GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

CTM Building Healthier Communities: Case for Change

October 2026

DRAFT V for DISCUSSION



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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

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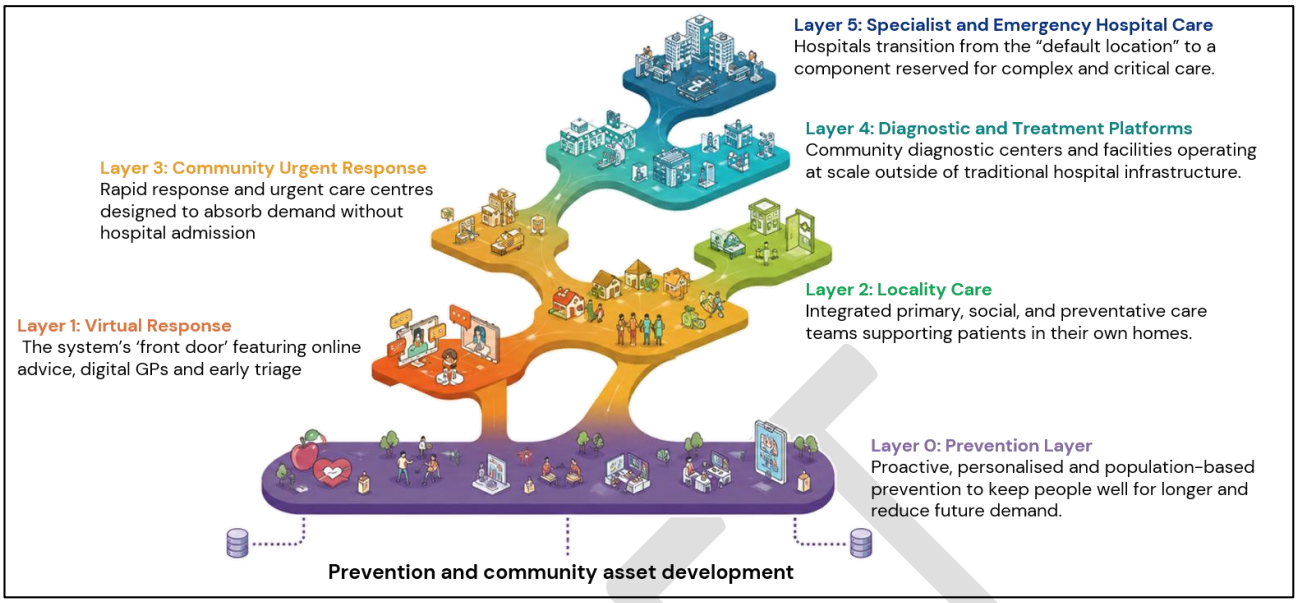


Figure: Proposed Layered Model of Care

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.

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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.

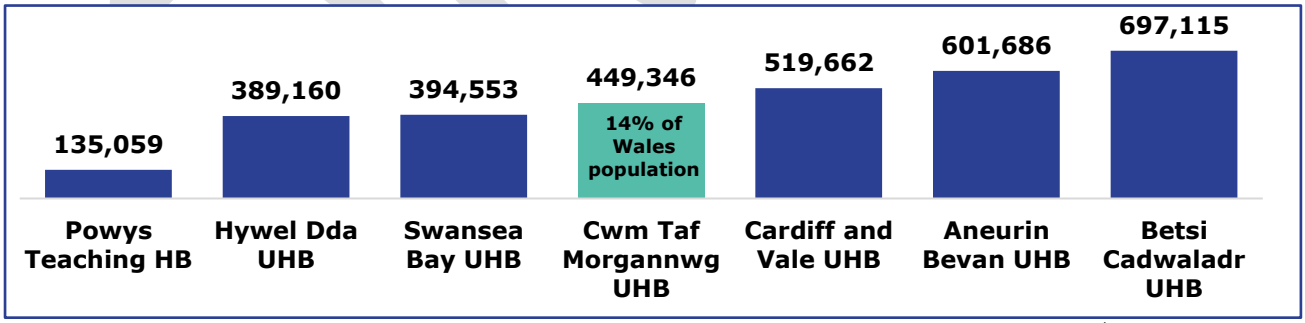


Figure 1.1.1 Mid-2024 population estimates by local health board (Wales) [1]

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

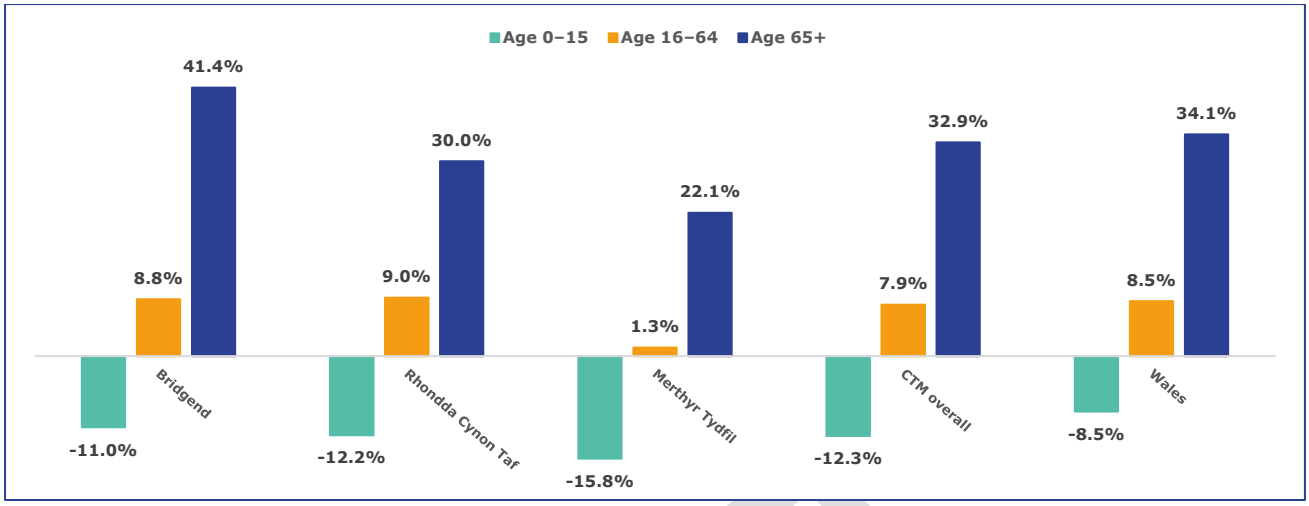


Figure 1.2.2 Population growth projections by Age band and Local Authority in CTM (Wales)[4]

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

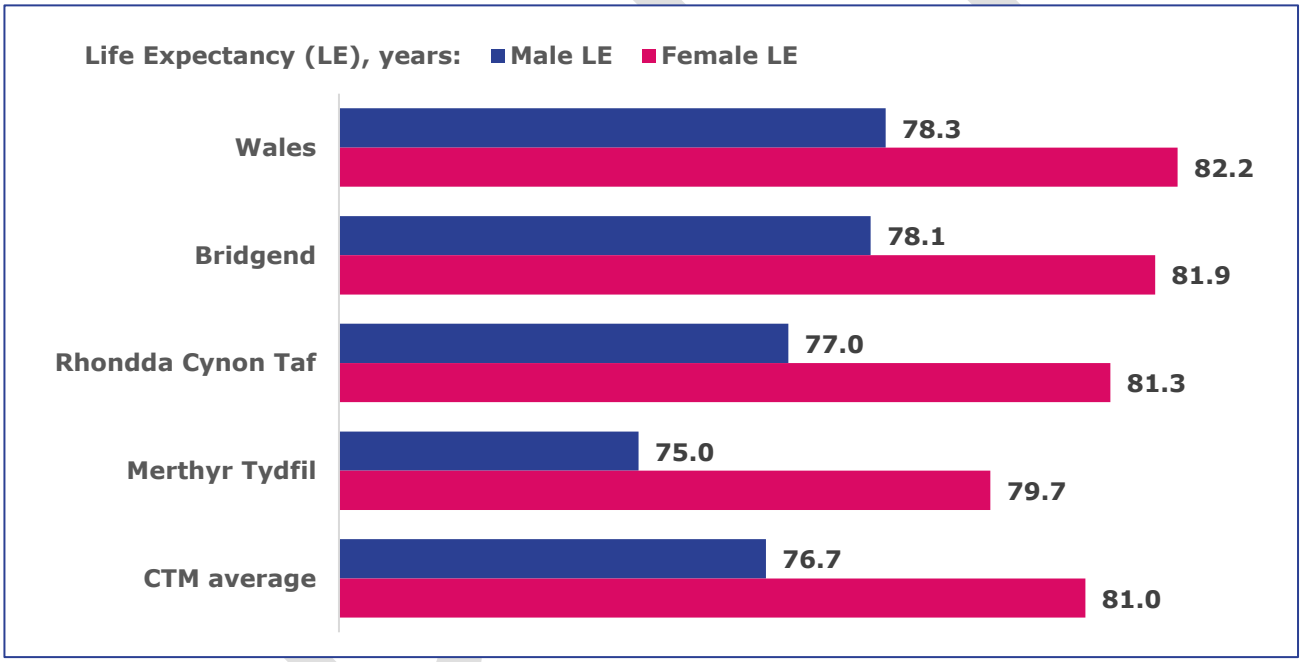


Figure 1.3.1 Average Life expectancy (years) in CTM & Wales by Age and Gender, 2022-24[5]

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.

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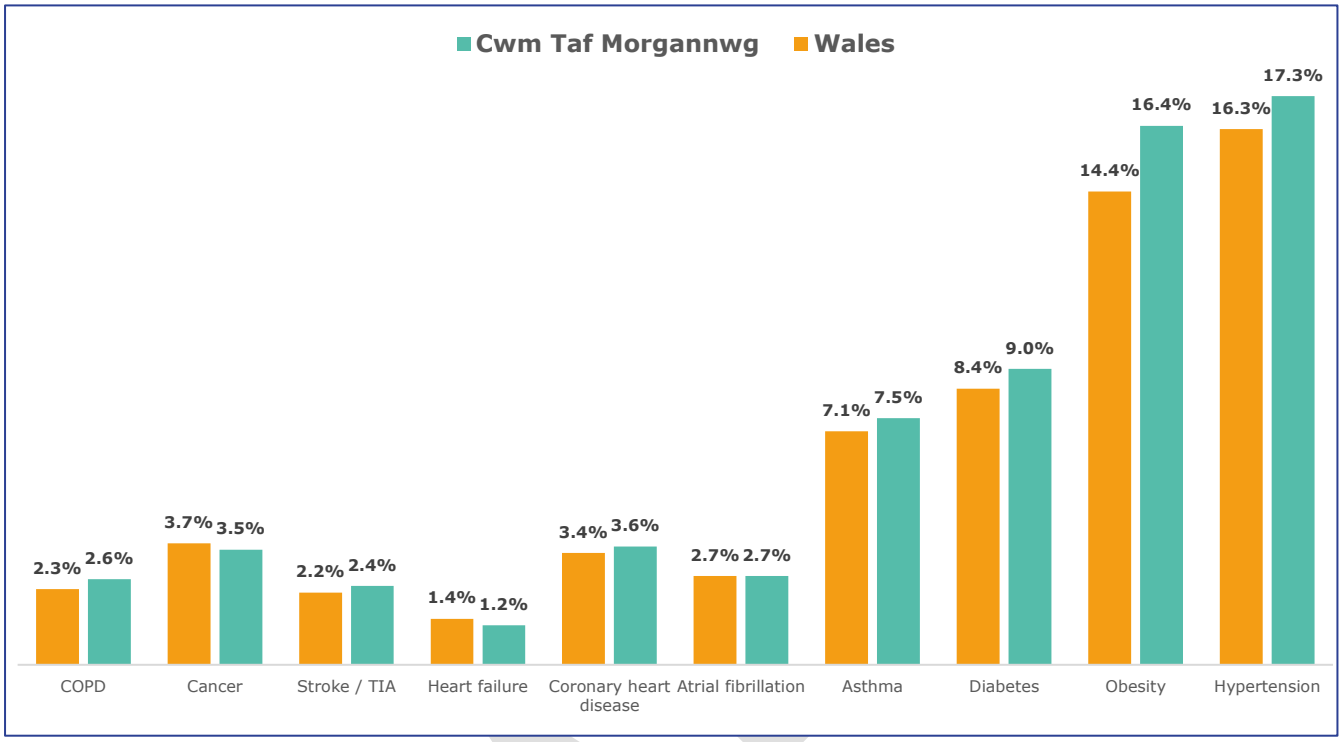


Figure 1.4.1 April 2024 Recorded prevalence of major conditions is higher in CTM than Wales[6]

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,

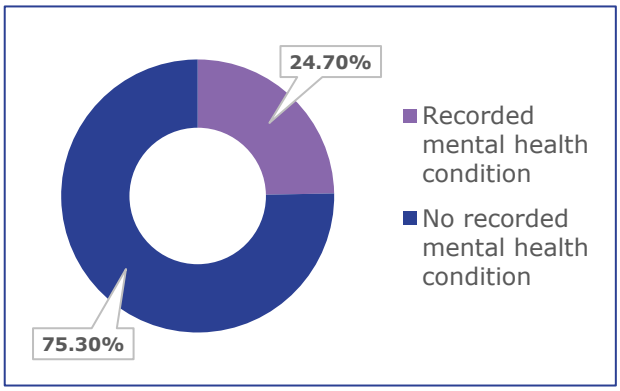


Figure 1.4.2 Recorded mental health conditions in CTM Share of GP-registered patients, 1 April 2025[7]

[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:

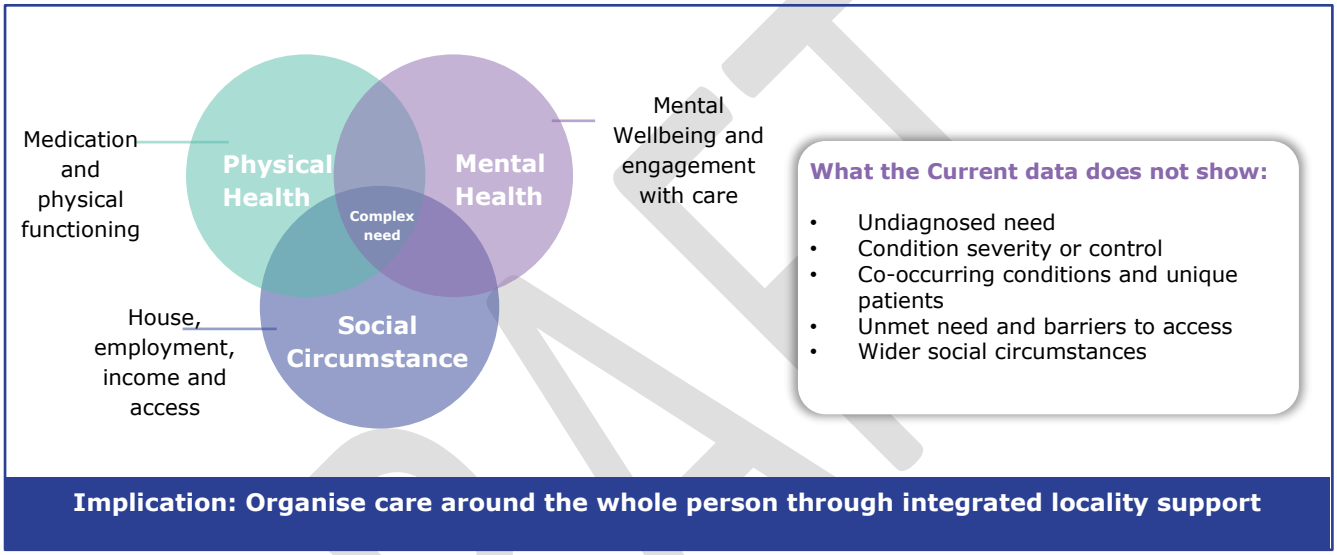


Figure 1.4.3 What Disease recorded conditions among registered patients

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.

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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.

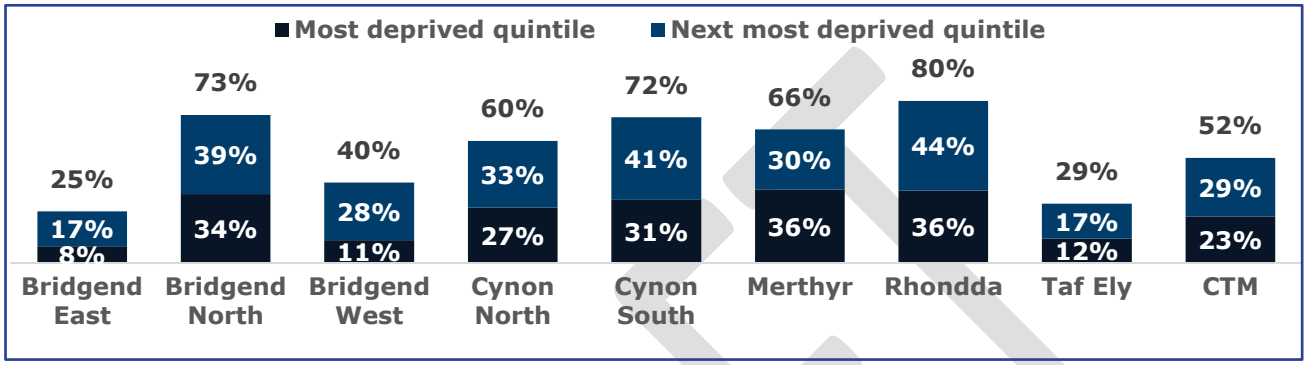


Figure 2.1.1: Proportion of residents in the two most deprived 2025 WIMD quintiles by primary care cluster[9]

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.

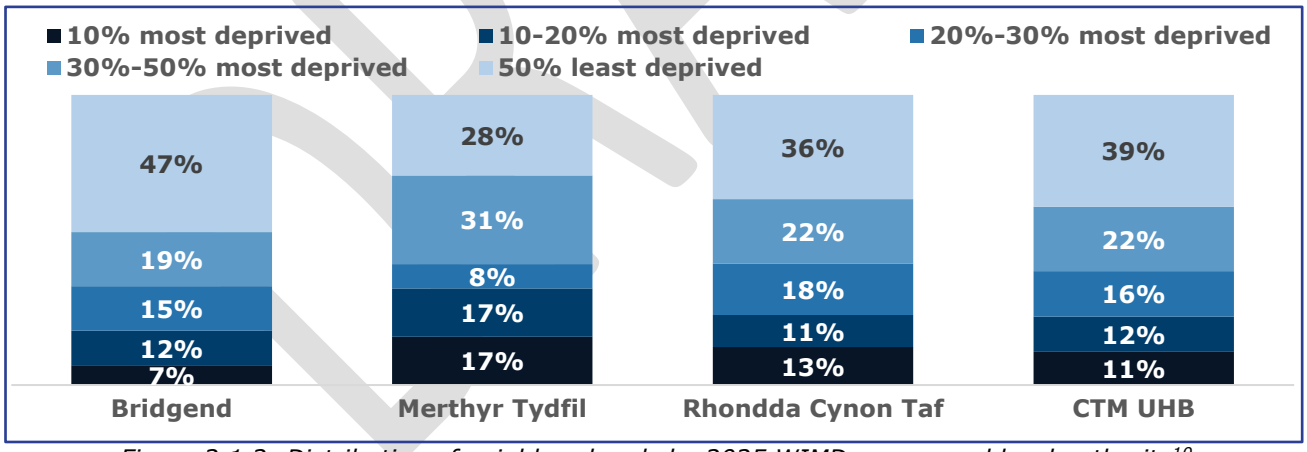


Figure 2.1.2: Distribution of neighbourhoods by 2025 WIMD groups and local authority[10]

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.

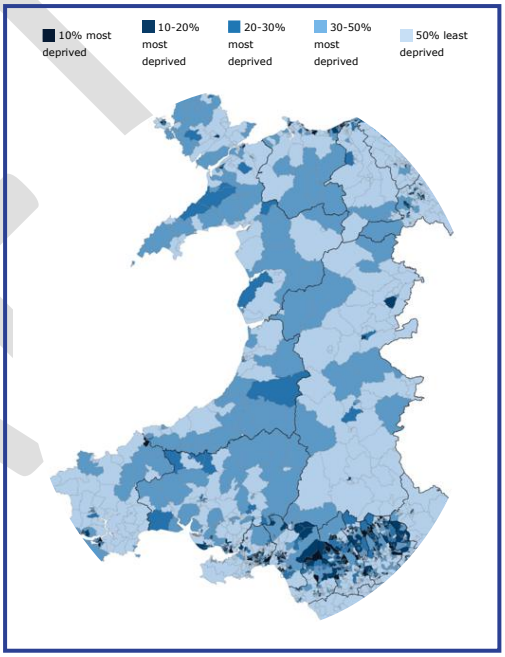


Figure 2.4.1 Distribution of inequality quintiles across Wales, 2025[11]

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.

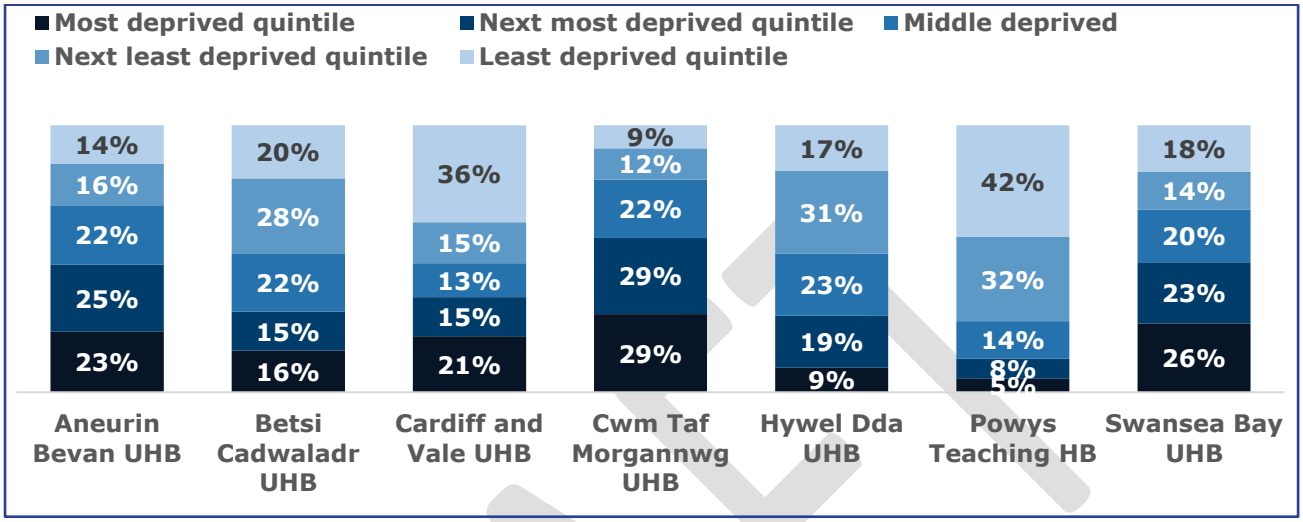


Figure 2.5.1: Proportion of the population by 2025 WIMD health-domain quintile and health board[12]

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.

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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.

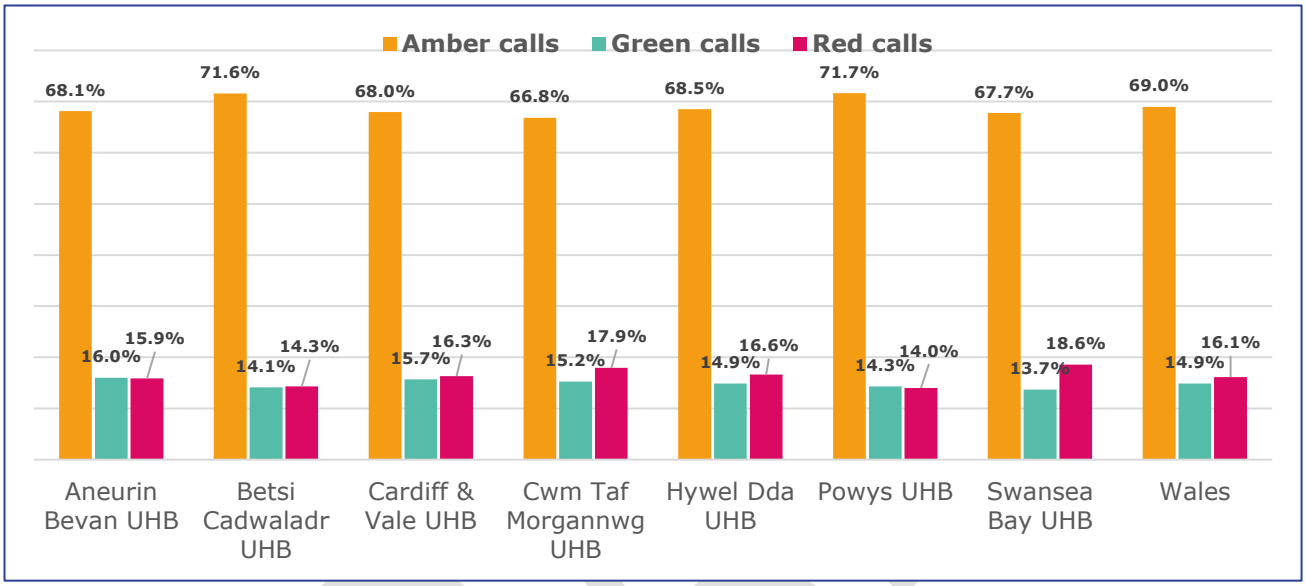


Figure 3.1.1 Distribution of Ambulance Calls by category for each Health Board and All Wales (2025)[15]

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%.

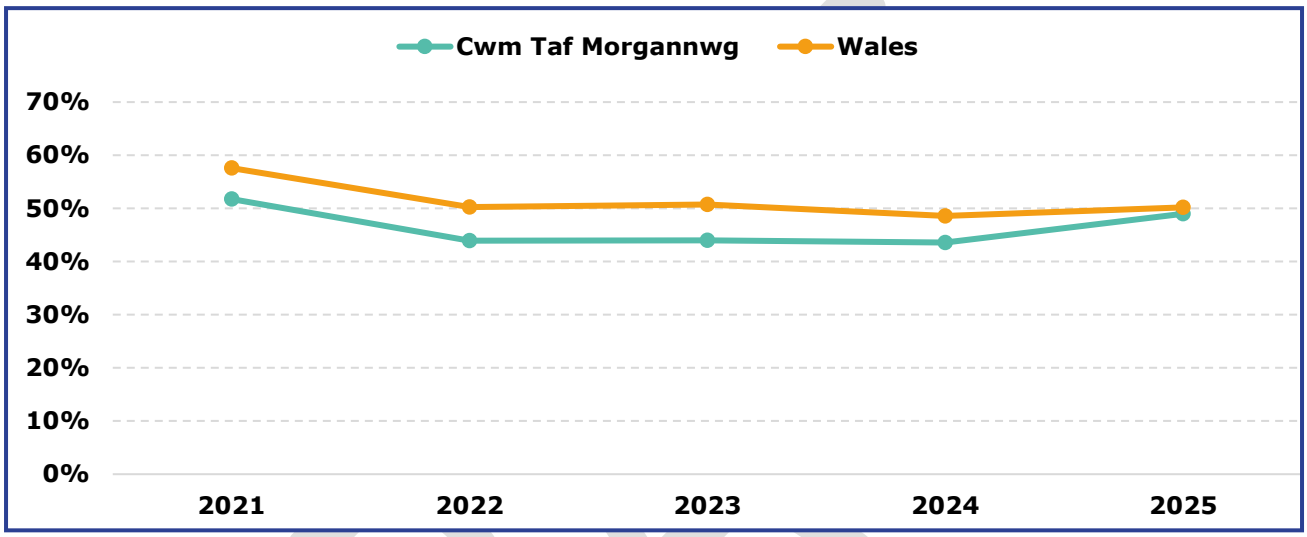


Figure 3.1.2 Annual average percentage of red-call responses arriving within eight minutes, CTM and Wales, (2021–2025)[16]

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.

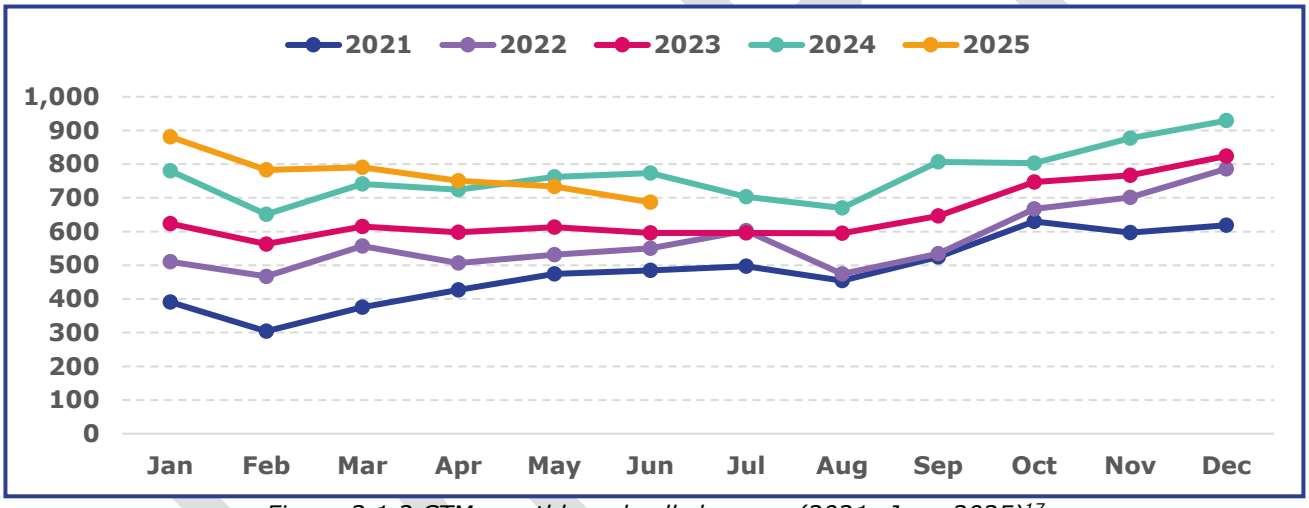


Figure 3.1.2 CTM monthly red calls by year (2021- June 2025)[17]

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.

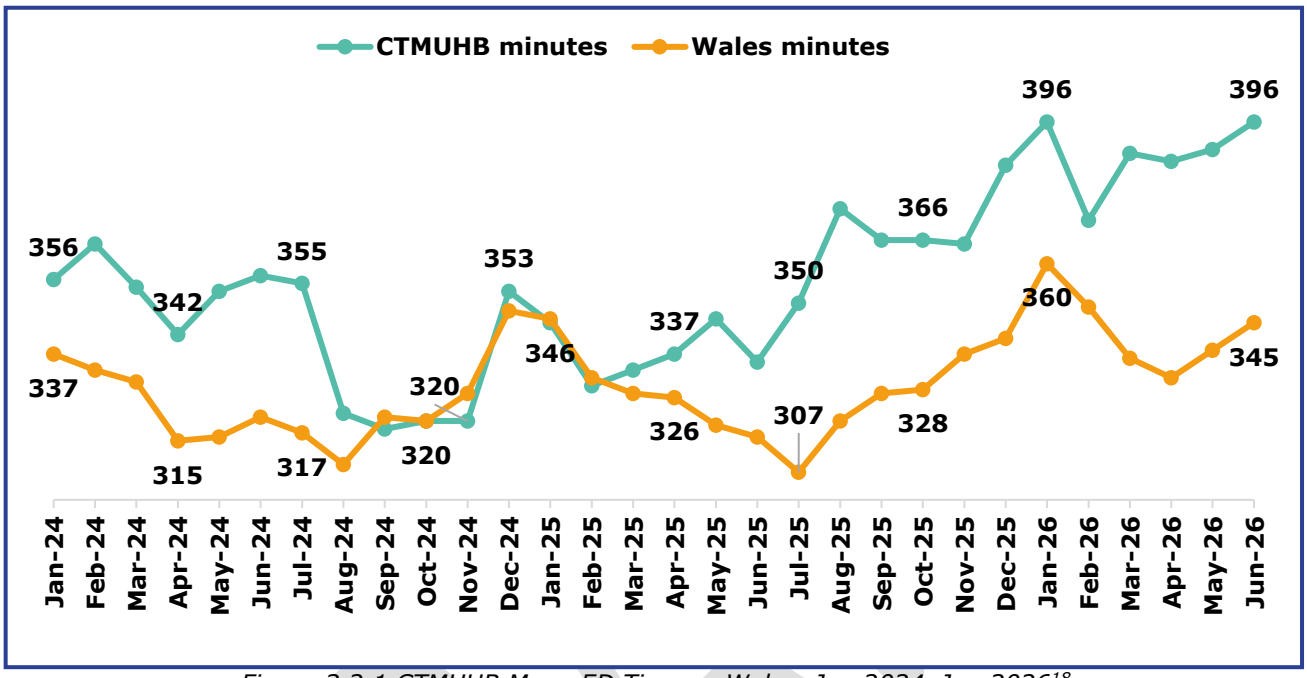


Figure 3.2.1 CTMUHB Mean ED Time vs Wales, Jan 2024–Jun 2026[18]

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.

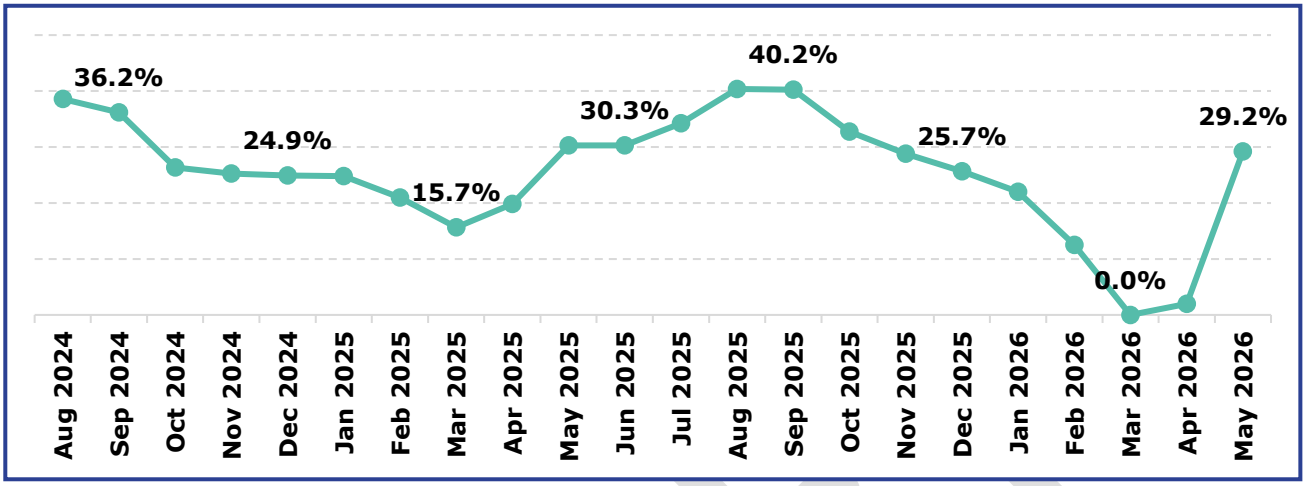


Figure 3.3.1 Percentage of CTM diagnostic pathways waiting over eight weeks (Aug'24 to Apr'26)[19]

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)

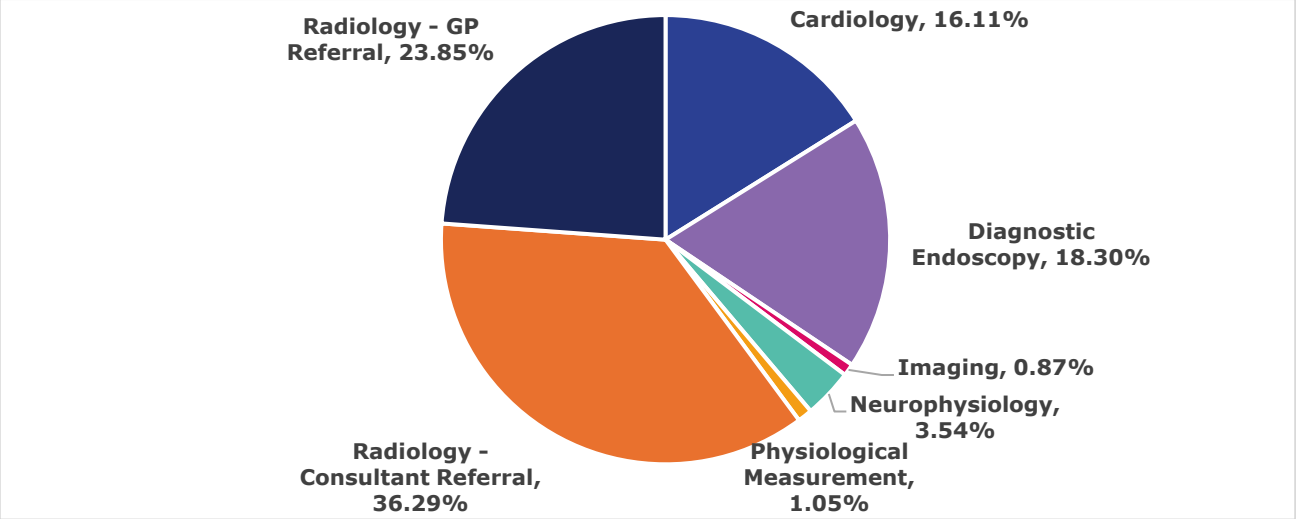


Figure 3.3.2 Composition of CTM's diagnostic waiting list by service group: Percentage share of total pathways waiting, August 2024 to May 2026[20]

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.

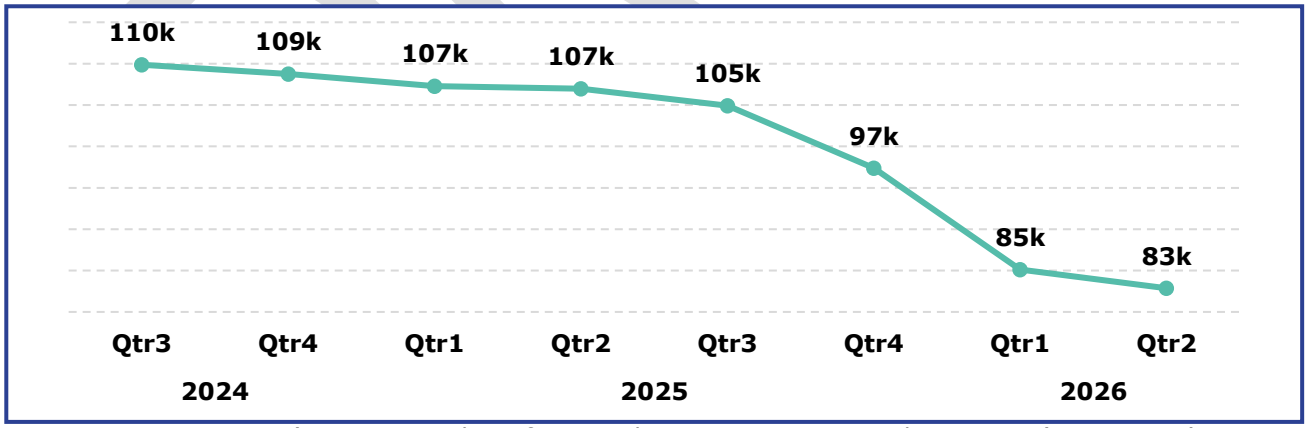


Figure 3.4.1 (Average number of RTT pathways waiting in CTM by quarter (2024–2026)

[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.

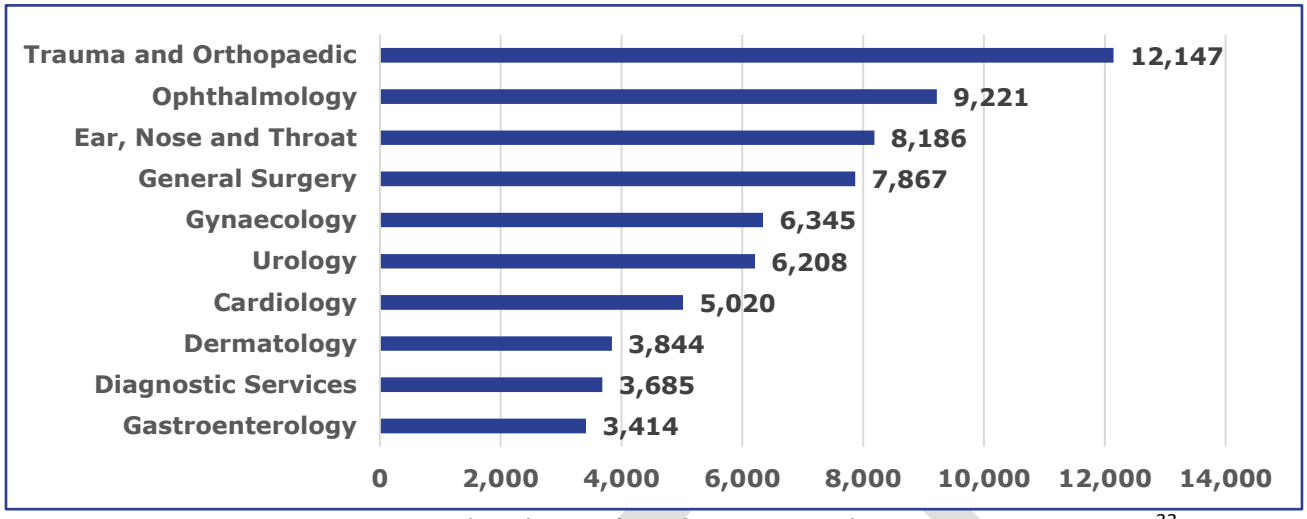


Figure 3.4.2 Top ten specialties by number of CTM RTT pathways waiting, May 2026[22]

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 2030 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.

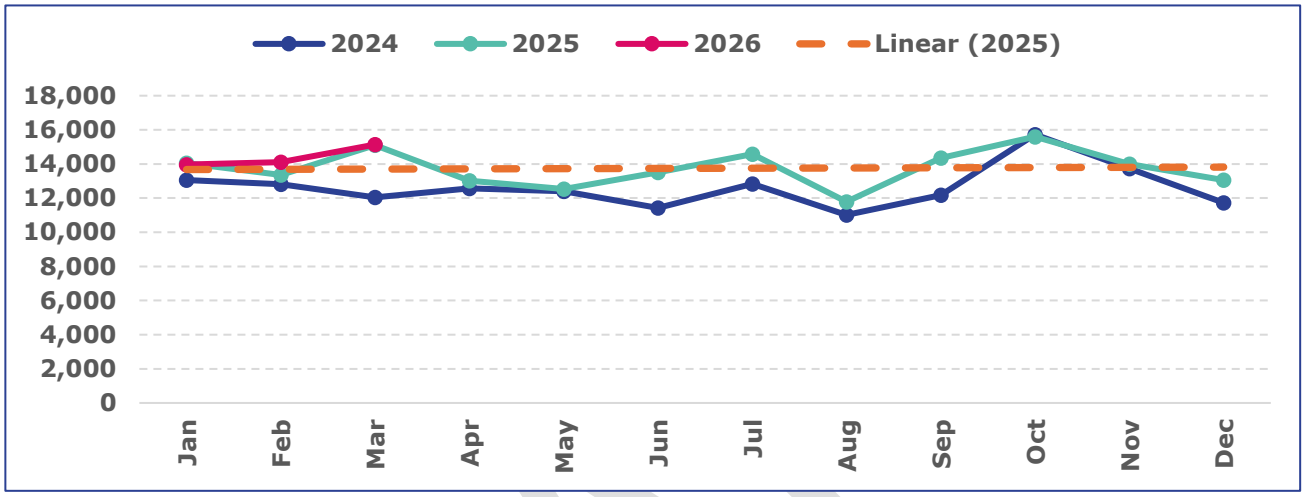


Figure 3.5.1 CTM year-on-year secondary mental health caseload (Jan 2024–Mar 2026)[23]

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.

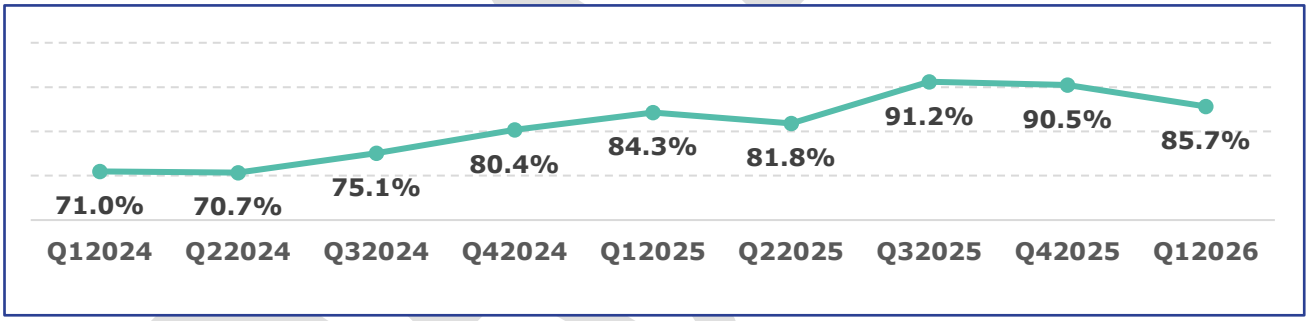


Figure 3.5.2 Percentage of CTM LPMHSS assessments completed within 28 days[24]

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.

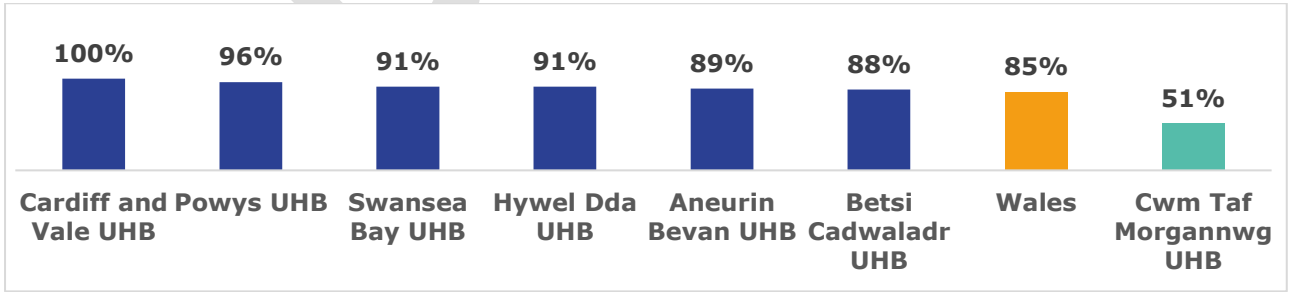


Figure 3.5.3 LPMHSS assessments completed within 28 days by Health board (March 2026) [25]

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.

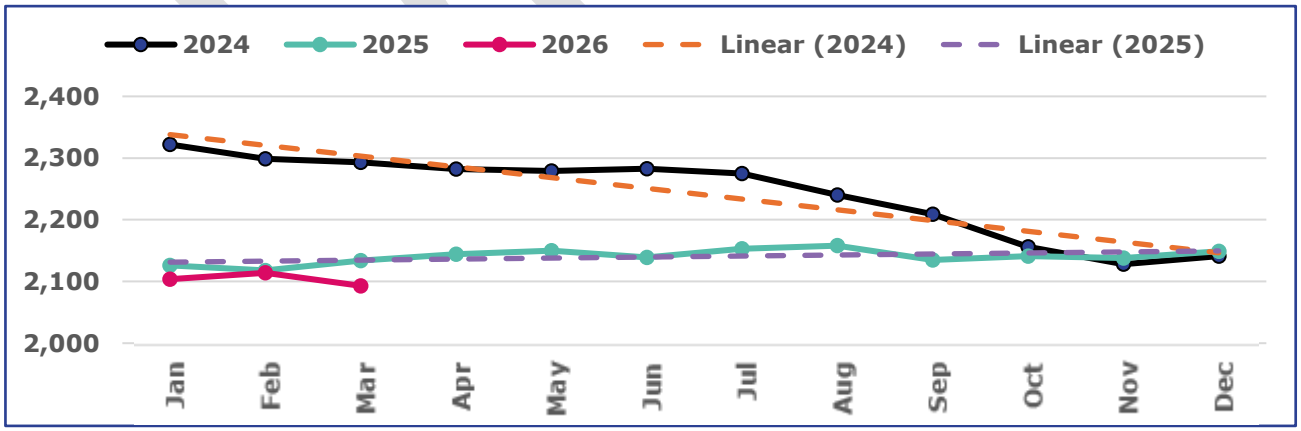


Figure 3.5.4 CTM year-on-year secondary mental health caseload (January 2024–March 2026) [26]

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.

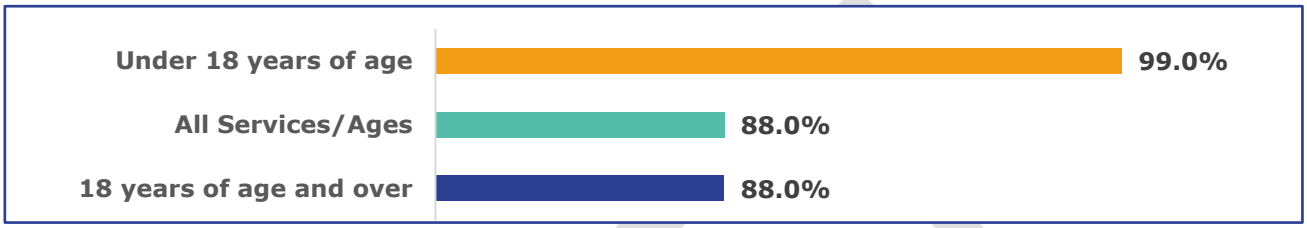


Figure 3.5.6 Percentage of CTM secondary mental health patients with a valid Care and Treatment Plan by age group (March 2026) [27]

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.

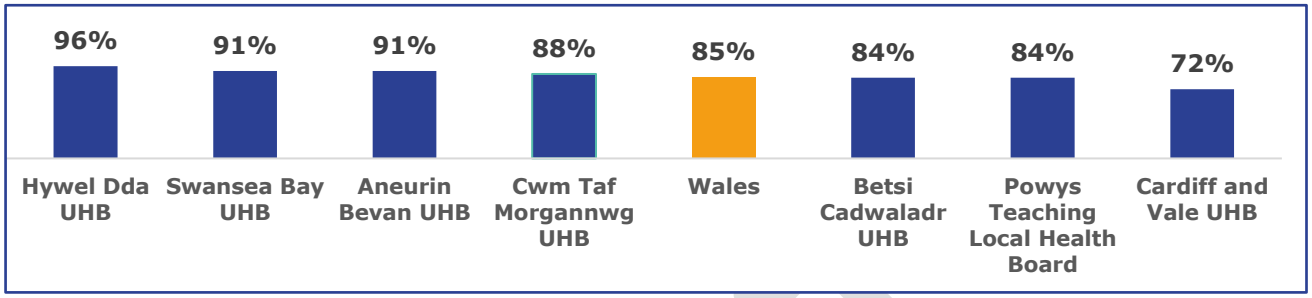


Figure 3.5.5 Percentage of secondary mental health patients with a valid Care and Treatment Plan by health board, March 2026[28]

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.

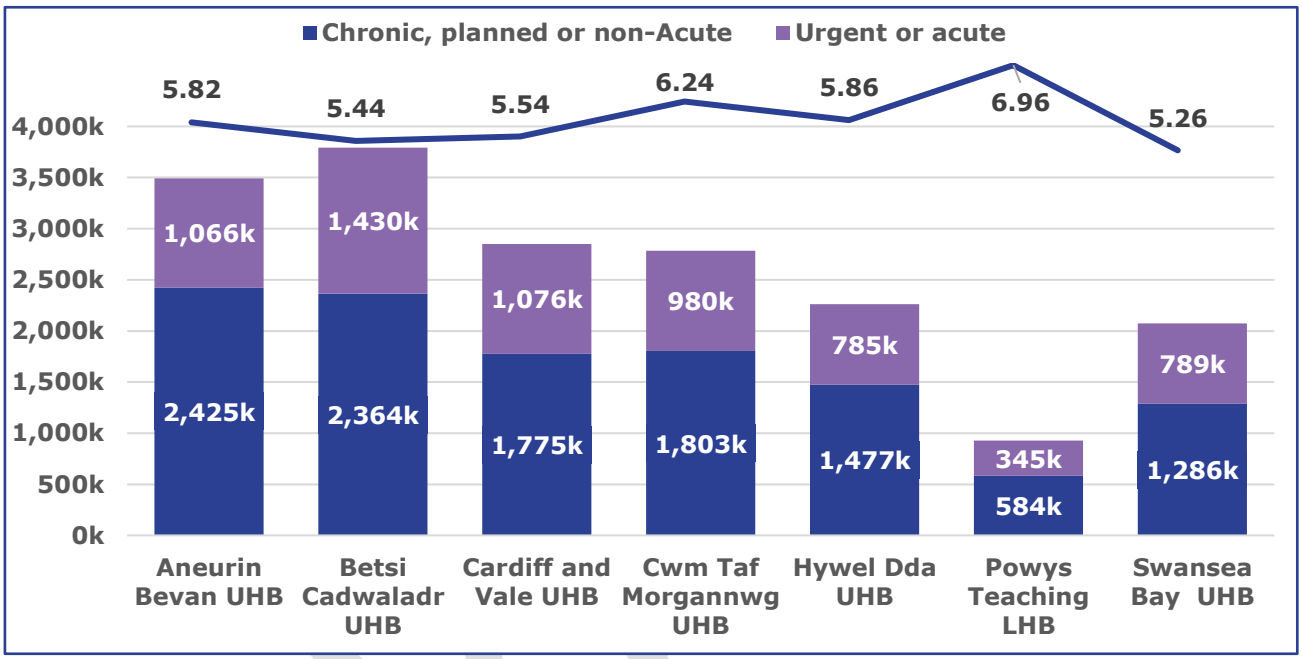


Figure 3.6.1 Number of general practice appointments by reason across LHBs and appointments per resident, 2024-25[29]

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.

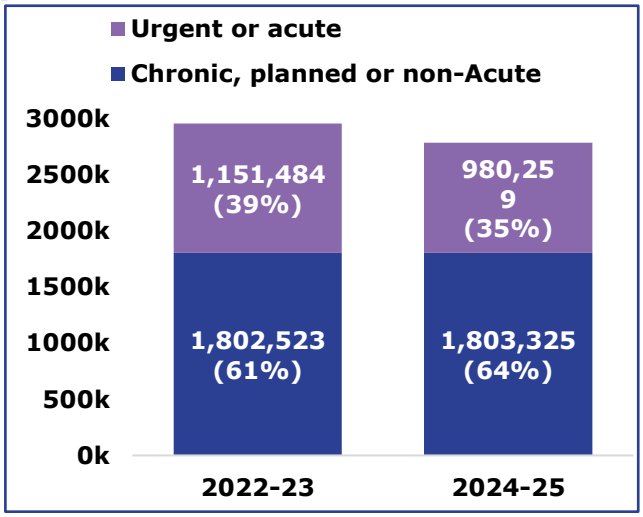


Figure 3.6.2 Number of appointments by reason at CTMUHB 2022-23 to 2024-25[31]

[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.

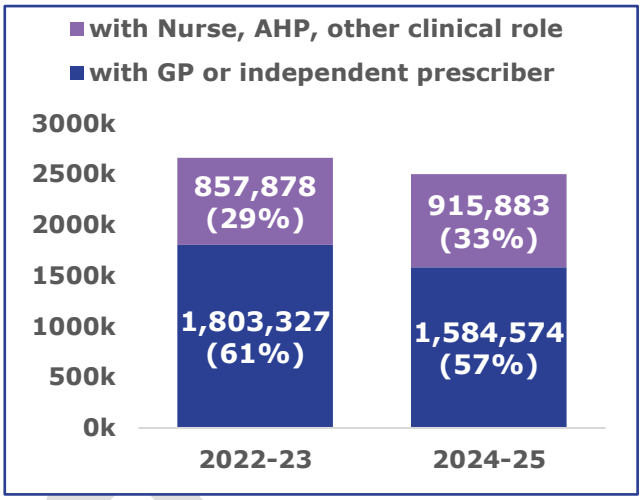


Figure 3.6.3 Number of appointments by practitioner type at CTMUHB 2022-23 to 2024-25[32]

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.

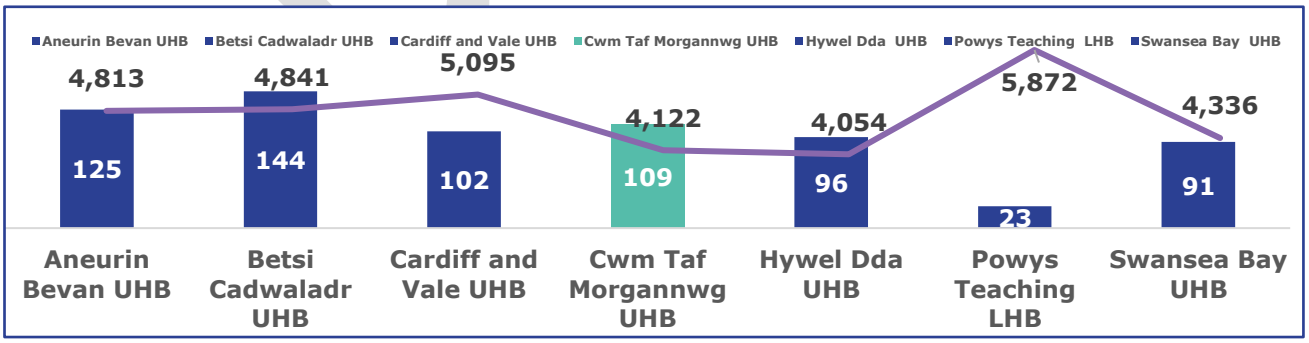


Figure 3.6.4 Number of community pharmacies, number of residents per pharmacy, 2024-25[32]

[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.

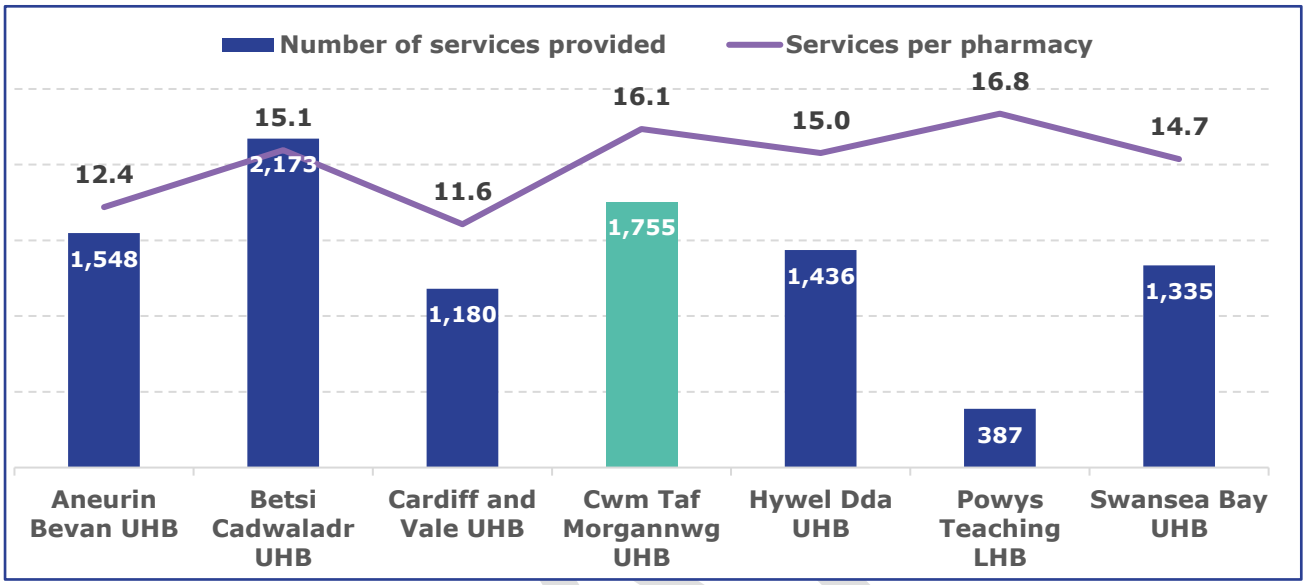


Figure 3.6.5 Number of pharmacy services and number of services per pharmacy, 2024-25[33]

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.

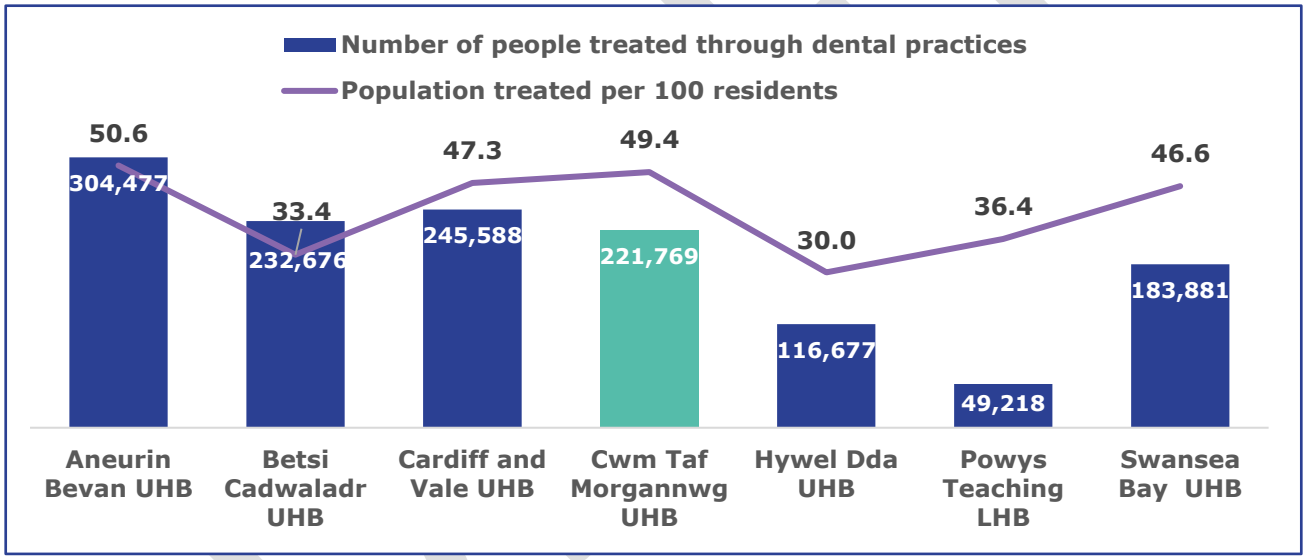


Figure 3.6.6 Number of patients treated by dental practices and number of patients treated per 100 population, 2024-25[34]

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

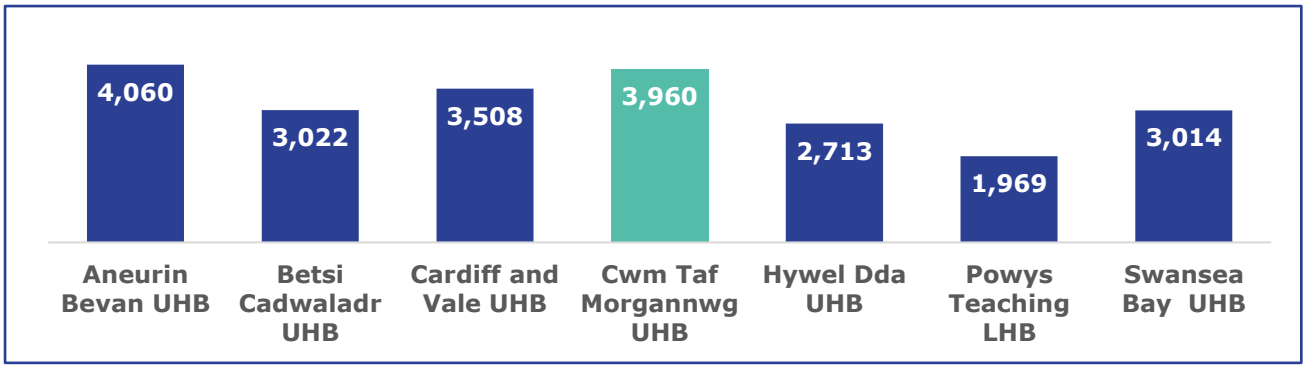


Figure 3.6.7 Number of patients treated per dental practice, 2024-25[35]

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

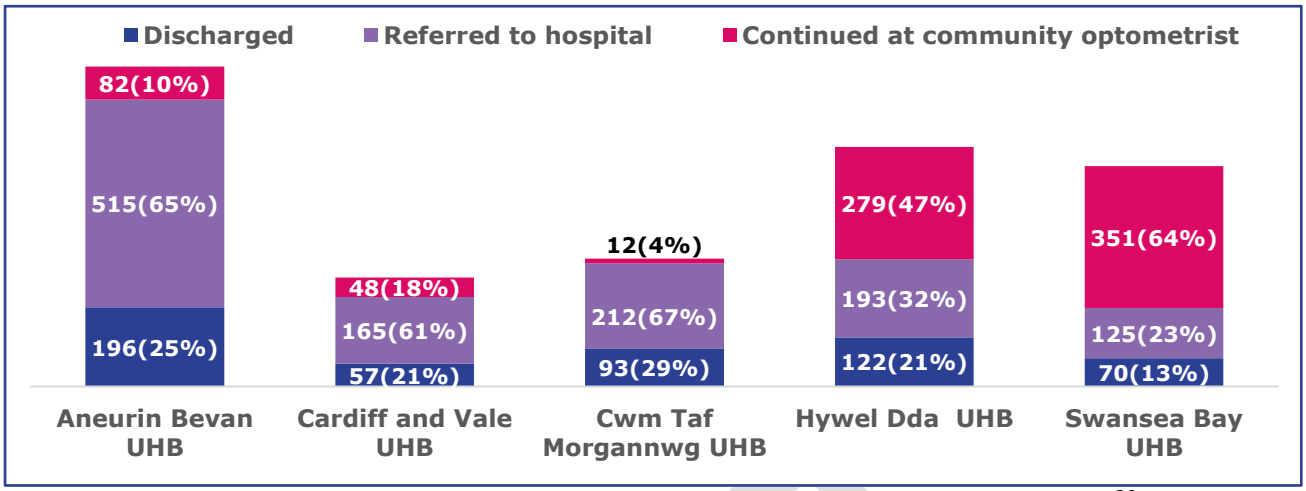


Figure 3.6.8 Number of optometry appointments WGOS4 by reason, 2024-25[36]

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.

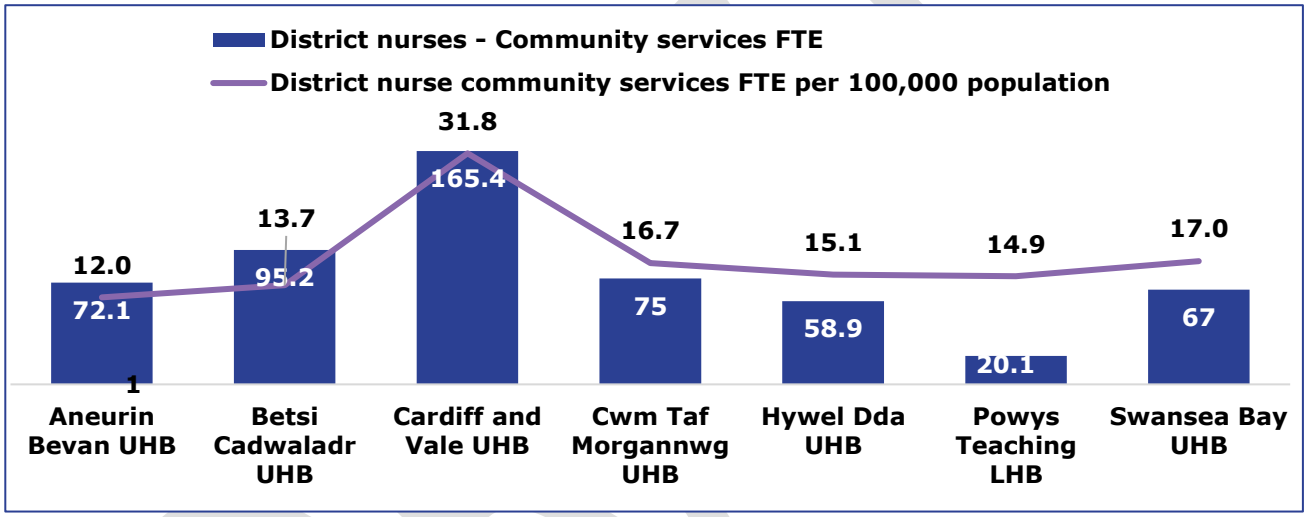


Figure 3.6.9 District nurse community service FTE and number of district nurse community service per 100,000 residents, Mar 2026[37]

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.

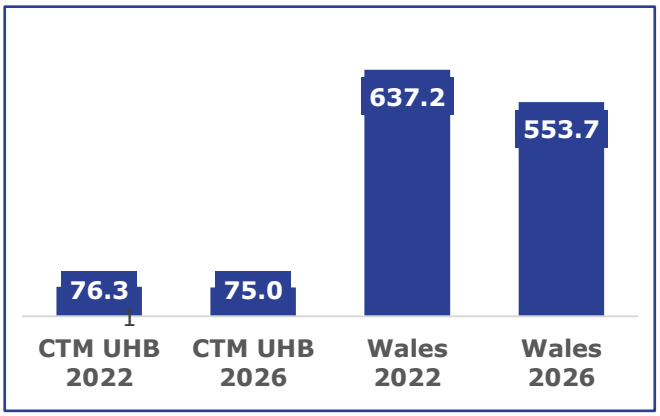


Figure 3.6.10 District nursing community services FTE, 2022-2026[38]

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

[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.

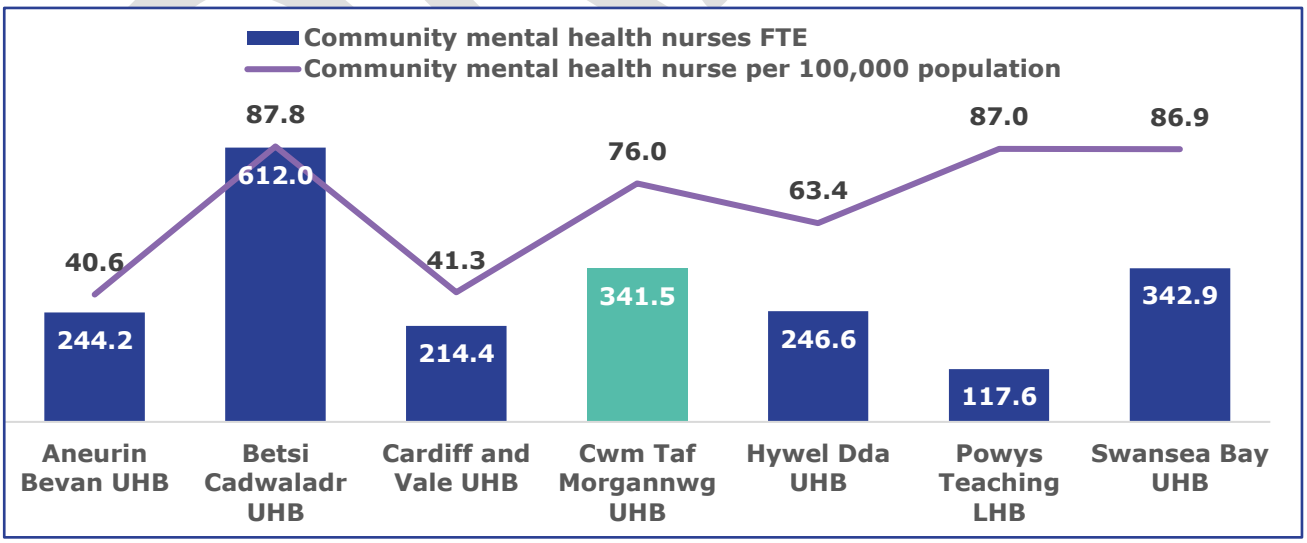


Figure 3.6.11 Community mental health nursing staff FTE and number of Community mental health nursing staff per 100,000 residents, Mar'26[39]

[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.

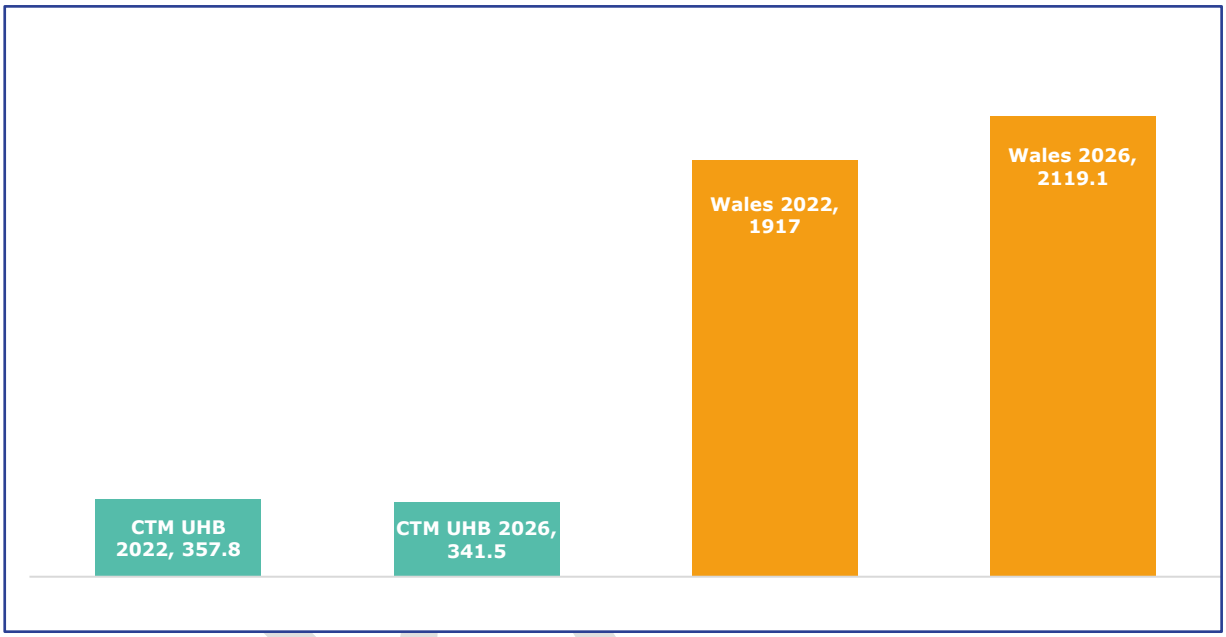


Figure 3.6.12 Community mental health nursing staff FTE Mar'22 to Mar'26[40]

[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

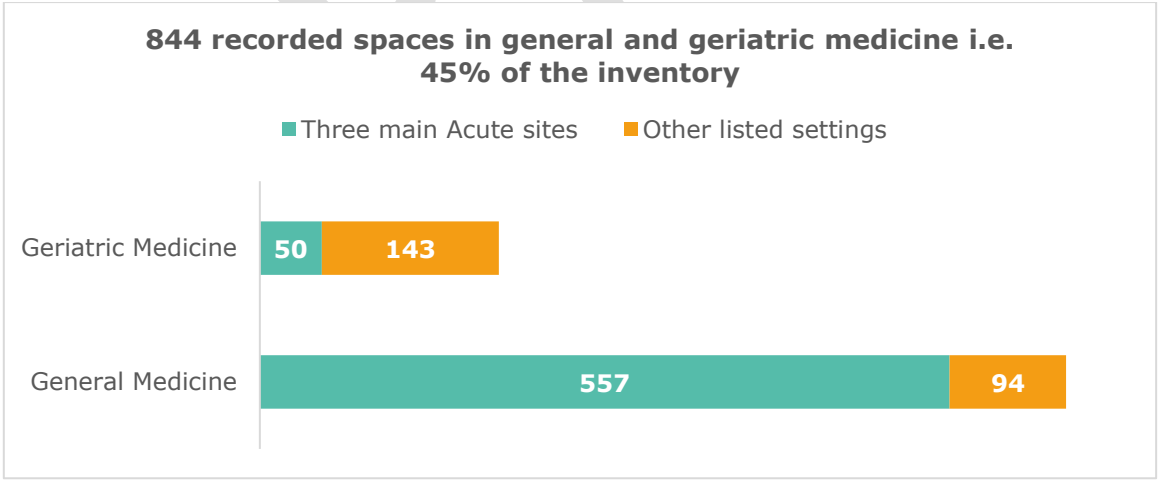
CTM's supplied inventory records 1,873 bed spaces across its hospitals and other services. Of these, 1,385, approximately 74%, are listed within the three main acute hospitals. General and geriatric medicine together account for 844 spaces, approximately 45% of the recorded total.

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.

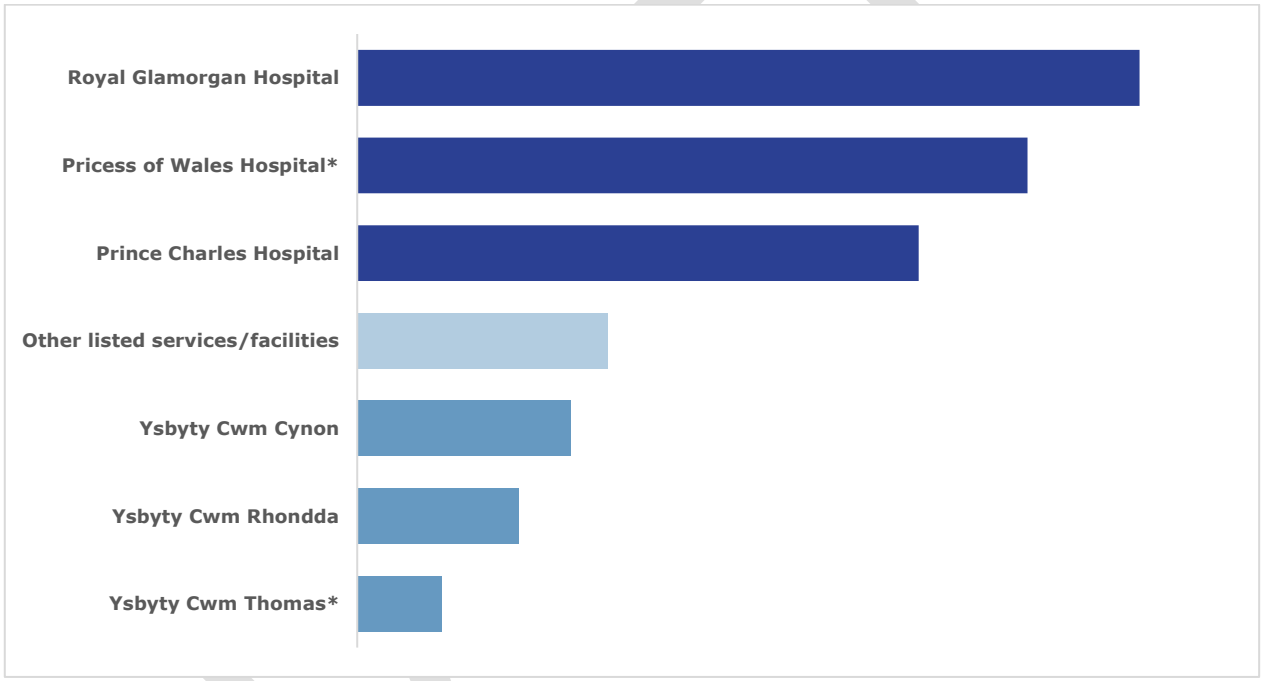
Community inpatient provision and home-delivered care fulfil different functions. Some people will require inpatient rehabilitation or continuing clinical support, while others may be supported appropriately through home-based services. A distributed model should therefore encompass both, recognising 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.*

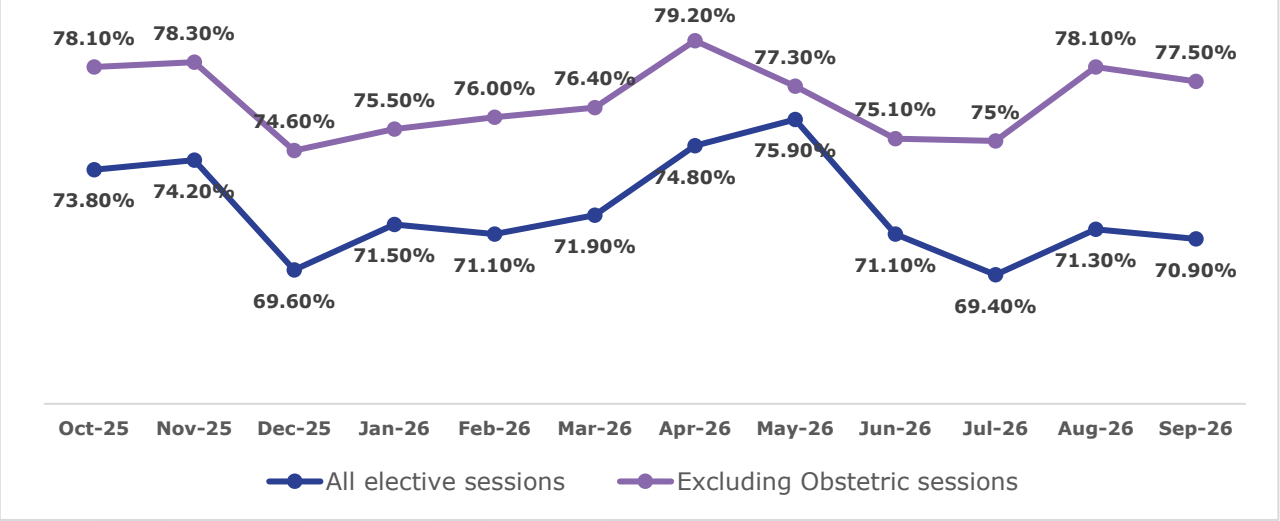
assessment, preparation, treatment and recovery, with the necessary clinical capabilities available at each stage.

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.

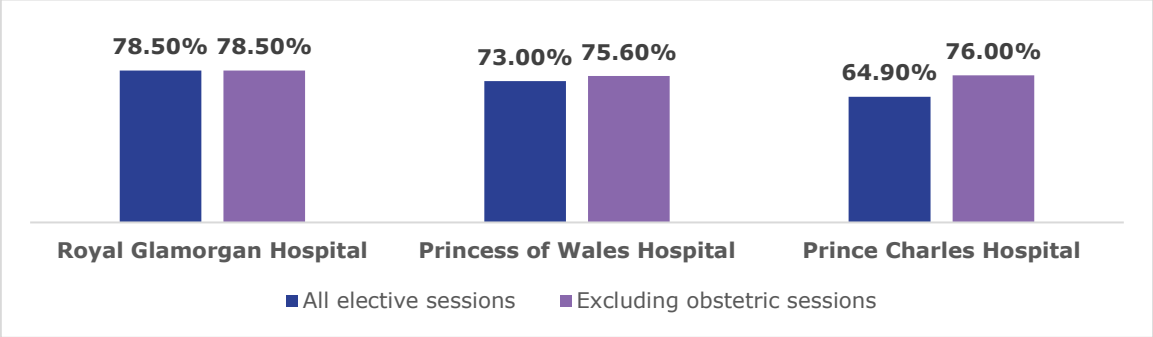
The supplied data do not establish which of these factors explains CTM's utilisation position. The data does establish and demonstrate that a capacity response based on scheduled hours alone would be incomplete. Expanding one component of the pathway can create pathway bottlenecks, leave treatment constrained 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.

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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%.

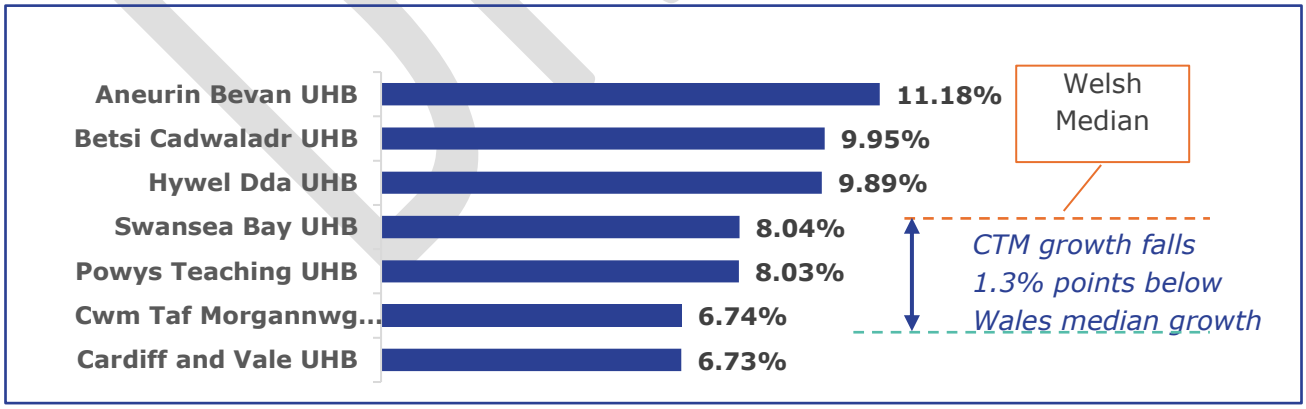


Figure 5.1.1 Percentage growth in directly employed FTE by Welsh health Board, Q1 2022 to Q1 2026[47]

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%.

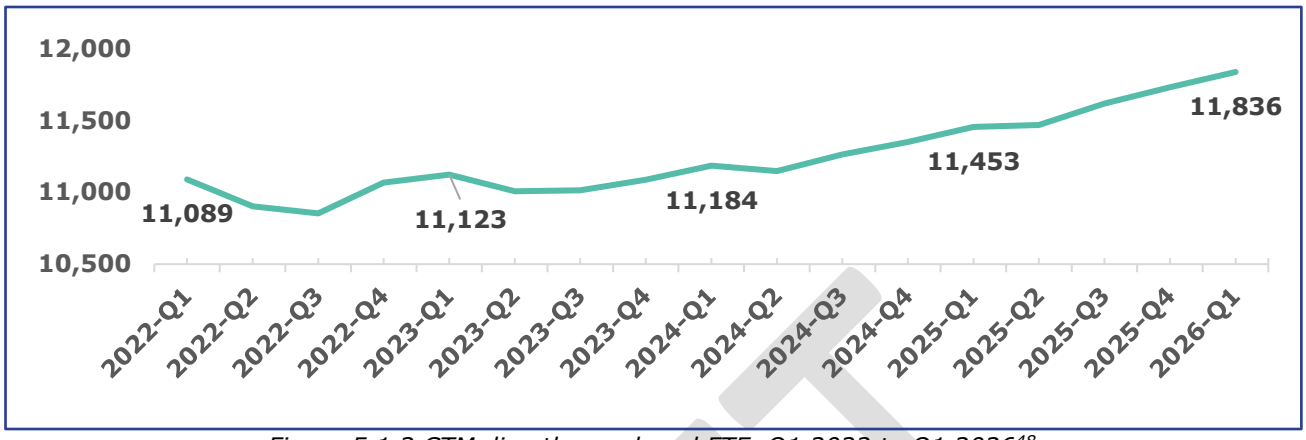


Figure 5.1.2 CTM directly employed FTE, Q1 2022 to Q1 2026[48]

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.

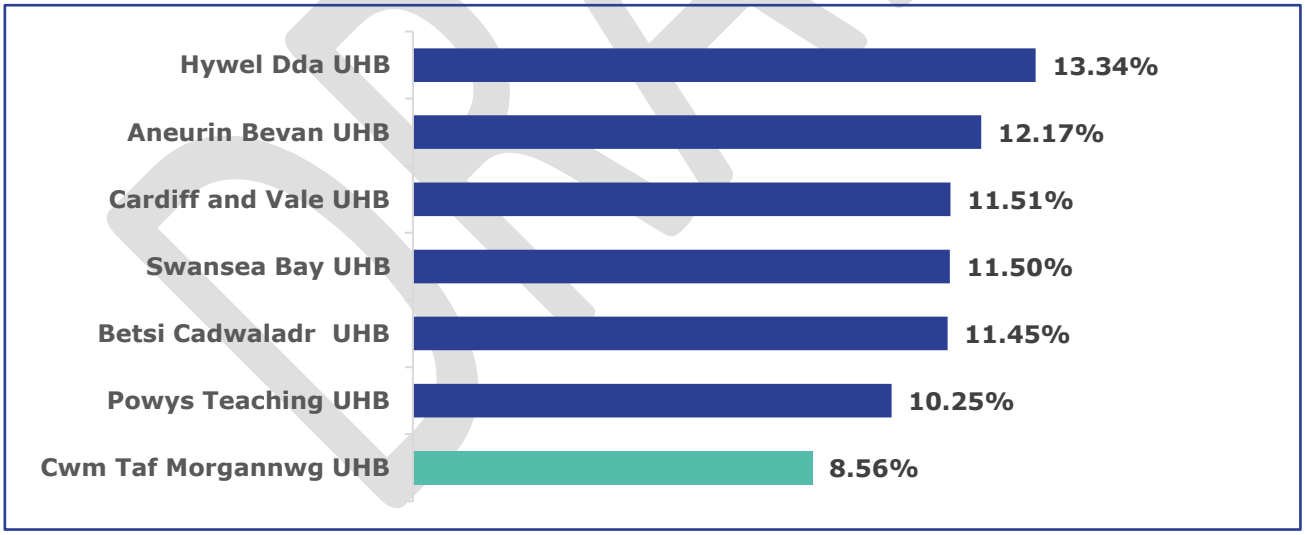


Figure 5.2.2 Change in FTE by staff group compared with the Welsh health-board median[49]

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%.

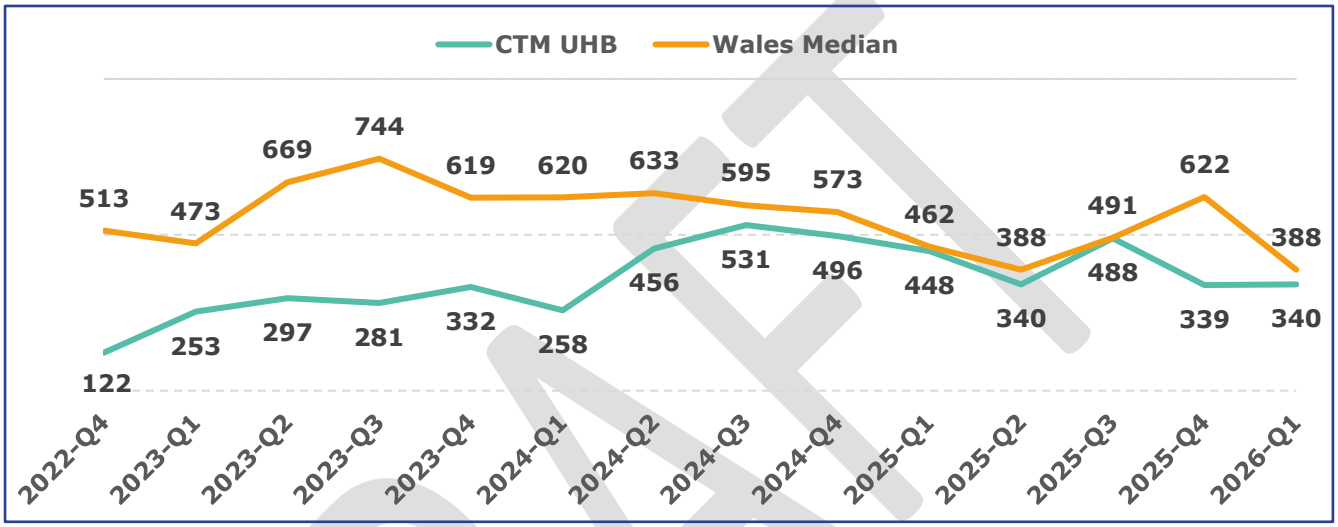


Figure 5.2.3 Reported FTE vacancies and vacancy rates, CTM and Welsh health-board median (2022 Q4 – 2026 Q1)[50]

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

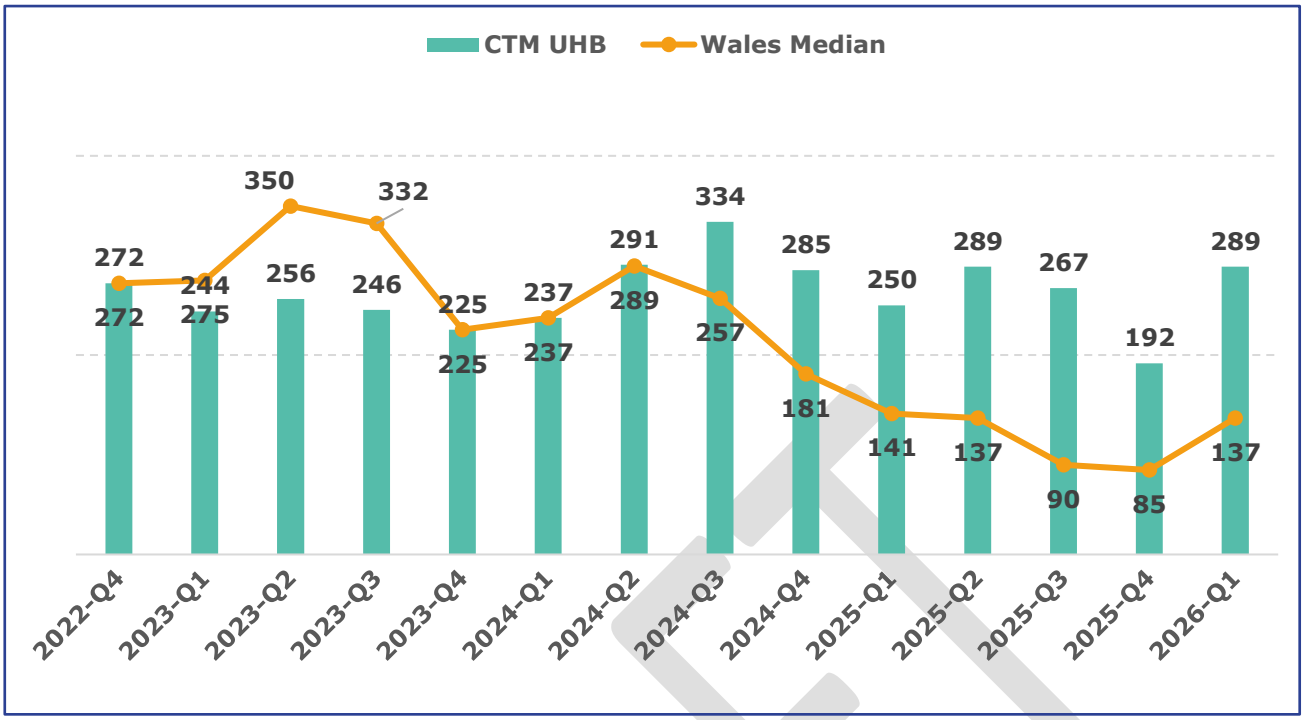


Figure 5.2.4 Registered nursing vacancy rate, CTM and Welsh health board median (2022 Q4 – 2026 Q1)[51]

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

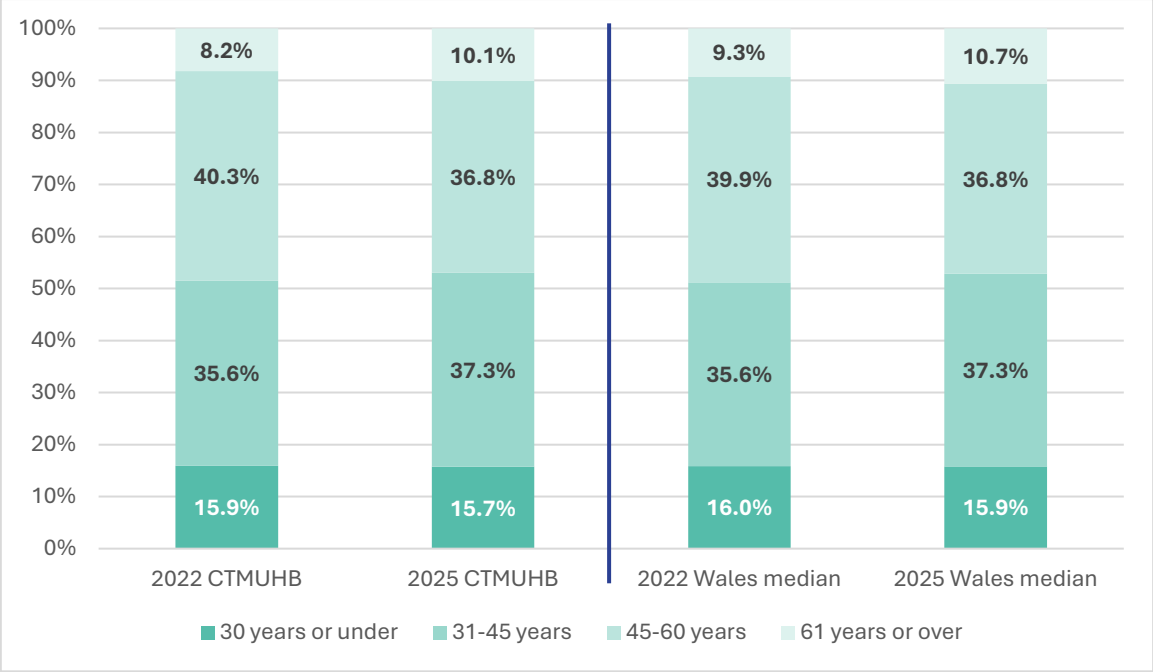


Figure 5.2.5 CTM workforce age profile compared with the Welsh health-board median, 2022 vs 2025[52] `

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.

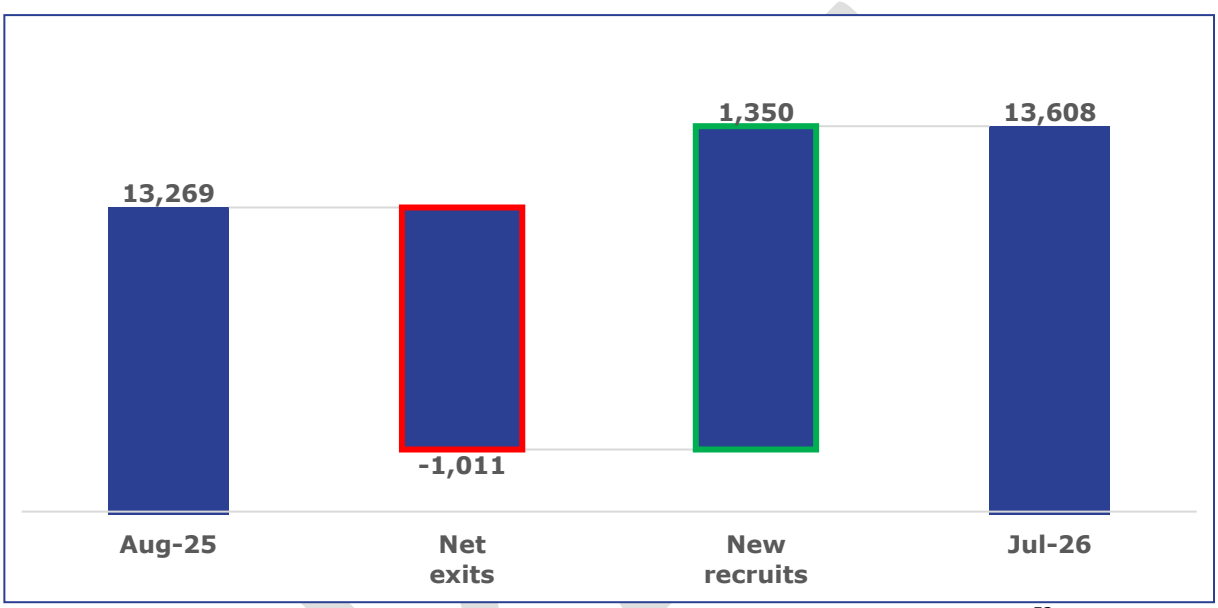


Figure 5.2.6 CTM workforce movement, August 2025 to July 2026[53]

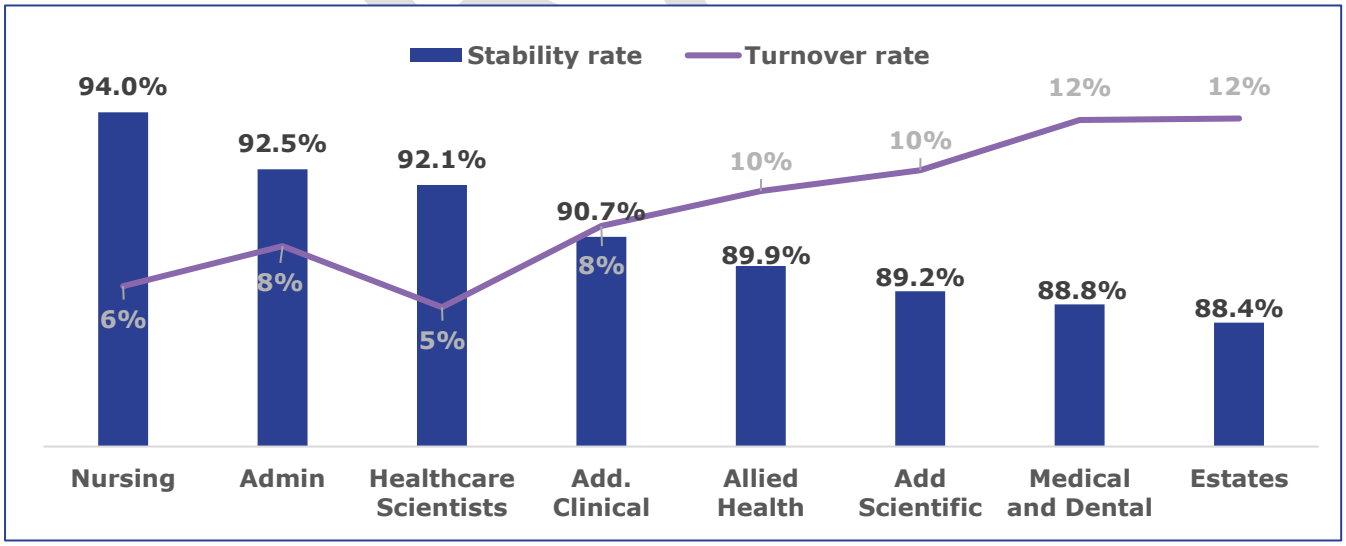


Figure 5.2.7 CTM stability rate, August 2025 to July 2026[54]

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

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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.

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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.
Stroke services	Placeholder for further examples as required	
Other		

Other changes have been driven by immediate safety, workforce or environmental pressures. These include temporary consolidation of acute stroke and inpatient gastroenterology services, relocation of the Prince Charles Health-Based Place of Safety, temporary closure of the Cefn Yr Afon mental-health rehabilitation unit, 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.

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