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

Contents

1 Introduction

Our Clinical Services Plan 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 population 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 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.

Our Plan will create a **single, integrated model of care** to deliver on our vision:

By 2035, we will deliver digitally enabled, person centred care closer to home, providing more equitable and sustainable services which start with a clear focus on prevention. We will do this by building capacity with our partners, informed by research and innovation, to meet people's needs.

Our model of care includes four interrelated care domains. Together these cover all our services and meets the needs of all our population. It is a deliberate move away from the traditional description of care as a series of clinical sectors and specialities.

Delivery of the changes set out in the Plan will require a focused, proactive effort across the breadth of our system, from our senior leadership to our clinical leaders and teams, the wider Health Board, and our partners. Through intentional, collective action to deliver this plan, we can set ourselves on the path to implementing a model of clinical service delivery in Cardiff and the Vale that is supportive of our workforce, financially sustainable, and effective in helping keep our population healthy.

The Plan starts by setting out what we aim to do to improve how we deliver for patients, making the compelling case for why we need to change our clinical services through to 2035. 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. Finally, we describe the engagement that informed this Plan, how we co-designed its content, and the principles that guide it.

2 A compelling case for change

The Case for a Single, Integrated Model of Care

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

Our Clinical Services Plan through to 2035 must be ambitious and radical. The consensus from our engagement and co-design with colleagues, communities and partners is that the current model does not 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 to reduce disease and crises starting at birth
- Integrates care around the needs of people
- Is 'community by design' rather than hospital by default
- Delivers value for money to achieve the highest possible quality of care for patients from our public funding
- Embraces scientific and technological innovation
- Is delivered in partnership with communities, councils, universities, neighbouring Health Boards, specialist NHS Trusts and the Third Sector
- Develops our workforce to play their part in delivering this.

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

Rising Levels of Need

Starting Well

To improve the health of our population in the long term we must prioritise the health needs of babies, children and young people.

We have made significant improvements in paediatric health and care, most recently developing integrated clinics for children bringing specialist paediatricians into local communities. This has reduced the demand for new appointments and the number of missed appointments by half, in addition to reducing waiting times from between 26-36 weeks to just 8 weeks.

Despite this progress, we know that over the lifetime of the Plan, the need for healthcare amongst children, young adults and parents will continue to rise. Local Authority population projections show:

An increasing **0-4-year-old** population (Cardiff **+3.1%** and Vale **+1.9%**), unlike the rest of Wales

29% of children in Cardiff and **24%** in the Vale, **live in poverty** (after housing costs)

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)

9% of mothers **smoked during pregnancy**

Uptake of key child vaccinations is also concerningly low, increasing the risk of avoidable infectious disease outbreaks such as measles.

Section three of this Plan details how we intend to address these challenges through the Starting Well care domain, which aims to coordinate services as a network designed around the physical, mental, and social needs of children, ensuring that every interaction contributes to improved outcomes. Increasingly, we will deliver services from community hubs, bring together services into integrated neighbourhood teams, and ensure we use the information available to predict and prevent ill health in early years.

Enabling Health and Wellbeing

In recent years we have implemented a wide range of initiatives to keep our population healthy and well.

These range from establishing community clinics in deprived areas, to increasing support for smoking cessation, and rolling out genetic testing for rare diseases and cancers. This Plan emphasises prevention and early intervention as being fundamental to the long-term sustainability of healthcare delivery.

Whilst we have already made progress, it is critical that we recognise how much more there is that we can and must do to manage the demand on services amongst our adult population over the course of the Plan's lifetime. Projections show that over the next 10 years:

The number of people in our two local authority areas will be among the fastest growing in Wales:

Vale of Glamorgan +7.3%

Cardiff +6%

All-Wales average of +3.7%

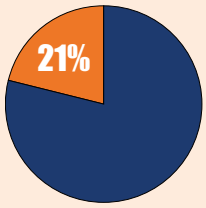
Over 10,000 more people in the Vale, and 24,000 more in Cardiff

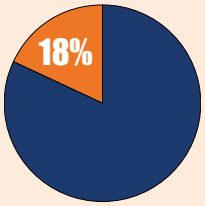
A rapidly ageing population, with the number of people aged 85 or over increasing by around 50% in the Vale and 40% in Cardiff. This means 5,200 more people in this age group.

There are stark differences in the life expectancy between people living in our least and most deprived areas. If you live in one of the least deprived areas across Cardiff and the Vale, you can expect to live 8.3 years longer as a woman and 9.3 years longer as a man than if you live in one of our most deprived communities. Despite efforts to reduce this disparity, the gap continues to grow.

Behaviour that drives ill-health and creates demand is often the result of wider economic, environmental and cultural conditions, such as affordability, time available to be active or prepare healthy food, income, and housing conditions. Across Cardiff and the Vale:

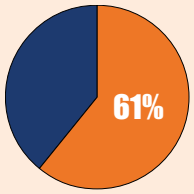
21% of adults are **inactive** (less than thirty minutes of physical activity each week)





18% of adults **drink more** than recommended guidelines

Across Wales, **61%** of adults report **feeling lonely** some or all the time.



All of this points to sustained increases in the health needs of our population with significant growth in long-term conditions and multi-morbidity. By 2035 there will be double the number of people living with four or more long term conditions. In addition, cancer rates and mental health issues are all projected to increase.

This is why continuing to deliver care using the current model will become more expensive, and crucially of lower value when matched against the underlying need of our future population.

We are aiming to address these challenges through the Enabling Health and Wellbeing care domain. Its purpose is to help people live well for longer by intervening earlier, preventing avoidable ill health, promoting wellbeing, and reducing unfair differences in outcomes.

This care domain will adopt a whole-person approach, recognising the interconnection of physical, mental and social needs, to deliver care that is proactive, targeted, and personalised to suit individual needs and circumstances. We will organise and integrate care around pathways rather than organisational, professional or service boundaries and we will deliver care closer to home where possible. This will help us reduce duplication, improve timeliness, and prevent crises and the need for escalation.

A Health and Care System Under Pressure

Projections show that our current workforce model will not be sustainable over the next decade. Supply pressures are intensifying due to an ageing workforce, declining fertility rates, growing international competition for key professions and rising economic inactivity linked to poor mental health. At the same time, demand on the workforce will increase as the population ages, long-term conditions become more prevalent, and care needs become more complex. These challenges are compounded by changing expectations around responsiveness, flexibility and wellbeing and the need to shift care from hospital-based models to community and integrated settings.

This is why we have placed such a focus on the need to reorientate our workforce in line with the evolving way in which we plan to deliver care. We recognise the extent to which the capacity of our workforce is stretched and that current workforce pressures are unsustainable. Only with a fundamental change in how we plan, develop and support our workforce, including new roles, skills, flexible ways of working and stronger retention, will we be able to deliver the ambitions of this Clinical Services Plan and meet future population needs.

Scheduled Care

We have made progress in reducing long waits for care across our services. This includes working with other Health Boards to create centres for care across organisational boundaries ensuring people can access planned care quickly. In the last year our Regional Ophthalmology Programme has made significant inroads, reducing the number of people waiting for cataract surgery by half.

Despite this progress, our services report real challenges in meeting current demand. Our system is already under severe pressure, and this will intensify as our population grows and health needs increase.

General 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

Single Cancer Pathway referrals have increased by **38%** and outpatient referrals by **10%** over the three years to 2025

Planned care waiting lists and times remain high, despite focused efforts to reduce them

Patients with long hospital stays (more than 22 nights) represent **60%** of the total length of stay but only **1%** of the population.

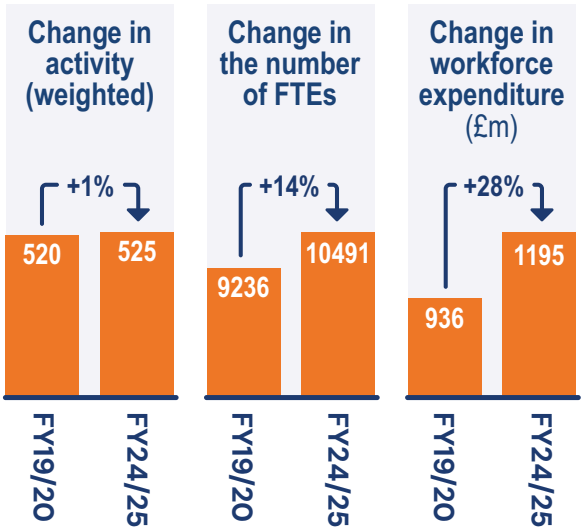
Our health and care system is characterised by having to focus on reactive and crisis care, with bottlenecks and delays at multiple points along the care pathway.

Patients and colleagues must navigate and overcome disconnects and silos within and between pathways and services, which is ineffective and stressful. We are not taking the opportunities that exist to prevent illness and crisis, work proactively, and provide alternatives to hospital. Hospital is too often the default solution.

Once admitted, patients stay in our hospitals too long. Our average length of stay is three days longer for scheduled care patients than our benchmark hospitals

If we carry on with our current model of care, we estimate that in the next five years we will need another **300–400** hospital beds and **3,600** more staff to cope with the predicted rise in demand. This is undeliverable and unaffordable

At the same time, productivity is falling and financial pressures are increasing. Between 2019/20 and 2024/25, there was a **24%** drop in workforce productivity in acute care settings (see figure 1 for activity relative to workforce and expenditure levels).



1. Includes all FTEs under the following clinical boards: Primary and Community Intermediate Care, Mental Health, Medicine, Specialist Services, Surgical Services, Children & Women.
2. Inflation-adjusted.

Source: NHS C&V UHB, StatsWales

Figure 1. *Change in Activity, the Number of Full-time Equivalents, and Workforce Expenditure Over Time*

Modelling shows we need to improve acute services productivity (e.g. length of stay, theatre utilisation) by 7% and to deliver a 2% per annum shift of care from hospitals to community-based services and prevention. Together, these would enable us to reach a point of financial balance. Without this, our deficit will continue to grow to as much as £560 million per annum by 2030/31.

Our Scheduled care domain, set out in section 3, describes how we will manage this increasing demand via the delivery of planned, non-emergency care in a way that is more personalised, preventative, digitally enabled and delivered as close to home as possible. Successful adoption of the model set forward in this care domain will result in improved accessibility of care across our populations, reduced waiting times, and consistent, standardised pathways of care.

High Acuity and Time Critical Care

We have continued to focus on improving care for people who need rapid access or who have severe, unstable, or life-threatening conditions. We implemented Safe@Home in 2024 in partnership with Cardiff Council, Vale of Glamorgan Council and the Welsh Ambulance Service Trust, aiming to prevent avoidable admissions by supporting people at home through a multidisciplinary team. Since its launch it has supported more than 1,000 people and helped avoid more than 9,200 hospital bed days. In 2024/25, we also reorganised our Emergency Unit and assessment units. This enabled our Health Board to achieve the best performance in Wales for ambulance handover times.

However, our system remains under significant pressure, with high numbers of patients coming to our Emergency Unit, long lengths of stay for inpatients, difficulties and delays in discharging patients, and limited alternatives to acute hospital care.

Emergency Unit attendances increased by **7%** over the two years to 2026

Our average length of stay for emergency medicine patients is almost **two days longer** than our benchmark hospitals

111#2 calls from people in mental health crises or requiring urgent support increased by **41%** during 2025/6.

This means that our solutions must address the systemic root causes rather than simply manage the symptoms. Our Plan's fourth care domain, *High Acuity and Time Critical Care*, emphasises early recognition, rapid intervention and coordinated escalation, ensuring people receive the right level of care first time whether at home, in the community, or in advanced hospital settings.

Over the next decade, new medicines supported by the advancement of predictive analytics and AI supported decision tools, delivered by a resilient and sustainable workforce of multidisciplinary teams, will enable early intervention, improved outcomes, and reduced unwarranted variation in high acuity and time critical care.

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.

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 considerable proportion of the country's highly specialised (low-volume and highly complex) services for the Welsh population.

We have also recently established Cardiff Health Partners with Cardiff University and Velindre University NHS Trust, a collaboration that aims to align discovery science, healthcare, education, and industry partnerships to accelerate innovation into clinical practice, improve health and equity, and drive inclusive economic growth and regeneration. We are focusing on three themes:

Tailoring prevention and treatment strategy for our population's health

Driving breakthroughs in Brain Science and Mental Health

Researching and delivering the next generation of treatments for complex cancers

Digital technology and capability are a crucial enabler of this Clinical Services Plan and the capacity of our services to transform through to 2035. The Digital Strategy (2025-2030) describes the significant challenges facing the Health Board caused by outdated digital infrastructure and fragmented systems.

The Welsh Government has a vision for an all-Wales Electronic Health Record, 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 towards proactive, joined up care.

3 A single, integrated model of care

Integration must be the driving force framing the long-term development of our clinical services. This is the clear message from our widespread engagement and exploration of the future for clinical services in Cardiff and Vale.

Our Clinical Services Plan through to 2035 will deliver on our vision through the delivery of a single, integrated model of care that covers all our services and meets the needs of all the populations we serve. It is a deliberate move away from the traditional description of care as an assortment of clinical specialities and sectors.

Our single, integrated model of care will be organised around four care domains (see **figure 2**). Together, these 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

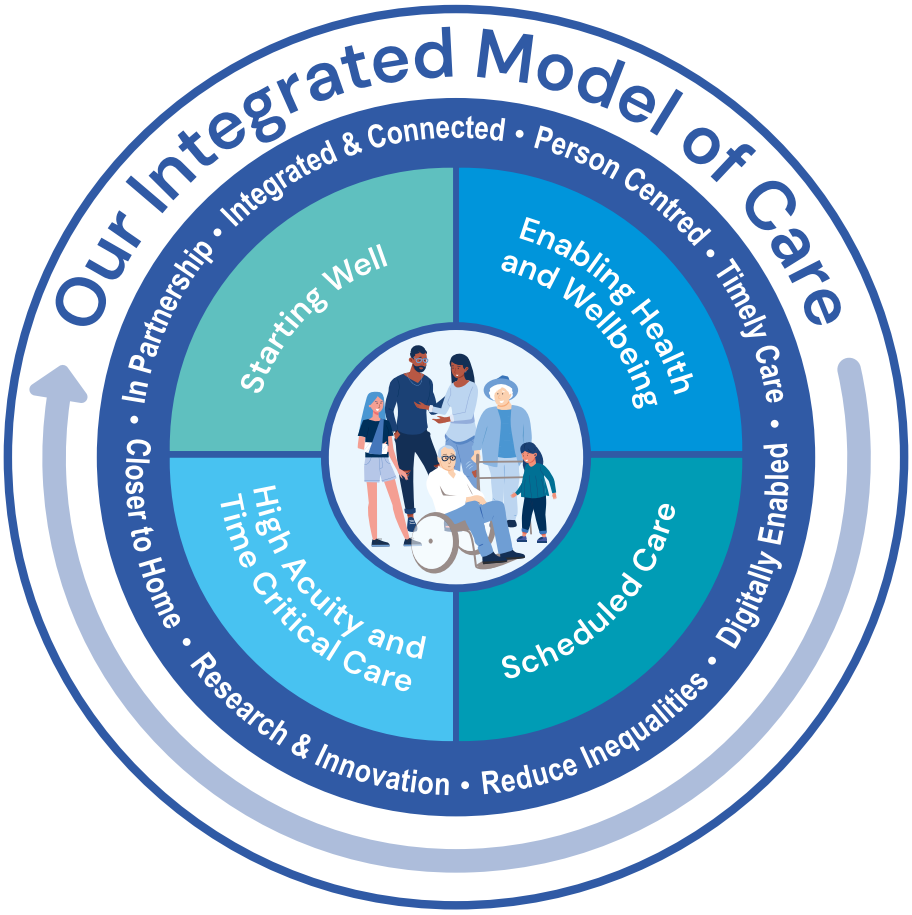


Figure 2. *Our Integrated Model of Care*

Each care domain is made up of **components** that together work to integrate care across all our services and settings. These components will form the framework for all our clinical services to develop their own more detailed long-term plans.

All our clinical services will play a key role in delivering all these care domains.

A. Starting Well

Overview

The Starting Well Care Domain outlines our commitment to ensuring that babies, children, young people and families in Cardiff and the Vale enjoy the strongest possible foundation for lifelong health, wellbeing and opportunity. This Domain is rooted in the guiding principles of 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 the 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 (including 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 in

their communities rather than at a single building and through a single, disconnected service.

Delivering this ambition can only be achieved by working with our partners, particularly the local authorities and third sector. This care domain mirrors and will be supported by the Regional Partnership Board's Starting Well Partnership bringing together the right partners to deliver the multi-agency changes needed to improve the First 1000 Days of a child's life.

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 continued 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 learns and continually betters itself to improve outcomes and experiences for future generations.

What the future looks like

The Starting Well Care 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 the recently launched Women's Health Hub, our Babies, Children Young People Plan and our RPB '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 to Emotional Wellbeing and Mental Health Services 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 services, 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 twenty-five. 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 information and a 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

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, Third Sector partners and communities. This care domain is rooted in the guiding principles of supporting people to live well, reducing health inequalities, and 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 into 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 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, reablement and domiciliary care and voluntary, community, and social enterprise partners, these teams will provide coordinated support for defined neighbourhood populations.

Integrated Neighbourhood Teams will adopt a whole population approach, co-designed with local communities, and will 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, coordinated with local authority Information Advice and Assistance services, 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-centric, episodic models to integrated, community-based care delivery. 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) to reduce 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 delivered in homes and communities, replacing Emergency Unit attendances and inpatient care
- Integrated Neighbourhood Teams as 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

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 care domain includes mental health and cancer.

Care will 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 necessary, it will increasingly be provided through resilient 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 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 diagnoses.

(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 that cross traditional

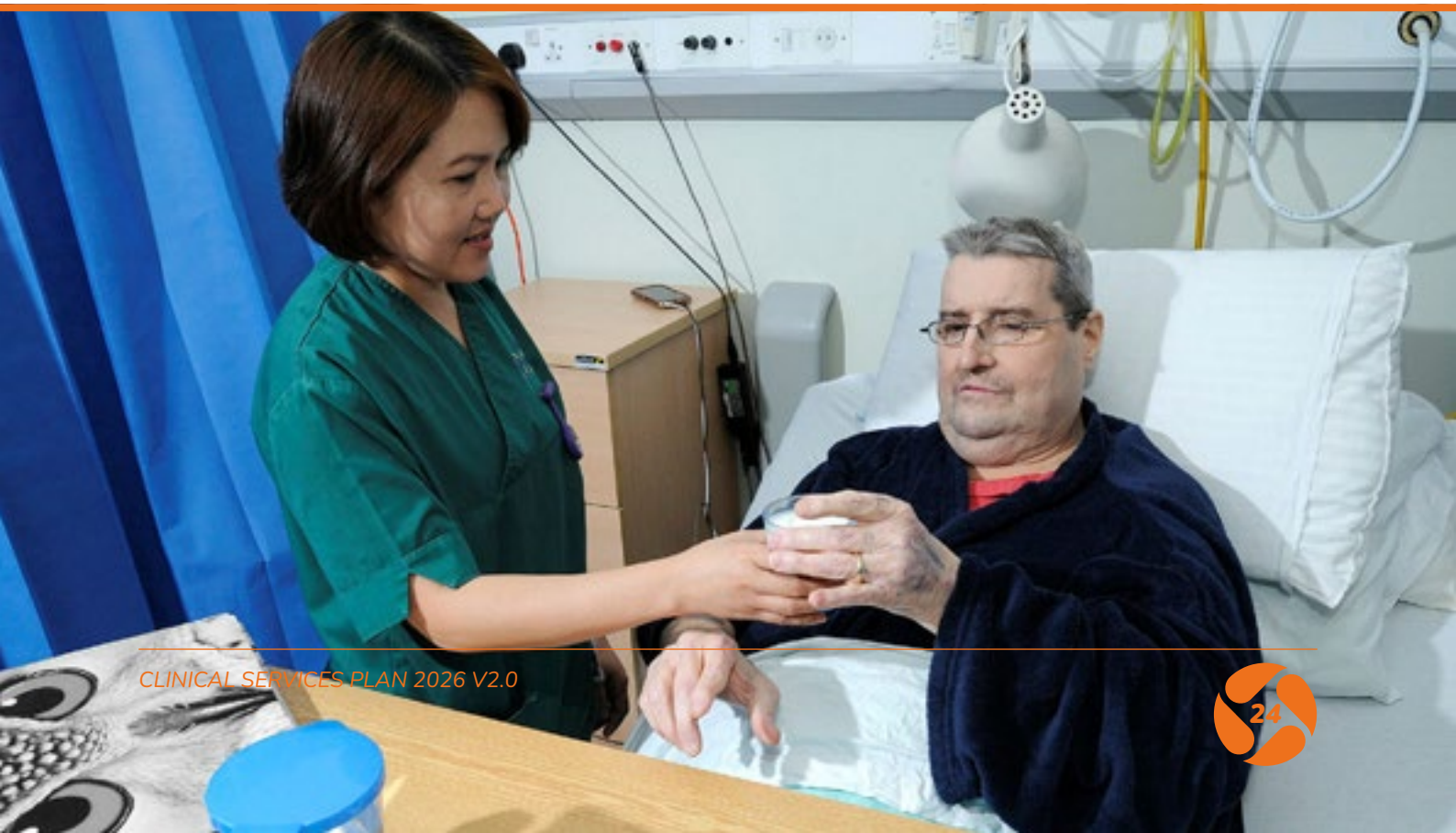
geographic and organisational boundaries. These will be within Cardiff and Vale and through our partnership with other Health Boards and Trusts in the South-East Wales region and our Specialised Services partnership with Swansea Bay University Health Board for those with the most complex and rare needs.

(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 care in a timely manner from referral to treatment, meeting all national waiting time standards for cancer and planned care
- Patients receive personalised, compassionate care that is convenient, under their control
- Scheduled care is delivered closer to people's homes where possible, and is 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 are in place, delivering improved outcomes, safety and patient experience.



D. High Acuity and Time-Critical Care

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 High Acuity and Time Critical 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 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, and 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 our services supported by our partnership with Cardiff University, Velindre University NHS Trust 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 needs are treated in a safe and timely way to deliver the best outcomes.

Outcomes

The right care is provided in the right place; services can 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 the time of day (24/7)

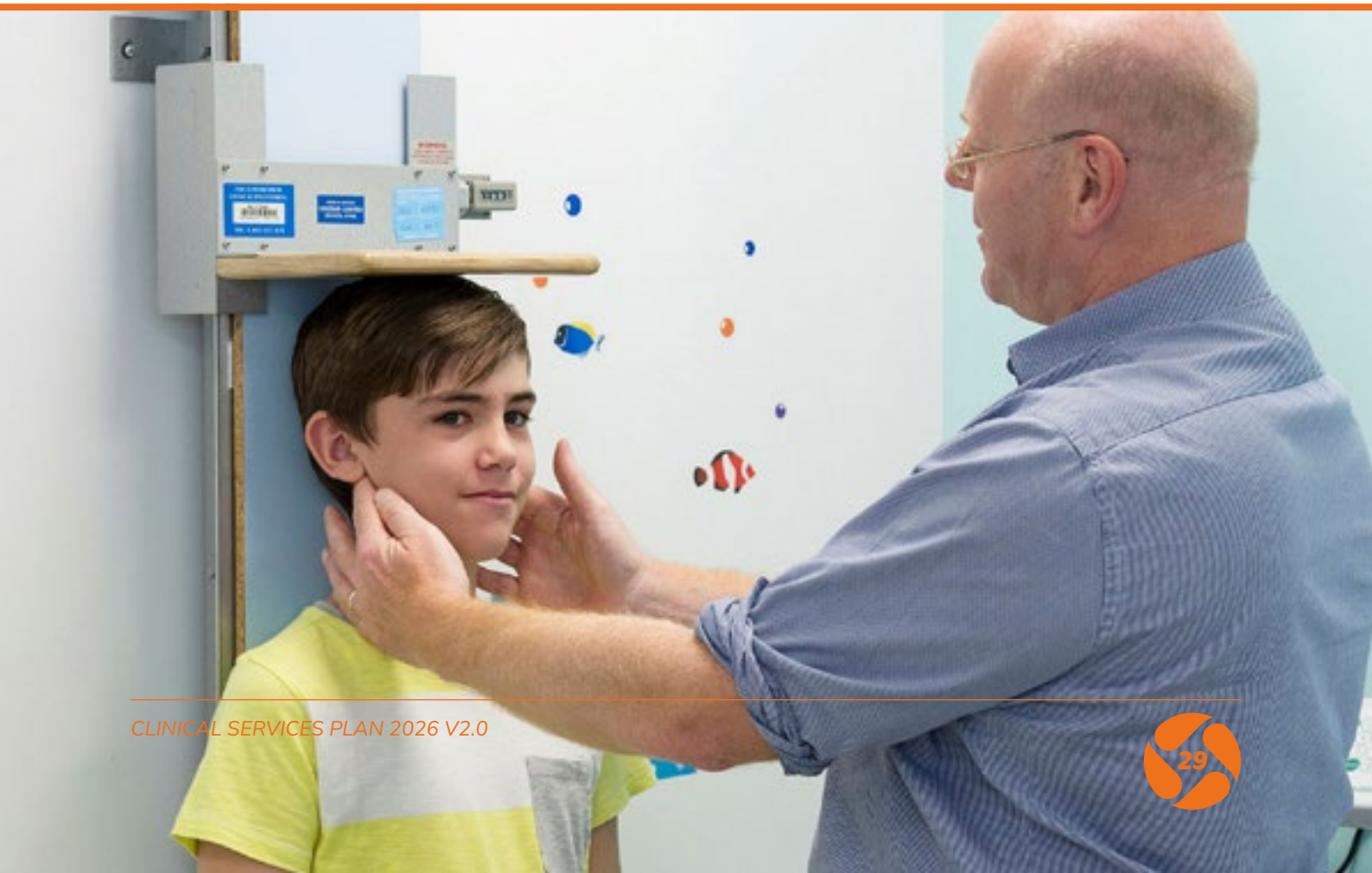
Care is consistent across Cardiff and Vale and South Wales, supported by effective clinical networks

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	Integrated digital care records and plans		

Figure 3. *The constituent components of each care domain*



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 vision for future services:

By 2035, we will deliver digitally enabled, person-centred care closer to home, providing more equitable and sustainable services which start with a clear focus on prevention. We will do this by building capacity with our partners, informed by research and innovation, to meet people's needs.

We 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.

4 Delivering our Clinical Services Plan

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 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 that supports our workforce, is financially balanced, and delivers for patients.

Priority One – 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 two describes 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 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 need to improve annual productivity in acute services (e.g. length of stay, theatre utilisation) by at least 7% to deliver care that is financially sustainable.

In the early years of this plan, we will give particular focus to:

(i) Reducing time spent in hospital

Data-based modelling tells us that it is within our gift to reduce our medical average length of stay from 12.8 days to as little as 4.5 days. By focusing on ward processes, reducing length of stay, strengthening clinical decision-making, and accelerating discharge across our hospitals, we 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 a focus on a range of programmes across which there are gaps between our current and projected potential productivity, such as theatres, outpatients, length of stay, and community services, as well as a focus on diagnostic stewardship and delivery against Getting it Right First Time (GIRFT) standards and High Volume Low Complexity principles and performance.

In the case of outpatients, for example, modelling tells us that through system and process-based improvements we can cut the average 'did not attend' rate by more than a third and lower the follow-up to first appointment ratio from 2.6:1 to 2:1, improving productivity on a system level, rather than through unsustainably increasing workload and pressure on our workforce.

(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 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

Prescribing will follow standardised, evidence-based pathways to ensure people receive the most clinically appropriate and cost-effective treatments. These pathways will be supported by value-based indicators and digitally enabled governance, making prescribing safer, more consistent, and more efficient across all services.

Priority Two - Changing the Demand for Healthcare

The case for change in section two also describes how the needs of our population will continue to increase, which will drive increased demand for health care. While our model remains reactive and hospital centric, this could slow our ability to invest in alternatives to hospital care and make the redevelopment of University Hospital 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% per annum shift of care from hospital to community and prevention. Our focus must start with those people with the highest needs.

Working in partnership will be vital to our success here. In practice, factors beyond healthcare services account for most (around 80%) of people's health outcomes, meaning partnership with Local Authorities, the third sector, and communities are essential to making a real difference.

Workforce redesign will also be critical to enable delivery of the new model of care closer to home.

(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 one of this plan, we will agree the local geographic footprints 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 of and access to care whilst reducing costs and time spent in hospital.

(ii) Unified mental health model of care

We will develop a unified mental health model of care in line with the new National Mental Health strategy as another key early building block. It responds to rising demand and acuity, and fragmented 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.

Key priority areas in the model will focus on:

- Acute flow and out of area
- Primary mental health services
- Discharge and social care interface
- Strengthening CMHT specialist pathways stabilisation
- ADHD / ASD demand and waits

The above model will rely on partnership and collaboration, strong leadership across the system and robust workforce planning and design and the development of integrated data systems.

(iii) Improving metabolic health

Focusing 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 earlier, we can prevent conditions such as chronic kidney disease, diabetes, and heart disease from worsening and reduce pressure on health services.

Priority Three - Designing 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 will 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 to as close to delivery as possible
- Supporting greater levels of partnership working
- Increasing 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 the 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 and operating on a business-as-usual basis, 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 and digital planning to ensure neighbourhood-based, multidisciplinary care is established as the foundation of the health and care system with 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 the 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:

University Hospital of Wales (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 colocation 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

As a Health Board we have one strategy and several long-term plans that set out how we will deliver on our vision (see **figure 4**). This plan sets out the future model of care, and sits alongside other long-term plans including:

Population Health – which aims to describe in more detail how we will increase life expectancy, reduce inequity, and shift more of the Health Board's focus and spending to prevention

People and Culture – which aims to describe the changes needed to Improve staff experience, wellbeing, inclusion and capability, ensuring our workforce is fit for the future and enabling the ambitions set out within our Clinical Services Plan

Digital – which aims to provide a clear roadmap for how digital technology will enable the transformation of clinical services

Estates – which aims to provide a clear, long-term plan to ensure the estate supports safe, high-quality services while maximising value, reducing risk and enabling targeted investment.

Collectively, these inform our Integrated Medium-Term Plan which is refreshed each year and sets out delivery in years 1-3.

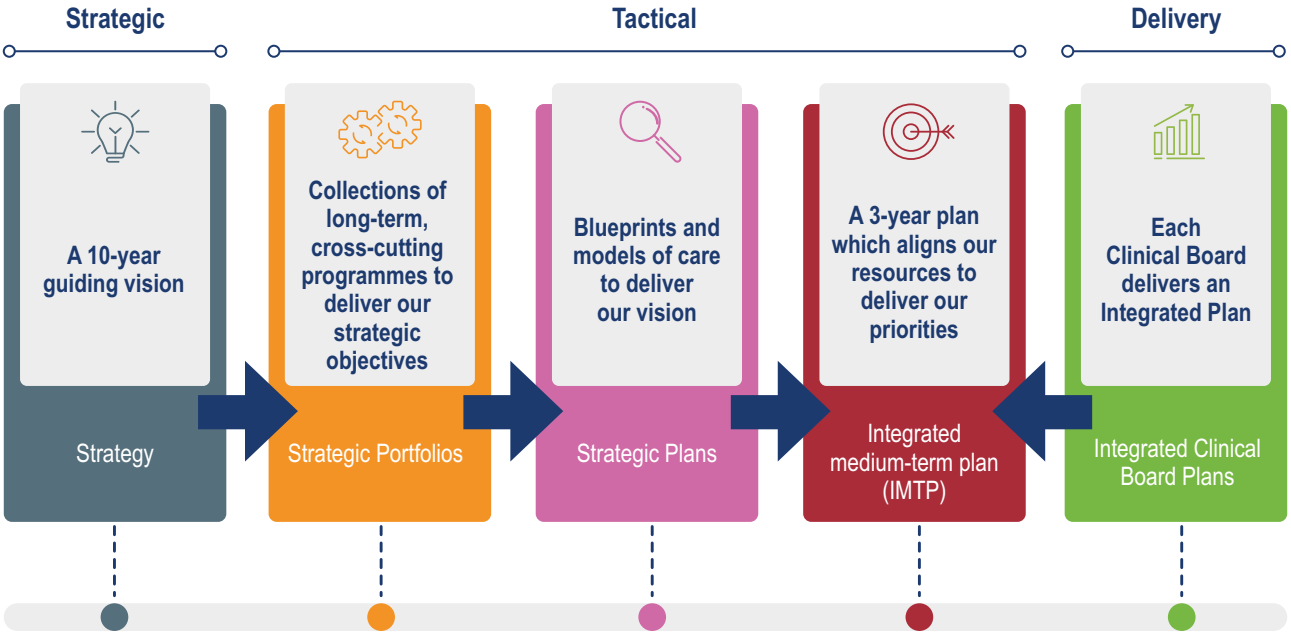


Figure 4. Interrelationships within the Strategic Planning Framework

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, the Board has approved several strategic portfolios. Collectively, these oversee our long-term transformation programmes and provide a disciplined, whole-system mechanism for turning our strategic plans into delivery. The focus of each portfolio is as follows:

1. **Population Health** - Improving population health outcomes and reducing inequalities
2. **People & Culture** - Creating the organisational conditions, leadership capability and cultural foundations required to deliver the future model of care
3. **Quality** - Ensuring safe, reliable, outcomes-driven care by embedding a whole-system Quality Management System and value-based approaches
4. **Clinical Services** - Redesigning services and pathways in partnership 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 allow for plans to develop jointly and alignment of information, resources and efforts

Ensure alignment with our workforce planning processes, 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 requirement for capital development across our infrastructure portfolio

Throughout this plan, there is an emphasis and reliance upon working with partners to deliver our ambitions for the people we serve. Coordination and alignment of strategic, tactical and operational planning and delivery across our partners will be supported through our established partnership governance arrangements, particularly the Cardiff and Vale Regional Partnership Board and Regional Joint Committee for South East Wales.

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.

shaping services for the future, together.

5 Co-design and principles

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 twenty-week period of public engagement with over fifty different engagement activities across our communities
- Thirteen weeks of engagement with staff and partners with more than sixty 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
- Co-production 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 four hundred 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 domain approach worked, and we gathered most of the content that is reflected in section three.

Clinical Services Planning Principles

These principles have been co-produced and tested with the public, colleagues from across the organisation, and our partners.They align to the National Health and Care Quality Standards and describe what is most important for our planning, they guide the content of this plan, and the underlying values that will govern its implementation. They are not aspirations, but rather statements of intent:

1. People will receive timely and effective care whether facing an emergency, a planned procedure or a crisis, ensuring best 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.

Acknowledgements

We would like to thank all staff, partners, patients and communities who have contributed their time, insight and expertise to shape this Clinical Services Plan—your collaboration has been central in reflecting our shared ambition for one integrated model of care that improves health, reduces inequality, and delivers care closer to home.

6 Glossary and references

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

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

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.

Productivity

The amount of healthcare activity and outcomes delivered (outputs) relative to the resources used to deliver them (inputs), such as workforce (time, cost and skills), money, medicines and infrastructure.

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 extremely sensitive to speed of recognition, diagnosis, and treatment, requiring 24/7 specialist capability.

Medical Illustration
Darlun Meddygol

Report designed by Medical Illustration

MedicalIllustration.CAV@wales.nhs.uk