Supporting greater levels of partnership working
- Increase the support Corporate teams give to local delivery

Alongside organisational change, we will progressively use digital, data and AI to reduce administrative burden, improve decision making, improve productivity and release capacity for frontline care.

Early priorities will focus on automating high volume, repetitive tasks such as clinical correspondence, discharge administration, ward clerical processes and performance reporting, alongside AI enabled support for workforce, finance and operational planning. These capabilities will be implemented within robust clinical safety, information governance and human oversight frameworks.

### **Year four onwards – embedding our single, integrated model of care**

By 2030, our focus will shift from redesign to consistency, maturity and sustainability. By 2035 our single integrated model of care will be embedded as business as usual, with stable regional networks, aligned infrastructure and workforce, digital and estates configured to support the integrated model at scale. The system will operate more predictably, with a sustained emphasis on population health, prevention, equity and value with clear roles for community, hospital and specialised services. This will include:

(i) Fully realising our ambitions for an Integrated Community Care system with our local authority and third sector partners through the mature delivery of programmes such as Community by Design, and our joint estates planning to ensure neighbourhood-based, multidisciplinary care is established as the foundation of the health and care system and community settings operating as the default for prevention, ongoing support and recovery.

(ii) Embedding sustainable, networked care through our partnerships to secure clinically resilient, high-quality and affordable service configurations. This will include delivery of agreed solutions for services at risk such as Cellular Pathology, Cardiac Surgery and Specialised Paediatrics with services located and networked to optimise outcomes, workforce sustainability and system resilience.

(iii) Services delivered from the site best suited to needs of the populations we serve according to their level of acuity, complexity and urgency. For most people, this will be care delivered close to their home. When hospital care is needed, this will mean that:

- UHW will function as the Health Board's primary centre for high-acuity, time-critical and highly specialised care, providing 24/7 access to emergency, critical care and tertiary services that require immediate intervention, specialist infrastructure and a critical mass of expertise. This includes services where outcomes are highly sensitive to delay and where co-location of specialist teams, diagnostics and critical care is essential.
- University Hospital Llandough (UHL) will be focused on routine scheduled care that can only be delivered in hospital settings and selected complex services that benefit from planned delivery or mental health services and

rehabilitation-focused services, including specialised rehabilitation. This separation enables care to be delivered in the most appropriate environment, protects capacity for time-critical services at UHW, and supports safer, more efficient patient flow across the system.

## Wider support for delivering this Plan

The scale of our ambition will require significant transformation across not only our services, but our estate, digital systems, data and infrastructure, our workforce and the wider system beyond healthcare.

In response to this, the Board has approved 6 strategic portfolios. Collectively, these provide a disciplined, whole-system mechanism for turning strategy into delivery ensuring the strategy and our long-term plans are translated consistently into action, with clear accountability, sequencing, and system-wide alignment.

The 6 transformation portfolios oversee the development of long term plans. Set out below:

Each portfolio oversees several programmes of work and are focussed focus on:

1. Population Health – Improving population health outcomes and reducing inequalities
2. Quality – Ensuring safe, reliable, outcomes-driven care by embedding a whole-system

Quality Management System and value-based approaches

3. Clinical Services – Redesigning services and pathways in partnership to deliver the future model of care
4. People & Culture – Creating the organisational conditions, leadership capability and cultural foundations required to deliver the future model of care
5. Infrastructure – Modernising and prioritising the Health Board’s digital, data and estates infrastructure so it can safely and sustainably deliver the future model of care
6. Future Generations – Leading decarbonisation, sustainability, research and innovation in a coordinated, system-level way.

Together these portfolios:

- Ensure that our efforts remain grounded in the needs of our population and the improvement of health and reduction in inequalities at a population level.
- Provide a consistent approach to detailed service and pathway planning with clear milestones, outputs, monitoring and reporting against delivery.
- Ensure a focus on our partnerships to ensure plans are developed jointly and information, resources and efforts are aligned.

- Ensure alignment with our workforce planning recognising that our workforce must be designed to deliver our new model of care, not the one we have today.
- Ensuring digital and estates plans are aligned given the likely requirement for capital development across our infrastructure portfolio.

Delivery will require continued leadership, partnership and disciplined implementation across the system. Through phased delivery, aligned enabling plans and ongoing partnership with colleagues and communities, this plan will move from strategy to action, shaping services for the future, together.

## 6. Glossary and references

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### **A Healthier Wales**

Welsh Government's national vision for health and social care, setting out a whole-system approach focused on prevention, early intervention, seamless care and supporting people to live well at home for as long as possible. It underpins the direction of travel for integrated, community-based models of care across Wales.

### **Care Domains**

The four organising parts of the single, integrated model of care: Starting Well; Enabling Health and Wellbeing; Scheduled Care; and High Acuity and Time-Critical Care. Together they describe how services work as one system across prevention, community, hospital and specialised care.

### **Community by Design (CbD)**

An approach to designing services around neighbourhoods, communities and local assets rather than organisational structures. Community by Design emphasises prevention, co-production, partnership working and delivering care closer to home.

### **Community Hubs**

Local, accessible places where health, social care, voluntary and community services come together. Community hubs support prevention, early intervention, coordinated care and easier access for people and communities.

### **Digital Front Door**

A single digital route for people to access health and care services, information and support. This includes online triage, advice, appointments and communication, helping people get the right support at the right time while reducing unnecessary system pressure.

### **Future Generations (Wales) Act 2015**

Legislation requiring public bodies in Wales to act in ways that improve social, economic, environmental and cultural wellbeing, using the sustainable development principle. It underpins long-term, preventative and integrated approaches to planning and delivery.

### **Genomics / Precision Medicine**

The use of genetic and genomic information to support earlier diagnosis, more personalised treatment and targeted prevention. This includes applications in cancer, rare disease and long-term conditions and is a growing strength and opportunity for Cardiff and Vale.

## **Integrated Community Care System (ICCS)**

A way of working where health, social care and community organisations act as one team to support people. It makes care easier to access, more joined-up, and centred on what matters to people and communities. By working together, we aim to provide the right support, in the right place – helping people stay well, live independently and feel connected to their community

## **Integrated Neighbourhood Teams (INTs)**

Multidisciplinary teams working within defined neighbourhoods to support local populations. These teams bring together health, social care and third-sector professionals to provide proactive, coordinated and preventative care.

## **Integrated Model of Care (Single, Integrated Model)**

A whole-system approach where prevention, community services, hospitals, specialised care and partners work as one system. The model focuses on outcomes, equity and sustainability rather than organisational boundaries.

## **Left-shift of Care**

A deliberate shift in activity and investment away from hospital-based, reactive care towards prevention, early intervention and community-based services that reduce avoidable demand on acute hospitals.

## **Marmot Principles / Marmot Nation**

An approach focused on addressing the social determinants of health and reducing health inequalities across the life course. In Wales this is supported through national policy and the Well-being of Future Generations Act.

## **Multidisciplinary Team (MDT)**

A group of professionals from different disciplines working together to plan and deliver care. MDT working supports holistic, person-centred care and enables staff to work at the top of their professional scope.

## **Scheduled Care**

Planned, non-emergency care covering the full pathway from referral and diagnostics through treatment, follow-up and long-term condition management, increasingly delivered through standardised, digitally enabled and community-based pathways.

## **Specialised Services**

Highly specialised, low-volume and complex services provided for a wider regional or national population, requiring specialist workforce, infrastructure and clinical networks to deliver safe and effective care.

## **Time-Critical Care**

Care for people with life-threatening or rapidly deteriorating conditions where outcomes are highly sensitive to speed of recognition, diagnosis and treatment, requiring 24/7 specialist capability.



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