Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

CTM Building Healthier Communities: Strategic Vision

September 2026

Draft for discussion



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Caveat: For the purpose of this report, the care model is referred to as the Layered Care Model.

To be drafted in consultation with CEO & Chair

1. Purpose and context

1.1 Purpose of this strategic vision

CTM is developing a Strategic Clinical Services Plan (SCSP) to guide how health and care should evolve in response to changing population needs, health inequalities and sustained pressure across the system.

This document sets out CTM's strategic vision for the future model of care. It describes the whole-system model that CTM is seeking to create by 2030, the experience it should provide for patients and citizens, their families and carers, the workforce and health and care partnerships, as well as the broad changes required across system.

At its centre is the 'Layered Care Model'. The model brings together prevention, virtual access, locality care, community urgent response, diagnostic and treatment platforms, and specialist and emergency hospital care within one connected system.

The strategic vision provides a common direction for CTM and its partners. It will guide the more detailed development of clinical models, service options and enabling plans during the subsequent stages of the Strategic Clinical Services Plan.

1.2 Role within the SCSP

This strategic vision bridges the Case for Change and the next phase of clinical service design.

The Case for Change establishes why CTM's current model needs to evolve. It sets out the evidence on population need, inequalities, demand, access, capacity, and workforce pressures.

This document responds by describing what the future model should seek to achieve across CTM. It defines:

- the ambition and principles for care in 2030
- the role and intended impact of each layer of the care model
- how the layers should operate as one connected model
- the future experience for people, the workforce and partners
- the high-level capabilities required to support the model

The next phase will apply this strategic vision to individual clinical areas. It will develop future pathways and service options, assess their implications and support the decisions required about future service delivery.

1.3 Scope and Boundaries of this document

The strategic vision considers the model of care across the whole system, including prevention, primary and community care, mental health, diagnostics, planned treatment, urgent response and specialist hospital services.

For each layer in the care model, the report describes:

- its purpose within the whole model
- the broad needs it should address
- the functions and forms of support it could provide
- the intended impact for people and the system
- its connections with other layers
- the high-level requirements for successful delivery.

The report remains deliberately strategic. It does not repeat the detailed evidence contained in the Case for Change or define clinical pathways for individual specialties. Nor does it determine future service or site configurations, specify workforce structures or establishments, undertake options appraisal or financial modelling, or provide a detailed implementation plan.

1. Purpose and context

1.4 How this strategic vision will be used

The strategic vision will provide a shared reference for our population, staff and partners to understand the future model of care CTM is seeking to deliver and what it could mean for them. It will support meaningful conversations about change, enabling people to shape how the model develops and understand the part they can play in putting it into practice.

CTM will use the vision to:

- guide the development of models and options for individual clinical areas and pathways
- test whether proposed changes support the intended experience and outcomes for people and communities
- identify dependencies between clinical services, partners and layers of care model
- align future workforce, digital, data, estates and investment planning
- inform the development of the transformation roadmap and future IMTP priorities

The vision does not pre-empt the outcome of future service design, engagement, options appraisal or consultation. It sets the direction and common framework for that work.

2. What has shaped the vision

CTM's strategic vision has been shaped by four connected sources;

1. learning from health systems internationally
2. evidence set out in the Case for Change
3. insight from local engagement
4. the direction of Welsh policy

Together, these sources support a move towards a more preventive, connected and community-focused model of care, while preserving timely access to specialist and emergency services when required.

2.1 Local evidence and engagement

The Case for Change shows that CTM's population is changing in both size and need. Ageing population, increase in multi co-morbidity and persistent differences in health outcomes will increase the requirement for coordinated support over longer periods. Demand and access pressures are already visible across primary, community, mental health, diagnostic, urgent and planned services, while workforce constraints limit the ability to respond by expanding existing provision.

The evidence indicates that providing more of the current pattern of care will not offer a sufficient or sustainable response. CTM will need to strengthen prevention, identify changing risk earlier and support more people to remain well and independent. Care will also need to become better coordinated across organisational and professional boundaries, with hospital capacity focused on patients whose needs require acute, emergency or specialist capability.

Engagement with CTM's clinical and operational leaders has reinforced this direction. An Improving Care Board workshop explored the experience that the future model should create for people, families and carers, the workforce, and partners and communities. Participants described the need for simpler access, greater continuity and fewer avoidable hand-offs. They also identified the need for more integrated ways of working, better use of information and stronger relationships with communities and partner organisations

Figure 2.1. Snippets for workshops and clinical lead sessions



Focused sessions with clinical leads added a pathway-level perspective. These discussions identified points of fragmentation and delay within current pathways and considered how earlier intervention, improved coordination and closer links between community and specialist services could improve care. The sessions did not seek to agree detailed future pathways. They helped test whether the emerging strategic vision could respond to the practical issues experienced across different clinical areas.

The discussions identified both common system issues and important differences between pathways. Common themes included fragmented referral and information flows, diagnostic constraints, workforce capacity, inconsistent access across sites and insufficient community capability to support timely step-down. However, the sessions also demonstrated that the balance between layers of care model will vary by clinical area. Some pathways offer greater scope for prevention, virtual support and community delivery, while others will remain substantially dependent on specialist diagnostics, procedures and hospital infrastructure.

Across the evidence and engagement, a consistent message emerges: CTM needs one system-wide direction for care, with sufficient flexibility to respond proportionately to differences in need, access and community circumstances.

2. What has shaped the vision

2.2 CTM 2030: Our Health, Our Future

CTM's corporate strategy, Our Health, Our Future: Building Healthier Communities Together, provides the organisational foundation for this strategic vision. It describes CTM's ambition across the life course, from starting and growing well through to living, ageing and dying well. The Future Model of Care should enable that ambition by connecting prevention, early support, community-based care and specialist services around the changing needs of people throughout their lives.

The strategy is organised around four strategic goals: Creating Health, Improving Care, Sustaining Our Future and Inspiring People. These goals provide a clear framework for considering what the future model must achieve.

Creating Health requires the model to address health inequalities, give equal attention to mental and physical health and work with communities to support wellbeing. Within the Layered care model, this responsibility extends beyond the Prevention and Community Resilience layer. Every layer should contribute by identifying risk earlier, preventing deterioration and responding proportionately to differences in population need.

Improving Care requires safe and compassionate care, timely access, digital transformation and the development of new models of care. The Layered Care model supports this by clarifying the role of different levels of care and strengthening the connections between them. Its purpose is to make access and movement across the system easier while ensuring that people receive specialist and emergency care when their needs require it.

Sustaining Our Future requires CTM to consider financial sustainability, value-based healthcare, environmental responsibility and an estate fit for the future. The strategic vision should therefore guide care towards the setting that can achieve the best outcomes and experience with the most appropriate use of workforce, infrastructure and financial resources. Future clinical models will need to consider value and sustainability alongside quality and access.

Inspiring People recognises that change depends on leadership, culture, inclusion and the workforce. The future model will require staff to work across traditional professional and organisational boundaries, supported by clear responsibilities, shared information and a culture that enables improvement. It should also contribute to CTM's role as a local employer and anchor organisation.

Together, the four goals provide a test for the Future Model of Care. The model should improve health and respond to illness, improve the quality and experience of care, use resources sustainably, and create the conditions in which the workforce and partners can deliver change.

Figure 2.2. Alignment of the care model with CTM's goals

CTM strategic goal	Contribution of the Future Model of Care
Creating Health	*Prevention, earlier identification of need, reduced inequalities, equal attention to mental and physical health and stronger community capability*
Improving Care	*Simpler access, coordinated care, timely diagnosis and treatment, safe escalation and digitally supported delivery*
Sustaining Our Future	*Appropriate use of each care setting, value-based decisions, sustainable workforce and infrastructure, and an estate aligned to future care*
Inspiring People	*Integrated working, inclusive leadership, development of skills, shared accountability and stronger collaboration with partners*

2. What has shaped the vision

2.3 Welsh policy and strategic direction

CTM's emerging vision reflects a consistent direction across health and care policy in Wales: improving population health requires the system to intervene earlier, organise care around people and communities, and rely less on reactive, hospital-based responses.

A Healthier Wales established the ambition for a whole-system approach in which health and social care services work together around the individual, with greater emphasis on prevention, wellbeing and care closer to home. The refreshed national plan strengthens this direction through earlier identification of need, integrated community services, equitable access and greater support for rehabilitation, recovery and independence. Together, these policies move the focus from treating individual episodes of illness towards supporting people over time and responding before needs escalate.[1]

The National Clinical Framework complements this ambition by emphasising consistent standards, evidence-informed pathways and clinical networks operating across organisational boundaries. Consistency does not require identical provision in every community. It means setting a common direction and quality expectations while allowing delivery to reflect differences in population need, geography and access. For CTM, this supports one overarching model of care with enough flexibility to respond to the different circumstances of Bridgend, Merthyr Tydfil and Rhondda Cynon Taf.[2]

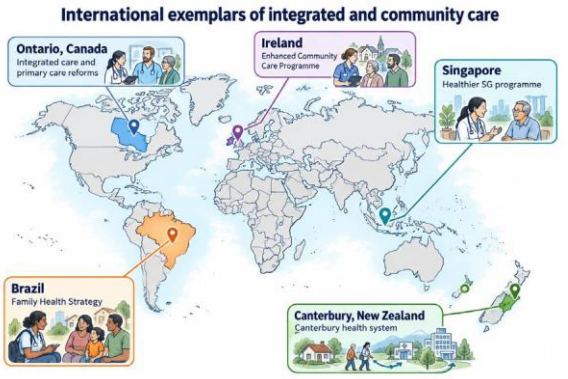
Community by Design broadens the perspective beyond formal health services. It recognises that place, relationships, community assets, and the wider conditions in which people live shape health. Prevention and care closer to home therefore require CTM to work with communities, local authorities and third-sector partners, building on local strengths and addressing the barriers that affect people's ability to stay well and access support.

Across this policy landscape, the common expectation is that services should operate as a connected system rather than as separate organisational offers. Prevention, primary and community care, mental health, social care, diagnostics and specialist services need to form part of a continuous model. Digital access, shared information and a flexible workforce should support that connection, while appropriate face-to-face and non-digital routes maintain inclusion.

The Layered Care Model translates this national direction into CTM's local context. It provides a framework for combining consistent system-wide expectations with responses proportionate to local need, stronger prevention with timely treatment, and greater community capability with specialist support when required.

2.4 International Learning

CTM reviewed five international examples to understand how other systems have responded to similar pressures:



No single exemplar provides a complete model that CTM could or should reproduce. Each reflects its own policy, funding and organisational context. Their collective value lies in showing how different systems have strengthened prevention, organised responsibility around defined populations, and connected primary, community, and specialist services.

Source: [1]Welsh Government: 2024 plan for health and social care; [2]Welsh Government: National Clinical Framework; [3]PHW Community by Design

2. What has shaped the vision

Several lessons are particularly relevant to CTM.

Responsibility for a defined population supports proactive care. Ireland, Singapore, Brazil and Ontario show the value of understanding the needs of an identifiable population and establishing clearer responsibility for maintaining relationships, anticipating need and improving outcomes.

Care closer to home requires deliberate investment in community capability for uplift. Redirecting activity away from hospitals without strengthening primary care, community services, workforce, infrastructure and local partnerships risks transferring pressure rather than resolving it.

Continuity depends on clear relationships and responsibility. People with ongoing or complex needs benefit from identifiable points of coordination. Responsibility, communication and collaboration should remain clear when they move between services or require a period of more intensive or acute care intervention.

The connections between services determine whether the model functions as a system. Shared pathways, relevant information and timely specialist advice allow services to respond collectively. Clear arrangements for escalation and the return of responsibility reduce delay and fragmentation.

Hospitals retain a central but more focused role. International experience does not suggest diminishing the importance of hospitals. It demonstrates how specialist expertise can support care across settings while hospital-based capacity concentrates on complex, critical and highly specialised needs.

Transformation requires sustained leadership and investment. The experience of Ireland and Canterbury shows that integration depends on stable governance, clinical leadership and long-term development of community capability. Changes to organisational structures alone do not create integrated care.

The international review therefore provides a source of design learning rather than a blueprint. CTM will need to adapt relevant principles to the NHS Wales context and test them through subsequent clinical service design.

The combined evidence, engagement, policy direction and international learning establish several requirements for the strategic vision.

I The model should begin with population needs and inequalities. CTM requires one overall direction for care, but the scale and emphasis of delivery should reflect differences between communities.

II Prevention should extend throughout the model. It should include supporting wellbeing, identifying risk earlier, preventing deterioration and helping people recover and maintain independence.

III Access and navigation should become simpler. People should be able to reach appropriate support without unnecessary referrals, repeated assessments or avoidable movement between services.

IV CTM will need stronger community based capabilities. Locality and community services should be able to coordinate care, respond earlier and support people whose needs cross traditional service boundaries.

V The layers of the care model should operate as one connected model, with data and digital capability and enablers as core to the model. Information, advice and responsibility should move with the person as their needs change. The model should support escalation when greater expertise or intensity is required and enable people to return to local support as soon as appropriate.

VI Specialist capability should support the whole system. Specialist advice and intervention should be available across settings where clinically appropriate, while hospitals continue to provide care that requires concentrated expertise, infrastructure or continuous clinical support.

Finally, clinical change must develop alongside the capabilities that enable it. Workforce, digital and data, estates, transport, partnerships, governance and investment will need to support the same direction. Without these foundations, pathway changes alone will not deliver the intended model.

These implications provide the basis for CTM's ambition for care in 2030, and the Layered Care Model described in the following chapters.



CTM’s ambition for care in 2030

3. CTM's ambition for care in 2030

CTM's ambition is to create a more preventive, connected and responsive system of care that helps people start, grow, live, age and die well. The Future Model of Care translates the direction established in Our Health, Our Future into an intended experience for people, the workforce, partners and communities.

By 2030, care should be easier to access and navigate, with greater emphasis on prevention, earlier identification of need and coordinated support at the most appropriate level. The model should enable more people to remain well and independent while ensuring timely access to diagnostics, treatment and specialist expertise.

CTM's future care continuum describes how that experience should operate as people's needs change. It begins with staying and managing well, progresses through earlier identification and coordinated local support, and provides access to enhanced, acute or specialist care when required. Recovery and support at home complete the continuum by helping people regain and maintain independence.

Hospitals will remain an essential part of the model, providing complex, specialist and emergency care. Their role should connect to stronger prevention, locality and community capability so people can avoid hospital where appropriate, access specialist care when required, and return home with coordinated support.

This ambition requires more than moving existing services between settings. It requires CTM and its partners to organise care around people and communities, share responsibility across boundaries and align workforce, information and resources behind a common model.

The future experience described in this chapter provides a strategic direction rather than an agreed specification for future services.

3.1 The future care continuum

The future care continuum describes the experience CTM wants to create as people's needs change. It provides a citizen-focused view of the model, while the layers of the care model describe the system capabilities required to deliver that experience.

The continuum is not a single pathway everyone follows in sequence. People may enter at different points, receive support from more than one layer of the care model at the same time and move between stages as their circumstances change. The model should make those movements timely and coordinated, with clear responsibility throughout.

- **Stay well**

  People and communities should have access to the conditions, information and support that help them maintain good physical and mental health. This includes action on prevention, healthy lifestyles, social connection and the wider factors influencing wellbeing.

  CTM should work with communities and partners to understand local strengths and barriers. Universal support should be complemented by targeted action for populations experiencing poorer outcomes or greater risk.

- **Manage well**

  People living with long-term conditions, disability or ongoing health needs should have the knowledge, confidence and support needed to manage their health as independently as possible.

  Support may include education, agreed care plans, medicines support, rehabilitation, peer or community support and appropriate digital tools. Self-management should not mean leaving people to manage alone. People should have clear routes back into professional support when their needs change.

3. CTM's ambition for care in 2030

Figure 3.1. CTM's future care continuum, showing movement towards more intensive support when required and return to staying or managing well following recovery



Note: The care continuum is cyclical, not linear. Following recovery, rehabilitation or a period of more intensive care, people should return to staying or managing well with appropriate ongoing support. People may enter the continuum at any point, move between stages in either direction and receive support from several stages at the same time. The purpose of the future model is to make these movements timely and coordinated, while helping people remain at the least intensive stage that can safely and effectively meet their needs.

- **Identify risk early**

  The system should identify changing need before it results in avoidable deterioration or crisis. This requires proactive review, population health intelligence and better use of information across services.

  Staff, people and carers should be able to recognise changes and know how to respond. Earlier identification should lead to timely action, with support proportionate to the person's needs and risks.

- **Receive coordinated local care**

  People with ongoing or complex needs should receive coordinated support through primary care, community health services, mental health, social care and community partners.

  Care should be organised around the person, with clear responsibility for coordination. Multidisciplinary teams should share information and draw on specialist advice where needed. People should not experience local care as a series of separate referrals or have to manage communication between services themselves.

- **Access enhanced care closer to home**

  When people require more intensive assessment, diagnostics, treatment or monitoring, CTM should provide these closer to home where this is clinically appropriate and sustainable.

  This may include community diagnostics, specialist outreach, rapid response, virtual care, rehabilitation or treatment delivered within local settings. Enhanced care should connect with local support and provide clear routes into acute or specialist services where needs cannot be met safely outside hospital.

- **Receive acute or specialist care**

  People should have timely access to acute, emergency and specialist care when their condition requires concentrated expertise, technology, infrastructure or continuous clinical support.

  Hospital care should form part of the connected model rather than operate as a separate destination. Hospital teams should have access to relevant information from earlier stages, and specialist expertise should support decision-making across the wider system where appropriate.

3. CTM's ambition for care in 2030

- **Recover and remain well at home**

  Planning for recovery should begin as early as appropriate. People should leave acute or specialist care with clear arrangements for rehabilitation, reablement, follow-up and ongoing support.

  Responsibility should transfer safely, with relevant information available to the teams supporting the person at home or in the community. People and carers should understand what happens next, how to manage ongoing needs and where to seek help if circumstances change.

  Recovery should include more than discharge from hospital. Its aim should be to help people regain independence, maintain wellbeing and reduce the risk of avoidable deterioration or readmission.

  The care continuum and Layered Care Model provide two complementary views of CTM's future system. The continuum describes the experience from the perspective of the person, while the Layered care model describes the capabilities and levels of support that make that experience possible. There is no fixed one-to-one relationship between a stage and a care model layer: several layers may contribute at the same time, depending on the person's needs.

3.2 What people, families and carers should experience

By 2030, people should experience a system that is easier to access, understand and navigate. Digital, telephone and face-to-face routes should connect people to the right support without requiring them to understand the organisations behind their care. Simpler access will depend on effective clinical navigation, clear responsibility and sufficient capacity beyond the point of entry. A new front door alone will not resolve delays or fragmentation.

Care should feel coordinated. People should not have to repeat their story, manage communication between teams or determine who remains responsible. Relevant information should follow the person, supported by clear coordination for those whose needs cross service boundaries. Continuity may be provided by an identifiable professional, a team or a shared care plan, depending on the person's needs.

Care should be provided at the most appropriate level. More support should be available within homes and communities where this is safe and effective. This does not mean transferring all hospital activity into community settings. The model should distinguish between needs that can be prevented or managed locally, care that requires enhanced community capability, and services that continue to depend on specialist expertise or hospital infrastructure. Shifts in activity must be matched by workforce, diagnostics, equipment, transport and digital capability.

Prevention and equity should run through the model. People should receive support earlier to maintain wellbeing, manage ongoing needs and prevent deterioration. CTM should combine a consistent core offer with additional support for communities experiencing greater need or barriers to care. Equal provision will not always achieve equitable outcomes.

Digital should widen access without creating exclusion. Virtual channels and shared information should improve choice, convenience and decision-making while remaining connected to face-to-face care and safe escalation. Non-digital routes must remain available.

People, families and carers should participate meaningfully in care planning. Care should reflect individual needs and preferences without shifting unreasonable responsibility onto people or unpaid carers.

3. CTM's ambition for care in 2030

Overall, the future model should feel simple to the person, even where the system behind it remains complex. CTM and its partners should manage that complexity through coordinated working rather than expecting people to navigate it themselves.

3.3 How the workforce should work

The future model will require staff to work as one connected workforce across professions, sites and care settings. Multidisciplinary input should be organised around need, with staff able to obtain advice and expertise without every question resulting in a referral or transfer of care.

Skills should be used differently. CTM cannot rely solely on recruiting more people into the current role pattern. Nurse-led and allied health professional-led care, advanced practice, broader use of support roles and specialist advice across settings could all form part of the future workforce. Any transfer of responsibility must be supported by time, funding, training and appropriate professional oversight.

Flexibility must not weaken continuity. People with ongoing or complex needs still require clear coordination and accountability. Continuity may not always mean seeing the same professional, but it should mean that information, responsibility and agreed actions are carried forward.

Technology should reduce friction. Staff should have access to relevant clinical and operational information when they need it. Shared records, better visibility of previous investigations and appropriate automation should reduce duplication and release time for care. Assess digital change across the full pathway so it does not add systems or administrative work.

Population insight should lead to action. Teams should use evidence and data to identify changing needs and target earlier intervention. This requires clear responsibility for defined populations and sufficient capacity to respond. Information alone will not create proactive care.

Leadership and culture will be as important as organisational structures. Staff should understand the purpose of the model, have the authority to improve care across boundaries and remain actively involved as CTM develops detailed clinical models.

3.4 How CTM should work with partners and communities

The future model cannot be delivered by CTM alone. Local authorities, primary care, social care, the third sector, communities and regional partners all influence health, access and independence.

Partnership should move towards shared ownership. Partners should be involved early in defining priorities and developing services. Where organisations share responsibility for outcomes, they need clear roles, decision-making arrangements, and aligned resources. Shared ambition without practical accountability is unlikely to change delivery.

Recognise community capability as system capacity. Community and third-sector organisations bring local knowledge, trusted relationships and practical support. Their contribution should not be treated as an informal or low-cost destination for demand displaced from statutory services. Where CTM expects partners to perform a sustained role, commissioning and partnership arrangements should recognise the capacity and funding required.

Information and responsibility should cross organisational boundaries safely. Shared records can improve coordination, but organisations must also understand who will review information and act on it. Clear routes for clinical advice, escalation and re-entry into formal services will be needed when people's circumstances change.

3. CTM's ambition for care in 2030

Different decisions belong at different geographical levels. Communities and localities should shape support that depends on local circumstances. CTM should provide appropriate consistency across the Health Board, while some specialist services, workforce requirements and infrastructure will require regional or national solutions.

Partnership should therefore form part of the operating logic of the Layered care model, rather than sitting alongside it as a separate engagement activity. The model will succeed only if organisations can align responsibility, information and resources around shared population outcomes.

3.5 Principles underpinning the future model

The future model will continue to develop through more detailed clinical design, engagement and options appraisal. The following service design principles provide a consistent basis for that work, helping CTM assess options and guiding implementation, while responding to different population and clinical needs.

System Design & Scope

Life Course Fit	Organise care around people's changing needs and goals, from starting well through to dying well, supporting continuity across life stages.
Whole System Approach	Plan services as part of a connected system, considering how changes affect people, workforce, partners and capacity across all layers of care.
Care Proximity	Provide care as close to home as is safe and effective, with timely access to specialist expertise and hospital services when required.

Inclusive & Preventive Care

Preventive Focus	Embed prevention throughout the model, supporting wellbeing, identifying risk earlier, preventing deterioration and helping people maintain or regain independence.
Equity & Access	Shape services around population needs and inequalities, addressing barriers to access and offering appropriate digital, telephone and face-to-face routes.
Person-Centred Care & Partnerships	Design care around people's goals, preferences and circumstances. Involve the population, staff and partners in understanding, shaping and delivering the future model.

Evidence, Innovation & Digital Transformation

Evidence Base	Use clinical evidence, population insight, service data and lived experience to inform design. Assess proposals against their expected impact on outcomes, experience, equity and value.
Digital Enablement & Innovation	Build digital and data capabilities into service design to support access, shared information, coordinated decisions and new ways of delivering care, while providing support and alternatives for people who need them.

3.5 Principles underpinning the future model

The future model will continue to develop through more detailed clinical design, engagement and options appraisal. The following service design principles provide a consistent basis for that work, helping CTM assess options and guiding implementation, while responding to different population and clinical needs.

Safe, Accountable Care

Quality & Safety	Maintain safety, effectiveness, dignity and compassion across every layer, with clear arrangements for escalation, handover and continuity of care.
Governance & Assurance	Establish clear accountability, clinical oversight and proportionate assurance for service changes, with responsibilities understood across organisational boundaries.

Resilient & Sustainable Delivery

Sustainability	Design services that are deliverable within workforce, financial and infrastructure capacity and can adapt to changing needs. Use modelling to assess resources, benefits and trade-offs over time.
Environmental Sustainability	Consider the environmental impact of service choices, including travel, estates, energy and resource use, while maintaining quality and equitable access.

These principles should guide the development of each layer and the connections between them. As the vision progresses into detailed design, proposals should demonstrate how they apply the principles, where trade-offs arise and how their impact will be assessed.



IV The CTM Layered Care Model

4. The CTM Layered Care Model

The CTM Layered Care Model provides the organising framework for the strategic vision. It brings together prevention, access, local care, urgent response, diagnostics, treatment and hospital services within one connected model.

The model describes the broad functions and levels of support that should be available across the system and how they should work together as people's needs change. It does not prescribe the detailed configuration of individual clinical services. Subsequent clinical design will determine how the model should apply to different populations, pathways and services.

4.1 The Model at a glance

The CTM Layered Care Model comprises six connected layers:

- Layer 0: Prevention
- Layer 1: Virtual Access and Response
- Layer 2: Locality Care
- Layer 3: Community Urgent Response
- Layer 4: Diagnostic and Treatment Platforms
- Layer 5: Specialist and Emergency Hospital Care

Figure 4.1. The CTM Layered Care Model



Prevention and community resilience provide the foundation for the model. The remaining layers offer different forms and levels of capability, from accessible advice and coordinated local support through to urgent response, diagnostics, treatment and complex hospital care.

The layers do not represent separate organisations, fixed service tiers or predetermined locations. Each layer describes a set of functions that different teams may deliver across several settings. Some capabilities may operate within people's homes or neighbourhoods, while others require Health Board-wide, regional or national infrastructure.

The model seeks to support people at the least intensive level that can safely and effectively meet their needs. This does not mean holding people within community services or delaying access to specialist care. It means providing the right capability early enough to prevent avoidable escalation while ensuring rapid access to more intensive support when required.

4. The CTM Layered Care Model

The model's value lies in the connections between its layers. People should be able to move between them without losing information, continuity or clarity about who remains responsible for their care. Expertise should also move across the model, allowing specialist advice and decision-making to support care in other settings where appropriate.

4.2 How to understand the Layered Care Model

The Layered Care Model is a connected system of care, not six separate tiers. Each layer describes a distinct set of functions and capabilities, but its effectiveness depends on how well it connects with the rest of the model.

One model, not six separate services

The layers do not represent individual organisations, fixed service locations or additional referral stages. A person may receive support from several layers simultaneously, coordinated around their needs.

For example, someone living with heart failure may use virtual monitoring, receive coordinated support from a locality team, access community diagnostics and continue to receive specialist oversight. The model should connect these contributions rather than require the person to move through a series of separate services.

Movement according to need

People will not enter the model at the same point or move through every layer in sequence. Some may remain well with preventive and community support, while others may enter directly through urgent, acute or specialist care.

Movement should be possible in both directions. When needs increase, people should have timely access to more intensive assessment and treatment. Following stabilisation or recovery, responsibility should transfer safely to local services and ongoing support.

The intention is not to prevent access to hospital care when it is required. It is to ensure that escalation results from clinical need rather than from gaps, delays or insufficient capability elsewhere in the system.

Prevention throughout the model

Prevention and community resilience underpin the model, but prevention is not confined to Layer 0. Every layer should contribute to maintaining wellbeing, identifying risk earlier, preventing deterioration and supporting recovery.

This may include proactive monitoring through virtual services, anticipatory care within locality teams, admission avoidance through community urgent response, earlier diagnosis and intervention, and prevention of complications or readmission following hospital treatment.

Functions rather than buildings

The layers describe what the system needs to do, rather than prescribing where every service should be located. Capabilities may be delivered in people's homes, community facilities, primary care settings, hospitals or through a combination of physical and virtual provision.

For example, diagnostic capability may range from home-based and point-of-care testing to community diagnostic facilities and complex hospital-based investigations. Similarly, specialist expertise may support care beyond the hospital through advice, outreach and shared decision-making.

Future location decisions should reflect clinical safety, population need, accessibility, workforce availability, service dependencies, and the scale required for sustainable delivery.

4. The CTM Layered Care Model

Delivery at the appropriate scale

Different parts of the model will need to operate across different geographical footprints. Prevention and community support should respond to neighbourhood and locality circumstances, while urgent, diagnostic, and specialist capabilities will require Health Board-wide, regional, or national arrangements.

The model therefore provides a consistent CTM-wide direction without requiring every community or pathway to adopt an identical configuration. The balance of capability should reflect population need while maintaining appropriate standards of quality, access and safety.

Clear responsibility across transitions

Integration requires more than connected systems and referral routes. People should experience continuity of information, decision-making and responsibility when several teams are involved or when their needs change.

Detailed clinical models will need to establish:

- who coordinates care
- when and how responsibility transfers
- what information follows the person
- how advice can be obtained without unnecessary referral or transfer
- how people escalate rapidly when their needs increase
- how responsibility returns to local or ongoing support following treatment.

These arrangements should reduce repeated assessment, avoid people being passed between services and ensure that no one is left without clear clinical ownership.

Supported by common system capabilities

All six layers depend on shared enabling capabilities, including:

- an integrated and adaptable workforce
- digital access and shared information
- population health intelligence
- suitable estates, equipment and transport
- effective partnerships with primary care, local authorities and the third sector
- clear governance and clinical accountability
- sustainable funding and resource allocation

These capabilities will need to develop alongside the clinical model. Without them, changes in where or how care is delivered could transfer pressure between services rather than improve outcomes or system sustainability.

The following slides 24 to 35 describe the purpose, core functions and intended contribution of each layer. They provide a common strategic framework for the detailed clinical models and service options that CTM will develop during the next phase.

Layer 0: Prevention

PURPOSE

Prevention underpins the Layered Care Model. Its purpose is to help people stay well and independent longer, reduce avoidable health inequalities, and identify emerging needs before they become more complex or urgent.

This layer applies to the whole population but should be proportionate to need. Universal action to promote health and wellbeing should be combined with targeted support for people and communities experiencing poorer outcomes, greater risk or barriers to accessing care.

Prevention should not be understood solely as lifestyle advice or individual behaviour change. It encompasses action on the wider determinants of health, protection from avoidable illness, early identification of risk, supported self-management and the development of community capability.

CORE FUNCTIONS

Layer 0 should bring together four connected functions:

- Understanding and targeting need: using population health intelligence to identify inequalities, emerging risks and populations that may benefit from earlier or additional support.
- Enabling people to stay well: providing health promotion, vaccination, screening, wellbeing support and the knowledge and tools people need to manage their health.
- Strengthening community capability: working with communities, local authorities and third-sector partners to build social connection, address wider determinants and connect people with local assets and practical support.
- Identifying and responding earlier: recognising changing needs and providing timely support before they lead to deterioration, loss of independence or avoidable use of urgent and hospital care.

Engagement highlighted that health services alone cannot deliver prevention. Its effectiveness will depend on people having access to trusted information, supportive communities and practical help, with clear routes into professional care when their needs change. The model must therefore connect population-level action, individual support and community capability rather than treating them as separate activities.

Self-care and community support should complement formal services. They should not shift clinical responsibility to individuals, families, or community organisations, or assume every community has the same resources and capacity.

Layer 0: Prevention

CONNECTIONS WITH OTHER LAYERS

Layer 0 connects with every other part of the model. Virtual access can provide information, guidance and routes into support. Locality teams can respond when people require coordinated or ongoing care. Community urgent response can intervene when there is a risk of crisis or avoidable admission.

The connection should also work in reverse. Following diagnosis, treatment or recovery, people should reconnect with preventive, self-management and community support to help sustain progress and reduce the risk of further deterioration.

Although Layer 0 provides the primary focus for prevention, every layer has a preventive role. This includes preventing deterioration, avoidable admissions, complications, functional decline and readmission.

INTENDED IMPACT

- improve health and wellbeing across the population
- help people retain independence
- identify and address need earlier
- reduce avoidable differences in outcomes
- slow or prevent deterioration
- reduce avoidable escalation into urgent or hospital care

REQUIREMENTS FOR DELIVERY

Effective prevention will require:

- shared intelligence about population need, risk and inequalities
- accessible, trusted and culturally appropriate support
- stronger links between public health, primary care and wider services
- sustainable partnerships with communities and the third sector
- clear navigation, advice and escalation routes
- proportionate information sharing
- investment that recognises benefits across organisational boundaries
- measures covering reach, outcomes, equity and independence.

Community organisations should be recognised as contributors to the overall model, but not as an informal or low-cost destination for demand displaced from statutory services. Where partners are expected to provide sustained support, explicitly consider the required capacity, funding, and infrastructure.

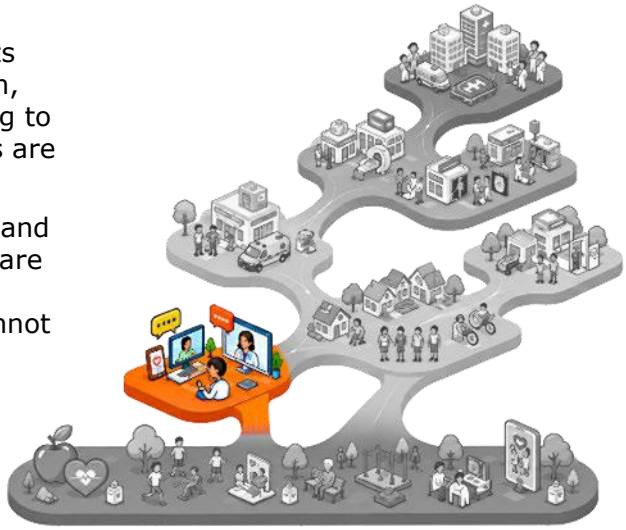
Layer 1: Virtual Access and Response

PURPOSE

Virtual Access and Response provides a clear and responsive front door to the Layered Care Model. Its purpose is to help people obtain trusted information, advice and an appropriate response without needing to understand how individual services or organisations are structured.

This layer should offer a blend of digital, telephone and other remote channels, connected to face-to-face care where required. It should make access simpler and more consistent while ensuring that people who cannot or choose not to use digital routes are not disadvantaged.

Virtual access should not be understood as a website, application or contact centre alone. Its value depends on the navigation, clinical decision-making, and service capacity behind the point of contact.



CORE FUNCTIONS

Layer 1 should bring together four connected functions:

- Information and advice: providing consistent and accessible information that helps people understand their needs, available support and when to seek further help.
- Navigation and signposting: directing people to the most appropriate service or community support without unnecessary hand-offs or repeated referrals.
- Assessment and early triage: identifying the nature and urgency of need and determining the most appropriate next response.
- Virtual care and follow-up: enabling remote consultations, monitoring, reminders and follow-up where these are clinically appropriate and convenient for the person.

Engagement indicated that people want simpler routes into care and clearer information about what will happen next. A more visible front door could support this, but it must connect to effective clinical navigation and timely responses. Simplifying access without strengthening the services behind it could expose unmet demand without improving people's experience or outcomes.

Layer 1: Virtual Access and Response

CONNECTIONS WITH OTHER LAYERS

Layer 1 should connect people directly with the most appropriate part of the model. This may include preventive and community support, coordinated locality care, urgent community response, diagnostics or acute and specialist services.

Where possible, advice and specialist input should be available without transferring responsibility unnecessarily. Where referral or escalation is required, relevant information should accompany the person so that they do not need to repeat their history or undergo avoidable reassessment.

Virtual access should also support people as they move back through the model. Following treatment or an acute episode, it can provide follow-up, monitoring and routes back into professional care if recovery does not progress as expected.

INTENDED IMPACT

- make it easier for people to find and obtain appropriate support
- improve consistency in the information and advice provided
- support earlier identification of changing or urgent needs
- reduce avoidable travel, appointments and hand-offs
- enable appropriate needs to be resolved remotely
- provide clearer routes into other layers of the model

REQUIREMENTS FOR DELIVERY

Effective virtual access and response will require:

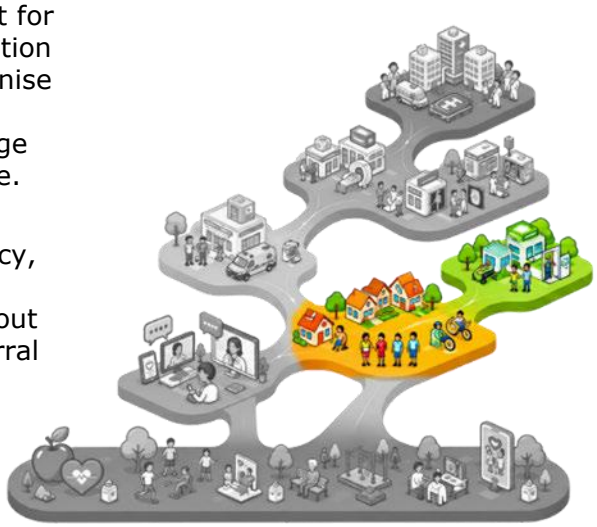
- clear and consistent access routes across digital, telephone and face-to-face channels
- effective clinical navigation and proportionate triage
- agreed protocols for escalation and transfer of responsibility
- access to relevant information across services
- integration with national digital platforms and existing local pathways
- workforce capacity to respond to demand generated through the front door
- accessible design and alternatives for people affected by digital exclusion
- measures covering access, resolution, safety, equity and user experience

Technology should support the service model rather than determine it. Digital channels should be introduced or expanded only where the associated workflows, clinical responsibilities and connections to other services are sufficiently clear.

Layer 2: Locality Care

PURPOSE

Locality Care provides coordinated, ongoing support for people whose needs cannot be met through prevention or a single episode of advice. Its purpose is to organise care around defined populations and communities, bringing together the capabilities required to manage ongoing, complex or changing needs closer to home.



This layer should connect primary care, community health services, mental health, social care, pharmacy, rehabilitation and community partners. Specialist expertise should be accessible where required without every request for advice resulting in a hospital referral or transfer of care.

Locality Care should not be interpreted simply as moving existing hospital services into community settings. It requires services to work differently around shared populations, with clear responsibility, appropriate capacity and access to the diagnostics and specialist support needed to manage people safely.

CORE FUNCTIONS

Layer 2 should bring together five connected functions:

- Proactive population-based care: identifying people who may benefit from earlier intervention, review or additional support.
- Coordinated multidisciplinary support: bringing together relevant professionals around the person's needs without requiring every case to enter a formal multidisciplinary process.
- Ongoing condition management: supporting people with long-term conditions, frailty, mental health needs, disability or multiple conditions.
- Rehabilitation and independence: enabling people to maintain or regain function through rehabilitation, reablement and practical support.
- Specialist advice into local care: allowing locality teams to access expertise without unnecessary referral or transfer to hospital-based services.

Engagement emphasised the importance of care feeling joined up to the person, particularly where several services are involved. People should not have to coordinate different teams, repeat their history or determine who remains responsible. Locality Care should therefore provide continuity of responsibility and information, whether this is delivered through an identifiable professional, a multidisciplinary team or a shared care plan.

The model should maintain a consistent CTM-wide expectation while allowing delivery to reflect differences between communities. Local variation may be appropriate where it responds to population need, but variation caused by unclear responsibilities, historical arrangements or unequal access to expertise should be identified and addressed.

Layer 2: Locality Care

CONNECTIONS WITH OTHER LAYERS

Locality Care provides an important coordinating point within the model. It should connect people with preventive and community support, receive referrals and information through virtual access, and access Community Urgent Response when needs escalate rapidly.

It should also connect with diagnostic and treatment platforms and specialist hospital services. Locality teams should be able to request investigations, obtain specialist advice and escalate care without creating unnecessary delays or repeated assessment.

Following urgent, diagnostic or hospital care, responsibility should return safely to locality services where ongoing support is required. Discharge or transfer should therefore be treated as a coordinated transition rather than the end of an isolated episode.

INTENDED IMPACT

- identify and respond to changing needs earlier
- improve continuity for people with ongoing or complex needs
- reduce fragmented referrals and repeated assessments
- support more care to be delivered safely closer to home
- help people retain or regain independence
- improve access to specialist advice
- reduce avoidable deterioration, crisis and hospital use.

REQUIREMENTS FOR DELIVERY

Effective Locality Care will require:

- clearly defined populations and geographical footprints
- shared understanding of the needs and assets within each locality
- multidisciplinary capacity across organisational and professional boundaries
- clear responsibility for coordinating care
- access to specialist advice, diagnostics and prescribing support
- shared information and care planning
- sufficient community, rehabilitation and social care capacity
- flexible workforce roles supported by appropriate governance
- measures covering outcomes, continuity, equity and independence

The shift towards locality-based delivery must be matched by workforce, funding, estates, equipment, transport and digital capability. Moving activity without strengthening these foundations could transfer pressure from hospitals into services that are not equipped to absorb it.

Layer 3: Community Urgent Response

PURPOSE

Community Urgent Response provides rapid assessment and time-limited intervention when a person's needs escalate but may still be managed safely outside hospital. Its purpose is to prevent avoidable deterioration and admission while ensuring that people who require emergency or specialist care reach it without delay.



This layer should bring together appropriate clinical assessment, diagnostics, treatment and practical support within people's homes or other community settings. It should operate as part of the wider urgent and emergency care system rather than as an isolated admission-avoidance service.

Avoiding hospital should not become an objective where admission represents the safest or most effective response. The emphasis should be on making a timely clinical decision and providing care at the appropriate level.

CORE FUNCTIONS

Layer 3 should bring together five connected functions:

- Rapid access and clinical assessment: enabling professionals and services to obtain a timely response when someone's needs deteriorate.
- Same-day community intervention: providing assessment, treatment and monitoring within the home or an appropriate community setting.
- Crisis prevention and stabilisation: responding to acute changes in physical health, mental health, function or social circumstances.
- Access to urgent diagnostics and specialist advice: supporting safe decisions without automatically transferring the person to hospital.
- Supported transition and follow-up: connecting people to locality, rehabilitation, social care or hospital services following the immediate response.

The response should address the person's needs as a whole. An urgent episode may arise from a combination of clinical deterioration, reduced mobility, carer breakdown, medication issues or changing social circumstances. Focusing only on the presenting condition may resolve the immediate episode without addressing the factors likely to cause further deterioration.

Engagement highlighted the need for quicker access to coordinated support when circumstances change. This requires sufficient response capacity and clear referral routes. A community urgent response offer will have limited impact if professionals cannot access it easily, if operating hours do not reflect patterns of need or if people must pass through multiple assessments before receiving support.

Layer 3: Community Urgent Response

CONNECTIONS WITH OTHER LAYERS

Community Urgent Response should be closely connected to Locality Care. Local teams should be able to escalate people rapidly when their needs increase, while urgent response teams should return responsibility safely once the person has stabilised.

Virtual Access and Response may identify urgent needs and direct people to this layer. Diagnostic and Treatment Platforms should provide timely access to investigations, while Specialist and Emergency Hospital Care should remain readily available when needs cannot be managed safely in the community.

The layer should also support movement out of hospital by providing short-term monitoring, treatment or rehabilitation where this enables a safe transition home. Step-up and step-down functions should be coordinated as part of one response rather than operating through disconnected pathways.

INTENDED IMPACT

- provide a timely alternative to hospital where clinically appropriate
- reduce avoidable deterioration and emergency attendance
- support safe treatment and monitoring closer to home
- improve coordination between community and urgent care services
- enable earlier supported discharge where appropriate
- reduce repeated crises by reconnecting people with ongoing support.

REQUIREMENTS FOR DELIVERY

Effective Community Urgent Response will require:

- simple and timely access for relevant professionals and services
- clear eligibility, response and escalation arrangements
- multidisciplinary clinical capability
- sufficient operating hours and capacity to respond reliably
- access to relevant records, diagnostics, prescribing and specialist advice
- mobile equipment and digital connectivity
- connections with ambulance, primary care, mental health, social care and hospital teams
- clear responsibility during and following the intervention
- measures covering timeliness, safety, outcomes and subsequent service use

Capacity should be planned against demand across the wider urgent and emergency care pathway. Creating a community response without aligning ambulance conveyance, hospital pathways and ongoing locality support could add another service boundary rather than improve flow.

Layer 4: Diagnostic and Treatment Platforms

PURPOSE

Diagnostic and Treatment Platforms provide the investigations, procedures and planned interventions required across the care continuum. Their purpose is to improve timely access, make better use of available capacity and enable more diagnostics and treatment to be delivered outside traditional hospital settings where this is clinically appropriate and sustainable.



A platform should be understood as a connected set of capabilities rather than a single building. It may include services delivered in people's homes, primary and community settings, dedicated diagnostic or treatment facilities and acute hospitals. The appropriate setting will depend on clinical complexity, workforce, equipment, supporting services and the scale required for safe delivery.

The aim should not be to relocate existing services without redesigning the pathway. Diagnostic and treatment capability should connect referral, assessment, testing, reporting, intervention and follow-up as one coordinated process.

CORE FUNCTIONS

Layer 4 should bring together five connected functions:

- Referral and pathway navigation: ensuring that requests are complete, clinically appropriate and directed to the correct investigation or treatment route.
- Diagnostic assessment and testing: providing access to imaging, pathology, physiological measurement and other investigations at an appropriate level.
- Planned treatment and procedures: delivering suitable interventions outside specialist hospital environments where this is safe and effective.
- Clinical interpretation and decision-making: ensuring that results are reviewed promptly and lead to clear action, advice or escalation.
- Capacity coordination: using shared information to manage demand, waiting lists, scheduling and available capacity across sites and settings.

Clinical insight highlighted that delays often arise across the whole pathway rather than from a single test or appointment. Improving capacity at one stage may have limited benefit if referral quality, reporting, specialist decision-making or follow-up remain constrained. The design of this layer should therefore consider end-to-end flow and clinical dependencies.

Success should not be assessed solely through the number of tests or procedures delivered. Measures should consider the time from referral to clinical decision or treatment, diagnostic quality, patient experience, equity of access and whether the intervention improves the complete pathway.

Expanding diagnostic capacity may identify additional unmet need and increase downstream demand. Workforce, reporting, treatment and follow-up capacity should therefore develop alongside testing capability.

Layer 4: Diagnostic and Treatment Platforms

CONNECTIONS WITH OTHER LAYERS

Diagnostic and Treatment Platforms should support every layer of the model. Prevention and Locality Care require access to screening, monitoring and investigations. Community Urgent Response needs timely diagnostics to support safe treatment outside hospital. Specialist and Emergency Hospital Care will continue to provide complex diagnostics and interventions that depend on concentrated expertise and infrastructure.

Virtual Access and Response may support electronic referral, booking, preparation and communication of results. However, digital access should connect to clinical review and clear follow-up rather than place responsibility on people to interpret or coordinate their own results.

Information and responsibility should move with the person. Referring professionals should be able to understand the status of requests, and results should be available to the teams responsible for subsequent decisions and care.

INTENDED IMPACT

- improve timely and equitable access to investigations and treatment
- reduce unnecessary hospital visits and travel
- support earlier diagnosis and clinical decision-making
- reduce repeated investigations and fragmented appointments
- enable appropriate planned care closer to home
- improve the resilience and productivity of clinical pathways

REQUIREMENTS FOR DELIVERY

Effective Diagnostic and Treatment Platforms will require:

- clear and standardised referral criteria
- access to clinical advice before referral where appropriate
- pathways that support direct-to-test and one-stop approaches where suitable
- coordinated booking, scheduling and waiting-list information
- sufficient technical, clinical and reporting workforce
- interoperable ordering, results and clinical information systems
- consistent quality, safety and governance arrangements
- suitable estates, equipment, maintenance and transport
- visibility of demand, capacity and utilisation across CTM
- timely arrangements for communicating and acting on results

Greater distribution of services should not create unwarranted variation or duplicate scarce capability. Decisions about location should balance accessibility with clinical dependencies, workforce sustainability, equipment requirements and the volumes needed to maintain quality.

Layer 5: Specialist and Emergency Hospital Care

PURPOSE

Specialist and Emergency Hospital Care provides the concentrated expertise, infrastructure and continuous clinical support required for people with acute, complex, life-threatening or highly specialised needs.

Hospitals will remain an essential part of the Layered Care Model. Their role should become more focused on care that genuinely depends on hospital-based capability, while expertise, diagnostics and treatment are made available through other layers where this is safe and sustainable.

This is not simply about reducing hospital activity. It is about ensuring that people receive hospital care promptly when they need it, that hospital capacity is used for the needs it is best equipped to meet, and that admission does not become the default response when effective alternatives are available.



CORE FUNCTIONS

Layer 5 should bring together five connected functions:

- Emergency assessment and stabilisation: providing an immediate response to serious illness, injury or deterioration.
- Acute inpatient care: delivering continuous monitoring, treatment and multidisciplinary support for people who require admission.
- Specialist and complex care: providing expertise, technology and infrastructure that cannot be safely or sustainably replicated across multiple settings.
- Complex diagnostics and interventions: undertaking investigations, procedures and treatments that depend on specialist teams or hospital facilities.
- Recovery and transition: beginning rehabilitation and discharge planning early and coordinating the transfer of responsibility to ongoing support.

Hospital-based specialists should also contribute beyond the physical hospital. Advice, virtual review, outreach and shared decision-making can support teams in other layers, improve earlier management and help avoid unnecessary transfers while maintaining access to specialist expertise.

Clinical insight demonstrated that hospital pressures often reflect constraints across the whole pathway, including access to diagnostics, community capacity, rehabilitation and follow-up. Hospital performance should therefore be considered in relation to how people enter, move through and leave the service, not only through internal hospital processes.

Success should not be defined solely by reducing admissions or length of stay. Measures should balance access, safety, outcomes, experience, flow and the sustainability of the services receiving responsibility following discharge.

Layer 5: Specialist and Emergency Hospital Care

CONNECTIONS WITH OTHER LAYERS

Layer 5 should be connected to every other part of the model. Community Urgent Response and Locality Care should be able to access specialist advice and escalate people rapidly when hospital assessment or treatment is required. Diagnostic and Treatment Platforms should provide clear routes into specialist decision-making and intervention.

The relationship should operate in both directions. From the point of admission, hospital teams should consider what will be required for the person to recover and return home. Relevant information, agreed plans and clinical responsibility should transfer safely to locality, rehabilitation, primary care and community services.

Hospitals should also contribute to prevention. This includes preventing complications and functional decline during admission, identifying future risks and connecting people with appropriate support to reduce the likelihood of deterioration or readmission.

INTENDED IMPACT

- provide timely access to emergency and specialist intervention
- reduce delays within hospital pathways
- ensure that specialist capacity is directed towards people who require it most
- minimise avoidable harm, functional decline and prolonged hospital stays
- support safe and timely recovery outside hospital
- strengthen clinical decision-making across the wider system

REQUIREMENTS FOR DELIVERY

Effective Specialist and Emergency Hospital Care will require:

- reliable access to emergency, acute and specialist expertise
- appropriate concentration of complex services and supporting infrastructure
- sufficient workforce capacity and sustainable clinical rotas
- timely access to diagnostics, theatres, critical care and specialist treatment
- digitised clinical workflows and access to relevant information
- real-time understanding of demand, capacity and patient flow
- early discharge, rehabilitation and recovery planning
- clear escalation and transfer arrangements with other layers
- specialist advice that can support care outside hospital
- clinical governance across organisational and service boundaries

The future configuration of hospital services should reflect clinical quality, workforce sustainability, access, infrastructure and interdependencies. Providing every service at every site may not be viable, but consolidation should not proceed without understanding its implications for travel, equity, resilience and the capacity of other services.

4. The CTM Layered Care Model

4.3 Connections across the Layered Care Model

The value of the Layered Care Model lies in how its components work together. Strengthening individual layers without improving the connections between them could create additional boundaries, referral points and delays.

People should experience one coordinated model, even where their care involves several teams, organisations or settings. This requires common arrangements for access, information, decision-making and responsibility across all six layers.

Access and navigation

People should be able to enter the model through several appropriate routes, including digital, telephone and face-to-face access. Whichever route they use, they should receive a consistent response and be directed to the capability best placed to meet their needs.

Navigation should extend beyond signposting. It may include clarifying the person's needs, resolving straightforward requests, coordinating appointments or connecting them directly with clinical or community support. People should not be expected to understand organisational boundaries to find the right service.

Coordination and continuity

Where several services are involved, responsibility for coordinating care should be explicit. This will be particularly important for people living with frailty, multiple conditions, mental health needs or circumstances that cross health and social care boundaries.

Continuity may be provided by an identifiable professional, a team or a shared care plan. It does not always require the same person to deliver every element of care, but it does require information, decisions and agreed actions to be carried forward.

Information following the person

Relevant information should be available wherever care is provided. People should not have to repeat their history unnecessarily, and professionals should be able to understand previous assessments, investigations, treatments and agreed plans.

Technical interoperability alone will not provide continuity. CTM and its partners will also need common expectations for recording information, maintaining it and acting on it. Access must be supported by appropriate consent, information governance and clear clinical accountability.

Expertise moving across the model

People should not always need to move to access specialist expertise. Advice, virtual review, outreach, joint working and shared decision-making should allow specialist capability to support teams in other layers where appropriate.

This can enable earlier decisions and help local teams manage greater complexity. However, advice arrangements should not leave responsibility unclear. The professional or team retaining responsibility must understand what action is required and when further escalation is necessary.

Escalation and de-escalation

People's needs may increase or reduce over time, and the model should support movement in both directions. Escalation should be timely when more intensive assessment or treatment is required, without people having to repeat earlier stages unnecessarily.

De-escalation should be equally deliberate. Following stabilisation, treatment or recovery, people should return to the least intensive layer that can safely meet their needs, supported by clear follow-up and routes back into care.

The objective is not to prevent movement into higher layers. It is to ensure that people escalate because of clinical need rather than service gaps and that they do not remain in intensive settings because appropriate support elsewhere is unavailable.

4. The CTM Layered Care Model

4.4 Applying the Layered Care Model proportionately

The Layered Care Model provides a consistent framework for CTM, but it should not produce an identical pattern of services for every population, locality or clinical pathway. Its application should reflect differences in need while maintaining common expectations for access, quality, safety and coordination across the Health Board.

The appropriate configuration should be determined by three considerations:

i. the needs and circumstances of the population

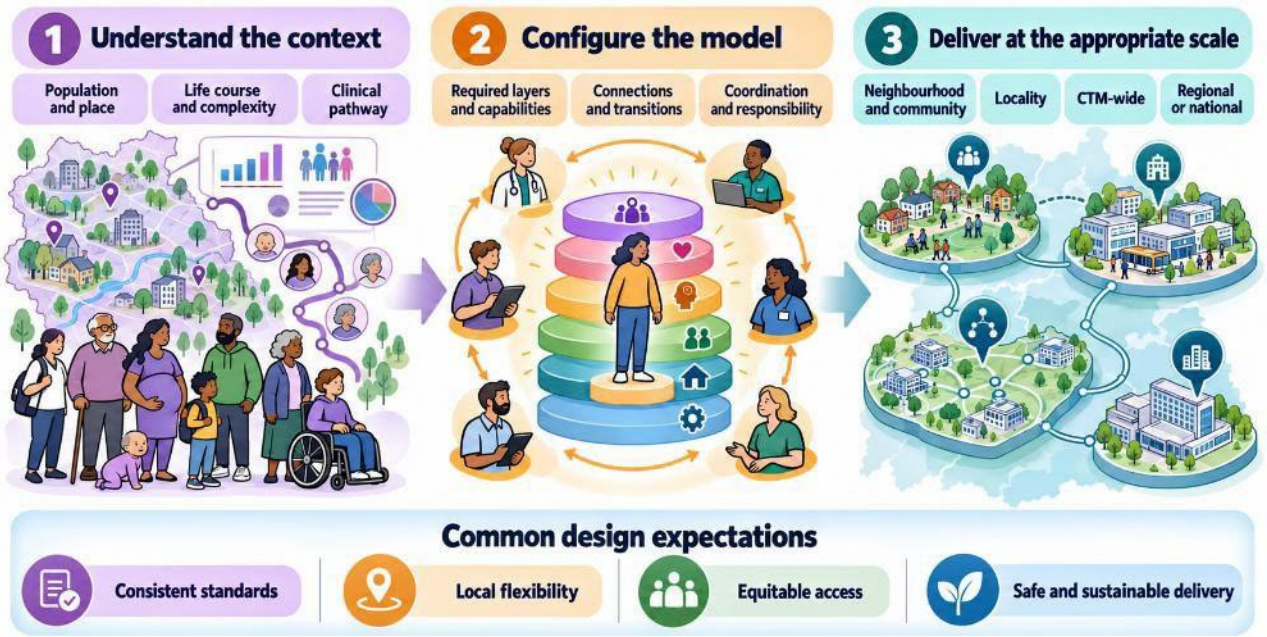
ii. how each clinical pathway draws on the different layers

iii. the geographical scale at which the required capabilities can be delivered safely and sustainably.

Applying one model proportionately

The framework below illustrates how CTM should translate the Layered Care Model into future clinical models.

Figure 4.2. Framework for applying the CTM Layered Care Model proportionately to different populations, pathways and geographical contexts



Responding to population and community need

The balance of capability across the layers should reflect differences in age, deprivation, geography, transport, housing, language, digital access and the availability of community support.

A consistent offer will not always produce equitable outcomes. Some populations may require different forms or more intensive support to achieve comparable access and outcomes. Population health intelligence, clinical evidence and local engagement should inform how the model is applied and where additional resources are directed.

The model should also respond across the life course. Children and families, working-age adults, people living with long-term conditions, older people with frailty and people approaching the end of life may draw on the same layers in different ways. Common mechanisms for access, coordination and transitions should be retained while the nature and intensity of support are adapted to need.

4. The CTM Layered Care Model

Applying the model to clinical pathways

Each clinical pathway will use the layers differently. Some may emphasise prevention, supported self-management and locality-based monitoring. Others will depend more on diagnostics, planned treatment or concentrated specialist expertise.

The Layered Care Model should not predetermine where every service will be delivered. Detailed clinical design should establish:

- which layers and capabilities the pathway requires
- how people enter and move through the pathway
- where coordination and clinical responsibility sit
- how escalation and recovery will operate
- what should be consistently available across CTM
- what should be adapted to specific population or pathway needs

This approach will allow CTM to maintain a common strategic direction without imposing a uniform service configuration across clinically different pathways.

Delivering at the appropriate scale

Not every capability should be organised at the same geographical level. Decisions should reflect accessibility, clinical quality, workforce sustainability, infrastructure, service dependencies and the scale required for safe delivery.

In broad terms:

- **Neighbourhood and community level**: community assets, social connection, practical support and locally tailored prevention.
- **Locality level**: coordinated primary, community, mental health and social care for defined populations.
- **CTM-wide level**: capabilities requiring common standards, shared infrastructure or coordinated use of workforce and capacity.
- **Regional or national level**: highly specialised services and capabilities that cannot be safely or sustainably provided within CTM alone.

These levels should not be treated as rigid boundaries. Some capabilities may combine locally accessible delivery with CTM-wide coordination or regional specialist support.

Balancing consistency and local flexibility

CTM should define the core capabilities, standards and outcomes expected across the model. This will provide consistency where variation could create inequity, fragmentation or clinical risk.

Local flexibility should be retained where it enables services to respond to population needs and community assets. Variation should be intentional, evidence-led and regularly reviewed, not a result of historical arrangements or unequal access to workforce and resources.

4. The CTM Layered Care Model

Testing future clinical models

As the strategic vision progresses into detailed design, each clinical model should demonstrate how it applies CTM's Service Design Principles within the Layered Care Model:

- System Design & Scope: How it responds to needs across the life course, which layers and capabilities it requires, and how people move between local and specialist care.
- Inclusive & Preventive Care: How it embeds prevention, addresses inequalities and access barriers, and involves people, staff and partners in shaping care around individual needs and goals.
- Evidence, Innovation & Digital Transformation: What evidence supports the proposed approach, how digital and data capabilities enable delivery, and how its impact on outcomes, experience and capacity will be assessed.
- Safe, Accountable Care: How it maintains quality and safety, with clear responsibility for coordination, handovers, escalation and assurance across services.
- Resilient & Sustainable Delivery: Whether workforce, funding and infrastructure can support delivery, how the model can adapt to changing needs, and how environmental impacts will be reduced.

The Layered Care Model provides an adaptable framework for this work. It establishes a common direction while allowing service configurations to reflect population needs, clinical evidence and local circumstances. Proposals should make trade-offs explicit and consider their effects across the whole system.



V

Bringing the model to life

5. Bringing the Layered Care Model to life

The Layered Care Model provides a common framework for CTM, but it will apply differently across clinical pathways. Different populations and conditions will require different combinations of prevention, ongoing support, diagnostics, treatment and specialist care.

CTM has identified a wider set of priority clinical areas for future model development. This chapter uses three of those areas, i.e., cardiology, orthopaedics and gastroenterology pathway, to illustrate how the Layered Care Model can be applied in practice. These examples are informed by the clinical engagement undertaken to date and offer different perspectives on how care could operate across the layers.

The three examples are not intended to represent the full range of CTM's priority areas or determine the order in which future clinical models will be developed. They have been used because, collectively, they demonstrate:

- different patterns of need and interaction with services
- different opportunities for prevention and earlier intervention
- the importance of diagnostics, coordination and specialist advice
- where care may be provided differently or closer to home
- where hospital-based capability will remain essential
- how responsibility should move across the pathway

Personas are used within each example to illustrate what the model could mean for an individual. They support the clinical analysis but are not the organising focus of the chapter. They should not be interpreted as representing every person using the pathway.

The examples are also not agreed future pathways or service configurations. They illustrate the strategic direction and thepotential contribution of different layers. Detailed clinical design, engagement and options appraisal will be required before decisions are made about specific services, roles, locations or investment.

5. Bringing the Layered Care Model to life

5.1 How to read this chapter

Each clinical example brings together three perspectives:

I. The person and what evidence tells us: who the person is, what matters to them, what they experience today, and what evidence and engagement tell us about the wider challenges their story represents.


5. Bringing the Layered Care Model to life

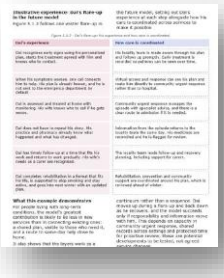
Example I: Dai, living with a long-term condition

II. The Layered Care Model: how each layer of the model could change care for people like them, comparing how care works today with how it could work in the future.


5. Bringing the Layered Care Model to life

Example I: Dai, living with a long-term condition

III. Illustrative experience: how the model could change one episode of their care, setting out their experience at each stage alongside how care is coordinated across services.



The examples should be read as applications of the strategic framework rather than complete pathway designs. They show how the model may help CTM think differently about the organisation of care, but they do not prescribe a single future configuration.

Not every example uses all six layers to the same extent. Some pathways depend heavily on prevention and ongoing locality support, while others require diagnostic platforms or concentrated specialist capability. This variation is intentional and demonstrates how the model should be applied proportionately.

Similarly, care closer to home does not mean relocating every service away from the hospital. The examples distinguish between:

- support that could prevent or identify need earlier
- care that could be delivered in local or community settings
- expertise that could reach into other settings without transferring the person
- services that continue to require specialist teams, equipment or hospital infrastructure

The personas provide a human perspective on these system relationships. They highlight how factors such as work, family responsibilities, mobility, confidence and ability to attend appointments affect people's experience. They do not determine the clinical pathway or imply that everyone will follow the same sequence.

5. Bringing the Layered Care Model to life

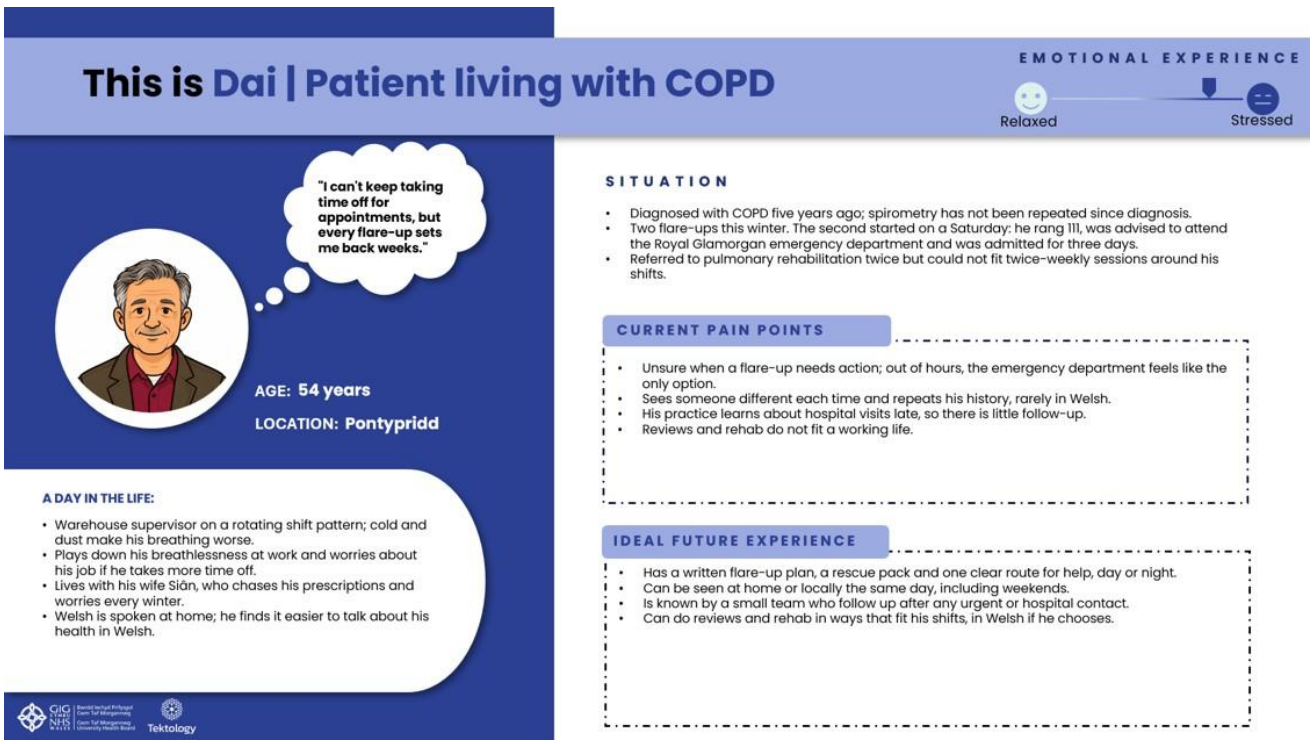
Example I: Dai, living with a long-term condition

Why this story matters

COPD is common across CTM's Valleys communities, where deprivation, smoking and a legacy of heavy industry shape lung health. Care for people like Dai is spread across general practice, community pharmacy, community teams, the Welsh Ambulance Service and hospital, and it is experienced as one journey only by the patient.

Dai's story follows one person across those services. It tests whether the Layered Care Model can deliver what the Quality Statement for Respiratory Disease and the Six Goals for Urgent and Emergency Care ask for: proactive support for people at higher risk, safe alternatives to admission, and a "home first" recovery. It also shows what has to change for the staff involved.

Figure 5.1.1 - Dai, living with COPD



What evidence and engagement tell us

Three findings are particularly important for the future model:

a. **Unplanned care is driven by gaps in access and response, not only by clinical severity.** Many exacerbations could be managed safely at home if an alternative were reachable when symptoms worsen, particularly out of hours.

b. **Continuity and information flow are the weakest links.** Plans, results and discharge information do not reliably follow the person between settings, so opportunities for early follow-up are missed.

c. **Proactive support is under-used.** Diagnostic review, pulmonary rehabilitation and prevention have strong evidence of benefit, but access and format limit uptake, particularly for people of working age.

5. Bringing the Layered Care Model to life

Example I: Dai, living with a long-term condition

Applying the Layered Care Model

Dai's needs are best met in the lower layers most of the time. The model's principal contribution is to keep him well through proactive locality care and to make Community Urgent Response a real alternative when his health deteriorates.

The table sets out how care works today and how it could work in the future model. The changes build on existing services and reflect the Quality Statement for Respiratory Disease and the Six Goals for Urgent and Emergency Care.

Table 5.1.1 - How each layer could change care for people like Dai

Layer	Now	Tomorrow
Layer 0: Prevention	Prevention is largely opportunistic and tied to the annual review. Support to stop smoking, stay active and be vaccinated is not routinely organised around people at rising risk.	Population risk information is used to reach people like Dai before winter. Prevention and community support are offered at times and in places that fit working lives.
Layer 1: Virtual Access and Response	Access depends on getting through at set times. Out of hours, advice is given without sight of his plan, and the emergency department becomes the default.	One clear route to advice and same-day help, day or night. Whoever responds can see his plan, and digital options handle routine needs.
Layer 2: Locality Care	Care is mostly reactive and spread across different contacts. Reviews are hard to attend, and the practice learns of hospital contacts late.	A locality team holds continuity and a shared, personalised plan, proactively reviews people with repeated flare-ups and is told promptly about any urgent contact.
Layer 3: Community Urgent Response	Community alternatives to admission are limited in hours and in how people can be referred, particularly at weekends.	Rapid assessment and treatment at home or close to home, reachable from every urgent route, seven days a week.
Layer 4: Diagnostic and Treatment Platforms	Diagnostic review and rehabilitation are not always accessible or flexible enough to fit around work.	Diagnostics and rehabilitation offered at locality scale in flexible formats, with results and non-completion fed back to the locality team.
Layer 5: Specialist and Emergency Hospital Care	Specialist input comes mainly at admission. Discharge information returns slowly and follow-up varies.	Specialist expertise supports community teams through advice and shared review. Admission is kept for clinical need with early supported discharge and plan returned to local team.

Reading across the table: the shifts are from reactive to proactive care, from single points of access to connected routes, and from one-off handovers to

shared plans and information. Most of the change builds on existing services and depends on capacity, information flow and workforce rather than new buildings.

5. Bringing the Layered Care Model to life

Example I: Dai, living with a long-term condition

Illustrative experience: Dai's flare-up in the future model

Figure 5.1.2 follows one winter flare-up in the future model, setting out Dai's experience at each step alongside how his care is coordinated across services to make it possible.

Figure 5.1.2 - Dai's flare-up: his experience and how care is coordinated.

Dai's experience	How care is coordinated
Dai recognises early signs using his personalised plan, starts the treatment agreed with him and knows who to contact.	His locality team is made aware through his plan and follows up promptly. Early treatment is recorded so patterns can be seen over time.
When his symptoms worsen, one call connects him to help. His plan is already known, and he is not sent to the emergency department by default.	Virtual access and response can see his plan and route him directly to community urgent response rather than to hospital.
Dai is assessed and treated at home with monitoring. His wife knows who to call if he gets worse.	Community urgent response manages the episode with specialist advice, and there is a clear route to admission if it is needed.
Dai does not have to repeat his story. His practice and pharmacy already know what happened and what has changed.	Information from the episode returns to the locality team the same day. His medicines are reconciled and he is flagged for review.
Dai has timely follow-up at a time that fits his work and returns to work gradually. His wife's needs as a carer are recognised.	The locality team leads follow-up and recovery planning, including support for carers.
Dai completes rehabilitation in a format that fits his life, is supported to stop smoking and stay active, and goes into next winter with an updated plan.	Rehabilitation, prevention and community support are coordinated around his plan, which is reviewed ahead of winter.

What this example demonstrates

For people living with long-term conditions, the model's greatest contribution is likely to lie less in new services than in connecting existing ones: a shared plan, visible to those who need it, and a route to same-day help close to home.

It also shows that the layers work as a continuum rather than a sequence. Dai moves up during a flare-up and back down as he recovers, and the model succeeds only if responsibility and information move with him. This depends on capacity in community urgent response, shared records across settings and protected time for proactive review; these are potential developments to be tested, not agreed

service changes.

5. Bringing the Layered Care Model to life

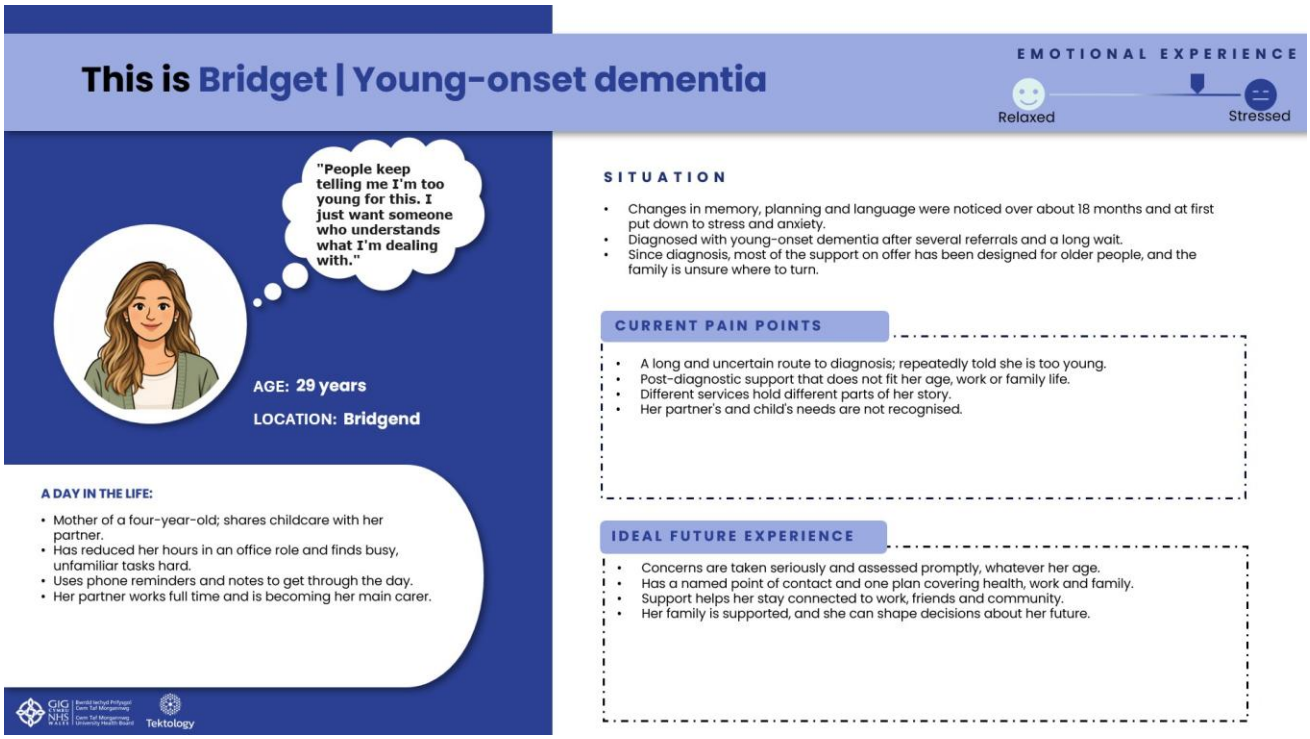
Example II: Bridget, living with dementia

Why this story matters

Dementia is one of the largest drivers of need across health and social care in CTM. Young-onset dementia is far less common, but it brings distinct needs: a harder route to diagnosis, and a direct impact on work, finances and young families. Most support is designed around older people.

Bridget's story tests whether the Layered Care Model can recognise need early when it does not fit the expected pattern, and then sustain coordinated support across health, social care and the third sector. It reflects the Dementia Action Plan for Wales, the All Wales Dementia Care Pathway of Standards and the rights of carers under the Social Services and Well-being (Wales) Act.

Figure 5.2.1 - Bridget, living with young-onset dementia



What evidence and engagement tell us

Three findings are particularly important for the future model:

a. Diagnosis is slower and less certain for younger people. Early symptoms are often attributed to stress, mental health or other causes, and assessment pathways are oriented to older age groups.

b. Post-diagnostic support is fragmented. Help is spread across health, social care and the third sector, with no single point of contact holding the plan.

c. Families carry the load early. Partners and children take on caring roles, often while working, and their needs are not consistently assessed.

5. Bringing the Layered Care Model to life

Example II: Bridget, living with dementia

Applying the Layered Care Model

Bridget's needs sit mainly in Layers 0 to 2, with specialist input from Layers 4 and 5 at diagnosis and at key points. The model's principal contribution is earlier recognition, a single coordinated plan and sustained support in the community. Community Urgent Response matters at moments of crisis, so that hospital is not the default.

The table sets out how care works today and how it could work in the future model. The changes build on existing services and partnerships and reflect the Dementia Action Plan for Wales and the All Wales Dementia Care Pathway of Standards.

Table 5.2.1 - How each layer could change care for people like Bridget

Layer	Now	Tomorrow
Layer 0: Prevention	Awareness that dementia can affect younger people is limited, so early changes are attributed to other causes. Community and peer support is largely designed for older people.	Greater awareness of young-onset dementia among the public and professionals. Age-appropriate peer, community and employment support, with carers connected early.
Layer 1: Virtual Access and Response	The family struggles to know who to contact as things change. Advice is spread across health, social care and the third sector.	One point of contact and a single route to advice, with her plan visible across services and digital tools that support independence.
Layer 2: Locality Care	General practice holds overall care but has limited support after diagnosis. Reviews focus on medicines rather than goals and family life.	A locality team with a named coordinator holds a shared plan covering health, work, family and future wishes, reviewed proactively with social care and the third sector.
Layer 3: Community Urgent Response	When a crisis occurs, such as carer exhaustion or a sudden change in need, options are limited and hospital or emergency respite becomes the default.	Rapid support at home from teams with dementia expertise, including crisis support for carers, avoiding unnecessary admission.
Layer 4: Diagnostic and Treatment Platforms	Specialist assessment involves long waits and repeated referrals, and services are oriented to older age groups.	Timely specialist memory assessment suited to younger people, including genetic counselling where relevant, with results shared with the locality team.
Layer 5: Specialist and Emergency Hospital Care	Specialist input is concentrated around diagnosis. Hospital stays can be disorientating and poorly coordinated with community support.	Specialist expertise supports the locality team over time. Any hospital care is dementia-friendly and returns her to an updated community plan.

Reading across the table: the shifts are from late, uncertain diagnosis to earlier recognition, from fragmented support to one coordinated plan, and from a focus on the patient alone to supporting the whole

family. Much of the change depends on health, social care and community partners working as one system around the person and their family.

5. Bringing the Layered Care Model to life

Example II: Bridget, living with dementia

Illustrative experience: Bridget's first year after concerns are raised

Figure 5.2.2 follows Bridget from the first concerns about her memory through her first year after diagnosis, setting out her experience at each stage alongside how her care is coordinated across services.

Figure 5.2.2 - Bridget's experience and how care is coordinated

Bridget's experience	How care is coordinated
Bridget and her partner raise concerns about her memory. They are taken seriously despite her age, and she is referred for assessment without delay.	The locality team recognises an atypical presentation and uses an agreed route for prompt referral to specialist memory assessment.
Her diagnosis is given with time to talk, written information and a named contact, with her partner present.	The specialist service shares the diagnosis and plan with the locality team within days, and post-diagnostic support begins straight away.
Bridget works with one coordinator on a plan covering her health, work, finances, childcare and wishes for the future.	The coordinator brings health, social care, employment support and third-sector partners together around one shared plan.
She joins an age-appropriate peer group, gets support to adjust her work and uses tools that help her stay independent.	Community and third-sector support for younger people is in place, and the plan is reviewed proactively as her needs change.
When her partner becomes exhausted and her needs change suddenly, help arrives at home the same day.	Community urgent response with dementia expertise provides support and short-term care at home, avoiding admission, and the locality team updates the plan.
Her partner and child are supported, and Bridget's wishes for the future are recorded while she can shape them.	Carer's assessment, family support and advance care planning are coordinated and reviewed regularly.

What this example demonstrates

For people living with dementia, particularly at a younger age, the model's greatest contribution is likely to lie in early recognition and continuous, coordinated support rather than episodic treatment: one plan, one point of contact and support that reflects the person's stage of life.

It also shows that the layers cannot work for Bridget without partners beyond the NHS. Social care, employers and the third sector are central to her plan, and the model depends on shared records, joint commissioning and dementia expertise in community teams. These are potential developments to be tested, not agreed service changes.

For Bridget, success would mean a diagnosis without years of uncertainty, one coordinated plan and a family that is supported. For CTM, it would mean designing dementia support around people and families rather than age bands.

5. Bringing the Layered Care Model to life

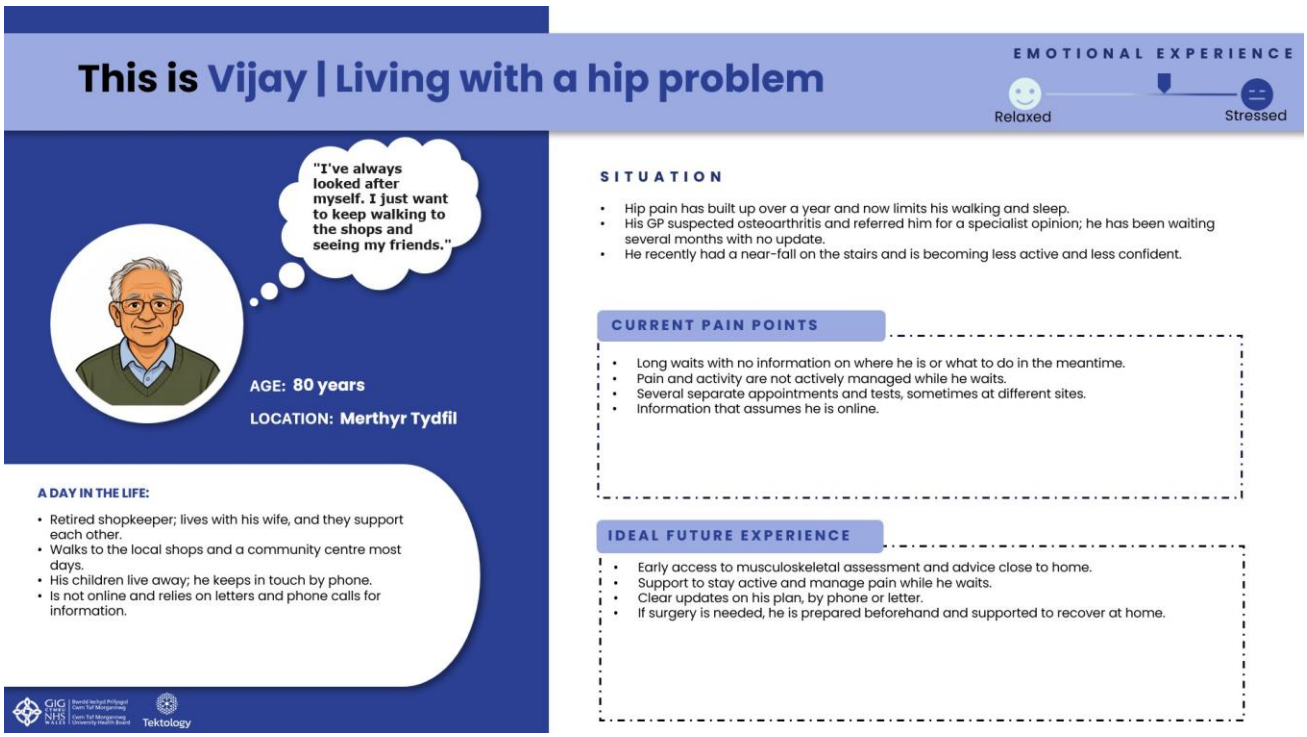
Example III: Vijay, living with a hip problem

Why this story matters

Musculoskeletal problems are among the most common reasons older people lose mobility and independence. Long waits for planned orthopaedic care in Wales mean many people wait in pain, become less active and are at greater risk of falls, so a single problem can become wider frailty.

Vijay is otherwise well. His story tests whether the Layered Care Model can keep a well older person well: early access to musculoskeletal support, help to "wait well", falls prevention and, if surgery is needed, a home-first recovery. It reflects national planned care priorities and the Six Goals for Urgent and Emergency Care.

Figure 5.3.1 – Vijay, living with a hip problem



What evidence and engagement tell us

Three findings are particularly important for the future model:

a. **Waiting is where decline happens.** Long waits can lead to deconditioning, falls and loss of confidence, turning a single problem into wider frailty.

b. **b. Early musculoskeletal support is used inconsistently.** Many people still reach specialist care through a GP referral and a long wait, rather than through early assessment and active management.

c. Digital exclusion widens the gap. Older people who are not online can miss updates and options, increasing uncertainty and unplanned contact.

5. Bringing the Layered Care Model to life

Example III: Vijay, living with a hip problem

Applying the Layered Care Model

Vijay's needs are best met in Layers 0, 2 and 4, with Layer 5 only if surgery is needed. The model's principal contribution is early musculoskeletal assessment, active support while he waits and a coordinated, home-first route through surgery if he needs it. Community Urgent Response matters if he falls.

The table sets out how care works today and how it could work in the future model. The changes build on existing services and reflect national planned care priorities and the Six Goals for Urgent and Emergency Care.

Table 5.3.1 – How each layer could change care for people like Vijay

Layer	Now	Tomorrow
Layer 0: Prevention	Support to stay active and prevent falls is not routinely offered to well older people until a problem escalates.	Strength-and-balance, activity and falls prevention offered early through local partners, to keep people like Vijay active and independent.
Layer 1: Virtual Access and Response	Information about his referral and wait arrives by letter, often late. Advice is hard to access without going online.	Clear updates on his plan and wait through his preferred channel, including phone and paper, with one number for questions.
Layer 2: Locality Care	He goes to the GP first, and referral to specialist care is the main route, with little support while he waits.	Direct access to musculoskeletal physiotherapy in the locality, with pain management, exercise and "waiting well" support, and regular check-ins.
Layer 3: Community Urgent Response	A fall or sudden worsening often leads to an ambulance and an emergency department attendance.	Rapid community response assesses falls and flare-ups at home, preventing unnecessary conveyance and admission.
Layer 4: Diagnostic and Treatment Platforms	Imaging and assessments happen at separate appointments, sometimes at different sites.	Joined-up assessment and imaging at locality scale, with results shared so decisions can be made in one visit where possible.
Layer 5: Specialist and Emergency Hospital Care	Specialist assessment comes after a long wait, and preparation for surgery and discharge can start late.	Specialist review informed by locality assessment. Preparation before surgery and discharge planning begin early, with rehabilitation at home.

Reading across the table: the shifts are from waiting passively to waiting well, from referral as the main route to direct access to musculoskeletal support, and

from late discharge planning to a home-first recovery. Most of the change builds on existing services and depends on locality capacity and community partners.

5. Bringing the Layered Care Model to life

Example III: Vijay, living with a hip problem

Illustrative experience: Vijay's hip, from first symptoms to recovery

Figure 5.3.2 follows Vijay from the first signs that his hip is limiting him to his recovery, setting out his experience at each stage alongside how his care is coordinated across services.

Figure 5.3.2 - Vijay's experience and how care is coordinated

Vijay's experience	How care is coordinated
When hip pain starts to limit his walking, Vijay is directed to local musculoskeletal advice rather than waiting for a GP appointment.	Locality musculoskeletal physiotherapy provides early assessment and an exercise and pain management plan.
Imaging and assessment happen close to home in as few visits as possible, and he understands what the results mean.	Diagnostics and assessment are coordinated at locality scale, and results are shared with his GP and the specialist team.
While he waits for a specialist opinion, he has regular check-ins, a strength-and-balance group and a number to call.	The locality team and community partners support him to wait well, monitoring changes and escalating if his condition worsens.
When he has a fall at home, he is assessed at home the same day and does not need to go to hospital.	Community urgent response assesses and treats him at home, informs the locality team and updates his plan.
He is prepared physically and practically before his hip replacement, his home is ready, and he goes home quickly.	The specialist team plans discharge from the start, with preparation before surgery and equipment arranged with community services.
Rehabilitation continues at home and in the community, and he is back walking to the shops and seeing friends.	Locality rehabilitation and community activity support his recovery and long-term independence.

What this example demonstrates

For older people who are otherwise well, the model's greatest contribution is likely to lie in keeping them well while they wait and recover: early support close to home, active management of pain and activity, and a home-first approach to surgery.

It also shows that planned care is not only a hospital pathway. Vijay's outcome depends on locality musculoskeletal capacity, community partners and information that reaches people who are not online. These are potential developments to be tested, not agreed service changes.

For Vijay, success would mean staying active, avoiding a fall-related admission and recovering at home. For CTM, it would mean planning orthopaedic care as one pathway, from prevention to recovery, rather than as a waiting list.

5. Bringing the Layered Care Model to life

5.5 What the clinical examples demonstrate

The three clinical examples illustrate how the Layered Care Model can provide a common direction while responding to different clinical needs. Cardiology highlights the relationship between ongoing management, diagnostics and specialist advice. Orthopaedics demonstrates the dependence of treatment outcomes on rehabilitation and recovery. The gastroenterology and colorectal example emphasises risk-based prioritisation, diagnostic capacity and clear transitions into specialist care.

Together, they reveal several implications for how CTM should develop the future model across its wider priority clinical areas.

Improve the complete pathway

Delays and fragmentation rarely sit within a single service. Diagnostic access, clinical review, treatment, rehabilitation and follow-up influence one another. Increasing capacity at one stage may move the bottleneck elsewhere unless the receiving services can respond.

The unit of improvement should therefore be the complete pathway. Proposals should demonstrate how changes affect access, clinical decisions, outcomes and capacity across the services involved.

Match the setting to the capability required

The opportunities for care closer to home differ between pathways. Advice, monitoring, ongoing management and rehabilitation may be delivered more locally where appropriate capability exists. Other activities will continue to depend on specialist teams, equipment and hospital infrastructure.

The model should distinguish between moving an activity, extending specialist expertise into another setting and improving coordination around care that remains hospital-based. Each can improve people's experience; relocation alone is not a measure of success.

Make responsibility visible

Across all three examples, people need to know what happens next and who is responsible. Teams need equivalent clarity about pending investigations, clinical decisions, onward referrals and follow-up.

Shared information should support this continuity, alongside explicit responsibility for reviewing results, acting on changing needs and completing agreed actions. A referral, discharge or transfer should connect the next stage of care without leaving people to coordinate it themselves.

Recognise the capacity behind new ways of working

Triage, specialist advice, nurse-led care, monitoring and multidisciplinary coordination all require time and resource. Community delivery also depends on sufficient rehabilitation, practical support and access to diagnostics.

These functions should be recognised within workforce and resource planning. Their benefits cannot be assumed if they are added to existing workloads without sufficient capacity, training or supporting infrastructure.

5. Bringing the Layered Care Model to life

Judge improvement through people's outcomes and experience

The personas illustrate how work, mobility, family responsibilities and uncertainty can affect access and participation in care. A pathway may appear efficient within an individual service while remaining difficult for the person to navigate.

Assessment should therefore consider whether people receive timely decisions, understand their care, avoid unnecessary repetition and regain or maintain independence. These outcomes should sit alongside measures of activity, waiting times, safety and resource use.

The examples provide an initial test of the Layered Care Model across three of CTM's priority areas. They establish a consistent way to consider the whole pathway while preserving the clinical differences between services. Chapter 6 sets out the shared capabilities required to translate this direction into delivery.



VI Strategic shifts and enabling conditions

6. Enabling the Future Model of care

Delivering the Layered Care Model will require coordinated changes to the workforce, information, infrastructure, partnerships, and resource use. These capabilities will determine whether CTM can strengthen prevention, deliver more local care, and maintain timely access to specialist services.

The clinical examples in Chapter 5 demonstrate how these requirements interact. Increased accessibility to diagnostics and sufficient reporting and treatment capacity. Earlier discharge depends on rehabilitation and community support. Virtual access requires clinical teams with the capacity and information to respond. Enabling plans should therefore develop alongside clinical design, with a shared understanding of dependencies and the consequences of change across the system.

CTM's existing strategies and programmes provide a starting point. The draft Digital and Data Plan, for example, identifies capabilities and initiatives that could support each layer, alongside constraints in workforce readiness, information sharing, infrastructure and delivery capacity. The Future Model of Care should help shape the priorities and sequencing of these enabling plans as clinical requirements become clearer.

This chapter sets out the capabilities needed to support delivery. It establishes strategic requirements while leaving detailed workforce models, technical specifications, service configurations and investment decisions to subsequent development and appraisal.

6.1 Workforce and ways of working

Organising capability around population need

- The future model will require workforce planning across complete pathways and populations, informed by CTM's population needs analysis and aligned with its People Plan and People's Experience Plan. Together, these should help connect the skills and capacity required with the needs of communities and the experience of people receiving and delivering care. CTM and its partners will need to consider where skills are required, how expertise can support care across settings and how teams will respond as people's needs change.
- This includes strengthening preventive and community capability while sustaining safe hospital services. Workforce requirements should reflect the work involved in assessment, coordination, rehabilitation and follow-up, alongside direct treatment. Moving activity into a different setting will be sustainable only where receiving teams have sufficient capacity and appropriate clinical support.

Enabling connected teams

- Multidisciplinary working should bring together the professionals needed to address a person's circumstances, drawing on primary care, community services, mental health, social care, therapies, pharmacy and specialist teams as appropriate.
- The intensity of coordination should be proportionate to need. Some people will benefit from a named coordinator and regular multidisciplinary review. Others may need timely advice between professionals and a clear shared plan. In both cases, teams should understand who holds responsibility, what actions are outstanding and how to obtain additional support.
- Specialist advice across settings could help locality teams manage appropriate needs and make earlier decisions. This contribution will need to be recognised within job plans, with agreed arrangements for advice, supervision and escalation.

6. Enabling the Future Model of care

Using skills effectively

- CTM should consider how nurse-led services, allied health professional roles, advanced practice and support roles could contribute to future clinical models. Administrative and coordination support may also free up clinical time currently spent arranging care or resolving avoidable process issues.
- Role development should follow an assessment of clinical need, competence and workload. Additional responsibilities require suitable training, supervision, protected time and professional accountability. Service redesign should also identify activities that can stop or be simplified, reducing the risk that new functions are added to already stretched roles and responsibilities.

Supporting adoption and workforce development

The draft Digital and Data Plan identifies barriers involving access to devices and systems, limited training capacity and pressure on digital teams. These conditions will affect the wider care model: staff cannot reliably work across settings or deliver virtual care without the tools, confidence and support to do so.

Workforce development should therefore include:

- preparation for new clinical and coordination responsibilities
- protected learning time and appropriate supervision
- role-specific digital and data skills
- practical support as teams adopt new workflows
- opportunities for staff to shape and improve the model

Leaders will need to support decisions that improve the complete pathway, including where benefits arise outside their own service. Staff experience, workload and retention should inform whether new arrangements are sustainable.

Planning the transition

Workforce change will need to be sequenced with clinical redesign and investment. Community and locality capacity may need to develop before activity can move safely, while hospital services continue to operate. Training, backfill and temporary overlap between existing and future arrangements should be recognised within delivery plans.

Planning should also distinguish between roles employed directly by CTM and contributions dependent on primary care contractors, local authorities or other partners. Changes across these boundaries will require joint agreement about capacity, responsibilities and resources.

6.2 Digital, data and information

Connecting the model through digital and data

- Digital and data capabilities should enable people, professionals and services to work together across the Layered Care Model. They should support earlier identification of need, simpler access, informed decisions and continuity as people move between settings.
- The draft CTM Digital and Data Plan provides the principal reference for these capabilities and their delivery priorities. It already maps digital requirements across Layers 0–5 and brings existing programmes, service needs and future opportunities into a common portfolio. As clinical models develop, their requirements should inform the plan's prioritisation and sequencing.
- The portfolio contains initiatives at different stages of readiness. Clinical models should therefore distinguish between capabilities available today, those being implemented and those requiring further development or investment.

6. Enabling the Future Model of care

Accessible routes into care

- Digital and telephone channels should help people obtain advice, manage appointments and understand what happens next. The Digital and Data Plan identifies relevant developments through the NHS Wales App, patient portals and the Patient Contact Centre Transformation Programme.
- These routes will need to connect to clinical navigation, booking and services with the capacity to respond. People should receive a consistent experience whichever channel they use, with relevant information carried forward when contact moves from a remote interaction to face-to-face assessment.
- Accessible design, assisted access and non-digital alternatives should form part of service planning. Success should be assessed through whether people reach appropriate support and have their needs addressed, alongside adoption of digital channels.

Shared information and coordinated workflows

- Professionals should have access to relevant records, investigations and care plans at the point of need. This is particularly important where primary care, community services, hospitals and social care contribute to the same person's care.
- The plan identifies shared records, electronic referrals, diagnostic ordering and results, and integrated workflows as enabling capabilities. Initiatives such as WPRS, Hospital Initiated Referrals and Straight to Test could support more coordinated pathways, subject to their scope and delivery status.
- Their value will depend on agreed ways of working. Teams should understand who reviews information, acts on results and follows up outstanding actions. Clinical and operational redesign should accompany implementation so that digital processes reduce duplication and make responsibility clearer.

Information supporting proactive care and improvement

- Population health intelligence should help CTM identify inequalities, understand changing need and target earlier support. Operational information should help teams manage demand, capacity and delays across complete pathways.
- The plan's dashboard and data developments provide a basis for this work, alongside PROMs, PREMs and patient feedback. However, its current-state assessment identifies inconsistent definitions, data quality issues and gaps in information flow. Strengthening these foundations will be necessary before more advanced analytics or automation can be used reliably.
- Insight should connect to decisions and action. Each clinical model should identify the information required, who will use it and what response it should trigger.

Reliable foundations and sustainable adoption

- The future model will depend on reliable infrastructure, connectivity, appropriate devices and secure access across care settings. Cyber resilience and continuity arrangements become increasingly important as services rely on shared information and digital workflows.
- The Digital and Data Plan recognises the need to stabilise essential systems, improve interoperability and retire legacy platforms. These activities should be treated as dependencies for service transformation, alongside more visible patient-facing developments.
- Implementation will also require clinical ownership, workforce training and ongoing support. Benefits should be evaluated through changes in care, staff workload, safety and experience, with service teams accountable for embedding the new ways of working.

6. Enabling the Future Model of care

6.3 Estates, equipment and transport

Aligning infrastructure with the model of care

- The Layered Care Model will require facilities and equipment that support care across homes, communities, diagnostic settings and hospitals. CTM should develop an estates plan alongside the model of care, translating emerging clinical requirements into a phased approach to infrastructure investment and adaptation. This should take account of population distribution, accessibility, workforce availability and clinical dependencies.
- CTM should consider how existing premises could support the model through adaptation, shared use or changes to operating arrangements, alongside any need for new facilities. A service's physical location is only one part of its accessibility: opening hours, appointment coordination, transport and the availability of appropriate staff will also determine whether people can use it.

Supporting locality and community delivery

Stronger locality care and community urgent response will require suitable places for assessment, treatment, rehabilitation and multidisciplinary working. These may include primary care premises, community facilities and shared spaces with partners, depending on the functions required.

Planning should consider whether facilities provide:

- accessible environments that meet different physical, sensory and communication needs
- appropriate clinical space, privacy and infection prevention arrangements
- reliable connectivity and access to relevant information
- equipment, storage and support services suited to the intended activity
- flexibility for different teams to use space effectively

Co-location may make joint working easier, but its benefits depend on shared pathways and clear responsibilities. Bringing teams into the same building will not, by itself, resolve fragmented care.

Connecting diagnostic and specialist infrastructure

- The draft Digital and Data Plan identifies the Orthopaedic Centre and Community Diagnostic Hub within the Llantrisant Health Park programme as relevant developments. Their relationship with the Future Model of Care should be made explicit, including which pathways they support and how they connect with existing sites.
- The contribution of these facilities will depend on the wider pathway. Additional diagnostic provision requires reporting capacity, clinical review and onward treatment. Planned surgical capacity requires preparation, rehabilitation and recovery support. Buildings, equipment and digital systems should therefore be planned alongside the workforce and operational arrangements needed to use them.
- Specialist and emergency hospital infrastructure will remain essential. Decisions about distributing or concentrating capability should consider clinical interdependencies, service resilience and the implications for people travelling between sites.

Equipping care in the home

- Providing more care at home may require portable diagnostics, monitoring devices, rehabilitation aids and other equipment. Availability alone is insufficient: services will need arrangements for delivery, installation, training, maintenance, retrieval and replacement.

6. Enabling the Future Model of care

- Home circumstances should inform whether a proposed model is appropriate. Space, connectivity, accessibility and the support available to the person may affect delivery. Equipment and digital tools should help people remain independent without placing unreasonable demands on them or their carers.
- Accountability for equipment should remain clear when several organisations contribute to care, including who responds when a device fails or the person's needs change..

Transport, accessibility and sustainability

- Transport should form part of pathway design from the outset. A service may be geographically closer yet remain difficult to reach because of public transport routes, appointment times, mobility limitations or the need for an accompanying carer.
- Future options should consider the number and purpose of journeys, opportunities to coordinate appointments, and the transport required by both people receiving care and mobile staff. Where specialist services operate across larger geographical areas, the consequences for access and inequalities should be explicitly assessed.
- Environmental sustainability should inform the use of estate, energy, equipment and travel. Changes should be assessed across the whole pathway, recognising that reduced patient travel may be accompanied by increased staff travel or additional facilities.

6.4 Partnerships and community capability

Planning around shared population needs

- Delivery of the Layered Care Model will depend on CTM working with primary care, local authorities, social care providers, the third sector and communities. Regional and national partners will also influence access to specialist services and shared infrastructure.
- These relationships should shape the model from the outset. Partners will need a shared understanding of population need, the outcomes they seek to improve and the contribution each can realistically make. This is particularly important where a change within health services creates additional demand for social care, housing support, rehabilitation or community provision.
- Existing partnership arrangements should provide the starting point for this work. The relationship between CTM's clinical priorities and regional population needs should help determine where joint planning and investment are required.

Recognising community capability

- Community organisations contribute trusted relationships, local knowledge and practical support that can help people remain well and independent. Their role may include social connection, navigation, support for self-management and reaching people who experience barriers to formal services.
- The availability of this support will differ between localities. Planning should identify existing strengths alongside gaps in provision, recognising that communities with greater need may have fewer resources available to respond.
- Where future pathways depend on a sustained contribution from community or third-sector organisations, the associated capacity and funding should be explicit. Arrangements should support continuity while remaining proportionate to the size and role of the organisation. Small organisations may require support to participate in contracting, information sharing and evaluation.

6. Enabling the Future Model of care

Making joint delivery work

Shared ambition will need to translate into practical arrangements at pathway level. Partners should understand:

- which functions each organisation will provide
- how people access and move between services
- who coordinates support when several organisations are involved
- how concerns are escalated and clinical advice obtained
- how changes in demand or capacity will be addressed

These arrangements should preserve statutory and professional accountability while making joint working easier. A referral to a community organisation should include clarity about what support it can provide and how the person reconnects with clinical services if their needs change.

Information sharing will also be important. The draft Digital and Data Plan identifies health and social care collaboration and community integration as relevant areas of development. Access should be proportionate to each partner's role, supported by agreed responsibilities for recording, reviewing and acting on information.

Involving people and unpaid carers

- People and communities should help define the outcomes, access arrangements and forms of support that matter to them. Engagement should include those who may be less visible through established groups or digital channels, so that service design reflects different experiences and barriers.
- Unpaid carers should be involved where appropriate and with the person's agreement. Their willingness, ability and support needs should inform care planning. Models that increase care at home should not assume that families can absorb additional responsibilities without assessment, information or practical help.

Aligning resources and commitments

- The costs and benefits of change may fall in different organisations. Investment in community support may improve hospital flow, while earlier discharge may increase demands on social care or unpaid carers. Joint planning should make these effects visible and establish how the required capacity will be sustained.
- Commitments should reflect what partners have agreed and can deliver. The strategic vision can establish the direction, but implementation will require clarity about ownership, resources and how partners resolve pressures that arise across organisational boundaries.

6.5 Governance and clinical design

Providing oversight across the model

The Layered Care Model will require governance that connects clinical redesign, enabling programmes and investment decisions. Changes within one pathway can affect workforce, diagnostics, community capacity and hospital services elsewhere. CTM should assess these consequences collectively as proposals develop.

A single CTM Strategic Improvement Delivery Unit (SIDU) is recommended to maintain oversight of the model and coordinate its translation into clinical service proposals. Its remit should bring together clinical, operational, workforce, digital, estates, finance and partnership considerations, with clear routes for people and communities to influence decisions.

The SIDU should operate within CTM's existing governance, with explicit delegated responsibilities and reporting arrangements. Formal approval of service changes and investment should remain with the bodies holding the relevant authority.

6. Enabling the Future Model of care

Maintaining a consistent approach to clinical design

The SIDU should provide a common basis for developing and assessing proposals across CTM's priority clinical areas. This should include:

- applying the agreed design principles and Layered Care Model
- testing proposals against population need, inequalities and intended outcomes
- reviewing evidence, options and the contribution of engagement
- assessing clinical safety, feasibility and resource requirements
- resolving dependencies and competing requirements across pathways
- recommending whether proposals are ready to progress

Clinical teams are required to lead and own the development of their models with operational and enabling colleagues involved from the outset. This will help identify delivery constraints while options remain open, rather than after a preferred configuration has been developed.

Proposals should make clear what is supported by evidence, what remains an assumption and what requires further testing. The illustrative pathways in Chapter 5 provide a starting point for discussion, rather than approval for particular service changes.

Connecting engagement with decisions

People, carers, staff and partners should have meaningful opportunities to shape the problems being addressed, the options considered and the outcomes used to judge success.

Governance should make this contribution visible. Proposals should explain how engagement has influenced the design, where views differ and how unresolved concerns will be considered. Clinical advice, lived experience and operational evidence should inform decisions alongside affordability and deliverability.

Where proposals affect services provided by partner organisations, their involvement and agreement will be needed at the appropriate stage. The SIDU should identify these dependencies early and ensure that CTM's plans do not assume commitments that partners have not made.

Aligning with service change and the IMTP

Development of future clinical models should follow CTM's service-change framework, with clear points for reviewing evidence, assessing options and determining readiness for approval or implementation. The governance route should recognise the engagement, impact assessment and assurance required for each proposal.

The IMTP should provide the mechanism for translating the strategic direction into phased delivery commitments. Each planning cycle should review:

- progress and learning from work already underway
- the readiness of proposals for further development or implementation
- workforce, digital, estates and financial dependencies
- the resources required and their affordability
- the outcomes and benefits expected during the planning period

This should allow CTM to maintain a longer-term direction while adjusting delivery to evidence, capacity and available funding.

6. Enabling the Future Model of care

Maintaining accountability through delivery

Each clinical model should have an accountable owner, supported by named leads for its enabling requirements. Design decisions, assumptions and dependencies should remain visible as work progresses into implementation.

The SIDU should review material changes that could affect the agreed model, including changes in scope, location, workforce or supporting capacity. It should also use implementation evidence and feedback to determine whether the model needs adjustment.

Oversight should remain proportionate. Routine delivery decisions should sit with the responsible teams, with escalation focused on issues that affect safety, strategic consistency, affordability or other parts of the system.

6.6 Finance and resource allocation

The Layered Care Model should guide how CTM aligns resources with population need and future clinical pathways. Investment decisions should consider outcomes, equity, quality and affordability across the complete pathway, including consequences for partner organisations, people and unpaid carers.

Care closer to home should not be assumed to cost less in every circumstance. Some changes may improve independence or release capacity without generating immediate cash savings. Financial assessments should distinguish between implementation and recurrent costs, productivity gains, avoided future costs and demonstrable reductions in expenditure. Reduced hospital activity will only release cash where associated costs can safely be removed.

Modelling the impact of service redesign

CTM should establish a shared, data-based approach to modelling proposed service changes. Using an agreed baseline of demand, activity, capacity, workforce and costs, it should compare current provision with alternative delivery scenarios.

The model should estimate:

- investment, transition and recurrent costs
- changes in demand and capacity across affected services
- workforce requirements and opportunities for redeployment
- potential cash savings, cost avoidance and productivity benefits

Assumptions about uptake, timing and outcomes should be explicit, with sensitivity testing to show how results change under different conditions. The level of analysis should be proportionate to the scale and risk of the proposal. Actual delivery results should subsequently inform the model and future decisions.

Investing and sequencing change

New capability may need to be established before existing provision can change. Workforce development, community capacity, equipment and digital integration may require upfront investment and a period of overlapping delivery. The draft Digital and Data Plan identifies comparable dependencies through system transition, dual-running and legacy retirement.

Investment should be prioritised against population need, expected outcomes, affordability and delivery readiness. This should recognise the longer timescales of prevention and enabling investment that supports several pathways. Where costs and benefits fall in different organisations, partners should agree how delivery will be funded and sustained.

The IMTP should translate agreed priorities into phased commitments, distinguishing funded delivery from proposals requiring further appraisal. Existing capacity should be adjusted only when alternative arrangements can safely meet need.

6. Enabling the Future Model of care

Demonstrating value

Each approved change should have a baseline, an accountable benefits owner and measurable expectations for costs, activity and outcomes. Finance and service leads should jointly assess whether benefits are being realised and whether pressures have transferred elsewhere.

Reviews should consider financial performance alongside safety, access, experience and workforce impact. Where assumptions do not hold, CTM should adjust the pace or scope of delivery.

6.7 Measurement, learning and improvement

TM should assess the Layered Care Model through its effect on people's health, experience and independence, alongside the sustainability of services. Measures should show whether care is becoming more preventive, accessible and coordinated, and whether improvements reach populations experiencing the greatest need.

A common outcomes framework should connect the strategic vision with individual clinical models. It should build on existing CTM reporting and the IMTP, with pathway-specific measures added where required.

Measuring what matters

A concise set of measures should provide a balanced view of progress:

Dimension	What CTM should assess
Health and independence	Changes in health outcomes, function, wellbeing and people's ability to manage daily life.
Access and equity	Timeliness of assessment and treatment, unmet need and differences in access or outcomes between population groups and localities.
Experience and continuity	Whether people understand their care, know who is responsible and experience coordinated transitions.
Quality and safety	Avoidable deterioration, complications, unplanned escalation and harm during or following changes in care.
Workforce and sustainability	Staff experience, workload, capacity, resource use and the financial consequences described in Section 6.6.

Activity measures should be interpreted alongside these outcomes. More virtual contacts or fewer admissions do not, by themselves, demonstrate improvement. CTM should assess whether needs are being met effectively and whether additional work or risk has moved elsewhere.

Establishing baselines and

responsibility

Each clinical model should define its intended outcomes, baseline position, measures and accountable owners before implementation. Targets against key performance indicators should reflect the available evidence, delivery timescales and the quality of the underlying data.

6. Enabling the Future Model of care

The Digital and Data Plan provides relevant foundations through dashboards, population insight and the use of patient-reported outcome and experience measures (PROMs and PREMs). These should be combined with operational information and feedback from staff, carers and partners. Where possible, results should be examined by locality and population group to identify whether benefits are distributed equitably.

Using evidence to improve delivery

Review should support decisions about whether to continue, adapt or expand a change. Early implementation should test assumptions and identify unintended consequences, including repeat contacts, delayed escalation, increased carer burden or pressure on receiving services.

The SIDU should use these findings to assess whether the model is delivering its intended benefits and whether changes to design or sequencing are required. Annual IMTP reviews should incorporate this learning into priorities and resource decisions, with more frequent review where safety or delivery concerns arise.

Turning the enablers into ACTION

TM should develop a coordinated plan alongside clinical service design, covering:

- **Workforce**: Align skills, capacity and new ways of working with population needs, the People Plan and People's Experience Plan.
- **Digital and data:** Align the Digital and Data Plan with emerging clinical requirements.
- **Estates, equipment and transport**: Develop an estates plan, identify equipment investment and replacement needs, and plan transport and accessibility arrangements.
- **Partnerships and governance:** Agree delivery responsibilities, executive ownership and the proposed Design Authority's remit.
- **Finance and investment:** Model activity, capacity, costs, savings and wider benefits, including transition funding.
- **Measurement and learning:** Establish baselines, track outcomes and experience, and use findings to improve delivery.

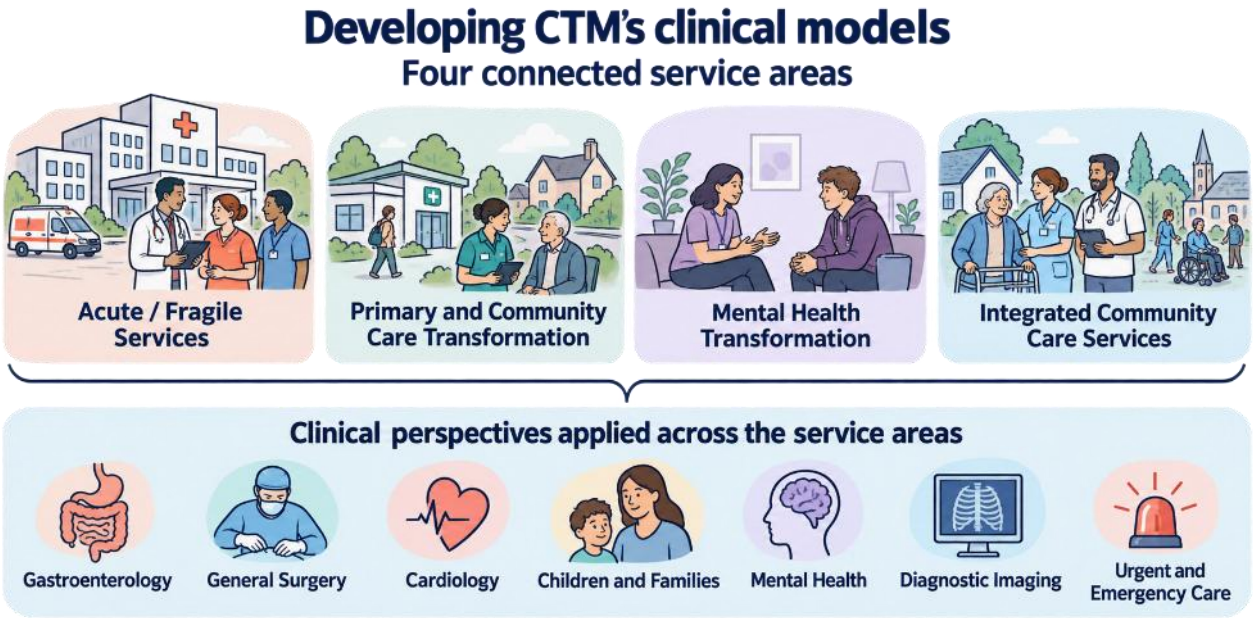


VII Taking the vision forward

7. Taking the strategic vision forward

The strategic vision establishes a common direction for CTM: stronger prevention, coordinated care closer to home and timely access to specialist services when required.

Together, the Case for Change and this vision contribute to the preparation and case-for-change foundations described in Phases 0–1 of the draft NHS Wales Service Change Operating Framework. The next stage should build on this work to develop, assess and refine clinical service options across the areas shown below. CTM should confirm readiness, outstanding evidence and governance requirements before progressing through the framework's subsequent phases.



I. Identify options, engage and refine

In line with Phase 2, clinical teams should work with people, carers, staff and partners to develop options grounded in population need, clinical evidence and CTM's Service Design Principles. Options should be assessed against agreed criteria, supported by demand and capacity modelling and assessments of workforce, finance, estates and digital requirements.

Relevant impact assessments should be developed and updated as options evolve. Engagement should shape the appraisal, with a clear account of how feedback has influenced proposals. The examples in Chapter 5 support this discussion but do not constitute agreed service configurations or determine implementation priorities.

II. Review options, determine consultation requirements and make decisions

In line with Phase 3, CTM should review the options appraisal, supporting evidence and engagement findings through the relevant governance arrangements.

Decision papers and business cases, where required, should explain the options, impacts, affordability, expected benefits and delivery requirements. Executive ownership and the proposed Design Authority's role should be clear, supporting established organisational accountability and approval routes.

7. Taking the strategic vision forward

III. Learn and adapt

For all the approved changes, a phased roadmap should align with the service-change framework and IMTP. Sequencing should reflect clinical need, workforce and infrastructure readiness, partner capacity and affordability, including investment required before activity can move safely.

Each change should have an accountable owner, a baseline and clear measures of success. Initial delivery should test assumptions where appropriate, with outcomes and feedback informing whether changes progress, adapt or pause.

Progression should be proportionate to the scale and impact of each proposed change, supported by the framework's governance gateways and updated evidence throughout.