The National Community HealthPathways Programme in Wales

Learning from the first 2 years

July 2025

CONTENTS

Acknowledgements

Planning, and promotion of the survey was facilitated by the programme teams in Aneurin Bevan University Health Board, Swansea Bay University Health Board, Cwm Taff Morgannwg University Health Board, Cardiff and Vale University Health Board, and Hywel Dda University Health Board.

Work to scope "What Matters to Us" was enabled by collaboration with Magda Golebiowska in Cardiff and Vale University Health Board Value in Health Team and Brett Denning, Bethan Clift, and Meredith Graham from the NHS Executive Planned Care Team.

Yma also would like to acknowledge the contributions to this work from Streamliners UK Ltd, Streamliners NZ Ltd, David Todd, and Care Unbound Ltd.

1 EXECUTIVE SUMMARY

Yma (Dyma Ni Ltd) and Here (part of Care Unbound Ltd) were commissioned by Streamliners UK Ltd in September 2024 to undertake Stage 2 of a project to collate learning, and support understanding of impact in the Community HealthPathways programme in Wales. The project followed on from data mapping in Stage 1 and delivered a learning framework, conducted primary data collection, and created a dashboard tool to support independent evaluation of the programme.

Insight is divided into five areas, determined through the "What Matters to Us" scoping exercise. NHS stakeholders identified what criteria they would measure the success of HealthPathways against, enabling the team to create a bespoke data visualisation tool to support their evaluation needs.

Impact presented here is separated into the mature implementation in Cardiff and Vale University Health Board and new implementations in Hywel Dda, Aneurin Bevan, Swansea Bay and Cwm Taff Morgannwg University Health Boards. Process and system observations presented here offer opportunities for refinement in the upcoming years of implementation and use of HealthPathways.

Creating a tool with value

Engagement in CAVUHB has progressed well and is on a par with successful established implementations in New Zealand, Australia and England.

The new sites are generally showing increasing engagement as the programme develops. Some Health Boards have higher levels of engagement per head of population, which offers potential for sharing best practice in communications and promotion activities between sites. Continued localisation of pathways, clinician engagement, pathway-based clinical education, and triage against agreed referral criteria are key strategies to increase engagement.

Supporting Clincial Practice

Survey data shows that not only is Community HealthPathways preferred as a source of guidance over NICE in 55% of users after only 2 years, in CAVUHB 78% if users prefer it. The majority also report that using Community HealthPathways, it is easier to find localised information on medication, tests, and investigations.

Building on existing feedback, collection of ongoing survey data throughout the transition to Business as Usual will provide insight into the development of the programme in the upcoming years. It will also identify areas of best practice and offer opportunities for sharing learning to continue to provide clinicians with the tools they need.

Improving Patient Experience

Analysis of pathways, and request pages across the live sites in Wales, showed that HealthPathways provides material to support clinicians in supporting patient shared decision making and self-care effectively. These resources can include links to patient information, links to PROMs and PREMs, current waiting list times, and additional specialist resources where appropriate. Providing a reliable central location for this information enables updated information to be shared quickly and reduces the number of sources of information clinicians need to check to find what they need.

Enabling a National Learning Health System

Prior to the implementation of HealthPathways in Wales, there was no national mechanism to embed evidence and policy into primary care practice in Wales. The system of national pathways created in collaboration with Clinical Information Networks, and medical specialists, and localised by Health Boards rapidly distributes best practice and learning across the country, while sharing the workload to benefit everyone. This creates opportunities for the health system to continuously learn and adapt based on insights from routine practice data and emerging evidence.

Improving Efficiency and Directing Resources

Wales has pioneered the Pathway Sharing by Default strategy, distributing the pathway development workload across all Health Boards. The approach is more efficient when used across a wide geographic area, where warranted local variation may be necessary, but all areas aspire to uphold the best clinical standards possible.

In comparison with other implementations globally, Wales localises pathways, on average, 72% faster than other countries including New Zealand, Australia, and England.

The recent NHS Wales Ministerial Advisory group report [1] requires Health Boards to tackle unwarranted variation as soon as possible. HealthPathways makes any unwarranted variation easier to detect.

Recommendations

The NHS Wales HealthPathways programme is progressing well. Recommendations for continuous improvement include:

- **Increase awareness and understanding** of the programme at the most senior levels within NHS Wales and the seven Health Boards to leverage the opportunity which the national programme provides, to identify and address areas of unwarranted clinical variation and deliver system transformation.
- **Build on the national engagement strategy** including National Clinical Networks, to maximise adoption. Share engagement best practice and lessons learnt from review of the first two years with Health Board implementation teams, in particular BCUHB as it is working towards launch in 2025.
- **Continue to support collection of feedback** through consistent survey roll out to evaluate the impact of Community HealthPathways as the programme matures
- **Continue to uphold rigorous guidelines** on pathway quality, including measures such as waiting list links, and patient information to support best practice on the ground.
- **Review best practice** around placement of waiting list links to quantify the time benefit of more detailed link inclusion.
- **Support benchmarking** of progress at a local, regional, and national level to ensure effective comparisons are being drawn and to maintain momentum of the programme into the future.
- **Encourage network collaboration** in new pathways to streamline localisation and provide opportunities to identify variation in local services, therefore optimising the impact the national approach affords as the foundation of system improvement
- **Develop an ongoing approach to evaluation** for the next phase of implementation and entry into "business as usual".

[1] https://www.gov.wales/nhs-wales-performance-and-productivity-independent-review Accessed 14 July 2025

- **Continue the pathway sharing by default** strategy and support setting and delivery of milestones to complete localisation in all health boards.
- **Review milestone and implementation options** to include and support launch in BCUHB and PTHB, maximising pathway development and usage, and support a truly All Wales delivery

Summary

In summary, the ongoing roll out of Community HealthPathways in Wales has brought national clinical expertise together to create a suite of nationally aligned and locally relevant clinical guidance. The programme serves to support reduction in unwarranted variation in care across Wales.

Ongoing implementation and engagement with the programme will continue to expand the impact within the NHS. Recommendations here focus on applying learning from the first two years to support continued growth, and the launch of the new Betsi Cadwaladr University Health Board site. The HealthPathways programme is working in support of national priorities and encourages cross organisational collaboration to optimise NHS care in Wales, now and into the future.

2 BACKGROUND

The All-Wales Community HealthPathways programme launched in Wales in early 2023, the first national implementation of the Streamliners New Zealand [2] product in the world. This programme builds on the experience of Cardiff & Vale University Health Board (CAVUHB), who launched HealthPathways in 2019 and have an extensive catalogue of pathways already developed. As a result, they have played a key role in the national programme and transition to Pathway Sharing by Default across Wales. Most recently Hospital HealthPathways was procured as part of the national programme for CAVUHB, which launched in summer 2024.

The Streamliners Evaluation Toolkit is available to all Health Boards through the online help function [3]. Use is not mandatory, and, at the time of the initial evaluation discussions, it was apparent that the data required for a national evaluation was not widely being collected. Furthermore, there was no national lens to collating data for the wider review of the programme.

Yma [4] was invited to craft a proposal, in conjunction with Care Unbound Ltd (Here) [5] who provides a data warehousing and analytics function, to supplement the evaluation of HealthPathways' impact in Wales. This proposal had three stages:

Stage1: Discovery – scoping and understanding the data and architecture

Stage 2: Development – building a suite of interactive real and near-time dashboards and specific pathway assessment

Stage 3: Scale – Business as Usual and legacy for Wales, development in other areas and a plan for scaling

Stage 1 concluded in April 2024. The findings mapped what data exists, where it was held and what it might show. Most importantly, this high-level scoping exercise demonstrated the scale of the data barriers to independent evaluation.

Stage 2 concluded in December 2024, having built a Wales-centred feedback dashboard for the target audiences to support internal and external evaluation. Stage 3 commenced in January 2025.

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[2] https://www.streamliners.com/ accessed 27 June 2025
[3] https://onlinehelp.healthpathwayscommunity.org/index.htm?39869.htm Last accessed 31st January 2025
[4] https://www.dymani.cymru/ Last accessed 16 July 2025
[5] https://hereweare.org.uk/ Last accessed 16 July 2025

2.1 Pre-existing HealthPathways evaluation

Global body of evidence

Following implementation in other countries, including Australia, New Zealand, and England, various evaluation models have been developed. However, implementation in Wales has been on a national scale and with Pathway Sharing by Default. Streamliners curates a library of relevant literature on these other evaluations. [6]

Health Board evaluation activity in Wales

Several Health Boards have initiated evaluation projects. In Aneurin Bevan University Health Board (ABUHB), the main areas of interest are:

- Site utilisation
- User Feedback
- Pathway Effectiveness

Recommendations have been made to facilitate evaluation of these areas, including use of a national survey (designed and delivered as part of this project), utilisation data sourced from Google Analytics, and the introduction of more tools to connect pathways to referrals, including support by (Digital Health and Care Wales) DHCW to adjust coding practices to enable better data capture, both for HealthPathways programmes and more widely.

In Swansea Bay University Health Board (SBUHB) between September 2024 and January 2025, they worked to understand their locally available data, conduct manual auditing projects to mitigate where there is a lack of automatically collected data and agree Key Performance Indicators (KPIs) for the programme going forward.

In Cardiff and Vale University Health Board (CAVUHB), the Value in Health Team is working to develop metrics against which to measure Hospital HealthPathways, and in future, Community HealthPathways. Dr Simon Davies has also historically carried out pathway audits for quality and developed a suite of internal dashboards to observe changes in primary care over time, relating to Community HealthPathways alongside other concurrently running initiatives.

The consistent message when reviewing Health Board evaluation plans and progress is the lack of suitably granular data against which they can measure the impact of HealthPathways on patient and

[6] https://researchbibliography.streamliners.co.nz/bibliography/ Accessed 27 June 2025

clinician experiences. There is motivation to change this process with the help of DHCW but changes to systems such as the Welsh Clinical Communications Gateway (WCCG), the national system for electronic exchange of clinical information, are frequently challenging and have very long timescales.

2.2 National Evaluation Workstream

The All-Wales Community HealthPathways programme is organised into five workstreams, including Evaluation. The Evaluation workstream unifies work to evaluate the programme across the stakeholder groups:

1. The Yma and Here team have developed the "What Matters to Us" framework to enable the NHS Executive to focus commissioning. A dashboard was produced, available to the NHS Executive, external evaluators, and Health Boards to assist evaluation.
2. The NHS Executive Planned Care Team are leading on the internal NHS evaluation workstream, including preparation of contractual reporting and commissioning auditing work to collect primary impact data.
3. Health Board programme team representatives attend for support, to share best practice, and collect feedback

Members of the Streamliners UK [7] team also attend, when possible, to contribute guidance, experience and support for the workstream.

The combined workstream outputs are required to complete the effective evaluation of Community HealthPathways in Wales, enabling the NHS Executive and Health Boards to develop their own evaluation strategies which meet their timescales and requirements.

Initial Scope

Following Stage 1, it was apparent that multiple data sources relevant to evaluation of HealthPathways in Wales existed, but data were not collated in a manner which would enable independent external evaluation. A need was recognised for a Wales-specific data source available to external organisations for the purpose of evaluation, leading to the development of the evaluation dashboard.

Thus, the initial scope of the dashboard was set out – to collate and provide information to feed into independent evaluation work at

[7] https://pathwaysalliance.uk/ accessed 27 June 2025

three levels – from a national lens, Health Board level, and at a local practice level information.

Subsequently, it was clear that alongside independent evaluation, the tool needed to facilitate internal evaluation by Health Boards. The scope of Stage 2 of this project is summarised in Table 1.

Table 1 Dashboard Project deliverables

Deliverable	Output
Evaluation Framework	Designed to suit NHS Executive and Health Board evaluation needs, the What Matters to Us framework presents a coherent set of questions and metrics against which the programme can be measured.
Data Collection	A survey for users was designed in collaboration with Health Boards and shared to gather user feedback. A small number of GP interviews were held to gather more in-depth insight
Data Collation	The Evaluation Dashboard tool presents Wales specific data designed to answer the prioritised framework questions clearly and consistently
Reporting	An evaluation report to summarise the findings and recommendations from the first two years of the programme

2.3 Community HealthPathways in Ministerial Guidance

In April 2025, the Ministerial Advisory Group published its independent report on the effectiveness of current NHS Wales arrangements, including planned care, diagnostics, cancer performance, and urgent and emergency care. The report made a list of recommendations, several of which are linked to the use of Community HealthPathways.

Recommendation 1 – Planned Care

"All Health Boards should, within three months, develop a plan to reduce referrals to traditional outpatients in high volume specialities. Particular attention should be given to unwarranted variation and specialities where per capita referrals rates are above the national median. Models that offer alternatives to traditional outpatient pathways should be rapidly identified and scaled. National Funding for Advice and Guidance and the National Pathways programme should continue. From June 2025, progress should be reported

monthly to Health Board and trust public meetings, and at individual monthly Performance & Productivity meetings."

Welsh Government's response:

- The Welsh Government accepts this recommendation.
- Outpatient transformation, including alternative models progressed through "national pathways work," is integral to the Planned Care Programme and a priority enabling action in the NHS Wales planning framework.
- Health boards are required to set out clear delivery plans to implement these models at scale and tackle unwarranted variation.
- Progress will be monitored through Health Board performance meetings.
- The continuation of national funding for Advice and Guidance and the National Pathways programme is implicitly supported by the acceptance and focus on scaling these models.

Community HealthPathways in Recommendation 1:

This recommendation is central to the purpose of Community HealthPathways. Community HealthPathways aims to provide clear guidance for referrals, thereby inherently supporting a reduction in potentially unnecessary or misdirected referrals.

It actively promotes alternatives to traditional outpatient appointments by outlining agreed management plans in primary care or other community settings.

Community HealthPathways directly supports the "National Pathways programme" by being a key vehicle for the development, dissemination, and localisation of these pathways. Encouraging the identification and scaling of effective alternative models by embedding them within the agreed local pathways.

Recommendation 2 – Planned Care

"All Health Boards and trusts should work to reduce variation in outpatient waiting times by adopting best practices in outpatient service management. Using existing specialty GIRFT Health Board and trust reports, the 16-specialty specific Further Faster guides, mandatory electronic triage of referrals, and adoption of the 29 pathways across the 6 specialties with the longest waits. From June 2025, progress should be reported monthly to Health Board and trust

public meetings, and at individual monthly Performance & Productivity meetings."

Welsh Government's response:

- The Welsh Government accepts this recommendation.
- This is seen as part of the outpatient transformation within the Planned Care Programme, with models progressed via "national pathways work."
- Implementation is a requirement for Health Boards, to be reflected in their plans and monitored.
- The NHS Executive has established clinical implementation network outpatient guides (playbooks), and Health Boards have individual GIRFT reports, which need to be integrated into plans.

Community HealthPathways in Recommendation 2:

Community HealthPathways is a key tool for disseminating best practices in outpatient service management. It supports electronic triage of referrals by providing clear, evidence-informed, and locally agreed criteria that clinicians can use to make consistent decisions.

Community HealthPathways facilitates the adoption of standardised pathways, including potentially the 29 pathways across the 6 specialties mentioned, by providing a platform for their localisation and easy access at the point of care.

Recommendation 9 – Cancer

"No additional cancer performance plans should be produced for 2025/26 and 2026/27. Instead, there should be an immediate focus on implementing a narrow but nationally mandated set of deliverables drawn from existing policy proposals. At the centre of this, drawing on the NOPs [National Optimal Pathways], NHS Wales should identify the single highest-impact pathway change for each of the five tumour types it has already identified as driving poor performance: skin, lower GI, breast, gynaecology and urology... For Lower GI, this focus should be more consistent implementation of symptomatic FIT... For gynaecology, this should be the consistent provision of post-menopausal bleeding services; for breast the provision of breast-pain services; and for skin the more standardised provision of tele dermatology services in primary care. In all cases, national specifications should ensure these initiatives are based in a primary care setting wherever possible, thereby reducing referrals to secondary care as a whole..."

Welsh Government's response:

- The Welsh Government accepts this recommendation.
- The interventions described are underway by the NHS Executive, with a focus on consistent implementation and impact assessment.
- Approved triage tests are being applied in primary and community care to better risk-stratify cancer referrals where possible.
- Recommendations related to primary care will be considered in primary care negotiation and contracting.

Community HealthPathways in Recommendation 9:

Community HealthPathways in Wales acts as the key operational vehicle to define, disseminate, and drive the consistent adoption of these specific clinical pathways. It provides the "national specifications" at the point of care and directly supports the management of conditions like those mentioned (FIT testing, post-menopausal bleeding, breast pain, and tele-dermatology for skin conditions) within the primary care setting, aligning with the recommendation's intent to improve cancer care delivery and efficiency. With current priority pathways identified and Red/Amber/Green (RAG) rated within the programme to support effective turnaround of pathway development.

Recommendation 11 – Cancer

"The Welsh Government should establish financial incentives in primary care to improve cancer performance, focusing on in-depth diagnostic work-up and subsequent safety-netting in order to reduce referral volumes and provide more diagnostic information for patient triage in secondary care. Given the five tumour types driving the majority of long waits nationally, initial incentives could include increased safety netting for FIT negative patients, the provision of breast-pain services, or the development of tele-dermatology arrangements outside of secondary care."

Welsh Government's response:

- The Welsh Government accepts this recommendation.
- Work is underway to support a wide range of diagnostic tests in primary care.
- The Government will work with clinical experts (starting with FIT/colorectal and tele-dermatology/skin) to embed these into

community diagnostic services and scale them with dedicated funding or via cluster plans.

- They will explore how funding can better drive service delivery and performance for these primary care-based initiatives, though contractual negotiations mean full delivery within 3 months is unlikely.

Community HealthPathways in Recommendation 11:

Community HealthPathways in Wales is not just a passive repository of information but an active programme developing, localising, and promoting evidence-informed, locally agreed clinical pathways. It provides the essential infrastructure and content to define the very services and protocols (like in-depth diagnostic work-up, safety-netting, primary care-led services for breast pain or tele-dermatology) that Recommendation 11 aims to incentivise.

Recommendation 14c – Urgent and emergency care HealthPathways"*...A rapid study should be undertaken within 3 months, by Welsh Government working with Health Boards, to identify which patient groups/pathways consistently experience the longest pathway of care delays, especially when associated with long time spent in emergency departments. This should be used to target investment in linked community services for winter and future budgets.*"

Welsh Government's response:

- The Welsh Government accepts this recommendation.
- A rapid study to identify these patient groups/pathways will be commissioned via the NHS Executive's Six Goals programme, building on recent work.
- Work on linking data for specific cohorts (e.g., non-injured fallers) has already occurred, leading to directives for investment in community-based falls response services.
- Health boards are expected to deliver improvements by utilising existing resources and working with partners to invest in community pathways through Regional Partnership Boards and prioritising funds like the Regional Integration Fund.

Community HealthPathways in Recommendation 14c:

Community HealthPathways can play a crucial role after the study identifies these patient groups and pathways. It can then be used to define the optimal community-based pathways for these identified patient groups ensuring consistent approaches to their care outside of the acute setting. This means if a patient group is identified as

frequently experiencing delays, Community HealthPathways can host the agreed new or improved community-based pathway for managing them more effectively, potentially avoiding ED attendance or facilitating quicker discharge.

Recommendation 20 – Operating model (specifically the role of the Medical Director of NHS Wales)

(among other responsibilities for the new Medical Director)

> *"Through the Health Board and trust medical directors and the associated clinical leadership teams, to drive and prioritise the implementation of HealthPathways (Pathway Alliance Programme)."*

Welsh Government's response:

- The Welsh Government accepts in part the recommendation for a new Medical Director post, proposing instead that the Deputy Chief Medical Officer (NHS) will be appointed National Clinical Director of NHS Wales, with specific delegated responsibility to provide medical leadership to the NHS Executive.
- The Government agrees with the requirement to strengthen medical leadership for areas including the implementation of HealthPathways.
- The newly defined National Clinical Director of NHS Wales will provide the strengthened clinical leadership for the work of the NHS Executive (now to be NHS Wales Performance and Improvement), which would include overseeing the HealthPathways (Pathway Alliance Programme) implementation.

Community HealthPathways in Recommendation 20:

This recommendation directly tasks senior medical leadership with driving and prioritising the implementation of HealthPathways, underscoring its strategic importance for standardising care and clinical transformation. This will reinforce its importance from a top-level clinical leadership perspective

3 APPROACH

Prior experience with data, knowledge of the programme, and capacity to independently access Streamliners' data shaped how development of the Evaluation Dashboard proceeded. For users to integrate the dashboard into their work, so that it could support effective evaluation, it was recognised that the following criteria would need to be met by any tools developed:

- Reduce friction and frustration compared to the alternative.
- Present consistent data reliably as a single source of truth that multiple users from different organisations can rely on and agree with.
- Display information intuitively so that users don't have to work to understand the message.
- Display information in a customisable manner to enable users to personalise their experiences and streamline their data extraction.
- Focus on information and metrics relevant to evaluation teams in Wales

3.1 Developing the Framework

Target Audience Engagement

The first stage in understanding what questions the framework would need to address required determining what its users would need. Through discussion with the NHS Executive and Streamliners NZ, it was established that the target audience included:

The NHS Executive Planned Care Team

The Planned Care Team hold responsibility for governance of the national HealthPathways programme and must demonstrate value to justify sustained investment. To this end, the team needs access to accurate, focused and easy to use metrics to inform programme decisions.

All Health Boards

Programme managers and Value in Health professionals have indicated a focused dashboard would be useful to them for both evaluation and operational purposes.

Besides operational use are the impact questions which can be used to show the value of the programme at the Health Board level.

Programme managers, while "tech savvy" cannot be assumed to have extensive PowerBI or Google Analytics knowledge, making this dashboard a one-stop option for the data that means the most to the Health Boards, reducing friction and improving efficiency in the programme as it moves into Business as Usual.

Most Health Boards who had launched during the national programme had not yet begun considering evaluation. However, CAVUHB launched Community HealthPathways independently in 2019 and so had a longer period over which evaluation was needed.

Connections were made with Magda Golebiowska in the Value in Health team at CAVUHB. Magda was starting evaluation work on the recently launched HHP. This presented an opportunity to understand what questions the Health Board needed answers to for their evaluation of the effectiveness of Hospital HealthPathways. Many of their questions would also be applicable to Community HealthPathways.

Streamliners

This dashboard is valuable as insight into the needs of HealthPathways Community members in Wales, and potentially globally to support their evaluation activities.

Independent Evaluation Partners

Through conversations with academics at Aberystwyth University, the team was able to scope out an academic evaluation package which would meet the needs of the national programme, which informed what data they might independently collect, and which data would need to be readily available to them. It also highlighted the requirement for the measurement criteria to be known in advance, which indicated that there was an additional requirement for the framework development to be completed in advance of independent evaluation activities starting. In due course, the Tritech Institute [8] was commissioned to undertake independent evaluation.

Establishing the Metrics

Once the target audiences for the dashboard were identified, an engagement phase was initiated to understand their evaluation pain points and how Yma, and Here could meet those needs. It was clear from the start that there were many ideas about what an evaluation of Community HealthPathways could ask, but no clear consensus.

[8] https://tritech.nhs.wales/ last accessed 16 July 2025

On discussion with the NHS Executive Planned Care Team, and the Value in Health team at CAVUHB, it was apparent that there was significant overlap between the organisations' need for information. At the time, no other Health Board was sufficiently progressed in their evaluation work to contribute to the framework, but they were subsequently asked for their feedback on the questions.

The metrics were grouped into themes (Figure 1), which were each defined and paired with a hypothesis against which metrics could be used.

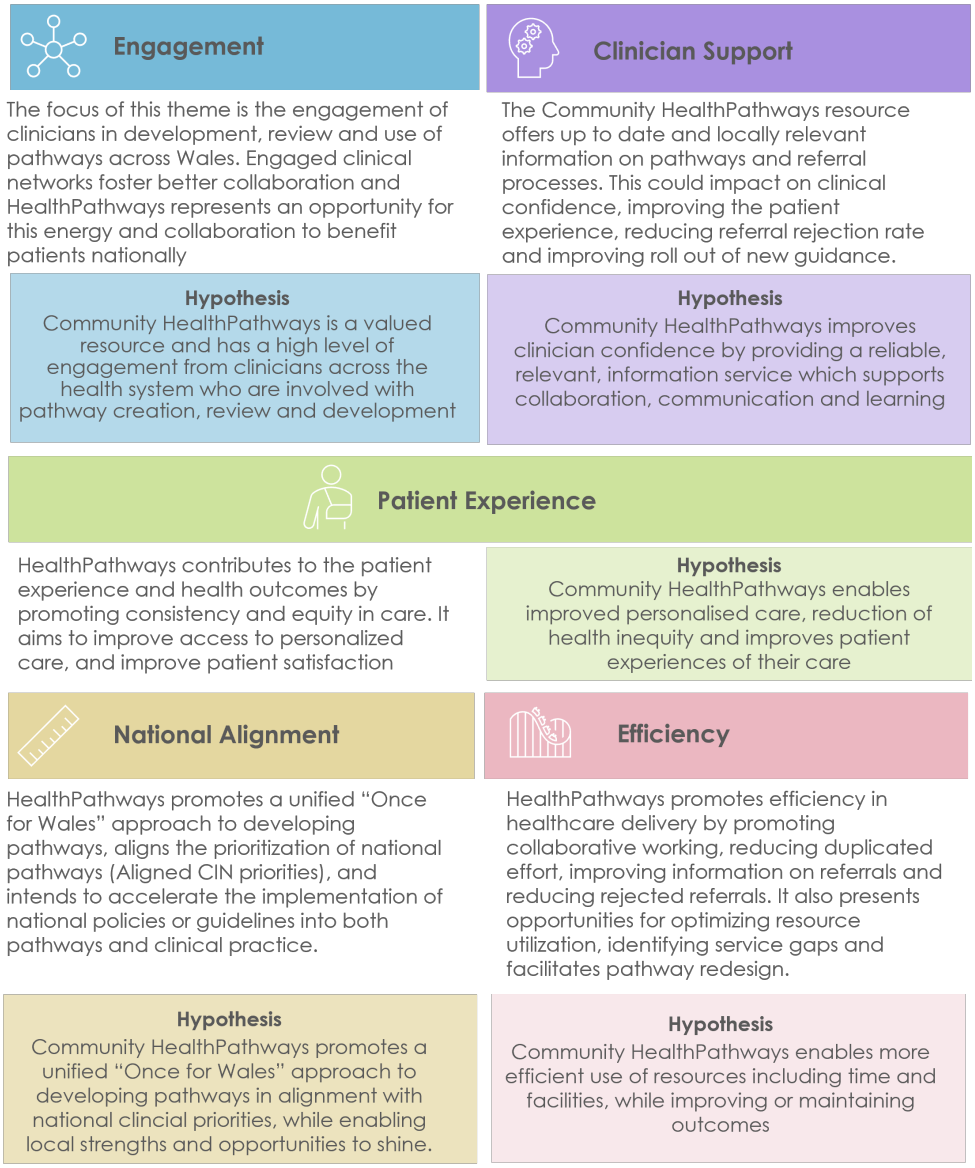

Figure 1 Themes extracted from the collation of questions, metrics and data sources

It was now possible to develop questions to test the hypothesis for each theme. A first iteration of questions was developed, and an

approach and associated baseline measure designed to answer the question. Data sources were then identified for each question, before being reviewed by the national workstream.

The questions were identified as short-, medium- or long-term pieces of work depending on data availability and access. Not all the questions are answerable at the time of writing because the data isn't being collected, is unsuitable or is unavailable.

26 individual metrics were identified during the "What Matters to Us?" engagement process. These metrics, divided across the five themes represented a broad range of the information a Health Board or the NHS Executive Planned Care Team might use to evaluate Community HealthPathways in the future.

Priority was given to a small number of questions by the NHS Executive Planned Care Team. This was done to focus data collection activities as it would not be possible to answer all the questions in the timeframe available. Priority was given to questions thought to be relevant to the national impact of the programme.

Priorities were chosen based in part on the existing data the NHS Executive has access to. While other questions might have been equally important, the ones listed as those that the team would find it more difficult to answer without the use of the dashboard as well as being the highest impact metrics against which to measure the programme (Table 2).

Other metrics were still of value to the stakeholders but were less of a priority because the data was already available elsewhere, and so work was not needed to collect it in this project, or that those metrics related to functions which were not as high a priority for the NHS at the time.

Question	Metric
Engagement Theme	
Do users and page views increase over time?	Numbers of users - Google Analytics
What are the most popular pathways in each areas, and why are those ones popular?	Pathway views - Google Analytics
Is there diversity of clinical role represented in pathway development?	Data on Clinical Editors and their job roles anonymised
Is the number of subject matter experts involved in pathwa development commensurate with other implementations of Community HealthPathways globally/in CAVUHB. Does this change over time?	Data on Subject Matter Expert identity anonymised
Patient Experience Theme	
Does Community HealthPathways help clinicians manage patient expectation well by providing resources and waiting times?	Option 1 – Ask Patients – out of scope Option 2 – Ask GPs during interviews Option 3 – Pathway review for information
Clinical Support Theme	
Do clinicians recognise Community HealthPathways as a valuable tool beneficial to their day to day working lives?	Interview and survey
Following the implementation of Community HealthPathways is there a measurable change in referral quality in conditions associated with localised pathways? Quality is quantified by referrers being accepted first time, following guidance or being directed to the correct place	Option 1 – CAVUHB referral data linking pathways to referrals and observe any changes over time with implementation Option 2 – NHS Executive initiative auditing at CIN level Option 3 – GP Perspective, interviews and surveys
Efficiency Theme	
Does a national implementation and pathway sharing by default use a different amount of resource than a Health Board by Health Board isolated approach would have done?	Investigate existing available Streamliners NZ and NHS Data on clinical editor time and potentially compare between Health Boards, depending on data available.
Does Community HealthPathways change the speed of decision making or change the amount of clinical time spend looking for information?	GP Interviews

Table 2 NHS Executive Planned Care Team priority metrics

Yma, Here and Streamliners worked together with Health Boards to collate and present the data to answer these questions in a way that was compatible with all users' needs. Feedback sessions during dashboard development were positive, and further modifications were made to adapt to the needs of the Tritech Institute. Ongoing data and functionality updates are funded until February 2026.

4 FINDINGS

Presented here are the findings relating to each of the What Matters to Us themes. CAVUHB is addressed separately from the other live Health Boards where appropriate, as the programme in CAVUHB is significantly more mature than in the rest of Wales.

4.1 User Engagement

User engagement metrics evaluate whether the target audience for Community HealthPathways is using the tool, and whether it is of value in their practice.

Do users and page views increase over time after launch?

Of a total of 107 survey responses received to date, almost 80% came from Health Boards with live Community HealthPathways sites.

Figure 2 shows almost three quarters of respondents from areas with live sites reported having used Community Health Pathways.

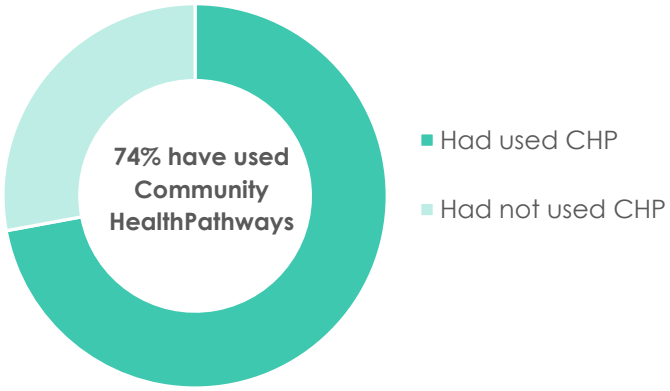

Figure 2 Percentage of survey respondents from Health Boards with live sites, who reported having used Community HealthPathways

Figure 3 shows the distribution of usage patterns in respondents from Health Boards with live sites, who reported having used Community HealthPathways previously, and that it was their preferred source of guidance.

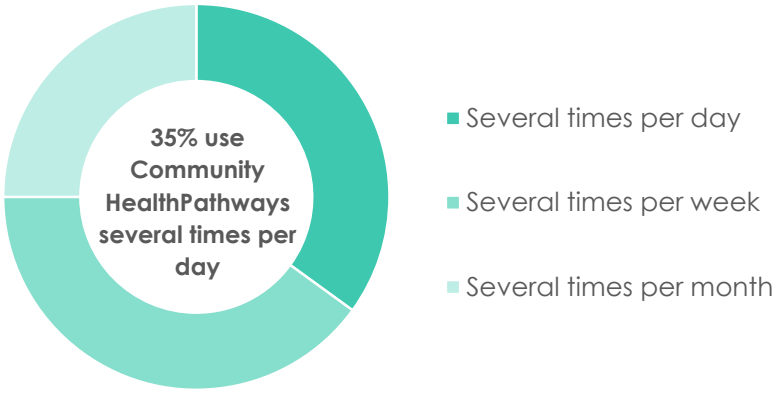

Figure 3 Pattern of use of Community HealthPathways for those reporting that it is their preferred source of guidance in Health Boards with live sites

User quantity metrics such as page views and counts of sessions can be used to understand the scale of engagement with CHP across Wales.

Across all sites, page views, and number of sessions have increased since launch. There is generally a notable spike in page views and sessions following launch, which then settles into a more organic upwards trend. Figure 4 shows the growth of page views in CAVUHB since launch. There is a spike in views during 2020, suggesting the still relatively new CAVUHB site was of value locally during the pandemic when there was a period of rapid updates to guidance. Figure 5 shows the growth of page views over time since launch for newer Health Boards in Wales.

Numbers are normalised to population size, leading to smaller but comparable values, and a higher apparent level of variation. Using absolute page views is not comparable as Health Boards have differing population sizes.

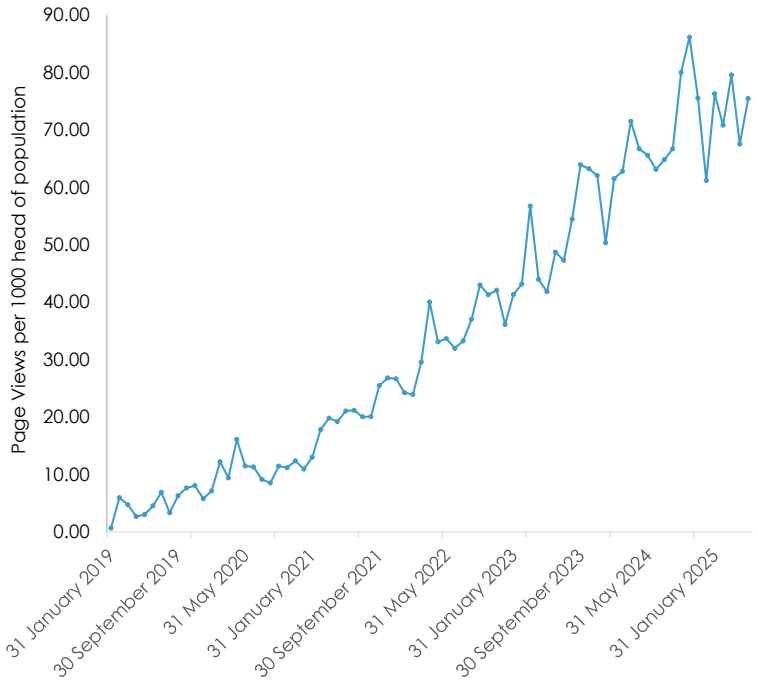

Figure 4 Total Page Views per 1000 head population in CAVUHB

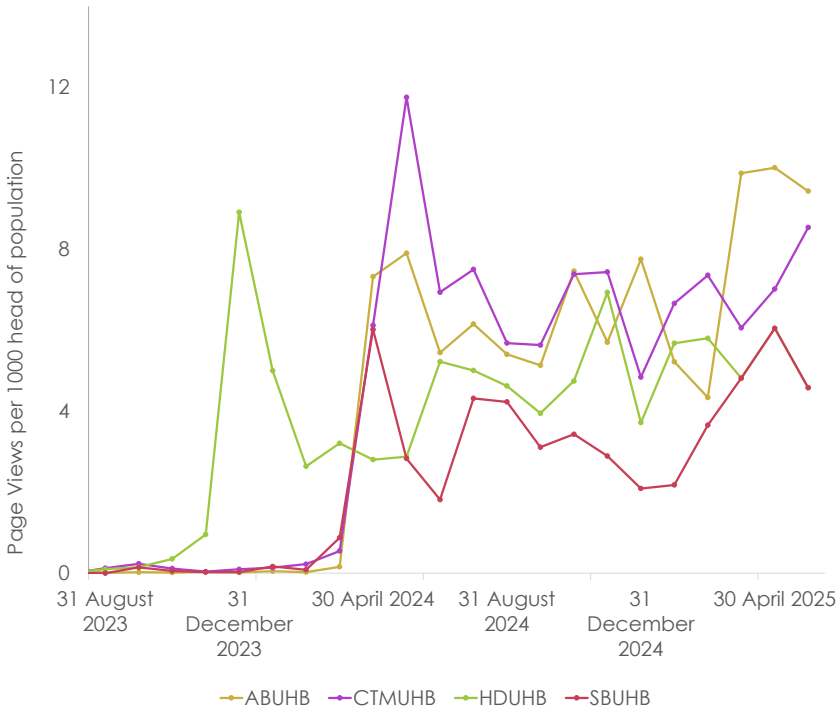

Figure 5 Total Page Views per 1000 head of population following launch in new Welsh sites

Page views can vary month to month, which may be due to changes in workforce, with new trainees joining at the same time of year, and with seasonal fluctuations. Conditions featuring in mainstream media may also be a factor in the variation [9], as raising awareness of a particular condition may make people more likely to seek support.

In May 2025, the National Community HealthPathways Programme in Wales surpassed 1,000,000 page views

One metric for engagement is to track the number of users. However, without individualised logins, it has not been a consistent measure of the number of individuals in Wales who are using the site. Instead, individual sessions [10] are used to gauge usage levels.

Figure 6 shows the growth in total sessions per month across the Welsh sites. CAVUHB is the largest component of this, with the newer sites launching and seeing an organic growth in sessions over time since launch.

There is a notable dip in sessions during the Christmas period, both in 2023 and 2024. This phenomenon is also observed in publicly available referrals data which suggests a general downtick in routine primary healthcare activities over the festive period.

[9] https://www.rpharms.com/resources/podcast-central/the-pj-pod/coping-with-the-davina-effect-on-hrt Accessed 2 June 2025

[10] A session is a visit to the site which can consist of any number of page views, searches or other activity. A single session lasts as long as a user continues to interact and will time out after 30 minutes. If after this point the user re-engages with the site it will register as a new session.

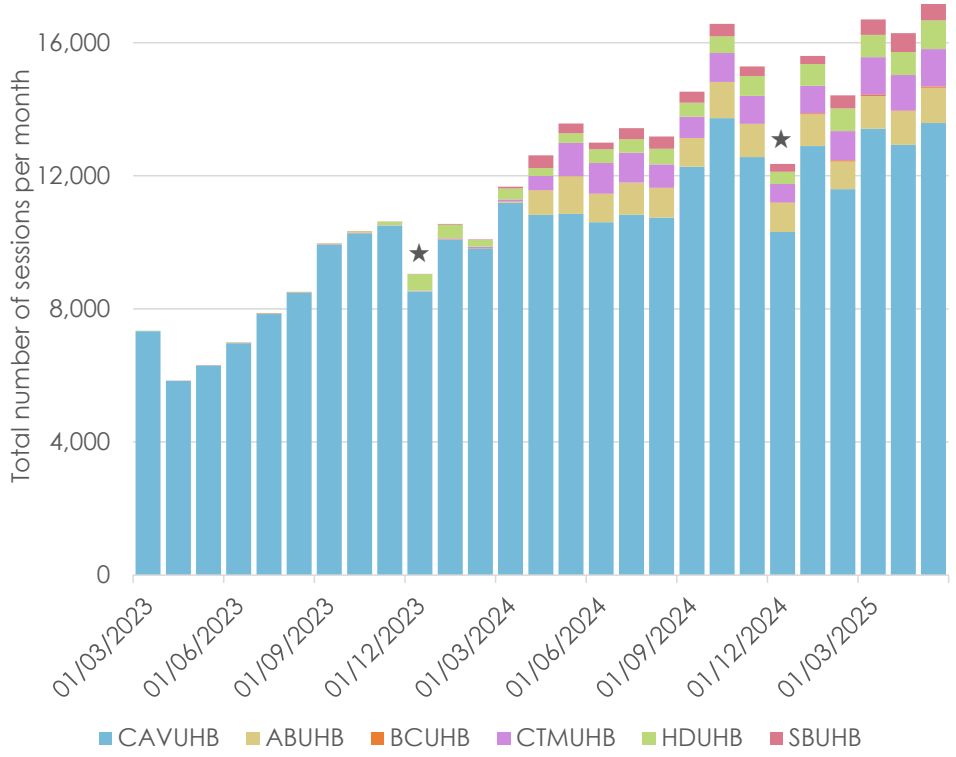

Figure 6 Total Sessions Per Month in Wales sites not including the Collaboration Site. Repeating reductions in views around Christmas annotated with ★

Is there diversity of roles represented in the clinical involvement in pathway development?

We assessed the value of the Community HealthPathways platform as a tool to connect a broad range of clincial experiences, to create optimal pathways. Wales, being the first time "Pathway Sharing by Default" has been implemented has seen this collaboration first hand.

Figure 7 shows the range of expertise involved in the Community HealthPathways programme. Of the 898 people identified across the national programme, 44% of contributors are medical specialists, contributing their subject specific experience to benefit all Health Boards, through pathway sharing.

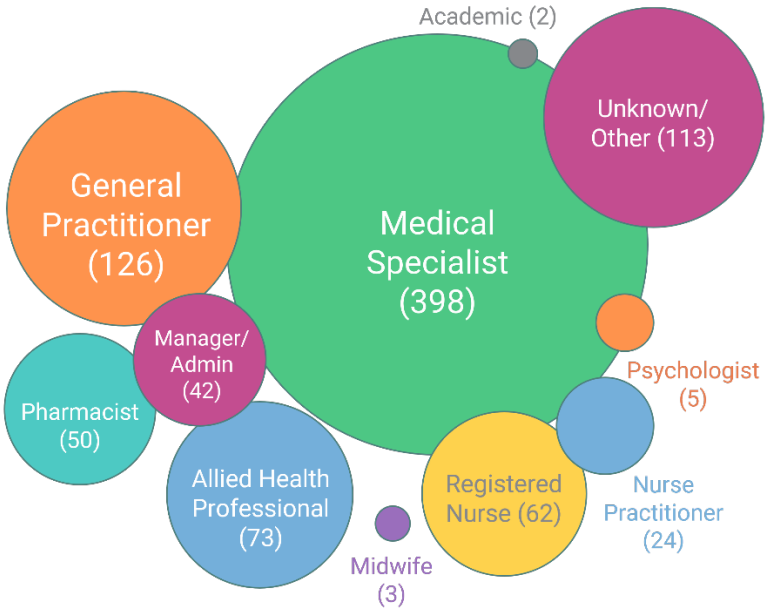

Figure 7 Range of professionals involved in the national programme in Wales between launch and late 2024 with number of each role represented by proportional size of the circle.

In addition, individual engagement, we also collected the level of collaboration being created across the health system. Figure 8 shows the range of engagement created by the national programme to date since its launch in 2023.

The programme has created working groups to share knowledge and processes between Health Boards. This evaluation has seen the benefits of the new networks, as programme managers from four Health Boards collaborated to develop wording for the feedback survey, and coordinated rolling it out, bringing together feedback across all areas in Wales with over 100 responses to date.

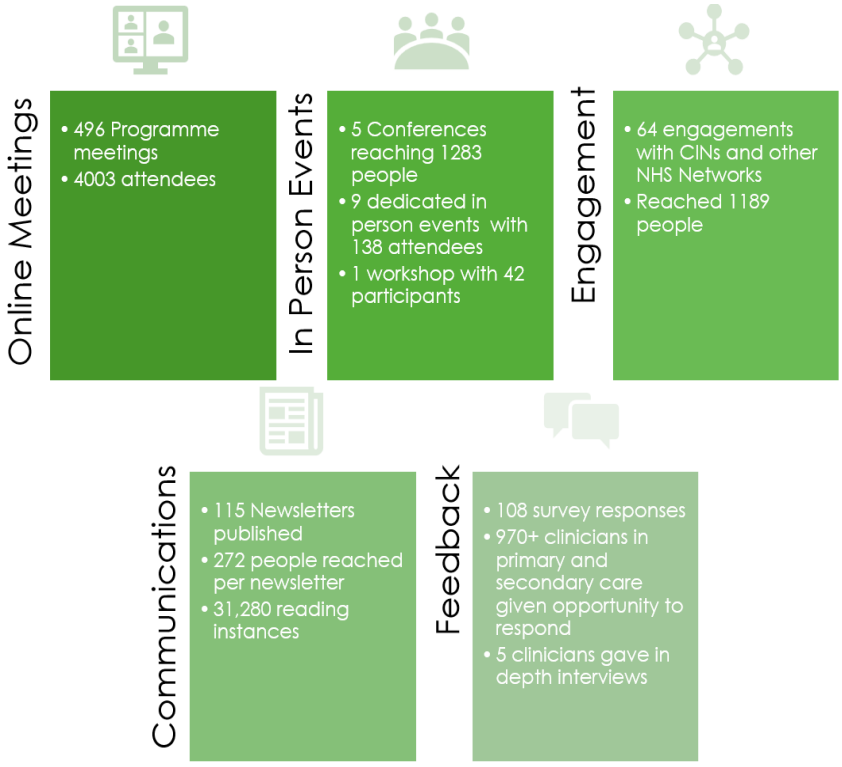

Figure 8 Graphic illustrating the number of engagement activities taking place since launch of the national programme in 2023

User Engagement Recommendation 1

The existing national engagement strategy involves National Clinical Networks. It is recommended to develop this further to build on the national strategy to maximise adoption across primary care roles.

Feedback received by programme teams can also offer insight into areas where engagement is particularly effective, for example, face to face engagement in CAVUHB during their implementation. Maintaining opportunities for programme teams to meet regularly and share their experience will enable sharing of engagement best practices. This is particularly valuable for Betsi Cadwaladr University Health Board (BCUHB) as it is approaching launch in 2025, and potentially Powys Teaching Health Board (PTHB) in the future.

4.2 Clinician Support

One of the unique strengths of Community HealthPathways is that it provides location specific guidance and support at the point of need. The success of HealthPathways in Wales depends on clinicians' views of the tool, and those that value it, sharing their knowledge and

practices with the upcoming generations. Yma conducted surveys and interviews to answer the following question:

Do clinicians recognise Community HealthPathways as a valuable tool beneficial to their day to day working lives?

Of the 62 survey respondents in all Health Boards with live sites, who also reported that they had used HealthPathways previously, the majority of people listed Community HealthPathways as their preferred choice for guidance. This increased to 78% of clinicians in CAVUHB. Similarly, most of the same respondents answered "Strongly Agree" or "Agree" when asked whether it is easy to find localised information on medication using their local Community HealthPathways site (Figure 10) which rises to 83% in CAVUHB alone.

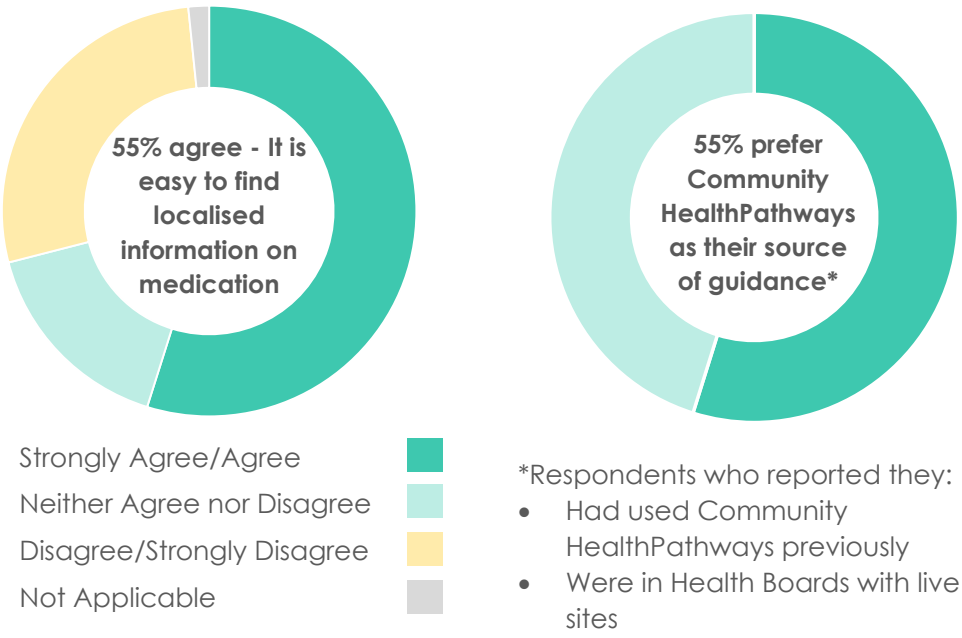

Figure 9 Survey responses to questions around usefulness of Community HealthPathways to clinical staff who reported using it previously, in Health Boards where there are live Community HealthPathways sites at the time of the response.

Figure 10 shows in sources of guidance used by those working in Health Boards with live Community HealthPathways sites, and who reported having used the platform previously. To date, Community HealthPathways and NICE CKS (National Institute of Clinical Excellence, Clinical Knowledge Summaries) are equal. This is remarkable considering most of the sites in Wales are early in their

implementation journeys at less than 2 years, and NICE Clinical Knowledge Summaries [11] was launched in 2013 and has been a fixture in primary care guidance for over a decade.

"When you need to access resources, you're not going to do it unless you can do it very, very quickly" – GP

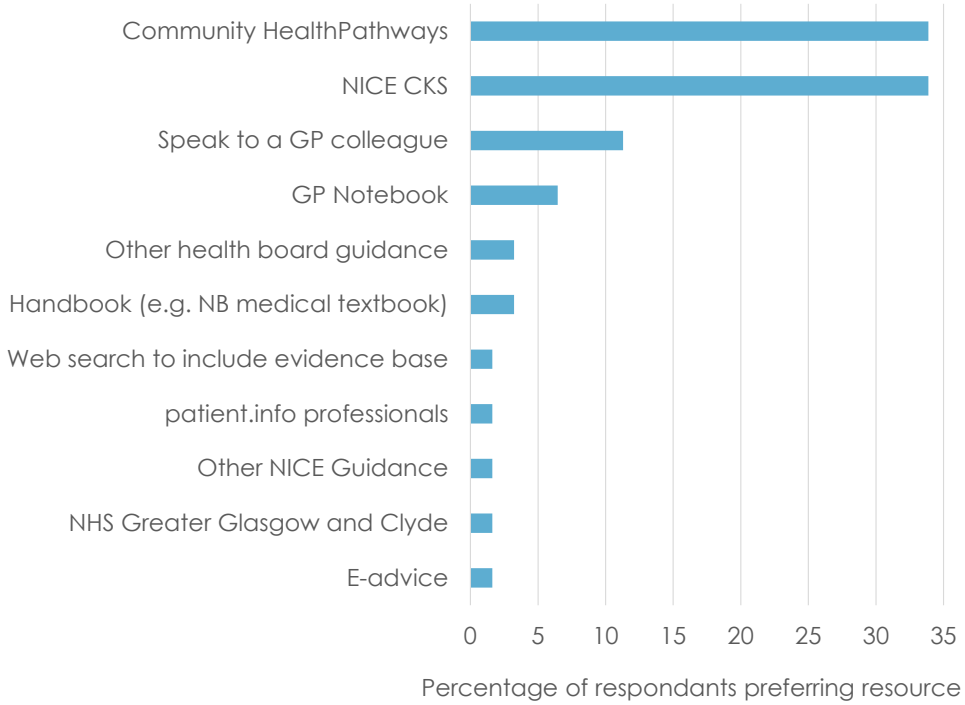

Figure 10 Guidance sources preferred by respondents in Health Board areas with live sites, and who had reported using Community HealthPathways previously

To understand what the guidance landscape might look like without HealthPathways, we reviewed responses from people who reported not having used Community HealthPathways previously. 65% used NICE CKS primarily. The next closest resources at around 4% each, included Consultant Connect, speaking colleagues, GP Notebook and using handbooks (e.g. NB medical textbook).

What are the most popular pathways being viewed in each area?

Pathway popularity provides understanding of where the clinical workforce seeks guidance and support. In younger sites, the popularity will be influenced by which pathways are live, however in

[11] https://cks.nice.org.uk/about/ Accessed 25 June 2025

more established sites with a wider range of localised pathways it could offer insight into local population needs.

Table 3 shows the top 10 most popular pathways by site (where Hywel Dda University Health board is abbreviated to HDUHB, Cwm Taf Morgannwg University Health Board is abbreviated to CTMUHB). It is notable that there are popular pathways which are not currently localised. This offers an opportunity to prioritise locally important pathways when considering work planning.

Table 3 Top 10 most popular pathways by site. localised pathways shown in black, and unlocalised pathways shown in orange (as of early July 2025).

ABUHB	CAVUHB	CTMUHB
Headaches in Adults	Abnormal Liver Function Tests	COPD
Abnormal Liver Function Tests	Headaches in Adults	Podiatry Assessment
Cows' Milk Protein Allergy	Vitamin D Supplementation	Headaches in Adults
Heart Failure	Hypertension	B12 Deficiency
Atrial Fibrillation	Faecal Immunochemical Test (FIT)	Iron Deficiency Anaemia in Adults
Vertigo	Hormone Replacement Therapy (HRT)	Abnormal Liver Function Tests
UTI in Adults	Hyperlipidaemia	Chest Pain
Haematuria	Polycystic Ovarian Syndrome (PCOS)	Polycystic Ovarian Syndrome (PCOS)
B12 Deficiency	Dyspepsia and Heartburn	Rhinosinusitis
Diabetes	Neck Lumps in Adults	Vertigo

HDUHB	SBUHB
Carpal Tunnel Syndrome	Vitamin D Supplementation
Hormone Replacement Therapy (HRT)	Postmenopausal Bleeding
Chest Pain	Soft Tissue Lumps and Sarcoma in Adults
Heart Failure	UTI in Adults
Atrial Fibrillation	Acute Lumbar Back Pain in Adults
Osteoporosis	Vertigo
Orthopaedics / Musculoskeletal	Headaches in Adults
Menopause	First Carpometacarpal Joint Osteoarthritis (CMCJ OA)
Angina	Hormone Replacement Therapy
Gout	Occupational Therapy Assessment

Section pages are those listing a group of pathways as links, for example, Gynaecology section, which contains a list of pathways in this clinical area.

There was less variation in the top section pages by site, with all the new Health Boards visiting the "Medical" section the most often. Figure 11 illustrates the frequency with which section pages appeared in the top 10 for section pages in the newer sites. Neither Cardiff nor any of the sites in England listed more than one "Section" page in their top 10, suggesting a change in search behaviour over time, which could improve efficiency as pathway coverage improves, and the use of Community HealthPathways becomes embedded.

Figure 11 Word Cloud showing the frequency section pages appeared in the top 10 section pages visited for ABUHB, CTMUHB, HDUHB and SBUHB.

The ease of navigation and consistency in layout between sites provides familiarity to locum GPs moving between sites, and to those new to practice, or undergoing training. Section pages enable someone to narrow down their search to a clinical area without knowing the precise pathway name and still being likely to be able to find it.

This observation was also made during interview feedback, where several experienced GPs suggested the sites were particularly helpful to new members of the team, and those that moved around frequently.

"We looked at Community HealthPathways as a practice and decided it would be useful for newly qualified GPs, clinicians who are new to the area and locums who move around Health Boards"- GP partner

"I use it quite often as a teaching aid now as well..." - Senior GP partner

"Would be really helpful for those in the early stage of training such as ST1 and ST2" (ST=Specialty Training years 1 and 2) - GP trainee

Community HealthPathways offers an opportunity to provide standardised training on guidance which would be applicable across Wales while still providing a localised view in the place the trainee takes up a position in time. This would require early integration into learning. For example, direct engagement with GP Training institutions, providing GP tutors with additional support and resources, and offering Continued Professional Development credits for existing clinicians to take time to familiarise themselves with the system and providing feedback on pathways.

"There are a lot of resources out there and it's about choosing the one that works well for you in that moment in time. Once you find something that works for you, you keep on using that"- GP trainee

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Does the presence of localised pathways affect referral quality, as measured by referrals being accepted first time, following pathway guidance or being directed to the right destination.

This question has been the most challenging to answer consistently across all the Health Boards. There is a patchwork of different types of data being collected in different areas, with differing levels of accessibility for external evaluation activities.

It is expected that localised guidance will facilitate a more efficient referrals experience for GPs by reducing the number of returned referrals. However, as there is no measurable connection between a person viewing a pathway, and creating a referral, it is not possible to directly link referral numbers to localised Community HealthPathways unequivocally. In addition, where HealthPathways reduces unwarranted variation, which is another potential outcome of using the system, the overall referral number may not change because over-referral is reduced but under-referral is also corrected, maintaining the total number, but providing significant benefit to the population and the NHS in Wales.

Survey data shows that the majority of users find HealthPathways helpful to find test and investigation information (Figure 12), in CAVUHB, this is 83% of respondents.

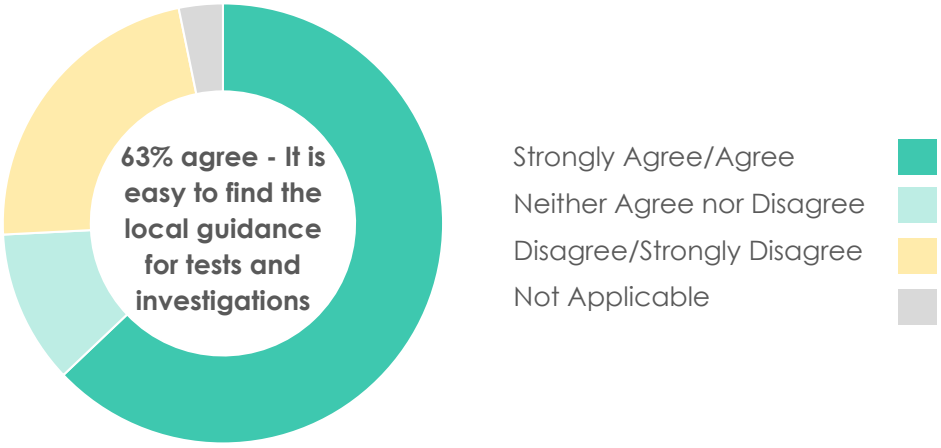

Figure 12 Survey response to question around value of Community HealthPathways guidance to clinical staff who reported using it previously, in Health Boards where there are live Community HealthPathways sites at the time of the response.

Understanding the challenges in answering this question was a driver for the NHS Executive Planned Care Team's work on audits of referrals into CIN specialities. This work is underway at the time of writing.

Dr Simon Davies in CAVUHB has also reported on the success of using Community HealthPathways alongside triage clinicians and Consultant Connect in managing referrals in the Health Board in 2024 [12]. In his presentation, Simon showed the impact of using HealthPathways alongside Consultant Connect, e-Advice, and Interface GPs. HealthPathways provided the localised clinical guidance, Consultant Connect provided acute or planned care query support, and e-Advice gave GPs advice from a consultant for clinical and referral queries.

Dr Davies estimated an annual saving of £374,424 on diagnostic imaging through the impact of Community HealthPathways on radiology referrals from the Knee, Shoulder and L-Spine pathways, freeing up diagnostic support availability.

He also reported the impact on the Urgent Suspected Cancer (USC) referrals of the Colorectal Cancer HealthPathways. In this case, the pathway introduced the requirement for a positive Faecal Immunochemical Test (FIT) prior to referral. The pathway advice

[12] "Planned Care Changes in CAV – The Reform Journey and an Evaluation of the Impact". Dr Simon Davies, Brisbane HealthPathways Conference 2024

alongside triaging, enabled rapid dissemination of advice into primary care, and a resulting reduction in the number of USC referrals.

Seeing changes in referral numbers, and GPs finding Community HealthPathways valuable are distinct metrics. To elucidate the differences, we also asked GPs in surveys and interviews of their experiences of creating referrals using Community HealthPathways

"I use Community HealthPathways to refresh my understanding on what a particular pre-referral process is and I find it very useful."- GP

Figure 13 shows feedback across 18 specialities for those respondents who reported that Community HealthPathways was their preferred guidance source (21 people). The questions indicate that the platform makes it easier for clinicians to find relevant referral guidance, they also largely find that guidance easy to follow. In specialities or areas where responses to the second question are less positive, it could be an indication of local need for support to meet referral criteria.

As discussed previously, the key to usage numbers is the tool being of value in practice, and the survey feedback indicates that Community HealthPathways is meeting a need in primary care.

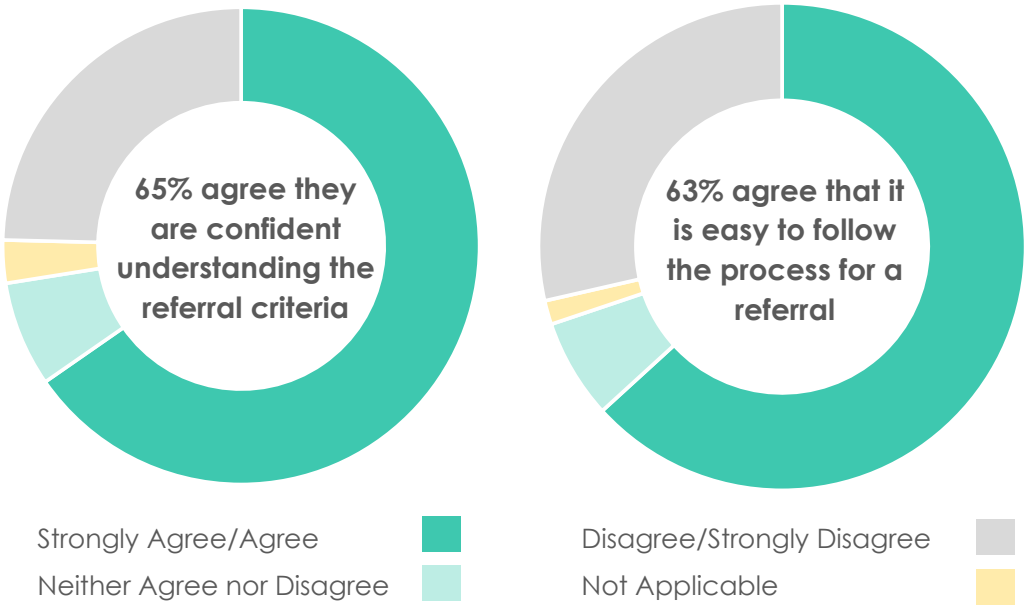

Figure 13 Responses from clinicians reporting Community HealthPathways as their preferred guidance source to the statements "I am confident in understanding the referral criteria for the following specialities" and "I find it easy to follow the advised process for referring a patient" across 18 specialities

"Sometimes GPs are capable of being quite focussed on thinking it could be one thing, and it just introduces other tests and things to do." - Senior GP Partner

"It introduced more investigations than I would have done otherwise." – Senior GP Partner

Clinician Support Recommendation 1

Continuing to collect survey feedback from GPs across Wales, including in newer areas (e.g. BCUHB) will offer insight into the ongoing impact of the programme as it becomes embedded. It also provides a national benchmark for progression of Community HealthPathways uptake and impact.

Referral Data

The Kings Fund identified three key elements in high-quality referrals in their report The Quality of GP Diagnosis and Referral in 2010 [13]:

Necessity Patients are referred as and when necessary, without avoidable delay

Destination Patients are referred to the most appropriate place first time

Process The referral process itself is conducted "well". For example, referrals contain the necessary information, include patient involvement in decision making, involve shared purpose and understanding of expectations, and ensure appropriate tests and investigations are completed prior to the referral being made.

Further The Kings Fund report suggested that while some referral activity is avoidable considering the three elements of quality referral behaviour, it warns against pursuance of overall referral rates as a measure of performance.

[13] The King's Fund. The quality of GP diagnosis and referral (2010) https://assets.kingsfund.org.uk/f/256914/x/5a07af163f/gp_inquiry_diagnosis_referral_2010.pdf Last accessed 31st January 2025

In their publication "Quality Patient Referrals" published by the Royal College of General Practitioners in 2018 [14], the RCGP emphasise the need to focus not on overall referral reduction in numbers, but in reducing unwarranted variation in referrals. They show that in some studies there is up to a tenfold variation in GP referral rates to a particular specialty within a single area. They address the complex reasons for this variation and emphasise the need for contextualisation in understanding referral data. Reasons given for the variation are complex and include:

- Demographic factors such as age and socioeconomic status
- Health needs of the local population
- Patient expectations
- Experience, interests and personality of individual GPs
- Capacity of the health system

The report also emphasises looking more closely at low levels of referrals as well as where levels are unusually high, not least because high referral rates may be an indicator of best practice. For example, a GP with a special interest is more likely to see more people with that condition, which may influence their personal referral rate. The RCGP state that while referral data on a local level can help identify areas for improvement, financially driven approaches have a tendency to assume that lower referrals is better, and as the UK population grows, gets older, and deals with more lifestyle related conditions such as obesity, blanket referral reduction measures risk targeting necessary referrals and not tackling the unwarranted variation.

During framework development, one question recurred as highly relevance and challenging to answer:

Following the implementation of Community HealthPathways, is there a measurable change in referral quality in conditions associated with localised pathways? Quality is quantified by referrals being accepted first time, following pathway guidelines, or being directed to the right place.

There are several implications to this question:

- Localised Community HealthPathways may improve referral quality coming into secondary care, meaning that fewer referrals

[14] https://www.rcgp.org.uk/getmedia/e3c078c8-962f-4d4c-8bc1-382eee35653a/RCGP-referral-management-feb-2018.pdf Last accessed 31st January 2025

are returned, saving primary care clinical time in repeating referrals, and secondary care resource in responding to repeated referrals.

- Localised Community HealthPathways may improve quality of referrals through adherence to guidance, which may suggest waiting for a certain amount of time before referring, or gathering additional testing data before referring, both of which reduce impact on secondary care resources.
- Localised Community HealthPathways may improve quality of referrals by indicating where patients could be referred to community or primary care options rather than secondary care as a default. For example, in the work presented by Dr Simon Davies on the combined effect of Community HealthPathways, triage clinician implementation, and Consultant Connect [15], there was a reduction in the number of diabetics referred to consultants and an increase in the number referred to specialist nurses, which is a less costly resource.

Three metric options were identified to address this question:

1. CAVUHB referral data, which links pathways to referrals by a triage clinician and a specialised implementation of WCCG. Gaining access to this data from pre-and post-launch timeframes, could show differences in referral quality through the number returned, and offer insight into the reasons for return.
2. NHS Executive Planned Care Team funded audits of Clinical Implementation Networks (CIN) related pathways, considering the quality of referrals. This does not have a baseline against which changes are measured and so forms a point in time, rather than indication of a change. Further audits in future could be added to show change over time following implementation.
3. Ask the GPs – through surveys and interviews, we asked the GPs whether they felt their referrals were being returned differently often following implementation, and if they were returned, was the feedback constructive.

Referral data is available by specialty on StatsWales [16] and shows referral numbers by Health Board, dating back in some cases to 2012, but from all Health Boards in their current configurations from April 2019. Most recent data available at the time of writing is until September 2024. Figure 14 shows the total number of referrals by

[15] https://www.consultantconnect.org.uk/ Last accessed 31st January 2025
[16] https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Hospital-Activity/Referrals Last accessed 31st January 2025

Health Board between April 2019 and September 2024. From this graph it is possible to see the variation month to month, including the decrease during the first year of the COVID Pandemic, and a smaller dip each year around Christmas.

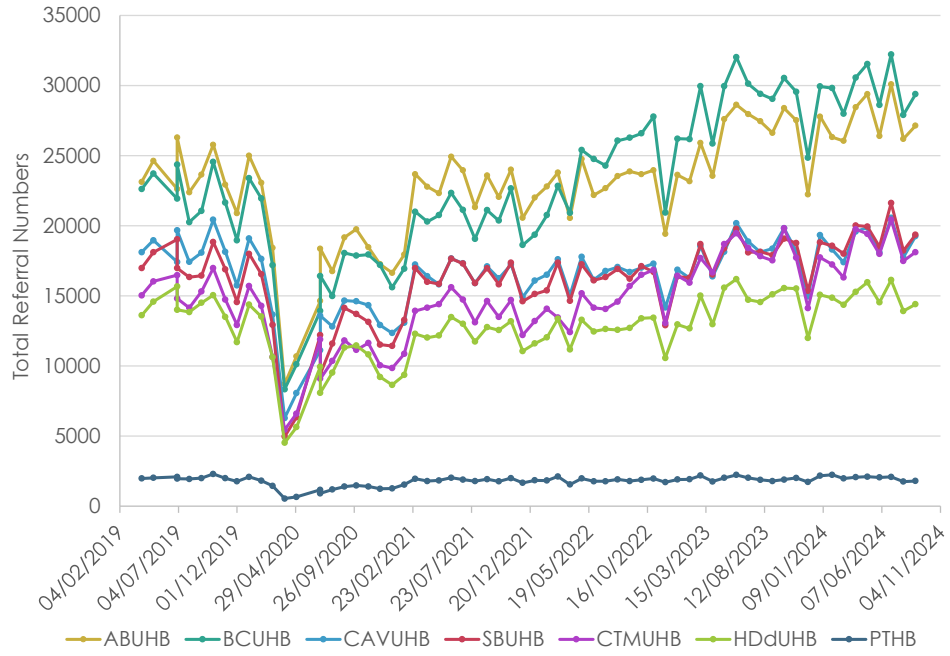

Figure 14 Total referrals for all Health Boards showing variation from COVID-19, and seasonal patterns

For each specialty area, there are various conditions which contribute to referrals in that area. Not all the conditions are covered by live localised pathways in each Health Board, meaning that there may be referrals not covered by Community HealthPathways contributing to the overall numbers for each specialty. Taking this into account alongside the known variability in referral numbers, it is not possible to establish a causative relationship between referral numbers and a single variable such as the use of Community HealthPathways in Health Boards where there is no connection recorded between a referral and a pathway.

In Wales, only CAVUHB have created a mechanism to connect individual Community HealthPathways with referral instances using the Welsh Clinical Communications Gateway (WCCG) although this is an imperfect system as the connection is not made by the referring clinician, it is made by the triage clinician on receipt of the referral.

WCCG does not have the same functionality in the other Health Boards. The system is administered centrally by DHCW and capacity to make changes is limited. Despite limitations, it still represents a

wealth of information on clinical behaviour change considering the Kings Fund quality measures.

An illustration of the multiple factors affecting referral reporting in Wales is included in the metadata attached to the Stats Wales data sets. Causes for variation in the data include:

- Inconsistent application of treatment codes between Health Boards.
- Health boards not submitting full data sets for periods of time.
- Variable reporting start points for different clinical areas.
- Changes in Health Board boundaries.
- Reporting changes from Main Specialty to Treatment Function Code
- Data for non-GP referrals from October 2014 includes additional sources of referral resulting in an increase in referrals going forward.

A blanket reduction in referral numbers in some instances is not the correct clinical outcome. There are areas of under-referral, and in these areas an increase in referral numbers is necessary to provide better care for the people of Wales. When considered as an aggregate number of referrals, this nuance is not visible, and potential benefits can be overlooked.

Improvement in unwarranted variation, as required by the MAG report[1], is a potential benefit of Community HealthPathways and requires a more focused analysis approach than that presented here. Using practice level referral numbers on a Health Board basis for high volume clinical areas may shed light on changes in variation before and after implementation of Community HealthPathways. This approach was suggested by Professor Sally Lewis, an international expert in Value in Health and former GP, who contributed to the recent MAG report[1]. This data is not available to the Yma, Here or Streamliners teams currently, and is not assessed in this report but is likely to be available to Health Board teams with data analytics support.

Clinician Support Recommendation 2

Work is required to understand the extent of unwarranted variation in referral numbers. Mapping changes in variation against implementation progress will provide insight into the impact of Community HealthPathways in alignment with the MAG[1] report.

4.3 Patient Experience

The Patient Experience theme is based on the hypothesis that Community HealthPathways enables improved personalised care, reduction in health inequity, and improves a patient's experiences of their care. Community HealthPathways contributes to the patient experience by promoting consistency and provides opportunities to identify inequity. It also aims to improve personalised care and patient satisfaction.

Direct patient feedback on their experiences of care is not available at this time. Therefore, a proxy was created, in the form of the priority question:

Does Community HealthPathways help clinicians to manage patient expectation well by providing resources and waiting times on the pages?

Pathway Quality

A manual audit of 40 live pathways on the Wales Collaboration site reported how many pathways contained resources which could support effective expectation setting. The following features were audited:

1. Self-care options explicit within pathway
2. Social Prescribing options explicit within pathway
3. Shared care decision making, or patient decision aid included within pathway.
4. PROMs/PREMs or other audits/outcome measures included in Information for Professionals
5. GP Education included in information for professionals.
6. Pathway is clear and short enough to allow the user to find the most important information readily.

From Figure 15 it is evident that the audited pathways are overwhelmingly found to be succinct, leading to easier use at the point of care, and where appropriate, GP education, and self-care options were explicit. This suggests these pathways support patient expectation setting by providing the clinicians with suitable resources.

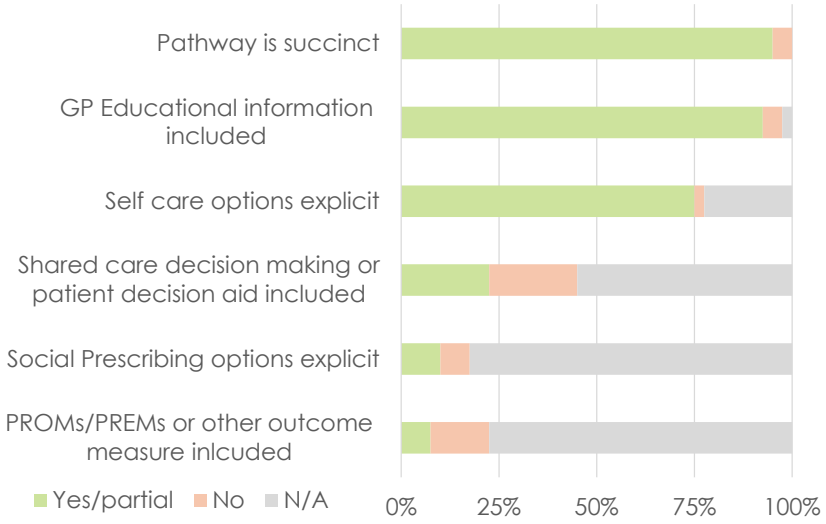

Figure 15 Prevalence of audited features in reviewed Wales Collaboration Site pathways.

Feedback indicated other systems provide the opportunity to immediately print patient resources and/or communicate directly with them - Other systems such as Accurx15[17] and Ardens16[18] software (in use in England and therefore used by some GPs who work on both side of the border) were mentioned as preferred methods of providing patient resources. These systems occupy different niches to Community HealthPathways, but offer features valued by the GPs interviewed, offering opportunities for future compound benefits.

"We send information to patients through text messages with links via Accurx"- GP partner.

"It would be quite nice if you had all Wales guidance [for patients] that we could access with each one [pathway]"- Senior GP Partner

Shared care decision making was not applicable to 55% of the pathways audited but found to be present in half those where it was appropriate. Social prescribing options, and links to other outcomes measures such as PROMs and PREMs was generally found not to be applicable to the pages audited. However, GP feedback indicated that PROMS links are valuable where they are appropriate and there is an opportunity for education where this is not the case.

[17] https://www.accurx.com/ accessed 24 June 2025
[18] https://ardens.org.uk/ accessed 24 June 2025

"Every pathway should either have appropriate points in the pathway where a PROM is measured, or it should have a good articulation of why PROMS are irrelevant."- GP

Patient Experience Recommendation 1

Continue to uphold rigorous guidelines on pathway quality, including measures such as waiting list links, and patient information to support best practice on the ground. Audits of future pathways against guidelines will provide insight into the success of the guidance, offering opportunities for continuous improvement as the programme matures in Wales.

Waiting List Information

Links to current wait times for referred patients would also support effective expectation setting. Links to waiting times are applicable to request pages on live sites, not to the Wales Collaboration site which contains unlocalised pathways. Waiting times are hosted on the NHS Planned Care website [19], which offers links to Health Board specific sites, through which current waiting times are listed by clinical specialty.

This analysis only looks at the number of request pages as a whole and does not exclude pages where waiting list times are not relevant. Considering the top 10 request pages containing waiting list information across all the Health Boards, we can get a better picture of which clinical areas have most lent themselves to the inclusion of waiting list information on their request pages - Figure 16

Figure 16 word cloud showing the distribution of clinical areas in the top 10 request pages with waiting time links

[19] https://111.wales.nhs.uk/PlannedCare/ accessed 29 May 2025

Figure 17 shows the differences in proportions of request pages containing links to waiting list times across the Health Boards. HDUHB has the largest number of request pages, at 277, and CTMUHB has the lowest number of pages at 75 (data as of May 2025).

Comparing the proportion of request pages containing links to the waiting lists, the data shows that CAVUHB has the lowest proportion of pages with links, and ABUHB and SBUHB have the highest proportion.

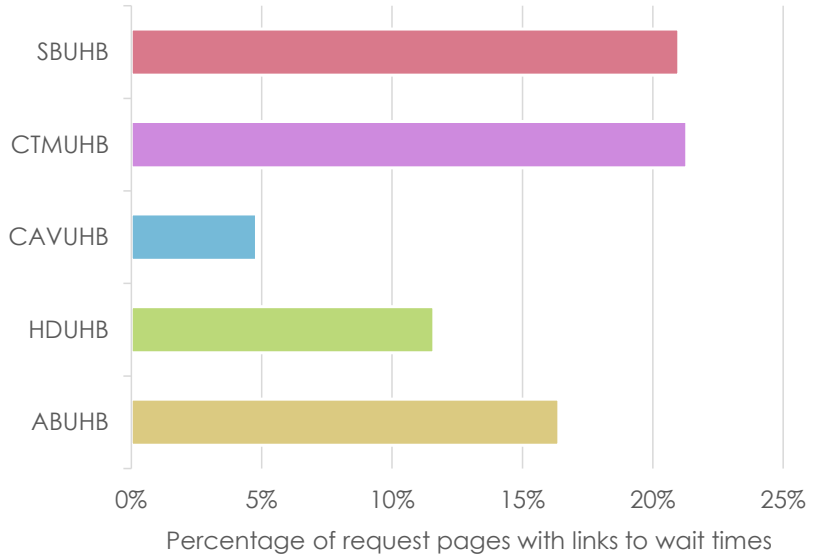

Figure 17 Proportion of request pages containing links to data which may support patient expectations around waiting times

Investigating this result shows three variations in the approach to providing waiting time information:

CAVUHB offers a standalone "outpatient information" page, which links to the waiting list site but does not often link to this page from request pages directly, which may account for the lower proportion of request pages with links.

HDUHB, SBUHB and ABUHB link from request pages directly to the front page of the waiting list site not into the relevant waiting list. Links to the Waiting List site do not appear elsewhere on the Health Board site.

CTMUHB links from request pages, directly to the relevant waiting list page for that specialty, whilst links to the waiting list site do not appear elsewhere on the Health Board site. Though this seems best from the user's perspective. This interpretation may improve efficiency at practice level by reducing the number of clicks required for GPs to find the information they need.

Page view data shows that request pages in CAVUHB receive significantly higher levels of traffic than the Outpatient Information page, where the link to waiting lists is available. The traffic is low, but not insignificant.

There is an opportunity to link existing request pages in HDUHB, SBUHB and ABUHB directly to the specialty the request is for, creating efficiency in primary care by reducing the amount of time spent searching on the Planned Care site.

All Health Boards could adopt the approach of CAVUHB in also including a link to waiting lists on the front page, helping primary care clinicians to access relevant information more quickly if they need to check outside of making a referral request.

Patient Experience Recommendation 2

Reviewing the best practice from CTMUHB on destination of waiting list links in request pages will help quantify the time benefit of more detailed link inclusion. If quantitative benefits are apparent, this can then be implemented in new request pages, and over time during the natural review process in existing request pages.

4.4 National Alignment

The National Alignment theme covered metrics related to All Wales benefits of Community HealthPathways. Networks of specialists have been formed and meet regularly as part of the national programme, maintaining momentum in developing nationally important guidance. All the Health Boards currently involved in the programme have adopted Pathway Sharing by Default, leading to a distributed workload to develop a comprehensive set of pathways.

Have all Health Boards adopted Pathway Sharing by Default?

All active Health Boards are participating in Pathway Sharing by Default. The maximum potential number of attached follower sites for each pathway is 5 – each of the currently active Health Boards. However, as BCUHB has only very recently joined the programme and is therefore excluded from the following analysis, the working maximum is 4.

Health Boards acting as "Attached Followers" receive automatic updates to those pathways when changes are made on the national pathway. "Detached Follower" status enables a Health Board to use a pathway on their site but the pathway may vary more substantially from the national pathway after localisation to accommodate necessary local variation. Health Boards can choose to adopt national updates. In both cases, Health Boards are notified when changes are made at a national level, improving communication efficiency in sharing new best practice and guidance.

Streamliners' data shows Health Boards infrequently opt for "Detached Following", with most pathways implemented as "Attached Following", maximising the national benefit of the programme. Figure 18 shows the proportion of pages for which each site is a lead region, which are followed in either attached or detached styles.

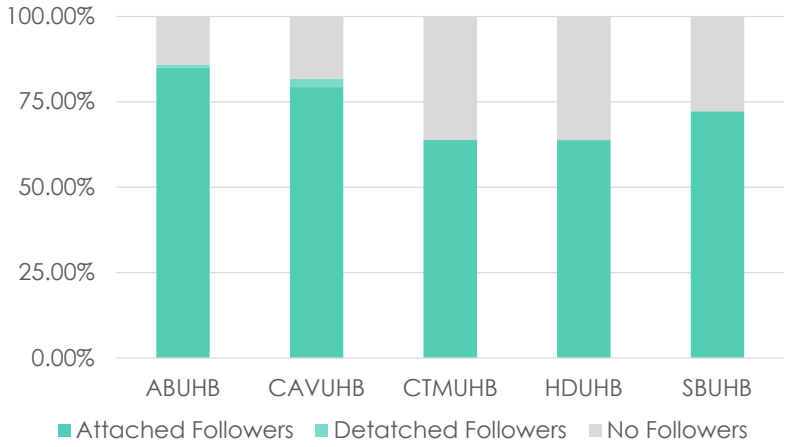

Figure 18 Attached and detached followers of pathways by lead site shown as a proportion of the potential maximum number of followers in Wales for the live pages on each site at the time of writing. This analysis excludes BCUHB as they are a new site and not currently leading on any pages.

How does the number of pathways on the collaboration site change over time?

Since the launch of the national programme, the collaboration site pathways have steadily increased. Figure 19 shows the growth of pathways on the site available for localisation and being developed. As new Health Boards come online, this stock of available guidance will accelerate their ability to reach high levels of coverage quickly.

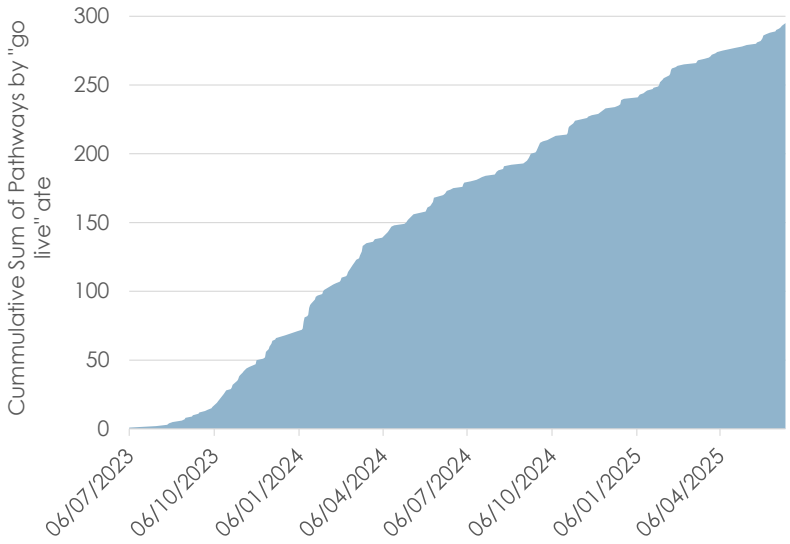

Figure 19 Cumulative pathways on the Wales Collaboration Site arranged by "go live" date

Anecdotal evidence has also been gathered during implementation, showing the value of Community HealthPathways as a national focus.

"In Wales there are various pathways that have been developed on an all Wales basis. But very often they're on various electronic computerised repositories that you have to log into and find. You've got to remember which of the electronic repositories each bit of information is in. That's why I'm hoping Community HealthPathways might be quite useful from the point of view if it is quick and easy to use and keeps all the information in one place." – GP during an interview with Yma

National Alignment Recommendation 1

Support benchmarking of progress at a local, regional and national level to ensure effective comparisons are being draw and to maintain momentum of the programme into the future.

Clostridioides difficile Pathway

C. difficile infection (CDI) rates in Wales have historically been high in comparison with England and Scotland. Surveillance data shows rates of 36.7 CDI per 100,000 population in Wales in comparison to 30.1 CDI per 100,000 in Scotland and 23.9 CDI per 100,000 in England [20].

[20] Tydeman, F., Craine, N., Kavanagh, K., Adams, H., Reynolds, R., McClure, V., Robertson, C. (2021). Incidence of *Clostridioides difficile* infection (CDI) related to antibiotic prescribing by GP surgeries in Wales. Journal of Antimicrobial Chemotherapy, 76(9), 2437–2445.

Despite rates declining in the early 2000s, there has been an increase in CDI since the COVID-19 Pandemic – 1172 cases of CDI were reported by Health Boards in Wales for April '22 – March '23. This is approximately a 7% increase in cases in comparison to the equivalent period in 2021/22 [21].

Increases in prevalence of CDI generally, means it is even more important that primary care clinicians can easily access the latest information easily to identify and treat quickly, and interrupt transmission in the community.

Prior to the development to the CDI pathway by CAVUHB, the sources of guidance were varied, including NICE guidance, and emailed updates from the Health Boards, informed by the UK Anaerobe Reference Unit. To check the most recent guidance, clinicians may have needed to search their email inboxes for the most recent update email.

Following the development of the standalone pathway for CDI, the majority of live sites in Wales are "Attached Followers", enabling swift updates to the current treatment guidance nationally, and potentially reducing the spread of CDI in the community.

Updating Guidance

During engagement with clinical leads a need was identified to update guidance on treatment of Polio. The clinical network reported during the meeting that Community HealthPathways was the "best way" to get the guidance update rolled out to as many people as possible.

There is also a national priority to update the guidance on unscheduled bleeding on Hormone Replacement Therapy, which must be communicated to GPs consistently. The alternative to using Community HealthPathways was reported to be a combination of emails, posters and Health Board teams attending physical events. The appropriate pathway will be updated, and all Attached Follower sites will reflect the changes, potentially reducing the need for more resource intensive communications activities in future.

Respiratory CIN

Prior to the national roll out of Community HealthPathways in Wales, the Institute for Clinical Science and Technology (ICST) Respiratory

[21] Public Health Wales. (2023). Wales HCAI Monthly Summary 2022-23 - Public https://public.tableau.com/app/profile/victoria6405/viz/WalesHCAIMonthlySummary2022-23-Public/FYUpdateSummary Accessed 19 February 2024

Toolkit [22] was a well-publicised source of respiratory guidelines, training and patient support tools.

Early programme engagement with the Respiratory CIN had been challenging, with some confusion about the role of Community HealthPathways and possible duplication with the ICST guidelines.

In June 2025 a meeting took place between the National Clinical Lead for Respiratory and members of the Community HealthPathways programme team, with the aim of understanding the possibilities that exist between Community HealthPathways and ICST.

The outcome of the meeting was a consensus on the need to have a single source of guidelines for primary care; and that Community HealthPathways could be used to reference ICST tools and assets that go beyond the content that would be held in a traditional Community HealthPathways pathway. Review of the asthma and Chronic Obstructive Pulmonary Disease (COPD) pathways showed that ICST was already referenced; and there are follow up actions to ensure the wider portfolio of pathways are also aligned.

Bone Health

The programme team have been invited to attend a range of network forums since the inception of Community HealthPathways in Wales. Once of these is the newly formed Musculoskeletal (MSK) National Strategic Clinical Network Leadership Group.

At a meeting in May, the National Clinical Lead for Bone Health was reporting difficulty in communicating with GPs in sharing information about a new Fracture Liaison Service (FLS). The Community HealthPathways programme team arranged a follow up meeting with the Clinical Lead to describe the opportunities that Community HealthPathways could offer the Bone Health Network.

The outcome of this was a short piece of engagement work to understand the visibility of FLS across Wales to Primary Care Cluster Leads. This information was then shared at a subsequent Bone Health Network meeting with connections made with required updates to the Osteoporosis pathway. The lead region Clinical Editor was connected with the network following the meeting with plans underway to align the pathway with the Network's latest quality statement.

[22] https://icst.org.uk/toolkits/respiratory-toolkit/ Accessed 10 July 2025

Understanding Variation

The MSK CIN has five live national priority pathways, and it is possible to review which Health Boards are following the pathway. Comparing the localisation details between Health Boards then enables the network to identify variation, and work to establish if it is warranted or not.

The Earwax pathway is also a good example of the use of the national programme to understand variation between sites. The observation of this pathway has resulted in an action for Yma to design a process by which unwarranted variation can be reported.

Ongoing Improvement

A Chronic Kidney Disease (CKD) pathway was developed by the Welsh Kidney Network, with several Health Boards involved in creating content during the initial writing process. The result of this highly collaborative activity is a pathway with no localisable content, meaning the pathway is the same across Wales.

The pathway is connected to ongoing Quality Improvement work on CKD in primary care, offering an opportunity to share best practice and create meaningful improvements in care, through the Community HealthPathways platform.

Not only is this approach more efficient than creating a pathway which requires localisation, it also enables conversation around equitable provision in different areas directly with the relevant network.

Following the pathway going live on the lead region site on the 16th of May there was a single communications event (the regular Pathway Sharing Meeting, facilitated by Yma and Streamliners UK). By the 6th of June half of the active Health Boards have the CKD pathway live.

The National Clinical Lead for Planned Care is building on this to develop a set of tools for primary care teams to use to complete their contractual obligations around the CKD Quality Improvement project, centred around the utilisation of Community HealthPathways.

National Alignment Recommendation 2

Encourage network collaboration in new pathways to streamline localisation and provide opportunities to identify variation in local services, therefore optimising the impact the national approach affords as the foundation of system improvement

National Alignment Recommendation 3

Development of an evaluation plan for the next phase of national implementation will draw from lessons learned in this phase and align the evaluation of this programme nationally as well as locally.

4.5 Efficiency

Nationally managed pathways create shared workloads, improving efficiency in creating and managing guidance. It also presents opportunities for evaluation of service delivery against need and enables targeted development of services.

Does a national implementation and pathway sharing by default use a different amount of resource than a Health Board by Health Board isolated approach would have done?

A manual audit of Streamliners' data was carried out by David Todd [23], a consultant commissioned by Streamliners NZ to support evaluation and the implementation in Wales.

This work is preliminary, as most sites in Wales are new, and do not have very high numbers of pages as yet. Considering average page or pathway development times using small sample sizes, results are susceptible to bias from one or two particularly fast, or slow to develop pages. However, additional data over time will add to this picture and can be revisited in the future for a more complete analysis.

Streamliners data show that localisation can take a widely varying time to complete, with some pathways taking only a week to localise, and some taking several years. Factors influencing these numbers include:

- **Complexity of localisation** – if the pathway originates from another global region there may be more work in localising it.
- **Engagement with local subject matter experts** – where localisation is started but then stalled, it could be a lack of local expertise to contribute

[23] Emerging Benefits Series Pathway Sharing by Default January 2025

- **Changing local priorities** - pathway localisation started but not completed because other pathways became more urgent
- **Method for localisation** - the data assumes all sites following the same process, but it is known that some teams prefer other processes, which can alter the apparent time taken, when the level of work is unchanged.
- **Number of concurrent activities** - In more established sites, effort is focused on reviews and updates instead of localising new pathways.

These factors considered, Figure 20 shows the comparison of average pathway localisation timescales, and number of localisations completed.

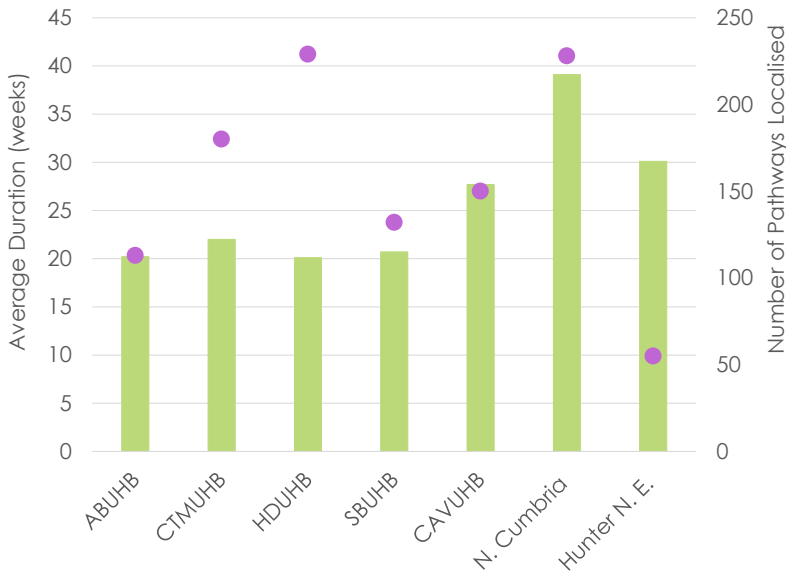

Figure 20 Comparison of early implementation average duration for localisation of in green. Data is from March 2023 to Mid-2025 (ABUHB, CTMUHB, HDUHB and SBUHB), or the first 24 months of implementation. Number of localised pathways during that period in purple

The data shows that the newer sites in Wales have a shorter average duration for localisation than the early implementation phases of other comparable sites including CAVUHB, North Cumbria, and Hunter New England. This could be due to Pathway Sharing by Default creating the opportunities for localisation of existing pathways. Comparison with early implementation data in BCUHB would complete this picture over the next couple of years.

Comparing the number of pathways being localised shows that short localisations aren't due to a smaller number of pathways being

localised since 2023 in Wales. HDUHB has the highest average number of localised pathways of all the sites being compared.

In comparison with other implementations more globally, Wales localises pathways on overall average, 72% faster than other countries including New Zealand, parts of Australia as well as England[23].

Efficiency Recommendation 1

Continuing the Pathway Sharing by Default approach as BCUHB comes online and PTHB potentially join in the future will maximise the efficiency in getting these sites operational quickly.

Does Community HealthPathways change the speed of decision making or change the amount of clinical time spent looking for information?

This impact is something that must be measured on a personal level, in comparison to their experiences prior to launch. In interviews, it was observed that many found it difficult to quantify how much time they took to find guidance before launch and therefore were unable to confidently state whether Community HealthPathways made the process faster.

Qualitative feedback received on this topic included themes on the value of Community HealthPathways as a comprehensive resource:

"Looking online for generic guidelines can be very time consuming and quality of information available would vary considerably. HealthPathways resolves this by holding the required information in one place." GP Interview

Suggestions for modification to page formats that could make them faster to navigate were made by several survey respondents. The suggestions themed around visual representation of a pathway process for ease of use during an appointment:

"The pathways are not visual enough for a quick reference read. Appreciate it is a difficult balance of brief succinct information and enough explanation." Survey response

"A simplified flowchart would have made the pathways clearer and easier to follow, particularly given the limited time constraints." Survey response

Some respondents indicated frustration where pathways had not yet been localised and suggested they would use the site more when it was more comprehensive. It is known from older sites that usage grows over time, which is likely to be the case in Wales also. This organic growth of the coverage of pathways, and therefore the user base occurs over several years – CAVUHB launching in 2019, and benefits are unlikely to be fully observed in as short a time frame as less than two years.

Efficiency Recommendation 2

Expanding coverage of sites in Wales will increase the reach of pathways, and their impact on information retrieval and day-to-day decision making. Including BCUHB and PTHB in milestone setting and review activities will help maximise pathway development and usage to support a truly All Wales delivery.

5 RECOMMENDATIONS

5.1 User Engagement

Build on the national engagement strategy including National Clinical Networks, to maximise adoption across primary care roles.

Feedback received by programme teams can offer insight into areas where engagement is particularly effective, for example, face to face engagement in CAVUHB during their implementation. Maintaining opportunities for programme teams to meet regularly and share their experience will enable sharing of engagement best practices. This is particularly valuable for BCUHB as it is approaching launch in 2025, and potentially PTHB in the future.

5.2 Clinician Support

Continue to support collection of feedback from GPs across Wales, including in newer areas (e.g. BCUHB) will offer insight into the ongoing impact of the programme as it becomes embedded. It also provides a national benchmark for progression of Community HealthPathways uptake and impact.

Work is required to understand the extent of unwarranted variation in referral numbers. Mapping changes in variation against implementation progress will provide insight into the impact of Community HealthPathways in alignment with the MAG[1] report.

Increase awareness and understanding of the programme at the most senior levels within NHS Wales and the seven Health Boards will help to leverage the opportunity which the national programme provides, to address unwarranted variation, and deliver system transformation.

5.3 Patient Experience

Continue to uphold rigorous guidelines on pathway quality, including measures such as waiting list links, and patient information to support best practice on the ground. Audits of future pathways against guidelines will provide insight into the success of the guidance, offering opportunities for continuous improvement as the programme matures in Wales.

Review best practice from CTMUHB on destination of waiting list links in request pages will help quantify the time benefit of more detailed link inclusion. If quantitative benefits are apparent, this can then be

implemented in new request pages, and over time during the natural review process in existing request pages.

5.4 National Alignment

Support benchmarking of progress at a local, regional and national level to ensure effective comparisons are being draw and to maintain momentum of the programme into the future.

Encourage network collaboration in new pathways to streamline localisation and provide opportunities to identify variation in local services, therefore optimising the impact the national approach affords as the foundation of system improvement

Develop an ongoing approach to evaluation for the next phase of implementation will draw from lessons learned in this phase and align the evaluation of this programme nationally as well as locally.

5.5 Efficiency

Continue the Pathway Sharing by Default strategy as BCUHB comes online and PTHB potentially join in the future will maximise the efficiency in getting these sites operational quickly.

Expanding coverage of sites in Wales will increase the reach of pathways, and their impact on information retrieval and day-to-day decision making.

Review milestone and implementation options to include and support launch in BCUHB and PTHB, maximising pathway development and usage, and support a truly All Wales delivery

6 CONCLUSIONS

Implementation and uptake of Community HealthPathways in Wales is progressing at pace. The first half of 2025 brought over a million page views since the national programme launched, a sixth Health Board online, and national engagement events.

User engagement is growing, with the majority of users across Wales reporting that Community HealthPathways is now their preferred source of guidance. CAVUHB presents a view of what the future could look like for the other Health Boards, with nearly 80% of users reporting Community HealthPathways as preferred.

We have shown how upholding good quality standards in developing pathways can support the patient experience. We have also shown how differences between pathway development processes offer opportunities for learning from best practice.

Clinicians report that Community HealthPathways supports their day-to-day practice and largely meets their needs. There were suggestions for a more visual approach, and that certain clinical groups would benefit even more from using Community HealthPathways, such as trainee GPs and locums.

The Pathway Sharing by Default approach supports fast roll out of nationally updated clinical guidance in many areas. This process of sharing development work has also resulted in pathways being localised more quickly that comparable implementations globally, and showcases the collaborative effort achieved by this national roll out.

Opportunities are presented for development in the near future, and further ahead, to bring the learning forward and maximise its value in Wales. Specialist networks have been mobilised to discuss complex national priorities, and there has been extensive cross Health Board collaboration.

Continuing to plan for future evaluation to ensure the programme is prepared in advance to show the impact of the work being undertaken and showcase the NHS in Wales nationally, and internationally. Recommendations are made here to maximise the value of the programme both for the NHS, and for the Health Boards, and individual clinicians using Community HealthPathways daily.