

Cardiff and Vale University Health Board
Shaping Our Future Clinical Services



Shaping Our Future
Wellbeing

SHAPING SERVICES FOR THE FUTURE, TOGETHER

*Colleague & Partner Engagement Report
March 2026*



Cardiff & Vale
HealthCharity
Elusenlechyd
Caerdydd a'r Fro

supported by Cardiff and Vale Health Charity

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1. Executive Summary

Cardiff and Vale University Health Board is currently developing its 10-year Clinical Services Plan which will set out the future model of care and transformation required to realise this new model. We engaged as widely as possible to ensure the plan is co-created and owned across the organisation, by our partners, and by the public. This report presents the findings of our colleague and partner engagement which ran for a period of 13 weeks, beginning at the end of November, until 27th February. Within this timeframe, we provided 67 opportunities for colleague and partner to engage in shaping the Clinical Services Plan, including two organisational wide workshops, Clinical Board sessions, webinars, face to face drop-in sessions across the whole Health Board and targeted forums such as Medical Advisory Group and Public Services Board. We also received 120 Microsoft Forms submissions to five focused questions. 73% of respondents of the form were from clinical roles, compared to 27% from non-clinical roles. Engagement included primary care contractors and third sector, so responses are not expressed as a percentage of UHW employees.

Our colleagues and partners broadly endorsed the vision and principles, but repeatedly emphasised that the real challenge is the delivery (“the how”) of the plan given current financial, workforce, digital and estates constraints. They asked for clarity on accountability, realistic prioritisation and visible feedback loops when the plan is in place. Themes were consistent throughout the engagement, highlighting digital fragmentation and the need for one system, workforce capacity challenges, estates and infrastructure barriers, and repeated calls for greater focus on prevention and community-based models.

This report collates colleague and partner insight to inform the Clinical Services Plan, ensuring the plan is deliverable and aligns to four care domains:

1. **Starting Well**
2. **Enabling Health and Wellbeing**
3. **Scheduled Care**
4. **High Acuity and Time Critical Care**



2. Engagement Methodology

Our colleague and partner engagement began at the end of November 2025 and ran for 13 weeks, concluding on 27th February. During this period, colleague and partners were offered 67 opportunities to participate, including two organisational wide workshops. The initial workshop enabled us to draft the proposed principles of the Clinical Services Plan which were then tested with our colleagues and partners throughout the remainder of the engagement period. This approach allowed us to coproduce, refine and amend the principles so they were realistic and that the whole organisation felt a sense of ownership. The proposed draft principles were:

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

Engagement sessions were delivered through a range of channels, including eight online webinars, multiple site-based drop-ins across the Health Board, partner meetings (PSB, RPB, CAV/Velindre Partnership), Clinical Board sessions, Primary Care clusters and contractor groups, and senior leadership forums such as SLT, MAG and ODG. A full list of engagement activities is provided in Appendix A.



A Microsoft Form was developed which asked our colleagues and partners to:

- Rate the principles from most important to least important
- Identify anything missing from the principles
- Consider whether the principles enable them to think differently about how they plan and deliver services
- Outline the single most important change that could improve patient care and outcomes in their area
- Suggest the steps needed to achieve this change

Respondents to the Microsoft Form represented a diverse range of areas across the organisation, including:

- All Wales Genomics Service
- Corporate functions (Medical Illustration, People & Culture, GP Management, Data Analytics, Research & Development)
- Therapies & Rehabilitation (Outpatient physiotherapy, Occupational therapy)
- Specialist Services (Haematology, Anaesthetics, Neurosciences, Major Trauma Services)
- Medicine Clinical Board (Emergency Unit, Acute Child Health)
- Primary, Community & PCIC (Community Nursing, Medicines Management, Community Pharmacy Business Unit, GP, Community-based MDT, Optometry, Pharmacy)
- Mental Health (Emotional Wellbeing and Mental Health, Psychology, Neuropsychiatry)
- Children & Women (School nursing, Paediatric Rheumatology)
- Critical Care (Adult Critical Care Department)
- Public Health

As we engaged with our colleagues and partners, including third sector and contractors, responses were not benchmarked across the UHB headcount. A thematic analysis was conducted across all sources, and the findings were mapped against the four domains.



3. Proposed Principles Feedback

The Microsoft Form asked respondents to rate the proposed principles from most to least important. A list has been provided below showing how people have rated these.

Clinical Services Plan Principles in Order of Importance:

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 care for people’s physical, mental, and social needs in all our services.
5. Getting help will become simpler, 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.

30% of respondents rated the principle “People will receive timely and effective care whether facing an emergency, a planned procedure or a crisis, ensuring best possible outcomes” as most important. This was closely followed by 28% who selected “People will be at the centre of their care, supported and empowered” as the most important principle. Meanwhile, 28% rated the principle “We will keep improving by listening, learning, and embedding research and innovation in everything we do” as the least important.

Additional comments in relation to the proposed principles

- Add a workforce focused principle covering retention, wellbeing, development and psychological safety.
- Make digital interoperability, data sharing and system usability explicit throughout the principles.
- Position estates as a core enabler of the plan ensuring they are safe and fit for purpose and not a background issue.
- Ensure equity and accessibility, including alternatives to digital-only approaches which may widen inequalities further.
- Be honest and realistic about the scope of the plan, particularly given the financial context. Our colleagues and partners emphasised avoiding overpromising on the scope risks credibility and delivery failure.
- Provide clarity on accountability, realistic prioritisation and visible feedback loops.
- Avoid widening inequality further, in relation to tertiary services eg. Aberystwyth patients declining treatment at UHW due to time away from home.

4. Findings by Care Domain

4.1 Starting Well

What is important to people:

- There was a strong emphasis on prevention and early help within the plan, particularly calls for investment in School Nursing, children's therapies and integrated rehabilitation to support development and reduce inequalities.
- There was a consensus on the need for joined-up pathways and improved data sharing and coordination between paediatrics, schools and community teams, alongside calls for improved transition to adult services.
- Equity and inclusion were highlighted as essential. People emphasised the importance of trauma-informed approaches, cultural competence and accessible communication formats to ensure families including children and young people can fully understand their care.
- People highlighted the importance of raising public awareness of self-referral pathways and emphasised opportunities for improved signposting via Health Visitors, First Point of Contact etc.

Most important changes that people want:

- To invest in babies, children and young people via:
 - School Nursing
 - Health prevention and promotion in schools which engage families
 - Ensuring pathways are seamless
 - Ensuring parents/carers, young people and children understand the next steps in their care
- Increased public awareness in self-referral pathways.

Steps to achieve this:

- Ring-fenced prevention programmes.
- Standardised early-help pathways.
- Strengthening data sharing across education, paediatrics and community settings.
- Co-produced, family facing information.
- Clear transition pathways from paediatrics to adult services.
- Clear communication to the public on the complete range of services available (such as Paediatrics SALT) and how to access them. Ensure these are easily accessible in different formats (eg not just digital) and that people of all ages understand them.



4.2 Enabling Health and Wellbeing

What is important to people:

- Primary Care colleagues highlighted structural underfunding as a barrier to keeping people well. They emphasised the need for the Health Board to recognise all four Primary Care contractors (GP, Pharmacy, Optometry and Dentistry) and to increase the focus on shifting appropriate care towards Community Pharmacy.
- GPs noted a “bounce back” loop, between GP practices and Community Pharmacy where patients are redirected between services. They stressed the importance of ensuring that all Community Pharmacies across Cardiff & Vale offer consistent services and provisions.
- Digital access was a recurring theme with repeated calls for a single digital system.
- Self-management and health literacy was seen as essential. People emphasised that health promotion and supporting people to take responsibility for their own health should be a core component of this care domain. They also wanted to see a stronger focus on prevention within the community, including greater use of Community Pharmacy to support people to live with chronic conditions. It was highlighted that the funding must follow activity, otherwise the shift is unrealistic.

Most important changes that people want:

- A meaningful upstream shift.
- Strengthen primary and community services.
- Keep people well and prevent the need for hospital care where possible.
- Moving community services out into the community and away from an acute setting. Teams have requested non-acute rehabilitation areas to prevent unnecessary admission.

Steps to achieve this:

- Fund primary care capacity (including community pharmacy independent prescribing pilots across the whole region and advice lines).
- Launch “Right care, right time” communications for the population – in particular community first and signposting.
- Embed health literacy from primary school onwards.
- Move services into community settings. Example: ABPI (Ankle Brachial Pressure Index), Point of Care Testing to be undertaken by GP or community nurses.



4.3 Scheduled Care

What is important to people:

- People consistently raised concerns about the number of different digital systems in use. They emphasised the need for a single, unified digital system to reduce duplication across the entire patient pathway and to improve booking processes and communication with patients when on waiting lists.
- People reported that limited diagnostic and rehabilitation capacity is a significant barrier to the smooth delivery of scheduled care, which directly affects patient flow and contributes to cancellation rates.
- Estates and access were also highlighted as important. Respondents stressed the need for fit for purpose facilities and better coordination of same day appointments to reduce repeat visits. They also noted ongoing issues with Maintenance Requests, which they feel are repeatedly ignored or not completed, which negatively impacts the quality of service delivery.
- Primary care teams felt it important to strengthen communication pathways to secondary care and highlighted the need for clear, accessible updates on waiting lists to give returning patients the most up to date information.
- Some respondents noted Scotland's 'Realistic Medicine' and emphasised that the Health Board should adopt this approach.

Most important changes that people want:

- Reduce waiting times by fixing flow and diagnostics.
- Working on a One Digital System and communicating with patients whilst they wait.
- Shift the focus away from processes, pathways and a one size fits all and prioritise what patients want from their care.

Steps to achieve this:

- Implementing a One Digital System for Electronic Patient Record with integrated booking and waitlist communications (which include Multi-lingual and non-digital options).
- Expand diagnostics and community rehabilitation to improve patient flow.
- Estates improvements.
- Encourage open conversations across the pathway so the focus shifts to understanding the patients' priorities, rather than simply following the process.



4.4 High Acuity and Time Critical Care

What is important to people:

- Respondents highlighted the need for an integrated digital pathway from pre-arrival (111, GP, WAST) to ED, wards and discharge. They emphasised the importance of real-time data to support time-critical decision making and shared records, digital passports/apps to reduce admin burden.
- People stressed the importance of Right patient, Right bed to reduce outliers, improve bed management and protect planned care capacity.
- Diagnostic and critical care estates were repeatedly raised as priorities including the need for timely access to imaging and fit-for purpose critical care environments.
- A default patient journey with measurable outcomes at each stage of the pathway. These stages to include Early recognition, rapid diagnosis, timely intervention, seamless recovery and discharge.
- Joined-up working across primary, community, secondary and regional partners to replace siloed specialities and geography models, emphasising that high acuity and time critical care cannot be based on secondary care delivery only.
- Proactive care for frailty (identify early is key, don't funnel through generic acute routes), with tailored care units and triage that reduce avoidable admissions. Discussions with the patient and family around their frailty is important.
- 24/7 senior decision making and optimised MDTs (including advanced practitioners and the Patient at Risk Team) to speed up decisions and investigations out of hours.
- Treatment Escalation Plans started in primary care and visible everywhere, ensuring clinicians across the whole pathway have access which guide acute decisions from the outset.

- Consistent 7 day services and "discharge first" thinking, including repatriation once tertiary care is complete to protect acute capacity.
- A system that learns (using Patient at Risk data, faster feedback loops, quality research and education cycle) and tackles behaviour culture change.
- Whole person care – embedding mental health, psychological support, clear communication and empowering patients throughout acute pathways.
- Equity and prevention – reduce unwarranted variation, strengthen prevention in primary and community care which will reduce burden on this care domain and stop low value interventions.

Most important changes that people want:

- Create a single digital urgent care front door with e-triage and decision support. Fix information fragmentation such as usable shared records and design systems that genuinely support clinical workflows, and the need to avoid simply shifting administrative burdens.
- Ensure critical care and diagnostics are ringfenced.
- Separate and fast-track frailty from generic acute admissions. Early identification in the community/ambulance is key, dedicated frailty capacity with rapid turnaround.
- Guarantee 24/7 senior clinical decision maker presence and expand advanced practitioner roles and PART cover overnight.
- Make Treatment Escalation Plans routine and ensure sharing and visibility. To be initiated in primary care and mandated and embedded in triage processes.
- Shift avoidable activity into community settings including admission avoidance, early therapy, step-down, 7-day community services. Ensure incentives and contractual arrangements in primary care influence willingness to take on shared care responsibilities.

- Create headroom by repatriating patients promptly post-tertiary care and stopping low value investigations/follow ups.
- Build a system that learns, adapts and improves – Use data we already have available (such as Patient at Risk, medical examiner, pathway data) to prioritise out of hours improvements and target variation.
- Embed mental health and psychology within acute MDTs and ensure inclusive terminology approaches across pathways.
- Strengthen behaviour and culture change including encouraging taking ownership, feedback, learning from past initiatives, psychological safety, employee wellbeing.

Steps to achieve this:

- Align 111/GP/WAST/ED with a common triage streaming model.
- Establish a unified, integrated model of care, creating easier communication channels for primary, community, secondary and regional partners to work together.
- Deploy e-triage with risk scoring (eg NEWS2) integrated to EPR.
- Improve real-time visibility and dashboards. Improve interoperability and reduce fragmentation by implementing shared records, digital tools and acceptable patient information that support decision making and pathway navigation.
- Invest in critical care estates.
- Scale community IV therapy.
- Prioritise early identification and timely intervention – strengthening systems for recognising deterioration (including frailty), enabling faster diagnosis and rapid access to the right care environment.
- Introduce dedicated pathways and settings for frail patients to avoid unnecessary acute admissions and ensure earlier, tailored intervention.

- Ensure consistent senior presence and multidisciplinary capability across all hours, reducing delays and supporting safe, timely decision making.
- Make Treatment Escalation Pathways routine, proactive and shared across all settings so patient preferences and limits are understood before a crisis.
- Adopt a “discharge from day one” approach, ensure seamless transitions between care settings, and repatriate patients promptly to create headroom in acute services.
- Use existing data, feedback loops and consistent review cycles to drive continuous learning, reduce variation and strengthen quality and safety.
- Expand and optimise advanced practitioner roles, embed mental health and psychological expertise, and encourage disciplines to take ownership aligned to their strengths.
- Focus on prevention in the community, address inequalities in access and outcomes and ensure consistent application of effective interventions across the region.



5. System Enablers

Throughout the engagement, a number of system enablers were identified and repeated:

- **Digital interoperability and usability**

- Emphasis on a “One Digital System” by co-designing with clinicians and enabling data flow across primary/community secondary care.

- **Workforce sustainability**

- Repeated concerns around capacity shortfalls, burnout, repeated unsuccessful business cases, retention issues, development and psychological safety. Calls for stabilising the current workforce through adequate staffing, retention and training. Colleagues have requested routine leadership walkabouts to increase visibility of leadership.

- **Estates & Infrastructure**

- Numerous access and safety risks, demoralising environments, parking barriers. Our colleagues described prolonged delays for essential repairs. Estates is seen as a critical enabler for the Clinical Services Plan to be a success.
- Colleagues have noted that departments cannot accommodate safe access for patients in some areas (Vascular Ultrasound, Medical Physics) and this creates inequitable care based on mobility.

- **Prevention & Community Shift**

- The requirement of an upstream shift, particularly in managing chronic conditions within the community.

- **Integration & flow**

- Improve discharge including earlier social care involvement, introduce on-site social workers, address outliers and LoS drivers, protect elective capacity.

- **Research and data**

- Embedding research in routine care and reducing low-value activity.



6. Next Steps

Following the completion of this engagement phase, the Clinical Services Plan will now move into the drafting stage. We will continue working closely with colleagues and partners throughout the drafting process to keep the conversation active and ensure the plan reflects the insight and experience of those delivering and receiving care. Once the plan is published, we will implement an 18-month communications and engagement plan to maintain momentum, support implementation and ensure engagement remains ongoing rather than ending at publication. It is important that the Clinical Services Plan is not viewed as a detailed service specific plan, an operational plan or a short-term delivery document. Instead, the Clinical Services Plan will provide a high-level strategic road map that aligns clinical service priorities with wider organisational strategy and provides the long-term vision and direction of clinical services through to 2035.

7. Appendices

7.1 Appendix A

Colleague and Partner Engagement

Some of the forums were attended multiple times throughout the engagement period to maximise engagement and keep colleagues and partners updated on progress. Returning to groups allowed us to check emerging themes and ensure colleagues and partners had repeated opportunities to contribute. A full list of engagement activities is below:

- X2 Organisational wide design workshops
- Drop-in sessions held in UHL, Cardiff Edge, CRI, Barry Hospital, UHW, Woodland House, St Davids
- 8 online webinars
- Ask Suzanne – local CAV engagement monthly forum
- Strategic Leadership Team – CAV leadership meeting
- Operational Delivery Group – Forum for high level operational updates, direction and action
- Assistant Medical Directors/Clinical Directors
- Directors of Nursing – meeting held internally for all Directors of Nursing
- Therapies Quality meeting
- Independent Members – meeting held for members as part of the Board
- Local Medical Committee – statutory representative body for GPs in the area
- Local Partnership Forum – the formal mechanism for the Health Board and Trade Union/Professional Organisation Representatives to work together to improve health services.
- Clinical Boards – Children & Women, Clinical Diagnostics & Therapies, Medicine, Mental Health, Specialist Services, Surgery, Primary, Community & Intermediate Care
- Integrated Planning Group – meeting held internally to ensure that plan development across the organisation is aligned, integrated and consistent with our organisational planning framework

- Internal Digital team
- Internal Public Health team
- Internal People & Culture team
- Internal Capital, Estates & Facilities team
- Primary Care Clusters – North, Cardiff West, Western Vale
- Staff Networks – One Voice, Access-Ability, LGBTQ+, Rhywd-iaith
- Regional Partnership Board – provides strategic leadership across health, social care and the third sector to integrate services and improve wellbeing, working under statutory duties in the Social Services and Well-being (Wales) Act 2014
- Regional Partnership South East Wales – Carries out the same statutory functions as the Regional Partnership Board, but for the South East region specifically
- Public Service Board – Vale of Glamorgan – meeting held for public service agencies and other stakeholders to discuss and plan how to improve the social, economic, environmental, and cultural well-being of a local area
- Public Service Board – Cardiff – meeting held for public service agencies and other stakeholders to discuss and plan how to improve the social, economic, environmental, and cultural well-being of a local area
- National Clinical Services Plan Group
- All GP surgeries, Optometrists, General Dentists and Community Pharmacy
- CAV/Velindre Partnership
- Community Pharmacy Wales
- Board and Quality Committee – provides advice to the Board with regard to the quality and safety of health services and the experience of patients, including public health, health promotion and health protection activities.
- Medical Advisory Group – a group providing expert clinical advice
- Senior Medical Staffing Committee – a forum representing senior medical colleagues
- Local Negotiating Committee – CAVUHB and the British Medical Association reps (BMA)
- Teaching session at All Wales Genomics Service

