CTMUHB Public Board Meeting

Thursday 26 November 2026, 09:00 - 13:00

The Hub, Royal Glamorgan Hospital, Llantrisant

Agenda

09:00 - 09:05
5 min

1. PRELIMINARY MATTERS

1.1. Welcome & Introductions

Information *Jonathan Morgan, Health Board Chair*

1.2. Apologies for Absence

Information *Jonathan Morgan, Health Board Chair*

1.3. Declarations of Interest

Information *Jonathan Morgan, Health Board Chair*

09:05 - 09:10
5 min

2. CONSENT AGENDA BUSINESS

Information *Jonathan Morgan, Health Board Chair*

The Chair will ask if there are any items from the Consent Agenda (Item 8) that Board Members wish to bring forward to the Main agenda for discussion

09:10 - 09:30
20 min

3. IMPROVING CARE - PART 1

3.1. Listening & Learning Story - Baby Loss

Discussion *Bereavement Midwifes*

09:30 - 10:10
40 min

4. GOVERNANCE/BOARD BUSINESS GOVERNANCE ACTIVITY

4.1. Action Log - To follow

Discussion *Jonathan Morgan, Health Board Chair*

4.2. Matters Arising not Contained within the Action Log

Discussion *Jonathan Morgan, Health Board Chair*

4.3. Board Committee and Advisory Group Highlight Reports

Discussion *Committee Chairs*

4.3.1. Quality, Safety & Experience Committee Highlight Report 22 September 2026 (including the Public Services Ombudsman for Wales Annual Letter)

Discussion *Carolyn Donoghue, Committee Chair*

- 4.3.1a QSEC Highlight Report 22 September 2026 UHB 26 November 2026.pdf (7 pages)
- 4.3.1b Appendix a - Annual Letter 2025-26 UHB 26 November 2026.pdf (14 pages)

4.3.2. Clinical Advisory Group Highlight Report 6 October 2026 and 3 November 2026

Discussion *Dr Alex Brown, Clinical Advisory Group Chair*

4.3.2 Clinical Advisory Group Highlight Report UHB 26 November 2026.pdf (7 pages)

4.3.3. Operational Delivery Committee 27 October 2026

Discussion *Rachel Rowlands, Committee Chair*

4.3.3 ODC Highlight Report 27.10.26 UHB 26 November 2026.pdf (8 pages)

4.3.4. CTMUHB Audit, Risk & Assurance Committee 3 November 2026

Discussion *Patsy Roseblade, Committee Chair*

4.3.4 ARAC Highlight Report 03.11.26 UHB 26 November 2026.pdf (7 pages)

4.3.5. Remuneration & Terms of Service Committee Highlight Report and Terms of Reference

Decision *Jonathan Morgan, Health Board Chair*

4.3.5a RTSC Committee Highlight Report October 2026 UHB 26 November 2026.pdf (5 pages)
4.3.5b RTSC ToR amends UHB 26 November 2026.pdf (11 pages)

10:10 - 10:30
20 min

5. INSPIRING PEOPLE

5.1. Chairs Report (Inc. Affixing of the Common Seal /and Chairs Urgent Action)

Decision *Jonathan Morgan, Health Board Chair*

5.1 Chairs Report UHB 26 November 2026.pdf (7 pages)

5.2. Chief Executives Report - To follow

Discussion *Paul Mears, Chief Executive*

10:30 - 11:30
60 min

6. STRATEGIC OUTLINE

6.1. Case for Change - Strategic Clinical Services Plan

Decision *Claire Thompson, Executive Director of Strategy & Transformation*

6.1a SCSP Case for Change documents UHB 26 November 2026.pdf (5 pages)
6.1b CTM case for change UHB 26 November 2026 (2).pdf (77 pages)
6.1c International exemplar review models of care UHB 26 November 2026.pdf (48 pages)
6.1d Strategic Vision UHB 26 November 2026.pdf (66 pages)
6.1e CTM_Digital and Data Plan UHB 26 November 2026.pdf (59 pages)

11:30 - 12:30
60 min

7. IMPROVING CARE - PART 2

7.1. Board Assurance Framework Report

Decision *Gareth Watts, Director of Corporate Governance*

7.1a BAF_COVER UHB 26 November 2026.pdf (5 pages)
7.1b BAF_SUMMARY UHB 26 November 2026.pdf (4 pages)
7.1c BAF UHB 26 November 2026.pdf (68 pages)

7.2. Integrated Performance Report (Quality, People & Operational Performance)

Discussion *Claire Thompson, Executive Director of Strategy & Transformation*

7.2 HB Integrated Performance Dashboard UHB 26 November 2026.pdf (27 pages)

7.3. Primary Care & Community Performance Metrics

Discussion *Gethin Hughes, Chief Operating Officer*

7.3 PCC Performance Report UHB 26 November 2026.pdf (20 pages)

7.4. Month 7 Financial Performance Report

Discussion *Sally May, Executive Director of Finance*

7.4 M7 Finance Report FINAL UHB 26 November 2026.pdf (24 pages)

12:30 - 12:35
5 min

8. CONSENT AGENDA

8.1. FOR APPROVAL

8.1.1. Unconfirmed Minutes of the meeting held on 24 September 2026

Decision *Jonathan Morgan, Health Board Chair*

8.1.1 Unconfirmed Minutes 24.09.26 UHB 26 November 2026.pdf (22 pages)

8.1.2. Unconfirmed Minutes of the Extra Ordinary In Committee Board held on 22 October 2026

Decision *Jonathan Morgan, Health Board Chair*

8.1.2 Unconfirmed Minutes In Committee Board Meeting 22 October 2026 UHB 26 November 2026.pdf (4 pages)

8.1.3. Annual Equality Report 2025 - 2026

Decision *Hywel Daniel, Executive Director for People*

8.1.3a AER Cover Paper UHB 26 November 2026.pdf (7 pages)
8.1.3b Annual Equality Report 25-26 UHB 26 November 2026.pdf (26 pages)

8.1.4. Amendments to Schedule 2.1 of the Scheme of delegation

Decision *Sally May, Executive Director of Finance*

8.1.4a Update to SoD Board Report 2026_27 UHB 26 November 2026.pdf (5 pages)
8.1.4b Appendix 1 - 06.POL_CG01_Schedule2.1.2SFIsSchemeofDelegation_FinalV21.pdf (45 pages)
8.1.4c Appendix 2 - Copy of Request changes to the Scheme of Delegation - July 2021.pdf (1 pages)

8.1.5. Winter Resilience and Seasonal Preparedness Plan

Decision *Gethin Hughes, Chief Operating Officer*

8.1.5 Winter Resilience & Seasonal Preparedness Plan UHB 26 November 2026.pdf (67 pages)

8.1.6. Welsh Language Standards Annual Performance Report 2025/2026

Decision *Hywel Daniel, Executive Director for People*

8.1.6a WL Standards Cover Report UHB 26 November 2026.pdf (8 pages)
8.1.6b WL Standards Annual Performance Report 2025 26 UHB 26 November 2026.pdf (44 pages)
8.1.6c Atodiad A Adroddiad MNG BIP CTM 2025 26 UHB 26 November 2026.pdf (16 pages)
8.1.6d Annex A_ MNG Report CTM UHB 2025 26 UHB 26 November 2026.pdf (15 pages)

8.1.7. Putting Things Right Annual Report 2025/26: Closing the Chapter and Transition to Listening to People

Decision *Richard Hughes, Executive Director of Nursing*

8.1.7a PTR_Annual_Report_2025-26_Cover Paper UHB 26.11.2026.pdf (6 pages)
8.1.7b PTR Annual Report 2025-2026 4 UHB 26 November 2026.pdf (28 pages)

8.1.8. Safeguarding and Public Protection Annual Report 2025/26

Decision *Richard Hughes, Executive Director of Nursing*

- 8.1.8a Safeguarding Annual Report 2025-26 UHB 26 November 2026.pdf (8 pages)
- 8.1.8b Safeguarding Annual Report 2025-2026 Final UHB 26 November 2026.pdf (33 pages)

8.1.9. Infection, Prevention & Control Annual Report 2025-2026

Decision *Richard Hughes, Executive Director of Nursing*

- 8.1.9a IPC_Annual_Report_2025_26_QSEC_Cover UHB 26 November 2026.pdf (8 pages)
- 8.1.9b IPC Annual report 2025 - 2026-BG UHB 26 November 2026.pdf (80 pages)

8.1.10. CTM 2030: Building Healthier Communities Together – IMTP

Decision *Claire Thompson, Executive Director of Strategy & Transformation*

- 8.1.10a IMTP report October 2026 UHB 26 November 2026.pdf (7 pages)
- 8.1.10b Appendix 1 CTMUHB Internal IMTP Framework and Guidance 2027-2030.pdf (42 pages)

8.2. FOR NOTING

8.2.1. Non-Routine Board Business (Forward Plan)

Information *Jonathan Morgan, Health Board Chair*

- 8.2.1 Non Routine Board Business Forward Plan 2026 UHB 26 November 2026.pdf (2 pages)

8.2.2. Annual Cycle of Business

Information *Jonathan Morgan, Health Board Chair*

- 8.2.2 CTMUHB Board Cycle of Business 2026 UHB 26 November 2026.pdf (9 pages)

8.2.3. Board Committee and Advisory Group Highlight Reports

Information *Committee Chairs*

- 8.2.3a Board Committee and Advisory Group Highlight Reports UHB 26 November 2026.pdf (3 pages)
- 8.2.3b App 1 Highlight Report MHAMC 26th August 2026 UHB 26 November 2026.pdf (5 pages)
- 8.2.3c App 2 HB ARAC Highlight Report 03.11.2026 UHB 26 November 2026.pdf (6 pages)
- 8.2.3d App 3 SDC Highlight report 10 November 2026 UHB 26 November 2026.pdf (6 pages)

8.2.4. CTMUHB Clinical Learning Academy Annual Report

Information *Richard Hughes, Executive Director of Nursing*

- 8.2.4a Clinical Learning Academy Annual Report UHB 26 November 2026.pdf (7 pages)
- 8.2.4b CTMCLA Annual Report Current (003) 2026 UHB 26 November 2026.pdf (64 pages)

8.2.5. Annual Presentation of Nurse Staffing Levels to the Board

Information *Richard Hughes, Executive Director of Nursing*

- 8.2.5a NSA Annual Report-for Nov UHB 26 November 2026.pdf (9 pages)
- 8.2.5b NSA 2026 QSEC Paper Final Approved-Appendix 1 UHB 26 November 2026.pdf (5 pages)
- 8.2.5c Appendix 2- Summary of Nurse Staffing Levels UHB 26 November 2026.pdf (3 pages)

12:35 - 12:40
5 min

9. CLOSE OUT BUSINESS

9.1. Any Other Business

Information *Jonathan Morgan, Health Board Chair*

9.2. Meeting Feedback

Discussion *Jonathan Morgan, Health Board Chair*

Is there anything we should do more or less of?
Have we managed our time well and allowed open and balanced discussion?
Have we considered our values and acted in a way that supports embedding our values across CTM?
Have we maintained a strategic focus?
Have we received sufficient assurance from a range of sources?
Has our discussion allowed us to better understand the risks that we are managing that may affect the achievement of our strategic goals?

12:40 - 12:40
0 min

10. Private/Closed Session Business

Information

There are no items at present requiring discussion in closed session

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12:40 - 12:40
0 min

11. Date and Time of the Next meeting

Information

The next meeting will take place on Thursday 28 January 2027

Version 2 August 2026

CTMUHB Public Board

Quality, Safety & Experience Committee Highlight Report

Eitem yr Agenda / Agenda Item	4.3.1
Dyddiad y Cyfarfod / Date of Meeting:	22 September 2026
Statws Cyhoeddi / Publication Status:	Open/Public.
	Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Sharon Edwards, Corporate Governance Officer
Cyflwynydd yr Adroddiad / Report Presenter:	Carolyn Donoghue, Committee Chair, Independent Member
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes, Executive Director of Nursing
Diben yr Adroddiad / Report Purpose:	For Noting
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	No action / decision required
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol* *Strategic Context:* *This report aligns to the following Strategic Pillars*	Improving Care
	If more than one applies please list below:
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan *(Reference relevant priority)*	Not Applicable

1. Introduction

1.1 This report had been prepared to provide the Board with details of the key issues considered by the Quality, Safety & Experience Committee at its meeting on 22 September 2026.

1.2 Key highlights from the meeting are reported in section 3.

2. Purpose of this Meeting

2.1 The purpose of the Quality, Safety & Experience Committee is to provide assurance to the Board on the provision of workplace health & safety and safe and high-quality care to the population we serve, including prevention through public health, primary and secondary care.

2.2 The Committee will:

- Put the needs of patients, carers and the public at the centre of all its business.
- Ensure appropriate arrangements are in place to support workplace health & safety.
- Provide evidence based and timely advice to the Board, based on local need, to assist in discharging its functions and meeting its responsibilities.
- Provide assurance to the Board in relation to the CTMUHB's arrangements for safeguarding the public and continuously improving the quality and safety of the services we provide.
- Ensure that care is delivered in accordance with the Health & Care Standards for Health Services in Wales.

3. Highlight Report

Alert / Escalate	A report on Redress was received. Members noted that a significant historic backlog remains, with 440 active cases, 295 open for more than 12 months and 197 awaiting investigation at the qualifying liability stage. Delays continue to impact patients and families, organisational learning and financial risk. Recovery options are being developed to address the backlog. Via the Unscheduled Care Group Highlight Report, Members noted concerns in relation to the Emergency Department (PCH) Safety & Governance. Members noted that ongoing patient safety and governance concerns have been identified through triangulation of incidents, complaints, GP concerns and reviews. Members noted that cultural, leadership and risk-control issues remain, with an improvement plan and Executive oversight in place. In relation to Maternity Services, Members noted that workforce pressures continue to affect service sustainability, including the ongoing suspension of home births. Current care remains safe; however, staffing and cultural issues continue to present longer-term sustainability risks requiring ongoing oversight.

	In relation to Health Visiting, Members noted that Industrial action is expected to continue until the end of October, resulting in reduced service activity and an anticipated backlog. Members were advised that safeguarding and families at greatest need are being prioritised, with mitigations in place and planning underway to manage the anticipated backlog and wider unmet need. In relation to LIMS 2.0 & Pathology Transformation Risks, Members noted that significant quality, safety and operational risks remain due to national delays affecting Blood Sciences and Blood Transfusion, with low confidence in planned delivery timescales. The Blood Transfusion risk has been escalated through Executive and national routes, with contingency options being explored.
Advise	Members received the Shared Listening and Learning Story which highlighted the need for earlier, coordinated transition planning, clear handovers and timely access to adult specialist services. It was noted that the Committee will maintain oversight of improvements arising from the learning. Patient Experience and Improvement Measurement The Committee emphasised the need to better demonstrate measurable outcomes arising from people's feedback and strengthen engagement with minority and seldom-heard communities. The Unscheduled Care Highlight Report was received. Members noted sustained system pressures continue in relation to patient flow, bed capacity and Pathway of Care Delays and noted that improvement activity is underway, with continued focus on strengthening consistency and partnership working across community and discharge pathways. Members received a report on Avoidable Mortality & Health Inequalities and noted significant health inequalities and variation in mortality remain across CTMUHB, with improvements in life expectancy having stalled and healthy life expectancy declining. The Committee emphasised the need for a stronger focus on prevention and earlier intervention to improve population health and reduce future demand on services.
Assure	An update on the Stroke Improvement Programme was received. Members noted significant measurable improvements were demonstrated across key stroke pathway indicators, including CT imaging, stroke unit admission, swallow screening and thrombolysis. Early Supported Discharge performance also

	exceeded the national average, although workforce and patient-flow pressures remain. Members received reports in relation to the Research & Development Strategic Action Plan and Annual Report and noted that positive external assurance was received from Welsh Government, with CTMUHB achieving full compliance with the terms and conditions of research funding for 2024/25. Progress was also reported in research recruitment, governance and commercial activity. A report on Mortality Review and Learning was received. Members noted that the mortality review process is comprehensive and generally functioning well, with 5,399 Medical Examiner referrals and 95% closed within the reported timeframe. Mortality intelligence is supporting targeted learning and improvement, including focused reviews in areas such as sepsis, surgery and fractured neck of femur, although review capacity remains an operational risk. In relation to Governance & Risk Management, Members noted improvements to the Board Assurance Framework and Organisational Risk Register had strengthened readability and alignment between strategic and operational risks, supporting more effective scrutiny.
Inform	The Planned Care Highlight report was received. Members noted that progress continues in reducing the HCQ ophthalmology backlog, alongside positive outcomes from the Surgical Same Day Emergency Care service. GI service fragility remains an area of ongoing focus. Members received the Mental Health & Learning Disabilities Highlight Report which highlighted that there were pressures relating to surge capacity, anti-ligature risks and CAMHS staffing. However, assurance was provided regarding previously reported patient safety incidents on Ward 14, with robust care plans in place and continued support for the multidisciplinary team. The Primary & Community Care Highlight Report was received. Members noted significant improvement was reported in paediatric dental waiting times, with a review of the lymphoedema service underway to better understand demand and patient need. The Committee endorsed the Annual Duty of Quality Report 2025/26 for Board approval, noting progress across the six domains of quality. QSEC emphasised that future reporting

	should demonstrate more clearly the impact and outcomes arising from improvement activity. The following items were received via the consent agenda for approval: • Unconfirmed Minutes of the meeting held on 21 July 2026 • Health, Safety & Fire Sub Committee Highlight Report • Pharmaceutical Needs Assessment • Water Safety, Infection and Risk Prevention Policy • Policy and Procedure for the Prevention and Management of Adult Inpatient Falls • Water Cooler and Ice Machine Policy • Authorised External Personnel Policy The following items were received via the consent agenda for noting: • Healthcare Inspectorate Wales (HIW) Improvement Plan Tracker Report • Individual Patient Funding Request Annual Report 2025-2026 • Decision Making and Consent Working Group Annual Report • Highlight Report from the Joint Commissioning Committee Quality, Safety & Outcomes Committee • CTM Carers Programme – End of Year Progress Report 2025/26 • Quality Dashboard Report (To include an addendum relating to Ombudsman activity) • Annual Cycle of Business • Non-Routine Committee Business (Forward Plan)
Appendices	Public Services Ombudsman for Wales Annual Letter and Annual Report

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)* Link to Strategic Risk(s) on the Board Assurance Framework (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	Strategic Risk 2 Service Transformation & Outcomes If more than one applies please list below:

Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales	
	If more than one applies please list below:	
Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Learning, Improvement & Research	
	If more than one applies please list below:	
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental Sustainability Impact (5Rs)	No - Not Applicable	
	If more than one applies please list below:	
Asesiad Effaith Impact Assessment		
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg *(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)* Equality & Welsh Language Impact Assessment Outcome *(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)*	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Summary of impact: Not appkicable Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Summary of impact: Not applicable	If no, please select a reason below. Choose an item. Named Executive/Board member sign off for no EWLIA completion:
Canlyniad Asesiad Effaith Ansawdd *(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)* Quality Impact Assessment Outcome *(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)*	Not applicable	
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report	

Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	

Ombwdsmon
Ombudsman
Cymru · Wales

Ask for: Complaints Standards
01656 641150
Caseinfo@ombudsman.wales

Date: 17 September 2026

Mr Jonathan Morgan
Chair
Cwm Taf Morgannwg University Health Board

By email only
CTM_BoardMember@wales.nhs.uk

Dear Jonathan

Annual Letter 2025-26

Our role

As the Public Services Ombudsman for Wales, we independently consider complaints about public services and investigate alleged breaches of the councillor Code of Conduct. We also set complaints handling standards for public bodies, drive continuous learning from complaints and undertake investigations into public services on our own initiative.

Purpose of this Annual Letter

This letter provides an update on our work for this period, and highlights key trends in Welsh health and public service complaints. It details performance specific to your organisation and outlines the positive actions we would like you to take.

Overview - a record-breaking year

This letter, as always, coincides with the publication of our Annual Report, which holds special significance this year as we mark our 20th anniversary. We closed our busiest year on record where the office received 4,507 duly made complaints across its public services and Code of Conduct remits — 27% more than last year, 47% more than 3 years ago, and 3 times as many as 20 years ago.

To meet this demand, we closed a record number of complaints, 29% more than last year and 43% more compared with 3 years ago. We intervened in 568 of complaints that we closed.

ombwdsmon.cymru
0300 790 0203
1 Ffordd yr Hen Gae, CF 35 5LJ
Rydym yn hapus i dderbyn ac ymateb i ohebiaeth yn y Gymraeg.

ombudsman.wales
0300 790 0203
1 Ffordd yr Hen Gae, CF 35 5LJ
We are happy to accept and respond to correspondence in Welsh.

Finding swift resolutions to complaints, where possible, remains important to us and benefits all parties involved. This year, 85% of our interventions included an element of Early Resolution, a process we hope has proved valuable to both your organisation and to complainants.

Despite the increased volume of cases, our case handling times remained efficient. Initial assessments and Early Resolutions were completed within 4 weeks - well ahead of our 6 week target. Additionally we maintained a downward trend in our average investigation time which was 54 weeks this year from 64 weeks in 2023-24.

Overview of health board complaints

During 2025-26, we received 1,351 complaints about health boards marking a significant 42% increase from the previous year. Clinical treatment in hospitals remains the most frequent source of concern. Additionally, complaint handling accounted for approximately 14% of complaints. While this represents a positive decline from 18% 2 years ago, specific concerns in this area are detailed below.

We intervened in 22% of health board complaints that we closed – compared to 27% last year.

Performance specific to your organisation

During 2025-26, we received 173 complaints about your organisation and closed 172 complaints (some of which may have been carried over from the previous year).

We intervened in 19% of the complaints we closed about your organisation.

We published 1 public report in the public interest relating to your Health Board. As you will be aware, this case concerned the removal of a patient from an orthopaedic surgery waiting list and there was a failure to rectify the position for more than a year despite the existence of complaints **(202400797)**.

Recommendations made and accepted by the Health Board included an apology, redress, audit of surgery waiting lists and governance oversight of it. I am pleased to note that whilst there was some delay in providing my office with satisfactory evidence a final recommendation has since been implemented satisfactorily.

Overall, we made 94 new recommendations to your organisation in the cases closed this year.

There were 93 recommendations that fell due during this period. Your organisation complied with 72% of these within the agreed timescales.

Detailed data on the complaints we handled about your organisation in this period can be found in the appendices below.

Improving compliance with our recommendations

We always take time to ensure that recommendations and timescales are agreed with public bodies before finalising them. Therefore we expect agreed deadlines to be met. Timely compliance is not, however, as high as it should be; with only 69% of our recommendations across Wales complied with on time as at 31 March 2026. Promptly delivering agreements to resolve injustice or hardship for individuals, and implementing systemic learning on time, is vital to build and maintain public trust in both our office and your organisation.

We recognise that unexpected challenges arise that make deadlines difficult to meet. In response to feedback from public bodies, we have adapted our approach moving forward: if you request a reasonable extension on or before the original deadline, and you meet that new date, it will be recorded as complied with on time. We hope this is a welcome adjustment that will help demonstrate a more accurate compliance rate over the coming years.

Supporting improvement of public services – key themes and our own initiative work

When an investigation reveals serious systemic risks that may affect many individuals, or offer wider sector lessons, we publish a public interest report. We published 9 such reports during this period, the vast majority concerning health boards. If you have not already done so, I encourage you to read these reports for their valuable insights - here.

Tragically, we have seen some instances of both individual shortcomings and wider systemic failures causing injustice to citizens in Wales. Key themes in this period have included: poor waiting list management (including inappropriate removal of patients from waiting lists); poor prescribing practice failures where we have seen communication and process breakdown between medical and pharmacy teams; and delays and clinical failures in urgent cancer referrals and ophthalmology.

We have also seen concerning complaint handling failures. Some health board complaint investigations have shown a lack of curiosity, objectivity and rigour which are essential to robust and thorough complaint investigation. In addition, we have seen failures to remain open and transparent with service users who have experienced harm, falling short of duty of candour requirements.

I strongly encourage all health boards and trusts to read the 5 public interest reports and recommendations issued during this period, and to use these insights to proactively strengthen your own complaint handling practices where appropriate.

We continue to expand the use of our own initiative powers. These allow us to investigate emerging issues proactively, addressing administrative failings before they multiply.

This year we issued a follow up report on public bodies' compliance with our previously published report on carers. You will recall I shared my original report with you given your role in identifying, assessing and supporting carers, especially during hospital discharge, and working collaboratively with others as part of an integrated system. Our follow up report can be found here.

Ongoing own initiative investigations

As at March 2026, we were conducting a further 4 own initiative investigations which focus, among other things, on:

- potential maladministration and service failure in health care
- how social landlords deal with complaints about disrepair and damp and mould.

We expect to complete this work later in 2026, and will determine then if the findings warrant publication in the public interest.

Our Complaints Standards Work

By the end of March 2026, all local authorities, health boards and 21 housing associations in Wales were operating under our model complaints policy. During 2025-26, we initiated the transition for the remaining housing associations and we expect them to be fully compliant by the end of September 2026.

Organisations that are already compliant, or will be shortly, account for 85% of new complaints about public services which we receive.

Our free complaint handling training remains highly requested; we delivered 58 sessions to public bodies across Wales this year, bringing our total since 2020 to over 600 sessions and 10,000 participants.

More broadly we expect to publish the data on complaints handled by local authorities in Wales during 2024-25 and 2025-26 in the Autumn.

Action we would like your organisation to take

To build on findings from this period, can I ask that your organisation takes the following actions:

- Present this Annual Letter and associated data to the Board at the next available opportunity and notify me of the planned meeting dates.
- Review the data in this letter, alongside your own data to better understand your performance, identify trends, and review your compliance with recommendations made by my office.

- Read the reports highlighted in this letter to extract relevant learning for your own Authority.

- Provide my office with a copy of your Annual Report for 2025-26 on the Duty of Candour and Quality.

- Inform me of the outcome of your considerations and proposed action plan at the earliest opportunity.

I would like to thank you, and your officers, for your continued openness and engagement with my office.

Yours sincerely

Michelle Morris
Public Services Ombudsman

Cc. paul.mears@wales.nhs.uk
ctm_psow@wales.nhs.uk

Information Sheet

Glossary of terms a guide to some of the terms used within our Annual Letters and Appendices.

Appendix A shows the number of complaints we received for all health boards in 2025-26. These complaints are contextualised by the population of each authority.

Appendix B shows the categorisation of each complaint received, and what proportion of received complaints represents for the Health Board.

Appendix C shows intervention rates for all health boards in 2025-26. An intervention is categorised by either an upheld complaint (either public interest or non-public interest), an early resolution, or a voluntary settlement.

Appendix D shows outcomes of the complaints we closed for the Health Board in 2025-26. This table shows both the volume, and the proportion that each outcome represents for the Health Board.

Appendix E shows the compliance performance of each health board.

Annual Letters - Glossary of terms

Term	Definition
Complaints received	The number of duly made complaints we receive about a Public Body.
Duly made complaint	A complaint about public services is duly made when: • the organisation is within our jurisdiction and • the organisation has replied or had the opportunity to reply and • the events complained about happened less than a year ago, or the complainant became aware of them less than a year ago (unless there was a good reason the complainant could not complain sooner) and • the complainant is entitled to bring a complaint and • we have the details we need e.g. name, contact details, organisation being complained about, we can understand the complaint. A complaint about a local councillor is duly made when: • we have the details we need e.g. name and contact details of the complainant, the name of the councillor and the Local Authority they are a member of • we have a signed declaration from the complainant and any third parties whose evidence has been submitted.
Early Resolution	A matter which is closed without investigation because there is an obvious solution and the body agrees to carry out action to resolve the matter. The body must give us evidence that it has taken action within the timeframe agreed.
Intervention	Cases which we have closed and we have either: • Upheld the complaint after investigation. • Resolved the complaint by way of Voluntary Settlement. • Resolved the complaint by way of Early resolution.

Voluntary Settlement	A matter which has progressed to investigation stage but closed without the investigation being completed because we agree that action which the body has voluntarily suggested it will take is appropriate to resolve the matter. The body must give us evidence that it has taken action within the timeframe agreed.
Uphold	A matter we have closed after investigation and where we found that something went wrong.
% of interventions	The number of public service complaints we closed that involved Early Resolution/Voluntary Settlement and those which we upheld following an investigation, divided by the total number of duly made public service complaints we closed in the reporting period.
Upheld %	The proportion of the complaints in which we intervened that we upheld in the reporting period, shown as a percentage.
Cases Closed	The number of complaints we closed during the reporting period. This may be different from the number we received because there may be some complaints we received in the previous reporting period but which we closed in this reporting period.
Recommendation	These are actions which we ask bodies to take within agreed timescales when we find something has gone wrong. These may be actions to help the individual complainant or systemic actions to help improve services for all service users. We can make recommendations as part of an Early Resolution, Voluntary Settlement or when upholding a complaint following investigation. When we make recommendations, organisations must provide evidence to us that they have complied.
Recommendations made	The number of recommendations we made to bodies during the reporting period. (1 April 2025 to 31 March 2026)
Recommendations falling due	The number of recommendations which needed to be complied with within the reporting period (1 April 2025 to 31 March 2026). Some recommendations will have been made in the previous reporting period but fell due within this reporting period.

Recommendations complied with in line with agreed target date %	The number of recommendations which were complied with by the agreed timescale as set out in Early Resolution, Voluntary Settlement or Investigation report (applicable for those falling due in 2025-26).
Population	Population is included to provide context, based upon the size of an organisation. However, it is recognised that complaints can be made by people who are not included in the population figure, for example, residents from outside the health board or local authority area, or non-contract holders. • For **local authorities**, population refers to the estimated total number of people living in the local authority area. The figures are taken from the StatsWales.[1] • For **housing associations**, population refers to the total stock at social rent, shown in units. This includes general needs stock, sheltered stock, other supported stock and extra care stock with non self-contained bedsits, hostels and shared housing. This figure is taken from StatsWales.[2] • For **health boards**, population refers to the estimated total number of people living in the health board area. The figures are taken from StatsWales.[3]

[1] Population estimates by local authority, year, sex and age | StatsWales
[2] Social landlord housing stock, including social and non social housing | StatsWales
[3] Population estimates by local health boards, year, sex and age | StatsWales

Appendix A – Complaints received (overview)

Health Board	Complaints Received	Population	Received per 1,000 residents
Aneurin Bevan University Health Board	263	601,686	0.44
Betsi Cadwaladr University Health Board	283	697,115	0.41
Cardiff and Vale University Health Board	230	519,662	0.44
Cwm Taf Morgannwg University Health Board	173	449,346	0.39
Hywel Dda University Health Board	172	389,160	0.44
Powys Teaching Health Board	31	135,059	0.23
Swansea Bay University Health Board	199	394,553	0.50
Welsh Ambulance Services University NHS Trust	37	-	-
Total	**1388**	**3,186,581**	**0.44**

Appendix B – Complaints received (by organisation)

Cwm Taf Morgannwg University Health Board	Complaints Received	% share
Admissions/discharge and transfer procedures	3	2%
Adult Mental Health	12	7%
Ambulance Services	1	1%
Appointment procedures (including outpatients)	5	3%
Care Homes	0	
Child and Adolescent Mental Health	0	
Clinical treatment in hospital	87	50%
Clinical treatment outside hospital; Dentist	0	
Clinical treatment outside hospital; GP	1	1%
Clinical treatment outside hospital; Other	4	2%
Clinical treatment outside hospital; Physiotherapist	0	
Complaints Handling	0	
Confidentiality	0	
Continuing care	2	1%
De-Registration	0	
Disclosure of personal information / data loss	1	1%
Finance and Taxation	0	
Funding	1	1%
Gender Identity Funding	0	
Health	32	18%
Housing	0	
Independent Health Care providers	0	
Medical records/standards of record-keeping	3	2%
Medication; Prescription dispensing	1	1%
Non-medical services	0	
Nosocomial (Framework)	0	
Other	1	1%
Other miscellaneous	0	
Out of Hours GP care	0	
Patient list issues	4	2%
Poor/No communication or failure to provide information	2	1%
Prisoner Care	1	1%
Recruitment and appointment procedures	0	
Referral to treatment time	5	3%
Rudeness/inconsiderate behaviour/staff attitude	7	4%
Services for vulnerable adults (eg with learning difficulties. or with mental health issues)	0	
Various Other	0	
Whistle-blowing	0	
Total	**173**	

Appendix C – Cases with PSOW intervention (overview)

Health Board	No. of interventions	No. of closures	% of interventions
Aneurin Bevan University Health Board	64	254	25%
Betsi Cadwaladr University Health Board	57	272	21%
Cardiff and Vale University Health Board	38	216	18%
Cwm Taf Morgannwg University Health Board	32	172	19%
Hywel Dda University Health Board	43	160	27%
Powys Teaching Health Board	7	28	25%
Swansea Bay University Health Board	49	195	25%
Welsh Ambulance Services University NHS Trust	8	36	22%
Total	**298**	**1333**	**22%**

Appendix D – Complaint outcomes (by organisation)

Cwm Taf Morgannwg University Health Board		% Share
Complaint investigation discontinued (with early resolution at assessment stages)	0	
Complaint investigation discontinued (without settlement)	1	1%
Decision not to investigate complaint	62	36%
Early resolution	27	16%
Matter out of jurisdiction	27	16%
Non-public interest report issued: complaint not upheld	9	5%
Non-public interest report issued: complaint not upheld with early resolution at assessment stage	0	
Non-public interest report issued: complaint upheld	4	2%
Non-public interest report issued: complaint upheld with early resolution at assessment stage	0	
Premature	41	24%
Public interest report issued: complaint upheld	1	1%
Public Interest report issued: complaint upheld with early resolution at assessment stage	0	
Special Interest Report	0	
Voluntary settlement	0	
Total	**172**	

Appendix E – Compliance performance comparison

Health Board	Number of recommendations made on complaints closed in 2025-26	Number of recommendations falling due in 2025-26	% of recommendations, complied with in line with agreed target date
Aneurin Bevan University Health Board	175	142	70%
Betsi Cadwaladr University Health Board	157	137	61%
Cardiff and Vale University Health Board	86	92	71%
Cwm Taf Morgannwg University Health Board	94	93	72%
Hywel Dda University Health Board	118	118	81%
Powys Teaching Health Board	9	10	70%
Swansea Bay University Health Board	143	144	60%
Welsh Ambulance Services University NHS Trust	23	36	83%

Version 2 August 2026

CTMUHB Public Board

Highlight Report from the Clinical Advisory Group

Eitem yr Agenda / Agenda Item	4.3.2
Dyddiad y Cyfarfod / Date of Meeting:	26/11/2026
Statws Cyhoeddi / Publication Status:	Open/Public. Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Dr Alex Brown, Clinical Advisory Group Chair
Cyflwynydd yr Adroddiad / Report Presenter:	Dr Alex Brown, Clinical Advisory Group Chair
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Dom Hurford, Executive Medical Director
Diben yr Adroddiad / Report Purpose:	For Noting
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	The Board are being asked to: 1. NOTE the concerns raised by CAG regarding meaningful clinical engagement in long-term strategy development and service planning. 2. CONSIDER CAG's recommendations for embedding multidisciplinary clinical engagement within directorate and care group strategic planning, including transparent prioritisation, communication of decisions and accountability for delivery. 3. SUPPORT the proposed exploration of a practical model of multidisciplinary strategic planning within a clinical directorate, with findings reported through appropriate executive governance structures.
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol* *Strategic Context:* *This report aligns to the following Strategic Pillars*	Improving Care If more than one applies please list below:

Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan *(Reference relevant priority)*	

1. Introduction

1.1 This report had been prepared to provide the Board with details of the key issues considered by the Clinical Advisory Group at its meeting on 6 October 2026 and 3 November 2026.

1.2 Key highlights from the meeting are reported in section 3.

2. Purpose of this Meeting

2.1 The Clinical Advisory Group (CAG) acts as Cwm Taf Morgannwg University Health Board's Health Professions Forum, providing a structured mechanism through which healthcare professionals can contribute to the Health Board's strategic development and decision-making.

2.2 The CAG provides balanced, multidisciplinary professional advice to the Board on matters affecting clinical services, patient care and service quality. It considers matters referred by the Board and may also raise issues identified through engagement with the wider clinical workforce.

2.3 The CAG facilitates two-way communication between healthcare professionals and the Board, ensuring that professional perspectives inform strategic discussions and that feedback on decisions and outcomes is shared with clinical colleagues.

3. Highlight Report

Alert / Escalate	Concern has been raised by colleagues in clinical engagement in decision making for the organisation. This has come from a few different sources: • The staff survey has shown a decline in positive responses to the question “I am involved in deciding on changes introduced that affect my work/area/team/department” from 51.5% in 2023 to 43.8% in 2025. • Many clinical teams report feeling disconnected from decision making within care groups and directorates. This has been reflected through discussion in CAG, Clinical Effectiveness Committee meetings and Medical Staffing Committees.

	Several services have been moved on the basis of emergency service changes for a period of years. It was raised that in some areas concerns had been raised about struggling services for some time prior to emergency service change without an agreed action plan, and now in some areas a perception of a lack of transparency regarding longer term plans for these specialties.
Advise	The evolving role of CAG Partly as a result of these concerns, and partly in response to diminishing engagement with CAG by clinical teams, the way CAG works is proposed to change. Within the remit of the model standing orders given to the Health Board, it is now proposed that CAG takes a thematic approach to its advice to the board, mainly focussing on 'big picture' concepts. The first 6-8 CAG meetings are proposed to provide a balanced clinical view on ideas to develop: • Clinical strategy, decision making and clinical engagement • Complaints, concerns, incidents – including ensuring a 'just culture' approach with systems learning • The staff survey, the people plan, and organisational culture • Research and Development, and how the R&D strategy can increasingly become part of the 'business as usual' work of the Health Board The intention of CAG, within its remit is to spend one session discussing each of these in a closed committee and another with key leaders and stakeholders, to ensure any advice given is useful, balanced, and in line with the strategic goals of the health board. CAG has also discussed with the Executive Director of Strategy and Transformation whether it could provide an ongoing multidisciplinary advisory function in relation to the Clinical Services Strategy. Members of CAG were happy to support this, while recognising that responsibility for service design and delivery remains with the relevant clinical and operational teams. CAG meetings (6th October 2026 and 3rd November 2026) on clinical engagement in the Clinical Services Strategy CAG have had both a closed session on clinical engagement and strategy as well as a session supported by Claire

	Thompson, in her role as Executive Director of Strategy and Transformation. Within this session we discussed the processes for developing strategy, national priorities and planning, and the evolving CTM clinical services strategy. CAG welcomed the work underway to develop the Clinical Services Strategy and strategy deployment framework. This provides a helpful and visible framework on which teams can develop a long-term vision. The closed session focussed largely on clinical engagement with the emerging strategic vision. There was some concern that the strategy in itself was useful but needs to be made clinically relevant for our teams. CAG have proposed that an engagement model is developed to put this in to practice, which is largely engaged at a Directorate level, but would feed in to Care Groups who would co-ordinate in to a longer-term model. As a clinical team, CAG felt there were some critical elements to any strategy, which are recommended if it is to translate to success among our clinical teams. These include that: 1. There would be genuine engagement at a directorate level - with dedicated, protected and, where possible, in-person sessions. This would involve support from directorate management, finance, workforce and clinical teams. 2. The process would identify longer term goals and routes to get there, rather than short term and immediate team planning. 3. The process would feed directly into IMTP and identify deliverable and realistic goals – including where longer-term ambitions are not immediately deliverable but are important, how we prioritise these. IMTP would become a well communicated process, with clear accountability for delivery. 4. There would be scope to talk about what clinicians either stop doing, or that digital or other solutions will significantly reduce the burden of doing. 5. The process should enable transparent discussion of how existing resources are allocated, including opportunities to release capacity, reduce costs and reinvest savings where financially practicable. Clinical teams should understand the criteria by which resources can be redirected, including where financial pressures prevent reinvestment, and be involved in assessing the wider benefits and consequences of proposed changes.

	6. There would be an honest discussion around the long-term plans for services currently on an emergency service change. 7. That discussions around service changes within directorates have support at and across Care Groups to ensure knock on effects (both positive and negative) are considered and managed - including enabling services such as diagnostics. 8. That engagement on and development of clinical strategy is given sufficient time and priority in directorates and care groups, including in formal assurance frameworks. 9. There would be a clear feedback mechanism to demonstrate how clinical input has informed strategic decisions, including transparent explanations where proposals cannot be progressed. Agreed priorities would have identified accountability mechanisms.
Assure	As a practical next step, the CAG Chair is exploring, with relevant executive, care group and directorate colleagues, an initial test of this approach within Respiratory Medicine - aligning goals to the strategic goals of the Health Board. This will provide an opportunity to test how clinical, operational, finance and workforce colleagues can work collaboratively to develop a realistic five-year service strategy, aligned with Health Board priorities and available resources. CAG recognises that there are financial constraints and clinical teams do not have access to more and more funding. Clinical teams will need to recognise this does not mean new money but would aim to provide a mechanism for clinical input into a transparent strategy enabling us to spend the finance we do have as effectively as possible. The ambition is that this could, if successful, lead to wider use of Directorate and Care Group support into developing strategy that could be consolidated both at care group and then executive level into a coherent strategy for the wider clinical teams, aligned to the model of Clinical Services Strategy as presented to the board by the Executive Director of Strategy and Transformation.
Inform	The above proposals are in line with the updated terms of reference for the CAG as approved by the Board in July 2026.

Appendices	Minutes from meetings 6 October 2026 and 3 November 2026 (available to Board Members on request)

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)* Link to Strategic Risk(s) on the Board Assurance Framework (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	Strategic Risk 2 Service Transformation & Outcomes
	If more than one applies please list below:

Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals	Not Applicable
	If more than one applies please list below:

Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Culture & Valuing People
	If more than one applies please list below:

Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Asesiad Effaith Impact Assessment		
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg *(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)* Equality & Welsh Language Impact Assessment Outcome	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Summary of impact: Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please select a reason below. Does not impact people Named Executive/Board member sign off

(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)	Summary of impact:	for no EWLIA completion:
Canlyniad Asesiad Effaith Ansawdd *(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)* Quality Impact Assessment Outcome *(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)*	Not applicable	
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report	
Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report	

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
CAG	Clinical Advisory Group
IMTP	Integrated Medium Term Plan
R&D	Research & Development

Version 2 August 2026

CTMUHB Public Board

Operational Delivery Committee – Highlight Report

Eitem yr Agenda / Agenda Item	4.3.3
Dyddiad y Cyfarfod / Date of Meeting:	26/11/2026
Statws Cyhoeddi / Publication Status:	Open/Public. Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Kathrine Davies, Corporate Governance Manager
Cyflwynydd yr Adroddiad / Report Presenter:	Rachel Rowlands, Committee Chair, Independent Member
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gethin Hughes, Deputy CEO/Chief Operating Officer
Diben yr Adroddiad / Report Purpose:	For Noting
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	As above
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol* *Strategic Context:* *This report aligns to the following Strategic Pillars*	Improving Care If more than one applies please list below:
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan *(Reference relevant priority)*	Not applicable

1. Introduction

1.1 This report has been prepared to provide the Board with details of the key issues considered by the Operational Delivery Committee at its meeting on 27 October 2026.

1.2 Key highlights from the meeting are reported in section 3.

2. Purpose of this Meeting

2.1 The purpose of the Committee is to provide assurance to the Board on the effectiveness of arrangements in place for securing the achievement of the Board's aims and objectives, in accordance with the standards of good governance determined for the NHS in Wales. In doing so, the Committee will seek assurance that there is ongoing development of an improving performance culture which continuously strives for excellence and focuses on improvement in all aspects of service delivery.

2.2 The Committee ensures that evidence based, and timely interventions are implemented to drive forward improved performance thereby allowing the Health Board to achieve the requirements and standards determined for the NHS in Wales, and as outlined within CTMUHB's Integrated Medium Term Plan.

3. Highlight Report

Alert / Escalate	• ODC Integrated Assurance Summary - The Committee piloted a new approach designed to triangulate the Board Assurance Framework (BAF), Organisational Risk Register and individual agenda reports around three themes: 1.operational recovery and winter readiness, supported by workforce capacity and culture; 2. financial delivery and recurrent sustainability; and 3.statutory compliance and infrastructure risk. Members welcomed the principle and considered the approach helpful, while identifying opportunities to strengthen it. In particular, future reports should more clearly connect evidence to the assurance questions, concentrate on risk, delivery, measurable outcomes and gaps in assurance, and enable members to track whether mitigating actions are having an impact. Members also cautioned against the approach becoming overly prescriptive and inadvertently restricting scrutiny of emerging matters. • The Committee received the Month 6 Finance and Performance Reports providing assurance that the Health Board continues to forecast an in-year break-even position, but noted significant delivery risks and a deterioration in the underlying recurrent position. The underlying forecast for the following year had moved from a £0.3m surplus to an £11.5m deficit, reflecting reliance on non-recurrent measures in the current year. Savings delivery was £9.9m

	against a £15.6m year-to-date target, with full-year savings forecast at £29m against a £31.3m target. The break-even forecast includes £4m of accountancy gains and £5m of reserves released non-recurrently, while £20.7m of downside risk remained. The Committee particularly noted that reported savings progress was not yet fully translating into reduced expenditure run-rates. Care Group performance also remained challenging, with a £28.1m forecast deficit and the largest forecast deficits reported within Planned Care (£9.8m) and Mental Health (£6.9m). The Committee therefore recognised the distinction between confidence in achieving the current-year break-even position and assurance regarding longer-term recurrent financial sustainability.
Advise	• The Committee received the Seasonal Planning Update. The Committee were advised that the plan had been developed collaboratively with partners, and noted that it was designed to reduce harm, minimise variation and strengthen resilience over the winter and bank holiday period. The plan is being delivered without additional funding, requiring existing resources to be deployed as effectively as possible. Outstanding dependencies included some detailed information from local authority partners and the continuing importance of effective discharge arrangements and Hospital at Home in maintaining patient flow. • The Committee received a presentation on the Specialist Palliative Care Service Implementation and noted that the revised specialist palliative care model was progressing, with staff undertaking a 12-week induction programme and the community-based model intended to extend specialist support to a larger number of patients. No significant concerns or negative patient impact had been reported during the transition at the time of the meeting. The Committee noted that a residual risk remained around recruitment of a specialist palliative care consultant ahead of implementation of the new model, although consultant support from Royal Glamorgan and Princess of Wales remained available. The Committee wished to retain oversight of this recruitment risk.
	• The Committee received a presentation from a representative of the NHS Wales Joint Commissioning Committee (NWJCC) on the Revised Ambulance Performance Measures. The Committee remained concerned about prolonged waits for patients in the community and Emergency Departments. While hospital

handover performance had improved, this had not consistently translated into improved ambulance availability within the Cwm Taf Morgannwg (CTM) footprint. The Committee were advised that the Joint Commissioning Committee (JCC) is scoping a demand and capacity review and considering options including health-board-level capacity and strengthened discussions with neighbouring Health Boards.

Members particularly highlighted risks to lower-acuity patients experiencing lengthy waits in the community and the need to make greater use of alternative pathways, including the Navigation Hub and Advanced Paramedic Practitioners. It was agreed that the quality and safety implications should also be triangulated through the Quality, Safety and Experience Committee and relevant JCC assurance arrangements.

- Organisational Risk Register – The Committee noted that the report continued to focus on improving the readability, consistency and evidence base of risk assessments, including the application of risk scores. It was noted that, reductions in individual risk scores could reflect either a genuine reduction in risk or more consistent application of the Risk Management Strategy and Policy.
- Board Assurance Framework - The Committee discussed BAF risk 1A relating to elective capacity and whether the improved position and additional funding justified reducing the current risk score. Members supported the principle that the BAF should remain dynamic and reflect the current risk position, while recognising uncertainty about sustainability and the distinction between regulatory requirements and the Health Board's wider ambitions. The Executive was to consider this further through the next BAF review.

- The Committee received the Quarter 2 Integrated Medium-Term Plan (IMTP) and noted progress against the Health Board's strategic priorities. The Committee noted an internal assessment from the lead Executive of substantial assurance regarding management of the IMTP with more limited assurance regarding delivery. Red-rated areas included job-planning compliance, implementation of Health Pathways and the national Total Factor Productivity model, which had not yet been released.

- Integrated Performance Dashboard – The Committee received the report noting that recovery trajectories were in place for key performance measures, including diagnostic

modalities. Ultrasound was identified as the principal driver of the over-eight-week diagnostic backlog, with recovery plans and additional capacity being deployed. The Committee requested that diagnostic recovery trajectories be incorporated into future performance reporting so that progress against plans and the impact of mitigations can be more readily assessed.

- The Workforce Metrics Report - The Committee noted the overall workforce position was broadly positive, although sickness absence remained above trajectory, with more than 40% of absence related to anxiety, stress and depression. Estates and ancillary services were also highlighted as an area of workforce risk because of sickness, turnover and succession planning pressures. Personal Development Review (PDR) compliance, job planning and return-to-work compliance were improving but had not reached target.

- The Committee received the NHS Staff Survey Update noting that the response rate had reached 18.8%, involving more than 2,600 colleagues, which was ahead of the equivalent point in the previous year. The Health Board's ambition remained a 50% response rate.

- The Digital and Data Delivery Report was received. The Committee noted that digital delivery had progressed, including completion of the ePMA implementation at Prince Charles Hospital, outpatient self-check-in at Royal Glamorgan and Prince Charles hospitals and Laboratory Information Management System (LIMS) microbiology implementation. However, delivery dates for the Blood Sciences and Blood Transfusion LIMS tranches remained uncertain.

  The recent cyber assurance audit had been completed, with updated reporting to follow once the Cyber Resilience Unit report was received. A digital benefits-realisation report was also being prepared in response to the Audit Wales Digital Transformation review, with a commitment to report benefits realisation to the Board by the end of the calendar year.

  The backlog of Subject Access Requests remained an area where the Committee could not yet receive full assurance. The Information Commissioner's Office remained engaged and was due to seek a further update in November. At the time of the meeting there was not yet an achievable

	recovery plan with credible clearance dates, although work was ongoing across Medical Records and Mental Health. The position was to be reviewed through the Independent Member catch-up arrangements rather than waiting until the next Committee meeting.
Inform	• The Committee Approved the Unconfirmed Minutes of the 28 July 2026 and the Unconfirmed In Committee Minutes of the 28 July 2026 ODC meeting. • The Welsh Language Standards Annual Performance Report 2025-26 was Approved. • The Equality Annual Report was Approved. • The Committee Approved the following Policies: - CTM Digital Supplier Management Policy - Records Management Policy - Recruitment and Selection Policy - Artificial Intelligence Governance and Safe Use Policy • The Committee Noted the following items: - Month 4,5 & 6 Monitoring Returns to Welsh Government - Joint Commissioning Committee, Planning, Performance & Finance Committee Highlight Report.
Appendices	• N/A

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)* Link to Strategic Risk(s) on the Board Assurance Framework (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	Strategic Risk 2 Service Transformation & Outcomes If more than one applies please list below:

Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant /	A Healthier Wales

Link to Wellbeing of Future Generations Act – Wellbeing Goals	If more than one applies please list below:

Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Whole-Systems Perspective
	If more than one applies please list below:

Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Asesiad Effaith Impact Assessment		
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg *(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)* Equality & Welsh Language Impact Assessment Outcome *(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)*	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Summary of impact: Not applicable Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Summary of impact: Not applicable	If no, please select a reason below. Choose an item. Named Executive/Board member sign off for no EWLIA completion:
Canlyniad Asesiad Effaith Ansawdd *(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)* Quality Impact Assessment Outcome *(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)*	Not applicable	
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report	

Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Operational Delivery Committee	27/10/2026	

Acronyms / Glossary of Terms	

CTMUHB Public Board

Audit, Risk & Assurance Committee Highlight Report

Eitem yr Agenda / Agenda Item	4.3.4
Dyddiad y Cyfarfod / Date of Meeting:	26/11/2026
Statws Cyhoeddi / Publication Status:	Open/Public. Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Kathrine Davies, Corporate Governance Manager
Cyflwynydd yr Adroddiad / Report Presenter:	Patsy Roseblade, Committee Chair, Independent Member
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance/Board Secretary /Sally May, Executive Director of Finance
Diben yr Adroddiad / Report Purpose:	For Approval
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	The Board are being asked to: - NOTE the highlight report - APPROVE a minor amendment to the Risk Management Strategy to reflect the enhanced role of the Operational Management Board (OMB) in the oversight of organisational risk, and to remove reference to the previous Care Group highlight reporting route to OMB.
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol* *Strategic Context:* *This report aligns to the following Strategic Pillars*	Improving Care If more than one applies please list below:
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan *(Reference relevant priority)*	Not applicable

1. Introduction

1.1 This report had been prepared to provide the Board with details of the key issues considered by the Audit, Risk & Assurance Committee at its meeting on the 3 November 2026.

1.2 Key highlights from the meeting are reported in section 3

2. Purpose of this Meeting

2.1 The role of the Committee is to advise and assure the Board on whether there are effective arrangements in place – through the design and operation of the Health Board system of assurance – to support it in its decision taking and in discharging the accountabilities for securing the achievement of the Health Board objectives in accordance with the standards of good governance determined for the NHS in Wales.

2.2 The organisation's system of internal control has been designed to identify the potential risks that could prevent Cwm Taf Morgannwg University Health Board achieving its aims and objectives. It evaluates the likelihood of the risks being realised, considers the impact should they occur, and looks to manage them efficiently, effectively, and economically. Where appropriate, the Committee will advise the Board and the Accountable Officer on where and how the assurance framework may be strengthened and developed further.

3. Highlight Report

Alert / Escalate	The following matters were considered by the Committee for escalation to the Board: • Losses and Special Payments Report - The Committee expressed significant concern regarding the increasing level of Welsh Risk Pool expenditure awaiting reimbursement. At 30 September, £37.6m had been paid but not reimbursed, an increase of £7.9m since the end of 2025/26. Members noted the potential impact on the Health Board's cash position, particularly as additional working capital cannot be drawn down for Welsh Risk Pool-related expenditure. The Committee requested a further assurance report at its next meeting on progress with outstanding case management/Learning from Events. • Audit Wales Review – Follow-up Outpatients - The Committee considered the Audit Wales Follow-up Outpatients Review, which identified limited progress against previous recommendations, worsening long waits, continuing weaknesses in waiting-list management and

	insufficient organisation-wide information on patient harm arising from delays. The Committee concluded that the report did not provide the level of assurance required and agreed that the position should be highlighted to the Board. Further consideration will be given to the appropriate ongoing assurance and escalation arrangements between the Audit, Risk & Assurance Committee, Quality, Safety & Experience Committee and Board.
Advise	• Procurement and Post Payment Verification – The Committee received the report and received assurance on Post Payment Verification activity, noting good progress in completing General Medical Services/General Ophthalmic Services visits and the successful Cwm Taf Morgannwg (CTM) pilot of the Pharmacy Winter Incentive Scheme verification process, subsequently rolled out across Wales. Minor improvements to the presentation and clarity of future reports were requested. The Committee Endorsed for Board Approval; the amendments to schedule 2.1 of the Scheme of delegation and the updated Financial Control Procedures (FCP's). • NHS Wales Shared Services Partnership (NWSSP) Internal Audit – The Committee noted the Progress Report and received assurance on delivery of the Internal Audit Plan, noting good momentum and improved progress compared with the previous year. Members welcomed the revised reporting approach, which enabled greater focus on areas of Limited Assurance, and supported deferral of the Integrated Medium Term Plan (IMTP) review to avoid duplication with planned Audit Wales work. • Internal Audit Review - Patient Pathway Outcome Management: The Committee noted the repeated Limited Assurance position, with concerns regarding management of exception reports, continued paper-based processes and potential patient harm. Further Executive assurance was requested on progress and patient impact, with cross-referral to the Quality, Safety & Experience Committee to be considered if sufficient assurance is not provided. • Internal Audit Review - Adult Neurodevelopmental Services - The Committee noted the Limited Assurance review and raised concern regarding action timescales to December 2027 given long waiting lists. Further assurance was requested on delivery timescales and interim mitigations.

- Internal Audit Review – Software Development Final - The Committee noted the Limited Assurance Internal Audit review of Software Development, primarily reflecting gaps in formal documentation and evidence of testing, security review and change control. Members requested timely completion of the agreed actions, particularly those relating to testing and assurance prior to deployment.

- Audit Wales – The Committee noted the Audit Wales Progress Report including good progress across the audit programme, completion of reviews on Estates, Follow-up Outpatients and Cancer Services, and ongoing work on Structured Assessment, agency usage and workforce planning. Members also noted that a national review of diabetes management and prevention will commence in the new year.

- Audit Wales Report – Estates - The Committee welcomed the positive Audit Wales Estates review, noting strong governance and estates management, with further improvement required in longer-term planning, safety and workforce capacity.

- Audit Wales Report – Cancer Services - The Committee welcomed the positive Audit Wales review of Cancer Services, noting strong leadership and improving performance, while recognising ongoing challenges from pathway delays, increasing demand and longer-term financial pressures.

- Outcome of the Committee Self-Effectiveness Survey 2025-26 -The Committee welcomed the positive self-effectiveness review, which concluded that Audit, Risk and Assurance Committee is a mature and effective Committee with strong governance, constructive challenge and effective relationships with assurance providers. A small number of improvement areas were identified, including strengthening feedback from the Board and Accountable Officer.

- Policy Framework Annual Update - The Committee welcomed the improved management of non-clinical policies, including strengthened oversight and monitoring, while noting that further work is required to address overdue policies and prioritise those presenting greater organisational risk.

Assure	• The Committee discussed the Local Counter Fraud Report and received assurance on delivery of the Local Counter Fraud work plan, including awareness training, fraud risk assessments and strengthened policies. Members noted the emerging fraud risk associated with the new resident doctor contract, particularly overtime payments, and welcomed the controls and proactive monitoring being undertaken to mitigate the risk. • Organisational Risk Register – The Committee reviewed the Risk Register and noted that the overall risk profile remained broadly stable but under sustained pressure, with several risks remaining at the highest levels. Members welcomed strengthened risk management arrangements and the triangulation of overdue audit recommendations with organisational risks, which identified no significant gaps requiring new risks to be raised. The Committee also Endorsed for Board Approval a minor amendment to the Risk Management Strategy to reflect the developing role of the Operational Management Board (OMB) in relation to organisational risk. OMB already approves the escalation of new risks to the Organisational Risk Register; the amendment will enhance this role by providing for OMB to consider proposed new and updated organisational risks collectively, supporting consideration of risk in the round, including cross-organisational implications and interdependencies. The amendment will also remove reference to the previous Care Group highlight reporting route, which is no longer in use. • Audit Recommendations Tracker - The Committee welcomed material improvement in the management of audit recommendations, with 85 actions across 12 audits proposed for closure. The revised reporting approach, providing greater focus on long-standing high-priority recommendations, residual risk and actions outside the Health Board's direct control, was welcomed. • In Committee – The Committee also received updates in closed session on the Organisational Risk Register - Business Sensitive Risks, the Local Counter Fraud Report – Cases Report and the Cyber Resilience, Critical Digital Incidents and Regulation Update
Inform	• The Committee Approved the following items: - Unconfirmed Minutes of the 4th August 2026 - Unconfirmed In Committee Minutes of the 4th August 2026

	• The Committee Noted the following Internal Audit Reports (Substantial and Reasonable Assurance) - Waiting List Initiatives – Final - PCH Key Project Objectives - Ward Audits – Final - Electronic Prescribing Medicines Administration (ePMA) – Final - Gastro-Intestinal Pathways Demand Management – Final - Neurodevelopment Services (Children & Young People) - End of Life Care Management
Appendices	None identified.

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)* Link to Strategic Risk(s) on the Board Assurance Framework (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	Strategic Risk 2 Service Transformation & Outcomes
	If more than one applies please list below:

Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales
	If more than one applies please list below:

Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Whole-Systems Perspective
	If more than one applies please list below:

Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Asesiad Effaith Impact Assessment

Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg *(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)* Equality & Welsh Language Impact Assessment Outcome *(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)*	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Summary of impact: Not applicable Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Summary of impact: Not applicable	If no, please select a reason below. Choose an item. Named Executive/Board member sign off for no EWLIA completion:
Canlyniad Asesiad Effaith Ansawdd *(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)* Quality Impact Assessment Outcome *(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)*	Not applicable	
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report	
Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report	

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Audit, Risk & Assurance Committee	03/11/2026	

Acronyms / Glossary of Terms	

Version 1 June 2026

CTMUHB Public Board

Remuneration and Terms of Service Committee Highlight Report

Eitem yr Agenda / Agenda Item	4.3.5
Dyddiad y Cyfarfod / Date of Meeting:	26 November 2026
Statws Cyhoeddi / Publication Status:	Open/Public. Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Louise Stait, Interim Assistant Director Governance and Risk
Cyflwynydd yr Adroddiad / Report Presenter:	Jonathan Morgan, Chair
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance/Board Secretary
Diben yr Adroddiad / Report Purpose:	For Noting
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	The Board is asked to: - NOTE the highlight report - APPROVE the proposed amendments to the RTSC Terms of Reference.
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol* *Strategic Context:* *This report aligns to the following Strategic Pillars*	Sustaining Our Future
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan *(Reference relevant priority)*	Not applicable - this is a routine Committee Highlight Report to the Board.

1. Introduction

1.1 This report has been prepared to provide the Board with details of the key issues considered by the Remuneration & Terms of Service Committee at its meeting held on 22 October 2026.

1.2 Key highlights from the meeting are reported in section 3.

2. Purpose of this Meeting

2.1 The purpose of the Remuneration & Terms of Service Committee is to provide:

- *advice* to the Board on remuneration and terms of service for the Chief Executive, Executive Directors and other very senior staff within the framework set by the Welsh Government.
- *assurance* to the Board in relation to the Health Board's arrangements for the remuneration and terms of service, including contractual arrangements, for all staff, in accordance with the requirements and standards determined for the NHS in Wales.
- *receive reports* relating to the remuneration and terms of service, including contractual arrangements, for Directors and Very Senior Managers of hosted bodies.

3. Highlight Report

Alert / Escalate	• The Committee undertook its annual review of the Terms of Reference and endorsed their renewal, subject to two minor amendments: to specify the Committee's role in relation to the NHS Wales Joint Commissioning Committee; and the attendance arrangements for the Chief Executive. • These amendments are marked as proposed track changes on the appended Terms of Reference, which the Board is asked to APPROVE.
Advise	• The Committee approved the extension of the Deputy Chief Commissioner arrangements within the NHS Wales Joint Commissioning Committee for a further year, having considered the leadership resilience and additional executive capacity provided by the role. • The Committee approved the extension of the Health Board's Deputy Chief Executive arrangements for a further year. Members noted the contribution of the arrangements to senior leadership capacity, organisational resilience and executive development. • The Committee considered the Health Board's new Executive and Senior Pay Recruitment and Remuneration

	Procedure, which had been developed following the qualified regularity opinion reported by Audit Wales in July 2026. The procedure strengthens governance arrangements by clarifying approval requirements, roles and responsibilities, and the records required when recruiting to Executive and Senior Pay posts. Subject to a minor amendment and confirmation from Audit Wales that the procedure was adequate, the Committee approved the procedure for publication and implementation.
Assure	• The Committee received assurance on the performance management and objective-setting arrangements in place for the NHS Wales Joint Commissioning Committee Chief Commissioner. Members noted the internal and external mechanisms supporting the arrangements and agreed that the collection of 360-degree feedback from Health Board Chief Executives and other stakeholders would be explored for 2027. • The Committee also received assurance on the performance management and objective-setting arrangements for relevant Very Senior Manager Directors within the NHS Wales Joint Commissioning Committee. Members noted that these arrangements are supported by ongoing leadership development and regular performance discussions, and that future reporting is intended to align with the Health Board's own Executive performance reporting. • The Committee considered the outcome of its 2025/26 Annual Self-Effectiveness Review. Feedback was positive across the areas assessed and no Committee-specific improvement actions were identified. The Committee will continue to benefit from wider governance improvement work being progressed across the Health Board.
Inform	• The Committee formally ratified two urgent decisions previously taken by Chair's Action in relation to redundancy arrangements, having noted the circumstances and actions taken to avoid redundancy. • The Committee noted its Action Log and Cycle of Business and confirmed the minutes of its previous meeting as a true and accurate record.
Appendices	Not applicable

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)* Link to Strategic Risk(s) on the Board Assurance Framework (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	Not applicable — this report provides a routine summary of Committee business

Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals	A More Equal Wales

Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Leadership
	Culture & Valuing People
	Learning, Improvement & Research

Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental Sustainability Impact (5Rs)	No - Not Applicable

Asesiad Effaith Impact Assessment		
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg *(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)* Equality & Welsh Language Impact Assessment Outcome *(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)*	Outcome for Equality: Not applicable — this is a routine Committee Highlight Report. Outcome for Welsh Language: Not applicable — this is a routine Committee Highlight Report.	Named Executive/Board member sign off for no EWLIA completion: Gareth Watts, Board Secretary and Director or Governance
Canlyniad Asesiad Effaith Ansawdd	Not applicable — this is a routine Committee Highlight Report and does not propose a service	

(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen) Quality Impact Assessment Outcome *(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)*	change or decision requiring a Quality Impact Assessment.
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report
Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
(Insert Details)	Click or tap to enter a date.	

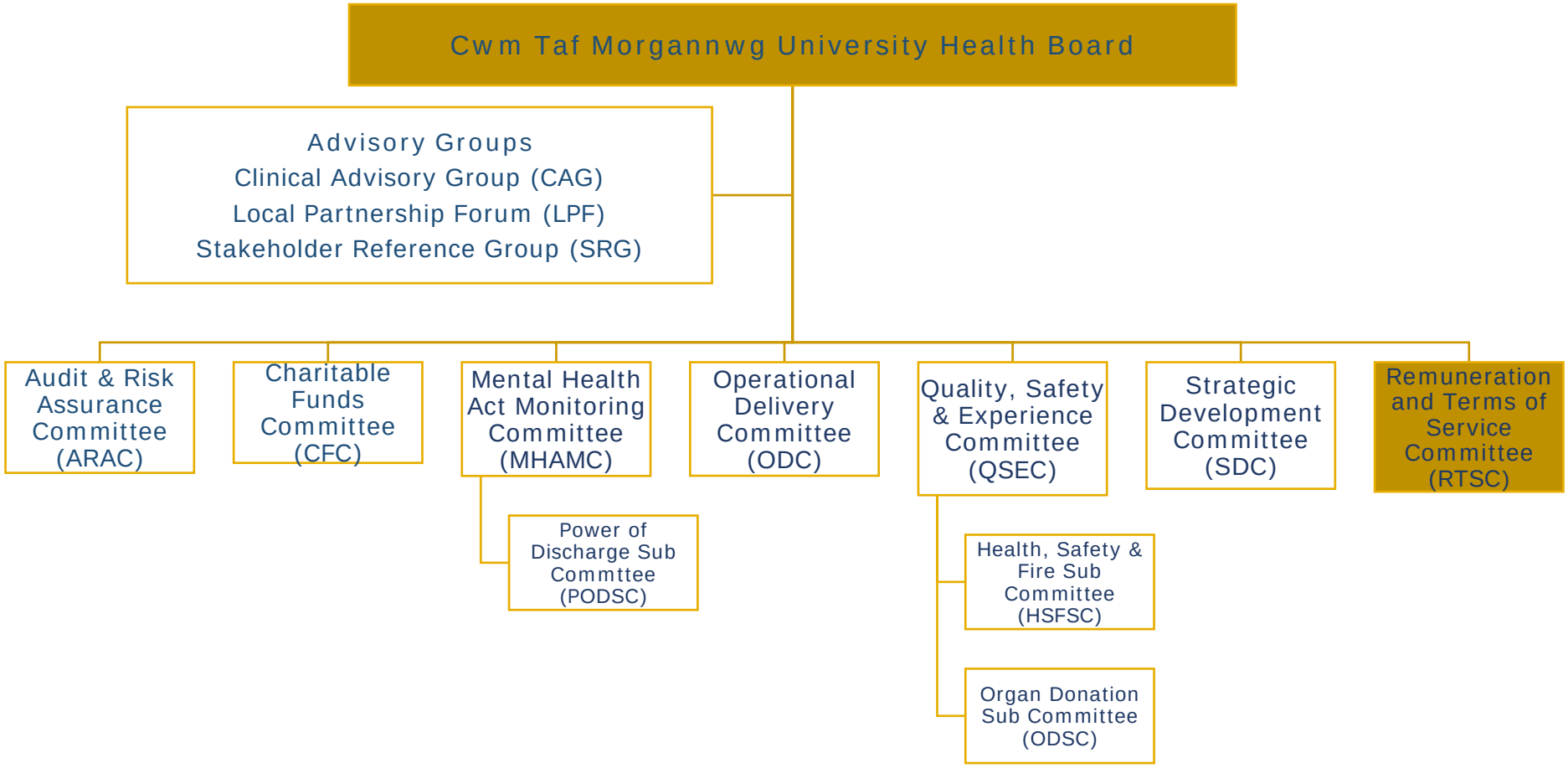
Acronyms / Glossary of Terms	

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

REMUNERATION & TERMS OF SERVICE COMMITTEE (RTSC)

Terms of Reference & Operating Arrangements
(Schedule 3.5 of the Standing Orders)

Last Approved: Health Board Meeting 26th March 2026
CTM_Corporate_Governance@wales.nhs.uk


Cwm Taf Morgannwg University Health Board
Advisory Groups
Clinical Advisory Group (CAG)
Local Partnership Forum (LPF)
Stakeholder Reference Group (SRG)
Audit & Risk Assurance Committee (ARAC)
Charitable Funds Committee (CFC)
Mental Health Act Monitoring Committee (MHAMC)
Power of Discharge Sub Commttee (PODSC)
Operational Delivery Committee (ODC)
Quality, Safety & Experience Committee (QSEC)
Health, Safety & Fire Sub Committee (HSFSC)
Organ Donation Sub Committee (ODSC)
Strategic Development Committee (SDC)
Remuneration and Terms of Service Committee (RTSC)

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Version Control

Version	Issued To	Date	Outcome	Next Review Date
Version 1	Health Board Meeting	26th September 2024	Approved	No later than the end of September 2025
Version 2	Health Board Meeting	26 March 2026	Approved	No later than March 2027
Version 3	Health Board Meeting	26 November 2026		No later than November 2027

Board Committee Arrangements: This schedule forms part of, and shall have effect as if incorporated in the Health Boards Standing Orders

1. Introduction & Constitution

1.1 The Cwm Taf Morgannwg University Health Board (CTMUHB) Standing Orders provide that "The Board may and, where directed by the Welsh Government must, appoint Committees of the Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees".

1.2 In accordance with Standing Orders (and the CTMUHB scheme of delegation), the Board shall nominate annually a committee to be known as the Remuneration & Terms of Service Committee (RTSC). The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set in this document.

1.3 Due to the nature of the business being considered at the RTSC these meetings will be held in private and papers/minutes will not be made publically available. A summary highlight report will be received at the Public Board meeting that follows.

2. Purpose

2.1 The purpose of the Remuneration & Terms of Service Committee is to act on behalf of the Board to:

- *Approve*, on behalf of the Board, the remuneration and terms of service for the Chief Executive, Executive Directors and other senior staff within the framework set by the Welsh Government; and
- *Provide Assurance* to the Board in relation to the CTMUHB's arrangements for the remuneration and terms of service, including contractual arrangements, for all staff, in accordance with the requirements and standards determined for the NHS in Wales
- as appropriate the Committee will *receive reports* relating to the remuneration and terms of service, including contractual arrangements, for Directors and Very Senior Managers (VSMs) of its hosted bodies, including the NHS Wales Joint Commissioning Committee.
- Perform certain, specific functions on behalf of the Board.

2.2 The Committee shall have no powers to develop or modify existing pay schemes.

3. Scope and Duties

With regard to its role in acting on behalf of the Board, and in providing advice and assurance to the Board, the Remuneration and Terms of Service Committee will comment specifically upon:

3.1 Remuneration and terms of service for the Chief Executive, Executive Directors, other Very Senior Managers (VSMs) and others not covered by Agenda for Change; ensuring that the policies on remuneration and terms of service as determined from time to time by Welsh Government are applied consistently;

3.2 Objectives for Executive Directors and other Very Senior Managers (VSMs) and their performance assessment;

3.3 Performance management systems in place for those in the positions mentioned above and its application;

3.4 Proposals to make additional payments to Medical and Dental Consultants outside of normal terms and conditions;

3.5 Proposals regarding termination arrangements, ensuring the proper calculation and scrutiny of termination payments in accordance with the provision of the regulations and in accordance with Ministerial instructions, Welsh Government guidance;

3.6 Consider and approve Voluntary Early Release applications and redundancy/severance payments in respect of Executive Director/Director posts, in line with Standing Orders and extant Welsh Government guidance.

3.7 The Committee to be advised also of all Voluntary Early Release Scheme applications and severance payments;

3.8 Approve any Strategic Advisor arrangements, including scope and pay;

3.9 In developing remuneration packages the Remuneration and Terms of Service Committee will ensure that there is:

- A clear statement of responsibilities of the individual posts and their accountabilities of meeting objectives of the organisation
- A means of assessing the comparative job weight
- Comparative salary information from the NHS, other public sector organisations and industrial service organisations.

Circumstances where Welsh Government Approval is required

Circumstances in which Welsh Government approval is required from an accounting perspective for individual end of employment payments. These are set out in the NHS Wales Manual for Accounts under the Losses and Special Payments chapter, however, in summary, these are:

3.10 Contractual Redundancy – CTMUHB has delegated authority from a financial accounting perspective to pay contractual entitlements so Welsh Government approval is not needed. However, for Executive Directors, Welsh Government do need to be aware before any such contractual arrangements are signed off with the individual and approved by the Director General / CEO NHS Wales as Accounting Officer.

3.11 Voluntary Early Release Scheme (VERS) – organisations have delegated authority for payments up to £50,000 as set out on the VERS Model Scheme rule. Payments over this level require Welsh Government Accounting Officer approval, and there is a template Business Case to submit to Welsh Government for approval.

3.12 Ex gratia / Settlement payment – any payment amount above contractual entitlement requires Welsh Government approval. Given that cases will be based on individual circumstances there is no set template, however Welsh Government have developed a spreadsheet with options to demonstrate that the course of action is cost effective and demonstrates value for public sector money, as any such payments should only be exceptional. The Losses and Special payment chapter also outlines the principles to follow and the checklist that must be completed and signed off.

3.13 In all of the above scenarios (3.10-3.12) the RTSC provides an essential role and must sign off the payment prior to submission to Welsh Government for final approval.

4. Membership

Members

4.1 The Membership of RTSC is as follows:

Chair	CTMUHB Chair
Vice Chair	CTMUHB Vice Chair
Members	All Independent Members

Support to Committee Members

4.2 The Director of Corporate Governance / Board Secretary, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and
- Co-ordinate the provision of a programme of organisational development for committee members as part of the overall Health Board's Organisational Development programme developed by the Executive Director for People.

In Attendance

4.3 The following should attend Committee meetings except when their personal remuneration and terms and conditions are to be discussed:

Executive Director For People
Deputy Director for People or the Assistant Director of Policy, Governance and Compliance *(Will attend to present papers and provide professional advice in order to facilitate the Committee deliberations)*
Director of Corporate Governance / Board Secretary
Chief Executive

~~4.3 Apart from the issue of the Chief Executive's personal salary and remuneration, the Chief Executive will be invited to attend meetings when the remuneration of Executive Directors and other members of the Senior Management Team is on the agenda for discussion.~~

By Invitation:

4.4 Other Directors / Health Board Officers may be invited to attend when the Committee is discussing areas of risk or operation that are the responsibility of that Director.

4.5 The Committee may also co-opt additional independent external members from outside the organisation to provide specialist skills, knowledge and experience.

5 Quorum & Attendance

5.1 A quorum shall consist of no less than three of the membership, and must include as a minimum the Chair or Vice Chair of the Committee.

5.2 The membership of the Committee shall be determined by the Board, based on the recommendation of CTMUHB Chair, taking into account the balance of skills and expertise necessary to deliver the Committee's remit, and subject to any specific requirements or directions made by the Welsh Government.

5.3 Any senior officer of CTMUHB or partner organisation may, where appropriate, be invited to attend, for either all or part of a meeting to assist with discussions on a particular matter.

5.4 The Committee may also co-opt additional independent external 'experts' from outside the organisation to provide specialist skills.

5.5 Should any officer member be unavailable to attend, they may nominate a deputy to attend in their place, subject to the agreement of the Chair.

5.6 The Committee can arrange to meet with Internal Audit and External Audit without the presence of officers, as required.

5.7 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters

6 Meeting Secretariat

6.1 The Committee Secretariat shall be determined by the Director of Corporate Governance/Board Secretary.

7 Frequency of Meetings

7.1 The Committee will meet as and when required and at least once per annum and shall agree an annual schedule of meetings.

7.2 Any additional meetings will be arranged as determined by the Chair of the Committee in discussion with the Lead Executive(s).

7.3 The Chair of the Committee, in discussion with the Committee Secretary, shall determine the time and the place of and procedures of such Committee meetings.

8 Withdrawal of Individuals in Attendance

8.1 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

9 Circulation of Papers

9.1 All papers will be distributed at least 7 calendar days in advance of the meeting.

10 Access

10.1 The Chair of the RTSC shall have reasonable access to Executive Directors and other relevant senior staff.

11 Accountability, Responsibility & Authority

11.1 The RTSC is an independent Committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

11.2 Although the Board has delegated authority to the Committee for the exercise of certain functions, as set out in these Terms of Reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens, through the effective governance of the organisation.

11.3 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

11.4 The Committee shall embed the CTMUHB's vision, corporate standards, priorities and requirements, e.g. equality and human rights, through the conduct of its business.

11.5 The requirements for the conduct of business as set out in the UHB's Standing Orders are equally applicable to the operation of the Committee.

11.6 The Committee is authorised by the Board to:

- Investigate or have investigated any activity within its Terms of Reference and in performing these duties shall have the right, at all reasonable times, to inspect any books, records or documents of the CTMUHB. It may seek relevant information from any:
    - Employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and
    - Any other Committee, sub Committee or group set up by the Board to assist it in the delivery of its functions.
- obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject to the Board's budgetary and other requirements;
- By giving reasonable notice, require the attendance of any of the officers or employees and auditors of the Board at any meeting of the Committee.
- Approve policies relevant to the business of the Committee as delegated by the Board.

Sub Committees

11.7 The Committee may, subject to the approval of the Health Board, establish sub Committees or task and finish groups to carry out on its behalf specific aspects of Committee business.

11.8 At this stage, there are no sub committees established.

12 Reporting

12.1 The Committee, through its Chair and members, shall work closely with the Board's other Committees, including joint/sub committees and groups, to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business;
- sharing of information.

12.2 In doing so, the Committee shall contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

12.3 The Committee may establish sub-committees or task and finish groups to carry out on its behalf specific aspects of Committee business. The Committee will receive an update following each sub-committee or task and finish group meeting detailing the business undertaken on its behalf.

12.4 The Committee will consider the assurance provided through the work of the Board's other Committees and Sub-Committees to meet its responsibilities for advising the Board on the adequacy of CTMUHB's overall assurance framework.

12.5 The Committee Chair, supported by the Committee Secretary, shall:

- Report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes the submission of a Committee update report as well as the presentation of an annual report within six weeks of the end of the financial year and timed to support the preparation of the Accountability Report. This should specifically comment on the adequacy of the assurance framework, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the Committee's self-assessment and evaluation.
- Bring to the Board's specific attention any significant matter under consideration by the Committee.
- Ensure appropriate escalation arrangements are in place to alert CTMUHB Chair, Chief Executive or Chairs of other relevant Committee, of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

12.6 The Director of Corporate Governance/Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committees performance and operation, including that of any sub-committees established. In doing so, account will be taken of the requirements set out in the NHS Wales Audit Committee Handbook

13 Applicability of Standing Orders to Committee Business

13.1 The requirements for the conduct of business as set out in the CTMUHB's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

14 Chairs Action on Urgent Matters

14.1 There may, occasionally, be circumstances where decisions which would have been made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Committee, after first consulting with at least two other members of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

14.2 Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

15 Review

These terms of reference and operating arrangements shall be reviewed on at least an annual basis

CTMUHB Public Board

Chair's Report

Eitem yr Agenda / Agenda Item	5.1
Dyddiad y Cyfarfod / Date of Meeting:	26/11/2026
Statws Cyhoeddi / Publication Status:	Open/Public. Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Jonathan Morgan, Chair of the Board
Cyflwynydd yr Adroddiad / Report Presenter:	Jonathan Morgan, Chair of the Board
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Jonathan Morgan, Chair of the Board
Diben yr Adroddiad / Report Purpose:	For Approval
Argymhelliad *(Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).* Recommendation (Linked to the "What Next" section above).	Members of the Board are asked to: • NOTE the report. • RATIFY the Affixing of the Common Seal as captured in section 3.1

1. Background

1.1 This report provides an update to the Board on relevant matters in my capacity as Chair of CTMUHB. It also outlines where I have been required to affix the Common Seal of the Health Board for which endorsement is sought.

1.2 This overarching report also highlights for Board Members the key areas of activity and where appropriate any associated risks, some of which are referred to within the business of the Board meeting. The report also highlights topical areas of interest to the Board.

2. Specific Matters for Consideration

2.1 Chair Update

Welsh Government budget 2027-28

Welsh Ministers published their draft budget for the next financial year on 17 November and although we won't have the official confirmation of our

budget for CTMUHB until the end of the year we will need to make some assumptions as we plan for April 2027 alongside our Integrated Medium Term Plan (IMTP). Over the past three years we have been the only Health Board to balance its budget, to take seriously our responsibilities to manage the finances delegated to us recognising the importance of spending taxpayers' money as effectively and efficiently as possible. This has meant difficult decisions, but it has given us the space to focus on the strategic direction of our services as we plan for the changes we need to deliver.

Next year will also mean difficult decisions and I have asked the Executive team to provide a range of scenarios to allow us to achieve what we need within our budgets. We will need to be honest about the scale of the challenges we face with increasing demands, poorer levels of public health, increasing staff costs and duplication of services across multiple sites. The challenge to us therefore is not just how we manage our finances next year but how we take the opportunity to change our services to become more cost effective.

Our Case for Change

This year I gave a commitment that the Board would publish its ambitions for the future before the end of this year. Today's meeting includes four major pieces of work; all connected to establishing the local health service of the future. A compelling Case for Change supported by a wealth of evidence, alongside our Building Healthier Communities Strategic Vision for the future model of care and our draft Digital and Data Plan 2026 – 2030 are all before the Board today for discussion.

The message whilst honest and stark is also exciting and optimistic.

We all know that services as they are now will not survive if we carry on as we are. However, the opportunity, ambition and drive to reimagine the services we provide and how we deliver them is strong. There is commitment across this organisation to build a healthcare system that doesn't just survive in the decades ahead, but one that is more rooted in our communities where we focus on prevention and earlier intervention, delivering better access and outcomes where support and services are more efficiently and effectively delivered through digital solutions, better and more informed data.

People will need to come with us, but we will also need determination and resolve to deliver change at pace. Ministers and politicians will need to understand the choices we face and help lead the conversations with our communities if we are to deliver on our commitments and those of Welsh Ministers. As Chair I am enthusiastic about what we are setting out today, it provides an honest assessment of what is needed and I look forward to working with the whole Board as we lead and implement the transformation we need.

2.2 Independent Member Recruitment Update

The Interviews for the Independent Member, Third Sector post were held on the 25 September, however, following the interview process, no successful candidate was appointed. We are currently liaising with Welsh Government (WG) to agree the next steps to appoint a suitable candidate.

2.3 Board Briefings and Board Development Sessions

The Board briefing held on the 1 October 2026 focussed on the following key areas as a Board:

- Health Visting Update
- LIMS Update
- Llynfi Valley Engagement Update
- Maternity Update

The Board briefing held on the 15 October 2026 covered the following:

- Case for Change Update – Clinical Services Plan
- Health Visiting Update

The Board Development Session held on 22 October 2026 covered the following:

- Adult Mental Health National Clinical Plan
- Case for Change - Strategic Clinical Services Plan (including the Digital & Data Strategic Plan)

The Board Briefing session held on the 5 November 2026 covered the following:

- NHS Confed Annual Conference
- Health Visitor Update
- Llynfi Valley Update
- Financial Position
- Operational Update

Diary Commitments

- Local Authority Leaders/Chair/CEO Meeting
- Independent Members/Chair/CEO Meeting
- 1:1 Chief Executive
- 1:1 Director of Governance
- 1:1 Vice Chair
- Chair Peer Group Meeting
- CTMUHB Public Board Meeting and In Committee Board Meeting
- Board Briefing/IM Catch Up Chair and CEO
- Consultant interview panels
- CTMUHB Board Development/Board Briefing Session
- Senedd Event
- NHS Confed Board Meeting
- End of Year Review Meeting with CEO

- Meeting between Welsh Government Health and Care Ministers and NHS Leaders
- Deputy Minister visit to IWHH and Ward 7
- MS and Councillor visit to Bridgend Health and Wellbeing Centre
- Structured Assessment Interview with Audit Wales
- Regional Partnership Meeting
- CTM Community Leaders' Network meeting
- Aberfan Memorial
- Staff Survey Site Visit – YCC
- Annual Conference and Exhibition
- Healthy Futures Maesteg - Engagement Event
- Cwm Taf Morgannwg Public Service Board
- CTMUHB QMS Board Development Session-Co Design Call
- Welsh NHS Alliance Audit & Risk Committee
- Welsh NHS Alliance Management Committee Meeting
- Chair/Vice Chair - Visit to Ferndale Managed Practice
- Visit to the Paediatric Respiratory/Allergy Nursing Team
- Sir Terence Stephenson visit to Wales organised by the NHS Alliance
- CTMUHB Research and Development Conference

2.6 Meetings / discussions with Local Politicians

- MS/MP monthly meetings with Chair/CEO

3. Key Risks / Matters for Escalation

3.1 COMMON SEAL

3.1.1 The Board is asked to ratify the use of the Common Seal applied since the Board last met;

- Contract between Cwm Taf Morgannwg University Health Board and Dr Clare Jane Hughes, Dr Neil Geraghty, Dr Angela Faye Evans and Dr Sarah Thomas all of Ashfield Surgery, Merthyrmawr Road, Bridgend, CF31 3NW - TIR Lease NHS Capital Builds relating to GP Surgery at Sunnyside Wellness Village, Bridgend.
- Contract between Cwm Taf Morgannwg University Health Board and Codi Homes and Communities Limited - TP1 relating to the Health Centre at Sunnyside Wellness Village, Sunnyside, Bridgend, CF31 4AR.
- Cwm Taf Morgannwg University Local Health Board relating to Council Offices and Bridgend Magistrates Court, Sunnyside, Bridgend - DS1 Cancellation of entries relating to a registered charge.
- Contract between Cwm Taf Morgannwg University Local Health Board and Codi Homes and Communities Limited of Exchange House, The Old Post Office, High Street, Newport, NP20 1AA - TR1 relating to The New Quarella Road Community Clinic and Bryntirion Maternity and Child Welfare Clinic.

- Licence to Occupy on Short Term Basis between Codi Homes and Communities Limited of Exchange House, The Old Post Office, High Street, Newport, NP20 1AA and Cwm Taf Morgannwg University Local Health Board - relating to the Bryntirion Maternity and Child Welfare Clinic, Elm Crescent, Bridgend, CF31 4EA
- Licence to Occupy on Short Term Basis between Codi Homes and Communities Limited of Exchange House, The Old Post Office, High Street, Newport, NP20 1AA and Cwm Taf Morgannwg University Local Health Board - relating to the New Quarella Road Community Clinic, Quarella Road, Bridgend.
- Contract between Expedite Project Services Limited of First Floor Unit 8, Greenmeadow Springs Business Park, Cardiff, CF15 7NE and Cwm Taf Morgannwg University Local Health Board - Collateral Warranty relating to Sunnyside Wellness Village, Bridgend between
- Contract between Cwm Taf Morgannwg University Health Board and MTX Contracts Ltd - Form of Agreement for NEC4 Engineering and Construction Contract – for works comprising design and construction of Llantrisant Health Park – Surgical Hub (Phase 2)

3.1.2 This requires endorsement by the Board as set out in the recommendations of this report.

4. Assessment

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)* Link to Strategic Risk(s) on the Board Assurance Framework (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	Strategic Risk 2 If more than one applies please list below: Strategic Risk 4 Strategic Risk 11

Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales If more than one applies please list below:

Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Learning, Improvement & Research

	If more than one applies please list below:

Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Asesiad Effaith Impact Assessment		
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg *(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)* Equality & Welsh Language Impact Assessment Outcome *(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)*	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Summary of impact: This is an overarching position report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment. Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Summary of impact: This is an overarching position report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment.	If no, please select a reason below. Policy/Plan/Proposal too broad Named Executive/Board member sign off for no EWLIA completion: Gareth Watts, Director of Corporate Governance
Canlyniad Asesiad Effaith Ansawdd *(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)* Quality Impact Assessment Outcome *(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)*	The number one focus of the Board and its business is to ensure good quality and safe patient care across all areas of its activity.	
Cyfreithiol / Legal	Yes (Include further detail below) Board endorsement of the Affixing of the Common Seal, is a requirement of the Board's Standing Orders.	

Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report
Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group /Forum Individuals	Date	Outcome
N/A	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
CEO	Chief Executive Officer
CTMUHB	Cwm Taf Morgannwg University Health Board
MS	Members of the Senedd
MP	Member of Parliament
Q&A	Question and Answer

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Version 2 August 2026

CTMUHB Public Board

Strategic Clinical Services Plan

Eitem yr Agenda / Agenda Item	6.1
Dyddiad y Cyfarfod / Date of Meeting:	26 November 2026
Statws Cyhoeddi / Publication Status:	Open/Public. Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	SCSP steering group, supported by Tektology
Cyflwynydd yr Adroddiad / Report Presenter:	Claire Thompson, Executive Director of Strategy & Transformation Stuart Morris, Director of Digital Rob Bleasdale, Chief Clinical Information Officer
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Claire Thompson, Executive Director of Strategy & Transformation
Diben yr Adroddiad / Report Purpose:	For Approval
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	Approval
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol* *Strategic Context:* *This report aligns to the following Strategic Pillars*	All Strategic Pillars Apply If more than one applies please list below:
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan *(Reference relevant priority)*	This suite of documents are foundations of CTM's 'Building Healthier Communities Together' strategy. They therefore provide significant strategic context for shaping the content of our IMTP 2027-30 which is itself the planning vehicle for delivering the changes required.

Crynodeb Gweithredol o'r hyn y mae'r adroddiad yn ei ddisgrifio:
Dechreuwch drwy grynhoi'r wybodaeth bwysicaf yn fyr. Dylai hyn roi dealltwriaeth gadarn o'r pwyntiau allweddol yn erbyn y 3 phennawd canlynol heb ddarllen yr adroddiad llawn:
Executive Summary of what the report is describing:

Start by summarising briefly the most critical information. This should provide a firm grasp of the key points against the following 3 headings without reading the full report:	
Beth *(crynodeb o'r sefyllfa / mater cyfredol a pham ei fod yn bwysig a thystiolaeth i gefnogi'r safbwynt hwnnw ac ati)* What *(summary of current position / issue & why it matters and evidence to support that position etc)*	As previously briefed to Committee and Board, a Case for Change and Strategic Vision are fundamental pre-requisites for transformation of our clinical model. The creation of these documents is intended to provide both the evidence base that the status quo is not an option and a compelling vision of the future. These 4 documents are aligned to do this and are presented for the Board to review and approve 1. CTM Case for Change 2. International Evidence Base 3. Strategic Vision 4. Digital and Data Plan
Felly, beth *(darparu dadansoddiad ystyrlon gan dynnu allan, fel y bo'n briodol, oblygiadau yn erbyn Strategaeth / Cynlluniau Cyflawni / risgiau Strategol neu Reoleiddiol CTMUHB ac ati ac unrhyw opsiynau ar gyfer mynd i'r afael â'r rhain)* So, what *(provide meaningful analysis drawing out as appropriate implications against CTMUHB Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)*	These documents are presented as foundational elements of our Strategic Clinical Services Plan. The first two are intended to be a position statement supporting the second two; the strategic vision and digital and data plan are aligned to ensure that a shift from analogue to digital delivery is at the heart of our clinical model. It is intended that the latter two may be amended following public engagement and iterated over the coming years as the model develops. The strategic vision will be at the heart of our IMTP and so ensure that Care Group and corporate team plans for 2027-30 are designed in service of the overall model of care. The strategic vision will provide the basis for pre-consultation engagement with our partners, people and population in Q4 of 2026-27, to ensure that the model has been tested and refined with those we serve.
Beth Nesaf *(crynodeb o'r camau gweithredu a fwriadwyd a'r manteision sy'n cefnogi'r dewisiadau a'r argymhelliad(au) sy'n cael eu gwneud)* What Next *(summary of intended action and benefits supporting the*	Subject to Board approval, the Health Board will enter a period of engagement around the Strategic Vision and iterate that ahead of a process to develop and assess more detailed options for service change, which would be subject to formal public consultation, in 2027-28. This engagement will be informed by our Strategic Engagement Plan, received at the last Strategic Development Committee, and more detailed

choices and recommendation(s)being made)	internal and external engagement plans are in development to support Q4 activity.

Argymhelliad *(Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).* Recommendation (Linked to the "What Next" section above).	To approve the 4 documents for use.

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)* Link to Strategic Risk(s) on the Board Assurance Framework (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	All Strategic Risks Apply
	If more than one applies please list below:

Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals	All Wellbeing Goals Apply
	If more than one applies please list below:

Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	All Enablers of Quality Apply
	If more than one applies please list below:

Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental Sustainability Impact (5Rs)	All Environmental Sustainability Impact (5Rs) Applies
	If more than one applies please list below:

Asesiad Effaith Impact Assessment		
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg *(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)*	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Summary of impact:	If no, please select a reason below. Policy/Plan/Proposal too broad At this stage and will be assessed at options stage

Equality & Welsh Language Impact Assessment Outcome *(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)*	Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Summary of impact:	Named Executive/Board member sign off for no EWLIA completion: Claire Thompson
Canlyniad Asesiad Effaith Ansawdd *(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)* Quality Impact Assessment Outcome *(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)*	At this stage a QIA has not been undertaken. As statements the Case for Change and International Evidence Base do not require QIAs. A QIA will be undertaken for the Strategic Vision and Digital and Data Plan as part of engagement with wider stakeholders and presented as part of 2027-28 plans. In addition, QIAs will need to be undertaken for any options or proposals for service change that arise from these.	
Cyfreithiol / Legal	Yes (Include further detail below)	
	There are legal risks related to any proposals for service change. These documents are intended to provide a sound basis for proposing and agreeing changes and therefore mitigate this risk.	
Enw da / Reputational	Yes (include further detail below)	
	There are reputational risks related to any proposals for service change. These documents are intended to provide an explicable and justifiable basis for change and therefore with sound engagement plans, to mitigate this risk.	
Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	Yes (include further detail below)	
	There will be resource implications in terms of capacity to undertake the work associated with these strategic documents, as well as in relation to service changes arising. The intention is for these to support a more efficient and effective delivery model for NHS services and thereby contribute to a sustainable future NHS.	

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Steering group, routine meetings & workshops	Q2-3 2026-27	Development of documents
Board development session (briefing)	22 October 2026	Supported
Executive Management Board	26 October 2026	Supported with comments to be included before Board

Strategic Development Committee	10 November 2026	Endorsed in draft for Board approval

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

CTM Building Healthier Communities: Case for Change

November 2026

Version 6



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Executive Summary

The evidence presented in this Case for Change shows that Cwm Taf Morgannwg University Health Board (CTM) faces changing population needs, persistent health inequalities, operational pressure, workforce constraints, and a challenging financial position. These pressures are interconnected and cannot be addressed sustainably by incrementally expanding the current model of care or by like-for-like capacity expansion.

The case for change also reflects the direction established through national policy and planning in Wales. A Healthier Wales calls for a shift towards prevention, integrated health and social care and services delivered closer to home. This has been reinforced through the National Clinical Framework, the Primary Care Model for Wales and the Community by Design approach, which promote consistent, person-centred pathways, earlier intervention and community-based care wherever this can be provided safely and effectively. The NHS Wales Planning Framework 2026–2029 makes population health and prevention, Community by Design and timely access to care explicit national priorities. CTM's proposed layered model provides a locally responsive framework to translate these national ambitions into service planning and delivery.

Health need is becoming more complex and unevenly distributed

CTM serves approximately 449,000 people across Bridgend, Merthyr Tydfil and Rhondda Cynon Taf. Although the population grew by 3.2% between 2014 and 2024, population growth alone does not explain the case for change. The bigger challenge is the changing composition, complexity, and distribution of health care needs.

More than 91,000 CTM residents are aged 65 or over, and the proportion of the older population is projected to grow faster than that of the rest of the population. This is expected to increase the prevalence of frailty, multimorbidity, dementia and other long-term conditions, alongside increased demand for rehabilitation, continuing care and support for unpaid carers and associated environments.

The issue of an ageing population is, however, compounded by localised variation. Healthy life expectancy in CTM is lower than the Welsh position for both males and females. The difference is particularly pronounced in Merthyr Tydfil, where healthy life expectancy is approximately seven to eight years below the Welsh level. This indicates that many CTM residents experience ill health earlier and live with its effects for longer.

Recorded prevalence of mental ill health, hypertension, obesity, diabetes, asthma and several cardiovascular conditions is also higher in CTM than across Wales. These conditions frequently coexist and are closely associated with people's mental health and socio-economic circumstances. The system therefore increasingly needs to support people with multiple, interacting needs over extended periods rather than responding only to individual episodes of illness.

Health inequalities are a central driver of the case for change

Approximately 53% of CTM's population lives in communities within the two most deprived Welsh quintiles, compared with around 40% across Wales. When considering the health domain of the Welsh Index of Multiple Deprivation, this rises to approximately 58%, the highest proportion among Welsh health boards.

The CTM-wide position also conceals marked variation between and within its three local-authority areas. Some communities experience persistent deprivation, poorer healthy life expectancy, premature mortality and overlapping physical, mental and social needs. Conversely, other communities face pressures associated with population growth, ageing, rurality, lack of transport links, or proximity to and the distribution of existing services.

These differences mean that equality of provision will not necessarily produce equitable access or outcomes. CTM requires a consistent system-wide offer, with common standards and coherent pathways, but the scale, accessibility and intensity of support will need to reflect local population needs and to address current actual or perceived barriers to care.

Historic service activity should not be treated as a complete measure of that need. Lower use of services may reflect better health, but it may also indicate unmet need, delayed presentation or difficulty accessing and navigating care. Future planning must therefore consider population need, inequalities and outcomes alongside existing activity.

Pressure is evident across the care continuum

Ambulance activity in CTM has become more heavily weighted towards immediately life-threatening calls. Red-call activity increased materially between 2021 and 2024 and represented approximately 17% of CTM calls during the first six months of 2025, compared with around 15% across Wales. Response performance improved during 2025, but approximately half of red-call responses still took longer than eight minutes.

Pressure is also evident within emergency departments, where average off-stretcher time has generally remained higher than the Welsh average. This should not be attributed to a single service or cause. Emergency-care performance can be affected by the number and acuity of attendances, ambulance availability, staffing, diagnostic turnaround, inpatient capacity, discharge processes and access to community and social-care support. The evidence therefore points to pressure across the wider urgent and emergency-care pathway.

CTM has made significant progress in planned care. Its referral-to-treatment waiting list reduced by approximately 25%, from around 109,900 open pathways in the third quarter of 2024 to approximately 82,900 in the second quarter of 2026. Nevertheless, the remaining requirement is substantial and is concentrated in a limited number of specialties, including trauma and orthopaedics, ophthalmology, ear, nose and throat, general surgery, gynaecology and urology.

Diagnostic waiting pressure has also been volatile and is concentrated particularly within radiology, endoscopy and cardiology. Different diagnostic services depend on different combinations of workforce, equipment, facilities, reporting capacity and pathway design. The remaining planned-care challenge will therefore require pathway- and specialty-specific responses rather than a single organisation-wide intervention.

Mental health services are managing substantial and variable referral activity alongside an ongoing secondary-care caseload. Mental and physical health needs frequently interact, reinforcing the importance of continuity and coordination between mental health, primary care, community services, social care and wider partners.

CTM has important assets, but community capacity cannot be assumed

CTM has strengths it will need to build on. General practice manages a substantial volume of continuing and long-term need. The Health Board has a comparatively dense community-pharmacy network, good population reach through dental services and examples of specialist assessment being provided through community optometry. These services provide an established platform for prevention, earlier intervention, and managing appropriate needs closer to home.

However, the evidence does not demonstrate that existing community services have sufficient capacity to absorb a major transfer of activity from hospitals. District-nursing capacity has remained broadly static, while CTM's community mental health nursing workforce has reduced. Some community pathways also remain relatively narrow or are not sufficiently connected to other parts of the system.

Moving activity without strengthening the receiving services would risk transferring pressure rather than resolving it. Any change in where care is provided will need to be supported by appropriate workforce, clinical leadership, infrastructure, digital capability and access to specialist advice.

The existing workforce model will become increasingly difficult to sustain

CTM's directly employed workforce increased by approximately 6.7% between 2022 and 2026, although this was below the growth recorded by most other Welsh health boards. Growth has been uneven between staff groups; reported vacancies have increased and registered nursing continues to experience material vacancy pressure.

Approximately one in ten CTM employees are now aged over 60, creating potential retirement, succession and knowledge-transfer risks. Workforce movement also means that a significant proportion of recruitment activity is required to replace people leaving rather than create additional capacity.

Recruitment will remain important, but CTM cannot assume that future demand can be met by recruiting sufficient additional staff into the same roles and working arrangements. The evidence supports greater emphasis on retention, succession, multidisciplinary working, appropriate skill mix, flexible deployment and the use of administrative, technical and digital support to release clinical time. This will require planned workforce transformation rather than workforce growth alone.

Financial sustainability depends on changing the model of care

CTM enters 2026/27 with an approved financial plan but carries a £9.2 million recurring financial challenge. The plan depends on delivering £31.3 million in recurring savings during 2026/27, with £23 million still to be identified when the plan was prepared.

Across the three-year period, CTM plans for £77.3 million of new recurring savings while responding to inflation, prescribing growth, continuing healthcare requirements, high-cost treatments, and other service and demand pressures. This leaves limited financial headroom to absorb further demand or cost.

The evidence does not mean moving care into community or digital settings will automatically reduce expenditure or increase service provision. Transformation may require additional capacity, enabling investment and a period in which existing and new services operate concurrently. Some costs, including medicines and continuing healthcare, are also influenced by factors that service redesign cannot remove.

However, the financial position shows that CTM cannot rely on additional funding to meet rising need through continued expansion of its current delivery arrangements. Short-term savings and longer-term transformation must be aligned so that immediate financial actions do not remove the capacity required to establish a more sustainable model.

The evidence supports a layered model of care

Taken together, the evidence demonstrates that CTM cannot sustainably respond by providing proportionately more of every existing service. It supports a shift towards a more preventive, proactive, coordinated and distributed model of care, with support provided as locally as clinically appropriate and specialist expertise concentrated where it is required.

The layered model therefore represents both a response to CTM's local evidence and a practical means of delivering the wider national direction for prevention, integrated community care, timely access and sustainable specialist services.

These findings provide the evidence base for CTM's proposed layered model of care, comprising:

- Prevention and Population health
- Virtual response
- Locality care
- Community and Urgent response
- Diagnostic and treatment platforms
- Specialist and emergency hospital care

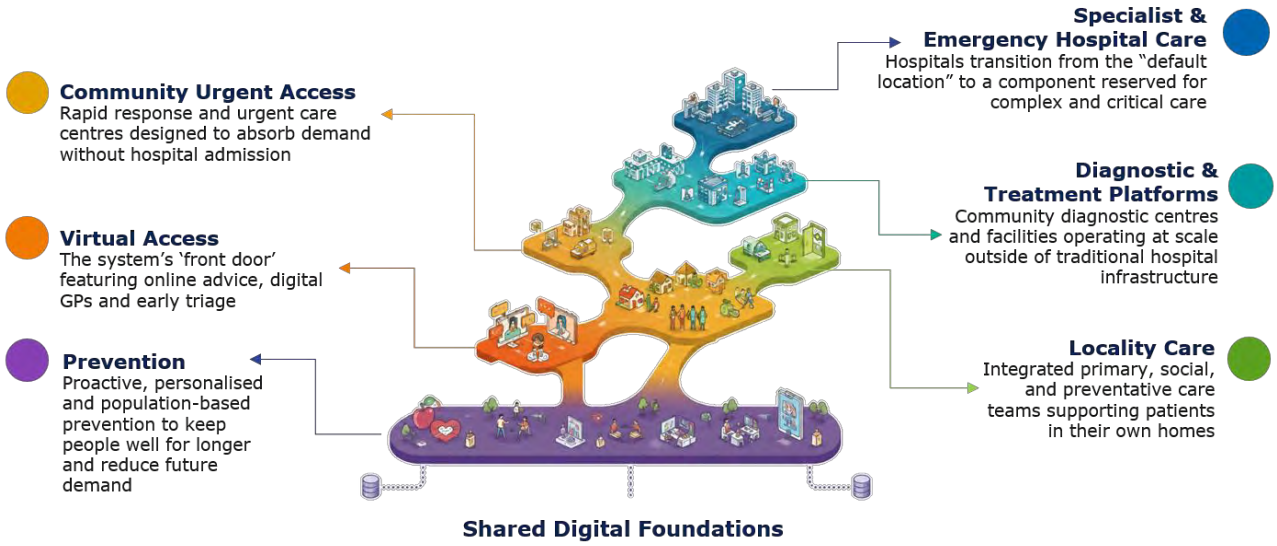


Figure: Proposed Layered Model of Care

The model is intended to match people to the appropriate level of support, identify and manage risk earlier, improve coordination and provide more care through local, community and virtual routes where this is safe and appropriate. It also recognises that people may need to move between layers as their needs change.

The layered model does not assume that all activity should move out of hospital or that community provision will automatically reduce cost. Hospitals will remain essential for emergency, acute and specialist care, while stronger community delivery will require sufficient capacity and investment. The strategic requirement is therefore to achieve a better balance across the care continuum rather than transfer activity from one pressured part of the system to another.

The case for change does not rest on any single trend or performance measure. It arises from the cumulative effect of poorer health, persistent inequality, increasing complexity, operational pressure, constrained community capacity, workforce risk and limited financial headroom. Together, these findings demonstrate why CTM's model of care must evolve and provide the basis for the next stage of detailed service, workforce, infrastructure and financial planning, which includes the extended use of private or not-for-profit service providers to support the current and future demand.

Scope

Cwm Taf Morgannwg (CTM) is progressing from earlier Acute Clinical Services Planning (ACSP) towards a broader Strategic Clinical Services Plan (SCSP). The SCSP will consider future clinical service configuration, service options, implementation implications and the decisions required across the Health Board.

This work builds on the ACSP and acts as an enabling stage in that wider SCSP journey. The scope is deliberately focused on two outputs: an evidence-led Case for Change and a Strategic Vision for the future model of care. It will support a shift towards a more distributed model of care, with more care delivered earlier, closer to home and through community, locality and partnership-based models, where clinically appropriate.

The **Case for Change** will outline why change is needed. It will draw on available evidence to describe current pressures, risks and limitations across the system, including population need, health inequalities, demand and access pressures, capacity constraints, workforce sustainability, service fragility and the experience of people using and delivering services. Its purpose is to establish a clear and credible evidence base for why the current model of care needs to evolve.

The **Strategic Vision** will translate the Case for Change into a clear direction of travel for care across CTM. It will describe how services can move towards a more preventive, proactive, connected and distributed model of care, while maintaining timely access to specialist and emergency hospital care. Setting out the principles and enablers required to guide future service and workforce planning, digital and data priorities, estates, partnerships and operational planning.

This work will provide a structured platform for the next stage of SCSP development. At this stage, it will not deliver the full scope of the SCSP, define detailed service options, appraise future service configuration, develop financial modelling, set out implementation plans or produce formal consultation material. These elements will form part of subsequent SCSP development, engagement and decision-making.

1. Health Needs

CTM serves approximately 449,000 people across Bridgend, Merthyr Tydfil and Rhondda Cynon Taf. Although the total population has grown gradually, the scale of population growth alone does not explain the case for change. The more significant challenge arises from the changing composition and distribution of need. The population is ageing, health outcomes vary markedly between communities, and a substantial proportion of people are already living with diagnosed physical or mental health conditions.

Discharge episodes and average length of stay by broad specialty group								
Broad specialty group	Elective		Emergency		Other		All admissions	
	FCEs	LOS	FCEs	LOS	FCEs	LOS	FCEs	LOS
All Specialties	7,350	20.3	58,874	7.1	712	4.6	**66,936**	**8.5**
All non-psychiatric specialties, excluding Geriatrics	5,897	6.6	55,048	4.8	702	3.6	**61,647**	**5.0**
All non-psychiatric	7,031	16.1	57,881	6.2	709	4.4	**65,621**	**7.2**
All Psychiatric specialties	317	112.9	988	60.0	2	**	**1,307**	**72.9**
Acute	5,891	6.6	54,928	4.8	685	3.7	**61,504**	**5.0**
Maternity	6	1.3	120	1.1	17	0.2	**143**	**1.0**
Geriatrics	1,134	65.4	2,833	32.5	7	**	**3,974**	**41.9**
Mental Illness	312	112.1	972	57.3	2	**	**1,286**	**70.6**
Learning Disability	5	**	16	227.1	0	–	**21**	**211.6**

Figure 1.0.1 Discharge episodes and average length of stay by broad specialty group Cwm Taf Morgannwg UHB (2024 – 2025)

In 2024-25, the Admitted Patient Care (APC) Database showed that CTM attendance of finished consultations recorded was 132,500, a 6% decrease on the year before. CTM saw 105,800 admissions during the year. Emergency presentations were down by 3,200 over the previous year to 59,200, of which 56% resulted in admission. There were 30,400 admissions from waitlists, an increase of 5%, indicating a changing landscape of how patients are accessing care. 71% of finished care episodes were ordinary admissions; however, 20% were day case episodes, while 9% were mothers delivering babies. 45% of all admissions involved a procedure or intervention.

During 2024–25, Admitted Patient Care data show that people aged 45–64 accounted for 19.9% of finished consultant episodes, while those aged 75–84 accounted for 17.7%. This may demonstrate that chronic disease process profiling may hit the 45- 64 age group, requiring multiple avenues of care delivery. Furthermore, the 75-84 age group may require more intense and longer stays within health facilities to ensure the correct pathways are in place for continuity of care. Geriatric bed days demonstrate

this with a recorded 26.2 bed days per admission. Psychiatric specialities showed 69.9 bed days recorded per admission.

Discharge episodes of care demonstrate mental health and psychiatric illness as two of the highest length of stay indicators, with geriatrics at 41.9 %.

These trends are likely to affect both the volume and nature of demand. Population growth will increase the number of people requiring services, while ageing and the existing burden of long-term conditions will increase the need for ongoing, coordinated and multidisciplinary support. At the same time, geographical differences in health outcomes mean that a uniform response across CTM may not direct resources and interventions towards communities with the greatest need. The evidence therefore points to a dual requirement: a consistent system-wide model that supports equitable access and reduces unwarranted variation, alongside sufficient local flexibility to adapt the scale, intensity and form of care to different community needs. This is central to the proposed layered model of care, in which universal prevention and self-management are complemented by enhanced, proactive support for people and communities at greater risk.

1.1 Population

CTM had an estimated resident population of 449,346 in mid-2024, equivalent to approximately 14.1% of the population of Wales. This made CTM the fourth largest of Wales's seven health boards by resident population.

During 2014-2024, CTM's population increased from approximately 435,476 to 449,346. This represents an increase of 13,870 people, or 3.2%, compared with growth of approximately 3.7% across Wales.

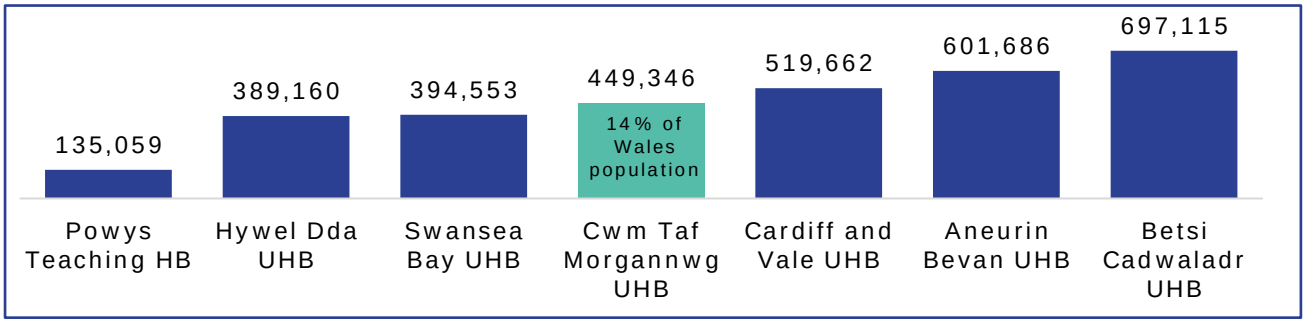


Figure 1.1.1 Mid-2024 population estimates by local health board (Wales) [1]

The population is not distributed evenly across CTM: Rhondda Cynon Taf has a larger population, meaning that it is likely to generate a higher absolute volume of activity across services. Merthyr Tydfil has the smallest population but the poorest life-expectancy outcomes within CTM. Bridgend has a smaller population than Rhondda Cynon Taf but a higher proportion of older residents. The scale, type and intensity of

[1] StatsWales(2024)

need must therefore be assessed using population volume alongside age, deprivation, morbidity, accessibility and service use.

This has an important implication for the future model: it requires a consistent system-wide approach, including common standards and more coherent pathways, but delivery cannot be uniform. The scale and emphasis of provision should be adapted to the circumstances of different communities.

This is not an argument for three separate models of care. It is a case for a single layered model that can respond proportionately to differences in population need.

1.2 Population and Ageing

In mid-2024, CTM's population included approximately 79,453 children and young people aged 0–15, 278,022 people aged 16–64 and 91,871 people aged 65 or over.

Area	Age 0–15	Age 16–64	Age 65+
Bridgend	25,369	90,414	31,747
Rhondda Cynon Taf	42,992	151,290	48,562
Merthyr Tydfil	11,092	36,318	11,562
Total Population by Age Band	79,453	278,022	91,871

Figure 1.2.1 Mid-2024 population estimates by local authority area within CTM[2]

CTM's overall age profile is broadly comparable with Wales, although it has a slightly higher proportion of children and working-age adults and a lower proportion of people aged 65 or over. In mid-2024, 20.4% of CTM's population was aged 65 or over, compared with 21.7% across Wales.[3]

The overall comparison masks important variation within CTM. Bridgend has the oldest population profile, with 21.5% of residents aged 65 or over, broadly in line with the Welsh proportion. Merthyr Tydfil has the highest proportion of children and young people, at 18.8%, compared with 17.1% across Wales, while Rhondda Cynon Taf has the highest proportion of working-age residents.

These differences indicate that CTM is responding to the national challenge of an ageing population, but that the scale and composition of need will vary locally. The future model should therefore provide a consistent offer across CTM while allowing prevention, access and service capacity to be tailored to the demographic needs of individual communities.

[2] StatsWales (2024)
[3] https://www.gov.wales/mid-year-estimates-population-2024-html

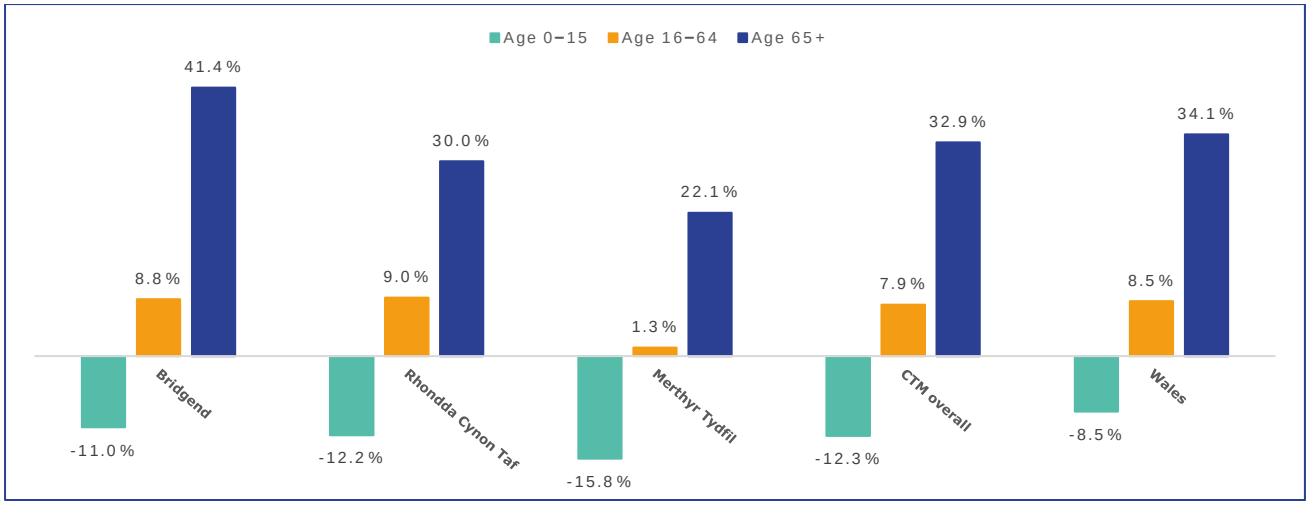


Figure 1.2.2 Population growth projections by Age band and Local Authority in CTM (Wales)[4]

Bridgend's older age profile may require a greater relative emphasis on healthy ageing and frailty prevention. Rhondda Cynon Taf may require the largest absolute volume of aged care services. Merthyr Tydfil's younger profile should not be interpreted as lower needs, as they may require a more tailored approach to child and adolescent services provision. The more significant change is projected to occur over time.[4]

A nearer-term point, such as 2032, should therefore be used for operational and capacity planning, with 2047 retained to show the longer-term strategic direction. The data shows growth among older residents is expected to be considerably greater than growth in the rest of the population.

At a population level, data shows increasing age is more likely to be associated with a higher prevalence of chronic disease, multimorbidity, frailty, dementia, sensory impairment and reliance on formal or unpaid care. The system will consequently need to support more people with several interacting needs over longer periods.

Without changes to the model of care, population changes will drive:

- Higher primary and community care demand
- More diagnostics and outpatient activity
- Greater long-term condition support needs
- More falls and avoidable hospital admissions
- Increased demand for community rehabilitation
- Longer hospital stays
- Greater pressure on carers and social care

Meeting this need through the current workforce and service model is unlikely to be sustainable. CTM will need to consider different workforce solutions, including multidisciplinary and team-based working, a broader skill mix and more flexible deployment across settings. This should be supported by models of care that identify risk earlier, coordinate support around the individual and provide more proactive care

[4] StatsWales (2022)

in people's homes and communities, while retaining access to specialist and hospital care when required.

The appropriate response is not simply to provide proportionately more of every existing service. The evidence supports stronger prevention, proactive long-term condition management and earlier identification of frailty and deterioration. It also points towards more integrated community support for people whose needs cross traditional organisational and professional boundaries.

These requirements provide an important rationale for the first three layers of CTM's future model:

- Population health and prevention
- Primary and community care
- Integrated community care services

1.3 Health outcomes

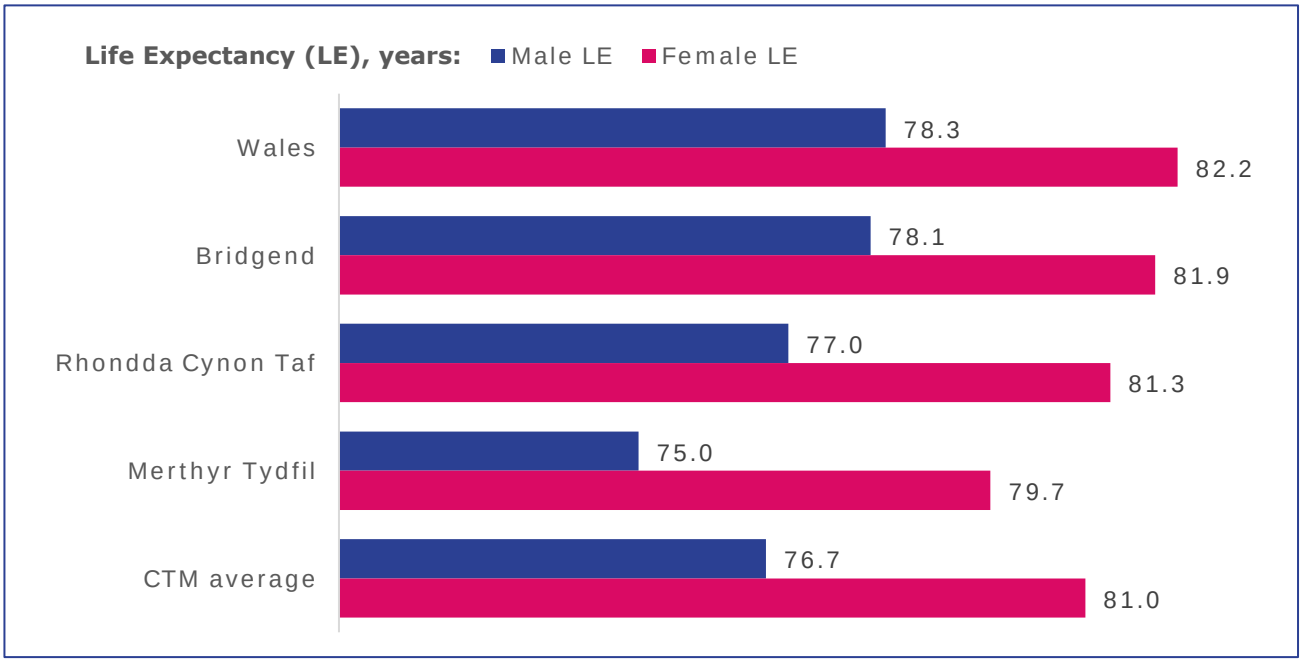


Figure 1.3.1 Average Life expectancy (years) in CTM & Wales by Age and Gender, 2022-24[5]

Population volume and age profile do not fully explain CTM's pattern of need. The bigger challenge is not only how long people live, but how many of those years they spend in good health.

In 2022–2024, healthy life expectancy in CTM was approximately 56.0 years for males and 55.0 years for females, compared with 59.2 and 58.5 years respectively across Wales. Compared with overall life expectancy, this suggests CTM residents can expect

[5] Life expectancy 2022 - 2024

to spend about 21 years in less than good health for males and 26 years for females, longer than the equivalent periods across Wales.

The position is particularly pronounced in Merthyr Tydfil, where healthy life expectancy was 51.7 years for males and 50.1 years for females. This is around seven to eight years below the Welsh position. Although women live longer than men, they are expected to spend substantially more years in poor health.

These findings point to a sustained burden of ill health rather than pressure arising due to ill health at an earlier age. Earlier onset and longer duration of poor health are likely to increase the number of people requiring ongoing support for long-term conditions, frailty and multiple interacting needs. This strengthens the case for earlier prevention, proactive risk identification, and coordinated multidisciplinary support, targeted particularly towards communities where healthy life expectancy is lowest.

1.4 Disease Profile

As of April 2024, approximately 117,306 patients registered with general practices were recorded as having or experiencing one or more mental health conditions. This represented 24.6% of registered patients, compared with 23.9% across Wales.

Several major physical health conditions also recorded a higher prevalence in CTM than the Wales average:

- Hypertension affected approximately 82,002 registered patients, representing 17.3%, compared with 16.3% across Wales
- Obesity was recorded for 16.4% of eligible patients, compared with 14.4% across Wales
- Diabetes affected approximately 35,109 patients, with a recorded prevalence of 9.0%, compared with 8.9% across Wales
- Asthma affected approximately 35,663 patients, representing 7.5%, compared with 7.1% across Wales.

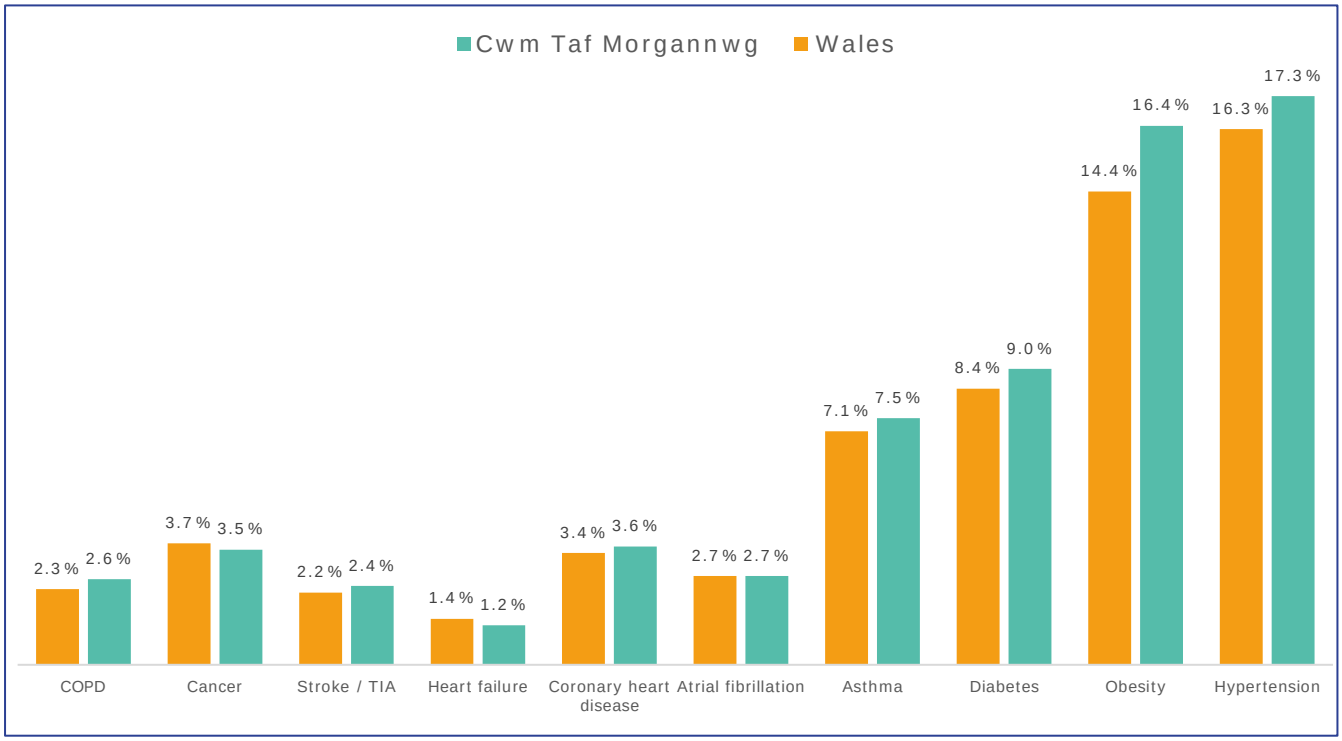


Figure 1.4.1 April 2024 Recorded prevalence of major conditions is higher in CTM than Wales[6]

CTM also recorded higher prevalence of chronic obstructive pulmonary disease (COPD), coronary heart disease, atrial fibrillation and stroke or transient ischaemic attack. The pattern was not universal: recorded cancer prevalence was slightly lower than the Wales average, while recorded dementia prevalence was broadly similar.

For example, more than 82,000 people recorded with hypertension represent a large population requiring risk management, medication optimisation and follow-up. Effective detection and control can reduce the risk of subsequent cardiovascular events, while missed diagnosis or poor control can contribute to avoidable stroke, coronary disease and hospital use. Obesity, hypertension, diabetes and cardiovascular disease also share common risks and frequently coexist. Treating them through separate, episodic pathways can create duplication and fail to address their combined effect on the individual.

The scale of recorded mental ill health is similarly important. If almost one-quarter of registered patients have a recorded mental health condition, mental health cannot be treated as a separate concern affecting only a small part of the population. It must be considered across prevention, primary care,

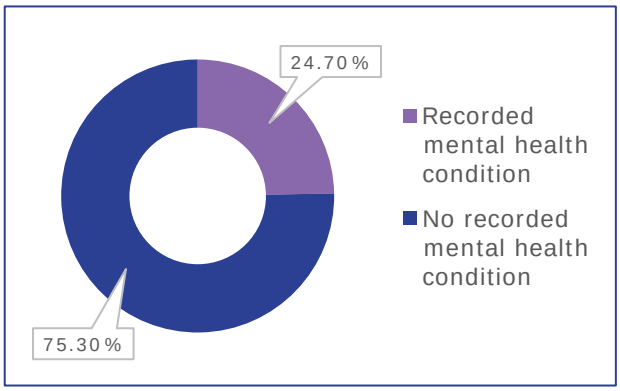


Figure 1.4.2 Recorded mental health conditions in CTM Share of GP-registered patients, 1 April 2025[7]

[6] Primary Care cluster data

long-term condition management, urgent care, and community services. Physical and mental health needs can also interact.

A mental health condition may affect a person's ability to manage medication, attend appointments, maintain employment or housing, or engage with preventive support. Conversely, living with persistent physical illness may affect mental wellbeing. The future model should therefore avoid creating artificial separation between physical and mental healthcare.

Disease-register data must be interpreted carefully. They represent diagnosed and recorded conditions among registered patients and do not show:

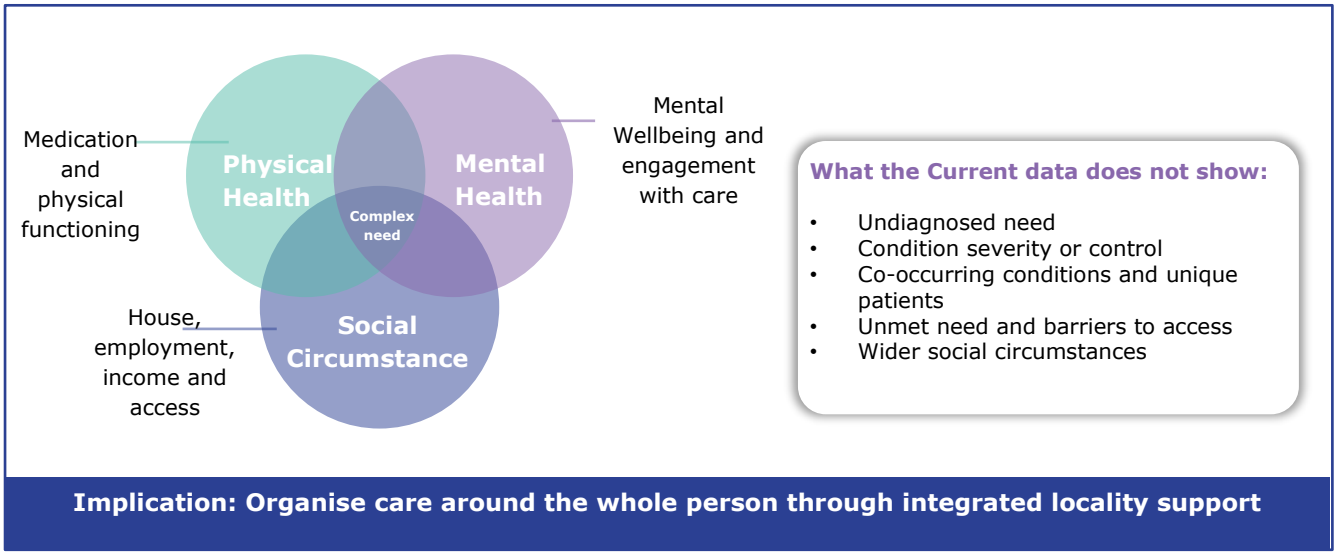


Figure 1.4.3 What Disease recorded conditions among registered patients

Individual condition counts should not be added together because the same person may appear on several registers. The figures show the scale of disease management, but not the number of people with complex needs.

Service intensity is usually driven less by a single diagnosis and more by interactions among several physical, mental, and social needs. CTM needs to understand how many people are living with multimorbidity, aged care or complex service provision, where they reside and how they currently access health services. The emerging implications and purpose of this case for change are that care needs to be planned around the person, which would then inform the revised care pathways. These points support stronger continuity of care between primary and community care, with integrated multidisciplinary support for patients with more complex needs.

Demographic and population changes, long-term illness and inequality should not be considered as separate pressures. They can interact and create a complex pattern of needs. As a result, future demand may not increase in a simple or linear way; a small increase in the number of people with complex health requirements can create disproportionate pressure across several services. Individuals may experience repeated

[7] Primary Care cluster data

assessments, multiple referrals, and duplicated appointments, causing delayed interventions due to poorly coordinated service provision.

Recorded activity may be affected and will not reflect finished or ongoing episodes of care that demonstrate underlying service enhancement needs. Lower use of a service in a community does not necessarily indicate better health or lower demand. It may reflect barriers to access, unmet need, lower diagnosis rates or reliance on informal support. Existing activity should therefore not be used as the sole basis for planning future capacity.

The changing population is likely to create pressure across the whole care continuum:

Emerging pressure	Likely implication for the model
Unequal health outcomes and preventable illness	Stronger population health, prevention and targeted early intervention
High prevalence of long-term physical and mental ill health	Accessible, continuous and proactive primary and community care
Ageing, frailty, multimorbidity and social complexity	Integrated multidisciplinary community services organised around the person
Increasing need for investigation, monitoring and planned intervention	More connected diagnostic and treatment provision, including care closer to home where appropriate
Escalation of unmet or poorly coordinated need	Protection of hospital capacity for acute, emergency and specialist care

Figure 1.5.1 Emerging pressures and likely implications on model[8]

The evidence should not be used to claim that all activity can or should move out of hospital. Some care will require continuation with acute specialty teams within high-acuity or primary care facilities. The strategic question for this case for change is which needs can be prevented, identified earlier or managed safely in a different setting, and which services must remain concentrated within hospitals.

1.5 The OECD Patient-Reported Indicator Survey (PaRIS) Findings

The OECD Patient-Reported Indicator Surveys (PaRIS) findings provide evidence on both patient-reported outcomes, including pain and quality of life, and patient-reported experiences of care, including continuity, coordination and involvement in decisions. Among participating CTM clusters, North Merthyr Tydfil and South Cynon reported the lowest quality of life and highest average pain. North Merthyr Tydfil also recorded the

[8] Tektology Analysis

highest continuity and trust in the healthcare system. However, respondents with chronic conditions in North Merthyr Tydfil were less likely to feel considered as a whole person and reported comparatively low involvement in care decisions.

These findings suggest that continuity and trust can coexist with substantial symptoms and a less positive experience of person-centred care. An established relationship with a professional does not, by itself, demonstrate that care addresses the individual's wider needs or involves them sufficiently in decisions. The response to CTM's changing population should therefore address daily functioning, independence and the outcomes that matter to individuals, alongside access and continuity. These are descriptive comparisons between participating clusters; the differences have not been statistically tested.

For service planning, recorded activity alone cannot establish whether needs are being met. People may have continuing relationships with healthcare professionals while experiencing substantial pain, poor quality of life or care that does not address their wider concerns. Increasing appointments or repeating existing patterns of follow-up may therefore provide an incomplete response. The Future Care Model should support coordinated care around the person, with meaningful involvement in decisions, shared care planning and clear responsibility for connecting the services they use.

The findings also show why Health Board-wide measures of patient-reported outcomes and experiences should be considered alongside results for individual clusters. Among respondents with chronic conditions, all Bridgend clusters and North Taf recorded the lowest continuity within CTM, while trust across participating CTM clusters ranged from 39% to 56%. CTM's overall trust score for respondents with chronic conditions was 47%, close to the all-Wales score of 46%, but below the reported OECD average of 62%. The overall result therefore conceals variation in local experience. These findings support common standards for access, quality and coordination across CTM, delivered through arrangements adapted to local population needs and circumstances. Consistency should concern the standard of care people can expect, while the location, intensity and means of delivery may differ. This reinforces the inequalities discussion that follows: population need should be understood through people's reported health and experience within communities, alongside age, population size and diagnosed conditions.

The PaRIS findings describe survey participants' responses rather than the whole CTM population; for instance, no practices from South Merthyr Tydfil participated, and differences between clusters have not been statistically tested. Therefore, interpret the findings as signals to inform future care, not as definitive rankings or evidence that particular service arrangements caused the reported outcomes.

2. Health Inequalities

2.1 Local variation

The CTM-wide position masks marked differences between places. At primary care cluster level, the proportion of residents living in communities within the two most deprived Welsh quintiles ranges from approximately 25% in Bridgend East and 29% in Taff Ely to 72% in Cynon South, 73% in Bridgend North and 80% in Rhondda.

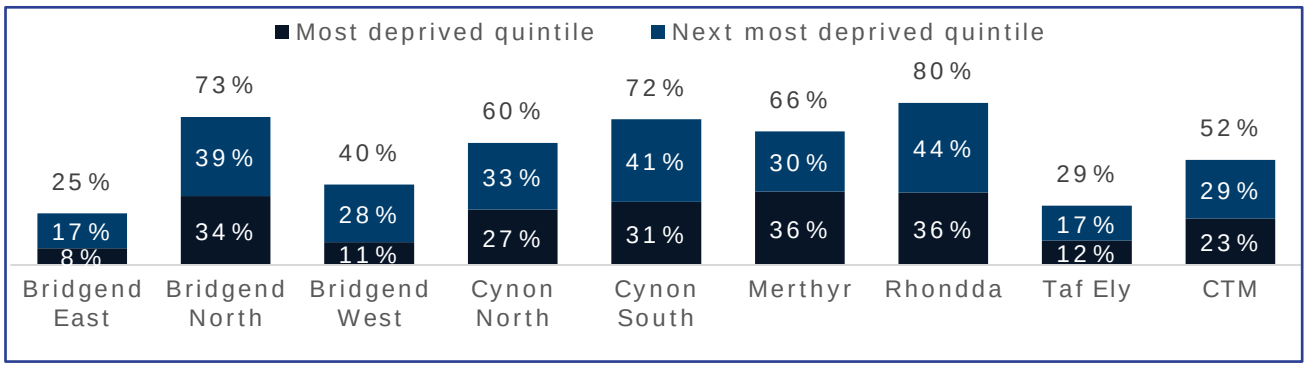


Figure 2.1.1: Proportion of residents in the two most deprived 2025 WIMD quintiles by primary care cluster[9]

Variation is also evident at local-authority level. Approximately 53% of neighbourhoods in Bridgend, 64% in Rhondda Cynon Taf and 72% in Merthyr Tydfil fall within the most deprived 50% of areas in Wales. Within Merthyr Tydfil, approximately one-third of neighbourhoods are among the most deprived 20% in Wales.

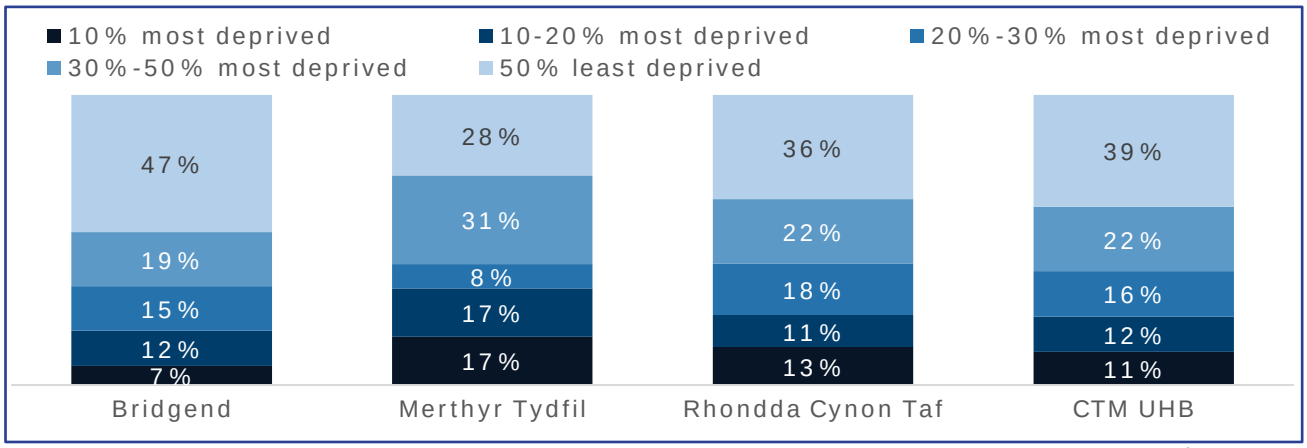


Figure 2.1.2: Distribution of neighbourhoods by 2025 WIMD groups and local authority[10]

The cluster and local-authority-level findings use different geographical units and should not be treated as directly interchangeable. The cluster analysis describes the proportion of residents exposed to deprivation within operational planning areas, whereas the local-authority analysis describes the distribution of neighbourhoods. Both nevertheless demonstrate the same strategic point: CTM-wide and local-authority averages conceal material differences within the population.

[9] WIMD(2025)
[10] WIMD(2025)

This variation has direct implications for planning and model of care development, ensuring they incorporate case mix and delivery methods in every locality. Areas with greater concentrations of disadvantage and poor health may require more intensive prevention, stronger outreach, proactive identification of need, greater support with care navigation and more accessible forms of local provision. Other areas may have requirements arising from population growth, ageing, rurality, transport or the distribution of existing services.

Deprivation should therefore inform, but not independently determine, decisions about resource allocation or service configuration. It must be considered alongside morbidity, population density, travel times, service quality, workforce availability, current capacity and patterns of utilisation. The relevant principle is proportionate universalism: a consistent offer across CTM, with the scale and intensity of support varied according to the level and nature of need.

2.2 Deprivation Concentration

Approximately 53% of CTM's population lives in communities within the two most deprived quintiles of the Welsh Index of Multiple Deprivation, compared with approximately 40% across Wales. This is the highest proportion among Wales's seven health boards and around 13 percentage points above the national benchmark. By contrast, approximately 18% of CTM's population lives in communities within the least deprived quintile.

WIMD is a relative, area-based measure. It combines evidence on income, employment, health, education, access to services, housing, the physical environment, and community safety. It does not mean that every individual living in a deprived area is deprived, nor does it capture every aspect of a person's circumstances. It nevertheless demonstrates that a comparatively large share of CTM's population lives in communities where several forms of disadvantage are concentrated.

This matters because wider socioeconomic conditions can influence health at several points. Income and employment affect the resources available to maintain health; housing and the local environment influence exposure to risk; transport and caring responsibilities affect access to services; and education, literacy and digital inclusion can influence people's ability to find, understand and act on health information. These factors do not operate independently of healthcare. They shape when people seek support, how easily they navigate services and whether they can sustain treatment or self-management over time.

A model that assumes all residents can travel, attend appointments, use digital channels, or coordinate support across multiple providers is unlikely to provide equitable access or outcomes. Care must therefore be designed around differing levels of need and barriers to access, with more intensive and accessible support available where disadvantage is greatest.

2.3 Deprivation Impacts

Deprivation can increase underlying health need while also making services more difficult to access. Relevant barriers may include:

- the cost, availability and reliability of transport;
- insecure employment or difficulty taking time away from work;
- caring responsibilities;
- unstable or unsuitable housing;
- language, literacy or communication requirements;
- limited access to digital devices, connectivity or skills;
- complex referral and appointment arrangements; and
- previous experiences or perceptions of health and public services.

The available deprivation evidence identifies where such barriers may be more likely to occur; it does not, by itself, prove that particular CTM services are inequitable or establish the size of any access gap. Assessing this will require analysis of service use, waiting times, patient experience and outcomes by locality and population group.

However, the risk has important implications for how existing activity is interpreted. Lower recorded activity in a community should not automatically be treated as evidence of lower need. It may reflect lower prevalence, but it could also reflect unmet or undiagnosed need, delayed presentation or difficulty accessing care. Conversely, higher use of urgent and emergency services should not automatically be characterised as inappropriate patient behaviour. It may indicate missed opportunities for prevention, earlier diagnosis, or planned support elsewhere.

Historic activity therefore provides only a partial basis for future models of care to inform capacity planning. It records the needs that have reached services under the current model; it does not fully reveal people who could have benefited but did not access care, entered pathways late or disengaged before completing treatment.

CTM's challenge is not simply that it serves a comparatively deprived population; deprivation and poor health are persistent, geographically concentrated and unevenly distributed across the Health Board. Local authority averages conceal marked variation; this is evident between communities, while some comparatively young populations experience substantial ill health and premature mortality. Population age alone is therefore insufficient to assess need or plan future provision.

Communities with greater underlying health need may also face greater practical, financial, transport, communication or digital barriers to accessing preventive, planned and ongoing care. The current evidence does not, by itself, demonstrate inequity within individual services. It does, however, show why historic activity cannot be assumed to represent the full distribution of need: lower use may reflect lower need, but it may also indicate unmet need, delayed presentation or difficulty accessing and navigating care.

A future model based principally on CTM-wide averages, historic patterns of service use or uniform provision could therefore perpetuate existing inequalities. CTM will need a

consistent system-wide model whose accessibility, capacity and intensity can be adapted to the level and nature of local need. This requires stronger prevention and earlier identification of risk, inclusive routes into care, accessible locality-based support, better continuity and coordination for people with interacting needs, timely responses when needs escalate, equitable access to diagnostic services, treatment and specialist hospital care.

2.4 Disadvantaged Communities

Four CTM neighbourhoods: Caerau (Bridgend) 1, Pen-y-waun 2, Penydarren 1 and Tylorstown 1 have consistently appeared among the 50 most deprived areas in Wales since 2005. Caerau (Bridgend) 1 was also among the ten most deprived areas in Wales in WIMD 2025.

Comparisons between successive WIMD editions require care because indicators, methodologies and geographical boundaries may change. The evidence should therefore not be interpreted as a precise longitudinal measure of whether deprivation within individual neighbourhoods has increased or decreased. Nevertheless, the repeated presence of these communities among the most deprived in Wales indicates that their disadvantage is deep-rooted rather than a short-term fluctuation.

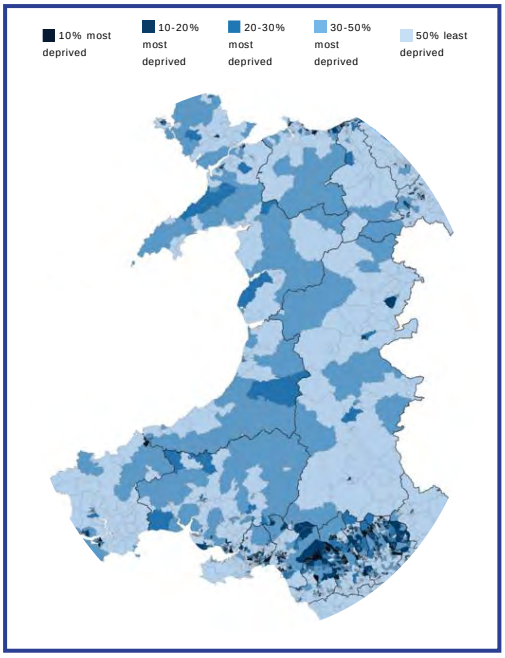


Figure 2.4.1 Distribution of inequality quintiles across Wales, 2025[11]

This has two strategic implications.

First, the associated health inequalities are unlikely to be resolved through isolated healthcare initiatives or short-term projects that do not deliver sustained improvements. Delivering service improvements will require long-term, place-based collaboration between CTM, local authorities, primary care, housing, education, wider public services, and community and voluntary organisations.

Second, persistent disadvantage strengthens the case for earlier intervention. If CTM responds principally once illness has developed or needs have escalated, it will continue to address the consequences of inequality without influencing the pathways through which poorer outcomes become established, in essence building healthier communities. The focus on preventative pathways, early-years support, proactive identification of risk and continuity of care are therefore important components of the response, even though their effects may take time to become visible in aggregate demand.

[11] WIMD(2025)

2.5 Health Inequality and Deprivation

The WIMD health domain presents an even more pronounced pattern than the overall deprivation index. Approximately 58% of CTM's population lives in communities within the two most health-deprived quintiles, the highest proportion among Wales's seven health boards. Only around 9% lives within the least health-deprived quintile.

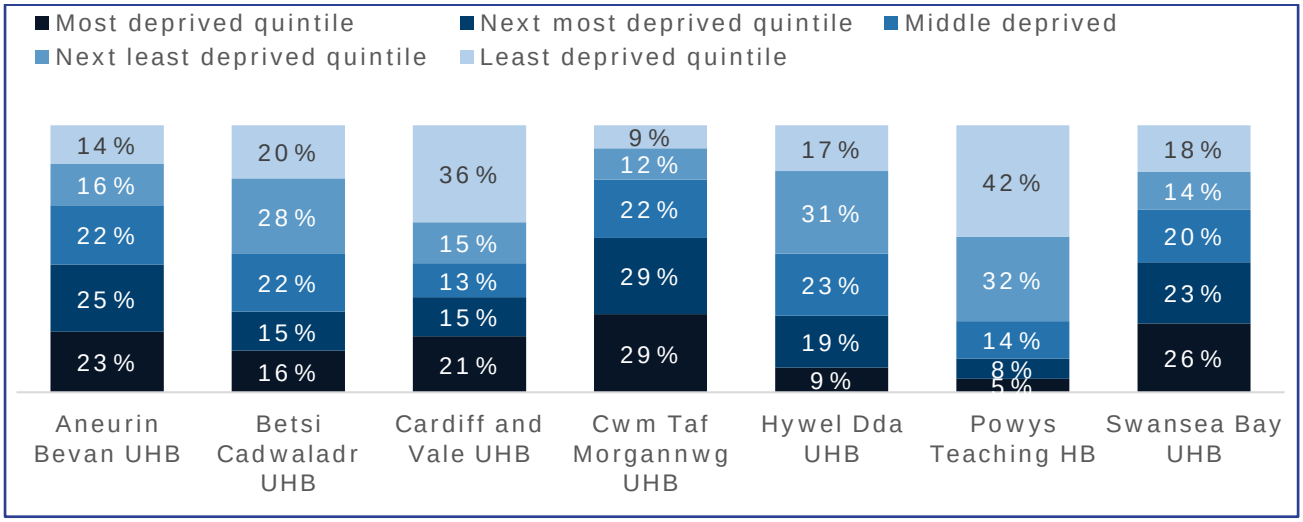


Figure 2.5.1: Proportion of the population by 2025 WIMD health-domain quintile and health board[12]

The health domain combines seven indicators covering premature mortality and aspects of physical and mental ill health. It ranks small areas according to their relative lack of good health. It does not capture every dimension of population health and cannot demonstrate that wider deprivation directly causes an individual health outcome. Some overlap may also exist between the health-domain evidence and other health measures used in this report, which should be recognised when interpreting the combined findings.

Nevertheless, the comparison is important. A greater proportion of CTM's population lives within the two most health-deprived quintiles than within the two most deprived quintiles of the overall index. This indicates that poor health is at least as geographically concentrated as wider socioeconomic disadvantage and, on the available measure, more so.

Merthyr Tydfil illustrates this relationship particularly clearly. Approximately 28% of its neighbourhoods are within the most health-deprived 10% of areas in Wales, almost three times the Welsh benchmark. Around 70% of its population lives in communities within the two most health-deprived quintiles, while none lives within the least health-deprived quintile.

This finding reinforces an important conclusion from the preceding section: a comparatively young population should not be assumed to have lower health needs. Merthyr Tydfil's profile of health deprivation, poorer life expectancy and premature

[12] WIMD(2025)

mortality indicates that substantial need can emerge earlier in life. An approach based primarily on age would therefore risk understating need in some parts of CTM.

The challenge is not confined to Merthyr Tydfil. Significant concentrations of health deprivation are also present within Rhondda Cynon Taf and Bridgend, including neighbourhoods that may be obscured by their wider local-authority averages. Planning at Health Board or local-authority level alone is therefore unlikely to provide sufficient precision.

2.6 Inequality Indicators

The individual indicators within the WIMD health domain show that inequality is not confined to a single condition, service or stage of life.

Low birth weight indicates that differences in health can emerge before birth and may be influenced by maternal health, nutrition, household circumstances, environmental exposure and access to antenatal support. Childhood obesity demonstrates that differences can become more established during early life, shaped by the interaction between family circumstances, food environments, physical activity, education and wider community conditions.

Recorded mental health conditions and chronic physical illness demonstrate substantial continuing need across adulthood. Where mental and physical health needs coexist, and particularly where they interact with insecure housing, employment, income or social circumstances, people may find it more difficult to manage medication, attend appointments or navigate multiple care pathways.

Limiting long-term illness reflects how poor health affects independence and everyday life. Cancer incidence and premature mortality point towards the cumulative consequences of exposure to risk, disease, access to care and wider socioeconomic circumstances over time.

Health indicator	Evidence across CTM
Premature mortality	**Higher premature mortality is concentrated in the northern valleys**. The highest rates occur in Plymouth 1, Tyn-y-nant 3 and Glyn-coch 1.
Limiting long-term illness	**Higher prevalence is evident in the northern valleys**. The highest rates occur in Coity Higher 1, Caerau (Bridgend) 1 and Brackla 3. Caerau 1 also experiences deep-rooted deprivation.
GP-recorded chronic conditions	**Higher prevalence is concentrated across north Bridgend, north Merthyr Tydfil and parts of Rhondda Cynon Taf**. The highest rates occur in Brackla 3, Glyn-coch 1 and Cyfarthfa 2.

Health indicator	Evidence across CTM
GP-recorded mental health conditions	**Higher prevalence is evident in north Bridgend and across Merthyr Tydfil**. The highest rates occur in Caerau 1, Sarn 1 and Brackla 3. Caerau 1 also experiences deep-rooted deprivation.
Cancer incidence	**Higher incidence occurs across Bridgend and Rhondda Cynon Taf**. The highest rates occur in Pontycymmer 2, Glyn-coch 1 and Tyn-y-nant 3.
Childhood obesity	**13.9% of CTM children aged 4–5 live with obesity**, compared with 12.8% across Wales. CTM has the joint-highest reported health-board point estimate in 2024–25.
Low birth weight	**Higher levels are concentrated in the northern valleys**. The highest percentages occur in Mountain Ash West 2, Pen-y-waun 2, and Rhydfelen Central and Llan 2. Pen-y-waun 2 also experiences deep-rooted deprivation.

Figure 2.6.1: Health Indicators and Evidence across CTMUHB, May 2026[13]

Several communities have higher prevalence/incidences across multiple indicators. While this does not establish a causal pathway, it suggests that health risks and poor outcomes overlap and are geographically concentrated rather than randomly distributed. The pattern is also consistent with the differences in life expectancy described in the preceding section.

The operational implication is that separate, episodic pathways may be poorly suited to people experiencing interacting physical, mental and social needs. A person may require clinical treatment, support with self-management, help navigating services, and coordinated input from health, social care, and community organisations. If those components are delivered independently, the individual, their family, or unpaid carers may be responsible for bringing them together.

The evidence therefore supports earlier and more continuous support across the life course. This includes maternity and early-years intervention, preventive support during childhood and adulthood, proactive management of long-term conditions and coordinated responses when needs become more complex. It does not remove the need for acute or specialist care; rather, it indicates that hospital treatment alone cannot address the conditions that lead some communities to experience illness earlier and poorer outcomes over time.

[13] *Welsh Index of Multiple deprivation (WIMD)2025 summary and selected indicator maps, published by CTM UHB Public Health team, May 2026*

3. Demand

Demographic change, long-term illness and inequality should not be considered as isolated pressures. They can interact and create more complex patterns of need.

An older person may be living with several long-term conditions alongside reduced mobility, social isolation, unsuitable housing or dependence on an unpaid carer. A working-age adult with a mental health condition may also have diabetes or cardiovascular risk, affecting their ability to work and manage their health. A child growing up in deprivation may experience physical and mental health needs that continue into adulthood.

As a result, future demand may not increase in a simple or linear way. A comparatively small increase in people with complex, poorly coordinated care and support can create disproportionate pressure across several services.

There may also be a difference between recorded activity and underlying need. Lower use of a service in a community does not necessarily indicate better health or lower demand. It may reflect barriers to access, unmet need, lower diagnosis rates or reliance on informal support. Existing activity should therefore not be used as the sole basis for planning future capacity. The changing population is likely to create pressure across the whole care continuum:

Emerging pressure	Likely implication for the model
Unequal health outcomes and preventable illness	Stronger population health, prevention and targeted early intervention
High prevalence of long-term physical and mental ill health	Accessible, continuous and proactive primary and community care
Ageing, frailty, multimorbidity and social complexity	Integrated multidisciplinary community services organised around the person
Increasing need for investigation, monitoring and planned intervention	More connected diagnostic and treatment provision, including care closer to home
Escalation of unmet or poorly coordinated need	Protection of hospital capacity for acute, emergency and specialist care

Figure 3.1.1 Emerging pressures and likely impact on model[14]

3.1 Ambulance activity

Ambulance data provides an important indication of pressure at the interface between the community, ambulance services and urgent and emergency care. Compared with Wales, CTM has a broadly similar overall distribution of ambulance calls, but a greater proportion is categorised as red. As of 2025, within CTM, the number of red calls has increased materially since 2021, despite reductions in amber and green activity.

[14] Tektology Analysis

This indicates the challenge is not simply increasing call volumes. The composition of recorded ambulance activity has shifted, with a larger share requiring the most urgent response.

In the first six months of 2025, approximately 17% of CTM ambulance calls were categorised as red, compared with around 15% across Wales. This was among the highest proportions recorded by Welsh health boards and broadly comparable with Swansea Bay.

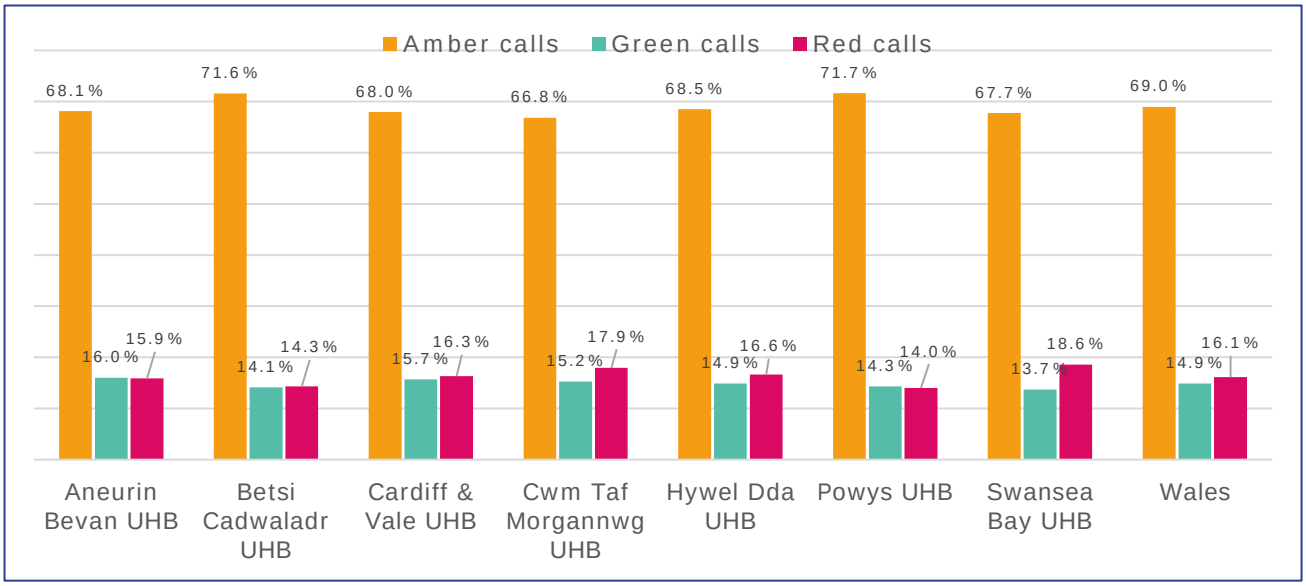


Figure 3.1.1 Distribution of Ambulance Calls by category for each Health Board and All Wales (2025)[15]

Red - Immediately life-threatening (someone is in imminent danger of death, such as a cardiac arrest); there is a target for 65%of these calls to have a response within 8 minutes.

Amber - Serious but not immediately life-threatening (patients who will often need treatment delivered on scene and may then need to be taken to hospital). There will be no time-based target for amber calls; instead, a range of clinical outcome indicators will be introduced to measure safety and quality outcomes.

Green - Non-urgent (can often be managed by other health services) and clinical telephone assessment. There is no official time-based target for these calls.

Amber calls accounted for approximately 69% of CTM's activity, close to the Welsh position of 70%. Green calls represented approximately 14%, slightly below the 15% recorded across Wales.

The difference between CTM and Wales is small, but it suggests that CTM's ambulance activity is somewhat more heavily weighted toward the highest-acuity category. This comparison describes the composition of activity rather than its overall scale. It does not demonstrate that CTM has a higher volume of ambulance demand relative to its population. Differences between health boards may also be influenced by population

[15] StatsWales Ambulance Data 2026

health, deprivation, age, access to other urgent-care services, geography and call categorisation.

CTM's response performance has improved and moved closer to the Welsh position

Between 2021 and 2024, the percentage of CTM red-call responses arriving within eight minutes remained below the Welsh position. CTM's performance fell from about 52% in 2021 to around 44% in 2022 and remained similar through 2024. Over the same period, the Welsh position was generally between 49% and 58%.

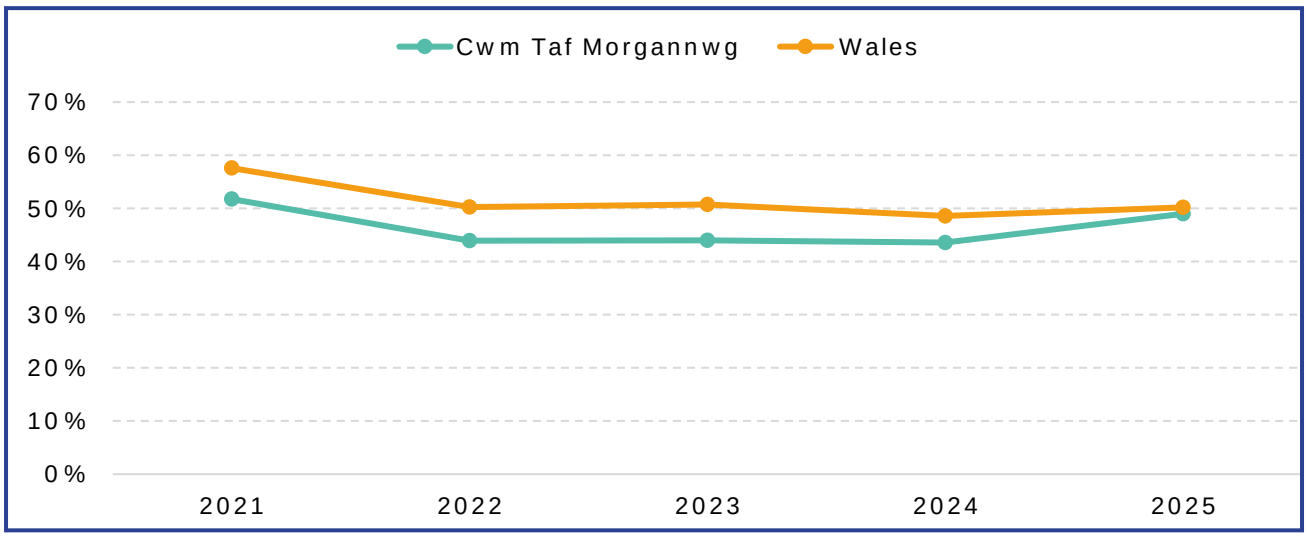


Figure 3.1.2 Annual average percentage of red-call responses arriving within eight minutes, CTM and Wales, (2021–2025)[16]

In the first six months of 2025, CTM's position improved to approximately 49%, narrowing the gap with Wales to around one percentage point.

The improvement is positive, particularly given the comparatively high proportion of red calls. However, the overall position remains challenging as approximately half of CTM's highest-priority calls did not receive a response within eight minutes.

Response performance cannot be attributed to ambulance capacity or call volumes alone. It is influenced by the number and location of available crews, travel time, concurrent incidents, time spent with patients, conveyance patterns and delays in transferring patients into hospital care. The available data show ongoing operational pressure but do not determine where, within the wider urgent and emergency-care pathway, the principal constraints arise.

The increase in red calls is a sustained change in CTM's activity profile

Within CTM, overall ambulance activity has not increased uniformly. Between 2021 and 2024, amber calls reduced from approximately 44,000 to 37,000, while green calls fell

[16] StatsWales Ambulance Data 2026

from approximately 11,000 to 8,000. In contrast, red calls increased from approximately 6,000 to 9,000, an increase of around half.

The 2025 figures cover January to June and must not be compared directly with the completed annual totals for 2021–2024. Nevertheless, approximately 5,000 red calls were recorded during the first six months of 2025, compared with around 9,000 for the full year 2024. This suggests that red-call activity remained elevated.

Monthly data indicate that higher red-call activity has persisted

Monthly red-call volumes increased progressively between 2021 and 2024. In 2024, activity remained above the corresponding levels in most earlier years and increased sharply during autumn and winter, from about 670 calls in August to more than 900 in December.

The first six months of 2025 remained elevated. Monthly red calls ranged from approximately 680 to 880 and were consistently above the corresponding months in 2021–2023. Taken together, the first half of 2025 was also slightly above the first half of 2024.

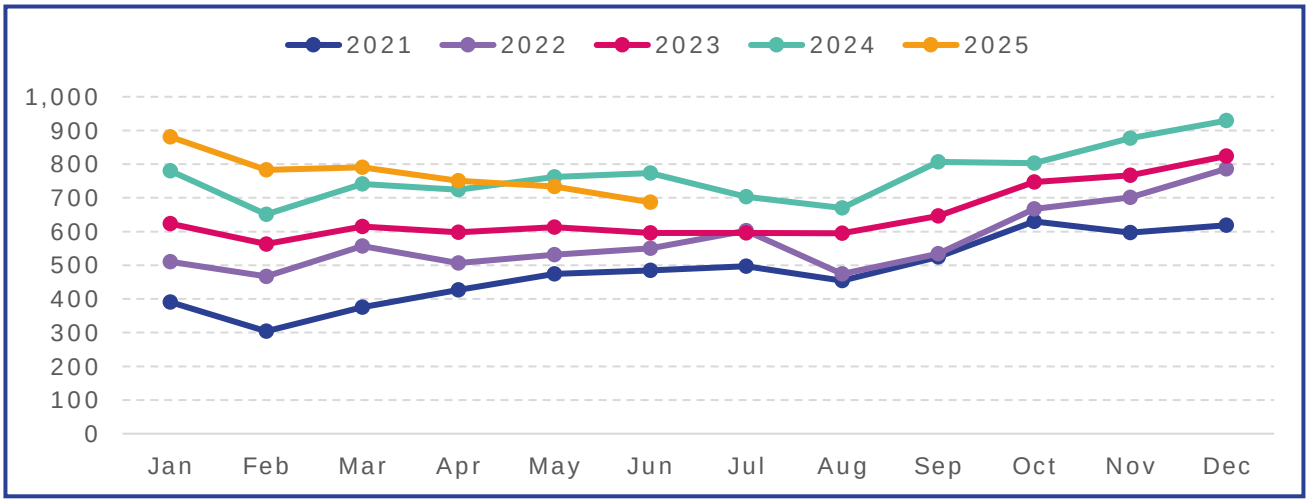


Figure 3.1.2 CTM monthly red calls by year (2021- June 2025)[17]

The evidence indicates that CTM's challenge is not simply overall ambulance demand; it is the increasing concentration of activity within the most acute category and the wider urgent and emergency care system's ability to respond reliably.

The future model will need to support earlier recognition and management of deterioration, timely access to urgent community and clinical assessment, and safe alternatives to ambulance conveyance where these are appropriate to patients' needs. It must also support effective hospital handover and flow so that ambulance resources remain available to respond to emergencies.

[17] StatsWales Ambulance Data 2026

3.2 Emergency-care performance points to wider patient-flow pressure[4]

Pressure is also evident within urgent and emergency care. CTM's mean time in emergency departments remained above the Welsh average for most of the period between January 2024 and June 2026, with the gap widening during the first five months of 2026.

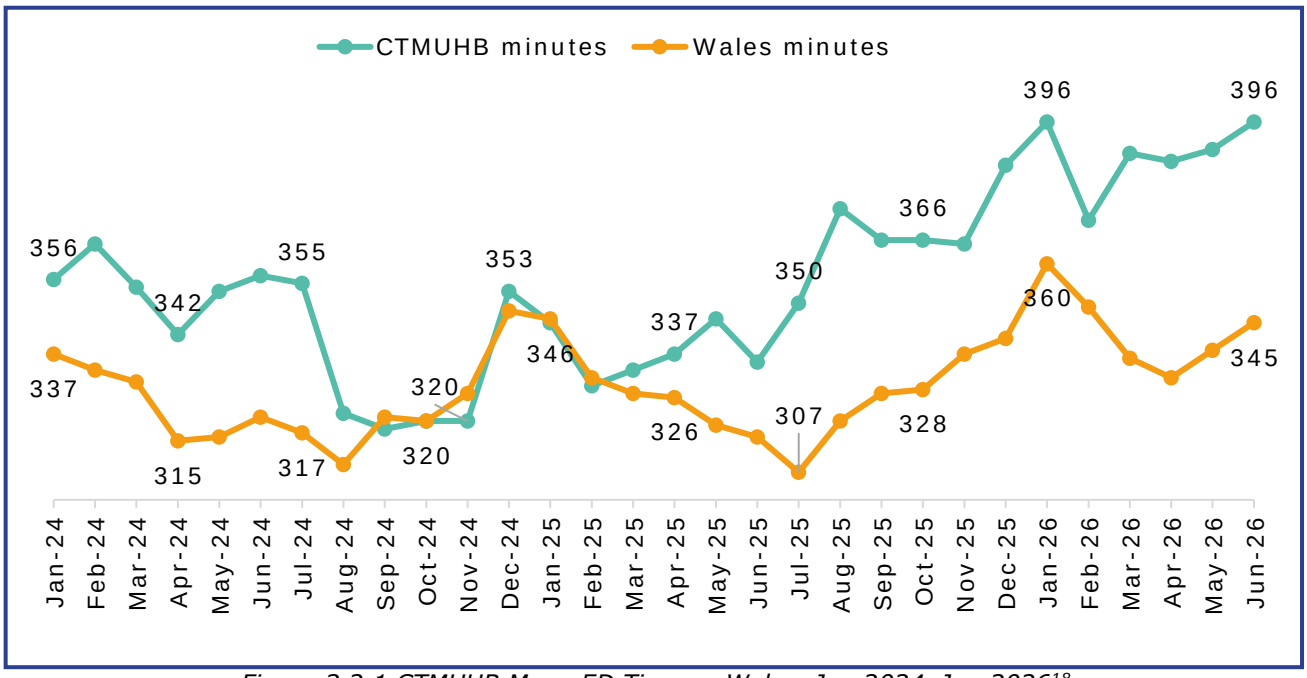


Figure 3.2.1 CTMUHB Mean ED Time vs Wales, Jan 2024–Jun 2026[18]

Longer emergency-department times may therefore reflect constraints across the wider urgent and emergency-care pathway, but the available chart does not establish which factors are driving CTM's position. Further analysis is required to distinguish pressure arising before arrival, within the emergency department and after a decision to admit. This represents a considerable patient-experience and operational concern. However, mean time in an emergency department does not reveal where or why delays arise. It can be influenced by the number and acuity of attendances, ambulance arrivals, staffing, diagnostic turnaround, clinical decision-making, access to specialist assessment, inpatient bed availability and the ability to discharge or transfer patients to other community or support services.

The response should therefore not be limited to increasing emergency-department capacity or assuming that changes elsewhere will resolve the problem.

Where clinically appropriate, timely virtual, locality and community urgent responses may help people receive support before their needs escalate or provide alternatives to hospital attendance and admission. However, CTM must also ensure acute assessment services and inpatient pathways have sufficient capacity and capability to provide safe, timely care for patients who clinically require a hospital response.

18 StatsWales (2024 Onwards)

The evidence demonstrates sustained operational pressure across planned and urgent care, although the form and causes of that pressure differ between pathways. Reported outpatient referrals increased materially in 2025 and have remained elevated. CTM continues to carry substantial diagnostic and Referral-to-Treatment (RTT) waiting lists, while patients are spending longer in emergency departments than the Welsh average.

These findings should not be interpreted as a single, proven sequence in which rising outpatient referrals have directly caused diagnostic backlogs or emergency-care delays. The available evidence does not yet determine whether the principal constraints arise from changing population need, access, capacity, productivity, pathway design, patient flow or a combination of these factors. Comparisons between health boards also require adjustment for population, service configuration, case mix and cross-boundary activity.

Nevertheless, the evidence indicates that CTM cannot assume its existing capacity and delivery arrangements will absorb current and future pressures. The future model will need to identify and manage need earlier where clinically appropriate, provide effective routes to advice and assessment, improve referral quality and navigation, and ensure timely access to diagnostic and treatment capacity. It must strengthen alternatives to emergency attendance and admission, improve flow into, though, and out of hospital, and retain sufficient acute and specialist capacity for patients whose needs require it.

These findings provide important design requirements for CTM's emerging model of care, but they do not determine the appropriate balance of capacity, workforce or investment between its layers. That will require pathway-level analysis connecting demand, access, activity, conversion rates, waiting times, outcomes, workforce, productivity, capacity and cost. CTM will also need to distinguish the immediate action required to address existing backlogs and operational pressures from the longer-term transformation intended to moderate future demand and prevent avoidable escalation.

3.3 Diagnostic Wait Times

Timely access to diagnostics is critical to earlier diagnosis, clinical decision-making and the progression of patients through planned-care pathways. Delays can postpone treatment, extend uncertainty for patients and create additional workload where people require further review while waiting.

CTM's diagnostic waiting-list position has varied materially since August 2024. The proportion of pathways waiting more than eight weeks initially fell, then increased again during 2025. Pressure is also unevenly distributed: radiology, endoscopy and cardiology account for most of the recorded waiting list, while the location to which pathways are attributed varies considerably between services.

This data describes the number of open diagnostic pathways at the end of each month. They do not directly measure diagnostic demand because the size and age of the waiting list reflect the combined effect of new requests, completed tests, pathway validation and other removals.

In August 2024, approximately 38% of CTM's diagnostic pathways had been waiting more than eight weeks. This proportion fell during the following months, reaching approximately 16% in March 2025. The improvement was subsequently reversed: the proportion waiting over eight weeks increased to around 30% by May 2025 and approximately 40% in both August 2025 and September 2025.

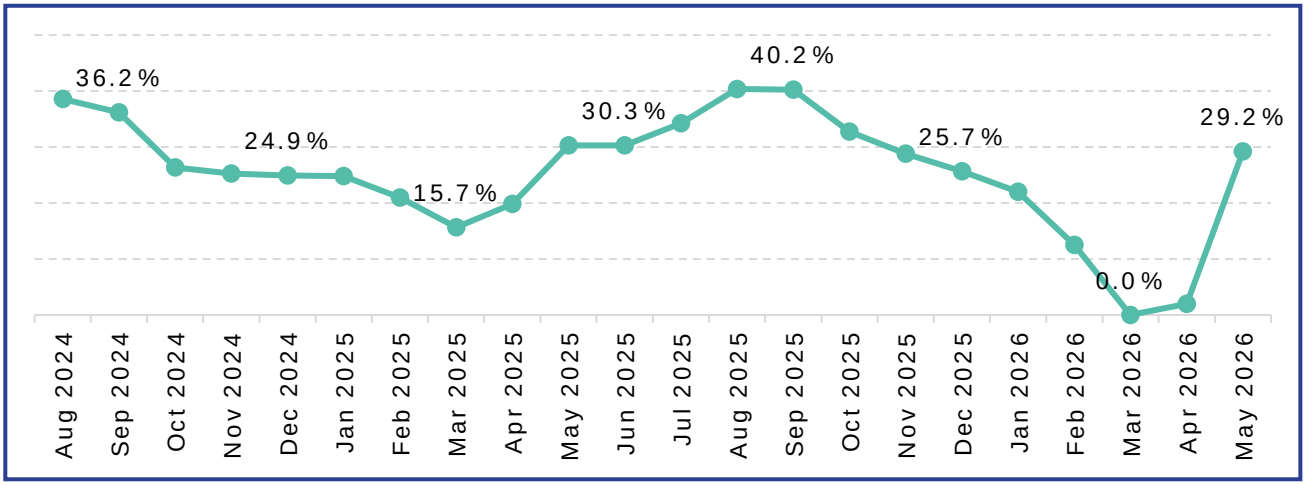


Figure 3.3.1 Percentage of CTM diagnostic pathways waiting over eight weeks (Aug'24 to Apr'26)[19]

The position improved again in late 2025 and early 2026, with the proportion waiting over eight weeks falling to about 22% in January 2026 and 12% in February 2026. The trajectory to February 2026 nevertheless shows volatility rather than sustained resolution of diagnostic pressure. Periods of improvement were followed by renewed increases, meaning that a sustained reduction in long waits had not yet been demonstrated.

The reported fall to near zero waiting over eight weeks in March 2026 and April 2026, followed by an increase to approximately 29% in May 2026, should not be interpreted as a genuine operational improvement followed by sudden deterioration. StatsWales identifies a data-quality issue affecting CTM's non-obstetric ultrasound pathways from March 2026, with the figures expected to be revised. As ultrasound may represent a material part of CTM's diagnostic waiting list, the aggregate position for March–May 2026 is not sufficiently reliable to support conclusions about recent performance.

CTM's diagnostic waiting list is not evenly distributed between services. Radiology pathways associated with consultant referrals accounted for approximately one-third to two-fifths of the total waiting list during most of the period shown, making this the largest recorded service group. Radiology pathways arising from GP referrals generally represented a further fifth to one-third of the list.

Taken together, the two radiology categories therefore accounted for more than half of CTM's recorded diagnostic waiting pathways during much of the period.

[19] StatsWales (2024 Onwards)

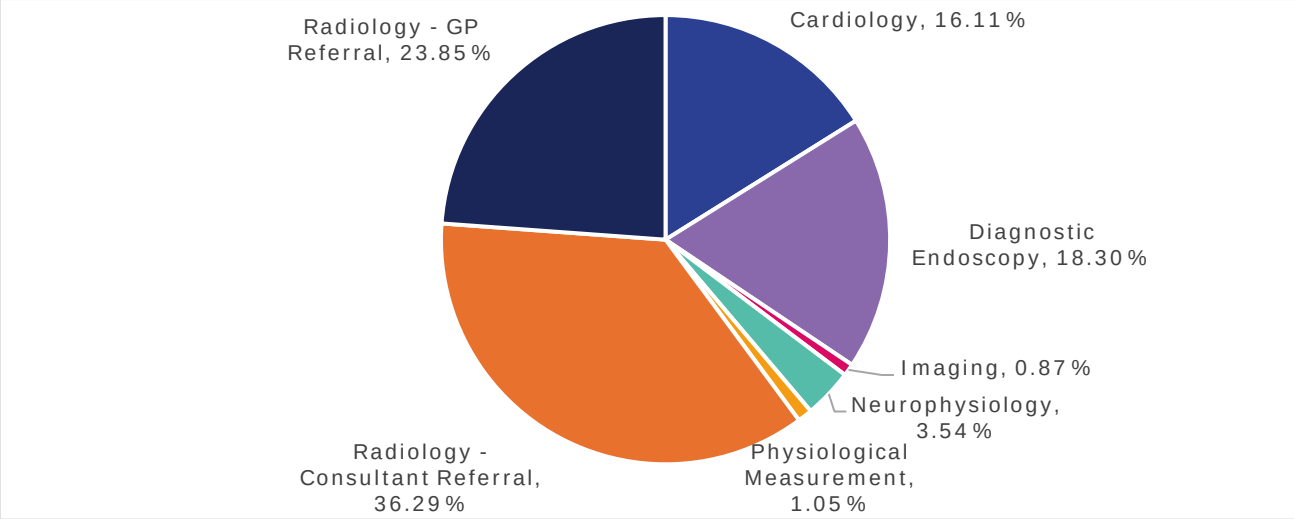


Figure 3.3.2 Composition of CTM's diagnostic waiting list by service group: Percentage share of total pathways waiting, August 2024 to May 2026[20]

Diagnostic endoscopy and cardiology represented the next-largest components. Endoscopy's share generally ranged from about 15% to 25%, while cardiology varied more noticeably, declining in the first half of 2025 before rising again in early 2026. Neurophysiology, physiological measurement and the remaining imaging category accounted for much smaller shares of the aggregate list.

The concentration of pathways within a limited number of services is strategically important. It suggests that CTM's diagnostic challenge cannot be addressed through a single, general capacity increase. Different diagnostic services depend on different combinations of equipment, facilities, specialist workforce, reporting capability and preparation or recovery arrangements. The causes of waiting-list pressure and the feasible responses will therefore need to be assessed at modality and pathway level.

The composition chart describes each service's share of the total list, not the severity of waits within that service. A large share may reflect a high underlying volume of appropriate diagnostic activity, while a smaller service may still have a high proportion of patients experiencing long waits. The analysis should therefore be supplemented by the total number and percentage waiting over eight weeks within each service.

The March–May 2026 composition should also be treated cautiously because the known ultrasound data issue may distort both the recorded radiology position and the calculated percentage shares of every other service.

Llantrisant Health Park has provided CTM with a major injection of diagnostic capacity to support patients' diagnostic pathways. This is further supported by an analysis of capacity modelling and a business case outlining this capability and service provision.

Recorded waiting pathways are distributed unevenly across CTM sites

The site-level findings highlight that pathways waiting over eight weeks are concentrated in different locations depending on the diagnostic service and

[20] StatsWales (2024 Onwards)

operationalisation. Prince Charles Hospital and the Bridgend site category account for substantial proportions of longer-waiting pathways across several services, while other locations contribute more narrowly.

This variation should not be interpreted as a straightforward comparison of site performance. CTM sites have different service portfolios, catchment populations, equipment, workforce and referral arrangements. Some diagnostics may operate through Health Board-wide waiting lists even where pathways are administratively attributed to a particular location.

The site analysis provides a basis for assessing whether CTM's diagnostic capacity could operate as a more coordinated network. Potential mechanisms include greater visibility of available capacity, integrated scheduling, shared waiting-list arrangements and offering suitable patients access to appointments across sites. Any approach must consider clinical suitability, patient choice, travel times, transport availability and the accessibility of services for communities facing the greatest barriers to care.

The future model will need to provide timely and equitable access to diagnostics across hospital and community settings. This may include stronger referral pathways, coordinated use of capacity across existing sites and, where clinically appropriate, delivery through community diagnostic facilities. CTM must also retain sufficient acute and specialist diagnostic capability for patients who require hospital-based provision.

3.4 Referral to Treatment Wait List

CTM has made material progress in reducing its referral-to-treatment waiting list[21]. The average number of open pathways fell from approximately 109,900 in Q3 2024 to 2,900 in Q2 2026, a reduction of around 25%. The improvement has been sustained across successive quarters and accelerated during late 2025 and early 2026.

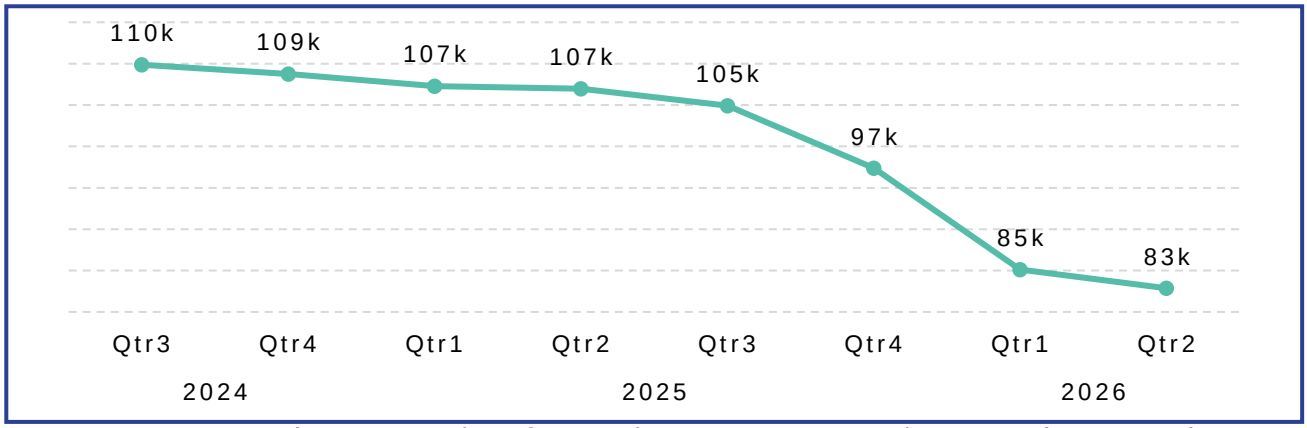


Figure 3.4.1 (Average number of RTT pathways waiting in CTM by quarter (2024–2026)

[21] StatsWales Waiting List (2024 Onwards)

This progress is significant, but the remaining planned-care backlog is substantial. More than 82,000 open pathways remained as of May 2026.

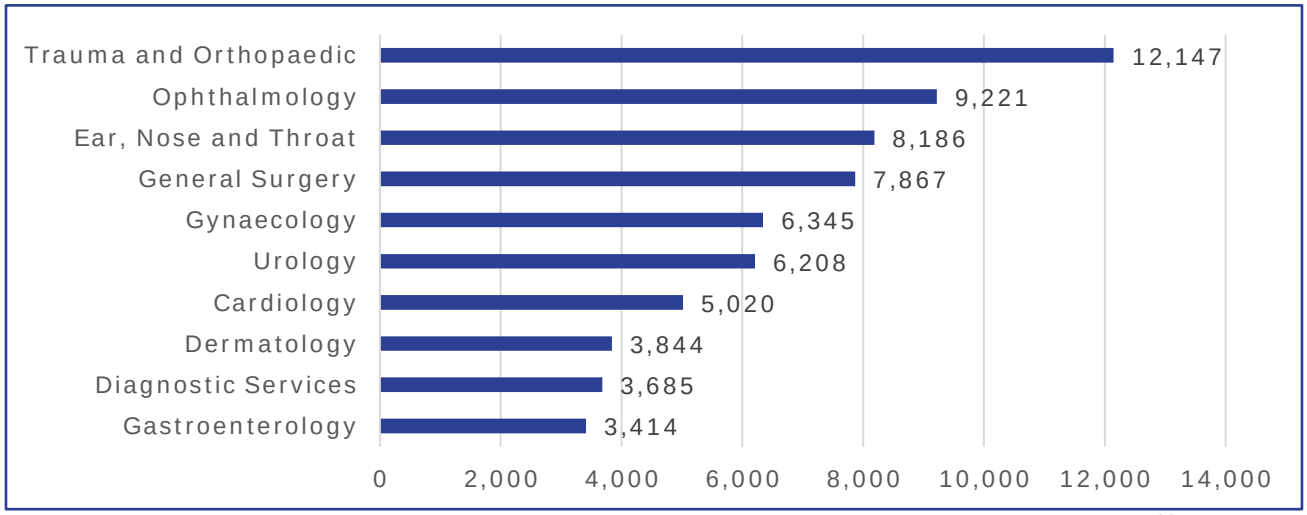


Figure 3.4.2 Top ten specialties by number of CTM RTT pathways waiting, May 2026[22]

Open pathways pressure is concentrated in a relatively small number of specialties. Trauma and orthopaedics had the largest list in May 2026, followed by ophthalmology, ear, nose and throat, general surgery, gynaecology and urology. Together, the ten largest specialties accounted for approximately four-fifths of CTM's open pathways.

The concentration of the waiting list indicates that a single organisation-wide intervention will not resolve the remaining challenge. Different specialties are likely to face different combinations of outpatient, diagnostic, workforce, theatre, treatment and follow-up constraints. The pathway response will therefore need to be tailored to the source of pressure within each service.

CTM has demonstrated that it can reduce its RTT waiting list; however, planned-care pressure remains concentrated in several high-volume specialities. The immediate priority is to sustain the progress achieved so far while addressing long waits and the specific constraints affecting the largest pressured services. The reduction in the overall list is encouraging and will continue to reduce long waits from the waitlists. This is supported by a recent capacity provision by Llantrisant Health Park, with capability mapping and a business case to support further service provision for CTM patients and families.

The future model of care will support more effective referral, diagnostic and treatment pathways while retaining sufficient specialist capacity to meet the needs of people already waiting. This Case for Change is heavily supported by the Strategic Vision and Clinical Service Plan to deliver CTM's vision of 'Building Healthier Communities Together' and will provide early intervention and alternative pathways helping to manage and reduce avoidable pathway additions, where clinically appropriate.

[22] StatsWales Waiting List (2024 Onwards)

3.5 Mental Health

The available evidence describes different parts of CTM's mental health pathway. Referral activity represents the volume entering local primary and mental health support services; assessment timelines indicate how promptly part of that demand is being addressed; and the secondary mental health caseload reflects the continuing responsibility for people receiving more specialist support. Care and Treatment plan coverage provides a further measure of recorded care coordination.

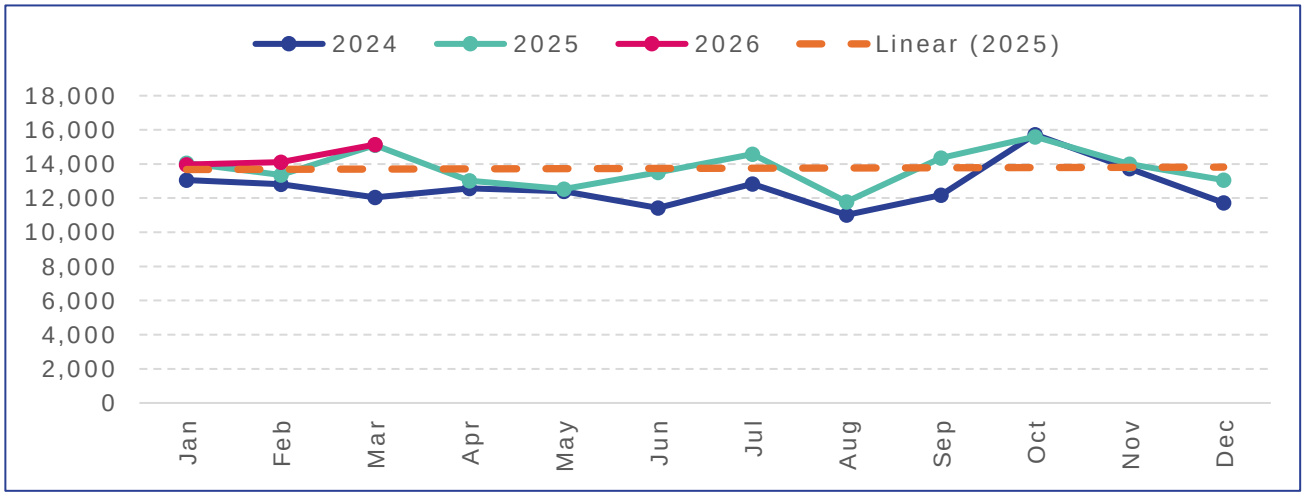


Figure 3.5.1 CTM year-on-year secondary mental health caseload (Jan 2024–Mar 2026)[23]

These measures should not be added together or interpreted as representing a single population. Nor do they establish a simple sequence in which referral volumes directly cause changes in waiting times or secondary care activity. Taken together, however, they provide evidence about the scale of activity, consistency of access and the continuing support required across the pathway.

Referral volume is not, by itself, a measure of mental health prevalence or unmet need. It may be influenced by population need, awareness, access arrangements, referral practice and service configuration. Nevertheless, it has immediate operational significance because CTM must assess new referrals while continuing to support people already within mental health services.

CTM recorded substantial monthly Local Primary Mental Health Support Service (LPMHSS) referral activity throughout 2024 and 2025. Referrals for mental assessment and services ranged between approximately 11,000 and 16,000 per month. The pattern does not show uninterrupted growth. It shows a consistently high level of activity with meaningful month-to-month variation. The available 2026 series covers only January to March and should not be compared with a full calendar year; however, activity during the opening three months indicates that the volume of referrals entering the pathway has remained substantial.

The variation between months is operationally important. Assessment capacity must respond to shorter-term changes in referrals as well as the underlying level of demand.

[23] StatsWales Mental Health Data

Planning around an annual average alone may conceal the pressure experienced during higher-volume months.

The data does not demonstrate whether individuals were referred more than once, the complexity of their needs or the proportion progressing into treatment. Further analysis is required to link referral volumes, including duplication, to unique patients, caseloads, workforce, assessment activity, treatment capacity, and outcomes.

Referral volume alone also does not determine assessment timelines. CTM's monthly trend indicates that the percentage of LPMHSS assessments completed within 28 days generally improved through parts of 2024 and 2025. Performance increased from the lower levels recorded in early 2024 and was often higher in 2025, although meaningful month-to-month variation remained.

This shows that CTM has achieved stronger assessment timeliness. However, it does not establish that the improvement was consistently sustained or identify the operational factors that supported the stronger periods. Variability may reflect changes in referral demand, workforce availability, assessment capacity, case complexity, cancellations, pathway design or recording practice.

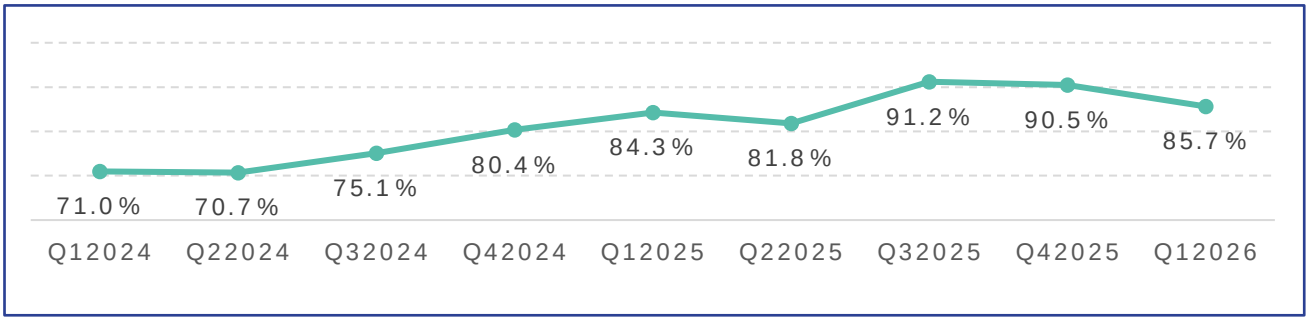


Figure 3.5.2 Percentage of CTM LPMHSS assessments completed within 28 days[24]

The latest health board comparison requires closer examination. In March 2026, 51% of CTM LPMHSS assessments were reported as completed within 28 days, compared with 85% across Wales. CTM's reported percentage was also below each of the other health boards shown.

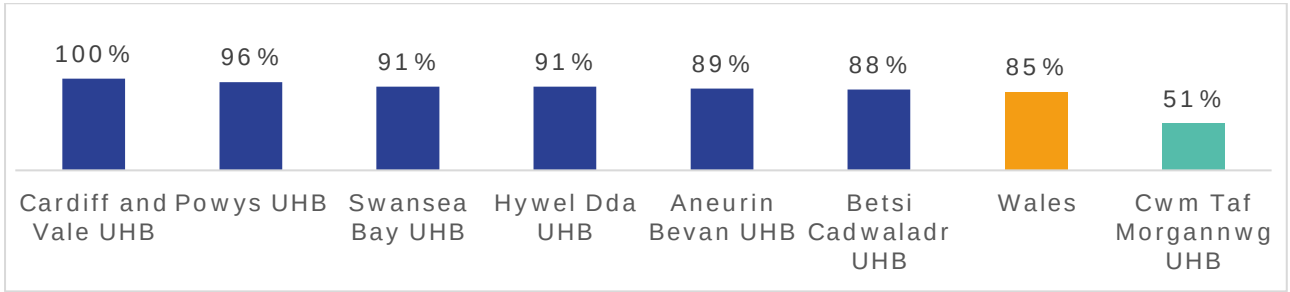


Figure 3.5.3 LPMHSS assessments completed within 28 days by Health board (March 2026) [25]

This represents an important access and operational concern. However, a single monthly comparison should not be interpreted as evidence of permanent deterioration

[24] StatsWales Mental Health Data
[25] StatsWales Mental Health Data

or as a complete assessment of CTM's mental health services. Comparisons between health boards may also be affected by population need, case mix, workforce, service configuration and recording practice. Mental Health and Learning Disabilities Care Group is working on a broader focus on data reporting issues, which will be resolved in the future.

The March 2026 value must be reconciled with the CTM time series before the latest position can be described definitively, because the two charts currently appear to report different results for the same month and indicator.

The 28-day measure also has limitations. It does not show how long people waited beyond the threshold, whether performance differed between localities or population groups, or what happened after assessment. Timely assessment matters, but it does not, by itself, demonstrate timely access to treatment or improved patient outcomes.

The evidence therefore shows substantial and variable referral activity alongside changes in assessment timeliness, but it does not yet establish the relationship between them. CTM will need to understand whether the latest position represents a short-term fluctuation, pressure concentrated within particular teams or localities, or a more sustained pathway constraint.

The secondary mental health caseload provides a different perspective on demand. It records the number of people receiving secondary mental health services at month-end rather than the number of new referrals received. It measures ongoing service responsibility rather than new activity entering the pathway.

The recorded secondary mental health caseload reduced during 2024, from approximately 2,320 people in January to around 2,140 by the end of the year. It then remained comparatively stable during 2025, generally fluctuating between approximately 2,130 and 2,160 people. The available January to March 2026 data continues to show a caseload of approximately 2,100 people.

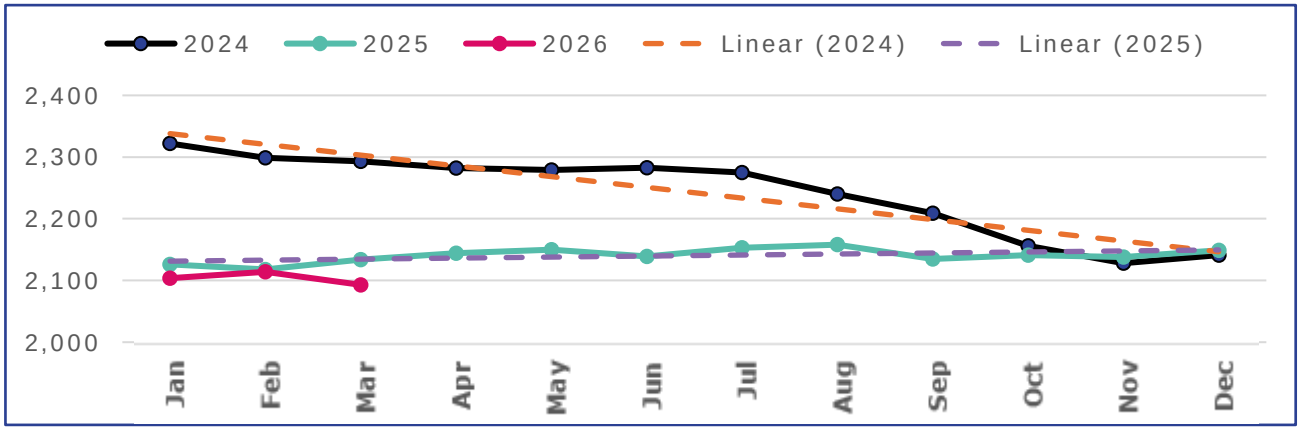


Figure 3.5.4 CTM year-on-year secondary mental health caseload (January 2024–March 2026) [26]

The reduction during 2024 should not be interpreted as evidence of lower underlying need or reduced workload. Caseload size can be affected by admissions, discharges,

[26] StatsWales Mental Health Data

transfers, pathway thresholds, service capacity, length of involvement and recording practice. The total does not reflect the severity or complexity of need. Two caseloads of the same size may require very different levels of clinical input depending on people's condition, risks, social circumstances and the intensity of support required. A comparatively stable caseload can coexist with changing pressure on individual teams. There was further variation by age. In March 2026, 99% of CTM patients aged 18 had a valid care and treatment plan, compared with 88% of patients aged 18 and over. Overall, across all services and ages, the rate was also 88%, reflecting the greater weight of adults within the secondary mental health population.

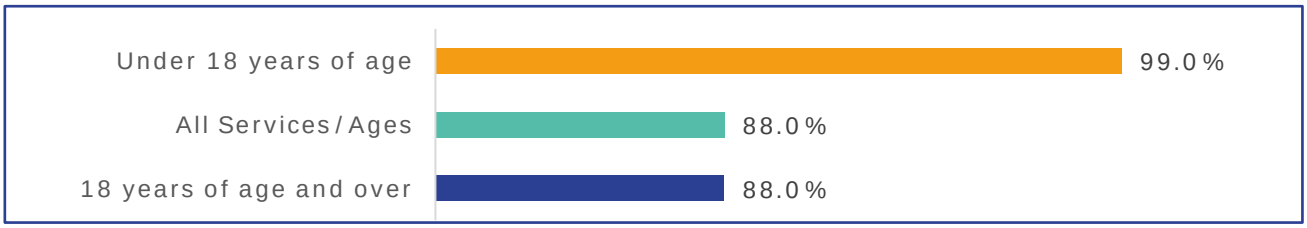


Figure 3.5.6 Percentage of CTM secondary mental health patients with a valid Care and Treatment Plan by age group (March 2026) [27]

The three proportions on the chart represent the separate rates within each population group and are not intended to add up to 100%. The higher recorded coverage for patients under 18 may indicate more consistent recording. However, the chart does not show the number of patients behind each percentage. A relatively small denominator could lead to greater percentage volatility from a small number of cases.

Differences between children's and adult services, eligibility criteria, pathway arrangements and recording practice should also be considered before drawing conclusions about the observed variation. Further analysis should examine whether the variation is persistent and whether valid plans are reviewed, shared and acted upon consistently.

The strategic implication is that CTM needs to consider flow and continuity alongside the absolute number of people receiving care. A sustainable pathway must support timely transitions into, through and from secondary services while maintaining continuity for people with persistent or complex needs. The relationship between primary and secondary mental health activity also requires further examination.

The available charts do not show how many LPMHSS referrals subsequently enter secondary services; how long people remain within each part of the pathway or whether delays arise when people move between services. Without this information, referral volumes and secondary caseloads should not be interpreted as a single measure of demand. This aligns with the emerging model's emphasis on coordinated support and timely escalation, without suggesting that specialist services will become less necessary.

[27] StatsWales Mental Health Data - 2

CTM's significance does not rest solely on being three percentage points above the Wales average. The secondary mental health caseload represents more than 2,000 people who may require coordination across mental health, primary care, community care and social care. Valid plans provide a potential foundation for that coordination, but their practical value depends on their quality and implementation.

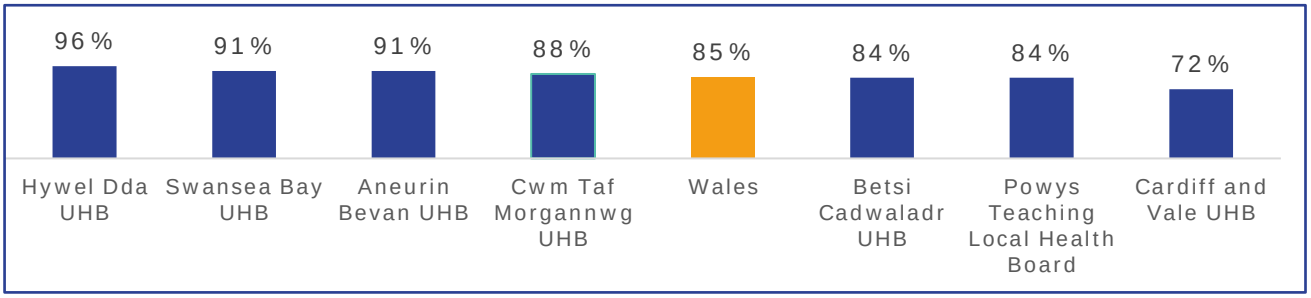


Figure 3.5.5 Percentage of secondary mental health patients with a valid Care and Treatment Plan by health board, March 2026[28]

The evidence therefore identifies an existing strength to build on. The opportunity is not simply to increase recorded coverage, but to ensure care plans actively support continuity, multidisciplinary working, and care organised around the individual.

The evidence presents a mixed but coherent picture. CTM is managing substantial and variable LPMHSS referral activity. Assessment timeliness improved during parts of the period but has not been consistently stable, and the latest comparative position requires validation and closer examination. At the same time, secondary services continue to support a substantial ongoing caseload, while recorded care and treatment plan coverage is above the Wales average.

These findings should not be interpreted as a proven sequence in which higher referral activity has directly caused lower assessment performance or increased pressure within secondary care. The datasets describe different stages of the pathway and do not show how individual patients move between them.

The longer-term requirement is to develop a pathway that identifies need earlier, provides effective navigation, strengthens continuity and coordinates support around the individual. These requirements align with the direction of CTM's emerging model without determining how capacity, workforce or investment should be distributed across it.

[28] StatsWales Mental Health Data - 2

3.6 Primary and community care

Primary and community care encompasses general practice, community pharmacy, dentistry, optometry, district nursing, community mental health services and the wider multidisciplinary teams supporting people outside hospital. Collectively, these services provide first-contact care, prevention, diagnosis, treatment, continuing support and care in people's homes and communities.

These services are particularly important for CTM because a substantial proportion of its demand is recurring, complex and shaped by long-term conditions and health inequalities. Strong primary and community care can identify risk earlier, maintain continuity and manage more needs locally, where clinically appropriate, reducing the likelihood that patients deteriorate or avoid hospital care where their needs can be met safely elsewhere.

The evidence indicates that CTM has important primary and community assets, but their ability to support a substantial shift from hospital-led care varies. General practice records comparatively high appointment activity per resident and manages a persistent volume of chronic, planned and non-acute appointments. Although the clinical skill mix has broadened, GPs and independent prescribers still deliver most appointments for which the practitioner type is identifiable. This does not establish that the current distribution is inappropriate, but it highlights the importance of ensuring that each need is addressed by the most appropriate professional.

CTM's comparatively dense community-pharmacy network and broad service availability provide a strong platform for resolving more needs locally through integrated access, triage and referral pathways. Dental services also reach a comparatively large share of the population through a practice base that has remained static, reinforcing the importance of prevention and sustainable use of existing provision. Community optometry resolves some episodes outside hospital, although recorded activity remains concentrated on referral filtering rather than continuing community monitoring.

The workforce position is more constrained. CTM's recorded district-nursing workforce has remained broadly static, meaning that a substantial expansion of home-based care cannot be assumed without additional capacity or changes in delivery. Community mental health nursing remains above the Wales population-adjusted rate, but its workforce has declined while the corresponding workforce across Wales has grown. Taken together, the findings identify valuable community assets but also show that supporting a substantial change in where and how care is delivered will require coordination, appropriate investment and workforce development.

The case for change is therefore not simply to increase activity within each service independently. CTM needs an integrated, locality-based model that connects these capabilities through shared pathways, multidisciplinary working and coordinated responsibility for defined populations. This would enable earlier identification and resolution of needs, extend specialist support into community settings, and focus hospital capacity on patients requiring acute or complex specialist care.

3.6.1 Primary care is absorbing substantial recurring demand, but activity alone does not demonstrate proactive care

General practice provides a principal point of contact for immediate health concerns, long-term condition management and planned care outside hospital. The volume and composition of appointments indicate the scale of recorded primary-care activity and how it is distributed across the general-practice clinical team.

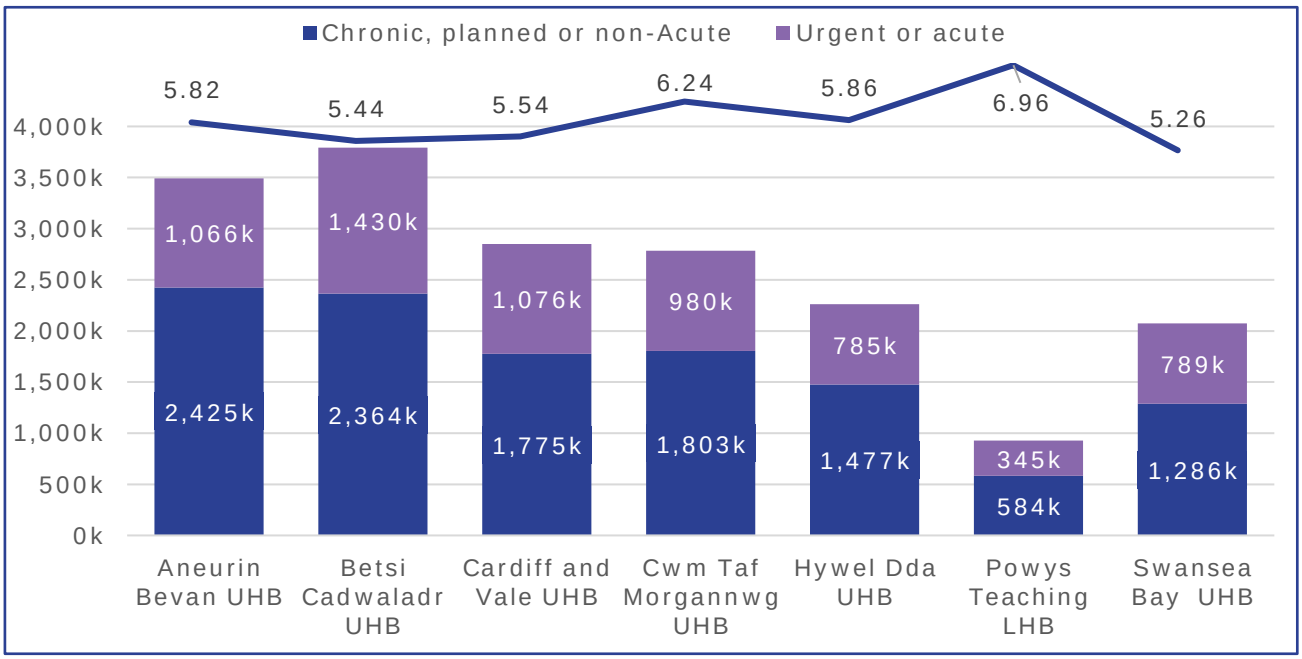


Figure 3.6.1 Number of general practice appointments by reason across LHBs and appointments per resident, 2024-25[29]

The nature of this workload matters. While total recorded appointments fell by about 5.9% between 2022–23 and 2024–25, chronic, planned, and non-acute appointments remained broadly unchanged at about 1.8 million. Their share of appointments consequently increased from 61% to 64%. Primary care is therefore managing a large, persistent ongoing need rather than demand dominated by isolated acute episodes. Around 1% of appointments were unmapped.

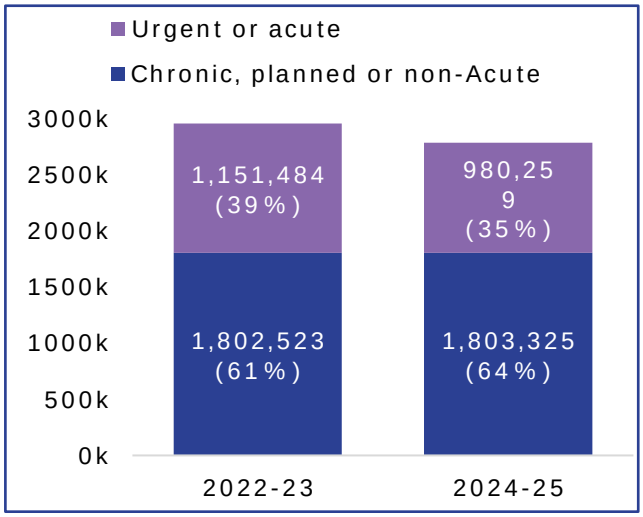


Figure 3.6.2 Number of appointments by reason at CTMUHB 2022-23 to 2024-25[31]

[29] StatsWales estimated number of GP appointments

[30] StatsWales estimated number of GP appointments

Delivery of appointments across the clinical team has broadened. Appointments delivered by nurses, allied health professionals and other clinical roles increased by 6.8%, from approximately 858,000 to 916,000. Their share of appointments with an identifiable practitioner type increased by approximately four percentage points. GPs and independent prescribers nevertheless delivered 57% of all recorded appointments in 2024–25, or about 63% of appointments for which practitioner type was identifiable. Practitioner type could not be identified for approximately 10% of appointments.

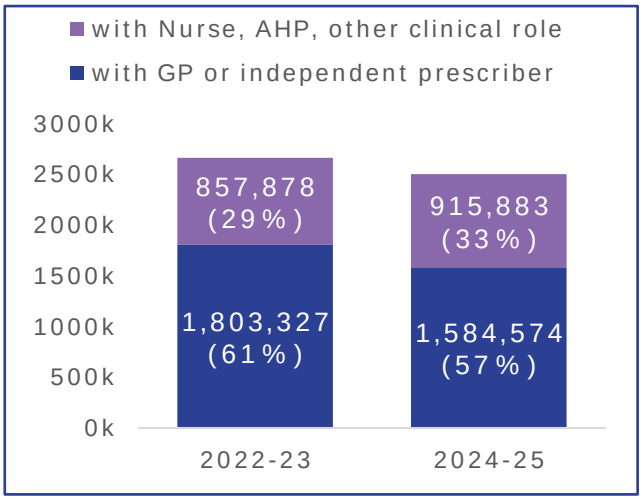


Figure 3.6.3 Number of appointments by practitioner type at CTMUHB 2022-23 to 2024-25[32]

The case for change is therefore not simply to create more appointments. Persistent ongoing need requires care organised around people's longitudinal needs, supported by locality-based multidisciplinary teams, proactive risk identification, and greater support for self-management. The broader clinical team should be enabled to address appropriate needs directly, allowing GP capacity to focus on diagnostic uncertainty, multimorbidity and clinical complexity.

3.6.2 CTM has one of Wales's strongest community-pharmacy platforms for distributed care

CTM's community-pharmacy network compares favourably with other Welsh health boards on both physical availability and breadth of service provision.

As of 2024-25, CTM has approximately one pharmacy per 4,122 residents, compared with one per 4,618 across Wales. This represents around 12% greater pharmacy availability per resident and is the second-highest pharmacy density among the seven health boards.

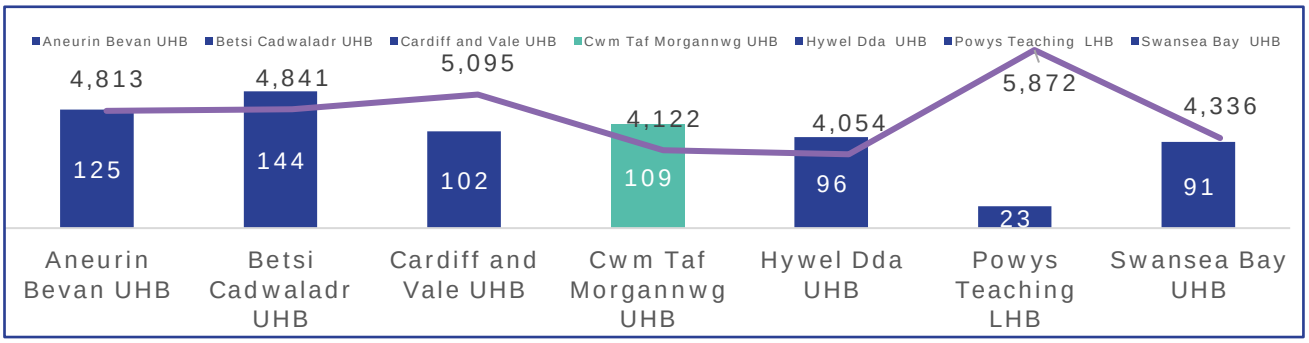


Figure 3.6.4 Number of community pharmacies, number of residents per pharmacy, 2024-25[32]

[31] StatsWales estimated number of GP appointments
[32] StatsWales number of community pharmacies

Each CTM pharmacy provides an average of 16.1 recorded services, compared with 14.2 across Wales. CTM ranks second only to Powys on this measure and is approximately 13% above the Welsh average. When network density and service breadth are combined, CTM has one recorded pharmacy service for every 256 residents, compared with one for every 325 across Wales, the strongest overall provision rate among the seven health boards.

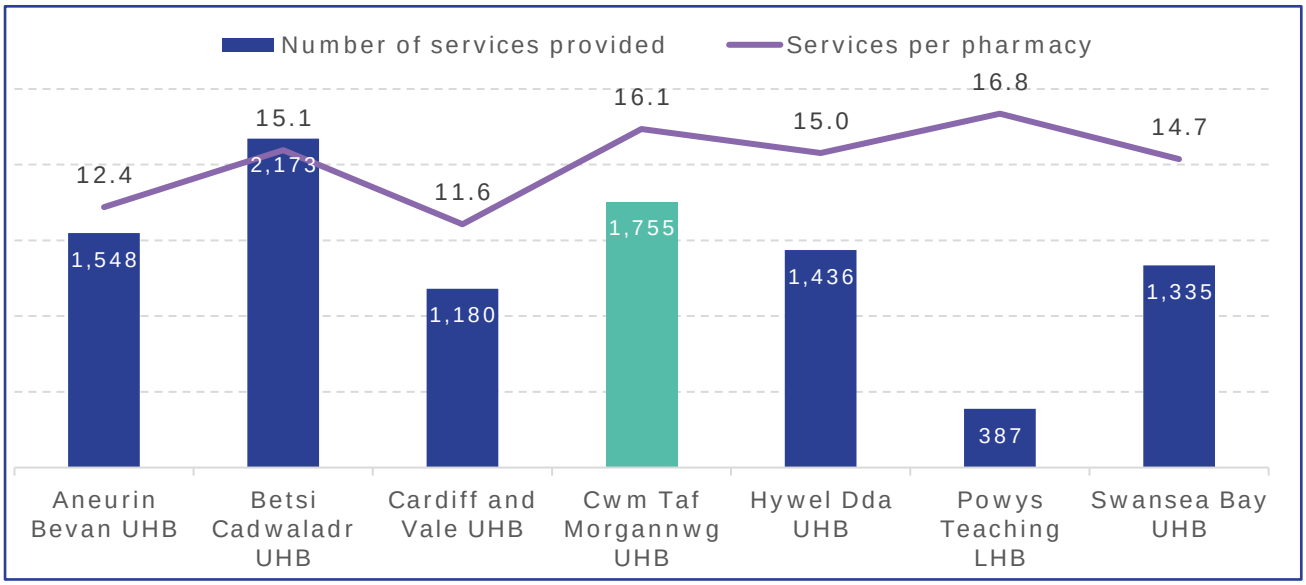


Figure 3.6.5 Number of pharmacy services and number of services per pharmacy, 2024-25[33]

The evidence identifies community pharmacy as an existing infrastructure strength. CTM has a relatively dense network offering a comparatively broad range of recorded services. This provides an established platform through which more minor-illness care, preventive support, medicines management and selected prescribing activity could be delivered closer to home where clinically appropriate.

However, service availability does not demonstrate that these services are being fully used or that they are resolving demand elsewhere in the system. CTM also records above-average general practice appointments per resident; this may reflect its greater underlying health need and does not, by itself, demonstrate insufficient pharmacy use. It nevertheless raises an important question about whether community pharmacy is sufficiently integrated into access, triage and referral pathways to resolve more appropriate demand outside general practice and hospital settings.

The case for change is therefore not primarily about expanding the overall number of pharmacy locations. It is about connecting CTM's comparatively strong network to a coordinated model of care through shared triage, clearer referral routes, broader access to independent prescribing and appropriate access to patient information. This would enable community pharmacies to address more suitable needs directly and allow GP and hospital capacity to focus on patients requiring more complex assessment or treatment.

[33] StatsWales number of services provided by pharmacies

3.6.3 CTM dental services reach a comparatively large population through a static practice base

Dental services are already delivered through a distributed network of community practices. The number of patients treated indicates the reach of this network, while the number of practices provides a broad measure of the physical capacity through which care is delivered.

In the period ending March 2025, approximately 221,800 patients were treated by NHS dental services in CTM. This was the fourth-highest aggregate volume among the seven health boards, reflecting differences in population size. Relative to population, CTM treated about 49.4 patients per 100 residents, compared with 42.5 across Wales. CTM had the second-highest treatment rate after Aneurin Bevan. CTM's practice base remained unchanged at 56 practices between 2022–23 and 2024–25. Over the same period, the number across the seven health boards fell from 434 to 407. Stability therefore distinguishes CTM from the contraction seen elsewhere, but it does not indicate expansion in response to changing need.

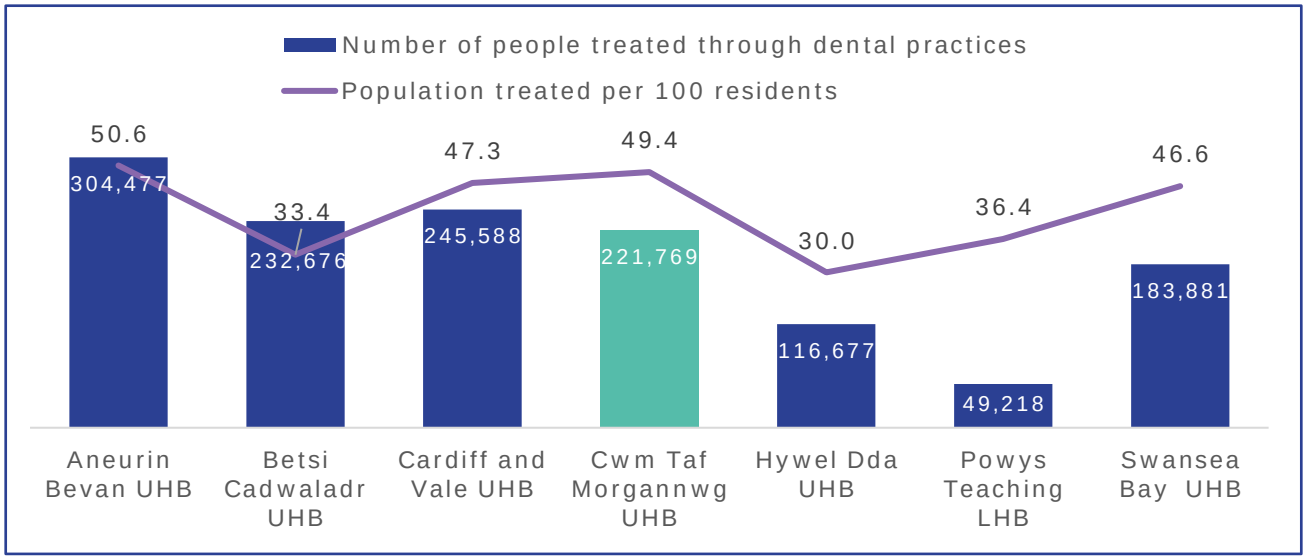


Figure 3.6.6 Number of patients treated by dental practices and number of patients treated per 100 population, 2024-25[34]

Each CTM practice treated approximately 3,960 patients, around 19% more than the Welsh average and the second-highest level among the health boards. This could reflect comparatively strong utilisation and treatment reach. However, it also indicates that each practice delivers a relatively large volume of care, potentially leaving limited headroom to absorb additional demand or expand preventive activity.

[34] StatsWales number of services provided by pharmacies

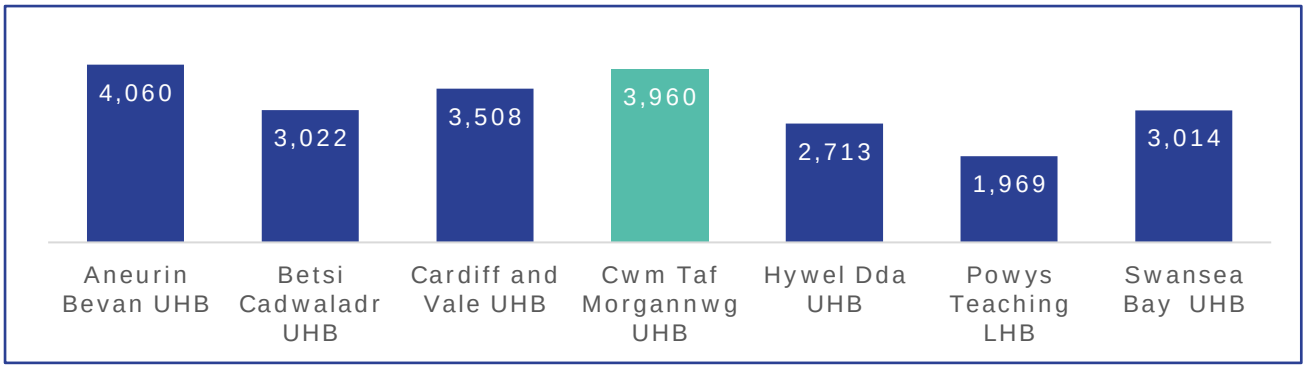


Figure 3.6.7 Number of patients treated per dental practice, 2024-25[35]

The evidence demonstrates the reach of decentralised dental delivery: CTM's community dental network records treatment for a comparatively large share of its population, predominantly outside hospital settings. The case for change is to maintain this community footprint and connect dental services more effectively with wider prevention, primary care and locality-based pathways. This could support earlier identification and management of oral health risks and reduce the likelihood of progression to more complex treatment. However, the number of practices and patients treated does not establish how much additional capacity exists, and CTM should not assume that future need can be met simply by increasing activity within the current practice base.

3.6.4 Community optometry is preventing some hospital referrals, but ongoing monitoring remains underdeveloped

Community optometry enables enhanced eye assessment, referral refinement and monitoring to be delivered closer to home. It provides a practical example of specialist capability being delivered through primary and community care rather than exclusively within hospital settings.

CTM recorded 317 enhanced community optometry appointments in 2024–25. Of these, 93 resulted in discharge, and 12 continued within community optometry. Together, 105 appointments, or 33.1%, concluded without hospital referral. This shows the pathway resolved some recorded episodes outside hospital, but it does not establish that every episode would otherwise have entered hospital eye-care services. Betsi Cadwaladr and Powys recorded no activity under this measure in 2024–25, limiting direct comparison across all seven health boards.

CTM's discharge rate was comparatively strong: 29.3% of appointments resulted in discharge, compared with 21.3% across Wales. However, 66.9% were referred to hospital, substantially above the Welsh figure of 48.0% and the highest rate among the five health boards reporting activity.

[35] StatsWales number of patients treated by dental practices

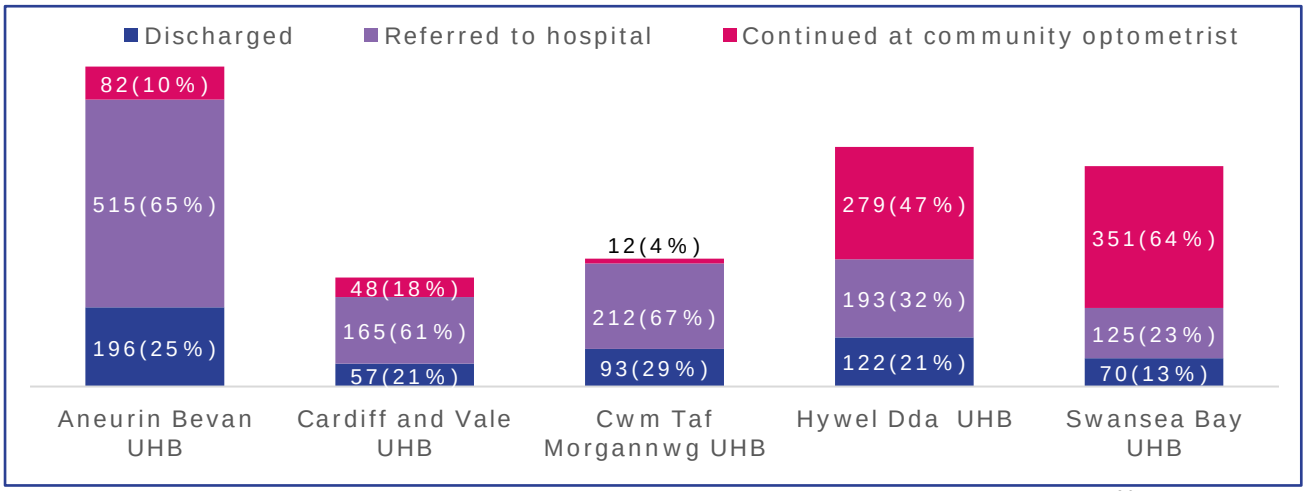


Figure 3.6.8 Number of optometry appointments WGOS4 by reason, 2024-25[36]

The most pronounced difference between CTM and Wales was the proportion of appointments resulting in continuing community management. This outcome applied to 4% of CTM appointments, compared with 31% across Wales. CTM's recorded activity therefore appears to be used primarily to determine whether hospital referral is required, rather than to retain patients for continuing management outside hospital.

This pattern is also reflected in appointment purpose. Of CTM's 317 appointments, 315 were recorded as referral filtering and only two as monitoring. Monitoring therefore represented 0.6% of CTM activity, compared with 16.9% across Wales. CTM's recorded activity is consequently concentrated on referral refinement rather than a broader community role encompassing ongoing monitoring.

CTM's recorded hospital-referral rate of 67% was above the Wales rate, but this does not necessarily indicate inappropriate referral. The difference may reflect patient complexity, eligibility criteria, commissioning arrangements, pathway maturity or recording practice.

Nevertheless, the evidence shows that community optometry can safely resolve some demand that would otherwise reach hospital. CTM can build on this existing capability by developing appropriate monitoring pathways, strengthening links with hospital ophthalmology and enabling more stable patients to remain under community care.

Community optometry already provides CTM with a working example of distributed specialist care, but its current role remains narrow. Expanding community monitoring would allow more suitable patients to receive ongoing care closer to home, while reserving hospital eye-care capacity for people requiring specialist investigation or treatment.

[36] StatsWales number of WGOS4 appointments

3.6.5 District-nursing capacity has remained flat despite its growing role in care at home

District nurses provide clinical care in patients' homes and community settings. Their work includes wound care, medicines support, long-term condition management, assessment of deterioration, palliative care and support following hospital discharge. They are therefore essential to reducing avoidable hospital use and enabling patients to return home sooner.

CTM's relevant community-nursing workforce has remained broadly unchanged. Headcount moved from 78 in March 2022 to 77 in March 2026, while FTE declined from 76.3 to 75.0. In March 2026, CTM had approximately 16.7 FTE per 100,000 residents, slightly below the Welsh level of 17.4.

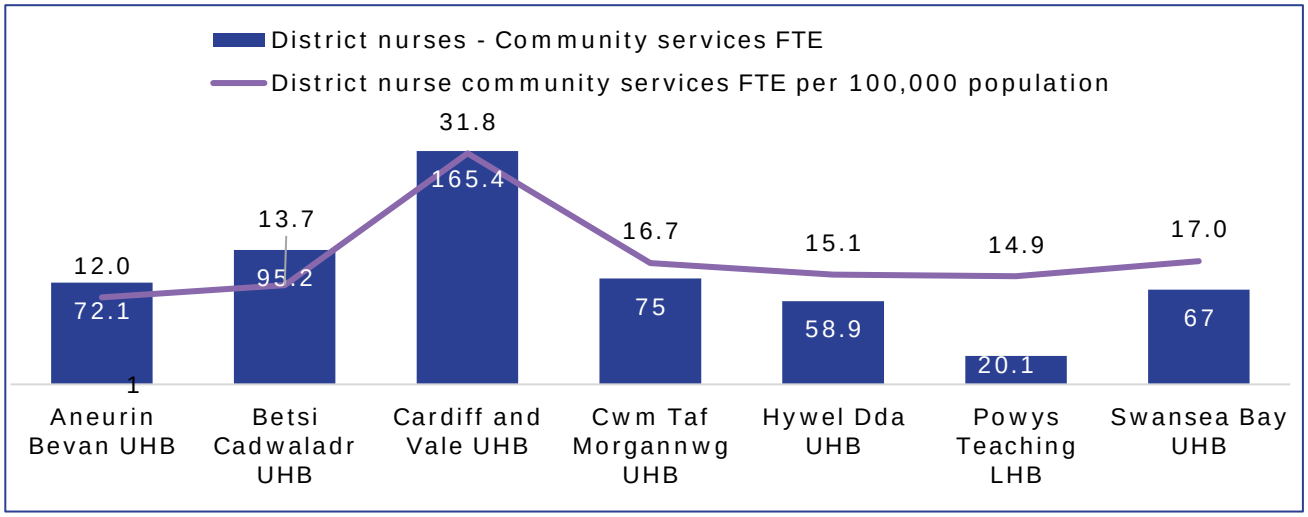


Figure 3.6.9 District nurse community service FTE and number of district nurse community service per 100,000 residents, Mar 2026[37]

CTM has maintained its workforce more successfully than Wales overall, where the corresponding headcount fell by 14%. However, stability does not indicate spare capacity. The workforce has not expanded to support a significant increase in the volume or complexity of care delivered at home.

The wider Welsh evidence illustrates the substantial and recurring nature of district-nursing activity. Across Wales, teams undertake approximately 220,000 visits each month for around 32,000

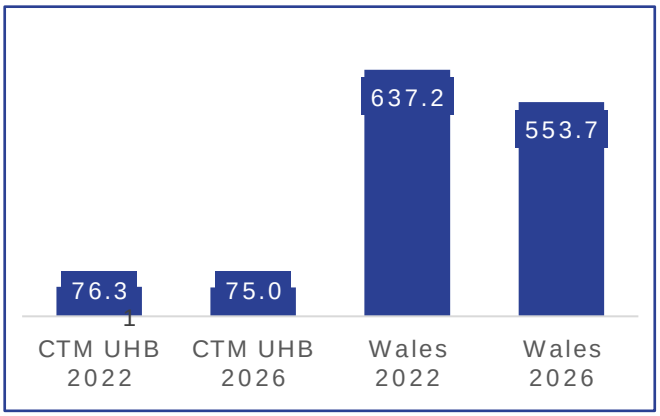


Figure 3.6.10 District nursing community services FTE, 2022-2026[38]

[37] StatsWales nursing staff by grade

[38] StatsWales nursing staff by grade

people. Approximately 40% of recorded activity relates to wound care and 10% to palliative and end-of-life care. Ageing, multimorbidity and moves towards earlier hospital discharge could increase the scale and complexity of support required from these services.

CTM cannot simply transfer additional hospital activity into existing community teams, as this would transfer pressure without increasing or releasing the capacity needed to deliver it. District nursing should operate as part of integrated neighbourhood teams, supported by shared caseload management, appropriate delegation, coordinated scheduling and, where clinically appropriate, remote monitoring. Teams will also require timely access to wider community and specialist services so that changing or escalating needs can be addressed effectively.

CTM's distributed model will depend on district nursing, but the recorded community-services nursing workforce has remained broadly static over four years. The future model must strengthen workforce capacity, skill mix and operational support while integrating district nursing with wider neighbourhood services. It cannot rely on existing teams simply absorbing a substantial increase in home-based activity.

3.6.6 Community mental health nursing capacity is comparatively strong but has not kept pace with Wales

Community mental health nursing provides an important foundation for supporting people outside hospital, maintaining continuity of care and coordinating input across services. In March 2026, CTM recorded 341.5 FTE community mental health nursing staff, equivalent to 76.0 FTE per 100,000 residents, compared with 66.5 across Wales. CTM therefore has a comparatively strong workforce base, ranking fourth among the seven health boards on this population-adjusted measure.

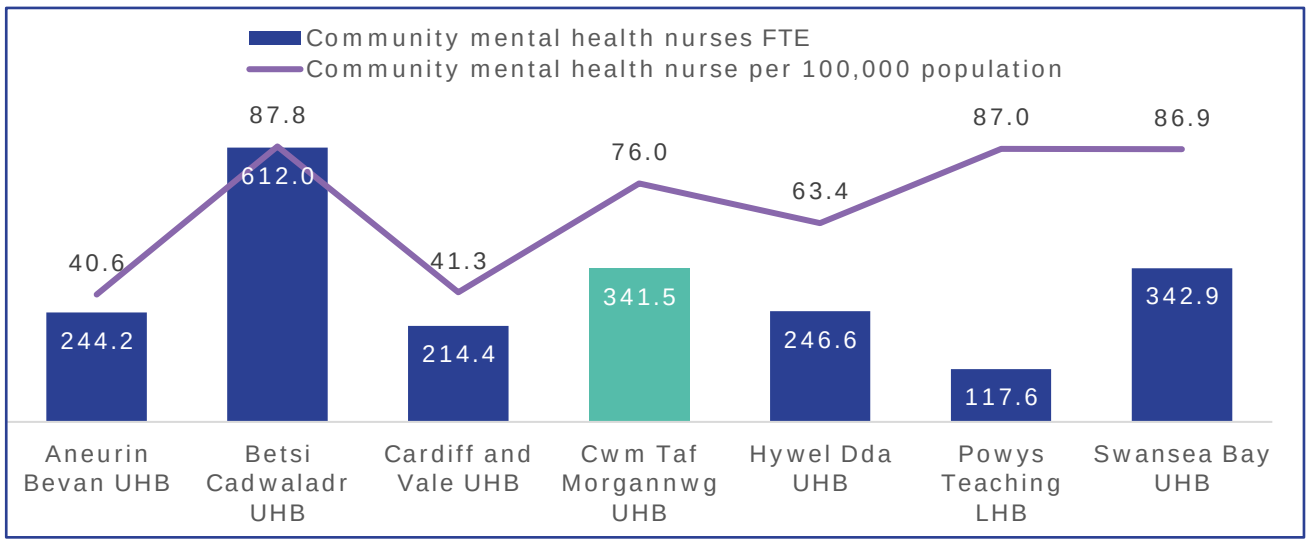


Figure 3.6.11 Community mental health nursing staff FTE and number of Community mental health nursing staff per 100,000 residents, Mar'26[39]

[39] StatsWales nursing staff by grade

However, CTM's position has weakened over time. Its community mental health nursing workforce fell from 358 FTE in March 2022 to 342 FTE in March 2026, a 4.6% reduction. Over the same period, the workforce across Wales increased by 10.5%, and CTM was the only health board to record a decline.

A more distributed model of care will require CTM to protect this capacity while developing a broader skill mix, enabling appropriate delegation and multidisciplinary working rather than relying predominantly on further growth in registered nursing roles.

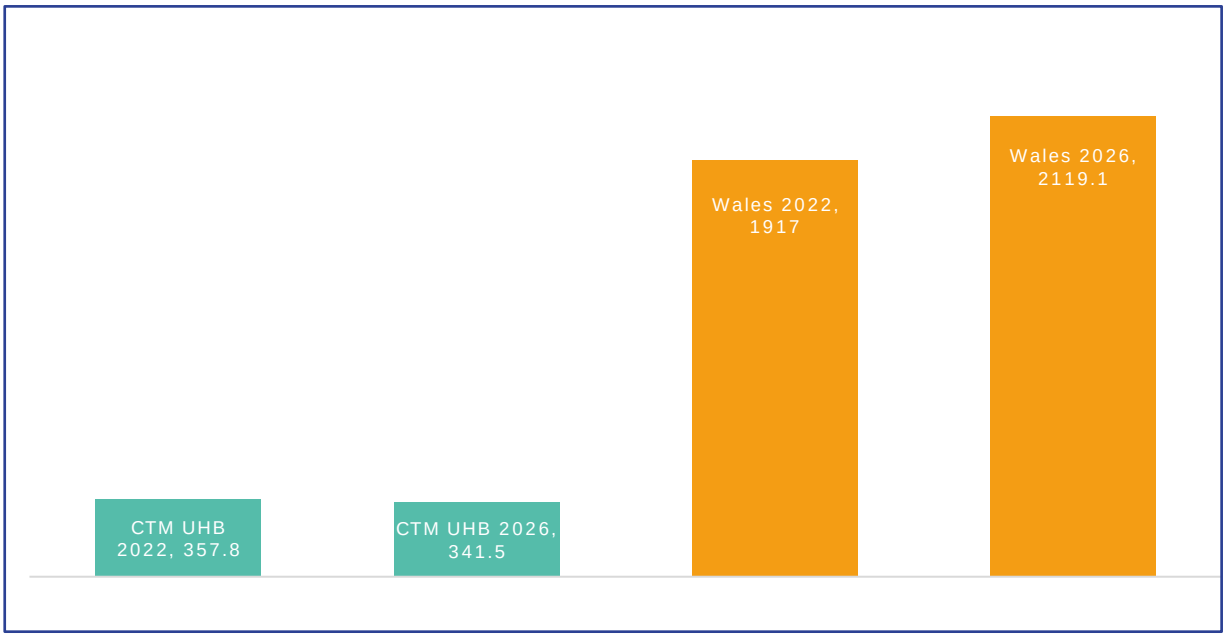


Figure 3.6.12 Community mental health nursing staff FTE Mar'22 to Mar'26[40]

[40] StatsWales nursing staff by grade

4. Capacity constraints are limiting responsiveness

4.1. Bed provision reinforces the need for connected care across the layers

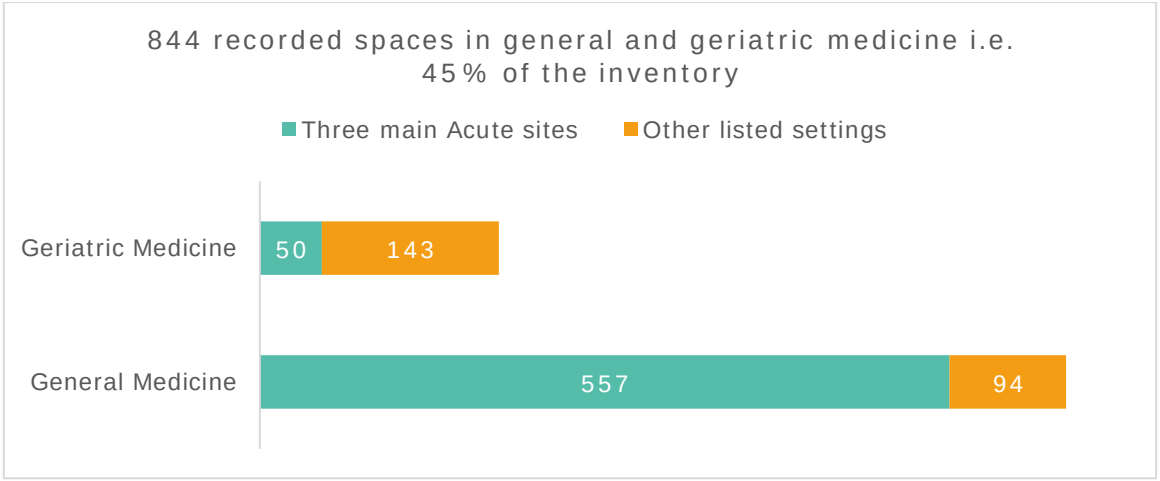
CTM's supplied inventory records 1,873 bed spaces across its hospitals and other services. Of these, 1,385, approximately 74%, are listed within the three main acute hospitals. General and geriatric medicine together account for 844 spaces, approximately 45% of the recorded total.

Considered alongside CTM's ageing population, and long-term ill health and inequalities, this distribution highlights the importance of medical and older-person pathways to the future capacity response. The implication for the future Care Model is to connect prevention, continuing support, management of deterioration, hospital treatment and recovery which will also encompass co-morbidity management and support. Each layer needs to contribute to a coherent pathway around the person, with safe movement between settings as needs change.

Medical and older-person provision connects several layers of care

General medicine accounts for 651 recorded spaces and geriatric medicine for 193. Of the combined 844 spaces, 607 are recorded within the three main acute hospitals and 237 elsewhere in alternate locations across CTM boundaries. Medical and older-person provision therefore already spans acute and community settings.

Figure 4.1.1 Recorded general and geriatric medicine spaces across acute and other settings[41]



This is a significant consideration for the future model. People requiring medical or older-person care may need different forms of support over time: prevention and risk management, ongoing management of conditions, a timely response to deterioration, acute treatment, rehabilitation and support to maintain independence. Organising these components separately can make continuity more difficult, particularly where needs cross clinical and organisational boundaries.

[41] Source: CTM Data received as of 30 Sept 2026

Access to acute care also depends on the interaction between where people live, their health and their socioeconomic circumstances. Frailty, reduced mobility and complex health needs may make travel more difficult, particularly for people dependent on carers or accessible transport. Distance from hospital, limited public transport, lack of access to a car, travel costs and work or caring responsibilities may create additional barriers to attending assessment, treatment and follow-up. These factors may compound disadvantage where health needs are greatest.

The Future Care Model should strengthen the connections between these forms of support while recognising that people's ability to access care is influenced by where they live, their health and their socioeconomic circumstances. Frailty, reduced mobility, limited transport and travel costs may make access to acute settings more difficult, particularly for people dependent on carers. Prevention and proactive care can address risks earlier; locality and community services can support ongoing needs and respond to deterioration where appropriate; hospital services provide acute and specialist treatment; and rehabilitation and recovery support enable people to move to an appropriate setting after treatment. These connections should enable suitable care closer to home while maintaining timely access to hospital services, supported by transport and care navigation where needed.

The occupancy data does not establish that admissions are avoidable or that bed utilisation can be increased; however, alternative models of care, supported by future models that assess patients earlier, can increase bed utilisation through hospital avoidance strategies that meet patients' needs. Care closer to home and community based supports where suitable and practical. The strategic value is in demonstrating the scale of medical and older-person provision and why these pathways should be central to developing the relationships between the layers.

Existing community facilities provide a foundation for recovery and continuing care

Ysbyty Cwm Cynon, Ysbyty Cwm Rhondda and Ysbyty George Thomas together account for 316 recorded beds, approximately 17% of the total. Their recorded provision includes general and geriatric medicine, rehabilitation, palliative care and old-age psychiatry.

This gives CTM an established infrastructure outside its three main acute hospitals on which to build. Within the Layered Care Model, these facilities can form part of the connection between treatment in an acute setting, community support and recovery, according to patients' clinical needs.

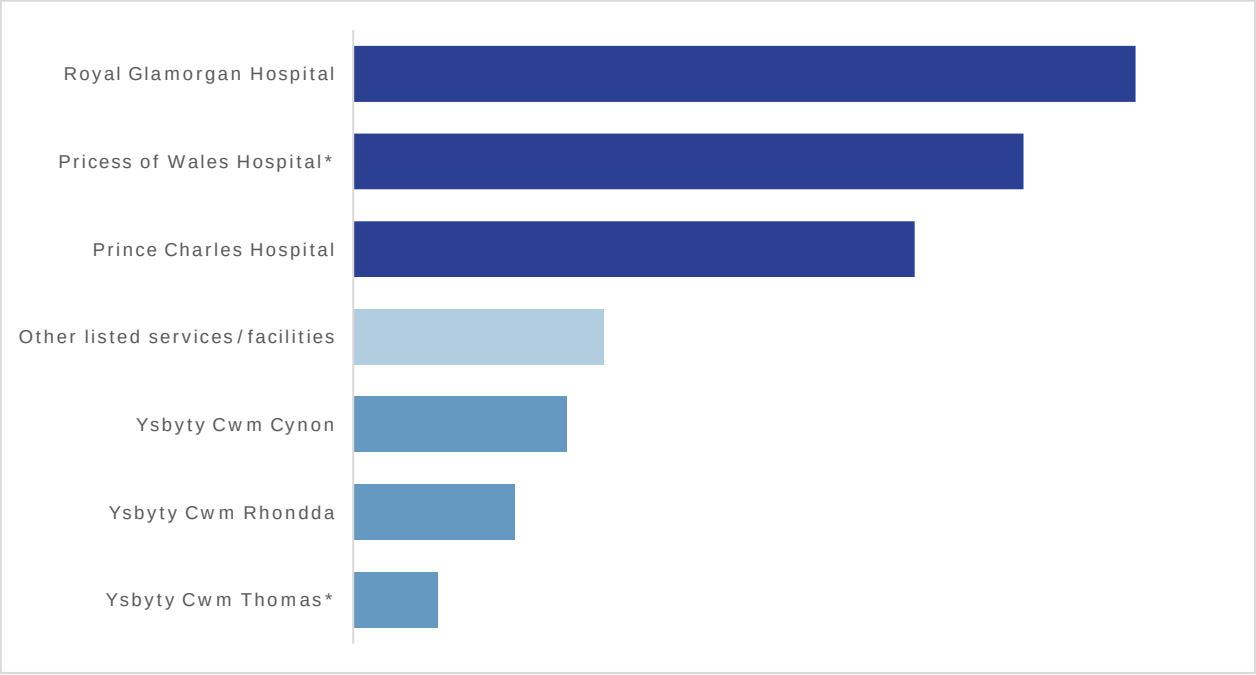
Community inpatient provision and home-delivered care fulfil different functions. Some people will require inpatient rehabilitation or continuing clinical support, while others may be supported appropriately through home-based services. A distributed model should therefore encompass both, recognising that moving care closer to home does not always mean removing the need for an inpatient setting. As the layered model transitions to reality, the supporting infrastructure such as digital systems, workforce readiness and mechanisms for accessibility are in place prior to implementation.

The implication is to clarify each setting's contribution within the pathway, so people receive the level of support they need, based on appropriate clinical risk stratification, without unnecessary fragmentation. Community facilities should connect to primary care, home-based teams, specialist advice, and social care (through developed inclusive pathway and model-of-care shifts, with supported MDT working and staffing structures, as well as physical and virtual infrastructure and data accessibility), rather than operate as a separate destination after acute treatment.

Acute hospitals remain an essential component of the model

Royal Glamorgan Hospital accounts for 538 recorded beds, Princess of Wales Hospital for 461 and Prince Charles Hospital for 386. Their combined share of approximately 74% demonstrates the importance of these sites within CTM's recorded bed network.

Figure 4.1.2. Recorded bed spaces by site[42]



**Separately listed mental health entries are included in 'Other listed services/facilities'*

The future Care Model will continue to depend on accessible, sustainable hospital services for people requiring emergency, acute and specialist care. Stronger linkages in other layers of the model should complement this capability, enabling appropriate care before or during admission and supporting continuity after treatment throughout episodes.

The hospitals also have different recorded specialty profiles. For example, Royal Glamorgan identifies 110 spaces classified as orthopaedics, compared with 26 at Princess of Wales and four at Prince Charles. General-surgery provision also differs between sites. Although classifications influence site-by-site comparisons, they demonstrate that the recorded capacity is specialised and cannot be treated as one

[42] *Source: CTM Supplied Bed inventory as of 30 Sept 2026*

interchangeable pool. The Future Model of Care will need to be developed with a clear understanding of nuanced differences in provision mix across acute settings.

For the future model, this also means connecting local and community provision to the appropriate diagnostic, treatment and hospital capabilities. Clinical need and available capabilities should determine a patient's movement between layers, with clear routes to specialist assessment and escalation.

The capacity response should strengthen the connections between layers

The principal implication of the inventory is that CTM's future capacity response needs to encompass the whole pathway. The substantial medical and geriatric provision, the existing community-hospital infrastructure and the different capabilities of the acute sites all point towards a model in which settings have complementary roles.

The Layered Care Model provides the framework for bringing these roles together. To achieve its aims, it must support earlier intervention, continuing care closer to home where appropriate, timely access to hospital treatment and coordinated rehabilitation and recovery. The connections are particularly important for patients whose needs change over time or require input from several services.

The direction of travel should therefore strengthen capabilities and relationships across the layers while maintaining the hospital provision required for safe care. The inventory supports this design requirement; it does not quantify how many beds could be released or demonstrate that a change in setting would automatically reduce costs.

Note on data: The supplied inventory includes assessment, day-care, ambulatory, discharge-lounge, home-leave and winter-pressure entries, and some ward descriptions may overlap. The 1,873 total represents recorded spaces rather than confirmed routinely staffed and available overnight inpatient beds. It describes the distribution of provision and does not establish occupancy, utilisation or sufficiency.

4.2. Outpatient capacity is predominantly allocated to continuing care[43]

CTM's supplied outpatient-capacity dataset records 671,929 appointment slots for the period. Of these, 527,721 (79%) are coded as follow-up and 142,539 (21%) as new appointments. A further 1,669 slots fall within an unspecified category. This equates to approximately 3.7 follow-up slots for every new-appointment slot.

The distribution shows the substantial capacity allocated to continuing assessment, treatment, monitoring and support. Alongside CTM's high prevalence of long-term physical and mental ill health, it indicates that the capacity response needs to address how ongoing care is organised, as well as access to first appointments.

Continuing care is a substantial component of provision

[43] *Source: CTM Data supplied as of 30 Sept 2026. The analysis interprets "F" as follow-up and "N" as new appointments; "X" remains unspecified. The dataset records slots rather than confirmed bookings or completed contacts and does not identify appointment duration, delivery setting or channel. It describes the composition of recorded capacity and does not establish utilisation, clinical appropriateness or the amount of capacity that could be released.*

The dataset encompasses medical and surgical specialties, mental health, rehabilitation and therapies. Rehabilitation is the largest recorded category, with 91,145 slots, approximately 14% of the total. Other substantial categories include general medicine, with 41,491 (xx%) slots; adult mental health, with 40,966 (xx%); paediatrics, with 32,059 (xx%); and speech and language therapy, with 28,711 (xx%).

Rehabilitation, dietetics, speech and language therapy and podiatry together account for 159,520 slots, approximately 24% of recorded capacity. These services demonstrate the scale of provision supporting treatment, recovery, function and independence, alongside diagnosis and specialist review.

Table 4.2.1. New, follow-up and other recorded slots across the ten largest specialty categories

Specialty category	New slots	Follow-up slots	Total slots*	Follow-up share
Rehabilitation	17,382	72,339	**91,145**	**79.4%**
General medicine	11,168	30,323	**41,491**	**73.1%**
Adult mental health	5,120	35,846	**40,966**	**87.5%**
Paediatrics	11,349	20,710	**32,059**	**64.6%**
Speech and language therapy	2,187	26,523	**28,711**	**92.4%**
Cardiology	3,231	23,892	**27,123**	**88.1%**
Mental illness	3,099	22,234	**25,333**	**87.8%**
Ophthalmology	5,481	18,617	**24,098**	**77.3%**
Dietetics	4,144	19,222	**23,366**	**82.3%**
Dermatology	4,967	17,240	**22,207**	**77.6%**

Recorded capacity encompasses substantial rehabilitation, therapy and mental-health provision alongside medical specialties. ***The future care model needs to connect treatment, continuing support and recovery.***

** Totals include 1,424 X-coded rehabilitation slots and one X-coded speech and language therapy slot. Specialty labels are retained as supplied; "Adult mental health" and "Mental illness" are separate recorded categories.*

Repeated contacts are clinically necessary for many patients. They may form part of the treatment programme, surveillance or continuing support and should not automatically be considered avoidable. However, the scale of this provision means that the organisation of continuing care is central to CTM's ability to respond sustainably to population need.

The future care model will need to support continuity over time, with clear responsibility for ongoing care and effective connections between the professionals

involved. This is particularly important for people whose physical, mental and functional needs require input from several services.

The balance between new access and continuing care differs by specialty

Several specialties contributing to CTM's planned-care waiting list also allocate substantial capacity to follow-up. Ophthalmology records 24,098 slots, approximately 77% of which are follow-up. Urology records 17,655 slots, with approximately 73% allocated to follow-up, while gynaecology records 19,552 slots, with approximately 71% allocated to follow-up. General surgery has a more balanced profile, with 8,450 follow-up and 7,492 new slots, giving a follow-up share of approximately 53%.

Table 4.2.2. New and follow-up slots in selected planned-care specialties

Specialty category	New slots	Follow-up slots	Total slots	Follow-up share
Ophthalmology	5,481	18,617	**24,098**	**77.3%**
Gynaecology	5,745	13,807	**19,552**	**70.6%**
Urology	4,849	12,806	**17,655**	**72.5%**
General surgery	7,492	8,450	**15,942**	**53.0%**
Ear, nose and throat service	4,042	7,011	**11,053**	**63.4%**
Orthopaedics	2,421	5,815	**8,236**	**70.6%**
Trauma & orthopaedic	1,625	3,228	**4,853**	**66.5%**
ENT	1,085	2,145	**3,230**	**66.4%**

These differences indicate that outpatient pressure requires a specialty-specific response. Initial assessment, treatment, surveillance and ongoing support have different clinical requirements, and a uniform reduction in follow-up would not reflect these differences.

The coexistence of substantial waiting lists and continuing-care commitments highlights the need to consider both within complete pathways. The figures do not demonstrate that follow-up provision causes waiting-list pressure. They do show why adding first-appointment capacity alone would be an incomplete response: patients entering a pathway may later require treatment, monitoring, and ongoing support.

The future care model therefore needs to connect timely first assessment with a sustainable approach to subsequent care. This includes preserving clinically necessary specialist review while enabling suitable ongoing support through primary, community,

home-based and virtual services, with clear access to specialist advice and reassessment.

The capacity response requires changes to how care is organised

The evidence points to a model that differentiates care by need rather than relying on a standard pattern of repeated appointments. Some patients will require regular specialist-led care. Others may be supported through shared care, multidisciplinary community input, virtual review, remote monitoring or patient-initiated follow-up, where clinically appropriate.

These arrangements must maintain clinical oversight, accessibility, and clear escalation routes. They also need to recognise the workload placed on receiving services and the ability of patients and carers to manage care between contacts. People receiving care from several specialties may be left to navigate separate appointments, reconcile advice and coordinate follow-up themselves. The Future Care Model should reduce this burden through coordinated care planning, clear clinical responsibilities and accessible navigation support, rather than rely on individuals to connect services. Changing the setting or channel of an appointment will not automatically reduce the clinical time required.

The substantial rehabilitation and therapy provision also reinforces the need to make recovery and independence integral to the future care model. These services should connect with medical, surgical, mental health and community pathways so that people receive coordinated support as their needs change.

Taken together, the data strengthen the case for a future care model that combines earlier intervention, continuing support closer to home where appropriate, coordinated recovery and timely access to specialist care. Such a model should build on existing provision while organising capacity around complete pathways and the level of support each person requires.

4.3. Elective capacity depends on the effectiveness of the whole surgical pathway[44]

CTM's supplied extract records 4,083 elective theatre sessions between October 2025 and September 2026, representing 26,455 scheduled hours. Adjusted utilisation was 72.1%, equivalent to approximately 19,084 recorded utilised hours.

Alongside the remaining planned-care backlog, this indicates that the capacity response cannot rely solely on scheduling additional theatre time. Appropriate theatre allocation should prioritise those with extended wait times for surgery to reduce waitlists and ensure patients with greater need are treated within the correct triage timeframe. CTM needs a future care model that enables patients to progress through

[44] *The extract covers elective sessions only. The supplied adjusted utilisation measure does not identify completed operations, the causes of unutilised time or patient outcomes. Zero-valued sessions, particularly in obstetrics, cannot automatically be interpreted as cancellations. The difference between scheduled and recorded utilised time is not an estimate of fully recoverable capacity.*

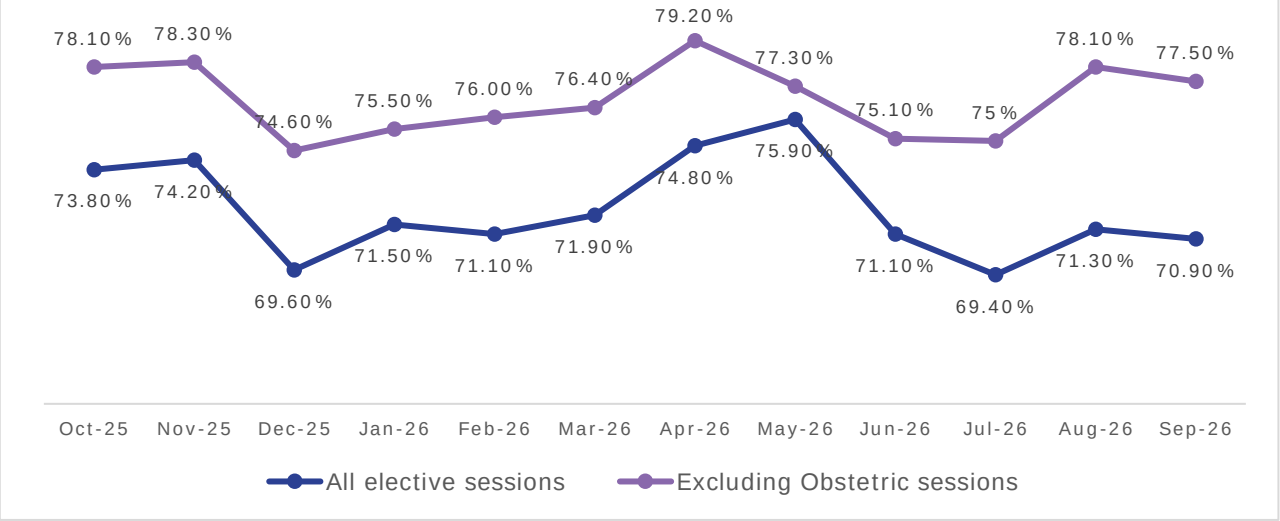
assessment, preparation, treatment and recovery, with the necessary clinical capabilities available at each stage.

Additional scheduled time will not automatically produce additional treatment

Approximately 7,371 hours separate scheduled time from recorded adjusted utilisation. Monthly utilisation remained between approximately 69% and 76%, showing that the difference persisted throughout the period.

This is strategically significant because it challenges the assumption that the principal response to waiting-list pressure should be more theatre sessions or additional physical infrastructure. Theatre time becomes productive treatment capacity only when it is matched with appropriately prepared patients, clinical teams, equipment and the support required after surgery.

Figure 4.3.1. Monthly adjusted elective utilisation – all elective sessions and a sensitivity excluding obstetric sessions



Note: Utilisation is shown both including and excluding obstetric sessions because their comparatively low recorded utilisation materially affects the overall result. The second series tests whether the pattern persists across the remaining elective sessions. It does not imply that obstetric provision is unnecessary or that its recorded utilisation represents avoidable spare capacity. Both series are weighted by scheduled session time.

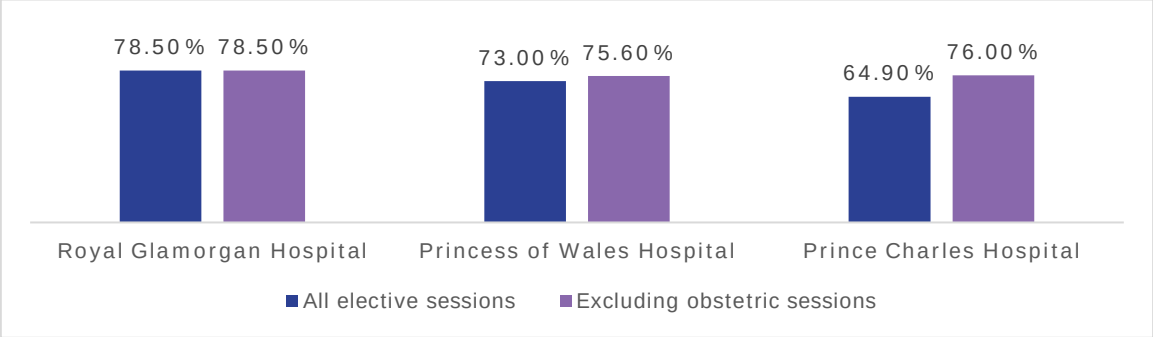
The supplied data do not establish which of these factors explains CTM's utilisation position. The data does establish and demonstrate that a capacity response based on scheduled hours alone would be incomplete. Expanding one component of the pathway can create pathway bottlenecks, leave treatment constrained by another, and add cost without a proportionate increase in care delivered.

For the future care model, this implies organising surgical capacity around the complete pathway. Preoperative assessment, diagnostics, optimisation and preparation should connect directly with treatment, while postoperative review, rehabilitation and support at home should form part of the planned episode of care. These functions may be delivered across different settings, but they need to operate as a coherent pathway.

Site averages conceal differences in the clinical purpose of capacity

Overall theatre utilisation was 78.5% at Royal Glamorgan, 73.0% at Princess of Wales and 64.9% at Prince Charles. However, excluding obstetric theatres narrows the range across the three hospitals to 75.6%–78.5%, with Prince Charles increasing to 76.0%.

Figure: 4.3.2. Specialty composition changes the hospital comparison



This materially changes the interpretation. The headline figures could suggest a substantial difference in the effectiveness of the hospitals' elective services. The sensitivity calculation shows that much of that difference is associated with their recorded specialty composition.

The clinical purpose of capacity matters. Some services require provision that supports responsiveness and resilience, as well as scheduled activity. The extract does not establish whether this explains the impact of obstetric activity data, but it demonstrates why a single utilisation measure should not be used to judge all provision in the same way.

The future care model therefore needs to distinguish the capacity required for predictable planned treatment from those supporting urgent or less predictable needs. Improving productivity should preserve the capacity necessary for safe care, rather than assume that every recorded difference represents removable provision.

The remaining challenge is relevant across several planned-care pathways

Excluding obstetrics, adjusted utilisation is 76.7%, leaving approximately 5,543 hours between scheduled time and recorded utilisation. The wider finding therefore remains even after accounting for this influential specialty group.

Recorded utilisation also differs between specialties: approximately 79% in general surgery, 76% in trauma and orthopaedics and ENT, 75% in gynaecology, 73% in oral surgery and 71% in urology. These figures should not be treated as a clinical productivity ranking. Different procedures, patient needs and session arrangements affect the use of time.

They nevertheless reinforce the need for responses suited to individual pathways. An organisation-wide assumption about recoverable theatre time would overlook differences in what is required to convert that time into treatment. Substituting an available session in one specialty cannot necessarily address pressure in another: the workforce, equipment and supporting services must also match the required care.

Table 4.3.3. Adjusted utilisation in principal recorded specialties

Specialty	Sessions	Scheduled hours	Adjusted utilisation
General surgery	1,441	9,264	**79.1%**
Trauma and orthopaedics	649	5,216	**76.3%**
ENT	487	2,886	**76.3%**
Gynaecology	699	3,614.5	**75.1%**
Oral surgery	136	1,012.5	**73.3%**
Urology	239	1,729.5	**71.2%**
Obstetrics	410	2,623	**30.3%**

The outpatient evidence strengthens this argument. Several surgical specialties combine new-assessment requirements with substantial continuing-care commitments. Improving access therefore requires the assessment, treatment and follow-up components to work together, rather than optimise each independently.

The future care model should support specialist treatment through stronger care before and after surgery

The strategic requirement is to use specialist treatment capacity better through coordinated support across settings. Suitable assessment, preparation and postoperative care may be provided locally, virtually or through community services, with access to specialist advice and escalation when needed. Hospital provision remains essential for surgery and for patients requiring inpatient or complex perioperative care.

This direction should support patients already waiting for treatment as well as longer-term prevention and earlier intervention. Prevention will not resolve the existing surgical backlog on its own, and transferring contacts outside hospital will not automatically release theatre capacity.

The evidence supports a future care model in which access, preparation, specialist treatment and recovery are planned together. Its contribution to capacity should come from making the whole pathway work more effectively, while preserving the clinical capabilities and resilience required for safe care.

4.4. Forward theatre provision supports both planned treatment and urgent surgical care[45]

CTM's supplied forward theatre schedule records 2,754 sessions, equivalent to 17,965 scheduled hours, between October 2026 and September 2027. Elective and day-surgery sessions account for about 71% of recorded hours, while emergency and trauma sessions account for the remaining 29%.

This mix illustrates the complementary functions that hospital services must retain within the future care model. CTM must provide timely specialist treatment for patients on planned-care pathways while maintaining the ability to respond to urgent surgical needs. Strengthening prevention and care closer to home should support these functions through earlier intervention, appropriate preparation and coordinated recovery, while preserving access to hospital treatment when required.

Figure 4.4.1. Composition of CTM's recorded forward theatre schedule, October 2026–September 2027[46]

Session category	Scheduled sessions	Scheduled hours	Share of recorded hours
Elective	1,453	9,380.5	**52.2%**
Day surgery	684	3,340.0	**18.6%**
Emergency	336	2,856.0	**15.9%**
Trauma	281	2,388.5	**13.3%**
Total	**2,754**	**17,965.0**	**100%**

Different clinical functions require different approaches to capacity

Elective and day-surgery provision depends on patients progressing reliably through assessment, investigation, preparation, and treatment. Read alongside the historical utilisation evidence, the forward schedule reinforces that allocating sessions is only one component of delivering planned care. The future care model should connect scheduled treatment with the services needed before and after intervention, including suitable support outside hospital.

Emergency and trauma provision serves a different purpose: it must remain responsive to less predictable clinical need. Capacity supporting this function cannot be judged solely against the expectations applied to a predictable elective list. The strategic

[45] *The extract records scheduled sessions rather than a confirmed, fully populated annual capacity plan. It does not establish staffed availability, patient bookings or the number of procedures that will be delivered. It also includes elective, day-surgery, emergency and trauma categories, whereas the historical utilisation extract covers elective sessions only; their totals are not directly comparable.*

[46] *The forward schedule is unevenly populated across sites and months. These figures describe the supplied extract, not a confirmed annual capacity allocation, and do not establish staffed availability or treatment volumes.*

requirement is to balance productive use of planned treatment capacity with sufficient resilience for urgent care, rather than treat all theatre hours as interchangeable.

Day surgery represents an established component of the recorded schedule, with 3,340 planned hours. It supports treatment without a planned overnight stay for clinically suitable patients. Its contribution depends on preparation, safe discharge and appropriate postoperative support; the schedule alone does not establish an opportunity to expand day surgery or reduce inpatient provision.

The forward schedule does not establish annual capacity sufficiency

Given how future schedules and workloads develop over near- and medium-term time horizons, recorded future hours fall within October–December 2026. Entries extend to different dates across sites and specialties: Royal Glamorgan's recorded sessions end in December 2026, while selected services at Prince Charles and Princess of Wales continue through September 2027. This pattern is consistent with scheduling populated to different planning horizons, rather than a confirmed reduction in future provision or capacity demand.

The schedule therefore illustrates the functions currently being planned but cannot establish whether annual treatment capacity will be sufficient to meet demand or reduce the remaining backlog.

The implication for the future care model is to sustain specialist and urgent hospital capabilities within a better-connected system of care. Earlier and local support should complement hospital treatment, while preparation, recovery and continuing care should enable patients to move safely between settings. The forward schedule supports this direction but does not quantify the additional activity or financial benefits it could deliver.

4.5. Financial balance depends on sustained savings and changes to the current model

CTM is forecasting delivery of its three-year statutory financial duty and enters 2026/27 with an approved plan. However, the underlying position remains constrained. The Health Board carries forward a £9.2m recurring financial challenge and faces further inflationary, service and demand-related costs during 2026/27.

The plan provides £20.9m of additional recurring Welsh Government funding, alongside £42.7m of recurring cost pressures and investment. It therefore depends on delivery of £31.3m of recurring savings to achieve a broadly balanced position in 2026/27.

At the point the plan was prepared, £8.1m of the savings target was supported by green or amber schemes, leaving £23.0m still to be identified. The plan also records £38.6m of quantified gross financial risk, including risks associated with savings delivery, delegated budgets, health visiting and NWJCC plans. Further risks relating to prescribing, Continuing Healthcare, planned-care requirements and digital investment remain unquantified.

The requirement is not confined to 2026/27. CTM's three-year plan assumes a further £23.0m of recurring savings in each of 2027/28 and 2028/29. In total, the plan requires £77.3m of new recurring savings across the three years, while maintaining a position close to break-even. This provides little capacity to absorb additional cost or demand beyond the assumptions already included in the plan.

Cost growth reflects increasing requirements for ongoing care and treatment

CTM has allowed £34.9m for inflationary, service and demand pressures in 2026/27. More than half, £19.7m, relates to service and demand pressures, with the remaining £15.2m arising from inflation.

A substantial proportion relates to services supporting people with continuing and complex needs:

- circa £5.3m for Continuing Healthcare and funded nursing care inflation and growth
- approx. £5.8m for primary care prescribing inflation and volume growth
- £6.3m for NICE-approved treatments and other high-cost drugs.

Together, these areas account for ~£17.4m or half of the identified inflationary and demand-related pressures. This is consistent with a population requiring more ongoing care, medicines and support over longer periods. However, some of these costs are externally driven and cannot simply be removed through service redesign.

Investment capacity is constrained and increasingly committed

The plan includes £2.0m of locally determined recurring service-improvement investment in 2026/27, rising to £3.9m in 2027/28 and £5.8m in 2028/29. Much of this provision is already associated with existing commitments, including electronic prescribing and medicines administration, digital cellular pathology, the Llantrisant diagnostic hub and the new Velindre Cancer Centre.

Other requirements, including local digital investment, DHCW programmes, planned-care delivery and infrastructure costs, remain to be confirmed. The scale of the savings requirement relative to the available improvement provision means CTM will need to prioritise investment carefully and demonstrate how transformation will improve outcomes, productivity or longer-term financial sustainability.

Implications for the future model of care

The financial evidence does not mean that moving care into community settings will automatically reduce costs. New models may require transitional investment, additional community capacity and a period in which existing and new services operate concurrently.

It does, however, demonstrate that CTM cannot rely on additional funding to sustain increasing demand through the existing model. The future model will need to:

- identify and manage need earlier
- reduce avoidable escalation and duplication
- improve productivity across complete pathways
- use workforce and physical capacity more flexibly
- align resources more closely with population need
- establish clear financial and outcome benefits for proposed changes.

CTM will need to distinguish short-term savings required to deliver the financial plan from longer-term transformation. Savings actions that reduce capacity without redesigning pathways could make it harder to respond to the population and operational pressures identified elsewhere in the Case for Change.

5. Workforce Capability

CTM's workforce has grown over recent years yet remains 1.3% below most other Welsh health boards. Growth has also been uneven between staff groups, with a substantial proportion of the increase concentrated in nursing roles, with comparatively limited growth in some other professions and support functions required to deliver multidisciplinary care.

At the same time, reported vacancies have increased, and the workforce is ageing. Approximately one in ten CTM employees are 60 years old or over, whilst the proportion of employees aged 30 or under has remained broadly unchanged. These pressures do not mean that workforce numbers alone determine service capacity. The workforce's contribution also depends on its composition, deployment, skills and upskilling, working arrangements, productivity, and the infrastructure available to clinical and non-clinical support.

Nevertheless, the evidence indicates that CTM cannot plan its future services on the assumption that it can recruit sufficient additional staff into the same roles and delivery arrangements. The future model will need to use the workforce more effectively, while continuing to recruit, retain, and develop the staff needed to provide safe and sustainable care as a result of this case for change.

5.1 Overall Workforce Growth

CTM's directly employed workforce increased from approximately 11,089 FTE in Q1 2022 to 11,836 FTE in Q1 2026, a net increase of around 748 FTE or 6.7%. This was the sixth-highest percentage increase among the seven Welsh health boards and approximately 1.3 percentage points below the Welsh health-board median of 8.0%.

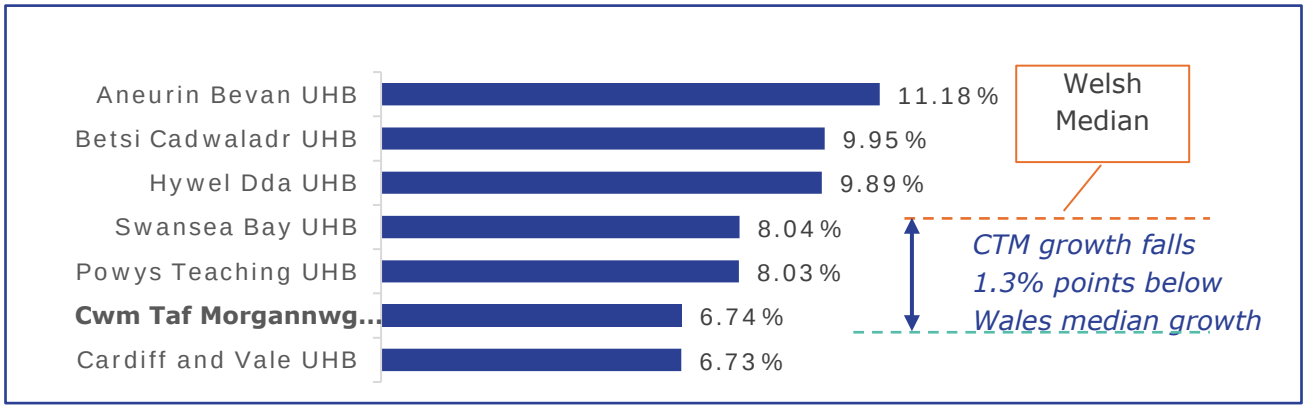


Figure 5.1.1 Percentage growth in directly employed FTE by Welsh health Board, Q1 2022 to Q1 2026[47]

Growth was not uniform over the period. CTM's workforce increased by less than 1% between Q1 2022 and Q1 2024, before growing more rapidly during the following two

[47] StatsWales, July 28,2026

years. Between Q1 2025 and Q1 2026 alone, total FTE increased by approximately 3.3%.

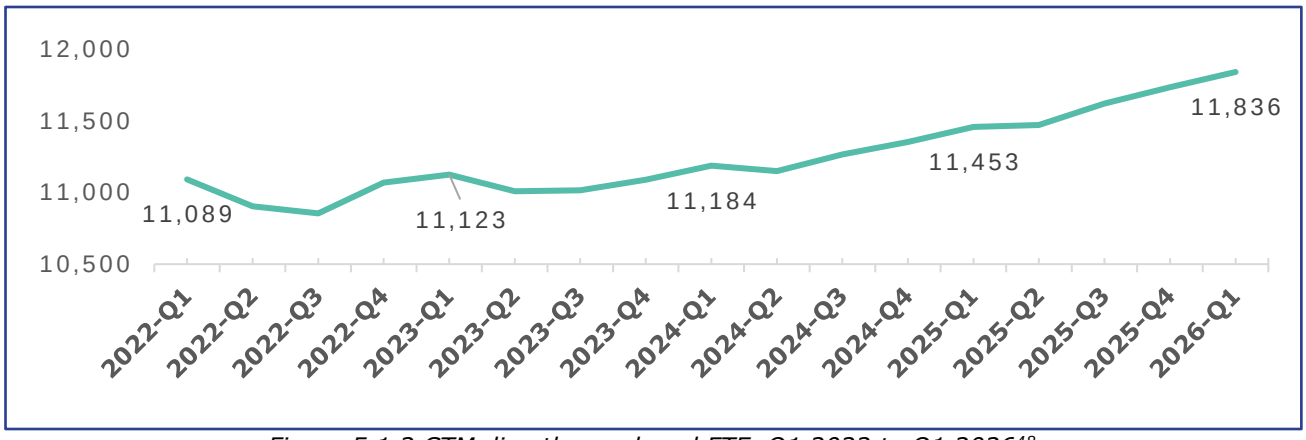


Figure 5.1.2 CTM directly employed FTE, Q1 2022 to Q1 2026[48]

The more recent increase is significant, but it is too early to conclude that it represents a sustained improvement in workforce supply. Nor does comparison with the Welsh median establish whether CTM has the right level of workforce. Absolute workforce requirements are affected by population need, service configuration, cross-boundary provision, organisational productivity and the extent to which services are delivered by primary care, local authorities, independent providers and voluntary organisations.

The evidence therefore supports a narrower conclusion: CTM's directly employed workforce has grown, but its rate of growth has been lower than most other Welsh health boards and has only accelerated relatively recently. Whether that growth has kept pace with need requires considering workforce trends alongside changes in population, demand, activity, service standards, and productivity.

5.2 Workforce Breakdown

Approximately 60% of CTM's reported net FTE increase between Q1 2022 and Q1 2026 was attributed to nursing, midwifery and health-visiting staff. Nursing remained CTM's largest directly employed staff group, accounting for approximately 48.2% of total FTE in Q1 2026.



Figure 5.2.1 Contribution of each staff group to CTM's net FTE change, Q1 2022 to Q1 2026

The scale of nursing's contribution partly reflects its existing size; this should not be interpreted as excessive dependence or inappropriate workforce growth. However, it

[48] StatsWales, July 28,2026

means that CTM's overall workforce trajectory is particularly sensitive to its ability to recruit and retain nurses and deploy them effectively. This could also imply that CTM is preparing for future service delivery changes and allowing for succession planning to bridge the gaps left by an ageing workforce.

Although nursing FTE increased by approximately 8.6% over the period, this was the lowest percentage increase among the seven Welsh health boards and approximately 2.9 percentage points below the Welsh health-board median. The evidence also indicates different rates of change across medical and dental, scientific, therapeutic and technical, administrative and estates, and support staff.

This uneven growth matters because the future workforce is not simply an aggregate number. CTM will require an appropriate combination of clinical, diagnostic, therapeutic, technical, administrative and support capability. A service may have sufficient total FTE but remain constrained if it lacks particular professions, specialist skills or supporting roles.

The evidence does not yet demonstrate whether the current staff mix is appropriate. Comparisons based on absolute numbers against a Welsh median are affected by differences in population, service portfolios and organisational responsibilities. Establishing a genuine workforce gap requires analysis of funded establishments, vacancy and turnover rates, activity, service demand and workforce requirements by profession, specialty and setting.

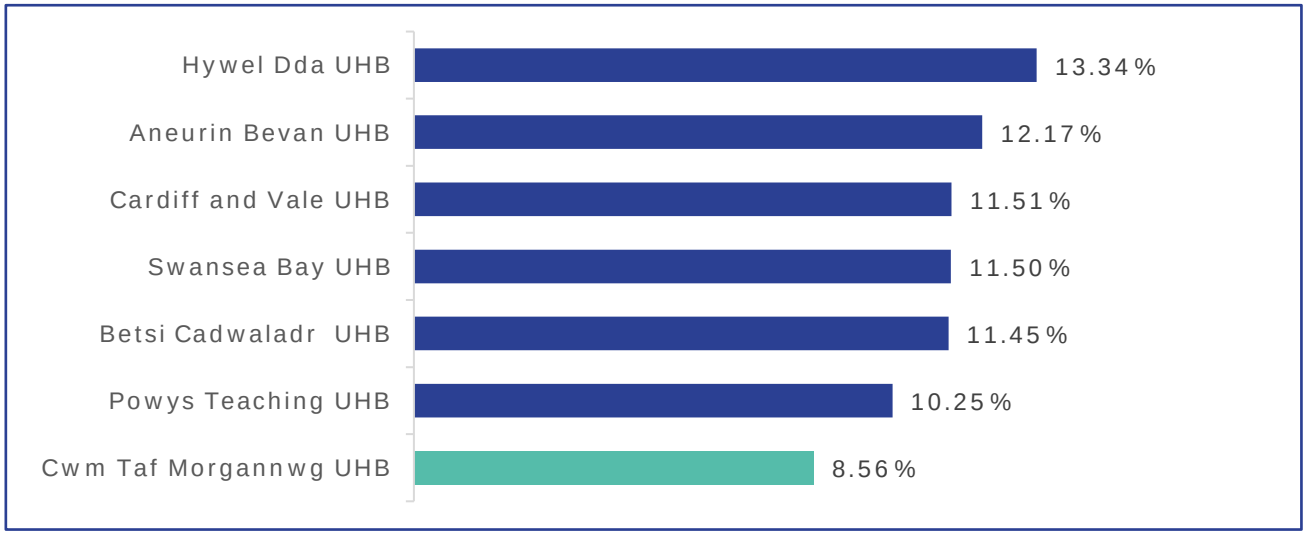


Figure 5.2.2 Change in FTE by staff group compared with the Welsh health-board median[49]

The strategic response should consequently extend beyond expanding individual staff groups. CTM will need to consider how roles work together, which activities require specialist clinical expertise, which other members of a multidisciplinary team can undertake safely, and where administrative, technical, or digital support could free up clinical time. Any change in skill mix must be designed around patient need,

[49] StatsWales, July 28,2026

professional standards and safe delegation rather than being treated primarily as a way to substitute lower-cost staff.

5.3 Workforce Management

Reported vacancies increased from approximately 122 FTE in Q4 2022 to 340 FTE in Q1 2026. Its reported vacancy rate increased from 1.1% to 3.0% over the same period. In contrast, the median vacancy rate across Welsh health boards reduced from approximately 5.1% to 4.8%.

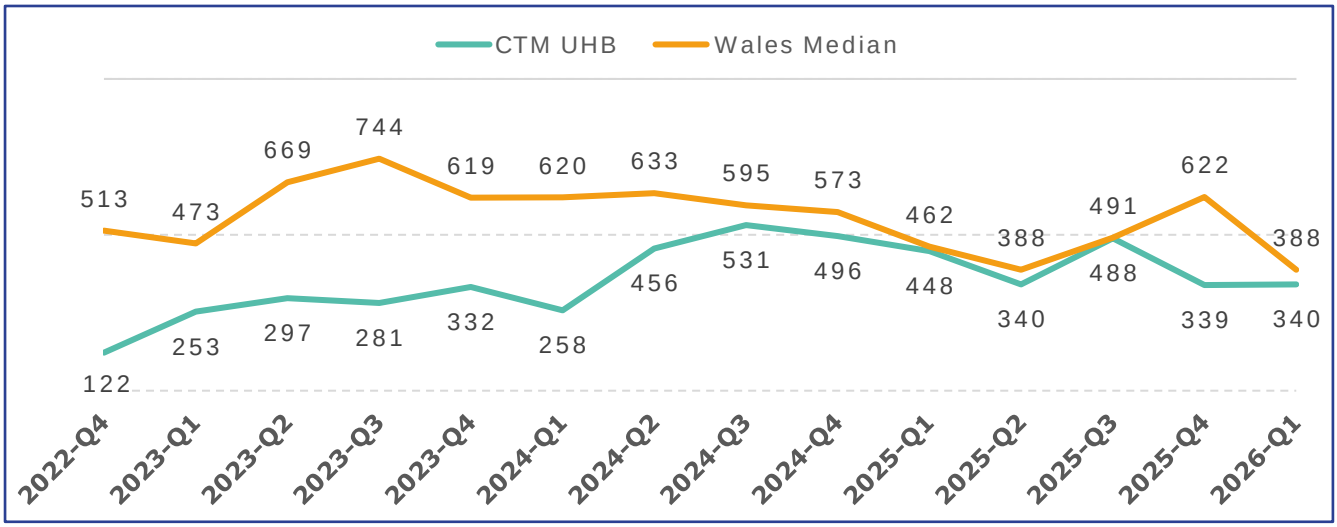


Figure 5.2.3 Reported FTE vacancies and vacancy rates, CTM and Welsh health-board median (2022 Q4 – 2026 Q1)[50]

The overall vacancy rate remained below the Welsh health-board median at the end of the period, which is an important qualification. The issue is therefore not that CTM currently has the highest overall vacancy burden, but that its position has deteriorated while the wider median has improved.

Vacancy data must be interpreted carefully, as recorded vacancies are influenced by the size of the funded establishment, whether posts are actively being recruited to, changes in reporting practice, and decisions to hold or remove posts. An increase may reflect greater difficulty recruiting, but it could also reflect establishment growth. Vacancy rates should therefore be considered alongside turnover, recruitment activity, time to hire, unsuccessful recruitment exercises and the use of bank and agency staff.

Registered nursing represents a more pronounced pressure. CTM reported approximately 289 registered nursing vacancies in Q1 2026, equivalent to a vacancy rate of 7.4%. This was above the Welsh health board median vacancy rate of approximately 5.8%.

[50] StatsWales, July 28,2026

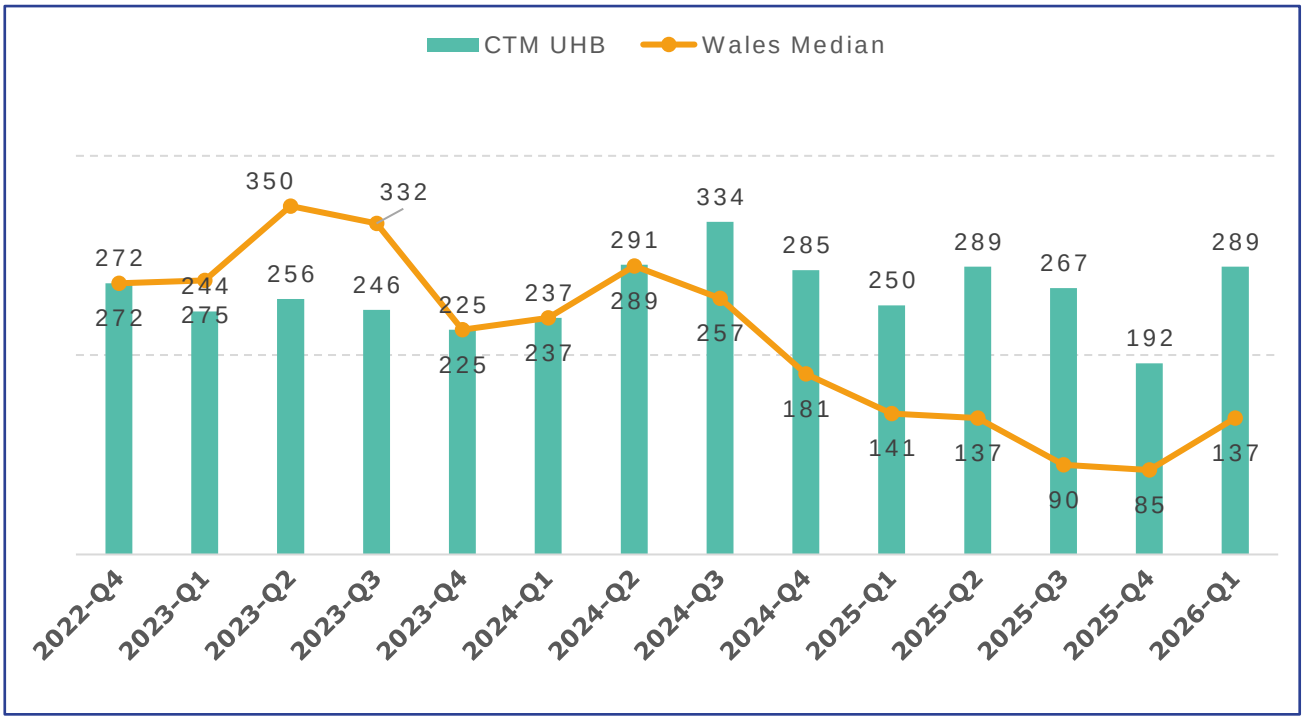


Figure 5.2.4 Registered nursing vacancy rate, CTM and Welsh health board median (2022 Q4 – 2026 Q1)[51]

Persistent nursing vacancies may affect roster allocations, resulting in reliance on temporary or agency staffing, continuity of care, staff workload and the ability to expand services. However, vacancy information alone does not demonstrate the operational effect. CTM will need to connect the data with safe-staffing requirements, roster fill, sickness absence, turnover, temporary staffing, service closures and patient outcomes.

The position reinforces the need both to strengthen recruitment and retention and to use registered nursing capacity carefully. This could include better administrative and logistical support, effective use of healthcare support workers, advanced and specialist roles, improved digital workflows, and clear multidisciplinary pathways. The purpose should be to enable registered nurses to focus more consistently on work that requires their expertise, while maintaining appropriate supervision, professional accountability and safe staffing

The proportion of CTM's workforce aged 61 or over increased from approximately 8.2% in 2022 to 10.1% in 2025. Approximately one in ten employees is therefore now over 60. Over the same period, the proportion aged between 46 and 60 fell by around 3.5 percentage points, while the proportion aged 30 or under remained broadly unchanged and slightly below the Welsh health-board median.

[51] StatsWales, July 28,2026

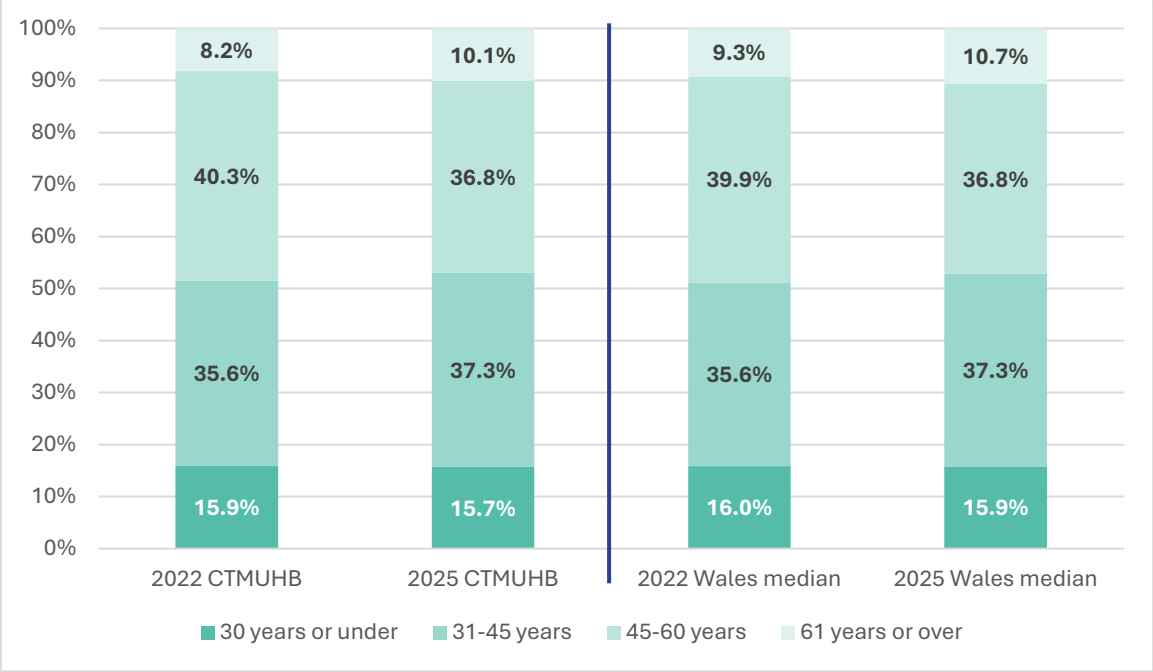


Figure 5.2.5 CTM workforce age profile compared with the Welsh health-board median, 2022 vs 2025[52] `

This pattern creates a potential succession challenge. CTM may lose experienced staff and institutional knowledge as more employees become eligible to retire, while the relatively stable proportion of younger employees provides limited evidence that the replacement pipeline is expanding.

However, the aggregate age profile does not show when staff intend to retire or where the greatest risks are concentrated. Some employees may remain in work beyond conventional retirement ages, reduce their hours or return under flexible arrangements. The strategic risk will vary considerably between staff groups, specialties and locations. A more detailed view of retirement exposure and succession requirements, with particular attention given to services that depend on small numbers of highly experienced staff, roles with long training pathways, and capabilities where there is already a vacancy or recruitment problem.

Knowledge transfer, leadership succession, flexible retirement, retention and education commissioning will need to be considered together. Future workforce planning should begin with the capabilities required to deliver care safely, before determining the appropriate combination of professions, roles, skills and technology. This does not mean reducing specialist expertise; it means reserving it for work that requires it and building wider team capability.

CTM's workforce is growing, but the headline increase tells only part of the story. Beneath the net growth is substantial movement of people into and out of the organisation, with recruitment having to replace many departing employees before it translates into additional workforce capacity. The pattern is also uneven: some care groups and staff groups appear considerably more stable than others, suggesting

[52] StatsWales, February 12,2026

workforce challenge is as much about retaining and sustaining capability as it is about recruiting it.

CTM's workforce increased from 13,269 to 13,608 employees, a net increase of 339. Of the workforce present at the start of the period, 12,258 remained, representing an overall stability rate of 92.4%. During the same period, 1,011 employees left while 1,350 joined. Put differently, CTM recruited approximately four employees for every one net additional employee, with departures equivalent to approximately 75% of recruitment volumes.

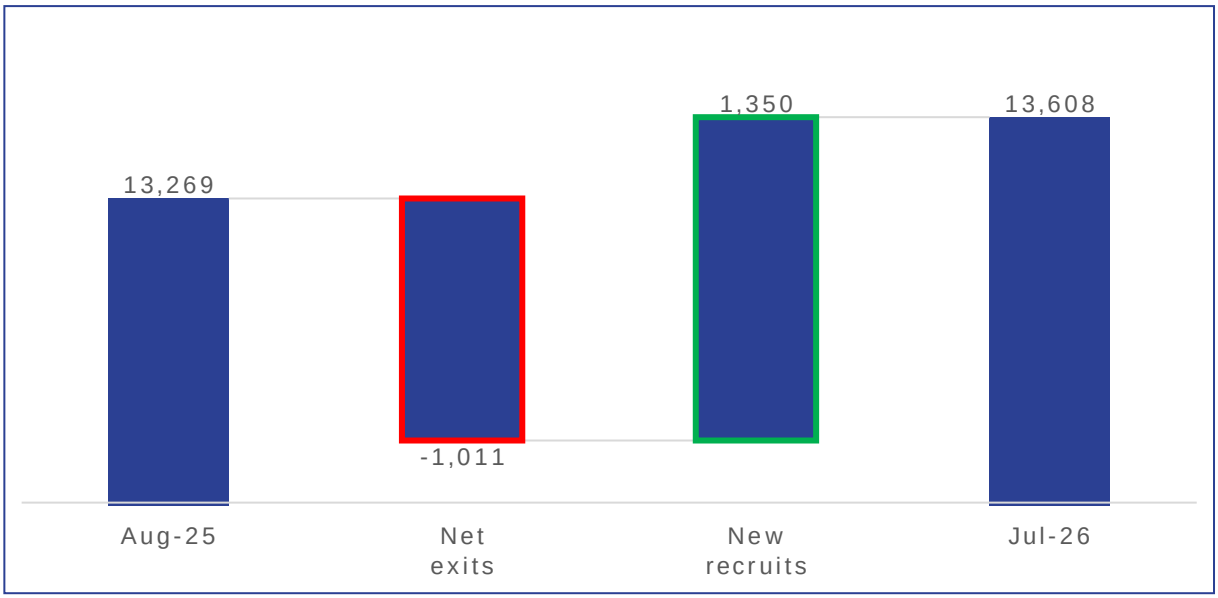


Figure 5.2.6 CTM workforce movement, August 2025 to July 2026[53]

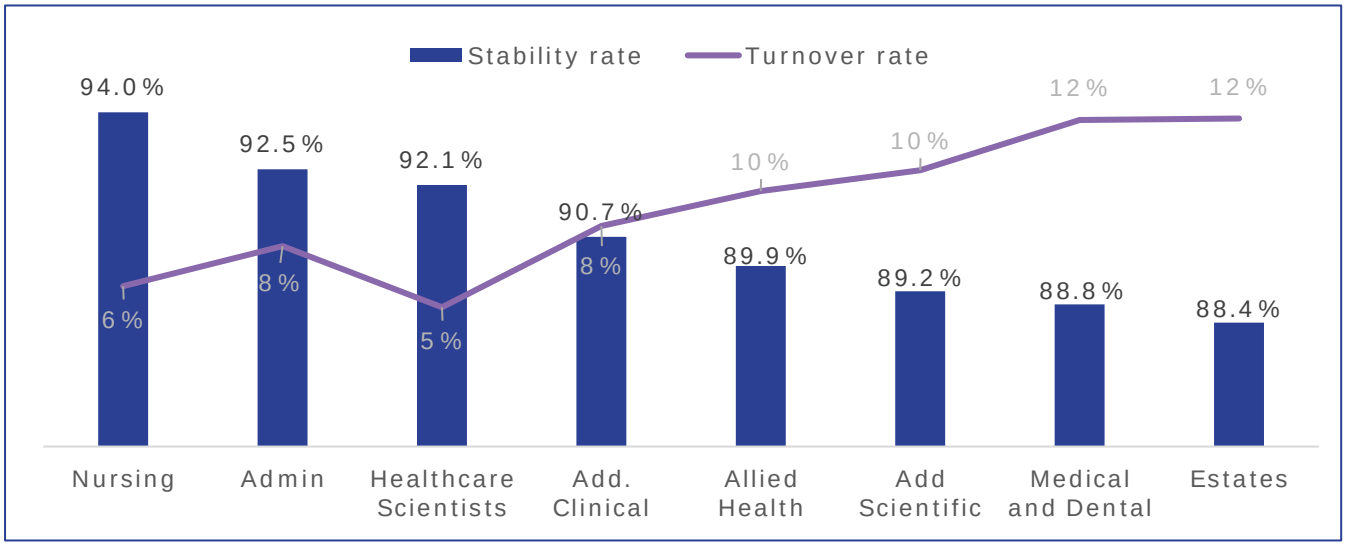


Figure 5.2.7 CTM stability rate, August 2025 to July 2026[54]

Variation is similarly pronounced across staff groups. Estates & Ancillary and Medical & Dental recorded the highest headcount turnover, at 12.4%, with Medical & Dental

[53] CTM Turnover and stability data
[54] CTM Turnover and stability data

retaining only 88.8% of its starting workforce. Additional Professional Scientific & Technical staff and Allied Health Professionals also recorded turnover of approximately 10.5% and 9.7%, respectively.

Registered Nursing & Midwifery presents a notably different picture: it recorded the highest stability at 94.0%, relatively low turnover of 6.1%, and net growth of 180 employees. This suggests workforce dynamics and potential responses differ materially by profession rather than reflecting a uniform organisation-wide challenge.

These patterns strengthen the case for moving beyond workforce growth and recruitment as the primary measures of workforce health. Sustained churn can absorb recruitment capacity, create repeated onboarding and training requirements, disrupt continuity and result in loss of organisational knowledge and experience. More importantly, replacing departures like-for-like may perpetuate existing workforce models rather than addressing how services need to operate in the future.

CTM has an opportunity to shift the workforce question from recruitment to retention and succession planning. This can be achieved by identifying the drivers of attrition in higher-churn clinical and non-clinical areas, learning from services and professions, demonstrating greater stability, and using workforce movement as an opportunity to reconsider roles that may no longer fit the future model of care delivery and future strategy, which includes how future skill mix informs future collaborative and innovative ways of working. Recruitment remains important, but sustainable workforce capacity will increasingly depend on retention, deployment and workforce redesigning working together.

5.4 Workforce transformation

The evidence points towards the need for workforce transformation, but it does not prescribe a single model. Moving more care into community, locality or virtual settings does not automatically reduce the workforce required. It may initially require additional capacity, new roles, training and double-running while new services become established. Some activity transferred from the acute hospital setting may remain dependent on the same scarce clinical workforce.

The relevant question is therefore not simply where staff are based; it will be how CTM can organise multidisciplinary capability around patients and pathways by extending the reach of scarce expertise and allocating specific duties to those who do not require regulated professional certification but can be overseen in practice by those who are regulated and experienced.

The workforce evidence identifies the following requirements for delivering the Future Care Model. These concern how capability is developed, sustained and deployed across the care continuum, rather than assuming that changing the location of care will reduce staffing requirements.

Table 5.4.1 Workforce evidence and implications for the Future Care Model

Evidence from the Case for Change	Strategic interpretation	Implication for the Future Care Model
Directly employed FTE increased by 6.7% between Q1 2022 and Q1 2026, compared with a Welsh health-board median of approximately 8.0%.	Workforce growth has occurred, but expansion of existing roles alone cannot be assumed to meet future requirements. The comparison does not establish a staffing shortfall.	Organise multidisciplinary capability around population needs and pathways across locality, community, diagnostic and hospital services. Recruitment should complement changes in roles, working arrangements and deployment.
Approximately 60% of net FTE growth was attributable to nursing, midwifery and health visiting. Growth differed between staff groups.	A future model requiring coordinated care needs a balanced range of capabilities. Increasing one profession does not automatically provide the supporting skills needed across a pathway.	Develop an appropriate mix of nursing, medical, therapy, pharmacy, care-coordination and support roles. Enable advanced and extended practice where appropriate, supported by competence, supervision and professional standards.
Registered nursing vacancies were approximately 289 FTE in Q1 2026, with a vacancy rate of 7.4%, above the Welsh health-board median of approximately 5.8%.	Nursing capacity is a particular constraint. Moving activity between settings may redistribute dependence on the same scarce expertise.	Protect work requiring registered expertise through appropriate support roles, safe delegation and effective workflows. Support community expansion with sufficient capability while sustaining acute and specialist services.
District-nursing FTE remained broadly static, while community mental-health nursing FTE fell by approximately 4.6% between March 2022 and March 2026.	Existing community teams cannot be assumed to absorb additional activity without changing their capacity or ways of working.	Strengthen the workforce supporting locality care and community urgent response before transferring responsibilities. Connect teams to specialist advice, shared care arrangements and clear escalation routes.
The proportion of employees aged 61 or over increased from 8.2% in 2022 to 10.1% in 2025, while the proportion aged 30 or under remained broadly unchanged.	Sustaining experienced capability is important alongside developing new roles. Age indicates potential succession exposure, rather than a definite retirement timetable.	Embed succession, knowledge transfer, flexible working and development pathways across the model. Retain specialist expertise while building wider team capability to provide appropriate care locally.
1,350 employees joined and 1,011 left between August 2025 and July 2026, producing net growth of 339. Turnover varied by profession.	Much recruitment replaces departing staff before adding capacity. Repeated replacement can consume resources and disrupt continuity.	Combine recruitment with targeted retention and sustainable team design. Stable teams and clear responsibilities are important for continuity of care, navigation, and reliable transitions between settings.

5.5 Technology

CTM have set a clear ambition to progress services from hospital centred models of care to a more preventative, digitally enabled, integrated care that delivers services closer to or within the patient's home environment. Patients will be supported and receive treatment through virtual models of care, locally based services, community teams and local diagnostic facilities. Digitisation creates opportunities for efficiency; however, if the current and future workforce is not prepared to change its working practices, duplication of effort and manual workarounds will be passed on to newly recruited or succession planned staff.

Technology should be presented as an enabler rather than an assumed source of workforce savings; however, poorly designed and deployed digital systems can add to workload as readily as well-designed, implemented systems can release time. Any expected workforce benefit should therefore be supported by current state workflow analysis, implementation capacity, training and measurable benefits. CTM's workforce has grown, and much of the increase has been concentrated in its largest staff group. Reported vacancies have risen; registered nursing faces material vacancy pressure, and approximately one in ten employees is now aged over 60. These findings challenge CTM, increasing pressure on its ability to build and sustain the workforce required for current services and future digitisation initiatives.

Comparisons based on workforce totals do not account for population need, service configuration, activity, cross-boundary provision or different delivery arrangements. Aggregate growth also says little about whether staff are located and aligned to services and places where they are required.

The workforce implications of the Future Care Model should be addressed through CTM's Strategic Workforce Plan, aligned with future service provision and the digital capabilities, skills and ways of working required to support delivery.

The future model will therefore need to use scarce expertise more deliberately, build effective multidisciplinary capacity, enable staff to work across hospital, community and virtual settings where appropriate, and reduce avoidable clinical and administrative workload which can be identified through current state mapping in preparation for digitisation.

These findings provide workforce design requirements for CTM's emerging model of care but do not determine the number, location or composition of staff required in each part of it. That will require activity-based workforce modelling that connects population need, service demand, pathway design, quality standards, productivity, workforce supply, affordability and implementation timescales.

6. Fragility of the current model & progress to date

The evidence in this document shows that CTM's current model of care needs to evolve to sustainably support the health care needs of the population it serves. The combined effects of population health need, persistent inequalities, operational pressure, workforce constraints and limited financial headroom cannot be addressed sustainably through isolated improvement initiatives or continued expansion of existing services. Similarly, to achieve a more patient- and community-centric approach to care prevention and delivery, CTM cannot drive change alone.

CTM is already progressing changes to sustain services, improve treatment pathways and develop care outside acute hospitals. A number of changes to hospital services have had to be made at short notice on a temporary basis, as a result of infrastructure or staffing challenges which reflect the pressures of delivering increasingly specialised services across three hospital sites.

Protecting planned treatment while strengthening specialist and recovery care

The Trauma and Orthopaedic service change provides the clearest reported example of benefits from reorganising a complete clinical pathway. Trauma care for Princess of Wales and Royal Glamorgan was consolidated at Royal Glamorgan, while elective inpatient arthroplasty was brought together at Princess of Wales through a dedicated 28-bed ward and three ultra-clean-air theatres. Orthogeriatric rehabilitation remained at Princess of Wales to support Bridgend patients locally.

The review reports 1,278 arthroplasty cases in the first year and an average length of stay of 2.6 days, compared with a stated pre-change range of five to eight days. It also describes dedicated multidisciplinary working, orthogeriatric input at Royal Glamorgan and improvements in nursing recruitment and retention. The elective ward has no registered or non-registered vacancies.

The significance extends beyond relocation. The change combines protecting elective capacity from emergency demand ('hot/cold' split), concentrating specialist teams, workforce development, and local rehabilitation. These are complementary features of a future model that connects specialist treatment with recovery closer to home.

Developing community and local provision

There are several other changes programmes that strengthen the community and recovery components of the Future Care Model. Their reported position and strategic contribution are summarised below.

Programme	Progress recorded in the documents	Implication for the Future Care Model
Community-bed redesign	Phase 1 community beds reconfiguration, repatriating 38 community beds to the Bridgend locality. Implementation planning involves operational, workforce, estates and communications teams.	Establishes a direction towards more equitable community provision, with 'Home First' where clinically appropriate and step-up capacity for needs that cannot safely be met at home.
Specialist palliative care and Hospice@Home	Engagement has informed redesign, with a commitment to reinvest funding in community-focused specialist palliative care in Merthyr and Cynon.	Shows a route for redirecting resources towards care at home while retaining specialist support.
Dementia day-service redesign	An independent review and engagement informed a proposed move from differing place-based models towards specialist community in-reach. Staff consultation and discussions with service users, families and local authorities are underway.	Supports a more consistent approach that brings specialist expertise to people where they live. Its contribution depends on the connection between health input, social-care alternatives and support for families.
Integrated Women's Health Hub	Implemented at Ysbyty Cwm Cynon in 2025, with evaluation and referral-pathway work underway.	Provides a foundation for more integrated local access to specialist services, with positive patient feedback.
Local health and wellbeing facilities	Bridgend Health and Wellbeing Centre construction and opening in 2026. The Llynfi Valley programme has a preferred site, engagement planning, design workshops and business-case development underway.	Local facilities can support integrated provision, and their contribution depends on aligning service design, staffing and estate readiness.

Other changes have been driven by immediate safety, workforce or environmental pressures. These include temporary consolidation of acute stroke and inpatient gastroenterology services and intermittent suspension of community / home birth services to prioritise acute maternity care.

These examples demonstrate that maintaining a service in a preferred location depends on sufficient workforce and a suitable clinical environment. The Future Care Model cannot therefore be implemented through relocation or decentralisation alone. Local provision must be supported by the expertise, staffing and escalation arrangements required for safe delivery and suitable physical and virtual infrastructure.

The progress to date demonstrates that CTM is already making improvements and operational changes to sustain services, protect treatment capacity and develop community provision. These changes provide practical foundations and learning for the

Future Care Model. However, they address specific services, sites or immediate pressures and do not yet constitute a coordinated response across the whole care continuum.

This strengthens the case for a whole-system approach that connects improvements already delivered and programmes in progress within a coherent Future Care Model. The next stage should build on this momentum, linking specialist treatment with earlier intervention, continuing care, community support and recovery. In this way, individual service changes can contribute to a consistent model organised around people's needs, with workforce, infrastructure and resources aligned across the system.

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

CTM Building Healthier Communities: International Evidence

September 2026



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1. International Exemplars

Health and care systems internationally are grappling with the same pressures now evident across Cwm Taf Morgannwg University Health Board (CTM): changing population needs, rising complexity, persistent health inequalities, constrained workforce capacity and growing demand for urgent and hospital-based care. These pressures cannot be met sustainably by adding hospital capacity alone. Reform programmes are working to prevent avoidable ill health, identify need earlier, strengthen care within communities and build continuity between primary, community, social and specialist services. This direction reflects a wider international movement towards integrated, people-centred care, although how it is translated and implemented into practice varies considerably between systems.[1]

This international exemplar review was undertaken to understand how different systems have approached that challenge, and what their experience could contribute to CTM's Future Vision. It considers models operating at several levels, from national reform programmes and regional integrated-care systems to locality, neighbourhood and community-led approaches. The breadth is deliberate. CTM's ambition depends on action at more than one level at once: coherent direction, infrastructure and specialist capability across the Health Board; coordinated planning and delivery for defined locality populations; and flexible, relationship-based responses shaped around the circumstances and assets of individual communities.

The review therefore looks beyond the formal structure of each system to how care is intended to work in practice. It pays particular attention to how models organise services around defined populations and places; connect prevention, primary care, community services, social care, and hospital provision; identify and respond to risk before needs escalate; and extend assessment, diagnostics, treatment, and recovery beyond traditional hospital settings. It also identifies how people enter and navigate each model, where responsibility for coordinating care sits, and how continuity is maintained as people move between services. These are the same capabilities the Bonsai model sets out, and the exemplars are read with that model in mind.

1.1 Scope and selection of exemplars

The aim of the review is not to find a single international model for CTM to reproduce. Each exemplar has developed within its own policy, funding, governance and cultural environment, workforce, geography, population density, local government responsibilities and the maturity of existing services all shape how a model works and what it can achieve. A similar population size may make an exemplar more relevant, but it does not by itself make a model transferable.

The review instead seeks the underlying design choices, care capabilities and enabling conditions that could be relevant to CTM. That means looking not only at the visible configuration of services, but at the workforce, digital, data, governance, funding,

[1] https://www.who.int/health-topics/integrated-people-centered-care

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infrastructure and improvement activities that allow those services to operate as a connected system.

A broad international landscape was considered, spanning whole-system reform, population-accountable partnerships, regional integration, hospital and community collaboration and neighbourhood-based delivery.

It was tested against eight selection lenses:

1. relevance to CTM's case for change
2. coverage of the care continuum
3. population scale and comparability
4. place and hyperlocal relevance
5. system breadth
6. evidence and maturity
7. transferability, and distinctive contribution, and
8. distinctive contribution

Five geographies were selected for detailed profiles, Ireland, Singapore, Brazil, Ontario and New Zealand, while six further models were retained as focused practice spotlights. The selected systems differ in how they are funded, with a mix of public and private funding. The review draws on the operating principles of each system, focusing on how care is organised and delivered rather than on the way it is financed.

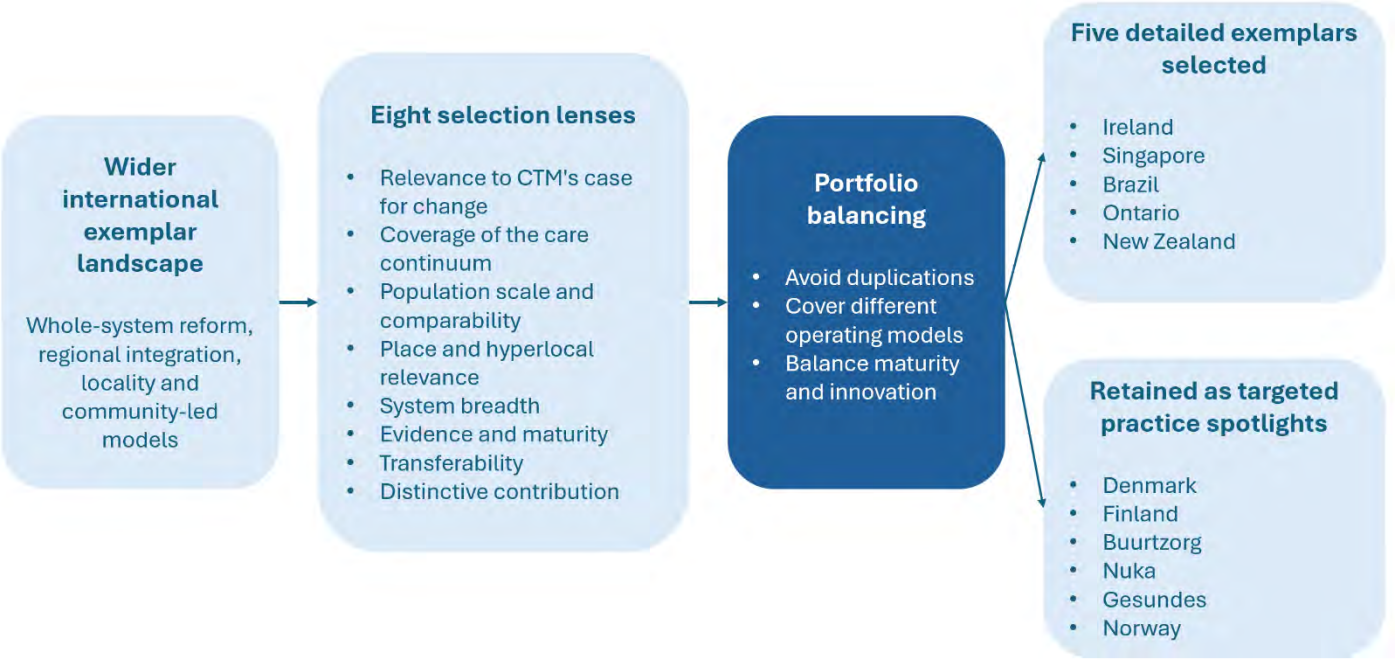


Figure 1.1.1. From the wider landscape to the five detailed exemplars

Each exemplar is examined as a named programme rather than as a whole health system. The five are summarised below, together with the distinctive contribution each offers, its relevance to CTM's primary, community and acute services, and the period over which it has developed.

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Selection Criteria	Ireland	Brazil	Singapore	New Zealand	Ontario (Canada)
Relevance to CTM's case for change	Care closer to home and stronger community capacity	Population responsibility and proactive community outreach	Prevention, early intervention and primary care continuity	Integrated pathways, demand management and community prevention	Population responsibility and connected primary care
Coverage of the care continuum	Broad coverage from prevention to hospital care	Strong in prevention, primary and community; coordination across interfaces	Strongest across prevention, primary care and community support	Canterbury provides system integration, Healthy Families strengthens prevention	Coordination across primary, community, hospital and ongoing care
Population scale and comparability	National programme with networks of approximately 50,000 people	National; teams responsible for ~2,000 to 3,000 people	National programme delivered through family doctors and regional clusters	Regional integration and selected community level delivery	Local teams and networks serving defined populations
Place and hyperlocal relevance	Local networks supported by community and voluntary partners	Defined neighbourhood territories with household-level outreach	Enrolled family doctors connected with community programmes	Strong hyperlocal focus through Healthy Families	Local partnerships responding to defined population needs
System breadth	Primary care, community teams, diagnostics, specialists, hospitals and voluntary partners	Primary care, community health workers, shared multiprofessional support, referral network	Family doctors, health clusters and community partners	Health, social care and partners beyond healthcare	Primary, community, hospital, mental health and home care
Evidence and maturity	Nationally implemented, with strong activity reporting but limited independent evaluation	Nationally implemented since 1994; strong but largely observational evidence	Nationally implemented, with longer-term evidence developing	Mature Canterbury experience and evaluated community programmes	Established but variable implementation, with outcomes evidence developing
Transferability to CTM	High, with adaptation of scale and governance	Moderate to high; transfer principles rather than workforce structure	Moderate to high, given different funding and delivery arrangements	High for regional integration and community-led prevention	High, with adaptation to the NHS Wales context
Distinctive contribution	Connected community care architecture	Neighbourhood population responsibility and proactive outreach	Prevention and continuity through a trusted family doctor	Regional integration and hyperlocal prevention	Population responsibility and networked primary care

Table 1.1.1. Criteria for Selection of the Five Exemplars

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The review focuses on named programmes and models within these geographies, rather than attempting to assess their health systems as a whole:

- Ireland's Enhanced Community Care programme, which connects general practice, Community Healthcare Networks, specialist community teams, diagnostics and chronic disease management as part of a wider shift towards care closer to home[2]
- Brazil's Family Health Strategy, in which multidisciplinary teams take continuing responsibility for a defined neighbourhood population and use community health workers to connect households with primary care, health promotion and ongoing support[3]
- Singapore's Healthier SG programme, a national preventive-health initiative built around enrolment with a family doctor, personalised health plans and connections to local health-promoting and community support[4]
- the Canterbury Health System, which provides a regional example of sustained pathway integration and closer working between general practice, community, hospital and social care, considered alongside Healthy Families New Zealand as a complementary example of locally led action on the wider determinants of health[5,6]
- Ontario Health Teams and Primary Care Networks, which illustrate how primary care can organise collectively within partnerships responsible for coordinating care for defined populations[7]

Together, these exemplars provide different but complementary perspectives. Ireland offers practical insight into the service architecture required to expand community-based care. Denmark illustrates how accountability, investment and pathway responsibility can support a wider rebalancing of the system. Singapore brings a strong emphasis on prevention, longitudinal relationships and proactive health management. Canterbury demonstrates regional integration and the redesign of pathways between community and hospital services, while Healthy Families New Zealand offers a more explicitly community-led and hyperlocal perspective. Ontario contributes learning on population accountability and the collective organisation of primary care within a broader local partnership.

The selected portfolio also spans different population scales and operating levels. National reforms help identify the policy, investment and infrastructure required to support system-wide change. Regional models offer learning closer to the scale of a Health Board, while locality and community-based approaches demonstrate how a consistent strategic framework can still allow services to respond to different local

[2] https://about.hse.ie/news/hse-enhanced-community-care-improving-health-outcomes-for-patients-across-ireland
[3] https://www.ism.dk/Media/638954298352847005/Danish%20Health%20Care%20Reform%202024%20%20in%20brief.pdf
[4] https://www.healthiersg.gov.sg/about/what-is-healthier-sg/
[5] https://assets.kingsfund.org.uk/f/256914/x/55e4db0bb9/quest_integrated_health_social_care_canterbury_nz_2013.pdf
[6] https://www.health.govt.nz/system/files/2023-01/case-study-healthy-families-commissioning-for-pae-ora-jan23.pdf
[7] https://www.ontario.ca/files/2024-01/moh-primary-care-networks-guidance-en-2024-01-23.pdf

needs. This combination is particularly relevant to CTM's intention to connect Health Board-wide capabilities with locality and hyperlocal delivery.

1.2 Research approach

Each detailed exemplar is assessed through a consistent framework. The analysis begins with the problem the model was intended to address, the population it serves and the geographical level at which care is organised. It then examines the model's layers of care, including prevention, primary and local care, enhanced community provision, urgent response, hospital and specialist services, and recovery or ongoing support. Digital and virtual care are considered as capabilities that connect these layers, rather than as separate destinations within the care journey.

The review also considers how each model operates: how people access support, who maintains continuity, how need and risk are identified proactively, how multidisciplinary teams work together and how escalation to, and recovery from, hospital care are managed. This is accompanied by an assessment of the enabling foundations, including workforce roles, information sharing, governance, funding, infrastructure and community participation.

Where outcomes are reported, the strength and nature of the evidence is made clear. Established models may have quantitative evaluations, qualitative accounts and longer-term implementation experience, while more recent programmes offer insight into strategic direction and system design but cannot yet demonstrate realised impact. Singapore's Healthier SG, launched in 2023, is an example of the latter, informative about direction but too recent to show long-term population outcomes.[3] Where evidence is largely observational, as with much of the Brazilian and Canterbury data, reported changes in activity or utilisation are not attributed to an exemplar unless the evidence establishes causality.

The findings therefore distinguish between demonstrated outcomes, reported experience and anticipated benefits. This allows the review to recognise promising practice without overstating what the evidence can support.

Ultimately, the relevance of each exemplar is considered through three practical questions:

- Which principles or features could CTM adopt?
- Which would need to be adapted to the NHS Wales and local CTM context?
- Which warrant further exploration through engagement, service design and development of the future operating model?

Used in this way, international experience provides a structured source of learning, not a blueprint, helping CTM make informed choices about the care model it wishes to create.

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1.3 The international exemplar landscape

The longlist was deliberately broad, so that no relevant model was overlooked before the five detailed exemplars were chosen. Models are grouped by their principal contribution rather than by country, because national policy and neighbourhood practice answer different questions: policy creates the conditions for change, while local models show how care is organised around a person or community. The landscape falls into five broad and overlapping groups.

A landscape spanning different levels of care

The international landscape can be understood through five broad and overlapping groups.

Area of Learning	Illustrative exemplars	Principal relevance to CTM
National and whole system reform	• Ireland • Denmark • Singapore • Finland	How policy, accountability, investment and infrastructure can support a wider shift towards prevention, integration and care closer to home
Regional and population-based integration	• Canterbury (New Zealand) • Ontario (Canada) • Gesundes Kinzigtal (Germany)	How organisations can coordinate services and accept greater responsibility for the outcomes of a defined population
Locality and neighbourhood delivery	• Ireland's Community Healthcare Networks • Ontario's Primary Care Networks (Canada) • The Buurtzorg Model (The Netherlands)	How multidisciplinary capability, continuity and coordination can be organised close to local communities
Community participation and proactive prevention	• Healthy Families New Zealand • Brazil's Family Health Strategy • The Nuka System of Care (The United States)	How communities, families and local assets can shape prevention, engagement and access
Hospital and community integration	• Canterbury (New Zealand) • Denmark • Norway	How specialist services, local provision and discharge arrangements can operate as a connected pathway rather than as separate parts of the system

Table 1.3.1 The international exemplar landscape by area of learning

These categories are not mutually exclusive. Several exemplars operate across more than one level and derive their value from connecting national direction with local delivery. Ireland's Enhanced Community Care programme, for example, is supported through a national programme but delivered through Community Healthcare Networks and specialist community teams. Brazil's Family Health Strategy combines a national framework with delivery organised entirely around defined neighbourhood populations. Singapore's Healthier SG programme similarly establishes a national framework while

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anchoring continuity in the relationship between residents, family doctors and community support.[8,9,10]

National reform and system conditions

Ireland, Denmark, Singapore, and Finland show that moving care closer to home depends on decisions about responsibility, resources, workforce, information and the relationship between general practice, community and hospitals, not on adding community services alone. Ireland is profiled in detail; Singapore likewise, for its emphasis on prevention and longitudinal primary care. Denmark's 2024 reform, effective from 2027, is retained as a spotlight on strategic direction rather than proven outcomes. Finland's 2023 transfer of health, social and rescue services to 21 wellbeing counties is relevant to governance but more structural than operational, and CTM already holds relatively integrated responsibilities as a Welsh Health Board.[11,12,13,14]

Regional integration and population responsibility

Canterbury, Ontario, and Gesundes Kinzigtal operates at a scale closer to CTM. Canterbury is profiled in detail for its pathway redesign and shared clinical leadership across the community–hospital interface; Ontario for population accountability and the collective organisation of primary care, noting that maturity varies between teams. Gesundes Kinzigtal is retained as a focused spotlight on incentives and shared savings, tempered by a WHO/OECD finding of no significant quality effect over 2006 to 2015 and a financial model unlike NHS Wales.[15,16,17,18]

Locality, neighbourhood and household delivery

Community Healthcare Networks, Primary Care Networks, and Buurtzorg demonstrate how continuity, multidisciplinary capability and coordination can be organised close to communities. Ireland's Community Healthcare Networks and Ontario's Primary Care Networks are covered within their detailed profiles, as the local delivery layer of larger national and regional models. Buurtzorg in the Netherlands is retained as a spotlight on relational care through small, autonomous nursing teams built around the individual's family, social network and existing community relationships. Its principles have already been tested in Wales: in 2017 the Welsh Government funded a Buurtzorg-based

[8] https://about.hse.ie/news/hse-enhanced-community-care-improving-health-outcomes-for-patients-across-ireland
[9] https://www.ism.dk/Media/638954298352847005/Danish%20Health%20Care%20Reform%202024%20%20in%20brief.pdf
[10] https://www.healthiersg.gov.sg
[11] https://about.hse.ie/news/hse-enhanced-community-care-improving-health-outcomes-for-patients-across-ireland/
[12] https://www.ism.dk/Media/638954298352847005/Danish%20Health%20Care%20Reform%202024%20%20in%20brief.pdf
[13] https://www.healthiersg.gov.sg/
[14] https://stm.fi/en/wellbeing-services-counties
[15] https://assets.kingsfund.org.uk/f/256914/x/55e4db0bb9/quest_integrated_health_social_care_canterbury_nz_2013.pdf
[16] https://www.ontario.ca/files/2024-01/moh-oht-hcp-guidance-doc-en-2024-01-22.pdf
[17] https://www.ontario.ca/files/2024-01/moh-primary-care-networks-guidance-en-2024-01-23.pdf
[18] https://wkc.who.int/docs/librariesprovider24/wkc-projects-documents/germany_case_study_policy_brief.pdf?sfvrsn=9aef2d1b_6&utm

Neighbourhood District Nursing pilot across three health boards, including Cwm Taf Morgannwg, and the independent University of South Wales evaluation found that the ethos of the model could transfer to a Welsh setting, though only with adaptation. It is not, however, a complete health system model and does not address the full range of diagnostic, urgent, hospital or specialist services within CTM's layered model.[19]

Brazil, Healthy Families New Zealand, and Nuka show how families and local assets shape prevention, engagement and access. Brazil's Family Health Strategy is profiled in detail for neighbourhood population responsibility and household outreach. Healthy Families New Zealand, considered alongside Canterbury, and the Nuka System of Care are retained as spotlights on locally led prevention and community ownership respectively.[20,21,22]

Connecting hospital and community care

A further group of exemplars addresses the interface between hospitals and local services. This is particularly relevant to CTM because the Future Vision is not intended to diminish the importance of hospitals. It seeks to clarify their role within a broader model in which specialist expertise can reach into community settings, people can avoid hospital where appropriate, and transitions back home are planned as part of a continuous pathway.

Canterbury provides practical experience of redesigning pathways across general practice, community and hospital services. Denmark's reform proposes a more explicit outward role for hospitals, including continued treatment responsibility following discharge. Norway offers additional learning through a system in which municipalities are responsible for primary health and care services while regional authorities oversee specialist services, and district medical centres can bring municipal and specialist provision together in local settings. This makes Norway useful for understanding shared responsibility across organisational boundaries, although it offers less prescription about the detailed frontline model than Ireland or Canterbury.[23,24,25]

This review confirms that the strongest learning for CTM will come from combining examples operating at different levels. National reforms can show how accountability, investment and common infrastructure support transformation. Regional models can demonstrate how services are integrated around a defined population. Local and hyperlocal examples reveal how care can become more proactive, relational and responsive to the circumstances of individual communities.

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[19] https://www.buurtzorg.com/about-us/buurtzorgmodel/
[20] https://www.gov.br/saude/pt-br/composicao/saps/esf
[21] https://www.health.govt.nz/system/files/2023-01/case-study-healthy-families-commissioning-for-pae-ora-jan23.pdf
[22] https://www.southcentralfoundation.com/nuka-system-of-care/
[23] https://www.ism.dk/Media/638954298352847005/Danish%20Health%20Care%20Reform%202024%20%20in%20brief pdf
[24] https://assets.kingsfund.org.uk/f/256914/x/55e4db0bb9/quest_integrated_health_social_care_canterbury_nz_2013.pdf
[25] https://www.regjeringen.no/en/topics/health-and-care/innsikt/the-structure-of-the-healthcare-system/id227440/

The five geographies selected for detailed review, Ireland, Singapore, Brazil, New Zealand and Ontario, collectively provide this breadth. They also offer sufficiently distinctive perspectives to avoid examining several models that answer essentially the same question. The remaining exemplars, including Denmark, Finland, Gesundes Kinzigtal, Buurtzorg, Healthy Families New Zealand, the Nuka System of Care and Norway, are retained as shorter practice spotlights where they contribute a specific feature, such as national reform direction, autonomous neighbourhood teams, community ownership, integrated health and social care responsibility or population-based incentives.

1.4 Ireland: Enhanced Community Care Programme

Strategic relevance to CTM

Ireland's Enhanced Community Care programme shows how a national ambition for care closer to home can be translated into a defined service architecture. Developed through the wider Sláintecare reforms, it strengthens prevention, general practice and community services while improving access to diagnostics and specialist expertise outside hospital.

It operates nationally across a population of 5.15 million, built on 96 Community Healthcare Networks each designed to serve about 50,000 people, with Community Specialist Teams for older people and chronic disease operating across roughly three networks, a population of around 150,000.[26,27]

Ireland is relevant to CTM because it combines three things central to the Bonsai model: it describes care through explicit levels of need and complexity, organises delivery around defined local populations, and connects primary and community services with diagnostics, specialist support, urgent response and hospital care. The comparison is not exact, Ireland's formal layered model focuses on selected chronic diseases, while Bonsai describes a whole-system architecture, but the Irish experience offers useful evidence about how the capabilities within CTM's six layers can be connected and organised at different population scales.

Context and ambition

Enhanced Community Care is rooted in Sláintecare, Ireland's long-term reform programme, which sought to move away from an episodic, hospital-focused system towards prevention, continuity and care at the lowest appropriate level of complexity.[28] The direction reflects real demographic pressure: between 2016 and 2022 the

[26] https://www.cso.ie/en/releasesandpublications/ep/p-cpsr/censusofpopulation2022-summaryresults/keyfindings/

[27] https://www.rezoomo.com/contentFiles/jobs/30799/attachments/10118_CHN%20GP%20Lead%20Information%20Sheet%202022.pdf

[28] https://data.oireachtas.ie/ie/oireachtas/committee/dail/32/committee_on_the_future_of_healthcare/reports/2017/2017-05-30_slaintecare-report_en.pdf

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population grew by 8 per cent while the number of people aged over 70 grew by 26 per cent, with more people living longer with chronic disease, frailty and multiple needs.[29]

The programme received €240 million to establish Community Healthcare Networks, Community Specialist Teams and related diagnostic and community services.[30] The investment matters: care cannot simply be redirected from hospital unless local services have the workforce, infrastructure, diagnostic access and specialist support to respond safely. The intended change is a shift in capability and resources, not only in referral expectations.

The operating model

Ireland's clearest formal layered model is the National Framework for the Integrated Prevention and Management of Chronic Disease, covering cardiovascular disease, diabetes, COPD and asthma. It is not a universal model for every pathway, but it expresses the clinical logic underpinning the chronic disease component of Enhanced Community Care.[31]



[29] https://www.cso.ie/en/releasesandpublications/ep/p-cpsr/censusofpopulation2022-summaryresults/keyfindings/
[30] https://www.hse.ie/eng/about/personalpq/pq/2022-pq-responses/december-2022/pq-60324-22-violet-anne-wynne.pdf?
[31] https://about.hse.ie/publications/hcp-national-framework-for-the-integrated-prevention-and-management-of-chronic-disease-in-ireland-2020-2025/

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Figure 1.4.1 Ireland's Model of care for the integrated prevention and management of chronic disease

The model comprises five levels.

- Level 0 is described as "Living well with chronic disease". It includes prevention, Making Every Contact Count, self-management support, telehealth and remote monitoring. The person and their ability to manage their health are the starting point, rather than a clinical institution
- Level 1 comprises General Practice. It includes structured review, assessment when a person's condition deteriorates, care planning, telephone triage and access to virtual specialist advice
- Level 2 introduces Community Specialist Ambulatory Care. This provides access to specialist teams, diagnostics, structured education, physiotherapy, dietetics, podiatry and cardiac or pulmonary rehabilitation
- Level 3 comprises Acute Specialist Ambulatory Care. It includes alternative outpatient pathways, respiratory outreach and other specialist services that require closer connection with acute expertise but do not necessarily require hospital admission
- Level 4 is Specialist Hospital Care. It includes emergency assessment, acute medical assessment, complex care and inpatient treatment requiring hospital resources

The model establishes a graduated response to need. General practice does not have to choose between managing a person alone and referring them into a conventional hospital pathway. Community specialist and ambulatory services provide additional levels of assessment, diagnostics and treatment between those two settings.

Movement is also intended to occur in both directions. A person may require more intensive support when their condition deteriorates but should return to general practice and community care once their needs stabilise. Early supported discharge and ongoing care at home are therefore integral to the model.

This provides a close parallel with the underlying logic of the Bonsai model. Both approaches seek to support people through the broadest and least intensive layer that can safely meet their needs, with progressively greater capability available as complexity increases. However, CTM makes several capabilities more explicit by separating Virtual Response, Community Urgent Response, and Diagnostic and Treatment Platforms into distinct layers.

The Older Persons and Chronic Disease Service Model provides a broader representation of how these levels are organised across home, community and hospital settings. It describes a connected continuum from living well at home, through Community Healthcare Networks and Specialist Ambulatory Care Hubs, to hospital care. Community diagnostics, residential care, rehabilitation, convalescent care and end of life support sit between and connect the principal settings.[32]

[32] https://assets.hse.ie/media/documents/Health_Regions_Integrated_Service_Delivery_Model.pdf

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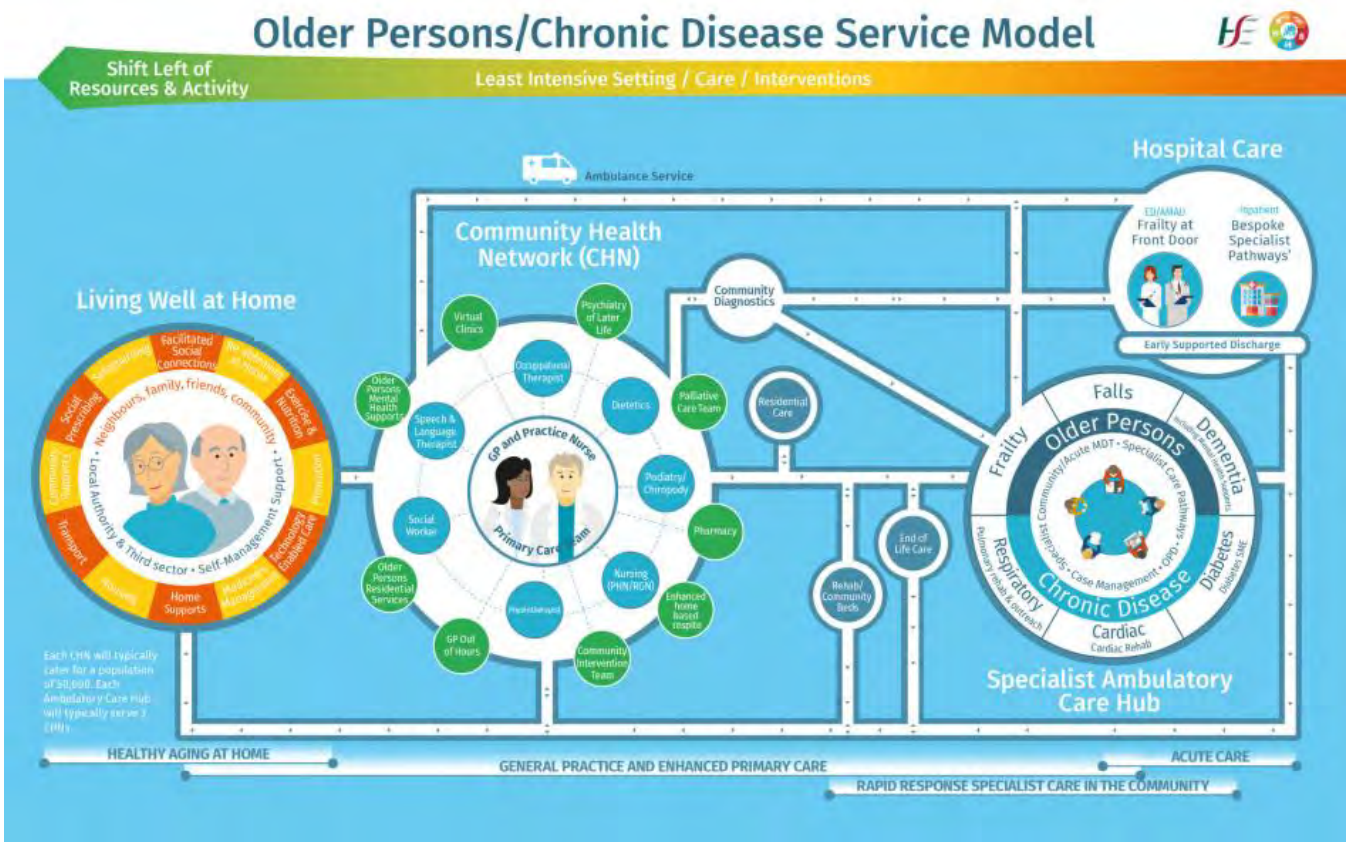


Figure 1.4.2 Older Persons and Chronic Disease Service Model, Ireland

The model begins with living well at home. Individuals are shown within their families, neighbourhoods and communities rather than solely as recipients of healthcare. Housing, transport, nutrition, exercise, social connection, community support and home support all affect whether people can maintain their health and independence. The model also recognises the contribution of local authorities and the third sector.

This is broader than Level 0 of the chronic disease pyramid and provides a closer parallel with CTM's Prevention Layer. Both recognise that prevention depends on the circumstances in which people live, the assets available within communities and the ability of different partners to act before needs escalate.

The next component is the Community Healthcare Network. General practice, the practice nurse and the primary care team sit at the centre, surrounded by community nursing, therapies, pharmacy, social work, mental health, palliative care, virtual clinics, community intervention, out of hours services and residential care.

The network creates a local organising structure through which professionals can develop shared care plans, discuss complex cases and coordinate services for a defined population. Its purpose is not simply to group existing services within a common geography. It is intended to support greater collective responsibility for local population need.

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This is most directly relevant to CTM's Locality Care layer. It demonstrates how general practice can operate within a wider multidisciplinary offer rather than as a collection of separate practices referring independently into community and hospital services. CTM's ambition is broader because Locality Care is intended to connect primary, community, social and preventive care. Nevertheless, the Community Healthcare Network provides a useful example of the relationships and local leadership needed to support such an offer.

When needs exceed the capability of routine primary and community services, people can access a Specialist Ambulatory Care Hub. The hubs support older people living with frailty, falls or dementia, and people with diabetes, cardiac or respiratory disease. They bring together specialist opinion, multidisciplinary assessment, rehabilitation, structured education and diagnostics outside traditional hospital settings.

These hubs provide the closest parallel with CTM's Diagnostic and Treatment Platforms. Both seek to make a broader range of investigations, specialist assessment and treatment available outside hospitals. They also illustrate why some capabilities need to operate across several localities. A specialist workforce, equipment, and diagnostic infrastructure may not be sustainable in every neighbourhood or locality, but platforms serving a larger population can still provide them closer to communities.

Hospital services remain an essential part of the Irish model, but their role becomes more focused. Frailty assessment at the emergency and acute medical front door, bespoke specialist pathways, inpatient treatment and early supported discharge connect hospital services to the wider community model. Hospital expertise can also reach into community settings through specialist outreach, virtual clinics, integrated consultants and shared pathways.

This is consistent with CTM's Specialist and Emergency Hospital Care layer. In both models, hospitals are not removed from the care continuum. They become more focused on emergency, critical, complex and specialist care that cannot be delivered safely elsewhere.

Access, coordination and movement between settings

The Irish model is designed around a combination of local continuity and access to progressively more specialised capability. General practice provides an important clinical relationship, while the Community Healthcare Network connects the practice to a broader multidisciplinary team. A clinical coordinator can support multidisciplinary meetings, care planning and the allocation of a key worker for people with complex needs.[33]

Where specialist advice is required, general practitioners and community teams can refer into Community Specialist Teams or use virtual clinics to discuss care with specialists. Access to community diagnostics allows more assessment and management to remain outside hospital.

[33] https://www.rezoomo.com/contentFiles/jobs/30799/attachments/10118_CHN%20GP%20Lead%20Information%20Sheet%202022.pdf

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When a person experiences an acute deterioration, Community Intervention Teams, rapid specialist response, frailty services and other hospital avoidance pathways can provide time limited care within the community. This includes nursing interventions, assessment, treatment and support for earlier discharge.

These capabilities align with CTM's Community Urgent Response layer. Ireland does not present them as a separate formal level within its five-level pyramid, but its wider service model clearly recognises the need for rapid response between general practice, specialist community services and hospital care. CTM makes this bridging function more visible by giving it a distinct layer within the Bonsai architecture.

Digital services also span the Irish model. HealthLink supports electronic referrals, the HSE Area Finder helps practices identify the appropriate local service, and virtual clinics give general practitioners access to specialist advice without requiring every patient to attend hospital. Telehealth and remote monitoring are included within the lowest level of the chronic disease model.

Ireland therefore treats digital capability mainly as an enabler operating across existing levels. CTM goes further by defining Virtual Response as the system front door. This provides a useful point of differentiation. The Irish experience demonstrates what virtual care can do, while CTM's model gives those functions a clearer role in access, navigation, triage, and early response across the whole system.

Population scale and local variation

The use of defined population units is one of the most relevant features for CTM. Community Healthcare Networks were designed around approximately 50,000 people, while Community Specialist Teams and ambulatory hubs commonly support several networks and a population of around 150,000.

This establishes different scales for different forms of capability. Local relationships, multidisciplinary primary care and understanding of population need can be organised at network level. More specialised staff, diagnostics, rehabilitation and equipment can operate across groups of networks where a larger population is required to sustain them.

The population figures should not be transferred directly to CTM. Ireland's own experience shows that actual network populations can exceed the original planning assumption and that areas with similar population sizes can have different service requirements. Age, deprivation, rurality, transport, workforce supply, disability and access to facilities all affect the level and type of capacity required.[34]

The transferable lesson is that CTM should define the most appropriate footprint for each Bonsai layer and capability. Some elements of prevention and community asset development will need to operate at a hyperlocal level. Locality Care will require a population large enough to support multidisciplinary teams while retaining strong local relationships. Community Urgent Response and Diagnostic and Treatment Platforms

[34] https://cnh.hseland.ie/media/f5ahhajk/19-erin-smith-health-needs-analysis-of-counties-meath-and-louth.pdf

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may need to serve several localities. Specialist and Emergency Hospital Care will require planning across the Health Board and, for some services, beyond CTM.

Enabling foundations

The Irish model depends on more than the visible configuration of services. Network managers and general practitioner leads provide local leadership. Clinical coordinators support multidisciplinary working, while Community Specialist Teams and Integrated Care Consultants connect community and hospital services.

Population profiling is intended to help each network understand its demographic, health and service needs. This enables local planning to reflect differences between populations rather than assuming that every network requires an identical service offer.[35,36]

Community and voluntary organisations are also incorporated into the model. In 2024, the HSE reported that more than 42,000 people received support through its partnership with ALONE, including social connection, housing support, technology and access to community services.[37]

The model also depends on investment in workforce, diagnostics, digital referrals, facilities and transport. This is directly relevant to CTM. The Bonsai model cannot be implemented through pathway redesign alone. Each layer will require sufficient capacity, clear clinical responsibility and the infrastructure needed to absorb the activity expected of it.

Evidence and reported outcomes[38]

HSE reporting indicates that Enhanced Community Care is delivering significant activity outside conventional hospital pathways. During 2024, Community Specialist Teams for older people recorded approximately 133,000 patient contacts. The HSE reported that 81 per cent of patients were discharged home following community intervention and estimated that more than 7,000 frail adults avoided an unnecessary hospital admission.

More than 645,000 structured chronic disease reviews were completed in general practice. The HSE also reported a 15 per cent reduction in hospital admissions among chronic disease patients between 2019 and 2023, compared with a 1.3 per cent reduction in medical admissions overall.

Community diagnostic activity included more than 280,000 radiology tests and almost 218,000 blood tests used to support the identification of new heart failure. Mobile radiology was provided to more than 7,000 nursing home residents, with the HSE

[35] https://www.rezoomo.com/contentFiles/jobs/30799/attachments/10118_CHN%20GP%20Lead%20Information%20Sheet%202022.pdf

[36] https://cnh.hseland.ie/media/f5ahhajk/19-erin-smith-health-needs-analysis-of-counties-meath-and-louth.pdf

[37] https://about.hse.ie/news/hse-enhanced-community-care-improving-health-outcomes-for-patients-across-ireland/

[38] https://about.hse.ie/news/hse-enhanced-community-care-improving-health-outcomes-for-patients-across-ireland/

reporting that 95 per cent were treated within their existing setting rather than transferred to hospital.

Integrated Care Consultants and their acute teams recorded more than 117,000 patient contacts in 2024. More than 900 virtual clinics were held, and the HSE reported an 85 per cent reduction in hospital attendance among patients using heart virtual clinics.[39]

These findings suggest that the model is expanding access to diagnostic and specialist capability outside hospital and enabling more care to remain within general practice and community settings. However, most national outcome figures are reported by the HSE as the programme provider. Published reporting does not consistently describe comparison groups, regional variation or the methodology used to estimate avoided admissions. The figures should therefore be treated as reported programme outcomes rather than definitive evidence that Enhanced Community Care caused every observed change.

An observational study published in 2025 provides some additional evidence concerning the contribution of community coordination. Among older people receiving support through ALONE, participation was associated with improvements in quality of life, personal capability and loneliness, together with reductions in some forms of health service use. The absence of a matched comparison group means that the study demonstrates an association rather than establishing causality.[40]

Relevance across the CTM Bonsai layers

Ireland shows that a connected, layered model can work in practice, which supports the direction of Bonsai and shows where CTM can go further. Table 1.4.3 sets out what each Bonsai layer can take from the Irish experience.

[39] https://about.hse.ie/news/hse-enhanced-community-care-improving-health-outcomes-for-patients-across-ireland/
[40] https://academic.oup.com/ageing/article/54/Supplement_4/afaf318.195/8371661

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CTM Bonsai layer	Learning from Irish System	Potential implication for CTM
Layer 0: Prevention Layer	Living well at home recognises the contribution of families, communities, housing, transport, local authorities and the third sector	Design prevention around population intelligence and community assets, not only clinical interventions
Layer 1: Virtual Response	Telehealth, remote monitoring, virtual clinics, telephone triage and electronic referral support care across the Irish model	Create a coherent digital front door that supports access, navigation, early triage and connection to every layer
Layer 2: Locality Care	Community Healthcare Networks organise general practice and multidisciplinary community services around defined populations	Establish a consistent locality architecture connecting primary, community, social and preventive care
Layer 3: Community Urgent Response	Community Intervention Teams, rapid specialist response, frailty services and hospital avoidance pathways provide alternatives during deterioration	Create an explicit bridge between Locality Care, diagnostics, specialist advice and hospital services
Layer 4: Diagnostic and Treatment Platforms	Specialist Ambulatory Care Hubs provide diagnostics, rehabilitation, education and specialist treatment across several networks	Organise selected diagnostic and treatment capabilities across groups of localities where greater scale is required
Layer 5: Specialist and Emergency Hospital Care	Frailty at the hospital front door, specialist pathways and early supported discharge connect hospital care back to community services	Focus hospitals on emergency, critical, complex and specialist care while designing clear outward connections

Table 1.4.3 Irish System's relevance to CTM Bonsai Layer

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CTM will need to apply the same discipline to the Bonsai model. Each layer will require a defined purpose, population footprint, service offer, access route and relationship with the layers around it. The movement of people must be accompanied by the movement of information, clinical responsibility and, where appropriate, workforce and resources.

Particular attention will be required at three interfaces. Virtual Response must connect people to the appropriate service rather than becoming an additional access channel operating separately from existing pathways. Community Urgent Response must bridge planned locality services and hospital care without creating another isolated service. Diagnostic and Treatment Platforms must be designed around pathway requirements and population need rather than being defined primarily by buildings.

Implications for CTM design

The Irish learning translates into some practical design considerations for CTM:

- Define, for each layer, a clear purpose, population footprint, service offer, access route and relationship with the layers around it.
- Ensure that when people move between layers, information, clinical responsibility and, where appropriate, workforce and resources move with them.
- Ensure that Virtual Response connects people to the right service rather than operate as an additional, separate access channel.
- Make Community Urgent Response a genuine bridge between planned locality services and hospital care, not another isolated service.
- Design Diagnostic and Treatment Platforms around pathway requirements and population need rather than around buildings.

The clearest lesson is that a layered model becomes operational only when the relationships between its layers are defined. It is the connections, local coordination, shared information, rapid response and clear hospital interfaces, rather than the layers themselves, that make care continuous around the person.

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1.5. Singapore

Singapore provides an example of a national health system that is deliberately shifting from episodic treatment towards prevention, continuity and population health. Its relevance to CTM lies in how national policy, regional health systems, family doctors, community organisations and digital services are being connected around defined populations.

Singapore introduced a major reform in the form of Healthier SG, which was launched nationally in July 2023. It is supported by Age Well SG and the more recent Age Well Neighbourhoods initiatives, which bring health, care, community support and accessible infrastructure together within areas that have higher concentrations of older people.

Taken together, these initiatives offer useful learning for the lower layers of the Bonsai model. Singapore is strongest in prevention, digitally supported access, primary care continuity and community support.

Context and ambition

Singapore faces the same demographic pressure now emerging across CTM. The country reached super-aged status in 2026, with more than one in five citizens aged 65 and above[41], and one in four projected to be 65 and above by 2030.[42] Rising chronic disease and an ageing population have driven healthcare spending upwards, with hospital and long term care demand growing fastest.

Healthier SG is Singapore's response and its largest healthcare reform in three decades. It sits within a longer national direction summarised as three shifts: beyond healthcare to health, beyond hospital to community, and beyond quality to value.[43]

The reform addresses a specific structural problem. Before Healthier SG, only three in five Singaporeans had a regular family doctor, and private general practitioners provided around 80 per cent of primary care attendances but often lacked the resources to manage complex, continuing need.[44,45] The reform therefore seeks to convert occasional, transactional contact into a continuing relationship, and to give primary care the information, capacity and incentives to work preventively.

Singapore's operating model

Singapore's model can be read as a stack that runs from national policy down to the individual, with hospital care connected to the side and digital capability running underneath. Figure 1.5.1 sets out this architecture.

[41] https://www.asiaone.com/lifestyle/age-well-neighbourhood-bedok-bukit-panjang-tiong-bahru-redhill

[42] https://www.trade.gov/market-intelligence/singapore-health-initiative

[43] https://speakingofmedicine.plos.org/2023/06/05/transforming-health-systems-equipping-primary-care-to-manage-the-health-of-singaporeans/

[44] https://www.moh.gov.sg/newsroom/white-paper-on-healthier-sg/

[45] https://www.thelancet.com/journals/lanwpc/article/PIIS2666-6065(23)00179-7/fulltext

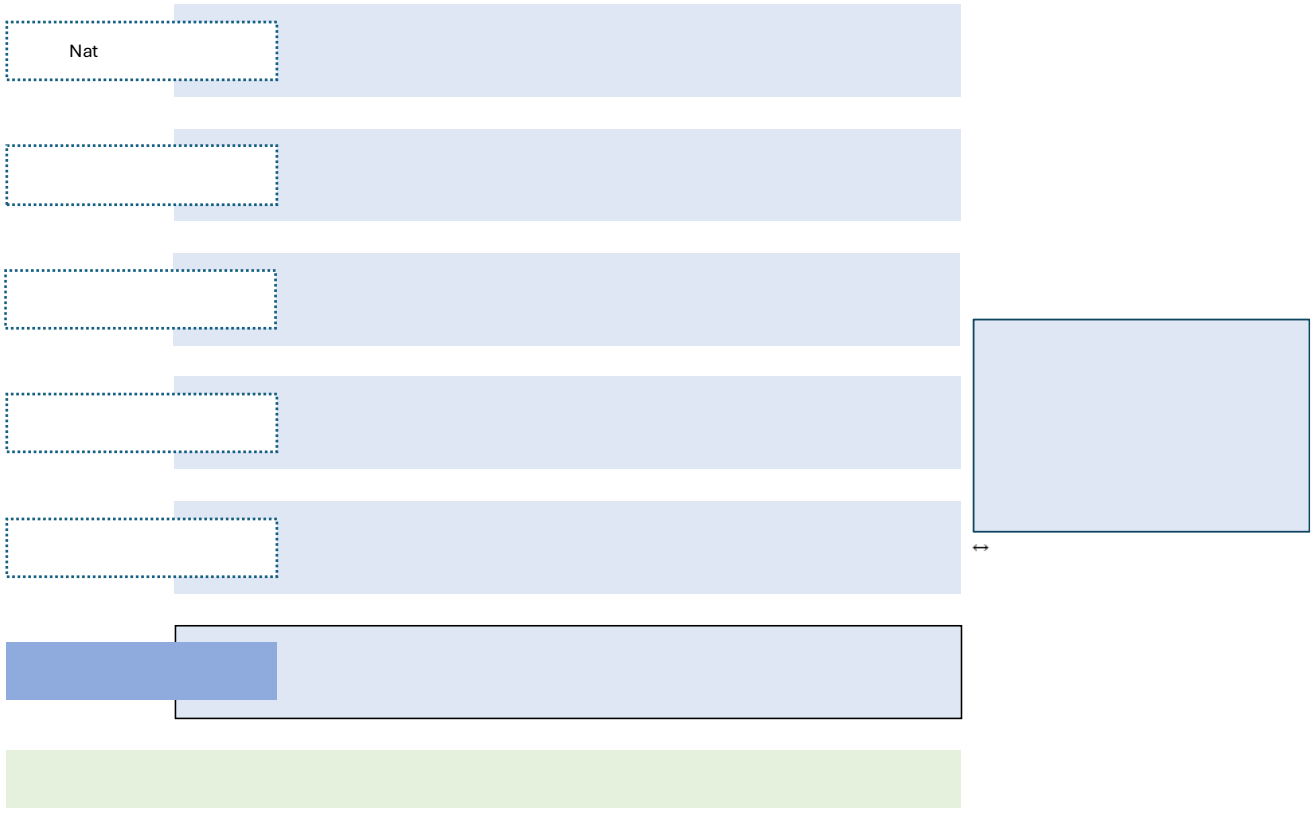
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At national level, Healthier SG provides the policy direction and the national enablers: shared clinical protocols, primary care funding and prevention incentives.[44]

Three public healthcare clusters act as regional health managers. Each is responsible for a population of approximately 1.5 million people and coordinates family doctors, hospitals and community partners, develops referral pathways, and reviews population needs and outcomes.[44] This provides a bridge between national policy and local delivery.

The primary care relationship sits at the centre. Residents aged 40 and above are encouraged to enrol with one family doctor, who takes ongoing responsibility for their preventive and primary care. Following enrolment, the resident and doctor agree a personal health plan covering lifestyle goals, screening, vaccination and the management of existing conditions, reviewed annually.[46]

Neighbourhood support surrounds the clinical relationship. Age Well Neighbourhoods and the wider community network bring together Active Ageing Centres, Community Health Posts, enhanced home personal care and community partners, so that prevention, social connection and basic health support are available close to home.[47]



[46] https://www.moh.gov.sg/newsroom/white-paper-on-healthier-sg/

[47] https://www.moh.gov.sg/newsroom/three-more-age-well-neighbourhoods-to-strengthen-support-for-seniors-in-the-community/

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Figure 1.5.1 Singapore's population health operating model

At the base sits the person, family and home. The model treats health goals, self management, social connection and the ability to age in place as the foundation rather than an afterthought. Hospital and specialist care connects to this stack rather than sitting within it, reached through the regional cluster when specialist assessment or treatment is required. Underneath, a digital foundation of HealthHub, Healthy 365, shared information and teleconsultation connects the layers.[46]

The primary care relationship in detail

The distinctive feature for CTM is not registration itself, which already exists in NHS primary care, but how Singapore uses the registered relationship. Enrolment is voluntary and opt-in. Residents already had access to GPs and polyclinics without it, so being counted requires an active choice to commit to one doctor and complete a health plan.[48]

Participating doctors work to national protocols covering prevention and major chronic conditions. They receive an annual payment for each enrolled person, adjusted for health risk and expected scope of care, in addition to fees for individual consultations.[49] This creates a financial mechanism for recognising preventive work and continuing population responsibility rather than rewarding activity alone.

The financing detail is not transferable. The relevant principle is that primary care needs sufficient information, capacity and incentives to identify risk, plan care proactively and sustain relationships. For CTM, the opportunity is to make more active use of already registered populations through risk identification, anticipatory planning and clearer connections between practices, locality teams and community services.

From national policy to neighbourhood support

Healthier SG recognises that clinical advice alone rarely changes health behaviour, so family doctors can connect people to programmes run by the Health Promotion Board, the People's Association, Sport Singapore and other community organisations.[49]

Age Well Neighbourhoods add a spatial dimension. The first neighbourhood rolls out in Toa Payoh in 2026, with Bedok, Bukit Panjang and Tiong Bahru Redhill following from 2027. Together, the four will cover more than 110,000 older people.6 Each brings enhancements to four components: Active Ageing Centres for social connection and prevention, Community Health Posts for basic assessment, coaching and teleconsultation, enhanced home personal care, and senior friendly neighbourhood infrastructure such as safer homes, streets and public spaces.[50]

[48] https://annals.edu.sg/healthier-sg-awareness-and-enrolment/

[49] https://www.moh.gov.sg/newsroom/white-paper-on-healthier-sg/

[50] https://www.moh.gov.sg/newsroom/three-more-age-well-neighbourhoods-to-strengthen-support-for-seniors-in-the-community/

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The last component is the most distinctive. The model treats place, safer homes, accessible streets and transport, as part of the care system rather than as separate infrastructure works. This is directly relevant to CTM, where access is shaped by transport, geography, deprivation and differences between communities. A locality model that ignores the physical environment misses a real lever.

Digital enablement

Digital capability is embedded across the model rather than bolted on. HealthHub gives residents access to their personal health plan, records, appointments and results, while Healthy 365 supports activity tracking and community programmes, connecting the family doctor, the individual's health goals and activity outside the clinic.[49] By the time of the White Paper, around 700,000 residents, roughly one in five adults, were already using Healthy 365 regularly.[49]

Technology is not the model in itself. Its value depends on a continuing clinical relationship, accessible community provision and the ability to move information across services. For CTM, this reinforces the need for Virtual Response to connect people to the wider model rather than operate as a separate digital channel.

Population scale and coordination

The use of defined populations is one of the most relevant features. Singapore's three clusters manage around 1.5 million residents as regional health managers, responsible for coordination, referral pathways, and outcome oversight.[51]

These clusters are far larger than CTM and should not be transferred as a unit of organisation. The transferable point is the function rather than the scale: a defined population held by an accountable coordinator, responsible for connecting providers and reviewing outcomes. CTM will need to decide the appropriate footprint for each Bonsai capability rather than adopting a single population size.

Evidence and maturity

Healthier SG has achieved substantial early implementation. By December 2025, more than 1.3 million residents had enrolled at over 1,100 primary care clinics nationwide.[52] These figures demonstrate reach and adoption, but they measure implementation rather than population impact. Enrolment is voluntary, and around eighteen months after launch only about half of the eligible population had enrolled.[53]

The evidence should therefore be read with care. An independent review at the two year mark treated enrolment as an early sign of acceptability but noted that bringing private GPs fully on board remains a live challenge, citing administrative burden and

[51] https://www.moh.gov.sg/newsroom/white-paper-on-healthier-sg/
[52] https://apps.who.int/gb/statements/EB158/PDF/Singapore-10.pdf
[53] https://annals.edu.sg/healthier-sg-awareness-and-enrolment/

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incentives to enrol simpler patients.[54] Singapore's Ministry of Health has itself indicated that the initial results of a healthier population will probably take ten years to appear.[51]

Age Well Neighbourhoods are less mature still, with services introduced progressively through 2026 and 2027. They should be treated as a promising development.

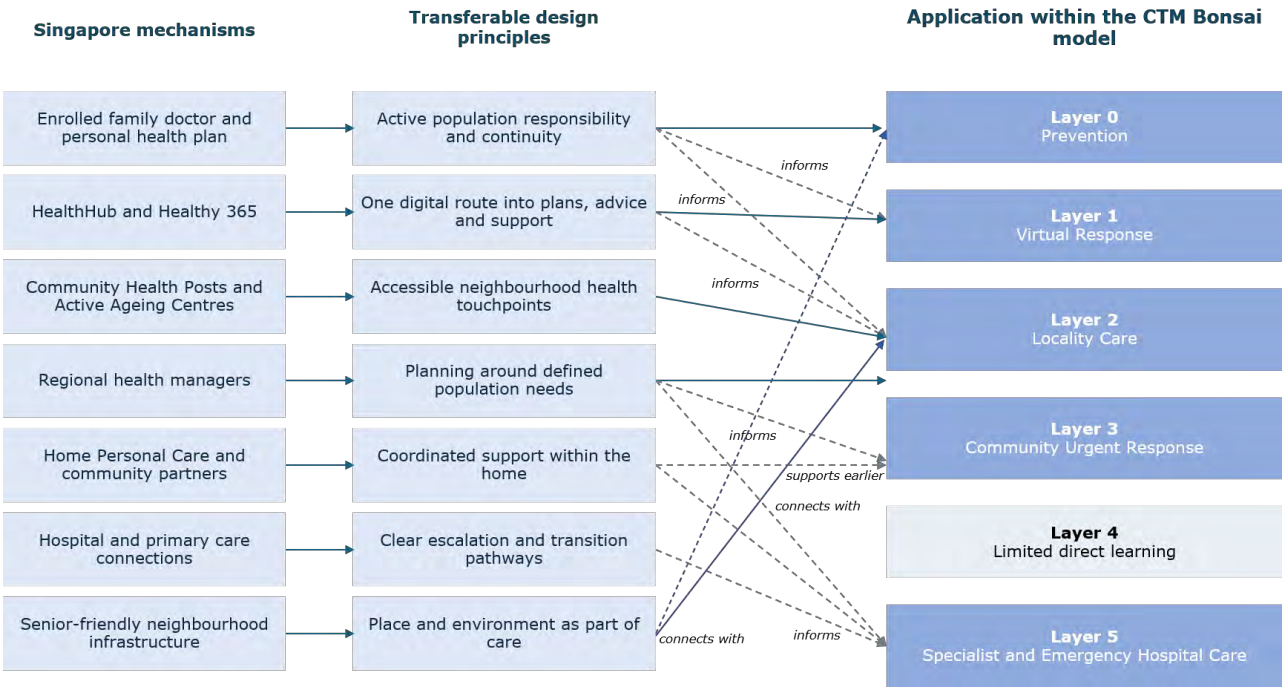


Figure 1.5.2 Singapore's population health operating model

CTM Bonsai layer	Learning from Singapore	Potential implication for CTM
Layer 0: Prevention	Enrolled family doctor, personal health plans, screening, vaccination and links to community activity make prevention a continuing relationship	Anchor prevention in a continuing relationship connected to community and local authority assets
Layer 1: Virtual Response	HealthHub, Healthy 365 and teleconsultation give one digital route into plans, advice and support	Build a coherent digital front door that is integrated with primary care and locality teams
Layer 2: Locality Care	Family doctors, Community Health Posts and Active Ageing Centres provide accessible neighbourhood touchpoints around defined populations	Organise locality care around registered populations, with neighbourhood touchpoints and attention to place
Layer 3: Community Urgent Response	Continuity can support earlier recognition, but urgent response is not a central feature of the model	Treat the learning as indirect; continuity can aid earlier detection and escalation

[54] https://www.thelancet.com/journals/lanwpc/article/PIIS2666-6065(25)00143-9/fulltext

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Layer 4: Diagnostic and Treatment Platforms	Limited direct learning within Healthier SG and Age Well Neighbourhoods	Draw diagnostic and platform learning primarily from other exemplars
Layer 5: Specialist and Emergency Hospital Care	Regional clusters connect hospitals to population health, but hospital redesign is not the focus	Connect hospitals through population health management rather than looking to Singapore for hospital redesign

Table 3.5.1 Learning from Singapore Across CTM Bonsai Layers and Potential Implications for CTM

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Overall, Singapore provides a credible example of prevention organised as a continuing relationship between the citizen, family doctor, community and regional health system. Its most useful contribution to CTM is the connection between population enrolment, personal health planning, digital access and neighbourhood support. It helps show how the lower Bonsai layers could work together to identify risk earlier and support people before their needs escalate into hospital care.

Implications for CTM design

The Singapore learning translates into four practical design considerations for CTM:

- Turn population responsibility into an active relationship with individuals, with a clear mechanism through which identified groups receive an agreed plan and continuing support.
- Connect prevention to accessible community opportunities, so that the Prevention layer draws on local authority and community assets rather than remaining a health promotion function.
- Design locality care around place as well as people, considering where people live, how they reach support and which community assets already exist.
- Build a single digital front door that connects the layers, providing access to advice, plans, appointments, monitoring and community support, but only where it is integrated with primary care and locality teams rather than operating separately.

The notable lesson is that prevention, digital access and locality care work only when they are joined into one relationship around the person. A continuing plan, a shared digital route, community assets and a strong local team can turn a registered population into a supported one.

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1.6. Brazil: Family Health Strategy

Strategic relevance to CTM

Brazil's Family Health Strategy is a mature model of neighbourhood primary care built around responsibility for a defined population. It is particularly relevant to CTM because it shows how prevention, proactive outreach, continuing care and local knowledge can be organised as the core operating model rather than added as separate programmes.

The model does not cover every part of the Bonsai model equally. Its greatest relevance is to Layers 0 and 2, with supporting learning for Layer 1. Its contribution to urgent response, diagnostics and hospital care is principally about coordination and continuity across interfaces.

Core operating model

Each Family Health Team is responsible for a defined geographical territory, typically covering around 3,000 to 4,000 people, with residents registered to a single team.[55] This is a financing parameter rather than a universal staffing formula, but it illustrates the scale at which continuing population responsibility is organised.

The minimum team normally includes a family or generalist doctor, a nurse, nursing support and community health workers. Oral health and wider professional support can be added according to local need. Teams normally work from a Basic Health Unit but also provide care in homes, schools and community settings.[56]

The model combines five functions that are often separated in conventional health systems.

Function	How it operates
Population responsibility	Every team has a defined territory and registered population
Continuing clinical care	The same local team provides routine care and ongoing condition management
Proactive outreach	Community health workers identify need and maintain contact with households
Population intelligence	Registration and clinical information are used to monitor risks, gaps and follow-up
Care coordination	The local team manages onward referral while retaining responsibility for continuity

Table 1.6.1 Brazilian 5 function Model

[55] https://www.commonwealthfund.org/publications/case-study/2016/dec/brazils-family-health-strategy-using-community-health-care-workers

[56] https://www.gov.br/saude/pt-br/composicao/saps/esf/equipe-saude-da-familia/faq

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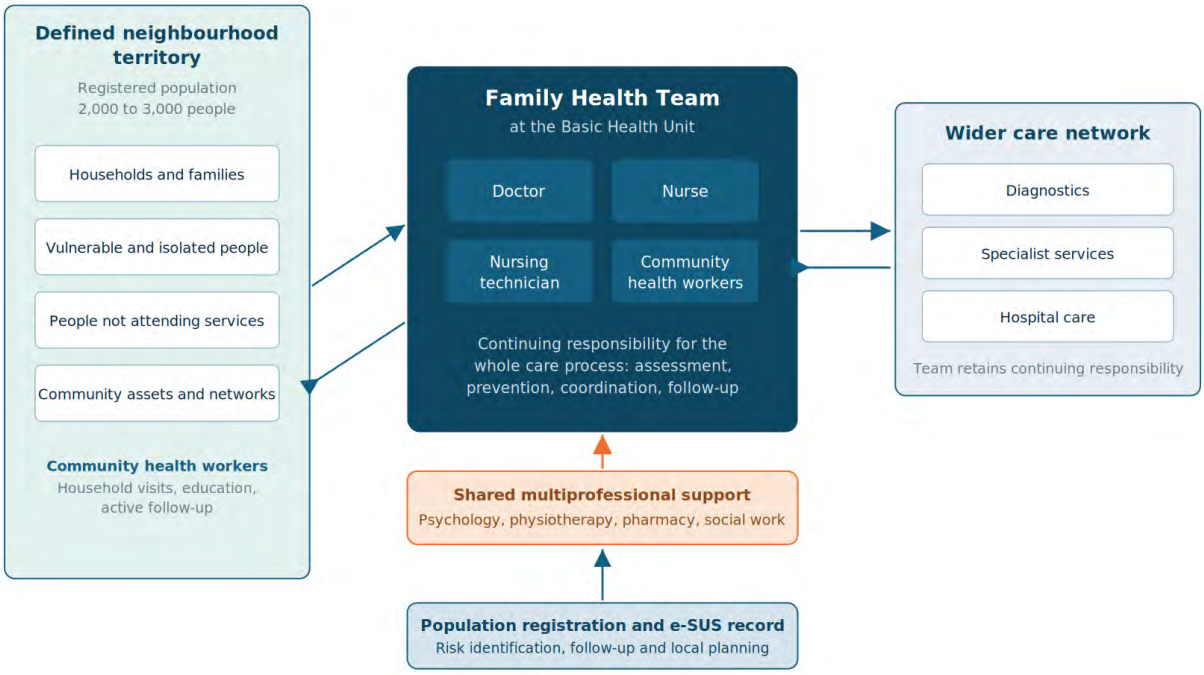


Figure 1.6.1 Singapore's population health operating model

Defined population responsibility

The starting point is a registered population rather than an unstructured volume of service contacts. Teams map their territory, register families and maintain information about health needs, vulnerability and patterns of access. This changes the unit of responsibility. The team remains responsible for people who attend regularly, people whose care is fragmented and people who have not recently made contact.

For CTM, this suggests that locality teams would require more than geographical boundaries. They would need:

- A defined population list
- Reliable information about need and vulnerability
- A shared locality caseload
- Processes for identifying people who are not engaging
- Measures covering the whole population, not only completed activity

Community connection and outreach

Community health workers undertake household visits, provide health education, identify emerging needs and connect people with the clinical team. They create a continuing relationship between the service and the community.[57] This matters because access is not treated as simply making services available. The model recognises that

[57] https://www.commonwealthfund.org/publications/case-study/2016/dec/brazils-family-health-strategy-using-community-health-care-workers

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some people require active contact, particularly where there is deprivation, poor mobility, low health literacy or limited trust in formal services.

CTM would not need to reproduce the Brazilian community health worker role directly. The transferable principle is to create an explicit community connection function. This could combine existing community health staff, third sector organisations, social prescribing, public health teams and trusted community networks.

Multidisciplinary locality care

The Family Health Team combines clinical continuity with neighbourhood knowledge. The doctor and nurse provide ongoing clinical care, while community health workers contribute household insight, prevention and follow-up. Wider disciplines are available through shared multiprofessional teams known as eMulti. These teams provide individual consultations, group activity, home input, remote advice, case discussion and joint care, and their composition is determined by the needs and service gaps of the local population.[58]

The design principle for CTM is that specialist community expertise should wrap around locality teams. It should not necessarily require every profession to be permanently located within every neighbourhood.

Population information and digital enablement

The e-SUS primary care record supports registration, clinical history, vaccination, continuing monitoring and local population analysis. The associated population dashboard allows teams to understand the needs of their territory and identify people requiring follow-up. The Ministry of Health reported in 2025 that the electronic primary care record was in use in more than 4,200 municipalities.[59]

The relevant lesson for CTM is the connection between information and action. Population data should lead to identified need, then to a team worklist, then to outreach or care, and finally to an updated record. A population health platform will have limited impact if it only produces reports. It must generate operational work for locality teams and record what happens next.

Relevance across the CTM Bonsai layers

Read as a set of operating flows, the model separates four different kinds of connections. Figure 1.6.2 sets these out.

[58] https://www.gov.br/saude/pt-br/composicao/saps/acoes-interprofissionais/emulti/orientacoes

[59] https://www.gov.br/saude/pt-br/centrais-de-conteudo/publicacoes/guias-e-manuais/2025/guia-ampliacao-e-qualificacao-no-seu-municipio-mais-saude-na-familia.pdf

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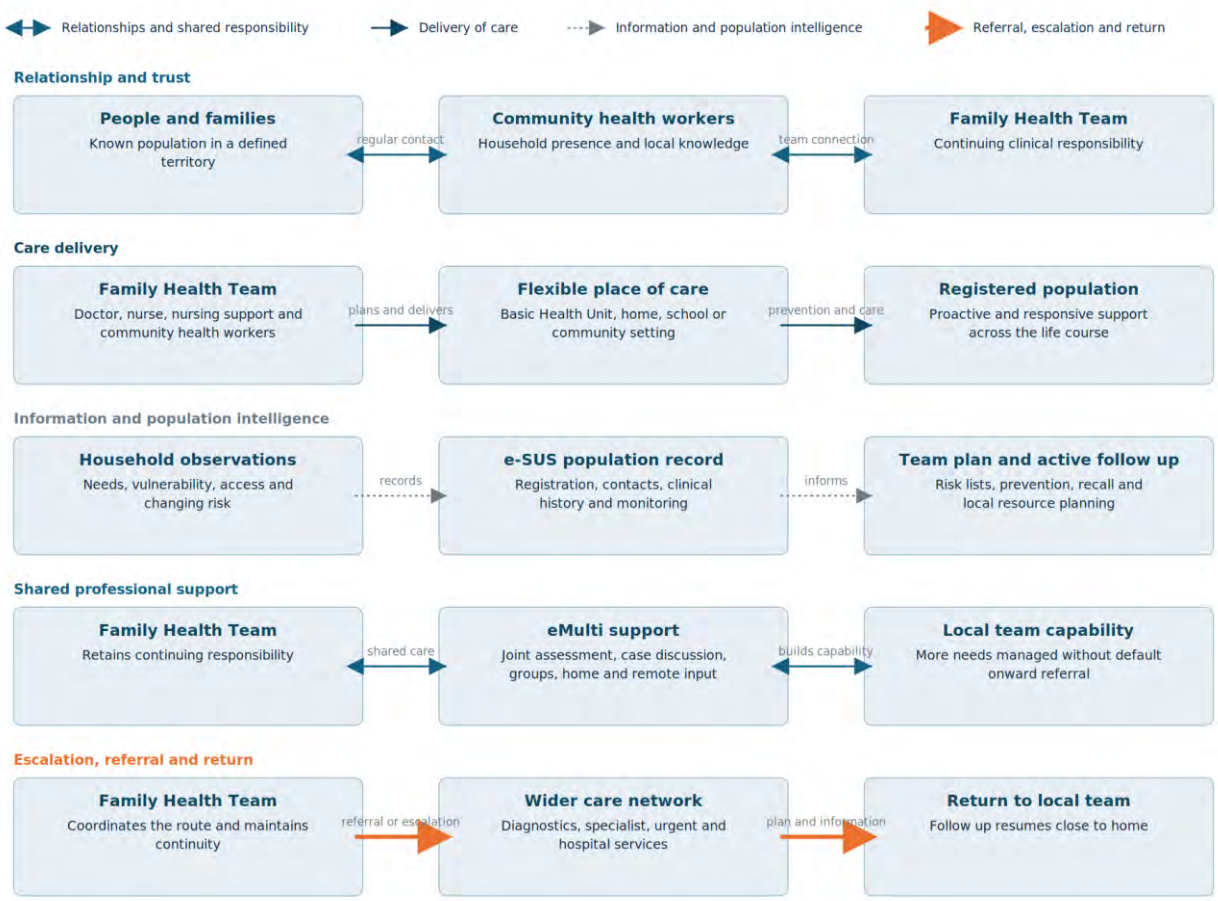


Figure 1.6.2 Family Health Strategy operating flows and their translation into the CTM Bonsai model

The four flows are distinct. Two-way arrows represent relationships, trust and shared responsibility. Solid arrows represent the delivery of care. Dotted arrows represent information and population intelligence. Thick arrows represent referral, escalation and return.

The diagram highlights an important principle. Onward referral should not end locality responsibility. Information and a clear continuing care plan should return to the local team after diagnostic, specialist, urgent or hospital care, so that follow-up resumes close to home.

Brazil provides its strongest direct learning for Layers 0, 1 and 2. It should not be presented as a complete layered care model. It is principally an operating model for the foundations on which the other CTM layers can be built.

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CTM Bonsai layer	Direct learning from Brazil	Potential implication for CTM
Layer 0: Prevention	Defined populations, household outreach, risk identification, health education and active follow-up	Combine clinical care with proactive outreach through a defined community connection function
Layer 1: Virtual Response	Population records, digital access, monitoring and digitally supported communication	Link the digital front door to population intelligence that generates worklists
Layer 2: Locality Care	Stable multidisciplinary teams with continuing responsibility for a neighbourhood population	Give each locality team an identifiable population and access to shared professional expertise
Layer 3: Community Urgent Response	Limited direct learning, though local teams can identify deterioration and support escalation	Use continuity to aid earlier detection; draw the response model from other exemplars
Layer 4: Diagnostic and Treatment Platforms	Coordination with diagnostics and the potential to provide selected investigations in larger facilities	Design diagnostic access around pathways, with clear links back to locality teams
Layer 5: Specialist and Emergency Hospital Care	Referral coordination and return of the care plan to the local team after specialist intervention	Maintain local responsibility and a defined route for information to return

Table 1.6.3. Brazil's Primary Care Experience and Its Relevance to the CTM Bonsai Model

Evidence of impact

The Family Health Strategy has been associated with improvements in access, infant mortality, cardiovascular mortality, avoidable hospital use and health equity.

A cohort study covering around 1.2 million low-income adults in Rio de Janeiro found that Family Health Strategy use was associated with a 44 per cent lower hazard of death, with a stronger association among groups experiencing greater socioeconomic

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disadvantage. The study used linked primary care, welfare and mortality records, although the authors recognised that unobserved differences between users and non-users could still have affected the findings.[60]

A separate nationwide analysis found that expansion of the Family Health Strategy was associated with reductions in heart and cerebrovascular mortality, particularly where coverage was higher and sustained over time.[61] The evidence therefore supports the value of comprehensive primary care and continuity, but it does not prove that any single component, such as community health workers, produced the outcomes independently.

Implications for CTM design

The Brazilian model suggests six practical design considerations for CTM.

- Locality teams should have an identifiable population for which they are responsible.
- Locality teams should have a shared view of health need, inequality, risk and recent service contact
- A defined community connection function should undertake outreach and identify unmet need.
- Wider professional expertise should be shared across locality teams according to population need.
- Digital information should generate active worklists for prevention, review and follow-up.
- Referral into higher Bonsai layers should include a defined route for information and responsibility to return to the locality team.

The strongest lesson is that Layers 0 and 2 should operate as one connected neighbourhood system. Prevention identifies need, community relationships support engagement, locality teams provide continuing care, and information connects the cycle. Together, these flows create ongoing responsibility for a known neighbourhood population.

[60] https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1003357
[61] https://www.bmj.com/content/349/bmj.g4014.long

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1.7 Ontario

Strategic relevance to CTM

Ontario is strategically relevant to CTM because it combines several complementary reforms that address the same challenge as the CTM 2030 Bonsai model: how to move the centre of gravity from episodic hospital treatment towards prevention, continuing primary and community care, home-based response and coordinated access to specialist services. The strongest transferable ideas are responsibility for a defined population, comprehensive interprofessional primary care, place-based partnership, navigation, community governance, enabling data spine and organised home-care capacity.[62]

Ontario should not, however, be described as operating one official province-wide "Layered Care Model".[63] The material reviewed brings together Ontario Health Teams, emerging Primary Care Networks, the Alliance for Healthier Communities' Neighbourhood Health Home proposal, Ontario Health at Home and Stepped Care. [64,] These have different sponsors, purposes and levels of maturity. They form a useful design repertoire, but not one settled statutory hierarchy that CTM can copy.[65]

The translation for CTM is therefore organisationally modest but operationally specific. CTM should use existing Welsh Cluster, pan-cluster and Regional Partnership Board arrangements as the chassis for a neighbourhood operating system, while defining how population accountability, access, multidisciplinary working, home-first response, information and resource movement operate across Bonsai Layers 0–5.

Core operating model

Ontario's relevant architecture is best understood as a connected set of functions. Ontario Health Teams provide the regional integration footprint;[66] Primary Care Networks strengthen primary-care leadership and shared capability;[67,68] the Neighbourhood Health Home describes a locally adaptable hub-and-spoke coordinating function;[69] Ontario Health at Home supplies home-care coordination and delivery capacity;[70] and community health organisations, link workers and public-health partners connect care with local assets and the wider determinants of health.

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[63] https://www.ontariohealthathome.ca/blobohahprod4cd80afe1b/wp-content/uploads/2025/07/HCCSS-2023-2024-OHaH-2024-2025-Annual-Report-EN.pdf

[64] https://www.ontariohealth.ca/clinical/primary-care

[65] https://www.allianceon.org/files/Vision_for_a_Health_Home_-_Alliance_for_Healthier_Communities.pdf

[66] https://hspn.ca/wp-content/uploads/2025/02/Ontario-Health-Teams-Central-Evaluation-March-2024-Policy-supports-for-integrated-care_new-models-and-approaches-from-a-comparative-international-study-for-Ontario-Health-Team.pdf

[67] https://www.ontario.ca/page/ontarios-primary-care-action-plan-january-2025

[68] https://www.ontario.ca/files/2024-01/moh-primary-care-networks-guidance-en-2024-01-23.pdf

[69] https://www.allianceon.org/Model-Health-and-Wellbeing-0

[70] https://www.ontariohealthathome.ca/blobohahprod4cd80afe1b/wp-content/uploads/2025/07/HCCSS-2023-2024-OHaH-2024-2025-Annual-Report-EN.pdf

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Component	Current status	Principal function	Most useful CTM translation
Ontario Health Teams	Province-wide regional architecture; maturity varies	Cross-sector integration for a defined population	Align Cluster/locality delivery with pan-cluster and RPB accountability
Primary Care Networks	Emerging across OHTs	Primary-care voice, attachment planning and shared capability[71]	Strengthen Professional Collaboratives and Cluster clinical leadership
Neighbourhood Health Home	Alliance-designed blueprint, not a statutory tier	Hub-and-spoke coordination, comprehensive care, equity and community governance	Define a neighbourhood health-home function rather than a new organisation or building
Ontario Health at Home	Operational provincial home-care organisation	Assessment, coordination, contracted provision, nursing and personal support	Integrate @Home, community nursing, social care and urgent response as one home-first pathway
Community health and link-worker model	Established in community-governed providers; variable local reach	Outreach, navigation, social prescribing and community connection[72]	Fund community assets and a clear connection function in every locality
Stepped Care 2.0	Mental-health and substance-use framework	Open access and matching intensity to need and preference	Use selectively in mental-health pathways, not as the architecture for all care

Table 1.7.1 Ontario Healthcare system Layers

Defined population responsibility

The Ontario reforms consistently shift attention from organisations and individual contacts towards responsibility for a defined population. Ontario Health Teams are organised around attributed populations, while the Primary Care Action Plan seeks universal attachment to publicly funded comprehensive primary care by 2029.[73, 74, 75] By August 2026, the province described a C$3.4 billion plan, more than 300 new teams, a target to connect two million additional people and 437,000 reported new connections since launch. These are government-reported implementation figures rather than independently verified outcome measures.

The Alliance's Neighbourhood Health Home adds a more local interpretation:[76] The neighbourhood may be geographic or defined around a population with shared needs,

[72] https://www.allianceon.org/Model-Health-and-Wellbeing-0

[73] https://news.ontario.ca/en/release/1007897/ontario-connecting-600000-more-people-to-a-family-doctor-or-primary-care-team

[74] https://hspn.ca/wp-content/uploads/2025/02/Ontario-Health-Teams-Central-Evaluation-March-2024-Policy-supports-for-integrated-care_new-models-and-approaches-from-a-comparative-international-study-for-Ontario-Health-Team.pdf

[75] https://www.ontario.ca/page/ontarios-primary-care-action-plan-january-2025

[76] https://www.allianceon.org/files/Vision_for_a_Health_Home_-_Alliance_for_Healthier_Communities.pdf

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and the hub can be a coordinating function located in an existing organisation rather than a new site. Responsibility includes people who attend regularly, people whose care is fragmented and people who are not visible through recent service use.

For CTM, "attachment" should be translated as relational continuity and clear responsibility rather than Canadian registration mechanics.[77] Every resident should know the first point of contact, and every locality team should know the population it is responsible for. CTM already has a valuable foundation: its population segmentation and risk-stratification work cover approximately 427,000 registered patients and can generate cohorts for proactive care.

Population responsibility should therefore include: a defined list or denominator; a shared locality caseload; information about need, deprivation and vulnerability; a method for identifying non-engagement and unmet need; named review responsibility; and measures covering the whole population rather than completed contacts alone. Predictive risk should be combined with professional judgement, equity weighting and community intelligence so that people facing barriers are not missed because they generate little recorded activity.

Community connection and outreach

Community connection is a core design feature, not an optional referral route. The Alliance model is rooted in community-governed primary healthcare and its Model of Health and Wellbeing. Link workers and navigators use relationship-based assessment, "what matters" conversations, warm connection and follow-up to connect people with welfare, housing, activity, peer support and other non-medical resources.

The transferable principle for CTM is not to reproduce one Ontario job title. It is to create an explicit community connection function that combines existing social-prescribing services, public health, third-sector organisations, community development, trusted networks and relevant community-facing health staff. It must include outreach for people affected by deprivation, transport barriers, poor mobility, low health literacy, language needs, digital exclusion or mistrust of formal services.

Social prescribing evidence remains promising but heterogeneous.[78] An international review found substantial variation in models and limited robust, transferable outcome evidence. Signposting alone can reproduce inequality when people lack confidence, transport, language support or digital access. Facilitated connection, feedback to the referrer and sustainable capacity in receiving organisations are essential.

For CTM, community assets should be commissioned as delivery capacity rather than treated as a low-cost destination for transferred demand. Link-worker deployment should be paired with recurring support for voluntary and community organisations, a maintained service directory, proportionate assurance and outcome feedback. Without this, waiting and exclusion will move rather than disappear.

[77] https://www.ontario.ca/page/ontarios-primary-care-action-plan-january-2025
https://news.ontario.ca/en/release/1007897/ontario-connecting-600000-more-people-to-a-family-doctor-or-primary-care-team

[78] https://pmc.ncbi.nlm.nih.gov/articles/PMC10549579/
https://doi.org/10.1016/j.healthpol.2024.104992

Multidisciplinary locality care

The Neighbourhood Health Home places comprehensive interprofessional primary care at the centre of the local model.[79, 80] A coordinating hub connects independent practices, community health services, pharmacies, home care, social services, public health and community assets. Wider professional expertise can be shared across several neighbourhoods; not every discipline needs to be permanently located at every site. [81]

Ontario evidence supports the plausibility of team-based care while showing that organisational form and payment design matter.[82] An ICES comparison found that Community Health Centres served more disadvantaged and clinically complex populations and had lower emergency-department use than expected after adjustment.[83] A 2026 matched cohort study found that community-driven interprofessional practices were associated with more attached patients per physician, higher visit volumes, better continuity and stronger delivery of most preventive services. Both studies are observational and do not prove that team structure alone caused the outcomes.

OHT evaluation and case-study evidence also show that primary-care participation requires credible leadership, administrative support, protected time, trusted relationships and influence over decisions. Representation without delegated authority or resourcing is unlikely to create integrated delivery and may increase general-practice workload.

For CTM, primary care should be the clinical anchor without making general practice the sole delivery vehicle.[84] The core neighbourhood team should include primary care, community nursing, therapies, pharmacy, mental health, social work/social care, care coordination and link-worker capacity. It should connect to public health, diagnostics, specialist advice, ambulance, housing, welfare and other community services through an extended network. Daily coordination should coexist with profession-specific clinical accountability.

Ontario Health at Home contributes the operational logistics that team models often lack.[85] Its predecessors served around 670,000 people in 2023/24 and delivered or coordinated more than 40 million personal-support hours and more than 10 million nursing visits. It also reported growth in neighbourhood models, rapid-response nursing, remote monitoring, community clinics and emergency-diversion approaches. These are useful operational examples, but coordination, contracted provision and direct delivery are not synonymous, and much of the reported evidence remains activity or before-after data.

Population information and digital enablement

[79] https://www.ontario.ca/page/ontarios-primary-care-action-plan-january-2025
[80] https://www.allianceon.org/files/Vision_for_a_Health_Home_-_Alliance_for_Healthier_Communities.pdf
[81] https://www.allianceon.org/files/Vision_for_a_Health_Home_-_Alliance_for_Healthier_Communities.pdf
[82] https://www.ontariohealth.ca/clinical/primary-care
[83] https://www.allianceon.org/files/Vision_for_a_Health_Home_-_Alliance_for_Healthier_Communities.pdf
[84] https://www.ontario.ca/page/ontarios-primary-care-action-plan-january-2025
[85] https://www.ontariohealthathome.ca/blobohahprod4cd80afe1b/wp-content/uploads/2025/07/HCCSS-2023-2024-OHaH-2024-2025-Annual-Report-EN.pdf

A strong data foundation is common to the Neighbourhood Health Home, Ontario Health Team evaluation and CTM 2030.[86] The operational sequence should be explicit: population information identifies need; the system creates a team worklist; a named person undertakes outreach or care; the result is recorded; and the information is used for further planning and improvement. A population-health platform has limited value if it produces reports without generating operational work.

The minimum shared dataset should include population denominators; attachment and continuity; risk and frailty; deprivation and inclusion-health indicators; current team and coordinator; care plans; medication; referrals; diagnostic results; discharge information; and safeguarding and end-of-life status, where lawful and relevant.[87] CTM should prioritise a longitudinal locality view and reliable information exchange before pursuing a single comprehensive platform.

Digital and virtual access should be treated as a channel rather than a mandatory first layer everyone must pass through. Online advice, remote review and monitoring can improve convenience and support earlier triage, but every pathway requires an assisted-digital and non-digital equivalent, accessible formats, translation and communication support, and a clear route to face-to-face assessment.

Data governance must combine lawful role-based access, data minimisation, transparent patient information and clear consent or legal-basis rules. Equity assurance should examine who is missing from risk lists and virtual pathways as well as who uses them. Local dashboards should be timely enough to support daily operations and rapid-cycle improvement, not only retrospective performance reporting.

Relevance across the CTM Bonsai layers

When considered as an operating system rather than an organisational chart, the Ontario material separates four kinds of connection. Relationship flows create trust, shared responsibility and community accountability. Care-delivery flows connect prevention, continuing care, outreach, home response, diagnostics and treatment. Information flows convert population intelligence into worklists and return results and care plans. Escalation-and-return flows move clinical responsibility to urgent, specialist or hospital care when required and return it with a clear continuing-care plan.

86 https://www.allianceon.org/book/5-Connecting-Care-Building-Neighbourhood-Health-Home-Access-and-Integration

87 https://news.ontario.ca/en/release/1007897/ontario-connecting-600000-more-people-to-a-family-doctor-or-primary-care-team

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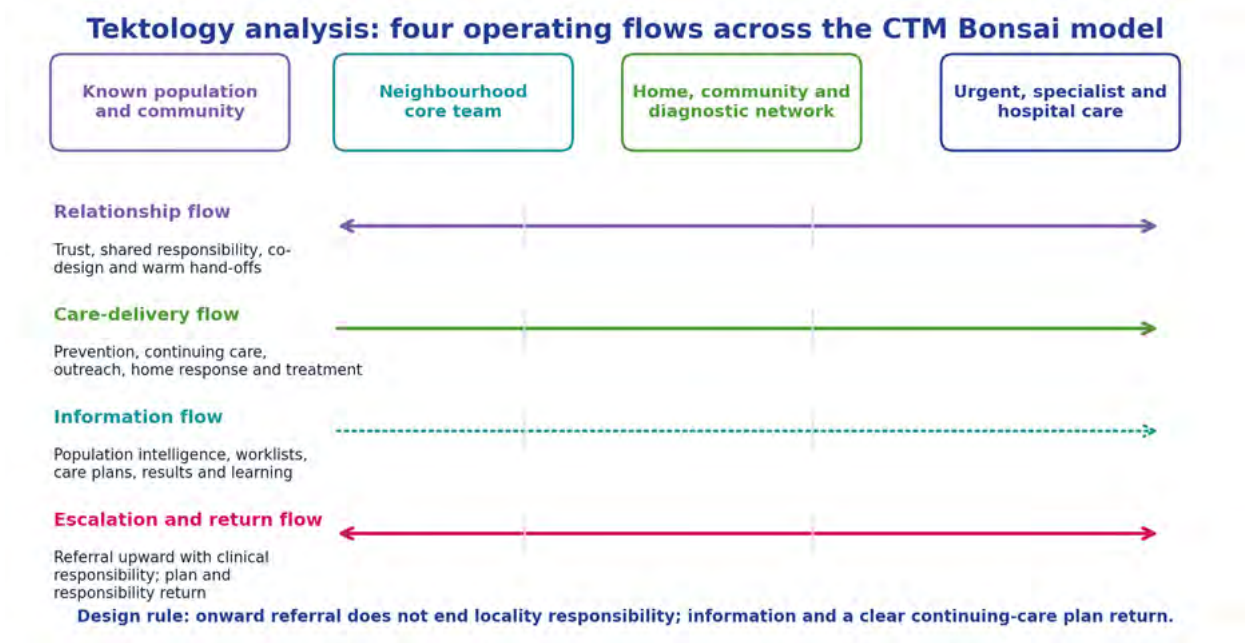


Figure 1.7.1 Ontario operating flows and their translation into the CTM Bonsai model.

The four flows should not be collapsed into a single referral pathway. A referral can transfer clinical responsibility for a period, but it should not end locality responsibility for continuity. Information and a clear plan must return after diagnostic, specialist, urgent or hospital care. Conversely, the locality team must have a reliable escalation route when risk exceeds neighbourhood capability.

For CTM, this means the Bonsai layers should behave as a coordinated continuum, not as a staircase that every person must climb. People may enter through different channels and move directly to the level that matches clinical need. Layer 0 supplies population intelligence and community connection; Layers 1–3 organise access, continuing care and rapid response; Layer 4 supplies networked diagnostics and treatment; and Layer 5 provides specialist and critical capability while supporting advice and safe return to locality care.

CTM Bonsai layer	Direct learning from Ontario	Potential implication for CTM
Layer 0: Prevention	Population accountability; community governance; link workers; equity and determinants of health	Use segmentation plus community intelligence; commission outreach and community assets; monitor reach and unmet need
Layer 1: Virtual Response	Primary care as front door;[88] digital/virtual options; navigation; stepped access in mental health	Create one navigation standard across phone, web and in-person routes;

[88] https://www.ontario.ca/page/ontarios-primary-care-action-plan-january-2025

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		connect contacts to worklists and closed-loop referrals
Layer 2: Locality Care	Neighbourhood hub-and-spoke coordination; comprehensive teams; PCN leadership	Build Cluster-based neighbourhood teams with named coordination, daily huddles and access to shared professional expertise
Layer 3: Community Urgent Response	Rapid-response nursing, home-care routing, remote monitoring and transition support	Integrate @Home, frailty, pharmacy, therapies, mental health, social care and ambulance interfaces with clear response standards
Layer 4: Diagnostic and Treatment Platforms	Community clinics, locally clustered provision and integrated referral	Design networked diagnostics around complete pathways; protect same-day access for urgent community teams and clarify result ownership
Layer 5: Specialist and Emergency Hospital Care	Whole-pathway integration, specialist advice and hospital-to-home transitions	Reserve hospital care for complex/critical need while providing rapid advice, virtual wards, interface geriatrics and supported discharge

Ontario provides the strongest direct learning for Layers 0–3 and for the interfaces between locality, home and hospital care. Its contribution to Layers 4 and 5 is principally about pathway design, specialist advice, coordinated transitions and the return of responsibility. It should not be presented as a complete layered-care model.

Table 1.7.2. CTM 2030 Bonsai model of care supplied with the commission

Evidence of impact

The evidence supports the component parts more strongly than the complete Ontario architecture. Team-based, community-governed primary care is associated with improved attachment, continuity, preventive activity and potentially lower-than-expected emergency use, but the main Ontario studies are observational and susceptible to residual confounding.[89, 90]

The independent Ontario Health Teams Central Evaluation identified the conditions required for integrated care:[91, 92] enabling policy, practical implementation support, learning-oriented accountability, financing that rewards collaboration, dedicated roles, usable shared data and explicit equity policy. It also found that fragmented financing, data incompatibility, workload and variable local capacity impede integration. This is evidence about implementation mechanisms and maturity rather than proof of a single OHT outcome effect.

Ontario Health at Home reports substantial delivery scale and promising service examples, including neighbourhood routing, rapid-response nursing, remote monitoring

https://www.ontariohealth.ca/clinical/primary-care

[89] https://www.ontario.ca/page/ontarios-primary-care-action-plan-january-2025
https://www.ontariohealth.ca/clinical/primary-care

[90] https://news.ontario.ca/en/release/1007897/ontario-connecting-600000-more-people-to-a-family-doctor-or-primary-care-team

[91] https://www.ontario.ca/files/2024-01/moh-oht-hcp-guidance-doc-en-2024-01-22.pdf

[92] https://news.ontario.ca/en/release/1004116/ontario-health-teams-now-providing-care-in-every-corner-of-the-province

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and community clinics. These show operational feasibility, but many reported results are programme activity or uncontrolled before-after measures[93]. They should inform design and testing rather than be treated as causal proof.

Hospital-at-home evidence is more mature[94]. Cochrane evidence supports admission avoidance for selected patients when programmes provide hospital-level clinical responsibility, rapid assessment, diagnostics, treatment, monitoring and escalation. Effects vary by population and programme, and home-first care is unsafe if it retains patients whose risk exceeds pathway capability.

Social prescribing has a plausible mechanism and encouraging wellbeing findings, but the international evidence base is heterogeneous and often limited by selection, weak comparators and incomplete economic analysis.[95] Outcomes depend on facilitated

[93] https://www.ontariohealthathome.ca/blobohahprod4cd80afe1b/wp-content/uploads/2025/07/HCCSS-2023-2024-OHaH-2024-2025-Annual-Report-EN.pdf

[94] https://www.cochrane.org/evidence/CD007491_hospital-home-services-avoid-admission-hospital

[95] https://www.allianceon.org/files/Vision_for_a_Health_Home_-_Alliance_for_Healthier_Communities.pdf

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connection and the capacity of community organisations, not only the presence of a link worker.

Overall, the evidence justifies staged implementation with baseline measurement, explicit mechanisms, comparator or phased designs where feasible, economic analysis, equity review and independent evaluation. CTM should scale functions only when safety, reliability, workforce feasibility and benefit have been demonstrated.

Implications for CTM design

The Canterbury experience suggests the following practical considerations for CTM:

- Give every neighbourhood or locality team an identifiable population and explicit responsibility for access, continuity, proactive care, unmet need and inequalities.
- Define the neighbourhood health home as a coordinating function and accountability, not automatically a new building, brand, board or statutory tier.
- Use primary care as the clinical anchor while creating a genuinely multidisciplinary core team and an extended network of shared professional expertise.
- Create one access and navigation standard across telephone, digital and face-to-face routes, including warm hand-offs, named coordination for complex patients and closed-loop referral.

The major lesson is that CTM Layers 0 and 2 should operate as one connected neighbourhood system. Prevention identifies need; community relationships enable engagement; multidisciplinary locality teams provide continuing care; home-first services respond to deterioration; information connects the cycle; and higher layers supply diagnostics, specialist intervention and rescue without severing local continuity.

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1.8 New Zealand: the Canterbury health system

Strategic relevance to CTM

The Canterbury health system in New Zealand is one of the most studied examples of whole-system integration. It shows how the separate parts of a health and care system can be made to act as one, so that people are kept well at home and the growth in hospital demand is moderated.[96]

Canterbury offers direct learning for locality care, virtual and digital connection, community urgent response and the relationship between community and hospital, as well as prevention. Its distinctive contribution is the connective tissue of an integrated system: a shared financial logic, shared clinical pathways, a shared record and collaborative governance.

Context and drivers

In 2007 and 2008 the Canterbury District Health Board faced clinical and financial pressure. It recorded a deficit of around NZ$16.9 million, had among the longest waits in New Zealand for elective procedures and radiation therapy, and its main hospital regularly reached gridlock.4 Modelling showed that continuing as it was would, by 2020, require an additional 450 acute hospital beds, 20 per cent more general practitioners and 2,000 more aged residential care beds. This was neither affordable nor achievable, and it created the case for change.[97]

The Christchurch earthquakes of 2010 and 2011 damaged hospital buildings and sharpened the need to use resources efficiently, accelerating work already under way.[108] The response was organised around a single unifying idea, that Canterbury was one system with one budget, in which each dollar could be spent only once and problems could not be solved by shifting cost from one part of the system to another

The operating model

The model combines a clear financial logic, investment in the community, strong primary care and a set of enablers that hold the system together. Figure 1.8.1 sets out this structure.

[96] https://www.kingsfund.org.uk/insight-and-analysis/reports/quest-integrated-health-and-social-care
[97] https://www.sciencedirect.com/science/article/pii/S2514664524011901

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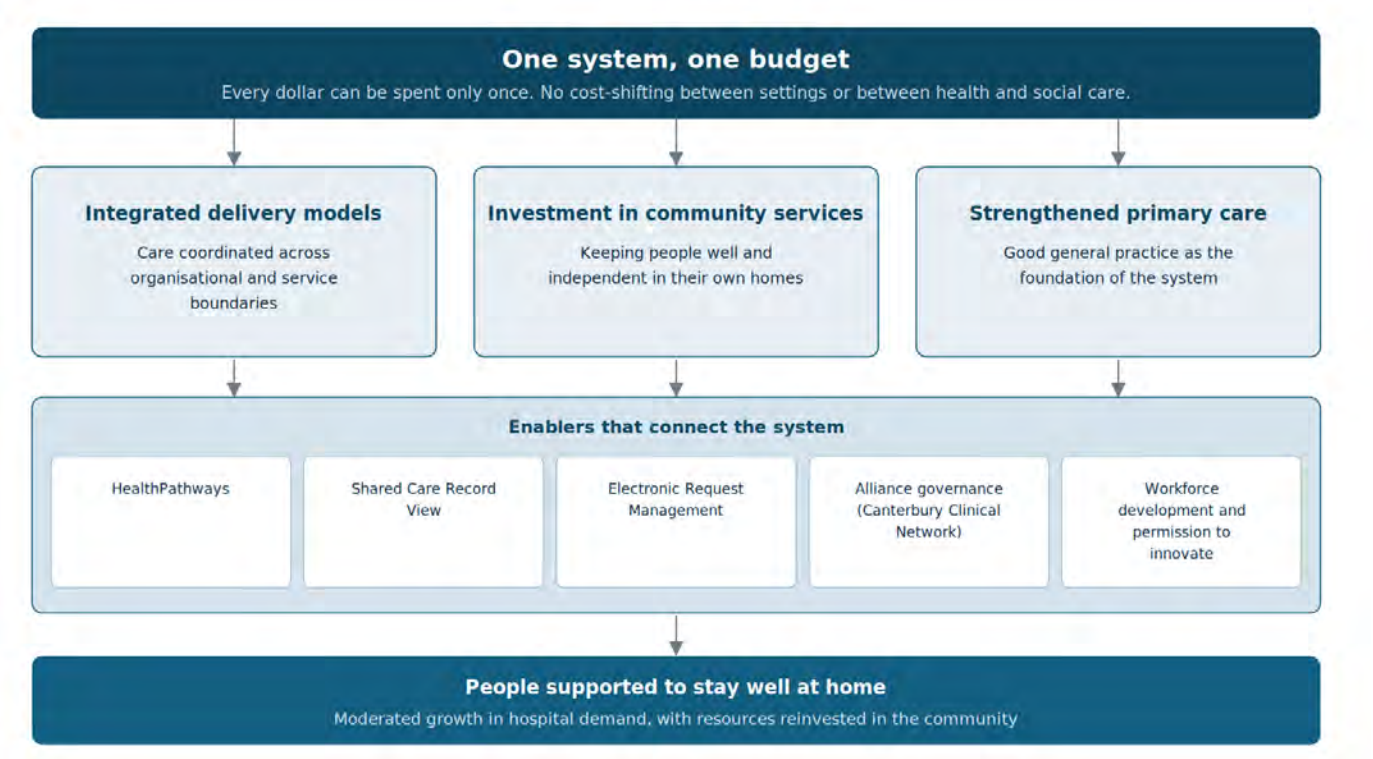


Figure 1.8.1 The Canterbury operating model: one system, one budget

To make the financial logic real, the price and volume schedule that governed payments to hospital departments, the equivalent of the NHS tariff, was scrapped, and departmental budgets were rebuilt from the base.[98] Contracting moved towards an alliance, in which providers share responsibility for the whole system through the Canterbury Clinical Network. The principle of the alliance is that everyone wins or everyone loses together, which removes the incentive to shift cost or risk onto another part of the system.[99]

Alongside this, Canterbury invested in giving staff the skills and the permission to redesign care, and in a set of digital enablers that let clinicians work to the same information and the same agreements across organisational boundaries.

HealthPathways

The most distinctive element is HealthPathways, a web-based set of clinical pathways designed jointly by general practitioners and hospital specialists. First produced in 2008, it sets out locally agreed guidance on how to assess, manage and refer patients for common conditions, together with request pages for tests and specialist advice.[100]

HealthPathways became, in effect, the way care is done in Canterbury. Around 80 per cent of general practice teams use it several times a week, with roughly 1.5 million

[98] https://www.kingsfund.org.uk/insight-and-analysis/reports/quest-integrated-health-and-social-care

[99] https://www.gov.scot/publications/national-care-service-integrated-care-studies-scfnuka-alaska-canterbury-new-zealand-models/

[100] https://ijic.org/articles/10.5334/ijic.3769

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page views a year, and it has been credited with contributing to a 43 per cent increase in access to elective surgery.[34] Localised versions have since been deployed across more than 30 health districts in New Zealand, Australia and the United Kingdom, covering a population of over 22 million.[101]

The transferable lesson for CTM is that shared, locally agreed pathways can be the connective tissue between primary and secondary care. They align clinicians around a common approach and reduce the fragmentation that comes from primary and hospital teams working to different rules.

Acute demand management and community services

Canterbury is strong on community urgent response. Its Acute Demand Management Service provides community-based acute care so that hospital is not the default when a person becomes unwell. In its early years the service was associated with a 4.6 per cent fall in emergency department attendance for aligned general practices, against a 7 per cent rise for others, at a cost of around NZ$11.90 per head of population.[102]

This sits within a wider pattern of shifting care closer to home, including support for older people to remain independent. The proportion of Canterbury residents aged over 75 living in residential care fell from around 16 per cent in 2006 to about 12 per cent in 2013, and the trend continued.[103] For CTM, the lesson is to build a genuine community urgent response so that admission is a considered decision rather than an automatic one.

Information and governance

Two further enablers hold the system together. A shared electronic record, the Shared Care Record View, together with an electronic request management system, lets clinicians across settings see the same information. And collaborative governance through the alliance gives clinicians collective leadership over how care is designed, rather than leaving change to contract negotiation alone.[104] The design principle for CTM is that a shared record, shared pathways and shared accountability are what allow separate organisations to behave as one system.

Translation into the CTM Bonsai model

Because Canterbury is a whole-system model, its learning reaches across the Bonsai layers rather than concentrating in one or two. Figure 1.8.2 maps its mechanisms to transferable principles and then to the layers they inform.

101 https://ijic.org/articles/10.5334/ijic.3769

102 https://www.cambridge.org/core/journals/primary-health-care-research-and-development/article/hospital-avoidance-an-integrated-community-system-to-reduce-acute-hospital-demand/D1216A016D66E72DD4459DF8D82E4270

103 https://www.kingsfund.org.uk/insight-and-analysis/reports/developing-accountable-care-systems

104 https://www.kingsfund.org.uk/insight-and-analysis/reports/quest-integrated-health-and-social-care

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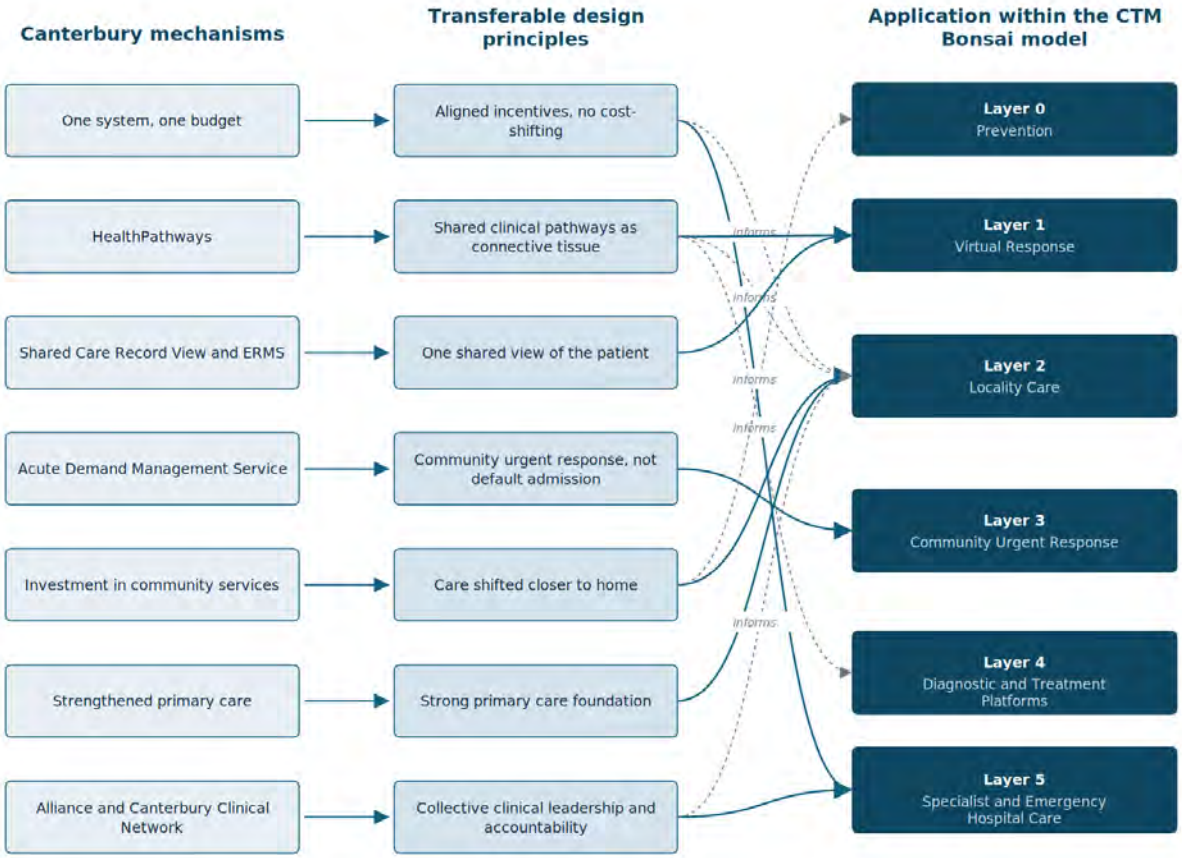


Figure 1.8.2 Canterbury mechanisms, transferable design principles and their application within the CTM Bonsai model

CTM Bonsai layer	Direct learning from Canterbury	Potential implication for CTM
Layer 0: Prevention	Keeping people, especially older people, well and independent at home moderates demand upstream	Invest in community wellbeing and independence as a way of reducing later hospital demand
Layer 1: Virtual Response	HealthPathways, a shared care record and electronic request management connect the system	Build shared pathways and a shared record as the digital connective tissue between settings
Layer 2: Locality Care	Strengthened primary care and community services with care shifted closer to home	Invest in primary care and community services as the foundation of locality care
Layer 3: Community Urgent Response	Acute Demand Management Service provides community-based acute care to avoid admission	Build a genuine community urgent response so hospital is not the default
Layer 4: Diagnostic and Treatment Platforms	Shared pathways and request pages improve direct access to diagnostics and specialist advice	Use agreed pathways to give primary care clearer, faster access to diagnostics
Layer 5: Specialist and Emergency Hospital Care	One budget and alliance governance align hospitals with the wider system rather than divesting from them	Align incentives so hospitals work in partnership with community and primary care, not in competition

Table 1.8.3 Lessons from Canterbury for Strengthening the CTM Bonsai Model

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Evidence of impact

Canterbury is associated with a sustained moderation of hospital demand. It avoided the large increases in beds and residential care that its own modelling had projected, supported more people at home, reduced the use of residential care among older people, and improved access to planned surgery.

This evidence should be read with the same care as the other exemplars. Much of it is system-level and observational, drawn from a single health economy over a period that also included major disruption from the earthquakes. It is difficult to attribute the results to any single component, such as HealthPathways or acute demand management, rather than to the combination and to sustained leadership over more than a decade.[105]

Constraints and transferability

The transformation took more than a decade and required sustained investment, which is itself a caution against expecting quick results.[106] From the mid-2010s Canterbury's financial position deteriorated, driven partly by the capital cost of earthquake repairs and a new hospital, but not only by these. By the 2019/20 year it recorded a deficit of around NZ$243 million, the largest of any board in the country, and about a third of all district health board deficits nationally despite serving around 12 per cent of the population. In 2020 this culminated in a governance crisis, in which most of the executive team, including the long-serving chief executive, resigned amid a dispute with the board and a Crown monitor over how to reduce the deficit.[107]

[105] https://www.kingsfund.org.uk/insight-and-analysis/reports/quest-integrated-health-and-social-care

[106] https://www.stuff.co.nz/national/health/124434252/mass-resignation-of-managers-may-have-saved-cashstrapped-dhb-money-chair-says

[107] https://www.stuff.co.nz/national/health/124434252/mass-resignation-of-managers-may-have-saved-cashstrapped-dhb-money-chair-says

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Two years later the national context changed entirely. The Pae Ora (Healthy Futures) Act 2022 disestablished all twenty district health boards, including Canterbury, and merged their functions into a single national organisation, Health New Zealand, on 1 July 2022.[108]

The lesson for CTM is twofold. Canterbury shows what integration can achieve, but it also shows that integrated systems need sustained funding, stable governance and protection from financial and structural shocks. CTM should therefore transfer the operating principles, aligned incentives, shared pathways, investment in community care and collective clinical leadership, rather than the specific New Zealand structures, which have since been replaced.

Implications for CTM design

The Canterbury experience suggests following practical considerations for CTM:

- Invest deliberately in community services and primary care to moderate the growth in hospital demand
- Build shared, locally agreed clinical pathways as the connective tissue between primary and secondary care
- Create a genuine community urgent response so that hospital admission is a considered decision, not a default
- Use a shared care record so that every part of the system works to the same information.
- Align incentives and share accountability through collaborative or alliance-style arrangements and collective clinical leadership
- Treat integration as a long-term investment that needs stable funding and governance, not a quick reconfiguration

The notable lesson is that integration is achieved through connection rather than reorganisation. A shared budget, shared pathways, a shared record and shared accountability are what allow separate organisations to behave as one system focused on the person.

[108] https://www.oag.parliament.nz/data/health-reforms/about-health-reform

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Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

CTM Building Healthier Communities: Strategic Vision

November 2026



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Caveat: For the purpose of this report, the care model is referred to as the Layered Care Model.

1. Purpose and context

1.1 Purpose of this strategic vision

CTM is developing a Strategic Clinical Services Plan (SCSP) to guide how health and care should evolve in response to changing population needs, health inequalities and sustained pressure across the system.

This document sets out CTM's strategic vision for the future model of care. It describes the whole-system model that CTM is seeking to create, the experience it should provide for patients and citizens, their families and carers, the workforce and health and care partnerships, as well as the broad changes required across system.

At its centre is the 'Layered Care Model'. The model brings together prevention, virtual access, locality care, community urgent response, diagnostic and treatment platforms, and specialist and emergency hospital care within one connected system.

The strategic vision provides a common direction for CTM and its partners. It will guide the more detailed development of clinical models, service options and enabling plans during the subsequent stages of the Strategic Clinical Services Plan.

1.2 Role within the SCSP

This strategic vision bridges the Case for Change and the next phase of clinical service design.

The Case for Change establishes why CTM's current model needs to evolve. It sets out the evidence on population need, inequalities, demand, access, capacity, and workforce pressures.

This document responds by describing what the future model should seek to achieve across CTM. It defines:

- the ambition and principles for care in future
- the role and intended impact of each layer of the care model
- how the layers should operate as one connected model
- the future experience for people, the workforce and partners
- the high-level capabilities required to support the model

The next phase will apply this strategic vision to individual clinical areas. It will develop future pathways and service options, assess their implications and support the decisions required about future service delivery.

1.3 Scope and Boundaries of this document

The strategic vision considers the model of care across the whole system, including prevention, primary and community care, mental health, diagnostics, planned treatment, urgent response and specialist hospital services.

For each layer in the care model, the report describes:

- its purpose within the whole model
- the broad needs it should address
- the functions and forms of support it could provide
- the intended impact for people and the system
- its connections with other layers
- the high-level requirements for successful delivery.

The report remains deliberately strategic. It does not repeat the detailed evidence contained in the Case for Change or define clinical pathways for individual specialties. Nor does it determine future service or site configurations, specify workforce structures or establishments, undertake options appraisal or financial modelling, or provide a detailed implementation plan.

1. Purpose and context

1.4 How this strategic vision will be used

The strategic vision will provide a shared reference for our population, staff and partners to understand the future model of care CTM is seeking to deliver and what it could mean for them. It will support meaningful conversations about change, enabling people to shape how the model develops and understand the part they can play in putting it into practice.

CTM will use the vision to:

- guide the development of models and options for individual clinical areas and pathways
- test whether proposed changes support the intended experience and outcomes for people and communities
- identify dependencies between clinical services, partners and layers of care model
- align future workforce, digital, data, estates and investment planning
- inform the development of the transformation roadmap and future IMTP priorities

The vision does not pre-empt the outcome of future service design, engagement, options appraisal or consultation. It sets the direction and common framework for that work.

2. What has shaped the vision

CTM's strategic vision has been shaped by four connected sources;

1. learning from health systems internationally
2. evidence set out in the Case for Change
3. insight from local engagement
4. the direction of Welsh policy

Together, these sources support a move towards a more preventive, connected and community-focused model of care, while preserving timely access to specialist and emergency services when required.

2.1 Local evidence and engagement

The Case for Change shows that CTM's population is changing in both size and need. Ageing population, increase in multi co-morbidity and persistent differences in health outcomes will increase the requirement for coordinated support over longer periods. Demand and access pressures are already visible across primary, community, mental health, diagnostic, urgent and planned services, while workforce constraints limit the ability to respond by expanding existing provision.

The evidence indicates that providing more of the current pattern of care will not offer a sufficient or sustainable response. CTM will need to strengthen prevention, identify changing risk earlier and support more people to remain well and independent. Care will also need to become better coordinated across organisational and professional boundaries, with hospital capacity focused on patients whose needs require acute, emergency or specialist capability.

Engagement with CTM's clinical and operational leaders has reinforced this direction. An Improving Care Board workshop explored the experience that the future model should create for people, families and carers, the workforce, and partners and communities. Participants described the need for simpler access, greater continuity and fewer avoidable hand-offs. They also identified the need for more integrated ways of working, better use of information and stronger relationships with communities and partner organisations

Figure 2.1. Snippets for workshops and clinical lead sessions



Focused sessions with clinical leads added a pathway-level perspective. These discussions identified points of fragmentation and delay within current pathways and considered how earlier intervention, improved coordination and closer links between community and specialist services could improve care. The sessions did not seek to agree detailed future pathways. They helped test whether the emerging strategic vision could respond to the practical issues experienced across different clinical areas.

The discussions identified both common system issues and important differences between pathways. Common themes included fragmented referral and information flows, diagnostic constraints, workforce capacity, inconsistent access across sites and insufficient community capability to support timely step-down. However, the sessions also demonstrated that the balance between layers of care model will vary by clinical area. Some pathways offer greater scope for prevention, virtual support and community delivery, while others will remain substantially dependent on specialist diagnostics, procedures and hospital infrastructure.

Across the evidence and engagement, a consistent message emerges: CTM needs one system-wide direction for care, with sufficient flexibility to respond proportionately to differences in need, access and community circumstances.

2. What has shaped the vision

2.2 CTM 2030: Our Health, Our Future

CTM's corporate strategy, Our Health, Our Future: Building Healthier Communities Together, provides the organisational foundation for this strategic vision. It describes CTM's ambition across the life course, from starting and growing well through to living, ageing and dying well. The Future Model of Care should enable that ambition by connecting prevention, early support, community-based care and specialist services around the changing needs of people throughout their lives.

The strategy is organised around four strategic goals: Creating Health, Improving Care, Sustaining Our Future and Inspiring People. These goals provide a clear framework for considering what the future model must achieve.

Creating Health requires the model to address health inequalities, give equal attention to mental and physical health and work with communities to support wellbeing. Within the Layered care model, this responsibility extends beyond the Prevention and Community Resilience layer. Every layer should contribute by identifying risk earlier, preventing deterioration and responding proportionately to differences in population need.

Improving Care requires safe and compassionate care, timely access, digital transformation and the development of new models of care. The Layered Care model supports this by clarifying the role of different levels of care and strengthening the connections between them. Its purpose is to make access and movement across the system easier while ensuring that people receive specialist and emergency care when their needs require it.

Sustaining Our Future requires CTM to consider financial sustainability, value-based healthcare, environmental responsibility and an estate fit for the future. The strategic vision should therefore guide care towards the setting that can achieve the best outcomes and experience with the most appropriate use of workforce, infrastructure and financial resources. Future clinical models will need to consider value and sustainability alongside quality and access.

Inspiring People recognises that change depends on leadership, culture, inclusion and the workforce. The future model will require staff to work across traditional professional and organisational boundaries, supported by clear responsibilities, shared information and a culture that enables improvement. It should also contribute to CTM's role as a local employer and anchor organisation.

Together, the four goals provide a test for the Future Model of Care. The model should improve health and respond to illness, improve the quality and experience of care, use resources sustainably, and create the conditions in which the workforce and partners can deliver change.

Figure 2.2. Alignment of the care model with CTM's goals

CTM strategic goal	Contribution of the Future Model of Care
Creating Health	*Prevention, earlier identification of need, reduced inequalities, equal attention to mental and physical health and stronger community capability*
Improving Care	*Simpler access, coordinated care, timely diagnosis and treatment, safe escalation and digitally supported delivery*
Sustaining Our Future	*Appropriate use of each care setting, value-based decisions, sustainable workforce and infrastructure, and an estate aligned to future care*
Inspiring People	*Integrated working, inclusive leadership, development of skills, shared accountability and stronger collaboration with partners*

2. What has shaped the vision

2.3 Welsh policy and strategic direction

CTM's emerging vision reflects a consistent direction across health and care policy in Wales: improving population health requires the system to intervene earlier, organise care around people and communities, and rely less on reactive, hospital-based responses.

A Healthier Wales established the ambition for a whole-system approach in which health and social care services work together around the individual, with greater emphasis on prevention, wellbeing and care closer to home. The refreshed national plan strengthens this direction through earlier identification of need, integrated community services, equitable access and greater support for rehabilitation, recovery and independence. Together, these policies move the focus from treating individual episodes of illness towards supporting people over time and responding before needs escalate.[1]

The National Clinical Framework complements this ambition by emphasising consistent standards, evidence-informed pathways and clinical networks operating across organisational boundaries. Consistency does not require identical provision in every community. It means setting a common direction and quality expectations while allowing delivery to reflect differences in population need, geography and access. For CTM, this supports one overarching model of care with enough flexibility to respond to the different circumstances of Bridgend, Merthyr Tydfil and Rhondda Cynon Taf.[2]

Community by Design broadens the perspective beyond formal health services. It recognises that place, relationships, community assets, and the wider conditions in which people live shape health. Prevention and care closer to home therefore require CTM to work with communities, local authorities and third-sector partners, building on local strengths and addressing the barriers that affect people's ability to stay well and access support.

Across this policy landscape, the common expectation is that services should operate as a connected system rather than as separate organisational offers. Prevention, primary and community care, mental health, social care, diagnostics and specialist services need to form part of a continuous model. Digital access, shared information and a flexible workforce should support that connection, while appropriate face-to-face and non-digital routes maintain inclusion.

The Layered Care Model translates this national direction into CTM's local context. It provides a framework for combining consistent system-wide expectations with responses proportionate to local need, stronger prevention with timely treatment, and greater community capability with specialist support when required.

2.4 International Learning

CTM reviewed five international examples to understand how other systems have responded to similar pressures:



No single exemplar provides a complete model that CTM could or should reproduce. Each reflects its own policy, funding and organisational context. Their collective value lies in showing how different systems have strengthened prevention, organised responsibility around defined populations, and connected primary, community, and specialist services.

Source: [1]Welsh Government: 2024 plan for health and social care; [2]Welsh Government: National Clinical Framework; [3]PHW Community by Design

2. What has shaped the vision

Several lessons are particularly relevant to CTM.

Responsibility for a defined population supports proactive care. Ireland, Singapore, Brazil and Ontario show the value of understanding the needs of an identifiable population and establishing clearer responsibility for maintaining relationships, anticipating need and improving outcomes.

Care closer to home requires deliberate investment in community capability for uplift. Redirecting activity away from hospitals without strengthening primary care, community services, workforce, infrastructure and local partnerships risks transferring pressure rather than resolving it.

Continuity depends on clear relationships and responsibility. People with ongoing or complex needs benefit from identifiable points of coordination. Responsibility, communication and collaboration should remain clear when they move between services or require a period of more intensive or acute care intervention.

The connections between services determine whether the model functions as a system. Shared pathways, relevant information and timely specialist advice allow services to respond collectively. Clear arrangements for escalation and the return of responsibility reduce delay and fragmentation.

Hospitals retain a central but more focused role. International experience does not suggest diminishing the importance of hospitals. It demonstrates how specialist expertise can support care across settings while hospital-based capacity concentrates on complex, critical and highly specialised needs.

Transformation requires sustained leadership and investment. The experience of Ireland and Canterbury shows that integration depends on stable governance, clinical leadership and long-term development of community capability. Changes to organisational structures alone do not create integrated care.

The international review therefore provides a source of design learning rather than a blueprint. CTM will need to adapt relevant principles to the NHS Wales context and test them through subsequent clinical service design.

The combined evidence, engagement, policy direction and international learning establish several requirements for the strategic vision.

I The model should begin with population needs and inequalities. CTM requires one overall direction for care, but the scale and emphasis of delivery should reflect differences between communities.

II Prevention should extend throughout the model. It should include supporting wellbeing, identifying risk earlier, preventing deterioration and helping people recover and maintain independence.

III Access and navigation should become simpler. People should be able to reach appropriate support without unnecessary referrals, repeated assessments or avoidable movement between services.

IV CTM will need stronger community based capabilities. Locality and community services should be able to coordinate care, respond earlier and support people whose needs cross traditional service boundaries.

V The layers of the care model should operate as one connected model, with data and digital capability and enablers as core to the model. Information, advice and responsibility should move with the person as their needs change. The model should support escalation when greater expertise or intensity is required and enable people to return to local support as soon as appropriate.

VI Specialist capability should support the whole system. Specialist advice and intervention should be available across settings where clinically appropriate, while hospitals continue to provide care that requires concentrated expertise, infrastructure or continuous clinical support.

Finally, clinical change must develop alongside the capabilities that enable it. Workforce, digital and data, estates, transport, partnerships, governance and investment will need to support the same direction. Without these foundations, pathway changes alone will not deliver the intended model.

These implications provide the basis for CTM's ambition for care and the Layered Care Model described in the following chapters.



CTM’s ambition for care

3. CTM's ambition for care

CTM's ambition is to create a more preventive, connected and responsive system of care that helps people start, grow, live, age and die well. The Future Model of Care translates the direction established in Our Health, Our Future into an intended experience for people, the workforce, partners and communities.

In future, care should be easier to access and navigate, with greater emphasis on prevention, earlier identification of need and coordinated support at the most appropriate level. The model should enable more people to remain well and independent while ensuring timely access to diagnostics, treatment and specialist expertise.

CTM's future care continuum describes how that experience should operate as people's needs change. It begins with staying and managing well, progresses through earlier identification and coordinated local support, and provides access to enhanced, acute or specialist care when required. Recovery and support at home complete the continuum by helping people regain and maintain independence.

Hospitals will remain an essential part of the model, providing complex, specialist and emergency care. Their role should connect to stronger prevention, locality and community capability so people can avoid hospital where appropriate, access specialist care when required, and return home with coordinated support.

This ambition requires more than moving existing services between settings. It requires CTM and its partners to organise care around people and communities, share responsibility across boundaries and align workforce, information and resources behind a common model.

The future experience described in this chapter provides a strategic direction rather than an agreed specification for future services.

3.1 The future care continuum

The future care continuum describes the experience CTM wants to create as people's needs change. It provides a citizen-focused view of the model, while the layers of the care model describe the system capabilities required to deliver that experience.

The continuum is not a single pathway everyone follows in sequence. People may enter at different points, receive support from more than one layer of the care model at the same time and move between stages as their circumstances change. The model should make those movements timely and coordinated, with clear responsibility throughout.

- **Stay well**

  People and communities should have access to the conditions, information and support that help them maintain good physical and mental health. This includes action on prevention, healthy lifestyles, social connection and the wider factors influencing wellbeing.

  CTM should work with communities and partners to understand local strengths and barriers. Universal support should be complemented by targeted action for populations experiencing poorer outcomes or greater risk.

- **Manage well**

  People living with long-term conditions, disability or ongoing health needs should have the knowledge, confidence and support needed to manage their health as independently as possible.

  Support may include education, agreed care plans, medicines support, rehabilitation, peer or community support and appropriate digital tools. Self-management should not mean leaving people to manage alone. People should have clear routes back into professional support when their needs change.

3. CTM's ambition for care

Figure 3.1. CTM's future care continuum, showing movement towards more intensive support when required and return to staying or managing well following recovery



Note: The care continuum is cyclical, not linear. Following recovery, rehabilitation or a period of more intensive care, people should return to staying or managing well with appropriate ongoing support. People may enter the continuum at any point, move between stages in either direction and receive support from several stages at the same time. The purpose of the future model is to make these movements timely and coordinated, while helping people remain at the least intensive stage that can safely and effectively meet their needs.

- **Identify risk early**

  The system should identify changing need before it results in avoidable deterioration or crisis. This requires proactive review, population health intelligence and better use of information across services.

  Staff, people and carers should be able to recognise changes and know how to respond. Earlier identification should lead to timely action, with support proportionate to the person's needs and risks.

- **Receive coordinated local care**

  People with ongoing or complex needs should receive coordinated support through primary care, community health services, mental health, social care and community partners.

  Care should be organised around the person, with clear responsibility for coordination. Multidisciplinary teams should share information and draw on specialist advice where needed. People should not experience local care as a series of separate referrals or have to manage communication between services themselves.

- **Access enhanced care closer to home**

  When people require more intensive assessment, diagnostics, treatment or monitoring, CTM should provide these closer to home where this is clinically appropriate and sustainable.

  This may include community diagnostics, specialist outreach, rapid response, virtual care, rehabilitation or treatment delivered within local settings. Enhanced care should connect with local support and provide clear routes into acute or specialist services where needs cannot be met safely outside hospital.

- **Receive acute or specialist care**

  People should have timely access to acute, emergency and specialist care when their condition requires concentrated expertise, technology, infrastructure or continuous clinical support.

  Hospital care should form part of the connected model rather than operate as a separate destination. Hospital teams should have access to relevant information from earlier stages, and specialist expertise should support decision-making across the wider system where appropriate.

3. CTM's ambition for care

- Recover and remain well at home

  Planning for recovery should begin as early as appropriate. People should leave acute or specialist care with clear arrangements for rehabilitation, reablement, follow-up and ongoing support.

  Responsibility should transfer safely, with relevant information available to the teams supporting the person at home or in the community. People and carers should understand what happens next, how to manage ongoing needs and where to seek help if circumstances change.

  Recovery should include more than discharge from hospital. Its aim should be to help people regain independence, maintain wellbeing and reduce the risk of avoidable deterioration or readmission.

  The care continuum and Layered Care Model provide two complementary views of CTM's future system. The continuum describes the experience from the perspective of the person, while the Layered care model describes the capabilities and levels of support that make that experience possible. There is no fixed one-to-one relationship between a stage and a care model layer: several layers may contribute at the same time, depending on the person's needs.

3.2 What people, families and carers should experience

In future, people should experience a system that is easier to access, understand and navigate. Digital, telephone and face-to-face routes should connect people to the right support without requiring them to understand the organisations behind their care. Simpler access will depend on effective clinical navigation, clear responsibility and sufficient capacity beyond the point of entry. A new front door alone will not resolve delays or fragmentation.

Care should feel coordinated. People should not have to repeat their story, manage communication between teams or determine who remains responsible. Relevant information should follow the person, supported by clear coordination for those whose needs cross service boundaries. Continuity may be provided by an identifiable professional, a team or a shared care plan, depending on the person's needs.

Care should be provided at the most appropriate level. More support should be available within homes and communities where this is safe and effective. This does not mean transferring all hospital activity into community settings. The model should distinguish between needs that can be prevented or managed locally, care that requires enhanced community capability, and services that continue to depend on specialist expertise or hospital infrastructure. Shifts in activity must be matched by workforce, diagnostics, equipment, transport and digital capability.

Prevention and equity should run through the model. People should receive support earlier to maintain wellbeing, manage ongoing needs and prevent deterioration. CTM should combine a consistent core offer with additional support for communities experiencing greater need or barriers to care. Equal provision will not always achieve equitable outcomes.

Digital should widen access without creating exclusion. Virtual channels and shared information should improve choice, convenience and decision-making while remaining connected to face-to-face care and safe escalation. Non-digital routes must remain available.

People, families and carers should participate meaningfully in care planning. Care should reflect individual needs and preferences without shifting unreasonable responsibility onto people or unpaid carers.

3. CTM's ambition for care

Overall, the future model should feel simple to the person, even where the system behind it remains complex. CTM and its partners should manage that complexity through coordinated working rather than expecting people to navigate it themselves.

3.3 How the workforce should work

The future model will require staff to work as one connected workforce across professions, sites and care settings. Multidisciplinary input should be organised around need, with staff able to obtain advice and expertise without every question resulting in a referral or transfer of care.

Skills should be used differently. CTM cannot rely solely on recruiting more people into the current role pattern. Nurse-led and allied health professional-led care, advanced practice, broader use of support roles and specialist advice across settings could all form part of the future workforce. Any transfer of responsibility must be supported by time, funding, training and appropriate professional oversight.

Flexibility must not weaken continuity. People with ongoing or complex needs still require clear coordination and accountability. Continuity may not always mean seeing the same professional, but it should mean that information, responsibility and agreed actions are carried forward.

Technology should reduce friction. Staff should have access to relevant clinical and operational information when they need it. Shared records, better visibility of previous investigations and appropriate automation should reduce duplication and release time for care. Assess digital change across the full pathway so it does not add systems or administrative work.

Population insight should lead to action. Teams should use evidence and data to identify changing needs and target earlier intervention. This requires clear responsibility for defined populations and sufficient capacity to respond. Information alone will not create proactive care.

Leadership and culture will be as important as organisational structures. Staff should understand the purpose of the model, have the authority to improve care across boundaries and remain actively involved as CTM develops detailed clinical models.

3.4 How CTM should work with partners and communities

The future model cannot be delivered by CTM alone. Local authorities, primary care, social care, the third sector, communities and regional partners all influence health, access and independence.

Partnership should move towards shared ownership. Partners should be involved early in defining priorities and developing services. Where organisations share responsibility for outcomes, they need clear roles, decision-making arrangements, and aligned resources. Shared ambition without practical accountability is unlikely to change delivery.

Recognise community capability as system capacity. Community and third-sector organisations bring local knowledge, trusted relationships and practical support. Their contribution should not be treated as an informal or low-cost destination for demand displaced from statutory services. Where CTM expects partners to perform a sustained role, commissioning and partnership arrangements should recognise the capacity and funding required.

Information and responsibility should cross organisational boundaries safely. Shared records can improve coordination, but organisations must also understand who will review information and act on it. Clear routes for clinical advice, escalation and re-entry into formal services will be needed when people's circumstances change.

3. CTM's ambition for care

Different decisions belong at different geographical levels. Communities and localities should shape support that depends on local circumstances. CTM should provide appropriate consistency across the Health Board, while some specialist services, workforce requirements and infrastructure will require regional or national solutions.

Partnership should therefore form part of the operating logic of the Layered care model, rather than sitting alongside it as a separate engagement activity. The model will succeed only if organisations can align responsibility, information and resources around shared population outcomes.

3.5 Principles underpinning the future model

The future model will continue to develop through more detailed clinical design, engagement and options appraisal. The following service design principles provide a consistent basis for that work, helping CTM assess options and guiding implementation, while responding to different population and clinical needs.

System Design & Scope

Life Course Fit	Organise care around people's changing needs and goals, from starting well through to dying well, supporting continuity across life stages.
Whole System Approach	Plan services as part of a connected system, considering how changes affect people, workforce, partners and capacity across all layers of care.
Care Proximity	Provide care as close to home as is safe and effective, with timely access to specialist expertise and hospital services when required.

Inclusive & Preventive Care

Preventive Focus	Embed prevention throughout the model, supporting wellbeing, identifying risk earlier, preventing deterioration and helping people maintain or regain independence.
Equity & Access	Shape services around population needs and inequalities, addressing barriers to access and offering appropriate digital, telephone and face-to-face routes.
Person-Centred Care & Partnerships	Design care around people's goals, preferences and circumstances. Involve the population, staff and partners in understanding, shaping and delivering the future model.

Evidence, Innovation & Digital Transformation

Evidence Base	Use clinical evidence, population insight, service data and lived experience to inform design. Assess proposals against their expected impact on outcomes, experience, equity and value.
Digital Enablement & Innovation	Build digital and data capabilities into service design to support access, shared information, coordinated decisions and new ways of delivering care, while providing support and alternatives for people who need them.

3.5 Principles underpinning the future model

The future model will continue to develop through more detailed clinical design, engagement and options appraisal. The following service design principles provide a consistent basis for that work, helping CTM assess options and guiding implementation, while responding to different population and clinical needs.

Safe, Accountable Care

Quality & Safety	Maintain safety, effectiveness, dignity and compassion across every layer, with clear arrangements for escalation, handover and continuity of care.
Governance & Assurance	Establish clear accountability, clinical oversight and proportionate assurance for service changes, with responsibilities understood across organisational boundaries.

Resilient & Sustainable Delivery

Sustainability	Design services that are deliverable within workforce, financial and infrastructure capacity and can adapt to changing needs. Use modelling to assess resources, benefits and trade-offs over time.
Environmental Sustainability	Consider the environmental impact of service choices, including travel, estates, energy and resource use, while maintaining quality and equitable access.

These principles should guide the development of each layer and the connections between them. As the vision progresses into detailed design, proposals should demonstrate how they apply the principles, where trade-offs arise and how their impact will be assessed.



IV The CTM Layered Care Model

4. The CTM Layered Care Model

The CTM Layered Care Model provides the organising framework for the strategic vision. It brings together prevention, access, local care, urgent response, diagnostics, treatment and hospital services within one connected model.

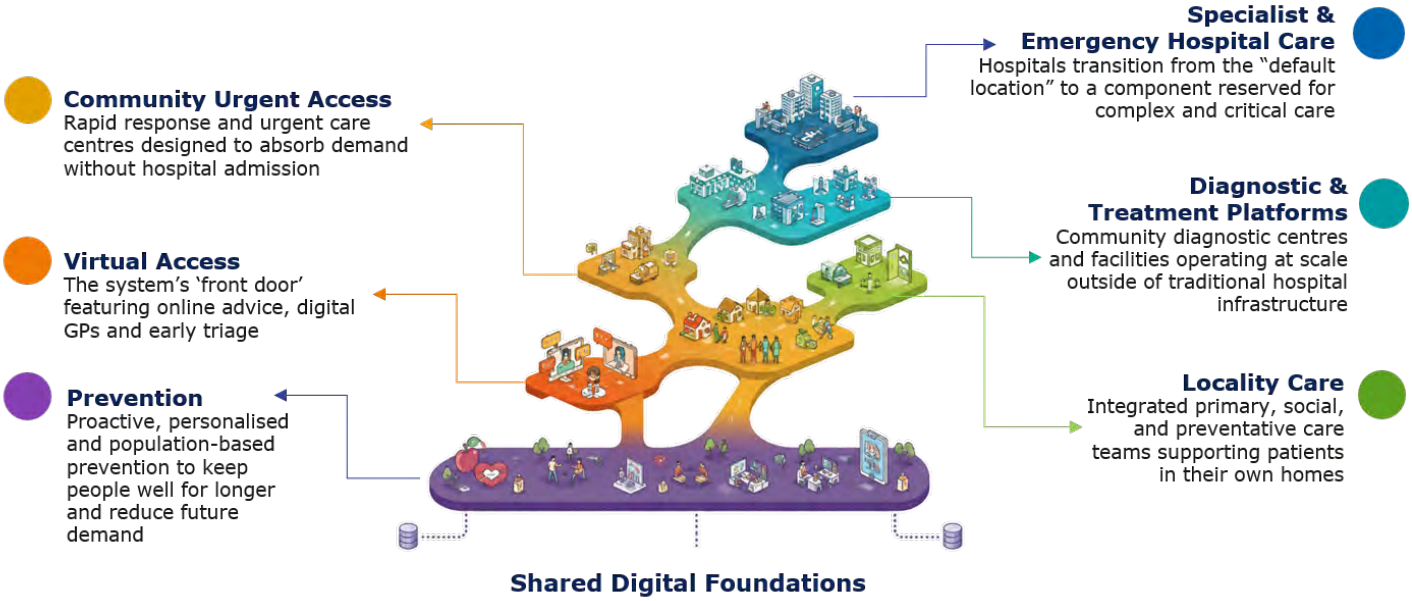
The model describes the broad functions and levels of support that should be available across the system and how they should work together as people's needs change. It does not prescribe the detailed configuration of individual clinical services. Subsequent clinical design will determine how the model should apply to different populations, pathways and services.

4.1 The Model at a glance

The CTM Layered Care Model comprises six connected layers:

- Layer 0: Prevention
- Layer 1: Virtual Access and Response
- Layer 2: Locality Care
- Layer 3: Community Urgent Response
- Layer 4: Diagnostic and Treatment Platforms
- Layer 5: Specialist and Emergency Hospital Care

Figure 4.1. The CTM Layered Care Model



Prevention and community resilience provide the foundation for the model. The remaining layers offer different forms and levels of capability, from accessible advice and coordinated local support through to urgent response, diagnostics, treatment and complex hospital care.

The layers do not represent separate organisations, fixed service tiers or predetermined locations. Each layer describes a set of functions that different teams may deliver across several settings. Some capabilities may operate within people's homes or neighbourhoods, while others require Health Board-wide, regional or national infrastructure.

The model seeks to support people at the least intensive level that can safely and effectively meet their needs. This does not mean holding people within community services or delaying access to specialist care. It means providing the right capability early enough to prevent avoidable escalation while ensuring rapid access to more intensive support when required.

4. The CTM Layered Care Model

The model's value lies in the connections between its layers. People should be able to move between them without losing information, continuity or clarity about who remains responsible for their care. Expertise should also move across the model, allowing specialist advice and decision-making to support care in other settings where appropriate.

4.2 How to understand the Layered Care Model

The Layered Care Model is a connected system of care, not six separate tiers. Each layer describes a distinct set of functions and capabilities, but its effectiveness depends on how well it connects with the rest of the model.

One model, not six separate services

The layers do not represent individual organisations, fixed service locations or additional referral stages. A person may receive support from several layers simultaneously, coordinated around their needs.

For example, someone living with heart failure may use virtual monitoring, receive coordinated support from a locality team, access community diagnostics and continue to receive specialist oversight. The model should connect these contributions rather than require the person to move through a series of separate services.

Movement according to need

People will not enter the model at the same point or move through every layer in sequence. Some may remain well with preventive and community support, while others may enter directly through urgent, acute or specialist care.

Movement should be possible in both directions. When needs increase, people should have timely access to more intensive assessment and treatment. Following stabilisation or recovery, responsibility should transfer safely to local services and ongoing support.

The intention is not to prevent access to hospital care when it is required. It is to ensure that escalation results from clinical need rather than from gaps, delays or insufficient capability elsewhere in the system.

Prevention throughout the model

Prevention and community resilience underpin the model, but prevention is not confined to Layer 0. Every layer should contribute to maintaining wellbeing, identifying risk earlier, preventing deterioration and supporting recovery.

This may include proactive monitoring through virtual services, anticipatory care within locality teams, admission avoidance through community urgent response, earlier diagnosis and intervention, and prevention of complications or readmission following hospital treatment.

Functions rather than buildings

The layers describe what the system needs to do, rather than prescribing where every service should be located. Capabilities may be delivered in people's homes, community facilities, primary care settings, hospitals or through a combination of physical and virtual provision.

For example, diagnostic capability may range from home-based and point-of-care testing to community diagnostic facilities and complex hospital-based investigations. Similarly, specialist expertise may support care beyond the hospital through advice, outreach and shared decision-making.

Future location decisions should reflect clinical safety, population need, accessibility, workforce availability, service dependencies, and the scale required for sustainable delivery.

4. The CTM Layered Care Model

Delivery at the appropriate scale

Different parts of the model will need to operate across different geographical footprints. Prevention and community support should respond to neighbourhood and locality circumstances, while urgent, diagnostic, and specialist capabilities will require Health Board-wide, regional, or national arrangements.

The model therefore provides a consistent CTM-wide direction without requiring every community or pathway to adopt an identical configuration. The balance of capability should reflect population need while maintaining appropriate standards of quality, access and safety.

Clear responsibility across transitions

Integration requires more than connected systems and referral routes. People should experience continuity of information, decision-making and responsibility when several teams are involved or when their needs change.

Detailed clinical models will need to establish:

- who coordinates care
- when and how responsibility transfers
- what information follows the person
- how advice can be obtained without unnecessary referral or transfer
- how people escalate rapidly when their needs increase
- how responsibility returns to local or ongoing support following treatment.

These arrangements should reduce repeated assessment, avoid people being passed between services and ensure that no one is left without clear clinical ownership.

Supported by common system capabilities

All six layers depend on shared enabling capabilities, including:

- an integrated and adaptable workforce
- digital access and shared information
- population health intelligence
- suitable estates, equipment and transport
- effective partnerships with primary care, local authorities and the third sector
- clear governance and clinical accountability
- sustainable funding and resource allocation

These capabilities will need to develop alongside the clinical model. Without them, changes in where or how care is delivered could transfer pressure between services rather than improve outcomes or system sustainability.

The following slides 24 to 35 describe the purpose, core functions and intended contribution of each layer. They provide a common strategic framework for the detailed clinical models and service options that CTM will develop during the next phase.

Layer 0: Prevention

PURPOSE

Prevention underpins the Layered Care Model. Its purpose is to help people stay well and independent longer, reduce avoidable health inequalities, and identify emerging needs before they become more complex or urgent.

This layer applies to the whole population but should be proportionate to need. Universal action to promote health and wellbeing should be combined with targeted support for people and communities experiencing poorer outcomes, greater risk or barriers to accessing care.

Prevention should not be understood solely as lifestyle advice or individual behaviour change. It encompasses action on the wider determinants of health, protection from avoidable illness, early identification of risk, supported self-management and the development of community capability.

CORE FUNCTIONS

Layer 0 should bring together four connected functions:

- Understanding and targeting need: using population health intelligence to identify inequalities, emerging risks and populations that may benefit from earlier or additional support.
- Enabling people to stay well: providing health promotion, vaccination, screening, wellbeing support and the knowledge and tools people need to manage their health.
- Strengthening community capability: working with communities, local authorities and third-sector partners to build social connection, address wider determinants and connect people with local assets and practical support.
- Identifying and responding earlier: recognising changing needs and providing timely support before they lead to deterioration, loss of independence or avoidable use of urgent and hospital care.

Engagement highlighted that health services alone cannot deliver prevention. Its effectiveness will depend on people having access to trusted information, supportive communities and practical help, with clear routes into professional care when their needs change. The model must therefore connect population-level action, individual support and community capability rather than treating them as separate activities.

Self-care and community support should complement formal services. They should not shift clinical responsibility to individuals, families, or community organisations, or assume every community has the same resources and capacity.

Layer 0: Prevention

CONNECTIONS WITH OTHER LAYERS

Layer 0 connects with every other part of the model. Virtual access can provide information, guidance and routes into support. Locality teams can respond when people require coordinated or ongoing care. Community urgent response can intervene when there is a risk of crisis or avoidable admission.

The connection should also work in reverse. Following diagnosis, treatment or recovery, people should reconnect with preventive, self-management and community support to help sustain progress and reduce the risk of further deterioration.

Although Layer 0 provides the primary focus for prevention, every layer has a preventive role. This includes preventing deterioration, avoidable admissions, complications, functional decline and readmission.

INTENDED IMPACT

- improve health and wellbeing across the population
- help people retain independence
- identify and address need earlier
- reduce avoidable differences in outcomes
- slow or prevent deterioration
- reduce avoidable escalation into urgent or hospital care

REQUIREMENTS FOR DELIVERY

Effective prevention will require:

- shared intelligence about population need, risk and inequalities
- accessible, trusted and culturally appropriate support
- stronger links between public health, primary care and wider services
- sustainable partnerships with communities and the third sector
- clear navigation, advice and escalation routes
- proportionate information sharing
- investment that recognises benefits across organisational boundaries
- measures covering reach, outcomes, equity and independence.

Community organisations should be recognised as contributors to the overall model, but not as an informal or low-cost destination for demand displaced from statutory services. Where partners are expected to provide sustained support, explicitly consider the required capacity, funding, and infrastructure.

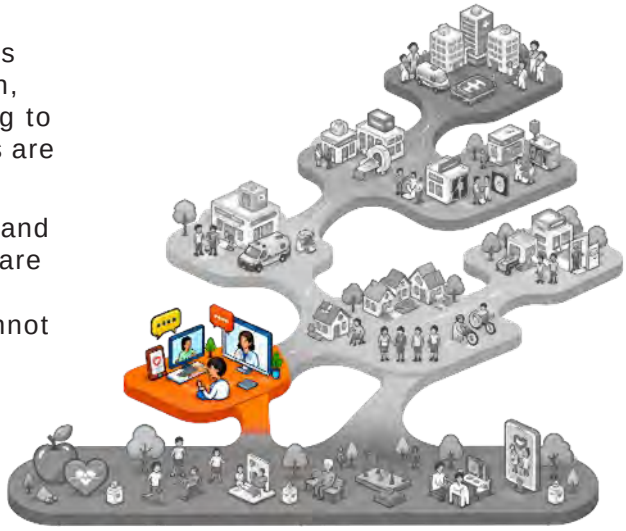
Layer 1: Virtual Access and Response

PURPOSE

Virtual Access and Response provides a clear and responsive front door to the Layered Care Model. Its purpose is to help people obtain trusted information, advice and an appropriate response without needing to understand how individual services or organisations are structured.

This layer should offer a blend of digital, telephone and other remote channels, connected to face-to-face care where required. It should make access simpler and more consistent while ensuring that people who cannot or choose not to use digital routes are not disadvantaged.

Virtual access should not be understood as a website, application or contact centre alone. Its value depends on the navigation, clinical decision-making, and service capacity behind the point of contact.



CORE FUNCTIONS

Layer 1 should bring together four connected functions:

- Information and advice: providing consistent and accessible information that helps people understand their needs, available support and when to seek further help.
- Navigation and signposting: directing people to the most appropriate service or community support without unnecessary hand-offs or repeated referrals.
- Assessment and early triage: identifying the nature and urgency of need and determining the most appropriate next response.
- Virtual care and follow-up: enabling remote consultations, monitoring, reminders and follow-up where these are clinically appropriate and convenient for the person.

Engagement indicated that people want simpler routes into care and clearer information about what will happen next. A more visible front door could support this, but it must connect to effective clinical navigation and timely responses. Simplifying access without strengthening the services behind it could expose unmet demand without improving people's experience or outcomes.

Layer 1: Virtual Access and Response

CONNECTIONS WITH OTHER LAYERS

Layer 1 should connect people directly with the most appropriate part of the model. This may include preventive and community support, coordinated locality care, urgent community response, diagnostics or acute and specialist services.

Where possible, advice and specialist input should be available without transferring responsibility unnecessarily. Where referral or escalation is required, relevant information should accompany the person so that they do not need to repeat their history or undergo avoidable reassessment.

Virtual access should also support people as they move back through the model. Following treatment or an acute episode, it can provide follow-up, monitoring and routes back into professional care if recovery does not progress as expected.

INTENDED IMPACT

- make it easier for people to find and obtain appropriate support
- improve consistency in the information and advice provided
- support earlier identification of changing or urgent needs
- reduce avoidable travel, appointments and hand-offs
- enable appropriate needs to be resolved remotely
- provide clearer routes into other layers of the model

REQUIREMENTS FOR DELIVERY

Effective virtual access and response will require:

- clear and consistent access routes across digital, telephone and face-to-face channels
- effective clinical navigation and proportionate triage
- agreed protocols for escalation and transfer of responsibility
- access to relevant information across services
- integration with national digital platforms and existing local pathways
- workforce capacity to respond to demand generated through the front door
- accessible design and alternatives for people affected by digital exclusion
- measures covering access, resolution, safety, equity and user experience

Technology should support the service model rather than determine it. Digital channels should be introduced or expanded only where the associated workflows, clinical responsibilities and connections to other services are sufficiently clear.

Layer 2: Locality Care

PURPOSE

Locality Care provides coordinated, ongoing support for people whose needs cannot be met through prevention or a single episode of advice. Its purpose is to organise care around defined populations and communities, bringing together the capabilities required to manage ongoing, complex or changing needs closer to home.



This layer should connect primary care, community health services, mental health, social care, pharmacy, rehabilitation and community partners. Specialist expertise should be accessible where required without every request for advice resulting in a hospital referral or transfer of care.

Locality Care should not be interpreted simply as moving existing hospital services into community settings. It requires services to work differently around shared populations, with clear responsibility, appropriate capacity and access to the diagnostics and specialist support needed to manage people safely.

CORE FUNCTIONS

Layer 2 should bring together five connected functions:

- Proactive population-based care: identifying people who may benefit from earlier intervention, review or additional support.
- Coordinated multidisciplinary support: bringing together relevant professionals around the person's needs without requiring every case to enter a formal multidisciplinary process.
- Ongoing condition management: supporting people with long-term conditions, frailty, mental health needs, disability or multiple conditions.
- Rehabilitation and independence: enabling people to maintain or regain function through rehabilitation, reablement and practical support.
- Specialist advice into local care: allowing locality teams to access expertise without unnecessary referral or transfer to hospital-based services.

Engagement emphasised the importance of care feeling joined up to the person, particularly where several services are involved. People should not have to coordinate different teams, repeat their history or determine who remains responsible. Locality Care should therefore provide continuity of responsibility and information, whether this is delivered through an identifiable professional, a multidisciplinary team or a shared care plan.

The model should maintain a consistent CTM-wide expectation while allowing delivery to reflect differences between communities. Local variation may be appropriate where it responds to population need, but variation caused by unclear responsibilities, historical arrangements or unequal access to expertise should be identified and addressed.

Layer 2: Locality Care

CONNECTIONS WITH OTHER LAYERS

Locality Care provides an important coordinating point within the model. It should connect people with preventive and community support, receive referrals and information through virtual access, and access Community Urgent Response when needs escalate rapidly.

It should also connect with diagnostic and treatment platforms and specialist hospital services. Locality teams should be able to request investigations, obtain specialist advice and escalate care without creating unnecessary delays or repeated assessment.

Following urgent, diagnostic or hospital care, responsibility should return safely to locality services where ongoing support is required. Discharge or transfer should therefore be treated as a coordinated transition rather than the end of an isolated episode.

INTENDED IMPACT

- identify and respond to changing needs earlier
- improve continuity for people with ongoing or complex needs
- reduce fragmented referrals and repeated assessments
- support more care to be delivered safely closer to home
- help people retain or regain independence
- improve access to specialist advice
- reduce avoidable deterioration, crisis and hospital use.

REQUIREMENTS FOR DELIVERY

Effective Locality Care will require:

- clearly defined populations and geographical footprints
- shared understanding of the needs and assets within each locality
- multidisciplinary capacity across organisational and professional boundaries
- clear responsibility for coordinating care
- access to specialist advice, diagnostics and prescribing support
- shared information and care planning
- sufficient community, rehabilitation and social care capacity
- flexible workforce roles supported by appropriate governance
- measures covering outcomes, continuity, equity and independence

The shift towards locality-based delivery must be matched by workforce, funding, estates, equipment, transport and digital capability. Moving activity without strengthening these foundations could transfer pressure from hospitals into services that are not equipped to absorb it.

Layer 3: Community Urgent Response

PURPOSE

Community Urgent Response provides rapid assessment and time-limited intervention when a person's needs escalate but may still be managed safely outside hospital. Its purpose is to prevent avoidable deterioration and admission while ensuring that people who require emergency or specialist care reach it without delay.



This layer should bring together appropriate clinical assessment, diagnostics, treatment and practical support within people's homes or other community settings. It should operate as part of the wider urgent and emergency care system rather than as an isolated admission-avoidance service.

Avoiding hospital should not become an objective where admission represents the safest or most effective response. The emphasis should be on making a timely clinical decision and providing care at the appropriate level.

CORE FUNCTIONS

Layer 3 should bring together five connected functions:

- Rapid access and clinical assessment: enabling professionals and services to obtain a timely response when someone's needs deteriorate.
- Same-day community intervention: providing assessment, treatment and monitoring within the home or an appropriate community setting.
- Crisis prevention and stabilisation: responding to acute changes in physical health, mental health, function or social circumstances.
- Access to urgent diagnostics and specialist advice: supporting safe decisions without automatically transferring the person to hospital.
- Supported transition and follow-up: connecting people to locality, rehabilitation, social care or hospital services following the immediate response.

The response should address the person's needs as a whole. An urgent episode may arise from a combination of clinical deterioration, reduced mobility, carer breakdown, medication issues or changing social circumstances. Focusing only on the presenting condition may resolve the immediate episode without addressing the factors likely to cause further deterioration.

Engagement highlighted the need for quicker access to coordinated support when circumstances change. This requires sufficient response capacity and clear referral routes. A community urgent response offer will have limited impact if professionals cannot access it easily, if operating hours do not reflect patterns of need or if people must pass through multiple assessments before receiving support.

Layer 3: Community Urgent Response

CONNECTIONS WITH OTHER LAYERS

Community Urgent Response should be closely connected to Locality Care. Local teams should be able to escalate people rapidly when their needs increase, while urgent response teams should return responsibility safely once the person has stabilised.

Virtual Access and Response may identify urgent needs and direct people to this layer. Diagnostic and Treatment Platforms should provide timely access to investigations, while Specialist and Emergency Hospital Care should remain readily available when needs cannot be managed safely in the community.

The layer should also support movement out of hospital by providing short-term monitoring, treatment or rehabilitation where this enables a safe transition home. Step-up and step-down functions should be coordinated as part of one response rather than operating through disconnected pathways.

INTENDED IMPACT

- provide a timely alternative to hospital where clinically appropriate
- reduce avoidable deterioration and emergency attendance
- support safe treatment and monitoring closer to home
- improve coordination between community and urgent care services
- enable earlier supported discharge where appropriate
- reduce repeated crises by reconnecting people with ongoing support.

REQUIREMENTS FOR DELIVERY

Effective Community Urgent Response will require:

- simple and timely access for relevant professionals and services
- clear eligibility, response and escalation arrangements
- multidisciplinary clinical capability
- sufficient operating hours and capacity to respond reliably
- access to relevant records, diagnostics, prescribing and specialist advice
- mobile equipment and digital connectivity
- connections with ambulance, primary care, mental health, social care and hospital teams
- clear responsibility during and following the intervention
- measures covering timeliness, safety, outcomes and subsequent service use

Capacity should be planned against demand across the wider urgent and emergency care pathway. Creating a community response without aligning ambulance conveyance, hospital pathways and ongoing locality support could add another service boundary rather than improve flow.

Layer 4: Diagnostic and Treatment Platforms

PURPOSE

Diagnostic and Treatment Platforms provide the investigations, procedures and planned interventions required across the care continuum. Their purpose is to improve timely access, make better use of available capacity and enable more diagnostics and treatment to be delivered outside traditional hospital settings where this is clinically appropriate and sustainable.



A platform should be understood as a connected set of capabilities rather than a single building. It may include services delivered in people's homes, primary and community settings, dedicated diagnostic or treatment facilities and acute hospitals. The appropriate setting will depend on clinical complexity, workforce, equipment, supporting services and the scale required for safe delivery.

The aim should not be to relocate existing services without redesigning the pathway. Diagnostic and treatment capability should connect referral, assessment, testing, reporting, intervention and follow-up as one coordinated process.

CORE FUNCTIONS

Layer 4 should bring together five connected functions:

- Referral and pathway navigation: ensuring that requests are complete, clinically appropriate and directed to the correct investigation or treatment route.
- Diagnostic assessment and testing: providing access to imaging, pathology, physiological measurement and other investigations at an appropriate level.
- Planned treatment and procedures: delivering suitable interventions outside specialist hospital environments where this is safe and effective.
- Clinical interpretation and decision-making: ensuring that results are reviewed promptly and lead to clear action, advice or escalation.
- Capacity coordination: using shared information to manage demand, waiting lists, scheduling and available capacity across sites and settings.

Clinical insight highlighted that delays often arise across the whole pathway rather than from a single test or appointment. Improving capacity at one stage may have limited benefit if referral quality, reporting, specialist decision-making or follow-up remain constrained. The design of this layer should therefore consider end-to-end flow and clinical dependencies.

Success should not be assessed solely through the number of tests or procedures delivered. Measures should consider the time from referral to clinical decision or treatment, diagnostic quality, patient experience, equity of access and whether the intervention improves the complete pathway.

Expanding diagnostic capacity may identify additional unmet need and increase downstream demand. Workforce, reporting, treatment and follow-up capacity should therefore develop alongside testing capability.

Layer 4: Diagnostic and Treatment Platforms

CONNECTIONS WITH OTHER LAYERS

Diagnostic and Treatment Platforms should support every layer of the model. Prevention and Locality Care require access to screening, monitoring and investigations. Community Urgent Response needs timely diagnostics to support safe treatment outside hospital. Specialist and Emergency Hospital Care will continue to provide complex diagnostics and interventions that depend on concentrated expertise and infrastructure.

Virtual Access and Response may support electronic referral, booking, preparation and communication of results. However, digital access should connect to clinical review and clear follow-up rather than place responsibility on people to interpret or coordinate their own results.

Information and responsibility should move with the person. Referring professionals should be able to understand the status of requests, and results should be available to the teams responsible for subsequent decisions and care.

INTENDED IMPACT

- improve timely and equitable access to investigations and treatment
- reduce unnecessary hospital visits and travel
- support earlier diagnosis and clinical decision-making
- reduce repeated investigations and fragmented appointments
- enable appropriate planned care closer to home
- improve the resilience and productivity of clinical pathways

REQUIREMENTS FOR DELIVERY

Effective Diagnostic and Treatment Platforms will require:

- clear and standardised referral criteria
- access to clinical advice before referral where appropriate
- pathways that support direct-to-test and one-stop approaches where suitable
- coordinated booking, scheduling and waiting-list information
- sufficient technical, clinical and reporting workforce
- interoperable ordering, results and clinical information systems
- consistent quality, safety and governance arrangements
- suitable estates, equipment, maintenance and transport
- visibility of demand, capacity and utilisation across CTM
- timely arrangements for communicating and acting on results

Greater distribution of services should not create unwarranted variation or duplicate scarce capability. Decisions about location should balance accessibility with clinical dependencies, workforce sustainability, equipment requirements and the volumes needed to maintain quality.

Layer 5: Specialist and Emergency Hospital Care

PURPOSE

Specialist and Emergency Hospital Care provides the concentrated expertise, infrastructure and continuous clinical support required for people with acute, complex, life-threatening or highly specialised needs.



Hospitals will remain an essential part of the Layered Care Model. Their role should become more focused on care that genuinely depends on hospital-based capability, while expertise, diagnostics and treatment are made available through other layers where this is safe and sustainable.

This is not simply about reducing hospital activity. It is about ensuring that people receive hospital care promptly when they need it, that hospital capacity is used for the needs it is best equipped to meet, and that admission does not become the default response when effective alternatives are available.

CORE FUNCTIONS

Layer 5 should bring together five connected functions:

- Emergency assessment and stabilisation: providing an immediate response to serious illness, injury or deterioration.
- Acute inpatient care: delivering continuous monitoring, treatment and multidisciplinary support for people who require admission.
- Specialist and complex care: providing expertise, technology and infrastructure that cannot be safely or sustainably replicated across multiple settings.
- Complex diagnostics and interventions: undertaking investigations, procedures and treatments that depend on specialist teams or hospital facilities.
- Recovery and transition: beginning rehabilitation and discharge planning early and coordinating the transfer of responsibility to ongoing support.

Hospital-based specialists should also contribute beyond the physical hospital. Advice, virtual review, outreach and shared decision-making can support teams in other layers, improve earlier management and help avoid unnecessary transfers while maintaining access to specialist expertise.

Clinical insight demonstrated that hospital pressures often reflect constraints across the whole pathway, including access to diagnostics, community capacity, rehabilitation and follow-up. Hospital performance should therefore be considered in relation to how people enter, move through and leave the service, not only through internal hospital processes.

Success should not be defined solely by reducing admissions or length of stay. Measures should balance access, safety, outcomes, experience, flow and the sustainability of the services receiving responsibility following discharge.

Layer 5: Specialist and Emergency Hospital Care

CONNECTIONS WITH OTHER LAYERS

Layer 5 should be connected to every other part of the model. Community Urgent Response and Locality Care should be able to access specialist advice and escalate people rapidly when hospital assessment or treatment is required. Diagnostic and Treatment Platforms should provide clear routes into specialist decision-making and intervention.

The relationship should operate in both directions. From the point of admission, hospital teams should consider what will be required for the person to recover and return home. Relevant information, agreed plans and clinical responsibility should transfer safely to locality, rehabilitation, primary care and community services.

Hospitals should also contribute to prevention. This includes preventing complications and functional decline during admission, identifying future risks and connecting people with appropriate support to reduce the likelihood of deterioration or readmission.

INTENDED IMPACT

- provide timely access to emergency and specialist intervention
- reduce delays within hospital pathways
- ensure that specialist capacity is directed towards people who require it most
- minimise avoidable harm, functional decline and prolonged hospital stays
- support safe and timely recovery outside hospital
- strengthen clinical decision-making across the wider system

REQUIREMENTS FOR DELIVERY

Effective Specialist and Emergency Hospital Care will require:

- reliable access to emergency, acute and specialist expertise
- appropriate concentration of complex services and supporting infrastructure
- sufficient workforce capacity and sustainable clinical rotas
- timely access to diagnostics, theatres, critical care and specialist treatment
- digitised clinical workflows and access to relevant information
- real-time understanding of demand, capacity and patient flow
- early discharge, rehabilitation and recovery planning
- clear escalation and transfer arrangements with other layers
- specialist advice that can support care outside hospital
- clinical governance across organisational and service boundaries

The future configuration of hospital services should reflect clinical quality, workforce sustainability, access, infrastructure and interdependencies. Providing every service at every site may not be viable, but consolidation should not proceed without understanding its implications for travel, equity, resilience and the capacity of other services.

4. The CTM Layered Care Model

4.3 Connections across the Layered Care Model

The value of the Layered Care Model lies in how its components work together. Strengthening individual layers without improving the connections between them could create additional boundaries, referral points and delays.

People should experience one coordinated model, even where their care involves several teams, organisations or settings. This requires common arrangements for access, information, decision-making and responsibility across all six layers.

Access and navigation

People should be able to enter the model through several appropriate routes, including digital, telephone and face-to-face access. Whichever route they use, they should receive a consistent response and be directed to the capability best placed to meet their needs.

Navigation should extend beyond signposting. It may include clarifying the person's needs, resolving straightforward requests, coordinating appointments or connecting them directly with clinical or community support. People should not be expected to understand organisational boundaries to find the right service.

Coordination and continuity

Where several services are involved, responsibility for coordinating care should be explicit. This will be particularly important for people living with frailty, multiple conditions, mental health needs or circumstances that cross health and social care boundaries.

Continuity may be provided by an identifiable professional, a team or a shared care plan. It does not always require the same person to deliver every element of care, but it does require information, decisions and agreed actions to be carried forward.

Information following the person

Relevant information should be available wherever care is provided. People should not have to repeat their history unnecessarily, and professionals should be able to understand previous assessments, investigations, treatments and agreed plans.

Technical interoperability alone will not provide continuity. CTM and its partners will also need common expectations for recording information, maintaining it and acting on it. Access must be supported by appropriate consent, information governance and clear clinical accountability.

Expertise moving across the model

People should not always need to move to access specialist expertise. Advice, virtual review, outreach, joint working and shared decision-making should allow specialist capability to support teams in other layers where appropriate.

This can enable earlier decisions and help local teams manage greater complexity. However, advice arrangements should not leave responsibility unclear. The professional or team retaining responsibility must understand what action is required and when further escalation is necessary.

Escalation and de-escalation

People's needs may increase or reduce over time, and the model should support movement in both directions. Escalation should be timely when more intensive assessment or treatment is required, without people having to repeat earlier stages unnecessarily.

De-escalation should be equally deliberate. Following stabilisation, treatment or recovery, people should return to the least intensive layer that can safely meet their needs, supported by clear follow-up and routes back into care.

The objective is not to prevent movement into higher layers. It is to ensure that people escalate because of clinical need rather than service gaps and that they do not remain in intensive settings because appropriate support elsewhere is unavailable.

4. The CTM Layered Care Model

4.4 Applying the Layered Care Model proportionately

The Layered Care Model provides a consistent framework for CTM, but it should not produce an identical pattern of services for every population, locality or clinical pathway. Its application should reflect differences in need while maintaining common expectations for access, quality, safety and coordination across the Health Board.

The appropriate configuration should be determined by three considerations:

i. the needs and circumstances of the population

ii. how each clinical pathway draws on the different layers

iii. the geographical scale at which the required capabilities can be delivered safely and sustainably.

Applying one model proportionately

The framework below illustrates how CTM should translate the Layered Care Model into future clinical models.

Figure 4.2. Framework for applying the CTM Layered Care Model proportionately to different populations, pathways and geographical contexts



Responding to population and community need

The balance of capability across the layers should reflect differences in age, deprivation, geography, transport, housing, language, digital access and the availability of community support.

A consistent offer will not always produce equitable outcomes. Some populations may require different forms or more intensive support to achieve comparable access and outcomes. Population health intelligence, clinical evidence and local engagement should inform how the model is applied and where additional resources are directed.

The model should also respond across the life course. Children and families, working-age adults, people living with long-term conditions, older people with frailty and people approaching the end of life may draw on the same layers in different ways. Common mechanisms for access, coordination and transitions should be retained while the nature and intensity of support are adapted to need.

4. The CTM Layered Care Model

Applying the model to clinical pathways

Each clinical pathway will use the layers differently. Some may emphasise prevention, supported self-management and locality-based monitoring. Others will depend more on diagnostics, planned treatment or concentrated specialist expertise.

The Layered Care Model should not predetermine where every service will be delivered. Detailed clinical design should establish:

- which layers and capabilities the pathway requires
- how people enter and move through the pathway
- where coordination and clinical responsibility sit
- how escalation and recovery will operate
- what should be consistently available across CTM
- what should be adapted to specific population or pathway needs

This approach will allow CTM to maintain a common strategic direction without imposing a uniform service configuration across clinically different pathways.

Delivering at the appropriate scale

Not every capability should be organised at the same geographical level. Decisions should reflect accessibility, clinical quality, workforce sustainability, infrastructure, service dependencies and the scale required for safe delivery.

In broad terms:

- Neighbourhood and community level: community assets, social connection, practical support and locally tailored prevention.
- Locality level: coordinated primary, community, mental health and social care for defined populations.
- CTM-wide level: capabilities requiring common standards, shared infrastructure or coordinated use of workforce and capacity.
- Regional or national level: highly specialised services and capabilities that cannot be safely or sustainably provided within CTM alone.

These levels should not be treated as rigid boundaries. Some capabilities may combine locally accessible delivery with CTM-wide coordination or regional specialist support.

Balancing consistency and local flexibility

CTM should define the core capabilities, standards and outcomes expected across the model. This will provide consistency where variation could create inequity, fragmentation or clinical risk.

Local flexibility should be retained where it enables services to respond to population needs and community assets. Variation should be intentional, evidence-led and regularly reviewed, not a result of historical arrangements or unequal access to workforce and resources.

4. The CTM Layered Care Model

Testing future clinical models

As the strategic vision progresses into detailed design, each clinical model should demonstrate how it applies CTM's Service Design Principles within the Layered Care Model:

- System Design & Scope: How it responds to needs across the life course, which layers and capabilities it requires, and how people move between local and specialist care.
- Inclusive & Preventive Care: How it embeds prevention, addresses inequalities and access barriers, and involves people, staff and partners in shaping care around individual needs and goals.
- Evidence, Innovation & Digital Transformation: What evidence supports the proposed approach, how digital and data capabilities enable delivery, and how its impact on outcomes, experience and capacity will be assessed.
- Safe, Accountable Care: How it maintains quality and safety, with clear responsibility for coordination, handovers, escalation and assurance across services.
- Resilient & Sustainable Delivery: Whether workforce, funding and infrastructure can support delivery, how the model can adapt to changing needs, and how environmental impacts will be reduced.

The Layered Care Model provides an adaptable framework for this work. It establishes a common direction while allowing service configurations to reflect population needs, clinical evidence and local circumstances. Proposals should make trade-offs explicit and consider their effects across the whole system.



V Bringing the model to life

5. Bringing the Layered Care Model to life

The Layered Care Model provides a common framework for CTM, but it will apply differently across clinical pathways. Different populations and conditions will require different combinations of prevention, ongoing support, diagnostics, treatment and specialist care.

CTM has identified a wider set of priority clinical areas for future model development. This chapter uses three of those areas, i.e., cardiology, orthopaedics and gastroenterology pathway, to illustrate how the Layered Care Model can be applied in practice. These examples are informed by the clinical engagement undertaken to date and offer different perspectives on how care could operate across the layers.

The three examples are not intended to represent the full range of CTM's priority areas or determine the order in which future clinical models will be developed. They have been used because, collectively, they demonstrate:

- different patterns of need and interaction with services
- different opportunities for prevention and earlier intervention
- the importance of diagnostics, coordination and specialist advice
- where care may be provided differently or closer to home
- where hospital-based capability will remain essential
- how responsibility should move across the pathway

Personas are used within each example to illustrate what the model could mean for an individual. They support the clinical analysis but are not the organising focus of the chapter. They should not be interpreted as representing every person using the pathway.

The examples are also not agreed future pathways or service configurations. They illustrate the strategic direction and thepotential contribution of different layers. Detailed clinical design, engagement and options appraisal will be required before decisions are made about specific services, roles, locations or investment.

5. Bringing the Layered Care Model to life

5.1 How to read this chapter

Each clinical example brings together three perspectives:

I. The person and what evidence tells us: who the person is, what matters to them, what they experience today, and what evidence and engagement tell us about the wider challenges their story represents.



II. The Layered Care Model: how each layer of the model could change care for people like them, comparing how care works today with how it could work in the future.



III. Illustrative experience: how the model could change one episode of their care, setting out their experience at each stage alongside how care is coordinated across services.



The examples should be read as applications of the strategic framework rather than complete pathway designs. They show how the model may help CTM think differently about the organisation of care, but they do not prescribe a single future configuration.

Not every example uses all six layers to the same extent. Some pathways depend heavily on prevention and ongoing locality support, while others require diagnostic platforms or concentrated specialist capability. This variation is intentional and demonstrates how the model should be applied proportionately.

Similarly, care closer to home does not mean relocating every service away from the hospital. The examples distinguish between:

- support that could prevent or identify need earlier
- care that could be delivered in local or community settings
- expertise that could reach into other settings without transferring the person
- services that continue to require specialist teams, equipment or hospital infrastructure

The personas provide a human perspective on these system relationships. They highlight how factors such as work, family responsibilities, mobility, confidence and ability to attend appointments affect people's experience. They do not determine the clinical pathway or imply that everyone will follow the same sequence.

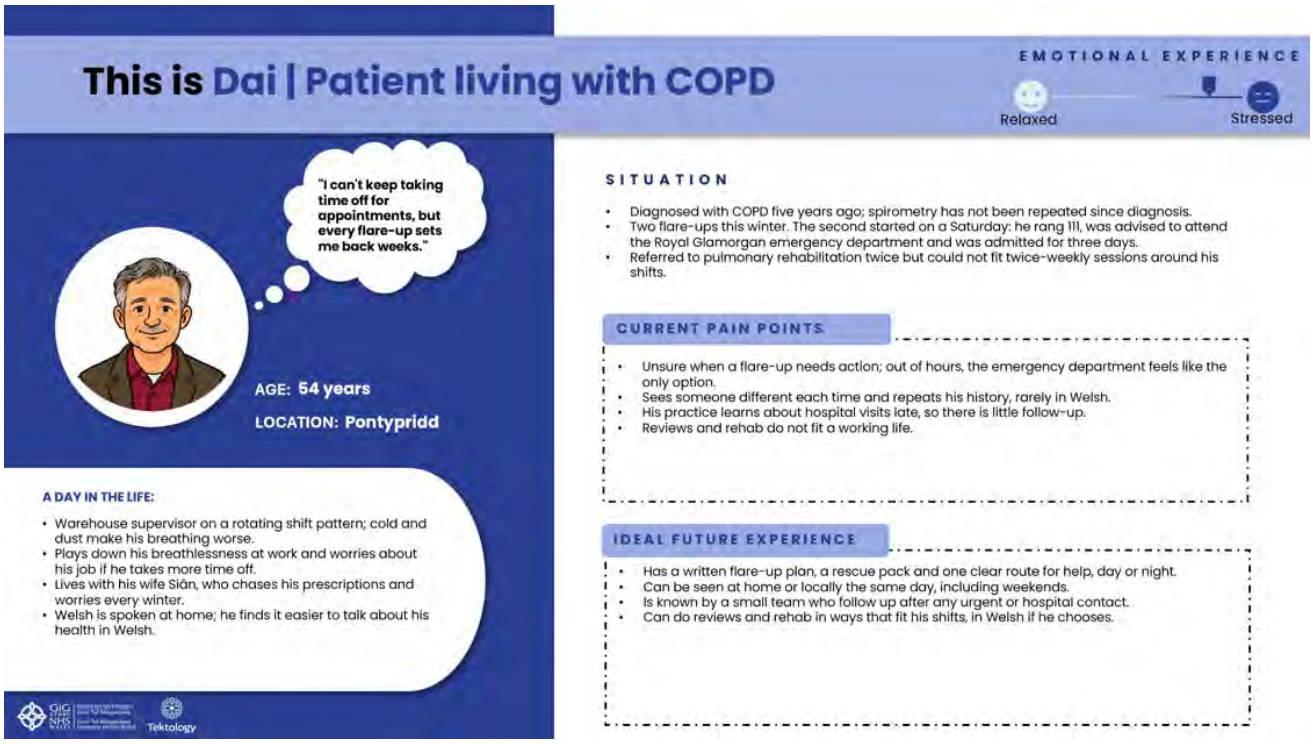
Example I: Dai, living with a long-term condition

Why this story matters

COPD is common across CTM's Valleys communities, where deprivation, smoking and a legacy of heavy industry shape lung health. Care for people like Dai is spread across general practice, community pharmacy, community teams, the Welsh Ambulance Service and hospital, and it is experienced as one journey only by the patient.

Dai's story follows one person across those services. It tests whether the Layered Care Model can deliver what the Quality Statement for Respiratory Disease and the Six Goals for Urgent and Emergency Care ask for: proactive support for people at higher risk, safe alternatives to admission, and a "home first" recovery. It also shows what has to change for the staff involved.

Figure 5.1.1 - Dai, living with COPD



What evidence and engagement tell us

Three findings are particularly important for the future model:

a. Unplanned care is driven by gaps in access and response, not only by clinical severity. Many exacerbations could be managed safely at home if an alternative were reachable when symptoms worsen, particularly out of hours.

b. Continuity and information flow are the weakest links. Plans, results and discharge information do not reliably follow the person between settings, so opportunities for early follow-up are missed.

c. Proactive support is under-used. Diagnostic review, pulmonary rehabilitation and prevention have strong evidence of benefit, but access and format limit uptake, particularly for people of working age.

5. Bringing the Layered Care Model to life

Example I: Dai, living with a long-term condition

Applying the Layered Care Model

Dai's needs are best met in the lower layers most of the time. The model's principal contribution is to keep him well through proactive locality care and to make Community Urgent Response a real alternative when his health deteriorates.

The table sets out how care works today and how it could work in the future model. The changes build on existing services and reflect the Quality Statement for Respiratory Disease and the Six Goals for Urgent and Emergency Care.

Table 5.1.1 - How each layer could change care for people like Dai

Layer	Now	Tomorrow
Layer 0: Prevention	Prevention is largely opportunistic and tied to the annual review. Support to stop smoking, stay active and be vaccinated is not routinely organised around people at rising risk.	Population risk information is used to reach people like Dai before winter. Prevention and community support are offered at times and in places that fit working lives.
Layer 1: Virtual Access and Response	Access depends on getting through at set times. Out of hours, advice is given without sight of his plan, and the emergency department becomes the default.	One clear route to advice and same-day help, day or night. Whoever responds can see his plan, and digital options handle routine needs.
Layer 2: Locality Care	Care is mostly reactive and spread across different contacts. Reviews are hard to attend, and the practice learns of hospital contacts late.	A locality team holds continuity and a shared, personalised plan, proactively reviews people with repeated flare-ups and is told promptly about any urgent contact.
Layer 3: Community Urgent Response	Community alternatives to admission are limited in hours and in how people can be referred, particularly at weekends.	Rapid assessment and treatment at home or close to home, reachable from every urgent route, seven days a week.
Layer 4: Diagnostic and Treatment Platforms	Diagnostic review and rehabilitation are not always accessible or flexible enough to fit around work.	Diagnostics and rehabilitation offered at locality scale in flexible formats, with results and non-completion fed back to the locality team.
Layer 5: Specialist and Emergency Hospital Care	Specialist input comes mainly at admission. Discharge information returns slowly and follow-up varies.	Specialist expertise supports community teams through advice and shared review. Admission is kept for clinical need with early supported discharge and plan returned to local team.

Reading across the table: the shifts are from reactive to proactive care, from single points of access to connected routes, and from one-off handovers to shared plans and information. Most of the change builds on existing services and depends on capacity, information flow and workforce rather than new buildings.

Example I: Dai, living with a long-term condition

Illustrative experience: Dai's flare-up in the future model

Figure 5.1.2 follows one winter flare-up in the future model, setting out Dai's experience at each step alongside how his care is coordinated across services to make it possible.

Figure 5.1.2 - Dai's flare-up: his experience and how care is coordinated.

Dai's experience	How care is coordinated
Dai recognises early signs using his personalised plan, starts the treatment agreed with him and knows who to contact.	His locality team is made aware through his plan and follows up promptly. Early treatment is recorded so patterns can be seen over time.
When his symptoms worsen, one call connects him to help. His plan is already known, and he is not sent to the emergency department by default.	Virtual access and response can see his plan and route him directly to community urgent response rather than to hospital.
Dai is assessed and treated at home with monitoring. His wife knows who to call if he gets worse.	Community urgent response manages the episode with specialist advice, and there is a clear route to admission if it is needed.
Dai does not have to repeat his story. His practice and pharmacy already know what happened and what has changed.	Information from the episode returns to the locality team the same day. His medicines are reconciled and he is flagged for review.
Dai has timely follow-up at a time that fits his work and returns to work gradually. His wife's needs as a carer are recognised.	The locality team leads follow-up and recovery planning, including support for carers.
Dai completes rehabilitation in a format that fits his life, is supported to stop smoking and stay active, and goes into next winter with an updated plan.	Rehabilitation, prevention and community support are coordinated around his plan, which is reviewed ahead of winter.

What this example demonstrates

For people living with long-term conditions, the model's greatest contribution is likely to lie less in new services than in connecting existing ones: a shared plan, visible to those who need it, and a route to same-day help close to home. It also shows that the layers work as a continuum rather than a sequence.

Dai moves up during a flare-up and back down as he recovers, and the model succeeds only if responsibility and information move with him. This depends on capacity in community urgent response, shared records across settings and protected time for proactive review; these are potential developments to be tested, not agreed service changes.

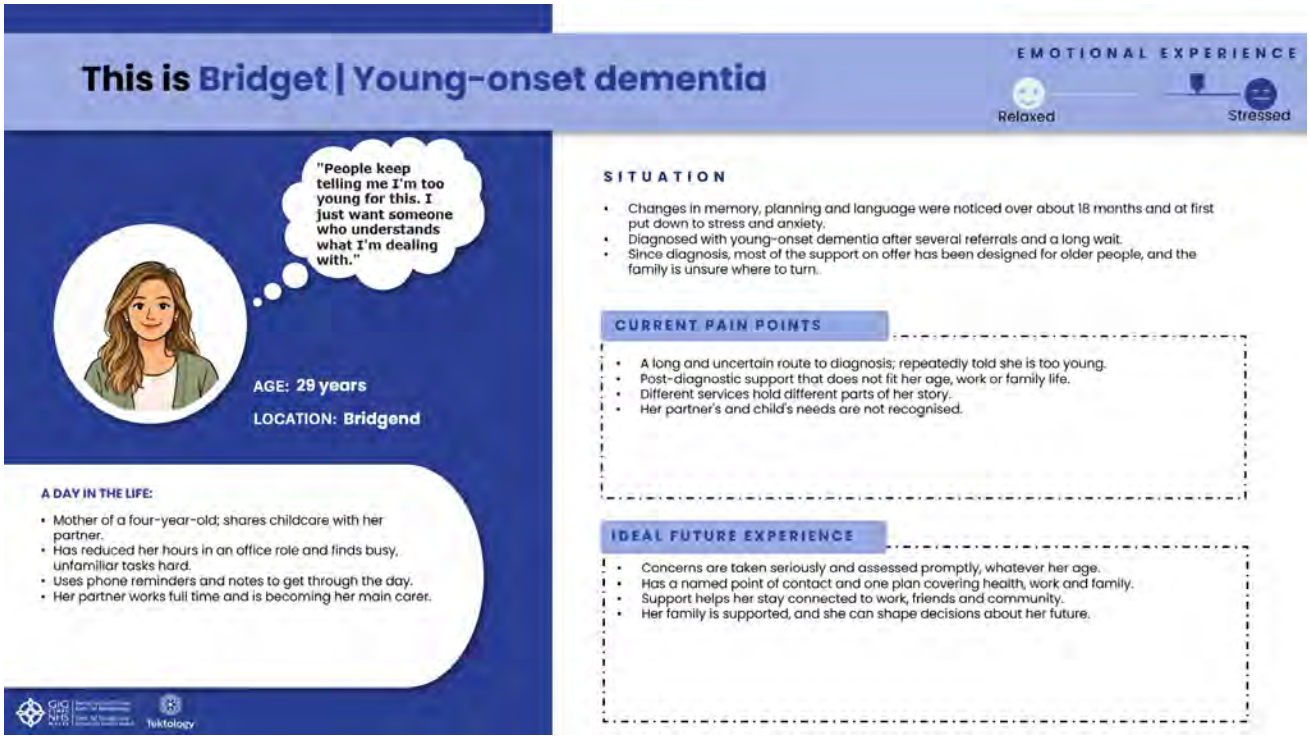
Example II: Bridget, living with dementia

Why this story matters

Dementia is one of the largest drivers of need across health and social care in CTM. Young-onset dementia is far less common, but it brings distinct needs: a harder route to diagnosis, and a direct impact on work, finances and young families. Most support is designed around older people.

Bridget's story tests whether the Layered Care Model can recognise need early when it does not fit the expected pattern, and then sustain coordinated support across health, social care and the third sector. It reflects the Dementia Action Plan for Wales, the All Wales Dementia Care Pathway of Standards and the rights of carers under the Social Services and Well-being (Wales) Act.

Figure 5.2.1 - Bridget, living with young-onset dementia



What evidence and engagement tell us

Three findings are particularly important for the future model:

a. Diagnosis is slower and less certain for younger people. Early symptoms are often attributed to stress, mental health or other causes, and assessment pathways are oriented to older age groups.

b. Post-diagnostic support is fragmented. Help is spread across health, social care and the third sector, with no single point of contact holding the plan.

c. Families carry the load early. Partners and children take on caring roles, often while working, and their needs are not consistently assessed.

Example II: Bridget, living with dementia

Applying the Layered Care Model

Bridget's needs sit mainly in Layers 0 to 2, with specialist input from Layers 4 and 5 at diagnosis and at key points. The model's principal contribution is earlier recognition, a single coordinated plan and sustained support in the community. Community Urgent Response matters at moments of crisis, so that hospital is not the default.

The table sets out how care works today and how it could work in the future model. The changes build on existing services and partnerships and reflect the Dementia Action Plan for Wales and the All Wales Dementia Care Pathway of Standards.

Table 5.2.1 - How each layer could change care for people like Bridget

Layer	Now	Tomorrow
Layer 0: Prevention	Awareness that dementia can affect younger people is limited, so early changes are attributed to other causes. Community and peer support is largely designed for older people.	Greater awareness of young-onset dementia among the public and professionals. Age-appropriate peer, community and employment support, with carers connected early.
Layer 1: Virtual Access and Response	The family struggles to know who to contact as things change. Advice is spread across health, social care and the third sector.	One point of contact and a single route to advice, with her plan visible across services and digital tools that support independence.
Layer 2: Locality Care	General practice holds overall care but has limited support after diagnosis. Reviews focus on medicines rather than goals and family life.	A locality team with a named coordinator holds a shared plan covering health, work, family and future wishes, reviewed proactively with social care and the third sector.
Layer 3: Community Urgent Response	When a crisis occurs, such as carer exhaustion or a sudden change in need, options are limited and hospital or emergency respite becomes the default.	Rapid support at home from teams with dementia expertise, including crisis support for carers, avoiding unnecessary admission.
Layer 4: Diagnostic and Treatment Platforms	Specialist assessment involves long waits and repeated referrals, and services are oriented to older age groups.	Timely specialist memory assessment suited to younger people, including genetic counselling where relevant, with results shared with the locality team.
Layer 5: Specialist and Emergency Hospital Care	Specialist input is concentrated around diagnosis. Hospital stays can be disorientating and poorly coordinated with community support.	Specialist expertise supports the locality team over time. Any hospital care is dementia-friendly and returns her to an updated community plan.

Reading across the table: the shifts are from late, uncertain diagnosis to earlier recognition, from fragmented support to one coordinated plan, and from a focus on the patient alone to supporting the whole family. Much of the change depends on health, social care and community partners working as one system around the person and their family.

Example II: Bridget, living with dementia

Illustrative experience: Bridget's first year after concerns are raised

Figure 5.2.2 follows Bridget from the first concerns about her memory through her first year after diagnosis, setting out her experience at each stage alongside how her care is coordinated across services.

Figure 5.2.2 - Bridget's experience and how care is coordinated

Bridget's experience	How care is coordinated
Bridget and her partner raise concerns about her memory. They are taken seriously despite her age, and she is referred for assessment without delay.	The locality team recognises an atypical presentation and uses an agreed route for prompt referral to specialist memory assessment.
Her diagnosis is given with time to talk, written information and a named contact, with her partner present.	The specialist service shares the diagnosis and plan with the locality team within days, and post-diagnostic support begins straight away.
Bridget works with one coordinator on a plan covering her health, work, finances, childcare and wishes for the future.	The coordinator brings health, social care, employment support and third-sector partners together around one shared plan.
She joins an age-appropriate peer group, gets support to adjust her work and uses tools that help her stay independent.	Community and third-sector support for younger people is in place, and the plan is reviewed proactively as her needs change.
When her partner becomes exhausted and her needs change suddenly, help arrives at home the same day.	Community urgent response with dementia expertise provides support and short-term care at home, avoiding admission, and the locality team updates the plan.
Her partner and child are supported, and Bridget's wishes for the future are recorded while she can shape them.	Carer's assessment, family support and advance care planning are coordinated and reviewed regularly.

What this example demonstrates

For people living with dementia, particularly at a younger age, the model's greatest contribution is likely to lie in early recognition and continuous, coordinated support rather than episodic treatment: one plan, one point of contact and support that reflects the person's stage of life.

It also shows that the layers cannot work for Bridget without partners beyond the NHS. Social care, employers and the third sector are central to her plan, and the model depends on shared records, joint commissioning and dementia expertise in community teams. These are potential developments to be tested, not agreed service changes.

For Bridget, success would mean a diagnosis without years of uncertainty, one coordinated plan and a family that is supported. For CTM, it would mean designing dementia support around people and families rather than age bands.

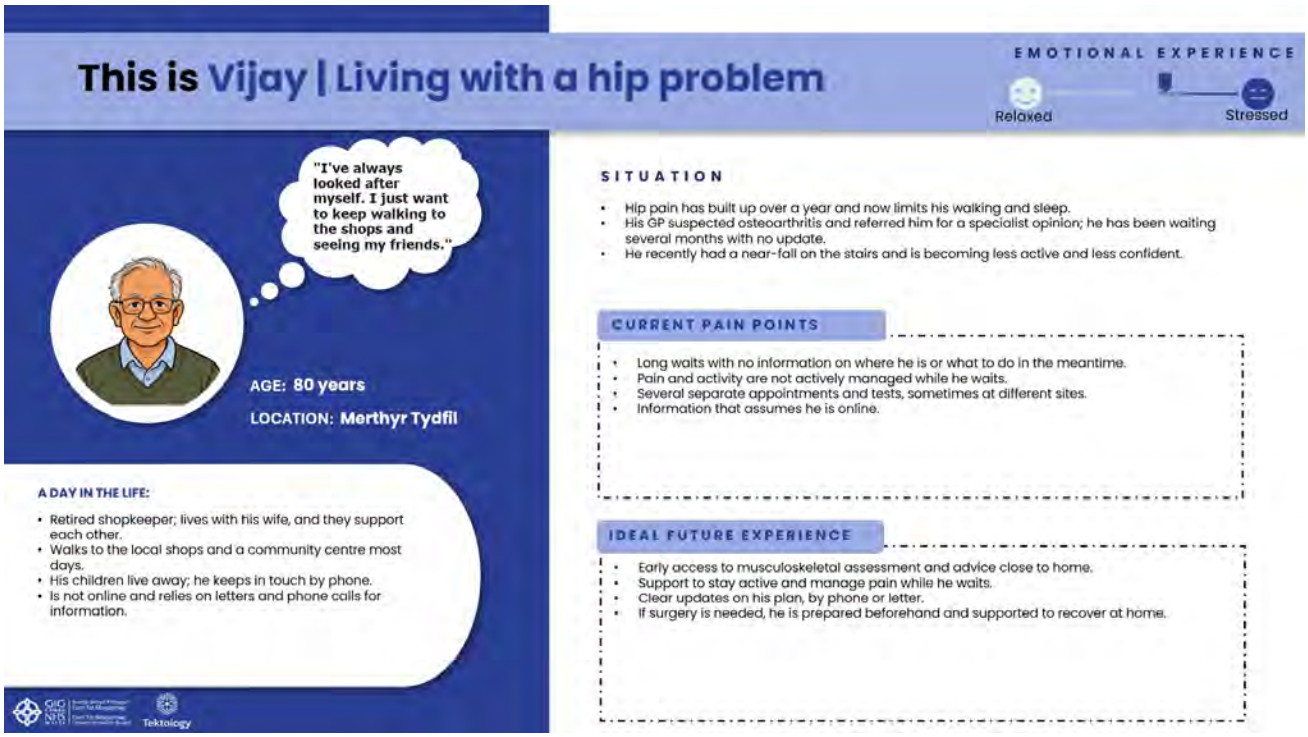
Example III: Vijay, living with a hip problem

Why this story matters

Musculoskeletal problems are among the most common reasons older people lose mobility and independence. Long waits for planned orthopaedic care in Wales mean many people wait in pain, become less active and are at greater risk of falls, so a single problem can become wider frailty.

Vijay is otherwise well. His story tests whether the Layered Care Model can keep a well older person well: early access to musculoskeletal support, help to "wait well", falls prevention and, if surgery is needed, a home-first recovery. It reflects national planned care priorities and the Six Goals for Urgent and Emergency Care.

Figure 5.3.1 – Vijay, living with a hip problem



What evidence and engagement tell us

Three findings are particularly important for the future model:

a. Waiting is where decline happens. Long waits can lead to deconditioning, falls and loss of confidence, turning a single problem into wider frailty.

b. b. Early musculoskeletal support is used inconsistently. Many people still reach specialist care through a GP referral and a long wait, rather than through early assessment and active management.

c. Digital exclusion widens the gap. Older people who are not online can miss updates and options, increasing uncertainty and unplanned contact.

Example III: Vijay, living with a hip problem

Applying the Layered Care Model

Vijay's needs are best met in Layers 0, 2 and 4, with Layer 5 only if surgery is needed. The model's principal contribution is early musculoskeletal assessment, active support while he waits and a coordinated, home-first route through surgery if he needs it. Community Urgent Response matters if he falls.

The table sets out how care works today and how it could work in the future model. The changes build on existing services and reflect national planned care priorities and the Six Goals for Urgent and Emergency Care.

Table 5.3.1 – How each layer could change care for people like Vijay

Layer	Now	Tomorrow
Layer 0: Prevention	Support to stay active and prevent falls is not routinely offered to well older people until a problem escalates.	Strength-and-balance, activity and falls prevention offered early through local partners, to keep people like Vijay active and independent.
Layer 1: Virtual Access and Response	Information about his referral and wait arrives by letter, often late. Advice is hard to access without going online.	Clear updates on his plan and wait through his preferred channel, including phone and paper, with one number for questions.
Layer 2: Locality Care	He goes to the GP first, and referral to specialist care is the main route, with little support while he waits.	Direct access to musculoskeletal physiotherapy in the locality, with pain management, exercise and "waiting well" support, and regular check-ins.
Layer 3: Community Urgent Response	A fall or sudden worsening often leads to an ambulance and an emergency department attendance.	Rapid community response assesses falls and flare-ups at home, preventing unnecessary conveyance and admission.
Layer 4: Diagnostic and Treatment Platforms	Imaging and assessments happen at separate appointments, sometimes at different sites.	Joined-up assessment and imaging at locality scale, with results shared so decisions can be made in one visit where possible.
Layer 5: Specialist and Emergency Hospital Care	Specialist assessment comes after a long wait, and preparation for surgery and discharge can start late.	Specialist review informed by locality assessment. Preparation before surgery and discharge planning begin early, with rehabilitation at home.

Reading across the table: the shifts are from waiting passively to waiting well, from referral as the main route to direct access to musculoskeletal support, and from late discharge planning to a home-first recovery.

Example III: Vijay, living with a hip problem

Illustrative experience: Vijay's hip, from first symptoms to recovery

Figure 5.3.2 follows Vijay from the first signs that his hip is limiting him to his recovery, setting out his experience at each stage alongside how his care is coordinated across services.

Figure 5.3.2 - Vijay's experience and how care is coordinated

Vijay's experience	How care is coordinated
When hip pain starts to limit his walking, Vijay is directed to local musculoskeletal advice rather than waiting for a GP appointment.	Locality musculoskeletal physiotherapy provides early assessment and an exercise and pain management plan.
Imaging and assessment happen close to home in as few visits as possible, and he understands what the results mean.	Diagnostics and assessment are coordinated at locality scale, and results are shared with his GP and the specialist team.
While he waits for a specialist opinion, he has regular check-ins, a strength-and-balance group and a number to call.	The locality team and community partners support him to wait well, monitoring changes and escalating if his condition worsens.
When he has a fall at home, he is assessed at home the same day and does not need to go to hospital.	Community urgent response assesses and treats him at home, informs the locality team and updates his plan.
He is prepared physically and practically before his hip replacement, his home is ready, and he goes home quickly.	The specialist team plans discharge from the start, with preparation before surgery and equipment arranged with community services.
Rehabilitation continues at home and in the community, and he is back walking to the shops and seeing friends.	Locality rehabilitation and community activity support his recovery and long-term independence.

What this example demonstrates

For older people who are otherwise well, the model's greatest contribution is likely to lie in keeping them well while they wait and recover: early support close to home, active management of pain and activity, and a home-first approach to surgery.

It also shows that planned care is not only a hospital pathway. Vijay's outcome depends on locality musculoskeletal capacity, community partners and information that reaches people who are not online. These are potential developments to be tested, not agreed service changes.

For Vijay, success would mean staying active, avoiding a fall-related admission and recovering at home. For CTM, it would mean planning orthopaedic care as one pathway, from prevention to recovery, rather than as a waiting list.

5. Bringing the Layered Care Model to life

5.5 What the clinical examples demonstrate

The three clinical examples illustrate how the Layered Care Model can provide a common direction while responding to different clinical needs. Cardiology highlights the relationship between ongoing management, diagnostics and specialist advice. Orthopaedics demonstrates the dependence of treatment outcomes on rehabilitation and recovery. The gastroenterology and colorectal example emphasises risk-based prioritisation, diagnostic capacity and clear transitions into specialist care.

Together, they reveal several implications for how CTM should develop the future model across its wider priority clinical areas.

Improve the complete pathway

Delays and fragmentation rarely sit within a single service. Diagnostic access, clinical review, treatment, rehabilitation and follow-up influence one another. Increasing capacity at one stage may move the bottleneck elsewhere unless the receiving services can respond.

The unit of improvement should therefore be the complete pathway. Proposals should demonstrate how changes affect access, clinical decisions, outcomes and capacity across the services involved.

Match the setting to the capability required

The opportunities for care closer to home differ between pathways. Advice, monitoring, ongoing management and rehabilitation may be delivered more locally where appropriate capability exists. Other activities will continue to depend on specialist teams, equipment and hospital infrastructure.

The model should distinguish between moving an activity, extending specialist expertise into another setting and improving coordination around care that remains hospital-based. Each can improve people's experience; relocation alone is not a measure of success.

Make responsibility visible

Across all three examples, people need to know what happens next and who is responsible. Teams need equivalent clarity about pending investigations, clinical decisions, onward referrals and follow-up.

Shared information should support this continuity, alongside explicit responsibility for reviewing results, acting on changing needs and completing agreed actions. A referral, discharge or transfer should connect the next stage of care without leaving people to coordinate it themselves.

Recognise the capacity behind new ways of working

Triage, specialist advice, nurse-led care, monitoring and multidisciplinary coordination all require time and resource. Community delivery also depends on sufficient rehabilitation, practical support and access to diagnostics.

These functions should be recognised within workforce and resource planning. Their benefits cannot be assumed if they are added to existing workloads without sufficient capacity, training or supporting infrastructure.

5. Bringing the Layered Care Model to life

Judge improvement through people's outcomes and experience

The personas illustrate how work, mobility, family responsibilities and uncertainty can affect access and participation in care. A pathway may appear efficient within an individual service while remaining difficult for the person to navigate.

Assessment should therefore consider whether people receive timely decisions, understand their care, avoid unnecessary repetition and regain or maintain independence. These outcomes should sit alongside measures of activity, waiting times, safety and resource use.

The examples provide an initial test of the Layered Care Model across three of CTM's priority areas. They establish a consistent way to consider the whole pathway while preserving the clinical differences between services. Chapter 6 sets out the shared capabilities required to translate this direction into delivery.



VI

Strategic shifts and enabling conditions

6. Enabling the Future Model of care

Delivering the Layered Care Model will require coordinated changes to the workforce, information, infrastructure, partnerships, and resource use. These capabilities will determine whether CTM can strengthen prevention, deliver more local care, and maintain timely access to specialist services.

The clinical examples in Chapter 5 demonstrate how these requirements interact. Increased accessibility to diagnostics and sufficient reporting and treatment capacity. Earlier discharge depends on rehabilitation and community support. Virtual access requires clinical teams with the capacity and information to respond. Enabling plans should therefore develop alongside clinical design, with a shared understanding of dependencies and the consequences of change across the system.

CTM's existing strategies and programmes provide a starting point. The draft Digital and Data Plan, for example, identifies capabilities and initiatives that could support each layer, alongside constraints in workforce readiness, information sharing, infrastructure and delivery capacity. The Future Model of Care should help shape the priorities and sequencing of these enabling plans as clinical requirements become clearer.

This chapter sets out the capabilities needed to support delivery. It establishes strategic requirements while leaving detailed workforce models, technical specifications, service configurations and investment decisions to subsequent development and appraisal.

6.1 Workforce and ways of working

Organising capability around population need

- The future model will require workforce planning across complete pathways and populations, informed by CTM's population needs analysis and aligned with its People Plan and People's Experience Plan. Together, these should help connect the skills and capacity required with the needs of communities and the experience of people receiving and delivering care. CTM and its partners will need to consider where skills are required, how expertise can support care across settings and how teams will respond as people's needs change.
- This includes strengthening preventive and community capability while sustaining safe hospital services. Workforce requirements should reflect the work involved in assessment, coordination, rehabilitation and follow-up, alongside direct treatment. Moving activity into a different setting will be sustainable only where receiving teams have sufficient capacity and appropriate clinical support.

Enabling connected teams

- Multidisciplinary working should bring together the professionals needed to address a person's circumstances, drawing on primary care, community services, mental health, social care, therapies, pharmacy and specialist teams as appropriate.
- The intensity of coordination should be proportionate to need. Some people will benefit from a named coordinator and regular multidisciplinary review. Others may need timely advice between professionals and a clear shared plan. In both cases, teams should understand who holds responsibility, what actions are outstanding and how to obtain additional support.
- Specialist advice across settings could help locality teams manage appropriate needs and make earlier decisions. This contribution will need to be recognised within job plans, with agreed arrangements for advice, supervision and escalation.

6. Enabling the Future Model of care

Using skills effectively

- CTM should consider how nurse-led services, allied health professional roles, advanced practice and support roles could contribute to future clinical models. Administrative and coordination support may also free up clinical time currently spent arranging care or resolving avoidable process issues.
- Role development should follow an assessment of clinical need, competence and workload. Additional responsibilities require suitable training, supervision, protected time and professional accountability. Service redesign should also identify activities that can stop or be simplified, reducing the risk that new functions are added to already stretched roles and responsibilities.

Supporting adoption and workforce development

The draft Digital and Data Plan identifies barriers involving access to devices and systems, limited training capacity and pressure on digital teams. These conditions will affect the wider care model: staff cannot reliably work across settings or deliver virtual care without the tools, confidence and support to do so.

Workforce development should therefore include:

- preparation for new clinical and coordination responsibilities
- protected learning time and appropriate supervision
- role-specific digital and data skills
- practical support as teams adopt new workflows
- opportunities for staff to shape and improve the model

Leaders will need to support decisions that improve the complete pathway, including where benefits arise outside their own service. Staff experience, workload and retention should inform whether new arrangements are sustainable.

Planning the transition

Workforce change will need to be sequenced with clinical redesign and investment. Community and locality capacity may need to develop before activity can move safely, while hospital services continue to operate. Training, backfill and temporary overlap between existing and future arrangements should be recognised within delivery plans.

Planning should also distinguish between roles employed directly by CTM and contributions dependent on primary care contractors, local authorities or other partners. Changes across these boundaries will require joint agreement about capacity, responsibilities and resources.

6.2 Digital, data and information

Connecting the model through digital and data

- Digital and data capabilities should enable people, professionals and services to work together across the Layered Care Model. They should support earlier identification of need, simpler access, informed decisions and continuity as people move between settings.
- The draft CTM Digital and Data Plan provides the principal reference for these capabilities and their delivery priorities. It already maps digital requirements across Layers 0–5 and brings existing programmes, service needs and future opportunities into a common portfolio. As clinical models develop, their requirements should inform the plan's prioritisation and sequencing.
- The portfolio contains initiatives at different stages of readiness. Clinical models should therefore distinguish between capabilities available today, those being implemented and those requiring further development or investment.

6. Enabling the Future Model of care

Accessible routes into care

- Digital and telephone channels should help people obtain advice, manage appointments and understand what happens next. The Digital and Data Plan identifies relevant developments through the NHS Wales App, patient portals and the Patient Contact Centre Transformation Programme.
- These routes will need to connect to clinical navigation, booking and services with the capacity to respond. People should receive a consistent experience whichever channel they use, with relevant information carried forward when contact moves from a remote interaction to face-to-face assessment.
- Accessible design, assisted access and non-digital alternatives should form part of service planning. Success should be assessed through whether people reach appropriate support and have their needs addressed, alongside adoption of digital channels.

Shared information and coordinated workflows

- Professionals should have access to relevant records, investigations and care plans at the point of need. This is particularly important where primary care, community services, hospitals and social care contribute to the same person's care.
- The plan identifies shared records, electronic referrals, diagnostic ordering and results, and integrated workflows as enabling capabilities. Initiatives such as WPRS, Hospital Initiated Referrals and Straight to Test could support more coordinated pathways, subject to their scope and delivery status.
- Their value will depend on agreed ways of working. Teams should understand who reviews information, acts on results and follows up outstanding actions. Clinical and operational redesign should accompany implementation so that digital processes reduce duplication and make responsibility clearer.

Information supporting proactive care and improvement

- Population health intelligence should help CTM identify inequalities, understand changing need and target earlier support. Operational information should help teams manage demand, capacity and delays across complete pathways.
- The plan's dashboard and data developments provide a basis for this work, alongside PROMs, PREMs and patient feedback. However, its current-state assessment identifies inconsistent definitions, data quality issues and gaps in information flow. Strengthening these foundations will be necessary before more advanced analytics or automation can be used reliably.
- Insight should connect to decisions and action. Each clinical model should identify the information required, who will use it and what response it should trigger.

Reliable foundations and sustainable adoption

- The future model will depend on reliable infrastructure, connectivity, appropriate devices and secure access across care settings. Cyber resilience and continuity arrangements become increasingly important as services rely on shared information and digital workflows.
- The Digital and Data Plan recognises the need to stabilise essential systems, improve interoperability and retire legacy platforms. These activities should be treated as dependencies for service transformation, alongside more visible patient-facing developments.
- Implementation will also require clinical ownership, workforce training and ongoing support. Benefits should be evaluated through changes in care, staff workload, safety and experience, with service teams accountable for embedding the new ways of working.

6. Enabling the Future Model of care

6.3 Estates, equipment and transport

Aligning infrastructure with the model of care

- The Layered Care Model will require facilities and equipment that support care across homes, communities, diagnostic settings and hospitals. CTM should develop an estates plan alongside the model of care, translating emerging clinical requirements into a phased approach to infrastructure investment and adaptation. This should take account of population distribution, accessibility, workforce availability and clinical dependencies.
- CTM should consider how existing premises could support the model through adaptation, shared use or changes to operating arrangements, alongside any need for new facilities. A service's physical location is only one part of its accessibility: opening hours, appointment coordination, transport and the availability of appropriate staff will also determine whether people can use it.

Supporting locality and community delivery

Stronger locality care and community urgent response will require suitable places for assessment, treatment, rehabilitation and multidisciplinary working. These may include primary care premises, community facilities and shared spaces with partners, depending on the functions required.

Planning should consider whether facilities provide:

- accessible environments that meet different physical, sensory and communication needs
- appropriate clinical space, privacy and infection prevention arrangements
- reliable connectivity and access to relevant information
- equipment, storage and support services suited to the intended activity
- flexibility for different teams to use space effectively

Co-location may make joint working easier, but its benefits depend on shared pathways and clear responsibilities. Bringing teams into the same building will not, by itself, resolve fragmented care.

Connecting diagnostic and specialist infrastructure

- The draft Digital and Data Plan identifies the Orthopaedic Centre and Community Diagnostic Hub within the Llantrisant Health Park programme as relevant developments. Their relationship with the Future Model of Care should be made explicit, including which pathways they support and how they connect with existing sites.
- The contribution of these facilities will depend on the wider pathway. Additional diagnostic provision requires reporting capacity, clinical review and onward treatment. Planned surgical capacity requires preparation, rehabilitation and recovery support. Buildings, equipment and digital systems should therefore be planned alongside the workforce and operational arrangements needed to use them.
- Specialist and emergency hospital infrastructure will remain essential. Decisions about distributing or concentrating capability should consider clinical interdependencies, service resilience and the implications for people travelling between sites.

Equipping care in the home

- Providing more care at home may require portable diagnostics, monitoring devices, rehabilitation aids and other equipment. Availability alone is insufficient: services will need arrangements for delivery, installation, training, maintenance, retrieval and replacement.

- Home circumstances should inform whether a proposed model is appropriate. Space, connectivity, accessibility and the support available to the person may affect delivery. Equipment and digital tools should help people remain independent without placing unreasonable demands on them or their carers.
- Accountability for equipment should remain clear when several organisations contribute to care, including who responds when a device fails or the person's needs change..

Transport, accessibility and sustainability

- Transport should form part of pathway design from the outset. A service may be geographically closer yet remain difficult to reach because of public transport routes, appointment times, mobility limitations or the need for an accompanying carer.
- Future options should consider the number and purpose of journeys, opportunities to coordinate appointments, and the transport required by both people receiving care and mobile staff. Where specialist services operate across larger geographical areas, the consequences for access and inequalities should be explicitly assessed.
- Environmental sustainability should inform the use of estate, energy, equipment and travel. Changes should be assessed across the whole pathway, recognising that reduced patient travel may be accompanied by increased staff travel or additional facilities.

6.4 Partnerships and community capability

Planning around shared population needs

- Delivery of the Layered Care Model will depend on CTM working with primary care, local authorities, social care providers, the third sector and communities. Regional and national partners will also influence access to specialist services and shared infrastructure.
- These relationships should shape the model from the outset. Partners will need a shared understanding of population need, the outcomes they seek to improve and the contribution each can realistically make. This is particularly important where a change within health services creates additional demand for social care, housing support, rehabilitation or community provision.
- Existing partnership arrangements should provide the starting point for this work. The relationship between CTM's clinical priorities and regional population needs should help determine where joint planning and investment are required.

Recognising community capability

- Community organisations contribute trusted relationships, local knowledge and practical support that can help people remain well and independent. Their role may include social connection, navigation, support for self-management and reaching people who experience barriers to formal services.
- The availability of this support will differ between localities. Planning should identify existing strengths alongside gaps in provision, recognising that communities with greater need may have fewer resources available to respond.
- Where future pathways depend on a sustained contribution from community or third-sector organisations, the associated capacity and funding should be explicit. Arrangements should support continuity while remaining proportionate to the size and role of the organisation. Small organisations may require support to participate in contracting, information sharing and evaluation.

6. Enabling the Future Model of care

Making joint delivery work

Shared ambition will need to translate into practical arrangements at pathway level. Partners should understand:

- which functions each organisation will provide
- how people access and move between services
- who coordinates support when several organisations are involved
- how concerns are escalated and clinical advice obtained
- how changes in demand or capacity will be addressed

These arrangements should preserve statutory and professional accountability while making joint working easier. A referral to a community organisation should include clarity about what support it can provide and how the person reconnects with clinical services if their needs change.

Information sharing will also be important. The draft Digital and Data Plan identifies health and social care collaboration and community integration as relevant areas of development. Access should be proportionate to each partner's role, supported by agreed responsibilities for recording, reviewing and acting on information.

Involving people and unpaid carers

- People and communities should help define the outcomes, access arrangements and forms of support that matter to them. Engagement should include those who may be less visible through established groups or digital channels, so that service design reflects different experiences and barriers.
- Unpaid carers should be involved where appropriate and with the person's agreement. Their willingness, ability and support needs should inform care planning. Models that increase care at home should not assume that families can absorb additional responsibilities without assessment, information or practical help.

Aligning resources and commitments

- The costs and benefits of change may fall in different organisations. Investment in community support may improve hospital flow, while earlier discharge may increase demands on social care or unpaid carers. Joint planning should make these effects visible and establish how the required capacity will be sustained.
- Commitments should reflect what partners have agreed and can deliver. The strategic vision can establish the direction, but implementation will require clarity about ownership, resources and how partners resolve pressures that arise across organisational boundaries.

6.5 Governance and clinical design

Providing oversight across the model

The Layered Care Model will require governance that connects clinical redesign, enabling programmes and investment decisions. Changes within one pathway can affect workforce, diagnostics, community capacity and hospital services elsewhere. CTM should assess these consequences collectively as proposals develop.

A single CTM Strategic Improvement Delivery Unit (SIDU) is recommended to maintain oversight of the model and coordinate its translation into clinical service proposals. Its remit should bring together clinical, operational, workforce, digital, estates, finance and partnership considerations, with clear routes for people and communities to influence decisions.

The SIDU should operate within CTM's existing governance, with explicit delegated responsibilities and reporting arrangements. Formal approval of service changes and investment should remain with the bodies holding the relevant authority.

6. Enabling the Future Model of care

Maintaining a consistent approach to clinical design

The SIDU should provide a common basis for developing and assessing proposals across CTM's priority clinical areas. This should include:

- applying the agreed design principles and Layered Care Model
- testing proposals against population need, inequalities and intended outcomes
- reviewing evidence, options and the contribution of engagement
- assessing clinical safety, feasibility and resource requirements
- resolving dependencies and competing requirements across pathways
- recommending whether proposals are ready to progress

Clinical teams are required to lead and own the development of their models with operational and enabling colleagues involved from the outset. This will help identify delivery constraints while options remain open, rather than after a preferred configuration has been developed.

Proposals should make clear what is supported by evidence, what remains an assumption and what requires further testing. The illustrative pathways in Chapter 5 provide a starting point for discussion, rather than approval for particular service changes.

Connecting engagement with decisions

People, carers, staff and partners should have meaningful opportunities to shape the problems being addressed, the options considered and the outcomes used to judge success.

Governance should make this contribution visible. Proposals should explain how engagement has influenced the design, where views differ and how unresolved concerns will be considered. Clinical advice, lived experience and operational evidence should inform decisions alongside affordability and deliverability.

Where proposals affect services provided by partner organisations, their involvement and agreement will be needed at the appropriate stage. The SIDU should identify these dependencies early and ensure that CTM's plans do not assume commitments that partners have not made.

Aligning with service change and the IMTP

Development of future clinical models should follow CTM's service-change framework, with clear points for reviewing evidence, assessing options and determining readiness for approval or implementation. The governance route should recognise the engagement, impact assessment and assurance required for each proposal.

The IMTP should provide the mechanism for translating the strategic direction into phased delivery commitments. Each planning cycle should review:

- progress and learning from work already underway
- the readiness of proposals for further development or implementation
- workforce, digital, estates and financial dependencies
- the resources required and their affordability
- the outcomes and benefits expected during the planning period

This should allow CTM to maintain a longer-term direction while adjusting delivery to evidence, capacity and available funding.

6. Enabling the Future Model of care

Maintaining accountability through delivery

Each clinical model should have an accountable owner, supported by named leads for its enabling requirements. Design decisions, assumptions and dependencies should remain visible as work progresses into implementation.

The SIDU should review material changes that could affect the agreed model, including changes in scope, location, workforce or supporting capacity. It should also use implementation evidence and feedback to determine whether the model needs adjustment.

Oversight should remain proportionate. Routine delivery decisions should sit with the responsible teams, with escalation focused on issues that affect safety, strategic consistency, affordability or other parts of the system.

6.6 Finance and resource allocation

The Layered Care Model should guide how CTM aligns resources with population need and future clinical pathways. Investment decisions should consider outcomes, equity, quality and affordability across the complete pathway, including consequences for partner organisations, people and unpaid carers.

Care closer to home should not be assumed to cost less in every circumstance. Some changes may improve independence or release capacity without generating immediate cash savings. Financial assessments should distinguish between implementation and recurrent costs, productivity gains, avoided future costs and demonstrable reductions in expenditure. Reduced hospital activity will only release cash where associated costs can safely be removed.

Modelling the impact of service redesign

CTM should establish a shared, data-based approach to modelling proposed service changes. Using an agreed baseline of demand, activity, capacity, workforce and costs, it should compare current provision with alternative delivery scenarios.

The model should estimate:

- investment, transition and recurrent costs
- changes in demand and capacity across affected services
- workforce requirements and opportunities for redeployment
- potential cash savings, cost avoidance and productivity benefits

Assumptions about uptake, timing and outcomes should be explicit, with sensitivity testing to show how results change under different conditions. The level of analysis should be proportionate to the scale and risk of the proposal. Actual delivery results should subsequently inform the model and future decisions.

Investing and sequencing change

New capability may need to be established before existing provision can change. Workforce development, community capacity, equipment and digital integration may require upfront investment and a period of overlapping delivery. The draft Digital and Data Plan identifies comparable dependencies through system transition, dual-running and legacy retirement.

Investment should be prioritised against population need, expected outcomes, affordability and delivery readiness. This should recognise the longer timescales of prevention and enabling investment that supports several pathways. Where costs and benefits fall in different organisations, partners should agree how delivery will be funded and sustained.

The IMTP should translate agreed priorities into phased commitments, distinguishing funded delivery from proposals requiring further appraisal. Existing capacity should be adjusted only when alternative arrangements can safely meet need.

6. Enabling the Future Model of care

Demonstrating value

Each approved change should have a baseline, an accountable benefits owner and measurable expectations for costs, activity and outcomes. Finance and service leads should jointly assess whether benefits are being realised and whether pressures have transferred elsewhere.

Reviews should consider financial performance alongside safety, access, experience and workforce impact. Where assumptions do not hold, CTM should adjust the pace or scope of delivery.

6.7 Measurement, learning and improvement

CTM should assess the Layered Care Model through its effect on people's health, experience and independence, alongside the sustainability of services. Measures should show whether care is becoming more preventive, accessible and coordinated, and whether improvements reach populations experiencing the greatest need.

A common outcomes framework should connect the strategic vision with individual clinical models. It should build on existing CTM reporting and the IMTP, with pathway-specific measures added where required.

Measuring what matters

A concise set of measures should provide a balanced view of progress:

Dimension	What CTM should assess
Health and independence	Changes in health outcomes, function, wellbeing and people's ability to manage daily life.
Access and equity	Timeliness of assessment and treatment, unmet need and differences in access or outcomes between population groups and localities.
Experience and continuity	Whether people understand their care, know who is responsible and experience coordinated transitions.
Quality and safety	Avoidable deterioration, complications, unplanned escalation and harm during or following changes in care.
Workforce and sustainability	Staff experience, workload, capacity, resource use and the financial consequences described in Section 6.6.

Activity measures should be interpreted alongside these outcomes. More virtual contacts or fewer admissions do not, by themselves, demonstrate improvement. CTM should assess whether needs are being met effectively and whether additional work or risk has moved elsewhere.

Establishing baselines & responsibility

Each clinical model should define its intended outcomes, baseline position, measures and accountable owners before implementation. Targets against key performance indicators should reflect the available evidence, delivery timescales and the quality of the underlying data.

6. Enabling the Future Model of care

The Digital and Data Plan provides relevant foundations through dashboards, population insight and the use of patient-reported outcome and experience measures (PROMs and PREMs). These should be combined with operational information and feedback from staff, carers and partners. Where possible, results should be examined by locality and population group to identify whether benefits are distributed equitably.

Using evidence to improve delivery

Review should support decisions about whether to continue, adapt or expand a change. Early implementation should test assumptions and identify unintended consequences, including repeat contacts, delayed escalation, increased carer burden or pressure on receiving services.

The SIDU should use these findings to assess whether the model is delivering its intended benefits and whether changes to design or sequencing are required. Annual IMTP reviews should incorporate this learning into priorities and resource decisions, with more frequent review where safety or delivery concerns arise.

Turning the enablers into ACTION

TM should develop a coordinated plan alongside clinical service design, covering:

- Workforce: Align skills, capacity and new ways of working with population needs, the People Plan and People's Experience Plan.
- Digital and data: Align the Digital and Data Plan with emerging clinical requirements.
- Estates, equipment and transport: Develop an estates plan, identify equipment investment and replacement needs, and plan transport and accessibility arrangements.
- Partnerships and governance: Agree delivery responsibilities, executive ownership and the proposed Design Authority's remit.
- Finance and investment: Model activity, capacity, costs, savings and wider benefits, including transition funding.
- Measurement and learning: Establish baselines, track outcomes and experience, and use findings to improve delivery.



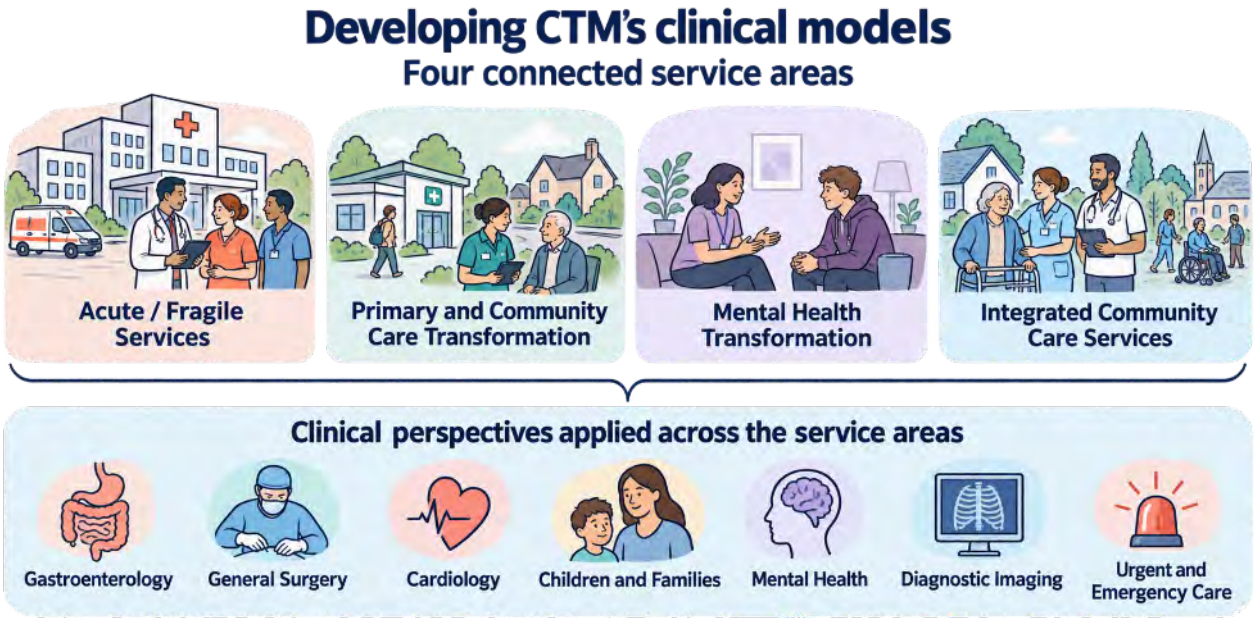
VII

Taking the vision forward

7. Taking the strategic vision forward

The strategic vision establishes a common direction for CTM: stronger prevention, coordinated care closer to home and timely access to specialist services when required.

Together, the Case for Change and this vision contribute to the preparation and case-for-change foundations described in Phases 0–1 of the draft NHS Wales Service Change Operating Framework. The next stage should build on this work to develop, assess and refine clinical service options across the areas shown below. CTM should confirm readiness, outstanding evidence and governance requirements before progressing through the framework's subsequent phases.



I. Identify options, engage and refine

In line with Phase 2, clinical teams should work with people, carers, staff and partners to develop options grounded in population need, clinical evidence and CTM's Service Design Principles. Options should be assessed against agreed criteria, supported by demand and capacity modelling and assessments of workforce, finance, estates and digital requirements.

Relevant impact assessments should be developed and updated as options evolve. Engagement should shape the appraisal, with a clear account of how feedback has influenced proposals. The examples in Chapter 5 support this discussion but do not constitute agreed service configurations or determine implementation priorities.

II. Review options, determine consultation requirements and make decisions

In line with Phase 3, CTM should review the options appraisal, supporting evidence and engagement findings through the relevant governance arrangements.

Decision papers and business cases, where required, should explain the options, impacts, affordability, expected benefits and delivery requirements. Executive ownership and the proposed Design Authority's role should be clear, supporting established organisational accountability and approval routes.

7. Taking the strategic vision forward

III. Learn and adapt

For all the approved changes, a phased roadmap should align with the service-change framework and IMTP. Sequencing should reflect clinical need, workforce and infrastructure readiness, partner capacity and affordability, including investment required before activity can move safely.

Each change should have an accountable owner, a baseline and clear measures of success. Initial delivery should test assumptions where appropriate, with outcomes and feedback informing whether changes progress, adapt or pause.

Progression should be proportionate to the scale and impact of each proposed change, supported by the framework's governance gateways and updated evidence throughout.

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg
Cwm Taf Morgannwg University Health Board

CTM Digital & Data Plan 2026–2029

November 2026



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FOREWORD

Cwm Taf Morgannwg University Health Board (CTM)'s ambition is to build healthier communities together. Achieving this means improving how people access and experience care, strengthening prevention and community-based services, supporting our workforce to work differently, and making the best use of the resources available to us. Digital and data are central to enabling that change.

This Digital & Data Plan sets out how technology, information and insight will support CTM's strategic priorities across Improving Care, Creating Health, Inspiring People and Sustaining Our Future. It is an enabling plan for CTM's strategic vision, helping services redesign care, make better-informed decisions and respond more effectively to the needs of our communities.

CTM already has significant digital capability in place. Over the next three years, the focus will be on building on that foundation by strengthening how information is digitally collected shared, improving access to trusted data, supporting the future model of care including Community by Design, improving patient access and experience, and giving colleagues the tools and insight they need to deliver safe, effective and responsive care.

The Plan recognises that technology alone does not create change. Realising the benefits of digital and data will depend on how well new capabilities are adopted, how services and pathways are redesigned, and how patients, staff and communities are supported through change. Digital inclusion, clinical safety, cybersecurity, governance and sustainable support will remain central throughout.

The three-year roadmap provides a clear and practical route from ambition to delivery. It brings together CTM's priorities in a way that reflects organisational need, available capacity and dependencies across local and national programmes. It will remain agile, allowing CTM to maintain focus on agreed commitments while adapting to changing service needs, evidence and emerging opportunities.

CTM will also prepare for the responsible use of AI where it supports better care, reduces avoidable workload and strengthens decision-making. Adoption will be evidence-led and proportionate, underpinned by appropriate safeguards, transparency and clear human accountability. The Plan will strengthen the data, interoperability, governance and workforce foundations needed to adopt emerging AI capabilities with confidence as they mature.

Success will depend on shared ownership. Patients and communities, clinical and operational teams, corporate functions, the Digital & Data team and national and delivery partners all have a role to play.

We would like to thank the colleagues and stakeholders who have contributed their experience, insight and challenge to the development of this Plan. Their input has helped shape a direction that reflects CTM's priorities and the realities of delivering change across a complex health system.

INTRODUCTION **TO CTM's** DIGITAL AND DATA PLAN

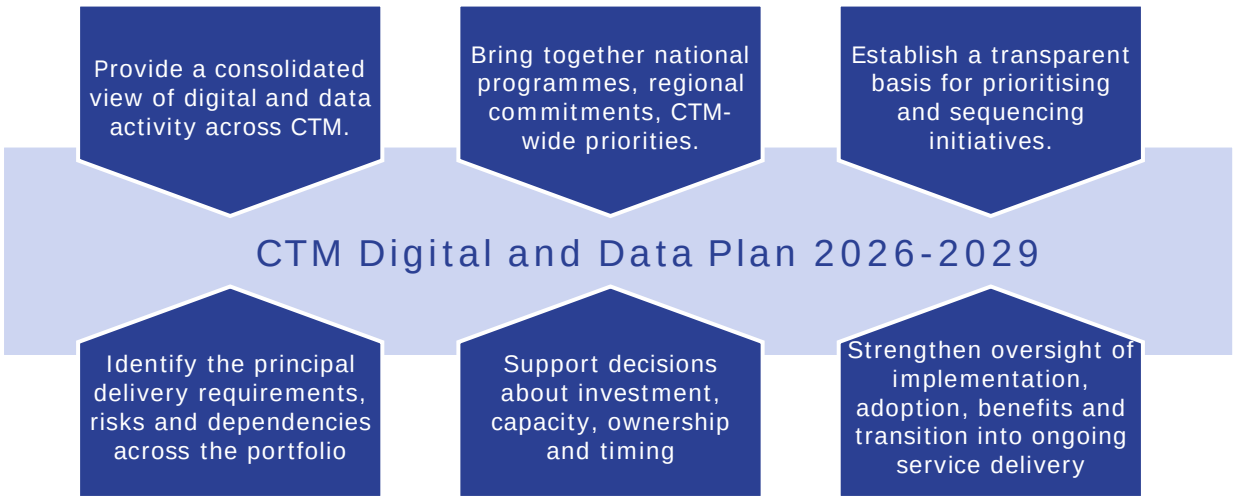


What is CTM's Digital and Data Plan

The Digital & Data Plan brings CTM's current commitments and future digital and data priorities together within one coordinated portfolio and three-year roadmap. It explains what CTM intends to deliver, how initiatives connect and what will be required to implement and sustain them successfully.

The portfolio includes initiatives at different stages of maturity. Some are established commitments already in delivery, while others require further definition, assurance, funding or mobilisation before implementation can begin.

Figure 2.1 : Purpose of Digital and Data Plan



HOW THE PLAN WILL BE USED

The Plan will provide a shared reference point for CTM's Board, executive leadership, care groups, corporate functions, the Digital and Data function and delivery partners. It will help CTM maintain a coordinated view of priorities, guide sequencing and investment decisions, identify dependencies and unresolved requirements, monitor delivery and benefits, and refresh the roadmap as circumstances change.

SHARED RESPONSIBILITY FOR DELIVERY

The Digital and Data team at CTM will coordinate the portfolio and provide specialist technology, data, information, cybersecurity and delivery expertise. CTM's clinical, operational and corporate teams will define service needs, shape solutions, support implementation and adoption, and own the intended benefits. National organisations, regional partners and suppliers will contribute where initiatives depend on shared platforms, information or delivery capabilities.

BUSINESS-AS-USUAL DELIVERY CONTINUES IN PARALLEL

While the plan focuses on pipeline of Digital & Data initiatives that require active prioritisation, sequencing and mobilisation, the team will continue to deliver the day-to-day activity required to operate and sustain its existing digital and data capabilities. This includes ongoing service support, maintenance, infrastructure and cyber activity, system administration, statutory and regulatory requirements, routine upgrades, supplier management and support for established digital services.

BAU activity will continue through existing operational arrangements and will remain an important consideration when assessing capacity, funding and competing delivery demands across the roadmap.

Strategic intent of the Plan

CTM's Digital and Data Plan 2026–29 supports the delivery of its Strategic Vision and Future Model of Care. It directs digital investment towards better population health, reduced inequalities and sustainable services. Its value will come from the changes it enables in how care is organised and delivered, and the difference those changes make to people and staff.

Digital and data integral to care

The strategic intent is to make digital and data integral to the design and delivery of care. Population insight should inform where support is directed. People should have greater opportunities to participate in their care, and staff should have the information and tools to work effectively across service boundaries. Alongside this, CTM needs the resilience and capability to sustain services and respond to future demands.

The plan establishes four priorities

Improve health and equitable access

Use data to understand population need, direct preventive action and support earlier intervention. Digital routes should make access easier, with support and appropriate alternatives available to those who need them.

Enable connected care

Make relevant information and expertise available across settings, supporting continuity, coordinated decisions and safe transitions between services.

Release capacity and improve productivity

Simplify workflows, reduce duplication and administrative burden, and make better use of workforce, diagnostic and treatment capacity.

Secure the foundations for transformation

Strengthen architecture, interoperability, data quality, cyber resilience and workforce capability so that individual investments contribute to a coherent model of care that can adapt over time.

Delivering the 2026–29 programme

The 2026–29 programme establishes the foundations and priority capabilities needed to support this direction. Clinical and population priorities should guide investment decisions, with clear links to service redesign, measurable benefits and affordability. Clinical, operational and digital leaders will need to take joint ownership of delivery, aligning the plan with workforce, estates and financial planning and relevant national NHS Wales programmes.

Scope and structure of **CTM's Digital & Data Plan**

WHAT THE PLAN COVERS

The Plan sets out how CTM will use digital services, technology and information to support patients, staff and services. It includes initiatives to improve patient access and communication, optimise clinical and operational systems, digitise workflows, strengthen data and analytics, and enable information to be shared securely across services.

To support sustainable delivery, the Plan also reflects needs that have been identified through stakeholder discussions across infrastructure, devices, cybersecurity and resilience, alongside workforce skills, training, adoption, governance, investment and benefits realisation. These needs will require further validation through detailed planning as the relevant initiatives are defined and mobilised.

New opportunities beyond the current portfolio, including those involving automation and AI, will be considered through a structured intake, assessment and assurance process before being incorporated into future updates to the portfolio and roadmap. This process will consider the identified need, evidence of value, organisational readiness, affordability, safety, governance, human oversight and sustainable ownership.

As access becomes increasingly digitally enabled, CTM will need to ensure that digital channels widen choice rather than create exclusion. Accessibility, digital confidence, connectivity and alternative non-digital routes will therefore remain important considerations in service design and implementation.

The Plan includes

Critical Commitments

Mandatory, time-critical or already committed initiatives that CTM must progress to meet service, national, regulatory or risk requirements.

Core capabilities

Foundational digital, data and workforce capabilities required to strengthen resilience and enable wider service transformation across CTM.

Follow-on Priorities

Important opportunities that support CTM's future vision of care, but require further development of critical commitments, core capabilities and other delivery conditions before they can progress at scale.

A LIVING PLAN

The Digital & Data Plan reflects CTM's priorities and the evidence available at the time of publication. It is intended to provide direction and discipline while remaining responsive to change. The portfolio will be reviewed regularly through CTM's governance arrangements. As initiatives mature and new information becomes available, they may be accelerated, rescheduled, reshaped, combined with related activity or stopped.

This approach will allow CTM to maintain a coherent direction while responding to emerging needs, new evidence and changes in the wider digital and healthcare environment. The Plan will evolve, while established Digital & Data services continue in parallel to maintain operational continuity across CTM.

Three-**year CTM's Digital And Data Roadmap**

We are here today

Q3 2026

- Maintain momentum across commitments already in delivery and address immediate operational, resilience and continuity priorities.
- Clarify the scope, ownership, funding route, technical requirements and dependencies of initiatives expected to progress from 2027.

2027

- Strengthen the shared digital, data and organisational capabilities required to support wider service and pathway change.
- Coordinate activity across care groups and actively manage competing demands on technical, procurement, clinical and change capacity.

2028

- Continue multi-year delivery and scale the capabilities mobilised during the earlier phases of the roadmap.
- Connect systems, information and digital workflows more effectively to support redesigned pathways and CTM's future model of care.
- Progress more complex initiatives as the required foundations, approvals, resources and external dependencies are put in place

2029

- Complete the later phases of longer-term and dependency-heavy initiatives within the current planning horizon.
- Extend established capabilities across relevant services, building on shared infrastructure, standards and delivery experience.
- Review progress and outstanding priorities to inform the next planning cycle and maintain alignment with CTM and national priorities.

BUSINESS-AS-USUAL DELIVERY CONTINUES IN PARALLEL



BEYOND 2029: FEEDING INTO THE NEXT PLANNING CYCLE

Supported by annual refreshes throughout the three-year period, the Plan will undergo a full portfolio refresh beyond 2029. This will consider delivery progress and learning, outstanding commitments, risks and dependencies, and emerging CTM, service and national requirements. It will determine which initiatives form the next set of Critical Commitments, Core Capabilities and Follow-on Priorities, and how they should be sequenced within the next roadmap.

Embedding AI responsibly to support CTM's future model of care

CTM is progressing its Community-by-Design ambition through the development of its future model of care. In parallel, CTM is aligning with the emerging direction for artificial intelligence (AI) across Wales, informed by the work of the Welsh AI Commission for Health and Social Care and DHCW's developing approach to AI adoption.

AI is expected to become an increasingly important enabler of CTM's clinical, operational and workforce priorities. The opportunity extends beyond individual technologies where AI can help CTM identify need earlier, make better use of information, support clinical and operational decision-making, reduce avoidable administrative burden and enable more proactive and responsive models of care.

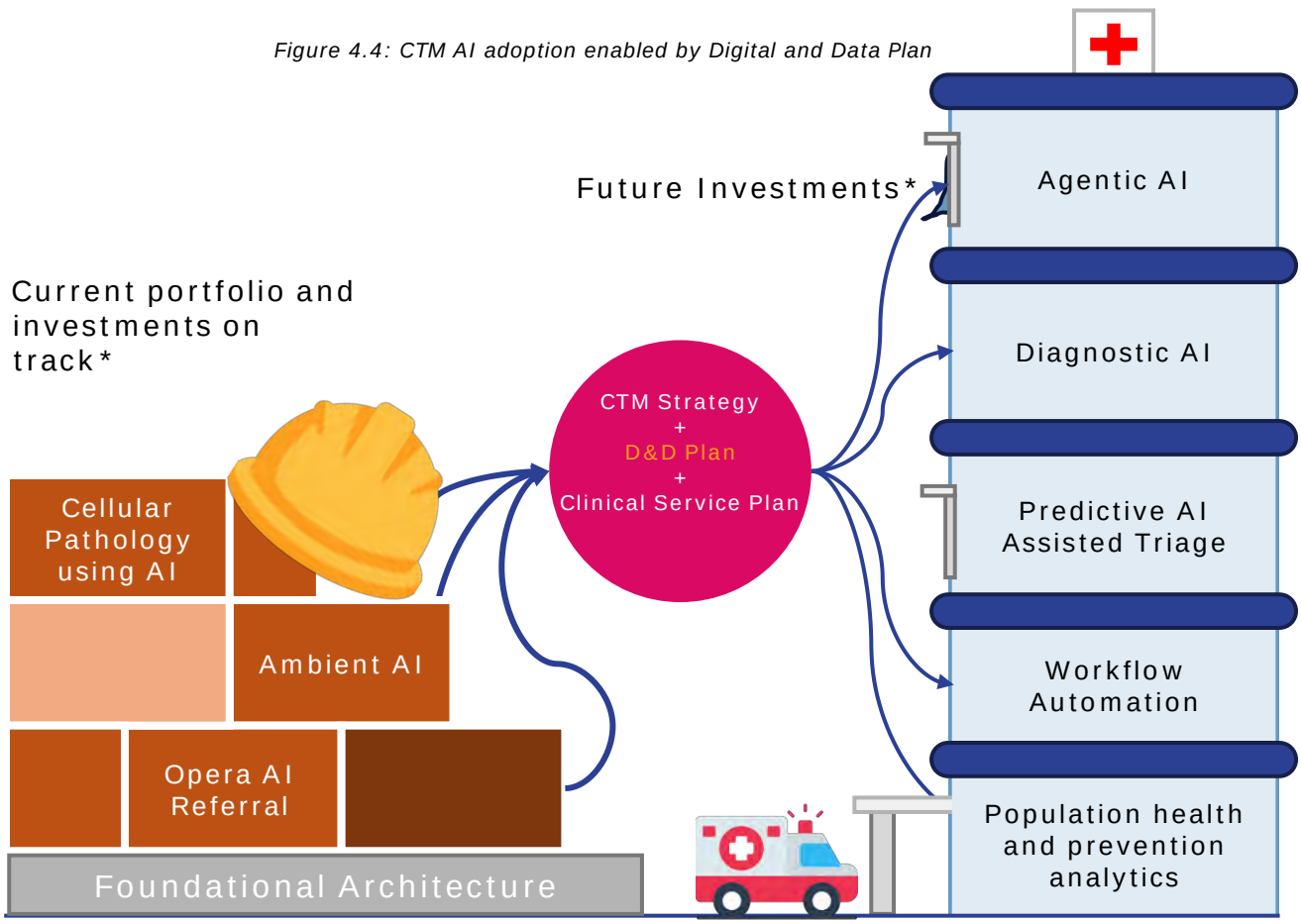
CTM's ambition is to create the suitable environment in which AI can be explored and adopted with confidence. AI is intended to form part of CTM's wider Digital & Data portfolio rather than operate as a separate technology programme.

The Digital & Data Plan therefore focuses on:

- strengthening the data, interoperability, infrastructure, governance and workforce capabilities required to support AI safely and sustainably
- creating a route for promising use cases to move from exploration into wider adoption where there is clear need, evidence and value.

The approach therefore needs to be progressive and proportionate, broadly reflecting the direction being taken nationally, which is establishing foundations before scaling capability and moving towards AI as a repeatable part of business-as-usual.

Figure 4.4: CTM AI adoption enabled by Digital and Data Plan



*As reflected during the conversation with the stakeholders

HOW THE PLAN **SUPPORTS CTM'S** FUTURE VISION



Digital and data plan will enable CTM's vision across every level of delivery

Figure 4.1 : Purpose of Digital and Data Plan

The Digital & Data Plan is a key enabler of CTM's future model of care, providing a coherent approach to digital priorities, data, technology, governance and enabling capabilities across the organisation.

CTM STRATEGIC FRAMEWORK	DIGITAL & DATA PLAN CONTRIBUTION
VISION What we want to achieve over the long term Building healthier communities together	Enable more connected, accessible and proactive care across CTM's communities.
STRATEGIC GOALS The high-level objectives that guide our work Sustaining Our Future · Inspiring People · Improving Care · Creating Health	Give teams the information, tools and digital capabilities needed to improve care, make earlier interventions and support better decisions.
STRATEGIC INITIATIVES Multi-year, whole-organisation priorities that will transform services	Provide the shared platforms, data foundations, integration capabilities and interoperability standards needed to redesign care across pathways, settings and communities.
CORPORATE PROJECTS Programmes that support delivery of the digital and data initiatives provided in care group IMTPs	Support successful programme delivery through integrated planning, actionable insight, standardised delivery approaches and sustained adoption
ENABLING PLANS Thematic plans covering areas such as workforce, estates, finance, research and people	Align digital investment, data, workforce capability and governance with CTM's wider transformation and delivery priorities.

One CTM vision, enabled by connected digital capabilities and trusted data.

CTM's future model shifts care earlier and closer to home

CTM's Case for Change and Strategic Vision set out a clear ambition to move from a predominantly hospital-centred model of care towards one that is more preventative, digitally enabled, integrated and delivered closer to home.

In practice, this means shifting more activity into prevention, early intervention, virtual care, locality-based services and community settings, supported by diagnostic and treatment capacity outside traditional hospital environments. Hospitals will remain a critical part of the model, increasingly focused on complex, specialist and emergency care. More patients will be supported through virtual channels, locality-based services, community teams and diagnostic facilities outside traditional hospital settings. Hospitals will continue to play a critical role, but they will be increasingly focused on complex, specialist and emergency care.

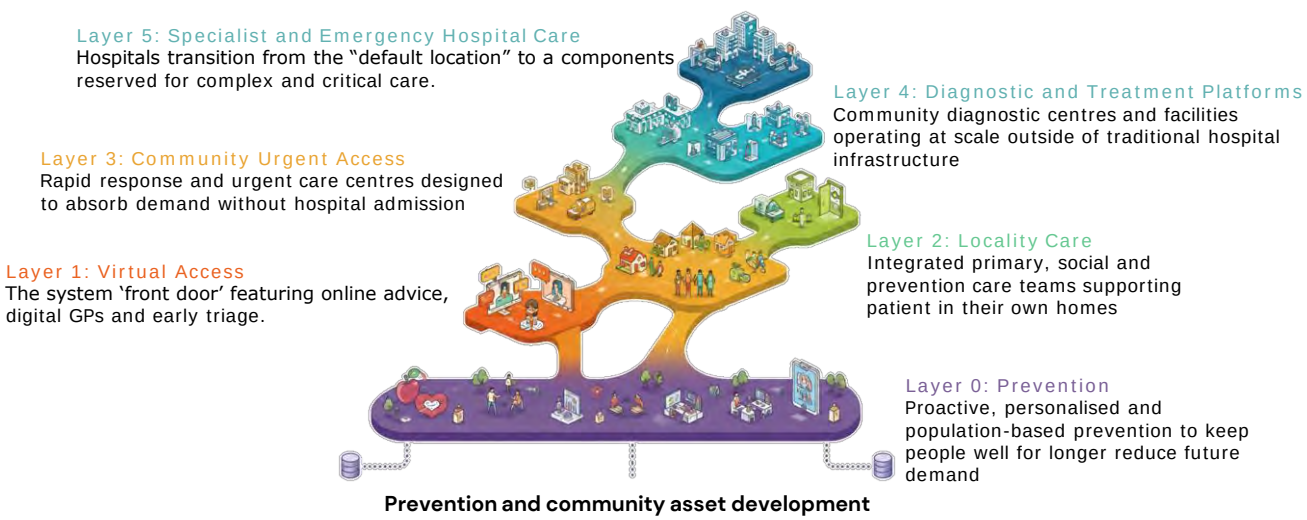
The Digital & Data Plan is a critical enabler of this transition, helping CTM translate its left shift ambition into the practical digital capabilities, data foundations and delivery priorities needed to make the future model of care work in practice.

The initiatives identified within the roadmap demonstrate how digital and data investment will support the development of each layer of care. Some initiatives will directly enable new models of access and service delivery, while others will provide the shared infrastructure, information and capabilities required across the whole system. Together, these initiatives will help CTM to:

- identify need earlier and support more proactive care
- give patients with simpler and more flexible routes into services
- enable professionals to access and share trusted information across care settings
- support more care to be delivered safely in communities and closer to home
- improve coordination between primary, community, secondary and tertiary care
- make better use of diagnostic, specialist and hospital capacity
- use data more effectively to manage demand, capacity, performance and outcomes.

The roadmap therefore connects CTM's strategic ambition with the digital and data capability development required to deliver it. It shows capabilities will develop progressively across the Future Model of Care while strengthening the shared foundations needed for services to operate as a more connected system.

Figure 4.2 Future Clinical Model of Care



Each level of care requires a different Digital and Data response to enable the shift

The future model of care sets out a progressive shift towards prevention, earlier intervention, care closer to home and more connected diagnostic and treatment services. Digital and Data will act as a core enabler across each layer, supporting more seamless access to information, coordination across settings, timely decision-making and more personalised care for patients, while enabling staff and clinicians to work more effectively across organisational and service boundaries. Appropriate and safe information sharing will be fundamental to this, enabling trusted information to follow the person across organisational and service boundaries and supporting more coordinated care. The table below summarises the shift expected at each level of care and the Digital and Data capabilities that will help enable it.

Level of care	What is the shift?	How Digital & Data enables the shift*
Layer 0 – Prevention	• From insight being used mainly to understand activity and demand. • To using joined-up population data earlier to identify risk, inequalities and opportunities for intervention before needs escalate, while supporting people to stay well and manage their own health.	• Population health analytics • Risk stratification • Predictive modelling • NHS Wales App and patient portal • Wearables and remote monitoring • Digital front door/self-referral • Community risk assessment and preventive care pathways • Targeted screening and immunisation • Online appointments for preventive services
Layer 1 – Virtual Access	• From access that can still rely heavily on telephone, face-to-face contact and multiple entry points. • To simpler and more consistent digital routes that help people self-refer, check their needs, manage appointments, access advice and care remotely, and stay informed.	• Patient self-referral • Patient care portal • NHS Wales App • Digital front door/symptom triage • Self-checking/digital wayfinding • POA digital screening • Booking/online appointments • Virtual consultations • Wearables and remote monitoring • Patient-focused messaging
Layer 2 – Locality Care	• From information, systems and workflows varying across community teams and services. To more joined-up multidisciplinary working around the person across primary, community, mental health and social care. Care is increasingly coordinated and delivered closer to home.	• Shared care record • GP/community system integration • Patient portal • E-Prescribing • Remote monitoring • Point-of-care testing • Diagnostic tools • Decision support • Community RPM • Workforce mobility tools • Care coordination tools • Integration with social care systems

*The capabilities shown include a mix of existing CTM capability, capability already in development and areas that may need to mature further as the future model of care develops.

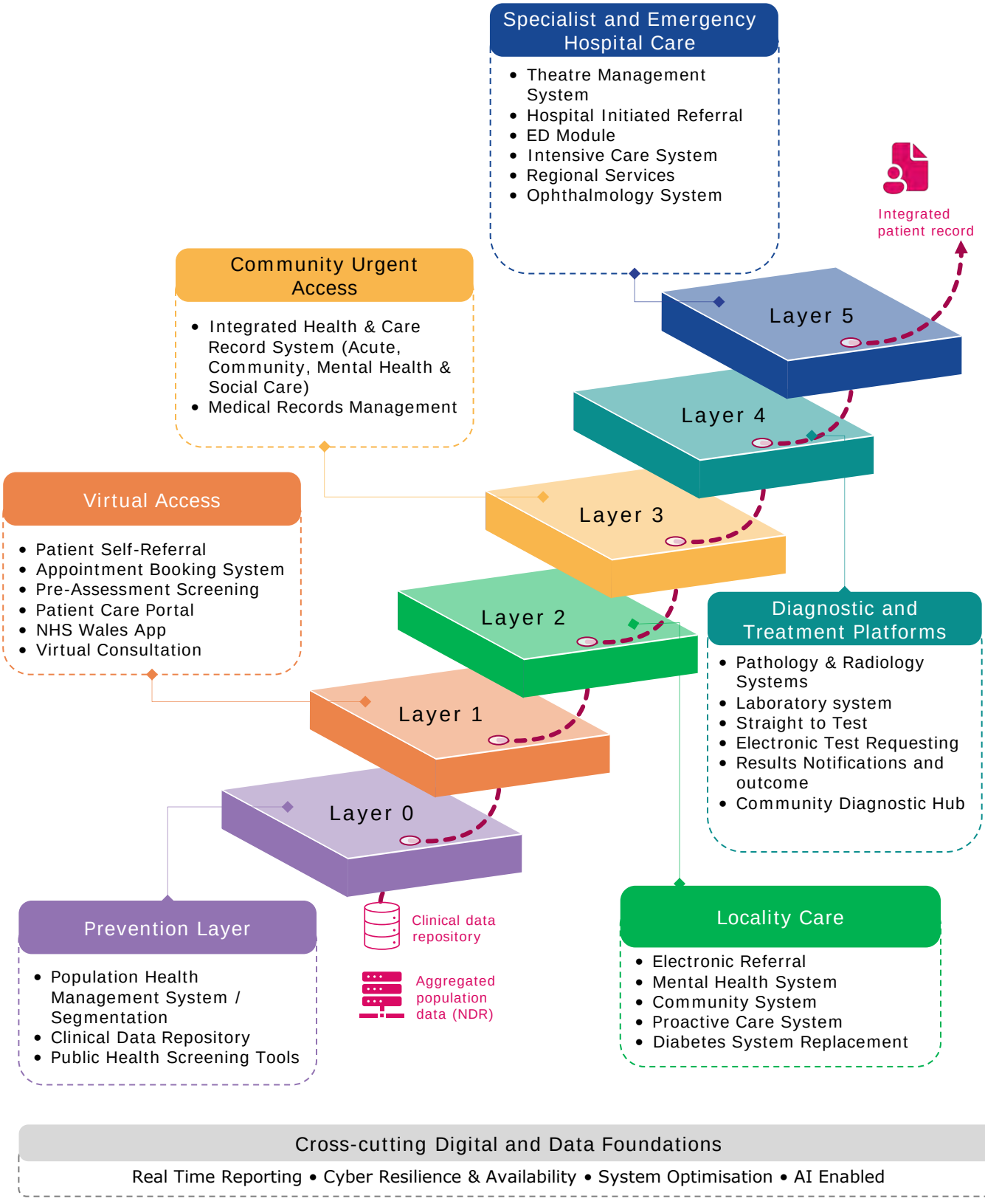
Digital & Data will connect urgent, diagnostic and specialist care around the patient

Level of care	What is the shift?	How Digital & Data enables the shift
Layer – Community Urgent Access	• From urgent needs sometimes progressing through fragmented referral, assessment and escalation routes. • To faster community-based assessment and intervention, with teams able to access the information and specialist support needed to make timely decisions. • Ongoing follow-up helps reduce avoidable hospital admission.	• Mobile assessment tools • Remote monitoring data • Clinical decision support • Shared care record • Community RPM • Virtual consultation • Digital care plans • Clinical communication tools • Workforce mobility • Care coordination tools • Virtual MDT • Patient portal • Patient-reported outcomes • Care escalation alerts
Level – Diagnostic & Treatment Platforms	• From diagnostic and treatment pathways operating across multiple systems, processes and sites. • To more standardised and connected pathways with improved visibility of referrals, results, capacity and patient flow. • This supports earlier diagnosis and more coordinated treatment.	• Enterprise imaging • AI for image analysis and diagnostics • Digital pathology • Total lab automation • Specimen tracking • Straight to Test • Community Diagnostic Hubs • Pre-assessment screening • Prescribing and medicines administration • Pharmacy automation • Same Day Elective Surgical Hub
Layer – Specialist and Emergency Hospital Care	• From specialist expertise often being accessed at a later stage or through separate organisational pathways. • To more integrated specialist, emergency and inpatient care, with specialist input connected into the wider CTM pathway and available at the right point in the patient journey. • Better coordination and information flow support continuity of care.	• Smart triage • AI triaging • ED module integration • Smart beds • Bedside technology • Clinical communication • Ophthalmology • Maternity • Operating room of the future • OR video integration • Enterprise-wide EPR • Digital transfer of care

To support this, Figure 4.3 highlights the Digital & Data Plan initiatives that will help enable each layer of the future model of care

The 2026–29 portfolio starts to build the capabilities needed for the future model

*Figure 4.3: D&D Initiatives across the Future Model of Care (non-exhaustive)**



Note: *Certain initiatives span more than one layer of the care model, reflecting their role in enabling integrated pathways and supporting care delivery across multiple settings.

III METHODOLOGY AND ENGAGEMENT APPROACH



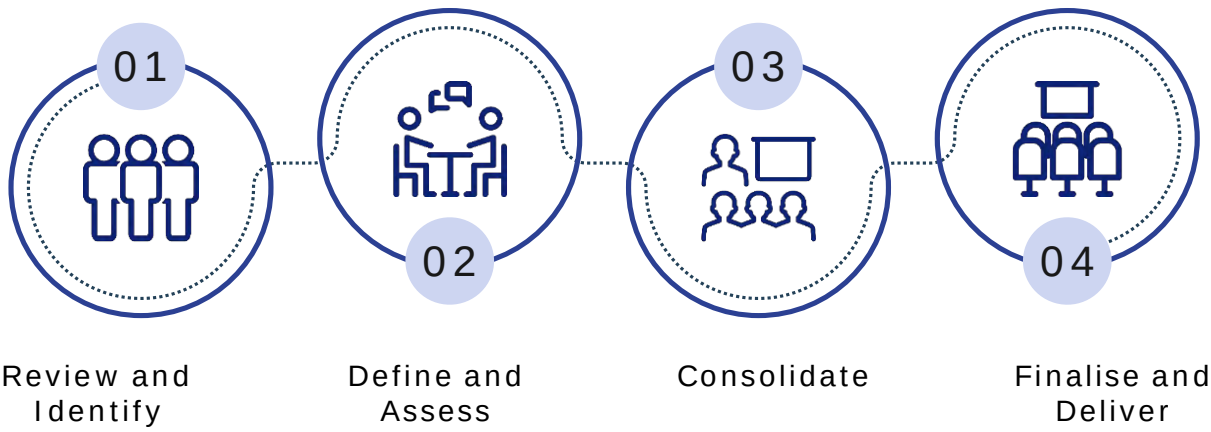
How the plan was developed

Overview

The Digital and Data Plan has been developed as a service-led delivery plan, not a standalone technology exercise. Led by the CTM Digital and Data team, with support from Tektology, it brings together CTM's future model of care, national and regional priorities, care group needs, and existing digital commitments into a single structured delivery route.

The approach was constructed to collate evidence before developing an actionable plan. It began with engagement, discovery and current state baselining between Aug 2025 and Nov 2025 to understand CTM's ambition, constraints and digital maturity. This was followed by four delivery phases between Mar 2026 and Jun 2026, helping to translate this into a prioritised, sequenced and deliverable Digital and Data roadmap to support CTM's strategic ambition.

Figure 5.1 Four-stage methodology



Phase 1: Review and Identify

Tektology reviewed the strategic and operational evidence base published across CTM, including the Corporate Strategy, Domain IMTPs, Digital and Data IMTPs and care group priorities (refer to appendix Table A.03 for details). The output was a consolidated view of the opportunity landscape of ~180, bringing together both Digital and Data-led initiatives and wider service-led opportunities requiring digital, data or technology enablement.

Phase 2: Define and Assess

The opportunity list identified through Phase 1 was tested and refined through workshops with Digital Senior Leadership Group (DSLGs), clinical leads and care group representatives. These sessions helped validate the relevance of each opportunity, remove duplication and understand where initiatives were already in flight, partially defined or dependent on wider service transformation. The remaining opportunities were then assessed against the agreed definitions of Critical Commitments, Core Capabilities and Follow-on Priorities.

As a result, the longlist was reduced from approximately 180 opportunities to around 120 prioritised initiatives

How the plan was developed

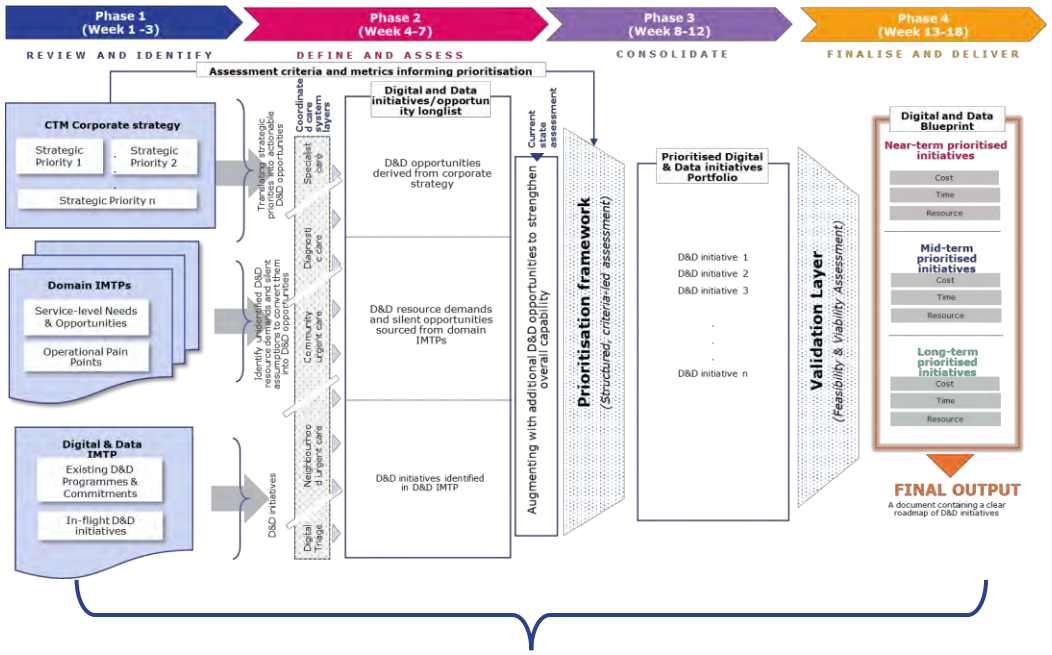
Phase 3: Consolidate

The refined longlist was consolidated into a prioritised D&D portfolio. Initiatives were assessed through a prioritisation framework (refer to appendix Table A.06) supported by stakeholder input and delivery judgement and were reduced to ~35 standalone initiatives defined under 24 overarching groups where applicable. A further validation process was then applied to test the strength, readiness and deliverability of each initiative.

Phase 4: Finalise and Deliver

The prioritised initiatives were mapped across delivery horizons to support practical sequencing and delivery planning. As part of this phase, each initiative was considered in relation to delivery timing, dependencies, risks, governance requirements and the level of support needed to progress. This ensured the roadmap was not only prioritised, but also realistic and actionable.

Figure 5.2 Phased approach towards building Digital and Data plan



20+ Documents Reviewed

INCLUDING
- IMTPs
- Clinical plan
- CTM UHB 2026–29 plan
- Existing digital & data materials

7+ Workshops conducted

INCLUDING
- Board members
- Non-executive Board
- DSLG
- Clinical Directorates

8+ Care-group discussions

INCLUDING
- DTPS
- Primary & Community Care
- Planned Care Including cancer
- Unscheduled Care
- Children & Families
- Mental Health & Learning Disability

180+ Initiatives identified

INCLUDING
- Critical priorities
- Backlogs
- BAU activity
- Future ambitions

CONSOLIDATED AND VALIDATED INTO

24 | FINAL DIGITAL & DATA INITIATIVES grouped into overarching categories

IV CURRENT STATE ASSESSMENT FINDINGS



Findings from the current state assessment

A clear understanding of CTM's current digital and data position is essential to shaping a delivery plan that is practical, prioritised and grounded in operational reality. CTM has already made visible progress across areas such as electronic prescribing, data warehousing, dashboard development, patient contact, maternity digital access and cyber resilience.

A current state assessment was undertaken during the development of the Digital & Data Delivery Plan in October 2025 and reflects the position captured through the information available at that point. While progress is evident, these developments sit within a wider environment that remains fragmented, capacity-constrained and dependent on a mix of local, national and programme-specific delivery routes.

The current state assessment combined secondary document review with interviews involving clinicians, data team representatives, SLGs and DSLG members across CTM. It provides the evidence base for the Digital & Data Delivery Plan, identifying what is working well, where delivery is being constrained, and what needs to change for digital and data to become a more consistent enabler of future care delivery.

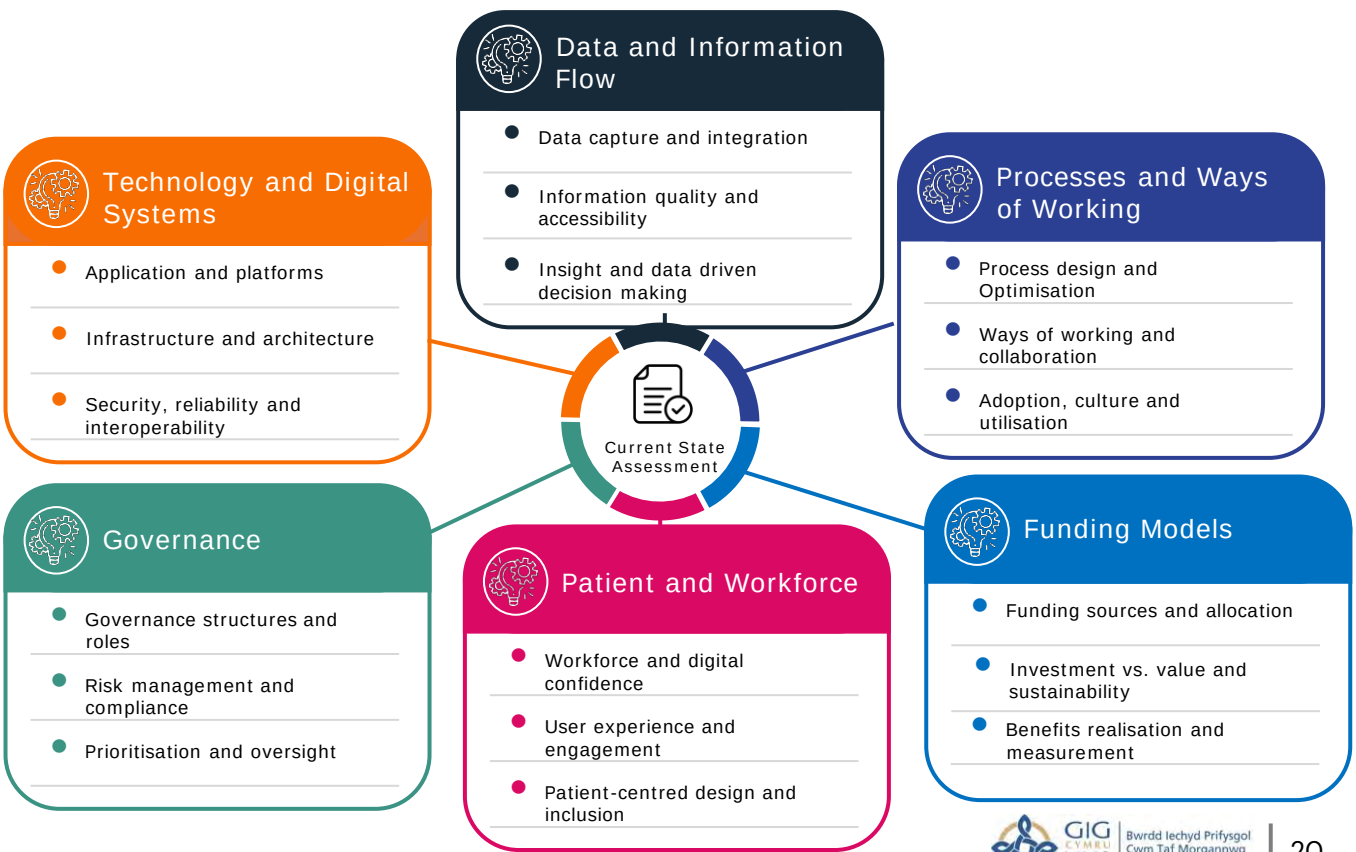
The findings are structured around six key pillars: technology and digital systems, data and information flow, processes and ways of working, governance, patient and workforce readiness, and funding model (refer to Figure 6.1)

Across these pillars, the assessment highlights a common pattern:

> CTM does not lack ambition or activity, but it needs a clearer mechanism to prioritise, govern, scale and sustain digital change across the organisation.

The assessment also identified 19 digital and 13 non-digital opportunities across the six pillars, supporting system-wide transformation (refer to appendix Table A.05)

Figure 6.1 Current State Assessment (Six Pillars Shaping CTM's Digital and Data estate)



Findings from the current state assessment

Technology and digital systems

The findings

CTM has made progress in strengthening its digital foundations, but the technology estate remains fragmented, duplicative and difficult to manage consistently.

155
digital systems
across clinical, estates and operational areas with limited systematic review, rationalisation and decommissioning.

What is happening today

- Redundant systems have created duplication, inconsistent ways of working and additional complexity for frontline teams.
- Mixed hosting arrangements, legacy infrastructure and unsupported technologies have increased maintenance effort and cyber, resilience and continuity risks.
- Inconsistent procurement and lifecycle management have diluted accountability for upgrades, support, rationalisation and retirement.

What this means for CTM

Without stronger lifecycle control, CTM risks continuing to invest in new technology while retaining the cost, complexity and risk of the existing estate.

How D&D plan will guide

- 13B — Rationalise the application estate and aim to systematically retire redundant, duplicate and unsupported systems.
- 13A — Strengthen the resilience and availability of critical infrastructure and services.

Data and information flow

The findings

CTM has established a data warehouse and expanded its reporting capability; however, fragmented source systems, inconsistent data standards and uneven integration continue to constrain trusted, timely and reusable insight.

>60
digital systems
known source systems currently feed the data warehouse.

What is happening today

- Requests from clinical and operational services to the central BI and analytics function are often managed reactively, with limited agreed prioritisation and self-service capability.
- Data definitions, coding and reporting logic are not being consistently standardised across source systems and reporting products.
- Gaps in patient-level data and linkage has limited end-to-end visibility of pathways, discharge and operational pressures.

What this means for CTM

Clinical/operational teams spend significant time reconciling data and producing reactive reports, rather than generating timely, actionable insight for decision-making.

How D&D plan will guide

- 9A — Strengthen accessible, timely reporting through Power BI Dashboard.
- 22 — Improve access to joined-up patient information through the Integrated Shared Care Record.
- 9B — Apply data and analytics to priority pathways.

CC Critical Commitments | CC Core Capability | FP Follow On Priorities | G Governance

Findings from the current state assessment

Processes and ways of working

The findings

CTM's digital change approach remains largely reactive, shaped by mandatory national programmes and locally driven care group or service priorities, rather than applying organisation-wide route.

Demand-led Prioritisation

across clinical, estates and operational areas responding to urgent needs.

What is happening today

- Fragmented digital change creates duplication, delays and avoidable workload, reducing capacity for frontline care and transformation.
- Inconsistent lifecycle management limits legacy-system decommissioning, increasing cost and complexity.
- Manual processes are creating inefficiency and risk in clinical care.
- CTM lacks a mature sandbox environment to test innovation safely.
- Unclear ownership, funding and routes to scale were cited as factors that were causing pilots to lose momentum.

What this means for CTM

Digital transformation capacity is spread across competing national and local priorities, making it difficult to scale successful improvements and sustain benefits through BAU.

How D&D plan will guide

- 13B Optimise existing systems, redesign workflows and strengthen adoption.
- G Build testing, business-analysis, training and rollout capacity.
- G Strengthen clinical input into digital design and delivery.

Governance

The findings

CTM is managing a growing, interdependent digital portfolio across local and national governance routes. However, portfolio-wide oversight, decision rights and escalation routes are not yet consistently defined.

Need

Unified PMO

to oversee the 24 D&D Plan initiatives and assess new initiatives entering the roadmap.

What is happening today

- No single PMO or portfolio route for prioritising digital initiatives or activities.
- CTM is locally accountable for digital delivery but remains dependent on DHCW for key platforms, APIs and integrations.
- Decision rights, ownership and escalation routes vary across programmes, creating inconsistency in how issues are resolved.
- Major programmes such as LHP,LIMS, RISP, and PCCTP require coordinated cross-board, supplier and service governance.

What this means for CTM

Decision-making, accountability and escalation arrangements vary between initiatives, creating a need for stronger portfolio-wide oversight.

How D&D plan will guide

- G Strengthen portfolio-level prioritisation, oversight and accountability.
- G Improve coordination with DHCW and other delivery partners to manage dependencies and protect delivery momentum.

CC Critical Commitments | CC Core Capability | FP Follow On Priorities | G Governance

Findings from the current state assessment

Patient and workforce

The findings

CTM has working towards patient inclusion and staff-led digital adoption, but readiness, capacity and engagement vary across services as structured feedback is not yet consistently embedded.

Uneven
Digital readiness
among workforce and limited usage of patient-facing experience.

What is happening today

- Some staff continue to face barriers accessing basic digital tools, while training and digital maturity vary across services.
- Dedicated training and change capacity is constrained, with teams supporting multiple digital workstreams.
- Test environments, super-users and clinical champions are supporting adoption in programmes such as ePMA and maternity, but these approaches are not consistently embedded.
- Staff and patient feedback loops are limited.

What this means for CTM

Variable readiness and engagement can slow adoption, increase reliance on central teams and limit the value realised from digital investment.

How D&D plan will guide

- G — Care groups highlight digital literacy across their 2026–29 IMTPs, including specialist roles to embed capability.
- 16 — Expand patient access, communication and self-service.

Funding models

The findings

Digital investment has increased, but funding remains reactive, fragmented and often capital-driven, with inconsistent routes for benefits tracking and scaling.

£9.5
Digital capital spend (2024/25)
Increased from £2.5m in 2022/23.

What is happening today

- Funding is short-term, late-cycle or linked to specific capital opportunities
- Benefits tracking is emerging but not consistently linked to reinvestment
- The D&D portfolio shows varying funding maturity: some initiatives are funded, while others require business cases, procurement funding or confirmation beyond 2026/27.
- Legacy systems, paper records and system limitations continue to create additional cost pressures.

What this means for CTM

CTM risks funding implementation without the recurrent capacity to sustain it, while inconsistent benefits evidence constrains prioritisation, scaling and value realisation.

How D&D plan will guide

- G — Sequence investment based on strategic value, readiness, dependencies and affordability.
- G — Confirm whole-life costs, funding sources, recurrent support and BAU ownership before delivery.

CC Critical Commitments | CC Core Capability | FP Follow On Priorities | G Governance

V DIGITAL & DATA PLAN-ON-A-PAGE



Purpose and role of the Plan

CTM Digital and Data 2026-29 plan is a practical roadmap that sets out how digital, data and technology can support CTM's strategic goals, future care model and service priorities over the next three years.

It brings together current initiatives, stakeholder feedback, current state findings and future opportunities into one prioritised and sequenced view. The plan is intended to help CTM understand what should be progressed, when it should happen, what it depends on, and how delivery can be tracked over time.

The plan should therefore be read in three ways:

- As a prioritised portfolio: to understand which Digital & Data initiatives should receive focus first
- As a delivery roadmap: to understand what should happen in Year 1, Year 2 and Year 3.
- As a decision-support tool: to identify the ownership, dependencies, risks and decisions needed to move initiatives into delivery

What the plan means for different stakeholders

Audience	What they should look for in the plan	What it helps them do
Board and Executive Leaders	The prioritised portfolio, 3-year roadmap, key risks, investment dependencies and decisions required	Confirm whether the plan is aligned to CTM's strategic goals, agree priority areas for investment, and unblock decisions around funding, workforce, governance and delivery capacity
Clinical Leaders and Care Teams	Initiatives linked to clinical pathways, care model alignment, patient flow, digital tools and information sharing	Understand which initiatives will affect clinical practice, validate whether priorities reflect service need, and identify where clinical input or ownership is required
Care Group and Service Leaders	Initiatives mapped to services, care group impact, sequencing, dependencies and delivery readiness	See which initiatives affect their services, confirm local priorities, identify operational constraints, and agree what can realistically be delivered in Year 1, Year 2 and Year 3

Purpose and role of the Plan

Audience	What they should look for in the plan	What it helps them do
Digital and Data Teams	Portfolio categories, enabling foundations, sequencing, dependencies and cross-cutting requirements	Understand the demand pipeline, identify foundational work needed, plan delivery capacity, and manage dependencies across systems, data, interoperability, reporting and adoption
Workforce, OD and Training Teams	Initiatives requiring new ways of working, adoption support, capability development or training	Plan the workforce support needed for successful adoption, including skills development, communications, change support and role-specific training
Corporate and Enabling Teams	Funding, procurement, IG, cyber, estates, workforce and governance dependencies	Identify where early support is needed to prevent delay, such as approvals, business cases, procurement routes, information governance reviews or cyber assurance
Patients, Families and Communities	Initiatives that affect access, communication, digital inclusion, self-service and joined-up care	Understand how the plan is expected to improve the way people access, navigate and experience care, while recognising where non-digital access and inclusion must be protected
System Partners	Initiatives requiring collaboration across primary care, community, local authority, third sector, regional or national partners	Identify where joint working is required, particularly around shared care pathways, interoperability, population health, prevention and care closer to home

Emerging roadmap (1/2)

Sr. No.	Initiative type	Initiative name	Dependencies on D&D initiatives	2026 Q3	2026 Q4	2027 Q1	2027 Q2	2027 Q3	2027 Q4	2028 Q1	2028 Q2	2028 Q3	2028 Q4	2029 Q1	2029 Q2	2029 Q3	2029 Q4
1	CC	LIMS Upgrade															
2	CC	RISP Migration															
3A	CC	Theatre System (TOMs) - Replatform															
3B	FP	Theatre System (TOMs) - Procurement	10A, 10B														
4	CC	Open Eyes – All Ophthalmology Services															
5	CC	WPRS roll out															
6	CC	HIR - Hospital Initiated Referral	5														
7	CC	S2T - Straight to Test	5														
8A	CC	Digital System Implementation - Intensive Care System	4														
8B	CC	Digital System Implementation - Pathology & Radiology ETR West															
8C	CC	Digital System Implementation - Full implementation of Integrated Women's Health Hub (IWHH)															
9A	CC	Demand Capacity Modelling - Entry Points, Demand & Capacity - Power BI dashboard support															
9B	CC	Demand Capacity Modelling - Development of Acute Frailty Dashboard to monitor and improve performance - ED module	19														
10A	FP	Llantrisant Health Park - Orthopaedic center	1, 2														
10B	FP	Llantrisant Health Park - Community Diagnostic Hub	2, 5														
11	CC	Diabetes System Replacement															
12	CC	Cyber Resilience and Availability															
13A	CC	System Optimisation - System Enhancements															
13B	CC	System Optimisation - Decommission Legacy Systems & Relevant Infrastructure															
14A	CC	Patient Care - Patient portal	16 A, 16B, 16C														
14B	CC	Patient Care - Patient self-referral booking system															
15	CC	The FIT (bowel cancer screening test) pathway															

Initiative type: Critical Commitment | Core Capability | Follow-on Priority

Roadmap stage: Prepare | Business case/De-risk | Procure (Build/Buy) | Deliver | Dependency on other initiative

Emerging roadmap (2/2)

c

Sr. No.	Initiative type	Initiative name	Dependencies on D&D initiatives	2026		2027				2028				2029			
				Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
16A	CC	PCCTP - Back Scanning of Medical Records and Digitisation															
	CC	PCCTP- Reduce Notes in Outpatient Appointments															
16B	CC	PCCTP - Omni-channel Support															
	CC	PCCTP - Integrating Text Reminder Solution into Omni-channel System															
	CC	PCCTP - Call Demand and Capacity Modelling	9A														
16C	CC	PCCTP - NHS Wales App															
16D	CC	PCCTP - Intouch Patient Check-in System															
16E	CC	PCCTP - Implement digital dictation across all areas															
17A	FP	Third party collaboration/Innovation - Exploration of RPA and Innovations for Process Improvements															
17B	FP	Third party collaboration/Innovation - Develop and embed digital pathways including virtual clinics															
18	CC	POA Digital Screening - Pre-operative assessment															
19	CC	ED Module															
20	CC	ePMA (8500 users) – Phase 1 Rollout Continuation & Phase 2 Implementation															
21	CC	Maternity (Badgernet Implementation)															
22	CC	Mental Health Single care record															
23	CC	The implementation of Cellular Pathology approaches including the use of AI															
24	FP	Community by design	*														

* Initiative remains at a conceptual stage, with key dependencies and delivery requirements still being defined

Initiative type: Critical Commitment | Core Capability | Follow-on Priority

Roadmap stage: Prepare | Business case/De-risk | Procure (Build/Buy) | Deliver | Dependency on other initiative

VI

PRIORITISED DIGITAL AND DATA INITIATIVES

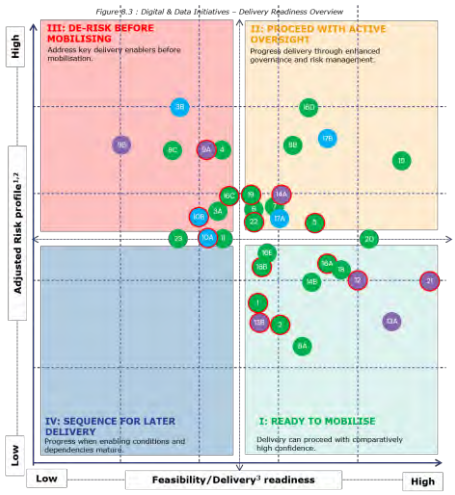


How to read this section:

The Digital & Data Portfolio mapping is structured across two complementary sections, combining an executive readiness matrix with detailed initiative-level insight to inform subsequent prioritisation, sequencing and delivery planning.

Portfolio Delivery Readiness
Provides an executive view of the Digital & Data portfolio through a 2×2 Delivery Readiness Matrix. The matrix enables readers to quickly understand:

- Quad I: Which initiatives are ready to mobilise based on current organisational readiness.
- Quad II: Which initiatives require active executive oversight during delivery.
- Quad III: Which initiatives require further readiness activity before mobilisation.
- Quad IV: Which initiatives are planned for later delivery as enabling conditions mature.



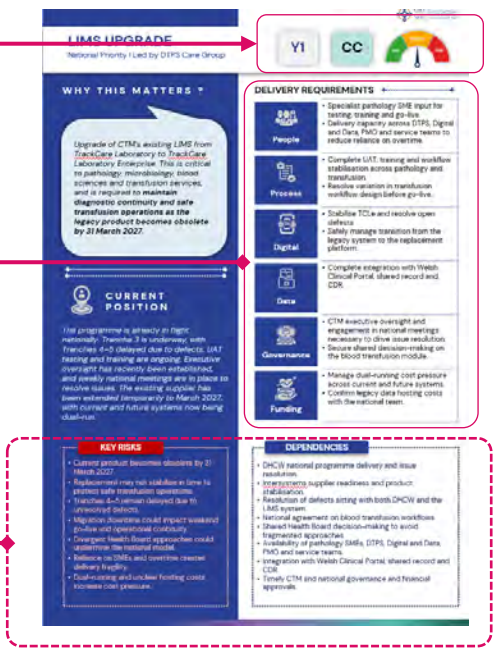
Each initiative has been assessed against a consistent methodology (refer to Table A.07) considering delivery feasibility, delivery risk and strategic importance

Annexure I: Provides a detailed profile of each initiative, outlining its strategic rationale, current progress, delivery requirements, dependencies, risks and implementation considerations that informs its position within the readiness matrix.

Delivery context
- Expected Delivery timeframe (Year 1–3)
- Initiative category
- Risk profile

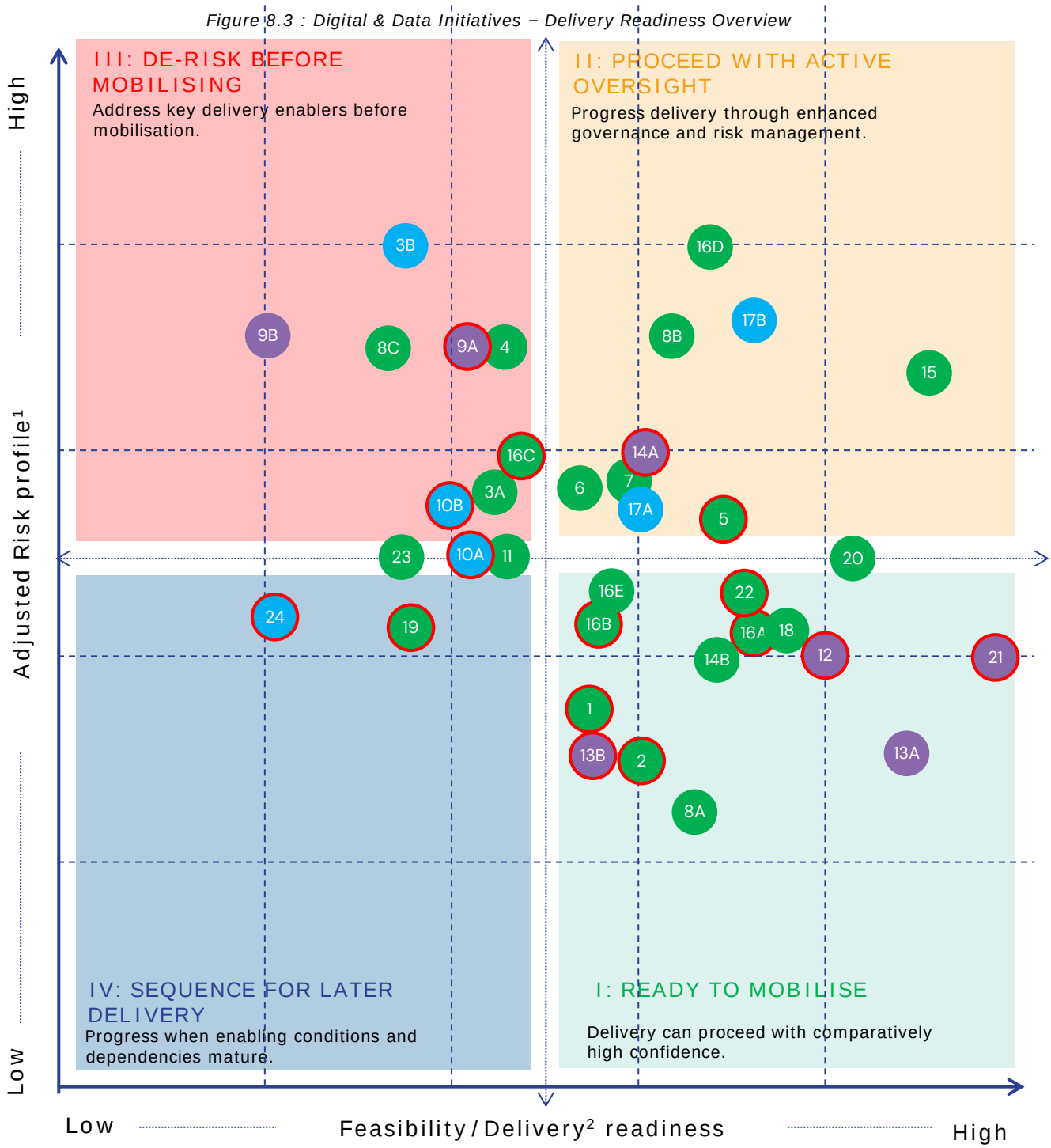
Delivery requirements
- Current progress
- Delivery requirements for People, process, digital, data, governance and funding

Implementation considerations
- Key risks
- Internal and external dependencies



CTM Digital and Data Portfolio – Readiness Matrix

Figure 8.3 : Digital & Data Initiatives – Delivery Readiness Overview



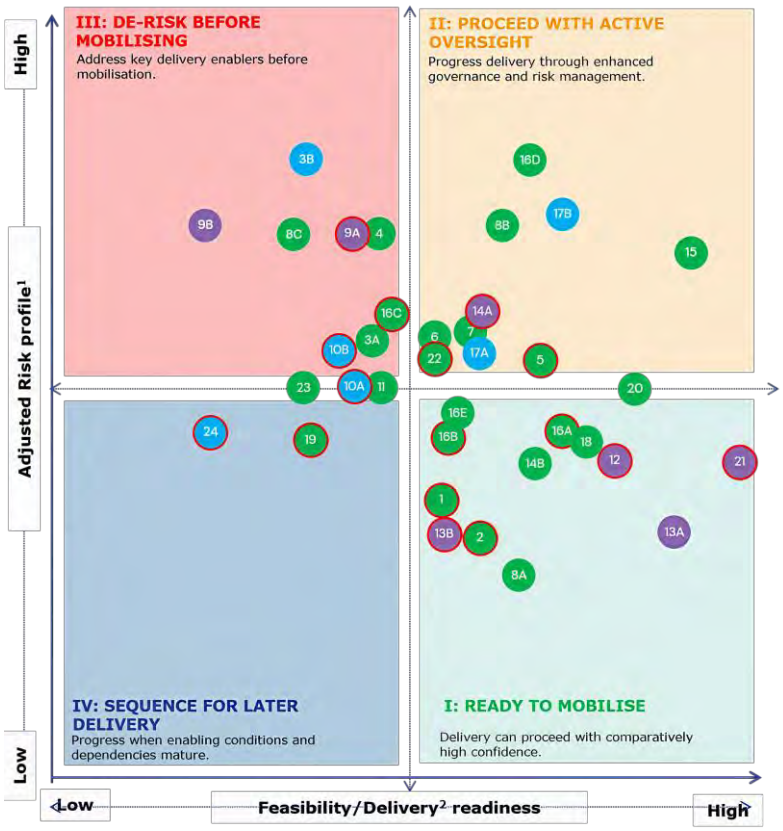
How to read the matrix

- Critical commitment
- Core capability
- Follow-on priority
- High Impact initiatives (Either National/Regional /CTM wide priority)

Note:

1. Overall delivery risk has been adjusted based on the evidence available at the time of assessment.
2. Delivery readiness reflects the current actions, milestones and implementation plans described by stakeholders during the discussions

CTM Digital and Data Portfolio – Readiness Matrix



How to read the matrix

- Critical commitment
- Follow-on priority
- Core capability
- High Impact initiatives (Either National/Regional /CTM wide priority)

Initiative type	Initiative name
1	LIMS Upgrade
2	RISP Migration
3A	Theatre System (TOMs) - Replatform
3B	Theatre System (TOMs) – Procurement
4	Open Eyes – All Ophthalmology Services
5	WPRS roll out
6	HIR - Hospital Initiated Referral
7	S2T - Straight to Test
8A	Digital System Implementation - Intensive Care System
8B	Digital System Implementation - Pathology & Radiology ETR West
8C	Digital System Implementation - Full implementation of Integrated Women's Health Hub (IWHH)
9A	Demand Capacity Modelling - Entry Points, Demand & Capacity - Power BI dashboard support
9B	Demand Capacity Modelling - Development of Acute Frailty Dashboard to monitor and improve performance - ED module

Type	Initiative name
10A	Llantrisant Health Park - Orthopaedic centre
10B	Llantrisant Health Park - Community Diagnostic Hub
11	Diabetes System Replacement
12	Cyber Resilience and Availability
13A	System Optimisation - System Enhancements
13B	System Optimisation - Decommission Legacy Systems & Relevant Infrastructure
14A	Patient Care - Patient portal
14B	Patient Care - Patient self-referral booking system
15	The FIT (bowel cancer screening test) pathway
16A	PCCTP - Back Scanning of Medical Records and Digitisation - Reduce Notes in Outpatient Appointments - Automation and roll-out
16B	PCCTP - Omni-channel Support - Integrating Text Reminder Solution into Omni-channel System - Call Demand and Capacity Modelling
16C	PCCTP - NHS Wales App
16D	PCCTP - Intouch Patient Check-in System
16E	PCCTP - Implement digital dictation across all areas
17A	Third party collaboration/Innovation - Exploration of RPA and Innovations for Process Improvements
17B	Third party collaboration/Innovation - Develop and embed digital pathways including virtual clinics
18	POA Digital Screening - Pre-operative assessment
19	ED Module
20	ePMA (8500 users) – Phase 1 Rollout Continuation & Phase 2 Implementation
21	Maternity (Badgernet Implementation)
22	Mental Health Single care record
23	The implementation of Cellular Pathology approaches including the use of AI
24	Community-By-Design Plan

CTM Digital and Data Portfolio (1/2)

Sr. No.	Initiative type	Initiative name	Readiness Score
1		LIMS Upgrade	
2		RISP Migration	
3A		Theatre System (TOMs) - Replatform	
3B		Theatre System (TOMs) - Procurement	
4		Open Eyes – All Ophthalmology Services	
5		WPRS roll out	
6		HIR - Hospital Initiated Referral	
7		S2T - Straight to Test	
8A		Digital System Implementation - Intensive Care System	
8B		Digital System Implementation - Pathology & Radiology ETR West	
8C		Digital System Implementation - Full implementation of Integrated Women's Health Hub (IWHH)	
9A		Demand Capacity Modelling - Entry Points, Demand & Capacity - Power BI dashboard support	
9B		Demand Capacity Modelling - Development of Acute Frailty Dashboard to monitor and improve performance - ED module	
10A		Llantrisant Health Park - Orthopaedic center	
10B		Llantrisant Health Park - Community Diagnostic Hub	
11		Diabetes System Replacement	
12		Cyber Resilience and Availability	
13A		System Optimisation - System Enhancements	
13B		System Optimisation - Decommission Legacy Systems & Relevant Infrastructure	
14A		Patient Care - Patient portal	
14B		Patient Care - Patient self-referral booking system	
15		The FIT (bowel cancer screening test) pathway	
16A		PCCTP - Back Scanning of Medical Records and Digitisation - Reduce Notes in Outpatient Appointments - Automation and roll-out	
16B		PCCTP - Omni-channel Support - Integrating Text Reminder Solution into Omni-channel System - Call Demand and Capacity Modelling	
16C		PCCTP - NHS Wales App	
16D		PCCTP - Intouch Patient Check-in System	
16E		PCCTP - Implement digital dictation across all areas	

Initiative type: Critical Commitment | Core Capability | Follow-on Priority

Readiness score: READY TO MOBILISE | PROCEED WITH ACTIVE OVERSIGHT | DE-RISK BEFORE MOBILISING | SEQUENCE FOR LATER DELIVERY

CTM Digital and Data Portfolio (2/2)

Initiative type	Critical Commitment	Core Capability	Follow-on Priority

Sr. No.	Initiative type	Initiative name	Readiness Score
17A		Third party collaboration/Innovation - Exploration of RPA and Innovations for Process Improvements	
17B		Third party collaboration/Innovation - Develop and embed digital pathways including virtual clinics	
18		POA Digital Screening - Pre-operative assessment	
19		ED Module	
20		ePMA (8500 users) – Phase 1 Rollout Continuation & Phase 2 Implementation	
21		Maternity (Badgernet Implementation)	
22		Mental Health Single care record	
23		The implementation of Cellular Pathology approaches including the use of AI	
24		Community-By-Design Plan	

The status of each initiative on the readiness matrix reflects the information available at the time of assessment and should therefore be interpreted as a relative view of delivery readiness rather than a judgement on strategic importance.

In some cases, initiatives may be strategically important or classified as Critical Commitments but still be sequenced for later delivery where scope, ownership, funding, dependencies or delivery requirements remain under development. For example, the ED Module is positioned for later delivery because it is still at an early stage of development and requires further definition before it can progress with confidence.

The same principle applies to Follow-on Priorities such as Community by Design. Although it is expected to progress within the 2026–2029 roadmap, it remains at a relatively nascent stage and therefore requires further work to define the delivery requirements, clarify ownership and dependencies, and address the key risks and enabling conditions identified through the readiness assessment.

The matrix should therefore be viewed as a dynamic portfolio tool. As additional information becomes available and delivery conditions mature, initiative positions can be revisited through the ongoing portfolio review and annual refresh process.

VII

FUTURE DIGITAL & DATA DELIVERY APPROACH



Guided and agile approach (1/2)

CTM's future Digital & Data delivery approach provides a consistent way to move initiatives from an identified service or organisational need through to implementation, adoption and benefits realisation. It is intended to create greater clarity on what is required before delivery begins, focus effort on initiatives that are sufficiently ready to progress, and ensure that implementation is followed through into sustainable change.

The approach applies across critical commitments, core capabilities and follow-on priorities, but should be proportionate to the scale, complexity and maturity of each initiative. Initiatives that already have clear sponsorship, funding, requirements and dependencies should be able to progress without repeating unnecessary discovery, while less mature initiatives may require further preparation before mobilisation.

1. Assess the need

Delivery should begin with a clear understanding of the problem or opportunity being addressed and the outcomes CTM is seeking to achieve. This includes understanding the service/ care group need, strategic relevance, expected value, urgency and any overlap with existing initiatives or capabilities. The aim is to establish why the initiative is needed and what change it is expected to enable before progressing into delivery.

2. Assess delivery readiness

Once the need is established, CTM should assess whether the conditions are in place to deliver successfully.

This includes considering:

- sponsorship and ownership
- funding and workforce capacity
- process and service readiness
- data and digital requirements
- governance and assurance requirements
- internal and external dependencies

The readiness assessment should identify where an initiative can progress and where further work is required to reduce delivery risk.

3. Prioritise and sequence

Need and readiness should then inform the positioning of the initiative within the wider portfolio. Initiatives should be prioritised and sequenced according to strategic importance, expected impact, urgency, readiness, dependencies and available delivery capacity, recognising that not every priority can or should progress at the same time. This enables CTM to maintain a realistic balance between delivering existing commitments, strengthening foundational capabilities and progressing future opportunities.

4. Prepare for delivery

Before mobilisation, any material gaps identified through the readiness assessment should be addressed.

Preparation may include confirming the sponsor and delivery owner, refining digital and data requirements, securing funding and resources and resolving dependencies. The emphasis is on de-risking delivery before significant implementation effort begins.

5. Deliver

Initiatives should then progress through implementation using a delivery approach appropriate to their scale and complexity, with multidisciplinary involvement from Digital & Data, clinical, operational and enabling teams as required. Delivery should maintain visibility of progress, risks, dependencies, resource requirements and emerging issues, while allowing teams to adapt implementation where circumstances change.

Guided and agile approach (2/2)

6. Adopt and embed

Implementation alone does not represent successful delivery. New capabilities need to be incorporated into day-to-day clinical, operational and corporate ways of working. This requires appropriate engagement, training, workflow redesign, communications, operational ownership and transition into sustainable support arrangements. The focus should be on ensuring that the capability is used consistently and becomes part of routine practice.

7. Review delivery performance and learning

Delivery performance should be reviewed at the end of implementation to understand how effectively the initiative was delivered and where lessons can strengthen future delivery. This should consider whether the initiative was delivered against agreed timelines and resource expectations, whether risks and dependencies were managed effectively, whether assurance was completed at the appropriate points, and whether implementation and transition into BAU were achieved smoothly. Any material variance should be understood and lessons captured so that they can inform the preparation, sequencing and delivery of future initiatives across the portfolio.

Intended clinical, operational, workforce or financial benefits should continue to be tracked through the relevant business case and initiative ownership arrangements.

New initiatives entering the portfolio

New Digital & Data needs may emerge through care group and clinical priorities, IMTP planning, the Digital & Data team, national programmes, regulatory requirements or emerging opportunities. These should enter through a consistent portfolio route, with initial consideration of strategic alignment, duplication, sponsorship, expected value and whether further discovery is required.
Where progressed, initiatives should then enter the delivery approach through Assess the Need, before moving through readiness assessment and prioritisation. The associated decision rights, accountabilities and escalation routes are set out within the Governance Model in the following section (refer to Section X).

Annual portfolio review and refresh

The Digital & Data Plan should be formally reviewed each year alongside CTM's wider planning and investment cycle, supported by ongoing portfolio oversight during the year. The review should consider delivery progress, changing strategic priorities, funding, capacity, dependencies, national developments and emerging service needs.
This should enable CTM to confirm, rephase, reclassify, add or retire initiatives, keeping the roadmap realistic and current. The Governance Model provides the ongoing structure through which these decisions are owned, assured, escalated and acted upon, helping the Plan operate as a living portfolio rather than a one-off planning exercise.

Seven-step delivery approach with continuous portfolio oversight

Multiple sources, one portfolio route.

- Care Groups/IMTPs
- Clinical teams
- Digital & Data team
- National requirements (e.g DHCW, P&I)
- Innovation and new opportunities

PORTFOLIO TRIAGE

Initial assessment to confirm need, check for duplication and assess strategic alignment

Outcome

Progress to Stage 1, combine, hold/explore, or do not progress

1	ASSESS THE NEED Why is the initiative needed?	Confirm the problem or opportunity and the expected outcomes
2	ASSESS DELIVERY READINESS Are the conditions in place?	Check ownership, funding capability and key dependencies
3	PRIORITISE & SEQUENCE Where should it sit and when can it progress?	Prioritise based on strategic importance, impact and readiness
4	PREPARE FOR DELIVERY What needs to be in place before mobilisation?	Address remaining requirements and finalise the delivery plan
5	DELIVER WITH CONTROL How will implementation be executed	Implement at pace with visible progress, risk management and assurance
6	ADOPT AND EMBED How will capability become routine practice	Embed into clinical and operational practical with training, support and transition to BAU
7	REVIEW AND LEARN What should we learn from delivery	Assess delivery performance, capture lessons and inform future initiatives

Lessons from initiative delivery inform future readiness and sequencing

ONGOING PORTFOLIO MANAGEMENT (runs alongside the lifecycle)
Monitor delivery, capacity, funding, dependencies and emerging priorities to keep the plan current and deliverable

- Portfolio oversight
- Stakeholder Engagement
- Risk and dependency management
- Alignment with national and organisational priorities

Portfolio decisions, ownership, assurance and escalation are enabled through the Digital & Data Governance Model.

QUARTELY PROTFOLIO HEALTH CHECKS

Review progress, risks, dependencies and emerging issues

ANNUAL PORTFOLIO REFRESH

Reassess and update the three-year plan

Confirm | Reclassify | Retire | Add | Rephase

VIII GOVERNANCE MODEL



Governance model

The Digital & Data Plan governance model provides the structure through which CTM can maintain oversight and control of the Plan as a continuously evolving portfolio beyond the initial three-year period roadmap. It supports timely decision-making, clear accountability, proportionate assurance and appropriate escalation.

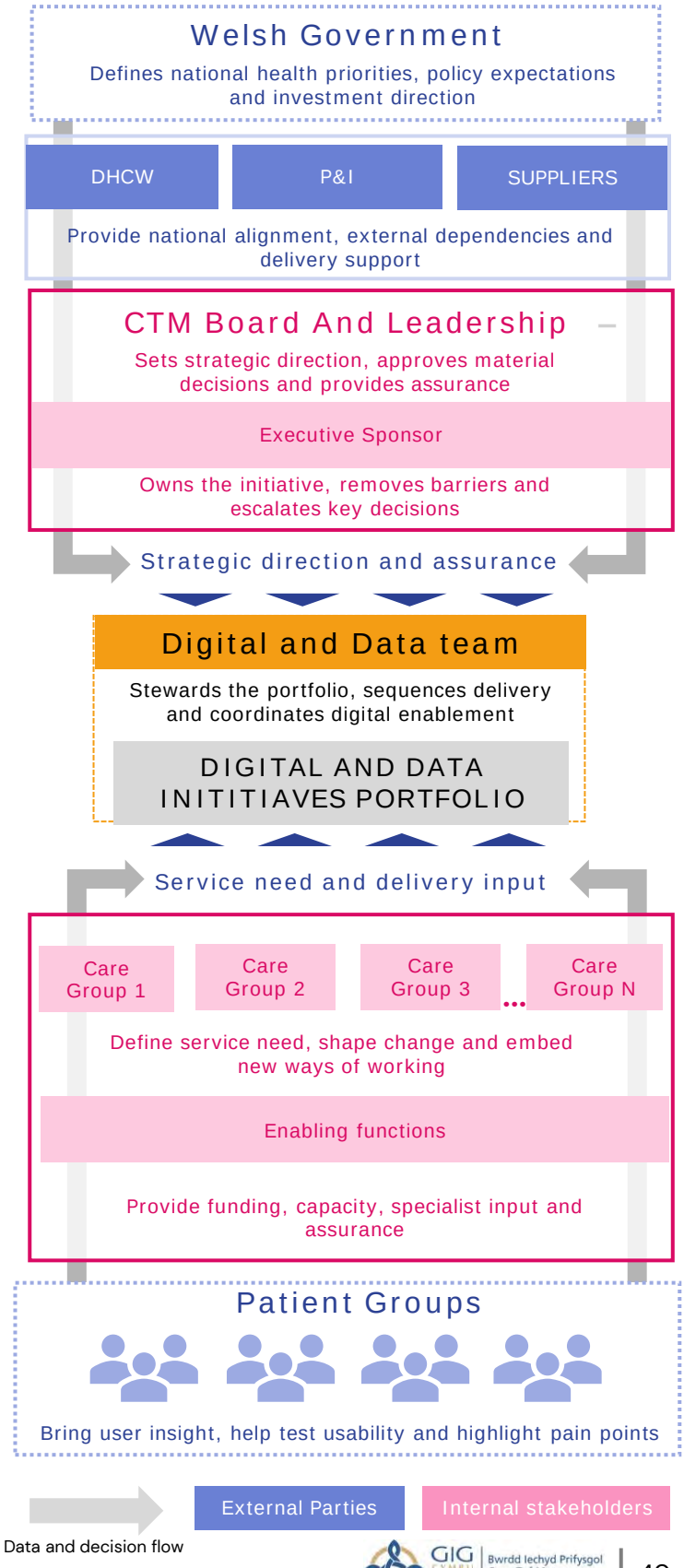
Governance of individual projects and programmes remains the responsibility of the relevant programme or project owner. The portfolio governance model therefore complements, rather than replaces, initiative-level governance.

Governance should enable a clear flow of information, decisions and escalation across CTM and its wider delivery environment. Care groups, clinical teams and enabling functions provide service and delivery input, while patient and workforce groups contribute user insight to inform relevant priorities, design and adoption considerations. The Digital & Data team maintains the integrated portfolio view, Executive Sponsors provide initiative-level accountability, and CTM Board and Leadership provide strategic direction, assurance and decisions on material portfolio matters. National policy, programme requirements and external dependencies should be reflected through engagement with Welsh Government, DHCW, P&I, suppliers and other relevant partners.

Through portfolio governance, CTM can approve, prioritise and sequence initiatives, reclassify or rephase activity as conditions change, escalate material issues or decisions, and retire initiatives where appropriate.

Each governance cycle should result in an updated portfolio position, with confirmed sequencing and funding requirements, agreed ownership and accountabilities, refreshed expected benefits and an updated contribution to CTM's IMTP. The detailed processes for initiative entry, delivery progression and annual refresh are set out within the Future Digital & Data Delivery Approach.

Figure 10.2 Digital and Data Plan Governance Model



How initiatives move through the portfolio

CTM will manage the Digital & Data Plan as a rolling three-year portfolio, bringing together what is already being delivered with opportunities that may enter delivery in future years.

Each planning cycle starts with the current year projects. These are initiatives already within the active portfolio and may be active, on hold, completed or cancelled during the year. Where an initiative is not completed within the current year, it becomes a rollover project and continues into the following year, ensuring that existing commitments remain visible when the next cycle is planned.

Alongside this active portfolio, CTM will maintain a forward-looking pipeline. New or emerging needs enter as pipeline requests, which may arise from service priorities, clinical or operational requirements, national direction, innovation or changes in technology. These requests then move through pipeline refinement and prioritisation, where they are developed and assessed to understand their relevance, readiness, dependencies, expected value and potential timing.

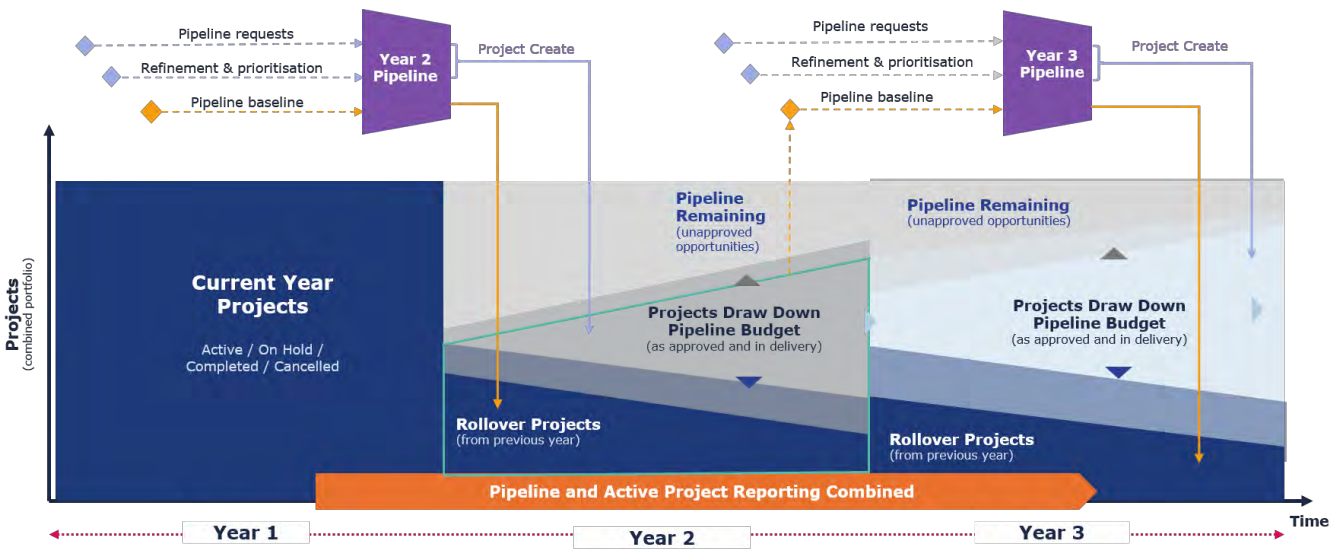
The outcome of this process is reflected in the pipeline baseline, which represents the agreed set of opportunities retained for future consideration at that point in the planning cycle. Where an opportunity is sufficiently developed and there is a clear route to ownership, funding and delivery capacity, it moves through project creation and enters the active portfolio as a delivery initiative.

Not all opportunities will progress immediately. Those that are not yet ready, funded or prioritised remain within the pipeline remaining, where they stay visible for further development or reconsideration in a later cycle. As approved projects enter delivery, they draw on the available pipeline budget and delivery capacity, meaning the balance between active projects, rollover activity and the remaining pipeline changes over time.

This cycle is repeated each year, creating a continuous flow between future opportunities and active delivery. Pipeline and active project reporting are combined so that CTM maintains a single view of what is being delivered now, what is continuing into the next year, and what remains under consideration for future delivery.

In this way, the model supports continuity of delivery while allowing the portfolio to evolve as priorities, readiness, funding, capacity and dependencies change across the three-year Plan.

Figure 10.3 Digital and data pipeline management discipline



How CTM reviews and refreshes the portfolio

Annual assessment and portfolio refresh

The rolling portfolio described on the previous page should be supported by a regular cycle of assessment, prioritisation and decision-making. As part of this cycle, the Digital & Data Plan should be formally reassessed each year alongside CTM's wider planning and investment process, providing an opportunity to review progress, test continued relevance and refresh priorities for the next stage of delivery.

The annual review should consider:

- continued alignment with CTM's strategic priorities and future model of care
- delivery progress and overall portfolio performance
- funding and workforce capacity
- material risks and dependencies
- changes in service/care group need
- national programme developments
- emerging priorities and opportunities

The annual review should enable CTM to confirm the portfolio, rephase or reclassify existing initiatives based on need, add new priorities or retire initiatives where appropriate.

The annual refresh should operate as an active portfolio-management process rather than a reporting exercise, helping CTM maintain a realistic, balanced and deliverable three-year roadmap and avoid continuing initiatives that are no longer sufficiently relevant, viable or deliverable. Quarterly health checks should support this by identifying emerging issues early and informing the formal annual assessment process.

Entry of new initiatives

During delivery of the current plan, new Digital & Data needs may emerge from care groups, clinical teams, corporate functions, the Digital & Data function, national programmes, patient and workforce insight, regulatory requirements or technology lifecycle risks.

These should enter the portfolio through a consistent triage process, considering strategic alignment, urgency, expected value, duplication with existing activity, sponsorship and ownership, affordability and capacity, technology and data requirements, interoperability, dependencies and delivery readiness.

The triage process should determine whether an initiative should be progressed, consolidated with existing activity, held for further development or not taken forward. Where further work is required, this may include additional discovery, evidence gathering or business-case development before a decision is made.

Once approved for inclusion, the initiative should have a clear sponsor and owner, intended outcomes, funding route, requirements, dependencies and indicative timescale. It should then be classified as a critical commitment, core capability or follow-on priority and sequenced within the portfolio.

Ongoing portfolio decisions

As priorities and delivery conditions evolve, governance should support timely decisions to continue, rephase, reclassify or retire initiatives, with material decisions escalated through the appropriate CTM governance route.

What success looks like

Success will be reflected in CTM maintaining a clear, controlled and responsive portfolio, with initiatives progressing at the right pace, material risks and dependencies surfaced early, and decisions taken in a timely way where delivery conditions change. Governance should provide sufficient visibility to support confidence in the roadmap, while allowing the portfolio to be rephased, reclassified, added to or retired as priorities and delivery conditions evolve.

Stakeholder involvement and accountability

Successful delivery of the Digital & Data Plan depends on clear accountability across the organisation. The Digital & Data team provides portfolio stewardship and technical enablement, while strategic, clinical and operational leaders retain accountability for the decisions, service changes and organisational conditions required to deliver the plan

The CTM Board and Executive Leadership Team should provide strategic direction and oversight of the overall portfolio. Their role should include confirming alignment with CTM's strategy, future model of care, and IMTP; approving material investment and portfolio decisions; holding executive sponsors to account; and receiving assurance on portfolio delivery, material risks, clinical safety, cyber resilience, and sustainability.

The Digital & Data team should support the governance of the plan by maintaining the integrated three-year roadmap, initiative register, dependency map, delivery-readiness position, risk profile and delivery and assurance information. The team should also provide the technical leadership and delivery support required across architecture, infrastructure, integration, data, interoperability, cyber security, information governance and clinical safety. In addition, it should coordinate relevant supplier and national dependencies and confirm the ongoing support requirements for each initiative. Operational change, adoption and associated service outcomes should remain the responsibility of the relevant clinical and operational owners.

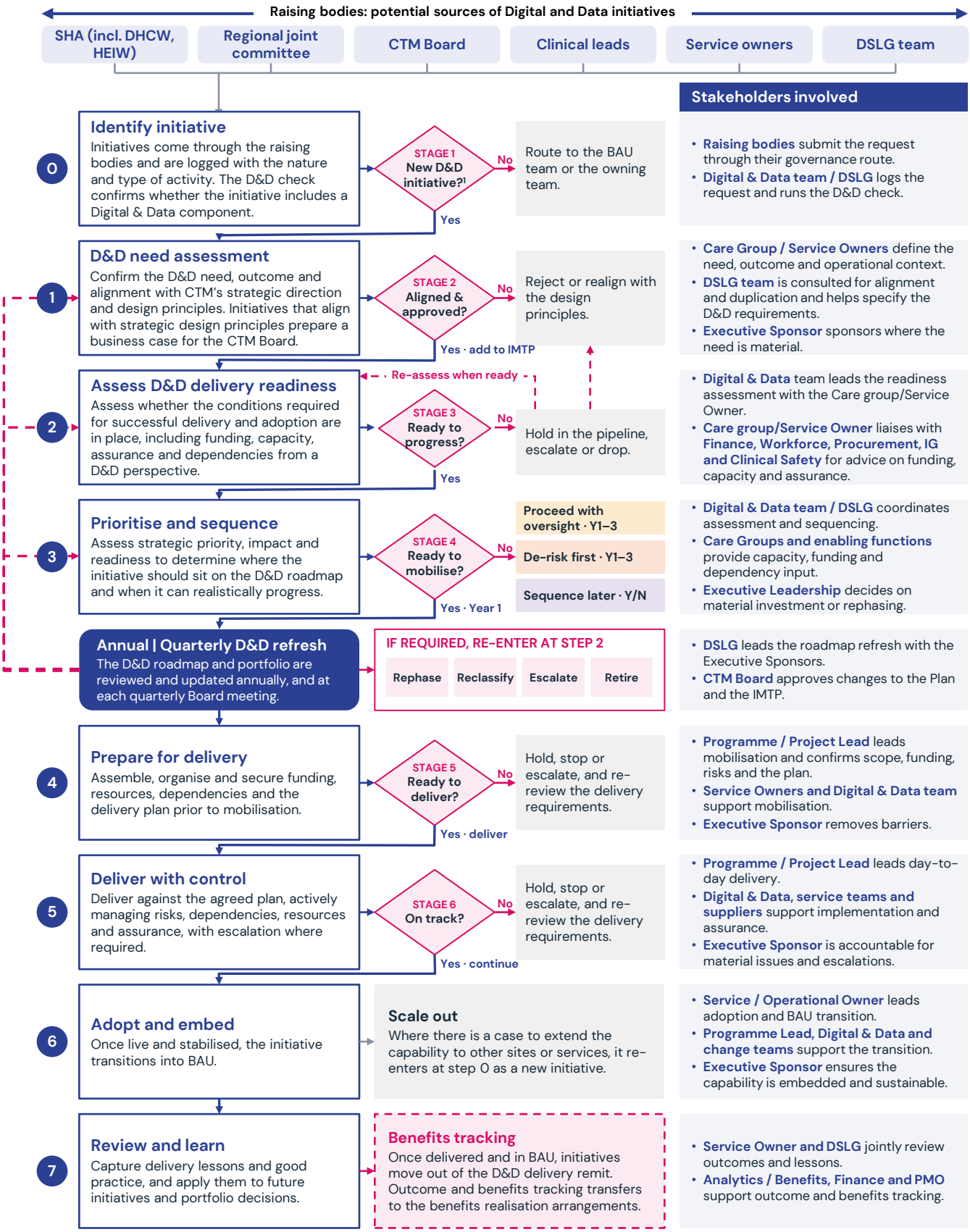
Care group leads/Clinical directorates should identify and surface emerging digital and data needs through IMTP planning or by engaging directly with the Digital & Data team. They should define the service need, confirm clinical and operational requirements, nominate appropriate owners and work with the Digital & Data team to support the delivery-readiness assessment. They should also provide the service-level input required to inform prioritisation and remain accountable for pathway change, adoption and service outcomes within their areas. The group should remain accountable for pathway change, workforce adoption and the service outcomes associated with their initiatives

Enabling functions, including finance, workforce, procurement, communications, quality and information governance, should provide specialist input where their decisions, capacity or assurance are material to delivery, rather than being engaged only at approval or implementation

Patients, communities and workforce representatives should also contribute where initiatives materially affect access, experience, workflow or inclusion. Their involvement should help CTM understand user needs, identify barriers, test whether proposed changes are usable, accessible and working as intended.

Where initiatives depend on DHCW, other NHS Wales bodies, suppliers or external partners, responsibilities and dependencies should be made explicit. External delivery should not dilute CTM's internal accountability, adoption and sustainability.

Proposed governance process for managing CTM wide D&D requirements



[1] New initiative: a new D&D product, system or service, or a refresh, update or extension into a new clinical or service area. Routine support stays BAU.

IX RECOMMENDATIONS AND NEXT STEPS



Translating the Plan into Organisational Action

The Digital & Data Plan will only translate into sustained impact if the delivery approach and governance model are applied consistently across CTM, at both portfolio and initiative level, while the organisation continues to address the current-state challenges identified through this work. The actions below set out the organisational disciplines that will be important to maintain over the life of the Plan.

CTM needs to	Lead and supporting ownership					Expected impact
	CTM Board / Executive Leadership	Executive Sponsor	Care Group / Clinical Leadership	Digital & Data Team	Enabling Functions / External Partners	
Plan together Co-develop Digital & Data needs through IMTP planning, with the Digital & Data team in confidence.			LEAD	LEAD		Better aligned priorities, less duplication and earlier visibility of feasibility, dependencies and capacity.
Mobilise when ready Use delivery readiness assessment* to determine which initiatives can progress now, which need further preparation and which should be sequenced later.		LEAD		LEAD		Fewer initiatives starting before they are ready, reducing avoidable delay, rework and delivery risk.
Manage the portfolio actively Use regular health checks and annual refreshes to rephase, reclassify, add or retire initiatives as priorities and delivery conditions change.	LEAD			LEAD		A roadmap that remains current, realistic and responsive to changing needs and opportunities.
Match ambition to capacity and funding Keep Digital & Data, clinical and operational capacity visible alongside funding and BAU demand.	LEAD			SUPPORT	SUPPORT	More realistic sequencing, better use of resources and fewer initiatives competing for the same capacity.

* refer to delivery approach explained in section IX

Legend: LEAD | SUPPORT

Turning the plan into real action

CTM needs to	Lead and supporting ownership					Expected impact
	CTM Board / Executive Leadership	Executive Sponsor	Care Group / Clinical Leadership	Digital & Data Team	Enabling Functions / External Partners	
Maintain clear ownership Ensure every initiative has a clear executive sponsor, clinical / operational owner and Digital & Data lead, with accountability through delivery and handover.						Faster decisions, clearer accountability and stronger transition into business-as-usual.
Manage dependencies Maintain a single view of key dependencies (across DHCW, suppliers, infrastructure, data and procurement) and actively coordinate across the portfolio.						Earlier visibility of knock-on impacts and more realistic timelines for dependent initiatives.
Strengthen shared foundations Continue to invest in infrastructure, data, interoperability, cyber resilience and lifecycle management to enable current and future initiatives.						Greater resilience, interoperability and reuse of core capabilities, reducing fragmentation across CTM.
Embed adoption and learn Build adoption and change into delivery, capture learning and use it to improve future initiatives.						New capabilities are consistently used, realising their intended value and informing a stronger, more predictable pipeline.

Legend:

X APPENDIX



Table A.01 :

CTM Leadership contributing to the Plan

	Name	Designation
1.	Jonathan Morgan	Chair
2.	Carolyn Donoghue	University
3.	Paul Mears	Chief Executive
4.	Gethin Hughes	Chief Operating Officer
5.	Sally May	Executive Director of Finance
6.	Dr Dom Hurford	Executive Medical Director
7.	Greg Dix	(Former) Executive Director of Nursing, Midwifery and Patient Care
8.	Hywel Daniel	Executive Director of People
9.	Philip Daniels	Executive Director of Public Health
10.	Lauren Edwards	Executive Director of Allied Health Professions and Health Science
11.	Claire Thompson	Executive Strategy Directorate
12.	Matthew Butt	Chief of Staff
13.	Gareth Watts	Director of Governance/Boards Secretary
14.	Kathy Mason	IM, Digital and Data
15.	Stuart Morris	Director of Digital
16.	Rob Bleasdale	Chief Clinical Information Officer/Consultant Cardiologist
17.	Suzanne Rodgers	Asst. Director Digital Transformation
18.	Rob Jones	Head Of Information
19.	Steve Macdonald	Asst. Director Digital Delivery
20.	Aled Holland	Head Of Clinical Systems

Table A.02 :

Clinical stakeholders contributing to plan

Name		Designation
21.	Richard Hughes	Executive Director of Nursing, Midwifery and Patient Care
22.	Simon Blackburn	Director Communications and Engagement
23.	Sarah Follows	Director of Operations, Unscheduled Care
24.	Owen Weeks	Care Group Medical Director (Unscheduled Care)
25.	Zoe Long	Operational Support Manager
26.	Sally Bolt	Care Group Medical Director of DTPS, Consultant Radiologist
27.	Carl Verrecchia	Care Group Service Director
28.	Mohamed Elnasharty	Care Group Director, Consultant obstetrician and gynaecologist
29.	David Andrews	Medical Director for Primary Care
30.	Sarah Bradley	Assistant Director for Primary Care
31.	Brahms Robinson	Mental Health Nursing Information Officer
32.	Sarah Argent	Consultant Child and Adolescent Forensic Psychiatrist
33.	Stephen Sarasin	Care Group Medical Director, Hip and knee surgeon

Table A.03 :

List of documents informing the plan

Sr. No.	Requested document name	Received Document Names
1	Coherent Strategy	CTM Strategy (Interim output)
2	Domain IMTPs	2026- 2029 CTMUHB Plan - draft v. 1.docx
3		IMTP Care Group Priorities DTPS.xlsx
4		IMTP framework 2026-29 plan - internal framework.pptx
5		IMTP investments mapped to risk register v1.pptx
6		MH LD Care Group Priority Template 2026-2027.xlsx
7		PCC Care Group Priority Template 2026-2027 v1.xlsx
8		Planned Care Service-level priorities 2026-27 V1.xlsx
9	Digital and Data IMTPs	Digital Systems PoAP.pptx
10		Digital Transformation - MRPC PoAP.pptx
11		Digital Transformation PoAP - Business Change & Benefits.pptx
12		Digital Transformation PoAP v2 Programmes and Projects.pptx
13		IMTP2627_draft131125.pptx
14	Additional Documents	C&F Care Group Priority Template 202627 DC V10.xlsx
15		Care Group Priority Template 2026-2027 USC.xlsx
16		CTM - Enabling Actions - 26-27 baseline.xlsx
17		Service Plan Expectations for Care Groups Guidance 2026-27.docx
18		Six Goals Health Board Plan 26_27 CTM.docx
19		Full Financial Plan 26-27.docx
20		Summary Financial Plan 26-27.docx
21		Copy of 20260331 - RECEIVED - CTM MDS 2026-27 - numbers added

Table A.04 :

Systems Technologies used to enable CTM 2030

System / Technology	Description	Touchpoint		
		Patient	Clinician	Staff
Shared Care Record	Provides a single, trusted view of patient information across health and care settings, enabling safer and more coordinated care.	✓	✓	✓
Welsh Clinical Portal (WCP)	Gives clinicians access to patient history, clinical documents, results and correspondence through a single clinical portal.		✓	✓
CITO	Provides digital access to clinical documentation and medical records, reducing reliance on paper-based notes.		✓	✓
Philips PACS	Stores and shares diagnostic images (X-ray, CT, MRI and Ultrasound) for rapid review across clinical teams.		✓	✓
BadgerNet	Supports digital maternity records, ensuring pregnancy information is available throughout the care pathway.	✓	✓	✓
ED Nerve center	A mobile-enabled Emergency Department electronic patient record (EPR) that digitises A&E workflows, including triage, clerking, clinical assessments, treatment, patient tracking and discharge. It provides real-time visibility of patient flow, waiting times, departmental capacity and safety escalations, enabling safer, faster and more coordinated emergency care.	✓	✓	✓
Netcall Liberty Converse (Omnichannel Platform)	Delivers consistent communication through telephone, SMS, email, webchat and digital messaging, providing one connected patient contact service.	✓	✓	✓
NHS Wales App	Provides patients with secure digital access to appointments, notifications, health information and NHS services.	✓		
Straight to Test (S2T)	Enables agreed clinicians to request diagnostic investigations directly before a specialist appointment, reducing delays to diagnosis and treatment.		✓	✓

Table A.04 :

Systems Technologies used to enable CTM 2030

System / Technology	Description	Touchpoint		
		Patient	Clinician	Staff
Integrated Clinical Systems	Connects information across clinical applications, reducing duplication and improving care coordination.		✓	✓
Virtual Care (Doccla)	Enables appropriate consultations and specialist reviews to take place remotely where clinically suitable.	✓	✓	
PROMs / PREMs	Collects patient-reported outcomes and experience measures to support ongoing monitoring and service improvement.	✓	✓	✓

Table A.05 :

Opportunities identified from current state

Pillars	Digital	Non-digital
Technology	• Resolve core infrastructure issues (printers, access control, desktop placement) • Ensure hardware/software compatibility (Windows, Synapse) • Digitise test requesting (CT, MRI, Ultrasound)	• Optimise ward/device layouts to support digital-first working
Data and information flow	• Enable secure reporting access and federated data architecture • Improve data quality/coding for AI-readiness • Strengthen CAF/NIST compliance with secure cloud breakout design • Integrate AI-driven summarisation, PROMs automation	• Build organisational capability for data-driven decision-making • Strengthen governance and stewardship of data assets
Processes and ways of working	• Apply reuse-before-buy framework • Explore digital factory/sandbox environment to dry test the probable technology solutions • Deploy RPA for admin workflows (e.g. ultrasound booking) • Embed digital-first BAU processes •	• Standardise initiative intake process (single funnel) • Embed decommissioning discipline in service planning • Strengthen clinical/service ownership of projects • Promote cross-pillar collaboration (digital, clinical, operations) • Use "Plan on a Page" demand tools
Governance	• Implement structured interoperability frameworks • Strengthen cyber compliance (CAF/NIST, secure cloud breakout)	• Establish central PMO with portfolio-level oversight of digital initiatives • Provide clear escalation forums for clinicians and staff to resolve challenges

Table A.05 :

Opportunities identified from current state

Pillars	Digital	Non-digital
Patient and workforce	• Build cross-specialty Digital Champion networks to support adoption • Scale digital skills audits and deliver targeted training in partnership with HEIW and the National Academy • Embed AI into workforce education through pilots, quick guides, and role-specific modules • Promote digital-by-default patient self-management tools (e.g., PIFU, remote monitoring)	• Strengthen visible change management support to reduce resistance and build confidence • Collect systematic patient and staff feedback to inform continuous improvement
Funding model	• Build on LHP as a digital-first exemplar to attract national investment • Pilot innovation-funded AI/RPA use cases with clear evaluation for scale-up • Tight contract management and vendor flexing for existing applications to extract maximum value from existing spend	• Create structured pathways to transition short-term funding into sustainable BAU investment backed by clear benefits realisation

Table A.06 :

Prioritisation Framework (1/2)

	Sphere of Impact Indicates how each initiative drives impact across care delivery settings and enabling functions		
	Non-clinical area of impact Indicates how each initiative enables system-wide delivery through core operational and enabling functions.		
	Workforce	Estates and facility	Admin/Ops
LOW (0)	No impact on workforce capacity, productivity, or experience (backend system changes with no staff-facing benefit)e.g.	No impact on estate utilisation or infrastructure footprint	No impact on operational workflows, duplication, or coordination
MEDIUM (1)	Indirectly supports workforce (e.g., training, digital tools, improved access to information, partial reduction in admin burden)	Improves estate efficiency indirectly (e.g., better scheduling, space utilisation insights, minor optimisation)	Improves operational efficiency (e.g., workflow tools, reporting, reduced duplication in specific functions)
HIGH (2)	Significantly improves workforce productivity and experience (e.g., automation, role redesign, flexible working, reduced admin burden, improved retention)	nables shift in care settings and optimised estate model (e.g., reduced reliance on acute infrastructure, supports community-based care, frees up physical capacity)	Transforms operational delivery (e.g., end-to-end automation, integrated systems, real-time data-driven decision-making, improved coordination across pathways)

Table A.06 :

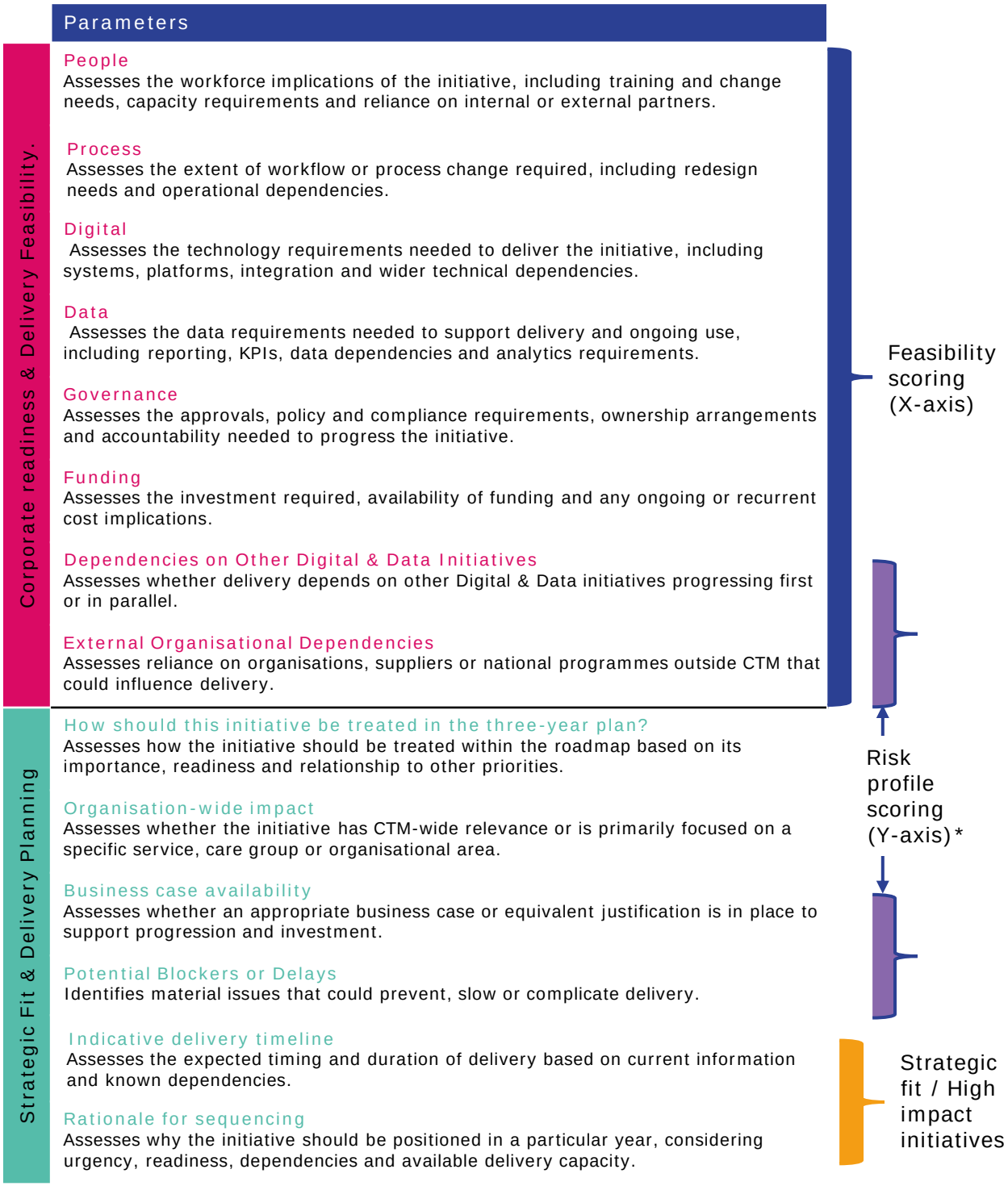
Prioritisation Framework (2/2)

	Sphere of Impact Indicates how each initiative drives impact across care delivery settings and enabling functions.				
	Level of care Indicates how each initiative supports the future model of care across delivery settings.				
	Virtual response	Locality/Bro care	Community urgent response	Diagnostic and treatment platforms	Specialist and emergency hospital care
LOW (0)	No impact on patient access, entry point, or triage (e.g., internal system upgrade with no front-end impact)	No impact on where care is delivered (remains hospital-centric)	No role in ongoing care, recovery, or patient management	No impact on diagnostics or treatment pathways	No impact on hospital demand, flow, or discharge
MEDIUM (1)	Indirectly improves access by enabling services (e.g., workforce training, backend system efficiency, partial digital enablement)	Enables locality-based care indirectly (e.g., shared records, workforce capability, coordination tools)	Supports continuity (e.g., monitoring tools, data sharing, discharge coordination)	Supports diagnostics indirectly (e.g., LIMS upgrade, reporting systems, workforce training)	Improves internal hospital efficiency (e.g., workflow tools, bed management systems)
HIGH (2)	Directly enables or transforms patient access through digital-first channels, triage, navigation, or routing to the right service first time	Directly enables delivery of care closer to home through integrated locality teams and services	Enables proactive, continuous, community-led care models that reduce need for hospital visits	Directly enables decentralised diagnostics/treatment at scale in community/local settings	Reduces unnecessary hospital utilisation and supports safe admission avoidance, flow, and discharge

Table A.07 :

Delivery Readiness Assessment Framework

The Delivery Readiness Assessment Framework was used to assess each initiative consistently across delivery readiness, feasibility, strategic fit and delivery-planning considerations. The outputs from this assessment were then fed into the prioritisation matrix, informing the relative readiness and risk position of each initiative and supporting portfolio prioritisation and sequencing across the three-year roadmap.



Note: Adjusted risk profile used in the matrix is calculated

Table A.08 :

Table of Acronyms

Term	Full form
APIs	Application Programming Interfaces
DSLG	Digital Senior Leadership Group
HEIW	Health Education and Improvement Wales
IWHH	Integrated Women's and Hospital Health services
KPI	Key Performance Indicator
LD	Learning Disabilities
MDS	Minimum Data Set
MH	Mental Health
MRI	Magnetic Resonance Imaging
MRPC	Medical Records and Patient Correspondence
NIST	National Institute of Standards and Technology (cyber framework)
OD	Organisational Development
PCC	Primary and Community Care
PIFU	Patient Initiated Follow Up
PoAP	Point of Access Programme
RACI	Responsible, Accountable, Consulted, Informed
SLGs	Senior Leadership Group
SMS	Short Message Service (text messaging)
UHB	University Health Board
USC	Unscheduled Care

Version 1 June 2026

CTMUHB Public Board

Board Assurance Framework Report – November 2026

Eitem yr Agenda / Agenda Item	7.1
Dyddiad y Cyfarfod / Date of Meeting:	Thursday 26 November 2026
Statws Cyhoeddi / Publication Status:	Open/Public.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Louise Stait, Interim Assistant Director Governance and Risk
Cyflwynydd yr Adroddiad / Report Presenter:	Gareth Watts, Director of Corporate Governance / Board Secretary
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance/Board Secretary
Diben yr Adroddiad / Report Purpose:	For Review
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	The Board is asked to: • Review the updated BAF and confirm that the contents provide adequate assurance and reflect recent discussions.
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol* *Strategic Context:* *This report aligns to the following Strategic Pillars*	All Strategic Pillars This report relates to the Board Assurance Framework as a whole and therefore aligns to all CTMUHB Strategic Pillars.
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan *(Reference relevant priority)*	The Board Assurance Framework supports delivery of the Integrated Medium Term Plan and Annual Delivery Plan by identifying, monitoring and reporting the principal strategic risks that may affect delivery of the Health Board's objectives, priorities and statutory duties.

Crynodeb Gweithredol o'r hyn y mae'r adroddiad yn ei ddisgrifio:
Dechreuwch drwy grynhoi'r wybodaeth bwysicaf yn fyr. Dylai hyn roi dealltwriaeth gadarn o'r pwyntiau allweddol yn erbyn y 3 phennawd canlynol heb ddarllen yr adroddiad llawn:
Executive Summary of what the report is describing:

Start by summarising briefly the most critical information. This should provide a firm grasp of the key points against the following 3 headings without reading the full report:	
Beth *(crynodeb o'r sefyllfa / mater cyfredol a pham ei fod yn bwysig a thystiolaeth i gefnogi'r safbwynt hwnnw ac ati)* What *(summary of current position / issue & why it matters and evidence to support that position etc)*	The Board Assurance Framework sets out the Health Board's principal strategic risks and provides a structured view of the controls, assurance, gaps and mitigating actions in place to manage them. All risks have been reviewed by risk owners and handlers as part of the November 2026 refresh. The November iteration of the BAF has focused on making the presentation of assurance clearer. The sources of assurance for the BAF risks have been reviewed and structured to reflect the "Three Lines of Defence" model: • Management assurance (First Line): evidence generated through the day-to-day management, delivery and monitoring of the services and activities responsible for managing the risk. • Specialist oversight and challenge (Second Line): evidence from specialist functions and governance arrangements providing scrutiny and challenge of how the risk is being managed. • Independent or external assurance (Third Line / External): evidence from Internal Audit, regulators, inspectors, accreditation, external review and other sources sufficiently independent of the management of the risk. *Wider committee scrutiny* During autumn 2026, the BAF has been introduced to the Audit and Risk Assurance Committee (ARAC); the Quality, Safety and Experience Committee (QSEC); and the Operational Delivery Committee (ODC), alongside its established consideration by the Strategic Development Committee. This is intended to strengthen the assurance loop by enabling committees to scrutinise the strategic risks within their respective remits and feed their conclusions into Board consideration.
Felly, beth *(darparu dadansoddiad ystyrlon gan dynnu allan, fel y*	The review of assurance following the Three Lines of Defence model has also highlighted some potential variation across the BAF. Management

bo'n briodol, oblygiadau yn erbyn Strategaeth / Cynlluniau Cyflawni / risgiau Strategol neu Reoleiddiol CTMUHB ac ati ac unrhyw opsiynau ar gyfer mynd i'r afael â'r rhain) So, what *(provide meaningful analysis drawing out as appropriate implications against CTMUHB Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)*	information and internal oversight are generally well represented, but the visibility of independent assurance varies between risks. This does not necessarily represent an assurance gap, but may provide a useful area for further development.
Beth Nesaf *(crynodeb o'r camau gweithredu a fwriadwyd a'r manteision sy'n cefnogi'r dewisiadau a'r argymhelliad(au) sy'n cael eu gwneud)* What Next *(summary of intended action and benefits supporting the choices and recommendation(s)being made)*	Move to quarterly risk reporting in 2027 The BAF and Organisational Risk Register are currently reviewed bimonthly. This is resource intensive and does not align with CTM's quarterly committee cycle. It is therefore planned that both move to quarterly reporting from 2027, enabling each cycle to include Executive review followed by committee scrutiny and, for the BAF, consideration by the Board. The BAF would consequently report to four rather than six formal Board meetings each year. Material changes in strategic risk would continue to be reported between cycles where required.
Argymhelliad *(Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).* Recommendation (Linked to the "What Next" section above).	The Board is asked to: • Review the updated BAF and confirm that the contents provide adequate assurance and reflect recent discussions.

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)* Link to Strategic Risk(s) on the Board Assurance Framework (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	All Strategic Risks on the BAF This report relates to the Board Assurance Framework as a whole and therefore has relevance to all strategic risks included within the BAF.

Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals	All applicable The Board Assurance Framework supports consideration of the Health Board's strategic risks across all relevant Wellbeing Goals. Individual strategic risk entries identify specific implications where relevant.

Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	All applicable The Board Assurance Framework supports oversight of strategic risks that may affect all Enablers of Quality. The specific relevance of each enabler is reflected within individual strategic risk entries where appropriate.

Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental Sustainability Impact (5Rs)	Yes - Applicable This report is an assurance update and does not propose any service change or operational decision. Environmental and sustainability implications are considered within individual strategic risks where relevant.

Asesiad Effaith Impact Assessment	
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg *(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)* Equality & Welsh Language Impact Assessment Outcome *(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)*	No separate Equality & Welsh Language Impact Assessment has been undertaken as this report provides an assurance update and does not propose a new policy, service change or decision. Equality & Welsh Language implications are considered within individual strategic risks where relevant. Named Executive/Board member sign off for no EWLIA completion: Executive Sponsor: Director of Corporate Governance / Board Secretary
Canlyniad Asesiad Effaith Ansawdd *(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)* Quality Impact Assessment Outcome	No separate Quality Impact Assessment has been undertaken as this report provides an assurance update rather than proposing a service change or operational decision. Quality implications are reflected within individual strategic risks where relevant.

(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)	
Cyfreithiol / Legal	Yes (Include further detail below) Legal and regulatory implications are captured within individual strategic risk entries where relevant.
Enw da / Reputational	Yes (include further detail below) The BAF is a key public assurance document. Reputational implications therefore arise from ensuring that the Health Board's principal strategic risks are accurately reflected and appropriately reported.
Effaith Adnoddau *(Pobl /Ariannol)* / Resource Impact *(People / Financial)*	Yes (include further detail below) This report does not request additional resources. Workforce, financial and other resource implications are considered within individual strategic risks where relevant.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Strategic risk owners and risk handlers	Oct-Nov 2026	Updates requested to support the September 2026 BAF refresh.
Executive Leadership Group, Board and Committees	Various	Previous iterations of the BAF have been reviewed through the established governance cycle. The document is iterative and continues to respond to Executive, Board and Committee feedback.
Executive Leadership Group	16 Nov 26	Review, scrutiny and management sign-off of the November 2026 iteration of the BAF.

Acronyms / Glossary of Terms	
BAF	Board Assurance Framework
CTMUHB	Cwm Taf Morgannwg University Health Board
ELG	Executive Leadership Group
IMTP	Integrated Medium Term Plan
P&I	Performance and Improvement

This summary provides an accessible overview of the Health Board's principal strategic risks against the four CTM 2030 strategic goals, and the current level of assurance over how they are being managed. It is intended to support Board and Committee discussion by highlighting the most significant gaps, the progress being made to address them, the factors that continue to limit assurance, and the expected direction of travel.

The summary should be read alongside the full Board Assurance Framework, which provides the detailed risk descriptions, controls, sources of assurance, actions and supporting evidence. It does not replace the full framework or seek to reproduce all of its content.

Risk no	Strategic Goal	Key strategic gaps we are addressing	Current score	Target Score	Target Score Date	Current Status September 2026; and Risk Treatment
	Creating Health / Creu Iechyd *Reducing health inequalities; Equal focus on mental and physical health; Supporting our communities; Being a healthy organisation*					
Four BAF risks are assigned to "Creating Health". All four of these BAF risks are also assigned to "Sustaining Our Future". Risk 11 is also assigned to "Improving Care"						
4	Effective Community and Partner Engagement in Service Changes and Developments Lead: Director of Communication, Engagement & Fundraising Committee: Strategic Development Committee	Gap 1: A consistent and embedded approach to engagement related to service change is not yet fully established across the Health Board Gap 2: Capacity within the engagement function remains insufficient to fully support organisational and population engagement requirements Gap 3: Digital engagement, insight and social listening capability is not yet sufficiently developed to support modern engagement approaches Gap 4: Regional engagement approaches and messaging are not yet fully co-ordinated across partner organisations	16 (C4xL4)	8 (C4xL2)	Dec 2026	Progress has been made through development of the Service Change SOP and the Maesteg/Llynfi Valley engagement programme (August 2026 onwards) represents a significant shift in public engagement. The Orlo platform for social media management, social listening and campaigning and surveying has been implemented, and training is underway to maximise its value. Recruitment of the Public Health Engagement Lead has been completed with post holder due to start in November. With these mitigations recently delivered the impact upon the risk is anticipated to be realised within the calendar year. Risk treatment: Treat with elements tolerated.
7	Fulfilling our environmental and social duties and ambitions Lead: Executive Director of Strategy & Transformation Committee: Strategic Development Committee	Gap 1: Climate adaptation and organisational preparedness for climate change are not yet fully embedded Gap 2: Decarbonisation and sustainable decision-making are not yet fully embedded across procurement, estates and organisational planning Gap 3: Capacity and investment remain insufficient to fully deliver environmental sustainability and decarbonisation ambitions	16 (C4xL4)	8 (C4xL2)	2030	The risk continues to be actively managed through the Climate Action Plan, decarbonisation programme, sustainability initiatives and partnership arrangements. Progress continues to be made, including through renewable energy, energy-efficiency and wider sustainability initiatives. However, the scale of change required remains significant and the pace of delivery is constrained by available capacity and investment. The current target score of 8 by 2030 remains challenging and will be reviewed to ensure that the target and timeframe remain realistic in light of available resources and the anticipated pace of delivery. Risk treatment: Treat with elements tolerated.
8	Prevention and early intervention to support healthy life expectancy Lead: Executive Director of Public Health Committee: Strategic Development Committee	Gap 1: Health Protection and Immunisation capacity remains insufficient to fully deliver its contribution to the Health Board's wider prevention and population health priorities. Gap 2: Population Health Management capability and infrastructure are not yet sufficiently developed to support population-based planning and intervention. Gap 3: A whole-system approach to prevention and inequalities with sufficient associated resource, is not yet fully embedded across the Health Board and partner organisations.	20 (C5xL4)	8 (C4xL2)	TBC	The risk is actively managed through population health, prevention, health protection and partnership programmes, with continued development of strategic frameworks and targeted interventions. However, the latest population health data continue to show declining Healthy Life Expectancy and worsening inequalities across the CTM population. While progress is being made in programme delivery, this is not yet translating into sustained improvement in population-level outcomes. Population Health Management capability, Health Protection capacity and whole-system delivery also require further development. Addressing this risk will require sustained, long-term action across the Health Board and its partners, including a greater focus of resources and services on prevention and earlier intervention Risk treatment: Treat with elements tolerated.

Risk no	Strategic Goal	Key strategic gaps we are addressing	Current score	Target Score	Target Score Date	Current Status September 2026; and Risk Treatment
11	**Delivery of an Integrated Care Model** Lead: Chief Operating Officer Committee: Strategic Development Committee	Gap 1: Digital and information-sharing infrastructure is not yet sufficiently developed to support integrated care. Gap 2: The evidence base and delivery model for sustainable primary and community care requires further development. Gap 3: System integration and partnership arrangements are not yet sufficiently mature to deliver a fully integrated model of care.	16 (C4xL4)	12 (C4xL3)	TBC	The risk is actively managed through integrated care transformation programmes and regional partnership arrangements. Progress continues in developing integrated models of care and joint working across the system, with greater certainty over the continuation of key regional funding streams providing some additional stability. Further work is required to embed operational and digital integration, sustainable primary and community care models, and more effective system-wide planning and decision-making. Risk treatment: Treat with elements tolerated.
Improving Care / Gwella Gofal *Delivering safe and compassionate care; Developing new models of care; Digital transformation for patients and staff; Ensuring timely access to care*						
All risks are assigned to “Improving Care” except for 4, 7, 8, 9						
1a	**Enough capacity to meet elective demand** Lead: Chief Operating Officer Committee: Quality, Safety & Experience Committee; and Operational Delivery Committee	Gap 1: Digital systems supporting planned care pathways are not yet fully developed or integrated. Gap 2: Cancer tracking and speciality-specific elective data remain insufficiently robust to support performance oversight and early intervention. Gap 3: Elective recovery and service redesign initiatives are not yet fully embedded across all specialties.	16 (C4xL4)	12 (C4xL3)	2030	Planned care performance continues to improve, supported by additional Welsh Government funding and associated capacity. This has strengthened the Health Board's position against national planned-care requirements, although challenges remain across some specialties and pathways. The current risk score of 16 has been retained while the sustainability of the improved position is assessed, including the extent to which additional capacity is recurrent. The next review will also consider the appropriate balance between current performance, longer-term sustainability, the Board's risk appetite and its wider ambitions for planned care. Risk treatment: Treat with elements tolerated.
1b	**Enough capacity to meet emergency demand** Lead: Chief Operating Officer Committees: Quality, Safety & Experience Committee; and Operational Delivery Committee	Gap 1: Urgent and emergency care improvement actions are not yet fully embedded or delivering sustained improvements in performance	20 (C4xL5)	12 (C4xL3)	2030	The risk continues to be actively managed through urgent and emergency care improvement programmes and whole-system actions to improve patient flow, discharge and access to care. Whilst progress continues and the overall trajectory is positive, sustained demand, workforce pressures and patient flow challenges continue to constrain emergency care performance. Further improvement is required before sufficient assurance can be obtained that capacity is consistently able to meet emergency demand and support a reduction in risk score. Risk treatment: Treat with elements tolerated.
2	**Ability to deliver improvements which transform care and enhance outcomes** Lead: Executive Director of Nursing / Executive Medical Director Committees: Quality, Safety & Experience Committee and Operational Delivery Committee	Gap 1: Quality intelligence and assurance arrangements are not yet fully integrated to provide a comprehensive and timely organisational view of quality, safety and performance. Gap 2: Ward assurance, safeguarding and related quality governance arrangements require further development and consistent embedding to provide reliable assurance across all services and settings. Gap 3: Organisational learning, improvement and feedback arrangements are not yet consistently embedded, and the impact of improvement activity is not always systematically measured or demonstrated. Gap 4: Concerns, complaints, redress and legal services arrangements require further strengthening to provide timely resolution, organisational learning and sustainable assurance.	16 (C4xL4)	12 (C4xL3)	TBC	The foundations of the quality management framework are largely in place, with progress made in strengthening governance, oversight and assurance. The remaining challenge is to embed these arrangements consistently across the organisation and demonstrate sustained impact. As this work matures, assurance is expected to strengthen and the risk score to reduce over time. Risk treatment: Treat
See also under “Inspiring People” and “Sustaining our Future”: Risk 3: Enough workforce to deliver the activity and quality ambitions of the organisation						

Risk no	Strategic Goal	Key strategic gaps we are addressing	Current score	Target Score	Target Score Date	Current Status September 2026; and Risk Treatment
5	Delivery of a digital and information infrastructure to support organisational transformation Lead: Director of Digital Committees: Operational Delivery Committee and Strategic Development Committee	Gap 1: Digital capability and adoption are not yet sufficiently mature to enable transformation at scale Gap 2: Digital workforce capacity and sustainable funding remain insufficient to deliver the required pace of transformation Gap 3: Digital maturity remains below the level required to fully support integrated, data-driven and digitally enabled models of care	16 (C4xL4)	12 (C4xL3)	TBC	The risk continues to be actively managed through delivery of digital transformation, infrastructure, cyber improvement programmes and regulatory compliance. Whilst progress is being made and the overall trajectory is cautiously positive, the risk remains elevated due to workforce and funding constraints, legacy systems, national dependencies and the evolving cyber threat landscape. Further progress is required before digital capability, capacity and resilience are sufficiently embedded to support a reduction in risk score. Risk treatment: Treat with elements tolerated.
6	Ability to maintain a safe and fit for purpose estate infrastructure Lead: Executive Director of Finance Committee: Operational Delivery Committee	Gap 1: National Skills shortage in Estates Roles (Private sector salaries are impacting the CTMUHB's ability to be competitive in the recruitment market) results in staffing challenges to deliver the estates functions. Gap 2: Backlog maintenance requirements continue to exceed available resources and funding. Gap 3: Available capital and revenue funding remains insufficient to maintain and improve the existing estate. Gap 4: Estate improvement works must be delivered whilst maintaining safe and uninterrupted services.	16 (C4xL4)	12 (C4xL3)	2031	We continue to actively manage this risk and expect improvement over time through prioritised capital investment and maintenance programmes; however, progress is constrained by limited capital availability and the scale of backlog maintenance, meaning the pace of risk reduction is currently limited. Risk treatment: Treat with elements tolerated.
10	Ability to develop a fit for the future estate to reflect our future clinical service model Lead: Executive Director of Finance Committee: Strategic Development Committee	Gap 1: A long-term estate strategy aligned to the future clinical service model is not yet fully developed. Gap 2: Sufficient capital funding has not yet been secured to deliver capital schemes.	16 (C4xL4)	8 (C4xL2)	2031	The risk is actively managed through strategic estate planning, development of major capital schemes and alignment with the emerging Clinical Services Plan. Whilst preparatory work and business case development continue, progress remains dependent on completion of the future clinical model and the availability of capital funding. Further progress is required before the Health Board can be assured that future estate requirements are fully understood and deliverable. Risk treatment: Treat with elements tolerated.
See also under "Creating Health" and "Sustaining our Future" – Risk 11 Delivery of an Integrated Care Model						
Inspiring People / Ysbrydoli Pobl *Visible and inspiring leadership; Promoting diversity and inclusion; Embedding our values and behaviours; Encouraging local employment*						
There is one BAF risk assigned to "Inspiring People". This risk is also assigned to "Improving Care" and "Sustaining our Future"						
3	Enough workforce to deliver the activity and quality ambitions of the organisation *(Including Culture, Values and Behaviours)* Lead: Executive Director for People Committees: Quality, Safety & Experience Committee and Operational Delivery Committee	Gap 1: Workforce planning is not yet consistently aligned to future organisational priorities, service transformation programmes and regional workforce requirements, limiting our ability to proactively shape the future workforce. Gap 2: Workforce deployment, productivity, digital systems and workforce intelligence capabilities are not yet sufficiently mature to optimise capacity, quality, efficiency and affordability. Gap 3: Recruitment, retention and attendance arrangements are not yet consistently delivering a sustainable, resilient and engaged workforce, resulting in workforce supply pressures and variable workforce experience. Gap 4: Organisational values, behaviours and approaches to staff experience are not yet consistently embedded across the	16 (C4xL4)	8 (C4xL2)	March 2029	This risk continues to be treated through targeted action under the CTM People Plan, workforce planning, recruitment, retention, and wellbeing, and productivity programmes. A reduction is expected over time, but remains constrained by national workforce supply, sickness absence, variable pay, affordability pressures and the pace of service change. Risk treatment: Treat with elements tolerated.

Risk no	Strategic Goal	Key strategic gaps we are addressing	Current score	Target Score	Target Score Date	Current Status September 2026; and Risk Treatment
		Health Board, impacting engagement, wellbeing, leadership culture and organisational performance.				
	Sustaining Our Future / Cynnal Ein Dyfodol *Becoming a green organisation; Ensuring our services' financial sustainability; Embedding value-based healthcare; Ensuring our estate is fit for the future*					
All BAF risks are assigned to "Sustaining Our Future" as well as also being assigned to other objectives. There is one BAF risk which is assigned to "Sustaining Our Future" but not assigned to any other objectives: Risk 9						
9	Failure to deliver a sustainable plan and manage revenue resources within the Revenue Resource limits set by Welsh Government (WG) Lead: Executive Director of Finance Committee: Operational Delivery Committee	Gap 1: Understanding of budgetary control and procurement processes in some services Gap 2: A recognised risk of shortfalls in savings delivery	20 (C4xL5)	12 (C4xL3)	TBC	We are actively managing this risk and expect progress through delivery of the IMTP and savings programmes; however, the level of financial challenge and delivery risk remains significant. The approved plan was to have a sustainable underlying position by 31 March 2027. As at Month 6 this is unlikely; this therefore remains a challenging target in the current financial climate. Risk treatment: Treat

Risk no	Strategic Goal	Strategic / Principal Risk	Lead(s) for this risk	Assurance committee	Current score	Target Score	Target Score Date	Risk Treatment /Status Update November 2026
1.	Improving Care, Sustaining our Future Click Here for Risk 1a Click Here for Risk 1b	a) Enough capacity to meet elective demand	Chief Operating Officer	Quality, Safety & Experience Committee and Operational Delivery Committee	16 (C4xL4)	12 (C4xL3)	2030	Treat with elements tolerated. Planned care performance continues to improve, supported by additional Welsh Government funding and associated capacity. This has strengthened the Health Board's position against national planned-care requirements, although challenges remain across some specialties and pathways. The current risk score of 16 has been retained while the sustainability of the improved position is assessed, including the extent to which additional capacity is recurrent. The next review will also consider the appropriate balance between current performance, longer-term sustainability, the Board's risk appetite and its wider ambitions for planned care.
		b) Enough capacity to meet emergency demand			20 (C4xL5)	12 (C4xL3)	2030	Treat with elements tolerated. The risk continues to be actively managed through urgent and emergency care improvement programmes and whole-system actions to improve patient flow, discharge and access to care. Whilst progress continues and the overall trajectory is positive, sustained demand, workforce pressures and patient flow challenges continue to constrain emergency care performance. Further improvement is required before sufficient assurance can be obtained that capacity is consistently able to meet emergency demand and support a reduction in risk score.
2.	Improving Care, Sustaining our Future Click Here for Risk 2	Ability to deliver improvements which transform care and enhance outcomes	Executive Director of Nursing / Executive Medical Director	Quality, Safety & Experience Committee and Operational Delivery Committee	16 (C4xL4)	12 (C4xL3)	TBC	Treat. The foundations of the quality management framework are largely in place, with progress made in strengthening governance, oversight and assurance. The remaining challenge is to embed these arrangements consistently across the organisation and demonstrate sustained impact. As this work matures, assurance is expected to strengthen and the risk score to reduce over time.
3.	Sustaining our Future, Improving Care and Inspiring People Click Here for Risk 3	Enough workforce to deliver the activity and quality ambitions of the organisation *(Including Culture, Values and Behaviours)*	Executive Director for People	Quality, Safety & Experience Committee and Operational Delivery Committee	16 (C4xL4)	8 (C4XL2)	March 2029	Treat with elements tolerated. This risk continues to be treated through targeted action under the CTM People Plan, workforce planning, recruitment, retention, and wellbeing, and productivity programmes. A reduction is expected over time, but remains constrained by national workforce supply, sickness absence, variable pay, affordability pressures and the pace of service change.
4.	Creating Health, Sustaining our Future Click Here for Risk 4	Effective Community and Partner Engagement in service changes and developments	Director of Communication, Engagement & Fundraising	Strategic Development Committee	16 (C4xL4)	8 (C4xL2)	Dec 2026	Treat with elements tolerated. Progress has been made through development of the Service Change SOP and the Maesteg/Llynfi Valley engagement programme (August 2026 onwards) represents a significant shift in public engagement. The Orlo platform for social media management, social listening and campaigning and surveying has been implemented, and training is underway to maximise its value. Recruitment of the Public Health Engagement Lead has been completed with post holder due to start in November. With these mitigations recently delivered the impact upon the risk is anticipated to be realised within the calendar year.

5.	Improving Care, Sustaining our Future Click Here for Risk 5	Delivery of a digital and information infrastructure to support organisational transformation	Director of Digital	Operational Delivery Committee and Strategic Development Committee	16 (C4xL4)	12 (C4xL3)	TBC	Treat with elements tolerated. The risk continues to be actively managed through delivery of digital transformation, infrastructure, cyber improvement programmes and regulatory compliance. Whilst progress is being made and the overall trajectory is cautiously positive, the risk remains elevated due to workforce and funding constraints, legacy systems, national dependencies and the evolving cyber threat landscape. Further progress is required before digital capability, capacity and resilience are sufficiently embedded to support a reduction in risk score.
6.	Improving Care, Sustaining our Future Click Here for Risk 6	Ability to maintain a safe and fit for purpose estate infrastructure	Executive Director of Finance	Operational Delivery Committee	16 (C4xL4)	12 (C4xL3)	2031	Treat with elements tolerated. We are actively managing this risk and expect improvement over time through prioritised capital investment and maintenance programmes; however, progress is constrained by limited capital availability and the scale of backlog maintenance, meaning the pace of risk reduction is currently limited
7.	Sustaining our Future, Creating Health Click Here for Risk 7	Fulfilling our Environmental and Social Duties and ambitions	Executive Director of Strategy & Transformation	Strategic Development Committee	16 (C4xL4)	8 (C4xL2)	2030	Treat with elements tolerated. The risk continues to be actively managed through the Climate Action Plan, decarbonisation programme, sustainability initiatives and partnership arrangements. Progress continues to be made, including through renewable energy, energy-efficiency and wider sustainability initiatives. However, the scale of change required remains significant and the pace of delivery is constrained by available capacity and investment. The current target score of 8 by 2030 remains challenging and will be reviewed to ensure that the target and timeframe remain realistic in light of available resources and the anticipated pace of delivery.
8.	Creating Health, Sustaining our Future Click Here for Risk 8	Prevention and early Intervention to support Healthy Life Expectancy	Executive Director of Public Health	Strategic Development Committee	20 (C5xL4)	8 (C4xL2)	TBC	Treat with elements tolerated The risk is actively managed through population health, prevention, health protection and partnership programmes, with continued development of strategic frameworks and targeted interventions. However, the latest population health data continue to show declining Healthy Life Expectancy and worsening inequalities across the CTM population. While progress is being made in programme delivery, this is not yet translating into sustained improvement in population-level outcomes. Population Health Management capability, Health Protection capacity and whole-system delivery also require further development. Addressing this risk will require sustained, long-term action across the Health Board and its partners, including a greater focus of resources and services on prevention and earlier intervention
9.	Sustaining our Future Click Here for Risk 9	Failure to deliver a sustainable plan and manage revenue resources within the Revenue Resource limits set by Welsh Government (WG)	Executive Director of Finance	Operational Delivery Committee	20 (C4xL5)	12 (C4xL3)	TBC	Treat. We are actively managing this risk and expect progress through delivery of the IMTP and savings programmes; however, the level of financial challenge and delivery risk remains significant. The approved plan was to have a sustainable underlying position by 31 March 2027. As at Month 6 this is unlikely; this therefore remains a challenging target in the current financial climate.
10.	Sustaining our Future, Improving Care Click Here for Risk 10	Ability to develop a fit for the future estate to reflect our future clinical service model	Executive Director of Finance	Strategic Development Committee	16 (C4xL4)	8 (C4xL2)	2031	Treat with elements tolerated. The risk is actively managed through strategic estate planning, development of major capital schemes and alignment with the emerging Clinical Services Plan. Whilst preparatory work and business case development continue, progress remains dependent on completion of the future clinical model and the availability of capital funding. Further progress is required before the Health Board can be assured that future estate requirements are fully understood and deliverable.

11.	Creating Health, Sustaining our Future, Improving Care  Click Here for Risk 11	Delivery of an Integrated Care Model	Chief Operating Officer	Strategic Development Committee	16 (C4xL4)	12 (C4xL3)	TBC	Treat with elements tolerated. *November 2026:* The risk is actively managed through integrated care transformation programmes and regional partnership arrangements. Progress continues in developing integrated models of care and joint working across the system, with greater certainty over the continuation of key regional funding streams providing some additional stability. Further work is required to embed operational and digital integration, sustainable primary and community care models, and more effective system-wide planning and decision-making.

Section 2 Strategic Risk Heat Map

Current risk scores in black

Target risk scores in *grey italic*

Consequence						
	5				8	
	4		*3,4,7,8,10*	*1a,1b,2,5,11,9*	1a,2,3,4,5,6,7,10,11	1b, 9
	3				*6*	
	2					
	1					
CxL		1	2	3	4	5
		Likelihood				

Strategic Goal(s):	Risk score 16
Improving Care • Delivering safe and compassionate care • Developing new models of care • Digital transformation for patients and staff • Ensuring timely access to care • Sustaining Our Future • Becoming a green organisation • Ensuring our Services financial sustainability Embedding value-based healthcare • Ensuring our estate is fit for the future	

Strategic Risk: Enough capacity to meet elective demand - (Risk No.1a)

If the Health Board is unable to meet demands for services at all points in the patient journey.	*Then* its ability to provide high quality and affordable care and to meet access targets will be reduced	*Resulting in* avoidable harm to patients, poor patient experience, diminished staff morale, and loss of trust and confidence from the wider community, ongoing overspends.

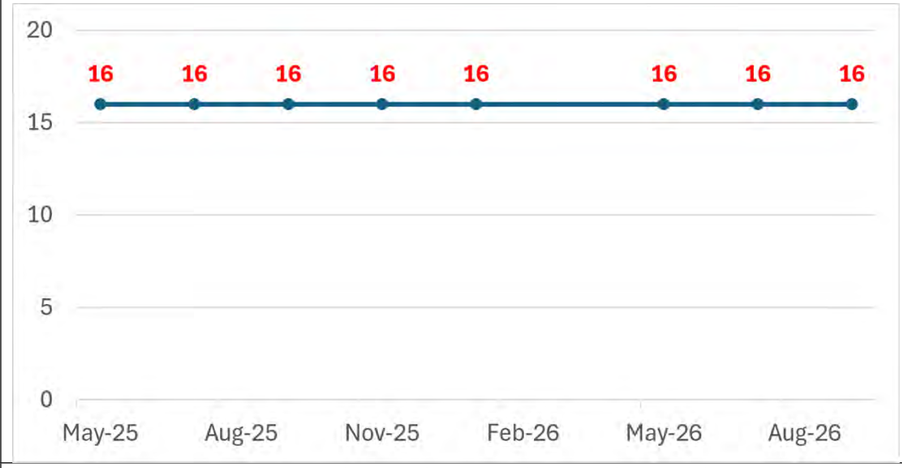
Risk Lead	• Chief Operating Officer • Executive Director of Strategy & Transformation	Assurance committee	• Quality, Safety & Experience Committee • Operational Delivery Committee (Performance Targets)

	Consequence	Likelihood	Score
Initial	4	5	20
Current	4	4	16
Target	4	3	12
Risk Appetite	Cautious *(quality and safety; trust and confidence; legal and regulatory)*		

Risk Score Trend this Period:

No change to risk scores this period.

Risk Score Trajectory



Rationale for assessment of risk score:
Including where risk score remains unchanged and for any changes

The risk score remains unchanged at 16 (C4xL4). Positive progress continues across a number of planned care, cancer and productivity improvement programmes, with sustained improvements in performance and capacity management. However, significant operational, workforce and capacity pressures remain, preventing a reduction in the risk score at this stage.

Key progress during this period includes:

- Cancer performance has remained above the 60% Suspected Cancer Pathway (SCP) target, resulting in automatic de-escalation to Level 1 routine monitoring. CTMUHB has maintained the

	top position in Wales for four consecutive months and an updated trajectory has been submitted. With Junes positing being 64.9% the highest achieved to date. • Progress has continued in reducing long waits, with all specialties aiming to maintain waits below 104 weeks, with the exception of Orthopaedics and Neurology. Welsh Government have confirmed funding to support ~~Phased funding is being released to support~~ the 104 delivery by March 2027. CTMUHB are currently working with the region to deliver this. • The Health Board's outpatient improvement programme has achieved zero patients waiting longer than 52 weeks, although Neurology waits transferred from Cardiff and Vale University Health Board continue to influence overall performance. • All theatres are now operational across the three acute hospital sites, supported by a revised theatre timetable introduced in April 2026 based on demand and capacity modelling. • Improvements have been made in theatre start times and in the use of See on Symptom (SOS) and Patient Initiated Follow-Up (PIFU) pathways. • The Orthopaedic Elective Unit at Princess of Wales Hospital continues to support dedicated elective activity, while consolidation of cataract surgery within the Princess of Wales Eye Unit has strengthened standardisation and delivery of High Volume Low Complexity (HVLC) pathways. • An increased focus on Ophthalmology productivity to achieve HVLC lists has commenced. • An Endoscopy Recovery Plan has been implemented to maintain recent improvements in performance. With additional weekend capacity commencing in September 2026. • The Productivity, Improvement and Transformation (PIT) Board has been refocussed on delivery of key specialty actions, including further implementation of SOS and PIFU pathways. • Continuous improvement has been demonstrated against elective demand trajectories across a range of services, including Mental Health and Learning Disabilities. However, the risk remains elevated due to: • Continued growth in patients waiting over 104 weeks, driven primarily by the recurring gap in Orthopaedics capacity and transfer of Neurology pathways from Cardiff and Vale University Health Board. • Routine operational pressures that continue to constrain elective capacity and reduce resilience during periods of increased demand. • Workforce recruitment challenges and reduced reliance on Additional Hours (ADH) and Waiting List Initiative (WLI) activity as pay arrangements are standardised. • The planned capital programme at Prince Charles Hospital, which will temporarily reduce theatre capacity while mitigation measures are developed. • Dependence on partner organisations, with financial and workforce pressures across local authority and third-sector services impacting the Health Board's ability to maintain capacity and patient flow. • The need to continuously evaluate both the opportunities and challenges arising from regional working arrangements. Whilst progress continues and the overall trajectory remains positive, further sustained improvement is required before the Health Board can demonstrate that elective capacity is sufficient to consistently meet demand and support a reduction in the risk score.
Risk Treatment Assessment *i.e. Treat, Tolerate, Transfer etc.*	It is recognised that there is an element of tolerating this risk in terms of the pace in being able to mitigate it. There are, however, ongoing risk treatment activity outlined in the mitigating actions section.

Current Control Measures
1. Strategic Planning and Improvement Programmes A suite of strategic programmes is in place to increase elective capacity, improve productivity and deliver planned care transformation in line with national policy and organisational priorities.

- Productivity, Improvement and Transformation (PIT) Programme.
- Planned Care Recovery Programme.
- Clinical Services Plan.
- Integrated Medium Term Plan (IMTP).
- National Planned Care Programme.
- Specialty-specific improvement trajectories.

2. Demand and Capacity Management

Processes are in place to manage demand, prioritise patients according to clinical need and optimise the use of available capacity across the organisation.

- Annual Demand and Capacity Plan.
- Waiting list management arrangements.
- Centralised utilisation of available capacity.
- Demand and capacity modelling.
- Interventions Not Normally Undertaken (INNU) application processes.
- Recovery planning and seasonal planning arrangements.

3. Elective Capacity and Service Transformation

A range of service redesign and capacity initiatives support delivery of elective care and reduce waiting times.

- Endoscopy insourcing arrangements.
- Elective surgery reconfiguration.
- Regional Ophthalmology Service arrangements.
- Additional theatre capacity, including the South Theatre at Royal Glamorgan Hospital.
- Theatre optimisation initiatives.
- Llantrisant Health Park development proposals.
- Cross-cutting improvement programmes covering theatres, diagnostics, outpatients, pre-assessment and therapies.

4. Governance and Programme Oversight

Formal governance arrangements oversee delivery of planned care recovery, performance improvement and service transformation.

- Improving Care Board.
- Operational Services Management Board.
- Planned Care Recovery Board / Planned Care Recovery Operations Board.
- Cancer Board.
- Six Goals / Unscheduled Care Board.
- Innovation Board.

5. Regional Partnerships and System Working

Partnership arrangements support integrated planning, pathway redesign and system-wide approaches to improving patient flow and elective performance.

- Regional Partnership Board programmes.
- Partnership Leadership Team.
- Commissioning Group.
- South East regional recovery programmes.
- Regional pathology collaboration.
- Partnership working with local authorities to improve discharge and patient flow.

Sources of Assurance (Internal and External)

Assurance is drawn from a range of management information, specialist oversight and independent review. These broadly reflect the Three Lines of Defence model and, taken together, provide evidence about elective performance, delivery of recovery plans and the impact of capacity pressures on quality and safety.

Management assurance (First Line)

Evidence generated through the day-to-day management and operation of the services responsible for managing the risk.

- Integrated Performance Report
- Assessment Dashboard and associated performance information
- Referral to Treatment and Cancer trajectories
- Planned Care Recovery reporting
- Productivity, Improvement and Transformation (PIT) Programme reporting
- Planning, Performance and Finance monthly reporting
- specialty-specific performance and improvement reporting, including areas experiencing particular pressure
- Care Group performance reviews
- harm reviews relating to the impact of waiting and delays
- Organisational and Care Group Risk Registers.

Specialist oversight and assurance (Second Line)

Evidence from specialist functions and arrangements which provide oversight, scrutiny and challenge of how the risk is being managed.

- organisational performance review and escalation arrangements
- Tactical Intervention arrangements where additional oversight is required
- review and escalation of patient safety impacts arising from planned care pressures
- programme-level scrutiny of Planned Care Recovery and PIT delivery
- monitoring and follow-up of patients not booked and other identified areas of pathway concern.

Independent assurance (Third Line / External)

Evidence from sources sufficiently independent of the management of the risk to provide objective review and challenge.

Independent and external assurance is provided through relevant national performance oversight, benchmarking and review arrangements. Opportunities to strengthen and more clearly identify independent assurance relating specifically to elective capacity will be considered as the BAF develops.

Key assurance findings this period

Current assurance demonstrates progress in several areas, including cancer performance, outpatient recovery and planned care improvement activity. The overall assurance picture remains mixed, with recovery uneven across specialties and continuing capacity constraints in some pathways. Taken together, the available assurance supports the current assessment of the risk but does not yet provide sufficient evidence of sustained improvement to support a reduction in the risk score.

Gaps in Controls / Assurances	Actions taken to Mitigate Gaps	Intended Impact of Mitigating Actions	Actual Impact of Actions (following implementation)
1. Digital systems supporting planned care pathways are not yet fully developed or integrated.	Actions already taken • Digital dictation consolidation and standardisation. • Consultant Connect implementation. • Use of Attend Anywhere to support virtual activity. • Progression of Welsh Patient Referral Service (WPRS) rollout. Further actions required / in progress • Digital pre-assessment system. • Theatre system optimisation. • Digital outpatient system implementation. • Continued reduction in manual processes. • Progress Patient Contact Centre work to address multiple booking processes and improve appointment-related digital contact.	• Improved monitoring of speciality utilisation and non-compliance. • Reduced missed opportunities within planned care pathways. • Reduced referral demand through improved pathway management. • Reduced waiting lists. • Reduced cancellations and non-attendance.	Digital developments to date have improved access to virtual activity, strengthened pathway management and increased visibility of speciality utilisation and performance. Improvements in digital processes and system standardisation are beginning to support reductions in missed opportunities and more effective management of referral demand and waiting lists, However, further development of digital outpatient and pre-assessment systems is required before the full benefits can be realised.

	• Continue digital and administrative validation of waiting-list cohorts, prioritised by clinical risk and length of wait		
2. Cancer tracking and speciality-specific elective data remain insufficiently robust to support performance oversight and early intervention.	Controls already in place • Weekly performance meeting • Training undertaken for all cancer trackers to ensure consistency and compliance with new guidance Further actions required / in progress • Implementation of online escalation process for all patients outside of agreed component waiting times. • CANISC (Cancer Network Information System Cymru) replacement ongoing. • Implementation of Breast, Urology & lower GI datasets • Maintain weekly validation of the 62-day cancer backlog to prevent patients moving back into backlog. • Continue patient-level tracking and escalation of pathology and tertiary referrals, and progress disaggregation of the Swansea Bay pathology SLA, beginning with Dermatology • Use the £450,000 endoscopy allocation to support in-sourcing and weekend activity, alongside focused pathway work including prostate.	• Improved performance oversight and earlier identification and escalation of pathway risks. • Improved visibility of pathway performance and waiting list management. • Sustained Suspected Cancer Pathway (SCP) performance above 60%. • Reduction in waiting list backlog across cancer and elective pathways. • Improved consistency, accuracy and robustness of speciality-specific elective data. • Full implementation of new datasets and escalation processes to support timely intervention and decision-making.	Improvements in cancer tracking arrangements, performance oversight and staff training have strengthened the identification and escalation of pathway risks. Sustained performance against the Suspected Cancer Pathway and increased focus on waiting list management have contributed to reductions in backlog across a number of services. However, further work is required to fully embed new datasets and enhance the reliability of speciality-specific elective data.
3. Elective recovery and service redesign initiatives are not yet fully embedded across all specialties.	Actions already complete • Regional Ophthalmology service expansion Further actions required / in progress • Trauma service reconfiguration. • Completion of theatre workforce recruitment. • Continued business continuity arrangements (ongoing). • Clinical Services Plan development. • Deliver the planned care recovery schemes supported by the nearly £11m allocation, covering more than 500 outsourced and 212 insourced patients. • Coordinate regional procurement for outsourcing to support value and avoid price escalation between Health Boards. • Continue theatre-efficiency improvement, anaesthetic recruitment and workforce realignment, with activity and financial impacts monitored together. • Continue weekly senior-nurse discharge reviews across acute, discharge-liaison and community teams to identify patients earlier for community pathways and improve flow	• Increase in activity • Reduced fallow sessions • Reduction in waiting times Reduction in >104 week wait across all specialities except that with a recurring gap.	Elective recovery initiatives have increased activity and supported reductions in waiting times across a number of specialties. Progress has been made in reducing the number of patients waiting over 104 weeks and improving elective capacity through service reconfiguration and additional workforce support. However, improvements remain uneven and are not yet fully embedded across all pathways, particularly where recurring capacity challenges remain.

Linked National Priority Measures
Access to Timely Planned Care • Number of patients waiting more than 104 weeks for treatment; • Number of patients waiting more than 36 weeks for treatment; • Percentage of patients waiting less than 26 weeks for treatment; • Number of patients waiting over 104 weeks for a new outpatient appointment; • Number of patients waiting over 52 weeks for a new outpatient appointment; • Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%; • Number of patients waiting over 8 weeks for a diagnostic endoscopy; and • Percentage of patient starting their first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route).
Current Performance Highlights
Detailed RTT and elective performance information is reported separately through the Integrated Performance Report and Planned Care Recovery reporting arrangements. Current performance demonstrates ongoing progress in cancer performance, outpatient recovery and elective capacity initiatives; however, challenges remain in reducing long waits and sustaining sufficient capacity across all specialties.
Were there any significant incidents affecting this strategic Risk this period:
None
Associated Risks escalated to the Organisational Risk Register
Strategic Gap 1: Digital systems supporting planned care pathways are not yet fully developed or integrated
No directly aligned ORR risks are currently escalated. This gap is being managed through planned care improvement, digital development and pathway modernisation programmes.
Strategic Gap 2: Cancer tracking and speciality-specific elective data remain insufficiently robust to support performance oversight and early intervention.
No directly aligned ORR risks are currently escalated. This gap is managed through performance improvement arrangements, cancer tracking processes, data quality initiatives and planned care governance.
Strategic Gap 3: Elective recovery and service redesign initiatives are not yet fully embedded across all specialties.

4491	Failure to meet demand across the patient pathway resulting in system-wide pressure on care delivery. *This risk reflects wider capacity, flow and demand pressures affecting the Health Board's ability to reduce waiting times and sustain planned care recovery.*	16
6294	Insufficient consultant workforce in endoscopy and gastroenterology. *This risk reflects the challenges associated with maintaining sufficient specialist capacity to support timely diagnosis, treatment and elective recovery*	20
6280	Suspension of the Regional Hepato-Pancreato-Biliary Service Model. *This risk reflects the impact of regional service dependencies and commissioning arrangements on timely access to specialist planned care pathways.*	16
5045	Insufficient neurology capacity impacting timely access to services. *This risk reflects the ongoing impact of workforce shortages, diagnostic constraints and inherited waiting list pressures on elective performance and long waits.*	16

Strategic Goal(s):		Risk score
Improving Care • Delivering safe and compassionate care • Developing new models of care • Digital transformation for patients and staff • Ensuring timely access to care •	Sustaining Our Future • Becoming a green organisation • Ensuring our Services financial sustainability Embedding value-based healthcare • Ensuring our estate is fit for the future	20
Strategic Risk: Enough capacity to meet emergency demand - (Risk No.1b)		
If the Health Board is unable to meet demands for services at all points in the patient journey.	*Then* its ability to provide high quality and affordable care and to meet access targets will be reduced	*Resulting in* avoidable harm to patients, poor patient experience, diminished staff morale, and loss of trust and confidence from the wider community, ongoing overspends.

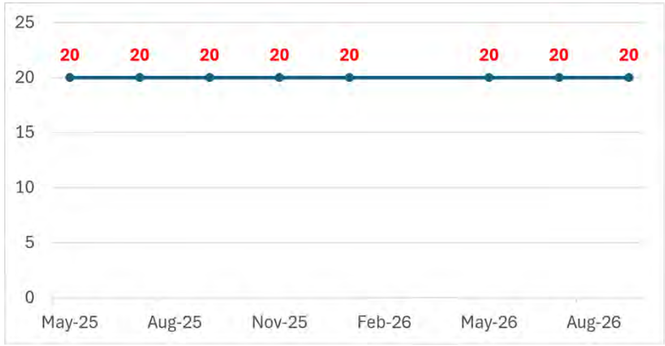
Risk Lead	• Chief Operating Officer	Assurance committee	• Quality, Safety & Experience Committee • Operational Delivery Committee (Performance Targets)

	Consequence	Likelihood	Score
Initial	4	5	20
Current	4	5	20
Target	4	3	12
Risk Appetite	Cautious *(quality and safety; trust and confidence; legal and regulatory)*		

Risk Score Trend this Period:

No change to risk scores this period.

Risk Score Trajectory



Rationale for assessment of risk score: *Including where risk score remains unchanged and for any changes*	The risk score remains unchanged. Whilst progress continues across ~~a number of~~several urgent and emergency care improvement programmes, significant system pressures remain which continue to constrain patient flow, emergency care performance and service resilience. Key progress during this period includes: • Improvements against ~~a number of~~several urgent and emergency care trajectories, including 45-minute ambulance handover performance, 12-hour Emergency Department performance and a reduction in lost ambulance hours. • Continued development of clinical pathways and operational arrangements to support emergency demand and maintain service resilience. • Progress in workforce recruitment and the ongoing development of sustainable staffing models across urgent and emergency care services. • Continued regional collaboration and whole-system working to support patient flow and access to care.

	However, the risk remains elevated due to: • The ongoing impact of temporary changes to stroke service provision and associated effects on capacity across the wider system. • Reconfiguration of bed capacity and continued diversion of emergency admissions between sites, placing additional pressure on operational resilience. • A high number of clinically optimised patients remaining within core bed capacity, impacting patient flow and timely access to care. • Capacity constraints within partner organisations, including local authority and third-sector services, which continue to affect discharge pathways and whole-system flow. • Workforce pressures, alongside a reduction in Additional Hours (ADH) and Waiting List Initiative (WLI) activity associated with pay standardisation arrangements. • Continued financial, workforce and environmental constraints affecting the pace of improvement. Whilst the overall trajectory is positive and improvement continues in a number of key performance measures, further sustained progress in patient flow, capacity management and whole-system working is required before the Health Board can demonstrate that emergency care capacity is sufficient to consistently meet demand and justify a reduction in the risk score.
Risk Treatment Assessment *i.e. Treat, Tolerate, Transfer etc.*	It is recognised that there is an element of tolerating this risk in terms of the pace in being able to mitigate it. There are, however, ongoing risk treatment activity outlined in the mitigating actions section.

Current Control Measures

Urgent & Emergency Care Improvement Programme

The Health Board's approach is aligned to the National Urgent and Emergency Care (UEC) Improvement Plan and associated local improvement programmes. Key areas of focus include:

- Strengthening community capacity and alternatives to admission.
- Single Point of Access (SPoA) providing central coordination.
- Improving patient flow and discharge across the UEC pathway.
- Improving patient safety and reducing harm associated with delays.
- Delivering consistent models of care, including front-door and frailty pathways.
- Improving demand and capacity management.
- Supporting workforce development, data utilisation and quality improvement.
- CTMUHB System Flow Operating Model developed and endorsed through the UEC Improvement Programme, providing a single Health Board approach to operational delivery, quality assurance, escalation and improvement from ward to board. This is supported by a System Flow Dashboard/intelligence platform and a bronze, silver and gold command-and-control framework to strengthen operational grip, standardise flow and discharge practice, and provide clearer escalation of barriers.

Governance and Oversight

A comprehensive governance framework is in place to oversee urgent and emergency care performance and improvement activity, including:

- Improving Care Board.
- Operational Management Board.
- UEC Programme Board / Unscheduled Care Board.
- Urgent and Emergency Care Collaborative (including STAMP).
- Programme Boards for key service areas including Stroke, Diabetes, Frailty and Orthogeriatric services.
- Project Boards including SDEC, UTC, Single Point of Access and FLS.

Operational Performance and Capacity Management

A range of operational controls support the management of urgent and emergency care pressures, including:

- Annual demand and capacity planning.
- Seasonal and winter resilience planning.

- Escalation and business continuity arrangements.
- Centralised management of capacity across the organisation.
- Clinically led prioritisation processes.
- Service recovery planning following periods of operational pressure.
- Interventions Not Normally Undertaken (INNU) arrangements where required.

Regional Working and System Collaboration

The Health Board works with regional partners to support patient flow, discharge and integrated care arrangements, including:

- Partnership Leadership Team arrangements with Local Authority and NHS partners.
- Regional commissioning arrangements.
- Regional programmes supporting patient flow and discharge pathways.
- Development of alternatives to admission and Discharge to Recover then Assess (D2RA) pathways.
- Collaborative work to address delays for patients medically fit for discharge.

Service Improvement and Transformation

A programme of service transformation is in place to improve urgent and emergency care pathways across the Health Board, including:

- Strategic Transformation of Acute Medicine Programme (STAMP).
- Stroke Improvement Programme
- Reduce waiting times for patients in Emergency Departments
- Single Point of Access developments.
- Same Day Emergency Care (SDEC) developments
- Optimise and Frailty programmes.
- Orthogeriatric improvement initiatives.
- Specialty-specific improvement trajectories.

Sources of Assurance (Internal and External)

Assurance is drawn from a range of management information, specialist oversight and independent review. These broadly reflect the Three Lines of Defence model and, taken together, provide evidence about urgent and emergency care performance, patient flow, delivery of improvement actions and the resilience of services.

Management assurance (First Line)

Evidence generated through the day-to-day management and operation of the services responsible for managing the risk.

- Integrated Performance Report
- Assessment Dashboards and operational performance information
- Directorate and Care Group performance reviews
- urgent and emergency care performance trajectories
- UEC Programme reporting
- Same Day Emergency Care Programme reporting
- Optimise Programme reporting
- Ambulance Handover and Emergency Department Improvement Plan monitoring
- service-specific performance and improvement reporting, including Stroke
- Organisational and Care Group Risk Registers.

Specialist oversight and assurance (Second Line)

Evidence from specialist functions and arrangements which provide oversight, scrutiny and challenge of how the risk is being managed.

- Executive Integrated Performance review
- organisational performance and escalation arrangements
- Targeted Intervention meetings and associated improvement monitoring
- specialist scrutiny of urgent and emergency care improvement plans and trajectories
- oversight of areas subject to increased operational pressure or intervention.

Independent assurance (Third Line / External)

Evidence from sources sufficiently independent of the management of the risk to provide objective review and challenge.

- Audit Wales Urgent and Emergency Care review

- national performance monitoring and external trajectory review arrangements, where these provide independent scrutiny
- regional scrutiny through the South-Central Stroke Operational Delivery Group, where this provides review or challenge independent of CTM's operational management arrangements.

Key assurance findings this period

Current assurance demonstrates progress against some urgent and emergency care measures, including ambulance handover performance, alongside continued development of arrangements to improve patient flow and service resilience. However, assurance also continues to demonstrate significant pressures, including prolonged Emergency Department waits, variation across sites and continuing system-wide constraints on flow and discharge. Improvement actions are therefore not yet sufficiently embedded or sustained to support a reduction in the current risk score of 20.

Gaps in Controls / Assurances	Actions taken to Mitigate Gaps	Intended Impact of Mitigating Actions	Actual Impact of Actions (following implementation)
1. Urgent and emergency care improvement actions are not yet fully embedded or delivering sustained improvements in performance	Completed actions / controls in place • Urgent Emergency Care Action Plan developed using recommendations from national reviews and guidance. • Unscheduled Care Transformation Programme established, supported by governance through the Single Point of Access Board and wider health board oversight arrangements. • ED Flow Action Cards introduced, including monitoring of patient handovers, triage times, first assessment and reducing 12-hour waits. • Ambulance escalation arrangements implemented and ED 12-hour Action Plan completed. • Urgent Care Summit and whole-system improvement work undertaken to agree priorities for patient flow, discharge and admission avoidance. • Service redesign commenced through STAMP, Same Day Emergency Care development and reconfiguration of emergency care pathways and capacity. Further actions in progress • Review and implement the Safe Transfer of Patients Policy and associated actions. • Complete work to reduce the length of stay for patients in Emergency Departments, specifically patients >12hrs. • Progress implementation of Strategic Clinical Services Plan priorities and Pathway 1 redesign. • Further develop Extended Emergency Medicine Ambulatory Care (EEMAC). • Continue whole system work to improve admission avoidance, discharge processes and patient flow. • Embed improvement actions through the Unscheduled Care Transformation Programme and monitor delivery against performance measures.	• Improved urgent and emergency care performance. • Reduction in 12-hour waits and delayed patient handovers. • Improved patient flow across the whole system. • Reduced length of stay in the Emergency Department. • Reduced risk of harm associated with prolonged waiting times. • Improved patient experience and outcomes. • More sustainable emergency care arrangements and capacity management.	As of September 2026, actions completed to date have strengthened governance, coordination and oversight of urgent and emergency care improvement. Improved performance monitoring arrangements are in place through ED Flow Action Cards and escalation processes, with greater organisational focus on patient flow, admission avoidance, discharge planning and emergency care capacity. Service redesign work has commenced across a number of pathways, providing a foundation for sustainable improvement, although performance remains inconsistent and improvements are not yet fully embedded across the health board.

Linked National Priority Measures

Ministerial Measures:

Access to Timely USC Services

- Zero patients >45 mins ambulance handover by March 2027
- Continuous improvement of patients waiting >12-hours and not exceed 1000 by March 2027

Access to Timely Planned Care Services in USC

As per Planned Care BAF

Current Performance Highlights

Detailed operational performance information is reported separately through the Integrated Performance Report and specialist programme governance arrangements. The Board Assurance Framework focuses on the strategic implications of current performance and the effectiveness of actions being taken to address the risk.

Current Performance Highlights (September 2026)

- Performance against the continuous improvement trajectory for patients waiting over 12 hours remains below the level required to provide full assurance that the risk is effectively controlled. Prolonged waits within emergency care settings continue to present significant operational, quality and strategic challenges.
- The ambulance handover improvement trajectory for patients waiting over 45 minutes was delivered, providing evidence of progress against one of the key national priority measures.
- Improvement trajectories are in place, and some indicators demonstrate positive progress; however, variation remains across sites and further work is required to fully embed changes and deliver consistent improvement.
- Delivery of urgent and emergency care improvement programmes continues to be monitored through established governance, performance and escalation arrangements.
- Whilst progress has been made in a number of areas, sustained improvement in patient flow, emergency care performance and whole-system resilience remains necessary before the Health Board can demonstrate sufficient assurance that the risk is reducing towards the desired level.

Were there any significant incidents affecting this strategic Risk this period:

September 2026: The intent of the Stroke Service temporary arrangement is to support service resilience, enable more effective use of the available specialist workforce, and maintain access to stroke assessment, treatment and inpatient care while workforce recovery actions continue. Although recruitment progress and return from maternity leave have provided some improvement, the consultant workforce remains fragile, with two substantive consultants currently on restricted duties and further maternity leave in place. As a result, the service continues to operate with limited resilience, and this remains a significant risk to sustainable stroke service delivery.

Associated Risks escalated to the Organisational Risk Register

Strategic Gap 1: Urgent and emergency care improvement actions are not yet fully embedded or delivering sustained improvements in performance.		
4491	Failure to meet demand across the patient pathway resulting in system-wide pressure on care delivery. *This risk reflects wider system pressures across urgent, emergency, inpatient and community services, including the impact of discharge delays, workforce constraints and whole-system capacity challenges on patient flow and emergency demand.*	16
5045	Insufficient neurology capacity impacting timely access to services. *This risk reflects the impact of non-delivery of certain aspects of the LTA with CAV ~~of~~ which is impacting on long waiting times, access to diagnostic and specialist care.~~workforce shortages, diagnostic constraints and~~ long waiting times on service capacity and timely access to care, contributing to wider pressures across the patient pathway.*	16
4632	Inability to deliver timely, high-quality stroke care across CTM. *This risk reflects continuing challenges associated with providing timely access to specialist stroke assessment, treatment and rehabilitation, including workforce, pathway and system capacity constraints*	16
3826	Emergency Department overcrowding impacting patient safety and quality of care. *This risk reflects the ongoing impact of patient flow, capacity and discharge pressures on Emergency Department performance, patient experience and delivery of national performance standards.*	15

Strategic Goal(s):		Risk score
Improving Care • Delivering safe and compassionate care • Developing new models of care • Digital transformation for patients and staff • Ensuring timely access to care	Sustaining Our Future • Becoming a green organisation • Ensuring our Services financial sustainability Embedding value-based healthcare • Ensuring our estate is fit for the future.	16

Strategic Risk: Ability to deliver improvements which transform care and enhance outcomes (Risk No.2)		
If the Health Board fails to achieve fundamental quality standards or implement improvements in practice and innovations	*Then* we may not be able to deliver safe, timely, compassionate and effective care in accordance with the Duty of Quality	*Resulting in* avoidable harm to patients, poor patient experience, diminished staff morale, potential for greater regulatory intervention and loss of trust and confidence

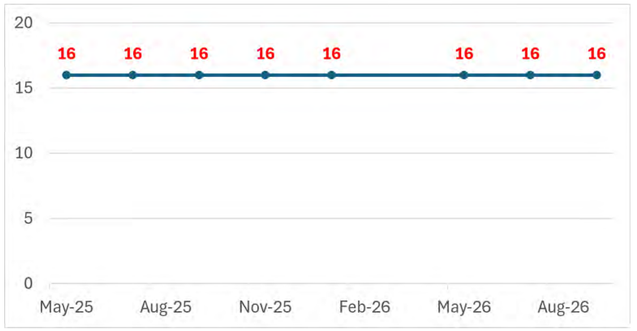
Risk Leads	• Executive Nurse Director • Executive Medical Director	Assurance committee	• Quality, Safety & Experience Committee • Operational Delivery Committee

	Consequence	Likelihood	Score
Initial	4	5	20
Current	4	4	16
Target	4	3	12
Risk Appetite	Cautious *(quality and safety; trust and confidence; legal and regulatory)*		

Risk Score Trend this Period:

No change to risk scores this period.

Risk Score Trajectory



Rationale for assessment of risk score: *Including where risk score remains unchanged and for any changes*	The risk score remains unchanged at 16. A wide range of quality improvement, patient safety, governance, learning and innovation arrangements remain in place and continue to provide assurance. However, the organisation recognises that further work is required to strengthen the framework, improve outcome-focused measures and ensure that assurance can be demonstrated consistently across all elements of this risk. The current score therefore remains appropriate while this work progresses. Work has taken place this cycle to strengthen the articulation of this risk to provide clearer lines of accountability, more meaningful controls and measurable indicators of improvement against the Duty of Quality. This review includes rationalisation of controls and assurances, clearer identification of gaps, and a stronger focus on evidencing how improvement activity contributes to safer, more timely, effective and compassionate care.

	The Executive Director of Nursing, Midwifery and Patient Care, will be leading a strategic reconfiguration of the Board Assurance Framework for this section to enable more meaningful and measurable objectives that directly influence our ability to reduce the current Duty of Quality risk score to an organisationally tolerated level. This work is essential to ensure that our approach to quality is not only compliant but impactful supporting the delivery of safe, timely, compassionate and effective care. Without this shift, we risk avoidable harm to patients, poor experience, diminished staff morale, increased regulatory scrutiny and erosion of public trust. The revised framework will provide a clearer pathway to improvement, accountability and assurance. Work on the revised framework is ongoing, with progress continuing beyond the original March 2026 deadline to ensure a comprehensive and effective outcome. Upon completion, the framework will provide an enhanced structure for improvement, strengthened accountability, and clearer assurance arrangements
Risk Treatment Assessment *i.e. Treat, Tolerate, Transfer etc.*	CTM is actively treating this risk through established quality, safety, improvement, governance and innovation programmes. The current programme of work is focused on strengthening organisational assurance, embedding continuous improvement and ensuring that quality outcomes can be measured more consistently across the organisation. CTM continues to target a risk score of 12, representing a level of risk that is considered organisationally tolerable. Achievement of this target will depend on evidence that the relevant controls are operating consistently and that learning and improvement are reducing the recurrence of avoidable incidents and harm. The target and target date will remain under review in light of this evidence and the effect of wider system dependencies.

Current Control Measures

Our current control measures can be grouped into five main themes:

1. Quality Governance and Strategic Frameworks
   - Duty of Quality and Duty of Candour arrangements.
   - Clinical Governance Frameworks, policies and Standard Operating Procedures (SOPs).
   - Infection Prevention and Control Strategy.
   - Safeguarding Strategy.
   - Clinical Effectiveness Committee.
   - Medicines Management governance arrangements.
2. Quality Assurance and Patient Safety
   - Mortality governance arrangements.
   - Harm Free Care Programme.
   - Ward Assurance Programme.
   - RADAR (Risk Assessment, Delivery and Assurance Review) governance arrangements.
   - Executive Patient Safety Walkabouts.
3. Learning, Experience and Engagement
   - People's Experience Framework.
   - Listening and Learning Programme.
   - PREMS (Patient Reported Experience Measures) and PROMS (Patient Reported Outcome Measures).
   - Citizen Voice (Llais) engagement arrangements.
   - Staff Ideas Scheme.
4. Improvement and Innovation
   - Improvement Community of Practice.
   - Quality Improvement training programme.

- Leading for Patient Safety Programme.
- iCTM Improvement Programme.
- Service Improvement Groups.

5. Supporting Infrastructure
   - Learning Academy.
   - Research and Development Strategy.
   - Workforce Productivity Programmes.
   - EPMA (Electronic Prescribing and Medicines Administration) implementation.
   - Legal, safeguarding and specialist quality functions.

Sources of Assurance (Internal and External)

Assurance is drawn from a range of management information, specialist oversight and independent review. These broadly reflect the Three Lines of Defence model and, taken together, provide evidence about the operation of controls, the quality and safety of services, and areas where further improvement is required.

Management assurance (First Line)

Evidence generated through the day-to-day management and operation of the services responsible for managing the risk.

- Quality Dashboard and Integrated Performance Dashboard
- Care Group Quality Reports
- Mortality reporting
- Infection Prevention and Control reporting
- RADAR reporting
- Maternity and Neonatal Dashboard
- National Clinical Audit and NCEPOD reporting
- Improvement Portfolio reporting
- concerns, complaints and patient experience reporting, including PREMs
- relevant annual and routine service reports

Specialist oversight and assurance (Second Line)

Evidence from specialist functions and arrangements which provide oversight, scrutiny and challenge of how the risk is being managed.

- Ward Assurance Programme
- Executive Patient Safety Walkabouts
- Learning from Events panels
- medicines safety governance
- safeguarding governance
- professional standards processes
- HIW improvement tracking
- coroner and legal oversight arrangements
- multi-agency safeguarding learning
- relevant organisation-wide quality and safety oversight arrangements

Independent assurance (Third Line / External)

Evidence from sources sufficiently independent of the management of the risk to provide objective review and challenge.

- Internal Audit
- Healthcare Inspectorate Wales
- Health Education and Improvement Wales
- General Medical Council National Training Survey
- Public Services Ombudsman for Wales
- external audit, accreditation and thematic reviews
- other relevant regulatory or external scrutiny

Gaps in Controls / Assurances	Actions taken to Mitigate Gaps	Actions underway / still to take	Intended Impact of Mitigating Actions	Actual impact of actions (once completed)
Gap 1: Quality intelligence and assurance arrangements are not yet fully integrated to provide a comprehensive and timely organisational view of quality, safety and performance.	• Mortality Board established, with organisation-wide arrangements introduced for the collection and oversight of mortality data. • CTMUHB representation established on the NHS Wales National Quality and Safety Framework workstream. • Benchmarking arrangements established through the National Quality and Safety Framework and NHS Wales Beacon Dashboard. • Live clinical quality dashboard implemented within maternity and neonatal services.	• Standardise mortality reporting across Care Groups. • Continue development and roll-out of clinical quality dashboards. • Further embed the National Quality and Safety Framework within organisational reporting. • Improve integration of quality, safety, performance and improvement intelligence.	• More comprehensive and timely quality assurance. • Improved visibility of quality and safety risks. • Better integration of intelligence from multiple sources. • Improved benchmarking and identification of variation. • Earlier identification and escalation of concerns requiring intervention.	As at November 2026, mortality oversight, national benchmarking and clinical quality dashboard arrangements have strengthened the availability and visibility of quality and safety information. The live dashboard within maternity and neonatal services has improved access to performance information, while participation in national arrangements has increased CTMUHB's ability to compare quality measures with other NHS Wales organisations. However, information remains held across several systems and further work is required to achieve a fully integrated and timely organisational view.
Gap 2: Ward assurance, safeguarding and related quality governance arrangements require further development and consistent embedding to provide reliable assurance across all services and settings.	Controls already in place / actions completed • Ward assurance arrangements established, including routine assurance visits, targeted reviews and point prevalence audits. • Ward Accreditation Programme developed and introduced across a number of clinical areas. • Safeguarding Strategy and Framework implemented. • Safeguarding dashboard developed and piloted. • Once for Wales safeguarding module piloted. • Governance and tracking arrangements strengthened for looked-after children's health assessments.	Further actions required • Review ward assurance arrangements and support development of a consistent and sustainable all-Wales approach. • Continue targeted assurance visits while future accreditation arrangements are considered. • Further refine and embed safeguarding dashboard and reporting arrangements. • Continue implementation and oversight of the Safeguarding Strategy workplan.	Intended Impact of Mitigating Actions • More consistent assessment of quality and safety standards across clinical areas. • Improved triangulation of ward-level assurance information. • More comprehensive and accessible safeguarding information. • Earlier identification and escalation of ward and safeguarding concerns. • Stronger assurance to committees and the Board regarding compliance and quality standards.	Actual impact of actions (once completed) As at November 2026, ward assurance activity and targeted visits have improved visibility of standards and areas requiring support. Safeguarding oversight has also strengthened through the strategy, dashboard, tracking systems and revised governance arrangements. These developments provide a stronger foundation for assurance, although further work is required to embed consistent arrangements across all services and settings and to establish the future approach to ward accreditation.
Gap 3: Organisational learning, improvement and feedback arrangements are not yet consistently embedded, and the impact of improvement activity is not always systematically measured or demonstrated.	Controls already in place / actions completed • Staff Ideas Scheme implemented. • Improvement into Practice training programme established and delivered. • Permanent funding secured for PREMs, with implementation under way across the Health Board. • Viva Engage launched to support staff communication and engagement. • Arrangements established for capturing patient, staff and community feedback. • Quality and Safety Assurance Group is being established, reporting through the Harm Free Care Strategic Oversight Group to the Quality, Safety and Experience Committee.	Further actions required • Continue roll-out and embedding of PREMs across services. • Increase awareness and use of staff and patient feedback mechanisms. • Further develop arrangements for integrating staff, patient, community and partner intelligence. • Continue promotion of improvement methodologies and staff engagement initiatives. • Strengthen measurement and reporting of the outcomes achieved through improvement activity.	Intended Impact of Mitigating Actions • Quality improvement increasingly embedded in everyday practice. • Staff have greater skills, confidence and opportunities to identify and implement improvements. • Staff, patient and community feedback is used more systematically to inform service design and improvement. • Better evidence of whether improvement activity is delivering the intended outcomes. • More integrated improvement intelligence to support organisational learning, decision-making and assurance.	Actual impact of actions (once completed) As at November 2026, the Staff Ideas Scheme, improvement training, PREMs and Viva Engage have increased opportunities for staff and patients to contribute ideas and feedback. PREMs information is now routinely reported to Care Groups and QSEC, strengthening oversight of patient experience. These developments represent progress towards a more integrated approach to organisational learning and improvement; however, feedback intelligence remains fragmented and the impact of improvement activity is not yet consistently measured or demonstrated.

Gap 4: Concerns, complaints, redress and legal services arrangements require further strengthening to provide timely resolution, organisational learning and sustainable assurance.	Controls already in place / actions completed: • Listening to People introduced as the national approach to managing concerns, complaints, incidents and redress. • Strengthened weekly oversight arrangements for concerns and complaints, including escalation and executive assurance. • Legal Services Organisational Change Process completed, with revised structures implemented and a recovery plan in place. • Governance arrangements, operating procedures and external stakeholder engagement strengthened to support more consistent management of legal, concerns and redress activity. • Revised policies and standard operating procedures have been introduced across the Legal Services portfolio and are being embedded in practice. • Monthly oversight meetings have been established between the responsible lead, Finance and the Legal Services lead.	Further actions required / in progress: • Embed the revised Legal Services, Redress and Claims structures and operating arrangements. • Strengthen identification, management and oversight of cases that may qualify for redress. • Improve compliance with performance requirements and reporting across concerns, complaints and redress processes. • Strengthen the identification, dissemination and monitoring of learning arising from concerns, complaints, claims, inquests and redress. • Complete the planned audit and review process to confirm that the revised policies and standard operating procedures are being consistently applied and are operating as intended.	Intended impact: • More timely, consistent and person-centred management of concerns, complaints and redress. • Improved compliance with statutory and organisational requirements. • A more sustainable and resilient Legal Services, Redress and Claims function. • Learning from concerns, complaints, claims, inquests and redress translated more consistently into service improvement and organisational assurance.	Actual impact of actions (following completion): As at November 2026, Listening to People, the Legal Services Organisational Change Process and strengthened oversight arrangements have improved the organisational framework for managing concerns, complaints, legal activity and potential redress cases. Revised structures, governance arrangements and stakeholder engagement have strengthened oversight and support more consistent escalation and organisational learning. However, recruitment to revised structures is not yet complete and the benefits are not yet fully embedded. Further evidence is required to demonstrate sustained improvement in compliance, timeliness and the translation of learning into measurable improvements in care and patient experience.

Linked National Priority Measures

Delivery of this strategic risk contributes to a range of national quality, safety, experience and improvement priorities. Key areas of alignment include:

Quality, Safety and Improvement

- NHS Wales Quality and Safety Framework.
- Health and Social Care (Quality and Engagement) (Wales) Act 2020, including the Duty of Quality and requirements relating to public engagement.
- National Value Based Healthcare Strategy.
- National Patient Experience Framework.
- Patient Safety Solutions Programme.
- NHS Wales national work on Learning and Improving.

These programmes support CTMUHB's approach to quality governance, organisational learning, service improvement, patient experience and assurance.

Infection Prevention and Control

- Six Tier One Infection Prevention and Control targets.
- National Infection Prevention and Control Guidance.
- NHS Wales National Infection Prevention and Control Framework.

These provide the national standards, governance arrangements and assurance mechanisms supporting safe care and infection prevention across all settings.

Safeguarding and Vulnerable People

- National Safeguarding Improvement Plan.
- Welsh Government programme to strengthen Mental Capacity Act implementation and Deprivation of Liberty Safeguards arrangements.
- Independent HIW/CIW review of Regional Safeguarding Board child protection arrangements.

These programmes support CTMUHB's safeguarding governance, assurance and continuous improvement arrangements.

Nursing, Workforce and Professional Leadership

- Chief Nursing Officer's Strategic Vision 2025-2030.
- National Nurse Education Standards.
- Dementia Care Standards.
- Chief Medical Officer priorities relating to clinical leadership and implementation of the Ministerial Advisory Group recommendations.

These programmes support workforce capability, professional leadership and the delivery of safe, high-quality care.

Population Health and Prevention

- Care Closer to Home priorities, including diabetes outcome measures.
- Children's Rights Charter.

These priorities support prevention, early intervention, improved outcomes and person-centred care.

Collectively, these national priorities provide the strategic and regulatory framework within which CTMUHB's quality, safety, experience and improvement programmes operate and against which ongoing assurance is measured.

Current Performance Highlights

Performance associated with this risk is monitored through the Integrated Performance Dashboard and associated quality, safety and experience reporting and governance. Key measures include:

Quality and Safety

- Quality Dashboard
- Maternity and Neonatal Dashboard
- Mortality Indicators
- Tier 1 Infection Prevention and Control Indicators
- Harm Free Care Outcome Measures (including falls, pressure ulcers and medication administration)
- Deteriorating Patient Measures (including Sepsis and NEWS scoring)
- Patient Safety Solutions compliance

Patient Access and Outcomes

- Cancer Standards
- Unscheduled Care
- Urgent and Emergency Care Programme
- Waiting List Delays

Mental Health

- Mental Health Measures

Experience, Learning and Concerns

- Listening to People (LTP) compliance measures (which have replaced Putting Things Right compliance reporting from 1 April 2026).

Collectively, these measures provide the principal sources of performance information used to assess delivery of this strategic objective and support triangulation of risk, performance and assurance.

Were there any significant incidents affecting this strategic Risk this period:

Nationally Reportable incidents (NRI) are managed in according with the Incident Management Framework and reported to the Quality, Safety & Experience Committee.
No Never Events since February 2026
The Health Board temporarily suspended community home births and closed the midwifery-led birthing unit at the Royal Glamorgan Hospital. The midwifery-led unit has subsequently reopened; however, the community home birth service remains suspended.
Health visiting services continue to operate under an improvement arrangement, with a reduced service in place. A taskforce has been established to review the position of children assessed as being at greater risk.
Constraints in the availability of isolation and negative-pressure rooms continue to present a potential quality and safety risk, particularly in advance of anticipated winter pressures.

Associated Risks escalated to the Organisational Risk Register

Strategic Gap 1: Quality intelligence and assurance arrangements are not yet fully integrated to provide a comprehensive and timely organisational view of quality, safety and performance

4672	Inability to achieve timely, accurate clinical coding and structured data standards.	15
Strategic Gap 2: Ward assurance, safeguarding and related quality governance arrangements require further development and consistent embedding to provide reliable assurance across all services and settings		
5554	Inability to meet Containment Level 3 standards, creating risks to patient and staff safety and statutory compliance.	20
6633	Failure to safely implement Blood Transfusion LIMS 2.0, including legacy data migration, testing and system deployment.	25
6475	Patient safety and service delivery risks arising from industrial action impacting Health Visiting services	16
4632	Inability to deliver timely, high-quality stroke care across CTM.	16
6433	Midwifery workforce staffing.	15
4691	Provision of safe and appropriate estate for Mental Health inpatient services.	15
6766	Security incidents and vulnerabilities across Health Board sites.	16
6629	GMC/HEIW conditions on Prince Charles Hospital Emergency Department.	16
Strategic Gap 3: Organisational learning, improvement and feedback arrangements are not yet consistently embedded, and the impact of improvement activity is not always systematically measured or demonstrated		
There are no risks underpinning this gap on the Organisational Risk Register at present		
Strategic Gap 4: Concerns, complaints, redress and legal services arrangements require further strengthening to provide timely resolution, organisational learning and sustainable assurance.		
6231	Failure to effectively manage concerns.	15
6232	Sustainability of the Legal Services function.	15

Strategic Goal(s):			Risk score 16
Improving Care • Delivering safe and compassionate care • Developing new models of care • Digital transformation for patients and staff • Ensuring timely access to care	Sustaining Our Future • Becoming a green organisation • Ensuring our Services financial sustainability Embedding value-based healthcare • Ensuring our estate is fit for the future	Inspiring People • Visible and inspiring leadership. • Promoting diversity and inclusion. • Embedding our values and behaviours. • Encouraging local employment	
Strategic Risk: Enough workforce to deliver the activity and quality ambitions of the organisation *(including culture, values and behaviours)* (Risk No. 3)			
If the Health Board fails to identify and plan for its current and future workforce requirements, and to promote CTMUHB as an attractive place to work	*Then* we may fail to ensure we have the right people with the right skills and experience, in the right place at the right time and cost to meet service demand.	*Resulting in* increased gaps in our workforce which adversely affect the quality of care, increased burden on other workforce and the employee experience, with a potential increase in variable pay impacting our ability to deliver high quality and affordable services fit for today and tomorrow.	

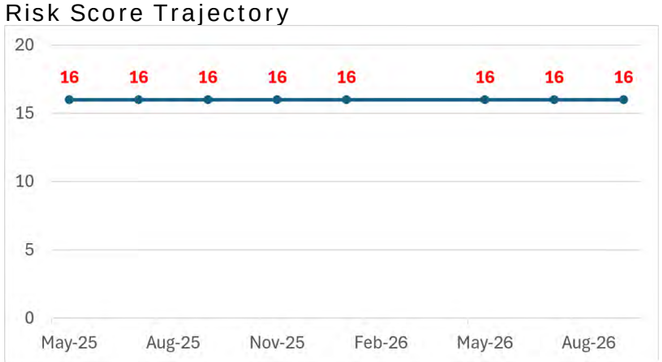
Risk Lead	• Executive Director for People	Assurance committee	• Quality, Safety & Experience Committee • Operational Delivery Committee

	Consequence	Likelihood	Score
Initial	4	5	20
Current	4	4	16
Target	4	2	8
Risk Appetite	Cautious *(quality and safety; trust and confidence; legal and regulatory)*		

Risk Score Trend this Period:

No change to risk scores this period.

Risk Score Trajectory



Rationale for assessment of risk score:
Including where risk score remains unchanged and for any changes

The workforce risk remains significant due to ongoing recruitment challenges, national supply constraints, sickness absence, variable pay reliance and workforce implications linked to service change. ~~While turnover and sickness are shown~~Turnover is improving but the reported rolling sickness rate has increased. Gaps~~g improvement, gaps~~ remain in hard to fill roles, job planning compliance and sustainable workforce models. The score remains unchanged at 16 because ~~workforce challenge~~these pressures s~~ ~~continue to affect service resilience, staff wellbeing, delivery of planned activity~~ and a re~~with a continued reliance on temporary staffing.

	The rolling 12-month sickness rate in September 2026 was 7.65% which is an increase of 0.07% on the 7.58% rate in ~~to~~ June 2026, and 0.49% higher than September 2025 (7.16%) ~~reported for September 2025~~, impacting on workforce available for service delivery and sustainability. ~~Som~~Absence is also a contributing factor to ~~e of this absence will account for~~ variable pay expenditure ~~where overtime, bank or agency has been utilised.~~ ~~was 7.58% and is slightly higher than the equivalent rolling 12-month period of the previous year (7.00%). The in-month June 2026 sickness rate is 7.21% which is higher than June 2025 (6.78%)~~. Turnover continues to fall, which is positive ~~news demonstrating that we are showing better resu~~indicator of improved retention~~lts at retaining our workforce~~. Turnover rates in October 2026 at 8.10% compared to 8.58% in October 2025. N&M turnover reduced from 7.25% in October 2025 to 6.25% in October 2026. This does however also means a reduction in the number of vacancies we have available, within budget, to meet student streamlining numbers to bring in a new workforce. ~~Turnover rates in October 2026 at 8.10% compared to 8.58% in October 2025 . N&M turnover reduced from 7.25% in October 2025 to 6.25% in October 2026.~~ Alongside this expenditure across variable pay remains high. ~~with~~ M&D agency and ADH spend for M4~~6~~ 2026/7 was £~~769k~~2.38m ~~with a year to date spend of £2.741m. For~~ . For Nursing and Midwifery bank and agency spend, including HCSWs, ~~the position for the year to date~~ at M4 ~~–~~ 6was reported as ~~£3.023m.~~£2.42m ~~Turnover continues to fall, being 8.16% in July 2026, compared to 9.00% in July 2025.~~ Job Planning ~~compliance~~ compliance is at 58% ~~as at~~ (October 2026) which is an increase of 11% on the 47% reported in~~at~~ ~~as at~~ July 2026 ~~was 47%~~. There ~~is~~ remains considerable variation between Care Groups and efforts to increase Job Planning figures continue to be addressed via the Medical Workforce Productivity Programme and new Recruitment Controls linking authorisation of Consultant Recruitment to speciality job planning rates. The increase is positive but still means that we have a gap in job plans to enable demonstration~~e~~ of compliance and~~,~~ effective deployment to meet patient activity.
Risk Treatment Assessment *i.e. Treat, Tolerate, Transfer etc.*	This risk is being treated through the CTM People Plan, workforce planning, recruitment, retention, and wellbeing, staff / TU engagement , CTM performance meetings (e.g. IPMs) and ~~productivity~~the Value & Effectivess programme~~s~~. A reduction is expected over time but remains constrained by factors noted above including national workforce supply, sickness absence, temporary spend, affordability pressures and the pace of service model change.

Current Control Measures

Strategic workforce controls

CTM People Plan, Integrated Medium-Term Plan (IMTP), Education & Training Plans (ETPs), national workforce planning frameworks and Welsh Government/NHS P&I drivers (e.g. Enabling Actions) provide the strategic controls for aligning workforce requirements with CTM2030, service change and national workforce priorities.

Recruitment and Resourcing

Job Evaluation, Vacancy Scrutiny Panel, Recruitment delivered via Trac and supported by NWSSP Recruitment Services, Medical Workforce Recruitment Planning, retention programme, lateral moves scheme, flexible working policy, and onboarding/exit insights are used to manage workforce supply, improve fill rates and support retention. Living Wage Employer – ensures fair pay and equity across CTM.

Workforce Productivity and Temporary Staffing

- Nursing & Midwifery Productivity Programme (NMPP) –includes bank and roster optimisation aligned to the Value and Effectiveness Programme.

- Medical Workforce Productivity Programme – includes increased job planning compliance, targeted medical recruitment, bank expansion agency reduction plans.
- HCRG Managed Service Provider for M&D Bank and Agency service (and AHP, PST and HCS agency requirements) - Live from July 2026.
- Rate Cards (Consultant and Non-Consultant) – ensure consistency and cost control.
- Bank KPIs and Agency Spend Tracker – phase 1 has been built and available in the nurse dashboard. Further work to develop the next phase remains under development with a specification to be agreed. This will support targeted improvement and oversight.
- Increased scrutiny and control in relation to both Worked WTE and temporary staffing use, led by the principles of P&I

Culture, Values and Behaviours (CVB)

- Organisational Values
- Leadership Development Programmes
- Staff Engagement and Recognition –and focus groups.
- Equality, Diversity and Inclusion Strategy
- Speaking Up Safely Guardians and anonymous reporting platform Work in Confidence (WiC) – strengthen psychological safety.
- Care Group Culture and Behaviour Plans – local responses to Staff Survey results embedded in delivery plans.

Sources of Assurance (Internal and External)

Sources of Assurance (Internal and External)

Assurance is considered across the key themes relevant to this risk. Sources are identified as management assurance (First Line), specialist oversight and challenge (Second Line), or independent/external assurance (Third Line / External) where appropriate, broadly reflecting the Three Lines of Defence model.

Workforce Data and Analytics

Management assurance (First Line)

- People/Workforce Metrics Report, including staff-in-post, turnover, sickness and return-to-work compliance, PDR, statutory and mandatory training, workforce profile, bank and agency spend, worked WTE, gender pay gap and staff engagement index. Reported to Operational Delivery Committee (ODC) and Local Partnership Forum (LPF) and included within the Integrated Performance Report to Board.
- Workforce data included within Value & Effectiveness Board, Nursing Productivity Programme Board and Medical Workforce Productivity Programme Board reporting.
- Workforce data included within Care Group Integrated Performance Meeting data packs.
- People Dashboard.

External oversight

- Quarterly vacancy returns submitted to Welsh Government for NHS vacancy statistics.
- Enabling Actions return.
- Ad-hoc NHS P&I (Performance and Improvement) returns.

Medical Workforce Productivity Programme Board

Management assurance (First Line)

- Patchwork/HCRG dashboards.
- Job-planning compliance.
- Medical Workforce Productivity Programme reporting.

Specialist oversight and challenge (Second Line)

- Audit updates and monitoring of recommendations through the Audit Tracker.
- Resident Doctor Contract CTM Group, alongside CTM participation in NWSSP and NHS Employers-led All-Wales groups.

Independent assurance (Third Line)

- Medical & Dental Variable Pay Audit and M&D Job Planning Audit.
- Medical Job Planning Re-Audit, final report June 2026.
- Medical & Dental Medical Rostering Audit and Sickness Audit.

Nursing and Midwifery Productivity Programme Board

Management assurance (First Line)

- Nursing Dashboard.

Specialist oversight and challenge (Second Line)

- Nurse Productivity Programme Board, with associated dataset updates, actions and targets. Reset and relaunch of the Programme in November 2026, including a new Variable Pay & Rostering Workstream.

Workforce Planning
Management assurance (First Line)
- Executive Leadership Group (ELG) approval of ETP Commissioning submission (Mar-26) to HEIW and regular updates relating to Student Streamlining.
- Strategic Workforce Planning update provided to Strategic Development Committee (SDC) in August 2026.

Specialist oversight and challenge (Second Line)
- Audit Tracker oversight of actions.

Independent / external assurance (Third Line / External)
- HEIW feedback on the Education and Training Plan submission, on receipt.
- HEIW Workforce Supply Oversight Group, focusing currently on nursing and midwifery student-streamlining vacancies.
- Audit Wales follow-up covering CTM agency usage and workforce planning, with outcome awaited.

Culture, Values and Behaviours
Management assurance (First Line)
- NHS Staff Survey results reported to Board and CTM committees, with local Care Group action plans and progress reported through Integrated Performance Meetings.
- Staff Survey briefings, with 87% of attendees agreeing with the corporate priority areas identified.

Specialist oversight and challenge (Second Line)
- Partnership forums, including LPF and LNC listening and engagement reviews.

External benchmarking
- All-Wales NHS Staff Survey benchmarking. CTM response rates increased from 18.1% in 2023 to 26.8% in 2024 and 35.6% in 2025, compared with a 2025 national average of 30%. The staff engagement index increased marginally from 70.4% to 70.5%.

Key assurance findings this period
The assurance picture remains mixed. Workforce retention, job-planning compliance, temporary-staffing controls and Staff Survey participation show areas of progress. However, sickness absence, workforce planning and deployment, and the maturity of workforce intelligence continue to require improvement. Further independent assurance will be provided through the awaited Audit Wales workforce-planning review.

Gaps in Controls / Assurances	Actions taken to Mitigate Gaps	Actions still in progress	Intended Impact of Mitigating Actions	Actual Impact of Actions (following implementation)
Gap 1: Workforce planning is not yet consistently aligned to future organisational priorities, service transformation programmes and regional workforce requirements, limiting our ability to proactively shape the future workforce.	Actions already completed • Workforce planning has been incorporated into CTM2030, IMTP and Education and Training Plan arrangements. • Workforce requirements for Regional Orthopaedics and Llantrisant Health Park Phase 2 were included in the Full Business Case submitted to WG for approval. • ~~have been considered within priority service and transformation programmes, including Regional Orthopaedics and the Llantrisant Health Park Full Business Case.~~ • ~~Workshops have supported workforce planning for priority areas, including~~	Actions still to do • Strengthen the alignment between workforce, service, transformation and financial planning particularly around IMTP and for strategic alignment • Complete and embed local workforce planning methodologies~~s~~ across Care Groups and corporate directorates. • ~~Strengthen the alignment between workforce, service, transformation and financial planning particularly around IMTP and for strategic alignment.~~ • Continue to develop coordinated regional and service-specific workforce plans, building on the work undertaken for priority programmes.	Intended impact of mitigating actions • A sustainable, skilled, modernised and affordable workforce capable of delivering CTM2030 and IMTP priorities. • Better alignment between workforce planning, service redesign, regional programmes and financial planning. • Earlier identification and management of future workforce requirements, skills gaps, supply constraints and affordability risks. • Appropriate and effective use of new and extended roles to improve skill mix and workforce resilience. • Audit Wales SWP outcomes will provide evidence of workforce	Actual impact of actions taken to date Workforce planning has become more closely aligned to organisational priorities and major transformation programmes. In particular, the work undertaken for Llantrisant Health Park, Regional Orthopaedics and other priority services has improved the articulation of future workforce requirements, staffing models and associated risks. Governance arrangements for new and extended roles have also been strengthened. However, local and regional workforce planning is not yet consistently developed or embedded across all services. Further work is needed before the Health Board can be assured that future workforce requirements,

	~~Perinatal, Ophthalmology and Theatres.~~ • ~~The Education and Training Plan commissioning submission was approved by the Executive Leadership Group and submitted to HEIW~~. • Student streamlining arrangements have supported recruitment of the September 2026 nursing and midwifery graduate cohort, with the Health Board meeting ~~the majority of~~most of its commitments. • A Strategic Workforce Planning update was provided to the Strategic Development Committee in August 2026. • Responded to the Audit Wales SWP Audit requirements for 2026/27. ~~Awaiting outcome from Audit Wales.~~ • ~~Governance arrangements have been developed for new and extended roles, including Physician Associates, Advanced Clinical Practitioners and Registered Nursing Associates.~~	• Ensure workforce plans clearly identify future staffing and skills requirements, supply risks, assumptions and affordability implications based on demand requirements~~.~~ • Embed consistent governance and evaluation arrangements for new and extended roles. • Monitor whether workforce plans and new workforce models are delivering the capacity and skills required. • Finalise the horizon scan to support leaders to prepare workforce solutions for current and future external and internal changes. • Awaiting assessment outcome from Audit Wales to confirm progress and actions to meet any gaps. • ~~Respond to any further findings arising from the Audit Wales follow-up review of agency usage and workforce planning.~~	planning maturity in supporting CTM service delivery and where priority focus is needed to address gaps.	affordability and delivery risks are being identified and managed consistently across the organisation.
Gap 2: Workforce deployment, productivity, digital systems and workforce intelligence capabilities are not yet sufficiently mature to optimise capacity, quality, efficiency and affordability.	Actions already completed • Medical and Nursing and Midwifery Workforce Productivity Programmes have been established, incorporating job planning, roster and bank optimisation, temporary staffing and agency reduction. • Scrutiny and control of worked whole-time equivalent capacity, workforce growth and temporary staffing use have been strengthened. • The Agency by Exception process has been introduced for nursing agency use. • New Variable Pay Framework introduced November 2026 for N&M. • A new managed service provider for Medical and Dental bank and agency staffing, and specified wider agency requirements, went live in July 2026. • Consultant and non-consultant rate cards have been introduced to support consistency and cost control. • Phase one of the Bank KPI and Agency Spend Tracker is available through the nursing dashboard.	Actions still to do • Evaluate job planning, rostering and temporary staffing controls in priority services. • Continue delivery of the Medical and Nursing and Midwifery Workforce Productivity Programmes and evaluate their impact. • Continue roll out of Variable Pay project. • Continue expansion of Staff Bank for N&M. • Improve Medical Job Planning compliance and reduce variation between Care Groups. • Complete the next phase of the Bank KPI and Agency Spend Tracker. • Agree and implement a consistent Health Board-wide approach to establishment reporting and control. • Continue to improve workforce data quality, dashboards and analytical capability. • Improve interoperability between workforce systems and reduce reliance on manual processes.	Intended impact of mitigating actions • Improved deployment and utilisation of the substantive workforce. • More effective rostering and increased use of appropriately skilled bank workers. • Reduced reliance on contigent staffing ~~agency staffing~~ and improved ~~control of~~ variable pay spend. • Improved Medical Job Planning compliance and reduced variation between services. • Consistent establishment control and a clearer understanding of funded, worked and available workforce capacity. • ~~Better workforce deployment and utilisation of substantive staff.~~ • More accurate and timely workforce intelligence to support strategic and operational decision-making. • Better-integrated workforce systems and reduced reliance on manual processes.	Actual impact of actions taken to date ~~Job planning is reported at 58% in Oct 2026, compared with 47% in July 2026. This demonstrates improved compliance but does not yet establish that deployment meets required activity.~~ Governance, reporting and oversight of workforce utilisation, productivity and temporary staffing have strengthened. The Agency by Exception process has supported early reductions in nursing agency use, and the expansion of the N&M Staff Bank has been over 700 new joiners in November 2026. Workforce growth (through the lens of totality worked WTE) continues to receive regular scrutiny through our internal governance arrangements. A review undertaken during September 2026 identified that workforce growth has stabilised, with some areas already demonstrating reductions in worked WTE following the introduction of strengthened workforce controls.

	• Nursing and Midwifery establishment reports have been developed, and workforce information is increasingly included in Care Group performance arrangements and corporate reporting. • Medical Job Planning and Medical and Dental Sickness audits have been undertaken, with improvement actions identified. • The People Systems Group has been established and preparation for ~~implementation of~~ ESR Go has commenced. • The new Resident Doctor contract was implemented on 1 August 2026, with continuing actions incorporated into the Medical Workforce Productivity Programme.	• Continue implementation of ESR Go and prepare for the Future Workforce Solution. • Complete outstanding actions arising from workforce audits and implementation of the Resident Doctor contract. • Demonstrate sustainable improvement in workforce utilisation, agency use and expenditure, bank utilisation and affordability		The effect of the Variable Pay project ~~temporary staffing~~ and new controls needs to be assessed, with a 3 month review planned for N&M actions taken. ~~alongside total variable pay, staffing coverage and service delivery~~. Establishment reporting, workforce dashboards and the inclusion of workforce information within Care Group performance arrangements have also improved organisational visibility. Job planning has risen to r58% in Oct 2026 (47% in July 2026). This demonstrates improved compliance but does not yet establish that deployment meets required activity. ~~Governance, reporting and oversight of workforce utilisation, productivity and temporary staffing have strengthened. The Agency by Exception process has supported early reductions in nursing agency use, and the new Medical and Dental bank and agency provider has been operational since July 2026. Establishment reporting, workforce dashboards and the inclusion of workforce information within Care Group performance arrangements have also improved organisational visibility.~~ The Resident Doctor contract was implemented on 1 August 2026. The interbnal CTM RD Contract Group is being relaunched to monitor , with continuing actions ~~now monitored through the Medical Workforce Productivity Programme~~. ~~However, it is too early to assess its full impact or that of the new managed service arrangements.~~ Establishment control, workforce analytics and system interoperability are not yet consistently mature across the organisation. ~~Medical Job Planning compliance remains at 47%, with variation between Care Groups. Further evidence is required to demonstrate that the strengthened arrangements are delivering sustained improvements in workforce capacity, productivity and affordability.~~

Gap 3: Recruitment, retention and attendance arrangements are not yet consistently delivering a sustainable, resilient and engaged workforce, resulting in workforce supply pressures and variable workforce experience.	Actions already completed • Recruitment and resourcing controls are in place, including vacancy scrutiny, job evaluation, recruitment through Trac and support from NWSSP Recruitment Services. • New Recruitment & Selection policy approved. • Recruitment training, guidance and SharePoint resources have been developed, supported by attraction and employer-branding activity. • Flexible working and lateral moves ~~arrangements have been introduced~~opportunities remain in place. • The ~~Moving On process was reviewed and relaunched in July 2026.~~ The Moving-On process continues to perform above target, achieving a 24% response rate in September. Ongoing promotional activity is in place to maintain engagement and support the collection of meaningful workforce insights to inform retention interventions. • ~~The Retention Steering Group has been re-established, supported by developing retention dashboards and exit information.~~ • Sickness absence reporting and analysis have been expanded, including reporting to the Executive Management Board. • An organisation-wide approach to sickness absence has been developed, supported by a short-term Enhanced Case Management Support project within acute and community wards. • The Enhanced Case Management Support project has increased the volume of case reviews, with measures established to assess its impact. • The Health Board has maintained Living Wage Employer status.	Actions still to do • Finalise and approve the Recruitment and Retention Plan. • ~~Complete and implement the revised Recruitment and Selection Policy and supporting procedures.~~ • Refresh the roles captured as "hard to fill" and the plans in place to address these challenges • Continue targeted recruitment and attraction activity for hard-to-fill roles, workforce groups and specialties. • Complete the development of a generic consultant job description ~~review of consultant job descriptions.~~ • Finalise expansion of Lateral Moves Scheme into Therapies. • ~~Embed the lateral moves and Moving On processes consistently across services.~~ • Improve the quality and use of exit and retention information to support targeted interventions. • Continue delivery of the organisation-wide sickness absence action plan. • Evaluate the impact of the Enhanced Case Management Support project and use the findings to inform the longer-term approach. • Deliver and evidence progress towards the planned reduction in sickness absence during 2026/27. • Demonstrate sustained improvement in vacancies, recruitment, turnover, attendance and reliance on temporary staffing.	Intended impact of mitigating actions • Improved workforce availability, stability and organisational resilience. • More consistent and timely recruitment processes. • Improved recruitment and retention in hard-to-fill roles and priority services. • Better use of retention and exit intelligence to target interventions. • Reduced voluntary turnover and avoidable loss of experienced staff. • Reduced sickness absence and earlier, more effective support for staff. • Reduced workforce gaps and reliance on temporary staffing.	Actual impact of actions taken to date Recruitment guidance, workforce attraction activity and retention intelligence have been strengthened. ~~The Moving On process has been relaunched and the Retention Steering Group re-established, providing a stronger basis for understanding and responding to retention concerns.~~ Turnover was 8.1~~0~~6% in ~~July~~ October 2026, compared with ~~9.00~~8.58% in ~~July~~October 2025. This indicates improvement in retention, but increased sickness absence continues to affect workforce availability. The turnover~~the reported turnover~~ position does impact on the ability to identify posts for student streamlining graduates. There are also several~~, although~~ recruitment challenges ~~remain~~ within ~~a number of~~ hard-to-fill/ national scarcity skills and ~~roles and~~ specialties. Sickness absence reporting and case management arrangements have also been strengthened. However, the rolling 12-month sickness rate to September~~June~~ 2026 was 7.~~58~~65%, compared with 7.~~16~~00% for the equivalent period in the previous year. The Enhanced Case Management Support project was launched in June~~August~~ 2026 and its impact is ~~still~~ being assessed to inform future focus. Sickness absence therefore continues to affect workforce availability, and it yet to be determined ~~is too early to determine~~ whether the new arrangements will deliver sustained improvement
Gap 4: Organisational values,	Actions already completed • Organisational values and culture, values and behaviours measures have	Actions still to do • Continue to embed local ownership of organisational values and expected	Intended impact of mitigating actions	Actual impact of actions taken to date ~~Staff Survey participation increased from 18.1% in 2023 to 26.8% in 2024 and 35.6%~~

behaviours and approaches to staff experience are not yet consistently embedded across the Health Board, impacting engagement, wellbeing, leadership culture and organisational performance	been incorporated into the CTM People Plan. • Leadership development, staff engagement, recognition and focus-group arrangements are in place. • The Equality, Diversity and Inclusion Strategy supports the wider approach to staff experience. • Speaking Up Safely Guardians and the Work in Confidence anonymous reporting platform have been established. • Care Group culture and behaviour plans have been developed in response to Staff Survey findings. • Staff Survey results are reported to the Board and relevant Committees, with local actions monitored through Care Group delivery and Integrated Performance Meeting arrangements. • Divisional Staff Survey information is shared to support local action and leadership accountability. • Staff Survey briefings have supported development of corporate priorities, with 87% of attendees agreeing with the priority areas identified. • Planning for the 2026 NHS Staff Survey has commenced and the Survey Leads Group has been re-established.	behaviours across Care Groups, directorates and services. • Strengthen leadership accountability for delivery and evaluation of local culture and behaviour plans. • Continue leadership development, engagement, recognition and speaking-up activity. • Use Staff Survey and local workforce information to identify variation and target support. • Deliver the 2026 Staff Survey and use the findings to assess progress and determine further priorities. • Evaluate whether local culture, leadership and engagement activity is improving staff experience and reducing variation. • Strengthen assurance to the Board and Committees concerning the impact of local culture and behaviour plans.	• Greater local ownership of organisational values and expected behaviours. • Improved and more consistent staff experience across the Health Board. • Increased confidence among staff to speak up, raise concerns and contribute ideas. • Stronger local leadership and accountability for organisational culture. • Improved staff engagement and reduced variation in experience between services. • Clear evidence that culture and behaviour plans are producing sustained change.	~~in 2025. The staff engagement index also increased slightly from 70.4% to 70.5%. Staff Survey findings are being used to inform corporate priorities and local Care Group action plans, supported by divisional information, Integrated Performance Meetings and established speaking-up arrangements.~~ Staff survey 2026 is well underway with weekly reporting into Exec and activation of local leadership with assurance via Integrated Performance Meetings. Response rate on 6 Nov 26 is 25% /3532 responses) Leadership development is in progress with 360 feedback for Inspire Alumni to enable insight into behavioural impact and planned for 2026/27 Inspire cohorts. This provides evidence of increased participation and a stronger organisational focus on culture and staff experience. However, the current evidence does not yet demonstrate that improvements in staff experience, values and behaviours are consistent across all services or that local interventions have delivered sustained organisational impact.

Linked National Priority Measures

Workforce

- 23. Agency spend as a percentage of the total pay bill
- 27. Percentage sickness rate of staff

Current Performance Highlights

Key Progress Highlights:

- ~~Workforce Planning: LHP Phase 2 w~~workforce section and workforce demand numbers- FBC submitted August 2026~~workforce critical path in development to support mobilisation once WG funding approved.~~
- ~~LHP OBC/FBC is to be finalised in June for sharing with HB Board Meetings in July 2026~~
- ~~Productivity & Agency Reduction: Launch of new Managed Service provision for M&D bank and M&D/AHP agency staff contract July 2026~~
- Variable Pay Project progresses. This has included increased control on A&C overtime (Executive approval for usage), reiteration of the A&C agency moratorium, a new Variable Pay Framework for Nursing & Midwifery including reinforcement of N&M agency authorisation requirements, Bank expansion, increased sign off of all M&D variable pay.
- CTM forecast year end agency spend is £18.8m compared to £26.7m in 2025/26
- AFC Bank: ~~800 Bank only workers identified, bank only workers following the Band 2-3 changes to ensure a viable, appropriately skilled and available bank workforce and on track to meet the deadline of July 2026.~~Band 2-3 bank assignments being updated from 1 December 2026 for substantive staff who have been identified as a Band 3 because of the All-Wales Healthcare Support Worker Framework. We are also working on the assessment of bank only workers against the framework to identify those who remain at Band 2 and those who will have a change of bank assignment to a band 3.
- AFC Bank: To support the cessation of nursing overtime only by exception, arrangements have been made to recruit to the Bank.

- Recruitment: ~~work progressing to update the~~ Recruitment & Selection policy and associated SOPs developed and approved.~~, Consultant job description reviews underway. international recruitment for hard-to-fill medical roles 2025/26 with NWSPP progressed, with two specialist grade psychiatrist started. An ITU doctor has been offered via NWSSP's overseas campaign and joined in June 2026.~~
- Student Streamlining Spring 2027: Work has begun to plan and prepare for the next cohort of nursing student streamlining and Flexi /OU students for Spring 27 (March 2027) and September 2027, it is anticipated that it will be challenging to identify vacancies to meet prospective student numbers ~~Able to meet majority of commitments to Student Streamlining numbers for Summer 2026 recruitment~~
- ~~Staff survey launch for 2026 agreed (October 6th 2026) survey leads group reestablished for programme development w.c. 30 Aug 2026~~
- Staff Survey 2026 launched with campaign running until end of November 2026.
- Inspire Leadership programme launched for 2026/27 with over 70 participants engaging our most senior leadership in their development and impact.
- Enhanced Case Management Support project has concluded with a review underway to inform next steps.

~~Return-to-work compliance has decreased from 72.5% in August 26 to 70.4%.~~

Were there any significant incidents affecting this strategic Risk this period:		
None identified.		
Associated Risks escalated to the Organisational Risk Register		
Gap 1: Workforce planning is not yet consistently aligned to future organisational, service transformation and regional workforce requirements		
6294	Insufficient consultant workforce in Endoscopy and Gastroenterology.	20
6280	Suspension of the Regional Hepato-Pancreato-Biliary service model.	16
Gap 2: Workforce deployment, productivity, systems and workforce intelligence are not yet sufficiently mature to optimise workforce capacity and affordability		
6629	GMC/HEIW Conditions on Prince Charles Hospital Emergency Department. Workforce, medical staffing and training arrangements are a key contributing factor to this risk. New escalation during the period.	16
Gap 3: Recruitment, retention and attendance arrangements are not yet consistently delivering a sustainable and resilient workforce		
6294	Insufficient consultant workforce in Endoscopy and Gastroenterology	20
5753	Inadequate Special School Nurse Provision. *Sept 2026: Risk score reduced to 16. Whilst the risk cannot be fully eliminated, staffing is currently at establishment. Longer-term work is required with Local Authority partners to review the future model of care and determine the Health Board's ongoing management of the residual risk.*	~~20~~ 16
6475	Patient safety and service delivery risks arising from industrial action impacting Health Visiting services	16
6232	Stability of the Legal Services Function.	15
Gap 4: Organisational values, behaviours and approaches to staff experience are not yet consistently embedded across the Health Board		
There are no risks currently escalated to the Organisational Risk Register under this strategic gap.		

Strategic Goal(s):	Risk score 16

Creating Health
- Reducing health inequalities
- Equal focus on mental and physical health
- Supporting our communities
- Being a healthy organisation

Sustaining our Future
- Becoming a green organisation
- Ensuring our Services financial sustainability Embedding value-based healthcare
- Ensuring our estate is fit for the future

Strategic Risk: Effective Community and Partner Engagement in Service Changes and Developments (Risk No.4)

If the Health Board *does* not engage effectively with our population to understand their needs, and with partners in local government social care and the third sector, to understand their viewpoints	*Then* we will fail to prioritise our efforts and resources appropriately, and to achieve a consensus for change in implementing our Population Health Strategy	*Resulting in* • Lack of trust between the community and the Health Board. • Loss of opportunity to build relationships and create an inclusive environment where people connect, collaborate, and share ideas. • Challenge to public decisions relating to future service developments due to limited engagement. • The inability to affect positive change in terms of improving health inequalities and health outcomes.

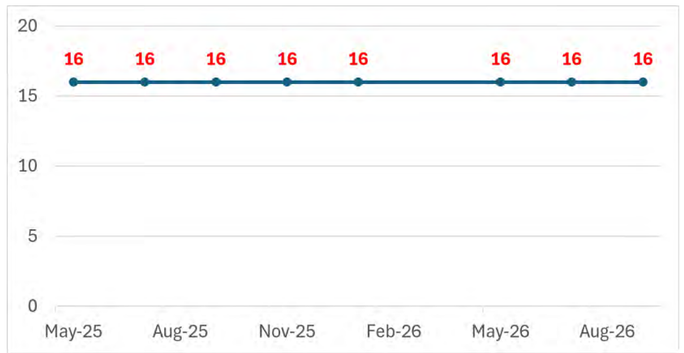
Lead Director	Director of Communications, Engagement & Fundraising.	Assurance committee	Strategic Development Committee

	Consequence	Likelihood	Score
Initial	4	5	20
Current	4	4	16
Target	4	2	8
Risk Appetite	Cautious *(quality and safety; trust and confidence; legal and regulatory)*		

Risk Score Trend this Period:

No change to risk score this period.

Risk Score Trajectory



Rationale for assessment of risk score: *Including where risk score remains unchanged and for any changes*	In recognition of the gaps identified around additional capacity requirements to develop and implement an engagement and involvement strategy associated with the Clinical Service Plan and wider service change requirement as well as the need to define a clearer process and procedure for supporting transformation and service change, the risk score was increased in terms of likelihood to a 4 in July 2025, and continues to remain at this level. The gaps are captured in the mitigating action plan section of this risk.

Risk Treatment Assessment *i.e. Treat, Tolerate, Transfer etc.*	This risk is being actively managed via the communications team and wider engagement function. As above, we will need to tolerate the fact that management of the risk will need to be ongoing while the organisation actively treats the risk by addressing the capacity, capability and technical gaps.

Current Control Measures

Strategies & Plans

- Strategic delivery framework
- Standard Operating Procedure for service change
- Social media strategy 2026
- CTMUHB Clinical Services Plan
- Regional Communications & Engagement Plan
- Service change and issue-specific communications and engagement plans (various)
- Creating Health PID
- Strategic Equality Plan

Engagement Forums

- Regional Partnership Board
- Public Service Board
- Stakeholder Reference Group
- Llais/CTMUHB Partnership Meetings
- Regional Engagement Group
- All Wales Engagement Group
- CTMUHB Strategic Engagement Forum
- CTM Leaders' Network
- Community Voluntary Councils (Interlink RCT, BAVO, VAMT)
- OPAG (Older Person's Advisory Committee)
- CTM 50+ Forums
- Llynfi Valley Stakeholder Reference Group
- Staff Q&A
- Leaders' Forum
- Armed Forces Health Partnership
- Health and Community Vaccination Working group

Sources of Assurance (Internal and External)

Assurance is drawn from management information, specialist oversight and external review, broadly reflecting the Three Lines of Defence model.

Management assurance (First Line)

Evidence generated through the delivery and management of engagement activity.

- Service change and issue-specific engagement activity and feedback.
- Engagement and insight arising through the Stakeholder Reference Group, Community Leaders' Forum and CTM Strategic Engagement Forum.
- Digital engagement and social-listening insight, including through the Orlo platform as this becomes embedded.
- Regional engagement activity and feedback from partner organisations.

Specialist oversight and challenge (Second Line)

Evidence from internal governance and partnership arrangements providing scrutiny and challenge of engagement activity.

- Executive Leadership Group and CTMUHB Board oversight of significant service change and engagement.
- Llais/CTMUHB Partnership Meetings and issue-specific engagement.
- Regional Engagement Group.
- Regional Partnership Board.

External assurance / oversight

Evidence from external partners or statutory processes providing additional scrutiny or challenge.

- Welsh Government service-change submissions and associated scrutiny.
- Welsh Government Heads of Communications arrangements.

- Llais feedback and challenge associated with service change and engagement.

Key assurance findings this period

Engagement capability is strengthening through the Service Change SOP, additional engagement capacity, implementation of Orlo and development of regional engagement arrangements. However, these are relatively recent developments and are not yet sufficiently embedded to demonstrate consistently effective engagement across all service-change activity.

Gaps in Controls / Assurances	Actions taken to Mitigate Gaps	Intended Impact of Mitigating Actions	Actual Impact of Actions (following implementation
Gap 1: A consistent and embedded approach to engagement related to service change is not yet fully established across the Health Board	Actions completed: • SOP completed with cross-department input. Work underway to implement. Further actions required • Implement the Health Board Service Change SOP and supporting arrangements. • Embed consistent approaches to engagement and consultation across service change programmes.	• Consistency of approach to service change across health board will ensure better management of change, resulting in greater credibility and effectiveness of engagement activities and more useful insight. • Earlier development and implementation of engagement plans will enable more effective prioritisation of resources and capacity.	The Service Change SOP has been developed with cross-departmental input, providing a stronger framework for planning and delivering engagement activities. This has improved consistency of approach and strengthened organisational readiness; however, implementation remains ongoing and benefits are not yet fully embedded across all service change programmes.
Gap 2: Capacity within the engagement function remains insufficient to fully support organisational and population engagement requirements	Actions completed: • Recruitment of new Public Health Engagement Lead (September 2026. Further actions required • Explore capacity within partner directorates for supporting engagement activities.	• Improved understanding and engagement response to population health priorities, enabling insight- and intelligence-led planning and delivery. • More proactive response to engagement requirements will increase reach and public/partner confidence in the health board and enable the development of campaigns, resources and priorities that match population need. • Improved capacity will enable health board to further develop relationships with community groups, third-sector partners, and hard-to-engage groups, resulting in richer-data, and greater insight to inform effective public engagement methods and resources. • Additional capacity to manage unexpected engagement need, e.g. for urgent service change, will lead to more effective, meaningful and timely engagement that maintains credibility and trust.	Additional capacity has been secured through Public Health funding and recruitment was completed in September '26 (post-holder due to start in November '26) This will increase the Health Board's ability to respond to engagement requirements and develop relationships with communities and partners.
Gap 3: Digital engagement, insight and social listening capability is not yet sufficiently developed to support modern engagement approaches	Actions completed: • Procurement and go-live of Orlo platform for social media management, social listening and public engagement has been completed.	• Significantly enhanced ability to produce, manage and monitor social media will enable health board to use these key channels to engage with, target, influence, understand, and respond to public and stakeholders. • Significantly improved insight into population sentiment, behaviour, trust and confidence will enable the health board to be far more responsive and informed in the management of change, and reach and impact of campaigns for behaviour change. • Significantly enhanced, AI-supported capability and capacity will enable greater reach, more impactful and more valuable	Orlo will provide strong foundations for improved insight gathering, targeting and public engagement; however, it will take time for the team to be trained in its use and for the full benefit of the platform to be realised.

		public engagement, resulting in more useable and influential data and insight.	
Gap 4: Regional engagement approaches and messaging are not yet fully co-ordinated across partner organisations	Actions completed • Development of regional engagement plan and associated resources with partners in AB and CAV Further actions needed: • Implementation of engagement activities during quarter 3, 26/27	• More visibility of regional working will increase confidence amongst staff, stakeholders and public in the value of regional working. • Joint planning and delivery of communications and engagement across the region will be more efficient, making best use of limited and capacity and enabling greater reach. • 'Story-telling' and messaging at regional-level will help to frame population need and system/service requirements.	Work has commenced with regional partners to develop a shared engagement approach and supporting resources. This has strengthened collaboration and improved understanding of regional priorities; however, arrangements remain in development and opportunities for fully co-ordinated regional engagement have not yet been fully realised.

Linked National Priority Measures

Nil

Current Performance Highlights

- Procurement of Orlo social media management, social listening and digital survey platform completed. Onboarding underway for implementation in September '26
- Recruitment process for Engagement Lead Officer (Public Health) underway. Should complete, September '26

Were there any significant incidents affecting this strategic Risk this period:

None identified.

Associated Risks escalated to the Organisational Risk Register

Nil

Strategic Goal(s):	Risk score 16

Improving Care
- Delivering safe and compassionate care.
- Developing new models of care.
- Digital transformation for patients and staff
- Ensuring timely access to care

Sustaining our Future
- Becoming a green organisation
- Ensuring our Services financial sustainability Embedding value-based healthcare
- Ensuring our estate is fit for the future

Strategic Risk: Delivery of a digital and information infrastructure to support organisational transformation – (Risk No.5)

If the Health Board does not accelerate its journey in becoming a digital and data organisation, that demonstrates an embedded culture of working digitally, organisational agility and strategic and functional clarity underpinned by operational sustainability	*Then* We will be unable to design and execute a Health Board wide strategy to transform services that are tailored to meet the needs of our people and our communities.	*Resulting in* Continuing health inequalities and poor population health outcomes, an inability to transform our cost base and our service design, which will result in slow progress towards improving our population's and patients' experiences, and continue to constrain our ability to work seamlessly across our region.

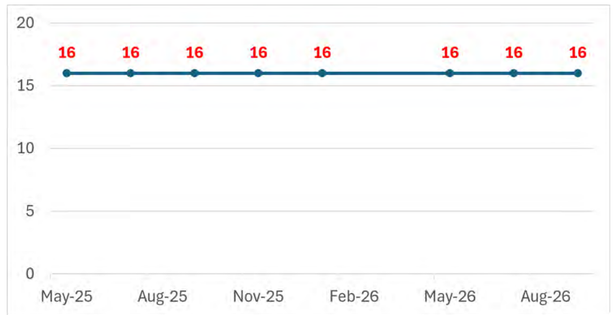
Risk Lead	Director of Digital	Assurance committee	• Operational Delivery Committee • Strategic Development Committee

	Consequence	Likelihood	Score
Initial	4	5	20
Current	4	4	16
Target	4	3	12
Risk Appetite	Cautious *(quality and safety; trust and confidence; legal and regulatory)*		

Risk Score Trend this Period:

No changes to risk score this period.

Risk Score Trajectory



Rationale for assessment of risk score:
Including where risk score remains unchanged and for any changes

November 2026: The risk score remains unchanged at 16 (C4xL4). Whilst progress continues across a number of digital transformation, infrastructure and cyber security programmes, significant strategic vulnerabilities remain which prevent a reduction in the likelihood score at this stage.

Key progress during this period includes:
- Continued implementation of the Digital, Data and AI Strategy, Cyber Improvement Plan and Information Security Policy.
- Strengthening of governance arrangements for artificial intelligence, supplier management and digital inclusion.

	• Ongoing improvements to digital infrastructure, cyber monitoring capabilities and clinical system standardisation. • Progress with key enabling programmes including digitisation of medical records, electronic prescribing medicines administration, shared care records and patient-centred contact services. However, the risk remains elevated due to: • The evolving cyber threat landscape and continuing exposure to cyber attack. • Ongoing capital, revenue and workforce constraints affecting the pace of digital transformation. • Continued reliance on legacy systems and a relatively low level of digital maturity compared to recognised benchmarks. • Dependencies on national programmes, suppliers and wider NHS Wales digital developments. • Resource challenges, including the overtime cessation for A&C has presented operational pressures. Whilst the overall trajectory is considered cautiously positive, further progress is required before the Health Board can demonstrate that digital capability, capacity and resilience are sufficiently embedded to support organisational transformation and justify a reduction in the risk score.
Risk Treatment Assessment *i.e. Treat, Tolerate, Transfer etc.*	It is considered that the Health Board is continuing to 'Treat' this risk as it has a number of actions it is taking forward to mitigate this risk.

Current Control Measures

Strategic Direction and Governance

The Health Board has established strategic and operational arrangements to support digital transformation, prioritisation and delivery of digital investment and improvement programmes. For example:

- Population Health Strategy.
- Digital & Data Delivery Programme.
- Project Portfolio Board.
- Digital Investment Fund.
- Digital Maturity Benchmarking.

Cyber Security and Information Governance

A range of governance, policy and assurance arrangements are in place to support cyber resilience, information governance and the safe use of digital technologies. For example:

- Cyber Improvement Plan (Aligned to the NIS Directive)
- Cyber Resilience & Availability Group.
- Cyber Incident Response Arrangements (including testing and exercising).
- Information Security, Records Management and Information Governance Frameworks.
- AI Governance Framework.
- Non-Corporate Communication Channels Policy.

Digital Transformation and Infrastructure

Programmes are in place to strengthen digital infrastructure, modernise clinical systems and support the delivery of digitally enabled services. For example:

- IT Infrastructure Review.
- Electronic Prescribing Medicines Administration Programme.
- Shared Care Record arrangements.
- Patient-Centred Contact Programme.
- Bridgend Clinical Systems Consolidation.

Digital Inclusion and Adoption

Workstreams are in place to support workforce adoption of digital technologies and equitable access to digital services. For example:

- Digital Inclusion and Accessibility Workstreams.

Workforce digital capability and business change initiatives.

Sources of Assurance (Internal and External)

Assurance is derived from a combination of programme governance, internal and external audit activity, information governance reviews, cyber assurance arrangements and routine reporting on delivery of the Digital & Data agenda. Collectively, these provide oversight of digital transformation programmes, information governance, cyber resilience, compliance and progress against strategic digital priorities.

Recent assurance activity indicates continued progress in a number of areas, including delivery of digital transformation programmes, strengthening governance arrangements and ongoing improvements to digital infrastructure and cyber resilience.

Internal Assurance

The Board receives assurance through a range of governance and reporting arrangements, including:

- Digital Programme Assurance Reports covering delivery of Digital & Data priorities within the IMTP.
- Medical Records Assurance Reports.
- Progress reporting against the Population Health Strategy.
- Clinical Safety reporting.
- Planning, Performance and Finance reporting.
- Reporting through Operational Delivery Committee and associated governance arrangements.

External Assurance

Independent assurance is obtained through external review, audit and compliance frameworks, including:

- Audit Wales reviews.
- Internal Audit reviews.
- All-Wales Information Governance Toolkit assessments and ICO reviews.
- NIS-D Cyber Assessment Framework and associated Cyber Resilience Unit (CRU) improvement monitoring.

Recent assurance highlights

- Review of ePMA Programme provided Substantial Assurance, with two recommendations:
- Discharge Advice Letters: clearly document the transfer of risk into operational business as usual.
- Business continuity: operational services to formally approve relevant standard operating procedures.
    - Discharge Advice Letter - Clearly articulate the transfer of risk to operational business as usual
    - Business Continuity – Operational services to approve standard operating procedures

- Review of Software Development provided Limited Assurane with eight recommendations, strengthening:
    - Software Development Governance and Standards
    - Workforce Competency and Resilience
    - Requirements, Design and Project Assurance Approval
    - Secure Development Assurance
    - Testing, Defect Resolution and Release Approval
    - Deployment, Readiness and Back-out Assurance
    - Post-release Performance
    - Change Control

Overall Assurance Position

Current assurance provides evidence that key governance, cyber security, information governance and digital transformation arrangements are operating effectively. Whilst assurance activity demonstrates progress across a number of programmes and control areas, it also highlights the continuing need to address workforce, resource, infrastructure and digital maturity challenges before full assurance can be obtained that the strategic risk is adequately controlled.

Gaps in Controls / Assurances	Actions taken to Mitigate Gaps	Intended Impact of Mitigating Actions	Actual impact of actions (following implementation)

Gap 1: Digital capability and adoption are not yet sufficiently mature to enable transformation at scale *Whilst significant investment has been made in digital technology, governance and infrastructure, digital literacy, skills and adoption are not yet consistently embedded across the workforce. This limits the Health Board's ability to fully realise the benefits of digital transformation, maximise the value of existing systems, and support organisational change at the pace required.*	Controls in Place / Actions Already Taken • Digital literacy, inclusion and workforce capability are established priorities within Digital & Data planning and IMTP proposals. • A structured Digital Champions network is being established, reconnecting existing champions and superusers while recruiting across services and professional groups to build digital confidence and capability. • Development of supporting infrastructure is underway, including a central Teams/SharePoint hub, baseline assessment of digital confidence and learning needs, and routes for frontline feedback. • Digital capability continues to be developed through local and national transformation programmes, supported by existing learning resources, digital inclusion and accessibility activity, and ongoing cyber awareness. • Engagement is being developed with professional and service leaders, with initial activity prioritising nursing and wider workforce representation. Further Actions Required • Develop a Digital and Data Literacy Strategy that brings together digital literacy, inclusion and clinical digital skills. • Launch and grow the Digital Champions network from January 2027, expanding participation across professional groups and services. • Establish baseline and ongoing measures of digital confidence, capability, adoption and benefits. • Continue engagement with nursing, medical leadership, CTM Education and Training and HEIW to embed digital capability development across the workforce.	• Increased workforce confidence and capability in the use of digital and data tools. • Improved adoption and utilisation of digital systems. • Greater consistency in digital ways of working. • Improved ability to deliver service redesign and transformation enabled by digital technology. • Increased return on investment from digital programmes and infrastructure.	Work completed to date has increased organisational focus on digital literacy, digital inclusion and workforce capability as critical enablers of transformation. Digital skills development is increasingly being incorporated within major change programmes, helping to build awareness and readiness for new ways of working. However, a consistent organisational approach is not yet fully embedded, and further work is required before digital capability is sufficiently mature to support transformation at scale.
Gap 2: Digital workforce capacity and sustainable funding remain insufficient to deliver the required pace of transformation *The scale of the Health Board's digital transformation ambition continues to exceed the available workforce, revenue and capital resources available to deliver it. Whilst progress is being made across a number of programmes, staffing constraints, specialist skills shortages, short-term funding arrangements and competing organisational priorities continue to limit the pace at which digital transformation can be delivered and embedded.*	Controls in Place / Actions Already Taken • Digital and Data workforce requirements are identified through the Integrated Medium-Term Plan and Digital & Data planning processes. • Available capital and revenue funding is prioritised towards the highest-risk areas and strategic priorities. • The 2025/26 Digital & Data capital programme was delivered on time and within budget, supporting investment in digital infrastructure, cyber resilience and digital enablement. • Additional funding opportunities continue to be pursued through national and local programmes. • Recruitment to priority posts is being progressed and specialist contract support utilised where required. • Workforce requirements continue to be reviewed through programme, portfolio and IMTP planning arrangements. Further Actions Required • Develop a sustainable workforce plan for Digital & Data services.	• Improved capacity to deliver digital transformation programmes. • Reduced reliance on contractors and short-term workforce solutions. • Increased resilience across Digital & Data services. • Improved delivery timescales for digital projects and programmes. • Greater ability to support service transformation and organisational priorities.	Investment in digital infrastructure, cyber resilience and transformation programmes has strengthened the Health Board's digital capability and enabled progress across a number of strategic initiatives. Workforce planning and targeted recruitment have also improved understanding of resource requirements. However, workforce, funding and capacity constraints remain significant and continue to affect the speed at which digital transformation can be delivered and sustained.

	• Continue recruitment to priority roles and reduce reliance on temporary arrangements where possible, recognising current constraints from vacancy approval processes. • Improve alignment between organisational demand, workforce capacity and available funding. • Secure recurrent funding to support critical digital and transformation functions. • Maintain a clear prioritisation framework where demand exceeds available resources.		
Gap 3: Digital maturity remains below the level required to fully support integrated, data-driven and digitally enabled models of care *Whilst significant progress has been made in the development of digital systems, infrastructure and governance arrangements, the Health Board's overall digital maturity remains below the level required to fully support integrated care, service transformation and data-driven decision making. Continued reliance on legacy systems, fragmented digital records and national system dependencies limits the pace at which the organisation can realise the full benefits of digital transformation. A number of associated operational and programme risks are managed through the Organisational Risk Register.*	Controls in Place / Actions Already Taken • A range of digital transformation programmes are underway to support the development of integrated digital services and clinical systems. • Electronic Prescribing and Medicines Administration implementation is progressing across the Health Board. • Shared care record arrangements are in place to support information sharing. • Patient-centred contact programme development is underway. • Digital maturity benchmarking is used to inform future planning and capability development. • Digital and data priorities are incorporated within the Digital & Data Strategy and Integrated Medium-Term Plan. • Ongoing engagement with Welsh Government, Digital Health and Care Wales and wider NHS Wales digital programmes supports alignment with national developments. Further Actions Required • Continue implementation of digital transformation priorities and enabling programmes. • Progress development of integrated digital records and digitally enabled patient services. • Improve the availability, quality and use of structured digital information. • Strengthen interoperability and integration across clinical and corporate systems. • Continue to influence and align with national digital developments and architecture.	• Improved access to timely, accurate and integrated information. • Better support for clinical decision making and service redesign. • Reduced reliance on paper-based and manual processes. • Improved patient and staff experience through digitally enabled services. • Increased organisational productivity and efficiency. • Improved digital maturity and readiness for future transformation.	Progress has been made in modernising digital services, strengthening governance arrangements and advancing key transformation programmes, including Electronic Prescribing and Medicines Administration, patient-centred contact services and wider digital enablement initiatives. These developments have improved the foundations for future transformation; however, the Health Board remains at an early stage of digital maturity and further progress is required before the full benefits of integrated, data-driven and digitally enabled care can be realised.

Linked National Priority Measures

Digital and Technology
National Clinical Framework (WHC 2021/03) Welsh Government, March 2021),
Quality and Safety Framework: Learning and Improving (WHC 2021/022 September 2021)
Value Based Health and Care
Coding standards

Current Performance Highlights

Detailed programme, operational and technical updates are reported separately through Digital & Data governance arrangements, programme boards and routine performance reporting. The Board Assurance Framework focuses on the strategic implications of delivery against the Health Board's digital transformation ambition.

Current Position (November 2026)

- Progress continues across key digital transformation programmes. Electronic Prescribing and Medicines Administration has gone live at PCH as planned. Phase 2 of the Ophthalmology referral system (OperaAI) remains in progress. The Patient-Centred Contact Transformation Programme continues to progress, with Intouch Flow Manager discovery commenced for Princess of Wales Hospital, automated clinical cancellation forms ready for pilot deployment, and approval received to award contracts for the programme's digital enablers.
- Adoption of digital services continues to increase, supported by ongoing developments in patient-facing technologies and digital clinical systems.
- Improvements have been made to digital infrastructure resilience, the core network switches have been replaced at PoW, RGH, KHHP and Dewi Sant. Planning is underway for the replacement at PCH
- Automation of cyber incident alerting and handling.
- Progress is also being made in the development of digital and data capabilities to support innovation, artificial intelligence and future service transformation.
- National programme dependencies, workforce capacity constraints and funding pressures continue to affect the pace and sequencing of some digital transformation initiatives.
- Whilst the overall trajectory remains positive, the Health Board's digital maturity remains below the level required to provide full assurance that digital capabilities are sufficiently embedded to support organisational transformation at the desired pace.

Were there any significant incidents affecting this strategic Risk this period:

Critical incidents under NIS-D: - There were no incidents reported to the CRU during this period. However, a small number of high-impact incidents did occur at both local and national level.

Associated Risks escalated to the Organisational Risk Register

Strategic Gap 1: Digital capability and adoption are not yet sufficiently mature to enable transformation at scale		
4672	Inability to achieve timely, accurate clinical coding and structured data standards.	15
Strategic Gap 2: Digital workforce capacity and sustainable funding remain insufficient to deliver the required pace of transformation		
4664	Cyber attack resulting in loss of critical services, data and potential extortion (including specialist cyber capacity and capability challenges).	20
4671	Ageing digital infrastructure impacting service resilience (including workforce and funding constraints affecting infrastructure renewal).	16
Strategic Gap 3: Digital maturity remains below the level required to fully support integrated, data-driven and digitally enabled models of care		
5276	Delay to LIMS 2.0 implementation impacting pathology service continuity	20
5761	Cross Health Board Data Sharing	16
3337	Lack of a Single Electronic Patient Record in Mental Health Services including CAMHS.	15
5040	Digital system integration dependencies.	15
4672	Inability to achieve timely, accurate clinical coding and structured data standards..	15

Strategic Goal(s)	Risk score 16
Improving Care • Delivering safe and compassionate care. • Developing new models of care. • Digital transformation for patients and staff • Ensuring timely access to care Sustaining our Future • Becoming a green organisation • Ensuring our Services financial sustainability Embedding value-based healthcare • Ensuring our estate is fit for the future	

Strategic Risk: Ability to maintain a safe and fit for purpose estate infrastructure – (Risk No. 6)

If: CTMUHB does not have enough capacity and/or resource to be able to deliver and maintain a safe and fit for purpose estate.	*Then:* there is a risk that it may not be able to maintain an estates infrastructure that keeps services functioning, meets statutory compliance regulations and provide enhancements / improvements for patient care and staff wellbeing for now and the future.	*Resulting in:* • An inability to deliver its services efficiently and effectively. • Poor environment and experience for patients and staff • Infrastructure problems • Unable to replace failing/ageing equipment. • Business continuity problems • Poor Estate compliance • Regulatory Compliance issues • Lack of digitally enabled facilities • High carbon footprint • Loss of services and productivity • Increased backlog maintenance

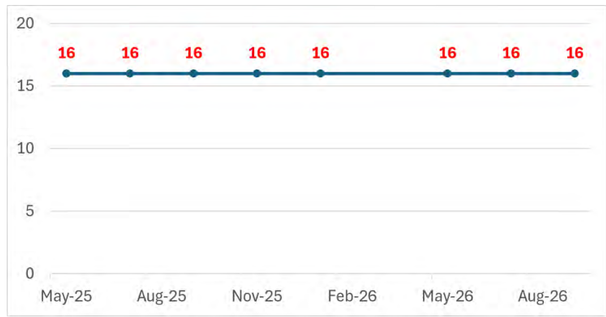
Risk Lead	Executive Director of Finance	Assurance committee	Operational Delivery Committee

	Consequence	Likelihood	Score
Initial	4	4	16
Current	4	4	16
Target	4	3	12
Risk Appetite	Cautious *(quality and safety; trust and confidence; legal and regulatory)* July 2026: Target risk score reviewed and revised to 12 to reflect a more realistic and deliverable position. We are actively managing this risk and expect improvement over time through prioritised capital investment and maintenance programmes; however, progress is constrained by limited capital availability and the scale of backlog maintenance, meaning the pace of risk reduction is currently limited		

Risk Score Trend this Period:

No change to risk scores this period.

Risk Score Trajectory



Rationale for assessment of risk score: *Including where risk score remains unchanged and for any changes*	A score of 16 has been calculated using the Risk Scoring Matrix and the 'Environment and Estate Infrastructure" Domain. Due to the pace of which mitigations will be realised the risk score has been reviewed and remains unchanged.

	Risk reviewed in April 2026 - due to this period in the financial year it is recognised that currently there is limited movement in available capital and therefore additional improvements and investments in infrastructure is limited. However, in November 2025 CTMUHB Board approved the Prince Charles Hospital (PCH) Refurbishment Project Finalised Phase 3 Full Business Case for submission to Welsh Government for capital funding – approval is awaited. In recognising the above position and recent data available from the Estates, Facilities, Performance Management System, which reports a figure of £95m, risk adjusted to £76m, for backlog maintenance the risk score remains unchanged.
Risk Treatment Assessment *i.e. Treat, Tolerate, Transfer etc.*	Whilst recognising the challenges outlined in this risk the health board is continuing to Treat this risk; however, pace of change is not at the desired rate and there are elements where the risk will need to be Tolerated.

Current Control Measures

- Prioritisation of Estate Activity based on risk-based decision making.
- Pursue all capital funding options from Welsh Government to address backlog maintenance and statutory compliance such as:
  - Applications to the Targeted Estates Fund (TEF) to access funding under the infrastructure monies.
  - Applications to the All-Wales Capital Programme on an annual basis.
  - Discretionary Capital
- Maximise current revenue allocations, optimised for statutory compliance and risk priorities.
- Maintenance Programme established managed via the Planet Facilities Management System (Planned and Reactive Maintenance Jobs).
- In 2024-2025 the estates' operational function was digitised, the estates operatives were provided with mobile devices so that they are now able to work in real time, this has helped to maintain performance despite the staff shortages.
- CTMUHB has the highest capital allocation in 2025-2026 than any other Health Board in NHS Wales. However, this still does not mitigate all the gaps in controls and the resulting impact of this risk.

Sources of Assurance (Internal and External)

Internal
- Regular monitoring through CTMUHB'S Executive Capital Management Group.
- Capital Scheme Delivery Programme.
- Annual Estates and Energy Performance Report received at the Operational Delivery Committee (and Planning, Performance and Estates Committee prior to that Committee being disbanded)
- Routine performance reports submitted quarterly to the Estates and Capital Governance Board and monthly at the Estates Operational Management Team meetings.
- Escalation of risks through the Capital and Estates Risk Escalation Group.
- Comprehensive internal audit programme.

External
- NHS Shared Services Partnership- Specialist Estate Services (NWSSP–SES) have collected Estates and Performance Monitoring system data (EFPMS) on behalf of Welsh Government.
- ISO 14001 Certification – Environmental Management achieved.
- Regular reporting and monitoring with Welsh Government.
- Comprehensive external audit programme.

Gaps in Controls / Assurances	Actions taken to Mitigate Gaps	Intended Impact of Mitigating Actions	Indicators of Success (following implementation of mitigating actions)
Gap 1: National Skills shortage in Estates Roles *(Private sector salaries are impacting the CTMUHB's ability to be competitive in the recruitment market) results in staffing challenges to deliver the estates functions.*	Actions already taken: • The Estates Directorate have engaged CTMUHB's Organisational Development department to see what can be done to reverse this recruitment and retention trend. • Concerns have been raised at a national level. Further actions needed / in progress: • Ongoing activity continues with the support of the People Directorate to explore routes	Improved recruitment and retention across Estates roles, increasing capacity to deliver core maintenance and compliance activity and supporting a more stable and sustainable estates function.	Recruitment and workforce planning activity has strengthened understanding of the challenges affecting Estates recruitment and retention. Ongoing attraction initiatives are helping to maintain workforce capacity; however, national workforce shortages and competition from the private sector continue to affect recruitment to key Estates roles.

	to further promote and attract candidates to roles advertised particularly around the Band 6 opportunities within the team as it is acknowledged that recruiting to these roles continues to be a challenge.		
Gap 2: Backlog maintenance requirements continue to exceed available resources and funding.	Actions already taken: • Secured Targeted Estates Funding (TEF) • Proactive in securing additional funding from Welsh Government when available.	Reduction in backlog maintenance and estate-related risks through delivery of prioritised schemes, resulting in a safer, more compliant estate and an improved environment for patients and staff.	Funding secured through Targeted Estates Funding (TEF) and other sources has enabled progress on a number of high-priority maintenance schemes and reduced risk in targeted areas. However, backlog maintenance continues to exceed available resources and remains a significant challenge.
Gap 3: Available capital and revenue funding remains insufficient to maintain and improve the existing estate.	Further actions needed / in progress: • Various business cases in development for example, Phase 3 Prince Charles Hospital, Llantrisant Health Park and Maesteg etc, all of which are ongoing schemes.	Securing capital investment to modernise infrastructure, reduce backlog maintenance and address statutory compliance risks.	Progress has been made in developing business cases and capital investment proposals for priority estate schemes. Whilst this has improved readiness to deliver future investment, delivery remains dependent on securing sufficient capital funding.
Gap 4: Deliver schemes within a live environment Estate improvement works must be delivered whilst maintaining safe and uninterrupted services.	Actions already taken: • Dialogue with service leads. • Secure decant where appropriate. Further actions needed / in progress: • Continue to maintain dialogue with service leads and secure decant where appropriate.	Safe delivery of capital works with minimal disruption to services, ensuring continuity of care and operational resilience during construction activity.	Estate improvement schemes continue to be delivered whilst maintaining operational services. Close collaboration with clinical and operational teams has supported safe project delivery; however, delivering works within a live healthcare environment continues to present operational and programme risks.

Linked National Priority Measures
Energy and Environmental Targets as listed in the CTMUHB Decarbonisation Action Plan (DAP). Deliver the Capital programme within the agreed Capital Resource Limit (CRL).
Current Performance Highlights
Please refer to the Estates Performance Report submitted to the Operational Delivery Committee in April 2025 available here: 29 April 2025 - Cwm Taf Morgannwg University Health Board The next submission will be shared with the Operational Delivery Committee on 30th April 2026.
Were there any significant incidents affecting this strategic Risk this period:

Associated Risks escalated to the Organisational Risk Register		
6235	Insufficient funding to address backlog maintenance across the estate.	16
6766	NEW: Security incidents and vulnerabilities across Health Board sites	16

Strategic Goal(s):		Risk score
Creating Health • Reducing health inequalities • Equal focus on mental and physical health • Supporting our communities • Being a healthy organisation	**Sustaining our Future** • Becoming a green organisation • Ensuring our Services financial sustainability Embedding value-based healthcare • Ensuring our estate is fit for the future.	16

Strategic Risk: Fulfilling our Environmental and Social Duties and ambitions (Risk No.7)

If the Health Board's decisions fail to reflect our values or consider the long-term environmental or social impact	*Then* we will not fulfil our Socio-economic duty, our statutory emission reduction targets, our Wellbeing of Future Generations objectives and our value-based healthcare principles	*Resulting in* negative environmental and social impacts, and loss of trust and confidence among stakeholders

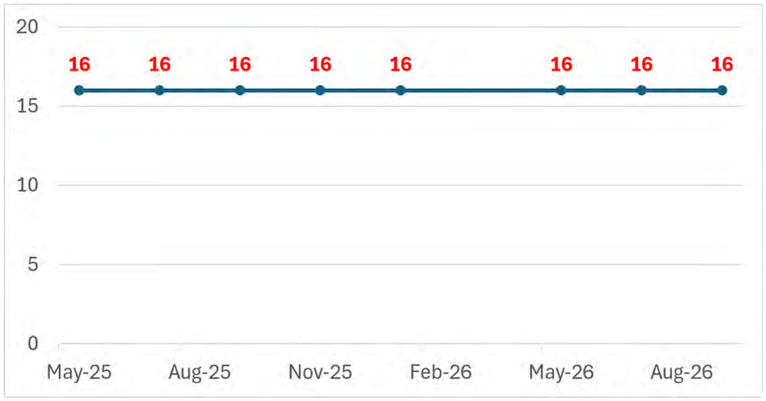
Risk Lead	Executive Director of Strategy and Transformation	Assurance committee	Strategic Development Committee

	Consequence	Likelihood	Score
Initial	4	5	20
Current	4	4	16
Target	4	2	8
Risk Appetite	Cautious *(quality and safety; trust and confidence; legal and regulatory)*		

Risk Score Trend this Period:

No change to risk scores this period.

Risk Score Trajectory



Rationale for assessment of risk score:
Including where risk score remains unchanged and for any changes

The current risk score remains unchanged at 16.
Progress has been made in strengthening governance arrangements, approving the Climate Action Plan, securing funding for decarbonisation initiatives and embedding environmental sustainability considerations into organisational planning.

Positive progress includes delivery of renewable energy schemes, achievement of GreenED accreditation across all Emergency Departments and continued development of sustainability and partnership arrangements.

	However, the risk remains elevated because climate adaptation and resilience arrangements are still maturing, significant investment is required to deliver long-term decarbonisation ambitions, and the pace of improvement continues to be constrained by workforce and financial capacity. Recent periods of hot weather across Wales have also reinforced the importance of continuing to strengthen organisational preparedness for climate-related risks. Whilst the overall direction of travel is positive, further progress is required before a reduction in risk score can be justified.
Risk Treatment Assessment *i.e. Treat, Tolerate, Transfer etc.*	It is recognised that there is an element of tolerating this risk in terms of the pace in being able to mitigate it. There are, however, ongoing risk treatment activity outlined in the mitigating actions section particularly around the Climate Adaption Plan.

Current Control Measures

Strategic Direction and Governance

Strategic oversight of environmental sustainability, climate adaptation and socio-economic responsibilities is provided through established governance arrangements and organisational strategies.

- Environmental Sustainability Group, reporting to the Strategic Development Committee.
- Climate Action Plan.
- CTM2030.
- Integrated Medium Term Planning (IMTP) process aligned to the Wellbeing of Future Generations Act.
- Sustainability Manager role.
- Public Service Board Climate Change Action Group.
- Building Healthier Communities Steering Group

Environmental Sustainability and Decarbonisation

A range of programmes and initiatives are in place to reduce the Health Board's environmental impact and support delivery of NHS Wales decarbonisation ambitions.

- All-Wales sustainable procurement approach.
- REFIT Programme (£11.4m energy-efficiency investment).
- Nitrous Oxide Decommissioning and Gas Capture Scheme.
- Green CTM Staff Forum.
- Waste management initiatives, including elimination of landfill for foodstuffs.
- Reduced use of environmentally impactful anaesthetic gases.
- Climate adaptation actions identified through the Climate Change Risk Assessment.

Social Value and Anchor Institution Activity

The Health Board continues to use its role as a major employer, purchaser and community partner to improve population wellbeing and reduce inequalities.

- Anchor Organisation programme.
- Community wealth building and local procurement initiatives.
- Building Healthier Communities Programme.
- Work to incorporate socio-economic duties within organisational planning and decision-making.

Partnership and Innovation

Partnership arrangements and innovation activity support the delivery of sustainability and wider environmental ambitions.

- Public Service Board partnership arrangements.
- Regional sustainability collaboration.
- Innovation activity focused on environmental sustainability and decarbonisation opportunities.
- Healthy Housing Alliance

Sources of Assurance (Internal and External)

Assurance is drawn from management reporting, specialist oversight and independent review, broadly reflecting the Three Lines of Defence model.

Management assurance (First Line)

Evidence generated through the management and delivery of environmental sustainability, climate adaptation and social-value activity.

- Wellbeing Statement accompanying the Annual Plan and progress reporting against the Annual Plan.
- Environmental Sustainability Annual Report.
- Climate Action Plan monitoring and reporting.
- Progress monitoring of major sustainability projects and investment programmes.
- Emissions reporting in line with the Welsh Public Sector Net Zero Carbon Reporting Approach.
- Heat survey outcomes (emerging)

Specialist oversight and challenge (Second Line)

Evidence from specialist functions and arrangements which provide oversight, scrutiny and challenge of how the risk is being managed.

- Decarbonisation programme reporting through the Strategic Development Committee.
- Environmental Sustainability Group oversight.
- Public Service Board and regional partnership arrangements, including climate-change activity.
- Climate Change Risk Assessment and associated monitoring of climate-adaptation priorities.

Independent assurance (Third Line / External)

Evidence from independent and external sources providing objective review, accreditation and challenge.

- ISO 14001 Certified Environmental Management System accreditation.
- NWSSP Internal Audit Services review of the Decarbonisation Action Plan and associated follow-up activity.
- Independent review of decarbonisation programme delivery and compliance with agreed actions.
- GreenED accreditation across the Health Board's three Emergency Departments.

Key assurance findings this period

Current assurance demonstrates progress in environmental sustainability and decarbonisation, including delivery of renewable-energy and energy-efficiency schemes and external accreditation. However, assurance is less mature in relation to longer-term carbon reduction, climate adaptation and the wider organisational impact of sustainability activity. Further progress and sustained investment are therefore required before a reduction in the current risk score can be supported.

Gaps in Controls / Assurances	Actions taken to Mitigate Gaps	Intended Impact of Mitigating Actions	Actual impact of actions (following implementation)
Gap 1 Climate adaptation and organisational preparedness for climate change are not yet fully embedded	Controls already in place / actions completed • Climate Action Plan approved by Board. • Board development sessions completed to improve awareness and understanding. • Regional Climate Change Risk Assessment (CCRA) developed through the Public Service Board. • High-level climate adaptation risks identified and incorporated into the Climate Action Plan. • Heat survey completed to review impact of extreme weather on CTM staff, patients and systems – over 900 responses Further actions required • Implement priorities arising from the Climate Action Plan. • Continue development of climate adaptation arrangements in line with Welsh Government policy. • Embed climate resilience considerations within strategic planning and service delivery. • Review responses by Climate Adaptation Subgroup and identify “quick wins” and required actions •	Intended impact • Improved organisational resilience to climate change. • Better understanding and management of climate-related risks. • More sustainable services capable of responding to future environmental challenges. • Survey: to inform national EPRR learning, response and planning, as well as internal	Actual impact of actions taken to date The Climate Action Plan has been approved and climate-related risks have been formally assessed and incorporated into organisational planning. Awareness of climate change impacts has increased through Board development activity and regional partnership working. However, implementation remains at an early stage and further work is required before climate adaptation is consistently embedded across all services.
Gap 2 Decarbonisation and sustainable decision-making are not yet fully embedded	Controls already in place / actions completed • Procurement representation established within Environmental Sustainability and decarbonisation groups. • All-Wales sustainable procurement approaches adopted. • Climate Action Plan approved.	Intended impact • Reduced organisational carbon footprint.	Actual impact of actions taken to date Significant progress has been made in establishing governance arrangements, sustainable

across procurement, estates and organisational planning	• Decarbonisation programme supported through the Sustainability Manager function. • REFIT programme funding secured for energy efficiency improvements. • Sustainability considerations incorporated into relevant organisational planning arrangements. Further actions required • Strengthen consideration of carbon impact within procurement decision-making. • Continue delivery of decarbonisation initiatives. • Develop and implement supporting organisational policies and strategies. • Monitor and report progress against Welsh Government decarbonisation requirements.	• Improved sustainability of procurement and operational decision-making. • Increased delivery of decarbonisation objectives. • Progress towards NHS Wales Net Zero ambitions.	procurement networks and decarbonisation programmes. Major energy-efficiency projects and low-carbon initiatives are underway, and sustainability considerations are increasingly incorporated into organisational decision-making. However, financial pressures and competing priorities continue to affect the pace of implementation and delivery.
Gap 3 Capacity and investment remain insufficient to fully deliver environmental sustainability and decarbonisation ambitions	Controls already in place / actions completed • Climate Action Plan approved and endorsed by the Board. • Sustainability Manager appointed to oversee delivery of the programme. • REFIT Programme funding of £11.4m secured to improve energy efficiency. • Targeted Estates Fund (TEF) funding secured for decommissioning of nitrous oxide and gas capture works. • Alternative funding opportunities actively pursued where available. • Sustainability and decarbonisation governance arrangements established. Further actions required • Secure additional capital investment to deliver Climate Action Plan priorities. • Continue delivery of major decarbonisation and energy-efficiency projects. • Identify and access alternative funding streams where available. • Maintain prioritisation arrangements where available funding is insufficient to deliver all planned schemes. • Recruiting Clinical Innovation Sustainability Lead (role will be in place until March 2027)	Intended impact • Increased delivery of Climate Action Plan objectives. • Reduced organisational carbon emissions. • Improved energy efficiency and environmental sustainability. • Increased resilience and sustainability of the Health Board estate. • Progress towards NHS Wales Net Zero ambitions • New clinical lead: support innovation and sustainbility across the system (clinical leadership)	Actual impact of actions taken to date Significant investment has already been secured for a number of decarbonisation and energy-efficiency schemes, including the REFIT programme and targeted estates funding initiatives. This has enabled delivery of priority sustainability projects and strengthened the Health Board's ability to reduce its environmental impact. However, the scale of investment required to achieve long-term decarbonisation ambitions continues to exceed currently available resources, and delivery remains dependent on securing additional funding and capital investment.

Linked National Priority Measures

Economy and Environment
- Emissions reported in line with the Welsh Public Sector Net Zero Carbon Reporting Approach
- Qualitative report detailing the progress of NHS Wales' contribution to climate action as outlined in the organisation's plan.

Qualitative report detailing evidence of NHS Wales advancing its understanding and role within the foundational economy via the delivery of the Foundational Economy in Health and Social Services 2021-22 Programme
The Welsh Government Energy Service have published an updated strategic delivery plan (SDP) which outlines the high-level actions for decarbonisation within the NHS covering 2025-2030.Actions contained in the SDP are being reviewed and allocated to strategic leads.

Wellbeing of Future Generations Act

A More Equal Wales – Socio Economic Duty

Current Performance Highlights

Decarbonisation and Environmental Sustainability

Progress continues in reducing the environmental impact of Health Board operations. All three Emergency Departments have achieved Bronze GreenED accreditation status and CTMUHB received two NHS Wales Sustainability Awards, whilst also securing national innovation funding to support the development of sustainable solutions to waste and environmental challenges. Decarbonisation reporting has continued throughout the year and the Annual Report and Accounts included reporting on progress against the Wellbeing of Future Generations Act objectives.
The solar installation at Coed Ely Solar Farm is now complete and will provide low-carbon electricity directly to Royal Glamorgan Hospital through an innovative private wire arrangement. A further project is underway to utilise surplus renewable energy generated locally to support Prince Charles Hospital. In addition, funding has been secured through the REFIT programme to support energy efficiency and carbon reduction initiatives across the Health Board estate.

Partnerships, Investment and Social Value
Progress continues through partnership arrangements, innovation programmes and wider sustainability initiatives. Significant external funding has been secured through national programmes to support environmental sustainability projects and innovation activity. Work also continues to embed the Wellbeing of Future Generations Act, socio-economic duties and Anchor Organisation principles within organisational planning and decision-making, supporting the Health Board's contribution to wider environmental, social and economic wellbeing objectives.

Were there any significant incidents affecting this strategic Risk this period:

During summer 2026, periods of exceptionally hot weather have highlighted the increasing frequency and impact of climate-related events.
Whilst CTMUHB maintained service delivery throughout these periods, the events reinforced the importance of climate adaptation, organisational resilience and effective partnership working in responding to environmental risks.
The experience has provided a practical demonstration of the relevance of the Health Board's Climate Action Plan and the need to continue strengthening preparedness for future climate-related events, including the potential impacts on vulnerable populations, infrastructure and service delivery.

Associated Risks escalated to the Organisational Risk Register

Linked to all three strategic gaps:		
5374	Fulfilling environmental and social duties. *This Directorate-led risk reflects the operational delivery of the Climate Action Plan, climate adaptation arrangements, decarbonisation programme, socio-economic duties and wider environmental sustainability objectives. It provides the principal operational risk underpinning this strategic BAF risk and supports all three strategic gaps.*	16
Gap 3: Capacity and investment remain insufficient to fully deliver environmental sustainability and decarbonisation ambitions		
6235	Insufficient funding to address backlog maintenance across the estate. *This risk reflects the financial and infrastructure constraints that affect the Health Board's ability to modernise its estate, improve energy efficiency and deliver elements of its longer-term decarbonisation ambitions.*	16

Strategic Goal(s):

Creating Health
- Reducing health inequalities
- Equal focus on mental and physical health
- Supporting our communities
- Being a healthy organisation

Sustaining our Future
- Becoming a green organisation
- Ensuring our Services financial sustainability Embedding value-based healthcare
- Ensuring our estate is fit for the future

Risk score
20

Strategic Risk: Prevention and early Intervention to support Healthy Life Expectancy (Risk No.8)

If CTMUHB does not effectively shift its services to prevention and early intervention and engage the population to improve their health	*Then* There will be a decrease in Healthy Life Expectancy (HLE) and an increase in the gap between the most and least deprived and an unsustainable health service. We will also fail to improve healthy life expectancy and reduce inequalities in healthy life expectancy	*Resulting in* poorer health outcomes, greater inequalities and an unsustainable health service.

Risk Lead	Executive Director of Public Health	Assurance committee	Strategic Development Committee

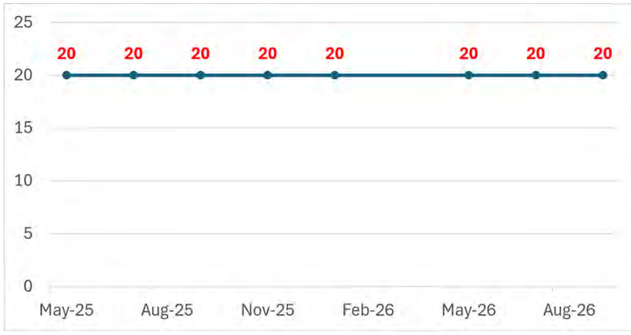
	Consequence	Likelihood	Score
Initial	5	4	20
Current	5	4	20
Target	4*	2	8
Risk Appetite	Cautious *(quality and safety; trust and confidence; legal and regulatory)*		

Risk Score Trend this Period:

*The consequence score has reduced for the target score assessment, as there will be an element of both mitigation and adaptation. The Health Board aims to reduce the behaviour and health risks (primary, secondary, tertiary prevention); however, the organisation will still need to adapt as appropriate.

No change to risk scores this period.

Risk Score Trajectory



Rationale for assessment of risk score: *Including where risk score remains unchanged and for any changes*	The current risk score remains unchanged at 20. Whilst progress continues through a range of prevention, population health and inequalities programmes, the latest population health data indicates that Healthy Life Expectancy (HLE) remains significantly below the Welsh average and continues to decline. Significant inequalities also persist across the CTM population, demonstrating that the scale and pace of change are not yet sufficient to improve long-term population outcomes. Current Position: Life Expectancy and Healthy Life Expectancy: The most recent data published in June 2026 by Public Health Wales shows that: • In CTM, Healthy life expectancy at birth is 55.0 years for females, and 56.0 years for males in 2022-2024; both significantly lower than the average in Wales (58.5 and 59.2 years respectively).

	• Healthy life expectancy has been decreasing in recent years across CTM and Wales, for both males and females. • Significant inequalities remain, with the gap in Healthy Life Expectancy between the most and least deprived populations continuing to widen In 2022-2024, the gap in Healthy life Expectancy at birth between the most and least deprived across Wales has increased from 15.3 years to 18.1 years for males, and from 18.5 years to 19.0 years for females. Recent analysis from the Office of National Statistics (ONS) shows that Healthy Life Expectancy declined across all three local authority areas within CTM between 2011-13 and 2022-24, for both males and females. In particular, the drop in female HLE is now lower than males in each LA. With Healthy Life Expectancy in CTM reducing, people are living for longer in ill health, utilising additional health care services and raising further questions about the sustainability of effective health care within the limited budget available. Deprivation: CTM has a higher percentage of more deprived areas than other Health Board areas in Wales, with 51.9% of the population in CTM living in the two most deprived fifths in Wales (WIMD, 2025). Linked to this, CTM lags behind the national average in healthy lifestyle behaviours and health outcomes and growth in healthcare demand may be higher than in the rest of Wales. Inequalities in Health: The gap in life expectancy at birth between the most and least deprived in CTM is now estimated at 6 years for males and 5.3 years for females. With regards to Healthy life expectancy, the gap is greater, at 10.7 years and 12.1 years for males and females respectively (PHW 2024). Population Changes: In CTM, the population is ageing; by 2040, a significant (20%) increase is projected in the number of people aged 65+, with the most significant (48%) increase in those aged 85+.The number of people with chronic diseases including cardiovascular diseases, respiratory diseases, diabetes and rheumatoid arthritis is also projected to increase significantly in the next 5 years therefore placing increased demand on services. Increasing levels of ill-health, an ageing population and growing prevalence of chronic conditions are expected to place further pressure on health and care services over the coming years. The risk therefore remains elevated due to: • Continued reductions in Healthy Life Expectancy. • Persistent health inequalities across the CTM population. • Capacity constraints and short-term funding arrangements affecting prevention and population health activities. • Slower than anticipated implementation of some prevention initiatives, including elements of children's weight management services • Ongoing gaps in the provision of preventative services such as the level 2 and 3 adult weight management service unable to meet demand, with excessive waiting lists of many years Increasing population demand associated with deprivation, ageing and chronic disease Overall Trajectory: Whilst not inevitable, the current trajectory indicates increasing health risks reduced healthy life expectancy and widening inequalities. Capacity to support a prevention and population health approach continues to be a challenge linked to short term funding for prevention activities in public health and competing priorities for existing resources across the health board.

	If CTMUHB is going to deliver a sustainable service for our population and meet our obligations under the wellbeing goals of the WBFGA (A more equal Wales, A healthier Wales) then a shift of resources and services to prevention and early intervention will be needed to effectively engage the population to improve their health.
Risk Treatment Assessment *i.e. Treat, Tolerate, Transfer etc.*	This risk is being treated and managed through programmes of primary, secondary and tertiary prevention across the health board, as well as in partnership with system partners to influence the wider determinants of health.

Current Control Measures

National Plans and Welsh Government Strategies/groups:

- "Healthier Wales",
- "Healthy Weight Healthy Wales",
- "Smoke Free Wales"
- Welsh Government Health protection Operational and Resilience Group
- Well-being of Future Generations (Wales) Act (WBFGA),
- Marmot Nation Principles

CTM Organisational Strategic Direction and Governance

- Strategic leadership and oversight of prevention, population health and inequalities is provided through established strategies, boards and planning arrangements:
- CTM2030.
- Creating Health Programme Board.
- Creating Health Delivery Plan.
- Local Public Health Team portfolio.
- Public Health input to IMTP planning.
- Contribution to the Wellbeing Assessments (PSB) and Population Needs Assessments (RPB) regionally
- Healthcare Public Health

Health Protection and Prevention Programmes

A range of programmes are in place to improve prevention, health protection and early intervention:

- Health Protection Strategy.
- All Hazards Health Protection Plan.
- Vaccine Equity Strategy.
- Healthy Weight Whole-System Approach.
- Help Me Quit Hospital Programme.
- PIPYN Service
- WISE Programme.
- Diabetes Strategic Plan.
- Cancer Inequalities Programme.
- Stroke Equity Programme.
- Behavioural Science Programme

Population Health Management and Intelligence

Population Health Management approaches are being developed to improve understanding of population need and support targeted intervention:

- Population Health Management Programme.
- Primary Care Cluster Population Health approaches.
- Population health analysis and prioritisation processes.

Partnership and Whole-System Working

- The Health Board works with partners to address wider determinants of health and reduce inequalities including;
- Regional Partnership Board

- Public Service Board
- Area Partnership Board
- Local Authorities
- Leadership Groups and Partnership Forums.
- Marmot programme arrangements.
- Public Health Wales and
- Third-sector organisations and community leaders

Sources of Assurance (Internal and External)

Assurance is drawn from management information, specialist oversight and external evidence, broadly reflecting the Three Lines of Defence model. Given the long-term nature of population-health outcomes, assurance includes both evidence of programme delivery and evidence of whether this is translating into improved population outcomes.

Management assurance (First Line)

Evidence generated through the delivery and monitoring of population health, prevention and health-protection activity.

- Wellbeing Statement and progress reporting against the Annual Plan.
- Creating Health Programme reporting.
- Director of Public Health Annual Report.
- Population Health Management Programme reporting.
- Health Protection and Vaccination Programme reporting.
- Integrated Performance Dashboard and population-health measures.
- Mental Health Strategic Updates.
- Acute Clinical Services Plan (ACSP) updates.
- Transformation Fund and Leadership Board updates.

Specialist oversight and challenge (Second Line)

Evidence from specialist and governance arrangements providing scrutiny and challenge of delivery and progress.

- Creating Health Portfolio Board reporting through the Transformation Board.
- Population Health and Partnerships Committee scrutiny of prevention, population health and partnership programmes.
- Health Protection governance and oversight arrangements.
- Regional Partnership Board reporting and partnership oversight.

External assurance / benchmarking

Evidence from external sources providing additional assessment, comparison or oversight.

- Public Health Wales population-health intelligence and benchmarking.
- Office for National Statistics Healthy Life Expectancy data.
- Welsh Government and NHS Wales population-health and prevention measures.
- Regional Partnership Board Annual Report, where this provides wider system assurance on partnership delivery.

Key assurance findings this period

The assurance picture remains mixed. There is evidence of continued programme development and delivery across prevention, health protection and population health. However, population-level evidence continues to show declining Healthy Life Expectancy and persistent inequalities. This indicates that programme activity is not yet translating into sustained improvement in the outcomes the risk is seeking to influence, supporting the continued high assessment of the risk.

Gaps in Controls / Assurances	Actions taken to Mitigate Gaps	Intended Impact of Mitigating Actions	Actual impact (following implementation of mitigating actions)
Gap 1: Health Protection and Immunisation capacity remains insufficient to fully deliver its contribution to the Health Board's wider prevention and population health priorities.	Controls already in place / actions completed • Recurrent funding secured from 2024/25 onwards. • Increase in allocation of £1.06m secured. • All Hazards Health Protection Plan signed off for implementation. Further actions required	• Sufficient capacity to deliver Health Protection priorities. • Improved resilience and sustainability of health protection services. • Reduced variation in delivery of Health Protection programmes.	Sept 2026: Additional recurrent funding has strengthened Health Protection capacity and supported implementation of the All Hazards Health Protection Plan. This has improved the Health Board's ability to deliver key Health Protection priorities; however, funding remains below the Welsh "Fair Shares" allocation and

	• Secure additional funding to address the remaining gap between CTM and the Welsh "Fair Shares" allocation. • Deliver remaining priorities within the Health Protection Strategic Plan.		capacity constraints continue to limit full delivery of the strategic plan.
Gap 2: Population Health Management capability and infrastructure are not yet sufficiently developed to support population-based planning and intervention.	Controls already in place / actions completed • Population Health Management programme established alongside Primary Care Clusters. • Population Health priorities identified through the Local Public Health Team portfolio. Further actions required • Continue implementation of the Population Health Management programme. • Develop and prioritise shared clinical record capability. • Establish a clearly defined strategic plan for delivery of Population Health Management.	Improved use of Population Health Management data to inform strategic planning and service delivery. Better targeting of resources towards population need. Improved population intelligence to support prevention and early intervention.	Sept 2026: Population Health Management approaches are becoming more established within Primary Care Clusters and are increasingly informing local planning and prioritisation. This has strengthened understanding of population need and opportunities for intervention; however, the programme remains at an early stage of development and full implementation has not yet been achieved.
Gap 3: A whole-system approach to prevention and inequalities with sufficient associated resource, is not yet fully embedded across the Health Board and partner organisations.	Controls already in place / actions completed • Creating Health Delivery Plan approved. • Creating Health Portfolio Board established. • Health Protection Strategy approved. • Vaccine Equity Strategy in place. • Healthy Weight Whole-System Approach established. • Help Me Quit Hospital programme implemented. • WISE programme in place. • Cancer Inequalities Group established. • Stroke Equity Audit recommendations being implemented. • Diabetes Strategic Plan in place. • Partnerships established through Regional Partnership Boards, Public Service Boards and leadership groups. • Marmot principles adopted across Public Service Board arrangements. • PSB Health Inequalities workstream established Further actions required • Continue implementation of Creating Health Delivery Plan priorities. • Embed prevention and inequalities objectives across all Health Board services. • Expand evidence-based prevention programmes where funding permits. • Strengthen collaborative action on wider determinants of health. • Improve outcome monitoring and measurement of health inequalities.	Increased investment in prevention and early intervention Improved Healthy Life Expectancy. Reduced inequalities in health outcomes. Reduced variation in access and outcomes across the CTM population. Better alignment of resources towards prevention and early intervention. Reduced burden of chronic disease.	Sept 2026: Significant progress has been made in establishing strategic frameworks, partnership arrangements and prevention programmes to support population health improvement. This has strengthened organisational focus on prevention, inequalities and wider determinants of health, while increasing collaboration with regional and local partners. However there remains insufficient resource in prevention and early intervention to influence the longer-term population health outcomes needed.

Linked National Priority Measures

Population Health – Ministers Measures Phase One

- Percentage of adults losing clinically significant weight loss (5% or 10% of their body weight) through the All-Wales Weight Management Pathway
- Qualitative report detailing progress against the Health Boards' plans to deliver the NHS Wales Weight Management Pathway
- Percentage of adults (aged 16+) reporting that they currently smoke either daily or occasionally.
- Percentage of adult smokers who make a quit attempt via smoking cessation services.
- Qualitative report detailing the progress of the delivery of inpatient smoking cessation services and the reduction of maternal smoking rates.

NHS Performance Framework Quadruple aim one:

- Percentage of children who are up to date with the scheduled vaccinations by age 5 ('4 in 1' preschool booster, the Hib/MenC booster and the second MMR dose)
- Percentage of children receiving the Human Papillomavirus (HPV) vaccination by the age of 15
- Percentage uptake of the influenza vaccination amongst adults aged 65 years and over
- Percentage uptake of the Respiratory Syncytial Virus (RSV) vaccination for those turning 75 years old
- Percentage of adult smokers who make a quit attempt via smoking cessation services.
- Percentage of adult smokers who make a quit attempt via smoking cessation services who are co-validated as quit at 4 weeks.
- Percentage of people who have been referred to health board services who have completed treatment for substance misuse (drugs or alcohol)
- Percentage of patients offered an index colonoscopy procedure within 4 weeks of booking their Specialist Screening Practitioner assessment appointment.
- Percentage of patients (aged 12 years and over) with diabetes who have had foot surveillance recorded within the last 15 months.
- Percentage of patients (aged 12 years and over) with diabetes who have had their urine albumin recorded within the last 15 months.
- Percentage of population (adult) receiving NHS dental care over a 24-month period – General Dental Services (GDS)
- Percentage of population (child) receiving NHS dental care over a 12-month period – General Dental Services (GDS)

Current Performance Highlights

Please refer to Integrated Performance Dashboard - Quadruple Aim 1.

Were there any significant incidents affecting this strategic Risk this period:

No

Associated Risks escalated to the Organisational Risk Register

6179	High and increasing prevalence of overweight and obesity in children and adults	20
5579	Rising childhood obesity rates resulting in an increase in obesity related conditions and poorer health outcomes.	16
5820	Potential inability to deliver all elements of the Health Protection Strategic priorities as a result of reduced allocation of funding.	12

Strategic Goal(s)	Risk score
Sustaining our Future • Becoming a green organisation • Ensuring our Services financial sustainability Embedding value-based healthcare • Ensuring our estate is fit for the future	20

Strategic Risk: Failure to deliver a sustainable plan and manage revenue resources within the Revenue Resource limits set by Welsh Government (WG) – (Risk No.9)

If the Health Board fails to deliver and sustain an approved Integrated Medium-Term Plan and manage its revenue resources within the 'Revenue Resource limits' set by WG.	*Then* we may fail to fulfil our two statutory financial duties (i.e. Approved IMTP and break even over 3-year period)	*Resulting in* Breach of statutory duties, application of the escalation framework by Welsh Government, trust and confidence in the Health Board (reputational impact).

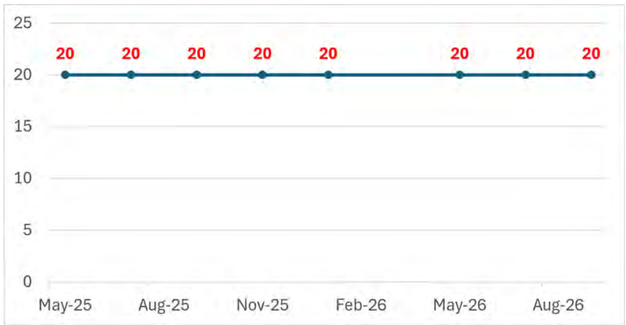
Risk Lead	Executive Director of Finance	Assurance committee	Operational Delivery Committee

	Consequence	Likelihood	Score
Initial	4	5	20
Current	4	5	20
Target	4	3	12
Risk Appetite	Cautious *(quality and safety; trust and confidence; legal and regulatory)*		

Risk Score Trend this Period:

No change to risk scores this period.

Risk Score Trajectory



Rationale for assessment of risk score:
Including where risk score remains unchanged and for any changes

As part of the 2026-2029 IMTP, the Health Board has submitted a balanced financial plan for 26/27 for both Capital & Revenue resource. Both of these plans include risks, particularly the Revenue Plan which includes the delivery of £31.3m of savings together with £38.6m of risks and an assumption that WG will support the £18.4m Welsh Risk Pool pressure if the HB delivers a break-even financial position.

Welsh Government has approved the 2026-29 IMTP.

~~The HB awaits the formal response of the submitted IMTP and if the plan is approvable, development of robust savings plans will be critical to provide WG with confidence upon the deliverability of the IMTP financial plan~~.

	The financial outlook for 2027/2028 and beyond looks very challenging and there is a significant risk to achieving a recurrent balanced financial plan. The month 6 ~~2~~ year to date position is reporting a £9.7 ~~£5.2m~~ deficit with a savings shortfall of £5.7 ~~£4.4m~~. Further cost pressures of £10m ~~£1.2m~~ have been partially offset by £1m ~~£0.3m~~ of unplanned additional income relating to the EPMA programme, and £4m accountancy gains. The recurrent position has deteriorated by £11.8m with a forecast underlying position of £11.5m being reported at Month 6. ~~will be reviewed following month 3 reporting.~~
Risk Treatment Assessment *i.e. Treat, Tolerate, Transfer etc.*	The financial plan highlights a high level of risk for in year achievement but with a far more significant level of risk for 2027/2028 and beyond. This risk will therefore be *treated* until there is confidence that the Health Board can achieve the planned break-even position.

Current Control Measures

Financial Management

- Financial Accountability letters to be issued by CEO.
- Budget setting process and Budgetary control framework paper to be presented to EMB for approval.
- Standing Financial Instructions
- Scheme of Reservation & Delegation
- Local Counter-Fraud Service
- Monthly financial performance reviews for Care Groups and corporate directorates

Sources of Assurance (Internal and External)

Assurance is drawn from management information, specialist oversight and independent review, broadly reflecting the Three Lines of Defence model.

Management assurance (First Line)

Evidence generated through the day-to-day management and monitoring of the Health Board's financial position.

- Monthly Finance Reports, including year-to-date position, forecast outturn and underlying financial position.
- Savings plan performance and delivery reporting.
- Monthly financial performance reviews for Care Groups and corporate directorates.
- Welsh Government financial monitoring returns.

Specialist oversight and challenge (Second Line)

Evidence from specialist functions and governance arrangements providing scrutiny and challenge of financial performance and control.

- Value and Efficiency Group oversight of savings delivery.
- Losses and Special Payments reporting to the Audit, Risk and Assurance Committee.
- Financial performance and delivery scrutiny through the Health Board's governance arrangements.

Independent assurance (Third Line / External)

Evidence from independent and external sources providing objective review and challenge.

- Internal Audit Programme.
- External Audit Programme.
- Annual Report and Accounts, including the externally audited financial statements.

Gaps in Controls / Assurances	Actions taken to Mitigate Gaps	Intended Impact of Mitigating Actions	Actual impact of actions (following implementation of mitigating actions)
1. Understanding of budgetary control and procurement processes in some services	• Deliver budget holder training within Care Groups/Directorates – *Ongoing throughout 2026/2027.* • Deliver procurement training to departments where compliance with procurement	Budget holders, through regular training, will be better informed in terms of process and best practice. Greater focus on compliance.	The actions are underway but any benefit to the impact on the financial position is being offset by inflationary and/or demand pressures.

	processes is low - *Ongoing throughout 2026/2027.*	Informed decision making through confidence gained through training and experience. Improvement in underlying position, visible through reporting of delegated budgets.	
2. A recognised risk of shortfalls in savings delivery	• Develop a more streamlined programmatic approach to planning and delivery of efficiency savings schemes, with a focus on cost reductions and managing expenditure within allocated budgets for 26/27 as well as identifying pipeline schemes in delivery for 27/28. • Disseminate the learning from the Health Board's Value Based Healthcare projects to drive service planning and improvement going forward. • Developing the Value & Efficiency Programme with a focus on 'Enabling schemes' to support savings identification and delivery.	A programmatic approach will support consistency and will help in clearly defining roles, responsibilities, and deliverables. Shared learning across directorates will identify areas of best practice and what has worked well.	The actions are underway, but as at Month 6 the latest forecast savings of £29m remains £2.3 m short of the £31.3m plan. Performance against the approved savings plan is reported via the Value and Efficiency Group.

Linked National Priority Measures

1. YTD position
2. Savings plan position

Current Performance Highlights

- The M6 ~~M2~~ YTD position is reporting a £9.7m ~~£5.2m~~ deficit against plan.
- Latest savings plans have identified £29.0m ~~£14.5m~~ of the £31.3m savings plan required.
- There remains a risk to delivering a balanced financial plan for 2026/27

Were there any significant incidents affecting this strategic Risk this period:

Demand and inflationary pressures are now ~~Non delivery of savings remains~~ the most significant cause for the year to date deficit.

Associated Risks escalated to the Organisational Risk Register

6596	Failure to reduce the £9.2m recurrent deficit at the start of 26/27 down to the planned £0.3m recurrent surplus at the end of 26/27	20
6597	Failure to achieve the planned break-even position in 2026/2027	20

Strategic Goal(s)			Risk score 16
Improving Care • Delivering safe and compassionate care • Developing new models of care • Digital transformation for patients and staff • Ensuring timely access to care		Sustaining Our Future • Becoming a green organisation • Ensuring our Services financial sustainability Embedding value-based healthcare • Ensuring our estate is fit for the future	
Strategic Risk: Ability to develop a fit for the future estate to reflect our future clinical service model – (Risk No.10)			
If CTMUHB is unable to invest in its estate so it's fit for future.	*Then* there is a risk that CTMUHB may not be able to deliver the required enhancements / improvements to support patient care and staff wellbeing for the future and to align with the strategic vision and ambitions.	*Resulting in* • Being unable to deliver its services efficiently and effectively in the right place with the right provision at the right time in modern and fit for purpose healthcare facilities. • Impact on environment for patients and staff • Future site development plans may not be fit for purpose. • Less ability to ascertain NHS capital or alternative financial support for the future development of its sites. • Lack of digitally enabled facilities • High carbon footprint	

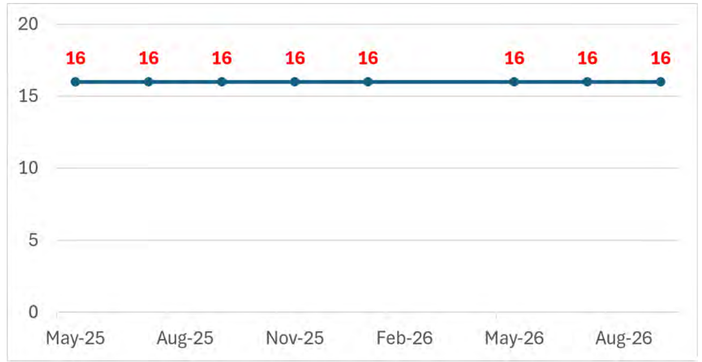
Risk Lead	Executive Director of Finance	Assurance committee	Strategic Development Committee

	Consequence	Likelihood	Score
Initial	4	4	16
Current	4	4	16
Target	4	2	8
Risk Appetite	Cautious *(quality and safety; trust and confidence; legal and regulatory)*		

Risk Score Trend this Period:

No change to risk scores this period.

Risk Score Trajectory



Rationale for assessment of risk score: *Including where risk score remains unchanged and for any changes*	A score of 16 has been calculated using the Risk Scoring Matrix and the 'Environment and Estate Infrastructure" Domain. Due to the pace of which mitigations will be realised the risk score has been reviewed and remains unchanged.

	Risk score reviewed in July 2026 and no changes made. The Strategic Clinical Services Plan is still being developed. Funding for the estate is based on the highest risk factor and therefore funding allocations are based on informed risk-based decision making.
Risk Treatment Assessment *i.e. Treat, Tolerate, Transfer etc.*	Whilst recognising the challenges outlined in this risk the health board is continuing to Treat this risk; however, pace of change is not at the desired rate and there are elements where the risk will need to be Tolerated.

Current Control Measures

The Health Board will continue to seek all opportunities for WG funding such as Targeted Estates funding (TEF) to address high priority backlog issues.

Sources of Assurance (Internal and External)

Internal
- Regular monitoring through CTMUHB'S Capital Programme Board.
- Capital Scheme Delivery Programme
- Project Boards established for specific capital schemes.

Gaps in Controls / Assurances	Actions taken to Mitigate Gaps	Intended Impact of Mitigating Actions	Actual Impact of Actions (following implementation)
Gap 1: A long-term estate strategy aligned to the future clinical service model is not yet fully developed.	Actions already taken: • Delivery continues against IMTP priorities • Strategic Clinical Services Plan development is underway. • Priority estate requirements have been identified through planning processes. Further actions needed / in progress: • Develop a comprehensive future estate strategy aligned to the agreed clinical model.	Continued investment targeted at highest-risk areas to maintain safe, operational estate infrastructure and support delivery of services while the longer-term estate strategy is being developed.	Delivery of IMTP estate priorities has continued, ensuring investment remains focused on the highest-risk and most critical areas. However, the future estate strategy remains dependent on completion of the Strategic Clinical Services Plan and is not yet fully developed.
Gap 2: Sufficient capital funding has not yet been secured to deliver Capital Schemes.	Actions already taken: • Development of business cases for major schemes including Prince Charles Hospital Phase 3 and Llantrisant Health Park. • Ongoing capital planning arrangements through IMTP processes. • Prioritisation of schemes based on organisational need and strategic fit. Further actions needed / in progress: • Secure approval and funding for priority capital schemes. • Continue development of business cases and supporting evidence. Explore future funding opportunities and alternative financing approaches where appropriate.	More effective use of available capital funding to progress priority schemes, supporting improvements to estate condition and enabling services to operate from safe and appropriate facilities.	Progress has been made in developing strategic business cases and preparing priority capital schemes for future investment. Whilst this has improved organisational readiness, delivery remains dependent on securing sufficient capital funding and approval of major projects.

Linked National Priority Measures

Current Performance Highlights

Were there any significant incidents affecting this strategic Risk this period:		
Associated Risks escalated to the Organisational Risk Register		
6235	Insufficient funding to address backlog maintenance across the estate. *This risk reflects the continuing pressure that backlog maintenance places on available estate resources and investment. It is a significant contributor to Strategic Risk 10 as estate funding and capacity are required both to maintain the existing estate and to develop facilities that support future clinical service models.*	16

Strategic Goal(s)						Risk score
	Improving Care • Delivering safe and compassionate care • Developing new models of care • Digital transformation for patients and staff • Ensuring timely access to care		Sustaining Our Future • Becoming a green organisation • Ensuring our Services financial sustainability Embedding value-based healthcare • Ensuring our estate is fit for the future		Creating Health • Reducing health inequalities • Equal focus on mental and physical health • Supporting our communities • Being a healthy organisation	16

Strategic Risk: Delivery of an Integrated Care Model (Risk No.11)		
If CTMUHB is unable to develop and deliver an integrated care model - both within the NHS and with wider social care and Third Sector partners - that is community based, proactive and which achieves greater continuity and coordination of care.	*Then there will be:* • A lack of collective responsibility for planning services, improving health and reducing inequalities in the population served. • Failure to wrap around robust community services which are responsive to patient needs around the GP practice teams. • A negative impact on Primary Care teams and demand for services resulting in instability of Primary Care services. • A negative impact on productivity and value for money; and • Limited support to broader social and economic development.	*Resulting In:* CTMUHB being unable to improve outcomes and reduce health inequalities for its population and therefore failure to deliver the objectives set out in CTM 2030.

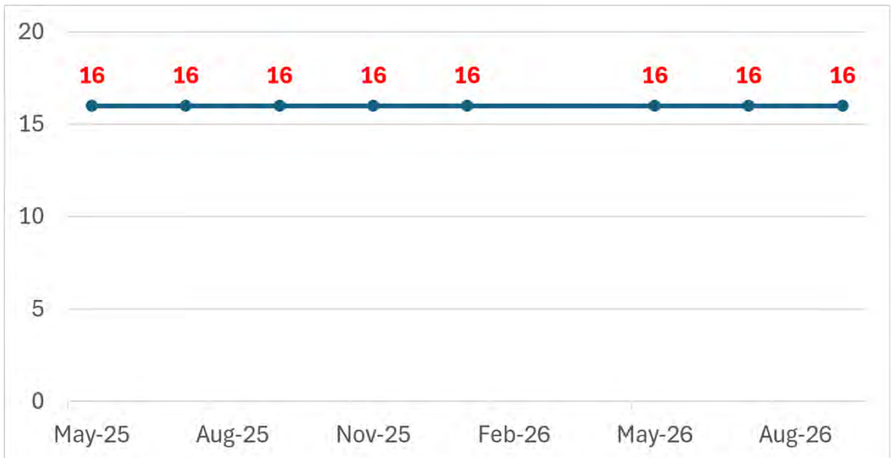
Risk Lead	Chief Operating Officer	Assurance committee	Strategic Development Committee

	Consequence	Likelihood	Score
Initial	4	4	16
Current	4	4	16
Target	4	2	8
Risk Appetite	Cautious *(quality and safety; trust and confidence; legal and regulatory)*		

Risk Score Trend this Period:

No change to risk scores this period.

Risk Score Trajectory



Rationale for assessment of risk score: *Including where risk score remains unchanged and for any changes*	The current risk score remains unchanged at 16. Significant progress has been made in strengthening integrated working through the Regional Partnership Agreement, development of the Integrated Community Care System (ICCS), expansion of Hospital@Home and maturing admission avoidance and discharge pathways. Work is also underway with the National Association of Primary Care to develop a

	future primary and community care model and implementation roadmap. However, the risk remains elevated because: • digital integration and information sharing arrangements are not yet fully embedded; • sustainable primary and community care models remain under development; and • further progress is required to achieve fully integrated planning, commissioning and delivery across partner organisations. Whilst the overall direction of travel is positive, further progress is required before a reduction in risk score can be justified.
Risk Treatment Assessment *i.e. Treat, Tolerate, Transfer etc.*	This risk is being treated and managed through transformation programmes across CTMUHB and in regional programmes with system partners

Current Control Measures

Strategic Leadership and Programme Governance

- A programme of work (Integrated Community Care System Programme) is in place to support development of integrated health and social care services across the CTM region, aligned to the Clinical Services Plan, CTM2030 and national integrated care priorities. The leadership of this programme sits under the Regional Partnership Board. This is supported by the Integrated Leadership Board and the Partnership Leadership Team. These are forums that bring together Health, Local Authorities and the Third Sector.
- Within CTMUHB, the transformation required to support this joint programme is managed through the Primary Care and Community Transformation Programme / Board (see below)

Integrated Care and Digital Enablement

Work is underway to develop the digital infrastructure, information sharing and governance arrangements required to support integrated models of care.

- Development of integrated community care records.
- Introduction of MOSAIC within local authority services and oversight from the Connecting Care Programme Board.
- Work to align health, primary care and local authority systems.
- Development of integrated performance frameworks and outcome measures.
- Community care digital record programme.

Primary and Community Care Transformation (Community By Design is the national programme)

A range of initiatives are in place to support development of sustainable primary and community care services and future delivery models.

- National Association of Primary Care review and model development work.
- General Medical Services transformation initiatives.
- Community Pharmacy transformation programme.
- Community Services transformation programme.
- Implementation of the National Single Point of Access (SPOA) Framework.
- Cluster development and strengthening of clinical leadership arrangements.
- Comprehensive listening and engagement activity to inform improvement programmes.

Partnership and System Integration

Partnership arrangements are in place to support joint planning, integrated commissioning and development of a more connected health and care system.

- Regional Partnership Agreement (Section 33).
- Regional Partnership Board arrangements.
- Regional Integration Fund and Capital Programme initiatives.
- Joint Partnership Boards in the three local authority areas.
- Regional Needs Assessment and Regional Area Plan.
- Collaboration with local authorities, third-sector organisations and wider system partners.

Population Wellbeing and Self-Management

Programmes are in place to support prevention, self-management and improved community-based care.

- 3Ps Programme.
- Community Voluntary Council partnership arrangements.

- Community by Design principles.
- Programmes supporting informed decision-making and self-management.

Sources of Assurance (Internal and External)

Assurance is drawn from management reporting, specialist oversight and external review, broadly reflecting the Three Lines of Defence model.

Management assurance (First Line)

Evidence generated through the management and delivery of integrated care programmes and services.

- Integrated Performance Report.
- Integrated Community Care System and primary/community care transformation programme reporting.
- Regional Partnership Board and Integrated Leadership Board highlight reports.
- Regional Integration Fund (RIF) and regional capital programme reporting.
- Integrated performance dashboards and outcome measures as these continue to develop.

Specialist oversight and challenge (Second Line)

Evidence from governance and partnership arrangements providing scrutiny and challenge of delivery and progress.

- Strategic Development Committee scrutiny of integrated-care and transformation programmes.
- Regional Partnership Board oversight of integrated-care priorities and programmes.
- Integrated Leadership Board oversight.
- Primary Care and Community Transformation Board oversight.
- Connecting Care Programme Board oversight of digital integration and shared-care arrangements.

External assurance / oversight

Evidence from external scrutiny and regional arrangements providing additional review and challenge.

- Welsh Government Integration Accountability Meeting outcomes and associated feedback.
- Welsh Government monitoring and oversight of Regional Integration Fund programmes.
- External review and feedback associated with nationally supported primary and community care transformation.

Key assurance findings this period

Current assurance demonstrates continued progress in regional collaboration, integrated community care and partnership working, including established governance arrangements and evidence of benefits from RIF-supported services. However, assurance remains less mature in relation to fully integrated digital arrangements, sustainable primary and community care models, and measurable system-wide outcomes. Continued RIF and IRCF funding from 2027/28 provides greater certainty over the continuation of key regional programmes, although future funding allocations are still to be confirmed by Welsh Government.

Gaps in Controls / Assurances	Actions taken to Mitigate Gaps	Intended Impact of Mitigating Actions	Actual impact of actions (once completed)
Gap 1 Digital and information-sharing infrastructure is not yet sufficiently developed to support integrated care	Controls already in place / actions completed • Community care digital record being developed and scoped. • Introduction of MOSAIC to replace WCCIS within social care. • Connecting Care Programme Board established. • Programme established to support implementation of integrated health and care records. • Work underway to align community, primary care and local authority systems. Further actions required • Implement integrated community care records. • Strengthen interoperability between health and social care systems.	Intended impact • Improved information sharing across health and care partners. • Better understanding of population need. • More joined-up care planning and delivery. • Improved ability to address health inequalities through shared intelligence.	Actual impact of actions taken to date Work has progressed to establish the digital foundations required to support integrated care, including development of shared records and strengthened collaboration between health and local authority systems. This has improved organisational readiness and alignment across partners; however, integrated records and information sharing arrangements are not yet fully implemented and benefits have yet to be fully realised.

	• Develop data sharing arrangements across partner organisations. • Continue implementation of Connecting Care priorities.		
Gap 2 The evidence base and delivery model for sustainable primary and community care requires further development	Controls already in place / actions completed • Review commissioned to explore alternative delivery models. • ~~Written output received from the National Association of Primary Care (NAPC).~~ Received formally by transformation board • Lessons identified from directly managed practices and national examples. • Primary Care and Community Transformation Board established. • Governance arrangements established to support development of integrated community services. • Evaluations of alternative service delivery models complete. Further actions required • Finalise the CTM primary and community care model and associated implementation roadmap. • ~~Complete evaluation of alternative service delivery models.~~ • Agree and implement future service models where appropriate. • Continue development of strategic plans for Primary and Community Services.	Intended impact • Sustainable GP and Primary Care services. • Financially viable practice models. • Improved resilience across the primary and community care system. • Strategic plan for Primary and Community Service	Actual impact of actions taken to date Work has improved understanding of alternative models of service delivery and strengthened the evidence base for future planning. Governance arrangements are now in place to support service transformation; however, further development and evaluation are required before sustainable models can be consistently implemented across the CTM footprint.
Gap 3 System integration and partnership arrangements are not yet sufficiently mature to deliver a fully integrated model of care	Controls already in place / actions completed • Regional Partnership (Section 33) Agreement established and signed by all partner organisations. • Joint Partnership Boards progressing through the Primary and Community Transformation Programme. • Development of Regional Needs Assessment and Regional Area Plan. • Ongoing partnership working with local authorities and regional partners. • Internal transformation programme re-profiled to align with integration ambitions. Further actions required	Intended impact • More effective system-wide decision making. • Greater alignment of resources and commissioning priorities. • Improved integration of health and social care services. • Improved outcomes through a genuine "single system" approach.	Actual impact of actions taken to date Partnership arrangements have matured and there is greater alignment between health, social care and regional planning processes. Shared governance structures and collaborative programmes are providing stronger foundations for integration; however, full system integration remains complex and requires further progress in commissioning, decision-making and organisational alignment before the intended benefits can be realised.

	• Continue development of integrated commissioning and decision-making arrangements. • Strengthen shared priorities and outcomes across partner organisations. • Embed a culture of joint working and system leadership. • Progress structural integration priorities where agreed.		

Linked National Priority Measures

Ministerial Priorities

- Timely access to care
- Population health and prevention
- Building community capacity
- UEC Programme ~~PROGRAMME FOR~~ (Urgent and Emergency Care)
- Community by Design

Current Performance Highlights

Integrated Models of Care and Community Services

Progress has continued in developing integrated and community-based models of care across CTMUHB and the wider region. The Hospital@Home service, established in October 2025, is now embedded within Health Board governance arrangements and is supporting the wider objective of providing alternatives to hospital admission and facilitating earlier discharge. A clinically-led audit has informed further development of community services and a comprehensive workforce model has been implemented, bringing together previously separate services within a more integrated approach.

The Navigation Hub and Single Point of Access (SPOA) continue to mature as key mechanisms for admission avoidance, demand management and clinically-led triage. Progress includes expansion of virtual ward models, support for care homes, development of urgent community pathways and further alignment with community nursing and therapy services. CTMUHB has also expanded its multi-agency falls response service across all localities, providing alternatives to ambulance conveyance and supporting earlier intervention closer to home.

The Primary and Community Care Transformation Programme remains focused on developing a sustainable future model for primary and community services. A mapping exercise of community services has been completed and shared with the National Association of Primary Care (NAPC), and a draft document setting out potential future models of care is being further developed through the Transformation Board. Work continues to develop a clear implementation roadmap and supporting strategic plans.

System Integration and Partnership Working

Partnership working across health, social care and the third sector has continued to strengthen. The Regional Partnership (Section 33/Part 9) Agreement has now been signed by CTMUHB and all three Local Authorities, providing a formal basis for joint accountability and future integrated service delivery. Regional Partnership Board structures continue to provide the principal governance arrangements for integration with social care and wider partners.

The CTM Regional Partnership has agreed a target model for an Integrated Community Care System (ICCS) for the older population, supported by an implementation plan, programme delivery arrangements and established governance. Good progress has also been made in developing shared approaches to discharge planning, community capacity management and Home First principles. Work continues to strengthen locality-based planning arrangements and Joint Partnership Board structures. In August 2026, an Integrated Manager post, developed jointly with Bridgend County Borough Council, was appointed to support closer operational integration and partnership working.

Regional Integration Fund supported services assisted 31,698 people during 2025/26, avoided 10,605 hospital conveyances, prevented 1,785 admissions, enabled 2,397 timely discharges and supported 12,801 people to remain independent.
Confirmation has been received that the Regional Integration Fund (RIF) and Integration and Rebalancing Capital Fund (IRCF) will continue from 2027/28. This reduces the previous risk of a funding “cliff edge”, although future funding allocations are still to be confirmed by Welsh Government.

Digital Integration and Shared Intelligence

Digital integration continues to develop as a key enabler of integrated care. Work is underway to develop integrated performance dashboards and shared reporting arrangements across health and local authority services. The Regional Integrated Services Director and regional team are working with partner organisations to develop locality-level dashboards that provide integrated managers with shared intelligence to support planning, performance management and delivery of regional priorities.
Allocation received to progress community digital solution, with options being developed.

Overall Position
Overall, CTMUHB has made progress in strengthening integrated working, community-based care, discharge arrangements and regional partnership governance. However, further progress is required to fully realise the benefits of integrated care, including development of sustainable primary and community care models, implementation of digital integration initiatives and continued maturation of joint planning, commissioning and decision-making arrangements across partner organisations.

Were there any significant incidents affecting this strategic Risk this period:

The growth of the ageing population relative to the working-age population, the rise of multimorbidity, and persistent health inequalities, particularly for preventable illness, are all issues that the National Health Service (NHS) will face in the years to come. The greatest contributors to ill health and social care needs include cardio- vascular disease, musculoskeletal disorders, cancer, mental health, dementia and chronic respiratory disease. As a result, the health and social are system will need to be more joined up to enable an increased focus for an integrated model to transform the way we work and care for people, whilst building on community resilience to meet the demand and timely access to care.

Typically, the winter months present additional pressure on the local authority and health board, because of increased rate of acuity, attributed to winter, which includes RSV and the biggest impact norovirus. As a result, the health board had a period of Business Continuity Incident declared and whilst the sustained operational pressure experienced through the Discharge Sprint and Business Continuity Incident (BCI) these periods acted as a critical opportunity for strengthened system wide working.

The Sprint enabled a step change in how the Health Board and Local Authority partners worked together, creating a heightened, shared focus on whole system flow, timely decision making and collective ownership of risk. Through daily multidisciplinary engagement, shared oversight of patient cohorts, and more frequent joint problem solving, partners were able to operate in a more co-ordinated and responsive way, particularly in relation to discharge planning, community capacity and support for people with complex needs.

Although good examples of working relations were noted and made a difference to patients and the whole system approach, there is a notable learning that the health board and partners have identified. This learning will be reflected in a health board and local authority session and work towards plans for next winter, and a whole system review.

Associated Risks escalated to the Organisational Risk Register

Gap 1: Digital and information-sharing infrastructure is not yet sufficiently developed to support integrated care.		
5761	Cross Health Board Data Sharing.	16
3337	Lack of a Single Electronic Patient Record in Mental Health Services including CAMHS.	15
5040	Digital System Integration Dependencies.	15
Gap 2: The evidence base and delivery model for sustainable primary and community care requires further development		
No currently escalated risks against this gap		
Gap 3: System integration and partnership arrangements are not yet sufficiently mature to deliver a fully integrated model of care		
4491	Failure to meet demand across the patient pathway resulting in system-wide pressure on care delivery.	16
6280	Suspension of the Regional Hepato-Pancreato-Biliary Service Model.	16

CTMUHB Public Board

Integrated Performance Dashboard

Eitem yr Agenda / Agenda Item	7.2
Dyddiad y Cyfarfod / Date of Meeting:	26/11/2026
Statws Cyhoeddi / Publication Status:	Open/Public.
	Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Senior Performance Monitoring Officer
Cyflwynydd yr Adroddiad / Report Presenter:	Claire Thompson, Executive Director of Strategy & Transformation & responsible Executive Directors
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Claire Thompson, Executive Director of Strategy & Transformation
Diben yr Adroddiad / Report Purpose:	For Noting
Argymhelliad *(Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).* Recommendation (Linked to the "What Next" section above).	The Board is asked to NOTE the Integrated Performance Dashboard.

1. Situation/Background

The Welsh Government's NHS Wales Performance Framework for 2026/27 sets out the national priorities and performance expectations for Health Boards and will inform the development of future reporting and performance assessment arrangements. The framework is available to read at the following URL: NHS Wales performance framework | GOV.WALES

This Integrated Performance Dashboard provides an overview of the Health Board's performance against key national and local measures. Whilst improvement has been achieved in some areas, services continue to operate within a challenging environment characterised by sustained demand, workforce pressures and capacity constraints. The report highlights areas of good performance, emerging risks and delivery challenges requiring ongoing management focus.

Supporting performance measures, trend analysis and benchmarking against other NHS Wales organisations are provided within the appendices.

2. Specific Matters for Consideration - Key Performance Highlights:

- Planned Care: RTT recovery continues; however, significant challenges remain. Provisionally, at the end of October 2026, 571 patients were waiting over 104 weeks against the national target of zero, with the greatest pressures in Orthopaedics and Neurology. Recovery remains dependent on workforce capacity, diagnostic availability and sustained elective productivity.

- Diagnostics: Performance improved during October, with the number of patients waiting over eight weeks reducing from 4,121 to 3,309. Despite this progress, demand continues to exceed capacity across key diagnostic pathways and recovery remains vulnerable to workforce, equipment and service resilience pressures.

- Cancer: Suspected Cancer Pathway performance sits below the 75% target at 66.1%. Whilst improved operational oversight and additional diagnostic capacity continue to support recovery, pathway performance remains constrained by diagnostic capacity, pathology turnaround times and reliance on tertiary providers.

- Urgent & Emergency Care:

  Please note: From 1 October 2026, the national methodology for reporting Emergency Department waiting times changed, with all waits calculated using the patient's administrative departure time only. Clinical exceptions and treatment end time adjustments are no longer included in national performance calculations. This change is intended to improve consistency and transparency in reporting across Wales.

  The revised methodology is expected to result in lower reported performance against Emergency Department waiting time standards as all patient waits will be counted consistently. As the change is being applied prospectively, performance from October 2026 onwards is not directly comparable with previous months.

  Ambulance handover performance improved in October, with handovers over 45 minutes reducing to 165 and 15-minute compliance increasing to 63.7%. However, patient flow remains a significant challenge, Emergency Department four-hour performance was 55.5%, and 2,305 patients waited over 12 hours, reflecting continued pressure on acute capacity and patient flow.

- Delayed Discharges & Patient Flow: Delayed discharges reduced to 232 and remain below the 12-month rolling average. Nevertheless, complex discharge requirements and community capacity constraints continue to impact bed availability and flow across the system.

- Mental Health: CAMHS continues to exceed national standards across key measures. Adult Mental Health performance remains below target, particularly for access to assessment, treatment and psychological therapies, with demand, workforce pressures and waiting list growth continuing to affect recovery. Enhanced performance oversight and recovery plans remain in place.
- Population Health: Childhood vaccination uptake improved to 90.8% but remains below the 95% target. Smoking cessation services continue to report positive outcomes, although delivery of national ambitions will require sustained focus on service capacity and engagement.
- Workforce: Progress continues across workforce development measures, including PDR and Core Learning compliance. Sickness absence remains elevated at 7.65% and continues to be the Health Board's primary workforce challenge, impacting capacity, productivity and service delivery.

Key Statistics

Planned Care	Period	Total Open Pathways	Waiting <26 wks for New OPA (Stage 1)	Waiting >26 wks for New OPA (Stage 1)	% Waiting >26 wks for New OPA	Waiting >104 wks for RTT
	Oct-26	88,283	38,879	12,246	31.5%	571

Diagnostics	Oct-26	Total Patients Waiting for Diagnostic Test	Patients Waiting <8 wks	Patient Waiting >8 wks	% Waiting >8 wks
		15,523	12,214	3,309	21.3%

Cancer Services	Sep-26	Total Patients Treated	Total Patients Treated within 62 days (SCP)	% Patients Treated within 62 days (SCP)	Number of patients waiting over 62 days from point of suspicion at month end (Sep 26)
		380	251	66.1%	502

Unscheduled Care	Oct-26	Total Ambulance Handovers	Total Handovers within 15 mins	% Handovers within 15 mins	Total Handovers over 45 mins	% Handovers over 45 mins
		2,000	1,273	63.7%	165	8.3%
		ED Attendances	Patients seen within 4 hrs	% seen within 4 hrs	Patients waiting >12 hrs	% waiting >12 hrs
	Major	15,694	7,897	50.3%	2,305	14.7%
	Minor	1,818	1,818	100.0%	0	0.0%
	Total	17,512	9,715	55.5%	2,305	13.2%

Delayed Discharges	Census Date	Acute	Mental Health	Community	Total
	21st Oct 26	79	25	128	232

Mental Health		Part 1a			Part 1b		
	Sep-26	Number of Assessments	Assessments within 28 days	% within 28 days	Number of Interventions	Interventions within 28 days	% within 28 days
	CAMHS	119	111	93.3%	99	86	86.9%
	Adults	457	298	65.2%	53	28	52.8%
		Part 2			Psychological Therapies within 26 wks		
	Sep-26	Total patients currently in receipt of secondary Mental Health services	Total patients who have a valid CTP at the end of the month	% with a valid CTP	Total patients waiting for PT	Patients waiting <26 wks	% waiting <26 wks
	CAMHS	138	131	94.9%	N/A		
	Adults	1,921	1,705	88.8%	1,868	991	53.1%

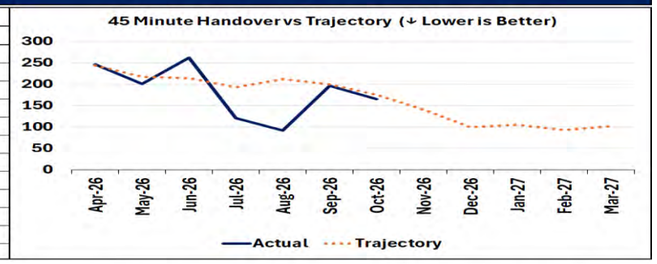
Quality & Safety	Oct-26	Number of Early Resolutions Reviewed	Number remained as Early Resolution	% remained as Early Resolution	Cumulative Number of Hospital Onset E.coli bacteraemia	Cumulative Number of Community Onset E.coli bacteraemia	% of all E. coli.specimens that are Hospital Onset
		120	105	87.5%	44	161	21.5%

Population Health	Qtr 1 2026/27	Estimated number of Smokers	Number of Smokers treated by Smoking Cessation Service	% of Smokers treated by Smoking Cessation Service	Predicted % of Smokers treated by Smoking Cessation Service during 2026/27 (based on Qtr 1 extrapolation)
		45,800	638	1.4%	5.6%
		Eligible Children aged 5 for scheduled vaccination	Uptake of the Eligible Children	% Uptake	
		1,105	1003	90.8%	

Unscheduled Care Performance against Health Board Trajectory 2026/27

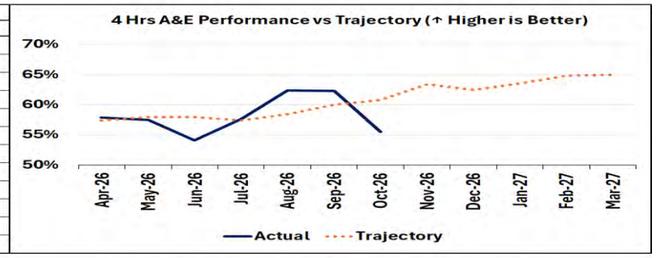
Number of ambulance patient handovers over 45 minutes (National Target is Zero)

Period	Prince Charles Hospital		Royal Glamorgan Hospital		Princess of Wales Hospital		CTMUHB	
	Actual	Trajectory	Actual	Trajectory	Actual	Trajectory	Actual	Trajectory
Apr-26	45	89	124	102	78	54	247	245
May-26	22	76	42	90	137	52	201	218
Jun-26	70	75	71	91	121	48	262	214
Jul-26	32	68	31	80	58	45	121	193
Aug-26	29	75	33	91	30	46	92	212
Sep-26	40	69	104	86	53	45	197	200
Oct-26	98	63	37	72	30	41	165	176
Nov-26		50		59		32		141
Dec-26		35		42		23		100
Jan-27		37		46		23		106
Feb-27		33		38		22		93
Mar-27		35		44		23		102



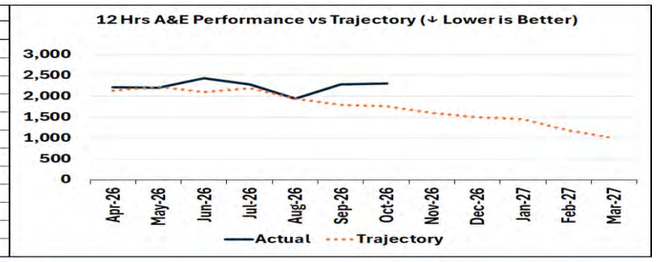
% of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge (National target is 95%)

Period	Prince Charles Hospital		Royal Glamorgan Hospital		Princess of Wales Hospital		CTMUHB (including MIU's)	
	Actual	Trajectory	Actual	Trajectory	Actual	Trajectory	Actual	Trajectory
Apr-26	55.5%	56.6%	54.8%	50.4%	48.5%	49.2%	57.9%	57.4%
May-26	54.5%	57.2%	54.4%	51.1%	50.1%	50.0%	57.5%	58.0%
Jun-26	51.6%	57.2%	48.1%	51.2%	44.4%	50.0%	54.1%	58.0%
Jul-26	53.6%	56.7%	56.4%	50.5%	45.7%	49.3%	57.6%	57.4%
Aug-26	56.9%	57.7%	66.3%	51.7%	51.9%	50.5%	62.4%	58.4%
Sep-26	55.3%	59.3%	65.3%	53.5%	52.4%	52.4%	62.3%	60.0%
Oct-26	47.3%	60.1%	54.9%	54.4%	48.6%	53.4%	55.5%	60.8%
Nov-26		62.7%		57.4%		56.4%		63.4%
Dec-26		61.8%		56.4%		55.4%		62.5%
Jan-27		62.9%		57.6%		56.7%		63.6%
Feb-27		64.1%		59.0%		58.1%		64.8%
Mar-27		64.4%		59.3%		58.4%		65.0%



Number of patients who spend 12 hours or more in all hospital major and minor emergency care facilities from arrival until admission, transfer or discharge (National target is Zero)

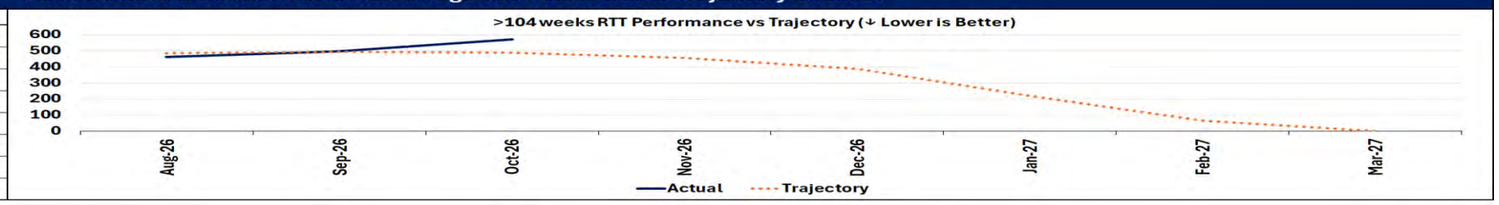
Period	Prince Charles Hospital		Royal Glamorgan Hospital		Princess of Wales Hospital		CTMUHB (including MIU's)	
	Actual	Trajectory	Actual	Trajectory	Actual	Trajectory	Actual	Trajectory
Apr-26	762	729	683	655	773	754	2,218	2,138
May-26	729	771	712	694	769	762	2,210	2,227
Jun-26	874	747	794	637	767	716	2,435	2,100
Jul-26	831	812	677	677	776	706	2,284	2,195
Aug-26	639	714	620	600	682	632	1,941	1,946
Sep-26	728	641	769	562	794	597	2,291	1,800
Oct-26	834	635	685	558	786	572	2,305	1,765
Nov-26		568		513		525		1,606
Dec-26		525		485		490		1,500
Jan-27		501		487		466		1,454
Feb-27		403		389		388		1,180
Mar-27		342		333		325		1,000



Planned Care & Cancer Performance against Health Board Trajectory 2026/27

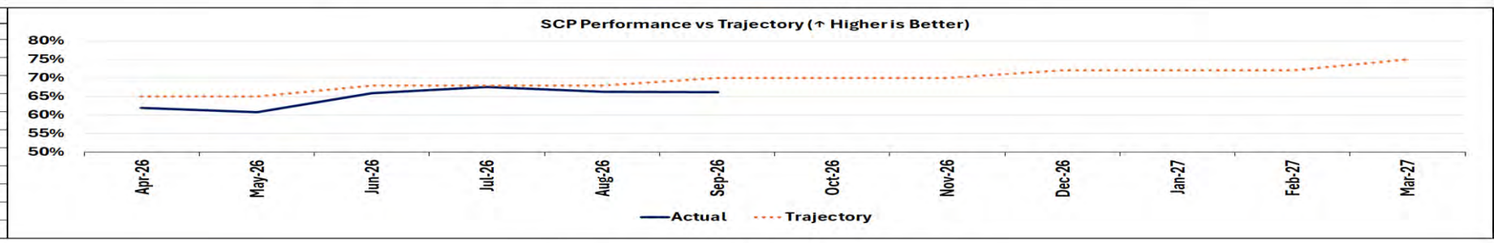
Number pf patients waiting more than 104 weeks for Referral to Treatment (RTT)

Period	Actual	Trajectory
Aug-26	462	485
Sep-26	498	495
Oct-26	571	490
Nov-26		457
Dec-26		388
Jan-27		218
Feb-27		66
Mar-27		0



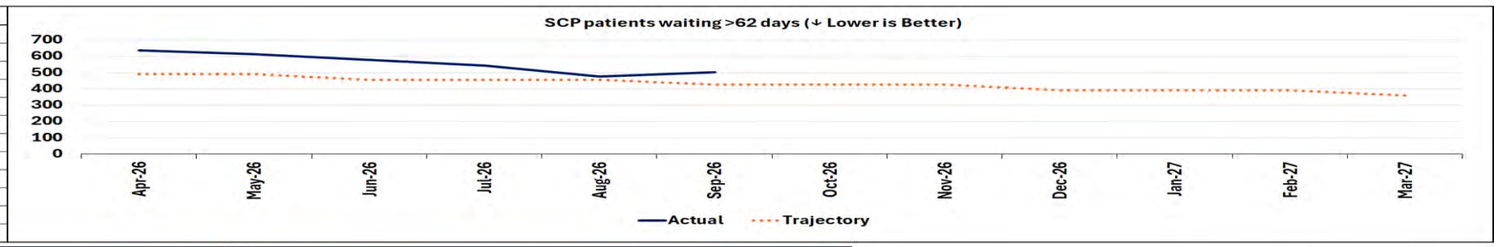
% of patients starting first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route)

Period	Actual	Trajectory
Apr-26	62.0%	65.0%
May-26	60.7%	65.0%
Jun-26	65.9%	68.0%
Jul-26	67.5%	68.0%
Aug-26	66.2%	68.0%
Sep-26	66.1%	70.0%
Oct-26		70.0%
Nov-26		70.0%
Dec-26		72.0%
Jan-27		72.0%
Feb-27		72.0%
Mar-27		75.0%



Number of cancer patients waiting >62 days to start treatment at the end of the month

Period	Actual	Trajectory
Apr-26	638	492
May-26	614	492
Jun-26	577	457
Jul-26	542	457
Aug-26	477	457
Sep-26	502	427
Oct-26		427
Nov-26		427
Dec-26		392
Jan-27		392
Feb-27		392
Mar-27		359



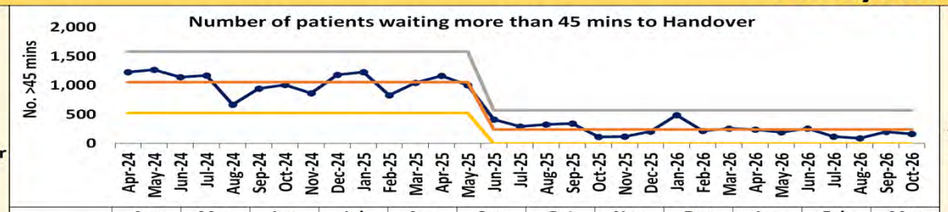
Key		
Worse than Plan	Within 5% of Reaching Plan	On/Better than Plan

2.1 The Cabinet Secretary's Key Delivery Expectations

Key Delivery Expectations

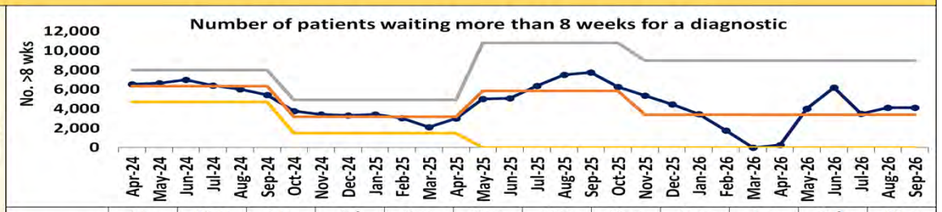
Timely Access to Care

Ensure no ambulance handover waits over 45 minutes



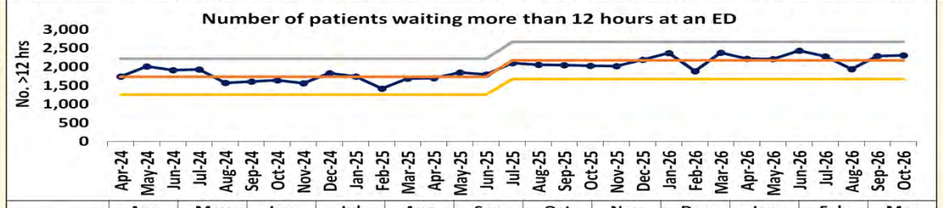
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2026/27	245	200	262	121	92	197	165					
2025/26	1,163	1,011	416	302	335	355	116	122	214	494	225	261
2024/25	1,226	1,269	1,141	1,169	669	946	1,010	866	1,184	1,228	827	1,043

Ensure maximum wait for diagnostics does not exceed 8 weeks



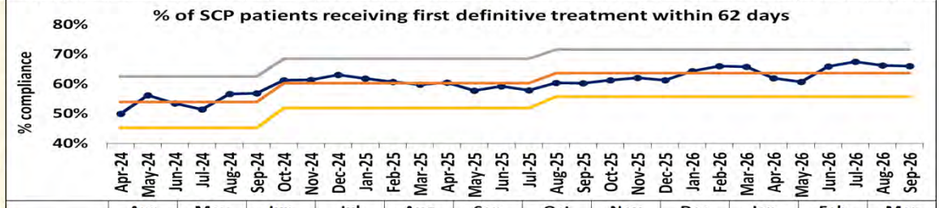
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/26	275	4,022	6,176	3,475	4,112	4,121	3,309					
2024/25	1,693	1,850	1,799	2,099	2,053	2,050	2,030	2,022	2,193	2,367	1,882	2,384
2023/24	6,549	6,646	6,989	6,403	6,031	5,417	3,764	3,414	3,329	3,426	3,037	2,113

Ensure no patient spends 12 hours or more in all major and minor emergency care facilities from arrival until admission, transfer or discharge



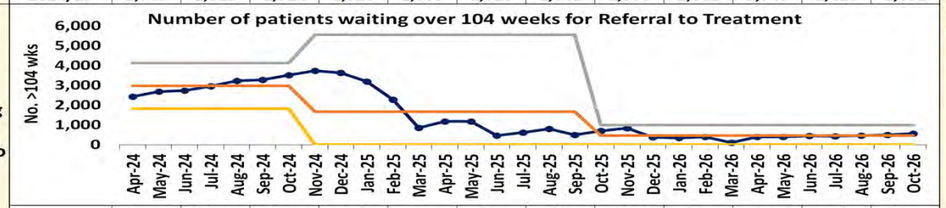
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2026/27	2,226	2,230	2,432	2,284	1,941	2,291	2,305					
2025/26	1,693	1,850	1,799	2,099	2,053	2,050	2,030	2,022	2,193	2,367	1,882	2,384
2024/25	1,745	2,015	1,914	1,928	1,569	1,610	1,642	1,566	1,832	1,745	1,420	1,691

Achieve the suspected cancer pathway target of 75% through implementing the nationally agreed pathways, while reducing the backlog of patients waiting more than 62 days by end of March 2027

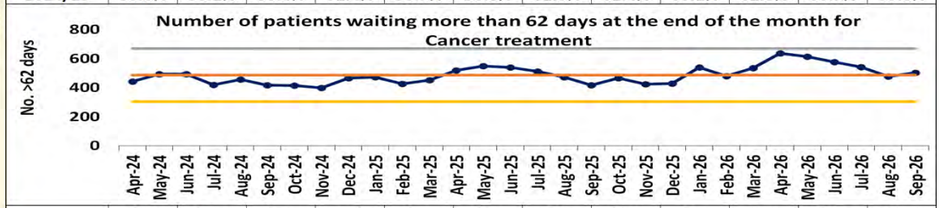


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2026/27	62.0%	60.7%	65.9%	67.5%	66.2%	66.1%						
2025/26	60.5%	57.8%	59.2%	57.9%	60.3%	60.3%	61.3%	62.0%	61.3%	64.3%	66.0%	65.8%
2024/25	50.0%	56.2%	53.4%	51.4%	56.7%	56.8%	61.3%	61.4%	63.1%	61.8%	60.7%	59.8%

No patients waiting more than 104 weeks for referral to treatment



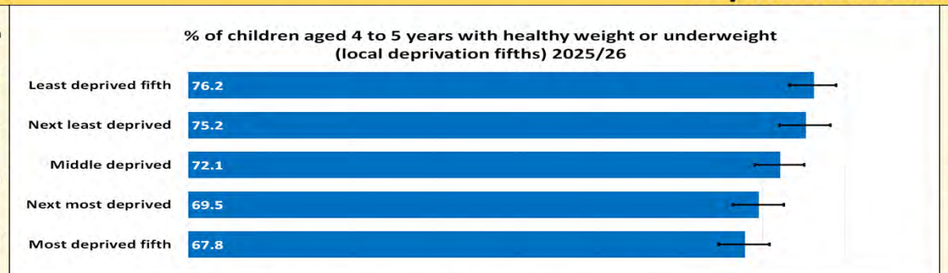
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2026/27	390	399	451	430	462	498	571					
2025/26	1,168	1,177	463	615	794	496	699	830	369	348	388	98
2024/25	2,435	2,680	2,738	2,956	3,226	3,277	3,516	3,736	3,643	3,189	2,277	856



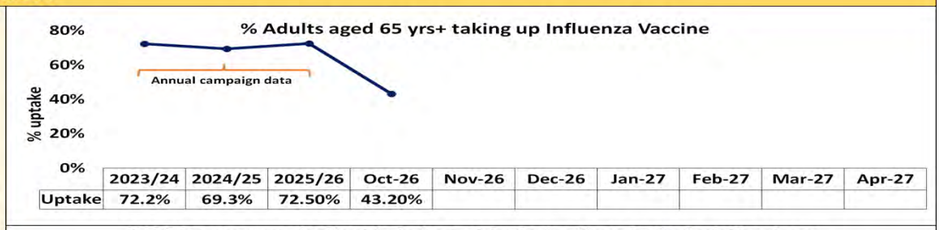
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2026/27	638	614	577	542	477	502						
2025/26	519	550	539	513	472	417	466	425	428	539	481	535
2024/25	444	494	493	420	457	418	415	399	465	474	426	452

Population Health & Prevention

Increase the proportion of children who are a healthy weight by halting the rise and contributing to a year-on-year decrease in the levels of overweight and of obesity as measured and reported through the National Child Measurement Programme, focusing on those most disadvantaged



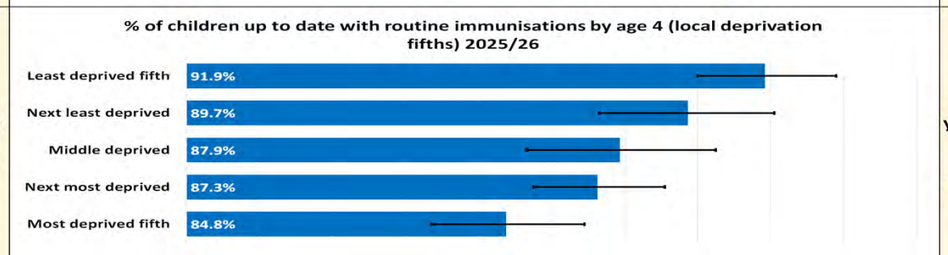
% uptake of the influenza vaccination amongst adults aged 65 years & over (Target 75%)



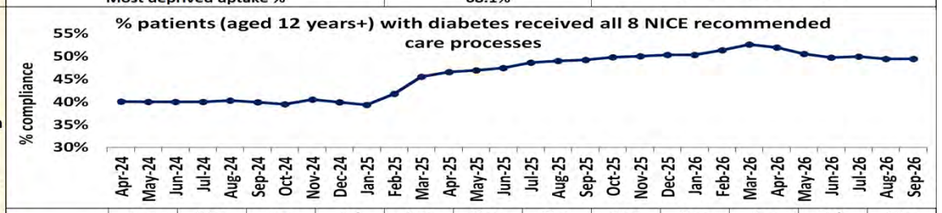
	2023/24	2024/25	2025/26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27	Apr-27
Uptake	72.2%	69.3%	72.50%	43.20%						

2025/26 season comparing % uptake in the most deprived and least deprived quintiles of areas		
Least deprived uptake %	78.3%	Inequalities gap is 10.2
Most deprived uptake %	68.1%	

% of children who are up to date with routine immunisations by age 4



Percentage of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes

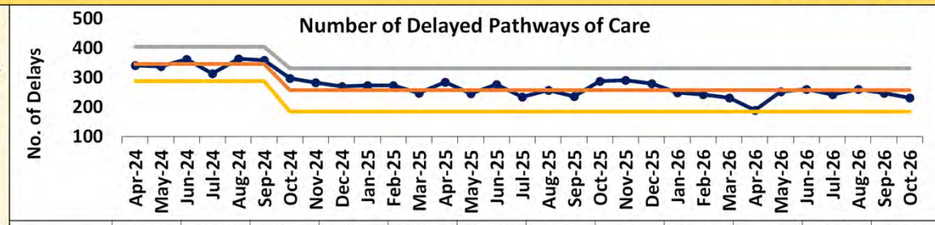


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2026/27	51.9%	50.5%	49.7%	49.9%	49.9%	49.9%						
2025/26	46.6%	46.9%	47.4%	48.6%	49.0%	49.2%	49.8%	50.0%	50.3%	50.3%	51.3%	52.6%
2024/25	40.1%	40.0%	40.0%	40.0%	40.3%	39.9%	39.5%	40.5%	39.9%	39.4%	41.8%	45.5%

Continued overleaf...

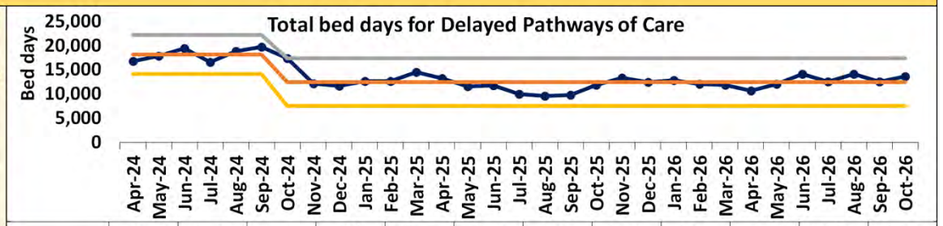
Community by Design

Deliver a 12-month reduction trend in both the number of people who are delayed in hospital and the total days delayed for these patients, as measured by the Delayed Pathways of Care dashboard



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2026/27	189	253	261	242	260	247	232					
2025/26	284	246	277	234	257	236	287	291	279	249	243	231
2024/25	341	338	362	313	363	359	297	283	270	274	273	248

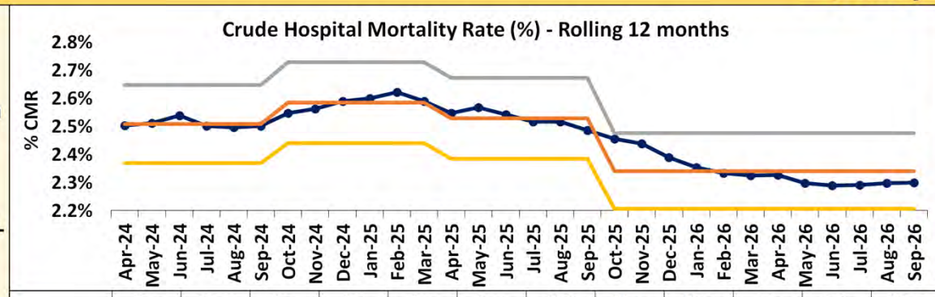
Deliver a 12-month reduction trend in both the number of people who are delayed in hospital and the total days delayed for these patients, as measured by the Delayed Pathways of Care dashboard



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2026/27	10,668	12,042	14,075	12,569	14,124	12,499	13,650					
2025/26	13,181	11,531	11,725	9,948	9,620	9,805	11,871	13,295	12,399	12,783	12,042	11,799
2024/25	16,721	17,807	19,407	16,598	18,786	19,719	17,317	12,100	11,648	12,656	12,657	14,488

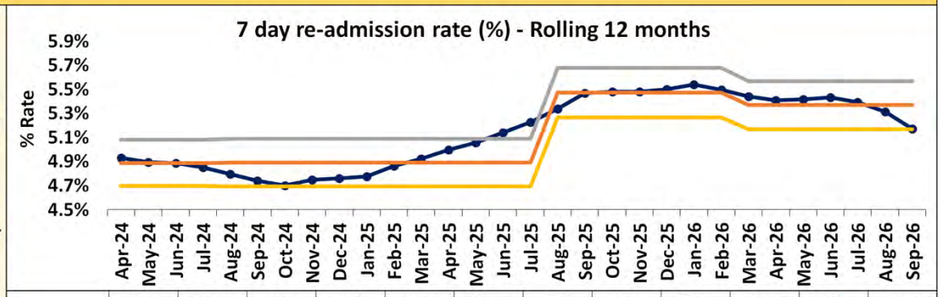
Quality & Safety

Downward trend in 12-month rolling average crude mortality while maintaining a flat 7-day readmission rate.



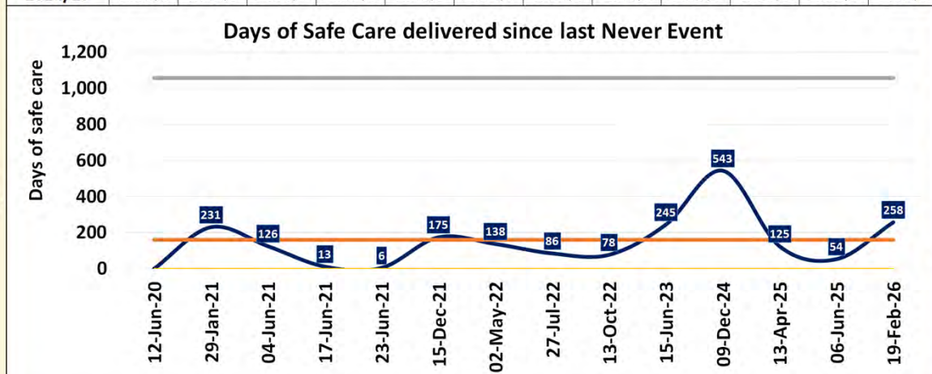
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2026/27	2.33%	2.30%	2.29%	2.29%	2.30%	2.30%						
2025/26	2.55%	2.57%	2.54%	2.52%	2.52%	2.49%	2.46%	2.44%	2.39%	2.35%	2.33%	2.33%
2024/25	2.50%	2.51%	2.54%	2.50%	2.50%	2.50%	2.55%	2.56%	2.59%	2.60%	2.62%	2.59%

Downward trend in 12-month rolling average crude mortality while maintaining a flat 7-day readmission rate.

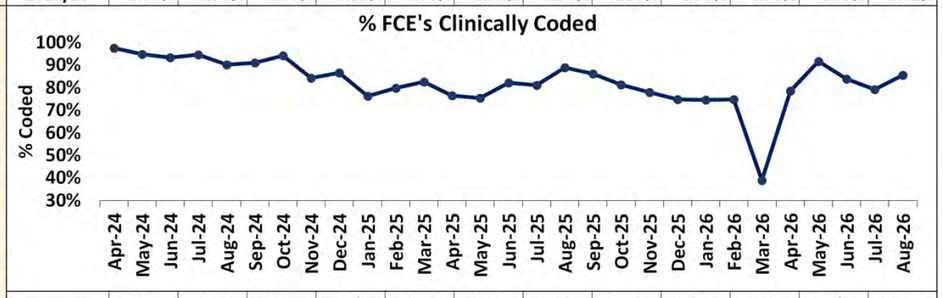


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2026/27	5.41%	5.42%	5.43%	5.39%	5.32%	5.17%						
2025/26	5.00%	5.06%	5.14%	5.23%	5.34%	5.47%	5.48%	5.48%	5.50%	5.54%	5.50%	5.44%
2024/25	4.93%	4.90%	4.89%	4.85%	4.80%	4.74%	4.70%	4.75%	4.76%	4.77%	4.86%	4.92%

Days of safe care delivered since the last never event

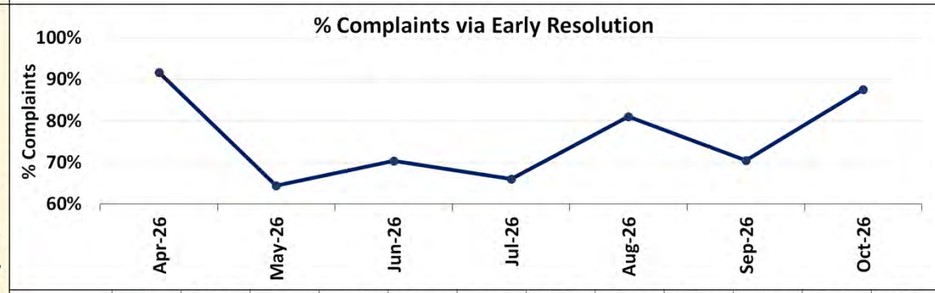


The clinical coding service must ensure that at least 95% of inpatient and day-case episodes are fully coded within one reporting month of discharge, in line with Welsh Government delivery measures.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2026/27	78.5%	91.6%	83.9%	79.2%	85.5%							
2025/26	76.3%	75.3%	82.1%	81.1%	88.9%	86.2%	81.3%	77.9%	74.8%	74.6%	74.8%	38.9%
2024/25	97.5%	94.9%	93.3%	94.6%	90.2%	91.0%	94.3%	84.3%	86.6%	76.3%	79.9%	82.5%

Percentage proportion of complaints dealt with via early resolution - target 40% by March 2027



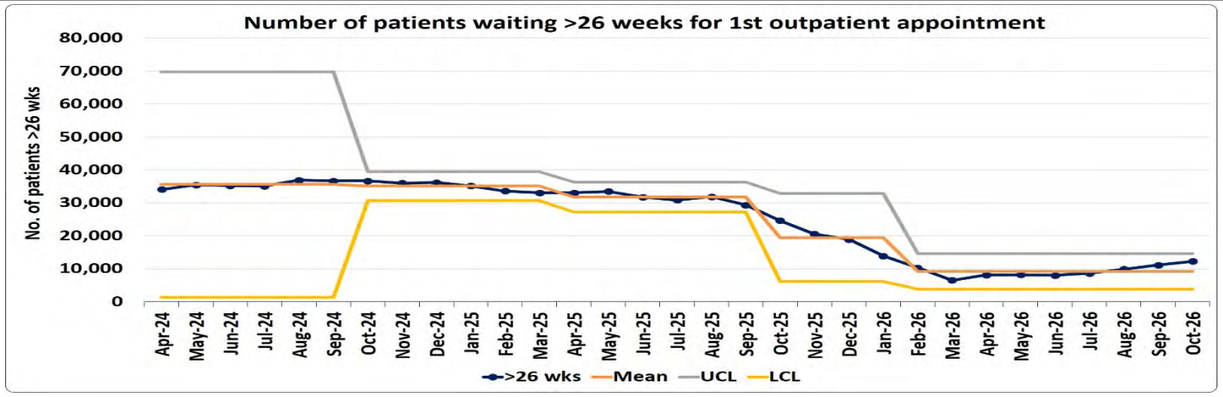
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2026/27	91.7%	64.4%	70.4%	66.0%	81.0%	70.5%	87.5%					

CTMUHB Planned Care Group

Referral to Treatment Times (RTT)

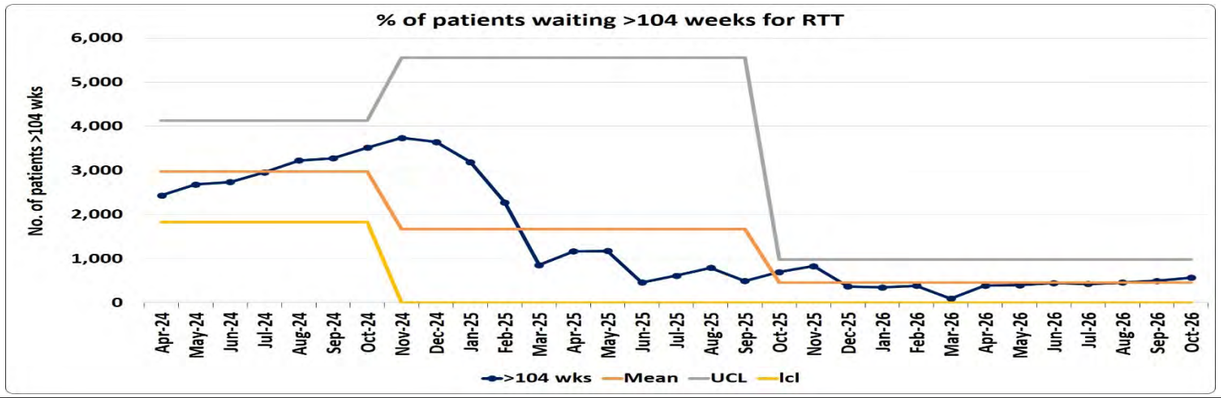
Number of patients waiting more than 26 weeks for a new outpatient appointment

Target - Zero	Oct 2026 – 12,246 (provisional)



Number of patients waiting more than 104 weeks for Referral to Treatment (RTT)

Target - Zero	Oct 2026 – 571 (provisional)



Total number of open pathways per specialty - October 2026 (provisional)

Specialty	Patients waiting >26 Weeks for 1st OPA	All patients waiting >52 Weeks to 104 Weeks	All patients waiting >104 Weeks	Total Open Pathways
Breast Surgery	0	0	0	695
Cardiology	1,094	235	0	5,039
Colorectal Surgery	167	350	0	3,619
Dermatology	845	0	0	5,603
Diabetes Service/Medicine	67	0	0	539
Diagnostics	0	0	0	4,820
Ear Nose and Throat Service	2,167	866	0	8,554
Endocrinology	155	0	0	973
Gastroenterology	351	11	0	3,329
General Medicine	30	17	0	646
General Surgery	255	705	0	4,683
Geriatric Medicine	4	1	0	312
Gynaecology	218	959	0	6,308
Haematology (Clinical)	24	0	0	246
Nephrology	2	0	0	169
Neurology	950	494	34	2,113
Ophthalmology	1,638	1,091	0	10,283
Oral Surgery	473	117	0	2,748
Orthodontics	171	0	0	440
Orthopaedics	1,587	2,904	537	12,507
Paediatric Neurology	1	0	0	2
Paediatrics	322	0	0	2,167
Pain Management	527	258	0	1,882
Respiratory Medicine	87	77	0	1,294
Restorative Dentistry	6	0	0	51
Rheumatology	266	43	0	1,310
Sport and Exercise Medicine	1	0	0	34
Therapies	0	0	0	1,407
Urology	794	644	0	6,045
Vascular Surgery	44	32	0	465
	12,246	8,804	571	88,283

How are we doing and what are our key concerns?

Planned Care performance continues to face significant challenges, with 12,246 patients waiting more than 26 weeks for a first outpatient appointment and 571 patients waiting more than 104 weeks for Referral to Treatment (RTT) at October 2026 (provisional), against a national target of zero. Demand for services continues to exceed available capacity across a number of specialties, contributing to the ongoing backlog of long waits.

The most significant challenge remains within Orthopaedics, which accounts for the majority of patients waiting over 104 weeks. Neurology also continues to experience sustained pressures associated with specialist workforce availability and capacity constraints. Whilst recovery programmes remain in place, performance continues to be affected by the scale of demand, workforce pressures and diagnostic dependencies.

What key actions are we taking and when do we anticipate improvement?

The Health Board continues to progress specialty recovery plans focused on reducing long waits and improving patient flow through outpatient, diagnostic and treatment pathways. Actions include ongoing waiting list validation, maximising available outpatient and theatre capacity, recruitment to key vacancies, productivity improvements and the use of additional support arrangements where appropriate.

Recovery programmes remain focused on reducing the longest waits and supporting continued progress against national RTT recovery expectations. Whilst improvements are anticipated as these actions continue and additional capacity becomes established, the pace of recovery remains dependent upon sustained workforce availability, elective capacity, diagnostic performance and management of ongoing referral demand.

What are the key risks and mitigations?

The principal risks to RTT recovery remain concentrated within Orthopaedics and Neurology, where a combination of workforce shortages, limited clinic and theatre capacity, increasing demand and diagnostic constraints continue to impact waiting times. These factors present a risk to achieving national recovery trajectories and eliminating long waits.

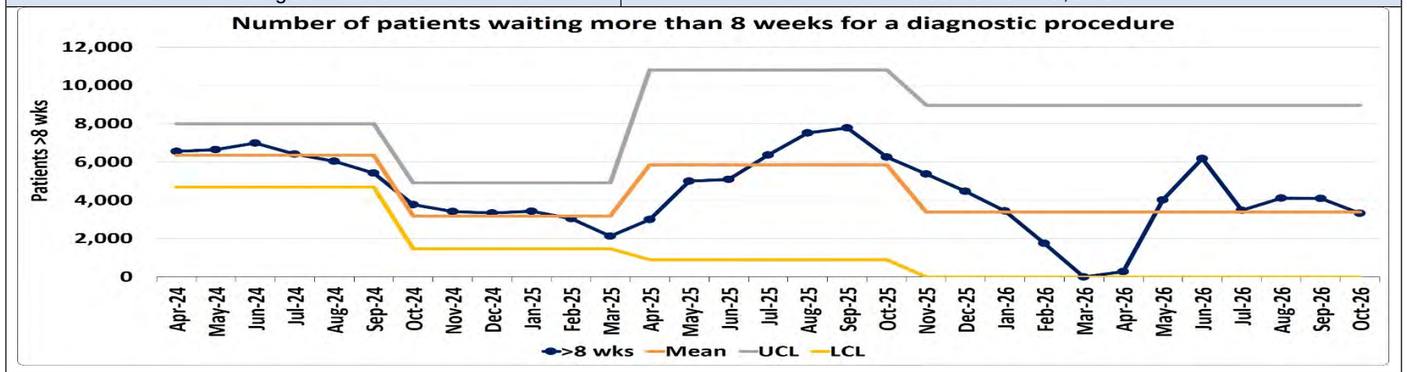
Mitigating actions include targeted specialty recovery plans, recruitment and retention initiatives, ongoing waiting list validation, additional outpatient and theatre capacity, pathway redesign and regular performance oversight. Recovery remains a key organisational priority, with continued monitoring of specialty-level performance to ensure available resources are targeted towards areas of greatest pressure.

CTMUHB Diagnostics, Therapies, Pharmacies & Specialties Care Group

Diagnostics

Number of patients waiting 8 weeks for a specified diagnostic

Target - Zero	Oct 2026 – 3,309



Number of Patients waiting >8 Weeks for a Diagnostic Test		Sep-26	Oct-26	Difference from last period
Cardiology Services	Echo Cardiogram	1,030	956	-74
	Cardiac CT	75	86	11
	Cardiac MRI	20	21	1
	Diagnostic Angiography	43	33	-10
	Stress Test	9	11	2
	DSE	12	6	-6
	TOE	0	0	0
	Heart Rhythm Recording	3	3	0
	B.P. Monitoring	0	1	1
Bronchoscopy		0	1	1
Colonoscopy		13	16	3
Gastroscopy		12	9	-3
Cystoscopy		4	3	-1
Flexi Sig		5	0	-5
Radiology	Non-Cardiac CT	6	4	-2
	Non-Cardiac MRI	115	94	-21
	NOUS	2,485	1,758	-727
	Non-Cardiac Nuclear Medicine	2	4	2
Imaging	Fluoroscopy	9	2	-7
Physiological Measurement	Urodynamics	48	46	-2
Neurophysiology	EMG	156	173	17
	NCS	74	82	8
Total		4,121	3,309	-812

Radiology:

How are we doing and what are our key concerns?

Radiology services continue to experience sustained demand across both Urgent Suspected Cancer (USC) and Referral to Treatment (RTT) pathways, resulting in ongoing challenges in achieving the eight-week diagnostic target. Despite these pressures, performance has improved in October, driven primarily by improvements in NOUS and MRI waiting lists.

The service continues to manage the residual operational impact associated with implementation of the Radiology Information System (RiS), including data quality validation and pathway assurance requirements. Capacity has also been affected by equipment reliability challenges and periods of MRI downtime, increasing reliance on non-recurrent solutions to maintain service delivery. Notwithstanding these pressures, the service remains focused on restoring sustainable capacity and improving patient access through a combination of workforce, productivity and pathway improvements.

What key actions are we taking and when do we anticipate improvement?

A comprehensive programme of service improvement remains underway to strengthen diagnostic capacity and improve pathway performance. Key actions include optimisation of CT and MRI templates, expansion of weekend MRI and NOUS capacity, targeted use of insourcing arrangements and deployment of additional clinical workforce support within ultrasound services. Workforce recruitment and training initiatives continue, with investment in the sonographer pipeline expected to deliver additional substantive capacity over the next 6 to 12 months.

Alongside capacity improvements, significant emphasis is being placed on data quality, validation and pathway management through full implementation of partial booking processes and engagement with national diagnostic improvement programmes. These actions are intended to improve both operational performance and the long-term sustainability of diagnostic services.

What are the key risks and mitigations?

Key Risks:

- Continued growth in diagnostic demand exceeding available capacity.
- Workforce recruitment and retention challenges within key imaging specialties.
- Reliance on non-recurrent funding, insourcing and outsourced activity to maintain performance.
- Ongoing data assurance requirements associated with RiS implementation.
- Reduced operational flexibility resulting from restrictions on premium rate overtime arrangements.

Mitigating Actions:

- Active demand and capacity management supported by service transformation and template optimisation.
- Continued recruitment, workforce development and investment in diagnostic training programmes.
- Targeted insourcing arrangements to support recovery and maintain patient flow.
- Robust data quality governance and validation processes to improve pathway integrity and reporting confidence.
- Participation in national improvement programmes to support more efficient, productive and sustainable diagnostic pathways.

Endoscopy:

How are we doing and what are our key concerns?

Endoscopy services continue to perform comparatively well, with sufficient capacity currently available to meet Urgent Suspected Cancer (USC), routine and surveillance demand. CTM remains one of the stronger-performing organisations in Wales for patients waiting over six weeks for complex endoscopy procedures. However, the service continues to manage a significant surveillance backlog alongside growing demand, while estate constraints, particularly at POW, limit operational flexibility and future productivity. Maintaining current performance will require continued investment in workforce, capacity and infrastructure.

What key actions are we taking and when do we anticipate improvement?

- Additional insourcing capacity for both BSW and non-BSW activity since September 2026.
- Planned Care Recovery funding has been approved to support diagnostic, USC and surveillance activity, with additional capacity introduced from the end of October 2026.
- The Phase 2 Endoscopy Sustainability Model has been submitted to support a longer-term service model aligned with National Endoscopy Programme recommendations.
- Clinical validation and partial booking processes continue to reduce the surveillance backlog and improve waiting list management.
- Future service planning remains aligned to JAG accreditation standards and Health Park developments.

What are the key risks and mitigations?

Key Risks: include limited specialist workforce availability for complex procedures, pressure on surveillance performance and estate constraints across endoscopy facilities. The focus on RTT recovery presents a risk that available endoscopy capacity may be diverted from the USC pathway, adversely impacting cancer waiting time performance.

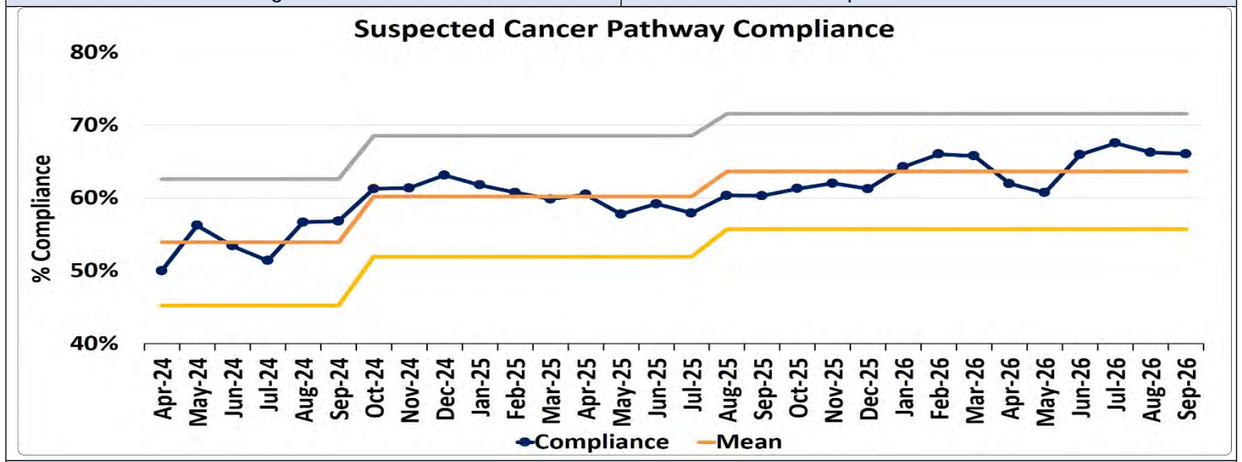
Mitigating Actions: include targeted additional insourcing capacity, workforce development through expansion of Clinical Endoscopist roles, strengthened operational escalation processes, and development of a centralised HSDU to improve service resilience. Active demand and capacity management ensures cancer pathways remain prioritised.

CTMUHB Planned Care Group

Suspected Cancer Pathway (SCP)

% of patients starting their first definitive cancer treatment within 62 days from point of suspicion

Target – 75%	Sep 2026 – 66.1%

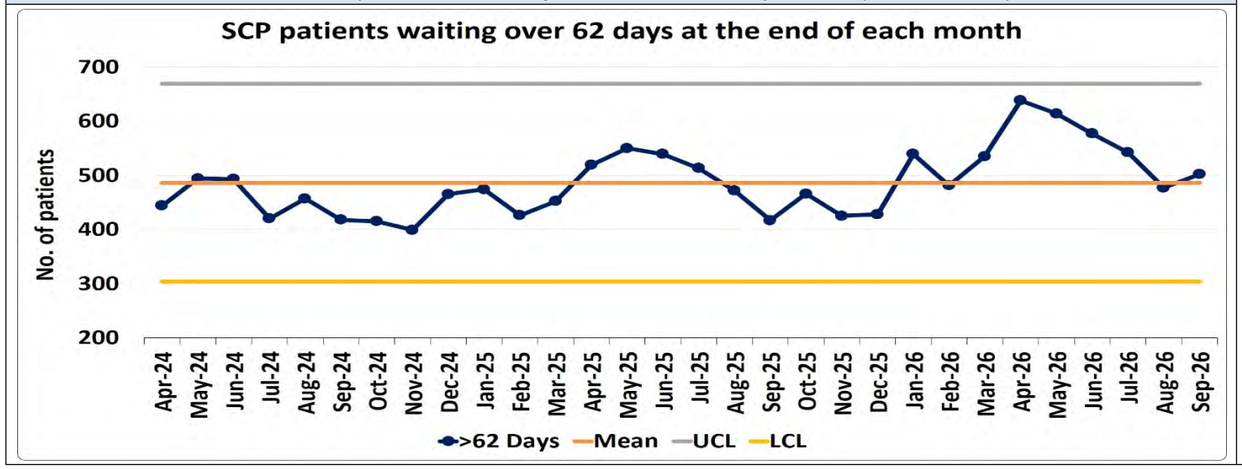


% SCP patients treated without suspensions per tumour site

CTMUHB - SCP % Treated Without Suspensions - September 2026

Tumour site	Treated in Target Without Suspensions	Patient Breaches	Total Treated	% Treated against Target of 75%
Head and neck	6	9	15	40.0%
Upper GI	7	13	20	35.0%
Lower GI	24	20	44	54.5%
Lung	24	11	35	68.6%
Sarcoma	1	1	2	50.0%
Skin (exc BCC)	103	7	110	93.6%
Brain/CNS	2	0	2	100.0%
Breast	33	8	41	80.5%
Gynaecological	6	3	9	66.7%
Urological	36	50	86	41.9%
Haematological	6	6	12	50.0%
Children's	1	0	1	100.0%
Other	2	1	3	66.7%
Total	251	129	380	66.1%

Number of SCP patients waiting more than 62 days from point of suspicion



How are we doing and what are our key concerns?

Suspected Cancer Pathway (SCP) performance in September 2026 was 66.1%, below the Welsh Government target of 75%, but remains significantly improved compared with historic performance and reflects continued progress in pathway management and operational oversight. Performance has been broadly sustained despite ongoing pressures across diagnostics, treatment capacity and tertiary provider pathways.

Key challenges continue to include endoscopy capacity, pathology turnaround times, reliance on tertiary providers and workforce pressures affecting both clinical and administrative functions. These factors contribute to delays at key stages of the pathway and continue to limit the pace of recovery. However, strengthened governance arrangements, improved pathway tracking and enhanced performance management continue to support greater operational control and earlier intervention where delays are identified. CTM Cancer Services remain at Level 1 (Routine Arrangements), reflecting sustained improvement in service oversight and delivery.

What key actions are we taking and when do we anticipate improvement?

A comprehensive recovery programme remains in place, focused on improving diagnostic capacity, reducing delays and strengthening pathway resilience. Key actions include additional USC endoscopy capacity, increased outpatient capacity within Breast and Dermatology services, enhanced tumour-specific performance reviews, continued use of digital pathway tracking and the recruitment of additional clinical capacity within Urology.

Work also continues with tertiary providers to improve pathway coordination and treatment timeliness, whilst administrative capacity is being reviewed to support effective pathway validation and tracking processes. Subject to improvements in diagnostic capacity and external provider performance, further incremental improvement is anticipated during the remainder of 2026/27.

What are the key risks and mitigations?

The principal risks to delivery of the national target remain endoscopy capacity constraints, delays within tertiary provider pathways, pathology reporting turnaround times, workforce availability and administrative capacity. These risks continue to impact the timeliness of diagnosis and treatment across a number of tumour pathways.

Mitigating actions include additional diagnostic capacity, targeted recruitment, strengthened operational oversight, routine escalation of delayed pathways, enhanced regional working arrangements and ongoing performance reviews to ensure risks are identified and managed at the earliest opportunity.

Whilst challenges remain, the service is operating within strengthened governance arrangements and continues to demonstrate improved control and sustained progress towards recovery.

CTMUHB Unscheduled Care & Acute Medicine Group

Ambulance Patient Handover & Emergency Department Waits

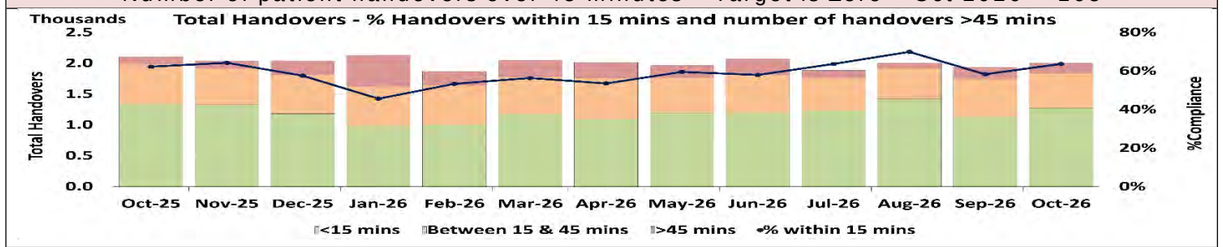
Median emergency ambulance response time to purple (arrest) & red (emergency) category calls

Target – each measure 6-8 minutes median | Oct 2026 – Purple = 07:19 / Red = 10:20

	Merthyr Tydfil		RCT		Bridgend		CTMUHB	
Period	Purple - Median Arrest Response	Red - Median Emergency	Purple - Median Arrest Response	Red - Median Emergency	Purple - Median Arrest Response	Red - Median Emergency	Purple - Median Arrest Response	Red - Median Emergency
Oct-25	04:02	05:58	08:16	09:38	09:31	10:09	07:45	08:56
Nov-25	04:25	07:40	07:35	09:52	07:35	08:48	07:05	09:07
Dec-25	05:35	09:20	08:45	10:59	08:40	10:38	08:14	10:40
Jan-26	05:52	10:30	08:49	10:20	08:11	10:19	08:33	10:20
Feb-26	05:57	07:57	07:09	09:58	08:07	11:09	07:16	09:54
Mar-26	06:15	08:24	07:32	11:02	08:28	11:03	07:44	10:34
Apr-26	07:07	09:04	08:15	11:26	07:05	11:28	07:54	10:56
May-26	05:06	07:57	08:25	11:31	09:01	11:18	08:14	10:55
Jun-26	06:13	09:24	09:43	11:52	07:46	10:48	08:39	11:07
Jul-26	05:50	09:02	06:47	10:40	05:57	09:36	06:21	09:51
Aug-26	05:34	07:39	07:46	11:40	06:32	09:33	06:55	10:00
Sep-26	05:39	09:17	10:13	11:13	09:24	09:43	09:26	10:24
Oct-26	05:49	08:33	07:23	11:21	08:05	10:08	07:19	10:20

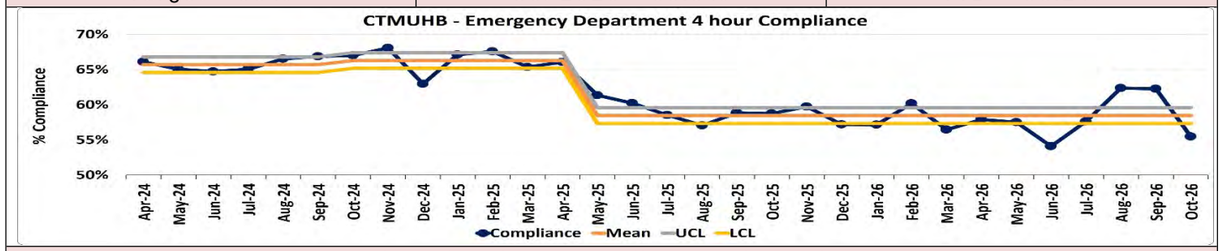
% patient handovers within 15 minutes Target – 80% - Oct 2026 = 63.7%

Number of patient handovers over 45 minutes – Target is Zero – Oct 2026 = 165



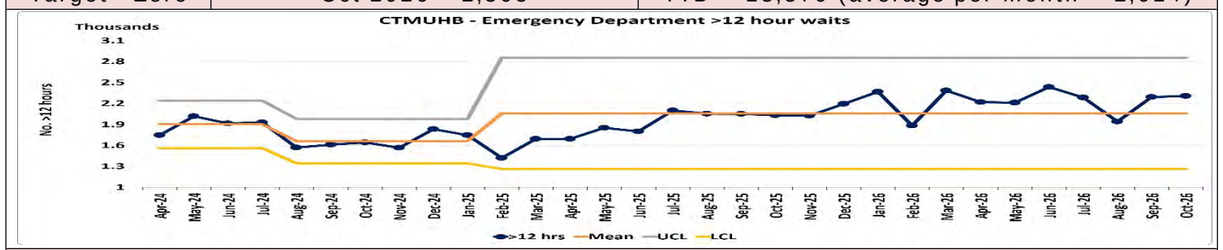
% patients spending <4 hours in A&E

Target – 95% | Oct 2026 – 55.5% | YTD = 58.2%



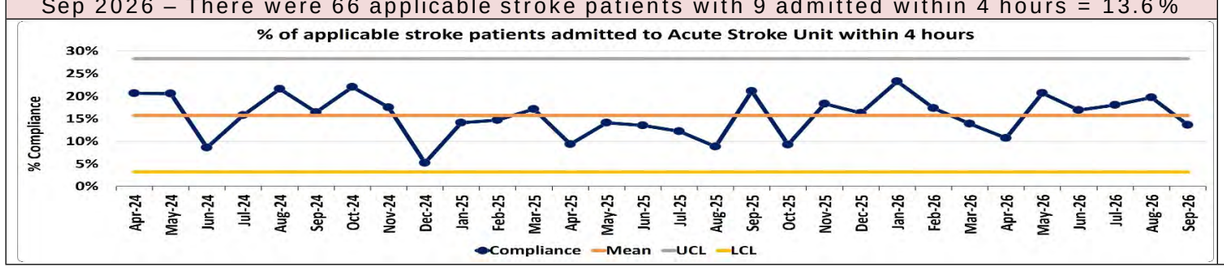
Number of patients spending >12 hours in A&E

Target - Zero | Oct 2026 – 2,305 | YTD = 13,379 (average per month = 2,614)



% of applicable stroke patients admitted to Acute Stroke Unit within 4 hours

Sep 2026 – There were 66 applicable stroke patients with 9 admitted within 4 hours = 13.6%



How are we doing and what are our key concerns?

Ambulance Patient Handover: Performance improved during October, with ambulance handovers exceeding 45 minutes reducing from 197 in September to 165 in October, alongside an increase in 15-minute handover performance from 58.2% to 63.7%. Despite this improvement, performance remains below the expected standard and continues to be impacted by patient flow constraints within Emergency Departments and across the wider acute system. Extended waits for assessment and admission continue to present risks to patient experience, safety and quality of care, particularly for frail and vulnerable patients.

Emergency Department Waits: Four-hour Emergency Department performance reduced to 55.5% in October, compared with 62.3% in September. This was anticipated following the removal of nationally agreed clinical exceptions from performance reporting from 1 October 2026. Twelve-hour waits increased marginally to 2,305, with the majority of delays relating to patients awaiting admission to inpatient beds. Demand remains high and system flow challenges continue to impact timely access to care.

Stroke Pathway Performance: Performance against the four-hour admission standard for applicable stroke patients remains significantly below the expected level at 13.6%. Delays continue to be influenced by Emergency Department congestion, access to diagnostics and inter-site transfers to the Royal Glamorgan Hospital Stroke Centre. Whilst performance remains variable, improving timely access to specialist stroke care remains a key priority.

What key actions are we taking and when do we anticipate improvement?

- Delivering the Urgent and Emergency Care improvement programme, including the 12-Hour ED Improvement Programme, to reduce ambulance handover delays, improve patient flow and minimise extended waits.
- Advancing the OPTIMISE, STAMP and EEMAC (Extended Emergency Medicine Ambulatory Care) work programmes, alongside expansion of same-day emergency care pathways, to reduce avoidable admissions and improve timely access to assessment and treatment.
- Strengthening oversight of patients experiencing the longest waits through enhanced escalation processes, demand and capacity management and improved operational control across the acute pathway.
- Driving improvement in stroke services through focused pathway management, daily multidisciplinary review and implementation of Pre-Hospital Video Triage to support earlier specialist assessment and treatment.

What are the key risks and mitigations?

Risks: High demand, constrained bed capacity and workforce pressures continue to impact patient flow, contributing to extended waits in emergency care and delays accessing specialist services, including stroke care.

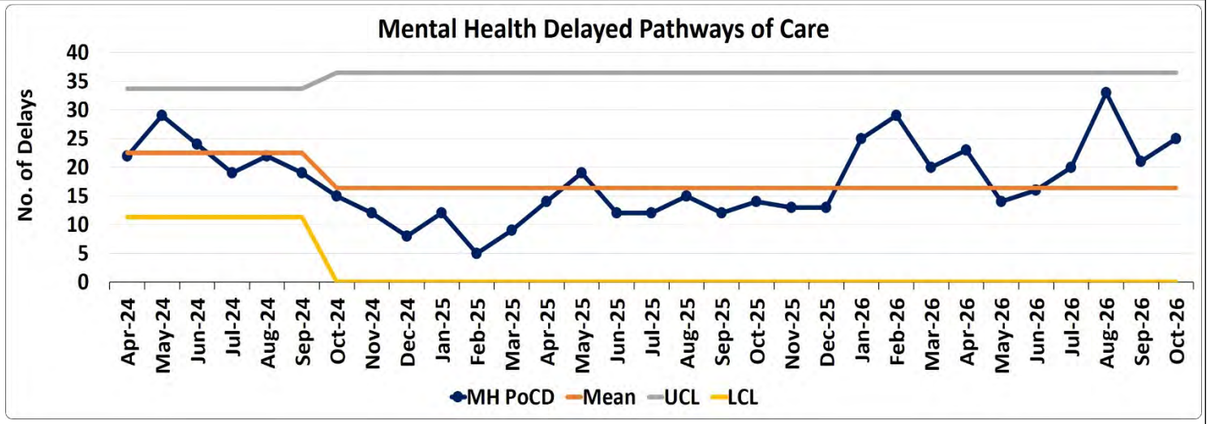
Mitigations: Delivery of the UEC improvement programme, implementation of OPTIMISE, STAMP and EEMAC, continued partnership working with WAST and strengthened operational oversight are supporting improvements in flow, timeliness and patient outcomes.

CTMUHB Efficient Services

Pathways of Care Delayed Discharges (POCD)

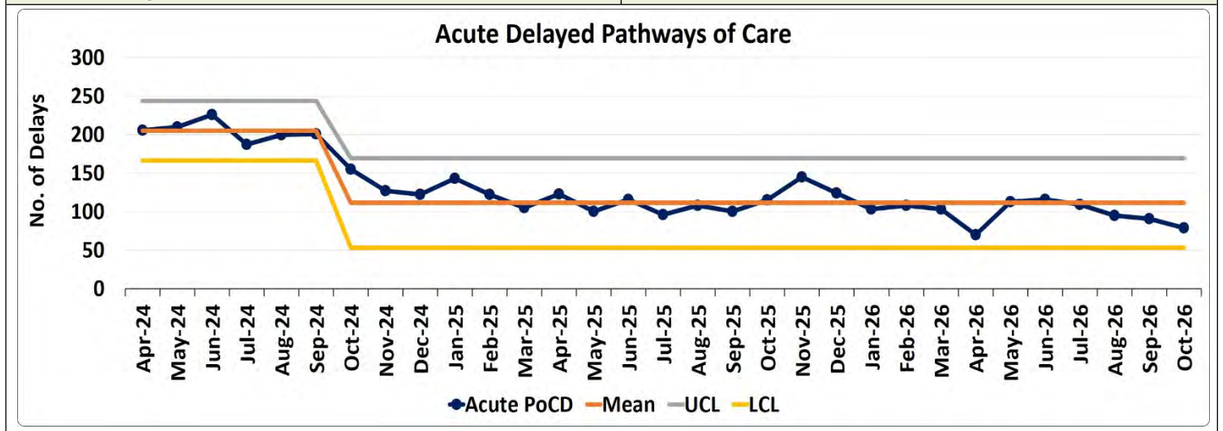
Number of Pathways of Care delayed discharges – Mental Health

Target – 12 month reduction trend | Census date 21st October 2026 - 25



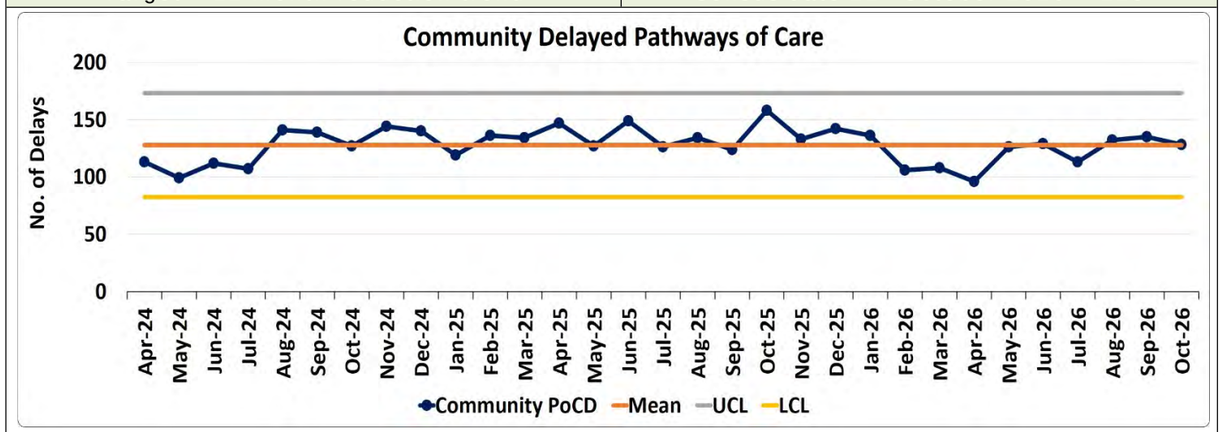
Number of Pathways of Care delayed discharges – Acute

Target – 12 month reduction trend | Census date 21st October 2026 - 79



Number of Pathways of Care delayed discharges – Community

Target – 12 month reduction trend | Census date 21st October 2026 - 128



How are we doing and what are our key concerns?

The October 2026 census recorded 232 Pathways of Care Delayed Discharges across Mental Health, Acute and Community services. This is 16 patients (6.5%) below the 12-month rolling average, indicating a modest improvement in the overall delayed discharge position. Acute delayed discharges have continued to reduce compared with historical levels and remain below the long-term average, whilst Community delays remain broadly stable. Mental Health delayed discharges continue to demonstrate month-to-month variation.

Despite the recent improvement, discharge performance remains affected by the complexity of patients awaiting discharge, particularly where progression is dependent on multi-agency assessments, specialist placements, statutory processes or complex care arrangements. These factors can result in extended lengths of stay and ongoing pressure on patient flow and bed capacity across the health and care system.

What are we doing and what are the key risks and mitigations?

Risks: Sustained pressure from patients requiring complex discharge arrangements may lead to delays in discharge progression and impact patient flow.

Demand for Pathway 3 services, assessment processes and availability of community support continue to present challenges across the system.

Mitigations: Work continues with local authority and system partners to improve discharge pathways through the EToC (Proportionate Trusted Assessment) programme, implementation of Home First principles and strengthened oversight of long-stay and complex cases.

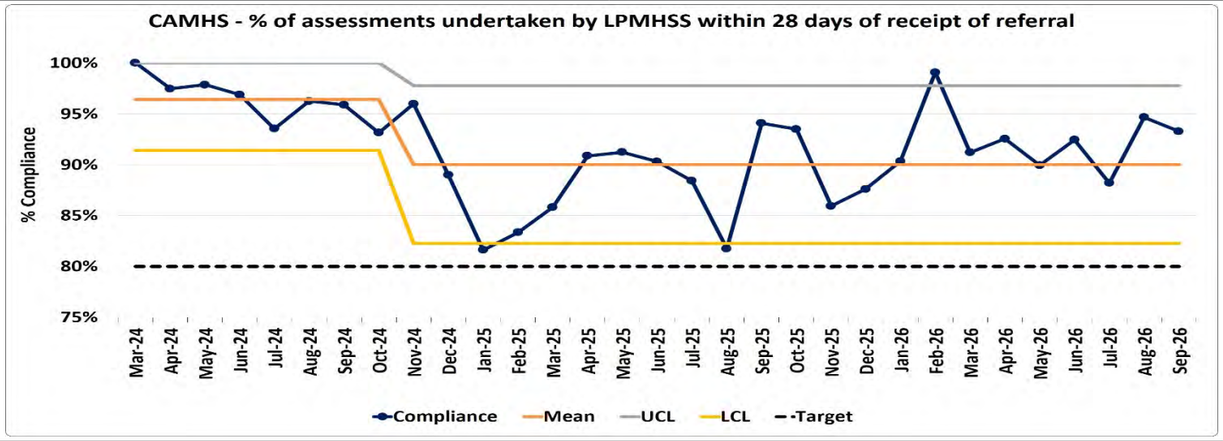
Established escalation processes remain in place to support timely progression of patients experiencing the longest delays.

CTMUHB Mental Health & Learning Disabilities Care Group

Child and Adolescent Mental Health Services (CAMHS)

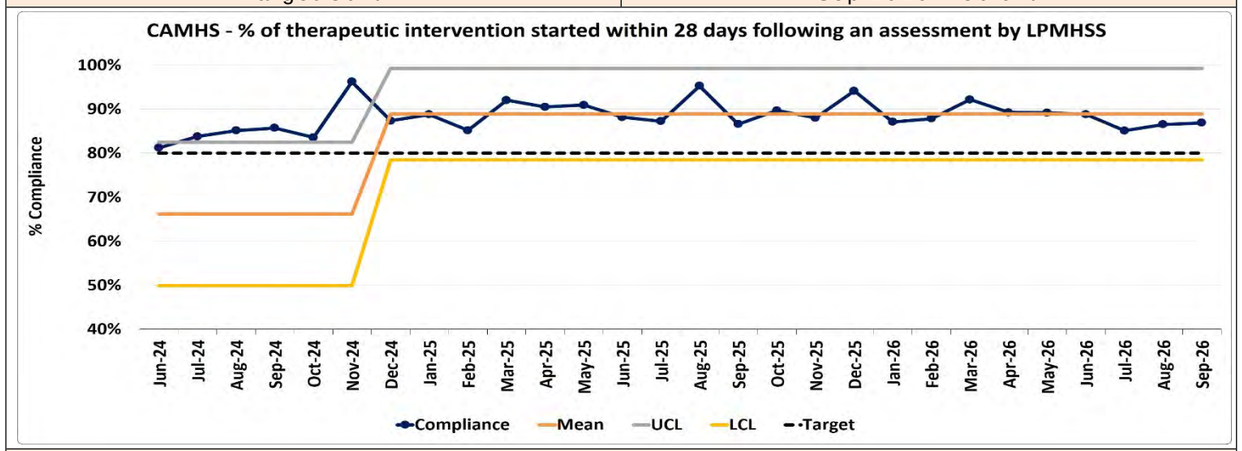
% of assessments undertaken by LPMHSS within 28 days of receipt of referral

Target 80%	Sep 2026 – 93.3%



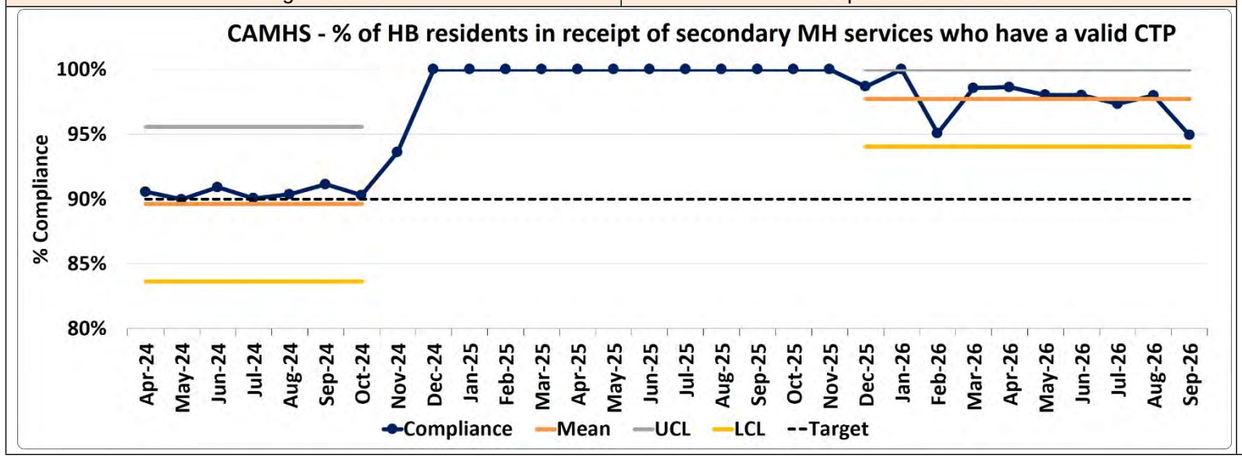
% of therapeutic intervention started within 28 days following an assessment by LPMHSS

Target 80%	Sep 2026 – 86.9%



% of HB residents who are in receipt of secondary MH services who have a valid CTP

Target 90%	Sep 2026 – 94.9%



How are we doing and what are our key concerns?

CAMHS continues to perform strongly against the Welsh Government Mental Health Measure standards, maintaining compliance above the prescribed targets across assessment, intervention and Care and Treatment Plan (CTP) measures. Performance has remained resilient throughout the reporting period despite fluctuations in service demand and operational pressures.

Performance against the assessment measure (Part 1a) remains robust, with 93.3% of patients receiving an assessment within 28 days of referral, exceeding the target of 80%. This reflects the service's continued ability to manage referral demand effectively and maintain timely access to care for children and young people requiring mental health support.

Performance against the intervention measure (Part 1b) also remains above target, with 86.9% of patients commencing therapeutic intervention within 28 days of assessment, compared to the target of 80%. This demonstrates the service's ongoing commitment to reducing delays between assessment and treatment and supporting timely progression through the care pathway.

Compliance with the Care and Treatment Plan measure (Part 2) is 94.9%, exceeding the required target of 90%. This reflects strong adherence to statutory requirements and continued focus on ensuring that service users have comprehensive, up-to-date care plans in place to support the delivery of coordinated, person-centred care.

What key actions are we taking and when do we anticipate improvement?

The focus has shifted from performance recovery to sustaining high levels of delivery and ensuring service resilience.

Key actions include:

- Continued delivery of the CAMHS improvement plan, development of therapeutic group capacity, strengthened partnership working with third-sector providers and the use of real-time performance monitoring to identify pressures early.
- Flexible workforce deployment and regular operational reviews support effective management of demand and capacity, helping maintain performance within target.

What are the key risks and mitigations?

The principal risks relate to fluctuations in referral demand, increasing complexity of presentations and potential workforce pressures during periods of reduced staffing availability.

Mitigations include daily performance monitoring, proactive demand and capacity management, flexible use of staff resources and strong governance arrangements.

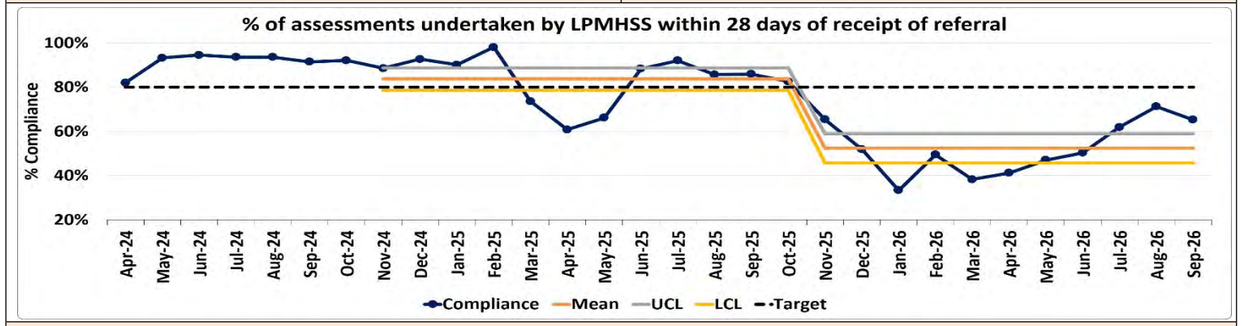
These controls provide assurance that CAMHS is well positioned to maintain current performance levels whilst responding effectively to future demand pressures.

CTMUHB Mental Health & Learning Disabilities Care Group

Adult Mental Health Services

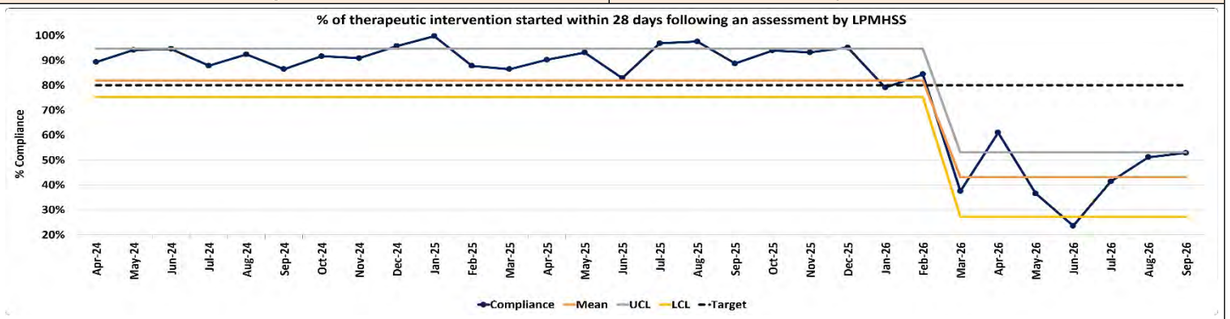
% of assessments undertaken by LPMHSS within 28 days of receipt of referral

Target 80%	Sep 2026 – 65.2%



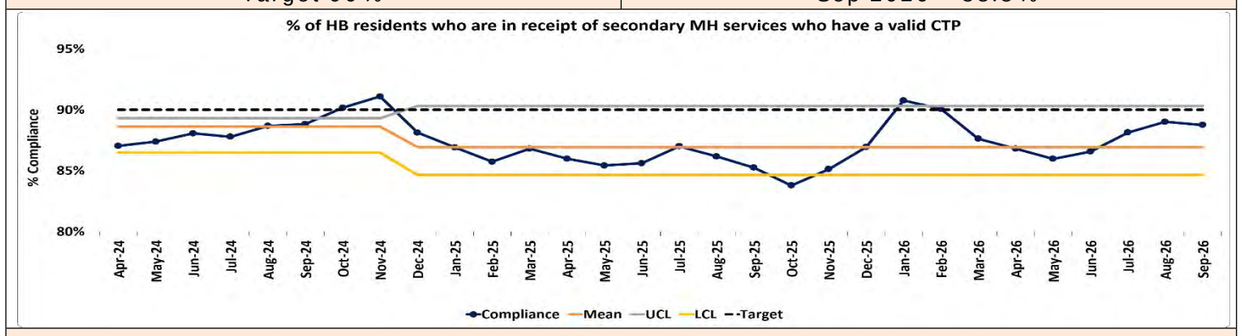
% of therapeutic intervention started within 28 days following an assessment by LPMHSS

Target 80%	Sep 2026 – 52.8%



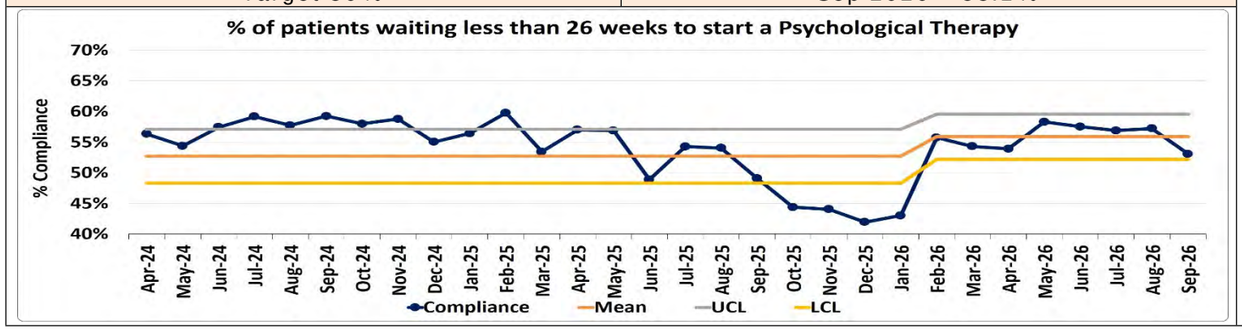
% of HB residents who are in receipt of secondary MH services who have a valid CTP

Target 90%	Sep 2026 – 88.8%



% of patients waiting less than 26 weeks to start a Psychological Therapy

Target 80%	Sep 2026 – 53.1%



How are we doing and what are our key concerns?

Performance across Adult Mental Health Services remains below target for several key measures. In September 2026, 65.2% of assessments were undertaken within 28 days of referral and 52.8% of patients commenced therapeutic intervention within 28 days of assessment, both below the 80% target. Care and Treatment Plan compliance was 88.8%, marginally below the 90% target, whilst Psychological Therapies performance was 53.1% against an 80% target.

Demand continues to exceed available capacity across a number of services, resulting in sustained pressures on assessment and treatment waiting times.

What key actions are we taking and when do we anticipate improvement?

- Delivering recovery plans across Primary and Secondary Mental Health Services, with a focus on reducing waiting times and improving pathway performance.
- Continuing recruitment and workforce optimisation initiatives to increase clinical capacity and improve service resilience.
- Strengthening demand and capacity management, waiting list validation and performance oversight to target unwarranted variation and support recovery trajectories.
- Reviewing models of care, including use of group interventions and pathway redesign, to maximise available capacity and improve timely access to treatment.

What are the key risks and mitigations?

Risks: Sustained demand, workforce vacancies, sickness absence and increasing waiting list pressures continue to impact service performance and recovery.

Mitigations: Ongoing recruitment activity, demand and capacity reviews, strengthened performance management arrangements, enhanced waiting list controls and regular operational oversight are in place to support performance improvement and maintain patient safety.

Performance across key Adult Mental Health measures remains below target and is subject to enhanced scrutiny through Care Group and Health Board performance governance arrangements.

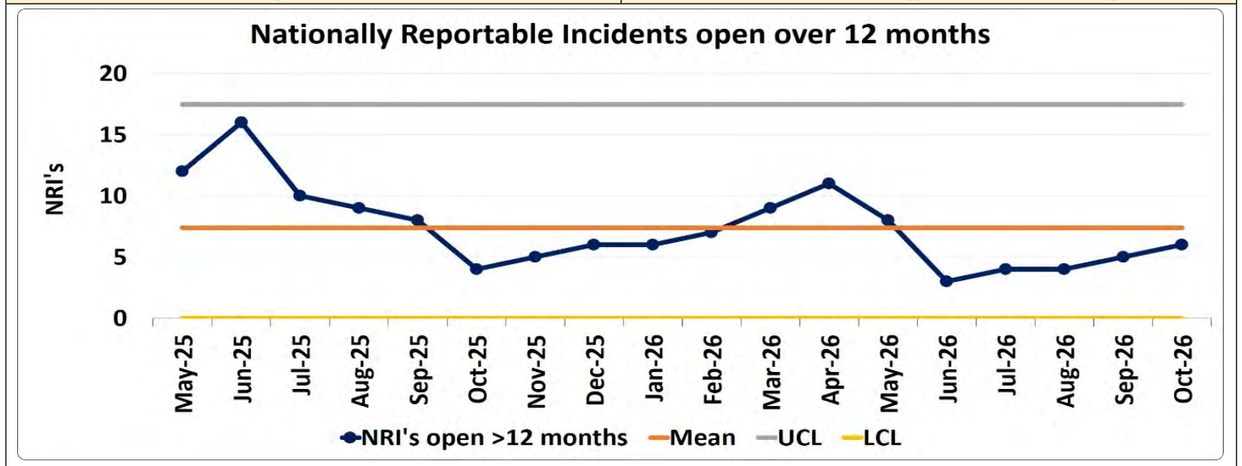
Recovery plans are monitored monthly, with areas of deteriorating performance escalated through established accountability and assurance processes to ensure timely intervention and executive oversight.

CTMUHB Safe Services

Nationally Reportable Incidents Open over 12 months

Target – Zero

Oct 2026 = 6 (provisional data)



Timely completion of nationally reported incidents remains a key element of CTM's commitment to patient safety, quality improvement and organisational learning. Meeting national reporting and investigation timescales ensures that incidents are reviewed while evidence is current, enabling robust investigations, timely implementation of actions and the rapid sharing of learning across services.

How are we doing and what are our key concerns?

Provisionally at the end of October 2026, 6 Nationally Reportable Incidents (NRIs) remain open beyond the 12 month threshold, with no key concerns or risks at present.

Delays arise for a range of reasons, including ongoing investigation, PMRT requirements, quality assurance, clinical and managerial sign-off, Executive approval and external dependencies, including police investigations. A significant proportion of overdue cases are progressing through the later stages of investigation, quality assurance or approval.

What key actions are we taking and when do we anticipate improvement?

A focused approach is in place to support the progression and closure of long-standing Nationally Reportable Incidents. This includes regular review with Care Groups and targeted Quality & Safety support, with cases reviewed to identify barriers to completion and escalated where progress is not being achieved.

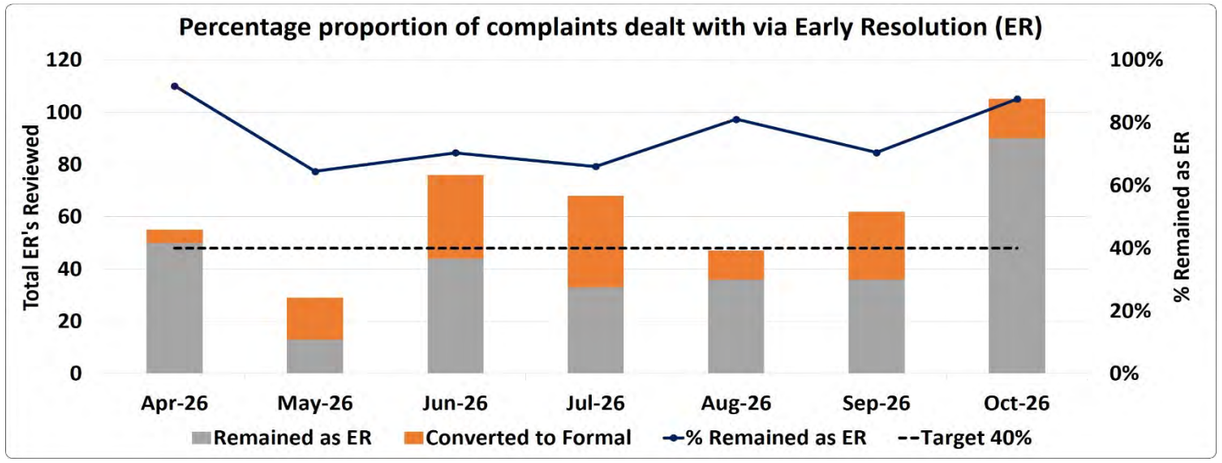
Oversight is being strengthened through routine trajectory monitoring and exception reporting, alongside clearer escalation of NRIs at risk of exceeding their agreed timescales.

Further improvement is anticipated as long-standing cases progress through investigation, quality assurance and approval. However, some complex cases remain dependent on external processes and therefore cannot be assigned a definitive closure date.

% proportion of complaints dealt with via Early Resolution (ER)

Target – 40% by March 2027

Oct 2026 – 87.5%



How are we doing and what are our key concerns?

Performance against the Early Resolution (ER) measure remains strong, with 87.5% of concerns resolved through the ER process in October 2026, more than double the target of 40%. Performance has remained consistently above target throughout 2026/27, demonstrating sustained success in resolving concerns promptly and locally, without the need for formal investigation.

The continued high ER rate reflects effective triage processes, early engagement with patients and families, and collaboration between services and the Concerns Team. While performance is positive, it remains important to ensure concerns are managed through the most appropriate pathway, with robust oversight to maintain the quality of resolution and maximise opportunities for learning and service improvement.

What key actions are we taking and when do we anticipate improvement?

Regular quality assurance reviews continue to support consistent and appropriate use of the ER pathway. Ongoing feedback, guidance and support are provided to services to strengthen decision-making and ensure patients receive timely and proportionate responses. Close collaboration between PALS, the Concerns Team and operational services will continue to support early resolution and minimise unnecessary escalation to formal complaints.

What are the key risks and mitigations?

Workforce pressures within the Concerns Team, including vacancies and sickness absence, present a potential risk to the sustainability of current performance levels. Although there has been no adverse impact on ER performance to date, prolonged capacity constraints could affect responsiveness and complaint handling times.

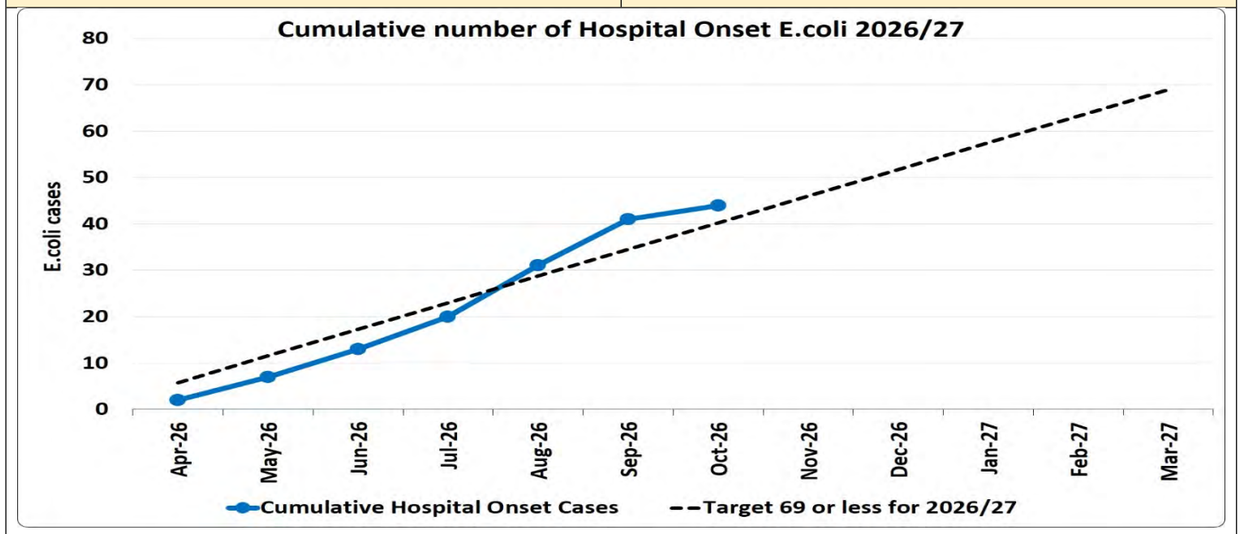
This risk is being actively managed through prioritisation of workload, resilience measures and ongoing monitoring of demand and capacity.

CTMUHB Safe Services

Cumulative number of hospital onset E.coli BSI cases (Bloodstream Infections)

10% reduction on the 2024-25 baseline (<69 cases)

Apr to Oct 2026 – Cumulative Cases = 44



Hospital Onset specimens are taken more than 2 days (where day 1 is day of admission) into a hospital inpatient stay.

How are we doing and what are our key concerns?

Between April and October 2026, CTM recorded 44 hospital-onset E. coli bloodstream infection (BSI) cases, representing 27% of all E. coli bacteraemia specimens reported. The hospital-onset rate was 5.54 per 1,000 admissions, which remains above the current all-Wales rate of 4.57 per 1,000 admissions, indicating a higher burden of healthcare-associated infection within CTM than is being experienced nationally. Hospital-onset infections are currently 10% higher than the same period in 2025/26, while community-onset cases have reduced by 16%, suggesting that the overall increase is being primarily driven by infections acquired during hospital care.

The rise in hospital-onset infections remains a key patient safety concern. Contributing factors include variation in infection prevention practices, lower-than-desired IPC training compliance and the absence of mandatory Aseptic Non-Touch Technique (ANTT) training.

What key actions are we taking and when do we anticipate improvement?

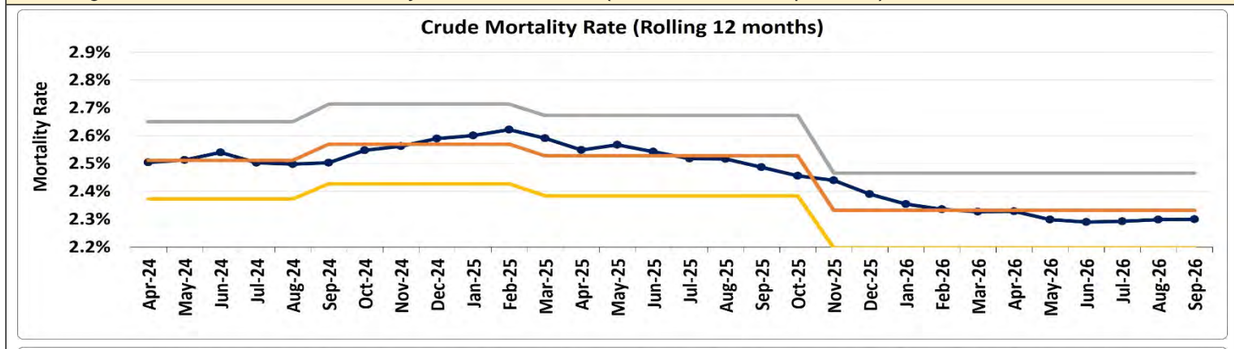
The Infection Prevention and Control Team continues to focus on reducing Gram-negative bloodstream infections through detailed case reviews, enhanced surveillance, ward-level improvement work and collaboration with community bowel and bladder services. Point Prevalence Surveys are also being used to identify risks and monitor compliance with infection prevention standards.

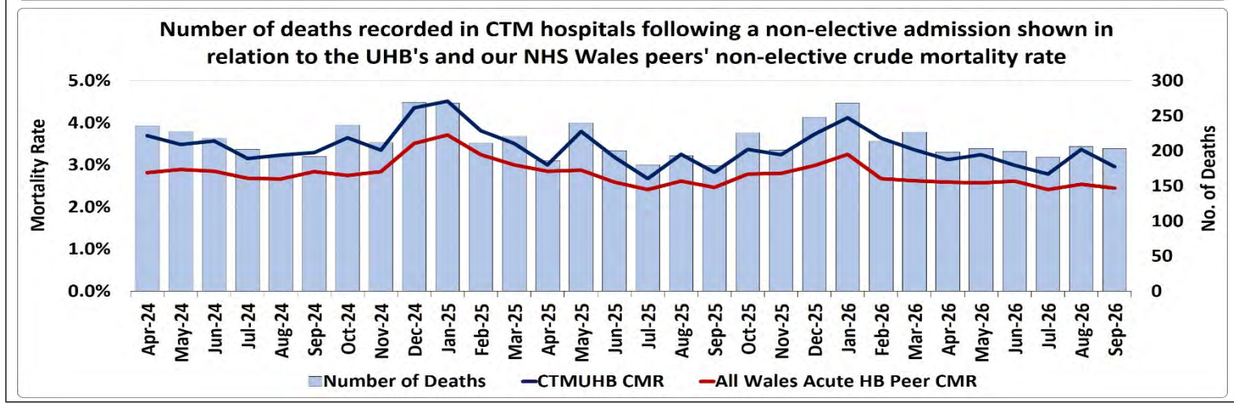
What are the key risks and mitigations?

Risks include rising hospital-onset infections, inconsistent compliance with IPC measures and variation in aseptic practice. Mitigating actions include targeted case reviews, shared learning, improved surveillance, reinforcement of PPE and Bare Below the Elbows standards, and a continued focus on reducing urinary catheter-associated infections.

CTMUHB Crude Hospital Mortality Rate

Rolling 12 month crude mortality rate is 2.30% (Oct 2025 to Sep 2026)





The rolling 12-month crude hospital mortality rate has continued to improve and is currently 2.30% (October 2025 to September 2026), representing the lowest level observed during the reporting period.

Overall mortality rates have reduced compared with previous years despite increasing levels of hospital activity and ongoing pressures on urgent and emergency care services.

Mortality is predominantly associated with emergency admissions, reflecting the higher levels of illness and complexity seen within this patient group. A seasonal pattern continues to be observed, with mortality typically increasing during winter periods when demand, respiratory illness and patient acuity are at their highest. Despite these pressures, recent mortality rates have remained lower than those seen historically.

The Health Board maintains robust arrangements for reviewing and learning from every patient death, supporting continuous improvements in the quality and safety of care.

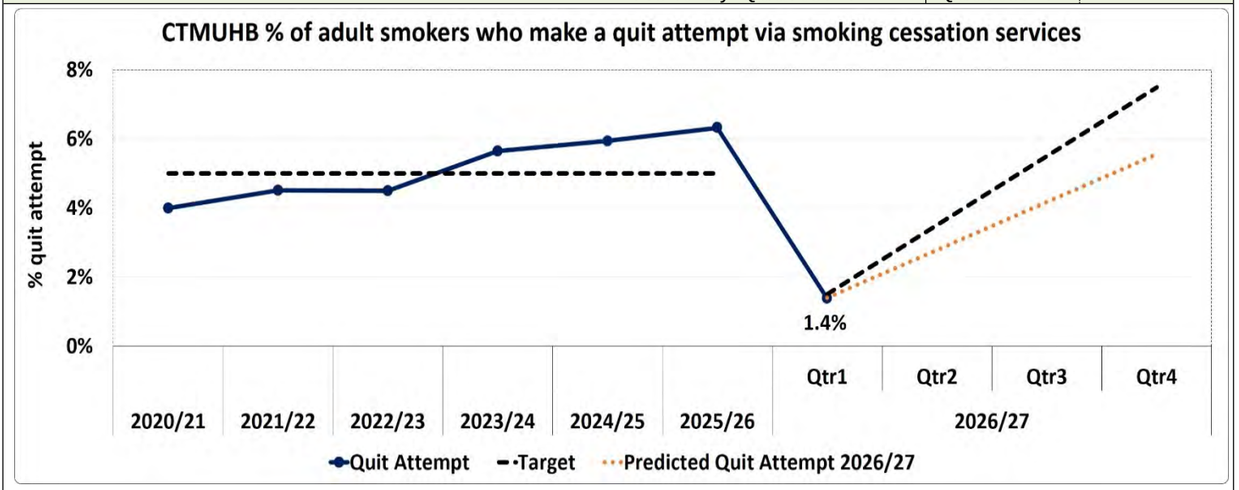
The Multidisciplinary Mortality Review Screening Panel continues to review all deaths in line with Welsh Government policy and the 2014 Palmer Report.

Further information is available in previous reports to Q&S committee (https://ctmuhb.nhs.wales/about-us/our-board/committees/quality-safety-committee/quality-safety-committee-documents/2022/15-november-2022/66-learning-from-mortality-reviews-update-20102022pdf/).

CTMUHB Improving Population Health & Wellbeing

% of adult smokers who make a quit attempt via smoking cessation services

Target		Performance	
7.5% Annual Target for 2026/27:	1.5% by Quarter 1	Quarter 1	1.4%
	3.5% by Quarter 2	Quarter 2	
	5.5% by Quarter 3	Quarter 3	
	7.5% by Quarter 4	Quarter 4	



% of adult smokers who are CO-validated as quit at 4 weeks

Target 2026/27– 40% Each Quarter	Quarter 1 = 7.2%

2026/27		
Estimated number of smokers	*Estimated % of CTMUHB population who are smokers*	*Estimated number of smokers needing to access smoking cessation to reach 7.5% of smokers during 2026/27*
45,800	**12.4%**	**3,435**
Number of smokers treated by the smoking cessation service during Quarter 1	*Number of smokers needed to have been treated to reach Quarter 1 milestone*	*Number of treated smokers followed up at their 4 week post quit date and who were CO-validated as successfully quitting during the quarter*
638	**687**	**46**
1.4%	**1.5%**	**7.2%**

How are we doing and what are our key concerns?

- At Quarter 1 for 2026/27, Health Board Help Me Quit (HMQ) services treated 1.4% of smokers, falling just short of the 1.5% set milestone target for the period.

<u>CO-validated quit target</u>

- Meeting the CO-validated quit target remains challenging due to the high proportion of virtual appointments, where CO readings cannot be taken. Our own client insight work indicates that approximately 90% of clients prefer telephone appointments and this flexibility increases engagement with the service. This pattern is consistent across the other health boards in Wales.

- All clients are followed up at 4 weeks to assess their quit status and this is recorded as 'self-reported' if CO validation cannot be undertaken. When combined, self-reported and CO-validated quit rates for Quarter 1 2026/27 stand at 47%.

What key actions are we taking and when do we anticipate improvement?

<u>CO-validated quit target</u>

- A proposed change to the national HMQ Community Pharmacy specification is expected to support improved CO validation.

- Face-to-face and mixed-model delivery approaches are continually being offered by the HMQ community service, although uptake is low. Scaling this delivery to a level sufficient to meet the CO-validated target is unlikely.

What are the key risks and mitigations?

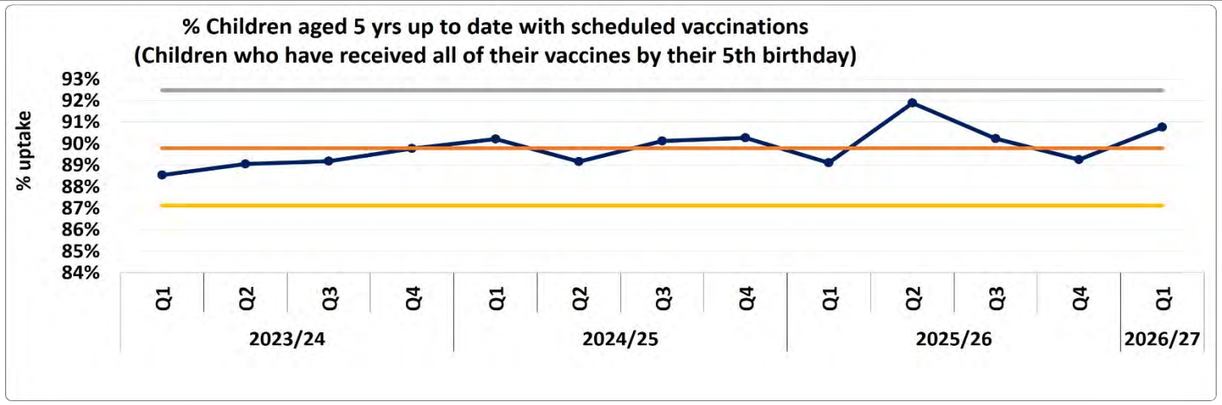
- The main risk facing Help Me Quit services is capacity to increase the number of smokers treated. Achieving the Welsh Government ambition of reducing smoking prevalence to 5% by 2030 will require a reduction from 46,000 to 18,000 smokers within 4 years, requiring significant further resource. However, smoking remains a major driver of harm in CTM, with 11% of deaths and 4% of admissions attributable to smoking annually. Reaching 5% prevalence would yield significant improvements in population health with resultant reductions in healthcare activity.

- Welsh Government have raised the target for % of adult smokers who make a quit attempt from 5% to 7.5% in 2026/27 (target milestones set for each quarter), meaning HMQ services in CTM will need to support an additional 1,000 smokers per year. While this will be difficult without further resource, we are implementing an ongoing programme of work to maximise referrals in secondary care, promote the service and develop a stakeholder network to support this.

CTMUHB Improving Population Health & Wellbeing

% of children who are up to date with the scheduled vaccinations by age 5

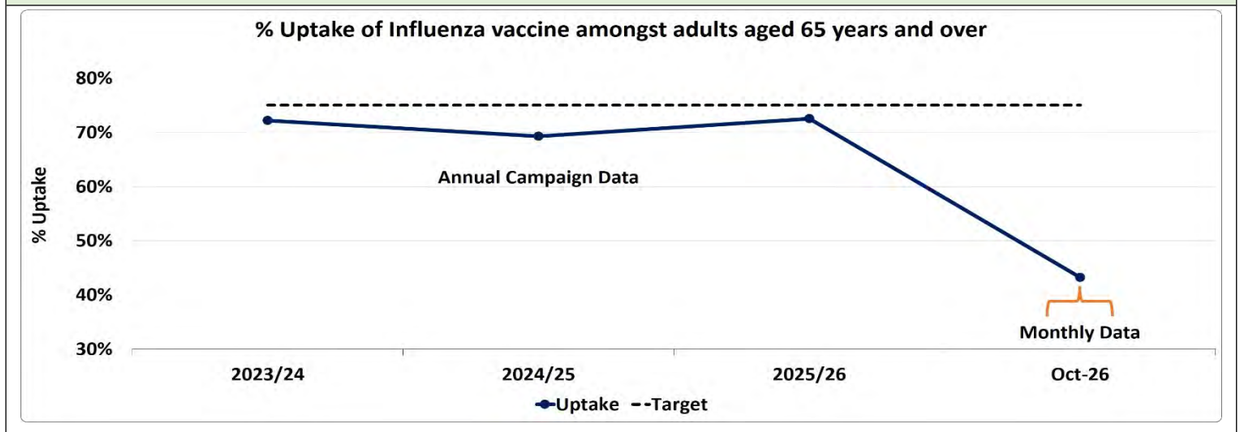
Target – 95%	Quarter 1 2026/27 – 90.8%



Quarter 1 2026/27 vaccine uptake by Local Authority	
Merthyr Tydfil	88.5%
RCT	91.2%
Bridgend	91.1%
CTMUHB	90.8%

% uptake of the influenza vaccination amongst adults aged 65 years & over

Target – 75%	Data as at 20th Oct 2026 – 43.2%



The main delivery of the 2026/27 Influenza Immunisation Programme is from Sep 26 to Feb 27, with adult vaccinations primarily starting in October.

How are we doing and what are our key concerns?

Performance against the childhood vaccination measure remains below the 95% national target although Quarter 1 2026/27 performance improved marginally to 90.8%. MMR uptake at age two has increased to 94.5%, demonstrating positive progress; however, maintaining and improving uptake remains a priority following the introduction of the MMRV vaccine, which has increased demand and appointment pressures across some primary care settings.

Overall vaccination performance has improved slightly, but coverage remains below the level required to maximise population protection. Particular focus continues on childhood immunisations and MMR uptake to reduce the risk of vaccine-preventable disease outbreaks.

What key actions are we taking and when do we anticipate improvement?

Primary Care and Child Health teams continue targeted support for GP practices with vaccination waiting lists exceeding fifty children, including additional clinics and increased appointment capacity.

Through Primary Care setting a targeted MMRV catch-up programme will commence in November 2026.

The meningococcal B vaccination campaign for university entrants and eligible 17 to 18 year olds continues to progress well.

Seasonal influenza programmes are underway across staff, schools, primary care, community pharmacy and health protection teams, with targeted catch-up arrangements in areas of low uptake and enhanced support for special schools.

Influenza Vaccination Uptake (65 Years and Over) - the most recent reported (20/10/2026) uptake for adults aged 65 years and over was 43.2% and falls substantially below the 75% target.

What are the key risks and mitigations?

Suboptimal vaccination coverage increases the risk of outbreaks of vaccine-preventable diseases, particularly measles, where 95% coverage is required to maintain effective population protection.

Mitigation includes close monitoring of clinic capacity, management of vaccination waiting lists and targeted catch-up activity.

There is also a risk that eligible adults and clinical risk groups do not receive influenza vaccination. This is being mitigated through targeted communications, improved access routes and ongoing uptake analysis to inform focused interventions.

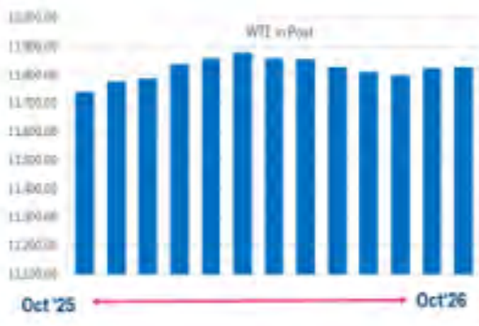
People Metrics Dashboard: November 2026

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Please note that reporting is based on the previous month's data. Exceptions include sickness data, which is reported two months in arrears, and annual census datasets such as the Staff Survey and Gender Pay Gap metrics.

GETTING THE BASICS RIGHT

CTM employs **13,606** staff in post (SIP), equal to **11,828.02** whole time equivalent (WTE) October 26. This is an increase of **0.03%** compared to the previous month (Sept 26). We have grown by **0.7%** (Oct 25 to Oct 26)



The biggest % increase in WTE is in Add Prof Scientific and Technical Staff Group by **4.4%** (Oct 25 to Oct 26)





Average age is **44 years**

25% of the workforce are aged 55 & over (Oct 26)

44% of Estates & Ancillary Staff Group are aged 55 & over (Oct 26)

MODERN WORKFORCE – SKILLS FOR THE FUTURE

Staff Turnover

Rolling 12-month turnover has reduced from **8.58%** (Oct 25) to **8.10%** (Oct 26)



Area with the highest turnover: **Estates & Ancillary (10.69%)**

Top reasons all Staff Groups: **Retirement & Voluntary Resignation**

Bank & Agency Spend

Bank & Agency spend (Sept 26):
M&D was **£2.38m**
NMR was **£2.42m**



Lateral Moves Scheme 445 eligible requests & 151 successful moves since launch (Feb 2024)

GREAT MANAGEMENT AND LEADERSHIP

PDR Compliance has increased: **75.96%** (Oct 26)

The target for PDR Compliance is 85%



Return to Work compliance is **70.4%** (Sept 26) which has increased from **58.1%** (Sept 25)

Statutory and Mandatory Training Compliance in Oct 26 for Level 1 is **81.99%**, and ALL Levels of Training is **75.63%**

The target for all Statutory and Mandatory Compliance is 85%

Improved Performance Static Performance Decreased Performance

Performance based on comparison to previous month or last reporting period e.g. yearly for Gender Pay Gap and Staff Engagement

AN INCLUSIVE & HEALTHY ENVIRONMENT

Sickness Absence: In month **7.40%** (Sept 26) which is **874** WTE lost in month. This is compared to **7.41%** (Sept 25). Rolling 12-month is **7.65%** Sept 26 compared to **7.16%** Sept 25.

40.9% of sickness (Sept 26 in mth) due to **Anxiety/Stress/ Depression/Other Psychiatric Illness**

Areas with the highest sickness: **Estates and Ancillary (10.65%)**





Gender Pay Gap 2026/27
Median Hourly Pay Gap is **9.7%**, a decrease from last year
Mean Hourly Pay Gap is **27.21%**, a slight decrease from last year

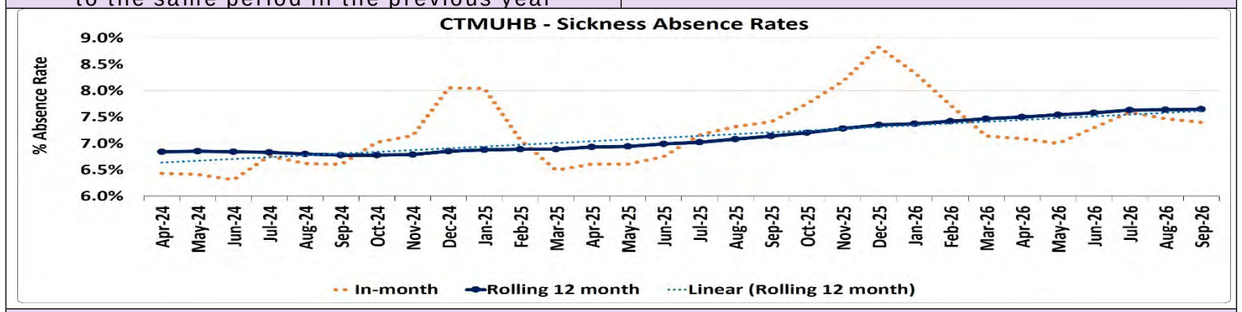


Staff Engagement 2025
Response rate was **35.6%**

CTMUHB Workforce Metrics

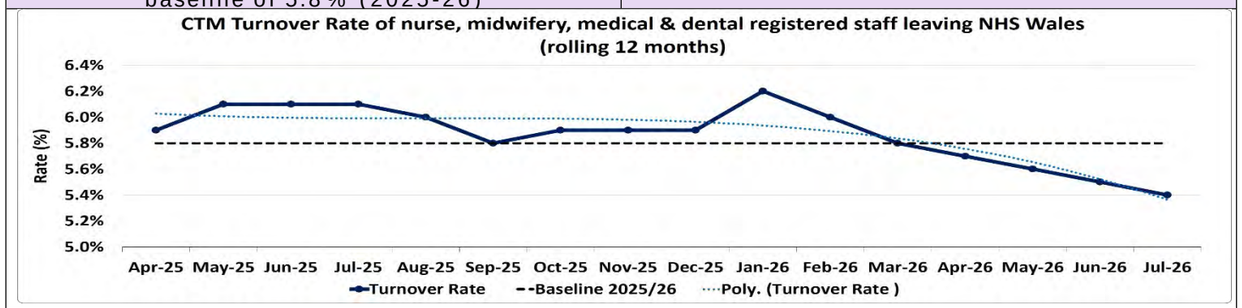
% of sickness absence rate of staff (rolling 12 months)

Target – Rolling 12 month reduction compared to the same period in the previous year	Sep 2026 – 7.65%



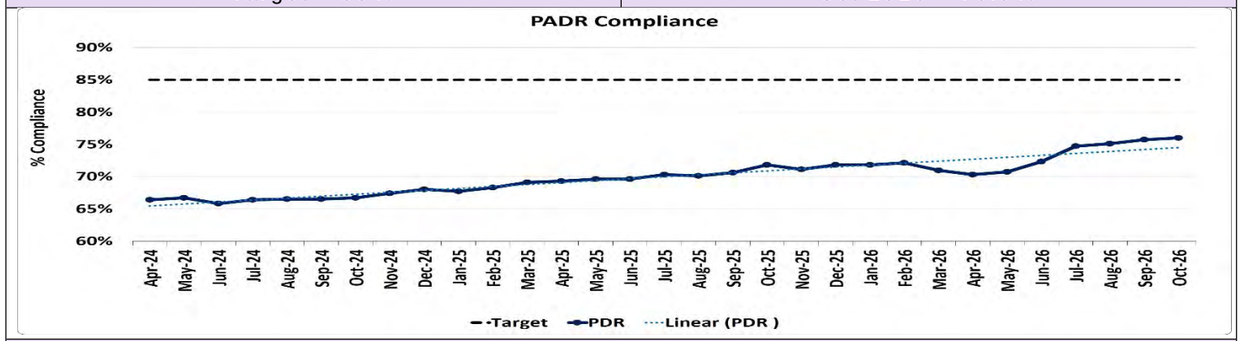
Turnover rate of nurse, midwifery, medical & dental registered staff leaving NHS Wales

Target – Rolling 12 month reduction against a baseline of 5.8% (2025-26)	Aug 2025 to Jul 2026 - 5.4%



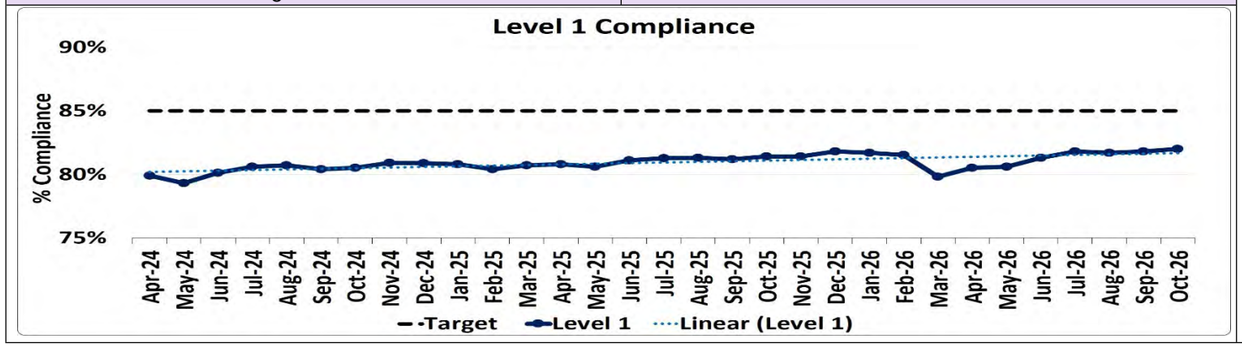
% headcount by organisation who have had a PADR/medical appraisal in the previous 12 months

Target – 85%	Oct 2026 – 76.0%



% headcount who have completed Statutory & Mandatory Level 1 competencies

Target – 85%	Oct 2026 – 82.0%



The overall workforce position remains stable, with a number of indicators demonstrating sustained improvement. Performance in staff development, mandatory learning and workforce retention provides confidence that the foundations required to support high-quality services are continuing to strengthen. Whilst sickness absence remains an area of focus, the direction of travel across the majority of workforce measures is positive and supports CTM's wider objectives of organisational resilience, quality improvement and sustainable service delivery.

Sickness Absence – How are we doing and what are our key concerns?

Sickness absence remains the principal workforce risk, driven largely by long-term absence. However, recent in-month performance has shown signs of stabilisation and remains broadly consistent with the same period last year.

The Health Board continues to prioritise staff wellbeing through targeted interventions and strengthened management support, recognising that improvements in attendance will be fundamental to workforce resilience, productivity and service delivery.

Risk: Sustained high levels of sickness absence reduce workforce capacity, increase reliance on temporary staffing arrangements and may impact service performance and financial sustainability.

Mitigating Actions: Delivery of the Health Board's attendance management arrangements, enhanced support for managers, early intervention approaches, wellbeing initiatives and targeted review of long-term absence cases.

Turnover Rate – How are we doing and what are our key concerns?

Workforce stability remains a relative strength, with turnover continuing to perform better than the baseline at 5.4% (baseline 5.8%). This reflects the effectiveness of ongoing retention and workforce planning initiatives in a challenging labour market.

Whilst recruitment pressures persist within a number of specialist areas, focused actions continue to support service resilience and longer-term workforce sustainability.

Risk: National workforce shortages and competition for specialist staff may impact recruitment, increase vacancy levels and place additional pressure on service delivery.

Mitigating Actions: Continued implementation of workforce planning, targeted recruitment campaigns, succession planning initiatives and retention programmes focused on hard-to-recruit professional groups.

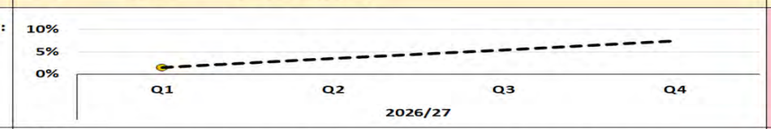
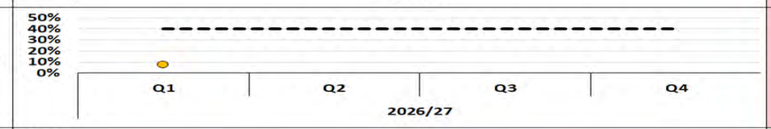
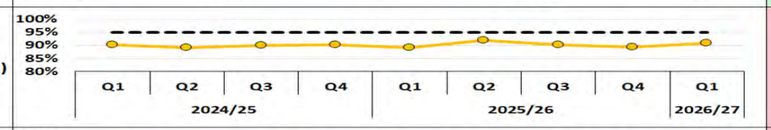
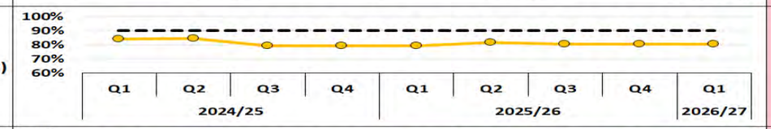
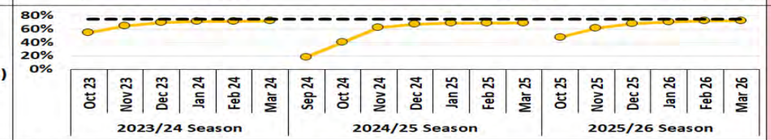
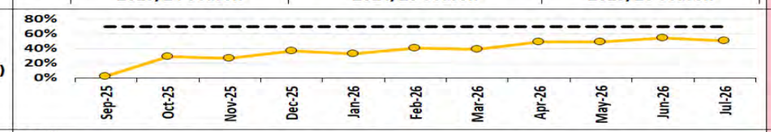
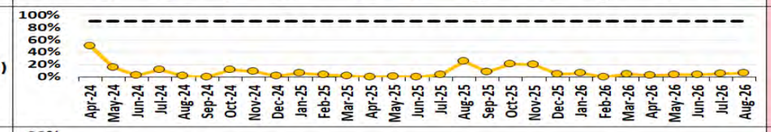
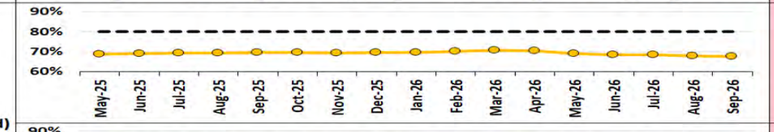
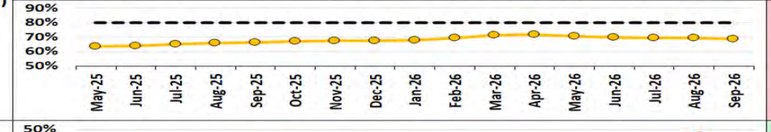
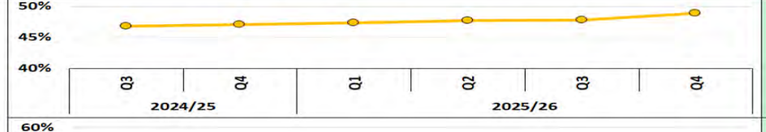
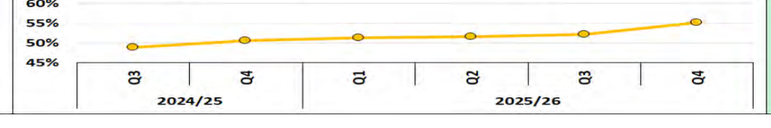
PDR & Core Learning – How are we doing and what are our key concerns?

Performance against Personal Development Reviews continues to improve, reflecting the organisation's commitment to workforce development and staff engagement. Compliance has increased to 76.0%, representing a 5.4 percentage point improvement on the previous year although remaining below the desired target of 85%. This positive trajectory strengthens the Health Board's ability to support staff performance, professional development and organisational effectiveness.

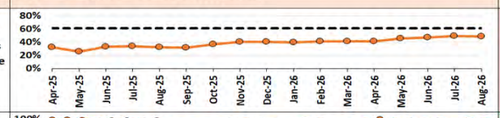
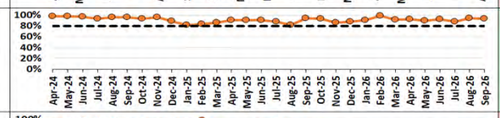
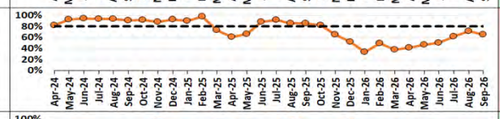
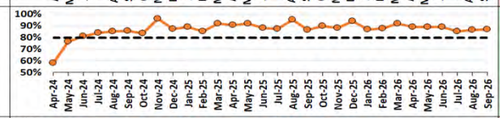
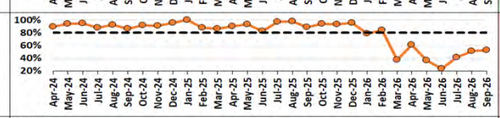
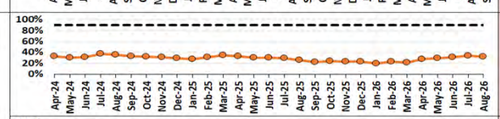
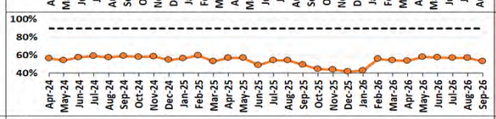
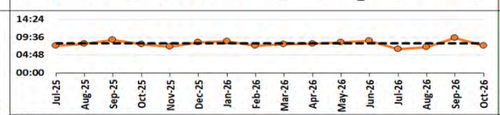
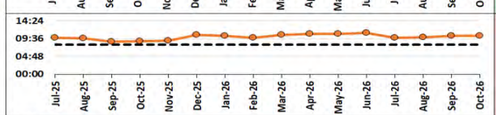
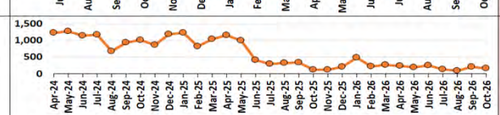
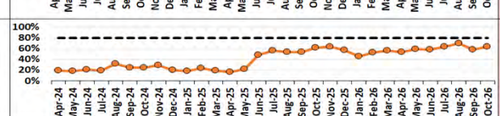
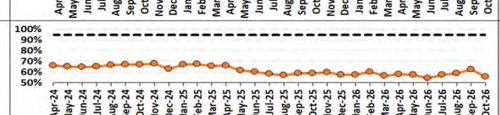
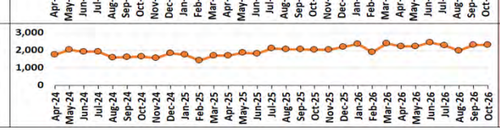
Compliance with Level 1 Core Learning now stands at 82.0%, falling just under the 85% target. CTM continues to focus on maintaining a competent, well-trained workforce and supports the delivery of safe, effective and high-quality care. The position remains on an improving trajectory towards the corporate target.

Risk: Non-compliance may limit opportunities for workforce development, succession planning and effective performance management, particularly within operationally pressured services.

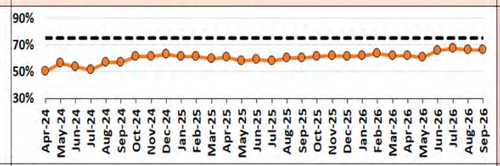
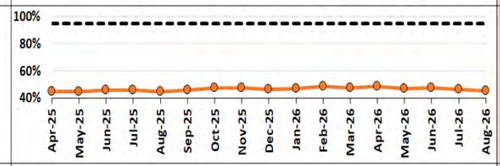
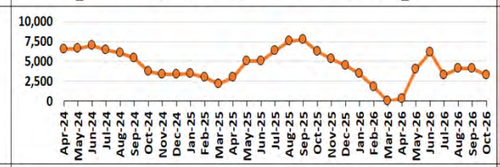
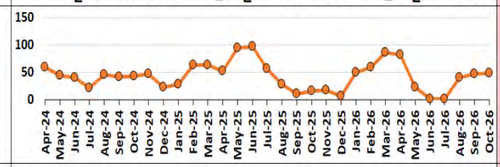
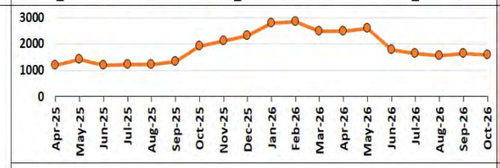
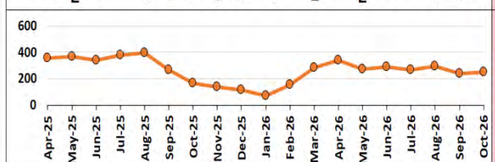
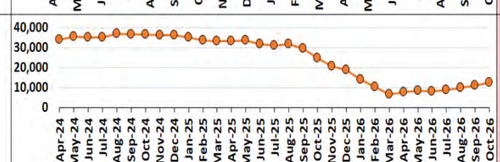
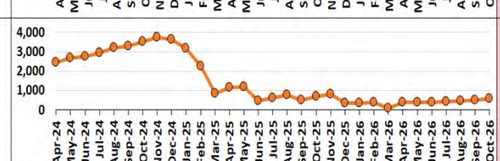
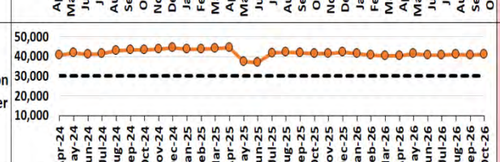
Mitigating Actions: Continued executive oversight, strengthened management accountability and targeted follow-up with areas below target to improve compliance and ensure staff receive appropriate development support.

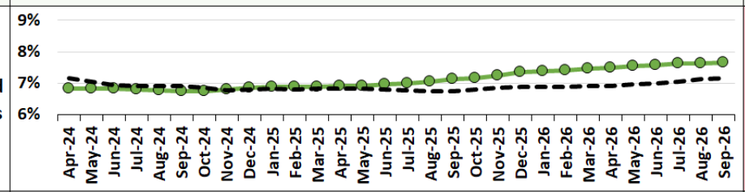
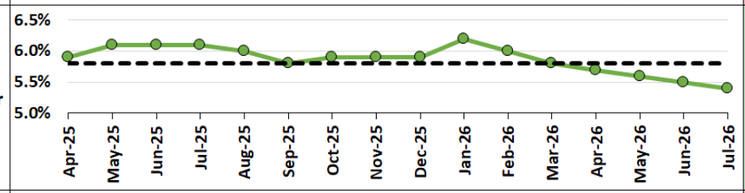
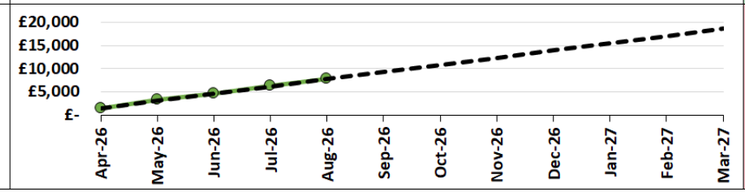
Quadruple Aim 1: People in Wales have improved health and well-being with better prevention and self-management				
Performance Measure	**Target**	**Key:** Trend / Target/Trajectory	**Key: Target Met** / **Target Failed** Latest Position	
Percentage of adult smokers who make a quit attempt via smoking cessation services	7.5% Annual Target: (Higher is good) 1.5% by Q1 3.5% by Q2 5.5% by Q3 7.5% by Q4		1.4%	Qtr 1 2026/27
Percentage of adult smokers who make a quit attempt via smoking cessation services who are CO-validated as quit at 4 weeks	40% each quarter: (Higher is good)		7.21%	
Percentage of people who have been referred to health board services who have completed treatment for substance misuse (drugs or alcohol)	80% (Higher is good)		86.1%	Q1 2026/27
Percentage of children who are up to date with the scheduled vaccinations by age 5	95% (Higher is good)		90.8%	Q1 2026/27
Percentage of children receiving the Human Papillomavirus (HPV) vaccination by the age of 15	90% (Higher is good)		80.6%	
Percentage uptake of the influenza vaccination amongst adults aged 65 years and over	75% (Higher is good)		72.5%	Next update expected Dec 2026
Percentage uptake of the Respiratory Syncytial Virus (RSV) for those turning 75 years of age	70% (Higher is good)		51.0%	Jul-26
Percentage patients offered an index colonoscopy procedure within 4 weeks of booking their Specialist Screening Practitioner assessment appointment	90% (Higher is good)		6.0%	Aug-26
Percentage of patients (aged 12 years and over) with diabetes who have had foot surveillance recorded within last 15 months	80% (Higher is good)		67.5%	Sep-26
Percentage of patients (aged 12 years and over) with diabetes who have had their urine albumin recorded within last 15 months			68.8%	
Percentage of population (adult) receiving NHS dental care over a 24-month period - General Dental Services (GDS)	Improvement compared to the same period in the previous year (Higher is good)		48.9%	Q4 2025/26
Percentage of population (child) receiving NHS dental care over a 12-month period - General Dental Services (GDS)			55.2%	

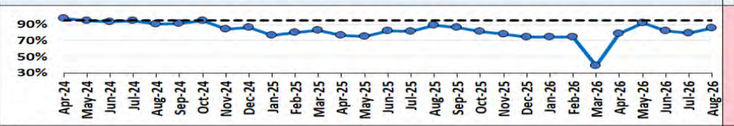
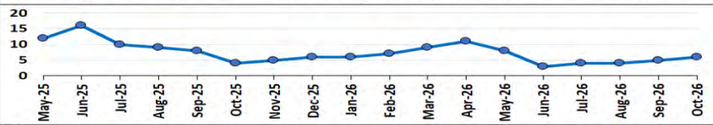
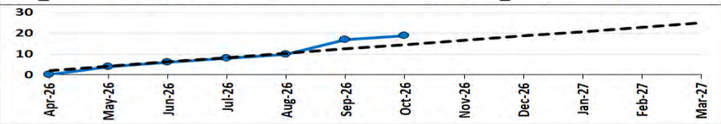
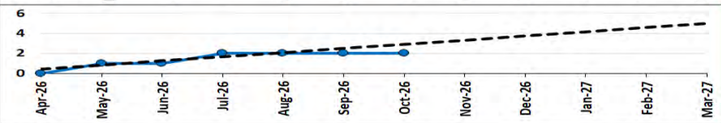
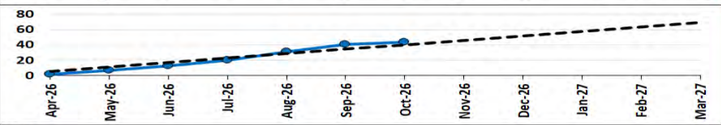
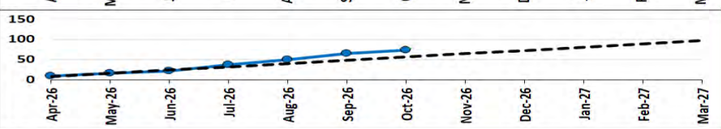
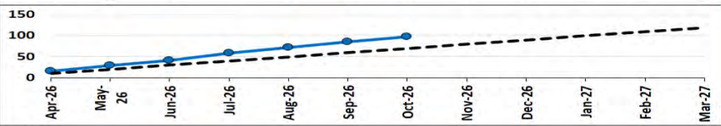
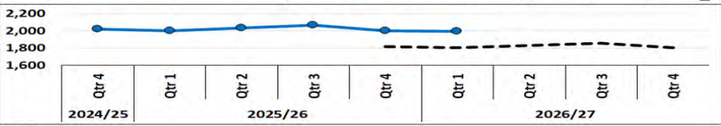
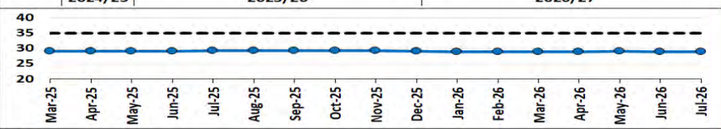
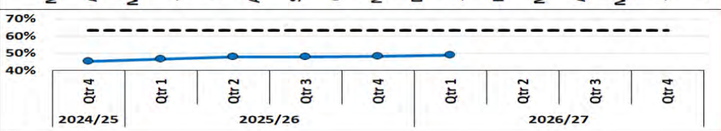
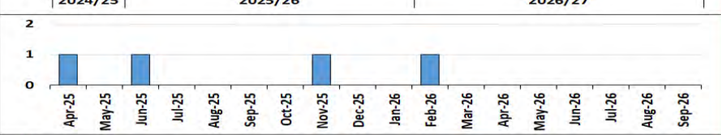
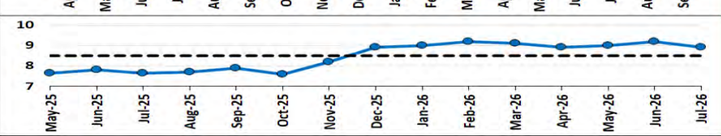
Quadruple Aim 2: People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement

Performance Measure	Target	Key: Trend / Target/Trajectory	Key: Target Met — Latest Position	Target Failed
Percentage of community pharmacies providing Pharmacist Independent Prescribing Service (PIPS)	70% or an increase of at least 20 percentage points on the March 2026 baseline (40.9%) towards 70% (Higher is good)		48.6%	Aug-26
% of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral (for those age under 18 years)	80% (Higher is good)		93.3%	Sep-26
% of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral (for those age 18 years and over)	80% (Higher is good)		65.2%	
% of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS (for those age under 18 years)	80% (Higher is good)		86.9%	
% of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS (for those age 18 years and over)	80% (Higher is good)		52.8%	
% of children and young people waiting less than 26 weeks to start an ADHD or ASD neurodevelopment assessment	80% (Higher is good)		32.1%	Aug-26
% of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health			53.1%	Sep-26
Percentage of people to have a heartbeat restored after a period of cardiac arrest which is subsequently retained until arrival at hospital (Return Of Spontaneous Circulation)	End of quarter on end quarter improvement (Higher is good)		14.3%	Aug-26
Median emergency response time to Purple: arrest category calls	Expected target range 6-8 minutes (Lower is good)		07:19	Oct-26
Median emergency response time to Red: emergency category calls			10:20	
Number of ambulance patient handovers over 45 minutes	Zero (Lower is good)		165	
Percentage of ambulance patient handovers within 15 minutes	80% (Higher is good)		63.7%	
% of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge	95% (Higher is good)		55.5%	
Number of patients who spend 12 hours or more in all hospital major and minor emergency care facilities from arrival until admission, transfer or discharge	Zero (Lower is good)		2,305	

Quadruple Aim 2: People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement

Performance Measure	Target	Key: Trend / Target/Trajectory	Key: Target Met	Target Failed
% of patients starting first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route)	75% (Higher is good)		66.1%	Sep-26
Percentage of R1 patient pathways, which have a target date allocated, waiting within their clinical target date or within 25% beyond their clinical target date for an outpatient appointment	95% (Higher is good)		45.5%	Aug-26
Number of patients (all ages) waiting more than 8 weeks for a specified diagnostic	Zero (Lower is good)		3,309	
Number of patients (all ages) waiting more than 14 weeks for a specified therapy	Zero (Lower is good)		49	
Number of adults waiting more than waiting more than 14 weeks for all audiology pathways (to include new & existing pathways for hearing aids, tinnitus & balance)	Zero (Lower is good)		1,586	Oct-26
Number of children waiting more than 6 weeks for all audiology pathways (to include new assessment and intervention pathways)			248	
Number of patients waiting more than 26 weeks for new outpatient appointment	Zero (Lower is good)		12,246	
Number of patients waiting more than 104 weeks for referral to treatment	Zero (Lower is good)		571	
Number of patients waiting for a follow-up outpatient appointment who are delayed over 100%	Reduction of at least 25% on March 2026 baseline (Lower is good)		41,021	

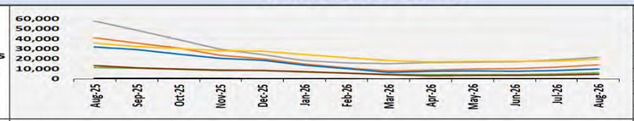
Quadruple Aim 3: The health and social care workforce in Wales is motivated and sustainable				
Performance Measure	**Target**	**Key:** Trend, Target/Trajectory	**Key: Target Met** / **Target Failed**	
			Latest Position	
Percentage of sickness absence rate of staff	**Rolling 12 month reduction compared to the same period in the previous year (Lower is good)**		**7.65%**	**Sep-26**
Turnover rate of nurse, midwifery, medical and dental registered staff leaving NHS Wales	**Rolling 12 month reduction against a baseline of 5.8% for 2025-26 (Lower is good)**		**5.4%**	**Jul-26**
Agency spend	**30% reduction in 2026-27 from 2025-26 outturn (£26,555 less 30% = £18,589)**		**£7847 (Numbers in £000's)**	**Aug-26**

Quadruple Aim 4: Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation, enabled by data and focused on outcomes				
Performance Measure	**Target**	**Key:** Trend / Target/Trajectory	**Key: Target Met**	**Target Failed**
			Green = Target Met / Red = Under	
% of episodes clinically coded within one reporting month post episode discharge end date	95%		85.5%	Aug-26
National Reportable incidents open over 12 months	Zero		6	Oct-26
Cumulative number of hospital onset Klebsiella spp BSI cases (bloodstream infections)	10% reduction on the 2024-25 baseline (Lower is good)		19	Apr - Oct 2026
Cumulative number of hospital onset Pseudomonas aeruginosa BSI cases (bloodstream infections)	10% reduction on the 2024-25 baseline (Lower is good)		2	
Cumulative number of hospital onset E.coli BSI cases (bloodstream infections)	10% reduction on the 2024-25 baseline (Lower is good)		44	
Cumulative number of MSSA BSI cases (bloodstream infections)	20% reduction on the 2024-25 baseline (Lower is good)		73	
Cumulative number of C.difficile infection cases	25% reduction on the 2024-25 baseline (Lower is good)		97	
Gabapentin and pregabalin DDDs per 1,000 patients	10% reduction compared to same period in the previous year (Lower is good)		1996.25	Q12026/27
Average quantity per item prescribed from start period for the reference basket of medicines	Prescribing interval of 35 days or where average is >=35 days in March 2026, an increase of at least 10% on March 2026 baseline of 28.9 (Higher is good)		28.8	Jul-26
Number of low Global Warming Potential (GWP) inhalers as a percentage of all inhalers prescribed	80% or an increase of at least 15 percentage points on the March 2026 baseline of 48.2% towards 80% (Higher is good)		48.9%	Q1 2026/27
Number of never events	Zero (Lower is good)		Zero	Oct-26
Overall HB patient experience score	8.5 (out of 10)		8.5	Jul-26

3. Appendix 2. Benchmarking – How do we compare to the rest of Wales?

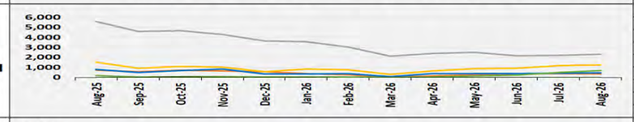
Planned Care & Cancer

Number of patients waiting over 26 weeks for a new outpatient appointment



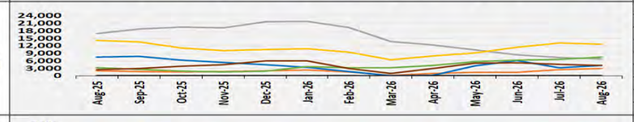
August 2026		
Health Board	Compliance	Rank
Powys	271	1st
SB	4,833	2nd
HDda	6,311	3rd
CTM	**9,874**	**4th**
AB	14,078	5th
C&V	19,762	6th
BCU	21,794	7th

Number of patients waiting more than 104 weeks for referral to treatment



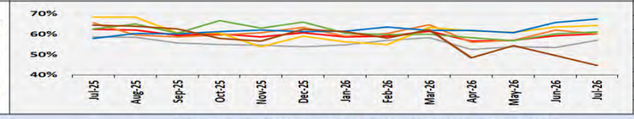
August 2026		
Health Board	Compliance	Rank
Powys	0	1st
SB	0	1st
AB	340	3rd
CTM	**462**	**4th**
HDda	698	5th
C&V	1,256	6th
BCU	2,312	7th

Number of patients waiting more than 8 weeks for a specified diagnostic



August 2026		
Health Board	Compliance	Rank
Powys	42	1st
AB	2,997	2nd
CTM	**4,110**	**3rd**
SB	4,165	4th
BCU	6,695	5th
HDda	7,565	6th
C&V	12,644	7th

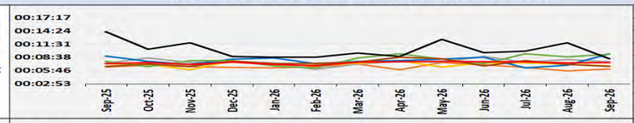
% of patients starting first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route)



July 2026		
Health Board	Compliance	Rank
AB	**60.2%**	**1st**
BCU	57.1%	2nd
C&V	64.4%	3rd
CTM	67.5%	4th
HDda	61.2%	5th
SB	44.7%	6th

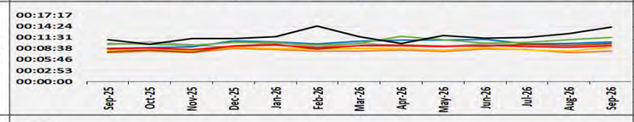
Urgent & Emergency Care/Acute Medicine

Median emergency ambulance response time to purple: arrest category calls



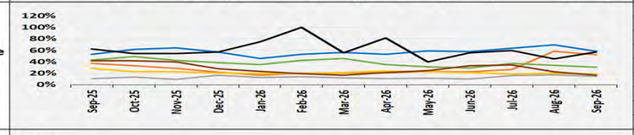
September 2026		
Health Board	Compliance	Rank
AB	06:09	1st
SB	06:40	2nd
C&V	06:46	3rd
BCU	07:43	4th
Powys	08:23	5th
HDda	09:22	6th
CTM	**09:26**	**7th**

Median emergency ambulance response time to red: arrest category calls



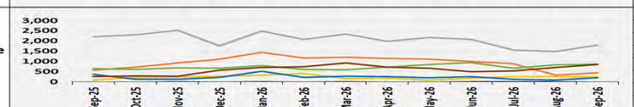
September 2026		
Health Board	Compliance	Rank
AB	08:01	1st
C&V	09:01	2nd
BCU	09:15	3rd
SB	09:58	4th
CTM	**10:24**	**5th**
HDda	11:33	6th
Powys	14:18	7th

Number of ambulance patient handovers within 15 minutes



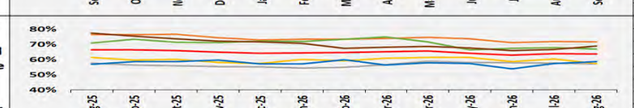
September 2026		
Health Board	Compliance	Rank
CTM	**58.4%**	**1st**
Powys	57.1%	2nd
AB	52.4%	3rd
HDda	31.0%	4th
C&V	18.9%	5th
SB	17.1%	6th
BCU	14.9%	7th

Number of ambulance patient handovers over 45 minutes



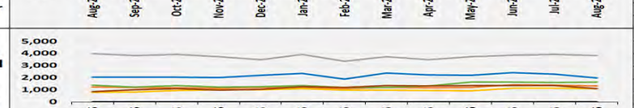
September 2026		
Health Board	Compliance	Rank
Powys	0	1st
CTM	**203**	**2nd**
C&V	246	3rd
AB	450	4th
SB	845	5th
HDda	879	6th
BCU	1,807	7th

% of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge



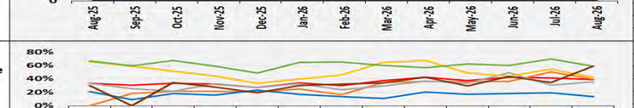
August 2026		
Health Board	Compliance	Rank
Powys	100.0%	1st
AB	71.9%	2nd
SB	69.1%	3rd
HDda	67.1%	4th
CTM	**58.7%**	**5th**
C&V	57.5%	6th
BCU	57.2%	7th

Number of patients who spend 12 hours or more in all hospital major and minor emergency care facilities from arrival until admission, transfer or discharge



August 2026		
Health Board	Compliance	Rank
Powys	0	1st
C&V	1,101	2nd
SB	1,117	3rd
AB	1,312	4th
HDda	1,621	5th
CTM	**1,978**	**6th**
BCU	3,848	7th

% of applicable stroke patients admitted to Acute Stroke Unit within 4 hours



September 2026		
Health Board	Compliance	Rank
HDda	59.3%	1st
SB	59.0%	2nd
C&V	42.9%	3rd
AB	39.6%	4th
BCU	36.0%	5th
CTM	**13.6%**	**6th**

Pathways of Care Delayed Discharges

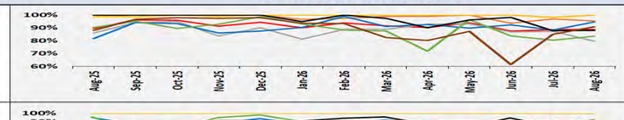
Number of Pathways of Care Delayed Discharges



September 2026		
Health Board	Compliance	Rank
Powys	68	1st
C&V	162	2nd
SB	180	3rd
AB	191	4th
HDda	222	5th
CTM	**247**	**6th**
BCU	347	7th

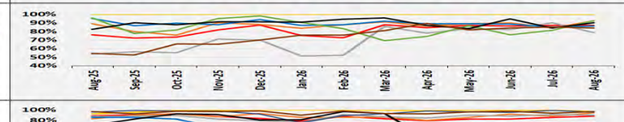
Mental Health Services

% of assessments undertaken by LPMHSS within 28 days of receipt of referral (CAMHS)



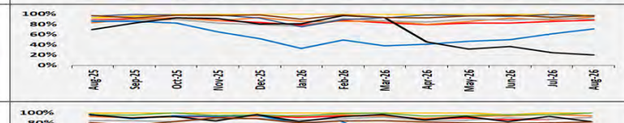
August 2026		
Health Board	Compliance	Rank
C&V	100.0%	1st
AB	95.4%	2nd
CTM	**94.7%**	**3rd**
SB	90.8%	4th
Powys	87.9%	5th
HDda	83.6%	6th
BCU	79.6%	7th

% of therapeutic intervention started within 28 days following an assessment by LPMHSS (CAMHS)



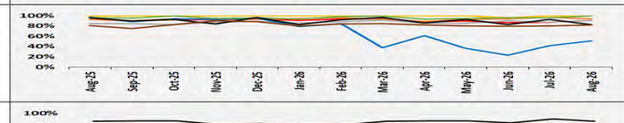
August 2026		
Health Board	Compliance	Rank
C&V	100.0%	1st
HDda	92.6%	2nd
AB	92.5%	3rd
Powys	90.0%	3rd
CTM	**86.5%**	**5th**
SB	84.2%	6th
BCU	78.8%	7th

% of assessments undertaken by LPMHSS within 28 days of receipt of referral (Adults)



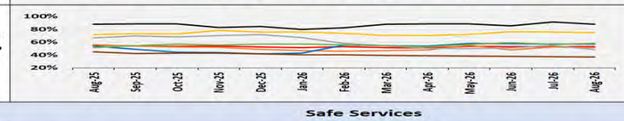
August 2026		
Health Board	Compliance	Rank
Powys	97.3%	1st
C&V	96.9%	2nd
HDda	96.0%	3rd
AB	94.3%	4th
BCU	90.2%	5th
CTM	**71.2%**	**6th**
SB	20.3%	7th

% of therapeutic intervention started within 28 days following an assessment by LPMHSS (Adults)



August 2026		
Health Board	Compliance	Rank
C&V	100.0%	1st
HDda	100.0%	1st
AB	93.9%	3rd
BCU	91.1%	4th
SB	83.1%	5th
Powys	82.3%	6th
CTM	**51.1%**	**7th**

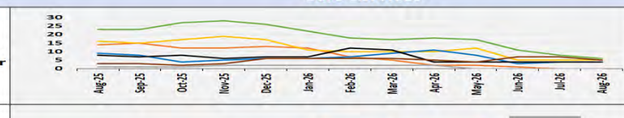
% of patients waiting less than 26 weeks to start a Psychological Therapy



August 2026		
Health Board	Compliance	Rank
SB	87.8%	1st
C&V	75.0%	2nd
HDda	58.0%	3rd
CTM	**57.2%**	**4th**
AB	51.3%	5th
BCU	48.6%	6th
Powys	37.0%	7th

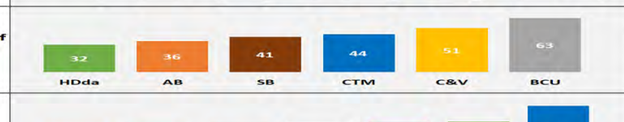
Safe Services

Number of National Reportable incidents that remain open over 12 months



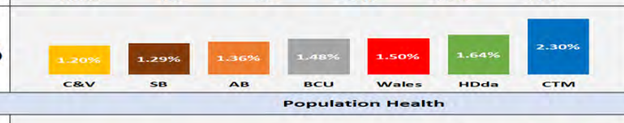
August 2026		
Health Board	Compliance	Rank
AB	0	1st
BCU	0	1st
CTM	**4**	**3rd**
Powys	4	3rd
C&V	5	5th
SB	5	5th
HDda	6	7th

Cumulative number of hospital onset E.coli BSI cases



Apr to Oct 2026		
Health Board	Compliance	Rank
HDda	32	1st
AB	36	1st
SB	41	3rd
CTM	**44**	**4th**
C&V	51	5th
BCU	63	6th

Crude Mortality Rate (Acute Health Boards)



(Rolling 12 mth) Oct 25 - Sep 26		
Health Board	Compliance	Rank
C&V	1.20%	1st
SB	1.20%	2nd
AB	1.20%	3rd
BCU	1.20%	4th
HDda	1.64%	5th
CTM	**2.30%**	**6th**

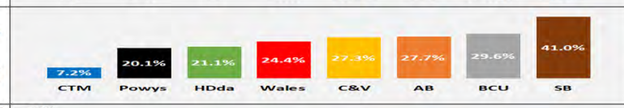
Population Health

Percentage of adult smokers who make a quit attempt via smoking cessation services



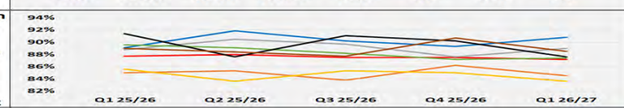
Qtr 1 2026/27		
Health Board	Compliance	Rank
AB	0.9%	1st
C&V	1.0%	2nd
SB	1.2%	3rd
CTM	**1.4%**	**4th**
BCU	1.7%	5th
Powys	2.2%	6th
HDda	2.4%	7th

Percentage of adult smokers who made a quit attempt via smoking cessation services who are CO-validated as quit at 4 weeks



Qtr 1 2026/27		
Health Board	Compliance	Rank
SB	41.0%	1st
BCU	29.6%	2nd
AB	27.7%	3rd
C&V	27.3%	4th
HDda	21.1%	5th
Powys	20.1%	6th
CTM	**7.2%**	**7th**

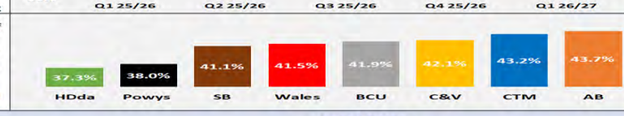
Percentage of children who are up to date with the scheduled vaccinations by age 5 ('4 in 1' preschool booster, the Hib/MenC booster and the second MMR



Qtr 1 2026/27		
Health Board	Compliance	Rank
CTM	**90.8%**	**1st**
BCU	89.0%	2nd
SB	88.5%	3rd
Powys	87.6%	4th
HDda	87.4%	5th
AB	84.5%	6th
C&V	83.6%	7th

Percentage uptake of the influenza vaccination amongst adults aged 65 years and over

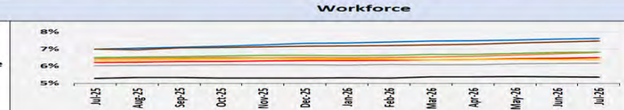
(2026/27 Flu season)



As at 20/10/2026		
Health Board	Compliance	Rank
AB	43.7%	1st
CTM	**43.2%**	**2nd**
C&V	42.1%	3rd
BCU	41.9%	4th
SB	41.1%	5th
Powys	38.0%	6th
HDda	37.3%	7th

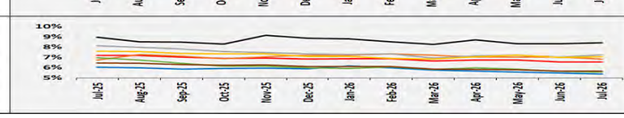
Workforce

% of sickness absence rate of staff



July 2026		
Health Board	Compliance	Rank
Powys	5.4%	1st
BCU	6.2%	2nd
C&V	6.4%	3rd
AB	6.8%	4th
HDda	6.8%	4th
SB	7.5%	6th
CTM	**7.6%**	**7th**

Turnover rate of nurse, midwifery, medical and dental registered staff leaving NHS Wales



July 2026		
Health Board	Compliance	Rank
CTM	**5.4%**	**1st**
HDda	5.6%	2nd
SB	5.7%	3rd
AB	6.8%	4th
C&V	7.1%	4th
BCU	7.2%	5th
Powys	8.4%	7th

4. Key Risks / Matters for Escalation

The key risks for all areas are covered in the summary and main body of the report.

5. Assessment

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)* Link to Strategic Risk(s) on the Board Assurance Framework (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	Strategic Risk 1a
	If more than one applies please list below:

Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales
	If more than one applies please list below:

Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Data to Knowledge
	If more than one applies please list below:

Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Asesiad Effaith Impact Assessment		
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg *(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)* Equality & Welsh Language Impact Assessment Outcome *(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)*	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE This is an overarching position report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment. Summary of impact: Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE This is an overarching position report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment. Summary of impact:	If no, please select a reason below. Choose an item. Named Executive/Board member sign off for no EWLIA completion:
Canlyniad Asesiad Effaith Ansawdd *(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)* Quality Impact Assessment Outcome *(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)*	This is an overarching position report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment.	
Cyfreithiol / Legal	Yes (Include further detail below) Activity where performance falls short of the Health Board's performance measures may result in impact to the patient's journey which may result in a risk of harm. Any potential harm could provide legal challenge.	

Enw da / Reputational	Yes (include further detail below) Activity where performance falls short of the Health Board's performance measures may result in impact to the trust and confidence in the Health Boards service provision.
Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	Yes (include further detail below) Workforce and financial resources are required to address the Planned Care Recovery plans and improvement trajectories within the Health Board.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	Date	Outcome
Claire Thompson	17/11/2026	Endorsed for Approval

6. Glossary of terms

Term	Definition
ABUHB	Aneurin Bevan University Health Board
BCUHB	Betsi Cadwaladr University Health Board
C&VUHB	Cardiff and Vale University Health Board
CTMUHB	Cwm Taf Morgannwg University Health Board
HDUHB	Hywel Dda University Health Board
PTHB	Powys Teaching Health Board
SBUHB	Swansea Bay University Health Board
WAST	Welsh Ambulance Services NHS Trust
PHW	Public Health Wales
HB	Health Board
WG	Welsh Government
CAMHS	Child and Adolescent Mental Health Services
CTP	Care and Treatment Plan
EEMAC	Extended Emergency Medicine Ambulatory Care
ER	Early Resolution
IPC	Infection Prevention and Control
LPMHSS	Local Primary Mental Health Support Services
NRI	Nationally Reportable Incident
OPTIMISE	Health Board patient flow and operational improvement programme
PADR/PDR	Personal Appraisal and Development Review
POCD	Pathways of Care Delayed Discharge
RTT	Referral to Treatment
SCP	Suspected Cancer Pathway
SDEC	Same Day Emergency Care
STAMP	System Transformation and Patient Flow Programme
UEC	Urgent and Emergency Care

CTMUHB Public Board

Primary Care and Community Performance Dashboard

Eitem yr Agenda / Agenda Item	7.3
Dyddiad y Cyfarfod / Date of Meeting:	26 November 2026
Statws Cyhoeddi / Publication Status:	Open/Public.
	Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Service Director and Medical Director for Primary Care and Community
Cyflwynydd yr Adroddiad / Report Presenter:	Gethin Hughes, Chief Operating Officer
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gethin Hughes, Chief Operating Officer
Diben yr Adroddiad / Report Purpose:	For Noting
Argymhelliad *(Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).* Recommendation (Linked to the "What Next" section above).	The Board is asked to NOTE the progress in the development of a Performance Dashboard for Primary Care and Community Services.

1. Situation/Background

This Performance Dashboard provides an overview of the Primary and Community Care Groups current performance position, highlighting key areas of achievement, operational pressure, risk and delivery challenge. This dashboard is still in development and focus has been on refining a key set of measures for sharing with the Board.

2. Specific Matters for Consideration - Key Performance Highlights:

GMS contract variations: There is no change to Contract variation position, and as a result it continues to show a stable position with no contract hand backs and no site closures. The GP escalation reporting is included again to demonstrate a static position in respect of pressures and the position compared to the rest of Wales.

Learning Disability Checks: Practices are being asked to achieve 75% delivery of annual health checks for their registered population with Learning Disabilities. Annual health check invitations and health checks performed fall below this target but the practices have until the end of March 2027 to reach the 75% target. The GMS team is working with practices with the lowest uptake rates to help them achieve this.

General Dental Services (GDS) Performance: The Dental Access Portal (DAP) remains the single route for allocation of new NHS dental patients under the 2026 GDS Contract. As of 7th October 2026, there were 5,479 patients waiting allocation compared to 4,923 in August 2026, patients were waiting allocation through the DAP. Bridgend continues to account for the largest proportion of patients but attributable to the contract hand backs and population demand. There were 5 contract hand backs at the end of March 2026 which increased the number of patients requiring allocation through the DAP.

Welsh General Optometry Services (WGOS): WGOS level 2 focuses on supporting patients with low vision. Between April and September 2026, the WGOS2 activity increased by 8% in total compared to 2025/26. Growth was seen across all bands compared to the same period in 2025/26. The largest growth has been in band 3 claims relating to Post-Op Cataract Follow-up and Other. This reflects the increase in regional and outsourced cataract programme. Secondary care planning and sharing of information on plans is vital to Primary Care planning and forecasting.

Independent Prescribing: Significant increase in activity compared to the same period in 2025/26, increased by 32%, indicating increased confidence in management of patients, more patients being managed entirely within Primary care with just 5% requiring onward referral to hospital services and increase in the number of optometrists qualifying for Independent Prescribing.

GPOOH and Navigation Hub: Performance for GP OOH and Navigation Hub remain strong. For GPOOH all but one target is reached – P1 target which is the Priority 1 patients (P1) those requiring urgent need. The hub is reliant on the information being sent via 111 and following this triage and dispatch. Solutions are being explored. Care Homes intervention continues to help avoid unnecessary admission avoidance to Emergency Departments and keep patients at home where appropriate.

HMPS Parc Prison: The Health Board is responsible for the delivery of health care provision within Parc Prison, Bridgend. The aim is to deliver the same level and quality of services that we would provide to the population living outside of this setting. Primary Care Services are

commissioned and delivered through independent GP, Optometry and Dental contractors. The monitoring of the contracts is undertaken robustly but can be limited and impacted by the day to day running of the Prison and the physical environment.

Challenges

The challenges within the Primary Care and Community Care Group remain the same and the greatest limiting factor is it has limited data and digital informatics support and there remains a large amount of manual data 'pull' required by teams, and lack dedicated Informatics expertise and support. The implementation of a community clinical software system would enable the Care Group to pull more meaningful information on activity and on outcomes across it's community services. Independent Contractor level for all professions and much of the data is pulled directly from practices at a National Level and must be verified by StatsWales before it is published within Primary Care Portal and other central repositories. Hence the data is largely out of date when published. The Care Group will continue to build and refine the dashboard and feedback on the information supplied will be welcomed.

CTMUHB Primary Care & Community

General Medical Services (GMS)

GMS Contract Variations

Indicator	Frequency	2024/25	2025/26	Quarter 1 Apr 26	May 26	Jun 26	Quarter 2 Jul 26	Aug 26	Sept-2026	Quarter 3 Oct-2026	Nov 26	Dec 26	Quarter 4 Jan 27	Feb 27	Mar 26
Practice Population	QUARTERLY	Raw List Size 1/4/24 469,454	Raw List Size 1/4/25 471,879	471,574			471,685						tbc		
No. of GMS Contracts in place	QUARTERLY	N/A	N/A	43	43	43	43	43	43	43					
No. of Managed Practices	QUARTERLY	N/A	N/A	1	1	1	1	1	1	1					
No. of practices at Level 3 or above	MONTHLY	N/A	N/A	8	8	8	8	10	10	10					
Access Targets 1-4 returns submitted on PCIP	QUARTERLY	N/A	100%	100%			100%						tbc		
Sustainability Applications	MONTHLY	N/A	N/A	0	0	0	0	0	0	0					
Current List Closures	QUARTERLY	1	1	1	1	1	1	1	1	1					
Branch Closure Applications	MONTHLY	0	1	0	0	0	0	0	0	0					
Branch Opening Applications	MONTHLY	0	0	1	0	0	0	0	0	0					
No. of GMS Contract Resignations	MONTHLY	N/A	N/A	0	0	0	0	0	0	0					
No. of Patients attached	MONTHLY	N/A	N/A	n/a	n/a	n/a	n/a	n/a	n/a	n/a					

How are we doing and what are our key concerns?

There is a total of 44 GP practices across the CTM footprint, and the table provides a snapshot view of General Medical Contracts' status. The table continues to show stable contract position with no contract hand backs this year.
The other key indicator is the escalation status, which practices use to indicate pressures. There has been since the beginning of the year an average of 9 practices reporting level 3 (very few reporting levels 4)

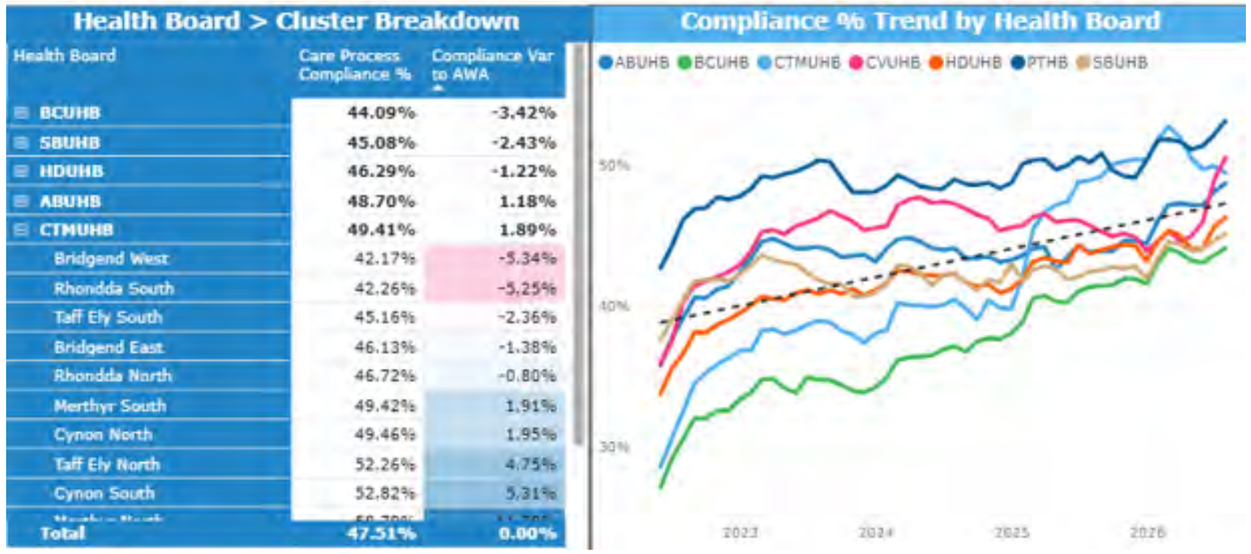
What key actions are we taking and when do we anticipate improvement?

Contract variations applications and sustainability issues are raised

What are the key risks and mitigations?

Contract hand back sometimes poses a risk, but it is also an opportunity.

Diabetes 8 Care Processes.



Health Board > Cluster Breakdown

Health Board	Care Process Compliance %	Compliance Var to AWA
BCUHB	44.09%	-3.42%
SBUHB	45.08%	-2.43%
HDUHB	46.29%	-1.22%
ABUHB	48.70%	1.18%
CTMUHB	49.41%	1.89%
Bridgend West	42.17%	-5.34%
Rhondda South	42.26%	-5.25%
Taff Ely South	45.16%	-2.36%
Bridgend East	46.13%	-1.38%
Rhondda North	46.72%	-0.80%
Merthyr South	49.42%	1.91%
Cynon North	49.46%	1.95%
Taff Ely North	52.26%	4.75%
Cynon South	52.82%	5.31%
Total	47.51%	0.00%

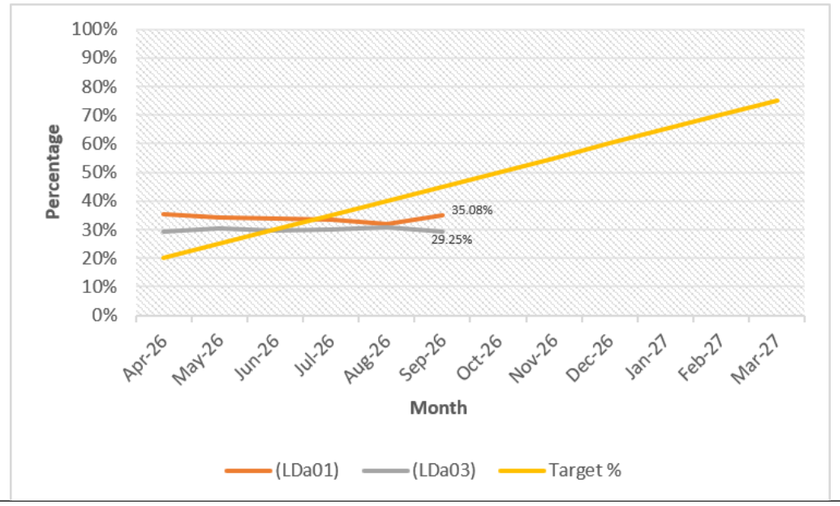
How are we doing and what are our key concerns?

The data is collated through the Primary Care Information Portal and shows a further downward trend over the past 3 months. In August the compliance rate was 49.41% 2026 compared to 47.51% in September. Reliant on GPs to undertake all 8 checks but achievement of a challenge. The data is showing that basic diabetic care is not being undertaken in enough patients in the larger practices - the two key indicators remain diabetic foot checks and album Uria checks. The low performing practices drag down the overall percentage.

What key actions are we taking and when do we anticipate improvement?
The GMS team arranging targeted discussions, share the evidence and schedule meetings with the Medical Director and the Diabetes Leads and GPs in the lowest compliant practices.

What are the key risks and mitigations?
The full 8 checks are not offered to patients, and diabetic care is not fully maximised. Consistent and robust monitoring and actions above will help to mitigate the risks and to reverse the trend.

Learning Disabilities Health Checks

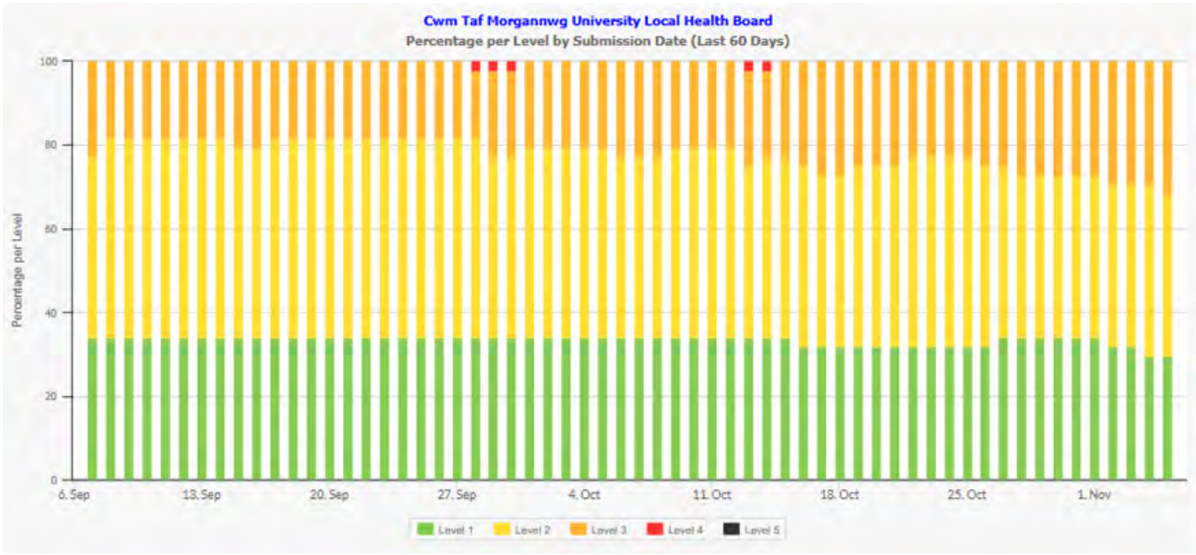


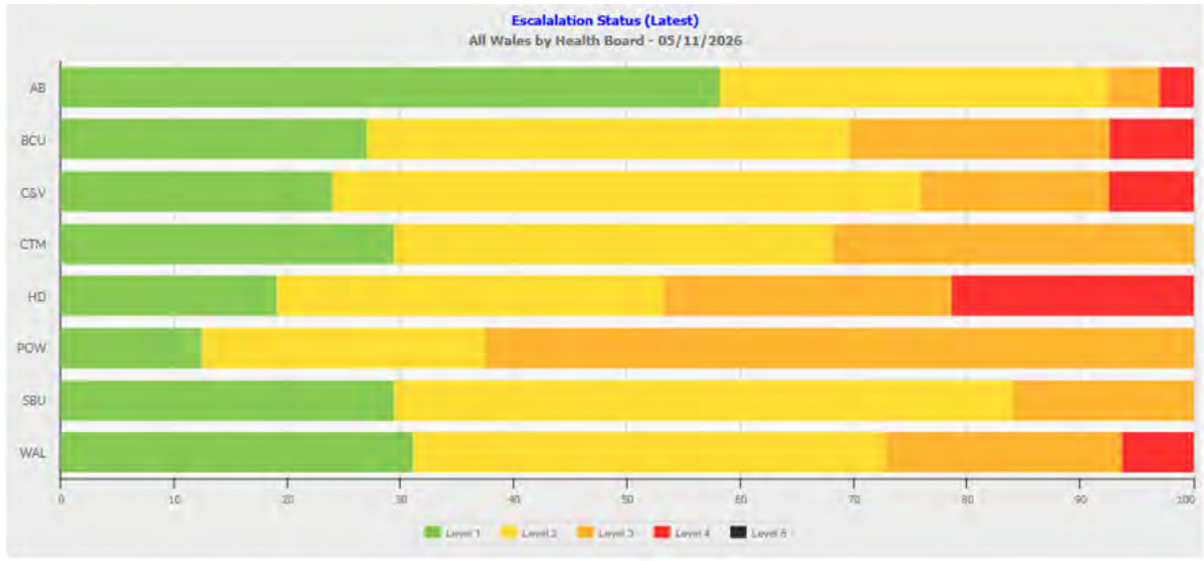
How are we doing and what are our key concerns?

Learning Disability monitoring was previously a supplementary service but is now within the core contract. The percentage target for the end of 2026-2027 is 75%. The data shows the number of patients invited to an annual health check in the previous 12 months LDa01 and number of annual health checks completed in the last 12 months LDa03. As of 1st October 2,332, patients were on LD registers across CTM UHB equating to 0.60% of the population of CTM UHB. This has not changed since the last reporting period.

- Annual health check invitations – 818 (35.08%) and increase compared to 749 (32.04%) in August.
- Annual health checks completed – 682 (29.25%) and a decrease on 718 (30.07%) in August.

Escalation Status for General Medical Services

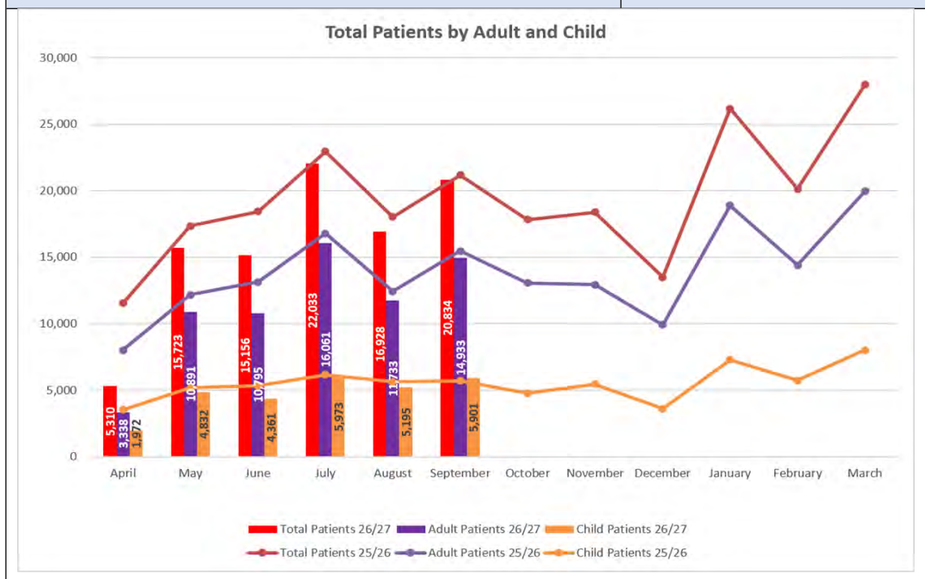




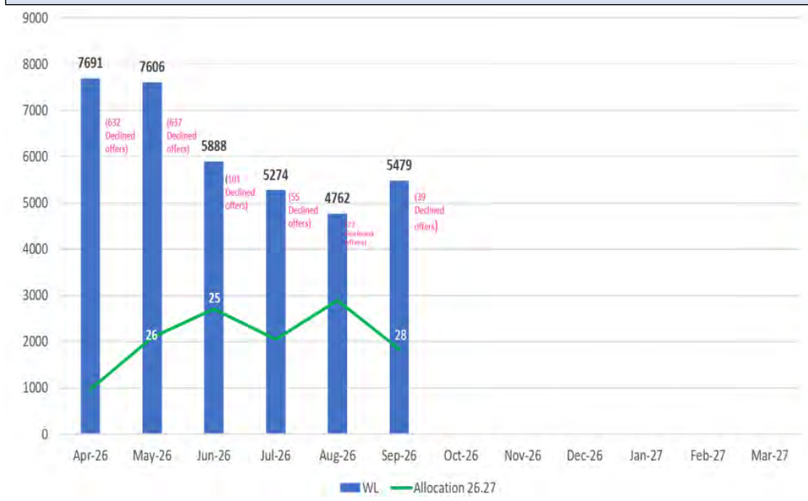
How are we doing and what are our key concerns? The above graph shows the escalation levels reported monthly by GP practices. The framework used is a National one and is tiered: level 1 equates to no pressure; level 2 is experiencing light pressures but no significant impact on service delivery; Level 3 experiencing some pressures impacting operational delivery but manageable; Level 4 is significant pressure impacting negatively on service delivery and having to make operational changes to remain functioning; Finally, Level 5 is where the business continuity critical. The data for CTM over the last year illustrates a static position with little variation. The top 5 reason for escalation remains, patient demand, staff absences (both clinical and administrative), recruitment difficulties and operational pressures. above shows us that the levels are relatively static. the Health Board can determine the need for targeted support or intervention. Level 1 matched demand and capacity. What key actions are we taking and when do we anticipate improvement? Reliant on all GP Practices to comply with the contractual requirement and to complete the escalation matrix every 30 days or sooner if their position changes. Local intelligence amongst the GMS team to identify issues and challenge practices if they feel there is under reporting or over reporting. Where possible the team will help support and provide advice where specific challenges are identified. Steady position and the stable escalation levels reflect the stable contact variation reporting or vice versa.	What are the key risks and mitigations? The team to continue to use local intelligence to have early discussions with practices if challenges become known.

DENTAL

General Dental Services: Total Patients Seen 2026/27 Split by



General Dental Services: Dental Access Portal



Area	No. of patients waiting	October Allocation Requests as of 7 Oct.
Bridgend	2,649	150
Cynon	105	100
Merthyr	491	150
Taff Ely	1,609	180
Rhondda	625	330
Total	5,479	910

How are we doing - Patient access continues to improve month-on-month, however following a dip in activity in August , September saw a recovery to similar levels at mid-year 2025/26. Activity has levelled to a slightly higher position than what was reported in August, with a strong recovery in September 20,834, August 16,928. This is an increase of 23% and is likely due to seasonal changes and practices working towards the mid-year position. The adult/child split remains broadly consistent with previous years, demonstrating balanced access across population groups,2026/27 Adults 71% and Children 29% mirroring last years position.

What key actions are taking place – There is variation in patient activity between practices. The Dental team continues to monitor performance, identify trends and targeted support for lower activity providers as well as maximising capacity. Data submissions are validated to help practices resolve data quality issues.

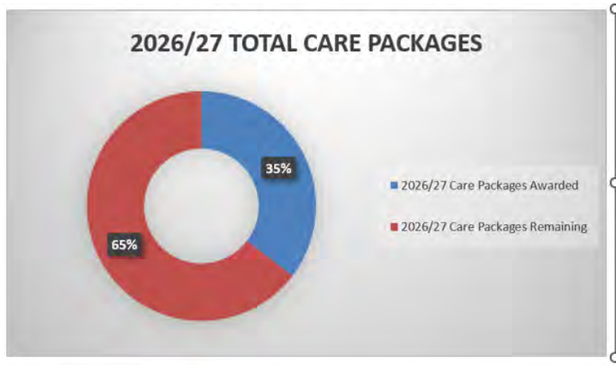
What are the key risks and mitigations – Underperformance by practices but this is being mitigated by
close monitoring.

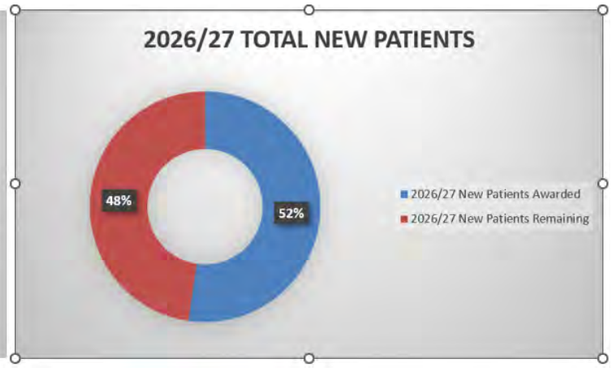
How are we doing: The DAP remains the single route for allocation of new NHS dental patients under the 2026 GDS Contract. There were 5 contract hand backs at the end of March 2026 which increased the number of patients requiring allocation through the DAP. As of September 2026, 5,479 patients were awaiting allocation through the DAP. This is an increase from June/ July. Despite the rise in Sep, overall, the waiting list has reduced significantly from 7,691 patients [April] to 5,479 patients [September], representing a reduction of approximately 29%. Monthly allocations remain significantly above the 2025/26 average of 961 patients, with 1,837 patients allocated in September 2026 across 28 practices. 910 in Oct to date. The increase in participating practices and sustained allocation activity indicates the portal is supporting improved access to routine NHS dental services across the Health Board.

What key actions are taking place – Continued monitoring of waiting list trends and activity monthly to inform commissioning of contracts. Continue to highlight nationally to highlight DAP functionality improvements and to use regular comms on social media to highlight the DAP for patients.

What are the key risks and mitigations –
High demand for NHS dental access remains, particularly within Bridgend where the largest proportion of waiting patients are currently registered. There are concerns the DAP does not hold sufficient new patients to meet practices contractual requirements. Mitigation is ongoing monitoring by the PCT continues.

General Dental Contract Performance (New patients and care packages)





How are we doing and what are our key concerns?

- Care Package (CP) and New Patient (NP) delivery continue to increase month-on-month as practices embed the requirements of the 2026 GDS Contract.
- By September 2026, providers had delivered £7.6m (35%) of the annual Care Package target and £417K (52%) of the annual New Patient target.
- New Patient delivery is performing more strongly than Care Package delivery and has exceeded the required mid-year requirement of 40%. However, it should be noted there continues to be variation across individual practices.
- NP delivery recovered in September and was the highest % activity reported YTD.
- Compared to that seen in August NP assessments (,1381) in September was (1,662) (+17%)
- CP performance remains below the expected 40% mid-year requirement, and continued growth will be required throughout the second half of 2026/27 to achieve contractual requirements.
- Variation between providers remains evident and is likely to reflect workforce capacity, appointment availability, and differing stages of transition the new contract model.

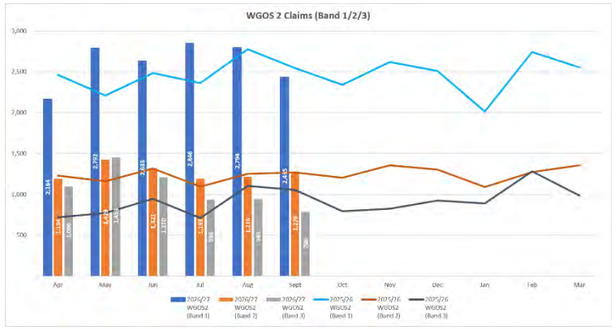
What key actions are we taking and when do we anticipate improvement?
New Patients: individual targeted performance discussions are taking place with Dental providers who are below the trajectory and the Primary Care Dental Team continue to monitor and support practices to maximise available appointment activity.

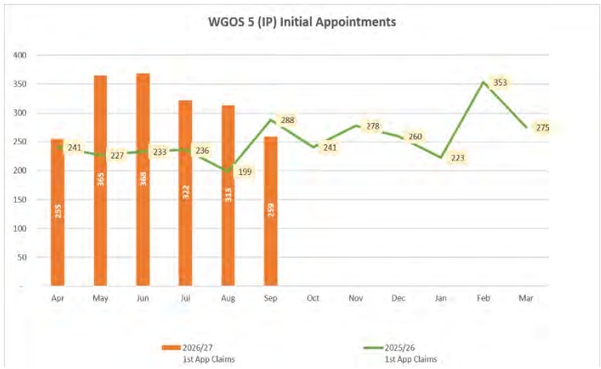
What are the key risks and mitigations?
Workforce capacity and appointment availability within Dental Practices continue to affect the ability of some practices to increase CP's and NP's activity. Work with providers.

OPTOMETRY

Welsh General Optometry Services (WGOS)

Low Vision Services (WGOS 2)





How are we doing and what are our key concerns?

Between April and September 2026 (YTD)

- WGOS2 activity increased by 8% in total compared to 2025/26.

Growth was seen across all bands compared to the same period in 2025/26:

- Band 1 YTD: 6% growth; this is attributed to an increase in referrals for acute eye problems.
- Band 2 YTD: 4% growth; this is attributed to an increase across all categories. The largest increase is for Glaucoma/OHT at 14%. For the first time since April Post-Operative Cataract Conversion ceases to be the biggest area of growth.
- Band 3 YTD: 21% growth; this is attributed to growth across all categories. The largest increase being Post-Op Cataract Follow-up and Other. This is expected due to the increase in regional and outsourced cataract programme.

What key actions are we taking and when do we anticipate improvement?

- Continued training and accreditation opportunities to be offered to performers and sign posting to HEIW.
- Continue monitoring activity and capacity requirements across cataract pathways.
- Review activity trends and ensure workforce planning support future growth.
- Growing pathway complexity and increasing utilisation require ongoing monitoring to ensure sustainable delivery and consistent access across the Health Board
- The sharing of cataract forecasted demand from Hospital Services is vital to enable the Primary Care team to be able to match future capacity with demand.

What are the key risks and mitigations?

Increased cataract acidity and surgery per annum - Workforce capability and availability of accredited practitioners in Primary Care may limit future growth as demand continues to increase.

To mitigate this regular sharing of forecast cataract and other enhanced services with the Primary Care team and alter Hospital Eye services to impact on primary care. Early discussions on the numbers planned will enable planning and forecasting by the primary care tea.

WGOS 5 Independent Prescribing (IP)

How are we doing and what are our key concerns?

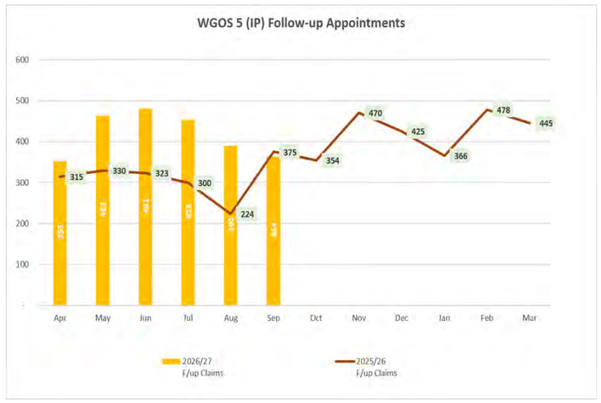
Data shows an increase in activity compared to 2025/26.

Initial Appointments: YTD 32% increase in urgent appointments compared to the same period in 2025/26.

Follow-up Appointments: YTD 34% increase in appointments provided in practice compared to the same period in 2025/26.

Key Drivers of Growth:

- Comparing follow-up activity with the same period in 2025/26, increased by 32%, indicating increased confidence in management of patients
- Approximately 95% of patients are managed entirely within primary care, with 5% requiring onward referral demonstrating effective filtering and reducing pressure on secondary care growth.
- Activity growth reflects an increase in the number of independent prescribers - qualified optometrists delivering WGOS 5 Board. Currently onboarding a further 5



newly qualified independent prescribers. This will support the WGOS 5 discharge when implemented.

What key actions are we taking and when do we anticipate improvement?

Continue to work with Planned Care team but no plan as yet to introduce a monitoring pathway for patients being discharged. Task and Finish Group to progress the work.

What are the key risks and mitigations?

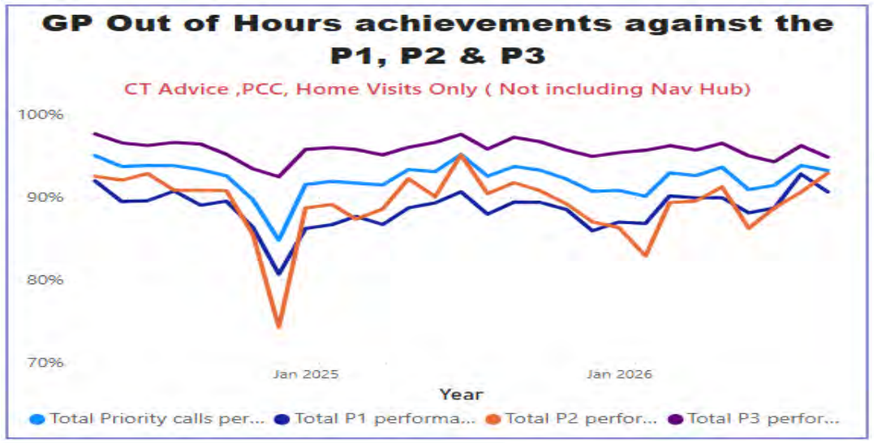
IP filtering is increasing year on year, retaining 95% of patients in primary care and reducing onward referrals into HES or the GP. This growth does impact budget for WGOS, which will increase further when the discharge pathway is implemented and the risk is demand will outstretch the budget. There is no agreed operational monitoring model and no shared record at present. Mitigating actions: Work required with Data and Digital and Planned Care to develop and implement a WGOS 5 monitoring pathway. Introduction of OpenEyes to enable the transfer of secure information exchange.

Progress is being monitored through the Eye Care Collaborative and reported through to Improving Care Board.

COMMUNITY

GP Out of Hours & Navigation Hub

GP OOHs



Performance Target/RAG Rating			
	Advice	Home Visit	PCC
P1	<60 mins 90.7%	<120 mins 0% (1 call only)	<120 mins 100%
P2	<120 mins 93.2%	<120 mins 80.6%	<120 mins 93.1%
P3	<240 mins 91.1%	<480 mins 94.8%	<360 mins 97.4%

GP OOHs

How are we doing and what are our key concerns?

- GPOOH activity decreased by 12.9% in September, with priority calls reducing from 6968 in August to 6069.
- In September 2026, the CT service managed 6,069 priority contacts, achieving an overall performance of 93.2%.
- P2 performance improved to 92.9%; the highest level recorded over the last three months.
- P3 remained the largest area of demand, accounting for 47% of all priority contacts and achieving 94.9% against target.
- Despite lower activity levels, performance remained consistently above 90% across all priority categories for HV, Advice and PCC calls combined: P1-90.7%, P2- 92.9% and P3-94.9.
-

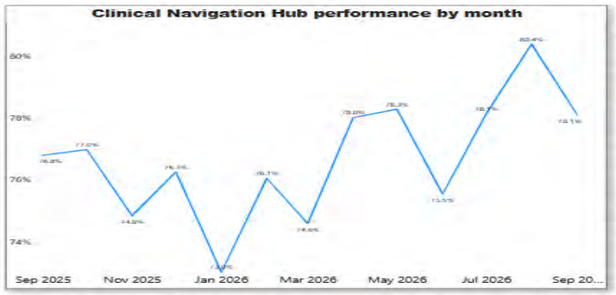
What key actions are we taking and when do we anticipate

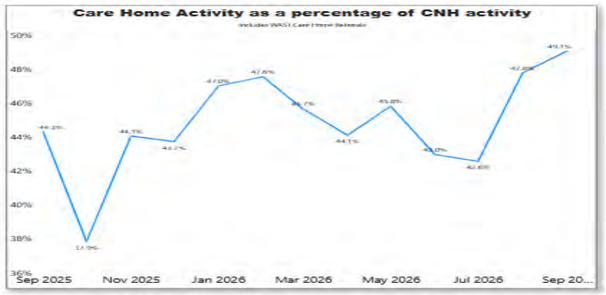
- P1 PCC calls require further investigation to understand the underlying causes as some call may wrongly be categorized as P1 Home Visiting by OOH Clinicians and '111 desk'.

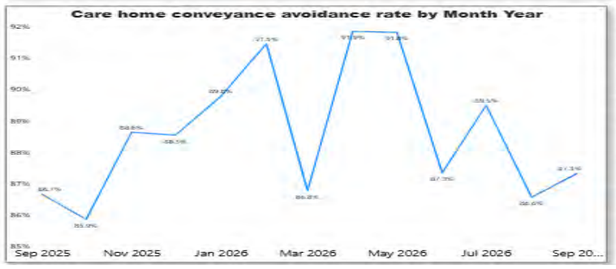
Risks

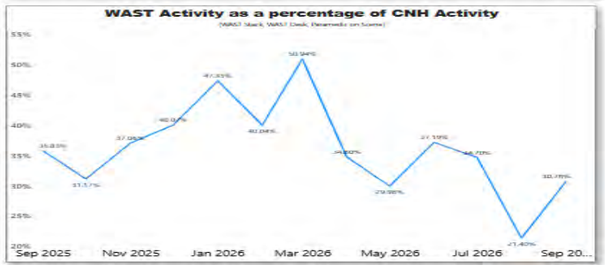
- Patients will receive a delay in the response for urgent calls and action will be dependent on the outcome of the review.

Navigation Hub	









Navigation Hub

In How are we doing?

Important note: Changes have been undertaken to the methodology used to identify and report Clinical Navigation Hub (CNH) activity. CNH contacts are now identified solely through their designated pathway, meaning activity figures are not directly comparable with previous reports.

Activity and performance: CNH activity reduced from 883 contacts in August to 818 in September (-7.4%), while overall performance improved slightly from 78.1% to 78.5%.

Demand profile: Care Home (239 contacts) and WAST Stack (167 contacts) remained the main drivers of demand, together accounting for 50% of all CNH activity. When combined with Paramedic on Scene (138 contacts), these pathways represented 66% of total contacts.

Care Home outcomes: Care Home conveyance avoidance remained strong at 89.5%, with 214 of 239 contacts managed without ambulance conveyance or ED referral.

Overall, September demonstrated continued service resilience, with 642 of 818 contacts (78.5%) managed without onward ambulance conveyance or ED referral. However, WAST Stack performance remained low at 41.3%, with 98 of 167 contacts requiring further intervention, highlighting an ongoing opportunity to improve outcomes within this pathway.

What key actions are we taking and when do we anticipate

- To maintain focus for the Care homes to prevent avoidable conveyance and expand role to support the further development of community pathway optimization Programme.
- To ensure that recruitment and shift fill for forthcoming months is maximized to delivery 7 day a week service
- To continue to develop new pathways with key stakeholders, namely acute hospitals, community services, including Local Authority stakeholders.

Community Hospitals

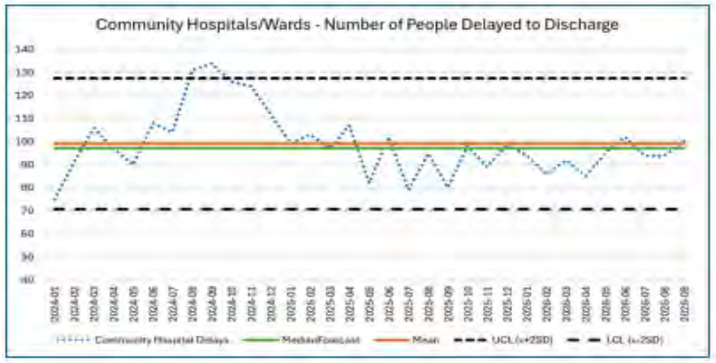
Community Hospital - Delays for Discharge

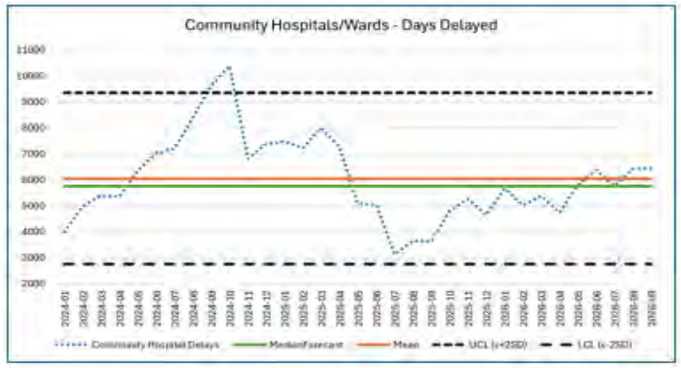
100
Number of Delays - September

94
Avg Delays Past 12 months

6,421
Total Days Delayed - September

5,531
Average past 12 months





Please note data is based on the following wards:
Angelton ward 3, YCC Ward 1-4, YCR Ward 1-4

How are we doing and what are our key concerns?

The data suggests that pressures on community hospitals stem from longer patient stays rather than increased admissions, reflecting greater patient acuity, enhanced care needs, and discharge delays.

From October 2025 to September 2026, the number of people delayed discharging from Community Hospitals/Wards has remained stable and within expected control limits. Performance was particularly favourable between February and May 2026, when delays remained below the overall mean. However, increases in June and September indicate that the lower levels have not yet been sustained sufficiently to demonstrate a further downward shift in performance. Overall, the significant improvement from the elevated levels experienced in 2024 has been maintained, but the data now suggests a stable plateau. The target is 31 days but the performance is exceeds this. There is increasing patient acuity and complexity and growing numbers of patients in the acute hospitals identified as requiring enhance supervision and this has impacted the discharge process. The overriding reason for the increase in delays is assessments (both nursing and social worker) currently 47% of patients on the wards. 23% waiting care home placements and 12% waiting Court of Protection. Flow for non-complex patients is below the target but there is a cohort of patients who are staying for longer periods of time.

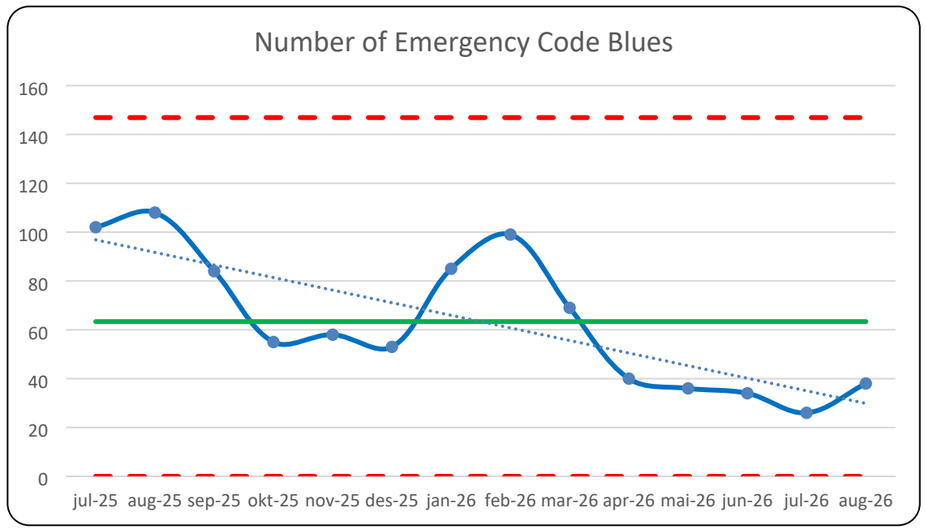
What key actions are we taking to and when do we anticipate

A deep dive, led by the PCC Head of Nursing, has been completed and a systematic weekly review meeting is now in place with Senior Nurses on each site and other MDT members to assess reasons for delays and agree individual actions. Weekly meetings with senior nurses across Planned Care, Unscheduled Care on each acute site and community sites to assess enhanced patients requiring transfer with the aim of de-escalation. The discharge policy is in the process of being reviewed to assess the current blockages. Discharge Liaison Nurses have also been placed within the Discharge Hub to provide clinical leadership and advice. Also Finally the PCC Nurse Director has taken on the role of joint Chair of the Integrated Discharge Board and revised the membership to get closer scrutiny over the whole flow process. Anticipating that the impact will start to be seen from November onwards, but close monitoring is taking place.

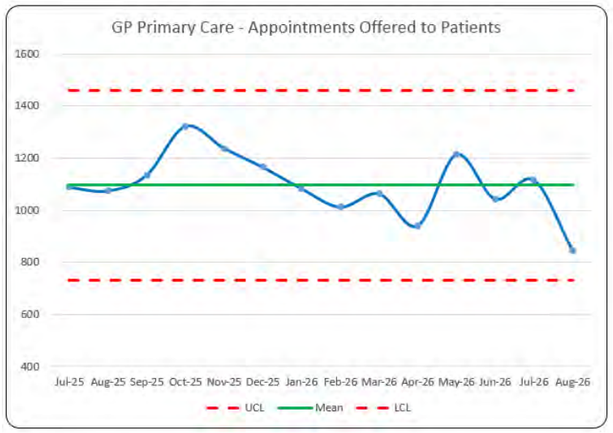
Risks and Mitigations being undertaken: Increasing delays for the patients in community hospitals continues to have a negative impact on the flow across the whole system. Inequity of access for patients and long waits for packages of care and de-conditioning of patients. Mitigating actions are detailed above.

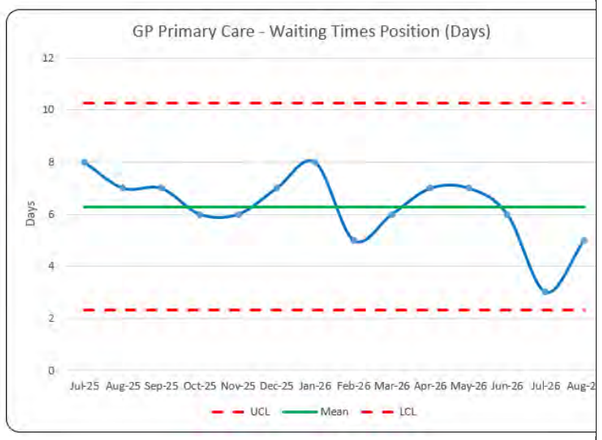
HMS Parc Prison

Emergency Code Blue calls



Access to GP Appointments and Waiting Times





How are we doing

Code Blues are called when a prisoner is displaying chest pains, difficulty in breathing, stroke symptoms, choking, fitting or unconsciousness – healthcare respond to each Code. Code Blue incidents has decreased from 102 in July 2025 to 26 in July 2026, which represents a 75% reduction over the 12-month period. There was a slight increase in August 2026 (38 codes)

Code Reds are called for incidents of severe loss of blood, suspected fractures or severe burns. The incidents of Code Reds are more stable.

What key actions are taking place – Emergency Code Blues are monitored to understand the level of emergency healthcare demand within the prison,Emergency Escorts to the Emergency Department are monitored to assess demand for external emergency care, with the data showing month-to-month variation but no sustained increase or decrease. Work is being undertaken between WAST and the Care Group to explore the option of a WAST paramedic on site.

What are the key risks and mitigations – Long waits at emergency department including those transferred from the prison. Staffing issues (capacity and attitude) to enable prompt transfer to emergency department for assessment. Long community ambulance waits affecting those who require ambulance transfer. To mitigate this the Care Group is working with WAST to explore the placement of a paramedic on the site.

How are we doing:

GP Primary Care Services are provided via an APMS contract by an independent contractor. The volume of appointments offered has remained broadly stable across the period, generally around 1,000 to 1,200 appointments per month, although activity reduced to approximately 850 appointments in August 2026. Despite this reduction, GP waiting times remained at 5 days in August, within the Independent Contractor contractual requirement for waiting times to remain below 7 days. Patient refusals/DNAs have also reduced significantly, from over 100 per month at their peak in late 2025 to exceptionally low single figures in recent months, indicating improved utilisation of available appointments. Overall, the data suggests that GP capacity is currently meeting demand, with improved patient attendance and waiting times within the contractual standard.

What key actions are taking place – the GMS Directorate is undertaking ongoing contractual performance meetings to ensure the contract is being delivered to meet the patients needs.

What are the key risks and mitigations?

- Patient availability is constrained by the HMP Prison operational regime including security and movement restrictions. Collaborative working between the Care Group and G4S continues to take place to ensure processes are aligned.

- The ability to increase service capacity is limited due to space constraints within the Prison. It is hoping that this will be resolved through the Prison Expansion plans and the needs of the primary care health provision is being fed into the business planning process.

3. Key Risks / Matters for Escalation

The key risks for all areas are covered in the summary and main body of the report.

4. Assessment

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)* Link to Strategic Risk(s) on the Board Assurance Framework (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	Strategic Risk 1a
	If more than one applies please list below:

Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales
	If more than one applies please list below:

Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Data to Knowledge
	If more than one applies please list below:

Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Asesiad Effaith Impact Assessment		
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg *(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)* Equality & Welsh Language Impact Assessment Outcome *(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)*	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE This is an overarching position report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment. Summary of impact: Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE This is an overarching position report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment.	If no, please select a reason below. Choose an item. Named Executive/Board member sign off for no EWLIA completion:

	Summary of impact:	
Canlyniad Asesiad Effaith Ansawdd *(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)* Quality Impact Assessment Outcome *(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)*	This is an overarching position report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment.	
Cyfreithiol / Legal	Yes (Include further detail below) Activity where performance falls short of the Health Board's performance measures may result in impact to the patient's journey which may result in a risk of harm. Any potential harm could provide legal challenge.	
Enw da / Reputational	Yes (include further detail below) Activity where performance falls short of the Health Board's performance measures may result in impact to the trust and confidence in the Health Boards service provision.	
Effaith Adnoddau *(Pobl /Ariannol)* / Resource Impact *(People / Financial)*	Yes (include further detail below) Workforce and financial resources are required to address the Planned Care Recovery plans and improvement trajectories within the Health Board.	

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	Date	Outcome
Primary Care and Community Quality, Performance Finance and Workforce meetings	23 October 2026	Endorsed for Approval

2026-27 Finance Report

Month 7

Summary

Situation

This Finance report outlines our financial performance for Month 7 (i.e. the period to 31st October 2026).

This Finance report is discussed at the Board, the Operational Delivery Committee (ODC) and the Executive Management Board (EMB) meetings.

A separate Finance Performance report has been prepared which sets out the financial performance of the individual Care Groups and directorates as at Month 7 (i.e. the Delegated budget position). This report is discussed at the ODC and EMB meetings.

Background

Section 175 of the National Health Service (Wales) Act 2014 places two financial duties on Local Health Boards:

- A duty under section 175 (1) to secure that its expenditure does not exceed the aggregate of the funding allotted to it over a period of 3 financial years
- A duty under section 175 (2A) to prepare a plan in accordance with planning directions issued by the Welsh Ministers, and for that plan to be submitted to and approved by the Welsh Ministers.

Our draft financial plan for 26/27 was submitted to Welsh Government (WG) at the end of March 2026. This plan showed a breakeven position with a net risk to the plan of £38.6m which has subsequently been approved by WG.

As the Health Board has achieved a breakeven position over the last 2 financial years (2024/25 & 2025/26) and has an approved plan, delivering the breakeven plan in 2026/27 would allow the Health Board to meet its financial duties.

Summary

Assessment	Recommendation
Overall revenue position - 2026/27: • The M7 position reported a breakeven position in month and a year-to-date deficit of £9.5m against our plan. • The current year forecast break-even position has been maintained at M07. • The risks to the breakeven forecast have been assessed at £19.4m. **Recurrent revenue position:** • The submitted IMTP for 2026/27 planned for an underlying recurrent surplus of £0.3m by the end of 2026/27. • As at M07 we are deteriorating the forecast underlying surplus at the end of 2026/27 to a deficit of £11.5m. **Cashflow:** • In M7 the cash balance was £3.8m, comprising £2.9m revenue and capital of £0.9m. **Capital position:** • An updated 2026-27 Capital Resource Limit of £136.2m was issued on 5th November 2026. • Expenditure to 31st October 2026 amounted to £50.2m. • The forecast outturn capital position is breakeven.	The Board, the Operational Delivery Committee (ODC) and the Executive Management Board (EMB) are asked to **DISCUSS** and **NOTE** the financial performance of the Health Board for the period to 31st October 2026.

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Executive Summary

Overall Revenue Position	• The M07 position reported a £0.2m surplus in month, giving a £9.5m year to date deficit. • The forecast current year break-even position has been maintained at M07. • The forecast recurrent position has maintained at a £11.5m deficit in M07. • The net opportunities/risks to the forecast break even position at M07 is £19.4m (M06: £20.7m) which are summarised on Page 20.
Savings Position	• Actual savings in M07 was £3.1m with year to date savings of £13.1m, which was £5.2m below the year to date target of £18.3m. • The M07 forecast in year savings is £29.2m, which is £2.1m below the £31.3m target. • The M07 forecast recurrent savings is £28.7m, which is £2.6m below the £31.3m target
Cash	• In M07 the cash balance was £3.8m, comprising £2.9m revenue and capital of £0.9m. This cash position is within planned levels.
Capital	• An updated 2026-27 Capital Resource Limit of £136.2m was issued on 5th November 2026. • Expenditure to 31st October 2026 amounted to £50.2m. • The forecast outturn capital position is breakeven.

Summary
Income & Expenditure Account

	M7 Actual	M7 YTD	Year End Forecast
	£m	£m	£m
01. Revenue Resource Limit	(134.0)	(919.9)	(1662.7)
02. Capital Donation / Government Grant Income	(0.0)	(0.0)	(0.2)
03. Welsh NHS Local Health Boards & Trusts Income	(6.1)	(41.4)	(70.8)
04. WHSSC Income	(1.5)	(9.1)	(15.5)
05. Welsh Government Income (Non RRL)	0.7	(1.9)	(3.3)
06. Other Income	(5.1)	(34.3)	(58.8)
Total Allocations & Income	**(146.1)**	**(1006.5)**	**(1811.2)**
08. Primary Care Contractor	15.3	104.4	180.1
09. Primary Care - Drugs & Appliances	9.0	64.4	111.4
10. Provided Services - Pay	66.3	464.7	794.2
11. Provider Services - Non-Pay	10.2	71.9	121.7
12. Secondary Care - Drugs	5.1	34.8	59.4
13. Healthcare Services Provided by Other NHS Bodies	26.4	183.8	315.2
14. Non-Healthcare Services Provided by Other NHS Bodies	0.0	0.0	0.0
15. Continuing Care and Funded Nursing Care	7.7	49.4	87.1
16. Other Private & Voluntary Sector	0.8	6.1	16.9
17. Joint Financing and Other	1.4	10.4	17.2
18. Losses Special Payments and Irrecoverable Debts	0.3	2.4	3.5
22. DEL Depreciation\Accelerated Depreciation\Impairments	3.2	23.9	41.0
23. AME Donated Depreciation\Impairments	0.0	0.0	63.5
25. Profit\Loss Disposal of Assets	(0.0)	(0.1)	(0.1)
Total Expenditure	**145.9**	**1016.1**	**1811.2**
Grand total	**0.2**	**(9.5)**	**(0.0)**

Key Points:

- The Summary I&E account shows the Health Board's Income & Expenditure by the categories used in the Monthly Monitoring Returns submitted to WG.
- The M07 year to date position is reporting a deficit of £9.5m.
- We are currently forecasting a year end break-even position.
- The main drivers of pressure in achieving the forecast break even position are:
  - Savings shortfall currently £5.2m
  - Clinical Negligence cost pressures – At M07 the position is reporting over £1.0m more than plan.
  - Continuing Health Care cost pressures – At M07 the position is reporting £2.7m over plan.
  - Provider LTA Income shortfall – At M07 the position is reporting £2.1m shortfall against plan.
  - Primary Care Prescribing - £1.3m greater than plan.

Year-to-Date Performance and Forecast

	Current Month	YTD	Year end Forecast
	£m	£m	£m
Month 1	1.4	1.4	0.0
Month 2	3.8	5.2	0.0
Month 3	2.2	7.4	0.0
Month 4	1.8	9.1	0.0
Month 5	0.6	9.7	0.0
Month 6	0.0	9.7	0.0
Month 7	(0.2)	9.5	0.0

Key Points:

- The M07 YTD overspend of £9.5m includes a £5.2m shortfall in savings.
- The initial financial plan assumed that 2025/26 was the final year of EPMA financial support, the Health Board has recently been informed that £1.9m funding will be provided by DHCW for 2026/27; this has resulted in a £0.8m improvement in M07.
- Further details of the key drivers for the YTD are provided overleaf.

Year-to-Date Performance and Forecast

	Delegated Year-to-Date £m	Non-Delegated Year-to-Date £m	Total M07 Year-to-Date £m	M07 Forecast £m	Recurrent Forecast £m	IMTP £m
Savings Shortfall	5.6	(0.4)	5.2	2.1	2.6	0.0
Operational Variances	10.4	(4.2)	6.2	3.8	9.2	0.0
Plan Phasing Adjustments	0.0	3.3	3.3	0.0	0.0	0.0
Financial Plan Improvements	0.0	0.0	0.0	0.0	0.0	0.0
Accountancy Gains	0.0	(4.0)	(4.0)	(4.0)	0.0	0.0
Additional Financial Allocation	0.0	(1.1)	(1.1)	(1.9)	0.0	0.0
Other Mitigating Actions	0.0	0.0	0.0	0.0	0.0	0.0
Grand Total	**16.0**	**(6.5)**	**9.5**	**0.0**	**11.5**	**0.0**

Key Points:

- The M07 position is reporting a £9.5m deficit (overspend) against the plan, of which £16.0m relates to delegated budgets.
- The main driver of the deficit position is the £5.6m shortfall in savings delivery.
- Operational variances continue within the delegated positions, with demand and activity being the main driver
- Additional Financial Allocations of £1.9m (£1.1m YTD) has been confirmed for EPMA programme.
- Accountancy Gains of £4.0m have been recognised in M07.
- A separate Finance Performance report has been prepared which sets out the Delegated financial performance of the individual Care Groups and directorates as at Month 7 (i.e. the delegated budget position). This report is discussed at the Operational Delivery Committee (ODC) and Executive Management Board (EMB) meetings.

Forecast Underlying Position

Underlying Position	Plan £m	Delegated Recurrent @ M07 £m	Non-Delegated Recurrent @ M07 £m	Total Recurrent @ M07 £m	Total Recurrent @ Prev Mth £m
Initial Financial Plan	**(0.3)**	**0.0**	**(0.3)**	**(0.3)**	**(0.3)**
Savings Variances	0.0	3.3	(0.7)	2.6	1.3
Operational Variances	0.0	12.1	(2.9)	9.2	10.5
Financial Plan Variances	0.0	0.0	0.0	0.0	0.0
Additional Financial Allocations	0.0	0.0	0.0	0.0	0.0
Accountancy Gains	0.0	0.0	0.0	0.0	0.0
Other Mitigating Actions	0.0	0.0	0.0	0.0	0.0
Grand Total	**(0.3)**	**15.4**	**(3.9)**	**11.5**	**11.5**

Key Points:

- The B/fwd recurrent deficit at the end of 2025/26 was £9.2m, the submitted IMTP for 2026/27 planned for an in-year recurrent surplus of £9.5m giving an underlying surplus of £0.3m by the end of 2026/27. The latest assessment has deteriorated to a £11.5m underlying surplus.
- The latest savings returns have indicated recurrent savings of £28.7m compared to the plan of £31.3m, giving rise to a recurrent shortfall of £2.6m.
- The latest review has indicated several growing cost pressures that are no longer anticipated to recover on a recurrent basis, these include Prescribing growth, Clinical Negligence claims, CHC growth, HMRC rates for travel expenses and activity driven non pay.

Non-Delegated Reserves

Reserves	Plan £m	Issued @ M07 £m	Balance Remaining £m	Anticipated Commitments £m	Current Year Forecast £m	Recurrent Forecast £m
IMTP Demand & Cost Pressures	4.3	1.6	2.7	1.6	(1.1)	0.0
IMTP Non-Recurrent Plans	0.5	0.0	0.5	0.0	(0.5)	0.0
Local Planned Care Reserves	1.4	0.0	1.4	0.0	(1.4)	0.0
Pre-committed business cases	2.0	0.0	2.0	0.0	(2.0)	0.0
Grand Total	8.2	0.9	6.6	1.6	(5.0)	0.0

Key Points:

- The approved plan identified £8.2m of reserves yet to be issued to delegated budgets.
- As at M07, £6.6m remains within the non delegated budgets.
- The latest forecast assumes that £5.0m of the reserves will not be required and will be released to support the balanced financial plan. This is anticipated to be a non recurrent benefit only.
- Further detail of the pre-committed business cases is provided on the next page.

IMTP Prior Committed Plans

Investment Plans	Plan £m	Issued @ M07	Balance Remaining £m	Anticipated Commitments £m	Current Year Forecast £m	Recurrent Forecast £m
EMPA Business Case	1.9	(0.0)	1.9	0	(1.9)	0
Digital Cellular Pathology Bus Case	0.1	0	0.1	0.0	(0.1)	0
Grand Total	**2.0**	**(0.0)**	**2.0**	**0.0**	**(2.0)**	**0.0**

Key Points:

- The approved plan identified £2.0m of prior approved business case commitments, as at M07, £0.0m has been confirmed and issued.
- Following confirmation from DHCW that the EPMA costs in 2026/27 will be funded, the initial planning requirement of £2.0m can be released to support delivery of the break-even financial plan.

Pay Expenditure Trends

Staff Group	Jul-26 £'m	Aug-26 £'m	Sep-26 £'m	Qtr2 Ave £'m	Oct-26 £'m
Administrative & Clerical	9.2	9.1	9.0	9.1	9.1
Medical And Dental	18.3	18.6	18.6	18.5	18.5
Nursing And Midwifery Registered	21.0	20.8	20.4	20.7	20.8
Add Prof Scientific And Technical	2.2	2.2	2.2	2.2	2.2
Additional Clinical Services	9.4	9.0	8.6	9.0	8.6
Allied Health Professionals	4.3	4.2	4.3	4.3	4.4
Healthcare Scientists	1.2	1.2	1.2	1.2	1.2
Estates And Ancillary	3.8	3.8	3.6	3.7	3.8
Students	0.0	.0	.0	.0	.0
Grand Total	**69.3**	**68.8**	**68.0**	**68.7**	**68.5**

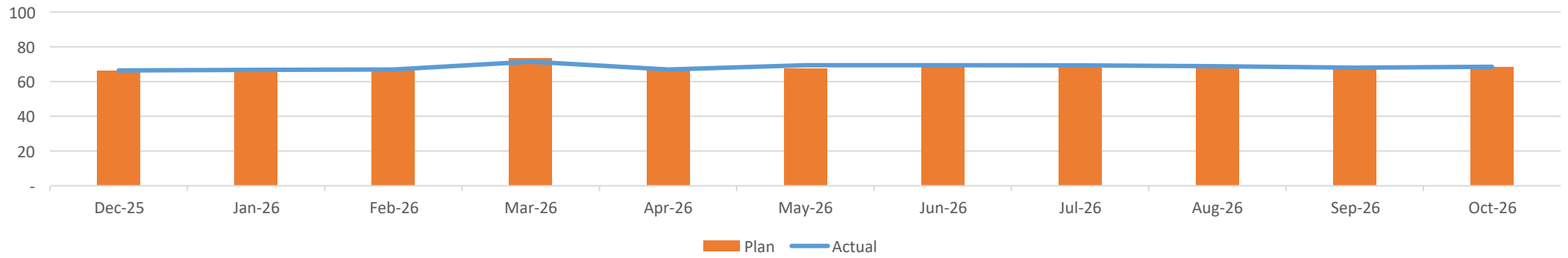
Spend category	Jul-26 £'m	Aug-26 £'m	Sep-26 £'m	Qtr2 Ave £'m	Oct-26 £'m
Core	62.5	61.8	61.5	61.8	62.1
Agency	1.6	1.5	1.3	1.6	1.2
Overtime	1.6	1.6	1.3	1.5	1.2
ADH	1.7	1.7	1.9	1.7	1.3
Bank	1.7	1.9	1.9	1.7	2.0
WLI	0.2	0.2	0.0	0.3	0.6
Grand Total	**69.3**	**68.8**	**68.0**	**68.6**	**68.5**

Key Points:

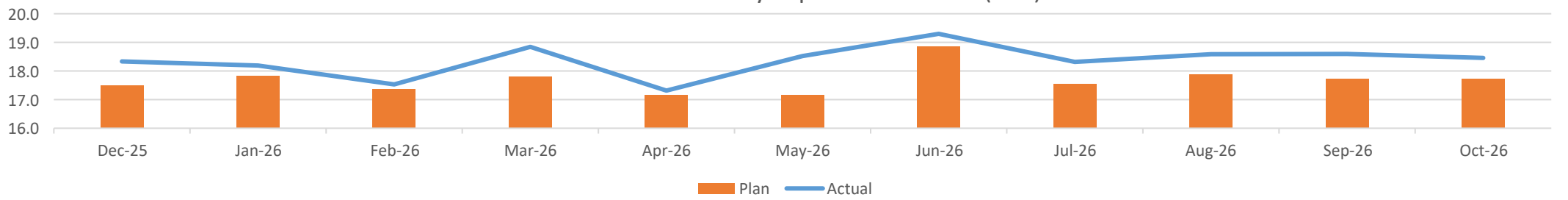
- Total pay expenditure in M07 was £68.5m.
- When compared with the M06 actual, the following variable pay movements occurred:
  - Increase in Core costs of £0.6m
  - Decrease in Agency of £0.1m
  - Decrease in Overtime of £0.1m
  - Decrease in ADH of £0.6m (Coding correction between ADH's and WLIs)
  - Increase in Bank of £0.1m
  - Increase in WLI of £0.6m (Coding correction between ADH's and WLIs)

Pay Expenditure Trends

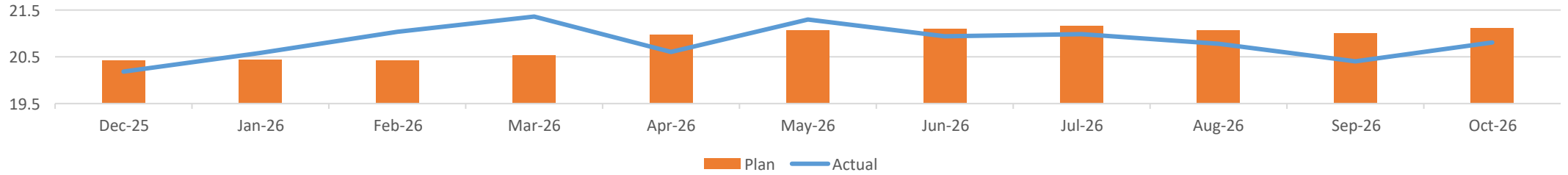
Total Pay Expenditure Trend (£'m)



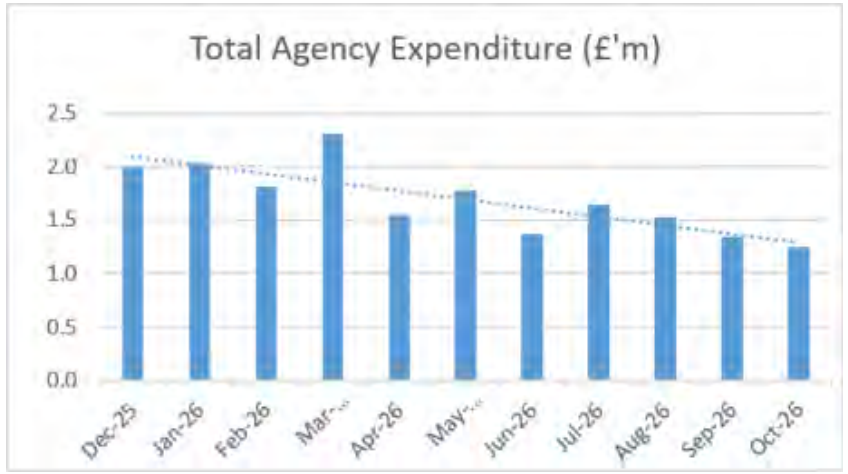
Medical & Dental Pay Expenditure Trend (£'m)

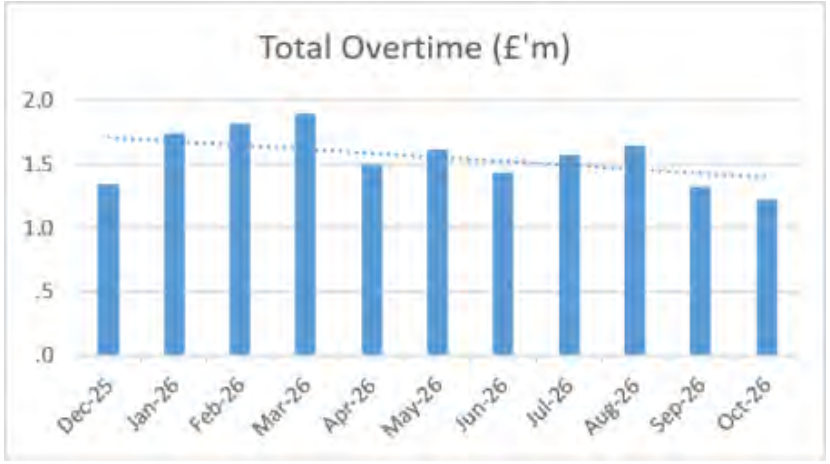


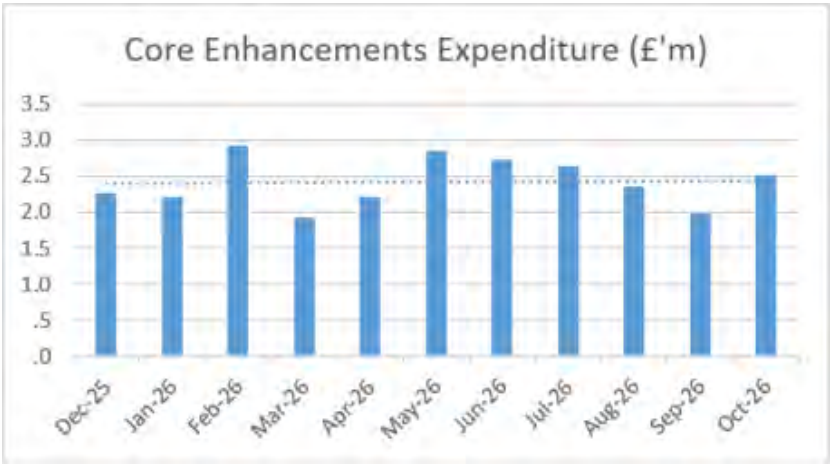
Nursing & Midwifery Pay Expenditure Trend (£'m)

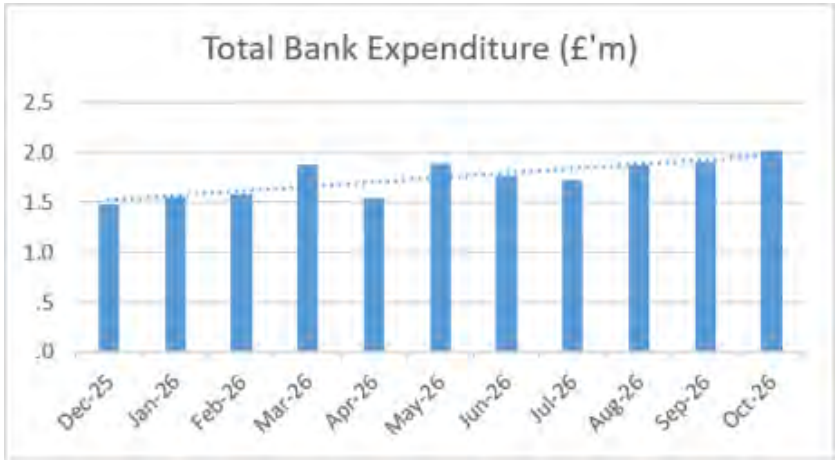


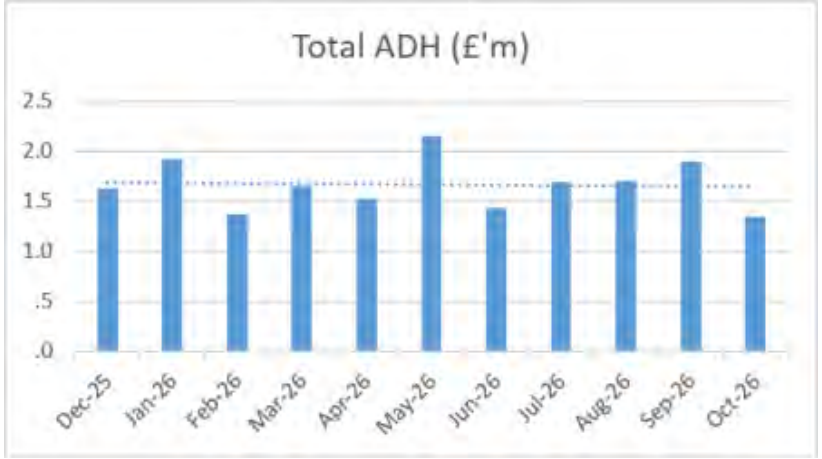
Variable Pay Expenditure Trends











Key Points :

- Agency spend – has decreased by £0.1m and overall, a downward trend.
- Overtime – has decreased by £0.1m when compared to M06, but overall, a decreasing trend.
- Core enhancements – has increased by £0.5m when compared to M06, with a flat trend.
- Bank – has increased by £0.1m in M07 compared to M06, with an upward trend.
- ADH spend – has decreased by £0.6m when compared to M06 (although this is primarily a coding correction), with a flat trend.

Non Pay Expenditure Trends

Non Pay Group	Jul-26 £'m	Aug-26 £'m	Sep-26 £'m	Qtr2 Ave £'m	Oct-26 £'m
Primary Care Contractors	14.2	14.0	14.1	14.1	14.6
Primary Care Drugs	8.8	8.6	9.9	9.1	9.0
Provider Non Pay	10.8	10.3	10.8	10.6	10.2
Secondary Care Drugs	4.6	4.8	5.5	5.0	5.1
Healthcare Commissioning	25.8	27.0	26.0	26.3	26.4
CHC & FNC	4.2	8.6	8.1	7.0	8.1
Other	8.6	6.1	6.0	6.9	5.8
Total Expenditure	**76.9**	**79.5**	**80.5**	**78.9**	**79.3**



Key Points:

- The total spend in M07 of £79.3m is £1.2m decrease when compared to M06. The main movements were:
- Increase in Primary Care Contractors by £0.5m. This is in relation to a timing issue where expenditure was anticipated to be incurred in future periods.
- Decrease in Primary Care Drugs by £0.9m. This is primarily a result of changes to NCL difference between prescribing and dispensing. This is offset by a corresponding adjustment to WG Income. There was also a continued deterioration in PAR growth following August data.
- Decrease in Provider Non Pay by £0.6m. This is due to a decrease in energy costs.
- Decrease in Secondary Drugs by £0.4m. This is due to lower drug costs across all services.
- Increase in Healthcare Commissioning of £0.4m. This is due to recognition of new JCC allocations.

Income Trends

Income Group	Jul-26 £'m	Aug-26 £'m	Sep-26 £'m	Qtr2 Ave £'m	Oct-26 £'m
Welsh NHS Income	6.0	5.8	5.9	5.9	6.1
JCC Income	1.5	1.4	1.1	1.3	1.5
Primary Care Contractor Income	1.5	1.2	1.3	1.3	1.3
CHC Income	0.8	0.8	0.8	0.8	0.7
Other Income	5.4	5.1	5.6	5.4	5.2
Total Income	**15.1**	**14.4**	**14.6**	**14.7**	**14.8**



Key Points:

- The total income in M07 of £14.8m is £0.2m higher than M06.
- The main movements were:
  - JCC Income – increase of £0.4m. This is due to an increase in ICD activity.
  - Other Income - £0.4m decrease. This is mainly due to a decrease in primary care prescribing income.

Income Assumptions WG

	REVENUE RESOURCE LIMIT				Resource Limit £'m
	HCHS £'m	Pharmacy £'m	Dental £'m	GMS £'m	
Confirmed Welsh Government Allocations	1,392.0	32.2	27.8	99.6	1,551.6
Anticipated Allocations:					
Capital	68.9				68.9
Welsh Risk Pool	(5.3)				(5.3)
Payaward 26/27	21.9				21.9
M&D Pay Award 26/27	7.1				7.1
Discovering a Digital Solution	0.8				0.8
ESR Recharges	1.5				1.5
GP IM&T Refresh Programme				1.4	1.4
AHW Prevention & Early Years	0.9				0.9
Planned Care Recovery	11.0				11.0
Other	2.6			0.4	3.0
Total Allocations	**1,501.4**	**32.2**	**27.8**	**101.3**	**1,662.8**

Key Points:

- As at M07 the confirmed Revenue Resource Limit (RRL) allocation was £1,551.6m.
- We are anticipating a further £111.2m of funding.

Income Assumptions - NHS

	Contracted Income	Non Contracted Income	Total Income
	£m	£m	£m
Swansea Bay University	25.0	0.0	25.0
Aneurin Bevan University	18.0	1.3	19.3
Betsi Cadwaladr University	0.0	0.4	0.4
Cardiff & Vale University	20.1	1.6	21.6
Cwm Taf Morgannwg University	0.0	0.0	0.0
Hywel Dda University	0.5	0.4	0.9
Powys	8.2	0.1	8.2
Public Health Wales	1.2	3.9	5.1
Velindre	0.0	11.5	11.5
DHCW	4.6	0.0	4.6
Wales Ambulance Services	0.0	0.1	0.1
JCC	14.0	1.1	15.1
HEIW	0.0	20.4	20.4
NHS Wales Executive	0.0	0.0	0.0
Total	**91.6**	**40.7**	**132.3**

Key Points :

- All LTA documents have now been submitted and signed.

Savings

	Month 7			Month 6		
	YTD	26/27	Rec	YTD	26/27	Rec
	£m	£m	£m	£m	£m	£m
Savings target as at M7	18.3	31.3	31.3	15.6	31.3	31.3
Actual and Forecast Savings	(13.1)	(29.2)	(28.7)	(9.9)	(29.0)	(30.0)
Total	5.2	2.1	2.6	5.7	2.3	1.3



Key Points:

- The M07 YTD savings is reporting £13.1m of identified savings, which is £5.2m below the YTD target of £18.3m.
- The forecast in year savings of £29.2m is £2.1m below the £31.3m target.
- The M07 forecast recurrent savings of £28.7m is £2.6m below the £31.3m target.

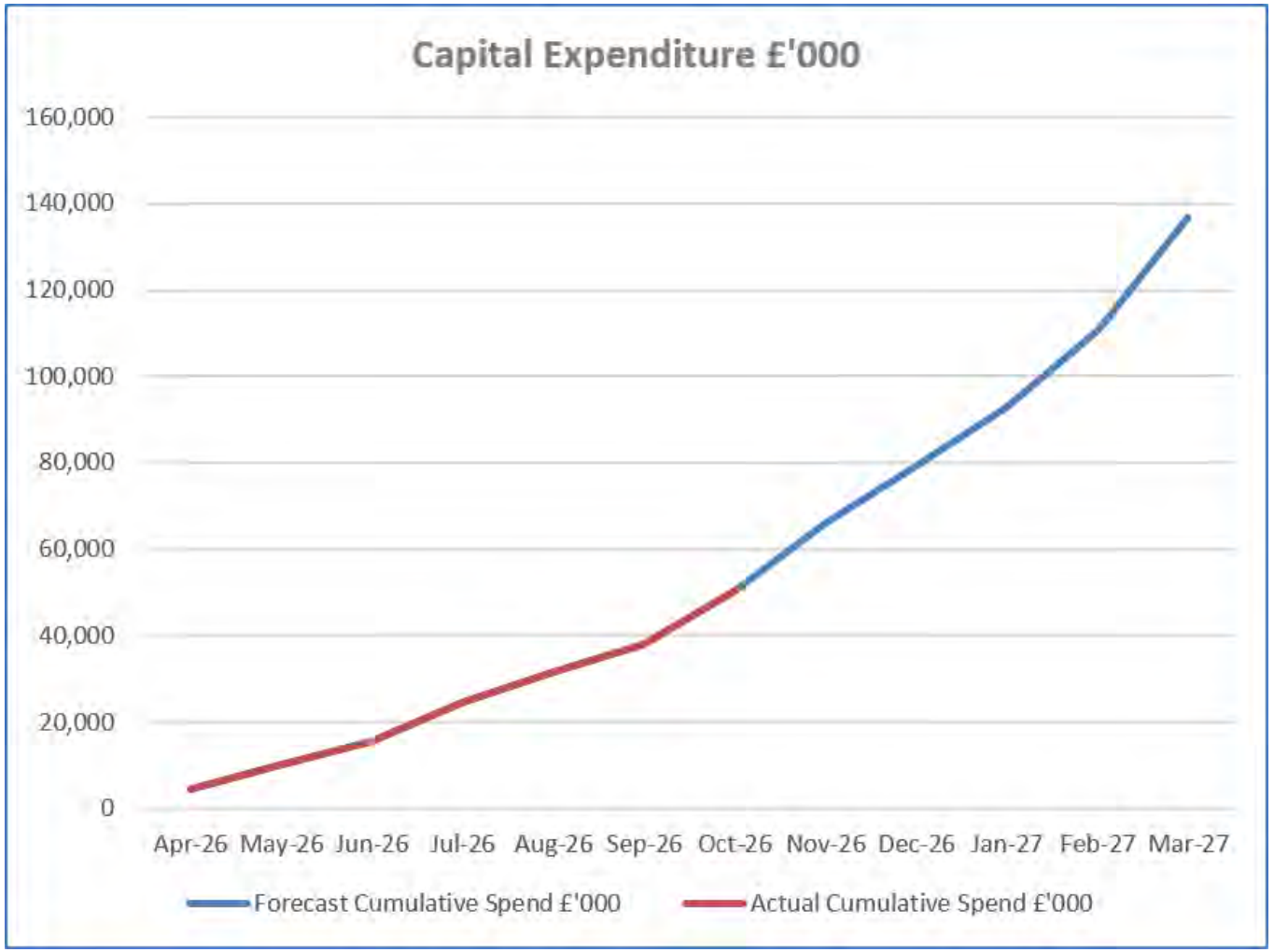
Risks & Opportunities

	Risk Level L/M/H	M7 £m	M6 £m	Comment
Funding risks:				
Risk of the 2026/27 pay award not being fully funded	L	Tbc	Tbc	Assumed to be fully funded in 2026/27 as per our anticipated allocation. Yet to be confirmed by WG.
Risk of the Resident Dr Contract changes not being fully funded	L	Tbc	Tbc	Assumed to be fully funded in 2026/27. Awaiting further details from HEIW before being able to assess impact. WG Yet to confirm funding position for 2026/27.
WG recurrent allocation for Welsh Risk Pool Pressure not being fully funded	L	13.8	13.8	Reflects latest forecast from NWSSP. See note 1 below
Other risks:				
Delivery Risk on Identified Savings Plans	M	0	0.3	Table C3
Delegated Risk Assessments	H	3.8	3.7	Risk adjusted cost pressures
Health Visitors Band 6 Dispute	H	0.2	0.8	See note 3 below
LTA Disputes	H	0	0.5	ABUHB have confirmed LTA activity alignment with CTM.
Primary Care Prescribing NCSO	M	0.6	0.6	NCSO Now reflected in forecast, further Q4 price adjustments remain a risk.
CHC Growth above Plan	M	1	1	M7 Forecast updated, risk of further deterioration.
Retention of Dental Underspend	L	0	0	See note 2 below
Total Risks		**19.4**	**20.7**	
Opportunities				
Balance sheet opportunities in 26/27	H	Tbc	Tbc	
Retrospective VAT recoveries	M	Tbc	Tbc	Potential DHCW VAT recovery
NWSSP Distribution Opportunities	H	Tbc	Tbc	Awaiting confirmation from NWSSP.
Total opportunities		**(Tbc)**	**(Tbc)**	
Net Risk		**19.4**	**20.7**	

Key Points:

- As at M07 we have identified risks to the forecast, amounting to £19.4m.
- There is a small number of potential opportunities that could help mitigate the identified risks which have yet to be confirmed.

Capital Expenditure



Key Points:

- The Capital Resource Limit for 2026-27 of £136.2m was issued on 5th November 2026.
- This is supplemented by a forecast of £0.170m of donated funds and £0.378m NBV of assets disposed of in this financial year giving an overall programme of £136.748m.
- Expenditure to 31st October 2026 amounted to £50.2M.
- The forecast outturn capital position is breakeven.

Statement of Financial Position

Balance Sheet	Opening Balance (01/04/2026) £'000	Closing Balance as at M7 £'000	F/Cast Closing Balance as at M12 £'000
Non Current Assets			
Property, Plant & Equipment	796,175	822,502	796,175
Intangible Assets	2,927	2,927	2,927
Trade and Other Receivables	104,127	104,127	104,127
Total Non-Current Assets	903,229	929,556	903,229
Current Assets			
Inventories	8,048	8,099	8,099
Trade and Other Receivables	117,362	134,471	119,471
Cash and Cash Equivalents	4,880	3,802	4317
Non Current Assets Classified as Held for Sale			
Total Current Assets	130,290	146,371	131,887
Current Liabilities			
Trade and Other Payables	213,179	169,806	198,250
Provisions	52,860	52,860	49,981
Total Current Liabilities	266,039	222,666	248,231
Non-Current Liabilities			
Trade and Other Payables	16,750	16,750	16,750
Provisions	103,749	108,218	108,218
Total Non-Current Liabilities	120,499	124,968	124,968
TOTAL ASSETS EMPLOYED	646,981	728,294	661,917
Financed By:			
General Fund	507,326	588,640	522,262
Revaluation Reserve	139,655	139,655	139,655
TOTAL	646,981	728,294	661,917

Key Points :

· The main changes in the balance sheet figures from M06 to M07 include the following:

- Provisions have increased by £8.6m, this is mainly due to an increase in value of the clinical negligence provision of £9.67m offset by reductions in the Personal injury and Permanent injury provisions of £0.71m and £0.57m respectively.
- Trade and other receivables have increased by £8.0m, this is due to an increase in the amount due from the Welsh Risk Pool for Clinical Negligence cases of £10.2m as detailed above, offset by a reduction in Non-NHS Prepayments.
- Trade and other payables have decreased by £6.8m, this is mainly due to the timing of the Pharmacy payment, which has resulted in a decrease in the Pharmacy accrual of £11.6m offset by an increase in trade creditors.

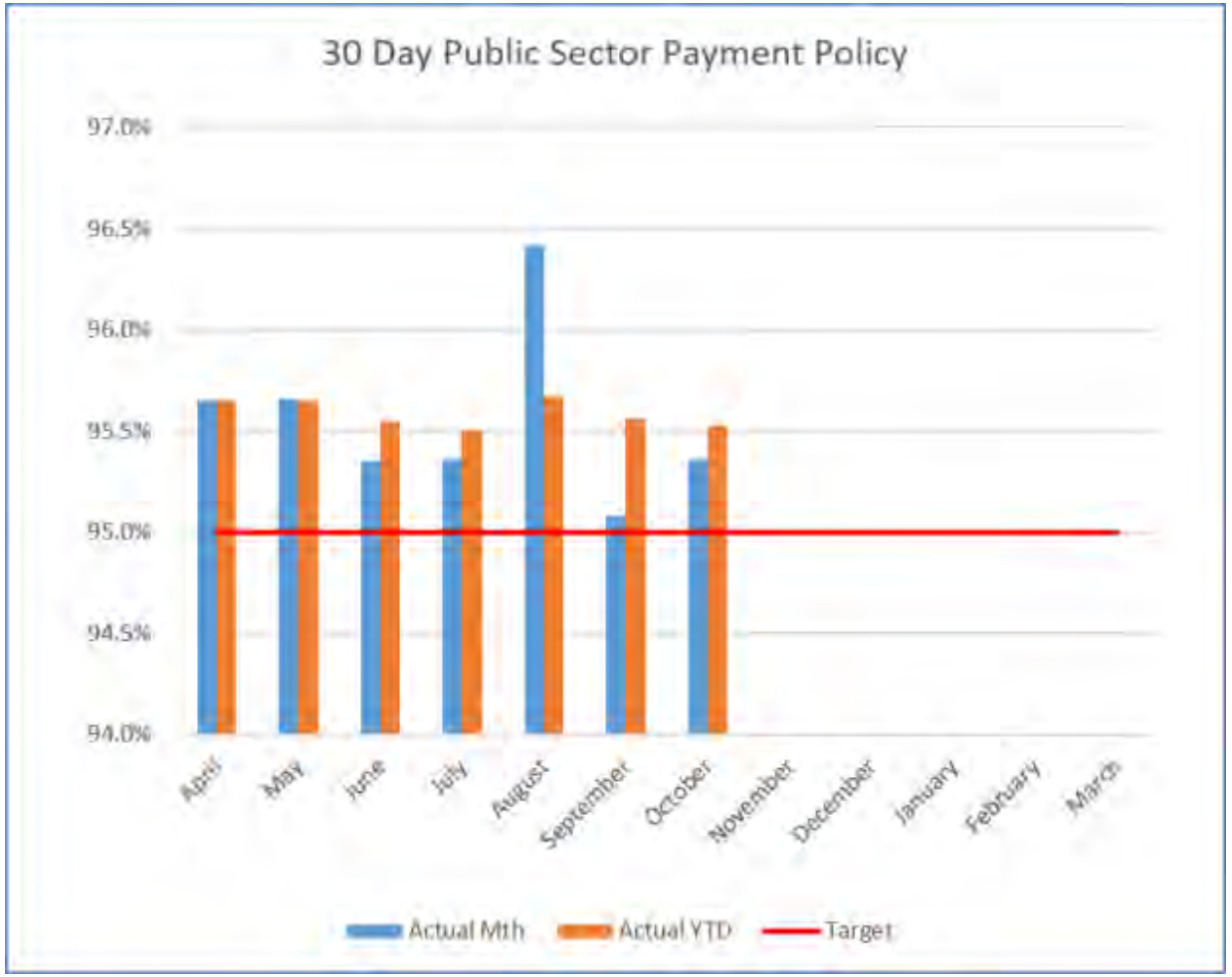
Cash Flow Forecast

Cashflow	Actual/Forecast												
	Apr £'000	May £'000	Jun £'000	Jul £'000	Aug £'000	Sep £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £'000	Total £'000
Receipts													
WG Revenue Funding	134,206	132,083	129,883	154,221	129,335	137,501	137,964	114,900	148,762	109,300	125,500	130,406	1,584,061
WG Capital Funding	14,000	12,500	1,400	6,900	9,200	8,400	8,500	8,400	15,500	12,000	14,100	27,823	138,723
Sale of Assets	84	1	0	51	0	21	1	0	0	0	0	0	158
Welsh NHS Org'ns	14,146	10,225	13,448	9,822	11,341	10,996	13,265	11,000	10,000	18,000	12,000	20,000	154,243
Other	3,375	6,769	5,840	2,841	6,215	2,826	7,588	4,000	4,500	7,500	5,000	8,000	64,454
Total Receipts	165,811	161,578	150,571	173,835	156,091	159,744	167,318	138,300	178,762	146,800	156,600	186,229	1,941,639
Payments													
Primary Care Services	21,258	21,156	24,602	31,865	9,378	22,676	33,269	9,809	34,626	10,281	20,286	24,093	263,299
Salaries and Wages	68,227	68,151	68,908	73,235	70,895	68,353	68,562	68,500	68,500	68,500	68,500	68,500	828,831
Non Pay Expenditure	62,165	62,059	54,650	63,434	67,760	57,055	59,967	51,000	59,000	55,000	55,000	63,739	710,829
Capital Payments	13,029	5,559	6,734	9,634	9,350	6,242	7,853	10,722	16,041	12,018	14,085	27,976	139,243
Other	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Payments	164,679	156,925	154,894	178,168	157,383	154,326	169,651	140,031	178,167	145,799	157,871	184,308	1,942,202
Net Cash In/Out	1,132	4,653	(4,323)	(4,333)	(1,292)	5,418	(2,333)	(1,731)	595	1,001	(1,271)	1,921	
Balance B/F	4,880	6,012	10,665	6,342	2,009	717	6,135	3,802	2,071	2,666	3,667	2,396	
Balance C/F	6,012	10,665	6,342	2,009	717	6,135	3,802	2,071	2,666	3,667	2,396	4,317	

Key Points within the Cash Flow Forecast :

- In M07 the cash balance was £3.8m, comprising £2.9m revenue and capital of £0.9m.
- At Month 7 the projected year end revenue balance is £4.3m and this includes a working balance request of £15m.

Public Sector Payment Policy



Key Points:

- The percentage for the number of non-NHS invoices paid within the 30 day target in October was 95.4%.
- The cumulative percentage year to date is 95.5%, which is above the target of 95%.

Agenda Item	8.1.1

Unapproved Minutes of the Public Board

Date and Time of Meeting	Thursday 24th September 2026 9:00a.m.
Venue	In Person, The Hub, Royal Glamorgan Hospital, Llantrisant

Members Present	Jonathan Morgan	Board Chair
	Kath Palmer	Board Vice Chair
	Carolyn Donoghue	Independent Member – University
	Hayley Proctor	Independent Member – Trade Union
	Neil Mesher	Independent Member – Commercial Business (Virtually)
	Kathy Mason	Independent Member – IT & Information Governance (Virtually)
	Helen Lentle	Independent Member – Legal
	Rhys Goode	Independent Member – Local Authority
	Paul Mears	Chief Executive Officer
	Dom Hurford	Executive Medical Director
	Gethin Hughes	Chief Operating Officer
	Hywel Daniel	Executive Director of People
	Lauren Edwards	Executive Director for AHPs and Health Science
	Claire Thompson	Executive Director of Strategy & Transformation
	Andrew Jones	Acting Deputy Director of Finance
	Richard Hughes	Executive Director of Nursing
	Philip Daniels	Executive Director of Public Health
	Lisa Curtis-Jones	Associate Board Member (Virtually)
	Paul Deenik	Associate Board Member
	Sarah Medlicott	Associate Board Member
In Attendance	Gareth Watts	Director of Corporate Governance/Board Secretary
	Stuart Morris	Director of Digital

	Simon Blackburn	Director of Communications, Engagement & Fundraising
	Daniel Price	Regional Director, Llais Cymru (Virtually)
	Emma Walters	Head of Corporate Governance & Board Business
	Juliet Brown	Chief Commissioner, NWJCC (in part)
	Stacey Taylor	Director of Finance & Information, NWJCC (in part)
Meeting Observers	Leigh Williams	UNITE the Union
	Kerry Roberts	UNITE the Union (In part)
	Claire Feiven	Member of the Public
	Shaun Huxton	UNITE the Union (In part)

Agenda Item	Meeting Business
1.	PRELIMINARY MATTERS
1.1	Welcome and Introductions
	The Chair welcomed everyone to the meeting, particularly those joining for the first time and guests and colleagues joining for specific agenda items. The format of the proceedings was also noted by the Chair.
1.2	Apologies for Absence
	Apologies for absence were received from: • Patsy Roseblade, Independent Member, Finance / Audit • Rachel Rowlands, Independent Member, Community • Sally May, Executive Director of Finance
1.3	Declarations of Interest
	There were no interests declared.
	Questions from the Public The Chair acknowledged receipt of public questions submitted by K Roberts, L Williams and C Feiven regarding the ongoing Health Visitor dispute. The Chair noted the substantial number of individual questions and requests for assurance raised and recognised the importance of the public question process in supporting the Health Board's commitment to openness, transparency and accountability. Members noted that the submissions covered a broad range of issues, including staff wellbeing, psychological safety, equality, safeguarding, service continuity, Job Evaluation, organisational communications and Board oversight. Given the volume and complexity of the matters raised, the Chair advised that a consolidated written response would be provided following appropriate factual verification. The Board acknowledged the vital contribution of Health Visitors and noted that assurance continues to be sought through established governance

	arrangements regarding staff wellbeing, safeguarding, service continuity and actions to support resolution of the dispute. The Chair then invited R. Hughes to present agenda item 4.1 before moving onto the rest of the agenda.
4.1	Health Visiting Industrial Action: Safeguarding Assurance, Risk and Recovery R. Hughes presented the Health Visiting Industrial Action update, advising that qualified assurance remained, with significant residual risks relating to reduced universal contact, workforce capacity, safeguarding and early identification of vulnerability. He emphasised the need to demonstrate completion of mitigating actions and a safe, sustainable recovery trajectory, noting that discussions with Welsh Government on potential resolution and national job specifications were continuing. The Chair emphasised the importance of supporting health visitors continuing to work during the industrial action and securing an early resolution, while stressing the need for a longer-term, Wales-wide model that recognised the future role, professional development and contribution of the health visiting workforce. He confirmed that his recent correspondence with the Minister reflected the qualified assurance position reported to the Board and advised that discussions with the Minister were being used to help influence a resolution that could have relevance beyond Cwm Taf Morgannwg (CTM). C. Donoghue advised that the Quality, Safety and Experience Committee (QSEC) had considered the health visiting industrial action in detail, providing a further route of assurance through which the associated risks and their management continued to be monitored L. Curtis-Jones provided assurance in her role as Chair of the Safeguarding Board and outlined the Safeguarding Board's oversight of the health visiting position, including regular liaison with CTM and local authority partners, support to triage cases and scrutiny of referral data to provide assurance that vulnerable children were not being missed. She also highlighted approaches made by the trade unions to the three local authorities and sought assurance regarding the Health Board's response. L. Curtis-Jones advised that C. O'Keefe, in her new role overseeing health visiting concerns, was meeting regularly with Heads of Service and operational leads to support coordination with local authority partners and the management of cases requiring intervention. R. Goode advised that Bridgend County Borough Council had considered a motion relating to the health visiting dispute, from which he had recused himself, and understood that the motion had been approved. He emphasised the importance of resolving the industrial action to enable staff to feel safe

	and able to return to work and sought an update on the next steps towards resolution. K. Palmer sought clarification on the timescale for agreeing the national job specification, recognising this as a key element in resolving the dispute, and asked whether the Board could take any further steps to encourage all parties to come together and reach agreement. In response P. Mears advised that discussions with Welsh Government regarding a potential resolution were ongoing, recognising the wider implications of any CTM solution across Wales. He outlined the engagement taking place through the Minister, Chief Nursing Officer and workforce routes to influence discussions and support a sustainable resolution. H. Lentle sought assurance regarding the impact of the health visiting industrial action on primary care and whether this was fully understood. R. Hughes and P. Mears both confirmed that no adverse impact had been reported at that stage, although further feedback would be sought from primary care colleagues about different levels of delivery and the position would continue to be monitored. The Chair emphasised the importance of supporting the wellbeing of health visitors continuing to work during the industrial action, recognising the increasing pressure on staff as the dispute continued. While reiterating the need for an early resolution and the return of the health visiting team, he stressed the importance of a longer-term, sustainable Wales-wide model that supported professional development and recognised the vital contribution of the health visiting workforce. In response, R. Hughes emphasised the immediate importance of supporting colleagues continuing to work during the industrial action and recognised the integral role of health visitors and wider public health nursing roles in the future of healthcare. He advised that, once the current position was resolved, there would be an opportunity to focus on the longer-term ambitions for health visiting and associated public health roles. The Chair confirmed that the health visiting industrial action would remain a standing item for the November Board meeting, with continued oversight through Board briefing sessions and the Quality, Safety and Experience Committee.
Resolution	The Board resolved to: • NOTE the qualified assurance position and the principal residual risks set out in this paper. • SCRUTINISE whether current controls remain adequate and sustainable while industrial action continues. • SUPPORT regular exception-based reporting on review completion, unmet need, residual risk, workforce capacity and recovery. • ENDORSE continued multi-agency validation, information sharing and escalation through established safeguarding governance.

	• NOTE that detailed confidential assurance is maintained through private Board and safeguarding routes.
Action:	Seek feedback from primary care colleagues on any impact arising from the health visiting industrial action and report the position through the ongoing Board oversight arrangements.
Action:	To retain the Health Visiting Industrial Action as a line item for the November Board meeting, with ongoing updates also provided through Board briefing sessions and QSEC.
2.	CONSENT AGENDA BUSINESS
2.1	The Chair asked members if there were any items from the consent agenda that Board Members wished to bring forward to the main agenda for discussion.
Resolution:	There were none.
3.	IMPROVING CARE – PART 1
3.1	Joint Commissioning Committee (JCC) Annual Update
	J Brown and S Taylor shared a presentation with the Board outlining the JCC's commissioning responsibilities, financial position and strategic priorities, with an increased focus on whole-pathway commissioning, improved outcomes and value. The Chair sought assurance on emerging specialist commissioning challenges. J. Brown highlighted outcomes, financial constraints and workforce fragility, advising on the need to determine which specialist services could be sustainably provided within Wales and where networked or cross-border arrangements were required. N. Mesher emphasised the importance of horizon scanning for new technologies and ensuring innovation was translated into clinical pathways, planning and investment. J Brown highlighted thrombectomy as an example where a whole-pathway approach could improve clinical outcomes while reducing wider health and social care costs. K. Mason sought assurance regarding the interface between specialist and local services and the availability of data to support pathway planning. J. Brown and S Taylor both acknowledged the need to strengthen JCC analytical capability and access to integrated population, clinical and financial data to support robust commissioning decisions and productivity improvement. P. Mears emphasised that the JCC commissioned services on behalf of Health Boards using Health Board resources and should therefore remain closely connected to local patient pathways. He added that he recognised the difficult balance between providing specialist services within Wales and ensuring sufficient critical mass, quality and financial sustainability, and stressed the importance of population-needs-led, data-driven commissioning aligned with the National Clinical Plan.

	The Chair sought assurance on what longer-term commissioning data was indicating about emerging challenges and pressures, emphasising the importance of horizon scanning to identify future risks and areas requiring action. In response, J. Brown highlighted outcomes, financial constraints and workforce fragility as the principal future commissioning challenges, highlighting the need to determine which specialist services could be sustainably provided within Wales and where networked or cross-border arrangements would deliver better outcomes and value, while retaining elements of care locally where possible. S. Taylor also added that, whilst significant data was available across NHS Wales, further development of analytical capacity and capability was required to strengthen oversight and decision-making. She highlighted opportunities to make better use of data and digital technology to understand future demand and improve productivity across commissioned pathways. K. Mason sought assurance regarding data and information flows between specialist commissioned services and wider care pathways, including whether the JCC had sufficient analytical capacity and capability to support effective pathway planning and analysis or remained reliant on Health Board resources. In response, J. Brown acknowledged the need to strengthen the availability and use of integrated population, clinical and financial data, together with the JCC's analytical capability, to better inform pathway planning and commissioning decisions. P. Mears emphasised that the JCC was a joint commissioner acting on behalf of Health Boards, using Health Board resources to commission services for their populations, and should not be viewed as an arm's-length body. He stressed that specialist commissioning should form part of the whole patient pathway, with decisions on the appropriate location of services informed by population need, quality, sustainability and critical mass, aligned with the National Clinical Plan. R Goode sought assurance regarding the equality impact of the pause in surgical elements of the Welsh Gender Service. J Brown advised that the decision followed safety concerns and established governance arrangements, with non-surgical services continuing, individual clinical reviews commencing and equality impacts remaining under review. C. Thompson emphasised the importance of strengthening partnership working, maintaining focus on delivery of existing strategic priorities and securing the best outcomes from available resources. She advised that she supported greater clarity regarding the definition of specialist commissioning and its alignment with Health Board clinical strategies and the National Clinical Plan. D. Hurford advised that he welcomed further engagement between the JCC and the Clinical Executive Peer Group to inform strategic priorities,

	emphasising the importance of a strong clinical voice and ensuring specialist commissioning decisions reflected whole-pathway priorities and local service needs. The Chair clarified that the JCC Chair participated in the NHS Wales Chairs meeting as an equal Chair and that this represented a communication rather than an assurance or accountability route to individual Health Boards, with his formal accountability being to the Minister. In response, J. Brown acknowledged that the assurance slide required greater clarity to distinguish formal governance arrangements from wider communication routes. She highlighted opportunities to strengthen partnership working through the Collaborative Commissioning Leadership Group (CCLG) and ensure stronger clinical input into JCC priorities, maintaining links between specialist commissioning, local services and wider pathways of care. P. Mears emphasised the need to deliver existing JCC priorities, particularly cardiac surgery and neonatal services, before expanding the programme further. He advocated a more data-driven, population-needs-based commissioning approach, with future priorities determined by required outcomes, quality and available resources, supported by appropriately focused clinical engagement. In response, D. Hurford emphasised that clinical engagement should focus on defining the overarching quality outcomes required for the population, rather than individual service-level preferences, enabling commissioning decisions to be driven by strategic clinical priorities.
Resolution:	The Board resolved to: • NOTE the Presentation.
Action:	None identified.
4.	GOVERNANCE & BOARD BUSINESS ACTIVITY
4.2	Action Log
	The Chair presented the action log and invited questions or comments on the items proposed for closure, the revised completion dates for actions remaining open or in progress. No further updates were reported.
Resolution:	The Board resolved to NOTE the: • action log • agreed the actions proposed for closure
Action:	None identified
4.3	Matters Arising not contained within the Action Log
	There were no matters arising to report
4.4	Board Committee and Advisory Group Highlight Reports
4.4.1	Quality, Safety & Experience Committee (QSEC) 21 July 2026 In addition to the Highlight report from the meeting held on 21 July, C Donoghue, Chair of QSEC Committee provided a verbal update to members on the items that the Quality, Safety & Experience Committee wished to highlight to the Board following the meeting held on 21 September 2026.

	C. Donoghue highlighted concerns regarding the redress backlog, emergency department safety and risk controls, maternity service sustainability and national delays affecting digital pathology systems. She also reported positively on significant improvements in stroke performance and patient outcomes, noting the clarity of the stroke report as a potential model for future reporting. The Chair welcomed the improvements in stroke services, noting that the emerging evidence during the agreed one-year extension to the temporary service arrangements would support the Board in making an informed decision on the future configuration of the service
Resolution:	The Board resolved to NOTE the update provided.
Action:	None identified.
4.4.2	Operational Delivery Committee (ODC) 28 July 2026 G Hughes, in the absence of the Committee Chair, provided an update on the items that the Operational Delivery Committee wished to highlight to the Board following the meeting held in July 2026. G Hughes highlighted two matters for escalation which were the Month 3 financial deficit, driven by continuing healthcare, medicines, operational pressures and under-delivery of savings, noting the enhanced controls in place. He also highlighted continuing concerns regarding delayed transfers of care, particularly Pathway 3 delays and their impact on boarding and patient flow from emergency departments, notwithstanding improvements associated with Hospital at Home.
Resolution:	The Board resolved to NOTE the update provided.
Action:	None identified.
4.4.3	Stakeholder Reference Group (SRG) 17 September 2026 P Deenik provided an update on the items that the Stakeholder Reference Group wished to highlight to the Board following the meeting held in September 2026. P. Deenik advised that the main matter for escalation was a membership update with two new expressions of interest which had been endorsed by the SRG for Board approval. H. Proctor sought assurance that the Group was effectively capturing stakeholder views and outcomes from engagement. Assurance was provided that the SRG remained an important part of the Health Board's wider engagement arrangements, complemented by more focused engagement where required. In response, P. Deenik provided assurance that the SRG was effectively capturing stakeholder views and enabling members to contribute. The Chair added that the SRG formed an important part of the Health Board's wider engagement arrangements, supplemented by more focused engagement where required.

Resolution:	The Board resolved to: • NOTE the update • APPROVE the two new member expressions of interests received
Action	None identified
4.4.4	Audit, Risk & Assurance Committee 4 August 2026 K Palmer in the absence of the Committee Chair, provided an update on the items that the Audit, Risk & Assurance Committee wished to highlight to the Board following the meeting held in August 2026. K. Palmer advised that there was one item to escalate in relation to the significant increase in clinical negligence claims and CTM's position as an apparent outlier for new claims, noting the associated quality, safety, financial and organisational learning implications. K. Palmer advised that further joint work between the Audit, Risk and Assurance Committee and Quality, Safety and Experience Committee would examine the underlying causes and trends while avoiding duplication of assurance. P Mears also highlighted related national work and proposed a Board briefing on the wider clinical negligence and risk arrangements, which was agreed.
Resolution:	The Board resolved to NOTE the update provided
Action:	To undertake a joint Audit, Risk and Assurance Committee and Quality, Safety and Experience Committee deep dive to review the underlying causes and trends associated with clinical negligence claims and identify any required action
Action:	Schedule a Board briefing session on clinical negligence and Welsh Risk Pool arrangements, including the associated quality, safety and financial implications.
4.5	Board Effectiveness Review G. Watts present the report which provided a positive overall assessment of Board effectiveness, noting characteristics associated with high-performing Boards, including constructive relationships, strong engagement and continued investment in development. He emphasised that the next stage of maturity should focus less on changing governance structures and more on strengthening organisational grip, accountability and the translation of assurance into measurable improvement and outcomes. G. Watts outlined work to strengthen the Board Assurance Framework and move committee meetings towards an assurance-led approach, structured around key assurance questions rather than sequential consideration of reports. This approach was to be piloted through the Operational Delivery Committee, with learning subsequently applied more widely. The Chair welcomed the review and highlighted the importance of aligning patient stories with the Health Board's strategic priorities, including Community by Design and the strategic clinical services work, so that patient

	experience helped demonstrate both the need for change and the impact of service transformation. H. Lentle advised that she supported the use of patient stories but stressed that the Board needed visibility of what changed as a consequence, rather than stories being considered in isolation. In response, the Chair emphasised the value of patient stories in informing Board decision-making and advocated greater alignment with the Health Board's strategic priorities. He agreed that the Board should have clear visibility of the changes made in response to patient experiences and the resulting impact on services and outcomes, supporting more frequent progress reporting. C. Donoghue welcomed the work being undertaken and highlighted the volume and complexity of committee business and questioned whether reports were sufficiently focused on impact and outcomes. She advocated shorter, more disciplined reporting which demonstrated whether interventions were working and, where they were not, what would be done differently. The positive approach used in the recent stroke report to the Quality, Safety & Experience Committee was identified as a potential model for other reports. P Mears emphasised the importance of demonstrating the changes made in response to patient stories and providing assurance on their impact. He suggested that progress should be reported at six-monthly intervals, rather than solely through the annual review, which was supported. H. Proctor supported greater use of patient stories to demonstrate the impact of service changes from the patient perspective, suggesting Hospital at Home as an example where patient experience could provide additional evidence of whether the intended improvements were being realised. P. Mears highlighted the emerging national Well-Led framework, noting that it was likely to inform future Board effectiveness assessments and potentially the structure of Board reporting. He suggested that the framework be considered at a future Board development session once the national requirements were clearer. P. Mears stated that, given the size and complexity of CTM, the challenge was ensuring that the appropriate level of assurance was provided in the right place, at the right time and in a concise way, with reporting focused on key risks, challenges, mitigations and their impact rather than detailed descriptions of activity. P. Mears advised about the training already provided to teams by the Governance Team on report writing and presentation preparation and supported continued development to ensure reports were concise and focused on key risks, challenges, mitigations and impact.

	D. Hurford emphasised the value of viewing services through the patient and population perspective, with patient stories aligned to strategic priorities and used to demonstrate the impact of subsequent service improvements. He acknowledged that the availability of patients willing to share their experiences could limit their use across all areas.
Resolution:	The Board resolved to NOTE the: • assessment of Board effectiveness and the findings • development opportunities • proposed areas of focus for 2027
Action:	Introduce six-monthly reporting to the Board demonstrating the changes and impact arising from patient stories, alongside the existing annual review.
Action:	Pilot the assurance-led committee approach through the Operational Delivery Committee pilot and use the learning to inform the development of arrangements across other Board Committees.
Action:	The national Well-Led framework to be considered at a future Board development session once the national requirements were clearer.
5.	**INSPIRING PEOPLE**
5.1	Chair's Report and Affixing of the Common Seal The Chair presented the report and highlighted the key matters: • Stakeholder and political engagement: The Chair reported a significant programme of engagement over the summer, particularly with Members of the Senedd, reflecting the increased number representing communities within the CTM footprint. Discussions had included the proposed Health and Wellbeing Centre for the Llynfi Valley, and visits had been arranged to Llantrisant Health Park to see progress on the development. He also suggested arranging a visit for Board Members. • Future shape of health services: The Chair advised on recent discussions with staff-side colleagues through the Local Partnership Forum and emphasised that healthcare services would change significantly over the next 5 to 20 years and that meaningful staff engagement would be essential in shaping new models of care, including Community by Design and greater use of digital technology. • Staff contribution and recognition: The Chair referred to the forthcoming Seren Annual Awards, thanking Board and Executive colleagues involved in shortlisting nominations. He stressed the importance of recognising the contribution of CTM's approximately 13,500 staff, particularly given the challenging working environment.
Resolution:	The Board resolved to: • NOTE the report • RATIFY the Affixing of the Common Seal
Action:	There were none.
5.2	Chief Executive's Report P Mears presented the Chief Executive's report and highlighted the following key matters:

	• Welsh Government escalation and accountability: P. Mears advised that CTM continued to make progress against its de-escalation criteria for urgent and emergency care and planned care. The first of the new-style Welsh Government accountability meetings, structured around the Well-Led framework, had been positive, recognising CTM's progress in quality, safety, performance and financial management while challenging the organisation to consider how it could improve further. A follow-up letter from Welsh Government was to be circulated to Board Members. • Cancer performance and IMTP: Continued improvement in cancer performance was highlighted, with CTM reported as having the best performance in Wales in July. The Board was also reminded that CTM's Integrated Medium Term Plan (IMTP) had been approved by Welsh Government, providing positive endorsement of both the financial plan and the organisation's ambitions for service change and improvement. • Llantrisant Health Park: Final approval had been received for Phase 2 of the development, with £122m capital investment for the regional Orthopaedic/arthroplasty centre. The facility was planned to include six theatres and 54 short-stay beds, with the potential to undertake 24 joint procedures each day. The diagnostic centre was expected to commence seeing patients in January 2028, followed by the Orthopaedic Centre approximately a year later. The development was also seen as an opportunity to consider more regional approaches to orthopaedic pathways and waiting lists across South East Wales. • Electronic prescribing (EPMA): P. Mears reported that the EPMA rollout had been successful, which had progressed from Princess of Wales Hospital to Royal Glamorgan Hospital, with Prince Charles Hospital and community hospitals to follow. Clinical feedback had been very positive, and the smooth implementation was attributed particularly to careful planning and strong on-the-ground implementation support. K. Mason commented that she welcomed the EPMA progress and asked whether the successful implementation-support model and expertise developed by the team would be retained for other digital implementations. S. Morris provided assurance that the model would be used for future rollouts, although it was recognised that some staff who had developed new skills might progress to other roles. K. Palmer highlighted the importance of communicating with patients regarding staff use of mobile devices for electronic prescribing, to ensure patients understood that devices were being used for clinical purposes.
Resolution:	The Board resolved to NOTE the report.
Action:	Follow-up letter from Welsh Government regarding escalation and accountability to be circulated to Board Members.
5.3	Strategic Equality Plan H Daniel presented the report to Members and highlighted that CTM had assessed its equality maturity at 3 out of 5, a rating agreed by Welsh Government. H. Daniel advised that the next phase should focus more

	strongly on impact and outcomes, with a smaller number of priorities pursued in greater depth. Positive progress had been made in addressing differential disciplinary outcomes, but representation and progression at senior levels, particularly for global majority staff, remained a significant challenge. H. Daniel advised that a Board development session was being considered to reset CTM's Equality Diversity and Inclusion (EDI) ambitions. Members discussed the role of staff networks including difficulties attracting membership and enabling staff to participate. H. Daniel confirmed that a review was underway with staff network Chairs with regard to the role of the networks to clarify their purpose and consider improved organisational support, protected time and internal promotion. D. Hurford highlighted the particular diversity of CTM's medical workforce, including its high proportion of Specialty, Associate Specialist, and Specialist (SAS) doctors from overseas backgrounds, emphasising why the equality agenda was particularly important for the organisation. N. Mesher challenged whether the considerable activity under the plan was translating into measurable change, particularly given the continuing lack of ethnic minority representation at senior and Board level. H. Daniel agreed that the emphasis needed to move from activity to evidence of impact, prioritising interventions with a stronger evidence base and changing course where interventions were not effective. The Chair also highlighted career progression, rather than recruitment alone, as a key issue. He stressed the need to support people from ethnic minority backgrounds to pursue senior opportunities and for public appointments to be promoted more proactively to communities that had traditionally been under represented. H. Lentle queried the timescale associated with the Gender Pay Gap Action Plan. H. Daniel advised that he would undertake to check this and provide the information outside of the meeting.
Resolution:	The Board resolved to NOTE the report
Action:	Schedule a Board development session to review and reset the Health Board's EDI ambitions and agree priority areas for future action.
Action:	Confirm and provide the timescale for delivery of the Gender Pay Gap Action Plan.
6.0	SUSTAINING OUR FUTURE
6.1	Month 5 Finance Update
	A Jones presented the Month 5 Finance Update and Highlighted the following: • Financial Position: The Health Board had reported an in month deficit of £0.6m and a £9.7m year-to-date deficit at Month 5, while maintaining the forecast break-even position. A. Jones stressed that this could not

	be achieved without improving the expenditure run rate. Financial risks were assessed at approximately £27m, including £18.4m associated with Welsh Risk Pool arrangements if break-even was not achieved. • Savings and cost pressures: The savings programme was £6.2m behind plan year to date, with a £3.7m shortfall forecast against the £31.3m annual savings requirement. Approximately £4m of accounting gains were mitigating the position in-year, but this reliance on non-recurrent benefits created a challenge for the recurrent position. Particular pressures included prescribing, continuing healthcare, independent mental health placements and clinical negligence. • Cash and capital: Cash remained manageable provided the Health Board delivered break-even. The capital programme was on track and, following the additional investment in Llantrisant Health Park, was expected to increase from £132.4m to approximately £150m during the year. • Expenditure controls: A. Jones highlighted action to improve control over variable pay expenditure, including agency, bank, overtime and additional duties. All available reserves had been released, with the position effectively being that schemes already commenced would continue, while those not commenced would not proceed. The Chair noted that although the monthly overspend was reducing, the £9.7m year-to-date deficit was materially worse than the comparable £6m position in the previous year. He cautioned that reliance on non-delegated resources to offset pressures was not sustainable and requested that the Executive Team's proposed actions be brought to a Board briefing session, particularly those areas within CTM's control. It was confirmed this could be done within the next couple of weeks. The Chair sought assurance that the potential financial implications associated with emerging quality and service pressures, including redress and maternity sustainability, were appropriately reflected within the forecast position. A. Jones, in response, emphasised the need for services increasingly to reprioritise existing resources, distinguishing essential requirements from desirable additions rather than continually adding expenditure N. Mesher sought clarification on the use of the non-delegated reserve and whether expenditure would need to reduce significantly during the remainder of the year. A. Jones explained that benefits and commitments were phased across the year and reiterated that the plan to achieve break-even was credible, but required greater control and constraint. P. Mears advised that the break-even position was challenging but achievable, subject to strengthened control of discretionary and temporary staffing expenditure. He emphasised that financial discipline was a collective organisational responsibility and should remain balanced with quality, safety and performance considerations.

	The Chair commented that he took a very hard line on financial balance and emphasised the need to maintain a firm approach to financial discipline, noting the statutory requirement to achieve financial balance and the responsibility to safeguard public funds. He stressed that maintaining financial control was essential to enable continued focus on service redesign and delivery of the Health Board's strategic ambitions. G. Hughes highlighted that improvements in productivity could generate additional costs, and referred to increased orthopaedic throughput as an example. He emphasised the need for the financial consequences of service redesign and increased activity to be appropriately reflected within longer-term financial planning. P. Daniels emphasised the importance of maintaining investment and focus on prevention and population health as part of the longer-term approach to financial sustainability, due to worsening healthy life expectancy and wider socioeconomic inequalities, which would otherwise increase future demand across hospital, primary and community services. D. Hurford advised that financial sustainability and quality and safety must remain equal considerations, and that sustainable finances were essential to maintaining safe, high-quality care for patients.
Resolution:	The Board resolved to NOTE the report.
Action:	Provide a Board briefing on the Executive Team's proposed financial recovery and expenditure control measures, including their anticipated impact on delivery of the year-end break-even position.
7.0	IMPROVING CARE - PART 2
7.1	Board Assurance Framework G Watts provided the Board Assurance Framework update report which had been endorsed by the Executive Leadership Group on 14th September 2026 G. Watts highlighted improvements in the articulation of strategic assurance gaps, mitigating actions and supporting evidence, together with a new summary format to improve Board oversight. G Watts advised that the principal risks relating to emergency care, capacity, prevention and healthy life expectancy, and financial sustainability remained scored at 20, although most risks demonstrated a positive direction of travel. G. Hughes welcomed the summary BAF and alignment of risks to the Health Board's strategic themes, and emphasised the need for greater clarity on the actions planned for the next reporting period to demonstrate progress and strengthen assurance. K. Palmer advised that it was good to see the progress being made on Risk 4 with regard to community and partnership engagement and sought assurance regarding the ambition to reduce the associated risk from 16 to 8 by December 2026. S. Blackburn, in response, acknowledged that it was ambitious; however, the target remained appropriate given the mitigations

	underway and emerging benefits from the engagement approaches developed in Maesteg and the Llynfi Valley.
Resolution:	The Board resolved to APPROVE the report.
Action:	None identified.
7.2	Integrated Performance Dashboard C Thompson introduced the Integrated Performance Report, noting that relevant sections had been considered through Committee scrutiny. G. Hughes reported continued improvement in cancer performance, with the Suspected Cancer Pathway reaching 67.5% and the number of patients waiting over 62 days reducing in line with trajectory. He highlighted ongoing work to streamline the prostate pathway, improve referral and treatment times with Velindre and strengthen diagnostic capacity. P. Mears referred to the skill mix in psychological therapies and advised on previous discussions about broadening the workforce model, including greater use of associate practitioners, noting that psychology leadership had not necessarily supported that approach previously. He added that Scotland appeared to achieve stronger performance using a broader skill-mix model and suggested CTM should revisit whether a different workforce model could help improve access and performance in psychological therapies. He also linked this to wider national changes around open access to mental health services. G. Hughes highlighted the focus on admission avoidance and alternative models of care, including remote monitoring for high-risk patients, which was demonstrating encouraging outcomes. He advised that work was underway to consider extending this approach to other long-term condition cohorts, alongside reducing length of stay and package-of-care delays. R. Hughes reported that nationally reportable incidents remained stable and early performance under Listening to People was positive. He highlighted E. coli as an ongoing concern and described further infection prevention and control work, including learning from the previous winter. R. Hughes also raised concerns regarding potentially inappropriate Personal Protective Equipment (PPE)/glove use, which was being explored with clinical teams. D. Hurford highlighted the sustained downward trend in hospital mortality and improvement in seven-day readmissions, providing reassurance that efforts to discharge appropriate patients earlier were not resulting in increased readmission. He also advised that following implementation of electronic prescribing at Princess of Wales and Royal Glamorgan hospitals, no prescription errors had been reported, compared with around four or five per month previously. L. Edwards referred to diagnostic capacity pressures in echo-cardiography, neurophysiology and sonography. She reported improved psychology waiting times, with no patients in secondary/specialist mental health waiting over 12 months and none

	in primary mental health services waiting over 18 months. She also advised on the improvements in stroke services while recognising continuing acute-service pressures. P. Daniels reported positively on smoking cessation, including a 52% four-week quit rate, while noting a slight decline in childhood vaccination. A targeted Measles, Mumps and Rubella (MMR) catch-up programme was planned from November, and the winter vaccination programme would particularly target clinically vulnerable people with chronic conditions. H. Daniel reported improvement in workforce measures. Return-to-work compliance had increased to 73%, nursing turnover had reduced to 6.18%, PADR compliance had reached 75%, and core learning compliance was 81.7%. He advised that the team were exploring whether rostering systems could provide more timely sickness absence information than the current payroll data and would report back on the actions being taken. H. Proctor referred to the package of care delays and queried what engagement was taking place with Local Authorities, given the apparent bottlenecks despite Hospital at Home. G. Hughes advised that the position varied between Local Authority areas and further work was needed to establish whether barriers related to process, capacity, price or the availability of care home beds. H. Proctor referred to staff sickness and questioned whether CTM sufficiently understood why staff were becoming absent, rather than concentrating principally on returning people to work. She highlighted the broad ESR category of stress, anxiety and depression and advocated a more preventative approach to staff wellbeing. In response, Hywel Daniel confirmed that the newly appointed Head of Employee Wellbeing was examining this through the Health and Wellbeing Plan, including the impact of sustained post-COVID pressures. He also supported further partnership work in this area. The Chair sought clarification regarding CTM's apparent outlier position for crude mortality. D. Hurford advised that CTM's crude mortality methodology differed from that used by some other Health Boards, resulting in limitations to direct comparison, and confirmed that national clarification had been sought. He provided assurance that benchmarking against more comparable organisations in England placed CTM around the middle of the comparator group, with service-level analysis being used to identify areas requiring further review and learning. The Chair suggested that explanatory narrative be included within the dashboard to clarify differences in mortality reporting methodology, noting that the current presentation could otherwise give a misleading impression of CTM's comparative position. G. Hughes also suggested that the inconsistency in mortality methodology should be raised with NHS Performance & Improvement (P&I) to explore how reporting could be standardised nationally.

	P. Daniels highlighted that crude mortality was only one measure and that the Board should also consider treatable, avoidable and preventable mortality. He advised that CTM has significant challenges arising from high levels of chronic disease and health behaviours, which contribute particularly to preventable mortality and suggested that it might be helpful to have a Board Briefing or Development Session on the work around mortality.
Resolution:	The Board resolved to NOTE the report.
Action:	Engage with NHS Performance & Improvement regarding the standardisation of mortality reporting and benchmarking across NHS Wales
Action:	Include explanatory narrative within future performance reporting to clarify differences in mortality reporting methodology and the limitations of comparative benchmarking.
Action:	Schedule a Board briefing/Development Session to consider the wider mortality position, including crude, treatable, avoidable and preventable mortality and the work of the Mortality Board.
7.3	Primary Care & Community Performance Metrics
	G Hughes presented the report to Members and highlighted the key matters for members attention. G. Hughes highlighted the challenges associated with manual data collection and the need to develop more automated reporting as services increasingly shift into community settings. He also updated Members on the Community by Design workshop, which had explored alternative approaches to chronic disease management, including community pharmacy, community diabetes, women's health and remote monitoring. K. Palmer welcomed the report and the availability of this type of primary and community care data, recognising the considerable work required to produce it in the absence of appropriate IT systems. N. Mesher also welcomed the information, particularly the patient-flow analysis, adding that it raised useful questions about how patients move through the system, including whether people presenting to general practice might be better supported through community pharmacy and whether patients subsequently returned to general practice because an alternative pathway had or had not been effective. He advised that he felt the data provided an important basis for understanding how the overall system could be improved. The Chair highlighted the historic imbalance in performance information, with systems having been designed predominantly around secondary care rather than primary care and community services. As care increasingly shifted into community settings, he advised that CTM and Welsh Government would need to determine what additional information should be collected to enable the Board to assess the effectiveness of those services and described the report as an important starting point.

	The Chair also welcomed the performance of the Navigation Hub, including increased activity and improved performance, and sought further understanding of its growing interaction with care homes. G. Hughes described the strong relationships developed with nursing homes and work being extended to residential homes, including specific work with Rhondda Cynon Taff (RCT) County Borough Council. Discussions were also underway with NHS Performance & Improvement about the potential for remote monitoring across the care-home sector. This could both increase staff confidence and enable earlier identification of deterioration, allowing earlier and potentially less intensive intervention in keeping with patients' advance care plans. S. Morris advised that some funding had been secured to begin exploring the procurement of a community digital solution to improve data collection and this would be taken forward in the second half of the financial year. However, he emphasised that this would potentially create a longer-term financial commitment and would therefore need to be understood by Finance colleagues and the Board as service models developed.
Resolution:	The Board resolved to NOTE the report
Action:	None identified
7.4	Strategy Deployment C Thompson presented the report to members that provided an update on progress in embedding the Strategy Deployment Framework, including improved alignment of performance management and the IMTP with the Health Board's strategic objectives and the introduction of a RAG-rated implementation dashboard. The Chair welcomed the positive direction of travel demonstrated through the Strategy Deployment Framework and sought confirmation of the timetable for the Strategic Clinical Services Plan case for change. C Thompson provided assurance that this would be considered at a Board briefing in October ahead of its planned progression through to the Board in November.
Resolution:	The Board resolved to NOTE the report
Action:	None identified
7.5	Wellbeing of Future Generations (Wales Act) work P. Daniels presented the refreshed Well-being of Future Generations objectives, aligned to CTM 2030 and the ambition to become a population health organisation. He highlighted partnership activity to reduce inequalities and improve population wellbeing, while advising of the significant challenges presented by declining healthy life expectancy across CTM. P. Daniels confirmed that Well-being of Future Generations activity would be monitored through the Creating Health Board and reported to the Strategic Development Committee every six months. He also highlighted proposed work to map CTM's expenditure on prevention, to understand current investment and whether resources could be used more effectively.

	The Chair welcomed the work being undertaken and suggested that the Public Services Board health inequalities partnership work would be reported to a further Board meeting, recognising that many determinants of poor health outcomes could not be addressed by CTM alone. In response, P Daniels advised that partners were undertaking a mapping exercise of their principal activities and that a workshop was planned for October, after which the work could be brought back to the Board. H. Lentle welcomed the report and noted the progress CTM had made in embedding the Well-being of Future Generations agenda at Board level. L. Curtis-Jones advised that similar work in relation to these principles were being taking forward within local authorities, including developments in Merthyr Tydfil and RCT, and supported bringing a further update to Board on local authority work addressing health inequalities. The Chair agreed that this would be scheduled for a future Board discussion.
Resolution	The Board resolved to NOTE the report
Action	Bring a future update to the Board on Public Services Board and local authority partnership activity to address health inequalities across CTM.
8.	CREATING HEALTH
8.1	Winter Preparedness Approach G Hughes presented the Winter Preparedness Plan, highlighting the collaborative regional approach focused on community resilience, capacity and safety, discharge and flows, and command and assurance. G. Hughes advised that the Plan was being presented to the Board for approval, explaining that it had been developed collaboratively across care groups, site teams, corporate services, local authorities and wider system partners, and had been tested through a multi-agency winter preparedness workshop. He stressed that it remained a live and iterative plan, which would continue to mature as modelling and operational arrangements were tested. K. Palmer welcomed the plan as an excellent document and sought assurance specifically regarding surge capacity and boarding, and queried whether boarding would be monitored individually across the hospital sites. In response, G. Hughes confirmed that the boarding position across all sites was captured three times each day and formed a live component of each site's status, informing its escalation and risk score. In relation to the query on surge capacity, G. Hughes advised that that there was no specific budget for surge, reinforcing the importance of managing demand within CTM's funded bed base wherever possible. However, contingency arrangements would remain in place so that, should additional surge capacity become necessary, it could be implemented safely.
Resolution	The Board resolved to APPROVE the Winter Resilience and Seasonal Preparedness approach.

Action	None identified.
9.	CONSENT AGENDA
9.1	FOR APPROVAL
9.1.1	Unconfirmed Minutes of the meeting held on 30 July 2026
Resolution:	The minutes were APPROVED.
9.1.2	Unconfirmed Minutes of the In Committee meeting held on 30 July 2026
Resolution:	The minutes were APPROVED.
9.1.3	Board Committee Annual Reports
Resolution:	The Annual reports were APPROVED
9.1.4	Pharmaceutical Needs Assessment
Resolution	The Assessment was APPROVED
9.1.5	People & Patient Strategic Plan 2026 - 2028
Resolution	The Strategic Plan was APPROVED
9.1.6	Annual Review of the Risk Management Framework
Resolution	The Risk management Framework was APPROVED
9.1.7	CTMUHB Research & Development Annual Report 2025-2026
Resolution	The Annual Report was APPROVED
9.1.8`	Annual Duty of Quality Report 2025 / 2026
Resolution	The Report was APPROVED
9.2	FOR NOTING
9.2.1	Non-Routine Board Business (Forward Plan)
	The Non-Routine Board Business (Forward Plan) was APPROVED
9.2.2	Annual Cycle of Business
Resolution:	The Annual Cycle of Business was NOTED
9.2.3	Board Committee and Advisory Group Highlight Reports
Resolution:	The Board Committee and Advisory Group Highlight Reports was NOTED.
9.2.4	Carers Annual Report
Resolution:	The Carers Annual Report was NOTED.
9.2.5	Highlight Report from the Joint Commissioning Committee
Resolution:	Highlight Report from the Joint Commissioning Committee was NOTED.
9.2.6	Shared Services Partnerships Committee Assurance Report 16 July 2026
Resolution:	The Shared Services Partnership Committee Assurance Report was NOTED.
10.	CLOSE OUT BUSINESS
10.1	Any Other Business
	C. Donoghue referred to the significant progress made by the Research & Development team, noting the positive outcome of the recent Health and Care Research Wales framework assessment and the considerable improvement since the previous review two years earlier and formally acknowledged the work that had been undertaken.
10.2	Meeting Feedback
	The Chair requested feedback on this meeting within the next two weeks.
11.	Private / In Committee Session
	Members noted there were no items that required discussion in a closed session.

12.	DATE AND TIME OF NEXT MEETING The next Board meeting will be held on Thursday 26 November 2026 at 9.00am

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Agenda Item	8.1.2

Unapproved Minutes of the EXTRA ORDINARY IN-COMMITTEE Board held on 22 OCTOBER 2026

Date and Time of Meeting	Thursday 22 October 2026 at 13:00pm
Venue	In Person, Medical Education Centre, Prince Charles Hospital

Members Present	Jonathan Morgan	Board Chair
	Kath Palmer	Board Vice Chair
	Paul Mears	Chief Executive
	Helen Lentle	Independent Member
	Kathy Mason	Independent Member
	Neil Mesher	Independent Member
	Carolyn Donoghue	Independent Member
	Patsy Roseblade	Independent Member
	Rachel Rowlands	Independent Member
	Gethin Hughes	Chief Operating Officer
	Sally May	Executive Director of Finance
	Lauren Edwards	Executive Director of Allied Health Professionals and Healthcare Sciences
	Richard Hughes	Executive Director of Nursing
	Claire Thompson	Executive Director of Strategy & Transformation
	Dom Hurford	Executive Medical Director (in part)
	Hywel Daniel	Executive Director for People
	Gareth Watts	Director of Corporate Governance
	Stuart Morris	Director of Digital
	Simon Blackburn	Director of Communications, Engagement & Fundraising
	Alex Brown	Associate Board Member
	Sarah Medlicott	Associate Board Member
In Attendance	Emma Walters	Head of Corporate Governance & Board Business

Agenda Item	Meeting Business
1.	PRELIMINARY MATTERS
1.1	Welcome and Introductions
	The Chair welcomed everyone to the meeting.
1.2	Apologies for Absence
	Apologies for absence were received from: • Hayley Proctor, Independent Member • Rhys Goode, Independent Member • Philip Daniels, Executive Director of Public Health • Paul Deenik, Associate Board Member • Lisa Curtis-Jones, Associate Board Member
1.3	Declarations of Interest
	No interests were declared in relation to the items on the In Committee agenda, over and above those already declared during the public part of the meeting.
2.	MAIN AGENDA
2.1	Health Visitors Dispute Update The Board received an update on the Health Visitors dispute and considered the proposed approach to securing a local resolution, as set out in the AO letter submitted to Welsh Government for approval. H Daniel reported that the previous Welsh Government-approved offer of a one-off, non-consolidated payment had been unanimously rejected by UNITE members and striking Health Visitors. Members were advised that the national review had been paused, although formal confirmation had not been received. Welsh Government had indicated that the dispute should be resolved locally. Following further discussions with Welsh Government and UNITE, the Executive proposed the development of a distinct, extended specialist Band 7 Health Visitor role, clearly differentiated from the Band 6 role, to enhance services for the Health Board population. The opportunity to move into the new role would be available to both striking and non-striking Health Visitors, with a proposed commencement date of 1 January 2027, subject to development and agreement of the job description with UNITE and completion of the banding process. The proposed settlement also included a one-off resolution payment of £2,200 per Health Visitor, pro rata, available to both striking and non-striking staff. The payment would be taxable, subject to National Insurance

	and pensionable. The intention was to facilitate a return to work on 2 November 2026. The AO letter outlined the proposed settlement, the rationale for the approach and the financial provision made for the current year. The Board noted that the financial implications would increase over time and that there might be opportunities to review the skill mix in future. P Mears advised that the proposed approach represented the most pragmatic route to resolving the dispute. A response from Welsh Government was awaited. The Chair reported that he had raised the urgency of approval with the Minister, who had agreed to speak with officials. The Board noted Welsh Government's wish to link the settlement to UNITE's participation in the national review. The Executive and Chair had made clear that they did not support such a condition. Members supported the proposed approach and sought assurance on audit engagement, communication with UNITE members and wider stakeholder messaging. H Daniel confirmed that UNITE had not yet communicated the offer to its members. G Watts undertook to discuss the proposals with audit colleagues and share the relevant information. In discussing communications, Members highlighted the need to explain the development of a new specialist role and the associated enhancement to services. P Mears advised that a request for a meeting had been received from Rhondda Cynon Taf Council and had not yet been answered. The Board approved the Executive approach. The Chair confirmed that any materially different terms arising from Welsh Government's response would be brought back to the Board for further consideration and approval.
Actions:	G Watts to discuss the proposed settlement with audit colleagues and share the relevant information. Implementation of the proposed Band 7 role would require the job description to be developed, agreed with UNITE and banded in readiness for the proposed commencement date of 1 January 2027. Any materially different settlement terms arising from Welsh Government's response to be referred back to the Board for further consideration and approval.
Resolution:	The Board resolved to: 3. APPROVE the Executive approach set out in the AO letter submitted to Welsh Government, comprising a one-off, non-consolidated resolution payment of £2,200 per Health Visitor, pro rata, and development of a new specialist Band 7 Health Visitor role, subject to Welsh Government approval.

	4. ENDORSE the position that settlement should not be conditional upon UNITE's participation in the national review. 5. REQUIRE any material changes to the proposed settlement to be brought back to the Board for further consideration and approval.
4.	CLOSE OUT BUSINESS
4.1	Any Other Business
5.	DATE AND TIME OF NEXT MEETING
5.1	The next meeting takes place on Thursday 26 November 2026

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

CTMUHB Public Board

Annual Equality Report 2025-2026

Eitem yr Agenda / Agenda Item	8.1.3
Dyddiad y Cyfarfod / Date of Meeting:	26/11/2026
Statws Cyhoeddi / Publication Status:	Open/Public. For Future Publication .
Adroddiad wedi'i baratoi gan / Report Prepared by:	Alex Grand, Strategic EDI Lead Lisa Whiteman-Pearce, Head of OD and Culture Hannah Williams, Assistant Director of Leadership and Culture
Cyflwynydd yr Adroddiad / Report Presenter:	Hywel Daniel, Deputy CEO/Executive Director for People
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Hywel Daniel, Deputy CEO/Executive Director for People
Diben yr Adroddiad / Report Purpose:	For Approval
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	The Board are asked to Approve the Annual Equality Report 2025-2026, prior to translation into Welsh and publication on the CTM website.
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol* *Strategic Context:* *This report aligns to the following Strategic Pillars*	All Strategic Pillars Apply If more than one applies please list below:
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan *(Reference relevant priority)*	The Strategic Equality Plan (SEP) 2024-2028 sets out high level commitments to delivering accessible and inclusive services and improving fairness and inclusivity as an employer. Priorities in any one year will include pertinent IMTP deliverables and achievements reported in that year's Annual Equality Report, published at the latest 31 March the following year.

Crynodeb Gweithredol o'r hyn y mae'r adroddiad yn ei ddisgrifio:
Dechreuwch drwy grynhoi'r wybodaeth bwysicaf yn fyr. Dylai hyn roi dealltwriaeth gadarn o'r pwyntiau allweddol yn erbyn y 3 phennawd canlynol heb ddarllen yr adroddiad llawn:
Executive Summary of what the report is describing:

Start by summarising briefly the most critical information. This should provide a firm grasp of the key points against the following 3 headings without reading the full report:	
Beth *(crynodeb o'r sefyllfa / mater cyfredol a pham ei fod yn bwysig a thystiolaeth i gefnogi'r safbwynt hwnnw ac ati)* What *(summary of current position / issue & why it matters and evidence to support that position etc)*	The Annual Equality Report 25-26 shows continued progress in embedding equality, diversity and inclusion (EDI) across the Health Board, including improved workforce data quality, some increased ethnic minority representation, stronger staff network engagement and much broader activity across services and infrastructure linked to the Strategic Equality Plan. However, significant inequalities remain, including a slightly reduced gender pay gap of 27.21%, underrepresentation of ethnic minority staff in senior leadership and Board roles, and continued disparities in staff experience, progression and wellbeing. These issues impact workforce sustainability, inclusion, patient experience and can risk compliance with statutory duties.
Felly, beth *(darparu dadansoddiad ystyrlon gan dynnu allan, fel y bo'n briodol, oblygiadau yn erbyn Strategaeth / Cynlluniau Cyflawni / risgiau Strategol neu Reoleiddiol CTMUHB ac ati ac unrhyw opsiynau ar gyfer mynd i'r afael â'r rhain)* So, what *(provide meaningful analysis drawing out as appropriate implications against CTMUHB Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)*	The report shows that EDI is becoming more embedded within CTM and our People Plan, but persistent inequalities will continue to present workforce, service delivery and reputational risks. Failure to address disparities in recruitment, progression and staff experience could undermine efforts to attract, retain and develop a diverse workforce. A recent, WG-ratified SEP self-assessment reinforced the need to shift from measuring activity to demonstrating measurable outcomes and reducing inequalities through targeted interventions and stronger accountability. Later this year, an independent, expert review of our data, position and plans will help refine priorities and target action where it can have the greatest impact.
Beth Nesaf *(crynodeb o'r camau gweithredu a fwriadwyd a'r manteision sy'n cefnogi'r dewisiadau a'r argymhelliad(au) sy'n cael eu gwneud)* What Next *(summary of intended action and benefits supporting the choices and recommendation(s)being made)*	Priority actions for the rest of this year and early next include preparing and publishing the Health Board's first Gender Pay Gap Report and Menopause Action Plan, further implementing the Workforce Equality Standard, strengthening inclusive recruitment and leadership development, improving equality data and fully embedding Equality and Welsh Language Impact Assessments into decision-making. These actions are intended to reduce inequalities, improve staff experience and representation, strengthen compliance and governance, and support delivery of CTM2030 through more equitable services and workforce outcomes.

Argymhelliad *(Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).* Recommendation (Linked to the "What Next" section above).	The Board are asked to Approve the Annual Equality Report.

1. Background / Context

1.1 The Annual Equality Report 25-26 Final provides assurance on progress made during 2025/26 against the Health Board's Strategic Equality Plan 2024-2028 and statutory duties under the Equality Act 2010 and Public Sector Equality Duty (Wales). The report highlights activity undertaken to improve services, equality of access, staff experience, community engagement and organisational governance, while recognising that workforce and health inequalities remain for several protected and underrepresented groups.

2. Strategic Insights

2.1 The report demonstrates positive progress in embedding equality, diversity and inclusion. However, key challenges remain, including a gender pay gap above the NHS Wales average, underrepresentation of ethnic minority colleagues in senior leadership roles, and ongoing disparities in workforce experience.

2.2 The findings reinforce the importance of strengthening the use of equality data, focusing on measurable outcomes and ensuring EDI considerations are embedded within workforce, service and organisational decision-making to support the delivery of strategic priorities and reduce inequalities across our communities.

2.3 In this reporting period, implementation of the People Plan 2025-2030 has embedded EDI within key workforce programmes, including anti-racism training, inclusive leadership development, sexual safety training, and the launch of the EDI Learning Forum. Workforce equality indicators also show some positive movement, including increased ethnic minority representation, improved equality data quality and greater engagement through staff networks.

2.4 In Services, targeted initiatives such as the Integrated Women's Health Hub, sensory facilities for neurodiverse children and enhanced chaplaincy provision demonstrate a growing focus on reducing inequalities and improving access for diverse communities.

2.5 These achievements are supported by strengthened governance arrangements and increased use of Equality and Welsh Language Impact Assessments, providing stronger foundations for delivering our strategic ambitions.

3. Risks and Opportunities

3.1 None pertaining to the publication of this report. However, the report (as well as the recent Workforce Equality Standard) does highlight current and ongoing workforce inequalities. There is a risk, without meaningful and targeted action, these inequalities will continue if not worsen, leading to ongoing opportunity cost, reputational risk and can impact workforce sustainability, patient experience and compliance with statutory duties.

3.2 In addition, the report highlights recent progress in improving governance processes relating to Equality and Welsh Language Impact Assessments (EWLIAs). This will help reduce the risk of suboptimal decision making, and the risk of enforcement action.

4. Compliance and Governance

4.1 Publication of the Annual Equality Report is a requirement under the Equality Act (Statutory Duties) (Wales) Regulations 2011, providing a summary of our activity and progress for the given reporting period, in this case April 2025 to March 2026. The deadline for publication is 31 March 2027.

4.2 A SEP Delivery Group, established in Q3 2025, provides frequent delivery updates, including barriers and challenges thereto, meeting quarterly with interim one to ones. A stronger emphasis on baselining and/or measurement of outcomes/evaluating impact will be made from Q3 2026 onward, addressing our own reflections and recommendations from Welsh Government.

5. Benchmarks

5.1 None pertaining to the publication of this report. However, with reference to matters of workforce equality, the Gender Pay Gap (GPG) is the key benchmarked dataset. There is no agreed target or deadline to eliminate pay gaps, however from Spring 2027, organisations will be required to publish GPG and Menopause Action Plans. As set out in the report, CTM's last published GPG is 27.21%, compared to a whole-NHS Wales average of 19.32%.

6. Conclusion

6.1 The Annual Equality Report 2025-2026 demonstrates that CTMUHB is making meaningful progress in embedding equality, diversity and inclusion as a core component of organisational delivery, rather than a standalone compliance activity. Positive outcomes during the year include expanded staff network engagement, some improved workforce representation, successful community partnerships addressing socio-economic inequality, development of inclusive workforce policies, and enhanced oversight of equality-related activity. While important challenges remain, particularly in relation to workforce representation at senior levels and the GPG, the Health Board has established stronger governance and clearer accountability, and is working toward a more

strategic, data-informed approach to addressing inequalities. This, along with feedback from WG, provides confidence that the organisation is well placed to build on current progress and deliver measurable improvements for staff, patients and communities during the remainder of 2026/27.

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)* Link to Strategic Risk(s) on the Board Assurance Framework (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	All Strategic Risks Apply
	If more than one applies please list below:

Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals	A More Equal Wales
	If more than one applies please list below:

Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	All Enablers of Quality Apply
	If more than one applies please list below:

Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Asesiad Effaith Impact Assessment		
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg *(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)* Equality & Welsh Language Impact Assessment Outcome *(Please write summary statement, if not undertaken provide reason*	Outcome for Equality (delete as appropriate): NA – reporting of annual position Outcome for Welsh Language (delete as appropriate): N/A - reporting of annual position	If no, please select a reason below. Policy/Plan/Proposal too broad Hywel Daniel

from dropdown and Executive sign off.)		
Canlyniad Asesiad Effaith Ansawdd *(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)* Quality Impact Assessment Outcome *(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)*	N/A – reporting of annual position	
Cyfreithiol / Legal	Yes (Include further detail below)	
	There is a legal requirement to publish an Annual Equality Report by the end of the following operational year.	
Enw da / Reputational	Yes (include further detail below)	
	Continued under-representation of minoritised groups in leadership roles and the compression of progression pipelines, and suboptimal staff experience may lead to reputational risk and the inability to attract, develop and retain a diverse and talented workforce.	
Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report	

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Hywel Daniel	11/09/2026	Approved
Hayleigh Jones	15/09/2026	Approved subject to amendments
EMB	28/09/2026	Approved
Operational Delivery Committee	27/10/2026	Endorsed for Board Approval

Acronyms / Glossary of Terms	
AER	Annual Equality Report
CTM(UHB)	Cwm Taf Morgannwg (University Health Board)
EDI	Equality, Diversity and Inclusion
EWLIA	Equality and Welsh Language Impact Assessment
GPG	Gender Pay Gap
OD	Organisational Development

SEP	Strategic Equality Plan
WES	Workforce Equality Standard
WG	Welsh Government

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Cymraeg

Mae'r ddogfen / ffurflen hon hefyd ar gael yn Gymraeg.
This document / form is also available in Welsh.



Cwm Taf Morgannwg University Health Board

Annual Equality Report

April 2025 – March 2026

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Foreword

At Cwm Taf Morgannwg University Health Board, we are committed to creating a health service where everyone is treated with dignity, fairness and respect. Equality, diversity and inclusion are not simply statutory responsibilities; they are fundamental to delivering high-quality care, supporting our people and improving outcomes for the communities we serve.

We also recognise that we are working in a time of significant challenge and uncertainty. Across society, we are seeing increasing inequality, economic pressures, changing public expectations and, at times, growing division. In this context, our commitment to equality, diversity and inclusion becomes even more important. These principles are not something we pursue only when circumstances are favourable; they are essential to how we lead our organisation, support one another and ensure that every individual feels valued, heard and able to thrive.

This Annual Equality Report reflects the progress we have made during 2025/26 in delivering our Strategic Equality Plan and meeting our responsibilities under the Equality Act 2010 and the Public Sector Equality Duty. It demonstrates how we are embedding equality into the way we make decisions, develop our workforce, design services and work alongside our communities.

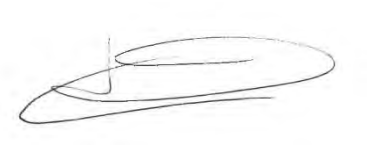
Over the past year we have continued to strengthen the foundations for lasting change. We have expanded opportunities for learning and development, deepened engagement with staff and communities, improved the quality of our workforce data, and seen encouraging progress in areas including ethnic minority representation, staff network participation and organisational awareness of inclusion. These achievements are a testament to the commitment of colleagues across the Health Board.

At the same time, this report is clear that important challenges remain. Significant inequalities persist in the experiences of some of our staff and communities. We continue to see disparities in workforce experience, a gender pay gap that requires sustained attention, and under-representation of some groups in senior leadership. Reducing health inequalities and creating truly inclusive services will require continued focus, collaboration and a willingness to challenge ourselves to do better.

As we look ahead, our ambition is to move beyond measuring activity and place greater emphasis on demonstrating impact. We will strengthen our use of data and evidence, improve accountability, embed equality considerations more consistently into decision-making, and continue developing inclusive leadership and recruitment practices. Above all, we will continue listening to our staff, patients and communities to ensure their experiences shape the improvements we make.

I would like to thank everyone who has contributed to this progress over the past year. Together, we are building a more inclusive organisation where everyone has

the opportunity to thrive and where equality is central to the care we provide every day.



Hywel Daniel
Deputy Chief Executive / Executive Director for People

Our Legal Duties

The Equality Act 2010 is a comprehensive piece of legislation designed to ensure fairness and prevent discrimination against individuals in the United Kingdom. At its core, the Act mandates that everyone should be treated equitably and with respect. This law protects individuals from being treated less favourably than others due to protected characteristics.

These characteristics are:

Sex	This covers males and females of any age. Under the Equality Act 2010. Sex means biological sex, referring to a person's sex at birth.
Disability	This encompasses individuals with physical or mental impairments that have a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities.
Age	This protects both younger and older individuals from age-based discrimination.
Race	This includes a person's colour, nationality, ethnic or national origins. It also recognises that individuals from different racial groups may speak different languages, and discrimination based on this is also prohibited.
Religion or Belief	This covers individuals who follow any religion, as well as those who would hold no religious beliefs. It also includes philosophical beliefs.
Sexual Orientation	This protects individuals of all sexualities.
Gender Reassignment	This refers to individuals who are intending taking steps to live in a different gender to the one they were assigned at birth, are undergoing a process of gender reassignment, or have already transitioned.
Marriage and Civil Partnership	This protects individuals who are married or in a civil partnership.
Pregnancy and Maternity	This safeguards the rights of women who are pregnant, have recently given birth or are breastfeeding.

To ensure we are upholding the principles of the Equality Act 2010 and treating everyone fairly, we are obligated to inform you about how we collect and utilise information. This transparency is crucial for demonstrating that our practices are equitable and non-discriminatory.

Furthermore, our services must be designed and delivered in a way that effectively meets the diverse needs of all people and communities we serve. We are also committed to ensuring that all individuals are treated fairly and with respect within our workplaces.



Furthermore, the Public Sector Equality Duty (Specific Duties) (Wales) 2011 requires us to:

- develop and implement a Strategic Equality Plan 2024 – 2028 (SEP), which details our: commitment and approach to promoting equality across all functions;
- ensure public engagement in decision-making by actively seeking and considering the views of diverse communities;
- maintain transparency through the publication of equality-related workforce and pay data to demonstrate our commitment to equal opportunities, guaranteeing the accessibility of our services and information for all individuals and considering the Socio-Economic status of our workforce and patients in all our decision making;
- consider the diverse needs of the population we serve in Cwm Taf Morgannwg and the surrounding area.

Our Strategic Commitments

Our current SEP articulates the objectives established to underpin and facilitate the achievement of our equality-based aims and intentions. Recognising the importance of continuous improvement, we undertake an annual review to assess our progress against these defined commitments highlighting both successes and areas requiring further development.

Services:	Improve the experience and health outcomes for our patients, ensuring that every patient has equity of access to the services that they need.
People:	Improved staff engagement and experience, attracting and retaining diverse talent and creating an inclusive environment in which all colleagues can thrive.
Community:	Make sure underrepresented groups and seldom-heard voices are involved at the outset of design and delivery.
Infrastructure:	Make sure equality diversity and inclusion are essential to the way that we operate.

Our People and Population

We provide primary, community, hospital and mental health services to the 450,000 people living in our three County Boroughs: Bridgend, Merthyr Tydfil and Rhondda Cynon Taf.

Our population groups aged 65 – 84 and 85+ are projected to have the largest increase by 2030, when the percentage of the population aged 65 and over is expected to increase by 30.4% and over 85 by 71.3%. These projections will have significant implications for the way in which we design and provide our increasingly integrated health and social care services, so that we can help the people living in our communities to live long and healthy lives, free from the limiting effects of multiple chronic conditions.

As of 31 March 2026, CTMUHB employed 13,204 staff. This provides a baseline for understanding the workforce equality information presented throughout this report, including representation and differences in staff experience and outcomes.

Gender Pay Gap

Our average Gender Pay Gap has reduced slightly over the past year, from 27.52% to 27.21%. While this represents modest progress, our Gender Pay Gap remains above the NHS Wales average of 19.32% and continues to be an area of strategic focus.

The Gender Pay Gap does not mean that women and men are paid differently for doing the same job. NHS pay is determined through national Agenda for Change pay scales. Instead, the gap reflects the overall distribution of men and women across our workforce and the different roles and working patterns they hold.

Several factors contribute to our current position:

- Women make up 76.22% of our workforce, compared with 23.78% men.
- Around 54% of our workforce work part-time. This includes 42.28% of women compared with 11.54% of men.
- Men remain disproportionately represented in higher pay bands, with comparatively fewer men employed in Bands 4 and 5 and a higher and increasing proportion of men employed from Band 7 upwards.

These patterns are reflected across much of the NHS workforce but do not lessen the importance of addressing them. During the coming year we will continue working with colleagues across NHS Wales to better understand workforce demographics, identify areas of good practice and develop evidence-based approaches to reducing the Gender Pay Gap.

Our work will include strengthening inclusive recruitment, supporting greater representation of women in senior leadership roles, encouraging more diverse recruitment into lower-banded roles where appropriate, and improving our understanding of the structural factors that influence career progression and

workforce participation. This work includes creating a recruitment working group to support the rewriting of our guidance and policies for recruiting managers.

To support this work, we have established a Gender Pay Gap and Menopause Working Group. This group will oversee targeted actions, informed by recent changes in employment legislation, culminating in the publication of our first Gender Pay Gap and Menopause Action Plan in Spring 2027.



Workforce Race Equality Standard (WRES) and Workforce Equality Standard (WES)

This year, we have seen progress across several development areas previously identified through the Workforce Race Equality Standard (WRES). The transition to the broader Workforce Equality Standard (WES) has also provided a wider understanding of workforce inequalities across protected characteristics. The highlights below reflect both progress made and areas where further action is required.

- Rates of undeclared ethnicity at board level reduced from 48% to 0%, giving us a clearer picture of ethnic representation. Our Workforce Equality Report for 2025/26 showed that non-disclosure of ethnicity at board level was linked to reduced confidence from staff.
- Staff Survey completion rates increased, giving us greater confidence that the findings reflect a wider range of staff experiences and voices, helping ensure improvement activity is informed by more representative staff feedback.
- The percentage of declared ethnic minority staff employed by CTMUHB increased from 7.8% to 8.3%. This is positive progress towards a more diverse workforce, although representation remains 2.3 percentage points below the NHS Wales position of 10.6%.
- Ethnic minority declared representation at Band 5 and above also increased from 7.1% to 7.7%, showing progress across these pay bands. However, the WES identifies continued underrepresentation at more senior levels, highlighting the need for further work to support fair career progression into these senior roles.
- The likelihood of ethnic minority staff entering the formal disciplinary process became more equitable, helping to build confidence that formal processes are applied consistently and fairly.
- Appraisal engagement remains uneven across staff groups, particularly for ethnic minority and some non-disclosing staff. This highlights the need for greater consistency in appraisal and access to development.

- Some staff groups continue to report higher exposure to harm, including harassment and discrimination, alongside uneven confidence in speaking up. This highlights the need to strengthen psychological safety and ensure staff experience consistent protection and response.
- Access to flexible working, workplace adjustments and other support remains generally positive. However, differences in workload pressure and burnout remain, indicating the need to improve workload sustainability.
- We have also seen an increase in the number of disabled staff in post from last year's figures to 4.99%. While this increase is encouraging, there is more work to do to improve the representation of disabled people across our workforce. As a Disability Confident employer, we will continue to focus on attracting, recruiting and retaining disabled staff.

We recognise that inequalities remain for our ethnic minority workforce. Ethnic minority applicants continue to be less likely to be appointed following shortlisting, remain under-represented in senior leadership roles, and there is currently no ethnic minority representation at Board level. The Workforce Equality Standard also highlights wider inequalities in workforce experience that require continued attention.

During the coming year, we will focus on reducing these inequalities by strengthening inclusive recruitment practices, expanding targeted learning and development opportunities, and embedding equality, diversity and inclusion and inclusive recruitment within our management and leadership development programmes. We will also develop our first Ethnicity Pay Gap Report and continue to improve the quality and completeness of workforce equality data, enabling us to better understand disparities, monitor progress and target action where it is needed most.

Strategic Alignment

Our CTM2030: Our Health, Our Future strategy sets the vision and provides the framework for decision-making and priorities within the Health Board, setting the strategic direction for all areas of our work.

During 2025/26, the implementation of the People Plan 2025-2030 strengthened the alignment between workforce priorities, organisational values and our commitment to equality, diversity and inclusion. Developed in response to staff feedback and aligned to the ambitions of CTM2030, the People Plan sets out how we will attract, develop, retain and engage our workforce while creating a CTM where everyone can thrive.

As part of the People Plan commitment to 'getting the basics right', a review of recruitment and selection processes was undertaken to identify challenges and opportunities for improvement. This resulted in actions to strengthen recruitment guidance, enhance manager training, improve support for internal applicants and promote greater consistency in recruitment decision-making. These

improvements support our aim of ensuring fair, transparent and inclusive employment practices for all applicants and staff.

The CTM2030 goal of Inspiring People also supports our role as an anchor organisation within the communities we serve. Throughout the year, we continued to work with partners including Careers Wales, the Department for Work and Pensions, schools, colleges and local authority employability teams to increase awareness of NHS careers and create accessible routes into employment. This included careers events, apprenticeships, work experience opportunities, internships and widening access programmes such as Project Search and Network 75. These initiatives help broaden participation, support social value objectives and encourage a workforce that better reflects the diversity of our communities.

The Strategic Equality Plan complements both CTM2030 and the People Plan by ensuring that equality, diversity and inclusion are embedded within workforce planning, recruitment, staff development and organisational culture. Together, these approaches support our ambition to create an inclusive organisation where people are treated with dignity and respect, have equitable access to opportunities and can achieve their full potential.

Our Staff Networks



ACCESS (Disability Network) is an acronym that stands for: Access Considerate Care Experience Services Support. We welcome staff with a range of accessibility needs: Neurological; sensory; physical and anyone with a special interest in others with these protected characteristics and our network has been established to a positive and safe culture where everyone can thrive.

WEN, the Women's Equality Network, supports the organisation in gaining a greater understanding of gender equality issues through members' lived experiences. These may intersect with people who share protected characteristics and backgrounds – an intersectional disadvantage.

The Race Equality Network (REN) supports Cwm Taf Morgannwg University Health Board's ambition to develop a positive and safe culture where all colleagues in CTMUHB can flourish and thrive and where everyone can be at their best.

Ffrindiau LGBTQ+ Network (Ffrindiau means 'Friends' in Welsh) was originally founded in 2017 and represents the lesbian, gay, bisexual, trans, and minority sexual orientations, gender identities, expressions, and sex characteristics both within Cwm Taf Morgannwg University Health Board and our hosted organisations.

Membership Numbers:

- Women's Equality Network (WEN): increased membership from 38 to 87,
- Ffrindiau (LGBTQ+) Network: since relaunch, membership is 36,
- ACCESS (Disability) Network: static membership of 46,
- Race Equality Network (REN): static membership of 265.

Over 2025/26, our network activities and achievements included:

ACCESS (Disability) Network

The ACCESS Network focused on strengthening inclusion for disabled and neurodivergent staff across CTMUHB:

- Neurodiversity: The appointment of a joint Chair with a focus on neurodiversity strengthened leadership and increased visibility and support for neurodivergent colleagues.
- Inclusive Recruitment: The network began exploring how the Health Board's Disability Confident status is being implemented in practice, engaging with recruiting managers and specialists to ensure commitments translate into meaningful action. This remains an ongoing priority.
- Accessible Environments: Work progressed to advocate for improved accessible facilities beyond minimum standards, including promoting more inclusive spaces that meet a wider range of staff needs.

Race Equality Network (REN)

The REN delivered a wide range of activity focused on awareness, engagement and staff support:

- Staff Voice and Support: Delivered drop-in sessions across all three main hospital sites (May 2025), providing safe, confidential spaces for staff to discuss experiences of racism, discrimination and inequality, and to inform organisational learning and improvement.
- Organisational Influence: Continued regular engagement with Communications and Corporate teams to ensure inclusivity in internal and external messaging and development opportunities.
- Network Development: Maintained active member engagement through regular meetings and peer support channels, while progressing initiatives such as a multicultural cookery book and exploring mentoring opportunities.

Women's Equality Network (WEN)

The Women's Equality Network continued to support gender equality and provide opportunities for engagement and shared learning:

- **International Women's Day (March 2026):** Recognised under the theme #GiveToGain, promoting collective action to address inequality and foster an inclusive culture.
- Member Engagement: Delivered regular meetings providing supportive spaces for women to share experiences and build connections.
- Book Club: Continued to grow its book club initiative, creating opportunities for reflective discussions on gender equality and women's lived experiences.
- Awareness and Advocacy: Supported broader awareness of issues affecting women in the workplace and beyond.
- Fundraising and Social Impact: Marked Domestic Violence Awareness Month (October) through a fundraising challenge, raising funds to support women and children affected by domestic abuse.



Ffrindiau (LGBTQ+) Network

The Ffrindiau Network established its role in supporting LGBTQ+ staff and promoting inclusion:

- Leadership: Appointment of a new network Chair provided renewed focus and direction for the network, relaunching in February 2026.
- Support and Representation: Continued to offer a safe and supportive space for LGBTQ+ colleagues, enabling peer connection and strengthening staff voice in shaping inclusive practices.
- Awareness Raising: Marked LGBTQ+ History Month (February 2026), including promoting learning opportunities to improve understanding of inclusive language and practices across the organisation.



All four networks continued to work together to strengthen intersectionality and inclusion across CTMUHB:

- All staff networks collaborated to organise a joint picnic in the park in Pontypridd to encourage collaboration and to discuss shared objectives.
- Delivered opportunities for staff to connect, share experiences, and celebrate diversity, creating safe spaces for dialogue and support, with each network having regular meetings for membership to meet and discuss issues or explore a wide range of topics.
- All four networks have welcomed a new Executive Sponsor, with strengthened governance and accountability.

- Strengthened engagement and staff voice, through embedded monthly meetings with the EDI and Employee Engagement teams, dedicated time in Strategic Equality Plan meetings to bring feedback, staff discussion and strategic support. This supports increased collaboration through joint working and shared initiatives, co-operating as networks to support one another.

Strategic Equality Plan Achievements

Services

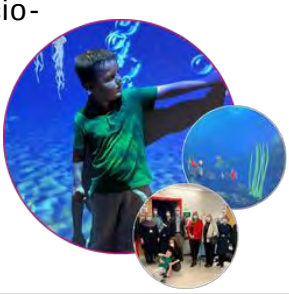
Paediatric Diabetes Education

Our paediatric diabetes team hosted sessions to support Year 6 pupils with Type 1 Diabetes and their parents/guardians with the transition to secondary school. The aim of the session was to support pupils in their transition to secondary school and to develop their independence and ability to manage their condition themselves.

Teaching children going into secondary school about diet and nutrition alongside how to manage their condition themselves can increase their confidence and ability to make better choices when not under parental supervision and can build independence. Educating parents on the increased risk associated with children moving to secondary school can make them more alert to any possible changes. The aim is to have less hospitalisations, fewer deaths, less medical interventions and more long-term stability of their condition, although long-term outcomes are yet to be seen. We are exploring extending the programme to other primary schools and potentially offer additional courses for children already in secondary school, working with external partners to develop additional resources for Special Education Needs and Disabilities (SEND) children who may have additional difficulties during this transition.

Healthy Travel Charter

In July 2025, we rolled out our Healthy Travel Charter. This Charter is a commitment by CTMUHB and other public bodies to work towards 18 actions over the next three years aimed at supporting healthier, more sustainable travel choices. This work contributes to our work under the Socio-Economic Duty, and supports our community, where 56.5% of residents live within the most deprived two-fifths of Wales. Through initiatives including active travel, public transport, the Cycle to Work scheme and flexible working, the Charter helps reduce some of the barriers associated with socio-



economic disadvantage, making it easier for people to travel, including to work with us, in ways that best meet their individual circumstances.

Immersive Room for Neurodiverse Children

With contributions and support from the community and CTMUHB Charity, Prince Charles Hospital (PCH) fundraised for and opened the first immersive sensory room for children with additional learning needs and/or neurodiversity in their A&E department. Children, especially those who have neurodiversity or mental health conditions, can struggle to regulate emotionally: this dysregulation can heighten during a medical emergency or routine medical examination or treatment like vaccinations, and cause distress, exacerbate symptoms and increase the risk of the child harming themselves or others.

Children having access to the room when attending the hospital helps them to self-regulate and calm themselves and provides a non-clinical environment and focal point during stressful situations. This can give medical staff opportunity to obtain more accurate observations, diagnosis and provision of more effective treatment, whilst minimising distress to the child. We are exploring if further funding could be sought to create more immersive rooms on other sites and on our paediatric and oncology wards.

CTMUHB Welcomes New Muslim Chaplain



We have previously identified a need within the health board for more inclusive spiritual care and support. In June 2025, we were delighted to welcome and appoint a Muslim Imam to our Chaplaincy service, to provide spiritual care and advice to patients and staff.

Since the appointment, the Chaplain has provided spiritual, pastoral and practical support to Muslim patients and their families, helping to ensure that religious and cultural needs are understood and respected during significant life events, including illness, childbirth, end-of-life care and bereavement. The role has also provided comfort and support to Muslim staff during difficult times.

The Chaplain has also provided advice and guidance to managers and executive leaders, supporting them to make decisions that better reflect the needs of people from different faiths and cultural backgrounds. This has included providing advice on catering, working arrangements and organisational policies, supporting a more inclusive workplace and helping ensure services meet the needs of the diverse communities we serve.

Integrated Women's Health Hub at Ysbyty Cwm Cynon (YCC)

Bringing a range of services for women's health together in one place, the first Integrated Women's Health Hub opened at YCC in February 2026. Contributing to

the Welsh Government's NHS Wales Women's Health Plan 2025-2035, this community-based services simplifies the process for women and girls (aged 13+) to get the care and support they need with menstrual health, contraception, post-natal care, and menopause support, through both in-person and virtual appointments.

Waiting lists for gynaecology and maternity services are long, and this can leave women managing symptoms and conditions alone with little specialist support. Timely, specialist access to women's health services means women in our community can be assessed, diagnosed and treated much quicker. This can help them maintain a healthy lifestyle, independence and good mental health. Early diagnosis and treatment can also reduce the risk of complications and ensure better outcomes for all patients. We are exploring the feasibility of opening more Women's Health Hubs at other sites so women can receive care more locally, as well as an online central Hub for all women.

People

CTM People Plan

This year, in response to our NHS Staff Survey results and following further in-depth discussions and feedback from staff, we were proud to launch our new CTM People Plan 2025-2030. This plan sets out our aims to support staff and improve our service over the next five years. These actions are all underpinned by four core themes that we identified required focused attention and will become the cornerstones of everything we do for our people at CTMUHB.

One of the themes identified during the 2024 NHS Wales Staff Survey was that our staff didn't feel that their feedback made a difference. In response to this, each month we publish on our internal intranet site the feedback we have received and the real actions we have taken to address it. This helps ensure that our staff feel their feedback is respected and listened to and that we will take action to address their concerns.

In the first nine months of the People Plan, we have:

- Launched our Work in Confidence platform, Speaking Up Safely Guardians and our new Anti-Sexual Harassment policy as part of our commitment to feeling safe, respected and able to speak up at work.
- Hosted our first Hate Crime Awareness Session in collaboration with South Wales Police to further our work on creating an inclusive environment and to align with our requirements under the All-Wales Anti-Racist Action Plan.
- We launched our new EDI Learning Forum to help strengthen and embed EDI within our organisation covering topics such as Anti-Racism, Neurodiversity in the workplace, Cultural Awareness in Healthcare and Inclusive Recruitment, among others.

- Began delivering sexual safety training. This bespoke training aims to improve respectful behaviour at work in relation to sexual safety and build confidence to bystanders to report incidents through CTM's multiple reporting routes. 92% of participants reported an increase in confidence to challenge inappropriate behaviour. We have also seen a correlation in the reduction in escalated complaints, and the training has been shortlisted as a finalist for an 'Excellence in Organisational Development' award by Healthcare People Management Association.
- Introduced mandatory Anti-Racism e-learning for all staff to support our commitment to creating a fairer, more inclusive workplace and improve understanding of racism and anti-racist behaviours. As of 31st March 2026, staff compliance was 85.81%.
- Launched Ignite: Managers Essentials, a new management development programme designed to support managers with key aspects of people management, including honest and challenging conversations, performance and development reviews (PDRs), and attendance management. Equality, diversity and inclusion have been embedded throughout the programme, and demand has been strong, with some sessions already fully booked into 2026 and additional dates under consideration.



- Supported Welsh language inclusion through recruitment workshops for managers and launched free Welsh language taster sessions, creating additional opportunities for staff to develop confidence in using Welsh in the workplace and supporting our commitment to Welsh language inclusion.
- Introduced a new workplace breastfeeding procedure, providing paid breaks, private spaces, flexible working arrangements and ongoing support for breastfeeding staff.
- Worked with the ACCESS Disability Network and Recruitment and Retention Leads to explore disability-related barriers to recruitment and career progression, helping to shape more inclusive workforce practices.
- Celebrated Disability History Month and promoted ACCESS, CTM's Disability Network, helping to raise awareness of disability, improve understanding of workplace barriers and support accessibility across the organisation.
- Celebrated Black History Month 2025 under the theme 'Standing Firm in Power and Pride', promoting awareness, reflection and learning through sessions exploring Black identity, health inequalities, inclusive leadership and lived experience, while recognising the contributions and achievements of Black communities.

Cultural Competence

In continuation of previous years' work, three CTM teams have completed and achieved awards through the Diverse Cymru Cultural Competence Certification

scheme. Corporate Nursing, People's Experience Team, and People Services and Organisational Development all teams achieved a Silver Award.

One of our award winners said

"By embedding cultural awareness, recognising diverse identities and addressing communication and access barriers, we enhance trust, dignity and emotional safety. This culturally informed approach improves wellbeing, reduces harm and ensures equitable, person-centred care for patients, families and communities."

Lateral Moves Scheme Expansion

The workforce lateral moves scheme has expanded from Band 6 Nurses to include Band 4 Healthcare Support Workers, supporting individuals to gain additional experience in other teams and develop skills to support progression.

This scheme has also begun capturing demographic information, to ensure equal opportunity to all our staff groups, and has so far found that:

- 16% of participants are in an ethnic minority, slightly higher than CTM staffing overall, but highlighting equal access and usage of the scheme
- 10% of colleagues who successfully completed a lateral move through the scheme have subsequently achieved a promotion, demonstrating the scheme's potential to support career development and progression opportunities.

Welsh at CTM and Recruitment

In April 2025, our Welsh Language Lead and our Recruitment and attraction lead co-led a series of sessions around attracting quality candidates during recruitment and meeting our Welsh Language Standards. This included a section on inclusive recruitment and developed and led by our EDI department. Further sessions to expand on this work and to progress inclusive recruitment have been scheduled.

One of the requirements under the Welsh language standards is to *promote and encourage* the use of Welsh at work. Part of our commitment on this is the attraction and retention of high quality, Welsh speaking staff to roles within the Health Board. All job specifications and job adverts are now crafted with the advice and guidance of our Welsh Language team to ensure they are compliant with the Welsh Language standards, and Welsh at skill level 3 is now listed as desirable in all job applications above a certain banding. This means applicants who apply with the relevant essential skills and have the required Welsh language skills are more likely to be shortlisted for roles, and subsequently our Welsh-speaking patients have a higher chance of being able to receive their care in their preferred language.

New Breastfeeding and Expressing Milk in the Workplace procedure

To mark World Breastfeeding week 2025, CTMUHB launched a new procedure for breastfeeding and expressing milk in the workplace. This procedure reflects our commitment to creating an inclusive, family-friendly environment, where our staff are supported in their infant feeding choices.

The procedure is part of our suite of enhanced family-friendly policies for CTMUHB staff and includes; Paid breaks for breastfeeding or expressing milk, Private, comfortable spaces (not toilets) with suitable facilities. Flexible working arrangements and adjustments to duties. Ongoing support from managers, including risk assessments and no time limit – support continues for as long as needed. Breastfeeding and expressing milk are a protected right and employers have an obligation to provide facilities to do this comfortably and safely. We want our staff to feel that their work and family life are balanced and integrated and to support them in their individual feeding journey.

Working parents who breastfeed or express milk can continue to do so for as long as they wish to and will be fully supported and given the flexibility to do so in a dignified, safe way that works for them. We will continue to review this procedure and seek feedback from staff around any changes that may need to be made.

HEIW Stepping into Leadership Programme:

This programme helps address the lack of representation of Black, Asian and minority ethnic staff in senior and executive leadership roles across NHS Wales. It focuses on supporting individuals who have the potential to progress but may face barriers that make it harder to reach these positions. Participants report increased confidence, a stronger leadership presence, and enhanced self-awareness, supporting their readiness to progress. The programme is designed to enable participants to apply their learning to real organisational priorities while developing their leadership capability.

CTMUHB aims to build on this by engaging participants in strategic initiatives, providing exposure to senior leadership environments, and supporting inclusive progression pathways.

EDI Learning Forum

In October 2025 we launched our EDI learning Forum. These monthly, one-hour sessions are guided learning opportunities with our EDI practitioner on a range of inclusion topics. Subjects have included Hate-crime awareness, LGBTQ+ informed healthcare, Neurodiversity in the Workplace, Cultural Awareness in Healthcare and Anti-Racism training; which is one of our requirements under the All-Wales Anti-Racist action plan.

All sessions were well attended and feedback has been positive. One attendee of the Neurodiversity in the Workplace session said, *"There was a refreshing focus on the positives neurodivergent colleagues can bring rather than the things they may struggle with."*

Each session focuses on one aspect of culture or inclusion and provides our staff with the opportunity to develop their knowledge and learn practical ways they can embed EDI in their day-to-day practice.

Providing a confidential, learning focused space allows staff to explore different areas of EDI and ask questions they may feel unable or unwilling to ask in other professional environments. The additional resources and practical advice given can impact patients and staff experiences and ensure everyone is treated with respect. This can lead to better patient outcomes, less complaints, better working environments, stronger team cultures and increased staff retention.

Community

Cohesive diversity in the valleys event

Once again, REN in collaboration with VEMS (Valleys Ethnic Minorities) hosted a cohesive diversity in the valleys event. Every year VEMS and our REN staff network organise a social event to bring members of our ethnic minority communities together and to foster closer relationships between these communities and the health board. Evidence shows that BAME patients have generally worse health outcomes and wait longer to access treatment and support. These events aim to encourage these underserved communities to have closer ties to the health board and routine and preventative care. Developing closer relationships with our ethnic minority communities not only encourages them to seek access to healthcare but it gives us the opportunity to understand the challenges these communities face and what they need from us. It allows us to work with the leaders of these communities and to make real, informed changes that have a direct impact on intersectionality, cohesion, culture and health outcomes.

Community Leaders' Network

The Community Leaders' Network is a multi-organisation project dedicated to improving financial, health and housing outcomes for pensioners in CTM. We know that our older patients find it more difficult to navigate newer digital systems and to access social media so they can risk missing out on vital support services and financial assistance. The Community Leaders' Network aims to work within the community to bridge the gap to these services for the older members of our community. Targeted support around pension credit and vaccinations, among other initiatives, help more pensioners retain their winter fuel allowance and receive lifesaving vaccinations against flu and other respiratory viruses.

Turning Ponty Blue

This five-day event arranged in partnership with RCT council and the dementia friendly Pontypridd steering group aims to raise awareness of dementia, encourage conversations and community spirit. Very often people with dementia and carers find they socialise less; they give up hobbies and things that are important to them. Turning Ponty Blue gives them the opportunity to connect with each other, make new friends, find additional support and contributes to building a dementia-friendly society within RCT. We aim to gather real-life insights and experiences that will shape future resources and support systems — helping individuals, organisations, and neighbourhoods better support people with dementia in all areas of life.

Warmer Homes

People in poverty often must make difficult choices especially in winter months. The choice between food and heating is a common one for some families. Lack of access to adequate heating throughout the winter months is linked directly to increased hospital admissions, long periods of illness and deaths. Providing families with additional financial support during the winter months means they can afford to keep their homes heated and reduces the risks of hospitalisation and preventable deaths. Initial evaluation of the multi-partner warmer homes innovation sprint to outreach to vulnerable individuals across CTM and support with income maximisation. A total of 1800 individuals were supported to claim approximately £2.5m in additional income that they were entitled to but not accessing. This has been delivered in collaboration with local authority, third sector and registered social landlords (RSL) partners and has helped support some of the region's most vulnerable. CTM is now supporting other health boards to take a similar approach at the request of Welsh Government.

Pride Cymru

CTM attended Pride Cymru as part of the wider NHS Wales participation. Education and awareness are a vital part of understanding the individual challenges members of our LGBTQ+ communities face. It helps us to offer support when needed and to provide gender informed and inclusive healthcare. By celebrating Pride month, we provide further support and visibility to this underserved community.



Project SEARCH

Project SEARCH is our award-winning partnership programme dedicated to empowering individuals with learning difficulties and/or autism through education and employment. This allows participants to gain valuable work experience along with life skills and to obtain a qualification, which can improve their chances of finding employment either within CTMUHB or in other organisations. This year Project Search provided supported internships to a further 13 candidates, following which 10 of them have gone on to employment or volunteer roles and 3 are actively job seeking. We will continue to provide supported internships and work towards expanding the number of apprentices we take on and the partner organisations we work with.



Infrastructure

Update on Llantrisant Health Park

Llantrisant Health Park (LHP) represents a significant investment in modern NHS infrastructure, bringing together Cwm Taf Morgannwg, Cardiff and Vale, and Aneurin Bevan University Health Boards. It will improve access to diagnostic services and planned care across South-East Wales, enabling shared use of specialist staff and resources and more consistent standards of care in response to growing demand.

In last year's Annual Equality Report, we promised to share updates on the project's progress. During 2025/26, the project reached a significant milestone with Welsh Government approval of Phase 1. Before construction could begin, the former British Airways buildings occupying the site were demolished, marking a major step in preparing the land for development. Phase 1 includes a Regional Diagnostic Hub providing CT, MRI and endoscopy services, helping to expand diagnostic capacity across the region and supporting efforts to reduce waiting times for patients. The Health Park is being designed to meet future population needs and to promote equitable access to care. Inclusive features, including single-sex and gender-neutral spaces, have been built into the design to support a positive experience for all patients, visitors and staff.

Equality and Welsh Language Impact Assessments (EWLIAs)

EWLIAs are the method for determining if policies, processes, service changes and more affect groups (including those with protected characteristics), how and to what extent. These impact assessments are completed alongside the writing and planning process to ensure all proposed policies and/or changes are made with for everyone and to inform decision-making from the outset. This reduces the chances

of any group being disadvantaged because of decisions we make, and/or ensure we identify and enact appropriate mitigations.

This year we intentionally improved the governance of EWLIAs, including being much clearer on the requirement for undertaking them. We have almost doubled the number completed in the previous year and have begun reviewing all our existing policies to ensure they are compliant. We have developed support sessions for colleagues leading EWLIAs, designed and delivered in collaboration and codesigned by the Welsh Language Development Service, and simplified the systems and processes supporting them

As part of our commitment to make sure Equality, diversity and inclusion are essential to the way we operate, there has been work this year to embed the Socio-Economic Duty into our decision-making processes. As part of this, it has been included in our Equality and Welsh Language Impact Assessment process

The newly created governance structure and processes will come into force in 2026/27 and ensure greater oversight and usage of EWLIAs.



Wellbeing Garden for Autistic People

This new space has an aim of improving the wellbeing of autistic adults through nature-based therapy. The five-session programme aims to build confidence, community, and wellbeing through meaningful connection with nature.

Governance

Throughout this year, we have created and embedded a new governance structure for overseeing our Strategic Equality Plan and its activities. This includes strengthened organisational oversight, accountability and monitoring. Not only does this provide further opportunities for including EDI work at senior, strategic and executive levels, but provides additional confidence in the direction of work and actions being undertaken through our equality work. Through this, equality work has become more of a responsibility embedded in all workstreams, rather than an isolated body of work. This is highlighted in this report, which continues to become less focused on workforce, and more on our service users, communities and the outcomes of our work.

Conclusion and Forward Look

There have been many strengths and activities across all pillars of the 2025/26 reporting year, including some achievements against the aims set out in our previous report. Our engagement with communities and stakeholders has been strengthened and is more widely represented in this year's activity and report. We have invested in further developing EDI knowledge and awareness and continued to identify and enact opportunities to better embed EDI throughout governance and decision making.

Important areas of focus this coming year will be:

- Preparing and publishing our first Gender Pay Gap Report and Menopause Action Plan.
- Strengthening communication, engagement and partnership working with staff, communities and stakeholders to support meaningful involvement in decision-making and service improvement.
- Embedding Equality and Welsh Language Impact Assessments (EWLIAs) consistently across policy development, service change and organisational decision-making.
- Expanding equality, diversity and inclusion learning and development opportunities to increase confidence, capability and understanding across the organisation.
- Improving access to translation and interpretation services to support equitable access to healthcare and improve patient experience.
- Embedding inclusive recruitment practices and targeted development opportunities to address inequitable outcomes for minoritised and underrepresented staff groups, particularly in relation to progression into senior and executive leadership positions.
- Supporting the development and progression of underrepresented groups through targeted development opportunities and evidence-informed interventions.
- Increasing the routine use of equality data, evidence and outcome measures to inform decision-making, monitor progress and target improvement activity.
- Strengthening governance, accountability and leadership oversight of EDI activity, ensuring clear ownership of actions and effective assurance arrangements.
- Establishing measurable baselines and monitoring arrangements to demonstrate progress and achieve tangible reductions in inequalities experienced by our staff and communities.

Through these priorities, we will continue to strengthen how equality, diversity and inclusion are embedded across the Health Board. Focus will be placed on improving inclusive recruitment and progression outcomes, reducing the Gender Pay Gap, strengthening engagement with staff and communities, and ensuring that EDI activity is increasingly informed by robust data, evidence and measurable outcomes.

We will continue to strengthen partnerships with our staff networks, patient-facing teams, community organisations, Public Health and other stakeholders to ensure

that lived experience helps shape decision-making and service improvement. In addition, further governance arrangements will be introduced to support the consistent use of Equality and Welsh Language Impact Assessments within strategic decisions, policy development and organisational change.

During 2026/27, we will also continue to develop our approach to workforce equality through implementation of the Workforce Equality Standard (WES), while maintaining our strong collaboration with NHS Wales organisations and Welsh Government. By strengthening accountability, improving assurance arrangements and focusing on measurable impact, we aim to deliver meaningful and sustainable improvements for our staff, patients and communities.

Acknowledgements

We would like to acknowledge and thank all our staff at Cwm Taf Morgannwg University Health Board, including our Staff networks, Communications team, Executive team, Board members, Public Health, Estates and Nursing Teams and our Services for their hard work and ongoing dedication. We would also like to extend a special thanks to Diverse Cymru, our Trade Union partners and our wider colleagues across NHS Wales for their continued support.

Useful Links

Strategic Equality Plan 2024 – 2028

CTM2030

Anti-Racist Wales Action Plan

People Plan 2025-2030

Contact Us

CTM_Equality@wales.nhs.uk

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Cymraeg

Mae'r ddogfen / ffurflen hon hefyd ar gael yn Gymraeg.
This document / form is also available in Welsh.



CTMUHB Public Board

Update to Scheme of Delegation

Eitem yr Agenda / Agenda Item	8.1.4
Dyddiad y Cyfarfod / Date of Meeting:	26 November 2026
Statws Cyhoeddi / Publication Status:	Open/Public. Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Owen James – Head of Corporate Finance
Cyflwynydd yr Adroddiad / Report Presenter:	Sally May – Executive Director of Finance
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Sally May, Executive Director of Finance
Diben yr Adroddiad / Report Purpose:	For Approval
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	For APPROVAL
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol* *Strategic Context:* *This report aligns to the following Strategic Pillars*	Not applicable If more than one applies please list below:
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan *(Reference relevant priority)*	Not applicable

Crynodeb Gweithredol o'r hyn y mae'r adroddiad yn ei ddisgrifio:
Dechreuwch drwy grynhoi'r wybodaeth bwysicaf yn fyr. Dylai hyn roi dealltwriaeth gadarn o'r pwyntiau allweddol yn erbyn y 3 phennawd canlynol heb ddarllen yr adroddiad llawn:

Executive Summary of what the report is describing:
Start by summarising briefly the most critical information. This should provide a firm grasp of the key points against the following 3 headings without reading the full report:

Beth *(crynodeb o'r sefyllfa / mater cyfredol a pham ei fod yn bwysig a thystiolaeth i gefnogi'r safbwynt hwnnw ac ati)* What *(summary of current position / issue & why it matters and evidence to support that position etc)*	The SoD has been updated in Section 12. Capital Investment, fixed asset registers and security assets. Updates to SoD require approval from the board. The changes to the SoD are detailed in Appendix 1 which includes track changes to be approved. The requested changes have been taken through Audit, Risk & Assurance Committee for review and have been endorsed for approval by the Board.
Felly, beth *(darparu dadansoddiad ystyrlon gan dynnu allan, fel y bo'n briodol, oblygiadau yn erbyn Strategaeth / Cynlluniau Cyflawni / risgiau Strategol neu Reoleiddiol CTMUHB ac ati ac unrhyw opsiynau ar gyfer mynd i'r afael â'r rhain)* So, what *(provide meaningful analysis drawing out as appropriate implications against CTMUHB Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)*	The changes are an update to titles, Committee names, and limits for variations to Capital Orders. The changes have followed an audit recommendation for an update to capital procedures which requires a change in limits. This has been discussed with Director of Finance and endorsed for approval by Audit, Risk & Assurance Committee.
Beth Nesaf *(crynodeb o'r camau gweithredu a fwriadwyd a'r manteision sy'n cefnogi'r dewisiadau a'r argymhelliad(au) sy'n cael eu gwneud)* What Next *(summary of intended action and benefits supporting the choices and recommendation(s)being made)*	Once this has been approved the SoD will be updated and put on the Sharepoint intranet and shared with appropriate officers.

Argymhelliad *(Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).* Recommendation (Linked to the "What Next" section above).	The Board is asked to Approve the update to the Scheme of Delegation.

1. Background / Context

As per the Standing Financial Instructions and Standing Orders changes to the Scheme of Delegation are to be approved by the Board

2. Strategic Insights

Scheme of Delegation (SoD)

Section 12 - Capital investment, fixed asset registers and security of assets includes updates to the SoD and Appendix 1 and 2 includes track changes to the SoD.

Appendix 1 - Amended Scheme of delegation – schedule 2.1

Appendix 2 - Request Changes to the Scheme of delegation

3. Risks and Opportunities

3.1 No matters for escalation.

4. Compliance and Governance

4.1 This report satisfies the requirements of the Standing Orders in relation to the update and approval of Scheme of Delegation

5. Conclusion

5.1 Board to approve the amendments to schedule 2.1 of the Scheme of delegation

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)* Link to Strategic Risk(s) on the Board Assurance Framework (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	Strategic Risk 9 Financial Sustainability (Revenue) If more than one applies please list below:

Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant /	Not Applicable

Link to Wellbeing of Future Generations Act – Wellbeing Goals	If more than one applies please list below:

Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Whole-Systems Perspective
	If more than one applies please list below:

Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Asesiad Effaith Impact Assessment		
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg *(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)* Equality & Welsh Language Impact Assessment Outcome *(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)*	Outcome for Equality (delete as appropriate): NEUTRAL Summary of impact: Outcome for Welsh Language (delete as appropriate): NEUTRAL Summary of impact:	If no, please select a reason below. Choose an item. Named Executive/Board member sign off for no EWLIA completion:
Canlyniad Asesiad Effaith Ansawdd *(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)* Quality Impact Assessment Outcome *(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)*	Not applicable	
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report	
Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact	There is no direct impact on resources as a result of the activity outlined in this report	

(People / Financial)	

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
SoD	Scheme of Delegation

Cwm Taf Morgannwg

UHB – Additional delegations linked to the SFIs

Cwm Taf Morgannwg UHB – Additional delegations linked to the SFIs

Version 21

SCHEME OF DELEGATION – VERSION CONTROL

Version		Date
18	Audit Committee January 2022 - Amendments to Section 14 B2 Disposals and Condemnations, Losses and Special Payments. Amendments to Section 11 Non Pay Expenditure Final Pay Controls	15/02/2022
18	OJEU Limits/ Threshold for Section 11 Non Pay Expenditure OJEU Threshold 2022 limits	22/02/2022
19	Audit & Risk Committee August 2022 – Amendments to various sections following new delivery model	22/08/2022
20	Amendment to delegations of the 'Waivers or exemptions to tender rules' in Section 11 and approval of compensation payments in Section 14	25/01/2024
21	Amendment to delegations for 'Individual Continuing Health Care Placement / Packages' in Section 9	15/08/2024

Introduction
The Standing Orders (SOs) and Standing Financial Instructions (SFIs) specify key responsibilities of the Chief Executive, Director of Finance and other Officers.

The Chief Executive's Job Description, together with their Accountable Officer Memorandum, sets out their specific responsibilities. Individual Job Descriptions determined for Director level posts also define in detail the specific responsibilities assigned to those post holders.

The SOs, together with its schedule of delegations, and the financial delegations set out in the SFIs form the basis of the Health Board's Scheme of Delegation to Officers.

This Schedule of additional delegations identifies those specific areas within the SFIs which require additional delegations from the Chief Executive, the Director of Finance and other Officers.

This Schedule should not be read in isolation and needs to be used alongside the full SFIs available via SharePoint.

A general principle to note is that, for automated processes, a Director may further delegate to a deputy during periods of absence although they will still retain responsibility for the delegation. Manual processes can only be delegated upwards (except for legal claims settlement where the Executive Director of Nursing may delegate to a deputy – see page 37).

The implementation of the new delivery model in August 2022, moved away from Locality Groups to Care Groups, this Scheme of Delegation provides an update to reflect the new Care Group Delivery Model.

Cwm Taf Morgannwg UHB – Additional delegations linked to the SFIs

Version 21

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Cwm Taf Morgannwg UHB – Additional delegations linked to the SFIs

Version 21

1. General

Ref	SFI requirement	SFI Ref.	SFI responsibility	Authority Delegated to
A	The Director of Finance is responsible for ensuring an ongoing training and communication programme is in place to affect these SFIs.	2.3.2	Director of Finance	All Heads of Finance
B	Ensure that any contractor or employee of a contractor who is empowered by the UHB to commit the UHB to expenditure or who is authorised to obtain income shall be covered by the SFIs	2.5.1	CEO	Care Group Service Directors, Deputy COO, Relevant Board Director

2. Audit, Fraud & Corruption, and Security Management

Ref	SFI requirement	SFI Ref.	SFI responsibility	Authority Delegated to
A	Ensuring there are arrangements in place to review, evaluate and report on the effectiveness of internal financial control, including the establishment of an effective Internal Audit function.	3.2.1	CEO	Board Secretary
B	Monitor and ensure compliance with Directions issued by the Welsh Ministers on NHS security management. Controlling and co-ordinating security.	3.6.1 3.6.2	CEO CEO	Assistant Director of Facilities Support Services Assistant Director of Facilities Support Services

3. Allocations and Financial Duty

Ref	SFI requirement	SFI Ref.	SFI responsibility	Authority Delegated to
A	Prior to the start of each financial year submit to the Board for approval a report showing the total allocations received, assumed in-year adjustments and their proposed distribution including any sums to be held in reserve Ensure that any ring-fenced or non-discretionary allocations are disbursed in accordance with Welsh Ministers' requirements; Periodically review any assumed in-year allocations to ensure that these are reasonable and realistic; and Regularly update the Board on significant changes to the initial allocation and the application of such funds.	4.0.2	Director of Finance	No delegation

4. Budgetary Control

Ref	SFI requirement	SFI Ref.	SFI responsibility	Authority Delegated to
A	Prepare and submit budgets for approval and delegation by the Board. Monitor financial performance against budget and plans and report the current and forecast position on a monthly basis and at every Board meeting. Any significant variances should be reported to UHB members as soon as they come to light and the Board shall be advised on any action to be taken in respect of such variances.	6.1.1 6.1.2	Director of Finance Director of Finance	No Delegation
B	All budget holders are required to sign up to their allocated budgets at the start of the financial year.	6.1.4	Budget holders	Formal sign off required at Care Group level - See B1 below

		Delegated to:	Signed off by:
B1	Delegation of the management of defined Revenue budgets to budget holders: i. Revenue budgets for Care Group Directors and Group Service Director ii. Revenue budgets for Corporate directorates iii. Reserves	i. Budget Holders ii. Budget Holders iii. Deputy DOF	i. Deputy COOs, Care Group Service Directors, Clinical Service Group Managers ii. Corporate Directors and Assistant Directors

Cwm Taf Morgannwg UHB – Additional delegations linked to the SFIs

Version 21

Ref	SFI requirement	SFI Ref.	SFI responsibility	Authority Delegated to
C	Ensure that appropriate and timely financial information is provided to budget holders and that adequate training is delivered on an on-going basis to assist budget holders managing their budgets successfully.	6.1.5	Director of Finance	Heads of Finance (for Non Care Groups)Assistant Directors of Finance (for Care Groups)
D	Delegation of the management of a budget to permit the performance of a defined range of activities (including pooled budgets)	6.2.1	CEO	Revenue budget - Director of Finance (See B1) Capital budget – Director of Finance
E	Delegation to include the authority to exercise virement and budget transfers	6.2.1	CEO	See E1 below

E1-Approval of variation of budgets, including authority to vire

Delegated Authority	Between budget lines	Capital to revenue *& vice versa*
Within a department	Budget manager plus line manager	Not allowed
Within a directorate; between departments	Clinical Service Group Manager	
Between Clinical Service Groups	Both Clinical Service Group Managers	
Budget transfers between Reserves and Delegated budgets	Deputy Director of Finance	

Cwm Taf Morgannwg UHB – Additional delegations linked to the SFIs

Version 21

Ref	SFI requirement	SFI Ref.	SFI responsibility	Authority Delegated to
F	Devise and maintain systems of budgetary control.	6.3.1	Director of Finance	Heads of Finance (for Non Care Groups) Assistant Directors of Finance (for Care Groups)
G	The Chief Executive is responsible for identifying and implementing cost and efficiency improvements and income generation initiatives in accordance with the requirements of the Medium Term Financial Plans.	6.3.3	CEO	Executive Directors
H	All monitoring returns must be supported by a detailed commentary signed by the Director of Finance and Chief Executive. This commentary should also highlight and quantify any significant risks with an assessment of the impact and likelihood of these risks	6.5.2	CEO and Director of Finance	No Delegation

5. Annual Accounts and Reports

Ref	SFI requirement	SFI Ref.	SFI responsibility	Authority Delegated to
A	Ensuring that financial reports and returns are prepared in accordance with the accounting policies and guidance determined by the Welsh Ministers and the Treasury and consistent with International Financial Reporting Standards.	7.0.3	Director of Finance	No Delegation
B	The UHB will publish an annual report, in accordance with guidelines on local accountability, and present it at its Annual General Meeting. The document will comply with the Welsh Government's Manual for Accounts.	7.0.5	Board	Director of Governance/Board Secretary

6. Banking arrangements

Ref	SFI requirement	SFI Ref	SFI responsibility	Authority delegated to
A	Ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made	9.2.1	Director of Finance	Head of Corporate Finance
B	The Director of Finance will prepare detailed instructions on the operation of bank accounts which must include: i. The conditions under which bank accounts is to be operated ii. Those authorised to sign cheques or other orders drawn on the UHB accounts	9.3.1	Director of Finance	i. Head of Corporate Finance ii. See B1 below

B1	**Day to day operation of bank accounts:** i. maintain list of approved signatories for manual payments ii. approval to authorize automated payments: •accounts payable[1] •payroll •primary care contractors iii. maintain list of bankline authorisers and users for internet banking transactions	i. Head of Corporate Finance ii. NHSWSSP Iii Head of Corporate Finance

[1]after confirmation from Head of Corporate Finance that sufficient funds are available in the bank account

7. Income, fees and charges and security of cash, cheques and other negotiable instruments

Ref	SFI requirement	SFI Ref	SFI responsibility	Authority Delegated to
A	**Income Systems**. Designing and maintaining procedures to ensure compliance with systems for the proper recording, invoicing, and collection and coding of all monies due. Ensuring that systems are in place for the prompt banking of all monies received. (i) General Offices in Hospitals (ii) Other Locations	10.2.1	Director of Finance Director of Finance	Head of Corporate Finance i. Assistant Director of Facilities Support Services ii. Heads of Department
B	**Fees and Charges**- Approving and regularly reviewing the level of all fees and charges , other than those determined by the Welsh ministers or by statute	10.3.1	Director of Finance	See below

	Fees and Charges:	Authority Delegated to
B1	**Long Term Agreements with other NHS bodies** i. Approval and Signing of the Long Term Agreement ii. Variations to the Agreement	i. Annual value up to £10m -Director of Finance Annual value over £10m- Chief Executive ii. Up to £200,000- Director of Finance Over £200,000 – Chief Executive

B2	**Service Level Agreements – NHS and Non NHS** Agreement to provide services with an annual value: i. up to £50,000 ii. £50,000 to £100,000 iii. Over £100, 000	i. Clinical Service Group Manager and Head of Finance (Non Care Groups), Assistant Directors of Finance (Care Groups) ii. Care Group Service Director and Deputy Director of Finance iii. Deputy Chief Operating Officer, Relevant Director and Director of Finance
B3	**Individual NHS patient treatment charges outside of LTAs and SLAs** Agreement to provide treatment: i. up to £5,000 ii. between £5,000 and £25,000 iii. over £25,000	i. Finance Manager – Commissioning & Contracting ii. Head of Finance – Financial Planning & Reporting iii. Deputy Director of Finance
B4	**Private Patients and overseas patients without reciprocal agreements** i. pricing policy and price structure ii. payment policy, including use of deposits, income guarantees, arrangements with insurance companies	i. Director of Finance ii. Director of Finance

B5	**Commercial sponsorship offers (including funding contributions for staff & non staff costs)** Agreement to receive commercial sponsorship or funding: i. up to £50,000 ii. £50,000 to £100,000 iii. Over £100, 000	i. Clinical Service Group Manager and Head of Finance (Non Care Groups) or Assistant Directors of Finance (Care Groups) ii. Care Group Service Director / Deputy COO and Deputy Director of Finance
B6	**Approval of concession arrangements**	Director of Finance
B7	**Commercial and non-commercial research projects and trials** Agreement to receive funding: i. up to £50,000 ii. £50,000 to £100,000 iii. Over £100, 000	i. Clinical Service Group Manager and Head of Finance responsible for Research plus Assistant Director for R&D ii. Relevant Board Director and Deputy Director of Finance plus Assistant Director for R&D iii. Relevant Executive Director and Director of Finance plus Assistant Director for R&D
B8	**Agreements for non patient care fees and charges (e.g. tenancy agreements rents, licenses)** Agreement to enter into agreements based on total annual income: i. up to £50,000 ii. £50,000 to £100,000 iii. Over £100,000	i. Clinical Service Group Manager and Head of Finance (Non Care Groups) /Assistant Directors of Finance (Care Groups) ii. Care Group Service Director/Deputy COO and Deputy Director of Finance iii. Relevant Executive Director and Director of Finance

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Ref	SFI requirement	SFI Ref	SFI responsibility	Authority Delegated to
C	**Debt recovery-** (i) Appropriate recovery action on all outstanding debts. (ii) Ensuring the Welsh Ministers' guidance on disputed debt arbitration is strictly adhered to.	10.4.1 10.4.4	Director of Finance Chief Executive & Director of Finance	Head of Corporate Finance Deputy Director of Finance
D	**Security of cash, cheques and other negotiable instruments-** Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable, and establishing systems and procedures for handling cash and negotiable securities on behalf of the UHB. The provision of adequate facilities and systems for officers whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;	10.5.1	Director of Finance	Head of Corporate Finance Assistant Director of Facilities Support Services/ Heads of Departments

8. Grant funding, procurement and contracts for goods and services

Ref	SFI requirement	SFI Ref.	SFI responsibility	Authority Delegated to
A	Maintaining detailed policies and procedures for all aspects of grant funding- i.e. awarding of grants	11.1	CEO	Director of Finance
B	Maintaining detailed policies and procedures for procurement, tendering and contracting	11.4.2	CEO	Director of Finance
C	All contracts exceeding the delegated limit[1], all acquisitions and disposals of land of any limit, and the acceptance of gifts of property, must receive the written approval of the Welsh Ministers before being entered into. (i) Contracts (ii) Acquisition and disposals of land, and acceptance of gifts of property	11.9.5	Board	(i) Director of Finance (ii) Director of Finance
D	**Procurement Thresholds** Minimum thresholds for quotes and competitive tendering arrangements	11.10	Director of Finance	Section 11C below
E	**Contract Management.** The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the UHB so as to ensure that obligations on delivery of business and operational objectives, and achieving value for money, are met	11.12.1	CEO	Executive Directors

[1]Current delegated limit for contracts before requiring Ministerial approval is £1m

9. Contracts for Health Care Services

Ref	SFI requirement	SFI Ref	SFI responsibility	Authority Delegated to
A	The CEO is responsible for ensuring the UHB enters into suitable Health Care Agreements or individual patient commissioning agreements where appropriate.	12.1	CEO	See A1 – A12 below
B	The Chief Executive will need to ensure that regular reports are provided to the Board detailing performance and associated financial implications of all Health Care Agreements	12.3	CEO	i. Director of Finance ii. Director of Planning & Performance

	Agreements for the purchase of services	Authority delegated to
A1	**Long Term Agreements with other NHS bodies** i. Approval and Signing of the Long Term Agreement ii. Variations to the Agreement	i. Annual value up to £10m -Director of Finance Annual value over £10m- Chief Executive ii. Up to £200,000- Director of Finance Over £200,000 – Chief Executive
A2	**Service Level Agreements - NHS** Agreement to purchase services with an annual value: i. up to £50,000 ii. £50,000 to £100,000 iii. Over £100,000	i. Clinical Service Group Manager and Head of Finance /Assistant Directors of Finance ii. Care Group Service Director and Deputy Director of Finance iii. Deputy COO, Relevant Director and Director of Finance

**For the purpose of the Scheme of Delegation, Executive Director refers to the post holder who has budget responsibility delegated by the CEO.

A3	**Grant funding agreements** Agreement to give a grant with a total value: i. up to £5,000 ii. £5,000 to £25,000 iii. Over £25,000	i. Clinical Service Group Manager and Head of Finance /Assistant Directors of Finance ii. Care Group Service Director and Deputy Director of Finance iii. Deputy COO, Relevant Director and Director of Finance
A4	**Individual Continuing Healthcare Placements /Packages** Authorisation of individual placements/packages following recommendation from the CHC Panel : i. Annual value up to £50,000 ii. Annual value up to £150,000 iii. Annual Value over £150,000 iv. Agreement of Changes to annual standard rates	i. Chair of CHC Panel ii. Relevant Executive Director / Nurse Director for Placements iii. Chief Executive and Director of Finance iv. Director of Nursing & Director of Finance
A5	**NHS Funded Nursing Care (FNC)** i. Authorisation of individual placements/packages following recommendation from a Nurse Assessor ii. Agreement of changes to annual standard rates	i. FNC Coordinator ii.Director of Nursing & Director of Finance

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A6	**Individual Patient Commissioning Agreements – NHS Providers and non NHS providers** Authorisation of individual agreements following recommendation from the IPC Panel: i. Annual value up to £50,000 ii. Annual value over £50,000	i. Director of Public Health ii. Chief Executive or Director of Finance
A7	**Primary Care Contracts – General Medical Services (excluding enhanced services)** i. Approval and Signing of the GMS contracts with practices ii. Variations to the Agreement iii. Payments under the contracts	i. Deputy COO ii. Deputy COO iii. Delegated to NHSWSSP
A8	**Primary Care Contracts – General Medical Services (Enhanced services)** i. Approval and Signing of agreements to provide Enhanced services ii. Variations to the Agreement iii. Payments under the Agreements	i. Deputy COO ii. Deputy COO iii. Delegated to NHSWSSP
A9	**Primary Care Contracts – General Dental Services** i. Approval and Signing of the GDS contracts with practices ii. Amendments to the Agreement iii. Payments under the contracts	i. Deputy COO ii. Deputy COO iii. Delegated to NHSWSSP
A10	**Primary Care Contracts – Pharmaceutical Services (including enhanced and advanced services)** i. Payments under the contracts or enhanced service agreements ii. Approval and signing of agreements to provide enhanced services	i. Delegated to NHSWWP ii. Director with responsibility for Medicines Management

A11	**Primary Care Contracts – General Ophthalmic Services** i. Payments under the contracts or enhanced service agreements ii. Approval and signing of agreements to provide enhanced services	i. Delegated to NHSWWP ii. Deputy COO
A12	**Providing services jointly with Local authorities under Section 32 and 33 of NHS (Wales) Act 2006.** i. Approval and Signing of the pooled budget arrangements ii. Amendments to the Agreement	i. Relevant Director and Director of Finance ii. Relevant Director and Director of Finance

10. Pay expenditure

Ref	SFI requirement	SFI Ref.	SFI responsibility	Authority Delegated to
A	The funded establishment of any department may not be varied without the approval of the Chief Executive or an officers with delegated authority (provided that the change in funded establishment is in line with the virement of budget approver under 4E)	13.2.2	CEO	Director of Finance
B	No Board member or UHB official may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration outside the limit of their approved budget and funded establishment unless authorised to do so by the Chief Executive.	13.3.1	CEO	Director of Finance

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	New Appointments, Bank and agency costs	**Delegated Approval / Sign Off by:**
B1	Employment of all fixed term and permanent staff – except medical consultants	VR form signed by Clinical Service Group Managers and Finance lead prior to submission to VCP
B2	Employment of fixed term and permanent staff (subject to any vacancy review policy in place)- Medical consultants only	VR form signed by Directorate manager and Finance lead prior to submission to Executive Catch up Meeting
B3	Nursing bank and On contract agency	Ward Manager
B4	Nursing agency Off contract	Clinical Service Group Manager
B5	Medical agency - On Contract - Off Contract Engagements above price caps as determined by Welsh Government (On and Off Contract)	Clinical Service Group Manager Executive Director Medical Director
B6	Engage non-medical, non-payroll staff (subject to contracting and tax assurance rules):*	**Director of W&OD and Head of Procurement to confirm agreement on off contract hires prior to any commitment.**
	- Below **£10k** gross commitment	Clinical Service Group Manager

	- **£10k** to **£25k** gross commitment	Care Group Service Director / Deputy COO
	- **up to £100k gross commitment**	Board/Executive Directors
	- **> £100k gross commitment**	Director of Finance or Chief Executive

[1]Urgent Out of Hours request to be approved by the Executive Director on call

Ref	SFI requirement	SFI Ref.	SFI responsibility	Authority Delegated to
C	Procedures to be presented by the Chief Executive for Board approval for the determination of commencing pay rates, condition of service, etc, for employees in accordance with pay, terms and conditions set out in Agenda for Change and other pay review bodies	13.3.2	CEO	Director of Workforce & OD
D	The Director of Workforce and Organisational Development is responsible for securing the provision of an efficient, value for money payroll service.	13.4.1	Director of Workforce & OD	No delegation
E	(i) Ensuring that any shared or hosted service arrangement is supported by appropriate contract terms and conditions, adequate internal controls and audit review procedures; (ii) Ensuring a sound system of internal control and audit review of any internally provided payroll service;	13.4.2	CEO	(i) Director of Workforce & OD (ii) Director of Finance Head of Corporate Finance
F	Appropriately nominated managers have delegated responsibility for: (i) Submitting time records, and other notifications in accordance with agreed timetables; (ii) Completing time records and other notifications in accordance with the contract of Service Level Agreements; (iii) Submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement	13.4.3	CEO	See below

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	General Payroll Approvals	Delegated to
F1	Grant additional increments to staff (outside of Department of Health national T&C)	Director of Workforce and OD Noted at Remuneration Committee
F2	Electronic and paper timesheets and other reporting forms to confirm: • Non-attendance at work; • sickness and absence records; • overtime, unsocial hours and on call.	Line Managers (as determined by Clinical Service Group Managers or equivalent)
F3	Travel and subsistence claims (via e-expenses)	Line Manager
F4	Annual leave applications	Line Manager
F5	Applications for carry forward of annual leave to next year within A4C limits/Medical & Dental Handbook	Clinical Service Group Manager (or equivalent)
F6	Annual leave carry forward to next year in excess of A4C limits	Executive Director
F7	Buying additional annual leave	Care Group Service Director (or Corporate equivalent) / Deputy COO
F8	Study leave applications	Line Manager
F9	Salary Sacrifice Scheme applications	Assistant Director of Workforce and OD
F10	Specific benefits in kind i. Lease cars ii. Authorised phone user, remote access and good apps	Clinical Service Group Manager (or equivalent)
F11	Termination Forms	Clinical Service Group Manager (or equivalent)
F12	Staff Change Forms impacting on pay (e.g. change of hours, re-grading, extension of fixed term contracts etc)	Clinical Service Group Manager (or equivalent

Ref	SFI requirement	SFI Ref.	SFI responsibility	Authority Delegated to
G	Ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and dealing with variations to, or termination of, contracts of employment (i) Non-medical posts advertised on NHS Jobs (ii) Non-medical posts not advertised via NHS Jobs (iii) Medical posts (wherever advertised)	13.5.1	Director of Workforce & OD	 (i) NWSSP (ii) & (iii) No delegation

G1	**Approve departure under agreement** (Voluntary Early Release)	All applications to be approved by Care Group Service Director / Deputy COO and Assistant Director of Finance and Head of Workforce & OD Plus Executive Directors of Finance and Workforce & OD – then final approval by the Remuneration Committee i. Any VER payments over £50k also need to be approved by WG.
G2	**Approve redundancy**	Remuneration Committee (subject to any Welsh Government approval mechanisms)
G3	**Approve departure under settlement agreement** (other than VERs)	Relevant Executive Director, Executive Director of W&OD and Executive Director of Finance and Remuneration Committee (subject to any Welsh Government approval mechanisms)

*Any agreements that are deemed contentious to be referred to Remuneration Committee

11. Non Pay expenditure

Ref	SFI requirement	SFI Ref.	SFI responsibility	Authority Delegated to
A	The CEO will approve the level of non pay expenditure and operational scheme of delegation and authorisation to budget holders and managers within the parameters set out in the UHB's scheme of delegation	14.1	CEO	See Below for Oracle and non Oracle requisitions[1]

[1] All Financial Limits shown below are **inclusive** of VAT, above £1m needs to be approved by Welsh Government

ORACLE REQUISITIONS	Authority Delegated to
Below **£1,500**	Tier 7 – Nominated Budget holder for specific cost centers
£1,500 to **£5,000**	Tier 6 - Head of Department or equivalent
Up to £25,000	Tier 5 - Clinical Service Group Manager (or equivalent)
Up to £50,000	Tier 4 - Acute Services General Manager (or equivalent)
Up to £100,000	Tier 3 – Care Group Director, Deputy COO, Director of Governance, Director of Digital
Up to £250,000	Tier 2 - Executive Director
Up to £500,000	Tier 1 – Director of Finance
Up to £1m	Chief Executive

Expenditure commitments made outside of the ORACLE requisition process		Authority Delegated to
Contracts for HealthCare Services	See Section 5	See Section 5
Pharmacy drugs ordered via Pharmacy system	i. Up to £10,000 per order (Pharmaceutical homecare orders only) ii. Up to £75,000 iii. Up to £50,000 iv. Up to £20,000	i. Homecare pharmacist ii. Head of Medicines Management iii. Chief Pharmacist iv. Pharmacy Team Leaders
Pension Agency Invoices (Injury Benefit/Compensation/ Final Pay Controls)	i. >£100,000 ii. <£100,000	i. Director of Finance ii. Care Group Service Director / Deputy COO or Relevant Director
Legal Claims and Defense costs	i. >£100,000 ii. <£100,000 iii. <£50,000 iv. <£5,000	i. Director of Finance or Chief Executive ii. Director of Nursing & Quality iii. Assistant Director Quality and Patient Experience iv. Head of Patient Experience

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Ref	SFI requirement	SFI Ref.	SFI responsibility	Authority Delegated to
B	Maintaining the list of managers who are authorized to place requisitions for the supply of goods and services for both Oracle and Non Oracle requisitions.	14.1.2 & 14.1.3	CEO	Head of Finance/Assistant Directors of Finance (Care Groups)
C	The Director of Finance will advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders should be sought.	14.3.1	Director of Finance	See Below

Value[1]	Minimum Competition[2]	Lead	Waivers, or exceptions to tender rules (*following consultation with Procurement Services)
Up to **£5,000**	Best value to be shown	Tier 5	Head of Department
£5,000 to **£24,999**	**3 quotations**	Procurement Services	Single Tender Action authorised by Director of Finance*
£25,000 to OJEU threshold for supplies and services[3] **£25,000** to **£1m** for works	**4 tenders**	Procurement Services	Single Tender Action authorised by Chief Executive AND Director of Finance*
Above OJEU threshold for supplies and services[3] to **£1m**	**5 tenders**	Procurement Services	Single Tender Action prohibited
Above OJEU threshold for works[4]	**Procured via Designed for Life: Building for Wales**	Procurement Services	Single Tender Action prohibited

Over **£1m (other than D4L)**	**WG approval required**	Procurement Services	-

[1] Total value inclusive of VAT.
[2] Subject to existence of suitable suppliers
[3] Threshold from January 2022 for Supply and Services is £213,477
[4] Threshold from January 2022 for works is £5,336,937
[5] Threshold from January 2022 for Light Touch Regime for Service is £663,540

	SFI requirement	SFI Ref.	SFI responsibility	Authority Delegated to
D	**Petty cash** • Purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance • Petty cash records are maintained in a form as determined by the Director of Finance	14.6.1	Director of Finance Director of Finance	Head of Corporate Finance Head of Corporate Finance
E	**Approve petty cash expenditure** i. up to £75 per transaction ii. over £75 per transaction			i. Budget Manager ii. Director of Finance
F	• The Chief Executive and Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance issued by the Welsh ministers. • The technical audit of these contracts shall be the responsibility of the relevant Director as set out in the UHB's scheme of delegation	14.6.2	Chief Executive and Director of Finance	Director of Planning

12. Capital investment, fixed asset registers and security of assets

	SFI requirement	SFI Ref.	SFI responsibility	Authority Delegated to
A	(i) ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon plans (ii) management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost (iii) ensure that any capital investment above the Welsh Ministers' delegated limit is not undertaken without approval of the Welsh Ministers and that confirmation of capital resources has been received; (iv) ensure that an annual capital programme is adopted by the Board prior to the commencement of the financial year (v) ensure the availability of resources to finance all revenue consequences of the investment, including capital charges (vi) ensure that any 3rd party use of NHS estate is properly controlled, reimbursed and reported	15.1.1	CEO	(i) to (v) Director of Finance (vi) Head of Capital Planning
B	The CEO will issue a scheme of delegation for capital investment management in accordance with the Welsh Ministers' guidance and the UHB's SOs.	15.1.7	CEO	See below

Capital Schemes funded by Discretionary Allocation

Discretionary Capital Programme Approvals	Gross Expenditure on Whole Project			
Approval / Sign Off[2] by:	**Initial Annual Discretionary Programme**	**New Approvals Schemes under £500k**	**Scheme over £500K to £1m**	**Schemes over £1m[1]**
Executive Board			Agree project mandate and priority	
Service Group Manager or equivalent	~~Sign~~ Approve Statement of Need (SON) ~~up to £50K~~	~~Sign~~ Approve Statement of Need (SON) ~~up to £50K~~	-	-
Group Service Director or equivalent	~~Sign~~ Approve Statement of Need (SON) ~~over £50K~~	Approve~~Sign~~ Statement of Need (SON) ~~over £50K~~	~~Sign~~ Approve Statement of Need (SON) and BJC if requested by ECMG	~~Sign~~ Approve BJC
Executive Director / Director of Clinical Services	-	-	~~Sign~~ Approve BJC	~~Sign~~ Approve BJC
Executive Director of Finance	-	-	Review and agreement	Review and agreement
Executive Capital Management Group (ECMG)	**Approve**	**Approve**	**Approve ~~BJC~~**	**Approve**
~~Finance, Performance and Workforce Committee~~Operational Delivery Committee (ODC~~FPW~~)	Noted	Noted	Noted	-
Health Board	-	-	-	**Approve**

[1] Projects over £1m need to get approval from the WG
[2] Signature indicates sufficient understanding and confidence in the details of the business case to confirm responsibility for support for the proposal

Commented [CB1]: All SONs are signed by Directorate Manager and Care Group Director regardless of value - this doesn't give any funding approval so removed limit

Commented [CB2]: Should this be Executive?

Capital Schemes funded by Welsh Government

Scheme under £1m	Scheme over £1m
Executive Team considers overall priorities and project mandates	
↓	↓
Scoping document submitted to WG followed by a scoping meeting with WG to jointly sign off	Scoping document submitted to WG followed by a scoping meeting with WG to jointly sign off
↓	↓
Business Justification Template signed of by Directorate manager and Executive Director	Strategic Outline Case signed off by ECMG and Health Board
↓	↓
ECMG Approve	Outline Business Case signed off by ECMG and Health Board
↓	↓
-	Full Business Case signed off by ECMG and Health Board
	↓
Submission to WG for approval	Final approval required from WG at each stage of Business Case process

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	SFI requirement	SFI Ref.	SFI responsibility	Authority Delegated to
C	The Director of Finance shall issue procedures governing the financial management, including variations to contract of capital investment projects and valuation for accounting purposes	15.1.8	Director of Finance	See Below

Variations to Capital orders ~~and payment authorisation~~

Delegated authority	~~Variations to Discretionary Schemes~~	Variations to Capital Schemes ~~funded by WG~~ [1] (within Approved Sum)	Financial monitoring and reporting	Enter lease arrangement (all types) total value
Up to **£5k**	~~Assistant Director of Planning~~	~~Externa~~l Project Manager (~~following agreement with the Head of Capital Planning~~ Groups of variations should be managed within a monthly limit of £20k per month Monthly reports to Head of Capital identifying instructions made	Head of Capital ~~Planning and Head of Finance~~	Up to £25k Head of Finance (Non Care Groups) /Assistant Directors of Finance (Care Groups) Over £25k Director of Finance
Up to ~~£50k~~**£20k**	~~Director of Finance~~	Head of Capital ~~Planning~~ Groups of variations should be managed within a monthly limit of £100k per month		~~Over £25k Director of Finance~~
Up to **£1~~5~~0k**	~~ECMG~~	Assistant Director of Capital and Estates/Programme Director Groups of variations should be managed within a monthly limit of £250k per month Delegated authority to approve variations of an urgent nature and seek approval retrospectively from the appropriate hierarchy~~Assistant Director of Planning~~		

Commented [CB3]: Removed payment authorisation as all payment authorisation is managed by the PM if in line with the order

Commented [CB4]: Align WG funded with Disc schemes as not sure what it adds and causes confusion with schemes that have two funding sources

Commented [CB5]: These are instructions to utilise contingency up to £5k , can this be with the PM as working within approved budget and likely to happen on all schemes

Commented [CB6]: Noting these are all still within original approved budget for the scheme can we increase delegations to match approval limits in oracle? If it cannot be contained within original budget then ECMG approval will be required

Up to **£~~215~~250~~00~~k**	~~ECMG~~	Executive Director of Finance Groups of variations should be managed within a monthly limit of £500k per month~~Director of Finance~~		
Over **£~~250~~100k**	~~ECMG~~	ECMG (Executive Director of Finance to be one of the approvers)		

[1] Excludes major capital schemes procured though the National or Regional frameworks where a Project Board has been set up with executive level membership. These schemes follow specific delegations below

Any variations to Capital Schemes ~~funded by WG that~~ that exceed the approved sum require ~~further~~ approval from ~~WG~~ECMG. This may result in an additional fubding request to WG

~~If further approval and funding is not provided by WG, the variations needs to be discussed at ECMG.~~

Delegated authority[1]	Variations to major capital schemes funded by WG (within Approved Sum). Applies only to schemes procured though the National or Regional frameworks where a Project Board has been set up with executive level membership	
Up to £5k	Internal Project Manager	External Project Manager can proceed with variations up to 5k if decision is required urgently and is immediately reported to the internal project manager or above Groups of variations should be managed within a monthly delegated authority which shall be a maximum of £25k
Up to £100k	Assistant Director of Planning	Generally only required In the absence of the Project Director. Groups of variations should be managed within a monthly delegated authority which shall be a maximum of £250k
Up to £100k	Project Director (or Programme Director/Deputy SRO if applicable to the scheme)	Groups of variations should be managed within a monthly delegated authority which shall be a maximum of £250k
Up to £250k	Director of Finance	Groups of variations should be managed within a monthly delegated authority which shall be a maximum of £500k

Over £250k	Project Board	Out of committee approval can be sought where the timing of meetings does not allow in line with the terms of reference for the Project Board

[11] Delegations apply if operating within existing overall scheme budget and does not impact in-year cash flow.

Any variation which impacts on the agreed financial outturn or the cash flow in- year requires approval from ECMG

	SFI requirement	SFI Ref.	SFI responsibility	Authority Delegated to
D	the maintenance of registers of assets, taking account of the advice of the Director of Finance concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted periodically	15.3.1	CEO	Head of Capital

13. Stores and receipt of goods

	SFI requirement	SFI Ref.	SFI responsibility	Authority Delegated to
A	(i) overall responsibility for the control of stores shall be delegated to a senior officer by the Chief Executive. (ii) The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Manager (iii) the control of any fuel oil and coal of a designated estates manager.	16.2.1	CEO	Clinical Service Group Managers Head of Medicines Management Head of Estates

[1]*Directorate Managers may delegate the day-to-day responsibility to departmental officers and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance*

B	Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance	16.2.4 16.2.5	Director of Finance Director of Finance	Head of Finance (Non Care Groups_ /Assistant Directors of Finance (Non Care Groups) Head of Finance (Non Care Groups) /Assistant Directors of Finance (Care Groups)

14. Disposals and condemnations, losses and special payments

Ref	SFI requirement	SFI Ref	SFI responsibility	Authority delegated to
A	**Disposals and condemnations** a. Prepare detailed procedures for the disposal of assets, including condemnations, and ensure that these are notified to managers. b. All unserviceable articles shall be condemned or otherwise disposed of by an officer authorized for that purpose by the Director of Finance.	17.1	Director of Finance	a. Head of Corporate Finance b. Following advice from appropriate heads of service (eg Clinical engineering, IM&T, Estates etc): Estimated value: • up to £1,000 Clinical Service Group Managers /Corporate manager • £1,000 to £10,000 Deputy Director of Finance • over £10,000 Director of Finance

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Ref	SFI requirement	SFI Ref	SFI responsibility	Authority delegated to
B	**Losses and Special payments** • Ensuring procedural instructions on the recording of and accounting for losses and special payments are in place; and that all losses and special payments cases are properly managed in accordance with the guidance set out in the Assembly Government's Manual for Accounts.	17.2.2	Director of Finance	Head of Corporate Finance
	• Ensure all financial aspects of losses and special payments cases are properly registered and maintained on the centralized Losses and Special Payments Register and that 'case write off' action is recorded on the system.	17.2.8	Director of Finance	Head of Corporate Finance
	• The Audit Committee shall approve the writing off of losses or the making of special payments within delegated limits determined by Welsh Ministers and as set out in Schedule 3 of the SOs.	17.2.9	Audit committee	See B1 Below
	• Ensure that all losses and special payments are reported to the Audit Committee at every meeting	17.2.13	Director of Finance	Head of Corporate Finance

B1	**Approve losses, write-offs and compensation payments due to:** i. losses of cash (theft, fraud, etc) ii. damage to buildings, fittings, furniture and equipment and property in stores and in use due to culpable cause (theft, fraud, arson) iii. extra contractual payments to contractors; iv. ex-gratia payments to patients and staff for loss of personal effects v. fruitless payments including abandoned capital schemes vi. ex-gratia payments - voluntary release payments to staff vii. bad debts and claims abandoned • No delegated approval over £50,000 – WG approval required	i. Chief Executive/ Deputy Chief Executive (within delegated limits issued by Welsh Government - £50,000) ii. Director of Finance(up to £25,000) Chief Executive/ Deputy Chief Executive (>£25,000 to within delegated limits issued by Welsh Government - £50,000) iii. Director of Finance (within delegated limits issued by Welsh Government - £50,000) iv. Nurse Directors (up to £10,000) Chief Executive/ Deputy Chief Executive (>£10,000 to within delegated limits issued by Welsh Government - £50,000) v. Director of Finance (up to £50,000) Chief Executive/ Deputy Chief Executive (> £50,000 to within delegated limits issued by Welsh Government - £250,000) vi. Remuneration Committee (within delegated limits issued by welsh Government- £50,000) vii. Head of Corporate Finance (<£1,000), Deputy Director of Finance (£1,000 to £10,000) Director of Finance (£10,000 to £25,000) Chief Executive (£25,000 to £50,000).

B2	**Approve compensation payments made under legal obligation** • Personal injury and medical negligence claims i. Up to £25,000 ii. £25,000 to £75,000 iii. £75,000 to £500,000 iv. £500,000 to £1m • Employment matters i. up to £20,000 ii. £20,000 to £50,000 iii over £50,000 • Other matters	• Personal injury and medical negligence claims- On receipt of legal advice to pay i. Legal Services Manager ii. Assistant Director Legal Services / Assistant Director of Quality & Safety / Deputy Executive Director of NursingDirector Legal Services / Assistant Director of Quality & Safety / Deputy Executive Director of Nursing iii. Director of Nursing, Midwifery & Patient CareDirector of Nursing, Midwifery & Patient Care iv. Chief Executive • Employment claims – on receipt of legal advice/tribunal i. Deputy Director of Workforce & OD ii Director of Workforce & OD iii Chief Executive • Chief Executive
B3	**Approve compensation payments made without legal obligation**	Chief Executive / Deputy Chief Executive (within delegated limits issued by Welsh Government - £50,000)

*Director of Nursing may delegate this authority to a Deputy during periods of absence.

15. Information Management & Technology

Ref	SFI requirement	SFI Ref	SFI responsibility	Authority delegated to
A	The UHB shall publish and maintain a Freedom of Information (FOI) publication scheme, or adopt a model publication scheme approved by the Information Commissioner.	18.1.2	Board	Board Secretary/Director of Corporate Services and Governance
B	The Director of Planning & Performance has responsibility for: • the accuracy and security of the computerised data of the UHB • ensuring that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes. • Where another health organisation or any other agency provides a computer service for financial applications, the responsible Director for IM&T shall periodically seek assurances that adequate controls are in operation. • ensuring that the risks to the UHB arising from the use of IT are effectively identified and considered and that appropriate action is taken to mitigate or control risk. This shall include the preparation and testing of an appropriate disaster recovery plan.	18.2.1 18.4.1 18.4.2 18.5.1	Director of Planning & Performance	No Delegation other than responsibilities for security of patient data is delegated to the Medical Director in the role of Caldicott Guardian
C	The Director of Finance shall ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation.	18.3.1	Director of Finance	Head of Finance

Cwm Taf UHB – Additional delegations linked to the SFIs

16. Patients' property

Ref	SFI requirement	SFI Ref	SFI responsibility	Authority delegated to
A	Ensuring patients or their guardians have appropriate information before or at admission, including that the UHB will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt	19.2.1	CEO	Heads of Nursing/ Heads of Service
B	Provide detailed written instructions on the collection, custody, investment, recording, safekeeping and disposal of patients' property	19.3.1	Director of Finance	Head of Corporate Finance

Cwm Taf UHB – Additional delegations linked to the SFIs

17. Funds held on Trust

Ref	SFI requirement	SFI Ref	SFI responsibility	Authority delegated to
A	The Schedule of Matters reserved to the Board and the Scheme of delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of funds are to be taken and by whom	20.2.2	Board	See below

Access to Charitable funds

Delegated authority	Approve expenditure from charitable funds
(i) Approval and setting up of designated fund signatories for new funds. (ii) Approval of changes to fund signatories	(i) Director of Finance (ii) Head of Finance/Assistant Directors of Finance
All expenditure requests for Charitable funds	To be submitted to Senior Finance Officer - Charitable Funds for initial review
Up to **£5,000 (non-contentious)**[1]	Designated fund signatories subject to confirmation from the Senior Finance Officer that sufficient funds are available
>£5k to £15k	Clinical Service Group Manager
>£15k to £30k	Care Group Service Director / Deputy COO or Relevant Director
>£30k to £50k	**Executive Director

Cwm Taf UHB – Additional delegations linked to the SFIs

Over £50k	Charitable Funds Committee

[1]The term "contentious" refers to the appropriateness of the expenditure either due to its nature or its compatibility with fund objectives and will be determined by the Senior Finance Officer - Charitable Funds during initial review.
**For the purpose of the Scheme of Delegation, Executive Director refers to the post holder who has budget responsibility delegated by the CEO.

Investment of Charitable Funds

	Investments	Authority
Investment of funds		
i.	Decision on nature and value of investment[1]	i. Audit committee with guidance from appointed investment advisors and Director of Finance
ii.	Placing of investment	ii. Charitable Funds Committee or Audit Committee via an authorisation to pay into the advisors' investment account

[1]The term "investment" refers to stocks, shares, bonds, property, unit funds or other instruments derived to generate a rate of return and/or valuation gains, other than interest bearing bank accounts

Cwm Taf UHB – Additional delegations linked to the SFIs

18. Retention of Records

Ref	SFI requirement	SFI Ref	SFI responsibility	Authority delegated to
A	CEO shall be responsible for maintaining archives for all records required to be retained in accordance with Welsh Ministers guidance.	21.1.1	CEO	Relevant Executive Director

Request for changes to the Additional delegations linked to the SFIs

Please return completed form to Owen James - Owen.James2@wales.nhs.uk

SoD Ref.	SoD Page No.	Main Task	Sub Task	Cwm Taf Morgannwg existing		Cwm Taf Morgannwg proposed		Reason for the change	Requested by:	Requested timeframe for implementation
				Limits	Authority delegated to:	Limits	Authority delegated to:			
12	30	Discretionary Capital Programme Approvals						Amendments to table of approval and sign off	Carolyn Blockley Head of Capital	Immediate
12	32/33	Capital Orders and payment authorisation						Amendments to title, table of delegated authority and footnote	Carolyn Blockley Head of Capital	Immediate

Meeting Name:	Public Board
Report Title:	Winter Preparedness Plan – Operational Update
Agenda Item:	8.1.5
Date of Meeting:	26 November 2026
Publication Status:	Open
Report Prepared by:	Sarah James – Deputy Chief Operating Officer
Report Presenter:	Gethin Hughes, Chief Operating Officer/Sarah James, Deputy Chief Operating Officer
Report Executive Sponsor	Gethin Hughes, Chief Operating Officer & Claire Thompson, Executive Director of Strategy and Transformation
Report Purpose:	Inform
Action / Decision Required:	The Board is asked to note the Winter Resilience and Seasonal Preparedness Plan, noting further development following the strategical overview provided in September 2026
Strategic Context: This report aligns to the following Strategic Pillars	Creating Health / Improving Care / Inspiring People / Sustaining Our Future
Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan (Reference relevant priority)	Supports the 2026/27 Annual Delivery Plan priorities for urgent and emergency care, care closer to home, safe acute care, discharge without delay, effective operational command and sustained elective capacity.

Executive Summary of what the report is describing: Start by summarising briefly the most critical information. This should provide a firm grasp of the key points against the following 3 headings without reading the full report:	
What (summary of current position / issue & why it matters and evidence to support that position etc)	CTMUHB has developed a Winter Resilience and Seasonal Preparedness Plan for 2026/27, aligned to national guidance and informed by whole-system partner engagement. Following a readiness assessment and multi-agency assurance workshop, actions have been identified to strengthen preparedness across community services, acute capacity, patient flow, workforce resilience and operational escalation. The plan provides the overall approach to coordinate and monitor the response to winter pressures and maintain safe, effective and sustainable services.
So, what (provide meaningful analysis drawing out as appropriate implications against CTMUHB Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)	The Winter Resilience and Seasonal Preparedness Plan supports CTMUHB's 2026/27 delivery objectives and strategic aim of providing safe, timely and sustainable services. It sets out the organisational and system-wide actions required to mitigate winter risks, protect urgent and planned care capacity and maintain patient flow. Board approval provides assurance that appropriate preparations are in place whilst recognising the need for ongoing monitoring and adaptation in response to evolving operational pressures
What Next (summary of intended action and benefits supporting the choices and recommendation(s)being made)	The organisation continue to embed winter operating arrangements and monitor delivery through established governance and assurance mechanisms. This will support a coordinated whole-system response to winter pressures, strengthen resilience, protect patient safety, maintain flow and help sustain both urgent and planned care services throughout the winter period.

Recommendation (Linked to the "What Next" section above).	**What is it you are asking the Board / Committee to do – APPROVE, ENDORSE, NOTE**
	Approve
Link to Strategic Risk(s) on the Board Assurance Framework (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	STRATEGIC RISK(s) 1a / 1b/ 2/ 3/ 4/ 5/ 6/ 7/ 8/ 9/ 10/ 11
	1a/1b & 11
Link to Wellbeing of Future Generations Act – Wellbeing Goals	Not Applicable / A Prosperous Wales / A Resilient Wales / A Healthier Wales / A More Equal Wales / A Wales of Cohesive Communities / A Wales of Vibrant Culture & Thriving Welsh Language / A Globally Responsible Wales
	If more than one applies, please list: A Prosperous Wales / A Resilient Wales / A Healthier Wales / A More Equal Wales / A Wales of Cohesive Communities
Environmental Sustainability Impact (5Rs)	Reuse / Refine / Reduce / Repurpose / Recycle / Not Applicable
	If more than one applies, please list: Not applicable
Link to Enablers of Quality	Not Applicable / Culture & Valuing People / Data to Knowledge / Leadership/ Learning, Improvement & Research / Whole-System Perspective
	If more than one applies, please list: Data to Knowledge / Leadership/ Learning, Improvement & Research / Whole-System Perspective
IMPACT ASSESMENT	
Equality & Welsh Language Impact Assessment Outcome (Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)	No direct differential impact is noted, subject to the safeguards and monitoring described in the assessment and business as usual arrangements. However, it is important to note that there is potential for adverse or disproportionate impacts may arise for any group if capacity is constrained, communication is inaccessible, reasonable adjustments are not maintained, community support is unavailable, or temporary service changes create barriers, including Age, disability, carers and socio-economic disadvantage require particular monitoring because winter pressure may amplify existing barriers and vulnerability. The health board have carried out an assessment and an Multi Disciplinary Team (regional and local partners) are engaged to manage and mitigate the risks. A Welsh Language assessment has been undertaken and no adverse impact has been noted as a result of this plan, compliance with the Welsh Language Standards remains a requirement throughout the winter period, including during periods of escalation, service pressure or temporary operational change.
Quality Impact Assessment Outcome (Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)	A quality impact assessment has been undertaken with a multidisciplinary review scheduled for the 21 September to sign off an agreed assessment.
Cyfreithiol / Legal	The plan supports the Health Board in meeting its statutory duties, including the Duty of Quality, equality and Welsh language requirements, and emergency preparedness and business continuity responsibilities. Any temporary operational changes will be managed through established governance, clinical risk assessment and decision-making arrangements.
Enw da / Reputational	Effective delivery will support public and partner confidence in the Health Board's preparedness and its ability to maintain safe, timely care. Failure to implement or adapt the plan in response to escalating pressures could adversely affect patient experience, performance and organisational reputation. This will be mitigated through transparent reporting, active operational oversight and timely escalation.
Resource Impact (People / Financial)	Implementation will require coordinated deployment of workforce, capacity and financial resources across the Health Board and partner system. Delivery will be managed through existing planning and governance arrangements; any additional resource requirement or financial commitment arising from emerging pressures will be assessed and escalated through the appropriate approval route.

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Prepared together. Delivered as one system

CTMUHB & Regional Partners Winter Preparedness & Resilience



Purpose and context

CTMUHB's integrated Winter Preparedness Plan 2026/27

1 Purpose

Provide assurance that resilient arrangements are being developed to maintain patient safety and flow, respond to forecast demand and sustain urgent and planned care through winter.

2 Planning approach

A system-wide and iterative approach, informed by Care Groups, site teams, corporate services, Local Authorities and partners, with plans refined as risks and pressures evolve.

3 Intended outcome

One regional plan focused on care closer to home, effective patient flow, resilient acute and community capacity, clear ownership and escalation.

Board-level message

The plan aligns to the national Planning Together for Winter framework and supports the Duty of Quality.

Board assurance is sought on the overall approach, recognising that demand and capacity modelling, workforce, discharge, community capacity and partner dependencies, will remain under active review.

WINTER PREPAREDNESS TIMELINE 2026/27

Key milestones from risk submission and plan development to winter delivery

11 Aug

WG / NHSPI risk submission

CTMUHB key risks submitted

8 Sep

Regional resilience workshop

Analyze & test modelling, review gaps and agree partner actions

Sep

Refine plan and assurance

Actions, confirm evidence and strengthen arrangements

24 Sep

Final plan

Finalise the national submission version

24 Sep

Board assurance

Board consideration of the plan

25 Sep

WG/NHSPI submission

Submit completed regional plan

Oct–Nov

Readiness and assurance

Further develop and confirm plans, exercise, test, brief and complete operational readiness

1 DEC Winter operating arrangements begin **7–21 DEC** Winter Sprint **31 JAN** Core resilience period closes and learning continues

Four regional priorities

The areas that organise the preparedness plan

1 Community resilience

Prevention, vaccination, frailty support and community-based urgent response.

2 Capacity and safety

Acute capacity, workforce resilience, infection prevention and surge planning.

3 Discharge and flow

Seven-day working, timely discharge and stronger whole-system pathway management.

4 Command and assurance

Shared intelligence, escalation arrangements, testing, learning and governance.

Demand and Capacity Modelling

Winter Demand and Capacity Modelling

Modelling has been undertaken to inform capacity planning. This will continue to evolve.

Ongoing refinement through discussions with Care Groups, Site Based Leaderships Teams and Local Authorities to strengthen system wide response around BH periods for acute, Mental Health and community sites.

Specific operational plans by site across community and acute will be fluid and updated onto this master document held by COO office.

High level Care Group and Site plans included later in this presentation to provide assurance of arrangements and developments as part of ongoing planning process. UEC Programme ongoing and central to winter resilience planning.

Data Modelling Summary: Winter 2026/27

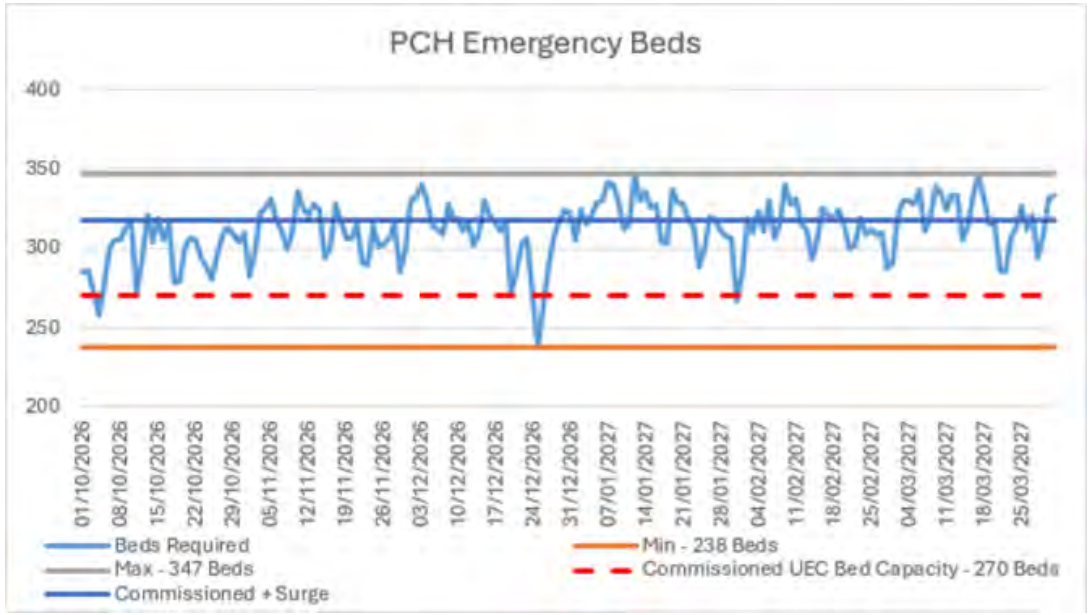
	UEC Only - 1 OCT 2026 - 31 MAR 2027					
	Forecast Minimum Demand	Forecast Peak Demand	Baseline UEC Bed Capacity	Current Surge Capacity	Peak Capacity Shortfall	Day's Peak Surge Required
PCH	238	347	270	48	29	67
POW	240	315	284	8	23	34
RGH	322	465	406	11	48	100
TOTALS	**800**	**1127**	**960**	**67**	**100**	

The table quantifies the forecast bed capacity gap for Urgent and Emergency Care (UEC), representing the additional surge beds required above both the commissioned bed base and the surge capacity that is routinely utilised during periods of increased demand.

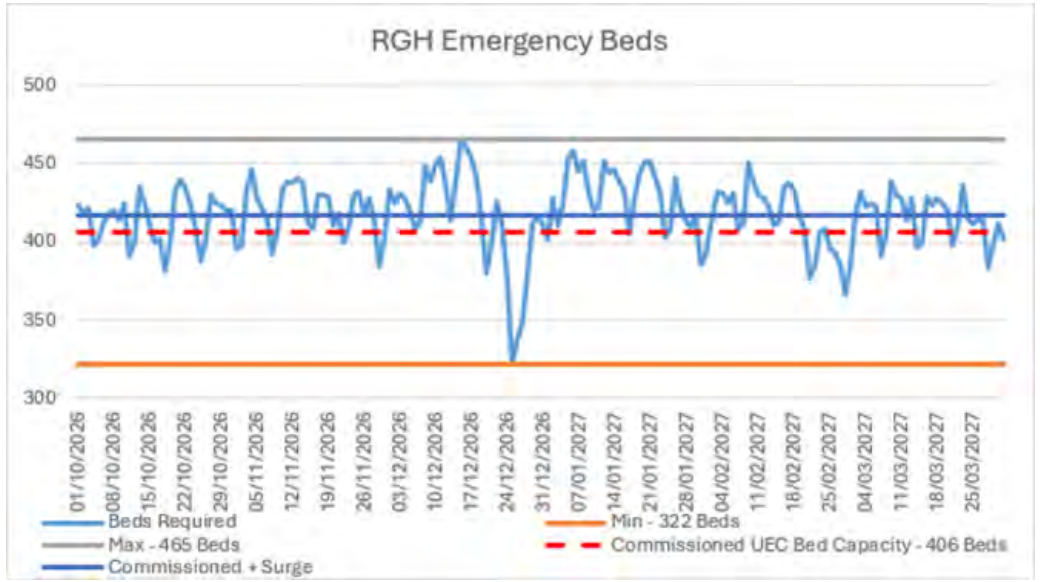
While the cumulative peak shortfall across all sites is approximately 100 beds, this should not be interpreted as a requirement for 100 additional beds to be operational simultaneously. Demand peaks occur at different times across Princess of Wales Hospital (POW), Prince Charles Hospital (PCH) and Royal Glamorgan Hospital (RGH), meaning the site-specific shortfalls do not all coincide.

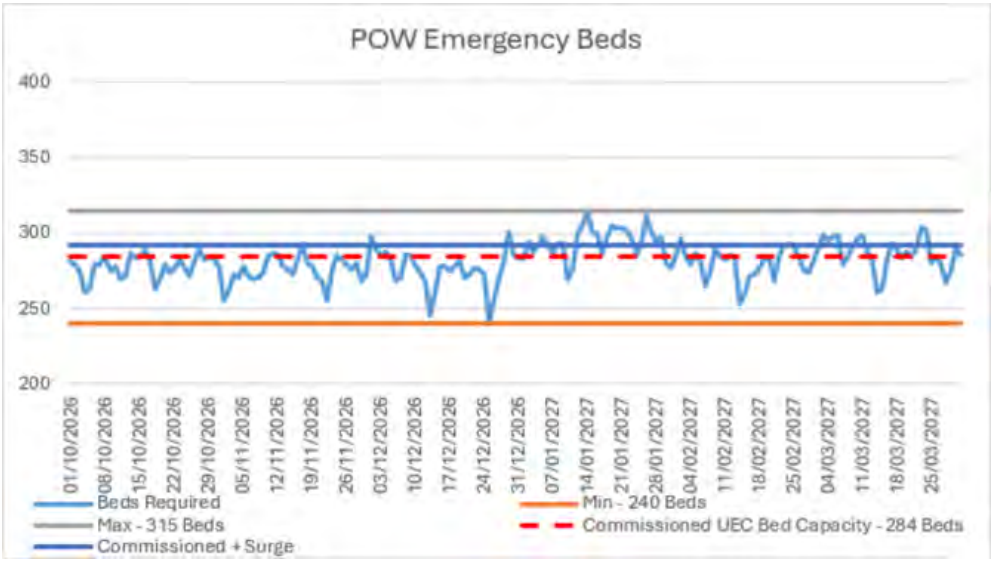
In response to the forecast increase in demand, each Care Group has developed a tailored winter resilience plan. These plans describe the core services and developments as well as the operational actions, escalation measures and mitigation strategies that will be implemented to manage periods of increased pressure, maximise available capacity and reduce the impact of forecast bed shortfalls on patient flow and service delivery.

Winter UEC : Demand and Capacity Data



- Commissioned and known surge capacity per Acute Site showing projected demand for **additional** surge beds and/or other mitigating measures.
- The bed deficit / demand number fluctuates throughout the winter period.
- Note: the projected bed deficit is not absolute – it will be impacted by system flow actions and factors. Care Group Plans and actions to manage system flow have been developed and continue to evolve. Refer to Care Group Plans and actions slides for details.





Next steps:

Informatics will:

- Produce monitoring charts for Actual Vs Projected Demand
- Work on an improved quick validation screen for POCD validation
- Support improved adoption of the existing Discharge Delay visualisation tools to facilitate conversations around supporting inventions to improve discharge readiness.

Infection, Prevention & Control

IPC & respiratory preparedness

Board assurance on plans to prevent, identify and manage winter infection pressures

PREVENT

1

- Outbreak Management Framework approved
- Targeted HCAI improvement programme
- Vaccination, antimicrobial and PPI actions
- High-risk ward rounds and device-care assurance

DETECT & PROTECT

2

- Daily ARI surveillance and Whiteboard reporting
- Isolation, cohorting and admitting-at-risk decisions
- Fit-testing and PPE assurance review
- Daily data-quality checks and exception escalation

RESPOND & ESCALATE

3

- Green, Amber and Red outbreak escalation
- Outbreak Control Cell and daily 11:00 meeting when activated
- Live action tracking, sitrep and communications
- Testing at PCH, RGH and POW before winter

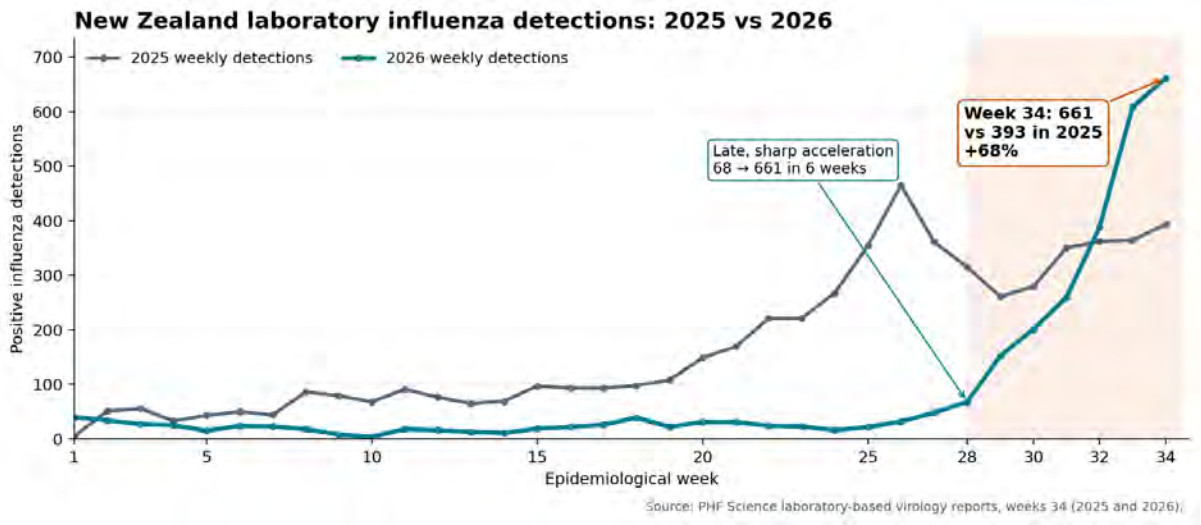
Action: Partners to endorse & sign off Infection Prevention and Control Winter Preparedness Plan 2026/27 – September 25, 2026

BOARD FOCUS Monitor implementation and exceptions through acute and IPC governance, with prompt escalation where actions or data quality fall behind plan.

Winter respiratory preparedness alert – Southern Hemisphere intelligence

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ALERT: No 2026/27 Welsh influenza winter model is available to this pack as at 11 September 2026; the public Welsh winter-modelling collection currently lists 2025/26 as the latest model. Use live surveillance and a rapid model-update gate.



NEW ZEALAND SIGNAL

PHF Science described a late 2025 respiratory peak, driven by influenza A(H1N1), influenza B and prolonged RSV. The 2026 laboratory series is now showing a particularly sharp late rise: weekly influenza detections increased from 68 in week 28 to 661 in week 34. At week 34 this is 68% above the 2025 weekly count (393). By week 34, 2026 cumulative detections were 2,968: influenza A 2,652 and influenza B 316, so the current rise is predominantly influenza A rather than B.

CTM IMPLICATION

Southern Hemisphere surveillance is an early-warning input, not a Wales forecast. The signal is relevant because local timing can diverge: RGH influenza accelerated earlier than the national seasonal expectation in 2025/26. Maintain early readiness, weekly CTM ARI review, flexible mask/cohort triggers and rapid revision when Welsh/PHW modelling becomes available.

IPC: one shared platform for winter

Cooperation across CTM to protect people and service capacity

IPC has worked across the HB to turn last winter's learning into a shared platform for preparedness and outbreak response.



Outbreak Framework

Faster response with clear escalation, responsibilities and action follow-up

IPC Winter Preparedness Plan

Shared with RGH, PCH and POW site managers and Heads of Nursing to guide readiness

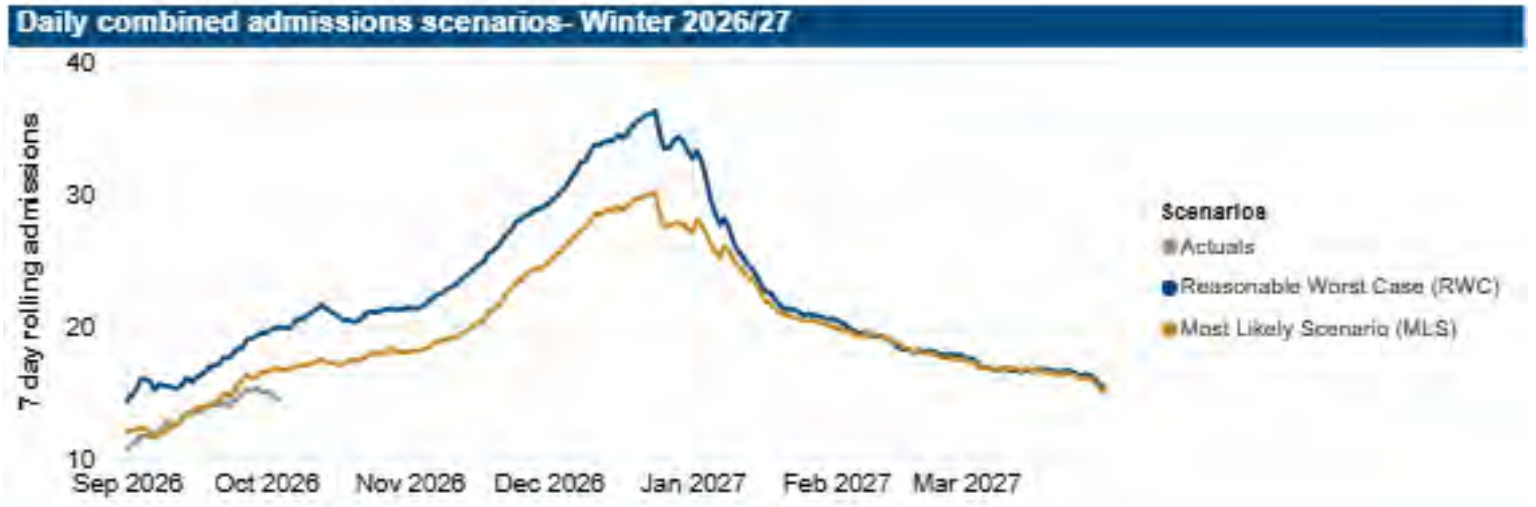
Protect patients, staff, visitors and service capacity

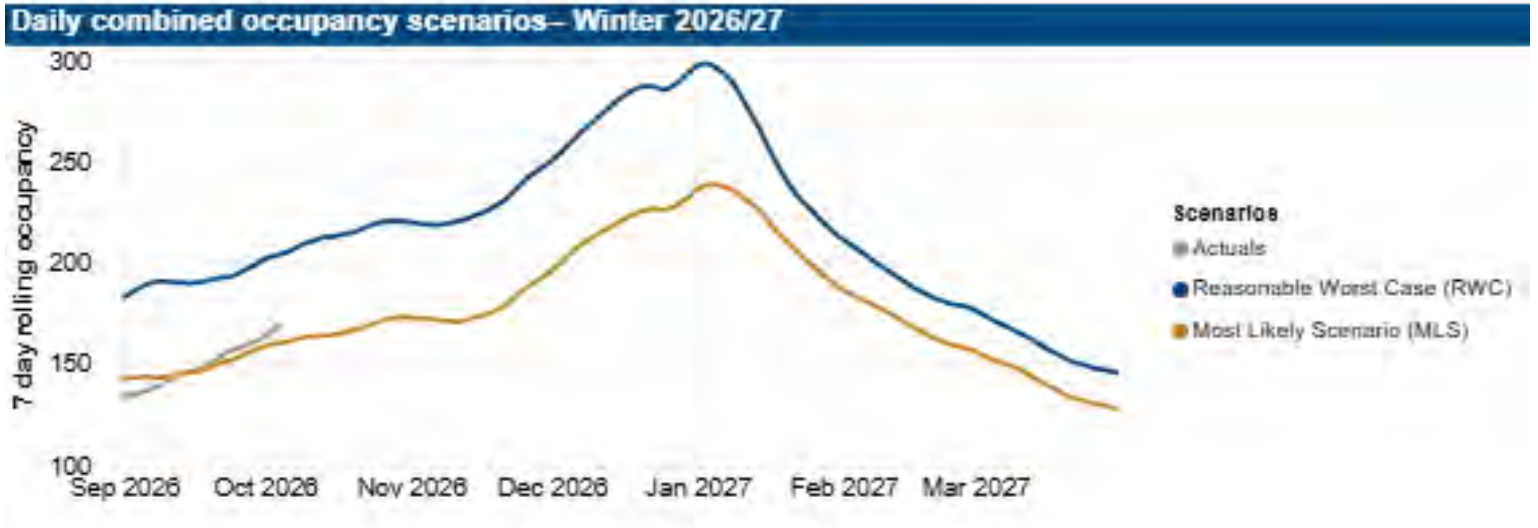
Local, regional and national intelligence guides prevention and rapid outbreak containment

CTM winter pressures are projected to peak in late December and early January

- CTM combined admissions and occupancy scenarios (COVID-19, Influenza, RSV and other ARI) suggests respiratory-related admissions and occupancy are likely to peak in late December (admissions) and early January (occupancy).
- Current activity is tracking broadly in line with the Most Likely Scenario (MLS), with admissions close to projected levels and occupancy slightly above forecast.
- Under the MLS combined admissions are expected to peak at around 30 per day, with occupancy reaching approximately 240 beds. In the Reasonable Worst Case (RWC), admissions could rise to around 36 per day, with occupancy approaching 300 beds. These projections provide a basis for monitoring trends and assessing potential winter capacity pressures.
- This projected trajectory is consistent with the rest of Wales model

Note: Data includes LAB CONFIRMED results and includes inpatients only





Welsh Government combined admissions and occupancy scenarios for CTM (COVID-19, influenza, RSV and other ARI): Reasonable Worst Case (blue) and Most Likely (orange), with actuals (grey) to 04/10/2026.

[Winter Modelling Dashboard - WG - Power BI]

Vaccination and Prevention

Winter Vaccination Delivery Plans and Priorities

Maximising key vaccination programmes

Children and young people

- 2-3 year old incentive programme with GPs
- School programme
- Equitable gelatine-free flu offer available across schools
- WIS recording at point of vaccination

Clinical at risk and 65+

- Mixed delivery model across GP's, Pharmacy and HB services
- Prioritised vaccination of care home residents and housebound patients with a co-administration approach where possible
- RSV, Flu and COVID co-administration maximised where clinically appropriate. Care homes are being prioritised.
- Targeted outreach for vulnerable groups including learning disabilities, homelessness and Gypsy Traveller communities
- Flexible clinics, outreach and mobile vaccination support
- Bespoke support to GP practices with RSV/flu programme through a mixed model
- Strengthening call/recall
- 103 pharmacies will support flu campaign

Communications and Engagement

- It Takes a Village will remain central to CTM UHB's winter vaccination communications. This award-winning, community-led campaign uses trusted local voices and recognisable imagery to promote vaccination uptake and was recognised at Public Health Wales' Vaccination Saves Lives Awards.
- New Engagement and Involvement Lead expected to be in post for the winter period and
- Specific communication plan for staff flu

Vulnerable groups

- All pupils who are home educated and on a school nominal roll are sent GP letters
- Collaboration and work ongoing between school nursing, health protection operational team and GPs for Special Schools

Staff

- Builds on improvements for last year
- Enhanced Care Group performance reporting to senior leadership
- Doubling of OH-led static clinics
- Expansion of ward and department based peer

Sustaining Emergency Trajectories

Health Board Trajectories – Cwm Taf Morgannwg UHB

	Handover < 45 mins	4 Hour Breaches	12 Hour Breaches	Pathway of Care Delays (POCD)	
				People Delayed	Total Days Delayed
Target	>90% in 15 mins by Q4 100% within 45 mins by Q4	65% by end of FY 2026/27 Incremental Improvement	7% or less	5% reduction each quarter	5% reduction each quarter
Mar 26 Baseline	2050 Total Handovers, Total 45 Mins 261, 87%	58.3% within 4 Hours (including Acute and MIU)	Actual 12 Hour Breaches 2362 13.1%	Actual – 231	Actual – 11,799
Apr'26	Actual 45 min 246 (88%)	56.6%	Actual 12 Hour Breaches-2207 (13.2%)	Actual – 189	Actual – 10,668
May'26	Actual 45 min 200 (90%)	58.6%	Actual 12 Hour Breaches-2206 (12.6%)	***Actual – 253***	***Actual – 12,042***
June'26	Forecast 45 min - 195 (90%)	59.2%	Forecast 12 Hour Breaches-2100 (12.3%)	246	11,440
July'26	Forecast 45 min - 208 (90%)	61.0%	Forecast 12 Hour Breaches-2197 (12.4%)	240	11,249
Aug'26	Forecast 45 min - 208 (90%)	61.6%	Forecast 12 Hour Breaches-1945 (11.8%)	234	11,059
Sept'26	Forecast 45 min - 200 (90%)	60.6%	Forecast 12 Hour Breaches-1800 (10.7%)	228	10,868
Oct '26	Forecast 45 min - 176 (91.5%)	60.9%	Forecast 12 Hour Breaches-1766 (10.2%)	222	10,687
Nov'26	Forecast 45 min - 141 (93%)	60.8%	Forecast 12 Hour Breaches-1607 (9.6%)	216	10,506
Dec'26	Forecast 45 min - 101 (95%)	66.7%	Forecast 12 Hour Breaches-1500 (9.0%)	210	10,325
Jan'27	Forecast 45 min - 106 (95%)	64.3%	Forecast 12 Hour Breaches-1453 (8.9%)	205	10,152
Feb'27	Forecast 45 min - 93 (95%)	62.1%	Forecast 12 Hour Breaches-1180 (7.8%)	199	9,980
Mar'27	Forecast 45 min - 103 (95%)	65.0%	Forecast 12 Hour Breaches-1000 (5.6%)	194	9,808

Joint Working and Whole System

Winter Priorities for Joint Working: Health and Social Care

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Integrated Discharge Services

- Align IDDB oversight with System Flow, with clear ownership of delays and escalation across health and social care.
- Strengthen MDT discharge hubs and Home First/D2RA challenge. Pull patients into appropriate community pathways and reduce avoidable Pathway 3 use.
- Progress EToC and Proportionate Trusted Assessment improvement with local authorities to reduce duplication and improve referral quality.

Reducing Pathway of Care Delays

- System Flow: progress the command-and-control model, supported by the Quality Management System for continuous learning.
- Use the live Flow Dashboard to target bottlenecks.
- Embed early discharge planning, effective board rounds and accurate EWB updates to enhance decision making.
- Resolve assessment and Pathway 3 barriers with local authorities, including legal processes and care-at-home capacity through Gold Super Stranded panels.

Integrated Risk and Escalation

- Link operational delivery, quality assurance and Bronze–Silver–Gold escalation.
- Use shared flow intelligence to agree actions, owners and review points, and escalate unresolved barriers across agencies.
- Review long-stay cases and discharge outcomes to identify recurring risks and drive learning.

Admission Avoidance

- Front Door Frailty: a proposed “turn the tap off” approach to avoid unnecessary admission, reduce deconditioning and expedite safe discharge.
- Bring frailty assessment and early CGA together with the DEWI project to reduce deconditioning. Link directly to H@H and its wider virtual MDT for rapid discharge.
- Proactively support frequent attenders through the Navigation Hub and community pathways.

CTM UEC Programme – cross Care Group Overview

Demand and capacity pressures within urgent and emergency care are primarily driven by avoidable hospital utilisation and delays in patient discharge. Cwm Taf Morgannwg UHB recognising recognises that successful implementation of the national strategy is critical to strengthening system resilience and maintaining safe, effective care throughout the winter.

The following domains are a focus:

National UEC Programme (CTM Wide)		
Hospital avoidance •SPoA •CCBC •Falls response •Timely access to care •Community point of care testing	Front door •EEMAC •H45 escalation policy •Increase in SDEC utilisation •Optimisation of first 72 hours •Mature front door frailty service	Discharge •Optimal hospital flow model •SAFER board rounds •Red to Green •Targeted work to unblock internal delays to discharge

Site Management **Plans**

Acute and Community Hospitals

Acute Sites : Target capacity Release Prior to Christmas

	Unscheduled Care Wards/beds	Planned Care Wards /beds	Additional
PCH	• 1 x Ward to be de escalated (24 Beds) • All Treatment Rooms de escalated (4 Beds) • All Double Boarding de escalated (5 Beds) • All Triple Boarding de escalated (4 Beds) Total = 37 Beds	6 x Beds de escalated across each ward on Surgical Floor (24 Beds)	Site Management Rota is currently being drafted, working towards an 8a presence during the Christmas Period as a minimum.
RGH	• Flu Assessment Bay in operation on Ward 4 to support the front door and acute medical flow (if required) • •Explore opportunity for additional SDM's to support periods of expected surge in demand • •Identify ward to be de escalated (22)beds • •Removal of boarding beds • Ward 1 Surge area to be de-escalated (12beds)	• Utilisation of data within planned care SLT meetings weekly update provided • Plan of surge capacity on elective wards with daily updates on capacity available • Additional staffing will be requested during peak periods to enable discharge and SDEC flow • Christmas plan will be finalised utilising elective capacity for surge.	Opportunity for additional Surge capacity via decommissioned wards – funding and workforce dependent.
POW	1 bay to be de escalated ACE (6 beds) 1 bay to be de escalated Ward 4 (6 beds) 1 bay to be de escalated Ward 9 (6 Beds) Boarding to de escalated Ward 15 (1 Bed) Maintain 1 ring fenced NIV bed (Ward 10) Maintain 1 ring fenced CCU bed (Ward 4) De escalate 4 beds Ward 11 Maintain 1 ring fenced Gynae bed (Ward 11) Total = 26 Beds	POW has 1 surgical ward (Ward 11) with 20 surgical beds fully utilised to support current demand. Ward 7 and Bridgend Clinic Elective Orthopaedics operational Ensure clinical pathway and appropriate capacity is maintained within RGH and PCH to support increased surgical demand over period.	Site Management Rota to be included in bank holiday/weekend plan.

Respiratory Surge & Cohorting Model

Illustrative Operational Model

An example respiratory surge and cohorting model has been developed which demonstrates how national guidance can be operationalised at site level during periods of increased respiratory demand or outbreak activity.

Key Principles

- Early identification and cohorting of respiratory patients.
- Designated respiratory pathways and escalation areas.
- Flexibility to adapt bed utilisation and specialty arrangements in response to emerging pressures.
- Robust IPC measures to minimise transmission and protect capacity.
- Clear operational command, decision-making and communication arrangements.
- Daily review of demand, capacity, flow and outbreak status.

Winter Preparedness Benefits

- Supports safe management of respiratory surges.
- Protects wider inpatient and specialty capacity.
- Maintains patient flow during periods of escalation.
- Provides a framework that can be adapted to different sites, estate configurations and operational circumstances.
- Demonstrates the Health Board's ability to rapidly operationalise national guidance and local escalation plans.

Community Hospitals Operational Plans

Approach

- Intensive focus on flow and discharge. Expedite discharges.
- Daily senior deep dives (Senior Nurses) of all patients with ward staff, DLNs, LAs and Hub to monitor actions and plans for discharge enabling early identification of system blocks and actions that need to be escalated to release capacity.
- Weekly enhanced Care meetings led by Community with Planned Care and USC.
- Clinical Leadership within the Discharge Hub via a DLN.
- Bed decant plan for ward and patient moves being developed to inform additional staffing requirements and mitigations.
- Beds will be flexibly and dynamically allocated to acute sites based on risk and escalation.

Care Group - Overviews

USC – Overview

All sites

- Reduce boarding arrangements.
- Restore 16 commissioned beds.
- Focus on Acute Medicine LOS <72 hours.
- Align frailty services to UEC demand.
- Implement GP SDEC First.
- Progress EEMAC implementation.
- Identify additional uncommissioned capacity, if required, to temporarily decompress sites with clear step down plans in place for swift exit.

Surge and additional capacity

- No funded additional surge - dynamic flexing of pre-identified capacity for short periods of time.
- De-escalation of commissioned capacity pre-Christmas to support a surge capacity plan for mobilisation over the first two weeks of January 2027
- Annual leave for Registered Nursing is suspended for the two-week Christmas period to support robust staffing plans
- Seek to support additional SDM for AMU ward rounds over the weekend and BH of the Christmas period

Specific Operational Measures Dec-January

- To review daily staffing levels – particularly Consultant - during holiday period and into January to ensure timely discharges continue during and in between bank holiday periods.
- Work with Site teams to plan and deliver the de-escalation of beds/wards across acute sites in run up to holiday period.
- Review of vacancy position across USC to ensure timely plans are in place and actioned to recruit/mitigate.

Risks and Issues

- The absence of additional inpatient bed capacity to support seasonal demand may result in sustained occupancy

Planned Care – Overview

Elective Capacity

Where possible, the elective programme will be maintained at all sites in line with the ministerial enabler to protect 90% of days planned care inpatient/day-case/theatre recovery capacity from unscheduled care pressures. However, theatre planning will remain dynamic through the 6:4:2 scheduling mechanism and a weekly utilisation forum.

Capacity identified in non-trauma services will be reallocated to ease some of the pressures on trauma across CTM. A test of change for a Trauma Discharge Ward is currently being developed with options for staff skill mix being explored.

Surge

An ITU surge SOP has been developed and shared. We plan to protect elective capacity throughout the winter and continue using IPDC capacity flexibly, notwithstanding some of the UCL trends which indicate we will be at 130%/140% of trauma capacity. This has identified challenges in stepping down to community sites due to capacity/bed availability. A workshop is being planned with Primary Care and other relevant Care Group colleagues to share bed modelling and identify ways to support discharge/step down processes.

Discussions are taking place to finalise the relocation of ophthalmology services to enable Surgical SDEC space within RGH. Options to bolster SDEC and SAU in RGH are going through formal communication process with timelines currently being agreed. Ward 11 in RGH will be opened overnight to support Surgery flow.

Critical Care

An ITU surge SOP has been developed and shared. PCH has a plan to open 9 beds in early October to support acute surgical flow through winter. Surgical SDEC will remain open in PCH. Critical care in PCH will be operating from a new 12 bed unit from October and will be used as surge ICU for CTM.

Staffing capacity / resilience

Peak in the winter months (Nov-Jan) recognised trend, these trends will be used to inform winter plans with proactive health and wellbeing interventions and work redesign, with a proactive focus on maintaining healthy working environments at local level. Additional workforce will be agreed in times of exceptional demand.

In hospital acute bed capacity

Scenario planning with CTM information leads in evolved stages. Currently working within a range of 6% to 20% additional demand on non-elective beds. However, work ongoing re trauma pathway and

Risks / Issues for discussion

Surge capacity is unfunded, therefore there is a risk to financial sustainability due to increases in variable pay.

Primary & Urgent Care - Overview

GMS

- Active monitoring of 44 practices through escalation framework
- Commissioning of supplementary services for frailty (16 practices), flu (43 practices)
- OWLs pending funding route as planned care committed
- To encourage GP practices to bring forward repeat prescribing ahead of the Christmas period where this is possible. Comms promotion of the same.

Out of Hours

- Consistent shift fill across the 3 PCCs and home visiting- reporting level 1.
- Extension of navigation hub and care home avoidance on weekends

Urgent Primary Care / Clinical Navigation Hub

- Expanded SPOA (Nav Hub) to operate 7/7.
- Integrated response with LA mobile responders to attend falls from the ambulance stack.
- Pro-active PTAS screening
- Urgent community response and virtual ward
- Admission avoidance – Care Home conveyances and direct access to SDEC.

Optom/Dental

- Continued rollout of WGOS 4&5
- Core service provision including urgent access

Risks/Issues for discussion

- Observing increase in GP sickness and therefore impact on locum reimbursement costs

HOSPITAL AT HOME WINTER ASSURANCE

2026/27

Targeted actions to release capacity, improve discharge and support admission avoidance

1 Protect capacity

- **Ring-fence HCA capacity** between 21 and 31 December for release in early January.
- **Rationale:** avoid capacity being held through Local Authority shutdown and handover periods.
- **Action:** agree and communicate the approach with acute sites.

2 Enable front-door discharge

- **IV pathway in progress** to support ED and SDEC turnaround and IV care in the community.
- **Predicted operational delivery:** November 2026.
- **Action:** confirm communications and referral arrangements with front-door services.

3 Make discharge reliable

- **Standard checklist:** TTH and MAR charts, equipment, key safe, district nursing and transport.
- **Care-home support:** direct Hospital at Home MDT input linked with the Navigation Hub.
- **Weekend focus:** address medication and urgent transport barriers.

4 Resolve delays early

- **Daily Discharge Hub oversight** of delayed eToCs, therapy, social-work and complex-discharge actions.
- **Escalation:** through Care Group, Local Authority, DLN and CHC routes.
- **Care-call constraint:** review medicines and consider safe family bridging with Hospital at Home support.

CURRENT POSITION **5 days** average from accepted eToC to discharge or transfer

IMPROVEMENT AIM **3–4 days** while continuing to work towards the 48-hour target

BOARD ASSURANCE

Hospital at Home actions are focused on releasing capacity at peak pressure, strengthening front-door alternatives and reducing avoidable discharge delay. Delivery requires clear communication with acute sites, front-door services, community teams and Local Authority partners.



Community Overview

Community Capacity

- Focus on Care Homes and supporting patients within their own home. Reassessment of patient needs whilst in own home – preventing admission.
- Frequent flyers development working in collaboration with Nav Hub.
- OOH district nursing capacity
- Specialist Nursing services current demand outweighs current available capacity.

Discharge Services

- Developing MDT triage in the discharge hub to reduce delays for assessment.

Community Beds and Surge Capacity

Current position:

- 100 Beds YCC plus 2 Surge
- 108 Beds YCR plus 2 Surge
- 10 Beds Ward 3 Angelton – 0 Surge
- Y bwthyn Newydd Bridgend SPC – 8 beds
- Y bwthyn RGH SPC – 8 beds

Total Current Capacity: 234 beds (238 including surge)

Staffing Capacity /Resilience

- Continued staffing issues OOH in SW@H
- Reliant bank for surge staffing
- Reliant on bank for enhanced care capacity.

Integrated Working with Local Authorities

- Proposed risk and escalation in line with new discharge service
- Straight to service model action plan in place for MTCBC
- Integrated winter plan IDDB

Risks/ Issues for discussion

- Workforce capacity ward 5 – recruitment is dependent on Community Beds Re-design Programme
- Appropriate Enhanced Care capacity in community sites
- Development and embedding of the new SPC provision

Children and Families – Overview

Total Beds

57 beds across 3 sites
- PWH: 16 beds (incl. 2 HDU)
- RGH: 19 beds (incl. 2 HDU)
- PCH: 22 beds (incl. 2 HDU)

PAU Capacity

- PWH:6 beds + 2 treatment rooms
- RGH: Ward 18 7 PAU Beds + 9 Booked spaces
- PCH:12 booked beds; 7 cubicles (flexible use incl. CAMHS/ALN) 1 cubicle accommodates 5 chairs to increase flow.)

Surge Response and Additional Capacity

- Twice-daily huddles across 3 sites
- Surge plan: 25% increase = 14 beds (6 PCH, 4 PWH, 2 RGH)
- 4 extra nurses per 25% increase (bank/agency/overtime)

Staffing and Resources

- Reliant on agency and overtime for surge staffing
- No issues with HB resources (kit, consumables, training)

Care & Clinical Pathways

- Multi-disciplinary agreements for respiratory support & transfers
- Paediatric nurses trained in non-invasive/invasive ventilation (annual update)
- Standard pathways for elective surgery and emergency care remain, subject to capacity

Escalation and Business Continuity

- Escalation policy ensures care close to home; triggers for diverting admissions only when necessary
- Supports local escalation and mutual aid (including external HB if needed)
- Surge plans incorporated into HB business continuity

Medicines Management- Overview

Contractor Engagement

WG incentive scheme for pharmacies:

- Manage sore throat & UTIs via CAS
- "Help Us Help You" campaign
- CAS patient experience feasibility study

Aim: Increase CAS activity for defined period.

Monitoring CAS/PIPS Activity

- CTM to track consultations before & during winter.
- Focus on sore throat & UTI.
- Engage pharmacies with low CAS/PIPS activity.
- Confirm claims via NECAF module.

Professional Development

- Signpost pharmacies to CPW/WG resources.
- Promote services via social media.
- Update patient-facing website content.

Acute Sites – additional clinical shifts

- Additional pharmacist on weekend shifts (2–3 hrs/day in ED/AMU) planned for Dec/Jan
- Extra clinical services on bank holiday weekends (voluntary).
- Team-based working with daily huddles (S2S template).

School Vaccine Programme

- Early opening at PCH for vaccine collection (health protection funding).
- Secured funding for extra couriers to speed vaccine transport to schools.
- Central procurement progressing; first stock drop successful.
- Addressing interim ordering challenges via redistribution.

Respiratory Care Bundle

- Continue secondary care respiratory bundle:
  - Steroid & antimicrobial rescue packs
  - Smoking cessation advice
  - Inhaler counselling
  - Medicines optimisation
  - Vaccination

Local Authorities

Local authority- Rhondda Cynon Taf

Actions
Rota: We will ensure sufficiency of senior management and director support (in hour and out of hour) to enable staff to escalate resource decisions where required – rota of RCT Social Care Director and Deputies for in work hours and via Emergency Duty Team out of hours. Telephone numbers provided.
There is a Staff Forum on 11th November, when we will be highlighting seasonal preparedness and outlining arrangements for senior management cover over the holiday period.
There is a local authority wide programme in place to update our emergency plans in the event of adverse weather, food and fuel shortages, power outages etc.
We will ensure sufficiency in our Single Point of Access arrangements to enable eTOCs to be processed in a timely manner to support hospital flow.
Following discussions with providers we will update CTM of arrangements for last dates for packages of care and care home admission during the Christmas and New Year period
We will flexibly deploy our assessment staffing resource to respond to surges in demand
We will hold daily communications with our home care providers via our brokerage service regarding packages of care, availability and capacity to provide early identification of risks to timely discharge
We will be speaking to our providers (home care, care home and supported living) in the forums that we have with them in November. We will update the UHB regarding arrangements over Christmas/New Year period once we have gathered information from all of the providers.

Local authority – Merthyr

Actions
• Rota: Out of hours rota arrangements
• Reablement and Initial response team equipped to take straight to service post hospital discharge
• Fast track approval of commissioning services i.e. Care Home
• Work with Families re the utilisation of interim placements where first choice is not available and reluctant discharge process is instigated
• Support our framework providers to take Straight to Service where appropriate
• Fast track social work assessment for complex discharge
• Provide one off winter payment to our commissioned homecare providers

Local authority – Bridgend

Actions
Maintain and monitor impact of the Care Home Project, a Hospital Avoidance Service for individuals with the frailest and most unstable physical or cognitive health in Bridgend County Borough Council.
Maintain presence at Business Continuity meetings.
Maintain twice weekly meetings with Flow Teams for update/ share information on progress. These meetings will increase in frequency in times of escalation. Widen attendance to Network Management.
Caseload review. Identify individuals' cases that could be transferred earlier to community colleagues who can undertake first reviews, for example make transfers as able, work more flexibly to support flow.
Cleanse individual cases on caseload that are awaiting transfer to other teams to expedite hand over
Ensure optimum staffing cover with available staff. Consider staffing capacity- if considering request for additional staffing- be clear on reasons- purpose, workload to be allocated, period requested for the additional cover.
Prioritise new hospital referrals across both Short and Long Term Social Work functions. Discharge coordinators to be utilised throughout the acute hospital setting.
At severest levels of escalation within the service, staff appraisals, statutory and mandatory training will be cancelled/rearranged.
Social Work teams will continue to use out of county placements where appropriate .
The social work teams will ensure families understand that homes with vacancies will need to be first for consideration until a place in chosen home becomes available.
Flexible use of the 6 social care beds in Bryn y Cae, within the scope of its registration- bridging, step up and reablement uses.

Support for people with chronic respiratory conditions and symptoms of breathlessness

Respiratory Winter Preparedness

Supporting high risk respiratory patients closer to home

- Virtual Respiratory Ward has transitioned from the Navigation Hub model to the Doccla virtual monitoring service.
- Ongoing community support provided through COPD Specialist Nurses and the Early Supported Discharge COPD Team.
- Asthma and COPD discharge bundles are embedded across acute sites to support timely discharge and reduce avoidable readmissions.
- Doccla is being expanded to support additional high risk patient cohorts, including targeted deployment within a Bridgend GP practice.

Rehabilitation and recovery

- Pulmonary Rehabilitation services are able to assess patients promptly.
- Direct links between Doccla and Pulmonary Rehabilitation support early intervention and ongoing self management following discharge.

Winter assurance

- Integrated respiratory support model combines virtual monitoring, specialist nursing, early supported discharge and rehabilitation services.
- Focus on admission avoidance, earlier discharge and proactive management of patients at greatest risk of deterioration over the winter period.
- the Education subgroup of the Respiratory Planning + Implementation group (predominately led by pharmacy) has been engaging with primary care colleagues to implement the All Wales Prescribing guidelines for COPD and Asthma.
- The ICST guidelines are embedded within CTM but both in-hours and out-of-hours GPs plus the community respiratory team have received a reminder email from the Care Group Medical Director sharing the guidelines.

Future development

- Development of a wider breathlessness pathway remains at an early stage and is expected to align with emerging Communities by Design workstreams.

Mortuary and Bereavement

Mortuary Escalation Plan

A four-level escalation framework, with cumulative actions at each stage

1 What

A structured escalation plan based on occupancy, remaining spaces, post-mortem backlog and specialist storage availability.

2 So what

Pressure at one site can rapidly become a Health Board issue. The plan uses transfers, contingency storage and progressive senior escalation to protect dignity, safety and flow.

3 Controls

Daily capacity calls, traceability, adequate staffing, timely collection, cross-site transfers and Datix/SAI reporting apply through escalation.

4 Committee ask

NOTE the framework and seek assurance that the operational dependencies can be mobilised.

Key assurance message

The escalation stages are cumulative: each higher level retains the controls from all preceding levels and adds further capacity, leadership and external escalation actions.

Escalation framework

Thresholds move from steady state to extreme pressure

LEVEL 1 • STEADY STATE

OCCUPANCY

Below 180 occupied

SITE CAPACITY

15 spaces at each site before Friday close

POST-MORTEM BACKLOG

PM backlog <5 days

LEVEL 2 • AMBER LOW

OCCUPANCY

180 occupied (76%)

SITE CAPACITY

Any site below 15 spaces

POST-MORTEM BACKLOG

PM backlog >5 days

LEVEL 3 • AMBER HIGH

OCCUPANCY

200 occupied

SITE CAPACITY

Any site below 10 spaces

POST-MORTEM BACKLOG

PM backlog >10 days

LEVEL 4 • RED

OCCUPANCY

225 occupied (95%)

SITE CAPACITY

Any site below 5 spaces

POST-MORTEM BACKLOG

PM backlog >15 days

Additional Level 3/4 indicators include bariatric and freezer-space thresholds.

Actions by escalation level

Operational response expands as pressure increases

1 Steady state	Daily site capacity calls; timely collection; cross-site transfers; maintain staffing, traceability and Datix/SAI controls.
2 Amber low	Weekend release by appointment; transfer into TS2 at PCH; seek additional post-mortem activity; maintain at least 15 spaces per site.
3 Amber high	Open internal contingency storage at PCH Nutwell; assess community body stores, contracted funeral director capacity, rental units and LRF provision.
4 Red	Advise HTA, Executive Board and LRF; transfer to external contingency storage; install rental or LRF contingency units.

Enduring operational controls

Controls that apply across all levels of escalation

1 Capacity intelligence

Daily calls to acute mortuary sites; maintain capacity logs; communicate risk level and figures to site leadership.

2 Flow and transfers

Prompt collection by funeral directors and Coroner service; transfer between sites or into contingency capacity as required.

3 Safety and dignity

Maintain full traceability of the deceased and sufficient staffing to meet demand.

4 Incident governance

Use Datix and SAI processes to capture and report risks and events through every escalation level.

5 Weekend readiness

Confirm weekend and bank holiday capacity, including additional-day provision and site-specific availability.

6 Leadership escalation

Progress from mortuary and cellular pathology managers to Directorate, Care Group, Clinical and Executive leadership.

Committee assurance: material dependencies

Areas where operational readiness should be evidenced

Contingency capacity	Availability and readiness of TS2, PCH Nutwell, community body stores, contracted funeral director provision and rental/LRF units.
Transport	Access to the hospital private ambulance, with D L Evans as the stated alternative where unavailable.
Post-mortem flow	Ability to secure additional post-mortem activity before backlog thresholds worsen.
Workforce	Sufficient staffing for routine activity, transfers, weekend releases and contingency arrangements.
Governance and communication	Reliable escalation from operational managers through Directorate and Care Group leadership to Executives, HTA and LRF at Level 4.

Assurance evidence: latest capacity position, contingency readiness checks, transport arrangements, staffing cover and escalation contact list.

Mortuary and Bereavement Winter Planning

ctmuhb.nhs.wales

Mortuary winter planning focuses on:

- Minimising delays in death certification processes – During winter 24/25, death certification completion times increased significantly. Reducing these delays will help maintain workflow and improve the experience for the bereaved.
- Implementing a Mortuary Occupancy Escalation Plan – This plan details actions to be taken as mortuary occupancy reaches certain thresholds, ensuring that deceased patients are treated with dignity and in accordance with Regulatory requirements (HTA).

Reducing delays in MCCD completion

- The CTM QR code to notify the Medical Examiner Service of a death was introduced at the end of Oct 25 and has had a positive impact on the management of MCCD completion.
- No complaints have been received to date, and the Clinical Director has been regularly communicating with mortuary and bereavement staff to identify and address any issues.
- The QR code notifies Bereavement Officers upon completion, providing oversight to ensure timely processing.
- It helps identify alternative potential QAPs involved in the deceased's care, reducing delays.
- The code includes links and guidance to promote a 'right first time' approach.
- It allows for delays in the process to be detected and escalated through an established escalation procedure.
- Data collected through this system is auditable, enabling identification of areas or specialties with poor compliance for targeted interventions.
- Overall, this supports managing mortuary occupancy by decreasing the length of stay.



Proposed Escalation Process for MCCD Completion Delays

2 days after death – if no QR code submitted, Bereavement team make contact with QAP and Consultant

→

3 days after death – if QR completed by medical team, Mortuary Management Team escalate to Care Group Manager

→

4 days after death – if QR not completed the CD, DM and DTPS team will escalate to Exec. Medical Director's Office

3 days after scrutiny completed – if MCCD not completed, Bereavement team make contact with Consultant

→

5 days after scrutiny completed – if MCCD not completed by medical team, Mortuary Management Team escalate to Care Group Manager

→

7 days after scrutiny completed – if MCCD not completed the CD, DM and DTPS team will escalate to Exec. Medical Director's Office

Facilities

Weather Warning Organisational Preparations

Yellow

Plan ahead thinking about possible travel disruption or delays;
Monitor the developing weather situation.
Latest forecast for changes in weather and worsening conditions
Review transport requirements
Internal/external gritting teams alerted
CTM Civil Contingencies Manager alerted
Regional Facilities Leads and ASGM alerted

Amber

Initiate Adverse Weather teams and site operational hubs;
Review staff rota's to ensure appropriate staffing levels during period of adverse weather
Put plans into place to support the most vulnerable patients in the community
Notify Executive Team and standby Silver command, and; the Chief Operating Officer will consider if outpatient clinics need to be cancelled?
Review Hospital accommodation to try and accommodate front line key clinical staff that need to stay on sites over night
Review and prepare transport requirements
Internal/external gritting teams alerted
Civil Contingencies Manager alerted
Regional Facilities Leads and ASGM alerted.

Red

Initiate Adverse Weather teams and hubs
Review staff rotas to ensure appropriate staffing levels during period of adverse weather
Notify Executive team and Gold command activated, and the Chief Operating Officer will consider if site outpatient clinics need to be cancelled
Put plans into place to support the most vulnerable patients in the community
Review Hospital accommodation to try and accommodate front line key clinical staff that need to stay over night
Internal/external gritting teams alerted
Civil Contingencies Manager alerted
Regional Facilities Leads and ASGM alerted
Link in with supporting agencies e.g. Mountain Rescue, Local Authority, Police.

HPV Service – Winter Resilience

HPV Services Resilience

- There are a total number of 16 HPV Machines across CTM – located in Acute and Community hospitals to support a current demand profile in each Region.
- There are processes in place to relocate machines across sites to support additional demand as required.
- We are currently in the process of confirming with IPC the appropriate use of HPV and UV where the type of infection allows.
- UV as an alternative treatment will support a quick turnaround of infected rooms to support patient flow.
- Double cleaning may be used as an additional fail-safe where appropriate and approved by IPC, helping maintain service continuity when HPV or UV treatment is unavailable or delayed.

Support to avoid delays

To maximise efficiency and avoid delays the following support is required:

Timely communication of planned discharge:

- Timely communication in respect of planned discharge or patient transfer to allow for the length of time required to treat rooms

Nurse Cleans

- Nurse cleaning to be carried out as appropriate to ensure that there are no delays in starting of HPV & UV treatment

HPV Chemical Cannisters

- Where purchased by clinical teams, orders need to be processed in a timely manner to maintain sufficient stocks. Minimum stock levels to be established and communicated.

Risk Mitigation

- A service maintenance and repair contract is being implemented to support the HPV machines.
- Supplier response times agreed for Emergency and normal service demands
- Deep clean plan in place to support preparations is advance of winter pressures

Staff Capability/Capacity

- Regional Capacity monitoring in place with predetermined escalation triggers.
- Staff training plan in place to maintain cover and support demand surges.

Behind the Scenes-Operational Arrangements

Escalation Process – Intelligence Triangulated from Met Office, Grittit, Local Authorities and Local Observations on the ground



De-escalation Process – Intelligence Triangulated from Met Office, Grittit, Local Authorities and Local Observations on the ground

From Red to Amber	Check weather reports. Liaise with hub leads and support services e.g.Falk, Mountain Rescue	Confirm status of public Transport	Liaise with Internal & External Gritting teams	Contact Assistant Director of Facilities and Civil Contingencies Manager	Liaise with Community Teams	Send out Organisational Communication out	Stand down to Yellow
From Amber to Yellow	Check weather reports and liaise with Hub leads	Liaise with internal & external gritting teams.	Confirm status of public transport	Contact Assistant Director of Facilities and Civil Contingencies Manager	Send out organisational Communication out	Stand down to Yellow	
From Yellow to stand down	Check Weather Reports and liaise with Hub leads	Liaise with Internal& External gritting teams	Confirm status of public transport	Contact Assistant Director of Facilities and Civil Contingencies Manager	Send Organisational Communication out	Deactivate Adverse Weather Policy and stand down staff. **Status Quo**	

NEPTS

NEPTS

CTMUHB are committed to working collaboratively with NEPTS to ensure that discharge and transfer resources are utilised effectively to improve patient experience, improve hospital flow and deliver value for money. Through proactive relationships, a range of actions are being developed and taken to deliver improved outcomes.

Strategic actions:

- NWJCC NEPTS CAG - partnership working between health boards and WAST
- NWJCC NEPTS Vision Group – development of actions aligned to the NWJCC NEPTS Future Vision

Health Board actions:

- Review discharge planning processes
- Development of discharge lounges RGH pilot underway
- Education and training on NEPTS bookings *(WAST to support with documentation)*
- Integrating Ambulance Liaison Officers into site meetings
- Reducing on the day booking requests
- Regular review meetings with NEPTS Leads

NEPTS continued

WAST actions:

Digital

- D+T Dashboard Live, continue to review and develop where necessary

Dynamic demand and capacity reviews

- Review D&T demand, crew availability and outstanding journeys throughout the day.
- Adjust allocations and redeploy available resources across localities as pressures change, matching crew capability to patient needs.

Maximising efficiency and resilience

- Use the roster review to strengthen D&T cover and resilience, aligning WAST and alternative-provider capacity with demand.
- Through the NEPTS Improvement Programme, improve journey planning and vehicle utilisation to make best use of available capacity.

Daily coordination

- Use the established D&T touchpoint channel and daily single point of contact to share demand, available crews and unresolved issues.
- Ensure liaison teams are engaged in daily activity and actively communicating forseen challenges for mitigation
- Keep the resource position updated and escalate capacity shortfalls to ODU early.

Discharge and transfer capacity

- Review WAST and commissioned-provider availability together, including weekend cover.
- Agree suitable redeployment or additional provision where gaps arise, subject to availability and patient requirements.

Joint working with Health Board teams

- Confirm expected discharges and transport requirements early with site and liaison teams.
- Escalate delays or journeys at risk, with a named owner and agreed review time.
- Maintain updates through the day so health board teams can plan around the confirmed transport position.

Out of Hours & Escalation

Executive Winter Contingency Escalation Arrangements

Executive on-call rota covered 365 days a year

Contingency measures:

Non-operational exec colleagues (corporate directors/deputies)

Senior care group or COO/DCOO buddy system for bank holidays & high-demand weekends

Escalation Policy:

Enacted Oct 1, 2025 (OMB sign-off)

Supports escalations in/out of on-call roster

45-minute escalation cards

EPRR:

Increased to 3 members for winter

Provides exec support in/out of hours

Monitors weather (Met Office), ground conditions (NRW), horizon scanning

Activates Adverse Weather Policy per SWLRF severe weather arrangements

Command and Control Hubs - Facilities

Facilities Adverse Weather Contingency

Lead: Deputy Service Director & Head of Facilities & Security
(supports Director of Facilities & D/COO)

3 hubs on standby or activated as required:

PCH, KHHP & YCC: Lead, 2 admin staff, 3–6 trained 4x4 drivers per shift

RGH, YCR & YGT: Lead, 2 admin staff, 3–6 trained 4x4 drivers per shift

POW, Glanrhyd & Maesteg: Facilities & Site Management, 2 admin staff, 3–6 trained 4x4 drivers per shift

Adverse weather rota maintained year-round; staffing scaled to alert level

Out-of-area pickups: Directed to PCH hub

Additional 4x4 resources:

Community district nurse teams: (1) vehicle per region

Medical Records Hub (Williamstown): (1) vehicle

GPOOH: (2) vehicles

Central hub transport available for support if required

Communication and Engagement

Seasonal Communications (October 2026 – March 2027)

Proactive

- Launch of "Keeping Winter Well" campaign – focus on prevention, winter messaging and community support
- Development of evergreen messaging (flu, cold weather, access to services, slips, trips and falls)
- Updates to Primary Care webpages
- Staff flu campaign
- Stakeholder collaboration for shared messaging
- Content collation and planning for Primary, Out of Hours and Urgent Care
- Launch of Viva Engage for informal staff wellbeing support
- GP prescriptions

Prevention

- Promote flu vaccination for public and staff
- Launch of "Keeping Winter Well" campaign – focus on prevention, winter messaging and community support
- Encourage warm home practices (layering, reducing draughts, community signposting to support)
- Educational content on minor illnesses and self-care to prevent attendance at ED

Reactive

- Crisis messaging templates (weather, travel, ED pressures)
- "Help Us Help You" messaging during peak periods
- ED video content to discourage inappropriate attendance
- NHS 111 Press 2 mental health support promotion
- IPC advice and guidance – responsible visiting, not attending if poorly
- Real-time social media monitoring and misinformation response
- Amplification of urgent care alternatives (Minor Injuries, OOH)

Escalation

- Stakeholder toolkit using padlet for use / sharing with communities
- Advisory graphics and messaging for busy ED periods
- Continued engagement with partners to adapt messaging
- Operational toolkit for Comms Team (weather, travel, crisis)
- Use of operational data to guide comms focus
- Transparent internal comms to support staff and patients

Risks / Issues / Dependencies

Risk	L	I	Current Score	Key Mitigations	Residual L	Residual I	Residual Score	RAG
Increased Demand, Respiratory Illness & Patient Complexity	5	5	25	Respiratory surge plans, Hospital @ Home, Navigation Hub, surveillance and capacity planning.	4	5	20	
High Bed Occupancy, Flow & Discharge Delays	5	5	25	Optimise, Site Flow, D2RA oversight, COFD reviews, discharge governance and partner working.	4	5	20	
Emergency Care, Ambulance Handover & Critical Care Pressures	5	5	25	SDEC, WAST collaboration, Care Home Pathway, Call Before Convey, escalation arrangements.	4	5	20	
Funding and Affordability of Winter Escalation Capacity	4	5	20	Capacity modelling, escalation triggers, operational command arrangements, workforce planning and deployment plans, utilisation review and financial monitoring of additional beds and staffing.	4	4	16	
Surge Capacity & Estate Constraints	4	5	20	Capacity modelling, alternative escalation capacity, contingency planning and estate reviews.	4	4	16	
Workforce Resilience	4	5	20	Workforce planning, fragile services review, severe weather planning and redeployment arrangements.	4	4	16	
Community Capacity & Community Bed Availability	4	5	20	Community capacity monitoring, mobilisation plans and escalation arrangements.	4	4	16	
System Co-ordination & Partner Capacity	4	4	16	Integrated governance, discharge pathway performance monitoring and provider oversight.	3	4	12	
IPC, Outbreaks & Respiratory Testing	4	5	20	IPC plans, outbreak management, cohorting arrangements and testing contingency plans.	3	5	15	
Mortuary Capacity & Resilience	3	4	12	Mortuary resilience plan, escalation triggers and mutual aid	2	4	8	

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Risk	L	I	Current Score	Key Mitigations	Residual L	Residual I	Residual Score	RAG
Maintaining level of community beds during re-design implementation phase	4	5	20	Following outcome of OCP phase indications are that there are no staff agreeing to transfer to YCC. A recruitment process will be undertaken for ward 5. The option of opening up the ward aligned to the closure of YGT is now not possible.	3	4	12	
Insufficient Therapy input	4	4	16	Discussions with Therapies Clinical Lead to re-align staff to meet community capacity. Alternative to restrict the admission criteria to wards 19 and 20.	2	3	6	

Next steps

Moving from preparedness activity to sustained winter delivery

1 Cascade

Share refined plans by the 2 November 2026 with colleagues and partners as appropriate

2 Mobilise

Confirm partner actions, communications, workforce arrangements and readiness activity.

3 Exercise

Test key arrangements and use learning to strengthen resilience before and during winter.

4 Operate

Use shared intelligence, governance and escalation arrangements throughout the winter period.

5 Review

Monitor delivery, emerging risks and outcomes, with learning carried forward.

Overall objective: one regional approach, clear accountability and continued Board visibility of material winter risks.

CTMUHB Public Board

Welsh Language Standards Annual Performance Report 2025/2026

Eitem yr Agenda / Agenda Item	8.1.6
Dyddiad y Cyfarfod / Date of Meeting:	26 November 2026
Statws Cyhoeddi / Publication Status:	Open/Public. Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Dr Ben Screen, Arweinydd y Gymraeg/ Welsh Language Lead
Cyflwynydd yr Adroddiad / Report Presenter:	Dr Ben Screen, Arweinydd y Gymraeg/ Welsh Language Lead
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Hywel Daniel, Deputy CEO/Executive Director for People
Diben yr Adroddiad / Report Purpose:	For Approval
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	The Board are being asked to APPROVE the report.
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol* *Strategic Context:* *This report aligns to the following Strategic Pillars*	Inspiring People If more than one applies please list below:
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan *(Reference relevant priority)*	Developing Welsh language capacity across CTM UHB, focussing particularly on developing the skills of the existing workforce and recruiting new Welsh speakers, is a commitment in the IMTP. The contents of the Annual Report, and the summary thereof in this covering paper, provides an update on progress with that work.

Crynodeb Gweithredol o'r hyn y mae'r adroddiad yn ei ddisgrifio:
Dechreuwch drwy grynhoi'r wybodaeth bwysicaf yn fyr. Dylai hyn roi dealltwriaeth gadarn o'r pwyntiau allweddol yn erbyn y 3 phennawd canlynol heb ddarllen yr adroddiad llawn:
Executive Summary of what the report is describing:

Start by summarising briefly the most critical information. This should provide a firm grasp of the key points against the following 3 headings without reading the full report:	
Beth *(crynodeb o'r sefyllfa / mater cyfredol a pham ei fod yn bwysig a thystiolaeth i gefnogi'r safbwynt hwnnw ac ati)* What *(summary of current position / issue & why it matters and evidence to support that position etc)*	CTMUHB is required by Welsh Language Standard 120 to publish an annual report relating to its compliance with Welsh Language Standards. This report satisfies that requirement, and this covering paper serves as a summary of the contents thereof.
Felly, beth *(darparu dadansoddiad ystyrlon gan dynnu allan, fel y bo'n briodol, oblygiadau yn erbyn Strategaeth / Cynlluniau Cyflawni / risgiau Strategol neu Reoleiddiol CTMUHB ac ati ac unrhyw opsiynau ar gyfer mynd i'r afael â'r rhain)* So, what *(provide meaningful analysis drawing out as appropriate implications against CTMUHB Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)*	• There has been further progress with growing the Welsh language in CTM UHB during the 2025/26 operational year. • Evidence of that progress can be seen in the 'Welsh Language & Culture Dashboard' in Appendix 1. This is a visual summary of progress with essential measures of development, such as the number of staff improving their Welsh language skills, the number of impact assessments completed and the number of vacancies requiring Welsh language skills, among other measures. • In addition to areas of progress, the annual report itself sets out the Standards with which CTMUHB remains non-compliant. Standards for which High Assurance cannot be reported account for 35% of all Welsh Language Standards. This represents legal and reputational risk to CTMUHB, notwithstanding the progress above. • The operational plan for 2026/27 continues to focus on the compliance controls and processes necessary to not only sustain current progress but to improve remaining areas of non-compliance, particularly within recruitment. This is in addition to cultural change initiatives such as leadership development to ensure this work is carried out in a co-operative, supportive and encouraging way.
Beth Nesaf *(crynodeb o'r camau gweithredu a fwriadwyd a'r manteision sy'n cefnogi'r dewisiadau a'r argymhelliad(au) sy'n cael eu gwneud)* What Next *(summary of intended action and*	This is a public report in relation to regulatory compliance, and it is recommended its contents are noted and that the report is endorsed for Board approval.

benefits supporting the choices and recommendation(s)being made)	

Argymhelliad *(Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).* Recommendation (Linked to the "What Next" section above).	The Board is asked to APPROVE the Welsh Language Standards Annual Performance Report for 2025/26.

1. Background / Context

1.1 The Welsh Language Standards Annual Performance Report is a narrative report on compliance with Welsh Language Standards, and the contents thereof are summarised in this paper.

2. Strategic Insights

2.1 Welsh language development is becoming embedded within core organisational planning. For the first time, Welsh language development has been incorporated into the Integrated Medium-Term Plan through a dedicated Welsh language delivery plan, demonstrating a shift from compliance activity towards strategic integration. This is supported by alignment with the People Plan 2025–2030 and the Health Board's 5-Year Strategic Plan for Clinical Consultations in Welsh.

2.2 A modest increase in organisational compliance can be evidenced. Standards for which High Assurance can be reported increased from 74 (2023/24) to 81 (2025/26), while Standards assessed as Low or No Assurance reduced from 29 to 18 over the same period. No Standards saw a reduction in assurance level during 2025/26.

2.3 Workforce data demonstrate year-on-year growth in Welsh language skills, particularly at Levels 3–5 (those most likely to support clinical conversations in Welsh). As recording rates have now stabilised, the increases seen during 2025/26 are more likely to represent genuine workforce development rather than improvements in data quality alone.

2.4 There has been increased engagement with the Welsh Language Development Service during the reporting period, and over 1,300 staff are estimated to have engaged directly with the Service during the year. Mandatory Welsh Language Awareness training has reached 76% of staff, 245 staff participated in Welsh language learning opportunities, and Welsh language development is now embedded within leadership and management development programmes. This supports broader organisational culture change and aligns with Cymraeg 2050, the national language strategy for Wales, and More Than Just Words ambitions, Welsh Government's plan for Welsh in health and social care, in addition to the Welsh Language Standards Regulations.

2.5 Governance and accountability arrangements continue to mature. Welsh language performance has received formal scrutiny through Board and Committee structures, supported by a defined audit methodology. These arrangements provide greater assurance regarding compliance risks and improvement planning.

2.6 One of the most significant developments during 2025/26 has been the continued integration of Welsh language development into organisational development and culture. Through the inclusion of Welsh language within leadership and management development programmes, targeted communications based on behavioural change principles, and increased leadership engagement, the Health Board is increasingly supporting long-term cultural change alongside regulatory compliance. This approach is intended to create an environment where Welsh becomes a more visible, normal and sustainable part of everyday service delivery.

3. Risks and Opportunities

3.1 Notwithstanding the benchmarking data showing improvement in core metrics in Appendix 1 and the progress described in Section 2 above, CTM UHB remains in breach with 35% of Welsh Language Standards.

3.2 The principal strategic challenge remains consistent delivery of Welsh language services across the organisation. Compliance concerns relating to recruitment assessment processes continue to affect the Health Board's ability to build Welsh language capacity in priority clinical services and frontline patient-facing roles.

3.3 To begin to change the issues described in 3.1 and 3.2, this operational year saw the creation of a recruitment decision tree to allow staff to categorise posts compliantly on job advertisements (such as 'Welsh Essential' or Welsh Desirable'), new standardised job advertisement wordings to encourage applications from those with Welsh language skills and increased manager training. These are a solid basis to build on during the 2026/27 operational year.

3.4 Lack of compliance carries legal, financial and reputational risk given the investigatory and enforcement powers of the Welsh Language Commissioner, as set out here.

3.5 The Welsh Language Statutory Delivery Group, established in June 2026, is a key opportunity to influence change operationally. Ensuring attendance at this Group by all Care Groups, and effective management of the action log at the appropriate level, will be key to ensuring further progress can be made on the ground.

4. Benchmarks

5.1 The Welsh Language Development Dashboard in Appendix 1 displays benchmarking data for core metrics of Welsh language development.

6. Conclusion

6.1 Further progress has been made on embedding Welsh Language Standards at a systemic level, improving processes and guidance to support compliance.

6.2 Challenges remain however operationally in relation to offering clinical services in Welsh, particularly within More Than Just Words Priority areas where care in Welsh has been clinically proven to affect patient outcomes. Frontline administration roles, such as receptions and call centres, are also unable to offer a service in Welsh.

6.3 Work during 2026/27 will focus on recruitment and workforce planning, in co-operation with the new Welsh Language Statutory Delivery Group, to build capacity to offer more of CTMUHB's services in Welsh.

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)* Link to Strategic Risk(s) on the Board Assurance Framework (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	Strategic Risk 3
	If more than one applies please list below:

Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals	A Wales of Vibrant Culture & Thriving Welsh Language
	If more than one applies please list below:

Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Culture & Valuing People
	If more than one applies please list below:

Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Asesiad Effaith Impact Assessment		
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg *(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r*	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please select a reason below.

rhestr ostwng a llofnodwch y Weithrediaeth.) Equality & Welsh Language Impact Assessment Outcome *(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)*	Summary of impact: Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Summary of impact:	Does not impact people Named Executive/Board member sign off for no EWLIA completion:
Canlyniad Asesiad Effaith Ansawdd *(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)* Quality Impact Assessment Outcome *(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)*		
Cyfreithiol / Legal	Yes (Include further detail below) This is a public report in relation to regulatory compliance and breaches therein.	
Enw da / Reputational	Yes (include further detail below) This is a public report in relation to regulatory compliance and breaches therein.	
Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report	

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Operational Delivery Committee	27/10/2026	ENDORSED FOR BOARD APPROVAL

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf Morgannwg University Health Board

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Dangosyddion Perfformiad Allweddol ar gyfer Datblygu'r Gymraeg
Key Performance Indicators for Welsh Language Developement

Total number of staff with Listening & Speaking Skills in Welsh at Level 3, 4 & 5

2025/26	2024/25
872 (+85)	787

Tyfu ein gweithlu dwyieithog: Recriwtio – Growing our Bilingual Workforce: Recruitment

Number of posts advertised as Welsh Language Skills are Essential

2025/26	2024/25
10 (+3)	7

Number of posts advertised as Welsh Language Skills Need To Be Learnt Once Appointed

2025/26	2024/25
5 (+5)	0

Tyfu ein gweithlu dwyieithog: Dysgu – Growing our Bilingual Workforce: Learning

Number of staff beginning a Welsh language course

2025/26	2024/25
245 (+41)	204

Number of staff expressing an interest in learning or developing their Welsh

2025/26	2024/25
212	252

Ymgorffori'r Gymraeg yn ein Diwylliant Sefydliadol - Embedding Welsh in our Organisational Culture

Number of staff completing a leadership development session with a focus on Welsh

2025/26	2024/25
76 (+76)	0

Number of Welsh Language Impact Assessments completed

2025/26	2024/25
35 (+23)	12

Mesurau Dangosol Eraill o Gydymffurfiaeth - Other Indicative Measures of Statutory Compliance

Percentage of Welsh Langauge Standards reporting High Assurance

2025/26	2024/25
65% (+3%)	62%

Number of complaints about Welsh Language compliance

2025/26	2024/25
4 (+2)	2

Number of requests received to translate between English & Welsh

2025/26	2024/25
4,266 (+1,564)	2,702

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Cymraeg

Mae'r ddogfen / ffurflen hon hefyd ar gael yn Gymraeg.
This document / form is also available in Welsh.



Cwm Taf Morgannwg University Health Board

Annual Welsh Language Standards Performance Report 2025/26

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About this report

Celebrating Cymraeg at CTMUHB: Our 2026 Update

This year, we've continued our commitment to delivering services in Welsh, in line with the Welsh Language Standards. This report highlights how we're embedding Cymraeg across our organisation—from the care we provide to the way we work every day.

We're proud of the progress we've made to promote bilingualism and support our Welsh-speaking communities. You'll find real examples of how we're putting our values into action in this report. Readers are welcome, as ever, to compare this report to the last. We are confident the trajectory can be seen clearly.

This report also meets the requirements of Welsh Language Standard 120. You can read our full compliance notice, setting out all of our legislative duties for Welsh, in Welsh here and in English here.

Want to know more about your right to use Welsh with us? See our patient information leaflet in Welsh here and in English here.

This report was approved by our Operational Delivery Committee in October 2026. We would be keen to hear your thoughts—email us at CTT_WelshLanguage@wales.nhs.uk in Welsh or English. You can also share feedback on your experience of care through our Patient Reported Experience Measures, in Welsh here and in English here.

Executive summary

This report tells the story of how Cwm Taf Morgannwg University Health Board (CTMUHB) has worked to strengthen its use of Cymraeg across its healthcare services during 2025/26. At its heart, it shows an effort to shift from compliance alone towards embedding Welsh as a normal, valued part of everyday healthcare that is seen, heard and spoken across our services.

Planning and Decision-making

Over the past year, the Health Board has taken steps to bring Welsh into the centre of its planning and decision-making. For the first time, a dedicated Welsh language plan forms part of its main organisational delivery plan, the Integrated Medium-Term Plan. Work has also continued on ensuring that Welsh Language Impact Assessments are completed, not only in terms of templates and guidance but also changing processes so as to ensure they are completed.

Measurable Progress

The report shows steady and measurable progress via a series of identified key performance indicators, as shown on Page 6. More staff than ever have Welsh language skills, more are learning, and participation in training continues to grow. At the same time, overall compliance with Welsh Language Standards ('Standards') has improved, with increases in assurance levels for some thereof.

Culture Change

A key theme throughout the report is culture change. Significant effort has gone into encouraging staff to use Welsh in their everyday roles — from awareness training and learning opportunities to visible campaigns and leadership development. Hundreds of staff have engaged with this work, and evaluation shows growing confidence and willingness to use Welsh with colleagues and patients.

Governance and Accountability

Strong governance underpins this progress. Clear leadership at Board level, structured monitoring of compliance, and the work of the Welsh Language Development Service ensure that improvements are planned and tracked. This includes a transparent approach to identifying gaps and driving continuous improvement.

The journey ahead

The report is also honest about ongoing challenges, and a full list of all Standards and their compliance status is included in Appendix 1. These challenges include ensuring consistent Welsh-language provision across all services, particularly in areas where it matters most such as those areas identified in the More Than Just Words Framework. Improving compliance around recruitment is also a recognised challenge. We continue to put meeting these challenges at the forefront of our development work for Welsh, as recognised below on Page 4 on our strategic planning.

1: Do you have a strategic approach to embed Cymraeg from Board to ward?

Integrated Medium Term Plan (IMTP)

The Integrated Medium-Term Plan explains how NHS organisations will use their resources over three years to deliver high-quality care that meets people's needs, with an annual plan complementing that work.

For 2026/27, Welsh language development was included through a clear, one-page plan setting out key priorities. This is the first time a dedicated Welsh language plan has been part of the submission.



People Plan and longer-term strategic planning

CTMUHB has published its People Plan for 2025–2030. It sets out what actions we will take to support our long-term strategy and create a workplace where everyone can thrive. One important measure of success is increasing the number of staff who can speak Welsh and improving their skills.

We are also continuing work on our 5-year plan to offer clinical consultations in Welsh. This supports national priorities and aims to make it easier for patients to receive care in their language of need.

Important goals in that 5-Year Plan include:

- Asking and recording patients their language preference (the "Active Offer").
- Increasing the number of bilingual staff.
- Promoting Welsh across the organisation.
- Raising awareness of language rights with our patients.
- Tracking progress with clear measures.



Annual operational planning

The Welsh Language Development Service has an operational plan each year, which brings longer-term planning into focus for that year. It brings in commitments in the IMTP, our People Plan and the 5-Year Strategic Plan into one detailed plan.

Progress on those priorities is outlined in this report.

2: How are you performing against core Welsh language performance indicators?

In our last report for 2024/2025, we shared a Welsh Language & Culture Dashboard.

Some of the metrics for that have slightly changed. The core ones, easily tracked over time, can be seen below with a comparison from last year.

To expand our ability to offer services in Welsh, we are focusing on a number of interconnected areas — each one playing a distinct role, but all working towards the same goal: **growing a confident, capable bilingual workforce across CTMUHB**.

- **Developing our workforce is the foundation**. By strengthening recruitment and supporting staff to develop Welsh language skills in the workplace, we are gradually increasing our capacity to deliver services in Welsh. This is why workforce metrics sit at the heart of the dashboard.
- **Supporting our managers and leaders** ensures this ambition is translated into everyday practice. When leaders understand their role and take timely, informed action, they create the environment where Welsh can thrive.
- **Embedding Welsh into decision-making** ensures that the language is not an afterthought, but a natural part of how we operate. Welsh language impact assessments help us consider opportunities and implications at the right point, reinforcing a culture where Welsh is routinely and meaningfully included.

These elements are not separate strands of work — they work together. Strong leadership supports workforce development; better-skilled staff make it easier to embed Welsh in practice; and consistent consideration of Welsh in decision-making helps sustain progress.

Alongside these core measures, there are three important indicators that help us understand the broader picture:

- Overall compliance with the Welsh Language Standards.
- Complaints relating to non-compliance.
- The number of translation requests received.

While these don't directly increase the size of our bilingual workforce, they give us valuable insight into how well Welsh is embedded within the organisation. In many ways, they act as a barometer — highlighting where the system is working well and where further attention may be needed.

Taken together, the dashboard tells a connected story: from building skills and leadership capability, through to embedding good practice, and ultimately strengthening our ability to deliver services in Welsh.

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Dangosyddion Perfformiad Allweddol ar gyfer Datblygu'r Gymraeg
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3: How have you promoted Cymraeg with your workforce and the public?

Embedding Welsh means evolving our culture, including improving how to support staff to use Welsh in their roles. That's why Communication and Engagement is a guiding theme, driving real change across the system.

Internal Communication Framework

Strategic communication supports change. When done well, it boosts engagement and helps staff commit to initiatives like developing Welsh.[1] Our updates follow the COM-B model—focusing on Capability, Opportunity, and Motivation—to support real Behaviour change across the organisation.[2]

We do this via four key categories, with examples throughout the report:

Da Iawn: celebrates staff best practice, using social proof to boost motivation.

It's More Than Just Words: highlights how Welsh improves patient experience—another motivator.

Staff Support: ensures access to resources and advice, building capability and opportunity.

Skills, Learning & Development: promotes training to grow Welsh language skills—enhancing capability to offer services in Welsh.



[1] Hargie, O., & Tourish, D. (2009). *Auditing Organisational Communication: A Handbook of Research, Theory, and Practice*. Routledge; Men, L.R., & Stacks, D.W. (2013). The impact of leadership style and employee empowerment on perceived organizational reputation. *Journal of Communication Management* 17(2), pp. 171-192.

[2] A more technical discussion can be found here: Mitchie, S. et al. (2011), The behaviour change wheel: a new method for characterising and designing behaviour change interventions. *Implementation Science* 6(42).

Well-promoted SharePoint site

There is a dedicated page for supporting staff to use Welsh at work and comply with the Welsh Language Standards. Accessible via the homepage of CTMUHB's staff intranet, it has been redeveloped using MS Office 365 tools and includes:

- Clear information on how to contact the Welsh Language Development Service.
- Latest news and updates.
- 'Why Welsh at CTM' video.
- Opportunities to learn Welsh and a simple booking link to 'Welcome-to-Welsh' sessions.
- Guidance on embedding Welsh and meeting the Standards.
- Resources to download such as bilingual Out-of-office templates.
- Information on staff rights to use Welsh at work.

Advice on complying with Welsh Language Standards

Guides on complying with Service Delivery Standards, Policy Making Standards, Recruitment & Appointing Standards and using Welsh in Communications & Engagement are available on SharePoint. We share these regularly with staff. This means that the Standards have been interpreted and simplified for the context of CTMUHB. These have all also been developed using the 'Welsh Voice/Llais y Gymraeg' strategy to foster belonging and respect, and CTMUHB branding, structured around 'Why', 'How', and 'What' we do in Welsh, and have practical examples and case studies included where relevant.

Welsh Language Awareness Mandatory ESR Module

An all-Wales online module, aimed at developing a consistent level of Welsh language awareness, is a mandatory training requirement. This module talks about the importance of Welsh in healthcare for Welsh speakers, the Welsh Language Standards and busts some common misconceptions about Welsh. As of March 2026, **76%** of staff in CTMUHB have completed it, which is just over 10,000 colleagues. The training must be completed every 3 years, so the completion rate may ebb and flow over time.

Engagement with CTMUHB staff

This year the Welsh Language Development Service engaged in many sessions, with 'engagement session' defined as following:

> A meeting, session or event, outside of the Welsh Language Development Service and excluding external meetings with people in similar Welsh Language roles across Wales, Welsh Government or other bodies and where the sole purpose of the meeting or part of it was specifically dedicated to the Welsh language.

- The Service held **181** different engagement sessions and meetings with staff and managers across the Health Board, helping embed awareness of Welsh language responsibilities and supporting a culture where Welsh is increasingly visible and used in everyday practice. Some notable examples among many were:
    - The whole-directorate Radiology session for staff across all sites.
    - The Lunch & Learn Session for all Pharmacy staff.

    - A presentation at the Planned Care Group Senior Management Team.
    - A presentation at the Health Care Support Workers Annual Conference.
    - Newly registered Nurse Induction and Student Nurse Inductions.
    - Newly appointed Medics Induction.
- There was **1** formal presentation at a Board Committee (Operational Delivery Committee).
- Welsh Language development work was requested to be subject to **1** formal presentation at a formal Board meeting of the Health Board.
- The Welsh Language Development Service held **2** series of site visits, with **2** visits in-year with a promotional stand at the Royal Glamorgan Hospital, Prince Charles Hospital and Princess of Wales Hospital.

These on-site, face-to-face site visits in particular have succeeded in raising the profile of Cymraeg across CTMUHB. The visits achieved the following levels of engagement:

- We shared **176** different resources including **55** lanyards and **85** badges. That's **140** new Welsh speakers and learners identifying themselves to other Welsh speakers just from site visits.
- We spoke to **115** members of staff about the Welsh language offer at CTMUHB.
- We spoke to **29** patients about Welsh in healthcare.

Taking advantage of the Welsh Language Development Service

The Welsh Language Development Service is the internal professional team for CTMUHB to support the organisation to comply with Welsh language law. In addition to all the engagement above, the team this operational year also:

- Provided bespoke and specialist compliance advice to **36** managers, ranging from recruitment to using Welsh with participants in research.
- Received **4,266** translation requests from **1085** different requesters, translating over 6 million words.
- Received **200** queries on learning Welsh from different managers.

Given the size of the Health Board, it is a difficult task to measure all engagement. However, taking all the above into account, it's likely that the Welsh Language Development Service engaged with over **1,300** different members of staff across the Health Board this operational year.

Engagement with Primary Care

Primary Care providers across the CTMUHB region can take advantage of the services provided by the Welsh Language Development Service for CTMUHB. This includes translation, learning Welsh, advice on using Welsh and receiving lanyards & badges for Welsh speaking staff.

This offer was shared at several different points during the year by both the Welsh Language Development Service and colleagues in the Health Board who work directly with Primary Care providers, such as our General Medical Services Management Team.

Here are some highlights:

- **13** practices requested translations
- **5** requested lanyards and badges for Welsh speaking staff, with **37** lanyards and badges shared. That's **37** Welsh speakers showing they're happy to speak Welsh with patients.
- The Welsh Language Lead met with the Chief Operating Officer of the Health Board & the Medical Director for Primary Care during the year to discussing further opportunities to promote Welsh.

The Welsh Language Development Service also attended the events below, on support to promote Welsh:

- Meeting of the General Medical Services Operational Group.
- Practice Managers Forum for CTMUHB, consisting of all Practice Managers from the Health Board area.
- Lunch & Learn Pharmacy recorded session, which included Community Pharmacy.
- Practice Nurse Development Day, with Practice Nurses from across the CTMUHB area.
- Primary Care Training Academy Steering Group on learning Welsh.
- Protected Time for Learning event in Bridgend for GPs.

Leadership & Management Development

Leaders and managers play an important role in shaping the experiences of our staff and service users. As such, that role continues in their developing and advocating for Cymraeg across the Health Board.

To support them, we have embedded Cymraeg into our in-house leadership and management development offers, creating opportunities for leaders to reflect on their own relationship with our language and understand their role in creating an organisation where Cymraeg can thrive:

Inspire: Leading Systems

Inspire is designed to bring our most senior colleagues together to build a thriving leadership community within CTM. The programme is built around our own pioneering 'Leadership Competency Framework', within which bilingualism and Cymraeg specifically are embedded.

Aligned to our 'Inclusion' module, senior leaders are supported to explore Cymraeg in CTM and the wider NHS Wales and political landscape. In doing so, we aim to embed the spirit of Cymraeg 2050 and Mwy na Geiriau [*More Than Just Words*] into organisational culture and policy. To date, **21** participants have completed the programme, with further cohorts due to start in September 2026.

Ignite: Manager Induction

Managers at all levels can now take advantage of a bespoke full-day session looking at the support available to them in their roles and the basics of managing a team. Part of this session includes exploring:

- How managers can support the use of Welsh in their role as managers.
- What support is available to them and their teams to embed Welsh.

- What the requirements of the Welsh Language Standards are in brief.

Launched in February 2026, **55** managers have completed this induction this operational year, increasing managerial understanding of their role in supporting Welsh language use within teams and service delivery.

A member of the Welsh Language Development Service also attends part of the day, along with other key support functions. This has allowed for further engagement with the Welsh Language Development Service, and after the February session for example, **14** resources to support the use of Welsh were shared and **3** managers asked for more information from the Team on learning Welsh.

CTMUHB's Charity, grant funding and promoting Welsh

The introduction of a specific Welsh language question within the grant application process for the CTM Charity has made a significant difference. Previously, it was difficult to understand how projects were considering the Welsh language, as this information was only available when applicants chose to include additional details, such as impact assessments or event information. The revised approach now provides clearer, more consistent insight and enables a more proactive focus on promoting Welsh across funded activities.

This has led to a number of clear outcomes:

Embedding Welsh in staff recognition events

- Charity funding supported staff recognition initiatives, including the Seren Awards and long-service celebrations, where the Welsh language was a key part of communication. Welsh was incorporated into all materials developed to promote these events. Consideration of the language also informed the development of award categories and the judging process, helping to ensure a more inclusive and culturally relevant approach.

Bilingual reporting and wider impact from the Veterans partnership event

- The Charity supported a Veterans partnership event in June 2025. A bilingual (Welsh and English) highlight report was produced, ensuring that learning, feedback and impact were accessible in both languages. Welsh was also used by veterans at the event. The report was shared nationally at the Armed Forces Employers Conference in Wales 2025, extending the reach of the partnership and promoting bilingual practice more widely.

Welsh language use in the Santa's Grotto project (Royal Glamorgan Hospital)

- As part of a Christmas Santa's Grotto project at the Royal Glamorgan Hospital (RGH), the applicant—who was a new Welsh learner—committed to producing all public-facing materials and signage bilingually. They also worked to include bilingual greetings when engaging with patients, visitors and staff. This included interactions

across the hospital as well as within the grotto itself, demonstrating a practical and personal commitment to increasing the use of Welsh in everyday settings.

Supporting Welsh-speaking children and families on the RGH Paediatric Ward

- Projects on the RGH Paediatric Ward, including the introduction of sensory equipment to support children between treatments, have begun to consider more actively how Welsh-speaking staff can support patients and their families through the Welsh language. These projects aim to create a calmer and more comfortable environment for children who may be distressed or anxious, while also recognising the importance of communicating in a patient's preferred language as part of delivering high-quality, compassionate care. The grant process contributed to ensuring Welsh was considered.

Overall, the inclusion of a Welsh language question has helped move consideration of Welsh from being occasional and inconsistent to something more visible, intentional and embedded across a range of projects.

CTMUHB is required by Standards 55 and 56 to publish information on applying for grants in Welsh and respond in Welsh to applications made in Welsh. However, CTMUHB has gone beyond this requirement and included a question in its processes on promoting Welsh further, demonstrating real commitment to using all touchpoints within our processes to promote our language in all ways we can.

4: How do you make sure the Health Board follows Welsh language law and protects my rights?

Clear communication and meaningful engagement are key to meeting our Welsh language duties and we also rely on regular monitoring to make sure we're delivering on our commitments.

The Welsh Language Development Service

A key part of complying with Welsh Language law is the Health Board's internal Welsh Language Development Service, led by the Welsh Language Lead.

The team supports staff by:

- Offering advice on Welsh language matters.
- Promoting Welsh language and culture using internal communications and engagement.
- Influencing and advising on organisational policy to embed Welsh.
- Supporting with the response to complaints and concerns around Welsh.
- Monitoring and ensuring compliance.
- Delivering language awareness.
- Managing and providing translation.
- Promoting learning Welsh, administering and managing the offer, and providing lessons on basic Welsh.
- Sharing resources to embed Welsh across the organisation.

Welsh Language Audit Methodology

A standardised audit methodology is used to measure compliance with each standard. While some Standards can be assessed through direct observation, others—such as bilingual documentation and temporary signage—require multiple data sources to form a reliable estimate.

Given the size, scale and complexity of our organisation, it is not practical to check every single instance of compliance. Instead, our approach uses representative data to provide a reliable overall assessment of compliance across the organisation.

For each Standard, we assign one of four assurance levels as defined below:

High Assurance: The organisation complies with all requirements under all circumstances except for on rare occasions.

Medium Assurance: The organisation is usually fully compliant, but there is non-compliance at some times or in relation to some requirements.

Low Assurance: The organisation complies at some times or in relation to some of the requirements, but does not comply fully and consistently.

No Assurance: The organisation does not comply with the requirements at all, or complies on rare occasions or in only a few respects.

The visual below shows the current organisational assurances levels for all Standards. For example, CTMUHB can reasonably report Medium Assurance with 20% of Standards.

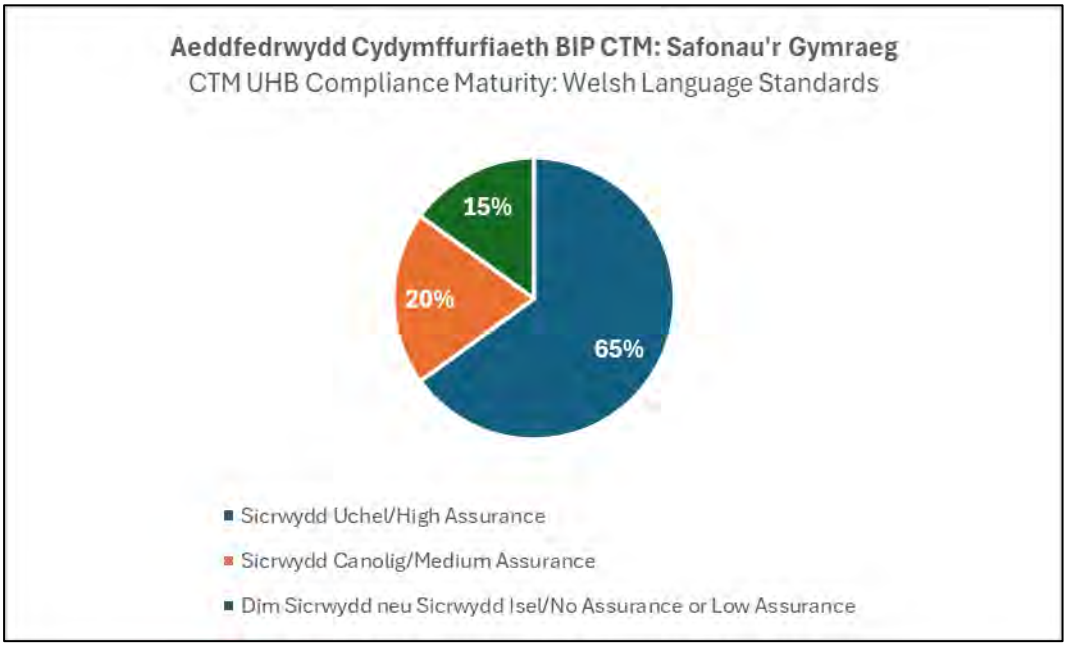


Table 1 below shows which Standards have seen an increase in assurance level compared to 2024/25. There has been no decrease in assurance levels for the 2025/26 operational year.

Table 1: **Increase** in assurance level since 2024/2025

Standards with which an **INCREASE** in assurance level has been achieved			
Standard	Change	Activity	Rationale
8	Low Assurance *to* Medium Assurance	Greeting callers to main telephone lines in Welsh	Internal monitoring showed the majority of calls monitored were answered with a bilingual greeting.
45	Medium Assurance *to* High Assurance	Treating Welsh no less favourably than English on social media	Internal monitoring on corporate and departmental accounts showed evidence Welsh was not being treated less favourably.
57	No Assurance *to* High Assurance	Assessing whether tender documentation should be published in Welsh	An assessment process for procurement is now in place.
72, 73 & 74	No Assurance *to* Medium Assurance	Considering and seeking views on the impact of policy decisions relating to Welsh in consultations	Guidance has been written and the requirements formalised in organisational policy.
91 & 95	No Assurance *to* High Assurance	Having a bilingual internal intranet site for staff	A process has been agreed for SharePoint translation and the required sections are now bilingual.

Readers were invited in 'About this report' to compare this report to previous reports and we are confident a clear performance trajectory can be seen. When compared with the previous two operational years:

	ASSURANCE LEVEL		
YEAR	HIGH ASSURANCE	MEDIUM ASSURANCE	NO OR LOW ASSURANCE
2025/26	81 Standards	25 Standards	18 Standards
As % of all Standards	*65%*	*20%*	*15%*
2024/25	*77 Standards*	*23 Standards*	*24 Standards*
As % of all Standards	*62%*	*18.5%*	*19%*
2023/24	*74 Standards*	*21 Standards*	*29 Standards*
As % of all Standards	*60%*	*17%*	*23%*

A full breakdown of compliance for each Standard is given in Appendix 1. Compliance with each Standard is measured using the audit methodology mentioned above.

Governance and assurance

The Welsh language and compliance in the forward plans of the Operational Delivery Committee, a key committee of the Board. Progress on compliance — alongside areas where standards are not yet fully met — was openly reviewed at the committee's formal meeting in October 2025.

The importance of the Welsh language was further highlighted at the Health Board's formal Board meeting in November 2025. This discussion provided a valuable opportunity to reflect on progress to date, recognise the challenges that remain, and showcase key developments — including our 5-Year Strategic Plan for Offering Clinical Consultations in Welsh (available in Welsh here and in English here).

Importantly, these conversations demonstrate a transparent and ongoing commitment to strengthening Welsh language provision. As matters of public record, details of these discussions are available to view in Welsh here and in English here.

Welsh Language Steering Group 2025/26

The Welsh Language Steering Group, chaired by the Board Secretary and Director of Corporate Governance, met during the operational year to support the work of embedding Welsh in services. Here are some highlights:

- Discussions on embedding the 'Active Offer' in day-to-day services, improving how patients' language preferences are recorded, and making Welsh-speaking staff more visible to support patient choice.
- The Group also helped strengthen systems and processes, including improvements to recruitment to ensure Welsh language requirements are applied, and the use of performance data to identify areas where further improvement is needed.
- Good progress was made in developing the workforce, with targeted Welsh language training (such as the 'Codi Hyder' scheme) helping to build staff confidence and address gaps in Welsh language provision.
- Work also began on developing a corporate Welsh Language and Culture Policy to provide clearer guidance for staff and support a more consistent approach across departments.
- As well as highlighting good practice and innovation, the meetings provided an open forum to identify challenges — such as inconsistent data recording and variation in compliance — helping to drive targeted action and continuous improvement.

Strategic alignment, mandatory organisation policy and processes

Below outlines what processes and policies are in place internally to ensure the Welsh Language Standards are followed by our staff.

Aspect of the Compliance Notice: ***What we must do***	**Guidance:** ***How we explain to staff how to do it in their work context***	**Mandated Policy:** ***How we have mandated that guidance so that staff are required to follow it at work***
Service Delivery Standards	Welsh Language Standards Compliance Protocols	Using Welsh at Work Policy (People 66)
Policy Making Standards	• Equality and Welsh Language Impact Assessment template • Equality and Welsh Language Impact Assessment Guidance • Summary of assessment must be recorded on all covering papers for Operational Management Board, Executive Management Board, Executive Leadership Group, Board Committees and Board with full assessment attached.	Policy for the Development, Review and Approval of CTMUHB Policies, Procedures and Other Written Control Documents (CG06) Approval Process for Polices, Procedures and other Written Control Documents (CG07) CTMUHB Service Change Management Standard Operating Procedure (drafted, to be approved in new operational year
Operational Standards: Recruitment	• Welsh Language Skills Categorisation Decision Tree • Step-by-step video guide to learn how to ensure the job advertisement and job description is bilingual • Welsh Language and Selection Guidance	Recruitment & Selection Policy (fully includes Welsh Language Standards and due to be ratified during the 2026/27 operational year).

Operational Standards: Internal use of Welsh	Various resources as uploaded to the SharePoint site, such as: • Out-of-office templates • Flow chart to decide what should be in Welsh for staff	Using Welsh at Work Policy (People 66)
Supplementary Standards: Complaints	The team responsible for recording complaints and concerns are trained to used DATIX (the system used to record complaints and concerns), and on the dropdown categories used to categorise the nature of the issue. This includes how to denote a complaint or concern is in relation to the Welsh Language Standards	The Listening to People Framework process is followed when receiving complaints and concerns in relation to the Welsh language, and this will be explained on our website when fully operational by August 2026.
Third party procurement, third-party commissioning and Long-term Agreements with other Health Boards	Procurement Welsh Language Impact Assessment	• Using Welsh at Work Policy (People 66). • Welsh language requirements written into tender specifications based on the Procurement Impact Assessment. • 3rd Party Commissioning Contracts Welsh Language Clause. • Long-term Agreements Welsh Langauge Clause.

5: Where am I most likely to be able to use Cymraeg with the Health Board?

This section provides readers with information on the current bilingual workforce of CTMUHB based on workforce data in March 2026. As of March 2026, **93%** of our workforce have recorded their skill level in Welsh from 0 (no appreciable ability) to 5 (proficient).[3]

Our current bilingual workforce

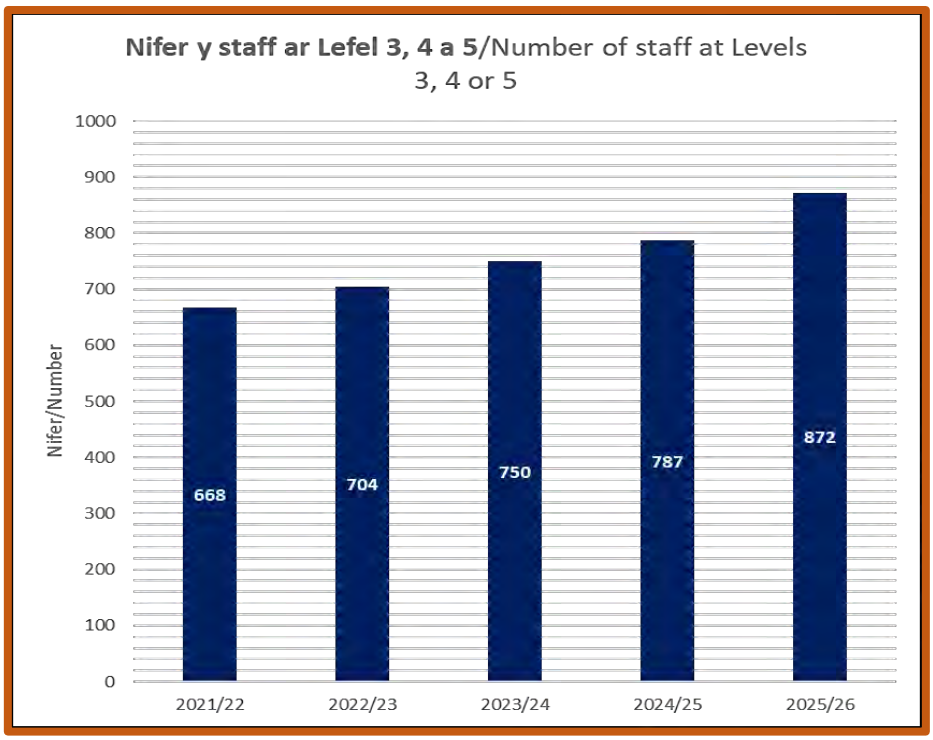
Below sets out the current number of staff who have Welsh language skills as of March 2026.

Level	Listening/Speaking Cymraeg				
	2023/2024	2024/25	**2025/26**	Difference on 24/25	Difference on 25/26 as %
0	8401	9067	9510	+443	+4.89%
1	1961	2081	2109	+28	+1.35%
2	305	320	347	+27	+8.44%
3	199	203	224	+21	+10.34%
4	248	264	292	+28	+10.61%
5	303	320	356	+36	+11.25%
Level	**Reading Cymraeg**				
	2023/2024	2024/25	**2025/26**	Difference on 24/25	Difference on 25/26 as %
0	8556	9312	9801	+489	+5.25%
1	1775	1822	1809	-13	-0.71%
2	302	314	341	+27	+8.60%
3	171	179	199	+20	+11.17%
4	233	247	270	+23	+9.31%
5	326	338	377	+39	+11.54%
Level	**Writing Cymraeg**				
	2023/2024	2024/25	**2025/26**	Difference on 24/25	Difference on 25/26 as %
0	8774	9556	10054	+498	+5.21%
1	1595	1615	1610	-5	-0.31%
2	288	306	332	+26	+8.50%
3	187	200	223	+23	+11.50%
4	195	205	224	+19	+9.27%
5	292	297	328	+31	+10.44%

This data shows increases year-on-year in the number of staff working for CTMUHB who have Welsh language skills.

The graph below illustrates this and shows the number of staff in the workforce with Level 3, 4 and 5 Listening/Speaking skills since March 2021. The graph focusses on Level 3, 4 and 5 as these staff are the most likely to be able to speak to patients in Welsh.

[3] 0 means no appreciable ability and 5 means a proficient speaker. A full description of what all the levels means can be found here.



Earlier increases may largely reflect improved recording rather than workforce change. But since recording compliance plateaued in March 2025, the further increase by March 2026 does provide clear evidence of real growth in Welsh-speaking staff at CTMUHB.

Where am I most likely to be able to use Welsh with clinical staff?

The analysis published in Welsh here and in English here in September 2024 sets out in detail which staff groups (i.e. nurses or therapists) and which areas are most likely to be able to use Welsh when you or a family member has an appointment or is an in-patient.

While it's not guaranteed in every situation, these areas are the most likely to offer services in Cymraeg, especially where your language preference has been asked and acted upon and where staff have identified themselves as Welsh speakers.

As shown in this report, CTMUHB also has processes in place to ensure Welsh-speaking staff can identify themselves as Welsh-speakers to our patients. This includes the uniforms nurses wear and giving Welsh-speaking staff lanyards where they are allowed to wear them.

Look out for the symbol on uniforms; this means the member of staff can speak Welsh and is comfortable doing so.

In fact, that member of staff could be one of:

- Over **200** of our nurses or midwives with skills in Welsh.
- Over **70** of our Healthcare Support Workers with skills in Welsh.
- Near **100** of our Therapists, Radiographers or Pharmacists with skills in Welsh.
- At least **35** of our doctors or consultants with skills in Welsh.

So even if you aren't accessing one of the services outlined in the detailed analysis in Welsh here and in English here, that doesn't mean a service doesn't have any Welsh speaking staff.

What about Primary Care, such as my GP?

Many Primary Care services in the CTMUHB region can offer their service in Welsh. Just access this tool here in Welsh and here in English under 'Find My NHS Service'. If the provider can provide some or all of its services in Welsh, the  symbol will be used to show this.

What about other types of services?

As well using Welsh at an appointment or when on our wards, and when staff have identified themselves as Welsh-speakers, our internal monitoring shows you can also be confident that:

- You will receive a response in Welsh if you write to us in Welsh.
- You will receive correspondence such as appointment letters in Welsh.
- You will see the Welsh language around you when you visit our sites on signs and displays.
- You can use our website in Welsh without any issues.
- You can access our most important social media channels in Welsh.

6: How have you improved skills in Cymraeg of your existing workforce?

What begins as a hesitant "bore da" in a busy ward or office is growing into moments of connection at CTMUHB—between colleagues, with patients, and within communities. Over the past year, the momentum behind learning or developing our Cymraeg hasn't slowed. This is about more than legislation, but about being understood, to show care in someone's first language, and to feel part of something bigger. These small, everyday acts are quietly shaping a more compassionate, confident and bilingual workforce.

What have we offered and how many took part?

Provision	Number of staff
2-hour Welcome to Welsh Sessions	173
10-hour Taster Sessions	18
Inspiring Confidence Scheme (Codi Hyder)	24
Mynediad, Sylfaen, Uwch and Gloywi (*funded for staff and provided in the community*)	30
Total	**245**

We evaluate as much as we can of our offer in CTMUHB. We delve into the impact of those numbers in the table below.

2-hour Welcome to Welsh Sessions: Learning the basics

Here's the numbers:

- **100%** of participants who completed the evaluation reported enjoying the sessions.
- We exceeded the annual target of **100** set for staff completing the sessions by **73%**.
- **41** sessions were held in total.
- **83** hours in total of tuition were provided.
- **25%** of learners progressed from Level 0 to Level 1 in Speaking and Listening on ESR.
- **65%** of staff who booked a session attended a session.

And here's the narrative:

- Staff who completed the Welcome to Welsh sessions represent a broad and diverse workforce, from frontline clinical teams and community care to administration, education and corporate services.
- Notably, over half (**52%**) were in clinical roles, underlining the importance of Welsh in day-to-day interactions with patients and families.
- Engagement is also growing, with increasing participation from leadership, planning and corporate functions. This shift reflects a more mature, organisation-wide approach—recognising that delivering the Active Offer relies not only on frontline staff, but on the systems, culture and leadership that support them.

Here's what the participants reflected:

- Participants valued the high-quality facilitation and subject expertise of the tutor, which helped create a safe, supportive and enjoyable learning environment.

- The interactive and practical nature of the sessions was praised, enabling learners to engage confidently and apply their learning in real time.
- Attendees reported increased confidence and motivation to use Welsh, alongside the development of core, foundational language skills that could be used immediately in the workplace.
- Practical aspects such as the session format, length and accessibility were generally well received, supporting effective engagement.
- Feedback also indicated that staff became aware of the sessions through a range of internal promotion routes, underlining the importance of continued visibility and communication to grow participation.

Good availability, friendly and knowledgeable tutor, adapted to meet learner needs

The session was split into separate one-hour sessions due to my specific learning needs. This was incredibly helpful as I was able to process what I had learnt in my own time before moving on

A great strength was that the class was small so we all got to practice regularly throughout the session. Another strength was that the vocabulary was work-based, so it gave us immediate words and phrases that we could begin to use

The tutor was fantastic/ bendegedig, Diolch! A great and pacy session. Enjoyed the practical component, hearing and repeating sentences. The tutor was friendly and very supportive, offering mild corrections where needed without undermining people's confidence

And did participants start using a bit more Cymraeg?

Yes, in fact 82% of those who answered the evaluation question said that they did start using a bit more of their new Cymraeg. As one participant said:

I started with simple bore da / prynhawn dda and do try to introduce myself in Welsh at meetings to try and increase my confidence.

Codi Hyder: Bringing out the Cymraeg we have

There are many people in Wales can speak a lot of Cymraeg but lack the confidence to use the Welsh they have. The Codi Hyder (*Inspiring Confidence*) Scheme aims to support staff in CTMUHB who want to use their Cymraeg but need a boost or a little support to do so.

Here's the most important numbers:

- **24** members of staff completed the Inspiring Confidence Scheme, increasing confidence to use Welsh in priority clinical services and strengthening capacity to offer Welsh-language consultations.
- **104** sessions held for the 4th and 5th cohort.
- **79%** were in clinical roles.

As a rolling total since 2024/25, here's how the scheme's been targeted in line with our 5-Year Strategic Plan for Clinical Consultations:

- **7** participants completed the scheme within Target Group 1 (areas where a staff member with Level 3 skills in Welsh is the only person with Welsh language skills).
- **19** members of staff in Target Group 2 (areas where there are staff with Level 4 and 5 skills in Welsh, as well as the staff member with Level 3 skills who took part).
- Of **105** service areas identified for targeting, **17** have now achieved the requirement of having at least one member of staff complete the Inspiring Confidence Scheme. This equates to **16%** of all identified areas since 2024/25

And here's the narrative:

- These staff already have a good level of Welsh and many work in roles that involve important or sensitive conversations with patients and families, making confidence in speaking Welsh especially important for delivering care.
- The data shows that experienced staff, including clinicians, educators and leaders, are increasingly looking to use Welsh more in their day-to-day work—not just for basic phrases, but in more meaningful conversations.
- The scheme helps build a more confident bilingual workforce, strengthens leadership in using Welsh and supports wider national ambitions by making Welsh a natural and visible part of everyday services.

Here's what the participants said:

- Immediate post-course feedback for the Inspiring Confidence Scheme was highly positive, emphasising the value of flexible, personalised delivery and high-quality tutoring.
- Participants valued one-to-one practice, tailored content and the chance to focus on language relevant to their roles.
- The tutor's supportive and approachable style created a safe learning environment, helping learners build confidence in using Welsh both socially and professionally.
- Many reported renewed motivation to continue learning, alongside early use of Welsh in the workplace.

- Although the course length was seen as a limitation, feedback shows a strong impact on confidence, skill progression and a growing willingness to use Welsh more regularly.

And did participants start using a bit more Cymraeg?

Yes. In fact, 84% of participants reported using more Welsh 3 months after completing the scheme. Here's what participants said about their use of Welsh after finishing.

Yes [I've used more Welsh], when talking to colleagues who speak Welsh where in the past I would have used English. More aware of colleagues who speak Welsh. Making the most of opportunities to speak Welsh wherever I go.

Radiology Secretary, Radiology

Yes, to help encourage a patient to have his trachea dressing changed who was declining care

Specialist Physiotherapist, Physiotherapy

I have more working terminology to use Welsh in the schools so I feel more confident.

Healthy Schools Practitioner, Public Health

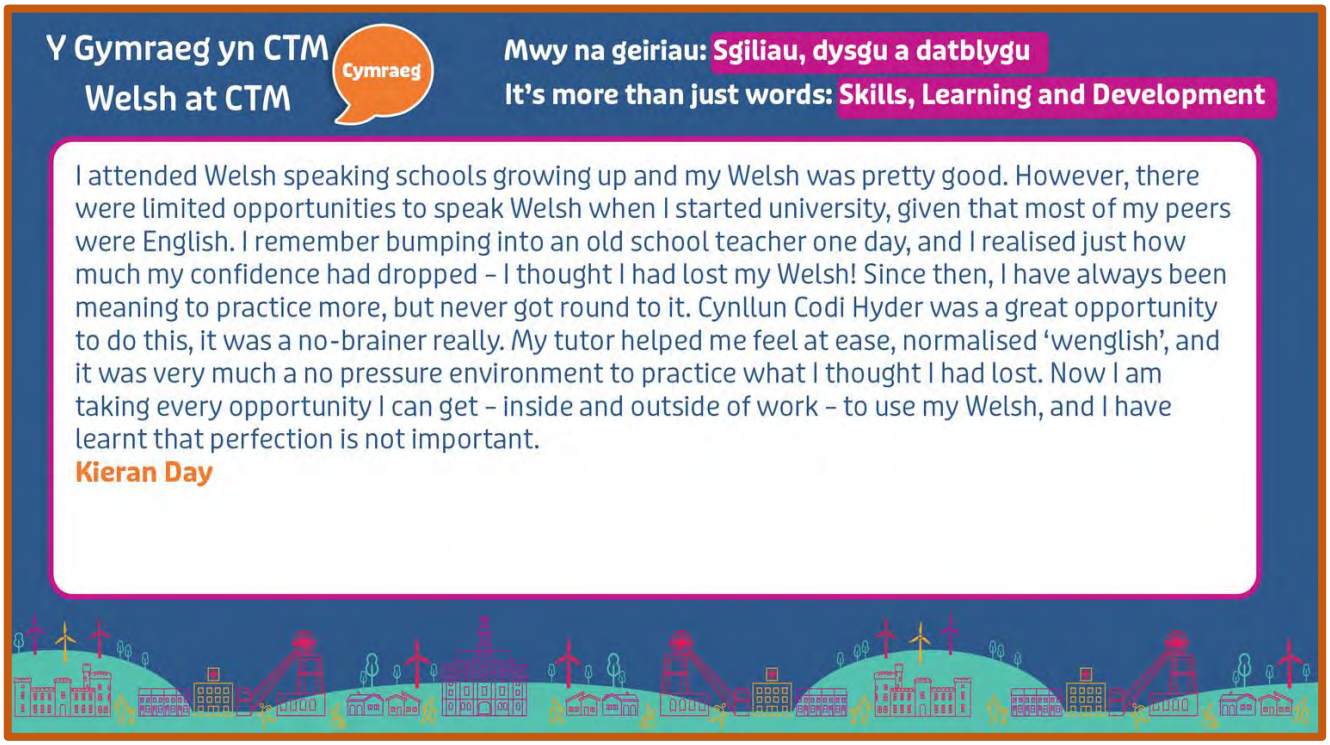
Yes, my child attends a Welsh Primary and where I have been speaking to the teachers in English, it was nice to have the confidence to converse with them in Welsh.

Primary Care Support Worker, Mental Health

Here's Tracey Pycroft, Chaplain, on her experience of developing her Cymraeg at work:



And Kieran Day, Clinical Psychologist, and his inspirational words below:



And here's Nadine, Practice Nurse, who was published in the *Nursing in Practice* newsletter about her Cymraeg journey. Da iawn Nadine!



7: How have you considered the skills in Cymraeg of your future workforce?

Developing the skills of our existing staff is an essential part of workforce planning to meet the needs of our Welsh-speaking service users. So is recruiting people with skills in Welsh.

Breakdown of Welsh language skills required for posts

The Welsh language skills category for all posts advertised by CTMUHB during the 2025/25 operational year are shown in the table below.

Welsh language workforce planning indicators[4]	
Welsh language skills are essential	10
Of which were clinical roles	*2*
Of which were frontline administration roles	*8*
Welsh language skills are desirable	1735
Welsh language skills need to be learnt once appointed to the post	5
Welsh language skills are not necessary	211

Processes and policy

The most important step in ensuring we actively recruit for Welsh language skills is assessing whether the role should be advertised as one of the below categories, based on an objective and recorded assessment:

- Welsh language skills are essential
- Welsh language skills are desirable
- Welsh language skills need to be learnt once appointed to the post
- Welsh language skills are not necessary

To facilitate this, the process in CTMUHB is as follows:

- When a vacancy is added to the internal system called Trac, the manager sees a link to the guidance for how to carry out that objective assessment.
- That guidance includes an objective decision tree tool so support managers to select the correct category for Welsh language skills.
- The 'authorization panel' within the recruitment system contains a section for the assessment based on that decision tree to be recorded.
- The manager then just selects one of the four categories as shown above from a dropdown so that the correct one appears on the advert.
- New job description templates include a dropdown based on that decision tree above to ensure that the skills category also appears on the job description.
- Finally, a compliance check on the Trac system ensures all material is bilingual and that the 'Role Requirements' section includes Welsh language skills where relevant, to ensure that Welsh language skills can be appropriately considered when shortlisting.

[4] Excluding all vacancies from the NHS Wales Joint Commissioning Committee.

- There is guidance on shortlisting candidates and effective ways of advertising roles to encourage applicants with skills in Welsh to apply.

The current Recruitment & Selection Policy also mandates that the Welsh Language Standards are adhered to. Work in the next operational year will focus on ensuring that policy is consistently followed.

Encouraging applicants from people with Welsh language skills

On all job advertisements, the following wordings are now added depending on the category:

Welsh Skills Essential: This post is advertised as Welsh skills are essential. This means Speaking & Listening at Level 3 (equivalent to CEFR B2) or above. We don't need fluency. Level 3 means basic conversations with patients about their everyday health. For more information, see 'Welsh Language Guidance' in the documents right at the bottom.

Welsh Skills Desirable: This post is advertised as Welsh Desirable. This doesn't mean essential; whilst the candidate doesn't need to have skills in Welsh, we'll consider it an advantage when short-listing and selecting candidates. This isn't 'fluency', just Speaking & Listening skills at Level 3 (equivalent to CEFR B2) or above. Level 3 means basic conversations with patients about their everyday health. For more information, see 'Welsh Language Guidance' in the documents right at the bottom.

Welsh to be Learnt on Appointment: This post is advertised as 'Welsh to be Learnt on Appointment'. This is an exciting opportunity and means we'll give you the skills in Welsh we need once you've been recruited if you don't already have skills in Welsh. We'll do this using our free and flexible internal offer alongside our partnership with Learn Welsh Glamorgan, helping you to gain the valuable skills needed to strengthen our bilingual organisation. For more information, see 'Welsh Language Guidance' in the documents right at the bottom.

A short guide is also attached to each job advertisement that explains what each level of Welsh from Level 0 to Level 5 means, in practical terms, so that it's clear for applicants what the levels of Welsh actually mean for them.

Engaging with the future workforce

During 2025–2026, a comprehensive programme of school and college engagement was delivered, comprising 12 events across a wide range of educational settings. These included multiple visits to Ysgol Garth Olwg (x3), single engagements with Ysgol Cardinal Newman and Ysgol Cwm Rhondda, and five sessions across Coleg y Cymoedd campuses (Nantgarw, Aberdare and Rhondda), alongside planned visits to Ysgol Rhydywaun and the University of South Wales.

The programme demonstrated strong breadth and consistency of engagement, reaching learners from Key Stage 3 through to further and higher education. Activities were tailored to each audience, including interactive classroom sessions, sixth form presentations, careers fairs, and targeted college workshops.

Across all settings, sessions focused on promoting careers within the NHS while emphasising the value of the Welsh language and bilingualism in healthcare. College sessions involved interactive discussions with Health and Social Care students (Levels 1–3), exploring career pathways and the practical importance of Welsh in patient care. These included quizzes, case studies (including 'More than Just Words' examples), and open discussions about barriers, personal experiences, and identity.

In Welsh-medium secondary schools, engagement included sixth form presentations, whole-school careers events (Years 7–13), and Q&A sessions, highlighting the wide range of NHS roles and progression routes such as apprenticeships, university study, work experience and volunteering. Resources from partner organisations (e.g. workforce planning tools, national careers platforms and NHS Jobs) were incorporated to provide practical guidance.

At Cardinal Newman (English-medium), delivery was adapted to a rotational careers format, enabling Key Stage 3 learners to practise Welsh in a supportive environment while gaining awareness of bilingualism as a valuable employability skill. Discussions also covered qualifications, recruitment expectations, and how Welsh language skills can support career progression.

A range of interactive learning methods were consistently used across all sessions, including:

- NHS careers overviews and application pathways
- Discussion of the importance of Welsh in the workplace and in healthcare delivery
- Interactive quizzes and scenario-based case discussions
- Job-matching activities and group discussions
- Open forums for reflection and sharing perspectives
- Typical session lengths ranged from 25–45 minutes.

Feedback from partner schools, colleges and careers professionals has been consistently positive, with stakeholders highlighting the value, relevance and impact of the sessions. Requests have been made to extend provision to additional campuses and future cohorts, and to share materials for wider use. The work has also strengthened relationships with external partners, supporting ongoing collaboration and future engagement opportunities

Training for recruiting managers

During the operational year, training on Welsh language and recruitment was offered to recruiting managers, so that their recruitment practices are in line with Welsh Language Standards and so that they are supported to actively recruit for Welsh language skills.

Here's some of our numbers:

- **201** managers took part.
- **117** were managers in clinical roles, recruiting staff into frontline care roles.
- **20** were managers in areas related to More Than Just Words, in line with our 5-Year Strategic Plan, including ward managers.

How effective was the training, based on the evaluation?

- **33%** of participants rated their knowledge of Welsh language requirements in recruitment as *GOOD* or *VERY GOOD* before the training. After the training, **100%** rated their knowledge as *GOOD* or *VERY GOOD*.
- **15%** of participants noted they were *CONCERNED* about Welsh language requirements in recruitment before the training and **50%** noted they were *NEUTRAL*. After the training, **53.3%** noted they were *COMFORTABLE* and **47.7%** noted *VERY COMFORTABLE*.

When asked what managers would change in their practices, this is what some of them said:

It has helped with the decision-making process regarding essential or desirable and has provided information about 'to be learned on appointment' which could be an option for us.

- Principal Occupational

Use of the flowchart to back up decision as to if Welsh language desirable/ essential etc - this was a new tool for me so will share with the wider team.

-Assist. Head of Physiotherapy

I'll be more mindful in considering whether jobs will be essential or desirable.

- Operational Support Manager Specialty Medicine, Unscheduled Care

I feel I have understanding of the requirements after the training, it was not what I thought prior to the training.

-Lead Chaplin

Well I like to think I was compliant before the training but being honest it was luck more than judgement where as now I can confidently say why I'm doing what I'm doing!

-Head of Orthoptic Services

I definitely have more of an insight into what level of recruitment (i.e. essential or desirable) I should choose.

-Cardiac Care Unit Manager

Understanding of the requirements has made it much clearer.

-Ward Manager, Neonatal Unit

It will make me look at my team as a whole and not just at the post I'm recruiting into re Welsh Language skills.

-Diabetes Team Lead

Ensuring we are using the desirable selection correctly.

-Directorate Support Manager, General Surgery

8: How have you dealt with complaints and concerns?

Members of the public can contact either the Welsh Language Commissioner or the Health Board directly about a language concern or a language complaint. When concerns are received, they are recorded on the central complaints system called DATIX. Four complaints were received during 2025/26.

This year the Health Board received the following complaints, with the resolution noted.

Details of the complaint	Resolution
Complaint 1: A complaint was received from a member of the public on 09/06/2025 about three elements relating to Prince Charles Hospital: 1. Lack of Welsh road signs 2. Lack of Welsh signs on signs by contractors 3. Lack of Welsh parking signs	The Programme Director for the hospital building programme carried out a review of road markings to determine where Welsh language provision can be included. In instances where space constraints prevent this, bilingual signage is to be installed as an alternative. The previously noted temporary signage on the fence has now been fully removed. In addition, a programme of work is underway to replace incorrect wayfinding signage. A significant proportion has already been addressed.
Complaint 2: A complaint was received from a member of the public on 1/10/25 regarding a form provided by the Health Board that was not available from the Primary Care provider, and the form did not indicate that a Welsh language version was available	Upon further investigation, it appears that this form had been provided in error. The original intention of the form was to be a helpful leaflet for practicing nurses. It should not have been provided to patients, and no patient information should have been added to it. The team responsible is in the process of withdrawing this form until it has been reviewed.
Complaint 3: A complaint was received from a member of the public on 2/12/25 regarding a form that was provided by the Health Board that was not available from the Primary Care provider, and the form did not indicate that a Welsh language version was available	Similarly to Complaint 2, upon further investigation, it appears that this form had been provided in error. The original intention of the form was to be a helpful leaflet for practicing nurses. It should not have been provided to patients, and no patient information should have been added to it. The team responsible is in the process of withdrawing this form until it has been reviewed.
Complaint 4: A complaint was received from a member of the public on 25/03/2026 regarding various matters not all related to the Welsh language. The complainant noted their dissatisfaction that: 1. Despite the 'Use your Welsh here' sign being displayed at the surgery, they were unable to use Welsh. 2. When corresponding with the Health Board's Concerns Team, the member of staff appeared to have used an online translation tool.	This concern is ongoing and will be resolved in the next operational year.

Conclusion

Overall, the report demonstrates clear and sustained progress in embedding Cymraeg across CTMUHB, with improved compliance levels, increased workforce capability, and stronger governance arrangements. There is evidence of a shift from a compliance-led approach to one focused on culture change and normalising Welsh in everyday practice.

However, we recognise risks remain around consistency of service delivery, particularly in frontline environments (e.g. telephony, reception, and availability of bilingual staff in frontline care).

To mitigate ongoing risk, recruitment and targeted learning will be the focus for work during the 2026/27 operational year. Updates on that work will be provided in our next annual report.

Appendix 1: Full breakdown of compliance with each Standard

WELSH LANGUAGE STANDARDS ASSURANCE ASSESSMENT FOR THE 2025-26 REPORTING YEAR				
Class of Standard: Service Delivery Standards				
Activity	**Standard(s)**	**Assurance level**	**Brief description**	**↓/↑ on 2024/25**
Correspondence	1, 4, 6 & 7	**HIGH ASSURANCE**	• Responding to Welsh correspondence in Welsh • Sending correspondence in Welsh at same time as English correspondence • Not treating Welsh correspondence from the UHB less favourably than English version • Stating we welcome correspondence in Welsh on correspondence from the UHB	**NO CHANGE**
	5	**MEDIUM ASSURANCE**	• Sending all correspondence (including email to external organisations) in Welsh and English unless language preference of the receiver is known	**NO CHANGE**
Telephony	8	**MEDIUM ASSURANCE**	• Greeting callers to main telephone lines bilingually	↑ From **NO ASSURANCE** to **MEDIUM ASSURANCE**
	9	**MEDIUM ASSURANCE**	• Informing a caller a service is available in Welsh	**NO CHANGE**
	10	**NO ASSURANCE**	• Dealing with calls to main telephone lines in Welsh	**NO CHANGE**
	11	**HIGH ASSURANCE**	• Not treating Welsh less favourably when advertising main telephone numbers	**NO CHANGE**
	12	**HIGH ASSURANCE**	• Having the same contact number for both Welsh and English main telephone services	**NO CHANGE**

	13	**HIGH ASSURANCE**	• Stating we welcome calls in Welsh where we publish our main telephone numbers	**NO CHANGE**
	14	**HIGH ASSURANCE**	• Where we collect performance indicators, ensuring we also collect data as relevant to the Welsh language to ensure we do not treat Welsh less favourably	**NO CHANGE**
	15	**HIGH ASSURANCE**	• Informing persons calling, in Welsh, that they can leave a message in Welsh	**NO CHANGE**
	16	**NO ASSURANCE**	• Informing persons calling, in Welsh, when a Welsh language service will be available where one isn't available	**NO CHANGE**
	17	**LOW ASSURANCE**	• Dealing with calls to departmental telephone lines in Welsh	**NO CHANGE**
	18	**MEDIUM ASSURANCE**	• Greeting callers to departmental telephone lines bilingually	↑ From **NO ASSURANCE** to **MEDIUM ASSURANCE**
	19	**LOW ASSURANCE**	• Where the UHB makes calls to individuals on a specific matter, asking whether that individual wishes to receive future calls in Welsh from the UHB, recording that wish and making those calls in Welsh	**NO CHANGE**
	20	**HIGH ASSURANCE**	• Any automated telephone systems that you have must provide the complete automated service in Welsh.	**NO CHANGE**
Internal meetings	21, 22, 22A & 22CH	**MEDIUM ASSURANCE**	• Asking those invited to a meeting whether they wish to use Welsh and facilitating the us of Welsh	**NO CHANGE**
In-patients and the Active Offer	23 & 23A	**HIGH ASSURANCE**	• Asking in-patients at admission their language preference and recording this	**NO CHANGE**
	24	**HIGH ASSURANCE**	• Having a ratified policy in place on asking in-patients at admission their language preference, for those patients who may not be able to note this themselves.	**NO CHANGE**
Case conferences	25	**MEDIUM ASSURANCE**	• Offering and providing case conference in Welsh when involving the patient	**NO CHANGE**

Public meetings and events	26	**MEDIUM ASSURANCE**	• Treating Welsh no less favourably when advertising and promoting public meetings and events, sending invitations and inviting speakers to public meetings and events, ensuring an interpreter is available at all public meetings and events and not treating the Welsh language less favourably in any way during the course of the meeting or event	**NO CHANGE**
	27	**HIGH ASSURANCE**	• Publishing and sending invitations to public meetings in Welsh and English	**NO CHANGE**
	28	**LOW ASSURANCE**	• When inviting persons to speak at a public meetings, asking those invitees whether they wish to speak Welsh. If Welsh, providing interpretation at the meeting where required.	**NO CHANGE**
	29	**LOW ASSURANCE**	• When arranging public meetings to which the public can contribute, asking attendees whether they wish to use Welsh, and if so, providing interpretation at the meeting.	**NO CHANGE**
	30	**MEDIUM ASSURANCE**	• Displaying written materials at meetings in Welsh and English.	**NO CHANGE**
	31	**MEDIUM ASSURANCE**	• Treating Welsh no less favourably than English when promoting events the Health Board has organised or contributed 50%+ funding to.	**NO CHANGE**
	32	**MEDIUM ASSURANCE**	• Treating Welsh no less favourably than English at events the Health Board has organised or contributed 50%+ funding to.	**NO CHANGE**
	33	**MEDIUM ASSURANCE**	• Producing publicity and advertising material in Welsh and English and treating Welsh no less favourably than English in that material.	**NO CHANGE**
Displayed material	34	**MEDIUM ASSURANCE**	• Displaying material in public (in all contexts)	**NO CHANGE**
Documents & Forms	36 & 37	**MEDIUM ASSURANCE**	• Documents and forms available in Welsh	**NO CHANGE**
	38	**LOW ASSURANCE**	• Noting on English versions that a Welsh version is available	**NO CHANGE**
Websites and digital media	39, 40 & 41	**HIGH ASSURANCE**	• Each text of the webpage available in Welsh including the homepage and new and amended pages	**NO CHANGE**

	42	**HIGH ASSURANCE**	• Noting clearly on each webpage that it is available in Welsh with a direct link	**NO CHANGE**
	43	**HIGH ASSURANCE**	• Providing interface and menus in Welsh on each page	**NO CHANGE**
	44	**HIGH ASSURANCE**	• Apps produced or commissioned by the Health Board available in Welsh	**NO CHANGE**
	45	**HIGH ASSURANCE**	• Not treating Welsh less favourably on corporate and departmental social media	↑ From **MEDIUM ASSURANCE** to **HIGH ASSURANCE**
	46	**HIGH ASSURANCE**	• Responding to Welsh messages in Welsh on social media (comments & DMs etc.)	**NO CHANGE**
Signage	47	**MEDIUM ASSURANCE**	• Displaying all signs including temporary signs in Welsh	**NO CHANGE**
	48 & 49	**HIGH ASSURANCE**	• Ensuring all signs including temporary signs in Welsh which is correct and with the Welsh in a position where it is likely to be read first	**NO CHANGE**
Reception services	50 & 52	**NO ASSURANCE**	• Offering a bilingual service at receptions and displaying a sign at reception welcoming the use of Welsh	**NO CHANGE**
	53	**HIGH ASSURANCE**	• Where staff members provide a reception service and can in fact speak Welsh, ensuring they wear a badge to convey that	**NO CHANGE**
Grants	54, 55 & 56	**HIGH ASSURANCE**	• Publishing documents relating to grants in Welsh, • Stating we welcome applications for grants in Welsh, and not treating an application for a grant submitted in Welsh any less favourably and • Informing a person who submitted an application for a grant in Welsh of the outcome in Welsh.	**NO CHANGE**
Tenders for contracts	57, 58 & 59	**HIGH ASSURANCE**	• Publishing invitations to tender in Welsh where relevant • Stating tenders may be submitted in Welsh and that Welsh tenders submitted in Welsh will be treated no less favourably, and	↑ From **NO ASSURANCE** to **HIGH ASSURANCE**

			• Informing a tenderer of the outcome in Welsh where they submitted the tender in Welsh.	
Promoting Welsh language services	60 & 61	**HIGH ASSURANCE**	• Promoting the Welsh language services we provide.	**NO CHANGE**
Corporate identity	62	**MEDIUM ASSURANCE**	• Treating Welsh no less favourably in how the UHB forms, revises and presents its corporate identity	**NO CHANGE**
Education courses for patients	63	**LOW ASSURANCE**	• Where health education courses are offered, undertaking an assessment of the demand for them in Welsh and offering them in Welsh	**NO CHANGE**
Public address systems	64	**HIGH ASSURANCE**	• Recorded messages over address systems being bilingual, with the Welsh message played first	**NO CHANGE**
Primary Care	65	**HIGH ASSURANCE**	• Designating an area on our website to promote Primary Care providers who are able to provide a service or part of a service in Welsh	**NO CHANGE**
	66	**HIGH ASSURANCE**	• Providing and promoting a translation service for Primary Care	**NO CHANGE**
	67	**HIGH ASSURANCE**	• Providing and promoting lanyards and badges that convey Primary Care staff speak Welsh	**NO CHANGE**
	68	**HIGH ASSURANCE**	• Providing courses, information or events so that Primary Care staff develop an awareness of the Welsh language and how it can be used in the workplace	**NO CHANGE**
Class of Standard: Policy Making Standards				
Activity	**Standard(s)**	**Assurance level**	**Brief description**	
Assessing policy for impact	69, 70 & 71	**MEDIUM ASSURANCE**	• Assessing new policies or reviewing and revising policies for the impact on Welsh	**NO CHANGE**
	72, 73, & 74	**MEDIUM ASSURANCE**	• Consulting on policy and considering the impact on Welsh	↑ From **NO ASSURANCE** to **MEDIUM ASSURANCE**

	75, 76 & 77	**LOW ASSURANCE**	• Research to assist policy making and considering the impact on Welsh	**NO CHANGE**
Assessing policy for impact within Primary Care	78	**NO ASSURANCE**	• Having a policy to ensure decision taken in regard to Primary Care consider the impact on the use of Welsh and treating Welsh no less favourably	**NO CHANGE**
	78A	**HIGH ASSURANCE**	• Publishing a review of that policy under Standard 78 five years after publishing it	**NO CHANGE**
Class of Standard: Operational Standards				
Activity	**Standard(s)**	**Assurance level**	**Brief description**	
Policy on internal use of Welsh	79	**HIGH ASSURANCE**	• A policy on using Welsh internally for the purpose of promoting and facilitating the use of the language	**NO CHANGE**
Contracts of employment in Welsh	80	**HIGH ASSURANCE**	• When offering a new post to an individual, asking that the individual whether he or she wishes for the contract of employment or contract for services to be provided in Welsh and if so provide it in Welsh	**NO CHANGE**
Paper correspondence relating to employment	81	**HIGH ASSURANCE**	• Paper correspondence relating to various aspects of employment sent to an employee	**NO CHANGE**
Workforce policies in Welsh	82	**HIGH ASSURANCE**	• Workforce policies relating to specific matters available in Welsh	**NO CHANGE**
Complaints by and against staff	83, 84 & 85	**HIGH ASSURANCE**	• Noting in policies and procedures that complaints may be made in Welsh or responded to in Welsh, holding meetings relating to complaints in Welsh, and informing parties of decisions relating to complaints in Welsh	**NO CHANGE**
Disciplinary procedures	86, 87 & 88	**HIGH ASSURANCE**	• Noting staff may respond to allegations in Welsh in documents and when bringing proceedings against them, holding meetings about allegations in Welsh and informing staff of the outcome in Welsh	**NO CHANGE**

Spelling and grammar software	89	**HIGH ASSURANCE**	• Providing staff with computer software for checking spelling and grammar in Welsh	**NO CHANGE**
Intranet	90, 91, 93 & 95	**HIGH ASSURANCE**	• Certain intranet pages being bilingual	↑ From **NO ASSURANCE** to **HIGH ASSURANCE**
	94	**HIGH ASSURANCE**	• Having a specific intranet page for promoting Welsh	**NO CHANGE**
Assessing Welsh language skills of employees	96	**HIGH ASSURANCE**	• Assessing the Welsh language skills of staff	**NO CHANGE**
Staff training	97	**MEDIUM ASSURANCE**	• Providing training on certain workplace matters such as Health and Safety	**NO CHANGE**
Training on using Welsh	98	**HIGH ASSURANCE**	• Training on using Welsh in meetings, interviews and complaint and disciplinary procedures	**NO CHANGE**
Basic Welsh lessons and using Welsh in managerial roles	99	**HIGH ASSURANCE**	• Providing a basic Welsh lesson and training on using Welsh in managerial roles	**NO CHANGE**
Providing further Welsh lessons	100 & 101	**HIGH ASSURANCE**	• Providing Welsh lessons for staff beyond a basic Welsh lesson	**NO CHANGE**
Welsh language awareness	102	**HIGH ASSURANCE**	• Providing Welsh language awareness training	**NO CHANGE**
Corporate induction	103	**HIGH ASSURANCE**	• Providing Welsh language awareness material as part of corporate induction	**NO CHANGE**

Logo and wording for emails	104	**HIGH ASSURANCE**	• Providing a logo so staff can show they speak Welsh in emails and a template so that they can create a bilingual out-of-office message	**NO CHANGE**
Providing lanyards and badges	105	**HIGH ASSURANCE**	• Providing badges and logos to staff so that they can show they speak Welsh	**NO CHANGE**
Assessing vacant posts	106 & 106A	**LOW ASSURANCE**	• Assessing vacant posts for what skills are needed in Welsh based one of 4 categories, and where 'Welsh Essential', 'Desirable' or 'Need to Be Learnt', noting this when advertising and advertising the post in Welsh	**NO CHANGE**
Encouraging applications in Welsh	107	**HIGH ASSURANCE**	• When advertising a post, you must state that applications may be submitted in Welsh, and that an application submitted in Welsh will not be treated less favourably	**NO CHANGE**
Welsh language recruitment material	107A	**HIGH ASSURANCE**	• Publishing application-related information in Welsh such as all application forms, assessment method information and job descriptions	**NO CHANGE**
Applications made in Welsh	107B	**HIGH ASSURANCE**	• Not treating an application for a post made in Welsh less favourably than an application made in English	**NO CHANGE**
Candidate's use of Welsh in interviews	108	**HIGH ASSURANCE**	• Ensuring that application forms for posts provide a space for applicants to indicate that they wish an interview or other method of assessment in Welsh, and if so offering this	**NO CHANGE**
Informing candidates of outcome	109	**HIGH ASSURANCE**	• Informing an applicant of your decision in relation to an application for a post in Welsh if the application was made in Welsh.	**NO CHANGE**
5-year strategy on providing clinical consultations in Welsh	110	**HIGH ASSURANCE**	• Publishing a strategy for every 5-year period around offering clinical consultations in Welsh	**NO CHANGE**
	110A	**HIGH ASSURANCE**	• Publishing a review of the strategy for every 5-year period around offering clinical consultations in Welsh	**NO CHANGE**
Workplace signage	111, 112 & 113	**MEDIUM ASSURANCE**	• Accurate bilingual workplace signage, with Welsh in a position it is more likely to be read first	**NO CHANGE**

Workplace recorded announcement	114	**HIGH ASSURANCE**	• Workplace audio announcements	**NO CHANGE**
Class of Standard: Record Keeping Standards				
Activity	**Standard(s)**	**Assurance level**	**Brief description**	
Record of complaints	115	**HIGH ASSURANCE**	• Keeping a record of all complaints received regarding Welsh language standards	**NO CHANGE**
Record of skills	116	**HIGH ASSURANCE**	• Keeping a record of Welsh languages skills as assessed under Standard 96	**NO CHANGE**
Record of skills needed for vacant posts	117	**HIGH ASSURANCE**	• Keeping a record, in relation to each financial year, of the number of new and vacant posts which were categorised (in accordance with standard 106) as posts where - o (a) Welsh language skills are essential; o (b) Welsh language skills need to be learnt when appointed to the post; o (c) Welsh language skills are desirable; or o (ch) Welsh language skills are not necessary	**NO CHANGE**
Standards which deal with supplementary matters				
Activity	**Standard(s)**	**Assurance level**	**Brief description**	
Supplementary matters as relevant to Standards	118	**HIGH ASSURANCE**	• Publishing the compliance notice on our website	**NO CHANGE**
	119	**HIGH ASSURANCE**	• Having a complaints procedure that notes how the UHB will deal with complaints relating to the Welsh Language Standards, and publishing it on the website	**NO CHANGE**
	120	**HIGH ASSURANCE**	• Publishing an annual report on compliance	**NO CHANGE**
	121	**HIGH ASSURANCE**	• Releasing to the Welsh Language Commissioner any information he or she has requested in relation to Standards	**NO CHANGE**

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board



Cyflawni'r camau gweithredu yn y Cynllun Mwy na Geiriau 2022-27: Am y cyfnod Ebrill 2025 – Mawrth 2026

Sefydliad	**Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg**

Cwblhawyd gan:	**Ben Screen, Arweinydd y Gymraeg**	**Dyddiad: Mai 2026**

DATA ALLWEDDOL: **Wrth ddyfynnu unrhyw ystadegau / data, rhowch ddyddiad / cyfnod adrodd cyfatebol.**

Sgiliau Cymraeg staff (ym mis Mawrth 2026 ac yn seiliedig ar ddata ar gyfer 93% o staff)

Lefel	Gwrando/Siarad Cymraeg				
	2023/2024	2024/25	**2025/26**	Gwahaniaeth ar 24/25	Gwahaniaeth ar 25/26 fel %
0	8401	9067	9510	+443	+4.89%
1	1961	2081	2109	+28	+1.35%
2	305	320	347	+27	+8.44%
3	199	203	224	+21	+10.34%
4	248	264	292	+28	+10.61%
5	303	320	356	+36	+11.25%
Lefel	**Darllen Cymraeg**				
	2023/2024	2024/25	**2025/26**	Gwahaniaeth ar 24/25	Gwahaniaeth ar 25/26 fel %
0	8556	9312	9801	+489	+5.25%
1	1775	1822	1809	-13	-0.71%
2	302	314	341	+27	+8.60%
3	171	179	199	+20	+11.17%
4	233	247	270	+23	+9.31%
5	326	338	377	+39	+11.54%
	Ysgrifennu Cymraeg				

	Lefel	2023/2024	2024/25	**2025/26**	Gwahaniaeth ar 24/25	Gwahaniaeth ar 25/26 fel %
	0	8774	9556	10054	+498	+5.21%
	1	1595	1615	1610	-5	-0.31%
	2	288	306	332	+26	+8.50%
	3	187	200	223	+23	+11.50%
	4	195	205	224	+19	+9.27%
	5	292	297	328	+31	+10.44%
Nifer y staff sy'n cwblhau hyfforddiant (rhwng Ebrill 2025 a Mawrth 2026)	**Cwrs Cwrteisi:** 173 **Cwrs Codi Hyder:** 24 **Cwrs Ymwybyddiaeth o'r Gymraeg:** 9,521					
Arolygon Cleifion / Defnyddwyr Gwasanaeth e.e. arolygon siopwyr cudd	**Nifer a manylion yr arolygon:** 0 arolwg **Adborth:** Ni dderbyniwyd unrhyw adborth yn ffurfiol. **Camau a gymerwyd yn sgil adborth:** Ddim yn berthnasol					

Diwylliant ac Arweinyddiaeth	
CAM GWEITH REDU	YMATEB GAN BIPCTM
2.	Dros amser, rydym yn disgwyl i'r holl staff iechyd a gofal cymdeithasol ddod i werthfawrogi'r gwahaniaeth cadarnhaol y gall dysgu a defnyddio'r Gymraeg ei wneud i'r profiad o ofal, sy'n ddull tymor hir o weithredu. Byddwn yn ategu cyrsiau ymwybyddiaeth ieithyddol gyda dull cyfathrebu sy'n seiliedig ar wyddor ymddygiad er mwyn sicrhau bod popeth rydym ni fel arweinwyr yn ei ddweud am y Gymraeg, ac fel sefydliadau a phartneriaethau, yn cyfrannu at y strategaeth hon. Bydd y dull hwn o weithredu yn adeiladu ar yr hyfforddiant ac ar y naratif cadarnhaol a amlinellir yn y cynllun. (Tymor byr i ganolig) Yn ystod y flwyddyn, ymgysylltodd Gwasanaeth Datblygu'r Gymraeg yn helaeth ar draws BIP Cwm Taf Morgannwg. Cynhaliwyd cyfanswm o 181 o sesiynau ymgysylltu gyda staff a rheolwyr, gan gynnwys sesiynau ymsefydlu, sesiynau ar draws cyfarwyddiaethau cyfan, cynadleddau a chyflwyniadau uwch reolwyr. Roedd y sesiynau ymsefydlu'n cynnwys rhai ar gyfer myfyrwyr, nyrsys sydd newydd gofrestru, a'r garfan newydd o feddygon. Yn ogystal, cafwyd 1 cyflwyniad ffurfiol i Bwyllgor Bwrdd a chais am 1 cyflwyniad arall ar lefel Bwrdd. Ymgymerodd y tîm hefyd â 2 gyfres o ymweliadau safle ar draws Ysbyty Brenhinol Morgannwg, Ysbyty'r Tywysog Siarl ac Ysbyty Tywysoges Cymru. Cynhyrchodd yr ymweliadau hyn sylw sylweddol, gyda 176 o adnoddau wedi'u dosbarthu (gan gynnwys 55 o gortynnau gwddf ac 85 o fathodynnau), gan alluogi 140 o staff i uniaethu'n weladwy fel siaradwyr neu ddysgwyr Cymraeg. Gwnaeth y gwaith ymgysylltu yn ystod ymweliadau gynnwys sgyrsiau gyda 115 aelod o staff a 29 o gleifion. Y tu hwnt i ymgysylltu uniongyrchol, gwnaeth y Gwasanaeth ddarparu cymorth arbenigol, gan gynnwys cyngor pwrpasol i 36 o reolwyr ar gydymffurfiaeth, ymdrin â 4,266 o geisiadau cyfieithu gan 1,085 o geiswyr (yn dod i dros 6 miliwn o eiriau), ac ymateb i 200 o ymholiadau dysgu Cymraeg. Yn gyffredinol, amcangyfrifir yr ymgysylltwyd â dros 1,300 o staff yn ystod y flwyddyn.

	Mewn Gofal Sylfaenol, cynyddodd ymwybyddiaeth a'r defnydd o'r cynnig hefyd. Gofynnodd 13 o bractisau am gymorth cyfieithu, tra bod 5 practis wedi gofyn am gortynnau gwddf a bathodynnau, gyda 37 o eitemau wedi'u dosbarthu. Mae hyn wedi gwneud staff sy'n siarad Cymraeg yn fwy amlwg. Roedd yr ymgysylltu strategol yn cynnwys trafodaethau gyda'r Prif Swyddog Gweithredu a'r Cyfarwyddwr Meddygol ar gyfer Gofal Sylfaenol, a phresenoldeb mewn fforymau a digwyddiadau hyfforddi allweddol ar draws Meddygaeth Gyffredinol, Fferylliaeth a Nyrsio. Roedd enghreifftiau o hyn yn cynnwys y Fforymau Nyrsys Practis a slot yn y Fforwm Rheolwyr Practis ar gyfer BIPCTM.
3	**Byddwn yn disgwyl i'r rheini sydd mewn rolau arwain gymryd rhan yn ein rhaglen Arwain mewn Gwlad Ddwyieithog. Mae'r rhaglen hon yn gweithio tuag at ymwreiddio ysbryd Cymraeg 2050 yn niwylliant sefydliadau a'u polisïau. Yn rhy aml o lawer, mae'r Gymraeg yn cael ei hystyried fel dim ond mater o gyfieithu neu ymarfer 'ticio'r bocs' wrth ddatblygu polisi. Mae'r rhaglen hon, sy'n seiliedig ar werthoedd, yn mynd y tu hwnt i'r gwaith hwnnw i ddeall effaith bosibl holl elfennau ein gwaith ar ein hiaith—ac i ddefnyddio'r hyn sydd gennym i ddefnyddio mwy ar yr iaith. *(Tymor canolig)*** Mae BIPCTM wedi datblygu ei brosesau datblygu arweinyddiaeth fewnol ei hun gyda nodau tebyg i'r rhaglen Arwain mewn Gwlad Ddwyieithog. Disgrifir y rhain isod. **Inspire: Arwain Systemau** Mae'r rhaglen Inspire wedi'i chynllunio i ddod â'n cydweithwyr lefel uchaf at ei gilydd i adeiladu cymuned arwain lewyrchus yn CTM. Mae'r rhaglen wedi'i hadeiladu o amgylch ein 'Fframwaith Cymhwysedd Arweinyddiaeth' arloesol ein hunain, lle mae dwyieithrwydd a'r Gymraeg yn benodol yn cael eu gwreiddio. Wedi'i halinio â'n modiwl 'Cynhwysiant', cefnogir uwch arweinwyr i archwilio'r Gymraeg yn nhirwedd ehangach GIG Cymru a'r dirwedd wleidyddol, eu hagweddau a'u hymddygiadau mewn perthynas â'r Gymraeg, a'u rôl wrth ymgorffori dwyieithrwydd yn CTM. Wrth wneud hynny, ein nod yw gwreiddio ysbryd Cymraeg 2050 a Mwy na Geiriau yn niwylliant a pholisi'r sefydliad. Hyd yn hyn, mae 21 o gyfranogwyr wedi cwblhau'r rhaglen, gyda charfannau pellach i ddechrau ym mis Medi 2026.

	Ignite: Ymsefydlu Rheolwyr Gall rheolwyr ar bob lefel bellach fanteisio ar sesiwn bwrpasol, diwrnod o hyd sy'n edrych ar y gefnogaeth sydd ar gael iddynt yn eu rolau a'r hanfodion o reoli tîm. Mae rhan o'r sesiwn hon yn cynnwys archwilio: • Sut y gall rheolwyr gefnogi'r defnydd o'r Gymraeg yn eu rôl fel rheolwyr. • Pa gymorth sydd ar gael iddyn nhw a'u timau i wreiddio'r Gymraeg. • Beth yw gofynion Safonau'r Gymraeg yn gryno. Wedi'i lansio ym mis Chwefror 2026, roedd 55 o reolwyr wedi cwblhau'r sesiwn ymsefydlu hon ym mis Mawrth 2026. Mae aelod o Wasanaeth Datblygu'r Gymraeg hefyd yn bresennol am ran o'r diwrnod, ynghyd â swyddogaethau cymorth allweddol eraill. Mae hyn wedi galluogi ymgysylltu pellach â Gwasanaeth Datblygu'r Gymraeg, ac ar ôl sesiwn mis Chwefror er enghraifft, rhannwyd 14 o adnoddau i gefnogi'r defnydd o'r Gymraeg a gofynnodd 3 rheolwr am ragor o wybodaeth gan y Tîm ar ddysgu Cymraeg.
Thema 1: Polisïau a chynlluniau ar gyfer y Gymraeg, gan gynnwys data	
5	**Canfod a datblygu ymchwil a data a fydd yn cryfhau ein dealltwriaeth a'n gwybodaeth lleisiau a profiadau siaradwyr Cymraeg sy'n defnyddio ac yn derbyn gwasanaethau, er mwyn cefnogi polisïau sy'n seiliedig ar dystiolaeth a chynlluniau ar gyfer y Gymraeg ym maes iechyd a gofal cymdeithasol. Bydd hyn yn cynnwys y gallu i ddarparu gwasanaethau dwyieithog, ac i ddangos tystiolaeth o sut mae Mwy na geiriau yn helpu i sicrhau gwell canlyniadau i unigolion. (Mae'r cam hwn yn cyd-fynd â'r gwaith a nodir yn adran 4 ar fapio'r data a'r broses o greu'r dangosfwrdd).** ***(Tymor canolig)*** Mae BIPCTM wedi parhau i gefnogi'r gwaith o weithredu Promptly a chasglu Mesurau Profiad a Adroddir gan Gleifion fel rhan o'r Fframwaith Profiad Pobl. Defnyddir y cwestiwn cenedlaethol, safonedig ar iaith ym mhob arolwg. Y dull cyfredol o gasglu data ar brofiad cleifion yn systematig yw'r Arolwg Profiad Cleifion. Mae hwn yn arolwg cenedlaethol gyda chwestiynau safonedig. Mae'n cynnwys cwestiwn ar iaith, ynghylch a allai'r claf ddefnyddio ei ddewis iaith. Yna gofynnir i'r claf ddewis iaith yn yr ail gwestiwn. Ar hyn o bryd, fodd bynnag, ni ellir defnyddio'r data hwn i lywio'r gwaith o gynllunio a darparu gwasanaethau Cymraeg oherwydd: • Nid yw'n bosibl allosod data ar lefel gwasanaeth; mae ond ar gael ar lefel Grŵp Gofal.

	• Nid yw'n bosibl croes-dablu'n uniongyrchol rhwng yr ateb i'r cwestiwn ynghylch a allai'r claf ddefnyddio ei ddewis iaith, a'r ateb i'r ail gwestiwn lle gofynnir i'r claf ddewis yr iaith a ffefrir mewn gwirionedd (e.e. y Gymraeg). Byddai hwn yn fater ar lefel genedlaethol.
6	**Datblygu adnoddau i helpu i brif ffrydio ystyriaethau ynghylch y Gymraeg mewn cynlluniau a pholisïau, yn enwedig mewn meysydd blaenoriaeth a lefelau uchel o ryngweithio â gwasanaethau. Bydd hyn yn cynnwys sefydlu llwybrau gofal Cymraeg ar gyfer unigolion agored i niwed mewn grwpiau blaenoriaeth penodol fel pobl hŷn, plant, iechyd meddwl, therapi lleferydd, anawsterau dysgu, a gwasanaethau strôc. (Tymor hir)** Amlinellir gwaith mewn perthynas ag Asesiadau o'r Effaith ar y Gymraeg ar gyfer y cyfnod adrodd hwn isod: • Mae templed o Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg integredig newydd, symlach wedi'i greu. Mae'r templed hwn yn cynnwys adran ar Mwy na Geiriau yn benodol. • Mae canllawiau wedi'u creu ar gwblhau'r asesiad, gyda chanllawiau ar sut y gall polisi neu newid effeithio ar Mwy na Geiriau. • Mae prosesau cyflwyno papurau i'r Bwrdd a Phwyllgorau, y Grŵp Arwain Gweithredol, Bwrdd Rheoli'r Weithrediaeth a'r Bwrdd Rheoli Gweithredol wedi'u cryfhau. Ni ellir cyflwyno papur heb y templed papur, gan gynnwys y crynodeb o'r asesiad effaith lle mae angen un. • Mae'r gofynion ar gyfer asesiadau effaith bellach wedi'u nodi'n glir yn y *Polisi ar gyfer Datblygu, Adolygu a Chymeradwyo Polisïau, Gweithdrefnau a Dogfennau Rheoli Ysgrifenedig Eraill BIPCTM* (CG06)*, y Broses Gymeradwyo ar gyfer Polisïau, Gweithdrefnau a Dogfennau Rheoli Ysgrifenedig eraill* (CG07) a *Gweithdrefn Weithredu Safonol Rheoli Newid Gwasanaeth BIPCTM,* sydd ar ddod. • Mae offeryn asesu effaith newydd ar gyfer gweithgareddau caffael wedi bod ar waith ers mis Ebrill 2026 mewn cydweithrediad â Phartneriaeth Cydwasanaethau GIG Cymru i sicrhau bod cyflenwyr 3ydd parti yn cadw at Safonau'r Gymraeg lle y bo'n berthnasol.
8	**Bydd fframwaith cenedlaethol cytunedig ar gyfer casglu a chyfuno data ar sgiliau iaith yr holl staff sy'n gweithio ym maes iechyd a gofal cymdeithasol yng Nghymru yn cael ei ddatblygu a'i weithredu. Dylai'r fframwaith fod yn orfodol lle bynnag y bo modd, a byddai angen iddo gyd-fynd â'r systemau a'r dulliau sydd ar waith ar hyn o bryd i gasglu a chyfuno data ar**

	draws y sectorau iechyd a gofal cymdeithasol, gan gynnwys gwasanaethau sy'n cael eu darparu yn Gymraeg. (Mae'n bosib y bydd angen cyllid/adnoddau ychwanegol er mwyn cyflawni hyn). (Tymor canolig) Fel ym mhob corff GIG Cymru arall, mae staff yn cofnodi eu sgiliau iaith ar y Cofnod Staff Electronig (ESR) gan ddefnyddio'r Raddfa ALTE 0-5 ar gyfer sgiliau iaith. Mae BIPCTM wedi datblygu dangosfwrdd mewnol sydd wedi'i gysylltu ag ESR sy'n diweddaru'n awtomatig drwy ESR. Mae hwn yn dangos sgiliau Cymraeg cyfredol staff ac yn cael ei ddiweddaru bob 3 mis. Mae'n arddangos y data hwn ar gyfer gwahanol lefelau (megis Grwpiau Gofal ac adrannau).
Thema 2: Cefnogi a datblygu sgiliau Cymraeg y gweithlu presennol a gweithlu'r dyfodol	
13	**Bydd sefydliadau iechyd a gofal cymdeithasol yn dod o hyd i fylchau yn sgiliau'r gweithlu mewn meysydd allweddol ac yn datblygu cynlluniau i fynd i'r afael â nhw. Bydd hyn yn cael ei ymwreiddio mewn cynlluniau sgiliau a gweithlu sy'n cael eu datblygu a'u cyflwyno mewn sefydliadau unigol, ac yn galw am weithio'n agos gydag AaGIC a GCC. *(Tymor canolig)*** Gweler yr ymateb i Gam Gweithredu 18 isod am y strategaeth gweithlu a hyfforddiant mewn perthynas â gwasanaethau sydd â niferoedd isel o siaradwyr Cymraeg.
14	**Byddwn yn disgwyl i holl gydweithwyr y GIG a gofal cymdeithasol ddilyn cwrs ymwybyddiaeth ieithyddol, a fydd yn egluro pa mor bwysig yw'r Gymraeg wrth ddarparu gwasanaethau ac fel un o anghenion cleifion. Ar ôl cyflwyno hyfforddiant ymwybyddiaeth o'r Gymraeg i bob gweithiwr proffesiynol ym maes iechyd a gofal cymdeithasol, byddwn yn disgwyl i'r hyfforddiant hwn gael ei ddarparu ym mhob disgyblaeth ar gyfer hyfforddeion, a'i gyflwyno fel rhan o'r broses gynefino i weithwyr newydd sydd heb wneud yr hyfforddiant yn barod. *(Tymor canolig)*** Roedd 9,521 o staff wedi cwblhau Cwrs Ymwybyddiaeth o'r Gymraeg ESR ym mis Mai 2026, pan luniwyd yr adroddiad hwn. Gan y bydd angen adnewyddu'r cymhwysedd bob tair blynedd, bydd y gyfradd gydymffurfio'n dechrau gostwng cyn cynyddu eto yn ystod y flwyddyn weithredol hon.

	Mae'r sesiwn sefydlu ar-lein ar gyfer cyflogeion newydd yn cynnwys adran graidd ar y Gymraeg a chyflwyniad fideo sy'n canolbwyntio ar y Cynnig Rhagweithiol a phwysigrwydd y Gymraeg i brofiad y claf. Defnyddir straeon staff a chleifion i wneud hyn. Gweler uchod hefyd, o dan Gam Gweithredu 2, ragor o fanylion am waith ymgysylltu ehangach mewn perthynas â'r Gymraeg.
15	**Bydd y Ganolfan Dysgu Cymraeg Genedlaethol yn datblygu ymhellach eu cynlluniau i gynnig hyfforddiant ar y Gymraeg i'r sectorau iechyd a gofal cymdeithasol, ac yn darparu amgylchedd sy'n galluogi pobl i ddefnyddio'r Gymraeg mewn gweithleoedd. Dylai hyn ategu'r broses anffurfiol o ddysgu iaith drwy adnoddau ac apiau ar-lein a fydd ar gael ar draws y sector. Gellid modelu hyn ar ddatblygiadau a gyhoeddwyd yn ddiweddar ar gyfer y gweithlu addysg. Dylai hyn gynnwys darpariaeth wedi'i theilwra i gefnogi ymarfer ym maes iechyd a gofal cymdeithasol, a dod o hyd i gyfleoedd (law yn llaw â chyflogwyr perthnasol) i gynyddu hyder staff i ddefnyddio mwy ar eu sgiliau Cymraeg ar ba lefel bynnag yn y gweithle. Rydym hefyd yn argymell bod Llywodraeth Cymru yn ystyried pa adnoddau sydd eu hangen i ddarparu cefnogaeth ddigonol ar gyfer cynllun o'r fath, gan gynnwys helpu cyflogwyr i ryddhau staff allweddol i fynd ati o ddifrif i ddysgu Cymraeg.** Mae gwaith wedi parhau mewn partneriaeth â'r Ganolfan Dysgu Cymraeg Genedlaethol a Dysgu Cymraeg Morgannwg. Mae hyn yn cynnwys: • Nodi'r anghenion craidd ar gyfer BIPCTM yn 2025/26 a chytuno ar ddarpariaeth amlinellol. • Cytuno ar wiriadau strategol rheolaidd rhwng Arweinydd y Gymraeg BIP, y Ganolfan Genedlaethol a Dysgu Cymraeg Morgannwg i sicrhau bod y ddarpariaeth yn cyd-fynd â'r galw. • Cyfarfodydd bob pythefnos rhwng y tiwtor a Rheolwr y Gymraeg i sicrhau cydweithrediad effeithiol ac y rheolir y cynnig ar gyfer BIPCTM. Mae'r gwaith ar dargedu'r Cynllun Codi Hyder yn strategol wedi'i gynnwys isod o dan Gam Gweithredu 18.

16	**Bydd sefydliadau yn diffinio lefel y sgiliau Cymraeg sydd eu hangen ym mhob hysbyseb swydd, yn unol â'r arferion gorau a welir mewn rhai byrddau iechyd ac awdurdodau lleol.** ***(Tymor canolig – canllaw i'w ddatblygu a'i rannu yn y tymor byr)*** Mae BIPCTM yn parhau i ddiffinio'r lefel o Gymraeg sy'n ofynnol ar dros **90%** o'r holl hysbysebion swydd lle mae sgiliau Cymraeg yn 'hanfodol', 'dymunol' neu 'angen eu dysgu ar ôl penodi'. Mae mwy o ddiffyg o hyd gyda swyddi Meddygol a Deintyddol, sy'n effeithio ar y cyfartaledd sefydliadol, ond mae gwaith wedi'i gynllunio yn ystod y flwyddyn i ystyried sgiliau Cymraeg ar gyfer swyddi meddygol. Mae BIPCTM wedi creu a chytuno ar y geiriadau canlynol ar gyfer pob swydd wag: *Sgiliau Cymraeg Dymunol:* *Rydyn ni'n hysbysebu'r swydd hon fel Cymraeg yn Ddymunol. Nid yw hyn yn golygu hanfodol; er nad oes angen i'r ymgeisydd feddu ar sgiliau Cymraeg, byddwn yn eu hystyried yn fantais wrth lunio rhestr fer a dewis ymgeiswyr. Does dim angen 'rhuglder', dim ond sgiliau Siarad a Gwrando ar Lefel 3 (sy'n cyfateb i CEFR B2) neu uwch. Mae Lefel 3 yn golygu sgyrsiau sylfaenol gyda chleifion am eu hiechyd bob dydd. Am ragor o wybodaeth, gweler 'Canllawiau'r Gymraeg' yn y dogfennau ar y gwaelod.* *Sgiliau Cymraeg Hanfodol:* *Mae'r swydd hon yn cael ei hysbysebu fel un lle mae sgiliau Cymraeg yn Hanfodol. Mae hyn yn golygu Siarad a Gwrando ar Lefel 3 (sy'n cyfateb i CEFR B2) neu uwch. Dydyn ni ddim yn chwilio am ruglder. Mae Lefel 3 yn golygu sgyrsiau sylfaenol gyda chleifion am eu hiechyd bob dydd. Am ragor o wybodaeth, gweler 'Canllawiau'r Gymraeg' yn y dogfennau ar y gwaelod.* *Cymraeg i'w Dysgu ar ôl Penodi:* *Mae'r swydd hon yn cael ei hysbysebu fel 'Cymraeg i'w Dysgu ar ôl Penodi'. Mae hwn yn gyfle cyffrous ac mae'n golygu y cewch y sgiliau sydd eu hangen arnom yn y Gymraeg ôl i chi gael eich recriwtio os nad oes gennych sgiliau Cymraeg eisoes. Byddwn yn gwneud hyn gan ddefnyddio ein darpariaeth fewnol hyblyg am ddim ochr yn ochr â'n partneriaeth â Dysgu Cymraeg Morgannwg, gan eich helpu i ennill y sgiliau gwerthfawr sydd eu hangen i gryfhau ein sefydliad dwyieithog. Am ragor o wybodaeth, gweler 'Canllawiau'r Gymraeg' yn y dogfennau ar y gwaelod.*

	Mae'r canllaw y cyfeirir ato uchod ym mhob geiriad wedi'i atodi i Trac ac felly mae'n ymddangos yn ddiofyn ar bob swydd wag. Mae'r canllaw hwn: • Yn rhoi rhagor o fanylion am yr hyn y mae 'hanfodol', 'dymunol', 'angen dysgu' a 'nid oes angen sgiliau Cymraeg' yn ei olygu i ymgeiswyr. • Yn rhoi mwy o fanylion am yr hyn y mae Lefel 3, 4 a 5 yn ei olygu'n ymarferol o ran defnydd iaith i ymgeiswyr, fel bod ganddyn nhw fwy na syniad haniaethol o'r hyn y gallai 'Lefel 3' ei olygu. Daw'r disgrifiadau hyn yn uniongyrchol o'r CEFR fel y gwelir yma, ac mae'r lefelau ALTE hefyd wedi'u croesgyfeirio â'r CEFR i'r rhai sy'n dod yn fwyfwy cyfarwydd ag ef. • Yn defnyddio iaith anogol a chefnogol fel bod ymgeiswyr yn llai tebygol o deimlo nad yw eu sgiliau Cymraeg yn addas neu fod angen 'rhuglder' sy'n rhwystr i lawer o ymgeiswyr posibl sy'n siarad Cymraeg. Mae'r dull hwn yn seiliedig ar y canlynol: • Mae gofynion y Gymraeg ar gyfer swyddi gwag yn BIPCTM wedi'u gosod ar Lefel 3 neu uwch yn ddiofyn, yn hytrach na'i gwneud yn ofynnol i reolwyr bennu a nodi lefel rhwng 1 a 5 ar gyfer pob swydd wag. • Yn gyffredinol, nid yw unigolion sydd â sgiliau Cymraeg ar Lefel 1 neu 2 yn gallu darparu gofal na gwasanaethau rheng flaen yn effeithiol yn Gymraeg. • Yn ogystal, mae'r broses o asesu gofynion lefel iaith ar gyfer pob rôl yn gymhleth ac o werth ymarferol cyfyngedig. Yn ei hanfod, mae gan ymgeisydd naill ai lefel o Gymraeg sy'n debygol o fod yn ddefnyddiol yn weithredol, neu beidio. Mae BIPCTM yn nodi bod Cam Gweithredu 16 yn ei gwneud yn ofynnol i sefydliadau ddiffinio'r sgiliau sydd eu hangen, fel y gwnaed yma. Ni ddefnyddir y gair 'asesu'.
17	**Cyflwyno'n raddol lefel "cwrteisi" sylfaenol o sgiliau Cymraeg, gan wneud staff yn fwy ymwybodol o'r effaith gadarnhaol y gall dysgu a defnyddio'r Gymraeg ei chael ar unigolion sy'n defnyddio ac yn derbyn gwasanaethau iechyd a gofal cymdeithasol. Erbyn diwedd oes y cynllun hwn, dylai pob aelod o staff sy'n gweithio ym maes iechyd a gofal cymdeithasol fod â lefel cwrteisi o sgiliau Cymraeg.** ***(Cyflwyno yn y tymor byr)*** Gall staff yn BIPCTM fanteisio ar sesiynau mewnol i ddatblygu lefel cwrteisi yn y Gymraeg ar ffurf sesiynau 'Croeso i'r Gymraeg' 2 awr o hyd. Gall staff archebu trwy ddolen fewnol. Ar gyfer y flwyddyn 2025/26: • Cymerodd 173 o staff ran yn y sesiwn fewnol. • Dywedodd 100% o'r cyfranogwyr a gwblhaodd y gwerthusiad eu bod wedi mwynhau'r sesiynau. • Gwnaethom ragori ar y targed blynyddol o 100 a osodwyd ar gyfer staff sy'n cwblhau'r sesiynau gan 73%.

	• Cynhaliwyd cyfanswm o 41 o sesiynau. • Darparwyd cyfanswm o 83 awr o hyfforddiant. • Symudodd 25% o ddysgwyr o Lefel 0 i Lefel 1 mewn Siarad a Gwrando ar ESR. • Gwnaeth 65% o'r staff a drefnodd sesiwn fynychu sesiwn. Hefyd: • Mae'r staff a gwblhaodd y sesiynau Croeso i'r Gymraeg yn cynrychioli gweithlu eang ac amrywiol, o dimau clinigol rheng flaen a gofal cymunedol i wasanaethau gweinyddol, addysg a chorfforaethol. • Yn nodedig, roedd dros hanner (52%) mewn rolau clinigol, sy'n tanlinellu pwysigrwydd y Gymraeg wrth ryngweithio o ddydd i ddydd gyda chleifion a theuluoedd. • Mae lefelau ymgysylltu hefyd yn tyfu, gyda chyfranogiad cynyddol gan swyddogaethau arwain, cynllunio a chorfforaethol. Mae'r newid hwn yn adlewyrchu dull gweithredu mwy aeddfed ar draws y sefydliad - gan gydnabod bod cyflawni'r Cynnig Rhagweithiol yn dibynnu nid yn unig ar staff rheng flaen, ond ar y systemau, y diwylliant a'r arweinyddiaeth sy'n eu cefnogi.
18	**Bydd sefydliadau'n datblygu ac yn gweithredu strategaeth gweithlu a hyfforddiant sy'n benodol ar gyfer y Gymraeg – gyda phwyslais cychwynnol ar fynd i'r afael â bylchau ym meysydd blaenoriaeth allweddol Mwy na geiriau, a'r rheini sy'n ddihyder (angen ystyried y posibilrwydd o weithio gydag arweinwyr tîm / rheolwyr / cyflogwyr hefyd i greu'r amodau i unigolion ddefnyddio eu Cymraeg). (Tymor canolig)** Mae'r ddogfen llinell sylfaen a gynhyrchwyd o dan Safon y Gymraeg 110, sydd ar gael yma, wedi ein galluogi i nodi meysydd o fewn y Bwrdd Iechyd: A. lle nad oes unrhyw siaradwyr Cymraeg o gwbl; B. lle mai'r unig staff sydd â sgiliau Cymraeg yw'r rhai ar Lefel 3, a C. lle mae yna siaradwyr Cymraeg ar Lefel 3, 4 a 5. Mae'r Cynllun Strategol 5 mlynedd ar gyfer Cynnig Ymgynghoriadau Clinigol yn Gymraeg wedi gosod y camau gweithredu canlynol: *Cynnig lle ar y Cynllun 'Codi Hyder' mewn partneriaeth â'r Ganolfan Dysgu Cymraeg Genedlaethol i feysydd gwasanaeth heb unrhyw siaradwyr Cymraeg ar Lefel 4 neu 5 ond lle ceir siaradwyr dihyder Lefel 3, yn ogystal ag i feysydd gwasanaeth sydd â siaradwyr Lefel 3 mewn meysydd Mwy na Geiriau eraill* I gefnogi'r uchod:

	• Roedd y cynllun strategol ar gyfer dysgu Cymraeg ar gyfer 2025/2026 yn canolbwyntio ar Grŵp B a C. • Mae'r data wedi'i drosglwyddo i daflen fonitro Excel sy'n nodi pa aelodau penodol o staff yng Ngrŵp B a C sydd angen eu gwahodd i'r Cwrs Codi Hyder, eu harbenigedd, cyfeiriad e-bost a'u rheolwr llinell. • Roedd y daflen fonitro'n nodi faint o'r staff hynny y bydd angen iddynt gwblhau'r cwrs i gyrraedd y targed mewnol a osodwyd yn y cynllun 5 mlynedd. Mae'r meysydd canlynol o dan Mwy na Geiriau wedi'u cefnogi yn ystod 2025/26, gyda chyfanswm o 24 aelod o staff yn cwblhau'r cynllun: • Therapi Iaith a Lleferydd • Seicoleg Oedolion – Tîm Iechyd Meddwl Cymunedol • Ward Gofal Dwys Seiciatrig, Ysbyty Brenhinol Morgannwg • Seicosis Ymyrraeth Gynnar • Tîm Mewngymorth/Cyswllt Cartrefi Gofal Pen-y-bont ar Ogwr
19	**Cychwyn ymgyrch hyrwyddo ac ymwybyddiaeth genedlaethol i wneud staff yn fwy ymwybodol o'r gwahaniaeth cadarnhaol y gall dysgu a defnyddio'r Gymraeg ei wneud i'r gwasanaethau maen nhw'n eu darparu. Bydd hyn yn cynnwys ymgyrchoedd recriwtio sy'n cyfleu pwysigrwydd y Gymraeg. Bydd yr ymgyrchoedd yn cynnwys modelau rôl ac astudiaethau achos ar y gwahaniaeth y mae defnyddio'r Gymraeg yn ei wneud i wella canlyniadau unigolion.** **(Tymor canolig)** Mae Gwobrau Blynyddol Seren CTM yn rhoi llwyfan sefydliadol allweddol i hybu'r Gymraeg a chodi ymwybyddiaeth o'i gwerth wrth ddarparu gwasanaethau. Mae'r Gymraeg wedi'i gwreiddio ym mhob rhan o'r gwobrau, gan gynnwys: • Cyfathrebu dwyieithog a hygyrchedd - deunyddiau ar gael yn Gymraeg a Saesneg, a gwahodd enwebiadau yn y naill iaith neu'r llall. • Integreiddio'r iaith i mewn i ganllawiau a beirniadu - mae'r canllaw ar gyfer ymgeisio yn annog enwebiadau sy'n tynnu sylw at sut mae'r defnydd o'r Gymraeg wedi cyfrannu at brofiad, hygyrchedd neu ganlyniadau cleifion. Mae beirniaid yn cael eu hannog i roi gwerth ar enghreifftiau lle mae ymarfer dwyieithog wedi cryfhau gofal, cyfathrebu neu gynhwysiant, gan sicrhau bod effaith y Gymraeg yn rhan o'r hyn y mae "da" yn ei gynrychioli mewn enwebiadau. • Mae enwebiadau'n cynnig mecanwaith i nodi a dathlu cydweithwyr sy'n defnyddio'r Gymraeg yn eu rolau – mae hyn yn helpu i greu modelau rôl gweladwy ac astudiaethau achos ymarferol.

	• Arweinyddiaeth glir, gan gynnwys cynrychioli Arweinydd y Gymraeg yng ngweithgor a phanel beirniadu'r gwobrau - mae hyn yn helpu i sicrhau bod ystyriaethau sy'n ymwneud â'r Gymraeg yn cael eu hadlewyrchu wrth wneud penderfyniadau.
20	**Bydd Gyrfa Cymru/AaGIC a GCC yn hyrwyddo pwysigrwydd sgiliau Cymraeg a'r cyfleoedd posibl a ddaw yn sgil hynny mewn gyrfaoedd ym maes iechyd a gofal cymdeithasol, gan ddefnyddio adnoddau porth Tregyrfa a thrwy sioeau teithiol a sesiynau ymgysylltu â phobl ifanc. *(Tymor byr/canolig)*** Yn ystod 2025–2026, cyflwynwyd rhaglen o 12 o weithgareddau ymgysylltu ag ysgolion, colegau a phrifysgolion ledled y rhanbarth, gan gynnwys ymweliadau ag Ysgol Garth Olwg, Ysgol Cardinal Newman, Ysgol Cwm Rhondda, a nifer o gampysau Coleg y Cymoedd, ac mae sesiynau wedi'u cynllunio gydag Ysgol Rhydywaun a Phrifysgol De Cymru. Gwnaeth y rhaglen ennyn diddordeb dysgwyr o Gyfnod Allweddol 3 hyd at addysg uwch, gan ddefnyddio cyflwyniadau pwrpasol, digwyddiadau gyrfaoedd, gweithdai a thrafodaethau rhyngweithiol i hyrwyddo gyrfaoedd gyda'r GIG a thynnu sylw at bwysigrwydd sgiliau Cymraeg mewn gofal iechyd. Roedd y gweithgareddau'n cynnwys trosolwg o yrfaoedd, canllawiau ar ymgeisio, cwisiau, astudiaethau achos, ymarferion paru swydd a thrafodaethau agored ar ddwyieithrwydd, gofal cleifion a dilyniant gyrfa. Roedd yr adborth gan ysgolion, colegau a gweithwyr gyrfaoedd proffesiynol yn gyson gadarnhaol, gyda rhanddeiliaid yn cydnabod gwerth ac effaith y sesiynau. Mae'r rhaglen wedi cryfhau partneriaethau, arwain at geisiadau am ymgysylltu pellach, a chreu cyfleoedd i ymestyn y ddarpariaeth i garfannau'r dyfodol a lleoliadau addysgol ychwanegol.

Thema 3: Rhannu arfer gorau a dull galluogi	
29	**Byddwn yn casglu ac yn rhannu enghreifftiau o arferion da arloesol sy'n bosibl ar draws y sector gan ddefnyddio safleoedd porth a hybiau sydd eisoes yn bodoli, gan gynnwys yr Hybiau Ymchwilio ac Arloesi. *(Tymor byr)*** Nid yw BIPCTM wedi ymgysylltu â Hyb Ymchwil ac Arloesi mewn perthynas â'r Gymraeg, ond mae wedi defnyddio rhwydweithiau eraill i rannu arfer da.
30	**Byddwn yn defnyddio'n Pecyn Cymorth Technegol Dwyieithog i sicrhau bod y gwasanaethau digidol yr ydym yn eu caffael a/neu'n datblygu yn cynnwys rhyngwyneb defnyddiwr dwyieithog lle bo hynny'n bosibl. O ran gwefannau gwybodaeth a chyngor byddwn yn dod a chyfieithwyr yn agosach at y broses creu cynnwys, gan gyd-ddrafftio yn y Gymraeg a'r Saesneg, fel ein bod yn cyfathrebu yn gliriach yn y ddwy iaith. *(Tymor byr)*** Mae'r tîm Digidol yn y camau olaf o gaffael galluogwyr digidol ar gyfer y rhaglen trawsnewid cyswllt sy'n canolbwyntio ar y claf. Nod y rhaglen hon yw trawsnewid sut mae cleifion yn rhyngweithio â'r Bwrdd Iechyd. Bydd yr holl dechnoleg sy'n delio'n uniongyrchol â chleifion yn ddwyieithog, ac mae'r ddogfennaeth dendro berthnasol yn cynnwys y gofyniad bod yn rhaid i'r cynigydd llwyddiannus sicrhau bod ei dechnoleg yn gallu gweithredu yn Gymraeg a Saesneg. Mae'r ddogfennaeth dendro hefyd yn cynnwys dolen i ddogfennau cyngor ar dechnoleg ddwyieithog a gynhyrchwyd gan Cymraeg 2050 o fewn Llywodraeth Cymru.
32	**Byddwn yn sicrhau bod Arweinwyr Gweithredol, Hyrwyddwyr a Swyddogion y Gymraeg yn cwrdd yn genedlaethol i rannu arferion gorau er mwyn sicrhau dull cyson o ymdrin â materion allweddol a datblygu mentrau i ddathlu llwyddiannau, gan gynnwys hyrwyddo Mwy na geiriau mewn cynlluniau gwobrau ac anrhydeddau sydd eisoes yn bodoli. *(Tymor byr)*** Gwahoddwyd BIPCTM i gyflwyno gweithdy ar ei raglen datblygu arweinyddiaeth fewnol, Inspire', ym mis Hydref 2025. Roedd hwn yn gyfle i rannu arfer da mewn perthynas ag un o elfennau hanfodol Mwy na Geiriau. Mae Arweinydd y Gymraeg ar gyfer BIPCTM wedi mynychu'r holl gyfarfodydd cenedlaethol perthnasol ac wedi cynrychioli BIPCTM.

35	**Mae arwyddion gweledol nid yn unig yn galluogi defnyddwyr gwasanaethau i wybod pa staff sy'n siarad Cymraeg, maen nhw hefyd yn cyfleu neges bod y Gymraeg yn rhan 'arferol' o'r broses bob dydd o ddarparu gwasanaeth, ac yn adeiladu ar ethos o berthyn. Byddwn yn ymestyn y prosiect Iaith Gwaith ledled Cymru er mwyn i weithwyr sy'n gallu cynnig gwasanaethau'n Gymraeg, neu'n rhannol gynnig gwasanaethau'n Gymraeg, allu dangos hynny'n rhwydd drwy wisgo bathodyn neu laniard Iaith Gwaith. Bydd ein systemau TGCh hefyd yn casglu, yn dangos ac yn rhannu gwybodaeth sy'n rhoi gwybod i ni fel unigolion a staff pwy sy'n gallu siarad Cymraeg a pha wasanaethau y byddan nhw'n eu cynnig yn Gymraeg – er mwyn i ni allu defnyddio ein Cymraeg gyda nhw. (Mae'n bosibl bydd angen cyllid/adnoddau ychwanegol er mwyn cyflawni hyn)** **(Tymor byr)** Gall staff Nyrsio a Bydwreigiaeth ofyn am wisg gyda'r bathodyn oren 'Siaradwr Cymraeg' wedi'i frodio arni. Yn ystod y flwyddyn, gofynnwyd i Uwch Nyrsys sicrhau nad yw staff sydd heb sgiliau Cymraeg yn gwisgo'r bathodyn. Gall staff sy'n gymwys i wisgo cortynnau gwddf gasglu un o unrhyw safle ysbyty dosbarth yn y Swyddfeydd Cyffredinol neu ofyn am un gan Wasanaeth Datblygu'r Gymraeg. I gyd, dosbarthwyd 140 yn ystod y cyfnod adrodd hwn. Gall wardiau cleifion mewnol sy'n defnyddio'r e-fwrdd gwyn nodi bod claf yn siaradwr Cymraeg gan ddefnyddio'r eicon 'siaradwr Cymraeg', sef baner Cymru. Dangosir enghraifft isod:

	
42	**Bydd pob corff iechyd ac awdurdod lleol yn penodi rhywun i fod yn gyfrifol am sicrhau bod camau gweithredu a thargedau'r cynllun yn cael eu cyflawni.** Fel y nodwyd yn y diweddariad diwethaf, y Cyfarwyddwr Gweithredol Pobl a'r Dirprwy Brif Weithredwr, Hywel Daniel, yw'r Aelod Bwrdd sy'n gyfrifol am Bortffolio'r Gymraeg.

Delivering the actions in the More than just words Plan 2022-27: For the period April 2025 – March 2026

Organisation	**Cwm Taf Morgannwg University Health Board**

Completed by:	**Ben Screen, Welsh Language Lead**	**Date: May 2026**

KEY DATA: **When citing any statistics / data, please provide a corresponding reporting date / time period.**

Welsh Language Skills of staff (as of March 2026 and based on data for 93% of staff)

Level	Listening/Speaking Cymraeg				
	2023/2024	2024/25	**2025/26**	Difference on 24/25	Difference on 25/26 as %
0	8401	9067	9510	+443	+4.89%
1	1961	2081	2109	+28	+1.35%
2	305	320	347	+27	+8.44%
3	199	203	224	+21	+10.34%
4	248	264	292	+28	+10.61%
5	303	320	356	+36	+11.25%

Level	Reading Cymraeg				
	2023/2024	2024/25	**2025/26**	Difference on 24/25	Difference on 25/26 as %
0	8556	9312	9801	+489	+5.25%
1	1775	1822	1809	-13	-0.71%
2	302	314	341	+27	+8.60%
3	171	179	199	+20	+11.17%
4	233	247	270	+23	+9.31%
5	326	338	377	+39	+11.54%

Level	Writing Cymraeg				
	2023/2024	2024/25	**2025/26**	Difference on 24/25	Difference on 25/26 as %

	0	8774	9556	10054	+498	+5.21%
	1	1595	1615	1610	-5	-0.31%
	2	288	306	332	+26	+8.50%
	3	187	200	223	+23	+11.50%
	4	195	205	224	+19	+9.27%
	5	292	297	328	+31	+10.44%
Number of staff completing training (between April 2025 and March 2026)	**Courtesy Course:** 173 **Confidence Building Course:** 24 **Welsh Language Awareness Course:** 9,521					
Patient / Service User Surveys e.g. secret shopper surveys	**Number and details of surveys:** 0 surveys **Feedback:** No feedback received formally. **Actions taken in response to feedback:** Not applicable					

Culture and Leadership	
ACTION	RESPONSE FROM CTM UHB
2.	Over time, we expect all health and social care staff to gain an appreciation of the positive difference that learning and using Welsh can make to the care experience. In the meantime we'll bolster language awareness courses with a behavioural-science communications approach so that everything we say about Cymraeg as leaders, and as organisations and partnerships contributes to this strategy. This approach will build on the training and on the positive narrative outlined in the plan. (*Short to medium term*) During the year, the Welsh Language Development Service delivered extensive engagement across Cwm Taf Morgannwg UHB. A total of 181 engagement sessions were held with staff and managers, including inductions, directorate-wide sessions, conferences and senior management presentations. The inductions included those for students, newly-registered nurses and the new intake of doctors. In addition, there was 1 formal presentation to a Board Committee and a request for 1 further Board-level presentation. The team also undertook 2 series of site visits across the Royal Glamorgan, Prince Charles and Princess of Wales hospitals. These visits generated significant visibility, with 176 resources distributed (including 55 lanyards and 85 badges), enabling 140 staff to visibly identify as Welsh speakers or learners. Engagement during visits included conversations with 115 staff members and 29 patients. Beyond direct engagement, the Service provided specialist support, including bespoke advice to 36 managers on compliance, handling 4,266 translation requests from 1,085 requesters (covering over 6 million words), and responding to 200 Welsh learning enquiries. Overall, it is estimated that over 1,300 staff were engaged with during the year. In Primary Care, awareness and uptake of the offer also increased. Thirteen practices requested translation support, while 5 practices requested lanyards and badges, with 37 items distributed. This has supported greater visibility of Welsh-speaking staff. Strategic engagement included discussions with the Chief Operating Officer and Medical Director for Primary Care, and attendance at key forums and training events across General Practice, Pharmacy and

	Nursing. Examples of this included the Practice Nurse Forums and a slot at the Practice Managers Forum for CTMUHB.
3	**We'll expect those in leadership roles to take part in our Leading in a Bilingual Country programme. This programme works towards embedding the spirit of Cymraeg 2050 in organisational culture and policymaking. All too often, Welsh is viewed as just an issue of translation or as a 'tick box' in policy development. This values-based programme goes beyond understanding the possible impact of language on all aspects of our work to using what levers we have to increase its use.** ***(Medium term)*** CTM UHB has developed its own in-house leadership development with similar aims to the Leading in a Bilingual Country programme. These are described below. **Inspire: Leading Systems** Inspire is designed to bring our most senior colleagues together to build a thriving leadership community within CTM. The programme is built around our own pioneering 'Leadership Competency Framework', within which bilingualism and Cymraeg specifically are embedded. Aligned to our 'Inclusion' module, senior leaders are supported to explore Cymraeg in the wider NHS Wales and political landscape, their attitudes and behaviours in relation to Cymraeg and their role in embedding bilingualism in CTM. In doing so, we aim to embed the spirit of Cymraeg 2050 and Mwy na Geiriau into organisational culture and policy. To date, 21 participants have completed the programme, with further cohorts due to start in September 2026. **Ignite: Manager Induction** Managers at all levels can now take advantage of a bespoke full-day session looking at the support available to them in their roles and the basics of managing a team. Part of this session includes exploring: • How managers can support the use of Welsh in their role as managers. • What support is available to them and their teams to embed Welsh. • What the requirements of the Welsh Language Standards are in brief.

	Launched in February 2026, 55 managers have completed this induction as of March 2026. A member of the Welsh Language Development Service also attends part of the day, along with other key support functions. This has allowed for further engagement with the Welsh Language Development Service, and after the February session for example, 14 resources to support the use of Welsh were shared and 3 managers asked for more information from the Team on learning Welsh.
Theme 1: Welsh language planning and policies including data	
5	**Identify and develop research and data that will strengthen our understanding and knowledge based on the experiences of Welsh language speakers accessing and receiving services, to support evidence-based policy and Welsh language planning in health and social care. This to include ability to provide bilingual services and to evidence how More than just words supports improved outcomes for individuals. (This action aligns with the work set out in section 4 on mapping the data and creation of the dashboard) (*Medium term*)** CTM UHB has continued to support the implementation of Promptly and the collection of Patient Reported Experience Measures as part of the People's Experience Framework. The national, standardized question on language is used in all surveys. The current method of systematically gathering patient experience data is the Patient Experience Survey. This is a national survey with standardized questions. It includes a question on language, around whether the patient was able to use their preferred language. The patient is then asked to select which language in the second question. Currently however the data from this cannot be used to inform the planning and delivery of Welsh language services because: • It is not possible to extrapolate data from service level; it is only available at Care Group level. • It is not possible to directly cross-tabulate between the answer to the question on whether the patient was able to use their preferred language, and the answer to the second question where the patient is asked to select what that preferred language actually was (e.g. Welsh). This would be an issue at a national level.

6	**Develop tools to support mainstreaming Welsh Language considerations into planning and policies especially in the priority areas and high levels of interactions with services. This to include establishing Welsh language care pathways for vulnerable individuals in identified priority groups such as older people, children, mental health, speech therapy, learning difficulties, and stroke services.** **(Long term)** Work in relation to Welsh Language Impact Assessments for this reporting period is outlined below: • A new, simpler integrated Equality & Welsh Language Impact Assessment template has been created. This template includes a section on Mwy na Geiriau specifically. • Guidance has been created on completing the assessment, with guidance on how a policy or change may impact Mwy na Geiriau. • Submission processes for papers to Board & Committees, Executive Leadership Group, Executive Management Board and to Operational Management Board have been strengthened. A paper cannot be put forward without the paper template including the summary of the impact assessment where one is required. • The requirements for impact assessments are now explicit in the *Policy for the Development, Review and Approval of CTMUHB Policies, Procedures and Other Written Control Documents* (CG06), *Approval Process for Polices, Procedures and other Written Control Documents* (CG07) and the forthcoming *CTMUHB Service Change Management Standard Operating Procedure*. • A new impact assessment tool for procurement activity has gone live since April 2026 in co-operation with NWSSP to ensure Welsh Language Standards are adhered to by 3rd party suppliers where applicable.
8	**An agreed national framework for the collection and collation of data on the language skills of all staff working in health and social care in Wales will be developed and implemented. This should be mandatory wherever possible and would need to align with systems and approaches currently in place for the collection, collation of data across the health and social care sectors including services that are provided in Welsh** **(Medium term)**

	As in all other NHS Wales bodies, staff record their language skills on the Electronic Staff Record (ESR) using the 0-5 ALTE Scale for language skills. CTMUHB has developed an internal dashboard linked to ESR that automatically updates from ESR. This displays the current Welsh language skills of staff and is updated every 3 months. It displays this data for various levels (such as Care Groups and departments).
Theme 2: Supporting and developing the Welsh language skills of the current and future workforce	
13	**Health and social care organisations to identify workforce skills gaps in key areas and develop plans to address them. This will be embedded in workforce and skills plans developed and delivered within individual organisations and involve close working with HEIW and SCW. *(Medium term)*** For the workforce and training strategy in relation to services with low numbers of Welsh speakers, see the response to Action 18 below.
14	**We'll expect all NHS and social care colleagues to follow a language 'awareness 'course which will explain how important Cymraeg is in service delivery and as a patient need. Following the introduction of Welsh language awareness training for all health and social care professional, we'll expect that this training is provided across all disciplines for trainees and introduced as part of the induction process for new employees in the health and social care workforce who have not already undertaken the training.** ***(Medium term)*** The number of staff who have completed the ESR Welsh Language Awareness Course, as of May 2026 when this reported was compiled, is 9,521. As the competency will need to be renewed every three years, the compliance rate will start to drop before increasing again over the course of this operational year. The online induction for new employees contains a core section on Welsh and a video introduction focussing on the Active Offer and the importance of Welsh to the patient experience. Both staff and patient stories are used to do this. See above also under Action 2 for more detail on wider engagement work around Welsh.
15	**The National Centre for Learning Welsh develop further their plans to offer Welsh language training to the health and social care sectors and provide an enabling environment on the**

	use of Welsh in workplaces. This should complement informal language learning through on-line tools and apps to be made available across the sector. Work has continued in partnership with the National Centre for Learning Welsh and Learn Welsh Glamorgan. This has included: • Setting out for 2025/26 the core needs for CTMUHB and agreeing outline provision. • Regular strategic check-ins agreed between the UHB's Welsh Language Lead, the National Centre and Learn Welsh Glamorgan to ensure the provision matches demand. • Fortnightly meetings between the tutor and the Welsh Language Manager to ensure effective co-operation and the management of the offer for CTMUHB. Work on strategically targeting the Codi Hyder [Inspiring Confidence] Scheme is included below under Action 18.
16	**Organisations to define the level of Welsh language skills required in all job adverts as per best practice in some health boards and local authorities** ***(Medium term – guidance to be developed and shared in the short term)*** CTMUHB continues to define the level of Welsh required on over **90%** of all job adverts where skills in Welsh are 'essential', 'desirable' or 'need to be learnt on appointment'. There continues to be a greater deficit with Medical & Dental posts, affecting the the organisational average but work is planned in-year to consider Welsh language skills for medical posts. CTMUHB has created and agreed the following wordings for each vacancy: *Welsh Skills Desirable:* *This post is advertised as Welsh Desirable. This doesn't mean essential; whilst the candidate doesn't need to have skills in Welsh, we'll consider it an advantage when short-listing and selecting candidates. This isn't 'fluency', just Speaking & Listening skills at Level 3 (equivalent to CEFR B2) or above. Level 3 means basic conversations with patients about their everyday health. For more information, see 'Welsh Language Guidance' in the documents right at the bottom.* *Welsh Skills Essential:*

	This post is advertised as Welsh skills are essential. This means Speaking & Listening at Level 3 (equivalent to CEFR B2) or above. We don't need fluency. Level 3 means basic conversations with patients about their everyday health. For more information, see 'Welsh Language Guidance' in the documents right at the bottom. *Welsh to be Learnt on Appointment:* *This post is advertised as 'Welsh to be Learnt on Appointment'. This is an exciting opportunity and means we'll give you the skills in Welsh we need once you've been recruited if you don't already have skills in Welsh. We'll do this using our free and flexible internal offer alongside our partnership with Learn Welsh Glamorgan, helping you to gain the valuable skills needed to strengthen our bilingual organisation. For more information, see 'Welsh Language Guidance' in the documents right at the bottom.* The guide referenced above in each wording has been attached to Trac and therefore appears by default on all vacancies. This guide: • Provides further detail on what 'essential', 'desirable', 'needs to be learnt' and 'no skills in Welsh required' mean for applicants. • Gives more detail on what Level 3, 4 and 5 mean practically in terms of language use for applicants, so that they have more than an abstract idea of what 'Level 3' may mean. These descriptions come directly from the CEFR as seen here, and the ALTE levels are also cross-referenced with the CEFR for those that are increasingly familiar with it. • Uses encouraging, supportive language so that applicants are less likely to feel their skills in Welsh are not suitable or that 'fluency' is required which is a barrier to many potential Welsh-speaking applicants. This approach is based on the below: • Welsh language requirements for CTMUHB vacancies have been set at Level 3 or above by default, rather than requiring managers to determine and specify a level between 1 and 5 for each vacancy. • Individuals with Welsh language skills at Level 1 or 2 are generally not able to deliver care or front-facing services effectively in Welsh. • Additionally, the process of assessing language level requirements for each role is complex and offers limited practical value. In essence, a candidate either possesses a level of Welsh that is likely to be operationally useful, or they do not. CTMUHB notes that Action 16 requires organisations to define the skills required, as has been done here. The word 'assess' is not used.

17	**Gradual introduction of a minimum "courtesy" level of Welsh language skills making staff more aware of positive impact that learning and using Welsh can have on individuals accessing and receiving health and social care services. By the end of the life of this plan, all staff working in health and social care should have courtesy level Welsh.** ***(Short term- introduction)*** Staff in CTMUHB can take advantage of internal sessions for courtesy-level Welsh in the form of 2-hour 'Welcome to Welsh' sessions. Staff are able to book on via a link internally. For the 2025/26 year: • 173 staff took part in the internal session. • 100% of participants who completed the evaluation reported enjoying the sessions. • We exceeded the annual target of 100 set for staff completing the sessions by 73%. • 41 sessions were held in total. • 83 hours in total of tuition were provided. • 25% of learners progressed from Level 0 to Level 1 in Speaking and Listening on ESR. • 65% of staff who booked a session attended a session. In addition: • Staff who completed the Welcome to Welsh sessions represent a broad and diverse workforce, from frontline clinical teams and community care to administration, education and corporate services. • Notably, over half (52%) were in clinical roles, underlining the importance of Welsh in day-to-day interactions with patients and families. • Engagement is also growing, with increasing participation from leadership, planning and corporate functions. This shift reflects a more mature, organisation-wide approach—recognising that delivering the Active Offer relies not only on frontline staff, but on the systems, culture and leadership that support them.
18	**Organisations to develop and implement a targeted Welsh language training and workforce strategy – with initial focus on addressing gaps in More than just words key priority areas and those who lack confidence (need to consider the potential for working with team leaders / managers /employers to also create the conditions for individuals to use their** **Welsh)** **(Medium term)**

	The baseline document produced under Welsh Language Standard 110, available here, has allowed for the identification of areas within the Health Board: A. where there are no Welsh speakers at all; B. where the only staff with Welsh language skills are those at a Level 3, and C. where there are Welsh speakers at a Level 3, 4 and 5. The 5-year Strategic Plan for Offering Clinical Consultations in Welsh has set the following action: *Offer a place on the 'Inspiring Confidence' Scheme in partnership with the National Centre for Learning Welsh to service areas with no Welsh speakers at Level 4 or 5 but where there are Level 3 underconfident speakers, as well as to service areas with Level 3 speakers in other More Than Just Words areas* To support the above: • The strategic plan for learning Welsh for 2025/2026 concentrated on Group B and C. • The data has been transferred to an Excel monitoring sheet noting which specific members of staff in Group B and C need to be invited onto the Confidence Building Course, their speciality, email address and their line manager. • That monitoring sheet noted how many of those staff will need to complete the course to meet the internal target set in the 5-year plan. The following areas under Mwy na Geiriau have been supported during 2025/26, with 24 members of staff completing the scheme in total: • Speech & Language Therapy • Adult Psychology – Community Mental Health Team • Psychiatric Intensive Care Ward, Royal Glamorgan Hospital • Early Intervention Psychosis • Bridgend Care Home In-Reach/Liaison Team
19	**Instigate a national awareness and promotion campaign to make staff more aware of the positive difference that learning and using Welsh can make to the services they provide. This to include recruitment campaigns articulating the importance of the Welsh language. The campaigns to involve role models and case studies on the difference use of Welsh has in improving outcomes for individuals.**

	Health and social care bodies to provide information on promotion campaigns they are also delivering to raise awareness of the difference learning Welsh can make. This should include case studies and awards which feature the Welsh language. **(Medium term)** The CTM Seren Annual Awards provide a key organisational platform to promote Welsh language and raise awareness of its value in service delivery. Welsh language is embedded throughout the awards approach, including: • Bilingual communications and accessibility - materials available in Welsh and English and nominations explicitly invited in either language. • Integration into guidance and judging - the awards entry guide actively encourages nominations that highlight how Welsh language use has contributed to patient experience, accessibility or outcomes. Judges are guided to value examples where bilingual practice has strengthened care, communication or inclusion, ensuring Welsh language impact is part of what "good" looks like in nominations. • Nominations provide a mechanism to identify and celebrate colleagues who use Welsh in their roles – this helps to create visible role models and practical case studies. • Leadership visibility, including representation of the Welsh Language Lead within the awards working group and judging panel - this helps ensure Welsh language considerations are reflected in decision-making.
20	**Careers Wales / HEIW and SCW to promote the importance and opportunities Welsh language skills can provide within careers in health and social care utilising the Tregyrfa portal resources and through roadshows and engagement sessions with young people.** ***(Short/medium term)*** During 2025–2026, a programme of 12 school, college and university engagement activities was delivered across the region, including visits to Ysgol Garth Olwg, Ysgol Cardinal Newman, Ysgol Cwm Rhondda, multiple Coleg y Cymoedd campuses, and planned sessions with Ysgol Rhydywaun and the University of South Wales. The programme engaged learners from Key Stage 3 through to higher education, using tailored presentations, careers events, workshops and interactive discussions to promote NHS careers and highlight the importance of Welsh language skills in healthcare. Activities included careers overviews, application guidance, quizzes, case studies, job-matching exercises and open discussions on bilingualism, patient care and career progression.

	Feedback from schools, colleges and careers professionals was consistently positive, with stakeholders recognising the value and impact of the sessions. The programme has strengthened partnerships, generated requests for further engagement, and created opportunities to extend provision to future cohorts and additional educational settings.
Theme 3: Sharing best practice and an enabling approach	
29	**We'll collate and share examples of innovative good practice which is accessible across the sector utilising existing portals and hubs including the Research and Innovation Hubs. *(Short term)*** CTMUHB has not engaged with a Research & Innovation Hub for Welsh language, but has used other networks to share good practice.
30	**We'll use our Bilingual Technology Toolkit to ensure that when we procure and/or develop new digital services, they will include a bilingual user interface wherever possible. For information and advice websites we'll bring translators closer to content creation, drafting in Welsh and English together, so that we communicate clearly in both languages. *(Short term)*** Digital are in the final stages of procuring digital enablers for the patient-centred contact transformation programme. This programme aims to transform how patients interact with the Health Board. All patient facing technology will be bilingual, and the relevant tender documentation includes the requirement that the successful bidder must ensure their technology can function in Welsh and English. The tender documentation also includes a link to advice documents on bilingual technology produced by Cymraeg 2050 within Welsh Government.
32	**We'll ensure that Welsh language Executive Leads and Welsh Language Officers and champions meet nationally to share best practice to ensure a consistent approach on key issues and develop initiatives to celebrate success including promoting More than just words within existing awards and accolade schemes. *(Short term)***

	CTMUHB was invited to present a workshop on its internal leadership development programme, Inspire, in October 2025. This was an opportunity to share good practice around a crucial element of Mwy na Geiriau. The Welsh Language Lead for CTMUHB has attended all relevant all-Wales meetings and represented CTMUHB.
35	**Visual markers not only enable service users to identify Welsh speaking staff but also to convey a message that Welsh is a 'normal' everyday part of service delivery and builds on ethos of belonging. We'll extend the Iaith Gwaith project across Wales to allow workers who can offer or partially offer services in Welsh to readily identify themselves by wearing Iaith Gwaith badges or lanyards.** Nursing & Midwifery staff can request uniform with the orange 'Welsh speaker' badge embroidered on to it when requesting uniform. Senior Nurses were requested during the year to ensure staff without Welsh language skills do not wear the badge. Staff who able to wear lanyards can collect one from all district hospital sites at the General Offices or request them from the Welsh Language Development Service. In total, 140 were given out this reporting period. In-patient wards using the e-whiteboard are able to note a patient is a Welsh speaker using the 'Welsh speaker' icon, which is the Welsh flag. An example is shown below. 

42	**All health bodies and local authorities to appoint a person to be responsible for ensuring delivery on the actions and targets set in the plan.** As noted in the last update, the Executive Director for People and Deputy Chief Executive, Hywel Daniel, is the Board Member who holds the Welsh Language Portfolio.

CTMUHB Public Board

Putting Things Right Annual Report 2025/26: Closing the Chapter and Transition to Listening to People

Eitem yr Agenda / Agenda Item	8.1.7
Dyddiad y Cyfarfod / Date of Meeting:	26.11.26
Statws Cyhoeddi / Publication Status:	Open Public
Adroddiad wedi'i baratoi gan / Report Prepared by:	Nigel Downes, Assistant Director of Quality & Safety Stephanie Muir, Head of Concerns, Clinical Audit & Compliance Kellie Jenkins-Forrester, Lead for Legal Services
Cyflwynydd yr Adroddiad / Report Presenter:	Nigel Downes, Assistant Director of Quality & Safety
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Executive Director of Nursing, Midwifery and Patient Care
Diben yr Adroddiad / Report Purpose:	For Assurance and Approval
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	The Board is asked to RECEIVE and NOTE the Putting Things Right Annual Report 2025/26 and the Health Board's performance during the reporting period, and APPROVE the proposed improvement priorities and ongoing governance and oversight arrangements as CTM transitions to Listening to People.
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol* *Strategic Context:* *This report aligns to the following Strategic Pillars*	Improving Care The report is relevant to strategic risks concerning the quality and safety of care, patient and public confidence, and regulatory and governance assurance.

	Board Assurance Framework – Risk 2
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan *(Reference relevant priority)*	Supports delivery of the Health Board's quality, safety, patient experience and governance priorities.

Crynodeb Gweithredol o'r hyn y mae'r adroddiad yn ei ddisgrifio: Dechreuwch drwy grynhoi'r wybodaeth bwysicaf yn fyr. Dylai hyn roi dealltwriaeth gadarn o'r pwyntiau allweddol yn erbyn y 3 phennawd canlynol heb ddarllen yr adroddiad llawn: Executive Summary of what the report is describing: Start by summarising briefly the most critical information. This should provide a firm grasp of the key points against the following 3 headings without reading the full report:	
Beth *(crynodeb o'r sefyllfa / mater cyfredol a pham ei fod yn bwysig a thystiolaeth i gefnogi'r safbwynt hwnnw ac ati)* What *(summary of current position / issue & why it matters and evidence to support that position etc)*	The Putting Things Right and Duty of Candour Annual Report 2025/26 provides an overview of complaints, patient safety incidents, Duty of Candour, Redress, claims, inquests and organisational learning across the Health Board. During the year, 1,613 complaints were received, comprising 631 formal complaints managed through Putting Things Right and 982 resolved through early resolution. A total of 586 formal complaints were closed, of which 424 (72%) were responded to within 30 working days. The report also covers 23,101 patient safety incidents, 177 Duty of Candour triggers, 107 Nationally Reportable Incident notifications and four Never Events. It describes the actions and learning arising from complaints, incidents, PSOW reports, claims, inquests, Regulation 28 reports and Learning from Events Reports, and provides a baseline as the Health Board transitions from Putting Things Right to Listening to People.
Felly, beth *(darparu dadansoddiad ystyrlon gan dynnu allan, fel y bo'n briodol, oblygiadau yn erbyn Strategaeth / Cynlluniau Cyflawni /*	The report provides evidence of established arrangements for managing complaints, patient safety incidents, Duty of Candour, Redress, claims and inquests, together with strengthened arrangements for organisational learning and oversight. Positive assurance includes the detailed

risgiau Strategol neu Reoleiddiol CTMUHB *ac ati ac unrhyw opsiynau ar gyfer mynd i'r afael â'r rhain)* So, what *(provide meaningful analysis drawing out as appropriate implications against CTMUHB Strategy / Delivery Plans / Strategic or Regulatory risks* *etc and any options for addressing these)*	investigation and response to the four Never Events, measurable improvement arising from Regulation 28 activity, strengthened inquest governance and an increase in first-time LFER approval from 16% to 31%. Assurance is not uniform across all areas. Complaint response timeliness, the Redress legacy backlog, the significant movement between initial and subsequent harm assessments, and consistent evidence that learning has resulted in sustained improvement require continued management attention. These issues have implications for patient experience, quality and safety, regulatory assurance and organisational reputation.
Beth Nesaf *(crynodeb o'r camau gweithredu a fwriadwyd a'r manteision sy'n cefnogi'r dewisiadau a'r argymhelliad(au) sy'n cael eu gwneud)* What Next *(summary of intended action and benefits supporting the choices and recommendation(s)being made)*	The Health Board will maintain oversight of complaint timeliness, overdue cases and the Redress backlog, with clear ownership and escalation through existing governance arrangements. Continued attention will also be given to the interpretation and assurance of harm grading, completion of actions arising from significant incidents, and the quality of evidence demonstrating that learning has resulted in improvement. The transition to Listening to People provides an opportunity to strengthen early and proportionate resolution, compassionate communication, thematic analysis, triangulation of concerns and safety intelligence, and accountability for improvement actions. Future reporting will support the Committee to assess both performance and the impact of learning across the organisation.

Argymhelliad *(Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).* Recommendation (Linked to the "What Next" section above).	The Board is asked to RECEIVE and NOTE the Putting Things Right Annual Report 2025/26 and the Health Board's performance during the reporting period; and APPROVE the proposed improvement priorities and ongoing governance and oversight arrangements as CTM transitions to Listening to People.

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)* Link to Strategic Risk(s) on the Board Assurance Framework (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	Quality and safety; public confidence; regulatory and governance assurance.

Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales A Healthier Wales; A More Equal Wales; A Wales of Cohesive Communities. Strengthening access, responsiveness, learning and accountability supports fairer and more person-centred public services.

Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Learning, Improvement & Research Learning, improvement and innovation; whole-systems perspective; leadership; workforce engagement.

Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental Sustainability Impact (5Rs)	No - Not Applicable

Asesiad Effaith Impact Assessment		
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg *(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)* Equality & Welsh Language Impact Assessment Outcome	Outcome for Equality: NEUTRAL Summary: The paper reports on performance and learning arising from Putting Things Right and does not itself propose a service or policy change. Any subsequent service	A separate EWLIA has not been completed because this paper presents external assurance information and proposes

(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)	changes arising from identified themes or learning will be subject to proportionate equality and Welsh language impact assessment Outcome for Welsh Language: NEUTRAL Summary: Any resulting public-facing communications will follow the Health Board's Welsh Language obligations.	oversight actions rather than a service redesign or policy change.
Canlyniad Asesiad Effaith Ansawdd *(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)* Quality Impact Assessment Outcome *(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)*	Positive. The proposed actions strengthen learning, recommendation compliance, accountability and oversight. No adverse quality impact has been identified.	
Not applicable / no direct legal decision sought.	There are no specific legal implications related to the activity outlined in this report	
	The report does not seek any specific legal decision. It provides assurance regarding the Health Board's arrangements for complaints, Redress and Duty of Candour and supports continued compliance with the relevant statutory and regulatory requirements.	
Moderate reputational relevance.	Yes (include further detail below)	
	Delay or repeat failings could affect public confidence. Transparent Board oversight and timely action provide mitigation.	
Manageable within existing resources, subject to prioritisation.	There is no direct impact on resources as a result of the activity outlined in this report	
	Actions require operational and executive ownership, central monitoring, thematic	

	review and evidence collation. Any additional resource implications identified through the action plan will be escalated through normal governance routes.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Quality, Safety & Experience Committee	24 November 2026	PENDING ENDORSEMENT
Executive Director of Nursing, Midwifery and Patient Care	November 2026	
Assistant Director of Quality & Safety	November 2026	Detailed review and finalisation
Q&S /Legal Services Leads	November 2026	Factual validation of relevant sections

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

PUTTING THINGS RIGHT & DUTY OF CANDOUR

ANNUAL REPORT 2025/2026

PUTTING THINGS RIGHT & DUTY OF CANDOUR

ANNUAL REPORT 2025/2026

1.0 Introduction

2.0 Feedback
- 2.1 Complaints
- 2.2 Public Service Ombudsman for Wales

3.0 Patient Safety Incidents and
- 3.1 Duty of Candour
- 3.2 National Reportable Incidents
- 3.3 Never Events

4.0 Legal Services
- 4.1 Redress
- 4.2 Claims

5.0 Inquests

6.0 Learning from Events Reports

7.0 Conclusion

1.0 Introduction

Putting Things Right is the process by which NHS Wales handles concerns, complaints, incidents, and claims in a consistent, fair, and transparent manner. It is governed by the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011, which set out the legal framework for managing feedback and ensuring appropriate redress when things go wrong.

The PTR process enables patients, families, carers, and staff to raise concerns about the care or services they receive or deliver. It ensures that:

- Concerns are acknowledged and investigated promptly
- Individuals affected are kept informed and supported
- Lessons are learned and shared to improve safety and quality
- Where appropriate, redress is offered in a timely and proportionate way

The Putting Things Right Annual Report 2025/2026 provides an overview of the Health Board's performance and activity in relation to how the organisation has managed Concerns including complaints, incidents, claims, redress and inquests between 1st April 2025 and 31st March 2026.

In addition, the report will provide a summary of the Health Board's implementation of the Duty of Candour requirements.

From April 2023, the Duty of Candour became a legal requirement for NHS bodies in Wales. The statutory guidance promotes openness, learning and improvement and requires care providers to be open and honest with service users and their families when the duty is engaged.

The Duty of Candour Statutory Guidance 2023 prescribes the actions that must be taken and supports the existing processes for 'Putting Things Right' (the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011) with updates made to the PTR Regulations to include the Candour Guidance.

This report also serves as the Health Board's closing annual account of the Putting Things Right framework, ahead of the transition to Listening to People. It therefore seeks not only to describe activity during 2025/2026, but also to reflect on the learning generated through complaints, patient safety incidents, Duty of Candour, redress, claims, inquests and external scrutiny. It identifies where assurance can be taken from current arrangements, where further improvement is required and how the learning from Putting Things Right will inform the Health Board's future approach to listening, responding and learning.

Putting Things Right

Overview 2025/2026

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Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

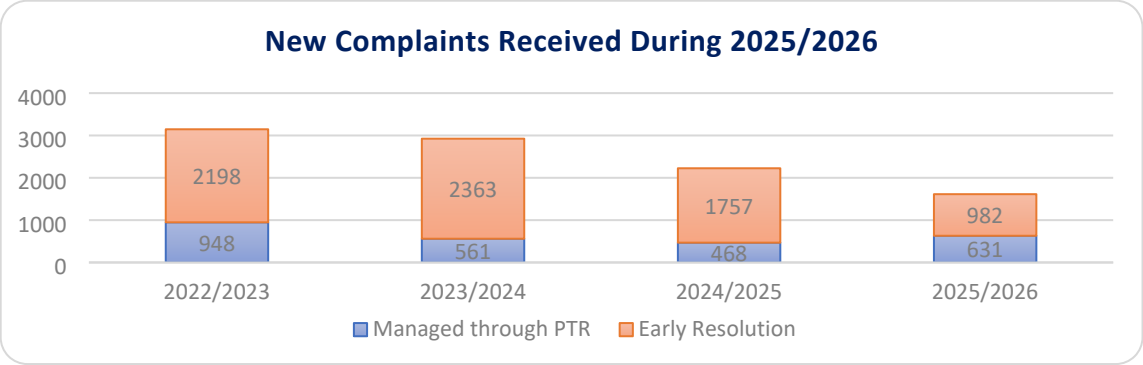


2.0 Feedback

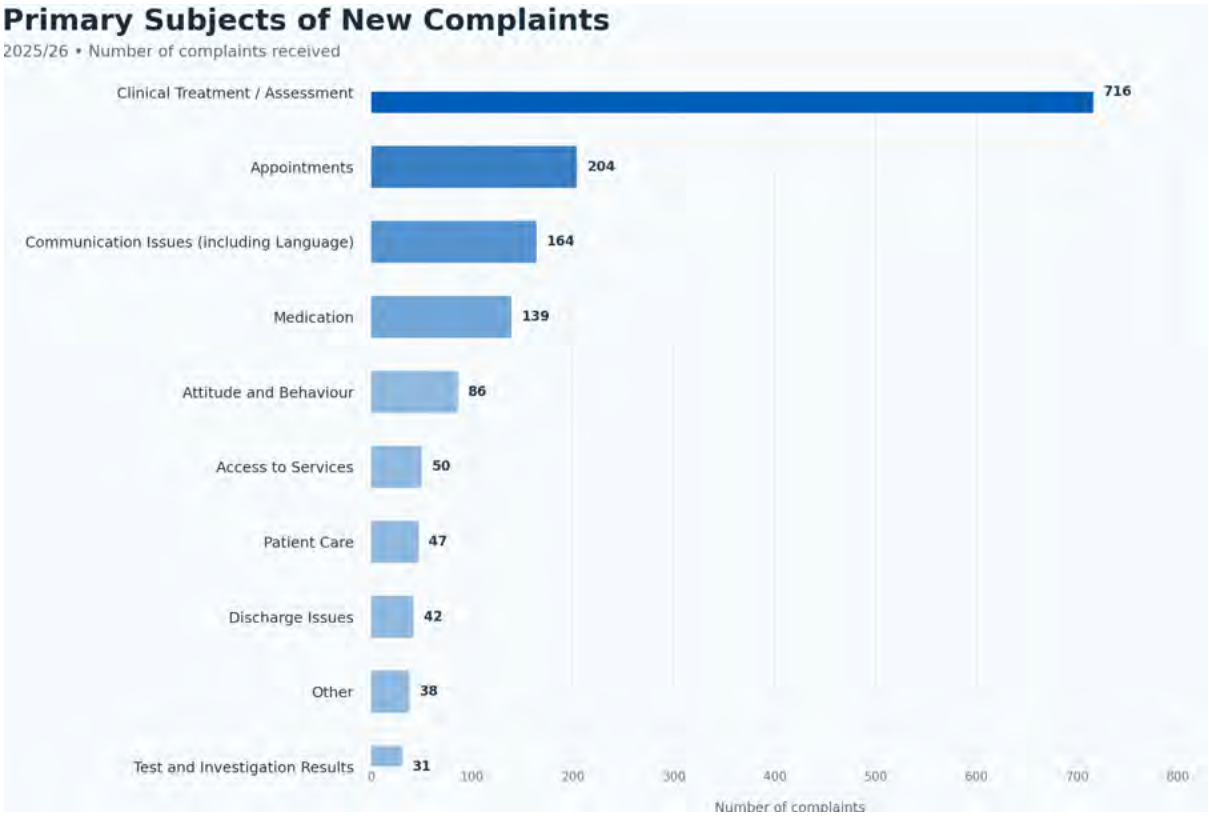
2.1 Complaints

New Complaints

During 2025/2026 a total of 1613 complaints were received by the Health Board, representing a decrease when compared with the previous year. Of the new complaints received, 631 were managed formally via the Putting Things Right process. The remaining 982 were managed as early resolution complaints. The trend for the last 4 years is reflected in the table below.

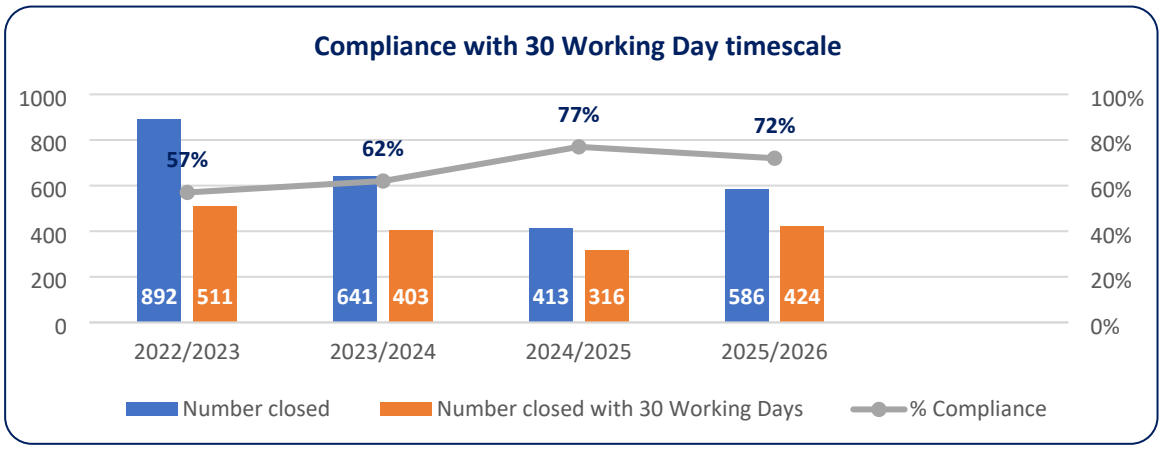


Complaints will often refer to a number of issues of concern regarding the services or care and treatment being provided by the Health Board. Identification of these issues assists in identifying themes and trends, to inform areas for focused improvement work. The top 10 complaints for 2025/2026 are provided in the chart below:



Complaints Closed during 2025/2026

During 2025/26, 586 complaints managed under PTR were closed. Of these, 35 progressed to the redress process. Of the 586 formal complaints, 424 (72%) were responded to within the 30 working-day target.

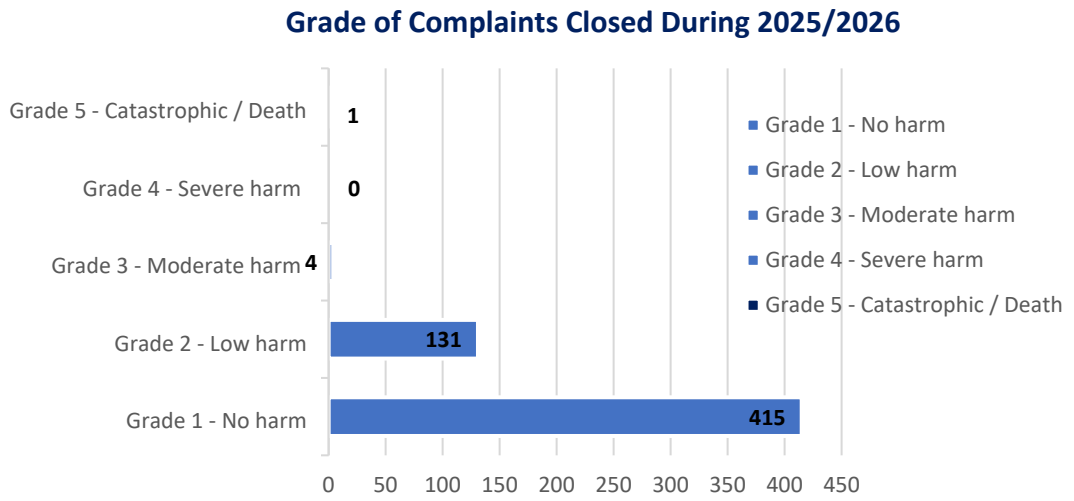


On closure of all complaints are graded from 1 (no harm) to 5 (catastrophic/death) in accordance with the All-Wales Grading Framework. During 2025/2026 of the 586 closed, 93% of complaints were closed with an outcome of grade 1 (415) and grade 2 (131).

The complaints data demonstrates that clinical treatment and assessment remains the most frequently recorded subject of concern, with appointments, communication and medication also featuring prominently. These themes indicate that learning cannot be addressed solely through the complaints process and requires coordinated ownership across clinical services, operational management, patient experience and quality improvement.

Care Groups review complaints data within the Quality, Safety, Risk & Experience meetings to identify recurring issues, agree proportionate improvement actions and provide evidence that those actions have resulted in change.

Performance against the 30 working day response target remained at 77%. Although this represents sustained compliance compared with the preceding year, almost one quarter of the relevant complaints were not concluded within the target. This remains an area requiring management focus. Further work is required to understand the principal causes of delay, distinguish unavoidable complexity from process delay and strengthen escalation and accountability where responses become overdue.

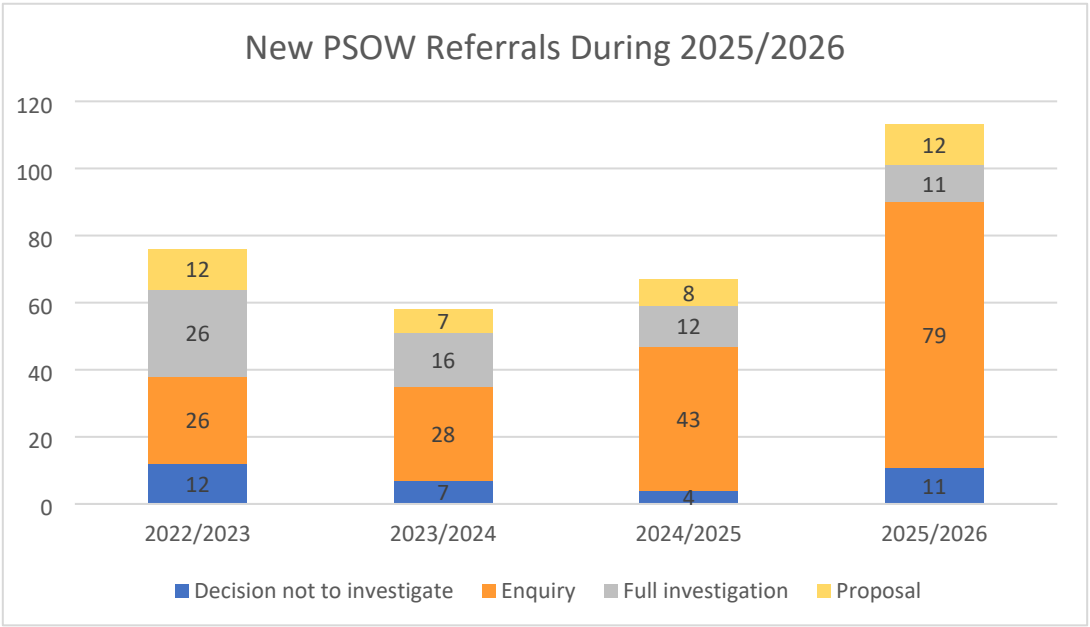


2.2 Public Service Ombudsman for Wales (PSOW)

The PSOW is an independent body established under the Public Services Ombudsman (Wales) Act 2005, with expanded powers under the 2019 Act. Where a complainant is dissatisfied with the complaints process or the response they receive from the Health Board, they can refer their case to the PSOW.

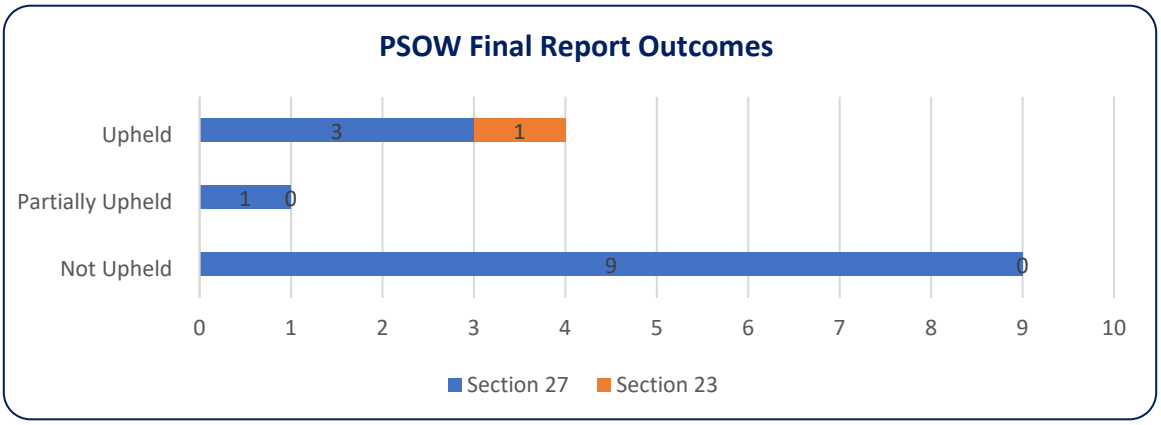
New referrals received

During 2025/2026, the Health Board received notification of 113 new referrals to the PSOW. This represents an increase when compared to the previous 12 month period. A trend and breakdown of PSOW referrals for the previous 4 years is provided in the chart below.



Final Reports

During 2025/2026 the PSOW issued 15 final reports to the Health Board. Of these, 4 were fully upheld and 1 partially upheld, whereby the Health Board accepted the recommendations and implemented actions to address the learning identified. A summary of the outcome of PSOW investigation final reports is provided in the table below.



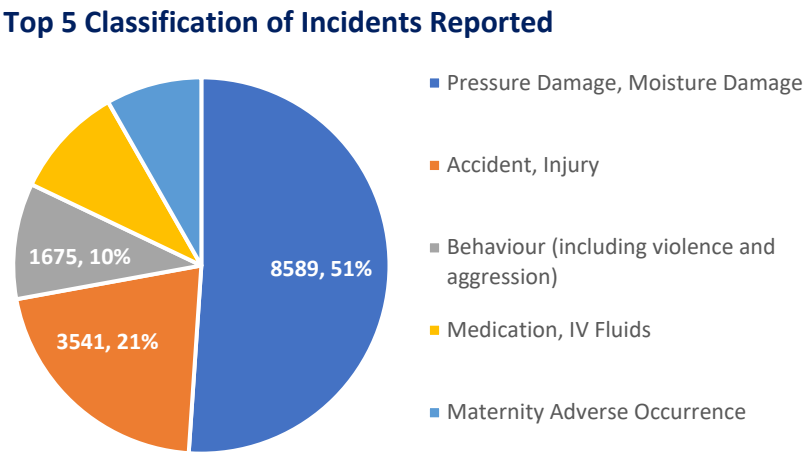
The final reports issued by the Public Services Ombudsman for Wales provide an important source of independent learning. During the reporting period, four reports were fully upheld and one was partially upheld, with recommendations accepted by the Health Board.

Key learning from the upheld and partially upheld reports centred on clinical record keeping, risk assessment, pain and medicines management, timely referrals and follow-up, communication, waiting-list controls, complaint investigation, consent and the Duty of Candour. Actions included sharing reports through clinical governance structures, issuing staff reminders and guidance, completing relevant training, incorporating learning into reflection and appraisal, reviewing local processes and undertaking targeted audits. Assurance has been provided through Care Group and Quality, Safety, Risk & Experience Committees and, where appropriate, the Board.

3.0 Patient Safety Incidents

During 2025/2026 there were 27,318 incidents reported, of which 23,101 (85%) were reported as the patient being the person affected (patient safety incidents).

Accounting for 73% (16,817) the top five Patient Safety incidents reported for the year relate to: Pressure Damage/Moisture Damage; Accident, Injury (including patient falls); Behaviour (including violence and aggression); Medication, IV Fluids and Maternity Adverse Occurrence. A breakdown of these is provided in the chart below.



3.1 Duty of Candour

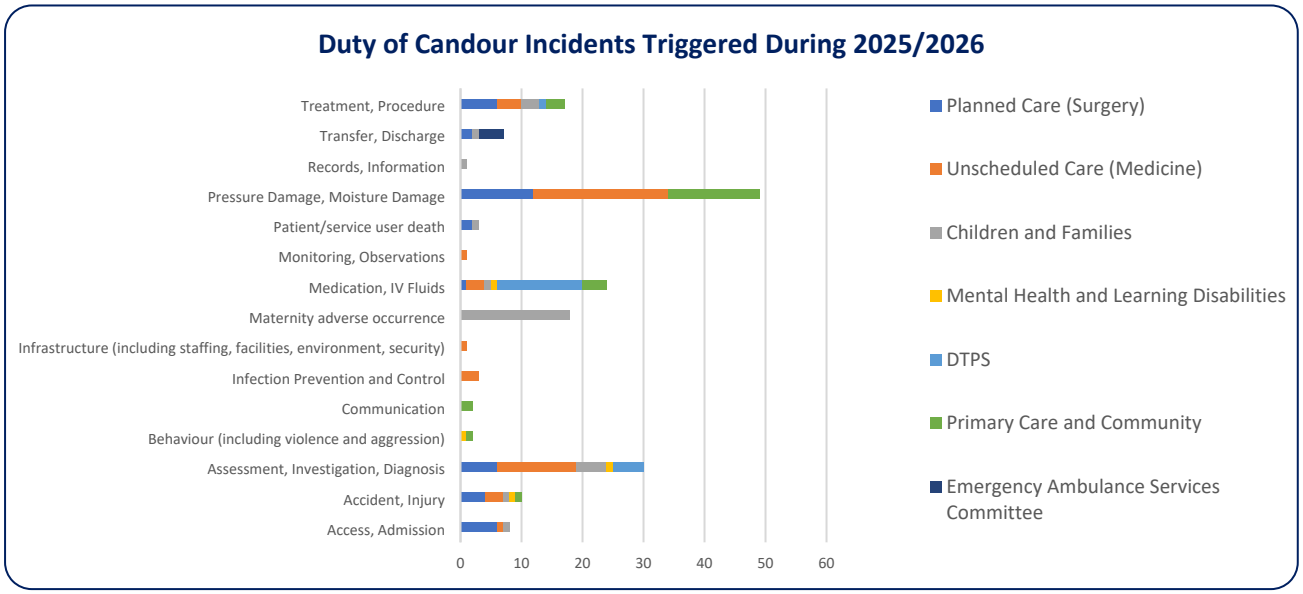
Of the 3,331 patient safety incidents initially reported as moderate harm or above in 2025/2026, 3,119 (94%) were subsequently assessed at a lower level of harm. Initial harm grading is recorded by the person reporting the incident based on the information available at that point and represents an early assessment. It may therefore reflect the patient's clinical condition or outcome before it has been established whether healthcare caused or contributed to the harm.

The initial assessment is subsequently reviewed through the Manager's Interim Harm Assessment, which provides a further management assessment based on the information available at that stage, including consideration of whether healthcare caused or contributed to the harm. Harm is reviewed again following investigation to determine the final post-investigation position. Movement between these stages should therefore be considered within the context of the incident review process rather than interpreted solely as retrospective downgrading.

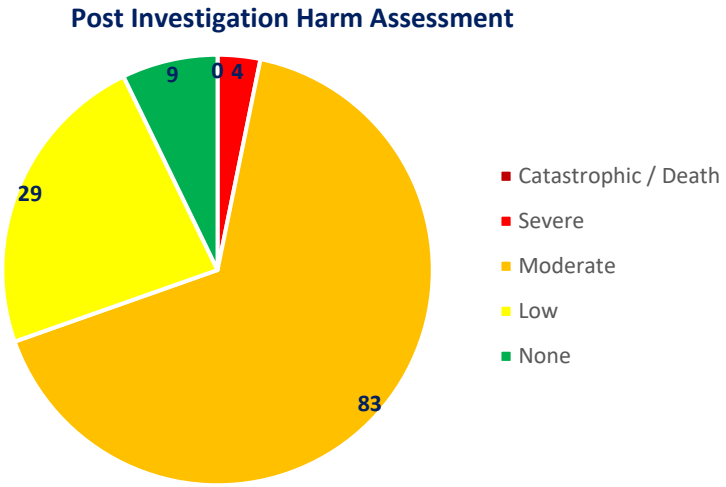
Further review has identified a number of factors that can contribute to differences between initial and subsequent harm assessments. These include the information available when an incident is first reported, interpretation of harm and causation, and clinical or specialist review processes where the level of harm cannot be fully determined until further assessment has taken place. A review of completed incidents has also identified cases where the initial harm grading was subsequently revised, as well as cases where further clinical or assurance review provided additional information about the harm caused or contributed to by healthcare.

Duty of Candour Triggered

During 2025/2026, 23,101 patient safety incidents were reported, of which 177 (0.8%) triggered the Duty of Candour. A breakdown of Duty of Candour incidents by classification and Care Group is provided in the chart below.



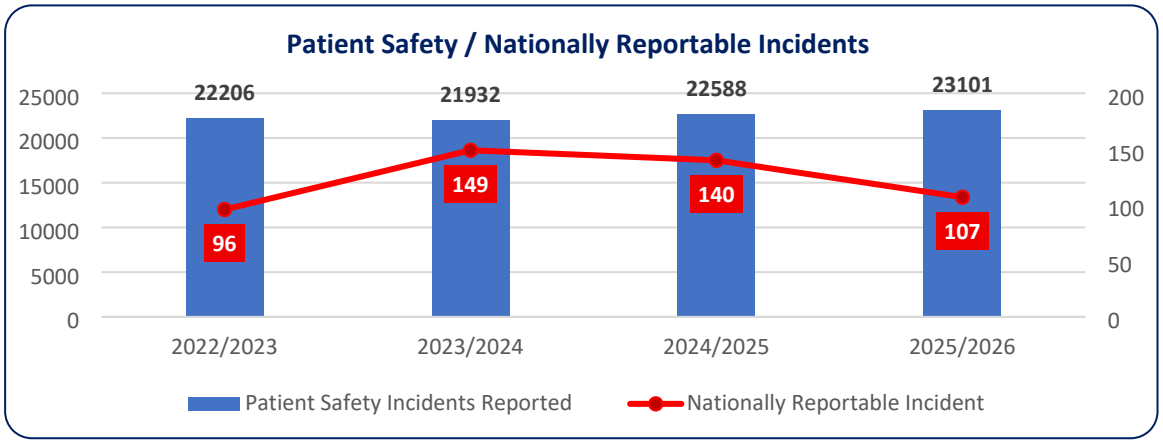
Of the 177 patient safety incidents which triggered the Duty of Candour, 125 have been closed. Of these, 38 (30%) were assessed following investigation as having resulted in low or no harm arising from healthcare. A breakdown is provided in the table below.



3.2 Nationally Reportable Incidents

Within the time period, 107 nationally reportable incident notifications were submitted to the NHS Wales Performance & Improvement Team. This represents a decrease when compared to the previous 12 months.

The incident reporting trend for the previous 4 years is reflected in the chart below.



Learning and assurance

Learning arising from Nationally Reportable Incidents is shared through established Care Group governance arrangements, including Quality, Safety, Risk & Experience meetings and governance trackers. Learning is disseminated through Heads of Nursing, Lead Nurses, Senior Nurses and ward/team leaders so that relevant messages reach local teams and services. The CTM Learning Repository, 7-Minute Briefings and the Quality and Safety Newsletter provide additional routes for sharing learning beyond the service in which an incident occurred.

Where recurring themes are identified, thematic review is used to consider whether wider action is required. Actions arising from nationally reportable incidents are recorded within action plans and monitored through clinical and Care Group governance arrangements. For example, within Mental Health and Community services, formal bi-monthly Action Learning Meetings provide multidisciplinary oversight of outstanding actions, review the robustness of supporting evidence and confirm how learning is shared with teams.

3.3 Never Events

Never Events are patient safety incidents that are wholly preventable, where there is guidance and safety measures that provide strong systemic protective barriers available at a national level.

Never Events have the potential to cause serious harm or death, although serious harm or death does not have to occur for an incident to be classified as a Never Event.

During 2025/2026, the Health Board reported four Never Events: one wrong implant/prosthesis, one retained foreign object following a procedure, one transfusion of incompatible blood and one wrong-site surgery.

Each Never Event represents a significant opportunity for organisational learning, as these incidents occur in circumstances where national guidance, safety processes and preventative controls are expected to be in place. All four Never Events reported during the year were subject to an initial rapid review to identify immediate risks, required actions and early learning, followed by a comprehensive Root Cause Analysis to establish the underlying contributory factors and system issues. Assurance has focused on the findings from both stages of review, the immediate actions taken to reduce risk, whether relevant policies, procedures and controls were operating as intended, and the actions required to address identified weaknesses. Action completion and implementation are monitored through established governance arrangements.

- Wrong Site Surgery
  A patient attended the Radiology Department for a planned right-sided fluoroscopic-guided nerve root block. The block was performed on the left side in error.

  The investigation identified a failure to fully adhere to LoCSSIP requirements. Although the WHO checklist had been completed, it was not read aloud with all clinicians present, reducing the opportunity to identify the incorrect site before the procedure commenced.

  Actions arising from the investigation included sharing the incident through the Radiology Governance Meeting, REALM and a pan-CTMUHB LASER briefing. Further actions included reinforcing the requirement for the WHO checklist to be completed correctly and read aloud, reviewing and updating Radiology LoCSSIP procedures, ensuring relevant staff receive LoCSSIP/checklist training and induction, and reflection by the staff involved. These actions focused on strengthening procedural checks and reducing the risk of recurrence.

- Retained Foreign Object
  During an elective right knee replacement in November 2025, a drill pin was unaccounted for during the instrument count. Surgery continued after searches of the patient's wound and theatre environment were unsuccessful. Postoperative imaging confirmed the pin was retained deep in the bone.

  An intraoperative X-ray should have been taken to locate the drill pin before wound closure. Improvement actions included revising the surgical count Standard Operating Procedure and sharing it across all theatre sites, disseminating learning through governance forums, reflection by the staff involved, and providing training on the knee replacement system used.

- Wrong Implant/Prosthesis
  In April 2025, a patient undergoing fixation of a right elbow fracture was identified during surgery as having received a left-sided implant.

As the fracture was appropriately reduced and aligned, the surgical team concluded that leaving the implant in place posed less risk than removing and replacing it. The patient recovered without recognised complications and was discharged from follow-up the following month.

The incident highlighted unclear communication within the procedural team and the absence of an independent check to confirm that the correct implant had been identified, received and documented before implantation.

Improvement actions included implementing and sharing a local Standard Operating Procedure for implant verification, disseminating learning through governance forums, supporting reflection by the staff involved, and training relevant staff in the use of the plating system involved in the incident.

- Transfusion of Incompatible Blood

  An investigation was undertaken following a Never Event involving the transfusion of an ABO incompatible blood unit to an 85-year-old patient who was receiving treatment at the Royal Glamorgan Hospital following a fractured neck of femur. During administration of a blood transfusion, it was identified that the blood product had been intended for another patient. The transfusion was stopped immediately after only a small amount had been administered, and the patient received enhanced monitoring and specialist review. The patient remained clinically stable; however, their planned surgery was delayed as a result of the incident.

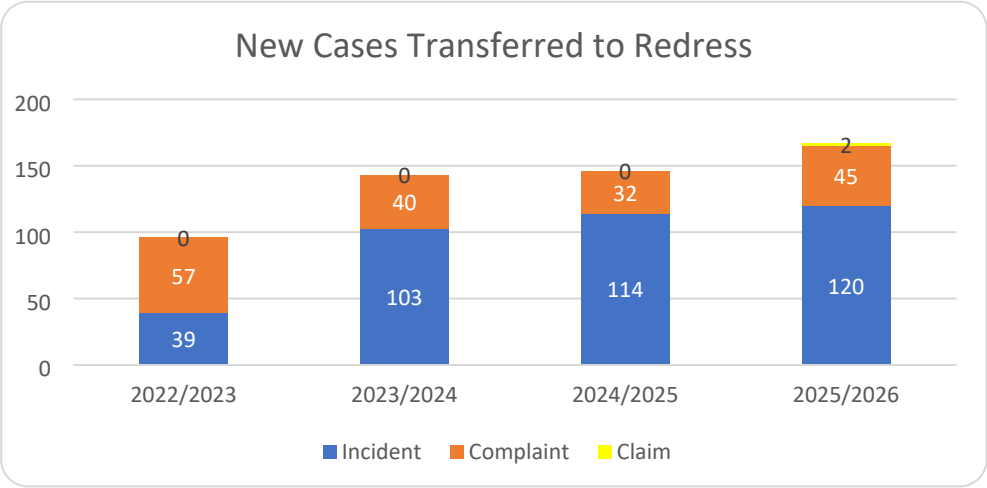
  The investigation identified that mandatory bedside patient identification and blood component verification checks had not been fully completed prior to administration. Contributory factors included environmental pressures within the Emergency Department, simultaneous clinical demands, and human factors relating to assumptions made during the checking process. Immediate actions were implemented to strengthen transfusion safety, including reinforcing compliance with transfusion procedures, restricting blood administration to appropriately trained and competent staff, targeted staff education, local audit and assurance activity, and organisation-wide sharing of learning to reduce the risk of recurrence.

4.0

4.1 Redress

New Cases Transferred to Redress

If during the investigation of a complaint or incident a breach of duty of care is identified which has potentially resulted in harm to the patient, there may be a qualifying liability. At this stage, the complaint will transfer into the Redress process for a further detailed investigation.



During 2025/2026, 167 cases were referred to Redress for review of breach of duty and for consideration as to whether the case is suitable for Redress. 120 were referred from the incident process, 45 from the complaint process and 2 from a claim process.

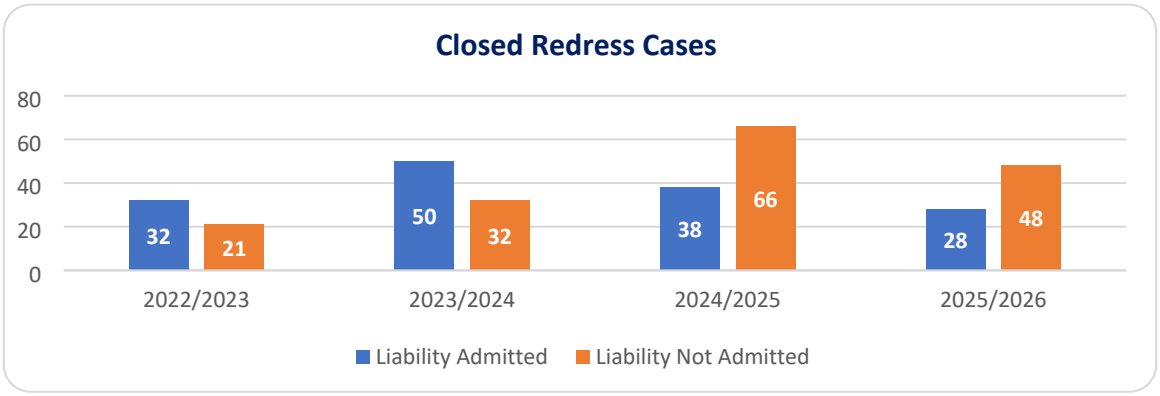
A breakdown of the classification of cases transferred to Redress is provided in the chart below:

Classification of New Redress Cases Received			
	Incident	Complaint	Claim
Access Admission	1	1	0
Accident, injury	2	1	0
Assessment, investigation, diagnosis	21	18	1
Behaviour (including violence and aggression)	1	0	0
Communication	0	1	0
Equipment Devices	1	0	0
Infection Control	2	1	0
Maternity adverse occurrence	2	0	0
Medication, IV fluids	2	2	0
Monitoring, Observations	1	0	0
Pressure Damage, Moisture Damage	33	1	1
Transfer, Discharge	0	1	0
Treatment, Procedure	54	19	0

Redress Cases Closed

It should be noted that Redress cases will not always be transferred and closed within the same financial year.

Cases closed in 2025/2026 may therefore include those received in earlier years. During this period, 76 redress cases were closed, including 28 where a qualifying liability was confirmed. The table below shows the four-year trend.



Ongoing Redress Case Management

As at March 2026, 409 Redress records were recorded as open on Datix Cymru. Of these, 248 remained at the Qualifying Liability investigation stage, 58 had qualifying liability identified, 39 were at offer-made stage and 28 had an offer accepted. After excluding cases where substantive case management had concluded but the record remained administratively open, for example pending reimbursement, response to an offer or completion of a Case Management Report, approximately 375 cases were considered live and ongoing.

The Health Board continued to manage a significant legacy backlog of Redress cases, many of which had exceeded expected timescales for investigation and resolution. The year-end position reflected a caseload accumulated over more than one financial year, with a substantial proportion remaining at the investigation and Qualifying Liability assessment stages. The scale of the legacy position continued to place pressure on the Health Board's ability to progress cases within expected PTR timescales.

During 2025/26, the Legal Services Team maintained a focused recovery programme aimed at reducing longstanding cases, improving oversight and progressing matters towards resolution wherever possible. Whilst this resulted in movement across a number of historic cases, progress was constrained by factors including case complexity, dependency on external expert evidence, capacity pressures within specialist clinical services and the need to manage legacy cases alongside ongoing Redress activity.

Enhanced recovery arrangements during the latter part of 2025/26 included detailed review and prioritisation of the open caseload, enhanced case-management tracking, action to address outstanding correspondence, targeted management of older cases and redistribution of responsibilities to provide greater protected capacity for Redress case management. Governance arrangements were also strengthened through the revised Redress process approved in December 2025 and the operation of a weekly PTR/Redress Panel involving Legal Services, Complaints and Quality & Safety, providing a mechanism for multidisciplinary review, timely legal input and escalation of cases where progression was delayed.

Delays in concluding Redress cases remain an area of organisational risk, as prolonged case progression can extend uncertainty for patients and families, delay opportunities to identify and embed learning and increase potential financial exposure. Backlog reduction and improved timeliness therefore remained a priority at year-end, supported through enhanced case review, strengthened reporting and escalation arrangements, targeted management of aged cases and ongoing monitoring through governance and performance frameworks.

4.2 Claims

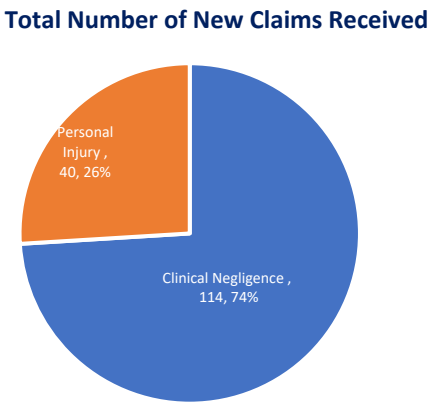
The management of clinical negligence and personal injury claims is an important component of the Health Board's wider approach to patient safety, governance and organisational learning. Under the Redress arrangements, where the value of a case is assessed as exceeding £25,000, the case will transfer out of the Redress process and be managed as a clinical negligence claim. Effective claims management seeks to ensure that cases are investigated and progressed in a timely, proportionate and robust manner, working collaboratively with the Welsh Risk Pool and NHS Wales Legal & Risk Services as appropriate. Claims also provide an important source of learning, enabling the Health Board to identify areas where care, systems or processes could be strengthened.

New Claims Received

During 2025/26, the Health Board received notification of 154 new claims, comprising clinical negligence (114) and personal injury (40) claims. The classification of these claims provides an important source of intelligence about the areas in which harm, liability and financial risk are arising and supports the identification of themes that may require further organisational learning and improvement.

The most significant feature of the 2025/26 data is the predominance of claims relating to treatment and procedures, which accounted for 95 of the 154 new claims (62%). A further 27 claims (18%) related to accidents or injuries, meaning that these two categories collectively represented almost four-fifths (79%) of all new claims received. Assessment, investigation and diagnosis, and behaviour including violence and aggression, each accounted for eight claims. The remaining claims were distributed across a range of lower-volume categories, including maternity adverse occurrences, patient/service-user deaths, information governance and confidentiality, transfer and discharge, work-related ill health, medication and IV fluids, pressure/moisture damage, and access/admission.

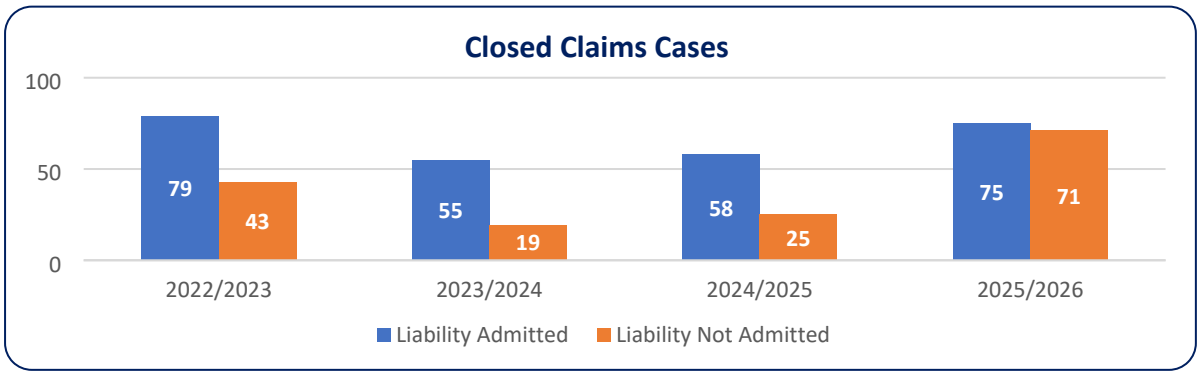
A breakdown of new activity is provided below:



Classification of New Claims Received	
Access Admission	1
Accident, injury	27
Assessment, investigation, diagnosis	8
Behaviour (including violence and aggression)	8
Ill health (work related)	2
Information Governance, Confidentiality	3
Maternity adverse occurrence	3
Medication, IV fluids	1
Patient/service user death	3
Pressure Damage, Moisture Damage	1
Transfer, Discharge	2
Treatment, Procedure	95

Claims Closed

During 2025/26, the Health Board closed 146 clinical negligence and personal injury claims. Of these, 75 cases, approximately 51%, were concluded following an admission of liability or a risk-based settlement, with the remaining 71 claims closed without such an outcome. It is important to recognise that a risk-based settlement may be made following consideration of the available evidence, litigation risk and proportionality and does not necessarily represent an admission of liability. The figures should therefore be considered as an indicator of claims activity rather than a direct measure of the quality or safety of care.



The number of claims closed represents a substantial increase in case resolution compared with previous years. Historical reporting shows that 77 clinical negligence claims were closed in 2022/23, 46 in 2023/24 and 68 in 2024/25. Previous improvement work included case cleansing and targeted work to progress matters to conclusion. Against this context, the closure of 146 claims in 2025/26 represents more than double the number closed in the previous year and reflects a significant level of activity in progressing the claims caseload.

Importantly, closure of a claim is not viewed solely as the conclusion of the legal process. During 2025/26, Legal Services strengthened arrangements

to identify, capture and disseminate learning arising from claims, Redress, inquests and litigation, with greater emphasis on linking legal findings to specific actions, responsible owners, supporting evidence and appropriate governance routes. Recurring themes are increasingly used to inform audit, training and wider improvement activity. The Health Board's claims management arrangements also require appropriate authority for admissions and settlements, completion of Welsh Risk Pool reimbursement requirements, and the facilitation and dissemination of learning following conclusion of claims.

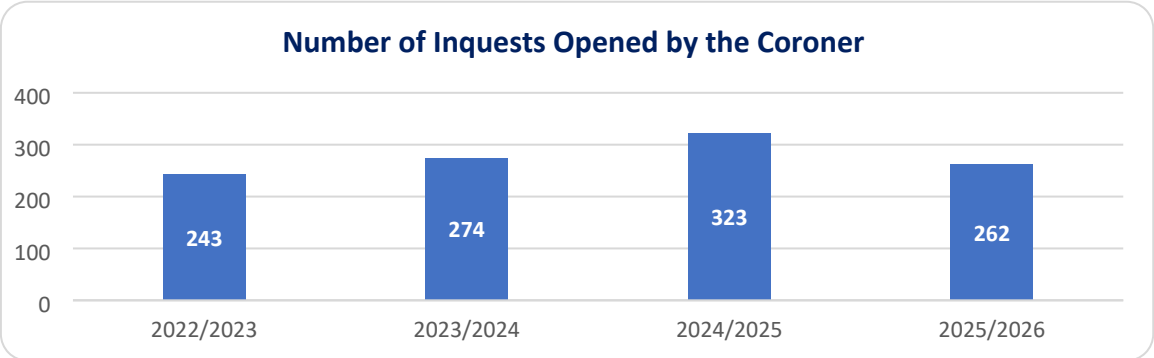
Taken together, the claims closure data demonstrates both significant activity in resolving the Health Board's claims caseload and the increasing emphasis being placed on ensuring that the conclusion of a claim leads, where appropriate, to organisational learning, demonstrable improvement and assurance that actions taken in response to harm are embedded and sustained.

5.0 Inquests

An inquest is a formal investigation by the Coroner to determine how a person died. They are held in certain circumstances, for example if the death was sudden or unexpected. The Health Board must provide information in accordance with the directions of the Coroner.

New Inquests Received

During 2025/2026 the Health Board received notification of 262 new inquests. This represents a decrease when compared with the previous 2 years. A trend graph of inquests opened over the 4-year period is provided below.



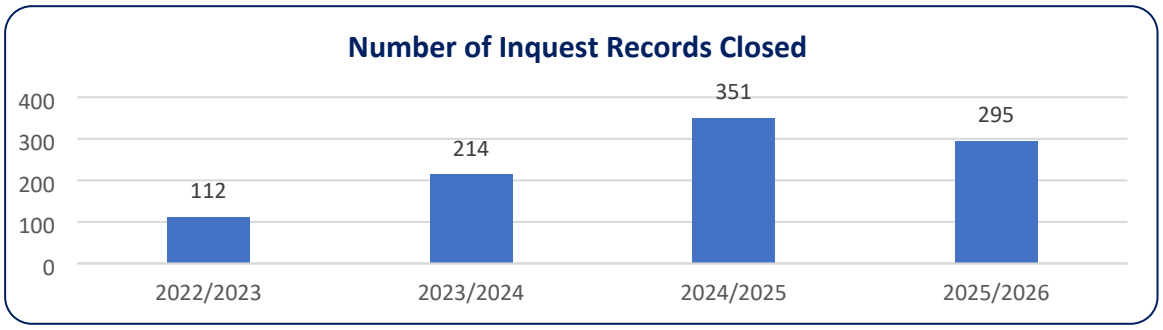
Of the 262 inquests opened, the highest number were received in the Unscheduled Care Group. A breakdown of inquests received by Care Group is provided below:

Care Group	Number
Children and Families	11
Diagnostics, Therapies, Pharmacy & Specialist Care	4
Mental Health and Learning Disabilities	50
Planned Care	63
Community	36

Primary Care	2
Prison	7
Unscheduled Care	89
Total	262

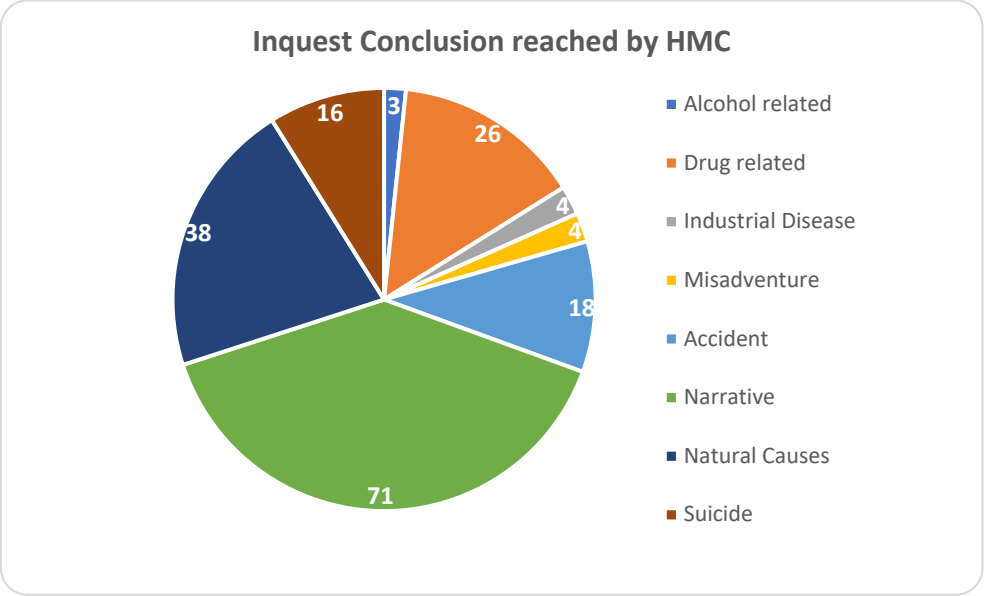
Closed Inquests

During 2025/26, 295 inquest cases were closed on the Health Board's Datix Cymru system. It should be noted that inquests will not necessarily be referred to the Health Board and closed within the same financial year and, consequently, closure activity should not be directly compared with the number of new inquests received during the period.



The level of closure activity was also influenced by targeted consolidation and reconciliation exercises undertaken with the Coroner's Office in June and November 2025. These exercises reviewed the recorded open caseload and enabled historic cases, where the Coroner's involvement had concluded but the corresponding Health Board record remained open, to be appropriately updated and formally closed. The increased closure activity during these periods should therefore be interpreted in this context and does not represent an equivalent increase in the number of inquests progressing to, or concluding following, a formal hearing. The exercises strengthened the accuracy of the Health Board's inquest data and improved alignment with information held by the Coroner's Office.

Of the 295 records closed during the year, information regarding the hearing date or conclusion was not available to the Health Board for 115 cases (39%). For the remaining 180 cases where conclusion information was available, narrative conclusions accounted for 104 cases and natural causes for 60 cases. Together, these represented 164 of the 180 cases (91%) for which a conclusion was recorded, with the remaining 16 cases concluding by other means. A breakdown of the conclusions recorded for inquests closed during 2025/26 is provided in the chart below.



Regulation 28 Reports

Following the conclusion of an inquest, the Coroner may make a report to prevent future deaths under Regulation 28 of the Coroners (Investigations) Regulations 2013. During 2025/2026, two Regulation 28 reports were issued to the Health Board. The key issues identified are summarised in the table below.

Health Board Reference Number	Inquest Hearing date	Date issued	Care Group	Conclusion reached by Coroner	Type of Regulation 28 Report	Main Issue
1648	31/03/25	31/07/25	Prison	Narrative	Alcohol, drug related medication deaths	Absence of specified timeframes for prisoners likely to be at risk from substance misuse
2480	22/02/26	24/02/26	Children and Families	Narrative	Hospital Death (Clinical Procedures and medical management) related deaths	Lack of equipment on crash trolley

Regulation 28 – 1648: Substance Misuse Services at HMP Parc

Following the inquest into the death of LP, the Area Coroner issued a Regulation 28 Report to Prevent Future Deaths. The Coroner identified concerns regarding the absence of specified timeframes within policies and procedures for intervention, ongoing support and allocation to Dyfodol substance misuse services for prisoners at risk of substance misuse. The Coroner considered that the absence of defined timescales created a risk of delay in prisoners receiving appropriate support and intervention.

In response, Cwm Taf Morgannwg University Health Board and Dyfodol reviewed the service arrangements and strengthened the framework for delivery and monitoring. Although the existing service specification did not explicitly prescribe intervention and case-allocation timescales, operational standards had been agreed and were being monitored monthly. The Health

Board confirmed that these standards would be formally incorporated into the revised service specification through the future procurement process, providing greater clarity and accountability.

A series of defined service standards are now in place, including next-working-day assessment for new prisoners, next-working-day responses to Substance Misuse Observation Records and Psychoactive Substances Rapid Response referrals, and a four-week target for commencement of one-to-one brief interventions. Recruitment and improved waiting-list management reduced the waiting period for brief interventions from six weeks in June 2025 to within the four-week target by August 2025. Weekly rolling group programmes have also been expanded so that individuals awaiting one-to-one intervention can continue to access substance misuse and recovery support.

Governance and oversight have also been strengthened through monthly operational and performance meetings, routine monitoring of caseloads and waiting times, and a monitoring spreadsheet maintained by the Prison Healthcare Directorate Manager. Further service development has been informed by a Health and Social Care Needs Assessment, HMIP inspection and a Royal College of Psychiatrists review. Proposals have also been developed to enhance recovery provision and psychological support, alongside work to strengthen clinical substance misuse provision, including assessment, monitoring, support for Opioid Substitution Treatment and release planning.

Regulation 28 – 2480: Standardisation of Resuscitation Trolleys

Following the inquest into the death of SM, the Coroner issued a Regulation 28 Report to Prevent Future Deaths raising concerns regarding the lack of standardisation of resuscitation trolleys across hospital settings. During the resuscitation there had been a delay in obtaining adrenaline. The Coroner identified that differing trolley configurations, combined with the regular rotation of junior doctors between hospitals and Health Boards, could result in staff encountering unfamiliar arrangements and create confusion during time-critical emergencies. The Coroner considered that greater standardisation of adult and paediatric resuscitation trolleys across Wales would reduce this risk.

In response, Cwm Taf Morgannwg University Health Board established a multidisciplinary Task and Finish Group involving Resuscitation Services, Pharmacy, clinical services and Clinical Education, supported by a comprehensive action plan and ongoing oversight through Patient Safety and Legal Services. The Health Board also contributed to the Welsh Government-led All-Wales response, recognising that sustainable improvement requires both local action and broader national consistency.

A review of resuscitation arrangements across Health Board sites confirmed that the content of cardiac arrest drug trays was already standardised in accordance with Resuscitation Council guidance, but identified differences in visual layout and presentation, particularly at Princess of Wales Hospital.

Action was therefore agreed to align paediatric arrangements at Princess of Wales Hospital with those at Prince Charles Hospital and Royal Glamorgan Hospital, including removal of the red paediatric drug boxes and adoption of the clear tray system to improve visibility, familiarity and rapid access to emergency medicines. The review was extended across wards, theatres, emergency departments and specialist services, with neonatal and CAMHS arrangements also considered.

The review also identified opportunities to strengthen medicines governance and staff familiarisation. Pharmacy and Resuscitation policies and SOPs are being rationalised to clarify responsibility for daily checks, replenishment and expiry monitoring and to ensure staff have access to current guidance. Training arrangements have been strengthened, with resuscitation trolley orientation being incorporated into medical induction, particularly for rotational and out-of-hours medical staff. Updated photographs, videos and visual guidance have also been developed to provide accessible orientation resources for new and rotating staff.

Wider learning arising from the inquest included the development of a CPAP transition and escalation checklist, which was incorporated into the CPAP SOP and shared through the All-Wales Paediatric Senior Nurse Forum. This related to a separate Coroner recommendation rather than the specific Regulation 28 concern.

Overall, the Health Board's response has focused on reducing variation, strengthening human-factors controls, improving staff familiarisation and reinforcing governance of resuscitation equipment and medicines. Progress has been monitored through a live Regulation 28 action plan and follow-up assurance arrangements, alongside engagement with the Welsh Government and Welsh Resuscitation Forum to support an All-Wales approach to learning and standardisation.

Improving the Management of Inquests

During 2025/26, the Legal Services Team undertook a significant programme of work to strengthen the management, governance and oversight of inquests across the Health Board. A revised Process for the Management of Inquests was approved and implemented from 1 December 2025, supported by standardised templates, staff guidance, internal checklists and clearer roles, responsibilities, timescales and escalation arrangements. The process has subsequently been further developed to incorporate risk-based case management, including routine RAG assessment, defined criteria for referral to Legal & Risk Services, monitoring and escalation of statement and disclosure deadlines, and early requests for extensions where deadlines are at risk.

Governance has been strengthened through weekly inquest review and escalation arrangements, systematic review of forthcoming hearings, improved forward planning, and enhanced scrutiny of high-risk and high-profile cases, including those presenting potential Prevention of Future Death concerns.

The Legal Services operating model has also been restructured to establish a dedicated Inquest function alongside Claims and Redress, providing clearer accountability and a greater specialist focus, with additional recruitment undertaken to strengthen capacity. Improvements to case recording and assurance have included review and cleansing of the open inquest caseload, strengthened use of Datix Cymru, development of audit arrangements, closer working with NHS Wales Legal & Risk Services and participation in the Welsh Risk Pool Inquest Network and Once for Wales workstreams.

Alongside improving operational compliance, Legal Services has placed greater emphasis on ensuring that learning arising from inquests and Prevention of Future Death reports is identified, shared and connected with complaints, claims, Redress and patient safety intelligence so that recurring themes can inform wider service improvement. This work represents a move towards a more proactive, risk-based and assurance-focused approach to inquest management, strengthening oversight of coronial deadlines and organisational risk, while improving the Health Board's ability to identify, share and act on learning arising from inquests.

6.0 Learning from Event Reports

Learning from Events Reports (LFERs) are a key component of the Welsh Risk Pool reimbursement process and provide a structured mechanism through which the Health Board demonstrates the learning and improvement arising from settled cases. The Health Board is required to submit a signed LFER within four months of the decision to settle a case. All cases considered for reimbursement are scrutinised by the Welsh Risk Pool for evidence that lessons have been identified and appropriate improvement actions have been implemented. An LFER therefore goes beyond describing the circumstances of an individual case, setting out what happened, what was learned, what has changed as a result, and the evidence demonstrating that improvements have been implemented and sustained. Importantly, both interim and final reimbursement may be deferred until the Welsh Risk Pool Committee is satisfied with the learning identified and the actions taken. The LFER process consequently provides an important mechanism for ensuring that learning arising from claims and Redress is translated into measurable improvements in patient safety, with appropriate governance, assurance and wider sharing of learning across the Health Board.

During 2025/26, the Health Board undertook a significant programme of improvement to strengthen the timeliness, quality and governance of Learning from Events Reports (LFERs) and ensure that learning arising from claims and Redress cases is translated into demonstrable and sustained improvements in patient safety. A formal multidisciplinary Learning from Events Panel was established, with defined terms of reference and assurance arrangements, to provide structured scrutiny of LFERs prior to

submission to the Welsh Risk Pool and to test whether identified findings are clearly linked to improvement actions, supporting evidence and ongoing monitoring.

Governance has been strengthened further through weekly Legal Services monitoring, weekly review of clinical LFERs, a fortnightly Personal Injury Panel and escalation arrangements for cases at risk of delay, alongside improved tracking of decisions, actions, responsible owners and deadlines. The quality-assurance process has increasingly focused on demonstrating not simply that an action has been completed, but what changed, what evidence demonstrates implementation, whether learning has been shared across relevant services and how the Health Board knows that improvement is being sustained, including through audit findings, training compliance, staff reflection and governance oversight.

Training and practical support have also been strengthened, including Welsh Risk Pool training, development and use of LFER checklists, targeted support to Care Groups and inclusion of LFER learning within the Legal Study Day programme. This work has resulted in a more consistent and evidence-based approach to organisational learning, with the Welsh Risk Pool noting that the standard of Health Board LFERs had significantly improved and the number of rejected submissions had reduced. First-time approval of LFERs by the National Learning Advisory Panel increased from 16% in 2024/25 to 31% in 2025/26.

The continuing focus is on ensuring that learning is not confined to individual cases, but is shared through appropriate multidisciplinary and Care Group governance structures, with recurring themes used to inform wider quality and safety improvement across the organisation.

A summary of Learning from Events Report activity during 2025/2026 is provided below:

	Claims	Redress	Total
Number of LFERs Triggered	84	95	179
Number of LFERs Due	74	76	150
Number of LFERs submitted	70	72	142
Number of LFERs Approved	102	73	175
Number of LFERs Deferred	58	29	87

The figures shown represent activity undertaken during 2025/26. As LFERs may progress over more than one reporting year, those submitted or approved during 2025/26 may have been triggered in an earlier year.

7.0 Organisational Learning

Putting Things Right established an important framework through which the Health Board could bring together concerns, complaints, patient safety incidents, redress and claims. The experience of operating the framework

has reinforced that recording activity alone does not demonstrate that learning has taken place. Effective organisational learning requires issues to be analysed across different sources, translated into clear actions, assigned to accountable leads and followed through to confirm whether the intended improvement has been achieved and sustained.

The information presented in this report identifies recurring areas requiring organisational attention, including clinical treatment and assessment, communication, appointments, medication, access to services and the management of pressure damage. The recurrence of these themes demonstrates the need to strengthen the connection between individual case learning, service level improvement and corporate assurance. Under Listening to People, the Health Board will use this learning to place greater emphasis on thematic analysis, triangulation of intelligence and evidence of measurable improvement, rather than relying predominantly on activity and compliance measures.

Learning Repository

The CTM Learning Repository provides a central place to capture and share learning from complaints, incidents, claims, inquests, audits and other sources of feedback. It helps us bring together insights that may otherwise sit within individual teams or services, making them easier to find and use across the organisation.

The repository supports learning across CTM rather than in silos. A lesson identified in one service may be relevant elsewhere, and sharing it gives other teams the opportunity to review their own practice and take action where needed. It also helps us recognise recurring themes and understand where an issue may need an organisation-wide response.

Over time, the repository will help create an organisational memory: a record of what we have learned, the actions we have taken and the difference those actions have made. This will help us retain knowledge when people change roles, avoid repeating work and demonstrate how feedback and concerns lead to meaningful improvement for patients, families and staff.

Quality and Safety Newsletter

The Quality and Safety Newsletter remains an important mechanism for sharing learning and promoting improvement across the Health Board. By bringing together themes and lessons identified through concerns, incidents, claims and redress cases, the newsletter helps ensure that valuable learning is disseminated beyond individual teams and services. It provides staff with regular updates on emerging risks, examples of good practice, trends in patient feedback, and actions taken in response to incidents and complaints. This supports a culture of openness, continuous learning and accountability, ensuring that experiences shared by patients, families and staff contribute to service improvement. The newsletter also highlights changes made as a result of investigations and reviews, demonstrating how learning from the Putting Things Right process directly

informs safer care, enhances patient experience and strengthens the quality of services provided across the Health Board.

7-Minute Briefings

The 7-Minute Briefing process continues to support the sharing of key learning from concerns, incidents, claims and redress cases across the Health Board. By presenting important lessons in a concise and accessible format, 7-Minute Briefings enable staff to quickly understand what happened, the contributing factors, the improvements implemented, and how learning can be applied within their own areas of practice. This approach promotes organisational learning, supports the dissemination of patient safety messages, and encourages reflection and discussion within teams. Through regular use of 7-Minute Briefings, the Health Board supports the dissemination of learning, reflection and discussion across teams, helping staff consider how learning can be applied within their own areas of practice.

Learning through incidents and nationally reportable incidents

Learning is identified through the review and investigation of incidents across all levels of harm, not solely through nationally reportable incidents. Relevant learning is shared through Care Group governance arrangements, governance trackers, team meetings, the CTM Learning Repository, 7-Minute Briefings and the Quality and Safety Newsletter. Where themes are identified, further thematic review is undertaken to determine whether action is required beyond the service in which the issue arose.

Care Group governance and action learning

Care Groups provide oversight of incident action plans and the evidence used to demonstrate completion. Within Mental Health and Community services, formal bi-monthly Action Learning Meetings bring together directorates to review outstanding actions, test the robustness of supporting evidence, confirm multidisciplinary oversight and agree how learning will be shared with teams. Minutes and agreed learning are disseminated through the relevant governance and team structures.

Medication safety learning

Medication incidents and themes are reviewed through Care Group medication scrutiny groups, which report into the overarching medication review arrangements. Learning is also shared through medication safety communications and the Quality and Safety Newsletter, supporting wider dissemination across Care Groups.

These arrangements provide multiple routes for identifying, reviewing and sharing learning. The report also recognises that activity is not always coordinated or measured consistently across the Health Board. Strengthening the visibility, coordination and evaluation of improvement activity will therefore remain important as the organisation transitions to Listening to People.

8. Conclusion

This report provides an overview of the Health Board's activity during 2025/2026 in relation to concerns, complaints, patient safety incidents, Duty of Candour, redress, claims and inquests. Throughout the reporting period, the Health Board has remained committed to promoting openness, transparency and learning, while ensuring that patients, families and staff are supported when concerns are raised.

During the year, the Health Board received 1,613 complaints, of which 631 were managed through the formal Putting Things Right process and 982 were resolved through early resolution approaches. Compliance with the 30-working-day response target remained at 77%, consistent with the preceding year. However, almost one quarter of relevant complaints were not concluded within the target, and improving timeliness remains an area requiring management focus.

Patient safety reporting remained strong, with 23,101 patient safety incidents recorded, reflecting a continued culture of incident reporting.

Duty of Candour was triggered in 177 cases during the year, with 125 of those cases subsequently closed.

While performance across many areas remains positive, the report also highlights ongoing challenges. Themes arising from complaints, incidents, claims and redress cases continue to identify opportunities for improvement in clinical treatment, communication, appointments, medication management and access to services. These themes remain consistent with previous years and reinforce the importance of maintaining focus on quality improvement, patient safety and experience.

The Health Board will continue to use the intelligence obtained through concerns, incidents, claims, inquests and Duty of Candour reviews to drive improvement activities and strengthen organisational learning. By bringing together patient experience, safety and quality information, the organisation is better positioned to identify emerging risks, address recurring issues and implement sustainable improvements across services.

As the organisation prepares for the implementation of Listening to People, the Health Board remains committed to building on the strong foundations established through Putting Things Right. The transition provides an opportunity to further embed a culture that values feedback, listens to the experiences of patients and families, acts upon learning and demonstrates measurable improvements in the quality and safety of care. Through continued collaboration, openness and a commitment to learning, the Health Board will seek to ensure that every concern raised contributes to positive change and improved outcomes for the population it serves.

9. Future Planning

The coming year will represent a significant period of change for the Health Board as preparations continue for the implementation of the *Listening to People* framework across NHS Wales. The transition from Putting Things Right to Listening to People presents an opportunity to further strengthen person-centred approaches to feedback, concerns, complaints, incidents and claims management, ensuring that the voice and experience of patients, families and carers remain central to service improvement.

During 2026/2027, the Health Board will continue to work collaboratively with Welsh Government, NHS Wales Performance & Improvement and partner organisations to prepare for implementation through the development of revised policies, procedures, governance arrangements, reporting mechanisms and staff training programmes.

Particular focus will be placed on ensuring that staff understand the wider aims of Listening to People, including early engagement, compassionate communication, timely resolution, organisational learning and demonstrating improvements arising from patient experiences.

The Health Board will also continue to enhance the use of Datix Cymru to support the recording, management and reporting of concerns, complaints, incidents and Duty of Candour cases. Work will focus on improving data quality, strengthening thematic analysis and ensuring that learning is systematically shared across services to support quality improvement, patient safety and organisational learning.

In addition, the Health Board will continue to strengthen integration between concerns management, patient safety, clinical audit, Duty of Candour, legal services and quality improvement processes. This approach will support a more coordinated response to issues raised by patients and families and ensure that opportunities for learning and improvement are identified at the earliest opportunity.

The implementation of Listening to People will be supported through ongoing engagement with staff, patients, carers and wider stakeholders to ensure that services are responsive, transparent and focused on delivering the best possible outcomes and experiences for the populations served by Cwm Taf Morgannwg University Health Board.

CTMUHB Public Board

Safeguarding and Public Protection Annual Report 2025/26

Eitem yr Agenda / Agenda Item	8.1.8
Dyddiad y Cyfarfod / Date of Meeting:	26th November 2026
Statws Cyhoeddi / Publication Status:	Public Open
Adroddiad wedi'i baratoi gan / Report Prepared by:	Claire O'Keefe, Head of Safeguarding
Cyflwynydd yr Adroddiad / Report Presenter:	Claire O'Keefe, Head of Safeguarding
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes Executive Director of Nursing, Midwifery and Patient Care
Diben yr Adroddiad / Report Purpose:	Assurance and approval
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	The Board is asked to receive the Safeguarding and Public Protection Annual Report 2025/26 and approve publication
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol* *Strategic Context:* *This report aligns to the following Strategic Pillars*	Improving Care Creating Health; Inspiring People; Sustaining Our Future
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan *(Reference relevant priority)*	Supports CTMUHB priorities for safe, effective and person-centred care through robust safeguarding governance, workforce capability, legal compliance, learning, partnership working and harm prevention.

Crynodeb Gweithredol o'r hyn y mae'r adroddiad yn ei ddisgrifio:
Dechreuwch drwy grynhoi'r wybodaeth bwysicaf yn fyr. Dylai hyn roi dealltwriaeth gadarn o'r pwyntiau allweddol yn erbyn y 3 phennawd canlynol heb ddarllen yr adroddiad llawn:

Executive Summary of what the report is describing: Start by <u>summarising briefly</u> the most critical information. This should provide a firm grasp of the key points against the following 3 headings without reading the full report:	
Beth *(crynodeb o'r sefyllfa / mater cyfredol a pham ei fod yn bwysig a thystiolaeth i gefnogi'r safbwynt hwnnw ac ati)* What *(summary of current position / issue & why it matters and evidence to support that position etc)*	The annual report assures CTMUHB's safeguarding and public protection responsibilities during 2025/26, demonstrating strengthened governance, service development, partnership working, digital improvement and organisational learning across the safeguarding portfolio.
Felly, beth *(darparu dadansoddiad ystyrlon gan dynnu allan, fel y bo'n briodol, oblygiadau yn erbyn Strategaeth / Cynlluniau Cyflawni / risgiau Strategol neu Reoleiddiol CTMUHB ac ati ac unrhyw opsiynau ar gyfer mynd i'r afael â'r rhain)* So, what *(provide meaningful analysis drawing out as appropriate implications against CTMUHB Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)*	Key achievements include strengthened safeguarding governance and oversight, implementation of the Once for Wales Safeguarding Module for PIPOT, enhanced supervision and digital systems, expanded IDVA/ISVA provision, improved MARAC and Court of Protection arrangements, and a reduced DoLS backlog. Demand remains high, with 3,288 child protection referrals, 747 adult safeguarding referrals and 1,527 DoLS applications. Continued focus is required on training compliance, workforce capacity, information sharing, statutory timeliness, data quality and delivery of the 2026/27 improvement programme
Beth Nesaf *(crynodeb o'r camau gweithredu a fwriadwyd a'r manteision sy'n cefnogi'r dewisiadau a'r argymhelliad(au) sy'n cael eu gwneud)* What Next *(summary of intended action and benefits supporting the*	During 2026/27, priorities are to embed learning; implement the Datix Safeguarding Module; strengthen information sharing, audit and digital oversight; progress MCA/DoLS and Court of Protection governance; deliver VAWDASV training and evaluation; and strengthen regional and MASH partnerships. Progress will be monitored through established safeguarding governance and reported to the Safeguarding Executive Group and Quality, Safety and Experience Committee.

choices and recommendation(s)being made)	

Argymhelliad *(Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).* Recommendation (Linked to the "What Next" section above).	The Board is asked to receive and note the Annual Report, approve the assurance presented, note the risks and 2026/27 priorities, and approve onward submission and publication, subject to final amendments.

1. 1. Background / Context

1.1The Safeguarding and Public Protection Annual Report 2025/26 provides assurance on how CTMUHB has discharged its responsibilities to safeguard children, adults at risk and other vulnerable groups, covering leadership, operational delivery, workforce development, legal compliance, quality improvement and multi-agency working

1.2The report covers the principal areas of safeguarding responsibility, including children and adults, Children Looked After, PIPOT, VAWDASV, MCA and DoLS, Court of Protection, training and learning, regional partnerships and MASH

1.3Governance during 2025/26 included quarterly reporting to the Safeguarding Executive Group, supported by Safeguarding Children and Adut Groups, care group governance and reporting to the Quality, Safety & Experience Committee.

2. Strategic Insights

2.1 The report demonstrates continued strengthening of safeguarding governance and systems. Safeguarding representation has been embedded within care group quality and safety arrangements, while digital developments have improved recording, visibility, escalation and thematic learning.

2.2 Service-specific achievements include strengthened Paediatric Emergency Department safeguarding practice; improved oversight of Children Looked After health assessments; enhanced multi-agency management of self-neglect; establishment of rapid review arrangements at HMP Parc; expansion of Health IDVA/ISVA provision; standardisation of CTMUHB contributions to MARAC; and improved Court of Protection processes.

2.3 Workforce capability has been supported through Link and Learn resources, a Learning and Education Hub, face-to-face Level 3 training, targeted MCA and DoLS education, and improved mechanisms for disseminating learning from

reviews, incidents, audits and feedback.

2.4 Demand remains significant. The report records 3,288 child protection referrals, 747 adult safeguarding referrals and 1,527 DoLS applications during 2025/26. It also records 1,359 Children Looked After within CTMUHB, with 1,310 health assessments completed by CTMUHB.

2.5 Progress should therefore be considered alongside continuing pressures relating to workforce capacity, increasing complexity, statutory timeliness, training compliance, data quality and the need to embed improvement consistently across all services.

3. Risks and Opportunities

3.1 Key risks are: variable compliance with some safeguarding training requirements; sustained demand and complexity; workforce capacity and resilience; delays or inconsistency in information sharing; maintaining statutory timescales; legal and regulatory exposure in MCA, DoLS and Court of Protection practice; and inconsistent data quality or visibility across services.

3.2 Mitigations and opportunities include implementation of the full Datix Safeguarding Module; development of dashboards and electronic audit tools; strengthened live oversight and escalation; revised policies, procedures and standard operating procedures; targeted education; multi-agency review processes; improved feedback from children, families, carers and staff; and clearer reporting through care group and corporate governance structures.

3.3 The annual report provides a platform to maintain organisational focus on prevention, early intervention, professional curiosity, person-centred practice and measurable learning from safeguarding reviews.

4. Compliance and Governance

4.1 The annual report describes how CTMUHB has worked to meet duties arising from the Social Services and Well-being (Wales) Act 2014, Children Acts 1989 and 2004, Wales Safeguarding Procedures, Mental Capacity Act 2005, VAWDASV (Wales) Act 2015, Domestic Abuse Act 2021 and associated statutory frameworks.

4.2 Assurance is provided through established safeguarding governance arrangements, quarterly reporting, specialist groups, care group quality and safety forums, audits, training compliance monitoring, incident and rapid review processes, and participation in regional and All-Wales safeguarding structures.

4.3 Priorities for 2026/27 include strengthening statutory compliance through revised documentation, audits and dashboards; embedding the full Datix safeguarding functionality; implementing new MCA and DoLS forms; updating policy in response to case law; and maintaining clear escalation and scrutiny through the Safeguarding Executive Group and Quality, Safety and Experience Committee.

5. Benchmarks and Performance Context

5.1 The annual report primarily presents internal year-on-year activity and improvement information. Child protection referrals increased from 3,008 in 2024/25 to 3,288 in 2025/26, while adult safeguarding referrals increased from 615 to 747.

5.2 Training performance remains an area for improvement. Management of Safeguarding People Level 3 compliance was 57.8% in quarter 4, while VAWDASV Group 1 compliance was 73.6%. These measures will require continued oversight and targeted action during 2026/27 to exceed the expected 85% national target.

5.3 Where national or peer benchmarking is not available within the annual report, assurance will continue to be strengthened using trend analysis, audit findings, statutory compliance measures and comparison through regional and All-Wales networks.

6. Conclusion

6.1 The annual report demonstrates material progress in governance, service delivery, digital systems, learning and partnership working across the safeguarding portfolio. It also presents a balanced account of continuing pressures and areas requiring further improvement.

6.2 Approval by the Board will confirm receipt of the assurance presented, support continued oversight of the 2026/27 priorities and enable onward submission and publication of the report.

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)*	Quality and patient safety; workforce capacity and capability; statutory and regulatory compliance; partnership working and information sharing.
Link to Strategic Risk(s) on the Board Assurance Framework (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	The Annual Report provides assurance on CTMUHB's safeguarding and public protection arrangements during 2025/26, highlighting strengthened governance, service development, partnership working, digital improvement and organisational learning.

Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant /	A Healthier Wales

Link to Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales; A More Equal Wales; A Wales of Cohesive Communities. Safeguarding activity supports prevention of harm, equitable access to protection and support, and coordinated community and partnership responses.

Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	All Enablers of Quality Apply
	Leadership; Workforce; Whole-systems approach; Information; Learning, improvement and research. The report evidence strengthened governance, education, digital oversight, audit, review, learning and multi-agency working.

Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental Sustainability Impact (5Rs)	All Environmental Sustainability Impact (5Rs) Applies
	Reduce; Rethink. Digital forms, dashboards, recorded learning and online resources reduce paper-based processes and support efficient use of staff time. No material adverse environmental impact is identified.

Asesiad Effaith Impact Assessment		
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg *(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)* Equality & Welsh Language Impact Assessment Outcome *(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)*	Outcome for Equality: POSITIVE Summary: The report supports equitable safeguarding responses for children, adults at risk, care-experienced people and victims of abuse. Priorities include accessible information, person-centred practice and improved feedback. Outcome for Welsh Language: NEUTRAL/POSITIVE Summary: Patient	A separate EWLIA is not required for the annual assurance report itself. Equality and Welsh language impacts should continue to be assessed within individual service changes, policies and implementation plans.

	information resources are to be available bilingually where required, including English, Welsh and accessible formats.	
Canlyniad Asesiad Effaith Ansawdd *(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)* Quality Impact Assessment Outcome *(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)*	POSITIVE. The report describes actions intended to improve safe, effective, timely, efficient, equitable and person-centred safeguarding practice. Continuing risks and priorities are transparently identified for oversight.	
Cyfreithiol / Legal	Yes (Include further detail below)	
	The report sets out assurance and improvement activity in relation to safeguarding legislation, MCA, DoLS, Court of Protection, VAWDASV and associated statutory procedures. Continued legal oversight is required as case law and national guidance develop.	
Enw da / Reputational	Yes (include further detail below)	
	Effective safeguarding governance protects public confidence. Failure to maintain statutory compliance, timely responses, workforce competence or effective partnership working could present reputational risk. The report identifies mitigations and priorities.	
Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	Yes (include further detail below)	
	Delivery relies on specialist safeguarding capacity, clinical and operational engagement, training time, digital development and commissioned support. Any additional resource requirements arising from individual improvement projects should be considered through established planning and business case processes.	

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Safeguarding Executive Group; Safeguarding Children Group; Safeguarding Adult Group; care group quality and safety governance arrangements; regional and All-Wales safeguarding partnerships.	18/08/2026	Throughout 2025/26 - oversight, scrutiny, partnership input and monitoring of safeguarding activity, learning, risks and improvement priorities.
Quality, Safety & Experience Committee	24/11/2026	PENDING ENDORSEMENT

Acronyms / Glossary of Terms	
PIPOT	Persons in Positions of Trust
IDVA	Independent Domestic Violence Advisor
ISVA	Independent Sexual Violence Advisor
MARAC	Multi-Agency
VAWDASV	Violence Against Women Domestic Abuse & Sexual Violence
DoLS	Deprivation of Liberty Safeguards
MCA	Mental Capacity Act
COP	Court of Protection
MASH	Multi-agency Safeguarding Hub
CTMUHB.	Cwm Taf Morgannwg University Health Board

Safeguarding and Public Protection Annual Report

2025/2026







Prepared by
Claire O'Keefe, Head of Safeguarding

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

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Foreword

This report demonstrates the effective leadership, commitment and operational support provided across all aspects of Safeguarding and Public Protection within Cwm Taf Morgannwg University Health Board, and how the UHB complies with legislative requirements, external standards and good practice guidance.

What does Safeguarding and Public Protection look like in Cwm Taf Morgannwg University Health Board (CTMUHB)?

Cwm Taf Morgannwg University Health Board incorporates the local authority areas of Bridgend, Merthyr Tydfil and Rhondda Cynon Taf with a total population of almost 440,000. Services are also provided to those living within neighbouring authorities.

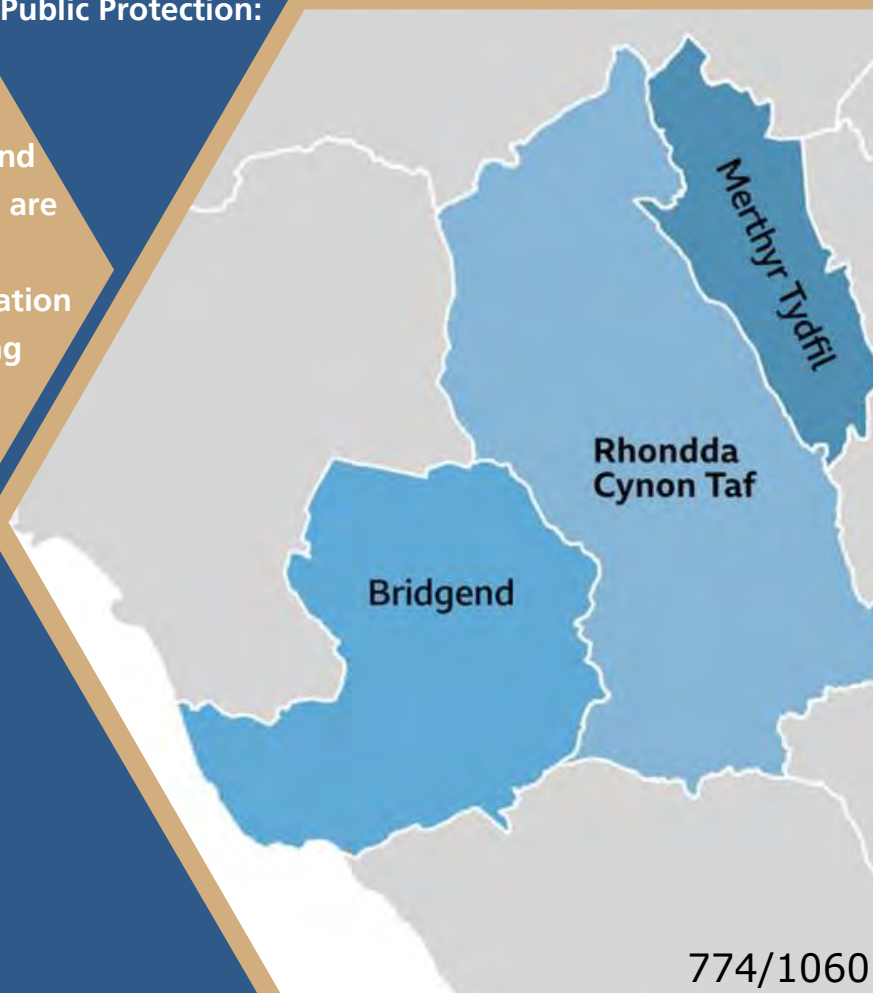
Safeguarding in Cwm Taf Morgannwg involves working with our colleagues and partner agencies to protect and prevent children and adults at risk of abuse, neglect or other kinds of harm.

Public Protection seeks to protect, promote and improve the health, safety and well-being of our population across Cwm Taf Morgannwg.

Strategic Objectives for Safeguarding and Public Protection:

- **There are effective measures in place within CTMUHB to safeguard people and protect children and adults at risk who are accessing its services.**
- **There is effective inter-agency co-operation in planning and delivering safeguarding and public protection services and in sharing information.**

The Health Board works within regional partnership arrangements throughout Cwm Taf Morgannwg



Key Areas of Work

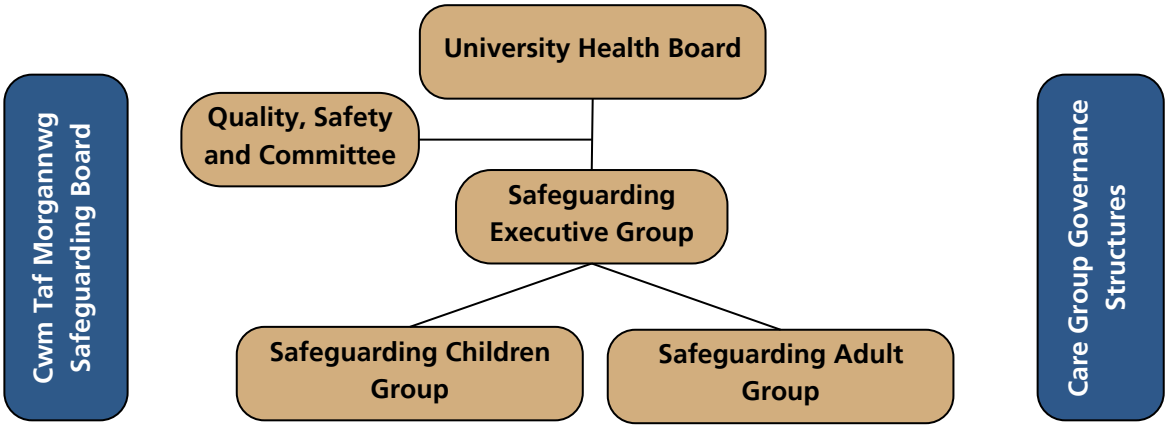
Paediatric Emergency Department (ED) Safeguarding meetings (PEM). Revision of ED trigger list and paperwork to identify and assess children and young people who may be at risk of abuse and/or neglect.	Widened safeguarding supervision to community services. Using the newly developed safeguarding supervision request form.	Quality of safeguarding supervision assessed via Microsoft feedback forms.
Developed digital information-sharing forms for use between secondary care, primary care services, and the local authority. Piloted at one hospital site to date.	Expansion of the health IDVA service across CTMUHB, supported by Value Based Health Care.	Development and approval of a digital mental capacity assessment form.
Review of CTMUHB Multi-agency Referral Assessment Conference (MARAC) contribution, with the development of a standard operating procedure to ensure a consistent approach across CTM.	Development of a leaflet for children who are care experienced to support transition into adult services.	Production of safeguarding Link and Learn modules, recorded and made available through the safeguarding SharePoint page.
Strengthened governance arrangements, ensuring safeguarding representatives attend care group Quality, Safety and Patient Experience meetings.	Development of a partnership response to near miss events at Parc Prison, reducing risks of suicide.	Implementation of improved Court of Protection database, ensuring improved oversight of cases.
Learning identified from Procedural Response to Unexpected Deaths in Childhood (PRUDiC) has influenced service improvements and pathways.	Utilising Welsh Government funding, reduced the backlog of Deprivation of Liberty Safeguard assessments.	Delivery of a comprehensive safeguarding training programme across medical, primary care, police, and multidisciplinary staff groups.

Organogram Structure

Corporate Safeguarding and Public Protection Team



Governance Arrangement and Reporting Structure



This chart illustrates the governance arrangements that supported the CTMUHB Safeguarding Team in fulfilling their statutory duties during 2025/2026. Quarterly reports were shared with the Safeguarding Executive Group for oversight and scrutiny.

Safeguarding Children

Our Aim

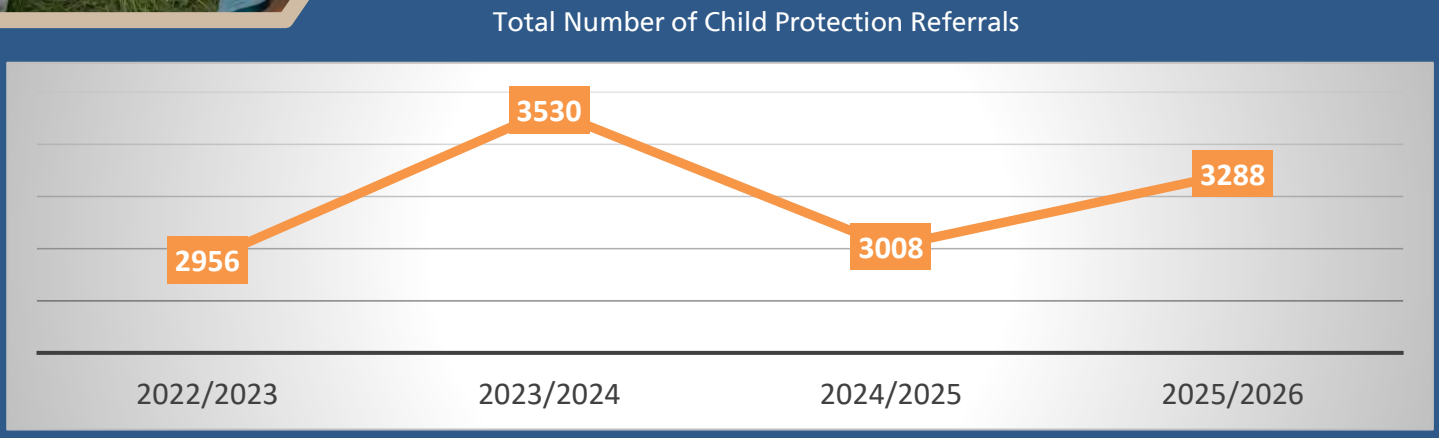
To ensure that children and young people in Cwm Taf Morgannwg, up to the age of 18, are protected from abuse, neglect or other kinds of harm and are prevented from becoming at risk of abuse, neglect or other kinds of harm and they live in an environment that promotes their wellbeing.



To ensure that the UHB complies with the related legislation and Procedures:

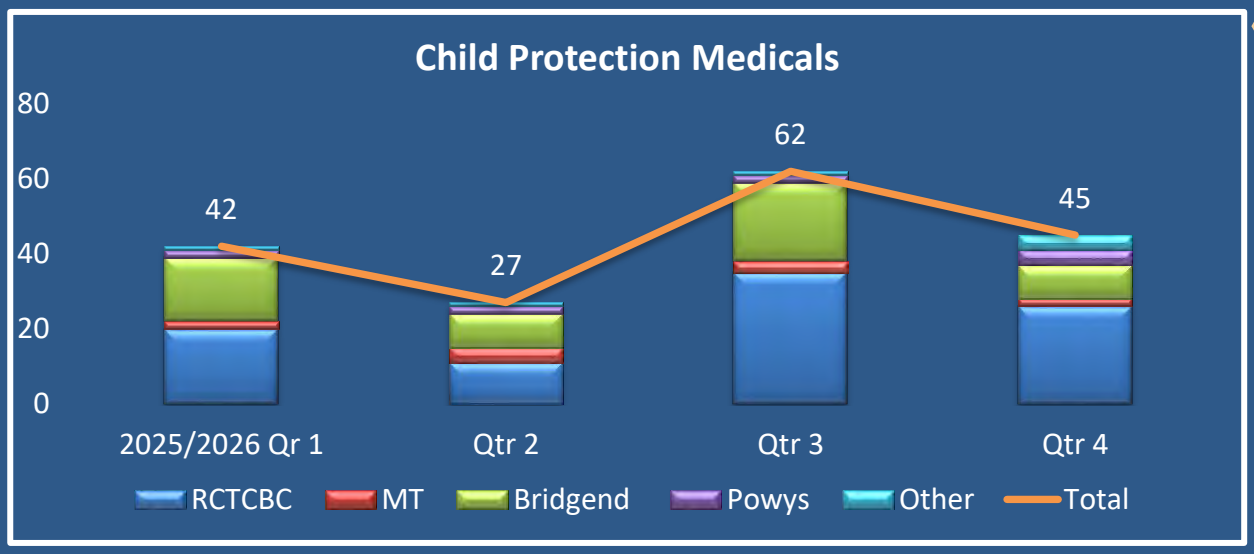
- Social Services and Well-being (Wales) Act 2014 – Part 7
- Children Act 1989 and 2004
- Wales Safeguarding Procedures 2019

What did we do



- A Paediatric Emergency Medicine (PEM) Safeguarding Group was established in September 2025 to strengthen safeguarding practice, consistency and partnership working across CTMUHB's three Emergency Department s. The group has delivered a number of key developments, including the formalisation of governance arrangements, implementation of a revised safeguarding trigger list across all sites, updates to the dog-bite referral pathway in line with national guidance, and in partnership with safeguarding, is working to strengthen information sharing processes from secondary to primary care.

- The introduction of a live log for Specialist Community Public Health Nurse services has been improved, providing oversight of service pressures, risks and safeguarding concerns, enabling timely escalation, informed decision-making and a more coordinated response to emerging issues. This has strengthened service resilience and assurance during periods of increased demand and workforce challenge.



- Annual audit plans have been extended to include safeguarding in Paediatrics, safe sleep, child protection medicals and physical injuries in children, ensuring effective safeguarding actions and quality referrals.

- Paediatrics and Emergency Department s have worked together to strengthen The Procedural Response for Unexpected Death in Childhood (PRUDiC) for 16/17 year olds. In addition, work is ongoing to ensure families receive appropriate support, particularly when there are multiple processes ongoing following infant deaths, i.e. Perinatal Mortality Review Tool (PMRT).

- Launch of a standard operating procedure to support the school nursing service in representing school-age children in safeguarding processes.

- Development of guidance to support practitioners in the management of Ano Genital Warts.

- Revision of the Was Not Brought Policy in line with NHS All Wales Principles.

- Developed a more robust way to collate feedback from children and their parents/carers. Feedback is accessible using a QR code as well as in a paper format, ensuring that opportunities are maximised to capture feedback to ensure the voice of the child influences service development.

- The Child Protection Medical Hub continues to ensure that "making every contact count" is applied within Safeguarding, offering support on health promotion, such as dental hygiene and signposting to other support agencies such as Mental Health and the Independent Domestic Violence Advocate (IDVA).

- Re-audit of safeguarding medical reports informed the development of a new child protection medical reporting template.



WHAT'S NEXT?

Work collaboratively with the Regional Safeguarding Board to strengthen the Procedural Response to the Unexpected Death in Childhood (PRUDiC) process, ensuring that families' voices are heard and reflected throughout. This will include the development and delivery of training to support consistent understanding and implementation of the process

Development of an implementation plan to support the launch of the full Datix Safeguarding Module

Implement learning from rapid reviews to improve the timeliness, quality, and effectiveness of information sharing between Midwifery, Children and Young People's Services, and GPs

Strengthen workforce awareness and understanding across CTMUHB to support the early recognition and effective response to child sexual abuse and exploitation

A Quality Improvement project focused on the dissemination of learning from a Child Practice Review, evaluating how the identified learning has been embedded across CTMUHB and identifying opportunities to further strengthen safeguarding practice

Strengthen communication and information-sharing arrangements between secondary and primary care by implementing system-based alerts to notify relevant professionals when children are added to the Child Protection Register

Children Looked After

Our Aim

To guarantee that Children in Care have their physical, emotional, and mental health requirements fulfilled. This includes conducting timely assessments, making referrals, and providing access to necessary healthcare services.

To ensure that the UHB complies with the related legislation and Procedures:

- Social Services and Wellbeing (Wales) Act 2014 – Part 6
- Towards a Stable Life and Brighter Future 2007 [statutory health assessments]
- The Care Planning, Placements, and Case Review (Wales) Regulations



What did we do ?

- Throughout 2025–26, the team continued to strengthen the quality and effectiveness of health assessments for children and young people through audit, service improvementand enhanced clinical oversight. A quality assurance audit of initial and review health assessments identified opportunities to improve consistency and strengthen the analysis of risks and implications for children, informing a clear programme of improvement. Feedback mechanisms have been developed for prospective adopters and carers to ensure that health information and support provided meets their needs and informs future service development.

- Significant operational improvements have been achieved through the introduction of streamlined systems for managing children's health reviews across CTM, improving oversight, planning and access to clinic appointments.

- Strong partnership working has continued with Children Looked After (CLA) teams, supported by regular multidisciplinary meetings, effective clinical supervision arrangements and delivery of Trauma-informed practice training. The Specialist Nurse has also continued to advocate for children and support foster carers and adoptive families through direct advice, guidance and coordination of care, contributing to improved experiences and outcomes for children.

- CTMUHB has signed up to the Corporate Parenting Charter, which sets out principles and promises public bodies must follow to support care experienced children and young people.



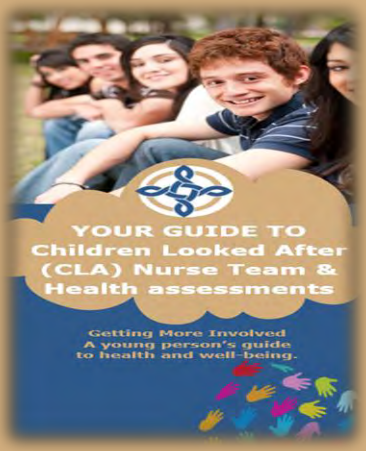


1359 Looked After Children in CTMUHB

254 Health Assessments completed outside CTMUHB

232 Children placed outside CTMUHB

1310 Health Assessments completed by CTMUHB (6-monthly for <5 yrs and annually for >5yrs)



Developed and introduced a child-friendly Welcome Leaflet to support children and young people in understanding the role of the CLA Nurse and the purpose of their health assessment. The leaflet was designed to provide clear, accessible information about what to expect throughout the assessment process, helping to reduce anxiety, encourage engagement, and ensure children and young people feel informed, supported, and empowered to participate in discussions about their health and wellbeing.

- Strong partnership working has continued with Children Looked After (CLA) teams, supported by regular multidisciplinary meetings, effective clinical supervision arrangements and delivery of Trauma-informed practice training. The Specialist Nurse has also continued to advocate for children and support foster carers and adoptive families through direct advice, guidance and coordination of care, contributing to improved experiences and outcomes for children.

- Improved quality and consistency of statutory health assessments through completion of an under 5 audit, development of targeted training resources, and promotion of child-centred assessment practice.

- Enhanced the voice of children, young people, and their carers by using feedback from surveys and engagement events to inform service improvements and resource development.

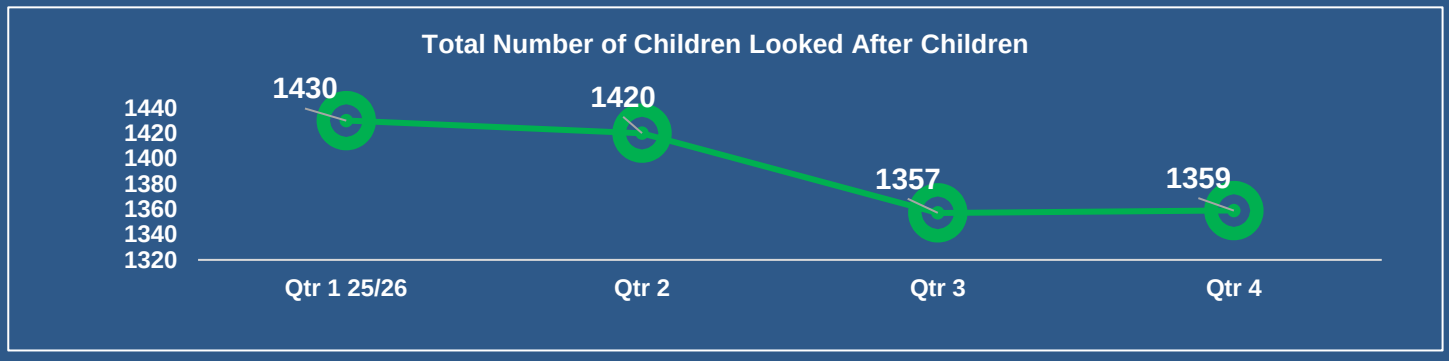
- Strengthened support for children entering care through partnership working with the Comfort Case charity, providing practical and emotional support at a critical time.

- Significantly reduced the backlog of Review Health Assessments by implementing streamlined processes and a new hybrid module.

- Improved compliance with statutory timescales through closer collaborative working with Children and Young People's services.

- Increased opportunities for care-experienced young people by developing employability resources and raising awareness of work experience and career opportunities within CTMUHB.

- Strengthened Multi-agency collaboration and service improvement through engagement with young people and key partners to ensure services remain responsive to their needs.



WHAT'S NEXT?

Build on existing digital resources for staff and the public, ensuring safeguarding information is accessible, up to date, and supports effective communication and engagement

Explore digital solutions to enhance connectivity with care experienced young people and enhance efficiency within the team to reduce administrative burden, streamline clinical documentation and report writing

Prepare for and support the successful implementation of the new CoramBAAF statutory health assessment documentation, scheduled for launch in June 2026

Strengthen the profile of the service by exploring branding opportunities that promote greater awareness, consistency, and recognition across CTMUHB and partner agencies

Continue to embed improvement initiatives to eliminate any remaining backlog by year-end, ensuring timely assessments and improved compliance with statutory requirements

Safeguarding Adults

Our Aim

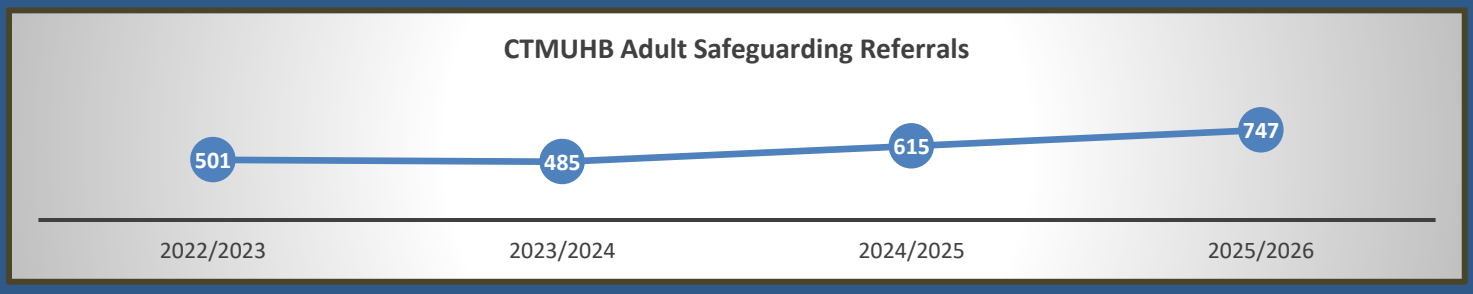
To ensure that adults in Cwm Taf Morgannwg, over the age of 18, are protected from abuse, neglect, or other kinds of harm and are prevented from becoming at risk of abuse, neglect, or other kinds of harm, and they live in an environment that promotes their wellbeing.

To ensure that the UHB complies with the related legislation and Procedures:

- Social Services and Wellbeing (Wales) Act 2014 – Part 7
- Health and Social Care (Quality and Engagement) (Wales) Act 2020

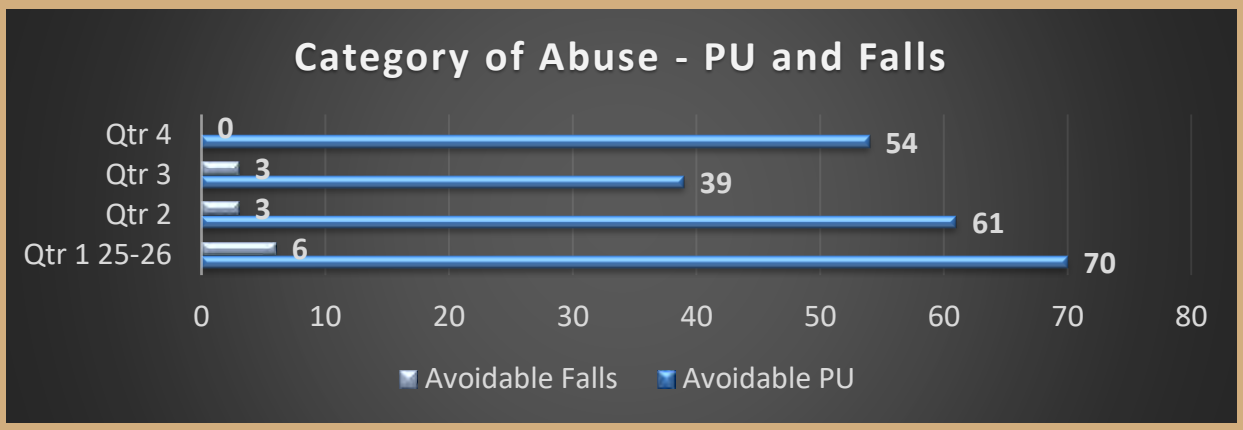


What did we do



- During 2025–26, CTMUHB Safeguarding Services continued to strengthen arrangements for safeguarding adults at risk through enhanced partnership working, preventative interventions and the embedding of learning from reviews. A significant focus has been the development of a Multi-agency approach to complex self-neglect, supporting practitioners to manage risk more effectively through self-neglect panels and multidisciplinary decision-making. This has promoted earlier identification of escalating risk, strengthened information sharing and ensured that safeguarding responses remain person-centred while balancing duties of protection and autonomy. The Health Board has also contributed to the development and implementation of updated self-neglect guidance, reinforcing professional curiosity, mental capacity considerations, advocacy, and coordinated Multi-agency risk management.

- Safeguarding representatives have continued to participate in rapid reviews following unexpected deaths, serious incidents and near-misses, ensuring opportunities for immediate learning are identified and shared across services. This approach has strengthened organisational learning, supported improvements in patient safety and enhanced the Health Board's ability to respond proactively to emerging safeguarding risks through multidisciplinary review processes. Learning from incidents is disseminated through governance structures, operational groups and safeguarding forums to support continuous improvement.



- The Health Board has continued to embed learning arising from the Single Unified Safeguarding Review (SUSR) process, which has replaced previous Adult Practice Reviews in Wales. Learning themes, recommendations and action plans are monitored through governance and safeguarding structures to ensure they translate into measurable service improvements. Key areas of focus have included professional curiosity, information sharing, Multi-agency collaboration, mental capacity practice, and earlier recognition of safeguarding concerns. This has supported a culture of continuous learning and strengthened assurance that lessons from reviews are informing frontline practice and improving outcomes for adults at risk.



HMP Parc Prison Healthcare Services – Annual Report Summary 2025/26

- During 2025/26, safeguarding arrangements within HMP Parc Healthcare Services have continued to strengthen through improved governance, clearer reporting pathways, enhanced documentation and targeted staff training. This has increased staff confidence in recognising and responding to vulnerability, self-harm and safeguarding concerns.

- A key achievement was the introduction of the multidisciplinary Suicide and Self-Harm Rapid Review Team, which reviews serious incidents within 72 hours to identify risks, agree immediate actions and share learning. This has strengthened Multi-agency collaboration, improved communication and supported a more proactive approach to patient safety.

- Positive outcomes include faster responses to emerging risks, improved management of repeat self-harm cases and enhanced safeguarding assurance through timely learning and review processes. Ongoing challenges remain in meeting the complex needs of a highly vulnerable population and maintaining workforce capability.

WHAT'S NEXT?

Delivery of co-produced training with Violence and Aggression, Mental Capacity Act and Emergency Department teams, further embedding Trauma-informed, person-centred approaches to supporting patients with complex physical and mental health needs, while ensuring the safety and wellbeing of both patients and staff

Develop and facilitate workshops across the Health Board to strengthen knowledge, confidence, and best practice in relation to Section 126 enquiries

Strengthen the integration of sexual safety principles within adult safeguarding practice by embedding the requirements of the All Wales NHS Anti-Sexual Harassment Policy into Health Board processes, guidance, and training, ensuring alignment with Section 5 of the Wales Safeguarding Procedures

Priorities for 2026/27 include further embedding learning from the rapid review process, expanding safeguarding training and continuing to strengthen a culture of early intervention, learning and prevention

Participate in the review of the Health Board Pressure Ulcer Policy and implement any required safeguarding amendments arising from the revised All Wales Pressure Ulcer Guidance

Utilising the Datix safeguarding model to improve management and oversight of Adults at Risk (AAR) referrals

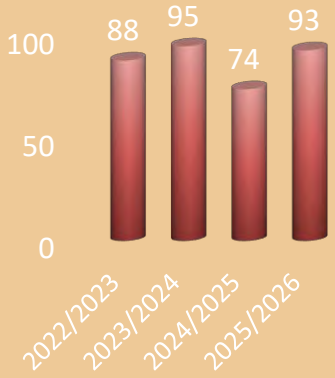
Person in a Position of Trust (PiPoT)

Our Aim

To ensure that patients/clients are safe in our care. To ensure that staff understand they have a duty to report concerns about the behavior of other staff members.

Raise awareness with our staff that their behaviour outside of work can directly impact on their working role.

Ensuring that there are effective inter-agency safeguarding processes and practice in place. That these are supported by robust workforce processes and risk assessments to ensure a proportionate response to concerns whilst safeguarding our patients/clients.



What did we do ?

- During 2025–26, CTMUHB continued to strengthen its arrangements for managing concerns relating to Persons in Positions of Trust (PiPoT), with a particular focus on creating a fair, supportive and proportionate approach for both staff and those accessing services. The Health Board reviewed and updated its policy and developed a staff support leaflet to ensure colleagues are fully informed about the process, available support mechanisms and expectations when concerns are raised. This work has helped reinforce a culture of transparency, learning and staff wellbeing.

- To improve organisational understanding and confidence, a PiPoT "Link and Learn" session was developed and recorded, providing accessible guidance on managing concerns, application of the risk management tool and the principles underpinning proportionate decision-making. A key message throughout the programme has been ensuring that staff support remains at the centre of the process, recognising the impact that safeguarding concerns can have on individuals whilst maintaining a robust approach to risk management and public protection.

- Significant improvements have also been made to governance and oversight through implementation of the Datix Safeguarding Module to support the recording, monitoring and management of PiPoT concerns. This has enhanced visibility of cases, strengthened assurance processes and improved the ability to identify themes, learning and actions arising from concerns.

- The Safeguarding Team has worked extensively to improve understanding of the distinction between employment conduct issues and transferable safeguarding risk within Section 5 procedures. Targeted training and awareness sessions have been delivered to Senior Nurses and incorporated into Healthcare Support Worker induction programmes.

- Joint working has been strengthened with Education providers, Universities and the Nurse Bank to support timely reporting, effective information sharing and coordinated risk management where concerns arise. Collectively, these developments have improved consistency of practice, strengthened safeguarding oversight and enhanced the Health Board's ability to manage risk while supporting staff through the process.

WHAT'S NEXT?

To ensure the voice of those impacted by Section 5 processes is included in strategy and risk management meetings

Review and update Health Board resources and policies to ensure alignment with any amendments to Section 5 of the Wales Safeguarding Procedures

Utilising the datix safeguarding model to improve identification of thematic learning and oversight of PIPOT referrals

Ensure the NHS Wales Anti-Sexual Harassment Policy is reflected in decision making and risk management planning

Violence Against Women Domestic Abuse Sexual Violence



Our Aim

Individuals who are victims of violence against women, domestic abuse, and sexual violence are treated and supported in a way that optimises their potential and life chances.

To ensure that the UHB complies with the related legislation and Procedures:

- Violence Against Women Domestic Abuse and Sexual Violence (Wales) Act 2015
- Female Genital Mutilation Act 2003 (amended by Serious Crime Act 2015)
- Domestic Abuse Act 2021

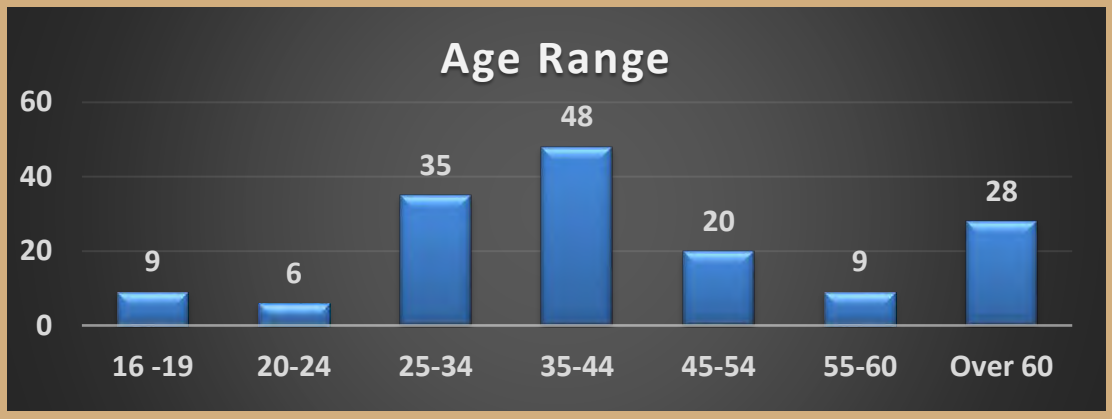
What did we do ?

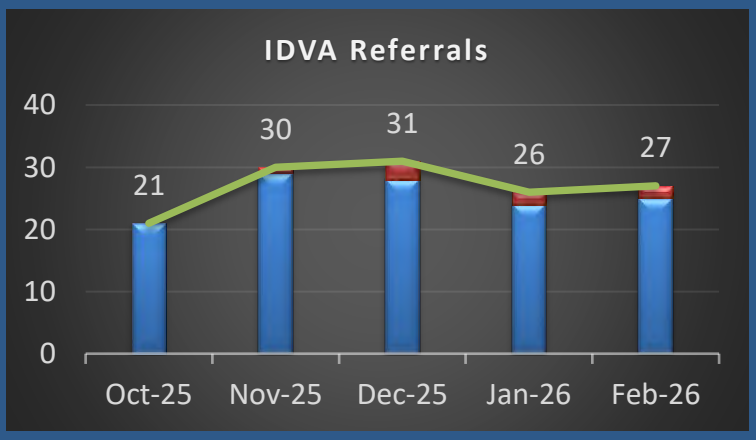
Health Independent Domestic Violence Advisor (IDVA) Service Development:

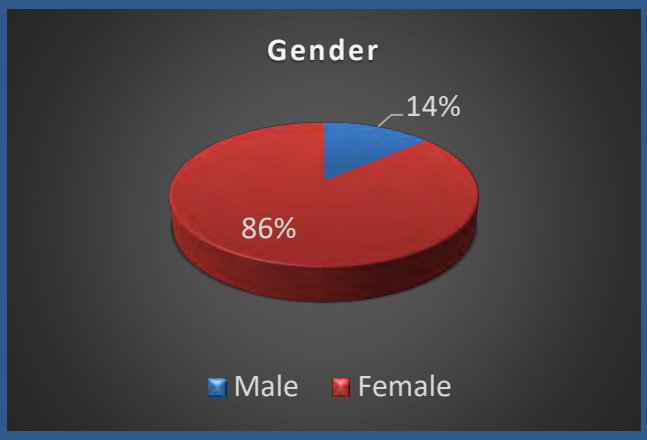
- Through the Value Based Health care (VBHC) programme, CTMUHB has successfully established a Health Independent Domestic Violence Advisor (IDVA) service across its three District General Hospitals, significantly strengthening the Health Board's ability to identify, support and respond to domestic abuse. The service provides specialist advocacy and support for both patients and staff experiencing domestic abuse and/or sexual violence, ensuring timely intervention and access to appropriate services.

- The Health IDVA team has also completed Independent Sexual Violence Advisor (ISVA) training, enhancing the Health Board's response to sexual violence and supporting the delivery of Trauma-informed care. Alongside direct support, the team has delivered education and awareness initiatives that have increased staff knowledge, confidence and competence in recognising abuse, responding to disclosures and providing appropriate support.

- The development of the Health IDVA/ISVA service directly supports the Health Board's Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) Strategy and 10 year Women's Health Plan by strengthening prevention, early identification, intervention and recovery pathways. Embedding specialist IDVA and ISVA expertise within acute healthcare settings has improved access to advocacy, safety planning and specialist community services, while contributing to a whole-system approach to safeguarding, reducing harm and improving outcomes for patients and staff affected by domestic abuse and sexual violence.







MARAC Review and Development of a CTMUHB Standard Operating Procedure

- During 2025/26, CTMUHB reviewed its contribution to Multi-agency Risk Assessment Conferences (MARACs) to strengthen health involvement in identifying, communicating and managing risk for individuals experiencing high-risk domestic abuse. This led to the development and implementation of a Standard Operating Procedure (SOP) that clearly defines roles, responsibilities and information-sharing processes for MARAC participation.

- The SOP standardises contributions from Mental Health Services, the Safeguarding Team and the Health IDVA/ISVA Service, ensuring consistent sharing of relevant health information to inform Multi-agency risk assessments and safety planning. As a result, governance, assurance and risk communication have been strengthened, supporting a more coordinated, Trauma-informed response and enhancing CTMUHB's contribution to protecting and supporting high-risk victims of domestic abuse.

WHAT'S NEXT?

Expansion of the All Wales Routine Enquiry to Mental Health and Emergency Department

Delivery of 26/27 VAWDASV training plan. Focus on increasing compliance with Group 1 and Group 2

Target Services with bespoke training delivery of Ask and Act training with a focus on elder abuse, coercive control and children and Young people

Explore opportunities to strengthen the Health Board's response to the 10-year Women's Health Plan

Utilising workforce reportable experience measures, understand what resources and support colleagues require to effectively recognise and respond to victims of domestic abuse and sexual violence

Evaluate IDVA / ISVA Service through Patient Reportable Outcome and Experience Measures.
Interpreting data to ensure effectiveness of service

Mental Capacity Act

Our Aim

The Mental Capacity Act provides a legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves.

Everyone working with and/or caring for an adult who may lack capacity to make a specific decision, must consider and comply with this Act when making decisions or acting for that person, when the person lacks the capacity to make a particular decision for themselves. The same rules apply whether the decisions are life-changing events or everyday matters.

What did we do ?

- During 2025/26, CTMUHB continued to strengthen Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) practice through targeted training, specialist advice, audit and quality improvement activity. A more bespoke training approach was introduced, reducing generic sessions and tailoring learning to specific staff groups using relevant case law and practice scenarios.

- The Health Board maintained active involvement in the Public Health Wales All-Wales MCA and DoLS NHS Workforce Group and contributed to a range of local forums, including the Consent Working Group, Restraint Working Group, MCA/MHA Group, Learning and Development Group and Stroke Multidisciplinary Team Variance Review and Learning Group. A new Health Board MCA Assessment Form was developed and approved, with implementation planned for July 2026, alongside updated patient information leaflets reflecting recent case law, available in English, Welsh and easy read formats.

- Additional capacity was supported through the secondment of a Court of Protection Lead Nurse and DoLS Team Leader. MCA Practitioners and Best Interests Assessors (BIAs) attended patient flow meetings across Ysbyty Cwm Cynon and Ysbyty Cwm Rhondda, providing specialist advice, supporting timely referrals and challenging practice where required. Ongoing support to clinical teams across primary and secondary care has improved the quality of capacity assessments and best interest decision-making, while ensuring that emerging legislation and its implications for the Health Board are appropriately escalated and considered.

- Between 1 April 2025 and 31 March 2026, the Safeguarding Team delivered 97 Level 3 MCA training sessions, demonstrating a continued commitment to developing staff knowledge, skills and confidence in safeguarding practice.

- A total of 1,509 evaluation responses were received during this period, with 97% of participants stating they would recommend the course to colleagues. Training quality remained consistently high, achieving average satisfaction scores ranging from 4.62 to 4.84 out of 5, reflecting the positive impact and value of the programme in supporting safe and effective practice across the Health Board.

- Training has been adapted to reflect the learning from Cwm Taf Morgannwg University Health Board v RW and Anor (2026). In addition, work is ongoing to ensure a robust process for the recording of Lasting Power of Attorney.



WHAT'S NEXT?

Development of 'Grab and Go' cards to assist with guidance on completion of capacity assessments and best interest records in addition to the updated forms

Update the MCA policy in line with recent Case law and Supreme Court judgment

Develop 7-minute briefing/flowcharts for the topics covered within the MCA, for example, Lasting Power of Attorney (LPA), Advanced decisions to refuse treatment (ADRT)

Commencement of Link and Learn session on completion of capacity assessment

Continue collaborative work at an All-Wales level to influence the future direction of MCA and DoLS services, including MCA and DoLS training, AGNI Judgement and a future All Wales MC assessment form

Continue to embed MCA and DoLS practice across CTMUHB through training, audit, quality improvement and governance arrangements

Deprivation of Liberty Safeguards

Our Aim

Ensure that the UHB follows the defined legislative processes and discharges the functions of the Supervisory Body and the Managing Authority.

To protect people who for their own safety and in their own best interests need care and treatment that may deprive them of their liberty but who lack the capacity to consent and where detention under the Mental Health Act 1983 is not appropriate at that time.

1527 DoLS applications received during 2025–26 (1% decrease compared to the previous year)

1,352 applications (89%) were submitted as Urgent Authorisations

564 Standard Authorisations granted, representing 37% of referrals received

What did we do ?

- Commissioned an external assessment agency to reduce the DoLS backlog, reduced to 30 outstanding cases by 31 March 2026.
- Continued collaborative work through the Public Health Wales (All-Wales) Mental Capacity Act and DoLS NHS Workforce Group.
- Participated in the Consent Working Group and Adult Frailty Group.
- Developed and piloted a new ward-based DoLS Audit Tool, with publication and monitoring planned through the Audit Management and Tracking (AMaT) system.
- Collaborated with Betsi Cadwaladr University Health Board and Swansea Bay University Health Board to develop a new All-Wales DoLS Form 1. Following a six-month pilot, the form received approval through the All-Wales MCA Governance Structure and is scheduled for rollout in July 2026.
- Continued to embed Mental Capacity Act (MCA) and DoLS practice across CTMUHB through advice, support, audit and training.
- Secondment of a DoLS Team Leader.
- Best Interests Assessors (BIAs) attended patient flow meetings on a fortnightly rotational basis across Ysbyty Cwm Cynon and Ysbyty Cwm Rhondda, providing advice on MCA and DoLS, supporting timely referrals and challenging practice where required.
- Continued to support clinical teams to improve the quality of DoLS referrals and authorisation compliance.



WHAT'S NEXT?

Develop and implement a new DoLS Power BI Dashboard linked to ward Electronic Whiteboards to improve oversight, monitoring and authorisation compliance

Support implementation of the new All-Wales DoLS Form 1 across CTMUHB

Continue to embed MCA and DoLS practice across CTMUHB through training, audit, quality improvement and governance arrangements

Continue collaborative work at an All-Wales level to influence the future direction of MCA and DoLS/LPS services

Roll out the new DoLS Audit Programme across all wards via AMaT to provide consistent assurance and compliance monitoring

Monitor emerging case law, legislative developments and national guidance relating to the Mental Capacity Act and Deprivation of Liberty Safeguards and Court of Protection, ensuring that CTMUHB remains compliant with its statutory duties

Court of Protection

Our Aim

To ensure CTMUHB adopts a robust and consistent approach to Court of Protection (COP) matters, maintaining compliance with the Mental Capacity Act, safeguarding patients' rights, and promoting timely, lawful, and person-centered best-interest decision-making for individuals who lack capacity.

What did we do ?

28 New Cases Since July 2025

60 Open Cases

- Created an experimental Court of Protection Senior Nurse role utilising Welsh Government Funding.
- Developed a New Court of Protection SharePoint page.
- Developed and implemented a New Court of Protection Policy and Procedure.
- Development of Court of Protection training for Senior Nurses and Wider Health Board. Communication and roll out plan implemented. With Electronic Staff Record enrolment and in person attendance.
- Digital Legal and Risk referral form completed with automated generating database.
- Quarterly COP Improvement Meetings discussed at the Safeguarding Operational Group.
- COP escalation processes discussed in regular Quality Safety Risk Experience meetings for all Care Groups.
- Collaborative working with Discharge Operational Group, Advocacy Services, Local Authority Leads, Legal and Risk Monthly Meetings and through the All Wales MCA / DoLS Network.
- Court of Protection awareness training during Safeguarding Week.
- Participation in the specification and tendering of the All-Wales IMCA contract which will include Local Authorities.



WHAT'S NEXT?

Development of a Lasting Power of Attorney alert system, policy and procedure

Strengthen the existing audit framework for the Court of Protection

CTMUHB will embed the legal principles arising from Townsend v Epsom and St Helier NHS Trust through strengthened governance, revised documentation, enhanced training, robust audit arrangements and clear escalation pathways to ensure all treatment decisions for adults lacking capacity are demonstrably compliant with the Mental Capacity Act 2005 and capable of withstanding legal scrutiny

Continue to raise the Court of Protection awareness through bespoke learning packages relevant to service areas

Training and Learning

Our Aim

To ensure CTMUHB staff are sufficiently trained and competent to be alert to the potential indicators of abuse, including concerns about the behaviour of staff, and know how to act and report on those concerns to fulfil statutory safeguarding duties under the Children Act 1989 and 2004, the Social Services and Well-being (Wales) Act 2014, the Violence Against Women, Domestic Abuse and Sexual Violence Act 2016, and the Counter-Terrorism and Security Act 2011.

What did we do ?

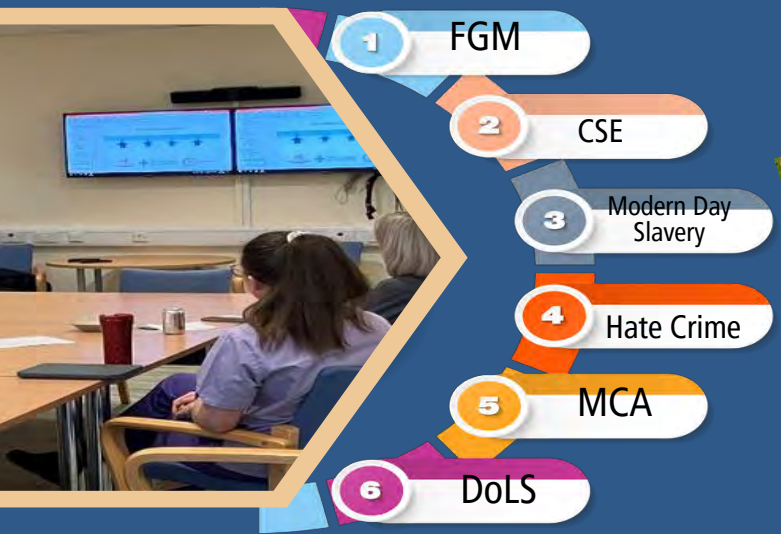
Safeguarding Education and Workforce Development

- During 2025–26, CTMUHB continued to strengthen safeguarding education, training and workforce development, ensuring that staff are equipped with the knowledge and skills required to safeguard children, adults at risk and vulnerable groups. Significant progress was made in modernising learning resources and improving accessibility to safeguarding education. Six "Link and Learn" sessions were launched and made available through SharePoint, alongside the development of a dedicated Learning and Education Hub providing access to safeguarding training opportunities, recorded learning sessions, newsletters, supervision resources, national guidance, SUSR learning and seven-minute briefings.

- The Health Board has developed a Safeguarding Training and Learning Group and monitoring group with service-wide membership to support dissemination of learning from incidents, reviews, audits and feedback across the organisation.

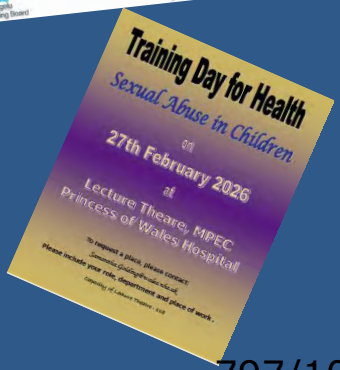
- The team are continuing to review and enhance safeguarding training programmes to align with updated Intercollegiate Documents and emerging risks. Face-to-face Level 3 safeguarding training was reintroduced, PREVENT awareness is being embedded within safeguarding programmes, and work has commenced on revising the CTMUHB Safeguarding Training Strategy.

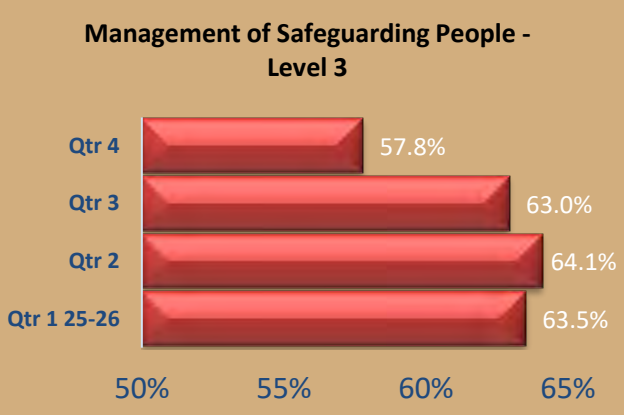
- Collaboration with Primary Care colleagues also strengthened, supporting implementation of the Royal College of General Practitioners Safeguarding Standards for General Practice and the delivery of safeguarding workshops and Level 3 learning opportunities for primary care practitioners.

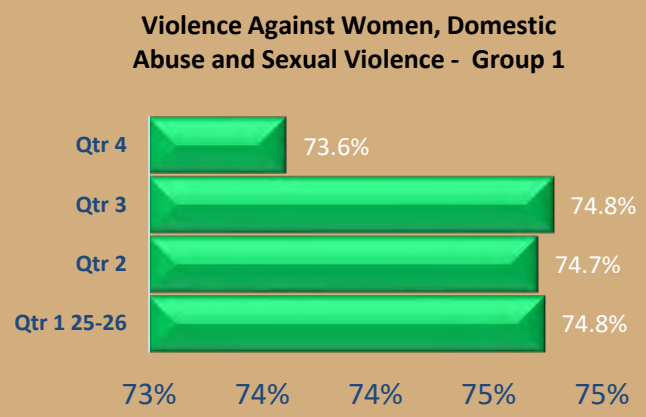












- Ongoing monitoring of training compliance, competencies and appeals processes has ensured the organisation remains aligned with national safeguarding training requirements. Monthly oversight processes were strengthened, including support for medical and dental services, while standardised feedback and evaluation mechanisms were introduced across learning programmes to support continuous improvement and assess the impact of safeguarding education on practice. Collectively, these developments have strengthened the Health Board's safeguarding culture, improved access to learning and ensured that staff remain informed of current safeguarding risks, legislation and best practice



- During Safeguarding Week, a comprehensive programme of health and safeguarding activities was delivered, including drop-in sessions, joint training events with voluntary and statutory partners, and a range of online learning opportunities. Topics covered included exploitation, professional curiosity, recognising physical injuries in children, the Mental Capacity Act (MCA), the Court of Protection (CoP), Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV), and ensuring the voice of the child and adult at risk remains central to safeguarding practice.

- Link and Learn recordings can be accessed on the Safeguarding SharePoint Site to support staff



WHAT'S NEXT?

Revision of the Health Boards safeguarding training strategy, ensuring it reflects the revised Intercollegiate Document (ICD), Royal College General Practitioners and National Training Framework

Exploring opportunities to merge training with other services/subjects to increase compliance in all levels of safeguarding

Launch of NHS Wales PREVENT E-Learning package – prioritising services identified as need first

Work with CTMUHB Training and learning department to explore opportunities to increase mandatory training compliance

Delivery of Multi-agency training across CTMUHB in support of the regional Exploitation Strategy

Working collaboratively with Training and Learning, Named Doctor, National Groups to increase visibility of medical compliance with Level 3 Training

Partnership Arrangements

Our Aim

Through collaborative working with our partner agencies, that children and adults at risk in the Cwm Taf Morgannwg area live safe lives.

Safeguarding in Cwm Taf Morgannwg is overseen by the regional Multi-agency Cwm Taf Morgannwg Safeguarding Board with responsibility for:

- Safeguarding Children and Adults at Risk
- Deprivation of Liberty Safeguards
- Multi-agency Safeguarding Hub (MASH)

The responsibilities and functions of the Board are set out in the statutory guidance under Part 7 of the Social Services and Wellbeing (Wales) Act 2014

What did we do ?

- Launch of Exploitation Strategy – October 2025
- Ensuring consistent primary health attendance at Self Neglect Panels
- Contributing to exploitation panels
- Participation in the development of the regional threshold document
- Launch of Bridgend's near miss protocol/pathway to aid in suicide prevention. Improving information sharing from Intensive Therapy Unit, Emergency Department and HMP Parc Prison
- Participation in the Adult Task and Finish Group in respect of S126
- Contribution to Multi-agency arrangements to MAPPA, Channel
- Development of Joint Policies / Protocols
- Review of risk register
- Contributed as reviewers and Panel members at Single Unified Safeguarding Reviews



MAPPA
Multi Agency Public Protection Arrangements

Bwrdd Diogelu Annibynnol Cenedlaethol Cymru
National Independent Safeguarding Board Wales

Cwm Taf Morgannwg Bwrdd Diogelu Safeguarding Board

Home Office

Llywodraeth Cymru Welsh Government

GIG CYMRU NHS WALES

Youth Justice Board Bwrdd Cyfiawnder Ieuenctid



Prevent Strategy



Multi-agency Safeguarding HUB

Our Aim
Through collaborative working with our partner agencies, that children and adults at risk in the Cwm Taf Morgannwg area are able to live safe lives.

MASH facilitates safeguarding by working together, in one place, sharing information and making collaborative decisions. Through MASH, a timely and proportionate approach to the identification, assessment and management of safeguarding, child and adult protection enquiries can be achieved. MASH is the 'front door' for all adult and child safeguarding referrals, including high risk domestic abuse.

What did we do ?

- CTMUHB continues to play an active role within the Cwm Taf Morgannwg Multi-agency Safeguarding Hub (MASH) governance arrangements through participation in the Cwm Taf MASH Silver Command Group, Bridgend Joint Operational Group and Cwm Taf Morgannwg Safeguarding Board Strategic Planning Group, contributing to strategic oversight, performance monitoring and the management of emerging safeguarding risks. Health representatives support the review of MASH performance indicators, identify operational challenges and obstacles, contribute to Multi-agency problem-solving, and provide safeguarding expertise to inform decision-making.

- CTMUHB also contributes to discussions relating to service developments, communication strategies and system-wide responses to safeguarding pressures, ensuring that health perspectives are embedded within partnership planning and delivery. Through ongoing engagement with the Silver Command Group, CTMUHB supports the continued development of effective, timely and coordinated safeguarding arrangements across the region.

- During 2025/26, CTMUHB developed and implemented a Health MASH Standard Operating Procedure (SOP) to strengthen consistency, governance and Multi-agency safeguarding practice. The SOP clearly defines roles, responsibilities, information-sharing arrangements and operational processes, supporting a standardised approach across the Health Board.

- The service enhanced data collection and performance monitoring through the increased use of Microsoft 365 platforms, enabling more efficient recording, improved oversight of safeguarding activity, and more timely reporting to support service improvement and assurance.

- Contributed health expertise to the development of improved adult safeguarding communication and referral pathways, including discussions regarding more resilient Multi-agency points of contact for Adults at Risk activity.

WHAT'S NEXT?

Further embed the Health MASH Standard Operating Procedure (SOP) through regular review, staff development and quality assurance activity to ensure consistent application and compliance with Multi-agency safeguarding arrangements

Contribute to the development of regional safeguarding priorities, ensuring health perspectives continue to inform strategic planning, service development and partnership initiatives across Cwm Taf Morgannwg

Support the transition to the new MASH premises, ensuring that co-location arrangements maximise opportunities for information sharing, partnership working and timely decision-making across agencies

Contribute to the review and implementation of revised Information Sharing Protocols for Children and Adults at Risk, ensuring arrangements reflect current MASH governance structures, legislative requirements and operational practice

Review CTMUHB representation and attendance at Cwm Taf Morgannwg Safeguarding Board (CTMSB) meetings and sub-groups, ensuring responsibilities are shared appropriately across the wider Safeguarding Team to strengthen resilience, succession planning and organisational representation

Continue to strengthen data quality, reporting and performance monitoring, utilising digital solutions to provide timely assurance, trend analysis and evidence-based service improvements. Embedding single and joint agency audit plan to monitor quality and effectiveness

Glossary

Child and Adolescent Mental Health Services	CAMHS	Specialised health services that assess and treat young people with emotional, behavioural or mental health difficulties.
Child Protection Conference	CPC	A Multi-agency meeting between a child's parents/carers, the child (if appropriate) and practitioners involved in the child's care, organised by the local authority. The aim of the conference is to look at all the relevant information and decide what steps need to be taken to ensure the safety and welfare of the child.
Child Sexual Exploitation	CSE	A form of child sexual abuse where an individual or group takes advantage of a power imbalance to coerce, manipulate or deceive someone under the age of 18 into sexual activity in exchange for something the victim needs or wants, and/or for financial advantage or increased status of the perpetrator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur using online technology including social media platforms.
Joint inspection of child protection arrangements	JICPA	Joint inspections to assess how local authorities, police and health services in Wales work together to help and protect children. The joint inspection of child protection arrangements (JICPA) is a Welsh only inspection and is similar to the joint targeted area inspections (JTAI) in England.
Children Looked After	CLA	A child who has been in the care of their local authority for more than 24 hours.
Multi-agency Safeguarding Hub	MASH	The purpose of a MASH is to bring together different agencies to enable fast information sharing with the purpose of making an efficient and fast decision to safeguard vulnerable children.
Multi-agency Public Protection Arrangements	MAPPA	A set of statutory arrangements to assess and manage the risk posed by certain sexual and violent offenders.
Multi-agency risk assessment conference	MARAC	A meeting involving statutory safeguarding partnerships and other services to share information and discuss those at the highest risk of domestic abuse to create a coordinated action plan.
Prevent		One part of the government's overall counter-terrorism strategy.
Procedural Response to Unexpected Deaths in Childhood	PRUDiC	This procedure sets a minimum standard for a response to unexpected deaths in children and young people up to the age of their 18th birthday. It describes the process of communication, collaborative action and information sharing following an unexpected death.

Summary and Conclusion

Key Achievements

Strengthened Multi-agency Safeguarding Practice	•Ensured health participation in a coordinated partnership approach to complex self-neglect, improving risk management and partnership working
Enhanced Safeguarding Governance and Systems	•Successfully implemented the Once for Wales Safeguarding Module for improved management and oversight of concerns for persons in a position of trust
Expanded Safeguarding Education and Training	•Launched new learning resources, Link and Learn sessions, and a Safeguarding Learning Hub to improve workforce capability.
Improved Organisational Learning	•Strengthened dissemination of learning from reviews, audits and incidents through the Health Board's safeguarding training and learning group.
Advanced VAWDASV and Specialist Support Services	•Continued delivery of VAWDASV priorities and development of specialist support Health Independent Domestic Violence Advocacy (IDVA) services .
Provided Strong Regional Safeguarding Leadership	•Maintained a contributory role in regional safeguarding partnerships, policy development and quality assurance activities.

Conclusion

During 2025/26, CTMUHB Safeguarding and Public Protection Services continued to strengthen safeguarding arrangements across the Health Board through improved governance, workforce development, partnership working and service innovation. Key achievements included the implementation of the Once for Wales Safeguarding Module, development of enhanced Multi-agency responses to complex safeguarding concerns, expansion of safeguarding education and learning resources, and continued delivery of VAWDASV priorities and specialist support services.

These achievements have strengthened the Health Board's ability to identify, respond to and manage safeguarding risks while promoting a culture of learning, professional curiosity and person-centred practice. Continued collaboration with partner agencies, regional safeguarding boards and services across CTMUHB has supported a coordinated approach to safeguarding children, adults at risk and vulnerable groups.

Whilst recognising ongoing challenges relating to workforce capacity, increasing complexity of need and compliance with some training requirements, the Health Board remains committed to continuous improvement. The priorities identified for 2026/27 will build upon the progress made this year, ensuring CTMUHB continues to provide effective safeguarding leadership, robust assurance and high-quality safeguarding practice across all services.

CTMUHB Public Board

IPC Annual Report 2025–26

Eitem yr Agenda / Agenda Item	8.1.9
Dyddiad y Cyfarfod / Date of Meeting:	26 November 2026
Statws Cyhoeddi / Publication Status:	Public
	Not exempt from publication. No patient-identifiable or commercially sensitive information is included in this cover report.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Filipe Leitão, Head of Nursing – Infection Prevention and Control
Cyflwynydd yr Adroddiad / Report Presenter:	Becky Gammon, Interim Deputy Director of Nursing
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Executive Director of Nursing, Midwifery and Patient Care
Diben yr Adroddiad / Report Purpose:	For Assurance and Approval
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	The Board are asked to receive the IPC Annual Report 2025–26, note the mixed assurance position, approve the 2026/27 priorities and support onward submission through the Health Board governance route.
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol* *Strategic Context:* *This report aligns to the following Strategic Pillars*	All applicable strategic pillars
	Improving Care; Creating Health; Sustaining our Future; Inspiring People.

Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan *(Reference relevant priority)*	The report supports the Annual Delivery Plan and IMTP priorities for safe, effective and person-centred care by providing assurance on HCAI prevention, outbreak management, IPC governance, workforce capability, environmental and decontamination risks, antimicrobial stewardship, community IPC and sustainability.

Crynodeb Gweithredol o'r hyn y mae'r adroddiad yn ei ddisgrifio: Dechreuwch drwy grynhoi'r wybodaeth bwysicaf yn fyr. Dylai hyn roi dealltwriaeth gadarn o'r pwyntiau allweddol yn erbyn y 3 phennawd canlynol heb ddarllen yr adroddiad llawn: Executive Summary of what the report is describing: Start by summarising briefly the most critical information. This should provide a firm grasp of the key points against the following 3 headings without reading the full report:	
Beth *(crynodeb o'r sefyllfa / mater cyfredol a pham ei fod yn bwysig a thystiolaeth i gefnogi'r safbwynt hwnnw ac ati)*	The Annual IPC Report 2025–26 provides Health Board-wide assurance on infection prevention governance, surveillance, outbreak management, decontamination, environmental risk, audit, training and service development.
What *(summary of current position / issue & why it matters and evidence to support that position etc)*	The overall assurance position is mixed. CTMUHB compares favourably with Wales for C. difficile, Pseudomonas aeruginosa and Staphylococcus aureus, but E. coli and Klebsiella spp. bacteraemia remain above the Wales benchmark. The IPC service model has strengthened through 12-hour acute-site cover, weekend and bank holiday on-call, Hub development, improved recruitment and an expanding Community IPC Team. Key assurance concerns remain: CDI improvement is not yet sufficient to meet the 25% reduction ambition; 86 outbreaks/periods of increased incidence affected 729 patients and 140 staff, with 652 bed days lost; Mandatory IPC training compliance remains below standard at 78.09%, with Medical and Dental staff at 38.22%; PPS findings demonstrate improvement in Bare Below the Elbow but continuing variation in hand hygiene and PPE/glove practice.

Felly, beth *(darparu dadansoddiad ystyrlon gan dynnu allan, fel y bo'n briodol, oblygiadau yn erbyn Strategaeth / Cynlluniau Cyflawni / risgiau Strategol neu Reoleiddiol CTMUHB ac ati ac unrhyw opsiynau ar gyfer mynd i'r afael â'r rhain)* So, what *(provide meaningful analysis drawing out as appropriate implications against CTMUHB Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)*	The report confirms that IPC improvement must be owned from ward to Board. Gram-negative bloodstream infection and CDI require cross-system action across acute care, primary care, community services, antimicrobial stewardship, catheter/device pathways, care homes and patient-flow decisions. Training compliance, ANTT assurance and blood-culture contamination should be treated as linked indicators of clinical practice reliability and leadership accountability. There are also active organisational risks relating to decontamination resilience, ventilation, isolation capacity, HCID preparedness, environmental compliance and digital capture of learning/actions. These risks require continued executive visibility, care group ownership and alignment between IPC, microbiology, pharmacy, estates, facilities, occupational health, PHW and local authority partners.
Beth Nesaf *(crynodeb o'r camau gweithredu a fwriadwyd a'r manteision sy'n cefnogi'r dewisiadau a'r argymhelliad(au) sy'n cael eu gwneud)* What Next *(summary of intended action and benefits supporting the choices and recommendation(s)being made)*	Priorities for 2026/27 are to: strengthen the Gram-negative and CDI reduction programmes; improve mandatory training compliance, particularly for Medical and Dental staff; embed the outbreak framework; expand Community IPC prevention work; use PPS as a recurring improvement and assurance tool for BBE, PPE, hand hygiene, devices and ANTT; progress decontamination, ventilation, isolation and HCID risk actions; and triangulate safety, sustainability and value from appropriate PPE/glove use. The Board are requested to APPROVE the Annual Report and ensure care groups act on the priorities and risks described.

Argymhelliad *(Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).* Recommendation (Linked to the "What Next" section above).	The Board is asked to: • RECEIVE and NOTE the IPC Annual Report 2025–26 and the mixed assurance position described. • APPROVE the 2026/27 IPC priorities and the proposed focus on Gram-negative bacteraemia, CDI, training compliance, PPS, outbreak governance, community IPC and infrastructure risks. • SUPPORT onward submission through the Health Board governance route and ensure care group ownership of actions arising from the report.

1. Background / Context

The IPC Annual Report 2025–26 summarises CTMUHB's position across HCAI surveillance, outbreak management, audit, education, IPC service delivery, decontamination, water and ventilation safety, sustainability and community prevention. It provides assurance against the Welsh Government Code of Practice for the Prevention and Control of Healthcare Associated Infections and sets out the main improvement priorities for 2026/27.

2. Strategic Insights

The Health Board has strengthened IPC infrastructure and responsiveness through an enhanced acute-site model, weekend and bank holiday on-call, Hub coordination, improved recruitment and Community IPC development. Performance is favourable against Wales for CDI, Pseudomonas and Staphylococcus aureus, but Gram-negative bacteraemia remains the main epidemiological challenge, particularly E. coli and Klebsiella spp. Community-onset infection is a major driver; therefore, acute controls alone will not deliver the scale of reduction required.

3. Risks and Opportunities

Key risks include persistent Gram-negative bacteraemia, CDI trajectory, mandatory training compliance, ANTT and blood-culture contamination, outbreak pressure, PPE/hand-hygiene reliability, isolation capacity, decontamination resilience, ventilation and HCID preparedness. Opportunities include a stronger Community IPC offer, targeted PPS cycles, improved digital action tracking, care group accountability, antimicrobial stewardship and safer, lower-waste PPE practice.

4. Compliance and Governance

Core IPC governance is in place through IPCC, quarterly reporting, surveillance via ICNet/HARP, microbiology input, RCA/review processes, audit, policies, water/ventilation and decontamination governance. Assurance is strongest where specialist oversight and audit are embedded, but several Code of Practice domains

remain partially compliant and require continued oversight, particularly training, environment, isolation, antimicrobial stewardship and laboratory/pathway standardisation.

5. Benchmarks

The annual report benchmarks CTMUHB against all-Wales rates. CTMUHB is below or favourable to Wales for CDI, Pseudomonas, MRSA and MSSA/Staphylococcus aureus indicators, but remains above Wales for E. coli and Klebsiella spp. bacteraemia. Annual organism data show CDI 164 cases, Staphylococcus aureus 113, E. coli 364, Klebsiella spp. 138 and Pseudomonas 14, with community-onset cases representing a substantial proportion of the burden.

6. Conclusion

The report provides reasonable assurance that IPC governance and service resilience have strengthened, but it also demonstrates that sustained improvement requires Board-to-ward ownership, cross-system prevention and measurable impact. Board approval is requested to maintain executive visibility and support delivery of the 2026/27 priorities.

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)* Link to Strategic Risk(s) on the Board Assurance Framework (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	Quality and Safety; Patient Safety; Operational Resilience; Workforce; Estates and Infrastructure. The report impacts strategic risk relating to avoidable harm from HCAI, outbreak-related service disruption, IPC training and competence, decontamination/ventilation/isolation resilience, antimicrobial resistance and public confidence. The report strengthens mitigation by setting clear priorities, governance routes and actions for 2026/27.

Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales A Healthier Wales; A Resilient Wales; A More Equal Wales; A Wales of Cohesive Communities. IPC supports safer care, prevention, resilience and reduced avoidable harm.

Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Learning, improvement and research

	Data to knowledge; learning, improvement and research; whole-system perspective; leadership, culture and valuing people. The report uses surveillance, audit, PPS and outbreak learning to drive improvement.

Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental Sustainability Impact (5Rs)	Positive / Reduce
	The report supports appropriate reduction in unnecessary glove/PPE use, waste reduction and value-based care. No adverse environmental impact is expected from receiving the report.

Asesiad Effaith Impact Assessment		
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg *(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)* Equality & Welsh Language Impact Assessment Outcome *(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)*	Outcome for Equality: NEUTRAL/POSITIVE Summary of impact: No negative equality impact identified. The report supports safer, more reliable IPC practice for all patients, staff and visitors, including vulnerable groups at higher risk of infection. Outcome for Welsh Language: NEUTRAL Summary of impact: No adverse Welsh Language impact identified. Communication materials and patient-facing information should continue to follow Health Board Welsh Language requirements.	Not applicable – EWLIA completion not required for this assurance cover report. Executive sponsor sign-off: Executive Director of Nursing, Midwifery and Patient Care

Canlyniad Asesiad Effaith Ansawdd *(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)* Quality Impact Assessment Outcome *(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)*	Positive. The report directly supports the Duty of Quality by strengthening assurance on safe, effective, person-centred care, reducing avoidable infection-related harm and identifying priority actions for 2026/27. A separate full QIA is not required for receiving the annual assurance report; individual improvement programmes or service changes should complete QIA/EQIA as required.
Cyfreithiol / Legal	Yes – supports compliance with the Welsh Government HCAI Code of Practice, Health and Care Standards, Duty of Quality and IPC governance requirements.
Enw da / Reputational	Yes – transparent assurance on HCAI, outbreaks, training and infrastructure risks supports public confidence. Failure to act could increase reputational risk.
Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	Yes – delivery requires care group leadership time and continued specialist/partner input. Some infrastructure actions may require capital or service investment; appropriate glove use demonstrates financial and sustainability benefit.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Infection Prevention and Control Committee / IPC governance route	09/06/2026	Reviewed and supported for onward approval.
Executive Director of Nursing / DIPC and IPC Senior Leadership Team	2025/26 and 2026/27	Key risks, assurance position and priorities reviewed through routine governance and operational escalation.
Quality, Safety & Experience Committee	21 July 2026	ENDORSED

Acronyms / Glossary of Terms	
ANTT	Aseptic Non-Touch Technique
BBE	Bare Below the Elbow

CDI	Clostridioides difficile infection
CTMUHB	Cwm Taf Morgannwg University Health Board
HCAI	Healthcare-associated infection
HCID	High Consequence Infectious Disease
IPC / IPCC	Infection Prevention and Control / Infection Prevention and Control Committee
OMB	Operational Management Board
PHW	Public Health Wales
PPE	Personal Protective Equipment
PPS	Point Prevalence Survey
IMTP	Integrated Medium Term Plan
EQIA	Equality Impact Assessment
QIA	Quality Impact Assessment

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

IPC Annual Report 2025-26

Creating Health, Sustaining our Future, Improving Care and Inspiring People



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Executive Summary

This Annual Infection Prevention and Control (IPC) Report provides the Health Board's review of infection prevention, healthcare-associated infection surveillance, outbreak management, decontamination, environmental risk, training, audit and strategic service development during the 2025/26 financial year. The report demonstrates a service that has strengthened its infrastructure and visibility during the year, while also operating within a complex infection prevention environment characterized by community-onset infection burden, winter pressures, antimicrobial resistance, estate constraints and variable compliance with core IPC behaviors.

The overall assurance position is mixed. CTMUHB compares favorably with the all-Wales position for several key organisms, including Clostridioides difficile, Pseudomonas aeruginosa and Staphylococcus aureus; however, Gram-negative bloodstream infection remains the most important epidemiological challenge, particularly E. coli and Klebsiella spp. bacteremia, where CTMUHB remains above the Wales benchmark. The Health Board achieved a reduction in hospital-onset E. coli and hospital-onset Pseudomonas aeruginosa, but the overall Gram-negative burden continues to be influenced by community-onset infection and device-related risks, especially urinary catheter-associated pathways.

C. difficile remains a central area of concern. Although the Health Board remains below the all-Wales rate, the annual position does not demonstrate the scale of improvement required to meet the 25% reduction ambition. The data show that the overall burden is predominantly community onset, while hospital-onset cases account for approximately 37% of cases. This means that acute controls remain essential, but they will not be sufficient on their own. A more ambitious cross-system Programme is required, incorporating antimicrobial stewardship, proton pump inhibitor review, primary care engagement, care-home and community pathways, postcode and deprivation analysis, timely isolation, environmental decontamination and strengthened case review.

The Health Board has made important progress in strengthening the IPC service model. The move towards a more integrated, Health Board-wide service has been supported by 12-hour IPC cover across acute sites, a weekend and bank holiday on-call arrangement, further development of the IPC Hub model, improved recruitment, and the continued growth of the Community IPC Team. These developments provide stronger resilience, better standardization and increased ability to respond to risk in real time. The Community IPC Team is particularly important because a sizable proportion of the infection burden is community onset, and sustainable improvement requires IPC influence beyond acute hospital settings.

The point prevalence survey Programme has provided valuable real-time assurance on the reliability of fundamental IPC behaviors. Bare Below the Elbows compliance improved in several areas and repeat survey work demonstrated that targeted feedback can produce measurable improvement. However, the expanded POW survey showed that high BBE compliance does not automatically translate into reliable hand hygiene or appropriate PPE use. PPE practice, particularly inappropriate glove use and failure to remove or change PPE between contacts, remains a key behavioural risk. These findings support the need for continued observational audit, leadership accountability, behavior-change methodology and integration of PPS findings with training, HCAI review, outbreak learning and sustainability work.

Financial stewardship and sustainability have also been strengthened through work on appropriate glove use. Non-sterile examination glove use reduced by approximately 605,800 individual gloves, with a related non-sterile spend reduction of approximately £20,658 and an overall examination-glove spend reduction of approximately £25,682 when sterile and non-sterile categories are combined. This

should be described as a quality, safety, sustainability and value outcome that is likely to have been at least partially supported by PPS and PPE/BBE improvement work. It should not be presented as solely caused by IPC intervention, as glove consumption is also affected by clinical activity, case mix, procurement, outbreak pressure and stock management.

Outbreaks and periods of increased incidence continued to place substantial operational pressure on the Health Board. The annual dataset records 86 outbreaks/PII, affecting 729 patients and 140 staff, with 652 bed days lost. Q4 was the most pressured period, reflecting winter viral activity and the system impact of influenza, norovirus and other transmissible infections. The report demonstrates that outbreak management requires a whole-system model, involving IPC, clinical teams, site management, patient flow, microbiology, facilities, estates, occupational health and executive leadership.

Training compliance remains one of the clearest Organisational risks. Overall IPC training compliance remains below the expected standard at approximately 78%, with particularly low compliance among Medical and Dental staff. This is not simply a training-delivery issue for the IPC team; it is a governance and leadership issue requiring care group ownership, professional accountability, and performance management. Low compliance weakens assurance that staff consistently understand and apply standard infection control precautions, ANTT, device care, antimicrobial responsibilities, isolation principles and PPE requirements.

The annual report also identifies continuing risks in blood culture contamination, ANTT assurance, decontamination resilience, ventilation safety, isolation capacity, HCID preparedness and the need for stronger digital capture of learning and actions. Work to improve caesarean section SSI surveillance, including standardization of training and linkage of SSI data with ICNet, is an important example of how the Health Board is seeking to strengthen case visibility, validation and timely investigation.

The following summary should support discussion at Infection Prevention and Control Committee and Executive level:

Assurance theme	Annual position	Executive implication
HCAI performance	Favorable against Wales for CDI, Pseudomonas and Staphylococcus aureus; above Wales for E. coli and Klebsiella spp.	Gram-negative reduction and CDI prevention require Board-level oversight and cross-system ownership.
Service model	12-hour acute-site cover, weekend/bank holiday on-call, IPC Hub development and improved recruitment have strengthened resilience.	The service is better placed to respond to risk, but impact evaluation and completion of remaining recruitment are required.
Community IPC support	Community IPC capacity has developed and links with PHW, local authorities, care homes and wider partners are improving.	Community-onset infection cannot be reduced through acute action alone; primary and community work must be central to 2026/27 plans.
Behavioral assurance	PPS work shows improvement in BBE but ongoing variation in hand hygiene and PPE use.	PPE misuse and variable HH require behaviour-change methods, ward leadership and repeated measurement.
Training compliance	Overall compliance remains below target, with Medical and Dental staff compliance particularly low.	This should be escalated as a leadership and care group accountability issue, not solely an IPC team issue.
Outbreak pressure	86 outbreaks/PII, 729 patients affected, 140 staff affected and 652 bed days lost.	Winter resilience and outbreak governance remain key operational risks.
Infrastructure and specialist systems	Decontamination, ventilation, isolation and HCID preparedness risks remain active.	Capital, estates, decontamination and IPC governance must remain aligned through risk registers and committees.
Sustainability and value	Substantial reduction in non-sterile glove use and overall glove spend.	Appropriate PPE use can support safety, sustainability and value, but attribution should remain cautious and evidence-based.

Key messages for the Committee and Executive Team

- IPC improvement must continue to be owned from ward to Board, with clear care group accountability for training, practice standards, outbreak response and delivery of actions arising from HCAI reviews.
- The Health Board should prioritize Gram-negative bloodstream infection and CDI as the major infection-reduction programmes for 2026/27, with explicit acute, community, primary care and antimicrobial stewardship components.
- PPS should remain a core assurance and improvement methodology because it provides direct evidence of observed practice, identifies behavioral risk and supports targeted intervention.
- Training compliance, blood culture contamination and ANTT assurance should be treated as linked indicators of clinical practice reliability.
- Decontamination, ventilation, isolation capacity and HCID preparedness should remain visible within Organisational risk and capital prioritization processes.
- The strengthened IPC service model provides a stronger platform, but the next phase must demonstrate measurable impact on infection outcomes, compliance, timeliness of review and sustained behavioral improvement.

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0 - INTRODUCTION

This Annual Infection Prevention and Control Report presents the position of Cwm Taf Morgannwg University Health Board (CTMUHB) for the 2025/26 financial year. It provides assurance on the governance, surveillance, prevention and control arrangements in place to reduce healthcare-associated infections, protect patients, staff and visitors, and support safe, effective care across acute, community and wider health and care settings.

Infection prevention and control is a fundamental component of patient safety and quality. It is also a whole-system responsibility. The prevention of healthcare-associated infection depends on the reliability of everyday clinical practice, the quality of the care environment, safe antimicrobial use, effective surveillance, rapid outbreak response, safe decontamination, adequate ventilation and isolation capacity, and the ability of staff at every level to recognize and act on infection risks. This report therefore reviews not only infection rates, but also the systems, behaviors and infrastructure that determine whether infection prevention practice is reliably delivered.

The report is aligned to the Welsh Government Code of Practice for the Prevention and Control of Healthcare Associated Infections, Health and Care Standards, national surveillance requirements and local governance arrangements. It also reflects the strategic direction of the Health Board and the need to embed infection prevention as a core element of safe care, operational resilience, quality improvement and public confidence.

The year has been characterized by a mixed epidemiological position. CTMUHB has performed favorably against Wales for some organisms, including C. difficile, Pseudomonas aeruginosa and Staphylococcus aureus, and has achieved important reductions in selected hospital-onset infections. However, Gram-negative bloodstream infection remains a significant challenge, particularly E. coli and Klebsiella spp. bacteremia, where CTMUHB remains above the all-Wales benchmark. C. difficile also requires sustained focus, as the overall burden remains strongly influenced by community-onset cases and the Health Board is not yet improving at the pace required to meet the national reduction ambition.

Operationally, the year has also been shaped by winter viral activity, norovirus and other outbreaks, high bed occupancy, pressure on side rooms, environmental decontamination challenges and the continuing need to balance patient flow with infection prevention requirements. These pressures reinforce that IPC cannot be delivered by specialist teams in isolation. Effective prevention requires visible clinical leadership, operational ownership, estates and facilities support, microbiology and pharmacy input, occupational health engagement, partnership with Public Health Wales and local authorities, and executive-level accountability.

During 2025/26 the IPC service has continued to develop. The introduction of 12-hour acute-site support, weekend and bank holiday on-call arrangements, further development of the IPC Hub model, improved recruitment and expansion of the Community IPC Team have strengthened the Health Board's ability to provide timely advice, respond to outbreaks, support clinical areas and extend IPC influence beyond the acute hospital environment. These service changes are important because a large proportion of infection risk sit across pathways rather than within hospital walls alone.

A key feature of the year has been the increased use of point prevalence surveys to assess observed practice. These surveys have provided practical assurance on BBE, hand hygiene and PPE use and have identified areas where improvement is possible and necessary. They have also highlighted the link between safe practice, sustainability and value, particularly in relation to appropriate glove use. The findings demonstrate that improvement is achievable when local data are shared, leadership is

visible and staff receive clear feedback; however, they also show that some behaviours remain inconsistent and require ongoing challenge.

The annual report should therefore be read as both an assurance document and an improvement document. It records areas of progress, but it also sets out where the Health Board must strengthen its controls. The priorities for 2026/27 must focus on converting learning into reliable practice, strengthening cross-sector prevention, improving training compliance, reducing Gram-negative and *C. difficile* infection burden, embedding surveillance and review processes, and ensuring that infrastructure risks remain visible and actively managed.

1-COMPLIANCE WITH THE CODE OF PRACTICE FOR THE PREVENTION AND CONTROL OF HEALTHCARE ASSOCIATED INFECTIONS - WALES

The Health Board has continued to maintain the Organisational infrastructure required to support IPC governance. This includes the Infection Prevention and Control Committee (IPCC), quarterly reporting, escalation of risks through appropriate governance routes, microbiology and laboratory support, policy review, surveillance through ICNet and HARP, RCA/review processes, environmental auditing, water and ventilation safety groups and decontamination governance.
The annual position demonstrates evidence of compliance across the key domains of the Code of Practice. However, the assurance position is not static. Several areas require continued focus: training compliance remains below the desired threshold; site-level variation in testing and microbiology pathways continues to complicate standardization; decontamination and ventilation risks remain active; and infection review processes require further strengthening to ensure learning is captured and acted upon rapidly.

Code domain	Annual evidence and assurance narrative	Gaps in assurance, mitigation actions and comments	Compliance rating
1. Appropriate Organisational governance, accountability and management systems	Board-level IPC leadership is in place through the Nurse Director, IPCC, quarterly IPC reporting, annual reporting, risk-register review, IPC strategy implementation, daily IPC site plans, ICNet/HARP surveillance and access to microbiology advice. These arrangements provide clear core governance from Board to ward.	Assurance can be improved due to limitations derived by tightening RCA timeliness, incomplete electronic learning/action tracking, training compliance below target and the need to further strengthen ward-to-Board escalation. Mitigation is to embed a lessons-learned matrix. There are also plans to create a board assurance framework to further strengthen the assurances in this domain,	**2. Compliant**
2. Decontamination of care equipment and medical devices	A Decontamination Specialist/Officer is in post; decontamination committee/site meetings, traceability systems, policies, protein testing, sterile services and endoscopy workstreams provide a recognized assurance structure. The annual report also describes ongoing central decontamination planning and service improvement activity.	There are active risks linked to ventilation constraints, refurbishment programmes and unresolved learning from the CJD investigation. Aim will be to work towards progress central decontamination, standardize equipment and close action logs through decontamination governance.	**2. Compliant**
3. Physical environment, cleaning and maintenance	Cleaning policy, National Standards of Cleanliness monitoring, AMaT environmental audits, facilities engagement, HPV/UV capability and capital/refurbishment input demonstrate active environmental IPC controls. IPC is sighted on estates work and provides advice on refurbishment and risk management.	Variation in audit performance, side-room pressure and inconsistent cleaning schedules reduce assurance. Mitigation is to strengthen joint IPC/facilities audits, implement new cleanliness standards, ensure facilities attendance at outbreak meetings, and prioritize capital and ventilation risks.	**2. Partially compliant**
4. Suitable, timely and accurate infection information and communication	IPC policies, isolation signage, ICNet alerts, daily IPC site plans, safe-to-start/site escalation meetings and outbreak cells provide multiple routes for timely communication to staff, patients, visitors and those responsible for care.	Assurance is constrained by the need for more consistent intranet/internet updates, clearer outbreak action logs, improved escalation from ward to site and more mature digital sitreps. Mitigation is to refresh IPC content, embed the outbreak framework and improve real-time reporting.	**2. Partially compliant**

Code domain	Annual evidence and assurance narrative	Gaps in assurance, mitigation actions and comments	Compliance rating
5. Staff engagement in preventing and controlling infection	Staff engagement is supported through mandatory IPC training, ANTT training, targeted education, audit feedback, point prevalence surveys for BBE/PPE, Datix/RCA processes, uniform/dress-code expectations and local leadership engagement.	Local ownership and behavioral compliance remain variable, with recurrent issues in BBE/PPE, ANTT and training uptake. Mitigation is to strengthen care group and professional accountability, implement IPC champions/link workers, continue PPS cycles, and ensure prompt escalation of repeated non-compliance.	**2. Partially compliant**
6. Suitable and sufficient isolation facilities	Single rooms are available across acute sites and IPC supports placement decisions through daily site planning, safe-to-start meetings, ICNet alerts for CPE/previous CDI and direct advice to patient-flow teams. Funding has been identified for negative-pressure rooms at RGH and POW.	Side-room scarcity, patient- lack of operational negative-pressure rooms in emergency departments remain significant risks (HB with lower number of negative pressures than recommended by WG). Mitigation is to progress the funded negative-pressure capital developments, maintain escalation for isolation delays, strengthen Datix reporting for failure to isolate and use risk-based placement protocols.	**2. Partially compliant**
7. Evidence-based IPC policies, NIPCM adoption and organism-specific guidance	IPC policies are in place and reviewed through IPCC; the NIPCM for Wales is used as the policy framework; core policy topics include SICPs, hand hygiene, PPE, transmission-based precautions, outbreak management, ANTT, HCAI reporting, antimicrobial stewardship, water, ventilation, and decontamination. Local work includes CDI, CSARO/CPE, CJD, TB, Candida auris, ARI, gastrointestinal infection and HCID preparedness.	Implementation assurance not consistent across all policies and several areas require clearer triggers, action tracking and local standardization,, CDI review documentation and decontamination. Limited number of staff trained on HCID, which limits the safe response capacity. Mitigation is audit implementation of high-risk policies, aiming at future measurement of implementation criteria within policies as well as ensure that PPS are looking into main policies implementations. Essential Care Group ownership	**2. Compliant**
8. Occupational health systems protecting staff from infection risk	Occupational Health arrangements support pre-employment assessment, staff immunization, exposure management, vaccination programmes, OH advice routes and outbreak support. IPC, OH and PHW collaboration supports staff protection for respiratory infections, HCID and vaccine-preventable diseases.	OH assurance reports to inform on immunization dashboards, clarify as well as fit testing compliance across the organization.	**2. Compliant**
9. Staff training, education and competence in IPC and decontamination	IPC Level 1 and Level 2 training, ESR monitoring, targeted training, ANTT training and decontamination education are available. The IPC team has delivered bespoke sessions and supports practice-development activity.	The Q4 position shows overall IPC training compliance of 78.09%, below the expected threshold, with Medical and Dental compliance at 38.22%. ANTT competency also requires strengthening. Mitigation is monthly compliance reporting, care group escalation, mapping to the All-Wales IPC Training and specialist workforce frameworks and role-based competency review.	**2. Partially compliant**
10. Organisation-wide antimicrobial stewardship programme	AMS is linked to CDI reviews, PPI review, microbiology advice, antimicrobial pharmacy input, QI collaboration, prescribing review and antimicrobial consumption data. The CDI workstream has strengthened collaboration between IPC, AMS, microbiology, PHW and epidemiology. The HB continues to be one of the highest prescriber of Antibiotics albeit significant improvements.	Mitigation is to expand community CDI review as well as support current project on community aiming at PPI dose reduction as prevention of CDiff.	**2. Partially compliant**
11. Compatibility of IPC with net zero and sustainability	IPC contributes to sustainability through safe reduction of unnecessary PPE use. The glove-use review shows 605,000 fewer non-sterile gloves used in 2025/26 compared with 2024/25, with a £20,685 reduction in non-sterile glove spend, plus a further £5,000 reduction in sterile glove spend despite a small increase in sterile glove-pair usage due to price change.	Attribution to PPS/BBE/PPE improvement is plausible but not definitive without triangulation against clinical activity, procurement trends and audit results. IPC works closely with QI team to support decarbonization changes.	**2. Compliant**

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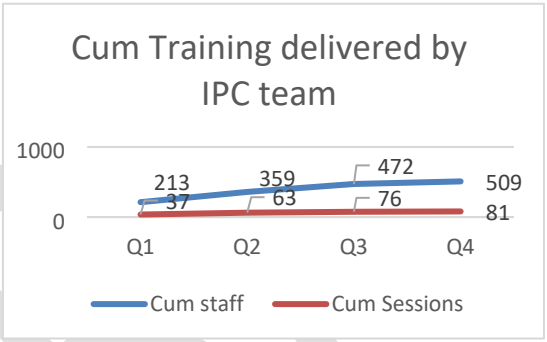
Code domain	Annual evidence and assurance narrative	Gaps in assurance, mitigation actions and comments	Compliance rating
12. Secure and adequate laboratory support	Accredited laboratory support, HARP/ICNet reporting, microbiology advice and surveillance data support IPC decision-making. Laboratory data underpin organism-specific monitoring, outbreak response and blood-culture contamination analysis.	Assurance is affected by laboratory capacity pressures, variation in diagnostic/testing methodology across sites and the need to standardize pathways for timely, equitable access. Mitigation is to review laboratory capacity, positivity and contamination rates, standardize testing pathways, and maintain microbiology escalation within IPCC and site governance.	**2. Partially compliant**

Table 1- Compliance review against the Code of Practice

2-TRAINING ACTIVITY AND WORKFORCE CAPABILITY

2.1-TRAINING DELIVERED

Training is in the core of the IPC role.
During the financial year the IPC team provided formal IPC training to 509 staff members (more 125 staff than last year - % increase) along the 4 quarters as shown in the following graphic:



Graphic 1 - IPC Cum Formal Training Provided per Quarter and staff attendance.

This only captures formal planned training delivery and not the opportunistic or delivered due to specific needs detected during IPC audits and investigations. IPC has supports other joint training initiatives such as Managing Safely, which is organized by the Heath and Safety department with a protected time for IPC training as well as the New Doctors Induction.

2.2-TRAINING ATTENDED

The IPC team continues to be an expert service to the Trust and have worked towards keeping their professional development up to date with the latest knowledge, enabling the team to provide a high level of support to the Health Board. It is essential that investment continues during this new financial year, to support the IPC team regarding it's knowledge development. For the new financial year, training should look into (not exclusively) preparing members of the team in key aspects such as water safety, decontamination and ventilations safety, due to the lack of expertise across the IPC team on this key areas. The IPC team will continue to endeavor to be present in other initiative such as National and Regional conferences and then ensure that all the learning is brought back to the organization, shared within the IPC team as well a broader audience and informs the IPC practices and advice.

Another internal initiative that has been put in place to ensure the team's knowledge is up to date and that all the team members possess the essential knowledge to be able to develop its role was the creatin of meeting every 2 months were several IPC teams are presented either by members of the team, other health experts within the Health Board and with some external speakers. The themes presented during the team meetings for shared learning were:

- *C. difficile* IPC Training
- ICNet Outbreak Management
- IPC in Mental Health
- Decontamination Endoscopes Ultrasound
- PPS BBE PCH
- ANTT Training for IPC team
- TB/NTM – A Whistle Stop Tour
- IPC Indications of CJD
- HLD Trophon Demonstration
- Legionella
- Consultation Project
- Multi Resistant Organisms
- HCID

The following table summarizes trainings attended by the team along the FY:

The following table summarizes other internal and external training attended by members of the IPC team - this is not an exhaustive list of training/courses attended:

Training	N staff attended
Decontamination and Sterilisation - Conference and discussion on current decontamination and sterilisation methods in use throughout healthcare,	1
Aspire - leadership and management course. - Cwm Taff provided leadership course covering the foundations of effective leadership and implementation in the workplace.	1
IP&C in Mental health - Conference discussing the challenges of IP&C practices in a MH setting. Demonstrations and ideas on overcoming these challenges.	2
MSc Module Epidemiology and Biostatistics - MSc module focusing on the epidemiology of disease and the impacts on population health. Focus on the transmission of pathogens and surveillance of emerging trends. Learning further focused on surveillance and collection of statistical data and utilising data to recognise emerging concerns.	1
Introduction to Hepatitis - Training course on being a compassionate leader and facilitating workshops to train others	1
Managing IPC in a mental health setting - Introduction to the complexities of managing IPC in a mental health environment.	1
Compassionate leadership course. - Training course on being a compassionate leader and facilitating workshops to train others	2
ANTT Assessor training - Training on principles of ANTT followed by practical assessment and assessment of assessing another colleagues	3
HCID – Train the trainer	1
Specialist ventilation systems for Healthcare	1
Specialist Decontamination for Healthcare	1

Combating CDI conference 2025 – Leeds	1
Cdiff learning session – PHW	1
Harp conference – IPC Summer Forum	3
IPC Conference 2025	2

Table 2- Training attended by the IPC team during the FY

2.3- IPC TRAINING COMPLIANCE

Training compliance remained one of the clearest Organisational risks throughout the year. The Q4 position reported overall IPC training compliance of 78.09%, which remains amber and below the expected target. Q2 compliance was 78.69%, indicating that improvement across the year was non-existent and therefore not sufficient to provide strong assurance.
The most concerning theme is the persistent low compliance among Medical and Dental staff. Q2 reported Medical and Dental compliance at 37.92%, the data indicated that there had been no significant improvement across the year (38.22% on Q4). This is important because clinical decision-making, antimicrobial prescribing, invasive device management, ANTT and patient placement decisions all require reliable IPC knowledge and ownership.
The report therefore concludes that training compliance cannot be treated as an IPC team issue alone. It requires care group leadership, professional group ownership, line-manager follow-up and integration into performance management. IPC can provide training, support, audit and specialist advice, but accountability for staff completion must sit clearly with clinical and managerial leadership.

The following tables and figures resume the data:

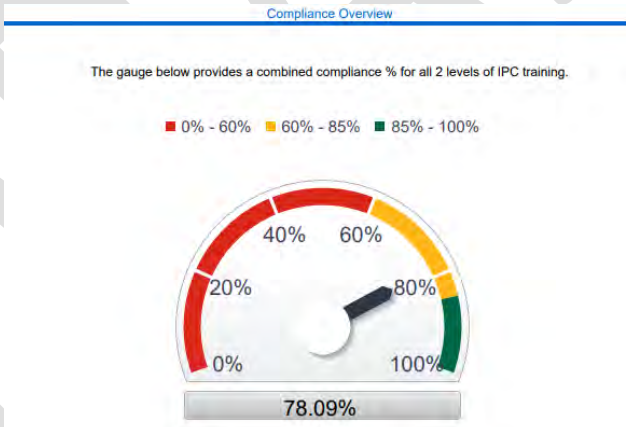


Figure 1 - Overall compliance with IPC mandatory training

As can be seen in above gauge, we have a sub-optimal compliance across both Level 1 and Level 2 training, leaving us in amber with only 78.09% with our staff completed the IPC training, if we look at both training by subject level:

Compliance by Subject Level

The table below provides a compliance percentage for each of the 2 levels of IPC training

Competence Full Name	Headcount	Competencies Required	Competencies In-date	Compliance %	Competencies Expiring in Next 90 Days	Predicted % in 90 Days
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	4465	4465	3749	83.96%	75	83.02%
NHS|CSTF|Infection Prevention and Control - Level 2 - 1 Year|	8702	8702	6533	75.07%	413	71.87%

Table 3 - Compliance with IPC mandatory training per Level

We can see that the lowest compliance is at Level 2, which is particularly concerning, because it is aimed to those staff that will be doing more invasive techniques with the patients and therefore will incur in higher risk of both causing infection or getting themselves infected.
To further understand this information, it is important to look at the compliance per staff group:

Compliance by Staff Group

The Table below provides an overall combined compliance % for each Staff Group

Staff Group	Headcount	Competencies Required	Competencies In-date	Compliance %	Competencies Expiring in Next 90 Days	Predicted % in 90 Days
Add Prof Scientific and Technic	420	427	327	76.58%	29	70.26%
Additional Clinical Services	2580	2580	2090	81.01%	130	77.79%
Administrative and Clerical	2629	2643	2224	84.15%	57	82.97%
Allied Health Professionals	822	822	670	81.51%	36	79.08%
Estates and Ancillary	1377	1378	1145	83.09%	9	82.58%
Healthcare Scientists	223	223	186	83.41%	4	82.96%
Medical and Dental	874	874	334	38.22%	21	36.73%
Nursing and Midwifery Registered	4220	4220	3306	78.34%	202	75.05%

Table 4- Compliance with IPC mandatory training per Staff Group

The data clearly highlights that the Medical and Dental staff group has the lowest compliance by a significant margin, with only 38.22% (albeit an improvement of 9,63% from last FY), followed by the Professional, Scientific, and technical group at 76.58% (15.32% increase from last FY). Conversely, the Administrative and Clerical staff demonstrate the highest compliance, despite their typically lower risk of patient interaction. Nurses and Midwives also show suboptimal compliance at 73.94%.
If we look at the data from a care group perspective:

Compliance by Care Group

The Table below provides an overall combined compliance % for each Care Group

Care Group	Headcount	Competencies Required	Competencies In-date	Compliance %	Competencies Expiring in Next 90 Days	Predicted % in 90 Days
110 Bank Care Group	2	2	1	50.00%	0	50.00%
110 Chief Operating Officer Care Group	1302	1303	1051	80.66%	10	80.12%
110 Children & Families Care Group	1445	1454	1064	73.18%	54	70.63%
110 Corporates and Hosted Care Group	1372	1373	1177	85.72%	23	84.85%
110 Diagnostics, Therapies, Pharmacy & Sciences Care Group	1757	1757	1433	81.56%	77	78.49%
110 Mental Health & Learning Disabilities Care Group	1255	1259	1020	81.02%	45	79.03%
110 Planned Care Care Group	2399	2405	1757	73.06%	92	70.44%
110 Primary & Community Care Group	1646	1647	1382	83.91%	85	80.39%
110 Unscheduled Care Care Group	1967	1967	1397	71.02%	102	67.72%

Table 5- Compliance with mandatory training per Care group

With exception corporate and hosted care group, all the other areas have low scores, in particular Unscheduled care and Planned care (Bank care group shows 50% compliance but has only 2 staff members attributed).
This overall compliance picture is concerning. Without a robust understanding of their responsibilities and effective infection prevention practices, staff are inadvertently placing patients, themselves, and the wider community at unnecessary risk, contravening the fundamental Hippocratic principle of '*Primum non nocere*' (First, do no harm).
Strategies to improve the compliance have been discussed between IPC and the Executive Director of Nursing but will require active participation of the organizational leadership to find workable solutions to improve compliance to a level that can provide adequate assurance on the delivery of safe care

3 – IPC SERVICE MODEL, STAFFING AND STRATEGIC DELIVERY

3.1 - OVERVIEW AND STRATEGIC CONTEXT

The 2025/26 financial year represented a significant period of consolidation and development for the Infection Prevention and Control (IPC) service across Cwm Taf Morgannwg University Health Board (CTMUHB). The service has moved from a predominantly site-based and reactive model towards a more coordinated, resilient and strategically directed service model, designed to support consistent infection prevention practice across all three acute hospital sites and across wider community interfaces.

This development has been necessary because the infection prevention landscape facing the Health Board has become increasingly complex. The organisation continues to manage persistent healthcare-associated infection risks, increasing antimicrobial resistance, significant winter respiratory pressures, environmental and estate constraints, decontamination challenges, and a high burden of community-onset infection. These risks require an IPC model that is visible, responsive and clinically embedded, but also sufficiently strategic to influence organisational systems, workforce behaviours and partnership working beyond the acute hospital setting.

The revised service model is therefore based on three linked principles: consistent access to specialist IPC advice, greater operational resilience across sites, and stronger strategic alignment between acute, community, microbiology, antimicrobial stewardship, estates, facilities, decontamination, Public Health Wales and local authority partners. These principles underpin the work described in this chapter and provide the foundation for the wider infection reduction programme set out across the Annual Report.

3.2 - DEVELOPMENT OF THE ACUTE IPC SERVICE MODEL

During the year, the IPC service continued to embed a more integrated acute-site support model. The model has strengthened the ability of the team to provide timely advice to clinical areas, support outbreak management, attend site escalation discussions, advise on isolation and patient placement,

and respond to areas of concern identified through surveillance, audit, incident review or operational escalation.

A key development has been the provision of 12-hour IPC support across all three acute sites. This has significantly increased the visibility and availability of the IPC team, particularly at times when clinical and patient-flow decisions are most likely to require rapid specialist input. The enhanced model supports clinical areas during extended daytime operational hours and enables IPC advice to be more closely aligned with real-time bed management, escalation meetings, outbreak control, environmental risk assessment and urgent clinical decision-making.

The extended acute-site model also provides greater equity of access across Prince Charles Hospital, Royal Glamorgan Hospital and Princess of Wales Hospital. This is important because each site has a different infection profile, estate configuration, patient-flow challenge and microbiology interface. A more consistent service model helps reduce variation in practice, strengthens the standardisation of advice, and supports a common approach to the implementation of Health Board policy and national guidance.

3.3 - ON-CALL SUPPORT DURING WEEKENDS AND BANK HOLIDAYS

In addition to the enhanced weekday model, the IPC service now provides an on-call service during weekends and bank holidays. This is a substantial improvement in service resilience and organisational response capacity. The on-call arrangement enables urgent IPC issues to be escalated and reviewed outside standard working patterns, including suspected or confirmed outbreaks, complex isolation decisions, significant environmental concerns, and urgent advice relating to transmissible infections.

This arrangement complements, rather than replaces, existing 24-hour microbiology advice. It provides a specialist IPC operational route for escalation when infection prevention decisions have immediate implications for patient safety, ward function, outbreak control or service continuity. The model has improved the Health Board's ability to maintain safe IPC practice during periods of reduced staffing, increased demand and heightened operational pressure.

The weekend and bank holiday provision has also improved continuity of advice. Previously, some IPC issues could only be reviewed retrospectively on the next working day unless urgent microbiology input was required. The new arrangement allows the organisation to act earlier, support clinical teams more consistently, and reduce the risk of delays in implementing transmission-based precautions, outbreak measures or environmental controls.

3.4 - CENTRAL COORDINATION, HUB WORKING AND STANDARDISATION

The development of the IPC Hub model has continued to be a central element of the service redesign. The Hub provides a coordinated point of oversight for operational IPC activity, supporting triage of requests, daily review of emerging risks, allocation of IPC resource, escalation of significant concerns and consistency of advice across the Health Board. This approach has strengthened the ability of the team to work as one Health Board service rather than as separate site-based functions.

Hub working supports resilience by enabling staff to be deployed according to risk, demand and capacity. It also supports improved governance because queries, outbreaks, audit findings, surveillance concerns and follow-up actions can be considered within a single operational framework.

This has helped improve situational awareness across the service and has supported more consistent communication with Heads of Nursing, site teams, patient-flow colleagues and operational managers.

The model has also supported the development of more standardised IPC processes. This includes alignment of outbreak recording, escalation routes, review documentation, audit feedback, surveillance follow-up and dissemination of learning. While further work remains to embed all elements of the model fully, the direction of travel is positive and has already increased the responsiveness and cohesion of the IPC service.

Service component	2025/26 position and assurance	Further development / next steps
Acute-site IPC support	A 12-hour IPC support model is now in place across all three acute sites, improving real-time access to specialist IPC advice, supporting patient-flow decisions and increasing visibility in clinical areas.	Continue to monitor demand, response times and consistency of advice across sites; ensure escalation pathways remain clear and sustainable.
Weekend and bank holiday on-call service	An IPC on-call service is now available during weekends and bank holidays, strengthening organisational resilience and enabling urgent infection prevention risks to be reviewed earlier.	Develop ongoing evaluation of call themes, frequency and learning to ensure the model remains proportionate and clinically effective.
Centralised Hub model	The Hub has improved triage, coordination, resource allocation, standardisation and oversight of emerging risks across the Health Board.	Continue to embed Hub processes, strengthen documentation and align digital systems to support robust governance.
Outbreak response	The strengthened model has improved responsiveness to outbreaks and incidents by supporting earlier advice, escalation, site ownership and multidisciplinary coordination.	Maintain focus on consistent outbreak documentation, lessons learned and post-incident review across all sites and community interfaces.
Community IPC Team	The Community IPC Team has been developed as a key strategic extension of the IPC service, with growing links to Public Health Wales, local authorities and community providers.	Further detail on CIPCT delivery is set out later in the report; priority work includes GP engagement, care home support and wider community surveillance.
Education and practice support	The IPC service has increased clinical-area visibility, supported targeted education, and contributed to staff awareness through site work, training and improvement initiatives.	Continue targeted education based on risk, audit findings, outbreak learning, HCAI reviews and areas of low compliance.
Strategic delivery and governance	IPC reporting through the Infection Prevention and Control Committee continues to provide formal oversight, escalation and assurance against national and local priorities.	Strengthen links between IPC strategy, Board Assurance Framework evidence, operational risk registers and measurable improvement outcomes.

Table 6 - IPC service model and assurance summary

3.5 - STAFFING POSITION, RECRUITMENT AND TEAM RESILIENCE

The staffing position within the IPC service has improved significantly during the year. Recruitment to vacant posts has progressed well and the service has now nearly recruited to all vacancies, with the exception of one Band 7 role. This represents a substantial improvement in the service's ability to maintain continuity, provide cross-site support and respond to both planned and unplanned infection prevention pressures.

The improved staffing position has had a direct impact on team resilience. Greater staffing stability has enabled more reliable site presence, improved cover arrangements, stronger internal support, increased capacity to participate in meetings and reviews, and better ability to maintain core functions during periods of annual leave, sickness absence or operational escalation. It has also supported the development of a more flexible workforce, with staff increasingly able to work across site boundaries and contribute to Health Board-wide priorities.

Although the position is substantially improved, the remaining Band 7 vacancy remains important. Band 7 capacity is central to senior operational leadership, complex case management, staff

supervision, escalation management, audit oversight and the translation of strategic priorities into day-to-day practice. Recruitment to this post should therefore remain a priority, both to complete the staffing establishment and to protect the sustainability of the expanded service model.

The service has also continued to strengthen internal ways of working. This includes clearer allocation of responsibilities, more consistent escalation, greater sharing of learning across sites, and improved coordination between acute and community IPC work. These developments are essential because the IPC agenda cannot be delivered through individual expertise alone; it requires a stable team infrastructure, consistent leadership, effective communication and an organisational model that allows specialist advice to be deployed where it is needed most.

Area	Current position	Assurance and continuing focus
Recruitment	Almost all vacancies have been recruited to, with one Band 7 vacancy remaining.	This provides significantly improved stability and capacity. The remaining vacancy should be prioritised to protect senior operational resilience.
Site coverage	The service now provides 12-hour support across all three acute sites.	This increases visibility, responsiveness and equity of specialist IPC advice across CTMUHB.
Out-of-hours resilience	Weekend and bank holiday on-call IPC support is in place.	This improves continuity and enables earlier action for urgent IPC risks outside standard working patterns.
Cross-site working	The Hub model enables more flexible deployment of IPC staff according to risk, capacity and demand.	Further embedding will support standardisation, reduce variation and improve organisational learning.
Community capacity	The Community IPC Team has become an increasingly important part of the service model.	Further development will support the Health Board response to community-onset infections and provider-facing IPC risks.
Leadership and supervision	Improved staffing has strengthened the ability to support staff, manage escalation and maintain core service delivery.	Continued focus is required on succession planning, staff development and senior clinical leadership.

Table 7- Staffing and resilience summary

3.6 - PROFESSIONAL LEADERSHIP, GOVERNANCE AND SPECIALIST ADVICE

The IPC service continues to provide specialist professional leadership across a broad range of infection prevention functions, including surveillance, outbreak management, HCAI review, audit, training, policy development, decontamination advice, environmental risk management and clinical practice improvement. The service operates within the governance structure provided by the Infection Prevention and Control Committee, which remains the primary forum for oversight, escalation and assurance.

Professional leadership has been strengthened through closer working with microbiology, antimicrobial stewardship, estates, facilities, decontamination, occupational health, patient safety and operational site teams. These relationships are critical because many infection prevention risks sit at the interface between clinical practice, infrastructure, patient flow, antimicrobial use and environmental management. The ability of IPC to influence these systems is therefore as important as the ability to provide direct advice to individual clinical areas.

The service has continued to support the development and implementation of Health Board policies, guidance and toolkits. This includes work to standardise outbreak management, support early escalation of transmissible infections, improve assurance on environmental decontamination, strengthen learning from HCAI reviews and provide advice on emerging risks. The continued alignment of IPC policy, surveillance, audit and governance is essential to ensuring that the Health

Board can evidence compliance with the Welsh Code of Practice for the Prevention and Control of Healthcare Associated Infections.

3.7 - COMMUNITY IPC TEAM AND SYSTEM-WIDE PARTNERSHIP WORKING

The development of the Community Infection Prevention and Control Team (CIPCT) is one of the most strategically important changes to the IPC service model. The detailed work of the CIPCT is explored further later in this report; however, its establishment is also central to this chapter because it changes the reach and purpose of the IPC service. It recognises that infection prevention cannot be delivered solely through acute hospital interventions and that a significant proportion of the Health Board's infection burden is community onset.

Significant work has been undertaken to build effective working relationships with Public Health Wales and local authority partners. These relationships are essential to ensuring a coordinated response to infection risks across care homes, supported living settings, domiciliary care, community services and other non-acute environments. During the year, the team has supported partnership responses to outbreaks and incidents, including COVID-19 and scabies, helping to strengthen communication, clarify roles and improve consistency of advice across organisational boundaries.

The partnership approach with Public Health Wales and local authorities has also supported a clearer understanding of the respective responsibilities of each organisation in managing community infection risks. This is particularly important where outbreaks affect vulnerable populations, where care providers require practical IPC support, or where multiple agencies need to coordinate risk assessment, communication, control measures and recovery planning.

The service is now progressing work to establish stronger working relationships with general practices. This is an important next stage because primary care has a central role in antimicrobial stewardship, early identification of infection risk, management of long-term conditions, wound care, urinary catheter management, vaccination, patient advice and referral into wider services. Building effective links with GPs will support a more joined-up approach to community-onset infections and will help ensure that learning from surveillance and HCAI review can inform practice across the whole patient pathway.

The strengthening of community partnerships should also support future work on surveillance, education, risk-based visits, outbreak learning and targeted improvement in settings where IPC expertise has historically been more difficult to access. While the team is still developing, the direction is positive and the early investment in relationships is an important foundation for future delivery.

3.8 - EDUCATION, CLINICAL VISIBILITY AND PRACTICE DEVELOPMENT

Education and clinical visibility remain core functions of the IPC service. The expanded service model has created greater opportunity for IPC staff to work directly with clinical teams, reinforce standard precautions, support local risk assessment, provide targeted training and respond to practice issues identified through audits, outbreaks, HCAI reviews and incident investigations.

The service has continued to emphasise that infection prevention is everyone's responsibility and must be embedded into routine clinical practice. This includes hand hygiene, bare below the elbows, safe

use of personal protective equipment, appropriate specimen collection, early isolation, safe management of invasive devices, environmental cleanliness and timely escalation of suspected infection risks. The value of IPC education is greatest when it is linked to real clinical scenarios and delivered in a way that helps staff understand why specific practices are required.

The improved staffing position and extended site presence support this more practice-focused model. Rather than relying solely on formal training, the service is increasingly able to provide advice in context, reinforce learning at ward level, support local leadership and respond to areas where compliance or assurance is variable. This approach is particularly important where audit findings, outbreak investigations or HCAI reviews identify recurrent themes requiring immediate feedback and sustained behavioural change.

3.9 - STRATEGIC DELIVERY DURING 2025/26

The IPC service has made significant progress against the strategic direction set out for 2025/26. The main achievement has been the strengthening of the service infrastructure itself: extended acute-site support, an IPC on-call model for weekends and bank holidays, improved recruitment, greater team resilience, continued development of the Hub model, and the establishment and early growth of the Community IPC Team.

These developments have increased the Health Board's capacity to respond to infection risks in a more timely and coordinated way. They have also improved the ability of IPC to contribute to wider organisational priorities, including patient safety, quality improvement, winter resilience, safe patient flow, antimicrobial stewardship, care home support, decontamination assurance and compliance with national standards.

The strategic delivery of IPC during the year should therefore be viewed not only through individual infection outcomes, but also through the strengthening of the systems required to reduce infection risk. The service is now better placed to identify risk, escalate concerns, support clinical areas, work across organisational boundaries and provide assurance to the Health Board. This improved infrastructure will be essential to sustaining progress during 2026/27.

Strategic objective	Progress during 2025/26	Impact on assurance
Improve responsiveness	Introduced 12-hour support across all acute sites and weekend/bank holiday on-call IPC arrangements.	Improved ability to provide timely advice, support outbreak control and reduce delays in IPC decision-making.
Strengthen resilience	Recruitment has progressed significantly, with only one Band 7 vacancy remaining.	Improved continuity, cross-site cover, staff deployment and ability to maintain service delivery during periods of pressure.
Standardise practice	Continued development of Hub working, common escalation routes and consistent advice across sites.	Supports more equitable access to IPC expertise and reduces variation in practice.
Extend IPC beyond acute settings	Developed the Community IPC Team and strengthened links with Public Health Wales and local authorities.	Improves the Health Board’s ability to influence community-onset infection risks and support providers outside hospital.
Develop system partnerships	Supported partnership management of COVID-19 and scabies outbreaks and began progressing GP relationship-building.	Strengthens multidisciplinary and multi-agency response to infection risks across the wider health and care system.
Embed strategic governance	Continued quarterly reporting and escalation through the Infection Prevention and Control Committee.	Provides Board-level assurance, visibility of risks and oversight of improvement actions.

Table 8 - Strategic delivery summary

3.10 - AREAS REQUIRING CONTINUED DEVELOPMENT

Although the IPC service model has strengthened considerably, further development is required to ensure that the new arrangements are fully embedded and sustainable. The priority is to complete recruitment to the remaining Band 7 vacancy and maintain the staffing stability required to deliver the expanded model. The service should also continue to evaluate the impact of 12-hour acute-site support and weekend/bank holiday on-call arrangements, ensuring that the model remains proportionate to demand and aligned to patient safety risk.

There is also a need to continue embedding the Hub model so that it becomes the consistent operating framework for the whole service. This includes strengthening documentation, improving the visibility of demand and response activity, standardising escalation pathways, and ensuring that learning from outbreaks, HCAI reviews and audits is translated into measurable action. A more structured approach to capturing themes and outcomes will support stronger assurance and allow the Health Board to demonstrate the impact of IPC interventions more clearly.

For the community service, the next stage is to consolidate relationships with Public Health Wales and local authorities while extending partnership working to general practice. This will be important in supporting antimicrobial stewardship, early recognition of infection risk, care home support, management of community outbreaks and targeted work on community-onset infections. The success of the community model will depend on clear pathways, shared expectations and practical mechanisms for joint working across Organisational boundaries.

- Complete recruitment to the remaining Band 7 vacancy and protect senior operational resilience.
- Evaluate demand, themes and outcomes from the 12-hour acute-site model and weekend/bank holiday on-call service.
- Continue embedding Hub processes, including triage, escalation, documentation and cross-site deployment.
- Strengthen community IPC pathways with Public Health Wales, local authorities, care providers and general practice.
- Improve the capture and dissemination of learning from outbreaks, HCAI reviews, audits and incident investigations.
- Ensure that staffing, service model and strategic delivery risks remain visible through IPCC, risk registers and the Board Assurance Framework.

3.11 - SUMMARY POSITION

The IPC service is now in a significantly stronger position than at the start of the reporting period. The introduction of 12-hour support across all three acute sites, the development of weekend and bank holiday on-call arrangements, the near-completion of recruitment to vacant posts, and the continued implementation of the Hub model have substantially increased the service's responsiveness and resilience.

The growth of the Community IPC Team has also strengthened the strategic reach of the service. Although this work is described in greater detail later in the report, the development of relationships with Public Health Wales, local authorities and emerging links with general practice demonstrates a clear move towards a whole-system infection prevention model. This is essential if CTMUHB is to reduce the burden of healthcare-associated and community-onset infections across the full patient pathway.

Overall, the service model is now better aligned to the current infection prevention risk profile of the Health Board. It provides stronger acute-site support, improved out-of-hours resilience, greater standardization, better partnership working and a more stable staffing platform. The priority for 2026/27 will be to consolidate these improvements, evidence their impact, complete the remaining recruitment, and ensure that the enhanced IPC model continues to support safe, high-quality care across acute and community settings.

4-ANNUAL AUDIT AND INSPECTION PROGRAM

The IPC team continued to move away from a static annual audit schedule towards a more responsive 'areas of concern' model. This approach uses AMaT submissions, outbreak intelligence, incident data, environmental concerns and local knowledge to identify areas requiring targeted support or checkpoint audit. The model is better aligned to risk because it allows IPC resource to be deployed where assurance is weakest or where harm is most likely.
Point-prevalence surveys were a major feature of the year. They provided rapid, visible and practical assurance on whether expected standards were being delivered in day-to-day practice. BBE and PPE-focused PPS work provided direct feedback to wards, recognized areas of strong compliance and identified areas requiring focused intervention.
The PPS Programme is especially important because it converts policy expectations into observed practice. It also provides an evidence base for action: where compliance is high, the report can describe and celebrate good practice; where compliance is weak, it allows targeted improvement rather than generic messaging.

4.1 PPS - PURPOSE AND SCOPE

This chapter summarizes the point prevalence survey (PPS) Programme undertaken across Princess of Wales Hospital (POW) and Royal Glamorgan Hospital (RGH) during the reporting period and immediately following year-end. The surveys provide direct observational assurance on whether core infection prevention and control (IPC) standards are being translated into routine practice at ward and staff-group level.
The principal focus of the Programme was Bare Below the Elbows (BBE), with the later POW survey extended to include hand hygiene (HH) and personal protective equipment (PPE). Collectively, these studies provide a practical measure of staff behaviors that are fundamental to reducing healthcare-associated infection, preventing cross-transmission and supporting safe patient care. The findings also provide a useful bridge between surveillance data, audit, training compliance and the wider IPC improvement Programme.

4.2 - SUMMARY OF POINT PREVALENCE SURVEYS UNDERTAKEN

This chapter summarizes the point prevalence survey (PPS) Programme undertaken across Prince Charles Hospital (PCH), Royal Glamorgan Hospital (RGH) and Princess of Wales Hospital (POW) during the reporting period, together with immediate post-year checkpoint work where this forms part of the same improvement cycle. The PPS Programme provides direct observational assurance on whether core infection prevention and control (IPC) standards are being translated into routine practice at ward, department and staff-group level.
The principal focus during 2025/26 was Bare Below the Elbows (BBE), with later work expanding to include hand hygiene, personal protective equipment (PPE), and, at PCH, PVC and urinary catheter care bundle compliance. Collectively, these studies provide an important measure of staff behaviors

that underpin safe care, effective hand hygiene, prevention of cross-transmission, safe device management, sustainability, and compliance with the Health Board's IPC policies.
The Programme should be interpreted as a quality-improvement and assurance approach rather than a static audit exercise. Its value is that it identifies real-world practice variation, makes non-compliance visible, enables immediate feedback, and supports targeted intervention. It also provides evidence that improvement is achievable when findings are escalated, local leadership is engaged and repeat measurement is undertaken.

4.2.1. - Summary of point prevalence surveys and related IPC observational work

The table below brings together the PPS and related observational work in chronological order. Where the available documentation provided limited numerical detail, the table summarizes the key finding and the assurance implication rather than overstating precision.

Date	Hospital	Focus	Scope / method	Key finding	Assurance implication
April 2025	PCH	Initial BBE compliance PPS	BBE compliance across wards and staff categories. The report also set out the rationale for BBE as a core requirement supporting effective hand hygiene.	Variable baseline position. Ward 11 achieved the highest overall compliance score at 95%; CCU and Ward 32 were lowest at 50%. Variation was seen across doctors, nurses, HCSWs and other staff groups.	Established the baseline for PCH and identified the need for targeted training, regular audits, feedback, recognition of good practice, visual prompts and leadership engagement.
June 2025	RGH	BBE compliance PPS	Inpatient areas over two working days; all observed staff groups, including nurses, doctors, HCSWs, facilities, catering, portering, phlebotomy, admin and students.	Marked ward and staff-group variation. Only a smaller proportion of wards reached green status. Jewelry was the most frequently observed breach, followed by nails, watches/fitness trackers and long sleeves.	Provided a baseline for RGH and highlighted the need for visible leadership, senior role-modelling and escalation where repeated breaches were observed.
August 2025	PCH	Repeat BBE compliance PPS	Follow-up to the April 2025 PCH PPS across inpatient areas after escalation to senior management, increased surveillance, enhanced IPC presence and targeted training.	Compliance ranged from 50% to 100%. Highest compliance was CCU at 100%, Labour at 90% and AMU at 92%. Lowest compliance was ITU at 50%, Ward 3 at 50% and Ward 2 at 54%. Seven wards improved, one by 50%; seven wards showed a marginal decrease and one remained unchanged.	Demonstrated that targeted intervention can improve compliance, but also showed that improvement was not universal. Ward 3 deterioration was linked to service change and agency staffing, indicating that Organisational change and temporary staffing can affect IPC reliability.
August 2025	POW	BBE compliance PPS	Inpatient areas over one working day, assessing clinical and non-	Generally strong BBE position. Twelve wards achieved green status and seven	Good overall assurance for BBE at POW, with targeted action required for red-rated areas and

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			clinical staff groups.	areas achieved 100% compliance, including AMU, Ward 5, Ward 8, Ward 12, NNU, A&E and ITU. Ward 14 at 67% and PICU at 13% remained red. Watches were the most frequent breach.	staff groups entering clinical areas, including non-registered and external staff.
January 2026	PCH	BBE follow-up PPS/poster summary	Follow-up assessment of BBE compliance at Prince Charles Hospital, highlighting high-performing teams, areas for improvement and actions to achieve consistent best practice.	Improvement was reported compared with earlier work. Eleven wards scored above 90%, nine wards achieved 100%, and Ward 32 was close to the green threshold. Fewer wards required urgent red-rated action than previously.	Shows a positive improvement trajectory at PCH. Continued monitoring remained necessary to prevent slippage in amber areas and sustain high performance.
February 2026	RGH	BBE follow-up PPS	One-day follow-up assessment across inpatient areas, comparing against the earlier RGH PPS.	Clear improvement. Most wards achieved green status. A&E improved from 52% to 100%. Ward 12 was the lowest scoring ward at 50%, showing deterioration from 79% in the previous audit. HCSWs accounted for the highest number of breaches.	Strong evidence that feedback and targeted work improved compliance, but residual ward-level and staff-group variation remained and requires continuing leadership attention.
April 2026	POW	Expanded BBE, hand hygiene and PPE PPS	Acute inpatient areas over 24 hours. Observations included BBE, hand hygiene and PPE compliance.	BBE remained strong, but hand hygiene was polarised and PPE was the weakest domain. PPE non-compliance included inappropriate glove use, failure to remove PPE between patient contacts and incomplete PPE use. Ward 7 recorded 0% PPE compliance at the point of observation.	Important finding: high BBE compliance does not guarantee reliable hand hygiene or correct PPE use. PPE behavior should be treated as a priority improvement workstream linked to quality, safety, sustainability and value.
April 2026	PCH	IPC Easter competition and device-care observation	Clinical areas across PCH; combined BBE, peripheral vascular catheter (PVC) and	Ward 12 achieved the highest combined score at 95% and was recognized as the	Useful engagement and recognition approach, but improvement may not be sustained

			urinary catheter (UC) care bundle compliance.	winner. However, the documentation identified a decline in BBE compliance, requiring renewed improvement focus.	without ongoing measurement and local ownership. Inclusion of device-care bundles reinforces the link to bloodstream infection prevention.

Table 9- PPS findings resume

During April 2026, the IPC team also conducted the easter IPC competition for device-care-observation, reports were not finaslised at the time this report was being produced and findings will be included in the next quarterly report.

4.2.2 - Overall interpretation

The expanded PPS evidence now gives a more complete Health Board picture because it includes all three acute sites. The Programme shows that BBE compliance can improve when data are shared, senior teams are sighted, IPC visibility increases and repeat measurement is undertaken. PCH and RGH both show evidence of improvement between baseline and follow-up work, while POW showed generally strong BBE compliance but identified important gaps in hand hygiene and PPE practice when the audit scope widened.

The principal assurance message is therefore balanced. The Health Board has evidence that PPS is an effective improvement mechanism, but the findings also confirm that compliance is not yet consistently embedded across every ward, staff group or IPC domain. Local culture, service change, temporary staffing, professional role-modelling and ward leadership appear to influence compliance as much as knowledge of policy. This means that improvement plans need to combine education with behavioral insight, leadership accountability and repeated observational measurement.

BBE compliance should be viewed as improving but fragile. Several areas achieved excellent compliance, including 100% ward-level scores, but red and amber areas persisted across the year, and PCH post-year observational work identified a decline in BBE compliance despite previous improvement. This suggests that BBE must remain a non-negotiable standard, supported by regular spot checks, ward-level ownership and escalation of repeated breaches.

The expanded POW survey is particularly important because it demonstrates that BBE alone is not a sufficient proxy for reliable standard infection control precautions. PPE compliance, especially glove use, was the weakest domain. The finding that staff used gloves for low-risk or non-clinical activities, failed to remove PPE between patient contacts and moved around ward environments wearing PPE is significant. Incorrect PPE use can increase cross-transmission risk, undermine hand hygiene, create a false sense of safety and contribute to avoidable waste and cost – support/advice is being sought with QI and behavioural team to find strategies to address the findings.

4.2.3 - SITE-LEVEL FINDINGS AND INTERPRETATION

PRINCE CHARLES HOSPITAL

PCH provides the clearest example of a repeat measurement cycle. The April 2025 PPS established a variable baseline, with Ward 11 achieving 95% and CCU and Ward 32 scoring 50%. The results supported targeted training, regular audit, staff feedback, visual reminders, recognition of good practice and leadership engagement.

The August 2025 repeat PPS demonstrated targeted improvement following escalation and enhanced IPC visibility. Seven wards improved, one by 50%, while seven wards declined marginally and one remained unchanged. Compliance ranged from 50% to 100%, with CCU at 100%, Labour at 90%

and AMU at 92%. The lowest scores were ITU at 50%, Ward 3 at 50% and Ward 2 at 54%. Ward 3's decline was linked to service change from Care of the Elderly to Elective Trauma and Orthopaedics and reliance on agency staffing, demonstrating that operational change can affect compliance culture and IPC reliability.

By January 2026, the PCH PPS reported further improvement, with 11 wards scoring above 90%, nine wards at 100% and Ward 32 narrowly missing the highest category. This suggests that the Programme had begun to embed more successfully. However, the April 2026 IPC Easter competition, which included BBE, PVC and urinary catheter care bundle compliance, identified a decline in BBE compliance, even though Ward 12 achieved an impressive combined score of 95%. This confirms that improvement requires maintenance and that compliance can regress when attention reduces or when ward conditions change.

The inclusion of PVC and urinary catheter care bundle compliance at PCH is a positive development because it links PPS methodology directly to bloodstream infection prevention. Given the Health Board's ongoing challenges with Gram-negative bacteraemia and blood culture contamination/ANTT assurance, future PPS work should continue to include device-care bundles where appropriate.

ROYAL GLAMORGAN HOSPITAL

The June 2025 RGH PPS showed significant variation in BBE compliance across wards and staff groups. Only a limited number of wards achieved green status, while many were in amber or red categories. Ward-level analysis suggested that culture and local leadership were important determinants of performance. Several wards achieved 100% compliance across nurses, doctors and HCSWs, but other areas recorded 0% compliance in at least one of these core patient-facing groups. A&E showed particular variability, with doctors at 42% compliance.

The February 2026 follow-up PPS showed clear improvement. Most wards achieved green status, and A&E improved from 52% to 100%, which is an important example of measurable improvement after targeted intervention. Residual concerns remained, including Ward 12, which scored 50% and deteriorated from 79% previously, and variable compliance in Ward 4, Ward 7, Ward 15 and CCU. HCSWs accounted for the highest number of breaches in the follow-up work, followed by nurses, with isolated breaches among doctors, pharmacy staff and physiotherapists.

The breach profile at RGH was dominated by jewelry, followed by nails, watches/fitness trackers and long sleeves. These remain important because they interfere with effective hand and wrist decontamination and can act as reservoirs for microorganisms. The RGH findings support continued real-time challenge, visible leadership and escalation where senior or registered staff are observed to be non-compliant, because role-modelling is essential to changing ward culture.

PRINCESS OF WALES HOSPITAL

The August 2025 POW BBE PPS demonstrated a generally strong position. Twelve wards achieved green status and seven areas achieved 100% compliance, including AMU, Ward 5, Ward 8, Ward 12, NNU, A&E and ITU. However, Ward 14 at 67% and PICU at 13% were red-rated and required immediate targeted intervention. The staff-group picture was also generally positive, with students, occupational therapy and physiotherapy at 100% and nurses, pharmacy, HCSWs and doctors also performing well. Lower compliance was identified in phlebotomy, ward clerks and outside social service workers, indicating the need to reinforce BBE expectations for all staff entering clinical areas, not only registered clinical staff.

The most common breach at POW in August was wearing watches, followed by nail-related breaches, long sleeves and jewelry. This differed from the RGH pattern, reinforcing that site-level improvement plans should be based on local breach types rather than generic messaging alone.

The April 2026 POW survey extended the PPS methodology to BBE, hand hygiene and PPE. This is the most mature PPS model in the current evidence base because it assessed multiple components of standard infection control precautions. BBE remained the strongest domain, with several wards achieving 100% or above 90%. Hand hygiene showed a polarised pattern, with some wards achieving 100% and others showing substantially lower compliance. PPE was the highest-risk domain, with widespread inappropriate practice and Ward 7 recording 0% compliance at the time of observation.
The April 2026 POW findings are important for the annual report because they provide direct evidence that PPE practice, particularly glove use, must remain a priority. The findings support the wider IPC sustainability narrative: appropriate glove use can reduce waste and cost, but the primary message must remain patient and staff safety. Gloves are not a substitute for hand hygiene and can contribute to cross-contamination when used incorrectly.

4.2.4 - Cross-cutting themes from the PPS Programme

Theme	Evidence from PPS findings	Implication for assurance	Recommended response
BBE compliance is improving but not consistently embedded	PCH and RGH repeat work showed improvement; POW demonstrated strong BBE compliance; however, red and amber areas persisted and PCH April 2026 work signalled possible decline.	Good evidence that PPS works as an improvement tool, but standards need sustained ownership and repeat measurement.	Continue regular PPS cycles, spot checks, feedback to ward managers and escalation of repeated breaches.
Local leadership and culture are major determinants	High-performing wards often performed well across staff groups; weaker areas showed cross-professional variation. Non-compliance among senior staff was specifically noted in RGH work.	Compliance is behavioural and cultural, not only educational.	Use ward leadership, senior nursing walk-rounds, medical leadership, IPC link roles and peer challenge.
Staff-group variation requires targeted responses	Doctors were low in some RGH areas; HCSWs had most breaches in the RGH follow-up; PCH and POW identified issues across clinical and non-clinical groups.	Generic messages will be insufficient.	Tailor interventions by staff group, including medical engagement, HCSW/nursing support and expectations for non-clinical staff entering clinical areas.
PPE practice and glove use are the weakest behavioral domains	The POW April 2026 expanded PPS identified inappropriate glove use, failure to remove PPE between contacts and inconsistent PPE use.	Incorrect PPE can increase transmission risk and undermine hand hygiene.	Develop a PPE/glove-use QI workstream using behavior-change methodology and link findings to sustainability and safe care.
Device-care bundle inclusion strengthens the Programme	The PCH Easter competition included BBE, PVC and urinary catheter care bundle compliance, with Ward 12 scoring 95%.	PPS methodology can support reduction of bacteremia and device-related infection risks.	Include PVC and urinary catheter care bundles in future risk-based PPS cycles, especially in areas with Gram-negative or line/device-related concerns.
Operational change can affect compliance	Ward 3 PCH deterioration was attributed to service change and agency staffing.	IPC compliance may deteriorate during service moves, staffing changes or periods of disruption.	Include IPC briefing, BBE/PPE/device-care expectations and early spot checks in service-change plans.
Breach-type analysis provides actionable intelligence	Common breach types included jewelry, watches/fitness trackers, nails, long sleeves and inappropriate PPE/glove use. Dominant breach type differed by site.	The Programme should not only report percentages; it should report what needs to change.	Track breach type over time and target communications accordingly.

Table 10- Cross-cutting themes from the PPS programme

ASSURANCE AND RISK ASSESSMENT

Assurance area	Current judgement	Rationale
BBE compliance	Moderate to good assurance, with local exceptions	Repeat work at PCH and RGH showed improvement and POW had generally strong BBE performance. However, persistent red/amber areas and post-year decline signals mean assurance is not complete.
Hand hygiene	Partial assurance	Only directly measured in the expanded POW survey, which showed strong performance in some wards but marked variation and missed opportunities after patient/environment contact.
PPE use	Limited assurance	The POW expanded PPS identified PPE misuse as the weakest domain, particularly inappropriate glove use and failure to remove/change PPE between contacts.
Device-care bundles	Emerging assurance	The PCH April 2026 work included PVC and urinary catheter care bundles and therefore provides a useful model for future IPC assurance linked to bacteremia prevention.
Improvement methodology	Good assurance	PCH and RGH repeat measurement demonstrated that targeted intervention, visible IPC presence and leadership engagement can improve compliance.
Sustainability of improvement	Partial assurance	Some areas improved, but others deteriorated or showed decline over time. Compliance requires continued measurement, escalation and local ownership.
Leadership and culture	Partial assurance	Strong ward-level performance appears linked to local culture and leadership, but senior staff non-compliance and cross-professional variation remain risks.

Table 11- Assurance and risk assessment

4.2.5 - Actions and Priorities for 2026/27 derived from PPS

- Continue scheduled and risk-triggered PPS cycles across all three acute sites using a consistent methodology, RAG approach and breach-type reporting.
- Create a standardized PPS template so that results can be compared by hospital, ward, staff group, domain and breach type over time.
- Retain BBE as a non-negotiable clinical standard, with real-time challenge, escalation of repeated breaches and visible support from senior nursing, medical and operational leaders.
- Prioritize PPE and glove-use improvement as a dedicated quality-improvement workstream, focusing on correct indications, hand hygiene before and after glove use, removal between patient contacts and prevention of environmental cross-contamination.
- Expand PPS methodology to include device-care bundles in targeted areas, especially PVC and urinary catheter care where Gram-negative bacteremia, line-related infection or ANTT concerns are present.
- Use PPS findings during service change, ward moves, staffing model changes and agency-heavy periods, as these conditions can affect practice reliability.
- Link PPS findings with mandatory IPC training compliance, ANTT assurance, blood culture contamination data, outbreak learning, HCAI review themes and PPE procurement data.
- Share learning from high-performing wards through local governance, safety huddles and IPC link roles, so that successful behaviors are spread rather than only correcting poor performance. Continue to create and distribute benchmark posters so each clinical setting can see how is performing in comparison with the remainer clinical areas
- Develop a PPS dashboard for IPCC and care group governance showing trends, actions completed, persistent red/amber areas and evidence of sustained improvement.
- Work with the Quality Improvement team to understand the behavioral drivers of PPE misuse, including perceived safety, habit, convenience, peer norms, equipment availability and local leadership expectations.

4.2.6 – Resume of Findings from PPS

The PPS programme has matured during 2025/26 and now provides meaningful ward-level and staff-group assurance across all three acute sites. It has demonstrated that improvement is achievable: RGH showed clear improvement between baseline and follow-up, PCH showed improvement across repeat cycles, and POW demonstrated generally strong BBE performance. The use of competition and recognition at PCH also shows how engagement can support improvement, provided that it is balanced with robust monitoring and escalation.
The programme also identifies important residual risks. BBE compliance is improving but remains vulnerable to local culture, service change, temporary staffing, role-modelling and loss of sustained attention. Hand hygiene and PPE require separate measurement because strong BBE compliance does not guarantee reliable standard infection control precautions. PPE misuse, particularly inappropriate glove use, is the clearest behavioural risk identified in the expanded POW survey and should remain a priority for 2026/27.
The annual report should therefore present PPS as a core IPC assurance and improvement mechanism. The next phase should focus on standardising methodology, embedding repeat measurement, strengthening escalation and linking PPS findings to broader infection prevention priorities, including Gram-negative bacteraemia reduction, blood culture contamination, ANTT assurance, device-care bundle reliability and sustainability. This will help ensure that observed practice becomes more consistently aligned with policy and that IPC improvement is owned from ward to Board.

5-SURVEILLANCE OF ALERT ORGANISMS AND OUTBREAKS

5.1 EPIDEMIOLOGICAL REVIEW AGAINST WELSH GOVERNMENT IMPROVEMENT GOALS

The epidemiological position presents a mixed picture. CTMUHB compares favourably with the all-Wales average for C. difficile, Pseudomonas aeruginosa, MSSA and MRSA rates, but remains above the Wales rate for E. coli and Klebsiella spp. bacteraemia. The key strategic conclusion is that Gram-negative bloodstream infection must remain a central priority for the Health Board.

The following table benchmarks the HB with all Wales:

Organism	CTM Rate/100,000	Wales/100,000	Dif%
E.Coli	81.52	68.1	-19.71%
P Aeruginosa	3.14	5.12	38.67%
Klebesilella sp.	30.01	23.70	-26.62%
Staph aureus (MSSA)	23.74	25.57	7.15%
Staph aureus (MRSA)	1.57	2.05	23.41%
Cdiff	36.73	42.12	12.8%

Table 12 - HCAI CTM rates and all-Wales benchmark

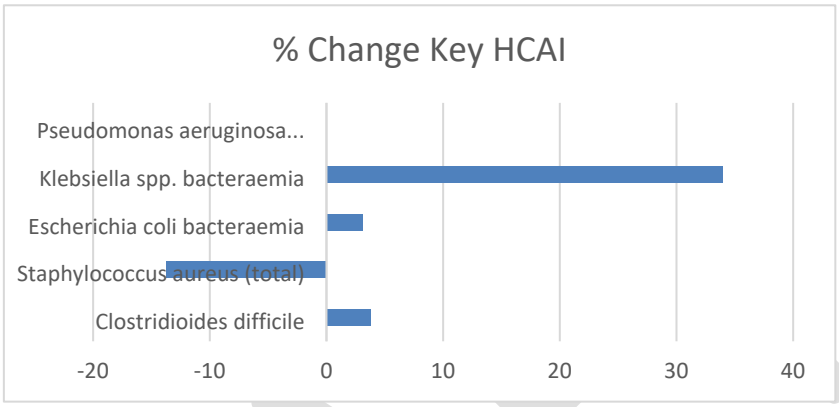
In the next table we can see the comparison of the number of cases with the previous financial year as well as a breakdown of CO and HO proportion:

Organism	2025/26 cases	2024/25 comparison	% change	CO	HO	HO %	Position
Clostridioides difficile	164	158	+3.8	103	61	37%	Below Wales; improvement not achieved for 25% goal
Staphylococcus aureus (total)	113	131	-13.74	74	39	35%	Slightly below Wales; HO cases

							require focused review
Escherichia coli bacteraemia	364	353	3.1	303	61	17%	Above Wales; HO reduction in line with goal
Klebsiella spp. bacteraemia	138	103	34	100	38	28%	Above Wales; Gram-negative concern
Pseudomonas aeruginosa bacteraemia	14	14	0	9	5	36%	Below Wales; HO reduction achieved

Table 13 - Annual organism-specific HCAI summary

The same data is condensed in the following graphic:



Graphic 2 - Change in key HCAI % compared with 2024/25

5.2 CLOSTRIDIOIDES DIFFICILE

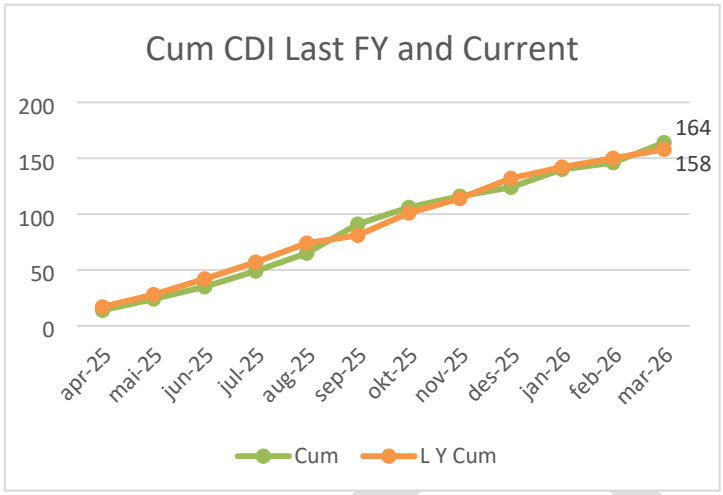
Improvement Goal: To reduce the overall burden of C. diff infection by at least 25% against the 2024-25 counts

CTM has recorded 164 cases of Clostridioides difficile infection (CDI) during the financial year to date, compared with 158 cases for the same period last year, representing an increase of 13.7%. Of these, 103 cases were classified as community onset and 61 as hospital onset, meaning that hospital-onset infections account for 37% of the total burden. The current CTM rate is 36.73 per 100,000 population, compared with an all-Wales rate of 42.12, placing the Health Board 12.8% below the national average.

This remains a comparatively favorable benchmarking position; however, the current trajectory is not delivering the 25% improvement goal. The data indicate that there has been an increase in total cases. It is therefore important that the Health Board maintains focus not only on reducing hospital-onset infection, but also on understanding and addressing the significant contribution made by community-onset disease.

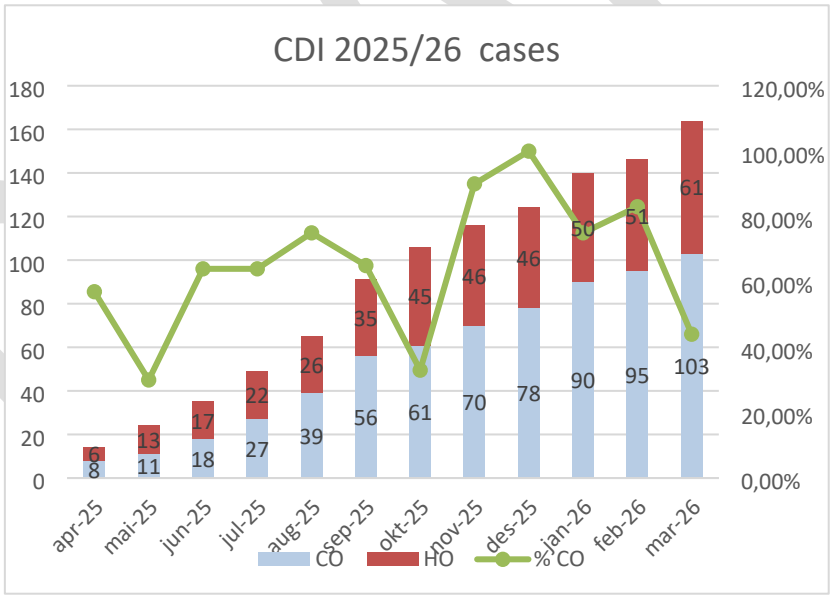
The graphics that follow provide a more detailed understanding of the cumulative trend, the relative contribution of community-onset and hospital-onset cases, and the variation seen across acute sites. Together, they show that progress has been made, but that sustained multidisciplinary action is still required if CTM is to translate this modest improvement into a more substantial and sustained reduction in CDI.

The following graphics summarize the current data:

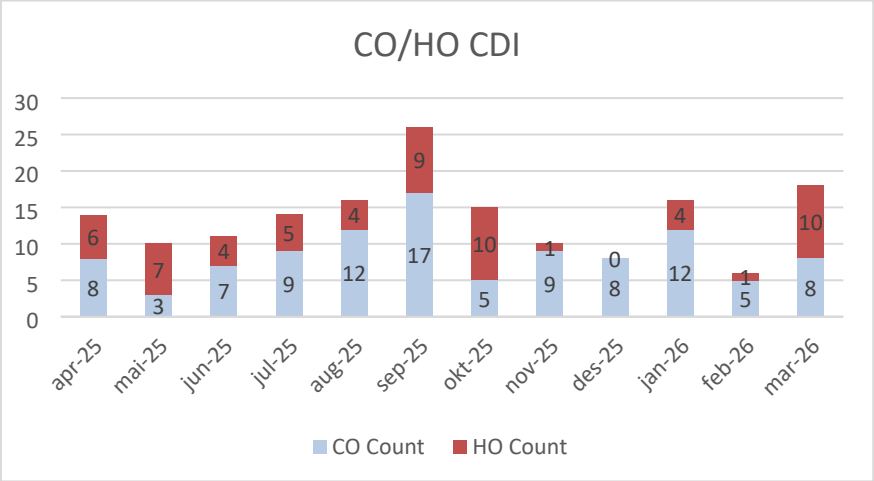


Graphic 3- Cumulative of CDI 2024/25 vs 2025/26

As we can see on Graphic 3, we currently more cases than same period last year by 3.8%, noting a trajectory change from November 2025.
The number of cases is significantly CO driven with 37% of cases being HO (Wales HO cases are 46%) and 63% CO. There has been a rising trend on CO cases as can be seen on Graphic 4 and 5:

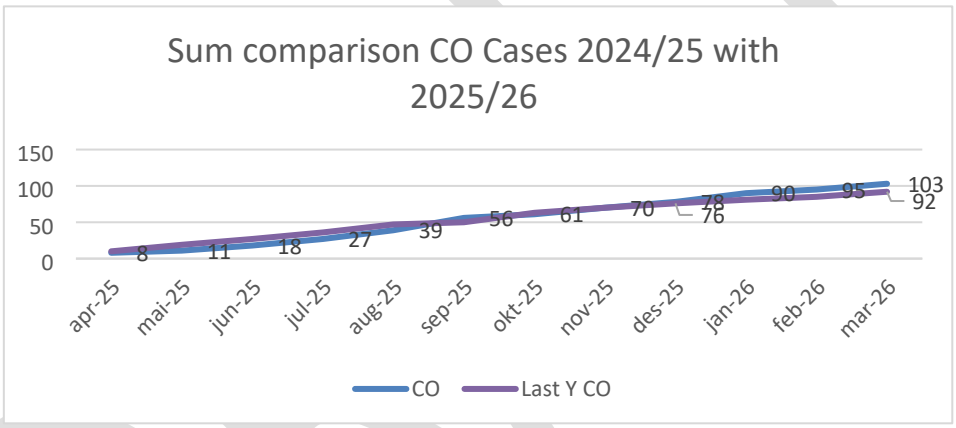


Graphic 4 - CDI 2025/26 HO and CO cases

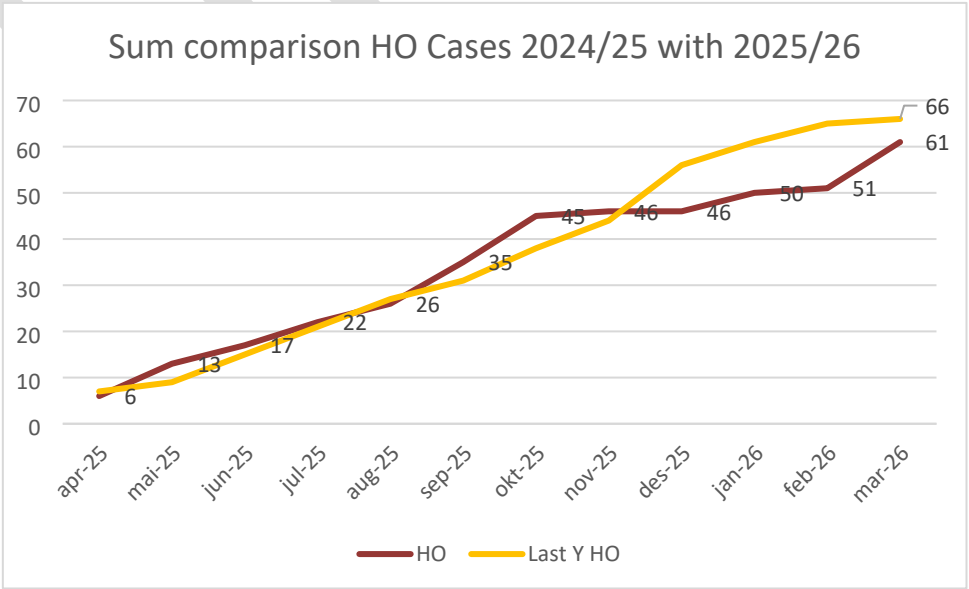


Graphic 5 - Ratio CO/HO cases 2025/26

If we look to compare the number of CO and HO cases from 2024/25 with 2025/26, we can see Graphics 6 and 7:



Graphic 6 -Sum Comparison of CO cases 2024/25 with 2025/26



Graphic 7- Sum Comparison of HO cases 2024/25 with 2025/26

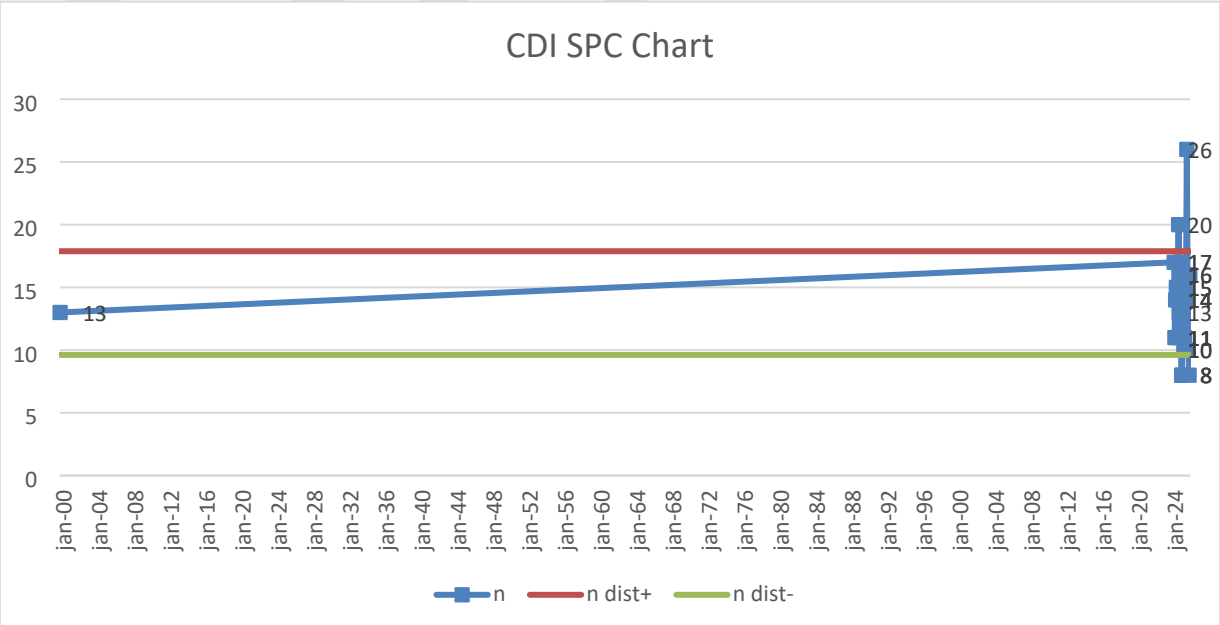
Graphics 3 to 7 show that the year-to-date CDI position is albeit the increase, from the point of view of HO cases the situation is slightly improved when compared with 2024/25, but that the pattern of reduction is uneven. Graphic 3 demonstrates that the cumulative total for 2025/26 has remained below the previous year for most of the reporting period, although the gap narrowed from November 2025 onwards. This suggests that the Health Board has achieved some improvement, but that the degree of reduction remains fragile and vulnerable to deterioration during periods of operational pressure.

Graphics 4 and 5 confirm that the overall CDI burden remains predominantly community onset. Community-onset cases account for 63% of all cases, while hospital-onset cases account for 37%. This is an important distinction, because it highlights that although acute-sector control measures remain essential, the total burden of disease cannot be fully understood or reduced through hospital-based action alone. The epidemiological picture continues to indicate that CTM must pursue an integrated approach spanning acute services, primary care and wider community interfaces, particularly in relation to antimicrobial stewardship, prescribing practice, case recognition and early response.

Graphics 6 and 7 show that reduction has only been driven by improvement in hospital-onset cases while in community-onset cases we saw an increase. Hospital-onset CDI has reduced by 17.9% compared with the same period last year, whereas community-onset CDI has increased by 12%. This is a positive signal in relation to acute-sector prevention and control, as it suggests that actions undertaken within inpatient settings are having some effect. However, it also reinforces that progress in community-onset infection has been limited, and that this is constraining the overall scale of improvement achieved by the Health Board.

Taken together, Graphics 3 to 7 indicate that CTM is moving in the right direction (albeit the total number increase of 3.8%), but not yet at the pace required to meet the annual improvement goal. The data support a dual analytical conclusion: first, the reduction in hospital-onset CDI is encouraging and should be protected through continued focus on timely isolation, environmental decontamination, antimicrobial stewardship and safe clinical practice; second, further work is required to understand the drivers of community-onset infection, as this remains the main determinant of the total CDI burden across the Health Board.

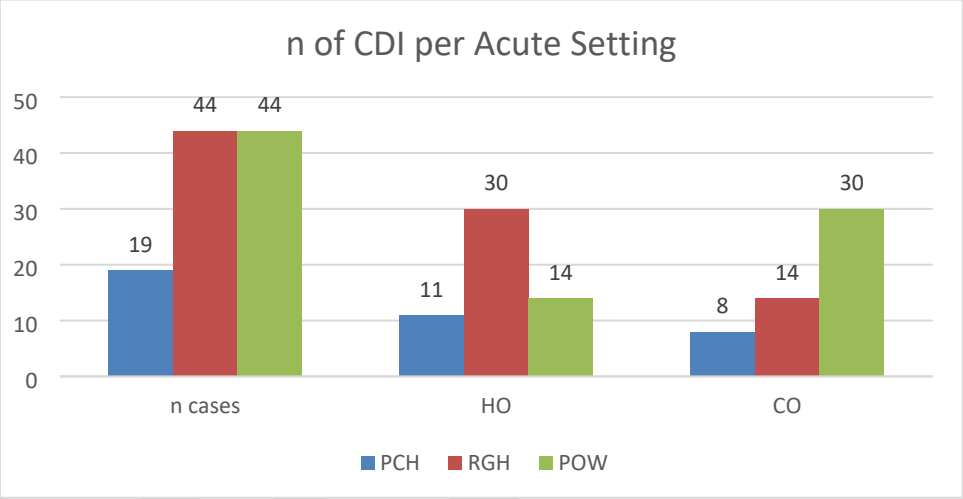
The following Graphic 8 shows the SPC chart for CDI during the financial year:



Graphic 8 - CDI SPC Chart

Graphic 8 shows the SPC chart for CDI during the financial year. Overall, the process appears to remain largely within expected control limits, with no clear evidence at this stage of a sustained step change or special-cause variation sufficient to confirm a stable improvement in performance. This is an important finding. Although the cumulative data show a reduction compared with the previous year, the SPC chart suggests that the observed improvement should still be interpreted cautiously.
From an assurance perspective, the chart indicates that CTMUHB has not experienced marked deterioration beyond expected variation, but neither has it yet demonstrated a consistently sustained shift that would confirm that improvement has become embedded in routine performance. In practical terms, this means that the current reduction should be regarded as encouraging but not yet secured. Continued surveillance over the coming months will be needed to determine whether current actions are strong enough to produce a durable change in the CDI trajectory.
The SPC chart therefore supports a balanced interpretation of the overall position: CTM is performing favorably and remains below the all-Wales rate, but further time and sustained control measures will be needed before the organisation can achieve a reliable long-term reduction.

The following graphic looks at the distribution of cases per acute site:



Graphic 9 - n CDI cases per acute site

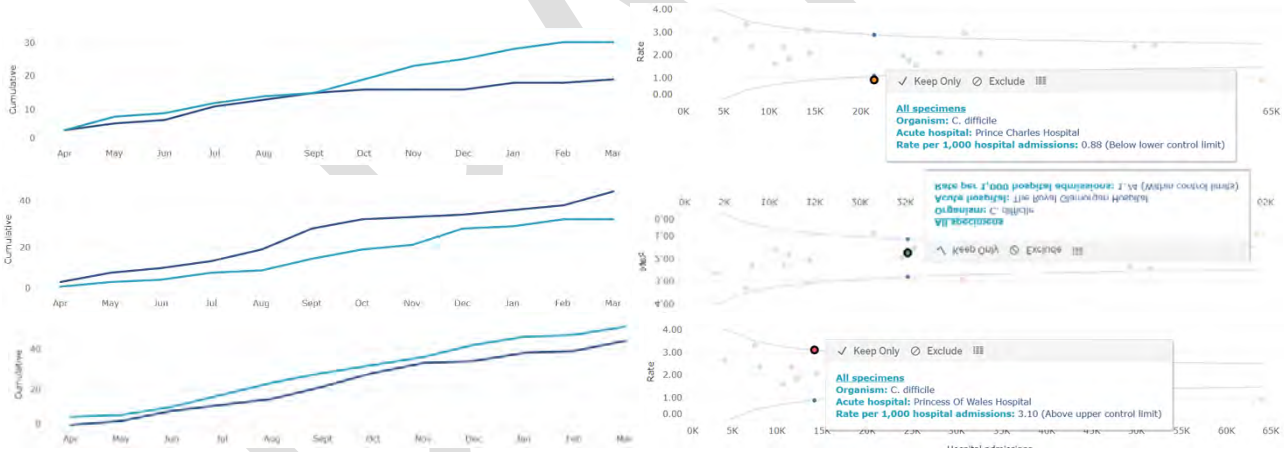
Hospital	n cases	HO	CO	Rate/100000 Hosp admissions	%HO
PCH	19	11	8	0.88	58%
RGH	44	30	14	1.74	68%
POW	44	14	30	3.1	32%

Table 14 - CDI per acute site

Graphic 9 and Table 14 demonstrate important variation across the three acute sites. Princess of Wales Hospital (POW) and Royal Glamorgan Hospital (RGH) each recorded 44 cases during the reporting period, while Prince Charles Hospital (PCH) recorded 19 cases. The case mix differs significantly between sites. At RGH, 30 of 44 cases were hospital onset, meaning that 68% of cases were acquired in hospital. At PCH, 11 of 19 cases were hospital onset, representing 58% of the site total. In contrast, at POW only 14 of 44 cases were hospital onset, with the majority of cases—30 in total—classified as community onset.

These differences are important because they suggest that the drivers of CDI are not uniform across CTM. RGH has the highest absolute number of hospital-onset infections, indicating the need for continued scrutiny of inpatient transmission risks, environmental decontamination, isolation practice and patient flow pressures. POW, by contrast, has a markedly higher burden of community-onset disease, which may reflect wider population factors, healthcare access patterns, testing practice, antimicrobial exposure, or other epidemiological influences that require further investigation. PCH currently records the lowest total number of cases and the lowest rate, suggesting a relatively more favourable acute-site position at this stage.

The following Graphics 10 provide additional context by comparing site-level performance over time and against all-Wales benchmarking. PCH has shown a more consistent reduction compared with the same period last year. POW increased above the previous year earlier in the reporting period, RGH has remained persistently above the previous year's cumulative line. Although this is concerning, the benchmarking element of Graphic 8 shows that both RGH and PCH remain within normal variation when compared with other acute sites across Wales, with RGH and PCH sitting within the lower to middle range of the national distribution. POW also remains within expected variation, but is positioned nearer the upper range and therefore compares less favourably.
The site-level analysis reinforces that CTMUHB does not have a single CDI problem but rather a mixed epidemiological picture requiring differentiated response. There is a need to maintain acute-site controls at RGH and PCH, while also deepening understanding of the factors driving the larger community-onset burden seen at POW. This site-specific interpretation is essential if the organisation is to move beyond broad generic action and target improvement efforts where they are most likely to reduce risk and case numbers.



Graphic 10 - Counts of CDI cases per acute setting and rates of CDI per 1,000 Hospital Bed admission all Wales

Key learning from the CDI reviews to date indicates that progress will depend on maintaining a strong focus on several recurrent themes.

1. Environmental decontamination remains a critical control measure. Rooms occupied by patients with CDI require cleaning with an appropriate sporicidal agent followed by hydrogen peroxide vapour (HPV) decontamination where indicated. Failure to complete HPV consistently, or difficulties in achieving this in high-turnover areas, risks reducing the effectiveness of terminal decontamination and may allow environmental persistence of spores.
2. Prescribing practice remains central to prevention. Reviews continue to demonstrate the need for better scrutiny of antimicrobial prescribing and proton pump inhibitor (PPI) use, including

clearer documentation of indication, dose and duration. Given the strong association between CDI and antimicrobial exposure, this remains one of the most important opportunities for sustainable prevention both in hospital and across the community.

3. Early recognition and prompt isolation are essential. Delayed identification of loose stools, delayed testing, or delayed placement of symptomatic patients into appropriate isolation increase the opportunity for onward transmission. Timeliness of response therefore remains as important as the technical quality of IPC measures themselves.
4. Baseline IPC practice must remain strong and reliable. Good hand hygiene, compliance with bare below the elbows principles, correct use of personal protective equipment and visible IPC leadership in clinical areas remain foundational requirements. These measures are particularly important during periods of bed pressure and high patient turnover, when the risk of compromised practice is greater.
5. Current learning reinforces that CDI should be viewed as a system issue rather than only an acute-site issue. The increase in community-onset infection suggests that action confined to inpatient settings will not be enough to deliver the required scale of improvement. Stronger alignment across primary care, antimicrobial stewardship, pharmacy, community services and epidemiological review will be necessary if CTM is to achieve a sustained reduction in total CDI burden.

IPC Actions:

The current action plan appropriately reflects the multifactorial nature of CDI prevention and should continue to be progressed with a focus on consistency, assurance and measurable impact.

Control of environmental risk is being reinforced through ongoing monitoring of HPV decontamination. Continued confirmation of completed and successful HPV cycles, which is essential both as an operational assurance mechanism and as evidence that expected standards of post-case decontamination are being achieved, nonetheless recent findings of linked cases in rooms that had completed cycles of HPV disinfection, highlight the need to keep attention to basics. No automated method is effective in isolation and requires highest levels of pre-cleaning by the domestics team.

Digital support within surveillance has improved through ICNet alerts for patients admitted with known CDI history. This allows the IPC team to identify risk earlier, contact clinical areas promptly and support timely isolation and review of relevant risk factors. This is an important example of how surveillance tools can support earlier intervention.

The review process is also being strengthened. Work to improve the robustness and timeliness of root cause analysis, revise CDI documentation and update the relevant ICNet experience packs should support more consistent learning, better thematic analysis and stronger governance. The proposed development of a matrix of common themes/thematic analysis is particularly important, as it would help convert case review learning into a clearer organisational improvement programme.

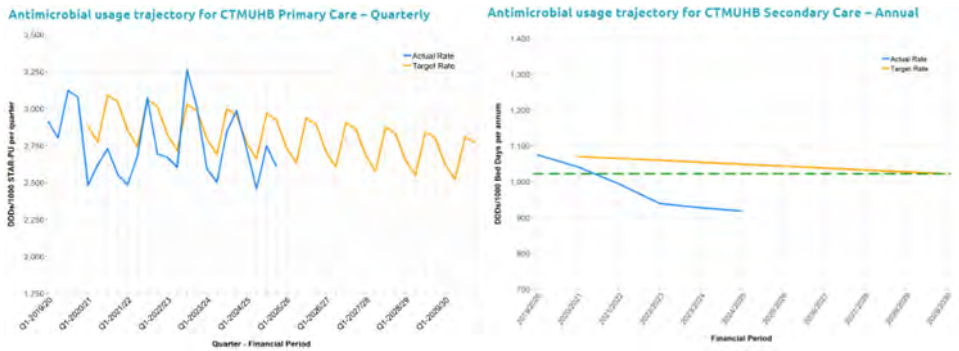
Collaboration with microbiology and gastroenterology on access to faecal microbiota transplantation where appropriate is essential. Currently FMT is available also at POW.

Point prevalence work and visible IPC support in clinical areas should continue, particularly where they can test whether expected standards are translating into day-to-day practice.

Overall, the actions identified are appropriate, but their impact will depend on disciplined implementation, regular monitoring, and a clear route for escalation where barriers remain unresolved.

While the actions outlined above are intended to reduce CDI within secondary care, the data presented shows clearly that improvement will only be partial unless equivalent attention is given to the community contribution. Community-onset infection remains the larger component of total CDI burden and, has not reduced. For that reason, CTM should continue to strengthen collaboration with

primary care, pharmacy, antimicrobial stewardship teams and Public Health Wales to ensure that prevention strategies extend beyond inpatient services.
The current reduction in antimicrobial prescribing across CTM is encouraging (Graphics 11) and should be viewed as an important enabling factor for long-term improvement. However, the persistence of CDI despite this positive direction indicates that prescribing alone does not fully explain the epidemiology. Continued work is needed to improve how learning is captured from case review, how common themes are identified, and how these themes are translated into practical action. The ongoing revision of CDI review documentation is therefore timely and should be supported as part of a stronger governance approach.



Graphic 11 - Antimicrobial trajectory primary and secondary care

Operational pressures continue to influence the ability to prevent transmission reliably. High bed occupancy, frequent patient movement and the practical difficulty of completing full cleaning and disinfection to the desired standard create conditions in which transmission risk may increase. This is especially relevant during winter and other periods of heightened service pressure, when the competing demands of patient flow and environmental safety become more difficult to balance. Sustained improvement will therefore depend not only on technical IPC interventions, but also on the wider operational environment in which those interventions must be delivered.
The variation seen across sites, particularly the larger community-onset burden at POW and the higher hospital-onset burden at RGH, suggests that a more nuanced epidemiological understanding is now required. CTMUHB should seek, with PHW support, to understand whether differences in testing practice, population characteristics, deprivation, access to care, prescribing patterns or other environmental and service factors are influencing the site-level distribution of disease. Without that deeper analysis, there is a risk that broad Health Board-wide conclusions may obscure local drivers and limit the effectiveness of improvement work.
In summary, the Health Board position is moderately improved and favourable when benchmarked against all-Wales rates, but not yet improving at the scale needed to meet the annual target. Progress has been achieved, in relation to hospital-onset CDI, but the overall burden remains strongly influenced by community-onset disease and by site-level variation. The immediate priority is therefore to sustain current acute-sector controls while strengthening the wider cross-sector response, so that the modest reduction already achieved can be translated into a more substantial and sustainable improvement over time.

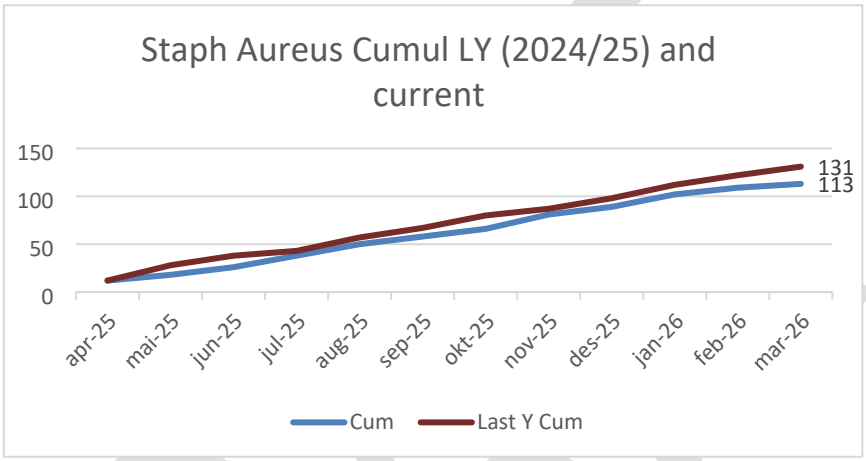
5.3 STAPHYLOCOCCUS AUREUS BACTERAEMIA

MSSA Improvement Goal: A decrease of at least 20% compared to the 2024/25 baseline counts for all Health Boards.

MRSA Improvement Goal: All Health Boards should have fewer MRSA BSI cases in 2025/26 than in 2024/25.

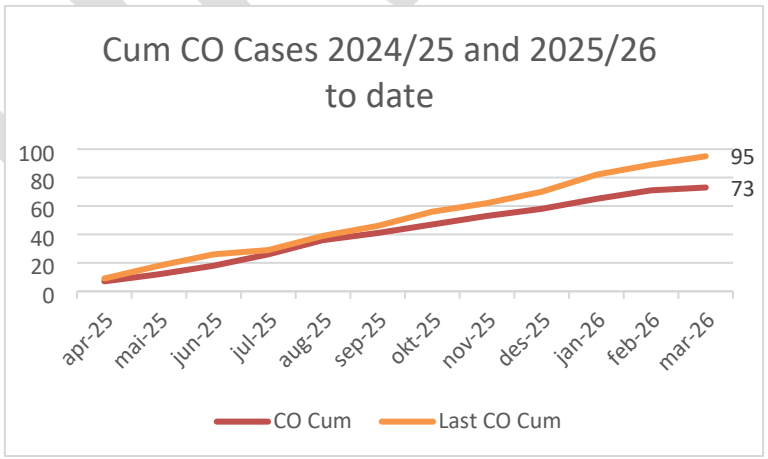
- MRSA bacteraemia is a never event but there were 7 cases this financial year – 6 HO and 1 CO
- Staph Aureus bacteraemia total of 113 against 131 last year – 13.7% reduction
- 74 cases Community onset and 39 Hospital onset (35% HO)
- All Wales rate/100 000 S. Aureus Bac – 25.31 CTM rate 27.62/100000 – 8.3% lower than lower than all Wales

The following graphic 12 shows the comparison between last year cases of Staph Aureus Bacteraemia compared to the current finantial year to date:

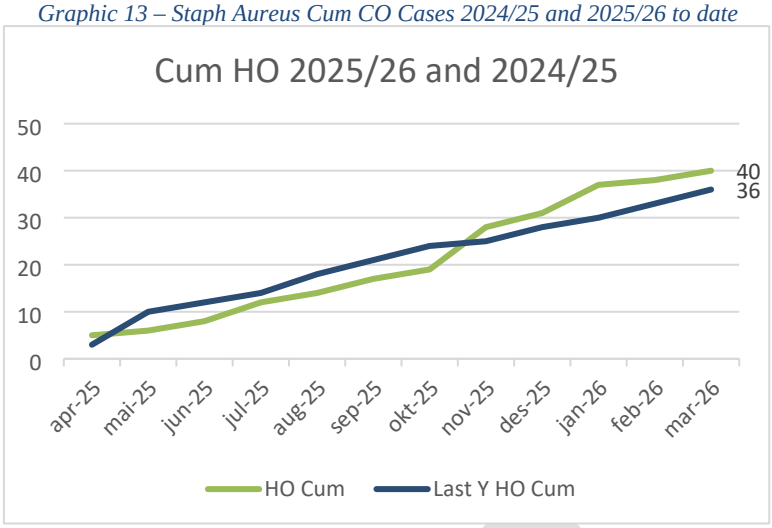


Graphic 12 - - Staph Aureus - cum 2025/26 and 2024/25

As we can see there has been a reduction on the total number of *Staphilococus Aureus* Bacteraemias of 18 cases to date (13.74% reduction), on the following Graphics 13 and 14 we can see the same data divided by CO and HO:

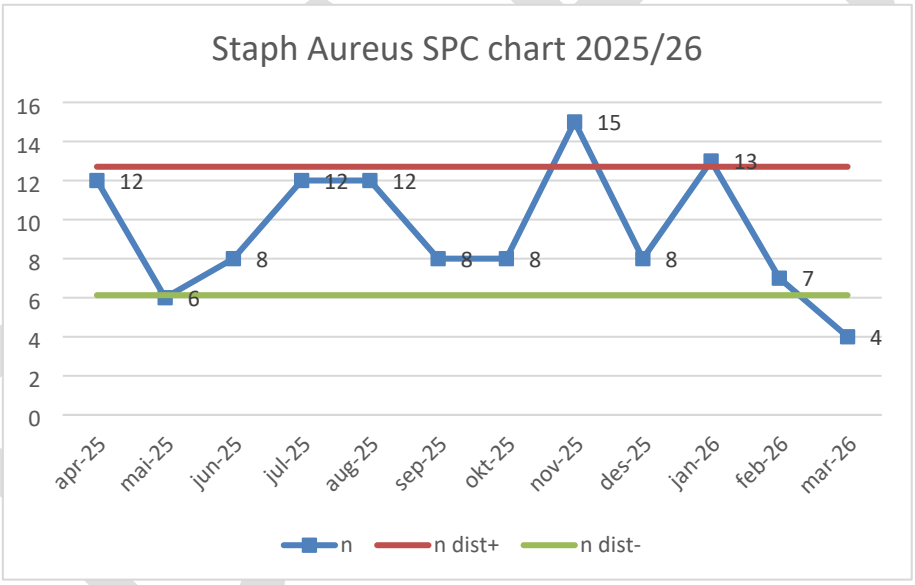


Graphic 13 – Staph Aureus Cum CO Cases 2024/25 and 2025/26 to date



Graphic 14 - Staph Aureus Cum HO 2025/26 and 2024/25

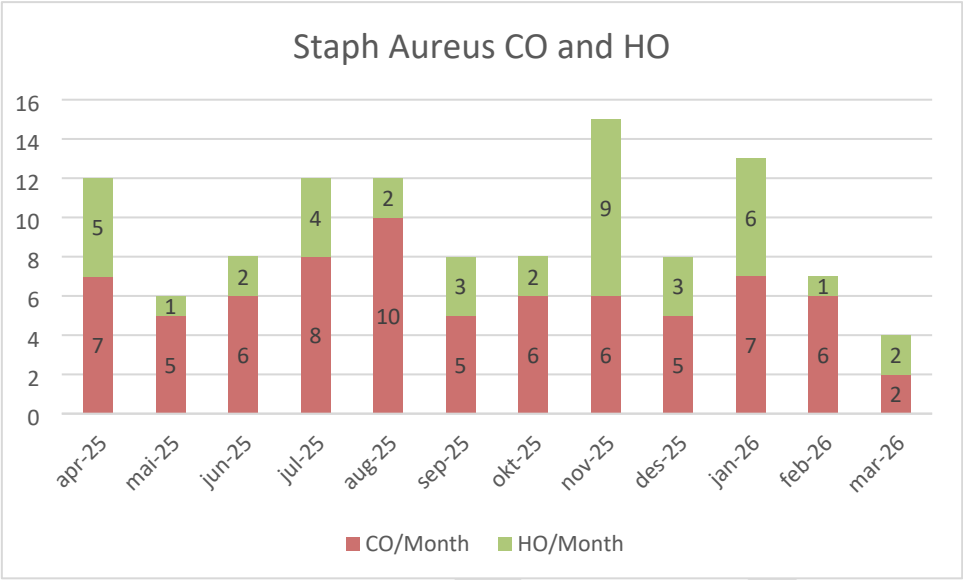
We can see thal albeit only 35% of the total number of cases being from HO cases, the reduction was achieved through reduction on CO cases, with 4 more cases of HO cases than last year same period. This shift on the higher number of HO cases compared to last year occurred in October, and can be also seen on the SPC chart:



Graphic 15 - Staph Aureus SPC chart 2025/26

According to the SPC chart, the point above the medium deviation interval occurred in November, likely a reflex of the rising on the number of cases but we can see a reduction from January. We will continue to monitor if this was a single event and we will continue on the path to reduction, since the overall SPC chart confirms the reduction trend that has been noted.
It is important to stress that while the overall reduction is a positive fact, it is concerning that we have not been able to achieve this reduction on HO cases.

On next graphic we can see the monthly distribution of CO and HO cases:



Graphic 16 - Staph Aureus CO and HO

As explained before, the HO cases account for a little more the 1/3rd of the cases with exception of November, where the number of HO cases surpassed the CO. The IPC team will continue to monitor this.

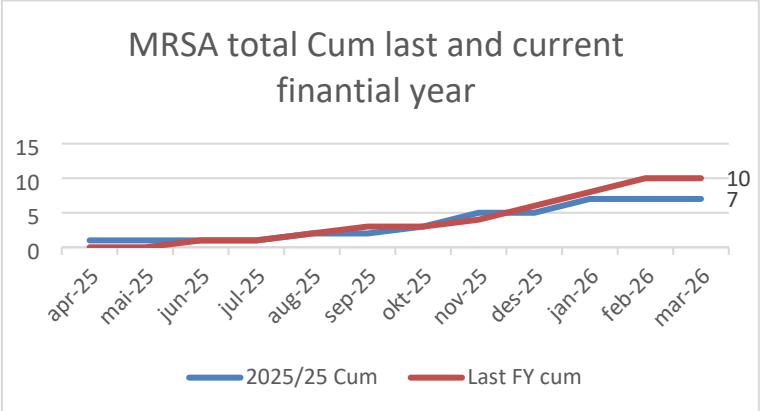
Preventable MSSA (Methicillin-sensitive Staphylococcus aureus) bacteraemia is currently categorized as a moderate risk. The Patient Care and Safety team has initiated rapid review meetings to evaluate these preventable infections and assess whether there have been breaches in the duties of candour and quality standards. The findings and lessons learned from these discussions are subsequently shared during site IPC meetings; however, additional efforts are needed to meet the established targets.

While it is crucial to focus on staff education regarding lessons learned and adherence to Aseptic Non-Touch Technique (ANTT) in the context of hospital-onset (HO) cases—especially concerning the insertion, maintenance, and removal of invasive devices—it is equally important to investigate the situation within the community. This should be conducted with the assistance of Public Health Wales (PHW) and the epidemiology team, particularly to identify the prevalence of infections in high-risk groups such as:

- Individuals with chronic wounds
- Diabetic patients
- Intravenous (IV) drug users
- Others at risk

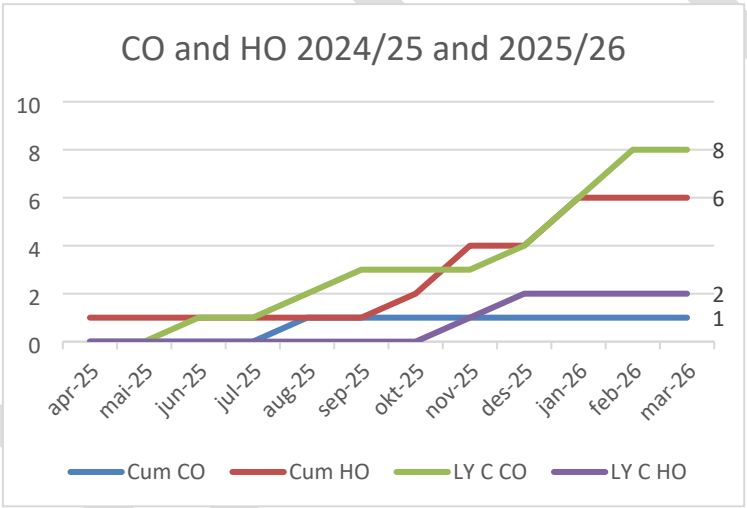
These factors may contribute to the elevated incidence of community cases. We are observing lower numbers to the previous year, and we continue to have lower rates than all Wales.

If we look at MRSA, we have a similar scenario. It is important to note that we are looking at a much smaller samples, which makes any analysis more complex. Looking at the total numbers, we had 7 cases reported this financial year, against a total of 10 last one, a reduction of 30% as can be seen on the next graphic:



Graphic 17 - MRSA total Cum last FY and current

While this aligns the HB with the National Reduction Goals we need to look into them with care since a deeper dive into the numbers reveals that this reduction, as already seen for Staphylococcus numbers as total, was mostly achieved through reduction on CO numbers from 8 to 2, while HO numbers have risen by 2 more cases from last year, as can be seen on the following graphic:



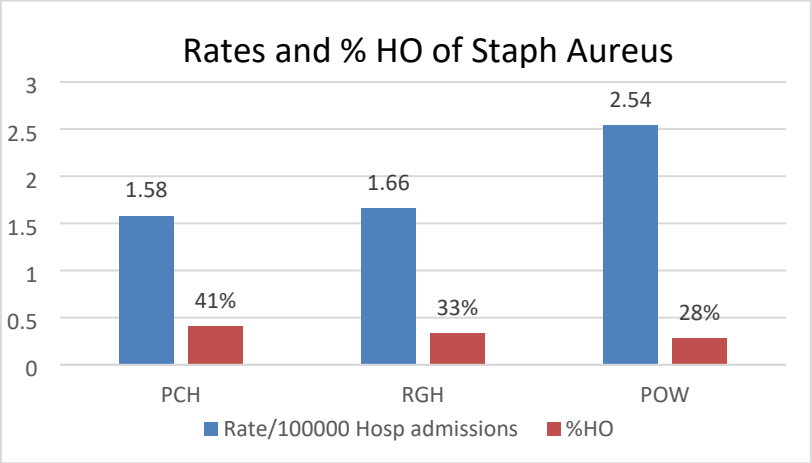
Graphic 18 - CO and HO 2024/25 and 2025/26

While this is concerning, it is important to stress the very small numbers of cases, which makes very difficult the interpretation of the numbers. It is more important to look at the current rates compared with last FY, where CTMUHB has seen a reduction for both MRSA (1.57/100 000 population – 23.41% lower than all Wales) and MSSA (23.41 per 100 0000 population).
MRSA rate has seen a reduction of 29.9% from last year 2.24 per 100 000 population and MSSA 12,4% as can be seen on the next table.

Organism	CTM 2024/25 rate/1000000CTM	2025/26 rate/Wales/100 00001000000	Reduction	Wales/100000	Dif% CTM?Wales
MSSA	27.1	23.74	12,4%	27.10	12.4%
MRSA	2.24	1.57	29.90%	2.09	24.88%

Table 15- MSSA and MRSA reduction and Wales Benchmark

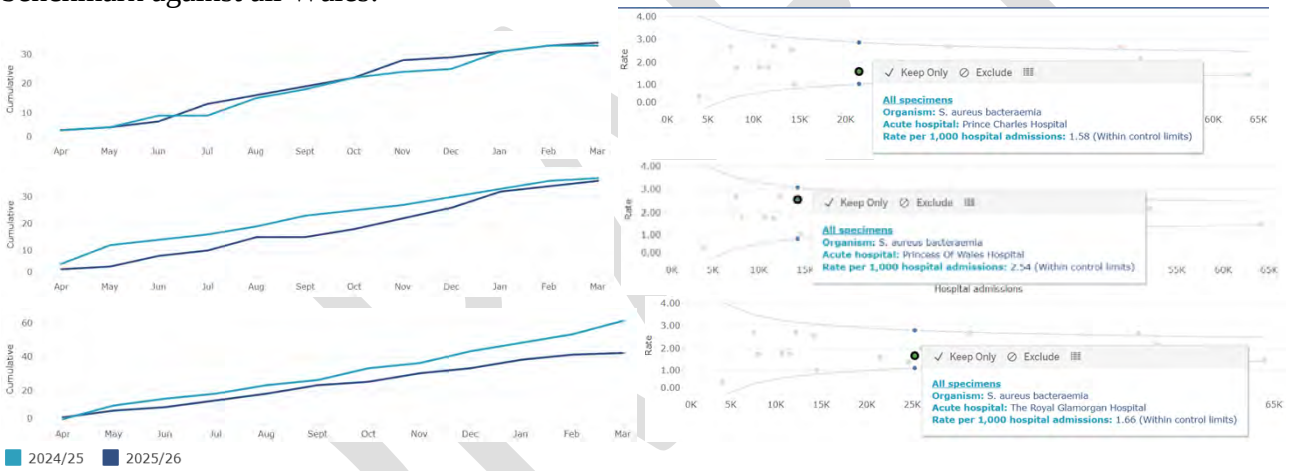
Looking again at Staphylococcus aureus bacteremia's by individual acute settings:



Graphic 19 - Cases and rate per site 2025/26

RGH had the highest total number of cases, but PCH had the highest total number of HO cases, nonetheless the lowest rate per 1000 admissions is RGH very close with PCH and the highest rate POW.

The following graphics will look into comparison with the previous financial year per site and benchmark against all Wales:



Graphic 20 - Cases per site 2025/26 and 2024/25 and benchmarking – Staphylococcus Aureus Bacteraemia

RGH and POW achieved a reduction on the number of cases compared to last year.
All 3 acute sites are within control limits with both PCH and RGH positioned on the lower than average compared to Wales and POW on the upper limits.
The IPC team has planned to continue the Point Prevalence reviews and will focus on the completion and accuracy of bundles for invasive devices. The result of the first PPS undertaken will be discussed later in this report.

5.3.1 – MRSA PREVENTABILITY

	Number of infections	Preventable infections	HO Infections
Q1	1	0	1
Q2	1	0	0
Q3	3	3	3
Q4	2	1	2
Totals for Cwm Taff financial year 25-26	**7**	**4**	**6**

Table 16 - MRSA Preventability

The preventable MRSA infections were attributed to :

- PVC
- Picc Line
- Post surgical graft site
- Hospital Acquired Pneumonia
- Skin lesion.

5.3.2 – MSSA PREVENTABILITY

	Number of infections	Preventable infections	HO Infections
Q1	25	1	11
Q2	31	3	13
Q3	28	2	11
Q4	14	6	6
Totals for Cwm Taff UHB financial year 25-26	**98**	**12**	**41**

Table 17 - MSSA Preventability

Regarding MSSA Bloodstream infection, about 12% were preventable, those were attributed to:

- PVC
- Urinary Catheters
- Arterial Line
- Total Hip Replacement

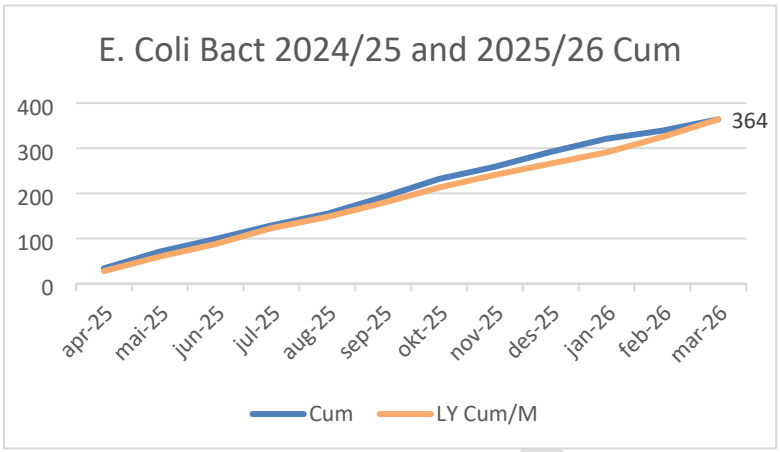
5.4 ESCHERICHIA COLI BACTERAEMIA

Improvement Goal: A reduction of at least 10% in cases of hospital onset E. coli BSI is expected vs the cases in 2024-2025.

Cwm Taf Morgannwg University Health Board cumulative monthly numbers of *E. coli* bacteraemia

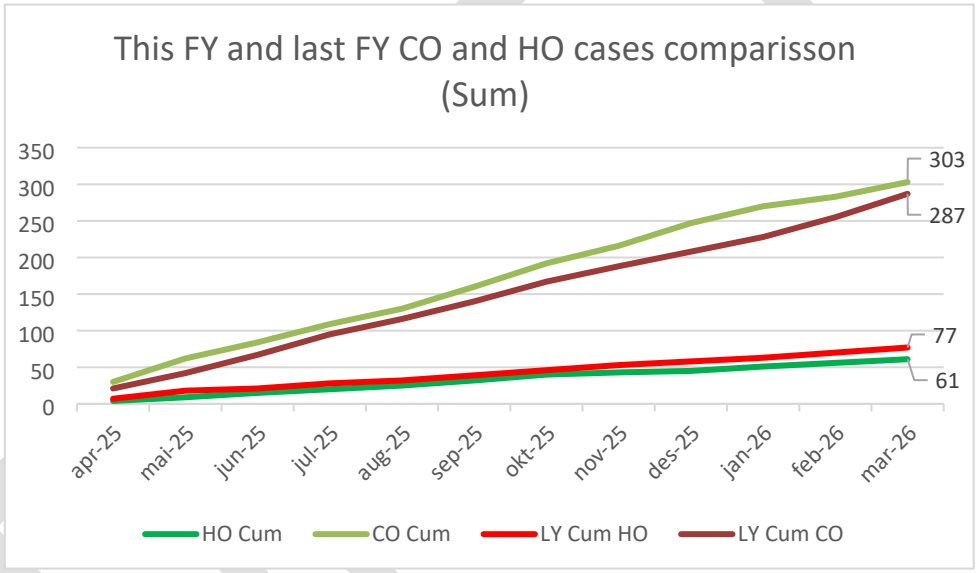
- This financial year we had a cumulative 364 cases, an increase of 3.1% from last year 353 cases
- HO cases reduction of 16 cases (20.8%)
- CO cases increase of 16 cases (5.6%)
- 303 cases Community onset and 61 Hospital onset (17% of cases are HO)
- All Wales rate/100 000 – 68.1, CTM rate 81.52 – 19.71% higher than all Wales

On Graphic 21 we can see the Sum comparison of all cases (CO and HO) cases for both 2025/25 and 2025/26:



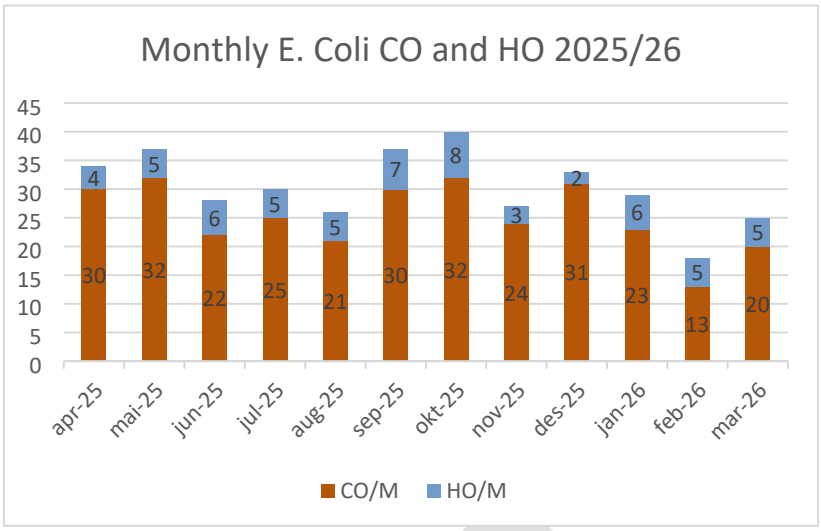
Graphic 21 - E. Coli Bact 2024/25 and 2025/26 Cum

We currently have a the same number of cases than same period last year, the following Graphic 22 shows how this is distributed between HO and CO cases:



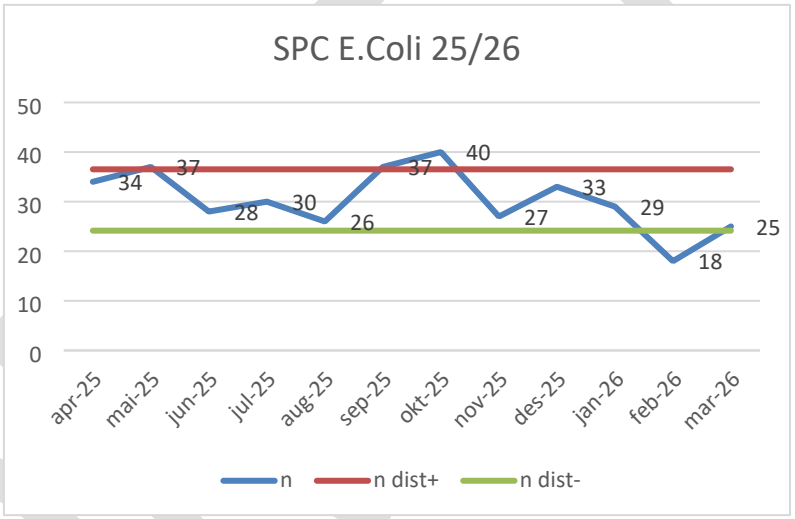
Graphic 22 – Financial years 2024/25 and 2025/26 Cum CO and HO comparison

As we can see the higher number of cases is mostly related with CO cases where there was an increase of 16 cases from last year same period (5.6%).
Regarding HO Cases there has been a reduction of 16 cases (20.8% reduction).
We are current in line with the expected reduction target for *Escherichia Coli* Bacteraemia, nonetheless it is important to point that CTM has a higher rate than all Wales, which is common also to *Klebsiella* Sp., making it an important priority for the HB to reduce the rates of Gram-bacteraemia's.
The following graphic shows monthly distribution between CO and HO cases 205/26 per month:



Graphic 23 - Monthly E. Coli CO and HO 2025/26

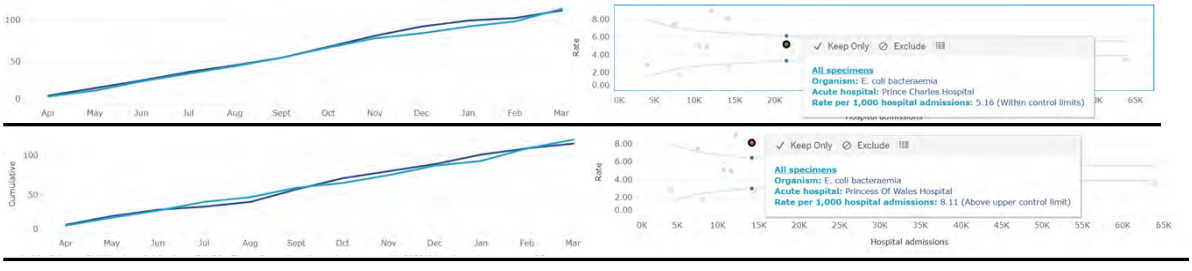
To better understand the current situation, it is important to look into the following SPC Chart:



Graphic 24 - SPC E.Coli 25/26

The SPC chart shows a process mainly inside the control limits with September and October passing the higher threshold for normal distribution and since then gradual reducing under the average with lowest point during February 2026.

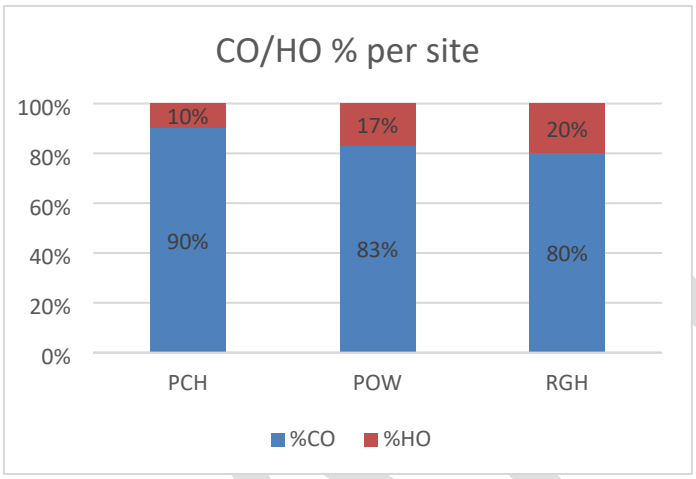
The following graphics show the distribution per acute site:





Graphic 25 - Cases per site 2025/26 and 2024/25 and benchmarking – Escherichia Coli Bacteraemia

As we can see, RGH had a higher number of cases than last year, POW saw a small reduction and PCH had nearly the same number of cases. The lowest rate on hospital admissions is PCH, very closely with RGH. Both RGH and PCH are within control lines but POW is above the control limit line with an rate per 1000 admissions of 8.11.
If we look at ratio CO/HO per site:



Graphic 26- CO/HO % E.Coli admissions per site

We can see that POW and RGH have very similar % of cases that are HO, while this is nearly halved by PCH, nonetheless the big majority of cases are CO cases. While the reduction target focus on HO cases, we need to acknowledge that CO will necessarily condition the HO cases and therefore it is essential to work towards an integrated strategy to tackle both.
More work will need to be put towards continue the reduction of Gram-negative blood stream infections and in particular E. Coli. Such as:

- Increase PPE awareness through online training and face-to-face sessions
- Strengthen ANTT training – ANTT training advised to be reinstated as mandatory for all staff doing invasive procedures, which will refocus the importance and compliance or embed this into all insertion and maintenance of invasive devices training
- Catheter insertion and management continues to remain a focus, with a planned point prevalence study to be completed to provide a gap analysis to target an improvement plan
- Continue to increase compliance with IPC training, with current compliance at 74%. The target goal for CTM will be to achieve at least an average compliance of 85% by the end of Q3.
- Joint work with bowel and bladder team to explore ways to ensure better implementation of catheter passport as well as identify other joint actions to support reduction of CAUTI
- Understand the impact of invasive device bundles move to digital may have had in clinical practice.

5.4.1 – ECOLI PREVENTABILITY

	Number of infections	Preventable infections	HO Infections
Q1	97	8	22
Q2	93	3	21
Q3	100	7	14
Q4	74	6	16
Totals for Cwm Taff UHB financial year 25-26	**364**	**24**	**73**

Table 18- E.Coli preventability

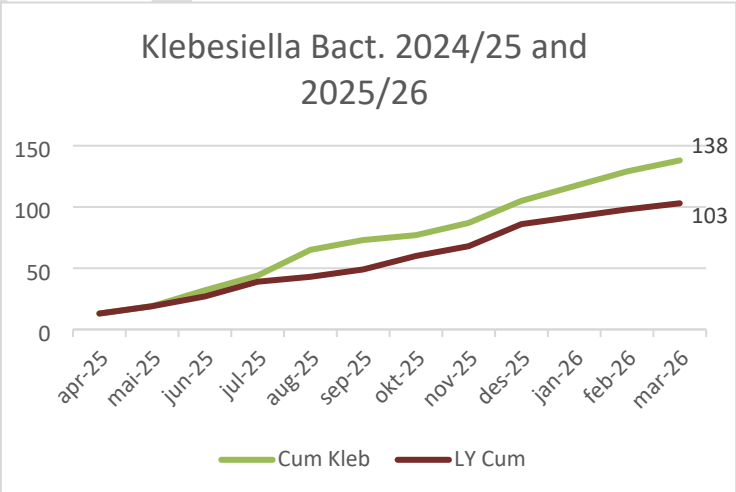
In table 18 we see a larger number of HO cases than the ones reported, this was due to a difference between the definition used by the IPC team and PHW on HO cases, this has now been corrected and confirmed HO cases – 61 cases.
Only about 6.6% of the total of bloodstream infections were deemed as preventable, nonetheless albeit the low number it is important that the HB continues to monitor and work towards reducing the rate of E.coli and other Gram negative bacteremia's.

5.5 KLEBSIELLA SPP. BACTERAEMIA

Improvement Goal: A reduction of at least 10% in cases of hospital onset Klebsiella spp BSI vs the cases in 2024-2025.

This financial year CTMUHB has recorded a cumulative 138 Klebsiella spp. bacteremia cases compared with 103 during the same period last year, representing an increase of 34.0%. Of these, 100 cases were community onset and 38 were hospital onset, meaning 28% of cases were hospital onset. CTMUHB's rate remains above the all-Wales rate (30.01 per 100,000 population compared with 23.70), confirming that Klebsiella spp. bacteremia continues to be a significant challenge for the Health Board. Although the national improvement measure is focused on hospital-onset cases, the overall pattern indicates that community-onset burden is also contributing materially to the position and must be considered within the wider response.

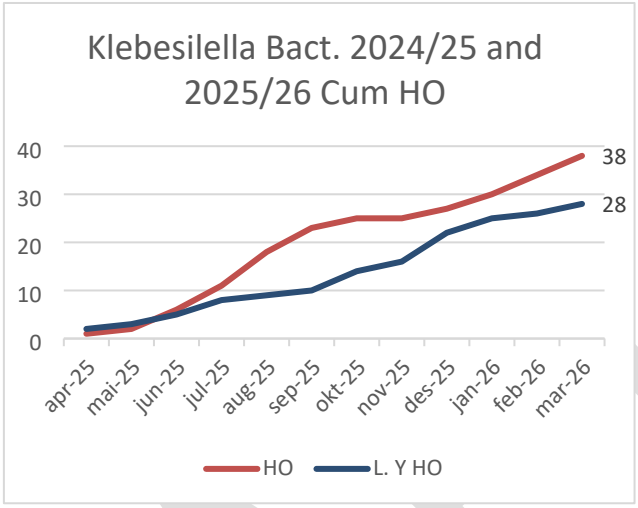
We can see this data on the following graphics:



Graphic 27- Klebsiella Bact. 2024/25 and 2025/26 Cum

The cumulative trend graphic (graphic 25) shows a clear divergence from the previous financial year, with case numbers remaining consistently above the 2024/25 comparator. This indicates that the increase is not attributable to a single isolated period, but rather reflects sustained pressure across the year. From an analytical perspective, this is important because it suggests a persistent epidemiological signal rather than short-term random fluctuation, reinforcing the need for continued investigation of both acute and community drivers of infection.

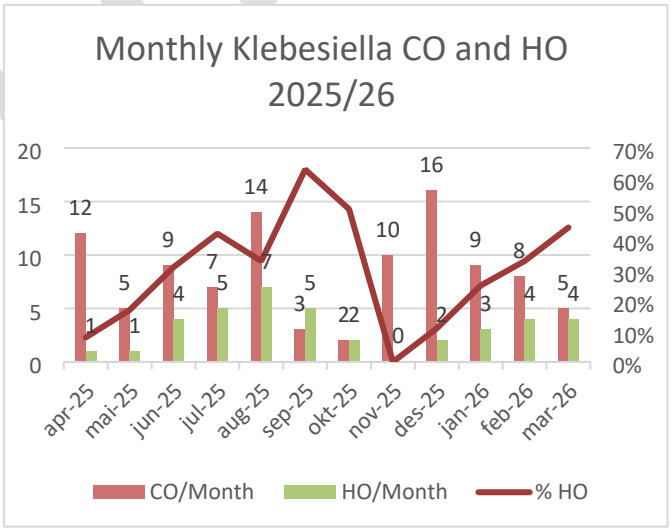
If we look only to HO cases, we can see the same:



Graphic 28- Klebsiella Bact. 2024/25 and 2025/26 Cum HO

The hospital-onset cumulative graphic (28) shows that hospital-onset Klebsiella spp. bacteraemia has also increased compared with the same period last year. This is particularly important in the context of the improvement goal, as it indicates that CTMUHB is not yet on the required trajectory for reduction. While the increase in hospital-onset cases is smaller in absolute terms than the overall increase, it remains operationally significant because these cases are more likely to reflect factors such as invasive device management, hydration, antimicrobial exposure, patient vulnerability and the challenge of maintaining consistent IPC standards.

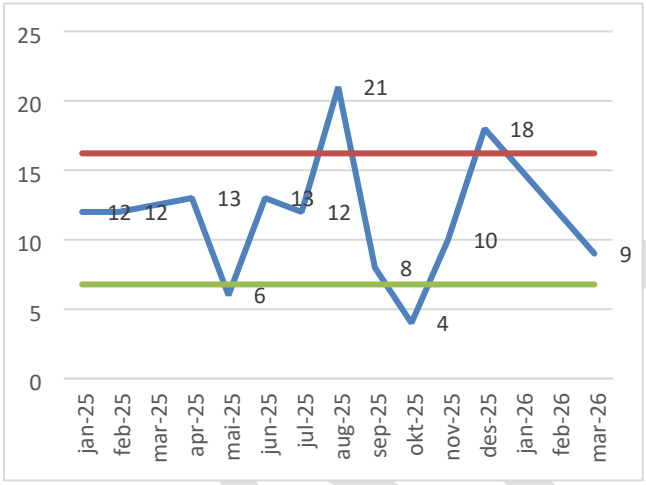
The following graphic shows the break between HO and CO per month during the current financial year:



Graphic 29- Monthly Klebsiella CO and HO 2025/26

The monthly distribution graphic (26) demonstrates that most Klebsiella spp. bacteremia cases remain community onset, but it also shows that the proportion of hospital-onset cases is not static across the year. Periods of higher overall activity appear to be accompanied by a rise in hospital-onset burden, suggesting that acute services are under greater risk when community prevalence is elevated. This supports the view that hospital-onset and community-onset cases should not be considered in isolation. A purely acute-based response is unlikely to deliver sustained reduction unless it is accompanied by stronger work across community services, catheter care, bowel and bladder pathways, hydration, antimicrobial stewardship and early recognition of patients at higher risk of deterioration or infection.

Looking into the SPC Chart:

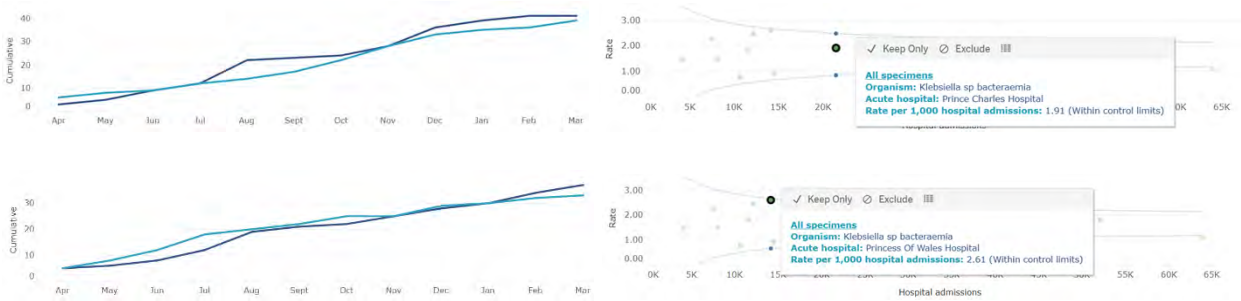


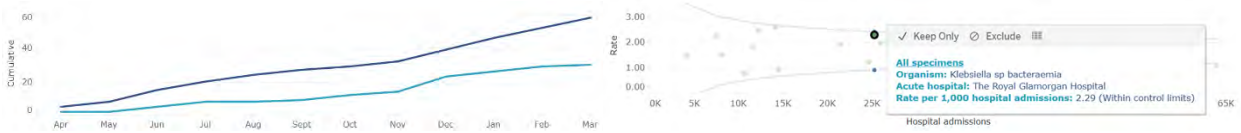
Graphic 30- Klebsiella SPC Chart

The SPC chart suggests a process that has shown instability over the year, with variation that merits further review rather than reassurance. This pattern indicates that the Health Board should continue to examine whether specific services, pathways, seasonal pressures or case-mix factors are influencing the increased burden. The purpose of this analysis is not only to explain past performance, but to identify where preventive action is likely to have the greatest impact. In practical terms, this means strengthening review of avoidable factors where possible, while also improving epidemiological understanding of the wider drivers behind the increase.

Klebsiella-related infections reductions actions has already been explored regarding *E.Coli* bacteraemia.

If we look into the next graphics, we will see the situation for each acute site:





Graphic 31 - Cases per site 2025/26 and 2024/25 and benchmarking – Klebsiella Bacteraemia

The site comparison and benchmarking graphic shows that all three acute sites have reported more cases than during the same period last year. Princess of Wales Hospital has the highest rate, although all three acute sites remain within control limits when benchmarked against comparable sites across Wales. This is an important distinction: although the position remains statistically within expected variation, it does not diminish the operational and clinical significance of the increase seen locally. The findings therefore support a balanced interpretation - CTMUHB is not an outlier in benchmarking terms, but the sustained rise in cases means that targeted local action remains necessary, particularly in relation to catheter-associated urinary tract infection prevention, invasive device practice, hydration and integrated work between acute and community teams.

5.5.1 – KLEBESIELLA PREVENTABILITY

	Number of infections	Preventable infections	HO Infections
Q1	32	3	10
Q2	41	7	13
Q3	32	8	4
Q4	33	7	11
Totals for Cwm Taff UHB financial year 25-26	**138**	**25**	**40**

Table 19- Klebsiella Preventability

There is a small difference on the number of HO cases in table 19 compared to the reported number, as explained previously for E.Coli, this is due to different case definitions between IPC team and PHW, this has now been corrected.
About 18% of the total number of cases investigated was deemed as preventable. Albeit the low %, it is important to note the lack of improvement regarding Gram negative bacteraemia's across CTM and therefore essential to work towards improvement. All preventable bacteremia have CAUTI as a source with the exception of 2. One of these was thought to be an infected PICC line and another due to urology stents.

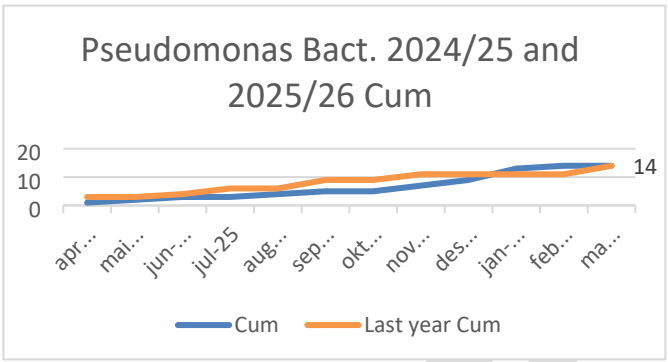
5.6 PSEUDOMONAS AERUGINOSA BACTERAEMIA

Improvement Goal: A reduction of at least 10% in cases of hospital onset Pseudomonas aeruginosa BSI vs the cases in 2024-2025 for the Health Boards that achieved the hospital onset improvement goal in 2024/25

This financial year CTMUHB has recorded 14 Pseudomonas aeruginosa bacteremia cases, unchanged from the same period last year. Of these, 9 were community onset and 6 were hospital onset. Hospital-onset cases have reduced by one compared with last year, equivalent to a 16.7% reduction, meaning that the Health Board is currently achieving the required improvement target for hospital-onset reduction. In addition, CTMUHB continues to compare favorably with the all-Wales position, with a rate of 3.14 per 100,000 population compared with 5.12 nationally. Taken together, these findings

suggest that, although vigilance remains essential, Pseudomonas aeruginosa bacteremia is n area of strength for the organization when compared with other bloodstream infection priorities.

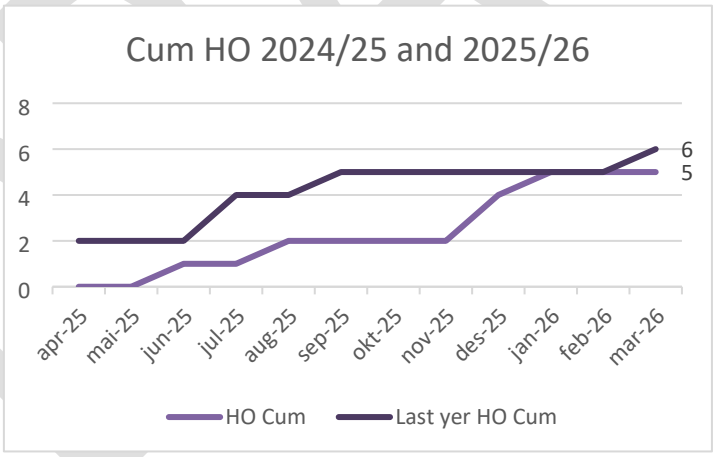
The following graphic shows the total number of cases (HO and CO) from last financial year compared to same period this financial year:



Graphic 32 - Pseudomonas bact. 2024/25 and 2025/26 Cum

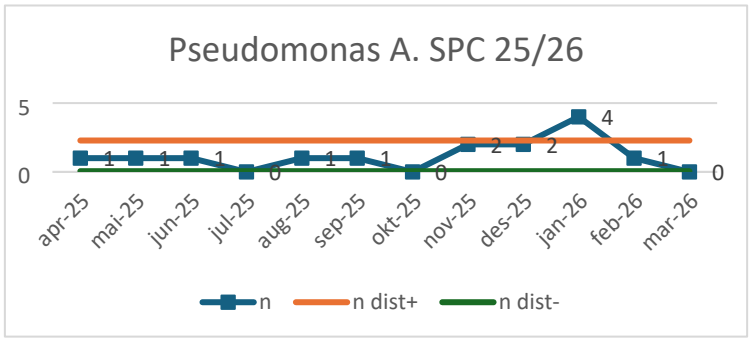
The cumulative total graphic (32) shows a broadly stable position year on year, with no evidence of a sustained upward drift. Stability is important in this context because case numbers are low and even small numerical changes can produce disproportionately large percentage movements. For that reason, interpretation should be cautious and should focus on the overall direction of travel rather than over-interpreting individual monthly changes. The key message from the cumulative trend is that CTMUHB has maintained control of this organism over the reporting period.

The following graphic compares the HO case (Cum) along the financial year:



Graphic 33 - Cum HO 2024/25 and 2025/26

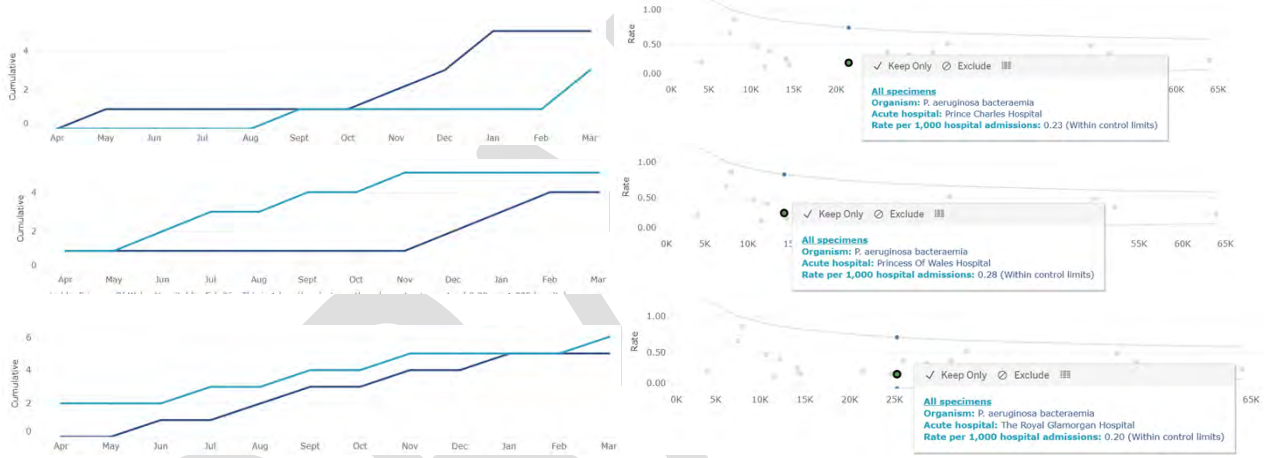
The hospital-onset cumulative graphic (30) demonstrates a small reduction compared with the previous financial year. Although numerically this represents only one fewer case, it remains consistent with the national improvement requirement. However, the very small number of cases means that performance should not be judged on percentages alone. The more meaningful interpretation is that hospital-onset burden has remained low and that CTMUHB has sustained a comparatively favorable position with a lower rate than all Wales, while continuing to monitor for any emerging change in pattern.



Graphic 34 - Pseudomonas Bact. SPC Chart

The SPC chart shows a stable process within control limits, with no sustained signal of special cause variation. This provides some reassurance that the current position is not being driven by an underlying deterioration in performance. Nevertheless, because the case volume is small, the chart should be interpreted alongside clinical intelligence and local review of individual cases. Continued emphasis on water safety, environmental controls, appropriate device management and adherence to standard IPC practice remains important to preserve this favorable position.

Looking at benchmarking our 3 acute sites within Wales:



Graphic 35- Cases per site 2025/26 and 2024/25 and benchmarking – Pseudomonas Bacteraemia

The site benchmarking graphic indicates that all three acute sites remain within control limits when compared with equivalent sites across Wales. This supports the view that the Health Board's overall position remains favorable. At site level, however, small case numbers can create apparent variation that may not be statistically meaningful, so interpretation should remain proportionate. The most appropriate conclusion is that current arrangements appear to be containing risk effectively, but that this should not lead to complacency. Ongoing surveillance, case review and reinforcement of core practice are still required to maintain the present standard.

PCH had more cases than last FY with 2 HO cases, while the past financial year there were 0 cases. The IPC team continues to monitor this closely, both cases were deemed as unavoidable after investigation.

From an improvement perspective, the priority for Pseudomonas aeruginosa bacteremia is to sustain performance. That means maintaining attention on water safety governance, invasive device practice, ANTT, hand hygiene, cleaning and staff compliance with IPC fundamentals. In contrast with areas such as Klebsiella spp. or E. coli, this section reflects a more positive performance narrative for CTMUHB. The challenge for the next FY is therefore to preserve the gains already achieved while ensuring that the organization continues to identify and respond quickly to any change in pattern.

5.6.1 PSEUDOMONAS PREVENTABILITY

	Number of infections	Preventable infections	HO Infections
Q1	2	1	1
Q2	2	0	1
Q3	4	0	2
Q4	6	0	1
Totals for Cwm Taff UHB financial year 25-26	**14**	**1**	**5**

Table 20 - Pseudomonas Bacteremia Preventability

Only one preventable pseudomonas bacteremia which has a source of a CAUTI – this was CO and managed in the community.

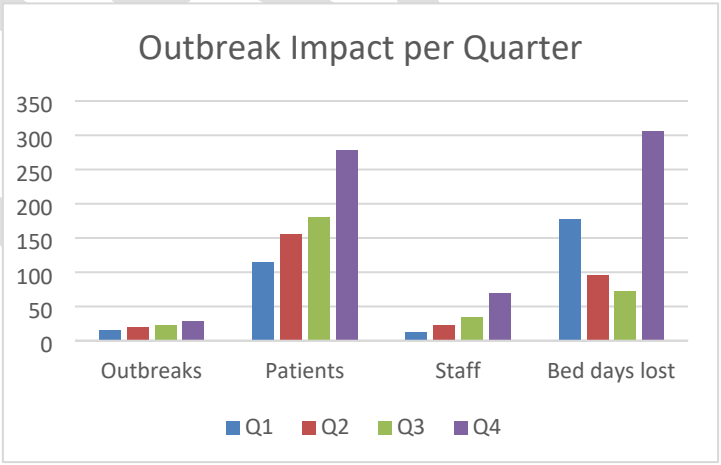
5.7 ACUTE RESPIRATORY INFECTIONS, NOROVIRUS AND OTHER OUTBREAKS

Winter pressures significantly affected IPC activity and operational resilience. Q4 acute respiratory infection data showed that respiratory pressure was driven by multiple pathogens, with Influenza A the most common recorded ARI, followed by RSV and COVID-19. This mixed-pathogen profile increased the complexity of patient placement, cohorting and escalation.
Norovirus was the most operationally disruptive organism during Q4. The annual outbreak data shows that norovirus was the largest contributor to bed-day loss across the year.

Quarter	Outbreaks	Patients	Staff	Bed days lost
Q1	16	114	13	178
Q2	19	156	23	96
Q3	23	181	35	72
Q4	28	278	69	306

Table 21 - Annual outbreaks/PII by quarter

The same information can be seen on the following graphic:



Graphic 36 - Outbreak Impact per Quarter

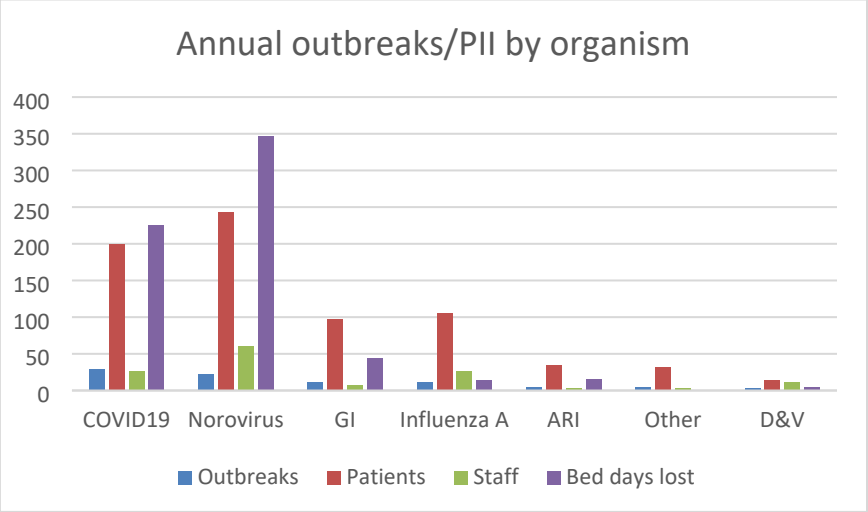
Where we can see that Q4 was the most affected quarter by combined number of outbreaks.
Looking into the following table we can see this same information by Organism/type of outbreak:

Organism	Outbreaks	Patients	Staff	Bed days lost
COVID19	29	200	26	226
Norovirus	22	244	61	347
GI	11	98	7	44
Influenza A	11	106	27	14

ARI	5	35	4	16
Other	5	32	3	0
D&V	3	14	12	5

Table 22 - Annual outbreaks/PII by organism

For easier understanding of the data, it has been compiled on the following graphic:



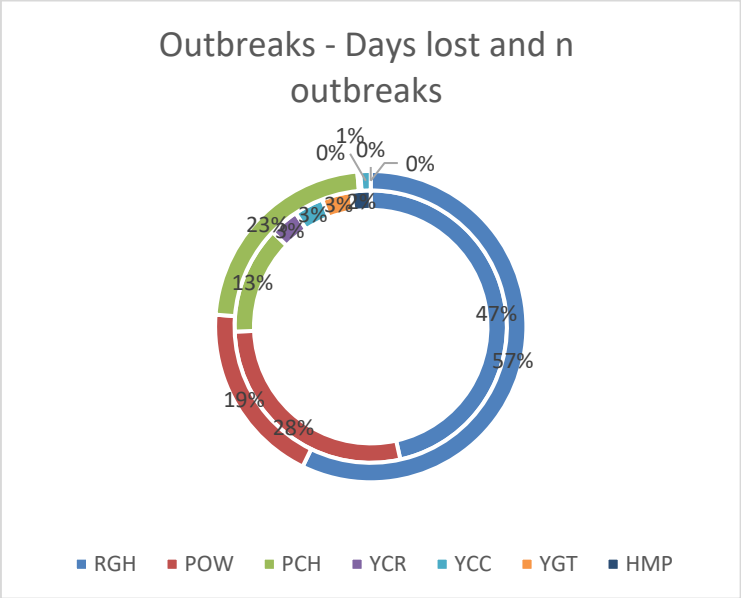
Graphic 37 - Annual outbreaks/PII by organism

Norovirus was the microorganism that affected the highest number of patients. It is important to point that very likely the number of positive cases in patients is under-represented due to limitations on testing in RGH, the site that had the highest number of outbreaks. The second most relevant was COVID-19, in both patients affected and bed days lost.
Influenza seems to have caused a more limited impact when looking into the data being presented, nonetheless, there have been 10 deaths from Influenza (HO) – 6 Flu A on part 1a of death certificate and remaining 1b or 1d. All cases were reviewed as part as a multidisciplinary team, with 2 cases identified as moderate harm and the remaining 8 cases, identified with low or no harm related to the increased incidence of Influenza. All cases were part of outbreaks and all of them occurred in Royal Glamorgan Hospital. Reflecting on the limited impact of influenza, we believe this was mainly related with the rapid response with quick setup of the IPC cell meetings, Universal use of masks and heighted IPC awareness across the organization, limiting the outbreaks mostly to RGH hospital and significantly reducing the impact in the remaining settings. This information validates the options taken during the height of flu infections.
Some factors prevented to reduce further the impact of the influenza outbreaks across the organization, in particular the fact that the first cases were detected earlier than in previous years and before what was in the winter modeling by PHW as well as the onset of cases following the severe scenario in the modeling, which was seen as a quick onset and wide spread at RGH.
The following table shows the distribution of outbreaks per site:

Site	Outbreaks	Patients	Staff	Bed days lost
RGH	40	352	77	373
POW	24	176	23	124
PCH	11	105	27	146
YCR	3	26	3	2
YCC	3	19	10	7
YGT	3	20	0	0
HMP	2	31	0	0

Table 23 - Annual outbreaks/PII by site

In the following graphic we can see the information regarding bed days lost per site:



Graphic 38- Outbreaks - Bed days lost and n Outbreaks

As has been discussed prior, RGH was the site most affected, with 57% of all days of bed lost and 47% of the total number of outbreaks. The reason for this is not fully clear and will require further investigation, but very likely is related with the very high activity on this site compared to the remainer, in conjunction with a very limited number of isolation space compared to PCH. Further reflection and investigation is advised to understand if there are any other variables contributing to this.

The key learning is that outbreak response requires a structured operational model, not an IPC advisory process alone.

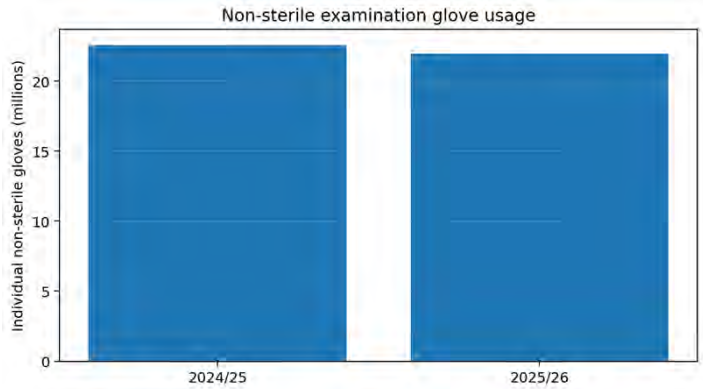
The IPC team has been working on the development of an outbreak response framework, to enable a quicker deployment of the IPC cell, with better governance and improved capacity for decision making. In parallel to this, the IPC team is also working into the development on an out of hours ARI guidance to support decision making when IPC is not available.

6. FINANCIAL STEWARDSHIP, SUSTAINABILITY AND GLOVE-USE REDUCTION

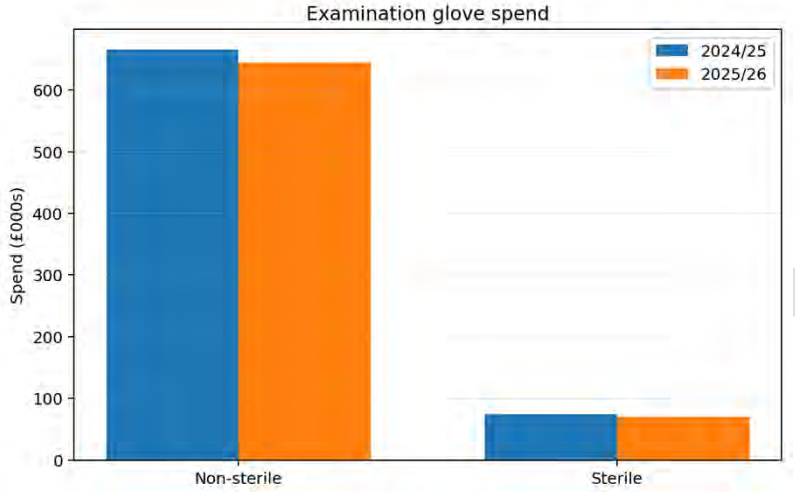
A separate review of non-sterile and sterile examination glove usage and spend compared 2024/25 with 2025/26. The data show a substantial reduction in non-sterile glove usage and spend, while sterile glove usage increased slightly but total sterile spend fell because of price reduction.

Category	Unit of issue	2024/25 quantity	2024/25 value	2025/26 quantity	2025/26 value	Quantity diff	Value diff
Non-sterile	BOX50	222	£1,740.16	136	£1,070.56	-86	-£669.60
Non-sterile	BOX100	225,623	£663,280.18	219,608	£643,291.55	-6,015	-£19,988.63

Table 24- Examination glove usage and spend comparison



Graphic 39- Reduction in non-sterile examination glove usage



Graphic 40- Examination glove spend by category

Non-sterile glove usage reduced from 22,573,400 individual gloves to 21,967,600 individual gloves, a reduction of 605,800 individual gloves. Non-sterile glove spend reduced by approximately £20,658.23. Sterile glove usage increased by 181 pairs, but spend still reduced by £5,024.27 due to price reduction. Overall examination-glove spend reduced by approximately £25,682.50.

The IPC point-prevalence Programme has visibly improved staff awareness and compliance with BBE and PPE standards, and the February 2026 follow-up PPS demonstrated marked improvement compared with July 2025, with most wards moving into green compliance and several areas achieving 100%.

In summary

During 2025/26, CTMUHB recorded a material reduction in non-sterile examination glove usage and spend. This reduction is very likely to have been supported, at least in part, by IPC point-prevalence surveys and targeted improvement work on the PPE use and Bare Below the Elbows. These interventions increased visibility of expected standards, enabled direct feedback to clinical areas and helped challenge unnecessary or inappropriate glove use. Because glove consumption is also influenced by clinical activity, case mix, outbreaks, procurement and stock management, the reduction must be described as a quality, sustainability and financial-efficiency benefit to which IPC improvement work made a credible contribution.

7. COMMUNITY IPC TEAM AND SYSTEM-WIDE PREVENTION

Community IPC Team Update (June 2025 – March 2026)

The Community IPC Team was set up in June 2025 and significant progress has been made to build a comprehensive service which is designed to support community settings across CTM. The Community IPC Team have built strong working relationships with Public Health Wales and local authority colleagues to improve IPC standards.
The Team's resource has recently been extended with plans to expand the current resource further. This will improve capacity and accelerate development of robust workplans whilst improving resilience within the team to respond to increased demands during outbreaks of infection. The enhanced workforce also enables the team to provide support consistently during the working week. Going forward, microbiologist support will also be needed to enable direct support to the team and the review of Community Onset Cdiff and bacteremia.

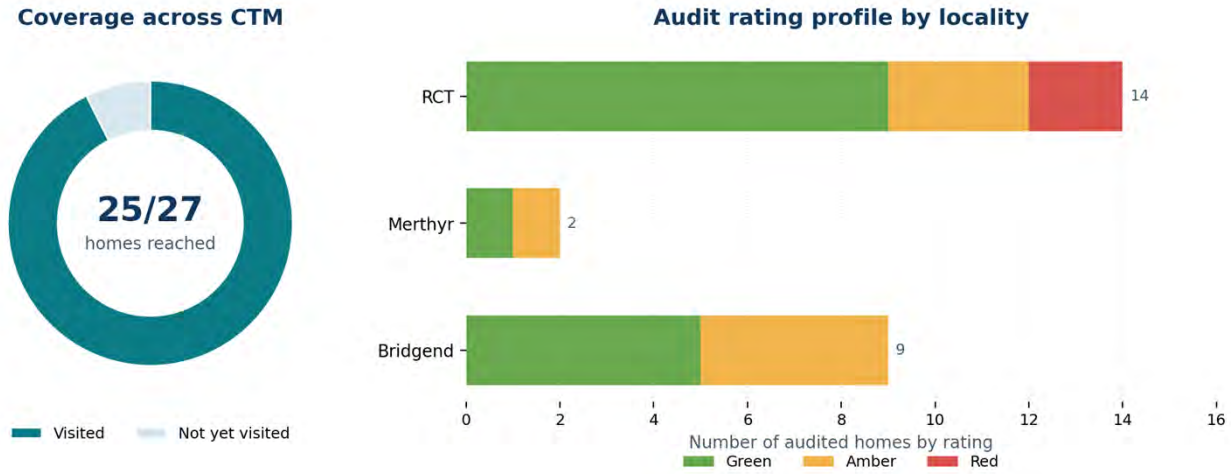
Nursing Homes

The Team have visited 25 of the 27 Nursing Homes across the CTM boundary. An IPC audit has been conducted in each of the homes and overall, the standards of IPC observed have been very good. A summary of the audit findings have been shared with the Care Home Managers for consideration and action.
A follow up offer of support has been shared with both care homes who initially declined the offer of support.

	Number of homes	Homes audited	Green rating (>90%)	Amber rating (80 - 90%)	Red rating (<80%)
RCT	15	14	9	3	2
Merthyr	2	2	1	1	0
Bridgend	10	9	5	4	0
TOTAL	**27**	**25**	**15**	**8**	**2**

Table 25 - CIPCt - Nursing Homes Visited

The following graphics display the coverage by the CIPCt for Nursing homes and the audit rating by locality:



Graphic 41- Nursing Homes Coverage and Audit rating profile by locality

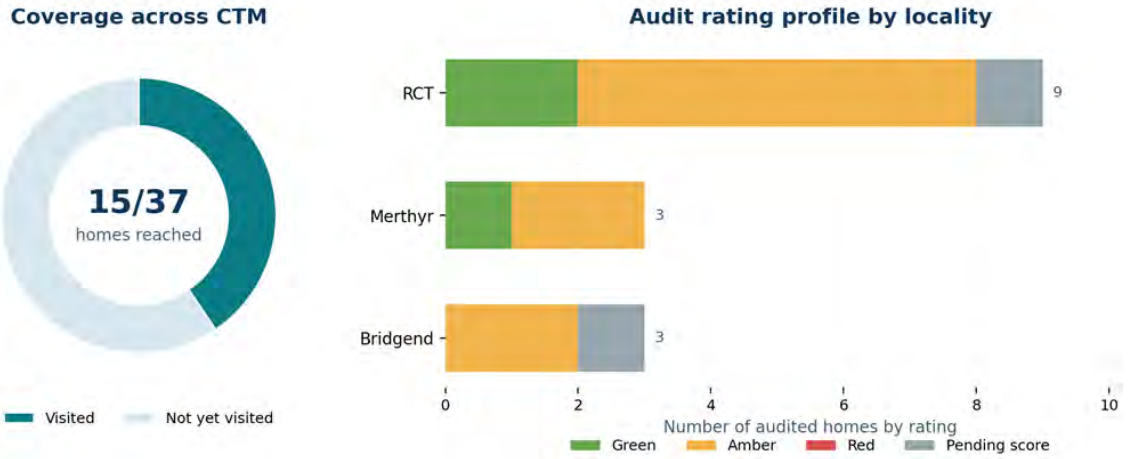
Residential Homes

The offer of an introductory visit and IPC audit has been extended to all residential homes.
An IPC audit has been carried out in 15 of the 37 residential homes. The team is working with commissioning teams in the local authorities to encourage Care Home Managers to access IPC support.
Follow up emails have also been sent to all care homes and further visits have been arranged in 2026.

	Number of homes	Homes audited	Green rating (>90%)	Amber rating (80 - 90%)	Red rating (<80%)	Score to be calculated
RCT	13	9	2	6	0	1
Merthyr	8	3	1	2	0	0
Bridgend	16	3	0	2	0	1
TOTAL	37	15	3	10	0	2

Table 26 - - CIPCt - Residential Homes Visited

The following graphic shows the IPC coverage at the moment this report was being produced and the audit rating profile by locality:



Graphic 42- CIPCt – Coverage and Audit rating by locality

Further work is needed to improve uptake of IPC support in the Bridgend and Merthyr areas. The support from the commissioning teams will be essential to support the IPC team on being able to visit and build a champions network across the Residential home Universe.

Training
An IPC training package has been developed and face to face sessions have been offered to all Home Managers. The training focuses on consistent use of standard infection prevention and control precautions and management of winter viruses including ARI and D&V.

The Community Team have delivered 20 sessions and delivered training to 201 care home staff. Excellent feedback has been received for the content and delivery of the sessions.
Further training will be developed through a shared electronically presentation to support face to face sessions.

Many of the larger care provider companies have a full Programme of education which includes IPC.

Outbreak management.
Scabies

The Community Team were notified of 11 outbreaks of Scabies in Care Homes between June 2025 and March 2026 which reflects the national increase reported. Being able to provide a timely response to support care homes to access treatment in a timely manner is critical during an outbreak to minimise further transmission. It is extremely difficult for Care Home staff to access treatment quickly which delays treatment for cases and contacts.

To reduce the delay, the Community Team is working collaboratively with Health Board colleagues to adapt a national PGD for treatment of contacts during outbreaks of Scabies in long term care facilities.

An information pack is being developed to support care homes during outbreaks.

D&V/ARI
PHW have requested support from the Community IPC Team during outbreaks of D&V/ARI. This proved difficult initially due to the limited resource but has now been agreed and an SOP for COVID-19 outbreaks is being developed to support the communication between community settings, local authorities, PHW and IPC as well as escalations.
The
Team has provided IPC advice over the telephone and visited the care homes in person where workload allows. This has been expanded with the increase of the number of staff allocated to the community team.

Networking.
The CIPC Team have developed links with local authority colleagues to support community settings. The Team have attended various meetings with commissioning teams in RCT, Merthyr and Bridgend and work is ongoing to support improvement in a variety of settings. The Team have attended a variety of care home and care provider meetings to offer support as can be seen on previous tables.

The Team is also present at national IPC and community setting meetings to enable sharing of ideas, participation in quality improvement projects and enables contribution to documentation/audit development to support improvements and standardization.

Recruitment.
The Community team is expanding following successful recruitment into a number of posts. There has been a limited resource since June 2025 but the additional resource has enabled the Team to be more proactive to support existing priorities and future work plans relating to IPC.
There is 1 vacant post and there are plans to relocate an IPC Nurse from the acute team into the community team to provide further support.

Community Vaccination Centers
The Team has visited the 6 community vaccination centers and shared recommendations with service leads. IPC recommendations relating to environmental issues and medicines management concerns have been identified and escalated.

ANTT

The Community IPC Team is working with District Nursing Teams across CTM to improve compliance with ANTT. Additional assessors have been trained to improve compliance with an aim to work towards bronze accreditation. This will be the first accreditation achieved within Cwm Taf Morgannwg UHB for ANTT and the Team will work with QI colleagues on the project.

Planned work for 2026/27 -

- From 1/4/26, provide IPC advice and support to Care Homes during outbreaks of Scabies and COVID. The Team will develop standardized information and supporting materials to share with care home staff during outbreaks of COVID and Scabies to ensure consistent messaging.
- Extend community IPC service to include community clinics, HMP Parc and GP surgeries.
- Develop an IPC link/Champion Programme.
- Review cases of CDI linked to care homes.
- Support domiciliary care teams
- Support Care Homes with COVID

At a glance, the CIPCt:



Figure 2- Resume CIPCt Activity

DRAFT

From a training, assurance and quality improvement work, the CIPCt work can be resumed as follows:

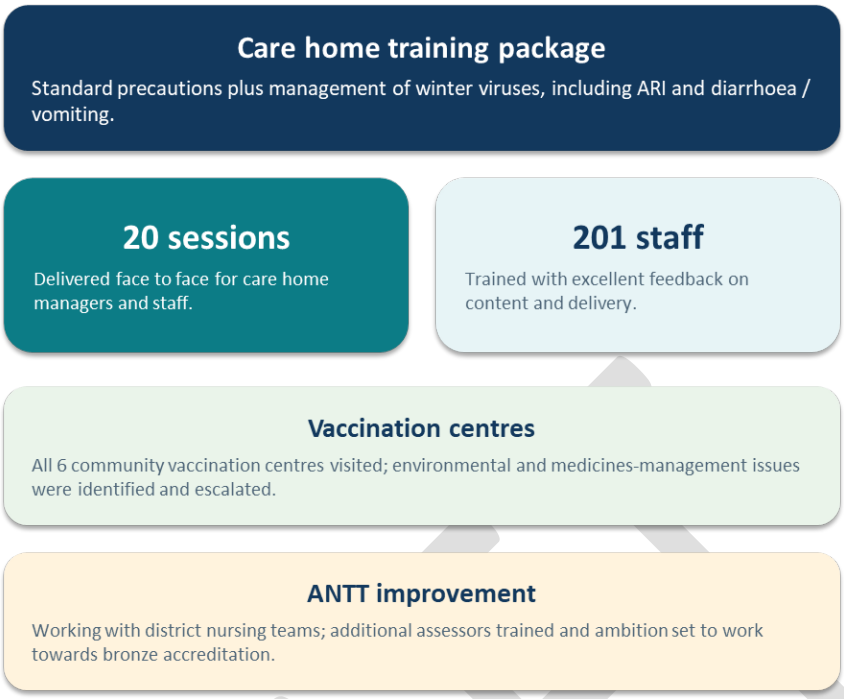


Figure 3- - CIPCt - Training, assurance and quality improvement work.

8. CAPITAL WORKS, DEVELOPMENTS AND REFURBISHMENT

Capital and infrastructure work remained closely linked to IPC risk. Key developments included continued involvement in the Llantrisant Health Park project, funding approval for central decontamination for CTM and Welsh Government funding for two negative-pressure rooms, one at RGH and one at POW. These developments are central to strengthening preparedness for highly infectious diseases, measles, airborne infections and future respiratory pressures.
Infrastructure risk is not limited to new builds. Existing estates constraints, ventilation limitations, decontamination capacity and side-room pressure all affect the Health Board's ability to deliver safe IPC practice. IPC involvement in capital planning must therefore remain early, visible and formally documented.

9. DECONTAMINATION

9.1 PURPOSE AND SCOPE

This chapter summarises the main decontamination governance, assurance, infrastructure and risk themes for inclusion within the IPC Annual Report. A separate Decontamination Annual Update Report, covering May 2025 to May 2026, has been prepared by the Decontamination Officer is be presented as an appendix/supporting report due to its technical complexity and level of detail required for decontamination assurance.

The purpose of this chapter is therefore not to duplicate the full technical report. It provides a concise Health Board-level overview of the key assurance messages, major service developments, principal risks and priority actions requiring continued oversight through the Decontamination Committee, Infection Prevention and Control Committee, estates governance, capital planning and the organisational risk register.

9.2 OVERALL ASSURANCE POSITION

Decontamination remains a critical component of patient safety, infection prevention and regulatory compliance. During the reporting period, CTMUHB maintained essential decontamination services across acute and community settings, including sterile services, endoscopy decontamination, ultrasound probe decontamination, ENT and maxillofacial scope decontamination, transoesophageal echocardiography probe reprocessing and community dental instrument decontamination.

The overall position is best described as partially assured. There is evidence of strengthened governance, improved professional oversight, approved audit tools, active engagement with Authorising Engineers and Welsh specialist networks, and significant progress on long-standing capital schemes. However, assurance is limited by non-compliant or ageing built environments, obsolete or end-of-life equipment, manual or paper-based traceability in some areas, variation in practice between sites, AP(D) capacity pressures, ventilation and air-change limitations, and reliance on interim mitigation where strategic solutions are not yet in place.

Area	Assurance judgement	Summary rationale
Governance and professional oversight	Improved assurance	Decontamination Officer in post; local decontamination meetings; Decontamination Committee reporting; engagement with AE(D), AP(D), NWSSP SES and All-Wales groups.
Audit and quality assurance	Improved assurance	CTMUHB decontamination audit tools approved; full audit rollout completed May-August 2025; action plans issued; next audit cycle scheduled from May 2026.
PCH CSSD refurbishment	Controlled but high-impact operational change	PCH CSSD closed from January 2026 for a major two-year refurbishment; interim activity decanted to RGH and POW HSDU; mobile endoscope decontamination unit installed to maintain endoscopy service continuity.
POW centralised decontamination facility	Strategic priority	Long-standing need now progressing through agreed enabling works, EBME relocation and redevelopment of the old pathology laboratory into a centralised decontamination unit. Target operational date is March 2027, subject to delivery of enabling works.
Built environment and equipment	Significant residual risk	POW endoscopy, urology and ENT arrangements remain dependent on ageing equipment, single-room environments, end-of-life storage cabinets or local manual processes pending centralisation.
Traceability and standardisation	Partial assurance	Robust paper systems are in place in some areas, but electronic tracking and fully standardised approaches are not yet consistently implemented.
Engineering support and AP(D) capacity	Limited assurance	AP(D) capacity is fragile, with limited site resilience and increasing demand from CSSD, endoscopy, capital works and maintenance requirements.

9.3 GOVERNANCE, COMPLIANCE AND ASSURANCE ARRANGEMENTS

Governance arrangements have strengthened during the year. The Decontamination Officer provides specialist oversight, chairs or attends local decontamination meetings, contributes to the Decontamination Committee, participates in the Authorised Person (Decontamination) group, and supports service, estates and capital discussions. The Health Board has also developed a positive and transparent working relationship with NWSSP Specialist Estates Services Authorising Engineers and the wider Welsh decontamination community.

The CTMUHB decontamination audit tools have been formally approved, with the IPC component separated so that IPC-specific elements can be monitored through the IPC audit programme. A comprehensive audit rollout was undertaken across CTMUHB between May and August 2025. Action plans were issued to services, feedback and support were provided, and progress is being

monitored through local decontamination governance. The next audit cycle is scheduled to recommence from May 2026.

Quality assurance reporting remains essential. Departments are expected to audit their decontamination traceability systems and provide continuing assurance to the Decontamination Officer through local quality assurance reports. Timely and consistent QA reporting should remain an explicit requirement during 2026/27.

9.4 SITE AND SERVICE-LEVEL SUMMARY

Service / site	Current position	Annual report implication / next step
Princess of Wales Hospital	The most significant strategic issue is the need for a centralised decontamination facility. Current endoscopy, urology, ENT and TOE probe arrangements remain operational but rely on mitigation within non-compliant or ageing environments. The centralised facility is planned for the old pathology laboratory once EBME is relocated.	Maintain risk register oversight; progress enabling works; monitor end-of-life equipment; confirm contingency options if centralised facility is delayed.
Royal Glamorgan Hospital	Centralised endoscope decontamination within CSSD supports endoscopy, theatres, urology, cardiology TOE and theatres. The temporary Vanguard unit used during POW roof-related disruption has been decommissioned and removed. ENT and Maxillofacial continue to use local Tristel Trio manual processes; additional ENT nasoendoscopes have been approved through TEF.	Use new ENT scopes to support movement towards safer centralised processing where feasible; maintain audit of manual processes; review scope capacity constraints for Maxillofacial.
Prince Charles Hospital	PCH CSSD closed in January 2026 for a major refurbishment expected to last approximately two years. Interim sterile services are supported through RGH and POW HSDU, with a mobile decontamination unit installed to support endoscopy. Service user feedback on the mobile unit has been positive to date.	Continue validation, testing, audit and IHEEM assurance; maintain oversight of decanted activity and ensure refurbishment governance remains connected to IPC and decontamination assurance.
Community and satellite sites	YCR and YCC ENT services use Tristel Trio for nasoendoscopes. Walkabouts are required to review probes and reusable medical device processes. Llantrisant Health Park requires stronger decontamination and IPC involvement during design and delivery.	Ensure Decontamination Officer and IPC are included in future LHP design decisions; confirm track and trace, compliant transport containers, storage, audit requirements and service model assurance.
Community Dental Service	Dewi Sant Health Park and Quarella Road decontaminate instruments within HSDU environments; other CDS sites currently undertake local decontamination. The traceability TEF bid was not approved. The strategic direction is movement towards centralised ISO 13485-accredited decontamination where feasible.	Develop phased centralisation plan, secure stakeholder engagement, identify instrument capacity requirements and ensure Sunnyside development pathways are fully planned with POW HSDU.

9.5 KEY DEVELOPMENTS DURING THE REPORTING PERIOD

Several important developments have improved the decontamination assurance framework during the reporting period:

- The PCH CSSD refurbishment programme commenced in January 2026, supported by Welsh Government funding. Interim arrangements have been established using RGH and POW HSDU capacity and a mobile endoscope decontamination unit on the PCH site.
- The long-standing centralised decontamination facility requirement at POW has been formally re-engaged, with the Decontamination Officer actively involved in design, planning and tender

discussions. Enabling works have been approved, an external contractor appointed, and the old pathology laboratory has been identified as the proposed location once EBME has been relocated.

- A CTMUHB-wide decontamination audit programme was delivered between May and August 2025, supported by approved audit tools, action plans and local meeting structures.
- The Health Board has strengthened external professional relationships with NWSSP SES, AE(D) colleagues and All-Wales decontamination forums, supporting greater technical challenge and transparency.
- Welsh Government Targeted Estates Funding submissions have supported progress in several areas, including the POW centralised endoscope decontamination scheme, decontamination equipment for SSD, ENT scopes at RGH and selected departmental improvements.
- Work is ongoing with HEIW and All-Wales colleagues on decontamination training and audit initiatives, including a standardised induction programme for Band 2 and Band 3 staff working within decontamination and sterilisation services.

9.6 PRINCIPAL RISKS REQUIRING CONTINUED OVERSIGHT

The Decontamination Annual Update identifies several risks that should remain visible within the IPC annual report narrative and organisational risk management processes. These risks are interdependent and require coordinated ownership between decontamination, IPC, estates, capital planning, service management and clinical teams.

Risk theme	Evidence / concern	Potential impact	Required mitigation
Non-compliant built environments	POW endoscopy single-room decontamination, urology layout limitations and wider infrastructure constraints do not fully meet current standards.	Patient safety, JAG/regulatory compliance and reputational risk.	Progress POW centralised decontamination facility; maintain interim controls and contingency planning.
Obsolete or ageing equipment	Discontinued Getinge Poke Yoke automated reprocessors in POW urology; end-of-life ENT controlled environment storage cabinets; ageing decontamination infrastructure.	Equipment failure, inconsistent reprocessing, lack of manufacturer training and limited resilience.	Maintain risk register entries; replace equipment through capital routes; ensure contingency if equipment fails.
Traceability limitations	Paper-based traceability remains in use for some Tristel manual processes; some reusable screws and plates at RGH/PCH do not support individual tracking.	Reduced auditability and potential future non-compliance with medical device traceability requirements.	Implement electronic tracking where feasible; standardise implantable device management; review reusable screws and plates.
CJD/sCJD screening and reusable devices	CJD policy is under review and mandatory pre-use reusable medical device screening has faced local pushback.	Prion transmission risk, device quarantine/destruction risk and governance risk if screening is inconsistent.	Secure senior endorsement, clear implementation timeline and escalation pathway for non-compliance.
AP(D) and engineering resilience	Limited AP(D) provision at sites and estates capacity pressures, including inability to provide expanded seven-day/24-hour support.	Reduced ability to maintain compliant engineering governance, permit-to-work processes and timely technical support.	Review AP(D) capacity, consider pan-CTMUHB decontamination support model and identify investment requirements.
Ventilation and air changes	Tristel wipe systems require a minimum of five air changes per hour; some areas have insufficient mechanical or natural ventilation.	COSHH, staff safety and decontamination compliance risk.	Risk assess areas, use alternative decontamination arrangements where standards cannot be met, and move towards validated automated systems where possible.
Insourcing and agency governance	Concerns were raised about agency or insourced staff undertaking or being present in decontamination areas without	Patient safety, regulatory, IPC, governance and reputational risk.	Mandate training evidence before decontamination activity; require formal project governance for all insourcing arrangements.

Risk theme	Evidence / concern	Potential impact	Required mitigation
	validated manufacturer-approved training evidence.		

9.7 PRINCESS OF WALES HOSPITAL CENTRALISED DECONTAMINATION FACILITY

The development of a centralised decontamination facility at POW is the single most important strategic decontamination scheme described in the annual update. The requirement has been recognised since Welsh Government audits in 2016 and was reflected in a Red/Amber JAG compliance position from 2018. The core issue is that existing local arrangements remain operational but rely on interim process controls rather than a fully compliant built environment with appropriate dirty-to-clean segregation.

The proposed centralised decontamination unit will support Endoscopy, Urology, ENT and Cardiology, while HSDU sterilisation services remain separate due to their different technical requirements. The facility is expected to provide a dedicated and purpose-designed environment with controlled workflows, centralised processing, standardised practice and improved quality assurance. Current planning is based on redevelopment of the old pathology laboratory after EBME relocation, with enabling works approved and an external contractor appointed. Subject to completion of the enabling works, the expected operational date is by March 2027.

Because this scheme has a long history and delays would prolong existing risks, the annual report should explicitly state that the centralised decontamination facility requires continued committee oversight. If short- or medium-term delays occur, alternative options should be actively explored, including relocation to another suitable on-site department or use of a modular decontamination facility capable of supporting Endoscopy, Urology and ENT activity.

9.8 CJD/SCJD AND REUSABLE MEDICAL DEVICE GOVERNANCE

CJD and suspected CJD present specific decontamination risks because prions are resistant to standard disinfection and sterilisation processes. The decontamination report highlights the need to manage all known, suspected or increased-risk patients in line with national TSE guidance and local policy. The CTMUHB CJD policy is under review, and this should remain a priority for approval and implementation.

The Decontamination Officer has requested that all services using reusable medical devices implement a mandatory pre-use patient checklist, including relevant CJD/sCJD screening questions before device use. Implementation has been delayed because of local challenges. The annual report should therefore make clear that senior leadership support is required to endorse the requirement, communicate expectations to operational managers and clinical teams, agree a timeline, and establish an escalation process for non-compliance.

9.9 MEDICAL DEVICE TRACEABILITY, ULTRASOUND PROBES AND IMPLANTABLE DEVICES

Traceability is a recurring assurance theme across the decontamination report. POW has transitioned fully to single-use implantable screws and plates, which removes the need for decontamination and reduces traceability risk. In contrast, RGH and PCH continue to use mainly reusable screws and plates, with some items still in circulation that do not support individual tracking. This requires review

because individual track and trace of implantable medical devices is expected to become a mandatory regulatory requirement.

Ultrasound probe decontamination is undertaken using a mixture of Trophon automated high-level disinfection systems, ultraviolet disinfection machines and approved detergent/disinfectant wipes for non-critical use. The report recommends engagement with Clinical Engineering to apply RFID tagging to mobile ultrasound machines. This would improve visibility of device movement, support audit and strengthen assurance that appropriate decontamination has occurred in each clinical setting.

9.10 INSOURCING, AGENCY AND TRAINING GOVERNANCE

An important governance concern is in relation to insourcing and agency activity in Endoscopy services. Manufacturer-approved training is a fundamental requirement for safe flexible endoscope and probe decontamination, including manual cleaning, endoscope washer-disinfector use and controlled environment storage cabinet operation. The report identifies gaps in documented assurance that all agency or insourced staff involved in decontamination had completed the required training.

This is a governance learning point. The Health Board should reaffirm that no agency or insourcing staff may undertake decontamination activity unless full manufacturer-approved training evidence is available and validated. Future insourcing arrangements should include a formal project governance structure with decontamination, IPC, AE(D), service management and senior nursing involvement. This is required to maintain patient safety, regulatory compliance and organisational assurance.

9.11 PRIORITIES FOR 2026/27

No.	Priority	Expected action
1	Maintain Board and committee oversight of high-risk decontamination issues	Ensure decontamination risks remain visible through IPCC, Decontamination Committee, AP(D) group, estates/capital governance and the organisational risk register.
2	Deliver POW centralised decontamination facility milestones	Monitor enabling works, EBME relocation, technical specification, equipment tendering, construction and contingency planning March 2027 target.
3	Maintain safe interim arrangements during PCH CSSD refurbishment	Continue validation, audit, QA reporting and IHEEM assurance for the mobile endoscope decontamination unit and decanted sterile services activity.
4	Strengthen AP(D) and engineering resilience	Review authorised person capacity, permit-to-work governance, estates support and potential pan-CTMUHB decontamination engineering model.
5	Improve traceability and standardisation	Progress electronic tracking where feasible, review reusable implantable device traceability and standardise decontamination systems across sites.
6	Implement CJD/sCJD screening for reusable medical devices	Secure senior endorsement, update policy, implement pre-use checklists and monitor compliance through local governance.
7	Address ventilation and air-change risks	Identify areas using Tristel or other chemical systems without adequate ventilation, risk assess, and implement alternative arrangements or capital solutions.
8	Strengthen insourcing and agency governance	Require validated manufacturer training and formal project governance before any non-CTMUHB staff undertake decontamination activity.
9	Continue audit and QA programme	Recommence audit cycle from May 2026, monitor action plans, and require departments to evidence traceability and equipment assurance through QA reports.

9.12 SUMMARY CONCLUSION FOR THE IPC ANNUAL REPORT

Decontamination services across CTMUHB have remained operational during a period of significant change, service pressure and capital development. The annual update provides evidence of strengthened specialist oversight, improved audit arrangements, constructive external relationships and meaningful progress on major strategic schemes. These are important positive developments and

should provide the IPC Committee with assurance that decontamination is receiving increased focus and governance attention.

However, the assurance position remains qualified. The Health Board continues to carry significant decontamination risks associated with ageing or obsolete equipment, non-compliant built environments, manual and paper-based systems, ventilation limitations, CJD/sCJD screening implementation, AP(D) resilience, and the governance of insourced or agency activity. The POW centralised decontamination facility and the PCH CSSD refurbishment are particularly important because their successful delivery will materially change the Health Board's risk profile.

The full Decontamination Annual Update Report should therefore be read alongside this IPC Annual Report chapter. It contains the detailed technical evidence, site-by-site assurance, risk descriptions, audit findings and recommendations required for specialist review. The role of this chapter is to summarise the key organisational messages and ensure that decontamination remains visible as a core IPC, patient safety, estates and regulatory priority for 2026/27.

10. WATER SAFETY AND VENTILATION SAFETY

Water and ventilation safety remain core IPC risk domains. Pseudomonas performance is favorable, but ongoing vigilance is required because water systems, drainage, outlets, ventilation and environmental conditions remain relevant to infection risk, especially for vulnerable patient groups and specialist areas.
Ventilation remains on the risk register. Decontamination areas also continue to be affected by ventilation and air-change issues. The Health Board should continue to maintain close alignment between IPC, Estates, Facilities, Decontamination and Capital teams.

11. BLOOD CULTURE CONTAMINATION AND ANTT ASSURANCE

Month	% contaminates over total samples	RGH A&E % contaminates over total samples	Target
Oct	7.60%	5.26%	3.00%
Nov	7.60%	5.88%	3.00%
Dec	6.23%	3.86%	3.00%
Jan	6.33%	3.43%	3.00%
Feb	8.89%	6.02%	3.00%
Mar	6.70%	4.82%	3.00%
Average	7.23%	4.88%	

Table 27 - Blood culture contamination rates, all hospitals/departments and RGH A&E

Blood culture contamination is a significant assurance concern. The average contamination rate was 7.23% across the reported hospitals/departments and 4.88% in RGH A&E, both above the 3% target. Contamination rates may indicate inadequate ANTT practice.
The data reinforces the need to improve IPC and ANTT training compliance, review blood culture practice in high-volume areas, widen data collection to include POW and PCH and extend it from A&E to ICU/ITU comparators across sites, and ensure clinical areas investigate local drivers of contamination.

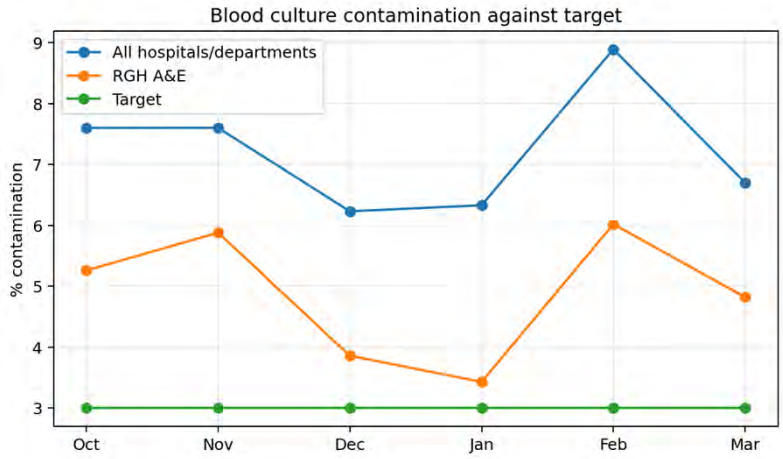


Figure 4 - Blood culture contamination rates against 3% target

IPC during the FY has work towards creating more awareness and become more visible. The IPC team concluded several PPS, with the majority regarding BBE and PPE, with significant improvement observed along the year. The IPC team also continues to deliver ANTT training but to enable the reduction on rates to the 3% mark, it is advisable that ANTT is re-instated as mandated for staff doing invasive procedures. Also it is essential that the care groups take leadership on their improvement trajectories and work, with IPC support, towards a sustained reduction in the contamination rates.

12 – SSI C-SECTION OVERVIEW

12.1. CONTEXT AND PURPOSE

This chapter summarizes the 2025 caesarean birth surgical site infection (SSI) surveillance position for Cwm Taf Morgannwg University Health Board (CTMUHB), with specific reference to Princess of Wales Hospital (POW), Prince Charles Hospital (PCH) and the overall Health Board position. It is intended for inclusion in the 2025-26 IPC Annual Report and should be read alongside the Public Health Wales HARP caesarean birth SSI reports and the CTMUHB SPC workbook.

Surgical site infection following caesarean birth remains an important patient safety, quality and experience indicator. Although many cases are identified after discharge and in the community, the prevention of infection is a whole pathway issue. Reliable surveillance, consistent diagnostic criteria, effective post-discharge reporting, robust wound care standards and prompt review of identified cases are essential to ensure that trends are interpreted accurately, and improvement action is targeted appropriately.

The current analysis is particularly important because the 2025 data show an increase in reported SSI rates at Health Board level and at both POW and PCH. The key question for assurance is whether the observed increase represents a signal of sustained deterioration or whether it remains within expected statistical variation. The analysis below indicates that, although the increase is real and should not be dismissed, the SPC data do not currently demonstrate a clear special-cause shift. This supports a proportionate response: continued caution, stronger standardization and enhanced validation rather than a conclusion that the process is definitively out of control.

12.2- DATA SOURCES, REPORTING METHOD AND INTERPRETATION

The Public Health Wales HARP report for POW covers the rolling year 1 January 2025 to 31 December 2025 and provides both POW and CTMUHB figures. The report confirms that the quarterly caesarean birth SSI report now uses a rolling-year reporting period and that Wales rates have been removed from quarterly reports. Instead, an aggregate baseline from the three years prior to the reporting period is provided for local comparison. This is an important methodological point because it means the most appropriate comparator for this chapter is the local baseline rather than an all-Wales quarterly rate.
The POW report also notes that the POW maternity unit was closed from 2 September 2024 until 17 February 2025, with redirection of activity during that period. This affects the interpretation of POW quarter-level data, particularly the absence of POW Q4 2024 data and the lower volume of POW activity in Q1 2025. For that reason, quarterly changes should be interpreted cautiously and the rolling-year and SPC views are more informative than any single quarter.
PCH quarterly values have been derived from the CTMUHB total less POW where required and checked against the supplied CTMUHB SPC workbook. This produces a coherent PCH profile for 2025: 1,033 valid procedures, 44 reported SSIs and an annual SSI rate of 4.26%. This is consistent with the PCH SPC series supplied in the workbook.

12.3- HEADLINE POSITION FOR 2025

Table 1 provides the headline annual position. The reported rate increased in each site-level view compared with the 2022-2024 baseline. The increase was greatest for POW and CTMUHB by relative percentage change, although the PCH rate remained the highest in absolute terms.

Measure	POW	PCH	CTMUHB
Baseline period	Q1 2022-Q4 2024*	Q1 2022-Q4 2024	Q1 2022-Q4 2024
Baseline valid procedures	1,824	2,745	4,569
Baseline SSIs	43	109	152
Baseline SSI rate	2.36%	3.97%	3.33%
2025 valid procedures	616	1,033	1,649
2025 SSIs	16	44	60
2025 SSI rate	2.60%	4.26%	3.64%
Change vs baseline	+10.17%	+7.3%	+9.31%
Predicted/expected cases	8 predicted	41 predicted	Approx. 55 expected on baseline rate
Variance from prediction/expectation	+8 cases	+3 cases	Approx. +5 cases

Table 28 - Headline caesarean birth SSI position, 2025 compared with the 2022-2024 baseline

**POW Q4 2024 was recorded as no data due to maternity unit closure. PCH values are derived from CTMUHB totals less POW values and aligned with the supplied SPC workbook.*

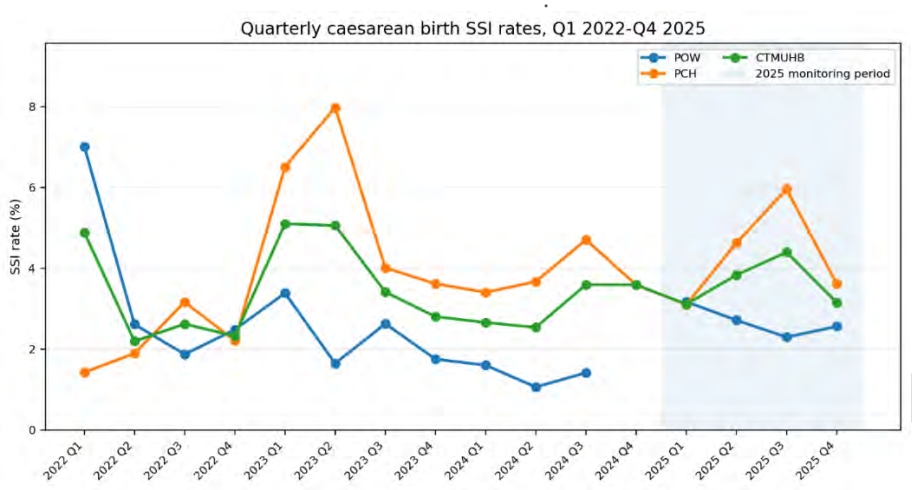
The data show that CTMUHB recorded 60 caesarean birth SSIs from 1,649 valid procedures in 2025, giving an annual SSI rate of 3.64% compared with a 3.33% baseline. POW recorded 16 SSIs from 616 valid procedures, giving a rate of 2.60% compared with a baseline of 2.36%. PCH recorded 44 SSIs from 1,033 valid procedures, giving a rate of 4.26% compared with a baseline of 3.97%. These figures confirm an increase across the Health Board, but they also show that the absolute numbers are small enough for quarterly variation to have a visible effect on the rate.

12.4- QUARTERLY PROFILE

Quarterly data are set out below. For POW, the first quarter should be interpreted in the context of the maternity unit reopening on 17 February 2025. For PCH, the highest quarterly rate in 2025 was seen in Q3. For CTMUHB, the highest quarterly rate was also seen in Q3, followed by a reduction in Q4.

Quarter	POW procs	POW SSIs	POW rate	PCH procs	PCH SSIs	PCH rate	CTMUHB procs	CTMUHB SSIs	CTMUHB rate
2025 Q1	63	2	3.17%	290	9	3.10%	353	11	3.12%
2025 Q2	184	5	2.72%	259	12	4.63%	443	17	3.84%
2025 Q3	174	4	2.30%	235	14	5.96%	409	18	4.40%
2025 Q4	195	5	2.56%	249	9	3.61%	444	14	3.15%

Table 29 - quarterly caesarean birth SSI activity



Graphic 43 - Quarterly caesarean birth SSI rates, Q1 2022-Q4 2025.

12.5- SPC INTERPRETATION AND ASSURANCE

The SPC review supports the user's interpretation, with one important caveat. The annual rates have increased compared with baseline; however, the quarterly rates do not currently demonstrate a pattern consistent with special-cause deterioration when assessed against conventional control limits based on the 2022-2024 baseline. In practical terms, this means the increase should be treated as an adverse signal requiring action and surveillance, but not as definitive evidence that the process has moved outside expected statistical variation.

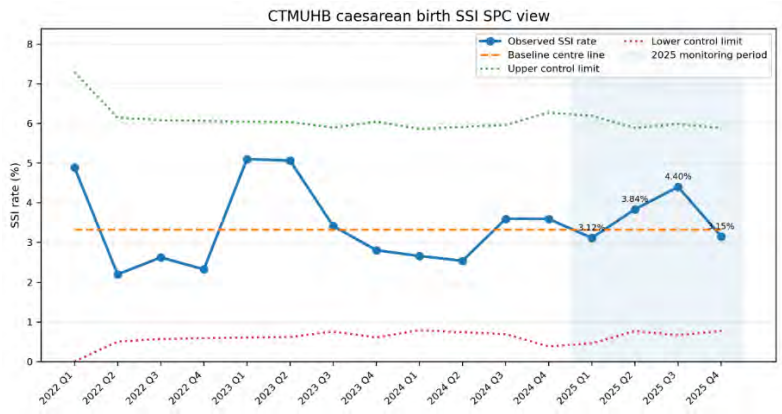
The PCH Q3 2025 point is the highest 2025 quarterly rate and sits above the baseline center line. It should therefore remain a focus for prospective review. However, the Q4 2025 PCH rate reduced to 3.61%, and no 2025 PCH, POW or CTMUHB point breached the calculated upper control limit in the SPC view. This supports a cautious but proportionate conclusion: the 2025 increase is concerning, but the data do not yet demonstrate a sustained special-cause shift.

The conclusion should be revisited as additional 2026 data become available. If the rate remains persistently above the center line, if successive quarters move towards the upper control limit, or if a single quarter breaches the upper control limit, this would strengthen the case for escalation and a more detailed case-level review.

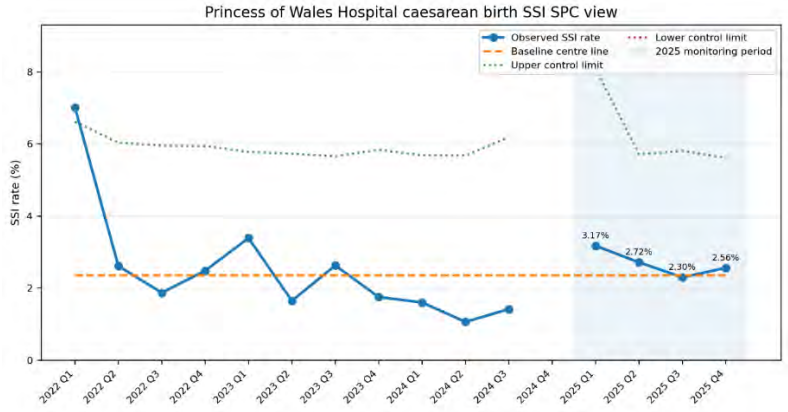
Site	Baseline center line	2025 annual rate	Highest 2025 quarter	SPC interpretation
CTMUHB	3.33%	3.64%	Q3: 4.40%	Above baseline annually, but all 2025 quarters remain within control limits.
POW	2.36%	2.60%	Q1: 3.17%	Above baseline annually; no 2025 quarter breaches the upper control limit.
PCH	3.97%	4.26%	Q3: 5.96%	Highest absolute rate; Q3 should be monitored, but the rate remains within

Site	Baseline center line	2025 annual rate	Highest 2025 quarter	SPC interpretation
				control limits and reduced in Q4.

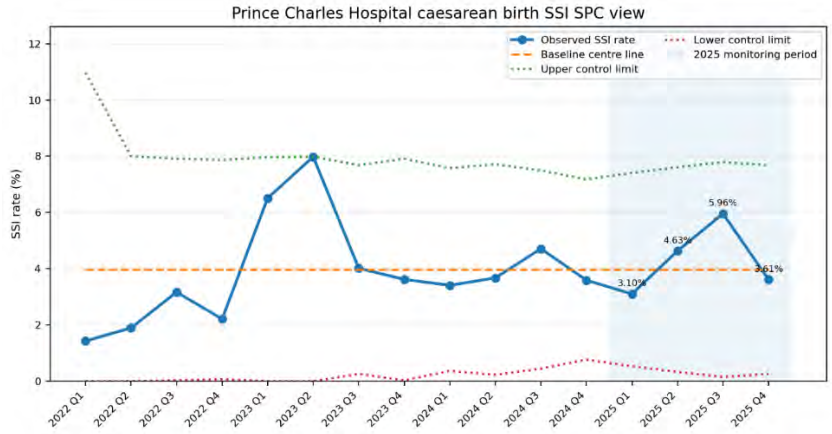
Table 30- . SPC interpretation summary



Graphic 44 - CTMUHB caesarean birth SSI SPC view.



Graphic 45- POW caesarean birth SSI SPC view.



Graphic 46 - . PCH caesarean birth SSI SPC view

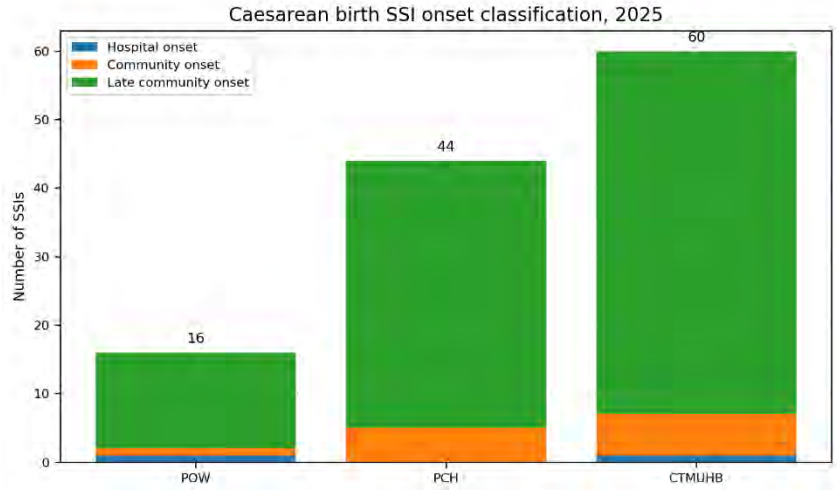
12.6. INFECTION ONSET, TYPE AND CASE CHARACTERISTICS

The majority of reported caesarean birth SSIs were late community onset. This is a key finding for governance and improvement. At CTMUHB level, 53 of 60 SSIs were classified as late community onset, representing 88.3% of reported infections. POW recorded 14 of 16 SSIs as late community onset, representing 87.5%. PCH recorded 39 of 44 SSIs as late community onset, representing 88.6%. This means the main opportunity for improved assurance is not limited to the inpatient episode, but

extends across discharge advice, wound surveillance, community midwifery review, GP identification and feedback of reported cases into the IPC and maternity governance systems.
Only one hospital-onset caesarean birth SSI was recorded across CTMUHB in 2025, and this was recorded at POW. There were six community-onset infections across CTMUHB, with one at POW and five at PCH. There were no infections with unknown onset. This pattern supports the need for stronger post-discharge surveillance and timely case review, while also recognizing that the infection prevention bundle begins before, during and immediately after the caesarean birth episode.
In terms of infection type, CTMUHB recorded 34 superficial SSIs and 26 complicated/deep infections. POW recorded a higher proportion of deep infections, with 9 deep infections and 7 superficial infections. PCH recorded 17 deep infections and 27 superficial infections. No organ-space infections were recorded in the POW or CTMUHB data.

Site	Hospital onset	Community onset	Late community onset	Total SSIs	% late community onset
POW	1	1	14	16	87.5%
PCH	0	5	39	44	88.6%
CTMUHB	1	6	53	60	88.3%

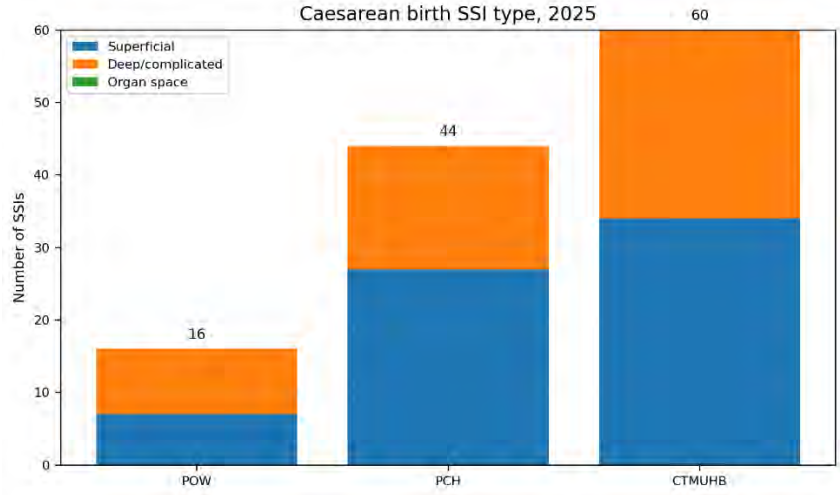
Table 31 - Onset classification of caesarean birth SSIs, 2025.



Graphic 47- Onset classification of caesarean birth SSIs, 2025

Site	Superficial	Deep/complicated	Organ space	Total SSIs	% deep/complicated
POW	7	9	0	16	56.3%
PCH	27	17	0	44	38.6%
CTMUHB	34	26	0	60	43.3%

Table 32 - Type of caesarean birth SSI, 2025.



Graphic 48 - Type of caesarean birth SSI, 2025.

12.7- DEMOGRAPHIC AND CLINICAL RISK PROFILE

The HARP demographic section provides useful context for targeted improvement. At CTMUHB level, the SSI rate was higher in the obese BMI group than in the healthy weight group: 42 SSIs from 790 procedures in the obese group, a rate of 5.32%, compared with 4 SSIs from 338 procedures in the healthy weight group, a rate of 1.18%. A similar pattern was seen at POW, where the obese BMI group recorded 11 SSIs from 309 procedures, a rate of 3.56%, compared with 1 SSI from 127 procedures in the healthy weight group, a rate of 0.79%. This does not imply that BMI alone explains the increase, but it does support targeted wound care, patient information and escalation advice for higher-risk groups.

Urgency of operation does not appear to be a strong differentiator in the 2025 data. At POW, elective and emergency caesarean birth rates were almost identical at 2.61% and 2.59% respectively. At CTMUHB level, the elective rate was 3.75% and the emergency rate was 3.54%. The data therefore suggest that the improvement focus should be broader than emergency caesarean births alone and should include the whole pathway and consistency of wound care practice across both elective and emergency activity.

Skin closure data should be interpreted with caution due to very small denominators in some categories. The overwhelming majority of procedures used dissolvable sutures. The apparently high SSI rate in the staples category reflects only two procedures across CTMUHB and should not be over-interpreted statistically. Nevertheless, the variation in materials and wound care products reinforces the importance of the work being progressed through the all-Wales SSI working group and local maternity governance to standardize procedure, materials and post-operative care.

Risk/domain	POW observation	CTMUHB observation	Interpretation
BMI	Obese: 11/309, 3.56%; healthy weight: 1/127, 0.79%	Obese: 42/790, 5.32%; healthy weight: 4/338, 1.18%	Higher SSI rate in obese BMI group supports targeted prevention and wound-care advice.
Urgency	Elective 2.61%; emergency 2.59%	Elective 3.75%; emergency 3.54%	No major difference by urgency; prevention should apply consistently to all caesarean birth pathways.
Skin closure	Dissolvable sutures used in 611/616 procedures	Dissolvable sutures used in 1,641/1,649 procedures	Dominant closure method; small numbers in other closure categories limit interpretation.
Onset	14/16 late community onset	53/60 late community onset	Post-discharge surveillance, wound review and feedback loops are central to improvement.

Table 33- Demographic and clinical interpretation points

12.8- SURVEILLANCE GOVERNANCE, CASE VALIDATION AND ICNET

Data completeness for 2025 was 100% for both POW and CTMUHB, compared with 97% during the 2022-2024 baseline period. This is a positive assurance point because it reduces the likelihood that the observed annual increase is simply due to incomplete denominator or form completion. However, data completeness does not, by itself, assure diagnostic consistency. The correct identification of SSI requires consistent application of surveillance definitions and reliable differentiation between expected wound healing, superficial wound concerns, and true SSI.

The annual report for the previous year identified a concern regarding possible over-reporting at PCH and noted that Public Health Wales supported validation work. The current year therefore needs to be interpreted within that wider surveillance-development context. The aim of the current improvement work is not only to reduce true infection risk, but also to ensure that reported SSI data are accurate, comparable and consistently defined across CTMUHB.

Work is underway to link caesarean birth SSI reporting data with ICNet. This is a significant governance development. Linking the SSI data to ICNet will allow IPC teams to view reported cases more directly, support timely review of case details, identify any clustering or recurring themes, and

provide earlier scrutiny where classification, onset or criteria require validation. It should also strengthen the feedback loop between maternity services, community midwifery, IPC and the Public Health Wales surveillance process.
The ICNet linkage should be developed as more than a data-transfer exercise. It should be embedded into a clear review pathway, including defined triggers for IPC review, agreement on which cases require multidisciplinary scrutiny, and a mechanism for feeding learning back to midwifery, obstetric, theatre and community teams.

12.9- IMPROVEMENT PROGRAMME: TRAINING AND STANDARDISATION

The all-Wales SSI working group has reviewed the caesarean birth SSI surveillance position and developed a package of training for midwives. The purpose of the training is to improve reliability of SSI identification and reporting, reduce the risk of over-reporting or inconsistent reporting, and support standardization of key procedures and materials across CTMUHB. This includes attention to wound assessment, surveillance criteria, dressings, documentation, escalation routes and consistency of post-discharge advice.
IPC and the Head of Midwifery are working together to deploy the agreed training package across CTMUHB, this will be first piloted at POW before deployed to PCH and with the end goal of all Wales adoption. This is an important mitigation because the majority of SSIs are being identified after discharge and because maternity, community midwifery, GP and IPC reporting pathways all influence the quality of surveillance. Standardizing practice should improve both infection prevention and the quality of the data used to assess the impact of prevention work during 2026.
The training should be positioned as a joint patient-safety and data-quality intervention. Better surveillance alone may initially appear to increase reported numbers if cases are identified more reliably; however, consistent criteria and documentation will ultimately provide a clearer and more accurate picture of true SSI burden. This will allow CTMUHB to distinguish between genuine deterioration, improved ascertainment and variation caused by inconsistent reporting.

Workstream	Purpose	Expected assurance gain	Suggested timescale
Midwifery SSI training package	Standardize identification, reporting and escalation of caesarean birth SSI.	Reduces variation and supports reliable case classification.	Deploy during 2026 with compliance monitoring.
Standardization of materials and procedure	Ensure consistent use of dressings, wound care advice and post-operative practice across CTMUHB.	Reduces unwarranted practice variation and supports fair comparison between sites.	Align with all-Wales SSI working group outputs.
ICNet linkage	Enable IPC teams to view SSI reports and support timely investigation and scrutiny.	Improves visibility, case review, cluster recognition and learning feedback.	Prioritize implementation and test reporting workflow.
Quarterly SPC monitoring	Review POW, PCH and CTMUHB rates against baseline and control limits.	Supports early recognition of sustained change or special-cause variation.	Report quarterly to maternity governance and IPCC.
Case-level thematic review	Review late community-onset and deep infections for common themes.	Identifies preventable factors across discharge, wound review and follow-up.	Begin with 2025 cases and repeat prospectively.

Table 34 - . Improvement work Programme for caesarean birth SSI surveillance and prevention.

12.10- PRIORITIES FOR 2026

The following priorities are recommended to maintain proportionate but robust assurance during 2026:

1. Complete deployment of the all-Wales SSI working group training package for midwives, with attendance and completion monitored through maternity governance – to be first deployed at POW and then PCH with end goal to be adopted all Wales.
2. Standardize agreed wound care procedures, dressings and post-operative advice across CTMUHB, ensuring that clinical practice and surveillance criteria are aligned.
3. Implement the ICNet linkage for SSI reporting so that IPC teams can view cases in a timely way and support case validation, investigation and thematic analysis.
4. Continue quarterly SPC monitoring for CTMUHB, POW and PCH, using the 2022-2024 baseline and reviewing whether any points breach control limits or whether sustained runs above the center line develop.
5. Undertake focused review of late community-onset cases, including the route of diagnosis, timing of symptoms, whether the woman was reviewed in person, criteria used, treatment given and any opportunities for earlier advice or escalation.
6. Use the demographic findings to strengthen targeted patient information and wound care support for higher-risk groups, particularly women with obesity or other risk factors that may affect wound healing.
7. Ensure that learning from reported cases is fed back through maternity, theatre, community midwifery, IPC and quality governance routes rather than remaining solely within surveillance reporting.

12.11- OVERVIEW ON CURRENT SITUATION AND WAY FORWARD

The 2025 caesarean birth SSI data show an increase in reported infection rates at CTMUHB, POW and PCH when compared with the 2022-2024 baseline. POW recorded 16 SSIs against 8 predicted, while PCH recorded 44 SSIs against 41 predicted. CTMUHB recorded 60 SSIs from 1,649 valid procedures, representing an annual rate of 3.64% and an increase from the 3.33% baseline.
The increase should be taken seriously, particularly because the majority of cases were late community onset and therefore depend on reliable post-discharge surveillance and communication across Organisational boundaries. However, the SPC review indicates that the current rates remain within expected control limits and do not yet provide clear evidence of special-cause deterioration. This supports the analysis that the increase should currently be interpreted as variation within the expected range, albeit adverse variation requiring caution and active management.
The agreed response is appropriate: deployment of the midwifery SSI training package, standardization of procedures and materials, improved validation of reported cases, and development of ICNet linkage to allow IPC teams to view reports and support timely investigation. These actions should improve both prevention practice and surveillance reliability. The 2026 data will be important in determining whether the 2025 increase resolves as common-cause variation or evolves into a sustained trend requiring escalation.

13. PRIORITIES FOR 2026/27

The priorities for 2026/27 should consolidate the progress achieved while addressing the persistent risks identified during the year.

- **Strengthen Gram-negative reduction:** focus on E. coli and Klebsiella spp. through CAUTI prevention, catheter care, hydration, antimicrobial stewardship, early recognition and community pathway work.

- **Deliver a more ambitious CDI Programme:** maintain acute controls while expanding community-onset analysis, including primary care prescribing, PPI review, postcode/deprivation mapping and care-home links.
- **Improve training compliance:** achieve a clear trajectory toward target, with particular focus on Medical and Dental staff and other low-compliance groups.
- **Embed the outbreak framework:** standardize OCC triggers, quorum, cadence, action logs, debriefs and digital reporting.
- **Build the Community IPC offer:** extend to residential homes, community clinics, GP settings, HMP Parc and domiciliary care, and develop an IPC link/champion network.
- **Strengthen decontamination resilience:** progress central decontamination, PCH refurbishment, AP(D) oversight, protein testing and risk register actions.
- **Use PPS as a quality-improvement tool:** continue BBE/PPE, device and ANTT point-prevalence reviews, linked to local ownership and measurable improvement.
- **Formalize financial and sustainability benefits:** report glove-use reduction as a credible quality, sustainability and financial-efficiency outcome with appropriately cautious attribution.

14. CONCLUSION

CTMUHB has demonstrated sustained commitment to infection prevention and control during a demanding and complex year. The Health Board has maintained core IPC governance, strengthened the specialist IPC service model, expanded community-facing IPC capacity, progressed point prevalence survey work, supported outbreak management and continued to provide expert advice across acute, community and strategic workstreams. The introduction of 12-hour acute-site IPC support, weekend and bank holiday on-call arrangements, improved recruitment and ongoing Hub development represent important improvements in resilience and responsiveness.

The annual infection position remains mixed. There are clear areas of progress, including reductions in hospital-onset E. coli, sustained favorable Pseudomonas performance and an overall reduction in Staphylococcus aureus bacteremia. These improvements indicate that targeted action, surveillance, clinical review and partnership working can make a difference. However, the report also demonstrates that improvement is not yet consistent or sufficient across all infection measures. Gram-negative bacteremia remains above the all-Wales benchmark, Klebsiella spp. has increased, and C. difficile remains below the Wales rate but is not improving at the pace required to meet the national reduction ambition.

The data also show that infection prevention is now increasingly a pathway issue. Community-onset infection accounts for a substantial proportion of CDI, E. coli, Klebsiella spp. and Staphylococcus aureus burden. This means that acute hospital controls, while essential, cannot deliver the full scale of improvement required. Sustainable reduction will depend on stronger alignment with primary care, community services, antimicrobial stewardship, pharmacy, care homes, local authorities and Public Health Wales. The developing Community IPC Team provides a strong foundation for this work and should remain a strategic priority during 2026/27.

The report identifies several Organisational risks requiring continued leadership attention. IPC mandatory training compliance remains below the expected standard, with particularly low compliance among Medical and Dental staff. Blood culture contamination rates indicate variation in ANTT and specimen collection practice. PPS findings show that BBE compliance is improving, but hand hygiene and PPE use remain variable, with inappropriate glove use a specific concern.

Decontamination, ventilation, isolation capacity and HCID preparedness risks also remain active and require sustained governance and investment.

The point prevalence survey Programme has been one of the most useful assurance developments during the year. It has demonstrated that observed practice can improve when data are collected, fed back and linked to targeted action. It has also shown that the Health Board must not rely solely on policy, training completion or annual audit to infer compliance. Direct observation, ward-level feedback, local ownership and repeated measurement are required to understand whether IPC standards are reliably embedded in practice.

The reduction in non-sterile glove use is a positive quality, sustainability and financial stewardship outcome. It is reasonable to conclude that PPS work and improved conversations about appropriate PPE use are likely to have contributed to this reduction, while recognizing that glove consumption is also affected by activity, case mix, outbreak pressure, procurement and stock management. The next phase should link safety, sustainability and value more explicitly by triangulating glove use, PPE compliance, hand hygiene data, HCAI outcomes and clinical activity.

The overarching conclusion is that CTMUHB has strengthened its IPC infrastructure and has clear examples of improvement, but the organization must now move from assurance of activity to assurance of sustained impact. The IPC team can provide expertise, surveillance, challenge, training, review and support, but the consistent prevention of infection depends on clinical teams, managers, care groups and corporate services owning infection prevention as part of everyday safe care. The priorities for 2026/27 should therefore focus on reducing Gram-negative bacteremia and CDI, improving training and ANTT assurance, embedding PPS and behavior-change work, strengthening community IPC pathways, maintaining outbreak readiness, and ensuring that decontamination, ventilation and isolation risks remain visible through Organisational governance.

With continued executive support, strong clinical leadership and a whole-system approach, CTMUHB is well placed to build on the progress made during 2025/26 and to translate the learning from this year into more reliable practice, stronger assurance and safer outcomes for patients, staff and communities.

INFECTION CONTROL DOCTOR – ANNUAL STATEMENT FOR 2025/26

As Infection Control Doctor for Cwm Taf Morgannwg University Health Board, I am pleased to provide this annual statement for the 2025/26 Infection Prevention and Control Report. The statement reflects my professional assessment of the Health Board's IPC position, the progress made during the year and the areas where continued improvement, clinical leadership and Organisational accountability will be required.

Infection prevention and control remains central to the delivery of safe, effective and high-quality care. Healthcare-associated infections cause avoidable harm, increase antimicrobial use, prolong hospital stay, contribute to operational pressure and affect confidence in services. Preventing infection is therefore not only a specialist IPC function; it is a core responsibility of every clinical team, every service and every professional group across the Health Board.

The 2025/26 report demonstrates that CTMUHB has strengthened several important IPC systems. The IPC service is more resilient than in previous years, with expanded acute-site support, weekend and bank holiday on-call arrangements, improved recruitment and continued development of the Hub model. The Community IPC Team is also an important development, reflecting the reality that many infection risks and many infection-prevention opportunities sit outside acute hospitals and across the wider patient pathway. These developments should improve the Health Board's ability to identify

risk earlier, support clinical areas more consistently and strengthen prevention across acute, community and partner settings.

There are areas of positive performance. CTMUHB compares favorably with Wales for C. difficile, *Pseudomonas aeruginosa* and *Staphylococcus aureus* rates. Hospital-onset *E. coli* has reduced, and *Pseudomonas* performance remains encouraging. There has also been useful progress in using point prevalence surveys to test whether core IPC practices are being delivered in real clinical environments. The improvement seen in BBE compliance following targeted work demonstrates that local data, visible leadership and repeated measurement can influence practice.

However, there are also important concerns. Gram-negative bloodstream infection remains a significant challenge, especially *E. coli* and *Klebsiella spp*. bacteremia. Although national targets focus on hospital-onset cases, the wider epidemiology makes it clear that community-onset burden strongly influences the overall infection picture. Prevention therefore needs a broader approach, including catheter care, hydration, wound and skin care, antimicrobial stewardship, primary care engagement and community pathway improvement.

C. difficile also requires sustained and more ambitious action. The Health Board remains below the all-Wales rate, but this should not create false reassurance. The current position is not sufficient to meet the reduction ambition, and the burden remains substantially community onset. Acute controls must continue, including prompt isolation, environmental cleaning and decontamination, antimicrobial review, PPI review and robust case investigation. However, these controls must now be matched by stronger community and primary care work, supported by pharmacy, microbiology, epidemiology and Public Health Wales.

I remain concerned about the reliability of some core clinical practices. Mandatory IPC training compliance remains below the expected level, and the particularly low compliance among Medical and Dental staff is a significant governance issue. Medical engagement is essential to antimicrobial stewardship, diagnostic decisions, device management, escalation, isolation decisions and clinical leadership of infection prevention. Improvement in training compliance must therefore be treated as a professional and managerial accountability issue, not simply as an IPC education issue.

Blood culture contamination rates and ANTT assurance also require continued attention. High contamination rates can lead to unnecessary antimicrobial treatment, diagnostic uncertainty, avoidable patient harm and increased laboratory and clinical workload. They may also indicate inconsistent aseptic technique. Strengthening ANTT competency, invasive device insertion and maintenance practice, and blood culture collection standards should remain a priority.

The PPS findings on PPE and glove use are particularly important. Inappropriate glove use can increase cross-contamination risk and may give staff a false sense of protection. Gloves are not a substitute for hand hygiene. The observed reduction in glove use and related spend is encouraging and is consistent with better conversations about risk-based PPE use, sustainability and value; however, it must be supported by assurance that glove reduction reflects safer, more appropriate practice rather than underuse where PPE is indicated.

Decontamination, ventilation, isolation capacity and HCID preparedness remain important areas of Organisational risk. These are not peripheral IPC issues: they are core safety systems. Continued investment, risk-register oversight, clear accountability and specialist advice will be required to ensure that services remain safe, compliant and resilient.

My professional view is that the Health Board has made meaningful progress in strengthening IPC infrastructure, but the next phase must focus on measurable impact. The priorities for 2026/27 should

be to reduce Gram-negative bacteremia and CDI, improve training compliance, strengthen ANTT and blood culture practice, embed PPS and behavior-change methodologies, develop community IPC pathways, improve digital capture of learning and actions, and ensure that infrastructure risks remain visible to the Board.

Infection prevention must continue to be owned from ward to Board. The IPC team will continue to provide specialist advice, surveillance, investigation, training and challenge, but sustained improvement will depend on clinical ownership, operational leadership, executive support and partnership across the wider health and care system. I would like to thank the IPC team, microbiology colleagues, antimicrobial stewardship colleagues, clinical teams, estates, facilities, occupational health, Public Health Wales and wider partners for their commitment during the year. Continued collective effort will be essential to protect patients, staff and communities and to deliver safer care during 2026/27.

Dr. Alexandra Tsitsopoulou
Microbiologist

DRAFT

Agenda item 8.1.10	26 November 2026	Strategic Development Committee	CTM 2030: Building Healthier Communities Together – IMTP

Report Details:	
FOI Status:	Please select: Open (Public)
If closed please indicate reason:	Not applicable
Prepared By: *If you do not wish for your name to be included in the public domain, please only include your job title*	Elizabeth Beadle
Presented By: *If you do not wish for your name to be included in the public domain, please only include your job title*	Claire Thompson and Sally May
Approving Executive Sponsor:	Claire Thompson Sally May
Report Purpose	Please Select: For approval
Engagement undertaken to date:	DLG August and September, EMB September, SDC November 2026

Impact Assessment:	
Indicate the Quality / Safety / Patient Experience Implications:	The IMTP is related to all aspects of quality and safety
Related Health and Care Standard	Accountability
Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	No – will be done at service level
Are there any Legal Implications /Impact.	No
Are there any resource (capital/Revenue/Workforce Implications / Impact?	Yes Delivery of the IMTP will have resource implications
Link to Strategic Goals	Please Select: Sustaining Our Future Inspiring People Improving Care Creating Health

IMTP update and context

- The board approved the current IMTP covering the period 2026-2029 on 26th March 2026. Welsh Government has approved this plan subject to accountability conditions which are awaited.
- The quarter one and quarter two delivery reports for 2026-27 identifies that:

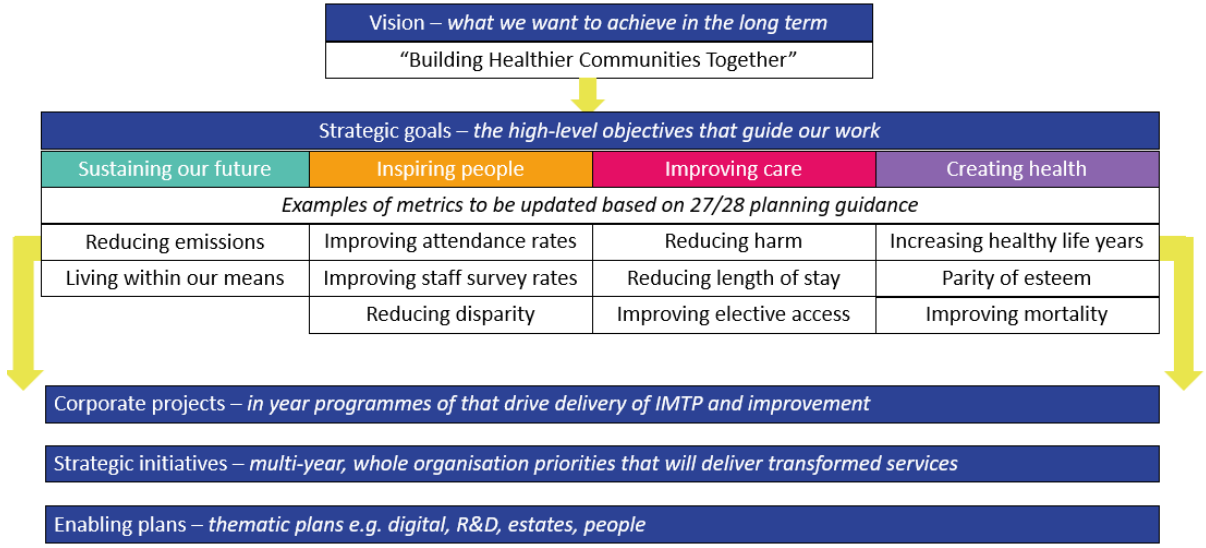
1. While progress continues across all portfolios, the performance metrics demonstrate a mixed picture, with some off trajectory. As noted in the planning process, not all performance requirements are deliverable in year.
2. There remain risks to the delivery of the expected year-end financial position for 2026-2027 which will impact on the plans for the 2027-2030 period.

- The financial context remains extremely challenging with a potentially more challenging allocation anticipated in 2027-28.
- The expectation is that existing planning and performance requirements will remain extant. The planning and performance frameworks for 2027-28 are not expected until later into the planning cycle. Pending issue of these policy documents, the Health Board's internal framework has been developed to support planning.

Planning approach 2027-2030

The forthcoming plan presents the delivery of our plans to 2030, which aligns with the delivery date of our CTM 2030 commitments and our organisational vision of building healthier communities together.

Focus will be on progress aligned to our corporate goals using our strategy deployment framework:



Financial Strategy

The key underlying financial strategy objectives remain as follows:

- To achieve breakeven in each financial year and to gradually reduce the level of recurrent deficit to achieve recurrent breakeven over a reasonable timeframe.
- To achieve year on year reductions in premium workforce costs and premium planned care costs.
- To achieve year on year improvements in efficiency, quality and value (outcomes relative to cost), including through population health management initiatives.
- To utilise financial improvement to re-invest in improving service quality and outcomes wherever possible.
- To achieve closer alignment over time between the needs-based formula funding allocations from WG, and our actual use of resources, and so improve equity of resource use.

To achieve the financial break-even position required to meet the statutory financial duties of the Health Board, the full financial challenge will need to be met with savings plans. For the IMTP planning purposes pending confirmation of the funding settlement for NHS Wales, the Health Board is using the Medium Case Scenario, which will require savings of £119m over the 3 years:

	2027/28	2028/29	2029/30	Total
Savings Requirement £'m	49.9	35.4	33.6	118.8

Internal planning assumptions

Planning assumptions developed and tested with DLG, ELG and EMB have been refined as set out below.

* All plans must align to strategy deployment framework and future vision for our model of care.

- Financial context will remain challenging – requirement for £49.9m of savings has been built into the planning assumptions and notional allocations included in the internal planning framework.
- Provisional delivery assumptions:
  - Ongoing requirements for urgent and emergency care are anticipated to remain extant – e.g. continued progress towards ED targets and the Six Goals Policy Framework requirements.
  - Planned care will require a minimum of maintenance of 104 weeks and N/OP requirements.
  - Indications of a focus on 78 weeks to be built into our forecasts.
  - Ongoing focus on cancer
  - New quality requirements likely to continue
  - Population health requirements (paediatric weight, addressing inequalities vaccination)

Specific Matters for Consideration:

- The final version of the internal planning framework is appended.
- This framework is founded on progress towards delivery of the organisational strategy within the financial envelope. There is a recognition that the challenging financial position will mean the plan must focus on managing within existing resource, delivering savings, and seeking to reduce or stop activities identified as lower value.
- Care groups and corporate teams are working on plans which will be reviewed and tested by the IMTP steering group.
- The anticipated later receipt of the NHS Wales Planning Framework is a concern; however, plans will be developed taking into account any early intelligence from Welsh Government.
- Updates will be provided to EMB on a regular basis through the planning cycle.

Key Risks / Matters for Escalation:

- The key risks to delivery of a balanced plan which meets organisational objectives are:

1. The impact of the current and anticipated financial position.
2. Resource constraints and service fragility.
3. Inability to fully invest in priority areas identified for the current plan due to resource constraints.

- The strategy deployment framework will drive prioritisation to maximise use of resources and progress towards the future service model.
- Early focus on savings plans will enable schemes to be more robustly tested. This will provide greater assurance for planning and facilitate earlier delivery in the next financial year.

Recommendation

The Board is requested to note the content of this presentation and to:

1. Approve the internal planning framework and guidance.
2. Note the risks to developing a plan that meets the statutory requirements for service delivery, all performance requirements, and deliver a break-even financial position and plans for mitigation.

Next Steps

Subject to endorsement of the approach at EMB, the ITMP planning process will be enacted as per this proposal.

CTM 2030
Ein Hiechyd
Ein Dyfodol
DATBLYGU CYMUNEDAU
IACHACH GYDA'N GILYDD

CTM 2030
Our Health
Our Future
BUILDING HEALTHIER
COMMUNITIES TOGETHER

CTM 2030: Building Healthier Communities Together

Cwm Taf Morgannwg University Health Board Three Year Plan - Internal Framework 2027 – 2030



1 INTRODUCTION – PURPOSE AND LEGAL CONTEXT ERROR! BOOKMARK NOT DEFINED.

2 PLANNING APPROACH FOR 2027-2030 5

3 CONTEXT ERROR! BOOKMARK NOT DEFINED.

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PURPOSE AND LEGAL CONTEXT

1.1 Context

Developing and implementing an integrated medium term plan (IMTP) is a statutory requirement for Health Boards alongside the associated duty to achieve a financial break-even position during the three-year period, in accordance with section 175(2) of the National Health Service (Wales) Act 2006 (as amended by NHS Finance (Wales) Act 2014).

It's purpose is to set out the Health Board's key actions over a three year period to deliver its statutory requirements to meet the health needs of its population.

The Health Board must ensure that the plan is delivered in line with the requirements of key legislation, including but not limited to the following:

- NHS Wales Act (2006)
- NHS Finance Act (2014)
- Quality and Engagement Act (2020)

1.2 Cwm Taf Morgannwg University Health Board

This local framework sets out the key requirements and supporting information to facilitate development of the 2027-2030 plan in line with both national policy and the Health Board's vision and Strategy.

The Health Board's three-year plan (Integrated Medium Term Plan 2027-2030 will articulate the focus of the Health Board's approach to realising our future vision over the next 3 years. Our CTM 2030 Strategy and strategic clinical services planning must be at the heart of this work to ensure that a focus on our four key aims underpins the medium-term plans.

Central to the three year plan will be the principle of maximising the collective resource of the Health Board to achieve our key priorities and deliver outcomes for patients. This is an important message particularly given the current economic landscape and the expectation that Health Boards deliver and achieve their targets within very challenging financial context. The focus of our efforts must be on transformation to deliver these aims. Our financial position in 2026-2027 remains challenging and further work is required in year to deliver our savings plans and we will need to consider this in our planning for the next three years.

The Health Board's plan will be delivered in the challenging context of ongoing growth in demand for services and the financial constraints felt across the public sector in Wales and beyond.

Our success in developing and delivering our plans means that for the last three years, we have had an approved IMTP and have delivered a balanced financial position for the last three financial years. Our organisation has driven transformation and continuous improvement and we increasingly recognise the need for fundamental change to the way we work to ensure our services are fit for the future, in line with the ambition of A Healthier Wales.

The improvements we have made have strengthened our organisational reputation and are reflected in improvements in our organisational escalation. During early 2026, the Health Board received confirmation of de-escalation for cancer performance. The following areas remain under scrutiny.

Area	Previous Status	Revised Status
Performance: Urgent and Emergency Care	Targeted Intervention (L4)	Targeted Intervention (L4)
Performance: Planned Care	Enhanced Monitoring (L3)	Enhanced Monitoring (L3)

Our plan must ensure that quality and safety are at its heart and must respond to our key risks in addition to continuing progress on key performance requirements across the breadth of the NHS Wales Performance Framework.

Our improvements in recent years demonstrate our focus on reducing risk improving health and improving access to care:

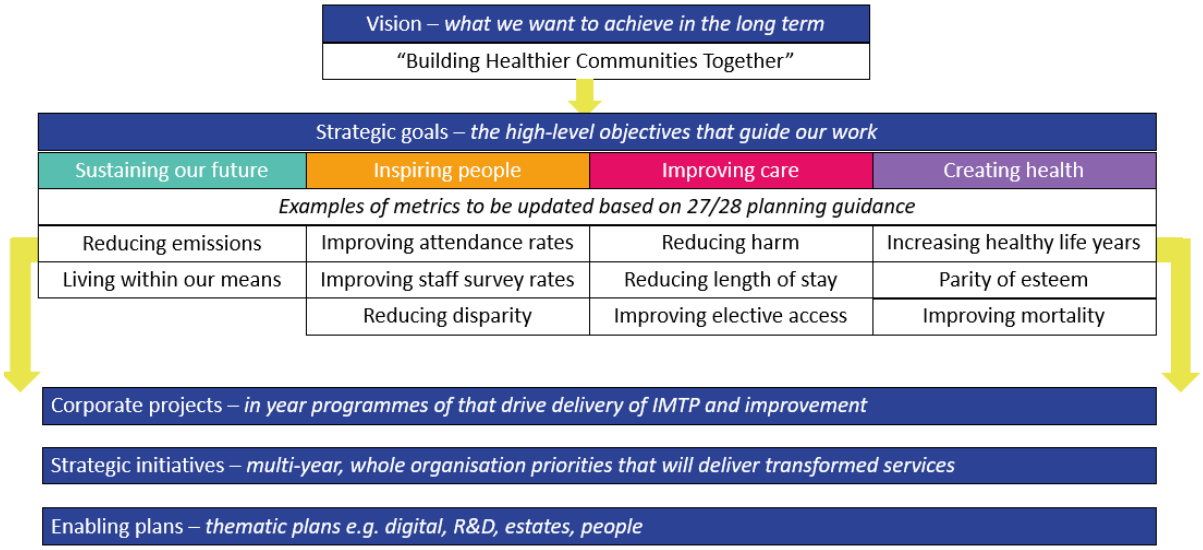
- Sustained improvement in delivery of the eight NICE recommended processes for diabetes.
- Downward trend in crude hospital mortality rates
- Ongoing improvement in access to definitive first cancer treatment within 62 days.
- An ongoing trajectory of improvement in planned care long waits.

- Sustained improvements in ambulance handover times across all sites, reflecting an organisation and system-wide response to managing risk and safety.

PLANNING APPROACH FOR 2027-2030

The forthcoming plan presents the delivery of our plans to 2030, which aligns with the delivery date of our CTM 2030 commitments and our organisational vision of building healthier communities together.

Focus will be on progress aligned to our corporate goals using our strategy deployment framework:



Learning from previous planning cycles

Our approach is founded on learning from our work to date. A survey following the last planning cycle identified the following themes.

- Early planning and collaboration are working well and should continue.
- The Plan on a Page approach is strongly supported, but supporting detail needs to be more accessible.
- Greater alignment between strategic priorities, resources, business cases and delivery plans is required
- Health inequalities and Marmot Principles should be more visible and measurable within the IMTP.
- Planning team support is highly valued.

- National planning processes and timelines create challenges for local IMTP development.
- Performance reporting should remain realistic and data-driven, recognising reporting lags and data availability.

Taking into account these learning points, the current cycle will maintain the strengths of earlier processes with a slightly different approach and timeline for submissions.

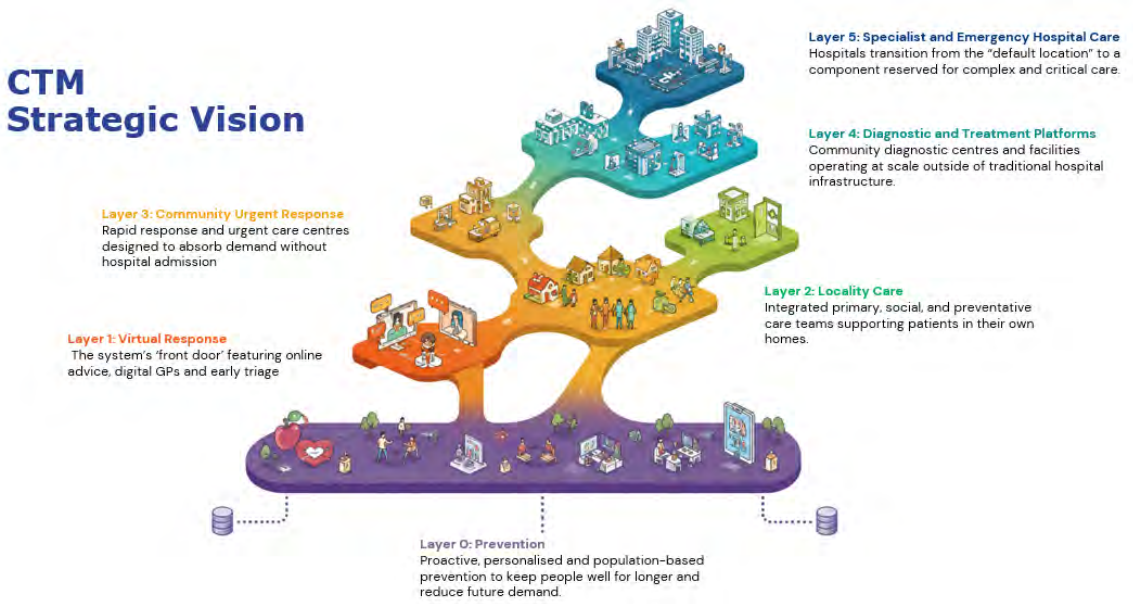
The approach is summarised in the image below:

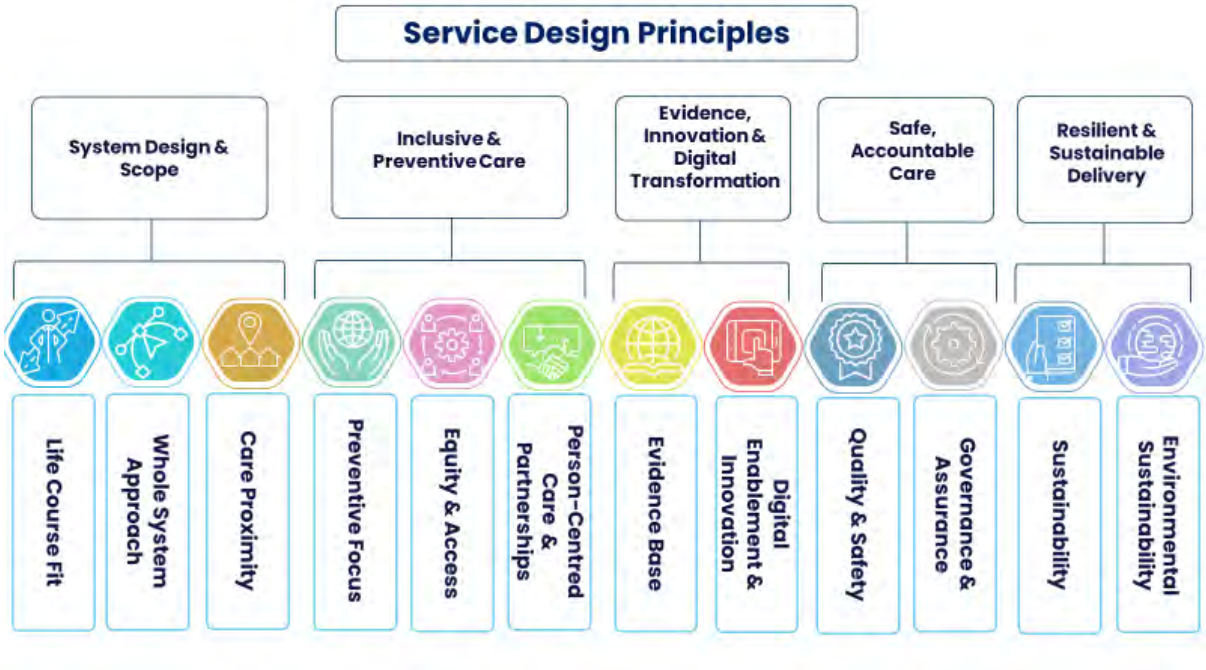


Key changes are:

1. A focus on delivery of the strategic vision for CTM (model of care). This will ensure services are provided in a sustainable way that moves us to a preventive, digital first and 'Community by Design' approach. The top five issues/plans to deliver the CTM strategic vision to be presented by each area for consideration in the planning process. These will require full appraisal of all resource requirements, enablers and inputs required for delivery and will need to be assessed against our strategic filter and the supplied prioritisation test.
2. A more detailed focus on the enablers for each key action area in our narrative plan. The plan on a page template is being refreshed to support points one and two.

3. In place of the detailed list of commissioning intentions, the requirements of each area will be aligned with the strategy deployment framework and the anticipated requirements of the planning framework. These will be highlighted for each care group.
4. Earlier commencement of development of savings plans supported by financial information based on the month 6 position.
5. Plans must also identify where there is opportunity to reduce, stop or alter current delivery mechanisms, and confirm disinvestment proposals.
6. Plans should rely on working within resource constraints to deliver safer, more equitable services, aligned to the CTM strategic vision for a new model of care. Where additional resource is proposed, teams must demonstrate that opportunities to stop, reduce, standardise, redesign or shift existing activity have been considered.
7. Completion of the detailed analysis must be undertaken prior to updating plans on a page.





Requirements

The requirements of care groups, strategic initiatives/ corporate programmes and corporate directorates are tabulated below:

Requirement	Care groups	Corporate teams	Programmes / initiatives
Capability analysis for delivery	Demand and capacity appraisal to inform delivery trajectory and scenario testing	✓	✓
Service plan template (aligned to workforce and financial plan)	✓		
Plan on a page and/or programme plan summary	✓	✓	✓
Finance plan	✓	✓	✓
Narrative chapter	✓	✓	✓
Completion of minimum dataset	✓	Finance People Digital and Data Public Health	

Support will be provided to care groups through Heads of Planning, Finance and People business partners. Discussion will be held with corporate teams both individually and via the supporting network of the IMTP steering group (Deputy Leadership Group).

The level of detail for the three years will vary but throughout there should be a focus on moving services towards the strategic vision:

- Year 1 - Firm: Plans should clearly describe, through narrative descriptions and plans on a page supported by completed mandatory templates, the actions, milestones and resourcing for the coming year. Resource considerations must include support from other service and corporate teams.
- Year 2- Indicative: Plans should indicate priorities, and anticipated actions, risks and impacts on resourcing for the second year. Details should be provided on key plans including anticipated performance trajectories, recognising these may alter.
- Year 3 - Outline: should show how the organisation proposes to make continued progress towards its strategic objectives, likely to be outline intentions, and known initiative/ programme milestones.

Indicative timeline

Our plan must be completed in time for full appraisal through our scrutiny process which comprises:

- Review and assessment by the Deputy Leadership Group
- Review and endorsement by Executive Management Board
- Scrutiny by the Strategic Development Committee (SDC) and
- Approval for submission by Board.

This must be completed in time for formal submission to Welsh Government, at the latest by 31st March 2027.

Key documents including the NHS Wales Planning Framework, NHS Wales Performance Framework and budgetary allocations are expected later in the autumn/winter period and our planning assumption will be refreshed in light of these. This may amend our indicative timetable for completion of plans.

Activity	Responsibility	Timescale
Confirmation of approach	Strategy and Transformation (S&T)	Completed
Refresh of population context	Public Health	Completed

Issuing internal Health Board Framework	S&T	19 October 2026
Demand and capacity/ activity information – current information to be shared with S&T team and requests for support confirmed	Care groups with support from S&T and Digital/ Data team	October 2026
Initial draft work for care group template and assessment of workforce/ financial implications and interdependencies/ support from other areas Supported via care group workshop sessions facilitated by Heads of Planning	Care groups Support from planners	October 2026
Submission of individual care group template with response to key requirements and top 5 service change care group priority changes supported by risk assessment. **To: Julie.Powell-Jones@wales.nhs.uk**	Care groups	23 November 2026
First draft savings proposals/ finance schedule completion.	All directorates	30 November 2026
Review and consideration of interdependencies and requirements	S&T team IMTP Steering Group	
Receipt of planning framework. Circulation to teams	WG S&T team	Anticipated November 2026
Collective review of care group plans	ICB	9 December 2026
Budget allocation	WG	Anticipated w/c 21/12/26
Corporate programme plans and chapters	Programme leads and SROs	20 December 2026
Corporate directorate chapters – first submission (N.B. Teams with interface with service plans may be indicative only)	Corporate teams	20 December 2026
Minimum dataset submissions	Care groups/ corporate teams	20 December 2026*
Revised service plan	Care groups	22 December 2026*
Submit revised finance plan	All directorates	29 January 2027*

(and any associated amendments to care group plans)		
First draft narrative plan	S&T team	January 2027
Draft IMTP Plan review by steering group	S&T team/ DLG IMTP steering group	January 2027
EMB review		January 2027
Final refinement of service/ corporate plans and service plans	All	January – 14th February
EMB review and endorsement of plan, as amended	S&T team/ EMB	February 2027
Approval sought at Strategic Development Committee	S&T team/ executive team/ SDC	February 2027
Deadline for submission of Draft IMTP to Health Board		March 2027
IMTP Board review for approval	Board	March 2027
Final submission to Welsh Government	CEO office & S&T team	31st March 2027
Progress reporting		Quarterly

OUR PLAN CONTEXT – POPULATION HEALTH

Cwm Taf Morgannwg (CTM) faces a combination of population ageing, entrenched deprivation, declining healthy life expectancy and comparatively poor health behaviours and outcomes. The population was estimated at 446,363 in 2025. The proportion aged 65 and over rose from 20% in 2021 to 20.9% in 2025, and the number aged 65+ is projected to reach about 116,200 by 2047, around 30% higher than current levels.

At the same time, people in CTM experience poorer health than the Wales average. Healthy life expectancy is consistently lower, self-reported good health has fallen, and avoidable mortality in 2024 was the highest among Welsh health boards for both males and females. These pressures are not evenly distributed. More than half of the CTM population lives in the two most deprived fifths in Wales, and people in the most deprived communities experience chronic conditions materially earlier than those in the least deprived areas.

We must plan not simply for more older people, but for a population in which ill health begins earlier, healthy life expectancy is falling, and need is concentrated disproportionately in deprived communities.

DEMOGRAPHY

The CTM population is ageing. Although the local age profile is not uniformly older than Wales, the direction of travel is clear: the share of people aged 65+ increased from 77,474 people in 2021 to 93,180 in 2025, while the share aged

15 and under decreased. Deaths have exceeded births in every year since 2021. By 2047, the population aged 65 and over is projected to be around 116,200.

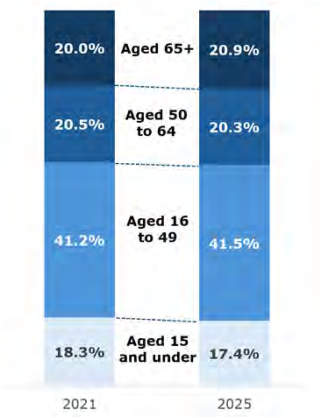


Figure 1. Population ageing in CTM. Source: CTM LPHT using ONS mid-year estimates and StatsWales projections.

This demographic shift is likely to increase demand for services associated with frailty, long-term conditions, multimorbidity, rehabilitation and support for independence. The effect is likely to be amplified by the comparatively poor underlying health of the population.

DEPRIVATION

In 2025, 51.9% of the CTM population lived in the two most deprived fifths in Wales. The burden is highest in Merthyr Tydfil, where 63.9% of LSOAs fall within the two most deprived fifths, followed by Rhondda Cynon Taf at 54.2%; Bridgend is lower but still substantial at 47.3%. The highest levels of deprivation are concentrated mainly in the northern valleys.

Area	% of LSOAs in two most deprived fifths
Bridgend	47.3%
Merthyr Tydfil	63.9%
Rhondda Cynon Taf	54.2%
CTM UHB	51.9%

The significance of deprivation is visible across the health profile. In the 2021 Census all three CTM local authorities had age-standardised rates of bad or very bad self-reported health above the Wales average of 6.9%; Merthyr Tydfil reported 9.3%.

HEALTHY LIFE EXPECTANCY

Across the UK, healthy life expectancy has declined in recent years, with widening inequalities between more and less deprived places. This pattern is

particularly important for CTM because both life expectancy and healthy life expectancy are consistently below the Wales average. Healthy life expectancy in

CTM has declined since 2019-21, largely reflecting a reduction in self-reported good health rather than a major change in mortality.

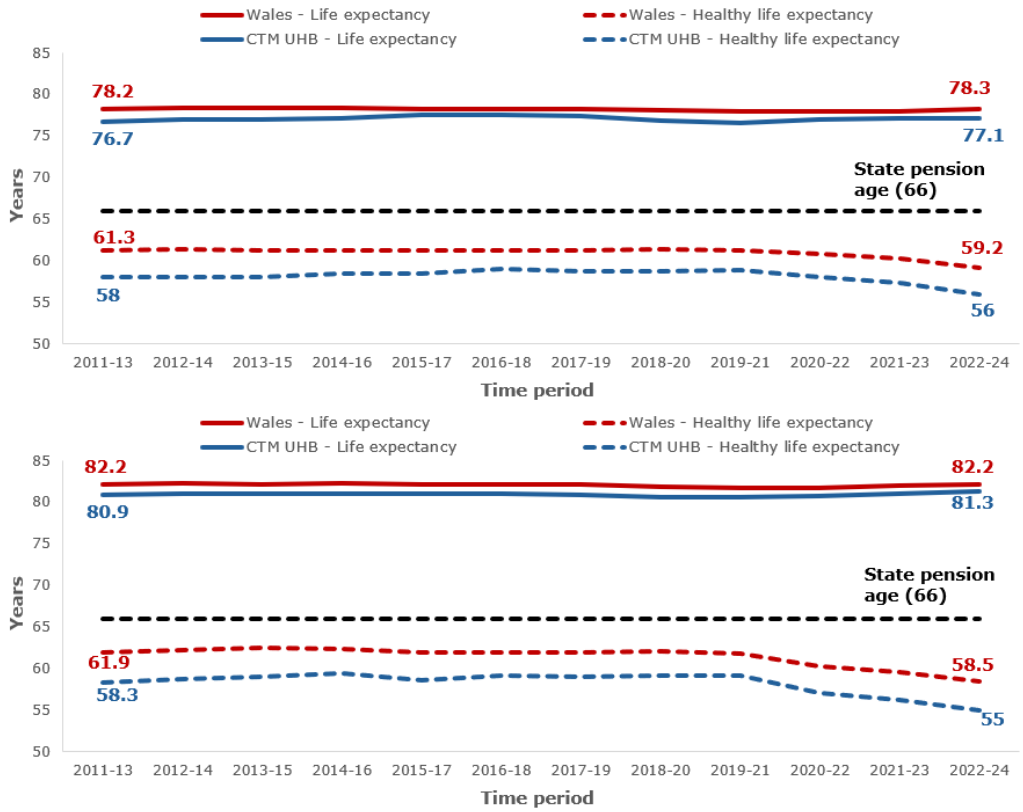


Figure 2. Life expectancy and healthy life expectancy trends in CTM. Source: CTM LPHT using Public Health Outcomes Framework data.

The practical consequence is a substantial period of life spent in poorer health. Both males and females in CTM are expected to spend around ten years in poor health before state pension age. Declining self-reported good health is particularly marked among younger working-age females, with a smaller decrease among males. Suggested contributory factors include earlier onset of disease, increasing diagnosis of mental health conditions, the effects of COVID-19 and wider determinants such as deprivation and public investment.

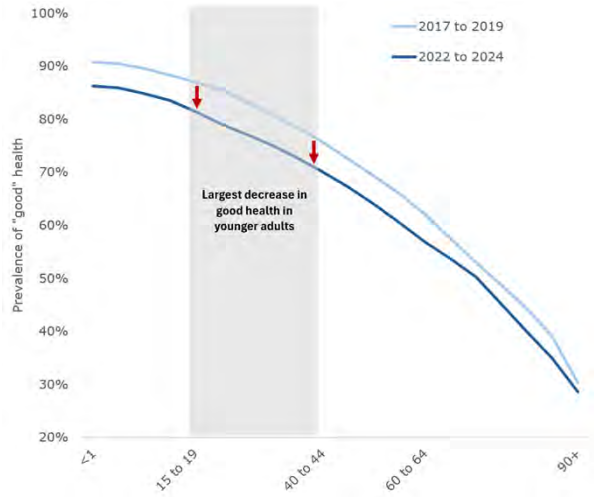


Figure 3. Percentage of females reporting good health by age, 2017-19 and 2022-24. Source: CTM LPHT using ONS modelled data.

INEQUALITIES IN HEALTHCARE

The most important feature of the CTM profile is not only poorer average health, but the size of the inequality within the population. In 2018-2020, males in the least deprived CTM areas lived around seven years longer and had around ten more years in good health than males in the most deprived areas. For females, the equivalent gaps were around five years in life expectancy and twelve years in healthy life expectancy.

People living only a few miles apart can experience a difference of roughly a decade in the number of years lived in good health.

AVOIDABLE MORTALITY

Avoidable mortality has fallen overall since 2001 in CTM and Wales, but CTM has experienced a recent increase. In 2024, CTM recorded the highest avoidable mortality rate among Welsh health boards for both males and females, with both rates significantly above the Wales averages. Across Wales, the male rate was 337.5 per 100,000 and the female rate 210.3 per 100,000.

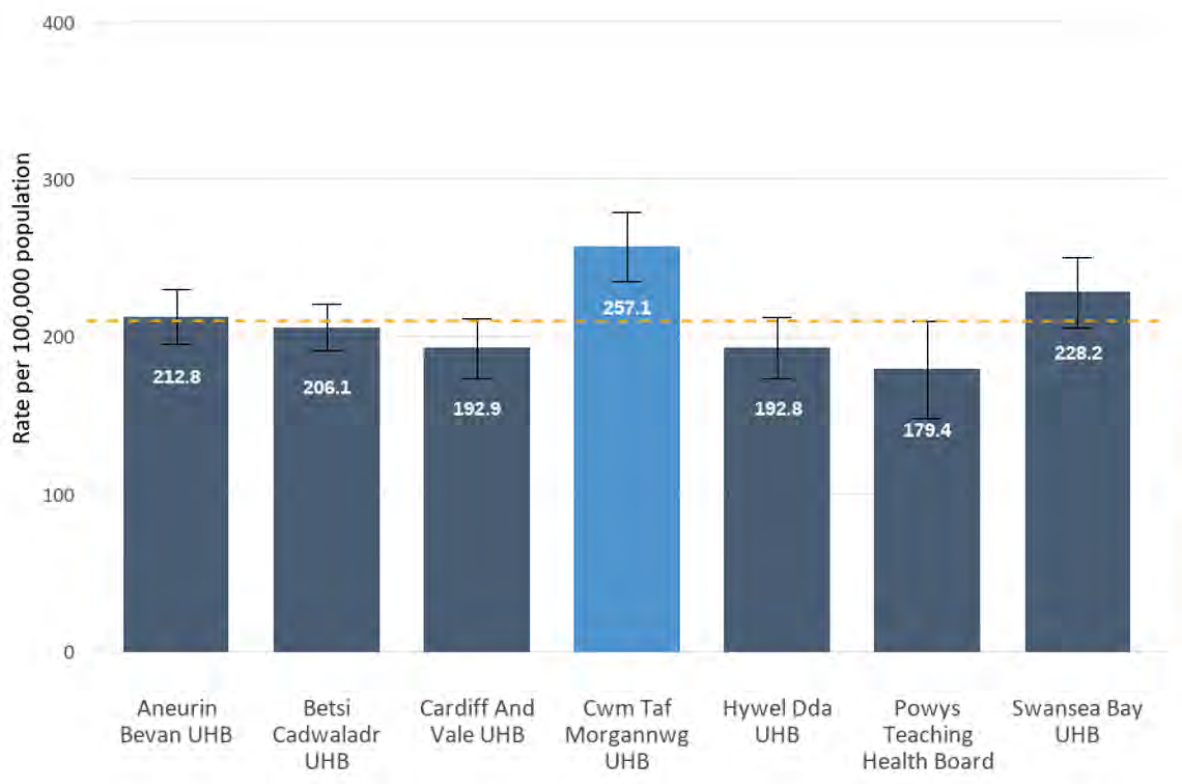


Figure 4. Avoidable mortality by Welsh health board and sex, 2024. Source: CTM LPHT using ONS avoidable mortality data.

There are also important differences within CTM. Bridgend has shown a steady decline and sits closer to the Wales average. Merthyr Tydfil has had the highest avoidable mortality in CTM since 2012-14, including a substantial rise from 2016-18, although rates have reduced after the pandemic. Rhondda Cynon Taf shows a slow long-term decline and has been broadly stable since 2019-21 apart from the COVID-19 period.

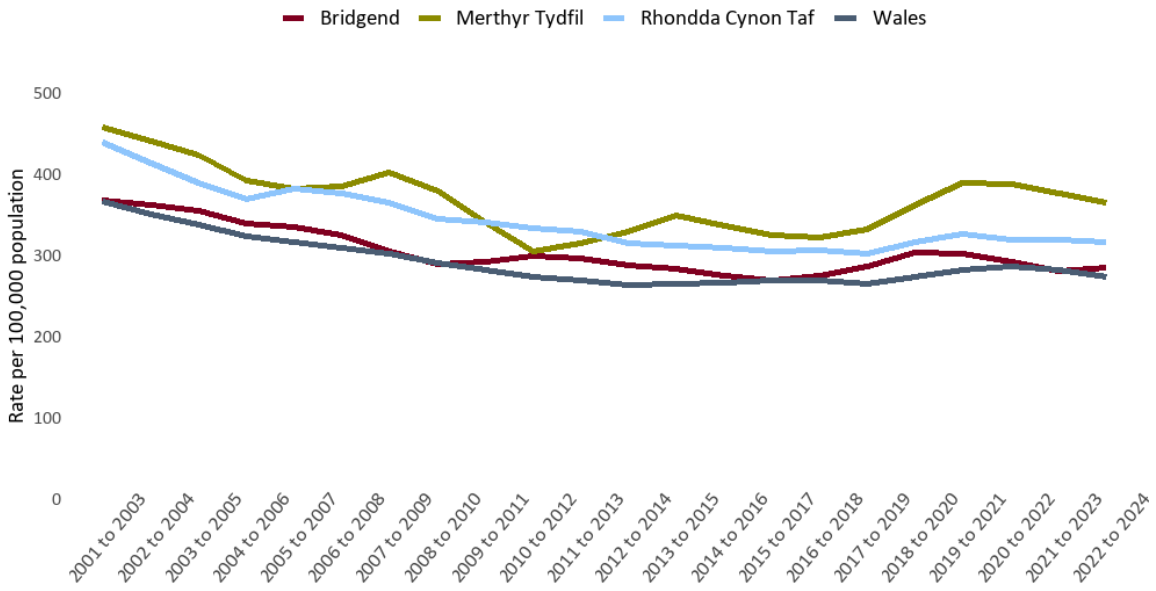


Figure 5. Avoidable mortality trend, CTM and Wales. Source: CTM LPHT using ONS data.

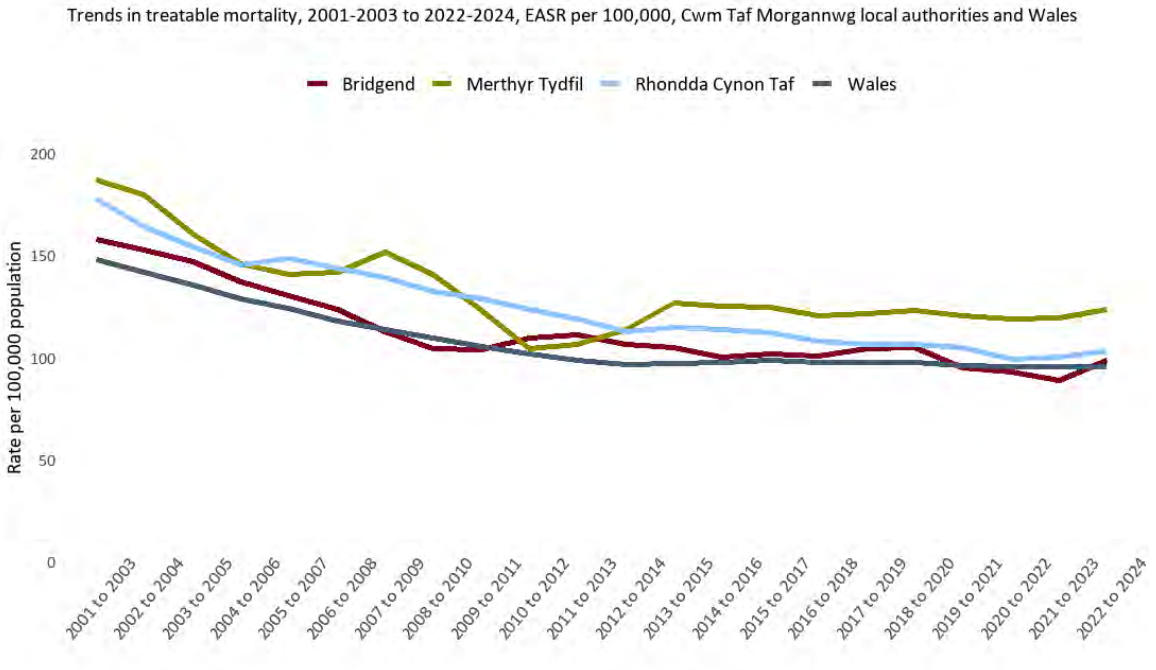


Figure 6. Treatable mortality in CTM. Source: CTM LPHT using ONS data.

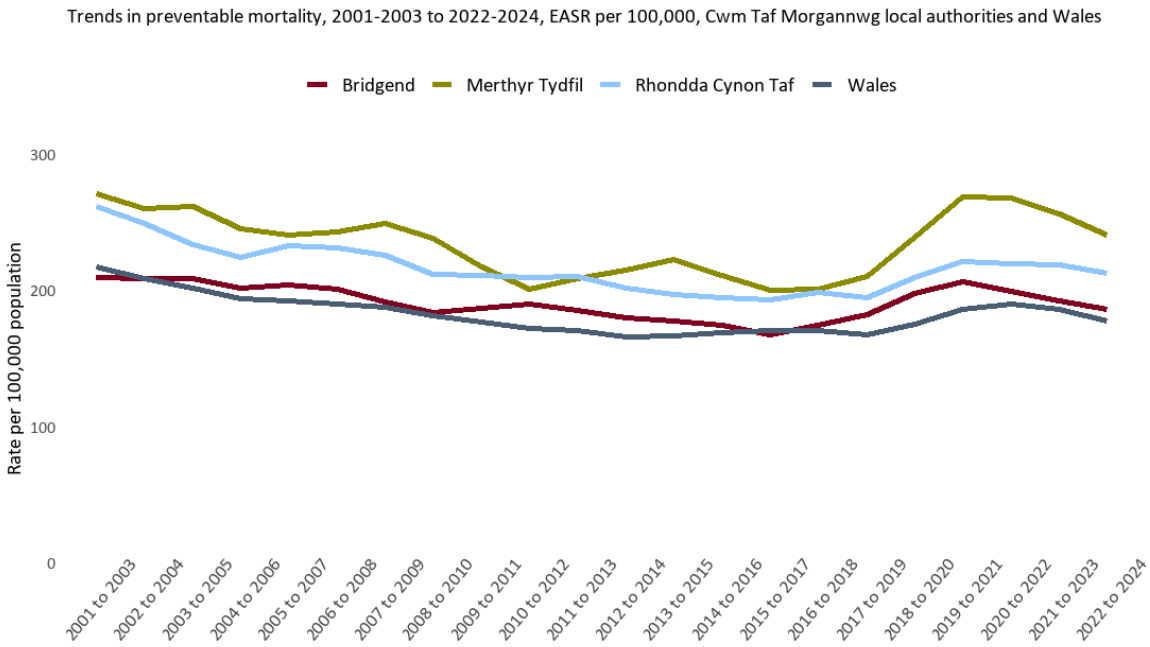
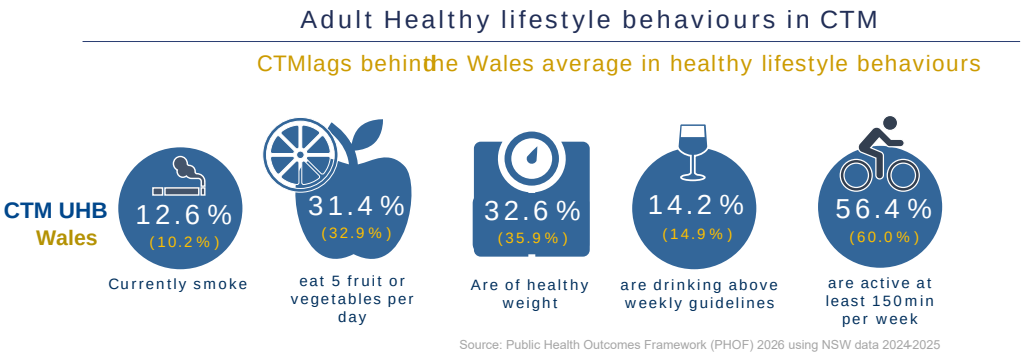


Figure 7. Preventable mortality in CTM. Source: CTM LPHT using ONS data.

Treatable mortality has been roughly stable since 2013-15, suggesting that improvements in outcomes amenable to timely and effective healthcare have stalled. Preventable mortality has declined over the longer term, but the trajectory is uneven, most notably in Merthyr Tydfil. Taken together, these measures point to the need for a combined approach: improving prevention and wider determinants while also strengthening access, early diagnosis and effective treatment.

HEALTHY BEHAVIOURS



- **Adults** in CTM are smoking and drinking alcohol more, exercising less, and have higher levels of overweight or obesity than in Wales.
- Smoking rates have dropped recently in CTM to 12.6%, from 14.6% in 2021/22 - 2022/23.
- Challenges in healthy lifestyle behaviours are also present among **school-aged children** and **adolescents**.

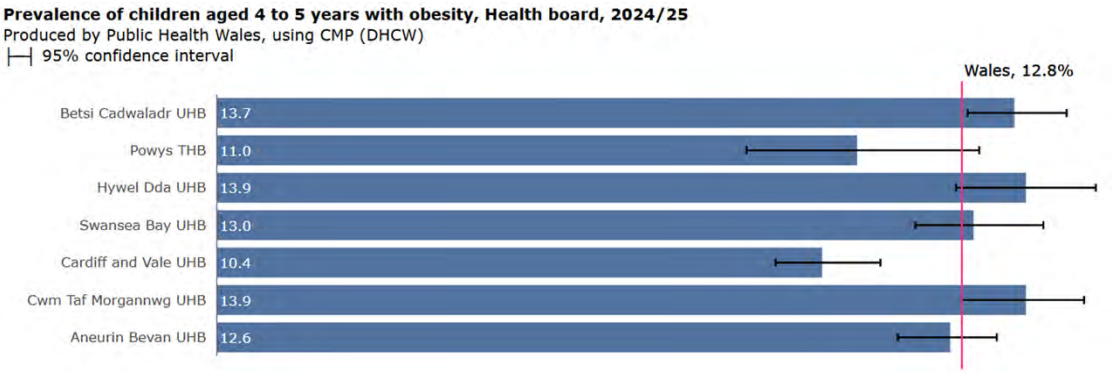


Figure 8. Childhood obesity in CTM, including the deprivation gradient. Source: Child Measurement Programme 2024/25, Public Health Wales.

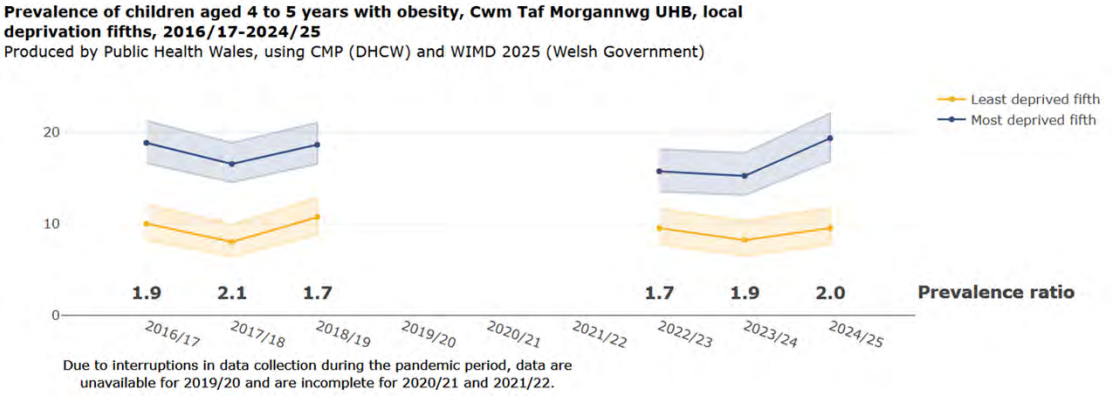


Figure 8. Childhood obesity in CTM, including the deprivation gradient. Source: Child Measurement Programme 2024/25, Public Health Wales.

Among working-age adults, 68.8% self-report as overweight or obese compared with 62.1% nationally, while 34.1% report obesity compared with 27.9% across Wales. Prevention therefore needs to operate across the life course and cannot rely solely on individual behaviour change; the scale and social patterning of risk point to the importance of environments, access and wider determinants.

MULTIMORBIDITY

Primary care segmentation data provide a particularly important insight for service planning. In CTM, inequalities in multimorbidity widen substantially from age 50 onwards. People in their 40s living in the two most deprived fifths have a higher mean Cambridge Multimorbidity Score than people in their 50s living in the least deprived fifth. In effect, more deprived communities experience the burden of chronic conditions around a decade earlier.

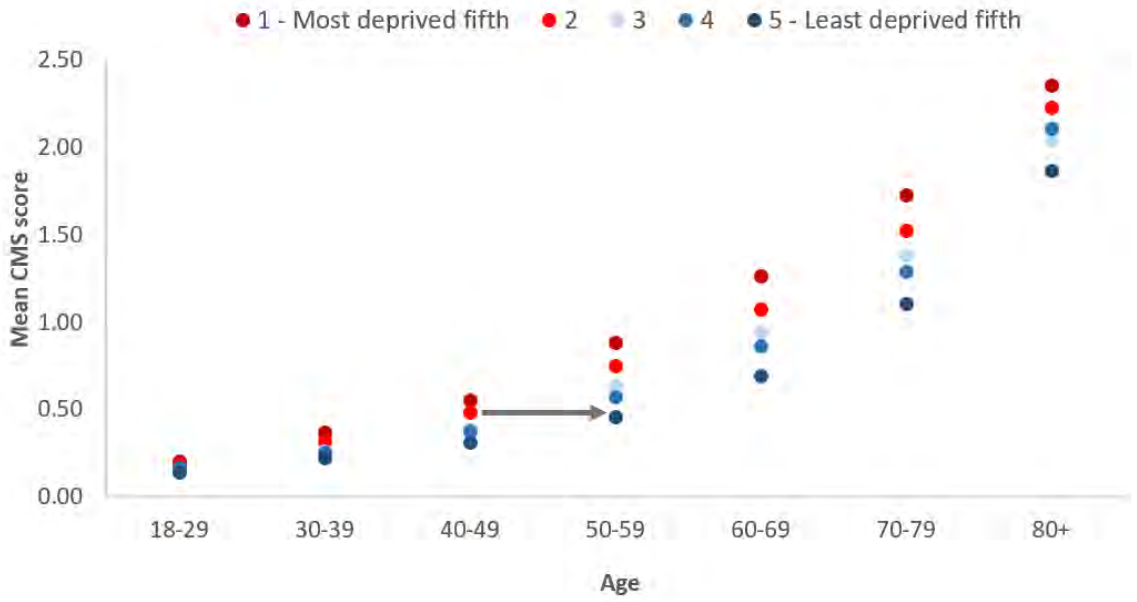


Figure 9. Mean Cambridge Multimorbidity Score by age and deprivation, CTM, 2025. Source: CTM primary care segmentation data.

This has material implications for conventional age-based models of care. A system that assumes complex need is predominantly a feature of older age risks underestimating demand among working-age adults in deprived communities. It also strengthens the case for anticipatory, integrated and place-based models that target need rather than age alone.

Statistical significance compared to Wales

Statistically significantly higher
Similar to Wales
Statistically significantly lower

Chronic condition	Bridgend East	Bridgend North	Bridgend West	North Cynon	South Cynon	North Merthyr	South Merthyr	North Rhondda	South Rhondda	North Taf Ely	South Taf Ely	CTM	Wales
Asthma	7.1%	8.3%	8.2%	5.6%	6.5%	7.5%	7.5%	7.4%	7.7%	7.3%	7.6%	7.3%	7.0%
Atrial Fibrillation	2.7%	2.8%	2.5%	2.4%	2.5%	2.6%	2.5%	2.6%	2.5%	2.3%	2.4%	2.5%	2.4%
Cancer	3.5%	3.8%	3.8%	2.9%	3.0%	3.7%	2.4%	3.2%	2.9%	3.1%	2.9%	3.2%	3.3%
COPD	1.8%	2.9%	2.1%	2.5%	3.0%	3.5%	2.0%	3.3%	2.6%	2.5%	1.6%	2.4%	2.1%
Dementia	0.7%	0.7%	0.6%	0.6%	0.5%	0.7%	0.6%	0.6%	0.7%	0.6%	0.6%	0.6%	0.7%
Diabetes (aged 17+)	8.1%	9.8%	7.2%	8.3%	9.6%	9.4%	8.7%	9.4%	9.3%	8.8%	7.2%	8.6%	7.9%
Epilepsy (aged 18+)	1.0%	1.3%	1.0%	0.9%	1.1%	1.2%	1.0%	1.2%	1.3%	1.0%	0.9%	1.1%	0.9%
Heart Failure	1.2%	1.8%	1.2%	1.0%	1.0%	1.2%	1.1%	1.0%	0.9%	1.0%	0.7%	1.1%	1.2%
Hypertension	15.8%	19.3%	13.9%	15.7%	17.4%	17.7%	16.1%	17.7%	16.7%	16.5%	14.6%	16.4%	15.0%
Learning Disabilities	0.5%	0.6%	0.6%	0.4%	0.5%	0.6%	0.3%	0.6%	0.6%	0.5%	0.3%	0.5%	0.5%
Mental Health	1.1%	1.2%	1.3%	1.1%	1.1%	1.0%	0.9%	1.3%	1.1%	1.1%	0.9%	1.1%	1.1%
Obesity (aged 16+)	11.7%	19.7%	11.0%	14.1%	18.2%	19.6%	14.2%	15.7%	19.0%	16.5%	11.2%	15.2%	13.6%
Osteoporosis (aged 50+)	0.6%	0.6%	x	x	x	x	x	x	x	0.4%	0.6%	0.4%	0.5%
Palliative Care	0.3%	0.4%	0.3%	0.3%	0.2%	0.3%	0.1%	0.2%	0.1%	0.2%	0.1%	0.2%	0.3%
Rheumatoid Arthritis	0.8%	0.9%	0.8%	1.0%	1.1%	1.1%	1.0%	1.0%	0.8%	0.8%	0.9%	0.9%	0.9%
Secondary Prevention of CHD	3.3%	4.0%	3.3%	3.3%	3.5%	3.7%	3.0%	4.0%	3.5%	3.3%	3.0%	3.4%	3.1%
Stroke & TIA	2.5%	2.7%	2.5%	2.0%	1.9%	2.4%	1.9%	2.4%	2.1%	2.0%	2.1%	2.3%	2.0%

Figure 10. Age-standardised prevalence of chronic conditions in CTM, 2024. Source: Public Health Wales primary care clusters dashboard.

Diabetes is one area where future demand is particularly uncertain but potentially substantial. Modelling in the source presentation suggests that by 2035/36 there could be between 31,000 and 75,000 people registered with diabetes in CTM. The breadth of this range underlines both the uncertainty and the value of prevention in influencing future service demand.

ORAL HEALTH

There has been sustained improvement in childhood dental health since 2008/09, but the remaining burden is substantial. In 2023/24, 21.9% of children in CTM were affected by tooth decay and 12.4% had untreated decay. In 2024, 41.2% of children in CTM experienced one or more oral-health-related quality-of-life impacts associated with dental caries, the highest prevalence in Wales and well above the Wales average of 28.1%.

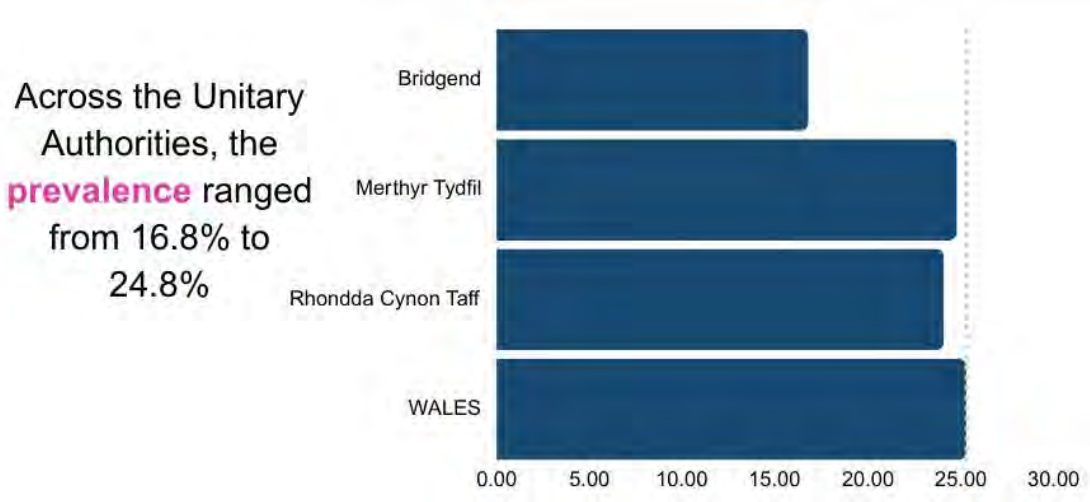


Figure 11. Childhood tooth decay in CTM. Source: NHS Wales Dental Epidemiology Programme, Picture of Oral Health 2024.

	One or more OHRQoL impacts			Visited the dentist in the last month		
	Prevalence (%)	95% Confidence interval		Prevalence (%)	95% Confidence interval	
		Low	High		Low	High
Aneurin Bevan UHB	37.7	35.3	40.1	16.0	14.1	17.8
Betsi Cadwaladr UHB	38.3	36.1	40.3	21.9	20.1	23.8
Cardiff and Vale UHB	16.8	13.7	19.9	6.2	4.2	8.3
Cwm Taf Morgannwg UHB	41.2	37.8	44.8	24.2	21.1	27.1
Hywel Dda UHB	13.9	11.4	16.3	8.8	6.9	10.7
Powys THB	38.0	31.8	44.3	11.5	7.4	15.6
Swansea Bay UHB	8.5	6.5	10.5	3.2	9.1	4.4
WALES	28.1	27.0	29.1	14.2	13.3	15.0

Figure 12. Oral-health-related quality-of-life impacts associated with dental caries. Source: NHS Wales Dental Epidemiology Programme.

VACCINATION

Childhood vaccination is an area of relative strength. During 2025/26 CTM recorded the highest or joint-highest uptake in Wales for several routine childhood vaccines and HPV. However, only 87.7% of children were up to date with vaccinations at age four in January-March 2026, and pre-school boosters and MMR2 remained below the 95% target. A deprivation gap in uptake persists.

Seasonal influenza vaccination presents a more immediate vulnerability. The target and Health Board ambition is 75%, yet uptake in 2025/26 was 45% among people aged 16-64 in a clinical risk group, 73% among those aged 65+ and 56% among children aged three. The particularly low uptake in clinically vulnerable working-age adults may increase avoidable winter morbidity and demand.

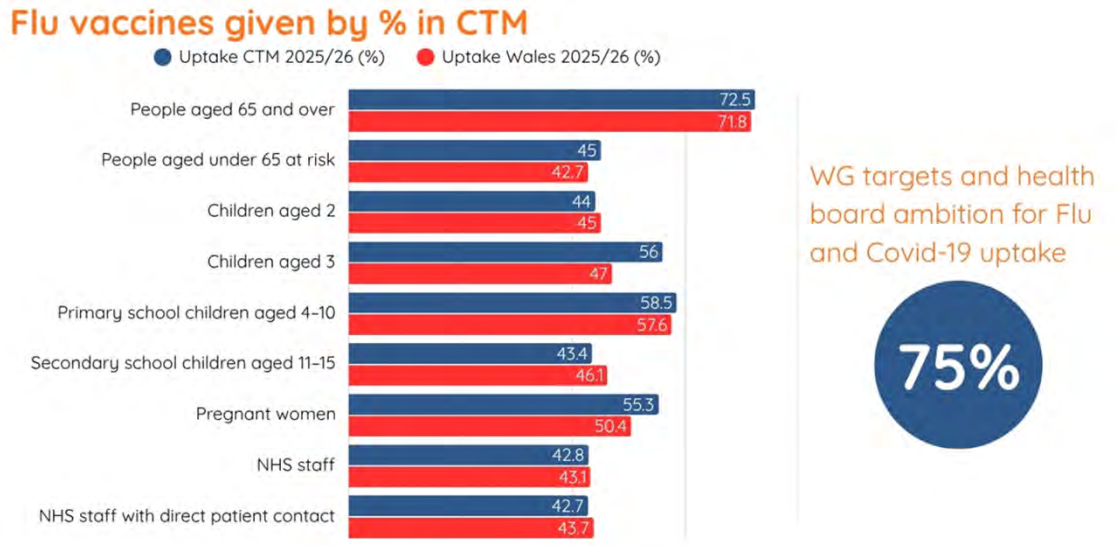


Figure 13. Influenza vaccination uptake in CTM, 2025/26. Source: CTM UHB Winter Respiratory Vaccination Programme and Wider Winter Impact Debrief.

PLANNING IMPLICATIONS

Plan for need, not age alone

Population ageing will increase demand, but multimorbidity is already occurring around a decade earlier in deprived communities. Resource and pathway design should reflect both age and deprivation-related need.

Shift the balance towards prevention

High avoidable mortality, obesity, poor diet, inactivity and declining healthy life expectancy indicate a sizeable preventable burden. Investment in prevention should be viewed as core demand management.

Make inequality reduction an organising principle

With 51.9% of the population living in the two most deprived fifths, universal approaches alone are unlikely to narrow gaps. Proportionate targeting should be built into planning, access and outcome measurement. The Health Board has committed to improving population health and reducing inequalities, with a commitment to becoming a Marmot organisation.

Strengthen working-age population health

The decline in good health among working-age adults, early multimorbidity and high obesity prevalence have implications for primary care, mental health, musculoskeletal services, economic inactivity and workforce participation.

Focus on avoidable and treatable mortality

The combination of the highest avoidable mortality in Wales and broadly stable treatable mortality supports renewed attention to prevention, early diagnosis, equitable access and effective treatment.

Use vaccination and oral health as targeted prevention opportunities

Relatively strong childhood immunisation provides a platform to build on, while gaps in pre-school coverage, influenza uptake and oral health point to specific populations where targeted action could deliver measurable gains.

Sources and notes

- ONS mid-year population estimates, 2025; 2022-based population projections via StatsWales.
- Welsh Index of Multiple Deprivation, 2025.
- Census 2021; Public Health Outcomes Framework/Public Health Wales; ONS modelled self-reported health data.
- ONS avoidable mortality data, 2024.
- National Survey for Wales; School Health Research Network Survey 2023; Child Measurement Programme 2024/25.
- CTM primary care segmentation data to December 2025; Public Health Wales primary care clusters dashboard.
- NHS Wales Dental Epidemiology Programme, Picture of Oral Health 2024.
- COVER 158, January-March 2026; CTM UHB Winter Respiratory Vaccination Programme debrief 2025/26.
- Health Foundation (2026), Healthy life expectancy trends in the UK: a watershed moment; and related evidence cited in the source presentation.

OUR VISION AND STRATEGY

As an organisation, our ultimate aim and vision is to build healthier futures together; ensuring that we work with our communities and partners to improve health as well as delivering safe and effective care.

CTM2030: OUR STRATEGY

CTM 2030: Our Health, Our Future is our organisational strategy, which was developed in conjunction with our staff, population and partners. The summary of CTM 2030 can be seen in the diagram below, setting our strategic goals and our 'life course' approach which supports the delivery of the goals. CTM 2030 covers all aspects of how we deliver and improve, focusing on the health of our population, delivery of safe care, working to be a sustainable organisation and achieving this through our commitment to our people.



STRATEGIC CLINICAL SERVICES PLAN

We are continuing to develop and progress our Strategic Clinical Services Plan with key actions in year incorporating the following key foundational components:

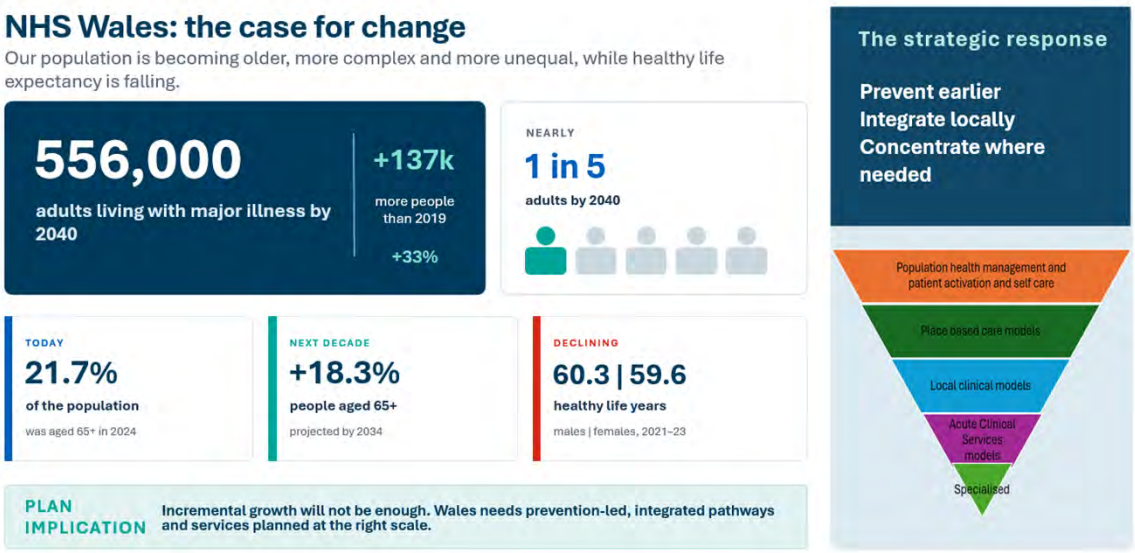
- Vision and strategic pillars
- Design principles
- Priority areas and a case for change framework
- A strategy deployment framework and operational management system
- Metrics and reporting, including a core SCSP dashboard

- Change tools, culture and corporate identity
- Engagement, co-production and clinical voice

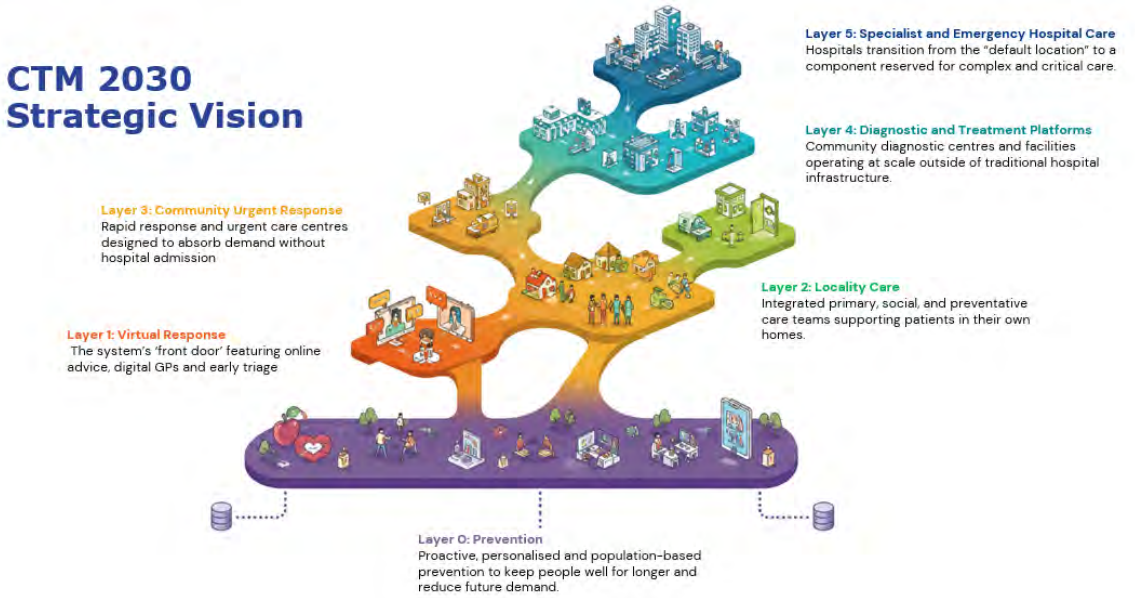
CASE FOR CHANGE

The population context section set out above made clear the challenges that we need to address to achieve our strategic aims and deliver our statutory duties.

The case for change has been summarised in the graphic below.



Our vision for the future is encapsulated in the system design set out below.



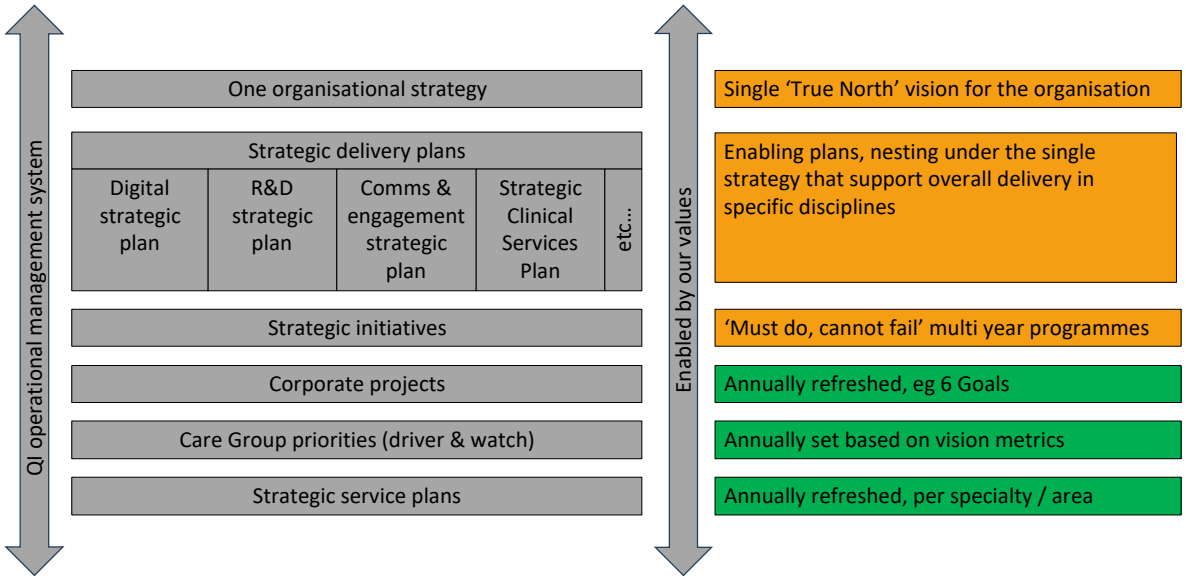
Our IMTP for 2027-2030 must articulate how we will move towards this future system. Each planning decision must be aligned with our ultimate aim of ensuring a primary focus on prevention, and facilitating a further shift towards out of hospital care and towards community services, where possible.

Further information will be supplied with supporting templates.

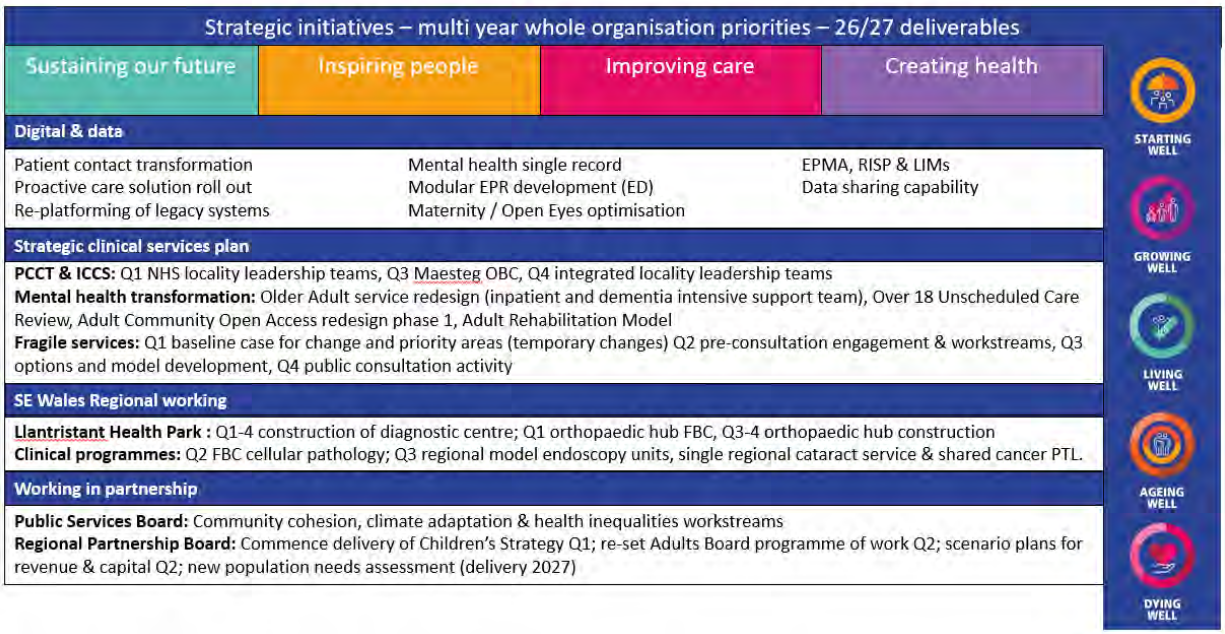
STRATEGY DEPLOYMENT

During 2026-27, we have been working to enhance our planning and performance management approach through a strategy deployment framework. This is a central mechanism to enable us to fully deliver the aims and objectives of our strategy by providing a structure to align the activity, architecture, culture and resourcing to of our organization to the vision of our organisation, as set out in the image below.

This structure enables a portfolio approach and encompasses all levels of the organisation, connecting our strategy to the work of all teams. This structure is set out below.



Our agreed strategic initiatives as set out in out 2026-2029 IMTP are described in the visual below:

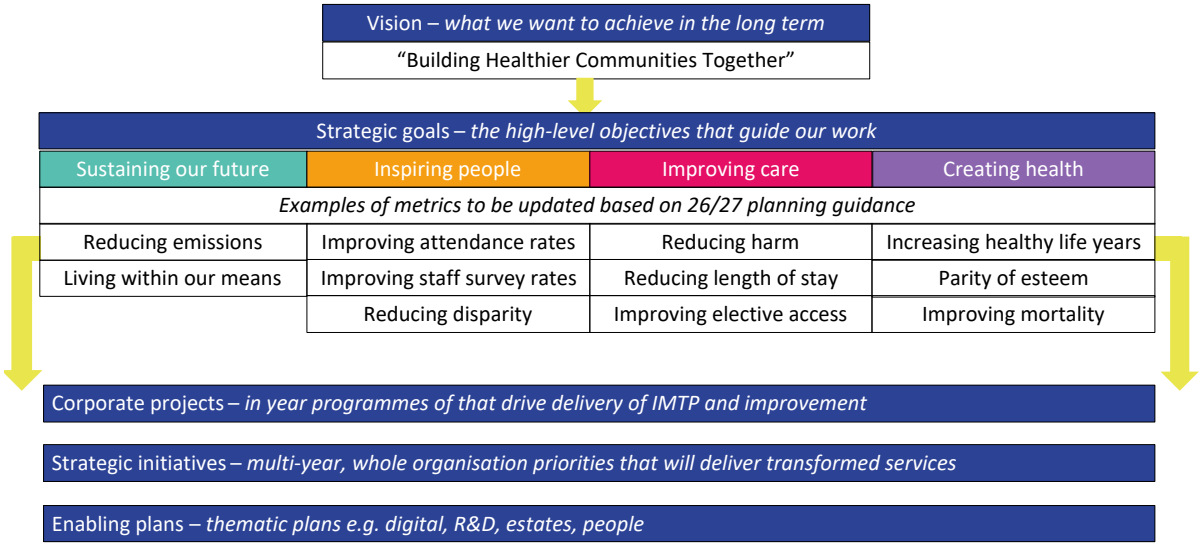


The current list of corporate programmes/ projects includes the following, all of which will be reflected in our plan:

- Urgent and Emergency Care Improvement Programme
- Productivity Efficiency and Transformation Programme
- Value and Effectiveness Programme
- Frailty
- Diabetes

MEASUREMENT

A suite of measures was collectively agreed for the 2026-2029 plan to test our progress. These are incorporated into performance structures for programmes and care groups, ensuring that our work delivers on our strategic intentions. The measures are set out below.



The structure of our IMTP for 2027-2030 will be designed around this framework, ensuring that the work towards our strategic initiatives, the delivery of our corporate programmes and key actions at care group level are coordinated and planned.

Each programme/ care group will be required to provide a forward look across three years, with a focus on outcomes supported by robust measurement.

QUALITY SAFETY AND EXPERIENCE

The Duty of Quality and delivery of high–quality care

Our Quality Strategy was developed in 2022 to cover the period 2022-2025. Its purpose was to enable the Health Board to deliver on the NHS Wales core value of putting quality and safety above all else and providing high-value, evidence-based care for our patients at all times. All plans are aligned to this strategy which is supported by a work plan for each year.

In our current plan for 2026–2029, we set out our intention to deliver a single, board-led Quality Management System aligned to the statutory Duty of Quality, underpinned by our renewed Quality Strategic Plan 2026/29 and an annual work plan that sets measurable objectives, assigns executive ownership, and enables routine Committee oversight of progress. This included full adoption of the all-Wales Listening to People approach from 1 April 2026, embedding Duty of Candour conversations, proportionate investigation and transparent learning, alongside strengthened incident management, earlier resolution of concerns and clear pathways into redress.

We also set out to publish and act on our People's Experience Strategy which received approval from the Board in September 2026, to expand bereavement and carer support (including the Carers Passport), and further normalise bilingual care through a consistent Active Offer so that experience drives improvement alongside safety and effectiveness.

We made a commitment to delivery of the requirements of the NHS Wales Planning Framework with respect to quality and safety:

- Downward trend in 12-month rolling average crude mortality while maintaining a flat 7-day readmission rate.
- Days of safe care delivered since the last never event, monitored using SPC T-Chart
- Percentage proportion of complaints dealt with via early resolution - target 40% by March 2027
- The clinical coding service must ensure that at least 95% of inpatient and day-case episodes are fully coded within one reporting month of discharge, in line with Welsh Government delivery measures. In addition, 90% of all identified coding errors must be corrected within 35 days of identification, ensuring timely and accurate data quality improvements across all health boards. There must be a focus on quality of coding with an emphasis on specificity, and comorbidity capture demonstrated by an increase in depth index by 10% year-on-year.

EXPECTATIONS OF SERVICE PLANS

- All service development and delivery plans must be fully aligned to the strategic quality goals.
- Developed in alignment with our People's Experience Strategy (2026), which is founded on the requirements of the All Wales People's Experience Framework (2025). Care groups are being asked to populate a draft assessment by 30th November 2026 and have an action plan in place to address any gaps going forward. This will inform the planning cycle and any service changes arising from it.
- All service development and change requirements identified across all services and teams must be:
    - Clearly demonstrated to contribute to delivery of key quality, safety and relevant standards. Measures must be supplied.
    - Subject to a Quality Impact Assessment (QIA) along with Equality Impact Assessment, where required.
    - Tested against the twelve quality domains set out in the Health and Care Standards.
    - Incorporate the service-level activity on people's experience to inform planning proposals and ensure activity is aligned with the framework set out in our current IMTP.



Further Information and Support

The Strategy and Transformation Team is working with the People's Experience Team to provide an extract of key themes from our People's Experience Forum to support planning.

People's Experience extract from our IMTP 2026-2029

1. People's Experience as a Strategic Driver

Board assurance

- People's experience routinely referenced in Quality, Safety and Experience reporting, with year-on-year improvement in key themes.
- Board assurance that experience insights inform at least one major service change annually.

Service / ward improvement

- Services demonstrate clear "You said – We did" actions and the difference these have made as a consequence.

- Experience themes routinely discussed and acted upon through local action plans.

2. Use of Real-Time Experience Insights

Board assurance

- Timely availability of experience insights and reduced recurrence of unresolved themes.
- Improved triangulation of experience, safety and outcome data.

Service / ward improvement

- Wards and services use real-time feedback to inform immediate improvement.
- Staff demonstrate confidence in using experience insights to change practice.

3. People's Experience Strategy (from 2026)

Board assurance

- Strategy launched, governed and reported through annual progress updates.
- Clear alignment between experience priorities and IMTP quality objectives.

Service / ward improvement

- Services translate the Strategy into local priorities and improvement activity.
- Co-production embedded within service redesign and improvement work.

4. Bereavement Services

Board assurance

- Compliance with Welsh Government Bereavement Standards and improved family feedback.
- Reduced variation in bereavement pathways across sites.

Service / ward improvement

- Staff trained in bereavement care and consistent pathways implemented.
- Learning from bereavement feedback demonstrably informs service improvement.

5. Support for Unpaid Carers

Board assurance

- Increased identification of carers and monitored uptake of the Carers Passport.
- Improved carer experience feedback and reduced concerns related to involvement.

Service / ward improvement

- Carers routinely identified and involved in care planning.
- Staff demonstrate awareness of carers' needs in practice.

6. PALS, Chaplaincy and Volunteering Services

Board assurance

- Improved accessibility, responsiveness and sustainability of services.
- Reduced escalation of concerns through earlier resolution and support.

Service / ward improvement

- Improved response and resolution times for PALS.
- Clear access to chaplaincy and volunteering support, with positive feedback.

PERFORMANCE

The performance requirements of the IMTP will be driven by our strategy deployment framework key measures plus the requirements for the NHS Wales Planning Framework and NHS Wales Performance Framework. Both national framework documents are in development and receipt is anticipated later in the autumn-winter period.

Consequently, indicative planning assumptions have been made with relation to performance.

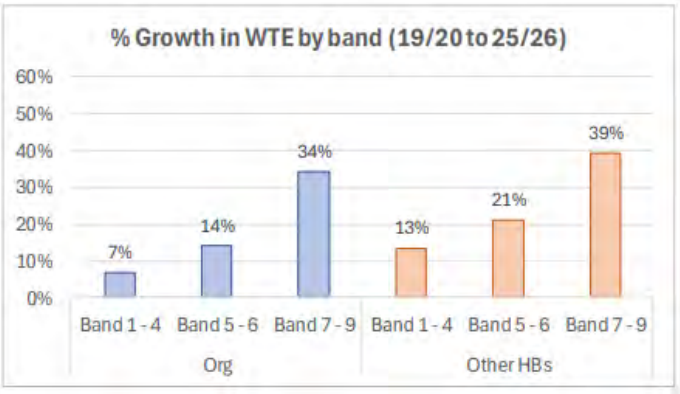
- The requirements of the 2026-2027 frameworks will remain extant and any performance delivery identified as unable to be met in year will be expected to be delivered in 2027-28.
- Ongoing requirements for urgent and emergency care are anticipated to remain extant – e.g. continued progress towards ED targets and the Urgent and Emergency Care Policy (formerly Six Goals) requirements.
- Planned care will require a minimum of maintenance of 104 weeks and 52-week N/OP requirements.
- Indications of a focus on 78 weeks needing to be built into our forecasts.
- Ongoing focus on cancer
- New quality requirements likely to continue
- Population health requirements (paediatric weight, addressing inequalities vaccination)

WORKFORCE

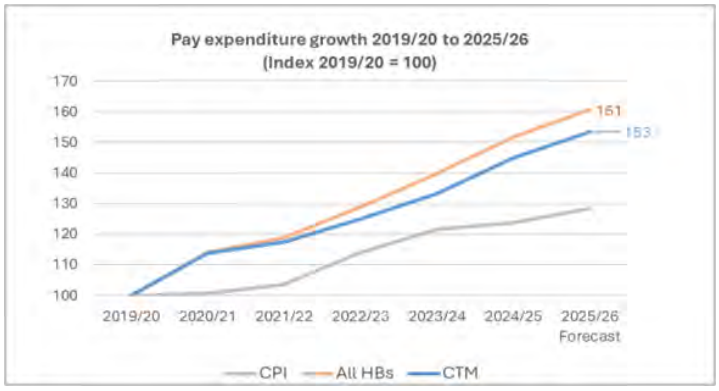
Our workforce remain at the heart of delivery of our strategy and our commitment to our team will continue to be reflected in the implementation of the People Plan.

Engagement of our workforce to understand their experience at work and the drivers of this is an ongoing commitment. We are seeking to increase our completion rate for the NHS staff survey further this year and have set ourselves a 50% target.

Our vision for the future is founded on different models of care and will require us to align our workforce to this blueprint. Any changes proposed by directorates will be required to align with the future direction of travel and support efficient use of resources.



Between 2019-20 and 2025-26, we have seen a growth in workforce and associated pay costs as set out in the charts left and below.



This has not been matched with a commensurate growth in productivity – our activity data indicates that key activity metrics have not yet reattained pre-COVID levels.

With ongoing pressures on our budgets and delivery, we are clear that we will be expected to ensure efficiency and effectiveness across all areas, including deployment and development of our workforce. The financial resource envelope will require us to continue to redesign services and roles and consider headcount reduction.

To support analysis of the current position and planning for the 2027-2030 period, updated worked WTE data by staff group and band, and establishment data will be provided to directorates by the People and Finance teams along with guidance regarding likely requirements for headcount reduction. Month 5 data is available and month 6 data will follow. Our Horizon Scan Summary 2025 is appended.

Directorate plans to achieve the quality, delivery and performance objectives must:

- Be supported by clear workforce plans aligned to demand and capacity planning (where applicable), which set out how redesign will contribute to the delivery of service transformation and improvement.
- Ensure alignment between demand and capacity plans (where applicable), service development priorities, financial plans and workforce plans. Any plans which require new or amended roles must clarify how the directorate will fund these through changes to existing structures and services or be clearly indicated (and assessed) as invest to save opportunities.
- Be supported by actions to reduce sickness absence and increase/ maintain performance development review and job planning compliance.

FINANCE

The key underlying financial strategy objectives remain as in previous years, as follows:-

- To achieve breakeven in each financial year and to gradually reduce the level of recurrent deficit to achieve recurrent breakeven over a reasonable timeframe.
- To achieve year on year reductions in premium workforce costs and premium planned care costs (waiting list initiatives and outsourcing).
- To achieve year on year improvements in efficiency, quality and value (outcomes relative to cost), including through population health management initiatives.
- To utilise financial improvement to re-invest in improving service quality and outcomes wherever possible.
- To achieve closer alignment over time between the needs based formula funding allocations from WG, and our actual use of resources, and so improve equity of resource use.

Statutory Financial Duty

Cwm Taf Morgannwg University Health Board (CTMUHB) has statutory duties required under the National Health Service (Wales) Act 2014, where section 175 places two financial duties on Local Health Boards:

- A duty under section 175 (1) to secure that its expenditure does not exceed the aggregate of the funding allotted to it over a period of 3 financial years
- A duty under section 175 (2A) to prepare a plan in accordance with planning directions issued by the Welsh Ministers, and for that plan to be submitted to and approved by the Welsh Ministers.

Cwm Taf Morgannwg University Health Board (CTMUHB) has achieved the requirement to have an approved plan for 2026/27 and is forecasting that the 3 year break even position for revenue and capital expenditure will also be achieved in 2026/27.

	2024/25	2025/26	2026/27
Plan approved by Welsh Ministers	Yes	Yes	Yes
3 year financial balance - Capital	Achieved	Achieved	Forecast Achieved
3 year financial balance - Revenue	Failed	Achieved	Forecast Achieved

To achieve the statutory financial duties in 2027/28 the Health Board would be required to prepare an approvable plan and deliver a break even capital and revenue expenditure position in 2027/28.

Financial Performance in 2026/27

CTMUHB has recently submitted its M06 Monitoring Return to Welsh Government (WG). This reported a forecast break-even position for 2026/27 and a forecast carry forward financial challenge at the end of 2026/27 of £11.5m deficit. This is a deterioration from the original 2026/27 Financial plan which had assumed a recurrent underlying surplus of £0.3m.

Financial Challenge in 2027/28 – 2029/30

A high level initial financial assessment of the scale of challenge that will be encountered for 2027/28 through to 2029/30 has been undertaken.

This assessment is based upon the following allocation assumption scenarios:

- Best Case – WG Revenue Allocation uplift of circa 1.5% plus pay awards and primary care contractor settlements would be fully funded.
- Medium Case - WG Revenue Allocation uplift of circa 0.5% plus pay awards and primary care contractor settlements would be fully funded.
- Worse Case - WG Revenue Allocation uplift of circa 0% (Flat Cash Settlement) but pay awards and primary care contractor settlements would be fully funded.

The table below summarises these scenarios for the financial year 2027/28:

	Best Case			Medium Case			Worse Case		
	R £m	NR £m	Total £m	R £m	NR £m	Total £m	R £m	NR £m	Total £m
B'Fwd Core Plan deficit	9.5	0.0	9.5	11.5	0.0	11.5	25.8	0.0	25.8
Assumed funding	(20.6)	0.0	(20.6)	(6.9)	0.0	(6.9)	0.0	0.0	0.0
Invest to Save repayments	0.0	1.1	1.1	0.0	1.1	1.1	0.0	1.1	1.1
Inflationary Pressures	18.0	0.0	18.0	17.8	0.0	18.8	19.9	0.0	19.9
Service and demand	15.1	0.0	15.1	19.0	0.0	19.0	22.9	0.0	22.9
Service improvement	1.8	0.0	1.8	4.5	0.0	4.5	6.2	0.0	6.2

Other Non-recurring costs	0.0	1.8	1.8	0.0	1.8	1.8	0.0	1.8	1.8
Financial Challenge	23.9	2.9	26.8	47.0	2.9	49.9	74.7	2.9	77.7

The scale of the financial challenge ranges between £26.8m to £77.7m depending upon the level of funding allocated by WG and the scale of inflationary and demand pressures anticipated.

Over the 3 year period of the IMTP, the overall scale of the financial challenge ranges between £55m up to £171m depending upon allocation levels and scale of inflationary and demand pressures.

Welsh Risk Pool

The financial assessments currently exclude the impact of the increased Welsh Risk Pool contributions on the basis that the current agreement with Welsh government remain in place. ie. WG will continue to support the Welsh Risk Pool contribution above the 2025/26 baseline value for organisations that achieve a financial balance position. If this is not the case, the anticipated impact for 2027/28 is estimated at a £23m further deterioration in the financial challenge.

Pay Award and Primary Care Contractor Settlements

The financial assessment assumes that the full impact of Pay awards for Agenda for Change and Medical & Dental will be fully funded by Welsh Government. It is also assumed that inflationary and investment settlements with Primary Care Contractors will be fully funded by Welsh Government

The Resident Doctor contract has been partially implemented in 2026/27, with implementation continuing to progress over the next 2 years. The financial assessment assumes that the full impact of the new contract on both training posts and locally employed Drs will be fully funded by Welsh Government.

Planned Care Improvement

The continuation of the levels of planned care activity and diagnostic activity that have been supported by direct WG non-recurrent allocations for planned care and diagnostic waiting times improvement have not been assumed to continue in the financial assessment. It is assumed that WG funding will need to be agreed prior to any additional activity being continued. This includes the potential development of utilising the Vanguard Theatres currently sited at RGH.

Investment Position

The scale of the potential financial challenge for 2027/28 – 2029/30 is significant, it is essential that the 3 year IMTP plan is based upon a zero investment principle unless funding can be sourced from Welsh Government or other recurrent sources.

Savings Requirements

To achieve the financial break even position required to meet the statutory financial duties of the Health Board, the full financial challenge will need to be met with savings plans that are fully delivered.

For the IMTP planning purposes pending confirmation of the funding settlement for NHS Wales, the Health Board is using the Medium Case Scenario, which will require savings of £119m over the 3 years:

	2027/28	2028/29	2029/30	Total
Savings Requirement £'m	49.9	35.4	33.6	118.8

This savings requirement equates to a 4.8% savings target for 2027/28, the table below provides an indicative level of savings required by each care group to achieve a financial break even position within delegated budget approval based upon the most recent underlying deficit forecasts.

Savings Requirement	2027/28	%
Planned Care	12.0	5.9
Unscheduled Care	4.0	2.5
W&C	5.0	5.5
DTPS	8.1	2.8
Mental Health	8.3	6.3
PC&C	3.1	3.7
Facilities	2.8	6.2
Corporate Directorates	5.3	4.0
Contracting & Commissioning	1.2	0.7
Total	49.9	4.8

An alternative approach of allocating savings targets on a straight apportionment basis would equate to:

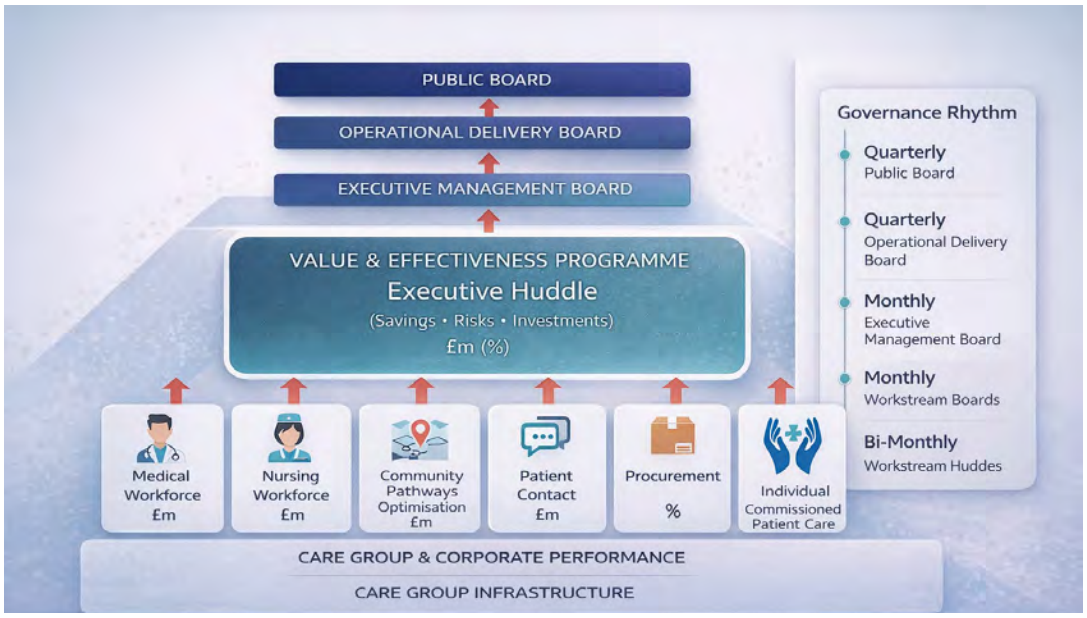
Savings Requirement	2027/28
Planned Care	7.8
Unscheduled Care	6.1
W&C	3.5
DTPS	10.8
Mental Health	5.1
PC&C	3.2
Facilities	1.8
Corporate Directorates	5.0
Contracting & Commissioning	6.7
Total	49.9

A pack will be supplied to all directorates based on the month 6 position and forecast with further guidance for completion.

EFFICIENCY PRODUCTIVITY AND VALUE

Value and Effectiveness Programme

Our value and effectiveness programme oversees a portfolio of activity, connecting care groups and programmes to coordinate activity to ensure we deliver value, maximise the use of resources and minimise waste. The image below shows the work streams and the governance structure. The activity of this programme coordinates activity responding to a number or enabling actions set out by Welsh Government and we anticipate further actions for 2027-2028.

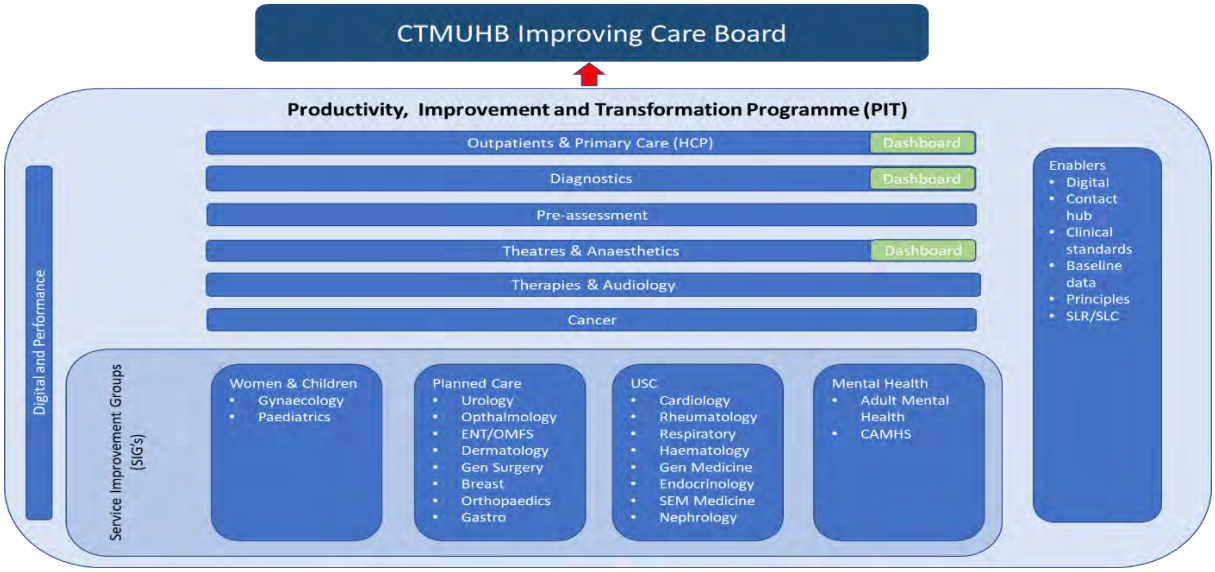


Productivity Innovation and Transformation Programme

The Productivity, Improvement and Transformation (PIT) Programme continues to oversee the improvement of both the efficiency and effectiveness of elective services, through optimising existing resource and reducing waste, whilst working to enhance patient outcomes. All areas of the programme are focused on the following crosscutting themes:

1. Increased efficiency
2. Enhanced Quality of Care
3. Optimised resource utilisation
4. Improved Patient Outcomes
5. Reduction of Variability
6. Data utilisation

7. Workforce Development



It is anticipated that this programme will continue and its activities will be reviewed in light of further enabling actions, once received with the Planning Framework.

These programmes will continue to be integrated in our planning and will be represented in the plan. Further information will follow.

RESEARCH DEVELOPMENT AND INNOVATION

Cwm Taf Morgannwg University Health Board's Research and Development has developed a strategy for 2025-2030 which sets out how the organisation will further develop its vision, infrastructure, research culture and impact, to maximise all opportunities to increase the development and delivery of research across the organisation. The vision statement confirms our ambition.

"To embed research as a core function in all that we do and harness the potential of research to address the health challenges of our population and the development of our workforce, to transform future clinical service delivery."

The strategic aims and objectives are set across primary care, secondary care, population health, community and social care and are applicable to all specialties and professions, both clinical and non-clinical.

It is expected that all areas will consider opportunities for research and the enablers in our plans on a page include this. Work is ongoing with the R&D team to plan mechanisms to ensure support is provided to teams during the plan development cycle. Further information will follow.

INNOVATION

Innovation is one of the means that can be used to develop new ways of doing things, ideas, products and services. Public service-led innovation allows the public sector to deliver more effective and efficient services and gives greater scope for business to generate innovative solutions for the public sector.

Innovation isn't just the successful exploitation of new ideas but the willingness to test and try out something new, that isn't guaranteed to work, but has the potential to make impactful and sustainable change a reality.

In CTMUHB transformational innovation is an encompassing systematic activity, which supports continuous improvement in quality, financial prudence and operational performance, helps deliver strategic change and improved population health outcomes through Value based approach.

These systematic activities are underpinned by strong leadership, an enabling culture with clear values, an engaged and motivated workforce, and robust link to partners in Local Authorities, Third Sector, Industry and Academia.

The Cwm Taf Morgannwg (CTM) Regional Innovation Coordination (RIC) Hub was established in the spring of 2020 originally to co-ordinate and support local innovation activity across CTM regional partnership and is hosted by CTMUHB. This was part of a Welsh Government (WG) policy commitment within '*A Healthier Wales'* to establish a nationally co-ordinated network of hubs within each Regional Partnership (RP) footprint.

Opportunities for innovation and access to support to test potential for innovation should be considered in the planning process. Teams are requested to include their biggest challenge in their planning return so that this can be considered for challenge-led innovation opportunities.

Health Board Meeting – Non Routine Board Business Forward Plan

(1st January 2026 to the 31st December 2026)

This forward plan is only to be used for one-off Adhoc items that do not require inclusion as routine business on the Annual Committee Cycle of Business.

Date of Request	Origin of Request	Requestor	Item Summary / Title	Nature of Request	Lead Officer	Executive Lead	Intended Meeting Date	Status
	Request received from the Director of Digital asking for this to be added to the Board agenda	Director of Digital	Business Case for Connecting care	To be presented to Board for approval	Director of Digital	Director of Digital	28 November 2024	In progress Awaiting revised date for presentation
27/11/2025	Reference made to this item at the November 2025 Public Board by the Executive Director for People	Executive Director for People	Focussed report on Behaviours	Report to include evidence-based behaviour change techniques	Executive Director for People	Executive Director for People	Was 26 March 2026 Date now to be confirmed	In progress Date for presentation to be confirmed.
11/05/2026	Captured as an action on the Board action log	Executive Director for People	Shift Patterns Update	To be presented to Board for approval	Executive Director for People	Executive Director for People	30 July 2026 26 November 2026 Now December 2026	On agenda This item was received and approved the July 2026 Board. A further update on next steps will be presented to the Board in December 2026
20/07/2026	Email request received from the Director of Corporate Governance	Director of Corporate Governance	Health Visitors Industrial Action	To be presented to Board for discussion	Executive Director of Nursing	Executive Director of Nursing	30 July 2026 24 September 2026 26 November 2026	On agenda via CEO Report An update on the current position is included in the Chief Executives Report on the agenda for the November 2026 meeting
30/07/2026	Action captured at the July 2026 Board meeting	Chief Operating Officer	Primary & Community Care Performance Metrics	To be presented to Board for discussion	Chief Operating Officer	Chief Operating Officer	24 September 2026 26 November 2026	Proposed for Closure Given this will now be a regular item on the Board agenda, this has been added to the annual cycle of business
30/07/2026	Action captured at the July 2026 Board meeting	Executive Director of Strategy & Transformation/Chief Operating Officer	Community Beds Provision	Further detail on community bed configuration to be brought to the board in the autumn, with ongoing communication to Bridgend Council.	Executive Director of Strategy & Transformation/Chief Operating Officer	Executive Director of Strategy & Transformation/Chief Operating Officer	26 November 2026	On Agenda via CEO Report This item will be presented to the November 2026 meeting via the Chief Executives Report

18/08/2026	Request received from the Director of Corporate Governance	Chief Operating Officer	National Clinical Plan for Mental Health Services	To be presented to Board for approval	Chief Operating Officer	Chief Operating Officer	28 January 2027	In progress This item will be presented to the January 2027 meeting
04/09/2026	Request received from the Interim Assistant Director of Governance & Risk	Interim Assistant Director of Governance & Risk	South East Wales Regional Pathology	To be presented to Board for discussion	Deputy Director of Allied Health Professions and Health Science	Executive Director of Allied Health Professionals and Health Science	26 November 2026 Now 2027 – Date to be confirmed	In progress This item will be presented to the Board in 2027
Completed Items								
3 January 2024	Request received from the Assistant Director of Governance & Risk for this item to be added to the forward work programme for Board	Assistant Director of Governance & Risk	Agency Reduction Plan and Decision Making Framework for CTM	To be added to Board Forward work programme following receipt of Welsh Health Circular in January 2024 which identified specific actions for Board/Committees	Deputy Director of People	Executive Director for People	Proposed for Closure	No longer required The Executive Director for People has confirmed this item can now be removed from the forward work programme.
27/05/2026	Email request received from the Director of Corporate Governance	Director of Corporate Governance	Pharmaceutical Needs Assessment	To be presented to Board for approval	Executive Medical Director	Executive Medical Director	24 September 2026	Completed This item was received and approved at the September 2026 meeting
10/07/2026	Email request received from the Patient Care & Safety Business Manager	Executive Director of Nursing	People & Patient Strategic Plan 2026-2028	To be presented to Board for approval	Executive Director of Nursing	Executive Director of Nursing	24 September 2026	Completed This item was received and approved at the September 2026 meeting

CTMUHB Board – Annual Cycle of Board Business

(1st January 2026 to the 31st December 2026)

The Annual Cycle of Committee Business has been developed to help plan the management of Board matters and facilitate the management of agendas and Board business. The Annual Cycle of Board Business will be complemented by a "Non-Routine Board Business (Forward Plan)" for 'one-off' Adhoc items raised during the course of meetings.

The role of the Board is set out in CTMUHB's standing orders which is available here: Standing Orders & Standing Financial Instructions - Cwm Taf Morgannwg University Health Board (nhs.wales), however, the Board's main role is to add value to the organisation through the exercise of strong leadership and control, including:

- Setting the organisation's strategic direction
- Establishing and upholding the organisation's governance and accountability framework, including its values and standards of behaviour
- Ensuring delivery of the organisation's aims and objectives through effective challenge and scrutiny of the LHB's performance across all areas of activity.

The membership of CTMUHB Board is available here: Board Members - Cwm Taf Morgannwg University Health Board. The Board meets at least 6 times per annum. Its anticipated that an Extra-ordinary Board Meeting will be required in June 2026.

Board Chair:	Board Vice Chair	Executive Leads for Agenda Planning
• Jonathan Morgan, UHB Chair	• Kath Palmer, Vice Chair	• Gareth Watts, Director of Corporate Governance & Board Business

Link to: Board Assurance Framework Dashboard

CTMUHB Board Business:

Improving Care Strategic Goal aligned to Committee Business
- Delivering Safe and Compassionate Care
- Developing new models of care
- Digital Transformation for patients and staff
- Ensuring timely access to care

Items of Business	Executive Lead / Or External Lead	Reporting Frequency	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Consent Agenda	Main Agenda	Prior Reporting Requirements e.g. Board Committee	Onward Reporting into WG	Alignment to Strategic Risks on the BAF
Shared Listening & Learning Story	Executive Director of Nursing	All Regular Meetings					Not reqd		Not reqd						X		Some stories may have already been received at the Quality, Safety & Experience Committee	No	Learning will support and inform mitigation for Strategic Risk 2
Shared Listening & Learning Stories Annual Reflection	Executive Director of Nursing	Annually											Defer to Jan 2027		X		The annual reflection may have already been received at the Quality, Safety & Experience Committee	No	Learning will support and inform mitigation for Strategic Risk 2
Putting Things Right Annual Report	Executive Director of Nursing	Annually									Defer to Nov				X		Quality, Safety & Experience Committee	Yes	Learning will support and inform mitigation for Strategic Risk 2
Ombudsman Annual Letter and Annual Report	Executive Director of Nursing	Annually														X	Quality, Safety & Experience Committee	No	Learning will support and inform mitigation for Strategic Risk 2

Improving Care Strategic Goal aligned to Committee Business CONTD.

- Delivering Safe and Compassionate Care
- Developing new models of care
- Digital Transformation for patients and staff
- Ensuring timely access to care

Items of Business	Executive Lead / Or External Lead	Reporting Frequency	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Consent Agenda	Main Agenda	Prior Reporting Requirements e.g. Board Committee	Onward Reporting into WG	Alignment to Strategic Risks on the BAF
Safeguarding Annual Report	Executive Director of Nursing	Annually													X		Quality, Safety & Experience Committee	No	Learning will support and inform mitigation for Strategic Risk 2
Carers Annual Report	Executive Director of Nursing	Annually														X	Quality, Safety & Experience Committee	No	Learning will support and inform mitigation for Strategic Risk 2
Clinical Education Annual Report	Executive Director of Nursing	Annually														X	Quality, Safety & Experience Committee	No	Learning will support and inform mitigation for Strategic Risk 2
Infection, Prevention & Control Annual Report	Executive Director of Nursing	Annually														X	Quality, Safety & Experience Committee	No	Learning will support and inform mitigation for Strategic Risk 2
Nurse Staffing Levels (Wales) Act Reports	Executive Director of Nursing	Every Six Months														X	Quality, Safety & Experience Committee	TBC	Strategic Risk 3
Board Assurance Framework Report	Director of Corporate Governance / Board Secretary	All Regular Meetings													X		Executive Management Board	No	Not applicable
Annual Review of the Risk Management Strategy & Framework	Director of Corporate Governance / Board Secretary	Annually							Def to Sep26						X		Audit, Risk & Assurance Committee	No	Not applicable - Setting of the risk management framework.
Audit Wales Structured Assessment and Audit Letter	Audit Wales Performance Lead	Annually													X		Audit, Risk & Assurance Committee	No	Management responses to recommendations will support the mitigations for risks within the BAF
Ministerial Advisory Group Updates	Chief Executive	Quarterly											Not reqd		X		Operational Delivery Committee	Yes	Responsive action will support the mitigations for risks within the BAF.

Improving Care Strategic Goal aligned to Committee Business CONTD. • Delivering Safe and Compassionate Care • Developing new models of care • Digital Transformation for patients and staff • Ensuring timely access to care																			
Items of Business	Executive Lead / Or External Lead	Reporting Frequency	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Consent Agenda	Main Agenda	Prior Reporting Requirements e.g. Board Committee	Onward Reporting into WG	Alignment to Strategic Risks on the BAF
Welsh Language Standards Annual Report	Executive Director for People	Annually														X	Operational Delivery Committee	No	Strategic Risk 2 Strategic Risk 7
Integrated Performance Report (Quality, People & Operational Performance)	Executive Director of Strategy & Transformation	All Regular Meetings													X		Operational Delivery Committee	No	Strategic Risk 1 Strategic Risk 2 Strategic Risk 3 Strategic Risk 8 Strategic Risk 11
Primary & Community Care Performance Metrics	Chief Operating Officer	All Regular meetings													X		Operational Delivery Committee	No	Strategic Risk 1 Strategic Risk 2 Strategic Risk 3 Strategic Risk 8 Strategic Risk 11
Our Models of Care/Service Transformation: • Integrated Care Model • Llantrisant Health Park • Primary Care & Community • Mental Health Transformation	Chief Operating Officer	As and when required													X		Operational Delivery Committee Strategic Development Committee	No	Strategic Risk 1 Strategic Risk 2 Strategic Risk 3 Strategic Risk 8 Strategic Risk 11
Audit Wales Annual Audit Report	Audit Wales – Finance & Performance Lead	Annually													X		Audit, Risk & Assurance Committee	No	Management responses to recommendations will support the mitigations for risks within the BAF

Improving Care Strategic Goal aligned to Committee Business CONTD. • Delivering Safe and Compassionate Care • Developing new models of care • Digital Transformation for patients and staff • Ensuring timely access to care																			
Items of Business	Executive Lead / Or External Lead	Reporting Frequency	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Consent Agenda	Main Agenda	Prior Reporting Requirements e.g. Board Committee	Onward Reporting into WG	Alignment to Strategic Risks on the BAF
Internal Audit Annual Audit Plan	Head of Internal Audit	Annually														X	Audit, Risk & Assurance Committee	No	Management responses to recommendations will support the mitigations for risks within the BAF

NWSSP Internal Audit Services – Head of Internal Audit Opinion	Head of Internal Audit	Annually						Extra-Ordinary Board Meeting							X		Audit, Risk & Assurance Committee	Yes	
Business Continuity Planning *(EPPR Annual Compliance Statement – Outlining Strategic Responsibility)*	Executive Director of Strategy & Transformation	Annually														X	Strategic Development Committee	No	Strategic Risk 1
Integrated Medium Term Plan Approval	Executive Director of Strategy & Transformation	Annually														X	Operational Delivery Committee	Yes	Activity outlined in the plan will have been considered with alignment to the BAF in the prioritisation process.
Strategy Deployment: • Digital • People Plan • Health Protection	Executive Director of Strategy & Transformation Director of Digital Executive Director for People Executive Director of Public Health	As and when required				Strategy Deployment Framework		~~People Plan~~ NHS Wales Staff Survey 2025								X		Strategic Development Committee	No	All Strategic Risks
Joint Commissioning Committee (JCC) Annual Update	JCC Lead	Annually						Defer to July 2026		Defer to Sep 2026						X		No	No	Strategic Risk 1 Strategic Risk 2

Improving Care Strategic Goal aligned to Committee Business CONTD. • Delivering Safe and Compassionate Care • Developing new models of care • Digital Transformation for patients and staff • Ensuring timely access to care																				
Items of Business	Executive Lead / Or External Lead	Reporting Frequency	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Consent Agenda	Main Agenda	Prior Reporting Requirements e.g. Board Committee	Onward Reporting into WG	Alignment to Strategic Risks on the BAF
Capital Plans & Business Cases (in accordance with Scheme of Delegation)	Executive Director of Finance	All Regular Meetings as and when required													X		Operational Delivery Committee	Case dependent	Strategic Risk 2 Strategic Risk 3 Strategic Risk 4 Strategic Risk 7
Strategic Business Cases for Approval	Executive Lead assigned to topic area	All Regular Meetings as and when required													X		Strategic Development Committee	Case dependent	Strategic Risk 2 Strategic Risk 3 Strategic Risk 4 Strategic Risk 7

Creating Health Strategic Goal aligned to Committee Business

- Reducing Health Inequalities
- Equal focus on Mental Health and Physical Health
- Supporting our communities
- Being a Healthy Organisation

Items of Business	Executive Lead / Or External Lead	Reporting Frequency	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Consent Agenda	Main Agenda	Prior Reporting Requirements e.g. Board Committee	Onward Reporting into WG	Alignment to Strategic Risks on the BAF
Executive Director of Public Health Annual Report	Executive Director of Public Health	Annually											Defer to Jan 27		X		Strategic Development Committee	No	Strategic Risk 2 Strategic Risk 8
Seasonal Planning Update	Chief Operating Officer	Annually													X		Operational Delivery Committee	No	Strategic Risk 2 Strategic Risk 8
CTM2030: Building Healthier Communities Together – Strategy Deployment Update	Executive Director of Strategy & Transformation	Annually													X		Strategic Development Committee	No	All Strategic Risks
Annual Review of the WBFGA Statement and Objectives	Executive Director of Public Health	Annually					Defer to Sept								X		Strategic Development Committee	No	Strategic Risk 7 Strategic Risk 8 Strategic Risk 11
SEW RJC Annual Review of Effectiveness & Activity	Director of Corporate Governance	Annually											Defer to January 2027		X		No	No	
SEW RJC Terms of Reference	Director of Corporate Governance	Annually											Defer to January 2027		X		No	No	
SEW RJC Highlight Report	Director of Corporate Governance	As and when required													X		No	No	

Inspiring People Strategic Goal aligned to Committee Business

- Visible and inspiring leadership
- Promoting diversity and inclusion
- Embedding our values and behaviours
- Encouraging local employment

Items of Business	Executive Lead / Or External Lead	Reporting Frequency	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Consent Agenda	Main Agenda	Prior Reporting Requirements e.g. Board Committee	Onward Reporting into WG	Alignment to Strategic Risks on the BAF
Chief Executives Report	Chief Executive	All Regular Meetings	✓		✓		✓		✓		✓		✓		X	✓	No	No	Topic dependent alignment to the BAF.
Chairs Report *(Inc. Affixing of the Common Seal /and Chairs Urgent Action)*	Chair	All Regular Meetings	✓		✓		✓		✓		✓		✓		X	✓	No	No	Topic dependent alignment to the BAF.
Annual Review and any Amendments of Standing Orders and Standing Financial Instructions	Director of Corporate Governance/Board Secretary	Annually and as and when amendments required.			✓										✓	X	Audit, Risk and Assurance Committee	No	Not applicable
Annual Report *(including Performance Report. Accountability Report and Remuneration Report)*	Director of Corporate Governance / Board Secretary	Annually						✓ Extra-Ordinary Board Meeting							X	✓	Audit, Risk and Assurance Committee	Yes	The Annual Report will reference the Strategic Risks facing the Health Board.
Annual Equality Report	Executive Director for People	Annually											✓		X	✓	Operational Delivery Committee	No	Strategic Risk 2
Strategic Equality Plan	Executive Director for People	Annually									✓				X	✓	Strategic Development Committee	No	Strategic Risk 2
NHS Staff Survey	Executive Director for People	Annually											✓ Defer to May 2027		X	✓	Operational Delivery Committee	No	Strategic Risk 2 Strategic Risk 3 Strategic Risk 4 Strategic Risk 7
Speaking Up Safely Annual Update	Director of Corporate Governance	Annually							✓						X	✓	Audit, Risk & Assurance Committee	No	Strategic Risk 3

Sustaining our Future Strategic Goal aligned to Committee Business

- Becoming a green organisation
- Ensuring our services have financial sustainability
- Embedding value-based healthcare
- Ensuring our estate is fit for the future

Items of Business	Executive Lead / Or External Lead	Reporting Frequency	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Consent Agenda	Main Agenda	Prior Reporting Requirements e.g. Board Committee	Onward Reporting into WG	Alignment to Strategic Risks on the BAF
Annual Statutory Accounts	Executive Director of Finance	Annually						Extra-Ordinary Board Meeting							X		Audit, Risk and Assurance Committee	Yes	Strategic Risk 9
Charitable Funds Annual Report and Annual Accounts	Executive Director of Finance	Annually													X		Charitable Funds Committee	No – Charity Commission.	Strategic Risk 2 Strategic Risk 9
Financial Performance Report	Executive Director of Finance	All Regular Meetings													X		Operational Delivery Committee	No	Strategic Risk 9
Capital Update	Executive Director of Finance	Quarterly											Defer to Jan 2027		X		Operational Delivery Committee	No	Strategic Risk 2 Strategic Risk 9
Climate Action Plan *(Endorse Annual Plan Submission and Carbon Emissions Submission to WG)*	Executive Director of Strategy & Transformation	Twice Per Annum			Annual Plan								Carbon Emissions – not reqd		X		Strategic Development Committee	Yes	Strategic Risk 7
Healthy Travel Plan *(Deployment Update -Output Measures and Success)*	Executive Director of Public Health	Annually							Defer to Nov				Defer to 2027		X		Strategic Development Committee	No	Strategic Risk 7 Strategic Risk 8
Annual allocation of budget setting	Executive Director of Finance	Annually													X		Operational Delivery Committee	No	Strategic Risk 2 Strategic Risk 9

Governance / Board Business Governance Activity • To support a strong governance framework to support effective and efficient Board Business. • Creating a culture of integrity, transparency, and accountability																	
Items of Business	Executive Lead / Or External Representative	Reporting Frequency	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Consent Agenda	Main Agenda	Prior Reporting Requirements e.g. EMB/OMB
Board Committee and Advisory Group Highlight Reports	Director of Corporate Governance/Board Secretary	All Regular Meeting	⚑		⚑		⚑		⚑		⚑		⚑		⚑ (where there are no matters to escalate)	⚑ (where there are matters to escalate)	No
Board Committee Annual Reports	Director of Corporate Governance/Board Secretary	Annually							⚑ Defer to Sept		⚑				⚑	X	No
Action Log	Director of Corporate Governance / Board Secretary	All Regular Meetings	⚑		⚑		⚑		⚑		⚑		⚑		⚑ If all actions are complete	⚑ If there are actions in progress / overdue actions	No
Minutes of the previous meeting (Public and Closed Session)	Director of Corporate Governance / Board Secretary	All Regular Meetings	⚑		⚑		⚑		⚑		⚑		⚑		⚑	X	No
Non-Routine Committee Business (Forward Plan)	Director of Corporate Governance / Board Secretary	All Regular Meetings	⚑		⚑		⚑		⚑		⚑		⚑		⚑	X	No
Annual Cycle of Business	Director of Corporate Governance / Board Secretary	All Regular Meetings	⚑		⚑		⚑		⚑		⚑		⚑ Annual Review		⚑ Except for the annual review in November	⚑ Annual Review in November only	No
Board Effectiveness Self-Assessment	Director of Corporate Governance / Board Secretary	All Regular Meetings	⚑		⚑		⚑ Formal Assmt defer to July		⚑ Formal Assmt defer to Sept		⚑		⚑		X	⚑	No

CTMUHB Board Assurance Framework Dashboard

Risk no	Strategic Goal	Strategic / Principal Risk	Lead(s) for this risk	Assurance committee
1.	Improving Care, Sustaining our Future  Click Here for Risk 1a Click Here for Risk 1b	a) Enough capacity to meet elective demand b) Enough capacity to meet emergency demand	Chief Operating Officer	Quality, Safety & Experience Committee and Operational Delivery Committee
2.	Improving Care, Sustaining our Future  Click Here for Risk 2	Ability to deliver improvements which transform care and enhance outcomes	Executive Director of Nursing / Executive Medical Director	Quality, Safety & Experience Committee and Operational Delivery Committee
3.	Sustaining our Future, Improving Care and Inspiring People  Click Here for Risk 3	Enough workforce to deliver the activity and quality ambitions of the organisation *(Including Culture, Values and Behaviours)*	Executive Director for People	Quality, Safety & Experience Committee and Operational Delivery Committee
4.	Creating Health, Sustaining our Future  Click Here for Risk 4	Effective Community and Partner Engagement in service changes and developments	Director of Communication, Engagement & Fundraising	Strategic Development Committee
5.	Improving Care, Sustaining our Future  Click Here for Risk 5	Delivery of a digital and information infrastructure to support organisational transformation	Director of Digital	Operational Delivery Committee and Strategic Development Committee
6.	Improving Care, Sustaining our Future  Click Here for Risk 6	Ability to maintain a safe and fit for purpose estate infrastructure	Executive Director of Finance	Operational Delivery Committee
7.	Sustaining our Future, Creating Health  Click Here for Risk 7	Fulfilling our Environmental and Social Duties and ambitions	Executive Director of Strategy & Transformation	Strategic Development Committee
8.	Creating Health, Sustaining our Future  Click Here for Risk 8	Prevention and early Intervention to support Healthy Life Expectancy	Executive Director of Public Health	Strategic Development Committee
9.	Sustaining our Future  Click Here for Risk 9	Failure to deliver a sustainable plan and manage revenue resources within the Revenue Resource limits set by Welsh Government (WG)	Executive Director of Finance	Operational Delivery Committee
10.	Sustaining our Future, Improving Care  Click Here for Risk 10	Ability to develop a fit for the future estate to reflect our future clinical service model	Executive Director of Finance	Strategic Development Committee
11.	Creating Health, Sustaining our Future, Improving Care  Click Here for Risk 11	Delivery of an Integrated Care Model	Chief Operating Officer	Strategic Development Committee

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Version 1 June 2026

CTMUHB Public Board

Board Committee and Advisory Group Highlight Reports

Eitem yr Agenda / Agenda Item	8.2.3
Dyddiad y Cyfarfod / Date of Meeting:	26/11/2026
Statws Cyhoeddi / Publication Status:	Open/Public. Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Emma Walters, Head of Corporate Governance & Board Business
Cyflwynydd yr Adroddiad / Report Presenter:	Gareth Watts, Director of Corporate Governance/Board Secretary
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance/Board Secretary
Diben yr Adroddiad / Report Purpose:	For Noting
Argymhelliad *(Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).* Recommendation (Linked to the "What Next" section above).	The Board is being asked to NOTE the following Highlight Reports: • Mental Health Act Monitoring Committee 26 August 2026 (Appendix 1) • Quality, Safety & Experience Committee 22 September 2026 (on main agenda) • Clinical Advisory Group 6 October 2026 and 3 November 2026 (On main agenda) • Remuneration & Terms of Services Committee 22 October 2026 (on main agenda) • Operational Delivery Committee 27 October 2026 (On main agenda) • CTMUHB Audit, Risk & Assurance Committee 3 November 2026 (On main agenda) • Hosted Bodies Audit, Risk & Assurance Committee 3 November 2026 (Appendix 2) • Strategic Development Committee 10 November 2026 (Appendix 3)

1. Situation /Background

1.1 In line with the Standing Order requirements each Board Committee and Advisory Group is required to submit a Highlight Report setting out its activities at each meeting. This also provides a mechanism for escalating issues to the Board as required.

2. Specific Matters for Consideration

A number of Committee/Advisory Groups have been held since the Board last met in September 2026.

3. Key Risks / Matters for Escalation

3.1 Key risks and any matters for escalation to the Board are set out in the appended Highlight Reports.

4. Assessment

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)* Link to Strategic Risk(s) on the Board Assurance Framework (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	Not applicable If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals	Not Applicable If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Not Applicable If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:

Asesiad Effaith Impact Assessment		
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg *(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)* Equality & Welsh Language Impact Assessment Outcome *(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)*	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Summary of impact: Not applicable Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Summary of impact: Not applicable	If no, please select a reason below. Choose an item. Named Executive/Board member sign off for no EWLIA completion:
Canlyniad Asesiad Effaith Ansawdd *(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)* Quality Impact Assessment Outcome *(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)*	Not applicable	
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report	
Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report	

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

CTMUHB Public Board

Mental Health Act Monitoring Committee Highlight Report

Eitem yr Agenda / Agenda Item	8.2.3 Appendix 1
Dyddiad y Cyfarfod / Date of Meeting:	26/11/26
Statws Cyhoeddi / Publication Status:	Open/Public.
	Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Sharon Edwards, Corporate Governance Officer
Cyflwynydd yr Adroddiad / Report Presenter:	Kath Palmer, Vice Chair (Chair of the Committee)
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gethin Hughes, Chief Operating Officer/Julie Denley, Deputy Chief Operating Officer
Diben yr Adroddiad / Report Purpose:	For Noting
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	The Committee are being asked to NOTE the report
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol* *Strategic Context:* *This report aligns to the following Strategic Pillars*	Improving Care
	If more than one applies, please list below:
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan *(Reference relevant priority)*	Not applicable

1. Introduction

1.1 This report has been prepared to provide the Board with details of the key issues considered by the Mental Health Act (MHA) Monitoring Committee at its meeting on 26th August 2026.

1.2 Key highlights from the meeting are reported in section 3.

2. Purpose of this Meeting

2.1 The purpose of the Mental Health Act Monitoring Committee is to provide assurance to the Board that the arrangements to monitor and review the way functions under the Mental Health Act are exercised on its behalf are operating appropriately and effectively and in accordance with legislation.

3. Highlight Report

Alert / Escalate	There are no matters requiring escalation.
Advise	Terms of Reference Annual Review The Committee reviewed proposed amendments to its Terms of Reference and identified the need for further clarification regarding arrangements for receiving assurance on implementation of the Mental Health (Wales) Measure 2010. Deep Dive Spotlight: Section 136, Emergency Department Waiting Times including Places of Safety The Committee received a detailed review of Section 136 activity and associated waiting times. Members welcomed the analysis, which identified key factors contributing to delays and informed a programme of improvement actions, including work relating to Section 12 doctor availability, AMHP deployment and liaison arrangements. The Committee also explored the impact of repeat detentions and assurance regarding partnership arrangements to support frequent presenters. A future update on progress against identified actions and improvement trajectories was requested.
Assure	Organisational Risk Register The Committee received assurance that mental health-related risks continue to be actively reviewed by accountable leads and aligned with Board risk tolerance. Members welcomed confirmation that the Tier 3 Eating Disorder risk is expected to

	be downgraded following the resolution of medical cover issues, demonstrating effective risk mitigation and a reduction in the overall risk profile. Mental Health Operational Group Update The Committee received assurance regarding ongoing work through the Mental Health Act Operational Group, including improvements to Section 136 processes, development of the Section 117 Aftercare Register and continued partnership working across organisations. Mental Health Act Quarterly Activity Report The Committee received assurance regarding Mental Health Act activity and compliance monitoring. Members noted two fundamental breaches during the quarter and requested greater detail on learning and mitigating actions to prevent recurrence. The Committee also welcomed a reduction in rectifiable errors compared to the previous quarter. Risks Relating to the Monitoring of the Mental Health Act The Committee received assurance that risks relating to the monitoring and implementation of the Mental Health Act continue to be actively managed. Members welcomed the introduction of a revised ward-based training approach, with the Mental Health Act Team working directly with individual wards to improve attendance, strengthen compliance and mitigate the risk of future breaches. Hospital Managers Power of Discharge Sub-Committee The Committee received assurance regarding the effectiveness of Hospital Managers arrangements and welcomed positive feedback from annual appraisals, ongoing recruitment activity and continued investment in training and development.
Inform	• The Unconfirmed Minutes of the meeting held on 27th May 2026 were approved. • The Annual Cycle of Business was noted. • The Forward Work Plan was noted.
Appendices	Not applicable

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd	Strategic Risk 2

(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg) Link to Strategic Risk(s) on the Board Assurance Framework (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	If more than one applies, please list below:	
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales	
	If more than one applies, please list below:	
Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Learning, Improvement & Research	
	If more than one applies, please list below:	
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental Sustainability Impact (5Rs)	No - Not Applicable	
	If more than one applies, please list below:	
Asesiad Effaith Impact Assessment		
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg *(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)* Equality & Welsh Language Impact Assessment Outcome *(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)*	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Summary of impact: Not applicable Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Summary of impact: Not applicable	If no, please select a reason below. Choose an item. Named Executive/Board member sign off for no EWLIA completion:
Canlyniad Asesiad Effaith Ansawdd *(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)* Quality Impact Assessment Outcome	Not applicable	

(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)	
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report
Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
AMHP	Approved Mental Health Professional

CTMUHB Public Board

Hosted Bodies Audit, Risk & Assurance Committee Highlight Report

Eitem yr Agenda / Agenda Item	8.2.3 Appendix 2
Dyddiad y Cyfarfod / Date of Meeting:	26/11/2026
Statws Cyhoeddi / Publication Status:	Open/Public
	Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Kathrine Davies, Corporate Governance Manager
Cyflwynydd yr Adroddiad / Report Presenter:	Patsy Roseblade, Independent Member/Committee Chair
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance/Board Secretary /Sally May, Executive Director of Finance
Diben yr Adroddiad / Report Purpose:	For Noting
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	No action or decision required.
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol* *Strategic Context: This report aligns to the following Strategic Pillars*	Improving Care
	If more than one applies please list below:
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan *(Reference relevant priority)*	Not applicable

1. Introduction

1.1 This report has been prepared to provide the Board with details of the key issues considered by the Hosted Bodies Audit, Risk & Assurance Committee at its meeting on 3 November 2026.

1.2 Key highlights from the meeting are reported in section 3.

2. Purpose of this Meeting

2.1 The Committee operates in accordance with the NHS Audit Committee Handbook, as appropriate.

2.2 The Committee also considers matters relating to the roles and responsibilities of committees hosted by CTMUHB on behalf of NHS Wales, as appropriate. Since 1 April 2024, this has included the NHS Wales Joint Commissioning Committee (JCC) and the National Imaging Academy Wales (NIAW). Meetings are therefore divided into two parts, with CTMUHB business and hosted committee business considered and recorded separately.

2.3 The purpose of the Committee is to advise and assure the Board on whether effective arrangements are in place, through the design and operation of the Health Board's risk and assurance framework, to support decision-making and the discharge of its accountabilities for securing the achievement of Health Board objectives in line with the standards of good governance for NHS Wales.

2.4 Where appropriate, the Committee also advises the Board and the Accountable Officer on where the assurance framework may require strengthening or further development.

3. Highlight Report

Alert / Escalate	There were no matters of concern for escalation or alert on this occasion.
Advise	The Committee received the Joint Commissioning Committee Strategic Update. The Committee noted updates on key areas of escalation, including the Welsh Gender Service, specialist services, mental health and ambulance services. The Welsh Fertility Institute had returned to normal operations, with ongoing monitoring of service sustainability. The Committee also noted progress with the neonatal service review, with early findings and recommendations expected to inform future Integrated Medium Term Plan (IMTP) planning, although data availability continued to affect progress.

	Action Log – The Committee reviewed progress against the Action Log, noted the position on outstanding actions and overall delivery. NHS Wales Shared Services Partnership (NWSSP) Internal Audit Progress Report – The Committee received the Internal Audit progress update and the review of the NWJCC Escalation and De-escalation Framework. Internal Audit reported that the programme was progressing, with further work underway and a risk management review due after Christmas. The escalation review provided reasonable assurance, with three medium-priority findings relating to improving awareness and learning from the framework, strengthening the timeliness of action plans and escalation meetings, and improving consistency in the identification, recording and scoring of risks. The Committee welcomed the positive outcome and noted the agreed actions to address the findings. The Committee received a report on Right Care, Right Person noting positive early findings from the Section 136 transport test of change, including reduced police conveyancing with no serious incidents reported. The formal evaluation is awaited and will inform discussions with Welsh Government on potential wider implementation and future funding. An overview of assurance arrangements for NHS 111 and Ambulance Services was received by the Committee and noted strengthened commissioning governance between the NWJCC and WAST, including enhanced performance oversight and development of new service specifications. Members sought clearer assurance on performance against contractual requirements, rather than assurance on processes alone, with further reporting to be developed through the Commissioning for Value Framework.
Assure	NWJCC Committee Assurance Framework - The Committee welcomed the populated Joint Committee Assurance Framework as a positive development towards a more strategic approach to risk. Two new risks relating to the Welsh Gender Service had been added and the renal dialysis capacity risk had reduced following additional capacity in South West Wales. The Committee requested further consideration of the high consequence scores assigned to the majority of strategic risks and the rationale for the proposed reduction in the ambulance risk consequence score.

	Organisational Risk Register – The Committee welcomed progress in developing the risk and assurance framework, noting changes to key risks. Further assurance was sought on the high consequence scores applied to strategic risks, particularly the ambulance risk, with NWJCC agreeing to review the scoring and alignment with NHS Wales best practice. Joint Commissioning Committee Audit Tracker – The Committee noted good progress against audit actions, including closure of the Traumatic Stress Wales actions and continued progress against the High Cost Drugs recommendations. National Imaging Academy Wales – Risk Register - It was noted that the risk profile remained unchanged, with ongoing workforce risks relating to training capacity and the availability of funded consultant posts. Progress on AI, research and continued quality accreditation was also noted. The Committee received and approved the revised Budgetary Control Procedure, which had been updated following Internal Audit recommendations to strengthen and clarify budget management arrangements within NWJCC.
Inform	• The Committee Approved the following items: - Unconfirmed Minutes of the 4th August 2026
Appendices	None identified.

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)* Link to Strategic Risk(s) on the Board Assurance Framework (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	Strategic Risk 2 If more than one applies please list below:

Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales If more than one applies please list below:

Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Whole-Systems Perspective
	If more than one applies please list below:

Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Asesiad Effaith Impact Assessment		
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg *(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)* Equality & Welsh Language Impact Assessment Outcome *(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)*	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Summary of impact: Not applicable Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Summary of impact: Not applicable	If no, please select a reason below. Choose an item. Named Executive/Board member sign off for no EWLIA completion:
Canlyniad Asesiad Effaith Ansawdd *(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)* Quality Impact Assessment Outcome *(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)*	Not applicable	
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol)* / Resource Impact	There is no direct impact on resources as a result of the activity outlined in this report.	

(People / Financial)	

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Audit, Risk & Assurance Committee	04/08/2026	Received and considered by the Committee.

Acronyms / Glossary of Terms	
NWJCC	NHS Wales Joint Commissioning Committee
WAST	Welsh Ambulance Services NHS Trust

CTMUHB Public Board

Strategic Development Committee Highlight Report

Eitem yr Agenda / Agenda Item	8.2.3 Appendix 3
Dyddiad y Cyfarfod / Date of Meeting:	26 November 2026
Statws Cyhoeddi / Publication Status:	Open/Public.
	Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Tyler Lewis, Corporate Governance Officer
Cyflwynydd yr Adroddiad / Report Presenter:	Kath Palmer, Vice Chair and Chair of the Strategic Development Committee
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Claire Thompson, Executive Director of Strategy & Transformation
Diben yr Adroddiad / Report Purpose:	For Noting
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	No action required, report is for noting only.
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol* *Strategic Context:* *This report aligns to the following Strategic Pillars*	Sustaining Our Future
	If more than one applies please list below:
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan *(Reference relevant priority)*	Not applicable

1. Introduction

1.1 This report had been prepared to provide the Board with details of the key issues considered by the Strategic Development Committee at its meeting on 10 November 2026.

1.2 Key highlights from the meeting are reported in section 3.

2. Purpose of this Meeting

In summary, the purpose of the Strategic Development Committee is to:

- Provide evidence based and timely strategic assurance to the Board to assist it in discharging its functions and responsibilities with regard to the:
  - Strategic direction;
  - Strategic planning and associated investments;
  - Long term financial sustainability
  - Setting our Culture;
  - People retention and succession planning.

- Scrutinise strategic risks on the Board Assurance Framework and their impact upon CTMUHB's ability to deliver its strategic ambitions.
- Provide assurance to the Board in relation to strategic decision-making, ensuring it is supported with a robust understanding of risks in relation to the achievement of organisational goals and strategic objectives.
- Provide assurance to the Board that, wherever possible, CTMUHB plans are aligned with partnership plans developed with Regional Partners, Local Authorities, Universities, Collaboratives, Alliances and other key partners.

3. Highlight Report

Alert / Escalate	• There were no matters requiring escalation to the Board on this occasion.
Advise	• The Committee supported a Shared Listening and Learning section to bring external provocation, challenge and inspiration to strategic discussions, with a forward programme and evaluation of learning and impact from the outset. • The Committee received the Strategic Deployment Framework, welcomed its greater clarity and requested a more visible shift from secondary care measures to population health, community care, culture and longer-term outcomes. • The Committee received the 2024/25 Programme Budget Report and requested future reports link expenditure trends to outcomes, strategic objectives, activity and other relevant intelligence, acknowledging the data's historic nature and limitations.

	• The Committee received the IMTP planning assumptions, noting an estimated savings requirement of £50m for 2027/28 and just under £119m over three years. Discussion emphasised productivity, transformation, clinical leadership, staff capability and clear choices on activity to stop, reduce or deliver differently. • The Committee received the Regional Partnership Board update, welcomed improved governance and the forward plan, and requested clearer measures of integrated teams' outcomes and benefits, including locality measures and service-user experience. • The Committee received the Public Services Board update, noting work on climate change, workforce wellbeing, active travel, young voices, community cohesion and health equity, and supporting continued partnership participation and leadership. • The Area Planning Board update highlighted extensive substance misuse harm, workforce and commissioning pressures, and no national strategy. Work continues to identify a suitable population health measure and improve information sharing after non-fatal incidents. • The Committee received the Public Health Strategic Delivery Plan, Creating Health mid-year update and Obesity Pathway Innovation Programme. Members supported their direction, requesting clearer alignment, prioritisation and impact evidence, continued focus on children's healthy weight services and sustainable funding for successful pilots. • The Llynfi Valley Health and Wellbeing Centre remained on track for Board consideration in March 2027. Members noted planning and community engagement progress, the developing design exceeding the £33.9m funding envelope, and separate needs to identify recurring revenue consequences and future gastroenterology provision. • The Committee received the Strategic Engagement Plan, emphasising accessible language, engagement with staff, children, young people and communities, and testing communications externally before wider consultation. • Regional Working for Clinical Services was deferred pending required approvals. • The Committee endorsed and recommended the Case for Change, Evidence Base, Strategic Vision and Draft Digital and Data Plan for Board approval. The Strategic Vision and Digital and Data Plan remain iterative. Members requested stronger governance and version control, a clearer partnership and social care narrative, closer alignment of digital investment with service transformation, and clearer benefits.

Assure	• The Board Assurance Framework was received and the Committee confirmed that the updates provided adequate assurance. Members requested a more realistic account of the current position and expected progress for sustainability and environmental risk, reflecting available resources and likely timescales, and noted the proposed move to quarterly reporting from 2027.
Inform	• The unconfirmed minutes of the meeting held on 19 August 2026 were approved. • The Annual Cycle of Business, Non-Routine Board Business Forward Plan and Climate Action/Carbon Emissions Update were noted through the consent agenda.
Appendices	• Not applicable

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)* Link to Strategic Risk(s) on the Board Assurance Framework (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	Strategic Risk 2 Service Transformation & Outcomes If more than one applies please list below:

Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales If more than one applies please list below:

Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Not Applicable If more than one applies please list below:

Effaith Amgylcheddol/ Cynaliadwyedd (5R) /	No - Not Applicable

Environmental Sustainability Impact (5Rs)	If more than one applies please list below:

Asesiad Effaith Impact Assessment		
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg *(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)* Equality & Welsh Language Impact Assessment Outcome *(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)*	Outcome for Equality: Not applicable due to the nature and purpose of this Highlight Report. Summary of impact: Not applicable due to the nature and purpose of this Highlight Report. Outcome for Welsh Language: Not applicable due to the nature and purpose of this Highlight Report.	If no, please select a reason below. Choose an item. Named Executive/Board member sign off for no EWLIA completion:
Canlyniad Asesiad Effaith Ansawdd *(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)* Quality Impact Assessment Outcome *(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)*	Not Applicable due to the nature / purpose of this Highlight Report	
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report	
Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report	

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
APB	Area Planning Board
BAF	Board Assurance Framework
IMTP	Integrated Medium Term Plan
R&D	Research and Development
RPB / PSB	Regional Partnership Board / Public Services Board

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

CTMUHB Public Board

CTMUHB Clinical Learning Academy Annual Report

Eitem yr Agenda / Agenda Item	8.2.4
Dyddiad y Cyfarfod / Date of Meeting:	26th November 2026
Statws Cyhoeddi / Publication Status:	Open/Public. Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Rebecca Boore Assistant Director CTMUHB Clinical Learning Academy
Cyflwynydd yr Adroddiad / Report Presenter:	Richard Hughes, Executive Director of Nursing, Midwifery and Patient Care
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes, Executive Director of Nursing
Diben yr Adroddiad / Report Purpose:	For Noting
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	For noting only
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol Strategic Context: This report aligns to the following Strategic Pillars*	All Strategic Pillars Apply
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan *(Reference relevant priority)*	The work of the Clinical Learning Academy directly supports delivery of the Health Board's Integrated Medium Term Plan (IMTP) and Annual Delivery Plan by developing the workforce capability, capacity and educational infrastructure required to deliver safe, high-quality and sustainable services. In particular, the Academy contributes to the strategic priorities of *Inspiring People, Improving Care, Creating Health and Sustaining Our Future*, supporting the ambition within CTM 2030 to improve population health, reduce inequalities and develop a skilled and adaptable workforce.

Crynodeb Gweithredol o'r hyn y mae'r adroddiad yn ei ddisgrifio: Dechreuwch drwy grynhoi'r wybodaeth bwysicaf yn fyr. Dylai hyn roi dealltwriaeth gadarn o'r pwyntiau allweddol yn erbyn y 3 phennawd canlynol heb ddarllen yr adroddiad llawn: Executive Summary of what the report is describing: Start by summarising briefly the most critical information. This should provide a firm grasp of the key points against the following 3 headings without reading the full report:	
Beth *(crynodeb o'r sefyllfa / mater cyfredol a pham ei fod yn bwysig a thystiolaeth i gefnogi'r safbwynt hwnnw ac ati)* What *(summary of current position / issue & why it matters and evidence to support that position etc)*	The CTMUHB Clinical Learning Academy Annual Report provides assurance on the progress and impact of Clinical Education across CTM UHB during 2025/26 and sets priorities for 2026/27. It demonstrates progress in strengthening educational governance, workforce development, multi-professional learning and alignment of education with service priorities. The report highlights the important contribution of education to workforce sustainability, service transformation, quality and patient safety, while identifying ongoing priorities around placement and educator capacity, educational infrastructure, sustainability and demonstrating the impact of educational investment. In summary, the report provides assurance that the Clinical Learning Academy is establishing the educational infrastructure and workforce capability required to support delivery of the Health Board's strategic priorities.
Felly, beth *(darparu dadansoddiad ystyrlon gan dynnu allan, fel y bo'n briodol, oblygiadau yn erbyn Strategaeth / Cynlluniau Cyflawni / risgiau Strategol neu Reoleiddiol CTMUHB ac ati ac unrhyw opsiynau ar gyfer mynd i'r afael â'r rhain)* So, what *(provide meaningful analysis drawing out as appropriate implications against CTMUHB Strategy / Delivery Plans / Strategic or Regulatory risks*	The report demonstrates that Clinical Education is a strategic enabler of CTM UHB's workforce, quality and service transformation priorities, rather than a standalone education function. Continued alignment of education, workforce planning and service need will therefore be critical to delivery of the IMTP and CTM 2030 ambitions. The key strategic risks relate to educator and placement capacity, educational infrastructure, sustainability of programmes and ensuring investment delivers measurable workforce and patient outcomes. Failure to address these could constrain workforce development and the Health Board's ability to respond to changing service and regulatory requirements. The Clinical Learning Academy will continue to strengthen educational governance, prioritise investment against workforce and service need,

etc and any options for addressing these)	expand multi-professional and innovative models of education, and improve evaluation of impact to provide assurance that education is contributing effectively to organisational priorities.
Beth Nesaf *(crynodeb o'r camau gweithredu a fwriadwyd a'r manteision sy'n cefnogi'r dewisiadau a'r argymhelliad(au) sy'n cael eu gwneud)* What Next *(summary of intended action and benefits supporting the choices and recommendation(s)being made)*	Continue delivery of the Clinical Learning Academy priorities for 2026/27, adopting a Quality Management System (QMS) approach to strengthen governance, assurance and continuous improvement. Priorities will include expanding interprofessional training and education, developing workforce and educational capacity, and actively pursuing income-generation opportunities to support longer-term sustainability and reinvestment in education.

Argymhelliad *(Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).* Recommendation (Linked to the "What Next" section above).	To note the Clinical Learning Academy's annual report.

1. Background / Context

1.1 The Clinical Learning Academy provides strategic coordination and oversight of clinical education across CTM UHB, bringing together professional education, workforce development, practice learning, simulation, interprofessional education and educational governance. During 2025/26, governance arrangements continued to mature through the Strategic Education Council, Multi-Professional Education Faculty and professional faculty structures.

1.2 Education activity supports both the current and future workforce, including significant undergraduate placement provision, continuing professional development, advanced practice and support-worker development. This positions education as an important enabler of workforce sustainability, service transformation and quality of care.

2. Strategic Insights

2.1 People: Education and workforce development support recruitment, retention, career progression and development of the current and future workforce. Continued expansion of interprofessional education will strengthen collaborative working and workforce flexibility.

2.2 Performance: Greater alignment between education, workforce and service priorities will enable educational resource to be targeted towards areas of greatest organisational need and support delivery of the IMTP.

2.3 Finance: Improved governance of educational investment, alongside development of income-generating opportunities and external partnerships, will support greater value from available resources and longer-term sustainability.

2.4 Quality: Adoption of a Quality Management System (QMS) approach will strengthen assurance, evaluation and continuous improvement, with greater focus on demonstrating the impact of education on clinical practice, patient safety and outcomes.

3. Risks and Opportunities

3.1 Key risks include educator and placement capacity, availability of protected educational time and suitable learning environments, financial sustainability and increasing demands on clinical services to support education. These could affect CTM UHB's ability to develop the workforce required for future service delivery.

3.2 There are also opportunities to build on CTM UHB's established education infrastructure through greater interprofessional delivery, simulation, external partnerships and income-generating education activity. The report already identifies examples of income-generating opportunities through university partnerships.

4. Compliance and Governance

4.1 Educational governance has strengthened through the Strategic Education Council, Multi-Professional Education Faculty and individual professional faculties, providing clearer oversight, accountability and escalation arrangements.

4.2 During 2026/27, the Academy will further develop these arrangements through adoption of a QMS approach, providing a more systematic framework for assurance, evaluation, risk management and continuous improvement across Clinical Education.

4.3 This will support alignment with relevant professional, regulatory and national education requirements, including preparations for emerging Nursing and Midwifery Council (NMC) requirements affecting advanced practice and other areas of professional development.

5. Benchmarks

5.1 External benchmarking is currently variable across the breadth of Clinical Education and should therefore be interpreted cautiously. However, the report provides evidence of strong performance in several areas. For example, Medical Education reported 96% overall undergraduate satisfaction, while Pharmacy reported 97% of students felt better prepared for practice and 90% would consider returning to work within CTM UHB.

5.2 CTM UHB is also demonstrating leadership in interprofessional education, with its work being shared through all-Wales networks and conferences. Further development of the QMS will provide an opportunity to establish a more consistent set of indicators and benchmarks for Clinical Education.

6. Conclusion

6.1 The Clinical Learning Academy is a strategic enabler of CTM UHB's people, performance, financial and quality priorities. The focus for 2026/27 will be to embed a QMS approach, strengthen interprofessional education, demonstrate impact and value, and develop appropriate income-generating opportunities to support sustainability.

6.2 Committee is asked to note the Annual Report, take assurance from the progress made and support the priorities identified for 2026/27.

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)* Link to Strategic Risk(s) on the Board Assurance Framework (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	Strategic Risk 3 Workforce Capacity & Culture Workforce Capacity and Culture: Developing a learning culture will be central to the Academy's approach, recognising learning as an enabler of workforce capacity rather than a competing demand. Embedding learning within practice will support workforce capability, retention, innovation and continuous improvement.

Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals	Choose an item. The work of the Clinical Learning Academy supports the Well-being of Future Generations (Wales) Act 2015, particularly the goals of A Healthier Wales, A Prosperous Wales and A More Equal Wales, through developing a skilled, sustainable workforce, widening access to learning and supporting improved quality of care. The focus on interprofessional education, partnership working and a learning culture also reflects the Act's principles of long-term thinking, prevention, integration and collaboration.

Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Learning, Improvement & Research
	Culture and Valuing People

Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental Sustainability Impact (5Rs)	No - Not Applicable

Asesiad Effaith Impact Assessment		
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg *(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)* Equality & Welsh Language Impact Assessment Outcome *(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)*	POSITIVE: The Clinical Learning Academy supports equitable access to education, development and career progression across the workforce. Widening participation, flexible development pathways and interprofessional learning have the potential to reduce barriers to progression, support workforce diversity and promote a more inclusive learning culture. POSITIVE: The Academy will support opportunities to learn, develop and deliver education through the medium of Welsh, where appropriate, and promote awareness of Welsh-language needs within clinical education. This supports a workforce capable of providing person-centred care in an individual's language of choice.	If no, please select a reason below. Policy/Plan/Proposal too broad Named Executive/Board member sign off for no EWLIA completion: Richard Hughes
Canlyniad Asesiad Effaith Ansawdd	A separate Quality Impact Assessment is not required as this report is assurance and strategic in nature and does not propose a	

(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen) Quality Impact Assessment Outcome *(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)*	material change to clinical services, pathways, staffing models or patient care. The work described is intended to have a positive impact on quality through strengthening workforce capability, educational governance, interprofessional learning and continuous improvement. Any specific future service or workforce changes arising from the report will be subject to the appropriate quality impact assessment process where required.
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report
Effaith Adnoddau *(Pobl /Ariannol)* / Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Quality, Safety & Experience Committee	24/11/2026	NOTED

Acronyms / Glossary of Terms	

Clinical Learning Academy

Cwm Taf Morgannwg University Health Board

Annual Report Academic Year

2025/26





What Will This Annual Report Tell You?

This Annual Report provides an overview of Clinical Education activity across Cwm Taf Morgannwg University Health Board (CTM UHB), including how we work with partners such as Higher Education Institutions (HEIs) and Health Education and Improvement Wales (HEIW) to deliver high-quality education and support workforce development.

The report highlights our achievements during 2025/26 and outlines our priorities for 2026/27. Through the continued development of the CTM Clinical Learning Academy, (CTMCLA) we aim to embed a culture of learning, innovation, and continuous improvement, ensuring our workforce is equipped to meet the evolving healthcare needs of our communities.

Key areas of focus include:

- Embedding lifelong learning across the workforce.
- Strengthening collaboration and co-production.
- Supporting learning, performance, and professional development.
- Promoting inclusive, multiprofessional education opportunities.
- Enabling staff to work at the top of their licence and maximise their impact in practice.
- Strengthening clinical and educational governance and quality.

High-quality education and training are fundamental to service improvement, workforce development, and better patient outcomes.

Introduction

Health Education Context in Wales

Health services across Wales continue to deliver the vision set out in *A Healthier Wales* (2018), supported by *Community by Design* (NHS Wales Performance and Improvement , 2026) and the *National Patient Safety Plan for NHS Wales 2026-2031* (NHS Wales Performance and Improvement 2026). Together, these frameworks promote person-centred care, prevention, patient safety, and continuous improvement.

The NHS in Wales continues to face increasing demand, widening health inequalities, workforce challenges, financial pressures, and rapid technological change. To meet these challenges, organisations must balance immediate service needs with long-term transformation, delivering high-quality and sustainable care closer to home.

HEIW, the strategic workforce and education body for NHS Wales, plays a key role in developing a skilled and sustainable workforce. Through its annual Education and Training Plan, HEIW commissions and supports education and training programmes that help shape the future workforce and improve patient outcomes.

CTM UHB continues to work closely with HEIW, partner Health Boards, and HEIs to support healthcare education and training across Wales. Significant investment from HEIW enables the Health Board to develop current and future workforce capability and support service transformation.

Context in Cwm Taf Morgannwg University Health Board

CTM UHB serves a population of approximately 447,000 people across Bridgend, Merthyr Tydfil and Rhondda Cynon Taf. The region experiences significant levels of deprivation and health inequality, particularly within the northern valley communities, which continues to influence health outcomes and service demand.

These challenges reinforce the importance of the Health Board's CTM 2030 strategy, which places improving population health, reducing inequalities, and developing a skilled, adaptable workforce at the centre of service delivery and transformation.



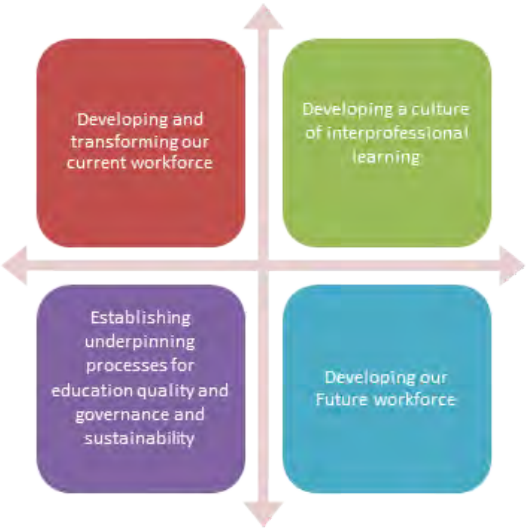
Clinical Education plays a vital role in developing a sustainable future workforce. Through widening access, educational partnerships, apprenticeships, and career development opportunities, we support inclusive pathways into healthcare careers and help build a skilled workforce that reflects the communities we serve.

Creating, Growing and Sustaining a Learning Culture in CTM UHB

Strategic Progress

During 2025/26, significant progress was made in delivering the strategic aims of the CTM Clinical Learning Academy (CTMCLA), following its Board approval and launch in April 2025. The Academy continues to strengthen CTM UHB's learning culture by promoting excellence in education, workforce development, and multi-professional learning.

An effective learning culture enables continuous professional development, supports workforce



Learning Environment and Culture

Strategic Direction

Our aim is to:

- Embed education and training as a valued part of organisational culture.
- Establish CTM UHB as a centre of excellence for multi-professional learning.
- Provide accessible, flexible, and high-quality learning environments that meet the needs of all professional groups.

Delivery

The CTMCLA provides a coordinated, multi-professional approach to education and workforce development across CTM UHB. Strong governance arrangements ensure education priorities remain aligned with organisational objectives and workforce needs.

During 2025/26, work continued to enhance learning and library facilities across acute sites and the Keir Hardie Academic Centre. While progress has been made, securing sustainable and dedicated education space remains a challenge amid increasing service pressures.

Future Direction

To support the long-term ambitions of the Clinical Learning Academy, consideration should be given to further develop a dedicated Multi-Professional Education and Learning Centre. This would provide a hub for education, simulation, innovation, research, and interprofessional learning, supporting workforce transformation and high-quality patient care.

Education Quality and Governance

Strategic Direction

CTM UHB aims to maintain a robust educational governance framework that:

- Provides assurance on the quality of education and training.
- Strengthens oversight of education activity and associated risks.
- Aligns education commissioning and workforce development with service priorities.

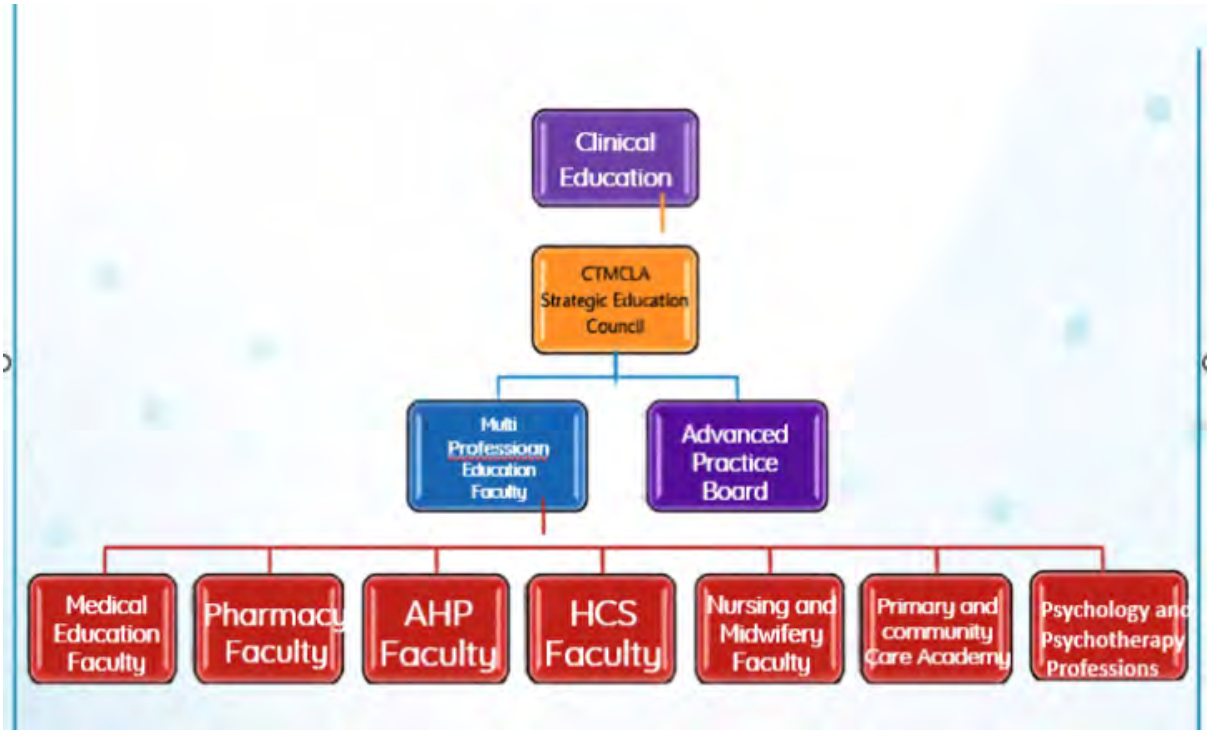
Delivery

During 2025/26, governance arrangements within the Clinical Learning Academy continued to mature, providing clearer leadership, accountability, and assurance for multi-professional education across the Health Board.

The Strategic Education Council (SEC) continues to provide strategic oversight of the Academy, ensuring educational activity aligns with organisational priorities, workforce requirements, and quality objectives.

The Multi-Professional Education Faculty (MPEF) became fully operational during the year, strengthening quality assurance through the review and scrutiny of educational strategies, policies, and key documents before submission to SEC.

Faculty structures have also been established across Nursing and Midwifery, Medicine, Allied Health Professions, Healthcare Science, Pharmacy, Primary Care, and Psychology and Psychotherapy Professions. These faculties support professional development, workforce transformation, educational quality, and the delivery of strategic priorities, contributing to a more cohesive and effective educational governance framework across CTM UHB.



Looking Ahead

Following the redesign of the senior management structure, including the appointment of an Assistant Director, a Lead for Healthcare Professional Education Quality and Governance, and a Business Support Manager, the CTMCLA will strengthen its strategic oversight of education governance and operational delivery. These roles will enhance quality assurance, compliance, risk management, project management, and governance processes across all professional groups, ensuring educational activity remains aligned with organisational priorities, regulatory requirements, and best practice. The Business Support Manager will further strengthen ongoing work programmes, support continuous improvement initiatives, and provide dedicated oversight of project management and business operations. This additional leadership and management capacity will support continuous improvement and strengthen the Academy's ability to demonstrate educational quality, effectiveness, impact, and sustainable service development.

Multi-professional Learning Approach

Direction
A high-quality multi-professional education model delivers equitable learning opportunities for all healthcare professionals and support staff, with interprofessional learning embedded throughout.

Progress
Significant progress has been made in interprofessional learning. Sessional leadership from Allied Health Professions (AHPs) and Pharmacy continues to strengthen this approach.

Professional faculties feeding into a Multi-professional Education Faculty have enabled collaborative learning that meets profession-specific needs while benefiting from shared expertise and perspectives.

CTM UHB remains a leader in interprofessional learning in Wales. During 2025/26, the interprofessional and simulation education offer expanded further, building on the success of the first Multi-professional Practice Education Facilitator post. Senior AHP and Pharmacy leadership roles, alongside dedicated administrative support, have improved alignment, streamlined processes, strengthened evaluation, and enhanced workforce development support.

Direction
Our workforce is our greatest asset. Clear educational frameworks and career development pathways will support staff to develop, progress, and achieve their professional aspirations within CTM UHB.

Developing our Future Workforce Overview

CTM UHB as an organisation contributes significantly to the education and training of healthcare professional students in Wales. Each year our organisation delivers undergraduate clinical placement training weeks including:

- > 6000 medical student training weeks
- > 10,000 student nurse/midwife weeks
- > 1600 AHP student weeks
- > 400 Pharmacy student weeks across Primary and Acute care

Over 2025/26 we have continued to work in partnership with six HEIs to deliver clinical placements for healthcare professional students:

- University of South Wales (USW) including– Nursing (all four fields of practice. Part-time route), Midwifery, Operating Department Practitioners and Part-time Occupational Therapy & Physiotherapy courses, along with Chiropractic, Medical Life Science, and Sport Science (income generating opportunities).
- Cardiff University including - Medical, Physiotherapy, Occupational Therapy, Health Care Sciences & Pharmacy
- Swansea University including – Nursing (Mental Health Field only), Paramedics, Physicians Associates and Pharmacy Students
- Cardiff Metropolitan University including - Speech and Language Therapy, Dietetics, Podiatry.
- Open University (Part-time distance learning) & Bangor University (Distance Learning) Nursing.

Focus on Nursing and Midwifery

Developing our Future Workforce

Schools and Colleges work

The Nurse Education Team continues to play a key role in supporting and inspiring the future workforce through outreach activities, work experience opportunities, and the promotion of nursing and healthcare careers. During 2025/26, 35 college students attended the Nursing Academy programmes at Princess of Wales Hospital and Prince Charles Hospital, while a further 16 students completed clinical work experience placements across CTM UHB sites.

This workstream is currently under review to ensure it remains both impactful and resource-efficient, balancing the needs of schools and students with the capacity of the Nurse Education Team to provide high-quality support.

The team also contributed to the Introduction to Healthcare event at the University of South Wales, which was attended by 63 students from Rhondda Cynon Taf and Bridgend. Following positive feedback, the event is planned to continue in 2026/ 27.

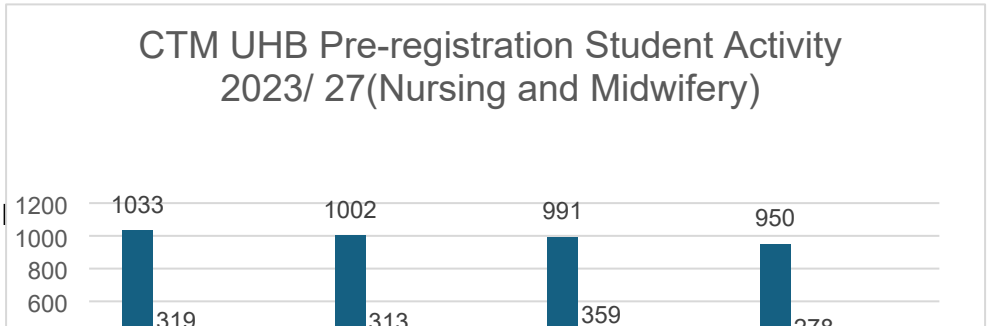
Working closely with Careers Wales and colleagues across CTM UHB, the Nurse Education Team actively promotes healthcare careers, raises awareness of education and employment pathways, and encourages young people to consider careers within the NHS. This collaborative approach includes partnership working with Medical Education to develop and facilitate the *Mini Work Observation Scheme* (see Medical Education section), further enhancing opportunities for students to gain insight into healthcare professions.

Practice Education Facilitator Team

The Practice Education Facilitator (PEF) Team works closely with clinical services and partner HEIs to coordinate student placements and support high-quality practice learning environments across CTM UHB. Through regular partnership meetings, educational audits, and ongoing evaluation of placement areas, the team helps ensure positive student experiences, supports learner progression, identifies areas requiring improvement, placement capacity expansion (10 new clinical placements obtained this year), and promotes excellent practice. This collaborative approach aims to develop students professionally while positioning CTM UHB as an employer of choice upon qualification.

The Health Board supports a range of pre-registration nursing and midwifery education pathways, providing over 10,000 placement weeks annually. These include full-time and flexible learning routes across Adult, Child, Learning Disability and Mental Health Nursing, together with a full-time pre-registration Midwifery programme.

The table below illustrates the number of Nursing and Midwifery students allocated to CTM UHB over the past four academic years.



The PEF Team provides educational, clinical, and pastoral support to pre-registration students throughout their placement journey, whilst also contributing to teaching within HEIs and delivering in house clinical skills sessions aligned to the 'Once for Wales' Nurse Inventory Framework. Although student numbers have remained relatively stable, the volume and complexity of student concerns have increased significantly, requiring enhanced support and placing additional demands on the team while maintaining high-quality learning experiences.

Recognising the challenges some neurodiverse students may face in practice learning environments, PEFs have worked with HEI partners to develop a Standard Operating Procedure (SOP) that ensures appropriate support and reasonable adjustments are identified and implemented before placements commence. This proactive approach has improved student confidence, engagement, wellbeing, and overall placement experiences, while ensuring consistent support throughout their educational journey.

The initiative has also increased awareness of neurodiversity within clinical teams, helping to embed a more inclusive culture and encouraging staff to seek support for their own additional learning needs. Building on these positive outcomes, a formal evaluation is required to assess the wider impact on learners and staff and identify opportunities to further strengthen inclusive practice across the Health Board.

International Pre-Registration Nurses

During 2025/26, CTM UHB continued to support pre-registration international nursing students in partnership with USW, with the first cohort expected to achieve Nursing Midwifery Council (NMC) registration in autumn 2026.

International Student Numbers

International Pre- Registration Numbers	
September 2023	31
April 2024	70

April 2025	54
April 2026	23
Total	178

The PEF team continues to work closely with USW and clinical teams to provide educational, pastoral, and cultural support, helping students adapt to the UK healthcare environment and succeed in practice. As cohorts progress towards registration and employment, this initiative is making a significant contribution to workforce sustainability and the delivery of high-quality patient care across CTM UHB.

Fitness to Practise (FtP) and Cause for Concern

The PEF team and Senior/Lead Nurse for Clinical Education work closely with HEIs, clinical teams, and corporate services to manage student concerns, contributing to Cause for Concern and FtP processes to support safe and informed decisions regarding student progression.

During 2025/26, partnership working with HEIs and the Safeguarding Team has been strengthened through improved communication and escalation pathways, enabling earlier identification and management of concerns. Safeguarding audits have also been introduced to identify trends and support quality improvement.

The PEF team continues to provide coordinated support for students, practice supervisors, practice assessors, and university colleagues, including tailored action plans where additional support is required. Regular team meetings and the introduction of a student pathway project have further improved continuity of support, enabling concerns to be tracked across placements and promoting consistency in decision-making.

Practice Supervisors and Practice Assessors

Pre-registration Nursing students in Practice Learning Environments require Practice Assessors (PA) and Supervisors (PS). The PEF team continue to deliver an annual schedule of PA and PS training to registrants to ensure they have the appropriate skills and knowledge to support our students in clinical practice and effectively complete the Electronic Practice Assessment documentation (ePAD).

Number of trained PS/PA numbers to pre-registration nurse numbers:



Developing and Transforming our Current Workforce

Health Care Support Worker Education

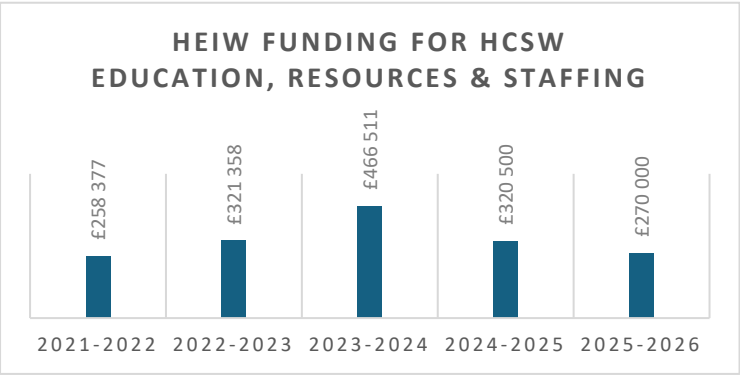
During 2025/26, the CTMCLA Health Care Support Worker (HCSW) Education Team have continued to support the development and career progression of HCSWs across CTM UHB, aligned to the All-Wales HCSW Career Framework. Funded through HEIW, the programme delivered HCSW Induction, NEWS Cymru training, and a wide range of continuing professional development (CPD) opportunities for staff across Nursing, Midwifery, AHPs, Healthcare Science, Pharmacy, Facilities, and Primary Care.

A key achievement was the successful delivery of the Spring 2025 HCSW Conference, which celebrated the vital contribution of all HCSWs across the Health Board. The event promoted career development, shared best practice, and strengthened professional identity, with feedback highlighting increased confidence, improved multidisciplinary relationships, and enhanced staff morale.

HEIW Funding for HCSW Education, Resources & Staffing

CTM UHB continues to receive funding from HEIW to support the education and development of HCSWs Band 2-4 in line with the All-Wales Skills and Career Framework for Healthcare Support Workers (HEIW 2016).

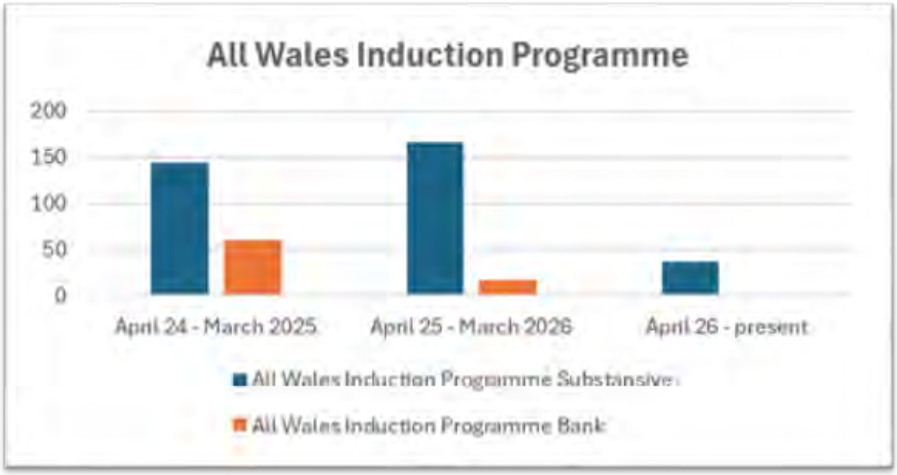
Quarterly monitoring and reporting on expected and actual expenditure internally within CTM and externally with HEIW continue, allowing early identification and reallocation of any potential underspend. The following graph illustrates the funding that has been allocated to the HCSW education within CTM UHB since April 2021 – March 2026.



HCSW All Wales Induction Framework (AWIF) Programme

All newly appointed HCSWs, including those recruited to the staff bank, are required to complete the in-house All Wales Induction Framework programme. This programme is mandatory for all HCSWs working across nursing, midwifery, and allied health professions.

The most recent attendance of bank HCSWs at the All-Wales Induction programme was in September 2025. Attendance for bank staff is currently on hold pending a review of available budgets and consideration of the impact of the ongoing Band 2/3 validation work within the staff bank workforce HCSW All-Wales Inductions numbers have remained steady each month with a total of 184 HCSWs attending between April 2025- March 2026. The HCSW Education Team currently has the capacity to support 15-20 HCSWs per month, based on available training room capacity and the required educator-to-learner ratio for assessment and support activities.



The HCSW All-Wales Induction programme does not run in December, as historical data indicates lower participation and higher attrition rates during this period, largely attributable to seasonal workload pressures across clinical services.

At the beginning of 2026, the All Wales HCSW Induction Programme was revised to align with updated Band 2 and Band 3 HCSW job descriptions. Within CTM UHB, this resulted in a four-day induction programme for Band 2 HCSWs and a five-day programme for Band 3 HCSWs, reflecting the additional clinical skills requirements of the role.

The programme has also been modernised, moving away from a workbook-based approach to a more streamlined classroom-based model, with competence assessed through practical activities and competency sign-off. This has enhanced both the learner experience and the efficiency of the assessment process. Looking ahead the Induction will include Band 2 HCSW impacted by the Validation process , additional skills days will also be developed to support the Validation of HCSWs moving from a Band 2 to 3 role to ensure they are skilled and competent.

Level 4 Certificate of Higher Education

To support HCSW career progression, the HCSW Education Team has strengthened partnerships with USW and Grŵp Llandrillo Menai (GLM), providing accessible Level 4 educational pathways and flexible routes into nurse registration.

Collaboration with Learning and Development and the Apprenticeship Academy has further enhanced workforce planning, career development, and educational data management.

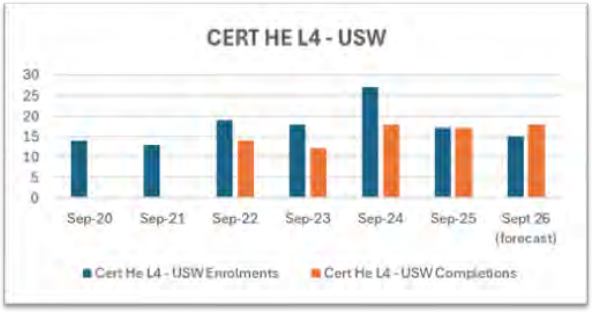
The Certificate of Higher Education (Cert HE) continues to provide HCSWs with valuable Level 4 qualifications, while offering a clear progression route to the BSc (Hons) Nursing

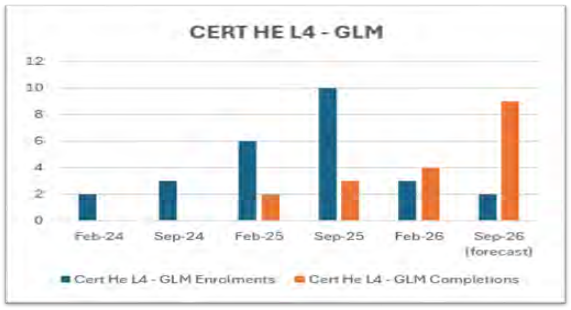
(Flexible Learning) programme. Strong enrolment and completion rates across both USW and GLM programmes demonstrate their success in supporting career progression and creating a sustainable pipeline into the future registered nursing workforce within CTM UHB.

In September 2025 and February 2026, a total of 30 Healthcare Support Workers (HCSWs) enrolled on the USW and GLM Level 4 programmes, representing continued growth

Year	USW	Open University	
	Autumn Cohort	Spring Cohort	Autumn Cohort
2023	18	3	4
2024	16	12	10
2025	22	8	5
2026	29 (proposed)	3	8

compared with previous years. Looking ahead, a further 18 HCSWs are forecast to enrol on the USW Certificate of Higher Education (CertHE) and/or GLM programmes across September 2026 and February 2027.





The majority of HCSWs see this pathway as a stepping stone to progression to the Part Time Flexible Route to Nursing either via USW or Open University routes.

BSc (Hons) Nursing (Flexible Learning) – Part Time Flexible Route to Nursing

This course allows eligible candidates to work toward Registered Nurse status and obtain a degree in one of four nursing specialisations, all while continuing their employment as HCSWs. CTM UHB has been supporting the flexi route since its instigation in 2017. Numbers are illustrated in the table below:

The Flexible Route to Nursing programme has seen sustained growth since 2024, with enrolment numbers increasing year on year. The September 2026 cohort is the largest to date, with 29 learners enrolled across multiple fields of practice, demonstrating the programme's success in supporting CTM UHB's commitment to growing its own nursing workforce.

During 2025/26, the HCSW Education Team worked closely with Workforce and Organisational Development colleagues to strengthen support for learners and improve retention within CTM UHB following qualification. A more standardised approach to manager support and workforce planning has also been introduced, helping to identify employment opportunities earlier and support successful transition into registered nursing roles

HCSW Conference Spring 2026

The CTM UHB HCSW Conference 2026 welcomed 146 attendees, including Healthcare Support Workers (HCSWs), line managers, educators, facilitators and exhibitors. The conference focused on career development, professional growth and progression pathways within Nursing, Midwifery and Allied Health Professions.

The conference showcased HCSW-led presentations, keynote speakers, quality improvement projects, exhibition stands, and interactive learning experiences. Highlights included the 360° Immersive Learning sessions and high-fidelity simulation with ‘Blodwyn’, which enhanced learning around patient care, communication, and clinical practice. A keynote session on wellbeing and resilience also inspired delegates to reflect on personal and professional development.

Feedback was highly positive, with attendees reporting increased confidence, knowledge, and motivation to improve practice and pursue career development opportunities. Engagement from Allied Health Profession colleagues was particularly encouraging, with plans to further increase participation from HCSWs across planned and unscheduled care services in 2027.

Overall, the conference provided a valuable opportunity for learning, networking, and celebrating the contribution of HCSWs, reinforcing CTM UHB's commitment to workforce development and excellence in patient care.

Nursing & Midwifery post registration

To support the streamlining process and facilitate the transition from pre-registration education to registered practice, the PEF team works collaboratively with Practice Development Nurses (PDNs) to deliver Student Streamlining (recruitment) events across HEIs, alongside internally hosted recruitment events. Clinical teams are actively involved in these events, providing prospective registrants with opportunities to explore specialty areas, understand local induction processes, and gain insight into career development pathways available within the organisation. The events also offer valuable information about the day-to-day realities of working within specific clinical environments, supporting informed career decisions and successful workforce integration.

Recognising the strong correlation between positive student placement experiences, effective early career support, and the retention of newly registered nurses, CTM UHB continues to provide a robust and comprehensive Newly Registered Nurse Induction and

Preceptorship Programme (NRNIP) for graduate nurses across all fields of nursing. During 2025, the programme was reviewed and updated to ensure alignment with the Chief Nursing Officer (CNO) for Wales Preceptorship Circular. In support of this revised approach, Role of the Preceptor training was introduced in August 2025. The NRNIP is continuously evaluated, and looking ahead a two-week intense programme will be held in Autumn 2026.

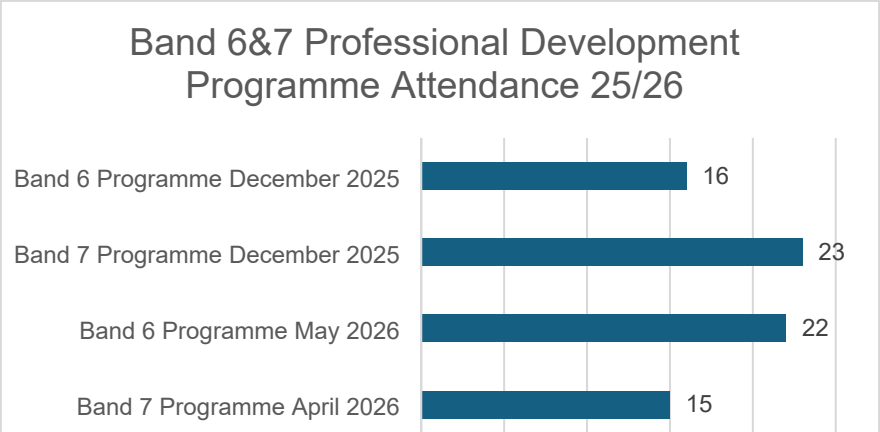
A key area of focus in response to the CNO for Wales Circular during 2025 was the development and implementation of Restorative Clinical Supervision (RCS) across CTM UHB. An implementation plan for RCS was submitted to the CNO, and members of the Practice Development Nurse (PDN) team successfully completed the RCS Train-the-Trainer programme at Cardiff and Vale University Health Board. This preparatory work enabled the introduction of a three-day supervisor training programme aimed at developing RCS capacity across CTM UHB. In addition, all prospective supervisors were required to complete the relevant e-learning package via Electronic Staff Record (ESR) prior to undertaking face-to-face training.

By the end of the reporting period, 26 RCS supervisors had been trained across the organisation, with further training opportunities initially planned to increase capacity. RCS was also incorporated into the NRNIP from Autumn 2025, reflecting the organisation's commitment to supporting staff wellbeing, professional development, and workforce retention.

Despite these initial developments, engagement with the RCS programme has been lower than anticipated, limiting the pace of implementation and wider adoption across clinical services. Consequently, the programme is currently undergoing a comprehensive review. This review is being undertaken alongside the development of a CTM UHB Restorative Clinical Supervision Policy, which is currently in draft and progressing through the organisation's governance processes. The outcome of this work will inform a revised implementation approach, ensuring future delivery is aligned with organisational policy, workforce priorities, and service needs, while improving accessibility, engagement, and sustainability across the Health Board.

Supporting Career Progression:

The Professional Development and Innovation Programme is a two-day course designed for Band 6 and Band 7 registered nurses, supporting the development of leadership, management, and innovation skills. The programme helps participants prepare for the next stage of their careers, strengthen professional practice, and build confidence in leadership roles. It has been well attended and consistently receives positive feedback, making it a valuable component of nursing workforce development within CTM UHB. The table below highlights the numbers that have attended.



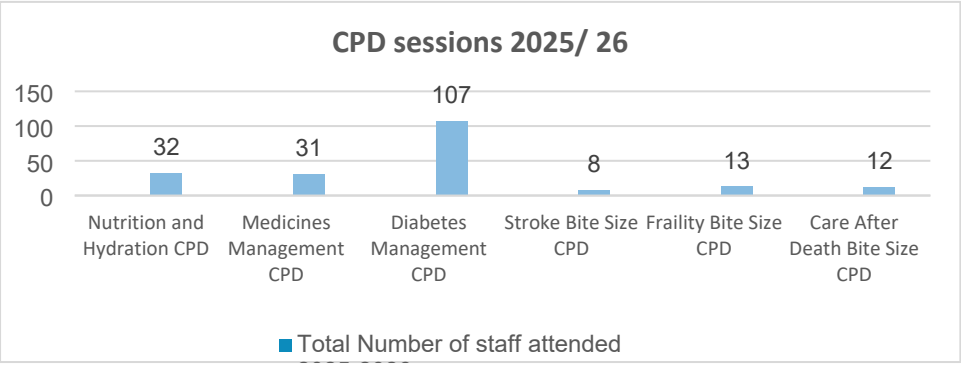
The PDN Team has continued to develop and deliver a range of CPD opportunities to support workforce development and enhance patient care. Examples delivered during 2025/26 included:

- Falls Training: A one-day programme for registered staff and HCSWs, designed to increase understanding of the impact of falls and strengthen knowledge of falls prevention strategies within both hospital and community settings.

In addition, the PDN Team coordinated a range of CPD education sessions delivered by subject matter experts in response to identified service and workforce needs. These programmes were commissioned to enhance staff knowledge, skills and confidence, supporting the delivery of safe and effective patient care. Topics included:

- Malnutrition
- Diabetes Management
- Stroke Management (Micro Session)

The table below outlines the number of staff who attended each programme during the reporting period



The ‘New to CTM UHB Day’ continues to support the successful induction and integration of newly appointed nursing staff. In October 2025, eight experienced nurses attended the programme, followed by a further six participants in June 2026. The study day introduces CTM UHB’s values and behaviours, while raising awareness of the key services, resources and support mechanisms available to staff across the Health Board.

Harm Free Care Study Day

In April 2026, the Harm Free Care Study Day was launched for Band 5 Registered Nurses following successful completion of their preceptorship period. 20 staff members attended the study day. The following sessions were delivered to strengthen clinical knowledge and support ongoing improvements in the quality and safety of patient care.

- Dementia
- Pressure Ulcer Documentation
- Blood Pressure Lying & Standing
- VTE Assessment & Management
- Nutrition and Hydration
- IPC - Management of UTIs

Looking ahead Harm Free Care Study days are planned 2026/27 and will align to the Harm Free Agenda and their impact will be monitored.

Practice Development Nurse Forum

The purpose of the PDN forum is to bring together all the PDNs from across the Health Board and to provide leadership and professional support to advance nursing education, workforce development and clinical practice across CTM UHB. The forum promotes lifelong learning, clinical skills development, student support, reflective practice and quality improvement, while working collaboratively with education providers, practice educators and healthcare teams to identify workforce needs, enhance learning environments and ensure staff are equipped to deliver safe, effective and compassionate care aligned with Health Board priorities and values.

Establishing Underpinning Processes for Education Quality, Governance and Sustainability

The Nurse Education Team has continued to strengthen its approach to educational quality, governance and sustainability by implementing more robust evaluation processes across its education programmes. This enhanced approach enables the team to better assess the impact and outcomes of educational delivery, ensuring that programmes demonstrate meaningful benefits for both learners and the wider organisation.

Alongside this, the team has undertaken a review of the resources required to support sustainable education delivery, ensuring that programmes are appropriately designed, adequately resourced and responsive to workforce needs. A key focus has been maintaining a balance between service priorities and educational provision, while ensuring all learning opportunities are underpinned by evidence-based practice and aligned with organisational and professional standards.

This work provides a stronger foundation for continuous improvement, informed decision-making and the delivery of high-quality education that supports workforce development across CTM UHB.

Developing a Culture of Interprofessional Learning

Interprofessional Placement Activity

The Interprofessional Education (IPE) team plays a key role in promoting collaborative learning across professions, providing leadership, guidance, and resources across CTM UHB and partner HEIs. CTM UHB continues to lead IPE development in Wales, supporting Health Boards to expand innovative interprofessional learning opportunities that strengthen teamwork and collaborative practice.

Strategic Framework

During 2025/26, a three-year IPE Delivery Plan was developed to embed interprofessional learning across the Health Board. The framework aims to build a more collaborative and adaptable workforce by improving understanding of professional roles, communication, and shared decision-making. This will support patient safety, quality of care, workforce experience, and the preparedness of students and newly qualified practitioners for multidisciplinary practice, while contributing to recruitment, retention, and improved patient outcomes, (see Appendix 1).

Celebrating Our Students and Educators

This academic year, two Student and Educator Celebration Events were held to recognise the achievements and contributions of learners, educators, and clinical teams. These events promote a culture of appreciation and excellence, showcase outstanding practice and innovation, and reinforce the Health Board's commitment to high-quality learning environments.

Two new award categories were introduced: **Health Care Support Worker of the Year and Interprofessional Education Placement of the Year**, recognising the vital role of support workers and the value of collaborative learning opportunities. The events also provided an opportunity to showcase the work of the IPE team through project poster presentations, highlighting innovation and best practice across the Health Board.







Structured Interprofessional Education (IPE) Activities

The IPE team continues to coordinate structured placement opportunities that provide meaningful interprofessional learning experiences beyond ad hoc exposure to multidisciplinary working.

During 2025/26:

- Over **2,000 IPE placement days** were arranged across multiple professions.
- **365 clinics** were made available for students to learn alongside other professions.
- **23 IPE Connection Sessions** were delivered, using case studies to explore how multidisciplinary working can improve patient outcomes.
- **30 student learning sessions** were provided, featuring expert speakers and opportunities for interprofessional reflection, networking, and shared learning.

-

Student-Led Activities

- **Cardiac Physiology Student Teaching:** Peer-led ECG training for nursing students, improving knowledge, confidence, and interprofessional understanding.
- **Medical and Nursing Skills Sessions:** Collaborative skills training that strengthened clinical competence and understanding of professional roles.
- **Physiotherapy and Occupational Therapy Teaching Sessions:** Case-based and simulation learning focused on preventing deconditioning, promoting independence, and enhancing multidisciplinary working.

Students as Educators: New Projects

A key achievement this year was the **"Hear Better, Care Better"** project, delivered in partnership with Swansea University and CTM UHB Audiology Services. This innovative placement enabled third-year audiology students to act as interprofessional educators, providing hearing-loss awareness and hearing aid troubleshooting training to frontline healthcare staff.

Over a one-week placement, students delivered training to **263 staff members across 13 professional groups** and developed practical resources to support clinical teams. The project demonstrated the value of students as educators while enhancing multidisciplinary understanding of hearing loss and audiology services.

Evaluation findings were highly positive, with staff reporting increased understanding of the audiology role (96%), confidence in applying learning to practice (94%), identifying appropriate referrals (92%), and communicating with patients experiencing hearing loss (93%). Overall, **96%** felt the training would improve patient care.

Audiology students also reported improved confidence in teaching, communication, leadership, and interprofessional working. The project's success has highlighted opportunities to expand similar student-led educational initiatives across other professions and clinical areas.



Please see our poster for this project - https://canva.link/yuul5eah40rw1qc

The IPE team have been asked to present this work at the Welsh Audiology Conference – September 2026.

This project has led the IPE team to be nominated for a CTM UHB Seren Award, and the Senior nurse for Clinical Education to be nominated for the Royal of Nursing, Nurse of the Year – Nurse Education Award.

Additional New Projects: Cross Health Board and University IPE Event (collective leadership)

In April, CTM UHB and Powys Teaching Health Board collaborated to deliver a large-scale IPE event for students on placement across both organisations. Focusing on the rehabilitation of a patient with a fractured neck of femur, the event combined profession-specific learning with simulation-based activities, involving Nursing, Occupational Therapy, Physiotherapy and Dietetics teams.

Students from Cardiff University and USW participated in simulated rehabilitation, handover and best-interest meeting scenarios, enhancing their understanding of professional roles, communication, teamwork and shared decision-making. Hosted within CTM UHB's simulation facilities, the event received highly positive feedback and supported the development of interprofessional working, person-centred care and collective leadership skills.

The IPE team submitted 6 poster abstracts for the HEIW IPE conference this year, all of which were accepted for poster presentations **(**see Appendix 2**)**

As part of the poster competition, CTM UHB came 1st (Audiology Project), 2nd (ECG confidence), and 3rd (Medical and Nursing Simulation), which we are incredibly proud of.

Interprofessional Education Simulation

Year One of the Simulation Strategy has focused on establishing strong foundations to support the sustainable development of simulation-based education across clinical education settings.

Key Achievements

1. Establishing Simulation Working Group
2. Mapping Current Simulation Activity
3. Building Faculty Capability
4. Strengthening Collaboration
5. HEIW Simulation Conference – CTM UHB team presented their collaborative simulation project in conjunction with local higher education institutions.
6. Simulation 3-year strategy agreed.

Challenges and Learning

Key challenges identified during Year One include:

- Variable access to simulation resources and protected faculty time
- Capacity pressures impacting the ability to expand simulation activity

Impact

Despite early-stage implementation, Year one activity has demonstrated positive impact through:

- Improved engagement with simulation as a learning modality
- Increased awareness of best practice in simulation-based education
- Engagement with HEIW simulation team

- Official CTM UHB Simulation Training developed and deemed successful. Evaluations positive **(**see Appendix 3).

Priorities for Year Two

- Stronger alignment between education delivery and patient safety priorities
- Further standardisation of simulation approaches and resources
- Continued development of simulation faculty
- Improved equity of access to simulation opportunities
- Strengthening evaluation and outcome measurement

Looking Ahead

Future priorities include;

- **Develop and implement the Interprofessional Education (IPE) and Simulation Strategy**, providing a clear framework to support collaborative learning, workforce development and high-quality educational delivery across CTMCLA.
- **Strengthen evaluation and impact measurement processes** to demonstrate the value and outcomes of internal CPD programmes, ensuring educational activity delivers measurable benefits for staff, services and patient care.
- **Continue to build and strengthen partnership working across CTMCLA faculties**, promoting collaboration, shared learning and alignment with organisational priorities.
- **Further enhance engagement with key stakeholders**, developing strong, sustainable relationships that support workforce development, innovation and service improvement.
- **Promote and celebrate achievements across all teams**, recognising excellence, sharing best practice and creating a positive culture of learning and continuous improvement.
- **Embed and strengthen educational programmes, governance arrangements and team development under the new leadership structure**, ensuring stability, consistency and a clear strategic direction for future growth.
- **Review of the Schools and Colleges workstream** to ensure its impact.

Focus on Allied Health Professions (AHPs)

Allied Health Professionals (AHPs) have made a significant contribution to the priorities of the CTMCLA through activity focused on workforce development, education governance, and the promotion of interprofessional learning.

AHP Faculty overview

The AHP Faculty was established during 2025/26 and has met on two occasions, with Terms of Reference formally agreed. Reporting to the CTMCLA Strategic Education Council, the Faculty provides strategic leadership for workforce development, education, and professional learning across Allied Health Professions.

Its purpose is to identify, plan and implement initiatives that support the development of a skilled, diverse and adaptable workforce, aligned with current and future service requirements, while also reflecting the priorities of CTM UHB and Welsh Government.

The Faculty is responsible for advancing clinical education quality, governance and sustainability; supporting the development of both registered and non-registered staff; enabling workforce transformation and professional growth; and creating a culture of collaborative, interprofessional learning across the Health Board aligning to the CTMCLA strategic aims.

Developing our future workforce

Careers events and work experience

AHPs have continued to provide work experience opportunities and careers events this year. For example, the Speech and Language Therapy (SLT) service has led on an all Wales offering twice a year for which participants from across Wales have grown in number and included several schools and colleges as well as interested individuals. (see appendix 4 for the poster advertising this event)

Pre-registration placements offered

The attached document outlines the all Wales placement plan for 2025-26 with the requirements for AHPs included, which were surpassed in many cases, with placements offered above these figures.

AHP HCS 2025-2026 Placement Plan.pdf

At the 2026 Student and Educator Celebration Event this year, AHP winners and runners up were as follows:

- Most Inspiring Student - (SLT)
- Allied Health Professional and Healthcare Science (HCS) Student of the year - (Physiotherapy)

Runners up: AHP & HCS Student of the year - (Speech and Language Therapy), Practice Educator of the year - (Physiotherapy)

Speech & Language Therapy Service

Cardiff Metropolitan University (CMU) changed the structure of year 3 placements for the first time this year. Instead of the final year 3 block being a mixed (2-day Adults'/2 days Paediatrics) 5-week block, students were offered either a full 20-day adult or paediatric block placement. Overall feedback from CTM UHB SLTs was positive. Our staff enjoyed having a better opportunity to embed a student into the team and offer them more opportunities to hold a consistent caseload.

There was biggest ever cohort of new SLTs graduate this year (a cohort of 43). Next year, these commissioned numbers have been reduced significantly to just 30 places. This will inevitably have a negative imROPpact on workforce recruitment over coming years.

Here are some examples of feedback from SLT placement evaluation feedback this year:

"Both placement educators were really understanding of my current level of SLT knowledge and personal/professional skills, happily answering any questions that I had. Everyone I met was really welcoming and willing to share their knowledge and expertise with me. Overall, I felt very much welcomed and supported, and that both placement educators wanted to ensure I experienced and learned as much as possible."

"I really valued how open my (SLT) PEs were in terms of asking questions or providing me with feedback. They really encouraged me and it was such a fantastic learning environment. I was so grateful to learn from each of them and I really enjoyed the whole experience."

At the Celebration event the 'Most Inspiring Student' gave a speech giving thanks to the adult SLT service. Here is an excerpt from her speech:

"*The team empowered me to take control of my clinical learning. Rather than taking over, they provided guidance, supervision and support, allowing me to make and justify decisions about different cases and improve my clinical understanding. This approach helped me build confidence in my clinical abilities, and I genuinely feel I left the placement a far more confident clinician than when I arrived.*

One of the most striking aspects of the placement was the team culture. Staff wellbeing was valued and actively encouraged. Daily walks, when the weather allowed, created opportunities for conversation, connection and team building. I was always invited to join but never felt pressured if I chose not to. The supportive atmosphere extended across the entire team. I never felt concerned about approaching senior team members, and I never felt like 'just a student'. From day one, the focus was on understanding my goals and identifying how the team could help me achieve them, working to my strengths and my level of comfort."

Occupational Therapy

OT – Student Placement offers 2025/26

Year	Cardiff Commissioned number	USW Commissioned number	Total
2022/23	84	15	99
2023/24	85	20	105
2024/25	82	18	100
2025/26	80	19	99

2025/ 26	Number of placement weeks/hrs per student	Number of students	Total hours of placement offered
Cardiff Uni –BSc	29 weeks @37.5 hr (=1087.5hrs per student)	69	75,037.5hrs
Cardiff Uni –MSc	29 weeks @ 37.5hr (=1087.5hrs per student)	11	11,962.5hrs
USW – Part-time placements	11 weeks @ 20hr (=220hrs per student)	11	2,420hrs

USW – Full-time placements	22 weeks @ 40hr (=880hrs per student)	8	7,040hrs
		99 Students	**96,460hrs**

Feedback from students on placement:

- "The team were amazing and treated me like I was part of them. They were open for discussions, always asking if I had questions and always included in me in the weekly structure.
  I mostly enjoyed the patient contact time and ward round opportunities."

- "I really enjoyed my placement and learnt a lot about stoke and OT in stroke, I was able to observe a lot of assessments and interventions and see a variety of patients"

- "I enjoyed being given every opportunity to observe a wide range of services offered by the Occupational Therapy team."

Physiotherapy

Physiotherapy student placement offers 2025/26 academic year

Academic year	Cardiff University	University of South Wales	Total
25/26	12	5	17
24/25	7	5	12
23/24	14	6	20

2025/ 26	Placement numbers	Placement weeks/hours	Total placement hours offered
CU BSc	49	4 weeks @37.5 = 150 hours per student	7,350 hours
CU MSc	23	8 weeks @37.5 = 300 hours per student	6,900 hours
USW Part time	20	4 weeks @18.75 = 75 hours per student	1,500 hours
USW Full time	30	4 weeks @37.5 =150 hours per student	4,500 hours
TOTAL	122		20,250 hours

The hours also include resit placement offers; these can vary in demand due to student circumstances. We have offered **122** placements in the last academic year. We have supported **3** elective student placements who are studying outside of Wales. This has been supported on an individual basis and subject to team availability.

Dietetics

The Nutrition and Dietetics Department continues to support the development of the future workforce through accessible education and training opportunities for Band 3 and Band 4 Healthcare Support Workers (HCSWs).

Whilst the training pathways are available, work is ongoing to establish sustainable local delivery models in partnership with further education providers, with discussions currently taking place with local colleges. This is national barrier and is being discussed and taking forward by the Welsh Dietetic Leadership Advisory Group (WDLAG).

A key challenge remains the entry requirements for the Level 4 qualification, which requires learners to have achieved a specified number of Level 3 credits. This continues to present a barrier for some members of the support workforce and is an area being explored collaboratively with education partners.

The department remains committed to supporting the future registered workforce through the provision of high-quality student placements across all clinical areas. Placement capacity has been maintained over recent years (2023/24–2025/26), although a planned reduction of approximately 20% in student placement numbers is anticipated by 2028/29.

Podiatry & Orthotics

CTM UHB Podiatry provides placements for Year 1 to 3 Cardiff Metropolitan University students, ranging from observational experiences in Year 1 to hands-on clinical practice in Years 2 and 3. Final-year students can also undertake an additional two-week specialist placement.

All final-year podiatry students successfully qualified this year; however, student numbers were significantly lower than previous cohorts due to high attrition rates. Reduced placement capacity and lower student recruitment may impact the future podiatry workforce across both NHS and independent sectors.

The podiatry programme has reduced placements by 20% for the September 2026 intake, creating further challenges for workforce supply. Orthotics remains a particularly vulnerable profession in Wales due to the absence of a local academic provider. CTM UHB Orthotics continues to support student placements, primarily for learners from the local area, helping to promote awareness of the profession and support future workforce development.

Developing and Transforming Our Current Workforce

Physiotherapy - Healthcare Support Worker training

There have been no further assessors trained in 2026 due to positive discussions with Apprenticeship Academy and ACT and a forthcoming transition to external provision of the full Agored Diploma programme. This will be re-evaluated later in the year to assess whether further assessor training will be required. Coordination of the programme will sit with ACT, with the delivery of training split between Physiotherapy, OT and the external provider dependent on the requirement for professional status of each unit. 10 HCSWs are ongoing on the full diploma programme progressing towards a target completion date of 31st March 2026, with 5 HCSWs transitioning to registration with ACT from September 2026. There are 2 remaining HCSWs progressing towards a target completion date of 31st March 2026 with the standalone credits programme.

There have further challenges in terms of disruption due to business continuity, resulting in delays for both learners and assessors. There has been closer scrutiny with reporting of progress with the HEIW/HCSW funding meetings hosted by Nursing education.

Mapping of Submission of learning units and number of assessors within the delivery of the Agored Cymru Level 3 Diploma in Physiotherapy Support Qualification

Numbers	Pre-2023	2023	2024	2025	2026
Registrations	19	4	1	4	5
Total Ongoing	14	18	19	20	12
Completed Diploma	0	1	0	5	0
Eligible for 25 credits, Access to Level 4	0	4	0	5	1
Enrolling for 25 credits, Access to Level 4	0	0	3	2	0

	Pre 2023	2023	2024	2025	2026	2026 Standalone (to date)	2026 Diploma (to date)	2026 Projected Total Standalone	2026 Projected Total Diploma
Credits Submitted for Certification	0	122	166	0	75	34	41	72	392
Active Assessors	7	18	18	20	20	20			
Newly Trained Assessors	11	12	1	0	0	0			

Occupational Therapy- Healthcare Support Worker training

The OT service continues to actively support OT support worker training. There are a total of 27 Agored learners working in Band 3 and Band 4 roles across the OT Service:

- Cohort 3 – there are 4 learners remaining with outstanding units to complete
- Cohort 4 there are a total of 14 learners – 10 are undertaking the full Agored and 4 completing the partial
- Cohort 5 there are a total of 9 learners – 4 are undertaking the full and, 5 are undertaking partial
- In 2025/26 a total of 62 units were certified for OT learners

OT service continues to have a Principal OT who is the Lead for both Agored and Pre-registration education, but this is not a dedicated role. Therefore, all Principal OTs also offer additional support as required to learners, assessors, students and supervisors in their own teams and services.
Both Agored and Pre-registration Education are standing items on the OT Service monthly Governance meeting agenda to ensure the entire OT Leadership Team always remain engaged and up to date on all pertinent issues.

The OT service has continually monitored and regularly reviewed the number and availability of our assessors and educators across the OT Service so that we can meet the needs of pre-registration students and our Agored learners in all areas.

Training and Development: AHP services support ongoing professional development through job planning, allocated SPA time, CPD opportunities, conferences, further education, and HEIW-funded Master's and Advanced Practice programmes. Development is aligned to PDR objectives and includes induction, rotational programmes, ACP pathways, clinical supervision, and wellbeing initiatives.

Supportive Work Environment: A strong focus on staff wellbeing, effective leadership, robust induction processes, competency frameworks, and access to Health Board leadership and management programmes helps foster a positive and inclusive workplace culture.

Developments across AHPs

AHPs also sit on the newly established Harm-Free Care Education Operational Group. The purpose of this group is to ensure education and training initiatives are aligned with national standards; local policies are in place to ensure best practice is promoted within the Health Board. This workstream will support the work aligned to the CTM UHB Strategy by focusing on living well and ageing well. This group will support the design and implementation of a training programme specifically targeted at the Harm Free Care agenda.

Recruitment and Retention: AHP services continue to promote careers through recruitment campaigns, recruitment events, and innovative retention initiatives such as the Band 3 AHP HCSW lateral moves scheme. Service-specific action plans informed by NHS Staff Survey results further support workforce engagement and retention.

Together, these initiatives help attract, develop, and retain a skilled and motivated AHP workforce across CTM UHB.

Creating a culture of Interprofessional learning

The next induction session for all AHP staff who have joined the Health Board since November 2025, including both registered and non-registered staff, will take place this autumn (see Appendix 5 for the programme)

At CTM UHB multi-professional education, development and communication are embedded within everyday practice and underpin collaborative working across professions and services.

Therapy Services actively participate in and contribute to the wider Interprofessional Education (IPE) programme across the organisation. Examples of recent contributions include:

- **Audiology** delivering teaching sessions to support staff in managing common hearing aid issues.
- **Podiatry** providing interprofessional learning opportunities within clinical settings.
- **Dietetics and Speech and Language Therapy (SLT)** facilitating learning experiences within oncology clinics.

- **SLT** delivering training on difficult conversations and communication skills.
- **Psychology** leading awareness and educational sessions.
- **Occupational Therapy (OT)** offering shadowing opportunities to colleagues from other professions.

Looking ahead, Dietetic and Occupational Therapy representatives will attend the HEIW Online Conference, "Realising Interprofessional Education Placements in Wales", on 15 September 2026. Learning and best practice from the event will be shared with the wider AHP workforce to support continued development of interprofessional learning opportunities across CTM UHB .

Alongside profession-specific education, AHP teams continue to make a significant contribution to interprofessional education through close collaboration with the Clinical Learning Academy and wider education teams. Dietetic staff have supported the delivery of educational programmes for nursing staff, Allied Health Professionals and the wider multidisciplinary workforce, promoting collaborative learning, enhancing understanding of professional roles, and supporting the delivery of high-quality patient care.

Focus on Pharmacy

Developing our Future Workforce

Pharmacy teams across CTM UHB have continued to support widening access and promote careers in pharmacy through participation in university open days, school careers events, national online careers programmes and work experience placements across primary and secondary care. Working with the Clinical Education and Learning & Development teams, bilingual careers resources have been developed to raise awareness of NHS career opportunities, and pharmacy has contributed to a multidisciplinary approach to careers promotion, ensuring young people receive information on the breadth of healthcare careers available. Work is also underway to increase engagement with younger pupils and expand multidisciplinary work experience opportunities.
These activities strengthen CTM UHB's future workforce pipeline by increasing awareness and accessibility of pharmacy and wider NHS careers among local young people. Early engagement, targeted outreach and high-quality work experience opportunities support recruitment, social mobility and workforce sustainability, helping to attract and develop the future healthcare workforce required to meet the Health Board's long-term service needs.

Pharmacy Undergraduates

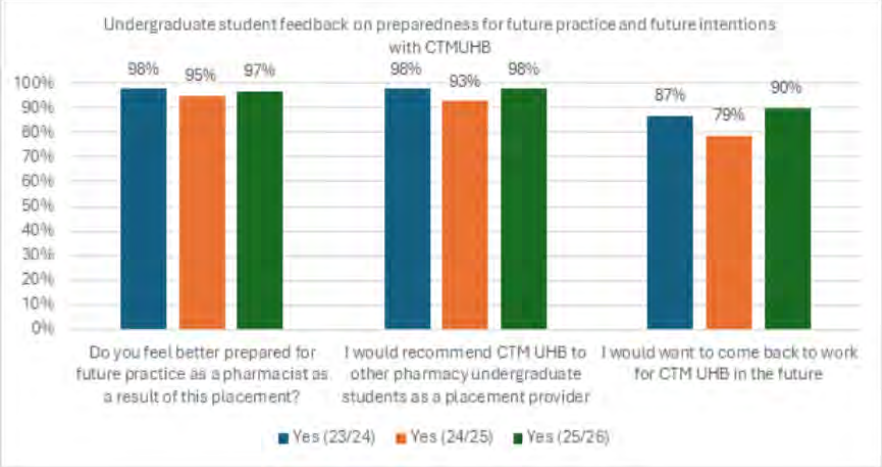
At the start of 2025/26, CTM UHB committed to providing **340 secondary care** and **20 primary care pharmacy placement weeks**. Following placement capacity challenges across Wales, the Health Board reviewed its provision and increased capacity to deliver **380 secondary care** and **20 primary care placement weeks**, ensuring students could access essential experiential learning opportunities.
In addition, standardised induction and placement review resources were introduced, and the undergraduate placement workbook was updated in response to student feedback, enhancing the overall placement experience.

Results in 2025/26 showed that:

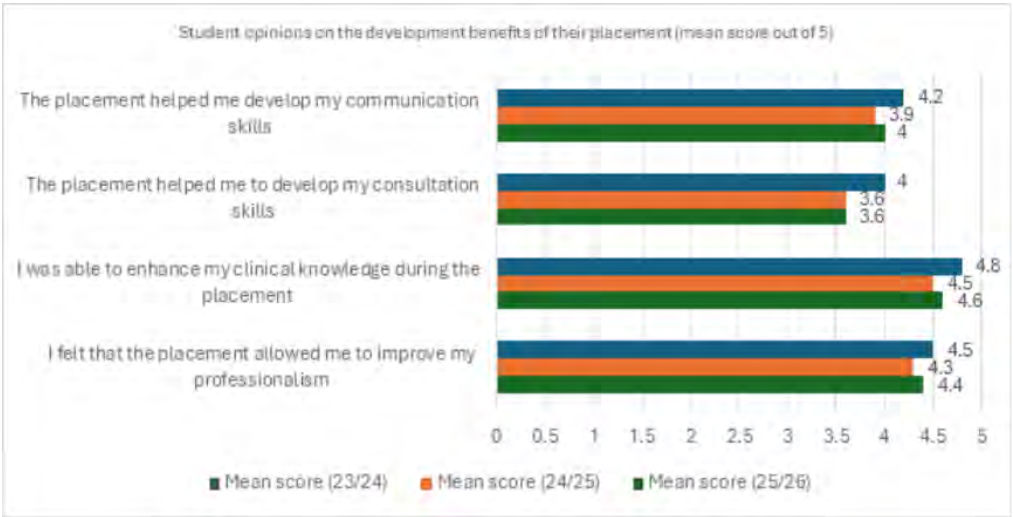
- 97% of students felt better prepared for future practice. This was an increase from 95% in 2024/25.
- 90% expressed interest in returning to work at CTM UHB. This was an increase from 79% in 2024/25.
- 81% of students found the workbook beneficial as it helped them to understand, plan and evidence their learning outcomes and Entrustable Professional Activities. This was an increase from 74% in 2024/25.
- 80% of staff found the induction slide deck useful, helping them feel better prepared to act as a practice supervisor.

The graphs below illustrate the responses;

Undergraduate placements: Student results – Preparedness for future practice 23/24 – 25/26

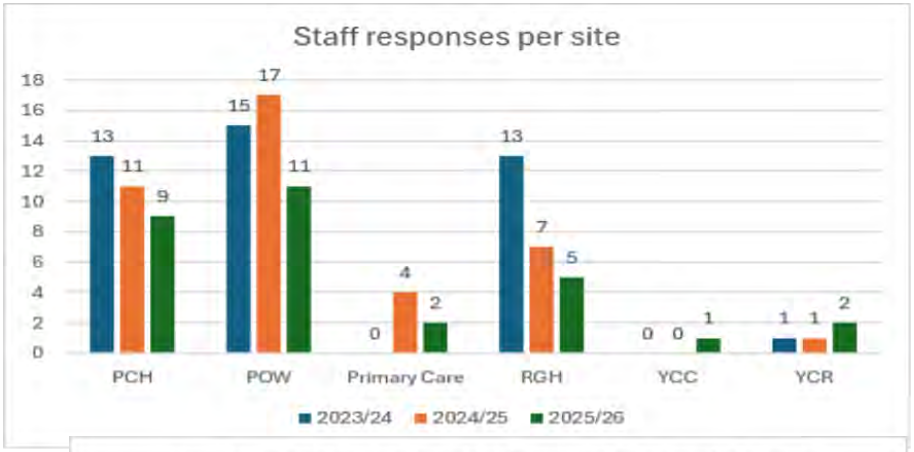


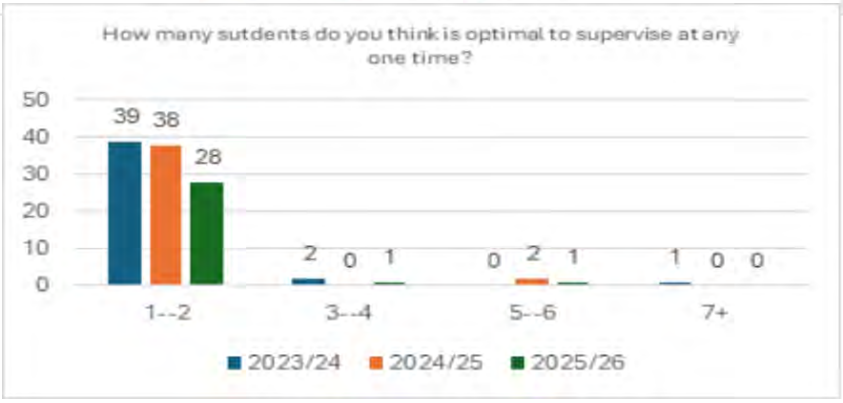
Undergraduate placements: Student results – Skills scores



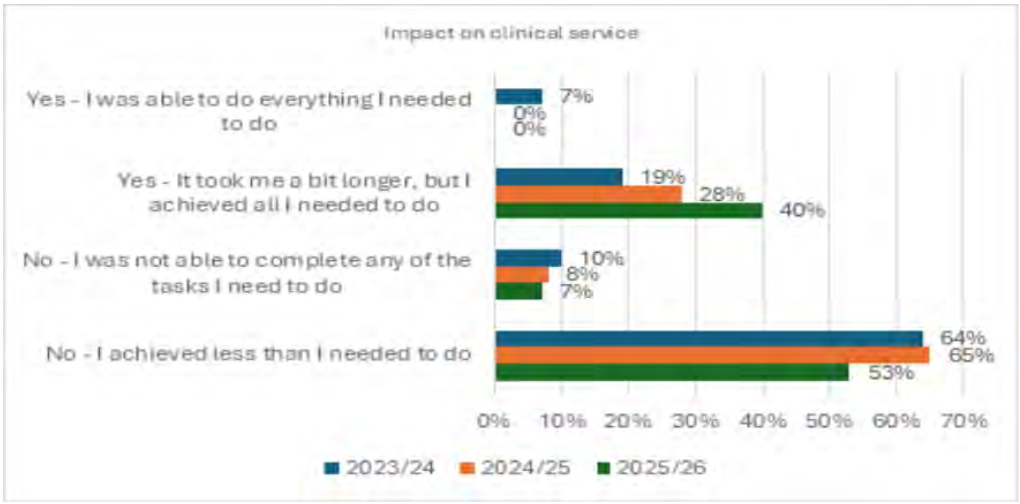
Staff results

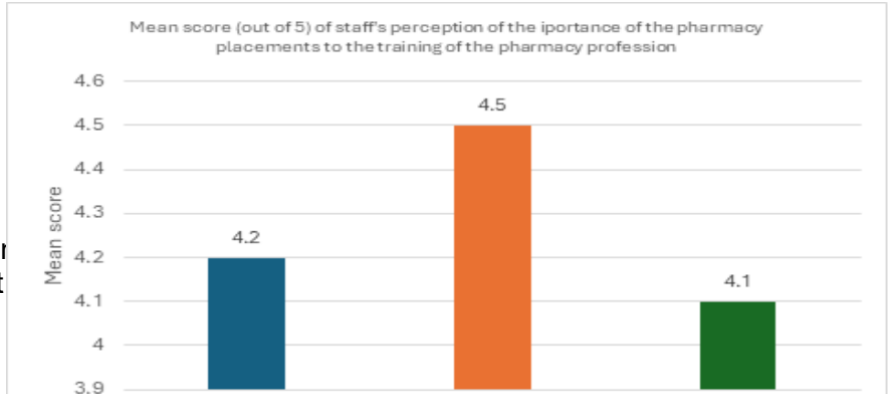
Undergraduate placements: Staff responses per site 23/24 – 25/26





Undergraduate placements: Staff results – Impact on clinical service





Outcome and Impact of Changes

Future Pharmacy Workforce

Placements continue to play a key role in workforce development, with **90% of students** reporting they would consider working for CTM UHB in the future, up from **79% in 2024/25**, highlighting the value of positive placement experiences in supporting recruitment and retention.

Developing Future Independent Prescribers

With the first pharmacists qualifying as independent prescribers at registration in August 2026, placements provide essential exposure to clinical practice, multidisciplinary working, and prescribing, helping students transition confidently into practice.

Embedding Placements into Pharmacy Practice

Placements are increasingly integrated into pharmacy services, with **97% of students** reporting they felt better prepared for future practice. Staff also recognised the importance of placements, reflecting a growing culture where education and workforce development are embedded within service delivery.

Organisational Impact

By providing an additional **40 secondary care placement weeks** above its agreed allocation, CTM UHB helped address placement pressures across Wales and ensured students continued to access the experiential learning required to meet GPhC standards. This demonstrates the Health Board's commitment to supporting the future pharmacy workforce.

Developing and Transforming our Current workforce

Pharmacy Assistant Technical Officer (ATO) Development

CTM UHB continues to invest in the development of its pharmacy support workforce, creating clear career pathways and enabling staff to work at the top of their scope of practice.

During 2025/26, 10 Pharmacy Assistants across the Health Board's three acute sites completed the new HEIW Medicines Management qualification. This programme equips staff with the knowledge and skills to become integral members of ward-based pharmacy teams, supporting medicines management activities and enhancing patient care.

Early benefits in areas where qualified Pharmacy Assistants are working on wards include reduced medicines waste, fewer dispensing-related tasks and increased capacity for Pharmacy Technicians to undertake patient counselling and support specialist services such as cardiac rehabilitation.

To support future workforce progression, three Pharmacy Assistants completed Access to Higher Education courses in Maths, English and Science, creating opportunities to progress to Pharmacy Technician training. A further three staff will enrol on the Science pathway in September 2026.

Work is also underway to introduce the Final Accuracy Checking qualification for Pharmacy Assistants in partnership with Pharmacy Workforce Development South (PWDS). Following final approval of supporting documentation, three Pharmacy Assistants are scheduled to enrol in October 2026. This development will support a future dispensary workforce model in which Pharmacy Assistants undertake dispensing and final accuracy checking activities, releasing Pharmacy Technician capacity for more clinically focused roles.

The department continues to maximise HEIW Healthcare Support Worker funding to support workforce development. Currently, six Pharmacy Assistants are undertaking the Buttercups Level 2 qualification, with a further six due to enrol before the end of 2026. This qualification ensures staff meet General Pharmaceutical Council requirements while developing the knowledge and skills necessary for safe and effective practice.

Impact

- Increased workforce capability and career progression opportunities.
- Greater utilisation of support staff within ward-based services.
- Enhanced capacity for Pharmacy Technicians and Pharmacists to undertake advanced clinical activities.
- Improved medicines management, efficiency and patient experience.

Pharmacy Technician Workforce Development

The Pharmacy Technician workforce continues to play an increasingly important clinical role across CTM UHB.

During 2025/26, 16 Pre-registration Pharmacy Technicians undertook the two-year Level 4 University of East Anglia qualification across Royal Glamorgan Hospital, Prince Charles Hospital, Princess of Wales Hospital and HMP Parc.

CTM UHB remains at the forefront of technician development in Wales through participation in the PWDS Enhanced Clinical Practice for Pharmacy Technicians qualification. This programme enables Pharmacy Technicians to undertake patient reviews and clinical prioritisation activities, supporting pharmacists and wider multidisciplinary teams to focus on patients with the greatest clinical need.

To date, **12** Pharmacy Technicians have completed the programme, working across Emergency Medicine, General Medicine, Maternity, Frailty and Surgical services. A further eight staff are currently enrolled, with the ambition for all Band 5 Pharmacy Technicians to undertake the qualification over the coming years.

The success of this innovative role development has received national recognition. Pharmacy Technicians have shared their experiences at national and regional events, including the Clinical Pharmacy Congress North and APTUK Welsh Branch meetings, highlighting CTM UHB's leadership in workforce transformation.

Further educational achievements during the year included qualifications in:

- Intensive Care
- Education and Training
- Leadership Development
- Analgesic Stewardship
- Mental Health First Aid

In addition, three senior Pharmacy Technicians are undertaking a MSc Leadership and Management with the University of South Wales.

Two Pharmacy Technicians successfully completed the HEIW 3D Leadership Programme, further developing their leadership, communication and project management skills, and presented their improvement projects in Cardiff in June 2026.

Homecare services have also benefited from workforce development, with one Pharmacy Technician completing and two currently undertaking the PWDS Prescription Validation qualification, enabling appropriately trained staff to validate prescriptions and release Pharmacist capacity for clinical activities.

Impact

- Expanded clinical contribution of Pharmacy Technicians.
- Increased workforce flexibility and service resilience.
- Greater capacity for Pharmacists to undertake independent prescribing, clinics and medicines optimisation.
- Enhanced multidisciplinary working and improved patient safety.
- Development of future advanced practice and leadership roles.

Trainee Pharmacists

During 2025/26, 19 Trainee Pharmacists successfully completed the HEIW Multi-Sector Foundation Trainee Pharmacist Programme across CTM UHB's three acute hospital sites.

The programme included multi-sector placements and a six-month prescribing placement, enabling trainees to achieve the competencies required for registration as Pharmacist Independent Prescribers (IPs).

The cohort achieved a 100% pass rate in the prescribing component, ensuring all trainees completing the prescribing pathway will join the General Pharmaceutical Council register as Independent Prescribers.

The programme is coordinated by a dedicated Training Programme Director, employed by CTM UHB and funded through HEIW, who oversees programme delivery, educational supervision, quality assurance and multi-sector collaboration.

Impact on Workforce and Patient Care

The introduction of pharmacists registering as Independent Prescribers represents a significant advancement in workforce capability and supports the national vision for pharmacist prescribing across Wales.

Newly registered pharmacists are entering practice with prescribing capability, consultation skills, clinical assessment expertise and supervised prescribing experience, allowing them to contribute more rapidly to patient-facing clinical services.

Key benefits include:

- Increased clinical workforce capacity.
- Enhanced medicines optimisation and antimicrobial stewardship.
- Reduced delays in treatment and discharge processes.
- Greater pharmacist involvement in prescribing decisions and patient management.
- Improved support for multidisciplinary prescribing models.
- Development of future advanced practitioners, consultant pharmacists and Designated Prescribing Practitioners (DPPs).
- Stronger recruitment, retention and workforce sustainability through clear clinical career pathways.

The programme also supports service transformation by creating opportunities for pharmacist-led models of care across medicines optimisation, outpatient services, specialty teams and discharge prescribing pathways, ultimately improving patient outcomes and service efficiency across CTM UHB.

Creating a culture of Interprofessional learning

Pharmacy and Medical Undergraduate Interprofessional Learning

To improve prescribing practice and patient safety, the Pharmacy team delivered 10 prescribing education sessions for Year 5 medical students, alongside sessions for F1 and F2 doctors during induction and throughout 2024/25.

A pilot interprofessional learning session at Princess of Wales Hospital brought together Year 5 medical students and trainee pharmacists to work through prescribing scenarios. Feedback highlighted increased confidence, improved understanding of prescribing processes, enhanced interprofessional collaboration, and the value of practical, pharmacy-led teaching in promoting safer prescribing. Future plans include earlier placement delivery and adaptation for electronic prescribing.



Looking Ahead for 2026/27

The introduction of Independent Prescribing at registration represents a significant advancement for the profession but also presents several workforce and educational challenges, including:

- Continuing to upskill the existing pharmacist workforce.
- Building sufficient DPP capacity across all sectors.
- Balancing service delivery requirements with prescribing training demands.
- Expanding prescribing opportunities within specialist clinical areas.
- Supporting the development of multidisciplinary prescribing models.
- Managing workforce and service risks associated with trainee progression and qualification outcomes.

Focus on Medical Education

Developing Our Future Workforce

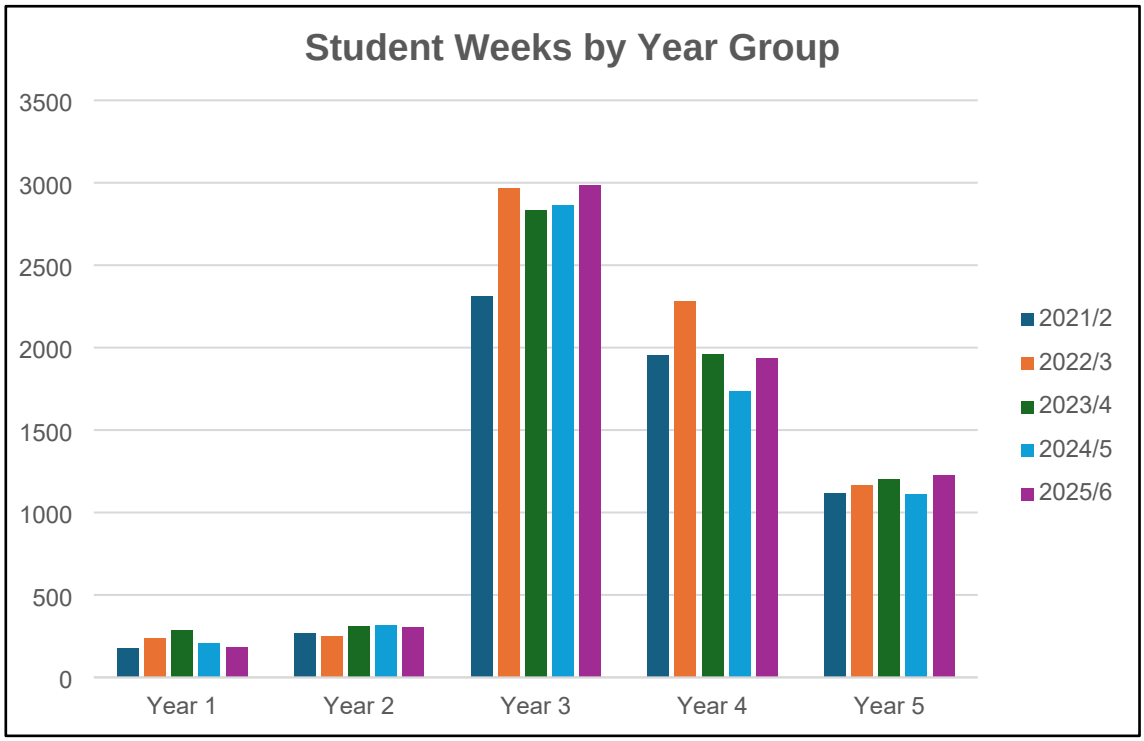
Medical Education continues to play a central role in developing the future workforce through the delivery of high-quality undergraduate and postgraduate medical education.

Despite what has been a challenging academic year for our undergraduate teams, we have continued to deliver a high-quality educational experience across CTM. On-going service reconfigurations across the Health Board requires considerable agility from both our educational and administrative teams.

Student data for 2025/26 is compared below with the previous academic year:

Year of Study	No. of Students					No. of Student Weeks				
	2021/22	2022/23	2023/4	2024/5	2025/6	2021/22	2022/23	2023/4	2024/5	2025/6
1	113	108	120	128	114	180	238	288	205	182
2	222	227	219	263	252	266	250	308	316	302
3	289	371	355	356	369	2312	2968	2836	2867	2985
4	262	320	245	217	242	1952	2284	1960	1736	1934
5	140	154	159	148	164	1120	1164	1200	1111	1229
ALL	1026	1180	1098	1112	1141	5830	6904	6592	6235	6632

The fluctuations in student weeks by year groups over the last 5 academic years is compared below:



This data demonstrates that the average number of student weeks in this period is 6438. This year we have been 200 weeks higher, last year we were 200 weeks lower, so overall the trend in the numbers is relatively static, rather than showing any increase.

During 2025/26, learner satisfaction remained exceptionally high, with overall undergraduate student satisfaction of 96% and several placements achieving 100% positive feedback

RGH placements for Y3 to Y5 (367 students) scored 99% positive, with just one student's evaluation preventing a 100% score;

- POW placements for Y1 to Y5 (499 students) scored 97% positive, with just 4 student evaluations preventing a 100% score;
- Phase 1 teaching across CTM scored 100% feedback;
- Of 51 placements evaluated pan-CTM (Y1 to Y5), 41 scored 100% student satisfaction; and

Child Health, Women's Health, Psychological Medicine and Y5 Senior Student Assistantship placements all scored 100% student satisfaction.

Strategic educational leadership was strengthened through the appointment of pan-CTM Honorary Senior Lecturers in Psychological Medicine and Surgery/Oncology, ensuring educational provision remains responsive to service transformation and workforce needs. The continued success of the Clinical Teaching Fellow programme further enhances the learning experience while supporting future recruitment and retention within CTM UHB.

The Education and Development Conference, Grand Round programme, and enhanced induction processes have provided valuable opportunities for resident doctors to develop leadership, quality improvement, research and educational skills. Positive feedback from resident doctor induction demonstrates the impact of these improvements and supports trainee integration into the organisation.

Widening access activities continue to support the long-term development of the future workforce. Working in partnership with local authorities and schools, Medical Education has implemented a targeted workplan to raise awareness of healthcare careers and improve access to medical education opportunities (see appendix 6 for workplan) A notable achievement this year was that all places on the Medical and Dental Work Observation Programme were allocated to learners residing within the CTM UHB area, demonstrating growing local engagement and aspiration. In addition to this Medical Education worked in collaboration with Nurse Education/AHP colleagues to develop and facilitate a Mini Work Observation week for aspiring healthcare professionals.



In 2026/27, this strategic aim will be further supported through the objective to **enhance engagement with resident doctors through a multi-level approach**, including the introduction of specialty and site-based resident doctor forums, continued development of induction processes, and extension of support to locally employed doctors. These initiatives will strengthen the learner voice, improve training experiences and support workforce retention.

Developing and Transforming Our Current Workforce

A key focus during 2025/26 has been strengthening the capability, support and engagement of educators and trainers across the Health Board. Following a comprehensive trainer survey, targeted actions were implemented to improve communication, visibility of development opportunities and educator engagement. The introduction of the termly Medical Education Newsletter and monthly pan-CTM Grand Rounds has created accessible platforms for continuing professional development and sharing educational best practice.



Significant transformation has also been achieved in simulation and clinical skills education. The transition from a site-based model to a coordinated Health Board-wide approach has enabled a more strategic and sustainable programme, supported by a defined Simulation Faculty. This has facilitated the expansion of simulation activity, development of train-the-trainer programmes, and increased provision of human factors and patient safety training. Annual educational events, including Educational Supervisor Development Days, the TED (Training, Education and Development) Conference and HEIW Professional Support Unit workshops, continue to support educator development and workforce capability.



Recognising that educator capacity remains constrained by competing service demands and limited time within job plans, a key objective for 2026/27 is to **further develop trainer support and development through improved evaluation, governance and recognition of educator roles**. This will include the development of best-practice guidance for job planning, strengthening recognition of educational activity and ensuring trainers are appropriately supported to fulfil their educational responsibilities.



Establishing Underpinning Processes for Education Quality, Governance and Assurance

A major achievement during the year has been the development and formal approval of the Medical Education Governance Framework, aligned to the GMC's *Promoting Excellence* standards. The framework establishes clear governance structures, defined roles and responsibilities, and transparent escalation pathways, strengthening educational oversight and accountability across CTM UHB.

Implementation of the framework has improved alignment between educational and clinical governance systems, enhanced organisational consistency and supported succession planning. Embedding the framework through faculty meetings, induction programmes and

wider organisational processes has increased awareness and accessibility among trainers, resident doctors and key stakeholders.

Robust quality assurance processes continue to support educational delivery. The Faculty Team maintains oversight of educational risks through regular monitoring and engagement with HEIW, while strengthened triangulation between Medical Education, Care Groups and the Medical Director has improved the management of educational concerns and facilitated timely interventions where required.



Building on these foundations, the 2026/27 objective to strengthen evaluation mechanisms, enhance governance arrangements for trainer development, and improve monitoring of resident doctor engagement will further support CTM UHB's commitment to educational quality, governance and assurance.

Developing a Culture of Interprofessional Learning

Significant progress has been made in embedding a culture of interprofessional learning across CTM UHB. The move to a coordinated Health Board-wide simulation model has expanded participation beyond resident doctors to include a broader range of healthcare professionals, creating opportunities for shared learning, multidisciplinary teamwork and human factors development.

The Education and Development Conference has further supported collaborative learning by bringing together educators, resident doctors and healthcare professionals to showcase innovation, quality improvement and educational practice. Similarly, Grand Rounds provide regular opportunities for knowledge exchange across specialties and professional groups, strengthening a shared culture of learning and improvement.

A key objective for 2026/27 is the establishment of a **Health Board-wide Simulation Faculty**, including the identification of faculty members, clarification of roles and responsibilities, and mapping of simulation activity across CTM UHB. This work will support

the expansion of interprofessional simulation training, identify opportunities for collaborative learning, and ensure a consistent and equitable approach to simulation-based education across all sites.

Through continued investment in simulation, educator development, learner engagement and governance, Medical Education is well positioned to support the development of both the current and future workforce while embedding a strong culture of continuous improvement and interprofessional learning across CTM UHB.

Looking ahead

Priorities for 2026-27 include;

- Consolidate and sustain widening participation and outreach activities embedded within the Medical Education Team's workplan.
- Strengthen partnership working with Cardiff University's Widening Access to Medicine Mentoring (WAMMS) team and the HEIW Foundation School to support aspiring medical students across CTM UHB.
- Continue to provide learners with guidance and support for entry to medical school, helping to develop a diverse future workforce.
- Build on strengthened operational processes and collaborative working to ensure the continued delivery of high-quality undergraduate medical education.
- Enhance departmental induction, resident doctor engagement, and evaluation of educational initiatives.
- Develop a more consistent Health Board-wide approach to simulation and trainer development, while improving equitable access to educational opportunities across specialties.
- Maintain a strong focus on educational governance, quality improvement, and learner experience.

Advanced and Extended Practice

CTM UHB continues to invest strategically in advanced and extended pharmacy practice through HEIW Advanced and Extended Practice funding. For 2025-26, funding has supported:

- Five pharmacist distance-learning diplomas
- One MSc in Healthcare Leadership (University of South Wales) for a Pharmacy Technician
- Cardiff University Credit Accumulator modules supporting enhanced and advanced credentialing pathways
- One Antimicrobial Stewardship course
- Two University of East Anglia clinical diplomas (Levels 4 and 5) for Pharmacy Technicians

Investment priorities were agreed with the Senior Pharmacy Leadership Team and aligned to workforce need, including strengthening Band 6 development, expanding independent prescribing capability, increasing the number of Advanced Clinical Pharmacists, developing Pharmacy Technicians in clinical roles, enhancing supervision capacity, and supporting staff to work at the top of their scope of practice.

Evaluation of the 2024/25 HEIW-funded programmes, undertaken in collaboration with Clinical Education, demonstrated a positive impact at individual, departmental and organisational levels. Thirteen pharmacists participated in advanced practice programmes, with 80% reporting enhanced specialist practice, improved clinical decision-making, stronger multidisciplinary working, increased medicines optimisation skills and greater preparedness for independent prescribing roles.

To strengthen critical care capability and resilience, pharmacists and Pharmacy Technicians have also undertaken, or are currently undertaking, United Kingdom Clinical Pharmacy Association (UKCPA) Critical Care training.

Impact

Investment in advanced practice has strengthened CTM UHB's clinical workforce capability, enabling pharmacists to deliver timelier, evidence-based and patient-centred care. It has enhanced prescribing practice, supported service redesign, improved multidisciplinary leadership and contributed to the development of the future advanced and consultant pharmacist workforce, supporting both succession planning and organisational resilience.

Education & Training governance

Independent Prescribing and Workforce Planning

A workforce mapping exercise completed across secondary care, primary care and prison pharmacy services provided the first comprehensive assessment of the Medicines Management workforce and established a baseline to inform future workforce planning and training priorities.

Analysis of the secondary care workforce highlighted significant progress in Independent Prescribing (IP) capability. As of 2025/26, 78% of Band 7 pharmacists and above in patient-facing roles were actively using their IP qualification, with those not yet qualified either undertaking or scheduled to undertake training through HEIW-funded development pathways.

With trainee pharmacists now registering as Independent Prescribers, there is an increasing requirement for appropriately qualified DPPs to supervise and assess prescribing competency. Workforce analysis identified 23 pharmacists across the three acute sites who met the criteria to undertake the DPP role.

To support this expanding requirement, pharmacists have undertaken Royal Pharmaceutical Society DPP training, and plans are underway to establish a CTM Pharmacy DPP Peer Support Network to strengthen professional support, governance and sharing of best practice.

Impact

Expanding the number of pharmacist Designated Prescribing Practitioners has increased CTM UHB's capacity to support prescribing education and training. This reduces reliance on medical supervisors, strengthens pharmacy-led workforce development, and helps ensure a sustainable pipeline of future pharmacist prescribers across the organisation.

Addressing these challenges will remain a key priority as CTM UHB continues to develop a highly skilled, sustainable and future-focused pharmacy workforce capable of meeting the evolving needs of patients and service

Focus on Psychology and Psychotherapy Professions

Developing Our Future Workforce

During 2025/26, CTM UHB's Psychology and Psychotherapy Professions (PPPs) made significant progress in developing a strategic plan aligned with Building Healthier Communities Together. Co-produced across the 14 psychology and PPPs, the plan outlines how the workforce will contribute to Creating Health, Inspiring People, Improving Care, and Sustainability.

A key focus is recognising the workforce as the foundation of effective healthcare delivery. By supporting a skilled, motivated and connected workforce, the professions aim to strengthen collaboration, promote psychologically informed care, and improve outcomes for patients, communities and staff. The principle of "inspired people inspire people" remains central to this approach.

Developing and Transforming Our Current Workforce

A major achievement during 2025/26 was the establishment of the **Psychology and Psychotherapy Professions Network** and the development of a profession-wide strategic plan aligned to CTM UHB priorities. Engagement events involving more than 50 professionals from across the psychology and psychotherapy workforce identified shared values and priorities, including workforce development, psychologically and relationally informed care, prevention and early intervention, sustainability, and outcome measurement. A professional leadership framework has also been drafted to support collaborative leadership and career development across all professional groups.

The network aims to develop a skilled, connected, and well-supported workforce that can maximise its contribution to the health and wellbeing of local communities. Through stronger collaboration with colleagues across CTM UHB, partner organisations, and local communities, the professions are helping to build workforce capability, support innovation, and deliver high-quality, person-centred care.

Key priorities include:

- Promoting the value and impact of psychology and psychotherapy expertise across healthcare and multi-agency systems.
- Maximising workforce potential through training, professional development, leadership opportunities, and recognition of professional contributions.
- Supporting multidisciplinary colleagues through education, consultation, and the application of psychological knowledge and skills to improve care.
- Adopting a whole-career approach to workforce development, from early education and professional training through to senior leadership.
- Strengthening collaboration across services and communities to support joined-up, person-centred care and improve population health outcomes.

Psychology Matters @ CTM

Throughout 2025/26, CTM UHB has contributed to the **British Psychological Society Psychology Matters** campaign, highlighting the breadth, impact and future potential of psychology and psychotherapy across our communities. This work shares the contribution our professions make across the lifespan and across services, from prevention and early intervention to specialist care. It also strengthens partnerships with communities, multi-agency colleagues and wider professional networks, raises the profile of psychology and psychotherapy, and inspires future interest in careers across the professions.
You can read about this work here: Psychology Matters: A series with Cwm Taf Morgannwg University Health Board | BPS

Annual Winter Conference

Looking ahead, the 2026 PPP Network Winter Conference, delivered in partnership with USW, will bring together practitioners, students, academics and aspiring professionals to share learning, strengthen networks, and explore innovation across practice, education and research. Aligned to the theme Building Healthier Communities Together, the event will support implementation of the PPPs Strategic Plan through presentations, workshops, posters and collaborative discussions.

HEIW Strategic Plan for Mental Health Workforce Implementation

- 15 PPPs working with children, young people and families completed HEIW-funded Level 2 Dyadic Developmental Psychotherapy (DDP) training, expanding trauma-informed and attachment-focused therapeutic provision within CTM UHB.
- Through HEIW-funded training, eight trainees completed the Cardiff University PG Certificate in Cognitive Behavioural Therapy (CBT) and four trainees completed the PG Diploma. To support learning, CTM UHB developed an internal introductory training programme. During 2026/27, work will focus on strengthening governance arrangements and exploring role development opportunities to maximise future clinical capacity.

Establishing Underpinning Processes for Education Quality, Governance and Assurance

CTM UHB supports clinical placements for a range of PPP trainees, with a current focus on strengthening training pathways through clinical placements, trainee supervision,

partnerships with Higher Education Institutions and a local Grow Our Own approach to recruitment and retention. With the exception of the Doctorate in Clinical Psychology and PGCert and Diploma in Cognitive Behavioural Therapy, psychological and psychotherapy professional training in Wales is not HEIW commissioned.

Psychology and Psychotherapy Training Placements

The newly established **Psychology and Psychotherapy Professions Faculty** provides a coordinated approach to governance, education, and workforce development across the psychology and psychotherapy professions.

During 2025/26, CTM UHB supported a wide range of professional training placements:

- **Systemic Psychotherapy:** Through partnerships with the Institute of Family Therapy and the Centre for Systemic Studies Wales , CTM UHB hosts four trainees undertaking supervised placements across adult and child mental health services, providing valuable experience in family and systemic practice.
- **Health Psychology:** Three trainee Health Psychologists are undertaking Professional Doctorate training with the University of the West of England, supported through HEIW funding and integrated within the Health Psychology and Public Health teams.
- **Art Psychotherapy:** CTM UHB continues to host placements for University of South Wales trainees, with three final-year trainees due to undertake placements across Adult and Older Adult Mental Health Services from September 2026. Several former trainees have successfully secured permanent roles within the Health Board.
- **Clinical Psychology:** Placements continue across all years of the South Wales Doctoral Programme in Clinical Psychology. A new systemic consultation programme for six second-year trainees has enhanced confidence in systemic practice and strengthened engagement with CTM UHB services.
- **Counselling Psychology:** CTM UHB hosts paid and honorary placements for doctoral counselling psychology trainees and has continued to develop its successful **Grow Your Own** model, supporting recruitment, retention, and career progression within the profession.

These placements play a vital role in developing the future psychology and psychotherapy workforce while strengthening recruitment pipelines and supporting high-quality patient care across CTM UHB.

Following historical recruitment difficulties, CTM became the second Health Board in Wales to develop a Grow Your Own pathway for counselling psychologists, demonstrating its commitment to staff development and retention. The programme has been highly successful: the first cohort of trainees is due to qualify this winter, and it is anticipated that they will secure substantive roles within the health board.

Creating a Culture of Interprofessional Learning

The PPPs play a key role in developing a psychologically informed organisation by sharing expertise through consultation, supervision, training, reflective practice and leadership. This supports trauma-informed care, staff wellbeing, service improvement, and strengthens the capability of the wider multidisciplinary workforce across CTM UHB.

Interprofessional Learning Highlights

Building Reflective Capacity in Child and Adolescent Mental Health Service (CAMHS) Psychology and psychotherapy colleagues have supported multidisciplinary teams across Community CAMHS through reflective practice, consultation and supervision. During 2025/26 this included:

- 92 consultation sessions
- 961 clinical case discussions
- 372 supervision and reflective practice sessions
- 46 hours of training
- 1,471 indirect psychological interventions

CAT-Informed Practice in Adult Mental Health
HEIW-funded Cognitive Analytic Therapy (CAT) training was delivered to approximately 60 multidisciplinary staff across community and acute mental health services. The programme strengthened trauma-informed care, communication, reflective practice and team working. Reflective practice groups have since been established across Community Mental Health Teams (CMHT) and acute settings, with a further 120 staff planned to receive training in 2026/27.

Behavioural Science for Service Improvement
A new Behavioural Science Team has been established to support service improvement, behaviour change initiatives and workforce development. The team provides training and support to Health Board, third sector and voluntary sector partners, as well as student nurses and midwives, helping embed behavioural science principles into everyday practice.

Storytelling for Health
CTM UHB continues to work in partnership with the University of South Wales Centre for Storytelling, co-hosting the International Storytelling for Health Conference and contributing to research, education and reflective practice initiatives that support health and wellbeing.

Focus on Healthcare Science Workforce

Developing Our Future Workforce

Healthcare Science (HCS) services continue to play a vital role in developing a skilled, sustainable workforce across CTM UHB through education, training, widening access initiatives and career development opportunities.

During 2025/26, Healthcare Science departments supported learners across a range of educational pathways, from work experience and apprenticeships through to Practitioner Training Programmes (PTP), Scientist Training Programmes (STP), postgraduate education and advanced practice development.

Key Achievements

- CTM UHB welcomed its first Audiology STP trainees through the South Wales consortium model.

- New advanced practice roles were established within Audiology, supporting service development and enhancing career progression opportunities.
- Cardiac and Respiratory Physiology continued to support undergraduate, postgraduate and specialist learners while developing innovative "grow our own" workforce initiatives, including alternative routes into HCS careers.
- Pathology hosted undergraduate HCS students undertaking clinical placements and continued to support Biomedical Scientist training through HEIW-funded educational pathways.
- Radiology expanded workforce development opportunities, including role redesign and targeted career progression initiatives aligned to service transformation priorities.

HCS teams also continued to promote careers across schools, colleges and community events, providing work experience opportunities and raising awareness of the diverse career pathways available within Healthcare Science professions.

Developing and Transforming our Current Workforce

Investment in workforce development remains central to sustaining high-quality Healthcare Science services and supporting future workforce requirements.

During 2025/26, HCS staff undertook a broad range of educational and professional development opportunities, including:

- Advanced Practice and Master's level education.
- Leadership and management development programmes.
- Specialist professional qualifications and accreditation.
- Degree and postgraduate study routes.
- Apprenticeship and support worker development programmes.
- Equivalence and advanced practice pathways supported through HEIW funding.

Across HCS services, a strong emphasis continues to be placed on career progression, succession planning and developing internal talent through a "grow our own" approach.

Examples of significant achievements included:

- Progression of Audiology staff through Advanced Practice, PTP and Higher Specialist Scientist training routes.
- Expansion of specialist training opportunities within Cardiac and Respiratory Physiology.
- Continued investment in Biomedical Scientist education, specialist qualifications and advanced practice pathways within Pathology.
- Ongoing professional development opportunities for Radiology staff, including specialist clinical skills, postgraduate education and leadership development.

Establishing Underpinning Processes for Education Quality, Governance and Assurance

HCS workforce development is underpinned by robust governance arrangements that ensure educational investment is aligned with workforce priorities, service needs and succession planning requirements.

Departments continue to utilise HEIW funding and national HCS frameworks to support:

- Advanced practice development.
- Workforce sustainability.
- Recruitment and retention initiatives.
- Service transformation programmes.
- Future leadership capability.

Governance processes ensure that education and training activity is monitored, evaluated and aligned to departmental workforce plans, enabling CTM UHB to respond proactively to future workforce challenges.

Creating a Culture of Interprofessional Learning

HCS professionals continue to make an important contribution to the interprofessional education agenda across CTM UHB.

During 2025/26, HCS teams delivered and supported a range of multidisciplinary learning opportunities, including:

- Teaching and skills sessions for nursing, medical and allied health professional students.
- Structured interprofessional placement opportunities across diagnostic services.
- Collaborative simulation and educational activities with university partners.
- Participation in Interprofessional Education (IPE) initiatives coordinated through the Clinical Learning Academy.

Pathology also continued its participation in innovative interprofessional learning activities, including simulation-based education focused on the patient journey of a blood sample, bringing together biomedical science and nursing students to enhance understanding of multidisciplinary diagnostic pathways.

Looking Ahead

Priorities for 2026/27 include:

- Expanding access to HCS career pathways and widening participation initiatives.
- Strengthening apprenticeship, degree and postgraduate education routes.
- Maximising opportunities through HEIW-funded equivalence and advanced practice programmes.
- Supporting leadership and succession planning across Healthcare Science professions.
- Increasing interprofessional learning opportunities and collaborative educational activity.
- Continuing to promote HCS careers through engagement with schools, colleges, universities and community partners.

Through these initiatives, HCS services will continue to support delivery of a highly skilled, adaptable and sustainable workforce, contributing to both service excellence and improved patient outcomes across CTM UHB.

Primary and Community Care Academy (PaCCA)

The Primary and Community Care Academy (PaCCA) supports education, training and workforce development across primary and community care services within CTM UHB. Working collaboratively with General Medical Services, community pharmacy, optometry, dental services and wider primary care teams, the Academy supports both clinical and non-clinical staff through education, workforce planning and professional development initiatives. In partnership with the Clinical Practice Educator (CPE) Team, PaCCA plays a key role in developing both the current and future workforce, enhancing professional capability, supporting robust educational governance and quality assurance processes, and embedding collaborative learning across professional and organisational boundaries.

Developing Our Future Workforce

Supporting the future primary care workforce remains a key priority. During 2025/26, PaCCA and the CPE Team continued to promote careers within primary care through careers events, university engagement and student placement opportunities.

Twelve General Practices across CTM UHB now host undergraduate nursing placements, increasing exposure to primary care careers and helping to strengthen future recruitment and retention. Bespoke primary care placements continue to provide learners with valuable insight into the breadth of services delivered within community settings.

The General Practice Nurse (GPN) Foundation Programme has continued to support succession planning and workforce sustainability. Three nurses commenced the programme during 2025/26, building on the success of previous cohorts, all of whom remain employed within their host practices. Additional funding opportunities are being explored to further expand the programme during 2026/27.

PaCCA has also undertaken a comprehensive workforce and skills review across primary care, providing valuable intelligence to inform future workforce planning, education priorities and service development.

Developing and Transforming Our Current Workforce

PaCCA and the CPE Team continue to provide a comprehensive programme of education, training and continuing professional development for the primary care workforce.

Key achievements during 2025/26 included:

- Delivery of accredited education pathways for GPNs and HCSWs.
- Support for progression routes from HCSW roles into registered nursing programmes.
- Provision of annual education programmes for GPNs and HCSWs based on workforce needs and service priorities.
- Ongoing mentorship and support for nurses undertaking academic and professional qualifications.
- Delivery of six Protected Time for Learning (PT4L) events supporting multidisciplinary workforce development across primary care.
- Significant support for the Integrated Women's Health Hub programme, including completion of a training needs analysis involving 105 staff and delivery of 21 multi-professional courses across 29 sessions.

In addition, the Academy continued to deliver its popular "PC Shorts" webinar series, providing accessible educational updates, clinical learning opportunities and governance information to primary care teams across CTM UHB.

Establishing Underpinning Processes for Education Quality, Governance and Assurance

Robust governance arrangements underpin all educational activity delivered through PaCCA and the CPE Team.

Training Needs Analysis, programme evaluation and continuous quality improvement processes are used to inform educational planning and ensure learning activity remains aligned to workforce requirements and organisational priorities.

During 2025/26, enhanced evaluation approaches were introduced using the Kirkpatrick Evaluation Model, enabling greater understanding of the impact of education programmes on professional practice, service delivery and patient outcomes.

The team continues to contribute to local, regional and national workforce development forums, ensuring primary care education remains aligned with Health Board priorities, CTMCLA objectives and national workforce strategies.

Creating a Culture of Interprofessional Learning

Interprofessional learning remains a central principle of the PaCCA

During 2025/26, PaCCA and the CPE Team continued to promote collaborative learning through:

- Multi-professional educational events and webinars.
- Interprofessional student placement opportunities.
- Practice Nurse and Healthcare Support Worker forums.
- Workforce development initiatives involving a wide range of professional groups.
- Collaboration with Higher Education Institutions and Practice Education Facilitators.

The Academy has also played a key role in the development of an All-Wales Multi-Professional Workforce Toolkit, designed to support employers and contractors in developing sustainable, multi-professional teams across primary and community care.

PaCCA continues to support initiatives that strengthen understanding of professional roles, enhance collaborative working and support the delivery of integrated, person-centred care closer to home.

Looking Ahead

During 2026/27, priorities will include further expansion of primary care placement opportunities, continuing development of the General Practice Nurse workforce, strengthening multi-professional education, and utilising workforce intelligence to support future service planning and workforce sustainability across primary and community care.

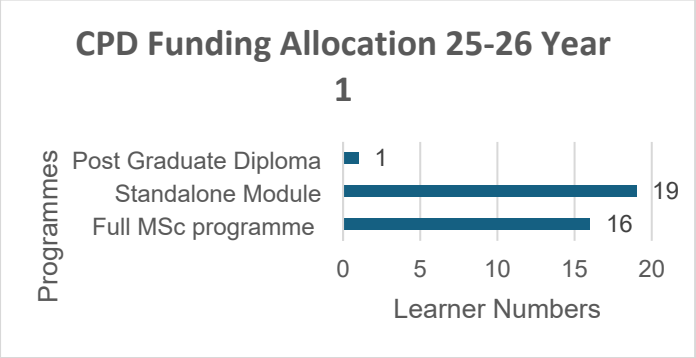
Focus on Continuing Professional Development (CPD) and Advanced Practice Funding

It is essential that continuing education for all staff is aligned to and centred on patient care and service developments. CPD funding can be accessed by nurses and midwives, Advanced Practice funding is available to Nurses, Midwives, AHPs, HCS , the Mental Health Workforce, PaCCA , whilst genomics funding is currently available to all Healthcare Professional groups. Both funding streams are allocated annually by HEIW.

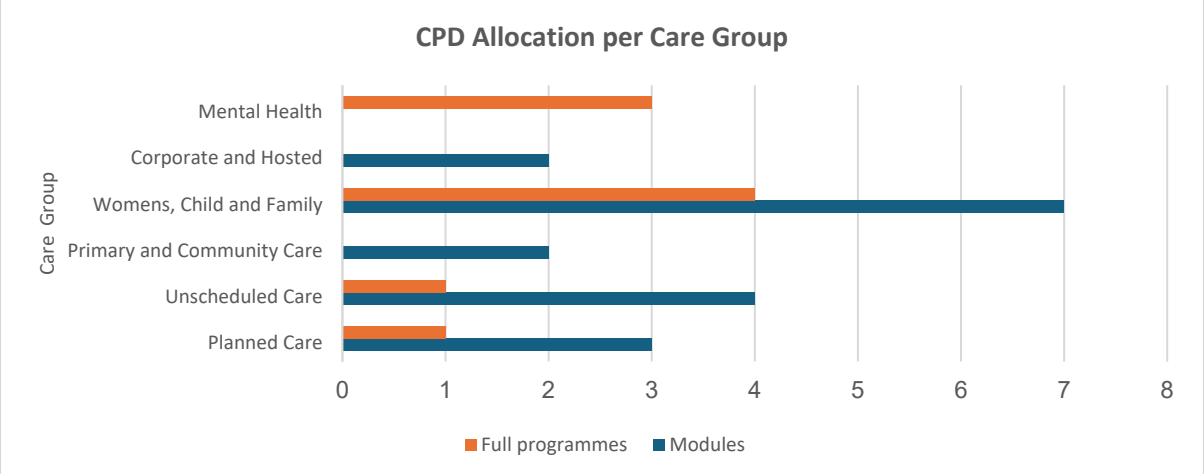
CPD Funding -Nursing and Midwifery

Clinical Education manages utilisation of a funding allocation from HEIW for continuing post-registration education (CPD) for nursing and midwifery. The equivalent of circa. 160 modules were available in 2025/26 via an internal application and allocation process.

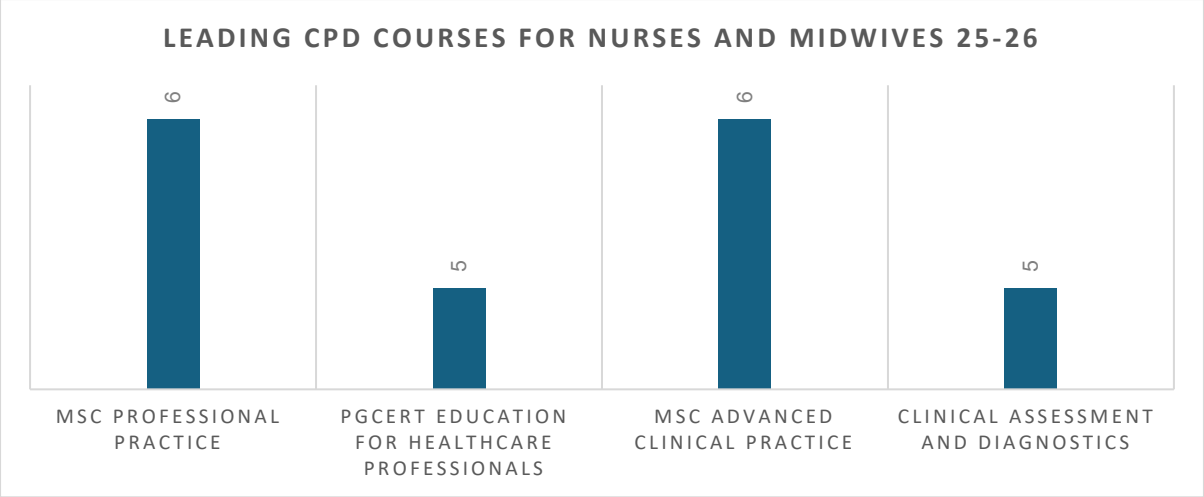
The Graph below displays the different programmes being undertaken.



This graph illustrates the numbers of Nurses and Midwives supported per Care Group.



This graph illustrates describes the top four courses undertaken by Nurses and Midwives for the first year of study.



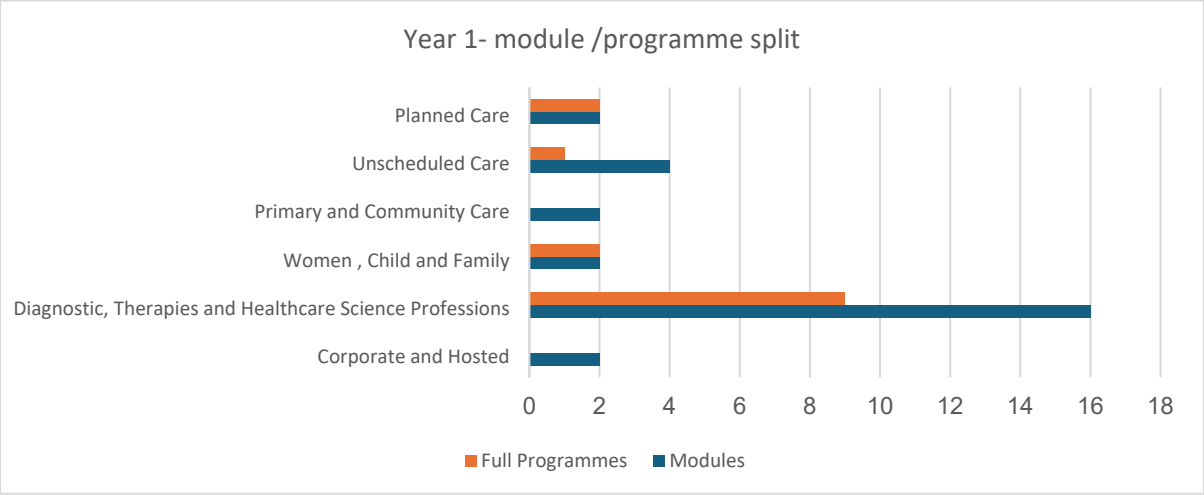
Advanced and Extended Practice

Advanced and Extended Practice Funding is allocated by HEIW annually, this table describes the total expenditure for 25/26.

Funding Stream	Total Places	Allocation £
Advanced & Enhanced Practice		£204,182.00
Mental Health to support delivery of strategic MH workforce plan		£108,507.00
Independent Prescribing	28	£49,000.00
Critical Care	18	£45,900.00
Medical Ultrasound	3	£20,150.00
Independent Authorisation of Blood Transfusion (IABT)	4	£9,996.00
Genomics		£1,295.00
SPQ (GPN/District Nursing)	On request	
SCPHN (Health Vising, School Nursing, Occupational Health)	On Request	
Total Investment		**£439,030.00**

Apart from Genomics, all education was fully utilised with an additional £16k allocated for education later in the academic year. The Nurse Education Team works closely with CTM UHB Genomics Oversight Board to promote and facilitate the uptake of Genomics education, this is being monitored.

The below graph describes the utilisation of Advanced Practice Funding per Care Group;



The different types of courses funded by this funding stream can be viewed in Appendix 7 which demonstrates the significant organisational investment in the following areas.

- Mental Health service development
- Psychological therapies capability
- Advanced prescribing practice
- Critical care workforce development
- Specialist patient-centred interventions

Impact of Investment

An evaluation was undertaken to assess the impact of Advanced Funding on professional development, service improvement, patient care, and the four pillars of practice. The findings demonstrated a positive impact across all areas, highlighting the value of continued investment in workforce development. To further strengthen the evaluation process, the methodology and survey questions will be reviewed and refined for 2025/26 to ensure meaningful measurement of outcomes and benefits.

The funding processes for both CPD and Advanced Practice have been further strengthened and refined over the past year to ensure that educational investment is aligned with workforce and service priorities. Enhanced governance arrangements and closer collaboration with Care Group Education Leads have improved engagement with the process, supporting informed decision-making and ensuring that the right individuals are accessing the most appropriate development opportunities to meet both current and future service needs.

Looking Ahead

Priorities include:

- Strengthening evaluation processes to better measure and demonstrate the impact of HEIW-funded education and development activities on workforce capability, service delivery and patient outcomes.
- Continuing to work collaboratively with clinical, operational and workforce colleagues to ensure funding application processes remain robust, transparent and aligned to service priorities and the Integrated Medium-Term Plan (IMTP).
- Maintaining strong partnership working with HEIW to maximise available funding opportunities and ensure educational investment supports current and future workforce requirements.

Focus on Resuscitation and Acute Deterioration

Developing and Transforming our Current Workforce

- The service develops and maintains the competence of the current workforce to recognise, escalate and manage deteriorating patients through targeted education, clinical support and standardisation of practice
- Over the last year, the service has focused on matching Level 2 and Level 3 Resuscitation course provision to organisational demand through workforce analysis and compliance monitoring. This includes ensuring staff undertake training appropriate to their role, clinical environment and patient risk profile, with regular review of the training needs analysis against national standards and local policies. The education programme also covers NEWS2, sepsis, acute deterioration and emergency response, supported by bedside coaching through Critical Care Outreach and the standardisation of resuscitation equipment and emergency response processes across hospital sites.

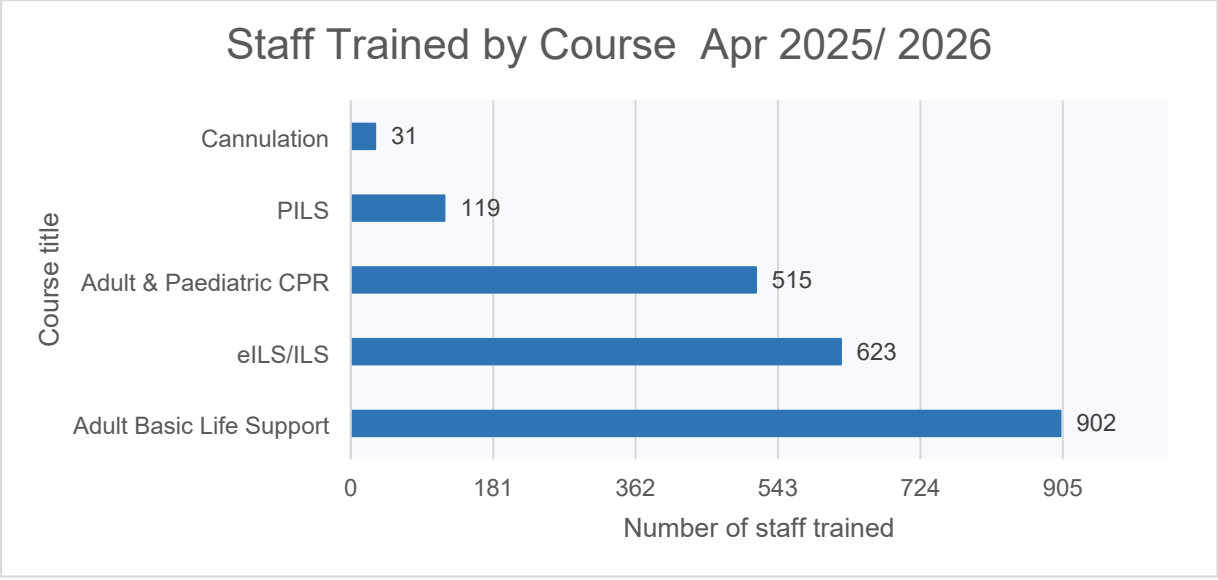


Fig 1. Number of staff trained in each course delivered

Developing a Culture of Interprofessional Learning

- The service promotes multidisciplinary learning and collaborative working to improve patient outcomes and strengthen organisational learning
- Interprofessional learning is delivered through multidisciplinary simulation involving medical, nursing, allied health professional and support staff. Cardiac arrest and deterioration debrief are used to identify learning opportunities, while lessons from patient safety incidents, audits and reviews are shared across services. Joint education with Emergency Medicine, Critical Care, Maternity, Paediatrics and Mental Health teams strengthen collaborative practice, with human factors and communication embedded throughout resuscitation training.

Establishing Underpinning Processes for Education Quality, Governance and Sustainability

- The service provides assurance that training, governance arrangements and improvement activities are effective, evidence-based and sustainable.
- Governance is provided through the Recognising Acute Deterioration and Resuscitation (RADAR) Group, supported by monitoring of mandatory Level 2 and Level 3 Resuscitation training compliance and regular review of training demand, capacity and course provision. Education programmes are reviewed against Resuscitation Council UK standards and organisational priorities. RADAR supported the standardisation of Early Warning Score systems across adult, paediatric, maternity and neonatal services, providing a common language for recognising and escalating deterioration and supporting safer patient care across settings. Assurance is further supported through regular audit of Early Warning Score completion and escalation, cardiac arrest outcomes, equipment checks, sepsis management and wider deterioration processes, alongside implementation of Call for Concern and other national patient safety initiatives. The service also develops and reviews SOPs, guidelines and competency frameworks.

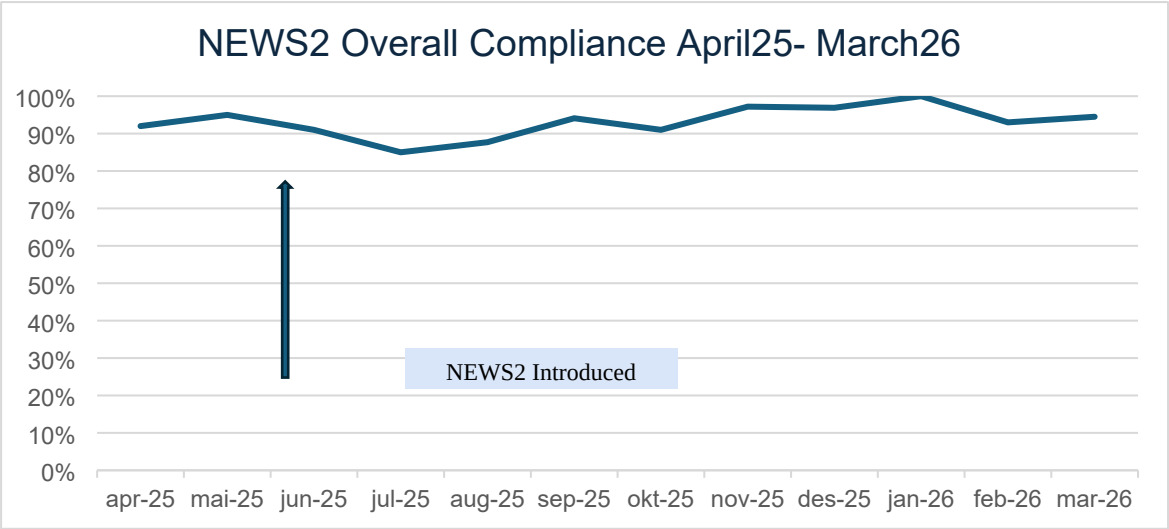


Fig 2. Compliance figures for NEWS2 (5 charts for each adult in patient ward areas are audited). PEWS/MEWS/NEWTT2 also audited monthly

Developing our Future Workforce

- The service develops a sustainable workforce capable of meeting future patient safety and service demands.

- The service works with universities to support student learning and future recruitment, develops specialist competencies in acute deterioration, resuscitation and patient safety, and expands simulation and digital learning opportunities. Service evaluation and demand forecasting are used to identify future workforce requirements.

- The permanent establishment of the Band 8b Lead Nurse role has provided dedicated strategic leadership and professional accountability across the service, strengthening coordination, governance oversight and the long-term sustainability of improvement programmes. Through effective workforce planning, multidisciplinary education, patient safety initiatives and robust assurance arrangements, the service enhances organisational resilience and supports improved outcomes for patients experiencing acute deterioration across CTM UHB.

Focus on Enhanced, Advanced and Consultant Practice

Enhanced, Advanced and Consultant Oversight Board

In June 2026, the Advanced Practice Board transitioned to the **Enhanced, Advanced and Consultant Oversight Board (EACOB)**, reflecting an expanded remit to support Enhanced, Advanced and Consultant level practitioners across CTM UHB. The Board provides strategic leadership and oversight for governance, workforce planning, education, professional development and service transformation associated with these roles.

Strategic Workforce Development

During 2025/26, an Enhanced, Advanced and Consultant (EAC) Career Pathways Project was undertaken to review the current EAC workforce across CTM UHB. The project examined governance arrangements, workforce requirements, educational provision, job planning, continuing professional development (CPD) opportunities and future workforce needs. Findings have informed the development of key workstreams focused on:

- Education and training governance
- Interprofessional learning and collaboration
- Future workforce development and succession planning
- Workforce transformation and career progression

Education, Development and Recognition

The Board continues to support practitioners through a range of educational and developmental initiatives, including:

- **Enhanced and Advanced Practice Portfolio Workshops**, delivered twice annually, supporting practitioners to build portfolios aligned to the Enhanced, Advanced and Consultant Practice Framework and the four pillars of advanced practice.
- **Advanced Practice Portfolio Mentorship Workshops**, supporting both practitioners and portfolio mentors, underpinned by locally developed guidance.
- **Advanced Practice Recognition Panels**, providing formal recognition, developmental feedback and professional support for Advanced Clinical Practitioners.
- A CTM UHB-wide **Enhanced, Advanced and Consultant Practice Forum**, facilitating networking, interprofessional learning, sharing of best practice and dissemination of local and national developments.

These initiatives continue to strengthen professional capability, support career progression and promote consistency in advanced practice across the organisation.

Supporting Workforce Transformation

The Board plays a key role in supporting the development of new Enhanced and Advanced Practice roles, providing advice on workforce planning, education requirements, governance arrangements, mentorship and role implementation.

During 2025/26, work continued to embed the use of the **All-Wales Generic Job Descriptions and Scope of Practice Frameworks**, supporting consistent recruitment, career progression and workforce planning. Guidance has been developed to support implementation across Band 6 Enhanced Practice, Band 7 Trainee Advanced Practice, Band 8a Senior Advanced Practice and Band 8b Lead Advanced Practice roles.

The Board also continues to oversee access to Master's-level Advanced Practice education, ensuring investment is aligned with workforce need, service priorities and succession planning.

Governance and Professional Standards

A dedicated Advanced Practice SharePoint resource continues to provide staff with access to national guidance, local policies, workforce resources and professional development information.

Key achievements during the year included completion of the revised **Diagnosis of Death for Adults Policy**, supporting all registered professionals undertaking this role, including nurses, allied health professionals and medical staff.

Work is ongoing to develop guidance relating to **Non-Medical Independent Prescribing Practice**, including audit and assessment processes to support safe and effective prescribing practice.

Looking Ahead

Priorities for 2026/27 include:

- Further development of EAC career pathways.
- Continued expansion of recognition and mentorship programmes.
- Strengthening workforce planning and succession planning arrangements.
- Supporting implementation of future Advanced Practice regulatory requirements.
- Expanding interprofessional learning opportunities for Enhanced, Advanced and Consultant practitioners.
- Hosting the CTM UHB Enhanced, Advanced and Consultant Practice Celebration Event in November 2026.

Through these developments, EACOB continues to support a highly skilled, sustainable and future-focused workforce, enabling practitioners to work at the top of their scope of practice and contribute to service transformation, workforce resilience and improved patient outcomes across CTM UHB.

Libraries and Knowledge Management

Library and Knowledge Services continue to provide an essential resource for staff and learners across CTM UHB, supporting education, evidence-based practice, research and professional development. Dedicated library facilities are available across all acute sites, offering 24/7 access to study spaces, IT facilities, electronic and print resources, and specialist librarian support.

Enhancing the Learning Environment

During 2025/26, investment was made to improve library facilities and accessibility, including:

- Upgraded IT equipment and enhanced digital infrastructure.
- Additional charging facilities and improved study spaces across library sites.
- Expansion of wellbeing resources, including wellbeing book collections, neurodiversity support tools, noise-cancelling headphones and collaborative wellbeing initiatives.
- Continued provision of flexible study environments to support different learning needs and preferences.

These developments reinforce the Health Board's commitment to providing inclusive, accessible and supportive learning environments for staff and students.

Digital Knowledge Resources

CTM UHB continues to expand access to high-quality digital knowledge resources to support clinical decision-making, education and research.

Key developments during the year included:

- Introduction of **UpToDate Expert AI**, making CTM UHB the first Health Board in Wales to implement this innovative evidence-based clinical decision support tool.
- Continued access to UpToDate and other evidence resources supporting safe, effective and evidence-based care.
- Introduction of EndNote reference management software to support research, quality improvement and academic activity.
- Delivery of targeted training sessions to improve staff awareness and utilisation of library resources.

Supporting Education and Workforce Development

Library staff have increased their contribution to educational and workforce development activities across the Health Board, including participation in:

- Careers and recruitment events.
- Medical induction programmes.
- CTM UHB Mini Work Observation Scheme.
- Training sessions promoting digital literacy, critical appraisal and evidence-based practice.

The team also played an active role in supporting learners and staff through tailored literature searching, information skills training and research support services.

Staff Development

The Library Team continues to demonstrate a strong commitment to professional development and continuous improvement. During 2025/26, staff undertook postgraduate study, professional accreditation and national networking activities, strengthening both individual expertise and collaboration across NHS Wales library services.

Impact and Utilisation

A review of the Royal Glamorgan Hospital 24-hour IT study facility highlighted the significant value of dedicated learning and workspace environments. Feedback demonstrated extensive use of the facility for clinical work, research, study, appraisals, professional development, quality improvement activity and on-call support.

The findings reinforced the importance of protected learning spaces within clinical environments and demonstrated the ongoing contribution of Library and Knowledge Services to workforce development, education, wellbeing and patient care across CTM UHB.

References

Health Education Improvement Wales (2016) All-Wales Skills and Career Framework FOR Healthcare Support Workers supporting Nursing and the Alloed Health Professions available at HCSW Career framework nursing and allied health professions

NHS Wales Performance and Improvement, (2026) National Patient Safety Plan for NHS Wales 2026-2031 available at National Patient Safety Plan for NHS Wales 2026 – 2031 - NHS Wales Performance and Improvement

NHS Wales Performance and Improvement (2026) Community by Design available at Community by design - Public Health Wales

Welsh Government (2018) A Healthier Wales available at A Healthier Wales

Appendices

Appendix 1 - CTMUHB IPE Strategic Framework

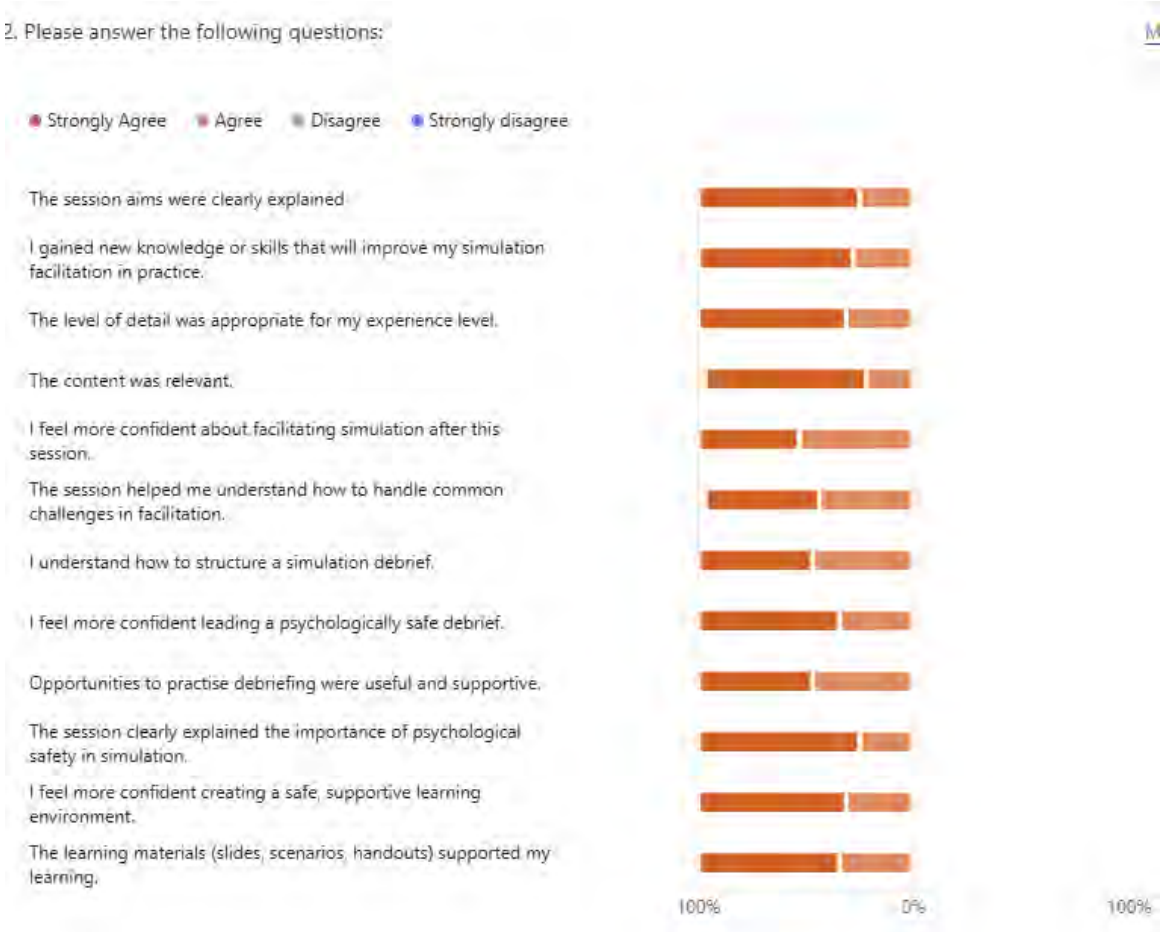
Appendix 2 –

IPE team Posters selected for HEIW IPE Conference 2026

1. The Journey of a Blood Sample - https://canva.link/3ffv45hwidpy909
2. Enhancing ECG Confidence Through Peer Led IPE - https://canva.link/9a6if1crs8gqodu
3. 3. Hear Better, Care Better: Audiology students supporting front line staff through IPE - https://canva.link/yuul5eah40rw1qc

4. Improving Interprofessional Competence in Nursing and Medical Students Through Structured Simulation and Debriefing. - https://canva.link/4g3kyvy3o1owlc5
5. IPE Connections, Enhancing IPE through case-based collaboration - https://canva.link/idfdxis5afzeyxl
6. Enhancing collaborative practice through Student Learning Sessions - https://canva.link/3vvy5vie2oi11ve

Appendix 3 – IPE Simulation Training Evaluations



Appendix 4- SLT SCHOOLS POSTER.docx

Appendix 5- CTMUHB AHP Joint Induction Programme

Appendix 6– Widening Access Work Plan - Medical Education

The table below illustrates how this workplan (green) aligns with the UK application process to medical school (orange):

Month	School Year	Topic *(Facilitators)*	School Year	Medical School Application Timetable
Sept		Contact Head Teachers / schools *(Widening access team)*	13	Sit UCAT Exam
Oct	13	The medical Interview & Mock interviews including MMI *(Clinical fellows / medical staff)*	13	Sit UCAT Exam UCAS application closes
Nov	12 12	Studying at a University Finance – course costs / SFW Routes to medicine and entry requirements *(Ideally F2F; TEAMS vis schools also possible)* Application for Medical Work Observation sent to Schools in CTM Catchment *(Widening access team)*	13 13	Sit BMAT Exam Attend Interviews
Dec	12 12	Studying at a University Finance – course costs / SFW Routes to medicine and entry requirements *(Ideally F2F; TEAMS vis schools also possible)*	13	Attend Interviews

Jan	12	**Parents evening:** Why go to University; Medical school information; Careers advice; Selecting a medical school; Application process; Admissions process; Key dates; Preparing for University ***(Face to Face; Widening access team)***	13	Attend Interviews
Jan	5&6	Primary school sessions ***(Year 3 SSC)***	13	Attend Interviews
Feb	11	A career in medicine: Career options Include info on subject choices and grades UG v PG courses ***(Ideally F2F; TEAMS vis schools also possible)***	13	Attend Interviews
Feb	5&6	Primary school sessions ***(Year 3 SSC)***	13	Attend Interviews
Feb/Mar	10	Interactive Days (x14) ***(CTFs/Widening access team)***		
Apr	12 8	Application for Medical Work Observation closes and shortlisting done. ***(Widening access team)*** Interactive Days **(FY2 "Near Peer" Doctors/Widening Access Team)**		
May	5&6 12	Primary school sessions ***(Year 4 SSC)*** UCAT training & UCAT mock (Bank questions / online material) ***(Clinical fellows)***	13	Confirm University choices UCAT Booking Opens
Jun	5&6 12	Primary school sessions ***(Year 4 SSC)*** WOBS induction ***(Widening access team)***		
Jul	12 12	Work Observation virtual sessions ***(Widening access team)*** Work Observation in hospital week ***(Widening access team)***	12	Sit UCAT exam

	10	Mini – Work Observation week ***(Widening access team, Cardiff University WAMMS & Nurse Education Team)***		
Aug			12 12	Sit UCAT exam Start writing personal statement

Appendix 7

AP FUNDING LETTER 2627.pdf

Glossary of Terms

Cwm Taf Morgannwg University Health Board	CTM UHB
Cwm Taf Morgannwg Clinical Learning Academy	CTMCLA
Practice Development Nurses	PDN
HealthCare Support Workers	HCSW
University of South Wales	USW
Allied Health Professional	AHP
Healthcare Science	HCS
Continuing Professional Development	CPD
Nursing Midwifery Council	NMC
Practice Education Facilitator	PEF
Higher Education Institute	HEI
Health Education Improvement Wales	HEIW
Practice Assessor	PA
Practice Supervisor	PS
Grwp Llandrillo Menai	GLM
Certificate in Higher Education	Cert HE
Chief Nursing Officer	CNO
Restorative Clinical Supervision	RCS
Primary and Community Care Academy	PaCCA
General Medical Council	GMC
Standard Operating Procedure	SOP
All Wales Induction Framework	AWIF
Cognitive Analytic Therapy Cognitive Analytic Therapy (CAT)	CAT
Speech and Language Therapy	SLT
Occupational Therapy	OT
Psychology and Psychotherapy Professions	PPP
Designated Prescribing Practitioner	DPP
Cognitive Behaviour Therapy	CBT
Child and Adolescent Mental Health Service	CAMHS
Scientist Training Programmes	STP
Practitioner Training Programmes	PTP

Clinical Practice Educator	CPE
Primary and Community Care Academy	PaCCA
General Practice Nurse	GPN
Designated Prescribing Practitioners	DPP
Recognising Acute Deterioration and Resuscitation	RADAR
Enhanced Advanced Consultant Oversight Board	EACOB
Enhanced Advanced Consultant	EAC

CTMUHB Public Board

Annual Presentation of Nurse Staffing Levels to the Board

Eitem yr Agenda / Agenda Item	8.2.5
Dyddiad y Cyfarfod / Date of Meeting:	26/11/2026
Statws Cyhoeddi / Publication Status:	Open/Public.
	Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Senior Nurse Professional Practice & Nurse Staffing Lead
Cyflwynydd yr Adroddiad / Report Presenter:	Richard Hughes
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes, Executive Director of Nursing
Diben yr Adroddiad / Report Purpose:	For Assurance and Noting
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	Receive the report; take assurance that the statutory Section 25B nurse staffing calculations have been completed in accordance with the Nurse Staffing Levels (Wales) Act 2016; and note that no changes were required to the approved establishments for wards remaining within scope.
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol* *Strategic Context:* *This report aligns to the following Strategic Pillars*	Improving Care
	If more than one applies please list below:
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan *(Reference relevant priority)*	Supports the Improving Care strategic pillar and annual delivery priorities for safe, effective and person-centred care, workforce sustainability and statutory assurance. The prescribed triangulated methodology uses acuity, quality, workforce and professional-judgement intelligence to determine and monitor nurse staffing levels, with established governance and approval arrangements providing assurance that

	staffing remains aligned to patient need.

Crynodeb Gweithredol o'r hyn y mae'r adroddiad yn ei ddisgrifio: Dechreuwch drwy grynhoi'r wybodaeth bwysicaf yn fyr. Dylai hyn roi dealltwriaeth gadarn o'r pwyntiau allweddol yn erbyn y 3 phennawd canlynol heb ddarllen yr adroddiad llawn: Executive Summary of what the report is describing: Start by summarising briefly the most critical information. This should provide a firm grasp of the key points against the following 3 headings without reading the full report:	
Beth *(crynodeb o'r sefyllfa / mater cyfredol a pham ei fod yn bwysig a thystiolaeth i gefnogi'r safbwynt hwnnw ac ati)* What *(summary of current position / issue & why it matters and evidence to support that position etc)*	This annual report provides the Board with assurance that the statutory calculation and approval requirements for adult acute medical, adult acute surgical and paediatric inpatient wards within Section 25B of the Nurse Staffing Levels (Wales) Act 2016 have been completed. It covers the reporting period from 1 October 2025 to 30 September 2026 and reflects the January and June 2026 biannual reviews, undertaken using the prescribed triangulated methodology and subject to Care Group governance review and formal endorsement by the Executive Director of Nursing as the designated person. At the end of the reporting period, 22 wards remained within scope: 12 adult acute medical, seven adult acute surgical and three paediatric wards. The reviews confirmed that funded establishments remained aligned with the calculated nurse staffing requirements, and no establishment changes were required for wards remaining within scope. Changes in aggregate establishment totals reflected service redesign and ward reconfiguration rather than a reduction in the calculated staffing requirements of in-scope wards.
Felly, beth *(darparu dadansoddiad ystyrlon gan dynnu allan, fel y bo'n briodol, oblygiadau yn erbyn Strategaeth / Cynlluniau Cyflawni / risgiau Strategol neu Reoleiddiol CTMUHB ac ati ac unrhyw opsiynau ar gyfer mynd i'r afael â'r rhain)*	The completed reviews provide assurance that the statutory Section 25B calculation and approval requirements have been met and that funded establishments remained aligned with calculated nurse staffing requirements for wards continuing within scope. This assurance is supported by application of the prescribed triangulated methodology, Care Group governance review and formal endorsement by the Executive Director of Nursing as the designated person. Changes in aggregate establishment totals reflect ward redesignation, amalgamation and service

So, what *(provide meaningful analysis drawing out as appropriate implications against CTMUHB Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)*	reconfiguration rather than a reduction in the calculated staffing requirements of in-scope wards. Continued assurance will depend on reliable SafeCare recording, professional judgement, workforce and quality intelligence, and timely escalation of emerging service changes through established governance arrangements.
Beth Nesaf *(crynodeb o'r camau gweithredu a fwriadwyd a'r manteision sy'n cefnogi'r dewisiadau a'r argymhelliad(au) sy'n cael eu gwneud)* What Next *(summary of intended action and benefits supporting the choices and recommendation(s)being made)*	During 2026/27, the Health Board will maintain assurance through continued monitoring of SafeCare compliance and improvements in the recording of acuity, dependency, professional judgement, mitigation actions and red flags. Workforce, quality and acuity intelligence will inform future establishment and skill-mix reviews, alongside proportionate implementation of SafeCare across relevant Section 25A services. Statutory compliance will continue to be monitored through established governance arrangements, with emerging service changes escalated promptly and the Health Board contributing to All-Wales work on operational guidance.

Argymhelliad *(Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).* Recommendation (Linked to the "What Next" section above).	The Board is asked to receive the report, take assurance that the statutory Section 25B nurse staffing calculation and approval requirements have been completed in accordance with the Nurse Staffing Levels (Wales) Act 2016, and note that the approved establishments for wards remaining within scope required no change at the reporting date.

1. Background / Context

The Nurse Staffing Levels (Wales) Act 2016, hereafter referred to as *the Act*, establishes a statutory framework intended to support safe, effective and compassionate nursing care through appropriate nurse staffing. The Act became law on 21 March 2016 and initially applied to adult acute medical and surgical inpatient wards from April 2018. Its scope was extended to include paediatric inpatient wards on 1 October 2021.

Statutory Guidance issued under the Act requires the designated individual, the Executive Director of Nursing, to formally present the nurse staffing

requirements for adult acute medical, adult acute surgical and paediatric inpatient wards to the Board. This provides the Board with visibility of how the Health Board has discharged its statutory responsibilities and enables members to consider the assurance provided through the calculation, review and approval process.

The Act places a duty on health service bodies to ensure that appropriate nurse staffing levels are maintained so that nurses have the capacity to provide safe, effective and person-centred care with sensitivity and compassion. The duty therefore links workforce planning and deployment directly to the quality, safety and experience of care provided to patients.

Section 25A applies across Health Board services and requires robust workforce plans, recruitment strategies, organisational structures and operational processes to support the provision of safe and effective nurse staffing. This broader organisational duty provides the foundation for workforce planning and governance beyond the ward areas subject to the specific calculation requirements under Section 25B.

Section 25B specifies the inpatient wards for which there is a statutory duty to calculate nurse staffing levels using a prescribed methodology. Within the Health Board, this established process is supported by a clear governance framework. In-scope wards undertake biannual acuity audits led by ward managers and senior nursing staff. The resulting data is triangulated with professional judgement, patient demographics, current staffing information and predefined nurse-sensitive quality indicators, including patient falls and hospital-acquired skin damage. Taken together, this evidence supports a rounded assessment of whether the calculated nurse staffing level remains appropriate to meet patient need.

This report provides the Board with annual assurance on the Health Board's compliance with the Section 25B calculation and approval requirements of the Nurse Staffing Levels (Wales) Act 2016. It summarises the position for the reporting period from 1 October 2025 to 30 September 2026, including changes to ward configuration or specialty designation that affected which areas remained within scope, and identifies the arrangements that will support continued statutory compliance.

2. Strategic Insights

Methodology: The January and June 2026 audit cycles applied the statutory triangulated methodology, drawing on SafeCare acuity data, professional judgement, care-quality indicators, workforce metrics and service context.

Governance and assurance: Ward-level calculations were reviewed through Care Group governance and endorsed by the Executive Director of Nursing in their capacity as the designated person. No changes were required to the approved establishments for wards that remained within scope.

Service redesign: Changes in overall establishment totals primarily reflected service redesign, with four wards moving to Section 25A, two wards

amalgamating into a single Stroke Unit, and four wards amalgamating into two Trauma Units.

3. Risks and Opportunities

Key risks and opportunities have been identified in relation to statutory nurse staffing compliance, workforce assurance and the effective use of workforce intelligence. Existing governance and assurance arrangements provide oversight of these risks, whilst continued development of integrated workforce, quality and acuity intelligence presents opportunities to strengthen workforce planning, service redesign and evidence-based decision-making.

Key Risks

Risk	Potential Impact	Mitigation
Delayed completion of statutory nurse staffing calculations	Failure to complete the required biannual calculations within agreed timescales may result in non-compliance with statutory requirements and reduce assurance regarding nurse staffing arrangements.	A structured six-monthly review cycle, multidisciplinary scrutiny and formal designated-person sign-off provide a robust assurance framework, supporting timely completion and early escalation of risks to delivery.
Inconsistent acuity and quality data	Incomplete or inconsistent SafeCare data may weaken the evidence base underpinning staffing decisions and reduce confidence in Board assurance regarding staffing adequacy.	Ongoing compliance monitoring, governance oversight and targeted improvement activity support the quality of acuity, quality and professional judgement data, strengthening decision-making and assurance.
Approved staffing establishments not maintained	Inability to sustain approved staffing levels may increase the risk of misalignment between workforce capacity and patient need, impacting statutory compliance and the delivery of safe, effective and person-centred care.	Care Group workforce, quality and performance oversight arrangements support early identification of pressures, timely escalation and corrective action to maintain safe staffing establishments.

Key Opportunities

Opportunity	Potential Benefit	Enabling Actions
Strengthening integrated workforce intelligence	Greater integration of workforce, quality, acuity and professional judgement information can enhance workforce planning, support service redesign and optimise skill-mix decisions, reducing future staffing risk and strengthening assurance.	Continued development of integrated data sources and proportionate expansion of SafeCare across relevant Section 25A services will support more informed and evidence-based decision-making.

Embedding SafeCare as a strategic workforce planning tool	Increased use of SafeCare data can strengthen the organisation's ability to evidence staffing decisions, identify emerging trends and provide proactive assurance regarding patient need and workforce capacity.	Ongoing compliance improvement, data-quality monitoring and utilisation of SafeCare intelligence within governance processes.
Enhanced triangulation of workforce and quality outcomes	Combining staffing, quality, patient experience and outcome data can provide richer organisational insight, supporting continuous improvement and more targeted investment decisions.	Further alignment of workforce, quality and performance reporting through existing governance arrangements.

4. Compliance and Governance

The June 2026 review was completed in accordance with Sections 25B and 25C of the Nurse Staffing Levels (Wales) Act 2016. Templates were created, completed and quality assured; findings were reviewed with Ward Sisters and Charge Nurses, Senior Nurses, Lead Nurses, Heads of Nursing and Care Group Nurse Directors; and final calculations were endorsed by the Executive Director of Nursing at formal designated-person sign-off meetings. Approved planned rosters include the agreed 26.9% uplift and a supernumerary Band 7 Ward Sister or Charge Nurse.

5. Benchmarks

The Health Board has used the All-Wales annual reporting template, supporting a consistent and transparent approach to statutory reporting across health boards and trusts. As the template does not provide comparative organisational performance data, assurance is derived from evidenced compliance with the prescribed triangulated methodology, completion of the required governance and approval processes, and confirmation that the calculated nurse staffing levels remain appropriate for wards within scope.

6. Conclusion

The Health Board has completed the required biannual nurse staffing reviews for Section 25B wards using the prescribed triangulated methodology. Ward-level calculations were subject to Care Group governance review and were formally endorsed by the Executive Director of Nursing as the designated person. On this basis, the Board can take assurance that the statutory calculation and approval requirements have been completed and that funded establishments remained aligned with the calculated nurse staffing requirements at the reporting date. No establishment changes were required for wards remaining within scope; changes in aggregate establishment totals reflected service redesign and ward reconfiguration rather than a reduction in their calculated staffing requirements. Continued assurance will be maintained through monitoring of SafeCare

compliance, workforce capacity, quality indicators and service developments, with emerging changes escalated through established governance arrangements.

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)* Link to Strategic Risk(s) on the Board Assurance Framework (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	Strategic Risk 3 Workforce Capacity & Culture
	If more than one applies, please list below:

Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals	Not Applicable
	If more than one applies, please list below:

Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Data to Knowledge
	If more than one applies, please list below:

Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies, please list below:

Asesiad Effaith Impact Assessment		
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg *(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)* Equality & Welsh Language Impact Assessment Outcome *(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)*	Outcome for Equality (delete as appropriate): NEUTRAL Summary of impact: The report applies a consistent statutory methodology across in-scope wards and does not propose a change that is expected to create a differential equality impact. Outcome for Welsh Language (delete as appropriate): NEUTRAL	If no, please select a reason below. Choose an item. Named Executive/Board member sign off for no EWLIA completion:

	Summary of impact: No specific Welsh-language impact has been identified from the annual assurance report or the approved nurse staffing establishments.	
Quality Impact Assessment Outcome *(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)* Quality Impact Assessment Outcome *(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)*	Positive assurance: the statutory triangulated review supports safe, effective, and person-centred care by aligning staffing levels with acuity, quality indicators, workforce information and professional judgement. No adverse quality impact has been identified from the approved establishments.	
Cyfreithiol / Legal	Yes — statutory compliance applies.	
	The report provides assurance that the Health Board has completed the statutory Section 25B calculation and approval process in accordance with the Nurse Staffing Levels (Wales) Act 2016 and associated statutory guidance.	
Enw da / Reputational	Yes (include further detail below)	
	Transparent annual reporting and robust governance support confidence in the Health Board's discharge of its statutory duties. Reputational risk would arise if audits, approvals or implementation were incomplete; this is mitigated through the established review, quality-assurance and escalation arrangements.	
Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	Yes (include further detail below)	
	No additional financial implications were identified at the reporting date for wards remaining within scope. The Autumn 2026 funded establishments matched the calculated requirements. Any future service redesign with clinical, workforce or financial consequences will be assessed through formal business cases and established governance processes.	

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Biannual nurse staffing acuity review meetings with the following Care Groups: Paediatrics Unscheduled Care	April & September 2026	Ward-level calculations reviewed and agreed through Care Group governance for

Planned Care		Planned Care, Unscheduled Care and Children and Young People.
EDoN/ DDoN meetings	April & September 2026	Final nurse staffing calculations endorsed by the Executive Director of Nursing as the designated person.
Quality, Safety & Experience Committee	24 November 2026	NOTED

Acronyms / Glossary of Terms	
CTM	Cwm Taf Morgannwg
EDon	Executive Director of Nursing
DDoN	Deputy Director of Nursing
NSA	Nurse Staffing Act
NSLWA 2016	Nurse Staffing Levels (Wales) Act 2016

Appendix 1

<table>
<tr><th colspan="4">Annual Presentation of Nurse Staffing Levels to the Board</th></tr>
<tr><td>Health Board</td><td colspan="3">Cwm Taf Morgannwg University Health Board</td></tr>
<tr><td>Date of annual presentation of Nurse Staffing Levels to Board</td><td colspan="3">26th November 2026</td></tr>
<tr><td>Period Covered</td><td colspan="3">This report presents the biannual nurse staffing level calculations for all wards within the scope of Section 25B and summarises changes to ward nursing establishments between 1 October 2025 and 30 September 2026.</td></tr>
<tr><td>Number and identity of Section 25B wards during the reporting period.

• Adult acute <u>medical</u> inpatient wards
• Adult acute <u>surgical</u> inpatient wards
• <u>Paediatric</u> inpatient wards</td><td colspan="3">Appendix 2 lists the wards covered by Section 25B of the Nurse Staffing Levels (Wales) Act 2016 (the 2016 Act) between 1st October 2025 and 30th September 2026 and their nurse staffing levels.
The following changes reduced the number of wards within the scope of Section 25B:
Prince Charles Hospital (PCH)
• Wards 7 and 8: amalgamated to a single Trauma Unit (change of two wards to one)
Royal Glamorgan Hospital (RGH)
• Ward 10: Change of speciality to a short-stay surgical unit operating a stay of less than 24 hours and was therefore redesignated under Section 25A of the Act.
• Ward 11: Change of speciality to a day-surgery ward and was redesignated under Section 25A of the Act.
• Wards 15 and 16: amalgamated to a single Trauma Unit (change of two wards to one)
• Wards 19 and 20: amalgamated to a single Stroke Unit (two wards to one).
Princess of Wales Hospital (PoWH)
• Ward 7: Change of speciality to elective short stay surgery and was redesignated under Section 25A of the Act.
• Ward 8: Change of speciality to a Surgical, Trauma and Rehabilitation (STaR) ward and was redesignated under Section 25A of the Act.
Paediatric inpatient wards
No changes were noted to the paediatric wards during this reporting period.</td></tr>
<tr><td></td><td>Adult acute <u>medical</u> inpatient wards</td><td>Adult acute <u>surgical</u> inpatient wards</td><td>Paediatric inpatient wards</td></tr>
<tr><td></td><td>Total: 12 adult acute medical inpatient wards, including one newly established Stroke unit through ward amalgamation.</td><td>Total: 7 adult acute surgical inpatient wards, including two newly established</td><td>Total 3
PCH Ward 31
RGH ward 17
PoWH Childrens ward</td></tr>
</table>

	PCH 2, 9, 11, 12 RGH 3, 5, 12, 14, Stroke (19 & 20) PoWH4, 9, 10		Trauma Units created through ward amalgamations. PCH 5, 6, Trauma (7 & 8) RGH 7, 8, Trauma (15 & 16) PoWH 11			
Required establishment (WTE) calculated (Autumn 2025)	**RN**	**HCSW/ NSW/ AP**	**RN**	**HCSW/ NSW/ AP**	**RN**	**HCSW/ NSW/ AP**
	279.39 WTE	230.85 WTE	202.36 WTE	190.63 WTE	93.97 WTE	19.10 WTE
WTE of required establishment funded (Autumn 2025)	279.34 WTE	230.85 WTE	203.19 WTE	190.70 WTE	93.97 WTE	19.10 WTE
Staffing requirements following Spring Cycle (Spring 2026)	**Adult acute medical inpatient wards**		**Adult acute surgical inpatient wards**		**Paediatric inpatient ward**	
Required establishment (WTE) calculated (Spring 2026)	**RN**	**HCSW/ NSW/ AP**	**RN**	**HCSW/ NSW/ AP**	**RN**	**HCSW/ NSW/ AP**
	279.39 WTE	230.85 WTE	175.89 WTE	168.13 WTE	93.97 WTE	19.10 WTE
WTE of required establishment funded (Spring 2026)	286.74 WTE	230.63 WTE	172.69 WTE	149.50 WTE	93.97 WTE	19.10 WTE
Staffing requirements at end of reporting period (Autumn 2026)	**Adult acute medical inpatient wards**		**Adult acute surgical inpatient wards**		**Paediatric inpatient wards**	
Required establishment (WTE) calculated (Autumn 2026)	**RN**	**HCSW/ NSW/ AP**	**RN**	**HCSW/ NSW/ AP**	**RN**	**HCSW/ NSW/ AP**
	283.18 WTE	223.74 WTE	189.17 WTE	162.45 WTE	93.97 WTE	19.10 WTE
WTE of required establishment funded (Autumn 2026)	286.74 WTE	230.63 WTE	189.41 WTE	160.03 WTE	93.97 WTE	19.10 WTE
WTE Supernumerary band 7 sister/charge nurse at end of reporting period (funded but	13.0 WTE (Stroke ward has 2 B7)		7.0 WTE		3.0 WTE	

excluded from planned roster)			
Using the triangulated approach to calculate the Nurse staffing level on section 25B wards.	The triangulated methodology set out in Section 25C of the 2016 Act provides the basis for calculating nurse staffing levels. As a minimum, the nurse staffing level for each ward within the scope of Section 25B must be reviewed every six months using the prescribed evidence-based approach. Acting on behalf of the designated person, the Health Board Nurse Staffing Lead coordinates the calculation process and ensures all required templates are prepared, completed and quality assured before formal review and approval at designated person sign-off meetings. For the January and June 2026 biannual acuity audits, information from multiple systems was collated and analysed for each Section 25B inpatient ward to inform the nurse staffing level calculations. The findings were reviewed collaboratively with Ward Sisters and Charge Nurses, Senior Nurses, Lead Nurses, and Heads of Nursing for each acute hospital, before approval by the relevant Care Group Nurse Directors. The following information is used to triangulate the data and provide a basis for discussion: • Current bed numbers and specialities, including any proposed service changes. • Patient acuity data from the January and June 2026 audit cycles, captured using the SafeCare system. • Care quality indicator data from the previous six months (including falls, medication errors, pressure damage, and serious incidents and concerns). • Workforce metrics, including mandatory training compliance, vacancy rates, recruitment activity, and sickness absence. • Clinical dashboards from the Datix system capturing care quality metrics and Power BI applications providing patient acuity and flow data. • Assurance that all workforce models include the agreed 26.9% uplift and a supernumerary Band 7 Ward Sister or Charge Nurse, in accordance with the Health Board's approved nurse staffing methodology and the requirements supporting delivery of the Nurse Staffing Levels (Wales) Act 2016. Templates are ratified by the relevant Ward Manager, Senior/Lead Nurse, Head of Nursing and Care Group Director of Nursing. Final templates are endorsed by the Executive Director of Nursing, as the designated person, at a formal sign-off meeting attended by the relevant Care Group Nurse Director, Head of Nursing and Health Board Nurse Staffing Lead. The planned rosters in Appendix 2 are approved by the designated person following the January and June 2026 acuity audits for Section 25B areas.		

Finance and workforce implications	The June 2026 acuity audit confirmed that nurse staffing establishments remained unchanged for all but one ward within the scope of Section 25B. Ward 7 RGH workforce was realigned within funded establishment to create a high care bay area within the head and neck ward due to the acuity and dependency of patients admitted and cared for in this clinical setting. The overall reduction in the adult surgical establishment since Autumn 2025 reflects the removal or redesignation of four wards under Section 25A and the consolidation of four wards into two Trauma Units. The three paediatric inpatient ward establishments remained unchanged. Care Groups continue to review services and will develop business cases where service redesign could have consequential clinical, workforce or financial implications. Care Groups will continue to review services and, where required, develop business cases for service redesign. Each business case will assess the clinical, workforce and financial implications, including any consequential effect on nurse staffing levels. Paediatric wards within CTMUHB continue to adjust deployment within their approved staffing levels in response to seasonal variation in patient acuity. These adjustments are managed through annual planning and within existing funded establishments; therefore, no additional financial implications have been identified at the reporting date.

Conclusion & Recommendations

Assurance position

The June 2026 biannual review assures that the statutory nurse staffing calculation process was completed in accordance with the Nurse Staffing Levels (Wales) Act 2016. Planned Care, Unscheduled Care, and Children and Young People Care Groups undertook a comprehensive review of patient acuity, activity, quality indicators, and workforce requirements across the preceding six months. The resulting ward-level calculations were subject to scrutiny and approval through established Care Group governance arrangements, with oversight from the relevant Care Group Nurse Directors and formal endorsement by the Executive Director of Nursing as the designated person. This process confirmed that the approved nurse staffing establishments remained appropriate for all wards within the scope of Section 25B at the reporting date, with no changes required.

The Board is asked to:

- Receive the report and take assurance that the statutory nurse staffing calculation requirements for Section 25B wards have been completed in accordance with the Nurse Staffing Levels (Wales) Act 2016.

- Note that no changes to the approved nurse staffing establishments were required for wards remaining within the scope of Section 25B at the reporting date. Any future service-related changes will be implemented only after completing the established clinical, workforce, financial and partnership governance processes.

Next steps for 2026/27

- Complete a biannual audit of SafeCare compliance across all Section 25B wards, report findings through the established nurse staffing governance route, and agree targeted improvement actions where recording of acuity, dependency, professional judgement, mitigations, or red flags does not meet the required standard.
- Triangulate workforce, quality, and acuity intelligence through each biannual review to identify and formally document any required changes to nurse staffing establishments or skill mix.
- Progress the proportionate implementation of SafeCare across community hospitals, mental health services, palliative care settings, and other Section 25A areas through an agreed implementation plan, with progress, risks and benefits reported through the established nurse staffing governance route.
- Monitor compliance with the Nurse Staffing Levels (Wales) Act 2016 through the established reporting cycle, escalate identified risks and required actions through the appropriate governance route, and provide Health Board input to the All-Wales development of operational guidance for Section 25A areas.

Appendix 2: Annual Presentation of the Nurse Staffing Level to the Board report. A summary of Nurse Staffing Levels for wards where Section 25B applies.

Health board/trust:	CTMUHB
Period of the report	1st October 2025- 30th September 2026
Adult Acute Medical inpatient wards	Start 13 - End 12

Spring calculations were completed in March 2026 and reviewed/endorsed through governance in April 2026.
Autumn calculations were completed in September 2026 and reviewed/endorsed through governance in September 2026

The number of staff per shift needs to be entered. The information should reflect the information on the informing patient template.

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the "nurse staffing level" is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within the data for this report. Further information is provided within the annual assurance report (https://ctmuhb.nhs.wales/about-us/governance-assurance/annual-reports-annual-accounts-annual-plans/reports1/ctm-uhb-annual-report-and-accounts/ctm-uhb/ctm-uhb-annual-report-accounts-2025-2026/?ts=1793116321462) on the additional multi-professional staff that contribute to the coordination and delivery of patient care.

Adult Acute Medical inpatient wards

Site	Name of Ward	Reported to the Board in November 2025						Calculated during spring 2026 cycle								Calculated during autumn 2026 cycle								Biannual calculation cycle reviews, and any changes made & rationale during the spring 2026 & autumn 2026 calculation cycles			Any reviews outside of biannual calculation, if yes, provide rationale for any changes made			
		SHIFT	Planned roster as stated within the annual presentation to the Board report (in November 2025)		Required Establishment as stated within the annual presentation to the Board report (in November 2025) including uplift 26.9%		TOTAL WTE Band 7 supernumerary ward sister/Charge nurse	Name of Ward	SHIFT	Planned roster calculated by the designated person during the spring 2026 cycle		Required Establishment as calculated by the designated persons during the spring 2026 cycle including uplift 26.9%		TOTAL WTE Band 7 supernumerary ward sister/Charge nurse	Date designated person calculated the nurse staffing level	SHIFT	Planned roster calculated by the designated person during the autumn 2026 cycle		Required Establishment as calculated by the designated persons during the autumn 2026 cycle including uplift 26.9%		TOTAL WTE Band 7 supernumerary ward sister/Charge nurse	Date designated person calculated the nurse staffing level	Completed (Yes/No)	Changed	Rationale	Completed (Yes/No)	Date	Changed	Rationale
			RN (band 5 &6)	HCSW (bands 2,3 &4)	TOTAL WTE RN (bands 5 &6)	TOTAL WTE HCSW (bands 2,3 &4)				RN (band 5 &6)	HCSW (bands 2,3 &4)	TOTAL WTE RN (bands 5 &6)	TOTAL WTE HCSW (bands 2,3 &4)				RN (band 5 &6)	HCSW (bands 2,3 &4)	TOTAL WTE RN (bands 5 &6)	TOTAL WTE HCSW (bands 2,3 &4)									
PCH	2	E	4	3				2	E	4	3					E	4	3											
		L	4	3	19,9	14,21	1		L	4	3	19,9	14,21	1	09.03.2026	L	4	3	19,9	14,21	1	04.09.2026	Y	N					
		N	3	2					N	3	2					N	3	2											
PCH	9	E	4	3				9	E	4	3					E	4	3											
		L	4	3	19,9	14,21	1		L	4	3	19,9	14,21	1	09.03.2026	L	4	3	19,9	14,21	1	04.09.2026	Y	N					
		N	3	2					N	3	2					N	3	2											
PCH	11	E	4	3			1	11	E	4	3			1		E	4	3			1								
		L	4	3	19,9	14,21			L	4	3	19,9			09.03.2026	L	4	3	19,9			04.09.2026	Y	N					
		N	3	2					N	3	2		14,21			N	3	2		14,21									
PCH	12	E	5	3				12	E	5	3					E	5	3											
		L	5	3	23,74	17,06	1		L	5	3	23,74	17,06	1	09.03.2026	L	5	3	23,74	17,06	1	04.09.2026	Y	N					
		N	3	3					N	3	3					N	3	3											
RGH	3	E	4	4				3	E	4	4					E	4	4											
		L	4	4	19,9	19,9	1		L	4	4	19,9	19,9	1	09.03.2026	L	4	4	19,9	19,9	1	04.09.2026	Y	N					
		N	3	3					N	3	3					N	3	3											
RGH	5	E	4	4				5	E	4	4					E	4	4											
		L	4	4	19,9	19,9	1		L	4	4	19,9	19,9	1	09.03.2026	L	4	4	19,9	19,9	1	04.09.2026	Y	N					
		N	3	3					N	3	3					N	3	3											
RGH	12	E	4	4				12	E	4	4					E	4	4											
		L	4	4	19,9	19,9	1		L	4	4	19,9	19,9	1	09.03.2026	L	4	4	19,9	19,9	1	04.09.2026	Y	N					
		N	3	3					N	3	3					N	3	3											
RGH	14	E	4	4				14	E	4	4					E	4	4											
		L	4	4	19,9	19,9	1		L	4	4	19,9	19,9	1	09.03.2026	L	4	4	19,9	19,9	1	04.09.2026	Y	N					
		N	3	3					N	3	3					N	3	3											
RGH	19	E	4	4				3	E	4	4					E	9	7											
		L	4	4	19,9	19,9	1		L	4	4	19,9	19,9	1	09.03.2026	L	9	7	43,59	32,69	2	04.09.2026	Y	N	Ward 19 merged with ward 20 to create a stroke unit				
		N	3	3					N	3	3					N	7	5											
RGH	20	E	4	4				20	E	4	4					E					Merged with ward 19 as a stroke unit								Ward location move to accommodate stroke services
		L	4	4	19,9	19,9	1		L	4	4	19,9	19,9	1	09.03.2026	L													
		N	3	3					N	3	3					N													
PoWH	4	E	6	4				4	E	6	4					E	6	4											
		L	6	4	33,69	13,62	1		L	6	4	33,69	13,62	1	09.03.2026	L	6	4	33,69	13,62	1	04.09.2026	Y	Y	Ward now has an 8 bedded CCU area- staffing not changed at present				
		N	6	1					N	6	1					N	6	1											
PoWH	9	E	4	3				9	E	4	3					E	4	3											
		L	4	3	19,07	13,62	1		L	4	3	19,07	13,62	1	09.03.2026	L	4	3	19,07	13,62	1	04.09.2026	Y	N					
		N	3	2					N	3	2					N	3	2											
PoWH	10	E	5	5				10	E	5	5					E	5	5											
		L	4	5	23,79	24,52	1		L	4	5	23,79	24,52	1	09.03.2026	L	4	5	23,79	24,52	1	04.09.2026	Y	N					Move of services to RGH due to critical incident and to centralise
		N	4	4					N	4	4					N	4	4											

Appendix 2: Annual Presentation of the Nurse Staffing Level to the Board report

Health board/trust:	CTMUHB
Period of the report	1st October 2025- 30th September 2026
Adult Acute Surgical Inpatient Wards	Start 10 - End 7

Spring calculations were completed in March 2026 and reviewed/endorsed through governance in April 2026. Autumn calculations were completed in September 2026 and reviewed/endorsed through governance in September 2026.

The number of staff per shift needs to be entered. The information should reflect the information on the informing patient template.

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within the data for this report. Further information is provided within the annual assurance report (https://ctmuhb.nhs.wales/about-us/governance-assurance/annual-reports-annual-accounts-annual-plans/reports1/ctm-uhb-annual-report-and-accounts/ctm-uhb/ctm-uhb-annual-report-accounts-2025-2026/?ts=1793116321462) on the additional multi-professional staff that contribute to the coordination and delivery of patient care.

Adult Acute Surgical Inpatient Wards

Reported to the Board in November 2025								Calculated during spring 2026 cycle								Calculated during autumn 2026 cycle								Biannual calculation cycle reviews, and any changes made & rationale during the spring 2026 & autumn 2026 calculation cycles			Any reviews outside of biannual calculation, if yes, provide rationale for any changes made			
Site	Name of Ward	SHIFT	Planned roster as stated within the annual presentation to the Board report (in November 2025)		Required Establishment as stated within the annual presentation to the Board report (in November 2025) including uplift 26.9%		TOTAL WTE Band 7 supernumerary ward sister/Charge nurse	Name of Ward	SHIFT	Planned roster calculated by the designated person during the spring 2026 cycle		Required Establishment as calculated by the designated persons during the spring 2026 cycle including uplift 26.9%		TOTAL WTE Band 7 supernumerary ward sister/Charge nurse	Date designated person calculated the nurse staffing level	New ward Name	SHIFT	Planned roster calculated by the designated person during the autumn 2026 cycle		Required Establishment as calculated by the designated persons during the autumn 2026 cycle including uplift 26.9%		TOTAL WTE Band 7 supernumerary ward sister/Charge nurse	Date designated person calculated the nurse staffing level	Completed (Yes/No)	Changed	Rationale	Completed (Yes/No)	Changed	Date	Rationale
			RN (band 5 &6)	HCSW (bands 2,3 &4)	TOTAL WTE RN (bands 5 &6)	TOTAL WTE HCSW (bands 2,3 &4)				RN (band 5 &6)	HCSW (bands 2,3 &4)	TOTAL WTE RN (bands 5 &6)	TOTAL WTE HCSW (bands 2,3 &4)					RN (band 5 &6)	HCSW (bands 2,3 &4)	TOTAL WTE RN (bands 5 &6)	TOTAL WTE HCSW (bands 2,3 &4)										
PCH	5	E	4	4					E	4	4						E	4	4											
		L	4	4	19,90	19,90	1	5	L	4	4	19,9	19,9	1	09.03.2026	PCH 5	L	4	4	19,9	19,9	1	04.09.2026	Y	N	Ward has a GAU/ Waiting room	N	N		
		N	3	3					N	3	3						N	3	3											
PCH	6	E	5	4					E	5	4						E	5	4											
		L	5	4	22,09	19,90	1	6	L	5	4	22,09	19,9	1	09.03.2026	PCH 6	L	5	4	22,09	19,9	1	04.09.2026	Y	N	Ward has SAU/ Waiting room (Saturday/ Sunday RN staff drop to 4 by day)	N	N		
		N	3	3					N	3	3						N	3	3											
PCH	7	E	4	4					E	4	3						E	8	8											
		L	4	4	19,90	19,90	1	7	L	4	3	19,9	19,9	1	09.03.2026	Trauma Unit (wards 7 & 8)	L	8	8	39,8	39,8	1	04.09.2026	Y	N	Trauma unit created August 2026	Y	Y		Trauma unit created by amalgamating wards 7 & 8
		N	3	3					N	3	3						N	6	6											
PCH	8	E	4	4					E	4	4																			
		L	4	4	19,90	19,90	1	8	L	4	4	19,9	19,9	1	09.03.2026	See ward above. Ward amalgamated with ward 7.							04.09.2026			Trauma unit created August 2026				
		N	3	3					N	3	3																			
RGH	8	E	4	4					E	4	4						E	4	4											
		L	4	4	19,90	19,90	1	RGH 8	L	4	4	19,9	19,9	1	09.03.2026	RGH 8	L	4	4	19,9	19,9	1	04.09.2026	Y	N		N	N		
		N	3	3					N	3	3						N	3	3											
RGH	9	E	3	3					E	3	3						E	6	2											
		L	3	3	18,06	14,21	1	RGH 7	L	3	3	18,06	14,21	1	09.03.2026	RGH 7	L	6	2	31,34	8,53	1	04.09.2026	Y	Y	Change in speciality and patient acuity, resulting in increased RN dependency.	N	N		
		N	3	2					N	3	2						N	5	1											
RGH	10 & 11	E	4	4					E								E													
		L	4	4	23,74	17,05	1	Separated to Ward 10 (Ward 11 falls under Section 25A as changed to standalone DSU)	L								L									Change of speciality now falls under Section 25A				January 2026 acuity audit Separated to Ward 10 (Ward 11 falls under section 25A as changed to standalone DSU)
		N	4	2					N								N													
RGH	15	E	4	4					E	8	8						E	8	8											
		L	4	4	19,90	19,90	1	Trauma Unit (wards 15 & 16)	L	8	8	39,8	39,8	1	09.03.2026	Trauma Unit	L	8	8	39,8	39,8	1	04.09.2026	Y	Y	Trauma unit created	N	N		
		N	3	3					N	6	6						N	6	6											
RGH	16	E	4	4																										
		L	4	4	19,90	19,90	1	See ward above. Ward amalgamated with ward 15.																		Trauma unit created following the January 2026 review.				
		N	3	3																										
PoWH	16	E	4	4					E	3	3						E	3	3											
		L	4	4	19,07	20,07	1	11	L	3	3	16,34	14,62	1	09.03.2026	11	L	3	3	16,34	14,62	1	04.09.2026	Y	Y	(Previously Ward 21 & Bridgend Clinic)	N	N		
		N	3	3					N	3	2						N	3	2											

Appendix 2 : Annual Presentation of the Nurse Staffing Level to the Board report

Health board/trust:	CTMUHB
Period of the report	1st October 2025- 30th September 2026
Paediatric Inpatient Wards	3

Spring calculations were completed in March 2026 and reviewed/endorsed through governance in April 2026. Autumn calculations were completed in September 2026 and reviewed/endorsed through governance in September 2026.

The number of staff per shift needs to be entered. The information should reflect the information on the informing patient template.

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within the data for this report. Further information is provided within the annual assurance report (https://ctmuhb.nhs.wales/about-us/governance-assurance/annual-reports-annual-accounts-annual-plans/reports1/ctm-uhb-annual-report-and-accounts/ctm-uhb/ctm-uhb-annual-report-accounts-2025-2026/?ts=1793116321462) on the additional multi-professional staff that contribute to the coordination and delivery of patient care.

Paediatric Inpatient Wards

		Reported to the Board in November 2025						Calculated during spring 2026 cycle							Calculated during autumn 2026 cycle								Biannual calculation cycle reviews, and any changes made & rationale during the spring 2026 & autumn 2026 calculation cycles			Any reviews outside of biannual calculation, if yes, provide rationale for any changes made			
Site	**Name of Ward**	**SHIFT**	**Planned roster as stated within the annual presentation to the Board report (in November 2025)**		**Required Establishment as stated within the annual presentation to the Board report (in November 2025) including uplift 26.9%**		**TOTAL WTE Band 7 supernumerary ward sister/Charge nurse**	**SHIFT**	**Planned roster calculated by the designated person during the spring 2026 cycle**		**Required Establishment as calculated by the designated persons during the spring 2026 cycle including uplift 26.9%**		**TOTAL WTE Band 7 supernumerary ward sister/Charge nurse**	**Date designated person calculated the nurse staffing level**	**SHIFT**	**Planned roster calculated by the designated person during the autumn 2026 cycle**		**Required Establishment as calculated by the designated persons during the autumn 2026 cycle including uplift 26.9%**		**TOTAL WTE Band 7 supernumerary ward sister/Charge nurse**	**Date designated person calculated the nurse staffing level**							
			RN (band 5 &6)	**HCSW** (bands 2,3 &4)	**TOTAL WTE RN** (bands 5 &6)	**TOTAL WTE HCSW** (bands 2,3 &4)			**RN** (band 5 &6)	**HCSW** (bands 2,3 &4)	**TOTAL WTE RN** (bands 5 &6)	**TOTAL WTE HCSW** (bands 2,3 &4)				**RN** (band 5 &6)	**HCSW** (bands 2,3 &4)	**TOTAL WTE RN** (bands 5 &6)	**TOTAL WTE HCSW** (bands 2,3 &4)			**Completed (Yes/No)**	**Changed**	**Rationale**	**Completed (Yes/No)**	**Date**	**Changed**	**Rationale**
PCH	**Ward 31**	**E**	5	1	**29,43**	**5,69**	**1**	**E**	5	1	**29,43**	**5,69**	**1**	09.03.2026	**E**	5	1	**29,43**	**5,69**	**1**	04.09.2026	**Y**	**N**					
		L	5	1				**L**	5	1					**L**	5	1											
		N	5	1				**N**	5	1					**N**	5	1											
RGH	**Ward 17**	**E**	5	1	**29,43**	**5,69**	**1**	**E**	5	1	**29,43**	**5,69**	**1**	09.03.2026	**E**	5	1	**29,43**	**5,69**	**1**	04.09.2026	**Y**	**N**					
		L	5	1				**L**	5	1					**L**	5	1											
		N	5	1				**N**	5	1					**N**	5	1											
PoWH	**Childrens' ward**	**E**	6	2	**35,11**	**7.72 HCSW M-F then 1**	**1**	**E**	6	2	**35,11**	**7.72 HCSW M-F then 1**	**1**	09.03.2026	**E**	6	2	**35,11**	**7.72 HCSW M-F then 1**	**1**	04.09.2026	**Y**	**N**					
		L	6	2				**L**	6	2					**L**	6	2											
		N	6	1				**N**	6	1					**N**	6	1											