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Interim Evaluation Report

**National Evaluation of Community
HealthPathways**

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Here at TriTech Institute, we support the development of healthcare solutions on a local, national, and global level offering designers and manufacturers a single point of access to the NHS through a collaborative and agile approach.

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Executive Summary

Situation

A national evaluation undertaken by Tritech in 2025 (referred to within this document as the 'initial evaluation') found evidence of the benefits and effectiveness of Community HealthPathways (CHP). It also identified a need for greater stakeholder engagement, increased awareness, and improved integration of CHP into routine clinical practice to maximise its potential. Several recommendations were made to strengthen implementation, governance, training, data quality, and evaluation arrangements.

As the current commissioning period approaches renewal, there is a requirement to provide robust evidence of the utilisation, effectiveness, and value of CHP within Hywel Dda University Health Board to inform local funding decisions. In parallel, evidence is required at a national level to support decisions regarding the recommissioning of CHP across Wales. While platform usage data are available, uncertainties remained regarding the extent to which CHP influences referral quality, adherence to clinical guidance, service demand, workforce efficiency, patient pathways, and wider system outcomes. Furthermore, previous evaluations highlighted limitations in the availability and consistency of routine referral and outcome data across health boards, presenting ongoing challenges for comprehensive impact assessment.

Consequently, this evaluation in 2026 has been commissioned to assess progress against previous recommendations, quantify current utilisation, and generate evidence on the clinical, operational, and economic value of CHP to support future local and national decision-making.

This report presents the interim findings, with a focus on the value that CHP brings to HDUHB and nationally. The final report with the final findings will be produced by the end of December 2026.

Evaluation Methodology

The TriTech Institute conducted a mixed-methods evaluation of the CHP platform, incorporating both quantitative and qualitative data collection approaches. The quantitative component focused on engagement metrics, including the extent to which the platform was utilised across Wales. In addition, referral metrics were examined, including referral rates within Hywel Dda University Health Board (HDUHB) and across Wales, as well as the appropriateness of referrals received within HDUHB. This analysis aimed to examine changes in referral activity and quality associated with CHP implementation and to explore its potential contribution to clinical decision-making and the efficiency of referral pathways. As this was an observational evaluation rather than a controlled study, observed changes cannot be attributed to CHP alone and may also

reflect wider changes in services, clinical practice and demand occurring over the same period.

Complementing this, a qualitative strand involved a survey distributed to Health Care Professionals (HCPs) across both primary and secondary care settings in Wales. The survey solicited feedback on the perceived value and utility of the CHP platform, including its perceived impact on how much time it has saved GPs during their daily practice. Additionally, a subset of HCPs participated in semi-structured interviews to provide deeper insights into their experiences and perspectives regarding the platform's implementation and effectiveness.

Findings of the Evaluation

Adoption and engagement across Wales: CHP has continued to expand substantially since the 2025 evaluation. The number of live pathways across Welsh CHP sites increased from 1,291 in May 2025 to 1,913 in August 2026. Across the most recent comparable 12-month periods, national page views increased from 357,394 to 443,998, representing growth of 24.2%. Engagement increased in most health boards with a full-year comparison available, including increases of 95.1% in ABUHB, 66.9% in CTMUHB and 58.5% in HDUHB. Swansea Bay was the exception, recording a 21.0% reduction in page views despite continued growth in pathway development. This is consistent with the more passive implementation approach within SBUHB, where the CHP programme has been paused since January 2026. Overall, these findings indicate that CHP is becoming increasingly established across Wales, although implementation maturity and engagement remain variable between health boards.

Changes in referral activity associated with CHP implementation: Data from HDUHB identified substantial changes in referral activity following implementation of CHP pathways. Across matched pre- and post-implementation periods, referrals decreased from 116,859 to 102,606, representing 14,253 fewer referrals, or a 12.2% reduction. Reductions were observed across all seven GP clusters, although the magnitude varied geographically. While the timing and direction of these changes are consistent with CHP potentially contributing to the observed reduction, the observational design does not establish causation and other contemporaneous changes in services, demand and clinical practice may also have contributed. Applying an indicative cost of £181 per referral, the observed reduction equates to approximately £2.58 million in potential equivalent resource release. This is an estimate of the value of potentially released capacity and should not be interpreted as a directly attributable or cash-releasing financial saving.

Recorded referral appropriateness also improved. Among referrals where comparable appropriateness data were available, the recorded inappropriate referral rate decreased from 6.5% before implementation to 2.6% afterwards, a relative reduction of 60% in the inappropriate referral rate. Of 120 pathways eligible for pathway-level comparison, 72 showed improvement, 43 worsened and five were unchanged. The pathway and GP-cluster analysis demonstrated considerable local variation, indicating that health-board-level results can mask important differences between clinical pathways and geographical areas. This provides an opportunity to use CHP data to identify pathways or locations where targeted pathway review, engagement or service improvement may be warranted.

Healthcare professional experience and perceived impact on clinical practice: The 2026 survey received 121 responses, of whom 102 reported actively using CHP. Respondents were predominantly from primary care (n=94), with limited representation from secondary care (n=8). The findings therefore provide valuable insight into the experiences of clinicians who engaged with the survey, many of whom were regular CHP users, but should not be assumed to be representative of the wider clinical workforce. In particular, the survey may underrepresent non-users, less engaged clinicians and those who have experienced barriers to adoption. Survey findings should therefore principally be interpreted as evidence of perceived value amongst respondents, rather than as population-level estimates of CHP's impact.

Within this context, the findings indicate substantial perceived value amongst CHP users. Among primary care respondents, 75% reported using CHP daily or multiple times each day, around 91% reported increased confidence in decision-making and more than three-quarters reported improved clarity of referral decisions. 71.3% reported that CHP had helped to reduce rejected referrals, and respondents also reported changes in diagnostic behaviour, including reductions in unnecessary investigations and increased appropriate testing.

The evaluation suggests that CHP may help reduce unwarranted diagnostic testing by providing clearer, evidence-based guidance on appropriate investigations. In the primary care survey, 60 of 94 respondents (63.8%) reported that CHP had reduced unnecessary tests, either alone or alongside increasing appropriate testing, indicating that CHP may support more targeted use of diagnostic resources.

Healthcare professionals also perceived value for patients. In the survey, approximately half of respondents identified improved patient safety as an area in which CHP provides value and 70.7% identified improved quality of care. Interviews reinforced these findings, with clinicians describing the value of clear red flags, escalation criteria and referral guidance in supporting safer and more standardised

patient management. However, direct patient outcome data were limited within the interim evaluation and these findings should therefore principally be interpreted as healthcare professional perceptions rather than demonstrated changes in patient outcomes.

Workforce and productivity value: CHP was consistently described as a time-saving resource. Approximately 90% of primary care respondents reported that CHP saves time when finding clinical guidance, and 88 respondents reported some time saving across their clinical day. Collectively, their reported time savings were estimated at 22.48 to 26.82 hours per working day. Applying profession-specific unit costs gives an estimated equivalent resource release of approximately £1.20 million to £1.38 million per annum among the survey respondents alone. These figures represent equivalent released staff capacity rather than directly cash-releasing savings. Given that they relate only to survey respondents, the potential national workforce benefit may be considerably greater, although the available data do not currently support robust extrapolation to all CHP users across Wales.

The qualitative evaluation also identified a broader workforce-development role. Clinicians described CHP as an educational and supervisory resource which can support trainees, locums and clinicians managing unfamiliar conditions or referral processes. By providing an accessible source of locally relevant guidance, CHP may reduce reliance on informal knowledge, support professional development and facilitate more autonomous clinical decision-making.

Value of a national approach: A particularly strong theme from the qualitative findings was the value of national standardisation combined with appropriate local adaptation. Interview participants described shared pathways as providing a common evidence-based framework for care across Wales while allowing referral routes and service information to reflect local arrangements. This was considered important for reducing unwarranted variation, facilitating shared learning and promoting greater equity between health boards. Participants expressed concern that a return to fragmented local approaches could increase duplication and variation and potentially contribute to a "postcode lottery" in access to care and standards of practice.

The national model therefore potentially creates value beyond the individual pathway or consultation by providing infrastructure through which evidence and learning can be developed once, shared across Wales and adapted locally. This combination of national standardisation and local relevance emerged as one of the distinctive strategic benefits of CHP.

Realising the potential of CHP as a whole-system transformation tool: The longer-term value of CHP is likely to depend on its development from a predominantly clinical reference and referral-support resource towards a platform that supports transformation across the whole healthcare system. The greatest potential value arises where nationally agreed evidence-based guidance and locally agreed pathways are understood, owned and consistently applied by both referring and receiving clinicians. Where primary care referrals are made in accordance with an agreed pathway but receiving services do not use the same pathway to support triage, referral acceptance or subsequent management, opportunities to improve consistency, efficiency and patient flow may be limited.

The evaluation therefore suggests that implementation maturity should be considered at a whole-system level rather than solely in terms of pathway availability or primary care utilisation. Mature implementation would include comprehensive pathway coverage, awareness and consistent utilisation in primary care, meaningful secondary care ownership and engagement, alignment of referral and triage processes with agreed pathways, and integration with clinical, referral and digital workflows. Greater interoperability and workflow integration may be particularly important in moving CHP from a resource clinicians actively choose to consult towards an embedded component of routine clinical decision-making.

Future implementation should therefore focus not only on increasing utilisation, but on strengthening shared clinical ownership, pathway compliance and integration across organisational and professional boundaries. This would provide a stronger foundation from which CHP could support standardisation, reduce unwarranted variation and contribute to more coordinated system-wide clinical decision-making.

Potential contribution to patient safety and clinical risk: Healthcare professional feedback identified patient safety as an important area of potential value from CHP, particularly through clearer referral criteria, red flags, escalation guidance and greater standardisation in clinical decision-making. These findings provide an encouraging signal of potential safety benefit, but direct patient outcome data were limited within the interim evaluation and therefore do not demonstrate that CHP has resulted in measurable improvements in patient safety.

An exploratory review of historic HDUHB primary care claims identified 23 claims, approximately 16 of which related to delayed, missed or inappropriate referrals. The types of failures identified included problems with referral processes, escalation and clinical information, which overlap with areas that CHP is designed to address through clearer referral criteria, escalation guidance and standardised pathways.

It is not possible to conclude retrospectively that CHP would have prevented individual incidents or associated costs. Nevertheless, the findings provide a plausible mechanism through which effective pathway adoption could contribute to improved referral governance, organisational learning and mitigation of future clinical risk. The potential value of CHP in this context should therefore be considered primarily in terms of patient safety, standardisation and risk reduction, rather than assuming direct avoidance of historic negligence costs.

Opportunities to realise further value: Despite generally positive findings, the evaluation identified a gap between pathway availability and consistent pathway use. Interview participants reported variable awareness and adoption, incomplete pathway development in some areas, and occasions where referrals continued to arrive without recommended investigations or evidence that relevant pathways had been followed. This suggests that simply developing pathways is insufficient to achieve their full potential and that implementation, engagement and integration into clinical workflows remain critical.

Healthcare professionals identified opportunities to improve integration with clinical record and referral systems, simplify access and login processes, improve navigation and search, enhance mobile access and ensure that pathways remain current and accurate. The findings also highlight the need to align pathway recommendations with service capacity. Redirecting care towards earlier intervention or conservative management will only deliver the intended benefits if sufficient workforce and resources are available at those stages of the patient pathway.

Due to varying levels of implementation maturity across Wales, the benefits observed to date may represent only a proportion of the programme's potential value. Further clinical, operational and system-level benefits may emerge as pathway coverage increases, shared ownership develops across primary and secondary care, interoperability improves and CHP becomes more consistently embedded within routine workflows. However, these potential benefits should be demonstrated through continued evaluation rather than assumed.

Overall implications if CHP were no longer available: Taken together, the interim evidence suggests that the loss of CHP without an equivalent replacement would be unlikely to represent a simple removal of a digital platform. It could result in the loss of clinical decision support, workforce capacity, nationally coordinated pathway infrastructure and a mechanism for promoting consistent referral practice across Wales.

The most plausible consequences identified from the evaluation are:

- More clinician time spent locating and interpreting clinical and referral information;
- Loss of some of the workforce capacity currently released through CHP use;
- Potential increases in unnecessary, inappropriate, incomplete or rejected referrals;
- Greater variation in clinical and referral practice;
- Reduced ability to standardise care and promote equity across Wales;
- Loss of a clinical education and workforce-development resource;
- Potential weakening of mechanisms supporting referral safety and governance;
- Duplication of pathway development and maintenance if health boards revert to separate local arrangements; and
- Loss of some of the value created through previous national and local investment in pathway development.

However, these consequences should be regarded as risks rather than predicted outcomes. The current evaluation cannot determine the counterfactual effect of withdrawal, nor can it demonstrate that all observed benefits are directly attributable to CHP. The scale of any impact would also depend considerably on whether CHP was withdrawn entirely or replaced with an alternative national or local system providing comparable functionality.

Conclusions

The interim evaluation provides encouraging evidence that CHP is becoming increasingly established across NHS Wales and is valued by healthcare professionals who use it regularly. The findings suggest that CHP has the potential to function as more than an information repository, supporting clinical decision-making, referral management, workforce development, knowledge translation and greater consistency of care. However, the strength of evidence differs across these potential benefits and the findings should be interpreted in the context of the observational evaluation design, relatively small survey and interview samples and predominance of primary care and engaged CHP users within the qualitative evidence.

Within HDUHB, implementation of CHP pathways was associated with 12.2% fewer referrals and a reduction in recorded inappropriate referrals from 6.5% to 2.6% across the matched analysis. These changes are consistent with CHP potentially contributing to improved referral management, but causation cannot be established and other contemporaneous factors may have contributed. The observed reduction in referrals equates to an indicative £2.58 million of potential capacity release when an estimated

referral cost is applied, but this should not be interpreted as a directly attributable or cash-releasing saving.

Survey and qualitative findings provide further encouraging signals of potential value, including reported improvements in clinical confidence, referral decision-making, diagnostic testing and clinician time, alongside perceived benefits for quality, consistency and patient safety. These findings principally reflect the experiences and perceptions of clinicians who participated in the evaluation and should not be assumed to represent the wider clinical population or direct changes in patient outcomes.

The longer-term strategic opportunity for CHP lies in its potential to operate as a whole-system transformation tool. Realising this potential will require more than increasing primary care utilisation. It will depend on shared ownership across primary and secondary care, consistent application of agreed pathways by referring and receiving services, strong clinical leadership, comprehensive pathway development, interoperability with existing digital systems and integration into referral, triage and clinical workflows.

As these conditions are not yet consistently present across Wales, CHP has not reached full implementation maturity and the benefits observed to date may represent only part of its potential value. The next phase of implementation and evaluation should therefore focus on demonstrating whether increasing maturity, interoperability and whole-system adoption translate into measurable improvements in patient pathways, clinical outcomes, resource utilisation and equity. This would provide a stronger evidence base for assessing CHP's longer-term contribution to healthcare transformation across Wales.

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Abbreviations

ABUHB	Aneurin Bevan University Health Board
BCUHB	Betsi Cadwaladr University Health Board
CAVUHB	Cardiff and Vale University Health Board
CHP	Community HealthPathways
CTMUHB	Cwm Taf Morgannwg University Health Board
GP	General Practitioner
HB	Health Board
HCP	Healthcare Professional
HDUHB	Hywel Dda University Health Board
IG	Information Governance
MRI	Magnetic Resonance Imaging
N/A	Not Applicable
NHS	National Health Service
NHSE	National Health Service Executive
NICE	National Institute for Health and Care Excellence
PIS	Patient Information Sheet
PREM	Patient Recorded Experience Measure
PROM	Patient Recorded Outcome Measure
PTHB	Powys Teaching Health Board
SBUHB	Swansea Bay University Health Board
R&D	Research and Development
UK	United Kingdom
WP	Work Package

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1 Situation

1.1 Background and context

Community HealthPathways (CHP) is a digital platform that provides health care professionals (HCPs) with access to nationally endorsed and locally agreed care pathways, evidence-based referral guidance, service information and clinical resources. It supports patient assessment, management and referral decision-making by combining national best-practice guidance with locally relevant service information. Through this integrated approach, CHP aims to improve clinical consistency, enhance the quality of referrals, and support the delivery of efficient, patient-centred care across Wales.

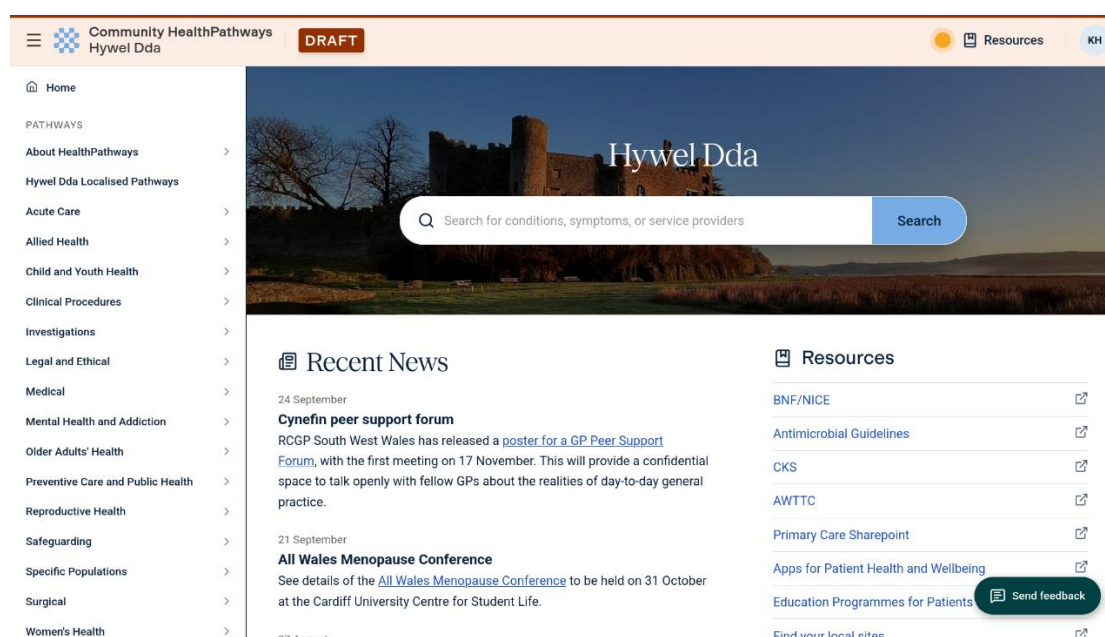


Figure 1. View of the CHP dashboard as seen by primary care HCP using the platform (new website design launched in September 2026).

CHP was first introduced within Cardiff and Vale University Health Board (CAVUHB) in February 2019.

During its initial deployment in Cardiff and Vale, the platform was associated with several notable improvements, including the largest reduction in ear, nose and throat (ENT) outpatient waiting lists reported in Wales. The introduction of pathway-based guidance was also linked to an approximate 66% reduction in MRI referrals for knee and spinal conditions, suggesting improvements in referral appropriateness and the more targeted use of diagnostic services.

The positive outcomes observed within Cardiff and Vale reinforced confidence in the wider applicability of CHP as a tool for service improvement across Wales. Stakeholders viewed the platform as having the potential to support more consistent clinical practice, strengthen referral quality, and contribute to improved patient pathways at both local and national levels. Furthermore, CHP was recognised as a strategic enabler capable of supporting a range of transformation programmes across planned and unscheduled care, primary care, mental health, and end-of-life services.

Building on the success of the Cardiff and Vale implementation, NHS Wales adopted CHP as a nationally coordinated solution in 2023. The decision to move to national procurement reflected both the demonstrated benefits achieved locally and the opportunity to provide all seven Welsh health boards with access to a common platform for the development, maintenance, and dissemination of evidence-based clinical pathways. This national approach aimed to promote greater consistency in care delivery, facilitate shared learning, and maximise the value of pathway development across Wales.

1.1.1 Once for Wales national rollout

The national rollout of the CHP platform across Wales has been delivered through a coordinated "Once for Wales" approach. Under this model, individual Health Boards take the lead in developing specific clinical pathways, which are then adapted by other Health Boards to reflect local service configurations and operational requirements. This collaborative framework aims to enable greater consistency in clinical standards while maintaining the flexibility needed to accommodate regional differences.

1.2 Current situation

To provide an independent and robust assessment of CHP, Hywel Dda University Health Board (HDUHB) and Streamliners have jointly commissioned the TriTech Institute and Innovation Team to undertake a comprehensive evaluation of the platform. Building on the findings of the 2025 national evaluation, this work will assess progress against previous recommendations, quantify the utilisation and adoption of CHP across HDUHB and Wales, and evaluate changes in referral quality, guideline adherence, clinical decision-making, workforce efficiency and wider system outcomes associated with CHP implementation.

CHP has now been implemented across all 7 health boards in Wales with Powys Teaching Health Board joining the programme in June 2026. The initial evaluation demonstrated the value of the platform while identifying opportunities to strengthen stakeholder engagement, increase awareness, improve integration with existing system and enhance data quality. As CHP has matured and expanded, there is now a need to

assess progress against these recommendations and further evaluate its clinical, operational and economic value.

The evaluation will also examine the economic value of CHP, including the benefits of a nationally coordinated programme, and will provide evidence to inform local funding decisions and national recommissioning arrangements for 2027/28. Through the analysis of routine data, stakeholder feedback, and targeted case studies, the evaluation aims to determine the clinical, operational, and financial value of CHP and support evidence-based decision-making regarding its future development and sustainability.

This interim report has been produced to support local and national commissioning decisions with a final report scheduled for publication in December 2026, providing a more comprehensive evaluation of outcomes and impact.

2 Evaluation methodology

A mixed-methods approach was adopted, combining quantitative survey data with qualitative interview data. All data collected were anonymised with no identifiable participant information.

In the early stages of the evaluation, key stakeholders were engaged in Hywel Dda and across Wales with the aim of determining what questions are important for the evaluation to answer in order to support further commissioning decisions. This included the medical directors, and stakeholders at NHS Wales Performance and Improvement to ensure the evaluation is targeting evidence in the areas that are important to decision-makers in Hywel Dda and across Wales.

2.1 Effectiveness of the CHP platform

2.1.1 Uptake of CHP

Data on the number of pathways developed and the number of CHP page views was provided through the HealthPathways Dashboard, which was developed to provide a real time view of various performance metrics of CHP. Uptake data on individual pathways was available at the health board level, allowing for direct comparisons of uptake between the different health boards.

2.1.2 Changes in referral activity associated with CHP implementation in HDUHB

In order to assess changes in referral activity associated with CHP implementation, the total number of referrals for each active CHP pathway in HDUHB was compared pre and post implementation, on a pathway basis for the duration that each individual pathway had been active. Both the number of referrals and the percentage of inappropriate referrals were compared pre and post pathway implementation, and figures were aggregated to give the overall difference pre and post implementation of CHP in HDUHB. The total cost of these aggregated referrals pre and post CHP implementation was estimated using the NHS England national cost collection data (NHS England, 2024).

2.1.3 Healthcare professional experience and perceived impact on clinical practice

2.1.3.1 CHP 2026 Survey

An independent survey was developed to assess the experience of individuals using CHP and its perceived impact on clinical practice across Wales (Appendix 2). The survey was mapped back to the findings and gaps identified in the original CHP evaluation to ensure we are building on that work and strengthening the evidence base. Specifically:

1. **Addressing evidence gaps:** The initial evaluation highlighted a lack of robust quantitative evidence around time savings, referral avoidance, and system efficiency. The survey includes targeted questions (e.g. time saved per consultation, referrals avoided/improved, admin time) to directly quantify these areas.
2. **Embedding behavioural insights:** Questions on frequency of use, the proportion of consultations, confidence in decision-making, and reliance on CHP align with the behavioural findings from the evaluation.
3. **Referral quality and pathway impact:** The survey included measures around referral decisions, rejected referrals, and diagnostics to build on the mixed findings in the initial report and improve understanding of the clinical impact at a local level.
4. **Usability and barriers:** The initial evaluation identified usability and integration as key barriers, the survey therefore captures current barriers to use, workflow integration, and alternative systems used. It is prudent to note that we have been asked to specifically look at the economic value over usability.
5. **System and economic value:** Questions such as “if CHP was no longer available” and how time saved would be reallocated are designed to support modelling of system-level impact and value for money.

In order to maximise responses in a short time window, the survey was shared with senior primary care and medical leadership representatives who chair national peer networks across Wales, with a request that the invitation be cascaded through relevant channels within each health board.

The intention was to support distribution to GP practices and practice managers across Wales and encourage participation and feedback. Relevant national primary care stakeholders and policy representatives were also copied into the communication to ensure awareness of the evaluation and engagement activity.

A direct email was sent to practice managers across Wales (appendix 5)

The survey was also promoted as a banner on the HealthPathways website.

As part of the survey, primary care respondents were asked to estimate the amount of time saved per day through CHP. These estimates were used to calculate the overall level of resource release. Profession-specific cost estimates were then applied using the PSSRU/CORE Unit Costs 2024/25 (Jones et al., 2026), enabling an estimate of the total equivalent resource value released as reported by survey respondents.

2.1.3.2 Stakeholder interviews and thematic analysis

The qualitative component explored perceptions of the contribution of CHP to clinical decision-making, referral management, service delivery, and the reduction of clinical negligence risk associated with referrals. Upon completing the survey, HCPs had the option to provide their contact details for follow-up interviews.

Semi-structured interviews were conducted online with participants from primary care, secondary care, and healthcare governance settings. Interviews were audio-recorded with participants' consent, professionally transcribed, and ranged from 18 to 46 minutes in duration.

Interview schedules explored participants' experiences and perceptions of CHP, including its use in clinical practice, impact on referral quality and efficiency, support for clinical decision-making, patient safety, barriers to implementation, pathway development, and perceived organisational benefits. The interview with the Redress and Legal Services Manager additionally explored common causes of primary care claims, referral-related failures, the consequences of delayed referrals, and the potential contribution of CHP to risk reduction.

Interview data were analysed using reflexive thematic analysis. Researchers familiarised themselves with the transcripts before undertaking systematic coding across the dataset. Codes were reviewed and grouped according to conceptual similarity to develop candidate themes, which were subsequently refined, defined, and named through an iterative process of analysis. This approach enabled the identification of both shared and contrasting perspectives across different professional roles and healthcare settings.

Three separate analysis were conducted for two groups of stakeholders that were interviewed: Primary and Secondary Care Clinicians, and Legal and Risk Perspective.

2.1.4 Value proposition of Community HealthPathways: Learning from GP medical practice indemnity (GMPI) claims

As part of the value assessment of CHP, a review was undertaken of historic primary care-related clinical negligence claims recorded through the Health Board's Datix system. The purpose was to explore the extent to which the types of failures identified in claims align with referral and escalation processes that CHP seeks to standardise and support. Claims were categorised and dated, and discussions were held with the HDUHB legal team to quantify the financial impact that could potentially be averted through pathway standardisation and adherence.

3 Findings

3.1 Commissioners perspective regarding evaluation priorities

As part of the national evaluation of the CHP programme, Medical Directors across NHS Wales were invited to provide feedback on the evidence requirements that would support future commissioning and recommissioning decisions. Respondents were asked to identify the outcomes, performance measures, benefits, and potential evidence gaps that they considered most relevant when assessing the programme's effectiveness, value, and long-term sustainability. The themes presented in this section summarise their perspectives and have informed the scope and priorities of the evaluation to ensure alignment with the needs of strategic decision-makers.

One response highlighted three interconnected themes: the need for robust baseline measures and demonstrable benefits, alignment with existing performance frameworks, and greater transparency regarding financial implications and sustainability.

3.1.1 Baseline data and demonstrating value

A key concern was the absence of clearly established baseline measures prior to the implementation of CHP. The respondent suggested that without an understanding of referral rates, outpatient activity, and condition-specific demand before programme introduction, it is difficult to reliably quantify impact, savings, or return on investment. This was viewed as a significant limitation when attempting to assess whether observed changes in service utilisation or outcomes can be attributed to CHP. The respondent emphasised that future evaluations should seek to establish, where possible, comparator data and longitudinal trends to provide a clearer assessment of programme effectiveness.

The response also highlighted the importance of clarifying the primary purpose of CHP. The respondent noted that different evaluation approaches would be required depending on whether the programme is intended to deliver financial savings, reduce referrals, improve clinical quality, or achieve a combination of these objectives. This reflects a broader need for the evaluation to clearly articulate the programme's intended outcomes and assess performance against those aims.

3.1.2 Alignment with existing system priorities

The respondent identified a perceived tension between CHP objectives and other performance targets operating within the NHS. In particular, they noted that reducing referrals from primary to secondary care may conflict with expectations around outpatient activity reduction and service transformation targets. This was described as

an example of potentially competing metrics, where success against one objective may inadvertently affect performance against another. The feedback suggests that successful implementation of national programmes requires careful alignment with existing policy and performance frameworks, alongside clear communication regarding how programmes support or replace current initiatives.

3.1.3 Financial transparency and sustainability

The respondent raised concerns regarding the introduction of centrally funded, nationally mandated programmes without sufficient clarity around expected costs, benefits, and long-term sustainability. While recognising the strategic importance of nationally directed initiatives, they expressed a need for earlier visibility of the financial model, anticipated efficiencies, and the distribution of costs and benefits across different parts of the healthcare system. Specifically, the respondent questioned where financial savings generated through CHP would be realised and whether the benefits accrued to the areas expected to support programme implementation.

This feedback highlights the importance of demonstrating not only whether benefits have been achieved, but also how those benefits are distributed across the system and whether they are sustainable once central funding arrangements cease.

3.1.4 Key implications for the evaluation

This response suggests that the evaluation should give particular attention to establishing robust baseline and comparator measures wherever possible to enable meaningful assessment of change over time. The evaluation should also seek to demonstrate attributable impacts on referral activity, service utilisation, and outcomes, while clearly distinguishing between financial, operational, and quality-related benefits. Consideration should be given to the extent to which CHP objectives align with wider NHS performance targets, as well as how costs, benefits, and any resulting savings are distributed across different healthcare settings. Finally, the evaluation should explore issues relating to sustainability, affordability, and long-term funding arrangements to assess the viability of the programme over time.

Overall, the respondent was supportive of a rigorous assessment of CHP but emphasised that future commissioning decisions will require stronger evidence regarding measurable impact, financial value, and strategic alignment within the wider NHS system.

3.1.5 Analysis of stakeholder response

Another response emphasised the importance of demonstrating that CHP delivers tangible improvements in clinical practice and service performance, rather than functioning solely as an information resource. The respondent noted that the underlying

concept of CHP is attractive; however, they highlighted concerns regarding variable adoption and inconsistent realisation of benefits. There was also a perception that previous pathway-based approaches had not led to a noticeable improvement in referral quality, creating a need for robust evidence to demonstrate that CHP can achieve meaningful change in this area.

3.1.6 Demonstrating clinical and operational impact

A central theme was the need for evidence that CHP influences clinical decision-making and improves referral practices. The respondent identified several outcome areas that would be important for future commissioning decisions, including referral appropriateness, referral quality and consistency, reductions in unwarranted variation in clinical practice, and reductions in unnecessary referrals. They also highlighted the importance of understanding wider system impacts, including effects on waiting lists, patient flow, and service demand.

The response suggests that stakeholders are seeking evidence of real-world service improvement, with an emphasis on demonstrating attributable changes in clinical behaviour and patient pathways rather than relying on measures of system activity alone.

3.1.7 Adoption and integration into clinical workflows

The respondent indicated that traditional usage metrics, such as webpage visits or pathway views, may provide limited insight into the programme's true value. Instead, they emphasised the importance of understanding the extent to which CHP is embedded within routine clinical workflows and actively used during patient management and referral decision-making.

A key recommendation was that CHP should become more closely integrated with referral management processes and digital healthcare systems. The respondent suggested that embedding pathway guidance directly within referral workflows could improve accessibility at the point of care, strengthen adherence to referral criteria, and create a clearer connection between pathway use and referral quality outcomes.

3.1.8 Value for money and return on investment

The response highlighted a need for stronger evidence relating to value for money, including avoided activity, productivity gains, and broader return on investment. This aligns with wider stakeholder expectations that future evaluations should move beyond measuring utilisation and focus on demonstrating measurable organisational and system-wide benefits.

3.1.9 Future development and innovation

Looking beyond current functionality, the respondent identified an opportunity for CHP to evolve into a more interactive clinical decision-support platform. They suggested that future development could include guided decision-making processes and the incorporation of intelligent technologies to support pathway selection, improve referral completeness, identify alternatives to referral, and promote evidence-based clinical decisions.

While framed as a future aspiration rather than an assessment of current capability, this reflects a broader expectation that digital clinical tools should become increasingly integrated, intuitive, and supportive of frontline decision-making.

3.1.10 Key implications for the evaluation

This response suggests that the evaluation should give particular attention to:

- The impact of CHP on referral quality, appropriateness, and consistency.
- Changes in clinical decision-making and clinician behaviour attributable to pathway use.
- Effects on referral activity, waiting lists, patient flow, and service demand.
- Levels of adoption within routine clinical workflows, beyond simple usage statistics.
- Evidence of return on investment, productivity gains, and avoided activity.
- The extent to which CHP is integrated with referral pathways and digital systems.
- Future opportunities for enhanced decision-support functionality and digital innovation.

Overall, the response indicates that future recommissioning decisions are likely to be influenced not only by evidence of current impact, but also by confidence that CHP can evolve into a more integrated, clinically embedded, and strategically important component of the digital health ecosystem in Wales.

3.2 Effectiveness of the CHP platform

3.2.1 Uptake of the CHP platform

The implementation of CHP across Wales followed a phased, health board-led approach. Cardiff and Vale University Health Board (CAVUHB) became the first organisation to adopt CHP, launching the platform on 14th February 2019 as the national pilot site. Following this initial implementation, wider rollout across Wales took place several years later. Hywel Dda University Health Board (HDdUHB) introduced CHP on 13 December 2023, with Cwm Taf Morgannwg University Health Board (CTMUHB), Aneurin Bevan University Health Board (ABUHB), and Swansea Bay University Health Board (SBUHB) implementing the platform during April 2024. More recently, Betsi Cadwaladr University Health Board (BCUHB) adopted CHP in July 2025, with Powys Teaching Health Board (PTHB) completing the national rollout in June 2026.

<i>Health Board</i>	<i>Date</i>
CAVUHB	14/02/19
HDdUHB	13/12/23
CTMUHB	10/04/24
ABUHB	19/04/24
SBUHB	23/04/24
BCUHB	14/07/25
PTHB	15/06/26

Table 3.1. Dates of CHP implementation across Welsh Health Boards.

Engagement with CHP can be measured through both the number of pathways developed and the extent to which those pathways are accessed by users, as reflected in page view activity. Data relating to pathway development and usage have been available through the CHP uptake dashboard at both national and health board levels since 21st June 2023. The initial evaluation examined uptake between 21st June 2023 and 31st May 2025. This report extends the evaluation period to include data from 1st June 2025 to 31st July 2026, providing an updated assessment of pathway development and user engagement across Wales and enabling consideration of uptake following full national implementation.

3.2.1.1 Number of pathways

The number of live pathways across CHP sites increased substantially between May 2025 and August 2026, reflecting continued development and expansion of pathway content across Wales.

	Live pathways May 2025	Live pathways August 2026
ABUHB	112	199

BCUHB		124
CAVUHB	398	406
CTMUHB	173	299
HDUHB	205	336
PTHB		1
SBUHB	120	194
Wales Collaboration	283	354
Total across all sites	1,291	1,913

Table 3.2. Number of live pathways on each of the CHP sites in May 2025 and August 2026.

Additionally, national pathway development has also expanded significantly, with 443 pathways available as of August 2026, an increase of 191 pathways compared with the initial report.

3.2.1.2 Number of page views nationally

During the time where pathway views were recorded from February 2nd 2022 to 31st July 2026, there were a total of 1,261,953 page views across all sites, which equates to around 396 page views per 1000 population (Figure 3.1).

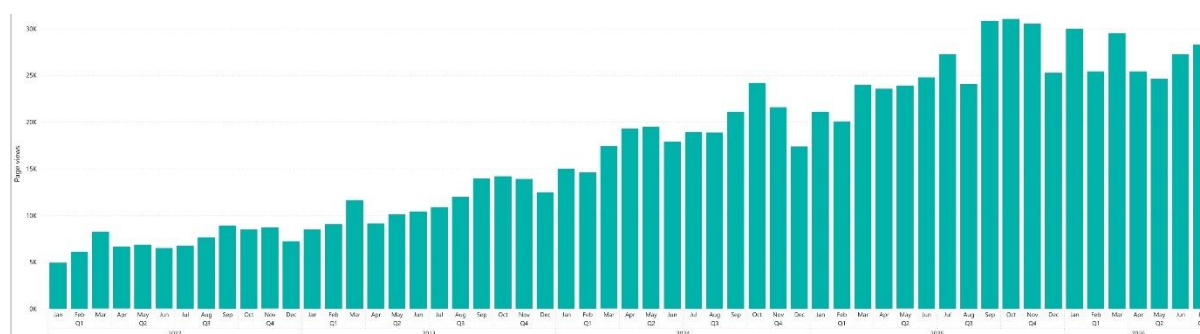


Figure 3.1. Page views per month, and cumulative sum of page views in Wales from February 2nd 2022 (Furthest date the dashboard will allow) to end of July 2026 across all sites.

As can be seen in figure 3.1 above, the total number of page views per month has steadily increased from 2nd February 2022 to July 2026, from 8,694 views in February 2022, to 36,883 views in July 2026, a 424% increase in views. When comparing the most recent 12 month period (end July 2025 to end July 2026) to the previous 12-month period, page views increased from 357,394 to 443,998 total page views indicating a growth of 24.2%, demonstrating the continued growth of engagement with the platform across Wales since the 2025 evaluation.

3.2.1.3 Uptake by health board

For the evaluation uptake has been explored for each of the active health boards individually:

3.2.1.3.1 Cardiff and Vale University Health Board

Since launch on 14th February 2019 until the end of July 2026, CAVUHB has had a total of 1,021,061 page views (content or section page only). This equates to around 1,965 views per 1,000 population. A total of 406 pathways were live in CAVUHB at the time of data extraction in August 2026, meaning each pathway has had a mean of 2,515 views.

Since the previous report, total page views in CAVUHB have remained steady, with 246,028 total views from end July 2024 until end July 2025, and 247,973 total views the following year from end July 2025 to end July 2026.

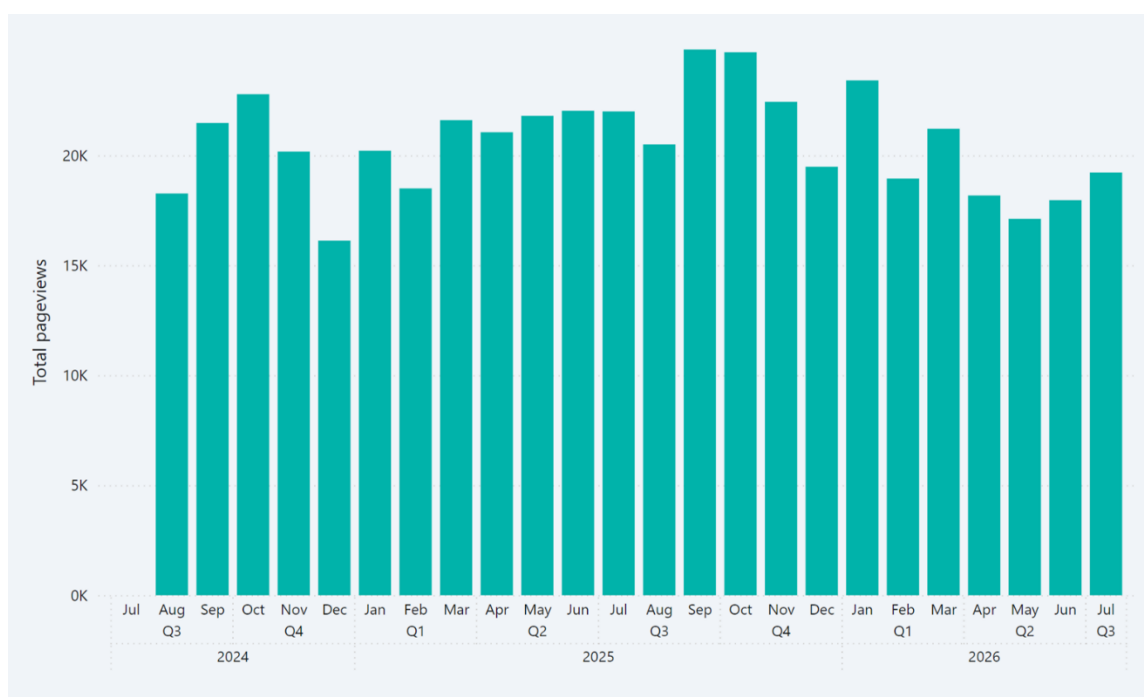


Figure 3.2. Page views per month for the last two years in CAVUHB, from 31st July 2024 to 31st July 2026. Total page views 494,001.

3.2.1.3.2 Hywel Dda University Health Board

From its launch on 13th December 2023 to 31st July 2026, HDUHB had a total of 54,015 page views. This equates to around 139 views per 1,000 population.

A total of 336 pathways were live in HDUHB at the time of data extraction in August 2026, meaning each pathway had a mean of 161 views.

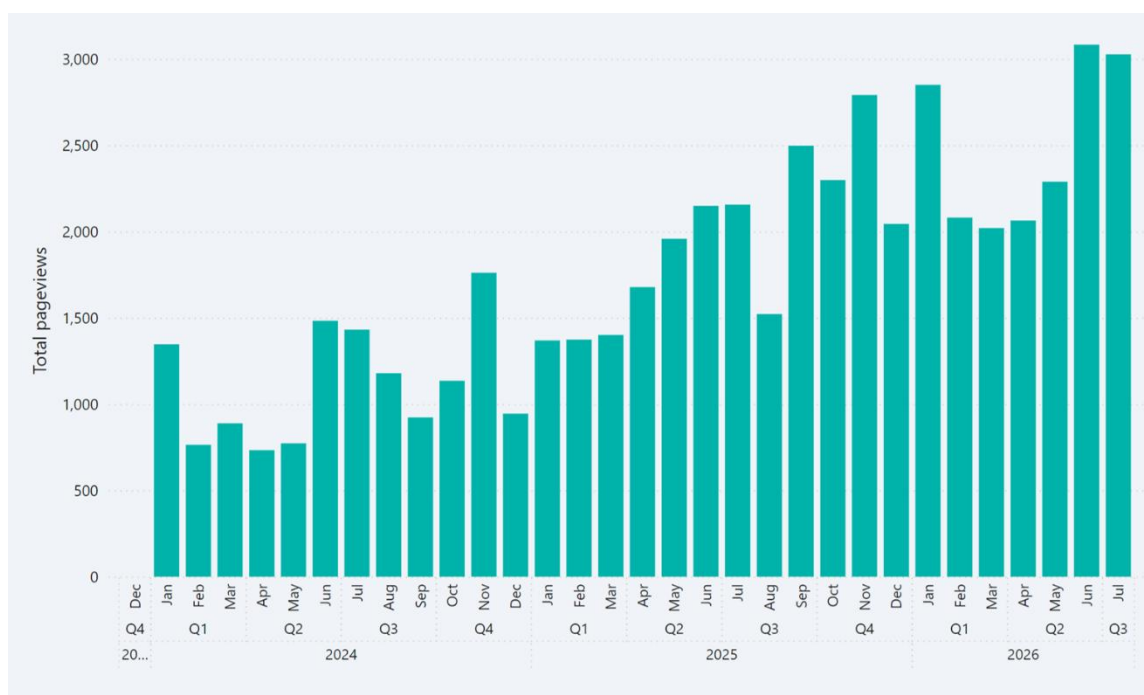


Figure 3.3. Page views per month from the implementation of CHP in HDUHB on the 13/12/2023 to July 2026. Total page views 54,015.

3.2.1.3.3 Cwm Taf Morgannwg University Health Board

From its launch on 10th April 2024 to 31st July 2026, CTMUHB had a total of 72,518 page views. This equates to around 161 views per 1,000 population. A total of 299 pathways were live in CTMUHB at the time of data extraction in August 2026, meaning each pathway had a mean of 243 views.

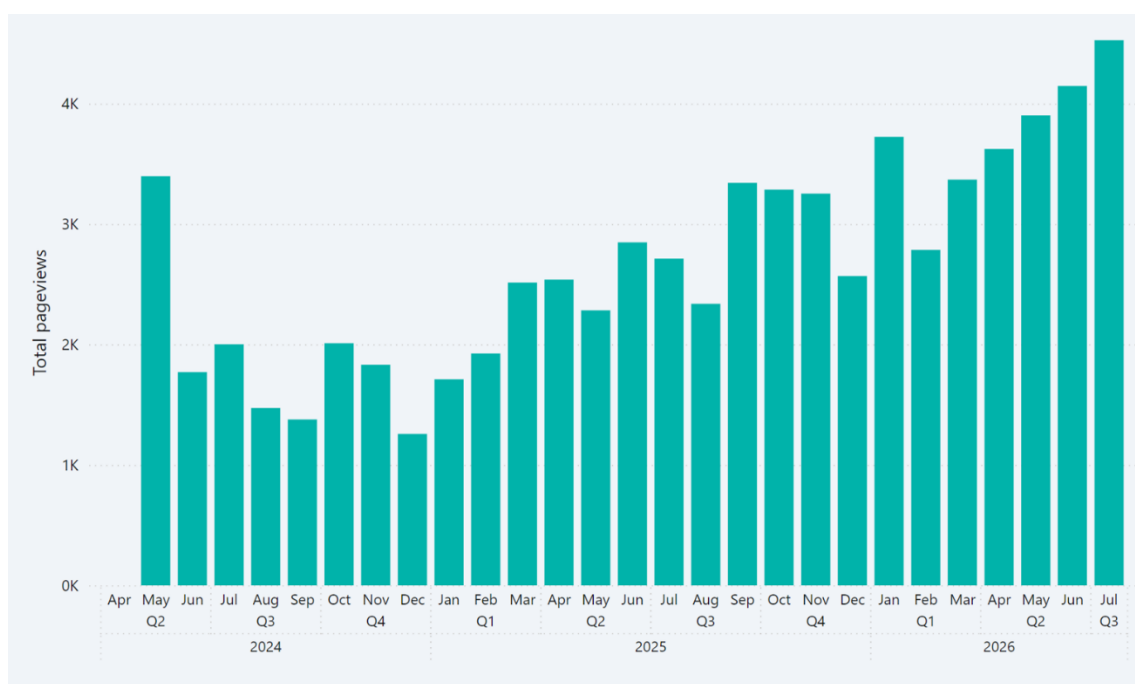


Figure 3.4. Page views per month from the implementation of CHP in CTMUHB on the 10/04/2024 to July 2026. Total page views 72,518.

3.2.1.3.4 Aneurin Bevan University Health Board

From its launch on 19th April 2024 to 31st July 2026, ABUHB had a total of 87,987 page views. This equates to around 146 views per 1,000 population. A total of 199 pathways were live in ABUHB at the time of data extraction in August 2026, meaning each pathway had a mean of 442 views.

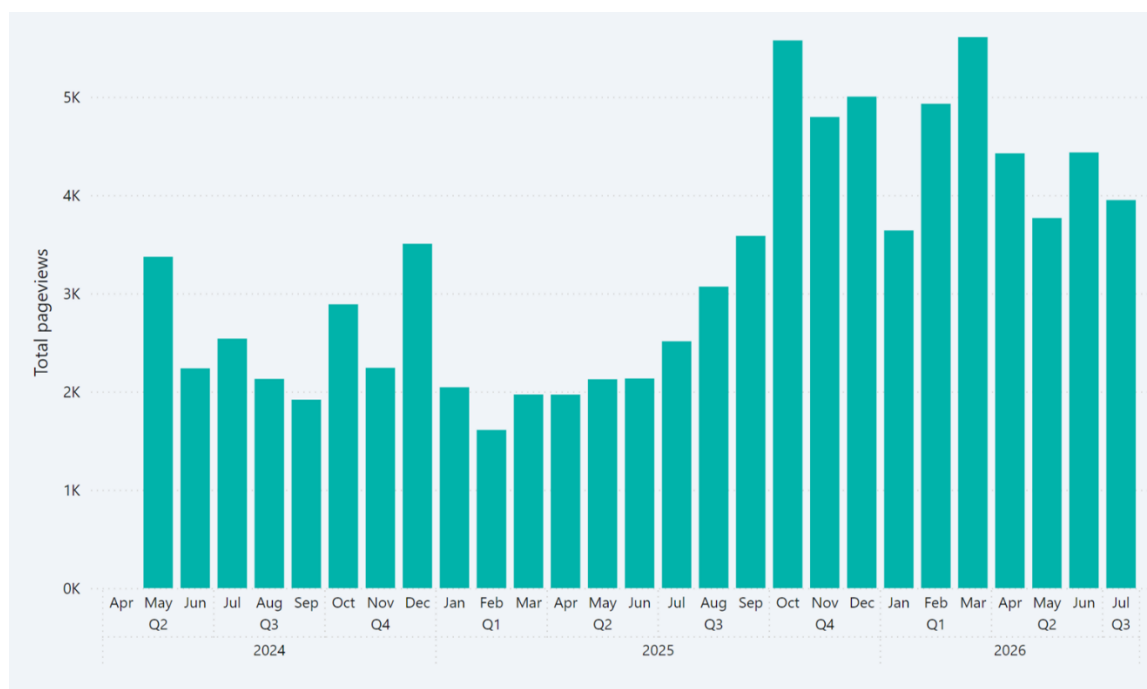


Figure 3.5. Page views per month from the implementation of CHP in ABUHB on the 19/04/2024 to July 2026. Total page views 87,987.

3.2.1.3.5 Swansea Bay University Health Board

From its launch on 23rd April 2024 to 31st July 2026, SBUHB had a total of 21,902 page views. This equates to around 56 views per 1,000 population. A total of 194 pathways were live in SBUHB at the time of data extraction in August 2026, meaning each pathway had a mean of 113 views.

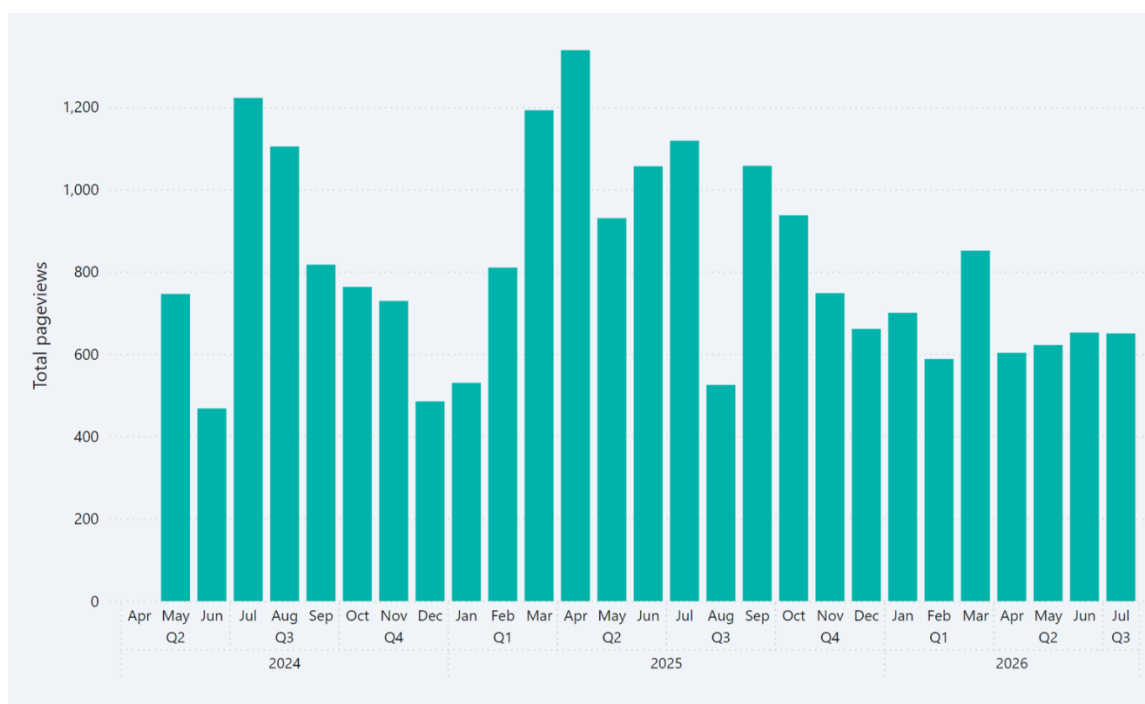


Figure 3.6. Page views per month from the implementation of CHP in SBUHB on the 19/04/2024 to July 2026. Total page views 21,902.

3.2.1.3.6 Betsi Cadwalader University Health Board

From its launch on 14th July 2025 to 31st July 2026, BCUHB had a total of 23,999 page views. This equates to around 34 views per 1,000 population. A total of 124 pathways were live in BCUHB at the time of data extraction in August 2026, meaning each pathway has had a mean of 194 views.

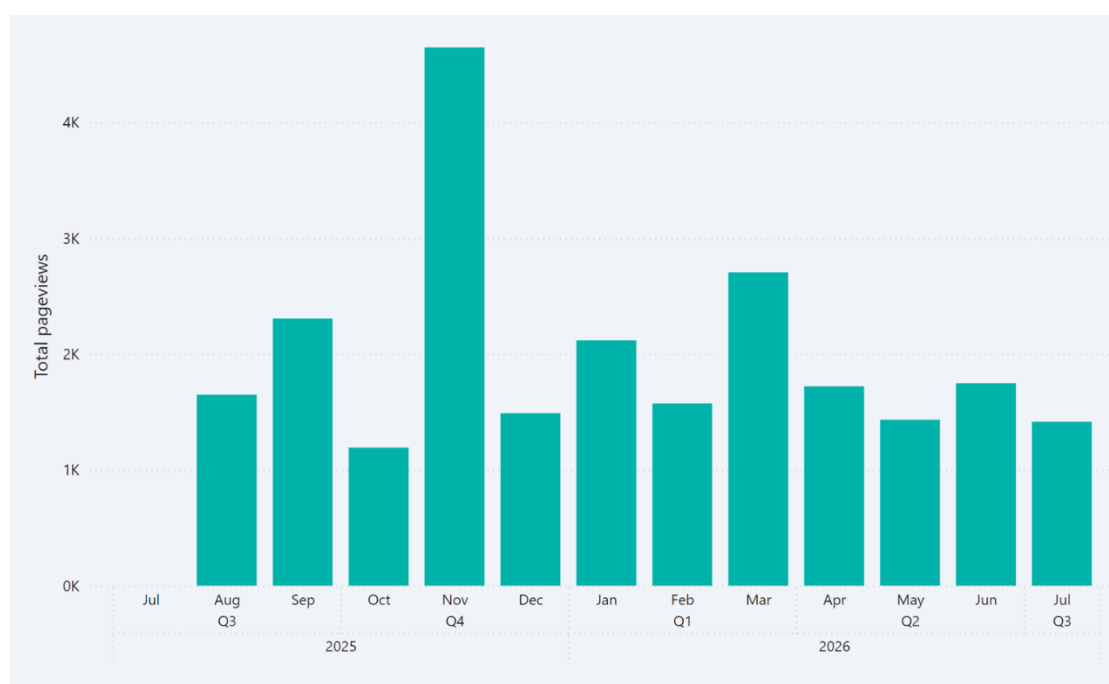


Figure 3.7. Page views per month from the implementation of CHP in BCUHB on the 14/07/2025 to July 2026. Total page views 23,999.

3.2.1.3.7 Powys Teaching Health Board

From its launch on 15th June 2026 to 31st July 2026, PTHB has had a total of 770 page views. CHP needs to be live in PTHB for a longer period to determine any meaningful metrics around uptake or engagement with the platform.

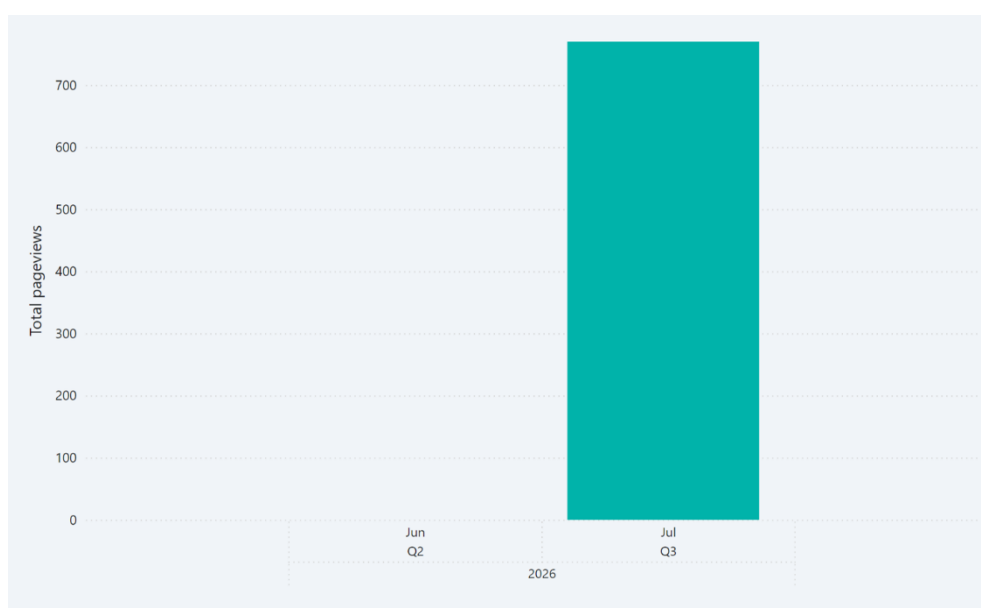


Figure 3.8. Page views per month from the implementation of CHP in PTHB on the 19/04/2024 to July 2026. Total page views 770.

3.2.1.3.8 Comparison of total page views in each health board

All health boards except for SBUHB have shown similar levels of growth to CAVUHB in terms of engagement through the total page views metric (Table 3.3). More data is needed to compare yearly engagement figures in BCUHB and PTHB, however, BCUHB has shown similar page views in their most recent full year when compared to other sites.

	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
CAVUHB	9,296	33,079	53,877 +62.9%	90,727 +68.4%	135,735 +49.6%	206,831 +52.4%	246,028 +19.0%	247,973 +0.8%
HDUHB						10,430	18,028	28,566 +58.5%
CTMUHB						9,332	24,482	40,868 +66.9%
ABUHB						11,603	27,051	52,786

								+95.1%
SBUHB						4,355	10,872	8,594 -21.0%
BCUHB							4,729	23,999
PTHB								1,718

Table 3.3. Yearly total page views for each yearly period running from end July each year, and percentage yearly growth for each of the HBs. Percentages shown for full year comparisons only. Data provided by Streamliners.

3.2.1.4. Most viewed pathways in HDUHB

Pathways that had the most engagement would be more likely to have an impact on referrals into secondary care. Total page views were included from December 2023 (when CHP went live in HDUHB) up until the end of July 2026.

Page Title	Page Views
Carpal Tunnel Syndrome	608
Abnormal Liver Function Tests	441
Hormone Replacement Therapy (HRT)	366
Chest Pain	281
Osteoporosis	258
Hyperlipidaemia	255
Menopause	247
Heart Failure	222
Acute Asthma in Children	215
Gout	212
UTI in Adults	211
Iron Deficiency Anaemia in Adults	205
Otitis Externa	205
Sub-fertility	203
Atrial Fibrillation	202

Table 3.4. The fifteen most viewed pathways in HDUHB and total page views from December 2023 – July 2026.

3.2.2 Case study: comparison of referrals in HDUHB pre and post implementation of CHP

Q – Has referral activity changed following CHP implementation?

In order to assess changes in referral activity associated with CHP implementation, the total number of referrals for each pathway was compared pre and post implementation, on a pathway basis for the duration that each individual pathway has been active.

Overall referral activity reduced following CHP implementation. Across the matched pre- and post-implementation periods, referrals reduced from **116,859 to 102,606** representing **14,253 fewer referrals (-12.2%)**.

This reduction was evident across all seven GP clusters, although the scale of change varied geographically. Reductions ranged from **6.0% in Amman/ Gwendraeth to 17.3% in North Pembrokeshire**, indicating that the overall reduction was not driven by a single locality but reflected a broader pattern across the Health Board.

Overall Change in CHP Referrals by GP Cluster

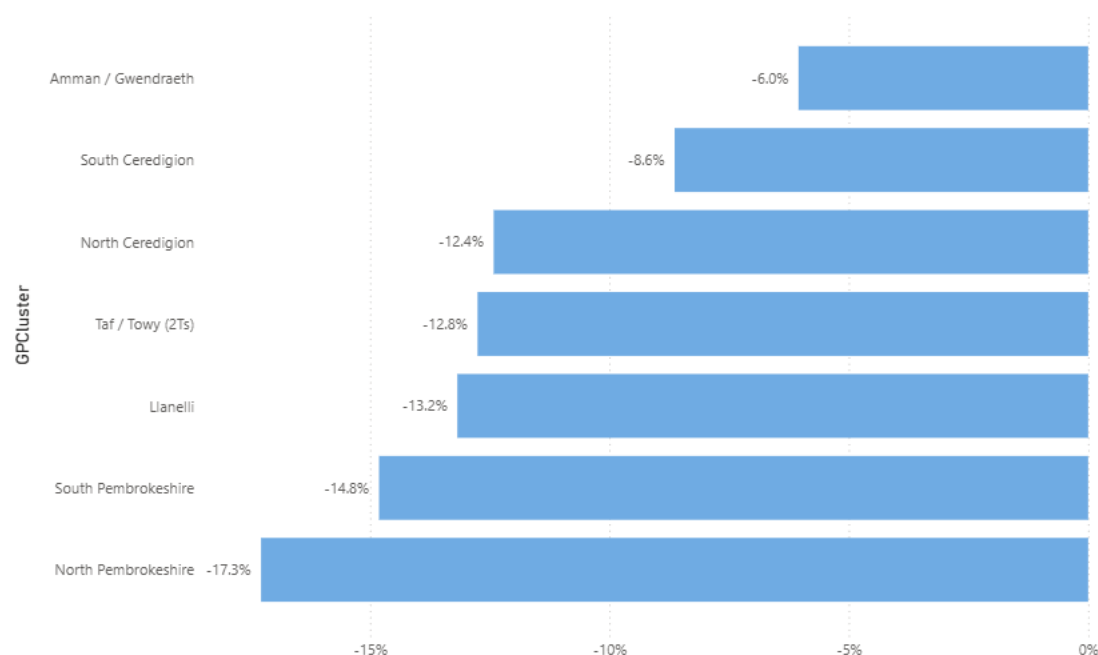
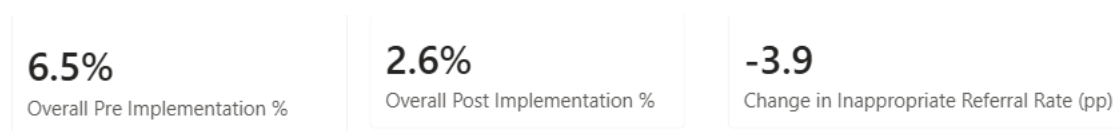


Figure 3.9. Overall percentage change in CHP referrals by GP cluster.

However, the scale of reduction varied between clusters, indicating that the extent of change following CHP implementation has not been uniform geographically. This variation is explored further at pathway and cluster level below.

Q – Has the reduction in activity been accompanied by improved referral appropriateness?

Recorded referral appropriateness also improved following implementation. Across referrals with a recorded appropriateness outcome, the overall inappropriate referral rate reduced from **6.5% pre-implementation to 2.6% post-implementation**, a reduction of **3.9 percentage points**.



120 pathways eligible for comparison: 72 improved | 43 worsened | 5 unchanged

Figure 3.10. Overall recorded inappropriate referral rate, pre- and post-implementation.

Of the 120 pathways meeting the minimum threshold for comparison, 72 (60.0%) showed an improvement, compared with 43 (35.8%) where inappropriate referral rates increased and five (4.2%) showed no change.

Taken together with the reduction in overall activity, these findings are consistent with a positive change in referral behaviour in the post-implementation period: fewer referrals overall, alongside a lower proportion of referrals recorded as inappropriate. However, pathway-level variation remains with approximately one-third of eligible pathways recording an increase in inappropriate referral rates.

**Outcome recorded completeness varies between pathways; consequently, appropriateness analysis is restricted to pathways with sufficient comparable pre- and post-implementation data.*

Q – Are referral changes consistent across pathways and geographical areas?

The overall reduction masks considerable pathway level variation. North Pembrokeshire, Taf/ Tywi and North Ceredigion showed the clearest tendency towards pathway level reductions, while Amman/ Gwendraeth and South Ceredigion had slightly more pathways increasing than decreasing.

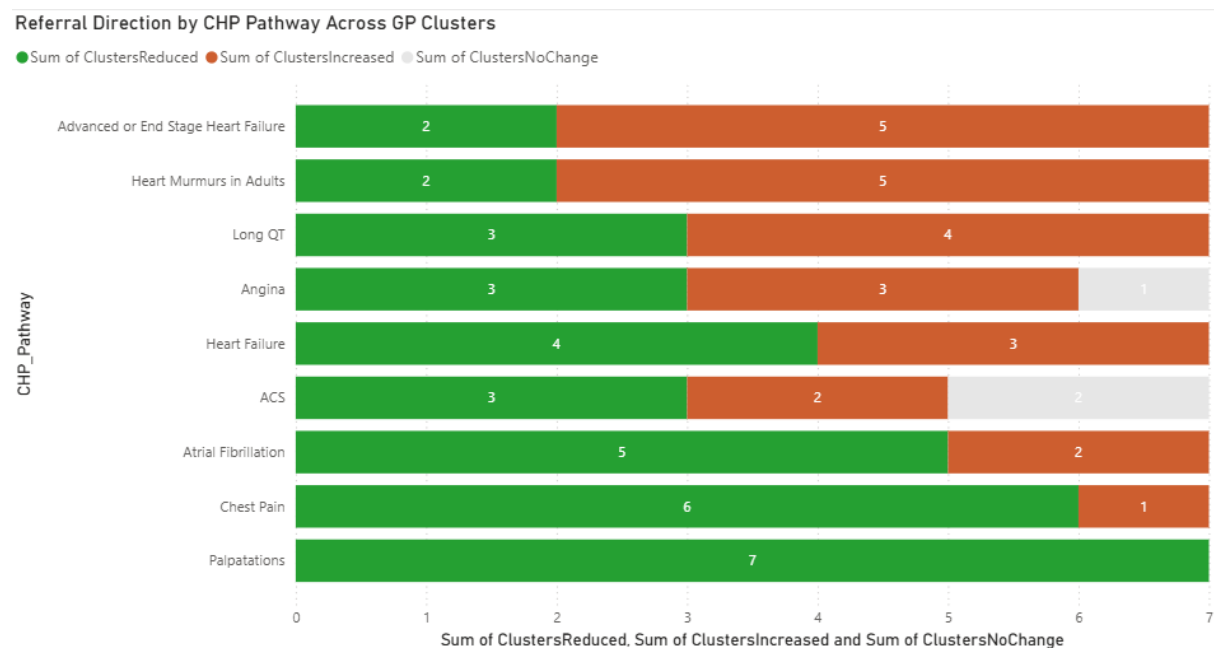


Figure 3.11. Direction of referral change by CHP pathway across GP clusters.

This is not inconsistent with the overall reduction in those clusters. Rather, it demonstrates that the magnitude of change matters as well as the number of pathways changing direction: a small number of high volume or substantially reducing pathways can outweigh increases across a larger number of lower volume pathways.

The reduction also does not appear to result from pathways simply ceasing to receive referrals. Across every cluster, more pathways started receiving referrals post implementation than stopped receiving referrals, suggesting continued or expanding pathway coverage alongside lower overall referral volumes.

Q – Which pathways demonstrated the strongest positive change, and where is further review warranted?

Inappropriate Referral Rate Before and After CHP Implementation

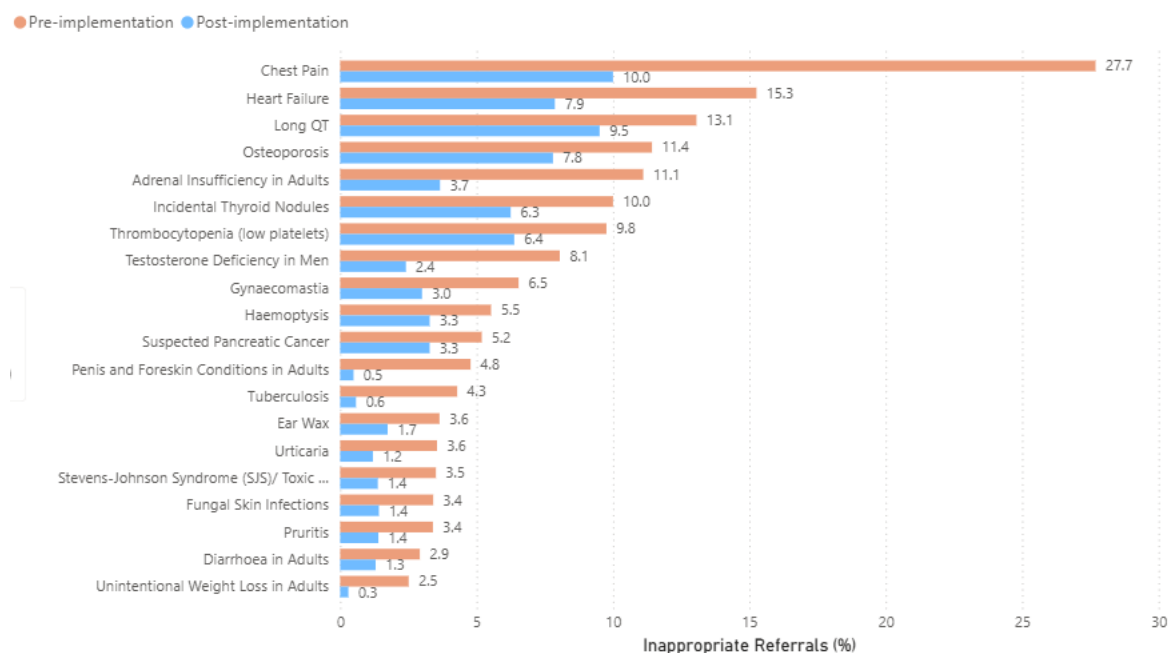


Figure 3.12. Selected pathways demonstrating changes in recorded inappropriate referral rates.

For example, Chest Pain demonstrated a substantial reduction in recorded inappropriate referrals, from 27.7% to 10.0% across several GP clusters.

The pathway-level results demonstrate that the overall improvement in recorded appropriateness was not evenly distributed. Several pathways showed substantial reductions in inappropriate referral rates, including Chest Pain, while others showed smaller improvements or increases.

These findings provide useful examples of pathways where referral behaviour appears to have changed positively following implementation. Conversely, pathways showing increased referral activity, worsening recorded appropriateness, or substantial geographical variation provide a focused group for service review.

Such patterns should not automatically be interpreted as poor performance. Increased activity may reflect improved case identification, changes in service availability or appropriate redirection of patients. Consideration of local context is therefore important when interpreting individual pathway results.

Q – What does the cluster analysis tell us?

Local implementation matters – Health Board level pathway results can conceal substantial geographical variation. For example, ACS was broadly unchanged overall (350 pre vs 356 post referrals), but individual clusters ranged from a 42.6% reduction in North Ceredigion to a 162.5% increase in South Pembrokeshire.

GPCluster	Amman / Gwendraeth	Llanelli	North Ceredigion	North Pembrokeshire	South Ceredigion	South Pembrokeshire	Taf / Towry (2Ts)
CHP_Specialty	Heatmap Pct Change	Heatmap Pct Change	Heatmap Pct Change	Heatmap Pct Change	Heatmap Pct Change	Heatmap Pct Change	Heatmap Pct Change
Cardiology							
Advanced or End Stage Heart Failure	1.5%	31.0%	-9.0%	52.9%	31.3%	-25.9%	115.4%
Heart Murmurs in Adults	129.3%	32.3%	76.7%	-34.0%	43.7%	-41.5%	91.3%
Long QT	24.5%	42.1%	-21.3%	40.0%	-20.0%	45.5%	-26.7%
Angina	2.1%	-10.2%	-42.6%	29.4%	0.0%	162.5%	-23.1%
Heart Failure	11.0%	13.6%	13.8%	-31.8%	-49.5%	-35.0%	-32.9%
ACS	0.0%	-10.2%	-42.6%	29.4%	0.0%	162.5%	-23.1%
Atrial Fibrillation	-43.6%	-45.4%	-15.5%	-29.4%	104.0%	-65.6%	33.3%
Chest Pain	-49.8%	-56.3%	-48.0%	1.9%	-46.4%	-4.0%	-75.9%
Palpitations	-65.3%	-43.9%	-46.7%	-40.0%	-52.9%	-56.3%	-44.4%

Figure 3.13. GP cluster variation in referral activity by pathway – Cardiology extract.

This illustrates why Health Board level results should not be considered in isolation. A pathway showing relatively little overall change may contain markedly different local patterns, potentially identifying opportunities for more targeted discussion with individual clusters or practices.

3.2.3 Case study: Value proposition of Community HealthPathways: Learning from GP medical practice indemnity (GMPI) claims

A review identified 23 primary care claims, of which approximately 16 related to delayed, missed, or inappropriate referrals to secondary care services. The incidents occurred between 2018 and 2025, with the majority predating the implementation of CHP. These claims involved a range of conditions including suspected cancer, urology, rheumatology, paediatrics, diabetic emergencies, vascular complications and urgent surgical referrals.

The harms described within the claims were significant and included:

- Delayed cancer diagnoses and treatment.
- Disease progression resulting in more invasive interventions.
- Major surgery and amputations.
- Long-term disability and reduced quality of life.
- Psychological impacts.
- Several cases where the alleged outcome was death.

The estimated financial consequences were substantial. Across the referral-related claims where financial estimates were available, the potential value of damages and legal costs exceeded £14 million, although this figure is heavily influenced by a small number of very high-value cases and should therefore be interpreted cautiously. More typically, individual claims ranged from tens of thousands to several hundred thousand pounds. Notably, one diabetic foot referral case alone carried an estimated value of over £10 million.

Importantly, discussions with the Health Board's legal and claims teams highlighted that many claims arise from failures to follow or complete referral processes, delays in escalation, or uncertainty regarding the most appropriate pathway of care. These are areas directly targeted by CHP through:

- Providing consistent referral criteria.
- Supporting timely escalation and decision-making.
- Improving navigation of community and secondary care services.
- Reducing unwarranted variation in referral practice.
- Increasing clinician confidence regarding appropriate management options.

While it is not possible to conclude retrospectively that CHP would have prevented specific incidents, the themes evident across the claims are consistent with the problems CHP has been designed to address. There is therefore a plausible mechanism through which effective adoption of CHP could contribute to reducing the likelihood of similar referral-related failures occurring in the future.

The review also highlighted an important governance consideration. Clinical negligence costs incurred by GP practices are typically reimbursed through the Welsh Risk Pool, provided that practices can demonstrate appropriate learning, service improvement and actions taken to reduce the likelihood of recurrence. In this context, the implementation and utilisation of CHP may provide evidence of a system-level response to identified risks by strengthening referral governance, standardising clinical pathways and supporting safer decision-making.

Consequently, the value of CHP should not be viewed solely in terms of potential avoidance of negligence claim costs. Rather, its contribution lies in supporting organisational learning, reducing clinical risk, improving consistency of care and demonstrating proactive measures to address known system vulnerabilities. Where referral-related incidents have occurred, CHP may form part of the evidence that appropriate action has been taken to mitigate future risk, potentially supporting reimbursement arrangements through the Welsh Risk Pool. Ultimately, the greatest value remains the prevention of patient harm and the improvement of patient outcomes through safer, more consistent care pathways.

3.2.4 Healthcare professional experience and perceived impact on clinical practice

3.2.4.1 The CHP 2026 Survey for Healthcare Professionals

The CHP 2026 survey was delivered to HCPs across Wales in July 2026. A total of 121 responses were received. The survey aimed to understand how CHP is used in practice and to explore its perceived impact on clinical decision-making, referral management, workflow, and service delivery. Findings presented in this report reflect respondent perceptions and experiences rather than objectively measured changes in clinical outcomes or service performance.

Have you heard of the Community HealthPathways (CHP)?

Out of 121 respondents, most respondents reported actively using CHP, with 102 respondents (84.3%) indicating that they currently use the platform. A further 12 respondents (9.9%) were aware of CHP but reported not using it, while 7 respondents (5.8%) had not previously heard of the platform. This represents an improvement on the 2025 survey, from which around 30% of respondents indicated they had not used the platform.

The findings indicate a high level of awareness and utilisation among survey respondents. However, as one of the methods of dissemination was carried out through the CHP landing page, this could skew the results towards those who were already aware of, engaged with, or exposed to CHP and these results should not be interpreted as reflecting awareness or utilisation levels across the wider healthcare workforce.

Which Health Board are you employed/based within?

Responses

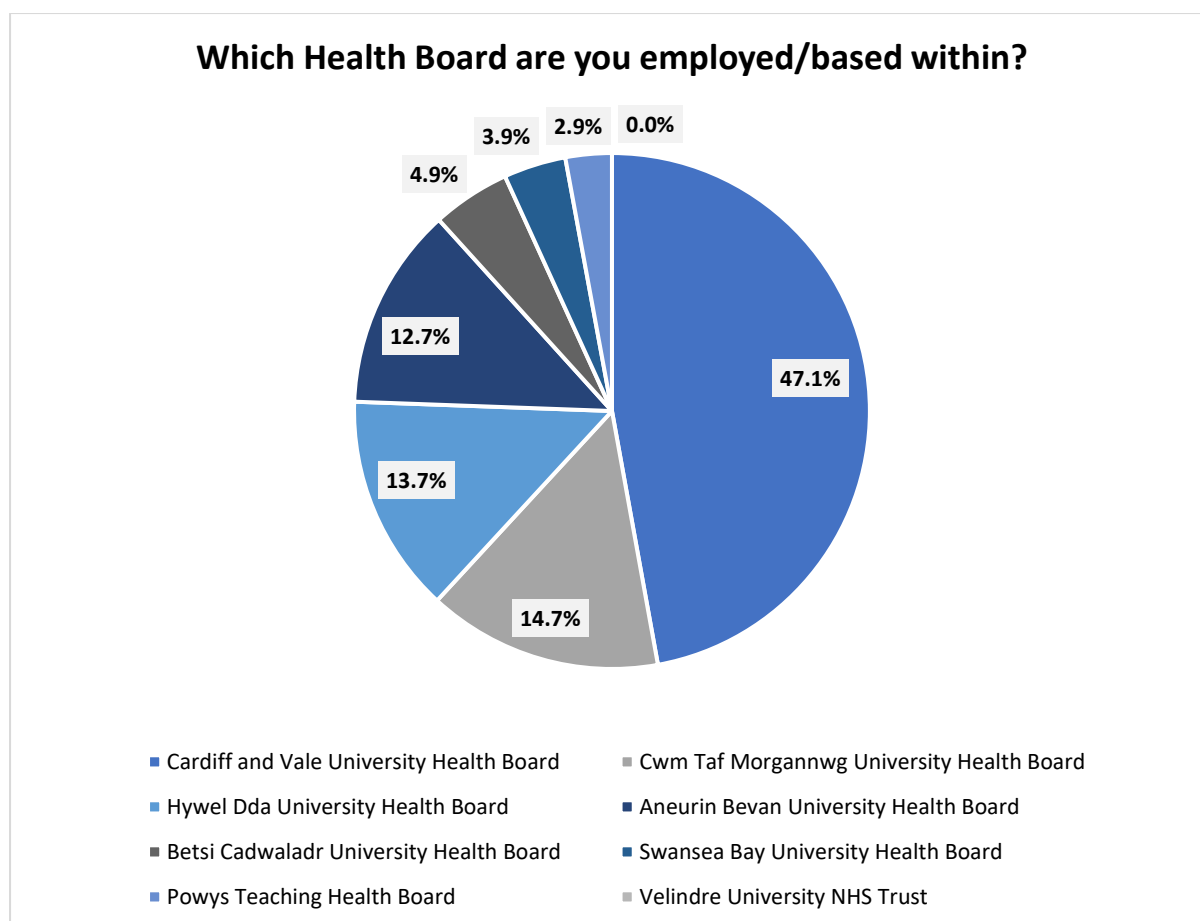


Figure 3.14. Pie chart showing which health board respondents are based in.
*Percentages are based on the 102 respondents who reported actively using CHP.

Responses were received from healthcare professionals across all Welsh Health Boards. The wide geographical distribution of respondents indicates that the survey captured views from diverse healthcare settings across Wales. Although almost 50% of responses were received from CAVUHB, engagement metrics suggest a much larger userbase in CAVUHB, and as such these findings could be representative of the overall user base of CHP.

Are you based in:

The majority of respondents worked within primary care settings (n = 94, 92.2%). Consequently, the findings presented in this report predominantly reflect those perspectives. The relatively small number of responses from secondary (n = 8, 7.8%) and intermediate (n = 2, 2.0%) care limits the extent to which conclusions can be drawn regarding those sectors.

Which best describes your role?

Responses

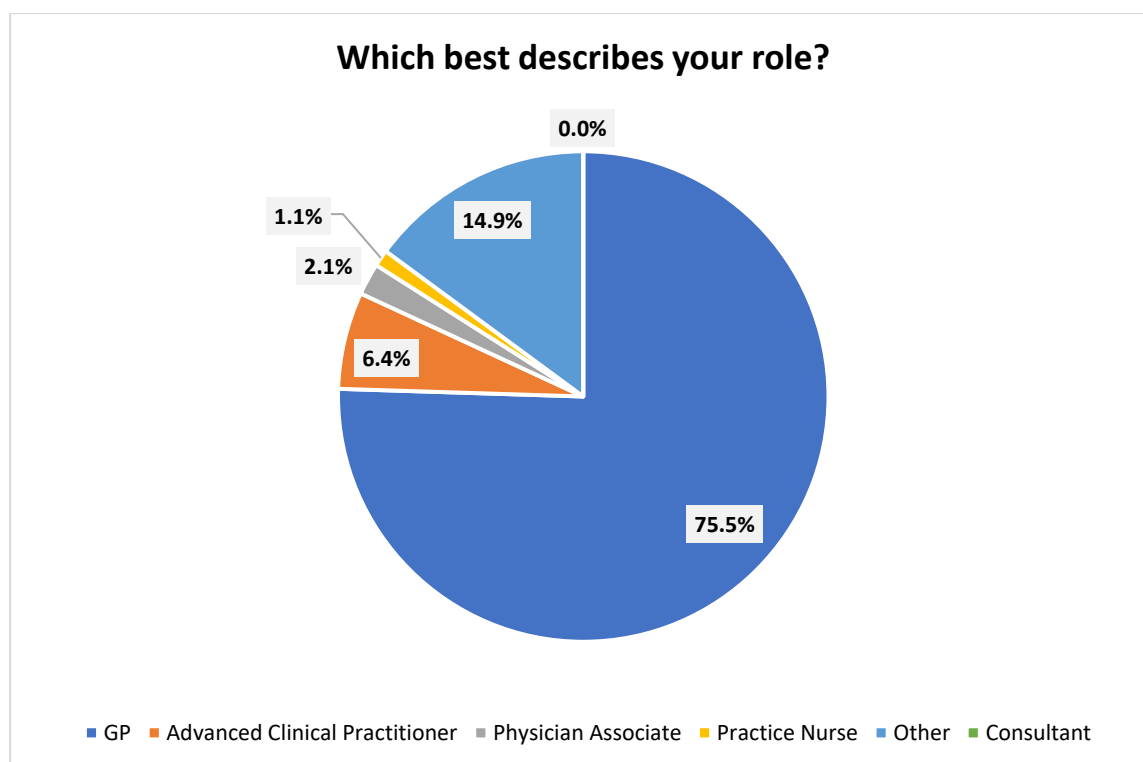


Figure 3.15. Pie chart showing roles of respondents. *Percentages are based on the 102 respondents who reported actively using CHP.

Respondents represented a range of professional groups including General Practitioners, GP Registrars, Pharmacists, Advanced Clinical Practitioners, Practice Nurses, Physician Associates, Medical Administrators, Physiotherapists and Secondary Care Clinicians. General Practitioners represented the largest respondent group.

Secondary Care Questions

Has CHP improved the efficiency of patient flow into your service? (e.g. more appropriate referrals, smoother triage)

Responses to this question were provided by **eight** secondary care respondents. Three respondents reported no change in efficiency, while three respondents indicated that CHP had improved efficiency to some extent, including one respondent who reported a significant improvement. One respondent felt that efficiency had worsened, and one selected "other". Given the small number of respondents and the variation in responses, the findings should be interpreted with caution and are not sufficient to draw firm conclusions regarding the impact of CHP on patient flow or service efficiency within secondary care settings.

In your view, has CHP contributed to: (Select all that apply)

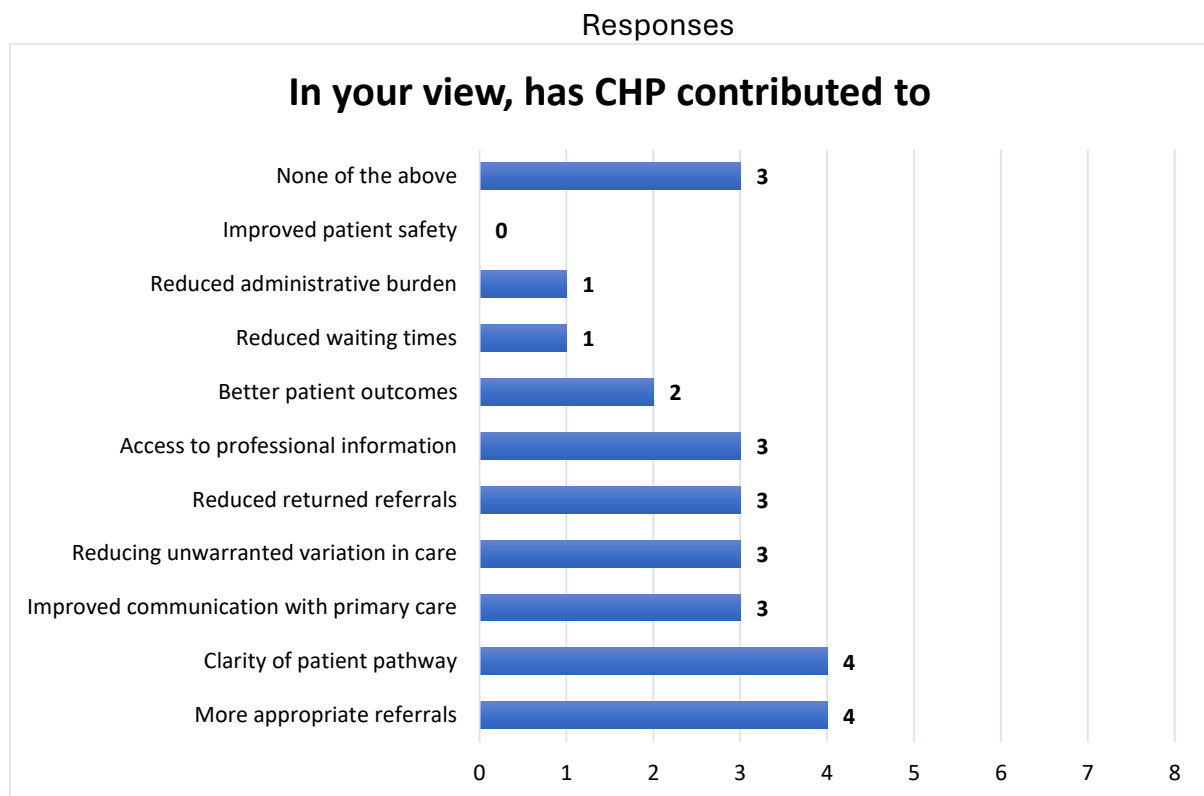


Figure 3.16. Secondary care responses showing perceived impact of CHP. Eight secondary care respondents answered this question. Respondents could select more than one option, therefore totals exceed eight.

Has CHP changed the time you spend on referral triage activities?

Responses

Yes, reduced time	3 respondents
No change	3 respondents
Yes, increased time	2 respondents

Table 3.5. Secondary care responses showing perceived impact of CHP on referral triage activities.

Respondents reported varying experiences regarding the impact of CHP on referral triage activities. Some reported reduced triage time due to clearer referral information and improved referral quality, while others reported no noticeable change. A small number reported increased time associated with reviewing pathways and referral criteria.

Do you believe CHP represents good value for the Health Board?

Among 8 respondents who answered this question, 4 considered CHP to represent good value for the Health Board. However, opinions varied, with some respondents reporting uncertainty or questioning the value achieved within their specific service area. Given the small number of respondents answering this question, findings should be interpreted cautiously.

Primary Care Questions

How often do you use Community HealthPathways (CHP)?

Responses	
Multiple times per day	42 respondents (45.7%)
Daily	27 respondents (29.3%)
Weekly	18 respondents (19.6%)
Monthly	6 respondents (6.5%)
Rarely	1 respondent (1.1%)

Table 3.6. Primary care responses showing frequency of CHP use (n = 94).

Among the 94 respondents based in primary care, a substantial proportion (75%) reported using CHP daily or multiple times each day. These findings suggest that CHP is used regularly by many respondents, indicating good engagement with the platform from those who responded.

What tasks does CHP save time on? (select all that apply)

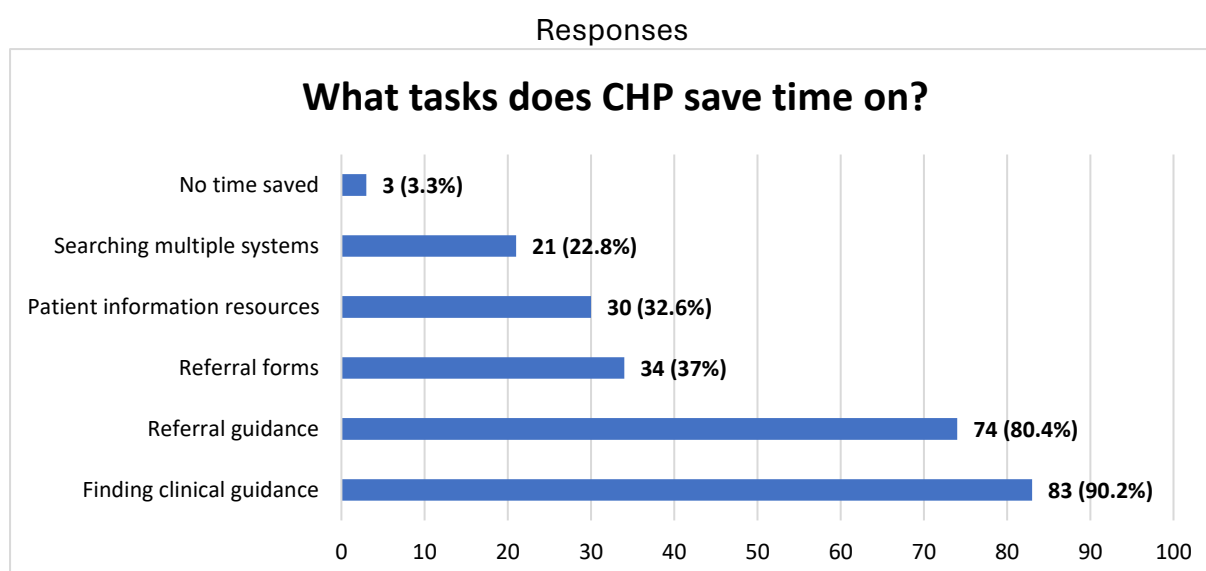


Figure 3.17. Primary care responses when asked what tasks CHP saves time on. *94 Primary Care respondents answered this question. Respondents could select more than one option, therefore totals do not sum to 94.

Respondents reported that CHP saves time across a range of clinical and administrative tasks. It was most commonly reported that CHP saves time on finding clinical guidance (90.2%) and accessing referral guidance (80.4%). Only around 3% of respondents indicated that they believed CHP did not save time.

Has CHP changed your referral decisions?

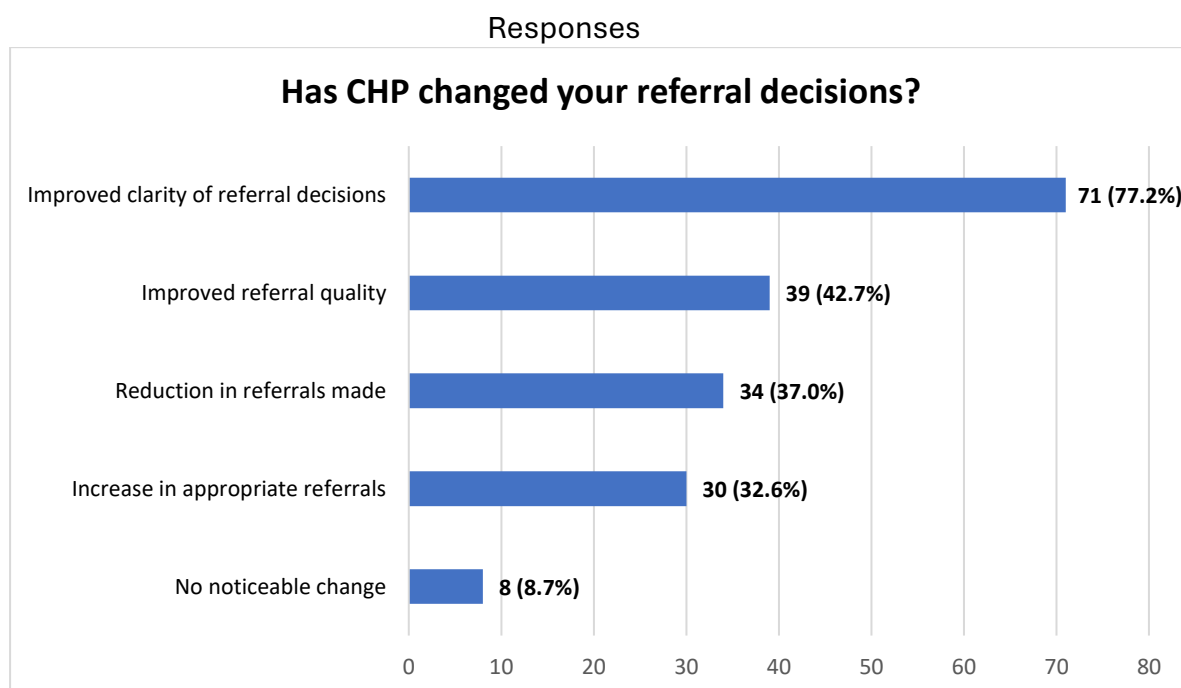


Figure 3.18. Primary care responses when asked if CHP has changed referral decision.

*94 Primary Care respondents answered this question. Respondents could select more than one option, therefore totals do not sum to 94.

Improved clarity of referral decision-making was the most frequently reported referral-related outcome with more than three-quarters of respondents indicated that CHP has helped clarify referral decisions. Smaller proportions reported improved referral quality, fewer referrals, or more appropriate referrals.

If you have had a rejected referral, have you been redirected to CHP?

Out of 94 respondents, 47 respondents (50%) reported being directed to CHP following referral rejection, while the other 47 respondents (50%) had not experienced this.

Do you think the use of CHP has reduced your rejected referral rate?

Out of 94 respondents, 67 respondents (71.3%) respondents reported that CHP had helped reduce rejected referrals through clearer referral criteria and improved understanding of referral requirements. However, 27 respondents (28.7%) respondents reported no noticeable change or were uncertain regarding any impact.

Has CHP influenced your use of diagnostic tests?

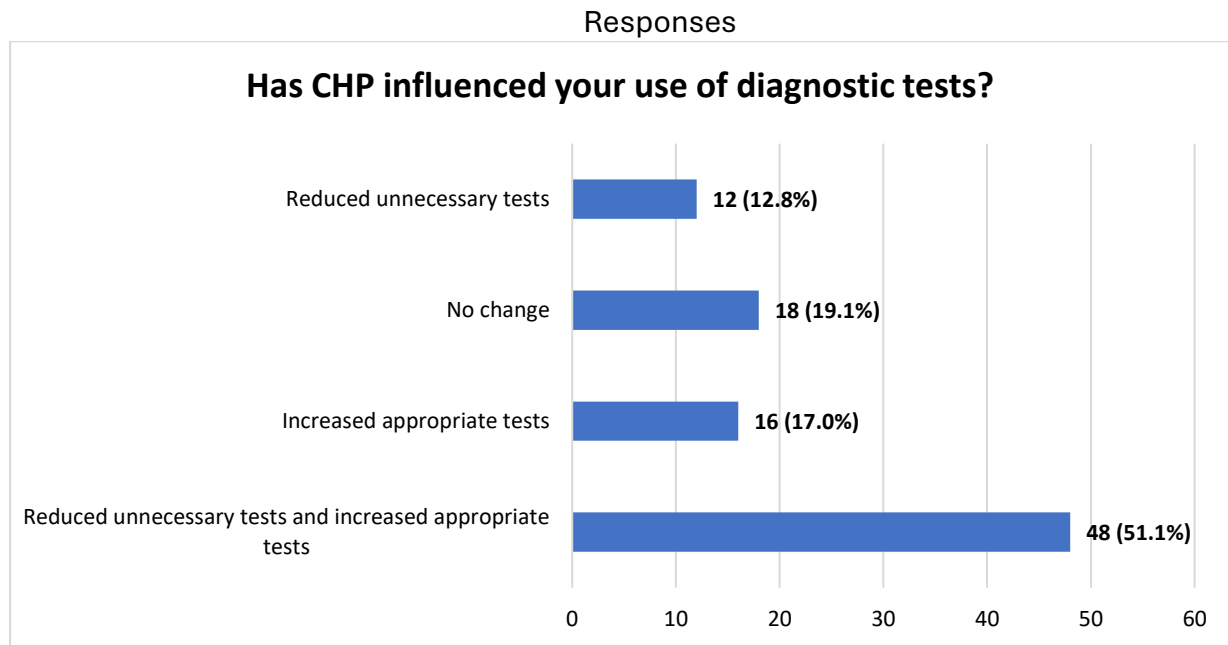


Figure 3.19. Primary care responses when asked if CHP has influence use of diagnostic tests. *A total of 94 respondents answered this question.

Around 64% of respondents reported that CHP had reduced unnecessary tests, either alone or alongside increasing appropriate testing. Only around 19% reported no change in their use of diagnostic tests.

In which areas does CHP provide value? (select all that apply)

Responses

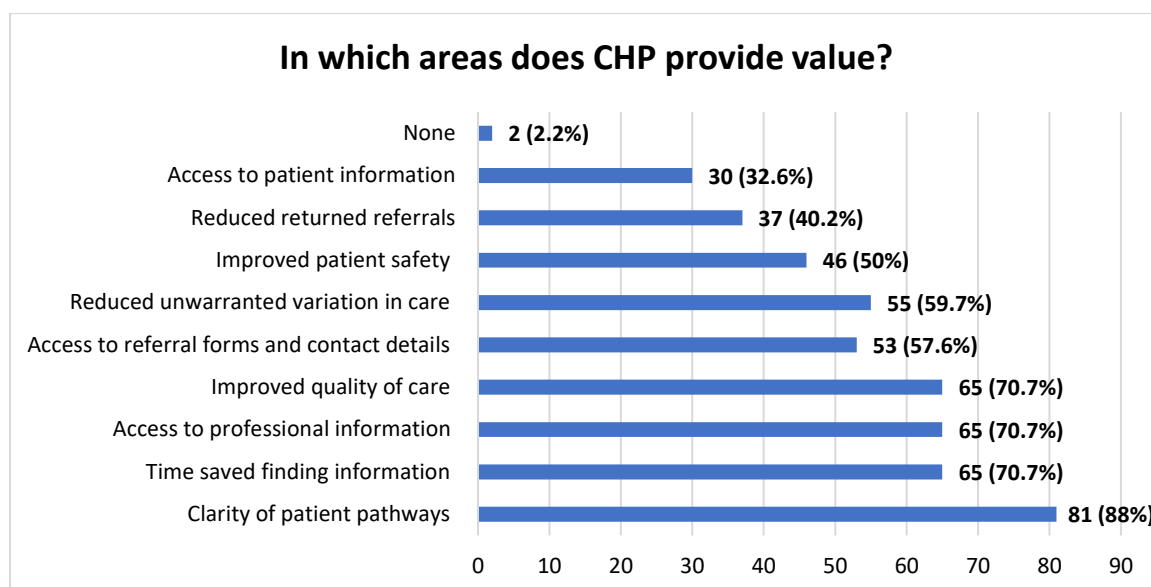


Figure 3.20. Primary care responses when asked in which areas CHP is perceived to provide value. * 94 respondents answered this question. Respondents could select more than one option, therefore totals do not sum to 94.

The most endorsed benefit of CHP was improved clarity of patient pathways. Time savings and easier access to professional information were also frequently endorsed. Notably, half of respondents reported perceived improvements in patient safety, while approximately two-thirds reported perceived improvements in quality of care.

How has CHP impacted your confidence in decision-making?

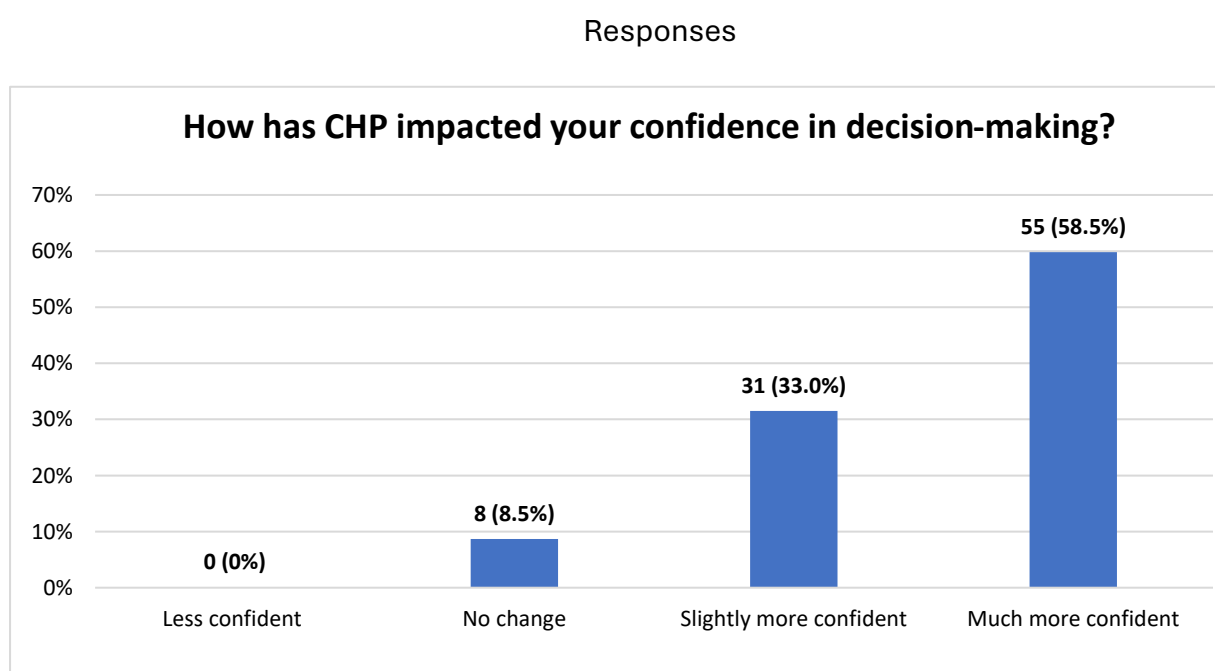


Figure 3.21. Primary care responses when asked how CHP has impacted respondents confidence in decision making. *Percentages are based on the 94 Primary Care respondents who answered this question.

Around 91% of respondents reported that they felt CHP has had a positive impact on their confidence in decision making, with only around 9% reporting no change, and no responses indicating lower confidence due to CHP.

If CHP was no longer required, how much additional time would be required for consultation? (per patient)

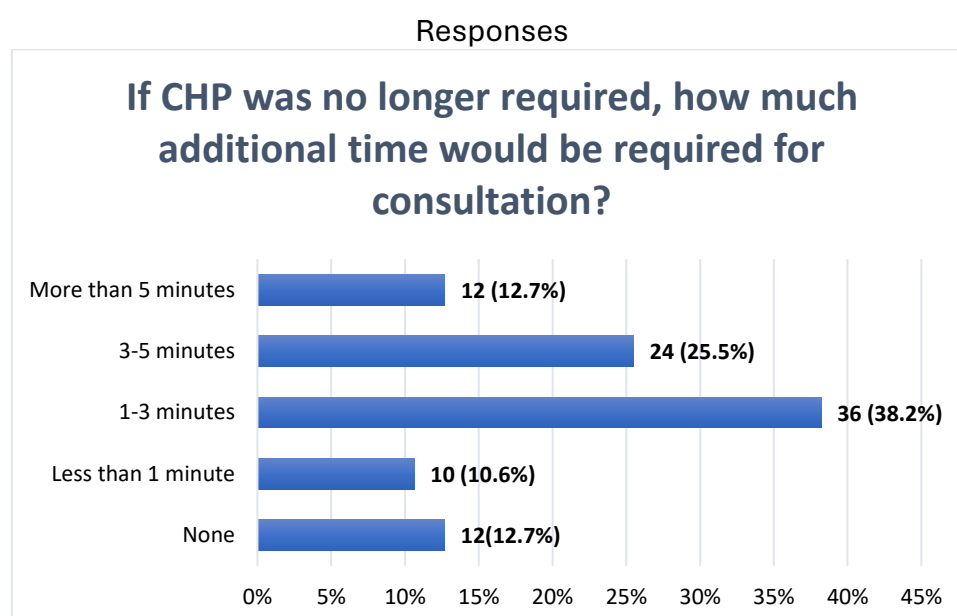


Figure 3.22. Primary care responses when asked how much additional time would be required for a consultation, if CHP was no longer required. * 94 respondents answered this question.

The majority of respondents reported that CHP saves them time per consultation, with only 12 (12.7%) respondents indicating no time saved. The amount of time saved per consultation varied between less than 1 minute and more than 5 minutes, with 1-3 minutes the most frequently cited (n = 36, 38.2%).

If CHP was no longer required, how much additional time would be required for referral? (per patient)

Responses

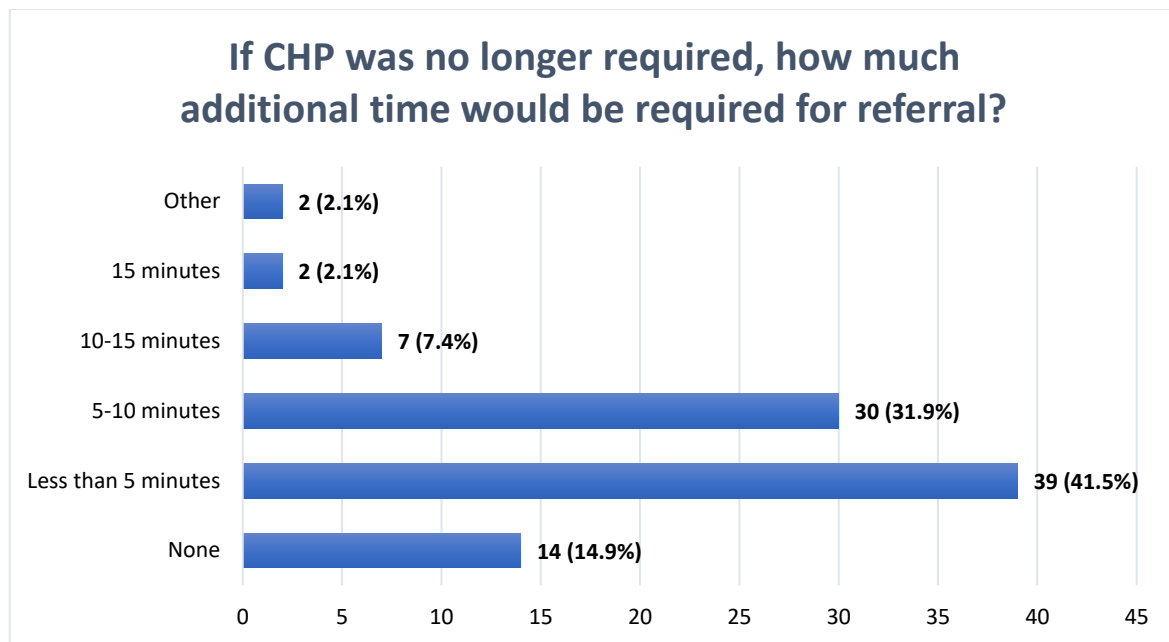


Figure 3.23. Primary care responses when asked how much additional time would be required for a referral if CHP was no longer required. * A total of 94 respondents answered this question.

Additionally, the majority of respondents indicated that without CHP additional time would be needed per referral, with only 14 (14.9%) indicating no additional time would be needed. The amount of additional time per referral ranged from less than 5 minutes to 15 minutes, with 'less than 5 minutes' being the most commonly cited amount of additional time (n = 39. 41.5%).

If CHP was no longer required, how much additional time would be required per clinical day?

Responses

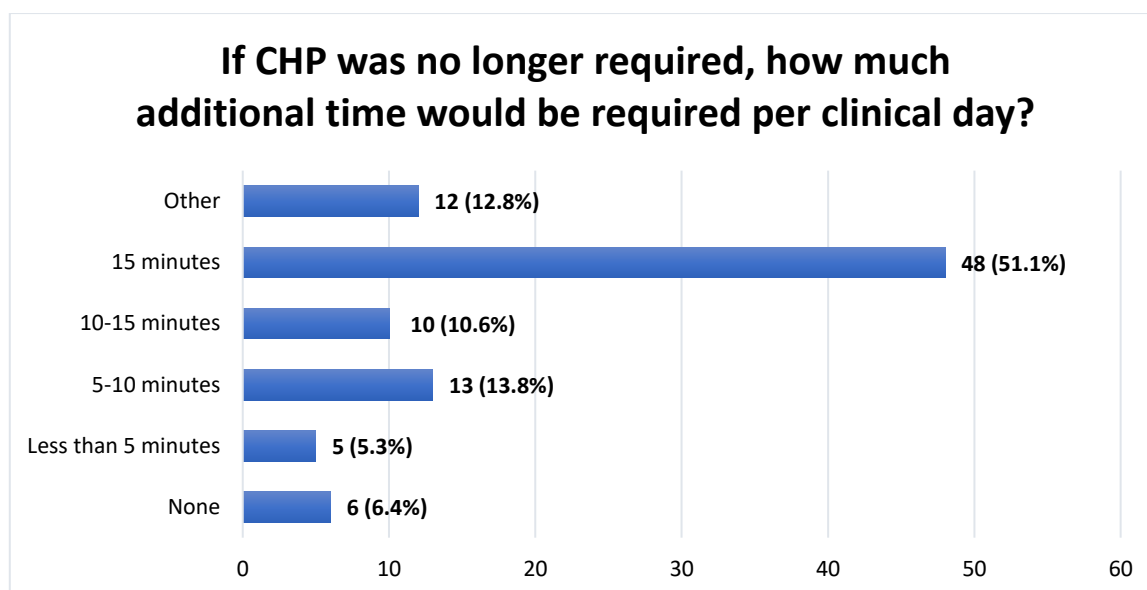


Figure 3.24. Primary care responses when asked how much additional time would be required per clinical day if CHP was no longer required. *A total of 94 respondents answered this question.

The majority of respondents indicated that CHP saves time throughout the clinical day, with only 6 (6.4%) respondents reporting no saved time. The amount of time reported to be saved throughout the clinical day varied from between 'less than 5 minutes' to '15 minutes', with '15 minutes' being the most frequent answer (n = 48, 51.1%).

How does CHP compare to other clinical decision-support resources you use (e.g. UpToDate, GP Notebook, BMJ Best Practice)?

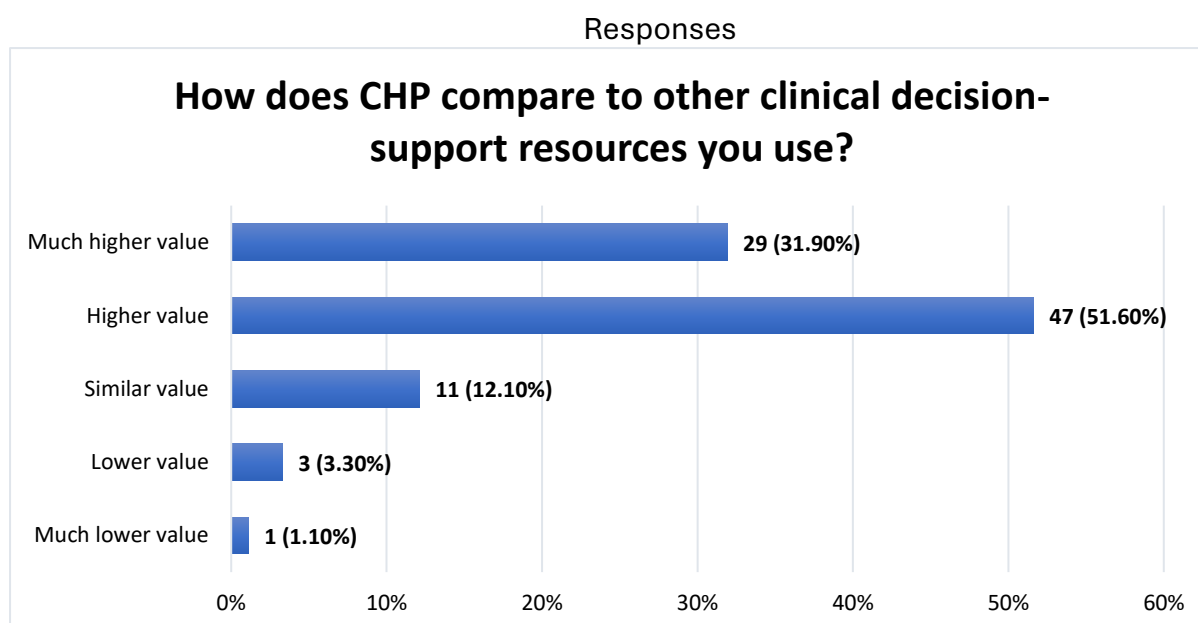


Figure 3.25. Primary care responses when asked how CHP compares to other clinical

decision-support resources. *Percentages are based on the 91 respondents who answered this question. 3 stated that they do not use other resources.

83.5% of participants reported that CHP offered higher or much higher value compared to other clinical-decision support tools.

If CHP was not available, what would you rely on instead?” (Select all that apply)

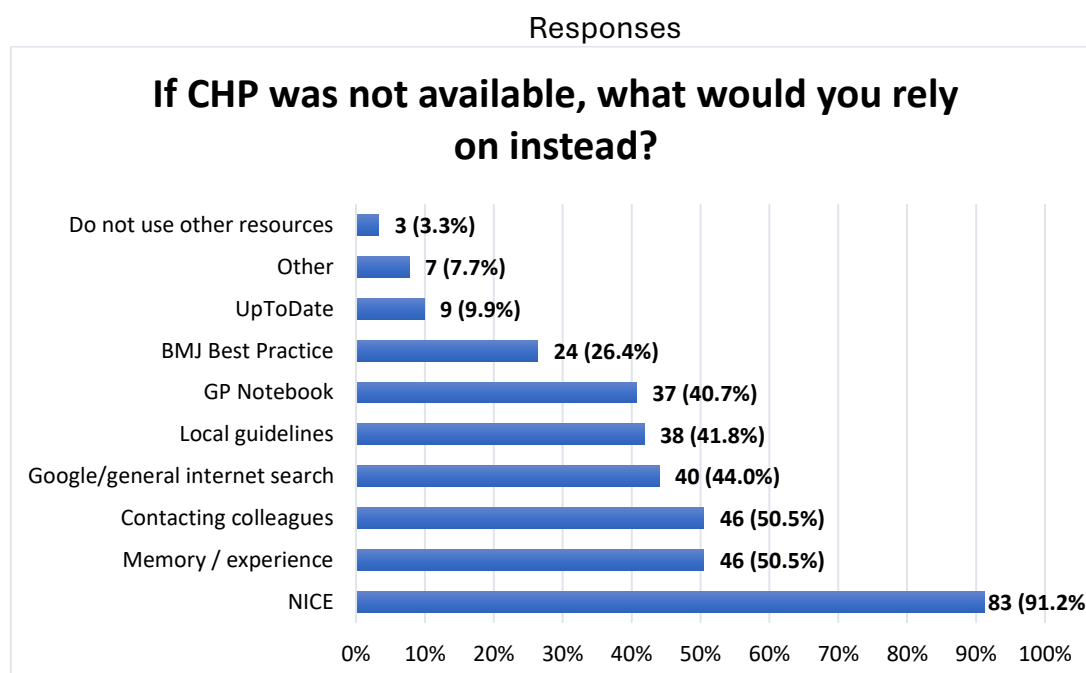


Figure 3.26. Primary care responses when asked if CHP was not available, what other resources would they rely on. *Percentages are based on the 94 respondents who answered this question. Respondents could select more than one option, therefore, percentages do not sum to 100%.

In the event that CHP were not available, respondents indicated that they would rely on a mixture of alternative resources including NICE guidance, GP Notebook, BMJ Best Practice, UpToDate, local guidelines, internet searches and consultation with colleagues.

What are the main barriers to using CHP more frequently?

Responses

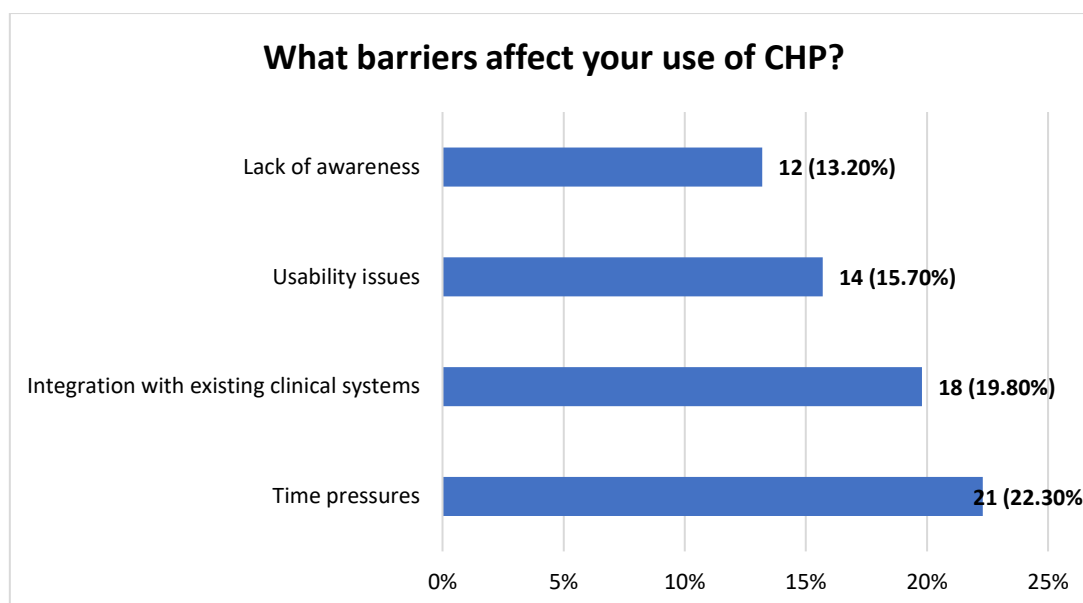


Figure 3.27. Primary care responses when asked what barriers affect their use of CHP.

*Percentages are based on the 94 respondents who answered this question.

Respondents could select more than one option, therefore, percentages do not sum to 100%.

Several barriers to use were identified. Time pressures were the most commonly reported barrier, followed by technical integration and usability challenges. Although the percentages reported are lower than those associated with perceived benefits, these findings indicate that barriers remain and may influence uptake and routine utilisation for some users. The survey findings therefore suggest opportunities for further system development, promotion, and integration rather than indicating universal satisfaction among users.

3.2.4.1.1 Thematic analysis of qualitative survey data

In addition to the quantitative findings, respondents were provided with opportunities to share additional comments regarding their experiences of using CHP. Review of the qualitative feedback identified several recurring themes relating to the perceived benefits of CHP, areas for improvement, and considerations for future development.

Clinical decision support

A common theme throughout the responses was the role of CHP in supporting clinical decision-making.

Respondents described CHP as a useful source of guidance when assessing patients, planning investigations, and making referral decisions. Several respondents reported that CHP provided reassurance that decisions were aligned with locally agreed pathways and current clinical guidance.

"I rely on CHP for almost every patient interaction and it gives me confidence to initiate investigations and management plans safely."

Respondents described CHP as an important source of support when managing unfamiliar presentations, navigating local referral pathways, and understanding Health Board-specific guidance. These comments suggest that CHP may play an important role in supporting workforce development, reducing uncertainty, and promoting consistency of practice among clinicians who are less familiar with local systems and pathways.

Pathway navigation and referral management

Respondents frequently reported that CHP improved understanding of local patient pathways and referral requirements. *One of the respondents said:*

"It helps avoid unnecessary referrals and directs patients to the correct department first time."

Comments indicated that having referral criteria, pathway information, and referral destinations available in a single location reduced uncertainty when determining the most appropriate next step for patient management. Several respondents noted that CHP assisted in identifying investigations required prior to referral and supported the preparation of more complete referral submissions.

Access to information

Many respondents identified the value of having locally relevant guidance, referral forms, contact information, patient resources, and pathway documentation accessible through a single platform. Respondents frequently reported that CHP reduced the need to search multiple websites, systems, documents, or colleagues for information required during consultations and referral decision-making.

Several respondents described CHP as a centralised source of information that brings together guidance, referral criteria, investigation requirements, referral forms, service contact details, and patient pathway information in one location. This was viewed as particularly valuable when managing unfamiliar clinical presentations, working across multiple Health Boards, or navigating frequently changing local referral processes. One of the respondents said:

"Having locally relevant information in one place saves time."

A number of respondents reported that CHP supported a more consistent approach to patient management by providing access to standardised guidance and referral processes. One of the respondents said:

"Patients are getting fair and equal care based on local guidelines."

Respondents described CHP as helping to align practice with local pathways and reducing uncertainty regarding referral requirements and management options.

Opportunities for improvement

While feedback was generally positive, respondents also identified several areas for further development. One respondent commented that:

"the login process can be time consuming and doesn't always work."

More broadly, participants highlighted the need for improved integration with existing clinical systems, more regular review and updating of pathways, and expansion of pathway coverage where gaps currently exist. Respondents also emphasised the importance of increasing awareness and promotion of CHP among healthcare professionals, alongside simplifying access and login processes. Some participants further noted that the effectiveness of CHP is dependent on pathways remaining current, accurate, and consistently used across services.

3.2.4.1.2 Summary of qualitative feedback

Overall, respondents viewed CHP as a valuable clinical resource that supports decision-making, referral management, access to information, and navigation of local pathways. Participants reported benefits relating to confidence in clinical decision-making, access to up-to-date guidance, and more consistent referral processes. Respondents also identified opportunities for further development, particularly around pathway maintenance, promotion and awareness, system integration, and ease of access.

3.2.4.2 Thematic analysis of interview data

Ten participants were interviewed across three datasets: six clinicians working in primary and urgent/community care settings, three participants from secondary care and pathway implementation roles, and one Redress and Legal Services Manager responsible for managing clinical negligence and personal injury claims. Participants were recruited from survey respondents who had indicated their willingness to take part in a follow-up interview.

3.2.4.2.1 Dataset 1– Primary and secondary care clinicians

Eight themes were identified through thematic analysis of primary care clinicians' interview transcripts.

Theme 1: CHP improves confidence in clinical decision-making

A prominent theme across interviews was the role of CHP in enhancing clinicians' confidence when making referral decisions. Participants commonly reported that CHP complemented existing sources of information, such as NICE guidance and provided reassurance that clinical decisions were aligned with current best practice and local pathways, thereby supporting autonomous decision-making. This was reported as particularly relevant and useful when managing more complex or unfamiliar presentations. However, it should be noted that this view was not universal and that some participants reported relying more on their existing clinical knowledge than CHP.

“You can't remember all of it. So, if it's there, it just gives you a lot more confidence, I think, to practice.”

Theme 2: CHP improves safety, referral quality and standardisation of care

Participants consistently perceived CHP as supporting safer and more standardised clinical care. A key mechanism underpinning this perceived benefit was the inclusion of clear red flags, escalation criteria, and referral guidance, which were viewed as helping clinicians identify serious conditions and make appropriate management decisions.

“It's clearly going to make it safer for the patient because it's highlighting the red flags.”

In addition to supporting safer clinical assessment, participants reported improvements in the quality and appropriateness of referrals.

Participants also described CHP as promoting consistency in clinical decision-making and reducing unwarranted variation in practice, with the potential for patients to receive a more consistent level of care regardless of the clinician consulted:

“[Patients] are getting the same standard of care, irrespective of who's seeing them.”

One participant expanded on this theme by highlighting CHP's role in reducing confusion arising from differences in referral processes across localities and hospitals. CHP was viewed as particularly valuable in translating national clinical guidance into locally relevant operational pathways. They also highlighted that CHP provides a unique mechanism for clarifying local referral requirements across geographical areas.

The strongest positive accounts centred on CHP's perceived contribution to value-based healthcare and its ability to reduce unwarranted variation in clinical practice. Participants described pathways as supporting timely, evidence-informed care by ensuring that patients receive appropriate interventions at the appropriate stage of their healthcare journey.

Theme 3: CHP as a workforce development and supervisory resource

Participants frequently described CHP as an important learning resource that supports knowledge development in addition to clinical decision-making. Beyond its role in guiding patient management, CHP was viewed as a tool that enables clinicians to expand their knowledge, develop confidence, and navigate unfamiliar clinical scenarios independently. Participants highlighted the benefits of CHP for trainees and less experienced clinicians who are developing their clinical knowledge and confidence. Participants described how access to structured guidance and locally relevant pathways can support learning in practice, particularly when managing unfamiliar conditions or referral processes. Variations in referral pathways and service configurations were described as potential sources of confusion, particularly for clinicians with less experience of local systems, such as locum GPs.

Some participants highlighted the educational role of CHP, particularly within primary care, describing its potential to raise knowledge levels and promote consistent standards of practice:

"We are able to use these pathways as an educational basis to bring up the knowledge and standard."

Theme 4: CHP supports patient communication and shared understanding

Participants described CHP as a valuable tool for communicating care plans, explaining clinical decisions, and managing patient expectations during consultations. The ability to access pathway information during patient encounters enabled clinicians to provide clear, evidence-based explanations and support shared understanding of management and referral decisions.

"When a patient sees [clinical recommendations] in black and white, it's really helpful."

Similarly, participants described how CHP supported conversations about referral decisions by providing a clear rationale for progression to specialist care and as a source of evidence-based self-management advice that could be shared with patients while they awaited specialist assessment or further investigation.

However, participants identified several limitations regarding patient-facing use of CHP resources. One participant highlighted concern around health literacy and accessibility, noting that some patients may be unable to engage with written information. Another raised additional concerns regarding how patient information is delivered and accessed is only accessible during a GP consultation.

Theme 5: The value of CHP will be realised through optimised localisation, integration and usability

Although participants were positive about the content and clinical value of CHP, they identified several opportunities to enhance its usability, implementation, and overall impact. A recurring theme concerned the importance of balancing local adaptation with national consistency. Participants consistently emphasised that one of CHP's key strengths is its ability to translate national guidance into locally relevant clinical pathways and referral processes.

While local relevance was considered essential, participants also recognised the benefits of maintaining consistency across healthcare systems. Several interviewees suggested that standardised national content could provide a common evidence base while allowing adaptation to local operational requirements.

However, one participant cautioned against excessive localisation, warning that pathways should remain guided by clinical need and evidence rather than solely reflecting existing service provision.

“There's a sort of danger that we develop pathways locally because of what we've got, not because of what we need.”

This perspective reinforces the view that CHP derives much of its value from successfully balancing evidence-based national guidance with local healthcare realities.

Alongside content considerations, usability emerged as the most frequently identified area for improvement. Although participants valued the information contained within CHP, several felt that the system could be easier to navigate and more effectively integrated into routine clinical workflows

Participants identified several practical developments that could further enhance CHP's functionality and integration into clinical practice, including:

- Integration with EMIS and other clinical record systems.
- Links to clinical risk calculators and decision-support tools.
- Improved mobile optimisation and development of a dedicated mobile application.

- Enhanced patient information resources, including QR-code access.
- Improved navigation and search functionality.
- Direct access through local intranet platforms.
- Closer integration with referral management systems and hospital platforms to create a more seamless clinical workflow.

Theme 6: The implementation and uptake gap

A further theme related to implementation maturity and clinician engagement, with suggestions that uptake had been limited in some areas because pathway development remained incomplete and awareness among clinicians varied.

“GPs have not found it hugely useful, partly because the pathways haven't all been built.”

Despite widespread support for the principles underpinning CHP, participants identified a substantial gap between pathway development and pathway utilisation in routine clinical practice. While pathways were generally viewed as valuable resources, their existence did not necessarily translate into consistent awareness, adoption, or adherence.

Some participants described limited observable impact within their specialty, noting that referrals frequently continued to arrive without the recommended investigations or evidence of pathway use. As a result, the anticipated improvements in referral quality and clinical management had not been fully realised.

Several potential explanations were suggested, including lack of awareness, time pressures within consultations, the growing volume of available guidance, and perceptions among more experienced clinicians that pathways add limited value to existing knowledge and practice. Other potential explanations related to how pathways were interpreted and applied in practice and implementation maturity.

As CHP has not yet reached a consistent level of implementation maturity across Wales, the benefits observed to date may represent only a proportion of its potential value. Further benefits may emerge as pathway coverage becomes more comprehensive, clinician awareness and utilisation increase, and CHP becomes more consistently embedded within routine clinical practice.

Theme 7: System design, governance and resource alignment

A substantial proportion of discussion focused on the organisational and structural factors that influence the effectiveness of CHP. Participants recognised that the success of clinical pathways depends not only on pathway content, but also on the governance

arrangements, approval processes, funding structures, workforce capacity, and operational systems that support implementation.

One of the participants highlighted challenges associated with pathway governance and approval processes, expressing frustration that nationally coordinated approval mechanisms could delay implementation even after local agreement had been reached:

“We've approved the local pathway and then we've had to wait a long time for the national leads to approve the pathway.”

A recurring concern was that pathways may redirect activity towards earlier intervention and conservative management without corresponding shifts in workforce or financial resources. Additionally, it was highlighted that pathways often require patients to complete conservative management before progressing to specialist services, yet the resources needed to deliver these interventions are not always available:

“The pathway specifically directs people to exhaust all conservative management prior to considering a hip or knee replacement, but the funding isn't there to support that part of the pathway.”

This highlights a perceived disconnect between pathway expectations and organisational resource distribution. Participants suggested that while pathways can support value-based care, the anticipated benefits may be difficult to realise if capacity remains concentrated at later stages of the patient pathway rather than where the greatest workload occurs.

Feedback emphasised the need for more agile content management processes and more effective feedback mechanisms that would enable users to report missing information, inaccuracies, or service changes directly within pathways and receive timely responses.

Theme 8: Driving value-based and equitable care and the value of a national approach

The role of CHP in promoting optimal conservative management before referral to secondary care or consideration of invasive interventions was emphasised. From this perspective, pathways help ensure that patients receive appropriate non-surgical treatment before progressing through the healthcare system:

“There's an assurance that that patient is being given the optimised non-surgical input prior to going through into secondary care.”

A recurring theme was the importance of national standardisation in promoting equity across health boards. Participants argued that shared pathways provide a common framework for care, reducing the likelihood that patients receive different treatment depending on their location or point of access to services.

Concerns regarding the potential withdrawal of CHP further reinforced its perceived value. It was suggested that removing pathways would reduce the guidance and educational support available to clinicians and could contribute to greater variation in practice. One of the participants warned that the absence of shared pathways could contribute to a healthcare

“postcode lottery”

whereby access to services and standards of care vary according to geographical location.

3.2.4.2.2 Dataset 2 - Legal & risk perspective

The following summarises an interview with the Redress and Legal Services team, exploring the potential impact of CHP on referral-related clinical negligence claims. Therefore, the analysis below is based on a single participant dataset, which limits the breadth of thematic development but still permits an exploratory thematic analysis following Braun and Clarke (2006).

Theme 1: Referral failure as the central driver of claims risk

The participant consistently identified referral-related failures as the dominant feature of primary care negligence claims and suggested that approximately two-thirds of reviewed primary care claims involved failures associated with referral decisions. Importantly, referral failures were not described as simple omissions. Instead, they reflected more complex breakdowns within decision-making processes. The participant identified two recurring mechanisms contributing to the issues observed: the failure to include critical information when making referrals, which can result in incomplete clinical assessments and delays in appropriate care, and the failure to correctly interpret or act upon investigation results, potentially leading to missed opportunities for timely diagnosis, treatment, or follow-up. These factors were highlighted as recurring themes underpinning the cases reviewed.

“They might have done a referral but they haven't listed something that they should have listed and therefore the referral's been rejected.”

Theme 2: Perceived potential of CHP to support safer referral decision-making

The most prominent theme concerning CHP was its perceived ability to function as structured decision-support systems.

The participant viewed CHP as a mechanism that simplifies referral processes and guides clinicians through complex decision pathways. Structured prompts were believed to reduce the likelihood that clinically significant information would be omitted.

The participant drew parallels with decision-support systems used in England for cauda equina syndrome and described evidence of claim reduction associated with such approaches.

The participant explicitly linked CHP use with the prevention of referral-related claims.

“I can't see how it couldn't reduce the numbers of claims that we've got coming in.”

Theme 3: Learning, accountability and risk management

The participant described negligence claims as important organisational learning opportunities rather than purely legal events. Learning was depicted as a mandatory component of claims management. When liability is admitted, organisations must demonstrate that corrective learning has occurred.

“We have to demonstrate that learning has taken place in all of our claims where we're making admissions of liability.”

Within this context, CHPs were viewed as a tangible and auditable risk mitigation intervention. This theme positions CHPs as part of a broader organisational strategy for demonstrating learning, improving safety, and preventing recurrence.

Theme 4: The economic value of prevention

The final theme concerns the substantial economic implications of referral-related claims.

The participant highlighted that negligence claims generate major financial costs for health systems, with some referral failures resulting in extremely high-value settlements.

“Claims cost the health board a huge amount of money, millions of pounds every year.”

The participant therefore viewed CHPs not only as patient safety interventions but also as important financial protection mechanisms. Although definitive outcome data are

not yet available, the participant believed the likely economic return would become evident as the system matures.

3.2.4.3 Streamliners survey of the NHS Wales Clinical Improvement Network (CIN)

A separate survey was delivered by Streamliners to staff who are part of the NHS Wales Clinical Improvement Network (CIN) in July and August 2026. The survey aimed to understand the perceptions of the value of a national programme amongst CIN members, who support the implementation of the National Clinical Framework across Wales.

A total of 7 responses were received, with overall positive views on the value of a nationally co-ordinated programme (Figure 3.28). The majority of respondents either agreed or strongly agreed that a nationally co-ordinated approach supports the translation of policy, guidance and evidence into clinical practice, and helps to reduce unwarranted variation. Additionally, the majority of respondents either agreed or strongly agreed that the benefits of a nationally co-ordinated programme would be difficult to achieve through separate health board led programmes.

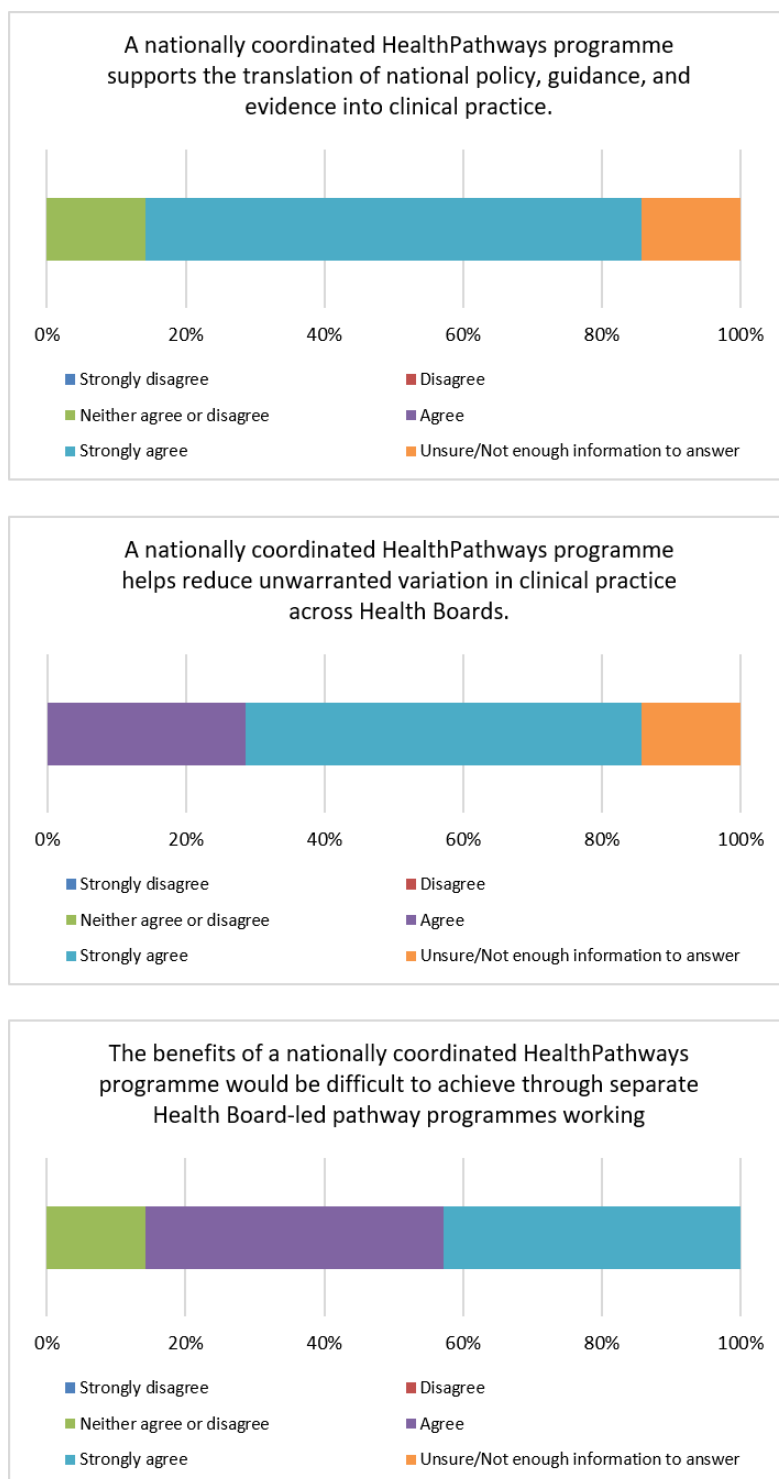


Figure 3.28. Responses to the Streamliners Clinical Improvement Network survey (2026). (n = 7).

Respondents were also invited to provide any additional comments on the value, benefits, limitations, or future role of a nationally coordinated HealthPathways programme.

Two important system-level themes emerged from the qualitative feedback: the need for strong clinical leadership to drive adoption and embed national programmes into practice, and the need for greater integration of CHP with existing clinical systems and workflows. Addressing these areas could further strengthen adoption, sustainability and the benefits realised from the programme.

3.2.4.4 Creating consensus and clarity across the system: development of the national pathway for back pain at point of care

The development of the national Back Pain in Adults pathway provides an example of how CHP can create value by bringing together clinicians and stakeholders from across the system to develop a shared understanding of clinical practice and referral processes. The pathway development process brought together GPs, spinal surgeons, physiotherapists, other specialist clinicians, patient representation, primary care representatives and contributors from across Welsh health boards. Through this process areas of genuine clinical and operational uncertainty were identified, including inconsistencies between existing guidance, ambiguity around clinical terminology and referral thresholds, and differences in interpretation of local and national referral arrangements. Rather than simply reproducing existing guidance, the CHP development process provided a structured mechanism through which these differences could be surfaced, referred to appropriate subject-matter experts and governance structures, and translated into clearer, agreed guidance for use at the point of care.

This illustrates a potentially important wider benefit of the CHP model: the value is not limited to clinicians accessing the final pathway but also arises through the collaborative process required to create it. Developing pathways on a Once for Wales basis can help establish consensus about what constitutes appropriate care, clarify areas where existing guidance or referral arrangements are ambiguous, and distinguish between elements that should be standardised nationally and those where legitimate local variation is required. In the Back Pain pathway, for example, the process identified and reconciled differing definitions of suspected cauda equina syndrome, clarified previously ambiguous timescales, refined clinical terminology and established greater clarity around referral routes and governance. The resulting pathway therefore represents not simply an information resource, but a shared and collaboratively agreed representation of how care should be delivered across the system, reducing the need for individual organisations or clinicians to resolve the same uncertainties independently.

Conclusion: The consensus process demonstrates how a shared national approach can create value at multiple levels of the healthcare system. Clearer and more consistent guidance supports frontline clinical decision-making and reduces unwarranted variation, with potential benefits for patient experience, equity and safety. Nationally, resolving areas of uncertainty once rather than independently within

individual organisations reduces duplication and supports NHS efficiency. Locally, more consistent and cost-effective investigation, management and referral of patients with back pain can improve the use of Health Board resources and clinical capacity. The value of the approach therefore extends beyond producing consensus guidance: it provides a mechanism for translating collective clinical expertise into improved patient care and more efficient use of resources across the system.

4 Value of Community HealthPathways

4.1 Value of CHP to patients

Although there is little evidence of the direct impact of CHP on patient outcomes in this evaluation, several findings indicate plausible mechanisms through which CHP may contribute to improved patient experience, quality, equity and safety. Within HDUHB, implementation of CHP was associated with a reduction in the recorded inappropriate referral rate from 6.5% to 2.6%. Qualitative findings also suggest that clearer referral criteria, red flags, escalation guidance and greater standardisation may support more consistent patient management. However, the evaluation did not directly measure whether these changes translated into improved patient outcomes.

Healthcare professionals also perceived value for patients. Around half of primary care survey respondents identified improved patient safety as an area in which CHP provides value, while 70.7% identified improved quality of care. Participants particularly highlighted the potential for shared pathways to reduce unwarranted variation and promote greater consistency and equity of care across Wales. These findings should be interpreted as healthcare professional perceptions and potential mechanisms of benefit rather than evidence of demonstrated improvements in patient outcomes.

4.2 Value of CHP to HCPs

Among healthcare professionals who participated in the evaluation, and particularly regular primary care users, CHP was generally perceived as a valuable clinical resource. Among primary care survey respondents (n = 94), 75% reported using CHP at least daily, while around 90% reported that it saved time when locating clinical guidance. More than 90% reported increased confidence in clinical decision-making. These findings indicate substantial perceived value amongst respondents but should be interpreted in the context of the relatively small, self-selecting sample, which predominantly comprised primary care clinicians and regular CHP users.

Qualitative findings reinforced this perceived value. Interview participants described CHP as both a clinical decision-support and knowledge-translation resource, helping them access relevant guidance, understand local referral processes and navigate increasingly complex systems of care. Participants also identified a role for CHP in education and workforce development, particularly through supporting learning, reinforcing best practice and reducing reliance on informal sources of information.

Overall, the findings suggest that CHP is highly valued by many of the clinicians who participated in the evaluation. However, the extent to which these perceptions are shared across the wider clinical workforce, particularly non-users, less engaged clinicians and secondary care professionals, remains less certain. Realising wider value is likely to depend on continued pathway development, stakeholder engagement, system integration and shared ownership across primary and secondary care.

4.3 Value of CHP to the NHS in Wales

The HCP survey indicated that CHP has saved primary care users time, with almost all of respondents reporting that CHP has saved them some time in a clinical day (n = 88, 93.6%). Using the survey responses, this was estimated at between 22.48 and 26.82 hours a day of combined time for these individuals.

Profession-specific cost estimates were then applied using the PSSRU/CORE Unit Costs 2024/25 (Jones et al., 2026), enabling an estimate of the total equivalent resource value released as reported by survey respondents. PSSRU/CORE Unit Costs are routinely used in Wales, particularly in NHS service evaluations, health economic analyses, research studies, and business cases where a nationally recognised source of unit costs is required. The Unit Costs programme provides nationally applicable cost estimates for health and social care services and is widely used across the UK when local cost data are unavailable.

Applying profession-specific unit costs to the time savings reported by survey respondents produced an estimated equivalent resource value of approximately £1.20 million to £1.38 million per annum across those respondents. This represents the indicative value of self-reported capacity release rather than a cash-releasing saving. As the estimate is derived from a relatively small and predominantly primary care sample containing a high proportion of regular CHP users, it should not be extrapolated directly to the wider workforce. However, it provides an indication that clinician time saving may represent an important area of potential value warranting further investigation at scale.

The evaluation identified changes in both referral activity and recorded referral appropriateness that were associated with CHP implementation, alongside healthcare professional perceptions that CHP influences referral decision-making. This was supported by the survey, from which 42.7% of respondents reported improved referral quality and 32.6% of respondents reported increased appropriate referrals due to CHP. Additionally, 71.3% of respondents reported that CHP had helped reduce rejected referrals through clearer referral criteria and improved understanding of referral requirements.

In HDUHB implementation of CHP was associated with an overall reduction in referral activity of 12.2%. Across the matched pre- and post-implementation periods, referrals reduced from 116,859 to 102,606 representing 14,253 fewer referrals. Applying an indicative unit cost of £181 per referral (NHS England, 2024), the observed reduction equates to approximately £2.58 million in potential equivalent resource release. This represents the indicative value of capacity associated with the observed reduction in activity and should not be interpreted as either a directly attributable benefit of CHP or a cash-releasing saving.

In addition to the reduction in overall referral activity following CHP implementation in HDUHB, a 60% relative reduction in recorded inappropriate referrals was observed, decreasing from 6.5% before implementation to 2.6% afterwards. This improvement in referral appropriateness may provide additional system benefits beyond those captured by the reduction in referral numbers alone, by potentially reducing avoidable clinical and administrative touchpoints, unnecessary investigations, referral triage and rejection, and subsequent re-referral. These effects could contribute to further capacity and resource release across both primary and secondary care, although this additional benefit has not been quantified within the current evaluation.

Additional potential value of CHP was identified as a potential mechanism to contribute to the reduction of pathway-related claims. A review of HDUHB Datix claims between 2018 and 2025 was carried out, and identified 23 primary care claims, of which approximately 16 related to delayed, missed, or inappropriate referrals to secondary care services. The historic financial consequences associated with these claims were substantial, potentially exceeding £14 million. This figure represents the estimated value of historic claims and should not be interpreted as a potential financial saving attributable to CHP.

While it is not possible to conclude retrospectively that CHP would have prevented specific incidents, the themes evident across the claims are consistent with the problems CHP has been designed to address. There is therefore a plausible

mechanism through which effective adoption of CHP could contribute to reducing the likelihood of similar referral-related failures occurring in the future.

4.3.1 Value of the national approach

Interview participants consistently emphasised that one of CHP's key strengths is its ability to translate national guidance into locally relevant clinical pathways and referral processes.

A recurring theme was the importance of national standardisation in promoting equity across health boards. Participants argued that shared pathways provide a common framework for care, reducing the likelihood that patients receive different treatment depending on their location or point of access to services.

Concerns regarding the potential withdrawal of CHP further reinforced its perceived value. It was suggested that removing pathways would reduce the guidance and educational support available to clinicians and could contribute to greater variation in practice.

CHP was viewed as an important mechanism for reducing inequity and promoting greater consistency across services. Qualitative findings highlighted concerns that a purely localised approach to pathway development could lead to greater variation, fragmentation and inconsistency in care. The development of the national Back Pain in Adults pathway provides a practical example of the value of the collaborative CHP approach, demonstrating how variation, ambiguity and professional disagreement can be surfaced, reviewed by relevant clinical and system stakeholders, and translated into an agreed and accessible pathway at the point of care. In doing so, CHP can provide greater clarity for clinicians while supporting more consistent clinical decision-making and care across Wales.

There may also be further value in using CHP as a mechanism for identifying variation between health boards. By making differences in pathway content, referral criteria and local service arrangements more visible, CHP could help distinguish legitimate local variation from potentially unwarranted variation. This could provide a valuable basis for national clinical discussion, shared learning and pathway improvement, supporting efforts to reduce unwarranted variation, promote greater consistency and ultimately reduce inequalities in care across Wales. One of the participants warned that the absence of shared pathways could contribute to a healthcare “postcode lottery” whereby access to services and standards of care vary according to geographical location.

Importantly, the potential value of a national approach depends not only on developing shared pathways, but on those pathways being understood, owned and applied across the whole healthcare system. Where referring clinicians use an agreed pathway to guide investigation and referral but receiving services do not consistently apply the same pathway to triage, referral acceptance and subsequent management, the opportunity to improve consistency and pathway efficiency may be limited. The longer-term transformational value of CHP is therefore likely to depend on strengthening shared ownership between primary and secondary care and embedding agreed pathways across the full patient journey.

Greater integration of CHP with clinical record, referral and receiving-service systems may also be important in achieving this. Interoperability should therefore be considered not simply as a usability improvement, but as an enabler of benefit realisation by embedding agreed pathways more directly within routine clinical decision-making, referral and triage workflows.

5 Conclusions

This interim evaluation provides encouraging evidence that CHP is becoming increasingly established across NHS Wales, with continued growth in pathway development and engagement across most health boards. However, implementation maturity remains variable, reflecting differences in pathway coverage, clinician engagement, local implementation approaches and the extent to which CHP is embedded within routine clinical practice.

Healthcare professionals who participated in the evaluation generally reported positive experiences of CHP, particularly in relation to access to locally relevant guidance, clinical confidence, referral decision-making, clarity of patient pathways and time saving. Qualitative findings also identified potential value in supporting workforce development, standardisation and reducing unwarranted variation. These findings provide important evidence of perceived value amongst participating clinicians but should be interpreted in the context of the relatively small and self-selected survey and interview samples, the predominance of primary care respondents and the high proportion of regular CHP users. They should therefore not be assumed to represent the experience of the wider clinical workforce.

Within HDUHB, CHP implementation was associated with a 12.2% reduction in referral activity across matched pre- and post-implementation periods, alongside a reduction in the recorded inappropriate referral rate from 6.5% to 2.6%. These findings are consistent with CHP potentially contributing to changes in referral behaviour and quality, but the

observational design does not establish causation and other contemporaneous changes in services, demand or clinical practice may also have contributed. Applying an indicative unit cost to the observed reduction in referrals gives an estimated £2.58 million in potential equivalent resource release. This represents the indicative value of potentially released capacity rather than a directly attributable or cash-releasing financial saving.

The survey identified a further potential source of workforce value through clinician time saving. Among participating healthcare professionals, reported time savings were estimated to represent between approximately £1.20 million and £1.38 million per annum in equivalent resource value. This estimate relates only to the participating survey respondents and represents self-reported capacity release rather than a cash-releasing saving. The available evidence does not support extrapolation of this estimate across the wider Welsh clinical workforce, although it indicates that workforce efficiency is an important area for further evaluation.

The evaluation also identified potentially important strategic value beyond referral activity and workforce capacity. CHP provides national infrastructure through which clinical evidence, professional consensus and local service arrangements can be translated into accessible care pathways. The national Back Pain in Adults pathway demonstrates how this process can surface areas of ambiguity and variation, facilitate multidisciplinary consensus and generate clearer shared guidance. This provides a potential mechanism for reducing duplication, supporting equity and addressing unwarranted variation across Wales.

The longer-term strategic opportunity for CHP lies in its potential to operate as a whole-system transformation tool rather than solely as a primary care clinical reference resource. Realising this potential will require nationally and locally agreed pathways to be understood, owned and consistently applied by both referring and receiving clinicians. Where referral decisions are aligned with CHP but triage, acceptance and subsequent management processes are not, opportunities to improve patient flow, consistency and system efficiency are likely to be constrained. Stronger secondary care engagement, shared clinical ownership and alignment of referral and receiving-service processes should therefore be priorities for future implementation.

Interoperability is also likely to be an important enabler of this transformation. Greater integration of CHP within clinical records, referral systems and receiving-service workflows could move pathway guidance from a resource that clinicians actively choose to consult towards a more embedded component of routine clinical decision-making. This may offer greater opportunity to improve pathway adherence, standardisation and coordinated care across organisational boundaries.

CHP has not yet reached a consistent level of implementation maturity across Wales. Consequently, the benefits observed to date may represent only part of its potential value. However, additional benefit should not be assumed: the next phase of implementation and evaluation should demonstrate whether greater pathway coverage, whole-system clinical ownership, interoperability and integration translate into measurable improvements in patient pathways, clinical outcomes, resource utilisation and equity. This would provide a stronger basis for determining the longer-term contribution of CHP to healthcare transformation across Wales.

6 Limitations

As part of the evaluation there were several limitations and barriers that were encountered when delivering the evaluation. These include:

6.1 Data access and lack of available data

During the evaluation period, access to data was limited, particularly relating to the impact of CHP on patient outcomes. Where data were not available, equivalent datasets were used e.g. Costing data included in the report is not Wales specific, and as such is an estimate of the cost of resources.

6.2 Small sample size of HCP survey and interviews

Due to the relatively small sample size of the HCP survey, results should be interpreted with caution. This is particularly applicable with the secondary care element of the survey, which had fewer than 10 responses. Additionally, the sample size for interviews was small with fewer than 10 HCPs across primary and secondary care. Additional bias could be introduced as the small number of participants interviewed had varying levels of involvement with CHP development and implementation, which may have influenced their perceptions of its value and effectiveness. Their views may therefore not be representative of the broader healthcare workforce or of clinicians with limited exposure to CHP.

As only one claims and redress team was interviewed, the views expressed represent those of one person only. Further data is needed to validate any conclusions.

6.3 Potential geographical bias

Almost a half of all survey responses were from HCPs based in CAVUHB, and as such, this could have introduced geographical bias to the survey, which may limit the extent to which findings reflect experiences across all healthcare settings and geographical areas.

6.4 Limitations of thematic analysis

The qualitative analysis was conducted using reflexive thematic analysis, which acknowledges that themes are actively constructed through researcher interpretation. Although themes were grounded firmly in participants' accounts and supported by illustrative quotations, alternative interpretations of the data are possible. Furthermore, the evaluation context may have encouraged participants to focus particularly on value, usability, and withdrawal risks, potentially shaping the content of responses.

6.5 Limitations of pre and post comparisons

When comparing referral numbers and quality of referrals pre and post implementation of CHP, the comparison does not imply causation and is correlative, as other factors could be present influencing the number and quality of referrals.

References

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Welsh Government (2026), Outpatient referrals, April 2012 onwards. Available at <https://stats.gov.wales/en-GB/9e8f6f1d-d4aa-457a-a675-cc0e2caef3a5/start>

Welsh Government (2026) (2), Population estimates by local health boards, year, sex and age. Available at <https://stats.gov.wales/en-GB/f7c81eb8-cf29-4d14-b964-04c155527e4d/start>

Appendices

Appendix 1: Indicative project timelines

	April	May	June	July	August	September	October	November	December
WP1									
WP2									
WP3									
WP4									
WP5									
WP6									
WP7									
WP8									

Interim short report

Final report

Task	Deliverable	Target date	Confidence
WP1: Project Preparation and Startup	Agreement of protocol.	31-May-26	
	Signing of contract.	31-May-26	
	Define data collection variables.	31-May-26	
WP2: Project Oversight	Develop monthly oversight meeting.	31-May-26	
	Develop monthly oversight template report.	31-May-26	
WP3: Evaluation Plan Development	Establishment of stakeholder database.	30-Jun-26	
	Develop a staged evaluation plan.	30-Jun-26	
	Data identification and design.	30-Jun-26	
	Development of data collection tools.	30-Jun-26	
	Define and agree data access.	30-Jun-26	



Appendix 2: CHP survey questions

Community HealthPathways Survey

Have your say on the future of Community HealthPathways - Win a £50 amazon voucher!

Thank you for taking part in this survey. This should take less than 8 minutes to complete. Please note that each question will adapt based on your previous responses.

This survey aims to understand how Community HealthPathways (CHP) is used by healthcare practitioners and to quantify its impact on clinical time, referral quality, administrative workload, and overall system efficiency. Your responses will help inform service improvement and assess the value of CHP across the health system. All responses will be anonymised and used for evaluation purposes only.

The findings from this survey will inform decisions about the future development and investment in Community HealthPathways.

Privacy Statement: *Hywel Dda University Health Board will use the information you submit, or have previously submitted, for the purpose of collecting feedback to support research projects and Trittech involvement, and to take any associated actions as required. Further information about your Data Protection rights in line with the provisions of the UK General Data Protection Regulation and Data Protection Act 2018, for example how to contact the Data Protection Officer, how long your information is held or how we process your personal information can be found at: Privacy notices - <http://hduhb.nhs.wales/about-us/governance-arrangements&our-information-notice/our-right/wivac>.*



* Required



1. Have you heard of the Community HealthPathways (CHP)? *

Yes - I use it

Yes - but I do not use it

No

2. Which Health Board are you employed/based within? *

Aneurin Bevan University Health
Board

Betsi Cadwaladr University

Health Board Cardiff and Vale

University Health Board

Cwm Taf Morgannwg University Health Board

Hywel Dda University Health Board

Powys Teaching Health Board

Swansea Bay University Health Board



3. Are you based in*

Primary Care

Intermediate care

Secondary Care

4. Which best describes your role?*

GP

Consultant

Advanced Clinical Practitioner

Practice Nurse

Physician Associate

Other

5. Please state your speciality/specialities *



6. Since the implementation of CHP have you seen improvements to referral pathways? *

7. Has CHP improved the efficiency of patient flow into your service? (e.g. more appropriate referrals, smoother triage)*

- ☐ Yes - significantly
- ☐ Yes - somewhat
- ☐ No change
- ☐ Worsened efficiency
- ☐ Other



8. In your view, has CHP contributed to: (Select any that apply) *

Reduced waiting
times

Better patient
outcomes

More appropriate
referrals

Reduced administrative burden

Improved communication with primary care

Reducing unwarranted variation in care

Clarity of patient pathway

Reduced returned referrals

Access to professional information

Improved patient safety

Other



9. Has CHP changed the time you spend on referral triage activities^{*}

Yes – Increased
time

Yes – Reduced
time

No change

10. Do you believe CHP represents good value for the Health Board? ^{*}

Yes
Unsure
No
Other

11. Please describe an example where CHP improved efficiency, reduced unnecessary work, or improved patient care:^{*}



Usage & Adoption

12. How often do you use Community HealthPathways (CHP)?

*

Multiple times per day

Daily

Weekly

Monthly

Rarely

Never



Time Saving

13. What tasks does CHP save time on? (select all that apply)*

Finding clinical guidance

Referral forms

Referral Guidance

Searching multiple systems

Patient information resources

No time saved

Other



Referral Impact

14. Has CHP changed your referral decisions (Select all that apply) *

It has reduced the number of referrals

It has increased the number of appropriate referrals

It has improved the clarity of referral decisions

It has improved the quality of referrals

No noticeable change

Other

15. If you have had a rejected referral, have you been redirected to CHP? *

Yes

No



16. Do you think the use of CHP has reduced your rejected referral rate? *

Yes

No



Diagnostics & Pathway Use

17. Has CHP influenced your use of diagnostic tests? *

Reduced unnecessary tests

Increased appropriate tests

Reduced unnecessary tests & Increased appropriate tests

No Change



Value Perception

18. In which areas does CHP provide value? (select all)

*

Access to referral forms and contact details

Access to patient information

Clarity of patient pathway

Reducing unwarranted variation in care

Reduced returned referrals

Access to professional information

Time saved finding information

Improved patient safety

Improved quality of care

None



19. How has CHP impacted your confidence in decision-making*

Much more confident

Slightly more confident

No change

Less confident



System-Level Impact

20. If CHP was no longer available, how much additional time would be required per consultation?

*

None

Less than 1 minute

1-3 minutes

3-5 minutes

More than 5 minutes



21. If CHP was no longer available, how much additional time would be required per referral?

*

None

Less than 5 minutes

5-10 minutes

10-15 minutes

15 minutes

Other



22. If CHP was no longer available, how much additional time would be required per Clinical DaY.?

*

None

Less than 5 minutes

5-10 minutes

10-15 minutes

15 minutes

Other



Behaviour and alternatives

23. How does CHP compare to other clinical decision-support resources you use (e.g. UpToDate, GP Notebook, BMJ Best Practice)? *

Much higher value

Higher value

Similar value

Lower value

Much lower value

Do not use other resources

Other



24. If CHP was not available, what would you rely on instead?" (Select all)

NICE

BMJ Best Practice

GP Notebook

UpToDate

Memory / experience

Contacting colleagues

Google/ general internet search

Local guidelines

Other



Barriers & Optimisation

25. What are the main barriers to using CHP more frequently?

Time
Awareness
Usability
Integration with systems
Not needed
Other

26. Can you describe an example where CHP saved time or avoided unnecessary work or improved patient care?



Experience

27. What is your experience of Community HealthPathways? or If you are willing to be contacted for a follow-up interview, please provide your email address:



End

28. Please describe the value this platform has created. Consider its impact on:

- Users (e.g. experience, productivity)
- Patients (e.g. outcomes, safety, experience)
- The organisation (e.g. service quality, operational efficiency, strategic value)
- Financial value (e.g. cost avoidance, savings, income generation, return on investment)

29. If you are willing to be contacted for a follow-up interview, please provide your email address (optional):

Appendix 3: Primary care HCP interview questions

1. Understanding HEALTHPATHWAYS and Your Role

1a. How would you describe Community HealthPathways (HEALTHPATHWAYS) and its purpose?

1b. Can you describe your role and how you use HEALTHPATHWAYS in your day-to-day practice?

Prompts if required:

- Frequency of use
- Clinical areas/pathways used
- Involvement in pathway development or review

Examples of Impact - *Saved time/Avoided unnecessary referral or investigation/ Improved patient care*

Can you provide an example of what might have happened without HEALTHPATHWAYS in that scenario?

2. Clinical Practice and Referrals

2a. How has HEALTHPATHWAYS changed the way you manage patients and referrals?

Prompts if required:

- Appropriateness of referrals
- Consistency of decision-making
- Alignment with guidelines

Examples of Impact - *Saved time/avoided unnecessary referral or investigation/ improved patient care*

2b. What would happen to your referral processes if HEALTHPATHWAYS was no longer available?

Prompts if required:

- Use of alternative resources
- Variation in practice
- Impact on referral quality

3. Efficiency, Workflow and Capacity

3a. What impact has HEALTHPATHWAYS had on your efficiency and workflow, if any?

Prompts if required:

- Time savings
- Ease of accessing guidance
- Reduction in unnecessary work
- **Examples of Impact** - Saved time/Avoided unnecessary referral or investigation/Improved patient care

3b. If HEALTHPATHWAYS was withdrawn, how would this affect your workload and service capacity?

Prompts if required:

- Time spent finding guidance
- Duplication of work
- Impact on appointment availability

4. Patient Safety and Quality of Care

4a. How has HEALTHPATHWAYS influenced patient safety and quality of care?

Prompts if required:

- Improved decision-making
- Standardisation of care
- Avoidance of delays or errors
- **Examples of Impact**

Can you provide an example of what might have happened without HEALTHPATHWAYS in that scenario?

4b. What risks to patient safety and quality of care, if any, do you think would arise if HEALTHPATHWAYS was withdrawn?

Prompts if required:

- Increased variation in care
- Risk of inappropriate referrals
- Delays in diagnosis or treatment
- Examples of Impact

5. Clinical Decision-Making and Confidence

5a. How has HEALTHPATHWAYS influenced your clinical decision-making?

Prompts if required:

- Use of evidence-based guidance
- Confidence in decisions
- Reduction in uncertainty
- **Examples of Impact**

Can you provide an example of what might have happened without HEALTHPATHWAYS in that scenario?

6. Confidence, Training and Behaviour Change

6a. Has HEALTHPATHWAYS affected your confidence in managing patients?

Prompts if required:

- Training and support
- Managing conditions in primary care
- Changes to roles/responsibilities
- Examples of Impact

Can you provide an example of what might have happened without HEALTHPATHWAYS in that scenario?

6b. How might your confidence or behaviour change if HEALTHPATHWAYS was removed?

Prompts if required:

- Increased referrals
- Reduced autonomy
- Greater reliance on secondary care

7. System-Level Impact and Value

7a. What do you see as the main value of HEALTHPATHWAYS to:

- You as a clinician
- Your organisation
- The wider healthcare system

Prompts if required:

- Referral quality
- Guideline adherence
- Demand management
- Patient experience

8. National vs Local Approach

HealthPathways in Wales is a nationally coordinated approach where care pathways are developed collaboratively by multiple health boards, enabling shared, standardised pathways while accommodating local service or process variations.

8a. What would you say is the value of a national HEALTHPATHWAYS approach with shared pathways across health boards?

8b. What would be the impact of moving to a purely local or non-standardised approach?

Prompts if required:

- Variation across Health Boards
- Duplication of work
- Sustainability
- **Examples of Impact**

9. Challenges and Areas for Improvement

9a. What challenges or barriers have you experienced with HEALTHPATHWAYS?

Prompts if required:

- Usability (try to move people beyond usability as covered lots in the previous evaluation)
- Integration into workflow
- Awareness

9b. Are there any improvements that you would make to HEALTHPATHWAYS or how it is integrated into your daily workflow?

10. **Final Reflections:** Is there anything else important we should understand about:

- The value of HEALTHPATHWAYS
- Usability of HEALTHPATHWAYS
- The risks of withdrawing HEALTHPATHWAYS

Appendix 4: Secondary care HCP interview questions

1. Understanding HEALTHPATHWAYS and Your Role

1a. How would you describe Community HealthPathways (HEALTHPATHWAYS) and its purpose?

1b. Can you describe your role and how you use HEALTHPATHWAYS in your day-to-day practice?

Prompts if required:

- Frequency of use
- Clinical areas/pathways used
- Involvement in pathway development or review

Examples of Impact - *Saved time/Avoided unnecessary referral or investigation/ Improved patient care*

Can you provide an example of what might have happened without HEALTHPATHWAYS in that scenario?

2. Clinical Practice and Referrals

2a. Since the implementation of HEALTHPATHWAYS, how has it change in the appropriateness of referrals? If there has been any change?

Prompts if required:

- **Examples of Impact**

2b. What would happen if HEALTHPATHWAYS was no longer available?

Prompts if required:

- Use of alternative resources
- Variation in practice
- Impact on referral quality

3. Patient Safety and Quality of Care

3a. How has HEALTHPATHWAYS influenced patient safety and quality of care?

Prompts if required:

- Improved decision-making
- Standardisation of care
- Avoidance of delays or errors

- **Examples of Impact**

Can you provide an example of what might have happened without HEALTHPATHWAYS in that scenario?

3b. What risks to patient safety and quality of care, if any, do you think would arise if HEALTHPATHWAYS was withdrawn?

Prompts if required:

- Increased variation in care
- Risk of inappropriate referrals
- Delays in diagnosis or treatment
- **Examples of Impact**

4. Clinical Decision-Making and Confidence

4a. How has HEALTHPATHWAYS influenced your clinical decision-making?

Prompts if required:

- Use of evidence-based guidance
- Confidence in decisions
- Reduction in uncertainty
- **Examples of Impact**

Can you provide an example of what might have happened without HEALTHPATHWAYS in that scenario?

5. Confidence, Training and Behaviour Change

5a. Has HEALTHPATHWAYS affected your confidence in managing patients?

Prompts if required:

- Training and support
- Managing conditions in primary care
- Changes to roles/responsibilities
- Examples of Impact

5b. How might your confidence or behaviour change if HEALTHPATHWAYS was removed?

Prompts if required:

- Increased referrals
- Reduced autonomy
- Greater reliance on secondary care

6. System-Level Impact and Value

6a. What do you see as the main value of HEALTHPATHWAYS to:

- You as a clinician
- Your organisation
- The wider healthcare system

Prompts if required:

- Referral quality
- Guideline adherence
- Demand management
- Patient experience

7. National vs Local Approach

HealthPathways in Wales is a nationally coordinated approach where care pathways are developed collaboratively by multiple health boards, enabling shared, standardised pathways while accommodating local service or process variations.

8a. What is the value of a national HEALTHPATHWAYS approach with shared pathways across health boards?

8b. What would be the impact of moving to a purely local or non-standardised approach?

Prompts if required:

- Variation across Health Boards
- Duplication of work
- Sustainability
- **Examples of Impact**

8. Challenges and Areas for Improvement

8a. What challenges or barriers have you experienced with HEALTHPATHWAYS?

Prompts if required:

- Usability (try to move people beyond usability as covered lots in the previous evaluation)
- Integration into workflow
- Awareness

8b. Are there any improvements that you would make to HEALTHPATHWAYS or how it is integrated into your daily workflow?

9. **Final Reflections:** Is there anything else important we should understand about:

- The value of HEALTHPATHWAYS
- Usability of HEALTHPATHWAYS
- The risks of withdrawing HEALTHPATHWAYS

Appendix 5: Email sent to medical directors

From: Hywel Dda UHB - Executive Medical Director

Sent: Tuesday, July 7, 2026 12:5

Dear Medical Directors,

I am writing to seek your input as part of the national evaluation of the Community Health Pathways (CHP) programme, which is being undertaken to inform future commissioning and recommissioning decisions across Wales.

Building on the recommendations and findings from the 2025 national evaluation, this work will provide a comprehensive assessment of the value delivered by CHP. The evaluation will examine:

- Adoption and utilisation of CHP across Wales and its integration into clinical workflows.
- The impact of CHP on referral quality, consistency, and evidence-based clinical decision-making.
- Wider system effects, including referral activity, service demand, waiting lists, and key clinical outcomes.
- User experience, clinician confidence, and behavioural change.
- Economic and organisational benefits, including cost-effectiveness, avoided activity, and the value of a nationally coordinated approach.
- Progress against recommendations from the previous evaluation.

As we develop the evaluation, we are keen to ensure that it captures the information that decision-makers will require to support recommissioning decisions planned for September 2026.

In that context, I would be grateful for your views on the following:

Are there any specific metrics, outcomes, evidence, analyses, or areas of focus that would be particularly helpful to you when considering the future recommissioning of the Community Health Pathways programme?

We are interested in understanding what information would provide the greatest assurance regarding value, impact, sustainability, return on investment, service improvement, clinical effectiveness, or system-wide benefits. Equally, if there are any perceived gaps in the evidence generated through previous evaluations that you feel should be addressed, we would welcome your feedback.

Our aim is to ensure that the evaluation reflects a balanced range of perspectives from across the NHS in Wales and produces evidence that is meaningful and actionable for those involved in future funding and commissioning decisions.

If you would like to contribute any thoughts, please respond by 20th July 2026, or feel free to contact me directly should you wish to discuss this in more detail.

Thank you in advance for your time and consideration.

Appendix 6: Email sent to practice managers across Wales



Help Shape the Future of Community Health Pathways in Wales

From Tritech Admin (Hywel Dda UHB - Generic Account) <TritechAdmin.hdd@wales.nhs.uk>

Date Wed 15/07/2026 12:12 PM

Dear Practice Managers,

The TriTech Institute at Hywel Dda University Health Board is currently conducting a national evaluation of **Community HealthPathways**. It is vital that we get feedback from Health Care Professionals (HCPs) in primary care about their experiences of using the platform and impact it has had on their clinical practice. The findings will play a key role in informing future decisions about the continued funding and availability of Community Health Pathways across Wales.

Please circulate this information to all clinical team members in your practice.

Your input is essential.

Please take a few minutes to complete the survey using the link below. Your feedback will directly contribute to the value case being developed for NHS Wales.

Survey Link:

[Community HealthPathways Survey – Fill in form](#)

All responses are anonymous, and no personally identifiable information will be collected.

Interested in Sharing More?

We are also looking to conduct short interviews with HCPs who are willing to share more in-depth insights into how Community HealthPathways has influenced their work.

If you're open to being contacted for a brief interview, please reach out to:

Marie Kathrens

Marie.Kathrens@wales.nhs.uk

Many Thanks

The Team at TriTech





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